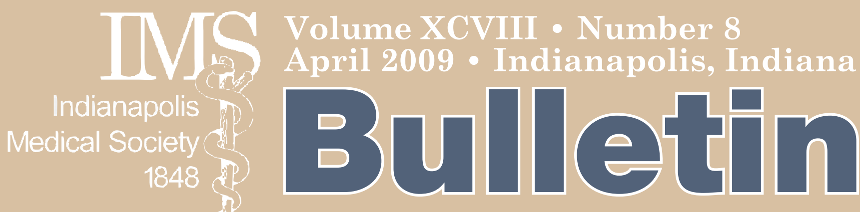

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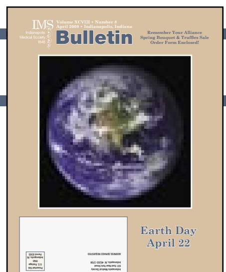

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President's Page

John P. McGoff, MD

"Be thankful we're not getting all the government we're paying for." – Will Rogers

For those of you who are regular readers, you may remember an article I wrote a few months ago about how disillusioned some of the young, idealistic, first time voters were going to be after the November election. Specifically, that all of the many campaign promises President Obama made, would never see the light of day. Well after the first thirty-five days of his Administration, I can say I was definitely wrong. He has a new $787 billion stimulus plan already passed and has proposed a ten-year budget with all of those grandiose campaign promises and then some.

I would like to touch on two topics in this new White House proposal that I think are particularly important to physicians: his new health care agenda and his income redistribution plan. Anyone who thought that the loss of Tom Daschel as the nominee for HHS Secretary would slow this train down was sorely mistaken.

President Obama's comprehensive ten-year budget plan includes a blueprint to create a $634 billion reserve fund as a "first step" towards health care reform. It is described as a "down payment" and it will probably end up to be over a trillion dollars by the time it is fully implemented. The plan's stated goal is to "put the United States on a clear path to cover all Americans."

As it stands now the budget blueprint provides only general guidelines on the reserve funds creation and its use. Here are of the few highlights contained in the recently released document.

Health and Human Services

The agency will actually get $1.6 billion less in 2010 than the previous budget, but it emphasizes healthcare information technology ($19 billion was already included in the stimulus bill) and use of cooperative effectiveness research to determine the most effective therapies and treatments for certain conditions. Be sure and stay tuned on how this is going to affect your practice.

Drug Prices

The new plan will negotiate with drug makers to reduce prices, similar to European models, and will speed access to generic drugs. No estimate has been given on savings for capping biotech company's market exclusivity for their new biologic drugs at 12 years. However, if you happen to have any pharmaceutical stocks in your 401K, see how the market reacted to these proposals. There will also be a "substantial" boost in funding to the FDA to improve drug safety.

There will be an increase for wealthier beneficiaries to pay higher Medicare Part D premiums and will call for pharmaceutical companies to increase rebates on drugs sold to Medicaid patients from 15-21%, resulting in a savings of $19.5 billion over the next decade.

Workforce Shortages

To address shortages, the plan allocates $330 million to be used towards loan repayment programs for physicians, nurses and dentists, who will work in underserved areas, as well as $73 million for improved access to care in rural areas.

Physician Payments

Noting that the SGR formula used to calculate Medicare payment changes would reduce payments by 21%, the proposal resets the budget baseline to zero taking the automatic cut off the table for now. No other details are provided in the document. It also signals the desire to tie incentives to the quality, rather than the amount of care provided.

Hospital Payments

Changes in reimbursement will include bundled payments intended to cover the cost of care for Medicare patients during their stay and 30 days post discharge, which will net $17 billion in savings over ten years.

Imaging Costs

To help build the proposed reserve fund, the plan would task radiology benefit managers to reduce Medicare imaging costs by a projected $70 million over the next 5 years and $260 million over the next decade.

Cancer Research and Disease Prevention

There is $211 million for autism research, screening and public awareness, as well as an additional $6 billion for NIH cancer research, which double current expenditures. One billion in new funding for community based programs for disease prevention and healthy behaviors. The budget includes funding for enhanced emergency care systems and expands treatment for addiction and substance abuse. It provides resources to reduce health disparities, which the President has identified as an important goal of his Administration.

This is just the opening salvo and must wind its way through Congress. Perhaps you noticed that your practice may be affected in one of those areas mentioned. It is

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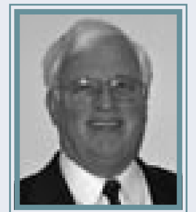

Past President's Perspective

Bernard J. Emkes, MD

The Demise of Common Sense!

In a prior editorial, I mused that there is a lack of common sense in regards to HEDIS measures. Requiring shots to be given prior to 2 months of age, when it makes no difference that they are given 3 or even 10 days later shows an extreme lack of common sense. Measuring 2 month immunizations at 3 months makes a lot more sense, and allows for appropriate leeway in the timing and completion of the measure with no change in outcome.

But the world in general, and health care specifically, seems to have lost all vestiges of common sense. In part, this has been dictated by the drive to reduce the rate of increase of health care costs and payment methodologies that vary from insurance plan to insurance plan. There is an old adage that says *rules are developed so as to avoid thinking*. That is nowhere truer than in health care. And now there is even another perverse twist on the "rule of rules." Now *"guidelines"* are being interpreted as rules, and applied for economic reasons and to avoid thinking – or to avoid applying common sense.

There are two nationally recognized sets of *guidelines* to determine at what level a patient should receive care. InterQual is a fairly straight forward set of *guidelines* that proscribe the "severity of illness" and "intensity of services" required to be an inpatient in a hospital. If these *guidelines* are not met, then Outpatient or Observation may be the more appropriate setting for the care rendered. Milliman Care Guidelines® is another *guideline* set that is being increasingly used by payers. This set is more process driven with expected progress defined day by day but with many exceptions for complicated patients or complex care. But Observation status under both of these sets of *guidelines* is time specific and cannot be continued forever. Observation status is used to determine the need for full inpatient hospitalization. If recovery is rapid, turn around is quick, and medical interventions are minimal, then Observation may be an appropriate setting.

However, BOTH of these sets are simply *guidelines* – and the patients are receiving the exact same care as prescribed by the attending physician whether Inpatient or Observation. It all comes back to payment methodology. Some payers pay differently if the patient is in one status or the other. And there is also the employer reporting angle. If a payer can report less "days per thousand" (this measure counts inpatient days only) to an employer, that somehow implies better "utilization management" and therefore lower costs for the employer. What employer does not want to hear that?

But here is the catch – the descriptors clearly state that these *guidelines* are meant for 85% or so of the population and for those cases where status is driven by a single diagnosis. Now I don't know what other physicians are seeing, but that patient with only one diagnosis is as rare as a unicorn – at least that is the case at our facility.

The developers of these *guidelines* tell us they are meant for non-physician health care reviewers and also constantly say that "physicians are not bound to these *guidelines"* and medical expertise must be interjected for exceptions and more appropriate application of these *guidelines*. There is a first and second step in the process of using these "*guidelines*." Nurses or other health care workers using these *guidelines,* and in discussions with other non-physician health care providers at hospitals, may believe that a lower level of care is proper. If there is disagreement, plans have developed a "peer to peer" process. An attending physician can discuss the case with a plan medical director, and hopefully resolve an impasse over approval of a procedure, or status of a patient.

In my experience, the "getting it right" or common sense resolution is rare. Plan medical directors, who are paid physician salaries, often default to *"the guidelines"* as law, scripture or whatever term one might choose to avoid thinking. It is therefore unclear to me why a physician needs to be paid by a health plan to read *guidelines*. Some plans do it well – but many do not apply medical expertise properly.

A lot of health care costs could be reduced by cutting out this layer. Very high priced physicians are reading what could be read by underlings. Oh, but wait, only a physician can deny care in Indiana. But most medical directors don't even want to assume that level of responsibility. Remember the disclaimer – we are only making decisions about what is paid for, it is always expected that the attending physician will do what he/she deems is necessary and appropriate for the patient.

That's right – attending physicians are expected to use common sense and provide the services necessary to diagnose and treat patients properly, but insurance plans default to *guidelines* to decide whether they will pay for a given service. Does this make any sense? Does this pass the "sniff test?" Of course not!

And where does this lead? One plan currently seeking NCQA accreditation, is expending resources trying to coerce doctors to get their children in prior to 8 weeks for first immunizations. If we can agree that it really makes no difference whether a child gets an immunization at 7.6 or 8.2 weeks, then why are we wasting precious health care resources on teaching doctors to be better managers of stressed out parents?

And since administrative costs for health care in America are 10% or more higher than in Great Britain, France or Canada, one wonders how much of that cost is

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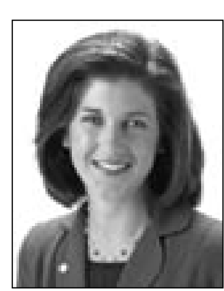

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Bulletin Board

William H. Beeson, MD, IMS Past President, is a Knox High School Hall of Famer 2009. Dr. Beeson participated in Cross Country – 3 years, Track – 4 years, Basketball – 4 years and was the 1969 Recipient of the Ben Bowen Award. *Photograph Courtesy of Knox High School*

Heidi M. Dunniway, MD, IMS Immediate Past President, was recently named as vice president of medical staff at St. Francis Hospital at Beech Grove and Indianapolis campuses.

John J. Wernert, MD, IMS Past President, was elected to the American Psychiatric Association (APA) Area IV Trustee position. Dr. Wernert has been an active participant on the national and local levels.

Donald L. Cline, MD, has announced his retirement and closure of his office, Reproductive Endocrinology Associates as of April 30, 2009.

Jeffrey R. Ginther, MD, has joined Riverview Orthopaedics and Sports Medicine, part of the Noblesville-based Riverview Medical Group.

Alan Bercovitz, MD, joined the Indianapolis-based St. Vincent Physician Network as a family practice physician.

Elizabeth D. Kline, MD, internist, was the ISMA Medical Mission Scholarship winner November 2008.

Douglass S. Hale, MD, Urogynecology Associates, Director Female Pelvic Medicine and Reconstructive Surgery Fellowship, Associate Clinical Professor: Indiana University/Methodist Hospital, was one of four faculty to participate in the first ever CME Webinar for the American Urogynecologic Society on "Avoidance and Management of Mesh Complications in SUI and Pelvic Floor Repair Surgery" in January, 2009.

Dr. Hale also recently presented "Cystocele Repair," "Evaluation and Treatment of Anal Incontinence," "Sacral Neuromodulation for Pelvic Floor Disorders" and "Robotic-Assisted Laparoscopic Pelvic Surgery" at the American College of OB/Gyn National 3 day course in Chicago, Illinois in November, 2008.

Dr. Hale along with former fellows, published in the *Journal of Pelvic Medicine & Surgery*, "DaVinci Assisted Laparoscopic Abdominal Sacral Colpoperineopexy" and Dr. Hale published a second article. "History of DaVinci and Robotic Surgery in Gynecologic Surgery."

Rick C. Sasso, MD, Indiana Spine Group, published an article in the peer-reviewed internationally journal, Spine. The article details a study comparing the functional outcomes after cervical disc replacement or anterior cervical fusion versus the functional outcomes seen after total hip and total knee arthroplasty.

Dr. Sasso was the guest keynote lecturer at the AO Spine North America Annual Meeting presenting, "Current Concepts of Cervical Artificial Discs," and "Excellence in Spine: Advanced Concepts in the Management of Spinal Disorders" in Sun Valley, Idaho in February 2009.

Martin C. Were, MD, *(photograph unavailable)* Regenstrief Institute, earned an American Medical Informatics Association 2008 prize for Best Student Paper published in the March/April 2009 issue of the Journal of the American Medical Informatics Association. The study was "Using Computerized Provider Order Entry and Clinical Decision Support to Improve Referring Physicians Implementation of Consultants' Medical Recommendations." The study reports on the success of a physician decision-support tool developed by Dr. Were and colleagues at the Institute.

Alan Bercovitz, MD

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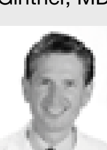

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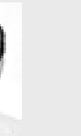

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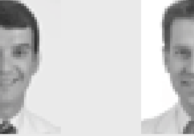

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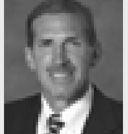

K. Donald Shelbourne, MD

Scott E. Urch, MD

John J. Wernert, MD

News from Shelbourne Knee Center at Methodist Hospital ...

K. Donald Shelbourne, MD, and his partner, **Scott E. Urch, MD,** conducted and presented the first of its kind study specifically examining teenage athletes' ability to return to competitive sports after undergoing ACL reconstructive surgery. The study was presented at the 2009 Annual Meeting of the American Academy of Orthopedic Surgeons (AAOS) in Las Vegas in February 2009.

Dr. Shelbourne gave three presentations, "Articular Cartilage Lesions Are Over-Treated," "Treatment Algorithm for Patellofemoral Dislocation or Malalignment" and "Single-Bundle ACL Reconstruction," at the Metcalf Memorial/Arthroscopy Association of North America Winter Meeting in Sun Valley, Idaho in February 2009.

News from Indianapolis Neurosurgical Group ...

Thomas J. Leipzig, MD, served as course director for the American Association of Neurological Surgeons' Weekend Update: Review of Clinical Neurosurgery by Case Management in Scottsdale, Arizona in February. He also lectured on cerebrovascular issues.

Jean-Pierre Mobasser, MD, spine surgeon, was a clinical instructor/faculty for Medtronic's minimally invasive spine surgery course held in Las Vegas in February 2009.

Two staff members from ING were named as finalists in the Indianapolis Business Journal's Health Care Heroes Awards. **Terry G. Horner, MD,** was a finalist in the Physician Category for his years of practice in the field of neurovascular surgery. **Aaron A. Cohen-Gadol, MD,** was recognized for his innovations in neurosurgery by being named a finalist in the Advancements in Health Care Category. Dr. Cohen-Gadol performed a hemispherotomy on a 20-month-old boy who suffered 30-40 seizures per day since his birth. Soon after surgery, the boy caught up with his developmental age, having been at a three-month-old developmental stage before surgery.

Eric A. Potts, MD, presented "Transcervical Odontoidectomy" at Grand Rounds at Clarian Health on February 11, 2009. IMS

Letter to the Editor

Who's Watching The "Watchers?"

We came home from work yesterday (03/04/09) only to have our profession assaulted on the front page of the newspaper. Apparently, a few doctors … none reported in Indianapolis … are asking their patients to sign an "I Will Not Talk Bad about My Doctor On-line Contract." Maybe this is an issue, maybe it isn't. The real question should be: **WHERE ARE ALL THE REPORTERS, WATCH DOG GROUPS, AND BLOGGERS WHEN IT COMES TO OUR PATIENTS BEING DENIED CARE?** Why do **WE PHYSICIANS** get maligned for the actions of a few over non-patient care issues, and we get no help trying to give our patients the care they need? It brings to mind the movie, "Network," where the actor shouts, "I'm mad as HELL, and I'm not going to take it anymore!"

Our Government, in its wisdom, has devised many plans to watch over our profession to prevent physicians from unnecessarily "padding" their personal bank accounts. We believe they do need somebody "watching the watchers," because our patients are being denied necessary care. MHS; i.e., Managed Health Services, is one of the three Managed Care Organizations for Hoosier Healthwise and the CHIP Program.

MHS decided that a child with Autism, reflux, and aspiration pneumonia did not need hospitalization after an endoscopy and bronchoscopy because the child had not desaturated or sufficiently aspirated under anesthesia.

Then, there was the 2 year-old with Cerebral Palsy and severe asthma requiring steroids and was denied feedings through his G-tube because the boy was above the 50th percentile in weight. Hello? Did it occur to the reviewer that the steroids may have resulted in non-muscle weight gain? Should we really wait until this child is malnourished to feed him?

Or, the child who needed two holes in her heart repaired and the doctors/hospital were going to have to do this as an OUTPATIENT! Incredulously, the only way this child could get her procedure approved prior to surgery was to be admitted for 3 days of "Observation." Only after three more calls … **and** direct Medical Director intervention … was the Inpatient Approval "granted."

How about the Pediatric Pulmonologist who wanted to admit to the hospital a child with Cystic Fibrosis for pneumonia – the fifth episode of pneumonia in 2 months. He was told that if an urgent admission was required he should send the child to the ED and admit them through the ED. *This simply makes no sense.* Doesn't a Pediatric Pulmonologist know more about Cystic Fibrosis than an ED doctor?

How about the Oncologist who saw a child, who lived 90 miles away, and diagnosed a neutropenic fever – the same recommendation – "Send them to the ED"? If the patient goes through an ED, then the Managed Care Organization has 72 hours to decide if the admission is required. The Oncologist literally carried this child into the ED, along with the antibiotics that had already been ordered to combat the neutropenic fever. Yes, the child *did* get admitted through the ED, but is this the **best care** we can give?

A large ENT group in Indianapolis reached their wits end, and finally, in desperation, they had to throw in the towel and say "no more patients" to MHS, as well as another Hoosier Healthwise Plan – MDwise Hoosier Alliance. Did they say that because they weren't getting even 20 cents on the dollar? NO! Did they do that because they were spending hours on the telephone getting pre-certs? NO! They did it, because they felt the better of the two options – not participate vs. give bad care – was to not participate!

Today (03/05/09), we learned that a child with persistent ear infections and an effusion since early December … after being treated almost continuously with antibiotics of various types … was **denied** ear tubes, because there were not 5 separate infections defined!

Regrettably, all of the instances above were actual patients and occurred as written. Two authors of this article were directly involved in the care of these patients.

Physicians will take almost anything. We will let Angie's List rate us. We will pay to jump through hoops so we can get paid less than 20 cents on the dollar. We will put up with a lot. **BUT ONE THING WE WILL NOT DO IS ACCEPT BAD CARE FOR OUR PATIENTS!** Funny thing, when the ENT group threw up their hands and said, "No more," MHS was willing to use the ENT specialty society's national guidelines for pre-certification. Should physicians have to quit in order to get the local companies to adopt scientifically-proven national diagnostics and treatment guidelines?

The Managed Care Organizations seem to be using the Milliman Guidelines. Yes, these are nationally-developed (with MD input), and yes, they are accepted *guidelines*, but they are being interpreted as "rules" which they are **not.** If the Milliman Guidelines are used as Rules, then one fails to allow for variation, multiple diagnoses, or co-morbidities. These guidelines are meant for one-diagnosis patients and, even then, only apply to 85% of the population. It is the lack of flexibility, the rigid application of guidelines as rules, and the inability to understand complex medical situations that are leading to what was referred to as "Moral Distress" in a New York Times article published February 6th, 2009.

What can we do to fix this for our patients? Maybe together we can get MHS, and others like them, to adopt nationally-recognized standards to help physicians like us deliver good, cost-effective medicine!

Perhaps eliminating some of the "watchful" oversight would allow more dollars for patient care.

Dr. Paula A. Hall, IMS Past President
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Money Sense

By James F. Ade

Six Ways to Help Safeguard the Future of Your 401(k)

Extreme market volatility has disrupted even the most sound retirement accounts, throwing asset allocations out of balance and risking future growth. Here's how you can get your 401(k) plan back on track.

For most 401(k) investors, the economic and market turmoil has had a sobering effect on their employer-sponsored plans. Still, as difficult as it may be to review your 401(k), now is an important time to take a hard look at the way your plan is constructed. Bull markets mask flaws in a portfolio, because people tend to take gains for granted. But when markets struggle there's less margin for error, so underperforming investments or imbalances in the way your portfolio is structured can really stand out.

A careful review of your 401(k) can help you identify changes that can strengthen this important retirement vehicle. Here are six ways to help you correct any imbalances in your plan that the market may have created, and position your retirement plan for better times ahead.

Check your diversification. A 401(k) plan might offer 15 or 20 fund choices, ranging from conservative fixed income to aggressive growth equity funds. Yet, many 401(k) participants' investment dollars are concentrated in just two or three funds. This is especially risky in a contracting market, because holding even one or two underperforming funds could have a damaging impact. Investment in five to seven funds spreads risk while keeping management relatively simple.

Rebalance. Make sure your choices reflect your personal risk profile and your nearness to retirement. For example, a moderate investor might target a mixture heavily weighted to large-cap growth funds, large-cap value funds and fixed income, with significantly less in international equities and cash. But market volatility can easily skew those proportions—some funds may drop sharply while others maintain their value or even gain. As a result, your asset allocation will change without any deliberate steps on your part.

You should consider your 401(k) in the context of your overall assets. The sum total of your holdings—not just your 401(k) investments—needs to be in balance. It really pays to sit down and discuss all your retirement assets with your Financial Advisor.

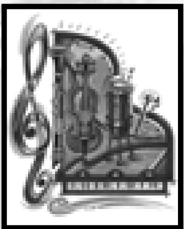
Identify poor long-term performers. Checking each fund you hold against its peers can help you determine whether that fund's performance, good or bad, is due to market forces or underlying fund problems. You can tell how a given fund has performed over the past one, three, five and 10 years, relative to an index of similar funds provided by monitoring agencies such as Morningstar or Lipper. You could have a good fund manager who performs badly in a given year, but if the longer perspectives also show the fund underperforming against the respective benchmark, you may want your money in another fund.

Assess fund fees. Some funds charge fees (typically a percentage of your overall purchase) when you buy shares, and again when you sell. This can become costly as you adjust your portfolio. Funds that charge according to the "net asset value" of your holdings don't carry these transaction fees—there are no additional charges for buying or selling as you see fit. When checking fees, that should be the first thing you consider.

Keep in mind that individual funds vary widely in terms of their operating expenses. Check the operating expenses for your holdings against the average for those in your plan and the benchmarks for similar funds, using guidelines from Morningstar or Lipper. A financial advisor can help you make these comparisons.

Implement changes carefully. Fixing your portfolio during a troubled market raises a fundamental question: How can you avoid losses from selling at depressed prices? If your portfolio is only moderately imbalanced, one simple strategy is to apply your changes moving forward with each new contribution from your paycheck. Over time, your assets can rebalance without selling a large number of shares.

Continued on page 34.



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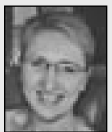
Surgery, 1994
Thoracic Surgery, 1997, 2006
Pediatric Cardiothoracic Surgery
University of Chicago, 1986



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Ofc – 542-0566
Fax – 682-4756
Email – conner@indyhousecalls.com
Web – www.indyhousecalls.com
Internal Medicine
Indiana University, 2005

Ertl, Janos Paul, MD
University Orthopaedic Associates
541 Clinical Dr., #600
46202-5233
Ofc – 630-6192
Fax – 630-8868
Orthopaedic Surgery, 1993, 2004
Orthopaedic Trauma
Loyola University, 1981

Goodman, Michael J., MD
Cancer Care Group, PC
St. Vincent Oncology Center
8301 Harcourt Rd., #100
46260-2082
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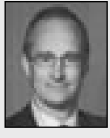
Radiation Oncology
Indiana University, 1986

Haider, Kathryn M., MD
IN Pediatric Ophthalmology/Strabismus
702 Rotary Cir.
46202-5175
Ofc – 274-8103
Fax – 274-1111
Ophthalmology
Pediatric Ophthalmology
University of Wisconsin, 2003



Hanan, Scott A., MD
CorVasc MD's, PC
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Surgery, 1992
Thoracic Surgery, 1994, 2004
University of Oklahoma, 1984

Koelsch, Michael G., MD
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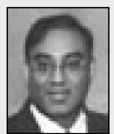
Surgery, 1997
Thoracic Surgery, 1999, 2007
Chicago Medical School, 1991



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Surgery, 2000
Surgical Critical Care, 2000
Thoracic Surgery, 2002
Vascular Surgery
Stanford University, 1992

Kouzmova-Moneva, Miroslava, MD
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Internal Medicine, 2000
Endocrinology, Diabetes & Metabolism, 2002
Plovdiv Medical Academy, Bulgaria, 1988

Miller, James C., MD
University Neurosurgical Assoc.
545 Barnhill Dr., EH 139
46202-5124
Ofc – 274-0272
Neurological Surgery
University of Iowa, 2000

Monev, Stefan D., MD
Rheumatology & Osteoporosis Spec.
St. Francis Hospital
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46237-8637
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Plovdiv Medical Academy, Bulgaria, 1985

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In Memoriam

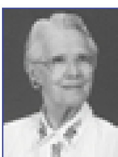
Fred Madison Wilson, MD
1914 - 2009

Fred Madison Wilson, MD, 94, Professor Emeritus of Ophthalmology, Indiana University School of Medicine, died January 23, 2009 in his home in Winter Haven, Florida, after a long battle with multiple myeloma. Dr. Wilson was born March 19, 1914 in Chicago, Illinois.

Dr. Wilson earned his pre-medical (1936) and medical degrees (1939) from Indiana University. He served a rotating internship at St. Vincent's Hospital, Indianapolis from 1939-1940. From 1945-1946, he studied at NYU Graduate School of Medicine in Ophthalmology in New York. Dr. Wilson returned to IU Medical Center as a Resident in Ophthalmology 1946-1948. From 1948-1949, He was an Ophthalmology Medical Instructor at the University of Illinois College of Medicine in Chicago.

A veteran, Dr. Wilson served as a Captain from 1942 until December 1945.

In private practice and serving on the faculty of IU Medical School, Dr. Wilson became Chairman of the Ophthalmology Department. He retired in 1979 after reaching the mandatory retirement age of 65.



Emma Jane Brownley, MD
1921 - 2009

E. Jane Brownley, MD, 87, Pediatrician, died February 9, 2009. Dr. Brownley was born in Princeton, Indiana on March 9, 1921.

Dr. Brownley entered nurses training in 1940. While working as a nurse, she attended Indiana University studying anatomy prior to entering medical school in 1949. She graduated from Indiana University School of Medicine in 1952 as Vice President of her class. Dr. Brownley interned at Salt Lake County General Hospital in Salt Lake City, Utah. She completed her pediatrics residency at Colorado General Hospital, Denver, Colorado and Riley Hospital for Children, Indianapolis, Indiana.

Dr. Brownley was in private practice in Speedway beginning in 1955. She retired in 1985.

An avid sports fan, Dr. Brownley enjoyed watching IU sports, camping, tennis and softball. She also traveled extensively to Europe, Central America and the Caribbean.

When she was honored in 2002 as a 50-year member, she remarked, "I very much appreciate what the Medical Society has done for me and my colleagues over the years. As for me, the private practice of Pediatrics was a big part of what I like to call a wonderful life."

John Henry "Jack" Warvel, Jr., MD
1930 - 2009

Dr. John Henry "Jack" Warvel, Jr. 78, passed away on March 4, 2009. He was born July 8, 1930 in Indianapolis, Indiana. He was a graduate of Harvard College, John Hopkins Medical School and completed a Fellowship at the Mayo Clinic.

Dr. Warvel was a member of Phi Beta Kappa and the Alpha Omega Alpha Honorary Medical Society. He served as a Captain in the U.S. Army Medical Corps, where he was Chief of Internal Medicine at the Seoul Military Hospital at Seoul, South Korea. There he also served as personal physician to General William Westmoreland.

Dr. Warvel joined his father's medical practice in Indianapolis in 1961, specializing in diabetes and endocrinology. His career spanned several decades, during which he served both as doctor and teacher. Dr. Warvel was known by his patients as an engaged and concerned doctor who was focused on their welfare, and by his colleagues and students as a tough and demanding physician whose aim was excellent patient care. He established one of the country's first Diabetes Patient Education Programs at Methodist Hospital. He was also a founder and advocate of the Indianapolis Diabetes Association.

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In Summary

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Clarian Health earns distinction and national recognition for its Advanced Ventricular Assist Device program

Clarian Health is the first hospital in Indiana to earn the Gold Seal of Approval™ and a Certificate of Distinction for its Advanced Ventricular Assist Device program. This distinction was awarded by the Joint Commission, the nation's predominant standards setting and accrediting body in health care, based on a review of compliance with national standards, clinical guidelines and outcomes of care.

To earn this distinction, Clarian's ventricular assist device (VAD) program must undergo an extensive, unannounced, on-site evaluation by a team of Joint Commission reviewers every two years. The program is evaluated against Joint Commission standards through an assessment of a program's processes, the program's ability to evaluate and improve care within its own organization, and interviews with patients and staff.

St. Francis is local host for national teleconference on how diversity affects end-of-life care

The St. Francis Palliative Medicine program will be the local host of a national teleconference focused on how diversity influences end-of-life decisions.

The Hospice Foundation of America's 16th annual National Bereavement Teleconference "Diversity and End-of-Life Care" is 1:30 p.m. to 4:30 p.m., Wednesday, April 29.

The program will be moderated by Frank Sesno, professor of media and public affairs at the George Washington University and a special correspondent with CNN. He will be joined by several medical experts, counselors, educators, and representatives from various cultural and faith-based organizations.

One of the goals of the teleconference is to examine the impact culture has at the time of death and bereavement.

Locally, the conference will be from 1:30 p.m. to 4:30 p.m., Wednesday, April 16. It will be broadcast at the St. Francis Hospital auditorium, 1600 Albany St., Beech Grove.

Rhi Sports Program Awarded Grants From Christopher And Dana Reeve Foundation, Craig H. Neilsen Foundation

Rehabilitation Hospital of Indiana Sports Program (RHISP) today announced that it has recently been awarded grants from both the Christopher and Dana Reeve Foundation and the Craig H. Neilsen Foundation.

The Christopher and Dana Reeve Foundation awarded RHISP with a $16,645 Quality of Life grant. Conceived by the late Dana Reeve, Quality of Life grants go to programs or projects that improve the daily lives of people with paralysis, with some emphasis on, but not limited to, paralysis caused by spinal cord injuries. Mrs. Reeve started the Quality of Life grants program to recognize and support organizations that help disabled individuals, their families and caregivers in ways that more immediately give them increased independence, day-to-day happiness and improved access.

Thirty-seven thousand dollars ($37,000) is also on its way to RHISP, thanks to The Craig H. Neilsen Foundation. This foundation's primary mission is to find a cure for spinal cord injury (SCI). Established in 2003, the foundation has funded programs supporting SCI research and rehabilitation, cancer research and children's charities. These programs include funding for basic scientific study, co-sponsoring the first-ever national SCI Summit and underwriting a fellowship to train physical medicine and rehabilitation doctors.

Continued on page 30.

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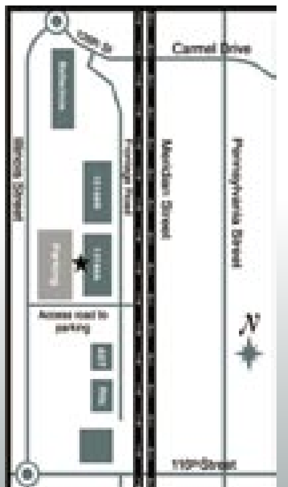

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Project Health

Carrie Jackson Logsdon, Director

Thank you, Meredith W. Cousin, MD

Meredith W. Cousin, MD, JWM Neurology, is Project Health's Volunteer Physician for the month of April. Born in Chicago, Dr. Cousin attended the University of Illinois College of Medicine, and Northwestern University Medical School for her residency and fellowship. Her primary specialty is Sleep Disorders and she is also interested in Epilepsy.

Her father was a Family Physician and she occasionally helped him, so by the time she was in junior high school, she knew she wanted to be a doctor. She said it took her awhile to decide what specialty attracted her. "Northwestern had a good sleep program, and after some exposure to that, I made up my mind." She credits Mark Alberts, MD, a stroke specialist at Northwestern as her greatest mentor. "He was very easy going and approachable whenever I had a question, so I spent a lot of time learning from him." As a result, she said stroke is still one of her interests.

Dr. Cousin came to Indianapolis and JWM because she wanted to be part of a larger group. "Neurology and Sleep Medicine are much harder to do in small groups." She said Indianapolis reminds her of a smaller Chicago atmosphere – most of the good parts and not many of the bad parts.

"We work closely with the Otolaryngologists to identify those patients who have true Sleep Apnea," said Dr. Cousin. "When we get a new doctor in our practice, we go around to lots of practices and do face-to-face visits and distribute sleep questionnaires that help them decide whether or not a sleep study is warranted." The doctor should ask the patient or spouse:

1. Do you snore?
2. Do you gasp for breath at night?
3. Do you have daytime sleepiness?

Sometimes spouses are more helpful than the patients, because the spouses are awakened by the snoring. "Wives can lay there and count the number of seconds the husband is not breathing before they start gasping for breath. What a lot of people don't realize is that the snoring puts one at risk for heart attack, high blood pressure, stroke, and lung problems. Studies on COPD patients show these patients almost always have Sleep Apnea, unless proven otherwise."

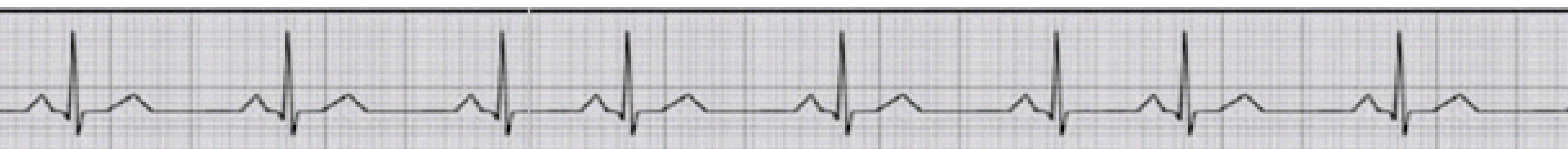
These days, Otolaryngologists won't do nasal surgery without a sleep study first. "They need to know exactly which anatomical part is causing the problem before they try to solve it with surgery." Dr. Cousin noted that surgery is only effective 50-60 percent of the time. Often, a CPAP machine is the only answer, and from their patient feedback, patients wouldn't give their CPAP machines up for anything.

Dr. Cousin says 2 percent of women and 4 percent of men have Sleep Apnea to the degree that they actually stop breathing in their sleep. Oddly enough, 3 to 5 percent of pregnant women and women in menopause have Sleep Apnea. Obesity puts one at risk.

Today's CPAPs are much smaller and very quiet so people can easily travel with them. "We have an 85-90 percent compliance rate with CPAPs. As with most treatments, follow-up is crucial. If you have a patient who is leery of this treatment method, they are also the most non-compliant patients." She revealed that Project Health patients are very compliant. "They have been so miserable for so long that to wake up without headaches, fully refreshed, thinking more clearly than ever and not falling asleep during the day makes them very grateful."

Dr. Cousin doesn't have much time for leisure activities, but she would love to take pottery classes. Her husband and kids are fans of Krav Maga, an Israeli self-defense class. "I've started exercising more and love to swim at the YMCA. We've signed up for triathlons in the past, but every time we've done that, I get pregnant." She wants to sign up for the Chicago Triathlon in the fall. We wish her great success in whatever she strives to do!

Project Health is very grateful to Dr. Cousin for giving so much to our patients. IMS



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Practices That Set The Standard

President's Page *(Continued from page 7)*

imperative that organized medicine follows this dialogue closely as it unfolds and works with our Congressional delegation to ensure that our patients are protected, as well as allowing for the continued viability of our practices.

The Administration said it hopes the plan includes a "little bit of pain" for every major healthcare stakeholder, and "that the appeal of insuring millions more people" will outweigh the objections to those changes. You have to ask yourselves how much more "pain" can we endure?

The more disconcerting piece of the budget plan is how to pay for this ambitious proposal. Half of the funding for the $634 billion dollar program is by a provision that would cap itemized deductions for Americans who make more than $250 thousand dollars. These changes would be phased in over the next few years. The other half would be achieved by cost savings to federally funded health programs, including $177 billion over the next decade by restructuring Medicare Advantage programs through a regional competitive bidding system.

Most physicians I have spoken with are conflicted. While all agree universal access is important, but at what cost? A good number of doctors will be caught by a combination of an increased tax rate on capital gains and their income, as well as a decrease in the ability to deduct their mortgage interest and charitable donations. Many of the physicians I know have a similar story to mine. We put ourselves through college and medical school with a combination of summer jobs, student loans and scholarships. We spent some 11 to 15 years, depending on your specialty, after high school graduation learning to become physicians. It represents years of incredible hard work and personal sacrifice.

To be a physician is one of the most rewarding careers one can have and that reward comes from not only knowing that you have somehow improved the health of others, but also with monetary remuneration. Many physicians are now being lumped in with Wall Street millionaires, because they have crossed that threshold of the group of "rich" people the President wants to make pay more. This small subgroup of people making more than $250,000/year, if taxed at ***100% of their income*** generates less than a trillion dollars, which is not nearly enough to fund the ambitious goals of this budget plan, which include not only a new agenda for health care, but education and the environment. Will there be incentive for future physicians to work that hard, if you are only going to be told your not giving enough?

As Hoosiers, we like gradual change and anything too radical we tend to be wary. With a market that is in a free fall, dropping 31 % in the first six weeks of our new President's administration, I think we will need Congress to step back, take a deep breath and have some prudent deliberation before considering many of these proposals. IMS

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Past President's (Continued from page 8)

related to the lack of common sense in the system today. Huge efforts on the part of physicians to get necessary care for their patients (and have that paid for), denials of care based on *guidelines* interpreted as rules, inadequate application of reason in medical necessity determinations and all the appeals, responses to appeals and second appeals for services HAVE to be a big part of that high administrative cost. If we cut all that out, and simply applied 10% of $2.2 trillion dollars to the actual care of individuals, I wonder what a difference we could make. Yes, that is $220,000,000 in administrative costs that are NOT present in other countries.

Let's get back to using some common sense to reduce health care costs! IMS

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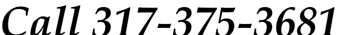

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Indiana **Professional Licensing Agency** PLA

Kristen Kelley, Director

Renewal season opens in April

All licensed physicians will be receiving renewal notices in the mail starting late April 2009. Please make sure that the Indiana Professional Licensing Agency has your most current address. Address changes can be emailed to *pla3@pla.IN.gov* along with your license number. The renewal notice will look different this year. **It will be in the form of a letter and will be mailed in a window envelope.** The notice will inform you of the need to renew your current MD/DO license as well as your Controlled Substance Registration with the State of Indiana. I strongly encourage everyone to renew online by visiting *www.pla.in.gov* and select the "License Express" option. The renewal fees have remained the same.

For the last few years the MLB has participated on the Indiana University School of Medicine's Workforce Taskforce. From the discussion of the taskforce one element was considered critical and that was the data collected by the surveys administered during the renewal of health care providers. The surveys have been conducted every two years for the last decade and are instrumental in determining workforce development issues that face Indiana.

The online survey is administered by the MLB on behalf of the Indiana Department of Health to capture current, relevant information about how the practice of medicine is administered in Indiana. Hardcopy surveys have become cost prohibitive to be administered therefore there is a need more than ever for renewals to be completed online. The survey is considerably shorter than in years past so it should literally only take a minute.

As with any online transaction, there are fees associated with renewing online. These fees are not collected nor in the control of the MLB and are a product of the credit card company and online provider. As you will find, the fee is in addition to the renewal fee. MLB and IPLA are consistently working to reduce these fees as we recognize they pose a burden to completing an online renewal.

If you are renewing a CSR (controlled substance registration) in addition to your medical license, please make sure you leave the section called "group" checked. This is not to renew a group of physician licenses, it is to renew your personal group of licenses – your medical license and all controlled substances registrations you have that are current.

Thank you in advance for your time and consideration of submitting your renewal online and completing the survey.

If you have any questions or concerns regarding your renewal, please email the Medical Licensing Staff at pla3@pla.IN.gov.

On-line license verification

The MLB has a new on-line secure official license verification system. Physicians, Hospitals etc. may go online and obtain an official license verification. The fee for each verification is $10.00 along with a minimal processing fee. Licensees would also need to use this system for official license verification to be sent to another state licensing Board, via email, as we will no longer be processing the paper verifications. This service can be accessed at *http://www.in.gov/pla/license.htm.* IMS

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CME & Conferences

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Community Hospital East

Second & Fourth Wednesdays — Chest Conference (Case Presentations)
Room 3436, 7:00 - 8:00 a.m.

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.

Third 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

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

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

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Friday, May 22, 2009
Emergency Medicine Symposium
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Friday, September 25, 2009
Arrhythmia and Heart Failure Symposium
The Renaissance Hotel
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Friday, December 4, 2009
Update in Cardiology
Location TBA

Visit *www.cardiofoundation.org* for program details and to register online. For more information, contact Suzanne Brown, (317) 338-6089.

Indiana Psychiatric Society

Spring Symposium
Appropriate Usage of Stimulants and Psychotropics in Unique Pediatric Populations
Saturday, April 25, 2009
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Local speaker experts include Dr. David Dunn (IU School of Medicine), Dr. Caroline Carney-Doebbeling (Indiana Office of Medicaid Policy & Planning) and Dr. Lynn Bradford (MDwise). Non-pharma event. Thanks to Indiana Office of Medicaid Policy & Planning, MDwise and Division of Mental Health & Addiction for their financial support.

For more information or to register, visit www.pdallc.com.

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April 1-2 — First International Cardiovascular Conference
Focus on the Middle East
IUPUI Campus Center, Indianapolis

April 4 — Colonoscopy and Endoscopy Technology Workshop
University Place Conference Center, Indianapolis

April 4 — Practical Pearls:
General & Community Pediatrics 2009
Ruth Lilly Learning Center, Indianapolis

April 14 — Pediatric Neurology for the Primary Care Provider
Methodist Hospital Conference Center, Indianapolis

April 24 — Diabetes Update VII
University Place Conference Center, Indianapolis

May 15 — 12th Annual Gastroenterology/Hepatology Update
University Place Conference Center, Indianapolis

May 20-21 — The Second International Conference for Individualized Pharmacotherapy in Pregnancy
IUPUI Campus Center, Indianapolis, Indiana

May 22 — 35th Annual Wishard Lecture
Methodist Hospital, Petticrew Auditorium
Indianapolis

June 4-5 — Garceau-Wray Lectureship
University Place Conference Center, Indianapolis

June 5 — Aortic Surgical Emergencies
Methodist Hospital, Petticrew Auditorium
Indianapolis

July 6-15 — 94th Annual Anatomy and Histopathology of the Head, Neck and Temporal Bone
Medical Science Building, IUPUI Campus
Indianapolis

July 17 — Review and Interpretation of the 2009 ASCO Meeting
University Place Conference Center, Indianapolis

Course dates and locations are subject to change. For more information, please visit http://cme.medicine.iu.edu or call 317-274-8353.

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We have more than 100 recurring meetings available. For a listing or more information, please visit http://cme.medicine.iu.edu or call 317-274-4220.

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University Place Conference Center & Hotel,
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A conference for primary care physicians that will provide comprehensive information for the diagnosis and treatment of spinal disorders, injuries and abnormalities. Sponsored by Indiana Spine Group.

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For more information call (317) 228-7000 or visit www.indianaspinegroup.com.

Please submit CME & Conferences information to mhadley@imsonline.org by the first of the month preceding publication.

St. Vincent Hospital & Health Services

April 6, 8	PALS Initial 9.5 credits Contact Kim Viehe @ 338-6786
April 10, 13	PALS Recertification 4.5 credits Contact Kim Viehe @ 338-6786
April 15, 17	ACLS Recertification 5.0 credits Contact Kim Viehe @ 338-6786
April 26-28	Physician Leadership Series 18.0 Credits Louisville, KY
April 29, 30	ACLS Initial 10.0 credits Contact Kim Viehe @ 338-6786
Every Tuesday at 7:00am	Internal Medicine Grand Rounds 1.0 Credit; Various topics Cooling Auditorium
Every Wed. at 7:00am	Cancer Conference 1.0 Credit; Various topics 3N classroom

St. Francis Hospital & Health Centers

Beech Grove Campus

Every Thurs. Tumor Board – 7:00 a.m.
For more information, call 317-783-8136.

The Indianapolis Medical Society

April

7 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg.
20 Alliance Delivery of Spring Bouquets & Truffles – Staff Appreciation Week
21 Executive Committee, Society, 6:00 PM, Sandwiches.
22 Administrative Professional's Day
28 IMS Sound Bites, 5:30-8:00, IMS, Snacks, "2009 Practice Life Line Highlighting the New Red Flag Rules," Kam MQuay and Amber Banks, Blue & Co., Rob Lee, R. Lee & Asociates, Brian Wheeler, WestPoint Financial Group

May

1 Alliance Scholarship Deadline
TBA MSE Board Meeting, Society, 6:15 PM, Sandwiches
18 IMS Advisory Breakfast, 7:30 am … prior to BOT
18 ISMA BOT, 9:00 AM
19 Executive Committee, Society, 6:00 PM, Sandwiches

June

2 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg.
10 Senior/Inactive Luncheon Meeting, Noon, Society, Presentation on the Tuskegee Airmen
13-17 AMA House of Delegates Annual Meeting, Chicago Hyatt, Chicago, IL
TBA Executive Committee, Society, 6:00 PM, Sandwiches
TBA Alliance – Scholarship Interviews
TBA Project Health Board Meeting, Society, 6:00 PM, Light Meal

July

21 Executive Committee, Society, 6:00pm, Sandwiches

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In Summary *(Continued from page 20.)*

Both of these grants will help RHISP support its competitive team programs. They will be used to purchase equipment such as sport wheelchairs and specific parts needed for the wheelchairs, including tubes, tires and axles. In addition, the grants will cover travel costs for the teams, as well as uniforms, facility rental for practices, special balls and referees for tournaments. RHISP also conducts recreational clinics that feature water skiing, rock climbing, scuba diving, tennis, self defense and body building – all of which require facilities and instructors, and all of which will benefit from these foundations' generosity.

Interactive Microsites Offer Simple Information on Aches and Pains

Look No Further for Answers on Knee, Shoulder, Foot, Back, Hip & Hand Pain

Brought to the community by Methodist Sports Medicine /The Orthopedic Specialists and Clarian Human Motion, the six sites include physician blogs that contain health related tips, findings from scientific studies and comments on recent orthopedic news. Additionally visitors will find FAQs on each of these six sites and have the ability to sign up for updates through email alerts or RSS feeds. Visitors are also encouraged to comment or share their stories on the sites, and even submit questions that will be answered by physicians.

All Methodist Sports Medicine / The Orthopedic Specialists physicians contribute to the microsites and each of the blogs is updated monthly.

The easy-to-remember microsites: *www.mykneehurts.info, www.myshoulderhurts.info, www.myfoothurts.info, www.myhandhurts.info, www.myhiphurts.info* and *www.mybackshurting.info.*

Regenstrief Institute Receives WHO Designation

The World Health Organization has designated the Regenstrief Institute's medical informatics group as the world's first WHO Collaborating Center for Medical Informatics.

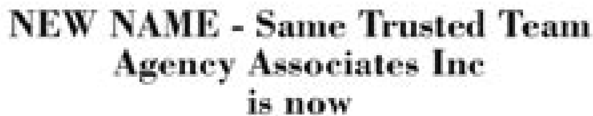
The four-year designation, given for the "design, application, and research of medical information systems," is recognition of the international leadership and depth of expertise of the Institute's medical informatics group in the innovative use of information technology within medicine. This formal designation enables the WHO to more directly draw upon these capabilities by making the Institute part of a larger international collaboration of experts.

Doctors Call for Change in How Non-active TB in Immigrant Children Treated

New guidelines proposed in the March 2009 issue of the journal *Pediatrics* by researchers from the Indiana University School of Medicine and Riley Hospital for Children may have a major impact on how pediatricians and family physicians treat non-active tuberculosis (TB) in children who are immigrants, internationally adopted or refugees. The researchers say the strategy should improve the health of this growing number of children and save healthcare dollars.

An estimated one-third of the world's men, women and children have TB. Most cases are non-active ones (also called latent) in which individuals have the TB bacteria in their body, but their immune system keeps it in check. While they are not actively sick they are at risk of developing active TB and spreading the disease.

Young children under age 5 with non-active TB have a higher rate of developing the active disease than adults. Estimates indicate that between 10 and 20 percent of these children will go on to develop active TB. To prevent this from happening, children with latent TB are treated with medication. IMS



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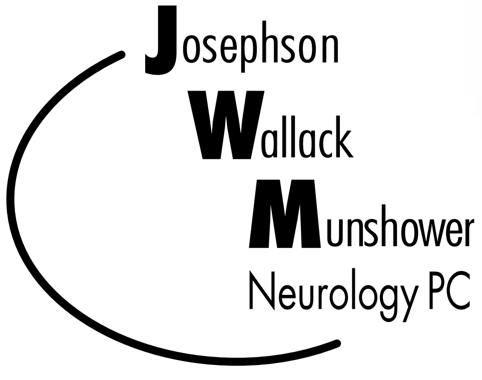

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Mary Ian McAteer (2011)
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Maria C. Poor (2011)
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Leanne M. Fortner (2009)
Robert J. Goulet (2009)
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Robert Michael Pearce (2009)
David M. Ratzman (2009)
Jeffrey M. Rothenberg (2009)
Bridget M. Sanders (2009)
David J. Scruby (2009)
Steven Richard Smith (2009)
H. Jeffery Whitaker (2009)

F. Keith Bean (2010)
Benjamin J. Copeland (2010)
Woodrow A. Corey (2010)
Sheila M. Gamache (2010)
Andrea L. Haller (2010)
Mark M. Hamilton (2010)
Timothy L. Hobbs (2010)
Andrew A. Johnstone (2010)
RoseMarie Jones (2010)
Martin Kaefer (2010)
Jeffrey J. Kellams (2010)
Anthony W. Mimms (2010)
Kimberly K. Short (2010)
Louis L. Winternheimer (2010)
Ronald L. Young, II (2010)

Keenan R. Berghoff, (2011)
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Money Sense *(Continued from page 14.)*

If, however, you uncover a serious imbalance or funds that simply aren't performing, it may be best to make changes even if it means incurring short-term losses. Over time, the value of having a balanced portfolio and strong funds should more than make up the difference.

Evaluate the features of your plan. Even the best 401(k) strategy will be hard to implement if the plan itself offers few choices or restricts your ability to change investments. It's best to have an open architecture with multiple funds and managers, rather than being locked into one proprietary fund family. Some plans limit your ability to transfer in and out of asset categories, or charge you a fee for it.

If you feel your plan is too restrictive, you may want to consider an "in-service rollover," which allows you to roll part or all of your assets into a separate IRA that offers a wider array of choices. This allows you to keep your 401(k) active, so that you can continue making contributions from your paycheck and receiving any matching contributions offered by your employer, while enjoying greater flexibility and control over those assets.

Not all company 401(k) plans offer this option, and you'll want to consult with your Financial Advisor and tax professional to weigh the potential benefits against any possible tax impact. (Note that in-service withdrawal payments are taxable if not deposited into an eligible retirement plan or account within 60 days of receipt.)

It's not inevitable that assets leak out of your 401(k) by virtue of changing markets, poor choices or high fees. By taking your plan through this six-step process, you can see to it that your retirement savings account is positioned to weather turbulent markets and make the most of more bullish times.

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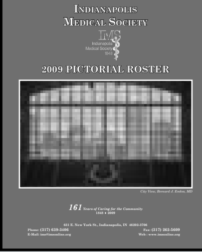

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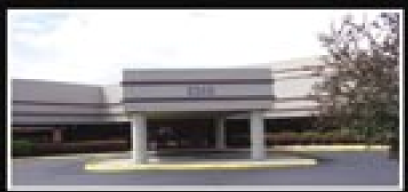

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