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Volume XCVIV • Number 3  
November 2012 • Indianapolis, Indiana

# Bulletin



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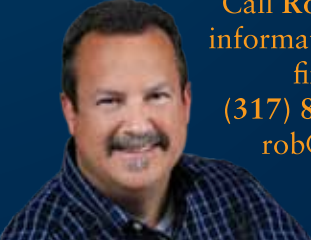
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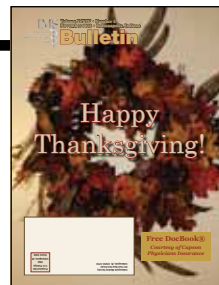
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## about our cover



On our cover:

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## The Medical Home

As a follow up to last month's article on ACOs, this month I am addressing a related topic, the patient centered medical home (PCMH). Studies show that health systems incorporating a solid primary care base provide more effective and efficient care than those that do not.<sup>(1,2)</sup> The PCMH is a **continuous care** model of health care that utilizes a **team approach** involving primary care as the focal point of coordination. A PCMH can be a key initiative of an ACO in the attempt to improve health outcomes and at the same time reduce costs. The origin of the PCMH goes back to the 1960s when the concept of continuous care started in pediatrics, and a model was defined by the American Academy of Pediatrics in 2002<sup>(3)</sup>. The concept and development of ACOs is much more recent, yet seems to get more attention than PCMH possibly due to fact that ACOs have a legislative provision of shared savings.

Since its inception, various PCMH programs have differed in composition. In 2006 the Patient-Centered Primary Care Collaborative (PCPCC), which is a coalition of many organizations of employers, physicians, advocacy groups, unions, health plans and hospitals, was founded to promote the PCMH as a means for improved care. The PCPCC describes the PCMH model as "primary care based that is patient centered, comprehensive, team-based coordinated, accessible and focused on quality and safety. It is supported by health information technology (health IT), provider payment reform focused on patient outcomes and health system efficiencies, and team-based education and training of the health professions workforce."<sup>(4)</sup> The PCPCC indicates there is support for PCMH from many sectors that include private insurance (including the large insurers such as WellPoint, Aetna, Humana, UnitedHealthcare), government (federal and state), and health care professions (such as American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association).<sup>(5)</sup>

To add some continuity and definition regarding medical homes, the National Committee for Quality Assurance (NCQA) has developed Physician Practice Connections and Patient-Centered Medical Home (PCC-PCMH) **voluntary standards** to assist in program development and recognition.<sup>(6)</sup> The Accreditation Association for Ambulatory Health Care (AAAHC) has been accrediting medical homes since 2009 and conducts onsite surveys as part of the accreditation process. The AAAHC standards include components of relationship, continuity of care, comprehensiveness of care, accessibility and quality.<sup>(7)</sup>

There has been growth in the number of PCMH providers and, there is data that demonstrates the PCMH to be an effective means of delivering health care to better meet the goals of the Institute for Healthcare Improvement's Triple Aim of better health outcomes, better care, and lower costs. Efforts to measure the effectiveness of the PCMH are ongoing and include the Agency for Healthcare Research and Quality (AHRQ).<sup>(8)</sup> Key measures are being developed to **standardize** PCMH evaluations that include cost and quality. This year the PCPCC released a summary of numerous PCMH outcomes that focused on cost and quality. The summary made note that different initiatives used different methods to analyze cost savings and quality improvement. Some reports came from academic peer-reviewed journals (typically slow and deliberate and suitable for publication), while others were industry generated (actuarial

with statistical tools for proprietary business practices).<sup>(9)</sup> The success of these programs has spurred interest in the private sector, with insurance companies developing new medical home projects. Of local interest is WellPoint, which announced this year a decision to invest in the medical home<sup>(10)</sup>, predicting that its PCMH efforts could reduce its projected medical costs in 2015 by 20%.<sup>(11)</sup> I interviewed Dr. John Clark of Indiana University Health Physicians (IUHP) who is in charge of the development of the recently implemented IU medical home, and he cited some early data showing a 5-10% reduction in the re-admission rate in the first two quarters of this year.

As a primary care provider I see how this team approach could enhance the care of my patients, especially the transitions of care from inpatient back to outpatient care. Preparation for office visits by other team members would be extremely valuable to me, as reconciling medications can be time consuming and can limit the time needed to address all concerns at the office visit. Review of preventive services prior to the office visit also provides the opportunity to identify and update any deficiencies at the time of the patient encounter that otherwise could be missed. Because of the increased costs of having a PCMH, insurance companies should recognize the added value provided to patients and should reimburse the additional time that physicians and staff spend on patient-centered management efforts outside the fact-to-face encounter (evaluation and management). In the Medicare Shared Savings Plan the potential additional revenue to the ACO from the government helps offset the increased infrastructure costs of utilizing a PCMH. The payment for care management services should not be taken from reduced reimbursement for evaluation and management (E & M) services but should come from the savings generated by improved utilization and outcomes. Considering the "moment of clinical and financial value" to which I have alluded in prior articles, the Medical home significantly enhances overall clinical activity. In addition to the improved outcomes, if realized savings are shared between all payers and providers, then enhanced reimbursement could also occur (assuming the increased cost of the PCMH does not exceed the amount of shared revenue received). I just received my first team member of our PCMH for my office and will provide follow-up about my experience in future articles.

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- <sup>(4)</sup>, <sup>(8)</sup>, <sup>(9)</sup>, <sup>(11)</sup> Nielson, Marci, Grundy, Paul, et al. Benefits of Implementing the Primary Care Patient-Centered Medical Home. A Review of Cost and Quality Results, 2012.
- <sup>(5)</sup> Ibid
- <sup>(6)</sup> en.wikipedia.org/wiki/Medical\_home
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- <sup>(10)</sup> Weaver, C., & Mathews A. (2012 January 27). An Rx? Pay More to Family doctors. *The Wall Street Journal*



## Pelvic Organ Prolapse – To Mesh Or Not To Mesh?



Nina Mutone, MD



Sara I. Diaz Valetin, MD

Pelvic organ prolapse (POP) is a common condition. Known by many names (“cystocele”, “dropped vagina” etc.), it is defined as the protrusion of the pelvic organs through the vaginal opening. The past several decades have seen significant increases

in our understanding of the complex factors underlying POP as well as improvements in treatment outcomes. Recent controversies regarding the use of vaginal mesh in the surgical repair of POP have created confusion for many patients seeking treatment. To better place this issue into context, it is useful to consider a different but comparable condition - abdominal hernia.

Like POP, abdominal wall hernias result from weakened muscular and connective tissue combined with the chronic effects of high intraabdominal pressure. For most of the 20<sup>th</sup> century, operative techniques for hernia repair were based on suture repair of the edges of the defect. Results were often disappointing, with recurrence rates approaching 50% for groin hernias and 80% for incisional hernias<sup>1</sup>. The use of synthetic mesh transformed hernia surgery. Studies showed recurrence rates after herniorrhaphy with mesh were dramatically reduced in comparison with suture repair<sup>2,3</sup>. The use of mesh for hernia repair is now considered standard of care. General surgeons routinely discuss the risks of mesh with their patients (graft migration, infection, adhesion), which depend in part on the type of mesh used and the surgical placement technique. However, in most patients, risks are minimal, and offset by the benefit of a higher surgical success rate compared with suture repair.

Female pelvic floor disorders present a comparable therapeutic dilemma. POP results from weakened tissues. Pelvic reconstructive operations utilizing the patients’ own (weak) tissues were the mainstay of surgical treatment for many decades, and recurrence rates for POP after surgery were as high as 50%<sup>4</sup>. With the evolution of female pelvic medicine and reconstructive surgery as a specialized discipline, scientific research began to shed light on the limitations of native tissue operations, particularly in patients with compromised tissues or other risk factors. Sacrocolpopexy, an abdominal operation that suspends the vagina to the sacrum using a permanent synthetic mesh, was introduced in 1973<sup>5</sup>. By the 1990s, several studies showing significantly better anatomic outcomes with sacrocolpopexy over traditional native tissue approaches had been published<sup>6-8</sup>. Recent advances in minimally invasive surgical techniques have significantly improved patient tolerability of this procedure, with safety and efficacy comparable to the open operation<sup>9,10</sup>.

More recent history has seen the introduction of “transvaginal mesh” procedures for POP. The rationale for pelvic reconstructive surgeons to utilize mesh placed *vaginally* (not *abdominally*) to repair POP came from the established long-term success of abdominal sacrocolpopexy as well as

from the success of midurethral sling procedures for stress incontinence. Proponents believed that this novel approach had the best of both worlds: the minimally invasive approach of the vaginal route combined with the long-term durability of mesh<sup>11</sup>. Unfortunately, these “transvaginal mesh” procedures were adopted rapidly despite a lack of long-term safety and efficacy data, and advertised for use among surgeons at all levels of surgical expertise without clear algorithms on patient selection. Subsequent scientific research did not show a clear benefit of transvaginal mesh over other procedures. In fact, the first randomized trial showed a significantly lower success rate (43 vs. 77%), higher reoperation rate (22 vs. 5%) and higher incidence of mesh complications (13 vs. 2%) for transvaginal mesh compared with the gold standard, minimally-invasive sacrocolpopexy<sup>12</sup>.

The media shock wave regarding transvaginal mesh was unleashed by the release of the FDA Safety Communication Update on Serious Complications Associated with *Transvaginal Placement of Surgical Mesh for Pelvic Organ Prolapse* (our italics)<sup>13</sup>. The purpose of the update was to inform the public regarding possible complications from transvaginal mesh, the most common of which is erosion of the mesh through the wall of the vagina. The report expressly states that “[m]esh placed *abdominally* for POP repair appears to result in lower rates of mesh complications compared to *transvaginal* POP surgery with mesh”, consistent with existing scientific literature. As stated in the joint American Urogynecologic Society/American College of Obstetricians and Gynecologists Committee Opinion, the conclusions and recommendations of the report do **not** apply to the use of synthetic mesh for treatment of *stress urinary incontinence (i.e. slings) or abdominal or laparoscopic repair of pelvic organ prolapse (i.e. sacrocolpopexy)* where the benefits of mesh are more clearly delineated and the risks are less.<sup>14</sup> It is not difficult to understand why the FDA report created such confusion among patients and the medical community.

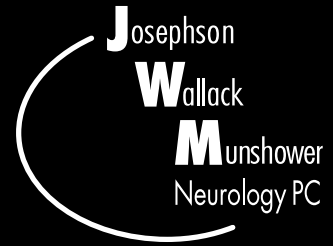
The FDA made no statement about mesh being “defective.” Synthetic mesh has been and continues to be used for many different types of surgical procedures. There has been no manufacturer-based “recall” of synthetic mesh, although due to negative publicity some manufacturers have stopped new production of their transvaginal prolapse repair kits. Patients who have undergone previous vaginal mesh procedures and are concerned about the recent media attention regarding mesh should be encouraged to talk to their physician. In most cases, in the absence of symptoms, treatment is not needed.

The reality is that all surgical operations involve some degree of risk. With the exception of mesh erosion, the potential complications mentioned in the FDA report are not exclusive to mesh procedures, and can occur after any vaginal surgery. The risk of mesh-related complications is unique to each individual and procedure, and should be discussed by patient and surgeon preoperatively in the context of full informed consent. Physicians specializing in the treatment of female pelvic floor disorders possess a level of skill and understanding that uniquely suits them to help patients suffering from POP make the best informed decisions regarding treatment. The

*Continued on page 12.*



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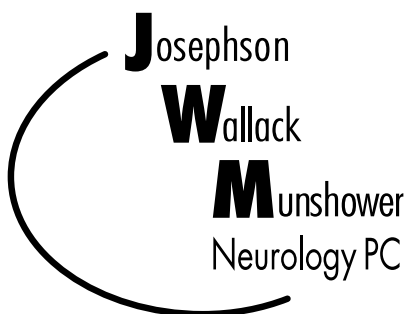
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From left to right: Sandra Dolny, PA-C; Jocelyn Bush, MD; John Fitzgerald, MD; Edward Kowlowitz, MD; Alina M. Clavijo-Passik, PhD  
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# Bulletin Board

**H. Clifton “Clif” Knight, MD**, has been elected to the board of directors of the American Academy of Family Physicians. The AAFP represents 105,900 physicians and medical students nationwide. Knight was elected to a three-year term by the AAFP’s governing body, the Congress of Delegates. As an AAFP board member, Knight will advocate on behalf of family physicians and patients nationwide to inspire positive change in the U.S. health care system.

Dr. Knight has been a practicing family physician in Indiana for nearly 25 years. He currently serves as chief medical officer for Community Health Network in Indianapolis, where he is responsible for quality of care, patient safety, medical education, research and medical staff support. In 2011, he was named to the Board of Trustees for Marian University in Indianapolis. He serves on the Indiana Medicaid Therapeutics Committee and the Indiana Medical Education Board. Dr. Knight also serves as a volunteer clinical assistant professor of family medicine at the Indiana University School of Medicine.

**W. Gregory Chernoff, MD**, was an invited speaker at the 3rd annual C.A.R.E. (Comprehensive Aesthetic Restorative Effort) Project held September 19-21, 2012 in San Diego, California. Dr. Chernoff discussed Multi Modality Scar Therapy focusing on improving scars and non-healing wounds with new fibroblast therapy. Project C.A.R.E. is a cooperative military and civilian program in effort to improve the physical appearance and psychological health, advance research, and provide continuity of care to wounded and traumatically injured service members.

**Michael H. Fritsch, MD**, Professor, Otolologist-Neurotologist, taught at the Otolaryngology National meeting in Washington DC about “Salivary Gland Endoscopy for Salivary Disease.”

**Stephen W. Perkins, MD**, of Meridian Plastic Surgeons was recently the master featured faculty speaker at the American Academy of Facial Plastic and Reconstructive Surgery Fall Meeting in Washington, DC. His lectures included the following: “The Key to Successful Facelifting Is a Lasting, Excellent Neckline: a 30-Year Perspective” and “Achieving an Excellent Neckline In Facelifting.”

**Rick C. Sasso, MD**, Indiana spine Group, served as a faculty member at a surgeon training program for cervical artificial disc replacements, which was held September 15, 2012 in Memphis, Tennessee. Dr. Sasso lectured on the United States FA trials on cervical disc replacements and taught the cadaver laboratory section on artificial disc replacements.

Dr. Sasso has been awarded his 12th patent from the US Patent and Trademark office. The most recent patent is a device and method to correct complex scoliosis deformities.

## News from Goodman Campbell Brain & Spine...

**Laurie L. Ackerman, MD; Joel C. Boaz, MD; Daniel H. Fulkerson, MD; and Jodi L. Smith, MD** had the following paper accepted for publication in the Journal of Neurosurgery: Pediatrics, “Radiographic and clinical outcome of syringomyelia in patients treated for tethered cord syndrome without other significant imaging abnormalities.”

**Daniel H. Fulkerson, MD**, traveled to Eldoret, Kenya to perform 17 neurosurgical operations at the Moi Teaching and Referral Hospital. While there, he gave two Grand Rounds lectures to local medical students on “Pediatric Brain Tumors” and “Pediatric Spine Cases.” Once home, Dr. Fulkerson gave a Grand Rounds presentation titled, “Neurosurgical Opportunities in Eldoret, Kenya” at Indiana University Health.

Dr. Fulkerson also gave a talk to the Arthrogryposis Multiplex Congenita Support National Meeting in Indianapolis, titled: “Diagnosis and Management of Tethered Spinal Cord.”

**Jean-Pierre Mobasser, MD**, was a featured lecturer at the Society of Minimally Invasive Spine Surgery Annual Meeting in Miami. He was the cadaver lab instructor for navigated percutaneous instrumentation and gave a lecture on guide wireless percutaneous screw placement.

**Mitesh V. Shah, MD**, was recently appointed to a three-year term as Secretary of the Neurosurgical Society of America, starting in 2013.



Laurie L. Ackerman, MD



Joel C. Boaz, MD



W. Gregory Chernoff, MD



Michael H. Fritsch, MD



Daniel H. Fulkerson, MD



Jean-Pierre Mobasser, MD



Stephen W. Perkins, MD



H. Clifton Knight, MD



Rick C. Sasso, MD



Mitesh V. Shah, MD



Jodi L. Smith, MD

## IMS Event Photos



Beverly Hurt, IMS EVP, and John J. Wernert, MD, Speaker, ISMA House of Delegates at the ISMA Convention in September 2012.



Outgoing IMS President Richard H. Rhodes, MD, (left) is joined at the podium by incoming President Bruce M. Goens during the installation of officers at the October 2, 2012 Board Meeting.

# In Memoriam



Alois "Doc" Eugene Gibson, MD  
1934 - 2012

Alois 'Doc' Gibson, retired Orthopaedic Surgeon formerly from Richmond, Indiana, passed away September 9, 2012 in Indianapolis. Dr. Gibson was born in Muncie, Indiana on June 21, 1934. He attended St. Lawrence Catholic School and graduated from Muncie Central High School in 1951. He was the Student Manager for the 1951 Muncie Bearcat Basketball State Championship team. He attended Kenyon College in Gambier, Ohio, and earned his undergraduate degree from Indiana University in 1955, and his MD from Indiana University School of Medicine in 1958. Dr. Gibson completed his General Surgery Residency at St. Vincent Hospital in 1960, and his Orthopaedic Surgery Residency at St. Vincent and Indiana University Affiliated Hospitals under in 1963 at the age of 29. He served as Clinical Instructor Emeritus in the Department of Orthopaedic Surgery at the Indiana University School of Medicine. Dr. Gibson authored and co-authored several orthopaedic publications.

Dr. Gibson served on the staff of Reid Memorial Hospital in Richmond, Indiana since 1963, serving as Chief of Surgery from 1984-1985. He was a retired Affiliate Staff member of St. Vincent Hospital and Health Care Center. He served as President of the Indiana Orthopaedic Society and the Indianapolis Orthopaedic Club. He was an Orthopaedic Consultant for the Crippled Children Program from 1967-1984, served on the board of the United Cerebral Palsy of Wayne County from 1963-1977, was 1989 Physician of the Year for the Community Council on Disability Awareness, and received Physician's Recognition Awards from the American Medical Association from 1994-2002. In 2000, Dr. Gibson was presented with the Otis R. Bowen, MD Distinguished Leadership Award for exemplary leadership with the George J. Garceau Professorship in Pediatric Orthopaedic Surgery by The Dean's Council of the Indiana University School of Medicine. He was an attending physician for the Pan-Am Games in Indianapolis in 1987 and was on the Board of Directors for Independent Residential Living from 2002-2008. Dr. Gibson was a member of American Medical Association, the American Academy of Orthopaedic Surgeons, the Indiana Orthopaedic Society, the American Orthopaedic Society of Sports Medicine, and the Indianapolis Orthopaedic Society.

Dr. Gibson served as a Major in the Indiana National Guard.

# Special Feature - Pelvic

(Continued from page 8)

question is not "to mesh or not to mesh," but in whom we put the mesh and under what circumstances.

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<sup>12</sup> Maher C, Felner B, DeCuyper EM, et al. Laparoscopic sacral colpopexy versus total vaginal mesh for vaginal vault prolapse: a randomized trial. *Am J Obstet Gynecol* 2011;204:360, e1-7.

<sup>13</sup> FDA Safety Communication: UPDATE on Serious Complications Associated with Transvaginal Placement of Surgical Mesh for Pelvic Organ Prolapse, July 13, 2011. Downloaded from <http://www.fda.gov/medicaldevices/safety/alertsandnotices/ucm262435.htm>

<sup>14</sup> Committee on Gynecologic Practice. Committee Opinion: Vaginal placement of synthetic mesh for pelvic organ prolapse. *Obstet Gynecol* 2011;118(6):1459-64.

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Emergency Physicians of Indpls., PC  
8111 S. Emerson Ave.  
46237-8601  
Ofc – 528-8148  
Fax – 528-8115  
Emergency Medicine, 1996, 2008  
Kirksville College of  
Osteopathic Medicine, 1991

**Diaz Valentin, Sara I., MD**

Urology of Indiana, LLC  
679 E. County Line Rd.  
Greenwood, 46143-1049  
Ofc – 859-7222  
Fax – 859-7220

Web – [www.urologyin.com](http://www.urologyin.com)  
Obstetrics & Gynecology, 2006, 2011  
Female Pelvic Medicine &  
Reconstructive Surgery  
University of Puerto Rico,  
San Juan, 2000

**Ettensohn, Kerry M., MD**

Anesthesiology, 2010  
Indiana University, 2005

**Faynboym, Semyon, MD**

Resident – IU School of Medicine  
Psychiatry  
St. George's University, Grenada, 2012

**Giedd, Travis W., MD**

Emergency Medicine  
Louisiana State University, 2009

**Griffin, Robert S., MD**

OrthoIndy  
Indiana Orthopaedic Hospital  
8400 Northwest Blvd.  
46278-1381  
Ofc – 956-1133  
Fax – 956-1170  
Anesthesiology, 1996  
Indiana University, 1991

**Henderson, Mark A., MD**

University Radiation Oncology Assoc.  
1701 N. Senate Blvd., #AG117  
46202-1239  
Ofc – 962-3172  
Fax – 963-5114  
535 Barnhill Dr., #RT041  
46202-5116  
Ofc – 944-2524  
Fax – 944-2486  
Email – [mahender@iupui.edu](mailto:mahender@iupui.edu)  
Radiation Oncology, 2009  
Indiana University, 2003

**Hsu, Daniel P., MD**

Goodman Campbell Brain and Spine  
355 W. 16th St., #5100  
46202-2274  
Ofc – 396-1300  
Fax – 924-8472  
8333 Naab Rd., #250  
46260-1983  
Ofc – 396-1300  
Fax – 396-1346  
Diagnostic Radiology, 2004  
Neuroradiology, 2006  
Medical College of Georgia, 1999

**Kinsella, Sandra B., MD**

Anesthesiology, 1988  
Indiana University, 1984

**Marlin, Margarita D., MD**

Resident – Franciscan St. Francis Health  
5230 E. Stop 11 Rd., #250A  
46237-6398  
Ofc – 528-8921  
Fax – 528-6916  
Family Medicine  
American University of the  
Caribbean, Montserrat, 2012

**Mulherin, Brian P., MD**

Hematology-Oncology of IN  
8301 Harcourt Rd., #200  
46260-2070  
Ofc – 415-6600  
Fax – 415-6649  
Internal Medicine, 2009  
Hematology/Oncology  
Loyola University, 2006

**Omery, Bilal M., MD**

Resident – IU School of Medicine  
Internal Medicine  
Indiana University, 2010

**Paracha, Ibrar F., MD**

Nephrology & Internal Medicine  
1801 N. Senate Blvd., #355  
46202-1252  
Ofc – 924-8425  
Fax – 924-6785  
Web – [www.indianakidney.net](http://www.indianakidney.net)  
Internal Medicine  
Nephrology  
University of Missouri, 2007

**Ritter, Stephen M., MD**

Methodist Sports Medicine  
The Orthopedic Specialists  
201 Pennsylvania Pkwy., #100  
46280-1393  
Ofc – 817-1200  
Email – [sritter@methodistsports.com](mailto:sritter@methodistsports.com)  
Orthopaedic Surgery, 2008  
Orthopaedic Surgery of the Spine  
University of Iowa, 2000

**Shemwell, Joan L., MD**

Advanced Healthcare Assoc., LLP  
5150 Shelbyville Rd.  
46237-2601  
Ofc – 782-1577  
Fax – 780-5539  
Internal Medicine  
Tulane University, 1981

**Sweeney, Meredith C., MD**

St. Francis Medical Group  
Indy Southside Surgical  
5255 E. Stop 11 Rd., #450  
46237-6341  
Ofc – 865-4800  
Fax – 865-4806  
Surgery, 2011  
Other Specialty  
University of Illinois, 2006

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# Project Health



Carrie Jackson Logsdon, Director

## Thank you, Ali O. Artar, MD



Ali O. Artar, MD of Josephson Wallack Munshower (JWM) Neurology, is Project Health's Physician of the Month of November. He specializes in sleep disorders medicine.

Dr. Artar was born in 1960. His parents came from overseas, and his father completed a Masters Degree in Food Science. They initially settled in Evanston, Illinois, and later moved to

Phoenix in 1972 after the company his father worked for was bought. A few years later, he moved overseas to finish high school and meet his relatives for the first time. He then entered medical school overseas, eventually earning his medical degree in medicine from the University of Ankara.

Shortly after entering medical school, his mother died. His father returned to the US and eventually remarried. While he was in medical school, Dr. Artar would travel to the US and enjoy his blended family during the summer months. He returned to the US and joined his family in 1987.

In the years that followed, Dr. Artar pursued an interest in research. Also, a friend of the family, who was a psychiatrist, had a great influence on him. "I will never forget when he said that if he had to choose between ten minutes of renal colic pain or ten minutes of an anxiety attack, he'd choose the kidney pain. That helped clarify things and was pretty motivating for me."

Dr. Artar started residency in general psychiatry at the University of Wisconsin Milwaukee Campus. He completed residency at the University of New Mexico School of Medicine in Albuquerque. During the last year of residency, he began to hear patients complain about difficulty sleeping even though their primary psychiatric symptoms were largely resolved. He put in an inquiry to the sleep disorders center and was referred to the sleep research center of the University of New Mexico. At the time they happened to be concluding a hypothesis generating study involving sleep-breathing disorders and posttraumatic stress disorder, and he became a co-author on that published paper. Their research had suggested that if one treats the underlying sleep disorder, the psychiatric problem might also improve.

Due to a longstanding interest in children's and adolescent mental health, Dr. Artar completed a two-year fellowship in child and adolescent psychiatry. He then worked as an assistant professor in child and adolescent psychiatry. This was followed by a one-year sleep medicine fellowship at the University of Michigan in 2004/2005.

Dr. Artar performs comprehensive evaluations involving sleep, medical, and psychiatric disorders. He states that our understanding of how medical, psychiatric, and sleep disorders are interrelated is steadily improving, and it is becoming more and more clear that treating one often helps treat the other, and that not treating one can often worsen, or even cause, the other. He says treating sleep disorders lessens the risk of motor vehicle accidents, improves mood and cognitive disorders, lessens risk of cardiovascular disorders such as hypertension, stroke, atrial fibrillation, can reduce or even eliminate

headaches, body-wide aches and pains, and gastrointestinal problems like heartburn. Also, it is often easier to lose weight and keep weight off when sleep disorders are treated. "The risk of developing or worsening other serious medical disorders, not to mention motor vehicle accident risk, is greatly reduced when individuals obtain sufficient, restorative sleep on a consistent basis."

Sleep apnea is one of the most common sleep disorders. "Now sleep testing is moving to home sleep apnea testing. It is getting more and more widespread and demanded more by insurers to decrease costs, and patients are more comfortable in their natural environment." If sleep apnea is diagnosed, continuous positive airway pressure (CPAP) therapy is a commonly used device for treating sleep apnea. "People often tell me that now that they are used to it, they won't sleep without it. They feel much better."

Dr. Artar is board certified in both general psychiatry and sleep medicine, and board eligible in child and adolescent psychiatry. In his spare time, he likes to remain active, doing weightlifting and cardiovascular training. He frequently visits his brother and sister-in-law in Chicago and often goes to Dayton, Ohio where his parents live.

Dr. Artar says seeing a Project Health patient is just another part of his daily practice. He says he feels honored to be a Project Health volunteer. On the contrary – we are the ones who are honored. Thank you Dr. Artar.

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Robert J. Alonso (2013)  
David S. Batt (2013)  
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Andrew A. Johnstone (2013)  
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Philip W. Pryor (2014)  
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Norman Mindrebo (2015)  
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Third  
Wednesday Neuro 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.

### Community Hospital North

First  
Wednesday Pediatric Grand Rounds  
Multi Services Rooms 1 & 2  
7250 Clearvista Dr. 7:30 - 8:30 a.m.

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

Fourth  
Thursday Psychiatry Grand rounds  
7250 Clearvista Dr.  
Multi-Service Rms. 1 & 2 7:30 - 8:30 a.m.

### Community Heart & Vascular/ Indiana Heart Hospital

First  
Wednesday Imaging Conference:  
rotates Cath & Echo Case Presentations  
TIHH MCV Boardroom Videoconference to  
CHE Bradley Boardroom &  
CHS Education Center Rm. 2-1910  
7:00- 8:00 a.m.

Third  
Wednesday Ken Stanley CV Conference  
TIHH MCV Boardroom Videoconference to  
CHE Bradley Boardroom &  
CHS Education Center Rm. 2-1910  
7:00 - 8:00 a.m.

Fourth  
Wednesday Disease Management Conference:  
rotates CHF & EP Case Presentations  
TIHH MCV Boardroom Videoconference to  
CHS Education Ctr. Rm. 2-1910, 7:00 - 8:00 a.m.

## Cancer Conferences

### Community Hospital East:

First & Third  
Wednesdays East General Cancer Conference  
Medical Staff Conf. Room, 12:00 to 1:00 p.m.

Fourth  
Wednesday East Multidisciplinary Breast Cancer Conference  
Medical Staff Conference Room  
7:00 to 8:00 a.m.

### Community Hospital North

First & Third  
Tuesdays North Multidisciplinary Breast Conference  
8040 Clearvista Parkway, Suite 550, 7:00 - 8:00 a.m.

First  
Wednesday North Chest Cancer Conference  
8040 Clearvista Parkway, Suite 550, 7:00 - 8:00 a.m.

Third  
Wednesday Melanoma Cancer Conference  
8040 Clearvista Parkway, Suite 550, 7:30 - 8:30 a.m.

### Community Hospital South

Third  
Wednesday South Multidisciplinary  
Breast Cancer Conference  
Community Breast Care Center South,  
533 E. County Line Rd., Ste. 101, 8:00 - 9:00 a.m.

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

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William H. Dick, MD

## Speaker: Dr. Scott Phillips

### The Space Program: Everyone's Gain

Dr. Scott Phillips is a graduate of Butler University and the Indiana University School of Medicine in 1990. He is certified in Ear, Nose and Throat Surgery and Allergy. Scott served our country in Desert Storm and has served on nearly twenty space missions as a Flight Surgeon Member of the Space Rescue Team. Dr. Phillips had lunch at a May meeting with the late Neal Armstrong, the first man on the moon.

There have been over 130 missions into space; the last landing of the space shuttle was on 21 July 2011. The International Space Station is still active with fifteen countries engaged in experiments. At this time, there are no plans for manned space flights, but private companies have some plans for spaceflight. In the past, Dr. Phillips served on a Black Hawk helicopter in case of an emergency with the astronauts. Scott is a Reserve Officer in the U. S. Air Force and a Flight Surgeon at Grissom Air Force Base. At present, they are working on refueling.



When Scott served in Florida at the Kennedy Space Center, the helicopter was positioned three miles away from the launch pad (see photo). The shuttle took off at 17,500 miles per hour. Dr. Phillips showed a slide of the runway at the Space Center. The shuttle lands at 280 knots and comes in at an angle that is three times steeper than a normal aircraft. In case of serious injury, astronauts are taken to appropriate regional hospitals. The Vehicle Assembly Building is 525 feet tall, has 125 air conditioners and has the largest open area of any building in the world.

Scott told us that there are over 30,000 rewards that have come from the space program. Smoke detectors date to the 1970's Skylab mission. LCD display on watches came from a quartz timing crystal, used little energy, and had low battery weight. Mylar is a metal alloy that is lightweight and provides



protection from radiation. Memory metals are important in space flight and are used in eyeglasses. A nickel titanium metal is used in vascular clips. Bar codes were developed to keep track of the thousands of spacecraft parts.

The joystick was a controller for the Apollo lunar rover. Athletic shoes were made from materials to absorb shock. Ski boots have insulation and flexibility. Weather satellites were sent up in April 1960. Satellite TV became a reality in July 1962. Firefighter breathing gear and battery-powered drills are spinoffs from the space program.

Medical innovations include the discovery of bone loss and the need to stimulate new bone formation with Fosamax, etc. Muscle atrophy was treated with resistance training; it spurred research in Growth Hormone. Circadian rhythms were better understood and jet lag was treated with melatonin. Advances in telemetry helped in monitoring cardiac vital signs and it led to progress in pacemakers. Further research in the 1960's led to desalination of salt water and to advances in renal dialysis.

Since there is no gravity in space, research into cancer and virus pathology can be made in a faster cycle. Robotic surgery came from small motors developed for space. Telemedicine is important today for sharing of information and for diagnostic purposes. Infrared photo detectors find invisible heat. This information is useful in breast cancer research and in the detection of forest fires. The list goes on.... It has been suggested that billions of kilowatts of solar power could be produced on the moon and sent back to Earth via microwaves.

At this time, no further moon landings are anticipated. It is possible to send our astronauts into space with Russian Soyuz rockets. China is in the early stages of their own space program and hope to put a man on the moon.

Further information can be found at: [www.NASA.gov](http://www.NASA.gov). We thank Scott Phillips for his dedicated service to our country!

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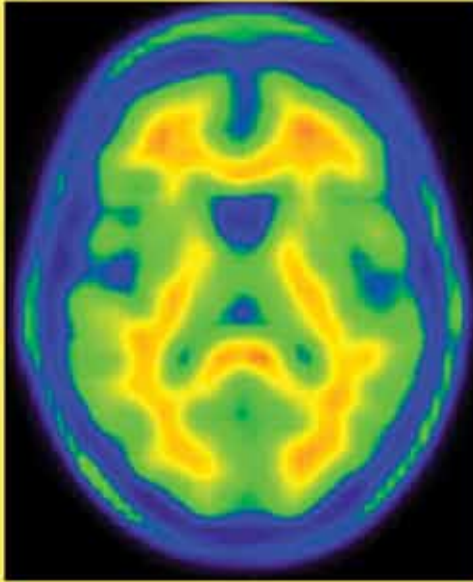
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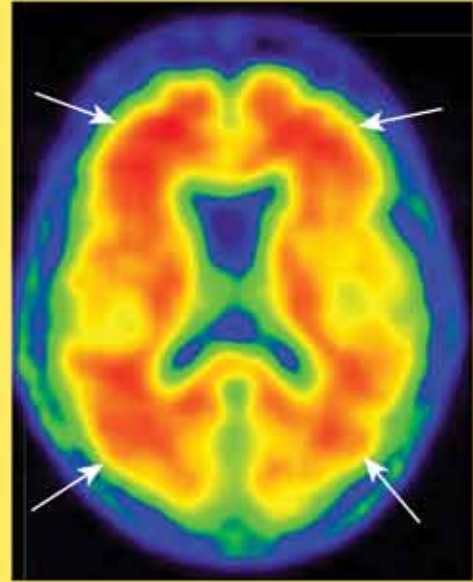
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