Indianapolis Medical Society 1848

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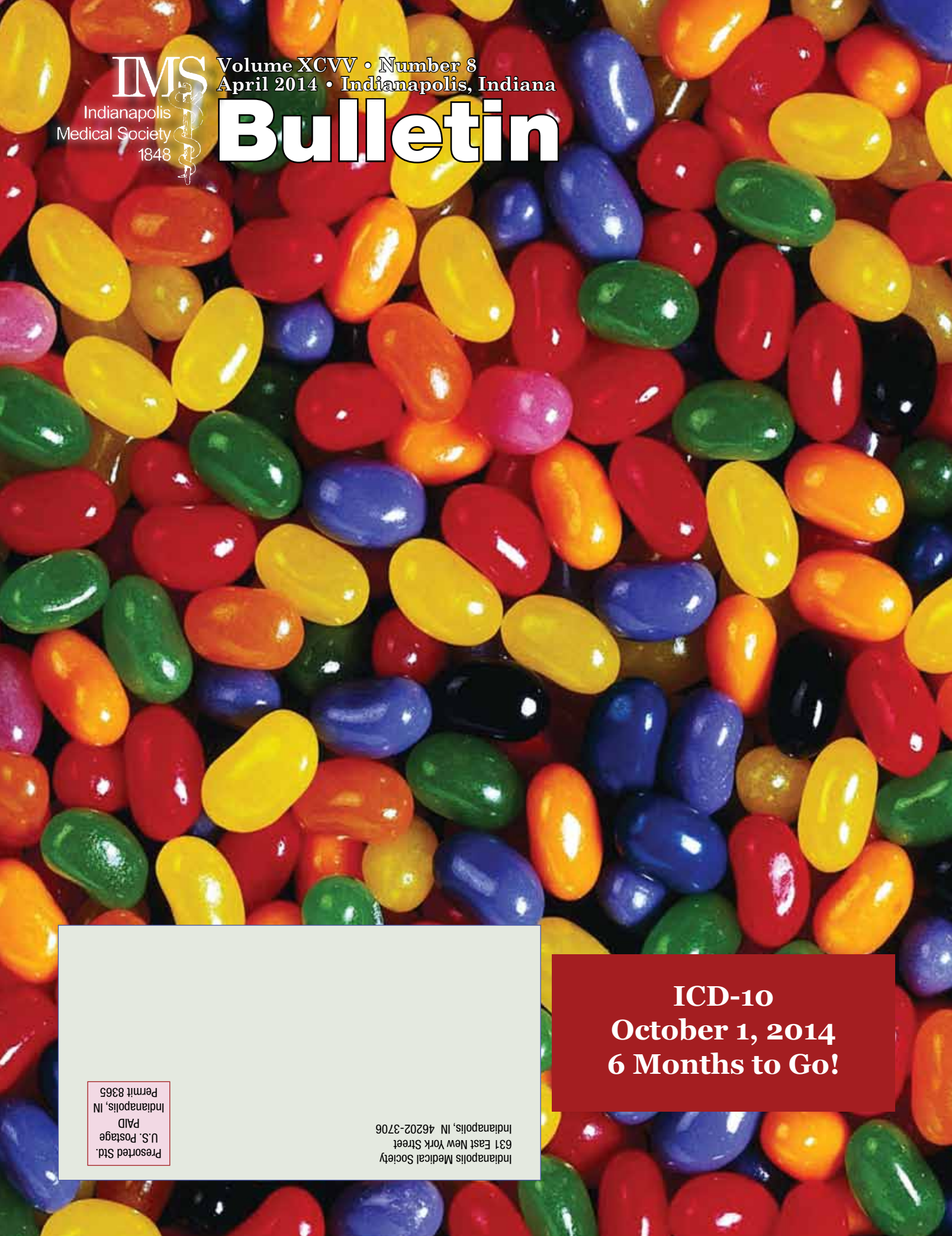
April 2014 • Indianapolis, Indiana

Bulletin



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President-Elect
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Marcia K. Hadley

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

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

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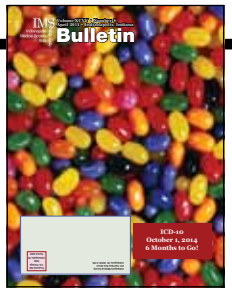
in this issue

Special Features

Departments

about our cover



On our cover:
"Jelly Beans"
Grab a handful of color!

ICD-10 is only six months away. Use the Free IMS Member Webinars on ICD-10 to discover what you need to know and do.

April ICD-10
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President's Page

Mark M. Hamilton, MD

Tort Reform - the lost step in the climb to affordable care

With so much of the recent healthcare news centered on Obamacare, the upcoming implementation of ICD-10 codes, and the rising cost of practicing medicine; I wanted to take this opportunity to shine a spotlight back on the issue of tort reform.

Fortunately for those of us practicing in Indiana, the Hoosier state is ahead of the curve when it comes to capping damages that may be awarded as a result of a medical malpractice lawsuit. But generally, the costs associated with malpractice insurance and practicing defensive medicine continue to affect all physicians.

Defensive medicine isn't the exception. It's quickly becoming the rule for doctors across the United States.

Jackson Healthcare, the nation's third largest healthcare staffing agency, recently polled physicians around the country and found that 75 percent of doctors admit to ordering extra tests, procedures and medicines just to be cautious in an attempt to avoid lawsuits.[1]

The American Association of Orthopaedic Surgeons says those numbers are conservative, citing surveys claiming[2]:

90 percent of physicians reported practicing positive defensive medicine in the past 12 months

92.5 percent of surgeons indicate they have ordered imaging tests to protect themselves from lawsuits

In a recent Gallup survey, physicians attributed 34 percent of overall healthcare costs to defensive medicine

Liability reform has been estimated to result in a 5 percent to 34 percent reduction in medical expenditures via a reduction in defensive medicine

42 percent of physicians reported that they had restricted their practice to avoid risky procedures, patients with complex conditions, or patients perceived to be litigious

The burden to pay these costs is shared by everyone, driving up health insurance premiums, taxes to cover public health insurance programs, co-pays and out of pocket costs.

Just how much does it cost? Defensive medicine accounts for nearly a quarter of all health care expenditures according to Gallup, with a total price tag as high as $650 billion annually.

The fear of medical malpractice lawsuits fuels much of the rise in defensive medicine. Fortunately Indiana is ahead of the pack when it comes to limiting damages awarded as a result of malpractice suits.

The maximum award stemming from lawsuits in which a doctor's negligence is alleged, is capped at $1.25 million. The Hoosier state has caps for punitive damages and state law limits what can be paid out of a Tort Claim Fund for state-liable accidents; $700,000 per individual and $5 million per incident.[3]

The Indiana State Medical Association with help from the IMS has been working to keep Indiana's caps in place. The American Medical Association has also been fighting this battle on a federal level, advocating for similar caps to protect doctors and hospitals across the country.

The AMA is also leading the way when it comes to policy research on this subject. The Association recently analyzed close to 10 independent studies that explored how limits on pain and suffering awards and medical liability risk affect insurance premiums, physician supply and defensive medicine costs. The research found that noneconomic damage caps reduce insurance company payouts and lower rates for doctors.

Not only do limits on damages save doctors money, but the AMA data showed they also helped to increase access to healthcare by decreasing physician shortages.

States like Indiana, California and Texas, which have enacted tort reforms, have lower medical liability premiums and more doctors. States without limits on non-economic damages have higher premiums and a lower number of doctors.[4]

The AMA's policy research over the past decade showed[5]:

Internists' premiums in states with caps were 17% less than in states without caps. General surgeons' and ob-gyns' rates were 21% and 26% lower, respectively.

A $250,000 award limit in states without effective reforms could result in premium savings of $1.4 billion.

The number of physicians practicing in high-risk specialties is 4% to 7% higher in states with caps.

A 60% increase in medical liability premiums between 2000 and 2003 was linked to a $7.1 billion increase in spending on physician Medicare services.

A 10% increase in claims payments was tied to a 1.5% to 1.8% increase in utilization of diagnostic and imaging procedures.

Physician specialty and advocacy groups like the Indianapolis Medical Society, the Indiana State Medical Association and the AMA have been pushing hard for tort reform at both the state and national levels, and will continue to do so.*

Continued on page 23.

Past President's Perspective

Paula A. Hall, MD

The big take-home message is nicotine is bad ...

Okay, I just sat through a Grand Rounds discussing Nicotine Addiction and the new E Cigarettes. The big take-home message is nicotine is bad … very, very bad, regardless of the form. At the end of the lecture, as a positive note, they tell us how there is going to be a push to increase the taxes on cigarettes. Now as I sat in the audience listening, it occurred to me that one way to decrease the high cost of health care is to eliminate the scourge of nicotine on the American public. And the only way we've had success in decreasing this smoking rate, is to increase the taxes. I was disappointed to hear that they are looking at a 50 cent increase in the taxes on a pack of cigarettes. If we were really wanting to do something to lower the high cost of healthcare, why wouldn't we asked for a $5 a pack user fee … on top of the taxes that are already there. I'm not smart enough to figure it out, but we also need to have a user fee for Bubblegum-flavored Nicotine Vapor Refills for the Electronic Cigarettes as well as, of course, the chewing tobacco products. I was frightened to hear that Indiana is a "test ground" for the E Cigarette market. It is time to show that Hoosiers are not "hicks," and that we care about the health and well-being of our population.

You can have the Affordable Care Act. You can take away fee-for-service. You can consolidate the insurance industry. But I venture to wager, that all of these put together, would not improve the health of all Americans, thus decreasing the cost of healthcare, as much as putting a significant user fee on nicotine products.

Nicotine is reported to be more addictive than cocaine and heroin. The amount of press that has been written about Phillip Seymour Hoffman, the actor who recently died of a heroin overdose, is astonishing. If even half of those words would have been used to write about the wisdom of having a user fee on nicotine perhaps we could have passed this in all the states' legislatures. The tobacco settlement has come and gone. Most of that money is not used on smoking cessation. But truly, the only thing that's ever been effective in decreasing the smoking rate has been increasing the cost of the tobacco products. So I ask you, when we know how to improve the health of Hoosiers and lower the cost of healthcare, why do we avoid taking real action?

Yes, I know the argument that smokers use, that if we are going to tax tobacco, we should also tax Fast Food because of the obesity epidemic. But I will share with you that I have a patient who owns two McDonald franchises, and she eats at McDonald's twice a day 6 days a week. At 50 years of age, she is at ideal body weight, does not have hyperlipidemia, hypertension, and is not diabetic. Yes, obesity is a major health problem. But she is proof that you can eat Fast Food regularly and maintain your health. (I'm thinking she doesn't eat Quarter Pounders with cheese and Fries like I do when I go to McDonald's.)

Yes, this is America. And, we have personal rights. I am not promoting taking away the *right* to use nicotine products, I am just suggesting that we collect a fee to help defer the cost of healthcare for those who choose to use nicotine products. It is time that we have a real discussion about the high cost of health care and how to really decrease the cost and improve the health of Americans. I would think that if every physician in the Indianapolis Medical Society got on board with this idea, we would do more to improve the health care of Hoosiers in one fell swoop than all of the healthcare we would provide during an entire year!

IMS

To submit articles, opinions or information, email ims@imsoline.org. Deadline is the first of the month preceding publication.

Bulletin Board

Richard D. Feldman, MD, is the recipient of the 2014 Nikitas Zervanos Outstanding Family Medicine Residency Program Director Award. This national award is presented annually by the American Academy of Family Physicians and the Association of Family Medicine Residency Directors. The award recognizes contributions to these organizations and leadership and service as a mentor to residents, other program directors, and family medicine teachers. The award was presented in Kansas City in March, 2014.

Tod C. Huntley, MD, the Center for Ear Nose Throat & Allergy, was part of the team of consultants that assisted Inspire Medical in their successful FDA submission for hypoglossal nerve stimulator implantation for obstructive sleep apnea. This therapy was approved by unanimous FDA vote in mid-February for use in CPAP-intolerant patients with moderate to severe OSA. Dr. Huntley will be the only surgeon in Indiana initially approved for implantation of HGN stimulators.

Chemen M. Tate, MD, was recently elected to the board of directors for the American Medical Women's Association (AMWA). Dr. Tate will serve a two year term on the board.

Jeffrey A. Cox, MD, *(photo unavailable)* a family physician specializing in diabetes and obesity, has joined St. Vincent Medical Group in Indianapolis.

Michael C. Large, MD, Urology of Indiana, coauthored a manuscript titled "Sex Disparities in Diagnosis of Bladder Cancer After Initial Presentation With Hematuria" in the February 15, 2014 issue of *Cancer*.

Rick C. Sasso, MD, Indiana Spine Group, was awarded with his 15th patent from the United States Patent and Trademark Office. Patent #8,512,380 is called "Posterior Fixation System" and is a design patent covering posterior cervical instrumentation.

Dr. Sasso was the invited visiting professor at Loyola University in Chicago, Illinois on February 12, 2014. He presented Grand Rounds to the Orthopaedic Surgery Department with their residents and fellows. Dr. Sasso's Grand Rounds presentation was titled "The Vertebral Artery in Cervical Spine Surgery."

He also served as a faculty member at the 7th Cervical Spine Research Society's Annual Hands-On Cadaver course. He taught current techniques of cervical spine surgery to spine surgeons from around the world.

Gerald C. Walthall, MD, medical director of palliative medicine, shared finalist honors in the Advancements in Health Care in IBJ's annual Health Care Heroes. Dr. Walthall, a retired otolaryngology surgeon, has been affiliated with Franciscan St. Francis Health for decades. He has served as chief of surgery and held numerous clinical and administrative leadership roles.

News from Goodman Campbell Brain and Spine…

Nicholas M. Barbaro, MD, coauthored a review of percutaneous treatments for trigeminal neuralgia in *Neurosurgery,* March 2014 (issue 1). At the February 2014 Winter Clinics for Cranial and Spinal Surgery in Snowmass, Colorado, Dr. Barbaro participated as a facial pain expert on a panel that presented case studies and controversies that arise.


Nicholas M. Barbaro, MD


Joel C. Boaz, MD


Aaron A. Cohen-Gadol, MD

Jeffrey A. Cox, MD


Richard D. Feldman, MD


Daniel H. Fulkerson, MD


Tod C. Huntley, MD


Michael C. Large, MD


Thomas J. Leipzig, MD


James C. Miller, MD


Jean-Pierre Mobasser, MD


Troy D. Payner, MD


Rick C. Sasso, MD


Chemen M. Tate, MD


Gerald C. Walthal, MD

Joel C. Boaz, MD, was a coauthor on a case illustration that described ventriculogallbladder shunt fracture and bile peritonitis in the January 2014 issue of the *Journal of Neurosurgery: Pediatrics.*

Aaron A. Cohen-Gadol, MD, has recently published an electronic article on the topic of internal carotid-artery bifurcation aneurysms appeared in the January 19, 2014 issue of *Neurosurgery*; a 3-D video showing surgical events accompanied this article. Dr. Cohen and coauthors have contributed to the literature on fluorescence-guided neurosurgery with a prospective study using fluorescein videoangiography during arteriovenous malformation surgery; the article was published in the February 2014 issue of *Neurosurgical Focus.* In the February 2014 issue of the *Journal of Neurological Surgery, Part B, Skull Base,* he coauthored a cadaveric study that elucidates a previously undescribed segment of the trochlear nerve.

Daniel H. Fulkerson, MD, and coauthors recently published three articles in the *Journal of Neurosurgery: Pediatrics.* In the January 2014 issue, a case illustration described ventriculogallbladder shunt fracture and bile peritonitis. Another article in the January issue reported the findings of a clinical and radiographic assessment of patients with neuromuscular scoliosis. A third article in the February 2014 issue retrospectively reviewed five cases of bilateral C-2 spondylolysis in very young children.

Thomas J. Leipzig, MD, directed the American Association of Neurological Surgeons' Maintenance of Certification (MOC)

Continued on page 12

New Members

Faulkner, Camra B., MD
Resident – St. Vincent Hospital
Family Medicine
Indiana University, 2011

House, Beve P., III, MD
Medical Associates, LLP
1500 N. Ritter Ave.
46219-3095
Ofc – 355-5041
Fax – 355-5693
Emergency Medicine, 1996, 2006
University of Kentucky, 1992

Phookan, Gautam, MD
Goodman Campbell Brain and Spine
2525 W. University Ave., #503
Muncie, 47303-3409
Ofc – (765) 288-0441
Fax – (765) 282-7879
Neurological Surgery, 2003, 2014
Assam Medical College,
Dibrugarh, India, 1983

Silvidi, Julius A., MD
Goodman Campbell Brain and Spine
2525 W. University Ave., #503
Muncie, 47303-3409
Ofc – (765) 288-0441
Fax – (765) 282-7879
Neurological Surgery, 1992
Northeastern Ohio University, 1981

Walter, Amanda M., MD
Resident – IU School of Medicine
Pediatrics
Indiana University, 2011

Bulletin Board *(Continued from page 11)*

Preparation and Neurosurgical Update course in Las Vegas, Nevada, in February 2014. He also presented a review of major, recent cerebrovascular studies and several case-management talks on cerebrovascular diseases.

James C. Miller, MD, and coauthors reported on a retrospective analysis of seizure occurrence with and without postoperative prophylactic antiepileptic drugs in the February 17, 2014 issue of the *Journal of Neuro-oncology*.

Jean-Pierre Mobasser, MD, was a faculty member at the February 2014 Winter Clinics for Cranial and Spinal Surgery. In March 2014, Dr. Mobasser taught a course on this topic, in Orlando, Florida, at the joint section meeting of the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons.

Troy D. Payner, MD, participated as moderator and panel expert during case discussions at the February 2014 Winter Clinics for Cranial and Spinal Surgery.

Drs. Cohen-Gadol, Leipzig, Payner and residents, coauthored an analysis of patients with perimesencephalic subarachnoid hemorrhage. This article was included in the February 19, 2014 issue of the *Journal of Neurological Surgery, Part A, Central European Neurosurgery*.

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In Summary

According to new study ICD-10 implementation costs "much more disruptive"

From the American Medical Association

New estimates of costs to implement the federally mandated ICD-10 code set by Oct. 1 are in some cases nearly three times more than previously estimated, according to a new AMA study.

Costs associated with ICD-10 implementation include training, vendor and software upgrades, testing and payment disruption. Compared to a similar study completed in 2008, these costs could be as much as $8 million for a typical large physician practice. For a small practice, implementation costs could be more than $225,000. The move is expected to be "much more disruptive for physicians" than previous mandates.

"The markedly higher implementation costs for ICD-10 place a crushing burden on physicians, straining vital resources needed to invest in new health care delivery models and well-developed technology that promotes care coordination with real value to patients," AMA President Ardis Dee Hoven, MD, said in a news release.

"Continuing to compel physicians to adopt this new coding structure threatens to disrupt innovations by diverting resources away from areas that are expected to help lower costs and improve the quality of care," Dr. Hoven said.

Current cost estimates are higher now "due to the need for testing, and the potential for increased payment disruption," the study reports. "A major element in cost is clearly the vendor/software upgrade category."

The study notes specialty practices will see the highest ICD-10 implementation costs, especially in productivity losses and payment disruptions, because of their higher revenues and per-hour rates.

The study estimates both pre- and post-ICD-10 implementation costs for average small, medium and large physician practices. While conservative cost estimates fall slightly below 2008 estimates, the range of expenses is much higher than the AMA's 2008 analysis, and many practices are expected to fall into the higher ranges.

"Because of variability in the size and specialty of practices, there is no 'one size fits all' implementation process for practices to follow," the study said.

The AMA has been able to keep ICD-10 at bay for more than a decade and continues to urge lawmakers to stop implementation of the code set. Physicians can ask their members of Congress to co-sponsor legislation to stop ICD-10 implementation, known as the Cutting Costly Codes Act of 2013, by sending an email through the AMA's Physician Grassroots Network.

As the AMA works to halt ICD-10, physicians should continue to prepare for the new code set. Access free educational resources from the AMA for practical insight into the preparation process, or visit the AMA Store for additional training opportunities and products.

AMA tells HHS ICD-10 financially disastrous for physicians

From the American Medical Association

Citing dramatically high costs and interference with quality improvements, the AMA on February 12, 2014 continued its efforts to stop ICD-10 implementation in a letter urging U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius to reconsider the mandated transition to the new code set, currently scheduled for Oct. 1.

In the letter, AMA CEO and Executive Vice President James L. Madara, MD, outlines the considerable drawbacks of requiring physicians to comply with the new code set by the Oct. 1 deadline.

"Physicians are being asked to assume this burdensome requirement at the same time they are being required to adopt new technology, re-engineer workflow and reform the way they deliver care; all of which are interfering with their ability to care for patients and make investments to improve quality," Dr. Madara said in the letter.

According to an AMA study released Wednesday, February 12, 2014, the cost to meet the ICD-10 requirements is dramatically higher than previously estimated. A small physician practice, for instance, can expect to spend anywhere from $56,639 to $226,105 to prepare for the new code set.

The letter emphasizes that ICD-10 implementation will be financially disastrous for physicians and impede progress to a performance-based environment.

"Given the significant cash flow interruptions stemming from previous Health Insurance Portability and Accountability Act (HIPAA) mandates, we expect the financial impact of ICD-10 on physicians will continue well beyond the Oct. 1, 2014, implementation date," the letter states.

Meanwhile, the absence of true end-to-end testing means physicians will be able to determine only whether their claim will be received—no information will be given about whether the claim will be paid, how much will be paid or whether the correct code was used in the limited testing the agency has agreed to facilitate.

"Adopting ICD-10 … is unlikely to improve the care physicians provide their patients and takes valuable resources away from implementing delivery reforms and health information technology," the letter states. IMS

Prediabetes – You Can Stop Diabetes Before it Starts

Given that 79 million Americans have prediabetes, it is likely that you have patients with this common, but treatable, condition. To help these patients and improve outcomes for your practice, you can refer people who have prediabetes to a Diabetes Prevention Program (DPP) at the YMCA of Greater Indianapolis. The DPP can have a positive impact on patients, providers, and communities such as ours seeking to reduce the incidence of type 2 diabetes.

The YCMA is participating in a Center for Medicare and Medicaid Innovation (CMMI) grant that pays for at-risk people over age 65 to attend an evidence-based diabetes prevention program in 17 communities across the country, including Indianapolis. (Adults under 65 who have prediabetes can participate as well, but need to pay out-of-pocket or be in a health plan that covers participation.)

"As the outcome data from this referral pilot project becomes apparent; IMS leadership and members physicians are pleased that the results and process would be available to both providers and patients in our community so all can benefit." Bruce M. Goens, MD, Immediate Past President, Indianapolis Medical Society. Indiana has an important history with the DPP. In 2008, researchers at Indiana University School of Medicine in Indianapolis demonstrated that the DPP could be implemented by the YMCA in the community, rather than by clinicians in a practice setting, increasing the opportunity for cost-effective use and spread of the DPP. (Source: Ackermann RT, Finch EA, Brizendine E, Zhou H, Marrero DG. Translating the Diabetes Prevention Program into the community. The DEPLOY pilot study. *Am J Prev Med.* 2008;35(4):357-63. doi: 10.1016/j.amepre.2008.06.035.)

The YMCA program is part of the CDC-led National Diabetes Prevention Program, and is designed to bring evidence-based lifestyle coaching programs for preventing type 2 diabetes into local communities nationwide. **The DPP can help delay or prevent the progression of prediabetes to diabetes through lifestyle interventions.** The one-year program is aimed at improving diet and physical activity and achieving moderate weight loss. The DPP is based on a program that has been shown to reduce the number of new cases of type 2 diabetes among adults ages 18-60 with prediabetes by 58 percent , and by **71 percent** in adults over the age of 60. (Source: National Institute of Diabetes and Digestive and Kidney Diseases)

Physician referral pilot project in Indianapolis

While physician practices can already refer patients with prediabetes to the YMCA's DPP, the American Medical Association (AMA) wants to help create a referral process that works well across different types of practices.

The AMA has partnered with the YMCA of the USA to:

- Increase education and awareness of prediabetes to promote screening by physicians of those at risk
- Increase physician referrals of people at risk for diabetes to the DPP at their local Y
- Create a feedback loop so the patient's experience at their Y becomes integrated into the physician's care plan, and to encourage physician-patient shared decision-making

The AMA has engaged Indiana University Health Physicians in a six-month pilot, during which AMA staff will work with some primary care physicians and their practices.

Along with the IU Health Physician pilot efforts, The AMA is encouraging all Indianapolis Medical Society physicians to participate to refer patients at risk for diabetes to this the Diabetes Prevention Plan Program.

"We clearly see the increase in people at risk for diabetes, I am pleased to see this pilot project as it offers enhanced access to our patients to a therapeutic life style intervention program for prevention," said Dr. Goens. "As a practicing physician for many years, I have seen in my practice the benefits of diabetes prevention but sometimes, for various reasons, access to a prevention program was a problem. The YMCA system is a great resource and therefore likely to help patients overcome those obstacles. As a clinician in the IU Health system, I am happy to be able to participate in this program and look forward to the improved outcomes that I am sure will be demonstrated," Bruce M. Goens, MD. "We are eager to help the AMA and YMCA create a referral system that integrates into our clinical practices, makes our patients feel comfortable and cared for, and improves outcomes by reducing incidence of diabetes," Dr. Goens said.

Creating more clinical-community linkages

Other AMA pilot projects are underway across the state of Delaware and in Minneapolis/St. Paul, MN. Once the pilot phase is complete in mid-2014, AMA will expand to more cities and physician practices, creating more clinical-community linkages.

The AMA is also engaging insurers to collaborate on strategies for expanded coverage of evidence-based services shown to prevent type 2 diabetes – including such services delivered in a non-clinical setting.

If you would like more information about the AMA's work with the YMCA, please contact Janet Williams at janet.willliams@ama-assn.org.

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Indianapolis Medical Society

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Delegates to the State Convention, September 5-7, 2014, Westin Hotel, Indianapolis

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C. William Hanke (2015)
Gerald T. Keener, Jr. (2015)
David H. Moore (2015)
Robert B. Pauszek, Jr. (2015)
J. Scott Pittman (2015)
John F. Schaefer, Jr. (2015)
Caryn M. Vogel (2015)

David S. Batt (2016)
Daniel J. Beckman (2016)
Carolyn A. Cunningham (2016)
Margaret M. Gaffney (2016)
David C. Hall (2016)
Ronda A. Hamaker (2016)
Mark M. Hamilton (2016)
Jeffrey J. Kellams (2016)
Stephen R. Klapper (2016)
Susan K. Maisel (2016)
David M. Mandelbaum (2016)
John P. McGoff (2016)
Dale A. Rouch (2016)

Alternate Delegates to the State Convention, September 5-7, 2014, Westin Hotel, Indianapolis

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

William C. Buffie (2014)
Brian D. Clarke (2014)
Robert E. Dicks (2014)
Doris M. Hardacker (2014)
Douglas J. Horton (2014)
Daniel E. Lehman (2014)
Ramana S. Moorthy (2014)
Maria C. Poor (2014)
Philip W. Pryor (2014)
Jason E. Rieser (2014)
Steven M. Samuels (2014)
Kenneth N. Wiesert (2014)

James P. Bastnagel (2015)
John H. Ditslear, III (2015)
Robert S. Flint (2015)
Tod C. Huntley (2015)
Norman Mindrebo (2015)
Robert Michael Pearce (2015)
David M. Ratzman (2015)
Michael A. Rothbaum (2015)
Jeffrey M. Rothenberg (2015)
Richard M. Storm (2015)
Jeremy T. Sullivan (2015)
H. Jeffery Whitaker (2015)
Allison E. Williams (2015)
Steven L. Wise (2015)

Robert J. Alonso (2016)
Ann M. Collins (2016)
Stephen B. Freeman (2016)
John Douglas Graham, III (2016)
Andrew A. Johnstone (2016)
Frank P. Lloyd, Jr. (2016)
Mercy O. Obeime (2016)
Ingrida I. Ozols (2016)
David L. Patterson (2016)
Michael A. Rothbaum (2016)
Jason K. Sprunger (2016)
Kenny E. Stall (2016)
Samuel T. Thompson (2016)
Ronald L. Young, II (2016)

Indiana State Medical Association Past Presidents

Jon D. Marhenke 2007-2008
Bernard J. Emkes, 2000-2001
Peter L. Winters, 1997-1998
William H. Beeson, 1992-1993
George H. Rawls, 1989-1990
John D. MacDougall, 1987-1988
George T. Lukemeyer, 1983-1984
Alvin J. Haley, 1980-1981

Indiana State Medical Association President-Elect

John J. Wernert (2013-2014)

House of Delegate Speaker, ISMA

Heidi M. Dunniway (2013-2014)

Seventh District Medical Society Trustees

Vicki M. Roe (2014)
John P. McGoff (2015)
Marc E. Duerden (2016)

Alternate Trustees

Robert A. Malinzak (2014)
John C. Ellis (2015)
G. Mitch Cornett (2016)

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Dental		Business Owners Policy
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		Malpractice Liability*

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CME & Conferences

Community Hospital East

First Wednesday	Critical Care Conference Bradley Board Room, 12:00 - 1:00 p.m.
Second Tuesday	Medical Grand Rounds Bradley Board Room, 12:00 - 1:00 p.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.
Every Other Month 4th Thursday	Psychiatry Grand Rounds 7250 Clearvista Dr. Multi-Service Rms. 1 & 2 7:30 - 8:30 a.m. begin 1/23/14

Community Heart & Vascular Hospital

First Wednesday	Imaging Conference: rotates Cath & Echo Case Presentations CHVH MCV Boardroom Videoconference to HVC Anderson Office, HVC East Office BR (Ste. 420) HVC South Office CR (Suite 2400) 7:00.- 8:00 a.m.
Third Wednesday	Ken Stanley CV Conference CHVH MCV Boardroom Videoconference to HVC Anderson Office, HVC East Office BR (Ste. 420) HVC South Office CR (Suite 2400) 7:00 - 8:00 a.m.
Fourth Wednesday	Disease Management Conference: rotates CHF & EP Case Presentations CHVH MCV Boardroom Videoconference to HVC Anderson Office, HVC East Office BR (Ste. 420) HVC South Office CR (Suite 2400) 7:00 - 8:00 a.m.

2014 Cancer Conferences
Community Hospital East

Third Thursday	East General Cancer Conference - CHE Medical Staff Conference Room 12:00 noon to 1:00, lunch provided
Fourth Tuesday	East Multidisciplinary Breast Cancer Conference - CHE Medical Staff Conference Room 7:00 to 8:00 am

Community Hospital North

First & Third Tuesdays	North Multidisciplinary Breast Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:00 to 8:00 am
Second & Fourth Wednesdays	North Multidisciplinary GI Oncology Conference - CHN 8040 Clearvista parkway, Suite 550 7:00 to 8:00 am
Second & Fourth Fridays	North Multidisciplinary Gynecologic Surgical Oncology Conference - CHN 8040 Clearvista Parkway, Suite 550 7:30 to 8:30 am
First Wednesday	North Chest Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:00 to 8:00 am
Third Wednesday	Melanoma Cancer Conference - CHN 8040 Clearvista Parkway, Suite 550 7:30 to 8:30 am

Community Hospital South

Second Wednesdays	South Multidisciplinary Breast Cancer Conference - CHS Community Breast Care Center South 533 E. County Line Rd., Suite 101 8:00 to 9:00 am

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

Indiana University School of Medicine/ Indiana University Health

IU – Methodist – Riley

May 9	17th Annual IU Gastroenterology/Hepatology Update Indiana History Center, Indianapolis
May 14-15	49th Annual Riley Child Care Conference Marriott Indianapolis North, Indianapolis
May 16	Spine Care Symposium: What Primary Care Needs to Know IU Health Neuroscience Center, Indianapolis
May 30	Mobile Computing in Medical Education Fairbanks Hall, IUPUI Campus, Indianapolis
June 6	1st Annual Neuroscience Summit IU Health Neuroscience Center, Indianapolis
July 12-19	99th Annual Anatomy and Histopathology of the Head, Neck and Temporal Bone Course IUPUI Campus, Indianapolis

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

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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 317-274-0104.

CME & Conferences

Indianapolis Medical Society

April
- 15 Executive Committee, Society, 6:00 PM, Sandwiches
- 24 Administrative Professional's Day (aka Secretaries' Day)

May
- 20 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
- TBD MSE Board Meeting, Society, 6:15 PM, Sandwiches

June
- 7-11 AMA House of Delegates Annual Meeting, Chicago, IL
- 11 Senior/Inactive Luncheon Meeting, 11:30 AM, Society, Speaker TBA
- 17 Executive Committee, Society, 6:00 PM, Sandwiches

July
- 15 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg.

August
- 19 Executive Committee, Society, 6:00 PM, Sandwiches

September
- 5-7 ISMA Convention, Indianapolis Westin. Indpls., 46204.
- 10 Senior/Inactive Luncheon Meeting, 11:30 AM, Society, Speaker TBA
- 16 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg. Dr. David R. Diaz will be installed as 141st IMS President.

October
- 15 Executive Committee, Society, 6:00 PM, Sandwiches
- 15 ISMA's Fall Legislative Dinner, Downtown Marriott

November
- 8-11 AMA House of Delegates, Dallas, TX
- 18 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg

December
- 10 Senior/Inactive Luncheon Meeting, 11:30 AM, Society TBD
- 16 Executive Committee Holiday Dinner, with Spouses

Membership Information with photos online on the Physician Finder page @http://imsonline.org/finder.php or in DocBookMD!

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President's Page

(Continued from page 7)

Despite the numbers demonstrating a significant cost savings associated with liability limits, there are groups working to stop states from implementing caps while actively trying to rollback limits that are already in place.

Medical malpractice lawyers have a lot to gain from unlimited damage awards stemming from malpractice lawsuits. That's why it's so important for physicians to get involved and stay involved with advocacy organizations. Active members benefit from an organization fighting to protect doctors.

In fact, a case stemming from an Indiana lawsuit has already made it to the State Supreme Court.

Timothy Plank filed a lawsuit against Community Hospitals of Indiana and Joseph Pavlik, MD, claiming the wrongful death of Plank's wife based on medical malpractice.

Mr. Plank alleged that the hospital had unreasonably delayed the delivery of an x-ray, which showed that Mrs. Plank had a dangerous, but treatable bowel obstruction. Had the x-ray been read promptly, Mrs. Plank could have had emergency surgery, which would have cleared the obstruction.

The jury found Dr. Pavlik not liable, but it awarded Mr. Plank $8.5 million against the hospital. The Indiana Malpractice Act (IMA) provides that the total amount recoverable in an action for medical malpractice may not exceed $1.25 million.

Mr. Plank appealed the ruling, calling the cap unconstitutional. In 2011, the Indiana Court of Appeals ruled that Mr. Plank was entitled to present evidence on whether the cap on damages, even if at one time constitutional, is now invalid because the original conditions that supported the law no longer exist.

Community appealed to the Indiana Supreme Court. On January 15, 2013, Indiana Supreme Court ruled in favor of Community on a technicality. It held that Mr. Plank had not properly asserted his claim of unconstitutionality in the trial court, and so it reversed the Court of Appeals and affirmed the trial court.[6]

Tort reform does not just allow financial relief for physicians, it also lowers the cost of medicine and improves access for all. I urge all physicians to stay active in your medical societies. It's one of the easiest ways to stay informed on the issue of tort reform and to make sure this issue stays at the forefront.

References:

1. http://www.forbes.com/sites/realspin/2013/08/27/defensive-medicine-a-cure-worse-than-the-disease/

2. http://www.aaos.org/news/aaosnow/dec10/advocacy2.asp

3. Ind. Code 34-18-14-3), Ind. Code 34-51-3-4 & 5), and Ind. Code 34-13-3-4

4. http://www.amaalliance.org/site/tort-reform/

5. http://www.amednews.com/article/20080303/profession/303039964/4/

6. http://www.in.gov/judiciary/opinions/pdf/01151301rdr.pdf)

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