Indianapolis Medical Society 1848

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Bulletin

Terra Cotta Warriors: The Emperor's Painted Army, *directly from China's Shaanxi Province*

Presented by Eli Lilly and Company Foundation.

May 10–Nov. 2, 2014.

The Children's Museum of Indianapolis

Indianapolis Medical Society
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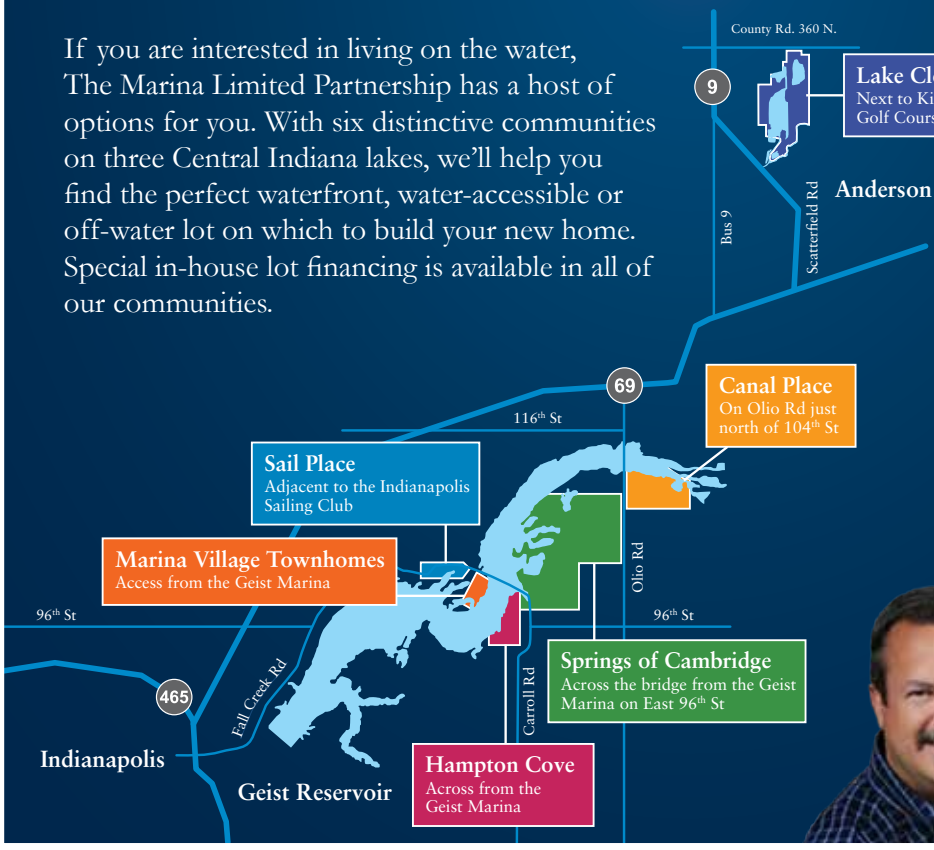

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We like to feature photographs or other artwork shared by IMS members on the cover of *The Bulletin*. Submit photographs, artwork, etc., to Beverly Hurt at the Society Office, bhurt@imsonline.org.

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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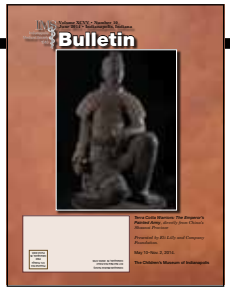

On our cover:
The Indianapolis Children's Museum Marching to Indianapolis in 2014!

Nowhere in the world have China's Terra Cotta Warriors been seen this way! For the first time ever, a museum pushes beyond showing the warriors as a traditional art display and engage families in the real science to help piece together this 2,200-year-old mystery, which many consider the Eighth Wonder of the World.

The extraordinary exhibit offers an up-close experience with real and rare objects, including eight warriors, a "painted" warrior head from the Xi'an dig pits and more than 100 other artifacts.

The exhibit explores how the unusually lifelike warriors were made by the first emperor's artisans--each one beautifully and uniquely hand-painted in rich colors. Interactives encourage families to become part of the archaeology team and investigate the real scientific research currently underway that helps us imagine what made this painted army so vibrant.

Visitors are encouraged to probe the science behind the warriors, and learn about their history and preservation for future generations. This one-of-a-kind learning exhibit is only seen in Indianapolis! Tickets available now.

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President's Page

Mark M. Hamilton, MD

The looming physician shortage in America: what it means for doctors and patients

There's a looming physician shortage in America, and it will likely hit the medical profession sooner than previously predicted. The supply of new physicians just isn't keeping up with demand. It's an issue that will affect millions of people, not just in of America, but across the globe.

There are a number of reasons for this prediction. The first is the rise in overall population growth. The current U.S. population is more than 315 million and growing. Americans are living longer with the help of breakthroughs in medical technology and advanced care management.[1] By 2030, 72 million Americans will be 65 or older, a 50 percent shift in age demographics since 2000.[2] The shift is mostly due to aging baby boomers. Seniors currently account for 12 percent of the population but will account for 21 percent by 2050. This growing, aging population will ensure more chronic disease and additional stress on the health care workforce.[3]

In a study published in *JAMA Internal Medicine*, researchers found that the baby boom generation is less healthy than many of their parents. It turns out that they have higher rates of hypertension, diabetes, obesity and high cholesterol than members of the previous generation.[4]

The findings "support an increased likelihood for continued rising health care costs and a need for increased numbers of health professionals as baby boomers age," the authors wrote. "Given the link between positive healthy lifestyles and subsequent health in this age group, the study demonstrates a clear need for policies that expand efforts at prevention and healthy lifestyle promotion in the baby boomer generation."

One of the biggest stress points is sure to be the care of the chronically ill, already a struggle for the Medicare program, particularly regarding patients with multiple chronic conditions.[5]

Couple that with the fact that one third of all U.S. physicians are 55 or older, and you've got the major ingredients for a doctor shortage.

Of the estimated 2.8 million registered nurses (RNs) and the 985,375 physicians currently working, one-third will likely retire in the next decade.[6] Workforce projections anticipate a critical shortage of between 91,500 to 130,000 physicians and the need for an additional 300,000 to 1.2 million registered nurses by 2020.[7]

Training new physicians, nurses, and other health professionals takes years, sometimes decades. Even if there were a spike in graduates coming out of nursing and medical schools, the number of available residencies is limited. The number of federally funded residency training positions was capped by Congress in 1997 by the Balanced Budget Act.

According to the Association of American Medical Colleges (AAMC), the 26,000 residency positions available for first year trainees will not be enough to provide training for the students graduating from medical school. The AAMC predicts this could happen as early as 2016.

The AAMC is pushing lawmakers to lift the cap on the number of federally supported residency training positions to ensure that there are enough physicians for our growing and aging population.[8]

The issue isn't isolated to primary care providers. The Association of American Medical Colleges also forecasts a shortage of medical specialists could outpace that of primary care doctors by as soon as 2015. This will inevitably mean individuals and families will face longer wait times, greater difficulty accessing providers, shortened time with providers, increased costs, and new frustrations with care delivery.

Another increase in patient demand stems from the Affordable Care Act, which is driving millions of previously uninsured Americans to the health care rolls. While providing insurance coverage to millions of new people is an admirable goal, medical care will suffer if there aren't more doctors to treat the influx of new patients. Workforce shortages could become catastrophic with new demand for medical services for the millions who are expected to enroll in Medicaid and the federal and state insurance exchanges. Doctors who are close to retirement age may simply decide to stop practicing rather than deal with the regulation, bureaucracy, and influx of new patients.

In some ways, the shortage of providers is even worse than the numbers indicate. Many primary care doctors and dentists do not accept Medicaid patients because of low reimbursement rates, and many of the newly insured will be covered through Medicaid.

Population demographics factor into the equation as well. One-fourth of America's population resides in rural areas but only 10 percent of physicians and 18 percent of nurse practitioners (NPs) practice in rural locations.[9]

Rural populations are generally poorer and more likely to participate in government assistance, creating the potential for high demand due to the Medicaid expansion in 26 states.[10] Geographical challenges affect the health of rural Americans through longer wait times, difficulty accessing care, long-distance travel, and limited resources.

According to the Health Resources and Services Administration, the federal agency charged with improving access to health care, nearly 20 percent of Americans live in areas with an insufficient number of primary care doctors. Sixteen percent live in areas with too few dentists and a whopping 30 percent are in areas that are short of mental health providers. Under federal guidelines, there should be no more than 3,500 people for each primary care provider; no more than 5,000 people for each dental provider; and no more than 30,000 people for each mental health provider.[11]

That's led the U.S. Department of Health and Human Services (HHS) to project the need for nearly 8,000 new primary care physicians in rural areas.[12]

Continued on page 23.

Special Feature ... *IMS Commentary:* Getting Needed Care

Distributed as an IMS News Release 4-14-2014

Many patients see physicians or have procedures and then feel like they are being cheated or are extremely disappointed because they get a bill that they expected their insurance company to cover. Why does this happen?

Patients receiving health care services need to be aware of what is occurring behind the scenes as physicians and others work to give patients care that is needed and the best available.

There is no question every patient office visit, procedure, or test is scrutinized for necessity and price. This leads to confusion, unpaid health care claims, and frustration on the part of patients, health care providers and insurers, not to mention delay in delivery of care while these differences are ironed out.

"Transparency," which would help patients, physicians and health care facilities, is nothing more than a buzz word. There are so many layers of rules and regulations that those providing care, can never be assured they will be paid for the services being provided. Also, those receiving the service, have no idea how much it will eventually cost them. Think about it; this system of buying something and not knowing how much you will have to pay is crazy! It is even worse because this system requires someone to order or provide the service ordered and they too have no idea if they will ever be paid. This lack of transparency results in billions of dollars of excess administrative costs every year.

As an example:

> Employers buy an insurance product which reassures the employer, if there is an employee that needs back surgery then the insurance will cover back surgery.

Here is where the case gets very complicated and confusing. Each employer buys a specific plan from an insurance company. But each insurance company has multiple plans which cover various options differently. Most employers add another layer and hire a company called a third party administrator (TPA) to oversee the plan, which allows this intermediary company to interpret the plan in their own way in an effort to save the employer money and the employee unnecessary procedures. So a physician or a health care facility does not know the details of each plan or how the particular TPA is going to interpret the plan. This varies from one TPA to another.

The physician office and hospital get approval for back surgery and the patient has back surgery. Let's suppose the physician chooses to do the surgery with a new piece of equipment or supply because they feel their patients heal faster and get back to work quicker when they use this process. But the particular health plan doesn't cover the cost of the equipment or supply because the TPA doesn't think it is necessary, even though they said they covered back surgery. Approvals are given by the health plan for the surgical procedure – not the various components of the surgery, so hospitals and physicians proceed to provide the best care using their best judgment and optimal techniques as defined by various specialty societies. Then later, denials of payment occur for certain portions of the care that each insurance plan individually considers "unnecessary, experimental, or investigational." Since these rules and policies differ by plan it is nearly impossible for physicians or hospitals to know ahead of time what is going to be paid for by the plan/employer - and more importantly what is not covered, thus making those costs patient responsibility.

It is important for physicians to perform at the top of their licensure and expertise. The special relationship between physician and patient determining the best treatment options should ideally include the costs to the patient. We physicians tend to discuss the costs we know – how long before the patient feels better and what are the risks and benefits of the treatment options. But the added and unknown variable costs hurt all of us.

This also places you as a patient in a situation where you and your physician have agreed on a treatment plan, and now your insurance is failing to pay for the care you agreed upon with your doctor as the best care for you. Financial responsibilities may fall to you in this circumstance.

We physicians of The Indianapolis Medical Society want to begin a dialog highlighting some of the difficulties we face as we work to improve health care delivery, communication, and the doctor patient relationship.

Unfortunately, there may be some physicians who provide unnecessary services to try to increase their bill. However, almost all physicians are honest and want what is best for their patient. There is simply some disagreement as to what is "best." There is no way that a physician could afford to hire enough employees to check to see if every single piece of equipment or product that they want to use in a procedure is covered by the hundreds of different insurance plans that their patients have. It would be doable if there was just one Anthem or one United Health Care plan – or even one set of rules that all plans had to follow. But there are multiple insurance companies and those companies have many different health plan options, as well as a wide variation in rules for each plan. Employers can also dictate what gets covered as long as they are paying the bill.

Frequently, there may be various opinions on the best way to care for a given patient (This is why we as doctors or you as patients sometimes ask for second opinions). But once the treatment plan is chosen and agreed upon by patient and physician and "approved" by the insurance company, the physicians, health care facilities and patients should all know how much they will receive as payment and how much they will owe out of pocket.

Inconsistent payment policies have a very significant effect of driving up health care costs. Having a single set of agreed upon guidelines makes all the sense in the world and would move health care costs in the right direction – down.

Unless and until there is real transparency, you, as a patient, are always at risk of having higher than necessary out-of-pocket costs. It is no wonder that few are really happy with the current health care system. Costs are high; administrative costs climb every year; and patients are continuously put in the position of "caught in the middle." You and your physician have agreed upon a plan of care that offers you the best chance of feeling better and improving your quality of life.

Then, some third party, based on rules that are inconsistent from payer to payer decides for you what gets paid. ... Patients should demand better. And we all will be patients at some time.

Respectfully submitted:

Doctors Bernard J. Emkes, John C. Ellis, Linda Feiwell Abels, Susan K. Maisel, Paula A. Hall, and Mary Ian McAteer

Bulletin Board

Robert A. Malinzak, MD, Franciscan Physician Network Joint Replacement Surgeons, the practice group affiliated with the Center for Hip & Knee Surgery at Franciscan St. Francis–Mooresville, will present an arthritis and hip and knee replacement seminar Wednesday, June 11, 2014, at the Comfort Inn and Suites, Columbus, Indiana. He will explain the latest procedures in joint replacement and arthritis treatments. Dr. Malinzak is a board-certified orthopedic surgeon specializing in joint replacement.

Randall J. Franiak, MD, with his partners opened his new local urgent care center, AFC/Doctors Express team on May 10, 2014. The new center is located at 7411 N. Keystone Avenue, Suite B.

Stephen W. Perkins, MD, Meridian Plastic Surgeons, recently was the Director at the Facial Plastic Surgery International (Dr. Perkins's foundation) 3rd Biennial Caribbean Facial Plastic Update Meeting in Nassau, Bahamas. He delivered the Welcome Address and also made presentations on the following topics: "Are Myotomies/Myectomies Really Worth Doing in Endoscopic Forehead Lift?;" "Are Surgical Facelifts a Thing Of The Past?" He also participated on the panel: "Midface: Fill, Lift, Implant or Combo?"

Dr. Perkins was also invited faculty at the recent European Rhinoplasty Summit in Munich, Germany. He made presentations on: "Why the Supratip Is So Important In Finesse Rhinoplasty;" "Why I Rarely Use The 'Tongue in Groove' Technique;" and "Spreader Flaps Versus Spreader Grafts." He was one of four faculty and the only U.S. surgeon to perform a live telecast rhinoplasty surgery. Dr. Perkins followed this Summit with a trip to Amsterdam, where he performed facial plastic surgery for two days in conjunction with a colleague.

Yuri McKee, MD, and **Francis W. Price, Jr., MD,** from Price Vision Group have begun to publish a new series of iBooks entitled, *The Digital Manual of Ophthalmic Surgery and Theory*. This represents a new format for educational material that seamlessly blends text, photos, drawings, videos and links to additional resources on the internet. The first book in this series describes Descemet Membrane Endothelial Keratoplasty ("DMEK") surgery, while the second iBook in the series includes chapters on keratoprosthesis surgery, ectasia screening, and femtosecond cataract surgery. Future editions are planned quarterly. This new series is available exclusively in the iBooks store for Apple devices.

Suzanne E. Montgomery, MD, has announced her book, *Letters Out of Africa*, is now available in paperback from Amazon.

Michael C. Large, MD, Urology of Indiana physician, was recently published in both *Cancer* and *International Journal of Urology* magazines. The articles were "Sex disparities in diagnosis of bladder cancer after initial presentation with hematuria: A nationwide claims-based investigation" in *Cancer*, and "Cystectomy and urinary diversion as management of treatment-refractory benign disease: The impact of preoperative urological conditions on perioperative outcomes" in *International Journal of Urology*.


Aaron A. Cohen-Gadol, MD


Andrew J. DeNardo, MD


Randall J. Franiak, MD


Michael C. Large, MD


Thomas J. Leipzig, MD


Robert A. Malinzak, MD


Yuri F. McKee, MD


Jean-Pierre Mobasser, MD


Suzanne E. Montgomery, MD


Troy D. Payner, MD


Stephen W. Perkins, MD


Francis W. Price, Jr., MD


John A. Scott, MD

News from Goodman Campbell Brain and Spine…

Aaron A. Cohen-Gadol, MD, and coauthors reported the results of a cadaver study to elucidate the anatomy of the nerve of McKenzie and its role in medically recalcitrant spasmodic torticollis; the article appeared in the *British Journal of Neurosurgery*, March 25, 2014. Dr. Cohen and a colleague also reviewed Harvey Cushing's contributions to posterior fossa tumor surgery in *Neurosurgical Focus,* April 2014 (36[4]).

Thomas J. Leipzig MD, Troy D. Payner, MD, and **Aaron A. Cohen-Gadol, MD,** reported on their experiences with perimesencephalic subarachnoid hemorrhage (PMSAH) and reviewed the clinical consequences in 88 patients; this work appeared in the February 19, 2014 issue of the *Journal of Neurological Surgery: Part A, Central European Neurosurgery*.

Jean-Pierre Mobasser, MD, has been appointed the team neurosurgeon for the Indiana Pacers and as a spinal consultant to the National Football League Combine, according to Becker's Spine Review.

Troy D. Payner, MD, Thomas J. Leipzig, MD, John A. Scott, MD, Andrew J. DeNardo, MD, Aaron A. Cohen-Gadol, MD, and residents published an analysis of aneurysmal subdural hematoma (aSDH) with long-term follow-up. To evaluate prognostic factors, the authors examined data from a prospectively maintained data base for patients presenting with aSDH from 2001-2013. The electronic publication appeared ahead of print in the *Journal of Clinical Neuroscience, January 24, 2014.*

Please submit articles, comments for publication, photographs, Bulletin Board items, CME and other information to mhadley@imsonline.org by the first of the month preceding publication.

New Members

Baenziger, Jennifer T., MD
Resident – IU School of Medicine
Internal Medicine/Pediatrics
Indiana University, 2010

Bosslet, Gabriel T., MD
IU Health
Pulmonary & Critical Care Medicine
200 W. 103rd St., #1100
46290-1018
Ofc – 948-5031
Internal Medicine, 2007
Pulmonary Disease, 2009
Critical Care Medicine (IM), 2010
Ohio State University, 2003

Damodaran, Ashvini, MD
Resident – IU School of Medicine
Internal Medicine
Hospitalist
University of Wisconsin, 2011

Franco, Angela M., MD
Resident – IU School of Medicine
Anesthesiology
Indiana University, 2009

Kelley, Katherine J., MD
Fellowship – IU School of Medicine
Pediatrics, 2013
Neonatal-Perinatal Medicine
Indiana University, 2010

McHugh, Patrick P., MD
Nephrology & Internal Medicine
1801 N. Senate Blvd., #355
46202-1252
Ofc – 924-8425
Fax – 924-8424
5255 E. Stop 11 Rd., #440
46237-6341
Ofc – 882-2857
Fax – 882-2873
Internal Medicine
Nephrology
University of Louisville, 2005

Patrick, Deborah J., MD
IU Health
Urgent Care East
326 S. Woodcrest Dr.
Bloomington, 47401-5314
Ofc – (812) 353-6888
Fax – (812) 323-8528
Family Medicine, 1985, 2006
Indiana University, 1981

Stone, Eddie M., MD
EmCare
6333 S. East St.
46227-7107
Ofc – 783-7474
Emergency Medicine, 1988, 2000
Tulane University, 1975

Worrell, Stewart S., MD
Northwest Radiology Network
5901 Technology Center Dr.
46278-6013
Ofc – 328-5050
Fax – 328-5053
Diagnostic Radiology, 2010
Duke University, 1999

In Memoriam

Philip W. Pryor, MD
1949 - 2014

Philip W. Pryor, MD, 64, passed away April 26, 2014. He was born July 1, 1949, in Bloomington, Indiana, and educated at Edgewood High School, Ellettsville, Indiana.

Dr. Pryor received his bachelor's degree in Industrial Engineering and masters in Systems Engineering from Purdue University. He then obtained his medical degree from Indiana University School of Medicine. Dr. Pryor completed his internship in surgery at the IU School of Medicine followed by residency in the Department of Orthopaedic Surgery. In 1985, he completed a spine surgery fellowship with a pioneer in the field at the New York State University, Buffalo General Hospital in Buffalo, New York.

Dr. Pryor was AAOS Board Certified in Orthopaedic Surgery. In 1987, he founded The Spine Institute, now located in Carmel.

He has conducted and published several scientific studies. Dr. Pryor was a member of the American Medical Association, a felllow of the American Academy of Orthopaedic Surgeons, Indiana Orthopaedic Society and the Simmons Surgical Society.

In his free time, Dr. Pryor enjoyed building computers, photography, and appreciating scenery. Most importantly, he had the opportunity to be "Papa" to seven grandchildren.

IMS Leadership, Delegates & Committees

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In Summary

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Stolen laptops lead to important HIPAA settlements

Two entities have paid the U.S. Department of Health and Human Services Office for Civil Rights (OCR) $1,975,220 collectively to resolve potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. These major enforcement actions underscore the significant risk to the security of patient information posed by unencrypted laptop computers and other mobile devices.

"Covered entities and business associates must understand that mobile device security is their obligation," said Susan McAndrew, OCR's deputy director of health information privacy. "Our message to these organizations is simple: encryption is your best defense against these incidents."

OCR opened a compliance review of Concentra Health Services (Concentra) upon receiving a breach report that an unencrypted laptop was stolen from one of its facilities, the Springfield Missouri Physical Therapy Center. OCR's investigation revealed that Concentra had previously recognized in multiple risk analyses that a lack of encryption on its laptops, desktop computers, medical equipment, tablets and other devices containing electronic protected health information (ePHI) was a critical risk. While steps were taken to begin encryption, Concentra's efforts were incomplete and inconsistent over time leaving patient PHI vulnerable throughout the organization. OCR's investigation further found Concentra had insufficient security management processes in place to safeguard patient information. Concentra has agreed to pay OCR $1,725,220 to settle potential violations and will adopt a corrective action plan to evidence their remediation of these findings.

OCR received a breach notice in February 2012 from QCA Health Plan, Inc. of Arkansas reporting that an unencrypted laptop computer containing the ePHI of 148 individuals was stolen from a workforce member's car. While QCA encrypted their devices following discovery of the breach, OCR's investigation revealed that QCA failed to comply with multiple requirements of the HIPAA Privacy and Security Rules, beginning from the compliance date of the Security Rule in April 2005 and ending in June 2012. QCA agreed to a $250,000 monetary settlement and is required to provide HHS with an updated risk analysis and corresponding risk management plan that includes specific security measures to reduce the risks to and vulnerabilities of its ePHI. QCA is also required to retrain its workforce and document its ongoing compliance efforts.

OCR has six educational programs for health care providers on compliance with various aspects of the HIPAA Privacy and Security Rules. Each of these programs is available with free Continuing Medical Education credits for physicians and

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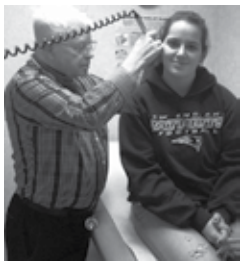

Have you ever thought about using your medical training to treat needy homeless and low-income individuals or families, only to realize you just couldn't risk the liability? Good Samaritan Health Clinic has you covered!

The Good Samaritan HC has been providing symptomatic & preventive primary physician care for the homeless and uninsured, FREE OF CHARGE, since 1992. This has been possible over the years because our clinic has been staffed by IMS and other **volunteer** doctors from central Indiana. Now, Good Samaritan urgently needs general practice and all specialty doctors to treat patients. ***Blanket malpractice insurance coverage is provided.*** If you want to be a "Good Samaritan" and make a difference without the risk, contact Pat Camano at (317) 638-2862 or e-mail pcamano@goodnewsminitries.com. Good Samaritan HC is operated by Good News Ministries.

Continuing Education credits for health care professionals, with one module focusing specifically on mobile device security: http://www.hhs.gov/ocr/privacy/hipaa/understanding/training

The Resolution Agreements can be found on the OCR website at http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/stolenlaptops-agreements.html

To learn more about non-discrimination and health information privacy laws, your civil rights and privacy rights in health care and human service settings, and to find information on filing a complaint, visit www.HHS.gov/OCR

From HHS.gov

Addressing Healthcare Workplace Violence

By: Laurette Salzman, MBA, CPHRM; ProAssurance Senior Risk Management Consultant

Violence in healthcare settings is very real, and hospitals are especially vulnerable. According to a study by the Emergency Nurses Association, the overall frequency of physical violence and verbal abuse for an ED nurse working 36.9 hours in a seven-day period is 54 percent.[1] Nurses affected were most often involved in triaging a patient, performing an invasive procedure, or restraining/subduing a patient; patients were the main perpetrators in all incidents.

The study also found physical violence rates increase as population density increases (9.1% rural vs. 14.1% large urban areas). The following tactics were found to decrease the odds of violence and verbal abuse:

- Use of panic buttons/silent alarms
- Enclosed nursing stations
- Locked or coded ED entries
- Security signs
- Well-lit areas

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It's also important to have a system-wide program in place to address workplace violence. The Joint Commission requires accredited hospitals to assess their risk of violence, develop written plans, and implement security measures.[2] Risks may vary by facility and department, underscoring the importance of individualized analysis.

A whitepaper on workplace violence in healthcare, published by ASIS International (an organization of security professionals with 35,000 members worldwide), recommends workplace violence teams adopt a multidisciplinary approach that includes: security, first responders, clinical staff, risk management, legal, human resources, administration, and other key stakeholders.[3] They cite the following five components of an effective workplace violence program:

1. Management commitment and employee involvement
2. Worksite analysis (including evaluating the physical environment)
3. Hazard reduction and response
4. Training
5. Recordkeeping and program evaluation

The ASIS whitepaper also includes a sample threat assessment checklist, a workplace violence policy, a list of common warning signs, and an assessment outline.

Additional training may also be necessary for employees in high-risk areas. These areas typically include emergency departments, ICUs, behavioral health, and operating rooms. The 2013 Workplace Safety & Patient Care Standards for Nursing Professionals (posted on rn.com) recommends that healthcare professionals, when confronted with potentially violent situations, should:

- avoid confrontation and retreat to a safe place, if possible;
- not approach or attempt to disarm an individual with a weapon;
- summon security or a behavioral response team, or call 911;
- remain calm—refrain from agitating or threatening a violent person; and
- isolate the individual—lock doors, direct traffic away from the area, and evacuate if possible.[4]

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American Lung Association "State of the Air 2014" Shows Indianapolis's Air Quality Worsening

Evidence warns that changing climate will make it harder to protect human health

Note: Trend charts, additional information and rankings for metropolitan areas and county grades are available at www.stateoftheair.org.

The American Lung Association's "State of the Air 2014" report released April 30 shows that Indianapolis has seen an increase in year-round particle pollution (soot) levels compared to the 2013 report. This is in spite of a trend seen across the nation of lower particle pollution levels. Indianapolis has experienced fewer unhealthy days of high ozone (smog) and more days when short-term particle pollution has reached unhealthy levels. Indianapolis ranked as the 20th-most polluted city in the nation for year round particle pollution, a worse ranking than last year's report.

Overall, "State of the Air 2014" found that nearly half of all Americans – more than 147 million – live in counties in the U.S. where ozone or particle pollutions levels make the air unhealthy to breathe. The 15th annual national report card shows that, while the nation continued to reduce particle pollution -- a pollutant recently determined to cause lung cancer -- poor air quality remains a significant public health concern. Additionally, a changing climate is making it harder to protect human health. Especially alarming is that ozone levels (smog), a powerful respiratory irritant and the most widespread air pollutant, were much worse than in the previous year's report.

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7:00 to 8:00 am

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- 7-11 AMA House of Delegates Annual Meeting, Chicago, IL
- 11 Senior/Inactive Luncheon Meeting, 11:30 AM, Society, Speaker: William Segar, MD, The History of Intravenous Therapy
- 17 Executive Committee, Society, 6:00 PM, Sandwiches

July
- 15 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg.
- 30 Juleps in July, 6:00-8:30, PM

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

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President's Page

(Continued from page 7)

Nurse practitioners and Physician Assistants can help to fill some of the gaps, but U.S. Labor Department workforce data shows there are far fewer nurse practitioners and physician assistants than doctors nationally, calling into question just how soon the gap of health care providers can be plugged.[13]

There is no easy answer to the problem. Patients will continue to live longer and use more care. An increased focus on preventative care will funnel some doctors and resources away from treating the sick.

The one thing we can do is continue to fight for the rights of doctors and patients. We can't stand idle while red tape, governmental regulation and increased certification requirements create hurdles that make it harder for young talent to enter the medical profession.

We owe it to patients to push back on issues that make it harder for doctors to deliver quality care. That's why your involvement in organizations like the Indianapolis Medical Society, the Indiana State Medical Association and the American Medical Association is so important. These organizations provide a platform that helps all of us stay informed and provides a voice for all physicians. Our involvement today can help change the direction of health care tomorrow.

Sources:

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[12] Council of State Governments, "Health Care Workforce Shortages Critical in Rural America," May 4, 2011, http://knowledgecenter.csg.org/kc/content/health-care-workforce-shortages-critical-rural-america

[13] http://www.usatoday.com/story/news/nation/2014/02/08/conquering-the-doctor-shortage/5307965/

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