

BULLETIN

EDITORIAL PG 10

Three Solutions to Help Lower Prescription Drug Prices

by MIKE BRAUN
UNITED STATES SENATOR



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LETTER FROM THE EDITOR:

Thank you for your readership! I hope you are enjoying our modern look and content.

The Bulletin is your magazine. If you have an idea or opinion you'd like to share, or an article you have written, please email me at mperrill@indymedicalsociety.org. We would love to publish it.

Sincerely,

Morgan Perrill
Executive Vice President



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THE PRESIDENT'S PAGE

CHRISTOPHER D. BOJRAB, MD

In 2010, the US Senate officially designated June 27 as National PTSD Awareness day. A few years later in 2014, the Senate declared the month of June as PTSD Awareness Month.

PTSD (Post Traumatic Stress Disorder) is one of the most frequently discussed medical conditions in the popular press. PTSD is a psychiatric disorder that occurs in patients who have experienced or witnessed a traumatic event (acts of violence, accidents, injuries, war/combat, rape, other assaults, etc.). Classic symptoms include intrusive thoughts about the incident, avoidance of things that remind one of the traumatic event, negative feelings and thoughts, hyperarousal/overreaction, etc.

It is estimated that up to 70% of adults will experience some type of trauma at least once during their lifetime. Up to 20% of those may eventually develop symptoms of PTSD. About 3-5% of Americans have PTSD at any point in time. Women are about twice as likely as men to develop PTSD (past year prevalence rates are 5.2% for females and 1.8% for males according to the National Institute of Mental Health). The lifetime prevalence is around 7-8%.

According to Veterans Administration experts, up to 30% of Vietnam Veterans experienced symptoms of PTSD, and about 13%-20% of Veterans from Desert Storm and Iraqi Freedom suffer from symptoms of PTSD. The need for science based, effective treatments for PTSD continues to grow.

The increase risk of PTSD in women is partly due to the increased rate of rape/sexual assault among women and the height rates of PTSD resulting from this.

There have been a number of standardized assessments used in diagnosing PTSD over the years. Perhaps the most commonly used instruments currently are the Clinician Administered PTSD Scale for DSM-5 (CAPS-5), the Structured Interview for PTSD (SIP), and the PTSD Symptom Scale Interview (PSS-I).

Patients with PTSD consume a disproportionate amount of healthcare services and healthcare dollars. There are a variety of treatments that can be helpful for patients suffering from PTSD. Not all patients with symptoms of PTSD require specific treatment by mental health professionals. Some patients will see spontaneous improvement over time or will receive benefit from the help/intervention of friends, family, or leaders in their



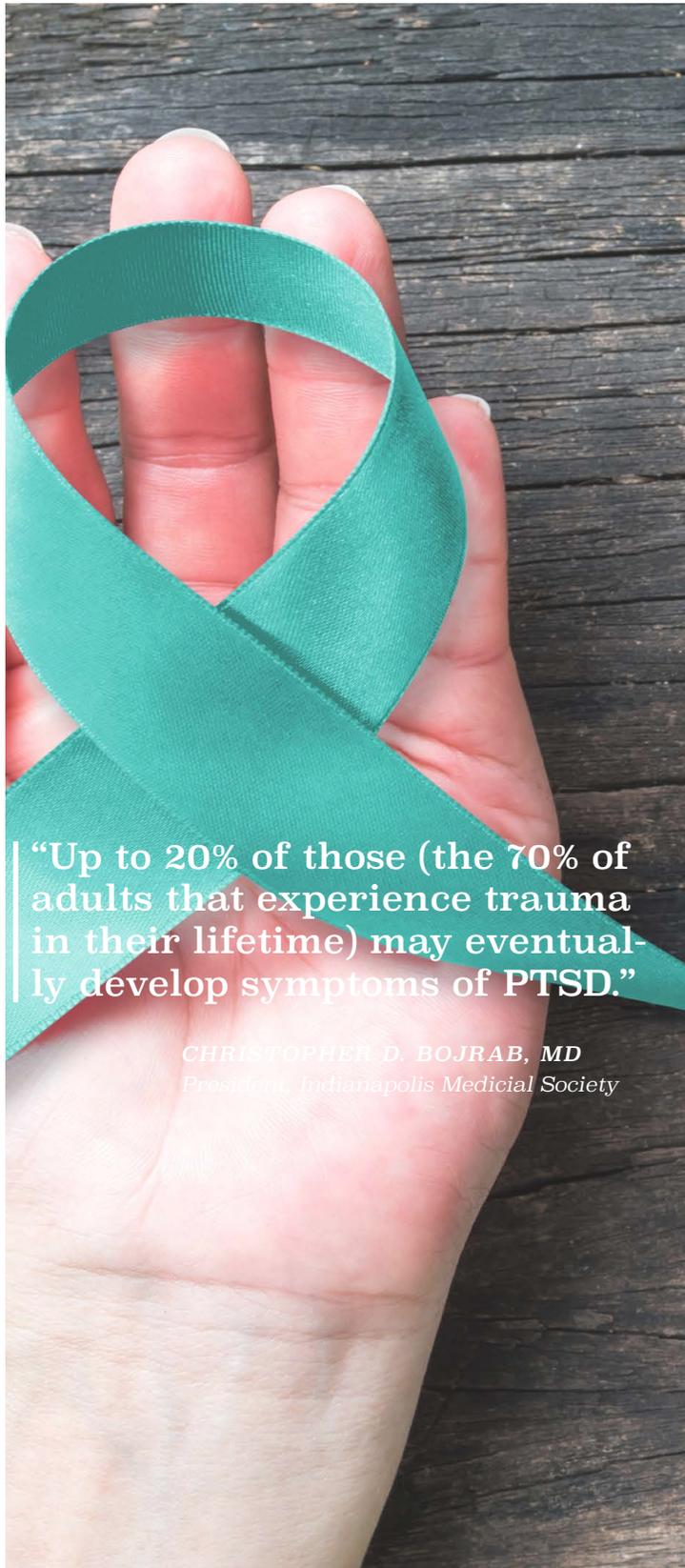
faith community.

However, many patients will require intervention by mental healthcare professionals using a variety of treatment modalities including both psychotherapeutic techniques such as Cognitive Behavioral Therapy, EMDR (Eye Movement Desensitization and Reprocessing) therapy, Exposure therapy, etc., as well as a number of different pharmacological treatments. Pharmacological treatments for PTSD include antidepressant medications, anxiolytics medications including benzodiazepines and non-benzodiazepine agents, mood-stabilizing medications/antipsychotic agents, anti-convulsant medications, and others. Regardless of the treatment approach used, one thing that has been shown in multiple studies is that providing patients with choices for treatment options is associated with improved outcomes.

Chris Bojrab MD

Chris Bojrab, MD
President, Indianapolis Medical Society

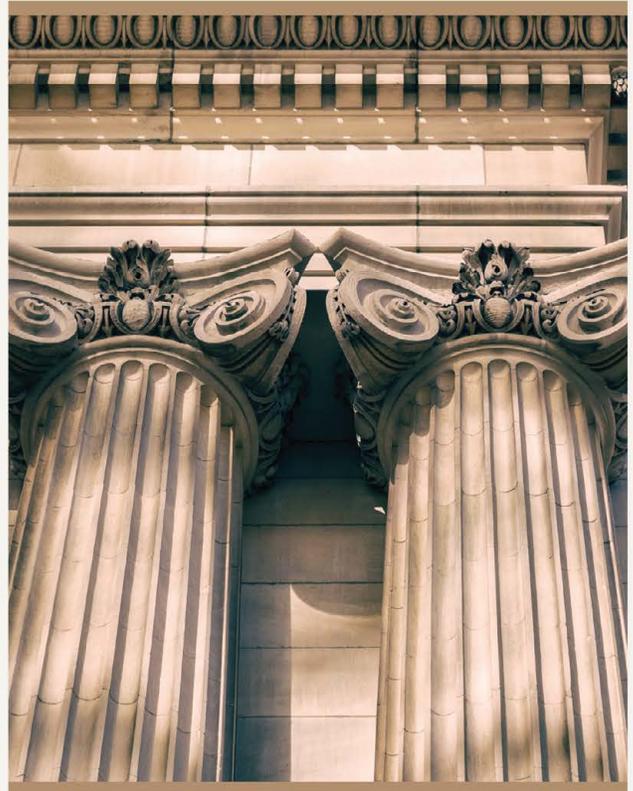
For more information on PTSD, visit the sites below:
www.psychiatry.org/patients-families/ptsd/what-is-ptsd
www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml
www.ptsd.va.gov
www.webmd.com/mental-health/post-traumatic-stress-disorder#1



“Up to 20% of those (the 70% of adults that experience trauma in their lifetime) may eventually develop symptoms of PTSD.”

*CHRISTOPHER D. BOJRAB, MD
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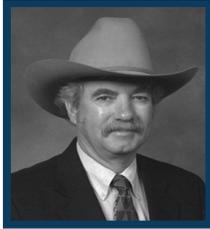
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FIFTY-YEAR CLUB

The Indianapolis Medical Society honors and thanks the following members for their fifty years of membership. Please join us in congratulating the newest members of the prestigious Fifty-Year Club. We are very grateful for their continued membership in IMS.

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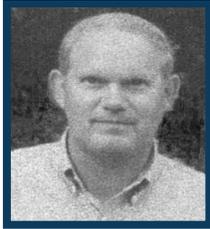
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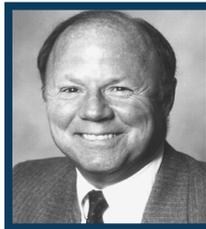
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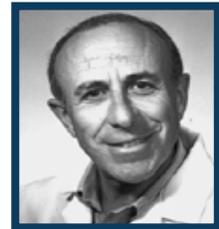
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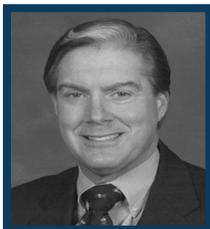
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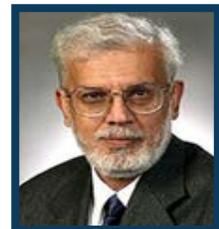
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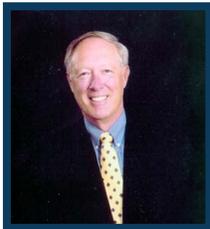
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Practical Legal Tips for Physician Employment Agreements

by TOM HUTCHINSON AND STEPHANIE ECKERLE,
Krieg DeVault LLP



The medical profession is constantly evolving and physicians face new challenges daily. While the first goal of physicians is to provide quality care to their patients, there are a number of other business and legal aspects that must be considered by physicians to maintain a sustainable practice. One issue that all physicians face is how best to negotiate employment agreements. Whether the physician is an owner of a practice that is hiring new physicians or the physician is seeking employment with a hospital, physicians should understand the basic legal framework of employment agreements. The following are important considerations when structuring, reviewing, and negotiating physician employment agreements:

1. Compensation Structures.

Compensation arrangements are always issues that can cause conflict. If dealt with proactively and transparently, they can be faced with ease. For any practice, it is critical that employment, ownership, management, and partnership structures, including compensation and profit-sharing, are clearly defined. Practices should take into account how to competitively compensate new recruits and how to clearly illustrate the path to partnership. Physician employment agreements should capture all aspects of a physician's compensation, including compensation for clinical services, supervision of nurse practitioners and physician assistants, medical directorships, bonuses, and other payments. Of course, financial arrangements must also comply

with the various state and federal laws.

2. **The Physician/Practice Obligations.** Many employment agreements go into great detail regarding the obligations of the physician to the practice. For example, the physician may be required to do the following: (1) comply with all laws, policies, and procedures; (2) fulfill the charitable mission of the practice (if a non-profit hospital); (3) complete all medical records daily; (4) perform certain administrative duties; (5) undertake educational activities or teaching obligations; (6) participate in peer review and quality improvement initiatives; and (7)

supervise other employees. Practices should clearly set forth these expectations in the employment agreement and in all related policies and procedures. Likewise, if there are certain obligations for the practice, those should also be detailed in the agreement. For example, the practice may provide

the physician with medical malpractice insurance (and tail coverage), certain staff and equipment, marketing resources, and billings and collections management. Other obligations of the practice, such as health insurance and paid time off, may instead be set forth in an employment policy.

3. **Scheduling and Location.** All employment agreements should clearly specify if the physician is full time or part time. In addition, the agreement should specify whether the physician

“Employment agreements can be a win-win for both the physician and practice when structured carefully and by taking into consideration the goals of both the practice and the employed physician.”



has on-call duties and whether those duties require being on call by phone or in-person. Lastly, the practice should be clear as to where the physician will be working. Often, the practice will want to specify that the physician may work at other locations “at the direction of the practice” or only with “the mutual agreement” of the parties.

4. Term and Termination. The employment agreement should clearly state the term of the agreement, whether there are any renewals, and how each party can terminate the agreement. The practice and physician both may want to be able to terminate the agreement for no reason or “without cause,” but should consider how much notice is appropriate. Often in physician employment agreements, the physician must give at least 90 days notice to terminate the agreement without cause. Furthermore, the practice may also reserve the right to terminate the physician “for cause” for a variety of reasons, including breach of the agreement, loss or suspension of licensure, violation of policies and procedures, or violations of law.

How you hire, discipline, fire, and treat physicians is often subject to scrutiny and potential litigation, so the termination provisions must be carefully drafted. For example, do you have the ability to terminate them without cause? Do you have to pay them for unused vacation time? Do you have to pay them for all outstanding wages? Will they be entitled to unemployment? All of these issues can be pitfalls that can lead to

litigation.

5. Confidentiality Clauses and Non-Compete Clauses. Confidentiality clauses in employment agreements are also important, as are non-competes and non-solicitation covenants. If a practice chooses to utilize a non-competes covenant, it should be reasonable and tailored to fit the physician’s work and the practice. For example, if the physician works at only one location, the practice may only want to restrict the physician from working within a certain geographic radius around that location and not others. In addition, the practice may want to consider whether they will enforce the non-competes if the physician is terminated “without cause” or whether they will offer the physician a buy-out option for the non-competes clause. Even if the practice chooses not to include a non-competes clause, the practice may want to consider having an exclusivity clause or being notified if the physician is going to engage in outside services, such as moonlighting at an urgent care center.

Employment agreements can be a win-win for both the physician and practice when structured carefully and by taking into consideration the goals of both the practice and the employed physician. If you have specific questions regarding employment agreements or other healthcare issues, please contact Stephanie Ecklerle (317) 238-6373 (seckerle@kdlegal.com) or Tom Hutchinson (317) 238-6254 (thutchinson@kdlegal.com) at Krieg DeVault LLP.



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Three Solutions to Help Lower Prescription Drug Prices

by MIKE BRAUN
United States Senator



“Career politicians have been talking about this problem for decades, and the only result we’ve seen is higher drug prices.”

Before being elected to the U.S. Senate last year, I spent 37 years building a business in my hometown. About 10 years ago, I made the move to self-insure my 900 employees, and I'm proud to have developed a plan that covers pre-existing conditions with no caps on coverage, and held premiums flat for those 10 years.

I have had the pleasure of meeting with many of you in my travels around Indiana, and many of you have shared with me your thoughts on how to address problems with our healthcare system. I appreciate that, and your expert perspective has helped me arrive at the solutions I'm working toward in Washington.

Today I'd like to share with you some solutions I've proposed to address the rising cost of prescription drugs: adding transparency to our pricing negotiations, clearing the way for more prescription drug approvals by the Food and Drug Administration (FDA), and providing oversight and accountability for the pharmaceutical industry.

PRICE TRANSPARENCY

Recently, HHS confirmed that "all or nearly all" of the drug price increases from drug manufacturers last month were being paid as rebates to pharmacy benefit managers or insurers, leaving Americans with higher drug prices. As a result, HHS proposed prohibiting these hidden rebates in government health care programs, which is a good first step, but we need to do more.

To drive down high drug costs, we need to shine a light on the negotiations between drug manufacturers, middleman negotiators and pharmacies. That's why I've proposed legislation to complement HHS's proposed rule for government health care programs to end these hidden rebates for private health insurance plans and require that any rebates be reflected in the price you see at your local pharmacy.

CLEAR THE WAY FOR MORE & FASTER DRUG APPROVALS

The FDA's lengthy and complex drug approval process is a significant obstacle to lower drug prices, which is contributing to shortages of life-saving drugs already available in other developed countries.

That's why I'm introducing a bill to create an accelerated approval pathway to act as a passing lane for prescription drugs that have already been approved for sale in other developed countries like the U.K. and Canada with a history of good clinical trials and available data.

If we can ensure supply chain safety for drugs manufactured outside the country, there's no reason to prevent them from being sold in the United States. This

accelerated approval pathway will foster competition, cut down on a long list of drug shortages, and create a better functioning drug market more reflective of the global economy without sacrificing safety for Americans.

CRACK DOWN ON ANTI-COMPETITIVE CORPORATE BEHAVIOR

I come from the business world, and the one thing that never fails to lower prices for consumers is more competition among companies. One way we can do this is by cracking down on anti-competitive practices by some pharmaceutical corporations such as extending patents to hold monopolies on certain drugs and paying competitors millions of dollars to stop them from creating generic drugs that patients depend on.

One simple tactic we can address is companies filing serial, frivolous "citizen petitions" against generic companies, delaying final FDA approval by months to years. Last year, the FTC filed a lawsuit against Shire ViroPharma which had submitted no less than 24 of these citizen petitions — delaying approval for a generic version of a drug that treats life-threatening gastrointestinal infections.

According to some healthcare experts these delays can yield drug makers millions of dollars in revenue. This gaming the system at Americans' expense needs to stop.

That's why I've introduced the Efficiency and Transparency in Petitions Act, which will require the FDA to publish additional information on these petitions and require petitioners to file them within a year of discovering the issue their petition is based on.

CONCLUSION

Career politicians have been talking about this problem for decades, and the only result we've seen is higher drug prices.

I'm confident that these three solutions — simplifying our drug price negotiations, clearing the path to the U.S. market for safe drugs, and cracking down on underhanded business practices by big drug companies — will begin to restore sanity to drug prices and security for Americans.

As I continue to travel the state and meet with healthcare professionals about how we can deliver results for American patients, I hope that you will contact my office to share your important perspective on these issues.

Take Care,
Mike Braun
U.S. Senator for Indiana

Impacting Change



by LOU BELCH & MORGAN PERRILL
The Corydon Group & Indianapolis Medical Society

How often have you been party to a conversation with fellow physicians complaining about a new requirement put on you by someone who does not understand what it means to be a physician? That intrusion into your practice could be from any number of sources; payors, administrators, employers or more likely, the government. You probably all agreed that decisions that impact public health are best made with input from physicians who live everyday trying to improve the lives of patients, and not with those who have no idea the unintended consequences of a quick fix or the ripple effects of a change in the healthcare industry.

What often happens next is what we call the “if they only knew syndrome”. You feel better because you complained to your colleagues. You found people that understood how you felt and agreed with you. You felt empowered, energized. Then you went home, and you didn’t have your friends, life got in the way and you did nothing about it and guess what, nothing changed. You all said, if (insert your favorite decision-maker here) only knew what I know, they wouldn’t make that decision. If you’ve experienced this (and we’re betting you have because we’ve all done this) then you’ve been victim to the “syndrome”. And let’s face it, we are all busy and creating change takes time, effort and a certain amount of self-confidence to speak up.

The good news, it isn’t as hard as you think. Every decision that impacts you has a process that allows you input and even opportunities to have decisions reconsidered. Even better news, as a member of the Indianapolis Medical Society and Indiana State Medical Association you have resources and staff that can help you navigate those processes. Your membership gives you access to other physicians who likely

have the same issues and provides you with legitimacy and strength in numbers.

Let us give you an example. Several years ago, Medicaid announced they were moving from a fee for service program to a managed care program. As ISMA leadership attended county medical society meetings across the state they heard a loud and clear message that physicians were concerned and wanted a seat at the table during the negotiations. These calls for action led to a Resolution by ISMA leadership to the House of Delegates that resulted in a task force that met monthly with state leadership to discuss the implementation of the managed care program. ISMA convened meetings of many County Medical Societies and many of our own IMS members were active on that task force. Did the physician community get everything they wanted? Of course, they did not. But was the program implemented better than it would have been without physician input? Yes, absolutely.

Not all Resolutions submitted to ISMA need to call for legislative action they can call for any number of actions whose results can be as effective. Just as Resolutions are not the only way to make an impact with decision-makers. What they all have in common is that they require a physician to identify a problem, propose a solution, and ask their fellow physicians for support. We bring this to you because we believe it may be time for another Resolution and task force. So the next time you find yourself complaining with your fellow physicians, don’t let yourself fall into the “if they only knew syndrome”, speak up, and speak out. We are One Voice, One Community, and One Profession and by coming together we can and will make things better.





TAKE NOTE:

Monday, July 15 is the deadline to submit resolutions for the 2019 ISMA Convention.

Submit resolutions online at www.ismanet.org under the About ISMA tab / Public Policy / Submit Resolutions

2019 ISMA Convention

September 13-15

Embassy Suites, Noblesville

2019 IMS Board Meetings (all members welcome)

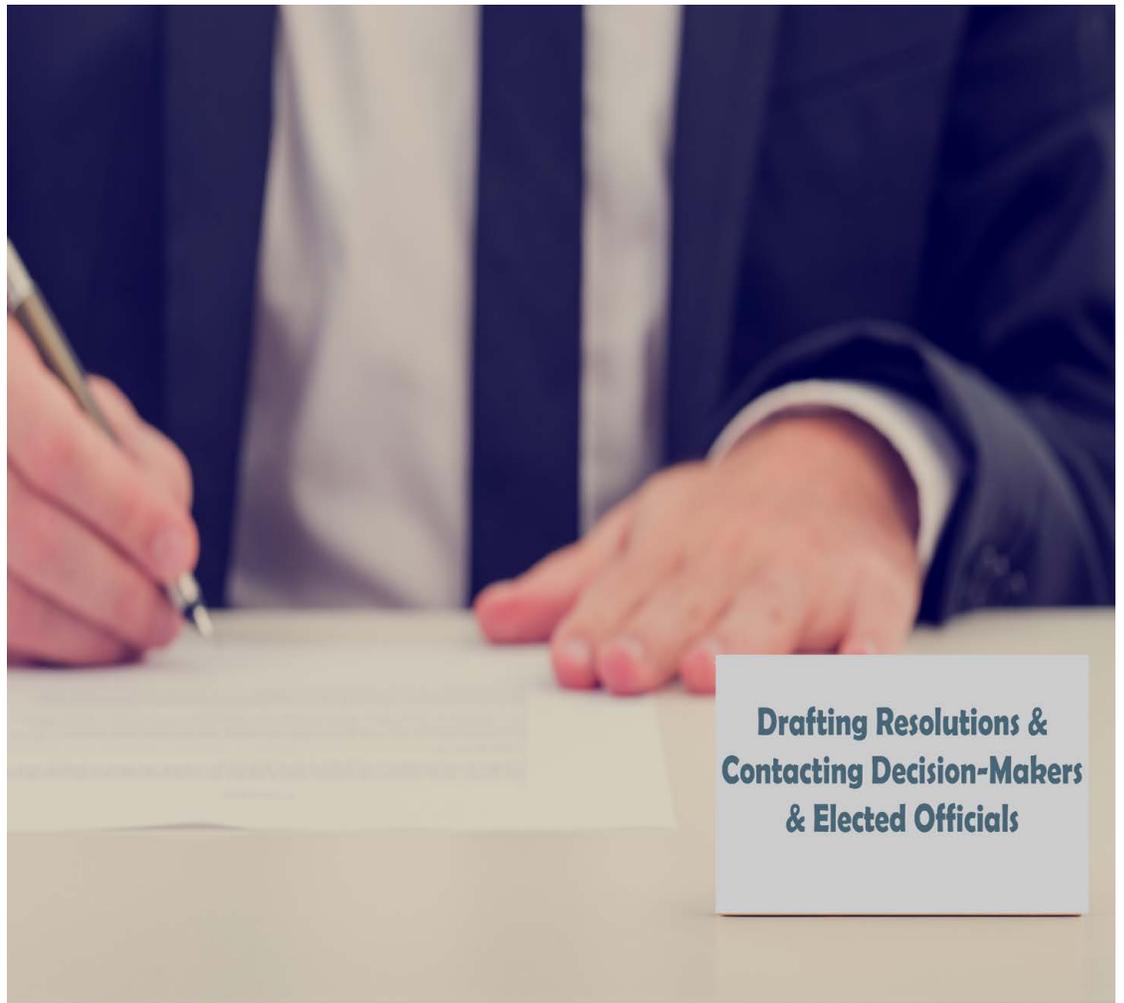
Tuesday, July 9 at 6 pm

Tuesday, September 10 at 6 pm

Tuesday, November 12 at 6pm

Location: Medical Academic Center
1322 N. Meridian Street, Carmel, IN 46032

RSVP 5 days prior to EVP, Morgan Perrill



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NOTE FROM THE AUTHOR:

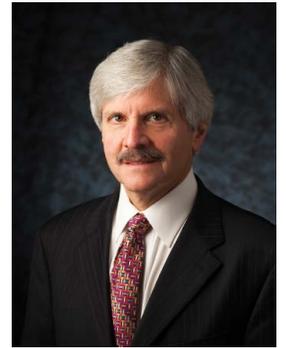
I am writing a new book that will be published by the Indiana Historical Society Press entitled, *What We Have Learned from Our Patients*. I am looking for stories from Indiana physicians, residents, and medical students (and possibly APRN's, PA's, nurses and psychologists) regarding how they were touched by a specific patient or what they have learned from a specific patient about life, the world, career, and oneself. Please contact me at richarddfeldman@gmail.com if you are interested in submitting a story or with questions.

NOTE FROM THE EDITOR:

The following are the opinions of one of our members. This article is published with the intent to encourage discussion. If you have an opposing viewpoint, please send it. We would be happy to publish it in next month's edition. Additionally, if you have an editorial you would like to share please feel free to submit it to me at mperrill@indymedicalsociety.org.



2019 Legislative Wrap-Up: We Should Do Better



by RICHARD D. FELDMAN, MD

IMS Board Member, Family Physician, Former Indiana State Health Commissioner

The United Health Foundation's annual state health rankings found Indiana to be the 10th worst in the country, waning three positions from last year. Rates of smoking, obesity, chronic diseases, infant mortality, drug deaths, cancer, and premature deaths are among the worst in the country. Indiana has one of the highest shortages of primary care physicians, dentists, and mental health providers. Tellingly, Indiana ranked 48th lowest in public health funding. Our poor Hoosier health is reflective of terrible lifestyle choices and lack of value placed on health by our policymakers. Indiana's unhealthy reputation continues.

How did the General Assembly perform this session in addressing our poor health status? Here is a brief overview:

Tobacco bills did not see passage again this year. These included increasing taxes on cigarettes, taxing e-cigarette liquids, and increasing the legal age to 21. Disappointing but certainly not surprising.

All marijuana bills never saw the light of day. Although the majority of states, including surrounding states, have enacted cannabis-related legislation, Indiana legislators remain firmly opposed. Don't expect any movement on medical marijuana anytime soon.

The enacted budget bill addresses physician shortages by increasing funding for medical student primary care scholarships, maintaining supplemental funding for family medicine residencies, and allocating development funding for new and expanded residency programs, mostly primary care. The budget bill also funds two excellent programs addressing infant mortality in at-risk women— the OB Nurse Navigators Program and the Nurse Family Partnership.

SB 394 was an extremely contentious bill that would have allowed advanced practice registered nurses (nurse practitioners) to practice and prescribe independently in Indiana. The medical community strongly opposed this legislation on the basis that APRNs simply do not have the clinical training to do so with only about 750 hours

of clinical experience before graduation. The legislation did not require any true additional post-graduate clinical physician-collaborative educational training. The bill was steamrolling to passage until Representatives Barrett and Fleming, both physicians, boldly challenged the bill. Legislators finally listened to reason and it died for lack of support. Thank goodness.

SEA 141 creates regulations for office-based buprenorphine prescribing for opioid addiction, assuring responsible and appropriate prescribing and treatment, yet not discouraging providers from treating their patients through onerous provisions. HEA 1007 requires obstetrical-care providers to assess for substance-use disorders in pregnancy and appropriately provide or refer for treatment.

HEA 1547 ensures that girls 16 and older will be able to make health care decisions regarding pregnancy, labor and delivery, and post-partum care if the parents are unavailable or uninvolved. Currently, teenagers can make decisions regarding the baby but not themselves. A much-needed rational change.

SEA 201 extends the list of providers who may opt-out of participating in pregnancy terminations, either by medications or surgical procedures, to PAs, nurses, and pharmacists. One ought to be able to follow one's conscience, but it should have included the requirement to refer to a willing provider to assure continuity of care.

HEA 1211 makes "dismemberment" second trimester pregnancy terminations illegal in Indiana unless the pregnancy is a serious threat to the health or life of the mother. The exceptions should have included fatal-fetal conditions. Although second trimester abortions are rare in Indiana, this procedure is the most common and felt to be the safest method. The ACLU has already filed suit.

Although there were some encouraging measures passed this year and some bills that were fortunately defeated, there were bills that missed the target and lost opportunities to enact much needed health-related legislation. We should do better.

THE BULLETIN BOARD

ANDREW JEA, MD



Andrew Jea, MD, recently joined his fellow authors in publishing a research paper in the *Journal of Neurosurgery: Pediatrics*. "Reconstruction of the anterior craniocervical junction using an expandable cage after resection of a C1 chordoma in a 5-year-old child: case report," appeared online ahead of print on April 12.

JEAN-PIERRE MOBASSER, MD



Jean-Pierre Mobasser, MD, president of Goodman Campbell Brain and Spine, also participated during the AANS annual meeting as an invited presenter for two breakfast seminars, titled: "New and Evolving Technologies for Minimally Invasive Lumbar Disc Surgery" and "Fast-Tracking Patients in Neurosurgery: Protocols and Pathways for Enhanced Recovery."

ERIC POTTS, MD



Eric Potts, MD, joined fellow co-authors with sharing new research in *Neurosurgical Focus*. "A comparison of minimally invasive transforaminal lumbar interbody fusion and decompression alone for degenerative lumbar spondylolisthesis" appeared in the May issue.

JEFFREY RASKIN, MD



Jeffrey Raskin, MD, served as faculty instructor for a course entitled, "Disconnection Surgeries. Stereotactic and Functional Neurosurgery Course." The course was held in Portland, Oregon on April 4-6. Dr. Raskin and Andrew Jea, MD, also gave an oral presentation on "Robotic laser ablation in the pediatric neurosurgical population: Epilepsy and Oncology,"

during the Indiana Chapter of the American College of Surgeons 66th Annual Scientific Meeting held on April 13 in Carmel, Indiana. He also co-authored a new research paper on "Intracranial arachnoid cysts: Pediatric neurosurgery update." It appeared in *Surgical Neurology International* on February 6.

MITESH SHAH, MD



Mitesh Shah, MD, recently served as a guest examiner for the American Board of Neurological Surgery Oral Boards held on May 4-5. Dr. Shah was also an invited Visiting Professor at the Mayo Clinic in Scottsdale, Arizona. His Grand Rounds lecture was on the "Utilization of Preop and Intraop DTI Imaging for Resection of Deep Seated Brain Lesions using a

Tubular Retractor system."

THERESA ROHR-KIRCHGRABER, MD



Theresa Rohr-Kirchgraber, MD presented at the IU Kokomo Women's Leadership Program on "The Impact of Sex and Gender in Health and Disease". She was recently a panelist for Summit Performances after the performance of "Same Blood: Stories of Inequity from Ten Black Women Living in Central Indiana".

Her paper Sex and gender in medicine The need for more attention to how sex and gender influences healthcare published in *healthManagement.org* Volume 19 issue 3 (2019) can be read at <https://iii.hm/vdl>

RICK SASSO, MD



Dr. Rick Sasso served as a faculty member at the inaugural launch course of the most recent FDA approved cervical artificial disc. He was asked to lecture on the current status of cervical disc replacement in the United States. The meeting was held in Dallas, Texas on May 4, 2019.

He also chaired a symposium titled "Challenges in Complex Posterior Cervical operations" at the annual "Global Spine Congress" meeting held in Toronto, Canada May 17, 2019. The talk Dr. Sasso gave was "Cervical Deformity".

Please submit Bulletin Board Information to ims@imsoline.org. Your photo in the IMS files will be used unless an updated picture is submitted with your material.

IN MEMORIAM

RICHARD BENNIGHOF SCHNUTE, MD



Richard was born on January 12, 1927 in Evansville, IN. He graduated from Bosse High School where he met his future wife when they were both freshmen. When Richard turned 18, he joined the Merchant Marines where he served as a cook during the Second World War. He also served in the Navy as a Chief Medical Officer aboard the USS George

Clymer. Dr. Schnute was board-certified in Internal Medicine and Endocrinology and practiced medicine for over 50 years. He was a professor Emeritus at IU School of Medicine and was a Fellow of the American College of Physicians. During his tenure, he taught a required course on Physical Diagnosis to all medical students. Richard was the recipient of the J.O. Ritchey Award of IU School of Medicine for excellence in medicine. IMS Member since 1959.

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CME & CONFERENCES

MONTHLY EVENTS

	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1st Week of the Month	Community North: Breast Cancer Conf. 7-8 am	Community East: CHE Admin Conf. 12-1 pm Community North: Psychiatry GR 12:30-1:30 pm Community North: Chest Cancer Conf. 7-8 am Community Heart & Vascular: Imaging Conf. 7-8 am		Community North: Forum 7-8 am Community South: South Case Presentations 12-1 pm
2nd Week of the Month	Community East: Medical GR 1-2 pm Community South: South General CHS 12-1 pm	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: M&M Conf. 7-8 am Community South: Breast Cancer Conf. 8-9 am St. Vincent Simulation Center: Pediatric GR 12-1 pm St. Vincent Womens: Neonatology GR 12-1 pm	St. Vincent: Echocardiography Conf. 7-8 am	Community North: Gynecological/Oncology Conf. 7-8 am
	Community North: Breast Cancer Conf. 7-8 am Community South: South Thoracic 8-9 am Community South: South Molecular 5-6 pm	Community North: Psychiatry GR 12:30-1:30 pm Community North: Melanoma 7:30-8:30 am Community Heart & Vascular: CV Conf. 7-8 am	St. Vincent Heart Center: Cardiac, Medical, Surgery 7-8 am	Community North: GU Conf. 7-8 am Community South: South Case Presentations 12-1 pm
	Community East: Breast Cancer Conf. 7-8 am	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: Disease Manage Conf. 7-8 am St. Vincent Womens: Perinatal Case 7-8 am	St. Vincent Womens: MFM Ultra Sound Series St. Vincent Simulation Center: Sim Debriefing Essentials St. Vincent Simulation Center: PMCH Crisis Management	Quarterly 1-4 pm 12x/Year 12x/Year

WEEKLY EVENTS

Day of the Week	Event
Monday	St. Vincent: General Cardiology 7-8 am
Tuesday	St. Vincent: Trauma Case 12-1 pm St. Vincent Womens: Neonatology Journal Club (every other month) 12-1 pm
Wednesday	St. Vincent: CCEP 7-8 am St. Vincent Heart Center: Interventional Cardiology 7-8 am St. Vincent: Advanced Heart Failure 7-8 am St. Vincent: Surgery Didactics 7:30-8:30 am St. Vincent: Surgery M&M 6:30-7:30 am
Thursday	St. Vincent PMCH: Pediatric Cardiothoracic Surgery & Cardiology Conf. 12-1 pm St. Vincent OrthoIndy: Fractures 8-9 am
Friday	

ONLINE EVENTS

Indiana University School of Medicine
 HPV Documentary, Someone You Love: The HPV Epidemic
<http://cme.medicine.iu.edu/hpvdocumentary>
 Opioid TeleECHO Clinic Providers and Prescribers Webinar
<https://iu.cloud-cme.com/opioidecho>

JULY EVENTS

July 14-19 Course on Anatomy & Histopathology of Head, Neck & Temporal Bone, IUPUI
 July 20 ASCO Review, IUPUI Campus
 July 30-Aug 1 Agile Implementation Boot Camp, HITS Building

AUGUST EVENTS

August 23-24 INAAP Pediatric Conference, Fort Wayne, IN

For more detailed information, please visit the events page on our website at www.indymedicalsociety.org/imsevents

To submit articles, Bulletin Board items, CME & events, opinions or information, email ims@imsoline.org. Deadline is the first of the month preceding publication.



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