

BULLETIN

STUDENT EDITORIAL PG 9

More than Skin Deep: Excising the Stigma of Plastic Surgery

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LETTER FROM THE EDITOR:

Thank you for your readership! And thank you to those of you who have been submitting articles! 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.

This issue is content heavy so I hope you're ready for some thought-provoking articles. I'll leave you with my positive thought for the month, a quote by Robert H Shuller, "The only place dreams become impossible is in your own thinking."

Morgan Perrill

Morgan Perrill
Executive Vice President



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THE PRESIDENT'S PAGE

CHRISTOPHER D. BOJRAB, MD

Richard Phillips Feynman (5/11/1918 – 2/15/1988) was a theoretical physicist who received his undergraduate degree from MIT and his PhD from Princeton. He is an interesting character, born in Queens, NY to parents from Belarus. At age 15 he reportedly taught himself algebra, geometry, trigonometry, and calculus (differential and integral). He applied to Columbia University but was not accepted at that institution because of a “quota on the number of Jews admitted” at the time and therefore ended up attending MIT. He originally majored in math but later switched to electrical engineering. He went on to begin his graduate work at Princeton where he received his PhD. He was recruited to work on a program that eventually became the Manhattan Project where he focused on uranium enrichment. He remained at Los Alamos for a number of years through the time of the death of his wife who had long suffered with tuberculosis. He later went to Cornell where he taught for a number of years. After leaving Los Alamos, his exemption for working on the Manhattan Project ended and he was subject to the draft. However, at his induction physical, he was given a 4-F medical exemption as he was felt to be clinically depressed. After leaving Cornell he was recruited by the California Institute of Technology (Caltech) where he became an acclaimed teacher, researcher, and lecturer. He won the Albert Einstein Award in 1954 and the Nobel Prize in Physics in 1965 for his work in quantum electrodynamics.

Feynman has been one of my intellectual heroes, not only because of his amazing mind and contributions to science, but because he was one of the early science communicators who understood the importance of skepticism and perhaps more importantly self-skepticism. I think about those two quotes of his written above almost every day, telling myself that I never want to be thought of as the doctor who is “often wrong but never unsure”.

As our medical knowledge base grows at an ever-accelerating rate, it becomes harder and harder to keep up with everything in our own specialty, to say nothing of medicine as a whole. Patients have increasing access to medical information, and I frequently hear colleagues complaining of patients and family members coming in questioning us or challenging us as a result of their “research” online. It is easy to become frustrated when this happens, very few people like to be challenged when it comes to their area of expertise. Sometimes it is difficult to navigate these encounters without coming across as condescending or irritated which, while understandable, may not ultimately be helpful in caring for our patients.



“I’m smart enough to know I’m dumb.”

“The first principle is that you must not fool yourself and you are the easiest person to fool.”

-Richard Feynman, PhD

Something that I have found helpful in these situations is to briefly explain to patients or families that I hear their concerns and admit that not even experts like us get it right 100% of the time. It is possible for us to make mistakes and at times to simply just be wrong. I find that if I share my thought processes regarding their diagnoses and treatment plan with them, coupled with an acknowledgement that we can course-correct and change our treatment plan if things are not proceeding as anticipated, they are much more likely to feel confident in their treatment.

Part of being an expert in any field involves a certain amount of neuropsychological humility, that is, understanding the limitations in our ability to accurately observe, interpret, understand, integrate, and remember our experiences and the world around us. We are all subject to some degree of preconceived notions, confirmation bias, expectation, and conflicts of interest. It is part of the human condition and is probably literally hard-wired into our brains. However, perhaps by trying to remain cognizant of these cognitive complicators and the ways in which they may influence our thinking, we can try to rise above them to a greater degree to become even more effective physicians for our patients in these times when it feels expertise is under attack.

Chris Bojrab MD

Chris Bojrab, MD
President, Indianapolis Medical Society

The Lifestyle Medicine Physician's Case to Self-Insured Employers

A Business Model for Physicians, a Bargain for Companies

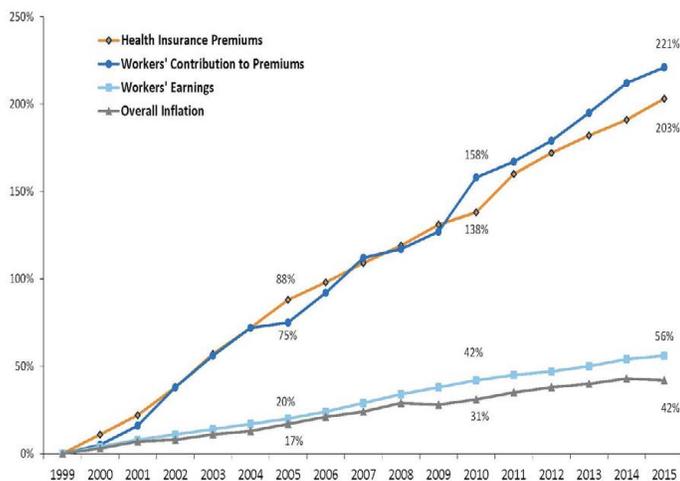
by MAHIMA GULATI, MD AND MARY DELANEY, MS PT, CWP (PICTURED)

Department of Internal Medicine, Middlesex Health Hospital, Middletown CT and President, Vital Incite, Indianapolis, IN



There is no arguing that modern US health care system is in dire need of reform. A majority of Americans have health care insurance through their employers¹. Employers are finding that the cost to provide insurance coverage has escalated at a much higher rate than inflation and has therefore limited their ability to provide raises or increase their workforce. Furthermore, we have seen little change in terms of policy that has impacted the demand on the healthcare system or the employer's budget².

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2015; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2015 (April to April).



Delaying a stitch in time costs nine.

The current efforts to reform healthcare are more like shifting the chairs on the Titanic. Some key efforts, like creating a high deductible plan with an accompanying HSA, were implemented as early as 2003. The high deductible health plans were introduced to help create more consumerism, with the belief that shifting costs to the consumer will drive the consumer to take more ownership in their healthcare costs and indirectly influence their overall health outcomes³. Current emphasis in the health market focuses on post-disease occurrence and not enough on how to create a more cost-efficient approach to provide resources for preventative needs.

Any attempt to create consumerism by increasing deductibles may have instead increased barriers to timely care. These efforts may initially show a decrease in medical spending, but the spending decrease is most likely due to a decline in utilization and can create a larger longitudinal dependence on the healthcare system⁴.

Less Health, More Cost

While this may seem obvious, we must make the case to employers first that improved health is critical to decrease medical spending and dependence on the healthcare system. If an employer is going to improve their healthcare spending, they must focus on keeping the healthy people healthy, and reversing chronic disease early in its course ("prevention is better than cure"). Since, approximately 20% of US adolescents are currently obese⁵, it is estimated that by 2050, more than 1 in 3 adults will have type 2 diabetes⁶. Compare this with the current rate of diabetes, which is 1 in 11 people, from 2015⁷. In Vital Incite's pool of just under 19,000 persons with diabetes, we found that a person with diabetes costs about \$10,000 more

1 <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

2 <https://www.kff.org/health-costs/report/2018-employer-health-benefits-survey/>

3 <https://www.healthaffairs.org/doi/10.1377/hlthaff.25.1.174>

4 <https://www.beckershospitalreview.com/finance/21-statistics-on-high-deductible-health-plans.html>

5 Hales CM, Carroll MD, Fryar CD, Ogden CL. Prevalence of obesity among adults and youth: United States, 2015-2016. NCHS Data Brief. 2017;288:1-8.

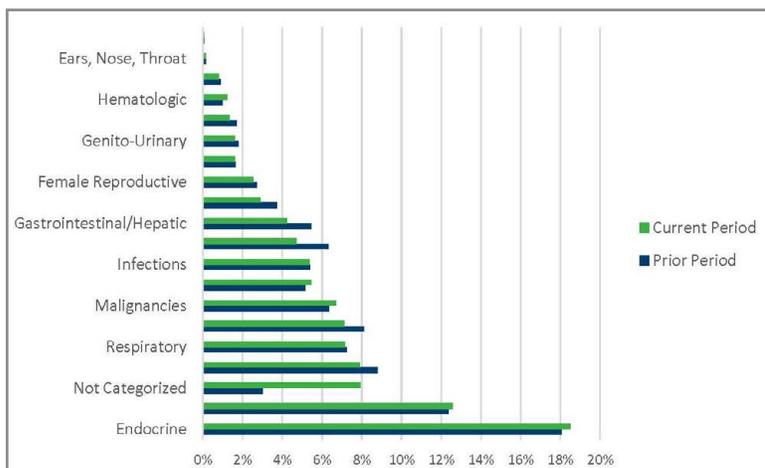
6 <https://www.cdc.gov/media/pressrel/2010/r101022.html>

7 <http://www.diabetes.org/diabetes-basics/statistics/>

per year than someone without the condition. This is consistent with national statistics, which estimate that in people with diabetes, an average \$9600 is attributed to diabetes medical expenditures alone⁸. In addition, in our data, we find only 27% of employees are at a healthy weight and in fact, 22% are morbidly obese and 21% are obese. This is again consistent with national data, 39.8% of all American adults are obese⁹. The medical cost for people who have obesity was \$1,429 higher than those of normal weight. Furthermore, as of now, 1 in 3 American adults are living with prediabetes¹⁰. The distance between prediabetes and overt type 2 diabetes is a mere 5 pounds and/ or 5 years (i.e. on an average, if a patient with prediabetes gains 5 pounds or ages by 5 years without implementing any therapeutic lifestyle changes, they are likely to transition to overt type 2 diabetes). Since pre-diabetes converts to type 2 diabetes at the rate of 9% per year¹¹, reducing its prevalence by addressing obesity will do far more to reduce the total cost of healthcare than focusing on diabetes treatment alone¹².

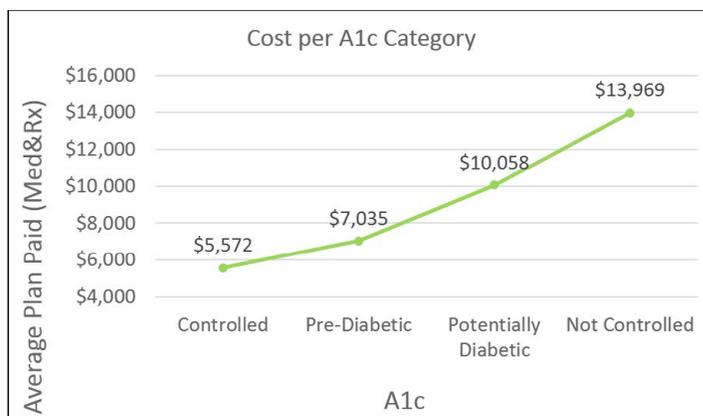
In the “State of US Health” report, high body mass and dietary risks are noted as the 2nd and 3rd highest risk factors impacting disability¹³.

Further, in Vital Incite data, we see that the top drug-related expense in 2018 is coming from Endocrine disease and we know that chief among those diseases is diabetes, with an estimated 90-95% of diabetics being Type 2 diabetic. This is very much in sync with national statistics, which estimate that of the \$329 billion spent annually on the cost of prescription drugs, almost 1/3rd (\$107 billion) is diabetes drug costs¹⁴.



There is a clear correlation between cost, A1c control, and weight, and we find in our data that every increase in BMI category accounts for about \$800 more in medical spending for the health plan (or employer) per person per year. When examining the correlation between A1c control and cost, we find that as persons move to less controlled A1c values, their cost incre-

mentally increases as well. This is corroborated from findings garnered by other national level data sets as well^{15,16}.



Value Based Plan Designs

The irony behind the development of value-based insurance plan designs is that key strategic decisions have been made between the carriers, hospital systems and the benefit advisors. Providers, especially in independent practices, are not connected to any strategic development and therefore their best interests may not be considered. Essentially there are three main groups paying for healthcare; the patient, the employer and the insurance carrier. If the patient has medical insurance, the patient is responsible for the amount that the insurance plan does not cover. The share that is paid by either the employer or the insurance company is dependent on if the employer is self or fully funded, which a company chooses for itself. In a fully funded account, the carrier takes on the risk of the plan. The employer pays only a pre-negotiated monthly rate for their premium and the carrier takes on the risk and responsibility for the total amount due. In the United States, approximately 39% of employers are fully funded¹⁷. Typically, smaller employers are more likely to be fully funded, but the threshold for the size of these employer groups vary by state. The most progressive self-funded state is Indiana, with more than 70% of employers being self-funded¹⁸.

In 2016, 40.7 percent of private-sector employers reported that they self-insured at least one of their health plans, up from 29.7 percent in 2000, the Employee Benefit Research Institute reported in February 2018.

From 2013 to 2016, the percentage of employers by size that offered at least one self-insured plan changed as follows:

- Small employers (fewer than 100 employees)—rose to 17.4 percent, up from 13.3 percent.
- Midsize employers (100 to 499 employees)—rose to 29.2 percent, up from 25.3 percent.

8 <http://care.diabetesjournals.org/content/early/2018/03/20/dci18-0007>

9 <https://www.cdc.gov/obesity/data/adult.html>

10 <https://www.cdc.gov/diabetes/data/statistics-report/prevalence.html>

11 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3891203/>

12 <http://care.diabetesjournals.org/content/30/11/2874>

13 US Burden of Disease Collaborators, et al. The State of US Health, 1990-2016: Burden of diseases, injuries, and risk factors among US states. JAMA. 2018; 319(14):1444-1472. Chart available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5933332/figure/joi180029f2/>

14 <http://www.actuary.org/content/prescription-drug-spending-us-health-care-system>

15 <https://www.cdc.gov/diabetes/diabetesatwork/plan/costs.html>

16 [https://www.ajpmonline.org/article/S0749-3797\(13\)00338-3/pdf](https://www.ajpmonline.org/article/S0749-3797(13)00338-3/pdf)

17 <https://www.shrm.org/ResourcesAndTools/hr-topics/benefits/Pages/self-insurance-ACA.aspx>

18 <https://www.ajmc.com/contributor/carol-berry-csfs/2015/08/waking-up-to-the-opportunity-of-self-funded-employee-health-benefits>

SPECIAL FEATURE *CONTINUED*

- Large employers (500 or more employees)—fell to 78.5 from 83.9 percent.

An employer determines if they will be fully funded or self-funded based on the administrative cost differences, their members' health care risk and the employers' ability to take on the risk of a potentially high year of medical spending. The value to be self-funded comes from the ability to be more flexible in plan design and less administrative fees. Further, if an employer is self-funded and can improve the health of their members and reduce the demand for medical care use, they reap the rewards in the long run. It is time for Lifestyle Medicine Board Certified professionals to arouse "the sleeping giant that is the self-funded employee health benefits market"¹⁹.

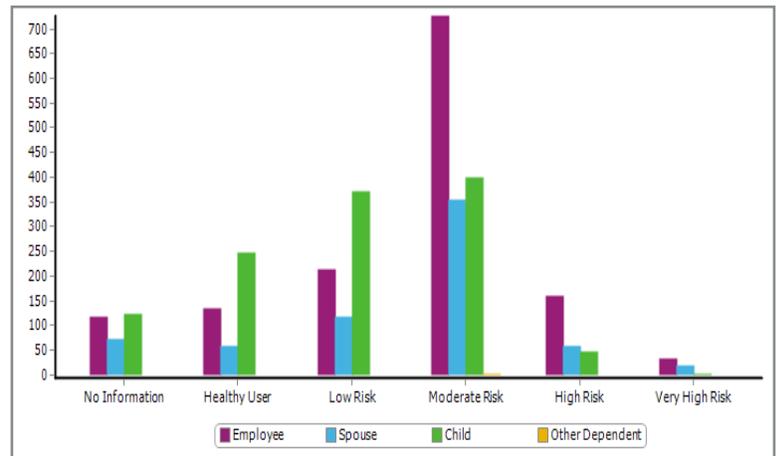
Employers' Understanding of Health and Healthcare

For the Lifestyle Medicine Practitioner to make the case for the value of Lifestyle Medicine to self-funded employers, and initiate collaboration is to help meet them where they are in their understanding of health and healthcare. Employers are accustomed to viewing reports that show trends in medical spending by cost per unit, overall spending by medical services and pharmacy costs. They will also typically see carrier reports that illustrate how compliant their covered lives are in taking medications if they have a chronic condition or having their age-related tests and procedures performed. They understand when emergency utilization is high or use of a more expensive drug is impacting cost. They also see and are concerned with the fact that average paid amounts for services are increasing year over year. However, there is little data to actually show employers the root cause of the demand on the healthcare system or the return of investment for their medication investment. An employer does not see data that shows them if the investment in healthcare is improving the health of their people, but instead is provided data to show the cost of the reaction to declining health.

If employers were able to understand root cause and see what is improving health, it is likely they would be making better investment choices. Johns Hopkins ACG[®] system²⁰ provides an objective view of risk control that helps employers gain insight into the health of their population. By using Resource Utilization Bands, JH allows us to illustrate which RUB category their members are and the average cost of each of those persons with similarly situated risk. The ACG[®] System places people of similar risk into 6 buckets; persons who have not enough information to identify risk, healthy, low risk, moderate risk, high and very high risk.

	No Information	Healthy User	Low Risk	Moderate Risk	High Risk	Very High Risk
Employer	\$2.79	\$354.41	\$960.67	\$4,851.10	\$18,969.33	\$59,299.37
Regional Benchmark	\$36.52	\$297.04	\$879.46	\$3,921.36	\$17,726.32	\$63,470.78

Being able to view their population in this structure allows an employer to objectively determine potential cost savings if they



were able to improve the control of a person with a chronic condition and move them from a high-risk RUB[®] category to a moderate RUB[®] category. Similarly, the employer also needs to see how important it is, to prevent the low risk people from moving into the high risk category (or the high risk people from moving into the very high risk category). Given that 1/3rd of our population already has prediabetes, and almost 2/3rd of workforce is either overweight or obese: this currently so called "low-moderate" risk population will very soon (but surely) progress to high risk category (type 2 diabetes or heart disease, etc.); if therapeutic lifestyle changes are not implemented. The cost of doing nothing is very high, almost unaffordable!

This objective ACG system view provides the return on investment in real dollars for the employer's population and creates an insight into the financial impact for interventions such as lifestyle medicine in a simpler way for employers to understand.

It bears mention that this disease progression may indeed impact employees who are otherwise moving up the ladder of work and business experience (e.g. a staff who's steadily worked hard over years to be promoted to a senior position, but is now faced with declining health as they grow older: thereby, adversely affecting their invaluable skill of experience and job sophistication. It's imperative that employers pay attention to nurturing the health of their employees in the earlier years, so the dividends of experience, skill sophistication can be reaped when the employee ages into a well-deserved higher position.

Leveraging Lifestyle Medicine

Most employers do care about their employees' health and want to invest in things that are beneficial, but they are frustrated that their efforts are not having a lasting impact. In our data, we found that only 61% of diabetics have controlled A1c values <=7% and only 27% have an optimally controlled weight (BMI <=25.0). Out of the 125 employers that we have data on and of those who have programs in place to improve health, only 14% of persons with a BMI of >=30 improved their BMI category in the last year. The employer sees these results as people not trying to engage, but perhaps it is a result of ineffective programs put in place.

¹⁹ Weintraub A. Healthcare VC Investing Could Hit A Record High In 2018. Forbes. <https://www.forbes.com/sites/arneweintraub/2018/07/12/healthcare-vc-investing-could-hit-a-record-high-in-2018/#7a77895165d2>. Accessed January 1, 2019.

²⁰ https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_057914.pdf

Further, we see most employers having an interest to improve diabetes/ prediabetes control, yet we found that only 11% of the persons we know with pre-diabetes improved their A1c out of the pre-diabetes range. Unfortunately, 10% of prediabetic employees moved into the diabetic range. For those that are considered uncontrolled diabetics with an A1c >7, we found that in the majority of cases significant investments in medications and diabetes management programs are only improving A1c levels by 1% or more in <50% of the cases. Unfortunately, most investments aimed at improving diabetes are having less impact than expected in improving overall disease control. Perhaps the real issue is that the wrong products are being implemented. When you compare this to outcomes for Lifestyle Medicine programs run by Board Certified Lifestyle Medicine practitioners, you quickly understand that these incorrect strategies are not working on the root cause of health; and yet are what are most frequently used in the market.

Employer Value Based Design – Real Change

With obesity starting at a younger age year after year, the demand on the healthcare system is only going to continue to climb²¹. Despite best efforts the average employee in the United States is not getting healthier, which means the demand on the system will only increase. Helping employers identify which programs will improve the root cause of health disparity will create sustainable change. Unfortunately, marketing campaigns and accompanying sales are well funded for so many easy-to-use solutions. This means that employers are trying these programs at a much higher rate²¹ than they are investing in lifestyle medicine options. Of course, the easy solutions are also the first choice for the employer, advisor or insurance carrier who is also very busy and will be attracted to programs that are simple to integrate. The “Herd Theory” also comes into play. Larger advisory firms are notorious for integrating the same type of product among all of their employers so that if something doesn’t work, it is not perceived as poor advice from the benefit advisor, but instead, the best they could do at that time. This is protecting the advisor’s relationship with their employers versus being bold and placing products that actually meet the needs of employees for each particular group. If everyone is doing it, it cannot be perceived as an incorrect choice, right?

\$15 billion in venture capital dollars were invested in wellness products in the first half of 2018²². With that investment, the demand is placed to sell the product and grow the company as quickly as possible. Although dollars are used to improve the product, investing in marketing and sales is critical to hit the goals of the investor. These sleek sales teams, with shiny explanations of why their products are best, catch the eye of advisors and employers. This means that products are put in place that look shinier but might not have the desired impact that will really create the change needed to improve short term medical spending and reduce the long-term dependence on the healthcare system²³.

What Board Certified providers of Lifestyle Medicine solutions have to offer are evidence-based products at lower prices, since you do not have as much invested in marketing and sales and

will not have the demand for large profit margins from your investors. That means you can offer solutions at reasonable prices and put in place performance guarantees that reduce the perceived risk for the employer and potentially offer greater rewards for you the provider. Unfortunately, in medical school not only are providers not taught how to use lifestyle medicine techniques, but they are also not taught how to improve their “business” of healthcare. Placing the business of healthcare back into the providers hands is essential to drive better outcomes. This finally gives providers the opportunity to establish the price they would need to be reimbursed to provide the service that will improve the health of those persons they serve. Novel idea in healthcare, isn’t it! How this is done is simply by creating the cost to provide the service and adding a reasonable margin, let’s say 25%. What will drive your ability to sell this is how efficient the provider is in providing the service required or how much risk they will take in extra incentive compensation.

Employers are seeing performance guarantees more often as they establish their strategies. Performance guarantees can establish that the provider has to pay back part of their fees if they do not reach goals and can also be provided extra incentive compensation if they have surpassed goals. An example of this can be illustrated in a Type 2 Diabetes management program. The goal might be that at least 55% of diabetics with an A1c >7 reduce their A1c by 1% within one year of engaging in a program. That is an easy goal for providers utilizing Lifestyle Medicine to achieve, but a stretch for most programs. Therefore, when trying to convince an employer to utilize your services, you can determine what their current rate of success is and provide outcomes guarantees to exceed that rate. For the employer, they typically are experiencing a \$2,000 increased expense for every A1c percentage greater than 7, and in return they can quickly and objectively understand their return on investment. If you provide your base fee with thresholds you are confident you can achieve and offer extra incentive compensations for hitting outcomes that exceed that base expectation, a provider can share in the savings and work to coordinate appropriate care for the employers/payers.

To further progress healthcare’s ability to drive down the demand on the healthcare system, having providers impact the plan design and expectations will be critical. Consider the following options for consideration in creating a value-based plan design.

- Primary care for chronic condition management considered part of expanded wellness provisions.
- Requirement that persons attend a comprehensive nutritional intervention program administered by a Lifestyle Medicine Board Certified provider prior to bariatric surgery.
- Requirement that comprehensive physical therapy assessment/treatment be completed before or in addition to chronic opioid treatment; and planting resources in place to provide this effectively.
- Appropriate Plan coverage for ancillary services that provide outcomes which could include:

21 <https://www.nber.org/papers/w24229.pdf>

22 Weintraub A. Healthcare VC Investing Could Hit A Record High In 2018. Forbes. <https://www.forbes.com/sites/arlneweintraub/2018/07/12/healthcare-vc-investing-could-hit-a-record-high-in-2018/#7a77895165d2>. Accessed January 1, 2019.

23 https://www.rand.org/content/dam/rand/pubs/research_reports/RR200/RR254/RAND_RR254.sum.pdf

- Nutrition counseling
- Mental health services
- Physical therapy
- Meal replacement

- Requirement that all patients with lifestyle associated chronic diseases e.g. overweight/ obesity, cardiovascular disease, type 2 diabetes, prediabetes, hyperlipidemia, fatty liver disease, essential hypertension, gestational diabetes, and in select cases: even type 1 diabetes and autoimmune diseases e.g. inflammatory bowel disease, etc. attend comprehensive, individually-tailored Lifestyle Medicine education programs administered by qualified Certified professionals.

- Reduce polypharmacy by:

- discontinuing medications that have been added but have not proven efficacious for the patient's condition (eg, discontinuing a hypertensive medication that did not improve the patient's blood pressure and switching to a better medication individualized to the patient rather than just adding on a new one.)
- Medication de-escalation where possible in the context of lifestyle treatment.

- Reduce need for novel agents and polypharmacy by reducing disease severity with adjunctive lifestyle treatment:

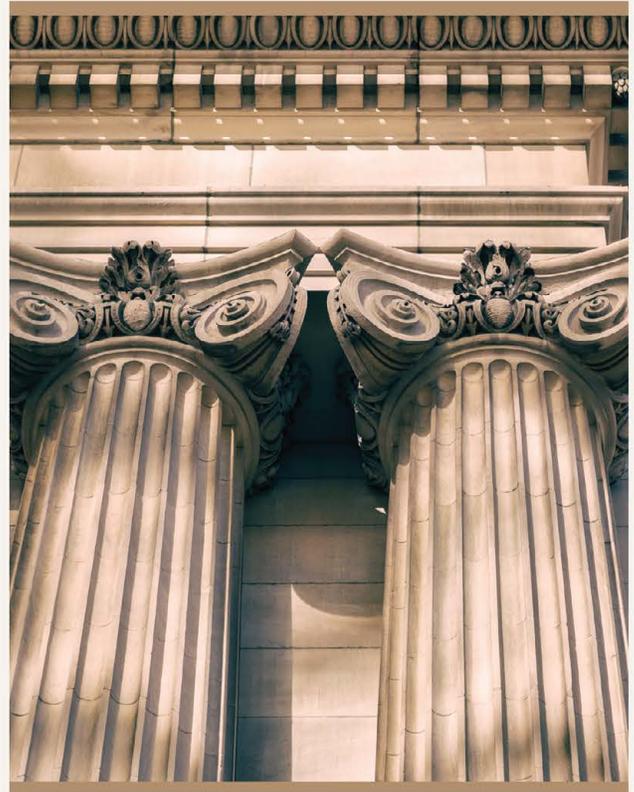
- Insurance coverage for lifestyle related treatment for patients who wish to pursue them alone or in addition to disease modifying agents for inflammatory conditions.
- Insurance coverage for all patients with anxiety and depression to enroll in behavioral health coaching +/- exercise program, as first like treatment or as an adjunct to an antidepressant/ anti-anxiety medication.

Using Lifestyle Medicine techniques and editing plan design to create improved outcomes will help reform healthcare as we know it. Having products offered to employers where they see an impact from their investment will motivate employers. This year, one such program was evaluated by Vital Incite. The case study showed that with lifestyle medicine techniques, persons were able to improve their control of diabetes, reduce their medication utilization and decrease excess associated spending²⁴.

In conclusion, value-based design plan created and administered by Lifestyle Medicine Board Certified professionals for employers presents a sound solution to the burgeoning epidemic of chronic diseases among American adults. Not only does it offer higher chance of reversing chronic diseases like type 2 diabetes, essential hypertension, etc.; it also promotes optimal health among the low risk, relatively healthy workforce. In addition, further outcomes research and health services research to continue to show the value-added benefit of Lifestyle Medicine to employers is necessary. To quote Dee Edington: "No company will be successful in a globally competitive world with anything but healthy and productive people". Lifestyle Medicine design plan offers exactly that.

²⁴ https://vitalincite.com/wp-content/uploads/2018/10/Carmel-Clay-Schools-Case-Study-Final-10-5-18_UPDATED-Title.pdf

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More than Skin Deep

Excising the Stigma of Plastic Surgery

by JENNY B. LIN, PHD & SIDHBH GALLAGHER, MD
IUSM MD/PhD Candidate / Assistant Professor of Plastic Surgery IUSM



Imagine for a moment that you were in a car accident and ended up with broken bones in your face. Or imagine you were caught in a fire that burned a significant portion of your body, or that your baby was born with a cleft lip, or that your mom has breast cancer requiring removal of her breast, or you have a surgery requiring removal of large amounts of infected or dead tissue.

Do you know what type of doctor would reset the bones in your face, graft new skin to your body, repair the cleft lip, reconstruct a breast, or use your own tissue to close large wounds that can't be closed with traditional methods? A Plastic Surgeon. Now compare this image to the first thing that comes to your mind when you read the words "plastic surgery". If you think plastic surgery is just for the vain and wealthy, think again.

The public perception of plastic surgery is largely shaped by popular media such that it is infamous for elective cosmetic surgeries like boob jobs, nose jobs, or the Brazilian butt lift. For most, getting plastic surgery is perceived as deceptive and unnatural. Celebrities are exposed for being "plastic", having paid to change their appearance to become more beautiful. On top of that, the plastic surgeon is often seen as arrogant, superficial, vain, or greedy – thought to be driven by their love of money. One of my colleagues was asked why she would waste her medical education by becoming a plastic surgeon – she was asked why she didn't want to help people. I cannot quite understand why she did not entertain a conversation with this person, but perhaps the explanation would have been long-winded and the stigma of plastic surgery too deeply ingrained. Most people don't realize that cosmetic/aesthetic surgery is just one part of the required training to become a plastic surgeon, and a highly variable portion of the practices of many academic plastic surgeons. Yet even among many medical students and physicians, the reputation of the superficial, vainglorious, plastic surgeon is pervasive; but it is not even close to why I, and many others, want to become a plastic surgeon.

“For millions of patients each year, plastic surgery has little or nothing to do with beauty, and more to do with feeling normal, confident, safe and belonging in society.”

For millions of patients each year, plastic surgery has little or nothing to do with beauty, and more to do with feeling normal, confident, safe, and belonging in society. A post-traumatic facial reconstruction, surgical correction of cleft lip or facial tumor, and a mastectomy for a transgender man all allow patients to live more safely and comfortably in a society where physical appearance can so strongly govern one's daily experience. Contrary to the publicized version of plastic surgery, I believe the essence of plastic surgery is to restore a balanced appearance, improve emotional well-being, quality of life, and even physical health. A post-traumatic rhinoplasty can substantially improve a patient's ability to breathe. An abdominoplasty to remove excess skin after significant weight loss prevents recurrent chronic skin infections. A breast reduction significantly alleviates chronic lower back pain. Hand surgery to correct congenital deformity can restore mobility and function. Peripheral nerve grafting can reduce phantom limb pain. A flap repair to reconstruct tissue after extensive wound debridement or to fill the defect created after removing a large skin cancer prevents massive tissue infection. All of these procedures are within the realm of plastic surgery and the plastic surgeons goal of improving a patient's quality of life.

I cannot dismantle the pervasive pre-conceived notions about plastic surgery, but I can certainly raise awareness for its breadth and depth and the profound impact it has on a patient's physical and mental health. I hope to progressively redefine the reputation of plastic and reconstructive surgery. Plastic surgery is so much more than Hollywood boob jobs, Nip tuck, Botched, or Dr. Pimple Popper. It is a huge contributor to the future of regenerative medicine and is a specialty that serves at the intersection of physical and mental health. It is a key player in LGBTQ health and safety. And it allows artistic creativity while demanding delicate precision to morph what was into what could be. I hope that by educating the public, and my fellow physicians, about the important role that plastic surgery plays in patients' lives we can start to reconstruct the perception of "plastic surgery".



Why We Collect

by SHIBLEY M. MUELLER, MD
Author, Inside the Head of a Collector



The Primary Reason We Collect

The reason we collect is simple. It makes us happy. In this faraway place, apart from the rest of our lives, we can imagine. This is different than when we are involved in the routine aspects of living; then, we can reliably predict much of what will happen.

On the other hand, with collecting, we don't know what to expect. It can take us anywhere. And, we can easily anticipate a whole new world of excitement.

Along with these expectations comes a quest for knowledge far beyond just reading. It broadens into joining associations related to our collecting specialty, meeting wonderful people, attending conferences, going on trips with like-minded groups, and individually pursuing destinations of interest. Finally, it can take over life itself. What a pleasure. Collecting isn't a job. Collecting isn't a hobby. It's better. It's a passion.

Secondary Reinforcers for Collecting

When we collect, we do not seek pleasure in a diffuse way; rather, we pursue it in a very specific manner. There are psychological reinforcers which feed into our pleasure center that spark our desire for these items.

One contributing motive is pride in acquiring special objects. This is heightened by gathering a group of like items together for the first time. During the search, excitement is further sharpened by identifying a rare piece that sets us apart from our peers and may provide recognition and admiration by associates.

Other collectors, aside from the rareness of the piece, want to acquire it at a modest price. That is their joy and gives them pride in being so astute. It's the possession for comparatively little money that excites them.

Then there are those who feel a sense of history when they assemble precious items. By owning antiques, they feel closer to the past or perhaps even dead ancestors, important people, or circumstances of long ago.

The reverse of feeling a sense of history is looking toward the future. This collector may hope to build a legacy by passing on special objects to future generations.

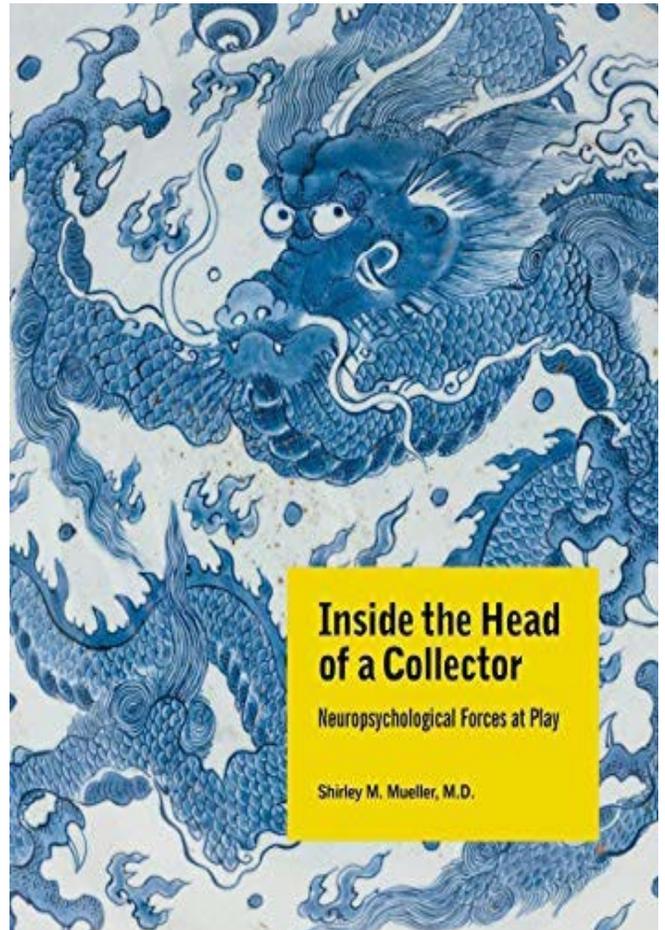
Some collectors find that the process of collecting provides intellectual satisfaction. The gathering of pieces in a specific area requires discipline, knowledge, and an eye for the unusual or particularly beautiful. This may have been the impetus for Stephen W. Bushell, a physician to His

Majesty's legation in Peking (present-day Beijing) at the end of the nineteenth century. As a medical doctor in a remote outpost, Bushell turned his hobby of collecting Chinese porcelain (readily available in Peking, but still a novelty in his home country of Great Britain) into a passion and then an avocation.

Collectors also gather what they consider treasures to enhance their network of friends; in other words, they have a social motivation for collecting. Perhaps their love of objects came first; then, somewhere along the way, they realized there are others like themselves. They may find them independently or join organizations for like-minded people. Friendships forged through these vehicles expand social lives.

The enjoyment of arranging and rearranging a collection can be the motivation for other collectors. Though this may serve as a means of control, it could also simply be the demonstration of organizational skills applied to collecting as taste and knowledge accumulate.

For more please see *Inside the Head of a Collector: Neuropsychological Forces at Play*.

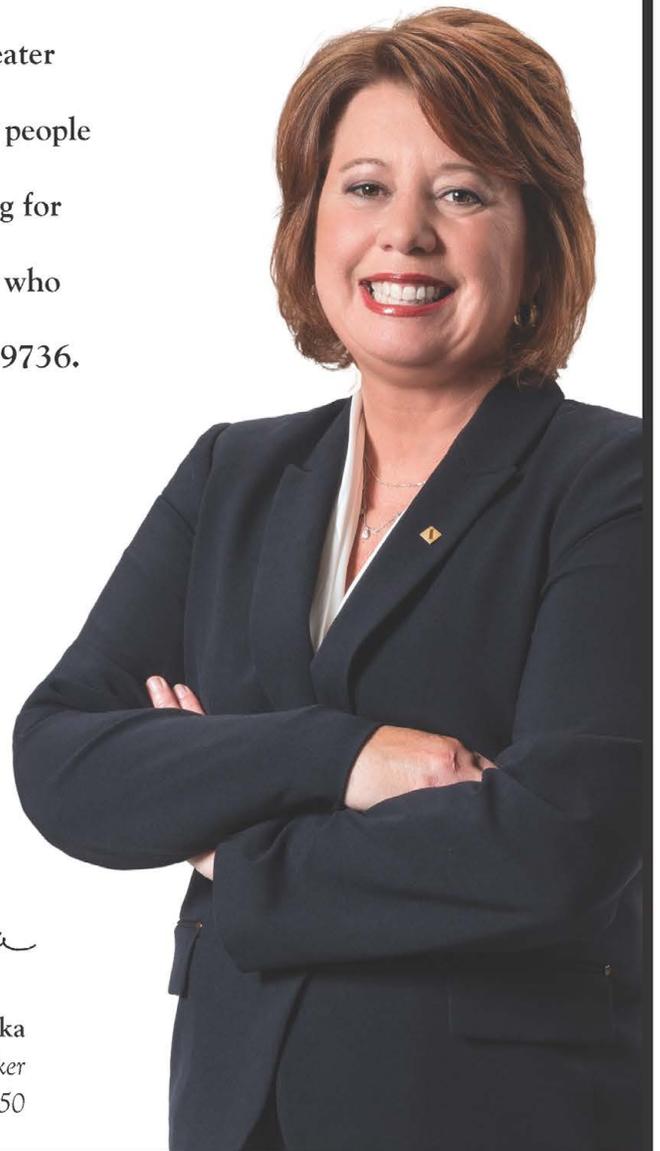


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The Story of Dr. Charles Bonsett

by RICHARD D. FELDMAN, MD

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

This is the story about an Indianapolis neurologist, Charles Bonsett, M.D., who believes he discovered an effective treatment for Duchenne muscular dystrophy over 50 years ago. Unfortunately, his discovery remains virtually unrecognized by the scientific and medical communities.

Dr. Bonsett is 98 years old and fears he will die without his discovery being used to treat the patients to whom he dedicated his professional career. In addition to his private practice, Bonsett was a clinical professor at Indiana University School of Medicine, and among other University directorships, led the Muscular Dystrophy Clinic at Riley Hospital for 30 years.

I have known Dr. Bonsett my entire career as a man of great intelligence, generosity, and integrity. I have heard him tell the story about his muscular dystrophy (MD) research multiple times. The story he relates is always exactly the same concerning the steps taken to define the problem in this disease and to identify the treatment. Bonsett's years of investigation of MD and his discoveries have been almost completely ignored by the world. Worse, his research has been mysteriously ridiculed and discredited.

MD is a fatal genetic disease resulting in weakness and death of muscle. Research has centered since the 1980's on the deficiency of a structural protein element of muscle called dystrophin, which is essential for the proper function of muscle. Dystrophin researchers have always had the ears of funders, including the Muscular Dystrophy Association affiliated Jerry Lewis, whose research funding has always flowed to supporting ways of fixing dystrophin. These organizations refused to even talk to Dr. Bonsett who pursued a different line of research. Really? He was denied the necessary big research money.

Dr Bonsett instead focused on a metabolic approach to the disease. He examined the steps in the Krebs Citric Acid Cycle, which he hypothesized was defective in

MD. Through systematically adding metabolites to muscle tissue cultures and observing the effects, he was able to find the main metabolic problem. He identified adenylosuccinic acid (ASA) as the crucial metabolite that when added to the culture corrected the problem and potentially became the treatment. MD is a complex dysfunction of multiple metabolic pathways rather than a secondary result of the dystrophin insufficiency.

Dr. Bonsett was able to secure limited local research funds from the Indiana MDA, United Way, and Community Hospitals Foundation in Indianapolis that lead to early stage FDA clinical trials of ASA. Fourteen children were given ASA and all but one (who died

of an unrelated medical problem) had reversal of their disease, some markedly. But the funding finally fell apart in 1990, and the process of drug development and manufacturing of ASA ceased. Dr. Bonsett watched nearly all of the children slowly die.

Did this brilliant neurologist actually find a treatment for Duchenne muscular dystrophy? I am certainly no expert in MD, but I know his research was honest, of excellent quality, and very detailed.

Bonsett's work was recently recognized by Australian researchers as very credible. His research should likewise be revisited by American medicine, muscular dystrophy advocate groups, and the pharmaceutical industry. Even the dietary supplement industry, more feasible from a financial and regulatory standpoint, could be a consideration. I am told that the future of MD research is gene therapy, but that will take many years to potentially unfold. Is there not anyone willing to listen?

Many roll their eyes at the mention of Bonsett's research. But just maybe, he deserves a Noble Prize in medicine.

“Many roll there eyes at the mention of Bonsett’s research. But just maybe, he deserves a Nobel Prize in medicine.”



Indianapolis Medical Society Resolutions

by IMS RESOLUTION SUB-COMMITTEE

Linda Feiwell Abels, MD, Bernie J. Emkes, MD and Mary Ian McAteer, MD

The Indiana State Medical Society (ISMA) is the policy-making organization for physicians of all specialties within Indiana. As a way to understand what is important to physicians throughout the state, ISMA seeks member physicians' input through the resolution process. Any member of the ISMA can submit resolutions for consideration to ISMA staff before the July deadline. The Indianapolis Medical Society Board (Board) discusses and formulates resolution ideas all year in preparation. In fact, societies, such as the Indianapolis Medical Society (IMS) can add their collective support to a resolution or idea through authorship as our Board has done this year.

At the annual meeting in September, delegates, elected from each county assemble to discuss these resolutions. The House of Delegates then votes on each resolution as amended by the discussions. Once accepted, a resolution informs and directs ISMA the will of the members. It is exciting to know that physicians' ideas, negotiated through collegial discussions will go on to influence both local and national health policy.

IMS has actively sought and encouraged our members to submit resolutions during board meetings this year. We invite speakers and members to share concerns and together utilize our wealth of experience toward finding solutions by creating resolutions for convention. At our most recent board meeting, four resolutions were selected to be supported by the Board. We, as the resolution sub-committee, appointed by the Board, want to share these with you.

In no particular order.

Doctor Patient Relationship:

RESOLVED, that ISMA seek legislation to ensure existing practices notify patients when their physician changes location or provide patients with adequate information to access their physician; and be it further

RESOLVED, that ISMA Seek legislation that that includes a requirement for physician approval on communication sent to patients by their previous practice.

This resolution was written to help the doctor/patient relationship in times of transition. All parties benefit when patients receive timely, honest answers to questions about a doctor's change of practice location or specifics. It is important that

Photos above are from the 2018 ISMA Convention. Photo credit for both photos goes to ISMA staff. We thank them for their use.

doctors have a voice in communicating change, since they know their patients well and are concerned about how they will be followed by remaining colleagues and assure continuity of care.

Statewide Syringe Service Program:

RESOLVED, that ISMA seek legislative action for a statewide syringe service program under the auspices of the Indiana State Department of Health.

Several counties in Indiana already have syringe service programs, but whether one can participate depends on both having an address in the county and remain in those counties. IMS physicians feel this is a barrier for those who may be homeless, as well as patients who move from an “exchange” county to one where no program exists. Confusion, lack of safer injections and a possible increase in transmissible diseases are all of concern. This resolution requests that syringe service programs, which includes wrap around addiction services, be accessible to residents of ALL Indiana counties.

Nicotine Replacement Therapy for Minors:

RESOLVED, that ISMA seek for immediate and thorough study of the use of all forms of nicotine delivery as well as all treatment options in populations under the age of eighteen; and be it further

RESOLVED, that ISMA align support for future legislative action to protect providers for off-label use of tobacco and nicotine cessation products until they become approved for minors; and be it further

RESOLVED, that ISMA seek AMA policy and federal regulation that encourages manufacturers of current nicotine delivery and treatment therapy approved for adults to study their products for the use in populations under the age of eighteen.

Nicotine replacement products for children. As we all know, nicotine addiction often occurs prior to age 18. The author will tell you about their nephew who was proud of having quit smoking, twice, by the age of 9. The issue is that nearly all nicotine replacement medications, patches etc. are only FDA approved for age 18 and older. Board discussion led to two changes:

- Request that pharmaceutical companies fund research to evaluate these products for those under 18 years of age for treatment, and
- In the intervening period, allow physicians to prescribe these medications, with reduced fear of prosecution or liability – other than that one encounters in all medical services.

Increasing Payments to Physicians providing Medicaid Services:

RESOLVED, that the ISMA encourage and support legislation in Indiana to raise payment rates for providers who treat patients through Medicaid and Hoosier Healthwise plans to match HIP 2.0 and Medicare rates.

Finally, this resolution came from one of our members who felt it important to re-introduce this year. It was not heard during the 2018 convention because of late submission. The Board agreed to lend their support dependent on a change to the resolved statement which the author agreed to and was grateful for the added support. It was successfully submitted for consideration at the 2019 convention.

The resolution process is a way for physicians to advocate for us as individuals and our patients and acknowledge our support for public health policies. Turning ideas and frustrations into positive action will improve the practice of medicine for us, our patients and our communities. We are looking forward to representing you at the 2019 ISMA Convention and encourage you to reach out to share your concerns before the September event. As always, please submit any ideas that come to mind to your Indianapolis Medical Society and Indianapolis State Medical Association for next year. We are here and want to hear from you.

Indianapolis Medical Society Resolution Sub-Committee



LINDA FEIWELL ABELS, MD



BERNIE J. EMKES, MD



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Greetings from
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THE BULLETIN BOARD

THERESA ROHR-KRICHGRABER, MD



Theresa Rohr-Krichgraber, MD recently presented at the Medical Women's International Association Centennial Meeting in NYC. "We can eradicate HPV: The Us vs HPV series". She also presented to a group of graduated medical educators on "Leveling the Playing Field: How Sex and Gender Impact Our Lives". She was the session lead for Maternal Health.

On August 5th, Dr. Rohr-Krichgraber will be presenting to the University of California at Irvine School of Medicine on "Sex and Gender: The Impact on Healthcare".

RICK C. SASSO, MD



Dr. Rick Sasso was involved with a paper published in the journal Neurosurgery. It is a multi-center, prospective, randomized, double-blind, FDA study on a new treatment for low back pain.

Markman JD, Rhyne AL, Sasso RC, Patel AA, Hsu WK, Fischgrund JS, Eddin AA, Vajkoczy P: Association between opioid use and patient-reported outcomes in a randomized trial evaluating basivertebral nerve ablation for the relief of chronic low back pain. Neurosurgery 2019.

Rick C. Sasso MD and Joe Smucker MD as well as an Indiana Spine Group Fellow and Resident published a paper in the most recent issue of the Journal of the American Academy of Orthopaedic Surgeons. This article outlines a protocol for the safe performance of outpatient Anterior Cervical Spine procedures.

Jenkins TJ, Snowden RD, Smucker J, Hsu WK, Riew KD, Sasso RC: No S.C.A.R.E. Protocol: A Streamlined Safety Protocol. J Am Acad Orthop Surg 2019.

Please submit Bulletin Board Information to ims@imsoline.org.

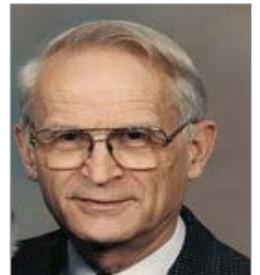
Your photo in the IMS files will be used unless an updated picture is submitted with your material.

IN MEMORIAM

JOHN "LEX" ALEXANDER CAVINS, MD

John Cavins was born on February 18, 1929 in Terre Haute, Indiana. He was a graduate of Mercersburg Academy and obtained a BA per Amherst College. John received his medical degree from John Hopkins University and then completed his residency in Hematology/Oncology from Ohio State University. John had a remarkable career in medicine including research that enabled the military to preserve blood for prolonged periods. He also did a project with Dr. Donnal Thomas that laid the groundwork later used in human bone marrow transplantation. Dr. Thomas received a Noble Prize for that work.

IMS Member since 1972.



PATRICK J. MCALEAVEY, MD

Patrick McAleavey was born on June 8, 1948 in Detroit, MI. He graduated from Bishop Luers High School in Fort Wayne, IN and earned his B.S. degree from Marquette University in 1970. Patrick received his M.D. from Indiana University School of Medicine in 1974. Dr. McAleavey practiced Anesthesiology at Methodist Hospital. He was a member to numerous programs including AMA and IMS. Dr. McAleavey loved DJ'ing directly from his anesthesia machine from his colleagues and patients.

IMS Member since 1977.

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 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
3rd Week of the Month	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
4th Week of the Month	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		
Annual		St. Vincent Womens: St. Vincent Simulation Center: St. Vincent Simulation Center:	MFM Ultra Sound Series Sim Debriefing Essentials 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>

SEPTEMBER EVENTS

Sept 6 Obesity Symposium Indianapolis, IN
 Sept 11 Obesity & Women's Health, Indianapolis, IN
 Sept 12-14 Midwestern Vascular Surgical 43rd Annual Meeting, Chicago, IL
 Sept 14 AMWA LIFT Training, Ivins, UT
 Sept 14 Clinical Innovation Summit, Plainfield, IN
 Sept 20 Diagnosis & Management of Foregut Motility, Indianapolis, IN
 Sept 21 Pediatric Practical Pearls, Indianapolis, IN
 Sept 23 AMWA LIFT, Washington, DC
 Sept 27 Fairbanks Conference on Clinical Medical Ethics, Indianapolis, IN
 Sept 28 IU Health Glaucoma Symposium, Carmel, 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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Terms End with Year in Parentheses

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John E. Krol (2020)
Ramana S. Moorthy (2020)

Thomas R. Mote (2019)
Mercy O. Obeime (2021)
Scott E. Phillips (2020)
Taha Z. Shipchandler (2020)
H. Jeffrey Whitaker (2020)

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** Indicates Voting Board Members, Term Ends with Year in Parentheses*

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David R. Diaz
Marc E. Duerden
John C. Ellis

Bernard J. Emkes
Bruce M. Goens
Paula A. Hall* (2020)
Susan K. Maisel* (2021)

Jon D. Marhenke
John P. McGoff* (2019)
Stephen W. Perkins
Richard H. Rhodes

John J. Wernert

DELEGATES

Delegates to the Annual State Convention

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

Linda Feiwell Abels (2021)
Mary Pell Abernathy (2021)
Christopher D. Bojrab (2021)
Ann C. Collins (2020)
Carolyn A. Cunningham (2019)
Julie A. Daftari (2020)

Darrell D. Davidson (2021)
Marc E. Duerden (2020)
Robert S. Flint (2021)
Bruce M. Goens (2020)
Paula A. Hall (2020)
Ronda A. Hamaker (2019)

Mark M. Hamilton (2019)
C. William Hanke (2021)
Chad R. Kauffman (2020)
Jeffrey J. Kellams (2019)
Susan K. Maisel (2019)
Mary Ian McAteer (2020)

Ramana S. Moorthy (2020)
Thomas R. Mote (2021)
Mercy O. Obeime (2020)
Robert M. Pascuzzi (2020)
J. Scott Pittman (2019)
David M. Ratzman (2021)

Michael Rothbaum (2021)
Jodi L. Smith (2021)
Eric E. Tibesar (2020)
John J. Wernert (2020)
H. Jeffrey Whitaker (2020)
Steven L. Wise (2021)

ALTERNATE DELEGATES

Delegates to the Annual State Convention

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

Ranai Abbasi (2021)
Jeffrey L. Amodeo (2021)
Nicholas M. Barbaro (2019)
Daniel J. Beckman (2019)
Brian D. Clarke (2020)
John H. Ditsler (2019)

Ann Marie Hake (2019)
Brian S. Hart (2020)
Tod C. Huntley (2019)
Kyle Jamison (2021)
David A. Josephson (2020)
Penny W. Kallmyer (2020)

Stephen R. Klapper (2019)
John E. Krol (2020)
David E. Lehman (2020)
David Mandelbaum (2019)
Christopher Mernitz (2021)
Martina F. Mutone (2021)

Ingrida I. Ozols (2021)
Stephen W. Perkins (2020)
Scott E. Phillips (2019)
Richard H. Rhodes (2020)
Dale A. Rouch (2019)
Amy D. Shapiro (2019)

Taha Shipchandler (2019)
Jason K. Sprunger (2019)
Richard M. Storm (2021)
Glenn A. Tuckman (2021)
*2 open positions

INDIANA STATE MEDICAL ASSOCIATION

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Jon D. Marhenke 2007-2008	William H. Beeson 1992-1993	George T. Lukemeyer 1983-1984
Bernard J. Emkes 2000-2001	George H. Rawls 1989-1990	Alvin J. Haley 1980-1981

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