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BULLETIN

SPECIAL FEATURE PG 06

PHYSICIAN POLITICIANS

By MERCY HYLTON
IMS Member, Board Member and Pediatric Emergency Physician

INDIANAPOLIS MEDICAL SOCIETY
EST 1848

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Note from the Editor

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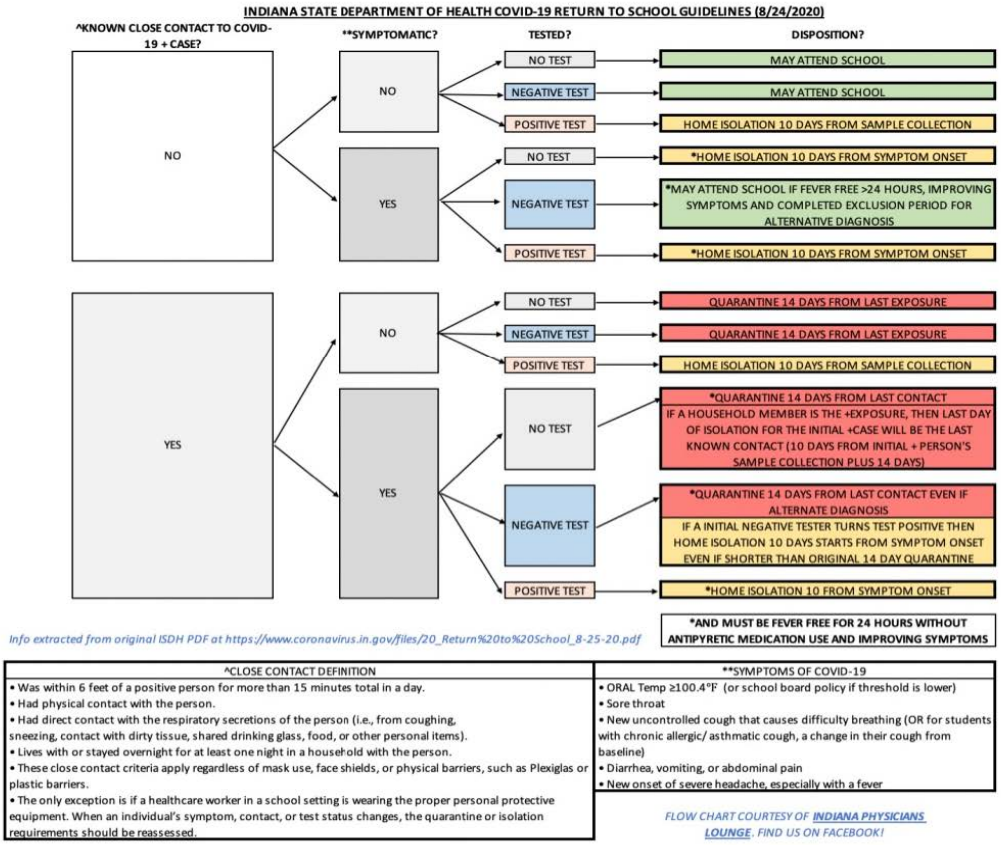

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LETTER FROM THE EDITOR

Members,

I hope you enjoy this month's full Bulletin. I would like to thank Dr. Bernie Emkes for sharing his thoughts on a previous editorial (found in the Exam Room). Also, thank you, to all of the contributors, for your time and effort to produce thought-provoking articles.

Congratulations to our new board members and ISMA leadership! Check out page 19 for updates.

Sincerely,

Morgan Perrill

Morgan Perrill
Executive Vice President

THE PRESIDENT'S PAGE

ERIC E. TIBESAR, MD

Happy beginning of fall to all my fellow IMS members. The month of September is upon us as we say goodbye to summer and welcome the cooler temperatures and nature changes that await the autumn climate. Of course, at the time of writing this letter, the forecast is showing mid to high 80's all week and very little rain so it's hard to think that fall is truly here. As the saying goes in Indiana, if you don't like the weather, just wait 5 minutes.

I was really struggling coming up with a topic or theme to write about this month. As I've said before, the obvious healthcare topic that dominates the news and is always on everyone's mind remains rather low hanging fruit to write about, but I don't want that subject to come up month after month and have nothing else to talk about. So, what can I discuss this month? Well, September is always an important month for the medical society because this is when we have our annual convention to discuss and vote on resolutions as well as vote on representatives to help lead our state in healthcare legislation. By the time this edition of the Bulletin comes out, the 171st Annual Indiana State Medical Association Convention (held on September 13) will likely be over but it will be dramatically different then prior years as it will be held virtually. Because of the pandemic, resolutions were not made and therefore little will be brought to the legislature from our medical society. But that doesn't mean we have to stop fighting and stop advocating for our profession.

After doing a little research, I was able to find some healthcare observances for the month of September. I wrote about monthly observances earlier in the year (prior to the pandemic and quarantine) but thought I would revisit that topic again. This month is National Childhood Obesity Awareness Month. It's no secret that childhood obesity is a major public health problem as current estimates put about 19-20% of children in this country in the obese category. As a pediatric gastroenterologist, this is a constant problem that I am dealing with in many of my patients and can be a major frustration in figuring out how to properly help these kids. We need better assistance for families with weight loss programs including dietitians, counselors, physical trainers, better school lunches, more after school programs and better incentives to keep a healthy weight.

This month we also celebrate Healthy Aging Month. Originally started by the American Academy of Ophthalmology to help vision screening for the elderly, we now focus on a program called Healthy People 2030, to improve the health and well-being for older adults. Focusing on injury prevention (falls are a leading cause of morbidity and mortality), dementia, infection, physical activity and more will put all older Americans on a path for improved health and wellness. Along those same lines, and sticking with the Healthy People 2030 goals, September is also National Food Safety and Education Month. Focus is again on preventing foodborne illnesses and promoting/regulating safe handling of food. Lastly, this month is also National Recovery Month, celebrating people in recovery from a substance abuse disorder.

It's always nice to have different causes and awareness campaigns each month to bring into focus different aspects of healthcare that might not otherwise get the attention it deserves. Keep all this in mind as we continue to practice and care for our patients day in and day out because, as we have discussed before, many things are getting lost or forgotten in this pandemic. As always, stay healthy, stay safe and keep fighting the good fight. See you next month.

Eric Tibesar
President
Indianapolis Medical Society

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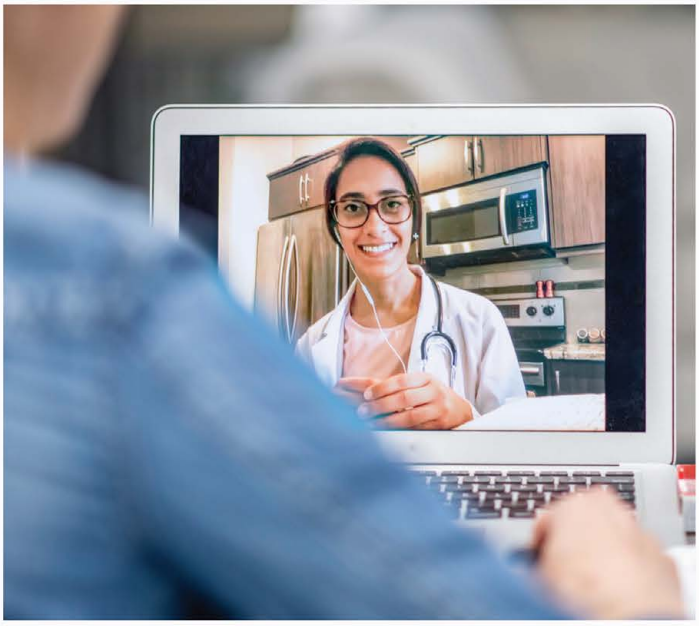

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2020 INDIANA House Of Representatives Physician Candidates

Rep. Brad Barrett, MD (R)
General Surgeon

Rep. Tim Brown, MD (R)
Emergency Medicine

Rep. Rita Fleming, MD (D)
OB/GYN

Don Westerhausen, MD (D)
Cardiologist

Physician Politicians

Meet the Physicians Vying for a Seat in Indiana's House of Representatives on November 3rd.

By MERCY HYLTON, MD
IMS Member, Board Member and Pediatric Emergency Physician

Four physicians are seeking election (or re-election) to the Indiana House of Representatives in 2020. Regardless of political affiliation, physician-legislators bring a needed practical understanding and experience in healthcare policy to the Indiana Statehouse. In 2018, three Representatives, Drs. Brown, Barrett and Fleming, were instrumental in informing the Republican and Democrat caucuses about concerns with HB 1097 and SB 394, both APRN independent practice bills, which were both eventually defeated. Physician expertise in the State Legislature is essential in crafting laws that protect all Hoosier patients.

Donald Westerhausen Jr., MD (D) is an interventional cardiologist seeking election for District 5 (portions of Saint Joseph county in NW Indiana, including Mishawaka and Granger). In 2018 Dr. Westerhausen ran against incumbent Representative Dale Devon ® who won by only a very small margin. Dr. Westerhausen would like to see an increase in Indiana's tobacco tax to raise revenue for tobacco related illnesses and prevention. He would like to prioritize access to quality and affordable reproductive healthcare for women as a way to improve Indiana's poor infant and maternal mortality numbers, improve access to mental health and addiction treatment, and work on ways to decrease the price of prescription medications. Learn more about Dr. Westerhausen at his election website: https://votewesterhausen.com.

Representative Tim Brown, MD ® is an emergency physician (retired). He is the ranking physician-legislator in the Indiana House, holding the seat for District 41 since 1994. District 41 includes portions of Montgomery, Boone and Tippecanoe counties and includes Crawfordsville. During the 2019-2020 term Dr. Brown was the Chair of the Ways and Means Committee. He is favored to remain undefeated in his 2020 election against his opponent Greg Woods (D).

Representative Rita Fleming, MD (D) is an OB/GYN (retired) who was elected to represent District 71 on the Indiana-Kentucky border (portions of Clark county including Jeffersonville) in 2018. Dr. Fleming practiced first as a registered nurse and then as a pediatric nurse practitioner prior to becoming a physician. Dr. Fleming's goals for her next term are to continue work on increasing access to birth control, maternal morbidity and mortality reduction in Indiana, and measures to support enhanced child and senior care. During the 2019-2020 term Dr. Fleming served on the Public Health Committee; the Commerce, Small Business and Economic Development Committee; and the Natural Resources Committee. In 2020, she is running against Libertarian candidate Russell Brooksbank.

Representative Brad Barrett, MD ® is a general surgeon (retired) who was elected to represent District 56 (large portions of Wayne County in eastern Indiana, including Richmond) in 2018. During the 2019-2020 term Dr. Barrett served on the Public Health Committee; the Ways and Means Committee; and the Agriculture and Rural Development Committee. Dr. Barrett's goals for his upcoming term, include measures to improve healthcare quality provided to all Indiana patients. In 2020, Dr. Barrett is running unopposed for re-election.

Sarah Baskett, MD

By MITRA SHARIFI and
THERESA ROHR-KIRCHGRABER, MD

What was your childhood and early education like?

I grew up as an only child, but I have a large family as my mother is one of 14. Yet no one in my family had ever gone to college and only a few graduated from high school. My mother had an eighth-grade education. My youngest aunt, Josephine, who I was named after, once told me she wanted to be a doctor. I idolized her as a young girl and so I started to say the same thing when asked what I wanted to do when I grew up. This thrilled my mother! Josephine has absolutely no memory of telling me this, but it stuck!

When I told my English teacher in high school, I wanted to go to be a doctor, I was told, "Oh no honey, you don't want to be a doctor, you want to marry a doctor". I had no clue what that meant, and I wasn't discouraged. I didn't have money to go to college, so I worked for a year and saved every penny. I eventually went to Earlham College and lived at home. Even my college advisor, who was a biology professor, kept trying to get me to consider other things besides medicine because he didn't think I could get in. But I got into medical school with fairly no problem at all!

What was your time like in medical school at IU?

I started medical school at Indiana University School of Medicine 1961. In my class there were 180 students which included 9 women. After the first year, 35 students flunked out leaving only 8 women.

I started medical school the same year I got married. In between my junior and senior year I gave birth to my oldest daughter. I actually decided to get pregnant at this time so that I could deliver in my time off before senior year. Believe it or not, I was the first person I know to take birth control! But my pregnancy was tough: I swelled up, my face broke out, and I got liver spots!

Medical school was the hardest thing I've ever done. It was especially difficult with a baby at home and living with my husband instead of with fellow classmates. I think I was sleep deprived the entire time! When I studied, I studied by myself whereas most people studied together. I think I was anxious and depressed the entire 4 years. As I got close to graduation, I thought to myself: If I feel this way, I need to figure out why because I have always been a very self-confident person. Is it just medical school? Is it being married that's doing this? Should I get a divorce? I told myself that if a divorce didn't change things, I would kill myself because I couldn't live like this.

I even considered dropping out my fourth year because it was so hard with a three-month-old baby at home. I remember calling my mother and telling her and she said, "Oh you can't do that! What would I tell people?" But in the end, I knew I wanted to achieve this goal and do it for myself.

I made it to the end of medical school and my attitude changed. I told myself, "I have this degree, no one can ever, ever take this away from me. And I have a husband who supports me." In those days it was thought that if you were a woman in medical school, you were taking the place of a man. It was assumed that you would not actually practice after you graduated. Even my mother-in-law told me when I graduated, "Oh it's so wonderful you went to medical school but of course you won't practice." And I told her, "Oh yes I will! Why would I put myself through this if I weren't going to practice!'

How were you treated by your fellow classmates and professors?

Of course, the guys were not supportive. For example, it was known that the guys had copies of all the old exams which they kept to themselves. One memory that stands out is that when we did the cadaver dissections, the guys were so excited when we reached the penis. It was the tradition that the girls had to dissect he penis all by themselves as the boys watched. As you can imagine, there was really no way to do so without causing the boys to laugh and laugh. Each of the

girls had a different approach. Some of the single girls played it up, but I tried to do it with a straight face. I did pretty well, but it got too much at a certain point. I remember my instruments were laying in my textbook, and I slammed my book closed, stormed out and started to cry. A couple of guys who had taken part did apologize to me after.

I was pregnant for a good portion of my third-year clerkships, and I would be told by faculty that I was not fit to be a mother if I was going to be a doctor. The interesting thing was that these men would be in the middle of externships that would take them away from home at least 4 nights a week—but they were not at all concerned about what kind of fathers they were.

Why did you choose psychiatry and how was residency?

After I graduated, we moved to Bloomington so my husband could do his masters while I worked as a student health physician and did my internship. I originally wanted to do pediatric cardiology. I looked at a program in Colorado, and they offered me a special mother's program in which instead of being on call every other night, we'd be on call every 3rd night and we'd spend an extra year in the program. When I ran it by my husband, he jokingly said, "If you do that program, I'll divorce you!"

So, I asked myself what else I could do. At that point, I looked for a more livable career, I thought about dermatology but could barely look at the pictures in the textbooks! I also thought about radiology and pathology, but it seemed like they were big fields where you had to master all of medicine.

I remembered that I really liked my psychiatry rotation. I felt like a career in psychiatry would give me a life that was manageable. I told myself I'd do child psychiatry and just make it through all the 'schizophrenic stuff'. But it turns out I really liked working with schizophrenics and didn't particularly care for child psychiatry. I think they're the bravest people on earth!

From there, we needed to find a place where there was a residency program for psychiatry for me and a doctorate program in microbiology for my husband. Therefore, we moved to Columbia, Missouri and joined the University of Missouri.

After my first year I decided I wanted to be in the program part time. I asked the chairman, Jim Weis, if I could do it '¾ the' time. He told me that he would work something out, because he told her how his own sister went to law school but then she got married and quit. He told her, "I don't want that to happen to you." We designed a schedule in which I finished the clinic at 3pm unless I was on call. I only had to spend an extra 3 months at the end of the residency in the substance abuse unit and it was considered a fellowship.

How did your work and career develop over time?

My career focused on doing psychotherapy, some medication clinics, and doing a lot of teaching. I was always affiliated

with a medical school in my career as that combination was always really important to me. I never really wanted to do private practice. Being in academia really allowed me to take time off, like a summer a couple of times. I even took off three years at one point.

While on faculty at Texas Tech, I had two children at home at the time so I wanted to work full time and be able to leave at 3pm—similar to what I had negotiated during my residency. I went to the dean and asked if this was possible. He looked at me and asked, "Well what will happen to your patients after 3 o'clock?" I told him, "The same thing that happens to your patients after 5pm o'clock." My self-confidence was clearly back!

I took some time off after I had my third daughter and the Texas Tech administration implemented their first paid maternity leave system because of that. A few years later my husband and I were feeling some burnout, so we took a break from academia and moved from Texas to Tennessee

I took three years off with the initial intent to take just one. When I was in training, I always felt like she was neglecting something, either it was my husband, children, or myself. So, this was time for me to take time to care for myself and others. I told people I was pursuing pleasure. We opened a photography studio and I took painting classes and gardened. Eventually I decided to work part time with the local community mental health center and also with Meharry Medical College teaching residents. Eventually my husband found that he didn't care for business and I missed having colleagues, so we moved to Richmond, Virginia in 1988 and I started work as a psychiatrist for the VA hospital.

My work at the VA was probably some of the best work I've ever done. I became a specialist in post-traumatic stress disorder right at the time when Vietnam veterans were coming in. We read every book that came about PTSD, read every article, went to many meetings, and we tried to figure it out. I did lots of teaching, I was the coordinator for the associated residency program, I taught psychotherapy, I supervised medication clinics, and I taught medical students.

I eventually retired at the age of 62 and have been retired for 19 years.

What did female leadership look like in your career?

Well when I was in medical school, I encountered no female faculty. During my internship, there were no women at my hospital. When I was hired in my first job as a psychiatrist at Texas Tech, my husband and I were one of the first 20 faculty hired for the medical school. That's when I finally saw more women in faculty positions and as medical students. When I eventually moved to Virginia in the late 1980s, I really felt that I was surrounded by women colleagues.

After I took those few years off from practice, I received a call from the Dean at Texas tech asking me if I would come back to the school as acting Chairman of the psychiatry department. I said yes and held that position for 18 months. Truth be told, I did not particularly enjoy that.

Being the only woman in that level of academia came with its own challenges. With my husband being associate dean of the medical school, I sometimes became aware of new things before other staff did. So during chairman meetings I would tell them what I knew and often the men would ignore me and just keep on talking. Then later when they found out that information, they would act like they had never heard it before. My daughter in computer security says the same thing happens to her to this day!

But sometimes I could joke about the situation. For example: Texas Tech has multiple campuses and there was a time when the faculty in Amarillo felt they were being ignored. As Chairman, I was asked to meet with them. They were grilling us and asking what we were doing for them. I went in there and said, "Well, I'm sleeping with the associate dean." There was dead silence and then everyone started to laugh.

How was your family life?

I fell pregnant again while doing my internship in Bloomington. But unfortunately, I had a stillborn. The grief of mourning that loss was greater than I expected. After that my husband and I decided to adopt, and we were fortunate to adopt a two-week old baby girl just four months after our baby died. Later, I accidentally got pregnant while on faculty at Texas Tech medical school and we had our third daughter.

My husband and I were able to split responsibilities in the house, especially when I went back to work as chairman. He had to learn how to change diapers, how to wake up in the middle of the night when I was on call. The only complaint my daughters had is that he couldn't do braids or ponytails!

How have you been spending your time after retiring?

My husband and I both retired in 2001, we moved to Smith Mountain lake in the southern part of Virginia. We lived on the lake from 2001-2019. Last November in 2019 we moved to northern Virginia to be closer to their daughters, as we both preferred that to being in a retirement community.

I loved my work. I loved my patients. I loved teaching. But I have not missed it one minute since I retired. I kept my license and volunteered at a community clinic for seven years after leaving the VA and subscribed to the New England Journal of Medicine, but I eventually lost my interest to keep up. My passion has moved to art and that has really blossomed for me. I have such wonderful memories of medicine, but I do not miss it at all.

When I first retired, I had a spiritual renewal as a Quaker. I started taking online seminary classes and audited the first two years of the degree. My husband started a non-for-profit during retirement for children coming from lower income to go to an educational camp. It really was an incredible program. I was on the board, but to tell the truth I don't particularly care for children! I eventually left that position and became invested in artistic hobbies like quilting. I was diagnosed with cervical cancer in 2008 and during this time I connected with friends who were artists who got me back into painting and using pastels. In retirement, I really became an artist.

What advice do you have for women entering their career in medicine?

I have a couple pieces of advice! As a doctor: do what you think is best for your patient. Write really good progress notes. And pay your malpractice insurance!

The only student loan that I took out was for a babysitter to come to our house every day. If I could give one piece of advice when you have kids, it is for you to have someone who can help take care of the children and clean the house. Especially if your spouse also works!

You can have it all. But it's not easy. You have to stand up for yourself. You have to be efficient and well-organized. I read When I say no I feel guilty and took away the message that you have to learn to tell people no and you are not required to give an explanation.

It's important not to get yourself so deeply in debt that you can't walk away from your job. You also need to stand up for yourself and ask for the salary you deserve. I never asked for extra money, I just wanted to be paid what everybody else was paid. You have to speak up and you have to know your worth.

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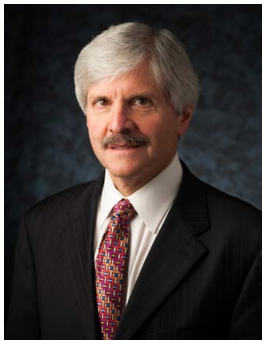
Obamacare vs. Medicare for All



By RICHARD D. FELDMAN, MD
IMS Board Member, MHM Board member and Past President, Former Indiana State Health Commissioner

The Affordable Care Act's future continues in doubt. Changes in Presidential leadership and Senate majority could portend a more positive outlook for the health-care law. Meanwhile, the U.S. 5th District Court of Appeals upheld a lower court's decision that the individual mandate became unconstitutional when Congress revoked the tax penalty for failure to buy insurance. This Fall, the U.S. Supreme Court will hear the case and decide if the mandate is unconstitutional, and if so, does it invalidate the entire law. Invalidation would result in loss of insurance and coverage safeguards for millions and plunge the health-care system into chaos.

Nevertheless, fixing Obamacare to create a better and more equitable law and potentially achieve universal health insurance coverage was the subject of a New England Journal of Medicine article. It's one of the clearest attempts to address this issue I have seen. Along with some of my own perspective, let me share its ideas.

Before Obamacare, our country failed to appreciably reduce either health-care costs or the percentage of the uninsured. After the ACA's enactment, the escalating costs moderated and the percent of uninsured fell from 16 to 9 percent. Still, Obamacare was far from a perfect system and never achieved universal coverage.

The NEJM article outlined four basic steps to achieve these goals. This wasn't necessarily an all or nothing proposal; enacting portions of it could be a "stepping stone" to universal coverage.

First, ensuring Medicaid expansion in all states could be accomplished with a combination of a penalty and an incentive. The "stick" is reducing the amount of federal matching rates for Medicaid for states that fail to expand, and the "carrot" is increasing the federal matching rate for those that do. It wouldn't need to be a large increase (2 percent) to make expansion essentially free for a typical state. Recall that the Supreme Court struck down the ACA mandatory state expansion as "unconstitutionally coercive", which required the expansion to retain the entirety of the Medicaid federal match. This small percentage would protect this action from such a judgement. It would also preserve coverage for Medicaid patients in states that refuse to expand.

Second, increasing eligibility and amounts of marketplace cost-sharing subsidies and premium tax credits is essential to making Obamacare more equitable and more appealing to individuals to obtain coverage. This would include expanding subsidies to people over 400 percent of poverty, the current limit. It appears to me that if one receives a subsidy, Obamacare is great, but for those who are not eligible, even those of middle income, the ACA is not necessarily so affordable.

And third, higher income people not obtaining coverage would be automatically enrolled in a "backstop" insurance plan, either public or private. Patients would be charged premiums through their income tax return.

Although controversial, the final step to ensure true universal coverage would be to grant undocumented immigrants, one-sixth of the population, eligibility for insurance programs by changes in immigration policies and paths to citizenship.

Financing sources to attain these changes could be similar to those already in effect for the ACA. Additionally, reducing the price of health-care services through various strategies including a public-plan option to increase private insurance competition could be implemented to reduce costs to the entire system.

Medicare for All proposals are exceedingly expensive and currently politically unfeasible. Given there is no coherent Republican health-care reform plan, fixing Obamacare would be an affordable and achievable way to proceed.

Note from the Editor

Editorials are opinions of the author and not the opinion of the Indianapolis Medical Society. Editorials are published with the intent to encourage discussion and opposing viewpoints are **welcomed**. Please submit articles for this publication to mperrill@indymedicalsociety.org.

COVID-19 Neurological Sequelae Yet to Come

By JOHN J. WERNERT, MD, MHA
Executive Medical Director, Norton Behavioral Medicine

Ten months in to dealing with the global impact caused by COVID-19, we know much more about its impact on the body. We know the virus causes massive activation of our immune systems, with multisystem reactions to this inflammatory condition. What is now being explored are the more insidious effects of COVID-19 on the brain and nervous system.

Mrs. Alice M – a 78 year old African American female widow was referred to our Behavioral Medicine HUB by her APRN Primary Care practitioner due to ongoing decline in her mood, cognitive cloudiness and complete lack of motivation. Alice had been through a difficult 2020 having contracted COVID-19 pneumonia in early February which resulted in a 5 day hospital stay. She did not require ventilator support and did not develop ARDS. However, her recovery has been slow and she has gone from being a social, animated and independent individual requiring minimal family support, to now requiring a family or church member checking on her every couple of hours. Her confusion has worsened and she now sits in her chair and does little around the house and requires prompting to perform her own hygiene. She had no prior psychiatric history and her memory previously had been sharp with only mild age-appropriate cognitive impairment. Her APRN had tried her on Zoloft for 3 months without much benefit. The family is concerned that she now has dementia and are asking about Alzheimer's medications. A recent head CT showed only age related changes and mild white matter changes. Her follow up COVID tests are negative.

Many patients who experience COVID-19 exhibit neurological symptoms, from loss of smell to post-infection confusion and an increased risk of stroke. There are longer-lasting consequences for the brain, including chronic fatigue syndrome, encephalitis and memory impairment. These effects may be caused by direct viral infection of brain tissue. But growing evidence suggests that the virus can cause ongoing impairment through the immune system, with inflammation contributing to lasting neurological changes after COVID-19.

Cognition is how we acquire knowledge, make sense of stored information and use it to complete tasks. Impairment in cognition affects your ability to retain information and recall past experiences (memory), your ability to concentrate (focus) and your ability to respond to stimuli (attention). Because COVID-19 involves a massive release of inflammatory signals, the impact of this disease on memory is a particular concern. That is because there are both short-term effects on cognition (delirium), and the potential for long-lasting changes in memory, attention and cognition. There is also an increased risk for cognitive decline and dementia, including Alzheimer's disease, during aging.

The potential connection between COVID-19 and persistent effects on memory is based on observations of other illnesses. For example, many patients who recover from heart attack or bypass surgery report lasting cognitive deficits that become exaggerated during aging. Another major illness with similar cognitive complications is sepsis — multi-organ dysfunction triggered by inflammation. In animal models of these diseases, we also see impairments of memory and changes in neuroimmune and neuronal function that persist weeks and months after illness.

Prevention of infection is obviously the primary goal, but treatments must be developed that address both the physical and neurological impact of the virus. Several emerging treatments for COVID-19 are drugs that suppress excessive immune activation and inflammatory states. Potentially, these treatments also will reduce the impact of inflammation on the brain and decrease the impact on long-term brain health.

Ms. Alice has continued to struggle and our conservative treatment measures have resulted in minimal improvement. Sadly, she may soon require assisted living or extended care if she continues to decline.

COVID-19 will continue to impact health and well-being long after the pandemic is over. As such, it will be critical to continue to assess the effects of COVID-19 illness in vulnerability to later cognitive decline and dementias. It will be many years before we know whether the COVID-19 infection causes an increased risk for cognitive decline or Alzheimer's disease. But this risk may be decreased or mitigated through prevention and treatment of COVID-19.

THE EXAM ROOM

After reading an Editorial in last month's Bulletin, that seemed to be a clear political statement regarding Corona Virus (COVID-19), it is important to express "the other side of the story". Since the IMS Bulletin allows physicians to express opinions in editorials, it is important to provide a "balanced approach".

The federal government and specifically President Trump and VP Pence were blamed for the unfortunate Corona virus epidemic, both the illnesses and the deaths, and for their "lack of leadership, confusing and changing recommendations and failure to listen to scientists". That is one opinion that has been clearly articulated nationally by the opposing political party.

Initial blame for COVID-19 needs to be assessed to China. While quietly hiding the Wuhan virus from the world for weeks or months and grounding all flights from Wuhan to other Chinese airports, the Chinese Government allowed any and all flights to other parts of the world. This led to world-wide dissemination of a virus that could have been much more easily contained.

Once this duplicity and purposeful cover up was discovered, our national leadership very quickly banned flights arriving from China (against the advice of medical specialists and others) thus reducing the importation of the virus. Soon thereafter, flights from Europe were curtailed when outbreaks there raised the risk to Americans from European visitors.

The administration has been chastised for NOT recommending more masks and sooner. The administration WAS following then available advice and guidance.

In early March, Dr. Anthony Fauci, a leading voice on the White House Coronavirus Task Force, told "60 Minutes" face masks were not necessary for the general population amid the novel coronavirus outbreak, noting that while masks might make people "feel a little bit better," they don't provide the protection folks believe they do and might create "unintended consequences."

By April, the CDC revised this recommendation to include the wearing of masks in certain social circumstances. But there was a problem. There was a lack of Personal Protective Equipment (PPE) as infections rose. There have been many explanations for this, but part of the issue was prior Presidents' (plural) outsourcing so much production of necessary medical equipment to foreign production that the USA was left with less capability to produce these items on our own. This also impacted employment within the USA and left the country dependent on foreign production. PPE supplies were depleted when this unexpected silent killer hit our shores. In an interesting twist, the USA became dependent for PPE on the very country that spawned the virus.

The administration has been chastised for NOT invoking the Defense Protection Act (DPA) to FORCE companies to change focus and produce needed pandemic materials. Voluntary responses are as follows (DPA not needed):

Mar 27, 2020 · We are already seeing some manufacturers of other products responding by voluntarily switching their production lines to make PPE in an effort to address shortages. This alert covers the possibility of expanding production in this way during this unprecedented global crisis.

March 20,2020 - He (VP Pence of the Corona Task Force) said Honeywell has converted a factory that had planned to move production to Mexico and is now going to produce 120 million masks per year. 3M, which the VP visited earlier this month, has increased its N95 respirator production to a rate of 420 million per year.

April 14,2020 - Less than a month after holding its first talks with ventilator company Ventec Life Systems about making the much-needed devices, General Motors Corp. GM said production had begun at its plant in Kokomo, Indiana. The Ventec V+Pro units are being produced under GM's $489.4 million contract with the U.S. Department of Health and Human Services. The contract calls for GM to provide 30,000 ventilators for the Strategic National Stockpile by the end of August and 6,132 by the end of June.

June 4,2020 - KOKOMO, Ind. – The General Motors plant in Kokomo is still hard at work producing ventilators to help hospitals in the fight against COVID-19 in the U.S. With a staff of about 700 people, GM is hiring 300 hundred more to help in the production. Employees need to build and ship 30,000 ventilators by the end of August as part of its contract with the U.S. Department of Health and Human Services. The plant in Kokomo ships around 96 ventilators a day, sometimes more than that. As of early June, the plant has shipped close to 3,000 ventilators across the country.

To be clear, 3M, Honeywell, and GM – Kokomo hired American citizens to do this work. And that does not include all the smaller companies, the private 3-D printed face shields and other materials.

Add to all this the provision of fully staffed hospital ships to both New York and Los Angeles (as far as I know, at no cost to those cities), the conversion of the Javits Center in NYC to a COVID Hospital within less than a couple of weeks, redirecting certain essential supplies to affected areas, and general offers of support when requested, it is hard to understand the unilateral opinion that the crisis was completely mishandled by the current administration. Even Mayor DeBlasio and Governor Cuomo initially applauded and seemed grateful for the acts, only to later claim – "not enough".

Were there mixed messages during this crisis – yes, as conditions changed, so did the message; were there changing messages – yes, as more medical information became available messages changed; and could some issues have been better handled – yes, isn't hindsight wonderful.

As a family medicine doctor, I always wanted to be asked for a second opinion. It gave me the chance to be a hero, because clearly the first doctor was WRONG. Having all the knowledge of what had been done incorrectly gave me a huge head start. That seems to be the case here. Hindsight is 20/20 and the second opinion can be made to look correct. But really, what could have been done better and more efficiently? At no time has there been a clearly articulated, precise, and medically vetted approach that would have resulted in a better outcome. Opinions differ as to masks, shut-downs, Chloroquine, plasma etc., There is enough blame to go around, as well as praise that should be shared.

Joe has a plan – but has anyone heard any of the actionable and objective steps that are different?

Lets work together to solve this blight. Just my point of view.

WELCOME NEW MEMBERS

Tanna J. Boyer, DO
IUHP Riley Hospital for Children
705 Riley Hospital Dr., Ste 2820
Indianapolis, IN 46202-5109
Anesthesiology
Philadelphia College of Osteopathic Med, 2008

Shannon M. Tighe MD
CPN Family Medicine & Pediatric Care
8150 Oaklandon Rd, Ste 130
Indianapolis, IN 46236-9554
317-621-1111
Pediatrics
Indiana University School of Medicine, 2003

Kazim M. Alwani, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Kilimanjaro Christian Med Col, 2021

Haley E. Calcagno, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Oregon Health & Science Unv Sch of Med, 2019

Nathan T. Connell, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Unv of Wisconsin Sch of Med/Pub Health, 2017

Alhasan N. Elghouche, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Indiana University School of Medicine, 2016

Megan E. Falls, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Sidney Kimmel Med Col at Thomas Jeff, 2019

Michael Farthing, MD
IUSM
Anesthesiology
Indiana University School of Medicine, 2016

Anjulie Gang, MD
Price Vision Group
Ophthalmology
University of Illinois, 2016

Alexander J. Jones, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Indiana University School of Medicine, 2019

Leah J. Novinger, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Robert Larner MD Col of Med, Vermont, 2016

Jaimin J. Patel, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
U of Miami Leonard Miller Sch Med, 2019

Cole P. Rodman, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Ohio State U Col of Med Public Health, 2020

Kolin E. Rubel, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Indiana University School of Medicine, 2017

Mohamad Z. Saltagi, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Indiana University School of Medicine, 2018

Dhruv Sharma, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Unv of Louisville Sch of Medicine, 2017

Elizabeth O. Shay, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Case Western Reserve U Sch Med, 2020

Tim J. Shin, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Ohio State U Col of Med Pub Health, 2018

Michael J. Ye, MD
IUSM Otolaryngology Head & Neck Surgery
Otolaryngology
Indiana University School of Medicine, 2018

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THE BULLETIN BOARD

THERESA M. ROHR-KIRCHGRABER, MD FACP

Dr. Rohr-Kirchgraber has been nominated for the AMA Inspiration Award, which recognizes physicians who have contributed to the achievements of women in the medical profession.

IUSM '21 student Laura Christopher and IMS Member Theresa Rohr-Kirchgraber, recently presented "The Great Gender Divide: Gender-related discrepancies of N95 mask protection" (2020). Sex and Gender Health Education Summit 2020 – Virtual Meeting. 5. https://jdc.jefferson.edu/sexandgenderhealth/5

IUSM Student Nicole Lindsay and IMS member Theresa Rohr-Kirchgraber presented , "The impact of sex and gender in health and disease: an elective" (2020). Sex and Gender Health Education Summit 2020 – Virtual Meeting. 14.https://jdc.jefferson.edu/sexandgenderhealth/14

IMS Member Theresa Rohr-Kirchgraber, MD presented with Drexel Medical student Kathryn Lindstrom "Women Authors in Medicine: A Gender Based Study on Authorship Opportunities and it's Implications in Promotions in Medicine" (2020). Sex and Gender Health Education Summit 2020 – Virtual Meeting. 33. https://jdc.jefferson.edu/sexandgenderhealth/33

IUSM student A. Sedaghat and IMS member Theresa Rohr-Kirchgraber presented, "Chronic pain: the importance of a sex and gender-based approach to treatment" (2020). Sex and Gender Health Education Summit 2020 – Virtual Meeting.25. https://jdc.jefferson.edu/sexandgenderhealth/25

RICK C. SASSO, MD

Dr. Sasso published, in a peer-reviewed journal: This is a multi-center prospective study evaluating anterior cervical surgery in diabetic patients.

Arnold PM, Vaccaro AR, Sasso RC, Goulet B, Fehlings MG, Heary RF, Janssen ME, Kopjar B: Two-year clinical and radiological outcomes in patient with diabetes undergoing single-level anterior cervical discectomy and fusion. Global Spine J, 2020.

Just published in the International Journal of Spine Surgery regarding performing virtual spinal evaluations in the Era of COVID-19.

Yoon JW, Welch RL, Alamin T, Lavelle WF, Cheng I, Perez-Cruet M, Fielding LC, Sasso RC, Linovitz RJ, Kim KD, Welch WC: Remote virtual spinal evaluation in the Era of COVID-19. Int J Spine Surg 14: 433-440, 2020.

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

JEREMY A. KIRK, M.D.

Jeremy was born June 6th, 1973 at Hollloman Air Force Base near Alamogordo, New Mexico. Jeremy attended primary schools at Yokota Air Base near Tokyo, Japan; Omaha, Nebraska; and Beavercreek, Ohio. After graduation from Beavercreek High School in 1991, Jeremy attended Wright State University, majored in microbiology and pre-medicine, and graduated in 1996. He received a scholarship to the Medical College of Ohio in Toledo where he graduated in June, 2002.

Dr. Kirk completed a three year residency program at St. Vincent's Hospitals in Indianapolis where he received board certification in Internal Medicine and later fellowship in Hospitalist. In 2005, he helped form the Adult Hospitalist Program at Hendricks Regional Health in Danville, Indiana. In 2017 Jeremy helped form and direct the Hospitalist Program at Witham Hospital in Lebanon, Indiana. IMS Member since 2002.

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: Electrocardiograph 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:	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: Intervention 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 School of Medicine

Indiana University School of Medicine is committed to providing valuable educational opportunities. Many of our educational activities usually offered as face-to-face meetings, have now transitioned to a virtual format in an effort to keep healthcare teams connected and engaged during the COVID-19 pandemic.

Current Virtual Series actives open to the public:

Grand Rounds: Dermatology, Gastroenterology, Medicine, Pathology, Pediatric, Psychiatry, Otolaryngology, OBGYN

Project ECHOs: Cancer Prevention & Survivorship Care, Integrated Pain Management

Education & Research: Child Neurology, Clinical Research Ed, Faculty Devel. Simulation, IU Health Pathology Digital Imaging, Neonatal & Prenatal Ed, Pulmonary Research

Schedule of activities, visit https://iu.cloud-cme.com

2020 Live Events

Oct 9 23rd Annual IU Gastroenterology Hepatology Update, IN History Center

For more detailed information, please visit the events page.

IMS is not responsible for the events listed. We recommend that before attending any CME/Conference events that you check with the provider to confirm the program is still available.

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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MEDICAL SOCIETY

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Ramana S. Moorthy *(2020)*
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Past Presidents' Council 2020

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

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John C. Ellis
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Susan K. Maisel* *(2021)*
Jon D. Marhenke
Mary Ian McAteer* *(2022)*
John P. McGoff
Stephen W. Perkins
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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)
Christopher D. Bojrab (2021)
Ann C. Collins (2020)
Carolyn Cunningham (2022)
Julie A. Daftari (2020)
John H. Ditsler (2021)
Marc E. Duerden (2020)
Richard D. Feldman (2021)
Robert S. Flint (2021)
Bruce M. Goens (2022)
Ann Marie Hake (2022)
Ronda A. Hamaker (2022)
Mark M. Hamilton (2022)
C. William Hanke (2021)
Chad R. Kauffman (2020)
Susan K. Maisel (2022)
Mary Ian McAteer (2020)
Ramana S. Moorthy (2020)
Thomas R. Mote (2021)
Mercy O. Obeime (2020)
Robert M. Pascuzzi (2020)
J. Scott Pittman (2022)
David M. Ratzman (2021)
Theresa Rohr-Kirchgraber (2022)
Jodi L. Smith (2022)
Eric E. Tibesar (2020)
Maureen Watson (2022)
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)
Laurie L. Ackerman (2022)
Jeffrey L. Amodeo (2021)
Brian D. Clarke (2020)
Doris Hardacker (2021)
Brian S. Hart (2020)
Kyle Jamison (2021)
David A. Josephson (2020)
Penny W. Kallmyer (2020)
John E. Krol (2020)
Daniel E. Lehman (2020)
James Leland (2022)
Christopher Mernitz (2021)
Martina F. Mutone (2021)
Ingrida I. Ozols (2020)
Scott E. Phillips (2022)
Richard H. Rhodes (2020)
Jason K. Sprunger (2020)
Richard M. Storm (2021)
Glenn A. Tuckman (2021)

Indiana State Medical Association

Past Presidents
**Indicates deceased*

John P. McGoff 2017-2018
Jon D. Marhenke 2007-2008
Bernard J. Emkes 2000-2001
Peter L. Winters 1997-1998
William H. Beeson 1992-1993
George H. Rawls* 1989-1990
John D. MacDougall* 1987-1988
George T. Lukemeyer * 1983-1984
Alvin J. Haley 1980-1981

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John C. Ellis

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