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BULLETIN

SPECIAL FEATURE

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Eating Elephants with Dr. Yancy

by MORGAN PERRILL and CALLEIGH SMITH
Executive Vice President
and Associate at The Cordyon Group

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TABLE OF CONTENTS

IN THIS ISSUE

SPECIAL FEATURES

ANNOUNCEMENTS

LETTER FROM THE EDITOR

Members,

Thank you to everyone who attended last month's virtual event with Dr. Eric Yancy. We had over 70 members register to attend and over 50 non-members, making it our largest virtual event to date. In case you missed it, we wrote a special feature covering the which you can find on page 6 of this month's edition.

Please stay tuned for upcoming announcements on upcoming virtual events, legislative news, and resolution and convention information.

Sincerely,

Morgan Perrill

Morgan Perrill
Executive Vice President

THE PRESIDENT'S PAGE

LINDA FEIWELL ABELS, MD

How effective are your communication skills? How quickly do you interrupt your patients? According to a study published in the Journal of General Internal Medicine, doctors listen to patients for only 11 seconds before interrupting them.

Effective communication is an art that requires you to be a respectful, empathetic listener and acknowledge what is said. It is clear, concise, concrete, correct, coherent, complete and courteous.

Medical education has implemented programs to teach communication skills to students and residents. Educational assessments and simulations have been added to facilitate learning these important skills. Among other things, students/ residents learn how to gather information and communicate findings with patients and colleagues, how to disclose the truth, how to deliver bad news, and how to have end of life communication.

Communication can be verbal, non-verbal, or visual. Verbal communication is dependent upon words to deliver a message. According to the AMA Journal of Ethics, only 12% of adults in the United States are highly proficient with health literacy. Thus, it is important to choose words appropriate to the recipient's level of knowledge. Repeating information with clear, concise talk is most beneficial to facilitate patient understanding. I remember being told in medical school that facts needed to be repeated 7 times before medical students would remember them. How many times do we need to repeat information to patients and how do you evaluate what they have heard and what they understand? Ask your patient if they will do anything differently in relation to their health after your discussion.

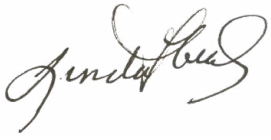
It is also important to consider cultural disparities and remove barriers when communicating with patients. Ask them what they prefer to be called. Some people do not want to be called by their first name and are shut off when this occurs. You can lose their attention before you begin.

Nonverbal communication is also important. Speak appropriately maintain eye contact. Set aside distractions. Use body language to show you are listening. Pull up your chair and speak at the level of your patient. Physicians who are rushed looking only at the computer or talking as they leave the room with their hand on the door send the wrong message and are certainly less effective.

Emotion control is an important aspect to consider in effective communication. Patients may be frightened or frustrated and not follow instructions or recommendations. It is important to consider that "non-compliance" may be due to lack of understanding or misunderstanding of what instructions have been given. Scolding or yelling at patients will likely lead to additional problems. It is important to be open minded and empathetic.

Poor communication skills lead to misunderstanding and frustration for the patient and the physician. It is important to understand what your patient needs and expects. Don't leap too fast. You will likely miss something and turn your patient off. Be sure to consider their nonverbal behavior. Watch for the blank look of an overwhelmed patient.

In summary, effective communication with open dialogue, active listening, and patient directed conversations will result in a more effective doctor/ patient relationship resulting in happier more satisfied patients and physicians.



Linda Feiwell Abels
President
Indianapolis Medical Society

Do you have any "medical bloopers" or miscommunications you would like to share? If so, please email them to me at Lfabels1111@gmail.com.

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Eating Elephants with Dr. Eric Yancy

by MORGAN PERRILL AND CALLEIGH SMITH
IMS Executive Vice President, Senior Director at The Corydon Group and Associate at The Corydon Group

Inspired. Overwhelmed. Humbled. Even a Little Awed. This is how we felt after participating in Dr. Eric Yancy's talk "The Truth About Healthcare Disparities In The Black Community" last month. During his one-hour presentation, Dr. Yancy educated us on how Indianapolis physicians can "take a couple of nibbles and bites" to solve this gargantuan issue.

Eric A. Yancy, MD is a native of Baton Rouge, Louisiana, and Southern University graduate. He attended Creighton University School of Medicine and was recognized as the Creighton University School of Medicine Alumnus of the Year in 2011. He completed his residency at Riley Hospital and has been practicing pediatrics in Indianapolis since, striving to provide for the under-served. Dr. Yancy has been a longstanding member of the Indianapolis Medical Society (IMS), and we were grateful for his candor and passion as he shared his experiences and provided us insight into his life.

"While discussing reimbursement and year-end bonuses from Medicaid he noted, "Those are as easy to get as it would be for me to go to Bankers Life and dunk on Myles Turner"(stated Dr. Yancy, a self-proclaimed enthusiastic Pacers fan)."

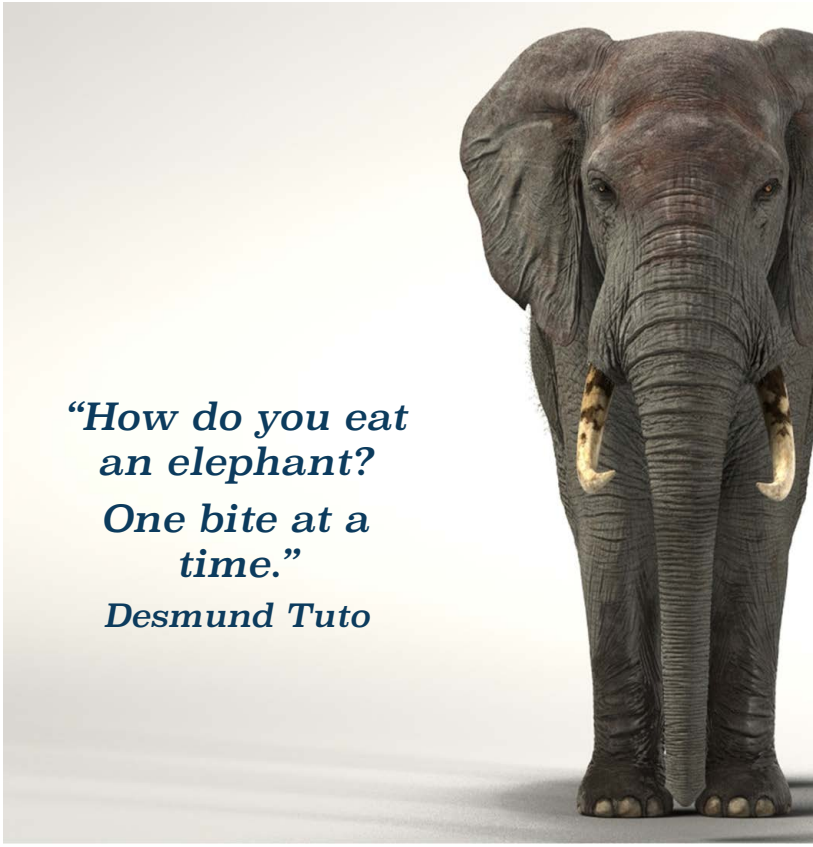
"Minority patients tend to benefit from minority doctors," stated Dr. Yancy, who went on to explain why that statement is accurate even today. We summarized this is because cultural knowledge leads to better communication, believability, and trustworthiness. In an example, Dr. Yancy mentioned when a young, Black girl visited a white dermatologist for a scalp condition with her mother. The dermatologist prescribed her a treatment that would require her to brush and wash her hair every evening, not considering that black females are unable to wash and brush their hair each day. This led to uncomfortable communication between the girl, her mother, and her physician and demonstrated the physician's lack of knowledge regarding the hair care regimen of Black women. Dr. Yancy expanded upon it further and explained how this is detrimental since the girl has been embarrassed, she will probably not return to receive care for her condition. The lack of cultural knowledge in this example created barriers between the physician and patient, rending the treatment ineffective and preventing a future accurate diagnosis.

The solution is easy, right. We just need to employ more Black physicians in areas where more black patients reside. The same could go for all ethnic groups if cultural knowledge is important for patient communication. If it is that easy, why is it such an uphill battle to recruit African American medical students?

If you can believe it, the medical school landscape has not changed much in the last two decades. "Enrollment lags and there are huge gaps of African physicians in their communities." Dr. Yancy took the audience back to the late 20th century when medical schools had admission initiatives for persons of color and those who were interested in serving their communities and explained while most of the students of color who were in those classes would be regardless, accusations of reverse racism still were rampant. Dr. Yancy spoke about his father's journey in trying to gain his master's in animal science. While he could have attended LSU twenty minutes from his home, the admission office considered race and he ended up attending Iowa State University 17 hours away. Dr. Yancy noted that while this was seen as problematic, there is

no backlash regarding legacy preferences even though they disproportionately help white individuals. Unfortunately, it has not improved when only 6% of the 2015 medical school graduates were Black or African American according to the Association of American Medical Colleges.

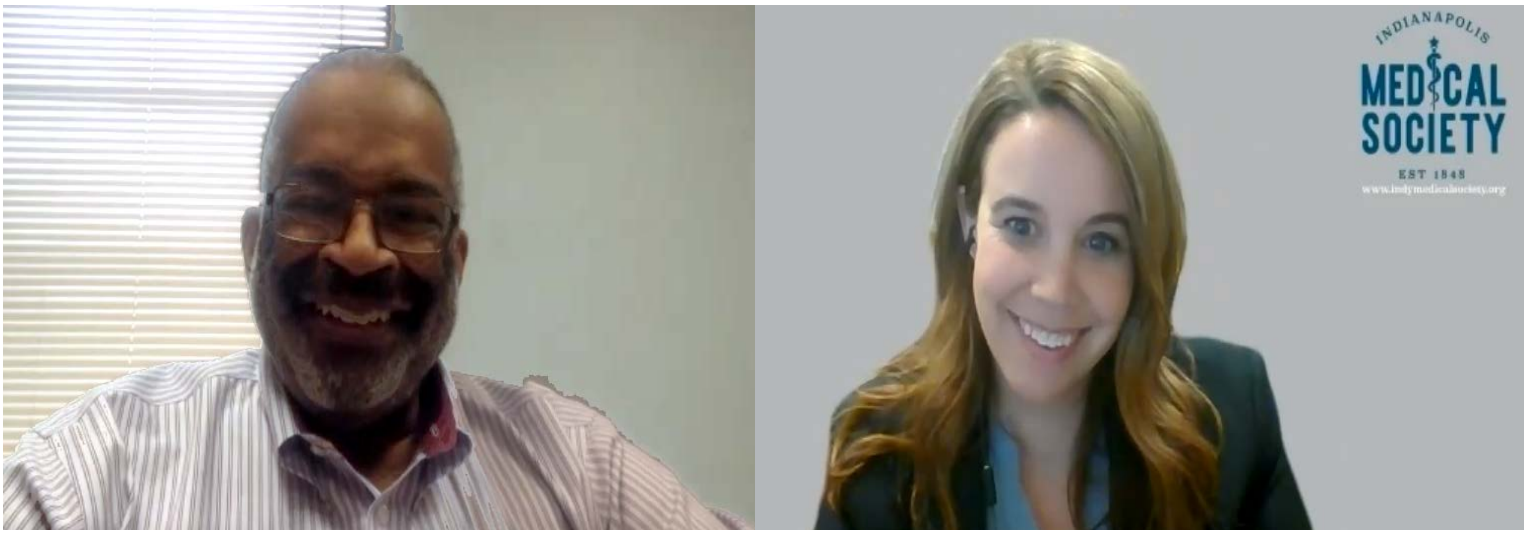
Dr. Yancy explained that after completing his residency he wished to open a practice in a disadvantaged area and could not receive a loan from any of the three largest banks in Indianapolis for being "too much a risk." Dr. Yancy expounded that you must be close enough to be accessible to patients but cannot be in the under-served areas or areas of higher crime. You are paying more to be closer to downtown, but physicians receive less in reimbursement because patients in under-served areas are often on Medicaid/Medicare. "If you can't get paid, you can't stay." It is a balancing act that is crucial to keeping your practice while serving those who need it most. While discussing reimbursement and year-end quality bonuses from Medicaid he noted, "Those are as easy to get as it would be for me to go to Bankers Life and dunk on Myles Turner." (Go Pacers!)



Other factors also prove serving these communities can be a challenge. On top of no-show rates which can be outside of the patient's control such as transportation and childcare issues, Dr. Yancy spoke on the challenges of patient acceptance or the lack of trust in someone who would care for them. He quoted Groucho Marx when saying "I wouldn't be a part of any club that would have me as a member." Many individuals from marginalized communities believe that if the physician in their area was good at what they did, they would not be in that area, but further and unreachable to them.

In the latter part of his presentation, Dr. Yancy mentioned small changes that everyone can make that can start tomorrow to nibble away at disparities. He began with a story about Mrs. Bernice Johnson, an eighty-nine-year-old Black woman, who came to the hospital with chest pains. When the attending walked into Mrs. Johnson's room after reviewing her file the physician says, "Good evening Bernice. I'm Dr. Smith, and I will be taking care of you this evening." Immediately some people in the audience knew why this was incorrect - "She's not Bernice." Typically, elderly Black individuals do not like to be called by their first name as they see it as a sign of disrespect. This mistake stratified the relationship and caused Mrs. Johnson to lose her confidence in the physician. Dr. Yancy noted the amount of communication a physician may get after that will be extremely limited. Being aware and following cultural norms can build trust and ensure positive communication between physician and patient.

After citing an occurrence where he was mistaken for a cafeteria worker rather than a physician, Dr. Yancy stressed the importance of second thoughts. He assured us that we are not responsible for our first thought, we are responsible for our second thought and how we choose to respond. He told the audience that after your initial thought, you need to remember that a physician's goal is



to help their patients get well. It is their responsibility as licensed medical officials to put preconceived notions or opinions to the side and do whatever it takes to help cure their patients. He also cited an example where a patient of his who was an attorney gave birth to a child and someone in the hospital assumed the woman and her child would need to apply for Women Infants Children (WIC) Resources and other available benefits. He noted that if the individual did not act upon their first thought, she would not have miscategorized the young woman.

Racial disparity is also seen in child abuse reporting. While Black children only make up 13% of the population, they represent 32.3% of child abuse victims; however, white children represent 51.2% of child abuse reports but comprise 70% of the US population. Black children are hospitalized longer than white children on average, but both severities of the injury and in-hospital mortality are higher in white children. White parents and caregivers are often given the benefit of the doubt more than parents or caregivers of color. Instances of child abuse on white children is reported less and is more severe while instances of child abuse on Black children is reported more and less severe. This leads to parents questioning whether to seek care because of the real fear of criminalization regardless of fault. Dr. Yancy explains, that this leads to "A mistrust of the system and possibly a delay in treatment of innocent conditions." Discipline varies with culture and recognizing alternative cultures is necessary to provide appropriate care for others.

Concluding the presentation with Q&A, many members of the Society wanted to know what they could do personally or collectively to improve the lives of minority patients. While Dr. Yancy mentioned better reimbursement, increasing the pool of physicians, he also stated, "Humility is an active practice." He stressed the importance of listening to the patient and ensuring that they feel like they are heard. It is the little things that show the most respect and open lines of communication.

One viewer asked how virtual visits affected care to the Black or under-served populations. Dr. Yancy responded,

"It has really been a good thing for a lot of under-served and Black patients. I can tell you what 99% of the rashes are. Now they don't have to take off work and worry about childcare. I can do most of what I do, minus the hands-on stuff, virtually. My patients have loved it. I have made a strong vein to the insurance companies that this needs to continue. It has made a huge difference. It has been really good. It has meant the world to those with transportation and work issues."

This is an elephant of an issue that will take numerous small bites. But a simple nibble can sometimes start a feeding frenzy. Dr. Yancy provided us with the utensils to take those first bites. We could not capture every aspect of Dr. Yancy's virtual discussion in this short piece, but we hope we were able to provide an overview of some of the wisdom he imparted. Please stay tuned for any upcoming events.

Did you miss this event?

Dr. Yancy is available to speak at other events. If you would like to book Dr. Yancy for an event, please reach out to him directly at eayancymd@aol.com.

Present and at the Table

by SUSAN K. MAISEL, MD AND JODI L. SMITH, MD
Co-Chairs of the IMS Resolution Review Committee

It is with great expectations of effecting positive impact in our ever-changing medical environment that the Indianapolis Medical Society has established the Resolution Review Committee to facilitate legislative proposals from our membership. The mission of the committee is to provide education, encouragement and support in developing, mentoring, vetting and researching resolutions to be submitted to and presented at the annual Indiana State Medical Association convention every fall. The committee will be active throughout the year to facilitate proposals as legislative concerns evolve.

To accomplish this mission, the Committee will be reaching out to the membership individually, as well as through notices and articles in the IMS Bulletin, through various IMS-sponsored programs and events throughout the year, as a call to action.

When we first entered medical school, we were instructed in the altruism of the medical profession, in the honor and privilege of caring for patients, in the satisfaction and rewards of collegiality, in the social responsibility that came with the honor, and especially in the autonomy of managing our patients and our practices. Autonomy??? Autonomy no more, for better or worse! In the corporate world of medicine, we have unwittingly lost the helm as sole "captains of our ship", we are part of a dance of entanglement that involves team care, federal and state governmental regulations, insurance companies directing care, prior authorizations, medical device and pharmaceutical companies, hospital associations and restrictive non-compete covenants. It is sometimes so overwhelming that we forget that we still have a voice. With the day-to-day frustrations of denials and appeals, federally mandated EMR, cuts in reimbursement, it is hard to feel in control, appreciated, respected, valued - it is easy to become apathetic.

The Indianapolis Medical Society has the potential to resuscitate and move us forward. But it is only as effective as its parts. In today's world, numbers mean everything. Members mean everything. To physicians, camaraderie and collegiality bring validation, new discoveries, and countless opportunities. To change the "medical world" we have to start somewhere, we have to become engaged again, we have to dance at the table, we have to dance with the (government, insurance and corporation) wolves. Where better than starting at the local level with our city, county and state medical societies where we can, with numbers, effect a change. Remember the "old days" where we gathered in the physician's lounges and hatched and developed ideas for better patient care and practice environments, and then moved mountains. Never has the time been more urgent, never has it been more important for us to gather, us the grassroots, into a cohesive voice! Nobody else will take the responsibility for the well-being of our profession. Nowhere else are we able to gather and act upon the interest of independent, employed, academic and administrative physicians, across all fields, under one roof, other than our local medical societies. I challenge every member to bring at least one new legislative issue to the forefront for action. I challenge all of us to organize grassroots gatherings to brainstorm on every aspect of the future of medicine, on our futures. Let the medical society play the ideas forward. Let us be examples and mentors to the physicians of tomorrow. Make our numbers count. Make a difference. Make the Indianapolis Medical Society a vehicle for our voices, for activism and for change.

The Resolution Review Committee looks forward to the challenges of the next year! You will be hearing from us, and we look forward with great anticipation to hearing from you!

Resolution Submission

Do you have a resolution to share with the committee? Feel free to email it to either co-chair or submit it to Morgan Perrill, Executive Vice President at mperrill@indymedicalsociety.org or ims@imsonline.org.

The committee will review and provide you feedback and/or a response on IMS support depending on your request. We look forward to hearing from you.

Salvation in a Bright Yellow Lego

by *Mercy Hylton, MD*
IMS Board Member, Founding Member of "Indiana Physician's Lounge"

Which parent hasn't experienced the agony of unguardedly stepping barefooted onto a hard plastic corner of their child's LEGO block, followed by uttering curse words and angry admonishments to their children to pick up their toys? A LEGO block recently brought me to tears, not in physical pain, but in relief and gratitude for God's grace in the face of the despair growing within me.

Over the "Year of COVID-19", our pediatric ER's patient volume declined with fewer typical respiratory and sports-related complaints. However, the acuity, complexity, and anxiety levels of visits rose with more child abuse, skyrocketing psychiatric complaints, more psychosomatic symptoms, and out-of-control chronic illnesses. I witnessed pediatrician colleagues being furloughed from jobs due to decreasing patient volumes and our most seasoned pediatric emergency nurses being stretched so thin that one after another they leave to find greener pastures, all the while watching many in our pediatric patient population suffer like never before. As human resources were tightened and other resources disappeared, there was growing resentment at the ceaseless, if always unspoken, the mantra of "*do more with less.*" Pediatric care has long been unfairly undervalued by the business of health care. *A recent string of sad patient cases over the last few months, as well as a loss in my own family, had fanned my building ember of grief and hopelessness.*

The ember burst into a flame with the distinct shrill ring of an incoming EMS call which interrupted a typical morning in our Pediatric ER. Despite the sound of sirens in the background and the sharp crackles of the speakerphone, we heard the words loud and clear.

"En route with a newborn delivered minutes ago at home in cardiac arrest."

Instantly, everything else around us blurred into the background. Our small team's focus crystalized on saving the tiny life barreling toward us with blazing lights and blaring sirens: calling for backup help from other units, readying our resuscitation room, assigning team member duties, and mentally reviewing our plan before the patient arrived. Nervous energy and anticipation were crackling like electricity in the room and adjacent hallway where, as is typical for newborn codes, twenty or so health professionals stood ready. For a moment, as we waited, I selfishly thought, *"Why is this happening? Why on my shift? I cannot handle any more sorrow."*

The baby arrived in the arms of a medic, was laid on the infant warmer and CPR was immediately resumed. It was soon noted that the baby's fragile skin was sloughing off during chest compressions. The condition of the baby's skin, among other things, told us that *the baby had likely died in the womb sometime before the perfectly formed tiny body ever made it to us*, even though based on the estimated gestational age, it was likely that baby showers had been given, names chosen, and a nursery readied. The fervent resuscitation attempts were soon tempered by acknowledgment of the inevitable

conclusion.

A nurse held the tiny, swaddled baby in her arms with a maternal tenderness which, for a brief moment, brought to my mind Michelangelo's beautifully heart-wrenching Pietà. I glanced around for a moment and noted that almost everyone in the resuscitation room was a woman, and most of them mothers: the physicians, nurses, respiratory therapists, pharmacists, EMS crew, social worker, and chaplain. My voice cracked as I thanked everyone who had run to aid another mother's baby. *All of us were now grieving with our unknown sister*, having been taken to a different part of the hospital, who had lost her baby.

As I walked out of the resuscitation room I saw one of my sweet nurses who was pregnant at the same gestational age. We held each other and sobbed. This one hit too hard, too close.

The next morning, with the exhaustion that comes after a long shoulder-shaking cry and with spending far more time at the hospital than at home for many days, I hurried to complete the EHR charts of some of the dozens of patients whom I saw the day before.

Mid-morning my salvation arrived: in the form of a tiny, bumble-bee yellow LEGO piece.

This tiny piece of yellow plastic was tightly wedged in a nostril of the beautiful toddler who had apparently placed it there for safe-keeping: easily visible, tantalizingly close, yet beyond the reach of the mother's fingers. I asked my questions about past medical history, in order to complete the computerized charting which would take me at least twice as long to complete as the entire patient encounter including the procedure.

"Any medical problems?"

"Sickle Cell Disease."

"Any prior surgeries?"

"None yet. But she is getting a bone marrow transplant next month. Her brother is a match," the mother said, pointing to the preschooler awkwardly stretched out on the armless hospital chair, sleeping soundly through all the chaos.

Silence for several moments. Then the unexpected sight and sound of my tears.

My Heavenly Father knew and answered. Before I had asked. Before I had even known what I needed. A cure for a much too common, painful, and deadly disease. *A reprieve for at least one mother from the trauma and sorrow of watching her child suffer from a previously incurable scourge*. A salve to my hopelessness and despair.

I asked the child's mother if we could pray together, and she said yes. We put our hands on this squirming, crying toddler and we prayed out loud that God in His power, glory, and mercy would please heal this child of sickle cell disease, keep her and her brother safe from all harm, bless the young boy who will be unknowingly giving his sister the gift of health and renewed life, and bless and strengthen the team who is doing this amazing work. The mother responded after each phrase loud enough to be heard above the ruckus in the small room: **Amen! Praise God!**

Easter and Mother's Day each arrived a little early for me this year. As a physician, I strive to prevent, cure and ease the suffering of my patients. *As a mother I relate to the anxiety and sorrow of parents as they hold their child: whether as the child's broken body is lowered dead off across over two thousand years ago, or in current times as they bring their sick, injured, or dying child to the hospital*. After a year of bearing witness to so much sorrow, My Heavenly Father knew that a tiny piece of yellow plastic wedged in the nose of a rambunctious toddler, and the hope wrapped around it, is what was needed to renew my weary spirit for a little while longer.

The COVID Reopening

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

Governor Holcomb is a Republican governor in a very conservative Republican state never known for its public health performance on most any parameter. I have been critical of some aspects of his COVID-19 emergency orders including his non-punitive mask mandate. Nevertheless, considering his situation, I believe he has done a reasonable and thoughtful job of balancing the public's health and supporting the economy over the past horrible year of illnesses, hospitalizations, and deaths.

With that said, Holcomb's recent rescinding of the state's mask mandate, capacity, and social distancing restrictions was disappointing. I anticipated that he would announce some loosening of restrictions but not an almost total withdrawal of state-level mitigation requirements. His decision was premature and not based on data and science - supposedly the basis of the state's way forward. Simply, we are not ready.

This was a political decision. The governor is in a tough situation with continuing pressure from the rightwing of his party to eliminate mitigation requirements. Republican lawmakers threatened a resolution to halt his current executive orders and introduced legislation to limit the governor's future emergency powers by convening the legislature. Not a good idea. The General Assembly couldn't even agree on a mask mandate for legislators this session. Holcomb responded in an attempt to maintain control.

The timing is not good. There is a false sense of security from experiencing a dramatic drop in daily COVID-19 cases, hospitalizations, and deaths, and low case-positivity rate of 4.5 percent. But 1000 cases daily are still too high and higher than before the huge surge that peaked in December. Case numbers and positivity rates here and nationally are rising again, ticking up after a plateau. And with many states totally reopening their economies, the more virulent United Kingdom variant circulating widely, crowded spring break gatherings, and locally with the NCAA tournament, we can only anticipate a resurgence of the virus. When we relax mitigation efforts, 2020 taught us that the virus surges.

Indiana can be proud of its immunization program, one of the most efficient and effective in the country. But still, only 2.8 million doses have been administered, and only 20 percent of the adult population has been fully immunized. We're far from the 80 percent required for herd immunity. And unfortunately, vaccine refusal is rampant.

Further, we are anticipating the arrival of other more infectious and deadly variants. The South African and Brazilian variants have the enormous potential for drastic reductions in vaccine efficacy. Variants are born and fueled by viruses spreading and mutating.

The messages from the governor are confusing to the public: The responsible thing to do is to continue to wear a mask, social distance, sanitize, and avoid big crowds. But the elimination of restrictions implies that the pandemic is all but over and it's safe to re-engage normally. He is relying on the conservative concept of "personal responsibility" as an answer to a public health crisis. Personal responsibility has never been an effective public health strategy. How many photos of mask-less crowds have we seen?

The governor has shifted the responsibility for the COVID-19 response to local governments and to businesses to maintain restrictions without the cover of statewide regulations. Indianapolis Mayor Hogsett will continue with the present restrictions, but most localities will not impose any new regulations.

With vaccinations progressing, in just a few more months we could be in a very different safer place. But now our state is open. Get ready for a setback.

Note from the Editor

Editorials are opinions written by the author and not the opinion of the 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.

Colleague Corner:
The 10 Question Interview

Ever wanted to get to know your fellow IMS members better? Check out the Colleague Corner of the IMS Bulletin. We've asked 10 questions of our members to learn more about them to share with you. Dr. David Diaz, one of two current District 7 Trustees, is sharing his answers with us this month.

1. Tell our readers little bit about yourself, your family life, background including medical school and specialty and where you work now.

I grew up in Newburgh, Indiana in the southwestern part of the state, right on the Ohio River. My family home sat high on a hill, so it had great views of the river, boats, sunsets, etc. Of course, that hill seemed a lot higher walking up than rolling or sledding down it. As a boy, I was an active camper and involved with the scouts. I grew up with an appreciation for nature that has continued all my life. My father was an immigrant from Spain, employed at ALCOA, and my mother was a full-time newspaper reporter and later town clerk-treasurer. I was the first in my family to attend and graduate from college, the University of Evansville (UE). Selling used cars one summer added to my understanding yet awareness of the vagaries of human behavior.

I attended IU for medical school and psychiatric residency. Always fascinated with human behavior as noted, so psychiatry was a good fit. I held a private practice at Community Hospital focused on consultation-liaison or CL psychiatry with a colleague for 13 years, then 5 as an employee of Community, and since 2007 I have been on the faculty at IU School of Medicine. I have also served 9 years as an attending, running a unit at a state hospital where I had numerous Deaf patients and published several peer reviewed studies about that topic. For the last several years, I have been a CL Psychiatrist at IU University Hospital and am now the program director of Indiana' s first CL psychiatry fellowship. CL psychiatry is the best way to thoroughly meld an understanding of general medicine and psychiatric concerns in a way that maximizes the health of patients.

I am married with two adult children, one a couple miles down the road from me with her husband and two daughters, 27 months and 4 months respectively, and a single son in beautiful Colorado Springs. In addition to my family, I enjoy reading, with an appetite for American literature and Ohio River steamboat history. I still enjoy nature, especially beautiful trees and the 17 varieties of Indiana frog and toad calls. The latter is always good for a few laughs at my expense from coworkers and students. I am quite proud of my roots in southwestern Indiana, my hometown of Newburgh, my alma mater the University of Evansville, and my sister and her family with 5 nieces and nephews who live in the area.

2. What attracted you to medicine and your specialty in particular?

I have always been interested in the brain and human behavior. I took a class in that subject at UE which discussed psychopharmacology which fascinated me. I enjoyed learning about theories about depression and psychosis and about medications that could help. Of course, we have a very long way to go in those areas.

I enjoy interesting stories as well, and just when you think you have heard it all, well, you haven't.

3. Was there someone who inspired your journey toward medicine or someone who inspires you daily? What would you say to them if you could?

Both my parents always told me I had the potential to do whatever it was I was interested in, and my maternal grandfather was inspiring in his behavior, his kindness, and not ever being in a hurry. I am still working on all of that, especially maybe the last one. I would tell my grandfather about being the first in my family to graduate from college.

4. What is the best and worst thing that has happened to you?

The best is easily being a father and more recently a grandfather!

The worst is my son at 18 had a cardiac arrythmia that resulted in arrest for several minutes and weeks in the neuro ICU, followed by rehab. He is, amazingly, alive, functioning but has cerebellar dystaxia, which all things considered is a miracle.

5. What is the biggest challenge you believe we face as physicians today?

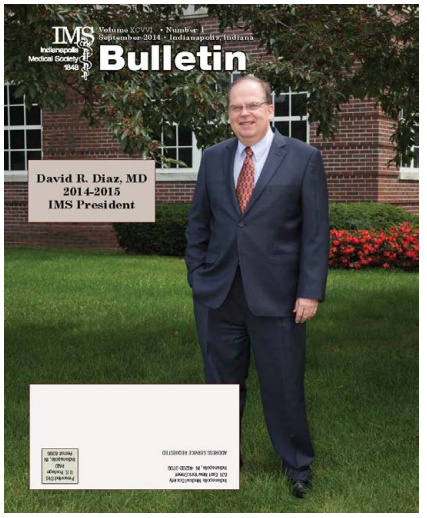
Educating the public. On all sorts of things. What goes into physician training in terms of qualification, sacrifice of time, costs, family life, etc. Beyond that, expectations for what medicine can do for patients, what the limits are, and what the costs are to make that happen. Ok, and liability issues.

6. Would you encourage another young person into a career in medicine?

I would but it has to be for the right reasons. They must be interested in making a difference in patients' lives, less so in money, and to be aware of the issues in #5 above including sacrifice, effort, and the potential for exposure to diseases like COVID.

7. Is there a stigma associated with or unknown fact about your specialty that you would like to share with other physicians?

Psychiatry has a significant stigma that has an impact not only on psychiatrists but on patients. Psychiatrists have been the butt of jokes, and that is one thing but patients that see psychiatrists even more so. That is where the real hurt comes in. Patients that feel that they cannot seek care. Patients that don't even feel they can tell their family or friends about their symptoms. So especially in the era of COVID there are a lot of patients who are alone, ill, and not seeking care. And the suicide rate is conservatively twice what it was. In terms of the economics of this issue we also have had legislation to try to make coverage for psychiatric illness comparable to people with other illnesses and enforced. (I don't like saying "medical" and contrasting that with "psychiatric" because the last time I checked the brain was part of the body). We have made progress in this area but must remain vigilant. This is an issue for psychiatrists but also for primary care doctors and for everyone that has a patient that may have psychiatric illness (as in every physician). Thank you for staying attuned to your patients' psychiatric needs and advocating for them.



8. If you could not be a doctor, what would you be?

College biology professor at a small liberal arts college.

9. What is your favorite inspirational quote?

"Success comes from going from failure to failure without loss of enthusiasm." Winston Churchill

10. Anything else you want to share with your fellow IMS members?

We as Indianapolis physicians are in a strong position to advocate for our patients and to educate the public about achieving their best health possible, as a community and as individuals. This is accomplished on a responsible, personal level as best as people are able and on a governmental and societal level as far as a healthy environment and access to quality medical care and solid coverage. We have what Theodore Roosevelt would term a bully pulpit, and if we don't feel have it we should seize the opportunity. As THE group representing all Marion County physicians (there is no other), we owe it to ourselves and the public. We must model healthy behavior to our patients and colleagues by taking care of ourselves and each other.

Thank you for sharing with us Dr. Diaz!

We would love to feature you in the next Bulletin in the Colleague Corner. If you are interested, please contact our editor, Morgan Perrill, at mperrill@indymedicalsociety.org. As our membership and events grow in a virtual capacity, we are looking for more ways to get to know each other through creative means. We hope you will consider participating in this new endeavor.

WELCOME NEW MEMBERS

Richard Reifenberg, MD
HealthNet
3403 E. Raymond St.
Indianapolis, IN 46203-4744
317-957-2028
Internal Medicine
Indiana University School of Medicine, 1996

Mikia Davis
Student
Marian University, Indianapolis, 2024

Nancy Githere
Student
Marian University, Indianapolis, 2024

Jasmine McDowell
Student
Marian University, Indianapolis, 2022

Cynthia Okoh
Student
Marian University, Indianapolis, 2023

Joshua McKinley
Student
Marian University, Indianapolis, 2025

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RICK C. SASSO, MD

Rick C. Sasso MD, Indiana Spine Group, gave the Keynote lecture titled "Cervical Deformity" at the Cervical Spine Research Society Asia Pacific section's annual meeting on March 26, 2021 which was held virtually due to the pandemic from Seoul, Korea.

Dr. Sasso also gave a lecture on "Anterior Cervical Technology Update" at the San Diego Spine Foundation Webinar Cervical Myelopathy and spinal cord injury: State of the art in 2021 on March 27, 2021.

ERIC A. YANCY, MD

Eric A. Yancy, MD, of Riley Children's Hospital was part of a small ensemble of medical workers to sign the National Anthem at the NCAA Finals game on Monday, April . He was nominated by one of his patient's fathers and his many YouTube videos of his baritone voice sealed the deal.

The ensemble was selected specifically to honor the work of our first responders. Dr. Yancy said he was honored to be among the group chosen to sing. But even more touching is the honor that it was a patient's father who made the call.

IN MEMORIAM

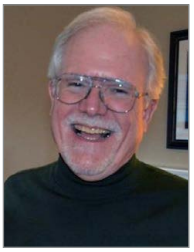
JAMES P. CRAWFORD, M.D.

James P. Crawford, MD, age 64, passed away peacefully at home on March 10 after an extended illness. Jim graduated with honors from JM Atherton High School, where he met his true love and future wife, Ruth Randolph Turner. He moved on to Georgetown College, where he graduated summa cum laude in 1979, with a BS in biology and chemistry. Jim went on to earn an MBA at Bellarmine University. In 1996, he graduated from the University of Louisville Medical School, where he served as class President all four years. Following an internship at U of L in Internal Medicine, he completed a three-year residency program in physiatry (physical medicine) at Indiana University. Dr. Crawford worked with patients to enhance and restore functional ability and quality of life to those with physical impairments with Rehab Associates of Indiana in Indianapolis. IMS member since 2002.

JOSE NICOLINI TORD, M.D.

Dr. Jose Nicolini Tord, age 92, of Indianapolis, Indiana passed away on Tuesday, March 9, 2021. Jose was born April 22, 1928 in Lima, Peru to the late Jose and Esther (Nicolini) Tord. He married Mary Helen Mikulka on June 6, 1964. Jose was a member of St. Pius X Parish, Knights of Columbus, Serra Club of Indianapolis and Opus Dei. He was also the former president of Peruvian American Medical Society. Dr. Tord practiced out of Winona Hospital, Community Hospital and Methodist for many years. IMS member since 1971.

DON B. ZIPERMAN, M.D.



Don B. Ziperman, M.D., 71, Indianapolis, passed away March 25, 2021. He was born July 31, 1949 to H. Haskell and Margaret Ziperman in Long Hospital in Indianapolis, IN. As the son of a colonel in the Army Medical Corps, Don grew up all over the world. He attended Indiana University, earning his Doctor of Medicine, graduating in 1974. Inducted into the Army in El Paso, TX in 1975, where he served his internship and residency at William Beaumont Army Medical Center, followed by his cardiology fellowship at Brooke Army Medical Center in San Antonio, TX. He left the Army as a Lt. Colonel and moved to Indianapolis with his family and joined what was then Indiana Heart Associates at Community Hospital. For 40 years, he served his patients, his practice and the Community Health Network as a distinguished interventional cardiologist. IMS member since 1981.

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

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.

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

MAY	
1	Clinical Innovation Summit - May 202
7	24th Annual Gastroenterology/Hepatology Update
10	Mandates and Behavioral Change Strategies: Impact on Immunization Practices and Public Health
12-13	56th Annual Riley Children's Health Pediatric Conference
20	COVID-19 Vaccines: Considerations in Practice
JUNE	
6-25	21 Indiana Alzheimer's Disease Research Center Memory University
17	Review and Interpretation of the 2021 ASCO Meeting

Please visit https://iu.cloud-cme.com for a list of Regularly Scheduled Series (RSS) activities.

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

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John C. Ellis
Bernard J. Emkes
Bruce M. Goens
Paula A. Hall
Susan K. Maisel* *(2021)*
Jon D. Marhenke
Mary Ian McAteer* *(2022)*
John P. McGoff
Stephen W. Perkins

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Salman S. Qureshi, Marian Student
Maham Nadeem, IU Student

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 (2023)
Carolyn Cunningham (2022)
Julie A. Daftari (2023)
John H. Ditsler (2021)
Marc E. Duerden (2023)
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)
Penny W. Kallmyer (2023)
John E. Krol (2023)
Susan K. Maisel (2022)
Mary Ian McAteer (2023)
Thomas R. Mote (2021)
Mercy O. Obeime (2023)
Ingrida I. Ozols (2023)
Robert M. Pascuzzi (2023)
J. Scott Pittman (2022)
David M. Ratzman (2021)
Jodi L. Smith (2022)
Eric E. Tibesar (2023)
Maureen Watson (2022)
Steven L. Wise (2021)
Crystal Zhang (2022)

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)
Doris Hardacker (2021)
Kyle Jamison (2021)
David A. Josephson (2023)
Kathryn Kelley (2023)
James Leland (2022)
Christopher Mernitz (2021)
Martina F. Mutone (2021)
Scott E. Phillips (2022)
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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David R. Diaz

Clerk
John C. Ellis

Seventh District

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Robert Flint (2021)

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Robert Flint (2021)

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