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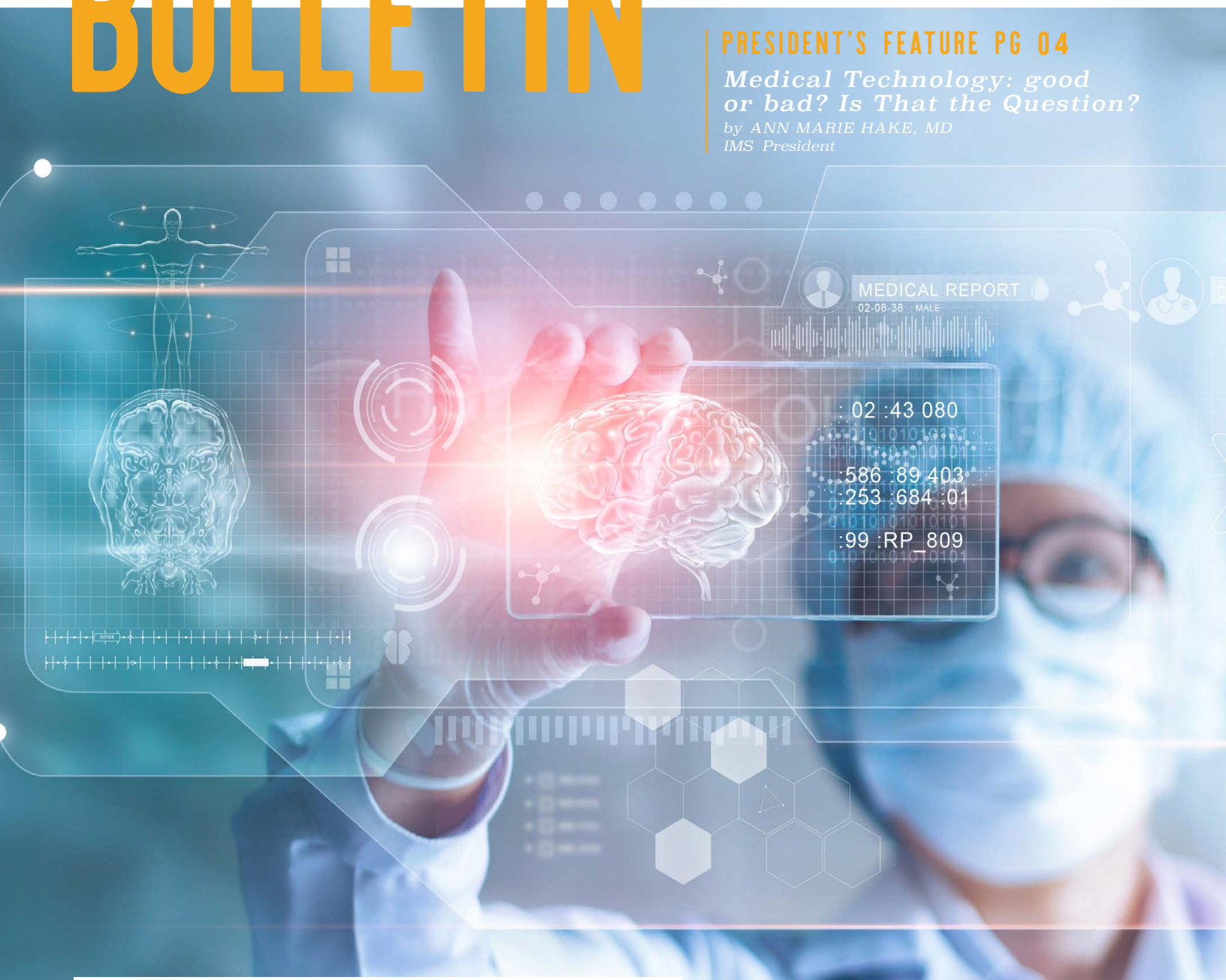
BULLETIN

PRESIDENT'S FEATURE PG 04

Medical Technology: good or bad? Is That the Question?

by ANN MARIE HAKE, MD
IMS President



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NOTE FROM THE EDITOR

Content, especially editorial articles, in the Bulletin are produced by the authors and are not the opinion of the Indianapolis Medical Society (IMS), IMS Board of Directors, or IMS Executive Committee. The goal of all articles and content contained in the Bulletin is to inspire debate and opinions among the membership on public health-related matters and keep the membership informed of issues facing physicians in central Indiana. Opposing viewpoints, comments, and counterpoint arguments are not only welcomed but encouraged and will be printed in the Bulletin by members of the Society by those who wish it. Members who wish to submit articles for publication should do so to me, Morgan Perrill, at mperrill@indymedicalsociety.org.

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THE PRESIDENT'S PAGE

ANN MARIE HAKE, MD

Is technology good or bad?

This was the essay question I was given when I took the SAT as a high school student. At that time, we would still literally hang up the phone, roll down the window, and film our vacations. The year 2000, which felt impossibly far in the future, would surely bring us flying cars, space travel, Dick Tracy-style wrist radios, and Star Trek-style tricorders. On the other side of the coin, pollution was damaging the environment, families were living farther apart from each other, and we lived under the constant fear of nuclear war.

Since that time, technology has continued to develop. Many of the amazing technologies that were the stuff of fiction are now reality – wrist-worn devices can now not only tell us the time, but can also be used to receive messages, detect ECGs, or measure our activity, stress, and sleep; computers that are more powerful than the one used for the Apollo missions can now be carried around in our pockets to give us instant access to vast stores of information, attend meetings with people around the world without ever leaving our homes, or learn of events in nearly real time; and robots and other machines can perform dangerous or menial and repetitive tasks that would otherwise impair the health and safety of human workers. The technology in development will soon be able to drive us to our destinations without needing a human driver, warn us of dangerous events ahead of time, or help screen for or diagnose conditions without the need for invasive or time-consuming testing.

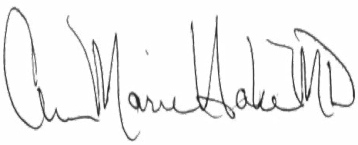
What is the downside of these advances? One major concern is the privacy of individuals and groups from whom these data are collected, and a related concern is the security of the data once it has been collected. Do individuals have a choice as to what data is collected, who may see the data, and how the data will be used? Another concern is the reliability and safety of the technology. Can we trust the data to represent accurately what is being monitored? Can we trust a self-driving car to stay in its lane? Can we trust an electronic medical record to be accurate and complete? Finally, another liability is the availability and accessibility of a given technology. Can the device or application be used by a wide range of people with varying educational, geographic, and economic status, or will it cause greater disparity because of complexity of use, limited production or distribution, or prohibitive cost?

The common thread through the promises and perils of technology is not necessarily whether the technology itself is good or bad. Rather, it is how the technology is used that determines whether it is beneficial or harmful. A stick can be used to support us while we are walking, and it can be used crack someone over the head. Fire can be used to warm us and cook our food, and it can be used to injure people and destroy things. Nuclear fusion can be used to power our cities, and it can be used to annihilate them. Although technology has changed over the millennia, human nature has not. Ideally, all technology would be developed and used solely for the benefit of its users; however, we humans are imperfect and subject to common human foibles such as greed, fear, anger, pride, envy, ignorance, and laziness, which can lead to the potential harmful effects of technology, whether intended or not. How can we avoid the harm that technology can potentially cause? While there is no guarantee, we at least have power over our own actions, and the ability to amend harm that we cause if necessary. I am also optimistic enough to think that goodwill, joy, and love are more powerful and contagious than our baser impulses; so, while we can not control the actions of others, we can contribute to and promote an environment that elevates

the more noble aspects of not just ourselves but of others. We all have the ability to help shift the balance toward technology's beneficial side of the coin over the harmful side, enabling technology to enrich rather than harm, whether that technology is a stick, a database, or a nuclear reactor. I am excited about the technological advances being made, and hopeful that we can continue to improve these advances to make them increasingly useful and helpful.

How has technology changed your life and your ability to care for your patients? What could make it better?

Sincerely,



Ann Marie Hake
President
Indianapolis
Medical Society

We want to alert you to the an upcoming event planned by the Doctor-Lawyer Committee. This committee is a collaboration between the IMS and the Indianapolis Bar Association (IBA). Mark your calendars and stay tuned fore more details to come.

SAVE THE DATE

Doctor - Lawyer Committee presents

Medical Malpractice Panel & Networking
Learn about Med Mal from attorneys and physicians.

Wednesday, November 16, 2022 - evening

Indianapolis Bar Association Offices (downtown)

Watch your email for more information.

The ISMA Should Evaluate the Way Professionalism Claims are Handled by the State Medical Board

by GABRIEL T. BOSSLET, MD, MA

IMS Member. Associate Process of Clinical Medicine, Pulmonary & Critical Care Medicine Fellowship Director, Assistant Dean for Faculty Affairs & Professional Development, IU School of Medicine

On December 16, 2021 I testified before the House of Representatives Committee on Employment, Labor and Pensions in opposition to House Bill 1001 (HB 1001). This bill would have made it illegal for employers to require vaccination against COVID-19 as a condition of employment in the State of Indiana.

As an ICU physician and a proponent of public health measures generally, I was there during the upswing of the worst COVID surge of the pandemic to argue that proposing and enacting this bill, which downplayed the role of vaccines in combating the pandemic, was unhelpful and would cause needless death. If I am honest, I was frankly pissed off- our ICUs were full of very sick unvaccinated people, many of which would not survive.

I had never testified before a governmental body before and was nervous, to say the least. The fact that I was in a packed room of well over 100 people and was one of only a handful of masked individuals was frustrating. It was obvious the crowd there to testify was not composed of many individuals who saw things the way I did.

I said my piece and stayed for the rest of the testimony- a lot of which was laden with falsehoods and conspiracy theories. I was floored to hear two physicians, using their credentials as fully licensed physicians in the State of Indiana, testify to the danger of COVID-19 vaccines using many of the ridiculous conspiracy theories being spouted by other anti-vaccine proponents. Direct quotes of these physicians' testimony (you can see this testimony by selecting the December 16, 2021 committee meeting- they begin at the 1:30:10 and 3:11:00 marks):

http://iga.in.gov/information/archives/2022/video/committee_employment_labor_and_pensions_0600/

> *"We are at almost 20,000 deaths and counting (from the vaccine) and there is [sic] no signs of stopping."*
>
> *"Seeing more dead people in the COVID vaccinated group than in the unvaccinated group because of something called antibody enhancement syndrome."*
>
> *"It does appear that these COVID19 vaccines make you more likely to get disease."*
>
> *"We now know that these vaccines cause those (female) egg cells to express the spike protein, they must necessarily be destroyed by the immune system cells when they do that, meaning that the out come of vaccinating young children is you must generate premature menopause. There is every reason to believe that had proper research on these vaccines been done for their fertility effects on women, what you would see is that you would start vaccinating 5-year-old girls and develop 25-year-old menopausal women. And there is no escaping that biochemical conclusion."*

At the time of the hearing there were issues surrounding this pandemic and the approach to public health throughout it that were up for reasonable debate. That is not what this testimony was. These physicians both spoke empirically verifiable false statements in public testimony to a government body. To say I was upset to hear this testimony would be an understatement.

To me this seemed to clearly be an issue for the State Medical Licensing Board to address. Medicine is a profession, and professions are self-regulating. We as physicians have a duty to police ourselves in ensuring that behavior carried out expressly as a physician lies within an admittedly wide area of acceptable practice, words, and behavior. This behavior includes advice and treatments given to individual patients within our scope of practice. However, it also must include advice given to the public regarding public health, especially in times of a public health crisis, such as the COVID-19 pandemic. So, not knowing the mechanism by which such things are handled, I wrote a letter to the seven members of the medical board outlining my complaint, expecting that the wheels of professional justice would help to safeguard the integrity of the medical license in the State of Indiana.

Several weeks later I received a letter from the litigation specialist of the Medical Licensing Board informing me that "After reviewing the documents that were submitted, we cannot assist you with this matter. You are always free to file a complaint with the Attorney General's Office if you feel that there has been a violation of the professional licensing code."

I was confused. Why would the Attorney General need to be involved? This was not a legal matter, but one of professionalism and I didn't understand why a lawyer would need to be involved in determining whether or not this would be the case. Undaunted, I submitted a complaint to the AG's office just to see what would happen (I was pretty sure I knew, however).

Soon I received the response I expected- the complaint was dismissed:

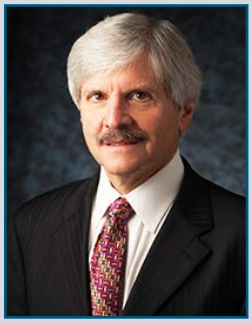
> "*In the Spring of 2021, a law was enacted that provides licensed professionals with extensive protections when they provide services related to the coronavirus pandemic. Now codified as Ind. Code §25-1-20, the law provides immunity from prosecution for certain categories of activities and generally raises the legal standard required for prosecuting a license case to 'gross negligence, will ful or wanton misconduct, fraud, or intentional misrepresentation.'*
>
> *"The law, which is retroactive to the beginning of the pandemic, takes into account the relative newness of COVID-19 and the ongoing efforts by the legal community to sufficiently study evolving variants and identify an unequivocal standard of care."*

That was it. I tried to explore the sections of the relevant Indiana code that lay out how and why the Attorney General's office needs to be involved in non-legal professionalism transgressions by physicians and could not find anything.

To me, this is an issue that should be handled by the physicians of the State Medical Licensing Board as a matter of governing behavior within their own profession to protect the integrity of the Indiana medical license. To have a lawyer be the gatekeeper for medical professional transgressions seems antagonistic to the internal regulation of professions.

ISMA resolution 22-004 calls for the ISMA to clarify via study of Indiana state code and regulation the mechanisms by which non-legal professionalism transgressions by physicians are supposed to be handled by the State Medical Licensing Board; and to suggest changes, if needed, to ensure that the medical profession can regulate the professional behavior of its members via the State Medical Licensing Board without gatekeeper involvement of non-physicians.

The Future of COVID Vaccines



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

For most Americans, the COVID-19 pandemic is behind them; they've moved on. Done. It's obvious from the small percent of people still masking. Even public health officials, understanding the realities of pandemic fatigue, now attempt to balance best public health recommendations with the public's willingness to comply with mitigation measures. Politically, the days of mitigation mandates are gone.

But the pandemic isn't over even though we act like it. It's estimated that nationally there are a million new cases of COVID daily and nearly 3,000 deaths weekly. Although nowhere near the past pandemic peaks, COVID cases, hospitalizations, and deaths are increasing again, and we anticipate a new surge in the fall. The worst of the pandemic, nevertheless, is probably over because of the collective immunity gained from past COVID infections and vaccinations.

However, the immunization rate is disappointing with 30 percent of eligible Americans forgoing vaccination and about half not receiving recommended booster doses. At this point, we can't expect the unvaccinated to ever roll up their sleeve. They've made their decision.

Because of relaxed attitudes, vaccine skepticism, and suboptimal vaccination rates, COVID viruses have been free to spread continually allowing them to mutate into a long progression of challenging variants. The newer variants, especially omicron, have been much more transmissible and evasive of vaccine protection. For now, the days of feeling safe after vaccination are over.

Initially, vaccination conferred extremely high protection against infection, hospitalization, and death. Unfortunately, the protection gained proved to be relatively short lived, especially for infection; the protection against severe disease has been more durable.

But now it's all about the currently dominant omicron subvariants BA.4 and BA.5. Especially BA.5, the most worrisome variant to date, is extraordinarily transmittable and largely escapes vaccine protection. Immunity from the initial two-dose series and boosters provide very little protection against infection from these new subvariants and wanes quickly. Importantly, boosters do renew protection against severe disease but only for a few months. Breakthrough infections are commonplace among the vaccinated and even boosted; those who were infected with earlier strains are experiencing reinfection.

There is some belief that we don't need a retooled vaccine that will include the newest omicron variants because the original vaccine (with boosting) still protects well against hospitalization and death. I disagree. Even mild or moderate severity COVID illness can be life changing. Rare but serious complications can occur, and up to 30 percent of people can develop long-COVID syndrome.

Time for an updated vaccine. Vaccine manufacturers have initiated developing the new generation of booster vaccines against omicron variants for the fall. The FDA has determined that the new boosters must include protection for BA.4/5. Most promising are "bivalent" vaccines which will combine the original vaccine for a core of broad protection along with protection against the new variants.

But ultimately what is needed is a "universal" or "pan-coronavirus" vaccine that will protect against the entire family of coronaviruses and future emerging variants certain to arise. Research has begun, but this is an extremely complex and difficult task to accomplish. For example, a universal influenza vaccine has eluded successful development for decades.

For now, the bivalent vaccine should provide better protection for current variants, and by extension, newly-evolving related variants. Will the next booster be the commencement of annual retooled COVID vaccines much like the yearly flu vaccine? That would signal the transition from pandemic to endemic disease. Let's hope so.

Recent CDC Report: Too Few People Treated for Hepatitis C

by VITAL SIGNS
Centers for Disease Control and Provention

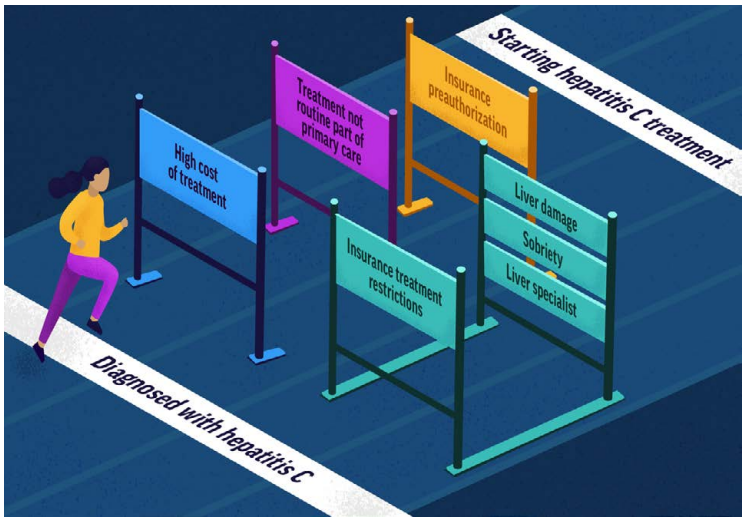
CENTERS FOR DISEASE CONTROL AND PREVENTION

Overview

Over 2 million adults in the United States have hepatitis C virus (HCV) infection, and new infections have continued to rise. Hepatitis C is usually spread through blood, often from injection drug use. Left untreated, hepatitis C can cause advanced liver disease, liver cancer, and death. In 2019, hepatitis C contributed to the deaths of more than 14,200 people in the United States; deaths associated with hepatitis C were higher for Black people (5 per 100,000) and Hispanic people (4 per 100,000) than for White people (3 per 100,000).

Hepatitis C is curable in more than 95% of cases. People who test positive for hepatitis C should be treated with direct-acting antiviral (DAA) medication. Timely treatment is important to prevent liver damage and further spread. Treatment saves lives, prevents ongoing spread, and can save costs by stopping the disease from progressing.

Safe and effective medications (DAAs) for hepatitis C have been available since 2014, yet few people receive treatment within one year of diagnosis. Expanding treatment for all people with hepatitis C is essential to reducing viral hepatitis-related disparities and eliminating hepatitis C as a national public health threat. Too many barriers to treatment remain, including getting diagnosed, being linked to care, and accessing treatment. Even among insured people, only about 1 in 3 receive timely hepatitis C treatment, and this is even lower among people with Medicaid insurance.



Challenges

To eliminate hepatitis C, more than 260,000 people should be treated every year. Right now, not enough people with hepatitis C are being treated yearly to reach the nation's viral hepatitis elimination goals. The number of people treated was highest in 2015 and declined to its lowest level in 2020.

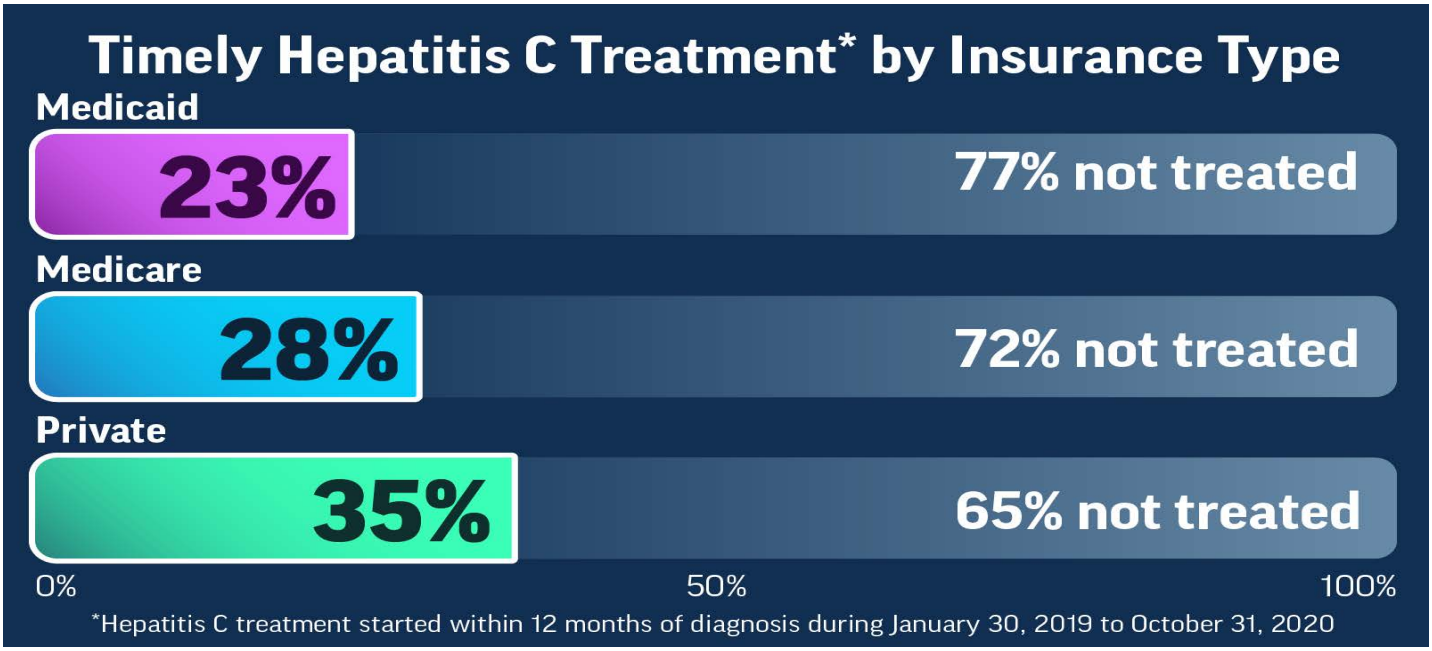
- When safe and effective DAAtreatment first became available in 2014, it cost about $90,000 per patient; while cost has come down considerably, the high cost of treatment remains a barrier to treatment for many.

- Many insurance providers still have restrictions in place, preventing many people with hepatitis C from accessing lifesaving treatments. These include:

  — The patient must have liver damage (called "fibrosis").

  — The doctor who writes the prescription must be a liver disease or infectious disease specialist.

  — The patient must be sober.



— The doctor must receive preauthorization approval from the insurance provider to start treatment.

- Treatment is not routinely integrated into primary health care.
- Not enough primary care providers are treating hepatitis C.

To Advance Health Equity

Healthcare providers, insurers, policy makers, and public health professionals should work to improve access to treatment for all people with hepatitis C.

- Remove eligibility restrictions and preauthorization requirements that make it difficult for people with hepatitis C to be treated and cured.
- Provide treatment where people receive other services, such as primary care offices, community clinics, syringe services programs, substance use treatment centers, and correctional facilities.
- Provide safe and effective treatment in as few visits as possible.
- Expand the number of primary care providers treating hepatitis C.

To Ensure All People with Hepatitis C Receive Treatment

Reduce barriers

- Eliminate hepatitis C treatment eligibility restrictions.
- Expand the number of primary care providers treating hepatitis C.

Link and treat

- Provide treatment in places where people with hepatitis C already receive care, such as primary care clinics, substance use treatment centers, and correctional facilities.
- Promote best practices for providers to offer simplified testing and treatment.

Everyone can

- Get tested for hepatitis C at least once in their lifetime.
- Talk to a provider to start treatment and get cured if you have hepatitis C.

Disclaimer: The full article and additional information including footnotes and references, are available on the CDC website at www.cdc.gov/vitalsigns/hepc-treatment/?ACSTrackingID=USCDC_449-DM86181&ACSTrackingLabel=New%20Vital%20Signs%20Report%E2%80%94Hep%20C%20for%20subscribers&deliveryName=USCDC_449-DM86181

Had Enough Compliance Challenges?

Don't Forget About the Stark Law's Group Practice Compensation Changes Effective January 1, 2022

by THOMAS N. HUTCHINSON, ESQ. and BRANDON W. SHIRLEY, ESQ.
Attorneys at Krieg DeVault.

Overview

Most health care providers face many compliance challenges in today's regulatory climate with the promise of many more to come in the new year. This burden may be particularly acute for physician group practices who must change the methodology for pooling and distributing overall profits under an important, and confusing, Stark Law exception starting January 1, 2022.

The Centers for Medicare and Medicaid Services ("CMS") reformed the Stark Law in December 2020. While most of these changes took effect in January 2021, CMS delayed reforms affecting group practice distribution methodologies to January 1, 2022 to give group practices sufficient time to review and change their physician payment plans. These changes were significant as they affected the calculation and distribution of "overall profits" under the Stark Law's Group Practice and In-Office Ancillary Services exceptions. Group practices using those exceptions to calculate and distribute overall profits from Designed Health Services ("DHS") must now meet the following requirements effective January 1, 2022:

• When pooling overall profits, group practices must aggregate all DHS profits from the entire group, or they may aggregate all profits from a component of the group so long as it has at least five physicians, before sharing overall profits.

• Group practices with components of five physicians must use the same distribution methodology for each physician in a component.

• CMS no longer allows group practices to split DHS profits by ancillary service or on a service-by-service basis, i.e., split pooling. Group practices may choose whether to distribute, or retain, DHS profits.

• Group practices must divide overall profits and calculate productivity bonuses in a reasonable and verifiable manner that is not directly related to the volume or value of DHS referrals.

The Stark Law is a strict liability law, which means that there is no flexibility or consideration given to Medicare or Medicaid providers who violate its requirements. The Stark Law exceptions and these changes to physician compensation are detailed and complex.

If your Group Practice is not in compliance with these changes, we can help you revise your plan quickly to comply before payments are made from a non-compliant plan. Please contact Thomas N. Hutchinson or Brandon W. Shirley to ensure your physician compensation methodology complies with the Stark Law and its recent changes to physician profit distributions.

Disclaimer. The contents of this article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general informational purposes only, and you are urged to consult with counsel concerning your situation and specific legal questions you may have.

Colleague Corner:

The 10 Question Interview

about H. CLIFTON KNIGHT, JR., MD

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

I am 61 years old and a native of Indianapolis. I graduated from Broad Ripple High School and Ball State University before going to the IU School of Medicine. I completed my family medicine residency at Community East Hospital in Indy. After a few years practicing in Flora, Indiana, I returned to Community Health Network and taught in the Family Medicine residency for several years, including serving as residency program director. I then was Chief Medical Officer for the Community Health Network system. From 2014 until 2020 I was the Senior Vice President for Education at the American Academy of Family Physicians (AAFP) headquartered in Leawood, Kansas. In 2020, I began in my current role as Assistant Dean of Clinical Affairs at Marian University's College of Osteopathic Medicine. My wife, Shelly, and I have been married for 39 years. We have 3 kids and 4 grandkids. I couldn't be more Blessed!

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

I always loved science. My high school chemistry teacher encouraged going into medicine. While growing up, no one in my family was in healthcare. My parents didn't go to college but I was always expected to. I followed my teacher's advice and went to college to become a physician. My first experience in healthcare was to become an Emergency Medical Technician. The more I experienced caring for patients, the more I loved it. During my fourth year of medical school, I did a family medicine rotation with Dr. Jeff Ferguson and that solidified my choice of specialty. The variety, continuity of care, and especially the relationships with multiple generations of families is what attracted me to family medicine.

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?

I am fortunate to have worked with several amazing role models and mentors. I have experienced amazing kindness and generosity in every step of my journey. To all I express my gratitude.

4. What is the best and worst thing that has

happened to you since becoming a physician?

My fondest memories in medicine revolve around providing prenatal care and attending deliveries. The teams of professionals I worked with made every day a pleasure. Watching the babies I delivered grow up was delightful. My most painful memory is caring for a close colleague who rapidly died from malignancy at a young age. That has truly haunted me.

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

Regulatory and administrative burdens that physicians face can be draining and diminish the sense of meaning and purpose in practicing medicine. Physicians need the autonomy and resources to fulfill their responsibilities and truly sustain a sense of satisfaction and accomplishment. Organized medicine, in partnership with patient advocacy groups and employers, is our best hope for influencing systemic changes that will truly provide insurance coverage for all, decrease administrative burden, shift resources to where they matter most, and result in widespread improved health outcomes.

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

Yes - IF they are interested for the right reasons. If they are pursuing medicine as a career to achieve lifestyle goals (income and prestige) then I steer them away from medicine. If they want the opportunity to have a positive impact on the people and communities they will serve despite the challenges they will face, I encourage them every step of the way. Becoming a master adaptive learner, expert critical thinker, diagnostician, and problem solver in the service of others will always be meaningful.

7. What has been the greatest but most rewarding challenge you've faced in your career?

While working for the AAFP, I led a team effort to develop resources to improve physician well-being. We created an annual conference on physician well-being that continues to attract hundreds of physicians each year. The Leading Physician Well-being program is a grant funded program now in its second year and provides training in leadership development, physician well-being, and performance improvement. Witnessing the resulting successful outcomes and appreciation from physician participants has been extremely gratifying.

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

I've thought about this many times and always feel a bit stumped. Perhaps a paramedic or maybe something totally unrelated, like a National Park Ranger.

9. What is your favorite inspirational quote?

"We must always be grateful and recognize that we are warmed by fires we did not build, drink from wells we did not dig, and are shaded by trees we did not plant" - We owe the same to future generations!

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

If you aren't actively involved in medical education, I encourage you to become a preceptor of medical students and residents. They will keep you on your toes, help you learn every day, and inspire you to remember why you went into medicine.

IN MEMORANDUM

LEROY H. KING, JR., MD

LeRoy H. King, Jr., MD went to be with the Lord on August 3, 2022. Lee was born in Paducah, KY, September 4, 1937, the only child of LeRoy H. King, Sr. and Goldia F. King. Lee graduated as Valedictorian from Tilghman High School. He received a scholarship to Duke University, where he was a member of Beta Theta Pi Fraternity. He earned his MD from Indiana University School of Medicine. Post graduate training in Internal Medicine and Nephrology was completed at Indiana University Medical Center. Lee then joined the teaching faculty at the Indiana University Medical Center and the Veteran's Administration Hospitals. Lee was a proud member of the United States Army from 1969-1971. Major King was on the clinical and teaching faculty at Walter Reed Army Medical Center in Washington D.C. He joined the staff at Methodist Hospital in 1971, and started the hospital's Kidney Transplant Program. On January 1, 1972, Methodist Hospital became one of the first private hospitals in the United States to perform a kidney transplant. Lee was a founding member of Nephrology and Internal Medicine, Inc. He remained in the group's clinical practice until his retirement. Dr. King was Board Certified in Internal Medicine, and was elected to Fellowship in the American College of Physicians. He was awarded the Honorable Order of Kentucky Colonels; served on the Medical Advisory Board of the National Kidney Foundation of Indiana; and was a member of Methodist Hospital Health Foundation. IMS member since 1971.

ROBERT DOUGLAS MCQUISTON, MD

Bob McQuiston was born in St. Louis, Missouri to Ralph and Barbara (Douglas) McQuiston. He was a 1962 graduate of North Central High School. He received his undergraduate and medical degrees from Indiana University where he was active in Sigma Nu fraternity and the IU Union Board. He completed his internship at the University of Wisconsin and his Surgical and ENT Residencies in San Francisco and Indiana. He finalized his education doing a Neuro-Otology fellowship at the House Ear Institute in Los Angeles. Bob received a Certificate of Distinction for 50 years in the Practice of Medicine from the Indiana State Medical Association. He maintained various hospital appointments at Methodist, St. Vincent and St. Francis hospitals. He served on the Indiana Medical Education Board from 1993 to 2015. He was a captain in the Indiana Army National Guard for 6 years. Bob was a proud member of Crooked Stick Golf Club for 40 years and loved his many years in Brown County fishing, golfing, hiking and sharing time with loved ones. He was a lifelong supporter of the Indianapolis Colts, Indiana Pacers, Indianapolis 500 and a 2016 inductee into the Indiana University President's Circle …Go IU! IMS member since 1974.

ROBERT DARRELL NATION, MD

Robert D. Nation, MD, died at Hoosier Village in Indianapolis on July 24, 2022, surrounded by his loving family and friends. Bob was born on June 19, 1934, in Arthur, Indiana to Edward and Cecile Nation. He graduated as Valedictorian from Oakland City High School in 1952, and from Purdue University in 1956. After working for 6 years as a Chemical Engineer, he found his true calling and earned his MD degree from Indiana University School of Medicine in 1967. Bob completed his residency in Family Medicine at Methodist Hospital in 1969. He practiced Family Medicine in Broad Ripple from 1969 until 1995. In addition, Dr. Nation served as Medical Director of Westminster Village North for 14 years, and as Medical Director of Hospice at Methodist Hospital for 12 years, finally retiring in 2001.

In 1961, Bob married the love of his life, Anne Turner, who survives. He is also survived by daughter Barbara (Joseph Feinberg), son John (Christine), grandchildren Audrey Lee, Declan Lee, Claire Nation, Alex Nolley, Garret Nolley, sister-in-law Jorita Nation, and many nieces and nephews. He was preceded in death by his brother William R. Nation. Bob loved spending time with his family and friends, playing golf, reading, and following the news. He was a lifelong advocate for peace and justice. He and his family enjoyed travel in the states and in Canada. In retirement, he and Anne continued to have wonderful trips in the US and Europe. Bob and Anne and family shared 42 active and special years at Saint Andrew Presbyterian Church, and now find their church home at Northminster Presbyterian Church. Bob and his family were very grateful for the support they received from many friends as he dealt with pulmonary fibrosis. IMS member since 1969.

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BRAIN AND SPINE

BULLETIN BOARD

STEPHEN W. PERKINS, MD

Stephen W. Perkins, MD of Meridian Plastic Surgeons, was an invited key faculty member at the AAFPRS "Advances In Rhinoplasty and Facial Rejuvenation" meeting in Miami. He presented lectures on the following topics: Use of Computer Imaging in a Facial Cosmetic Practice, Importance of Fine Tuning the Nasal Tip in Rhinoplasty, Surgical Lip Enhancement Better Alternative. He also participated in a Rhinoplasty panel discussion.

Dr. Perkins was also an invited key faculty member at the 107th Indiana University School of Medicine's Annual Course on Anatomy & Histopathology of the Head, Neck & Temporal Bone. He presented a lecture on the topic of Rhinoplasty and participated in the Laboratory Dissection that followed.

RICK C. SASSO, MD

• Rick C. Sasso MD, Indiana Spine Group, served as a faculty member at the 17th annual International Spine Symposium "State of Spine Surgery Think Tank" which was held in Cabo San Lucas, Mexico June 22-25. Dr. Sasso was asked to lecture on current surgical techniques for treating cervical myelopathy due to multilevel cervical stenosis, and he led a symposium on Cervical Disc Replacement.

The 17th Annual State of Spine Surgery Think Tank. June 22-25, 2022. San Jose del Cabo, Mexico.
Lecturer: 3-level cervical myelopathy with kyphosis
Symposium Panel: Cervical TDR-a decade of experience: Outcomes, osteolysis, infection and revisions

• Rick C. Sasso MD, Indiana Spine Group, served as Chairman of the Cervical Spine Research Society Surgical Techniques course which was held for Spine Surgery Fellows at the Medical Academic Center. The faculty consisted of the most accomplished Cervical Spine Surgeons in the country (all previous CSRS Presidents) and they all convened at the most advanced learning center-the MAC housed at Indiana Spine Group.

Cervical Spine Research Society: Hands-On Surgical Techniques Course. July 21-23, 2022. Medical Academic Center: Carmel, Indiana.
Course Chairman
Lecturer: C1-2 Posterior Fusion: Lateral mass screws C1 and C2 pedicle, pars, translaminar screws;
Emergent airway control after anterior cervical procedures (Cricothyroidotomy)
Cureus 13: e20274, 2021.

WELCOME NEW MEMBERS

ACTIVE

NEIL D. FARREN, MD
Neil D. Farren, MD
Indiana Spine Group
13225 N Meridian St
Carmel, IN 46032-5480
Pain Medicine
Indiana U Sch Med, 2019

THOMAS J. HARDACKER, MD
Urology of Indiana, LLC
120 Avon Market Pl Ste 200
Avon, IN 46123-6021
Urology
Indiana U Sch Med, 2015

CALEB J. LARSEN, DO
Emergency Medicine
Midwestern Univ, Chicago Col of Osteo Med, 2018

RESIDENTS

AARON P. BECKER, MD
IUSM - Psychiatry Residency
355 W 16th St Ste 4800
Indianapolis, IN 46202-2392
Psychiatry
Indiana U Sch Med, 2021

DAN O. PFEIFLE, MD
IUSM - Pulmonary/Critical Care Fellowship
Pulmonary Critical Care Med
Sanford Sch of Med of the Univ of South Dakota, 2019

ADAM S. PROKAI, MD
Medical Associates LLP
7150 Clearvista Dr.
Indianapolis, IN 46256-1695
Emergency Medicine
Indiana U Sch Med, 2019

THOMAS M. SHELTON, MD
Internal Medicine
Marian University, 2022

STUDENTS

SAMANTHA J. ANDRYK, DO
Marian University, 2024

ALEC L. RHODES, DO
Marian University, 2024

JASON ZHANG, DO
Marian University, 2024

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

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.

INDIANAPOLIS
MEDICAL SOCIETY
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Board of directors 2022

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Thomas R. Mote *(2022)*
Scott E. Phillips *(2023)*
Eric E. Tibesar *(2024)*
Bui T. Tran *(2022)*
Maureen L. Watson *(2022)*
Joseph Webster, Jr. *(2022)*

Past presidents' council 2022

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

Christoper D. Bojrab* *(2023)*
Carolyn A. Cunningham
David R. Diaz
Marc E. Duerden
John C. Ellis
Bernard J. Emkes
Bruce M. Goens
Paula A. Hall
Jeffrey J. Kellams
Jon D. Marhenke
Mary Ian McAteer* *(2022)*
John P. McGoff
Stephen W. Perkins

Advisory Board Members 2022

Caitlin J. Harmon, Resident
TBD, 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.

Ranai Abbasi (2024)
Linda Feiwell Abels (2024)
Christopher D. Bojrab (2024)
Ann C. Collins (2023)
Carolyn Cunningham (2022)
Julie A. Daftari (2023)
Marc E. Duerden (2023)
John H. Ellis (2024)
Richard D. Feldman (2024)
Bruce M. Goens (2022)
Ann Marie Hake (2022)
Ronda A. Hamaker (2022)
Mark M. Hamilton (2022)
C. William Hanke (2024)
Doris M. Hardacker (2024)
Penny W. Kallmyer (2023)
H. Clifton Knight, Jr. (2022)
John E. Krol (2023)
Mary Ian McAteer (2023)
Ramana S. Moorthy (2024)
Mercy O. Obeime (2023)
Ingrida I. Ozols (2023)
Robert M. Pascuzzi (2023)
J. Scott Pittman (2022)
David M. Ratzman (2024)
Jodi L. Smith (2022)
Eric E. Tibesar (2023)
Maureen Watson (2022)
Steven L. Wise (2024)
Crystal S. 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.

Laurie L. Ackerman (2022)
Gabe Bosslet (2024)
Allison Case (2024)
David Crook (2024)
Richard Hahn (2023)
Paula Hall (2022)
Caitlin J. Harmon (2023)
Brian S. Hart (2023)
Melanie Heniff (2024)
David A. Josephson (2023)
Kathryn J. Kelley (2023)
John Kincaid (2024)
James F. Leland (2022)
Katie McHugh (2024)
Tom Mote (2023)
Valerie Pai (2024)
Scott E. Phillips (2022)
Bui Tran (2024)
Alexandar T. Waldherr (2023)
Joseph Webster (2024)

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

Executive Committee

Board Chair
David R. Diaz

Vice Speaker
Alex Choi (2024)

Seventh District

Trustees

David R. Diaz (2023)
Robert Flint (2024)

Alternate Trustees

Mary McAteer (2024)
Mercy Hylton (2025)

President

H. Clifton Knight, Jr. (2023)

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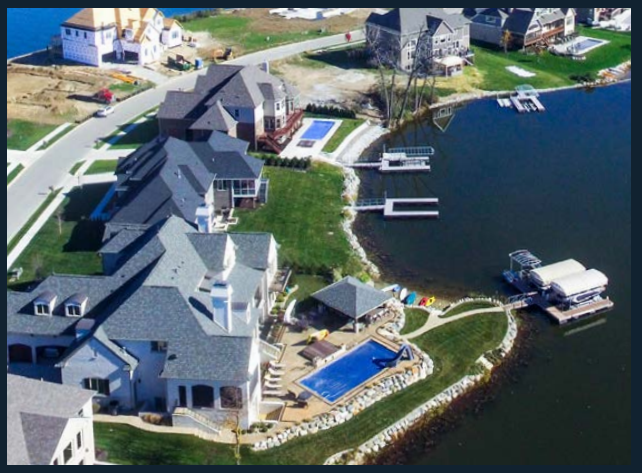

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