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BULLETIN

EDITORIAL PG 06

Post-Truth Era

by RICHARD FELDMAN, MD

IMS Board Member, MHM Board Member, and Past President, Former State Health Commissioner

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TABLE OF CONTENTS

IN THIS ISSUE

SPECIAL FEATURES

ANNOUNCEMENTS

NOTE FROM THE EDITOR

The IMS Bulletin is now accepting advertising for the 2023 ad calendar. Anyone interested should contact our office at 317-639-3406 or email our editor at mperrill@indymedicalsociety.org for a 2023 Media Kit.

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

MERCY O. OBEIME, MD

Greetings my fellow IMS members. It is Fall, and most families have completed back-to-school activities. Hopefully, everyone has all the resources to do well this school year. I want to use this month to focus on an initiative related to Diversity, Equity, and Inclusion (DEI).

The Indiana State Medical Association (ISMA) has launched an online toolbox, "Drive for Five," and a webpage to assist physicians and their patients in accessing resources concerning Social Drivers of Health (SDOH). SDOH are the nonmedical factors that influence health outcomes.

Drive for Five is a one-stop SDOH resource page for physicians and their practices. Visit www.ismanet.org/driveforfive to gain free, instant access to the platform. The name Drive for Five comes from the five SDOH domains from Healthy People 2030: health care access and quality, neighborhood and build environment, social and community context, economic stability, and education access and quality. A committee of ISMA-member physicians has vetted all Drive for Five resources.

In April, ISMA announced the start of the multifaceted SDOH initiative. They were then awarded a $75,000 grant from the Physicians Foundation moving this multifaceted initiative addressing social drivers of health (SDOH) forward in the Hoosier State.

Through the project, ISMA will develop tools, resources, and data collection to support physicians across the state in their understanding of SDOH and their integration of SDOH into their medical practices as part of their regular patient care.

Prior to securing the grant in 2022, ISMA had already incorporated whole-person health into its strategic priorities and defined action steps related to SDOH. However, thanks to the award, the three-year timeline for those goals has been reduced to one year, mainly because the grant allowed ISMA to hire Michelle O'Rourke as Social Drivers of Health Project Coordinator.

This initiative comes at a critical time, as Indiana has ranked between 37th and 41st in the nation for quality of health for over a decade.

ISMA plans to convene chief medical officers, physician group leaders, and independent practi-

THE PRESIDENT'S PAGE

MERCY O. OBEIME, MD

tioners statewide to discuss ways to address SDOH from the perspective of those at the ground level, to share ISMA's vision, and to request these stakeholders' continued participation in SDOH summit meetings.

Utilizing the information and feedback gathered at these summit meetings ISMA hopes to expand the list of SDOH resources available across the state and eventually offer free online education sessions. The goal is to focus these sessions on the current landscape of known SDOH issues and barriers to improved patient outcomes in Indiana, describe best practices to incorporate SDOH into practice, and review tools available to physicians.

ISMA will then work with physician practices that are ranked in the bottom quartile for health factors and health outcomes in Indiana to develop individualized plans to integrate a framework for addressing SDOH in their practices and connecting their patients to community-based resources.

The focus will be on identifying barriers within their practices and their communities, recognizing new opportunities to engage patients with social services, developing a new system framework with a team-based approach, formalizing screening tools and protocols, and supporting additional education and training.

ISMA plans to monitor progress and track successes. Lessons learned throughout the process will be communicated back to ISMA leadership as part of the strategic planning process so that further discussions can take place around any needs identified around community capacity, administrative burdens and creating financial incentives.

ISMA is seeking member volunteers for an SDOH task force to explore and evaluate the present state of SDOH in Indiana, review the successes and barriers physicians are experiencing, and provide recommendations as to the best tools and resources that should be developed to support providers. The task force will meet approximately once per month.

I encourage you to get involved. If you are interested in participating, please contact Ranae Obregon robregon@ismanet.org.

Drive for Five can also be accessed by visiting the SDOH page under "Resources" on www.ismanet.org. The page also offers additional information on SDOH in Indiana.

Sincerely,

Mercy O. Obeime
President
Indianapolis Medical Society

Post-Truth Era

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

Robert F. Kennedy, Jr. was once one of the country's leading and most effective environmental lawyers. Kennedy was known as an extremely intelligent, charismatic, and politically astute individual who challenged the fossil fuel industry. Tough, determined, dedicated, and persistent in his litigation, his work was grounded in evidence-based science.

Since 2005, he has promoted conspiracy theories, falsehoods, pseudoscience, and disinformation. He is now the most prominent face of the anti-vaccine movement, leading the anti-vaccine group, the Children's Health Defense (banned from Facebook and Instagram).

America is waist deep in the "post-truth era", rife with anti-science, baseless beliefs, and propaganda of which I have previously written. Evidenced-based scientific views are replaced with pseudoscience or unproven or misleading assessments. Often these dangerous fabricated ideas are promulgated for personal or political advantage. To Kennedy's credit, the Kennedy family (although rebuking his claims) and others close to him trust that he is sincere in his beliefs with the best intentions of protecting the common good.

Incredibly, a significant proportion of Americans are gullible enough to embrace outrageous falsehoods. Post-truth public discourse is increasingly driven by what people want or expediently claim to be true rather than what is verifiably true.

History teaches us that troubled, unstable, and uncertain times are fertile ground not only for disinformation but also for bigotry, intolerance, and extremism. Kennedy has made some disturbing comments in these regards. Be careful Bobby.

Is Kennedy another victim of the post-truth era or a purveyor of anti-science and conspiracy theories?

He claims that a specific type of mercury (thimerosal) contained in vaccines, virtually eliminated in 2001, is related to childhood autism even though the prevalence of autism has since increased. Even Rolling Stone retracted Kennedy's 2005 article on the dangers of mercury-containing vaccines.

He claims that Dr. Anthony Fauci and Bill Gates were in a profiteering conspiracy with the COVID vaccine industry. He purports that vaccine mandates and pandemic mitigation efforts were comparable to Hitler's Holocaust. He alleges that COVID vaccines are too dangerous to receive and alternatively touts treatments with ivermectin and hydroxychloroquine. Kennedy denies that he is anti-vaccine (once asserting being anti-unsafe vaccine) even though his comments and actions are extensively documented.

These positions have been soundly debunked as baseless or overwhelmingly determined as invalid by high-quality scientific studies. His claims are based on pseudoscience, manipulated data, or misleadingly interpreted data. Some studies have been retracted by the very publications in which they appeared.

Kennedy's departure from evidence-based science to garbage science and unfounded conspiracy theories is difficult to understand. He selectively ignores good science and relies on dubious unscientific reports to support his positions. Perhaps Kennedy's views and suspiciousness were shaped by his environmental work confronting unscrupulous fossil-fuel companies that provided biased "scientific" studies while industry-influenced regulatory agencies did nothing. But his extrapolation to other issues is not justified. His judgments are those of a litigator, not a scientist.

Kennedy is now a presidential candidate. His rhetoric is dangerous, especially since he's from a renowned family which gives him enormous credibility. Kennedy was considered by then President Trump to lead a "vaccine panel" to study vaccine safety and industry integrity. Fortunately, it never happened.

Kennedy is a purveyor of fringe science that extends outrageously beyond vaccine-related issues. But I consider him mostly a victim of the post-truth era. He and a good portion of the American public, distrust scientific institutions, powerful corporations, and government while being enamored by demagogues and conspiracy hucksters.

An Opposing Viewpoint:

Why Do We Castrate and Sterilize?

by FRANCIS W. PRICE, JR, MD
IMS Member and Ophthalmologist

Young bulls are castrated (made into steers) for a number of reasons, and one of the clearest lists of reasons is provided by Ontario, Canada (https://www.ontario.ca/page/castration-calves):

1) To stop the production of male hormones and semen.

2) Prevent mating and reproduction after the age of puberty.

3) Produce docile cattle that are easier to handle compared to bulls.

4) Decrease aggressiveness, mounting activity (sexual activity), and injuries.

5) Decreased costs associated with fencing and handling compared to bulls.

6) Provide higher quality beef.

In the April, 2023 issue of the Bulletin, an editorial by Alison Case, MD makes the argument that we should allow young adolescents, or even younger children, to undergo chemical and surgical castration and sterilization and subject them to a lifetime of hormone replacement therapy. So, the underlying question is why?

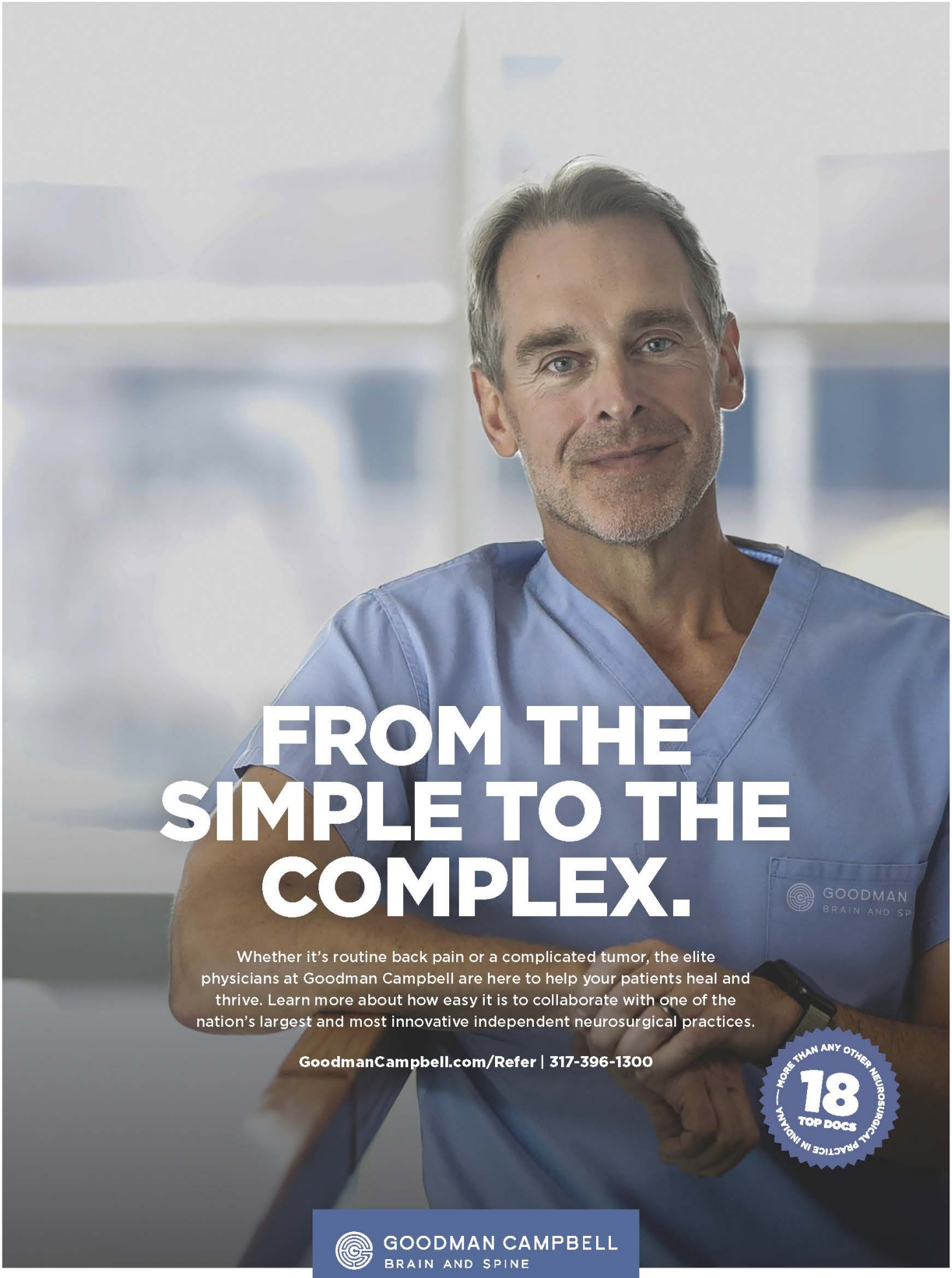
Lifelong Consequences to Treat Temporary Problems

Our first directive is to do no harm; however, gender affirming care puts children going through a temporary condition on a one-way course of treatment with irreversible, lifetime consequences. Retrospective studies suggest that only 12% to 27% of youth who experience gender dysphoria persist into adulthood. In other words, the vast majority (73% to 88%) overcome the dysphoria without hormone treatments, surgical castration, and sterilization. In contrast, Dr. Case notes that with gender affirming care, after consultation with a physician, patients pursue hormone therapy "in almost all cases" and that nearly 90% of patients who transitioned persisted in their new gender.

Young children love imagining and creating fantasies that change over time. They have no appreciation of the gift of sexuality and what they might be giving up. They cannot actually become another sex no matter how hard they try or are misled by others. Every somatic cell in their body will still have either an "X" and "Y" chromosome or two "X" chromosomes. These children will never have the pleasure of procre-

NOTE FROM THE EDITOR:

All editorial articles, including responses or opposing viewpoint editorials are written in the words of the author and do not represent the viewpoints of the Indianapolis Medical Society. These articles are printed to encourage meaningful and collegial debate among physician members. All member viewpoints are welcomed and will be printed if the spirit of which the intent remains intact.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ation or the pleasure of true sexual intercourse.

A related question is why do we call treatments designed to change or negate one's biological sex "gender affirming" when they are actually gender altering? More importantly, why would we seek to "affirm" a patient's gender when it does not match physical reality? This is not how we treat other conditions. We would not treat anorexia by "affirming" the patient's inaccurate body image or paranoia by "affirming" irrational fears. Only "gender affirming" care tries to alter physical reality to match mental impressions, and at the cost of castration, sterilization, and a lifetime of hormone replacement therapy.

Are we creating a problem rather than solving it?

Another major concern with promoting "gender affirming" care is why are the current incidents of gender confusion so outside of historical norms. Historical studies estimated the prevalence of gender dysphoria in adults from 0.005% to 0.014% for males and 0.002% to 0.003% for females. In contrast, more recent studies found 1.2% to 4.1% of adolescents reporting a gender identity different than their birth gender – hundreds if not thousands of times higher. There is also evidence of geographic clustering and correlations based on race, socio-economic status, and social media use as well as high correlations with the presence of other mental health disorders. In addition, prevalence of young females seeking gender reassignment now exceeds males. These factors suggest that the current spike in gender dysphoria involves something other than a bona fide medical condition.

Part of the problem with the topic of gender dysphoria is the shout down response to any criticism of this movement to castrate and sterilize children. I have attached references to an article from the Wall Street Journal entitled "A Medical Journal's False Consensus on 'Gender-Affirming Care'" by Sapir and Wright. This article describes a survey of over 1600 parents whose children were previously comfortable with their bodies/genders and had the sudden onset of gender dysphoria brought on by social media and peer interactions. While the article was initially accepted by a peer-reviewed journal, it was later pulled due to activist pressure on the publisher. It was pulled presumably because the authors had gotten consent from participants to publish the results but did not specify it would be published in a peer reviewed journal. Our medical practice participates in many clinical trials, and we have never seen "peer-reviewed journal" specified in a consent.

Downplaying Adverse Events

Another attached article from the Wall Street Journal discusses Europe's movement away from castration and sterilization of children and the political polarization around this topic. Europe has moved away from the castration and sterilization of children with gender dysphoria because the medical evidence does not support it along with the incidence of adverse events. (

Dr. Case states that providing delayed puberty in normally maturing adolescents, castration, and sterilization of children, especially adolescents, saves lives. Applying these treatments on large scale is relatively new and it will take a few decades to determine if more lives are saved or lost with these treatments. Suicides do occur in those who have had transgender treatments; perhaps more importantly, the rate of suicides in adolescents has increased as the movement for transgenderism has been gaining momentum – rather than decreasing it. Moreover, as we all know in medicine, it would take a randomized, controlled study over a few decades to prove her point, and that would be difficult or impossible to carry out in the U.S. – the consent would be interesting to say the least.

Dr. Case's article also glosses over that all of these children will need some long-term hormonal therapy and the potential adverse effects. What are the long term – decades long - effects of using hormones from the opposite gender? At the very least, there will be confused bodies and cells. Use of hormonal supplements in women is associated with increased risk of cancer and one should expect to see that in the males receiving these hormones as well. Similarly, puberty blockers have long been used to delay puberty in children who are developing precocious puberty before the normal ages. There is a lack of long-term data on using these in normally maturing adolescents.

Fantasy versus Realty

In the fantasies of computer games, or with social media, one can easily change one's gender subliminally giving the illusion that it is in one's power to do so in real life. But real life is different.

The story of the Emperor's New Clothes is the classic example of the difference between speaking reality and endorsing a fantasy. It took a child not constrained by social pressure to point out the absurdity of the emperor's illusion of wearing clothes when he was not. Now we are being asked – actually told in medical schools – to ignore the reality we can readily discern with our senses, lab tests, and physical exams to endorse people's claims that they are something they are not. We are supposed to endorse letting biological males compete in women's athletic events, which in the worst cases places biological females at physical risk, and in all cases appears to be a form of physical/mental abuse against the biological females. As physicians, are we asking these biological females if they have been placed in an abusive situation? We should be!

In summary, these treatments should be called what they are: castration and sterilization. The need for these irreversible treatments for what has historically been a rare and largely transitory condition is questionable at best. Gender transitioning also requires long-term use of hormones not typically present in the cells of the bodies receiving these treatments – and that will lead to other long-term "adverse events" that only become apparent with time. By promoting these treatments, we are, in effect, carrying out an experiment on our children.

Wall Street Journal Articles related to this topic:

1) Medical Journal's False Consensus on Gender-Affirming Care, by Leor Sapir and Colin Wright. June 9, 2023 4:08pm ET

2) U.S. Becomes Transgender-Care Outlier as More in Europe Urge Caution, by Jothan Sapsford and Stephanie Armour. June 19, 12:01 am ET

3) The Endocrine Society's Dangerous Transgender Politicization, by Roy Eappen and Ian Kingsbury. June 28, 2023, 2:35pm ET

4) A Biologist Explains Why Sex is Binary, by Colin Wright. April 9, 1:15pm ET.

Are You a Good Listener?

by LISA A. PERIUS, CAE
Vice President of Association Management, The Corydon Group

Think about the people in your life you consider to be good listeners. They probably pay attention to what you have to say and show interest by the ways they respond. Sometimes they may help you solve problems. Chances are, they make you feel good when you talk to them. Are you a good listener? Ask yourself these questions.

Do you create a safe and welcoming environment for listening?

When somebody wants to tell you something, do you put away distractions like phones and other devices? Do you clear your mind of other thoughts so you can pay attention to what the other person has to say? If it's not a good time or the place isn't right, do you suggest a better time and place, then follow through to make sure the conversation happens?

A good listener signals their attention by eliminating distractions, including distracting thoughts, and focusing on the other person. These signals let the other person know that it's safe to talk and that you are ready to listen. A good listener also recognizes when a moment or place isn't right for attentive listening and arranges to talk at another time or in a different place.

Do you show that you're listening?

As another person talks to you, do you show that you're listening by turning your body toward them and making eye contact? Do you give signs that you're paying attention, such as smiles, concerned expressions, nods, or leaning in? Do you say words or make sounds of encouragement, such as "I see," "Really?" "Ooh," or "Mm hum"? Do you adopt an open body posture (without crossing your arms in front of you, for example)?

A good listener shows that they are listening by their body movements, facial expressions, and verbal responses. These need to be authentic indications of interest, not forced or faked, or they send the opposite message: that you don't really care.

Do you respond in ways that show you're listening and trying to understand?

Do you ask questions to clarify what the other person is saying and encourage them to tell you more? Do you repeat back or summarize key parts of what the other person has told you, in your own words, to make sure you've understood?

Listening isn't a passive act. It's an interaction with another person. A good listener does some talking, not with the intent to dominate the conversation but instead to draw the other person out, understand what they are saying, and learn what they have to share.

Do you listen without interrupting or changing the focus of the conversation?

Do you let the other person complete their thoughts, even when there are stretches of silence as they weigh what they want to say next? Do you hold back from jumping in or interrupting while the other person is talking? Do you help keep the focus of the conversation on what the other person has brought up?

A good listener is patient and gives the other person time to complete their thoughts. A good listener doesn't interrupt, finish the other person's sentences for them, or take the conversation in another direction by steering it toward their own concerns.

Do you respond with empathy and support?

When someone shares a difficult or emotional experience, do you show empathy for their feelings and offer appropriate support? When

a person shares heated emotions, do you help them calm down and consider responses that might be helpful and productive? When you listen, do you help the other person feel better about themselves?

A good listener tries to understand how the other person is feeling and shows empathy for their emotions, both positive and negative. A good listener helps a person who is upset or angry look at their experience from different perspectives and consider thoughtful ways to respond. A good listener offers support and encouragement to help the other person take appropriate next steps and feel better about themselves.

Do you listen with an open mind?

Do you react with genuine interest and curiosity when someone shares an opinion or experience that challenges your beliefs? As you listen, do you challenge assumptions—your own and the other person's—in an effort to gain a better understanding of the situation? Are you open to new views and perspectives, rather than reacting defensively or with judgment? A good listener keeps an open mind, welcoming different perspectives and new ideas, even when they challenge the listener's beliefs or suggest that the listener has been wrong about something.

Good listening takes engagement.

Good listening goes far beyond making eye contact and nodding (both of which can be overdone by someone trying to appear that they are listening when their mind is somewhere else). Good listening requires focus and patience. It requires thoughtful and empathetic responses. Far from being a passive activity, it requires real engagement.

No one is a good listener in all ways and all situations. However, you can become a better listener—more often and when it really matters—by considering and practicing these elements of the skill of listening.

Morgan, H. (2023, January 12). Are you a good listener? (B. Schuette & E. Morton, Eds.). Raleigh, NC: Workplace Options (WPO).

CME & EVENTS

Community Health Network

Week Day	Monday	Tuesday	Wednesday	Thursday	Friday
First Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM	• GI/Colorectal Tumor Board, 7-8AM • Community Heart & Vascular Conference, 7-8AM • Critical Care Conference, 12--1PM • East Theater, 12-1PM • Psychiatric Grand Rounds, 1-2PM • Head & Neck Tumor Board, 5-6PM	• Thoracic Tumor Board, 7-8AM	• GU Tumor Board, 7-8AM
Second Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM • Network Medcal Grand Rounds, 12-1PM	• GI/Colorectal 7-8 AM • Breast & Lung Screening Tumor Board, Anderson 7-8AM • Community Heart & Vasculara Conference 7-8AM • Psychiatry Journal Club, 1-2PM • Head & Neck Tumor Board, 5-6PM		• Neuro Tumor-Board, 7-8AM • South Case Pre-sentation 12 PM
Third Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM • Molecular Tumor Board, 5-6PM	• GI/Colorectal Tumor Board, 7-8AM • Community Heart & Vascular Conference, 7-8AM • Melanoma Tumor Board, 7:30-8:30AM • Psychiatry Grand Rounds, 1-2PM • Head & Neck Tumor Board, 5-6PM	• Thoracic Tumor Board, 7-8AM	• GU Tumor Board, 7-8AM • South Case Pre-sentation 12 PM
Fourth Week	• GYN Tumor Board, 7-8AM • Hematology Tumor Board, 8-9PM	• Breast Tumor Board, 7-8AM	• GI/Colorectal Tumor Board, 7-8AM • Head & Neck Tumor Board, 5-6PM	• Thoracic Tumor Board, 7-8AM	• Neuro Tumor Board, 7-8AM

For more information regarding Community Health Network CME or program information, contact Jeff Carter at 317-621-3845.

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

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.

CME & EVENTS

Indiana University 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.

Online Activities
For Online Programs, including scheduled series and for individual specialties, visit: https://iu.cloud-cme.com

September 18 IBD Gut Club: Interdisciplinary Inflammatory Bowel Disease Conference | 7:00 pm - 8:30 pm | Phoenix Theater (Multipurpose Room)

September 29 Long Lecture | 8:00 am - 3:00 pm | Goodman Hall, Indianapolis

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CHRIS BOJRAB, MD

Dr. Chris Bojrab testified in front of the Interim Study Committee on Public Health, Behavioral Health, and Human Services this month. On September 13, Dr. Bojrab served as one of the expert witnesses on possibility of enacting state legislation regarding the use of psilocybin therapy and drugs in patients to treat severe mental illness. You can view a recording of this hearing on the Indiana General Assembly webpage, iga.in.gov, under the session/video/recordings tabs and by searching for the Interim Committee on Public Health, Behavioral Health, and Human Services, Interim Committee on and selecting the September 19, 2023 hearing.

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Julie A. Daftari *(2025)*
Ronda A. Hamaker *(2023)*
Doris M. Hardacker *(2023)*
Brian S. Hart *(2023)*
Mercy M. Hylton *(2025)*
Penny W. Kallmyer *(2024)*
Clif Knight *(2023)*
John E. Krol *(2023)*
Katie W. McHugh *(2025)*
Ramana S. Moorthy *(2023)*
Scott E. Phillips *(2023)*
Jodi L. Smith *(2025)*
Eric E. Tibesar *(2024)*
Mary Jean Vorwald *(2025)*
Chris Wilson *(2025)*
Maria Wilson *(2025)*

Past presidents' council 2023

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

Linda Feiwell Abels
Christoper D. Bojrab* *(2023)*
Carolyn A. Cunningham
David R. Diaz
Marc E. Duerden* *(2024)*
John C. Ellis
Bernard J. Emkes
Bruce M. Goens
Paula A. Hall
Jeffrey J. Kellams
Mary Ian McAteer* *(2025)*
John P. McGoff
Stephen W. Perkins

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)
Laurie L. Ackerman (2025)
Christopher D. Bojrab (2024)
Ann C. Collins (2023)
Julie A. Daftari (2023)
David Diaz (2024)
Marc E. Duerden (2023)
Richard D. Feldman (2024)
Ann Marie Hake (2025)
Paula Hall (2025)
Ronda A. Hamaker (2025)
C. William Hanke (2024)
Doris M. Hardacker (2024)
Mercy Hylton (2025)
Penny W. Kallmyer (2023)
Clif Knight (2025)
John E. Krol (2023)
Mercy O. Obeime (2023)
Ingrida I. Ozols (2023)
Robert M. Pascuzzi (2023)
J. Scott Pittman (2025)
Haley A. Pritchard (2025)
David M. Ratzman (2024)
Jodi L. Smith (2025)
Eric E. Tibesar (2023)
Bree A. Weaver (2025)
Tracey Wilkinson (2025)
Steven L. Wise (2024)

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.

Vinayak Belamkar (2025)
Gabe Bosslet (2024)
Alison Case (2024)
David Crook (2024)
Richard Hahn (2023)
Brian S. Hart (2023)
Melanie Heniff (2024)
Richard Huber (2025)
David A. Josephson (2023)
Kathryn J. Kelley (2023)
John Kincaid (2024)
Diane Kuhn (2025)
Katie W. McHugh (2024)
Rick Reifenberg (2025)
Caroline Rouse (2023)
Alexandar T. Waldherr (2023)
Joseph Webster (2024)
Monica Wehby (2025)
Maria Wilson (2025)
Chris Wilson (2025)

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

President
David R. Diaz

Vice Speaker
Alex Choi

Seventh District

Trustees

Robert Flint (2024)
Mary McAteer (2026)

Alternate Trustees

Mercy Hylton (2025)
Clif Knight (2026)

President

Jodi Smith (2024)

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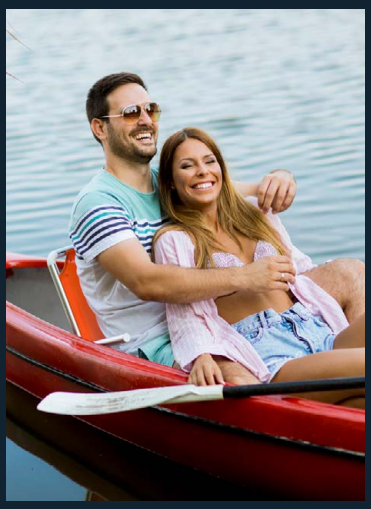

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- Choose Your Lot
- Choose the Lake Lifestyle