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BULLETIN

PRESIDENT'S ARTICLE PG 04

Women's Health: Obesity

by JOSEPH WEBSTER, JR, MD
IMS President

Indianapolis Medical Society
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NOTE FROM THE EDITOR

We hope you enjoy this month's edition of the Indianapolis Medical Society Bulletin. Most of our content or ideas for content are provided by our members. Ultimately, 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. 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

JOSEPH WEBSTER JR, MD

Article by Joseph Webster, IMS President with contributions by Dr, Maram Said (top, right) and Dr. Christopher Crawford (bottom, right)

In last month's Bulletin, I wrote about a program at Noblesville High School that is creatively using its Anatomy and Physiology course to introduce students to the medical profession. If you want more information about the program, you can reach out to Linda Tomczuk at linda_tomczuk@nobl.k12.in.us. She would love our support via mentorships or contributions. I plan to share more similar programs happening around central Indiana in upcoming editions.

This month I'm writing about a health issue that I am personally passionate about. I currently serve as the Physician Anesthesiologist Champion for Patient Safety in Obstetrics for Ascension Women's Hospital, Ascension St. Vincents Carmel, and Fishers' labor and delivery rooms. This article about Women's health will start with broadly looking at how obesity affects women specifically in pregnancy and later look at current surgical and medical options for treatment.

Per the Richard M. Fairbanks Foundation on *Indiana's Obesity Epidemic:* 2019, "obesity has increased over the past several decades becoming one of the most significant preventable causes of morbidity and mortality in the United States." Rates have steadily increased in Indiana from 20% to 34% and, in 2019, Indiana's obesity rate was the 12th highest in the United States.

The CDC's *Indiana -State Nutrition, Physical Activity and Obesity Profile* states that 29.6 % of Indiana residents have a BMI >30 (obese). Class III obesity or a BMI >40 affects more than 11.5% of the population of American women. The effect is so dramatic that beginning on June 26, 2022, the Indiana Health Coverage Programs (IHCP) revised the prior authorization criteria for bariatric surgery and will consider it medically necessary for the treatment of morbid obesity.

I spoke with Maram Said, DO, FACOG specifically about the gynecology effects of pregnant women and obesity. Dr. Said is a practicing OBGYN with Ascension Medical Group at St. Vincent Women's Health with a primary focus on minimally invasive surgery and gynecology as well as obstetrical care. Here is an overview of what I learned:

Dr. Webster:
Dr. Said, I know you and Dr. Crawford (Chris Crawford, MD) had a very successful dinner talk this year about this topic. I'll be talking to him later but what are the main concerns with obesity around pregnancy in women?

Dr. Said:
The issue of obesity in obstetrics can generally be listed into the subtopics, overall health, ovulation and menstrual disorders, and obstetrical and delivery risks.

Overall health: The International Agency for Research on Cancer (IARC) 2020 report found strong evidence for obesity and the risk of 13 different cancers. Postmenopausal breast, colorectal, endometrial, esophageal, pancreatic, renal, liver, stomach, gallbladder, ovarian, thyroid, multiple myeloma, and meningiomas are among the areas that the obese population is more likely to develop.

Obstetrical Risks: Obesity in pregnancy increases the risk of diabetes mellitus, hypertension (Pre-eclampsia and Eclampsia), thrombosis, postpartum hemorrhage, shoulder dystocia, fetal demise, inaccurate fundal height, and OB assessment, and difficult and failed epidurals, and cesarean delivery.

Obstetrical care should involve thorough counseling on the risk of loss, early glucose tolerance testing (GTT) in addition to the routine testing, lifestyle change with diet/exercise, weight gain recommendations, Maternal-Fetal Medicine consultation, antenatal testing including growth ultrasounds and non-stress testing, adjusting delivery timing as well

THE PRESIDENT'S PAGE

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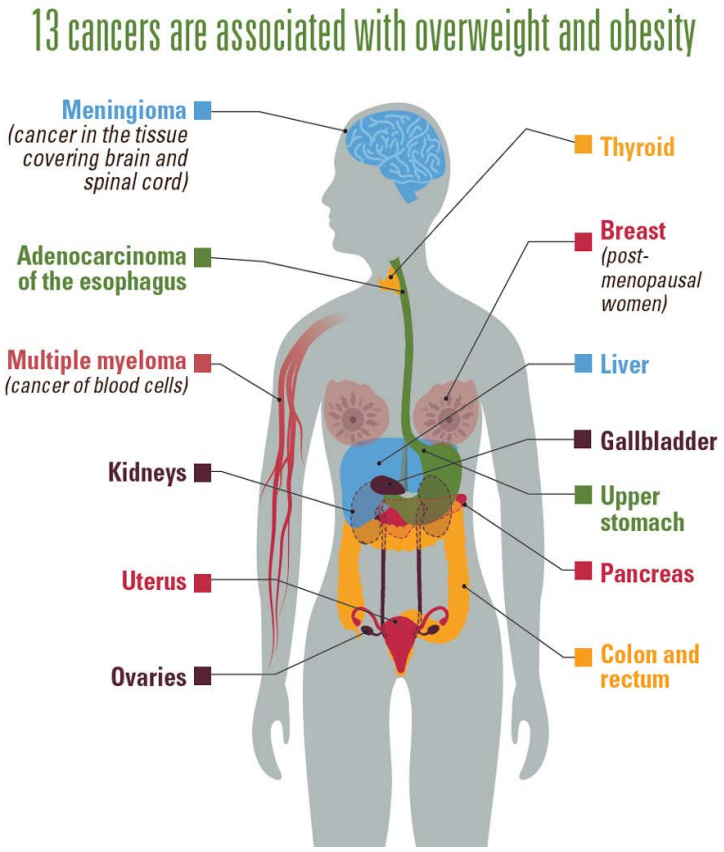


Obesity and Cancer: A Current Overview of Epidemiology, Pathogenesis, Outcomes, and Management. Cancers 2023.

as type of delivery.

Postpartum care can be complicated by lower milk production, depression and inflammation, coagulation risks, and postpartum infection risk.

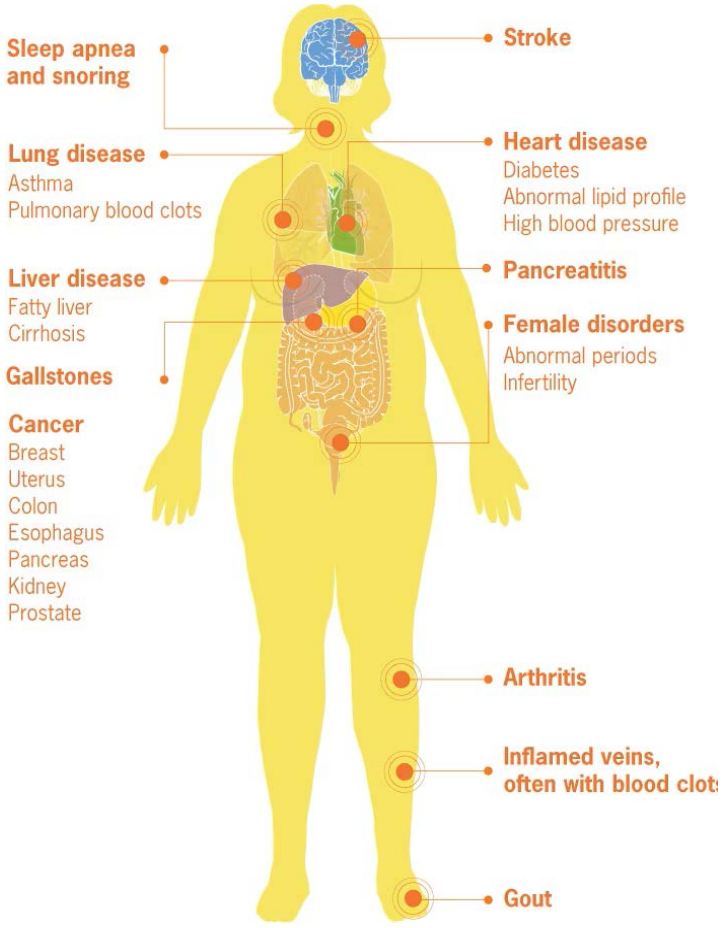
Dr. Webster:
That's a list and I know you can go in more depth.

Dr. Said:
Oh yes. We could talk about menopause and obesity and how hormone replacement therapy for obese women is more difficult or even controversial due to the risks of breast cancer, VTE, and cardiovascular disease. We do offer many options but often need to ensure personalized counseling for her risk factors and ensure her menopausal symptoms are truly menopause and not other conditions such as diabetes, thyroid disease, etc.

Contraception also has its risks which are similar to that of HRT. Remember, the increased BMI is associated with increased unopposed estrogen production, particularly in the adipose which is converted by aromatase to estrogen and causes other issues of concern. Obesity creates a higher incidence of infertility and polycystic ovary syndrome.

Additionally, when we counsel women on surgical care and types of surgical interventions, we have to consider intraoperative positioning, their ability to be placed in trendelenburg positioning for robotics and laparoscopy, limiting who can have endometrial ablation due to the risk of hyperplasia if prior obesity or pcos (unopposed estrogen), and it even affects our in office exams and ability to do a thorough pelvic exam for screening not just gynecology problem visits.

I think we need to look at the whole patient and how obesity affects her care. We must be her advocate without shaming and while using patient-friendly unbiased counseling to offer her



Obesity-associated morbidity. Image by CDC

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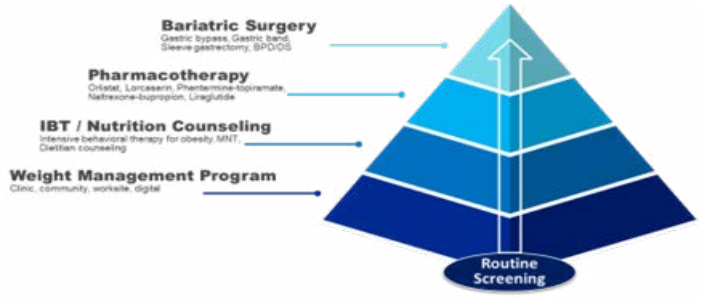
JOSEPH WEBSTER JR, MD



National Institute of Health

improved health and quality of life. Obesity is a health crisis that affects all aspects of women's health.

Dr. Webster:
Thank you so much Dr. Said for sharing some highlights from your presentation.

Although exercise and diet are recommended ways to avoid morbidity and obesity, obviously this doesn't always work, and other ways may need to be considered.

Christopher Crawford, MD, FACS, FASMBS is a general surgeon who works in Carmel, Indiana with the Ascension Medical Group St. Vincent, Meridian Surgery. He specializes in bariatric and anti-reflux surgery.

Dr. Webster:
Dr. Crawford, if a patient is unsuccessful with diet, exercise, GLP-1 agonists, etc., what weight loss options do you offer?

Dr. Crawford:
Well, there are a few procedures available. There's a Laparoscopic Assisted Gastric Banding (LAGB), Laparoscopic Sleeve Gastrectomy (LSG), Roux-En-Y Gastric Bypass (RYGB), and the Biliopancreatic diversion with Duodenal Switch (BPD-DS). Surgery is primarily reserved for BMI > 35 but can be applied to even BMI 30-35 with comorbidities that are not responding to medical treatment.

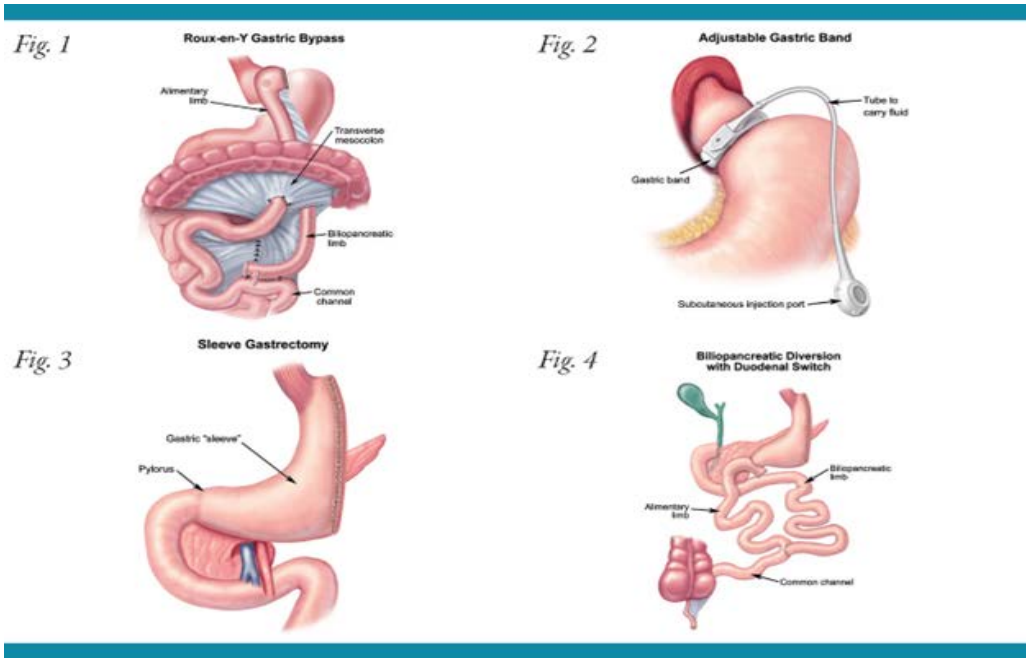
Dr. Webster:
That last one sounds aggressive. What are the Estimated Weight Losses (EWL) for these procedures and are they permanent?

Dr. Crawford:
The LAGB has an EWL of 14-60 % after 7-10 years and involves the use of an adjustable band to create an upper gastric pouch restricting the inlet and producing early satiety and limiting food intake. It is reversible.

The LSG has an EWL of 50-55% after 5-9 years. It involves the excision of the lateral aspect of the stomach to create a smaller gastric tube This limits food intake and increases GLP-1. It is not reversible.

RYGB has an EWL 60-70% after 7-10 years. The stomach is transected to create a proximal gastric pouch which is anastomosed to a Roux-En-Y proximal jejunal segment therefore bypassing the remaining stomach and duodenum. This is reversible.

Finally, BPD-DS is a sleeve gastrectomy with an intestinal bypass of all but 100-150 cm of distal ileum. EWL is 60-80 % after 7-10 years and limits digestion and absorption. This procedure induces extensive nutrient and caloric malabsorption.



Society Of American Gastrointestinal Endoscopic Surgeons (SAGES)

THE PRESIDENT'S PAGE

JOSEPH WEBSTER JR, MD

This is partially reversible.

Dr. Webster:
What criteria do you use?

Dr. Crawford:
Of course, there are a lot of factors, but some include weight, weight loss history, commitment, and lack of exclusions. Examples of weight are BMI>40 kg/m² with no comorbidities or a BMI 30-34.9 with diabetes or metabolic syndrome. Commitment is the expectation that the patient will adhere to postoperative care, follow-up, medical and dietary management.

Exclusion criteria include BMI <30; reversible endocrine disorders that can cause obesity; current drug or alcohol abuse; and the lack of competence of risks, benefits, and the required lifestyle changes.

Dr. Webster:
Thank you, Dr. Crawford, for sharing.

Not everyone has a BMI qualifying for surgery or desires a surgical solution initially. Some people have found success with glucagon-like peptide agonists. The NIH states that glucagon-like peptide-1 receptor agonists are a class of medications utilized in the treatment of Type 2 diabetes and obesity. The GLP-1 agonists stimulate insulin secretion after an oral glucose load. In Type 2 diabetes, this process can become blunted or even be absent. GLP-1 can revive insulin secretion. The most commonly reported side effects are nausea, vomiting, and diarrhea that can lead to acute kidney injury. Major hypoglycemic episodes have not been reported.

Weight loss of an average of 2.9 kg compared to placebo and a lowering of both systolic and diastolic blood pressures are all shown as effects of these drugs. The main complaint is rebound weight gain after medication cessation.

In UPI.com, Dennis Thompson writes about regular exercise to maintain weight loss achieved using Ozempic. He states "... it is actually possible to stop taking the medication without large weight regain." Their studies show regular exercise of 2 hours a week can help maintain the beneficial effects a year after treatment termination.

Of note, recently the maker of Ozempic and Wegovy has been granted government approval to be marked to help cut the risk of heart attack, heart

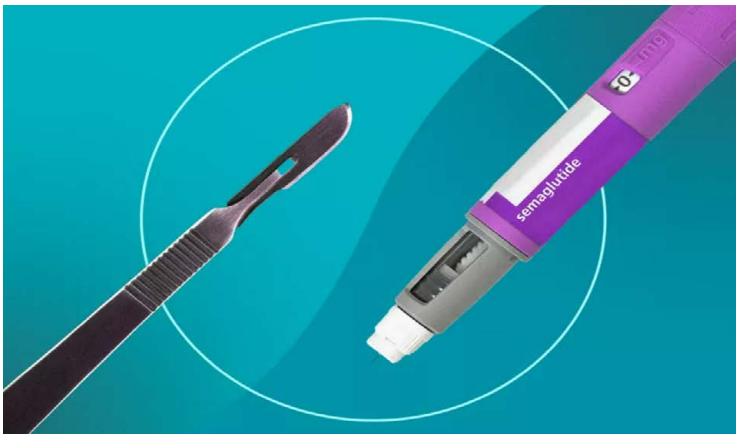


Photo Illustration by Joules Garcia for Verywell Health; Getty Images

disease, and stroke. "Wegovy is now the first weight loss medication to also be approved to help prevent life-threatening cardiovascular events in adults with cardiovascular disease and either obesity or overweight," John Sharretts, the FDA's diabetes and obesity czar, said in the press release. "This patient population has a higher risk of cardiovascular death, heart attack, and stroke. Providing a treatment option that is proven to lower this cardiovascular risk is a major advance for public health."

In an interview with NPR, cardiologist Martha Gulati of Los Angeles' Cedars-Sinai Medical Center said "The hope is that insurers will start understanding that this is not a vanity drug."

I hope you have found this month's article informative. Until next time.

Sincerely,

Joseph Webster

Joseph Webster, Jr
152nd President
Indianapolis Medical
Society

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EDITORIAL

The Corporatization of Medicine

by RICHARD FELDMAN, MD

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

The corporatization of medicine. It can't be good for patients. I know it's not good for physicians.

The corporatization of medicine removes much of the essential autonomy of physicians. According to the Physician's Advocacy Institute, almost 75 percent of physicians in the U.S. are now employed with half of all physician practices owned by hospital systems (for-profit and non-profit), large insurance companies, private-equity businesses, hedge funds, large physician-owned corporations, and others.

Employed physicians, especially primary care doctors, are mainly evaluated and paid on the basis of productivity. The more patients a provider sees, the more revenue generated, and the greater worth the provider has to the corporation. Quality care and patient satisfaction are relatively small parts. Ever wonder why your physician has very limited time to listen and address your medical concerns? That's likely why.

Medscape Medical News reports that 10 percent of U.S. physicians are either employed by or work under the control of the parent company of UnitedHealthcare - just one of the insurance companies employing physicians.

Robert McNamara, M.D., emergency physician and cofounder of Take Medicine Back, is quoted in the same Medscape article, "To have the doctors now working for the insurance industry conflicts with a physician's duty to put the patient first."

The business of medicine has become very complicated, expensive, financially risky, and very challenging for private-practice physicians. Corporatization provides capital investment, greater financial stability, business expertise, and market leverage for reimbursement and attracting patients. But there is a price paid.

Corporatization wouldn't be necessarily bad if it operated on the highest ethical and moral ground. But it doesn't. Employed physicians are increasingly pressured directly or indirectly to alter their medical care to maximize the bottom line. Corporations taking control of clinical operations is not always consistent with preserving the traditional healing role of the physician and the time-honored doctor-patient relationship.

It is commonly thought that half of physicians are "burned out" from long hours worked, loss of practice control, productivity pressures, and the burdens and the complexities of contemporary medical practice, much of which exacerbated by corporatization.

On top of burnout, many physicians suffer from "moral injury", well-articulated in a New York Times Magazine article, "The Moral Crisis of America's Doctors". They're struggling, discouraged, and frustrated that they have violated their physician core values in fulfilling the expectations of a corporate-dominated profit-driven health-care system that values revenue over providing the best care to sick vulnerable patients. Patients are too often denied the care they deserve and need. Physicians under the productivity gun are unable to spend sufficient time with their patients and to be sensitive to their needs. The article explains that physicians "feel complicit in the betrayal of patients".

The corporate takeover in health care causes ethical and moral dilemmas for providers. Physicians are trained in an ethos of service. The needs of patients always come first, and financial benefit should not be in the equation.

There are a very few bright spots. The corporate model of "value-based care" and the "direct care" model of private practice provide more emphasis on quality and personalized care.

Legislation loosening corporate control may help. But ultimately, until our health-care system drastically changes from volume-based to quality-based, nothing will change.

As my colleague, Dr. David Blank wrote me recently, "Physicians seem to have lost our place as the captains of the ship. I hope we don't get stuck just rowing down in the galley, chained to our oars."

Lessons Learned from Change Healthcare

by BARRETT BOODY, MD and RICK SASSO, MD
Indiana Spine Group and IMS Members

In 480 B.C., when King Xerxes attempted the second Persian invasion of Greece, their invasion from the beach landing into the mainland was quickly imperiled by the strategic narrow pass of Thermopylae. The Spartans entrenched themselves at the choke point and for three days, they inflicted disproportionate Persian casualties due to this oversight from the Persian army. While the story is typically recounted to highlight the bravery and courage of the Spartans, the object lesson for this commentary is the catastrophic consequences of unanticipated choke points.

Change Healthcare, a subsidiary of United Health Care provides IT solutions and assistance for hospitals and physician practices, such as revenue cycle management, analytics, clinical decision support, and most notably as a clearinghouse. The clearinghouse acts as an intermediary between providers and payors, providing both submission of claims to payors as well as the receiving and handling of collections for claims paid. Due to the perceived complexity and immense scale of managing claims, most providers and hospitals opt for this third-party vendor to automate and handle this aspect of the revenue cycle. This has become a highly desirable service and subsequently, a very lucrative business, as Change Healthcare in 2023 managed over half of the US healthcare financial transactions between providers and payors, totaling over 1.5 trillion dollars. On February 21st, 2024, Change Healthcare shut down its clearinghouse to mitigate and contain damage from a cyberattack. Many physicians were unaware of both the outage and, quite frankly, even as to what Change Healthcare does. Additionally, for the size and scope of the consequences of the shutdown, minimal national news covered the story.

When I initially sat down to write this article, I intended to write a commentary on why physicians and hospitals should avoid clearinghouses and eliminate this unnecessary middleman from healthcare. Instead, I see this as an opportunity to discuss choke points in healthcare organizations and why we should start paying attention. In the not-so-distant past, COVID brought supply chain disruptions to hospitals and practices that heavily relied on a single medical supply vendor. Following this, we saw labor shortages and an increasing frequency of ransomware attacks on EMR systems, hospitals, and physician practices. Even recently, AT&T nationwide cell service outage for less than a day had a significant impact on the ability to communicate within organizations. And today, our issue is cash-flow disruptions from a clearinghouse failure.

The issue is that our increasing reliance on third-party vendors to take over and manage aspects of physician practices and hospitals has left us vulnerable in unpredictable and potentially catastrophic ways. In a supposed effort to streamline operations and create efficiencies at scale, we have outsourced critical business components. Of these practices that lean heavily on third-party vendors, I would suppose many organizations haven't comprehensively modeled the risk nor the necessary response in the scenario that third-party vendors fail to deliver. Risk is an inevitable part of running a business, but unmodeled risk is dangerous. What would we do if Epic or Cerner were offline for a month? What if the internet was out for a week or even just a day? Businesses that leverage third-party vendors must have viable risk mitigation and go-forward strategies in the event of catastrophic failure.

> "RISK IS AN INEVITABLE PART OF RUNNING A BUSINESS BUT UNMODELED RISK IS DANGEROUS."

While anger and outrage specifically at the Change Healthcare clearinghouse situation is both satisfying and appropriate, it demonstrates that we have failed to understand the lesson. Settling for outsourcing critical components of our businesses and overdependence on third-party vendors will create vulnerabilities and choke points. This is no longer hypothetical, as we have seen this play out several times already this decade. If we understand and learn from this lesson, we can avoid or mitigate the next "once in a generation" event that seems to be occurring with appalling frequency.

None of this is what we learned during medical school or residency and none of this is easy. We've been sold the idea that the business side of medicine is too onerous and too complicated and that physicians should just focus on practicing medicine. Demonstrating excellence in both business operations and clinical practice is not for the faint of heart, if recent events have taught us anything, this will only continue to become more challenging. When departing for war, Spartan mothers would implore their sons to "return with your shield or on it". This is the level of confidence and courage necessary.

Colleague Corner: The Interview

Please join us in learning more about our newest IMS Board Member, Dr. Daniel Udrea. Not only is Dr. Udrea new to the board, he is new to IMS, having joined in September 2023. Learn more about our newest go-getter who is jumping in with both feet and taking advantage of every opportunity IMS has to offer.

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

Hello everyone! My name is Daniel Udrea, although most folks call me Danny. I'm born and raised in Dayton, Ohio where I completed my undergrad in Human Biology. I completed my medical education at Loma Linda University School of Medicine, followed by an Emergency Medicine residency and Anesthesia Critical Care Medicine fellowship at Loma Linda University Medical Center. I hold board certifications in both Emergency Medicine and Anesthesia Critical Care Medicine. Currently, I practice full time as an Assistant Professor in the Departments of Emergency Medicine and Pulmonary Critical Care Medicine at Indiana University School of Medicine. My clinical practice is primarily at IU Methodist Hospital.

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

I've always been deeply passionate about science and driven by a strong desire to impact people's lives in a meaningful way. This passion led me to medicine, where I found my calling in Emergency Medicine, followed closely by Critical Care Medicine. These fields are all about being on the frontline, dealing with critical situations that demand quick thinking and immediate, yet thoughtful, action. There's a unique challenge in meeting patients at their most vulnerable and working to stabilize and care for them, which I find incredibly rewarding. Moreover, these specialties allow me to stay in tune with the community's health needs, aligning perfectly with my interest in health advocacy. By working in these areas, I'm doing more than just providing urgent care; I'm also contributing to broader public health initiatives and striving to improve the well-being of our community. To me, it's a perfect blend of my interests and aspirations, where I can make a real difference.

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?

My parents have been a constant source of inspiration throughout my journey in medicine. Their unwavering support and encouragement have been instrumental in helping me pursue my dreams. I will never stop expressing my deepest gratitude for their love, sacrifices, and the values

they've instilled in me, which have shaped me into the physician and person I am today.

4. What is the best and worst thing that has happened to you since becoming a physician?

The best thing about being a physician is the privilege of being entrusted with the care of patients during their most challenging times and the opportunity to make a meaningful difference in their lives. The worst aspect is witnessing the devastating effects of illness on patients and their families, and the emotional toll it can take on healthcare providers. This is one of the many reasons why I stay actively involved in health advocacy.

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

One of the biggest challenges physicians face today is the increasing overload of administrative tasks and regulations, which can detract from the time and energy we can devote to patient care. Balancing the demands of providing high-quality, compassionate care with the need to navigate complex healthcare systems and maintain our own well-being can be a significant struggle.

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

Yes absolutely. I'd encourage folks who are passionate about science, helping others, and making a difference, to consider a career in medicine. While the path is challenging, the rewards of positively impacting patients' lives and contributing to the advancement of healthcare are immeasurable. It's essential, however, to have a clear understanding of the dedication and sacrifices required.

Testifying at the 2023 National AMA Meeting in Washington, DC

Selfie with my good friend and former AMA board member, Karthik Sarma, MD PhD.

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

If I were not a physician, I would likely pursue a career in architecture or structural engineering. I've always loved to create and design things that add function to our lives. Become a physician, however, hasn't been a compromise as I use these skills to create high fidelity, low cost simulation models for medical education.

8. What is your favorite inspirational quote?

The simple phrase "Do The Right Thing" became engrained in me from my mentor Dr. Vi Dinh back in medical school. When grappling with difficult cases or choices, I can vividly recall Dr. Dinh's voice emphasizing the need to act ethically and with empathy. His wisdom has been a guiding light through the intense pressures of being a physician, constantly reminding me to prioritize patient wellbeing above all else while never compromising my principles. It transcended just being a catchphrase - it shaped my fundamental promise to strive for excellence in medicine while staying true to my moral compass.

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

I'm excited to be a part of the Indianapolis medical community and I'm looking forward to collaborating with my colleagues to improve patient care and advance the field of medicine. I believe that when we work together, share knowledge, and support one another, we can make a significant positive impact on the health and well-being of our community.

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

April 12	Riley Children's Health Pediatric Trauma, Burn, & Emergency Care Symposium | 8:15 AM - 4:45 PM | Dallara IndyCar Factory, Speedyway, IN | AMA PRA Category 1 Credits (7.50 hours)
April 19	Updates in Pediatric Gastroenterology for the Primary Care Clinician | 8:00 AM - 12:00 PM | Ritz Charles, Carmel, IN | AMA PRA Category 1 Credits | Registration online
May 7	LGBTQ+ Healthcare Conference| Virtual |

Indiana State Medical Association

To Register For the live webinars, visit: www.ismanet.org

April 12	Physician Advocacy Advance Leadership Program | Hybrid | 10 AMA PRA Category 1 Credit
May 21	Women in Medicine Virtual Discussion: Women in Medicine General Discussion | Free for Members | Live Webinar | AMA PRA 1 Credit
June 7	ISMA Recognition Services - 2024 CME Provider Training, workshop for health care organizations directly accredited by the IMSA | Free | 322 Canal Walk, Indianapolis
July 16	Women in Medicine Virtual Discussion: Processing Your Emotions through Grace, Vulnerability and Forgiveness | Free for Members | Live Webinar | AMA PRA 1 Credit
Nov 19	Women in Medicine Virtual Discussion: Trauma Informed Care | Free for Members | Live Webinar | AMA PRA 1 Credit

Don't forget about ISMA Mobile Learning. You can download the ISMA Online app and view and complete online CME content at your convenience. Visit www.ismanet.org for more information.

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.

WELCOME NEW MEMBERS

Active

Joshua J. Armbruster, DO
Medical Associates LLP
7150 Clearvista Dr
Indianapolis, IN 46256-1695
Emergency Medicine
U of Osteo Med & Sci, 2005

Steven C. Kim, MD
Central Indiana Urology
9240 N Meridian St, Ste 200
Indianapolis, IN 46260
Urology
U of IL Col of Med, 1994

Bogumila Kopczynski, MD
Medical Associates LLP
7150 Clearvista Dr
Indianapolis, IN 46256-1695
Emergency Medicine
Second Moscow Inst, Russia, 1993

Robin H Ledyard, MD
Community Physician Network
7300 Shadeland Sta
Indianapolis, IN 46256-3919
Family Medicine
IU School of Med, 1987

Joanna E Manghelli, DO
Medical Associates LLP
7150 Clearvista Dr
Indianapolis, IN 46256-1695
Emergency Medicine
Kirksville Col of Osteo Med, 2014

Craig S. Schneider, MD
Cancer Care Group P.C.
8111 S Emerson Ave
Indianapolis, IN 46237-8601
Radiation Oncology
U of Maryland Sch of Med, 2018

Donald P. Snyder, MD
Donald P. Snyder MD LLC
4725 Statesmen Dr, Suite A
Indianapolis, IN 46250-5645
OBGYN
IU School of Med, 1986

Sandeep P. Sorin, MD
OrthoIndy
8402 Harcourt Road
Indianapolis, IN 46260-2074
Trauma Surgery
U of Rochester Sch of Med, 2012

Graydon Taylor, DO
Community Anesthesia Associates, PC
Anesthesiology

Peter R. Wasky, MD
OrthoIndy
8402 Harcourt Road, Suite 125
Indianapolis, IN 46260-2094
Orthopedic Surgery
IU School of Med, 2017

Hanna Webb, MD
Nephrology
IU School of Med

Students

Nathaniel J. Martine
TBD
Marian Col of Osteo Med, 2027

BULLETIN BOARD

JOSEPH D. SMUCKER, MD

Congratulations Joseph D. Smucker, MD as he was selected as an Honoree of the IBJ Health Care Hero Award, Physician category.

Dr. Joseph Smucker is a distinguished spine surgeon with the Indiana Spine Group, but he is also noted for his skills as a mentor, instructor and a researcher responsible for notable advances in spinal care.

A big proponent of education and mentorship, Smucker is a leader in the Indiana Spine Group Fellowship program and teaches physician assistant students from local and regional programs. His leadership positions include serving as chief of surgery at Indiana Spine Hospital and as president of medical staff at Ascension Carmel Hospital. He also serves on the American Board of Orthopedic Surgeons and the American Academy of Orthopedic Surgeons.

He vigorously promotes teamwork and consistently attributes success to collaboration among the myriad specialties needed not just for a successful surgery but also for a smooth recovery.

He also created the Indiana Spine Registry—a digital storehouse containing clinical data about many thousands of Hoosier spinal cases. That ever-growing fund of knowledge is configured as a searchable database practitioners can use to discover what works, what doesn't, and under what circumstances. The system is connected with the American Spine Registry and the Cervical Spine Research Society Registry, contributing to an even larger information pool.

"I love clinical trials, but they can take five to 10 years to mature, and you're only trying to answer one question," Smucker said. "Now, with a registry, you're saying, 'Here's my patient population as a whole. Let's collect meaningful data from all of them, and then we can go back and ask meaningful questions over time that perhaps we haven't even thought of today."

IN MEMORIAM

C. CONRAD JOHNSTON JR., MD

C. Conrad Johnston Jr. M.D. passed from this life at age 94 on January 22nd a devoted husband, father, and grandfather. He was born in Statesville, NC and was raised in Mooresville, NC, and attended Episcopal High School in Alexandria, VA. He went on to attend Duke University for undergraduate and medical school, graduating in 1955. He completed his internship at Duke Hospital, residency at Barnes Hospital in St. Louis, and a research fellowship at Indiana University School of Medicine. Remaining at IU as a faculty member, in 1969, he was promoted to Professor of Medicine at which time he became Chief of Endocrinology and Metabolism, a position he held until 1994. In 1997, he was named as a Distinguished Professor.

Con served on many committees locally, nationally, and internationally regarding osteoporosis. He was Vice Chairman and Chairman of the Health and Hospital Corporation Board of Trustees. He also served as President of the National Osteoporosis Foundation. He received the Sandoz Prize for Gerontological Research in 1993. In 1996, he received the Frederic C. Bartter Award from the American Society of Bone and Mineral Research for outstanding clinical investigation into the disorders of bone and mineral metabolism. In 1998, he received the Yank D. Coble, Jr., M.D. Distinguished Service Award of the American Association of Clinical Endocrinologists. In 2020, he was presented with the Bicentennial Medal for his distinguished service to Indiana University. In addition, Con served as Captain in the United States Air Force and was a 33rd degree Mason. He was a member of the Second Presbyterian Church, where he served as an Elder, Woodstock CC, and as part of the Dramatic and Contemporary Clubs. He was a supporter of both the Indianapolis Symphony Orchestra and the Indianapolis Museum of Art. IMS member since 1985.

LEE HOYT MILLER, MD

Dr. Lee Hoyt Miller, M.D., age 87, of Cortez, Florida passed on February 26, 2024.

Hoyt was the son of G.L. Hoyt Miller and LaVerne M. Miller. He was born November 16, 1936 at Danville, Illinois. Soon thereafter, the family moved to Indianapolis, Indiana, where, at Howe High School, he met the love of his life, Katheryn A. Wilkens (daughter of Dr. Irvin W. Wilkens, M.D. and Delta M. (Newton) Wilkens). They were married on June 20, 1959.

Hoyt graduated from Wabash College in 1959 where he sang first tenor with the Wabash College Glee Club under the direction of his mentor and close friend, Bob Mitchum. At Wabash, he was a proud member of his social fraternity, Sigma Chi. He has remained close with his Sigma Chi brothers and his fellow Class of ’59 classmates over the years. In 1963, he graduated from Indiana University School of Medicine and, after completing a residency in family medicine at Methodist Hospital in Indianapolis, he joined Drs. Dan McLaren and Hal Williams in their medical practice, Devington Family Physicians. He later formed Castleton Family Physicians with his medical partners. He was a staff officer at Community Hospitals of Indianapolis where he also served as Clinical Director of the Family Practice Residency Program. He was a member of the Indianapolis Medical Society, Indiana State Medical Association, Indiana Academy of Family Physicians, American Medical Association and was a Fellow in the American Academy of Family Physicians.

INDIANAPOLIS
MEDICAL SOCIETY
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Delegates

Delegates to the Annual State Convention

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

Ranai Abbasi (2024)
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Christopher D. Bojrab (2024)
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Ann C. Collins (2026)
Julie A. Daftari (2026)
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Richard D. Feldman (2024)
Ann Marie Hake (2025)
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Doris M. Hardacker (2024)
Mercy Hylton (2025)
David A. Josephson (2026)
Penny W. Kallmyer (2026)
Kathryn J. Kelley (2026)
Clif Knight (2025)
John E. Krol (2026)
Mercy O. Obeime (2026)
Ingrida I. Ozols (2026)
Robert M. Pascuzzi (2026)
J. Scott Pittman (2025)
Francis W. Price, Jr (2026
Haley A. Pritchard (2025)
David M. Ratzman (2024)
Thomas P. Schleeter (2026)
Jodi L. Smith (2025)
Eric E. Tibesar (2026)
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)
David Crook (2024)
Richard Hahn (2026)
Brian S. Hart (2026)
Melanie Heniff (2024)
Richard Huber (2025)
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

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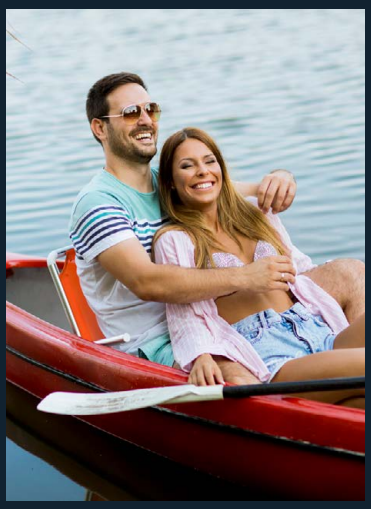

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