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Articles to be submitted for publication in LM must be received on electronic file on the first day of the month, two months preceding publication.

Opinions expressed herein are those of individual contributors and do not necessarily reflect the position of the Greater Louisville Medical Society. LM reminds readers this is not a peer reviewed scientific journal.

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Circulation: 3,800
What’s better than changing a life?
Changing two.

As sisters, Madeline and Camille were used to sharing things. Their dolls. Their toys. And, a rare condition called Tethered Cord Syndrome.

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Tennis, Part 2

A couple of months ago, I wrote about my experience at a tennis tournament with my daughter, Mackenzie. I was lucky enough to attend another one, with a different but maybe even better result.

Last time, I talked about the “zonals,” a team-style tournament in what is typically an individual sport. I mentioned that it was the most fun of almost all tournaments due to the team atmosphere, but what I didn’t know when I wrote the article is that my daughter’s team actually won, an amazing feat since rarely does anyone beat Florida.

This last week, we went to another team tournament, but on the first day, the Kentucky Team went 0 for 24 against Georgia. It was pretty obvious that we were not going to have the same experience as last tournament.

On day No. 2, it rained, causing us to move indoors and stressing everyone out. After getting up at 6 a.m. and waiting five hours, Mac finally got on the court to play. She won the first set pretty easily but lost the second, was up the third 5-2 only to end up at 6-6 necessitating a tiebreaker. I must confess that I could not watch anymore after 5-5 in the third set. Watching my daughter play tennis generally sends me on a rapid trip through the Kubler-Ross stages (anger, depression, denial, etc.), and sometimes I find that it is better to just go sit in the car, which is what I did. A bit later, I decided to go in and see what actually happened, but at the same time, I noticed an ambulance pulling up to the racquet club.

Apparently, at 6-6 in the tiebreaker, Mackenzie hit a winning shot. As her opponent ran to try to return it, she slipped on the netting between the courts and hit her head on a metal support beam. Her opponent lost consciousness, and I am told there was “blood everywhere.” By the time I had returned, she was awake, alert, with ice on her head and waiting to be taken to the hospital for an evaluation.

Mackenzie had won her match by a “KO” (and while not unusual in boxing, it is a little odd for tennis).

So, while the neurologist (me) was nowhere to be found, one of the fathers on the Kentucky Team, a physician, helped Mac’s opponent, along with the Kentucky coach and all the kids. It didn’t matter what team you were on at that point, everyone supported the effort to ensure that the injured player was cared for.

The tournament subsequently progressed with less excitement, and the Kentucky Team did eventually win a fair number of matches. Later, everyone gathered at the conclusion of the tournament for the awards ceremony. To the Kentucky Team’s surprise, they were given the Sportsmanship Award and each child received a watch noting this honor. Apparently, several parents from other teams recommended our kids for this award, due to their caring attitude and how they supported the efforts to help their opponent when she was injured. It was at this moment that I realized that I was more proud of Mackenzie and her teammates for their performance in this tournament than in the previous one.

We also have the same opportunity to support others through our involvement in the Greater Louisville Medical Society. Even though many of us might be in competition with each other on a daily basis (practices compete with each other for patients, many of us work for competing health systems, or insurance companies, etc.), we have the opportunity to band together and support causes that benefit our community and others less fortunate than ourselves. The GLMS Foundation supports others through its medical missions, programs for providing indigent care and its support of health careers and scholarships. The foundation also provides funding to Supplies Over Seas, The Healing Place, the Ronald McDonald House and other nonprofit organizations. You can support the foundation for an extra $100 over your regular GLMS dues. If you join, you will be recognized by a small foundation seal printed next to your name in next year’s roster (kind of like a GLMS Good Sportsmanship Award).

Another group that supports both the physicians in the GLMS and many local causes is the GLMS Alliance. The GLMS Alliance can provide both social interactions for spouses of GLMS members as well as volunteer service opportunities. This organization provides support for Gilda’s Club Louisville, The Healing Place and Hospital Hospitality House along with several others. Please turn to page 10 for more information and the GLMS Alliance dues statement in this issue.

Thank you for your support of GLMS, the foundation and the alliance.

From The President

Lynn T. Simon, MD
GLMS President

Note: Dr. Simon, a neurologist, is senior vice president and chief medical officer of Jewish Hospital and St. Mary’s HealthCare.
A Pearl Beyond Price

Tori Murden McClure rowed solo across the Atlantic Ocean — twice. Everyone asked her, "Why?" In her deeply moving and masterful account of this, A Pearl in the Storm, she wished to curl her lip and think of Sir Leigh Mallory and Everest and answer, “Because it’s there.” But in the beginning, she believed it was to prove she could. She would prove that a woman could row as far and as fast as a man. She sought heroic adventure, the thrill of success, and the joy of testing all her limits, physical, intellectual, psychic. In the end she risked her life, battered her body and endured the loneliness of the vast, empty sea. But she found her heart. She found it full of gratitude for human intimacy, and gratitude for human vulnerability, things she had always considered as meant for others, not herself.

Human intimacy is the currency of life, and therefore the currency of doctoring. It is the privilege and the duty we have, not only to recognize the needs of another person, but to pinpoint how we can meet them. Ms. McClure, an attorney (and a builder, a teacher, a plumber, a sailor, a skier to the South Pole, an electrician, a scholar and an engineer) has also a Master of Divinity degree from Harvard. She has spent her life between rows in the service of others. When she wanted to help the homeless and the drug-addicted, she did that. When she wanted to help the city of Louisville in Mayor Abramson’s administration, she did that. When she wanted to lead youth wilderness explorations, she did that. But it took the living solitude of the ocean to hammer into her heart a true understanding that needing to love and needing to be loved are two sides of the same human coin, that tearing down one’s Berlin Wall of isolation is an act of emotional freedom, not of weakness.

Reading her book makes me grateful for so many things. There is the overarching thankfulness that she survived Hurricane Bonnie’s spun-off storms, Hurricane Danielle (which hit her twice) and Hurricane Earl. There is the hometown satisfaction of reading about Helen Longley, Barry Bingham, Maura Temes and many others here who helped her build and rebuild her boat the “American Pearl.” There is the wonder of her descriptions of the ocean; she writes about the water and the whales and the waves better than anyone. There’s the appreciation of the awesome competence of everything she does (including making the reader laugh). There’s the suspense of the passage tempered by the relief that I know the happy ending. In that summer of ’98 I, like so many people who only knew her through the newspapers, with all of her family and friends, could only wait back home and hope for her safety.

It is prudent, when you watch patients suffer and their families in fear, to disconnect yourself to some degree, enough to make good decisions without being overwhelmed by sadness. We learn as we go into medicine to take stock of what we’ve done well and be grateful for that, to blunt the misery of the mistakes we have made. Gratefulness for patients’ improvement and for all the enormous effort of colleagues, nurses, clerks, scrub techs, janitors, administrators, etc., is something we feel every day. But even greater is thankfulness for the grace of forgiveness, because we all need it. We have all taken too little time with someone, scribbled something in haste, made major blunders someone else repaired and judged someone as whiny when we could have been charitable. We have all been guilty of too much emotional disconnect and of too little. We have together dodged firestorms of bullets behind the shield of someone wiser, someone senior or someone junior with a fresher outlook and newer data. What we need is the will, the sense and the humility to forgive ourselves.

December is the month of presents, and I can think of no better gift than Tori’s book to amaze, amuse and remind us of gratitude, that pearl beyond price.

Note: Dr. Barry practices internal medicine with Norton Community Medical Associates - Barret.

The views expressed in this commentary or any other article in this publication are not those of the Greater Louisville Medical Society or Louisville Medicine.

If you would like to respond to an article or commentary in this issue, please submit your response in the form of a Letter to the Editor. You may submit Letters to the Editor online @ www.glms.org or by e-mailing our editor directly at editor@glms.org. The GLMS Editorial Board reserves the right to choose which letters will be published.
Letter to the Editor

Elizabeth Martin Doyle, MD, FAAP

September 20, 2009

Dear Dr. Barry:

The most recent issue of Louisville Medicine was full of interesting, thought-provoking articles. I truly enjoyed reading your editorial about insurance companies and the primary care physician, and I certainly identify with your feelings.

I did have some concerns with the article highlighting the Healthy Start initiative of the Louisville Health Department. First of all, this is a wonderful program for our moms and new babies, and I applaud Dr. Troutman and his staff for their great successes. One problem with the article is in the graphics. Right beneath Dr. Troutman’s face sits a large baby bottle. The second concern I have is that breastfeeding support as an aspect of the Healthy Start program is not mentioned at all in Dr. Troutman’s writing.

Kentucky ranks near the bottom of the 50 states when it comes to breastfeeding. The benefits of breastfeeding to the baby, mother and society are numerous: reduced health care costs, fewer missed parental work days for childhood illness, less maternal breast cancers, reduced environmental impact, improved maternal/infant bonding, etc. I could go on and on about the benefits of breast milk over formula.

The KY WIC program has done a wonderful job trying to improve Kentucky’s breastfeeding rates with its breastfeeding food packages and peer counselors. This aspect of the Healthy Start program was not even mentioned in the article. The depiction of the bottle on the title page of the article highlights the fact that breastfeeding is not the norm in our culture, despite its multiple benefits over formula-feeding.

I urge Louisville Medicine to consider being a leader in our community in helping to make breastfeeding a cultural norm and to be more cautious about its depiction of infant feeding.

Thank you for your consideration,

Elizabeth Martin Doyle, MD, FAAP, Certified Lactation Counselor
Staff Physician, Norton Medical Associates-Shepherdsville
Norton Suburban Hospital Breastfeeding Education and Support Team
Chapter Breastfeeding Coordinator, KY Chapter of the AAP

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James Patrick Murphy, MD

WE ALL EXPERIENCE EVENTS THAT VECTOR THE COURSES OUR LIVES TAKE. Some we realize at the moment they occur. Some we will never acknowledge. And some we can only appreciate after time allows maturity, clarity and humility. As I ponder the mentors in my life who fashioned these seminal moments – mentors who hail from the ranks of friends, family, educators and ministers – one little Irish fellow with an elfish stare, hacking cough and stubby fingers with a stick of broken chalk always within their grasp, deserves a prominent place – even though I didn’t know it at the time.

Dr. McGeehan was not the popular, touchy-feely college professor whose schedule fills up before the freshmen get their chance to register. On the contrary, it was easy to secure a spot in his classroom. He was considered to be the toughest of the chemistry professors from whom we had the opportunity to choose. I was an “undecided” first-semester freshman, away from home for the first time and not quite sure how this college thing was going to work out. Dr. McGeehan helped welcome me to academia by throwing a piece of chalk at my head on the first day of class when he caught me snickering with a classmate. But the biggest blow to my ego occurred a week later when on my first test he awarded me a D.

The grades were posted later that day. A shiver of relief rolled over my body when I saw that I had actually received a B on the test and more importantly, a B in the class for the semester. I had done it. I was relieved as I was to have made the grade, I also felt a sense of loss due to the passing of this colorful character, Dr. McGeehan, who had the impeccable timing to check out on the very day of the final exam.

A few days later, Dr. Chumley found me in the chemistry lab cleaning out my desk. Our conversation was brief, unexpected, and rendered me speechless.

"Dr. McGeehan said you were the hardest worker in his class," Dr. Chumley said. “He really thought you would make a good doctor. When he asked me to take over the class for the final exam, with all that he had on his mind, Dr. McGeehan made sure I knew you needed at least a B on the final so you could get a B in the class. Well, you got your B, and it was the lowest B that I gave out. You just made the cut. Dr. McGeehan saw something special in you, and I hope you never forget that.”

Organic was the last chemistry class I took as an undergraduate. I successfully completed my pre-med curriculum and was accepted to medical school – as an English major. Since that time my career has led me to places as varied as the decks of aircraft carriers, the jungles of Brazil and the hallowed halls of the Mayo Clinic. There’s likely much more to come. Apparently, being a physician is what I was meant to be. And it might not have happened had it not been for the little wheezy leprechaun professor who made sure I got the grade I deserved.

I gave a valiant effort, but calculus, comparative anatomy and Shakespeare were jealous mistresses and would not be ignored. By the time of the final exam in organic chemistry, I had pretty much decided that if I got a C it was a sign I should rethink my medical ambitions and focus on writing the great American novel.

It was a cold Missouri December morning as we filed into the classroom for the organic chemistry final exam. Judgment day. Around me sat the best and the brightest of the pre-med hopefuls, the casual prerequisite science students having fallen by the wayside after freshman year. Would I measure up?

I thought it odd that Dr. Chumley, one of the other chemistry professors, was standing at the head of the class near the chalkboard, holding in non-stubby fingers what appeared to be our exams. I didn’t have to wait long for his explanation. “I will be administering your final exam today. Dr. McGeehan died this morning.”

Silence.

Then my friend sitting next to me took the opportunity to give a quick motivational talk. “Let’s do this for Dr. McGeehan,” he whispered to me, as though we were in the locker room preparing to win one for the Gipper. I could not muster a fitting reply. My not-so-stubby fingers were a little numb. All I could do was regroup, focus and give my best effort in this losing cause.

The grades were posted later that day. A shiver of relief rolled over my body when I saw that I had actually received a B on the test and more importantly, a B in the class for the semester. I had done it.

*Scientists use the Greek letter nu to represent the frequency of light, which can be expressed as its speed c divided by its wavelength lambda.*

Note: Dr. Murphy practices Pain Management with the Murphy Pain Center.
What's Happening in November?

November is usually a colorful month full of ever-changing weather, delicious smells from the kitchen and the wearing of new fall clothes. This is the month of Thanksgiving, and everyone has many blessings for which to be grateful.

On November 19, the GLMS Alliance members will be meeting at Broadway Baptist Church to assemble Christmas gift bags for The Healing Place. Last year the alliance individually wrapped 450 Christmas presents and gave them to The Healing Place residents. This year, The Healing Place is especially in need of fall and Christmas decorations due to the newly opened women and children's facility. Betty Allen is the chairman of The Healing Place service committee. If you have any items to donate, please e-mail her at elizabethallen44@hotmail.com.

This month the GLMS Alliance program and luncheon will be at the Speed Art Museum on Tuesday, November 10, at 10:30 a.m.
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Just take a look.
The title of this article is not original to me, but was coined by my uncle, Myron Weiss, in a 1935 speech over the National Broadcasting Company Station. Myron Weiss (from now on, Uncle Mike) was the associate editor of TIME, the weekly news magazine founded by Henry Luce. Uncle Mike was my father’s oldest brother and born in Cleveland, Ohio, in 1896. He graduated from Harvard before age 20 with a major in Shakespeare and was an ambulance driver in France with Gen. Pershing’s army during World War I. Uncle Mike, an intelligent and prescient man, became the first science and medical editor of the new TIME magazine. His speech was found by my brother, Allan Weiss, in our father’s papers, and now, 70 years later, is completely relevant to our current national debate on the cost of medical care.

The editor of Louisville Medicine asked me to summarize his ideas. Rather than paraphrase Uncle Mike’s thoughts, I have elected to include portions of his speech relevant to our current national debate. Uncle Mike had a wizardry of his craft with an enchanting, cynical sense of humor that hopefully will be conveyed in the excerpts presented. He begins his speech with these lines:

President Roosevelt may yet tell you how to pay your doctor’s bills. In his message on Social Security, he refused to touch on the matter, but promised to do so soon. You may expect some legislation right away, although the American Medical Association, for your good, will oppose it!

He follows his opening comments with remarks concerning three broad systems of paying for medical treatment:

1. The present system of Private Practice.
2. The spreading system of State Medicine.
3. The budding system of Sickness Insurance.

Experts with vested interests are fighting over these systems – most maliciously.

He then delivers an overview of the history of American Medicine, beginning with saddle medicine doctors in pioneer times, followed by the current hospital system that the patient must pay for:

The patient must pay for all of this if he possibly can. The bill for a major operation runs from $250 up. Rather than take less, the surgeon prefers to take nothing, to call his two hours’ work “charity.” Then there is the big hospital bill which you must pay. It is big because hospitals must pay the wages of big staff and the cost of food, laundry, even mortgages. But, if you are poor, you can get all this for nothing. Your rich neighbors indirectly pay your bills.

In 1935, the country was at the height of the Great Depression – much more severe than our current Great Recession, but there are parallels:

Most of you have lost most of your money in this depression. Many of you can truthfully say you have not a penny to your name. Even the very rich do not put aside much money to pay the doctors these days.

At that time, in the big cities like New York, Chicago and Los Angeles, doctors were getting as low as 50 cents for an office call. Some had abandoned medicine and were driving taxi cabs. In 1929, the average income of all American doctors was $50 a week. This dropped further during the Depression when this article was written. Uncle Mike goes on to say that “the doctors in sanitariums have done a remarkably good job” during this difficult period. He then follows with a discussion of the American Medical Association and its spokesman, Dr. Morris Fishbein:

Among the most unselfish societies of unselfish men that nations have ever produced are the American and Canadian Medical Associations. The American Association is the more articulate of the two and its most articulate member is its spokesman – Dr. Morris Fishbein. Dr. Fishbein, representing the entire medical profession, mortally hates and fears being hired by a politician or an insurance agent. Dr. Fishbein strides through the country, denouncing State Medicine and health insurance. Cries he, “Let us doctors alone. We will take mighty good care of the sick, as we always have, and if you have no money, we will treat them free and make our rich patients pay the difference.”

There was some more discussion, but in the end, Uncle Mike says to a very great extent, Dr. Fishbein is correct.
But:

Sociologists, insurance men and politicians are crowding the doctors. President Roosevelt and his message on Social Security gave the doctors a mighty push, although already functioning among us are State Medicine and sickness insurance. The two systems are bound to spread.

The third part of this essay summarizes the three systems of medicine (private/state/sickness insurance). Then a series of quotes:

Under the system of private medicine, the doctor is a professional man. The government gave him a license to be his own boss, to live or starve as he might. Under State Medicine and sickness insurance, doctors for the most part work for wages. They abandon their professional freedom. And most of them like it, for each fortnight, they know just how much money they can bring home to the wife and children.

Under State Medicine, taxes would pay the doctors’ bills. This works in the United States Army, in hospitals for war veterans, in insane asylums, in county poor farms and in municipal hospitals. But in the United States, it depends, especially in charity hospitals, upon the help of private doctors who contribute their services for nothing.

State Medicine will not necessarily give patients inferior doctoring. But what we must always remember is that men have an inner urge to give their best to their work, no matter what the circumstances of payment.

The system which doctors call “sickness insurance,” but which insurance men prefer to call “health insurance” seems to me to have a better chance to spread through the United States and Canada.

In simplest terms, sickness insurance requires every employed man and woman who earns less than $2,000 a year, say, to give up part of his wages to pay for his sickness policy. His boss puts up another share of the premium and the state taxpayers, the rest. The federal government, it is intended, will finance the beginning of the system and guarantee payment of benefits when working men and women get sick. People who do not work for wages, people like farmers and cobblers, have no privilege under the plan now being developed, but they are certain to find organizations to take them cheaply. This system matches the Workmen’s Compensation laws of many states.

Under a new system of sickness insurance, I can foresee good, conscientious doctoring.

The final part of his speech:

I prefer the system of private practice. But State Medicine and sickness insurance are establishing themselves. We must accept the new pair, confident they bring with them good for multitudes of our penniless people and for thousands of our dollarless doctors.

AMEN! M

Note: Dr. Weiss practices Cardiovascular Diseases with Medical Center Cardiologists PSC.

Continued from page 13

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Doctor Andrew Dailey is a lifelong Louisvillian, growing up in the Highlands area of town. He completed his medical school and residency training with the University of Louisville. He currently specializes in Nephrology after completing his fellowship training in 2008. Outside of work his interests include swimming, running and vacations to Disney World with his family. He is married to Dr. Stephanie Dailey and has a two year old daughter, Ella, as well as a new arrival due this February.

Stephanie Hill Dailey MD

Stephanie Hill Dailey MD grew up in Liberty, a small Kentucky town. She completed medical school, an internal medicine residency, and a nephrology fellowship at the University of Louisville. She is certified by ASDIN in Interventional Nephrology. She is married to Andrew Dailey MD and is the proud mother of two year old Ella. Her personal interests include traveling and gardening.

Leslie Ford MD

Doctor Ford grew up in Tompkinsville, Kentucky. After attending college at Western Kentucky University, she moved to Louisville where she completed medical school, residency, and fellowship training at the University of Louisville. She is board certified in Internal Medicine and Nephrology and is ASDIN certified eligible in Interventional Nephrology. Her areas of interest include chronic kidney disease and hemodialysis access management.
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INTRODUCTION

Melanoma is the result of malignant transformation of melanocytes, which are derived from the neural crest. Malignant melanoma is the sixth and seventh most common cancer in men and women, respectively. The melanoma incidence rate will increase roughly 5 percent in 2008, relative to 2007. This increase has been seen year-to-year in the past. It is estimated that 62,580 cases of invasive melanoma and 54,020 cases of melanoma in situ will be diagnosed in the United States. Factors which are associated with increased risk for the development of melanoma include: family or personal history of melanoma, fair skin types prone to easy sun burning, lightly colored eyes, red or blonde hair, multiple nevi, the presence of atypical (also known as dysplastic) nevi and a personal history of one or more blistering sunburns.

CLINICAL TYPES OF MELANOMA

Melanomas occur in four main clinical types, including lentigo maligna melanoma, superficial spreading melanoma, nodular melanoma and acral lentiginous melanoma. With early detection of melanoma, it is possible to cure this potentially life-threatening malignancy. Dermatologic evaluation should include a careful history, taking to assess risk factors and a thorough and complete cutaneous examination including the scalp, feet and genitalia. Historically one of the most frequent findings suggestive of melanoma are reported changes in size and color. An acronym was devised in the 1980s to aid in consideration of a diagnosis of melanoma and is known as the “ABCDEs.” An acronym was devised in the 1980s to aid in consideration of a diagnosis of melanoma and is known as the “ABCDEs.” (Table 1) We find it to be useful as we discuss self-examination with patients. If a melanoma is clinically suspected, histopathological diagnosis and appropriate microstaging are next steps. If the lesion is large, then a sampling may be performed without fear of effect on the prognosis. Whenever possible a full excision of a suspicious lesion is best; however, there have been several studies that suggest that clinical diagnosis is best performed by dermatologists to avoid excisions of multiple benign lesions including seborheic keratoses. Delay in diagnosis can adversely affect prognosis, but there has never been an effect noted by delay that involves weeks to months, thus it is not necessary for patients to be seen within days of the suspicion of diagnosis. When an appropriate appointment time is not available by routine methods, it behooves the referring physician to make a personal call noting the urgency of the condition. A full dermal thickness specimen is needed for appropriate staging. This may be obtained by an excisional, incisonal (deep shave), or punch biopsy. Superficial shave biopsy or small punch biopsies (i.e. 2mm punch into a 6mm lesion) should be avoided to prevent improper staging or histopathologic misdiagnosis.

Histopathologic characteristics that predict prognosis include Clark level and the Breslow measurement of the thickness of the lesion. Clark described five levels of invasion from in situ to invasion of the subcutaneous tissue. The Breslow thickness of a melanoma is measured in millimeters from the granular layer of the epidermis to the greatest depth of tumor invasion. (Table 2) Clark level and Breslow thickness are considered the most important predictors of survival in melanoma.

The management of melanoma requires the expertise of several disciplines including primary care, dermatology, dermatopathology, surgical oncology and medical oncology. The only standard treatment for cutaneous melanoma is early recognition and surgical removal of the primary tumor. Surgical decision algorithms are based on tumor thickness. (Table 3) Lymph node evaluation either via elective lymph node or sentinel lymph node is rec-

Continued on page 19
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Prevention

Preventative measures to help decrease the incidence of melanoma include: monthly self skin examinations, use of sunscreen (sun-protection factor 15 or higher), wearing protective clothing, avoiding the sun at peak hours, avoiding tanning beds and a complete skin examination by a physician knowledgeable in melanoma detection.


Note: Dr. Cassis is an assistant clinical professor in the University of Louisville’s Division of Dermatology and practices with Cassis Dermatology & Aesthetics Center. Dr. Callen is chief of the Division of Dermatology and practices with Associates in Dermatology PLLC.
A N AMBULANCE PICKS UP A PATIENT WHO IS HAVING A HEART ATTACK. Unfortunately, the closest hospital with the capabilities to treat the patient has notified EMS that it’s on diversion because of overcrowding. The paramedics need to decide their next move – find a hospital, as quickly as possible, that has the ability to save the patient’s life.

Two documents produced by the Greater Louisville Medical Society’s Public Safety Committee aim to address such problems caused by diversion. The Metro Louisville Standardized Hospital Diversion Plan was endorsed by the Board of Governors in July 2008. More recently, the committee approved the Pre-Hospital Emergency Triage Flow Sheet – a grid that lists the self-reported emergency capabilities of each hospital in the region, from STEMI (acute cardiac ischemia) to burns to obstetrical to psychiatric.

“There is a tremendous amount of work reflected in this matrix,” said Daniel J. O’Brien, MD, a committee member who is a professor of Emergency Medicine at U of L. The Public Safety Committee serves as a neutral corner where the different stakeholders – physicians, hospitals and EMS – can come to work on curbing diversion in the community, Dr. O’Brien said.

Diversion happens because of several factors. “We are dealing with a national epidemic of emergency department and hospital overcrowding, and similarly a tremendous overutilization of the 911 system to get people to those facilities,” said Neal Richmond, MD, chief executive officer of Metro Louisville EMS.

When hospitals become overwhelmed, emergency department triage slows down and ambulances get backed up in the bays. “Ambulances have to shop around for open emergency departments, which has two potentially critical effects – spending a lot of time where ambulances aren’t available because we’re backed up in emergency departments or traveling around the city trying to find places to get those people,” said Dr. Richmond, a Public Safety Committee member.

The problem can be heightened by weather events like last year’s wind storm and large-scale events like the Ryder Cup. “When you most need it not to happen is when it starts to happen,” Dr. Richmond said.

Metro Louisville EMS handles 130,000 dispatches each year, Dr. Richmond said. With the average call taking an hour, delays at the hospitals can add up quickly to disrupt the system.

Diversion, as defined in the hospital diversion plan, should only occur “when patient safety cannot be assured at an ambulance patient’s preferred hospital because its resources have been exhausted and, therefore, ambulance patients are sent to hospitals that are not the ambulance patients’ primary clinical or geographical choice.”

The Pre-Hospital Emergency Triage Flow Sheet creates accountability so there are no misunderstandings between either EMS or the hospitals about the patients they can treat. “This is a way to make it more formalized so that every hospital agrees they can accept a certain type of patient and provide the care that’s needed,” said Bill Smock, MD, a U of L Emergency Medicine professor who chairs the Public Safety Committee. “We’ve solicited input from every facility and every EMS agency so that we can provide the most appropriate medical care for the residents of the region.”

Ken Wilson, MD, associate vice president of clinical affairs for Norton Healthcare and committee member, said GLMS has fostered an environment for dialogue among the stakeholders on diversion, all of whom want to improve patient care but come to the table with different priorities. “We as a committee are beginning to address the pre-hospital care of patients more directly than we have in the past,” Dr. Wilson said. “We’ve built some trust, but because it’s such a complex issue, that’s an ongoing process.”

The hospital diversion plan, which states that patient safety is the only reason for declaring diversion, created an oversight committee to develop a monitoring system for assisting hospitals in reviewing their performance. Dr. Wilson said that the Diversion Council is currently adjusting the data collection process so that an oversight committee can begin meeting to evaluate progress and assist hospitals in efforts to reduce hours spent on diversion.

“Diversion should be the exception rather than the rule,” according to the plan, which set a goal for each hospital to reduce diversion hours by 10 percent in a year. Richard Bartlett, the Kentucky Hospital Association’s emergency preparedness/trauma coordinator, said diversion is a longstanding problem going back to the 1980s in Louisville. All hospitals today are looking at internal strategies for diversion avoidance because they don’t want to turn patients away, he said. “Not every hospital can deal with every issue,” Bartlett said. “We’re becoming more specialized as we go along – not every hospital delivers babies anymore, not every hospital deals with severely burned patients. So this (the triage flow sheet) helps EMS try to get people to the right facility faster.”

Note: Ellen R. Hale is the communications associate for the Greater Louisville Medical Society.
# PRE-HOSPITAL EMERGENCY TRIAGE FLOW SHEET

**GREATER LOUISVILLE MEDICAL SOCIETY**

**PUBLIC SAFETY COMMITTEE/DIVERSION COUNCIL**

This information will be available in emergency vehicles and facilities as a guide to the care and transportation of critically ill or injured patients. HOSPITAL CHOICE, while driven in large part by patient and physician request, WILL BE INFLUENCED BY MATCHING THE PATIENT’S PRESUMED PROBLEM WITH THE CAPABILITIES OF AREA HEALTHCARE FACILITIES. THIS FLOW SHEET WILL PROVIDE GUIDANCE TO PREHOSPITAL PROVIDERS IN FACILITATING THAT PROCESS.

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The Pre-Hospital Emergency Triage Flow Sheet will be updated as hospitals report changes in their capabilities to the GLMS Public Safety Committee. The document, with definitions for the Type of Emergency categories, will be posted online at www.glms.org.

**Hospital Key:**

- **AUD** Norton Audubon Hospital
- **BHE** Baptist Hospital East
- **BNE** Baptist Hospital Northeast
- **JWH** Jewish Hospital
- **JHS** Jewish Hospital Shelbyville
- **JME** Jewish Medical Center East
- **JMNE** Jewish Medical Center Northeast
- **JMS** Jewish Medical Center South
- **JMSW** Jewish Medical Center Southwest
- **KCH** Kosair Children’s Hospital
- **NBH** Norton Brownsboro Hospital
- **NOR** Norton Hospital Downtown
- **SME** Saints Mary & Elizabeth Hospital
- **SUB** Norton Suburban Hospital
- **VA** Veteran’s Admin. Medical Ctr.
- **UL** University of Louisville Hospital
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The Intensive Care Unit (ICU) holds lessons of value for our current health care reform debates. Properly adapted, ICU management principles provide a far better approach to these discussions than what we have experienced to date.

ICU management principles arose from insights of respected medical figures. In 1854, Florence Nightingale and 38 volunteers organized new units that they called “monitoring units” in Crimean battlefields for critically wounded British soldiers, and they reduced mortality dramatically. In 1926, pioneer neurosurgeon Walter Dandy established the world’s first hospital ICU in Boston. In the 1952 Danish polio outbreak, anesthesiologist Bjorn Ibsen formed a respiratory ICU and enlisted 200 medical students to manually pump oxygen-enriched air to intubated victims (this was before Carl-Gunnar Engström invented the positive pressure ventilator). The polio ICU unit experience led Ibsen to develop the first set of ICU management principles. These principles have evolved to guide current physicians in methodically assessing ICU patients on a system-by-system basis, with measured intervention determined by monitoring each system. In general, the nine physiologic systems monitored are: cardiovascular, central nervous, endocrine, gastrointestinal/nutrition, hematology, microbiology/sepsis, peripheral/skin, renal/metabolic and respiratory.

What lessons does this methodical, system-by-system ICU approach have for health care debates? To date, these debates have been marked by uncivil demonstrations and rude outbursts that have trampled opportunities for open discussions of legitimate policy differences and sensible compromises toward progress. Much of this poor behavior arises from pre-conceived, global “yea” or “nay” emotional stances that disallow any consideration of component issues and block thoughtful consideration of the multifaceted proposals that address one of the most complex social and economic problems of our era. A far better approach would be the ICU model of system-by-system assessment with measured intervention guided by component monitoring. In analysis of health care reform proposals, a set of principles replaces the physiologic systems of ICU methodology, and proposals are monitored by measuring their position on each of the principles. Individually, we can each outline our own set of principles, or rank those derived by respected bodies, according to our values. Some fine choices of principles for consideration come from the Institute of Medicine (IOM) and our societies of organized medicine.

The Institute of Medicine of the National Academies offers five guiding principles in its report, Insuring America’s Health: Principles and Recommendations. These principles are that health care coverage should be: (1) universal; (2) continuous; (3) affordable to individuals and families; (4) affordable and sustainable for society; and (5) effective, efficient, safe, timely, patient-centered and equitable. While well-conceived and widely accepted, these are exceptionally broad generalizations.

The American Medical Association (AMA) has refined these principles into a more specific list of seven (later nine) principles that have become more usable in policy analysis. The AMA principles are as follows:

1. Health insurance coverage for all Americans.
2. An insurance market that expands choices of affordable coverage and eliminates denials for pre-existing conditions.
3. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.
4. Investment incentives for quality improvement, prevention and wellness initiatives.
5. Repeal of the medical physician payment formula (SGR) that would trigger steep cuts and threaten seniors’ access to care.
6. Implementation of medical liability reforms to reduce the cost of defensive medicine.
7. Streamlining and standardizing insurance claim processing to eliminate unnecessary cost and administrative burdens.
8. Additional funding for primary care services, without offsetting reductions in specialty care.

Gordon R. Tobin, MD

Continued on page 24
Continued from page 23

These principles conform to the IOM guidelines and provide a specific template for principle-by-principle evaluation of specific health care reform proposals.

How does this approach work in practice? At the time of this writing, the Senate Finance Committee, chaired by Sen. Max Baucus, has just released a draft of its long-awaited proposal. Applying the principle-by-principle approach modeled on ICU protocol, monitor alarms immediately sound on two issues that are high priorities in my ranking. First, the draft does not include a permanent repeal of the faulted SGR formula. It simply maintains the status quo and defers the cumulated physician payment reduction to next year at an increased level (a reduction of more than 25 percent). Second, it pays for increased primary care reimbursement by equal cuts in specialty services. These two elements violate both the IOM principle of sustainability and the AMA principle of preserving seniors’ access to care. Individually and collectively, we must immediately voice strong, serious concerns about these elements to our elected representatives as the draft moves toward becoming the Senate version. By the same principles, the House of Representatives’ version (H.R. 3200) is very acceptable and far better on these two issues. Other issues will likely be exposed as we hold the ongoing process to scrutiny by our principles.

Florence Nightingale, Walter Dandy and critical care physicians carrying their legacy manage critically ill patients with a component-by-component approach. However, the best possible outcome for the whole patient is the greater goal. In health care, the IOM and AMA have defined well the component principles of effective reform. Again, however, the ultimate goal is a sustainable system that brings better health to all Americans. 

Note: Dr. Tobin is chairman emeritus of the Division of Plastic and Reconstructive Surgery with University Surgical Associates PSC.

HEALTH CARE REFORM: A SPECIALIST’S VIEW

David Seligson, MD

The national debate on change in health care reminds me of the fishing boats returning to Gloucester Harbor. The deckhands use the time to gut and clean their catch. Behind the boat, eager seagulls swarm to catch the entrails as they are swept from the bloody deck. The birds fight over the pieces. They swoop in close to grab a tasty morsel. So the special interests—from the socialists to the abortionists—are gathering to grab what they can from the terrible carnage.

A health care initiative billed as a way to avoid looming future fiscal disaster is like blaming the orphan Jane Eyre for being a naughty child. If we have national money problems, they are due in no small part to an executive appetite past and present for overseas wars and to the failure to internally regulate the banking system. So let’s recognize health care reform for what it is—a grab for a substantial portion of the gross national product. What it should be is an initiative to use dollars better in the pursuit of good health.

To my thinking, the debate is framed by three myths—universal health care, primary health care providers and public health. Let me explain. The devil’s in the details. Most agree that too many people are uninsured, but who will be included in the new universe for care, and what will they receive? Few would argue that everyone with a displaced femur fracture should get orthopedic care, but do we provide treatment for an illegal alien with fibromyalgia? Important special interest lobbies promote a wide variety of causes. How then do we decide what is covered and for whom? The Oregon experiment tried to prioritize medical care and draw a line on what was and what was not covered. This initiative failed. An ineffective treatment may nonetheless be popular. Insurance companies have excluded “pre-existing conditions.” This limitation of services is a rallying point for those promoting reform. Surely some boundaries need to be drawn carefully if we are to succeed at a sensible apportionment of resources. Today, federal initiatives have saddled the health industry with administrative mandates that increase costs and decrease the quality of what can be done for patients. Some of our best, brightest and most experienced have retired from the burdens of imposed paperwork and draconian audits. Could we begin by limiting the hostility with which the government approaches medical care?

The second myth is that so-called primary health care providers will provide for a more rational and cost-effective use of resources by reducing, among other things, duplicate and unnecessary tests. These are the very folks whose limited skills in physical diagnosis and common sense have created an explosion of sophisticated and meaningless diagnostic testing. These are the folks who taught me to put on my answering machine. ”If this is an emergency, call 911 or go to your nearest emergency room.” Answering the same questions from the same patients and relatives over and over may increase “customer satisfaction,” but it will not detect a lesion less than one centimeter in diameter and remove it. We tried the “gatekeeper” approach a decade ago and it failed. National services have attempted to quantify everything from prescription writing to Continued on page 26
Murphy Pain Center provides its patients leading care as confirmed by being the region's first and only practice to be awarded the distinction of:

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by the American Academy of Pain Management
rates of specialist referrals. These measures ration services, encourage the sick to leap across lines to the specialists, and fail to address the issues of real increased costs as our understanding of human medicine increases. Nor will so-called “evidence-based” research serve to curb our appetite for atorvastatin sodium (Lipitor) – nearly every overweight Medicaid patient is on it. It may yet be shown that less bacon is more effective in reducing cardiovascular complications than costly cholesterol-lowering agents.

Finally, we entertain the fantasy that public health needs more resources to help improve our general well-being and to lower health care costs. This means more money on largely ineffective programs such as the campaigns to reduce smoking and wear seat belts. Try getting an immunization against shingles – impossible. In today’s proposals, public health initiatives to fund everything from tai chi to acupuncture are under discussion. Logically, if all those Chinese are doing it, shouldn’t it work for us too? A walk through Beijing should satisfy you about the general state of health in the People’s Republic. More money for the folks who are out there killing chickens and/or pigs to prevent the plague? More letters about the benefits of lettuce from “Health Maintenance Organizations?” Not with my tax dollars, I hope.

Sensible steps include identifying and publicizing the administrative costs of health care so we can compare and control them. We must reduce the use of all diagnostic tests that do not lead to therapeutic interventions. Does a patient with knee arthritis and a recent triple bypass really need an MRI of the knee? Did my 94-year-old mother require a CT abdomen after passing a fecal impaction? (She refused it.) We should limit the salaries of executives working in health care industries funded by federal tax dollars. We should eliminate aggressive programs that attempt to recover tax money but actually drive up health care costs to hospitals.

Note: Dr. Seligson is vice chair of the University of Louisville’s Department of Orthopaedic Surgery and practices with Orthopaedic Trauma Associates PSC.

AN HONEST LOOK AT HEALTH CARE REFORM

Michael J. Kelley, MD

The sad fact of the current health care debate is that both sides are wrong. What makes this even more tragic is that America’s health care system desperately needs meaningful reform. Without it, we will continue to dig ourselves deeper into debt. Our industries will lose their competitive edge in the global economy. Health care will slip out of the financial grasp of even more Americans. Despite the stakes, the politicians in Washington offer us either something-for-nothing false solutions or, on the other side of the aisle, ridiculous scare tactics.

The No. 1 problem with America’s health care is that it is too expensive, about double what other countries spend for the same results. As we face nearly double-digit yearly increases in health care spending, the solution must focus on cutting health care costs. If we can accomplish making health care affordable, we will not only help solve the problem of 46 million uninsured but also make our industries more competitive in the global market.

1. We need to eliminate waste.
   
   Too many dollars go to pay for tests, procedures and medications that cost many times more than equally effective alternatives without offering any added benefit. We can no longer afford to choose brand-name medications and higher-priced procedures simply because they are newer rather than better. In a nutshell, it comes down to a very simple, straightforward question: “Is this worth the money it costs?” We ask ourselves this many times per day when we buy food, clothing, cars, you name it. Yet this is a question that is rarely heard in an exam room. Until somebody pays attention to cost, health care will never become affordable.

   In a British system, the government worries about cost and will not cover services that do not yield – in its judgment – sufficient value. Americans hate being told what they can or cannot have. Health Savings Accounts, or HSAs, may offer a way to get people to ration their own health care dollars while not skipping needed preventive care. Even better, businesses could do what my private practice does: take the savings from lower insurance cost and feed the money right back into the employees’ HSA accounts. This “creates” money to cover deductible expenses. If employees manage the money wisely, they get to keep it for retirement. If they spend it, there is no great loss to them as it did not come out of their personal savings. HSAs cover things like preventive care in full with no out-of-pocket costs.

2. We need to fix medical problems before patients are broken by them.

   In America, our health care professionals are the best in the world at fixing medical disasters. But due to our current reimbursement system, we are among the worst at preventing...
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medical problems. You all have heard the saying “a stitch in time saves nine.” It also would save us about a trillion dollars in health care costs. We need to refocus our system to prevent expensive medical disasters before they happen. Seventy-five percent of health care dollars get spent on treatment of chronic diseases, many of which could be prevented by better lifestyle choices (see No. 3 below). Just five problems make up the bulk of our spending: heart attacks, heart failure, emphysema, asthma and diabetes. It is shocking how many people with these problems do not receive long known, well proven standard of care preventive measures for their illnesses. It is also shocking that many people with these problems continue self-destructive behavior such as smoking, overeating and sedentary lifestyles. These facts offer a strong argument for re-invigorating primary care.

3. We need to need less health care.

One of the easiest ways to save on health care spending is to simply need less health care. We need to work on smoking, the growing obesity epidemic and our sedentary lifestyle. Large self-insured companies are leading the way in this area. They are using a combination of sticks and carrots to push their employees toward healthier living. I know of two in our area (Ford and Humana) that are trying to reduce their health care costs by improving their employees’ habits. One key is making sure money saved on avoiding poor choices ends up right back in employees’ pockets rather than right back in corporate pockets.

4. We need to make health care portable.

People should not lose affordable coverage and pre-tax benefits just because they change jobs. This would allow patients to bargain shop for a broader range of less expensive plans. It would also increase awareness of just how much of an individual’s paycheck goes toward health care premiums. Currently, patients are lulled into inaction when it comes to bargain shopping for health care because they never see all that potential salary their employers are shifting toward premi-

5. We need to mandate that everyone have insurance.

This would be controversial. I believe the often-quoted estimate of 46 million uninsured Americans may need closer examination. Roughly 12 million already qualify for a government health plan but are not enrolled. Around 9.5 million are not citizens and therefore need their own separate debate of whether or not we should cover health care for non-citizens. Approximately nine million of the uninsured have annual incomes of >$75,000 and therefore could likely afford insurance they have avoided buying. That cuts the number down to a still unacceptable but far smaller figure of approximately 15 million people. Of those, roughly half are temporarily without insurance due to job changes (see No. 4 above). This leaves about seven million long-term uninsured persons. I believe this is a number we could tackle with small modifications of current programs rather than a major overhaul.

6. We need to end insurance monopolies.

Currently, most major cities are monopolized by one or two insurance companies. This allows the company to drive up cost while driving down quality. Anytime a competitor pops up, it is either crushed or bought. We already have antitrust laws to break up monopolies. These laws either need to be applied or modified to bring competition back to the managed care market.

A single-payer system has already been tried in the United States: Medicare. It saves on administrative cost but has been unsuccessful at decreasing the nearly double-digit yearly increase in overall cost. As it stands now, it is slated to go broke. This doesn’t seem like much of a solution. The way Medicare has tried to control cost is simply to cut reimbursements for every service across the board. So, low-priced “bargain” care options take the same cut as high-priced rip-offs. That is part of the reason there has been a shift away from patient care toward providing high-priced, high-tech tests and procedures. (It is also a large part of the reason primary care is now on life support.) If we want to save money with a single-payer system, we will need to start performing cost benefit analyses of medical interventions and not cover the services, medicines and procedures that do not justify their cost. This is what England does. It does work. It is a legitimate solution. It is rationing of health care. So proponents of a single-payer system need to quit ducking the word, embrace it and de-stigmatize it if they can.

7. Medical malpractice reform is a medical cost savings “no-brainer.”

Patients in no way benefit from eye-popping multimillion dollar awards. Trial lawyers are heavy contributors to Democrats, and yet when the Republicans held both parts of Congress and the White House, malpractice reform didn’t get done. Let’s face it. No matter how much sense it makes, malpractice reform will not occur until doctors break out their checkbooks and start contributing 10 times more to political campaigns than they currently do. (Even better, they should run for office and support physician candidates.)

Our health care system is off the rails and headed for a cliff. We need reform. In order to have meaningful reform, we will need to have an honest dialogue. Opponents will need to set aside the fear-mongering and do the heavy lifting of constructing legitimate alternatives to the significant flaws in the current proposals (such as they won’t save money). Proponents will need to admit they are asking for sacrifice. If nothing else, they are asking for the sacrifice of no longer mindlessly wasting health care money, and maybe sacrificing unfettered choice. It’s a tall order to ask our elected officials to have a reasoned and rational debate on health care. In this time of great national need, it’s time to shun the lobbyists’ cash, avoid the temptation to scapegoat and fan the fear, and put country before political gain.

Note: Dr. Kelley practices Internal Medicine and Pediatrics with Internal Medicine & Pediatric Associates.
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GLMS would like to welcome and congratulate the following physicians who have been elected by Judicial Council as provisional members. During the next 30 days, GLMS members have the right to submit written comments pertinent to these new members. All comments received will be forwarded to Judicial Council for review. Provisional membership shall last for a period of two years or until the member’s first hospital reappointment. Provisional members shall become full members upon completion of this time period and favorable review by Judicial Council.

Candidates Elected to Provisional Active Membership

Chandran, Swapna Kartha (20994)
Manoj Chandran, MD
401 E Chestnut St Ste 701 40202
383-8303
Otolaryngology 08
U of Louisville 02

Christensen, Tannika (20789)
Greg L. Christensen, PhD
1023 New Moody Ln Ste 201
LaGrange KY 40031
225-4480
Family Practice 05
U of Utah 01

Greenberg, Benjamin Dee (20474)
Elisa Pardo
Pediatric Anesthesia Dept 5090 P
O Box 740041 40201
502-451-9949
Anesthesiology 09
New York State 04

Betz, Donna L (20772)
Christopher Betz
130 Stonecrest Rd Ste 106
Shelbyville KY 40065
647-1000
Lake Erie College of Osteopathic Med 99

Branson, Shellie Ann (9559)
Ralph Green
2015 Herr Ln Ste D 40222
426-0088
Pediatric Dentistry 88
U of Louisville 84

Howie, Katherine Elyse (20941)
William Burtinett
207 Sparks Ave Ste 200
Jeffersonville IN 47130
812-283-4441
U of Kansas 06

Mayfield, IV Pete (2522)
Sonne
2051 Clevendence Blvd
Clarksville IN 47129
812-280-9145
Internal Medicine 87
U of Louisville 83

Candidates Elected to Provisional Associate Membership

Loveless, Meredith Buonanno (20987)
James W. Loveless
401 E Chestnut St Unit 410 40202
277-5999
Obstetrics Gynecology; Gynecology
U of South Alabama 00

Whiteley, Amanda Susanne (18029)
101 W Muhammad Ali Blvd 40202
589-8600
Psychiatry
U of Texas 04

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The international glaucoma community joins Louisville in mourning the untimely passing of Thom J. Zimmerman, MD, PhD, on August 4, 2009. In Louisville, Thom may have been best known as a nationally ranked senior amateur tennis player honing his skills at the Boat Club, or perhaps for frequenting the city’s pool halls at all hours in pursuit of a round of three-rail billiards. In his spare time, he served from 1986 to 2001 as chairman of the Department of Ophthalmology and Visual Sciences at the University of Louisville, where he spearheaded the fundraising that led to the renovation and expansion of the Kentucky Lions Eye Research Institute. This facility, completed in 1997 and representing an enduring legacy of his leadership, houses both state-of-the-art research facilities and the Rounsavall Eye Clinic, a premier clinical care center devoted to improving the visual health of all Kentuckians.

A lifelong academician, Thom was trained at the University of Illinois, the University of Florida and Washington University in St. Louis. Thom received training both as an eye specialist and as a pharmacologist, and he was widely considered to be the first formally trained pharmacologist dedicated to the research and development of ocular drugs. While still a graduate student, he began the experiments that led him to the development of timolol, a paradigm-changing eye drop that became the standard therapy for glaucoma for two decades. He refused to rest on his laurels. Thom’s career is stacked with similar accomplishments, including the development of novel laser techniques and surgical approaches to treat glaucoma. A highly sought-after lecturer, Thom delivered innumerable invited lectures all around the globe, racking up enough frequent-flier miles to visit Jupiter. Along the way, he published nearly 350 scholarly papers and wrote or co-wrote more than a dozen books. His magnum opus, the 895-page Textbook of Ocular Pharmacology, was published in 1997 to critical acclaim and stands today as the definitive reference in its field.

Perhaps Thom’s greatest contribution to medicine was in his role as teacher. During his lengthy career, which began at Louisiana State University (where he served as acting chairman his first year out of training!) before he moved to Louisville as chair in 1986, he trained more than 40 clinical fellows, who treat patients with glaucoma now on five continents. In his role as mentor he was consistently patient, gracious and supportive, and his teaching was always peppered with delightfully offbeat humor.

Summarizing his professional life is far easier that capturing the essence of Thom on paper. Thom was larger than life. With a passion for Versace, fast cars (he amassed an extensive assortment of collectible roadsters), and Kentucky’s own Maker’s Mark, Thom exuded personality and charisma, with more than a touch of flamboyance and self-aggrandizement. In some, such behavior would be tedious; Thom, however, raised it to an art form. To know Thom was to love him – because he wouldn’t have it any other way. Any equation with Thom in it was solved simply: if he was there, you wanted to be there with him.

Invariably at conferences, Thom could be found in the hallway or in the hotel bar, colorfully dressed in haute couture, holding court for hours at a time surrounded by colleagues – nay, fans – who felt fortunate just to be in his presence. His easy manner and engaging wit captivated those around him. Those of us who knew him well cherished every moment in his presence as a gift. We knew then, as we know now, that he was unique among us and that we will never see the likes of him again. As one colleague put it upon learning of his death, “I’ve lost my rock star.”

His passing at the obscenely young age of 66 will be mourned by his immediate family, of course: his wife Tinker, his daughter Jessica and his grandchildren Elsa and Maslin. But Thom’s extended families – and this includes virtually everyone whose life he ever touched – share their grief palpably. For us, the post-Thom world will go on, but it just isn’t as much fun as it used to be.

-Tony Realini, MD, associate professor of ophthalmology with the West Virginia University Eye Institute.
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THE UNITED STATES MARINES CORPS HAS PLAYED AN IMPORTANT ROLE IN THE LIVES OF MANY MEN AND WOMEN OF KENTUCKY.

Perhaps more important is the role Kentuckians have played in the history of the United States Marines. From Lt. Presley O’Bannon, who proudly carried our colors “to the shores of Tripoli,” to Lt. Col. Rich Higgins, who bravely sacrificed his life in his service in Lebanon, to the multitude of Kentucky Marines who have fought in “every clime and place” from the time of Tun Tavern and the Revolutionary War to the present engagements against terrorism around the world, the men and women of Kentucky have heard the call to arms and have responded in a fashion to make each of us proud.

In their honor, a group convened in Lexington, including a “Few Good Men” (and women) and their supporters and friends, at Keeneland on May 23, 2008. Veterans Day on November 11, the anniversary of the armistice ending World War I, marks an appropriate time to remember this event. The group gathered to support and celebrate the men and women of the United States Marine Corps who have over the history of this great country and to the present day sacrificed health, safety, convenience, comfort and family for the privilege of wearing the Eagle Globe and Anchor into harm’s way in support of our nation’s goals.

The “Legends of the Corps” event featured a number of distinguished guests, including General Al Gray, former (29th) commandant of the USMC, other general officers of other services and distinguished civilian leaders as well. The guest of honor was Col. Wesley Fox, USMC, retired, who was awarded the Medal of Honor (among numerous other combat awards) for his valorous service in Vietnam and Korea.

Veterans of all services, from both peacetime and combat, were present to honor these old heroes and the men and women who remain in uniform today, shoulder-ing the burden for all of us who continue our lives here at home.

The true guests of honor, however, were the young Marines, wounded in combat, recovering from those wounds, yet holding their heads high, proud to have served, proud of their service, proud of their country and their Corps, and thankful to be American. They were the focus of this event. As you know, medical care has been increasingly moved forward in combat zones, and the quality and speed of that care has increased enormously over the years. Injuries that once were uniformly fatal are now treated successfully, resulting in the survival of severely challenged (they would never say handicapped) young men and women. Additionally, these young people want to return to a full life and do not see that their injuries and losses, even though catastrophic, should keep them from enjoying a full and fulfilling life.

Continued on page 37

Larry Griffin, MD

To the Shores of Tripoli

Photos by Bill Straus Photography Inc., Lexington, KY
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Unfortunately, funds from Veterans Affairs, etc., only go so far in allowing and supporting this goal to full re-establishment as close to a normal life as possible.

The funds raised in this event went toward the Injured Marine Semper Fi Fund, an organization totally of volunteers that directs funds for the complete rehabilitation and return to active life for wounded Marines and members of other services injured in combat while serving with Marines. (I, of course, count Navy Corpsmen in Marine units as Marines, though other Navy, Army and Air Force personnel often serve with Marine units and are likewise subjected to combat injuries.)

I am proud to say that as a result of outstanding civilian and corporate support, as well as the support of the military community, more than $250,000 was raised, a goal that seemed somewhat improbable at the time, given the relatively small venue. A check for that amount has been delivered to the fund and will go a long way toward the rehabilitation of young Marines who sacrificed limb or function for our country’s goals. A list of donors, as well as photos from the event, may be viewed by visiting the MCCCK Web site listed below.

A number of physicians in this community contributed to this effort. Some of you have experience in the military. Many others of you have someone close to you in harm’s way. All Americans owe a debt of gratitude to all who have, presently do, and those who will serve.

We are not a country at war until all of us together support those who carry the fight forward. Until that happens, we are a military service at war with a country whose people use the excuse of not liking the war to avoid their commitment to the men and women who carry the load for them day after day. For those of you who have not contributed, I urge you to do so. Please send your tax-deductible check to the Injured Marine Semper Fi Fund, a 501(c)(3) tax-exempt organization, to the Marine Corps Coordinating Council of Ky., P.O. Box 355, Prospect, KY 40059. A receipt for your contribution for tax purposes will be sent to you in acknowledgement of your gift.

For more information about the Injured Marine Semper Fi Fund, you may visit the national Web site at www.SemperFiFund.org. You may also visit the Marine Corps Coordinating Council of Kentucky Web site at www.KentuckyMarines.org.

Note: Dr. Griffin practices Obstetrics/Gynecology with Women’s Care Physicians of Louisville.
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<th>Name</th>
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<td>Todd W. Vitaz, M.D.</td>
<td>Neurosurgery</td>
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<td>Stephanie A. Wagner, M.D.</td>
<td>Neuro-oncology</td>
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<td>Aaron C. Spalding, M.D., Ph.D.</td>
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