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Blackout Stories
Patti Bingham, CMM; Teresa McCammon, LPN; Robert William Prasaad Steiner, MD, PhD; Tina Yuan, MD

The tragic saga of ‘Typhoid Mary’
M. Saleem Seyal, MD, FACC, FACP, FRCPC, FAHA

Favorite Places
Teresita Bacani-Oropilla, MD; Deborah Ballard, MD; Mary Barry, MD; Jeremy P. Gerwe, MD; Thomas James, MD; Dave Langdon

An Ethical Dilemma
Barbara S. Isaacs, MD

The University of Louisville Health Care Policy on Vendor: Mitigating Conflict of Interest and Improving Education
David J. Doukas, MD
It is hard to believe that the holiday season is already in full swing. Even the bad economic news which has surrounded us these last three months has not slowed the coming season. In fact, it seemed to hasten its approach. With rising worries that none of us will be able to afford the high priced gifts purchased in recent years, merchants unveiled Christmas and Hanukah displays before Halloween was complete.

Regardless of its arrival date, the holiday season always brings with it the task of finding the “right gift.” I do not know how many of you subscribe to this concept, but it is a difficult one to achieve. Year after year, holiday after holiday, the quest to find that perfect gift continues. Each year, after the unwrapping is complete, you search faces to make sure that everyone is content, that the gifts were in fact “perfect,” and that all your hard work has paid off.

If you do subscribe to this concept, or know any of us poor souls who do, then you understand that it often seems to take a lot of money to achieve perfection. There is always some point during the holidays when I stop and wonder what people gave each other during the Great Depression to show the depth of their love and respect for each other. This holiday season, though, that seems an even more apt reflection.

What if there were no pennies to scrape together to purchase the new camera, video game, earrings, etc. that we think makes that “perfect” gift? What if, after years of working hard every day, we found that there simply was no money in the bank? What would that perfect gift become?

I have a feeling that without money to cover the search, the perfect gift might become even more precious, and even more difficult to give. I wonder if any of you have heard the statement I have heard so many times over the years: “I just want to spend time with you.” Often, in the midst of a busy practice, meeting with friends and acquaintances, and spending time on my hobbies, it is hard to figure out exactly where the time went. The requests for more time fall by the wayside, simply because there does not ever seem to be any extra to share.

Maybe, though, the “perfect” gift is not something that costs more money, or is bigger and better each year. Maybe it is simply giving yourself: giving your time – and maybe, just maybe, it is the hardest gift of all to give. Longfellow once said, “Give what you have. To someone, it may be better than you dare to think.” It might even be better than YOU dare to think.

Happy holidays to each of you.

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It is hard to believe that the holiday season is already in full swing. Even the bad economic news which has surrounded us these last three months has not slowed the coming season. In fact, it seemed to hasten its approach. With rising worries that none of us will be able to afford the high priced gifts purchased in recent years, merchants unveiled Christmas and Hanukah displays before Halloween was complete.

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Happy holidays to each of you.
Multi-tasking will not be surprising to learn this, but I was. We can't really multi-task. We just delude ourselves into thinking we are. All we do, the researchers say, is some guy about the tree removal bill another, faster and faster and faster and faster. Meanwhile we ride our bicycles and talking on your cell phone. You just checked again? Probably, because nowadays we expect so much information. We missed the flow of instant information from September because he never answered your text or your e-mail. While you were reading this, were you watching the ESPN ticker. We had no MSNBC. We were interrupting our concentration. We pay attention to every stimulus. We prioritize our attention to any one stimulus. Our ability to multi-task is a universal human characteristic to recognize how trivial much of that information is. But we keep it all straight? There is only one focused concentration. We pay attention with a vengeance. But the effort of concentration takes its toll.

Doctors have insatiable curiosity. They must constantly switch and turn back and forth from visual processing to language processing. When they find is that we can do this, we get faster and faster and faster, but at the expense of remembering what it was we just did, because we were concentrating so hard on getting it all done. They wonder how many other things I was concentrating on, that day in 2006. My life was separated and isolating, each of us toast the absent, and quiz the nephews. Perhaps I was just depressed at the state of Cardinal basketball that winter, or perhaps, because it was In The News that I'd been diagnosed by the resident, teach the resident, talk to the family, talk to the pharmacist; round on the next one; repeat. And repeat. And repeat. Meanwhile we are interrupted, paged, texted, and distracted by CNN in the patient rooms with its pictures of California wildfires, the war in Mosul and 97-yard punt returns. How do we keep it all straight? There is only one focused concentration. We pay attention with a vengeance. But the effort of concentration takes its toll.

As you read this, are you watching the weather channel? The blackout in September was a rude awakening for many of the electronically-attached. We, admittedly are still to have roofs over our heads, had no electricity, had no heating, had no running water, had no sewage in our basements and mostly incredibly lucky not to have 10 feet of snow. Pundits decry the rise of the celebrity culture, the critical mass of obsession with Britney et al. I think “obsession” should be reserved for the future of our nation. On the other hand, finding out that Joe the Plumber owed back taxes made my day.

Those of you more up-to-date than I was hemodynamically stable, he was happy not to be good to go. He was happy not to be admitted, whereas I was shocked that I'd missed the bad news that he'd need admission. But when I checked the hospital EMR, lo and behold, he'd been diagnosed by the resident, teach the resident, talk to the family, talk to the pharmacist; round on the next one; repeat. And repeat. And repeat. Meanwhile we are interrupted, paged, texted, and distracted by CNN in the patient rooms with its pictures of California wildfires, the war in Mosul and 97-yard punt returns. How do we keep it all straight? There is only one focused concentration. We pay attention with a vengeance. But the effort of concentration takes its toll.

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Multi-Merrying

Those of you more up-to-date than I am will not be surprised to learn this, but I was. We can’t really multi-task. We just delude ourselves into thinking we are. All we do, the researchers say, is switch our attention from one thing to another, faster and faster and faster and faster.

As you read this, are you watching YouTube or The Tube or riding your stationary bike and talking on your cell to some guy about the tree removal bill from September because he never answered your text or your e-mail, which you just checked again? Probably, because nowadays we expect so much from ourselves that there is never enough time to do too little. We only have enough time to do too much.

The blackout in September was a rude awakening for many of the electronically-attached. We, admittedly are incredibly lucky not to have 10 feet of sewage in our basements and mostly still to have roofs over our heads, had no ESPN ticker. We had no MSNBC. We missed the flow of instant information, recognizing how trivial much of that information is – but still we missed it.

One of my favorite characters of all time, Lucia in E. F. Benson’s novel “Make Way for Lucia,” used to greet her friends excitedly with the query, “Any news?” It is a universal human characteristic to gossip. The urge to know is unquenchable. The urge to share that knowledge, ditto, or we would still be inventing wheels of stone. Pundits decry the rise of obsession with Britney et al. I think “obsession” should be reserved for issues of greater merit, such as the future of our nation. On the other hand, finding out that Joe the Plumber owed back taxes made my day.

Doctors have insatiable curiosity and need endlessly to accomplish. We must see the patient, register and organize the data in our memories, analyze, ponder and decide. Then we write the orders, call the consultant, do the procedure, teach the resident, talk to the nurse, talk to the family, talk to the pharmacist; round on the next one; repeat. And repeat. And repeat. Meanwhile we are interrupted, paged, texted, and distracted by CNN in the patient rooms with its pictures of California wildfires and stolen children and bombings in Mosul and 97-yard punt returns. How do we keep it all straight? There is only one way: constant, unflagging, acutely focused concentration. We pay attention with a vengeance. But the effort of concentration takes its toll.

Neuroscientists say that we have “executive processes” that order and prioritize our attention to any one stimulus. We must constantly switch and turn back and forth from visual processing to spatial processing to auditory processing to language processing. When they study us in the PET and MRI, what they find is that we can do this, we get faster and faster and faster, but at the expense of remembering what it was we just did, because we were concentrating so hard on getting it all done.

Got that? Or were you instant-messaging? We are becoming a nation, especially if we are under 25, of people who have heard of everything current but may recall very little of the past. Why should we, they say, we have it digitized.

Patient care has changed since digitization. Some doctors type on the laptop while taking the history. I can write and take a history simultaneously, but typing? Would I ever get to look at the patient’s face again? Every note might have that computer-generated, needless wordiness that meets every bullet point for insurance billing, but hides any “news” in the onslaught of verbiage. (I would have to learn to type the numbers without looking, too, and find out later that I had recorded a blood pressure of 732/55.)

Last week I found to my horror that I had forgotten an entire admission for one 87-year-old man. He came into the office with rectal bleeding and since I had failed to record that colonoscopy in my paper office chart, I had to tell him the bad news that he’d need admission. But when I checked the hospital EMR, lo and behold, he’d been diagnosed by scope in February 2006, and since he was hemodynamically stable, he was good to go. He was happy not to be admitted, whereas I was shocked that I’d forgotten. Mostly I don’t forget things like that, or at least I didn’t used to. So I wonder how many other things I was concentrating on, that day in 2006. Perhaps I was just depressed at the state of Cardinal basketball that winter, or perhaps, because it was In The Computer, I forgot. “Letting the computer remember” is the first step towards cognitive sloth: we must resist the machines.

Yet some of the machines are so much fun. Their power is seductive. They amuse us and alarm us, spread both truth and lies, bring instant life (grandchild picture on the cell phone) and instant death (IED detonation). They connect us across unfathomable time and distance, yet our enjoyment of them is separate and isolating, each of us absorbed by our own little device.

At Christmas when we gather the clan, toast the absent, and quiz the nephews on the merits of individual BlackBerries, we might remember the coziness of the September blackout, the conversations with neighbors, the life out in the street instead of in front of the flickering tube. We must not, dependent as we are on the machines, let them become the master. 

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Blackout Stories

When Hurricane Ike struck the Gulf Coast in mid-September, it produced winds that made mince-meat of hundred-year-old trees in Cherokee Triangle and downed power lines all over the city of Louisville and its surrounding areas. The sun was out and there was no sign of rain, but the wind did plenty of damage as church-goers were getting back from morning worship on Sept. 14. By that evening, hundreds of thousands of Louisville residents were without power. Physicians in the east end, the Highlands and everywhere in between were without power both at home and at work when they reported Monday. Some didn’t get their power restored until nearly two weeks later. In the meantime, many gained a new appreciation for electricity, their neighbors and their colleagues as they pitched in where they could to help others clean debris, salvage refrigerated food and keep their medical practices going on battery-operated light. Below are some stories physicians and their medical staff members shared with us about the days the stoplights, porch lights and hospital hallways of Louisville went black.

Handling appointments and paperwork, ‘old school’ style

Ironically, a tree fell and cut all power in the front office but the back office (Clinical Area) had power. We were able to save immunizations and see patients comfortably. Luckily, our phones worked. We just had to handle all appointments and paperwork “old school” style. We had no power for seven days. Our little patients were taken care of but the claims had to wait. Thank goodness for the sunny weather.

Teresa McCammo, LPN
Practice Manager, Kids R Great Pediatrics in New Albany

My Neighborhood Response

I live in the greatest neighborhood with the best neighbors...

On the day of the windstorm, many in my Highlands neighborhood were out cutting downed branches while the winds were still blowing. There was no rain - it seemed so unusual. We knew immediately who on the street had major structural problems with their homes from fallen trees and branches. We were all empathetic, and some a bit frightened.

When we knew we were without power, one neighbor called out for a potluck dinner for our block. We would start at 6:30 p.m. It is something that we do at least once each year, and others have annual seasonal parties. We were ready and unashamed. “Shoot, this could turn out to be a fun time,” I thought to myself!

They set up chairs and tables in the street near the curb. We usually have such events at the end of the street on the turn around, but it was blocked by trees and downed power lines. So they set up in the street - almost in front of my house. Varieties of food and drink came from everyone. While there was still sunlight, those with gas stoves brought out their home cooking. Others with store-bought foods for another occasion anted up what we could. We did not expect much traffic, since power lines and trees blocked easy access on the crossroad too.

We had a feast that went into the darkness on the street in front of my home, as the remnants of hurricane Ike moved to the northwest. The storm, loss of power and isolation was a cause for a get together, in the neighborhood where I live. It was a most pleasant and memorable event, at least in the beginning.

Robert William Prasaad Steiner, MD, PhD
Cat bites and flashlights

I worked at our Prospect office on that Monday. There was a lady who walked in with a severe cat bite. The cat never bit anybody in the past. But she got wild on Sunday night when there was no power. We had to clean her wound with two flashlights in the exam room.

Tina Yuan, MD

Cell phones to the rescue

We’re a Peds office. We made the assumption that there were some patients in the city who did not lose power and would possibly assume that we would be here to see their children. We were right; we did have some patients show up. Our answering service still had power so our phone calls were forwarded to three cell phones. Boy, did we rack up some cell minutes. We had no lights so we used flashlights and battery-operated otoscopes to see patients. We had two staff members stationed on the first floor of the building to offer patients the opportunity to reschedule or to escort them to the second floor.

On the second floor they were met by another staff person to escort them to the waiting rooms lit with battery-operated lanterns and windows with opened blinds. We could not administer any vaccines - which were removed from the premises on Sunday evening to one of the doc’s homes, where the refrigerator was being powered by a generator. (On the third day, Tuesday, worried about the refrigerator temp, we retrieved our vaccines: her refrigerator died within the hour of retrieval). We could still do some limited testing (i.e., urine dips and strep tests).

Oh, and did I mention that we have electronic medical records? Amazingly, we remembered how to use paper! We did a lot of cleaning (had to get those dust bunnies hiding behind computers, etc.) and restocking. It was chaos at first but we made it through the first day. The second day we were still without power but had learned many lessons the day before which made expectations and operations much easier. Finally the power returned in the late afternoon of the second day. However, we were still without phones for another day - cell phones to the rescue! We had patients comment as to how dedicated we were. We feel so fortunate to have such a dedicated group of physicians and staff!

Patti Bingham, CMM
All Children Pediatrics, PLLC
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The tragic saga of ‘Typhoid Mary’

The phrase “Typhoid Mary” connotes a woman scorned and polluted, full of contagious bacteria, a reservoir of inexhaustible infectious agents (in this case typhoid bacillus) and a generally filthy, unkempt cook who willfully infects others through her cooking. This pejorative moniker is permanently associated with an Irish immigrant to America by the name of Mary Mallon who landed in New York near the end of the 19th century as a parent-less, bewildered and destitute teenager. After going through the mandatory and expected travails of a newly-arrived impoverished immigrant, she eventually became an itinerant cook who worked in the kitchens of the well-to-do families in New York for short periods and changed her cooking job locations frequently. Unbeknownst to her, at least initially, she was cursed with being a “healthy carrier” of typhoid bacillus and transmitted the disease to her co-workers and many members of several households she worked for, some of whom developed the full-blown disease. After a determined health investigator traced several outbreaks of typhoid fever to her as the culprit for spreading the disease, she was captured, forcibly restrained and incarcerated. All kinds of indignities were inflicted upon her and she was eventually kicked out of New York City and ended up living the rest of her miserable life in virtual seclusion on North Brother Island.

Much has been written about Typhoid Mary, an appellation that has stuck with her name, much to her chagrin at the time. These accounts include books, essays, sensational newspaper and magazine articles, works of fiction (novels, comics, plays) and a Public Broadcasting Service movie (“The Most Dangerous Woman in America”). Judith Walzer Leavitt’s book, “Typhoid Mary - Captive to the Public’s Health” is a thoroughly researched book primarily dealing with her incarceration and the troubling issue of civil liberties and public health. Another, “Typhoid Mary - An Urban Historical” is a beautifully written account that I enjoyed immensely, written by the quirky New York chef at the Brasserie Les Halles, Anthony Bourdain. He is the star of a great show, “No Reservations” on the Travel Channel about sampling and savoring the culinary delights of the world and proclaims that, “I write, I travel and I eat—and I am hungry for more.” Bourdain is mainly interested in Mary Mallon the cook, a tormented woman in a hostile man’s world. The book is a sympathetic account of Mary’s life, which is a tribute “from one cook to another.”

Shrouded in mystery, the early life of Mary Mallon remains largely unknown except that she was born in Cookstown, County Tyrone, Ireland, about 1869. At the age of 14 she came to America, in steerage, in search of a better life. She started her young life as a cook in New York.

A wealthy banker by the name of Charles Henry Warren had rented an immaculate house during the summer of 1906 in the affluent community of Oyster Bay, Long Island for his family’s vacation. He had brought several maids and a cook along. Mr. Warren’s daughter fell ill and was diagnosed with typhoid fever. This was quite unusual because typhoid, by the then conventional wisdom, was associated with poverty and filth. In rapid succession several other family members, two maids and a gardener, fell victims to the disease. Negative publicity for this retreat for the New York elite would have been very undesirable and the owner, George Thompson, sought help from local health authorities and other experts since no case of typhoid had ever

“I have been in fact a peep show for Everybody even the Interns had to come see me and ask about the facts already known to the whole wide world---

- Dr. Parks has even had me illustrated in Chicago… I wonder if he, Said Dr. Wm. H. Park, would like to be insulted and put in the journal and him or his wife called Typhoid William Park.”

(Reproduced exactly as it was written by Mary Mallon in her affidavit)
been reported there in the past. After thorough investigation, which included analysis of drinking water, examination of the toilet, outhouse, manure pit and the cesspool, no source of infection could be found. Finally, a New York “sanitary engineer” by the name of Dr. George Soper (not a medical doctor) was consulted. Soper embarked upon a comprehensive evaluation including the names of all visitors and full review of the findings of other experts. He immediately zeroed in on the mysterious cook, a Mary Mallon who was hired as a replacement but had left hurriedly without any notice about three weeks after the sickness in the household commenced. She was described as a 40 year old, tall, buxom blonde with blue eyes who was a good cook, if somewhat unkempt, and not easy to talk to. Poring over her employment records, he soon discovered, to his amazement, that without exception, there were outbreaks of typhoid wherever Mary Mallon was employed!

Dr. Soper, the self-appointed medical sleuth, was onto something and he toiled doggedly to find this culprit. His break came when an incident of typhoid was reported in a household in New York City’s Park Avenue in March of 1907. Several family members were stricken with the disease and a young daughter was near death. The cook working there fit the description of Mary Mallon. He immediately rushed over to the said house and, in his uncontainable zeal, approached the accused cook in her kitchen. He hurriedly pronounced his suspicion that she was making people sick and asked her, in front of her co-workers and the lady of the household, to provide him with samples of her blood, urine and feces. This was not a great way to start the very first meeting! Thereupon Mary understandably flew into a rage and as Soper wrote later in his famous pamphlet of 1939 entitled, “The Curious Case of Typhoid Mary”:

“… She seized a carving fork and advanced in my direction. I passed rapidly down the long, narrow hall, through the tall iron gate, out through the area, and so to the sidewalk. I felt rather lucky to escape. I confess to myself that I made a bad start. Apparently Mary did not understand that I wanted to help her.”

Continued on page 17
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Continued from page 14

Soper went away empty-handed but unharmed and Mary was petrified, angry and defensive since he had accused her of being a killer. She reportedly insisted, according to another conversation outside the house, that she had never had typhoid fever and that she couldn’t possibly spread the disease. Soper on the other hand was quite confident that she was a killer and a menace to society and had to be put away. He tried to talk to her once again on another day but to no avail. He followed her one night from her place of work to her residence in a seedy part of town where she apparently shared an apartment with an alcoholic man by the name of Breihof. Soper now clandestinely befriended Breihof and bought him much-craved alcohol to get information. One evening, with Breihof’s acquiescence, he and an accomplice waited patiently for Mary to return. This intrusion and confrontation bore no fruits for Soper but did make Mary angrier and more paranoid. Acknowledging his failure as a detective and negotiator, he approached the commissioner of the New York City Health Department and recommended that Mary be arrested immediately. He gleefully wrote in his pamphlet:

“I called Mary a living human culture tube and chronic typhoid germ producer. I said she was a proven menace to the community. It was impossible to deal with her in a reasonable and peaceful way, and if the Department meant to examine her, it must be prepared to use force and plenty of it.”

The initial overture of the health department was to dispatch a woman physician by the name of Josephine Baker to talk to Mary. She was rebuffed. The next day, however, Dr. Baker arrived in a horse-drawn ambulance with four burly police officers and approached the house. On seeing the arresting party, Mary bolted, and the search was on. It lasted for three hours since Mary was hidden by a sympathizer. Eventually she was caught and placed in the ambulance, all the while kicking, screaming and spewing obscenities. Dr. Baker literally had to sit on her, restraining her with the help of several police officers. Mary Mallon, an impoverished Irish immigrant, was now officially a prisoner. Her American Dream had shattered completely. She was confined to a stark room at the Willard Parker Hospital, and to add to the humiliation, the required specimens were duly procured and the stool analysis revealed a “pure culture of typhoid bacilli.”

With Mary safely ensconced in the hospital, Dr. Soper paid a visit to suggest to her that she should get her gall-bladder surgically extirpated. He explained that he also wanted to write a book about her fascinating case, and promised that she could have all the profits in return for full disclosure as to when she contracted typhoid fever and how many people she had infected. Mary completely refused the offer and Soper went away empty-handed again.

In 1907, Mary Mallon was banished to North Brother Island east of Bronx, New York, in a small house near the Riverside Hospital that had been built hastily for the typhus patients in 1885. It was curious that her civil liberties were yanked away from her without indictment, trial or conviction. Journalists flocked to the island to get her story. She was given the horrible moniker of “Typhoid Mary” although some sympathetic accounts were written about her as well. Fifty other persons were designated as healthy typhoid carriers in New York State alone at that time, but Mary was the only one imprisoned. She remained in that dismal state at the island for two years and became “so prostrated with grief and trouble… that my eyes began to twitch, as she wrote in her affidavit for habeas corpus when she appeared before the court in 1909. Despite sympathetic media coverage and impassioned pleas by Mallon’s attorney, the court however decided in the health department’s favor and Mary Mallon went back to her sorry cottage, despondent, angrier and bitter. In 1910, the new health commissioner took pity on her and abruptly released “that unfortunate woman.” She was simply asked to uphold personal cleanliness and refrain from preparing food for others. Upon her release, she remained extremely bitter towards the people who ruined her life and decided to file a lawsuit against the city and several doctors connected with the case. The lawsuit, however, never came to trial and was dropped. She also went back on her promise to the health department, failing to report periodically as directed, and simply went underground. She worked briefly as a laundress but eventually returned to the profession she knew best—cooking—under different aliases, and for the next five years drifted from place to place. By that time she knew for certain that she could spread the disease and probably out of bitterness and spite, simply did not care anymore.

In 1915, an outbreak of typhoid was reported at the Sloane Hospital for women and Mary Mallon was squarely found to be associated with the outbreak. She was apprehended without resistance this time, and was returned to North Brother Island where she lived for another 23 years, resigned to her fate. During that time she worked in the
laboratory at the Riverside Hospital and in 1918 was allowed to make unsupervised trips to New York. She was known to have periodic spells of uncontrollable rage and was described by one journalist as “a moody, caged, jungle cat.” In December 1932 she didn’t show up for work and was found to have suffered a severe stroke. After five more years of living as an invalid, she died on Nov. 11, 1938, and was buried in St. Raymond’s Cemetery in the Bronx. It is worth noting that Mary’s total body count was 53 infected individuals with typhoid fever and three confirmed deaths, but her notoriety and the punishment she received was quite disproportionate to the disease and death for which she was held responsible. In fact, at the time of her death in 1938, there were 237 other healthy typhoid carriers living in New York under health department observation who were otherwise free citizens.

The sad and harrowing story of this poor immigrant was the source of fierce debate regarding individual liberty and freedom on the one hand and the power of the health establishment on the other hand, to take that liberty away from an individual considered to be a menace to society. It is to be noted that Congress had passed the Pure Food and Drug act of 1906 which had resulted in clean water, non-contaminated dairy products, newer and better kitchen appliances and better waste disposal systems. Sick immigrants and those suspected of infectious disease were routinely detained and quarantined or deported to avoid the spread of disease on American soil. This debate, in a modified form, still rages on. The specter of immigrants as a source of contagion has been with us for a long time and still persists, and is thoroughly documented in a superbly-researched book, “Silent Travelers—Germs, Genes and the “Immigrant Menace” by Alan M. Kraut. Examples include the following: HIV/AIDS afflicting the Haitian refugees who were forcibly held in Guantanamo Bay, the case of Chinese who were considered to be responsible for the bubonic plague epidemic in San Francisco, and the Jews were thought to be the carriers of tuberculosis. More recently the presence of drug-resistant strains of tuberculosis among immigrants from sub-Saharan Africa and Southeast Asia has been scrutinized. Was Typhoid Mary persecuted because she was a woman, because she was a cook, because she was unrepentant, or because she was Irish, an ethnic group that was unwelcome at that time? We will never know exactly why this one woman was singled out to receive such harsh punishment and endure scandalous publicity.

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Whether it’s a faraway exotic locale, a spot in your backyard or a distant memory, everyone has a favorite place or places. With the cold weather setting in and the rush of the holidays upon us, the Greater Louisville Medical Society’s editorial board thought it would be a good time to share with you our favorite places.

Deborah Ballard, MD

One of my favorite places is right here in Louisville, Kentucky. I have loved going to the Speed Art Museum since my days as an undergraduate student at the University of Louisville. I still go there often and always come away feeling inspired and uplifted.

When I came to the University of Louisville in 1980, I had zero discretionary income. I remember how my equally impoverished roommate and I literally scraped our change together to make enough money for a McDonald’s Happy Meal once weekly. Needles to say, we did not go out much.

One place I could go for free was the Speed Art Museum. To a country girl, it was the grandest place I had ever seen. I was awed by the marble foyer, the twin staircases, the ancient artifacts, and the dignified docents. Like many an art student before me, I spent quiet afternoons sitting on the cool marble floor copying the great masters’ works. I still feel transported to another era when I enter The English Renaissance Room and the Tapestry Room. I find it is almost magical to look at the Syrian female statuette that was carved 2000 before Christ, or the Egyptian jar thrown by a potter 2000 years even before that.

Most of all, I am overwhelmed by the beautiful paintings. To this day, I remain amazed that pigments laid down on canvases hundreds of years ago by skillful and meticulous human hands can still be so vibrant. You can almost see George Peter Alexander Healy tatting the lace on Sallie Ward’s blue dress (1813-1894) and taste the juicy raspberries and peaches so brilliantly rendered by William Mason Brown (1828-1898).

Medical school did not allow much time for museum going. However, after my first son was born during my fourth year, and I often took him to exhibits for children there. I cried years later when I read one of his college papers. For psychology class, he wrote about a positive early childhood experience. He described the day that he and I spent at the Speed visiting an exhibit about Babar the Elephant (Jean and Laurent de Brunhoff-1931-2003). He was perhaps three or four years old at the time. I remember sitting on the floor there with him in my lap, reading, as his little finger pointed to the delicate pastels. I was so pleased to know that the day stayed etched not only in my mind, but also in his as a very happy memory.

Over the years, I have attended numerous exhibits and events at the Speed. I especially loved the Man Ray exhibit, the Portraits exhibit, and the Impressionist exhibit. I have been there for After Hours and lectures. It always feels like coming back to a familiar old friend.

Last year, I took a drawing class there and was delighted to find I could still render an accurate likeness and remembered how to shade and use proportion.

Recently, I attended a truly wonderful lecture at the Speed titled “Monet in Normandy.” Many of us in the audience shed tears to hear how Monet’s work was forever changed by the loss of his beloved muse, model, and wife, Camille. Before her death, she was a constant figure in his paintings. He even painted her on her deathbed—one last heartbreaking attempt to preserve the bond he held with her through his art. After she died, decades passed before he would paint people again.

I love the Speed Art Museum. I am glad to know plans are in the works to expand it, employing the most gifted architects the world has to offer. It is a delightful place, full of happy memories for me. It is a great place to nurture your inner artist, learn about history, and expose your children to great art, old and new.

Dave Langdon, director of public affairs for the Metro Louisville Department of Public Health and Wellness

One of my favorite places in the world is the Art Institute of Chicago. As a teen and a young adult the Art Institute was the one place where I could just “hang out.”

Now when I go home to Chicago, I stop by the Art Institute to visit old friends and familiar places. I might do a little finger-picking with Picasso’s The Old Guitarist. In my younger days, I used to stand near him and strike up conversations with attractive young women by pointing out the under-painted heads that were barely visible. Maybe I’ll stop by to see the grimly determined van Gogh’s Self-Portrait in his Bedroom at Arles. I’ll peer into the eyes of those gaunt Midwesterners in Grant Wood’s American Gothic with that far-away look that I’ve also seen in the eyes of so many of my relatives. I’ll swap quotes from The Little Red Book with Andy Warhol’s Mao, who takes me back to my youthful experimentation with radical politics.

In many ways visiting the Art Institute now puts me back in touch with my deceased mother. A high school graduate and housewife most of her life, my mother answered an ad in the Chicago Tribune in the mid-1970s and got a job there to put her fifth child through college. Today the position that she held requires an MFA degree.

The Art Institute of Chicago remains a place that puts me in touch with my deeper self. To paraphrase Picasso, it is a place where I can wash the dust of daily life from my soul.
Mary Barry, MD,
editor of Louisville Medicine

Mother taught us to bird-watch. As children we walked the top of the floodwall from Brewer Avenue all the way to Chickasaw Park, daring each other to jump from the highest parts and laughing at the barriers that sat uselessly atop the wall. I remember my first scarlet tanager flashing past, shining so in the June sun that I almost lost my balance.

Nowadays we stay down low, on the Shawnee Riverwalk, the perfect chigger-free birding path. Early on Sunday mornings the bikers sail silently past as we stare out toward the water. In the spring and fall it is warbler heaven: we are looking mostly down or straight ahead, and not straight up into the canopy of green. At Bernheim we have to crank our necks to strain our eyes overhead, but on the Riverwalk our lines of sight are kinder. The bikers recognize the trances we go into (standing stock-still in the middle of the path, binoculars fixed, muttering “Show me your HEAD dammit, do you have stripes?”) and they’ll call out before we’re mowed down. The golfers arrive about eight or so, and as they hit their drives we hear the satisfying twack.

The “milk bottles” of my youth are still there on the Indiana side. The river smells the same, the current runs fast and high in the spring, and if we are lucky we will hear kingfishers flying down the bank.

Looking through binoculars spoils the ordinary view of life. We see everything in hi-def. When you bring your glasses finally down for the day, you lose the incredible clarity, the crystal brightness of beautiful detail, and your heart breaks a little every time.

Jeremy P. Gerwe, MD

At about 9:15 am on a Saturday morning you may find me stumbling slowly with a slightly antalgic gait and a broad beaming smile, trying desperately to make it to the car. Believe it or not I love those moments! Unfortunately anymore though, with my life as a resident, my schedule keeps me here in Louisville and only rarely back home in Milford, Ohio with my parents.

However, if the opportunity does arise, I love to work out with my dad who is now 51 years old. Even at that age, years of dedication to lifting and physical activity have kept him in shape and able to out-lift and out-work me and most people I know. For some odd reason, a strange sensation of painful pleasure consumes me after those workouts. Perhaps it’s the sense of accomplishment along with the endless supply of endorphins pumping through my veins that keeps me longing for the next workout. Perhaps it’s simple that I’m an “adrenaline junkie” if you will. Nevertheless, after that hour or so, I see things more clearly, and my mind seems sharper and keener. While physically gingerly bridging the parking lot, my mind is soaring with sun as it breaks through the morning skies.

Here in the ‘Ville, I miss those moments, and over the years I’ve been resigned to fly without the jump start of a lifting partner. Fortunately though I have discovered that it only takes a four mile run, an eight to ten mile bike and a half mile swim to recreate one of those mornings back home. Endurance training has become a new hobby of mine and now the steaming halo I wear leaving the Mary T. Meagher center is my crown of accomplishment and sign of a great workout.

While I still never pass the opportunity to get to Cincinnati for a Saturday morning, it’s nice to know that no matter where I happen to be, I can always find some way to satisfy that mysterious urge to expend myself.

Teresita Bacani-Oropilla, MD

During World War II, the Japanese invading army reached the shores of a sleepy town on the Philippine Pacific coast called Manay. My father, then a government official, was sought after so he evacuated our family inland towards the mountains. At the edge of the jungle we farmed and lived among the indigenous native Mandayans to sit out the war.

One of my chores was to fetch our working carabao (a water buffalo) from the pasture on a hill at day’s end. On one of these days, the sky was aglow with reds and purples against the deep blue of the mountains. The Casauman River silently wound its way between a pristine jungle in the valley below. Muted drum beats from a distant celebration faintly echoed through the trees. The air was cool and sweet as I inhaled and beheld all this beauty. To a budding adolescent still unfettered by the burdens of the world, and full of hope for the future when the war would end, that was the most beautiful and peaceful spot in God’s creation. It still lingers as a precious treasure in my memory.

Thomas James, MD

Like many physicians in-training, I spent my college years focused on science courses. Medical school time was devoted to basic sciences and clinical rotations.

So as a resident in Philadelphia, I felt the need to expand my interests beyond that of medicine. I began auditing literature and art history courses at night at the University of Pennsylvania. Philadelphia offered a wealth of art museums from the Rodin Museum to the Museum of Art (made infamous as a training station for Rocky Balboa). But my greatest respite from the toils of night call came with periodic trips to New York’s Museum of Modern Art. The train rides to the Big Apple were frequent enough that as a resident I invested in membership in MoMA to save on the admission costs. I enjoyed wandering the galleries, listening to the docents and art devotees describe various works over the past two centuries. Brilliant colored Fauves, warm Impressionists, mind-bending masters of Dada, and campy Pop/Op art greeted my every visit.

Now, decades later, I visit New York much less frequently. I no longer have my membership in MoMA—but whenever I visit the city, I do try to get to this oasis. Not only do these rarer trips allow me to visit with my old friends that grace the walls of the Museum of Modern Art, but it also carries me back to a more straightforward time. MoMA continues to be my destination of choice.
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An Ethical Dilemma

Barbara S. Isaacs, MD

One of the charges of the Bioethics Committee of the Greater Louisville Medical Society is to educate ourselves and our community regarding issues of medical ethics. In that spirit, we are beginning a series of articles in *Louisville Medicine* discussing various real ethical issues encountered by members of this committee, many of whom serve on the ethics committees of our local hospitals. As a committee, we are interested in your comments and feedback on this article as well as future ones in the series. Do you like the format? Are there specific issues you would like to see discussed?

The case:

On a pleasant Saturday afternoon (in my experience and for some unknown reason, almost all ethics consults occur at night or on weekends or holidays) in June, the ICU nurse called on behalf of Dr. Isabella Help, requesting an ethics consultation. Mr. Ben Weezin is a 66-year-old gentleman with oxygen-dependent COPD in the ICU, with runs of ventricular tachycardia, in spite of multiple trials on anti-arrhythmic medications. He had been cardioverted several times during this admission. He had refused to have an implanted defibrillator and he wanted to go home to die. His adult children wanted him to stay in the hospital.

The doctor was frustrated. He wanted the patient to take advantage of everything 21st century medicine and the latest technology had to offer. He did not know what to do when the patient said he wanted to go home to die. He explained to the patient that the runs of ventricular tachycardia were becoming longer, and would eventually prevent his heart from pumping adequate amounts of blood to his brain and his body. He would die without therapy. The patient said he knew that and that was okay with him. He was ready to die.

The nurse had talked extensively with the patient and felt he knew what he was doing. Mr. Ben Weezin was quite frustrated with all the people in the hospital (doctors and nurses and therapists) who wanted to “do things.” He was tired of “being fooled with.” He really was ready to die. He knew the medications he had taken were not helping his arrhythmia. He knew his COPD was not going to get better. He knew that he did not want to be shocked again. He knew he was extremely weak before the hospitalization and continued to be so.

The nurse had already suggested a psychiatry consult, and by the time I had called, the psychiatrist was in the room evaluating the patient. I asked the nurse to call me back after the psychiatrist was through. The psychiatrist determined that the patient knew exactly what he was doing and was aware of the consequences.

The patient’s wife was unhappy, but supportive of his decision. The children said they would help take care of him at home. However, they knew CPR, and promised to bring him back to the hospital if he arrested at home.

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As the ethics consultant what would you do? Pick as many as you feel are appropriate:

1) Send him home and let the children take care of him and bring him back when he arrests.
2) Help him to make out a living will and assign a healthcare surrogate before leaving the hospital, keeping one copy in his chart and the other in his wife’s purse.
3) Get him oxygen and a hospital bed for home.
4) Get palliative care and/or hospice involved.
5) Make him sign a “leaving against medical advice” form.
6) Have him fill out a Kentucky Emergency Medical Services Do Not Resuscitate Order to take home, so that the EMS would not resuscitate him against his wishes if they were called to the home.

Discussion:

1) Send him home and let the children take care of him and bring him back when he arrests.
This answer is clearly the wrong answer. Most ethical issues are not clear cut. However, doing something (bringing him back to the hospital for treatment he does not want) that is clearly against the patient’s wishes is not the proper choice. The patient has the right of autonomy and can decide his own fate. Mr. Ben Weezin has decided he wants to go home to die. It is not his children who have the right to make this choice for him. Furthermore, if Mr. Ben Weezin is unable to make his own decisions and has no living will or other advance directive, it is his wife who is legally recognized as the decision maker on his behalf, not his children.

2) Help him to make out a living will and assign a healthcare surrogate before leaving the hospital, keeping one copy in his chart and the other in his wife’s purse.
These documents would be quite helpful to Mr. Ben Weezin. They would outline clearly what treatment Mr. Ben Weezin wants, and, more importantly, what it is that he does not want. Appointing a healthcare surrogate would give someone the power to make decisions on his behalf if he cannot do so himself. A healthcare surrogate is supposed to make decisions keeping in mind the wishes of the patient.

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3) Get him oxygen and hospital bed for home.

4) Get palliative care and/or hospice involved.
   Both of these answers (3 & 4) cover the same message. Mr. Ben Weezin does not want to stay in the hospital. Neither does he want a defibrillator. What he does want is to be able to live out his days at home as comfortably as possible. A hospital bed, oxygen, and medications for air hunger would all alleviate some of his suffering. He has never said he does not want any care. He has said he does not want artificial prolongation of his life.

5) Make him sign a “leaving against medical advice” form.
   If you make Mr. Ben Weezin sign this form, his insurance will probably not pay for the admission. It is true that Mr. Ben Weezin has told Dr. Iwanna Help he does not want the implanted defibrillator. But he did not tell Dr. Iwanna Help to stop caring for him or to quit administering his other medications. He has continued his oxygen and bronchodilators and everything else. He just declined one type of therapy.

6) Have him fill out a Kentucky Emergency Medical Services Do Not Resuscitate Order to take home, so that the EMS would not resuscitate him against his wishes if they were called to the home.
   In the state of Kentucky, there is now a law stating that if you have this EMS-DNR form (downloadable from the GLMS website) properly filled out or are wearing the bracelet, EMS will not resuscitate you. This form is used for nursing home patients as well as persons living in their own homes.

The resolution of this case:

The patient did have a living will, healthcare surrogate form and an EMS-DNR form filled out before he left the hospital. A copy of these documents was placed in the chart. Another copy was put in his wife’s purse, where she could hand the EMS-DNR form to the EMS if necessary. Oxygen, a hospital bed, and home medications were arranged for by Dr. Iwanna Help.

Please contact GLMS staff member Donna Jones with your feedback on this article. She can be reached by e-mail at donna.jones@glms.org or by phone at 502-736-6308.

Dr. Isaacs chairs a local hospital ethics committee and serves on two other ethics committees including the GLMS Bioethics Committee.
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NOTE: GLMS members’ names appear in boldface type. Most of the above references have been obtained through the use of a MEDLINE computer search.

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The University of Louisville
Health Care Policy on Vendor: Mitigating Conflict of Interest and Improving Education

David J. Doukas, MD

Life is often about timing. The University of Louisville is no different. After a two and a half year journey to come to grips with a policy addressing key aspects of conflict of interest in our academic medical center, external forces joined together to influence the unanimous passage of this important new policy. Outside of Louisville, the American Medical Student Organization has been a vocal opponent of industry influence in academic medicine. AMSA launched the PharmFree Campaign in 2002, in which academic medical centers were assessed for their policies (or lack thereof) regarding conflict of interest in vendor relationships, and issued a web-posted “report card” with Grades A to F based on containing and/or lessening industry influence. Of note, the University of Louisville (until recently) garnered an “F” grade by having no policy in this regard, nor one in process. The American Association of Medical Colleges similarly has been discussing industry relationships with AMSA in the past half decade. AAMC had not in the past had a strong proscriptive stand in this arena. Lastly, the Council of Ethical and Judicial Affairs of the AMA also had previously not been forceful about vendor relations.

Inside UofL

The genesis of the new UofL policy had both internal and external components. The internal components were in the form of an initiative within the UofL Ethics Committee on conflict of interest beginning in the fall of 2005. The overall aims were to improve patient care by reducing actual and perceived conflicts of interest in the selection of treatment and to mitigate vendor presence with learners at UofL educational venues. Though met with a consensus to proceed, it was decided that a more measured approach was warranted, with a deliberative phase of debate. The Ethics Committee had opportunities to form “pro” and “con” policy teams in a vigorous debate during committee meetings over several months. As this process unfolded, the policy was revised to account for issues that arose in our deliberations. Once revision reached what was considered a draft ready for public viewing, the policy was then vetted to the following administrative leaders: the UofL Hospital Chief of Staff, the Interim Dean of the School of Medicine, the director of University Physician Associates, as well as the Medical Directors of the Ambulatory Care Building at UofL. At this point, several helpful comments were collated into a further revised draft. This draft was then presented to the current dean of the School of Medicine, who encouraged one-on-one discussions with clinical chairs on the impact of patient care. Key policy revisions on sampling, means of sampling, and how to allow funding for CME activities through a central accounting method then enabled a semi-final draft to be presented to the UofL Medical Council. This was done during the spring of 2008, with an opportunity for questions and debate over two meetings. Medical Council convened a Sub-Committee on the Vendor Policy, with two clinical chairs, one pre-clinical chair, a house staff council representative, and the chair of the Ethics Committee. The first agenda issue was finding a common ground that we all agreed upon — and in this case it was a “floor” provided by AAMC policy.

Just at that moment in time, the AAMC announced a new policy that would greatly restrict all vendor interactions at academic medical centers. AAMC’s report proposed (and would be voted on in June 2008) a “firewall” policy whereby sampling, gifting, detailing, etc. would be severely restricted. UofL is an AAMC member, and as such would need to follow such a mandate (in this case it was ultimately passed in early June). When we then re-convened, the draft vendor policy was re-tuned to this stringent level of restriction, and at the same time AMA’s Council of Ethical and Judicial Affairs announced a proposal to cut all aspect of relations between industry and academic medical centers except for treatment trials. These events precipitated a rapid and engaged coalescence of all the sub-committee members around the vendor policy as proposed to Medical Council, with appropriate revisions to verify that all

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aspects of the AAMC policy were followed. This policy (see Figure 1) was then presented to the full Medical Council June 23, 2008, with the author acknowledging, "Once we thought this policy was Cutting Edge, but now, once passed will be merely Cutting Edge." The policy passed unanimously.

Figure 1
Approved unanimously, UofL Medical Council on July 23, 2008

University of Louisville Health Care Policy on Vendors – redacted for length

The policy applies "to all hospital and office settings owned, operated by, or rented by UofL Health Care where UofL medical students, residents, and fellows work, practice medicine, conduct research, or are educated by University of Louisville-salaried faculty." It is intended to not alter current policies or standing of clinical research endeavors, or the conflict of interest or pharmacy and therapeutics policies of UofL, and has no standing for other hospital sites. Vendors are defined as “pharmaceutical company and medical equipment representatives, as well as including equipment and service providers.” As such, there has been a long-standing past history of vendors giving faculty, staff, residents, and medical students gifts, trips, incidental office supplies, etc. that were branded or promoted a brand or specific product. These gifts are viewed within the profession as well as by the public as a conflict of interest, because of adverse events and expensive care (using sample medications) as well as perceived commercialization of the healer’s role in patient care.

The policy in full can be viewed on the Internet at: [link]

- Prohibits any form of gifts (whether cash or an item of any value).
- Prohibits vendors from product or brand detailing (including all displays of products, cash incentive programs for prescribing, product pamphlets, pre-printed prescription pads with product names, and other materials).
- Vendor visits are allowed to faculty only by appointment (as set forth by protocols approved by individual administrative units) for updates on new products, education regarding existing products, discussions of support for unrestricted education grants, and supply of pharmaceutical samples, competitive selection by clinical committees for new products, services, or devices, and in-service training for products to faculty and staff that have been duly deliberated upon and selected for use at UofL Health Care.

Vendors must be credentialed with UofL Pharmacy or Operating Room.
- Educational Grants: This policy does allow for unrestricted educational topic-focused or general grants from vendors for Continuing Medical Education (CME) and Graduate Medical Education (GME) activities. Unit or topic-specific funds will be accounted for through a central process in the office of the Assistant Vice President for Finance, UofL Executive Vice President for Health Affairs. General grants (i.e., non-unit or topic specific) will be placed in trust within this office.
- Allow for pharmaceutical samples to be given to UofL Health Care clinical sites, with the assistance of UofL Pharmacy for appropriateness. UofL Health Care is dedicated to attempting to implement a voucher plan with area pharmacies to mitigate the need for sample medications.
- Vendors are not allowed into the following locations: patient care areas, operating rooms, delivery rooms, emergency rooms, medical student and resident lounges, and staff elevators except to provide in-service training or assistance on devices and equipment, for example, in the operating room. Except in emergency circumstances, there must be prior disclosure to and consent by the patient or surrogate (if the patient is incapacitated) whenever possible, i.e., if it is known ahead of time that a vendor will be involved.
- Education programs for students, trainees, staff, and faculty should be developed and implemented by UofL-HSC schools and by individual departments on vendor marketing, as well as the subtle influences that such promotion has on physician decisions.
- Adherence to the principles outlined in this policy is not reserved for duty hours.
  - Off campus, non-UofL endeavors (such as paid lecture-ships) are strongly discouraged.
  - Travel funds may not be directly given to any UofL faculty, residents, or students, except in the cases of legitimate reimbursement or contractual services to those Vendors.
  - Vendor interaction of UofL faculty members in the course of representing legitimate professional organizations will be governed by the policies and procedures of the specific organization.
  - UofL faculty, residents, or students are prohibited from engaging in any form of ‘ghostwriting’ of any presentations, publications, or other forms of media product.
  - Implementation and monitoring of this policy will be made at the administrative unit level.

Dr. Doukas is a professor of medical humanism and director of the Division of Medical Humanism and Ethics in the Department of Family and Geriatric Medicine at the University of Louisville.
I have young children and I want to ensure their financial stability in the event that something should happen to me. A friend told me that I should establish a trust, but I assumed trust was only for the ultra wealthy. What is a trust and how much would my family benefit?

A trust is nothing more than a financial planning tool utilized to make sure your cherished belongings and hard earned assets go to your loved ones, churches, schools or organizations in the manner which you want. Trusts are often perceived as tools for the ultra wealthy, when in reality they can help attain a variety of common financial planning goals including reducing taxes on your estate, keeping your assets private from the public, distributing property, funding life events for family members, protecting monies for and from family members. The trust document is a legal agreement in which assets are given by one person to be kept and controlled by another person for the benefit of a third person or party. The grantor provides the assets and creates the trust. The trustee is the person or company responsible for managing the trust. The beneficiary is the entity or person who receives the benefits of the trust.

There are many different types of trusts but the most common are living trust, irrevocable trust and charitable trusts. Living Trust, which commonly are created during the lifetime of the grantor, benefit both the grantor as well as the beneficiaries. Irrevocable trust which makes the trust the owner of an asset such as life insurance and provide many tax advantages to the decedent estate. Charitable trusts provide a way to help support charitable organizations and offer potential tax benefits to the grantor.

Many factors should be considered before establishing a trust such as your personal situation, financial status, and beneficiaries' needs. Remember a trust is a legal document that involves many tax rules as well as regulations that can be complex. You should consider the counsel of an experienced estate planning professional before implementing such strategies.

I know that I need life insurance, but I am not sure that I am ready to make a significant financial investment. What are my insurance options?

In today’s economic market, consumers have many available options with regards to life insurance. Once you understand the different types of life insurance available, you can choose the best option that will meet your and your family’s needs. In general there are two broad types of life insurance that are Term coverage and Permanent coverage. The correct coverage can be determined based on your family’s current economic situation, future goals and financial preferences.

Term life insurance covers the insured for a fixed period of time which can range anywhere from one year to thirty years. Generally term insurance is inexpensive and only provides the owner with a dollar amount benefit; typically term coverage has no savings or investing element. Usually this type of life insurance expires at the end of the planned term period, but sometimes can be renewed with evidence of good health. Some term insurance does offer the ability to convert to a permanent policy without evidence of insurability based on your age and health at the time the policy was issued.

Permanent life insurance is specifically design to be kept for an extended period of time if not throughout the insured’s entire life. Typically there are three choices when it comes to this type of coverage Whole Life, Universal Life and Variable Universal Life. Whole Life is very simple as well as a very common form of permanent coverage; it provides premiums that remain consistent over the life of the policy. Universal Life provides the policy owner with flexibility to adjust premiums as well as the benefit amount as changes occur in their lives. These types of plans often times include a savings or investing element usually called a cash value. Lastly, Variable Universal Life allows the policy owner the ability to allocate a portion of their premium to different investment options while providing a death benefit. Also Variable policies typically do not offer the same guarantees as the other types of insurance. When purchasing Variable Universal Life the policy owner needs to consider investment objectives, investment risks, company expenses/charges and always remember this is a security which must be sold with a prospectus and as with any security it is possible to lose money within the policy.

Many factors should be considered before purchasing the protection and peace of mind that life insurance can provide. All life insurance policies are legal contracts between you and the insurance company. You should consider the counsel of an experienced estate planning professional to determine which life insurance option is right for you.

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THIS IS AN ADVERTISEMENT
The Great Influenza: 
The Epic Story of the Deadliest Plague in History
by John M. Barry (Penguin Books, 2005)

Book reviewed by
M. Saleem Seyed, MD, FACC, FACP, FRCP, FAHA

"This must be some new kind of infection or plague" (Dr. William Welch, on observing autopsies of influenza victims at Fort Devens, MA)

Two Poems of the era:

I had a little bird,
Its name was Enza,
I opened the window,
And in-flew-enza

And wear the gauze.
Protect your jaws
From septic paws.

We are being repeatedly told by the health officials that the specter of the 1918 Influenza pandemic, which was the worst of all the other pandemics with its swift and ferocious lethality, is poised to revisit again and possibly soon. More than 50 million people perished worldwide during the “Spanish Flu” that lasted from March 1918 to June 1920, decimating the young, robust and apparently healthy individuals between the ages of 20 and 50, in addition to the vulnerable population of the infants and the elderly. The pandemic was called “Spanish Flu” by the Allies of WWI because Spain was not involved in the war, had no censorship and the accounts of the flu were published in the Spanish media, while the true danger and frequency of the disease was significantly minimized in the USA and elsewhere. Approximately 675,000 Americans died but the largest number of deaths (20 million, according to one estimate) occurred in India. Harvey Cushing of the Johns Hopkins University called these victims “doubly dead in that they died so young.”

Epidemiologists believe that the next flu pandemic is long overdue and according to a study published in Lancet in 2006, applying historical death rates to modern population data, a death toll of 51 to 81 million (median of 62 million) can potentially be expected, should a new flu pandemic of equal severity strike. By contrast, the relatively milder outbreaks of Asian influenza of 1957 and Hong Kong pandemic of 1968 resulted in fatalities of two million and one million people respectively with the highest death rates among the elderly and the infirm. The threat of an imminent pandemic gained momentum in 2003 with circulation of the H5N1 bird flu virus, a highly virulent virus with transmissibility to mammals and potentially to humans, which propelled a large scale worldwide preparedness initiative. Due to preventive measures and vaccine, antiviral and antibiotic agent availability, the World Health Organization maintains that the death rate may be much lower (7.4 million), though still staggering. On May 8, 2006, the Louisville Metro Health Department under the directorship of Dr. Adewale Troutman, hosted the Louisville Influenza Pandemic Preparedness Unit which was published in the September issue of Louisville Medicine.

John M. Barry is neither a physician nor a scientist but an American author whose meticulously researched book about the 1918 Flu pandemic, “The Great Influenza” of 2005 was named the year’s outstanding book on science or medicine by the National Academy of Sciences and was a New York Times best seller. The book is a powerful narrative of the events during this devastating pandemic and describes, in detail, the cultural and political milieu of that era. When the virus struck in America, death roamed the cities, mass graves were dug for the immense numbers of the dead, there were casket shortages and the stench of rotting corpses filled the overwhelmed morgues. The public health authorities were ill-prepared and the government was poorly responsive to the needs of the sick, with distraction imposed by WWI being fought thousand of miles away.

Some might consider the first several chapters of the book a distraction from the subject of influenza, but I, being perpetually enamored with medicine and medical education, am extremely pleased that they deal with this subject. Chapter one opens with the description of the momentous occasion, on September 12, 1876, of the launching of the venerable Johns Hopkins University in Baltimore with the keynote address being delivered by the English scientist Thomas H. Huxley. The pre-eminent pathologist at the Johns Hopkins, Will-Sm Henry Welch, has been called the “Dean of American Medicine” who transformed American Medicine by creating his cadre of scientists, later called “Welch Rabbits” who became teachers of pathology all over the country.

His protégés will confront the influenza of 1918 through the Rockefeller Institute for Medical Research, directed by his right-hand man, Simon Flexner. The Flexner Report of 1910, authored by Simon’s brother Abraham, was a catalyst for the standardization of medical education, which then commenced in earnest. Abraham Flexner was an effective fund-raiser who was able to raise vast sums of money from the American philanthropists for improving many medical schools and the face of medical education and research will never be the same.

It is theorized that the virus strain (a subtype of H1N1) responsible for the deadliest pandemic of 1918 originated in Fort Riley, Kansas, by viruses in poultry and hogs and then transferred to humans, while another theory maintains that it was a direct jump from the birds to humans. The genetic sequence of the 1918 virus was announced in 2005 from samples recovered from 1918 flu victims (buried in the Alaskan permafrost and American soldiers). The flu epidemic most likely started in Fort Riley, Kansas, and later spread to the civilian population and subsequently to France because of the overcrowding and dismal “war conditions” which facilitated a swift spread of the infection. William Welch was asked to go to Camp Devens in the vicinity of Boston on a drizzly day in September 1918, where the outbreak was raging. He was shocked to see the young soldiers dying like flies from the devastating flu. Bodies littered the place, blood oozing from their orifices. Welch gathered a team of scientists who scrambled to find preventive measures to stem the tide of this hurricane of an epidemic. Philadelphia was next and the city was gripped with fear as the epidemic spread ferociously, claiming thousands of lives with astonishing rapidity. Welch himself became very ill, most likely contracting a milder form of the flu, and eventually withdrew from further involvement. Richard Pfeiffer of Berlin had isolated a bacillus (now called Hemophilus influenzae) which he wrongly thought was the causative agent of the deadly flu. Meanwhile, New York was hit with the sweeping epidemic as well and masses of people were dying. Vaccine and anti-

Continued on page 37
Stroke, or brain attack, is the number one cause of disability among adults in America, and the number three cause of death. It occurs when the blood supply to part of the brain is cut off. Without the oxygen blood provides, that part of the brain dies, and the functions it controls are lost.

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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

<table>
<thead>
<tr>
<th>Name</th>
<th>Years of Service</th>
<th>Address</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brees, Carol Ellen</td>
<td>20194</td>
<td>UL OB/GYN</td>
<td>Internal Medicine 2007 University of Louisville</td>
</tr>
<tr>
<td>McCants, Kelly</td>
<td>17439</td>
<td>401 East Chestnut Street Suite 310 40202 584-8563</td>
<td>Cardiovascular Diseases; Internal Medicine 2005 Meharry Medical College 2001</td>
</tr>
<tr>
<td>Christopher</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jennifer B. McCants</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yassine, Lina</td>
<td>(20094)</td>
<td>4003 Kresge Way Suite 400 40207 895-4263</td>
<td>Endocrinology; Diabetes Metabolism; Internal Medicine 2005 University of Jordan 2000</td>
</tr>
<tr>
<td>Nizar Attallah</td>
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Candidates Elected to Provisional Associate Membership

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<th>Address</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mohan, Pradeep Sharma</td>
<td>(20277)</td>
<td>401 E Chestnut St Unit 710 40202 583-8303</td>
<td>Hand Surgery; Plastic Surgery American University of the Caribbean School of Med 1986</td>
</tr>
<tr>
<td>Sumedha P. Mohan</td>
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<tr>
<td>Pile, Nancy S</td>
<td>(10464)</td>
<td>Alliance 315 E Broadway M53 40202 629-7050</td>
<td>Diagnostic Radiology 1992; Albany Medical College 1986</td>
</tr>
<tr>
<td>Stacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foster, Jeffrey L.</td>
<td>(2008)</td>
<td>231 East Chestnut Street 40202 629-7661</td>
<td>Department of Radiology 1995; Diagnostic Radiology 1990 University of Cincinnati</td>
</tr>
<tr>
<td>Slaughter, Mark S</td>
<td>(20012)</td>
<td>201 Abraham Flexner Way Ste 1200 40202 583-8383</td>
<td>Thoracic Surgery 2005; General Surgery 2002 Indiana University</td>
</tr>
<tr>
<td>Martha Slaughter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sarah Mullins</td>
<td></td>
<td>304 Mount Mercy Drive Pewee Valley KY 40056 241-8611</td>
<td>Family Practice 1978 University of Louisville</td>
</tr>
</tbody>
</table>

Candidates Elected to In Training Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Years of Service</th>
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<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mullins, Anthony Dale</td>
<td>(19587)</td>
<td>40292</td>
<td>Emergency Medicine Rush University 2006</td>
</tr>
<tr>
<td>Sarah Mullins</td>
<td></td>
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</tbody>
</table>

Continued from page 34

serum against the Bacillus influenzae were administered all over the country with no sign of abatement of the epidemic. Scores of health-care workers including physicians died and JAMA was filled with their obituaries. In New York, sneezing and coughing without a gauze mask on was punishable by jail and a $500 fine. Prescott, Arizona, made the shaking of hands illegal. The very fabric of society lay in tatters and the very existence of civilization was threatened. By late November 1918, the virus had swept the whole world. Some lingering effects were later theorized to be secondary to the neurotoxicity of the flu virus, including the patients in Oliver Sacks’ 1973 book “Awakenings.” It was associated with schizophrenia, post-influenzal psychosis and an increase in the incidence of suicide.

Simon Flexner, figures prominently in the research to find the causative agent for the deadly flu. Paul Lewis and Oswald Avery did pioneering work but it would be a decade later in the early 1930s when Richard Shope isolated the virus from pigs and subsequently, British researchers isolated the virus from humans, using Shope’s technique.

John M. Barry’s excellent book is a monument in chronicling the history of a terror-stricken era in 1918 detailing the swift spread of a deadly pandemic, the frenetic and dedicated scientific work by many, and the inadequacy of the government’s preparedness. Great strides have been made since then in the medical treatment and prevention of influenza, but Barry warns against complacency and government minimization of the danger in these days of possible bioterrorism. The book is eminently readable and is highly recommended.

Further Reading:
4- Siegel, Mark: Bird Flu- Everything You Need to Know About the Next Pandemic. John Wiley & Sons, Inc. NJ. 2006
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