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Ulysses Syndrome

One of the privileges of our Greater Louisville Medical Society presidency is to be able to participate in the AMA National Advocacy Conference. The conference opened with the President’s Forum, an opportunity for medical society and professional society presidents, president-elects and other leaders to share their innovative ideas and their challenges as well as explaining how the AMA might help them. I was pleased to see that GLMS is doing well compared to some of our colleagues across the country with capturing more than 80 percent of our area’s physicians as members. We are utilizing Internet innovations such as LinkedIn (social networking), YouTube (video), Flickr (photos) along with our Web site, e-mails and hard-copy publications to communicate with our members. Many are utilizing Facebook, Twitter and other modalities that we likely should consider. I was pleased to see that we did have a novel idea, our specialty “speed dating” event for medical students. Several other interesting ideas were presented; many we can learn from and apply locally, such as programs for physician leadership development and initiatives that help raise the visibility and image of physicians in the community.

Along with hearing about what the AMA is doing, or trying to do, for its members, there was an opportunity to meet with our representatives in the House and Senate to discuss “what is important to physicians.” The first challenge, of course, is that there is no real consensus as to “how physicians feel.” We are a very diverse group of bright and talented individuals (emphasis on individuals) and the expectation that doctors can be all adequately and “appropriately represented” by any group (AMA, KMA or GLMS) is not realistic. So, as physicians, are there some things with which all physicians might agree?

The SGR was certainly a very timely discussion while we were in Washington. It was during our visit that one of our senators from Kentucky held up the short-term fix on the SGR (Was it a coincidence that this was resolved the evening after our meeting with him? Yes, very likely!). But, this seemed to be one issue that physicians unite around. Most physicians would likely not support a 21 percent cut in payment. Most physicians also support some sort of tort reform. Addressing the overwhelming administrative complexity that physicians have to navigate would seemingly be a third point of agreement.

However, once we get down the list a little further, opinions start to diverge. The conversations start to heat up even more when solutions are proposed. But my experience in Washington did leave me with the impression that physicians as well as our representatives are very passionate about health care. It was noted in one of our meetings that there has not been a subject in recent history that the public has attended to more or debated more vigorously. I suspect that is because it affects all of us in such a personal way.

There was an analogy that I read in a publication from the Governance Institute that likened health care reform to Ulysses Syndrome. This was initially described in the Canadian Medical Association Journal in 1976 “in reference to a long and trying journey by a patient and his physician consequent to stumbling on a falsely positive finding on routine screening. Such a spurious finding can initiate a series of wearing, wearying diagnostic adventures and misadventures, with ultimate return, empty-handed, to the point of departure, as Ulysses returned to Ithaca after his harrowing 10-year odyssey.”

The business of health care and the many proposed solutions are enormously complex. And with this complexity, any changes in the system will likely produce unanticipated and unintended consequences. But will our leaders actually enact change? Or will health care reform just be another example of Ulysses Syndrome?

Note: Dr. Simon, a neurologist, is senior vice president and chief medical officer of Jewish Hospital and St. Mary’s HealthCare.
There’s No Crying in Baseball

So said Tom Hanks as Jimmy Dugan, team manager in *A League of Their Own*, spawning a line so classic that it’s bucked up hurtin’ cowboys ever since. But there was a lot of crying the last weekend of February, after Hall of Famer and Sen. Jim Bunning single-handedly blocked the extension of jobless benefits and COBRA coverage for 400,000 Americans at the outset. At this writing, if Congress fails to act, that would mean up to 3 million Americans going broke, and bare of health insurance, by May. Cries of outrage have scorched the airwaves, with Twitter suggestions ranging from “Let’s fire him and take his benefits away” to “Is he interested in training whales?” With one stroke, Bunning also blocked the temporary fix for the Sustainable Growth Rate (SGR) physician payment formula, setting in motion a 20 percent pay cut for 600,000 doctors who care for patients and veterans, including more than 8,000 MDs here in Kentucky. In October, he also voted against Senate Bill 1776, which would have killed the SGR and modernized Medicare physician payment.

In 2008, Bunning voted in favor of extending unemployment benefits, which casts doubt on his explanation that he voted “No” for aid to the jobless as a matter of long-standing principle. He cited “not increasing the national debt and using economic stimulus funds instead.” If money was his main reason, then why in January did he vote against the bipartisan “Pay As You Go” bill to establish a Federal Budget Deficit Commission to study ways to pay now instead of later?

Just what are his principles, I wonder. He voted against the 2009 Children’s Health Insurance Program improvement act, so apparently better access to care for kids is not his issue. He voted against allowing the FDA to regulate tobacco products and he voted against the Tobacco Education Act, thus showing considerably more worry about Big Tobacco campaign contributions than about tobacco-related cancers. He voted against the Lilly Ledbetter Act, which ensured equality for women and minorities in disability payment disputes, so one cannot say that he cares deeply about fair treatment of the average worker. In August he voted against the Supplemental Cash for Clunkers program. In 2005 he voted against the Hurricane Katrina Relief Amendment, seeming to signal that suffering, homeless Americans who’d lost all that they owned needed no help from Congress. He voted against the Hate Crimes Act and against the National Volunteer Programs Extension, apparently seeing no urgency to help gay people or liberals. He voted against the Medicare Act of 2008 and against all versions of the Senate health care reform bills supported by Democrats, except for the final vote on Christmas Eve: he was the only senator who had left the city and failed to vote on that historic legislation. Clearly, his votes do not indicate an overriding concern for the welfare of sick people, or old people, or working people, or children, or the doctors who care for them. It’s not just Kentuckians he seems to disdain. Twice he has voted against giving the residents of Washington, D.C., their own representative in the U.S. House. Even our men and women on active duty can’t count on his support: in October he twice voted against the 2009-10 Defense Appropriations Bills.

Since he failed to garner enough support in his own party to run again this fall, one might think that the past year represents his big chance to vote “on principle only:” no donors to assuage, no party apparatchiks to appease. In the past, he has voted a big “Yes” on the principle of denying illegal aliens everything, and on Reinforcing Border Fencing. He voted “Yes” on reauthorizing the Patriot Act. But since announcing that he won’t run, he has voted “Yes” on Carrying Concealed Firearms and on Allowing Loaded Guns in National Parks (‘cause there’s such a foreign terrorist threat in Red Rock, Montana). Most of his other “Yes” votes over the years involved overturning Roe v. Wade, and he favors banning gay marriage. Studying his voting record reveals that he’s against a whole lot more than he is for.

Right now it would embarrass a lot of Kentuckians less if he took ever longer weekends. Short of that, it might behoove the senator to listen to 680 U.S. neurosurgeons. According to the AMA’s *American Medical News*, our neurosurgical colleagues for the first time released a national survey, led by the American Association of Neurological Surgeons, showing that more than half will stop providing certain services if the SGR fiasco is not fixed. Forty percent will limit new Medicare patients and 18 percent will stop accepting them. Fifty-three percent will reduce the time they spend with Medicare patients. Many noted they will have to reduce staff, defer buying equipment (including electronic medical records) and may refer complex cases elsewhere more than before. Since 2005, the neurosurgeons have noted an overall reduction of 59 percent in Medicare patients seen because of low payments. Those they do see travel farther to be evaluated. If the neurosurgeon needs consultative
help, 67 percent now note marked difficulty and delay in referring patients to medical and surgical sub-specialists.

Reed Abelson, writing in The New York Times on February 28, has pointed out that experts in health policy, no matter what their stand on the current health reform controversy, have agreed that doing nothing will continue to bankrupt governments, businesses and families. By 2020, the average insurance premium, viewed as percent of family income, will rise to 24 percent (from 11 percent in 1999), adding the cost of another 20 million uninsured to the wallets of those with insurance. He cites (though it appears Mr. Bunning et al have not listened) the Commonwealth Fund’s estimate that had President Nixon’s proposals passed, we would have spent a trillion dollars less by now; if President Clinton’s 1994 plans had passed, we’d have saved some $500 billion per year.

Legislators continue to look for targets for saving money on health care. Nearly all the commercial insurance companies made a significant profit for 2009, despite losses in their “employed” books, by relying on increased Medicare business and raised premiums. Yet without federal health reform they will not bear a larger share of cost-cutting. So a state senator in New Hampshire has introduced a bill to regulate hospital prices. If legislators see doctors as prime targets, then the SGR may not get repealed. What, then, would doctors do? What should we do? It’s very difficult for doctors to say to the patient in front of them, right now, what they may believe should happen to theoretical patients, people they have not met. That is, we can go on strike by not taking new patients and not doing elective procedures on existing patients. But the legislators know they have us over an ethical barrel in the end, for it is the rare doctor who would actually get rid of all current Medicare patients and opt out of Medicare entirely. On the other hand, if doctors all over the country refused to take or see Medicare patients, the ERs would be overburdened, and ER doctors would work the most and get paid less and less. Hospital systems would be horribly strained, there would be no ICU beds, and referring relationships would break down. If Katrina failed to engage Bunning’s compassion, would the sight of thousands of the elderly ill stranded in ER waiting rooms do any better?

There’s no crying in baseball, but there’s about to be a lot of spitting in medicine. Doctors’ voices have been heard the least because we have behaved the best. If spitting on the patients who rely on us is required to save our practices, should we and will we be able to do it? LMI

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.

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GUEST COMMENTARY

Strike Three?

Without question, I believe that I can assert that my friend and classmate, Dr. Mary Barry, and I agree that A League of Their Own remains an eminently quotable movie. I further concur with Mary that the voting record of Sen. Jim Bunning remains largely inscrutable to me. I do take some solace, however, from knowing that his Kentucky senatorial colleague, Sen. Mitch McConnell, seemed similarly befuddled about his behavior when, on ABC’s This Week March 7, he remarked that anyone who knows Jim Bunning knows that no one tells Jim Bunning what to do.

Our agreement above notwithstanding, I must disagree with Mary’s opinion that Bunning’s litany of historic voting inconsistencies, or this current vote on benefit extension, has any real causal relationship to the Medicare dilemma in which we all find ourselves. Perhaps another baseball allusion might pertain here. I am sure that in Bunning’s Hall of Fame career as a pitcher, he hit his spots with his pitches far more often than not and, in so doing, “got the out.” He also undoubtedly “hung some curves” and let his fastball “get up in the strike zone” from time to time, but he got away with it and still “got the out.” Whether, on this most recent vote, the senator’s behavior represented him “hitting his spot” (i.e. he made a thoughtful and principled decision to not fund a bill for which we have no money) or him “getting away with one” (i.e. his vote was the callow, cynical and duplicitious act of a bitter, cantankerous old man giving us all one last “one finger salute”) is ultimately irrelevant. He is correct in stating that, however little

Daniel W. Varga, MD

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we may like it, we cannot afford the
SGR fix or anything else right now.

Thomas Sowell, the Rose and
Milton Friedman senior fellow on
public policy at the Hoover Institution
at Stanford University, recently present-
ed a four-part series, “Alice in Health
Care,” that captures the crux of the
problem. Distilling the series to its
essence, Sowell argues that our current
health care payment system costs too
much because it irreparably and disin-
genuously distances our beloved
patients from the real cost of the health
care services that they receive; that we
continue to ignore the fundamental
reality that making the mousetrap
better costs money; that state and
federal health care policy decisions
arising from our technological
advances rarely include an honest
appraisal of the real costs attached to
those decisions; that the typical recon-
ciliation of the cost imbalance is to ask
doctors and hospitals to take less for
their services; and that the current
system is inexorably driving the best
and brightest out of and away from our
profession. I could not agree more
strongly with Dr. Sowell’s reasoning.

Unfortunately, a “Yes” or a “No” from
Bunning on the SGR or on the health
care reform proposals that have
heretofore been presented has no
impact on this reality because those
proposals have had little to do with
that reality.

To bring Sowell’s argument even
closer to home, consider how our
single biggest insurer, Medicare, reim-
burses hospitals for the care they
provide in greater Louisville. Using the
most recent publicly available Medicare
Cost Report (source: American Hospital
Directory, 2008 cost report informa-
tion), one will find that Louisville’s local
hospitals all lose money taking care of
Medicare patients. While this informa-
tion may come as no surprise, the
scope and scale of the loss can be stag-
gering. Excluding University of
Louisville Hospital and Kosair Children’s
Hospital, Louisville hospitals lost on a
severity adjusted basis anywhere from
$90/case (Jewish & St. Mary’s) to
$710/case (Baptist Hospital East) to
$3,500/case (Norton Healthcare). On an
aggregate basis, that inequity reflects a
real payment to cost disequilibrium of
anywhere from $1.5 million/year to
almost $57 million/year for Louisville’s
three largest health care providers.

One frequently hears the con-
tention that hospitals lose money
simply because they are inefficient and
unreliable, and there exists evidence to
support some aspects of that con-
tention. Yet, even if one allows for fairly
egregious estimates of waste and care
attributable to poor performance, there
remains an enormous hole out of
which hospitals must dig. Knowing that
you start in the hole on your biggest
single payer also triggers the need for
cost shifting and service reconfigura-
tion to compensate. Thus, none of is
shocked when hospitals go to war with
insurers and with each other to ensure
payment that backfills the Medicare
losses and to garner market share in
clinical services that reimburse well. We
do not have the same granularity of
data for physician reimbursement, but
we know qualitatively that any physi-
cian practice that is largely dependent
on Medicare as its payment source is
unfeasible without subsidization from
some other source. In the end, all
providers eventually become the
unwilling arbiters of the discordances
of the existing payment system.

Nothing in the SGR extension and
nothing in the proposed health system
reform proposals addresses these dis-
cordances, and neither does Bunning’s
vote one way or the other.

I would also take issue with Mary’s
assertion that, as a profession, our only
options in this quandary are either to
acquiesce to the inevitable or take our
bat and ball, quit and go home. As
understandable as the referenced neu-
surgeons’ survey results may be, they
also reflect a disappointing lack of
alternatives. Our response to the
endemic infectious diseases that
ravaged centuries of humankind
entailed quite a bit more than a wring-
ing of hands or a wailing against the
travails of tending to the sick with no
hope for cure. So too has our response
to the chronic illnesses that supplanted
pestilence as the leading causes of
pain, suffering and death. In every situ-
ation in which our profession has found
itself, we have honestly and transpar-
tently assessed the predicament, eleg-
antly diagnosed the cause, and boldly
and courageously rendered treatment.

We have also held ourselves
accountable for the complications of
that diagnosis and treatment. One of
the consequences of the way that our
model of care has evolved is that this
model of care costs too much, and it
leaves us with a set of queries that
must be addressed. How do we control
unnecessary utilization without bureau-
ocratic rationing? How do we achieve
higher reliability and transparency
without making medicine cookbook?
How do we advance transmission of
and compliance with the scientific evi-
dence base without stifling innovation?
How do we compensate a physician
equitably for the whole cost of what it
takes to be a physician without break-
ing the bank? These and a dozen other
health policy questions pose countless
considerations, but I find it hard to
believe that solving for these problems
is fundamentally more difficult than
solving for polio, smallpox or testicular
cancer.

These issues are hard, and,
whether for the good or the bad,
Bunning will not be around to have to
answer them. Hopefully, we will.
Hopefully, the talented and committed
membership that makes up GLMS will,
like Mary Barry and others, contribute
their voice to this critical discussion.
Hopefully, we will remember our singu-
lar position in this debate and take
control of it. Hopefully, we will also
remember my favorite line from A
League of Their Own: “If it wasn’t hard,
everyone would do it. The hard … is
what makes it great.”

Note: Dr. Varga, an internist, is chief medical
officer of Saint Joseph Health System in
Lexington.
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Vitamin D has been traditionally viewed as a hormone that regulates skeletal metabolism and calcium homeostasis. Most tissues have receptors for vitamin D, however, and in recent years vitamin D has been linked to many non-traditional functions and illnesses, such as muscle weakness and balance, cardiovascular disease, diabetes mellitus, colorectal cancer, infection and autoimmune disease. Therefore, the vitamin D-endocrine system is a subject of substantial current interest, and is the subject of many recent reviews.1-3

There are two forms of vitamin D, D3 (cholecalciferol) and D2 (ergocalciferol). D3 is a prohormone produced in the skin from 7-dehydrocholesterol by ultraviolet sunrays while D2 is produced by plants and yeast. Certain foods are fortified with D2, including orange juice, breakfast cereals, milk, margarine, cheese and yogurt. The daily intake of vitamin D that is sufficient to maintain bone health and normal calcium metabolism in healthy people is actively debated. While the traditional recommendation has been 200 IU in children and young adults and 400 IU in those over age 70, others have proposed from 400 IU to 1700 IU as ideal. Both forms of vitamin D are converted in the liver to 25-hydroxy vitamin D (25OH-D; calcidiol), and are further metabolized to 1,25 dihydroxy vitamin D (1,25(OH)2-D; calcitriol) by 25OH-D-1 hydroxylase, CYP27B1, primarily in the kidney under the control of parathyroid hormone. Calcitriol binds the vitamin D receptor with high affinity and is viewed as the active ligand; however, many tissues express CYP27B1 and can convert 25OH-D to calcitriol. This finding has led to the idea that normal plasma levels of 25OH-D are required for a variety of physiological functions.

The current approach to evaluating vitamin D status is the measurement of the level of 25OH-D in serum. 25OH-D is a biomarker for vitamin D status because it is not tightly regulated, has a long half-life and its plasma level correlates best with symptoms and signs of vitamin D deficiency. On the other hand, serum 1,25(OH)2-D levels are maintained by increasing levels of PTH and do not typically decrease until vitamin D deficiency is severe. In patients not taking vitamin D supplements, almost all of the circulating 25OH-D is 25OH-D3. Because both vitamin D2 and D3 may be found in serum and circulate bound to a transport protein, vitamin-D binding globulin, the measurement of 25OH-D is complex, and various assays are available. The gold standard is liquid chromatography followed by mass spectroscopy (LCMS). This assay measures both D2 and D3, which are added to determine the total 25OH-D level. The instrumentation for this method is expensive, and there is some variability among laboratories that use this method. Immunoassays employing antisera that recognize both D2 and D3 represent a less costly and more readily available approach, providing results that tend to agree closely with LCMS.

The optimum 25OH-D level remains to be precisely defined. Vitamin D status is often categorized, however, as severely deficient (< 10 ng/ml), deficient (10-20 ng/ml), insufficient (20-30 ng/ml) or optimal (> 30 ng/ml). The optimal level of at least 30 ng/ml is based on the inverse relationship between serum PTH and 25OH-D, with PTH levels tending to rise as 25OH-D levels fall below 30 ng/ml. Calcium absorption from the GI tract appears to be reduced with 25OH-D levels below 20 ng/ml. Older adults have reduced GI calcium absorption and higher PTH levels than do young adults and may need higher levels of 25OH-D to prevent secondary hyperparathyroidism. Although vitamin D is produced in the skin and can be obtained from the diet and supplements, vitamin D deficiency is common. Using a cutoff for vitamin D deficiency of <20 ng/mL, 30 percent of the U.S. population over age 20 years is thought to be deficient, and an additional 40 percent are insufficient. Lower levels are found in women than in men, in those who have dark skin, are institutionalized or wear clothing that covers their entire bodies, and values overall are lower in the winter months due to less sunlight exposure. In older individuals, the skin cannot synthesize vitamin D as effectively as in younger persons. Patients with malabsorption from intestinal disorders or resection, including after bariatric surgery, and those with hepato-biliary disease...
are frequently vitamin D deficient. 25OH-D levels are also lower with increasing obesity and in Type 2 DM perhaps because vitamin D, a fat-soluble steroid, is sequestered in adipose tissue. In a study of young women seen in the University of Louisville Hospital (ULH) emergency room in January-March 2007 (Figure 1), mean (±SD) 25OH-D levels were 13.0±11.8 ng/ml, and 51 percent of all women and 61 percent of the African-American women had levels below 10 ng/ml.

Vitamin D status has a substantial and established impact on bone mineral density and fracture risk. Bischoff-Ferrari et al found a positive relationship between the level of 25OH- D and bone mineral density in the hip among various ethnic groups. Furthermore, low 25OH-D levels increase the risk for hip fracture, and daily supplementation with cholecalciferol and calcium reduces the likelihood of developing a hip fracture. Patients in whom the bone mineral density is lower in the wrist or hip than in the spine, or those with reduced serum calcium or phosphate levels, or elevated serum levels of alkaline phosphatase, PTH or chloride should be evaluated for vitamin D deficiency.

There is also a growing literature linking vitamin D status to the anabolic activity of muscle, the renal-cardiovascular system, the immune system, terminal differentiation in several tissues and the growth of cancer cells. Vitamin D receptors are found in skeletal muscle, and vitamin D deficiency can cause myopathy especially of the proximal muscles. For example, there was a positive relationship between 25OH-D levels and jump velocity and height among adolescent girls, and 25OH-D and calcitriol concentrations are positively associated with muscle strength and function in older adults. Some trials suggest that vitamin D supplementation improves physical performance and reduces falls in the elderly. Vitamin D may also play a role in cardiovascular disease (CVD). Vitamin D receptors are found in cardiomyocytes, vascular smooth muscle cells and endothelium, and individuals deficient in vitamin D are more likely to have, or are at risk of developing, CVD. There are also case reports linking dilated cardiomyopathy to vitamin D deficiency. 25OH-D levels are reduced in patients with Type 2 DM. Calcitriol stimulates insulin secretion, and several case-control and observational studies suggest that vitamin D deficiency might increase the risk for Type 2 DM. A meta-analysis also revealed that among infants treated with oral vitamin D supplementation, the risk for developing Type 1 diabetes mellitus was reduced by 29 percent. Experiments have demonstrated that calcitriol is antiproliferative, promotes cell differentiation, induces apoptosis, inhibits telomerase expression and suppresses angiogenesis. These experiments have led to many studies relating vitamin D to cancer prevalence and progression. Most research has focused on colon and breast cancer, two cancers that are linked to obesity and insulin resistance. A meta-analysis found that the risk of developing colorectal cancer was 50 percent lower in subjects with serum 25OH-D levels that exceeded 33 ng/ml than in those with levels below 12 ng/ml. Equally provocative was one study from the UK in which subjects with 25OH-D levels <20 ng/ml and the bb BsmI vitamin D receptor genotype were 6.82 times more likely to have breast cancer than were subjects with levels above 20 ng/ml and either the BB or Bb receptor genotype.

Vitamin D is of special importance in pregnancy. The developing fetus draws calcium from its mother, and there is an elaborate mechanism to maintain calcium metabolism during pregnancy. PTH-related peptide (PTH-rp) is produced by the placenta, 1,25(OH)2 D levels rise and PTH levels decline, and intestinal calcium absorption is increased. Prenatal vitamins generally contain 400 IU of vitamin D and 600 mg elemental calcium, and two tablets are recommended daily. Nevertheless, vitamin D deficiency is common in pregnancy. Adverse health outcomes, such as preeclampsia, low birth weight, neonatal hypocalcemia, reduced postnatal growth, bone fragility and the development of autoimmune diseases may be partly related to low maternal vitamin D levels during pregnancy and in infancy.

Vitamin D deficiency can be treated with 2000-4000 IU of cholecalciferol daily or with 50,000 IU of ergocalciferol weekly for eight to 12 weeks with monitoring of 25OH-D levels. Many but not all studies have shown that D3 is somewhat more bioactive than is D2. In general, it takes 12 weeks for maximum levels to be achieved due to distribution of vitamin D in adipose tissue. Thereafter, daily maintenance doses of 1000-2000 IU are recommended. Higher doses or more frequent administration is needed in patients with malabsorption. Vitamin D intoxication is very unlikely to occur, although co-treatment with hydrochlorothiazide, which lowers urinary calcium excretion, can produce hypercalcemia.

In summary, measurement of 25OH-D is an increasingly important test in the Endocrine laboratory, and there is substantial evidence that vitamin D deficiency is extremely common in children and adults. Low vitamin D may be partly due to obesity and an indoor sedentary lifestyle, and because of concerns that exposure to excess sunlight predisposes to skin cancer. The skeletal effects of vitamin D deficiency are well documented, and the skeletal benefit of replacement in those who are vitamin D deficient has been established. Many extra-skeletal actions of vitamin D have been proposed from epidemiological studies, and research to ascertain the significance of these associations and to document the effects of vitamin D treatment is actively under way.
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Rebecca Terry, MD
Gynecologist
Women First

Continued from page 11

2008;88(2):500S-6S.


Note: Dr. Chang is a clinical fellow with the University of Louisville’s Division of Endocrinology, Metabolism and Diabetes. Dr. Miller is professor of pathology and laboratory medicine. Dr. Winters, professor of medicine, is chief of the division.
The 14-year-old boy, knocked to the ice during a youth hockey tournament, was unable to tell the emergency medical technicians where he was. The EMTs, also observing that his neck was tender, treated and monitored him until an ambulance arrived. The first responders, in this case, were students from Bellarmine University who are members of a campus EMT organization – one of 200 such groups in the country, according to the National Collegiate EMS Foundation.

The Bellarmine Emergency Response Team, which began covering on-campus events during the fall semester, serves a dual purpose. It’s an opportunity for students at the private university of 2,600 to make their campus safer and a chance for them to explore the possibility of a medical career.

“It doesn’t compare to medical school or being a doctor,” said junior Evan Kuhl, the team’s founder and director. “But at the same time, it gives you a taste of the critical thinking and the patient contact.”

In high school, Kuhl decided to enroll in an EMT course after stopping at a car wreck and feeling frustrated he couldn’t do anything more to help the victim lying in the road than call 911. As a freshman in the pre-med program at Bellarmine, Kuhl was asked to speak at a senior seminar class interested in a service project involving campus emergency care.

Kuhl remembers telling the class the concept would “never work.” Yet he was back the following week with a proposal. Once student government leaders granted approval, organizers pitched the idea to Louisville Metro EMS. Chief Executive Officer Neal Richmond, MD, responded by giving Bellarmine students 10 free spots in the summer EMT course in 2008.

Junior Marina Dolzhanskaya, who has received acceptance to the University of Cincinnati’s College of Pharmacy, completed her EMT training with Louisville Metro EMS at that time, spending every Monday, Wednesday and Friday learning and practicing basic life support skills.

During the 2008-09 academic year, Kuhl and the other EMTs put together an extensive handbook that allowed the Bellarmine Emergency Response Team to earn administration approval to voluntarily provide emergency medical services at campus events beginning this fall. Ambulance service is still contracted for many events.

“The Bellarmine Emergency Response Team is a phenomenal group,” said Fred Rhodes, vice president for academic and student life. “This organization is an excellent example of our teaching, learning and service to others.”

The team also has pushed for first aid education on campus, particularly among students in nursing, physical therapy and respiratory therapy. The EMTs offer an online course and test skills to grant first aid and CPR certification to students. They also teach about two classes each month. In the fall, they held an event called Super CPR Sunday, where about 80 students earned CPR certification.

“It’s great to have these EMTs here, but they’re not always going to be right where they need to be when something happens,” Kuhl said.

Louisville Metro EMS includes the Bellarmine EMTs in working major community events like Thunder Over Louisville, the Kentucky Oaks and Derby and the Ironman triathlon.

“Evan and his remarkable team have taken an extraordinary step to bring an enhanced level of health and safety to their campus and to our community,” Dr. Richmond said. “It has been a special pleasure for us to work with the students, faculty and administration at Bellarmine, not only to accomplish what they have, but to really put to test all those elements that ought to come out of a great college education – vision and initiative, dedication and commitment, knowledge and execution.”

The ambulance ride-alongs that are required during EMT certification have proved to be a valuable experience for the students. During one run, Kuhl met Raymond Orthober, MD, who offered him the chance to shadow physicians in the emergency room at University Hospital.

“This gives me a head start in knowing medical terms, learning about patients, getting patient contact,” said Kuhl, who finds his EMT work helps him keep his eyes on the prize of becoming a doctor. “It keeps your mind focused on what you’re doing now. It’s such a long path to get there.”

Stacie Harris, also in Bellarmine’s pre-med program, finished her EMT certification in December.

“I wasn’t really sure what my specialty was going to be and then I did my ride times for my class,” she said. “I really can see myself doing this for the rest of my life. I like the fast pace of it.”

By next fall, Kuhl predicts there will be about 18 student EMTs at Bellarmine. Whether they’re teaching CPR to their classmates or attending to an injured boy on an ice rink, they’re preparing for a future of coming to the rescue of others.

Note: Ellen R. Hale is the communications associate for the Greater Louisville Medical Society.
The Norton Healthcare family offers its appreciation to and honors Dr. Jesse Wright for 35 years of selfless service to the Norton Psychiatric Center, Norton Hospital, Norton Healthcare, the psychiatry field and the community at large. His positive impact will forever be a part of Norton Healthcare.

Dr. Wright served as clinical director and then medical director of Norton Psychiatric Center from 1975 through 2009, and as president of the Norton Hospital medical staff during challenging times. He is recognized nationally and internationally as a leader and dedicated researcher in the field of psychiatry and has authored seven books about psychiatry and mental illness. Among his many accomplishments, Dr. Wright is a pioneer in the field of cognitive-behavior therapy to treat people with depression, anxiety and other disorders.

We thank Dr. Wright for the substantive and sustaining contributions he has made in understanding and treating mental illness. We also wish him well in his continuing role as a professor and vice chair of the Department of Psychiatry and Behavioral Sciences at the University of Louisville and as director of the U of L Depression Center.
James* is 47 years old, a morbidly obese Caucasian with Type 2 Diabetes and advanced congestive heart failure. His stringy gray hair trails over his plethoric face, his shirt pocket bulges with a pack of Marlboros, and he smells like cigarettes and fried food. He forces a grin and hands me a glucose log smeared with blood and grease. I cannot read the few words or numbers he scrawled in his diary. After losing his anterior left foot to a diabetic ulcer, he got disability from his job as a cook. He used to go to the emergency room when he felt sick, but now that he has a medical card, he can go to the doctor to get diabetic supplies and medicine. But James cannot read beyond a first-grade level. All my beautiful pamphlets and books are useless to him. He and I are expected to get his HBA1C to 7.0. It is going to be tough.

So how did James and I get here? Obesity, sedentary lifestyle and smoking are major reasons for the huge U.S. burden of chronic disease. One very crucial determinant of these behaviors is educational attainment, which is highly correlated with socioeconomic status and health. The United States and particularly Kentucky have an enormous problem with both low general literacy and health literacy.

The first Kentucky Health Literacy Summit was held February 26, 2010, at the Seelbach hotel in Louisville. It was co-sponsored by Humana and the University of Kentucky. In-depth information from the summit may be found online. Shocking statistics presented at the summit include:

- 90 million adults cannot understand the information on their prescription labels, appointment cards and consent forms.
- 42 percent of Kentuckians read at the two lowest levels of literacy.
- One in five U.S. adults is functionally illiterate.
- Marginal health literacy produces an extra $200 billion in U.S. health care costs annually.
- 100 out of 120 Kentucky counties have median incomes below the poverty level, and 54 of those counties are in Appalachia.

Physicians in greater Louisville should know that 39 percent of adults in the Phoenix Hill neighborhood of Louisville have no high school diploma. In Jefferson County, Kentucky, 25 percent of young people (especially boys and African-Americans) drop out of high school. Only 25 percent of the population earns a college degree.

The correlation between education and health is seen across all countries, races and ethnicities. In a study on cardiovascular risk in Aberdeen, Scotland, the authors found that “the prevalence of multiple risk factors ranged from 25.9% among college graduates to 52.5% among those with less than a high school diploma or equivalent.”

In an ambitious study of 120 countries, researchers determined there has been little progress worldwide in improving the health of people with the lowest education. “With the exception of black males, all recent gains in life expectancy at age twenty-five have occurred among better-educated groups, raising educational differentials in life expectancy by 30 percent. Differential trends in smoking-related diseases explain at least 20 percent of this trend.”

Low educational attainment is a proven risk factor for cardiovascular disease and cancer, the top two causes of mortality in the U.S. and the rest of the developed world. Why does the U.S. have so many people with low literacy? Cynthia Duncan, author of Worlds Apart: Why Poverty Persists in Rural America, told Frontline: “Chronic poverty in rural areas, and urban areas for that matter, really represents long-term neglect and lack of investment – a lack of investment in people as well as communities. And in the rural areas that I know in America, that lack of investment began as deliberate efforts by those in power – local elites or employers – to hold people back. Because it has worked for them, to keep their labor force vulnerable, keep them powerless.”

The lack of education of immigrants – legal and illegal – to this country is a growing problem. Illegal immigrants tend to work in very low-paying jobs, often with no benefits, and may not even try to assimilate into mainstream American culture. As a result, the U.S. is amassing a growing population of people who cannot read or write English, are illiterate even in their native language and are doomed to lives of poverty, ill health and marginalization.

Education is necessary for a healthy population. Education confers more than just knowledge or skills. Education empowers people to think logically, make good health choices, afford good food, access safe exercise venues and advocate for themselves. It creates a social norm where health is valued and unhealthy...
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behaviors such as smoking are rejected. “Educate and inform the whole mass of the people,” Thomas Jefferson said. “They are the only sure reliance for the preservation of our liberty.” How robust and effective can a democracy, an economy or a health care system be when one-fifth of its population is illiterate?

As Louisville Metro Public Health and Wellness Director Adewale Troutman, MD, MPH, pointed out during his presentation at the Health Literacy Summit, “Literacy is one of the measures that determines the Physical Quality of Life Index and must be in place before populations can benefit from more health care providers.”

By the time an adult develops a chronic disease such as coronary artery disease or COPD, he or she has probably already finished formal education, and there is not much a physician can do to change that. For those with low educational attainment and health literacy, physicians and public health researchers must find better strategies to help patients comply with preventive and treatment plans. The American Medical Association’s Health Literacy Kit is a very useful resource for all physicians. While some physicians may view this as yet another demand on their time and resources, they must realize that inadequate communication leads to bad patient outcomes and many successful lawsuits against physicians.

If physicians want to lessen the burden of chronic illness on our society, they must recognize the clear correlation between educational attainment and health. They must advocate for better education for all as a primary prevention strategy and help those patients with low literacy under their care now.

* The patient’s name has been changed.
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Abraham Flexner and His Educational Ideals

“Before the gates of excellence the high gods have placed sweat. Long is the road thereto, and rough and steep at the first. But when the height is achieved, then there is ease, though grievously hard in the winning.”

- Hesiod (Greek poet, 700 B.C.)

“I was nothing but an industrious and perhaps intelligent thief, all my ideas having been taken from others and I deserving at most the credit of getting them and putting them together.”

- Abraham Flexner
During the Progressive Era in the early part of the 20th century, Abraham Flexner – an almost obscure ex-principal of a preparatory school in Louisville, Kentucky – suddenly became an influential critic and an authority on educational matters, particularly medical education, even though he was not a physician. The groundbreaking Flexner Report became the lightning rod and an iconic document castigating the commercial enterprise of medical education. The report pointed out the drawbacks of the extant system of medical education, and Flexner offered an exhaustive and well-thought-out program to implement his educational ideals for standardization, thus ushering in an era of widespread reform aptly named the “Flexnerian Revolution.” Although medical education reform had been under way for several years, the publication of the Flexner Report and the subsequent implementation of the proposed reform hastened the demise of the for-profit diploma mills. It also brought about the triumph of standardization of medical schools – resulting in full-time teaching staff and laboratory research.

Abraham Flexner was a lifelong student, and his educational philosophy can best be understood by following his life history. His thinking regarding the synthesis of science and humanities evolved over the years, in keeping with the dynamic forces changing the world. His educational journey is summed up by an entry at the Institute for Advanced Study (IAS) Web site: “Flexner devoted much of his life to education, attempting to gain a better understanding of its place in society. He questioned the role of higher education in America, strove to understand the place of the American university, and dedicated himself to improving the system of medical education in the United States. He authored books and reports on the subject, and his efforts continue to resonate today.” From his impoverished upbringing in Louisville to achieving the pinnacle of power and prestige when he stood in the limelight as an educational reformer, critic and icon, his multifaceted life became the quintessential American success story.

Early Years in Louisville

Abraham Flexner was the youngest son of nine children born to a poor Jewish immigrant couple in the Louisville of the Reconstruction South. At home, the significance of education as a Jewish heritage value was stressed from the very beginning, and young Abraham, an avid and voracious reader, excelled at academics. At Louisville Male High School, he was a stellar student and president of the Athenaeum Society (a debate club) and won several prizes. In addition, at age 15 he worked in the Louisville Library and listened to the discussions of the city’s elite, who used the library as a venue for intellectual discourse. He “absorbed this like a sponge” to spur his intellectual growth. Among those who frequented the library, which at that time was not open to the public, were: prominent attorney Louis N. Dembitz; Ellen Semple, who later was a notable geographer at the University of Chicago; the blind poet Morrison Heady; the theologian John A. Broadus; and the Brandeis family including Louis Brandeis, the future U.S. Supreme Court justice. Flexner’s eldest brother, Jacob, ran a successful pharmacy where local physicians gathered for discussion. His brother Simon was an autodidact and had such significant interest in pathology and microscopy that local physicians sought his opinion at Jacob’s pharmacy. Abraham Flexner apparently enjoyed these conversations dealing with current medical literature by the locally prominent medical men.

Off to Johns Hopkins

In 1884, at age 17, Abraham Flexner departed for Baltimore to attend the new Johns Hopkins University due to Jacob’s urging and financial support. Taking this step, Abraham would later recall that it “marked the turning point in the history of our family.” At the new progressive university modeled after the German system, his intellectual growth mushroomed and he wholeheartedly delved into his studies. With funds dwindling, he finished his courses in a hurry by doubling up on classes, thanks to the flexibility of Daniel Coit Gilman, the president of the university. Flexner was an acolyte of Gilman and would remain so for the rest of his life. Imbued with “Gilmanism,” Flexner “devoted himself to the Hopkins spirit of scientism and to its emphasis upon experimentation, research, and independent study.” By his own admission, Gilman’s influence permeated Abraham Flexner’s subsequent work at the Carnegie Foundation, the Rockefeller Foundation’s General Education Board and the Institute for Advanced Study.

Mr. Flexner’s School in Louisville

In June 1886, at age 19, Abraham Flexner graduated with a bachelor’s degree from Johns Hopkins University and returned to Louisville Male High School as a teacher. Commencing his career as an educator, he dove into the growing literature and theories about education and started to write articles about his own educational philosophy and politics for national publica-
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tions. In 1889, he published his first article in a Chicago magazine, “The Ultimate Importance of the Kindergarten Idea.” He echoed his contemporary John Dewey in emphasizing the beginning of the ongoing educational process that nurtures both mental and spiritual components. He described the idyllic atmosphere of the classes and called the newly introduced concept of kindergarten an “unspeakable gain.” He wrote about the kindergarten child’s interest “in imitating the birds, the raindrops, or the snowflakes, or . . . watching an insect in motion” as “not only scientific but emotional.” He believed strongly that the child should be stimulated to learn by observing and by doing.

Flexner’s biographer, Thomas Neville Bonner, points out that “at this stage of his life, he was clearly swept up in the romantic idealization of childhood,” which was a hallmark of the early progressive movement in education.

After teaching at his alma mater for several years and at the urging of a local attorney whose son needed preparatory tutoring for eventual college admission, Flexner started his own private school with the enrollment of five students in 1890. “Mr. Flexner’s School” was a highly successful venture with a national reputation. It flourished immensely because of his unique and progressive educational ideas and had an enrollment of more than 100 students by the time it was sold in 1905. When asked by Charles Elliott, then-president of Harvard University, about his educational approach, Flexner said: “It was all quite simple. I treated these boys as individuals, and I let each go at his own pace. I took hold of pupils where they were strong, not where they were weak, and having whetted their appetite by success in one field, usually succeeded in arousing interest in another.” John Dewey, an ideological colleague in the progressive movement in education, opened his own experimental school in Chicago four years after Flexner’s in Louisville. Flexner was influenced by some European educational models where students were given full freedom in their own methods of living and learning. He criticized, for example, the unyielding and rigid curriculum of the time in elementary and secondary training in the United States in his famous article of 1899, “A Freshman at Nineteen.” In his subsequent article published in The Atlantic Monthly in 1904 titled “The Preparatory School,” long after he had established Mr. Flexner’s School in Louisville, he stated that the child’s school life “will be coextensive with his whole life, seeking to enlist his total physical, moral and mental powers, to cooperate intimately with his domestic and spiritual interests.” He examined secondary school education in his article “A Modern School,” published in 1916. He was proud of his unconventional pedagogic methods while principal of his experimental school where “the school operated without rules, without examinations, without records, and without reports.” “I relied,” wrote Abraham Flexner in his autobiography, “upon other things: first, enthusiasm; second, cleverness in outwitting students who tried to dodge their responsibilities; third, good humor; and finally, emulation and competition.”

**Goodbye to Louisville**

Writing to his wife in September 1904, Flexner let it be known that he was ready for a change in his career after 19 years of being bound to Louisville like Prometheus: “I want to influence in some measure the life of my time in so far as that can be done through education.” To broaden his own educational horizons, he sold the school in 1905 and studied at Harvard for one year, working with Hugo Munsterburg in psychology and with Josiah Royce in philosophy, and received his master’s degree in philosophy. He had brief stops at Oxford and Cambridge to learn about their educational organizations but eventually settled in Berlin for a year to attend the local university. Enamored by the German educational model, which was considered the best in the world at the time, he wrote a scathing critique titled The American College (published in 1908) discussing the drawbacks and deficiencies of the American college education. On his return to the United States, he was recruited by Henry Pritchett, president of the Carnegie Foundation for the Advancement of Teaching, to conduct a survey of the then-extant 155 medical schools in North America. He commenced this in 1908 at the behest of the American Medical Association, which remained supportive behind the scenes.

**The Flexner Report**

Medical Education in the United States and Canada, published in June 1910, was an instant success as an epitome of muckraking journalism. His book, now eponymously called the Flexner Report, won critical acclaim. His program, when implemented through the philanthropy of the Rockefeller Foundation which quickly had hired him away from the Carnegie Foundation, brought sweeping changes in medical education. His report was a catalyst in the standardization of the education of physicians in this country and abroad. A high-quality medical school, according to Flexner’s ideals, should be part of a university, connected to a hospital with full-time teaching faculty and hold stringent requirements of at least two years of pre-medical basic sciences (chemistry, physics and biology). Bedside teaching with a mentor was emphasized: “The student is to collect and to evaluate facts. The facts are locked up in the patient. To the patient, therefore, he must go.”

Continued on page 24
Flexner stressed that it is impossible for the medical student to obtain encyclopedic knowledge, but an ideal of lifelong self-learning by scientific method should be put in the students’ possession. Flexner was one of the fundamental innovators of medical education with his exhortation of self-learning. All teachers of medicine do not necessarily need to be research-oriented since “there is room for men of another type, the non-productive, assimilative teacher of wide learning, continuous receptivity, critical sense, and responsive interest. Not infrequently these men, catholic in their sympathies, scholarly in spirit and method, prove the purveyors and distributors through whom new ideas are harmonized and made current. They preserve balance and make connections.” The synthesis of scientism and humanism is hinted at in these sentences, and this is a strong and convincing plea to widen the possibilities for dedicated teachers to make a career in medical education.

Flexner believed not only in curative medicine but also in prevention. His idealized image of an educational experience for a young physician was quoted by Dr. Sherwin Nuland as the one from which he “emerges, equipped with sound views as to the nature, causation, spread, prevention, and cure of disease, and with an exalted conception of his own duty to promote social conditions that conduce to physical well-being.” These ideas had been expressed by the German pathologist Rudolph Virchow in the 19th century and influenced the founding of the Institute for Human Relations at Yale University by its dynamic dean, Milton Winternitz.

Flexner’s caustic and incisive critique of medical education rightly stressed the importance of a scientific basis for medical education and the necessity of a university setting, also containing a brief passage about humanistic elements. Flexner was thus aware that: “The practitioner deals with facts of two categories. Chemistry, physics, biology enable him to apprehend one set; he needs a different apperceptive and appreciative apparatus to deal with other, more subtle elements. Specific preparation is in this direction much more difficult; one must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of the physician’s horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility ... It goes without saying that this type of doctor is first of all an educated man.”

Flexner would later become a much more vocal and insistent reformer to add humanistic education in the curriculum of medical education. Nuland very cogently points out: “The wisdom of any of us is circumscribed by our relatively limited experience of life. We expand it by studying literature, history, philosophy, and the evolution and beliefs of societies not our own.”

Philanthropy and Educational Reforms

Flexner conducted surveys of public education in the South, in Maryland schools and in Gary, Indiana. In 1916, the Lincoln School was established at the Teachers College of Columbia University as an experimental school for elementary and secondary curriculum along progressive ideas promulgated in his article “A Modern School.” According to historians, this school had a lasting influence on American education. The reorganization of medical schools began in earnest with $50 million from John D. Rockefeller, with more money added by other philanthropists including George Eastman, Payne Whitney, J.P. Morgan and the Carnegie Foundation. Flexner was able to raise more than $600 million to implement his programs. Many schools including Johns Hopkins, Washington University, the University of Chicago, Vanderbilt, Yale, Howard and Rochester received these funds to improve physical facilities, laboratories and the implementation of full-time plans. His books about comparative medical education in Europe and his compilation of lectures as a Rhodes Trust lecturer, later published as Universities, were highly acclaimed. He was not just “master of the survey” but an uncontested icon in medical education.

Institute for Advanced Study

After retiring from the Rockefeller Foundation at age 62 and firmly ensconced as the premier theorist in higher education, in 1933 he accepted a bequest of $8 million from a department store magnate from Newark, New Jersey, Louis Bamberger, with his sister Caroline Fuld, to start the Institute for Advanced Study (IAS) in Princeton, New Jersey. Flexner was founder and director. The IAS was the result of one man’s vision in founding a higher education edifice in the middle of the Great Depression that was quite dissimilar to the university model, a place where no classes were taught, no degrees were awarded and there were no financial pressures. The IAS became a fortress of learning, a platonic haven for scholars, physicists, mathematicians and logicians. Flexner was singularly responsible for enticing Albert Einstein to join the IAS. He had envisioned this intellectual powerhouse as “a haven where scholars and scientists may regard the world and its phenomena as their laboratory without being carried off in the maelstrom of the immediate.” The IAS represented the pinnacle of Flexner’s educational ideals and his “worship of excellence.” Additionally, it would serve as an example of his efforts to harmonize the humanities and sciences. The IAS eventually consisted of three schools: the School of Mathematics, the School of Humanistic Studies and the School of Economics. He retired from the IAS in 1939 at the age of 72 but continued writing books, including his two autobiographies, I Remember in 1940, and another revised edition, Abraham Flexner: An Autobiography, published posthumously in 1960. Abraham Flexner’s successors remained faithful to his vision in providing an ideal environment for high-level research by a small number of eminent permanent professors and transient members.

Although Abraham Flexner was a classics scholar (he studied Latin and Greek at Johns Hopkins University and later taught the subjects at his Louisville school), he subsequently favored a progressive educational model similar to John Dewey’s, rejecting the idea that the study of classic languages or algebra “trained the mind” or that certain subjects should be retained because they were traditional. Flexner believed that
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the child should be stimulated to learn by observing and by doing. For high school and college students, he believed in recommending aesthetics, music, art and literature for the intellectual reward. Regarding medical education, Flexner’s ideas were congruent with his general education philosophy of learning by doing. Self-learning was stressed as he stated, “On the pedagogic side, modern medicine, like all scientific teaching, is characterized by activity. The student no longer watches, listens, memorizes; he does. His own activities in the laboratory and in the clinic are the main factors in his instruction and discipline.”

Abraham Flexner was a man of vision and courage and a strong advocate for the adoption of high standards in the preparation of future physicians. He considered medical school a “public service corporation,” and once the educational requirements were fulfilled according to the Flexnerian credo, Charles Boelen contends that Flexner may have made the implicit assumption that work on determining the quality of medical practice, work force distribution, health services performance and eventually the health status of people would follow. That, of course, has not happened and much work still needs to be done. The “worship of excellence, not mediocrity” was the theme that guided Flexner throughout his career; it formed the foundation of his educational elitism and the backdrop for his educational efforts. In 1953 he prepared a detailed proposal for establishing a “foundation for humanistic and related studies” at the request of philanthropist Paul Mellon. Although the plan did not come to fruition, one has to marvel at Flexner’s supreme self-confidence.

On May 19, 1956, celebrating Abraham Flexner’s birthday and close to half a century after his famous report was published, deans from every medical school in America along with the nation’s top cabinet officials gathered at The Waldorf Astoria in New York to pay tribute to Flexner and hail him as the man who made “the greatest single contribution” in the history of the teaching of medicine. In the recent establishment of a Japanese university reform effort called the 21st Century Centers of Excellence Program, the topic of excellence was paramount; some educators argued to keep commercialism at bay from the centers just as Flexner had done by establishing the Institute for Advanced Study with the atmosphere of complete freedom for scholars. Flexner died at the age of 94 in 1959, and in the words of his biographer, Thomas Bonner, he is described very aptly as “an esteemed figure in American life. His life had been full of remarkable, even historic, achievements.” During his life as an educational reformer and critic, he was feared and revered by the educational hierarchy, medical and non-medical, and his influence still endures 100 years after the publication of the Flexner Report.
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We were here for you yesterday. We are here for you today. We will be here for you tomorrow.
2010 is the 100th anniversary of Abraham Flexner’s landmark critical evaluation of American medical education, which is titled Medical Education in the United States and Canada but universally called the “Flexner Report.” When published in June 1910, this document created an earthquake in the American medical landscape, and aftershocks have followed ever since. Flexner was born, raised and pursued his early career in Louisville, and many remnants of his time here persist. None, however, is more relevant to Flexner and his era than Louisville’s Old Medical School, now the home of the Greater Louisville Medical Society. This historic landmark has both a personal and a symbolic relationship to Abraham Flexner, and this centennial is a most appropriate time to review and celebrate these linkages.

Although The Old Medical School Building was home to the University of Louisville School of Medicine for the 60 years between 1910 and 1970, it was erected by the Louisville Medical College, one of a cluster of proprietary schools that thrived in Louisville during the 19th century. Just three years after Abraham Flexner’s 1866 birth, Louisville Medical College was established by young Civil War physicians, who wished to practice and teach the advanced skills they acquired during the war. During the next 20 years, their endeavor thrived to the point that the faculty were willing to invest in an elegant new building for the school. Under the emerging leadership of Clinton Kelly, MD, a lot was purchased on the corner of First and Chestnut streets, just two blocks east of the City Hospital (later called the Louisville General Hospital), the clinical anchor for any Louisville educational venture. Dr. Kelly engaged the architectural firm of Clarke and Loomis to design and construct an imposing structure in Romanesque Revival architecture, a style that was much in vogue at the time. Between 1891 and 1893, the limestone structure with its signature Romanesque tower was built.

During construction and thereafter, the building would have been a daily sight for Abraham Flexner, who lived just one short block to the east at 216 E. Madison St. (where Jewish Hospital now stands). Flexner would have walked past this site daily on the way to his last year of teaching at Louisville Male High School, and subsequently to his new venture as founder of a college preparatory academy, which brought him great success and greatly enhanced his educational insights. As Abraham’s teaching career blossomed, his older brother Jacob also realized a lifelong dream. Jacob’s ambition to become a physician was dashed with the business failure of his merchant father, Moritz, after the Panic of 1873. Jacob had to become a pharmacist, and he ultimately purchased his own pharmacy on the corner of Market and Fifth streets. His first $1,000 of profit sent Abraham to Johns Hopkins for his undergraduate degree. In the mid-1890s, Jacob left pharmacy to finally become a physician, with a degree from the Hospital College of Medicine in 1895 and a subsequent degree from Louisville Medical College in 1902. Thus, the personal connections of the Flexners to Louisville’s Old Medical School Building were close indeed.
More important, however, were the symbolic linkages of Louisville’s Old Medical School to Abraham Flexner and his era. The building initially represented the proprietary system of the 19th century that Flexner would come to condemn in his report. However, when the Louisville private schools merged into the University of Louisville School of Medicine, the building came to represent the university-affiliated system that Flexner advocated. Although Louisville Medical College was a fine and forward-looking educational institute during the 1870s and 1880s, profound changes were on the horizon. The rising fields of bacteriology, microscopic anatomy, pathology and physiology heralded the rise of scientific medicine, which would differentiate the profession from the theoretical cults and serve better the needs of patients. Proprietary schools such as the five in Louisville (Louisville Medical College, Louisville Medical Institute, Kentucky School of Medicine, Hospital College of Medicine and Kentucky University) were rapidly falling behind. Their tuition-based financing could not support the full-time basic science faculties that scientific medicine required. A select handful of university schools, led by Johns Hopkins University in Baltimore, were emerging and leaving behind the proprietary system. A groundswell of criticism was arising from progressive educators about the proprietary system, and these educators and the American Medical Association began a relentless, focused attack on the proprietary system after the turn of the century.

As this was happening, Abraham Flexner’s vision was expanding. In 1905, he sold his successful private high school to pursue graduate work at Harvard University and in Europe. He wrote a sharp critique of higher education in America, which attracted the attention of Henry Pritchett, head of the Carnegie Foundation. Pritchett had just allied with the American Medical Association and the progressive medical educators to plan an attack on the proprietary educational system. Flexner was hired by Pritchett and the Carnegie Foundation to execute that attack, which resulted in the 1910 publication of the Flexner Report.

Inevitably, spring follows winter every year. Yes, including this one. April has always been a month that I have looked forward to. It is exciting to plan for the budding birth of spring. I love all of the flowering trees, and the wonderful tulips and daffodils popping through the soil. The colors and fragrances are so welcome after a cold winter.

This month the GLMS Alliance will sponsor the Day at the Races on Saturday, April 24. It is opening day at Churchill Downs. This is a fundraiser for health careers grants. The recipients of this money are in training for allied health careers. They are an important part of the ancillary people necessary to assist physicians in their daily work, i.e. medical technicians, radiology technicians, nurses, nurse assistants, etc. The GLMS Alliance would appreciate if physicians would refer people for this grant. The GLMS Alliance also has another program that goes directly to medical students for their needs.

The cost for a ticket to the Day at the Races is $75, and $16 is tax-deductible. Please send your check to Sandy Fowler, 1806 Kline Court 40205, or Missy Hubbuch, 2904 Riedling Drive 40206. Also, include a self-addressed, stamped envelope so you can receive your tickets. Seating is limited. The last day to purchase tickets is April 16. See you there! 

Note: Dr. Tobin is chairman emeritus of the University of Louisville’s Division of Plastic Surgery and practices with University Surgical Associates PSC. Dr. Weiss practices Cardiovascular Diseases with Medical Center Cardiologists PSC. Dr. Conner is a retired anesthesiologist.
The Educational Philosophy of Abraham Flexner: Creating Cogency in Medical Education

BY MARC H. ZELENKA

Reviewed by
M. Saleem Seyal, MD, FACC, FACP

This 180-page book, published by an outfit that only publishes scholarly books aimed at research libraries, is an account of the educational philosophy of Abraham Flexner written by M.H. Zelenka, a visiting professor of education and life sciences at Indiana University in Bloomington. Writing in the foreword, B. Edward McClellan, an IU professor emeritus of the history of American education, underscores Flexner’s contribution in hastening the demise of commercial medical schools through his several reports including the seminal Flexner Report of 1910. His subsequent reports fueled the ascendance of university-based medical schools during the early part of the 20th century, not only in the United States and Canada, but also in a number of European countries.

The first chapter details the biography and educational journey of Abraham Flexner. It traces his humble beginnings in Louisville, Kentucky, where he was born to a Jewish immigrant couple as the sixth child of nine. A stellar student in high school, he was exposed to the discussions of Louisville physicians who gathered at his brother Jacob’s pharmacy as well as the Louisville notables who held discussions at the public library. He was a voracious reader and felt driven to excel academically. After his high school graduation, he was sent to the newly established Johns Hopkins University in Baltimore, Maryland. Obtaining his bachelor’s degree in a record two years, he returned home and started teaching at his alma mater, Louisville Male High School. “Mr. Flexner’s School” was established and was a highly successful enterprise where he applied his experimental pedagogic methods. He married his first female student, Anne Lazier Crawford, who eventually became a famous writer of plays and won critical acclaim for her Broadway play, “Mrs. Wiggs of the Cabbage Patch.” He sold his school in 1905 and spent a year at Harvard studying psychology and philosophy. After obtaining his master’s degree, he sailed to Europe and spent time in educational institutions in England and France, finally settling in Berlin. He was tremendously impressed by the German educational model and subsequently wrote a scathing critique titled The American College.

On his return to the United States, he was commissioned to be a surveyor of medical schools by the Carnegie Foundation for the Advancement of Teaching. The survey of 155 schools (with an additional eight osteopathic schools) was performed in collaboration with the Council on Medical Education of the American Medical Association and lasted for 18 months. Medical Education in the United States and Canada was published in June 1910 and made Abraham Flexner an educational icon whose opinion was sought far and wide. He was then commissioned to conduct a survey of medical education in Europe that was published in 1912. Another survey for which he was well-known in Europe was about “Prostitution in Europe.” He was then hired by the Rockefeller Foundation and became responsible for disbursing huge sums of money to implement his reforms for the standardization of medical education, thus ushering in an era called the “Flexnerian Revolution.” He conducted a series of surveys of public education and was instrumental in building the Lincoln School in cooperation with the Teachers College of Columbia University. He remained with the Rockefeller Foundation for 15 years and was constantly in the limelight as the prime mover and shaker in educational matters and philanthropy. After his retirement from the Rockefeller Foundation, he delivered the Rhodes Trust lectures at Oxford University in 1928. After his return, he became involved in a project that he had dreamed of for a long time. Through the philanthropic bequest of Louis Bamberger and his sister Carolyn Fuld of Newark, he opened the fabled Institute for Advanced Study as its founder/director in Princeton, New Jersey. It became a platonic haven for scholars, scientists and mathematicians. He recruited Albert Einstein to join the institute.

The rest of the book minutely and carefully details Abraham Flexner’s prodigious literary output, expounding on educational themes in his articles and books. With a meticulous analysis of Abraham Flexner’s 79 books and articles, the author provides a critical evaluation of the educational ideas and ideals in Abraham Flexner’s writings. A progressive humanist ideology in the training of students and physicians appears to be the central theme. “Flexner’s broad based, expansive and inclusive ideas on education form a lucid and candid philosophy of education that is progressive, pragmatic, and practical in its application,” Zelenka writes. Abraham Flexner (and his equally famous brother Simon Flexner) has languished in obscurity for half a century, despite the Flexner Report being cited frequently, and his biography was not written until 2002. Thomas Bonner’s definitive biography of Abraham Flexner titled Iconoclast (Johns Hopkins University Press, 2002) is liberally quoted throughout Zelenka’s book. In the February 2010 issue of Academic Medicine, which is the centenary issue celebrating the Flexner Report, 27 articles have been published related to Abraham Flexner and the Flexner Report.

In his book, Zelenka provides a conceptual framework based on the Flexnerian credo of synthesizing scientific studies with humanistic studies in preparing physicians for the future. Zelenka rightly considers Abraham Flexner one of the foremost and profound philosophers of the past century. His book is meticulously researched, richly detailed and amply referenced. It could not have come out at a more opportune time–when we are celebrating the centennial of the Flexner Report in Louisville, his city of birth.
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

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<td>40202</td>
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<td>Coldwell, Douglas Michael</td>
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<td>40202</td>
<td>Vascular Intervent. Rad. 95, 05</td>
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<td>Kapoor, Sandeep</td>
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<td>40215</td>
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Candidates Elected to Provisional Associate Membership

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<td>Tallapaneni, Kavitha</td>
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<td>Osmania Medical College 94</td>
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<td>47150</td>
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Membership
If someone makes unspeakable accusations against a colleague, do you convict before getting the facts? Or do you wait until you hear both sides? If you are like many clinicians, your first inclination is to convict, which suggests you may suffer from a “J (Judgment) gene deficiency.” This inherited abnormality, located near the JFK, Elvis and Birther genomic loci, seems especially expressed among those in the health care profession.

During residency, our university team would sometimes hospitalize patients otherwise managed by local physicians. “In the day,” even before any evaluation, we assumed the patient was already being mismanaged. This conclusion was not based upon objective findings, but rather derived from our lofty status as “academicians.” By definition, we were smarter and more up-to-date than the private practice rubes in the surrounding Louisville area. To the extent I ever expressed manifestations of a J gene deficiency during medical training, I was wrong.

During initial office visits, it is not uncommon for patients to begin their medical history by ruthlessly trashing previous doctors. Clinicians without the J gene deficiency are usually able to ignore such diatribes and avoid the temptation to automatically think ill of their colleagues. These clinicians are able to deduce what might be said about them, when these same patients go to their next doctor.

During my work in clinical research as an investigator for more than 400 clinical trials, it is disheartening to hear all the name-calling regarding the pharmaceutical industry, often based upon scientific “evidence” that is biased at best and blatantly false at worse. Even without a J gene deficiency, I suppose clinicians cannot be faulted for believing many of these lies, given that these accusations frequently originate from “respected” media-hound academicians who are published by major medical journals. These observations are then seized upon by opportunistic politicians and, of course, the media. In recent years, many clinicians have been surprised when major scientific organizations and regulatory agencies take positions in opposition to the conclusions reached in the breathless frenzy to demonize pharmaceuticals and pharmaceutical companies. Among some scientific opinion leaders, the degree of bias has reached the point where it was stated: “The three major medical journals are becoming more like British tabloid newspapers – all they lack is a bare-chested woman on page 3.” This is not to say that pharmaceutical companies are faultless. Some of their decisions are wrong, others are debatable, and yet others are, well, puzzling. However, fault can be found in all sectors of health care delivery. For example, should we judge the entire medical profession based on the monthly mailings of Kentucky doctors who have their medical licenses suspended or revoked? I suppose the answer depends on whether you are J gene positive or negative.

After attending scientific sessions and reading published works, it is disconcerting to hear and read colleagues who criticize how other doctors (and society) fail to fulfill their professional obligations and patient-care responsibilities, only to witness these same individuals disrespecting colleagues through name-calling and engaging in activities that are not in the best interests of patients. It seems the J gene deficiency not only applies to the inability for some clinicians to objectively judge others but also applies to an inability for some clinicians to objectively judge themselves. The point is that one does not have to be disagreeable to disagree. Dr. Mary Barry (editor of Louisville Medicine) is known for writing biting editorials in her zealotry to “save puppy dogs.” (Yes, this is a metaphor.) While most clinicians who disagree with Dr. Barry respond with thoughtful rebuttals, her compassionate canine commentaries inexplicably exacerbate the vitriolic wrath of those with J gene deficiency. Socialist-minded “letter to the editor” writers decry Dr. Barry’s unwillingness to embrace a global takeover of puppy dog safety and object to Dr. Barry’s failure to support universal control of the ethical treatment of all microbes, macrobes and non-life planetary materials. (“Titanium isotopes are people too!”) Conversely, Dr. Barry is also often savaged by strict capitalists, who feel that puppy dog salvation should be left to free market forces.

So what to do? What treatment options are available for J gene deficiency? A good start is to acknowledge that none of us is without fault. In addition, other potential interventions include the following:

1. For J gene deficient clinicians who relentlessly criticize others, a potentially applicable quote derived from my experience might be: “No one will ever see the best in you if you are always looking for the worst in others.”

Alternatively, they could simply heed the words of Thumper, who once said: “If you can’t say anything nice
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(about someone), don’t say nothin’ at all.”

2. For J gene deficient clinicians who believe the worst in others without knowing the facts, another potentially helpful quote from my experience might apply as well:

“Those who always speak ill of others are pathetic, small-minded little people. Those who always believe them are the same.”

3. Finally, J gene deficient clinicians who are in recovery might gain comfort from a lesson that took me years to learn, which is: “No one gets more credit than those who give credit to others.”

The point is that no matter how convincing and horribly compelling the accusations, an examination of the facts may prove the exact opposite is true. (I mean, do you really know? For sure?? Really???) Just as with the management of any other disease, obtaining the facts is the first step toward an accurate diagnosis. It is only after obtaining an objective and accurate diagnosis that a reasonable judgment can be made. Because in our efforts to do what is in the best interest of patients, it is most often the case that: “Thoughtful solutions exist but will never be implemented until we stop all the mindless chatter that makes us so stupid and ineffectual.”

LM


Note: Dr. Bays is medical director and president of L-MARC Research Center. The first four articles in this series were published in Louisville Medicine in December 2005, March 2006, October 2006 and December 2006.
Observations on a Medical Mission

Teresita Bacani-Oropilla, MD

Tucked at the foot of Mt. Talomo, Philippines, is a small city called Calinan. Once covered with primeval forests, it is now bisected by a road, the Buda, that starts from the gulf coastal city of Davao in the south, traverses the Bukidnon plateau and extends to the city of Cagayan de Oro and the northern provinces of Mindanao Island.

The soil being rich and blessed with rain all year round, Calinan is surrounded by lush mango and vegetable farms as well as an orchid farm or two. Fragrant kalachuchis and varicolored bougainvillas dot the countryside. The air is crisp and cool. Beneath the old crater of Mt. Talomo is a rich aquifer that has been tapped to supply clean mountain water to the cities below.

A few miles away is the Philippine Eagle Center that aims to restore the dwindling population of the majestic Philippine eagle by breeding them and returning them to the wild. With the spread of civilization, the native tribes that inhabit these once-verdant jungles have gradually lost their hunting and fishing grounds. Their culture, language and quaint music...
Our efforts were local.
The recognition was national.

In the wake of last August’s massive flash flooding, our dedicated staff put forth a truly amazing effort to first evacuate the hospital, then have it up and running again within a week. In recognition of this extraordinary accomplishment, Modern Healthcare has presented Sts. Mary & Elizabeth Hospital with its Spirit of Excellence Award, for the category of C.A.R.E.S. (Compassion, Accountability, Respect, Enthusiasm and Service). We are certainly proud to receive this recognition. But we are even prouder to have a staff that has shown, without a doubt, just how much they really care about serving our community.
have been contaminated and adulterated. Now and then, they leave their haunts to hawk their handicrafts to tourists. Their life spans rather brief, their orphaned children are distributed among relatives. The territory of one tribe, the Matigsalugs (those who live near the rivers), is near the Calinan area. In time, they could reach extinction.

Into this land in the 1940s came a logger who realized the impact that the inroads of civilization would cause. When he was asked for the use of his logging roads to connect the south to the north roads of the Buda, he predicted correctly that in 20 years the character of the place would change forever.

With a growing population of settlers, he primed and designated one of his sons, Dr. Ruben Robillo, to serve the increasing medical needs of the people. Thus, the Isaac Robillo Memorial Hospital was established.

Modest by U.S. standards, it nevertheless has an emergency room, two operating rooms, a delivery room for obstetric and gynecologic patients, a thriving pediatric-medical outpatient department and capabilities for X-rays, sonography and basic laboratory tests. Several local family physicians take turns at being house officers. In a place where helmets have yet to be completely implemented, the most common serious surgical emergencies are motorcycle injuries.

Members of the University of Santo Tomas (UST) Medical Class of 1962 have been organizing medical missions to their native Philippines for a number of years. Dr. Nemesio Bucayu, an anesthesiologist and member of the Greater Louisville Medical Society, led the mission this year. It took three years from conception to realization. Supplies of medicines and equipment, including some from our own Supplies Over Seas, had to be collected and shipped before the arrival of the participants. Practicing medical members had to obtain temporary licenses from the Philippine government. An active U.S. medical license is a prerequisite. Patients had to be screened for eligibility, i.e. indigence, and dates of the mission had to be coordinated. Local doctors had to be available for eventual follow-up of post-op patients. Services, medications and hospital stay were free for eligible patients. Participants paid for their own fare and lodging while there.

Last-minute complications, such as escalating hostilities between opposing political camps and a massacre in a neighboring province, understandably caused some volunteers to postpone participation. Nevertheless, the successful outcome of the 19 major operations – breast removal, thyroidectomy, oophorectomy, hemiorrhaphy – and 30 minor operations on lumps and bumps – cysts, lipomas, papillomas, sometimes ulcerated from constant trauma – relieved their long-suffering owners of worry and discomfort, making the procedures well worth the effort. In the meantime, long-standing friendships were revived, new ones were made, promises of future missions were started and gratefulness was expressed to the sponsoring rotary and other civic groups, and individual sponsors for their lavish offerings of food, transportation and entertainment.

In retrospect, the greatest find of all was the gem of a doctor who, although at first under duress, took on the challenge of his father’s dream and expanded on it. Rendering much-needed medical services, encouraging conservation of resources as much as possible without retarding progress, setting up an orphanage, educating the orphans to preserve their remaining tribal customs and generously allowing people of good faith to help him in fulfilling his vision, he embodies, in one way or another, our own desires to do our best in the places and situations that we encounter in our lives.

Medical missions have a way of reopening our eyes, letting in bursts of fresh perspectives about the world we live in. This one did it for me again. 

Note: Dr. Oropilla is a retired psychiatrist.
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Save the Date
The GLMS President’s Soiree
May 23 Louisville Science Center
On the best of days, Chicago’s O’Hare airport can be a rather bleak place. Having to wait four hours on a cold winter day for a connecting flight to India did not make things better. The Christmas decorations did little to dampen my sense of boredom. I had tried to spice things up by grabbing a bite at the Wolfgang Puck eatery. I had gone through all my cell phone messages and finished calling the residents with last-minute instructions. The only other people at the gate, an Asian couple, appeared to be engrossed in looking at electronic memories captured on their newly acquired digital camera. Two trips to the Starbucks and restroom were no cure for the sense of boredom that had set in. More travelers seemed to gradually congregate and wait aimlessly, but we still had more than an hour to go. I decided to take a little stroll and passed the Hudson Booksellers kiosk for the third time.

The picture on the cover appeared to belong to a cultured, self-assured and distinguished young man in his 20s or 30s in decidedly Western garb. He seemed European, and yet there was something intriguing about the contrasting fez that adorned his head. It brought back memories of similar images I had seen at our ancestral home during my own childhood. The term “Orientalist” conjured images of some Mata Hari, T.E. Lawrence or perhaps the White Mughals in my own imagination. I had never heard the name Lev Nussimbaum before.

The Orientalist is his story. It is an absolutely riveting tale based in the early 1900s about the scion of a Jewish family who owned oil wells in Baku, Azerbaijan. The contrasts of this remarkable life are both stark and riveting. Indeed, it would be extremely hard to make up a character of this complexity for a book that is part biography, part adventure, part detective story and part historical account. The book is truly a case of fact besting fiction. His life was a Gordian knot of contradictions, which makes the book a veritable page-turner.

Tom Reiss, the author of this biography, is a wonderful storyteller and literary sleuth extraordinaire. In this book he appears to have solved the mystery of one of the 20th century’s most prolific and yet almost unknown novelists and authors. He intertwines into the biography long forgotten historical narratives of the times that Lev lived in. It is the story of one Lev Nussimbaum who was born to an Ashkenazi Jewish family and grew up in predominantly oriental and Muslim Baku, Azerbaijan. Born a Jew, he converted to Islam, wore turbans in the coffeehouses of Berlin and Vienna, claimed to be related to the royal house of Bukhara and wrote under Mohammed Essad Bey and Kurban Said. Lev’s father was decidedly the capitalist owner of oil wells, while his mother was an avowed Communist (who may have even helped Stalin). She had tragically committed suicide when Lev was very young. Trouble seemed to find the Nussimbaums (father and son) no matter where they traveled. They witnessed the crumbling of two empires and two world wars. The vicissitudes of history saw great wealth and great poverty twice in one lifetime. Lev’s journey from Baku through Istanbul, Berlin and Hollywood ended in relative obscurity in Positano, on the Amalfi coast of Italy. At a time when Russia saw the dawn of communist ascendancy and mayhem, Germany saw the rise of right-wing Nazi murder and mayhem. He experienced and hated both, and yet decided on leaving the comfort and wealth of America and returned to Mussolini’s Italy. It is the story of an individual who had written 16 major literary works by the age of 30 and was dead at 36. These include biographies of Hitler, Stalin, Tsar Nicholas II, Lenin and Reza Shah, in addition to several international biographies and memoirs.
best sellers such as *Blood and Oil in the Orient* and *Ali and Nino*.

Through his main subject Reiss explores the world of the Orientalist movement in general and Jewish Orientalists/Islamists in particular. The latter often disguised themselves as Bedouins and dervishes and held a pro-Muslim, pan-Semitic worldview. The author invokes from earlier times the names of Maimonides (Musa ibn Maymun), who wrote all his work in Arabic as court physician to Saladin, and Samuel ibn Nagrela, who led Muslim armies into battle and wrote commentaries on the Quran while serving as vizier to the king of Granada in Andalusia. Yet he saw no conflict in teaching the Talmud at the same time. In today’s world, it is hard to believe that in the 1920s many Zionists felt a deep kinship to Arabs. Such tidbits of information enrich an already wonderful and thoroughly enjoyable narrative. Some anecdotes continue grabbing the reader’s attention. I was unaware, for example, that Hitler’s first press secretary was a Harvard-educated man, Putzi Hanfstaengel, who later switched sides and worked for Roosevelt and swore that the Nazi “Seig Heil!” chant found its inspiration in the Harvard chants from frenzied Harvard-Yale football games.

Tom Reiss does more than justice to both Lev and the reader of this “one in a lifetime” character for a biographical work. He tells the story of a prolific author whose life and death are shrouded in mystery, and where fantasy and reality meld imperceptibly. It was a life that was as much at home in a turban and bandolier or scimitar and suit. The book is annotated and referenced well, enjoyable for the narrative and scholarship. At a time when chasms between the Occident and Orient seem to open, when differences among Muslim and Christian and Jew seem to widen, the life of someone who could straddle the divides and be comfortable is inspirational. The book is truly a labor of love that took the author through 10 countries. His elegant obsession is almost as compelling as Lev himself. I will undoubtedly read it again.

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Note: Dr. Gadre is the Heuser Hearing Institute Endowed Professor in Otology and Neurotology in the Department of Surgery and Division of Otolaryngology-Head and Neck Surgery at the University of Louisville.
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