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Carotid Artery Stenting and CREST: An Update
Charles B. Ross, MD, RPVI, FACS

Out of the Rubble: Louisville Medical Community Displays Generosity after Earthquake in Haiti
Ellen R. Hale

GLMS Annual Report 2010
Debate on Health System Reform Defines Active GLMS Year
Ellen R. Hale

Issues in Public Health and Preventive Care: Addressing Public Health Needs in Louisville Metro
Deborah Ann Ballard, MD

One Hundred Years of the Flexner Report
M. Saleem Seyal, MD, FACC, FACP

Jacob’s Pharmacy: Where the Flexners’ Remarkable Futures Were Compounded and Dispensed
Gordon R. Tobin, MD, Rick Bell, Morris M. Weiss, MD, Eugene H. Conner, MD

Two Physicians, One Historic Place
Ellen R. Hale

From the President
Time Flies
Lynn T. Simon, MD

Physicians In Print

We Welcome You

Doctors’ Lounge
Free the Runny-Nosed
Mary G. Barry, MD

Prescription Pseudoephedrine – A Definite Maybe
Tracy Ragland, MD

Pseudoephedrine Scheduling or ... a Date with Methamphetamine?
William S. Smock, MD, FACEP, FAAEM

Who’s On First
Gordon R. Tobin, MD

Letter to the Editor
Capt. Robert E. Arnold, MD, USN, Ret.
Murphy Pain Center provides its patients leading care as confirmed by being the region's first and only practice to be awarded the distinction of:

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Time Flies

OMG, has it really been a year? We began with a strategic plan focused on how the Greater Louisville Medical Society would influence, educate and adapt to health care reform. As president, I have been asked to represent the medical society in discussions with our local legislators, as well as visit Washington to interact with other government officials. The medical society officers and several of the GLMS committees have also enlisted the support of our elected representatives. We have attempted to more broadly engage and educate GLMS members on the complexities of each new proposal so our voices could be better heard. Our members needed to think about how health care reform might change the nature of their practices in order to be more prepared to adapt and be successful in the future.

When meeting with our elected officials in Washington, I noted in each their passion and commitment. All were intelligent individuals who cared about the issues but had very differing philosophies and approaches in their proposed solutions. All had rational arguments (with “research” or “history” or “experience”) to support their views. It seemed to me that it was not unlike our profession. Different physicians might have different approaches to the same clinical problem, and where there is no specific “best practice” or “evidence” that one is better than another, one might argue passionately that his or her approach is better based on personal experience or philosophy.

During this past year, I began to realize (both through experience and by receiving some very pointed e-mails) that “representing” the members of GLMS, particularly about a topic so complex and personal as health care reform, was very challenging. The officers and the Board of Governors, individually and collectively, spent many hours studying, discussing and debating the best approach for GLMS regarding the many issues and concerns raised by health care reform. The primary focus for the society leadership has been on how these changes would affect the physician-patient relationship, the art and science of medicine, and access to health care (how physicians interact with our community), as these represent the cornerstones of the GLMS mission.

I received feedback, both positive and negative, throughout the year. I believe that one of the strengths of GLMS is the diversity of opinion of its membership. Many physicians are very passionate about their profession and their beliefs, and this is a good thing! Discussing and debating our different views is helpful and necessary. However, as an organization, I believe we are better off determining what unites us rather than focusing on those issues that we cannot agree upon. And again, I think that brings us back to our mission.

In order to better represent our membership, you will note some changes in this edition of Louisville Medicine. The Editorial Board is actively seeking physicians to submit articles on a wide variety of topics that represent the great diversity of opinions that we have within GLMS in the new section entitled “Doctors’ Lounge.” I strongly encourage members to present their views for publication. Let’s challenge each other with provocative and innovative thoughts, ideas and views. That can only make us stronger. And while we respect the diversity of opinion within our organization, let us also search to find areas of common ground that will help GLMS move forward and become a trusted source of information and counsel for not only our patients, but also our community and elected officials.

This is the focus of the 2010 strategic plan: to elevate our influence, and enhance the role and the perception of physicians in our community. I appreciate the great work of the physicians who participated in this year’s strategic planning session. I am excited by the direction they have created for the society. Dr. Kim Alumbaugh will provide the leadership and vision to drive this plan forward.

It is hard to believe that a year has come and gone. Thank you for the opportunity to serve the society during a challenging and historic time.

Note: Dr. Simon, a neurologist, is senior vice president and chief medical officer of Jewish Hospital and St. Mary’s HealthCare.
Long awaited results of the National Institutes of Health-funded Carotid Revascularization Endarterectomy vs. Stenting (CREST) trial comparing the safety and efficacy of carotid artery stenting (CAS) with carotid endarterectomy (CE) for prevention of stroke were announced on February 26, 2010, at the International Stroke Conference in San Antonio. This trial will have a major impact on patients who are referred for consideration for carotid intervention, and so, a brief review for referring physicians is warranted.

CAS began to emerge as a potentially viable alternative to CE in the mid-1990s, stimulating organization of CREST in 2001. Because of uncertainties relating to the safety of CAS in various cohorts of patients, access to CAS has been restricted to patients with certain medical or anatomic conditions placing them at increased risk for complications with CE. Access to CAS has been additionally restricted to hospitals approved by the Centers for Medicare and Medicaid Services (CMS) to offer CAS and, in asymptomatic high-risk patients, to clinical trials and registries at such hospitals. Major policy decisions relating to reimbursement and access have been postponed, at least to date, in anticipation of CREST.

CREST, unlike other trials which had focused on high-risk surgical patients, randomized 2,502 patients who were at normal surgical risk to receive either CAS or CE. Procedures were performed by rigorously selected surgeons and interventionalists in 117 United States and Canadian public and private hospitals and required nine years to complete. Primary endpoints were stroke, myocardial infarction (MI), and death within 30 days of the index procedure, and ipsilateral stroke up to four years following the procedure.

In comparison of primary endpoints, the overall safety and efficacy of the two procedures was equal (7.2 percent CAS vs. 6.8 percent CE, p=0.51). Further scrutiny of the data, however, reveals important differences. More MIs, most apparently minor, occurred following CE (2.3 percent CE vs. 1.1 percent CAS, p=0.03) whereas more strokes occurred following CAS (4.1 percent CAS vs. 2.3 percent CE, p=0.01).

Though most peri-procedural strokes were classified as “minor,” when the effect of procedural complications on quality of life was analyzed, those patients who had suffered a peri-procedural stroke fared worse than those who had had MIs. This is important because carotid interventions, whether CE or CAS, are performed for the sole purpose of stroke prevention.

CREST data revealed no differences in the safety and efficacy of CAS vs. CE in women compared to men nor in patients classified as symptomatic vs. asymptomatic. However, age was important. Younger patients, less than 69 years of age, fared slightly better with CAS, whereas those older did better with CE. The paradoxical effect of age on the safety of CAS, due to multiple issues including diffuse atherosclerotic disease, tortuous anatomy of the aortic arch, great vessels and internal carotid artery, and decreased cerebral reserve, has been an important point for consideration in patient selection for the two procedures. CAS in octogenarians has been shown to produce higher complications than observed in younger patients.

Technical excellence, high-volume practice and restraint in patient selection seem to be especially important for safe carotid intervention in the elderly.

Beyond the 30-day peri-procedural period, CREST revealed no differences in the efficacy of CAS vs. CE in the prevention of stroke. Late ipsilateral stroke occurred in 2 percent of CAS patients vs. 2.4 percent of CE patients, p=0.85.

Interventionists who participated in the CAS arm of CREST were rigorously screened for technical proficiency and outcomes before being allowed to randomize patients. There were no differences in outcomes of CAS no matter what type of specialist performed the intervention, including cardiologists, vascular surgeons, neurosurgeons, neuroradiologists and interventional radiologists. Additionally, the results of both CE and CAS were the best ever reported in any large, randomized clinical trial for stroke prevention.

Patients enrolled in CREST were randomized to either CAS or CE. Both groups received optimal medical therapy, including but not limited to antiplatelet therapy, statins, antihypertensive therapy targeted to modern treatment goals, assistance with smoking cessation and blood glucose control for those with diabetes. Over the past decade, medical interventional therapy has become so effective that compliant patients are thought to have an annual risk of stroke less than that of the surgical group in the asymptomatic carotid atherosclerosis study, i.e. a risk of stroke less than 1 percent per year. Thus, CREST already has been criticized for absence of a “medical therapy only” arm for the asymptomatic group of patients, and there is a general mandate that future trials randomize between CE, CAS and “medical therapy alone” groups.

CREST will produce much important data, anticipated to emerge in a series of publications over the next few years.
Roberto A. Penne-Casanova, M.D., CWS

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CREST almost certainly will force the hand of CMS and third-party payers to modify policy toward reimbursement for CAS. Thus, it can be anticipated that CAS will become a less restricted alternative to CE generally available for patients who may be candidates for invasive therapy for stroke prevention. The work of translation of clinical trial procedures and outcomes to clinical practice now begins, and this will be a time of critical importance for patients.

For those physicians who refer patients to specialists for consideration for carotid revascularization, it is important to step back and remember that the singular purpose for both CE and CAS is stroke prevention. The American Heart Association has established guidelines for the performance of CE, and these guidelines have been implicitly applied to CAS as well. For intervention in an asymptomatic patient, the risk of procedural stroke or death of a carotid intervention should not exceed 3 percent. In symptomatic patients, i.e. those who have had an ipsilateral hemispheric stroke or transient ischemic attack (TIA) or retinal ischemic event within six months, 6 percent is the ceiling. The specialist must weigh the risk of stroke posed by the natural history of a particular carotid lesion against the risk of stroke or death, which might complicate the procedure. As restrictions on CAS are relaxed and more and more practitioners seek training and development of personal experience with the procedure, i.e. challenge the learning curve, it is of paramount importance that the best interest of an individual patient remains the only factor in determining CAS vs. CE. A risky CAS procedure in an elderly, symptomatic patient with a diseased, tortuous aortic arch cannot be substituted for a technically straightforward CE. Likewise, when restrictions are relaxed, CAS as an alternative to CE must be provided as an option for appropriate patients.

Both CE and CAS have important roles to play in the prevention of stroke, and the CREST results are particularly exciting in that they support CAS as a viable alternative. Both procedures and their peri-procedural processes of care have continued to evolve with time and, when utilized for appropriate indications, with sound technique and in properly selected patients, are safe and efficacious. As with other evolving areas in medicine, clinical judgment may once again prove to be the ultimate determinant of an individual patient’s outcome.


Figures
This patient is a 75-year-old female first referred from southeastern Indiana for an extensive, high-grade, recurrent carotid stenosis six years following endarterectomy. The lesion was treated with CAS. Figure 1 demonstrates the angiographic appearance of the right carotid artery 14 months following CAS.

The patient presented for routine follow-up at which time significant progression of a recurrent left carotid stenosis, seven years following left CE, was noted. (Figure 2) The lesion was treated with the ACCULINK/ACCUNET (Abbott Vascular, Santa Clara, California) CAS system used in CREST, with resolution of the stenosis. (Figure 3)

Although the patient had multiple comorbidities, she spent a total period of six hours in bed following the procedure and was able to return home to Indiana the following morning. She continues to do well. 

Note: Dr. Ross is associate professor of surgery and chief of the Department of Surgery’s Division of Vascular Surgery and Endovascular Therapeutics at the University of Louisville School of Medicine. He practices with University Surgical Associates and is principal investigator of the CHOICE and CABANA clinical registries for carotid artery stenting at Norton Hospital.
In the late 1960s, electricity was available in Port-au-Prince for only three hours each day. Residents pushed two-wheel carts through the streets. David T. Allen, MD, enjoyed quiet evenings playing chess with colleagues by candlelight on the veranda of the Grand Hotel Oloffson after a day of work on malaria eradication as an epidemiologist with the Centers for Disease Control and Prevention.

On February 12, a month after a magnitude 7 earthquake devastated Haiti’s capital, Dr. Allen was back, serving with a team of physicians in Eliazar Germain Hospital and resting in the evenings on the same veranda of the same hotel.

He is one of many Louisville physicians who responded to the disaster by traveling to Haiti to provide medical care. Others in the community contributed time and money to the relief effort, with Supplies Over Seas – a program of the Greater Louisville Medical Society Foundation and Hand in Hand Ministries – taking a leading role.

After the earthquake, Dr. Allen contacted the CDC, which linked him to a Florida-based anesthesiologist who was organizing a team to assist the Haitian staff at the 45-bed hospital with surgeries. The team provided closed and open reductions of lower extremity fractures, wound care, skin grafts, hand surgeries, cast changes, corrections of external fixators, incisions and drainages. Dr. Allen focused on organizing and distributing supplies.

“They were shoulder-high in boxes that were unopened and unlabeled,” said Dr. Allen, who has been retired for five years. “We didn’t know what we had.”

By the time he left Haiti on February 25, most people had safe drinking water and food, but housing was lacking. He was struck by the development of Port-au-Prince – despite the rubble – into a city with reliable electricity, traffic congestion and cell phone communication. But the homeless needed tents to survive the rainy season.

“The degree of destruction defies adequate expression in words – it is a war zone of incomparable proportions in this hemisphere,” Dr. Allen wrote in his journal. Aftershocks woke him twice during his trip.

LEARNING TO IMPROVISE

Joshua W. Meier, MD, who practices with Children’s Orthopaedics of Louisville, considered traveling to Haiti after receiving e-mails from the American Academy of Orthopaedic Surgeons asking for volunteers. He contacted colleagues from his pediatric fellowship and joined a team assembled by Le Bonheur Children’s Medical Center in Memphis, Tennessee, which has operated an outpatient clinic at a convent in Haiti since 1997.

After arriving on January 30, the team provided general medical care at the clinic for several days before one of the sisters told the doctors that surgeons were needed at Sacred Heart Hospital in Port-au-Prince. Dr. Meier spent the next week at the hospital, participating in two to five surgeries each day.

“We couldn’t fix things the way we normally would,” he said, explaining that patients only had a sheet of paper for a chart.

The lack of history proved challenging. Once, a man had already received anesthesia when an X-ray showed a plate in his leg. Between the language barriers and the confusion at the hospital, the man’s previous operation hadn’t been communicated, Dr. Meier said.

One side of the hospital was damaged in the earthquake, but the operating rooms functioned well. Large tents were set up outside for treating patients. Dr. Meier taught family members of patients how to change dressings but also did a number of dressing changes under sedation. He marked bandages with information for those who would provide future care to the patients.

Dr. Meier and the team headed for home on the one-month anniversary of the earthquake.

‘DEALING WITH THE DEAD’

Coroner Barbara Weakley-Jones, MD, was deployed to Port-au-Prince on January 31 with the U.S. government’s Disaster Mortuary Operational Rescue Team. The group set up a portable morgue at the airport for identifying American citizens who died in the earthquake and arranging transportation home.

Dr. Weakley-Jones has been a member of DMORT since the September 11 terrorist attacks, but this was her first deployment. Unfortunately, a GI virus shortened her stay.

“I’d do it again in a heartbeat,” she said. “I feel like even my short time down there was worth it, and I was doing something good for somebody even though I was only dealing with the dead.”

VENTURING TO REMOTE AREAS

Another group of Louisville physicians witnessed the lack of medical care among those not directly affected by the earthquake. Thomas McKechnie, MD, organized a group working with the Illinois-based nonprofit Haitian Christian Outreach that included the following GLMS physicians: Walter E. Badenhausen Jr., MD; Brian Beanblossom, MD; Robert Beanblossom, MD; John J. Hill, MD; Scott Kuiper, MD; Daniel MacMillan, MD; and J. Steve Smith, MD. Their base from February 14 to 22 was Jacmel, a coastal city about 25
miles west of Port-au-Prince. The physicians split into two groups to work at clinics in remote mountain areas.

Dr. Badenhausen, a retired orthopedic surgeon, said many of the Haitians suffered from malnutrition, parasites and anemia. In one surgical case, he removed a mass on the foot of a young girl so she could wear shoes and attend school.

Meanwhile, Dr. Brian Beanblossom and others ventured six hours up into the mountains to a mission built by a Haitian pastor. He estimated they saw more than 1,000 patients in an area where there had been no medical care for a year and a half.

Dr. Beanblossom, a cardiologist, had been to Haiti with his wife and children for a Christian mission trip in July. “We have a heart for Haiti, so when the earthquake happened I tried to get there as fast as I could,” he said.

Headaches, back pains, vision problems and burns were common complaints among the people, whose lifestyle involves cooking over open fires. The doctors met one young man whose ankle had been burned as a child and grew abnormally, causing him to walk on the end of his tibia. Dr. Beanblossom said he hopes to arrange to bring him to the United States for surgery.

“Haiti really looked no different to me than it did in July,” said Dr. Beanblossom, who found hope in sharing his Christian faith with the Haitians. “You can get easily frustrated, thinking ‘What good is this to treat somebody’s blood pressure for two weeks and then they’ll never get medicine again?’ But it means a lot for people to know there’s somebody else who cares enough about their plight to at least help them for a little bit.”

Robert H. Couch, MD, went on another Haitian Christian Outreach trip at the end of March to continue the organization’s efforts in the country.

SUPPLYING THE WORK

In Louisville, Supplies Over Seas stepped up to rush vitally needed medical supplies to Haiti. Founded in 1993, SOS was well-positioned to respond. Immediately after the earthquake, hundreds of volunteers came to its warehouse to sort and pack supplies. Hospitals and other medical facilities donated supplies and encouraged staff to make financial contributions.

Among the volunteers at SOS were Muhammad Babar, MD, and others with the Association of Physicians of Pakistani Descent of Kentucky and Indiana. Dr. Babar said the regional organization of about 150 doctors sympathized with the Haitians, since Pakistan was struck by a devastating earthquake in 2005. They wanted to work with local organizations on Haiti relief, giving $2,000 to SOS and the same amount to Edge Outreach, which provided water purification after the earthquake.

“Because of our medical background, that helped SOS in the sorting of the items,” Dr. Babar said. “We are hoping to have a long-term relationship with organizations like SOS and Edge Outreach.”

SOS sent an initial shipment of two pallets with Florida-based Agape Flights on January 17. A 40-foot container, which was sponsored by Baptist Healthcare System, left on February 3 for distribution by Food For The Poor.

In addition to Baptist Healthcare System, three other organizations pledged $12,500 to sponsor containers: Jewish Hospital & St. Mary’s HealthCare and the JHSMH Medical Staff, the Baptist Hospital East Medical Staff and Depuy Orthopaedics, a Johnson & Johnson company based in Warsaw, Indiana.

“Even as the headlines fade, SOS staff and volunteers continue to work diligently to gather, process and send critically needed medical supplies to Haiti working with trusted sending partners to ensure that the supplies are responsibly distributed,” Senior Executive Allen Montgomery said.

Note: Ellen R. Hale is the communications associate for the Greater Louisville Medical Society.
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he Greater Louisville Medical Society spent the year tracking the constantly changing status of federal health system reform legislation and ensuring GLMS remained an active participant in the discussions, a top goal of our strategic plan. From a members’ forum with U.S. Rep. John Yarmuth in September to a series of articles by physicians in Louisville Medicine, GLMS provided a space for dialogue. The Board of Governors adopted a Statement on Health System Reform in January that outlined eight principles to guide GLMS in advocacy efforts. As health system reform became law in March, the focus turned to educating members and helping them adapt to changes as they are enacted.

Under the leadership of President Lynn T. Simon, MD, GLMS also made important contributions to the community in patient safety, practice management assistance and preventive health, all in keeping with the GLMS mission to: promote the science, art and profession of medicine; protect the integrity of the physician-patient relationship; advocate for the health and well-being of the community; and unite physicians to achieve these ends.
Health System Reform

GLMS launched the Physicians’ Forum on Health Care Reform in an effort to boost physician viewpoints in the national debate. A meeting bringing together physicians and Rep. Yarmuth at GLMS on September 1 included an extended question-and-answer session. The professional networking site LinkedIn provided an online tool for members to join the GLMS group and join in conversations about reform. Vice President Deborah A. Ballard, MD, recorded a Hot Button video editorial on WAVE-TV sharing a statement to the general public from GLMS about the overall need for health system reform that would include universal access, insurance reform, liability reform and the preservation of the patient-physician relationship. Finally, a collection of six articles by physicians with diverse opinions were published in the October and November issues of Louisville Medicine.

The Statement on Health System Reform set out principles with which much of the membership agreed, including: health insurance coverage for all Americans; insurance market reforms; assurance that health care decisions remain with patients and their physicians; investments and incentives for quality improvement, prevention and wellness initiatives; repeal of the Medicare physician payment formula; medical liability reform to reduce the cost of defensive medicine; and streamlining and standardizing insurance claims processing. “Acknowledging that health system reform is an imperfect and ongoing process, the Greater Louisville Medical Society strongly encourages its members and their patients to contact their elected representatives in Washington to let them know first-hand that they support these principles, and to share their personal opinions on the specifics of health system reform proposals as they arise,” the statement read in part.

Assistance for Physician Practices

GLMS responded to the announcement that recovery audit contractors were headed to Louisville-area practices. The RACs, contracted by the Centers for Medicare and Medicaid Services, look for underpayments and overpayments to Medicare. GLMS held a series of eight workshops during the summer before unveiling a RAC Audit Toolkit, available free for member practices and for $499 for non-members. As part of the toolkit, the GLMS professional relations staff and the Professional Healthcare Institute of America included an audiovisual training presentation, implementation resources such as appeal and extension letters and a Microsoft Access tracking database program with a video tutorial. The database serves as a step-by-step guide to monitoring RAC activity. The toolkit was marketed by Medical Society Professional Services, which also began examining vendors that assist practices with implementation of Electronic Medical Records. MSPS endorsed the following preferred vendors that offer special services to members: NetGain Technologies, National Insurance Agency, National Processing Company, Intelligent Collections System and Republic Bank.

A major victory for GLMS physicians and their practices came in October when Blue Cross/Blue Shield paid $128 million as part of the settlement of a national class-action lawsuit. Staff had worked two years earlier with the Managed Care Advisory Group to collect funds from the settlement for physician members. GLMS forwarded the names of all its practicing physician members to MCAG except those who chose to opt out. The $150,000 for GLMS class members was evenly distributed among about 2,600 physicians. Motivated to use the money for collective good, the Board of Governors encouraged physicians to designate their checks for donation to the GLMS Foundation and/or The Healing Place. A total of $32,000 was donated.

The Physicians Take AIM at Diabetes program moved into its second phase with a new infusion of grant funding. The program supports family practitioners, internists and endocrinologists in achieving national recognition as providers of high-quality care to diabetes patients. The first phase of Take AIM began in January 2008, with 45 GLMS physicians meeting the standards of the National Committee for Quality Assurance’s Diabetes Recognition Program. The DRP designation brings opportunities for financial benefits to providers through performance and quality incentive programs. The second phase allowed Take AIM to also offer an audit for the Physician Quality Reporting Initiative, a voluntary program of CMS that results in additional reimbursements for Medicare patients.

The work of the Physician Practice Advocacy Committee’s Insurance Issues Resolution Committees for each major insurer in the region continued, with each IIRC meeting quarterly with Anthem, Humana, National Government Services, Passport and United Healthcare about member difficulties and carrier policy initiatives. GLMS built on the success of holding open forums with each insurer in 2009 and set a schedule of roundtables for members and each insurer’s representatives to have dialogue in 2010.

PPAC also commissioned the third annual payer survey, which showed that Passport was the only carrier among seven to earn a higher overall rating in 2009 than in 2008. The survey was conducted in October with GLMS physician practices, asking questions related to claims handling, pre-certifications/prior authorizations, call centers, voice response systems, web sites and physician rating systems/contracts. While the IIRCs discussed the survey results with each carrier to identify ways to improve, GLMS staff emphasized the need for practices to document problems and submit hassle reports, so they can be addressed.

Though the recession hit many employers and staffing companies severely, Medical Society Employment Services had several achievements: increasing the number of direct hires from a year ago, increasing the number of job orders for nurse practitioners and physician assistants from a year ago and becoming one of the few staffing agencies in Louisville that maintains a licensed nursing pool.

Patient Safety Projects

The Patient Safety Task Force introduced a medication card in February to help individuals carry current records of their medications and other health information at all times. In the absence of an electronic prescribing system, the task force wanted to ensure treating physicians know what drugs their patients are taking to decrease harmful drug interactions. The form was posted on www.glms.org for physicians and patients to print and use. It was also published in the spring issue of Vital Signs, the GLMS wellness magazine distributed in members’ offices.

The Trends in Medicine Committee developed a Controlled Substances Agreement, endorsed by the Board of Governors in November. The Quality Improvement and Patient Safety Committee assisted with the document – a sample physician-patient agreement to serve as a resource for doctors who prescribe controlled substances to communicate their expectations to their patients.
Prevention and Public Safety Efforts in the Community

GLMS partnered with the Louisville Metro Department of Public Health and Wellness to inform both physicians and patients about the H1N1 virus. Beginning in May, when the first case appeared in Louisville, GLMS communicated information through blast e-mail and faxes. The fall issue of Vital Signs was dedicated to educating our citizens about how to protect themselves through vaccination. Medical Society Employment Services assisted with the recruitment of nurses and medical assistants to administer the vaccines in public clinics. The department directly immunized 78,000 children and adults and distributed 228,000 doses to health care providers, resulting in 42 percent of Louisville residents receiving the vaccine. GLMS was recognized as a partner on the H1N1 immunization project in March by Public Health and Wellness.

The Community Health Committee promoted the YMCA of Greater Louisville’s new 16-week Diabetes Prevention Program. Physicians were encouraged to refer patients who have been diagnosed with pre-diabetes to the program. For the third year, the committee organized a health fair at the Fairdale Community Fair. About 20 groups participated in the event, which offered free tests and screenings.

Dr. Simon participated in a news conference at the launch of a Louisville Metro EMS initiative alerting hospital cardiac teams when an ambulance transports a patient suffering from a ST-segment elevation myocardial infarction. The project is part of the Public Safety Committee’s continuing work to decrease hospital diversion. The committee expanded on its Standardized Hospital Diversion Plan by developing a Pre-Hospital Emergency Triage Flow Sheet. The grid lists the self-reported emergency capabilities of each hospital in the region, from STEMI to burns to obstetrical to psychiatric. The flow sheet creates accountability between EMS and the hospitals about the patients they can treat.

Communications Improvements for Members

GLMS unveiled a new user-friendly Web site design in July with many additional features, such as an online roster (for members only), a site search tool, online membership applications, a Flickr photo gallery of GLMS events and an online hassle report form. Pages were devoted to resources on frequently changing topics like health system reform and H1N1 flu.

Louisville Medicine awarded prizes in the second annual Richard Spear, MD, Memorial Essay Contest. The theme was “Medical Mentors.” Clifford Kuhn, MD, wrote the winning essay in the practicing and life member category, while Evan R. McBeath won the student/resident category. Lyle Bohlman, MD, received an honorable mention. The winning essays, as well as several strong entries, were published in Louisville Medicine. The theme for the third annual contest was announced, “The Unforgettable Patient.”

Connections with Medical Students

Engaging medical students and residents in GLMS activities was a priority. At House Staff Orientation, a record 138 incoming residents became GLMS members. Dr. Simon addressed first-year medical students in August at the annual White Coat Ceremony. GLMS provided white coats to the 160 incoming students, and 134 chose to activate their membership and have a professional 5-by-7 portrait taken. The Leadership and Program Development Committee made the free portraits available for the first time.

The annual Physicians Are Linked with Students (PALS) mentoring program kicked off in November with more than 70 physicians and first-year students meeting at a dinner. In March, the PALS program held its first Fat Friday trolley hop, which began with refreshments at The Old Medical School Building.

A new event to help students select their specialties took place in February. GLMS agreed to co-sponsor the Specialty Speed Networking event when approached by the University of Louisville’s student AMA chapter. Mimicking the methods of speed dating, several medical students chatted with a physician for five minutes before moving on to repeat the “dating” process at the next table with a physician from a different specialty. Sixteen GLMS physicians participated, sharing their perspectives with about 50 medical students.

Finally, the annual Match Day celebration for soon-to-be graduates took place at GLMS in March.

Advocacy in Kentucky and Beyond

The delegation to the Kentucky Medical Association Annual Meeting in September was highly successful. Gordon R. Tobin, MD, was elected as president-elect, while Bruce A. Scott, MD, retained his position as AMA delegate after an election. Declining AMA membership resulted in KMA losing one of its five delegate positions. Robert A. Zaring, MD, also kept his spot as AMA alternate delegate. Former GLMS Alliance president Anita Garrison was installed as KMA Alliance president. GLMS submitted eight resolutions, all of which passed the House of Delegates.

GLMS leaders participated in several lobbying opportunities. Efforts during the KMA Day at the Capitol on January 27 led to the introduction of a bill addressing economic credentialing. Another key event was the American Medical Association National Advocacy Conference in March in Washington, D.C., which focused on finding a permanent fix to the Sustainable Growth Rate formula for Medicare payment to physicians.

GLMS Foundation

Following its 50th anniversary year in 2008, the GLMS Foundation pursued its four strategic goals of medical missions, health care careers and scholarships, indigent health care and The Old Medical School Building Fund.

Two areas of the building were dedicated during an open house in March. Robert S. Howell, MD, had the fourth floor dedicated to the Christopherson Gross Anatomy Lab in honor of his mentor and friend, the late William Christopherson, MD. A room on the garden level that served as the first research laboratory in the building was dedicated to the late Harold Kleinert Lounge by his family, colleagues and friends. The role of The Old Medical School Building in Louisville’s medical history entered the spotlight when two major conferences came to the city. The Southern Association for the History of Medicine and Science held its annual meeting in Louisville. As part of the program, attendees enjoyed a reception at GLMS and toured the building. In May, the University of Louisville School of Medicine and Jewish Hospital hosted the Flexner Report Centennial Symposium, a national event capped off by a dinner and lecture at The Old Medical School Building.

The GLMS Foundation presented a $10,000 donation to The Healing Place at its 20th anniversary celebration in October. Most of the 15 founding physicians of The Healing Place attended the event, which recognized the medical society for taking on the management of a homeless shelter in 1989 and building it into Kentucky’s largest shelter recovery program for the homeless and addicted. The donation was given for THP’s new Women and...
Children’s Community at 15th and Hill streets, which began housing residents around Thanksgiving.

The value of Supplies Over Seas, a program of the GLMS Foundation and Hand in Hand Ministries, was demonstrated in the aftermath of the January earthquake in Haiti. SOS quickly responded by sending an initial shipment of life-saving medical supplies just five days after the disaster. Hundreds of volunteers processed supplies for a 40-foot container sponsored by Baptist Healthcare System that was shipped during the first week of February. SOS also equipped local physicians and nonprofit groups traveling to Haiti with supplies. Three additional sponsorships of containers for Haiti were secured from Jewish Hospital & St. Mary’s HealthCare and the JHSMH Medical Staff, the Baptist Hospital East Medical Staff and Indiana-based DePuy Orthopaedics.

The GLMS Alliance, led by President Millicent Evans, also contributed to both THP and SOS. Members assembled Christmas gift bags for THP clients and provided holiday decorations for the Women and Children’s Community. The GLMS Alliance held its annual Doctors’ Day for retired physicians in March, honoring Norton G. Waterman, MD, who founded SOS in 1993. The annual Day at the Races to benefit healthcare system that was processed supplies for a 40-foot container sponsored by Baptist Healthcare System that was shipped during the first week of February. SOS also equipped local physicians and nonprofit groups traveling to Haiti with supplies. Three additional sponsorships of containers for Haiti were secured from Jewish Hospital & St. Mary’s HealthCare and the JHSMH Medical Staff, the Baptist Hospital East Medical Staff and Indiana-based DePuy Orthopaedics.

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Three-Year Goals and Objectives (not listed in priority order)

Goal 1: Increase the influence of physicians and the medical profession in our community.

1.1 Continue to influence the discussions and decisions around health care reform.
1.2 Increase the influence of GLMS in changes in local health care delivery.
1.3 Collaborate with entities to promote to community leaders and the public the role of the medical profession as leaders in the provision of health care.
1.4 Continue efforts to promote health care organizations and the GLMS Mission Statement.
1.5 Develop a plan to elevate the influence of physicians and the medical profession in health care. The Greater Louisville Medical Society will be the most effective medical society in the U.S. in terms of service to its members and the community.
1.6 Establish mechanisms to place physicians who can actively participate on public and private boards.
1.7 Update the public relations action plan to use the public media to promote the level of professionalism and the profile of physicians.
1.8 Establish programs to develop their leadership skills.
1.9 Develop mechanisms to measure the effectiveness of GLMS’ efforts to influence changes in local health care delivery.
1.10 Re-establish a mini-internship program for community leaders, and develop a plan in conjunction with the Louisville Science Center to deliver health care information.
1.11 Establish at least two community projects that address the needs of the underserved.
1.12 Examine medical ethical issues and communicate to appropriate audiences.
1.13 Increase members’ knowledge of the benefits of the Foundation, engagement of members in the Foundation, and marketing of the philanthropic activities of the Foundation and Society.
1.14 Maintain relationships and communications with the University of Louisville School of Medicine, and respond to requests for educational assistance.

Goal 2: Demonstrate the value of GLMS to the membership.

2.1 Develop and implement an action plan that helps members and GLMS adapt to changes resulting from health care reform discussions.
2.2 Continue to monitor changes in the nature of physician practices.
2.3 Where changes in the nature of physician practices are identified, develop programs and services that meet the needs of affected physicians.
2.4 Identify opportunities and implement plans to make daily medical practice easier.
2.5 Develop programs and services that improve patient safety.
2.6 Monitor and continue to influence nationally recognized peer developed quality measures appropriate for patient care, and communicate these efforts to members.
2.7 Continue to provide peer support and dispute resolution.
2.8 Establish programs to improve physician skills in business and practice management.
2.9 Provide effective and efficient communications to members and the Society’s various publics.
2.10 Engage members to increase a sense of community and social interaction within GLMS.
2.11 Continue to implement an action plan that results in increased membership in GLMS.
2.12 Provide appropriate practice management programs and services.
2.13 Pursue health plan accountability.
2.14 Evaluate, monitor and take action as appropriate for emerging external physician grading/rating programs.
2.15 Align and integrate committees and work groups to the work of the Board and Strategic Plan, and complete a comprehensive review each year.
2.16 Identify ways to collaborate with the Foundation to accomplish the Foundation’s four initiatives and the GLMS Strategic Plan.

Goal 3: Conduct an effective legislative program.

3.1 Continue to influence legislation that impacts physicians and patients.
3.2 Work to place physicians who can actively participate on health care policy setting boards.
3.3 Ensure that GLMS is effective in:
   a. Identifying priority legislative and regulatory issues;
   b. Involvement with KMA for determining priority issues for legislative action; and
   c. Involvement with legislators and the public in working the issues.
3.4 Maintain coordination among the leaderships of the KMA, AMA, and other physician organizations for active participation and mutual benefit.
3.5 Ensure GLMS’ engagement in the development of future KMA leadership.
### Greater Louisville Medical Society
#### Statement of Activities
January-December 2009

<table>
<thead>
<tr>
<th>Changes in net assets</th>
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<tbody>
<tr>
<td>Dues</td>
<td>$702,295</td>
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<tr>
<td>Louisville Medicine Advertising</td>
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<td>GLMS News Advertising</td>
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<tr>
<td>Roster Sales &amp; Advertising</td>
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<tr>
<td>Centralized Application Processing Services</td>
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<tr>
<td>Society Office Services</td>
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<tr>
<td>Sponsorship Revenue</td>
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<tr>
<td>Administrative fee from Medical Society</td>
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<tr>
<td>Professional Services</td>
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<tr>
<td>Administrative fee from GLMS Foundation</td>
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<tr>
<td>Vital Signs</td>
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<td>Web Site Advertising</td>
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<td><strong>Total Operating Revenue</strong></td>
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<tr>
<td>Investment Income</td>
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<tr>
<td><strong>Total revenues</strong></td>
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#### Program service expense

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<tr>
<td>Committee and general administration</td>
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<tr>
<td>Roster</td>
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<td>Centralized Application Processing Service</td>
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<td>Society office services</td>
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<td>Vital Signs</td>
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<td>Web Site</td>
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<tr>
<td><strong>Total expenses</strong></td>
<td>1,968,345</td>
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Net increase in unrestricted net assets: 113,238

Gain (loss) on sale of investments: (8,835)

Unrealized gain (loss) on marketable investments: 239,355

**Changes in net assets**: $343,757

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### Greater Louisville Medical Society
#### Statement of Financial Position
December 31, 2009

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<td><strong>CURRENT ASSETS</strong></td>
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<td>Cash/cash equivalents</td>
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<td>Accounts receivable</td>
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<td>Prepaid expenses</td>
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<tr>
<td><strong>INVESTMENTS AND OTHER ASSETS</strong></td>
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<td>Investments at market value</td>
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<td>Annuity contracts</td>
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<td><strong>PROPERTY AND EQUIPMENT</strong></td>
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<tr>
<td>Leasehold improvements</td>
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<td>Office equipment</td>
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<tr>
<td>Less accumulated depreciation</td>
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<tr>
<td><strong>TOTAL ASSETS</strong></td>
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<table>
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<tr>
<th>LIABILITIES AND NET ASSETS</th>
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<tr>
<td><strong>CURRENT LIABILITIES</strong></td>
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<td>Accounts payable</td>
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<tr>
<td>Accrued expenses</td>
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<tr>
<td>Unearned income</td>
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<tr>
<td><strong>DEFERRED RETIREMENT BENEFITS</strong></td>
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<tr>
<td><strong>NET ASSETS</strong></td>
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<tr>
<td>Unrestricted</td>
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<tr>
<td><strong>TOTAL LIABILITIES AND NET ASSETS</strong></td>
</tr>
</tbody>
</table>

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May 2010 17
Addressing Public Health Needs in Louisville Metro

Deborah Ann Ballard, MD

“Start where you are, Use what you have, Do what you can.”
-Arthur Ashe

On the day this article was written, March 23, President Obama signed the Patient Protection and Affordable Care Act into law. The bill expands health insurance coverage for Americans by restricting the insurance industry’s ability to deny coverage and increasing the number of people eligible for Medicaid, among a number of other things. The bill assures that most Americans will have health care coverage up front, not only when they develop a devastating illness and enter a hospital.

The cost of providing health care to the U.S. was much higher than the cost of providing it to other developed democracies before the bill, and unless major structural and policy changes are made, it will go even higher now. Therefore, cost serves as a real impetus to change those things we can. It is unfortunate that the suffering of our fellow Americans is not enough impetus on its own.

The U.S. spends 75 percent of its health care dollars on chronic diseases, most of which are preventable. This provides a wonderful win-win situation: reduce the burden of chronic, preventable diseases; reduce human suffering; and reduce costs. Nobody loses if chronic disease is reduced, except perhaps pharmaceutical and medical supply companies that grow rich off the sick, and even they will not lose in the long run. They will just need to adjust their business models.

When you examine the reasons Americans are burdened with so much chronic disease, you discover we have many serious root causes to be addressed. Racial and ethnic discrimination, lack of education, poverty and deeply ingrained trans-generational learned helplessness and hopelessness are the root causes of poor health. These causes cannot be adequately addressed in a 15-minute office visit with a health care provider. This is why policy and structural changes must be made. Policy changes may occur at the federal level, but they must be implemented locally by each and every community in the United States by the people who live in those communities. Policy and structural changes that promote equality, education, economic advancement, equal access and a sense of empowerment are best accepted when they are championed by local people, not the federal or even state government.

Matthew Zahn, MD, medical director for the Louisville Metro Department of Public Health and Wellness, noted that Louisville’s recent smoking ban is one of the most important policy changes to improve local health. The department has recently taken on the issue of trans fat in foods prepared at area restaurants and bakeries. While stopping short of calling for an all-out ban, the department will soon be engaging in a massive public education campaign accompanied by a possible menu labeling initiative.

The Department of Public Health and Wellness has also just won a $7.9 million Communities Putting Prevention to Work grant from the U.S. Department of Health and Human Services. The grant will fund 23 citywide projects that will, among other things, make healthier foods available in schools, build community infrastructure to encourage biking and walking, and make fresh produce more readily available by implementing “Healthy in a Hurry” stores in underserved neighborhoods.

These projects will implement structural change aimed at reversing the growing tide of chronic disease. The projects also are aimed at addressing the social determinants of health in the neighborhoods.

In 2006, the Department of Public Health and Wellness established the Center for Health Equity in West Louisville. The center works to address the root causes of health disparities by supporting projects, policies and research to change the relationships among health, longevity and socioeconomic status for the better. Among many other projects, the center awards small grants to grassroots community organizations to fund projects aiming to reverse health inequities through policy change.

The Center for Health Equity has also just begun a Men’s Health Initiative, which is taking public health to the streets through such projects as health screenings in barbershops. Darryl Turpin, MPA, community outreach coordinator for Public Health and Wellness, oversees the Men’s Health Initiative that seeks to identify economic and social barriers keeping men from accessing health care and engaging in preventive care, and to develop strategies to empower men to overcome those barriers.

Some groups in the Louisville area addressing root causes of poor health are:

1. Louisville Metro Department of Public Health and Wellness and the Center for Health Equity
2. Federally Qualified Health Centers
3. Foundation for a Healthy Kentucky
4. Freidel Committee for Health System Transformation
5. Fit Kentucky
6. Urban League
7. Kentucky Cancer Program
8. American Cancer Society
9. American Diabetes Association
10. American Heart Association
11. American Lung Association
12. March of Dimes
13. National Association for the Mentally Ill
14. Kentucky ACTION
15. Kentucky Voices for Health

Continued on page 20
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- Pediatric Pain
- Interstitial Cystitis / Pelvic Pain
- Reflex Sympathetic Dystrophy
- Sports Injuries
- Migraine Headaches, Whiplash
- Acute & Chronic pain
- Low Back Pain & Sciatica
- Management of Cancer Pain

We specialize in the following procedures:
- Acupuncture & Prolotherapy
- Radiofrequency Neuroablation
- Spinal Endoscopy & I.D.E.T.
- Epidural Lysis of Adhesions
- Spinal Cord Stimulation
- Intrathecal Pump for Pain
- Discography & Vertebroplasty
- Independent Medical Examinations
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A. J. Nair, M.D.
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T : 502 995 4004 | F : 502 933 5559 | E : info@painstopshere.org | W : www.painstopshere.org
This is not an exhaustive list. I hope any organizations not listed will contact the Greater Louisville Medical Society and let us know what they are doing to improve the health of our population. The point is that there are many organizations already in place working on obesity, smoking, physical fitness, cancer prevention, access to healthy foods and exercise, and social justice issues. These are grassroots organizations made up of our neighbors, friends and colleagues. I highly encourage physicians to become involved with these organizations and lend their unique knowledge to their efforts.

A new day has dawned in American health care, and I believe it is a cause for celebration, not anxiety or despair. All major social changes are fraught with struggle and strife, but we have everything we need to solve our health care issues in our own communities. It is time to get cracking.

Note: Dr. Ballard is the director of community outreach for the Norton Cancer Institute’s Prevention and Early Detection Program. She thanks the following for their contributions to this article: Sarah E. Walsh, MPH, CHES, health research coordinator, Kentucky State Data Center, Urban Studies Institute, University of Louisville; Dave Langdon, BS, director of communications and public affairs, Louisville Metro Department of Public Health and Wellness; Matthew Zahn, MD, medical director, Public Health and Wellness; and Darryl Turpin, MPA, community outreach coordinator, Public Health and Wellness.
Fabulous 4 bedroom, 4 full and 3 half bath home with huge walk-out in Indian Hills. Large vaulted living room with floor to ceiling creek stone fireplace, granite bar, built-in media center and surround sound with access to the deck. Gourmet kitchen with custom maple cabinets, Asko dishwasher, Gannenau stovetop, and warming oven all remain. First floor master suite features 2 walk-in closets, double vanity with granite countertops, marble and glass block shower, Kohler Jacuzzi tub, and private bidet and water closet. The vaulted library with built-in bookshelves, full bath, and fabulous river views can be used as a fourth bedroom. The spacious, full daylight walk-out has an open great room with creek stone fireplace, large semi-circle bar perfect for entertaining. 2 large bedroom suites each with its own bath, 2 additional half baths, and an office. The wine cellar features beautiful mosaic windows, custom artist mural, and security system. Additional 3.282 acre adjacent lot with river views available for $1,000,000.

$1,950,000
One Hundred Years of the Flexner Report

“Such a rattling of dead bones has never been heard in this country before or since. Schools collapsed to the right and left, usually without a murmur.”

-Abraham Flexner
The Flexner Report, published on June 11, 1910, under the auspices of the Carnegie Foundation for the Advancement of Teaching (CFAT), is named after its author, Abraham Flexner—a distinguished educational theorist and an ex-principal of a preparatory school in Louisville, Kentucky. This landmark and groundbreaking report released in book form as Medical Education in the United States and Canada has reached the century milestone of its existence and has withstood the test of time. The introduction is written by Henry Pritchett, the main architect of the survey and president of CFAT. The introductory chapter is a carefully worded yet scathing critique of the extant deplorable state of the commercial enterprise of proprietary schools for the “enormous over-production of un-educated and ill trained medical practitioners”... “in absolute disregard of the public welfare.” The book has 346 tightly packaged pages, with the first half (Part I) containing several chapters about the history of medical education from the early colonial days to 1910, medical sects (homeopathy, osteopathy, eclectic medicine, physiomedical sect), the course of study during the four years at the medical school and the postgraduate school, financial aspects of medical education, and chapters about women and African-American medical education. The second half (Part II) is a detailed account of the survey results of all 155 medical schools in the United States, arranged alphabetically by state with descriptions of 12 postgraduate schools and eight Canadian schools. The Flexner Report has proved to be an enduring historical document that contained not only stinging descriptions of medical schools included in the survey but also a blueprint for reform and standardization of medical education in the United States. It hastened the demise of for-profit proprietary medical schools and catalyzed much-needed reform in the way medicine was taught. Flexner’s meteoric rise from an almost obscure teacher from Louisville to an educational critic-authority and icon was amazing. For the next several decades, he enjoyed the limelight as an unconested reformer of medical education and as the person most responsible for the disbursement of the philanthropic largesse, mostly of the phenomenally wealthy Rockefellers, to improve medical education. The publication of the Flexner Report earned Abraham Flexner everlasting fame, and the implementation of his reform program brought him the title “Father of Modern Medical Education.” Hans Zinsser, MD, a famous bacteriologist and man of letters, called him the “Uncle of Modern American Medicine.”

Status of Medical Education in the United States at the Beginning of the 20th Century

During the late 19th and early 20th century, there were three systems of training for medical students in America: the apprentice-ship system; commercial or proprietary schools; and university-affiliated medical schools. For-profit proprietary schools were almost everywhere, and anyone with the ability to pay tuition could enroll due to lax and non-standardized entrance requirements. After listening to the interminable didactic lectures for a portion of two years, students could earn an MD degree and start practicing. From these unregulated proprietary schools came an overproduction of ill-trained physicians, who were becoming a national disgrace. The reform movement in medical education had proceeded for at least two decades but became more urgent after the establishment of Johns Hopkins University’s School of Medicine as the preeminent edifice of an exemplary institution that would serve as a comparator for the rest of the medical schools in the country during Flexner’s survey. The American Medical Association had created the Council on Medical Education (CME) in 1904 precisely to raise the standards of medical education. A grading system had been developed, and 160 medical schools had been surveyed in 1906 by Nathan P. Colwell, MD, secretary of the CME. However, the results were not made public for fear of upsetting the member physicians, some of whom were receiving handsome financial rewards by teaching at or owning the commercial schools. Eighty-two of the surveyed schools received the Grade A (approval) rating, 46 received the Grade B (imperfect but redeemable) rating and 32 schools received the Grade C (beyond salvage) rating. Because of the grading system, 29 schools closed between 1906 and 1910.

What was needed was a dispassionate, objective outsider with no fear of retribution from the members of the AMA. Arthur Dean Bevan, MD, the president of the CME, approached Pritchett to independently perform a survey of the medical schools that would appear above the internecine struggles in medicine. Enter Abraham Flexner, who was 42 years old and, after a self-improvement educational sojourn to Harvard, Oxford and Berlin universities, had returned to America and was in fact looking for a job. An interview was arranged with Pritchett, most likely through the help of his brother Simon Flexner, who had become the first director of the Rockefeller Institute for Medical Research after an illustrious career as a pathologist at Johns Hopkins and the University of Pennsylvania. Abraham Flexner carried a letter of introduction from Ira Remsen, the president of Johns Hopkins, andaced the interview with Pritchett, who had read and admired his book The American College. That book was a merciless critique of the flawed pedagogic system of college education. Flexner got the job after two meetings. Flexner initially thought that he had been mistaken for his brother the doctor, but was assured that it was he that Pritchett was interested in hiring as the surveyor of the medical schools even though he had never set foot in a medical school. Sherwin B. Nuland, MD, summarized it thus: “What was needed was a roving detective-gadfly who could study the debilities of the nation’s system of medical education and then prescribe the process by which they might be resolved. This was not a job for a committee; it could only be done by a single individual of such proven ability that his conclusions would be trusted and his recommendations unhesitatingly instituted. At the critical moment, the critical individual appeared, in the person of Abraham Flexner.”

The Survey

Before embarking on his whirlwind survey, Flexner the layman took a crash course in the nuances of medical education. He read surgeon Theodor Billroth’s classic book, Lehren und Lernen der Medizinischen Wissenschaften, which was later translated into English in 1924 under his direction, with an introduction by William Welch, MD. It was titled The Medical Sciences of the German University. In Chicago, Flexner pored over the survey reports prepared by Colwell for the CME and talked to AMA personnel. He later returned to Johns Hopkins and conferred with Welch, the avuncular and phenomenally powerful “Dean of American Medicine.” Flexner met with other notable physicians at Johns Hopkins including Drs. William Halsted, Franklin Mall, John Abell and William Howell — “a Continued on page 24

M. Saleem Soyal, MD, FACC, FACP

MAY 2010 23
few others who knew what a medical school ought to be.” Johns Hopkins would remain Flexner’s benchmark and exemplar against which other schools were compared. His blitzkrieg tour of 155 medical schools in the United States and Canada commenced in January 1909, guided by his own personal maxim “ambulando discimus” (we learn by going about), and concluded in April 1910. During those 16 months, he criss-crossed the length and breadth of the North American continent mostly via train, sometimes via horse and buggy, and occasionally in Ford’s Model T that had made its debut in 1908, Flexner examined the entrance requirements, size and training of the faculty, finances of the school, adequacy of the laboratories, and the hospital facilities. What he reported in his now-famous book was astounding: he found the system of medical education in disarray with a lack of uniform standards, mostly didactic, rote-learning teaching methods, and very limited financial and teaching resources. “There probably is no other country in the world in which there is so great a distance and so fatal a difference between the best, the average, and the worst,” he wrote in his book.1

The Report and its Aftermath

Medical Education in the United States and Canada was a sensation and caused a widespread stir in the country. Some have described it as a “genteel bombshell” or an “earthquake in medical education.” The public was apprised of the plethora of ill-trained physicians and the need for substantially decreasing the number of physicians. An ideal medical school would offer selective admission of motivated young men and women and would have adequate facilities for laboratories and research, university affiliation, ample clinical material with the attached hospital, and a motivated and competent faculty. Flexner suggested that there should be a drastic reduction in the number of medical schools from 155 to 31. Front-page stories were written about the report in prominent newspapers. The New York Times of July 24, 1910, declared most medical schools “factories for the making of ignorant doctors.” Within a decade, there were 85 schools left in the country. Flexner never minced words. His stinging descriptions of the awful conditions that he found in almost 66 percent of the schools he surveyed and described as “utterly hopeless” are still a testament to his eloquence. For example, he called Kentucky “one of the largest producers of low-grade doctors in the entire Union.” Chicago, with its 14 schools, was described as the “plague spot of the country.”

Death threats were received for this comment, but he was not deterred and went to the city to deliver a speech without any harm. Even his hometown school in Louisville did not escape his tempest. “The hospital facilities are therefore poor in respect to both quality and extent … the classes are unmanageably huge; the laboratories overcrowded and undermanned; clinical facilities, meager at best, broken into bits in order to be distributed among the aggregated faculty.”

The timing of the Flexner Report was ideal, providing a wealth of information and opinion about the status of medical education, and later the report was a catalyst in procuring the flow of money to medical schools from philanthropic foundations. The report with its dated but not obsolete language remains highly relevant even today. The Flexner Report was not just a damning indictment of the sorry state of medical education but a seminal document studded with originality. According to a distinguished historian and Flexner biographer, Thomas N. Bonner: “Here was no pliant, hired hand doing what he was told but a fiercely independent man who had informed himself so well that from then on, it was Flexner … who became almost overnight the most sought-after authority on matters affecting medical schools.”

After Abraham Flexner had finished his report on medical education in Europe in 1912, he was hired by the General Education Board (GEB) of the Rockefeller Foundation in 1913. He was then commissioned to survey the brothels in Europe and wrote in 1914 Prostitution in Europe, which was responsible for the lack of red light districts in America. He had been invited to appear in front of the Haldane Royal Commission in London in October 1910 where the Flexner Report had already been acknowledged. There he provided his candid perspective on medical education in Britain, and Flexner’s recommendations were largely endorsed in the Haldane Commission Report of 1913. Over the next 15 years he was the prime mover and shaker as assistant secretary and then secretary at the GEB. He wielded tremendous influence in doling out massive sums of money to select medical schools (Johns Hopkins, the University of Chicago, Vanderbilt University, the University of Rochester, Iowa University, Yale University, Howard University and others) to implement his program of reformation including building new facilities and equipping laboratories, and introducing his full-time teaching plan that was quite controversial. His multifaceted endeavors continued after his retirement from the GEB in 1928. Another report by Flexner may be cited about overcrowding of the medical curriculum: “Medical curricula the world over contain too many subjects as well as too much material … Men become educated by steeping themselves thoroughly in a few subjects, not by nibbling at many. The medical curriculum cannot aim to produce physicians ready for practice.”2 Flexner gave Rhodes Trust lectures in Europe that were later published as his highly acclaimed book Universities. In 1930, he became the founding director of the Institute for Advanced Study (IAS) in Princeton, New Jersey, through the philanthropic bequest of the Bambergers (Louis and his sister Carolyn Fulld). Into this “Scholar’s Paradise,” “Platonic Haven” and “Intellectual Powerhouse,” he was able to entice prominent mathematicians, physicists and logicians. One of the prize catches was Albert Einstein. Flexner retired from the IAS in 1939 at age 73 but remained active in writing books and articles and engaging in educational activities until his death in 1959.

Re-Assessment of the Flexner Report

The Flexner Report garnered unusual attention in 1910, and the interest has not diminished in the report itself or its author even though 100 years have elapsed since its publication. The reception was not uniformly positive, however. “Those whose oxen were gored were more than critical, many were outraged … One brought suit for libel, many wrote violent letters of protest, some of them anonymous.”

“In the 10 decades since, a gaggle of medical historians have mined the report for scholarly nuggets … Many have written glowingly of how Flexner, backed by the substantive support of philanthropists Andrew Carnegie and John D. Rockefeller and the crème de la crème of academic medicine, dragged the profession out of the muck and mire of the not-so-good-old-days.”3 Flexner was uniformly admired among the historians and medical educators of the 1950s and 1960s, save for a few who criticized his acerbic and caustic language, abrasiveness and vehement opinions. On his 90th birthday in 1956, when he had already been an educational legend for close to 30 years, Flexner was hailed in the presence of a large number of deans of medical schools as the man who had made
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Continued from page 24

“the greatest single contribution in history” to the teaching of medicine.

There was a sea change in Flexner’s reputation in the 1960s and 1970s, according to Bonner, due to changes in perspective and new styles of historical writing. Flexner was blamed by these revisionist writings, as Bonner points out, for the heavy emphasis on scientific research and high technology medicine at the expense of holistic components of medicine. He was variously called a prize academic snob, arrogant, elitist, etc., and his report was called “probably the most overrated document in American medical history.” Most recent writings do show a fresh outlook on the man and the report named after him. Bonner has written a magisterial and definitive biography with a wealth of information from archival material gathered from disparate places.

Since its publication, the Flexner Report has generated heated discussions and debate and many theses. Books and articles have been written about the report and the man behind it. An appraisal of medical education in Britain was detailed in the context of 50 years after the Flexner Report, and the author points out: “The present evolution of British medical education is in essence based on the views propounded half a century ago by Abraham Flexner, and it is interesting to examine the current balance-sheet of profit and loss which has followed the almost unquestioning academic acceptance – and tardy implementation – of the recommendations which he made between 1910 and 1912.”

In November 1985, a conference titled “Flexner: 75 Years Later – A Current Commentary on Medical Education” was held to commemorate the 75th anniversary of the Flexner Report at the University of Medicine and Dentistry in New Jersey. The proceedings of the conference were published. In June 1986, another conference was held at the University of Illinois College of Medicine in Chicago, and the papers presented were compiled in book form.

Offering a medical educator’s perspective at the century mark of the Flexner Report, University at Buffalo surgery professor Eddie Hoover offers drastic changes for an overhaul of the medical education enterprise including re-engineering the pre-medical, medical and residency education models – adding business economics courses, and training in medical ethics, patient safety issues and more. The Flexner centenary issue of Academic Medicine published by the Association of American Medical Colleges (AAMC) in February 2010 contains 27 excellent and thoughtful articles dealing with the Flexner Report and its impact over the last 100 years, not only in the United States but other countries as well (including offshore medical schools). To address 21st century health care needs, which have currently taken center stage in this country, there are calls for taking another look at our much more complex system of medical education as compared to the one during Flexner’s day. Darrell G. Kirch, MD, president and CEO of AAMC, has cogently pointed out that in the aftermath of the Flexner Report, academic medicine responded to the challenge with a high-caliber system of education, a solid scientific foundation and training for state-of-the-art practice, but the cultural shift and new trends of the new century need to be embraced and understood to achieve transformational change in medical education. David M. Irby and his co-authors inform us that a new 2010 Carnegie report will be issued this year that will “generate the same excitement about educational innovation and reform of undergraduate and graduate education as the Flexner Report did a century ago.”

The case for “another Flexner Report” and the need for a modern-day Abraham Flexner have been strongly made: “someone to pull the disparate parts together, to shake up the lethargy and complacency, to streamline medical education into the 21st century.”

Edward C. Halperin, MD, MA, FACR, dean of the University of Louisville School of Medicine, and colleagues provide succinct yet thorough biographic information about Flexner and then discuss several historical questions in detail, including: his views about African-American medical education shaped by his upbringing in the segregated post-Reconstruction South, the medical education of women, whether the report was original or derivative, whether the report made any difference and whether the report is an icon.

The Flexner Report Centennial Symposium is being held in Flexner’s hometown on May 4 in collaboration with Jewish Hospital and the University of Louisville School of Medicine. Prominent national medical educators and Flexner experts will gather, discuss and celebrate his work and its continuation this century.


Note: Dr. Seyal practices Cardiovascular Diseases with River Cities Cardiology MPC.
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Jacob’s Pharmacy: Where the Flexners’ Remarkable Futures Were Compounded and Dispensed

On the southeast corner of Fifth and Market streets in Louisville’s old business district of the 19th century is a long-forgotten site that stands as a monument to a band of brothers from an exceptional family.

Framed by rusting, iron columns covered by layers of old paint is the place that housed Jacob Flexner’s Pharmacy over a century ago. That pharmacy gave the essential economic opportunities to three sons of immigrants Moritz and Esther Flexner that transformed their humble, base metal origins into golden achievements through the alchemy of American opportunity. Thus the pharmacy site also symbolizes the uniquely American story about high achievement in a society freed from barriers to success imposed by an entrenched class structure. Jacob’s Pharmacy sustained the entire Flexner family in an especially difficult financial time. It also became the launching pad for the careers of Abraham and Simon, who rose to levels of accomplishment and fame that still shine historically, even as the site of origin fades under successions of new tenants, layers of paint and the neglect that comes from amnesia of times past.

Humble Beginnings and High Goals

Jacob Flexner was born in 1857, the first child of Moritz (Morris) and Esther Abraham Flexner. Shortly before marriage, they were both newly arrived immigrants from western Germany. They came from a group who embraced Reform Judaism, the liberal branch of Judaism that was new and taking root in that part of Europe at the time.

Continued on page 30
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Continued from page 28

Many settled in the Southern United States because they did not require the strict kosher diet and rules that were nearly impossible to follow in the rural South of the mid-19th century. The Flexners had no resources beyond family bonds, commitment to hard work, love of education and trust in the American promise. Morris rose from a rural peddler to a hat merchant of respectable success, but he wanted his sons to rise above him as educated professionals. Jacob’s goal was to become a physician, which was supported by the family’s blessing and pride.

Jacob’s Medical Dream Dashed

The panic of 1873 ruined Morris’ successful business partnership with Emanuel Hirsch and plunged his family back into poverty. Jacob never forgot the dismal Christmas Eve when his father disclosed his financial ruin and informed Jacob that medical school had become impossible, as Jacob’s earnings had become a necessary contribution for the family’s survival. Morris proposed the alternate route of becoming an apprentice pharmacist, rising through a pharmacy career, and transitioning into medicine. Today this seems unusual, but in the 19th century that pathway was quite common, as there was substantial overlap between pharmaceutical and medical education, with common core courses such as chemistry and materia medica. Some pharmacists became physicians, and a few continued dual careers. Jacob’s apprenticeship was long and arduous but filled with fascinating experiences that are vignettes of the era. A most memorable one for Jacob occurred one night while tending a Louisville pharmacy alone, where he was robbed by a notorious outlaw named Red Leary, once of the Quantrell gang that also produced Jesse and Frank James. He also recalled assisting a local medical school physician on a grave-robbing expedition. Jacob’s long, hard days as apprentice paid off, and he ultimately was able to enter the Louisville College of Pharmacy, where he graduated second in his class in 1878.

A Risky Venture Succeeds

With degree in hand, Jacob took the risk of a large loan in 1878 to purchase an established drugstore on Market Street. With diligence and hard work, he built his reputation, and he achieved economic success quite rapidly. To keep alive his dreams of a medical career, Jacob kept a small library of up-to-date medical books and journals. He purchased one of the first microscopes in the region for analysis of urine and other specimens, and he courted the patronage of the best Louisville physicians. These resources, and Jacob’s passion for intense scientific discussion and debates, made his pharmacy a daily gathering place and discussion forum for Louisville’s most respected physicians. This was the manner of the era for what we now call continuing medical education, and it gave Jacob a substantial informal medical education. At home, Morris’ health was failing, and Jacob became acting head of the family, with his pharmacy providing its major support. Jake’s assertive leadership, influence and interests were thus extended to his younger siblings.

Abraham’s College Opportunity

Jacob’s Pharmacy played a key role in obtaining higher education and in the ultimate legacy of Abraham Flexner. Jacob’s strong personality, outspoken manner and passion for debate intimidated younger family members, especially Simon, but Abraham more resembled Jacob, and he was inspired and energized by Jake’s aura and intellectual aggressiveness. Intellectually gifted, outgoing and charming, Abraham thrived in Louisville’s fine public school, Male High School, and he set sights on a college education. Jacob learned from a friend about a new vision of college education being developed at Johns Hopkins University in Baltimore. Jake firmly decided that this was for Abraham, and he committed the first $1,000 of profit from his then-solvent pharmacy to fund Abraham at Johns Hopkins. Abraham began in 1884, and through a doubled academic load and intense work, he completed his degree in two years. At that time, Johns Hopkins was assembling an enlightened medical faculty under the inspired leadership of William H. Welch, MD, and Abraham attended lectures by Dr. Welch and heard his philosophy of medical education. The fortuitous conjunction of Welch, his educational philosophies and Abraham Flexner at that moment returned benefits to the Flexner brothers repeatedly over the years, and ultimately served American medicine enormously.

Simon’s Awakening

Jacob’s Pharmacy was key to Abraham’s educational opportunity, but it completely transformed Simon Flexner’s life and propelled him to a most unexpected fate. Simon ultimately became a giant of medical research with landmark discoveries in meningitis, dysentery and poliomyelitis, and he became the organizing director of the Rockefeller Institute for Medical Research. His early years, however, gave no clue to that potential. Born in 1863, Simon became a reclusive child with behavior problems, perhaps in response to Jacob’s dominance and his father’s increasingly heavy alcohol consumption. Simon later described himself as a “delinquent,” and recounted how his father gave him a tour of the city jail to show him how he would likely end up. He avoided school and never finished the sixth grade. However, a near-fatal bout of typhoid fever, then taking an apprentice position in Jacob’s drugstore, changed Simon’s attitudes profoundly. Although he remained quiet, his aimlessness changed to intellectual discipline and intense, self-taught pursuit of science. He and Jake had a history of conflict, but they got along well in pharmacy work. Old resentments mellowed, but competitiveness emerged. Simon was driven to work longer, read more, compound more meticulously, and outperform Jake in every way. The touchstone of Simon’s awakening was the microscope that Jacob had purchased. Simon embraced the opportunity to study everything possible, starting with nature and progressing to tissue, which ultimately included pathological specimens brought in by cooperating physicians. (In today’s climate, a physician might lose his license, or worse, for such an act.) Simon became progressively focused on learning advanced pharmacy and microscopy until, like Jake, he became able to enter the Louisville College of Pharmacy. To the amazement of all and his mother’s delight, he graduated first in his class in 1882.

Continued on page 32
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Continued from page 30

This ultimately led to a negotiated matriculation at the Medical Department of the University of Louisville, where the dean, Dr. James Bodine, personally mentored a non-clinical, scientific curriculum and granted Simon an MD degree in 1889 on the condition that he pursue pathology and laboratory work rather than clinical practice. A year later, Johns Hopkins University again entered the Flexner lives. Through Abraham’s contacts and with $500 from Abraham’s successful teaching career, Simon went to Baltimore. Finally, he gained the opportunity to study under Dr. Welch, who had become the American leader in the field of pathology. Simon’s natural intelligence and diligence plus Welch’s mentorship launched a stellar career that would lead him to professorship at the University of Pennsylvania in 1899 and ultimately to directorship of one of the world’s great biomedical research institutions.

From their mutual pharmacy beginnings, the lives and fortunes of the Flexner brothers again intertwined, as Simon’s emerging scientific prominence earned him a seat on the board of the Carnegie Foundation for the Advancement of Teaching. Shortly thereafter in 1908, the American Medical Association approached the Carnegie Foundation president, Henry Pritchett, to conduct and publish a comprehensive analysis of American medical education. Simon strongly recommended his brother Abraham to Pritchett for that task. Abraham was hired, and he frequently consulted Simon in the project. The resulting articulation of principles and survey of schools became the legendary 1910 *Medical Education in the United States and Canada*, universally called the Flexner Report. The exposed of faulty schools by the report was an immediate sensation, and it became a major factor in upgrading medical education by its scrutiny and ranking of schools and its call for mergers and closures of unift institutions. Abraham’s reputation was established, and spectacular opportunities followed in succession. Thus, the outstanding accomplishments and legacy of both Simon and Abraham can be traced through a winding path back to Jacob’s drugstore on Louisville’s old Market Street.

**Jacob’s Second Chance**

As his brothers’ careers soared, Jake was left behind, and he seemed to reap no benefits from his personal and professional sacrifices for his family. But just as Jacob’s Pharmacy had served Abraham and Simon, it would come to fulfill Jacob’s dream in a most unusual manner. Jacob’s second chance to become a physician came by the same unwelcome circumstances that destroyed his first chance exactly 20 years earlier. In 1893, another panic bankrupted Jacob’s drugstore. Ironically, this freed him to pursue the medical career he had always wished. He entered medical school and obtained the MD degree in 1895, probably at the Hospital College of Medicine, a proprietary school on East Chestnut Street. Then he obtained postgraduate training in Obstetrics and Gynecology at the Mothers & Babies Hospital in New York City in 1897. On completion, he returned to Louisville and began medical practice. In 1902, he obtained a second MD degree from the Louisville Medical College, a proprietary school housed in the grand building that is now home to the Greater Louisville Medical Society. Jacob ultimately built a good reputation and busy practice. He became the only Flexner brother of that generation to remain in Louisville, and he had a long and productive career. He was a founding member of the Jewish Hospital Medical Staff in the Department of Internal Medicine and Neurology. Keeping contact with his brothers, he used advanced therapies developed by Simon at the Rockefeller Institute, such as the first regional use of antimeningococcal serum for spinal meningitis. Simon also gave Jacob access to other advanced therapies, including insulin just after its discovery. Jacob’s long, productive career continued into the 1920s. His son, Morris, also entered medicine, and received his MD degree from Johns Hopkins University, with postgraduate work in Pediatrics. He returned to practice in Louisville, enjoyed a strong reputation as an outstanding diagnostician and served as president of the Jewish Hospital Medical Staff.

**A Vanishing Profession and a Bygone Era**

After retiring in the 1920s, Jacob reflected on his career as a pharmacist and his unusual pathway into medicine in a 1931 article for *The Atlantic Monthly*. In his recollections, his years in pharmacy and his drugstore provided unique memories, but his years as a physician were the most gratifying. He spoke with pride of his ability to compound pharmaceuticals accurately from raw ingredients. He regretted the coming of large pharmaceutical companies and their manufactured drugs, which he feared would turn pharmacists into bottle-filling shopkeepers. His greatest satisfactions, however, were his medical experiences, as expressed in the following section from his 1931 reflections.

“I feel rather sure that, with Dr. Ed Grant of Louisville, I was the first to demonstrate the value of diphtheria antitoxin south of the Ohio River. The first patient was a little girl who lived in a tiny room behind a wretched grocery store. The child was all but dead, her pulse had nearly stopped, and the awful membrane covered her mouth, lips, and nose. I administered the antitoxin according to instructions, using the old Koch syringe, which is a syringe having a bulb and not a plunger. Next morning, to our great satisfaction, I was able to remove almost all of the membrane from the child’s throat and mouth, and with her mother’s faithful care she made a good recovery. She was a tractable little girl and I remember taking her one of the dolls of which my own children had quite an excess. Many years later, when I was practising medicine, a young woman came into my office and told me that she was the child to whom I had administered that first antitoxin. When she confided to me that she still had the doll I had given her and that her mother and father had never ceased to be grateful for what I had done for them, I experienced that solid pleasure which does not often come to any man but a doctor.”

In Louisville’s old business district, the shell of Jacob’s Pharmacy still stands as silent witness to these events, and it reminds us that the “solid pleasure” of being a doctor remains just as true for us as it was for Jacob Flexner a century ago. 

Note: Dr. Tobin is chairman emeritus of the University of Louisville’s Division of Plastic Surgery and practices with University Surgical Associates PSC. Mr. Bell is a Louisville historian and former executive director of the U.S. Marine Hospital. Dr. Conner is a retired anesthesiologist. Dr. Weiss practices Cardiovascular Diseases with Medical Center Cardiologists PSC.
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In the fourth floor of a striking building at the corner of First and Chestnut streets, students in the University of Louisville School of Medicine studied the human body in Gross Anatomy Lab. In a corner room of the building’s bottom floor, a coal furnace operated while the education of the next generation of physicians proceeded.

William Christopherson graduated from the School of Medicine in 1942, served as an Army medical officer during World War II and returned to the University of Louisville as part of the medical school faculty in 1948. As chair of the Department of Pathology beginning in 1956, Dr. Christopherson made his mark with students by teaching Gross Anatomy Lab and contributed groundbreaking research, particularly in gynecologic pathology.

Harold Kleinert graduated from medical school at Temple University in 1946 and completed his general surgery residency in Detroit. When Dr. Kleinert was recruited to the University of Louisville in 1953, he asked for laboratory space to pursue research in vascular surgery. He moved into the coal bin, abandoned after the heating system switched to gas. His work in that room led to a pioneering career as a hand surgeon.

In recognition of Dr. Christopherson, who died at age 91 in 2007, and Dr. Kleinert, and their role in the history of The Old Medical School Building, the Greater Louisville Medical Society Foundation dedicated the spaces where each physician’s legacy was borne on Sunday, March 7. For the occasion, a cadaver box sat in the Christopherson Gross Anatomy Lab, distinguished by its original tile floor and skylight. The Harold Kleinert Lounge – remod-
eled with a kitchenette, recliners and flat-screen television – features a display case of items from his career and a bust crafted by five fellows he taught. Family, friends and colleagues of the Christophersons and Kleinerts gathered to celebrate the two distinguished lives as well as the collective effort of GLMS physicians to preserve The Old Medical School Building.

Robert S. Howell, MD, medical society president in 1976-77, was a student of Dr. Christopherson, graduating from U of L's medical school in 1952 and following in his mentor's footsteps by becoming a pathologist. Dr. Howell, who partnered with a team of physicians to rescue the abandoned Old Medical School in the 1970s and reopen the building as the home of the medical society in 1981, made a generous contribution to the GLMS Foundation to establish the Christopherson Gross Anatomy Lab.

“Thirty years ago, when the restored beauty of this building was just a vision of some dedicated volunteers, we discovered that no physician ever forgets the profound experience of Gross Anatomy Lab,” GLMS Foundation President Thomas Reichard, MD, told the guests. “Seeing the space again evokes wonderful and some not-so-wonderful memories of our colleagues and mentors at the start of our journeys in the practice of medicine.”

Dr. Reichard added: “This medical society and foundation can never adequately thank Dr. Howell for his incredible contribution to our medical profession and the community.”

Katy Christopherson recalled her husband’s sense of humor for the audience, calling him “a man of few words.” Once, when he was given an award, he stood up and said, “Of the recognitions I have received, this is the most recent,” she remembered. Another time, Dr. Chris, as he was affectionately known, found out that a medical student took on the project of cleaning up the morgue. When Dr. Chris confronted the young man who was “trembling in his shoes,” Katy said, he surprised him by awarding him a full scholarship.

“I’m really deeply touched that Bob (Howell) has chosen this way to honor Chris,” she said. “Chris gave his life to the university and to his students.”

“I’m very proud of my father and my mom,” added Walter Christopherson, who attended the dedication with his wife, Catherine. “I think when I was born I won the lottery. So much of his life was figuring out how he could do something for someone to help them. I miss him very much.”

Richard S. Wolf, MD, who was treasurer of the steering committee to save The Old Medical School Building, presented Dr. Howell and Katy Christopherson each with a framed photograph of Dr. Chris in his white coat, smoking his pipe.

Dr. Kleinert’s wife, Sharon, coordinated the effort to establish the Harold Kleinert Lounge, a place for physicians and GLMS staff to take a break. In her remarks, Sharon said the purpose of the room was appropriate considering Dr. Kleinert could “fall asleep in any position” and treasured a cup of coffee or tea during his long days of work. She revealed that she kept the project a secret from her 88-year-old husband until the morning of the dedication, then read a poem she wrote for the occasion.

Hanging on the walls of the cozy lounge are framed copies of a Louisville Medicine article by Gordon R. Tobin, MD, “From Coal Bin to Diamond Mine: Where Harold Kleinert Mined Surgical Gems with a Coal Shovel and Bare Hands” and a 1978 article in People, “Medics: Dr. Harold Kleinert Reattaches Severed Limbs Through the Fine Art of Microsurgery.” A display case holds his plaque for serving as president of the American Society for Surgery of the Hand in 1976, various surgical instruments and a photograph of the surgeon taken by one of his patients during an operation.

“The coal-bin laboratory became the genesis for a legacy of remarkable contributions to the emerging fields of microsurgery, limb replantation and ultimately limb transplantation,” Dr. Tobin wrote.

The following family members and colleagues contributed to the lounge: Sharon Kleinert; Harold and Jane Kleinert; Amil and Susie Kleinert; Chrissy (Kleinert) Schrot and Randy Schrot Jr., MD; Jim Kleinert, MD, and Toni Kleinert; Jeaniene and Bob Rueff; Louisa L. Kleinert; Jorge and Tara Reis; Kleinert Kutz Hand Care Center; Erdogan Atasoy, MD; Amitava Gupta, MD; Morton L. Kasdan, MD; Michelle Deanne Palazzo, MD; Huey Y. Tien, MD; Tsu-Min Tsai, MD; and Thomas W. Wolff, MD.

As the afternoon of the dedication and open house concluded, the Christophersons and their friends sat around a table, laughing. Dr. Kleinert stretched out in a recliner in the lounge, gazed around him searching for any evidence of his former lab and quietly said: “Never once did I think of doing this in this room. I never thought I could be this comfortable in this room, surrounded by friends.”

Note: Ellen R. Hale is the communications associate for the Greater Louisville Medical Society.

POEM ON DISPLAY IN HAROLD KLEINERT LOUNGE

How do we show honor to this man
Harold Earl Kleinert, who has devoted his life to care of the hand? Maybe, we can note his many years of focused work with signs from our own hands.

We could give him a thumbs up to recognize a difficult job well done.

We could innumerate on each of our ten digits the innovative surgical procedures he has developed, the instruments he has designed, and the 'firsts' he has accomplished.

We could give him a high five in recall of the exemplary care he has provided to the thousands of diseased, defective and traumatized hands.

We could clap our hands together in applause for extending his knowledge from our community to the world through the number of young surgeons he has trained.

We could raise our index finger and proclaim that we think he is still 'number one.'

We could give him an A-Okay sign to acknowledge he has earned his quiet retirement on Pleasant Run, waving a fond farewell to the daily grind.

We could raise our arm and pump our fist to say YES!, this room is now yours.

But maybe the best is the simplest … We could reach out to shake his hand or pat his shoulder, and offer our congratulations and thanks for touching our lives.

-Sharon E. Kleinert, March 7, 2010
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NOTE: GLMS members’ names appear in boldface type. Most of the references have been obtained through the use of a MEDLINE computer search which is provided by Norton Healthcare Medical Library. If you have a recent reference that did not appear and would like to have it published in our next issue, please send it to Alecia Miller by fax (736-6363) or e-mail (alecia.miller@glms.org).
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.

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Sindh Medical Col 90

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Cardiovascular Diseases 93, 03
Internal Medicine 90
Ohio State University College of Medicine 87

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Louisville Medicine is actively seeking physicians to submit articles on a wide variety of topics that represent the great diversity of opinions within GLMS in this new section, Doctors’ Lounge. All are welcome to submit articles by e-mailing editor@glms.org.

Mary G. Barry, MD
Louisville Medicine Editor
editor@glms.org

Free the Runny-Nosed

This winter the Metro Council and other legislative bodies considered banning the sale of Sudafed (pseudoephedrine) over the counter. The ban failed to pass this time but no doubt will come up again. Supporters want its help to curb the spread of methamphetamine production and abuse. Meth users become addicted rapidly and terribly, neglecting everything in their lives, especially their children, and regularly make “cooking” mistakes that explode their homes and everyone in them. The pro-ban legislators, backed by the Kentucky Narcotic Officers Association, believe that requiring the prescription-only sale of Sudafed will reduce the abuse of methamphetamine. But Daviess County Sheriff Keith Cain disagrees. Cain was instrumental in getting our 2005 Sudafed-purchasing law passed and has been honored by the Department of Justice for his efforts in curtailing the spread of meth labs. Writing on March 10 in The Courier-Journal, he says that “Aside from higher health care costs to legitimate consumers, a prescription mandate provides no real-time sales tracking, no sales blocking, and less access to sales information by law enforcement.” He argues that because of the 2005 electronic tracking law, meth lab seizures are up. Criminals who produce meth commonly pay others to go buy their supplies. If the prescription-only ban passes, he says, law enforcers would lose the evidence necessary to prosecute and stop these methamphetamine cooks. We know the meth laws on the books are working: each month since its inception, stores are blocking 10,000 grams of Sudafed requests per month.

In mid-March two new laws were proposed that independently might help reduce meth abuse further. The Kentucky Senate voted 38-0 to ban previous meth offenders from ever buying Sudafed again, and the House passed a bill to reduce the monthly allowable amount from 9 grams down to 7.5 grams per purchaser per month (for you math-challenged, that’s 250 30 mg. pills).

Making drugs prescription-only has not exactly cured our narcotics abuse problems in this state. Internet sales, domestic and foreign drug gangs, plus physicians who prescribe unscrupulously, keep Kentuckians well supplied despite controlled substance regulation. The Department of Justice Web site reports that in 2009 Mexican drug-trafficking organizations remained the primary suppliers of “ice” meth and also of cocaine in our state. The Kentucky State Police magazine reports that meth lab detection in 2009 rose 60 percent to 716 labs found, in part due to tracking and in part due to the ease of the newer “one-pot” or “one-shake” production method. It’s so easy that producers are moving more and more into the city, using multi-family houses and parked cars and vans now to cook the meth. Most meth abusers in the state are between 18 and 25 years old, and the heavily rural nature of meth abuse has begun to shift more to the cities. Rehab centers report that most users who come in for help have no health insurance, and that is not likely to change for a while.

Have the legislators concerned with this problem been paying enough attention to the health insurance crisis in this country? Patrick Howington reported in the C-J of February 21 that fully one-third of Kentucky adults younger than 65 – nearly 900,000 people – do not have health insurance. According to a University of Cincinnati study commissioned by the Foundation for a Healthy Kentucky, since early 2008 the proportion of uninsured adults has risen from 23 percent to 33 percent. It should come as no surprise then that since 2008 the jobless rate has risen from less than 6 percent to about 11 percent. Howington reported that this year our state Medicaid offices have enrolled about 3,400 recipients a month, up from 588/month before the 2007 recession. How many of those 900,000 uninsured adults have runny noses? A lot. In Kentucky, Lexington topped the 2008 Asthma and Allergy Foundation’s “Worst Cities for Spring Allergies” list, and Louisville came in 21st.

Last June Javed Sheikh, MD, an assistant professor of medicine at Harvard, wrote in an eMedicine Specialty article that more than 20 percent of Americans (40 to 50 million of us) suffer from allergic rhinitis and its complications: asthma, more frequent respiratory infections, disturbed sleep, and loss of energy and well-being. More than half of adults with allergic rhinitis (and more than 80 percent of children) have sleep-disordered breathing, with fragmented sleep cycles and repeated arousals, and suffer the resultant daytime fatigue, loss of productivity at school and work, and weight gain. Poor sleep and snoring are highly associated with sleep apnea, and the estimate for coexisting allergic rhinitis and obstructive sleep apnea runs about 20-25 percent for adults, though it’s less than 5 percent for children. We know that sleep apnea, untreated, shortens life spans at enormous cost.

Ten years ago the direct and indirect costs of the allergic rhinitis burden in this country were estimated in a J. Clin. Allg./Immunology article at more than $5 billion a year. Dr. Sheikh cites Goetzel’s 2004 data, gained from a group of 375,000 employed adults, as showing allergic rhinitis to be the fifth-most costly condition in America. This is higher than the costs for any cancer, or for diabetes, and does not include asthma: asthma was ninth, all by itself. He updates the 2009 cost estimates, including the

Continued on page 40
cost of low productivity, absenteeism, doctor visits, ER and hospital stays, and all drug costs as between $9 billion and $11 billion. In 2005, ambulatory care visits accounted for half the expense of prescription drugs: an average $185 per person per year vs. $305 in drug costs, for employed people with good insurance coverage. That’s some very expensive sneezing already, and if we force patients to find doctors, pay out of pocket for the visit and then the medication, we will have a huge surge in not only the cost of care but in the burden of untreated disease.

Besides allergy miseries, there is the common cold. I wish I’d bought stock in Kleenex back in the day. Millions of us stay on our feet, with noses not running directly onto our desks and loved ones, by alternating Sudafed and chicken soup. I dearly hope that I do not have to diagnose every cold of my every patient in order for them to have symptom relief from heinous viruses. I’d like to have some office time to fill out all the forms I must, not to mention time to prevent and treat atherosclerosis, for example, or pneumonia, or diabetes, or diverticulitis, or COPD, or osteoporotic fractures, or some other burden of serious illness that requires more expertise than reading cold remedys labels. The FDA had the sense to make non-sedating antihistamines like Claritin and Zyrtec available without prescription, and from a safety standpoint, billions of doses of Sudafed have been sold and taken without “smoking gun” side effects. If you are not in your first trimester, not afflicted with sensitivity to caffeine or arrhythmia, not under age 6 and not undergoing hyperbaric treatment, then a small dose of Sudafed will most likely agree with you just fine.

Perhaps law-abiding allergy sufferers of this state should form our own “Runny Nose Party.” We can meet on the steps of City Hall and demand that our years of good citizenship should be rewarded with safe, legal, electronically recorded access to Sudafed. Heavy-handed legislation that punishes the masses for the misdeeds of the few – as wasteful and sad as these are, as much as drug use raises crime rates – is still not fair legislation. Take my fingerprints – please! But don’t take my Sudafed.

Note: Dr. Barry practices Internal Medicine with Norton Community Medical Associates-Barret.

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

If you would like to respond to an article or commentary in this issue, please submit your response in the form of a Letter to the Editor. You may submit Letters to the Editor online @ www.glms.org or by e-mailing our editor directly at editor@glms.org. The GLMS Editorial Board reserves the right to choose which letters will be published.
it) and opposition from groups like the National Sheriffs’ Association, the idea will continue to be considered as one of many valid tools that could be helpful.

While developing an opinion on this issue, I continued to ask myself, “Do the potential positives of prescription-only pseudoephedrine outweigh the many potential negatives?” My first thought was self-serving. I envisioned patients burning up the phone lines demanding their prescriptions and scoffing at my suggestion to make an appointment in order to properly and safely receive a new prescription. The eye-rolling I would encounter as I, the lowly “GP,” explained the risks of blood pressure issues, arrhythmias, drug interactions and insomnia, as well as the limited effectiveness of pseudoephedrine and the signals to watch for that would suggest a problem more significant than the common cold, would be no fun. The legal concern was there as well. I don’t want to be a cop. Even worse, doctors might be vulnerable to trouble for inadvertently prescribing too much pseudoephedrine to patients. After these initial thoughts, my skepticism was a little more altruistic. Could this idea exacerbate the problem? Supposedly, the current electronic tracking system in Kentucky by law cannot be used to monitor prescription drugs. This seems odd, as KASPER is a system well-known by Kentucky doctors to do just that. It seems those laws could be changed with a little work. If not, though, the theory is that cops would lose the ability to track meth manufacturers. Another potential negative is the “OxyContin factor.” OxyContin and other painkillers, methadone and benzodiazepines are all examples of prescription drugs that are widely abused and can lead to great human suffering. They can also alleviate suffering when used correctly, something that can never be said for meth. Although we have no proof of this, many of us assume that, most likely, more people would be using/abusing these products if they were over-the-counter. Using the same logic, we may also conclude it is very possible that fewer people would have access to meth if pseudoephedrine were not an over-the-counter medicine. As doctors we love science, however, and we’d like to see some proof before we get too excited about any hypothesis.

Oregon has taken the lead in the United States in the area of prescription-only pseudoephedrine. The Oregon Alliance for Drug Endangered Children passionately supports reversing the 1976 decision to move the drug from prescription-only to over-the-counter status. The group compellingly argues that the rise of the meth problem to epidemic proportions began in the late 1970s and early 1980s following this decision. They also point to the pharmaceutical industry as a major player in overstating the effectiveness of pseudoephedrine as a cold remedy and using propaganda to angle the law-abiding public regarding peoples’ “rights” to avoid physician consultation and therefore “excessive cost” before having access to the drug. In 2006, Oregon lawmakers responded and passed a law making pseudoephedrine prescription-only. Since that time, the number of meth lab incidents in Oregon has decreased from around 185 in 2005 to 10 in 2009. The state also tracks meth-related ER visits and hospitalizations and has reported these have diminished over the same time frame, although finding hard data on this for me was difficult. It is widely believed, in Oregon at least, that the changes made since 2006 have been overwhelmingly positive in the struggle to overcome the meth epidemic.

The federal Combat Methamphetamine Epidemic Act of 2005 moved pseudoephedrine behind the counter. It also requires pharmacies to collect information on purchasers. This information is used to track specific individuals and to limit the quantity purchased to no more than 9.0 grams in a 30-day period. Nine grams translates into a minor pharmaceutical stockpile of 300-30mg tablets per month. If a person were to take the maximum “recommended adult dose” for two weeks continuously his/her needs would total 96 tabs. So why are 300 tablets made available every month? Is this the extent of the effort exerted to fight an epidemic? No wonder we’re losing. Who do you think got the last word on this issue in Kentucky’s recent legislative session as House Bill 497 to schedule pseudoephedrine died in committee? Was it the doctors and police that daily deal with this disease, or was it the industries that reap the profits?

In 2005 the state of Oregon took the courageous step of restricting the sale of pseudoephedrine to individuals with a valid prescription. So what happened on July 1, 2006, when the law went into effect? Did thousands of Oregonians go around with untreated congestion? Did the workload of pharmacists, family physicians, ER docs and allergists increase? Did medical costs skyrocket?

Continued on page 42
et or the cost of pseudoephedrine increase? The answer to all these doomsday predictions is a resounding: NO! And guess what, “smurfing” (“smurfing” is the practice of paying friends, acquaintances and strangers to purchase a 30-day supply) stopped, the number of meth labs plummeted, meth-related health care and criminal justice costs dramatically declined, doctors and pharmacists were not overrun, and on my last trip to Oregon I didn’t meet one person with a stuffy nose.

As health care providers we understand that there is very rarely only a single drug to address a condition or disease. Aren’t we lucky that nasal congestion can be treated with a multitude of over-the-counter remedies? There is broad-based support and sound medical reasoning for again making pseudoephedrine a “prescription only” drug (it was scheduled by the FDA before 1976). Police departments, prosecuting attorneys, fire and EMS agencies, emergency physicians, health departments and medical societies all recognize the devastating impact of methamphetamine and are lining up in support of legislative changes that will protect the health of Kentuckians and save lives. Nationally the story is the same, as the DEA and the U.S. Department of Justice strongly support the “prescription only” route to limit pseudoephedrine.

As a professor in the Emergency Department at the University of Louisville Hospital, I see the hollow eyes and rotten teeth of the meth-addicted young woman who sells what is left of her body for her next fix of this extremely addictive drug. I hear the screams of the young man who was the meth “cook” (before the bottle exploded in his hands) as the skin of his hands and arms is peeled away by the burn unit nurses. I touch the pain as I push a chest tube between the ribs of a bleeding delivery boy, shot and robbed by a meth addict who would do anything to get money to buy more meth. Unfortunately, these Kentuckians will most likely never meet the representatives and senators from this great Commonwealth who had the power to change their date with methamphetamine.

Note: Dr. Smock is professor of emergency medicine at the University of Louisville School of Medicine. He chairs the GLMS Public Safety Committee.

Who's On First

The great value of debates and contrasting opinions is to stimulate us readers in critical analysis and re-examination of the issues, and perhaps unsettle our fixed views. In the April Louisville Medicine, Dr. Mary Barry and Dr. Dan Varga – with an assist from Sen. Jim Bunning – have done exactly that. I did enjoy their baseball quotes and analogies, but after months of watching backroom vote deals, orchestrated obstruction, deeming-to-pass plans and shouted slurs, another old vaudeville baseball script seems more descriptive of our current politics.

When the rhetorical dust is brushed off the plate after each “at bat” of the Bunning/Barry/Varga lineup, one finds less conflict and more complementary insights into the cost, financing and money flow conundrum that burdens America’s health care system. Senator Bunning led off, but his hit was universally called foul, for he voiced the simple truth at an inconvenient moment that expenses must be covered by payments, and that our deficit errors have vastly exceeded our hits and runs for far too many innings. For Bunning’s moment of inconvenient truth, leagues of commentators and the other 99 senators loudly booed him and called for a trip to the showers. Thus, he achieved a feat more rare than a no-hit doubleheader – creating the only bipartisan moment in recent memory.

Sensing a hanging curve, Dr. Barry took a swing. In doing so, she added further evidence that continuing the Medicare Sustainable Growth Rate fiasco will surely impair patient access to care. Fielding that, Dr. Varga added data that Medicare also short-changes many hospitals, as well as all physicians, and he reminded us that the consumers’ view of the field is largely blocked.

Who’s getting all of our money? (No, he’s on first.) Dr. Barry cited The New York Times (NYT) investigative reporter Reed Abelson, who has written extensively on the financing maldistribution in health care. His well-researched articles include the following: widespread medical bankruptcies among the insured (NYT, 6/30/09), low percent (66-74%) of private insurance premium dollars going for medical care (NYT, 11/02/09), court judgments against private insurance companies for systematically defrauding doctors (NYT, 1/15/09) and enormous profits pitched to the big, branded drug companies (NYT, 3/21/10). Even one of T-ball age can read these signals.

Insightful writers have long noted that the line between comedy and tragedy is very thin and far less defined than the stripe between fair and foul. The slapstick displays by many of the public and their elected legislators have crossed that line repeatedly in recent months. Even Abbott and Costello have been upstaged by the yearlong, farcical distortions of facts and parliamentary contortions. However, laughter about this goofy process stops cold when the outcomes are counted. Every day of the same past year, and each day that our tragically dysfunctional system continues, 14,000 fellow citizens lose health insurance coverage, 5,000 undergo the agony of medical bankruptcies, 125 of the uninsured meet premature death and uncounted souls bear agonizing suffering. This grim procession is accompanied by the stadium organ theme of annual double-digit health insurance premium increases and escalating gross overcharges for drugs and medical devices. If we continue this game, our children and grandchildren will be peering through an outfield fence knothole as Asian and European teams play for the pennant.

What’s up next? No, he’s on second. However, “I Don’t Know” left third to become a media commentator expert. Also, “I Don’t Care” wandered from shortstop to join his like-minded pals in the stands, all of whom just wish this inning was over so they can rush out to buy more consumer goods, more entitlements and more entertainment – all on credit, of course. Who pays? No, he’s already safe on first, remember?

Note: Dr. Tobin is chairman emeritus of the University of Louisville’s Division of Plastic Surgery and practices with University Surgical Associates PSC.
Letter to the Editor

I would like to comment on the book review by Dr. Seyal of the book Oath Betrayed by Steven Miles, MD. I have not read the book and don’t intend to as I am bombarded with anti-American, anti-doctor and anti-military media ad nauseam and do not need one more. It should not surprise anyone that there are rogues out there who act inappropriately whether they are doctors, preachers, plumbers, writers, etc. The question is whether they acted alone or with their government’s blessing and whether they were punished.

About Abu Ghraib: The military personnel acted inappropriately and were punished. The loss of retirement benefits amounts to a six-figure fine. I am not aware of any medical personnel present, and the author posed the question “Where were the doctors, nurses and medics while these abuses were happening?” I suppose they were where they were supposed to be, at their duty station or in bed etc. I would like to make one point. Nobody died at Abu Ghraib. Nobody suffered physical pain at Abu Ghraib. Nobody had any permanent physical disability at Abu Ghraib. Contrast this with the treatment by the Islamic terrorists who, with the blessing of their leaders, cut off heads with chain saws, gassed innocent people, threw people off third-story buildings and beat to death and blew up thousands of innocent people.

Now as to waterboarding. I am not aware of any medical involvement with this procedure, and again nobody died, was permanently injured or suffered pain. They were scared, certainly, and as a result of waterboarding provided valuable information which undoubtedly saved American lives.

Finally, as to the statement about extraordinary renditions “practiced by the institutions of local governments in collaboration with American personnel” on the island of Diego Garcia. I was at Diego Garcia for a time while I was in the Navy. It is a small island in the middle of the Indian Ocean and has been a part of the British Empire for over a hundred years. In the mid-1900s, the British gave the few dozen remaining natives generous handouts and then relocated the natives to India. They then leased the island to the United States and a naval base was built there. This is a supply depot and only active duty personnel is allowed there, along with about 40 British administrators.

This statement by Dr. Miles is blatantly false, and I am of the opinion the rest of his book is also, written for political expediency not compassion.

I would like to close with one word for Dr. Miles or anyone else. If you can provide to me names and documentation of any United States military medical personnel who had anything to do with torture, I will personally deliver them to the JAG offices of the appropriate service.

Capt. Robert E. Arnold, MD, USN, Ret.

Editor’s Note: There were detainee deaths. The August 2004 Schlesinger Report (the Independent Panel to Review Dept. of Defense Detention Operations) to Secretary Donald Rumsfeld (available online at Findlaw.com) noted five cases of detainee deaths as a result of abuse, with 20 more deaths in all of Iraq not fully investigated at the time. Abu Ghraib was described as seriously overcrowded, under-resourced, and under constant attack: five U.S. soldiers died there in a July 2003 mortar attack, and multiple detainees died from incessant insurgent attacks as well. The report, based on Gen. Antonio Taguba’s Army investigation, attributed the occurrence of abuses primarily to a marked breakdown of military training and leadership, with command reliance on noncommissioned personnel, particularly former civilian corrections workers, plus significant problems with coordination among military police, the CIA, and military intelligence. The CIA records of its detainees and interrogations remain classified. Additionally, U.S. forces there had to serve in a real-life combat setting not properly equipped or secured because of its “behind the lines” designation. No U.S. doctors were accused by Gen. Taguba at Abu Ghraib.
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<thead>
<tr>
<th>Advertiser</th>
<th>Page</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>AP Assurance</td>
<td>8</td>
<td><a href="http://www.apassurance.com">www.apassurance.com</a></td>
</tr>
<tr>
<td>Clark Memorial Hospital</td>
<td>29</td>
<td><a href="http://www.clarkmemorial.org">www.clarkmemorial.org</a></td>
</tr>
<tr>
<td>Floyd Memorial Hospital</td>
<td>33</td>
<td><a href="http://www.floydmemorial.org">www.floydmemorial.org</a></td>
</tr>
<tr>
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<td>25</td>
<td><a href="http://www.hugroupky.com">www.hugroupky.com</a></td>
</tr>
<tr>
<td>Jewish Hospital</td>
<td>IFC</td>
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<tr>
<td>Kentuckiana Allergy Asthma &amp; 36 Immunology</td>
<td>36</td>
<td><a href="http://www.kentuckianaallergy.com">www.kentuckianaallergy.com</a></td>
</tr>
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<td>Kentuckiana Pain Specialists</td>
<td>19</td>
<td><a href="http://www.painstopshore.com">www.painstopshore.com</a></td>
</tr>
<tr>
<td>KMA Insurance Agency</td>
<td>20</td>
<td><a href="http://www.kmainsurance.com">www.kmainsurance.com</a></td>
</tr>
<tr>
<td>MAG Mutual Insurance Co</td>
<td>27</td>
<td><a href="http://www.magmutual.com">www.magmutual.com</a></td>
</tr>
<tr>
<td>Medical Society Employment Services</td>
<td>7</td>
<td><a href="http://www.gifms.org">www.gifms.org</a></td>
</tr>
<tr>
<td>Murphy Pain Center</td>
<td>4</td>
<td><a href="http://www.murphyspaincenter.com">www.murphyspaincenter.com</a></td>
</tr>
<tr>
<td>National Insurance Agency</td>
<td>31</td>
<td><a href="http://www.niai.com">www.niai.com</a></td>
</tr>
<tr>
<td>Passport Advantage</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Practice Management Services</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Professional Office Solutions LLC</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>Professionals’ Purchasing Group</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td>ProNational Insurance</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Remax (Margaret Helvey)</td>
<td>21</td>
<td></td>
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<tr>
<td>Republic Bank &amp; Trust Co</td>
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<td><a href="http://www.republicbank.com">www.republicbank.com</a></td>
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<td>Rolimar PSC</td>
<td>7</td>
<td></td>
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<tr>
<td>Semonin (Jasmin Ahmed, Marsha Segal)</td>
<td>21</td>
<td></td>
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<tr>
<td>State Volunteer Mutual Insurance Co</td>
<td>31</td>
<td><a href="http://www.svmic.com">www.svmic.com</a></td>
</tr>
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<td>The Pain Institute</td>
<td>OBC</td>
<td><a href="http://www.thepaininstitute.com">www.thepaininstitute.com</a></td>
</tr>
<tr>
<td>VanZandt Emrich &amp; Cary</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Wakefield Reutlinger (Ken Reutlinger)</td>
<td>20 &amp;</td>
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