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**COACHING THE HEALTH CARE TEAM**

Now that the presidential election is over and it appears that Obamacare is here to stay (for a while?), we can expect increasing utilization of health care with expansion of Medicaid and formation of health insurance exchanges covering more of our population (not necessarily a bad thing). With physician shortages looming, providing care will become an increasingly significant issue over the next several years. Nurse practitioner (NP) and physician assistant (PA) organizations see this as an opportunity and are already lobbying for more autonomy without supervision. Soon enough, you may see NPs with “Dr.” in front of their names, as there is a push to pursue doctoral nursing degrees.

The primary question I would ask is, “Do NPs and PAs have enough knowledge to care for and refer patients appropriately to physicians?” We all know NPs and PAs with significant years of experience who can function somewhat independently, but getting there requires decades of close mentorship by physicians. With the increasing percentages of NPs and PAs coming into the market (it seems every nurse I know is taking classes to become an NP), most lack the mentorship, knowledge, hours of training and basic service background required. Therefore, more autonomy would not be a wise move.

Over the past several years, I have had the opportunity to assist several PAs with training via surgical rotations. I have found nearly all to be very intelligent, with good undergrad GPAs, who could have probably easily gone to medical school. When asked why they didn’t, most responded with “too rigorous, too lengthy, too much responsibility, and not the lifestyle I want.” When I ask those practicing NPs and PAs about having more autonomy, by far most (about 90 percent) actually want physician supervision, as they feel they lack the added knowledge to do what is right for the patient, and they do not want to miss something important.

An argument may be made that due to lack of health care delivery in more remote areas of our country, NPs and PAs should have more autonomy. However, with the increasing capability of teleconferencing, videoconferencing and EHRs, those in remote areas can now easily be an integral part of the health care team with appropriate physician supervision and leadership. Certainly with the increasing cost of medicine, and the fact that NPs and PAs, in general, tend to overutilize diagnostic testing, physician oversight is essential going forward.

As the 2013 Kentucky legislative session approaches, we do not want to be blindsided as we were by both the optometry bill and the pill bill. We have all heard that a strong defense is a good offense, and now is the time to put one in the end zone.

Recently, Wayne Tuckson, MD, put together an informal group from GLMS to meet with our local state legislators regarding the problems associated with House Bill 1 and our recommendations for its needed adjustment. We were received well, and the legislators indicated that they gained valuable insights from our meeting that they wished they had prior to the last session. They told us that they are interested in ongoing dialogue regarding House Bill 1 and other issues pertaining to health care. With smart plays like this, we should be able to move the ball down the field.

Scope of practice will likely be a similar issue in the upcoming legislative session. I think most legislators would welcome collaboration with physicians to determine how best to utilize NPs and PAs in our state. Let’s not be spectators, idly watching the game. The time to reach out to legislators is now, and the message is clear. We are the coach of the medical team. We can send in the plays, give extenders the ability to change up as necessary depending on the situation, but also give them the means to come to us for direction as needed.  

Note: Dr. Williams practices General Surgery with Associates in General Surgery.
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PART 1

Morris M. Weiss, MD, FACC, FAHA, FACP

Any attempt to compose a history of medicine in Louisville’s African American community would have been less than complete until August 6, 2010, when I arranged for the copper time capsule box embedded in the Judge Alex Heyburn cornerstone of the Red Cross Hospital to be exhumed. This relic from 1950 revealed a rather barren medical landscape, even in light of the prized new building. Now, a more complete portrait and accounting of African American medicine in Louisville can be penned. Enough information is available to flesh out in some detail much of what evolved from 1872 to 1976, when the Red Cross Hospital (at the end called Community Hospital) declared bankruptcy and shuttered its wards.

History of Louisville National Medical College and the Red Cross Hospital: African American Medicine in Louisville, Kentucky – 1872 to 1976

Contents of July 16, 1950, time capsule.

Two major institutions dominated African American medicine in Louisville in the last quarter of the 19th century and into the 20th century. They are the Louisville National Medical College (1888-1912), founded and ruled by William Henry Fitzbutler, MD, and the Red Cross Hospital (1899-1976). Along the way, a few physicians, an important nurse, and an administrator – key figures in our story – are highlighted.

The organization of this paper is a challenge. The protagonist from the Louisville National Medical College (LNMC) is William Henry Fitzbutler. This brilliant, perceptive and strongly opinionated physician with boundless energy was the force that propelled LNMC into arguably the best proprietary African American medical school of the 19th and early 20th centuries. So, to understand LNMC, we must dissect Fitzbutler and the school’s faculty, consisting of his wife, children and original partners.

The Red Cross Hospital (RCH) presents another problem.

During the 77 years of the hospital’s existence, no one person or group of physicians or administrators stands out like Fitzbutler. The real protagonist of the Red Cross Hospital is the institution itself, with the support and admiration of Louisville’s African American community. The original building was on the edge of west Louisville at Sixth and Walnut streets (now Muhammad Ali Boulevard), but after a few years, the hospital moved to the South Shelby Street campus. At this site, a series of houses and buildings were frequently remodeled, rebuilt and eventually demolished – except for the final building, commissioned in 1950. In these inanimate structures, doctors, nurses, technicians, administrators, lay volunteers and wealthy donors, usually working in obscurity, added muscle, nerves, a brain and, most importantly, a heart to a very proud haven for the care of the sick and injured African American population of the Falls City.

I will set sail with William Henry Fitzbutler and arrive at my port of destination: the Red Cross Hospital.

WILLIAM HENRY FITZBUTLER

William Henry Fitzbutler, better known as Henry Fitzbutler, was born December 22, 1842, and christened William Henry Butler. Later in life, he added “Fitz” to “Butler” and was known primarily as Henry.

His father was William Butler, a slave coachman in Virginia. His mother’s name we do not know; all we know is that she was an indentured white immigrant from England. Fitzbutler was the first African American graduate from
Continued from page 7

Detroit Medical College. In 1871, the University of Michigan regents passed a resolution allowing any Michigan resident to enroll at the university. The resolution did not mention, and therefore did not exclude, African Americans and women. After graduating from medical school in 1872, Henry, his wife and by then their three young children, moved to Louisville, Kentucky. It must have been a hot steamy summer day when the newly minted physician arrived in the Falls City. The Fitzbutlers decided to come to Louisville because there were an estimated 18,000 African Americans living in the city – and no African American physician.2

The next year, in 1873, Dr. Fitzbutler organized a state convention in Louisville to consider educational interests of African Americans. He accepted chairmanship of the Education Committee. Resolutions demanded equal school privileges for African American children in Kentucky, which became the basis of agitation in and out of the Kentucky State Legislature. In 1874, at a convention in Covingston, Kentucky, Dr. Fitzbutler was the chief opponent of a resolution advocating separate schools as the best course of action.

He also acted as the preceptor for young men interested in practicing medicine. At that time, there were four medical schools in Louisville – all closed to African Americans. The two medical colleges in America best equipped for African American children in Kentucky, which became the basis of agitation in and out of the Kentucky State Legislature. In 1874, at a convention in Covingston, Kentucky, Dr. Fitzbutler was the chief opponent of a resolution advocating separate schools as the best course of action.

The University of Michigan was an outstanding student and soon finished the medical curriculum of chemistry, toxicology, anatomy, therapeutics, and surgery. In 1879, he graduated with his degree in medicine, Henry transferred to the University of Michigan. After two years of Detroit Medical College, with the usual contract to cut roads through the forest from Canadian villages around Amherstburg, serving as a surveyor and a contractor to lay out the roads, and also was a part-time school teacher. In addition to these diverse activities, Henry began his medical education as a preceptor with Dr. Pearson. We see at this early period the ambition, intelligence and motivation that drove him throughout his life.

In 1864, Henry enrolled in the preparatory course at Adrian College. Two years later, he married Sarah, the daughter of W.H. McCurdy. After three years of marriage, in 1869, Henry enrolled as the first African American in the Detroit State Medical College. His wife and two young children remained in Amherstburg and lived with the widower Dr. Pearson, who continued to mentor Henry and urged his protégé to pursue his medical education.

After two years of Detroit Medical College, with the usual curriculum of chemistry, toxicology, anatomy, therapeutics, physiology, gynecology and principles in the practice of medicine, Henry transferred to the University of Michigan. In 1872, he was the first black student to graduate from the University of Michigan College of Medicine.

His graduate thesis survives at the University of Michigan, it concerned Cardiology. As a cardiologist, I have had the pleasure of reading his well-written paper, incorporating all the 19th century knowledge of cardiac physiology and pathology.5

We know little about why Fitzbutler chose Louisville, other than that it was a business opportunity. Unfortunately, he left no diaries or memoirs, and only one page of his newspaper, *The Ohio Falls Express* (published weekly from 1879-1901), survives.6 The newspaper is lost forever.

Continued on page 10

William H. Fitzbutler (etching possibly from a photograph), cover of the Journal of the National Medical Association, 1952.
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and we have been deprived of Fitzbutler’s passion, ideas, philosophy and foibles. The McCurdy family is said to have a few reminiscences, but nothing ever was written down.

Dr. Pearson possibly suggested: “Fitzbutler – go South, young man, because southern blacks need medical help.” The Falls City area was providing enormous wealth from wholesaling, warehousing, commission business and shipping. The Civil War had ended seven years before, and America’s South was in the throes of the Reconstruction period. Louisville was a gateway to the South and the Louisville & Nashville Railroad was far-flung in both rail and water transportation. During the Civil War, the L & N Railroad and Louisville profited from shipment of Union troops and supplies.

When he settled in Louisville, Fitzbutler became the first regular physician of the then-called “colored race” to enter the practice of medicine in Kentucky, and he attracted much attention. This attention was accelerated by his involvement in social and political issues during the Reconstruction period.

Louisville was controlled by an oligarchy at this time, and some predicted this “damn Yankee from Canada would not last long.” He ignored the establishment and became active in community affairs. Dr. Fitzbutler and the famous medical educator Abraham Flexner, who was born in Louisville and was a contemporary of Fitzbutler, both commented that “Louisville was a Confederate-leaning society.”

In addition to his thriving medical practice, his political activities and the medical school, Fitzbutler published The Ohio Falls Express newspaper. The single page of one issue is in the archives of the University of Chicago library. A photocopy can be found in the University of Louisville Ekstrom Library archives.6 Prior to 1879, Fitzbutler contributed to The Planet, an African American newspaper founded by Alfred Froman in 1872, the year Fitzbutler arrived in Louisville. When Froman moved to Memphis, Tennessee, Fitzbutler began publication of The Ohio Falls Express and was the owner and editor-in-chief until his death 22 years later. The paper did not survive his death.

The newspaper included local news, the announcement of deaths, church and lodge events, and was printed exclusively for the African American community. With it Fitzbutler continued his crusade for equality in human rights and education, which he believed necessary for all members of society.

Throughout the 1880s and 1890s, Fitzbutler’s energy never waned. In 1889, the first six students graduated with MD degrees from LNMC. The school’s first classes were conducted at the United Brothers of Friendship Hall at the corner of Ninth and Magazine streets. Commencement ceremonies were held at Center Street Methodist Church in Louisville.

In 1901, Dr. Henry Fitzbutler died from “acute bronchitis.” He is buried in the Greenwood Cemetery in Louisville.7

REFERENCES
2. Red Cross Hospital: History of Service. A photographic Record 1898 to 1988 compiled by J. Scott Lux, MA, CADC, May 2009, Volumes 1 & 2. This volume, the work of the late J. Scott Lux, is unpublished, but copies have been presented to the Filson Historical Society and the Archives Division of the University of Louisville Ekstrom Library. This is the most extensive collection of photographs, newspaper articles and hospital broadsides ever assembled about the Red Cross Hospital. (The volumes have only spiral bindings.)

Professor of History Thomas Owens saved at the time of bankruptcy proceedings 26 boxes of assorted records (board minutes, hospital proceedings and financial records). These are found neatly filed and preserved in the University of Louisville Ekstrom Library Archives Division. A third and fascinating source is a 1939 magazine entitled Souvenir, published October-November 1939, Lucille E. St. Clair, Editor. I believe the only copy of this issue (no other issues are known to exist) resides in the Filson Historical Society. This issue of Souvenir was dedicated to Red Cross Hospital. Rare photographs and excellent biographical portraits of the original hospital fathers make this the single most valuable source to understand the early Red Cross Hospital.
6. Ohio Falls Express – one page (1891) – a copy in the University of Louisville Archives. Microfilm project 70. Original at the University of Chicago.

Note: Dr. Weiss practices Cardiovascular Diseases with Medical Center Cardiologists. He is a member of the Innominate Society, Louisville’s medical history society.
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They come from Central America and Iraq and Haiti and the Sudan to East Washington Street on Saturday mornings, where they head to the basement of St. Joseph Catholic Church. Inside the recently renovated space, they find volunteer doctors and nurses ready to examine and treat them at no cost. This is the Family Community Clinic, a nonprofit that opened its doors in January 2011 specifically to provide free health care to the uninsured in Louisville.

“There are literally tens of thousands of indigent people in our own city,” said George Fischer, one of the clinic’s founders. “It’s very sad that we have in our own city underserved people that we’re passing by every day. Our mission over the long haul is to take care of these underserved people.”

The walk-in clinic operates from 8 a.m. to noon each Saturday. There are four exam rooms. Pediatrician Fernanda Nota, MD, who serves as medical director, describes it as an immediate care center for acute illnesses. Patients can be treated for colds, flu, sore throat, cough and allergies. Doctors also see adults for respiratory illnesses, skin conditions and minor injuries, while they perform well-child checkups and sports physicals for children. Hearing and vision tests are done. There is a small lab. Doctors try to write prescriptions for generic medications that can be filled for $4. Dr. Nota said patients are directed to other free or low-cost resources in the community for such things as vaccinations, mammograms and prenatal care.

The Family Community Clinic currently averages 15-20 patients each Saturday, or about 700 patients annually. Sixty percent of patients are Hispanic, many of whom are undocumented individuals. Others hail from a variety of countries, according to clinic manager Mary Lee Eady, RN, BSN, MSN. The volunteer staff always includes a Spanish interpreter.

“These are patients who have no place to go,” said Dr. Nota, who recalled one female patient who was unable to hear until getting an ear irrigation. “She was so grateful.”

Father David Sanchez and a group of St. Joseph parishioners teamed up with Fischer to establish the clinic, which is modeled on the People’s Health Clinic in Park City, Utah. Fischer said he traveled to Park City in 2010 and learned that a donor had just purchased new equipment for the facility, open daily with a volume of 10,000 patients each year. The staff was willing to give Fischer the used equipment (worth about $500,000) if he could move it out quickly.

“Within 48 hours, I got a trailer and a van and loaded all their equipment,” Fischer said.

The clinic depends on volunteer physicians, who are asked to commit to no more than one shift per month. Liability insurance is available. Medical students also can be of assistance.
Dr. Nota said the clinic is seeking specialists willing to volunteer their services, either at the clinic or by accepting referrals for one or two patients per month they would agree to treat pro bono. She pointed to cardiologist Michael Imburgia, MD, as a valued partner who offers free clinics on a regular basis. In particular, the Family Community Clinic is seeking gastroenterologists and neurologists.

“Our big need is specialists,” Dr. Nota said.

In January, the Family Community Clinic plans to expand with hours on Tuesdays from 5-9 p.m. The minimum number of total volunteers needed per shift is nine.

“It’s a very professional operation, even though we’re still small,” said Fischer, who noted that the clinic even has an EHR system. “We can open as fast as we have qualified volunteers to help us.” To volunteer, go to www.famcomclinic.org and click on “Volunteers.”

Note: Ellen R. Hale is the communications associate for the Greater Louisville Medical Society.
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Aerogrammes: and Other Stories
By Tania James
Publisher: Alfred A. Knopf, New York, 2012

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

Tania James is a native Louisvillian who now resides in Washington, D.C., and is the daughter of Dr. K. James, a local cardiologist. Atlas of Unknowns was her irresistibly engrossing debut novel, published in 2010 to rave reviews. She has now written an exquisite mélange of nine riveting short stories in this book. She appeared at Carmichael’s Bookstore on Frankfort Avenue as part of her book tour on a sweltering day in May to a rousing welcome by her fans, friends and family, including her beaming parents. Before signing my copy of the book, she asked me if I wanted it written “To Uncle Saleem.” But I opted for just plain “To Saleem,” and she obliged. According to the norms of the Indian-Pakistani culture, as an expression of respect, every male or female acquaintance of the family is an uncle or an aunt respectively.

An “aerogramme” or “aerogram” was a thin, foldable, gummed and pre-stamped letter sent by international airmail that was first used in Iraq by the British in 1933 and later introduced in the United States for 10 cents in 1947. I used to anxiously wait for my older brother’s aerograms from the United States to Pakistan and, after my arrival here, I used to exchange aerograms with my younger brothers and my late mother in Pakistan. Relegated to the dustbin of history, aerograms have been out of circulation in the United States since 2006. The fictional story “Aerogrammes” is a haunting tale of a retired Indian émigré, Hari Paniker, who used to own a produce store on Chenoweth Lane. Because of worsening dementia, he has been “temporarily” placed in the Renaissance Gardens, a nursing home, by his 38-year-old son, Sunit, who enjoys “a year-long vacation interrupted by sporadic jobs” rather than a job that offers yearly vacation. Hari Paniker befriends his neighbor, May, and they start frequenting the cafeteria together and then back to his or her room for small talk. She shows him an aerogramme from India, and it appears to have been written by a Satyanand, her adopted Street Angel from Bombay who thanks her for her generous donation of $20 with which he was “able to buy a chappal (a flip-flop sandal) and plenty of rice for the family.” Hari discovers some discrepancies in the next two aerogrammes from India and is convinced that the Street Angel business is most likely a trick to extract donations, but May won’t hear of it. Her grandniece, Leanne, who is a nurse at Baptist East, visits May, while Sunit calls Dad about a job offer in New York. The story is emotionally charged, with May becoming delusional due to her multiple strokes and thinking that Satyanand is going to pay a visit soon. When she challenges Hari that he does not have a son since he never visits, Hari produces a childhood picture of Sunit. May, however, promptly tells him that it is in fact a picture of Satyanand, her adopted son, and not Sunit – Hari’s real son!

“Lion and Panther in London” is an interesting story that deals with two legendary wrestler brothers, Gama and Imam, from British India in the 1900s. They have arrived in London to challenge anyone to wrestle with them, but no contender shows up for a while. They are bored in their rented house, keeping themselves busy with exercise, wrestling practices with one another and playing chess. Eventually, their tour manager, Mr. Benjamin, nervously suggests that the matches can be “fixed” and, if they want to make money, they should consider taking the fall on occasion, but both brothers scoff at the idea. Mr. Benjamin eventually arranges for some challengers for both Gama and Imam, and both brothers defeat all wrestlers. They are dubbed the Lion and the Panther of the Punjab (area of India where they had hailed from) respectively. The final bout of Gama with the Polish wrestler Zbyszko for the coveted title of world wrestling champion culminates in a draw, to the chagrin of the spectators. When a rematch is scheduled, the Polish wrestler skips town and Gama, by default, is declared the champion. There are very tender moments and feelings between the brothers, with Imam’s deep respect and virtual worship of his elder brother from their childhood days. The specter of a “fixed” match, however, hangs in the air.

With deft narration, these beautifully constructed stories that deal with complex yet tender interpersonal interactions between the characters are a delight to read. Note: Dr. Seyal practices Cardiovascular Diseases at River Cities Cardiology.
The Lost Pearl
By Lara Zuberi
Publisher: CreateSpace Independent Publishing Platform, July 2012

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

Dr. Lara Zuberi is an immigrant physician, a hematologist-oncologist married to her interventional cardiologist husband, Omer Zuberi. Both live in Jacksonville, Florida, with their young son. The Lost Pearl is Dr. Zuberi’s debut novel, and the story is narrated in the first person by Sana, the main character in the book.

Sana is 9 years old and lives in a posh area of Karachi, Pakistan, with her younger brother and her loving parents. The idyllic life is shattered irrevocably by the tragic death of her father from an assassin’s bullet while he is in his study. The last moments of her father’s death are etched in Sana’s memory and will torment her perpetually and immeasurably, since she happens to be behind the curtain and witnesses the bullet’s impact close up. On top of that, she even sees the face of the assailant. This cataclysmic event changes things in multiple ways including her mother’s eventual remarriage, her friction with her stepfather over that decision and the dislike she harbors for her stepfather. She makes a momentous decision to move far, far away from her family under the guardianship of her paternal aunt and her husband, who are a childless couple living a comfortable life in California.

She describes growing up in the United States with the usual immigrant angst and her long acculturation process, sometimes exhilarating and sometimes exasperating. Sana narrates the political landscape of Pakistan encompassing almost two decades. She visits her family, now including her new sister, in Pakistan, but the strained relationship with her mother and essentially no relationship with her stepfather continues. These sojourns to Pakistan, however, keep her grounded with her past including memories of her father, her culture and visits with the family. She works hard, is academically sound and pursues journalism at the renowned Stanford University. Her meeting with Ahmer at Stanford is serendipitous. Once they start talking and getting to know one another, both know that they are soul mates. Ahmer is also from Karachi, is studying law and has had a terribly sad past, losing his parents as a child. They start spending much time together and are emotionally very compatible. The fortuitous encounter blossoms into love and eventual engagement, with wedding plans in Pakistan. There are many twists and turns in the story, and they keep the reader engaged until the very end, which is rather unexpected but very intriguing. For a debut novel, Dr. Zuberi has done a superb job indeed. Her book is available at the Amazon and Barnes & Noble websites.

Note: Dr. Seyal practices Cardiovascular Diseases at River Cities Cardiology.
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895-5124
I can remember when diagnostic radiologists could easily lose the battle for the hearts and minds of referring physicians by declaring, “Study not indicated.”

I seem to recall that this was almost a triumphant war cry among the residents in the Radiology Department at “Old General” (Louisville General Hospital on Chestnut Street). The good thing was that it did generate a one-on-one, in-your-face discussion with the resident from the referring team, and one way or another the appropriate test was done. I have to believe that our resistance was often motivated by the relative brutality/injury one would feel was being inflicted on the patient for a dubious outcome (especially, this meant those of the “rule out” category). I still shudder at the thought of air encephalography (brain herniation), Pantopaque® myelography (every drop to be removed otherwise, in addition to suffering the worst headache imaginable, the patient would eventually return with problems related to arachnoid adhesions), direct carotid sticks and the relatively benign hypotonic duodenography. Then, in the mid-’70s, along came EMI (yes, Ringo was involved) and Godfrey Hounsfield in the U.K.; Allan Cormack in the U.S.; and the CAT scan era was born.

Almost in anticipation of the future development of medical imaging, Diagnostic Radiology and Therapeutic Radiology became separate specialties in 1973. Technological advances in CT scanning started slowly at first but proceeded relentlessly, from the 1980s on, with increasingly detailed images that became indispensable to clinical diagnosis and management. Increased resolution and thin slice technology did not necessarily mean increased exposure dose for the patient. Increased frequency of CT scanning did. During fluoroscopy and vascular/interventional procedures where technologist and radiologist would be in the same room as the patient undergoing the examination, heavy lead aprons and the need to record “fluoro times” were constant reminders that we were dealing with a not-entirely-benign imaging modality. CT allowed the radiology staff to work outside the scanner room without the worry of possible radiation exposure. Perhaps these are just some of the reasons why the known exposure of the patient to ionizing radiation took a back seat to clinical need and relative ease of use.

According to the National Cancer Institute at the National Institutes of Health, the use of CT in adults and children has increased about eightfold since 1980. Annual growth in the last decade averaged 10 percent, with between 5 million and 9 million CT scans being performed annually on children in the United States. It is estimated that currently CT scans account for approximately 49 percent of the U.S. population’s collective radiation dose from all medical X-ray examinations. CT is the largest contributor to medical radiation exposure in the U.S. population.

In October 2008, the FDA was required to investigate reports of excessive radiation exposure to individual patients undergoing CT brain perfusion scans. The lay press reported these cases including the side effects that were easy for readers to visualize, i.e. obvious hair loss and scalp reddening and blistering. The potential for early cataract
formation was also repeatedly mentioned. It was not too surprising that suddenly questions about the safety of ionizing radiation were popping up everywhere, with the main concern being the potential for causing cancer in individuals receiving multiple diagnostic CT scans. As recently as September 4, 2012, I came across the following from American Medical News: “CT cancer risk prompts high-tech efforts to cut radiation dose. Physicians are urged to skip unneeded tests. Now more facilities are adopting methods that can dramatically slash the radiation delivered from the scans.” (Radiation physics for lawyers anyone?)

In fairness to our professional bodies, by 2006 the membership of the Society for Pediatric Radiology had determined that guidelines for and control of the use of CT scans in the pediatric population had to be established. By the summer of 2007, the Alliance for Radiation Safety in Pediatric Imaging launched its campaign, Image Gently®. In addition to the Society for Pediatric Radiology, the founding organizations in the alliance were the American College of Radiology, the American Association of Physicists in Medicine and the American Society of Radiologic Technologists.

In April 2010, E. Stephen Amis Jr., MD, and Priscilla F. Butler, MS, authored the “ACR White Paper on Radiation Dose in Medicine: Three Years Later.” This reported on the developments that had occurred since the initial recommendations of the alliance’s panel in 2007 and the launch of the Image Gently® campaign. One of the outcomes of the 2010 white paper was the establishment by the ACR and the Radiological Society of North America of the Joint Task Force on Adult Radiation Protection. Since that time, the Image Wisely® campaign has been developed “to create educational resources for radiologists, medical physicists and technologists who provide medical imaging care within the United States and to communicate the availability of these educational resources using a wide variety of electronic and print media.”

Each of these two campaigns has its own website: www.imagegently.org and www.imagewisely.org.

The websites are easy to navigate with separate sections for patients/parents/guardians as well as health care professionals. Simple imaging record charts can be downloaded for patient use, functioning in much the same way as immunization records. In addition, these charts should help educate the population as far as imaging tests that use ionizing radiation versus those that do not. There are even posters available showing why “one dose does not fit all,” which has become one of the mantras of pediatric imaging. The websites are worth looking at for anyone who orders imaging tests. There are many useful links to peer-reviewed articles including such subjects as CT technology and dose modification. Although the primary focus of ionizing radiation dose reduction is CT utilization, both campaigns address other radiologic imaging modalities including interventional radiology, computed radiology, fluoroscopy and nuclear medicine.

Clearly the optimization of each diagnostic CT scan to each individual patient is no easy task. It would be disingenuous to think that tweaking machines, multiplying protocols and flooding the market with new, expensive technology will put us in a safe zone. For one thing, there will still be a difference between exposure and absorbed dose for each patient and each study. Ultimately, the purpose of imaging is to optimize resolution (technical) and ensure that each imaging study contributes to the establishment of the clinical diagnosis.

The mnemonic for the campaign efforts is easy to remember: “ALARA = As Little As Reasonably Acceptable.” I hope this will not just become a new shrub in the radiologists’ hedgerow, but that a greater mutual understanding will move us beyond “study not indicated.”

Note: Dr. Amin is a retired diagnostic radiologist.
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Strange, isn’t it? Each man’s life touches so many other lives. When he isn’t around he leaves an awful hole, doesn’t he?”
– Clarence from “It’s A Wonderful Life”

Sometimes I feel like the Greater Louisville Medical Society Alliance is the George Bailey of the medical community. We are in the background, offering support, resources, encouragement and a lot of love … just like that old Building and Loan in Bedford Falls. But unlike George, I don’t need a visit from an angel looking to earn his wings to make me realize that it is a wonderful life and a wonderful Alliance.

Just take a look at what’s been going on recently and you can see that the world is a better place because of the Alliance. Many people are unaware that one of the ways we support our medical community is by providing a member for the board of the GLMS Foundation. In October, we built camaraderie and supported the GLMS Foundation when we met and toured the historic Old Medical School Building. The Greater Louisville Medical Society and GLMS Foundation staffs were so warm and welcoming and sent us home with a lovely souvenir book of the Wolf Gallery. My favorite part of this event was looking over the archived pictures from 1980 during the time when Barbara Davis was president of the GLMSA.

In November, the GLMSA met at Gilda’s Club. The Gilda’s Club mission is to create welcoming communities of free support for everyone living with cancer – men, women, teens and children – along with their families and friends. The GLMSA served a meal to Gilda’s Club members. We also wrapped gifts for a School Choice holiday party. School Choice offers scholarships to low-income children throughout Greater Louisville to attend their family’s quality school of choice.

On December 1, we will be doubling as Santa’s helpers at the Nativity Academy. The Nativity Academy at St. Boniface is a private middle school serving students of academic promise in the Louisville area from low-income families. We have had a couple of “just for fun” events recently as well. Our members gathered for a wine and bourbon tasting at Taste Fine Wines and Bourbons in the trendy NuLu neighborhood. Afterwards, we walked down to the Garage Bar for some delicious food in the avant-garde atmosphere inspired by the creative minds behind Louisville’s world-famous 21c Museum Hotel. From the great response to this event, I’m sure we will be scheduling a similar event in the spring.

We also gathered at the Frazier History Museum to visit the “Diana: A Celebration” exhibit. In that same spirit, our December 4 meeting will be a visit to the historic Wakefield-Scearce Galleries in Shelbyville with lunch to follow at the Science Hill Inn.

Should auld acquaintance be forgot and never brought to mind? Not in 2013. We will keep the GLMS Alliance busy as we partner with School Choice for a health fair on Saturday, January 12, at the Nativity Academy. We also will continue our work with the Kentuckiana Science Center, GLMS and Jewish Hospital to present Pulse of Surgery for middle and high school students from all over Kentucky. Our partnership with Jefferson County Public Schools to collect used medical texts continues in 2013. And we are now and will continue to collect gently used OR scrubs, yoga pants and new ladies underwear to donate to the Center for Women and Families in Louisville.

As you can see, it’s a wonderful life and a wonderful time to join in the fun and the work of the GLMS Alliance. Happy holidays! [IM]

Note: Contact Adele Murphy at adelepmurphy@aol.com or 502-664-5925.
Gingerbread and Gluhwein
Mary G. Barry, MD

When you fly to Munich from ATL, if you’re lucky the sun comes up about two hours before you land. You can watch the more haphazard fields of France give way to the unmistakable rolling farmland of Bavaria, green and neat, with baroque onion-domed churches rising above tiled roofs. It looks like a homecoming to me now, but the first time I went in winter, from my Delta window there were no green fields. We saw long swathes of snow carved by gray slivers of road and black trees. It was new, it was cold, and it was Christmas.

Cold and I go badly together. I only interviewed for residency below the Mason-Dixon line. I wear so much fleece that static electricity sends blue sparks from my fingers. When my patients flinch from cold hands, I tell them I have alien blood. I like it to be 85 and sunny and then maybe, at midday, I will shed my socks and boots. Munich with a foot of snow, at 10 degrees below zero, was terrifying. I would be a guest, to be a part of all activities and boot. Munich with a foot of snow, at 10 degrees below zero, was terrifying. I would be a guest, to be a part of all activities outdoors, and not the one in charge of the timetable. I foresaw frostbite.

Goetz’s parents Hans and Hertha met us at the airport with their dog, Bobbi, a doe-eyed dachshund who was incurably amorous. Only Hertha could spit the word “Basta!” at him and he would, for a moment, be cowed into behaving. Bobbi was shivering despite his tartan car blanket. I took this as a bad omen, and snuggled up next to him in the back seat.

With Anne, Linde and the rest, we had a breakfast of fresh pretzels, cheese, fruit and cucumbers, and cookies—wondrous cookies! Hans’ living room was lined with books top to bottom, bird feeders hung outside the window, and Hertha liked my hostess gift, a silver pineapple that Dr. Greg Brown had approved of. This was promising. Inside it was warm and golden and lovely. Outside we launched into a full schedule of visiting, sightseeing and getting ready for Christmas Eve, when all across German Christendom the towns are still, the real wax candles on the trees are lit, and families draw close in their homes. It’s not a time for strangers, by tradition. (No wonder baby Jesus stayed in the manger.) I was just Goetz’s American, not quite a stranger but not yet a daughter.

In Munich we headed straight for the Christkindlmarkt in Marienplatz, the main downtown square, where we had hot cocoa and then gluhwein (“glow” wine: hot red wine, mulled and spiced) and then sausage and more gluhwein. The mug warmed my fingers and Hertha warmed my heart, as she charmed the imposing sales staff of Loden-Frei. Loden-Frei is what Byck’s used to be. It’s in the heart of downtown, stocks the genteel sort of dry goods, and has eagle-eyed saleswomen who are formidably capable. Hertha was intent on getting Goetz a presentable coat for Christmas, so soon he was surrounded by women who studied him seriously, stood him this way and that, and fit his shoulders perfectly. They took care of him in a proprietary maternal way, for after all he was a son of Munich, and they had standards to uphold. I enjoyed it immensely.

At night we took walks, for exercise, tramping through the neighborhood snow, sliding on the wooded paths, admiring the very occasional candle display in a window. There was no Hillcrest Avenue sort of Christmas décor. Rarely, a Santa-on-a-ladder dangled from a chimney. No trees lit up living rooms; it was not yet time. The wind whistled past my ears and sliced through my layers of down. From time to time, I counted my toes to see if they were still all there, and warmed my nose with my glove. My glasses fogged up uncontrollably. They spoke kindly to me in German, and I smiled a lot in English.

On the 22nd we drove the autobahn to Aschau, a little town at the foot of the Alps, to their summer house where Christmas was always kept. Huge shopping went on at the bakery, the butcher and the Edeka grocery. The Germans actually close everything for three days, including Boxing Day, and only gas stations are open; you have to stock well up on every breakfast staple, and plan meals minutely. Later we went to the FrauenIsle, the convent island in the center of the Chiemsee, a gorgeous lake dubbed the “Bavarian Ocean.” Ice drifted on the waves. The wind howled off the water and cut into my knees, the ferry rocked, and I thought of my ancestors. They had come across the Atlantic in steerage, in the winter, with no fleece to keep them warm. They had standards to uphold. I enjoyed it immensely.

Christmas Eve Mass by tradition was the children’s service, late in the afternoon, and featured boy shepherds in green felt hats and lederhosen. They had a rousing Munchkin sort of entrance that brought down the house; then girl angels sang the story of the Manger. The church was old, simple on the outside and shining with gold and ornate marble carvings on the inside. It did not look at all like St. Louis Bertrand, the family seat of my clan. After, we carried candles lit from the altar precariously, gingerly, all the way through the village and up the long hill to the house, which glowed at the edge of the woods, off by itself. Cattle lowed and the horses from the farm next to us stamped at their barn door. Feeding time was nigh, and so was our Christmas, where I was far away from Sixth and St. Catherine, but next to the one closest to my heart.

Holidays to Remember
Stories celebrating the season from the Louisville Medicine Editorial Board
My mother, a Holocaust survivor, was fiercely proud of being an American and a Christian. My siblings and I were born in America and attended public schools. My family was religious: We went to synagogue every Saturday, stayed home from school while observing Jewish holidays, and experienced home prayer and religious traditions. In public schools, prayer was dinner table conversation. My family was religious: We went to synagogue, and Bible reading were prohibited in public schools, I was elated – now there was not a daily reminder to my friends that I was different from them! My parents were involved in the Civil Liberties Union at the time, and school prayer was dinner table conversation. My family was religious: We went to synagogue every Saturday, stayed home from school while observing Jewish holidays, and experienced home prayer and religious traditions. My mother, a Holocaust survivor, was fiercely proud of being an American, and for her America meant religious freedom, with separation of church and state. She had experienced firsthand the devastation that intolerance and religious bias can bring. The First Amendment of the Constitution, “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . .” was her mantra.

We were taught how to work hard and be self-sufficient. We grew our own fruits and vegetables, raised cattle for meat and dairy, and even had chickens and hogs for a while. I was glad when we stopped raising chickens and hogs because they really stank. When my siblings and I got old enough, we all had jobs to do. We knew we would have a big Christmas if the tobacco crop was good that year.

We celebrated Christmas Mass at midnight in the same place my ancestors had worshipped two centuries prior. My mother played the organ, and there was no choir. The congregation sang cheerfully and boisterously, if not on key. The priest would break out the incense, and we always wondered if one of the altar boys would pass out from its pungent aroma.

Christmas and New Year’s Eve were the only time we had “party food” like soda pop and potato chips. We loved all the Christmas TV shows like “Rudolph the Red-Nosed Reindeer,” “A Charlie Brown Christmas,” “Frosty the Snowman” (remember Burl Ives?) and my favorite, “The Little Drummer Boy.” One year when I was probably 7 or 8 years old, my uncle Frank came over dressed as Santa Claus and handed us all our presents from a huge red velvet sack. I got a Drowsy doll and a set of art supplies. I was never so happy.

Christmas in those days was simple and sweet and magical. I wish I could go back there just one more time.

Hanukkah Happiness
Jonathan E. Hodes, MD, MS, FACS
I became aware that being Jewish was different from the kids around me in public school, and this was most evident in public school during the mandatory morning prayer. As an independent-thinking young person, and Jewish person, I simply was not going to say this prayer, but by not saying the prayer, I was “different.” When the Supreme Court ruled in 1962 and 1963 that mandatory prayer and Bible reading were prohibited in public schools, I was elated – now there was not a daily reminder to my friends that I was different from them! My parents were involved in the Civil Liberties Union at the time, and school prayer was dinner table conversation. My family was religious: We went to synagogue every Saturday, stayed home from school while observing Jewish holidays and experienced home prayer and religious traditions. My mother, a Holocaust survivor, was fiercely proud of being an American, and for her America meant religious freedom, with separation of church and state. She had experienced firsthand the devastation that intolerance and religious bias can bring. The First Amendment of the Constitution, “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . .” was her mantra.

Christmas time in elementary school was a very challenging time for me. The trees and ornaments and Santa and elves and reindeer and sleighs and and and . . . the richness of the Christmas tradition OVERWHELMED any non-Christian one. The school pageants and crèche and Christmas art projects, the play “A Christmas Carol,” the mall holiday displays and Macy’s windows, the caroling and the bell-ringing Santa, and all the presents my friends got were just hard to bear. If I’m honest, as a child it was
Continued from page 25

visiting some Jewish friends and reading in my room. Something was up.

My buddies were greeted by the smell of latkes. If you haven’t had the gastronomic opportunity of indulging in this coronary artery-clogging, smile-inducing hedonistic fried Jewish soul food – be sure to get invited to a Hanukkah party! These fried potato pancakes originated in Eastern Europe but are enjoyed from northern England to the Middle East. The aroma of cooking latkes can be overwhelming but remarkably welcoming. Mom had even made sufganiot – homemade jelly doughnuts! Hanukkah celebrates a miracle that occurred after the Maccabees successfully conquered Jerusalem and rededicated the Temple in 167 BCE (Before the Common Era). The legend indicates that there was only one small flask of oil to rekindle the eternal light of the Temple – enough to last for one day, but miraculously the flask lasted eight days, the time needed to press and purify more oil.

After my friends and I played in my room with some of the cool toys they got for Christmas, we were called for dinner. The doors to the living room remained shut. After one of my mother’s truly remarkable dinners, including latkes with sour cream and applesauce, Dad said we would light the menorah and play dreidel before having sufganiot.

We went into the living room, and for the first time in my short life it was decorated with Hanukkah streamers, crepe dreidels, stars of David and menorahs, sparkles on the table and a pile of wrapped presents! All five of the family menorahs were set up with all the candles ready for lighting, and there was a sixth menorah for my friends to light as well. Mom and Dad had thought of everything. With the light from 54 candles blazing, we played dreidel and opened presents, peeled the gold foil off the chocolate coins and ate a thousand dollars worth of dreidel money, then stuffed ourselves with the crispy homemade doughnuts oozing sweet jelly. As the candles extinguished themselves one by one and the smell of wax-smoke was evident, I said good night to my friends and went up to bed. Wow! That was a Hanukkah to remember! And yes, I did get a tallit bag that year, but I also got the coolest toy of the season – a Hot Wheels track and several Hot Wheels cars!

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**Pajamas, A Sign of the Times**

Teresita Bacani-Oropilla, MD

At our 25th medical class reunion, a classmate seemed overweening in praise of her granddaughter. The little girl had a matching outfit like hers and marched with our class. Promising never to do the same, I found out that one must never say never, that one of the greatest joys grandparents have is to show off their grandchildren. One falls in love with them, wants them to be in sight, much like a besotted lover. One heaps lavish gifts on them, and likely overvalues their assets. It takes discipline not to condone their antics when they cross certain lines, and to maintain consistency in explaining values that one should hold dear.

Birthdays and holidays are special times to indulge them. As they grow in number and age, one treasures and hoards their uniqueness, yet tends to preserve their unity as one flock. One establishes patterns and traditions that one hopes they will remember so as to keep them together through the years, and maybe pass them on to their progeny in the future. Lastly, one tries to be fair and treat them equally well despite one’s tendencies to – well, overdo.

Precious now are the pictures of them as toddlers, dressed alike in red suits, or of the group innocently singing “Happy Birth-
The last Christmas gift I gave my grandmother was a framed photograph of my husband and me standing next to a glistening 18-inch tree on our piano, which Nana had made for me about 10 years earlier. The tree sparkles with white lights, strands of pearls and red rosebuds, with a cardinal perched on top. I hoped the photo would convey our deep love for her, because there wasn’t much else Nana needed a year ago. At 85, she finally had to leave the home she and my late grandfather had built in 1951 in the Pennsylvania town where I grew up, in favor of an assisted living facility where she was cared for very nicely in her own room. She had heart problems, breathing problems and short-term memory loss, but she remained characteristically full of joy. I’m thankful we spent one last Christmas together. She died in March after a hospitalization led to emergency surgery and multiple complications.

During my childhood, Nana and Papa made Christmas magical for everyone in my family. I remember it as the same every year. We would arrive at their home to an enormous pot of soup for lunch. My brother, my two cousins and I would each open the 18-inch tree on our piano, which Nana had made for me about 10 years earlier. The tree sparkles with white lights, strands of pearls and red rosebuds, with a cardinal perched on top. I hoped the photo would convey our deep love for her, because there wasn’t much else Nana needed a year ago. At 85, she finally had to leave the home she and my late grandfather had built in 1951 in the Pennsylvania town where I grew up, in favor of an assisted living facility where she was cared for very nicely in her own room. She had heart problems, breathing problems and short-term memory loss, but she remained characteristically full of joy. I’m thankful we spent one last Christmas together. She died in March after a hospitalization led to emergency surgery and multiple complications.

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**CANDIDATES ELECTED TO PROVISIONAL ACTIVE MEMBERSHIP**

- **Bailen, Erica Lane** (31105)
  217 Breckenridge Ln
  40207
  895-9421
  Pediatrics 09
  U of Louisville 06

- **Boswell, Mark Vance** (30100)
  Barbara A. Boswell
  530 S Jackson St
  Rm C2A01  40202
  852-5851
  Anesthesiology 88, 09
  Pain Management
  93, 04,14
  Hospice & Palliative Medicine 10
  Case Western Reserve
  U 84

- **Clark, Kelly J (17671)**
  3821 Ormond Rd
  40207
  Psychiatry 97,06
  U of Wisconsin 89

- **Daniel, Stanley**
  Robert (18659)
  Kings Daughters Dr
  Frankfort KY 40601
  875-5240
  Emergency Medicine
  U of Alabama 06

- **Downing, John** (30313)
  Sheryl M. Downing
  301 E Muhammad Ali Blvd  40202
  852-0710
  Ophthalmology 70
  U of Louisville 62

- **Fogle, Anne Marie** (31203)
  Michael Ross Fogle
  4420 Dixie Hwy
  Ste 114  40216
  449-6464
  Family Medicine 05
  U of Louisville 02

- **Hill Ali, Marlyce R (18893)**
  Jermaine A. Ali
  Internal Medicine
  U of Louisville 02


Bays HE. Long-term (52-78 weeks) treatment with colesevelam HCl added to metformin therapy in type 2 diabetes mellitus patients. Diabetes Metab Syndr Obes 2012;5:125-34.


Continued on page 32
Many of you knew and worked with Bob. Bob received his Doctor of Medicine degree from the University of Louisville in 1975. He was board certified in both Internal Medicine and Gastroenterology. He began a private gastroenterology practice that was later named Gastro East Physicians and practiced until his retirement in 2004.

Bob, as everyone called him, was a native of Louisville and was devoted to his hometown. He always said that Louisville was a wonderful place to pursue a medical career because of the high caliber of physicians in the community and the strong culture of commitment to learning, research and innovation in so many different areas of medicine.

He was a natural teacher, and patients and medical personnel alike often commented that he had a real knack for explaining diagnoses and procedures to people in different ways that helped to reduce anxiety and increase understanding. He loved being a physician, and that showed in his performance, infectious smile and upbeat manner.

So many more things could be written about Bob, but one gentleman who had been his patient for years summed it all up eloquently. He simply said, “Dr. Kraft was the best doctor I’ve ever had and the best man I’ve ever known.”

To celebrate and honor the hard work and dedication of Bob, an anonymous donor has created the Robert Pfeiffer Kraft, Jr., MD Endowed Scholarship Fund at the University of Louisville School of Medicine. This fund will assist students seeking a medical degree at the School of Medicine. To receive additional information regarding the Robert Pfeiffer Kraft, Jr., MD Endowed Scholarship Fund, please contact Allison Gardner at 502-852-7817 or allison.gardner@louisville.edu.
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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 email (alecia.miller@glms.org).

LOUISVILLE MEDICINE

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Santa came first. Later, individual presents to each other were passed out. I recall Donnie got a wooden machine gun, and he spent the rest of the day killing the “yellow Japanese.” The only toy that I can remember that Santa brought for me was a large blue and black rubber truck. I spent many hours playing with it the next several years. I think that I kept the old rubber truck until after high school, but by then all the paint had fallen off. My sister Pam got another doll and some furniture, as I recall. She had a hard time growing up with her first two brothers, plus the three more brothers yet to come.

Christmas lunch, called dinner, was Meme’s domain. My mother was a good cook, but Stella Hayden had no peer. With Granddaddy out of the kitchen, she was queen of her castle. She had a huge wood-burning stove that took wood on both sides and heated water internally as well. She usually roasted a fat hen and made sage dressing with canned oysters inside. She made both mashed potatoes and potato salad. She made the giblet gravy that I loved so much to spill over the mashed potatoes and dressing. She made pecan pie from the nuts that she picked up from the wild pecan trees along the Ohio River. The nuts were very small and very tasty. It took the whole family several hours to crack the nuts she collected. She also made fruit salad from fresh fruit and coconut. Yes, she cracked the coconut fresh from the shell. She made the best homemade biscuits in the whole world and pan-fried her cornbread. I can taste this meal now by simply recalling it.

Grandmother Hayden always started the games to be played after dinner. She loved Monopoly, Chinese checkers and any type of card game. She got the games started and tried to take part in all of them at the same time. I always laugh to myself every time I play, when I recall that my sainted grandmother cheated at cards.

The evening meal was generally leftovers but included deviled eggs and Granddaddy’s country ham, sausage and bacon to be put on the homemade biscuits. Granddaddy Hayden always said the blessing before any meal under his roof. Much to the surprise of us all this evening, my mother asked his permission to say the grace before the meal. She wanted to pray for the safe return of our father and her beloved husband from the war. Again, I cannot recall what she said, but I will never forget how she said it.

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“Tou muen se muen.”
–Haitian Creole for
“All humans are people.”

When the devastating earthquake struck Haiti in January 2010, homes and buildings collapsed. The presidential palace in Port-au-Prince, near the epicenter, was almost entirely destroyed. More than 250,000 lives were lost in the earthquake, while another 1.5 million people were displaced. Most moved into tent cities.

A deadly disease is threatening another “pillar” that sustains the structure of Haitian society. Cervical cancer, so closely linked to high rates of poverty and illiteracy, is believed to be the leading cause of death among women in Haiti. When women die of cervical cancer, mostly at ages 35-55 when everyone needs them most, Haitian families suffer.

“The entire family complex begins to fall apart,” explains Robert D. Hilgers, MD, MA, CAE, a gynecologic oncologist who is seeking to expand cervical cancer screening in Haiti through a nonprofit organization he founded, called the Women’s Global Cancer Alliance. “The real pillars of Haiti are the women. They are the ones who give strength to the society and to the family. And they’re the ones who hold the family and community together under the most adverse of circumstances.”

Dr. Hilgers, speaking to the GLMS Foundation’s Medical Missions and Indigent Care Committee, described the life of a Haitian woman as being very difficult. Many women earn money by cooking on the street or preparing charcoal to sell. Charcoal is used to heat living spaces, resulting in a high incidence of childhood asthma and pneumonia.

In Haiti, 90 percent of women have no access to cancer care, Dr. Hilgers said. Pap smears are generally not available; neither are pathologists to read the tests. Cancer doesn’t get as much attention as other pressing health problems like HIV/AIDS, tuberculosis, malaria, childhood diarrhea and malnutrition. There is no cancer treatment center and no radiation therapy. As cervical cancer advances, women become incontinent, develop a foul odor and suffer a tremendous amount of pain. They are pushed to the margins of their families and society, often leaving them isolated. They may not even know that it is cancer that is killing them.

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“When treatment is not available, prevention is the solution,” Dr. Hilgers said. The Women’s Global Cancer Alliance is raising awareness about cervical cancer through education, both to physicians and women themselves, and establishing “see-and-treat” clinics. One has been operating in Gros Morne (population 30,000) for two years, screening almost 2,000 women in that time. WGCA is working on developing another clinic and training center in the larger nearby city of Gonaives (population 300,000), located about 100 miles north of Port-au-Prince.

The see-and-treat method involves using ordinary household vinegar (Dr. Hilgers calculates that one gallon of vinegar can potentially save 250 women’s lives; four gallons can save 1,000 Haitian women). The cervix is painted with vinegar, which allows the clinician to see a clear picture of the cervix. Using a colposcope, worrisome lesions can be evaluated and, if necessary, frozen using liquid nitrogen delivered through a cryosurgical gun. This approach is 90 percent effective, Dr. Hilgers said.

There may be some pelvic discomfort, but no significant morbidity. The procedure can be performed in one visit to the clinic. HIV screening can also take place at the clinic.

The WGCA is raising money to operate the clinic in Gonaives for five years, which will require about $500,000. The WGCA held a three-day cervical cancer prevention conference in Port-au-Prince this month with the American Society of Colposcopy and Cervical Pathology, Haiti’s Ministry of Health, JHPIEGO (an affiliate of the Johns Hopkins School of Public Health), and Partners in Health, a Boston-based group that is constructing a new 320-bed teaching hospital about 60 miles outside the capital in Mirebalais.

“Every child deserves a mother,” Dr. Hilgers said. For more information on WGCA, visit www.womensgca.org.

Note: Ellen R. Hale is the communications associate for the Greater Louisville Medical Society.
I had only a few minutes. I learned to smile, make eye contact and try to understand how their physical, emotional and spiritual worlds came together to create their health. And the most amazing thing was that I was there to practice integrative medicine. I was there to see the whole person and try to understand how their physical, emotional and spiritual worlds came together to create their health. And I had only a few minutes. I learned to smile, make eye contact and listen before beginning my round of questions, and then hope that this would be enough.

At the other end of my walk was the private holistic medicine center, calm and beautiful compared to the chaotic streets. The waiting room had real wood, beautifully soft sofas and a whole wall of windows shining all over you. It was hushed up there, high above the noisy streets, with only the twinkling of chimes in the background. The exam rooms had sconces on the walls. Smells of lavender and citrus hung in the air. The patients were wealthy, intelligent, attractive and optimistic. But they were also demanding and anxious, often coming with stacks of Internet research. Down the hall I had a therapist, nutritionist, massage therapist, acupuncturist and homeopath, and we would have once-weekly conferences to discuss difficult or interesting cases.

It was a fascinating year. I learned to be committed and thoughtful from the community health center; I learned about new systems of medicine and the latest evidence from the private clinic. I attended classes on homeopathy, Reiki, medical hypnosis, functional medicine and more. I struggled with a lack of continuity in both locations and wondered how I would find the time and connection with patients. I was there in New York in order to bring together my idea of being a physician and a healer. I wanted to bring together the best of conventional medicine with a whole-person approach.

Finishing the fellowship, I looked for a practice where I could see patients who want to be able to bridge conventional and alternative medicine but in the context of evidence-based care. For the past two years, I’ve been grateful to be at a family medicine practice within walking distance of my house here in Louisville.

On a typical morning, I see a middle-aged man with the familiar list of diabetes, hypertension and hyperlipidemia. My patient is very motivated to lose weight and eat well, but at the same time is slowed by the difficulty of exercise and healthy diet. So we try to go at it together, looking for types of exercise that are fun, food changes that are realistic and sustainable, gathering labs and data as we go but still in the context of this complex and lovely and stressful world.

Next I head to a 4-month well visit, distracted by the baby’s vibrant smiles from the task before me – to monitor growth, developmental milestones, calorie intake, sleep habits, safety and parental concerns, and document it all along the way.

I find that I’m already a little behind as I head into my next patient, a new patient in her 40s with persistent fatigue. She is looking for a holistic approach, or answers, or both. We talk about her family and her daughter who is in college. She lives alone and sleeps poorly. She has had the same office job for 15 years and fears she is allergic to the building. We check labs for anemia, vitamin deficiencies, thyroid. We look at supplements for anxiety and sleep and ways to reduce allergy exposures. She agrees to begin a daily restorative practice, yoga or meditation. (I will see her back in two weeks to go over labs, and she will tell me that she is walking several times a week and the melatonin is helping with her sleep, but she is gaining weight and feeling frustrated.) Then I dash to my office to pump milk for my 9-month-old, put away the bottles and clean the supplies.

From there I see a 60-year-old female with asthma and COPD who only comes in with an acute exacerbation, next a 5-year-old with a rash, then a college student with an upper respiratory infection and then a well woman exam where I counsel the patient she doesn’t need a Pap for another two years. I advise a male teacher about environmental measures and herbal supplements that may help his worsening allergies, and then I navigate the lengthy problem list for my 83-year-old male accompanied by his daughter. I take time then for phone messages, pharmacy callbacks, rehab orders and mail, then zip home for lunchtime with my daughters before afternoon clinic. It feels full, but I love the work itself and the relationships formed in the process.

And so these days I smile at my own luck. I see 3-day-old babies, white-haired sweet little old ladies, healthy moms, persons with 15 chronic medical conditions and everything in between. I run into my patients at the farmers’ market. I ask my librarian patient for book recommendations. If I’m lucky, I see three generations of a family. Most importantly, I get to be a continuous part of my patients’ health care. Some days I have the opportunity to ask about the ways in which my patients take care of themselves – I may be able to delve into nutrition and sleep and stress reduction more completely. Other days, we have to focus on when to check sugars and setting up a colonoscopy. But I know that I get to have the long view.

Note: Dr. Busse practices Family Medicine with Norton Community Medical Associates-Highlands.
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Calling Timeout

Since April, when we began the all-consuming EMR, there are days it’s well past noon and I have not eaten since 5, except for Hershey bars. There are days I don’t even look at work email or AOL till suppertime, days I miss Jazzercise and days I fail to mail the birthday card or even buy it, for my clan of loved ones. I am continuously sleepless now, going on eight months, even more than at Grady, when I could sink into eight or nine hours when off call. My prospects for improvement will only appear on Memorial Day, when I should have finally succeeded in abstracting 25 years of medical records on 2,000 people into the Epic system, and will then only need to keep up with the damn thing.

For sanity I continue to call the 30-second timeout (Words with Friends moves, the officials’ timeout (check on hospital patients in Carelink while signing various important pieces of paper) and the TV timeout (my favorite: when my call is put on hold for any reason, I read the ESPN and Breaking News apps on my cell). Even better is the game-update function, where I can follow faraway soccer matches – and the Olympics, ah the matchless Olympics, what a massive dose of cheering-up they brought us all.

So when my thoughts turn to December and Christmas, I think about giving, and about time. I spent years of summers doing nothing but laundry, reading books and swimming. I got to walk to the library twice a week to get more books, but straightway went back to whatever chair my older sisters had not commandeered. The modern child has a scheduled life (which is why they grow up with so many more practical skills than we did) but I wish, for them, a Christmas of unfettered hours, lots of new books and daydreaming. For their parents, my colleagues who have to do everything I do AND raise their kids, I wish several Mary Poppinses who magically appear and render children bathed and smiling, with completed homework in hand. As for the teachers who assign gradeschoolers the sort of projects where you build your own ziggurat – fix on them. If you can fit Tab A into Slot B, I consider you qualified for at least high school. Having to invent a Tab A for a Slot B, to construct a temple of any kind out of available household materials, is a nightmare destined to provoke mutiny. I’d steal time from those teachers and make them grade 500-word essays on “Drywall: Ten Ways To Use Those Big Orange Buckets.”

There are a lot of us out there living on borrowed time – people on chemo, people in war zones – who know it’s borrowed and live that way. Most of the rest of us prefer to pretend that Later is really Never, for who can hold his own mortality in his mind? One benefit of never having enough time, I have discovered, is a surreal appreciation of the clock. I can tell you to the minute what time it is these days, and every grain of happiness I snatch from the maw of Epic I snatch speedily, with greed, and with gratitude. The big crumbs – like home football games – and the little ones, like the first junco of December and Christmas, I think about. I seize and hold dear. Every minor pleasure is more meaningful these days. Got a sunrise? Check. Got a joke? Check. Got some more ice? Wow!

Time with the ones you love is the most precious gift of all. I think of our men and women far away, getting shot at on our behalf, and wish them home safe with their families. Missing major rituals is only one of the things they give up for us. Every minute I have with my family makes me happy, and I wish the same joy for them.

As for greed, I quote Franz Messerli, MD, in NEJM of Oct. 18: “There was a close, significant linear correlation (P < 0.0001) between chocolate consumption per capita and the number of Nobel Prize laureates per 10 million persons among 23 countries.” It’s those flavonoids that increase cognitive function, you see. Switzerland won, far and away, if you throw out Sweden (home court advantage). The U.S., Ireland and Germany were even, but all below the Brits, Austria, Norway and the Danes. China was last. By Dr. Messerli’s calculations, “The minimally effective dose seems to hover at 2 kg per year, and the dose–response curve reveals no ceiling on the number of Nobel laureates at the highest chocolate dose level of 11 kg per year.” (Only 11 kg? They’re pikers.) However, he advises caution. “The specific dose of chocolate needed to increase the odds of being asked to travel to Sweden is uncertain, and the research is evolving.”

Therefore, for general giving, to increase our IQs, aim our thoughts like lasers and help us type even faster, I suggest milk chocolate. Dark chocolate is for the intellectual type – you know who you are. We warrior types stick with our K-ration milk bars, and wish you a happy new year.

Note: Dr. Barry practices Internal Medicine with Norton Community Medical Associates-Barret. She is a clinical associate professor at the University of Louisville School of Medicine, Department of Medicine.
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