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ON THE COVER: Get to know GLMS President James Patrick Murphy, MD, MMM. Story on page 20.

GLMS Mission
Promote the science, art and profession of medicine; Protect the integrity of the patient-physician relationship; Advocate for the health and well-being of the community; Unite physicians regardless of practice setting to achieve these ends.

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[Images of the GLMS Mobile App interface and logos for App Store and Google Play]
CHANGE YOUR DEFAULT FUTURE

Breaking rocks?

In the closing days of my Master of Medical Management program at USC, Professor Dave Logan introduced to our class the concept of a default future, the future that will happen if nothing is done to change it. He then asked the class – 22 seasoned physicians – to describe what health care would look like in 10 years:

“Everything will be automated and impersonal.”

“You’ll have to wait two years to get a hip replacement.”

“It will be a two, no three tier system.”

“The doctor-patient relationship will be history.”

“Managers will run everything.”

“Doctors will be worker bees.”

“Patient care will suffer.”

“I will finally get to go home at 4:30, because everything will shut down.”

What struck me is that no one mentioned that doctors would be paid less money. This was the Marshall School of BUSINESS, yet none of these professionals put lower income at the top of their list of worries. Which is precisely why these physicians, all physicians, need to be leaders – not just managers, not just worker bees.

I have been a GLMS officer for the past three years, and at every board meeting it stared at me from the backside of my name placard – our mission statement. Only in the past few months have I really taken notice. It is so elegant:

Promote the science, art and profession of medicine.

Protect the integrity of the patient-physician relationship.

Advocate for the health and well-being of the community.

Unite physicians regardless of practice setting to achieve these ends.

Doesn’t this sum up why you and I became physicians? Isn’t this a stark contrast to the default futures predicted by my USC cohorts?

I remember very little about the blur that was my first week of medical school, but I will never forget the question that one of the PhD types posed to our class. He asked us to raise our hand if we went into medicine to save the world. Without hesitation almost every hand enthusiastically went up.

“Then you are in the wrong place,” he smugly blurted into his lavaliere mike. “Go learn how to grow corn in the desert. Then you will save the world.”

This made me think. Why did I want to be a doctor? Was it for the prestige? The respect? The money? The power? Or was it because I wanted to have a profession where I could touch the lives of others? Relieve the suffering of a single individual? Of a multitude?

It has been my privilege to be a physician for more than 28 years. And while I still can’t fully answer the question of why I wanted to become a doctor, I can definitely say why I want to wake up tomorrow and be a doctor. It is in that mission statement.

Some of you are in the whirlwind that is medical school, others are developing confidence to match the bravado that carries you during the early years in practice, some are grinding away against the current of the faceless third-party, and some are looking back and wondering if they should have tried to grow corn on sand.

There is a default future out there. Somehow, you know what it is. If you pause and think, you can even say it out loud so it seems more real. And it will come to pass, unless you make a decision to act – unless we make a decision to act.

I am asking you to unite with your partner, your mentor, your colleagues, your spouse, your patients and me. Together we can take the first steps to change the default future. It has to start somewhere. It can start here. Right now.

We have core values that we share, and when our strategy is in line with achieving the greater good our choice of profession becomes a higher calling.

Communication is paramount. And we must communicate passionately and effectively. Connect with your colleagues via tweets and email (mine is president@glms.org). Join a committee, attend the meetings, call legislators, write letters to the editor, join the GLMS Alliance with your spouse and look to GLMS for leadership development opportunities. As soon as possible, download the new GLMS mobile app and read the alerts, publications and notices.

Lead. Manage if you must, but you must lead.

Breaking rocks?

Dave Logan told us of a band of laborers sweating in the hot sun in some poverty-stricken Third World country. They were pinging away at rocks with small hammers, relentless, sweat pouring, dust choking. But amazingly they seemed happy despite the mind-numbing conditions. When one was asked how he could not be miserable in the mundane task of breaking rocks, he replied, “I’m not breaking rocks, sir. I am building a cathedral.”

Let’s make a new future.

Let’s build a cathedral. 

Note: Dr. Murphy, board-certified in Anesthesiology, Pain Medicine and Addiction Medicine, is the president and medical director of Murphy Pain Center. He is an assistant clinical professor at the University of Louisville School of Medicine and serves on the board of the International Association of Pain and Chemical Dependency.

For instructions on how to download the new GLMS mobile app, go to www.glms.org and click on Download the New GLMS Mobile App under the Physician Alerts.
GLMS PHYSICIANS GIVE BACK TO COMMUNITY DURING MAYOR’S WEEK OF SERVICE

ELLEN R. HALE

The physicians of the Greater Louisville Medical Society joined with more than 107,000 Louisville citizens who engaged in acts of compassion during the second annual Give A Day Mayor’s Week of Service, which took place April 13-21. GLMS hosted two special events designed specifically for the Give A Day effort as a way to contribute to the health and well-being of the community.

PARENTS UNDERSTANDING PILLS (PUPIL)

In partnership with Jefferson County Public Schools, GLMS held an educational program about prescription drug abuse called Parents Understanding Pills (PUPIL) on April 16 at Valley High School. Led by President James Patrick Murphy, MD, MMM, the event was free and open to the public. Statistics show that one in five teens has used a prescription drug to get high or change their mood, and two-thirds report getting them from relatives or friends – not the street. In his talk, Dr. Murphy asked the attendees to commit to a six-part pledge to keep young people safe from prescription drug abuse: secure my meds, dispose of my meds, educate myself, share with others, talk with my kids and get help.

He also invited Marlyce Burkardt-Neal to share her story of losing two children to prescription drug overdoses. Burkardt-Neal opened a bakery called Marlyce’s Place as an avenue for speaking to people about getting help for substance abuse. “These are my children,” she told the audience at PUPIL, holding a family portrait. “I don’t want them to be forgotten.”

An advocate for the safe and proper prescribing of controlled substances by physicians, Dr. Murphy said he is motivated by what he calls “Marlyce’s rule.” “If I can prescribe medications and do it in a way that Marlyce would be OK with, then you can have the meds,” he said.

GLMS selected Valley High School as the location for PUPIL because it is one of the JCPS 5-Star Schools with a medicine, health and the environment professional career theme. The medical society has been assisting these programs at Moore, Valley and Waggener so that students can pursue careers as physicians or other health care providers.

BODY WORLDS VITAL TOUR

Alumni from the medical society’s Wear the White Coat program were treated to an after-hours tour of BODY WORLDS Vital at the Kentucky Science Center on April 18. The event was an opportunity for the community leaders who participated in the shadowing program in 2011 and 2012 to reconnect with GLMS physicians and see how the human body is affected by disease. BODY WORLDS Vital is an acclaimed anatomy exhibit featuring entire human bodies preserved by plastination.

“Similar to your shadowing experience, we hope this tour gives you yet another inside look into medicine, and that it will spark new ideas in our ongoing dialogue about health care,” Board Chair Russell A. Williams, MD, told the alumni.

LaQuandra Nesbitt, MD, MPH, director of Louisville Metro Public Health and Wellness, introduced the exhibit, pointing specifically to a specimen showing the effect of fat deposits on the body and to specimens displaying the “drastic difference” between a healthy lung and a lung damaged by smoking. “What you see through the BODY WORLDS exhibit is that there are some things related to the environments we design for our community that hamper our community’s ability to live healthy lives,” Dr. Nesbitt said. “While our doctors are prescribing the best treatment, we still need an infrastructure in our community to be supportive of people doing things like getting 150 minutes of physical activity every week or making sure they’re consuming 3-5 servings of fruits and vegetables every day.”

Also during the Mayor’s Week of Service, GLMS physicians...
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volunteered at BODY WORLDS Vital during regular exhibit hours, sharing their expertise in medicine with visitors.

SUCCESS OF GIVE A DAY

Physicians care for the community in countless ways year-round, but the Give A Day initiative was an opportunity for GLMS to showcase a week’s worth of service. GLMS asked members to report all volunteer activity for the week in order for the medical society to make a collective submission to Give A Day officials. Through this, GLMS heard from 77 volunteers totaling more than 250 hours of service. That number included 55 hours of pro bono patient care.

In the end, Mayor Greg Fischer announced that more than 107,000 volunteers engaged in acts of caring, surpassing last year’s total. The first Give A Day effort in 2012 resulted in Louisville being named “Most Livable City” by the U.S. Conference of Mayors.

“We saw Give A Day week really take root this year and connect with people of all ages and groups of all sizes from classrooms to major corporate meetings, reminding us that there are endless ways both simple and highly creative to show compassion and to help others,” Fischer said.

GLMS looks forward to continuing to showcase the inherent compassion of the physician community by participating in Give A Day in future years. “This was a great first year, but we think this is a drop in the bucket for physician community service,” Dr. Williams said. “If we work on increasing our service and reporting more of our service next year, I'm convinced we can gain more media exposure for physicians' constant selfless acts of kindness.”

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

The Greater Louisville Medical Society
Proudly Recognizes Our Volunteers
at the Kentucky Science Center
BODY WORLDS Vital Volunteers

January 20-May 19, 2013
The following volunteers shared their expertise in medicine with visitors at BODY WORLDS Vital.

PHYSICIANS
Kris T. Abeln, MD
Deborah A. Ballard, MD, MPH
Mary G. Barry, MD
Susan M. Berberich, MD
John P. Howard, MD
John D. Kolter, MD
Bryan A. Loy, MD
Alice E. Minter-Sauer, MD
James Patrick Murphy, MD, MMM
Rinit H. Pancholi, MD
Vaughn W. Payne, MD
Todd J. Purkiss, PhD, MD
John F. Rice, MD
Bruce A. Scott, MD
Charles B. Severs, MD
Bakula S. Sheth, MD
Frances E. Weinstock, MD
Fred A. Williams Jr., MD

MEDICAL STUDENTS
Heather Bellis-Jones
Cullen Clark
Anna Cooper
Azra Drijevic
Kit Hunter
Sarah Khayat
Eric Kreps
Venkat Ramakrishnan
Evan Rhea
Sean Trusty
Annie Walsh

Thank You for Giving of Your Time to Contribute to Our Community!

Pulse of Surgery Volunteers

2012-13 School Year
The following medical students served as speakers at Pulse of Surgery, inspiring middle and high school students to pursue careers in medicine.

Cullen Clark
Jenna Harty
Katie Huber
Justine Landi
Suzanne McGee
Joanna Ohlendorf
Peter Ostling
Sean Trusty
Matthew Zeiderman
GOAL I. IMPLEMENT STRATEGIES TO ENGAGE EMPLOYED PHYSICIANS.
Objective 1.1 Conduct focus groups for employed physicians, to better understand their needs and expectations.
Objective 1.2 Develop programs and services to meet needs identified in Obj. 1.1.
Objective 1.3 Expand physician leadership programs recognized by hospitals.
Objective 1.4 Examine the feasibility of launching a profitable education division.
Objective 1.5 Seek opportunities to expand quality improvement initiatives in conjunction with hospital systems.
Objective 1.6 Conduct a rigorous Return on Investment process to determine the real dollar value of GLMS membership per dues dollar required, and communicate to members and employers.

GOAL II. CONDUCT EFFECTIVE YEAR-ROUND LEGISLATIVE ADVOCACY.
Objective 2.1 Develop a “playbook” of legislative goals and expectations.
Objective 2.2 Communicate goals to legislators on a year-round basis.
Objective 2.3 Engage KMA and other stakeholders to develop joint legislative strategies and initiatives.
Objective 2.4 Facilitate one forum of representatives of all medical and surgical specialties and subspecialty societies operating in the GLMS market, to encourage coordination of shared mission and goals.
Objective 2.5 Enlist three key contact physicians per Jefferson County legislator.
Objective 2.6 Determine whether KMA Fifth District Delegation, a subgroup of Delegates or a separate committee, should coordinate GLMS’ legislative advocacy.
Objective 2.7 Establish a new name identity for the (2.5 & 2.6) political advocacy team.
Objective 2.8 Identify legislative candidates supportive of GLMS/KMA legislative goals and provide appropriate assistance.
Objective 2.9 Identify potential physician candidates supportive of GLMS/KMA legislative goals, encourage them to run and provide appropriate assistance.

GOAL III. DETERMINE THE NEEDS OF YOUNGER PHYSICIANS, AND OFFER THEM MEANINGFUL SERVICES.
Objective 3.1 Conduct focus groups of physicians in practice five years or fewer, to better understand their needs and expectations.
Objective 3.2 Develop programs and services to meet needs identified by Obj. 3.1.
Objective 3.3 Create ongoing education on contracting and negotiation skills.
Objective 3.4 Evaluate members’ desire for GLMS to improve the “community” of physicians through social contact, and create opportunities.
Objective 3.5 Continue education and mentoring programs for medical students, resident physicians and fellows.

GOAL IV. IMPROVE THE SOCIETY’S ORGANIZATIONAL EFFECTIVENESS.
Objective 4.1 Build a contemporary membership information database and supporting IT structure to meet evolving GLMS membership, peer review and communication requirements.
Objective 4.2 Increase recruitment and retention of members.
Objective 4.3 Evaluate opportunities to include and involve southern Indiana physicians.
Objective 4.4 Review committee charters, leadership and membership to clarify goals, meet stakeholder needs, and measure success.
Objective 4.5 Decrease committees by 20%, increase participation while decreasing the number of face-to-face meetings.
Objective 4.6 Review and revise the business plans of CAPS and MSPS as needed, with respect to market changes.
Objective 4.7 Implement the Strategic Plan by assigning objectives to appropriate committees to develop action steps and budgets.
Objective 4.8 Review a staff-generated implementation progress report every three to six months at a Board of Governors meeting.
“As physicians, we have so many unknowns coming our way…

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I wondered why her medicine bottles always had their tops off. Time and again, I would remind her to close them, only to find them without the tops again, the very next day. I attributed these lapses to forgetfulness of old age.

Martha was an 84-year-old twice-widowed lady who lived across the street from us. In those days, not too long ago and still within living memory, it was considered “the thing to do” to be watched over by neighbors surrounding her. People talked to each other and valued the shared responsibility and the joy of making it work. Cathy would drop by to see if she had fixed and eaten her meals. Lynn might check in case she needed something from the grocery. Ric and I would look in when we came in from work to see how the day went. In the summer, she would fix a sandwich and a cold drink when our son mowed her lawn.

Checking one day, to see why she limped when she walked, revealed toenails in the shape of ram’s horns that had grown under her toes, pressing them like knives when she put pressure on them. They must have grown there, hidden for years, covered by her socks and shoes. Rock hard, these nails had to be carefully cut with a scissor-like tool that artisans use to cut through galvanized iron. Carefully cut and filed to size, a monthly checkup and refiling, assured a normal gait thereafter.

She wore two wedding rings. One was given her by her first husband, her first love, a soldier that she had to bring home from Chicago after he survived the Great Pandemic Influenza of 1918. The other was given by the widower of the couple’s erstwhile friend several years after she died. With this husband she happily shared their mutual pasts and whatever was left of the future, until he too left her bereft and alone.

Life was hunky-dory until Ric found her on her kitchen floor after work one day. She had fallen while fixing breakfast; the frying pan was still smoldering eight hours later. Refusing to be hospitalized, she had home care after her fractured hip was immobilized. Checking her one early morning, however, she was shivering and cold. Her evening caretaker had slept and left her uncovered during the night. To the nursing home she went that day.

In a mobile society such as ours, where nuclear families are the style and extended families no longer live nearby, the Marthas of this world are becoming more common. Their problems are unique and may be so simple to resolve, but we have to be aware of them. Their minds and personalities may still be intact, but their aging bodies can no longer cope with the demands of living alone. A single misstep can shatter a fragile equilibrium. They now need made-to-order support systems.

As many of these tales go, Martha never left the nursing home to go back to the home that she loved.

Oh – the open pill bottles? A childproof pill bottle can be manipulated and opened by a child with ease, but only with great difficulty by an 84-year-old lady. It was never a question of forgetfulness. Better to leave them open than to wrestle with them for the next dose. To that I can attest.

Note: Dr. Oropilla is a retired psychiatrist.
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Over the 175-year history of the University of Louisville School of Medicine, its buildings transcended function to express the noble purpose of medicine and aspirations of civic and physician leaders. These visions were elegantly proclaimed in the first building of 1838, which is now nearly forgotten. Planning began upon the school’s 1837 founding, with architect Gideon Shryock choosing the inspirational Greek Revival style, then recently introduced by Thomas Jefferson. When erected, the building became the most spectacular structure in young, growing Louisville and was a bold statement of the leading role the school’s medical services and sciences would take thereafter (Fig. 1).

**Louisville’s Medical Acropolis: Chestnut Street**

The heart of ancient Greek cities was an acropolis, a promontory selected for both religious and defensive purposes. The most well-known is that of Athens, site of the magnificent Parthenon. In Louisville, Chestnut Street became, and remains, our medical acropolis. Every home of the U of L School of Medicine and its primary teaching hospitals have been on Chestnut Street. Moreover, the “Chestnut Street corridor” (two to three blocks on either side) includes virtually every other early medical institution, including the Schools of Dentistry, Pharmacy and now-extinct medical schools that would arise but ultimately merge with U of L. “Temples” of our Chestnut Street “acropolis” made Olympian medical contributions and secured prominence in medical history.

**The First “Temple” Grounds**

The site of Louisville’s first medical “temple” was on the southwest corner of Eighth and Chestnut streets, on a plot called College Square. In the 1839 catalog, Founding Dean Lunsford Yandell Sr., MD, wrote that “it is handsomely situated on a lot of four acres... remote from the business quarter of the town; and when completed, will be decidedly the most extensive and well-arranged building of its kind in the Union.” The site was also a brilliant financial action, as the once-remote surrounding acreage originally purchased by the city for $3,400 was subdivided into lots surrounding the square, which appreciated with city growth and ultimately sold for almost $70,000. This paid the $45,000 building construction and provided $20,000 for the library, chemistry equipment and teaching aids.

Circumstances dictated that the first session began immediately in fall of 1837, with building planning incomplete. Therefore, the first-year classes were held in the City Workhouse adjacent to the intended site. These quarters were most inadequate, but observing the new structure’s progress sustained faculty spirits.

**Symbolism and Inspiration in Design**

Civic and faculty leaders intended a magnificent edifice that would respectfully proclaim transcendence of the young city beyond a rough, frontier village, express the noble stature of medicine and attract students and faculty. They employed Kentucky’s premier architect, Gideon Shryock (Fig. 2), who had...
recently designed the State Capitol (Old Capitol of 1829), the Arkansas Territorial Capitol and Transylvania University’s Morrison Hall at Henry Clay’s request. Shryock (1802-1880) was a native of Lexington and had become a leading practitioner of American Greek Revival architectural style. That style arose in the mid-18th century when Europeans gained access to the ruins of ancient Greece, which was previously blocked by Ottoman Empire rulers. Thomas Jefferson’s interest brought the style to the United States, and his 1803 appointment of Benjamin Latrobe as surveyor of U.S. public buildings gave it prominence. Latrobe’s overall plan for the U.S. Capitol in Greek Revival style did not prevail, but it appears in many Capitol interior chambers that he designed. Latrobe’s apprentice, William Strickland, was Shryock’s instructor.

Shryock was strongly influenced by the Ionic Temple of Minerva (Athena) Polias at Priene (Fig. 3). His designs reflected its Ionic six-column façade (Fig. 4) and added graceful spiral staircases and towering windowed domes or spires. These features are well-expressed in the old Kentucky Capitol (Fig. 5). Shryock used this style’s elegance to command admiration and respect in public buildings, including the Louisville Medical Institute (LMI), U of L’s first home.

The cornerstone was laid in February 1838 with Masonic honors and oratory by Chancellor George M. Bibb, who stated that “history will write in [this monument] her imperishable record … and the gratitude of generation after generation [will be] enlightened by the beams of science radiating from the Louisville Medical Institute ….” Shryock’s signature features shone forth, with Ionic columns flanking the entrance and a prominent windowed spire (Fig. 6). The design captured the spirit of Medicine, with the façade expressing classic groundings and the spire proclaiming aspirations to excel. Dr. Yandell claimed that it “cured depression.” Of its spire, Dr. Yandell stated, “When the steeple which surmounts this edifice was erected, it was the last in honor of medicine upon which the sun shown in his journey down the evening sky – the first to greet the traveler coming from the ‘far west.’” The school was Louisville’s greatest early architectural achievement and a worthy “temple” to Minerva Medica.

**INTERIOR STRUCTURE REVEALS EDUCATIONAL PRIORITIES**

The interior structure expressed educational priorities of the time. In 1852, Dr. Yandell recorded this description:

“It contains three lecture rooms capable of seating between four and five hundred persons each, four dissecting rooms, apartments for the several professors, a Faculty Room, a Library Room, a spacious apartment for the Museum, together with various rooms in connection with the laboratory.

The Chemical Lecture Room, with the laboratory and other accessory apartments, occupies more than half of the first story of the building, the former extending upwards toward the third story. This great elevation gives to this room an amphitheatrical form which is of the greatest utility in demonstrative lectures. The series of rooms connected with the chemical theater, used for chemical research, the preparation of experiments, the preservation of apparatus, etc., form with it, as extensive and convenient a suite of apartments as could be desired. Occupying the remainder of the basement are the dissecting rooms, four in number, and well ventilated.

In the west end of the building is the Medical Hall, in which the lectures on Physiology, Materia Medica, and Theory and Practice are delivered. It is about the same capacity with the Chemical Lecture Room and affords seats for upwards of four hundred students. In front of the airy and tasteful vestibule is the Library room, lofty and well lighted. The third story is occupied by the Anatomical Theater, the Museum and the Faculty and Professors’ rooms. The room devoted to the Museum is a magnificent apartment, 60 feet by 45, and 20 feet in height. The Anatomical Theater, in which lectures on Obstetrics and Surgery, as well as those on Anatomy are given, is arranged upon the most improved plan with reference to demonstrations. In the rear of the professor’s table are figures, in plaster of Paris, of Venus and Apollo, for the illustration of the male and female form. This room is lighted thoroughly by a cupola and skylights. Gas is conducted into all the rooms for the convenience of dissection and evening lectures. Ventilation was studied in the construction of every part of the building, and in order more perfectly to secure this important object.

(continued on page 17)
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(continued from page 15)

the lectures are so distributed that two are seldom delivered consecutively in the same room.”

Note that laboratory space for students was virtually absent, excepting rooms for practical anatomy (hands-on dissections). The three great amphitheaters reveal lectures and demonstrations as the era’s principal teaching methods. Emphasis given the Museum apartment reveals the importance of that teaching resource.

FROM WUNDERKABINETTS TO MUSEUMS

Specimens and models provided graphic illustrations of anatomy, embryology and pathology. Some were kept in cabinets of professors, who displayed or passed them during lectures. Others were housed in the Museum apartment for viewing throughout the term. Dr. Yandell described the Museum as follows:

“…The osseous, ligamentous, vascular, nervous, and muscular systems of man are exhibited in numerous preparations made from the human subject, besides which there are numerous models in wood, plaster, and wax, useful in demonstrations to the class. A striking and beautiful part of the collection consists of a series of models by Auzoux, representing the nervous system, and the respiratory, digestive, and circulatory apparatus of the several families of the animal kingdom. From the Museum of Thibert in Paris, a splendid series of models has been procured, within the last two years, illustrative of diseases in the various parts of the body. These models are executed with remarkable skill and have been found of eminent advantage in the lectures on Pathological Anatomy, Obstetrics, Medicine, and Surgery. With the morbid specimens preserved in alcohol, the number of which is constantly increasing, they form a pathological cabinet of great value and attractiveness. Added to the rest, the Museum contains a fine suite of paintings for the illustration of the obstetrical lectures.”

Medical teaching cabinets and museums were descendants of Renaissance-era displays called Wunderkabinets (cabinets of wonders) or Wunderkammer (room of wonders), which held objects of amazement, curiosity or value collected from the worlds of nature, antiquities, art, science or medicine (Fig. 7). As transoceanic trade arose, many specimens came from afar, and collections brought owners great pride. Many contained extensive botanical collections or human and animal specimens, such as malformations of birth or disease, which evolved into teaching objects for medical schools (Fig. 8). Notable examples are Dr. John Hunter’s extensive collections in London’s Hunterian Museum, Philadelphia’s Mutter Museum and elements of the British Museum.

THE MEDICAL LIBRARY

A library of 1,200 volumes was assembled for the first session of 1837-38. Over the 1838 summer, Joshua B. Flint, MD, professor of surgery, traveled to Europe with $15,000 for additional library books, chemical apparatus and teaching aids. In 1841, Charles Caldwell, MD, again visited Europe to further expand these resources. These procurements produced one of America’s finest medical libraries, described by Dr. Yandell as follows: “The library … contains about four thousand volumes carefully selected. … it embraces the old medical classics, in Latin and Greek; many rare and costly monographs, in quarto and folio; a large number of volumes in the sciences allied to Medicine; many of them elegantly illustrated …” In December 1856, the building burned. During the fire, the students saved two-thirds of the library books by throwing them out of the near windows onto the cow pasture below. Many of those rescued books from the original library remain in the Kornhauser Library historical collection, which is the only known remnant of the original Louisville Medical Institute.

AMPHITHEATERS: INSTRUCTIONAL PERFORMANCE STAGES

Central to instruction were carefully prepared lectures and demonstrations given in the three amphitheaters. However, the most significant amphitheater in U of L’s history was built in 1840 off-site (now the northeast corner of Floyd and Chestnut streets) and joined to City Hospital (Fig. 9). Led by Charles Caldwell, MD, the faculty built this clinical amphitheater at their own expense. Medical schools of the era were intended to provide didactic instruction, not clinical experience. Private physician preceptors, locally or in remote cities, provided patient contact. However, U of L’s founding corresponded to advocacy by French medical educators for clinical-pathological correlation in schools. From the beginning, rounds with students were held at City Hospital and were enormously valued. This clinical amphitheater was the first west of the Alleghenies, and it greatly expanded integration of teaching with clinical experience. This gave Louisville early leadership in this major change of educational philosophy that had originated from Paris. Daniel Drake, MD, who had just joined the faculty in 1840, recognized the significance. He dedicated the structure and stated, “The erection and opening of this hall may, indeed, without ostentation, be regarded as an era in the history of medical instruction in the west.” In the octagonal structure, 400 encircling seats with skylights gave each student full view of patients undergoing examination or operation. There was a corridor for bringing patients from hospital wards (continued on page 18)
“without exposure or inconvenience.” In the 1840-41 catalog, Dean Henry Miller, MD, noted “into this, the patients are brought for examination in the presence of the whole class, seated so as to see and hear all that passes. The operative surgery and postmortem inspections of the hospital are performed here [note that before Semmelweiss and his aseptic insights, autopsies and surgeries were done at the same site – GRT], and twice a week clinical lectures on medicine and surgery are delivered.” Thus, U of L established early a tradition of strong clinical instruction that became an enduring hallmark.

RELICS OF THE PAST

The original U of L building was destroyed by fire in December 1856 and rebuilt, but without its trademark spire (Fig. 10). With the 1909 merger of schools into modern U of L, the grand, newer (1893) building of the Louisville Medical College at First and Chestnut streets was made U of L’s home, and the Eighth Street building became a city high school. Along with many historic 19th-century structures, it was ultimately destroyed by urban renewal, which was often blind to history. The site now holds a branch of Jefferson Community College. The 1893 U of L building at First and Chestnut also faced urban renewal destruction, but it was saved by the foresight of GLMS, which renovated it for headquarters that remain today.

Like fragments of ancient Greek temples, only a few relics of the original school remain. The only known authentic remnants are original books from the library, now in the Kornhauser Library historical collection. Symbolically, a museum room was kept when the Greater Louisville Medical Society saved the old Louisville Medical College building from urban renewal destruction. In Wunderkammer tradition, it now displays antique medical instruments and historical artifacts, rather than anatomic specimens. A fine example of Shryock’s architectural legacy is the Old State Capitol in Frankfort, a beautiful and well-preserved structure. It is the assassination site of Kentucky’s 34th governor, William Goebel.

The principal remaining artifact representing the U of L building legacy is Louisville Metro Hall, formerly the Jefferson County Courthouse, which has a very similar exterior (Fig. 11). It was designed by Shryock at the same time as LMI (1837) as the intended State Capitol, an initiative of Louisville promoter James Guthrie. However, the capital was not moved from Frankfort, and the building stood uncompleted for years. The original design was more elaborate, with Doric porticos on all facades and a soaring glass spire, like that of LMI. After failure of the capital transfer initiative, plans were reduced in scale, the glass spire never constructed and only the main entrance portico built. Thus, it became externally a close replica of the old LMI building. It is now the Mayor’s Office and seat of Metro Government, with a west-end amphitheater-like council hall. Rather than male and female forms of Apollo and Venus, images of past mayors and judges are prominently displayed. This building was also slated for demolition during urban renewal, but Frank Lloyd Wright intervened for preservation, saying, “Louisville’s architecture represents the quality of the old south; we should not build this type of building anymore, but we should keep those we have left.”

The original library books, the GLMS Museum Room and Shryock’s remaining buildings stand as “columns of ancient temples” that echo the vanishing history of a heroic era surrounding the founding of Louisville’s medical heritage. LM

Note: Dr. Tobin is a professor at the University of Louisville School of Medicine, Department of Surgery, Division of Plastic and Reconstructive Surgery. He practices with UofL Physicians-Plastic & Reconstructive Surgery. Dr. Tobin is a member of the Innominate Society, Louisville’s medical history society.
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Our paths first crossed at the Naval Hospital in San Diego. Pat, a flight surgeon, volunteered for active duty during the buildup to Desert Storm. Two years later, he finished his residency, and we started an Anesthesia practice in Elizabethtown. Pat led our group to become the Anesthesia provider for Hardin County. After reaching this goal, Pat wanted to go further in his specialty. We studied intensely together to pass the pain boards, but board certification was not enough of a challenge for Pat. Even after becoming one of the first board-certified pain specialists in the country, he decided to get further training by the best in the field and secured a fellowship at the Mayo Clinic.

Pat sets definitive goals and has core values that do not waver. He can be counted on as a passionate ally of those in pain, a crusader against the scourge of prescription drug abuse, a tireless defender of the patient-physician relationship and a staunch advocate for physicians. Pat’s involvement with regulators in crafting prescription guidelines and his GLMS-sponsored ROPE (for physicians) and PUPIL (for parents) drug abuse seminars are examples of his activism. Operation Smile medical missions, student mentorships, gratis faculty work at U of L, community educational seminars, instructive and inspiring literary pieces and pro bono medicolegal work are a few of Pat’s other interests. He is recognized locally, nationally and internationally as an expert in the fields of Pain Medicine and Addiction Medicine. When Pat told me he was granted the privilege of serving as president of the Greater Louisville Medical Society, I could sense the excitement in his voice and knew this journey had amazing potential.

Pat has told me that he wishes there were two of him. As enthusiastic as he is about being a physician, he is very passionate about his role as husband and father. In May, he will be married 28 years to Adele – an amazing person herself – who just finished her year as president of the Greater Louisville Medical Society. Their children, Sara (22), Cameron (20) and Kellen (14), are imaginative individuals, each on artistic journeys just like their dad. Pat’s father, Jim, is his hero – a church deacon, Little League coach and City of Louisville firefighter for 31 years. His mother, Jo Anne, is his inspiration. After Pat and his brother Joe entered middle school, Jo Anne went back to school herself and achieved (continued on page 22)
Clockwise
Dr. Murphy with his sons, Kellen (left) and Cameron (right), supporting U of L at a 2013 Final Four basketball game; Father-daughter dance with Sara; With his wife, Adele, on their honeymoon in Grand Teton National Park; With Sara as a newborn; Dr. Murphy and Adele on their wedding day; Dr. Murphy with his brother Joe; Dr. Murphy with his parents at his medical school graduation; Dr. Murphy and Adele on a recent trip to Hawaii for the AMA Interim Meeting.

Introducing James Patrick Murphy, MD, MMM
President, Greater Louisville Medical Society 2013-2014
her dream of becoming a registered nurse. Jo Anne's devotion to caring for the ill and Jim's steadfast service to his community were the major reasons Pat decided to go into medicine.

Pat is a creative individual. His mnemonics helped me pass my own board exam. During his fellowship at the Mayo Clinic, his pain pump “music video” prompted standing ovations. He once donned a body suit painted with nerves to teach injection technique to anesthesia residents. In recognition of his communications skills, Pat was chosen for the Mayday Fellowship, which supports pain-related media and policy initiatives. He was the winner of Louisville Medicine's Richard Spear, MD, Memorial Essay Contest in 2010 for “The Fawn.” To better acquaint you with Pat, read it online and prepare to be moved (www.glms.org/Content/User/Documents/Essays/TheFawn.pdf).

The path of Pat's career offers another glimpse into who he is. After graduating from Durrett High School in Louisville, Pat enrolled at Westminster College in Missouri and majored in English. At Westminster, Pat discovered his love of theatre but never lost sight of his ultimate goal of a career in medicine. He received the Family Practice award in medical school, trained in Psychiatry during his internship, studied Aerospace Medicine in the Navy and served as a flight surgeon onboard the aircraft carrier USS Enterprise.

After returning to Louisville, his clinical focus was Pain Medicine. He also was a pediatric anesthesiologist for Kosair Children's Hospital and volunteered for Operation Smile missions. After building his reputation locally as an interventional pain specialist, he embraced multidisciplinary management, including responsible use of controlled substances, becoming one of Kentucky's first physicians board-certified in Pain Medicine and Addiction Medicine.

By now, it should not surprise you that his favorite quote is from a poem by Rudyard Kipling: “If you can fill the unforgiving minute with sixty seconds’ worth of distance run, yours is the Earth and everything that's in it.”

And perhaps he may have a few extra unforgiving minutes these days, since on May 17 he completed his studies and graduated from the University of Southern California's Marshall School of Business with a Master of Medical Management degree.

Pat is primed to take over the helm at GLMS. Expect energy, innovation and inspiration from my colleague and friend James Patrick Murphy. LM

Note: Dr. Durkan is an anesthesiologist in Elizabethtown, Kentucky.
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It has been an incredible year and a true privilege to serve as president. I have been blessed with a great group of GLMSA members and a network of “extended family” throughout our state and even the United States. We are all bound by the same core values and the mission to support physicians’ families, health education and the wellness of our community. And we did it joyfully.

There are so many people for whom I am grateful, whose lives intersected with mine over the past year. At the risk of leaving out someone deserving of gratitude, I will pay particular homage to a few. The KMA and KMA Alliance have always been there for me. Thank you to KMAA President-Elect Rhonda Rhodes and Immediate Past President Millicent Evans for serving as my mentors. The dynamic duo of Drs. Don and Nancy Swikert has had my back since even before I took over as GLMSA president. Don is the current KMA Alliance president, thus proving the Alliance is not just for stay-at-home-moms anymore (our own GLMSA board has two male members for next year). Way to go, fellas!

My GLMSA board has been superb. We have had a great time putting together the various functions, supporting charities, raising money for scholarships and just plain having fun. There have also been the important tasks of legislative advocacy – phone calls, letters, emails and personal visits to Frankfort. We had great turnout at meetings and generated new ideas. Whenever I needed something done, our board stepped up like the team that it is. I am turning over the gavel to a remarkable person, Ilene Bosscher. I am grateful for her willingness to lead us onward and am certain she will feel the same love and support from the members as I did.

The GLMS Board of Governors has welcomed me into its monthly meetings, listened to my reports, publicized our events and encouraged me at every turn. The GLMS Foundation has provided financial resources, offered guidance and expressed gratitude for our contributions to its mission. Thanks to all.

The GLMS staff was invaluable. Lelan Woodmansee is the consummate glass-is-half-full leader. Bert Guinn and Ellen Hale made sure that communication with our members and the entire GLMS was meaningful and effective. The rest of the staff was great as well. I always felt I could count on everyone in the GLMS office to come through for us, no matter how small the detail or how large the task.

Our GLMSA members are to be thanked as well. Every person who paid their dues can take pride in knowing that their financial support was spent wisely in fundraising, promoting membership and advocacy. I want to especially thank the members who opened their homes to us for meetings and social gatherings. We had a fun year, thanks to you.

Finally, I want to thank my family and the staff at Murphy Pain Center for putting up with my recurring preoccupation with planning and my absences for meetings. I especially want to thank my dear husband and fellow GLMSA member, Pat, for his love, encouragement and help with my monthly Louisville Medicine articles. I get to return the favor now, as he takes over as president of the Greater Louisville Medical Society this month.

I believe in the GLMS Alliance. I believe that we are more relevant now than ever. We are living in an era of immense and rapid change. Innovations, legislation, litigation, dwindling resources, the continual assault on the physician’s scope of practice and constant pressure from diminishing compensation are just some of the issues facing our medical families in the coming years. Regardless, I am confident the GLMS Alliance will continue to be a supportive, assertive and effective group of believers. It has been my honor and privilege to participate in this mission as your president.

Note: Contact Adele Murphy at adelepmurphy@aol.com or 502-664-5925.
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WHAT DID WE LEARN FROM THE SPORT TRIAL?

PART I DISC HERNIATIONS

MAXWELL BOAKYE, MD, MPH, MBA, FACS

Often I am treating and performing far more complex spinal surgery, but occasionally I see a patient with a seemingly simple problem of a disc herniation. Very recently, I saw two such patients with lumbar disc herniation in my neurosurgery spine clinic. Both patients had right L5/S1 disc herniation with classic right S1 radiculopathy. One of them responded well to nonoperative therapy including selective nerve root injections and, as a result, elected not to have surgery. The other patient did not respond well to nonoperative therapy and underwent an L5/S1 microdiscectomy with good resolution of his symptoms. These two patients illustrate the two main management strategies available for patients with lumbar disc operation. Even in such cases, I find careful assessment and patient counseling is necessary in order to achieve optimum outcomes. The main treatment decisions are whether surgery should be done and, if so, what outcomes can be expected. In the new era of health care, we must constantly ask whether the procedures we perform improve patient outcomes.

Lumbar discectomy is the most common operation for back and leg pain in the United States. Treatment generally involves a variety of nonoperative options including physical therapy, oral analgesics and selective nerve root injections. But a subset of patients will fail six to 12 weeks of nonoperative treatment. In patients who fail nonoperative therapy, discectomy may be performed to relieve symptoms. Despite being a relatively simple procedure with a seemingly straightforward indication for surgery, i.e. unrelenting radiculopathy, there is about a 15-fold variation in regional discectomy rates in the United States. The reasons for this rather large geographic variation are unclear but may be due to lack of clear evidence for the effectiveness of microdiscectomy. So what exactly does the evidence say about whether discectomy should be performed?

The Spine Patient Outcomes Research Trial presents the best evidence to date on the efficacy of surgery for disc herniation. SPORT, a $15 million NIH-funded trial, enrolled 501 patients with lumbar radiculopathy from lumbar disc herniation who had failed six weeks of nonoperative care. The trial was a randomized multicenter study comparing surgery to nonoperative therapy for the treatment of lumbar disc operation. It involved 13 medical centers with multidisciplinary spine practices in 11 states from 2000 to 2004. Results of the SPORT trial became available in June 2006. Since then, there have been almost 40 papers, making this a high-impact trial addressing key aspects of decision making for patients with disc herniation. All physicians who take care of patients with lumbar disc herniation should be familiar with the many papers that have resulted from the SPORT trial. This trial also examined the efficacy of surgery for spondylolisthesis and lumbar spinal stenosis. Future articles will address those issues. As for the approach to herniated lumbar disc treatment, what have we learned?

The first and most important finding from the SPORT trial is that surgery is superior to nonoperative therapy for patients with lumbar disc herniation who had persistent symptoms despite six weeks of nonoperative therapy. At four years of follow-up, surgery demonstrated significantly greater improvement in all the primary and secondary outcomes. At four years, surgical discectomy resulted in costs per quality of life adjusted years (QALY) of $20,600, making it an extremely cost-effective procedure.

But does this tell the whole story? If so, why the persistent variation in discectomy rates? As usual, the devil is in the details. First, the return to work (RTW) rates were not different between the surgery and nonoperative groups. Therefore, even though surgery resulted in greater improvements in patient satisfaction and pain relief, it did not translate into increased RTW rates. Second, the posthoc analysis showed that although all groups benefited from surgery, improvements in patients with obesity and diabetes were much less. Workers’ compensation patients benefited initially from surgery, but the beneficial effects of surgery dwindled over time, and at two years there was no difference between workers’ comp patients who underwent surgery versus nonoperative care. Outcomes were significantly better in patients with symptoms of less than six months duration and in patients with higher educational levels. Therefore, while surgery was superior to nonoperative care, individual results varied depending on patients’ characteristics.

The SPORT trial generated controversy among surgeons based on the way the results were initially reported and on how the analysis was done. Initially, based on an intention to treat analysis, the investigators reported that surgery was not superior to nonoperative treatment in this patient population. These headlines made the various media outlets. However, the intention to treat analysis was flawed, necessitating revisions in subsequent publications about trial results. The study had an extraordinarily low adherence to protocol rates. Forty-two percent of patients randomized to surgery did not undergo surgery, and 45 percent assigned to nonoperative care underwent surgery – making the intention to treat analysis implausible. Intention to treat analysis is based on initial randomization, regardless of whether patients received their assigned treatments. It is the recommended analytic methodology for clinical trials. If, however, there are high crossover rates, the effect of randomization is lost. This would tend to bias results toward the null hypothesis, i.e. no difference between groups. The investigators resolved this by combining the randomized and observational arms of the study and performing an as-treated analysis, therefore effectively converting the study from a randomized trial to an observational trial. When the as-treated analysis was performed, the investigators found that the intention to treat analysis significantly underestimated the benefits of surgery. Patients who underwent surgery had significantly greater improvements in outcomes, and this was the main message reported in their subsequent publications. It is important to note that the loss of randomization effect means that the results of the as-treated analysis are subject to selection bias or differences between groups. Analysis of the cohorts showed that although there were differences between groups, the surgery group had more characteristics that are generally associated with poorer outcomes, once again biasing toward the null effect – so that the actual benefit of surgery was potentially greater.

Why is this an important study despite these flaws? This represents the best study to date, and NIH would

(continued on page 29)
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probably not fund another $15 million study of this scope. It also provided important data on surgical complication rates, variations between centers, reoperation rates and long-term nonoperative care outcomes. It also established the durability of surgical results and allowed assessment of the cost-effectiveness of surgery. The overall complication rate (5 percent) was low, showing surgery was safe. The most common complication was dural tear (4 percent), but this had no effect on long-term outcomes. Reported reoperation rate was 6 percent by one year, 8 percent at two years, 9 percent at three years and 10 percent at four years postsurgery. Fifty percent of reoperations were for recurrent herniations at the same level.

With regard to variations among treatment centers, the SPORT trial showed there were no long-term differences in patient-reported outcomes between centers. Unadjusted analysis showed there were, however, significant differences in reoperation rates. Reoperation rates ranged from 2 percent to 12 percent for Year 1, 4 percent to 16 percent for Year 2, 2 percent to 17 percent for Year 3 and 4 percent to 21 percent for Year 4. In addition, there were some differences in short-term complication rates such as dural tears (0-4 percent) and postoperative wound infection (0-10 percent).

What Does This All Mean for Clinical Practice?
Determining the best treatment for disc herniation and predicting outcomes is not as simple as it seems. We now know that patients who respond well to nonoperative care may continue to improve and do not risk permanent damage to the nerve or eventual surgery. Next, in patients who fail nonoperative therapy, surgery is safe, beneficial and durable, and cost-effective. The data suggest reoperation rates and short-term complication rates vary by center; however, this needs to be confirmed in risk-adjusted analyses in a larger sample size. The presence of obesity, diabetes and workers’ comp conditions may adversely influence individual patient outcomes, and patients should be counseled accordingly. The fact that long-term outcomes are similar suggests that the method of surgical decompression or amount of bony removal do not influence eventual outcomes. Even though discectomy does not appear to influence return to work rates, improvements in patient quality of life and reductions in pain symptomatology are desirable outcomes. Therefore, patients with disc herniation who have failed six to 12 weeks of nonoperative care should be referred for surgical consultation. In patients who underwent surgery, greater durations of symptoms (> six months) were associated with poorer outcomes.

References

Note: Dr. Boakye is chief of spinal neurosurgery and director of the neurosurgery outcome and translational research lab at the University of Louisville School of Medicine, Department of Neurosurgery. He practices with UofL Physicians-Center for Advanced Neurosurgery.
GLMS would like to welcome and congratulate the following physicians who have been elected by Judicial Council as provisional members. During the next 30 days, GLMS members have the right to submit written comments pertinent to these new members. All comments received will be forwarded to Judicial Council for review. Provisional membership shall last for a period of two years or until the member’s first hospital reappointment. Provisional members shall become full members upon completion of this time period and favorable review by Judicial Council.

**Candidates Elected to Provisional Active Membership**

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<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Caldecott-Johnson, Susan (31419)</td>
<td>William Caldecott-Johnson</td>
<td>220 Abraham Flexner Way Ste 1500 40202 502-584-3377</td>
<td>Pediatrics 96,06 Neurodevelopmental Disabilities 04 U of Cincinnati 89</td>
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<tr>
<td>Johnson Schulz, Brittany Lea (18043)</td>
<td>Paul Schulz</td>
<td>UL Radiology 530 S Jackson St Rm C07 40202 502-859-5875</td>
<td>Radiology 10 U of Louisville 05</td>
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<tr>
<td>Swint, Susan Lorch (31457)</td>
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ETHICAL DILEMMAS IN MODERN MEDICINE

We are pleased to present “Ethical Dilemmas in Modern Medicine,” a joint effort of the GLMS Bioethics Committee and Emerging Medical Concepts Committee. In this space, the committees highlight an ethical question faced by physicians and provide their best answer for guidance.

QUESTION
I am an employed primary care physician with a large hospital network. I have a patient who needs a needle biopsy of a suspicious lesion identified on MRI. The nurse case manager in my office wants to schedule the procedure with the hospital-based interventional radiologist. However, the radiologist is new to the system and has just recently completed training. For many years, I have referred my patients to another interventional radiologist who has recently joined another hospital system. I have great confidence in his abilities and, if I or a family member needed the procedure, I would want him to do it. My employer tracks my referral patterns, and my compliance is considered in both my bonus compensation and contract renewal. What is the right thing to do?

ANSWER
RUTH SIMONS, MD
Bioethics Committee, former chair

In ethics, as in life, things are rarely black and white. The physician (you) is a fiduciary* in the physician-patient relationship, with a duty to provide the best care for your patient. In this instance, it would include taking a good history, doing a complete physical exam, ordering appropriate tests and making appropriate referrals for further care.

Your dilemma lies at this last step. Should you refer to the physician you know and trust, bonus be damned, or should you refer to the one within the hospital system? What considerations are germane here?

1. The patient requires a competent practitioner to do the biopsy. What is known of the new physician? First, he is newly graduated and may therefore be relatively inexperienced. On the other hand, he may well be an extremely talented practitioner from a top training center, up to date on the latest, best techniques. The other interventional radiologist may be skilled, experienced and reliable to give accurate, timely results. Or he may be your friend, possibly a golf buddy? Do you have enough information here to judge which physician will best serve your patient? How could you (or your nurse case manager) find out how good the new physician is?

2. How demanding is the procedure that is required? Is this a straightforward case, or is it challenging? Does either the new kid on the block or the established practitioner have special skills that are important for this particular case?

3. Are there other considerations that may be important to the patient? For instance, is there a difference in insurance reimbursement for an in-house practitioner versus an out-of-system one? How much will the patient be out of pocket in either case? The best practitioner in the world cannot help the patient who cannot afford him.

There are also some other duties the physician has. One is to his employer who, after all, pays his paycheck, but additionally is striving to maintain a sustainable health care system to the benefit of you, your nurse case manager, the other hospital employees and, last but not least, the patient who appreciates having a physician and hospital available to address his health care needs.

This can be the tricky part. How much independence does the physician have to exercise clinical judgment, especially if he is an employee with a contract? The answer, I think, is that he should be able to exercise full clinical judgment and ideally not have to fear reprisal. (I may be naïve about the latter part.) But this is where the physician has expertise that health care executives do not. Unfortunately, this is NOT the same thing as doing whatever you want. Put another way, it does not mean that you reap the benefits of employee status without the responsibilities (or legal requirements) of said agreement. It means you may have to work hard(er) to satisfy yourself that good care is provided and know when to buck the constraints of your institution.

4. For this reason, it would behoove you to refer within the system as much as possible to support the system that supports you. Undoubtedly, the majority of your patients are from in-house referrals.

Here is the lowdown:

A. Make an effort to reassure yourself of the competence of the new physician and develop a relationship with him. If this is a large hospital system, you may have more than one practitioner available to refer to – find out who is the best and refer accordingly.

B. If there is a particular situation where you feel the other interventional radiologist has special skills that warrant this referral, then you should make that referral, document why and make sure the powers-that-be know why in this instance the referral is appropriate.

C. You should NEVER make your referrals on the basis of your annual bonus concerns (the meaning of fiduciary comes in here).

D. If you have concerns about the competence of the new employee, you should make them known to the hospital system, so that appropriate steps can be taken.

E. If you have concerns about the ethics/standards/employment practices of the hospital system that you work for, you should take further steps – depending on the circumstances, you might consult your lawyer, notify the state medical society, etc. Of course, you should always have your lawyer help you when you are negotiating your contract so you have no unpleasant surprises later.

F. If you feel that your hospital system has a commitment to the bottom line at the expense of quality patient care, then you should leave rather than lend your good name to a shoddy enterprise.

*Merriam-Webster definition of “fiduciary.” In law, a person in a position of authority whom the law obligates to act solely on behalf of the person he or she represents and in good faith. Examples of fiduciaries are agents, executors, trustees, guardians, and officers of corporations. Unlike people in ordinary business relationships, fiduciaries may not seek personal benefit from their transactions with those they represent.

Note: Dr. Simons is medical director for Hosparus. To submit an “ethical dilemma” to GLMS for a future column, email physician.education@glms.org.

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If we can invent an atom-smasher, how come we can't invent a paper-smasher?

Things that waste doctors’ and nurses’ time cut access to patient care. While I cannot begin to list these evils, I can testify that trying not to hold grudges against them uses as much of my psychic energy as it saves. Some are annoyances; some rank high on the major teeth-grinding index; others can actually hurt patients.

Dr. Amy Funkenstein, writing in the *Annals of Emergency Med* of April 22, cites the one million hours of psychiatrists’ time – per year – wasted by commercial insurers’ insistence on preauthorization of “now” admissions for people with clear suicidal or homicidal thoughts and intent. During her Psych residency at Harvard and working with 10 other residents via the Cambridge Health Alliance, she led a three-month study of how long it takes to get permission to admit such people to a safe unit. Only in Psychiatry is such emergent admission also the province of the payor. In all other specialties, we may admit people emergently either “fully” as inpatients or as “observation” status (higher out-of-pocket cost to patient) based solely on our medical judgment (I always wonder if they are paid on the rate of denials, but doubt I could actually find that out). The average doctor-time required in the ER in her study of 53 patients was 38 minutes. Extrapolate that to the 1.6 million urgent Psych admissions per year, and that’s a million hours of doctor-time. That is one million hours not spent on evaluating and treating patients, not spent on coordination of care with nurses and counselors, not spent in group therapy, or research, or continuing education. That is one million hours of phone incarceration.

And, after all that, only one of the 53 patients was denied admission. The other 52 spent hours and hours in the ER awaiting permission to go upstairs, with a median time of 8.5 hours, the shortest wait being three hours, and the longest wait 20. (Dr. Funkenstein herself once cared for a very sick adolescent for three days in the ER, since no permission could be obtained over a long weekend.) That also represents 13.6 million patient-hours of waiting, and waiting, and waiting, and all the while trying to hold onto life and not death. That represents untold numbers of ER staff hours, wherein the incredibly overtaxed ER personnel must somehow keep safe the actively suicidal, while simultaneously resuscitating the near-dead and triaging the living. None of that makes sense, unless you consider the big-money companies’ profit and loss statements, which truly govern health care in this country.

The study’s senior author, Harvard attending Dr. J. Wesley Boyd, said, “Private insurers are obstructing care by requiring preauthorization before a qualified psychiatrist can admit a dangerously ill patient. Placing profits ahead of health in this situation.

 Medicare, whose mission is to serve U.S. citizens, has no such requirement for preauthorization. Medicare apparently respects doctors and their senior patients more than its bottom line, at least in this situation.

Medicare-associated pharmacy benefit managers are however recalcitrant to the max. Generally, I can convince commercial insurers to pay – finally – for some fancy non-formulary medicine when I can show them that the patient has dutifully tried Drugs A, B, C, D, E and F. Not so for the 90-day mail-aways of the world: their PA forms require double the effort. First you fill out the Request one, then you have to fill out the Real one, and then, brazenly and against all reason, the dirty rats require the patient to try a drug they cannot tolerate AGAIN, “because 90 days have now elapsed” since the last try. This is sheer harassment, akin to making doctors detail, on a quarterly basis, just how and why their hemiplegic or quadriplegic or severely neurologically impaired patients remain disabled. Why, if their arms were paralyzed before, do they and we have to submit yet another form that asks way too many questions, including one asking if they can lift 0-10 pounds repeatedly/frequently/occasionally/or not at all? I have taken to writing in permanent black Magic Marker “Remains Paralyzed since 1982. No Miracle Has Occurred.” So far it has worked.

Now we have the Patient-Centered Home to contend with. Providing one is simply being a traditional internist or family doctor, in my book, something my practice has done since its inception in the 1930s. But now we have new documentation, new boxes to fill in via EMR, new explanations to give to bewildered patients who ask worriedly, “Are you moving?” “Does this mean I have to pay a fee just to be your patient?” and my favorite, “What if I change my address?” (That reminds me of Yogi Berra, and so I answer them, “Nobody goes there anymore, it’s too crowded.”)

Yogi also said, “It gets late out there early.” I hope it is not too late, one day, for someone too distressed to wait hours in the ER. This country has been staggered recently by both terrorists and mass murderers, at least two of whom were insane. Until mental health care matters enough to the people who sit in expensive boardrooms, there will be millions more tears shed, and it will get very late, very early, for far too many.

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.
THE WHITE RABBIT

DAVID SELIGSON, MD

The patient looked well. She was wearing a short-sleeved dress that showed off her arms. "Well you are really doing fine now, aren't you?" Actually, she had gone back to work as a doctor several days ago, and her progress had been reported to me by a mutual patient. "What was that nail made of?" she asked. "Titanium. But why do you want to know?" "Well that must have been some kind of special titanium," she replied. "It cost $27,000." She moved her arm around a bit to show how well it worked, but not so well as to belie her request for additional pain medication. (We even KASPER colleagues today, and her record was clean, so she got a modest refill.) Now I tried to explain that the nail really didn't cost that much. Its actual price to the hospital was around $2,700 but it had been marked up, as was explained to me by a helpful hospital administrator, to the price of a small BMW, because some insurance paid the hospital a percentage of the charge. At any rate, her out-of-pocket cost would be fixed by the amount her carrier paid the hospital, and so she would pay a percentage of that sum, which would amount to a few hundred dollars. She rolled her eyes.

Why does the logic of this explanation still escape me? Does McDonald's charge $45 for a Big Mac and expect to receive $4.50 at the cash register? The economics of health care, for which we as physicians are all tasked to attempt cost savings, has been increasingly obscured by this chaotic arithmetic. "It's arithmetic," as Bill Clinton said in his Democratic convention speech. But is it really?

When I was younger, we used to summer in Onset, Massachusetts. Onset is just on the Boston side of the Cape, north of the Cape Cod Canal. The canal begins at an inlet picturesquely called "Buzzard's Bay." This was where I learned to swim when I was 4. After a weekend of breath-holding underwater, blueberry picking with my grandmother and generally trying to catch skin cancer and/or poison ivy, we headed back home, but not before stopping at the White Rabbit Tea Room. Lunch was a great treat because the White Rabbit Tea Room, unlike our cottage on Onset Bay, had comprehensive electricity with a real refrigerator and not just an ice chest, so there was blueberry pie and ice cream for dessert. Inevitably, at the end of the meal, my dad reviewed the bill. In those days, bills were handwritten by the waitress and manually summed and taxed. There were no machines, no computer tickets and no credit cards. Dad never just took a bill and paid it. He would note each item, the price and re-compute the sum. Nearly always he found a discrepancy. It was part of the ritual of lunch with my parents to bring back the server and get the bill corrected. Curiously, I cannot ever remember being undercharged.

I recently obtained itemized hospital bills for patients undergoing screw removal from the ankle syndesmosis. In this procedure, the patient comes to the hospital the day of surgery, is prepared in a preoperative area, is given a general gas anesthetic, has removal of a bone screw, recovers in a postoperative area and goes home the same day. The typical charge for this service is $10,000. Interestingly on the printout, "direct costs" are listed around $1,200 and "total charges" at $3,000. I am not an economist and do not hold any degree like an MBA, but perhaps I am being told that the hospital is paying $1,200 to its suppliers for things like medications, needles and the like, and then applies a multiplier to some of these charges to get the "total charge." Things like the laundry bill and the telephone operator would be considered "indirect charges." More alarming than the not-obvious relationship between the direct and the total charges are the charges for services totally unrelated to the procedure that was performed on the patient. For example, a patient having a screw removed from the ankle has a cost charge on the breakdown for both inpatient psychiatry and high-risk obstetric services. To meet the expenses of its total operation, the hospital spreads out direct and indirect costs of its services to possible areas of positive cash flow. Since I do not have, as explained, an MBA, my source for definitions is "accounting coach" via Google. Here I could confirm that the actual items paid for in the performance of a procedure, like screw removal from the ankle, are indeed the "direct charges" that would include, for example, the made-in-the-P.R.-of-China OR gloves, the drapes and the anesthesia gases.

It is instructive to consider the recent complaint from a colleague that he was charged more than $1,000 for a chest X-ray. So I had my manager call a community health outlet, explain that she had fallen against a coffee table and hurt her chest and ask what it would cost out of pocket to have chest X-rays taken. They replied that the service would cost between $60-75 depending on how many films were taken. Now my colleague with the big bill for a chest X-ray had insurance. His insurer, for reasons not clear to me, allowed $600 for the X-ray. So the insurer paid the hospital about $100. The patient paid the difference to the hospital, $500 plus $60 more since he also had to pay a "co-pay." In this example, the hospital justifies the $1,000 fee with the knowledge that the insurer and patient can at times be made to pay more than the value of the service. The co-pay is rationalized as a tool to reduce "overutilization" of services. Markups vary depending on the item. The multiplier can be 2 or, in the examples of the intramedullary nail and the chest X-ray, 10. Comparison shopping in this environment is virtually impossible. It is further hard to make any sense out of being a cost-conscious provider. Since a prescribing doctor never gets the full picture of cost, charges and the markup, it is hard to be responsive to the request of administrators to choose "low-cost" options. It is not always the best value to pay the lowest price. Sometimes sophisticated tools result in improved throughput. If one buys a cheap shoe cover, maybe more would be discarded than if better ones had been used.

A recent "special report," "Why Medical Bills Are Killing Us" by Steven Brill, appeared in TIME magazine on March 4, 2013. Reading this report will anger you. The report is a much more detailed version of what I have been talking about. We cannot really "partner" with the high-paid administrators who are eating us alive. Does a legislative solution exist? Probably not! Attempts to legislate to control overhead may only result in higher fees, as health systems managers try to keep their returns high.

In a recent investigation published online, Rosenthal, Lu and Cram attempted to obtain
pricing for total hip replacement from two hospitals in each state and the District of Columbia as well as the prices for 20 "top-ranked" orthopedic hospitals. A standard scenario of an uninsured 62-year-old grandmother paying “out of pocket” for her hip replacement was used to gather the data. Not only did the investigators find it difficult to obtain pricing from most of the hospitals, but there was a wide variation in the price estimate, from $11,100 to $125,800. Looking at the data, there appears to be no relationship between hospital ranking as a perceived measure of quality and the estimated bill. Further, the $100,000 spread in possible charges is greater than the usual large payor and Medicare reimbursement, which is in the range of $10,000 to $25,000. The investigators concluded, "Many health care providers are not able to provide reasonable price quotes." Most restaurants, like the White Rabbit Tea Room, offer a menu with a price. True, certain specialty items like the "catch of the day" might be listed with "market price" on the menu, but most of us who eat out make choices based not only on our appetites but also on the estimated bill. My dad always guided us to the modest side of the menu — it would have been unthinkable to order the sirloin when chopped steak would do. On the consumer side, patients are not encouraged to comparison shop for medical care, but to allow the insurer and the health care administrators to work out the details of the bill and the actual charges to the patient. In this process, the hospital issues a bill to the patient with truly mind-boggling charges in the hundreds of thousands of dollars. The insurer then informs the patient that insurance has covered all but a few hundred dollars of the bill as a consequence of the annual deductible and co-pay. The patient is grateful that he/she did not have to bear the full bloodsucking charge for the medical intervention.

It is necessary to point out that the charge for a service is not the same as its cost, and as has just been explained, the charge and cost to the patient are not at all the same, or may not bear a systematic relationship one to the other. There are some parallels in other industries. We have come to accept in air travel, for example, that the same service may be sold at different prices depending on when or how the ticket was purchased, and on who actually bought the ticket. The fundamental difference in medicine is that the creation of the charge does not bear a systematic relationship to the service that was provided. This is a new economics — werewolf economics — and is unique and quite unlike anything else in our capitalism.

I received a letter on good paper with expensive embossed letterhead. The lawyer explained that his patient had been grievously injured and was trying to "put his life back together." The patient was well-satisfied with my treatment. In consideration of his hospital bills in excess of $130,000, would I not consider "writing off" my fee? I had several thoughts. First, this was better than a lawsuit. The second idea was that perhaps my malpractice carrier would also write off part of what I was paying annually to stay in practice (this seemed unlikely). So I called the lawyer on the phone and engaged him in a conversation about the value of services. We both, after all, had completed professional school after college and we both, after all, had expenses to maintain our offices and stay licensed to practice. Figuring that the value of services billed by the hospital, even allowing a reasonable profit, was about $60,000-70,000, I suggested that I would be willing to write down my fee proportional to the lawyer's willingness to write down his fee. I did get a modest check for my work on the patient, but I didn't ask if the lawyer had actually reduced his fee.

What can be done? The attitude that bills in any amount can be rendered because insurance will pay what it wants is an intolerable attitude. Insurance reimbursement may not be logical either. Consider the $600-plus allowance for a simple chest X-ray. Bills must have some understandable relationship to the service that was provided. In many instances, patients are terrorized by their unexpected and unpleasant need for health care.

We think less logically when taken somewhere with chest pain, or with hemorrhage, or with a broken bone. Prospective shopping for reasonable rates is unrealistic. Nor do we need an overregulated system. Whenever government attempts rules or fee schedules, we have unexpected, and irrational, consequences. My hospital administrator's aged mother-in-law broke her wrist. I made a special effort to see her in the emergency department, do a reduction and plating in surgery and get her home the next day. Some arcane rule requires a three-day hospitalization for reimbursement. The administrator lost the value of a pair of business class plane tickets to London, since he had to pay the whole bill out of pocket.

We need first a basic state law like the old Massachusetts fundamental speed law — charges for services have to be "reasonable and proper." In Massachusetts, they do not have a maximum speed limit — only the admonition that, "No person operating a motor vehicle on any way shall run it at a rate of speed greater than is reasonable and proper, having regard to traffic and the use of the way and the safety of the public." Most folks understand that $27,000 for an intramedullary nail is not reasonable. Secondly, we have to be better consumers. Patients should be entitled to an accounting of what they were charged for by a set time after the completion of the service — say, 60 days. We need more than a total bill; my dad always asked for an itemized breakdown at the White Rabbit. Finally, there ought to be a simple non-confrontational pathway to dispute unreasonable charges, like the commission similar to the mechanism for disputing credit card charges. Nationally, health care policy is being set based on economic calculations derived from accounting practices that are not grounded in the concept of value for service. We need to bring an end to this era of werewolf economics as quickly as possible.

Note: Dr. Seligson is professor and vice chair of the University of Louisville School of Medicine, Department of Orthopaedic Surgery. He practices with UofL Physicians-Orthopedics.

‘A TRILLION HERE, A TRILLION THERE…’

GORDON R. TOBIN, MD

Compliments to Dr. Mary Barry for her excellent summary (“Not Just March Madness,” April 2013) of Steven Brill’s “A Bitter Pill,” the TIME magazine exposé of stunning hospital and pharmaceutical overcharges. Mr. Brill’s article should be required reading for every physician and every potential patient (i.e. everyone), and it should be paired with viewing “Escape Fire,” the March CNN special on health care system dysfunction.

I have one correction. The LM editorial states, “in order to get the Affordable Care Act passed, Medicare was forbidden to negotiate the prices of drugs…” In fact, prohibition of Medicare negotiating prices with drug manufacturers was enacted seven years earlier in the 2003 Prescription Drug, Improvement and Medicare Modernization Act. Moreover, the ’03 MMA not only mandated that Medicare accept manufacturers’ list prices, but it provided no revenue support or spending cut offsets from other programs to pay for this new drug entitlement (Part D). Therefore, physicians writing Part D prescriptions add an estimated $724 billion each 10 years to the Medicare debt our children must face. This will continue indefinitely, unless repealed or funded. This fiscal outrage was intentional and resulted directly from campaign contributions and lobbying of pharmaceutical companies.
during the ’03 MMA passage effort.

Brill’s exposé illustrates how elimination of market checks and balances in the hospital and pharmaceutical sectors has crippled cost control. Simultaneously, the American Medical Association has documented how mergers and acquisitions have eliminated competition among private health insurers, creating insurance monopolies in most metropolitan markets (AMA’s “Competition in Health Insurance,” 2007, annually updated). Simultaneously, the percent of premium paid to providers fell from about 95 percent to under 80 percent. The combination of increased hospital revenues and plummeting practice revenues has facilitated hospital purchases of once-independent physician practices, which further weakens checks and balances in the medical marketplace.

These problems have no easy solutions. Brill notes that a single-payer system would eliminate chargemaster abuses. However, “Medicare for All” advocates overlook significant unsolved weaknesses of Medicare that would afflict any expansion. Medicare costs also suffer from enormous overcharges for drugs and devices, which are not chargemaster-derived, but generated by campaign contributions and lobbying of Medicare’s governing body, Congress. The ’03 MMA was a perfect example of this abuse. No solution to this unchecked corporate influence on single-payer system governance has been defined.

A second problem with Medicare is premium/benefit imbalance. The average couple pays only one-third in lifetime premiums (approximately $115,000) for lifetime benefits received (approximately $350,000). All efforts to achieve balance by any sensible combination of increased premiums or reduced benefits have been totally gridlocked, without foreseeable resolution. Again, large Medicare debt is passed to our children.

Ultimately, physicians may be the only hope of health care cost control, as therapies require our orders. We must demand transparency and become much better informed of costs, as Brill advocates. We must engage our patients in understanding cost consequences and cost-efficiency. Also, we must call out overutilization schemes in private and public arenas and press for premium/benefit balance in Medicare, including allowing drug price bargaining and obtaining funding for Part D.

Economic analysts estimate that one-third of our nearly $3 trillion annual health care costs are wasted by inefficiencies, overutilization and overcharges, such as those cited above and those identified by Mr. Brill. If he were here to describe annual health care waste, the late Sen. Everett Dirksen would have to inflate his famous wisecrack to, “A trillion here, a trillion there, and pretty soon it adds up to real money.” There is nothing wise in our trillion dollar annual waste, as it adds up to vast debt and appalling sacrifices in real unmet needs.

Note: Dr. Tobin is a professor at the University of Louisville School of Medicine, Department of Surgery, Division of Plastic and Reconstructive Surgery. He practices with UofL Physicians-Plastic & Reconstructive Surgery.

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LETTER TO THE EDITOR

DEBORAH ANN BALLARD, MD, MPH

I n response to my article on “How Integrative Medicine Can Improve Patient Outcomes and Advance the Accountable Care Organization Model,” Dr. Philip Browne states that I “espouse the current trend toward including unproven techniques in standard medical practice” and that “acupuncture and healing touch date back to the pre-scientific era and rely on improbable concepts for acceptance ... they are examples of placebo medicine” (“Letter to the Editor,” April 2013).

I do not espouse the use of any therapy that is not evidence-based – quite the contrary. I clearly state that integrative techniques should be subjected to the same scrutiny as standard therapies. Although there is a growing body of evidence about which therapies work and which do not, there is a definite need for ongoing research, and that research is being conducted by some of the most prestigious medical centers in the United States, the Consortium of Academic Medical Centers for Integrative Medicine.

Placebo medicine is a pejorative term used to describe mind-body medicine. The fact is that mind-body therapies work very well for certain conditions in receptive individuals. Why should they not be offered? Rather than being unscientific, they are actually based on quantum physics and an ever-expanding understanding of how energy and matter are just different forms of the same entity. Remember E=mc^2 from Physics 101?

Above everything else, I am a pragmatist and a public health advocate. I want to see public health improve and health care costs go down. I want to empower my patients with sustainable, accessible, inexpensive, effective and safe therapies and practices that make them healthy. It matters not to me whether these therapies come from an ancient healing tradition or modern Western medicine. I believe in using all therapies that alleviate suffering, elevate the dignity of each person, are cost-effective and advance the health and wellness of the most people. I believe continued research in integrative medicine will offer an expanded array of such therapies.

I just returned from the American College of Physicians annual meeting in San Francisco.

In the Update in Rheumatology by Atul A. Deodhar, MD, MRCP, Tai Chi was ranked as effective as NSAIDS and acetaminophen.

Kevin Barrow, MD, of the Osher Center for Integrative Medicine, also provided an excellent review, “Complementary Medicine: What works, what doesn’t?” Takeaways: Current evidence shows that acupuncture provides effective treatment for postoperative pain, nausea and vomiting, and osteoarthritis. Tai Chi improves CHF, CHD, Parkinson’s disease and fibromyalgia. Yoga improves mental health and low back pain.

Integrative therapies do not appeal to all patients, but they do offer alternatives that are just as effective as conventional therapies for many chronic illnesses, pain and psychiatric disorders. In order to best serve patients, physicians need to know the evidence for the appropriate use of integrative therapies and include them in the treatment options.

Note: Dr. Ballard is with Holiwell Health Consultation.
The American College of Physicians and the Federation of State Medical Boards have gotten together and published a position paper on how doctors should behave on the “new frontier” of the Internet (http://annals.org/article.aspx?articleid=1675927). At 14 pages and nearly 6,000 words, this is one heck of a hefty instruction manual. The authors (http://annals.org/article.aspx?articleid=1675927) have tried for accuracy. The voice of caregivers has never been more vital. I believe the greatest problem with medicine right now is not the lack of available treatments, but rather, a lack of patient education. Patients cannot truly share in decision-making unless they have “the real story.” Both patients and doctors are starved for candid unfiltered information. Social media does real, real well.

1. Do not fear social media. It’s an amazing tool for advancing the greater good. The voice of caregivers has never been more vital. I believe the greatest problem with medicine right now is not the lack of available treatments, but rather, a lack of patient education. Patients cannot truly share in decision-making unless they have “the real story.” Both patients and doctors are starved for candid unfiltered information. Social media does real, real well.

2. Never post anything when angry. Never is a big word but it fits well here. Nothing further needs to be said. Just don’t do it. A corollary: Do not post while neurologically impaired: I’ve said some really dumb things in the haze that encompasses one right after a bike race. (Insert another grin.)

3. Strive for accuracy. People will read what you post. I’ve written many times that blog posts are not journal articles, but that doesn’t mean you should get lazy with words. Here is the problem: You think electrophysiology is complicated. See what happens when you try being absolutely precise with the English language.

4. When in doubt, pause. Sleep on it. Re-read. Remember the permanency of digital media. You are a doctor, not a journalist. You have time.

5. Don’t post anything that can identify a patient. Changing details of the case is not enough. It’s especially important not to post in real-time. Avoid terms like, “this morning,” or “today.” It’s one thing to tell a story about a patient you saw two months ago; it’s yet another to talk about the patients you saw today. Don’t underestimate privacy.

6. Ask permission. If you want to write about a specific case, get permission from the patient.

7. Be respectful. Don’t say anything online that you wouldn’t say in person. If you are critical of someone, pretend that you are going to run into him or her at a meeting next week. Put yourself in their shoes. Try to understand their position. You think they are conflicted; what about your conflicts? My wife once told me that all unsolicited advice is self-serving. (Hoosiers are just so sensible.)

8. Assume beneficence. I’ve been in health care for two decades and can testify that truly bad people are a rarity. Most of us aim to do what is right. Some say doctors are too protective of each other; but the thing about medicine is that it’s much easier to practice with a time machine. Social media tempts one to toss stones. Resist that urge.

9. Be careful “friending” patients online. I say careful because I don’t like rules. Clearly, some patients can also be friends. The lines here are blurry. My attempt at a solution is to have a DrJohnM Facebook page and a regular John page. I try to steer patients to the professional page. I am also a bit old-fashioned with Facebook. I try to avoid posting compromising stuff – even though it would be fantasy to think doctors are any less human than non-doctors.

10. Educate yourself and ask questions. One of the best references for caregivers interested in learning more about social media is Kevin Pho’s new book: Establishing, Managing, and Protecting Your Online Reputation: A Social Media Guide for Physicians and Medical Practices. Another nifty thing about social media is that many of the experts are approachable. If you email (or direct message) experts like Ves Dimov, Kevin Pho, Wes Fisher, Jay Schloss, Wendy Sue Swanson or Bryan Vartebedian, they are likely to respond with helpful tips. That’s nice. In my limited experience, health care social media is populated with nice people.

The bottom line is always the same: Success comes from mastery of the obvious. Common sense, decency, truth and admitting one’s mistakes will rarely steer you wrong.

Note: Dr. Mandrola practices Cardiac Electrophysiology with Louisville Cardiology Group. This was posted on April 18 at www.drjohnm.org. He also blogs at http://blogs.courier-journal.com/prime/author/jmandrola and http://blogs.theheart.org/trials-and-fibrillations-with-dr-john-mandrola.
ALLERGY DROPS: A NEW STUDY PROMOTES DROPS AS MODERATELY EFFECTIVE

DEREK DAMIN, MD

My Twitter feed and news subscriptions are all buzzing about the latest publication on sublingual immunotherapy, an alternative to conventional allergy shots. The Journal of the American Medical Association published a review in its March 27 issue titled “Sublingual Immunotherapy for the Treatment of Allergic Rhinoconjunctivitis and Asthma.” This publication looks at the effectiveness of sublingual drops for nasal allergies and asthma.

What is Immunotherapy?

When it comes to immunotherapy and allergies we classify the way it is administered into two categories: 1. subcutaneous (shots) and 2. sublingual (drops under the tongue). The idea is that exposures through the nose, lungs and eyes are generally the cause of allergies. Exposing the body through the gut (drops) or directly into the body (shots) are routes that tend to promote tolerance.

Specifics

Sixty-three studies were examined; almost all of the studies took place in Europe. The article indicates in eight of 13 studies, 40 percent showed improvement in asthma symptoms versus its comparator (which included placebo, medications and other sublingual treatments) and nine of 36 rhinitis studies showed a greater than 40 percent improvement versus its comparator. Medication use was reduced by 40 percent in 16 of 41 studies.

Remaining Questions

There is a tremendous amount of interest in allergy drops, and for good reason. But there are a few unanswered questions board-certified allergists should consider before adopting widespread use.

1. When will allergens be made specifically for sublingual use in the United States? In the United States, there is not an FDA-approved formulation for sublingual use. If providers are using allergens for sublingual use, there is a good chance they are using allergens manufactured for injection purposes "off-label.”

2. What is the optimum dosing schedule and strength? There is a broad range of strengths and dosing schedules in the European articles published: from once a week to several times a day. Doctors using drops in the U.S. are using their best estimate as to what would be an effective dose.

3. What is the duration of therapy? Should it be continuous or could it be administered before a season or exposure? We know allergy shots should be continued for three to five years to achieve a prolonged, if not lifelong, benefit. The best duration for sublingual therapy is yet to be determined. Studies range from several years to using just prior to a particular season. Again, in the United States, until more studies define the best duration, it’s a doctor’s best guess at duration of therapy.

4. Can multiple allergens be mixed in one vial? It is common in the United States to use multiple allergens in someone’s allergy shots. Dr. Harold Nelson, often revered as the ultimate source of knowledge when it comes to immunotherapy in the United States, points out in his editorial of the article that only one of the double-blind, placebo-controlled trials used more than one allergen at a time.

5. How does it compare to conventional allergy shots? That question remains unanswered. Data does not exist directly comparing long-term outcomes for each treatment. I think most board-certified allergists would assert that conventional shots are currently more effective, based on what we know, for most people with longer durations of benefit. But this could change as research in the United States grows.

Advantages and Disadvantages

The most attractive features of sublingual therapy will likely be safety (reduced anaphylaxis risk compared to shots) and convenience. Who wants to make several trips to the doctor over several years if sublingual therapy is shown to be as effective?

The disadvantages are a lack of answers to the questions above and the cost. It is generally not covered by insurance since there is no FDA-approved formulation in the United States. Oral irritation appears to be a common side effect. Access can also be an issue. Given the unanswered questions, many board-certified allergists are not yet prescribing. Look for that to change as more studies are published.

Conclusion

The point of my article is to promote what is still unknown about sublingual immunotherapy. Ask a lot of questions. Take into account your specific situation and needs, weighing the benefit and risks of all available therapies. Be an informed patient before pulling out your wallet to pay for out-of-pocket therapy that still does not have an FDA-approved formulation in the United States.

Note: Dr. Damin practices Allergy and Immunology in Louisville. He blogs at http://drdamin.wordpress.com. This was posted on March 29. Dr. Damin will open Allergy Partners of Louisville in January 2014. To learn more or contact him, visit www.facebook.com/drDamin.

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