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President, Bruce Scott, MD

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WHERE I COME FROM

My first exposure to organized medicine was in 1987 when I attended a meeting of the Texas Medical Association (TMA) as a representative from my medical school. During the meeting, delegates discussed their frustration with the fact that the Texas Supreme Court had, once again, shot down (that's Texas talk) the Professional Liability Reform legislation they had worked so hard to pass. They concluded there was only one thing to do – replace the Supreme Court . . . They were serious! Over the next two election cycles, I witnessed Texas Supreme Court incumbents fall as new justices, more favorable towards liability reform, were elected. Texas has since enjoyed over twenty years of liability reform.

As the country western song says, “This is where I come from,” from an organized medicine perspective, at least; I was actually born and raised in Louisville. In Texas I saw first-hand the influence of a powerful medical association. This is my vision for GLMS.

Shortly after arriving in Louisville, I was greeted by Drs. Ken Peters, Bob Goodin, Bob DeWeese and other leaders with vision. They guided my early path to ensure I stayed involved. More recently, I have been honored to work with David Bybee, Fred Williams, Russ Williams, and Pat Murphy – all great leaders. We at GLMS are blessed that so many have been willing to share their talent. We are also supported by an incredible staff led by Lelan Woodmansee, an amazing talent that we have been fortunate enough to capture and hold onto for all these years.

The TMA achieved its seemingly unreachable goal by engaging members and having them connect with their friends, patients and the business community. The GLMS has similar potential. Our membership percentage among local physicians is unheard of in today’s medical associations. We make up the majority of the KMA and thus send the majority of delegates to the KMA House each year.

The GLMS leadership is engaged. If there is a public health issue, the GLMS is naturally informed and involved as the head of the public health department is a member of our board. There’s an issue at the medical school? Let’s ask the dean; she’s on our board as well. Over the past several years, GLMS officers have served on the boards of local charitable organizations, been involved in forums on issues ranging from the Affordable Care Act to environmental issues, and participated in Leadership Louisville to connect to our business community.

Not sure if involvement is worth your time? The New York Times seems to think it is—NYT reporters have been present at two of our meetings in the past six months. Did you know that several of our resolutions were considered this year by the Kentucky State Legislature? Still not convinced that our delegation to the KMA can make a difference?

As a group, we can. However, we need the entire membership involved to make the presence of physicians felt in Louisville. If the city faces a medical issue, the mayor’s first thought should be to call the GLMS. When local or state elected officials need to vote on a health care issue, they should be concerned with the position of the GLMS because they know we represent the physicians and patients of Louisville. Local business leaders are coming to understand the economic impact of physicians and our practices both directly—by our employee payrolls and indirectly—by the health of our community.

If you are not involved in GLMS you should ask yourself why – why miss this opportunity to shape our future?

How can you become engaged? You can join a committee or a task force (GLMS has over 20, certainly one for every interest). You can write an article for Louisville Medicine. You can support one of our humanitarian efforts through the Foundation or The Healing Place, engage community leaders in our Wear the White Coat program, join our delegation to the KMA to influence state and national policies, support a candidate that will listen to our cause, email or call your representative about a medical issue, mentor students or residents to share your joy for our profession or your specialty, meet with representatives of third party payors to help resolve ongoing issues, or volunteer to provide medical care to the underserved — GLMS offers all of these opportunities. It is simply your choice whether or not you take advantage of them.

Dr. Scott, board certified in Otolaryngology-Head & Neck Surgery, is the president of Kentuckiana Ear, Nose, and Throat, PSC.
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Toni Ganzel, MD, MBA

The University of Louisville School of Medicine has a long, rich history of training future physicians for our Commonwealth. We are very proud of this heritage and duty-bound to maintaining our reputation for producing highly skilled, compassionate physicians.

Many colleagues and members of the public have contacted me with questions about the recent decision on the part of the Liaison Committee on Medical Education (LCME), our accrediting body, to continue our status as a fully accredited medical school with all rights and privileges, but to place us in probationary status. So, I am very pleased to have this opportunity to provide details about why we were placed on probation and what we are doing to address the LCME concerns.

First, let me summarize the primary issues that led to the LCME decision. The LCME action was largely based on two major areas of concern: 1) the adequacy of our preclinical instructional building related to the class size, and 2) the pace of change in our preclinical curriculum. In addition, some changes at both the nuts and bolts and policy levels need to be made in terms of curriculum oversight, and some language in our educational agreements must be addressed.

Regarding the preclinical instructional building, when the LCME conducted its accreditation visit in 2005, we were cited on issues with the gross anatomy lab and the number of seats in the lecture halls relative to class size. These issues were resolved by adding dissection tables and upgraded technology in the gross lab and by adding seats, upgraded technology, and a wireless network in our lecture halls. Then, when we implemented a laptop requirement, we added electrical outlets. Despite these improvements, when the LCME team conducted its April 2013 visit, they concluded the facility was inadequate, specifically the lecture halls, small group classroom space and student study space.

Conceptual plans

Conceptual plans for future renovations.

Some spaces have already been updated to include upgraded technology and study spaces.

for a new $60M instructional building were also created five years ago, but the economic situation and state budget challenges prevented moving forward with funding approval. Because those challenges are still present, in 2013 we developed plans and secured funding for a $7.5 million major renovation of the existing instructional building, which will include two large interactive lecture halls, new small group learning labs and classrooms, a new student lounge and private study areas, and a robust technology infrastructure to better support innovative academic technologies. These renovations will be completed in August, in time for the arrival of the class of 2018.

In addition, we recently completed a renovation in the Kornhauser Library that dramatically expanded and enhanced student study spaces.

The second major LCME concern focused on the pace of change in our preclinical curriculum. Our clinical curriculum has always been a strength of the school, but at the time of the site visit in 2005, the preclinical curriculum was still quite traditional, departmentally controlled, discipline-based and largely lecture-driven. One of the LCME Education standards requires “integrated institutional responsibility in a medical education program for the overall design, management, and evaluation of a coherent and coordinated curriculum.” In 2005, the school was cited on this standard for lack of central control of the curriculum. We addressed one issue by changing the school’s bylaws to increase empowerment of the Educational Policy Committee. Changes were also made in the curriculum to increase clinical integration in the first and second year, and reduce the number of lecture hours and increase the amount of active learning, which brought us back into compliance. Then, in 2012 we launched a revised, temporally integrated second year curriculum, which linked courses across the year through team based learning.
opportunities. We began designing a completely integrated first year curriculum, which will be implemented in 2014. Although the plan was presented to the site team, the LCME judged us out of compliance. We are all very excited about this new curriculum and look forward to welcoming our incoming first year class to both a new curriculum and new instructional space.

So far as the timeline for moving out of probation status, we will submit a formal action plan to the LCME in early August, which will be reviewed at the October 2014 LCME meeting. We anticipate that a follow-up site visit will occur in summer 2015 and reconsideration of our status will take place in October of 2015.

In terms of outcomes and performance, the numbers for the medical school have never been higher. We have a great story to tell in that regard, a 99 percent pass rate on Step 1 national board exams (4 points higher than the national average), 98 percent on Step 2 (with a mean score 3 points higher than the national average). This is a tribute to our students as well as our faculty and reflects the overall quality of the educational program. In March we had one of our most successful Match Days in our history, with 97 percent of graduating students matching with one of their top choices. Regarding student engagement and satisfaction, 96 percent of our 2013 graduates were highly satisfied with their overall educational experience (7 points higher than the national average), and 95 percent were highly satisfied with administrative access and responsiveness, 20 points higher than the national average. We are very proud of these numbers and the positive feedback we get from program directors about the quality of our graduates.

Let me assure you also that we are working diligently and expeditiously to address all of the nuts and bolts and policy issues that the LCME identified. I am happy to report that many of the changes requested have already been implemented, and we are confident that all remaining changes will be implemented this coming academic year. And, as we do so, we will continue to provide outstanding care to our patients, conduct life-saving research, and partner with our community to achieve the common goals of healthier people and improved health care.

We were pleased to receive full accreditation, but disappointed with probationary status. This is not the place we want to be. However, we are prepared to make all changes necessary to address the LCME concerns, which, in the end, will make our educational program even stronger.

I hope that many of you will become regular visitors to the LCME link we have created at the School of Medicine homepage so that you can access the regular updates we will be posting, as well as photos of the Library and Instructional Building renovation projects: www.louisville.edu/medicine/renovation.

Note: Dr. Ganzel serves as the Dean of the University of Louisville School of Medicine.
Two of the most common questions I get when my colleagues find out I’m running for Congress are, “Why?” and, “Are you still practicing?” Both are excellent questions.

Why am I running for Congress? There is really no single reason for my decision. At 60 years of age, I believe I have acquired some wisdom, and my goals have become increasingly less about myself and more about others. Most of us have our political views, but they rarely rise to a level that would cause us to give up the profession we love. Just yesterday, after visiting a post-op patient, I was reminded just how much I would miss it. Yet when the very reason I love medicine is in jeopardy, I find my inhibitions fade away. It was the sweeping changes in medicine we have all witnessed in recent years that ultimately pushed me to run for office, to preserve the profession I love.

My father was a physician. He practiced family medicine, and later psychiatry, from our home while I was growing up. When I was young the entire first floor of our house was his office, including his consultation, examining, and waiting rooms. I remember my mother sending the patient bills out from our kitchen table after she served as nurse. These were some of the experiences that led me to follow my father into the medical profession.

I trained at Columbia University P&S, Harvard Medical School, and UCLA. I stayed on as a full-time academic faculty surgeon at UCLA and was made Chief of the Urology Service at one of the VA medical centers in LA. After moving to Louisville in 1992, I practiced in a group for 14 years, and I now operate as a solo practitioner.

I believe the medical profession is the most honorable and rewarding career one can pursue, and it is worth fighting to preserve. Most of us gave up some of the best years of our young lives to become physicians. And after all of the years we spent in training, we are now being told how to practice medicine by bureaucrats.

While our problems began years ago, it sure seems like we just stepped into a sinkhole. There is no end to the regulators at every level who believe they know better than us how to treat patients they have never seen or examined.

CMS and insurance companies have been hampering patient care for years by coding and reimbursement disincentives. Now we have entered the world of full-time regulopathy with the so-called Affordable Care Act. The Secretary of Health and Human services has been given enormous powers to control clinical practice with the help of 150 new agencies, boards, and committees who have already written over 20,000 pages of new rules and regulations we must follow.

The private practice of medicine in a typical small group is essentially dead. Even large groups and hospitals are finding it increasingly difficult to meet their financial and regulatory burdens.

I have experienced most every kind of medical practice arrangement from full-time academic to VA and county hospitals, and most recently private practice in both group and solo settings. I understand the long hours, frustrations, and stress physicians are under from various sources. Physicians have one of the highest burnout rates of any profession and it is only going to get worse as we lose more control of our practices and lives with 70,000 new ICD-10 codes, excessive computer documentation requirements, and ever-growing pressure from employers to increase productivity.

Surveys show that the two most common reasons cited by doctors for leaving practice are the costs and headaches of government and insurance regulations and the high cost of new IT requirements. Keeping a viable practice amid falling reimbursements and rising overhead is both overwhelming and unsustainable, yet we remain the target of bureaucrats in Washington.

Physicians are easy targets because we have rightly committed ourselves to the care of our patients first. It is not from callousness or selfishness that we oppose the health care takeover. Rather, we understand that an independent medical profession—not one subject to the dictates of the government, insurance companies, or hospitals—provides the best patient care. Theirs is a different agenda. They have never taken the Hippocratic Oath, but we did. Physicians are patients’ true advocates.

Physicians are also easy targets because we have very little political clout. We make up only 0.2 percent of the population. Our vote doesn’t add up to much. Politicians don’t have to worry about being voted out of office by doctors. Even our professional PACs have little effect on them. They win votes by promising our services on their terms, not by listening to us.

(continued on page 10)
Unfortunately, Washington is going to have an increasingly loud voice in how we practice medicine. They will determine the relationship we have with our patients. The only way we can affect the outcome is to put more physicians in Congress. Twenty physicians are currently serving in Congress, including three Senators. That gives us 3.7 percent representation. Lawyers, on the other hand, are 43 percent of House members, 60 percent of the Senate. While I’d much rather remain in the operating room, it seems Washington is the only place to go to make a stand.

Am I still practicing? Yes. I am not in the financial position to jump into full-time campaigning this early. It is abundantly clear why Congress is populated with multimillionaires like my opponent. The political pros never cease reminding me of the need to raise campaign funds.

Maintaining my practice has been a challenge. I have cut my hours by about 50 percent in order to straddle the requirements of campaigning and keeping the lights on both at home and in the office.

Fortunately, a grueling surgical residency and decades of practice have prepared me well for the ordeal.

I have spent the last 60 years as a patient and more than 30 as a practicing physician. I can assure you that if I am given the honor of serving as the representative for Louisville, I will put the interests of the patient and physician, as well as every citizen, as my top responsibility.

And one last question - would I do it again? Hmmm... Ask me in November.

Note: Dr. Macfarlane practices Urological Surgery with Urology Care LLC.
Relentlessly, Time marches on, season by season, and the years fly by. This year a harsh winter, reluctant to leave, is being pushed by an impatient spring to let go and make way so graduations, ball games, the Derby, and June weddings can take place in balmy weathers.

Likewise, as relentlessly, but with less success, has been the wish by the now fading older generations to retain old customs, norms, ways of thinking, and traditions dear to their hearts. They are losing the battle in favor of actions borne of ideas of individual freedoms that everyone is supposed to be entitled to.

Thus this tale of a wedding.

Much to the dismay of her conservative parents, a bride-to-be asked their blessing on what she was about to inform them. In a nutshell, she and her fiancé had decided to get married sooner than expected. The wedding would not be in church but on a grassy knoll in the park, presided over by a female licensed friend. It would be informal, and she would not walk to the altar with an entourage, nor would she be wearing a long white gown and veil like the rest of her cousins had done.

The future groom had just acquired a junior faculty position as a neurologist and was ready to settle down. Our bride-to-be was entering her fourth year of medical school, and he had offered to assume financial responsibility in lieu of her parents after the marriage. That, in the bride's culture, would be an affront to their parental honor, i.e. giving a bride away in marriage without having finished her education under their auspices.

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Furthermore, like the unique receptions of the ever present neighboring Hollywood stars, the couple would have one with a Middle Eastern oriental setting with guests reclining on pillows and ottomans on thickly carpeted floors. Sans spoons and forks, guests would break bread with their hands and dip these morsels in delicious bowls of sauces and concoctions.

In passing, she was contemplating a prenuptial agreement, similar to a no fault car accident insurance, in case they made a mistake and did not get along!

Thirty years ago, these were mind boggling, radical ideas that caused a lot of consternation and family consultations! How do you explain to relatives, invited or not, that these were modern times and children (in the eyes of extended family that was still their category) were allowed to plan their own weddings regardless of the desires of others, that a marriage is valid between consenting adults regardless of who officiates? They had to know that in the U.S.A. the bride's family, not the groom's, pays for the reception unless otherwise specified, that it is not a breach of protocol to sit around tables on the floor instead of on cloth covered chairs.

As planned by the couple, their marriage was celebrated on a bright sunny morning in a Los Angeles park. As a concession to her mother, the bride was beaming in a long white wedding dress without a train and a veil. The female friend who presided wore a black toga and looked like a minister. The bride and groom said the proper "I Dos" and stepped on their wine glasses at the same time. It is believed this was assurance that one would not dominate the other. Best of all, it was evident the couple respected and loved each other dearly and had successfully negotiated the perils of mixed cultures and traditions of their families with aplomb.

At the reception they did concede to have silver knives and forks for those who hesitated to use their hands. In another break of tradition, at the courtyard was a tiered chocolate wedding cake, (not white), elaborately decorated with multicolored intertwining vines and flowers. It was as tasty as it looked. The wedding, from start to finish, was indeed a memorable experience for all who were present.

The bride and groom never signed a prenuptial agreement. It was just a passing thought. Their son now teaches at a college, their daughter after a few semesters in London is finishing college. Between the two of them, they have taught medical students year after year and are still treating patients, he as a neurologist, she an internist.

Who is it that said, “Love conquers all?”

Or another, who said, “All is well that ends well?”

Are these sayings true? I M

Note: Dr. Oropilla is a retired psychiatrist.
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There is only one Dr. Bill Smock in Louisville, Kentucky. For that matter, there’s only one Dr. Bill Smock in the whole United States. Louisville lucked out on this one.

William (Bill) Smock, MD, has spent his entire adult life helping people. Inspired by his grandfather, Spafford Ackerly, MD, who served as chairman of psychiatry at the University of Louisville, Dr. Smock has led a life with one foot in medicine and the other in emergency services since he became a volunteer firefighter at age 17.

The first few steps of his career show an intense interest in understanding the minds and bodies of the everyday human being. Born and raised here, Dr. Smock took a city job as an Emergency Medical Technician (EMT) right out of high school.

“I worked the West End from midnight to 8 a.m.,” said Smock. “That was my first real exposure to the needs of public health. I delivered babies on bathroom floors. I saw inhumanities, people shooting, stabbing, stealing from each other, domestic violence, everything. It was an eye-opening experience for a white boy from the East End.”

Back in school, Dr. Smock studied at Centre College, earning a Bachelor’s in Psychobiology before returning home to earn a master’s degree in Anatomy. During that time, he served as an investigator for the medical examiner’s office, analyzing motor vehicle collisions and reconstructing injuries. “This was my first introduction to forensic medicine,” he said. It was an area of expertise that would continue to fascinate him for decades.

Dr. Smock began collaborating with Kentucky’s chief medical examiner, Dr. George Nichols. Together, the two men created the first clinical forensic medicine program in the country. Louisville seemed like a fitting location to test the potency of their program.

“There was an article in the Journal of the American Medical Association in 1986 which talked about the need for physicians to be specially trained in the practice of living forensics. We had pathologists, but there were no physicians in the United States specially trained to address the forensic needs of living patients. If you were shot, you would have to die for a forensic expert to look at your wounds,” said Dr. Smock.
With the help of Dr. Nichols and Dan Danzl, MD, chairman of Emergency Medicine at the University of Louisville, Dr. Smock worked to create the first fellowship in clinical forensic medicine within the United States in 1993-1994.

When asked how many people participated in the first fellowship, Dr. Smock laughs and holds up a finger. "One. Just me. " In the 20 years since, just three others completed the fellowship. The fellowship was the logical extension of a 1990 consultation service created by Smock and Nichols to examine living victims and suspects when Louisville police were skeptical of their stories.

"Dr. Nichols or I would go examine the victim in the hospital. Usually, it was child abuse. It could be shooting, could be strangulation, could be stabbing." For the next six years, Dr. Smock worked as the program's director, even while serving as a hospital resident.

Dr. Nichols took responsibility for the program when he retired from the chief medical examiner position in 1997. In that time, Dr. Smock received his own office with the title of Police Surgeon and hired three nurses who help with examinations and evaluations. His work was set.

"I've known Bill for 30 years," said Louisville Chief of Police Steve Conrad. "His work has given us great insights we really wouldn't have had any other way. The science behind what he does is astonishing, and knowing Dr. Smock is there to be able to give the highly skilled aid he's capable of offering is very, very important in our work."

Last year, a woman came into the emergency room wounded and accusing her boyfriend of stabbing her. An emergency room physician examined her wounds and corroborated her story. Shortly after, a court found the boyfriend guilty of felony assault and sentenced him to jail. The detective on the case, Jimmy Johnson, contacted Dr. Smock's office for a second look.

When Dr. Smock's evaluation was complete, based on location and characteristics of the injuries, it was clear to him that the woman's wounds were self-inflicted.

"As soon as I saw the tell-tale characteristics, I called the detective. I testified before Judge Gina Calvert, and later that day they brought the man out of jail," said Dr. Smock. "The judge told the wrongfully convicted boyfriend, 'What you were saying, that you didn't do it, is absolutely true.' And he broke down right there in the courtroom. It was very emotional."

"The science of living forensics helps medical professionals reconstruct injuries to better understand the nature of how they were inflicted. This knowledge protects the innocent from a miscarriage of justice. That's what this is all about," said Dr. Smock, who credits Detective Johnson for considering the forensic consultation at all. "He's an outstanding domestic violence detective."

"We highly value Dr. Smock's opinion," said Johnson, equally appreciative. "He's pretty much the resident expert in deciphering injuries and helping to confirm or deny statements. It's comforting to have an expert such as him to fall back on when you have questions."

As an example, Dr. Smock explained the three basic questions which should be answered when evaluating gun shot wounds. "Which wound is the entry and which is the exit? What was the range of fire? And what was the bullet's trajectory? When we're trying to determine what happened, we have to determine if the injuries are consistent with what the victim says or with what the accused shooter says.

"We've had several cases where people shoot themselves, gang members, and try to blame it on an opposing gang member. So who's the jury going to believe? The victim has two holes in them. The person shot normally has a little more credibility, but our job is to determine, are the injuries consistent with the history?"

The work Dr. Smock is doing is slowly taking hold across the country, but he has been instrumental in teaching his living forensics evaluation to nurses, physicians and police officers in major cities from Boston to Las Vegas.

In fact, he spent the first days of April training members of the Dallas, Texas, homicide department in the forensics of officer-involved shootings. "I'm planting seeds and saying that in order to address the problems you're having with your investigations, this is what you need to do."

One of Dr. Smock's biggest goals for the near and distant future is the spread of the program known as FNE, Forensic Nurse Examiners. He hopes to train nurses across the United States to carry out forensic examinations on living victims in the most effective and compassionate way while the patient is still in the emergency room.

"The benefits are multi-fold. One is that nurses do a much better job than physicians in their examinations. Physicians are running a busy ER, and they can't take an hour or longer to give that victim the proper care and attention they need. And this may be the most traumatic event in that person's life," he said. "At least 20 years from now, my goal is that we will have forensic nurse examiners in every
trauma center across the country. The model already exists.”

Assistant Commonwealth Attorney Chris Foster has worked with Dr. Smock for many years and visited San Diego, Calif., with him to train in the recognition of neck trauma via strangulation. “Our office has a great relationship with Dr. Smock. We rely on him to give us frank opinions. He’s consistently educating the juries. He’s educating us on the medical aspects of our cases. I admire his patience, his desire to teach, and I believe we often do a better job of handling cases due to his involvement.”

Not one to merely sit at his desk, Dr. Smock also serves as a tactical physician for the Louisville SWAT team, a position he’s had for over 20 years. “I’m the last person in the stack. I’m the last person, and I stop at the door. It doesn’t do the team any good if I get shot. But, I’m right up there in a ballistic vest, a ballistic helmet. I have to complete the same training and meet all of the physical qualifications, shooting qualifications.” The St. Matthews Police Department, the Jeffersontown Police Department and the Floyd County Sheriff’s Department in Indiana all call on Dr. Smock to assist as a SWAT tactical physician as well.

LMPD SWAT Officer Eric Culver has worked on the team with Dr. Smock for ten years. “Dr. Smock serves as the lead tactical medic. He’s trained the team in how to effectively use tourniquets, do combat dressing, pack wounds and more,” said Culver.

“Dr. Smock deploys on missions with us. He dresses with us and has the same equipment minus a firearm. He’s right there to apply medical aid as he sees fit. If there are kids in the situation, he’ll be the one to make sure they’re okay,” Culver continued. “It’s great we have him, because he’s an essential tool for our tool box.”

Beyond the medical examinations, the SWAT missions and the court cases, Dr. Smock found time to raise a family with his wife of 28 years, Cathy, a nurse. The couple has three children, all of whom are interested in following their parents’ footsteps into public service.

With family, friends, students and colleagues, Dr. Smock also annually visits the African nation of Kenya. Together with University of Louisville graduate and Kenyan Member of Parliament Wesley Korir, Dr. Smock has worked to give thousands upon thousands of villages fresh water and medical supplies through a program known as WaterStep. He’s already planning his next trip for this July where he’ll take 13 University of Louisville medical students, many of whom will be making the journey for the first time.

Dr. Smock, 56, has no plans of slowing down any time soon. “Why would I retire from a dream job that I love to do? I think we’re here to help people, and I would do this even if I weren’t paid. I am as happy as any physician could be.”

Note: Aaron Burch is Communications Specialist for the Greater Louisville Medical Society
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The group of ten stealthily rounded the bend on the Riverwalk in Shawnee Park one cool, clear morning in early May and there she was. Standing knee deep in the weeds, noted internist and accomplished birder Dr. Mary Barry was stalking another colorful spring migrant. We were on a group outing with the Beckham Bird Club of Louisville. The group meets monthly at the Clifton Center with a featured speaker but offers organized field trips two to three times a week to local and bi-state birding hot spots for camaraderie and to help sort out the difference between the Nashville and Connecticut Warbler.

Just as the spring brings a carpet of vernal green grass and pink and white trees and flowers, it also brings back a kaleidoscope of colorful birds to further decorate the meadows and forests. The tiny Ruby-Throated Hummingbird returns from his winter sojourn in South America. Scarlet Tanagers and Baltimore Orioles once again add musical accompaniment to the crisp spring mornings. Birders love the spring, particularly April and May - roughly two billion birds move through the USA in the spring. And thanks to the seasonal increase in testosterone, the males are often wildly colorful and are singing to attract a mate.

The same event moves the other direction after breeding in the fall. Twice as many birds head south beginning in late July and extending into October. Having molted they are generally not as brightly adorned and no longer singing but still worth watching. Birding is a year round pursuit with changes in bird populations with the seasons. This recent winter saw an invasion of Snowy Owls and Red-necked Grebes from up north. Each season yields new surprises.

I became interested in birds as a child when our parents left us at our grandparents for out of town football weekends. Our grandmother raised Canaries for show but also had a large breakfast room window with lots of feeders outside. We learned early on “little bites like the Chickadee” not realizing the tiny gray and black jewel ate half his weight in sunflower seeds daily. Our grandmother gave us a life list book to record our sightings. My first entry was in 1957, a Robin. To the same book I just added number 692, a Blue-footed Booby spotted off the coast of California. To those that watched the movie The Big Year where all three participants saw over 700 birds in one year that may not seem like a lot. But that’s a lifetime of looking. The movie, by the way is very cute and quite accurate bird-wise. It gives a good account of the lengths some birders will go to in pursuit of their feathered friends.

In 1979 while studying internal medicine in Kalamazoo, Michigan, I met Dr. Mark Whiteside, now an infectious disease specialist in Key West. We found we had a common interest in birding. We embarked on our
first bird trip to South Texas and the Rio Grande Valley that November, rolling down the highway in his ’57 Chevy Bel Air. In the first 45 minutes walking the boardwalk in Santa Ana NWR near Brownsville, Texas, we spotted twelve new birds we had never seen before, lifers! And Mark knew them all. He had studied. As the years went on my brother Rick joined up and continued our yearly trips around the country in search of lifers. We call ourselves the ROAD SHOW and we will take our third trip to Alaska this summer; while we have a friendly competition on our “numbers” it’s just great company.

Birding is a lot like dermatology, very visual with subtle clues differentiating species. But birds sing, telling you who they are and how upset they may be. Patients sing too and if you listen carefully they will often tell you what is wrong with them.

Birding takes you places you would never otherwise visit. My brother and I have watched birds on all seven continents. Memorable trips include walking among the penguin nests on the Antarctic Peninsula, watching eagles and buzzards wait for the cheetahs and hyenas to finish with the freshly killed wildebeest in Tanzania, canoeing past a Great Potoo on the Amazon River in Peru, and spotting a Red-whiskered Bulbul in a park in his native Hong Kong (they can also be found as exotics in Miami and LA). We have been lucky enough to see the world bird by bird.

Birding is a relatively simple hobby. All you need is a good pair of binoculars and a field guide, now available as an app on your smart phone that includes bird songs. A spotting scope helps bring in distant shore birds and ducks. To attract birds, set bird feeders outside your window. Hang them from the gutters. You will be surprised how close the birds get. Start with a small oil sunflower seed feeder for Cardinals, Blue Jays, Chickadees and Titmice. Add a thistle tube feeder for Goldfinches and House Finches. In the summer, add a hummingbird feeder with a simple 5:1 mixture of water to sugar. In winter, a suet cake will attract a variety of woodpeckers, nuthatches and the Carolina Wren. Don’t forget a shallow birdbath. Birdhouses for Eastern Bluebirds and House Wrens work on most lots. I have a Cooper’s Hawk that occasionally stakes out my feeders, but that’s nature.

A tank of gas will get you to any of the state parks in Kentucky where the Kentucky Ornithological Society meets twice a year in the spring and the fall during the migration. Local Louisville birding hot spots include Bernheim Forest, Joe Creason Park, the Anchorage Trail, the Falls of the Ohio State Park and Cave Hill Cemetery. I have been to Mammoth Cave yearly for 25 years but only toured the cave for the second time last year. The birds are that good, particularly in the spring.

I enjoy golf and touring Civil War battlefields. Both sites are also great for birding. I remember past golf trips pointing out birds to non-birders; by the end of the trip they were showing me Red-headed Woodpeckers which love the trees along the fairways and Great Egrets which roost and nest in wetlands along southern courses. My first Ferruginous Hawk was spotted on Mission Hills Golf Course in Palm Springs.

Birding is a great respite from a medical office. It moves you outside and gets you in tune with nature. Put out some feeders. You will be pleasantly surprised who comes to visit.

Note: Dr. Win Ahrens practices Dermatology with Advanced Dermatology and Dermaesthetics of Louisville.
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(left) Dr. Scott and wife, Christy, on their wedding day, June 1, 1985; (right) Big game fishing in Cabo; (below) Dr. Scott with his siblings.

(left) With both sons at a Notre Dame football game, 2013; (right) The Scott’s in Venice, 2002.

(left) Celebrating his parent’s 60th wedding anniversary on the Bourbon Trail; (above) Sacred Heart Academy Father Daughter Dance with daughter Stephanie, 2011; (right) At The Natural Bridge, 2000.
Introducing

Bruce Scott, MD
President, Greater Louisville Medical Society
2014–2015

Ian Scott

My dad is probably the hardest working person that I know, and one of the most successful. He is the president of his private practice group, medical director of his surgery center, an accomplished speaker, and a member of several boards. He has been extremely involved in organized medicine at the local, state and national levels since his residency, when he served as Chair of the AMA’s Resident Physician Section. Since then he has served on the Board of Trustees of both the AMA and the AMA Foundation, and continues to serve on the boards of the GLMS and KMA. He firmly believes that physicians working together can affect positive change for both physicians and patients.

Dad is the fifth of six children born to Lou and Ethel Scott. Neither of his parents attended college; in fact his dad left high school at the age of sixteen to help support his family during a difficult economy; yet, it is obvious that there was a strong emphasis placed on education in their home. All six children attended private schools, and then continued on to college; three went further to attain master’s degrees and two earned doctoral degrees. This was not easily accomplished on a single blue collar salary. Everyone was expected to help pull their own weight. My dad sometimes worked three jobs at a time (including a 5:00 AM paper route every morning before school). His hard work paid off with his admission to Vanderbilt University (where he met my mom, Christy at the beginning of his freshman year), and then to the University of Texas Medical School, where he earned a scholarship giving him in-state tuition – at the time that was $400 a year – things have certainly changed.

After graduating from medical school in Galveston, and completing a residency in otolaryngology, he and my mom moved to Houston, where Dad completed a facial plastic surgery fellowship. It was during their time in Texas that my two older siblings were born - Preston (23, Notre Dame) and Stephanie (21, Miami)

(continued on page 22)
University. Upon completion of his fellowship, Dad returned to Louisville to join Drs. Cohen, Silk and Rudwell in practice. That’s when I came along – I’m 18, and will be the last of this generation to graduate from St. Xavier High School.

Despite his myriad accomplishments, my dad still works with that same grit he had growing up, never too proud to come out in the yard and dig up a drainage pipe with me or mulch or sod or seal the driveway. In his free time, there is nothing he loves more than to cheer on the Louisville Cardinals; he also loves to cheer on the Fighting Irish, and through the years could be heard above others in the stands cheering on my brother at St. X tennis matches, my sister at Sacred Heart field hockey games, and me at St. X lacrosse games. (I am confident that he will soon be cheering on the USC Trojans.) He is a do-it-yourself addict, often prompting my mom to ask if his real job is as a physician or a handyman. He is a perfectionist, always searching for any way to make something better, and always quick to try and solve any problem he sees. He loves being a dad, loves playing with his kids, whether that be a fierce game of nine-square on the driveway, the annual campout, fishing, snow skiing, water skiing and tubing, white water rafting or just joking around at the dinner table. He can often be heard talking to others about how proud and happy he is to be a father. He is a loving son, ever thankful of the people who made him the man he is today. He is a loving husband, as happy as he could be with my mom, whether it be travelling (something they both love) to Europe, Napa, the beach or national parks, or on the back deck, the dog in his lap, and a glass of wine (from the cellar he built in our basement) in his hand as they just sit and talk.

(continued from page 21)
He remains humble in his success and never forgets what is truly important to him: his family and his friends. If it is difficult for him to balance all of his pursuits, he never shows it, constantly wearing a smile that exposes his infectious zeal for life. He always wants to help, and loves nothing more than to teach others what he knows, whether that be about plumbing or the potential problems associated with a crooked septum. He leads through example, never quitting until a job is entirely done, and teaching me always to do the same. At the end of the day, I can honestly say that I strive to have his passion, his heart, his patience, and his excitement for everything that he does, something I know he will bring as President of the Greater Louisville Medical Society.

Note: Ian Scott is Bruce and Christy Scott’s youngest child. He recently graduated from St. Xavier High School and will be attending University of Southern California in the fall.
Dr. Sherwin Nuland (1930-2014)
A TRIBUTE TO A REMARKABLE PHYSICIAN-WRITER

M. Saleem Seyal, MD, FACC, FACP

“I just loved Shep. He was such a kind, generous and smart man. He definitely had strong opinions about lots of things but he always articulated them beautifully. For my money, he was the best doctor-writer of our era and was a serious doctor—always endeavoring to heal those around him. I will miss him. But thank goodness, his words and life will live on in all those wonderful books.”

Howard Markel, MD, PhD (via e-mail to Dr. Seyal)

George E. Wantz Distinguished Professor of the History of Medicine

Founding Director, Center of the History of Medicine

The University of Michigan

Dr. Sherwin Nuland was a famous author who has been well known for his highly acclaimed book entitled “How We Die – Reflections of Life’s Final Chapter” that was published in 1994. This influential book engendered a national debate about end-of-life care and garnered him a National Book Award. Two decades after publication of that seminal book, Dr. Nuland passed away at his home in Hamden, Connecticut on March 5, 2014. The world has lost a highly elegant wordsmith with a razor-sharp mind who has left behind a tremendous legacy of many books and essays along with his candid, honest and beautifully eloquent talks and lectures – all will be cherished for a long time. “He was incapable of composing a sentence that wasn’t clear, elegant, and true,” wrote Dr. Markel in his in-memoriam piece about Dr. Nuland in the March 10, 2014 issue of The New Republic. He was a brilliant surgeon who worked for 30 years at the Yale-New Haven Hospital where he served as a clinical professor of Surgery at the Yale School of Medicine and subsequently, even after his retirement from the OR, he continued to teach Bioethics and History of Medicine at Yale.

He was born in the East Bronx as Shepsel Ber Noodleman on December 8, 1930 in an impoverished household, and lived with his Russian Jewish immigrant parents and several other relatives in a cramped apartment in a crowded tenement. His Yiddish-speaking father, Meyer Nudelman, came to the United States at age 19 and worked as a semi-skilled worker in the garment trade and adamantly refused to assimilate or learn English, “a man with no past… he never figures this country out,” Dr. Nuland later stated. Meyer had several physical disabilities and was dependent on Shep to help him navigate the stairs in their apartment and treacherous New York streets during snow. Meyer displayed frequent bouts of rage and his violent temper terrified the family. In his haunting autobiographical book “Lost in America—A Journey with My Father,” Nuland wrote a brutally honest account of his upbringing under terribly difficult circumstances when he was continually “living with a sense of looming tragedy….. Death was part of the legacy and lore of our family.” His grandmother who lived with the family had lost her three sons to tuberculosis. His mother had one stillbirth and lost another son at age three. Sherwin was near death with diphtheria at age three. His mother died of colon cancer and due to lack of funds and facilities was unable to get any meaningful treatment. In his memoir, he vividly remembers the horrible odors that emanated from his mother’s room along with the bloody pads. The death of his mother, the pillar of the family, was very hard on young “Shep” who was 11 years old then. It “catapulted me into forced maturity,” he said in his C-SPAN interview in 2005. He had serious but brief bouts of obsessive thoughts and depression during this adolescent phase of his life; those later would return with ferocity and confine him to a mental institution. The epigraph of the book is attributed to the Jewish philosopher Philo of Alexandria: “Be kind, for everyone you meet is fighting a great battle.”

He frankly admitted to being extremely embarrassed by his father’s lack of Americanization and his overall disposition regarding his physical handicaps, violent temper and poor communication skills. Sherwin Nuland changed his name legally, primarily for it to sound American and also for better prospects to gain admission in medical school. He indulgently and with focused determination, honed his proficiency in English since he firmly believed that “the way out was the English language.” He desperately wanted to be completely unlike his father and wanted to be a mainstream American. After his college years at the New York University in 1951, he elected to
get out of New York and as if to get away from his demanding and violent father, he was accepted at Yale for his medical education.

After obtaining his medical degree in 1955, he started his surgical residency at Yale-New Haven Hospital and served as the chief resident in his final year of training. His feelings towards his father softened eventually with the physical distance between them and after learning that his father’s disabilities were secondary to tabes dorsalis—manifestation of tertiary syphilis. He started a thriving surgical practice in New Haven, got married and had two children. At age 42, his life was turned upside down as he lapsed into a more severe and incapacitating bout of depression and obsessive thoughts that lasted for over a year and required institutionalization in the early 1970s. Divorce from his first wife unsettled him significantly, his practice suffered and he was again close to being financially ruined. Frontal lobotomy was considered by his senior physicians but one psychiatrist resident, Dr. Vittorio Ferrero intervened and alternatively recommended electroconvulsive therapy which was carried out with excellent clinical response. Dr. Nuland courageously narrated the story of his depression, and the beneficial effect of electroconvulsive therapy, in unflinching detail during his famous 2001 Technology, Entertainment and Design (TED) talk. This talk was released in October 2007 and “remains one of the most powerful moments in the conference’s history,” according to TED’s Curator, Chris Anderson. Sherwin re-married in 1977 to his second wife, Sarah Peterson, and they had two more children. He returned to his two passions—surgery and writing. He retired from surgery in 1991 and pursued full-time his writing and speaking career, with remarkable success.

“The Origins of Anesthesia” is a beautiful leather-bound book edited by Dr. Nuland and produced in the Historical library of the Yale School of Medicine. In addition to his excellent introduction, he wrote commentaries that preceded each historical paper in original form with extensive bibliography.

“Medicine—The Art of Healing” is a coffee table picture book of medical progress reproducing “a cavalcade of medical images with great appeal,” including the Hippocratic Oath, Theodore Billroth operating in Vienna in front of an eager audience, and the first operation under ether at the Massachusetts General Hospital in 1846. He includes a portrait of John Hunter, a great self-experimenter and anatomist, the Four Doctors of the first faculty of Johns Hopkins (1905), the famous painting “The Doctor” by Sir Luke Fildes (1891) and many others with detailed descriptions.

“Doctors—The Biography of Medicine” published in 1988 is a tour de force of the history of medicine from antiquity to modernity. The companion book is a magnum opus with fabulous pictures, of a large coffee table size published 20 years later. Dr. Nuland has taught twelve lectures for the Teaching Company based on these books, where one can listen to the eloquent and thorough knowledge of this consummate physician-writer-medical historian on DVD or CD.

“How We Die,” published in 1994, sold over half a million copies, won the National Book Award in 1994 and was a finalist for the Pulitzer Prize in non-fiction in 1995. The book stimulated discussion about end-of-life care and demythologized death by maintaining that death results from violence, disease or aging. He castigated the futility of fighting death when it is inevitable, by use of modern and expensive means to prolong life unnecessarily. Talking about death with dignity, he wrote, “The dignity we seek in dying must be found in the dignity with which we have lived our lives.” Engaged in a debate with the “life extenders/anti-aging crowd,” he stated matter-of-factly, “It is my debt to everything that has come before me and it is my obligation to everything that comes after me that I die within my allotted time.”

He was a contributing editor of The New Republic and The American Scholar and served as a board member of the Hastings Center. He wrote brief but very informative biographies of Moses Maimonides, Ignac Semmelweis and Leonardo Da Vinci. 

Note: Dr. Seyal practices Cardiovascular Diseases with Floyd Memorial Medical Group-River Cities Cardiology.

**DR. SHERWIN NULAND’S BOOKS:**

3. Doctors—The Biography of Medicine, Alfred A. Knopf, 1988
10. The Doctor’s Plague: Germs, Childbed Fever and the Strange Story of Ignac Semmelweis, Great Discoveries, 2004
13. The Uncertain Art; Thoughts on a Life in Medicine 2008
14. The Soul of Medicine; Tales From the Bedside, 2009
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I spend a fair amount of time thinking about the future of medicine. I dream of tiny machines that we can send afloat in patients’ bloodstreams that will detect cancer at the cellular level. I think often about the way policy in health care could alter our paradigms so that we receive increased compensation for treating people before they get sick rather than after. I wonder how the community I will practice in will look twenty years from now, whether we will integrate ourselves with Physical Therapists and Optometrists or do our best to isolate our profession. But mostly I wonder about my patients.

I hope that they will like me. I get anxious when I think about them dying. I imagine sitting across from them and solving their problems, so that they can leave my office healthier and happier. I have conversations with them in my mind, discussing the importance of this or that medication and I go over discussing the importance of healthy living each time, asking what they eat and if they are able to exercise, and what prevents them from leading the life they desire. In my future, I always discuss more, prescribe less, integrate my plan with the patient’s and make sure they understand where we are heading.

As usual, life taught me a valuable lesson when I needed it most.

Yesterday I helped my grandfather spread mulch across his yard. I didn’t know I would be helping him, but when we got there he was about to start his second load so I volunteered. He doesn’t use the bagged or bulk kind; he makes his own. We rode down to the corner of his lot and he showed me a pile of decomposing leaves from two years ago. Beside it, last year’s leaves were in much better shape but were already a deep brown. He told me that every year he brings all the leaves from the yard and heaps them up into a pile, which ends up being about forty feet long and three of four feet wide. He lets them rot, essentially, for two years and then spreads the resulting compost in the areas of his yard that need it most, one shovelful at a time.

I was about to tell him that I thought he should just buy some chemicals and spread them around like everyone else when I stopped to think. I looked around. His lawn wasn’t perfect, but it looked pretty good. It was green and healthy nearly everywhere. Who knows how much money had saved? And already in his eighties, doing work like this surely kept him healthy. Further, he was reducing the amount of chemicals required to keep his lawn respectable.

What a metaphor, I thought. Here I stood, a future physician, ready to throw chemicals at a problem rather than take the harder, but likely better and more holistic route. In an age of Medicine ready to throw physical-exam skills aside for sake of better imaging, and ready to ditch lifelong patient relationships for “Any Provider,” I think it helps us all to remind ourselves that sometimes the old ways are the best.

Note: Ben Rogers is a first-year resident in internal medicine at Washington University in St. Louis.

Andrea Baumann, COO
ProRehab, PC
Thunder over Louisville as we know it now started 25 years ago as a giant fireworks display at the end of the Redbirds game at Cardinal Stadium (the inaugural celebratory fireworks started at the Chow Wagon in conjunction with the They’re Off luncheon of 1989). Although it is now preceded by several events starting in February this year, including the They’re-Off! Luncheon and the Fillies Derby Ball, Thunder was initially designed and is currently still considered to be the opening ceremony for this year’s three weeklong event known as The Kentucky Derby Festival celebration. This year was the diamond jubilee year for Thunder over Louisville and once again featured the U.S. Navy’s Blue Angels after an eight year absence. Thunder over Louisville includes many military and civilian airplane fly-bys every year leading many spectators to say that they come to see the air show just as much as the fireworks show. Thunder Over Louisville is recognized as the largest fireworks display and one of the five largest air shows in North America. It is reported that one million dollars in fireworks are sent into the dark night sky during this event, drawing both a national and international audience. The attendance at this year’s event was estimated to be 650,000—700,000 spectators, including the many people watching the air show and fireworks on the 125 pleasure crafts located on the Ohio River.

The Kentucky Derby Festival has grown into a nationally, and possibly internationally, known and multiple award-winning organization that has produced 70 annual festival events with the support of 4,000 volunteers. However, the role of the many dedicated veteran volunteers that who make up the Ohio River part of the Thunder celebration may be less well known and therefore under-appreciated. River people know that through the weeks before Thunder each year, the Ohio River is often swollen and sometimes flooded with winter and spring rains, melted northern snow. The river might be full of logs and sometimes submerged trees. Just before this year’s Thunder, the river pool rapidly increased from 12 to 19 feet. On the Thursday before Thunder, the current was five to six times normal and wind gusts were reported up to 50 MPH. This severely complicated the required setting of the multiple anchors and their buoy markers that are required for the air show to be staged. When in place, this buoy system enables the required center line marker boat to be accurately positioned so the air show planes can lock on to her for their acrobatic maneuvers.

Several long term and veteran volunteers are required to set up the Ohio River stage. They perform many of their duties long before the air show and the fireworks show begin, enabling them both to proceed and to function. John Hollis is a 20 year veteran volunteer. Each year he places his 41 foot Sea Ray in the center of the Thunder “air box” and also assumes a lead role as the centerline marker boat. The huge tow boats and barges used for Thunder require the advance placement of a 12,000 pound anchor just below the Clark Memorial (second street bridge). Kevin Roppel is another 20 year veteran volunteer of Thunder. He is involved with the advance recruitment of the pleasure boats that make up the picket line and many of the water management activities that make both shows possible. This year I was privileged to accompany him on the river to help him to set up and to accomplish the several tasks assigned to him.

The picket line is made up of several volunteer pleasure boats and
their crews. They form a visible point of reference line across the Ohio River just upstream before the Big Four (walkway) Bridge. These boats are required to sit at anchor on Saturday from 1:00 p.m. to the end of the Thunder celebration. Should any of the upstream pleasure boats that are on hand to enjoy the show drift downstream below the picket line, they are re-directed back upstream by either the harbor police boats or the US Coast Guard. A towing service is available to manage any disabled boats. All this activity requires several organizational and planning meetings. When Thunder is completed, as a safety precaution, the harbor police escort all the pleasure boats that were watching the day-long event back up the river, at idle speed, as far as the head of Six Mile island and Captain's Quarters.

In previous years, Kevin Roppel has provided multiple functions the day of Thunder, including the pickup of the parachutists and boat exhibition crew. This year he attended several command organizational meetings and recruited the picket line boats. He was also involved with a special Blue Angels' meeting related to their requirement of a different "air box" for their performance. His day of Thunder responsibilities included the movement of the WAVE 3 personnel and the retrieval of the Blue Angel air show buoy and anchor - within a 15-minute window - just after the Blue Angels had completed their performance. I was invited by Kevin to attend the final command briefing held on Friday at 5 p.m., at the Galt House, the day before Thunder. I was favorably impressed by the way the various professionals and volunteers interacted with each other to accomplish their common goal. It was exceptionally exciting for me to meet and greet the US Navy's Blue Angel pilots. I had previously experienced US Navy and US Marine pilots at work while serving briefly as a Lt. Commander and chief medical officer aboard the super carrier USS Forrestal (CV-59). As it turned out, my nighttime observations of flight operations under battle conditions on an aircraft carrier had left a lasting and positive impression.

Our first official task on the Saturday morning of Thunder was to pick up the WAVE 3 personnel and equipment led by Kent Taylor. At 12:00 noon they were waiting for us at the Great Lawn Marina downtown near the Crab Shack. Their stated plan was to film the developing crowds on both sides of the river, do some live spots, and to do a live interview with our Captain. We all had a laugh when we realized that he wore an advertising shirt, but that it was not of his company. We also had some fun filming Kent Taylor driving Kevin's boat, the Contender.

At 4:30 p.m. we were programmed to pick up the buoy and anchor that marked the center of the "air box" used by the Blue Angels. They require a different "air box" from the other performing aircraft in the show. This operation has to be performed in about 15 minutes or the show would stop. We were required to get to the buoy station, approach this buoy downstream, hook it, and bring it aboard along with its 40 pound anchor, chain, and 100 feet of line. We then had to remove ourselves from the "air box" in the time allotted. The trick was not to get any of the apparatus involved with our two giant outboard motors and try not to damage or to scratch the boat. This stressful situation was further complicated by the fast current, the high velocity winds, and the knowledge that we would hold up the air show schedule if we were not successful. We made it out of the "air box" with the twin 350 HP engine throttles pushed far forward just in time for the next planes arrival. Kathy Henderson and Michelle Roppel were involved with the actual retrieval of the buoy and anchor. They managed the combined weight of the buoy, anchor, chain, and line on time and without incident. It was great fun to work with a crew that could accept the responsibility for an important function while looking good doing it. Kathy managed to get a bit muddy and to break one fingernail representing our only casualty for the day.

Our next operation, after the air was over, was to again go back downtown to the Great Lawn docks at 7 p.m. to pick up and transport Kent Taylor and the Wave 3 crew back up the river to the Nugent Sand Company. Their plan was to ride back downtown on the huge towboat when it moved the four barges containing the digitally operated fireworks into firing position. Once the towboats and barges were downtown and in place, our job was to pick up the Wave 3 news crew and bring them back to port just before the event started. While waiting in the dark for the tow to weigh anchor, our task was made more difficult due to a lack of cell phone reception based on the number of phones in local use. It was also difficult to determine which towboat the news crew was on in the dark. We realized that we were close to the start of the event when some fireworks were set off and that we must hurry to embark our news crew passengers. After finding them onboard the most downriver towboat, they told us that they could stay on the towboat while the fireworks were released. We hit flank speed to move safely into our picket zone away from the fireworks show, getting out of harm's way just as it began.

The fourth and final assignment of the day for our crew was to again go down the river after Thunder was over to collect the filming crew from the tow boat. It was pitch dark, the wind was blowing hard, and the current was very fast. As we came under the Clark Memorial (2nd Street) Bridge, we soon recognized the large buoy marking the 12,000 pound anchor that helped hold the towboat and four barges in place. We followed the four barges back to the towboat only to realize that in fact it took two huge towboats to hold the barges in place. Both were running in forward gear at idle speed. Our task was to approach the two towboats by going upstream in their wake. This was accomplished on the first try without incident and our four filming charges, their cameras, life jackets, and equipment, were safely aboard our boat, the Contender. On the way to take the TV crew back downtown, we learned that only the first three barges contained fireworks. The barge nearest the towboats contained sand to protect the two towboats and their crews.

The Kentucky Derby has provided to this community the most exciting and well known two minutes in sports. Supported by this same community, the Kentucky Derby Festival has provided a world class three week event and community celebration. Each scheduled event is staffed by professionals and the required number of veteran and first time volunteers. I was honored this year to be among the volunteers on the Ohio River and to play a small non-speaking role in the river production. After this weekend experience, and my several years on the river, I trust that I have now become a river person, and therefore, I am entitled to say, "River people do it better." LM

Note: Dr. Henderson is a clinical professor at the University School of Medicine, Department of Pediatrics.
Dr. John Urton was a psychiatrist in a private practice with three dear friends, Bob O’Conner, Luther Pearce and Pat Galla. They were affiliated with Our Lady of Peace Hospital.

He started medical school in 1956 as a family man with three children. Another child was born during his school years and one more during his internship. Big families were the norm at that time.

His choice of a specialty was a shock to his fellow classmates. They had never pictured the class jokester in that field.

He was a down-to-earth, plain spoken doctor who tried to help his patients find their way back to becoming functioning individuals in society.

He had a supreme joy in his life. He was always interested in trying new things, even to the extent of building his own hang-glider and parasail. These were not always successful ventures; one almost ended in drowning.

Still, even after suffering two separate broken necks, he never lost his enthusiasm for life or will to live.

His children saw a father who dared to live life to the fullest, to never be afraid. His friendships were lasting and always filled with fun.

He was a special man that I was fortunate to share a life with for almost 64 years. It wasn’t enough.

- Kitty Urton
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JUNE 2014 31
Candidates Elected to Provisional Active Membership

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.

PHYSICIANS IN PRINT


NOTE: GLMS members’ names appear in boldface type. Most of the references have been obtained through the use of a MEDLINE computer search which is provided by Norton Healthcare Medical Library. If you have a recent reference that did not appear and would like to have it published in our next issue, please send it to Jennifer Howard by fax (502-736-6363) or email (jennifer.howard@glms.org).
Furthering the new perspective of our Medical Society Alliance requires that we first look backward into world history to understand more deeply the context of our founding and our future. Two hundred years before our founding in the early 1700s the Industrial Revolution was beginning and change was the word of the day. You see the world had been predominately family-centered, agrarian, and rural for all of its history and then was becoming industrial and urban at a speed that society could barely comprehend or adjust to competently. Before the revolution doctors and other professionals and craftsmen practiced in offices or workshops that were most likely a part of the home, with their families present.

The revolution required fathers to leave these familiar settings for the factories and leave their families at home, which had rarely happened in history except for military service. Later in the 1800’s high schools with teachers and coaches of athletic sports filled the void left when fathers left the home for the factories. This opened up the ability of many more women to volunteer outside of the home while their children left the home for school. In 1900 only six percent of married women worked outside the home. Hence, the founding of The Greater Louisville Medical Society Alliance was in 1926 to organize the spouses of doctors to volunteer to benefit the medical community in Louisville.

To check in with medical history here is to realize antibiotics had not been developed by Alexander Fleming yet and American society at that time was structured with male professionals and female spouses so that was adopted as the model of our Alliance. This model served well for many years but society had not stopped changing. World Wars, the women’s movement, the development of preschool, no-fault divorce, and many laws protecting women from discrimination have come into force in our society, and their effects have created a new normal. Today female medical students make up 57 percent of medical school classes and 74 percent of married women work outside of the home. The model the Alliance was founded to serve has completely changed in the past 88 years and just as those founders of our Alliance came together and realize the need, their mission, and their method, we must realize what needs to change and what needs to be retained.

This past year The GLMS Alliance had a 44 percent increase in paid membership, which is a sign to all of us that we are still relevant and able to maintain our Alliance. There is much to be addressed and planned for in the future and it is quite an exciting time in our history to reevaluate and align ourselves with our mission, the current needs of our community, and to incorporate the technology revolution into our methods, all to serve the Louisville medical community to the best of our abilities. I have enjoyed the past year as the President of the Alliance, and I look forward to being a part of this organization in this time in history and in the future.

Note: Contact Ilene Bosscher at alliance@glms.org or (502) 552-7319. To contact the Men in the Alliance Committee, email alliancemen@glms.org.
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Some of my patients end up at local anti-aging clinics. They look in the mirror in horror. They find themselves sweating and moodier and fatter and limper and more tired, and they cannot stand it. They go in search of miracle cures, and often they find them – expensively, and at their own risk.

Local doctors who run these places advertise all kinds of services, but nearly all require a high-priced excursion to the lab first. Every known measure of metabolism must be “baselined” as one patient called it. Insulin growth factor, ACTH and cortisol, estradiol, progesterone, several kinds of testosterone measurements (in both men and women), CBC, complete metabolic profile, every possible thyroid function test, individual vitamin levels, insulin levels, prolactin, and fancy lipid profiles with all the small dense and the large fluffy and the lipoprotein subsets: all are ordered and discussed in detail, with little notes on the reports exclaiming over minute deviations as well as actual abnormalities.

After that, they really get down to business (and business is the main theme here: this is quite a profitable undertaking across the country). Patients receive all kinds of compounded creams, and men may receive FDA approved preparations of testosterone. Some get growth hormone; many get small doses of antidepressants, but in my patients that is rare. Mostly it is a cocktail of vitamins, sex hormones, and sometimes low doses of phentermine, if they are on the weight loss plans. The vitamins are frequently bought there and are of course, costly but “purified” and “individualized.”

But the lab expense does not end there. Depending on the prescriber, many times a year more hormone levels must be done to keep the patient “balanced.” Often these are urinary or salivary and sometimes they require blood draws. No more creams would be forthcoming without this cost, so patients ante up regularly.

But they like it. The ones who are not scared by the whole thing and ask me about it up front, tend to go back until they run out of money, their menopause symptoms wane, or they lose their belief in the benefit. Of course, huge investments up front tend to foster belief in the treatment – it’s just human nature. And if creams are not enough, there’s more to hook the customer. One local site advertises Cancer Prevention, and I quote: “If your body is breaking down estrogen into a cancer promoting pathway, we can teach you which vitamins, supplements, and foods that can redirect the estrogen into the ‘good’ pathways.” Frequently there are “Wellness Consultations” that offer “biomarker testing” and all kinds of nutritional tests: amino acid levels, enzyme levels and certain body proteins can all be charged for, and then tinkered with, using “customized vitamin therapy based on an individual’s results.” I have one patient who is now at a skeletal 105 lbs because of advice to only eat certain things based on the “neolithic profile.” This person is proud of such weight loss and insists that all the vitamin supplements amount to superpowers.

Some sites offer botox, cellulite reduction, and dermal fillers. Some offer genetic testing and “immune system analysis” and “Cognitive Enhancement with Memory Protectors,” this last a masterpiece of marketing that mainstream science has so far failed to verify. Children can have “neurotransmitter testing.” My patients have undergone heavy metal testing and “detoxification” of various kinds, including chelation therapy. These tend to be the patients who look askance at all FDA approved medicine, but go broke buying shark cartilage and blue green algae pills; they write me evangelistic testimonials about chelation.

Under the Dietary Supplement Health and Education Act of 1994, compounded hormones applied to the skin are considered to be supplements, as herbs are. Therefore, all this prescribing is akin to the same legal regulation as homeopathy (not much).

The American College of Obstetricians and Gynecologists (ACOG) has written
(continued from page 35)

an official Committee Opinion which essentially refutes any assertion that bio-
identical hormone therapy is preferable, much less comparable, to FDA approved
treatments. “Because of a lack of FDA oversight, most compounded preparations
have not undergone any rigorous clinical testing for either safety or efficacy, and the
purity, potency, and quality of compounded preparations are a concern.” In addition,
the numerous blood, urine, and saliva tests used by these anti-aging clinics come
under fire. “There is no evidence that hormonal levels in saliva are biologically
meaningful.” They state, and I agree, that “If treatment is initiated for symptom control,
subjective improvement in symptoms is the therapeutic end point, and there is no need
to assess hormone levels. Hormone therapy should not be titrated to hormone levels
(serum, urinary or salivary).”

My patients are in the main convinced that all this is safe and though they have all signed some kind of release, hardly any

forms, give chemo, operate on someone, make an exact diagnosis, or save lives in the emergency room. It’s a cynical but lucrative use of one’s medical license. People will pretty much buy anything that promotes youth and beauty, especially if some doctor promises them it will work. There’s a chiropractor who advertises online, who gives coffee enemas for anti-aging (only with pesticide-free organic coffee that he sells you, of course!) using the Dead Sea Scrolls as his reference. I cannot say that most anti-aging clinics are promising results from coffee enemas. But I’d sure like to see the scientific studies that offer Level I evidence for these practices – and since these creams are not subject to FDA approval, I have a feeling such studies are very hard to come by.

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.

M EDICAL CAMOUFLAGE

Larry P. Griffin, MD

One of my most valued experiences is based on my time with the Navy and Marine Corps, in which, over a 23-year period, I was given the opportunity to learn and practice skills which I would never have developed.

In hostile environments, or in areas where covert operations are conducted, a critical skill is camouflage to prevent your targets from either detecting you at all, or at the very least misdirecting their activities so that they do not interfere with your agenda of strategy and tactics to accomplish your ultimate goal.

I don’t know about you, but I am really sick and tired of having every new initiative of the hospital being couched in terms of “best practices,” “patient safety” or “collaborative practice,” or bolstered by the arguments that it is being forced by JCAHO, CMS, the ACA, or some special organization with a single purpose or agenda in order for the hospital to get another “badge of approval” for its marketing schemes. And it’s not that I don’t believe in the concepts of patient safety and best practices. I am solidly behind those concepts. I just hate the idea that proper concepts of patient centered practice are inappropriately utilized for other purposes.

After all is said and done, most of those activities have nothing centrally to do with quality patient care or any evidence based best practices, but are intended solely to establish centralized control over the practice of medicine. The concept of the out of control doctor, for example, has expanded from appropriately insisting that physicians not treat co-workers in the hospital like chattel, to the idea that any criticism of the nursing staff for not doing the job entrusted to them by our patients and us is a threat to the individual’s self esteem, and therefore is a reason to send the physician a threatening letter without, of course, the benefit of the physician’s input in the first place. This is certainly an effective way of letting an individual physician know who is in charge, but also effectively stifles criticism of poor practices by hospital personnel.

Decisions are being made on a daily basis by hospital administrators, practice managers, and others which directly impact
on the priorities in our practice, the services available to patients, the quality of the care they receive, and the philosophy of the care to be provided with little or no input from the physicians empowered by law to provide that care.

If you want to see an administrator or manager sweat, suggest a meeting of the physicians who practice without one of them present, and discussing an agenda developed by the physicians, not by the managers. The single biggest fear of the current system would be a physician organization to discuss grievances, address patient quality issues of real concern, and once again place control of actual medical practice back into the hands of those who provide day to day care of patients.

Note: Dr. Griffin practices Obstetrics and Gynecology with Women's Care Physicians of Louisville.

LETTER TO THE EDITOR

Edgar A. Lopez MD. FACS

Physicians: Independent professional practitioners or employees controlled by health care's big players?

In the New York Times issue of February 14, 2014, an article written by Elizabeth Rosenthal and titled, “Apprehensive, many Doctors shift to Jobs with salaries,” the following information caught my attention:

Today, accordingly to the AMA Statistics, in the USA:

- 60% of Family Doctors and Pediatricians are employees.
- 50% of General Surgeons are employees.
- 25% of Surgical specialists including ENT, Ophthalmologists and others are employees.
- In 2007 24% of Cardiologists were employed; it jumped to 35% in 2012.
- Local Hospitals in the State of New Jersey bought, just recently, 22 private Cardiology practices.

These statistics reflect the rapid demise of the concept of the Private Delivery of Medical Care that has fallen in this country into the tentacles of the Private Health Insurance Companies that continue to siphon off, in a macabre way, the tax money that is supposed to be used for Health Care. Instead the funding of Private Health Care in the USA, the richest industrialized country in the world, is all about profiteering and the Wall Street dance of the stock market as it relates to escalating health care costs for everybody.

In the mean time, The Affordable Care Act has only brought more sophistication to the Profiteering Process of the Private Health Insurance Companies while still more than 45,000 citizens a year die because of lack of Health Insurance. Believe me these victims are hard working middle class citizens; they are not the immigrants (documented or otherwise), they are not the Veterans of War, they are not from the top 1%, they are not from below the poverty line, they are hard working individuals, low level executives and college graduates, adjunct Professors, low level employees of the same Private Health Insurance Companies, etc. who carry exorbitant deductibles in the newly baptized Platinum, Gold, Silver, Bronze plans that, in my opinion, rather than precious metals names should be called “chatarra” (which in Spanish means: scrap metal).

The concept of Incremental Health Care Reform sponsored traditionally and continuously by serious institutions like the AMA and the American College of Surgeons is another clear manifestation of a non-viable, non-sustainable system for funding and delivery of Health Care. It just doesn't work and the price for the ones left behind the affordability wagon is: death, debt, despair and mental illness plaguing the streets.

When you have an acute catastrophic illness and you are, for whatever reason, underinsured or even worse uninsured (don't know which one is worst) there is absolutely no time to wait for incremental shenanigans.

My dear colleagues, the only viable solution to save the Private Practice of Medical Care (Funding and Delivery) in this country and at the same time serve Everybody In and Nobody Out is a Single Payer System based on the bill introduced in the US Congress on repeated occasions thru the years by Rep. John Conyers: HR-676. We can call it also: Improved-Expanded Medicare for All, from birth to death and without the participation of the Private Health Insurance Industry. That bill will save at least 400 billion dollars a year, to begin with.

HR 676 is properly explained in the Web. Just Google HR676 and read the bill. Everybody's back is covered including the low level employees of the Private Health Insurance Companies.

I want to respectfully invite the Current President of the GLMS and the President Elect to a public conversation including Members of GLMS to discuss why HR 676 doesn't have the support of certain Medical Organizations. It is not even discussed. You bring your team of experts and I will bring mine.

Logistics and details can be properly planned.

Note: Member of Physicians for a National Health Program (PNHP) and founding Member of KY Chapter of PNHP.
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