LOUISVILLE MEDICINE

GREATER LOUISVILLE MEDICAL SOCIETY

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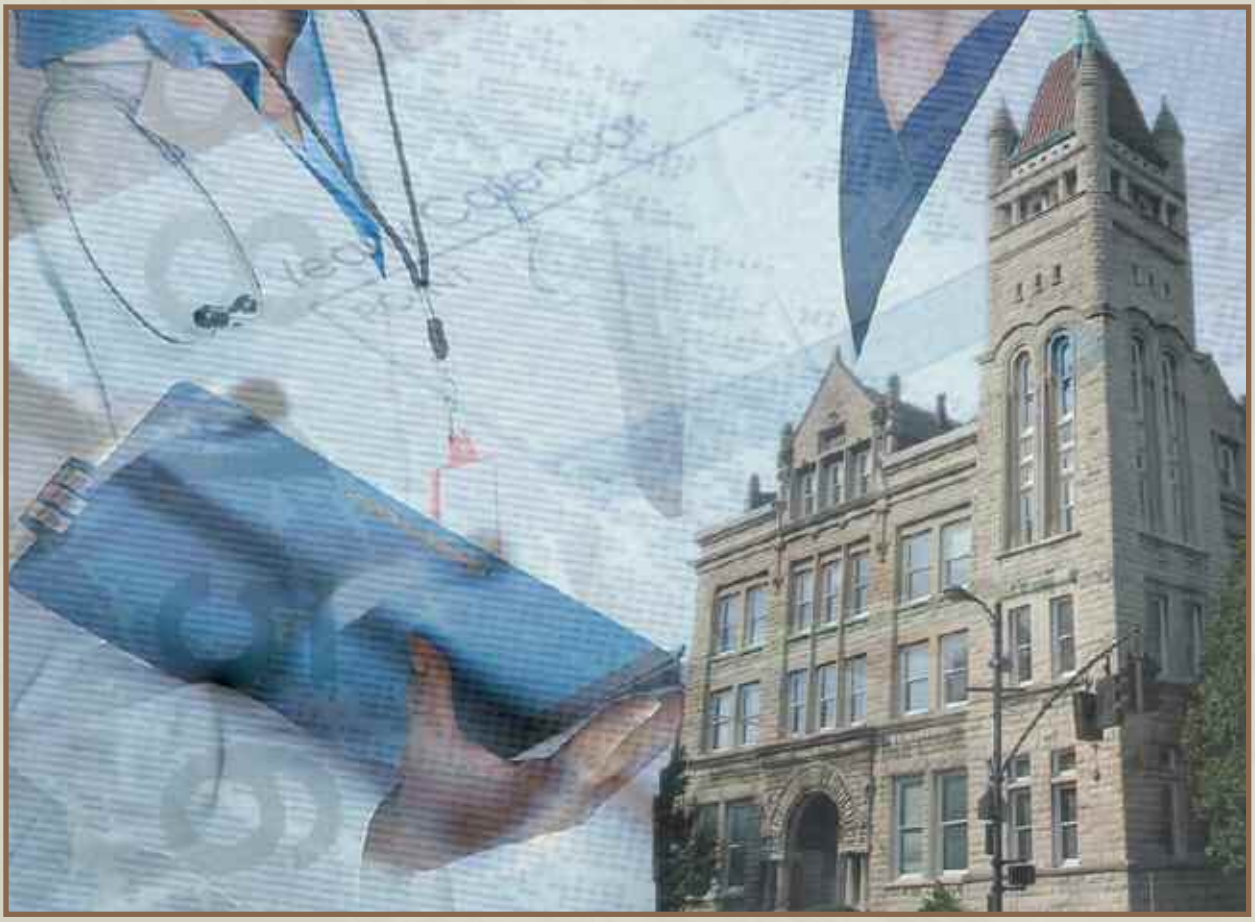
VOL. 55 NO. 12 MAY 2008



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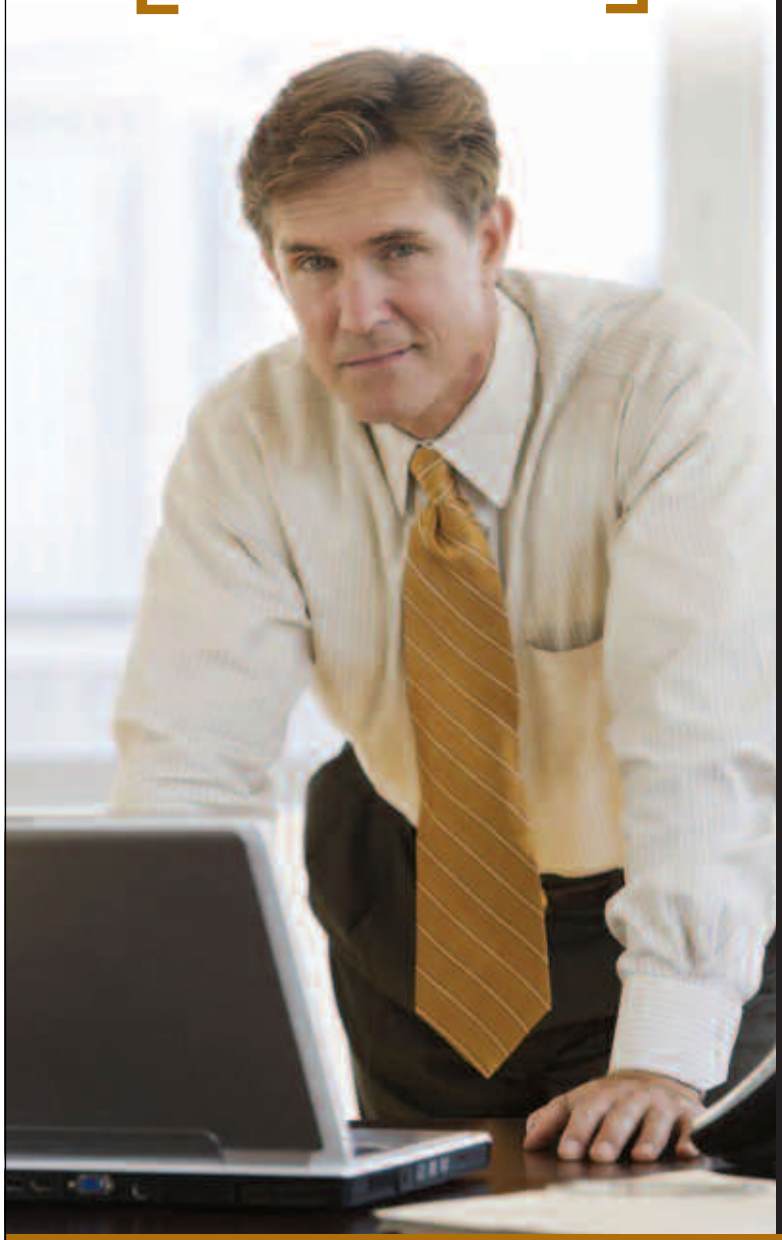

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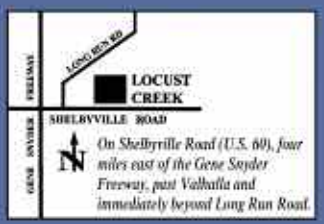

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LOUISVILLE MEDICINE
GREATER LOUISVILLE MEDICAL SOCIETY
VOL. 55 NO. 12 MAY 2008

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FEATURE ARTICLES

LOUISVILLE MEDICINE is published monthly by the Greater Louisville Medical Society, 101 W. Chestnut St. Louisville, Ky. 40202 (502) 589-2001, Fax 581-9022, www.glms.org.

Articles to be submitted for publication in ***LM*** must be received by the 1st day of the month, two months preceding publication.

Opinions expressed herein are those of individual contributors and do not necessarily reflect the position of the Greater Louisville Medical Society. ***LM*** reminds readers this is not a peer reviewed scientific journal.

LM reserves the right to make the final decision on all content and advertisements.

Circulation: 3,800

DEPARTMENTS

From The President

Randy Schrodt, Jr., MD
GLMS President

I would like to take the opportunity of my last president's column to express what an honor it has been to serve for the past year. I continue to be amazed by the scope of the activities of our society and it's members. I have also come to appreciate how critical a role our society has in helping determine the direction of medical practice in the coming years. At our recent annual strategic planning meeting, we had the opportunity to review the status and progress on various objectives and goals identified the previous year. The full strategic plan implementation report was 43 pages, and our accomplishments as a society are broad and impressive. Among the major initiatives are a few that deserve comment:

- The Trends in Medicine Task Force has begun review of the results of our commissioned survey on how physician employment by hospitals and other entities influences reimbursement, independent medical decision-making, referral patterns, and membership in GLMS. We anticipate new roles for the medical society in the coming years, including independent peer review and arbitration, and defining the ethics of issues such as non-compete clauses and the potential impact of employment on the physician-patient relationship.
- Nearly half of our members have been in practice 10 years or less, and the Leadership and Program Development Task Force is working on strategies to engage our younger members in GLMS activities and future leadership roles.
- GLMS continues to be recognized as the independent representative voice of the medical community. The role of the medical society in disaster planning has been acknowledged by invitations to be members on the HERA Region 6 and the Louisville/Jefferson County Executive Crisis Group.
- We have over 30 active committees that deal with issues as diverse as electronic medical record systems (Louisville Health Information Exchange: LouHIE), and quality improvement (such as our "Take AIM at Diabetes" program). GLMS has an effective legislative and advocacy process, and our society is increasingly being asked to provide our opinion on medical issues by our local, state and congressional leaders.
- GLMS is in excellent financial condition, our strategic planning and implementation systems are working well, our membership is at an all-time high, and our over 80 percent membership rate is one of the highest in the country. Perhaps our greatest asset is the collective good will and respect of our patients and the community at large. When we speak with a unified voice, the medical community can be extremely influential with politicians, business leaders, insurance companies, hospital systems, and the media.

Again, it has been an honor to be a representative of our society in various capacities over the past year, and I want to be among the first to welcome Mike McCall as our new president. Mike has agreed to continue the monthly column. I know he has many innovative ideas and I look forward to working together on the Board of Governors. I also want to thank outgoing chairman of the Board of Governors Dave Watkins for his tenure, and especially for his support and guidance. People have asked me dozens of times over the past year how much time the president's job has taken, and I honestly reply that it has been made easy by the truly incredible GLMS staff under the wise and dedicated leadership of Lelan Woodmansee. LM

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Commentary

Mary G. Barry, MD
Louisville Medicine
Editor
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NOT EXACTLY ROBIN HOOD

The best article in the April 1 *New York Times* was not, unfortunately, an April Fool.

Reporter Mary Williams Walsh explained in detail one of the reasons that the Social Security disability funds (SSI) will run out of money in about 20 years. That reason is the insistence by private disability insurance companies that claimants file for permanent SSI benefits, despite dubious qualification. This serves to get these claimants off their rolls, thereby shifting the payments onto the backs of the taxpayers. If SSI runs out of money, millions of Americans would go bankrupt, lose all ability to buy needed medications, lose their personal physicians, and join the hopeless hordes of the uninsured.

Unum Group, one of the world's largest disability insurers, took in revenues of $10.5 billion dollars last year. Ten billion! They paid out only $4 billion in claims, thus raking in profits on the order of the oil companies and Halliburton. Unum Group and Cigna have been sued by whistle-blowers who seek federal redress against this practice of "recklessly dumping people on Social Security's doorstep, without properly screening them to ensure a chance of qualifying." Why do the claimants go ahead and apply to SSI, even if they think they'll get better? Contracts say that companies can immediately stop paying any claimant who refuses. Additionally, the amount of the "claims reserve" funds that companies must keep bears directly on profits. These funds, intended to pay future claims, must be invested cautiously in short-term, more liquid funds instead of whatever is deemed most profitable. "It's all about the numbers," said one of the plaintiffs. This lawsuit will be heard in Boston in the fall. Plaintiffs include employees of these companies, attorneys who represent the disabled claimants, and the claimants themselves.

SSI spokesmen estimate that the investigation and processing of one person's claim costs about $1,200. The current backlog at the end of 2007 was 750,000 cases, extending the average wait for a hearing in front of an administrative law judge to 512 days, more than double the wait time for the year 2000. If the claim is pursued through several appeals, which it nearly always is unless the claimant has a clear-cut advanced cancer, the cost per case can rise above $4,500. The federal plaintiffs' law firm estimates that this industry practice of turfing the majority of claims to SSI has cost the government hundreds of millions of dollars over the last decade.

Unum Group has been sued more times than it can count, according to the *Los Angeles Times*, which quoted California Insurance Commissioner John Garamendi saying, "Unum is an outlaw company. It is a company that for years has operated in an illegal fashion." Unum was forced by legal settlements obtained by state regulators in 2004 and 2005 to re-review hundreds of thousands of case denials. As of mid-2007, it had reviewed only 10 percent of those. (Can't cut into the billions of profits by hiring properly trained and well-motivated workers, now can we?) Mr. Garamendi investigated this company for illegally placing a 24-month benefit limit on any case involving a psychiatric disability and for knowingly applying a wrong legal definition of disability, among other charges. Unum has been sued by claimants for videotaping them without their knowledge or consent (a practice about which I routinely warn my patients, after one of them got to view her tapes by legal order). Unum has been sued for delaying rightful payments for months and years. Unum has been sued for denying legitimate claims, for retroactively changing the date of a policy, and for insisting that some other insurance company must be liable to pay.

There are weeks I fill out 10 disability forms. We all have patients who must contend with three or four disability companies (each one of which requires a new form every three months). These companies employ the time-honored legal tactic of drowning the opponent in paper. There is very little evidence of continuity or even literacy in their approach. Typically, they repeatedly ask me to estimate how many pounds my patient can lift how often, and how long she can stand/sit/walk/bend/push/crawl even though she has been a quadriplegic for 20 years. Sometimes I just write "REMAINS TOTALLY QUADRIPLEGIC" across her form and sometimes I write "CRITICALLY PARALYZED FROM NECK DOWN SINCE 1985: DID YOU READ THE LAST FORM?" and yet, three months later, the same form appears. The executive functions of reason and thought appear nowhere in the disability insurers' lexicon. My attorney friends say, "Always say the word 'severe' if you believe the person to be disabled – it's the only word the computer is set to count."

I'll use the word "severe." People who prey on the sick and injured, then send you and me the bill, deserve raw frontier justice. A Mississippi chain gang is not harsh enough. I hope the Boston judge is a hanging judge, a judge who will fine these companies some of those billions to reimburse the taxpayers. I hope this judge walks severely, talks severely, carries a big gavel – and always, always, wins on appeal. LM

If you would like to respond to an article or commentary in this issue, please submit your response in the form of a Letter to the Editor. You may submit letters to the Editor online @ www.glms.org or by emailing our editor directly at editor@glms.org. The GLMS Editorial Board reserves the right to choose which letters will be published.

How to be a Happy Doctor – A Prescription: KY 20052

Timir Banerjee, MD

PREMISE: I have found that several of my colleagues are afraid to retire. The reasons are multiple but mostly because many are unable to decide what the future might look like and the possibility of having to deal with being a "non-doctor." I believe most doctors, as part of their personality, like to have control of the future. I have interviewed a large number of physicians in the two years prior to writing this essay. In the following article I will share some experiences that others may find exciting and possibly want to incorporate in the armamentarium of the stage of "after doctoring."

PRELUDE: I believe preparation of the mind has been one of the most important ingredients in my finding happiness as I slide down the hill of life on the way to the "valley of peace." There are some among us who think that they are walking. I am afraid the hill is steep on the down curve just like it was in the up-curve. I am convinced and I have accepted that there are no papers attached to the clipboard that will need to be filled out and there are no "co-payments" that will need to be paid because we will be seen at the designated time, no matter what. We cannot break this appointment and we are unable to be late. This one-time punctuality is maintained by the Master Doctor.

I believe life is like a residency except that during residency training we usually know approximately our potential time of graduation. So I have told myself that I will be prepared for graduation with an active mind even though my body may not remain as strong as I would like it to be. The strength of the mind is determined by our memory and ability to think and make decisions that may sound dare-devil. So I make it a point to read daily, keep in touch with friends who are encouraging and help those that might need my help. The choreography of the cosmic dance of Nataraja (Lord Shiva) and the cadence have been organized from the time we were born, much like the number of heartbeats we are supposed to have before the music stops. Well, it actually never stops. We just don't hear it. There can only be so many divisions of cells before the telomere becomes too small. It is not "All sound and fury signifying nothing" because we can either change the rhythm of the music or sing a different rendition. That's jazz, isn't it? Nat King Cole said it best in "Straighten Up and Fly Right."

Planning: Are you planning to be happy? I don't believe it can be done. Because we don't get up and say

we will be happy five years from now. Happiness is like contentment and is a feeling. It cannot be bought. Temporary pleasures are not happiness. They are joyful experiences much like vacations that always end with a return to reality. But we can plan to make money, be more prominent, be more generous, be more kind to others, etc. Sense of happiness is an elusive phenomenon Bertrand Russell wrote about in his excellent book "Conquest of Happiness." Sometimes we think that if we either have certain things or attain a certain stage in society we will be happy. In reality, if the mind is not prepared for the solace when we reach "there" we won't know if we are happy, or just there. Happiness is like the stage of Mahamudra, as Buddhists describe it. It may be like the state the baby sheep is in soon after it is born because it knows exactly where its mother's teats are located and it wiggles its tail in joy when it finds the favored organ.

Happiness is the stage when Govinda in Herman Hesse's "Siddhartha" realizes all there is to be had is right in front of him. It is a stage when we can cherish the joy of a mother's heart dancing in ecstasy because her own flesh and blood is not crying of hunger. **On the other hand if one is planning to be unhappy it is easy to do.** We can be mean, tease or bully and be greedy, conceited and self-righteous. These actions will certainly make us understand that we are unhappy, particularly when we are sitting quietly on the toilet seat and thinking.

Most of us surgeons possibly have a genetic predisposition of high energy. It is this energy that must drive us to bring joy to others not necessarily by writing prescriptions or by operating on brain tumors. This energy of ours must be transformed into a power of empowerment for another to succeed. We are all shaped by our life experiences, be it positive or negative. I believe our job is to make the experiences of others more positive through the sharing knowledge and expertise. I think demonstration of gratitude is of paramount importance in planting the seed of happiness. It is transmissible by action and not by lectures.

I woke up on my 60th birthday and planned to write to those teachers and professors of mine who changed me. I did not know most of their addresses but I knew the schools and the departments where they had taught. Do you know that I received several phone calls subsequently expressing joy and surprise? Dr. Dietz Wolfe was one of my instructors when I was an intern. I tracked him down and when I called him he was thrilled and asked me to visit him in Salem, Ind. "Don't come before 11 though because that is when I wake up, "he told me." "I am 92, you know." I called Ohio State University and thanked the professor of surgery for my education. Dr. Robert Zollinger and Dr. W. E. Hunt had passed on but I wanted to thank someone who was there now. I feel I reached my potential thanks to the help of the professors there. Special software was given to me that had become part of my brain computer. I had modified it and now was ready to offer them an updated version if they wished to download. It was my spirit. It was my energy. It was a time when I was thrilled to hear the voice of the next generation and ponder and share my trials and tribulations during the training.

I have learned to empathize. I called a couple of doctors who were students and rotated through neurosurgery when I was the chief resident. They are now in different parts of the country but they were thrilled to know that I acknowledged their help in getting charts ready and that they taught me how good penmanship is important and a necessary ingredient to avoid mistakes in medicine.

I called my geography teacher in India. He had passed on, but the school said that they would notify his family that I had called. Happiness is not a soap that washes off the dirt of the body. It is an emollient that soothes our skin and stays on the body and fills the chuck-holes and roughness. I had accepted that I was not very smart because even Rhodes Scholars are sometimes incapable of distinguishing between correct actions and indiscretions. I have never been a scholar.

One of the characteristics of most doctors is an inherit stubbornness. This quality is necessary to be a good doctor. I believe when we are done doctoring this skin has to be shed. We are used to telling people what to do so it is hard to give it up. The old adage, "I have many faults but being wrong is not one of them," is the hardest thing to overcome. It sits like a big boulder in the middle of the highway. The best way to push it aside is to ask our friends for help. It is the slipperiness of humility that allows it to be pushed aside much the way the Chinese built the Forbidden City—all the big rocks were moved by combined efforts of many during the time there was ice on the ground. **Happiness is the child of humility.**

Mahatma Gandhi said that there is not a day in a man's life when he cannot serve. My interpretation of this is that we must go out of our way to serve. As a doctor, we provide service every day; however, to be happy I think we have to go beyond our calling. We have to wash the feet of those that no one cares about much the way our God did for the disciples and told them to do so. I think Mother Teresa died happy. She came to Calcutta and was a school teacher. But she found happiness by dedicating her life to serving. Jesuit priests all over the world have given of themselves to society. A Jesuit priest at St. Joseph's Infirmary once gave me a Canadian dollar after I had removed stitches from his leg. "You will make many of these in your life but this has the blessing of an 80-year-old man," he said to me. I told him I would keep it with me

Continued on page 10

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as long as I lived. I still have it pasted with scotch tape as it has withered from handling and age. The blessing is always new and I didn't steal it from Joseph. It was given to me much like it was by the Bishop to John Val Jean as he lay in the candlelight in Victor Hugo's "Les Miserables." I think it is carrying a blessing that gives us happiness. There is a hidden strength in a blessing. It is stronger than the Chakras at the umbilicus. It is the power of Ohm. Actually the Sanskrit word and the electrical energy are very similar. It gives us the power of passing on a blessing. There is a lot more to a certain saying than what one might think, the supplication that the little Seventh-day Adventist children said in the '60s, "I am a little missionary trying to do my part, if you give me a dollar I will love you with my heart." It is the loving that gives us happiness. **Love is the mother of happiness.**

Precipitating Factors: Many of us are impulsive. Many are impatient. However, most of us have a high tolerance for discomfort because it is not possible to be a surgeon otherwise. We learn to make decisions under stress and we are flexible. But as I talked with my colleagues and evaluated my own life, it became apparent that loving is a difficult task for us. This is not necessarily one kind of love or the other such as agape, parental or spousal. Many of us are deficient in one area or the other. I recall going to see a woman psychologist after I got divorced. I wanted to find out what it was I was doing wrong. I wept non-stop at first and only then realized I had missed the boat. My love was conditional. It was the hardest thing to overcome. I wanted to be in control all the time. It is in being vulnerable that we have happiness. It is the openness and trust that is important for this dish. If you don't believe me go and see "Bronco Billy" again. The doctor who worked with Clint Eastwood was happy! I think Mel Gibson's movie about what women think brings temporary enjoyment but not happiness. I am convinced as we mature, women think totally differently about the area below the umbilicus, although so many guy jokes are directed towards that area. One prominent neurosurgeon once said that finding happiness in a conjugal relationship should be a race to see who can make the other happier. I say, "Always lower the toilet seat when finished." At least that is a start! I visited my daughter at Bryn Mawr a few times. There was a sign outside, "Man inside." The sign inside said, "Lower the seat. You are going to wash your hands anyway." So I wash my hands every day trying to overcome the issue of control. We doctors try to control our wealth even after our death. My father used to say, "Give it all away when you are alive and see the joy." I believe it.

I am not implying that having a frontal lobotomy as the character Jack Nicholson depicted in "One Flew over the Cuckoo's Nest," or having an Amnestic syndrome, are necessary ingredients for happiness. The determination and persistence we have within us as doctors can help us to try new opportunities. Our courage can help us in risk taking. I mean, doing things that we have never done before.

I think there is happiness and joy in challenging ourselves in areas to improve human suffering, to bring dignity to those who have been downtrodden, to be outraged, and to act in a way as to be like a brick on a road on which others will walk to a better world. But we don't have to conquer everything. We don't have to drink "life to the lees." We can be instruments of peace. We don't have to do our best all the time. We don't have to serve on the opponent's weak backhand. I believe happiness is in playing the forehand and keeping the ball going. It is in staying in the game that we have happiness. When one wins, the game is over just like when the other loses. There are a few among us who are bent on traveling from one cruise to the other. There are some among us who like to perfectly hit the white ball into a little hole. Happiness is in recognizing that there are no perfect games because there is someone somewhere who is better. So I am going to control my desire for living in the best house, and I am going to not worry if I have drunk only the next-best Chateau Mouton Rothschild.

As one scholar put it, desire is a habit. If you remove the "h," abit remains. If you remove the "a" the bit remains. If you remove the "b" still it remains. So I am trying to conquer my desires and believe in Lord Krishna as written in "Bhagavad Gita" that my responsibility lies in my actions only and not in the result. We are a result-oriented society. Here, quarterly reports are important for success. I know how to be happy. Am I successful in that?

The Feeling: Happiness is when everyone knows that something is magically different about us but we may not be aware. It is a time when I am not gasping on the Watterson, using expletives to vent my frustration or twisting the truth when I receive a speeding ticket. It is a time when work is fun, toil is joy and the sound of the nail I hammer to build a Habitat House releases echoes of joy for someone else. This happens even if I hit the wrong nail (ouch), while building bridges of brotherhood in a foreign land. Wow! This is the time when you buy a six-pack of Heineken from a Duty-free store because it is cheaper than buying two beers at the airport bar. Then you share a few with strangers. You recognize that you have had enough! Everybody loves a free beer. There is still time left before the flight boards. This may be the last flight but I shared joy.

I think we reach a time in our lives when we are ready to ride the SHIP, Society of the Happy Immigrant

Physicians, to the sea of the "Valley of the shadow of death." Here we are all immigrants but legal. The Master issues the passport when we are born. It never expires because no one actually dies. It is the acceptance of transformation of the eternal energy, Ohm, Nirvana, salvation, when birth is converted to death: two stages in the same cycle except during the former we move and moan and during the latter we are silent. God said, "I am the resurrection…He who believeth in me shall never die." I want to be with Him. **Happiness is in learning that God's spirit will find another body to quicken!**

Summary: I believe happiness and success are not mutually exclusive. We don't have to smoke cannabis. However, to find happiness we have to get out of the elusive rat race of desire because it is insatiable and we will be consumed even if we punctuate it with periodic cruises and other distractions. We must make time to love others and ourselves. We must bring joy to others by challenging ourselves and going places to help where our fathers couldn't. Happiness is in giving up control and surrendering. We have an opportunity to be happy through humility. Let us look at Sandro Botticelli's "Mystic Nativity" painting and watch the depiction of devils fleeing underground to hell and the winding path on earth leading to Christ recalling. This is imagery from Dante's "Divine Comedy." We should read poetry, learn to be humorous and always remember Thomas Gray's "Elegy Written in a Country Churchyard":

"Let not ambition mock their useful toil
Their homely joys and destiny obscure."

They are my brothers and sisters. Since we do not know our "Hayflick limit" we might as well be happy. (Dr. Leonard Hayflick of Wistar Institute determined that most cells in cell culture divide 50 times before they die. During the process they demonstrate signs of senescence and the telomere gets progressively smaller to carry genetic material.) When the fuse gets too small we can't run from it before it explodes. Life is fragile! LM

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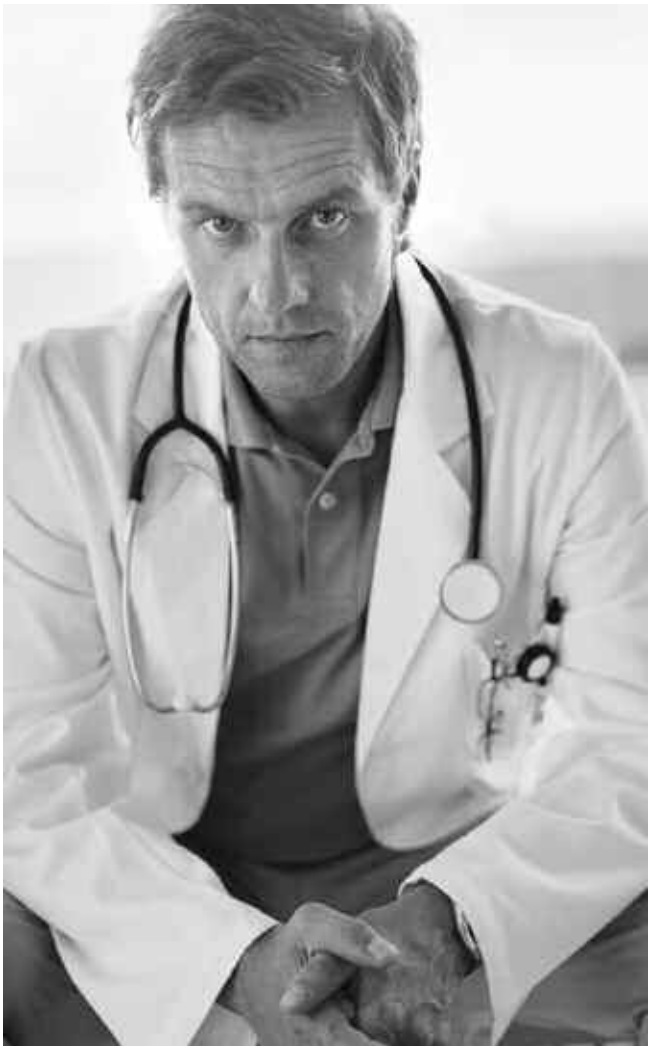

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IN REMEMBRANCE

CHARLES EUGENE WAGNER, PH.D.

(1923-2007)

"Today we will be discussing the anterior compartment of the thigh. But first…the limerick of the day!" Thus began uncountable lectures over the 54-year teaching career of Dr. Charles Eugene Wagner, professor of anatomical sciences & neurobiology at the University of Louisville. A tall, thin man of formal bearing, but informal spirit, Dr. Wagner, "Chuck or Charlie," stood rather stiffly in something close to the anatomical position before a screen displaying images on 2 x 2 slides, pointing out flawlessly and succinctly salient structures with his prized wood pointer ("The bulb never burns out," he would say).

Dr. Wagner's professional life was devoted to teaching gross anatomy and he was impressively accomplished in this endeavor. He naturally became a valuable mentor to his younger colleagues. More importantly, he was a friend and confidant.

Dr. Wagner was born in Memphis, Tenn. in 1923. He earned his A.B. in Biology from Princeton University and his Ph.D. in zoology from Indiana University. He began his academic career at the University of Louisville in 1952 and rose through the ranks to professor in 1970. He served the School of Medicine as assistant dean for admissions and student affairs from 1961 to 1965 and as associate dean of admissions from 1965 to 1974. Dr. Wagner continued to teach after his formal "retirement" as professor emeritus from 1991 to 2006. During his long and distinguished teaching career, Dr. Wagner received several honors and awards originating from both students and peers.

Dr. Wagner was preceded in death by his beloved wife and helpmate, Peggy, and he is survived by his three sons, Martin, David and Paul, and two grandchildren. His devotion to his family was profound and he spoke of them often with obvious love.

Chuck's penchant for organization was startling. He had lists for every conceivable situation, and these were filed in neatly labeled folders that bulged in several file cabinets. He saved documents and records compulsively. He was, as a result, the unofficial departmental historian and archivist. He placed a high value on having all rules and policies in writing, and he did love rules. He expected everyone, including himself, to follow them.

Dr. Wagner's love for his profession and his teaching subject was passionate. A stickler for detail, he demanded precision in terminology and description. He was an expert anatomist and a marvelous teacher. Dr. Wagner was scrupulously honest and thoroughly professional. He set the standard for ethical conduct and integrity, yet his demeanor toward the rest of us was warm and nurturing. His sometimes quirky humor and always pedantic personal style endeared him to students and colleagues alike. He was truly loved by all.

We can readily imagine Chuck Wagner standing in the anatomical position by the gates of heaven regaling St. Peter with a series of his most prized limericks. We are left poorer, but heaven is richer for his presence there. He was our beacon and our model, and we shall miss him terribly.

L_M

– G. Stephen Nettleton, Ph.D. and Ferrell R. Campbell, Ph.D.

Survey Takes Guesswork Out of Medical Society's Strategic Planning

By Matthew Ralph

Physicians in greater Louisville are generally satisfied with what GLMS has to offer, according to the findings of a Louisville-based economist and survey researcher.

Michael Bewley, of Enalysis, was commissioned last year to survey some 1,141 existing and potential members in the region. His findings were developed from a total of 326 responses—29 percent—to questionnaires delivered by hand, e-mail and fax to physicians over a month-long period in July and August of last year. The goals of the survey were wide-reaching.

"The primary purpose of the GLMS Membership Survey was to appraise and measure awareness of, opinions about the importance of, and satisfaction" held by Louisville area physicians with the services and benefits offered by the medical society, Mr. Bewley wrote in his final report, dated Oct. 8, 2007.

Bert Guinn, director of communications and membership for GLMS, called the survey the "most comprehensive" ever conducted by the society. "For new member recruitment, there's nothing like communicating the true physician perspective," Mr. Guinn said. "Before this comprehensive survey, we had to guess. Now, we know. Likewise, we no longer have to guess why some physicians have chosen not to be members." About 12 percent of respondents were non-members.

Lack of time was one of the reasons indicated by non-members for not joining. Time was also a factor indicated by members for not being involved more. Tradition, meanwhile, was the primary reason cited by respondents for joining. Listing in the annual pictorial roster was judged the most recognizable, most used and most important member benefit offered while vendor endorsements were ranked as the least recognizable and least important.

Findings indicated that 87 percent of all respondents classified their practices as "private," but when combining private practices managed by a hospital and physicians employed directly by a hospital the percentages of "solely" private practices decreased dramatically. Mr. Bewley has been commissioned to conduct a subsequent study looking more in-depth at the decreasing numbers of solely private practices and the impact this could have on the medical society and its membership. The margin of error for the statistical results was 4 percent, Mr. Bewley stated.

Mr. Guinn said the survey results have been distributed to all of the GLMS departments and will be used to "evaluate the level of awareness of their particular services for members and non-members as well as to gauge their own staff performance in each area."

"This will help us all tweak our services and determine how we should focus our communication efforts," Mr. Guinn said.

Continued on page 17

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Continued from page 15

One example of how GLMS departments are using the survey results already is an electronic report the Professional Relations department launched in late March. Dottie Hargett, director of professional relations, said the report will be going out to all members monthly, keeping them abreast of the latest information related to quality and advocacy. The Practice Q&A (Quality & Advocacy) Report will feature valuable tips and a host of other tidbits and resources ranging from insurance carrier updates to new claims information.

"We want members to be able to take advantage of the services we're offering," Mrs. Hargett said. Many of the department's services ranked low in the area of familiarity and awareness with those surveyed. For example, 62 percent of those surveyed were not aware of the department's Practice Management Hotline.

Survey results will also be used to assist elected officers during strategic planning sessions to help decide where the society's global priorities should be placed in the coming years. "It's always good and sobering to get a report card," Mr. Guinn said. "I see this survey as kind of a performance evaluation from our true customers: our members." "If we are not doing what a majority of our members want us to, then we have failed in our mission," Mr. Guinn added. I am pleased to see that overall we are doing a good job. I'm also glad to see that there is room for improvement."

For the full report, go to www.glms.org and log-in to the member's only area. If you do not know your member number or password, call the membership department at 736-6334.

The following is a sample of the survey's findings:

GLMS services and benefits are relatively well known by area licensed physicians.

Survey respondents indicated the following services or benefits as the most recognizable:

1. Listing in annual pictorial roster;
2. Subscriptions to Louisville Medicine, GLMS News, eVoice, and Vital Signs (for patients);
3. Eligible to serve on GLMS committees and task forces;
4. Right to vote in GLMS annual election;
5. Contributing to the improvement of public health by generating sustainable non-profits such as The Healing Place, Supplies Over Seas, and Health Promotion Schools of Excellence;
6. GLMS Web Site: www.glms.org.
7. Voice of Medicine to local, state, and national governments in collaboration with the KMA/AMA;
8. Fighting collectively for liability reform, Medicare reform, public smoking ordinances, and other worthwhile causes such as motorcycle helmet laws;
9. Inclusion in GLMS Referral Service: Live phone attendant and online physician finder;
10. Preserving The Old Medical School Building through the GLMS Foundation.

Survey respondents indicated the following services or benefits as the most important:

1. Listing in annual pictorial roster;
2. Fighting collectively for liability reform, Medicare reform, public smoking ordinances, and other worth while causes such as motorcycle helmet laws;
3. New members receive deep credentialing discount through CAPS;
4. Identifying negative payer trends and working to resolve them for members;
5. Inclusion in GLMS Referral Service: Live phone attendant and online physician finder;
6. Resolving grievances between members and patients;
7. Contributing to the improvement of public health by generating sustainable non-profits such as The Healing Place, Supplies Over Seas, and Health Promotion Schools of Excellence;
8. CME centralized tracking online;
9. Access to Insurance carrier Hassle Report Form;
10. Subscriptions to Louisville Medicine, GLMS News, eVoice, and Vital Signs (for patients).

Continued on page18

Sample from GLMS Membership Survey. Full report available at www.glms.org.

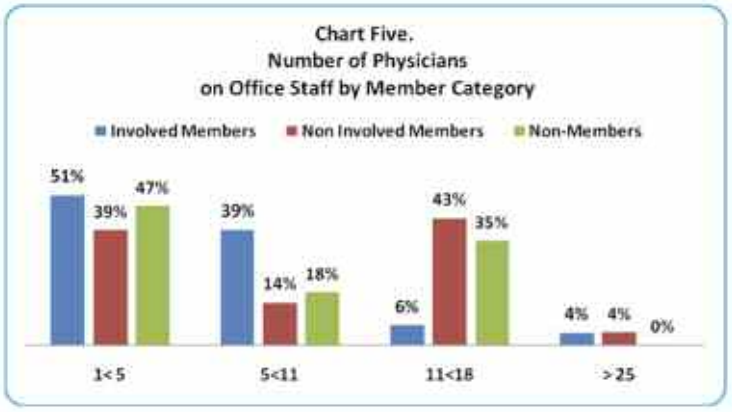


Chart Five indicates that relatively fewer physicians from offices with 11 and over office physicians are joining the GLMS and/or becoming involved with GLMS once they join.

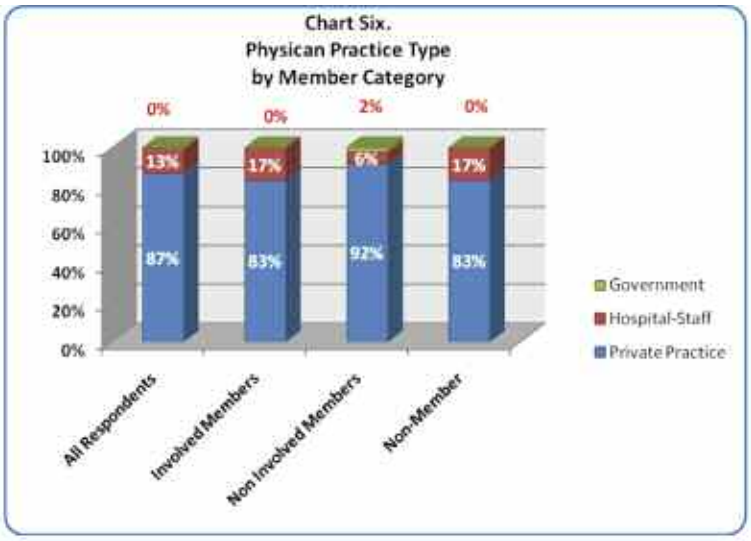


Chart Six represents survey respondent type classifications of their practices. 87% of all survey respondents classified their practices as "private".

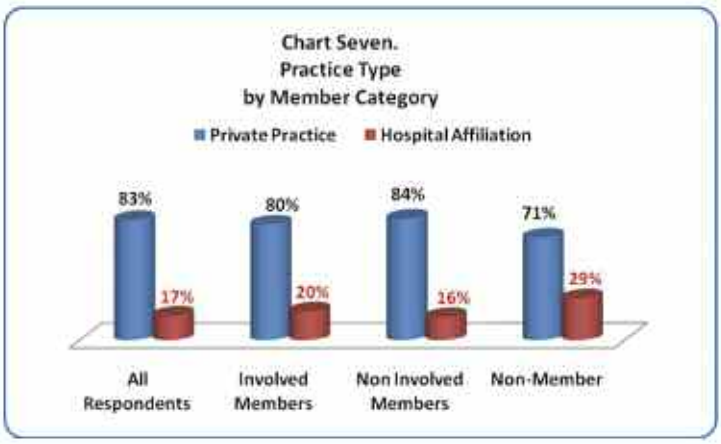


Chart Seven shows that when combining private practices managed by a hospital and physicians employed directly by a hospital, the percentages of "solely private practices" decreases per category.

Sample from GLMS Membership Survey. Full report available at www.glms.org.

TABLE THREE. GLMS MEMBERSHIP REASONS BY MEMBER CATEGORY	Involved Members	Non Involved Members
Tradition	22%	25%
Professional credibility	6%	19%
Networking opportunities	11%	17%
To support GLMS efforts on behalf of local physicians	17%	15%
To receive information about the practice of medicine	25%	14%
Professional advancement/ career development	18%	7%

Table Three indicates that tradition was the primary reason respondents generally joined GLMS.

Chart Eight reveals that the lack of time is the primary reason indicated by non-members for not becoming more involved in GLMS activities. Non-members also indicated that the lack of time prevents them from joining GLMS.

TABLE SEVEN. LEVEL OF INVOLVEMENT SOUGHT	Involved Members	Non Involved Members
My dues support is all I can do at this time	46%	56%
I would like to serve on a committee	30%	4%
I would like to seek a leadership position	10%	4%
I would like to lobby for physician interests	9%	34%

Interestingly, Table Seven shows that non-involved member respondents indicated they would like to become more involved if they could lobby.

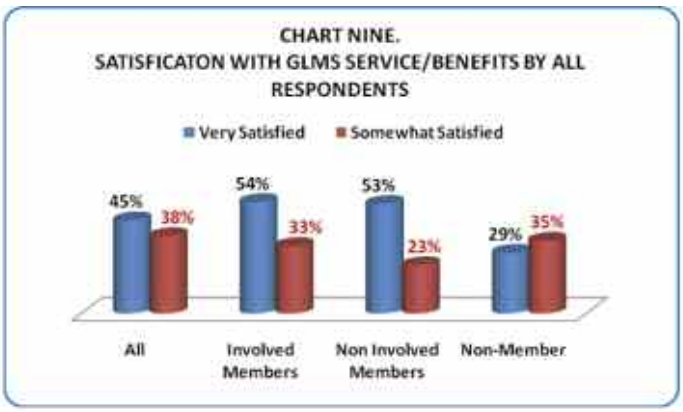


Chart Nine indicates respondent satisfaction with GLMS membership based upon the following question: All things considered, how satisfied are you with your membership in GLMS?

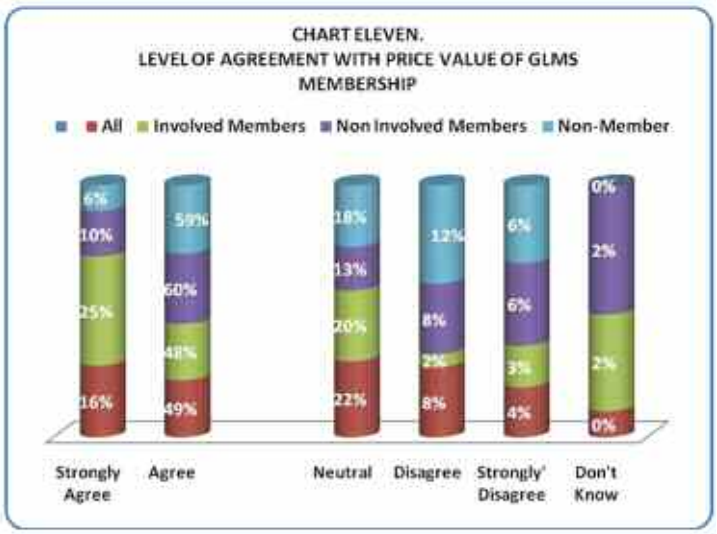
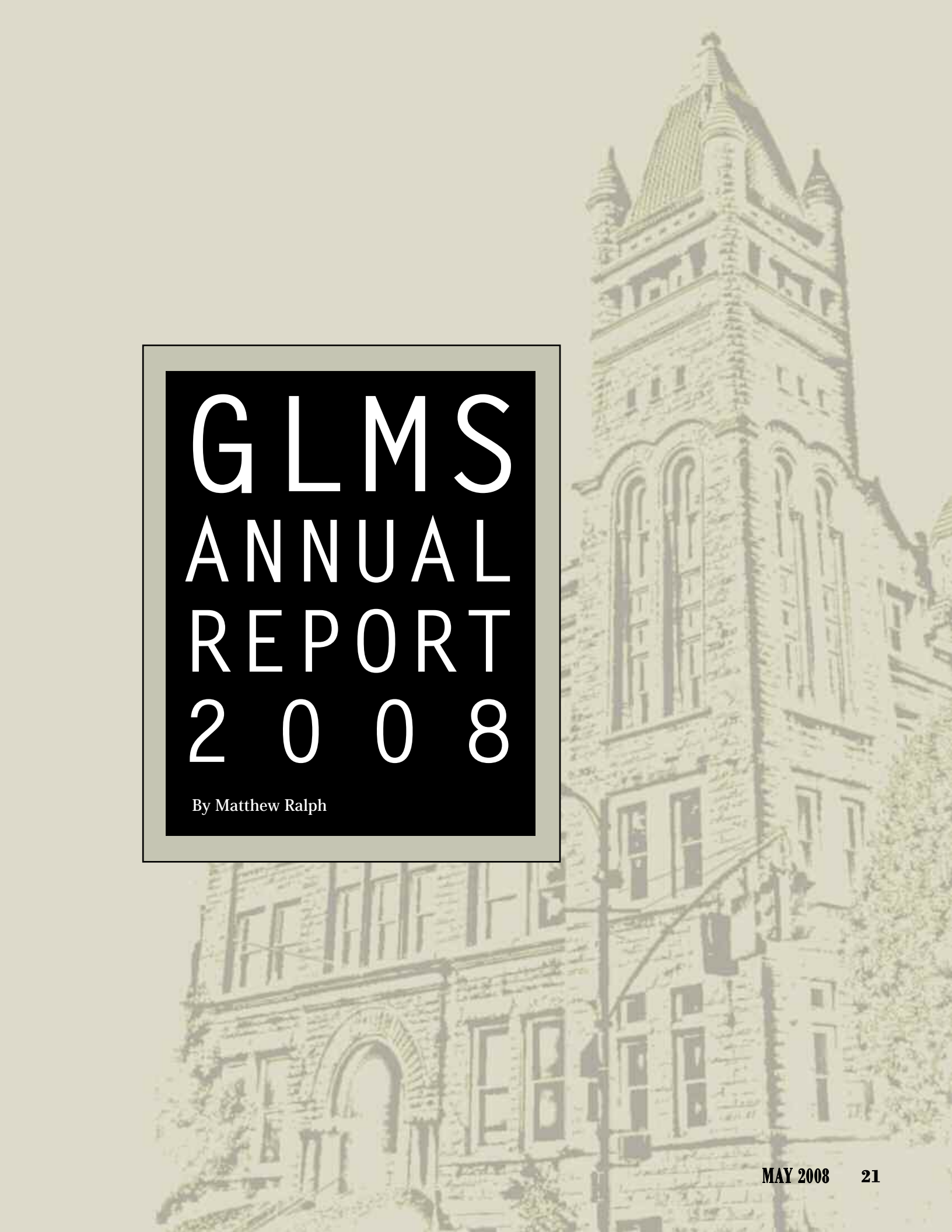


Chart Eleven shows the level of agreement with the pricing/value of GLMS membership.

LM



GLMS ANNUAL REPORT 2008

By Matthew Ralph

A pair of community health and wellness expos, a quality initiative aimed at diabetes treatment, and an essay contest launched in memory of a beloved physician are just a few of the highlights of a year that also saw the end once and for all of legal indoor smoking in public venues across the city.

From the highlights that grabbed local media headlines to the lesser known feats accomplished around committee tables and in public gatherings, the leadership, physicians, staff and countless volunteers of the 3,637-member Greater Louisville Medical Society accomplished its four-pronged mission to:

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

Under the guidance of President **Randy Schrodt Jr., MD**, many of the chairpersons of the society's 30 committees stepped aside in 2007 to make room for emerging leaders to take a more active role. The changes in committee leadership were part of a vision Schrodt had at the onset of his presidency to encourage more involvement at the committee level.

Schrodt, a psychiatrist, also oversaw the creation of two task forces. The Trends in Medicine Task Force was created to study the effect on society membership of an increasing number of physicians being employed by hospitals or large practices and the Leadership and Program Development Task Force was brought to life in order to discover ways to bring younger members into active society roles.

Past GLMS President Randy Schrodt Jr., MD, speaks to incoming residents at the New Resident Orientation in June 2007.

One of the first things Dr. Schrodt did upon taking the helm was to commission a comprehensive survey of area physicians, both members and non-members alike, to gauge interest and awareness of the many services the society offers (see complete report on that survey on page 15).

Dr. Schrodt wrote a monthly column in *Louisville Medicine*, sharing his opinions on health care reform, politics and the state of medicine.

Thanks to the effort of the communications department, GLMS received well over 100 hits (TV, radio & print) in the local and state media for its numerous initiatives and news releases. Likewise, GLMS received public praise from **Mayor Jerry Abramson** and **Adewale Troutman, MD**, director of the Metro Department of Public Health and Wellness, for its major role in helping to secure an amended and more comprehensive smoking ban. The society was honored again publicly by Mayor

Emery Wilson, MD, director of the Kentucky Institute of Medicine (left) and Kim Alumbaugh, MD, talk about the physician shortage in the state on WFPL-FM 89.3 show "State of Affairs" in February 2008.

(from left) Robert Powell, MD, Adewale Troutman, MD, director of the Louisville Metro Public Health and Wellness Department, and Louisville Metro Mayor Jerry Abramson at a 2007 press conference to discuss the smoking ban.

Abramson and Greater Louisville Inc. at an awards ceremony for its Well@Work wellness program, which was chosen as this year's Mayor's Healthy Hometown Work Site Wellness model for small organizations.

(left) Stephanie Woods, a GLMS advocacy specialist, gets her blood checked during a free health screening for employees in December. The screening was part of the award-winning GLMS Well@Work program.

PROMOTING THE SCIENCE, ART AND PROFESSION OF MEDICINE

In September, GLMS leadership presented the Kentucky Medical Association delegation with a record 16 resolutions covering items ranging from assisting practices with electronic medical record implementation to motorcycle helmet legislation. All but three of the resolutions were adopted during the annual meeting. The approximately 2,000 members classified as active in the GLMS make up about 39 percent of the total active membership of the KMA.

The society's credentialing service, Centralized Applications Processing Services, or CAPS, introduced new services to members including continuous credentialing and an educational series. Future plans include creating an online filing cabinet for renewable credentialing documents for GLMS members.

The society joined with the League of Women Voters for the first time to sponsor a debate between attorney general candidates—Democrat **Jack Conway** and Republican **Stan Lee**—in October. Dr. Schrodt was instrumental in casting the vision for this extraordinary partnership and seeing it through to fruition.

In January, the society's Board of Governors hosted **Lt. Gov. Daniel Mongiardo, MD**, at one of their meetings not long after the former state senator was sworn into office. Mongiardo outlined his plan to push for a statewide electronic health network during his talk with the board. While board members were mostly in agreement with the importance of e-health and its potential for reducing medical errors, some

Lt. Gov. Daniel Mongiardo, MD, talks to the GLMS Board of Governors in January about his plans to push a statewide e-health initiative.

expressed concerns with many of the issues Mongiardo did not touch on such as tort reform and profiteering by insurance companies.

NetGain Technologies, a technology management company, and National Insurance Agency, were added to the list of vendors endorsed by Medical Society Professional Services, or MSPS, the for-profit arm of the society. NetGain and NIA join IC Systems, National Processing Company and Republic Bank as vendors endorsed by MSPS under the leadership and direction of MSPS President **Stephen S. Kirzinger, MD**. GLMS members receive excellent customer service, preferred pricing, and other benefits when they employ the use of these preferred vendors.

Lobbying efforts in Frankfort centered on a push for the Patient Physician Partnership, a statewide campaign by the KMA targeted at addressing a state shortage, according to national standards, of about 2,300 doctors. The partnership, backed in part by leg

Thomas K. Slabaugh, MD, president of the Kentucky Medical Association, spoke about the Patient Physician Partnership during a news conference at the state capital in Frankfort on Jan. 30. Also pictured are Emery A. Wilson, MD, (right), director of the Kentucky Institute of Medicine and Preston Nunnelly, MD, KMA's state legislative chairman.

islation introduced during the 2008 legislative session, aims to ease health insurance burdens on patients and doctors, increase support for medical education, reject predatory lawsuits, improve Medicare and Medicaid funding and ensure physicians remain leaders in health care delivery.

National lobbying efforts focused primarily on blocking the looming 10 percent Medicare physician payment cuts. Working with the KMA and the American Medical Association, GLMS members contacted Congress to voice opposition to the plan. In the waning hours of the 2007 legislative session, Congress passed a law postponing the cuts by six months and instead gave a 0.5 percent increase in the payment rates. Lobbying efforts continue as the expiration of the six-month reprieve on cuts comes to an end next month.

In addition to letter writing and phone calls, President Schrodt and President-Elect **Michael McCall, MD**, traveled with GLMS staff to Washington D.C. in April for the annual AMA Advocacy meeting, where they had a chance to meet with Kentucky legislators and advocate for patients, the medical profession and the future of medicine.

GLMS President Elect Michael McCall, MD, poses for a photograph with U.S. Senator Mitch McConnell at the U.S. Capitol in March.

GLMS President Randy Schrodt Jr., MD, poses for photo with U.S. Congressman John Yarmuth at the U.S. Capitol in March.

The Professional Relations department, meanwhile, launched a monthly electronic report in late March aimed at providing physicians and office managers up-to-date information relating to practice management, advocacy and quality initiatives and services provided by the department. The report is called the GLMS Practice Advocacy and Quality Report (Practice Q &A Report) and will be sent electronically to all members at the beginning of every month. Professional Relations also created a phone hot line, enhanced web-based resources for members and polled office managers on numerous advocacy issues like charging for missed appointments and increased processing time for Medicare enrollment.

Physician Practice Advocacy Committee Chair **Michael Dee, MD**, oversaw a host of initiatives and services throughout the year ranging from a survey to identify communication barriers between insurance carriers and member physicians to establishing a support system and hot line for physicians attaining and sharing their new 10-digit National Provider Identifier numbers. Through a sub-committee, frustrations expressed by radiologists over the amount of administrative work placed on member practices by insurance carriers were also addressed. An educational series was held monthly on clinical practice advocacy issues and quarterly meetings with each of the

five major insurance carriers were held.

PROMOTING THE INTEGRITY OF THE PHYSICIAN-PATIENT RELATIONSHIP

An initiative aimed at improving the health of diabetes patients in Louisville was unveiled in September. Through a $70,000 grant from health care company Novo Nordisk, the Take Aim at Diabetes program has allowed the medical society to offer practice assessment, education for staff and patients, and tools for providing assistance and resources at no cost to the physician. The grant process was initiated by **Hiram C. Polk, Jr., MD**, former chair of the Quality Improvement and Patient Safety Committee and is being overseen by present chair **John N. Lewis, MD**.

The same committee coordinated the local efforts of the national Bridges to Excellence initiative and contributed to the Kentuckiana Health Alliance Quality Improvement Consortium, known as KHAQI-C. The committee also developed and published a glossary of quality terms available on the Web site (and regularly updated) to help physicians navigate through the alphabet soup of quality initiative acronyms and provided clinical input to the Quality Surgical Solutions "Surgical Time Out Survey" of local and state surgeons and hospitals.

The communications department continued its efforts facilitating communication between physicians and their patients about medical topics through the quarterly patient publication *Vital Signs*.

The six-page glossy publication—20,000 are distributed of each issue to patients through member physicians' offices—covered topics ranging from childhood asthma and stretching to kidney stones and colon cancer in four issues printed in the last year. Edited by **Charles Smith, MD**. The publication is supported by the employment services offered by the Medical Society Professional Services which promotes its employee services on the back of every issue.

ADVOCATING FOR THE HEALTH AND WELL-BEING OF THE COMMUNITY

An air quality study three years in the making proved what health officials have been saying all along: the only way to dramatically improve air quality is to eliminate indoor smoking altogether in public venues. University of Kentucky researcher **Ellen J. Hahn, DNS, RN**, presented findings in a news conference at The Old Medical School Building in February showing that the comprehensive ban had contributed to a dramatic improvement in air quality, even in venues with separately ventilated smoking rooms.

Local residents took advantage of free health screenings during a two-day Health & Wellness Expo at the Fairdale Community Fair in September.

While the controversy was brewing over a previous smoking ban later deemed unconstitutional by a judge for its exemption of Churchill Downs, the GLMS Community Health Committee—chaired by **Robert Powell, MD**—organized a two-day Health & Wellness Expo for the first time in September at the Fairdale Community Fair. Visitors to the free health expo took advantage of free health screenings for blood pressure, glucose levels and asthma. Among other things, smoking cessation

materials were distributed and information was provided.

Free health screenings were also offered to the public in the fall through a program offered in low-income neighborhoods by the Louisville Metro Department of Public Health and Wellness. A number of members participated in the project, making it possible for more than 1,600 people to be screened over an eight-week period ending in November.

Also in the fall, Board Chairman **David R. Watkins, MD**, organized a team of 13 physician volunteers to provide physicals to some 300 Special Olympians at the Kentucky Special Olympics MedFest.

The society also co-sponsored a pair of forums drawing attention to socio-economic and racial disparities in health and the growing number of uninsured Kentuckians. The first came in March, a week before the airing of the PBS special, "Unnatural Causes," which discusses how social circumstances are contributing to the risk of disease. Louisville was featured prominently in the first hour of the four-part series. The town hall meeting hosted by the Metro Health Department was opened to the public at the Kentucky Center for the Arts. The second forum was a gathering in April at the Galt House of legislators, business leaders, health care professionals and prominent community groups called The Innovation Forum on Kentucky's Uninsured. Speakers and presenters at the forum discussed what other states are doing to address the concerns of those without health care protection and allowed attendees to brainstorm ways to meet the medical needs of the half-million uninsured Kentuckians.

An electronic health record bank under development called the Louisville Health Information Exchange, or LouHIE (pronounced Lou-ee), gathered

Judah Thornewill, acting executive director of the Louisville Health Information Exchange (LouHIE) spoke to the GLMS Board of Governors about the progress of the electronic health record bank at a meeting in December.

steam last year with a community survey (the results showing public support for the service as long as safety could be ensured were announced at a news conference hosted by GLMS), development of a business plan and voiced support of the effort by state officials, perhaps most notably Lt. Gov. Mongiardo. The system's development coincided with developments on a national scale by technology giants Google and Microsoft, which both started test runs of systems to store and maintain electronic health records.

The Healing Place, a charity born out of the GLMS Foundation as an outreach program, made an exciting step forward in its efforts to provide hope for those struggling with alcohol and drug addiction by leading a $19 million fundraising campaign for a new women's facility. The innovative facility will replace their currently overcrowded quarters expanding services and availability for women and families torn apart by addiction.

In other GLMS Foundation-supported charity developments, Supplies Over Seas announced a partnership with Hand in Hand Ministries, a non-proselytizing international service organization based in Louisville. Through the partnership, HHM will take over operation of SOS with consultation and direct funding for operations by the Foundation over the next three years. The partnership is expected to bring SOS, started by member physicians in 1993, in closer touch with the people in third world countries. Donations of medical supplies help since HHM has the

resources and staff to travel abroad and sponsor trips to assess situations, build relationships and develop long-term solutions.

UNITING PHYSICIANS TO ACHIEVE THESE ENDS

An Actors Theatre production of William Shakespeare's "The Tempest" provided a unique social networking opportunity for about 100 physicians and their spouses in January. Thanks to the sponsorship of health care revenue company ZirMed, a pre-show chat with the theater's artistic director, social hour and tickets to the sold-out event were free for all GLMS members.

Members had several opportunities during the year to connect with medical school students and residents at the University of Louisville. GLMS physicians were invited to go on a field trip with medical students to see "Bodies, The Exhibition" in Cincinnati and made guest appearances in Gross Anatomy Labs at the invitation of Medical School Dean **Edward C. Halperin, MD**. GLMS also played host to more than 100 residents as they unsealed their fates at the annual Match Day event.

As in previous years, GLMS signed up nearly 100 new resident members at the New Resident Orientation and purchased the white coats for the UL medical students at the annual White Coat Ceremony.

Medical students at the University of Louisville School of Medicine show off their white coats donated by the GLMS during a ceremony held at the medical school campus in August.

President Schrodt spoke at both events providing encouragement to our future leaders in medicine.

Another program connecting physicians with medical students, Physicians Are Linked to Students (PALS), welcomed a record number of physicians serving as mentors to freshman medical students at an October kick-off dinner. The annual program, chaired by Chairman **Patrick Murphy, MD**, has 26 physicians serving as mentors to 91 students.

Tia Alton, a U of L medical student and Jim Wittliff, Ph.D., at the Physicians Are Linked to Students kick-off dinner in October.

Students and physicians were invited and encouraged to submit original essays about the everyday practice of medicine for the first ever GLMS essay contest, named in memory of **Richard Spear, MD**. The annual contest, organized by *Louisville Medicine* Editor **Mary G. Barry, MD**, is open to all GLMS members in March. Winners of the contest, which has categories and cash prizes for practicing and retired physicians, physicians in training and medical students, will be announced and published in the September issue of *Louisville Medicine*. Other essays will be published in subsequent issues as deemed appropriate by the Editorial Board.

As shown in the monthly *Louisville Medicine* columns by its dynamic president, Anita Garrison, the GLMS Alliance (a group that seeks to unite physician spouses) has been as active as ever with fundraisers like the "Day at the Track" at Churchill Downs and events like the "Sassy Hats" Luncheon at the Kentucky Derby Museum.

THE YEAR AHEAD

Continuing where his colleague **Randy Schrodt, MD**, left off, new GLMS President **Michael McCall, MD**, will be leading the society in the year ahead. For the first time, there will be a vice president in the mix of officers. The new officer post will be filled by the second place finisher in the 2008 election for president-elect.

With the help of a committed team of devoted volunteers, the leadership team is aiming to build on this year's successes and continue to bring a membership already in large number satisfied with what the society has to offer (according to the membership survey) more reasons to be proud of organized medicine in the Derby City.

2007 FINANCIALS

Greater Louisville Medical Society
Statement of Activities
January – December 2007

Changes in net assets		
Dues	$	714,658
Louisville Medicine Advertising		208,193
GLMS News Advertising		54,794
Roster Sales & Advertising		265,094
Centralized Application Processing Services		524,545
Society Office Services		3,440
Administrative fee from Medical Society Professional Services		47,000
Administrative fee from GLMS Foundation		38,000
Vital Signs		45,000
Web Site Advertising		7,400
Other Operating Revenue		9,193
Total Operating Revenue		**1,917,317**
Bequest		100,000
Investment Income		131,537
Total revenues	$	**2,148,854**
Program service expense		
Committee and general administration	$	858,730
Louisville Medicine		236,318
GLMS News		92,419
Roster		204,684
Centralized Application Processing Service		485,340
Society office services		1,960
Vital Signs		54,284
Web Site		19,586
Total expenses		**1,953,321**
Net increase in unrestricted net assets		195,533
Gain (loss) on sale of investments		37,064
Unrealized gain (loss) on marketable investments		(64,712)
Changes in net assets	$	**167,885**

CONCLUSION

As you've seen in the highlights compiled in this report, 2007-08 was an extremely productive year for the society. Keeping in mind that this report is only a quick snapshot of the past year, this may very well have been the most dynamic and productive year yet in the society's 115-year history.

This perhaps can be best summed up by the words of a former member who recently relocated to another state.

"Over the last few years I have seen the transformation and transition of JCMS into GLMS and the commendable work GLMS has done on behalf of the patients and the physicians of KY," Muhammad K. Ali, MD, writes. "Trust me; I have yet to see anything remotely similar by any city, county or state medial society or association [in this state]. Keep up the great work and thank you so much."

2007 FINANCIALS

Greater Louisville Medical Society
Statement of Financial Position
December 31, 2007

ASSETS		LIABILITIES AND NET ASSETS	
CURRENT ASSETS		CURRENT LIABILITIES	
Cash/cash equivalents	$ 518,756	Accounts payable	$ 49,535
Accounts receivable	138,627	Accrued expenses	14,494
Prepaid expenses	46,671	Unearned income	406,123
	704,054		**470,152**
INVESTMENTS AND OTHER ASSETS		DEFERRED RETIREMENT BENEFITS	
Investments at market value	1,468,668		77,686
Annuity contracts	77,686		
PROPERTY AND EQUIPMENT		NET ASSETS	
Leasehold improvements	85,926	Unrestricted	1,733,910
Office equipment	307,972		
Less accumulated depreciation	(362,558)		
	31,340		
		TOTAL LIABILITIES	
TOTAL ASSETS	**$2,281,748**	**AND NET ASSETS**	**$2,281,748**

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Stanley A. Gall., MD

"Far too many adults become ill, are disabled, and die each year from diseases that could easily have been prevented by vaccines."

-Centers for Disease Control and Prevention

Each year approximately 50,000 adults in the United States die from diseases that vaccines can prevent.(1) That exceeds the annual total for all traffic-related deaths in this country, (2) exceeds the number of persons dying from breast cancer and the number of persons dying from HIV/AIDS. This data compares with fewer than 100 childhood deaths annually from vaccine-preventable diseases.

Immunization guidelines from the Centers for Disease Control and Prevention (CDC) recommend a continuum of immunity from infancy through adulthood to improve the odds for good health throughout life. Vaccines recommended for adults protect against more than a dozen infectious diseases (see table 1).

Unfortunately, these vaccines are not widely administered, leaving not only adults, but also physicians needlessly vulnerable to potentially deadly illnesses. Today there are vaccines to protect against influenza, pneumonia, and other invasive pneumococcal diseases; tetanus, diphtheria, and Pertussis, hepatitis A and B, herpes zoster (shingles), human papilloma virus-spectrum disease; measles, mumps and rubella (German measles) and varicella (chickenpox).

The adult immunization concept has faltered because of a lack of knowledge and interest by the general public and many physicians; a lack of payment by Medicaid, Medicare and private insurers; and the failure of development of an adult vaccine program that continues the successful vaccine for children (VFC) program. An additional problem has been the lack of teaching of vaccines in medical schools and residencies.

Vaccine-preventable diseases carry high personal costs for individuals and are a major economic impact for society (table 1- page 35). The real cost of some diseases like hepatitis B and HPV infection are only realized decades after the initial infection when they lead to chronic liver damage, liver cancer, and cervical cancer respectively. Pertussis, the only vaccine-preventable disease on the rise in the U.S., can have significant consequences for adults and be fatal to infants.

The burden of disability and death from vaccine-preventable diseases represents a huge public health challenge. Consider Influenza: the overall societal costs of moderately severe influenza outbreaks may be $10 billion or more, excluding the value of lost years of life.(3) Annual Medicare hospital reimbursements for treatment of influenza can reach $1 billion.(4)

The cost grows with other vaccine-preventable diseases. Hospital care represents 90 percent of all treatment costs for adult pneumococcal infections.

Hepatitis B-related liver disease kills 5,000 people and costs an estimated $700 million annually for health care and productivity-related losses. Improving immunization rates in adults will help reduce personal suffering and the economic impact on society.

Low adult coverage rates compared to children

More than 90 percent of young children in the U.S. receive most of the vaccines recommended for them.(5) This is in contrast to low adult coverage rates shown in table 2 for influenza and pneumococcal disease, two of the costliest preventable diseases by both health and dollar measures, demonstrating that (1) adult Americans have a far greater appreciation for the importance of vaccinations in childhood than in later years and (2) the nation has not made the same sustained commitment to vaccination in adults as children. In 2005, more than $234 million was appropriated by the federal government to buy vaccines for use in public health programs: only an estimated 4.5 percent was used for vaccines for adults.(6)

Immunization during pregnancy offers a unique two-for-one protection. Pregnancy presents a special window of

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opportunity to protect an adult and a newborn simultaneously. There is no evidence of risk to the developing fetus from inactivated vaccines given to the mother. In fact, the CDC specifically recommends inactivated influenza vaccine for women who will be pregnant during the influenza season and other inactivated vaccines as indicated.

Barriers to adult immunization

- Lack of awareness: many adults are unaware of the potential risks of vaccine-preventable diseases, the need for booster doses to maintain maximum protection and the availability of newer vaccines. Many adults, health care workers among them, fail to consider that immunization can protect themselves, their families, and their patients.
- Lack of resources and knowledge: many health care providers fail to keep an adequate supply of vaccines on hand or do not keep up with vaccine guidelines. This is an important issue because doctors influence their patients' receptiveness to vaccines.(4) In a recent National Foundation for Infectious Diseases (NFID) survey, 87 percent of respondents said they were likely to be vaccinated if their physician recommended it, but only 41 percent said they were likely to ask for a vaccine if their doctor did not mention it.(7)
- Lack of incentives: health care providers may lose money when vaccines are administered to adults because of inadequate payment. Private insurance, Medicaid and Medicare all have financial and structural barriers that discourage routine immunization of adults.
- Lack of infrastructure: the health care system has not focused on developing the means to achieve high immunization rates in adults, with the exception of influenza and tetanus. For influenza, a long-term effort from local, state, federal governments, medical organizations, consumer groups, media, and alternative vaccination sites has heightened awareness of target populations for the vaccine. In reality, the target for influenza vaccines should be universal vaccinations for everyone each year and not focus on target groups.

Adult immunization rates are especially low among Hispanic, African-Americans and other minority groups(8) and the nation's 34 million foreign-born residents often enter the country with gaps in vaccination that put them at greater risk for diseases such as Hepatitis A(9) and rubella.(10)

Adult immunization must become a fundamental part of routine patient care. The success of childhood immunization programs was achieved in making vaccinations a standard feature of early-childhood visits.(5) Health care providers should be familiar with the latest adult vaccination schedule (www.cdc.gov/vaccines). Nurses, nurse practitioners, physician assistants, pharmacists and other professionals who have meaningful contact with adult health care consumers. should discuss and provide vaccination at all opportunities including well, sick and follow-up visits.

Changing behaviors of health care providers and consumers alike is a long-term process of education and reinforcement. Consumers should know that research is revolutionizing the field of immunization and that they need to participate in maintaining their own health. Health care providers should recognize that when recommending and or referring patients for all appropriate vaccines, they are endorsing high-quality care and the safety of their patients and communities.

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Table 1

Disease	Estimated number of cases/year	Disease consequence
Influenza and complications	15 to 60 million [a]	1% of all cases are hospitalized/yr -36,000 deaths annually (8% of those hospitalized)
Pneumococcal disease -pneumonia -bacteremia -meningitis	 500,000 50,000 30,000	UP to 175,000 people hospitalized annually: 5-7% die 20% death rate Neurological deficits (deafness to severe brain damage) seizures, coma
Hepatitis B	40,000	5,000 deaths annually Permanent liver damage Cirrhosis: liver cancer
Hepatitis A	270,000[b]	100 deaths annually Jaundice, nausea, vomiting, fatigue, fever
Pertussis	15,600	Bacteria pneumonia, loss of hearing, taste, risk of infant death
Herpes Zoster (shingles)	750,000-1,000,000	Incapacitating pain blindness, facial paralysis Loss of hearing, taste
HPV	> 6,000,000 [c] 10,900 cervical cancer	3,700 deaths due to cervical cancer, 4.0 million abnormal pap smears, 1.0 million new cases genital warts, 1.4 million cases CIN 1, 440,000 cases CIN 2, 3

a. Cases in all age groups including children
b. Estimated average number of infections before hepatitis A vaccine became available in the U.S.
c. The estimate of 6.2 million new HPV infections per year is for both men and women.

MMWR 2006; 55 (no RR-15)
MMWR 2006; 55 (RR-10) 1-42
MMWR 2002; 51 (RR-2): 1
MMWR 2006; 55 (RR-3) 1-34
MMWR 1997; 46 (RR-8) 1

Table 2: Current Adult Immunization Rate Lag Far Behind Natural Goals

Vaccine	Covered (yr)	2010 Healthy people coverage goal
Influenza 18-64 years, high risk [(a)] ≥65 years Healthcare workers	 15.5%(2006) 64.1% (2006) 42.0% (2006)	 60% 90% 60%
Pneumococcal disease [(a)] 18-64 years, high risk ≥ 65 years	 22% (2005) 63.7% (2005)	 60% 90%

[(a)] Non-institutionalized

MMWR 2006; 55 (32) 883-893

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The Grown-up with Congenital Heart Disease

Robert Solinger, MD, FAAP, FACC

Introduction

One of the paramount accomplishments of medicine in the last half of the 20th century was the success of childhood interventions for congenital heart disease (CHD) and the creation of a large cohort of adult congenital heart disease (ACHD) survivors. A major challenge for the first half of the 21st century is how to address the long-term surveillance and health care needs created by the transformation of complex and moderate CHD from a fatal to a lifelong condition.

Demographics

The incidence of infants born with CHD is approximately 10 per 1,000 live births. These patients can be divided into three groups: complex, moderate and simple heart disease. (1,2)

Complex heart disease, which is estimated to occur in 1.5 per 1,000 live births, includes conduits, valved, or nonvalved, cyanotic CHD (all forms), double-outlet right or left ventricle, Eisenmenger's syndrome, Fontan procedure, functional single ventricle, heterotaxy syndromes, hypoplastic left heart syndrome, interrupted aortic arch, pulmonary atresia (all forms), pulmonary vascular obstructive disease, transposition of the great arteries, congenitally corrected transposition of the great arteries, and truncus arteriosus. (1,2)

Congenital heart defects classified as moderate have an estimated prevalence of 2.5 per 1,000 live births and consist of the following lesions: aorto-left ventricular fistulae, anomalous pulmonary venous drainage, atrioventricular canal septal defects, ostium primum atrial septal defect, coarctation of the aorta, Ebstein's anomaly, infundibular right ventricular outflow obstruction, patent ductus arteriosus (not closed), pulmonary valve regurgitation (moderate to severe), pulmonary valve stenosis (moderate to severe), sinus of Valsalva fistula aneurysm, sinus venosus atrial septal defect, subvalvular or supravalvar aortic stenosis, tetralogy of Fallot, and ventricular septal defects with various associated lesions. (1,2)

Patients are considered to have simple CHD if they have isolated congenital aortic valve disease, isolated congenital mitral valve disease (except parachute mitral or cleft leaflet), isolated patent foramen ovale/small atrial septal defect; isolated small ventricular septal defect, mild pulmonary stenosis, previously ligated or occluded patient ductus arteriosus, repaired secundum or sinus venosus atrial septal defect without residua, or repaired ventricular septal defect without residua. (1,2)

History

In 1994, Moller ct al. reported that approximately 85 percent of children born with CHD could expect to reach adulthood. (3) That number is rapidly approaching 95 percent. As a result, the current estimated number of adults with CHD is one million, with approximately 400,000 having moderate to complex CHD. (4,5) Today, more adults than

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children have CHD, and their number is steadily growing.

The clinical approach to the ACHD patient is unique in cardiovascular medicine. Each patient, despite having similar diagnoses to others within ACHD, will be anatomically and physiologically unlike each other. (6) For example, with coarctation of the aorta (COA), the type of repair (end-to-end anastomosis, extended end-to-end anastomosis, subclavian flap, patch aortoplasty, balloon aortoplasty, balloon/metal or endovascular covered stent, or conduit), age at repair (newborn, infant, child, teenager, adult), associated defects (bicuspid aortic valve, ventricular septal defect, mitral stenosis, hypoplastic left heart syndrome, Shone's complex), and arch anatomy all portend particular long-term risks. There are different specific long-term risks for tetralogy of Fallot, transposition of the great arteries, and other moderate and complex lesions. While the general approach can be standardized to a degree based on the main diagnostic category, it must be individualized for each patient based on the particulars of each patient's anatomy, surgical and/or catheter interventions, and resultant issues.

Present

Toward the end of the 20th century, as a significant number of adults left pediatrics for adult care it quickly became apparent that there was a problem. Many complex patients, particularly those who underwent surgery before 1980, reported being told that they no longer needed to see a cardiologist, and many adults who have CHD reported believing themselves "cured" following childhood or adolescent surgeries.

In retrospect, these reports should not be surprising given the lack of knowledge about long-term ACHD outcomes at the time and the commonly held belief that these surgeries were curative. (1) What is more surprising is that many adult patients report the misperception they are "fixed" has been reinforced rather than corrected by their current health providers. When moderate or complex patients are cared for by primary care providers without being referred to even a community level cardiologist, this lack of referral can itself provide further evidence to the patient that they are "cured."1

Adult patients often refer to phrases such as "complete surgical correction" or "total surgical repair" to explain their perception of being fixed. To those unfamiliar with the complexities of CHD, these phrases can imply that the heart is "totally corrected" or "cured." In survivors of the arterial switch for transposition of the great arteries, parent statements that their child now has "normal heart anatomy," because he or she underwent an "anatomic repair" are common. Few understand that an arterial switch, like virtually all-complex CHD surgery, leaves behind abnormal hemodynamics and anatomy. Such phrases may also contribute to the general community provider's lack of awareness of ACHD as a chronic disease.

The possibility that many complex ACHD patients perceive themselves as graduates of cardiac care is supported by data suggesting that only a minority of adults living with CHD continue to seek appropriate levels of care. In the Natural History Study published in 1993, 40 percent of patients studied had not had a cardiac examination in over 10 years.7 Similarly, a study from the Canadian Adult Congenital Heart Network Consortium in 2004 reported that only 37 percent to 47 percent of patients had successfully transitioned from pediatric cardiology care to adult medicine; 27 percent had not been evaluated since turning 18 years of age.8 This rate of transition is expected to be lower in the United States than in Canada, given the more organized nature of the Canadian care system, the frequent transfer of patients to adult CHD clinics at age 18, and the lack of financial barriers to medical care.

Present Problem

The emerging consensus in congenital heart care is that health surveillance matters; delays in care can result in needless disability and loss of life. One illustrative example is Tetralogy of Fallot. In Tetralogy of Fallot, the patient may appear to be completely asymptomatic from their point-of-view, and when asked, reply that they are doing well. Yet, if there is significant pulmonary regurgitation, over time the persistent volume overload on the right ventricle (RV) eventually leads to severe RV enlargement, tricuspid insufficiency, RV dysfunction, malignant arrhythmias, LV dysfunction, congestive heart failure and death. Unfortunately, it may be late with respect to the RV's decline, since their "perceived" ability to exercise decreases ever-so-slowly over time. Thus, it is critical that these patients be followed in a center where there is expertise in determining the timing of a pulmonary valve implant, which should be performed by an experienced congenital heart surgeon before the RV becomes dysfunctional.

Yet, this new patient population is currently being followed by a variety of physicians, including primary care physicians who are called upon to participate in a critically important way in the health maintenance of the patient and the management of coexisting diseases and conditions. While approximately half of all adults with CHD are low risk and can be managed cost-effectively at the PCP level, it is recommended that patients of moderate and complex CHD should receive consultative cardiac care in specialized centers from physicians who have specific training and expertise in the care of children and adults with CHD.

Solution: The Congenital Heart Center at Norton/Kosair Children's Hospital

Although the Focus of care is in transition, the 32nd Bethesda Conference on the Care of Adults with CHD provided guidelines and recommendations with respect to the development of ACHD centers. (9) Norton Hospital, in junction with Kosair Children's Hospital, has created a Congenital Heart Center. Further, the administration is committed to recruiting an adult cardiologist to develop the adult program within that center. In the interim, adult patients with CHD are being followed by their primary care physician and adult cardiologist, with the pediatric cardiologists serving as consultants for their congenital heart disease. The center presently has three interventional cardiologists, an electrophysiologist trained in the various congenital malformations and specific electrical pathways, two congenital heart surgeons, several echocardiographers, pediatric cardiologists, three cardiovascular nurses and a large group of supporting personnel. In addition to the adult cardiologist, the hospital has authorized the recruitment of a trained cardiac MRI/CT scan physician to provide state-of-the art imaging.

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We Welcome You

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

Malaya, Ramon M (19831)
Angie K. Malaya
1138 Lexington Rd Ste 230
Georgetown KY
40324
867-6744
General Surgery 2000
Baylor College

McCubbin, Jason Patrick (12317)
Audubon Medical Plaza West
2355 Poplar Level Rd Ste 200
40217
636-7444
Internal Medicine
University of Louisville 2002

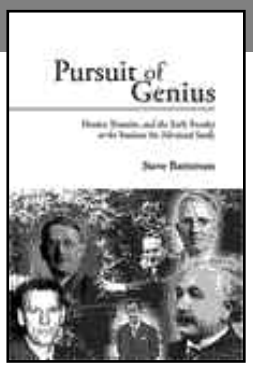
Oldham, Jr John S (10879)
Heidi Oldham
Bluegrass Bariatric Surgical Associates
3900 Kresge Way Ste 42
40207
859-992-2272
General Surgery 2007
University of Louisville 1995

Sweeney, Christopher Lowell (19668)
530 S Jackson St
40202
589-6788
Internal Medicine 1999 Pediatrics 2001
Southern Illinois University

Candidates Elected to Provisional Associate Membership

Folz, Emily (19742)
Rodney J. Folz, MD, PhD
1214 Spring St Ste 2 Jeffersonville IN
47130
812-283-5950
Diagnostic Radiology 1994
Washington University

Knox, Ellen (16948)
Robert Ricketts
510 Spring St Jeffersonville IN
47130
812-282-1888
Psychiatry 1989
University of Louisville



Pursuit of Genius -
Flexner, Einstein, and the Early Faculty at the Institute for Advanced Study

by Steve Batterson
A K Peters Ltd, 2006

Book reviewed by
M. Saleem Seyal, MD, FACC, FACP

"...a haven where scholars and scientists may regard the world and its phenomena as their laboratory without being carried off in the maelstrom of the immediate..." *Abraham Flexner, 1931*

"I am very happy in my new home in this friendly country and the liberal atmophere of Princeton." *Albert Einstein, 1935*

The founding of the Institute for Advanced Study in 1931, in Princeton, N.J., was a seminal event in the annals of higher education in the United States. This special place of learning was the brainchild of a middle-aged educator, Abraham Flexner, and came to fruition through the philanthropy of the Bambergers (Louis and his sister, Caroline Fuld) of Newark, N.J. This was an unusual culmination of one man's vision coupled with the generosity of two remarkable individuals resulting in the creation of a modern version of Plato's Academy in the United States amidst the great Depression. This unique institute currently consists of four schools, including mathematics, social science, natural sciences and historical studies, with 26 permanent faculty members and 190 vsiting members, as of 2006. Both T.S.Eliot, a Nobel Prize-winning author and John Nash (of "A Beautiful Mind" fame) once resided there. This educational enterprise does not confer any degrees, there are no scheduled classes, and no dissertations or theses are required from the permanent faculty or visiting members.

On the eve of the 75th anniversary of the founding of this "intellectual powerhouse," Steve Batterson has written a long overdue book about the history of this somewhat mysterious place where many Nobel Laureates resided and the likes of Albert Einstein, Kurt Godel, J.P.Oppenheimer and John Von Neumann scribbled on blackboards and held discussions during afternoon tea sessions. The book also details the behind-the-scenes intrigue, conspiracies, petty jealousies and mundane concerns of the faculty and power struggles of the board members and the learned "members" of IAS.

In the late 1920s, Abraham Flexner visited and gave lectures at Oxford University in London (later published as a book entitled "Universities"). He was particularly impressed by the setup of All Souls College, which had resident scholars but no students or classes. He had, by that time, already retired twice from two important jobs. He retired from his first job as principal of a private preparatory high school, called "Mr. Flexner's School" in his native Louisville, which he ran successfully for 15 years. Then as a restless 40-year-old educator he embarked on broadening his own horizons by studying at Harvard, Oxford and Bonn universities. Upon his return from Germany, he was hired as the surveyor of the then 155 extant medical schools in North America by the Carnegie Foundation for the Advancement of Teaching. The incisive and damning "Flexner report" of 1910 quickly catapulted him into educational icon status. He then joined the Rockefeller Foundation to implement his medical education reforms through the generosity of Rockefeller's philanthropy, a job he performed splendidly for 15 years.

Considered an educational wizard, he was approached by the aging and fabulously wealthy Bambergers, who wanted to leave a legacy in creating an educational institution by bequeathing their largesse to a noble cause. Initially, their objective was to create a Jewish medical school in Newark, but Abraham Flexner had his own ideas. He wanted to establish a scholarly haven where scientists, mathematicians, physicists and other scholars could reside and do their work, unencumbered by financial worries. He wanted to get "men and women of genius, of unusual talent and of high devotion." He had decided Princeton as the location and, after much wrangling, was able to persuade the benefactors and establish the IAS in 1930. He started the arduous process of faculty recruitment initially for the School of Mathematics/Physics, including the legendary group of Albert Einstein, Herman Weyl, John von Neumann, Oswald Veblen, James Alexander and Marston Morse—Europeans and Americans. By 1939, two other schools of economics/politics and humanistic studies were completed. Because of faculty rebellion, narrated with painful detail by Batterson, Abraham Flexner was regrettably forced to resign in 1939 and the torch of directorship of the IAS passed on to Frank Aydelotte, whose tenure lasted until 1945. Abraham Flexner had confessed to his successor that, "they wanted opportunities for scholarship, with high salaries (which he provided), but they also wanted managerial and executive power (which he was against) ⋯ and intrigued to get them indirectly."

Thus another chapter came to a close in the multifaceted and varied life of Abraham Flexner. He had succeeded brilliantly in creating an innovative institution in the annals of American education, one which has endured and thrived to this day. *The New York Times* described him as a "militant educator fighting for the higher things of life and especially for the education of the gifted" and the IAS as the "constructive embodiment of his philosophy." In 1947, Robert Oppenheimer, the famous scientist-administrator who was the director of the Manhattan Project, became the director of IAS and remained in that position until 1966. The subsequent history of the IAS is summarized in much less detail in the final chapters. Flexner's resignation as the Founder-Director of IAS was a traumatic experience for him, since he was betrayed by the very scholars whom he'd hired as faculty. He delved whole-heartedly into writing his autobiography- "I Remember" (Simon & Schuster, 1940) and quite magnanimously, he omitted his famous quarrels with Felix Frankfurter, Albert Einstein, Oswald Veblen and many others.

Although the Flexner-Veblen model of "membership" in the IAS has been widely applauded and is functional to this day, there has been criticism of the faculty component. Some have maintained that by the time one is appointed to the faculty, one's best work has already been done. Gertrude Stein's quotation, "It takes a lot of time to be a genius, you have to sit around so much doing nothing," is worth remembering even though she was not talking about the IAS. Richard Feynman, the charming physicist who participated in the Manhattan Project in Los Alamos, N.M. was a member of the IAS but declined an offer for a faculty position , preferring the university environment. His perspective is worth quoting;

"When I was at Princeton in the 1940s I could see what happened to those great minds at the IAS, who had been specially selected for their tremendous brains and were now given this opportunity to sit in this lovely house by the woods there, with no classes to teach, with no obligations whatsoever. These poor bastards could now sit and think

Continued on page 42

Alliance Activities

by Anita Garrison, GLMS Alliance President

Has it been a year already? May is the month the GLMS Alliance moves from one Alliance year to another. As we meet on May 12 for the "It's a Spring Thing" luncheon and annual meeting, Cheryl Houston, KMA Alliance President, will install our new officers and we will say thank you and good-bye to those who have served faithfully this past year.

Thank you to my husband, Neal Garrison, MD, for his incredible support this past year. He has been my cheerleader and advocate as I sometimes worked in the wee hours to put some finishing detail on a flier, article, or "fretted" over some of the planning for the Alliance. He was 100 percent behind my position as president of the Alliance this year and gave me the gift of patience and encouragement with the time I needed to spend on Alliance business.

Thank you to all the physician spouses of the Alliance Board of Directors, both officers and committee chairs. Because you were willing to sometimes eat store-bought pizza or look the other way when some home things were overlooked, your Alliance Board spouse was able to attend an event or meeting or help with other volunteer efforts of the Alliance. Please continue to support these efforts and encourage your spouse to join if they are not yet members. *Watch for that dues mailing and give it to your spouse!* ***Please!***

Thanks to the generosity of our members we:

- Raised approximately $5,000 at our annual "Day at the Track" for health careers scholarships.
- Provided $2,300 for Christmas gifts for 500-plus men and women who seek shelter and rehabilitation at The Healing Place.
- Provided $2,000 to Hospital Hospitality House.
- Provided $1,000 to the U.S. Marine Hospital Foundation for restoration of this important medical historic landmark.
- Showered Gilda's Club with knitting, sewing and other craft materials for the support of people and their families affected by cancer.

Thanks to the 2007-08 Board of Directors for their faithful meeting and activity attendance, support for me and willingness to help in various ways. It has been a joy to work with such a delightful group of ladies. I consider many of them dear friends. **With their help, and that of many of our members, we were able to:**

- Welcome new members at our fall brunch;
- Hold a craft shower;
- Decorate The Healing Place for the holidays and wrap Christmas gifts;
- Provide meals for Thanksgiving, Christmas and on a monthly basis for people who used Hospital Hospitality House while their loved ones were hospitalized;
- Enjoy a wonderful Christmas Tea in Bardstown;
- Indulge in an evening of spa fun where we welcomed some new members;
- Participate in an educational program at Kentucky Organ Donor Affiliates;
- Hold a successful Doctor's Day Luncheon to honor GLMS retired physicians;
- Get the word out about legislative issues relating to our physician spouses and their practices;
- Provide opportunities for friendships among medical families with Lunch Bunch, Walk n'Talk and Bridge.

Thank you 2007-08 Board!

Mimi Prendergast – Pres-Elect and Fall Fundraiser
Jeannie Kral - Vice-President and Membership

I have been honored to be a part of the GLMS Alliance as we work to fulfill our mission *to encourage support among doctor's families and to promote health education and community service.* I look forward to enjoying a less hectic schedule and working with Mimi and her new board in the coming year.

Happy Spring!

Rhonda Rhodes - Corresponding Secretary and Health Careers
Michelle Feger - Financial Secretary and Roster
Adele Murphy - Treasurer
Barbara Davis - Parliamentarian
Susan Yared, Advisory and Day at the Track
Ruth Ryan - Advisory and Finance
Jo Ann Daus - Advisory
Debbie Bruenderman- Advisory
Antoinette Linville - Medical Foundation
Barbara Cox – EMS
Joan Rumisek – Program & Fall Brunch/May Lunch
Ann Kasdan - Foundations, KMAA/AMAA
Arlene Redinger - Bridge
Millicent Evans & Fu Mei Tsai - Doctor's Day
Margaret White - Friends
Lisa Sosnin - Gilda's Club
Betty Allen - The Healing Place
Marie Schwab - Hospital Hospitality House
Angie DeWeese - U.S. Marine Hospital
Kat Mushkat - Walk n' Talk
Mitch Shirrell - Advisory
Marcia James – Legislation
Shirley Wheeler - Communications
Daphne Franklin - Liaison to Intern/Resident Spouses
Alice Cowley - McDowell House

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

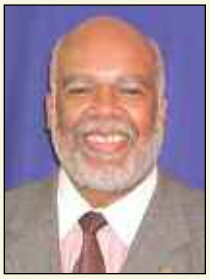
BOOK REVIEW Continued from page 40

clearly all by themselves, OK? So they don't get an idea for a while. They have every opportunity to do something, and they are not getting any ideas."

Feynman goes on to imply that without the intellectual stimulation from the students and without enough activity or challenges, creativity declines. While Flexner recruited brilliant scholars in the 1930s with the understanding that there were "no duties, only opportunities," by the 1940s, IAS was getting a reputation as "a magnificent place where science flourishes and never bears fruit." It is, however, important to remember that in June 1946, John Von Neumann built a high-speed computer in the basement of Fuld Hall at the IAS. It was later unveiled in June 1952 by Robert Oppenheimer and Von Neumann as the fastest electronic brain in the world, thus launching the computer revolution many decades later. Steve Batterson, the author of "Pursuit of Genius" was appointed as a member of IAS in 1980 after earning his Ph.D. in mathematics. He maintains that the role of faculty is an extraordinary resource for the members and the mere inspiration derived from walking in the footsteps of Einstein and others was extremely worthwhile. Writing in his diary in 1948, Abraham Pais, who resided at the IAS campus commented, "This is an unreal place. Bohr comes into my office to talk, I look out of the window and see Einstein walking home with his assistant. Two offices away sits Dirac. Downstairs sits Oppenheimer…"

Batterson's book is well-researched with extensive references to the voluminous correspondence of Flexner, plus material gathered from a myriad of archival sources. I highly recommend it. Another book worth reading about the subject is Ed Regis's "Who Got Einstein's Office—Eccentricity and Genius at the IAS" (Addison –Wesley, 1987). The definitive biography written by Thomas Neville Bonner entitled "Iconoclast—Abraham Flexner and a life in Learning" should be read in tandem with the "Pursuit of Genius." LM

PBS Series Highlights Health Disparities Forum held to raise awareness and spur action



Adewale Troutman, MD, MPH, MA

More than 500 people crowded into the Bomhard Theater at the Kentucky Center for the Arts on March 20 to preview a portion of the ground-breaking Public Broadcasting System health series, "Unnatural Causes: Is inequality making us sick"?

Following the screening, the event became a town hall meeting to discuss issues raised by "Unnatural Causes" and to begin to formulate community strategies in response to the series. On hand were series producers Llew Smith and Christine Herbes-Sommers. Also on hand were several Louisville residents who star in the opening episode. "Unnatural Causes" examines the social determinants of health. It explores how the social conditions in which Americans are born, live and work profoundly effect health and longevity, even more than medical care, behavior or genes.

Despite the fact that the United States spends more than twice as much per person on health care as other industrialized countries – 16 percent of the Gross Domestic Product in 2006 - our country has some of the worst health outcomes among industrialized nations. We rank worse than 28 other countries in life expectancy (including Jordan) and worse than 29 other countries in infant mortality (including Slovenia).

Why is this? "Unnatural Causes" gives what may be a surprising answer for many.

The series coincides with the election year debate focusing on the estimated 47 million Americans lacking health coverage. While embracing the essential need for universal health care, "Unnatural Causes" goes further, questioning what makes Americans ill in the first place. The series probes why economic status, race and zip code are more powerful predictors of health status and life expectancy than good genes or even smoking, exercise, or nutrition. The centerpiece of the four part series is an hour-long opening episode, "In Sickness and in Wealth," filmed in Louisville.

The lives of Jim Taylor, CEO of University Hospital; Tondra Young, a medical technician and lab supervisor; Corey Anderson, a maintenance worker; and Mary Turner of the Portland neighborhood, illustrate how social class shapes access to power, resources, and opportunity, all of which affect our health and life expectancy. As Mary Turner said at the town hall meeting, "I live it. My friends live it. My neighbors live it."

"In Sickness and in Wealth" shows Louisville Metro Public Health and Wellness Department data maps that indicate 5 and 10 year gaps in life expectancy between our city's rich, middle and working class neighborhoods. This pattern is repeated across America. Here are a few national statistics:

- People in the highest income group can expect to live, on average, at least six and a half years longer than those in the lowest. Even those in the middle (families of four making $41,300 to $82,600 per year in 2007) will

die, on average, two years sooner than those at the top.

- Low-income adults are 50 percent more likely to suffer heart disease than top earners. Those second from the top are almost 20 percent more likely than those at the top.
- Rates of illness for U.S. adults in their 30s and 40s with low income and lower education are comparable to those of affluent adults in their 60s and 70s.

This is not just a problem of the poor and people of color. Almost all of us are affected. There is a continuous wealth gradient, or pyramid, with health tracking wealth from top to bottom. Those at the top hold the most power and resources and, on average, live longer healthier lives. The rest of us do worse – some even much worse. It's not just the poor who are dying. Those in the middle are almost twice as likely to die an early death as those at the top. Should the amount of money we have determine how long we live or who gets sick or who doesn't?

I don't believe so. People should have the same opportunity to live their lives no matter what their socio-economic status or their race. Health is a basic human right. This is the single most important health issue of our time! "In Sickness and in Wealth" features the opening of the Center for Health Equity in Louisville and offers the center as one possible solution focusing on improving health by advocating policy change. Established by Mayor Jerry Abramson in 2006, the Center for Health Equity is involved in initiatives focusing on crime reduction, economic development, infrastructure building, youth engagement, and community empowerment. "It's a focus we are very concerned about," Mayor Abramson said.

"In Sickness and in Wealth" aired on the Kentucky Educational Network (KET) on Thursday, March 27 at 10 p.m. At 9 p.m. that night KET1 also aired the locally produced "Unnatural Causes: A Connections Special." The show featured highlights from the town hall meeting as well as interviews with health experts from across the state. The other three episodes of "Unnatural Causes" aired on KET on successive Thursdays.

We look at the event on March 20 as a first step toward making the lives of all Louisville citizens healthier. We hope to involve the public, the business sector and community educators and others in making the health playing field more level. If you would like to participate in strategizing, planning or even just learning more, phone the Center for Health Equity at 574-6616. **LM**

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