ST. LOUIS METROPOLITAN
MEDICINE
VOLUME 42, NUMBER 5 OCTOBER / NOVEMBER 2020

ELECTION 2020

The Candidates on Health Care

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Graphic design by Lisa Troehler Graphic Design, LLC

St. Louis Metropolitan Medicine (ISSN 0892-1334, USPS 006-522) is published bi-monthly by the St. Louis Metropolitan Medical Society, 1023 Executive Parkway, Suite 16, St. Louis, MO 63141; (314) 786-5473, FAX (314) 786-5547. Annual Subscription Rates: Members, $10 (included in dues); nonmembers, $45. Single copies: $10. Periodicals postage paid at St. Louis, MO. POSTMASTER: Send address changes to: St. Louis Metropolitan Medicine; 1023 Executive Parkway, Suite 16, St. Louis, MO 63141.

Advertising Information: www.slmms.org/magazine, or editor@slmms.org or (314) 786-5473. Online copies of this and past issues are available at www.slmms.org/magazine.

Printed by Messenger Print Group, Saint Louis, MO 63122.

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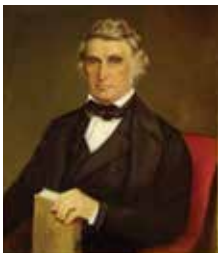
Election 2020

Features



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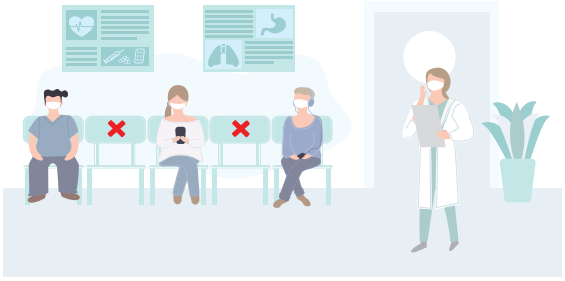

News

Mask Up . . . Because It's the Right Thing to Do

The following article by SLMMS President Jason Skyles, MD, originally appeared in the August 21 St. Louis Business Journal.

Jason Skyles, MD

One of our best prevention strategies available now is simple and straightforward—the wearing of face masks to help prevent the spread.

The COVID-19 pandemic has most certainly upended our economy, our community and our everyday way of life. In medicine, it has changed how we deliver health care services and impacted all of our practices. Until there is an approved medication to treat or a vaccine to prevent COVID-19, our focus is on providing necessary services while minimizing risk to our patients, our co-workers and ourselves.

One of our best prevention strategies available now is simple and straightforward—the wearing of face masks to help prevent the spread. The Centers for Disease Control and Prevention has recommended that people wear face coverings in public settings when social distancing cannot be adequately achieved. Multiple studies published over the last few months have concluded that mask wearing was associated with reduced risks of infection; further research indicates that states that imposed mask mandates saw declines in new cases greater than those that did not.

Despite this evidence, why do we still have individuals refusing to wear face coverings during a pandemic? Why do we witness people wearing a mask to enter a business that requires them, but removing them once they are inside? Perhaps it's because mask wearing is simply not well understood.

Covering your mouth and nose with filtering materials serves two purposes—it protects you from inhaling harmful materials, but more importantly it also helps prevent you from exposing others to infectious droplets that might be expelled during normal conversation or respiration. Think of it this way—if given the choice between having surgery performed by a team not wearing masks vs. a team that does, it's safe to assume all patients would prefer the team with masks. It's widely accepted that face coverings under these circumstances reduce the risk of surgical site infection that could be caused by droplets generated during the surgical team's conversations or breathing. Face coverings do the same in blocking transmission of COVID-19.

Yes, there have been confusing messages during the pandemic. Initially, face coverings were only recommended for those who were symptomatic prior to isolation or awaiting test results. But as data emerged that documented transmission of COVID-19 from persons without symptoms, the recommendation was expanded to the general community. Some people are carriers of the disease for a few days before becoming ill; others never show symptoms at all. But no one is immune, and older adults and those with chronic conditions are the most vulnerable.

The physicians of the St. Louis Metropolitan Medical Society are calling upon our business leaders to set the example in your organizations. We need to make mask wearing more socially acceptable.

In my own medical practice, a health care worker recently tested positive for the coronavirus. But because of routine mask wearing and other preventative measures, no other employees were infected. The media has widely reported the case of the two infected stylists at a hair salon in Springfield, Mo. But because both were wearing masks, none of their clients tested positive.

The physicians of the St. Louis Metropolitan Medical Society are calling upon our business leaders to set the example in your organizations. We need to make mask wearing more socially acceptable. We need

to educate those who challenge the mandate and overcome their objections. We need people to understand that face coverings are intended to ***protect others***, and should be worn properly covering both the nose and the mouth.

Mask mandates are not a violation of your personal freedoms, and it's not the government attempting to control you. Mask wearing is a matter of social decency. And for some, it just might be the difference between life and death. Quite simply, when combined with social distancing, frequent hand washing, and limits on large gatherings, it's our best available path to controlling the pandemic and returning our society and economy to normal.

Jason Skyles, MD, is a diagnostic radiologist with West County Radiology at Mercy Hospital St. Louis.

Is Your Patient a Human Trafficking Victim?

Free virtual education program explores how to recognize the signs

"Human Trafficking and the Impact on Healthcare"
Thursday, November 12, 5:30 to 7:30 p.m.
Free of charge over Zoom
Registration: www.slmms.org

Learn about the role health care providers can play in identifying victims of human trafficking at this free virtual education program presented by SLMMS, along with the League of Healthcare Experts and the Missouri Chapter of the American College of Healthcare Executives.

Health care providers are in a vital position as they often are the only professionals to interact with trafficking victims who are still in captivity. Having expert assessment and interview skills enables a provider to identify trafficking victims. This program aims to provide clinicians with knowledge and the specific tools they may need to assist victims in the clinical setting.

Nicole Ensminger, human trafficking response program manager with Ascension Via Christi Health, Inc. of Wichita, Kan., will be the speaker. She will also moderate a panel of providers trained in the identification and recognition of human trafficking victims.

The program is open to all SLMMS members and their staff members; pre-registration is required. CME credits are pending.

Appointed to AMPAC Board


Dr. Elie C. Azrak

Elie C. Azrak, MD, MHA, FACC, FSCAI, has been appointed to the board of directors of the American Medical Association Political Action Committee (AMPAC). The two-year term begins December 1. Dr. Azrak is a SLMMS past president and current Missouri delegate to the American Medical Association.

As the AMA's bipartisan political action committee, AMPAC's mission is to find and support candidates for Congressional offices, whether it is a new candidate for office who will make physicians and patients a top priority, or a candidate running for reelection who has proven to be a friend of medicine.

On the appointment, Dr. Azrak said, "Political engagement and political action are hallmarks of the democratic process. Influencing policy through support of elected members of Congress is a critical avenue to getting the voice of organized medicine heard."

Dr. Azrak also has been a Missouri State Medical Association councilor since 2013 and served as 2013 president of the National Arab-American Medical Association.

SEEKING VOLUNTEER PHYSICIANS

Casa de Salud, a free clinic serving uninsured and underinsured immigrants and refugees, is seeking volunteer physicians, particularly in the areas of internal medicine, family medicine, gynecology and psychiatry. For more information, info@casadesaludstl.org.

SLMMS STATEMENT ON MASK WEARING

The Medical Society in August issued a statement advocating mask wearing among the public to help prevent the spread of COVID-19. To read the full statement, visit http://bit.ly/SLMMS-mask.

Meet Your 2021 SLMMS Officer and Councilor Nominees

Election takes place online November 1-25

The St. Louis Metropolitan Medical Society is pleased to announce the slate of officer and councilor candidates who will lead the organization in 2021. The election will take place online at www.slmms.org from Nov. 1 to 25.


Dr. Jennifer L. Page

Jennifer L. Page, MD, will succeed automatically to the position of 2021 SLMMS president from her current status as president-elect. Dr. Page is board certified in physical medicine and rehabilitation, and serves as the medical director of acute rehabilitation at Mercy Hospital South.

She earned her undergraduate and medical degrees from the University of Missouri-Kansas City, and completed an internship at Mercy Hospital St. Louis. She was chief resident at Rush Presbyterian St. Luke's Medical Center in Chicago.

Dr. Page has served as SLMMS president-elect in 2020, as vice president in 2019, and as councilor from 2016-2018. She has previously chaired the SLMMS Finance and Endowment Committee and serves on the Publications Committee. She was an AMA delegate as a resident physician, an alternate delegate for the Young Physician Section, and was on the board of the Missouri State Medical Foundation from 2007-2012.

A native of St. Louis, she joined SLMMS in 1996. She resides in Creve Coeur with her husband, Sam Page, MD, and their three sons.

Up for election will be candidates for president-elect, vice president and secretary-treasurer along with four councilors. Councilors are elected to three-year terms; an additional eight councilors will continue their unexpired terms.

Learn more about our candidates by reviewing their biographies that follow. To help gain insight on their thoughts of practicing medicine during this challenging time, we have asked them to respond to the question, "How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine?"

Erin S. Gardner, MD | President-Elect


Dr. Erin S. Gardner

Practice: Dermatology and Mohs surgery, Dermatology Specialists of St. Louis at Missouri Baptist Medical Center. Certified, American Board of Dermatology.

Education: B.A., University of Missouri. M.D., Vanderbilt University. Internship and residency, Washington University School of Medicine/Barnes Hospital, Duke University School of Medicine/Duke University Medical Center; American College of Mohs Surgery fellowship, Methodist Hospital, Houston.

Birthplace: Springfield, Mo.

SLMMS/MSMA/AMA Service: SLMMS vice-president, 2020; councilor, 2019; delegate to MSMA convention, 2018 and 2019. SLMMS Finance and Endowment Committee Chair 2020; SLMMS Executive Committee and Publications Committee member. Joined SLMMS 2007.

Other Professional Organizations: Past president, Missouri Dermatological Society; technology chair, St. Louis Physician Alliance; Public Policy Committee, American College of Mohs Surgery; EHR Task Force chair and Advisory Board Executive Committee member, American Academy of Dermatology; member, AMA, MSMA, St. Louis Dermatological Society, American Society of Dermatologic Surgery.

Honors and Awards: Chief resident in dermatology, Duke University.

Personal: Wife, Emily Gardner; children, one son and three daughters. Hobbies and interests: Tennis, running, reading, spending time with family. Reading interests include history, biographies of courageous and resilient leaders, and the study of moral virtue and political systems.

How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine? Medicine and society are confronted with a challenge not seen at this magnitude in a century. Organized medicine must and has stepped into the breach. Since its founding in 1836, SLMMS has worked not only to foster the care of our patients but also to promote the practice of medicine for physicians. Through advocacy, communication and education strategies, we can lead during the COVID-19 pandemic, providing society with useful information and helpful day-to-day approaches, and providing physicians with timely resources and steadfast championing for important causes in the practice of medicine.

Mark C. Gunby, DO | Vice President


Dr. Mark C. Gunby

Practice: Internal medicine/geriatrics. Physician with the BJC Medical Group. Certification: Geriatric medicine. Hospitals: Mercy Hospital South, Missouri Baptist Medical Center.

Education: B.S.N., University of Tulsa; D.O., Oklahoma State University College of

Continued

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** "Typical rate charged by financial advisors" claim is based on a 2016 *InvestmentNews* study (http://blog.runnymede.com/how-much-to-pay-a-fee-only-advisor-a-look-at-average-annual-fees) showing an average advisor fee of 1.01% for an account valued at between $1 million and $5 million. Rates charged by financial advisors vary. Other fees and transaction costs apply. Similar services may be available from other investment advisers at a lower cost.

All indices are unmanaged and investors cannot actually invest directly into an index. Unlike investments, indices do not incur management fees, charges, or expenses.

This is a hypothetical example and is for illustrative purposes only. No specific investments were used in this example. Actual results will vary.

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Osteopathic Medicine; Internship, Oklahoma State University Medical Center, Tulsa; Residency, SSM Health Saint Louis University Hospital, internal medicine; Fellowship, Saint Louis University Hospital, geriatric medicine.

Birthplace: Columbus, Ohio.

SLMMS/MSMA/AMA Service: SLMMS councilor, 2018-2020; SLMMS Executive Committee, 2020; Physician Grievance Committee, 2018-2020; Joined SLMMS 2015.

Other Professional Organizations: American College of Physicians, American Geriatrics Society, Missouri State Medical Association.

Honors and Awards: Outstanding House Officer Award, Saint Louis University Hospital Nursing Department, 1992; Lemmon Company Outstanding Clinician Award, 1988; Sigma Sigma Chi National Honoring Osteopathic Service Scholarship Fraternity.

Personal: Wife, Trish Gunby (Missouri State Representative, 99th District). One son and one daughter. Hobbies: travel, fitness, family time.

How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine? I feel SLMMS provides a collective voice for all physicians no matter what the current climate or situation. The COVID-19 pandemic has impacted everyone's practice of medicine, and membership in organized medicine has helped with education, positive/realistic guidance and legislative support. As a member of both SLMMS and MSMA, I feel I am not alone in my struggles of dealing with a changing medical practice environment. I also feel the support provided through SLMMS participation will strengthen with growing membership and feedback from physicians across all specialties.

Robert A. Brennan, Jr., MD | Secretary-Treasurer


Dr. Robert A. Brennan, Jr.

Practice: Obstetrics and gynecology; Ob-Gyn House Doctor at SSM Health St. Clare Hospital-Fenton. Certified, American Board of Obstetrics and Gynecology.

Education: A.B., Saint Louis University; M.D., Saint Louis University School of Medicine; Internship and residency, ob-gyn, Mercy Hospital St. Louis.

Birthplace: St. Louis.

SLMMS/MSMA/AMA Service: SLMMS secretary-treasurer, 2018-2020; councilor, 2015-2017; secretary-treasurer, 2014; secretary, 2008-2010; councilor, 2004-2007 and 2011-2013; Physicians' Wellness Conference chair, 2007-2009. Chairperson, SLMMS Continuing Medical Education Committee; Member, SLMMS Executive, Grievance, and Finance and Endowment Committees; MSMA first vice president, 2012-13; 3rd District councilor, 2013-present. Joined SLMMS 1979.

Other Professional Organizations: American Medical Association; St. Louis Obstetrical and Gynecological Society; American College of Obstetricians and Gynecologists; Society of Ob-Gyn Hospitalists.

Personal: Wife, Joan Brennan; family, four sons and three grandchildren; Hobbies: walking, archery, reading.

How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine? SLMMS can support physicians in many different ways, including the following: physician education by providing resources from the U.S. Centers for Disease Control and Prevention, the Missouri Department of Health and Senior Services, and the Missouri Telehealth Network; encouraging mask usage, social distancing and hand washing; providing resources for legal aid, wealth management and trust protection through our established vendor relationships; running interference when issues arise for practices establishing telemedicine; identification of legal issues through legislative updates; maintaining relationships with community leaders including the St. Louis Metropolitan Pandemic Task Force and the St. Louis County Department of Public Health; and supporting health care workers experiencing COVID-19 mental health issues by strongly promoting the Missouri Physicians Health Program.

Sara I. Hawatmeh, MD | Councilor


Dr. Sara I. Hawatmeh

Practice: Internal medicine; Physician in practice with Sam Hawatmeh, M.D. P.C., a member of Southside Comprehensive Medical Group, St. Louis; Certified, American Board of Internal Medicine; Hospitals: Mercy South, St. Luke's Hospital, St. Luke's Des Peres Hospital.

Education: B.S., University of Miami; M.D., Ross University School of Medicine; Internship and residency, St. Luke's Hospital (chief resident 2017-18).

Birthplace: St. Louis.

SLMMS/MSMA/AMA Service: MSMA Young Physician Section Vice Councilor, 2020-21; YPS Secretary; Joined SLMMS 2018.

Other Professional Organizations: American Medical Association; National Arab American Medical Association; American College of Physicians; Obesity Medicine Association.

Community/Volunteer Activities: Nairobi Mission Project, Nairobi, Kenya, 2014; Family Hope Charity, Chicago, 2014; Salybia Mission Project, Carib Territory, Dominica, 2010-2012.

Personal: Hobbies and interests: traveling, spending time with family, health and wellness activities.

How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine? In a time of uncertainty and constant change, it is important for physicians to have strong leadership, a more consistent flow of data, and a large network to gather and share reliable information. Now more than ever, our patients and colleagues rely on us to help navigate through this difficult time with the most up-to-date and accurate information. SLMMS can provide that support and serve as a resource for the St. Louis physician community by organizing networking and online events, as well as creating an arena for physicians to collaborate about the constantly evolving changes in medicine at local, state and national levels.

Otha Myles, MD | Councilor


Dr. Otha Myles

Practice: Internal medicine and infectious disease; Founder/Medical Director of Myles Healthcare, LLC; Certified, internal medicine and infectious disease, National Board of Physicians and Surgeons; Hospitals: Christian Hospital, Barnes-Jewish West County Hospital, SSM Health St. Mary's Hospital, SSM Health St. Clare Hospital, St. Luke's Hospital, St. Luke's Des Peres Hospital.

Education: B.S., Howard University; M.D., University of Maryland; Internship, residency and infectious disease fellowship at the former Walter Reed Army Medical Center, Bethesda, Md.

Birthplace: Hayti, Mo.

SLMMS/MSMA/AMA Service: Joined SLMMS 2017.

Other Professional Organizations: National Medical Association (local chapter is Mound City Medical Forum), Infectious Disease Society of St. Louis, Society of Internal Medicine, Missouri State Medical Association, St. Louis Physician Alliance.

Community/Volunteer Activities: Doorways, board member; Urban League; United Way of Greater St. Louis, Food Outreach.

Personal: Wife, April Tyus-Myles, MD, pediatrician; children, two daughters. Hobbies and interests: jogging, bicycling, reading, traveling, spending time with family.

How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine? SLMMS has represented physicians in St. Louis for almost 200 years and has a mission to "support

Continued

and inspire members to achieve quality medicine through advocacy, communication and education." In that role, all physicians in the metropolitan region should be able to depend on SLMMS to support their practice of medicine, building stronger relationships with patients, and pursuing leadership opportunities in the health care industry. SLMMS forging relationships with physicians and advocating for their leadership in our health care community is a winning situation for all those involved.

David M. Niebruegge, MD | Councilor


Dr. David M. Niebruegge

Practice: Neuroradiology; neuroradiologist in practice with West County Radiology Group, Mercy Hospital St. Louis; Certified, diagnostic radiology and diagnostic neuroradiology, American Board of Radiology.

Education: B.S., Saint Louis University; M.D., Loyola University-Chicago School of Medicine. Internship, Resurrection Medical Center, Chicago; Residency, Saint Louis University Hospital; Fellowship, Mallinckrodt Institute of Radiology at Washington University.

Birthplace: Belleville, Ill.

SLMMS/MSMA/AMA Service: MSMA delegate. Joined SLMMS 2007.

Other Professional Organizations: Radiological Society of North America; American Society of Neuroradiology; American College of Radiology.

Community/Volunteer Activities: CYC coaching.

Personal: Wife, Andrea Niebruegge; children, three sons. Hobbies and interests: cycling, weightlifting, fishing, camping.

How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine? During this unprecedented global pandemic, our once-stable medical profession has been upended by quarantines, unemployment and civil unrest. Patients are scared and bombarded by misinformation. Yet many have difficulty accessing their physicians due to loss of insurance, fear of getting sick, and decreased doctor availability. Now, more than ever, physicians need the support and expertise of their local medical societies and local governments to navigate through these difficult times. Through education, fellowship and shared legislative purpose, SLMMS unites physicians across all specialties. I am excited to do my part to maintain SLMMS as a valuable resource within our community.

Farheen N.K. Raja, MD | Councilor


Dr. Farheen N.K. Raja

Practice: Ophthalmology; comprehensive ophthalmologist, West County Ophthalmology; Certified, American Board of Ophthalmology. Hospitals: St. Luke's Hospital, SSM Health Cardinal Glennon Children's Hospital.

Education: B.A., Saint Louis University; M.D., Saint Louis University. Internship, Forest Park Hospital; Residency, Saint Louis University Eye Institute.

Birthplace: Morristown, N.J.

SLMMS/MSMA/AMA Service: Joined SLMMS 2016.

Other Professional Organizations: American Academy of Ophthalmology; Association of Physicians of Pakistani Descent of North America; Missouri Society of Eye Physicians and Surgeons; Missouri State Medical Association.

Personal: Husband, Furqan Raja, MD, nephrologist; children, three sons. Hobbies and interests: travel, cooking, trying new restaurants, spending time with family.

How can SLMMS best support physicians in the St. Louis region, especially given the impact of COVID-19 on the practice of medicine? There is no event in recent history that has brought physicians, health care and public health to the forefront of society as COVID-19 has. The Medical Society can support physicians by helping navigate the ever-changing landscape of Medicare and third-party payers, especially in regard to telemedicine. It should continue to work with elected officials to educate them on how best to mitigate the spread of COVID-19, without making it partisan. It is important to maintain an organized front when advocating for our profession and patient safety with legislators. Physicians need to become actively involved in dictating how health care policy is shaped. SLMMS provides a bridge to connect physicians with policy makers to make changes to provide better health care for the diverse communities of St. Louis. Members could also benefit from more wellness events or resources to address the emotional toll COVID-19 has had on physicians.

Continuing on the Council (Terms began in 2019 or 2020)

- **M. Lauren Council, MD**
- **Emily D. Doucette, MD**
- **Kirsten F. Dunn, MD**
- **Luis A. Giuffra, MD**
- **Mark S. Pelikan, DO**
- **David L. Pohl, MD**
- **Damien L. Ricklis, MD**
- **Richard H. Wieder, MD**

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Where They Stand: The Candidates on Health Care Issues

Candidates for U.S. Congress, Missouri Governor and County Executive offer their thoughts on issues of concern to St. Louis-area physicians

Voters' choices in the November 3 general election will help shape the future of health care. *St. Louis Metropolitan Medicine* sought responses on several major health care questions from candidates for the two St. Louis-area U.S. House seats, Missouri Governor and St. Louis County Executive. Thanks to all the candidates who took time in their busy schedules to respond to our questions.

U.S. Congress, Second District

- **Ann Wagner, Republican (Incumbent)**
  www.annwagner.com
- **Jill Schupp, Democrat**
  www.jillschupp.com
- **Martin Schulte, Libertarian**
  www.martinvschulte.com

What lessons have we learned from COVID-19, and how can we be better prepared for future pandemics?

Wagner: We have learned that we need more resources and public engagement to quickly implement testing, contact tracing and isolation protocols while promoting masks and social distancing. I am developing these lessons into best practices that will permanently improve our public health readiness and keep Missouri's families safe. I have introduced legislation to permanently expand telehealth services, protect the vulnerable and nursing home residents, improve global health security, shore up the U.S. supply of treatments, and improve the National Strategic Stockpile. We must also protect health care providers from burnout, address health care disparities and mental health, and urge the WHO to increase international cooperation.

Schupp: COVID-19 has illuminated health care access disparities and the need for affordable insurance, including through a public option. Pandemic preparedness must include protections for our health care responders and those with whom they come into contact, including their families. There must be protocol for public adherence to a standard of guidelines designed by medical professionals based on science. Following the advice of experts matters. Robust testing, tracing and treatment infrastructure must become the national norm. Standards designed by epidemiologists and care providers based on real-time information must be reported and utilized for decision making.

Schulte: Medical professionals have shown a tremendous amount of resilience and flexibility during the pandemic. In my view, those efforts were stagnated by manufacturing and supply chain deficiencies. If we were to better prepare for future pandemics, we would need to emphasize "raising the line" as well as "flattening the curve." As medical professionals are limited to the tools and medicines on hand, manufacturers and supply chains will need to focus on transitioning from efficient models to rapid production. Nobody knows the time or impact of the next pandemic; an accelerated sourcing timeline will improve the quality of medical care.

What actions would you take to control the rise in drug prices and end shortages of needed drugs? Do you support removing the "safe harbor" provision of the 1987 Medicare Act that exempts hospital group purchasing organizations (GPOs) and pharmacy benefit managers (PBMs) from anti-kickback provisions?

Wagner: We must stop drug companies from taking advantage of consumers while maintaining our country's incredible access to lifesaving medicines. We must review any law that affects drug prices and drug shortages and ensure all patients can access groundbreaking cures and pay reasonable rates. I was proud to vote for H.R. 19 to lower prices and ensure that Missourians and their doctors have access to the price of their medications before they ever go to the pharmacy. This bill would force transparency into the system, limit how much seniors pay for their drugs on Medicare and expand access to rebates, lower the cost of insulin, and cut cancer treatment costs. I also voted for bipartisan legislation to bring generics to market faster.

Schupp: As I meet (virtually) with people throughout the district, the high cost of prescription drugs is an issue that comes up often. I support the bipartisan Lower Drug Costs Now Act (which my opponent voted against). Allowing

Medicare the power to negotiate directly with drug companies will lower costs for privately insured Americans, too. Washington has been remiss as prices of drugs have skyrocketed. I support examining the anti-competitive behavior of PBMs in the marketplace, while considering the effectiveness of coordination of care. Patients need affordable prescription prices as well as the most effective care possible. One cannot preclude the other.

Schulte: I recognize intellectual property rights and would be open to extending market exclusivity of drugs to reduce prices. If those drug manufacturing companies are unable to provide the needed medications for patients within a reasonable time (whether through increased production capacity or outsourcing) or price gouge then those companies should lose the market exclusivity and the open market will reduce prices and increase availability. I do not support the removal of safe harbors because it is projected to increase the federal deficit by $200B as studied by the Centers for Medicare & Medicaid Services.

Do you favor or oppose lowering the Medicare eligibility age to 60? Why?

Wagner: I will always fight to strengthen the health care safety net for all Missourians. With Americans enjoying longer, healthier lives, we must protect Medicare while ensuring that younger Americans can access affordable care. Lowering the age of Medicare eligibility would indiscriminately replace private health care spending with up to $100 billion in public funds per year at a time when Medicare's trust fund is a few years away from depletion. The best way to protect elderly, disabled and vulnerable adults is to increase quality health care options for all. I support premium assistance to those who have lost their jobs during the pandemic; ending surprise medical billing; telehealth and expanding HSAs; and protecting those with pre-existing conditions, while reducing premiums and prescription drug prices.

Schupp: I support a public option. One advantage is that it will allow people aged 55 to 65 to buy into Medicare. This population is the one insurers are most apt to try to avoid covering. Creating a public option allows this group to purchase quality insurance without negatively impacting the long-term fiscal health of the program. This will help fund the pool, and these individuals, by virtue of their younger ages alone, will be actuarially less in need of more expensive care than those in the system. These insured patients will pay premiums until eligibility at age 65.

Schulte: Medicare was designed to provide care for the latter stage of life; life expectancy past retirement age has more than doubled since its inception. I oppose lowering the Medicare eligibility age for two reasons: it will increase costs for those who are under the Medicare eligibility age and decrease the emphasis on living productive lives. Too many people have paid into this promise from the government and have made life decisions based on this promise. Expanding the system will not fix the years of legislative neglect nor extend the Medicare exhaustion point.

U.S. Congress, First District

- **Anthony Rogers, Republican**
  www.facebook.com/BetterThanTheBeatles
- **Cori Bush, Democrat**
  www.coribush.org
- **Alex Furman, Libertarian**
  www.facebook.com/alex4MO

Anthony Rogers did not respond to our questionnaire.

What lessons have we learned from COVID-19, and how can we be better prepared for future pandemics?

Bush: The COVID-19 pandemic has highlighted the dangers of failing to invest in preventive care, precautionary measures and adaptive resources. It reminds us that health care cannot be connected to job status; that unhoused communities deserve safe housing; that poverty, unemployment and evictions magnify public health crises. We must guarantee universal health care through Medicare for All. We must listen to scientific and medical experts when creating public policy. And with another public health crisis that disproportionately impacts people of color, we must work harder to ensure that health care providers actually represent the communities they serve in.

Furman: COVID-19 has taught us we need to leave pandemics to medical professionals, not bureaucrats and technocrats and rogue judges. People and businesses need to decide for themselves what actions they are comfortable taking and what their own level of risk should be. COVID has also taught us that inflationary monetary policy leaves us without savings required to quarantine for any effective amount of time.

What actions would you take to control the rise in drug prices and end shortages of needed drugs? Do you support removing the "safe harbor" provision of the 1987 Medicare Act that exempts hospital group purchasing organizations (GPOs) and pharmacy benefit managers (PBMs) from anti-kickback provisions?

Bush: Yes, I support removing the "safe harbor" provision. It's clear that pharmaceutical corporations are driven by their bottom line, not making medical interventions accessible to

Continued

Candidates on Health Care — *continued*

those who need them. We must end price gouging once and for all, and ensure that the prices of prescription drugs are capped at reasonable limits. When we transition into a single-payer health care system under Medicare for All, we will provide free prescriptions. Lastly, we must continue to prepare for current and future public health issues—and guard against drug shortages—via robust public funding for drug research and development.

Furman: I would completely sever any and all government ties with the medical field. All regulation, taxation and subsidy—gone. This would lead to two things: 1) An outright crash in the price of medicine as Big Pharma liquidates itself and the industry restructures itself; 2) An unprecedented level of investment and production in the newly liberated industry.

Do you favor or oppose lowering the Medicare eligibility age to 60? Why?

Bush: Yes, absolutely. By lowering the Medicare eligibility age to 60, we can cover thousands of Missourians currently unable to access crucial and even lifesaving care. But we can't stop there; we must finally guarantee universal, quality care for every person across the nation via Medicare for All.

Furman: I favor abolishing all medical subsidy.

Missouri Governor

- **Mike Parson, Republican (Incumbent)**
  www.mikeparson.com
- **Nicole Galloway, Democrat**
  www.nicolegalloway.com
- **Rik Combs, Libertarian**
  www.combsformissouri.org
- **Jerome Howard Bauer, Green Party**
  www.facebook.com/Jerome-Bauer-Green-for-Missouri-Governor-354827564704728

  Jerome Howard Bauer did not respond to our questionnaire.

What lessons have we learned from COVID-19, and how can we be better prepared for future pandemics?

Parson: There have been a lot of lessons, but one of the most important is the effectiveness of our "box-in" strategy to protect the most vulnerable. "Box-in" mobilizes facility-wide testing in senior centers and veterans homes to test all residents and staff the moment we know anyone in the facility is positive. This is why Missouri has been able to avoid the terrible outcomes for seniors that we saw in early breakout states like New Jersey and New York. The other important lesson is that the state must communicate frequently and clearly. That is why I continue to have frequent press briefings on COVID-19.

Galloway: The most important thing the governor can do in a public health emergency is to convene public health experts and follow their consensus advice. I do not believe the current governor has been willing to do that. For instance, Gov. Parson's continued resistance to a statewide mask rule, which public health experts in Missouri and the White House have advised Missouri to adopt. Coordinating response, resource distribution and scaling capabilities are all important elements of responding to a pandemic. But, every decision must be guided by science and data, not politics.

Combs: Biggest lesson learned is to ensure accountability in lockdowns by having the decision-making process in the hands of elected officials rather than appointed officials. Too much power in the DHSS and local health departments. That said, we must ensure the proper PPE is stocked and stored for future use. Lockdowns are ineffective (e.g., Sweden versus the rest of Europe) and must not occur. Hygiene is important and personal space a must.

Now that Medicaid expansion has passed in Missouri, what steps need to be taken to implement expansion per the Affordable Care Act?

Parson: A few years ago, Missouri would have been unprepared for Medicaid expansion. But I appointed Todd Richardson as the Director of Missouri HealthNet (Medicaid) to meet exactly this kind of challenge. Right now, Todd is convening experts to make sure expansion in Missouri is as smooth and cost effective as possible.

Galloway: Voters have spoken, and eligibility for Medicaid will be expanded. The question is whether opponents interfere with its implementation through the appropriations process or other attempts to hinder Missourians from receiving health care. I supported expansion and campaigned in favor of it. Governor Parson publicly opposed it and campaigned against it. Missouri should follow the lead of so many other states that have realized public health and fiscal benefits from expansion. Those benefits of expansion will be a key part of our coronavirus recovery. We can do it without raising taxes or cutting other programs as many other states have done.

Combs: The biggest issue looming for Medicaid expansion is the amount of money Missourians must pay out in the coming years. The budget will have to be adjusted to fund this new requirement, and where does that funding come from? What

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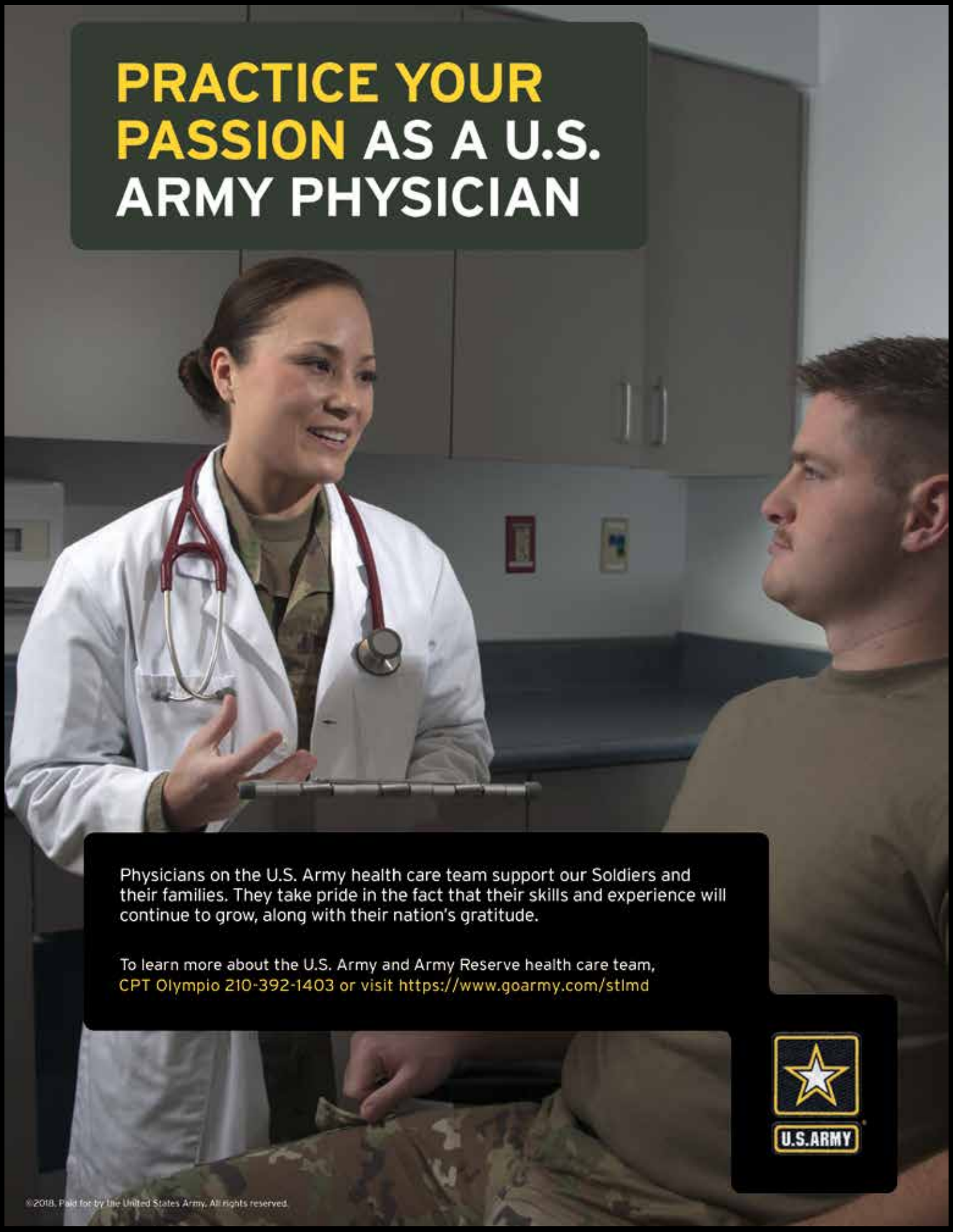
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Candidates on Health Care — *continued*

state funding needs reduction and/or elimination? Medicaid is a large part of the state's budget and growing exponentially; so where will Medicaid be in 5 or 10 years? Another looming question is that of continued federal funding share ... with the national debt nearing $30 trillion, how long can Missourians expect the federal government to continue their levels of funding?

Though physicians (MD and DO) undergo many more years of education and training, other specialties such as nurse practitioners are lobbying for legislation to grant them similar scope of practice authority without physician supervision. What is your position on granting greater scope of practice authority to nurse practitioners and other health care professionals?

Parson: I believe it is important to acknowledge the value and distinctions of specialized medical training. Missouri needs to maintain and expand our trained workforce of highly skilled health care professionals to meet the needs of our citizens today and in the future. Any discussions of statutory changes regarding expanded scope of practices should be focused on areas of our state where acute shortages of highly trained health care professionals exist, with the goal of providing all regions of Missouri with the highest quality health care possible.

Galloway: When government considers regulatory changes in the field of health care, safety must be given strongest possible consideration against economic benefits of a proposed rule change. Many of our rural areas lack physicians, and access to even primary care is a significant issue. If patient safety can be preserved or enhanced, and regulatory changes generate clear economic benefits to patients, providers, or insurers, it should be open for consideration.

Combs: I fully concur with health professionals being granted more scope of responsibility and greater freedom to practice unsupervised. Moreover, I would favor the state no longer license health practitioners, but have the individual disciplines regulate themselves.

St. Louis County Executive

- **Paul Berry, III, Republican**
  www.facebook.com/BerryForSTLCounty
- **Sam Page, MD, Democrat (Incumbent)**
  www.sampage.com
- **Theo Brown, Sr., Libertarian**
  www.twitter.com/p77601
- **Elizabeth (Betsey) Mitchell, Green Party**
  www.betseymitchell.com

Paul Berry, III, and Theo Brown, Sr., did not respond to our questionnaire.

What lessons have we learned from COVID-19, and how can we be better prepared for future pandemics?

Page: We've learned that racial disparities and the resulting inequity is not just a moral crisis, but a public health crisis, and that politics cannot dictate health mandates. Preparing for the future demands increasing access to care throughout our community to improve health outcomes for our most vulnerable. Passing Medicaid expansion gave hundreds of thousands of Missourians access to care, and we are directing our COVID-19 resources where we can improve access even further. We are prioritizing preventive and primary care, healthy communities, and the theme that we're all in this together so we have a society that is more resilient.

Mitchell: St. Louis County Department of Health must maintain detailed disaster plans for potential emergencies.

Candidate Q&A continues on page 25

COVID-19 UPDATE

Alex Garza, MD, SLMMS member and incident commander of the St. Louis Metropolitan Pandemic Task Force, gave an update on COVID-19 to the SLMMS General Society Meeting on Sept. 15.

Private School Directory

Forsyth School

Forsyth School is a leading independent, co-educational elementary school for children age 2 through Grade 6. Located across the street from Washington University and Forest Park in the Wydown-Forsyth Historic District, Forsyth provides an unforgettable experience on a one-of-a-kind campus with classrooms in six re-purposed, historic homes. The challenging and engaging curriculum fosters independence and prepares students to thrive in secondary school and beyond.

6235 Wydown Blvd.
St. Louis, MO 63105

314-726-4542
www.forsythschool.org

VIRTUAL OPEN HOUSE
Saturday, October 24, 9:00–10:00 a.m.

New City School

For over 50 years, New City School students have received an education that is rigorous and joyful in equal measure. Children age 3 through 6th Grade participate in a hands-on, experiential curriculum guided by the theory of Multiple Intelligences, allowing them to develop their individual strengths and grow into confident, joyful learners who are successful academically, knowledgeable about themselves and others, and who value diversity. Alumni attend some of the most reputable secondary schools, and are prepared to lead in classrooms and beyond. New City School is dedicated to sustaining a socio-economically diverse community, and offers a Variable Tuition program to support families at different income levels.

5209 Waterman Blvd.
St. Louis, MO 63108

314-361-6411
www.newcityschool.org

VIRTUAL OPEN HOUSES
November 7 and January 14

Addressing Racial Disparities in Medical Education

From MCAT scores to Alpha Omega Alpha membership, gaps remain

By Matthew Gaubatz and Aboubacar Kaba

There are persistent racial disparities in academic performance throughout all levels of medical education. Where, specifically, do these disparities rear their heads? What causes them? And, most importantly, what can we do to ameliorate this differential performance in medical education? These are some of the most pressing questions that those involved in medical education have been asking across the country in recent years.

Where do we find racial disparities in medical education?

One of the most poignant examples of a racial disparity in medical education is induction into the Alpha Omega Alpha Honor Medical Society (AOA), a prestigious award conferred to the nation's top medical students in their last years of medical school. AOA is highly valued by residency program directors in choosing medical students for their programs, and the NRMP Residency Program Director Survey showed that program directors ranked membership as a 3.9 out of 5 in importance for offering interviews and ranking applicants on their match lists.[1]

Academic performance is one of the main determinants for eligibility for induction into the AOA, but even here, at the highest point in medical school—after at least 12 years of primary and secondary education, four years of college and three years of medical school (19 years total!)—racial disparities remain present. In fact, a recent study at Yale found that Black and Asian medical students were less likely to be chosen for AOA than white and Hispanic students even after adjusting for factors like U.S. Medical Licensing Examination (USMLE) Step 1 scores, research productivity, community service, leadership activity and Gold Humanism membership.[2]

Yet evidence shows that these disparities in academic performance arise long before medical school. In 2018, among high school seniors taking the SAT, the white and Asian students had mean scores of 1,123 and 1,223 (out of 1,800), respectively, while Black and Hispanic students had mean scores of 946 and 990, respectively.[3] For the Medical College Admission Test (MCAT), American Association of Medical Colleges' (AAMC) data for the 2019-2020 application cycle showed that white and Asian matriculating students scored an average of 512 and 514 (out of 528), respectively, while Black and Hispanic matriculants both had a mean score of 506.[4] Despite these lower scores, however, there was no evidence of bias against Black or Latino students, based on their subsequent performance in medical school as well as admission data which showed that medical schools admit all applicants at similar rates.

Black and Asian medical students were less likely to be chosen for AOA than white and Hispanic students even after adjusting for factors like U.S. Medical Licensing Examination (USMLE) Step 1 scores, research productivity, community service, leadership activity and Gold Humanism membership.

These disparities persist on the two licensing exams all medical students must pass to become doctors: USMLE Step 1 and Step 2 Clinical Knowledge (CK). According to the AAMC, native English-speaking white male U.S. citizens scored an average of 233 on Step 1 and 243 on Step 2 CK (both out of 300).[5] When correcting for MCAT score and undergraduate GPA, Black and Asian students scored an average of four points lower on Step 1 and Hispanic students scored an average of two points lower.[5] For Step 2 CK, Black students scored an average of three points lower, Asian students scored an average of four points lower, and Hispanic students scored an average of one point lower.[5] What does this mean for medical students? Could medical schools be doing more to educate their underrepresented minority (URM) students, or do these tests themselves have an inherent bias that causes inequitable performance among students of varying populations?

What drives these racial disparities in medical education?

To answer this question, we need to recognize that standardized testing is not perfect. It takes into account both knowledge and test-taking ability, the latter of which is largely a learned skill, meaning that students who have more access to high-quality standardized testing practice and coaching usually perform

Matthew Gaubatz

Aboubacar Kaba

Matthew Gaubatz and Aboubacar Kaba are fourth-year students at Saint Louis University School of Medicine and student members of SLMMS. They can be reached at matthew.gaubatz@health.slu.edu and aboubacar.kaba@health.slu.edu.

better on subsequent standardized testing. However, it is also for these exact reasons that it can serve as a rough estimate of education quality.

Clinical grades during the third year of medical school are one of the most important measures of performance during medical school, including selection into AOA. In most medical schools, clinical grades include how a medical student did clinically—caring for patients, documenting the patient's visit, answering questions during rounds or didactics, and working as part of a team—as well as performance on a standardized NBME test.

To highlight the ubiquitous importance of standardized testing, at one institution—Saint Louis University School of Medicine (SLUSOM)—grading breakdowns showed that approximately 75% of the variation in clerkship grades is attributed to these NBME exams while only 25% is attributed to clinical acumen.

This disparity in clinical grading is supported by data from the University of California, San Francisco, which showed that URM students scored on average only one-tenth of a point lower on clinical grades but received half as many honors grades and one-third as many inductions into AOA as non-URM students.[6] Their data again suggested that the differences were because of standardized testing, highlighting the "amplification" of small differences into larger outcomes.

How can we ameliorate racial disparities in academic performance in medical education?

Ultimately, the solution is reaching racial, academic and socioeconomic equity in our society so that all students have the same access to high-quality education from birth through graduate school.

In the short term, however, it is incumbent upon academia to provide equitable interventions for students with disparate educations based on societal factors. These students need diverse role models and mentoring from those who have gone before them to help them navigate their unique challenges in medical school. This necessitates an active effort to increase both the number of URMs in medical school and high-achieving students in AOA, and as an added benefit, diversity of background and thought will enrich the breadth of AOA's core values which include academics, research, leadership, professionalism, service and teaching.

How can medical schools implement these objectives?

At SLUSOM, some changes made by the senior associate dean of undergraduate medical education and recently appointed AOA faculty advisor include removing Step 1 scores from AOA eligibility, blinding CVs, and using a rubric to assign objective values to leadership, scholarship and service.

Have these changes been successful? That answer is not entirely straightforward. While AOA membership this year at SLUSOM now reflects the racial composition of the class, the class does not represent the racial composition of the nation. This additional disparity has spurred the admissions office to redouble its efforts to recruit more URM students, a group that SLUSOM has an excellent history of recruiting and admitting but not matriculating. This is due in part to increasingly competitive scholarship offers at other institutions; however, a renewed dedication to diversity has led SLUSOM to prioritize similar efforts in an attempt to correct this with future classes.

Students may enter medical school with a history of lower test scores, but with targeted efforts, medical schools can coach these students to mitigate these differences after matriculation.

Even with these well-intentioned solutions, trying to fix the problem at the end is difficult. These disparities in academic performance exist long before medical school, so it is essential to fix disparities at their root. Or is it?

Perhaps what is and will be the most important change that medical education can make is a commitment to applying a growth mindset as opposed to a static mindset. Students may enter medical school with a history of lower test scores, but with targeted efforts, medical schools can coach these students to mitigate these differences after matriculation. Many students entering medical school may find out quickly that their previous study habits do not cut it in their pre-clinical coursework. Consequently, like SLUSOM, medical schools can target these students with additional resources to teach new study habits and catch them up to the level of their peers in standardized testing.

In conclusion, there is much work to be done and room for optimism. We recognize that medical schools and AOA are increasingly dedicated to diversity in medicine. Moving forward though, we must all resolve to actively implement tangible changes and not merely discuss them academically, until the day when racial disparities are erased from society, and this of course includes our medical honor societies.

References

1. National Resident Matching Program, Data Release and Research Committee: Results of the 2020 NRMP Program Director Survey. National Resident Matching Program, Washington, DC. 2020.
2. Boatright D, Ross D, O'Connor P, Moore E, Nunez-Smith M. Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society. *JAMA Intern Med.* 2017;177(5):659-665. doi:10.1001/jamainternmed.2016.9623
3. U.S. Department of Education, National Center for Education Statistics. (2019). Digest of Education Statistics, 2018 (NCES 2020-009), Table 226.10.
4. Association of American Medical Colleges. (2019, 10 16). 2019 FACTS: Applicants and Matriculants Data Table A-18. Retrieved from Association of American Medical Colleges: https://www.aamc.org/system/files/2019-10/2019_FACTS_Table_A-18.pdf
5. Rubright JD, Jodoin M, Barone M. Examining Demographics, Prior Academic Performance, and United States Medical Licensing Examination Scores. *Acad Med.* March 2019. Vol. 94, Issue 3, pp 364-370 doi: 10.1097/ACM.0000000000002366
6. Teherani A, Hauer KE, Fernandez A, King TE Jr., Lucey C. How Small Differences in Assessed Clinical Performance Amplify to Large Differences in Grades and Awards: A Cascade With Serious Consequences for Students Underrepresented in Medicine. *Acad Med.* 2018;93(9):1286-1292. doi:10.1097/ACM.0000000000002323

This article is provided through the Medical Society's partnership with Greater St. Louis Medical Group Management Association, www.mgmastl.org

Who Moved the Magazines?

And other changes from COVID that we will keep

By Julie Guethler

The other day, the physician owner of our practice approached me and asked what I thought about doing away with magazines in the waiting room. We, like a lot of offices, removed them as part of our COVID cleanliness response. I told him that I'm writing an article, and I'm intrigued by which of our COVID changes will be kept.

So, I went to our staff and got responses that ranged from keeping telehealth to leaving the doors propped open so that the patients can have more of a "non-touch" experience. Extra chairs in the hallway not only help with social distancing, but also provide more seating on busy days.

While none of us ever thought we would experience something like this pandemic in our lifetime, it can, and I would argue, should be a time for self-reflection and for examining all of your office processes to see what is still working and what is now obsolete.

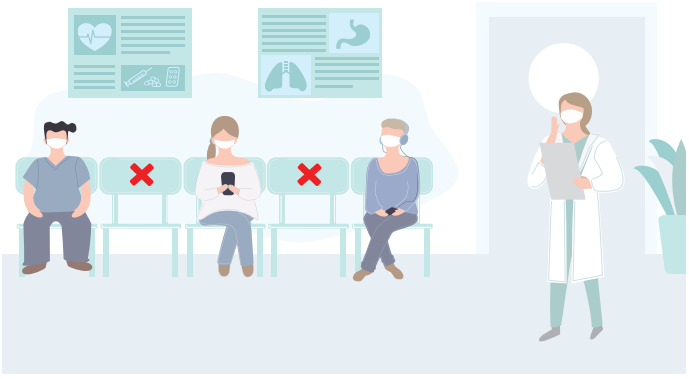
One of my staffers appreciated the cross-training that we stepped up to help accommodate new processes and hopes that it continues. I agree—knowing the challenges that others face daily is a good way to build a team and cut down on the "us vs. them" mentality. A fresh set of eyes working in a new area brings new ideas. The physicians and I are very proud of our staff and how they have continued to work, even in the face of fear and uncertainty.

Julie Guethler

Julie Guethler is practice administrator with Associates in Dermatology and Cutaneous Surgery in Chesterfield and the owner of Transform Healthcare Strategies. She is a board member of Greater St. Louis MGMA. Julie can be reached at guethler@sbcglobal.net.

Wearing masks when we are just not feeling well will likely feel more "normal" to us than in the past—even if it is "just a cold." For most of my 30 years in management, I have worked to convince staff to stay home when sick, take care of themselves and save others from their illness. We have talked in-depth about how to create a culture of wellness. One thing our physician owner pointed out to me is that even physicians are often encouraged to come to work sick—keep working at any cost. This, in turn, sets the tone for the practice. Encouraging wellness will continue to be a focus for us.

One area where we have really stepped up our process is utilizing our real-time eligibility system more consistently and effectively. Due to some changes that insurance companies have instituted not allowing the backdating of referrals, identifying patients without active referrals has become a focus. This allows us to always have access to insurance information regarding benefits so we don't have to touch patient insurance cards, thus making patients and staff more comfortable. COVID has increased our awareness of using tools that we have available to us.



While none of us ever thought we would experience something like this pandemic in our lifetime, it can, and I would argue, should be a time for self-reflection and for examining all of your office processes to see what is still working and what is now obsolete.

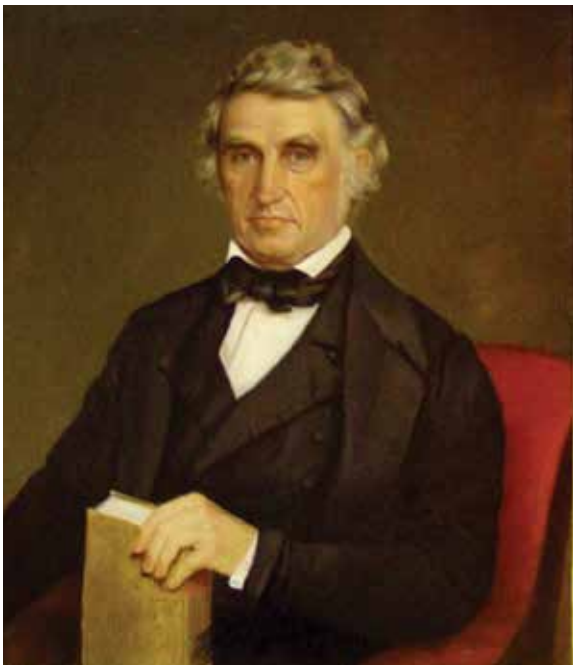
Finally, a shameless plug for Greater St Louis MGMA: Please consider offering a membership to your manager(s) today. The investment you make will come back to your many times over in collaboration and ideas that come from participation.

Dr. William Beaumont's Newspaper Advertising Sparked Controversy in the St. Louis Medical Community

Pioneering St. Louis physician raised knowledge of gastric digestion but was often at odds with other local physicians

By Robert M. Feibel, MD

Dr. William Beaumont (1785-1853) (Fig. 1) was internationally known for his groundbreaking experiments about the physiology of gastric digestion. While he was the most famous physician and surgeon in St. Louis in the 1830s and 1840s, he was also embroiled in various controversies during his time here.



(Fig. 1) Dr. William Beaumont (1785-1853)

Beaumont began performing studies of gastric digestion as an Army surgeon in Michigan. In 1835, the Army transferred him to the Jefferson Barracks Military Post near St. Louis. Beaumont later resigned from the Army and entered civilian medical practice here. He was a very successful and prominent practitioner, well known in society, and was a founding member and later president of the St. Louis Medical Society.

Dr. Robert M. Feibel

Robert M. Feibel, MD, SLMMS member, is professor of clinical ophthalmology and visual sciences, and director of the Center for History Of Medicine at Washington University School of Medicine.

Ad Violated Medical Society Rules

Because of his increasingly heavy workload, Beaumont wished a partner and chose Dr. James Sykes as his associate in practice, although he was very reluctant to share his practice. He wanted complete control of his own affairs and did not want to share his profits. Few details are available on Dr. Sykes. His father may have been a famous physician in Delaware, active in government and politics who served as governor of that state. Sykes came to St. Louis in about 1839 and left about 1852, moving to St. Joseph in western Missouri where he served as the health officer for that city from 1852 to 1855. He probably died in 1857.

The Society reported that this advertisement violated the bylaws. Beaumont, who was quick to take offense, and not known for his tact, refused to apologize for or to explain this advertisement.

In an effort to establish their association, Beaumont and Sykes published the following advertisement in the *Daily Missouri Republican* newspaper on March 19, 1839 (Fig. 2). It is the earliest reference to ophthalmology in St. Louis that this author could find.

DR. WM. BEAUMONT & JAMES SYKES,
(the latter late of Maryland,)

HAVING associated themselves in professional business, hope satisfactorily to extend their practice to all branches of Physic and Surgery incident to this community.

Dr. Sykes having had much experience and success in OPTHALMIC SURGERY, will be able to afford effectual relief in most of the diseases of the Eye.

Dr. S. may be found for the present at the National Hotel, except when professionally engaged.

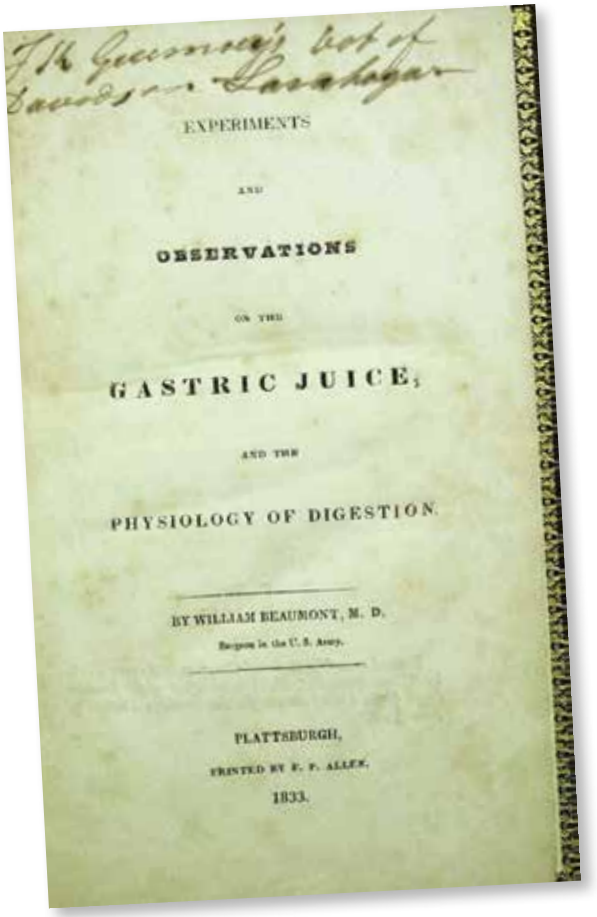
St. Louis, March 19. dtf

(Fig. 2) The Daily Missouri Republican *newspaper, March 19, 1839*

This provoked a storm of controversy in the St. Louis Medical Society, which, of course, wished to differentiate its ethical practitioners from other advertisers who were not fully trained

Continued

physicians and surgeons or practiced unorthodox medicine. One of the bylaws of the Medical Society stated that no member would announce by publication in a newspaper "his pretensions to superior qualifications." Beaumont had been one of the 20 charter members of the Society when it was founded in 1836. He had been chairperson of the membership committee, and thus had made enemies by dropping from the membership rolls several physicians he judged not suitable for membership.


EXPERIMENTS

AND

OBSERVATIONS

ON THE

GASTRIC JUICE,

AND THE

PHYSIOLOGY OF DIGESTION.

BY WILLIAM BEAUMONT, M. D.

Surgeon in the U. S. Army.

PLATTSBURGH,

PRINTED BY F. P. ALLEN.

1833.

(Fig. 3) Title page of Experiments and Observations on the Gastric Juice and the Physiology of Digestion

Several extraordinary meetings of the Society were held during the spring of 1839 to investigate this advertisement. The Society reported that this advertisement violated the bylaws. Beaumont, who was quick to take offense, and not known for his tact, refused to apologize for or to explain this advertisement, and angrily chose to defend his protégé and continue publication of this notice. He could have avoided the coming strife if he had withdrawn the advertisement, but he was not ready to admit error. The members of the Society debated acrimoniously, and at the meeting of May 3, they passed a resolution that asked that Drs. Beaumont and Sykes "Be respectfully requested to discontinue said advertisement." As it turned out, Beaumont and Sykes lost both their partnership and personal friendship from the ill will arising from this fracas. They dissolved their partnership in 1841 and later went to court to contest disputed medical fees.

At this time, medical practitioners in our city were at odds with each other over a variety of issues, one of which was what qualifications allowed a physician to join the Medical Society. Unfortunately for Beaumont, the ill will arising from this dispute split local practitioners into several warring factions, and involved Beaumont in several medical-legal court cases. Beaumont's foray into advertising expertise in ophthalmology would cost him dearly.

Denounced in Court

In 1840, one year after the medical advertisement, Beaumont was denounced in court and in the public press during a legal trial arising from a case of manslaughter. The owner of a local newspaper, Andrew J. Davis, was attacked and badly beaten on the head with an iron cane by a prominent politician named William P. Darnes. Darnes blamed Davis for libeling him in his newspaper. Davis suffered severe cranial trauma with depressed skull fractures. The attending doctors, including Sykes, called Beaumont in consultation, and Beaumont performed an emergency cranial trephination to remove bone splinters and elevate the skull fragments off the brain. However, Davis died a week following the surgery.

Darnes was indicted for manslaughter, and the case attracted great attention in the St. Louis press. Darnes' lawyers defended him by claiming that the patient died not from the injuries inflicted on him by Darnes but because of Beaumont's surgery. As the trial progressed, the bitter divisions that had plagued the Medical Society affected the case as several physicians who were antagonistic to Beaumont testified that his surgical care of Davis was incompetent. Darnes' lawyers even ridiculed Beaumont's medical reputation and the conclusions of the research in his book on digestion. Although Darnes was convicted of manslaughter, it was obvious that Beaumont's reputation had suffered much more damage than that of Darnes.

Two months after this trial, Beaumont was elected president of the Medical Society, but this did not lessen his bitterness, devoting his inaugural address to complain about the animosity of the local medical profession and their willingness to testify against their colleagues rather than trying to heal these divisions.

Medical Malpractice Case

Beaumont was also involved in a famous medical malpractice case, known nationally at that time (1846) as the "Missouri Typhlo-Enteritis Case," also called "The Mary Dugan Case," after the name of the patient. Typhlo-enteritis meant, at that time, a purulent inflammation of the cecum and the surrounding structures in the lower abdomen. Beaumont had not been

involved in the initial care of this patient who developed a fecal fistula following a surgical puncture of the abdominal abscess, but only later called in as a consultant by the operating surgeon. Beaumont was named as a co-defendant in the malpractice case brought by the patient. All his former enemies from the Medical Society, including his former partner Sykes, testified against him. A physician favorable to Beaumont took Dr. Simon Pollak, who had just arrived in the city, to examine the involved patient one day. However, the next day one of Beaumont's enemies also took Pollak to examine the same patient; both physicians asked Pollak to support their position on the patient. Apparently, physicians both loyal to and antagonistic to Beaumont courted all new physicians arriving in the city. Simon Pollak later became the first ophthalmologist in St. Louis.

The jury acquitted Beaumont and his co-defendant. However, embittered by these medical-legal cases, Beaumont resigned from the Medical Society. Beaumont died in 1853. Pollak stated that he knew Beaumont well and considered him a "thorough gentleman." Unfortunately, many physicians in St. Louis would have disagreed.

Beaumont's research cut away all this tangle and proved that the active principle in digestion was the gastric juice, and that it functioned mainly, but not solely, through chemical action involving hydrochloric acid.

Beaumont's Legacy

In spite of these professional and personal conflicts, Beaumont's reputation will endure as the first serious and influential medical scientist in American history, and he holds a distinguished position in the history of human physiology. His 1833 book, *Experiments and Observations on the Gastric Juice and the Physiology of Digestion* (Fig. 3), was a milestone in clinical research, using direct observation of the gastric digestive process, both in vivo and in vitro. Beaumont's book immediately attracted wide and favorable attention, both in the United States and abroad, and was acknowledged as a major contribution to the knowledge of digestion.

Having no formal training in medical science, Beaumont had the good sense to report his observations without any prior prejudices or theories, and to limit his conclusions to what he had personally observed. In fact, he did not even have the opportunity to review the known literature on digestion until he had completed his research, certainly an unusual process today but probably the best method that Beaumont could have pursued.

Prior to his work, the process of digestion was entirely unknown, with many fanciful theories proposed. Beaumont's research cut away all this tangle and proved that the active principle in digestion was the gastric juice, and that it functioned mainly, but not solely, through chemical action involving hydrochloric acid. He also made correct observations on the flow of food and gastric juice in the stomach, observed the mechanism of action of the pyloric valve, and even investigated the effects of emotion such as fatigue on the production of gastric juice.

Like many famous scientists, Beaumont observed and published a new method of investigation, which stimulated further techniques of scientists in this field. Sir William Osler wrote: "Beaumont is the pioneer physiologist of this country, the first to make an important and enduring contribution to this science." Beaumont is a superb example of a physician rising to the opportunity presented to him to further our profession.

References

Horsman R. Frontier Doctor. *William Beaumont, America's First Great Medical Scientist*. Columbia and London: University of Missouri Press, 1996.

Nelson RB, III. *Beaumont. America's First Physiologist*. Geneva, IL: Grant House Press, 1990.

Myer JS. Life and Letters of *Dr. William Beaumont*. St. Louis: C. V. Mosby Company, 1912.

Osler W. William Beaumont. A Pioneer American Physiologist. *JAMA* 1902:39;1223-1231.

Members of the AMA Alliance national board met in St. Louis in August. Alliance member Sue Ann Greco, pictured back row second from right, is serving is 2020-2021 AMA Alliance president.

Alliance Holiday Sharing Card

This holiday season, please join the Alliance in supporting the AMA Foundation and Missouri State Medical Foundation with its annual Holiday Sharing Card project. Donors to the annual appeal are listed in the electronic holiday sharing card and in the December issue of *St. Louis Metropolitan Medicine* and *Missouri Medicine*. Help support the foundations that work to strengthen the patient-physician relationship and improve the health of our communities. Please send your check payable to the **AMA Foundation** or the **MSM Foundation** by November 10 to: to: Gill Waltman, 35 Frontenac Estates Dr., St. Louis, MO 63131. For further information, gillian.waltman@gmail.com.

Statement of Ownership, Management and Circulation (USPS Form 3526)

1. Publication Title: St. Louis Metropolitan Medicine. 2. Publication No.: 006-522. 3. Date of filing: September 29, 2020. 4. Issue Frequency: Bi-Monthly. 5. No. of issues published annually: (6). 6. Annual subscription price: $10-Members; $45-Nonmembers. 7. Complete mailing address of known office of publication: St. Louis Metropolitan Medical Society, 1023 Executive Parkway, St. Louis, MO 63141-6323. Contact person: James Braibish, (314) 786-5473. 8. Complete mailing address of the headquarters or general business office of the publisher: St. Louis Metropolitan Medical Society, 1023 Executive Parkway, St. Louis, MO 63141-6323. 9. Full names and complete mailing addresses of publisher, editor, and managing editor: Publisher: St. Louis Metropolitan Medical Society, 1023 Executive Parkway, St. Louis, MO 63141-6323. Editor, David M. Nowak, 1023 Executive Parkway, St. Louis, MO 63141-6323; Managing Editor, James Braibish, 1023 Executive Parkway, St. Louis, MO 63141-6323. 10. Owner: St. Louis Metropolitan Medical Society, 1023 Executive Parkway, St. Louis, MO 63141-6323. 11. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of the total amount of bonds, mortgages, or other securities: None. 12. Tax Status: Has not changed during the preceding 12 months.

13. Publication title: St. Louis Metropolitan Medicine. 14. Issue date for circulation data: August/September 2020. 15. Extent and nature of circulation. Average No. Copies Each Issue During Preceding 12 Months: a. Total no. copies (net press run), 1,583. b. Paid circulation (1) Mailed outside-county paid subscriptions, 120. (2) Mailed in-county paid subscriptions, 1,013. (3) Paid distribution outside the mails including sales through dealers and carriers, street vendors, counter sales, other, 0. (4) Paid distribution by other classes of mail through USPS, 0. c. Total paid distribution (sum of 15b(l), (21, (3) and (4)) 1,133. d. Free or nominal rate distribution (1) Outside-county, 64. (2) In-county, 80. (3) Mailed at other classes through USPS, 13. (4) Distribution outside the mail, 14. e. Total free or nominal rate distribution, 170. f. Total distribution (sum of 15c and 15e), 1,303. g. Copies not distributed, 280. h. Total (sum of 15f and 15g), 1,583. i. Percent Paid (15c divided by 15f times 100), 87%. No. Copies of Single Issue Published Nearest Filing Date: a. Total no. copies (net press run), 1,550. b. Paid circulation (1) Mailed outside-county paid subscriptions, 119. (2) Mailed in-county paid subscriptions, 1,003. (3) Paid distribution outside the mails including sales through dealers and carriers, street vendors, counter sales, other, 0. (4) Paid distribution by other classes of mail through USPS, 0. c. Total paid distribution (sum of 15b(l), (21, (3) and (4)) 1,122. d. Free or nominal rate distribution (1) Outside-county, 63. (2) In-county, 83. (3) Mailed at other classes through USPS, 12. (4) Distribution outside the mail, 5. e. Total free or nominal rate distribution, 163. f. Total distribution (sum of 15c and 15e), 1,285. g. Copies not distributed, 265. h. Total (sum of 15f and 15g), 1,550. i. Percent Paid (15c divided by 15f times 100), 87%.

16. Paid electronic copies: 0. 17. This information is printed in the October/November 2020 issue. 18. I certify that all information furnished on this form is true and complete. David M. Nowak, Editor.

WELCOME NEW MEMBERS

Thank you for your investment in advocacy, education, networking and community service for medicine.

Jessica A. Gold, MD
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MD, Yale University, 2014
Born 1987, Licensed 2018 ► **Active**
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Born 1982, Licensed 2018 ► **Active**
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Born 1982, Licensed 2014 ► **Active**
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Born 1986, Licensed 2016 ► **Active**
Certified: Internal Medicine

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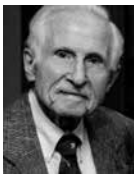
Born 1968, Licensed 2000 ► **Active**
Certified: Internal Medicine

Jay R. Seltzer, MD
3009 N. Ballas Rd., Ste. 142A, 63131-2322
MD, Univ. of Missouri-Kansas City, 1980
Born 1965, Licensed 1988 ► **Active**
Internal Medicine

Stanley M. Wald, MD



Stanley M. Wald, MD, an internal medicine physician specializing in gastroenterology, died June 7, 2020, at the age of 97.

Born in New York, N.Y., he earned both his undergraduate and medical degrees at Washington University. He completed an internship at Michael Reese Hospital in Chicago, and his residency in internal medicine at the Veterans Administration Hospital (Jefferson Barracks) in St. Louis, followed by a fellowship in gastroenterology at Barnes-Jewish Hospital. From 1947-1949, he served as a physician in the U.S. Army Medical Corps. He was a member of the teaching faculty at Washington University School of Medicine for more than 40 years, and practiced at the former Barnes and Jewish hospitals. Dr. Wald joined the St. Louis Metropolitan Medical Society in 1953.

He was predeceased by his first wife Natalie Wald. SLMMS extends its condolences to his wife Priscilla Dale Wald; his children Dr. Mark Wald, Dr. Jeffrey Wald, Deborah Wald, Tim Gagen, and Ann Roberson; his 12 grandchildren; and his six great-grandchildren.

George C. Kaiser, MD

George C. Kaiser, MD, a cardiothoracic surgeon, died July 1, 2020, at the age of 91.

He was born in the Bronx, N.Y., and graduated from Lehigh University. He earned his medical degree and completed his internship at Johns Hopkins University School of Medicine. Following two years of military service, he studied at the National Heart Institute and completed his residency in general and thoracic surgery at Indiana University School of Medicine. Dr. Kaiser joined Saint Louis University in 1963, where he distinguished himself over the next 35 years, establishing and serving as chief of the Division of Cardiothoracic Surgery. He achieved national prominence as a key member of the team that performed the first heart transplant operation west of the Mississippi at SLU in 1972. He also served as chief of surgery at the Veterans Administration Hospital in St. Louis and as chief of cardiac surgery at SSM Health St. Mary's Hospital.

He was elected as president of the St. Louis Thoracic Surgery Society, the Southern Thoracic Surgical Association, and the world's largest cardiovascular surgical association, the Society of Thoracic Surgeons. He served on the editorial boards of seven medical journals, and authored more than 200 publications during his career. Dr. Kaiser joined the St. Louis Metropolitan Medical Society in 1963.

He was predeceased by his first wife Jane Haggart Kaiser. SLMMS extends its condolences to his wife Lois Kaiser; his children Dr. Barbara Kaiser, Charles C. Kaiser, and Lt. Col. (ret.) James Haggart Kaiser; and his eight grandchildren.

William H. Danforth, MD

William H. Danforth, MD, an internal medicine physician who served for 24 years as chancellor of Washington University, died September 16, 2020, at the age of 94.

Born in St. Louis, he received his undergraduate degree from Princeton University and his medical degree from Harvard Medical School. After completing his internship at Barnes Hospital, he served as a U.S. Navy medical officer for two years during the Korean War. He returned to St. Louis to complete his residency in internal medicine and cardiology at Washington University and its affiliated hospitals.

Dr. Danforth joined the faculty of Washington University School of Medicine; in 1965 he was named president of the medical school and vice chancellor of the university. He was appointed Washington University's 13th chancellor in 1971, and served in that capacity until his retirement in 1995.

During his tenure as chancellor, the university rose to national prominence, with significant increases in its endowment and dramatic growth in academics. In 2006, the university renamed the Hilltop campus the Danforth Campus in honor of his contributions. Dr. Danforth also chaired the Danforth Family Foundation for more than 30 years, and helped establish the Donald Danforth Plant Science Center, named for his father, a former Ralston Purina CEO.

Dr. Danforth joined the St. Louis Metropolitan Medical Society in 1965. In recognition of his distinguished career in civic, academic and medical affairs, he received the SLMMS Robert Schlueter Leadership Award in 1993, the medical society's highest honor.

He was preceded in death by his wife Elizabeth Gray Danforth and his daughter Cynthia Danforth Prather. SLMMS extends its condolences to his children Maebelle Danforth, Elizabeth Danforth and David Danforth; his 13 grandchildren; and his eight great-grandchildren.

PARTING SHOTS

"The Check Is in the Mail"

By Richard J. Gimpelson, MD

Many of us have heard this from patients who owed money for their care. Probably many of us have said the same statement when talking to a creditor. Well, the new promise that everyone wants to hear is, "The vaccine is in the syringe."

The FDA has approved convalescent plasma to treat COVID-19 for emergency use. This is great but a vaccine would be better since it would prevent infection by COVID-19. President Trump has spoken about a successful vaccine before the end of the year and maybe even by the end of October. This is definitely opportune if someone is running for president of the United States and has constantly been bombarded by negative accusations from members of the opposition.

The FDA often takes years to approve a drug for marketing to the general population. Some have claimed the vaccine may not be effective or possibly even dangerous if promoted by President Trump. Let me educate the doubters. The president has no control over the FDA approval of any medication for marketing. The FDA must be convinced that a drug is safe and effective before approval.

Here is the pathway for a drug to go through the FDA Investigational New Drug Application (IND) process. A more detailed description is on the FDA website.[1]

The process begins with preclinical testing on laboratory animals and what is proposed for human testing. At this point the FDA decides if the drug is reasonably safe to test on humans. If the IND is approved by the FDA and an Institutional Review Board (IRB), clinical trials in humans can begin. The IRB is a panel of scientists and non-scientists in hospitals and research institutions that oversee clinical research. The IRB then approves the clinical trial protocols that describe how testing will be done and the type of people to be studied.

Dr. Richard J. Gimpelson

Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. The opinions expressed in this article do not necessarily represent the opinion of the Medical Society. Send comments on this column to editor@slmms.org.

Next are the phases to the testing:

Phase 1: Involves healthy volunteers to determine frequent side effects, how the drug is metabolized and excreted. Typically, 20 to 80 subjects are involved with the emphasis on safety.

Phase 2: May begin if no unacceptable events or toxicity in Phase 1. The emphasis is now on effectiveness. The goal is to obtain preliminary data on whether the drug works in people with a certain disease or condition. This phase includes a few dozen to several hundred people. If Phase 2 is successful, the FDA and sponsors meet to decide how large Phase 3 should be.

Phase 3: May begin if effectiveness is shown in Phase 2 and no adverse safety problems occur. This phase will have several hundred to possibly several thousand people. Safety and effectiveness are diligently observed and reported to the FDA before the drug can be approved for marketing.

If the FDA approved a drug for marketing, post-market studies are still needed and presented to the FDA. This phase also requires a meeting between the FDA and the drug sponsor. All during the three phases, the IRB and FDA continue to review the drug.

The company sponsor still needs to file a New Drug Application (NDA) with the FDA to obtain approval before it can be marketed as a new drug. The NDA includes all animal and human data and analysis of this data as well as how the drug behaves in the body and how the drug is manufactured.

The FDA has up to 60 days to decide if it will even review the NDA. If there is additional information needed, the FDA can refuse to file the NDA until that information is obtained. If the FDA allows the NDA to be filed, it can take almost a year to review. If the FDA reviewers feel additional information is still needed, the company sponsor must provide this information.

Essentially, there are 12 steps before a drug is approved for marketing and more if additional information is needed. Each of these 12 steps takes time and can be extended if information is missing or incomplete. Thus, it is unlikely for drugs to be approved rapidly. Because COVID-19 has a significant morbidity and mortality rate as well as serious economic consequences, the FDA has probably (my opinion) put its review ahead of other products submitted for approval.

In addition the FDA is probably (again my opinion) working with extra reviewers because of the high priority of getting the vaccine to market.

I have been an investigator or principal investigator in over 40 FDA trials of drugs or surgical instruments and will be amazed if the COVID-19 vaccine is marketed before the end of 2020. However, it would be wonderful, indeed, if the vaccine would become available this year. Once the vaccine is available, the order in which groups of people will be selected to receive the vaccine will have to be determined. My recommendations:

1. First responders, police officers, firefighters, EMTs, hospital personnel working with COVID-19 patients, the president and vice president of the United States and the Supreme Court justices
2. Other hospital personnel who may have indirect contact with COVID-19 patients
3. All military personnel
4. Old people like me and others at any age with at-risk medical conditions
5. Teachers providing in-classroom education
6. Children
7. Other adults
8. Local, state and federal employees including elected officials
9. Anyone who feels President Trump tainted the COVID-19 vaccine approval process can wait until President Trump is out of office in 2021 or 2025

Reference

1. U.S. Food & Drug Administration website, The FDA's Drug Review Process: Ensuring Drugs Are Safe and Effective. https://www.fda.gov/drugs/drug-information-consumers/fdas-drug-review-process-ensuring-drugs-are-safe-and-effective Infographic: https://www.fda.gov/drugs/drug-information-consumers/fda-drug-approval-process-infographic-vertical

CANDIDATES ON HEALTH CARE *continued from page 14*

What can and should St. Louis County be doing to increase access to health services and improve conditions supporting health for low-income, minority populations in the county?

Page: Our region has a history of racial inequity. Health services must be easy to access. As part of our COVID response, we have supported federally qualified health centers operating in underserved areas. Equity expert Professor Jason Purnell is helping us invest the CARES Act funding where it's most needed. We've dedicated $2.6 million to food security, over $10 million in homelessness prevention and rental, mortgage and utility help. We've distributed over 2.5 million masks and provide free, reusable masks at every public library. My administration will continue to direct resources to where they're needed most.

Mitchell: Due to downsizing and chronic underfunding, many families are unable to get care at our once excellent County clinics. We must study how many families have no access to primary and preventive care, and how to expand health services to meet these essential needs, especially in vulnerable low-income, minority neighborhoods.

What should be the public health criteria to open schools for in-person classes?

Page: First, we need widespread adoption of the mask mandate. We need widely available rapid testing. Right now, virtual schooling is the best option. While the rate of new cases among 15- to 19-year-olds continues to increase, the rate of cases among younger students has remained relatively steady. For that reason, we expect to be able to recommend a return to in-school learning for younger students first, but we're not ready to offer a timetable. We will continue to share information on our website, stlcorona.com. Any decisions will be made in close communication with our schools.

Mitchell: When teachers, school nurses, employees and administrators have a demonstrable science-based program for preventing spread of infection at school, and when community infection rate remains low, schools may re-open, barring no new infections.

HARRY'S HOMILIES©

Harry L.S. Knopf, MD

ON VOTING

"Now is the time for all good men to come to the aid of their country."

This phrase (or similar phrase) was first attributed to Patrick Henry. Then it became a way to practice typing skills. But this month it is a battle cry: VOTE. It has never been more important!

Dr. Knopf is editor of Harry's Homilies.© He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.