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MEDICINE
VOLUME 40, NUMBER 2 APRIL / MAY 2018

# Vigilance *on* Vaccinations

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# How Do We Approach Anti-Vaccination Attitudes?

*By Christopher A. Swingle, DO, Medical Society President*

*Medical Society President Christopher A. Swingle, DO*

To know how to intelligently respond, we need to examine where the fabrications are coming from, who the consumers are, why they give it credence and what can be done to convince them otherwise.



There are many things that, as physicians, we universally take for granted. One does not need a background in medical statistics to understand that seat belts save lives and reduce injuries in car accidents. Nor do you need to have an epidemiology degree to know that tobacco smoking is causative for lung cancer.

At some point in your undergraduate classes, you almost certainly heard the story of Edward Jenner, the milkmaids and the resulting smallpox vaccine. Thanks to Dr. Jonas Salk, a true hero of the 20th Century, the last U.S. polio case was in 1979.[1] The benefits of vaccination clearly outweigh the risks. Therefore measles, mumps, rubella and diphtheria should be nearly unknown today … right?

Something else that we undoubtedly learned in our medical training is not found in a textbook, but is taught all the same. From the level of nations down to the individual, people do not necessarily share the same values. Between nations, this manifests as diplomatic disputes and war in the worst possible scenario. On the physician-patient level, it is the case of the physician convincing a diabetic who places greater value in the psychological comfort of fast food about the value of diet and exercise. We think that because the medical values we have spent years studying are second nature to us, logically they should be obvious to everybody. They are not.

## Anti-Vaccination Movement Is Long-Standing

Even in Edward Jenner's time, there was an anti-vaccination movement.[2] Sir William Osler got so fed up with the "anti-vaxxers" of 1910 that he dared them to expose themselves to smallpox and promised to personally pay for the resulting funeral expenses. He did not get any takers.[3] Historically, anti-vaccination sentiment gains momentum once the worst infectious diseases were no longer visible to the public. Now that there is a whole schedule of vaccinations, many of the most dreaded childhood infectious diseases have lost visibility. From this place of comfort and safety made possible by widespread vaccination, we now have to contend with a resurgent anti-vaccination movement.

Spend a few minutes on social media, or watch the feel-good daytime television shows ubiquitous in patients' hospital rooms. Wouldn't it be nice to have the same reach to millions that charismatic opportunists like Dr. Oz or Jenny McCarthy have? Could a few snarky pro-vaccination Facebook memes go viral and change minds our way for once? Until such time, physicians will have to leverage the physician-patient relationship in a smart and persuasive way.

To know how to intelligently respond, we need to examine where the fabrications are coming from, who the consumers are, why they give it credence and what can be done to convince them otherwise.

According to a paper by Kata,[3] the origin of misinformation typically starts with valid scientific debate on the risks of vaccination. One would hope that debate would be based on honest data presented after a rigorous peer-review. Unfortunately, the fraudulent *Lancet* paper by Wakefield from 1998 (finally retracted by that journal in 2010 after 12 years of damage had already been done) calls even that assumption into question.[4] From there, the debate is spun to conform to the anti-vaccination agenda and then reaches the public, typically through social media.

## Study Examines Common Traits of Anti-Vaccination Believers

One question that needs to be answered is, "What traits do anti-vaccination believers have in common?" Hornsey et al. tackled this question and found some commonalities while dispelling a few stereotypes.[5]

Surprisingly, there seems to be no real correlation between vaccine attitudes and socioeconomic status or educational level. Much better predictors are a high level of conspiratorial thinking, a low tolerance to infringement on perceived personal freedom, aversion to needles or blood and religious issues. But most importantly, the consumers of misinformation are most commonly concerned parents.

A large part of why people buy into the anti-vaccination mindset is confirmation bias; when presented with evidence opposing existing beliefs, patients and parents will reject the information out of hand. A German study demonstrated that subjects will perceive increased risk to vaccination after only five to ten minutes of time on an anti-vaccination websites.[6] Additionally, a Canadian study suggested that the odds of parents perceiving vaccines as unsafe rose considerably for those who searched for vaccine safety information on the internet.[7] Herein lies the problem: From the skeptical point of view, these websites present valid questions. From our point of view they are absurd and dangerous, but providing evidence for an absence of risk is painfully difficult. How can you expect to find common ground in this scenario, much less be persuasive?

Rather than confrontationally going after anti-vaccination groups, physicians must clearly articulate a message on the consequences of being unvaccinated.

Frustratingly, direct pro-vaccination messages may not be simply unhelpful, but can potentially backfire. Nyhan et al. found that not only did none of their four approaches to directly educate concerned parents with CDC-sourced pro-vaccination materials help, but also further reinforced the exaggerated perception of risk.[8] The adversarial model that worked so well against the tobacco industry is unlikely to be helpful here. Moreover, nobody likes being lectured or talked down to, no matter how misguided their beliefs might be.

## Education on the Consequences of Not Vaccinating

Horne et al. tried a different approach; instead of directly taking on vaccine misinformation, experimental parent groups were educated on the consequences of not vaccinating their children. They had success with the group that was shown pictures of children with mumps and rubella, along with a letter from a mother of a measles patient. Disappointingly, a second group that was educated on the nonexistence of a vaccine/autism link remained as unconvinced as ever.[9]

So we have evidence for an approach that potentially works for a select group of patients, but obviously much work remains to be done. On the individual level, I believe it has to come back to the doctor-patient relationship. Patients will continue to trust physicians who listen to their concerns. If we do not have that trust, we cannot reasonably hope to persuade on the real risks and benefits of vaccination. On the societal level, we need communicative physician leaders to engage the issue, not the activist. Rather than confrontationally going after anti-vaccination groups, physicians must clearly articulate a message on the consequences of being unvaccinated.

On a lighter note, if you need a break after reading this, look up ZDoggMD's clever *House of Cards* parody, "Magna Cum Measles" on YouTube.[10] While I cannot recommend his hilariously unorthodox approach to a skeptical mother as a "best practice," it is still a very funny three-minute skit on the subject of vaccination.


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# Opioids – A Modern-Day Epidemic

*By David M. Nowak, Medical Society Executive Vice President*

*Executive Vice President David M. Nowak*

Statisticians have compared the number of daily opioid deaths as the equivalent of a large passenger jet crashing each and every day.

The opioid crisis has emerged as the first epidemic of the 21st century. Recent statistics tell us that drug overdoses claim nearly 64,000 lives each year, or about 175 people per day. Over the last 15 years, the opioid epidemic has earned its place in U.S. history as the most deadly drug epidemic ever.

The intensity of the problem was magnified with recent statistics released by the U.S. Centers for Disease Control and Prevention. They reported that emergency room visits in the 15-month period from July 2016 to September 2017 due to suspected opioid overdoses climbed about 30% across the country. The largest increase of prevalence by region was in the Midwestern states. Here in Missouri, the rate of increase was 21.4%. In Illinois, it was 65.6%.

More sobering are the most recent numbers released by the National Center for Health Statistics on life expectancy in the United States, which declined for the second consecutive year in 2016. Life expectancy in the U.S. had not fallen two years in row in more than 50 years, since the early 1960s. The major culprit identified by federal officials was the increase in fatal opioid overdoses.

Statisticians have compared the number of daily opioid deaths as the equivalent of a large passenger jet crashing each and every day. Strangely enough, if airplanes were falling from the sky that often, most likely air travel would come to a complete stop until we figured out what was causing the problem. But not so with opioid related deaths—is it the social stigma of addiction? Or have we as Americans become numb to the problem?

Fortunately, that may be changing, and numbness is turning to action. Government leaders are declaring a national emergency, one that impacts every state, every county, every income group, and almost all ages. Millions of us know at least one individual, or one family, that has struggled with the problem of addiction. The March 5, 2018, issue of *Time* magazine tackled the problem with a brutal depiction of the horrors of addiction told through essays and photographs entitled "The Opioid Diaries." It was the first issue in the magazine's 95-year history devoted entirely to one photographer's work. *Time* called it "a visual record of a national emergency—and it demands our urgent attention."

Over the past several years, the Medical Society has not been shy in calling for action related to reducing prescription drug abuse. Several articles have been written in this publication by area physicians on the problem, and for many years we have advocated for a prescription drug monitoring program in Missouri. We celebrated when the St. Louis County Council passed legislation to create a county-based PDMP, thanks to the stalwart efforts of SLMMS member and County Councilman Sam Page, MD, and have steadfastly promoted physician enrollment in the program. In less than one year, the St. Louis County PDMP has been adopted by 58 jurisdictions across Missouri, representing 79% of the state's population and 92% of its health care providers, and boasts more than 6,000 registered users. This year, SLMMS is sponsoring a resolution calling for legislation to adopt St. Louis County's program as Missouri's statewide PDMP.

On Saturday, April 21, SLMMS takes another step in addressing the epidemic. The Medical Society is proud to partner with Clayton Behavioral and the Missouri State Targeted Response to the Opioid Crisis to present "What's My Role in Addressing the Opioid Crisis? – A Conference for Physicians Who Want to be Part of the Solution," a free half-day CME symposium for St. Louis St. Louis-area physicians. Two keynote speakers will help identify the most promising medical and harm-reduction practices being used to decrease opioid-related morbidity and

mortality. A panel discussion featuring four St. Louis area physicians will highlight practical tools for doctors, illustrating how treatment of Opioid Use Disorder fits into the continuum of care. We hope you will join us for this timely and informative conference (see details on page 7 or visit www.slmms.org for the link to online registration). A big thank you to SLMMS member Luis Giuffra, MD, PhD, and Ned Presnall of Clayton Behavioral, and Rachel Winograd, PhD, of the Missouri STR for helping organize this event.

Physicians across the country are stepping up to take leadership roles to help combat the opioid epidemic. With promising treatments on the horizon, and continued government support of education programming, we can make a difference.

# SLMMS Physician Insurance Survey 2.0

This spring SLMMS is repeating its highly successful physician insurance survey, designed to capture the perspectives of physicians (and their staffs) on the pre-certification process and dealing with insurance companies. More than 300 St. Louis-area physicians participated in the initial survey in 2016. Repeating the survey will allow us to measure attitudes and performance over time and provide more information about physician satisfaction working with insurance companies to the larger St. Louis community. This is an excellent opportunity to make your voice heard.

Again this year, it is an online-only survey, and takes only a few minutes to complete. Physician members with a current email address on file with SLMMS should have received your invitation to participate. Several physician groups or hospital medical staffs are also distributing the survey link for us. If you receive multiple survey invitations, you only need to complete it one time. If you have not received a survey link, please contact Dave Nowak in the SLMMS office at dnowak@slmms.org and the link will be forwarded to you. The survey will remain open through mid-April or until the required number of completed questionnaires have been received.

# "Health Care, Politics & Beer" Social and Educational Event for SLMMS Members Hosted by the League of Healthcare Experts

*"If given the truth, [the people] can be depended upon to meet any national crisis. The great point is to bring them the real facts—and beer."*

*– Abraham Lincoln*

Mark your calendars and plan to attend a social/educational event for SLMMS members on Wednesday, June 6, from 5:30 to 8:00 p.m. at the GC Brewery, 11411 Olive Blvd. in Creve Coeur. "Health Care, Politics & Beer," sponsored by the League of Healthcare Experts, will include a behind-the-scenes brewery tour and craft beer sampling, then appetizers and an educational program presented by Cora Butler, JD, and Brian McCook, CPA. Continuing Medical Education (CME) credits will be awarded for participation in the educational program (not the brewery tour and craft beer sampling!).

The League of Healthcare Experts is a St. Louis-based consortium of seven business organizations that provide an ongoing series of free health care educational programs, strictly instructional in nature, that introduce experts who can assist physician practices with many services. The participating companies are Anders CPA + Advisors, DataFile Technologies, Enterprise Bank & Trust, GBS Information Systems, HealthCore Value Advisors, Keane Insurance Group and Keystone Technologies.

The program will include:

**"Mr. Toad's Wild Ride, or, Healthcare Policy & Legislation in Washington, DC,"** presented by Cora Butler, JD, president and CEO of HealthCore Value Advisors, will examine and discuss the current status of health care policy and law as reflected in proposed or enacted legislation, identify key distinctions between the ACA and current proposed legislation, describe its impact on key stakeholders, and recognize key strategies for future success.

**"Tax Cuts and Jobs Act,"** presented by Brian McCook, CPA, partner with Anders CPA + Advisors, will dive into the new tax rates and how they will directly impact health care organizations and their physicians, including the lowered corporate tax rate; individual income brackets for physicians, interest deduction limitations; and qualified business income deduction for pass-through entities.

This event is free but advance registration is required, and will be limited to the first 75 registrants. Register online at www.leagueofhealthcareexperts.com/slmms/. For more information, contact Dave Nowak in the SLMMS office at 314-989-1014, ext. 105, or Ann Grana at 314-541-2220. Join us for an evening of fun social time with colleagues, craft beer sampling and appetizers, an interesting program and stimulating conversation.

**"HEALTH CARE, POLITICS & BEER"**

Wednesday, June 6
5:30 to 8:00 p.m.

GC Brewery, 11411 Olive Blvd., Creve Coeur

Register: www.leagueofhealthcareexperts.com/slmms/

# SLMMS Renews Approved Provider Status for Keystone Mutual

SLMMS recently renewed its agreement with Missouri-based Keystone Mutual as the only approved provider of medical professional liability insurance for its members. Keystone provides SLMMS member-physicians with a 10% discount on their medical malpractice insurance premiums.

"We applaud the product Keystone Mutual has provided to our member physicians over the past five years," explained Christopher A. Swingle, DO, SLMMS 2018 president. "Keystone continues to protect our members and offer them sound risk management. We enjoy the trusted relationship between our organizations."

SLMMS first approved of Keystone and began the partnership in 2012, and has renewed the designation twice. The current agreement extends through the end of 2020.

"We are honored to have this status from such an outstanding organization," said Jim Bowlin, Keystone's CEO. "We enjoy protecting the reputations of the Society's physician members, and look forward to continuing our service to them for many years to come."

# What's My Role in Addressing the Opioid Crisis?

*A Conference for Physicians Who Want to be Part of the Solution*

**Half-day workshop sponsored by the St. Louis Metropolitan Medical Society, Clayton Behavioral, and the Missouri State Targeted Response to the Opioid Crisis**

## Saturday, April 21, 2018
## 8:30 a.m. to 12:30 p.m.

**Emerson Auditorium - St. Luke's Hospital, 232 S. Woods Mill Rd., Chesterfield, MO**

**This conference is free and open to all physicians, but you must register in advance. Continuing Medical Education (CME) credits will be awarded.**

**Registration:**
**https://bit.ly/opioidslmms**

*For more information, contact the St. Louis Metropolitan Medical Society at 314-989-1014*

## Program:

**8:30 a.m.**
Registration and continental breakfast

**8:55 a.m.**
Welcome:
- Christopher Swingle, DO, 2018 President, St. Louis Metropolitan Medical Society

**9:00 a.m.**
Reversing the Opioid Epidemic: The Science of Opioid Use Disorder Treatment
- Luis Giuffra, MD, PhD

**10:00 a.m.** Break

**10:15 a.m.**
Integrating OUD Treatment Across the Healthcare System: Opioid Use Disorder in Pain Management, Emergency Medicine, and Primary Care
- Corey Waller, MD

**11:15 a.m.**
Panel Presentation:
"Practical Tools for Physicians"
- Larry Lewis, MD, moderator
- Ravi Johar, MD
- Sam Page, MD
- Douglas Pogue, MD
- Evan Schwarz, MD

**12:30 p.m.** Adjournment

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# The Future of the American Health Care System

*Editor's Note: The following is in response to a Dec. 5* JAMA *forum article by Andy Slavitt, former acting director of the Centers for Medicare & Medicaid Services from 2015 to 2017.*

Yogi Berra said, "It's tough to make predictions, especially about the future."

We are not making predictions but we do have a few suggestions.

We are attempting to address three issues: Cost of health care (national), affordability and availability.

Our health care system which is Medicare plus Medicaid plus private insurance is not working well. Health care is the largest industry in America, consuming approximately 17 percent of the GDP. Many patients are still uncovered, and the "Obamacare" Affordable Care Act (ACA) mosaic of private plans is clumsy and inefficient. The Congressional Budget Office has found that Medicare administrative costs are approximately 3 percent compared to about 10 percent for private insurance for similar populations.

U.S. Sen. Bernie Sanders of Vermont has proposed "Medicare for all" as a solution to health care availability. He proposes to do away with Medicare as we know it and institute a new single-payer national health insurance system. He would abolish our most efficient health care program. We are opposed to a single-payer system as inefficient and unaffordable.

We recommend continuing Medicare as a fee-for-service system: over age 65, no changes; under age 65, $10,000 deductible. Medicare supplement insurance rates under 65 would probably run from $100 to $700 per month depending on age. Those who chose not to buy a supplement would have "catastrophic health insurance." There would be no uninsured. For those under the poverty level, Medicaid would cover the deductible. ACA changes in Medicaid would be rolled back. Deductibles are essential to control costs.

This program would cost less than private insurance-based ACA. Current Medicare reimbursements are modest but few physicians have opted out of the program. Some 54 percent of physicians favor increasing Medicare coverage to lower age groups. Medicare is our most cost-effective system, and we should take advantage of it. Changes here are incremental and feasible compared to single payer.

Yogi said, "You've got to be very careful if you don't know where you're going because you might not get there."

George Bohigian, MD
President, SLMMS, 1979

Terence Klingele, MD
President, St. Clair County, Ill. Medical Society, 1985

# HARRY'S HOMILIES©

**Harry L.S. Knopf, MD**

## ON VACCINATION AND PREVENTION

An ounce of prevention is worth a pound of cure.
*– Benjamin Franklin*

Dr. Franklin did not know about vaccines, but his aphorism was surely prescient. Immunization to prevent disease in humans and animals is now so common that it is easy for today's parents to forget about history: There was widespread disease and death before the development of vaccines. Even today, the recent epidemic of Zika wreaked havoc until there was enough "herd immunity" and colder weather to interrupt the carnage. The refusal to accept vaccination is grounded on only a slim number of factors, while the evidence for protection by vaccine to an individual and society is overwhelming. Let us not forget to urge all of our patients and friends to "stay current" with vaccines unless there are bona fide health risks. And, as an aside: wouldn't it be good if we had a vaccine that prevented bad behavior? But that is a subject for future discussion. …

*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.*


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The Muny celebrates its 100th season in Forest Park this summer, and SLMMS members won't miss a single show when you use your member discount to purchase new season ticket subscriptions through the Muny Corporate Advantage Program (MCAP).

The program allows members to enjoy huge savings (20-50%) when compared to purchasing single tickets, and is the equivalent of getting up to three shows free. The centennial season includes classics like "Meet Me in St. Louis," "Gypsy," "The Wiz," "Annie," and "Singin' in the Rain," plus the Muny premieres of "Jerome Robbins' Broadway" and "Jersey Boys."

Through the MCAP program, you'll receive guaranteed same seats for all seven shows in Terrace A or Terrace B only.

Subscribers have ticket exchange privileges, and the first option to renew the same seats for future seasons. To obtain your savings, use the Medical Society's promo code **SLMMS18CA** when ordering tickets by phone, online or in person at the Muny box office. This code is good only on new season ticket subscriptions purchased between April 6 and May 6, 2018, is not retroactive to prior season ticket purchases or renewals, and may not be used for individual ticket purchases.

Visit www.muny.org to view the 2018 season, show dates and ticket prices. For complete details, download the SLMMS MCAP program flyer at www.slmms.org. If you have questions about the discount program, contact Jane Schell at the Muny at 314-595-5708 or jschell@muny.org.

# Regions Bank Offers Doctor Mortgage Program

Through a new partnership with the Medical Society, Regions Bank is now offering SLMMS members a top-notch mortgage loan program designed especially for physicians—the Regions' Doctor Mortgage Program. Regions Mortgage recognizes that borrowers in the medical profession are unique, whether you are an experienced physician or just beginning your residency. The program simplifies the mortgage process for physicians, providing the ability to exclude deferred student loans from the loan qualification process, plus extra benefits for the physician when closing the loan.

The program is open to all MDs and DOs, including residents and fellows. The Doctor Mortgage Program features include:

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- Private mortgage insurance (PMI) not required
- Only available for primary residences, single-family residences, and townhomes

To learn more about Regions' Doctor Mortgage Program, contact Thomas Shepherd (NMLS #587686) at 314-239-0539 or thomas.shepherd@regions.com and mention that you are a SLMMS member.

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# Reversing the Opioid Epidemic: A Call to Action

## Data increasingly shows effectiveness of opioid substitution therapy

*By Luis Giuffra, MD, PhD; Ned Presnall, LCSW; and Rachel Winograd, PhD*

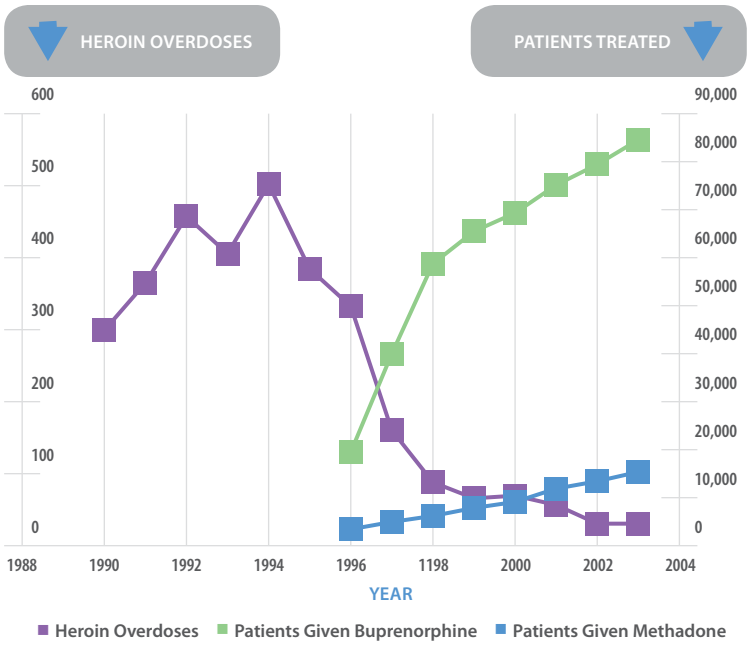
The epidemic of accidental opioid poisoning has received increasing media coverage as opioid-related deaths have skyrocketed. But the magnitude of the problem is still largely unappreciated. From 2000 to 2016, more than 600,000 people died from drug overdoses, most involving opioids.[1] Drug-related mortality in the United States has surpassed peak annual deaths related to AIDS, gun violence and car accidents. Perhaps most troubling, between 2016 and 2017 the rate of death was increasing faster than ever, with a 22 percent increase in annual deaths.[2]

An increasing body of data clearly shows that long-term opioid substitution therapy (using buprenorphine or methadone, two of the World Health Organization's essential medications) is the most effective treatment intervention for opioid dependence. This past October, the Global Commission on Drug Policy published a position paper, "The Opioid Crisis in North America," in which it argued that "prejudice against opioid substitution therapy with methadone and buprenorphine—and the over-regulation of these drugs—has negatively affected the response to the crisis." From treatment services data, they estimated that "only 8-10 percent of treatment programs offered opioid substitution therapy, often provided for periods too limited to be effective."[3] The reality in the United States is that the vast majority of opioid dependence treatment providers and organizations are still attached to an abstinence-only model, overlooking the life-saving potential of opioid substitution therapy.

Although it is crucial for substance use disorder treatment programs to integrate effective pharmacotherapy for opioid use disorder (OUD), it is unlikely that psychosocially oriented programs (i.e., excluding medications) can manage the opioid crisis by themselves. The most recent Cochrane review found that adding intensive psychosocial treatment, such as contingency management or cognitive behavioral therapy, to methadone and buprenorphine in federal opioid treatment programs had no effect on retention or illicit opioid use.[4] Intensive psychosocial requirements often create an obstacle to enrollment or retention in pharmacotherapy.[5] Although the data overwhelmingly supports a medical model of opioid use disorder treatment, there is an abysmally low fraction of physicians willing and able to prescribe the necessary medications. A call to action among physicians is desperately needed.

There is strong evidence that delivering pharmacotherapy in any setting where patients present with opioid use disorder can have a significant impact on mortality. A recent cohort study of 122,885 patients receiving methadone and 15,831 receiving buprenorphine over 1 to 13 years found that all-cause

**Chart 1: Impact of Buprenorphine in France**




Source: Carrieri MP, et al. Buprenorphine use: the international experience. *Clinical Infectious Diseases* 43.Supplement 4 (2006): S197-S215.



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Rachel Winograd

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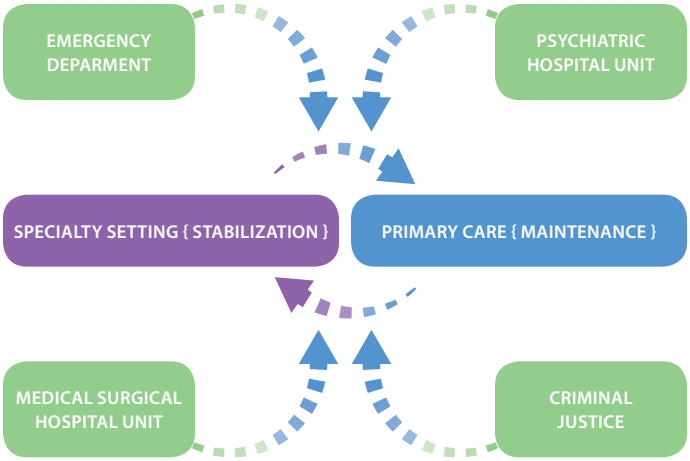
mortality was three and two times higher respectively when persons were not receiving pharmacotherapy.[6] In 1997, France approved buprenorphine treatment for opioid use disorder without requiring special training or certification of physicians. About 20 percent of primary care physicians began prescribing, and the increase in buprenorphine therapy corresponded to a decrease in opioid-related mortality (Chart 1).[7]

Similar results were associated with Baltimore's 2003 buprenorphine initiative.[8] In 2017, Rhode Island implemented methadone and buprenorphine treatment for all incarcerated individuals with opioid use disorder. In just one year, overdose deaths associated with recently incarcerated individuals decreased 60 percent. The number needed to treat (NNT) to prevent one death in this population was 11.[9]

**Chart 2: Health Care Integration of OUD Treatment**




The magnitude of the opioid crisis, the lack of access to effective pharmacotherapy, and the clear need to prioritize pharmacotherapy over psychosocial treatment has led to the development of "low-threshold" models of buprenorphine treatment to supplement geographically sparse and capacity-limited opioid treatment programs.[10] In low-threshold models, maintenance buprenorphine treatment is provided in primary care settings and referrals to intensive treatment (e.g., an opioid treatment program or residential program) are made to stabilize consumers who return to primary care for maintenance. "Hub-and-spoke,"[11] "co-op,"[12] "nurse care manager,"[13] and ECHO (Extension for Community Healthcare Outcomes)[14] models have significantly increased the capacity for low-threshold buprenorphine treatment in Vermont, Maryland, Massachusetts and New Mexico.

Missouri's Department of Mental Health is using federal funds from the State Targeted Response to the Opioid (STR) to recruit medical prescribers throughout the health care system to begin addressing opioid use disorder wherever it presents. Missouri's "Medication First" model emphasizes emergent access to proper pharmacotherapy and the elimination of all unnecessary barriers to ongoing medical treatment. Missouri's STR team has targeted not only substance use disorder programs but also hospital EDs, infectious disease consults, primary care clinics and criminal justice settings to catalyze full integration of opioid use disorder treatment in the health care system (Chart 2). Health care integration of treatment is by far the most important strategy for reducing opioid-related mortality and morbidity. This cannot be done unless more physicians get involved. There are simply not enough psychiatrists or addictionologists to cover the overwhelming need for treatment.

The St. Louis Metropolitan Medical Society, in conjunction with Clayton Behavioral and the Missouri State Targeted Response grant, is offering a symposium on Saturday, April 21, on how you can help curb this devastating epidemic. See page 7 or visit www.slmms.org for more information.

Regardless of your specialty or practice setting, we urge you to become a waived prescriber of buprenorphine and to help address the epidemic. Missouri's State Targeted Response offers free waiver trainings and technical support. A buprenorphine waiver training will be offered on Saturday, June 2. Details can be found at https://missouriopioidstr.org/.

If your organization or practice would like consultation or training related to the Medication First model of buprenorphine treatment, please contact us.

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# Vigilance *on* Vaccinations

## Emphasis needed to maintain high childhood immunization rates, raise teen and adult coverage, and counter misinformation

*By Jim Braibish, St. Louis Metropolitan Medicine*

Measles outbreaks in the past few years—including most recently the announcements of a potential case in Chesterfield and 10 cases in suburban Kansas City[1]—give reminder to the consequences when unvaccinated individuals contract the serious diseases we are trying to immunize against.

While immunization rates overall remain stable or are increasing, public health officials suggest there is much room for improvement. There also is the need to counter the anti-vaccination misinformation that continues to be spread over the internet and that patients bring to the physician's office.

### Current Status

Missouri scores well in immunizations against major childhood diseases. In measles, mumps and rubella, Missouri ranks 20th at 92.9% of children ages 19-35 months immunized, according to the Centers for Disease Control National Immunization Survey. The national rate is 91.1%.[2] The Missouri Department of Health & Senior Services (DHSS) notes that more than 95% of Missouri's 74,000 kindergartners were fully immunized against measles, mumps and rubella; diphtheria, tetanus and pertussis (whooping cough); varicella (chickenpox); hepatitis B and polio.[3]

However, the state is behind the national average in teenage vaccinations. In 2016, the Missouri rate for three doses of HPV vaccination was 35.4% in girls and 26.3% in boys, compared to the national rates of 43% and 31.5% respectively. The meningococcal group had 66.2% coverage in the state in 2016, compared to 85.6% nationally. Missouri's teenage immunization rates have been increasing in recent years.[4]

Increasing vaccination against the cancer-causing Human papillomaravirus is a priority for DHSS, said Kerri Tesreau, acting director for the Division of Community and Public Health. "We encourage providers to educate parents and their teens on HPV vaccination. The focus should be cancer prevention," she said.

Adult immunization is another concern. About three-fourths of adults age 65 and over in Missouri have received the pneumococcal vaccination, while only a third of those age 60 and over have received the shingles vaccination and one third of all adults get the flu vaccination, according to DHSS.

### Barriers to Vaccination

What barriers stand in the way of raising vaccination rates?

Some have to do with cost and access. National CDC data shows immunization rates are generally lower for African Americans and persons living below the poverty level.[5] Tesreau cited the need for access to providers at times that are convenient to patients, and the problem of those who do not seek routine checkups for themselves or their children when vaccines could be administered.

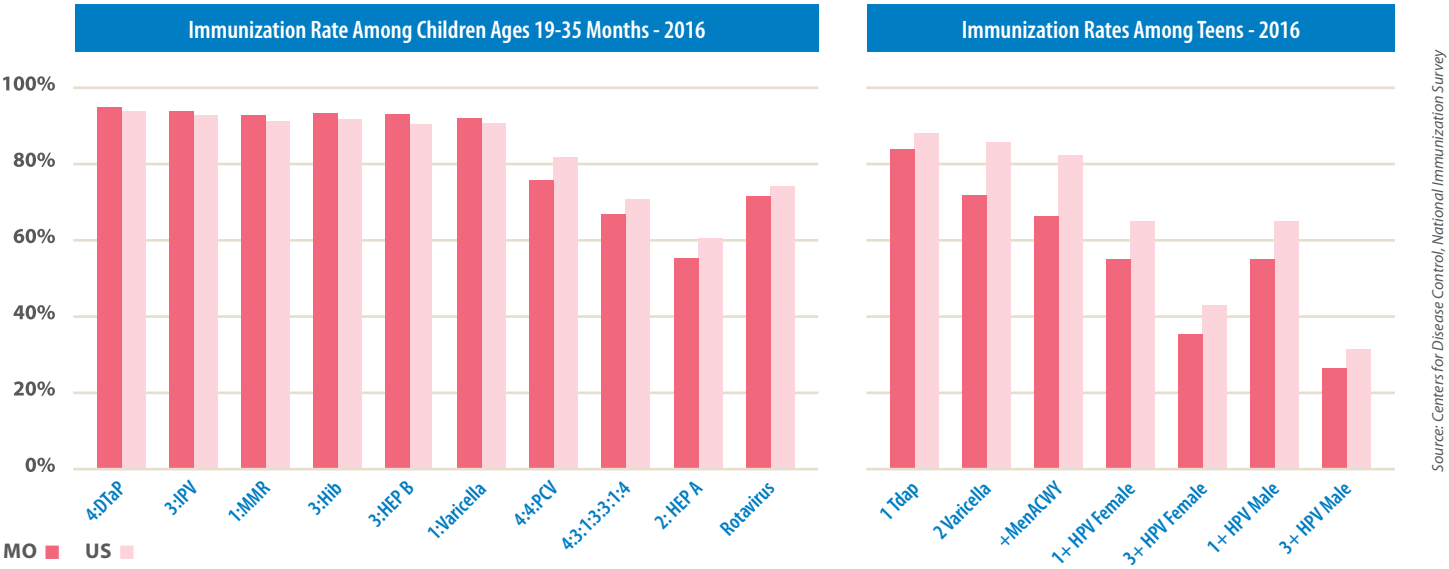
Some children are not vaccinated because their parents do not have insurance or cannot afford it. For these children, the federally funded Vaccines for Children program provides free vaccines for children who are uninsured or for those whose insurance does not provide vaccine coverage or has a dollar cap. Any medical provider authorized to prescribe vaccines in Missouri may apply to become a Vaccines for Children provider.

The City of St. Louis Department of Health has initiatives targeting socioeconomic disparities. "We partner with Betty Jean Kerr People's Health Centers to provide a walk-in immunization clinic to citizens. We also try to address these disparities by referring citizens to navigators who assist clients with getting enrolled in Medicaid or Gateway to Better Health," said Meredith Nalick, nurse supervisor of women and adolescent health services for the department.

### Anti-Vaccination Sentiments

Nalick added that they hear concerns about side effects of vaccination, especially fear of autism, along with objections to the number of injections and objections on moral or religious grounds. In Missouri, just over 2% of kindergartners had religious exemptions to vaccination on file with the state in 2016. This is a slight increase over the 1.56% reported in 2011.

The purported link between vaccines and autism is rooted in a now-discredited 1998 study published in *The Lancet* by Andrew Wakefield, MD, alleging a link between the MMR vaccine and autism. *The Lancet* later retracted the article after it was found the data was false. See further discussion of Dr. Wakefield in the article by Arthur Gale, MD, on page 16.




Nalick commented, "As long as questions are raised about immunizations, there will always be a threat to herd or community immunity. This is why as a public health authority, it is our duty to educate the public on why immunization is important to ease and dispel these concerns. Keeping the vast majority of the population immunized reduces the risk of widespread outbreaks."

Faisal Khan, MBBS, MPH, (SLMMS), director of the St. Louis County Department of Public Health, added, "The anti-vaccination belief is based on ignorance, fear and a poor understanding of the scientific process—all in spite of a preponderance of evidence in support of vaccines."

## Improving Vaccination Rates

The Department of Health & Senior Services offers these suggestions to physicians on how to help improve vaccination rates:

- Make strong, clear, consistent and concise recommendations to parents and guardians about the importance of immunizing their children
- Leverage electronic health records to learn your clinic's immunization rate
- Use standing orders for vaccinations for all age groups and vaccinations
- Offer office hours that are convenient for working parents, such as evening or Saturday hours
- Provide immunizations on a walk-in basis
- Use reminder recall systems to remind parents of vaccinations that are due
- Bundle vaccination recommendations—all vaccinations are important
- Discuss all recommended vaccinations at each visit, even if your patient has refused a vaccination in the past
- Use the state's web-based immunization information system (registry), ShowMeVax, to look-up and report immunization administration.

Nalick reinforced those recommendations: "Make all clinical encounters count by checking vaccination records and considering the visit an opportunity to administer needed vaccinations. Be prepared to listen to concerns and educate parents. Institute standing orders for nurses to administer needed vaccinations on the spot independent of physicians. Administer combination vaccinations to alleviate fears of receiving too many shots at once. Improve access to vaccinations by allowing walk-ins, short wait times, supportive staff, and convenient hours. Utilize EMRs and electronic alerts for staff to generate reminders for clients, such as mailing reminder cards."

At the community level, much also can be done. Dr. Khan suggested, "We need greater community awareness of the threat posed by vaccine-preventable diseases. The business community should encourage all employers and employees to view vaccination as a safe and effective way to prevent workforce absenteeism due to illness."

Dr. Khan summarized the importance of the issue: "Vaccines are the star public health success story of the last 70 years. They have saved millions of lives worldwide and have eradicated diseases such as smallpox and polio because of focused vaccination campaigns coupled with health education efforts the world over. It is an absolute crime for the United States to still be mired in debates about vaccines in 2018. Vaccines save lives!"

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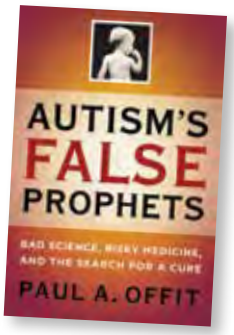
# Book Review: *Autism's False Prophets: Bad Science, Risky Medicine and the Search for a Cure*

## The story of the doctor behind the discredited study linking autism and vaccination, and his continued anti-vaccination advocacy

*By Arthur Gale, MD*

*Editor's Note: This article originally appeared in* St. Louis Metropolitan Medicine *in December 2010. It is being reprinted here because of its relevance to the vaccination issue.*




*Autism's False Prophets*, by Paul Offit, MD, describes the unsuccessful attempt by fringe scientists, advocacy groups and personal injury lawyers to link autism with vaccines. It is a morality tale about falsification of research, discredited expert witness testimony, and a media mainly interested in ratings and sensationalism rather than scientific evidence. It reveals a legal system where personal injury lawyers are driven by the lure of huge financial settlements, judges have no background in science or medicine and juries have little understanding of the scientific method. It is a story that has been repeated over and over in the United States with other products that have been ultimately been proven safe. It is a story that will undoubtedly be repeated in the future unless changes are made in our legal system.

The author, Paul A. Offit, MD, is chief of infectious diseases at Children's Hospital in Philadelphia, professor of pediatrics at the University of Pennsylvania School of Medicine, and a co-inventor of a rotavirus vaccine. Dr. Offit is one of the heroes in the sordid autism story. In the 1990s, after becoming aware of nine deaths from measles in the Philadelphia area, Dr. Offit vigorously spoke out against the anti-vaccine hysteria that was then sweeping the country. As a result, he received death threats against himself and his family and, for a period of time, had to hire armed security guards for protection.


Arthur Gale, MD

*Arthur Gale, MD, is a past president of SLMMS and frequent contributor to St. Louis Metropolitan Medicine and Missouri Medicine. His writings over the past five-plus years have been compiled into a recent book, A Doctor's Perspective on Medical Practice in the Twenty-First Century, available on Amazon.com. Dr. Gale can be reached at agalemd@yahoo.com.*

### Links First Alleged in England

The story begins in England in 1998. Andrew Wakefield, MD, a gastroenterologist published an article in *The Lancet*, which concluded that the Measles Mumps Rubella vaccine, MMR, caused autism. The press sensationalized the findings, which in turn produced a mass hysteria across the U.K. and Ireland. Vaccinations decreased, and, as expected, epidemics of measles broke out causing some deaths.

In 2004, six years after Dr. Wakefield's article, a *London Times* reporter, Brian Deer, made some devastating allegations about Dr. Wakefield's research to the editors of *The Lancet*. Dr. Wakefield had been given $100,000 by personal injury lawyer Richard Barr. Five of the eight autistic children in Dr. Wakefield's study were clients of Barr.

At that time, the British government had a unique program known as the Legal Services Commission which provided money to law firms for the investigation of claims. Law firms actually supervised the scientific research! The commission controlled over $1 billion. Reporter Deer found that the commission had provided $30 million to the Barr law firm—$20 million of which went to the law firm and only $10 million to doctors and research scientists. Later investigations revealed that Dr. Wakefield received not $100,000 but $800,000 from Barr to support his research. A number of other researchers, both in the U.K. and the U.S. who had supported Dr. Wakefield's findings, also received large stipends from Barr's law firm.

The final chapter of the MMR autism scandal was written in 2010, two years after the publication of Dr. Offit's book. Britain's General Medical Council found Dr. Wakefield guilty of "serious professional misconduct," saying that he had presented his work in an "irresponsible and dishonest" way and that he had shown "callous disregard" for the children in his study. The Council struck his name from the U.K.'s medical register. *The Lancet* retracted his article.

Dr. Wakefield has never shown the slightest remorse for his disgraceful actions. He continues his "research" today in the United States with funding from advocacy groups and personal injury lawyers. *Editor's Note: Dr. Wakefield met three times with*

*members of a Somali community in Minnesota in 2010 and 2011; this is the community that was struck by a measles outbreak in 2016 (Washington Post, May 5, 2017).*

## Challenges in the United States

In the U.S., the supposed link between vaccines and autism was based not only on MMR but also on the mercury-containing preservative, thimerosal. According to Dr. Offit, the link was first proposed by two mothers of autistic children and was published in an obscure journal with a miniscule circulation.

Congressman Dan Burton, an opponent of vaccines and the grandparent of an autistic child, chaired a Congressional hearing on the harmful effects of vaccines. A number of national celebrities hopped on the anti-vaccine bandwagon, the most influential of whom was Robert Kennedy, Jr., an environmental lawyer and professor emeritus at Pace University School of Law.

The media fanned the flames about the link between vaccines and autism, and, as in England, a wave of mass hysteria against vaccines broke out in the U.S. It didn't seem to matter that 10 epidemiological studies demonstrated that MMR doesn't cause autism and that six studies showed that thimerosal doesn't cause autism.

But scientific evidence didn't deter the anti-vaccine expert witnesses. They sued some researchers and scientific organizations that were most critical of their work for $1,000,000. After the expenditure of much time and money by the defense, the suit was eventually dropped.

The anti-vaccine advocates were not finished. Even though all of the studies by reputable scientists in peer-reviewed journals had established that neither MMR nor thimerosal cause autism, they took their case to federal court.

The judges evaluated three separate cases representing 5,000 claimants. Their decisions were handed down in 2009 one year after the publication of Dr. Offit's book. Despite Dr. Offit's doubts about their qualifications, all three judges performed admirably in thoroughly evaluating the testimony and sifting the evidence. They found that neither MMR nor thimerosal caused autism. In 2010, the U.S. Court of Appeals upheld the lower court's ruling.

Some of the scientists who testified in federal court described Dr. Wakefield's research as outright fraud. One stated: *"The petitioners have been the victims of bad science conducted to support litigation rather than to advance medical and scientific understanding of autism."*

This blunt statement goes to the heart of the problem. If, as the evidence indicates, Dr. Wakefield and the personal injury lawyers who sponsored his research did commit fraud, why should they not be criminally prosecuted? Many innocent children were harmed and some even died as a result of their shameful scheme.

# Legislature Considers Bill to Modernize Telehealth Use

## Would allow MO HealthNet reimbursement for telehealth, give providers more latitude

*By Todd A. Zigrang, MBA, MHA, FACHE, ASA, and Jessica L. Bailey-Wheaton, Esq.*

The Missouri Legislature is considering legislation (HB 1617), sponsored by Rep. Jay Barnes (R-Jefferson City), to update and expand the use of telehealth services for Medicaid patients covered by MO HealthNet. HB 1617 attempts to modernize language from Rep. Barnes' 2016 legislation which was passed with similar intentions, but resulted in unexpected restrictions to the breadth and applicability of telehealth use. HB 1617 aims to increase health care access for MO HealthNet beneficiaries, incentivize providers to further incorporate telehealth in their practices, and reduce the cost of care.[1]

The bill passed the House on Feb. 1 and the Senate held a committee hearing on the bill on March 7. *Editor's Note: The Missouri State Medical Association strongly supports this legislation and testified in favor of it at the March 7 hearing. "Telehealth is a great resource for areas that deal with a shortage of health professionals and MSMA supports this effort to make health care more accessible throughout the state," MSMA said in its weekly legislative report.*

The evolution of telehealth has significantly changed with federal health care reform measures, as well as state variations in regulatory and reimbursement rules. When the concept of telehealth was first implemented in the early 2000s, barriers such as lack of broadband access significantly affected implementation in rural Missouri.[2] However, with the broad adoption of electronic health records under health care reform, adequate hospital broadband access became more commonplace. As of October 2017, most states had a formal definition of telehealth and/or telemedicine and provided some form of Medicaid reimbursement for live video consultations.[3] Beyond that, states have varying policies. Only 15 states have implemented policies for "store-and-forward" technology, which allows for electronic transmission of medical material, e.g., videos and photographs, for diagnostic use.[4]

### HB 1617 Impact on Missouri Medicaid

The original version of HB 1617 included language that, among other things: specifically eliminated the need for a tele-presenter during consultations,[5] expanded telehealth platforms to include any device or technology that meets Health Insurance Portability and Accountability Act standards (e.g., potentially Skype or FaceTime), and increased the list of eligible patient locations including the patient's home. It also imposed a distance requirement for reimbursement of the consultation.[6]

However, the bill has been subsequently revised to remove much of this language, and now simply prohibits the development of rules or restrictions for reimbursement based on patient distance from the provider or patient location, as long as clinicians can ensure that these services meet the same standard of care that is expected in face-to-face consultations. Additionally, the revised bill relaxes language pertaining to reimbursement for store-and-forward technology and school-based telehealth care for children. Even with these changes, HB 1617 places Missouri among the more progressive states with regard to telehealth, and it remains one of only nine states that reimburses for remote patient monitoring, store-and-forward technology, *and* live video consultations.[7]

> The Missouri State Medical Association strongly supports this legislation and testified in favor of it at the March 7 hearing.

While Missouri has not expanded Medicaid under the Affordable Care Act, a public petition to approve such an expansion is currently underway, for potential inclusion on the November 2018 ballot.[8] If this initiative succeeds, enrollment in MO HealthNet (almost 700,000 as of December 2017)[9] will likely expand, increasing the demand for health care services, particularly in areas with a lack of access to care. Enhanced telehealth opportunities provided by HB 1617 could help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*Their website is https://www.healthcapital.com.*

not only increase access, but offset existing and impending physician manpower shortages.[2]

## What HB 1617 Means for Missouri Providers

HB 1617, while potentially increasing access to care for MO HealthNet beneficiaries, also allows providers unprecedented latitude in utilizing clinical judgment when providing telehealth services. Specifically, the bill transfers responsibility from the Missouri Department of Social Services to health care providers insofar as determining the appropriateness of a "place of service," i.e., where the patient is located during a consultation.

This gives individual clinicians the opportunity to provide efficient, routine care for patients who lack transportation options, are unable to leave home, or are located too far away to reasonably attend an appointment. It will also provide an additional revenue stream for physicians and an opportunity to expand their patient base outside of their immediate geographic region. In an era of highly regulated and scrutinized health care delivery, HB 1617, while relatively limited in scope, can be considered a step in the right direction for providers wishing to restore practice autonomy, develop meaningful patient relationships, and increase access to health care in Missouri.


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# Sam L. Page, MD, Honored by SLMMS Alliance

The SLMMS Alliance presented Sam L. Page, MD, with its annual Doctor of the Year Award at its Feb. 9 dinner. Dr. Page currently serves on the St. Louis County Council and is a former state representative. He led the effort to establish a county-based prescription drug monitoring program now in use across much of Missouri

The Doctor of the Year Award recognizes a Medical Society member who has been an advocate for the profession of medicine, an advocate for quality health care, a role model for future physicians, and a supporter of the Alliance.

Dr. Page was elected to the County Council by special election in August 2014 to represent the 2nd District to serve the remainder of an unexpired term. In 2016, he was re-elected for a four-year term. He was elected council chair in January 2017 and re-elected as chair in 2018. In this role, he has persistently advocated for accountability and transparency in county government.

His most notable accomplishment has been establishing a unique and unprecedented prescription drug monitoring program based out of St. Louis County that has expanded to include 58 jurisdictions across Missouri representing 79 percent of the population. For years, the Missouri Legislature has not acted to set up a PDMP, leaving Missouri as the only state in the nation without this tool that is regarded as essential in the fight against misuse of prescription pain medications.

Dr. Page was elected to the Missouri House of Representatives in 2003 and served for six years. In 2008, he was the Democratic nominee for Missouri lieutenant governor, losing a close race.

Practicing in anesthesiology and pain management with Western Anesthesiology since 1997, he is an attending physician at Mercy Hospital St. Louis. He also is an adjunct assistant professor of anesthesiology and critical care at Saint Louis University School of Medicine.

*Sam Page, MD, with his wife, Jennifer Page, MD, displaying the award.*

A graduate of the University of Missouri-Kansas City School of Medicine, he was selected into Alpha Omega Alpha medical honor society, and he completed his residency at Northwestern University and a fellowship in pain management at Washington University. He is married to Jennifer L. Page, MD, a physiatrist and a member of the SLMMS Council. They have three children.

In his acceptance remarks, Dr. Page strongly encouraged physicians to become more visible in advocacy, especially in this time of rapid change in health care. He urged physicians to seek elected office and other community leadership positions.

"Your role doesn't stop in the exam room," he said. He recalled past times when physicians were more visible in community leadership.

He also suggested that physicians mentor medical students and residents. He acknowledged the late Carol Williams, MD, SLMMS past president who passed away in January, for her role in mentoring both him and Dr. Jennifer Page while they were in medical school.

# North Side Clinic Recognized

Also at the Doctor of the Year dinner, a certificate of appreciation and a donation check were presented to Judy Bentley, president and CEO of CHIPS Health and Wellness Center, a north St. Louis clinic providing donated care to uninsured and underserved individuals. Founded in 1990 by Bentley, CHIPS (Community Health in Partnership Services) provides primary care, screenings and wellness education in over 25,000 service encounters each year, utilizing physicians and other health providers that donate their services.

*Pictured, Judy Bentley, second from left, with Alliance members Sandra Murdock, Sue Ann Greco and Angela Zylka.*

## Day at the Legislature

*Alliance members from across the state joined with the Missouri State Medical Association for their annual legislative day at the Missouri Capitol. Pictured from left, Sue Ann Greco of St. Louis; James Conant, MD, and state Alliance president Marsha Conant of St. Joseph; MSMA lobbyist Jeff Howell; Diana Corzine of St. Joseph; state Alliance vice president-legislation Kirk Doan; state Alliance president-elect Gill Waltman and Jo-Ellyn Ryall, MD, both of St. Louis.*

## "Drugs Are Not for Me"

*Alliance members gave a "Drugs Are Not for Me" presentation to students at Loyola Academy on Feb. 26. Pictured, Kelly O'Leary shares the story of the loss of her son Derek to opioid abuse. Angela Zylka, looks on at left. Sandra Murdock, not pictured, also joined in the presentation.*

## Supporting Medical School Students on Match Day

*Friday, March 16, was National Residency Match Day, when medical graduates learn the locations of their residencies. Alliance members, on behalf of the SLMMS and MSMA Alliances, helped salute the graduates during Saint Louis University's Match Day breakfast at the Chase-Park Plaza Hotel. Five graduates won the Alliance's prize drawing for cash awards and luggage. Pictured, Benjamin Reid, Angela Zylka of the Alliance, John Poehlmann, Lara Pape, Phillip Henry, Sandra Murdock of the Alliance, and Patricia Amorado.*

# Medical Schools

J. Steven Ekman

**J. Steven Ekman**, SLMMS medical student member, was appointed to the American Medical Association Council on Long-Range Planning & Development. He is a student at Washington University School of Medicine and has been a member of SLMMS since 2014.

# Hospitals

**St. Luke's ACO**, a subsidiary of **St. Luke's Hospital**, has been selected as one of 124 new Medicare Shared Savings Program Accountable Care Organizations (ACOs). The ACO includes St. Luke's Medical Group physicians, St. Luke's Hospital, and its outpatient services and skilled nursing facility, St. Luke's Surrey Place. ACOs must meet quality standards to ensure that they improve care coordination and provide care that is appropriate, safe and timely.

## Going Home to Help *continued from page 25*

"When my lab colleagues heard that I was giving the car away, they insisted on filling it with things the family needed. I bought new car seats and a new double stroller, and staff from all four of my hospital laboratories donated clothing, toys, shoes, housewares and more," Dr. Cooke said. "I was so happy to see the labs participating and adopt this family."

By late September, her mother's white Cadillac CTS was packed and ready. She flew Curtis to St. Louis to pick up the car and drive it back.

"I know my mom would have been so happy to know her car went to a family in need. She was my inspiration for this gift. My mom and dad previously gave away at least three other cars over the years to others in need. She was a wonderfully generous woman and could never walk away from anyone she saw who needed a helping hand."

Dr. Cooke also is serving the community with frequent media appearances in support of American Red Cross blood drives, noting that the last few months have brought one of the worst-ever shortages of blood and platelets.

*Some of the information for this article came from a story in the Nov. 20* BJC Today.

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

### Rebecca L. Aft, MD
660 S. Euclid Ave., #8109, 63110-1010
MD, Washington Univ., 1992
Born 1956, Licensed 1997 ► **Active**
*Surgery*

### Mark D. Belcher, MD
12174 Natural Bridge Road, 63044-2017
MD, George Washington Univ., 1990
Born 1959, Licensed 2000 ► **Active**
*Anesthesiology*

### Jeffrey L. Blatnik, MD
660 S. Euclid Ave., #8109, 63110-1010
MD, Case Western Reserve Univ., 2007
Born 1980, Licensed 2015 ► **Active**
*Surgery*

### Sarah E. Boutwell, MD
1035 Bellevue Ave., #400, 63117-1844
MD, Univ. of Alabama, Birmingham, 2011
Born 1982, Licensed 2014 ► **Active**
*Cert: Internal Medicine*

### David M. Brogan, MD
660 S. Euclid Ave., #8322, 63110-1010
MD, Washington Univ., 2009
Born 1980, Licensed 2015 ► **Active**
*Surgery of the Hand*

### Amy E. Cyr, MD
660 S. Euclid Ave., #8233, 63110-1010
MD, Univ. of Nebraska, 2002
Born 1975, Licensed 2009 ► **Active**
*Surgery*

### Emily D. Doucette, MD
6121 N. Hanley Road, 63134-2003
MD, Univ. of Missouri-Columbia, 2011
Born 1984, Licensed 2014 ► **Active**
*Family Practice*

### Mark H. Gregory, MD
555 N. New Ballas Rd., #110, 63141-6884
MD, Univ. of Vermont, Burlington, 1986
Born 1956, Licensed 1992 ► **Active**
*Cert: Internal Medicine*

### Mark J. Hoffman, MD
4921 Parkview Pl., 14A, 63110-1032
MD, Washington Univ., 1999
Born 1971, Licensed 2002 ► **Active**
*Internal Medicine*

### Kirsten A. Jansen, MD
224 S. Woods Mill Rd., #255S, 63017-3513
MD, Univ. of Kansas, 2011
Born 1985, Licensed 2017 ► **Active**
*Orthopedic Surgery*

### Cristine Klatt-Cromwell, MD
660 S. Euclid Ave., #8115, 63110-1010
MD, Univ. of Oklahoma, 2011
Born 1985, Licensed 2017 ► **Active**
*Otolaryngology*

### Hannah R. Krigman, MD
660 S. Euclid Ave., #8118, 63110-1010
MD, Univ. of North Carolina, 1988
Born 1962, Licensed 2015 ► **Active**
*Cert: Anatomic Pathology*

### Raffi K. Krikorian, MD
3760 S. Lindbergh Blvd., #101, 63127-1374
MD, Higher Institute of Medicine, Bulgaria, 1984
Born 1959, Licensed 1991 ► **Active**
*Cert: Cardiovascular Disease*

### Xinrong Lu, MD
12266 DePaul Dr., #100, 63044-2541
MD, Nantong Medical College, 1995
Born 1972, Licensed 2011 ► **Active**
*Neurology*

### Amy C. McClintock, MD
12255 DePaul Dr., #600, 63044-2515
MD, Saint Louis Univ., 2011
Born 1984, Licensed 2015 ► **Active**
*Sports Medicine*

### Abraham B. Medaris, MD
10004 Kennerly Rd., #364B, 63128-2190
MD, Ross Univ., Roseau, Dominica, 2010
Born 1979, Licensed 2014 ► **Active**
*Psychiatry*

### Elena Minakova, MD
1 Children's Plaza, NWT8, 63110-1002
MD, Univ. of California Davis Sch. of Med, Davis, CA, 2011
Born 1982, Licensed 2017 ► **Active**
*Neonatal-Perinatal Medicine*

### Tracy W. Norfleet, MD
4921 Parkview Pl., #14A, 63110-1032
MD, Louisiana State Univ.,2002
Born 1977, Licensed 2006 ► **Active**
*Internal Medicine*

### Adam M. Parker, MD
12255 DePaul Dr., #500, 63044-2515
MD, Univ. of Missouri-Kansas City, 2011
Born 1986, Licensed 2016 ► **Active**
*Rheumatology*

### Christy L. Richardson, MD
12255 DePaul Dr., #403, 63044-2515
MD, Univ. of Missouri-Columbia, 1990
Born 1960, Licensed 1996 ► **Active**
*Cert: Endocrinology*

### Nikhat Salamat, MD
12255 DePaul Dr., #500, 63044-2515
MD, King Edward Medical College, Pakistan, 1996
Born 1972, Licensed 2004 ► **Active**
*Cert: Pulmonary Disease*

### A. Weldon Schott, DO
2326 Milpark Dr., 63043-3530
DO, Texas Coll. of Osteopathic Medicine, 1978
Born 1950, Licensed 1985 ► **Active**
*Cert: Anatomic Pathology*

### Harmeeta K. Singh, MD
1034 S. Brentwood, #450, 63117-1249
MD, Kempegowda Inst. of Medical Sciences, Karnataka, 2004
Born 1975, Licensed 2009 ► **Active**
*Cert: Psychiatry*

### Sarah E. Snell, MD
10601 Twilight Drive, 63128-1220
MD, Univ. of Louisville, 1998
Born 1972, Licensed 2009 ► **Active**
*Cert: Surgery*

### Rishi N. Sud, MD
12655 Olive Blvd., 63141-6291
MD, Chicago Medical School, 1998
Born 1971, Licensed 2017 ► **Active**
*Cert: Family Practice*

### Rishi K. Vasireddy, MD
1035 Bellevue, #305, 63117-1845
MD, Gandhi Medical College, India, 2005
Born 1980, Licensed 2015 ► **Active**
*Family Practice*

### Suresh Vedantham, MD
510 S. Kingshighway, 6th Fl., 63110-1016
MD, Univ. of Chicago, 1992
Born 1968, Licensed 1998 ► **Active**
*Cert: Vascular & Interventional Radiology and Radiology*

### James Zhu, MD
2326 Milpark Dr., 63043-3530
MD, Hunan Medical College, 1984
Born 1962, Licensed 2002 ► **Active**
*Cert: Cytopathology*

## Bernard C. Randolph, Sr., MD

Bernard C. Randolph, Sr., MD, a family practice physician, died Jan. 20, 2018, at the age of 95.

Born in New York City, he earned his undergraduate degree from City College of New York and his medical degree from Howard University School of Medicine. He completed his medical training at the former Homer G. Phillips Hospital and the former People's Hospital.

Dr. Randolph served in the U.S. Air Force during the Korean War and earned the rank of captain. He had a private practice in north St. Louis and served on staff at the former Deaconess Hospital and the former Central Medical Center. He also organized free community health screenings.

Dr. Randolph joined the St. Louis Metropolitan Medical Society in 1966, and became a Life Member in 2010. Dr. Randolph was a past president of Mound City Medical Forum, and a member of the National Medical Association (NMA). In 1963, he was part of the NMA delegation that met with President John F. Kennedy to promote legislation to create Medicare and help end racial discrimination in hospitals. In 1974, he founded the St. Louis Council on Environmental Health and Safety.

SLMMS extends its condolences to his wife, Billie Coleman Randolph; children, Bernard C. Randolph, Jr., MD; Dana G. Randolph; and Paul A. Randolph; and his four grandchildren.

## Milton Kardesch, MD

Milton Kardesch, MD, an internist, died Jan. 27, 2018, at the age of 89.

Born in New York City, he earned his undergraduate and medical degrees from the University of Buffalo. He completed a residency in internal medicine as a U.S. Public Health Fellow in cardiology at the Veterans Administration Hospital in St. Louis, and a fellowship in cardiology at the former Barnes Hospital.

Dr. Kardesch served in the U.S. Air Force. He was in private practice and served on staff at the former St. Joseph Hospital-Kirkwood.

Dr. Kardesch joined the St. Louis Metropolitan Medical Society in 1959, and became a Life Member in 2007.

He was predeceased by his wife, Shirley Kardesch. SLMMS extends its condolences to his children, Ellen Trovillion; David Kardesch, MD; and Matthew Kardesch; and his nine grandchildren.

## Stanley C. Becker, MD

Stanley C. Becker, MD, a board-certified ophthalmologist, died Feb. 9, 2018, at the age of 92.

Born in St. Louis, Dr. Becker received his undergraduate degree along with his master's and PhD at Washington University. He obtained his medical degree from the Chicago Medical School. He completed an internship at the former Jewish Hospital of St. Louis and his residency in ophthalmology at the Veterans Administration Hospital in St. Louis.

Dr. Becker served in the U.S. Army Air Corps from 1943 through 1946. A pioneer in cataract surgery, he was an author and researcher in glaucoma medicine. He was in private practice while serving as an assistant clinical professor in the Department of Ophthalmology and Visual Sciences at Washington University for more than 50 years.

Dr. Becker joined the St. Louis Metropolitan Medical Society in 1959, and became a Life Member in 2003.

SLMMS extends its condolences to his daughter, Karen Launis.

## Wallace E. Stuart, MD

Wallace E. Stuart, MD, a dermatologist and pediatric dermatologist, died Feb. 27, 2018, at the age of 83.

Born in Freedom, Pa., Dr. Stuart received his undergraduate degree from the University of Santa Clara, Calif., and medical degree from Saint Louis University. He completed his internship at the former Saint Louis City Hospital and his residency in pediatrics at SSM Health Cardinal Glennon Children's Hospital and a secondary residency in dermatology at Barnes-Jewish Hospital.

Dr. Stuart was in private practice and was on staff at the former St. Joseph Hospital-Kirkwood, the former Alexian Brothers Hospital and St. Anthony's Medical Center. He wrote a book entitled *Sun Bullets* that covered acne, sun damage and skin diseases of the older adult.

Dr. Stuart joined the St. Louis Metropolitan Medical Society in 1962.

SLMMS extends its condolences to his wife, Sylvia Stuart; his children, Wally Stuart, Lois Cella, Wade Stuart, Lori Patterson, Lara Shuey and Leah Hose; along with his grandchildren and great-grandchildren.

PARTING SHOTS

# The Prudent Layperson: Rest in Peace

*By Richard J. Gimpelson, MD*

We are all becoming aware of Anthem's policy to reduce unnecessary ER visits by retroactively refusing to pay for some of their insured's care after a diagnosis has been made. This denial is made regardless of whether the insured believed there was an emergency.

Anthem bases the decision on the idea that the prudent layperson should know if there is an emergency or not. I challenge this premise based on the question of who is the prudent layperson.

In addition, why should the prudent layperson know if they are experiencing an emergency, when the physicians in the ER may need time to decide if there is an emergency? Is it a heart attack or heartburn? Is it a stroke or a migraine? Is the respiratory infection pneumonia or a cold? Is the body ache and fever a simple viral infection or influenza? Bleeding from an external injury is obvious, but are there also internal injuries? Is it a leg cramp or a blood clot?

There are many other scenarios that can encourage the prudent layperson to seek help in the ER. Anthem wants the prudent layperson to make their own diagnosis and then decide whether to go to an urgent care center or ER. I have used urgent care centers and they are great, but if in doubt I would recommend going to the ER.

Dr. Richard J. Gimpelson

*Richard J. Gimpelson, MD, recently retired from his gynecological surgery practice and is a past SLMMS president. He shares his opinions here to stimulate thought and discussion, but these do not necessarily represent the opinion of the Medical Society. Your comments on this column are most welcome and may be sent to editor@slmms.org.*

Just who is the prudent layperson? Can the person with an IQ of 90 or lower be a prudent layperson? Can the elderly college professor with chronic illness be a prudent layperson? In fact, can a hypochondriac be a prudent layperson? It is obvious that Anthem wants to save money, but the insured often still needs medical care. Studies have shown that ER care only accounts for 2-10 percent of all medical costs,[1,2] with less than 8 percent of ER visits considered non-urgent. However, non-urgent does not mean unnecessary, and most of these patients still need to be in the ER.[1]

Anthem wants to treat the insured like illness is a sporting event. In football and baseball, the instant replay sometimes overrules the initial call made by the referee or umpire. This change in the call is made because the play has been recorded by a video camera, and the officials take a time out to review the tape. ER physicians cannot always make a diagnosis without laboratory studies, radiology imaging, or other methods of evaluation that require time. Sometimes observation is the only way to get to the correct diagnosis. There is no instant replay for emergencies. The patient should never be penalized for misinterpreting his or her own signs and symptoms.

Some insureds on a tight budget may hold off going to the ER, even when they have a true life-threatening emergency. If Anthem succeeds with retroactive refusal to pay, and other insurers follow Anthem's lead, we may be saying many times, "Prudent layperson, may you rest in peace."

Medical emergencies are not a sporting event.

References


1. Medical Expenditure Panel Survey. U.S. Department of Health and Human Services. 2008.
2. Lee M, Zink B, Shuur J. Owning the Cost of Emergency Medicine: Beyond 2%. *Annals of Emergency Medicine*. November 2013.

# Going Home to Help

## Physician assists Hurricane Harvey victims in hometown; donates car to family in need

*By Jim Braibish, St. Louis Metropolitan Medicine*

When Hurricane Harvey struck last August, it was a call to action for SLMMS member Rhonda Cooke, MD. It also gave her the opportunity to continue a family legacy of service.

Growing up in Baytown, Texas, on the east side of the Houston metropolitan area, she has been personally affected by two hurricanes. Hurricane Alicia in 1983 flooded her former childhood home and those of many friends and former neighbors. As a medical resident in 2008 in nearby Galveston, Hurricane Ike damaged her home.


**Left, Dr. Cooke delivering infant supplies for hurricane victims in Bastrop, Texas.**

**Right, Curtis Owens, whose family lost everything in the hurricane, with Dr. Cooke's car in St. Louis packed with supplies ready to make the drive back to Houston.**

"When I saw the pictures of Hurricane Harvey's aftermath, it brought back painful memories," Dr. Cooke said. "I knew I had to do something."

A week after the hurricane, Dr. Cooke was on her way to Texas for a 10-day trip to assist in relief efforts, taking time from her practice as laboratory medical director at Missouri Baptist Medical Center, Progress West Hospital, Barnes-Jewish St. Peters Hospital and Missouri Baptist Sullivan Hospital. Her lab colleagues collected four large suitcases of supplies for cleanup and infant care for her to take to Houston.

With travel into Houston remaining difficult just a week after the storm, she flew to Austin where she connected with friends and purchased additional supplies. She rented a large pickup truck to drive to Houston with her cargo that included large tarps, carpet knives, mosquito spray, nitrile gloves and face masks to help with cleaning up and securing damaged homes, along with diapers, baby wipes, baby formula and assorted paper products. Some of the supplies were delivered in Bastrop, Texas, an inland community where residents were displaced by flooding.

Once in Baytown, a childhood friend put her in touch with the Cedar Bayou Grace United Methodist Church. "The church itself had been under three or four feet of water. They had set up a relief center in a satellite building. I delivered my truckload there and also made a cash donation to help with the meals they were serving to residents and first responders."

Next stop was the Baytown neighborhood where her father owns rental property. "Along with my brother and a friend, we spent most of the week doing cleanup for elderly residents. We cleared out debris and secured roofs with tarps," she said.

That was just the beginning. Through her aunt's church in Liberty, Texas, she learned of a family that had lost everything. They were staying in a Red Cross shelter at the church. The father, Curtis Owens, was looking for work to enable him to provide for his family, including a 12-year-old, a 10-month-old and an infant just four weeks old.

"I sent a monetary donation and spoke with a church member about the family, and she shared their needs with me," Dr. Cooke said. "One of them was a car, since the hurricane had destroyed theirs. I had been driving my mom's car since her death in 2015. I was having a hard time letting go of it, but this seemed like the right opportunity."

*continued on page 21*

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