

ST. LOUIS METROPOLITAN MEDICINE

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Decision 2018

The Candidates on Health Care

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On Mentorship

As practicing physicians, we can be a valuable resource to younger doctors and students

By Christopher A. Swingle, DO, Medical Society President



Medical Society President
Christopher A. Swingle, DO

You never know
what kind of mark
you can leave in the
lives of those who will
come after you when
you offer of yourself.

As physicians, we hear about burnout on a daily basis. It is a rare day when the various medical email newsletters I receive don't mention the subject. There is even a joke on social media that Dr. Kevin Pho's excellent KevinMD blog¹ should be renamed the "Burnout Blog" due to how many articles he shares on the subject.

The problem is finally out of the shadows and being actively discussed, which is certainly a step forward. However, as with any systemic problem, the reasons for burnout are multifactorial and there is no one clear solution. One study suggests small, independent practices are more resistant to burnout.² Other studies identify the most at-risk specialties and suggest exercise and work/life balance as protective strategies.³

Some factors are easily changed, but many are not; the opportunity cost of changing specialties is prohibitive and student loan debt frequently makes a reduction in hours unrealistic. Despite this, there is one positive strategy that I feel is overlooked: one cannot understate the importance of mentorship to bring meaning and purpose back to the vocation of physician.

Recently, SLMMS Executive Vice President David Nowak and I visited some of the first-year medical students at Washington University. This meeting was in the first few weeks of their classes, and they were just as eager and nervous as you would expect brand-new first-years to be. The Washington University student section of the American Medical Association had a presentation about the AMA and the value of organized medicine. I gave an extemporaneous pitch for SLMMS, wondering in the back of my mind what value to a first-year medical student

a metropolitan society could offer that a national organization could not. The answer was, and is, obvious to me: the chance to network with older, experienced physicians in a setting outside the hierarchy of medical education.

To these medical students, I made my message clear: there's nowhere else but SLMMS where you can meet physicians socially, get the straight scoop on medical issues and not worry about having to impress attendings for a good evaluation. In fact, there is evidence that an ideal mentor is one who is not a potential academic evaluator of the mentee.⁴

I emphasized that if you need an older role model to talk through your hopes, fears, victories and defeats with, we have dozens who would love to lend an ear. The positive response David and I got back from the students was overwhelming. I'm happy to report that we have approximately 30 new student members of SLMMS from our visit, and we are making arrangements with the students at Saint Louis University for a similar presentation.

This tells me something that we should already know, but perhaps don't appreciate enough: there is desire from our younger colleagues for connection. They can talk to other students, interns, residents, fellows and attendings all day in the formal academic setting, but what avenues for mentorship do they have outside of the classroom and wards? As practicing physicians, we can offer a safe harbor to discuss career plans, medical legislation, personal finances, work-life balance and perhaps even the Cardinals' chance of making the playoffs. The benefits to a mentee are obvious.

However, and it is a fair question, why would a physician want to assume the role of a mentor? To begin with, there is the professional satisfaction of being looked to as a trusted authority. A mentor's own skills and perspectives can be challenged, refined and improved through the relationship. Other benefits to the mentor include a stronger sense of career success and a renewed sense of purpose and pride.⁵ Could it be that serving as a mentor is an antidote to each one of the typical symptoms of burnout?

This tells me something that we should already know, but perhaps don't appreciate enough: there is desire from our younger colleagues for connection.



It is important to note that I do not see opportunities for mentorship limited to the medical student. The challenges of beginning or joining a practice, the finer details of hospital employment, the work of academia; these paths have all been well traveled by countless physicians after their specialty training. We are fortunate enough to have representatives from all these realms in our society, with knowledge and experience that transcends specialties and practice environments. Again, no other medical organization in this city has this kind of depth and diversity.

On a personal level, I would have never begun my journey into organized medicine without the encouragement of some of the senior members of my group and specialty who have served SLMMS, MSMA and the AMA with distinction. In January, I asked SLMMS members to become like the mentor they once had, or wished they had. After all, you never know what kind of mark you can leave in the lives of those who will come after you when you offer of yourself. ◀

Christopher A. Swingle, DO, is a nuclear medicine radiologist with West County Radiology at Mercy Hospital St. Louis.

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ST. LOUIS METROPOLITAN MEDICAL SOCIETY



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Express Scripts CMO to Present 2018 Hippocrates Lecture



Dr. Steven Miller

Transparency in drug pricing will be the focus of the 16th annual Hippocrates Society Lecture sponsored by the St. Louis Society for Medical and Scientific Education (SLSMSE), the charitable foundation of the Medical Society, set for Tuesday, Oct. 30. The event will again be held at Spazio Westport, 12031 Lackland Rd. in Maryland Heights, with a cocktail reception beginning at 6:00 p.m. followed by dinner and the lecture at 7:00 p.m.

Steve Miller, MD, senior vice president and chief medical officer for Express Scripts, will be the featured speaker. His topic will be "Drug Pricing Transparency: What Doctors Need to Know to Provide Care in a Murky World." His lecture will help promote understanding of the roles of different players in the drug supply chain and how drug prices are set, as well as introduce tools for physicians to use to better help patients get effective and affordable medications. He will also emphasize policies physicians should advocate for and against to improve the system for both providers and patients.

Dr. Miller is a nationally recognized advocate for fair drug pricing and has spoken throughout the United States on this topic. His expertise represents years as a medical researcher, clinician and administrator. He has served as CMO for Express Scripts since 2006, focused on clinical matters including prescribing initiatives, specialty solutions and overall development of products that make prescription drugs safer and more affordable.

He previously held faculty positions at Washington University School of Medicine, and served as medical director of the BJC/ Washington University Renal Network. From 1999 to 2005, he was vice president and chief medical officer at Barnes-Jewish Hospital, Washington University School of Medicine.

He received his medical degree from the University of Missouri-Kansas City, trained in the pathology and research fellowship at the University of Alabama at Birmingham, and was the William J. and Dorothy Fish Fellow in Cardiology at the University of California, San Francisco. Dr. Miller also trained in internal medicine at the University of Colorado, and in nephrology and transplantation at Washington University. He also earned an MBA from the Olin School of Business at Washington University.

Notices about the Hippocrates Society Lecture have been mailed to all SLMMS members. CME credit will be available for the lecture. The event is free and open to all SLMMS members, including medical student members. There is a \$40 per person fee for spouses, guests and non-members. Reservations may be made by contacting Liz Webb at 314-989-1014, ext. 100 or lizw@slmms.org. Deadline for reservations is Wednesday, Oct. 24. ➔

2018 SLMMS HIPPOCRATES LECTURE

Tuesday, October 30, 2018

Spazio Westport

12031 Lackland Rd., Maryland Heights

6:00 p.m. – Cocktail Reception

7:00 p.m. – Dinner immediately followed by lecture

Free for SLMMS members;

\$40 for non-members and guests

Speaker: Steve Miller, MD, Senior Vice President & Chief Medical Officer, Express Scripts

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— Rabbi Hillel

In memory of Sen. John McCain

Some of you may recognize this quote. It is ancient. The late Sen. John McCain was fond of a similar saying: "There is no greater satisfaction than to serve a cause greater than oneself." Both this and Rabbi Hillel's quote embody what we hope for our elected leaders: Be bold enough to run; be selfless enough to serve; and be smart enough to know what it's about. In these days of poor performance by many of our elected leaders, we should all VOTE and vote thoughtfully. If not NOW, WHEN? ➔

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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Meet Your 2019 SLMMS Officer and Councilor Nominees

Election takes place online November 1-25

Your Medical Society is pleased to announce the slate of officer and councilor candidates who will lead the Society in 2019. The election will take place online at www.slmms.org from Nov. 1 to 25.



Dr. Ramona Behshad

Ramona Behshad, MD, will succeed automatically to the position of 2019 SLMMS president from her current status as president-elect. Dr. Behshad is an assistant professor at Saint Louis University School of Medicine in the Department of Dermatology. She is certified by the American Board of Dermatology and the American College of Mohs Micrographic Surgery.

She obtained her undergraduate and medical degrees from Case Western Reserve University. She completed her internal medicine internship at Banner Good Samaritan Hospital in Phoenix and her dermatology residency at Case Western Reserve. She completed a Mohs surgery fellowship in St. Louis.

Dr. Behshad has served as SLMMS president-elect in 2018, vice president in 2017 and councilor from 2014-2016. She is a Young Physician Section councilor for MSMA. She also is active in the American Society for Dermatologic Surgery and the American College of Mohs Surgery.

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

Learn more about our candidates by reviewing their biographies that follow. To help give insight on their thoughts about the Medical Society, we have asked them to respond to the question, "How can SLMMS make the most impact to support physicians in the St. Louis region?"

Jason K. Skyles, MD | President-Elect



Dr. Jason K. Skyles

Practice: Diagnostic radiology, West County Radiology. Certified, American Board of Radiology. Hospitals: Mercy Hospital St. Louis and Mercy Hospital Washington.

Education: B.S. and B.A., Saint Louis University. M.D., Saint Louis University School of Medicine.

Internship, Forest Park Hospital; residency and fellowship, Wake Forest University.

Birthplace: St. Peters, Mo.

SLMMS/MSMA/AMA Service: SLMMS secretary-treasurer, 2016-2017; councilor, 2018, 2012-2015. Joined SLMMS 2011.

Other Professional Organizations: American Roentgen Ray Society, Radiological Society of North America, Society of Breast Imaging.

Honors and Awards: Alpha Omega Alpha, Phi Beta Kappa.

Personal: Wife, Kristin; two sons and two daughters.

How can SLMMS make the most impact to support physicians in the St. Louis region? I believe SLMMS can make the biggest impact by assuring accurate and timely distribution of information regarding health care policy to all physicians in the St. Louis region. We provide a forum for physicians of all specialties to discuss the important issues regarding us and our patients. During these discussions, position statements and talking points can be developed and disseminated to give the providers in our region a unified voice.

Jennifer L. Page, MD | Vice President



Dr. Jennifer L. Page

Practice: Medical director, acute rehabilitation, Mercy Hospital South. Certified, physical medicine and rehabilitation, pain management. Hospitals: Mercy Hospital South, Mercy Hospital St. Louis.

Education: B.A. and M.D., University of Missouri-Kansas City. Certification: physical medicine and rehabilitation, pain management. Internship, Mercy Hospital St. Louis; chief resident, Rush Presbyterian St. Luke's Medical Center, Chicago.

Birthplace: St. Louis.

SLMMS/MSMA/AMA Service: SLMMS Councilor, 2016-2018; Publications Committee. Delegate, AMA Resident Physician Section, 1992-94; alternate delegate, AMA Young Physician Section, 1997-98. Board member, Missouri State Medical Foundation, 2007-12. Joined SLMMS 1996.

Other Professional Organizations: American Academy of Physical Medicine and Rehabilitation.

Community/Volunteer Activities: Boy Scouts and Cub Scouts parent volunteer and committee chair. Committeewoman, Creve Coeur Township 2008-2012.

Personal: Husband, Sam Page, MD; three sons. Hobbies and interests: Kayaking, spending time with family camping, watching my sons' high school cross country and water polo games, travel. Former NFL Kansas City Chiefs cheerleader.

How can SLMMS make the greatest impact? SLMMS is the chief advocate for patients and their physicians in the St. Louis metropolitan area. SLMMS interacts with elected officials and third-party payers to fight for patient safety and public health initiatives. It provides important representation for St. Louis physicians within the Missouri State Medical Association and American Medical Association. SLMMS has a significant impact with hospital systems, and media, to keep the best interest of our patients as our highest priority. The strength of the organization is the physician members and volunteer leaders who drive our policy and advocacy. Medicine is changing and SLMMS is our unified voice.

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



Dr. Robert A. Brennan, Jr.

Practice: House obstetrician-gynecologist, SSM Health St. Clare Hospital-Fenton. Certified, American Board of Obstetrics and Gynecology. Assistant clinical professor in the Department of Obstetrics, Gynecology and Women's Health at Saint Louis University School of Medicine.

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

Birthplace: St. Louis.

SLMMS/MSMA/AMA Service: SLMMS councilor 2015-2017; secretary-treasurer, 2018, 2014; secretary, 2008-2010; councilor, 2004-2007; 2011-2013. Physicians' Wellness Conference chair, 2007-2009. MSMA first vice president, 2012-13; 3rd District councilor, 2013-present. Joined SLMMS 1979.

Other Professional/Community Activities: St. Louis Obstetrical and Gynecological Society, American College of Obstetricians and Gynecologists, Society of Ob/Gyn Hospitalists.

Personal: Wife, Joan Brennan; children, four sons. Hobbies: running, archery, reading.

How can SLMMS make the greatest impact? SLMMS can make the most impact to support physicians in the St. Louis region in several ways. First, it can work to see that employed physicians have a firm place in the society. The society could provide legal assistance in reviewing contracts. The society should assist our female colleagues in finding child care and nannies. The society should continue its effort in tort reform and tail coverage. The society should continue to hold wellness conferences. And if problems arise, the society should provide appropriate referrals. Finally, the society should vigorously implement the findings of the recent membership survey.

Emily D. Doucette, MD, MSPH | Councilor



Dr. Emily D. Doucette

Practice: Family and community medicine. Chief medical officer, St. Louis County Department of Public Health. Hospital: SSM Health St. Mary's Hospital.

Education: B.S., Truman State University. M.D., University of Missouri-Columbia School of Medicine. Internship and residency, University of Missouri Healthcare; chief resident. M.S. in Public Health, Saint Louis University.

Birthplace: Kansas City, Kan.

SLMMS/MSMA/AMA Service: Joined SLMMS 2018.

Other Professional/Community Activities: St. Louis Academy of Family Physicians, board member; Missouri Academy of Family Physicians, board member; American Academy of Family Physicians; North American Primary Care Research Group; Society of Teachers of Family Medicine; St. Louis Regional Health Commission, proxy board member, member of the Provider Services Board, chair of the Community Health Center Workforce Development Workgroup; Integrated Health Network, proxy board member.

Honors and Awards: Fellow, American Academy of Family Physicians; Alpha Omega Alpha; Phi Beta Kappa; AAFP and Bristol Myers Squibb Award of Excellence in Graduate Medical Education.

Personal: Husband, Jason Newman, MD. One daughter. Hobbies and interests: Travel, running, cooking, exploring the world anew through the lens of my infant daughter.

How can SLMMS make the greatest impact? I am thrilled to be considered to represent the St. Louis County Department of Public Health and the primary care and public health communities on the SLMMS Council. As a relative newcomer to the organization, I look forward to learning about collaborations between direct clinical care and public health initiatives. We all know that most of what affects a person's health occurs outside of the exam room, and as physicians in this community we can and should have an important seat at the table when considering public health policy and programming that affect the region. I envision SLMMS as a potential intersection between a diverse physician group and the public health sector which can bring unique perspectives to population health visioning. I hope to be able to foster and encourage that collaboration to improve health in our community.

Continued on page 8

Kirsten F. Dunn, MD | Councilor



Dr. Kristin F. Dunn

Practice: Internist, Mercy Virtual. Certified, American Board of Internal Medicine, American College of Physicians.

Education: A.B., Harvard College. M.D., Saint Louis University. Internship and residency, Stanford University Hospital and Clinics.

Birthplace: Jefferson City, Mo.

SLMMS/MSMA/AMA Service: MSMA Young Physician Section vice chair, 2018-2019; MSMA annual convention Young Physician Section delegate and Reference Committee member, 2018. Joined SLMMS 2017.

Other Professional/Community Activities: American College of Physicians Missouri Chapter; Missouri physician representative for Health-E(quity) Network for Change.

Honors and Awards: Alpha Omega Alpha; American Medical Women's Association Glasgow-Rubin Achievement Citation; Alpha Sigma Nu Jesuit Honor Society; Merck Book Award; Washington University School of Medicine Department of Medicine House Staff Teaching Award.

Personal: Husband, Tim Dunn, MD; children, one son. Hobbies and interests: baking, comedy.

How can SLMMS make the greatest impact? Many physicians want their primary focus to be providing the best care to their patients. SLMMS can help facilitate that goal by representing the profession and advocating for patients in a more unified manner. As the health care environment evolves, it is critical that physicians have a major role in shaping the changes necessary to bring better, affordable and more equitable care to our entire population. Through organized medicine, physicians can gain leadership training and a support network and become involved to whatever degree they desire.

Erin S. Gardner, MD | Councilor



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, 1997; 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 delegate to MSMA convention, 2018. SLMMS Publications Committee member. Joined SLMMS 2007.

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

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 make the greatest impact? SLMMS should continue to zealously pursue its longtime triple mission of advocacy, communication, and education. The practice of medicine in 2018 is beset by technological, organizational, and economic winds of change. Physicians have perhaps been less compelled in other eras to engage with other stakeholders in shaping the way that health care unfolds in our communities. We physicians can no longer afford to stand by and allow others to dictate how we can and how we cannot care for our patients. SLMMS helps us unite and speak with a collective voice. We are stronger when we band together for the benefit of our patients and our practices alike.

Luis A. Guiffra, MD, PhD | Councilor



Dr. Luis A. Guiffra

Practice: Psychiatry. Medical director, Clayton Behavioral; Clinical professor of psychiatry, Washington University.

Education: M.D., Cayetano Heredia University, Peru; Ph.D., Yale University. Internship and residency, Washington University.

Birthplace: Lima, Peru

SLMMS/MSMA/AMA Service: Joined SLMMS 2000. MSMA member.

Other Professional/Community Activities: Peruvian American Medical Society, former board member; Cayetano Heredia Alumni Foundation, current board member.

Honors and Awards: UK Mental Health Foundation Fellowship, St. Mary's Hospital, London, 1989; MacArthur Foundation Training Fellowship, 1990-1991; National Alliance

on Mental Illness Mortimer Goodman Award, 2011; Best Doctors in America, 2007-2018.

Personal: Wife, Milagros Giuffra; children, one son, one daughter. Hobbies: WWII History, travel. Regularly participate in medical missions to Peru.

How can SLMMS make the greatest impact? The practice of medicine is rapidly changing, and few physicians would say that the changes are for the better. In a time where the interests of insurers, hospitals and physicians are rarely aligned, SLMMS is a voice for doctors in our region. SLMMS has a long tradition of advocacy and support of St. Louis physicians, and continues to be innovative in securing services and opportunities for us. I am personally grateful for the support I've received from SLMMS on the efforts to make our community aware of the extent and terrible consequences of the ongoing opioid epidemic. As a member of the Council, I hope to continue this line of work.

Continuing on the Council (Terms began in 2017 or 2018)

- Christopher C. Bowe, MD
- Munier El-Beck, MD
- Mark C. Gunby, DO
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Emergency Physicians Respond on ED Utilization Question

Editor's Note: The following was submitted by the Missouri College of Emergency Physicians in response to the article on emergency department usage by the St. Louis Area Business Health Coalition in the August-September St. Louis Metropolitan Medicine.

By Evan Schwarz, MD, FACEP, FACMT, and Jonathan Heidt, MD, MHA, FACEP, Missouri College of Emergency Physicians

As representatives of the Missouri College of Emergency Physicians, we need to respond to the recently published article "Local Collaboration Aims to Reduce ED Visits While Strengthening Physician-Patient Relationships" due to misleading statements and faulty conclusions.

Before addressing these, it is important to state that emergency physicians (EPs) are concerned about over-testing and over-treatment, along with the overall increasing cost of health care. EPs are at the forefront of reducing unnecessary testing via clinical decision rules and evidence-based medicine as demonstrated by the Society of Academic Emergency Medicine's conference regarding this topic.¹⁻³ In Washington, EPs developed a list of best practices that significantly reduced costs.⁴

The article states that 16.5% of ED admissions were avoidable using an unexplained list of diagnoses. However, this is an inaccurate and dangerous conclusion. According to the

International Journal for Quality in Health Care, only about 3.3 % of ED visits might actually be avoidable.⁵ Through experience we know the methodology of using an end diagnosis to determine if the visit was appropriate is problematic and flawed. This strategy caused Missouri to pass legislation and led to Anthem being sued in Georgia. It is a violation of the prudent layperson standard which is enshrined in both federal and state law. By using the diagnosis and not the presenting symptoms, it forces a patient to self-diagnose, which they may not be able to do.

Most patients that present to an ED need to be there. The Centers for Disease Control determined only 5.5% were considered non-urgent in 2015.^{6,7} The American College of Emergency Physicians (ACEP) also found that less than 5% of ED visits were avoidable.⁸ A study by Renee Hsia, MD, reviewed 115,081 charts and determined that only 3.3% (95% CI 3.0-3.7) of ED visits were avoidable.⁵ They also concluded that lack of access and not intentional, inappropriate use of the ED was driving many of these visits. This myth that EDs are overrun by patients with non-emergent or non-urgent complaints is designed to shame patients from seeking care.

The article also states that EDs contributed to 48% of all medical care in the United States. Neither of the provided references support this statement. The reference by Kringos et al. evaluated primary care in *Europe*.⁹ After reviewing the literature, their main conclusion was that strong primary care was associated with higher levels of health care spending, albeit with a reduced rate of growth.

Regarding potentially avoidable hospitalizations, stronger primary care was associated with lower admission rates in asthmatics. While this intuitively makes sense, the lower rates of admission in some cases were due to not having enough inpatient beds. That being said, the article also concluded that accessible and comprehensive primary care could reduce avoidable hospitalizations. Assuming this is true, none of the recommendations proposed would accomplish this. Telling patients to only go to the ED for a skeletal injury if "bone is visible" as instructed in their "Provider Playbook," is beyond ridiculous. Delaying necessary emergent care will only increase costs and worsen patients' conditions.



Dr. Evan Schwarz

Evan Schwarz, MD, FACEP, FACMT, completed his emergency medicine residency at Washington University School of Medicine. Afterward, he completed a fellowship in medical toxicology and obtained additional board certification in addiction medicine. He is currently an associate professor of emergency medicine and the Medical Toxicology Section Chief at Washington University School of Medicine. He is a member of the board of directors for the American College of Medical Toxicology and the current president of the Missouri College of Emergency Physicians.



Dr. Jonathan Heidt

Jonathan Heidt, MD, MHA, FACEP, completed his emergency medicine residency at Washington University School of Medicine. Afterward, he obtained a Master of Health Administration degree at the University of Missouri-Columbia School of Medicine. He is currently an assistant professor and medical director of emergency medicine at the University of Missouri-Columbia School of Medicine. He is the immediate-past president of the Missouri College of Emergency Physicians.

The other citation does evaluate the U.S. health care system.¹⁰ It was written by three emergency physicians, one of whom is now on the ACEP board of directors. They found that EDs contributed an average of 47.7% of the *hospital-associated* medical care delivered in the U.S., not all medical care as claimed. As nearly 50% of hospital admissions are initiated in the ED, this is hardly surprising.¹¹

Patients with private insurance, workers' compensation, Medicaid, Medicare, self-pay and charity care were included. It's unclear that these last four categories are represented by the St. Louis Area Business Health Coalition (BHC) as their membership mostly includes private businesses.¹² More importantly, the article concluded that vulnerable populations such as Medicare and Medicaid beneficiaries or those with psychosocial impairments drove this use—populations not necessarily served by the BHC. In fact, the total percentage of health care expenditures spent on emergency care is likely less than 7%.^{13,14}

We agree that we need to be efficient with our health care spending. However, arbitrarily limiting access to the ED is wrong for patients and is unlikely to significantly impact cost.

Another reason the article cites for decreasing ED utilization is the fragmentation of care. We readily admit that the ED and primary care physician's electronic health record may not be integrated which could fragment care. The solution, though, is not to tell patients that would benefit from going to the ED, not to go there. Instead, educating patients to bring their discharge documents to their follow-up appointments would provide greater benefit.

What is further confusing about the article's point, though, is that it seems to advocate for patients going to urgent care facilities instead of the ED. While there are patients that are appropriate to be evaluated in an urgent care center, it is unlikely this will improve care fragmentation; rather, it appears the author is more concerned about reduced costs to insurance companies.

Also, there is no standard definition of an urgent care center in Missouri. As such, testing possibilities differ in each facility. Assuming that urgent care centers can handle all forms of allergic reactions, minor head injuries and minor bone breakages (no bone penetration) as claimed in the Playbook, is incorrect. In addition, we are not aware of any clinical guideline that differentiates emergent vs. non-emergent fractures simply by if the bone is penetrating the skin.

After the third paragraph of this article, no further citations are given, making it impossible to know if the information

stated is solely the opinion of the BHC. The article's three consequences of inappropriate ED use lack citations that would enable an interested reader to understand the basis of the BHC's conclusions.

Finances alone seem to be the true motivation of this essay. Of the five reasons the BHC's website lists to join the Coalition, all appear to be solely focused on cost saving without including objectives to improve health outcomes.¹⁵

We agree that we need to be efficient with our health care spending. However, arbitrarily limiting access to the ED is wrong for patients and is unlikely to significantly impact cost. Many of the proposed solutions offered by the BHC don't have evidence demonstrating improvement of health outcomes and appear solely focused on potential cost savings.

Given that access more than anything else seems to be the driver of potentially avoidable ED visits, we wonder why the article did not discuss extending primary care hours, incorporation of telehealth, or changing the health care system so that primary care physicians are better reimbursed. —

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Local ACOs Collaborate to Improve Care

Goal is to improve quality and patient satisfaction

Editor's note: The following was submitted jointly by members of the ACO collaborative.

With the goal to enhance the patient experience, improve clinical quality and limit unnecessary spending, Accountable Care Organizations (ACOs) have continued to expand. Growing from 480 Medicare ACOs in 2015 to 561 as of January 2018, ACOs serve more than 12.3 million Medicare fee-for-service patients nationwide.

In the St. Louis area, six ACOs—BJC, Mercy, Missouri Health Plus, St. Louis Physician Alliance, SSM Health and St. Luke's—serve more than 225,000 patients and have produced almost \$58 million in Medicare savings to date. Average quality scores in 2017 for the six ACOs was 94%.

“Every health system in St. Louis is rallying around the three-part aim—better health, better care, lower cost—and if we satisfy that, we all win.”



Inspired by the collaborative work being done by other ACOs across the country, our local ACOs now are collaborating in an effort to share best practices, increase care coordination, and most importantly, improve patient health outcomes and satisfaction. Each ACO remains organizationally and financially independent through this informal collaboration.

Goals of the group include:

- Collaboration during targeted periods of care along the continuum, such as post-acute services, and on specific chronic diseases, such as ESRD
- Sharing information with social services and government agencies who interact with our patients
- Educating elected and government officials about ACOs and population health

The six ACOs are working together under CMS guidelines to share clinical information, such as notifications of ED visits and hospitalizations, so that care managers can ensure patients are appropriately scheduled for transition of care visits in a timely fashion to improve outcomes and reduce readmissions. Currently, the organizations are working with several skilled nursing facilities to standardize care protocols and ensure a smooth transition for patients from hospitalization to post-acute care and back to primary care. Again, this collaboration does not involve any financial relationship or transactions between the organizations, they are simply working together to share best practices and improve patient care.

“We are very excited to work with other health care providers in the St. Louis region to find innovative ways to improve care for our patients,” states BJC ACO Medical Director Nathan Moore, MD.

Added Jason Hand, MD, Mercy St. Louis department chair for adult primary care medicine: “Every health system in St. Louis is rallying around the three-part aim—better health, better care, lower cost—and if we satisfy that, we all win.”

Jen Wessels, MD, vice president of SSM Health Medical Group, related that “the best minds in St. Louis health care are coming together to benefit all of our patients in the region.”

The Medicare ACO program design is such that notification of program savings comes several months after a performance year. Collaborating on joint initiatives can continue the forward momentum of change and improved patient outcomes desired by these organizations—while waiting for CMS to determine the impact to health care's bottom line. ➤

ST. LOUIS-AREA ACOs

BJC

www.bjcaco.org

Start Year: 2012
Beneficiaries: 40,551
Program Savings: \$22.4M
Track 3 MSSP
PCPs: 307
Total Physicians: 691

Mercy*

www.mercy.net/accountable-care-organization

Start Year: 2013, 2015
Beneficiaries: 120,000
Program Savings: \$5.5M
Track 1 MSSP
PCPs: 750
Total Physicians: 2,100

Missouri Health Plus

www.missourihealthplus.com

Start Year: 2017
Beneficiaries: 12,500
Program Savings: \$5.9M
Track 1 MSSP
PCPs: 136
Total Physicians: 151

SLPA ACO

www.stlouisphysicianalliance.com/aco

Start Year: 2015
Beneficiaries: 18,000
Program Savings: \$23.6M
Track 1 MSSP
PCPs: 87
Total Physicians: 411

SSM Health

www.ssmhealth.com/aco

Start Year: 2014
Beneficiaries: 22,030
Program Savings: N/A
Track 3 MSSP
PCPs: 103
Total Physicians: 383

St. Luke's Hospital

www.stlukes-stl.com/aco

Start Year: 2018
Beneficiaries: 13,500
Program Savings: N/A
Track 1 MSSP
PCPs: 50
Total Physicians: 350

*Data covers two ACO entities across a four-state region and is not exclusive to the St. Louis area.

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Where They Stand: The Candidates on Health Care Issues

Candidates for U.S. Senate and Congress offer their thoughts on issues of concern to St. Louis-area physicians

Voters' choices in the November 6 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 U.S. Senate from Missouri and two St. Louis-area U.S. House seats. Thanks to all the candidates who took time in their busy schedules to respond to our questions. Multiple attempts were made to contact all candidates.

U.S. Senate

- **Claire McCaskill, Democrat (Incumbent)**
www.clairemccaskill.com
- **Josh Hawley, Republican**
www.joshhawley.com
- **Craig O'Dear, Independent**
www.craigodear.com
- **Jo Crain, Green Party**
www.missourigreenparty.org/jo_crain_for_us_senate
- **Japeth Campbell, Libertarian**
www.facebook.com/Campbell4Liberty

Josh Hawley and Japeth Campbell did not provide responses.

What are your priorities for enabling our health care system to provide the most affordability, accessibility and quality?

McCaskill: I support improving the health care system to ensure that all Missourians can access quality, affordable coverage. To this end, I have co-sponsored bipartisan legislation to bring down premiums in the individual marketplace. I have also worked with my Republican colleagues to remove burdensome reporting requirements for businesses. I introduced legislation to allow anyone without an insurance provider in their county's individual market to buy health insurance on the DC exchange. And I strongly support maintaining the requirement that insurance companies cover Missourians with pre-existing conditions, unlike my opponent, who is suing to end that requirement.

O'Dear: We need innovation in our health care business model. Our pricing model now is cost-plus, with virtually

no transparency or competition. We need a system less focused on paying for treatments and procedures and more focused on incentives for maintaining health and achieving positive outcomes. We have the health care expertise, the technology, the innovative capabilities, the entrepreneurial spirit to achieve better health care at less cost. Innovation is happening. But we need a political system that facilitates it, and encourages the development of a better private sector business model.

Crain: I am for the Medicare for All option that provides for mental, dental and physical therapy options. We rail about mentally ill people killing people with weapons so now it is time to end that problem as well. We have far too many people who have purchased health care in the "market" finding that the insurance is pretty worthless. Those people would have no problem understanding the actual cost of our current health care is much greater than advertised and, in fact, is killing people. The whole purpose of insurance is denying care so that the insurance companies make money!

Recent surveys show that an increasing number of physicians support a single-payer health system. What considerations do you think are important in determining whether a Medicare for All system should be adopted?

McCaskill: I support allowing Americans to buy into Medicare starting at age 55 and working to improve our current system. I do not believe that it is appropriate for the federal government to tell Americans who collectively bargained for better employer-provided health care plans that they need to give up those plans and take whatever the government gives them. I also do not believe that a single-payer system is fiscally responsible—nor would it fix the underlying causes of rising health care costs. Therefore, I am not convinced that a single-payer health system is the right thing for our country.

O'Dear: Medicare for All means a health care system completely controlled by the single payer, which would be the federal government. I understand the attraction of such a system to many. I think we can and would do better if we keep our health care a predominantly private sector industry. The business model for health care, and the preferred insurance program, are two separate issues. I believe there may be a role for a public option in our insurance program, if we ever develop a rational approach to such a program. Extending Medicare eligibility to people at a younger age is an example.

Crain: The real issue is that currently insurers get a huge chunk of the health care dollar. I want insurers out of the mix entirely (except for some exceptions that the wealthy might like to have like cosmetic surgery and other kinds of treatments that are not necessary but some people want. But no more camel's whole body in the tent!) We pay twice as much for ½ as much as other countries with socialized medicine. And get worse outcomes as noted by the mortality rates for women and children and minorities.

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?

McCaskill: We must do more to bring down the skyrocketing cost of prescription drugs. That's why I worked across the aisle to conduct investigations into why pharmaceutical companies were raising prices on consumers. This investigation led to bipartisan legislation to increase competition in the pharmaceutical market and lower the cost of prescription drugs. I support measures to increase transparency in the drug pricing process by manufacturers, PBMs, and insurance plans, without increasing premiums. That's why I was the lead cosponsor of the Patient Right to Know Act to remove the pharmacy gag clauses in the ACA, employer plans, and Medicare.

O'Dear: Transparency in drug pricing should be mandatory. Doctors should know the cost of prescribed treatment. Profit margins for drug manufacturers should be transparent. Negotiated pricing between manufacturers and insurers should be accessible. Patients should know the cash price for prescriptions versus insurance copays. Eliminate excess regulatory barriers that prevent production of new drugs and generics. Additional competition in the marketplace would reduce the overall cost of medication. Medicare should be allowed to negotiate prices directly with manufacturers. I support removing exemptions for GPOs and PBMs from anti-kickback provisions. They should not be allowed to receive dark money from drug manufacturers.

Crain: I would make it illegal for pharmaceutical companies to advertise again. Drugs are really too dangerous for the industry to convince people who don't know enough that they just must have this drug or that. I would also like to see wholesale bargaining with the drug industry as a product of Medicare for All for cheaper prices as well as agreements to manufacture some needed drugs that are somewhat rarely used. Kickbacks to doctors and a board to decide the bargaining and the rare drugs to be manufactured should be illegal.

U.S. House, First District

- **William (Lacy) Clay, Democrat (Incumbent)**
www.lacyclay.org
- **Robert Vroman, Republican**
www.facebook.com/VoteVroman
- **Robb Cunningham, Libertarian**
www.facebook.com/RobbLibertarian

Robert Vroman and Robb Cunningham did not provide responses.

What are your priorities for enabling our health care system to provide the most affordability, accessibility and quality?

Clay: I am very proud to cosponsor Medicare for All as a public option under the Affordable Care Act. The profound difference between my opponents and I is that I have always believed that access to quality health care is a basic human right...not a commodity.

Recent surveys show that an increasing number of physicians support a single-payer health system. What considerations do you think are important in determining whether a Medicare for All system should be adopted?

Clay: The Medicare for All legislation that I am proud to cosponsor would generate billions of dollars in health care savings by streamlining paperwork and introducing efficiencies of scale that will save money and save lives.

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?

Clay: My top priority in lowering the costs of Rx drugs is lifting the ban on importation of most prescriptions and allowing Medicare to negotiate bulk drug pricing as is currently done by the VA and the Department of Defense medical service.

Continued on page 16

Candidates ➤ *continued from page 15*

U.S. House, Second District

- **Cort VanOstran, Democrat**
www.cortforcongress.com
- **Ann Wagner, Republican (Incumbent)**
www.annwagner.com
- **Larry Kirk, Libertarian**
www.facebook.com/KirkforLiberty/
- **David Arnold, Green Party**
https://electdavidarnold.weebly.com/

Rep. Wagner, Larry Kirk and David Arnold did not provide responses.

What are your priorities for enabling our health care system to provide the most affordability, accessibility and quality?

VanOstran: In America every person should have access to quality, affordable health care. Allowing private insurers to hold the reins on the market has put their profits ahead of people and their doctors for far too long. The Affordable Care Act was never perfect. Now we need to commit to strengthening and improving it and expanding Medicare and Medicaid. By doing so, we will see greater market participation and lower premiums for everyone.

Recent surveys show that an increasing number of physicians support a single-payer health system. What considerations do you think are important in determining whether a Medicare for All system should be adopted?

VanOstran: A Medicare for All program should be the long-term goal for our nation's health care. Multiple bipartisan studies show up to \$2 trillion in national health care expenditure savings with the adoption of a single-payer plan. But we won't be able to shift trillions into the public sphere overnight; the move will have to be incremental. That is why I support allowing younger people like myself to buy into Medicare to both drive down premiums and protect its solvency. The bottom line is that every dollar we spend on premiums could go toward improving America's health care, rather than insurance companies who profit.

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?

VanOstran: The rebate retention process for PBMs is opaque, and has resulted in massive profits to a few big companies—without an increase in quality of care. I support the elimination of the safe harbor provisions that allow companies like this to take advantage of sick people. Everyone deserves access to the drugs they need to lead a healthy, happy life. To tackle this problem, we need to address the monopolies created by the patent abuse of pharmaceutical companies. Encouraging the production of generic and biosimilar drugs will not only lower costs and increase competition, it will help to avoid shortages.

Medical Marijuana Proposals on Missouri Ballot

Physician Organizations Cite Lack of Research and Public Health Risk

Three proposals will go before Missouri voters on the November 6, 2018 ballot to legalize the use of marijuana for medical purposes. Each of the three proposals would establish regulations and licensing procedures for marijuana dispensary, cultivation, testing and marijuana-infused product manufacturing. Each would impose a tax on the retail sale of marijuana and license fees for marijuana-related facilities.

Here is how the three proposals differ:

- **Constitutional Amendment 2** would impose a 4% tax on retail sales that would be used by the Missouri Veterans Commission for health and care for military veterans, minus program administrative costs.

Continued on page 20

Leaders – Born or Made?

Four steps to develop a skilled leader

By Julie Guethler, Greater St. Louis MGMA

With the upcoming elections, it seemed appropriate to look at the age-old discussion of whether leaders are born or made. While some would argue for *nature*, I am making the case that *nurture* also plays a role.

Developing leaders within our organizations can be challenging. While I have held many leadership roles, I reached out to an expert to break down four foundational steps to developing leaders and assisting in their continual growth.

David Hults, executive director of Activ8Careers and the Job Shapers Network, discusses this on his website as “The Hard Truth About Leadership” when he says: “When it comes to being a real manager or leader, there are so many essential skills—like knowing how to motivate your team, make needed changes while minimizing pushback, and create accountabilities and reward systems to breed a healthy corporate culture. But few have learned how to develop the concepts of trust, open dialogue and being transparent as a leader. In short, it takes real training coupled with hands-on coaching and accountability from their directors to develop a skilled leader.”



Julie Guethler

Julie Guethler is the owner of Transform Healthcare Strategies, providing consultative services to physician practices in the areas of revenue cycle management, workflows, space design and interim management services. She is a past president of Greater St. Louis MGMA. Julie can be reached at guethler@sbcglobal.net or 314-420-1067.



Here are the four steps that Hults recommends:

1. Find Mentors Who Practice What They Preach

I have had the good fortune to follow some great leaders—starting with my parents and throughout my career as a medical practice manager and now as a consultant. Sometimes they came in the form of physicians with whom I have worked, employees, and vendors. Positioning yourself to be receptive to information is key.

2. Develop Accountabilities

We all need a level of accountability. Find an accountability partner—another manager, perhaps. This keeps us on track.

3. Seek Opportunities for Self-Development

Here I must make a shameless plug for the Greater St. Louis Medical Group Management Association. Meeting with other members and business partners is a great way to find resolution to issues and problems within the practice. Consider allowing your managers to participate. The only thing worse than losing great employees is keeping ones that don't develop.

4. Mentor Others

Often, one of the best ways to develop yourself is helping others grow. A goal of a leader should be giving back. In doing so, you complete the cycle of true leadership. You will get back as much as you invest and usually more.

Now, in the words of the founders of Intel: “Don't be encumbered by the past—go and do something wonderful.” ➔



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continued on next page



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Medical Marijuana — continued from page 16

- **Proposition C** would impose a 2% tax on retail sales that would be used for veterans' services, drug treatment, early childhood education and public safety, minus administrative costs.
- **Constitutional Amendment 3** would impose a 15% tax on retail sales along with a wholesale tax. Funds generated by the taxes and license fees would fund a newly created research institute which would regulate and license marijuana facilities. It also would conduct research toward developing cures for cancer and other diseases. Springfield, Mo., attorney and physician Brad Bradshaw would appoint the institute's board and be its research director.

The St. Louis Metropolitan Medical Society, the Missouri State Medical Association, the Missouri Association of Osteopathic Physicians & Surgeons and other state and local medical societies have gone on record as opposing the three proposals. In its statement, SLMMS "opposes such measures until a) The U.S. Drug Enforcement Administration reclassifies marijuana to allow for increased scientific research; b) Extensive research

studies demonstrating health benefits have been completed; and c) Necessary changes are made to federal laws permitting the use of marijuana. Until there is evidence supporting its effectiveness as a drug, SLMMS feels the potential for abuse outweighs any perceived medical benefits." —

MORE INFORMATION

- American Medical Association Council on Scientific Affairs Report: *Clinical Implications and Policy Considerations of Cannabis Use*, May 2017. <http://bit.ly/AMA-Cannabis>
- National Academies Report, *The Health Effects of Cannabis and Cannabinoids: Current State of Evidence and Recommendations for Research*, January 2017. <http://bit.ly/NatAcad-Cannabis>

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

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Born 1989, Licensed 2016 ➤ **Resident/Fellow**
Cert: Internal Medicine

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Cert: Rheumatology

WELCOME STUDENT MEMBERS

Saint Louis University School of Medicine

Julie Jin
Dylan J. Leonard
Brienna C. Milleson
Daniel D. Sprehe

Washington University School of Medicine

Favour A. Akinjiyan
Emmanuel Arhewoh
Nadia H. Bakir
Jennifer L. Berrian
Michelle Cai
Sarah Ning Chiang
Taylor E. Cogsil
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Andrew T. Coxon
Drew E. Del Toro
Patrick H. England
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Alexis P. McGraw
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Dana Sous
Jonathan Z. Tang
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Cyrus Zhou



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 cards 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 complete this form and return it with your check payable to the **AMA Foundation** or the **MSM Foundation** by November 10 to:

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St. Louis, MO 63131

For further information, gillian.waltman@gmail.com

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☐ Missouri State Medical Foundation (*select one*) ☐ General Fund ☐ Alliance Scholarship Fund

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Simon Horenstein, MD



Simon Horenstein, MD, a neurologist, died June 17, 2018, at the age of 93.

Born in Providence, R.I., he earned his undergraduate degree from Brown University. He obtained his medical degree from the University

of Illinois School of Medicine where he also completed his internship. He completed his neurology residency at the New England Center Hospital and Boston City Hospital.

Dr. Horenstein served in the U.S. Army from 1943-1946 and the U.S. Navy from 1951-1953.

He was professor and chairman of the Department of Neurology at Saint Louis University School of Medicine. He served as the founding chief of the neurology service at the VA Hospital in St. Louis.

Dr. Horenstein joined the St. Louis Metropolitan Medical Society in 1973, and became a Life Member in 2009.

He was predeceased by his first wife, Mary Joan Gunville. SLMMS extends its condolences to his wife, Ilene Horenstein; his children, Joshua Horenstein, Deborah Prendergast and Jonathan Horenstein; and his five grandchildren and four great-grandchildren. —

James M. Whittico, Jr., MD



James M. Whittico, Jr., MD, a board-certified surgeon, died Aug. 21, 2018, at the age of 101.

Born in Williamson, W.Va., Dr. Whittico received his undergraduate degree from Lincoln University in Chester County, Pa., and his

medical degree from Meharry Medical College in Nashville, Tenn. He interned and completed his surgical residency at the former Homer G. Phillips Hospital, and a surgical fellowship at Washington University School of Medicine.

Dr. Whittico served in the U.S. Army Medical Corps from 1942 to 1946. He was Missouri's first African-American to become a military hospital chief surgeon in active combat during World War II, rising to the rank of lieutenant colonel. He received the Bronze Star and Meritorious Combat Service Ribbon.

He served as the chief of the Rehabilitation Pilot Project at Homer G. Phillips Hospital. He entered private practice in 1952, and was a clinical professor of surgery for many years at Saint Louis University School of Medicine. He also served as a surgeon and acting medical director of the St. Louis Metropolitan Police.

Dr. Whittico joined the St. Louis Metropolitan Medical Society in 1957, and became an Honor Member in 1977. In 1987, he received the SLMMS Robert E. Schlueter Leadership Award, the Medical Society's highest honor. He was the first African-American physician to serve on the St. Louis Board of Health and Hospitals. He was past president of Mound City Forum, Missouri Pan-Medical Society and the National Medical Association, a past chair of the Missouri State Board of Registration for the Healing Arts and a past chair of the Missouri State Board of Health.

Dr. Whittico is predeceased by his wife, Gloria Thompson Whittico. SLMMS extends its condolences to his children, Jarrhet Whittico and Joi Whittico; and his two grandchildren. —

Steven I. Plax, MD



Steven I. Plax, MD, a board-certified pediatrician, died Sept. 4, 2018, at the age of 83.

Born in St. Louis, Dr. Plax received his undergraduate degree from Washington University and his medical degree from

University of Missouri-Columbia School of Medicine.

He interned at Strong Memorial Hospital in Rochester, N.J. and completed his pediatric residency at St. Louis Children's Hospital.

Dr. Plax served in the U.S. Air Force from 1964 to 1966. He was an assistant clinical instructor in pediatrics at Washington University School of Medicine and saw patients at St. Louis Children's Hospital.

Dr. Plax joined the St. Louis Metropolitan Medical Society in 1966, and became a Life Member in 2002.

SLMMS extends its condolences to his wife, Julie Plax; his children, Danny Plax, MD; Katie Plax, MD; Ted Plax and Andy Plax; and his 11 grandchildren. —

There Is No Such Thing as a Free Lunch

By Richard J. Gimpelson, MD

The above title has also been slightly changed at times to read, “There is no such thing as a free ride.” Finally the New York University School of Medicine (NYU) has disproven this old saying by essentially providing the “free lunch” and the “free ride” with no strings attached. Thanks to gifts totaling \$450 million and plans for raising an additional \$150 million (total of \$600 million), NYU will give all incoming medical students free tuition for all four years of medical school. In addition, the current medical students will receive free tuition for their remaining medical school years.

The savings at NYU amount to \$55,000 per year. The one hitch to the generous support is that room and board is not covered. In New York City this can amount to over \$25,000 per year. In my opinion, the free tuition alone is a most generous gift and needs no attached warning. As far as I could investigate, there is no other medical school in the United States that matches the offer from NYU.

One of the pluses expected by NYU is that medical students will be able to go into a field of medicine that is truly attractive to them rather than choose a high-paying specialty to help repay their debt quicker. According to the Association of American Medical Colleges, 75 percent of all doctors in the United States graduated with debt.

Many medical schools give a mix of need- and merit-based scholarships with some providing partial and some providing full tuition coverage, but none are for all students in their program. Many medical schools would truly love to offer full free tuition to all of their students, but at the present time, the money is not there. The good news is that some medical schools are pursuing generous donors to help achieve full free-tuition programs.

Some concerned medical schools claim that a full tuition-free program may attract students that do not really have medicine as a career first choice. It is difficult for me to support the above claim since those of us who chose the field of medicine knew that the educational commitment, before actually entering the practice of medicine, can take six to ten years. My own commitment to become board certified in obstetrics and gynecology was eight years after getting a BS in electrical engineering. I have never regretted a day of the eight years in training, although sometimes it was hard to get up in the morning after over 36 hours awake on-call and routine service (old rules, thank heaven).

A legitimate concern can be raised that if more medical schools adopt tuition-free programs, will those schools with smaller endowments have trouble attracting the best students? This may happen, but the standards required for entrance into any medical school are so high that there are many more top students applying to medical schools than there are places available for acceptance into all the medical schools in the United States.

An increased number of tuition-free medical schools will open up medical education to many very qualified applicants who may not have the personal or family wealth to afford current medical school tuition. It will enable these individuals to pursue their life goal. In the old days, my tuition at the University of Missouri-Columbia School of Medicine was \$250 per semester for the first three years and \$275 for the last year. Total expenses for my last year were \$3,000 (tuition, room, board, my three dates and gasoline at 19.9 cents per gallon). It was hard to graduate medical school with much debt in those times, even at the most expensive medical schools in the country. Unfortunately, times have changed for the worst as far as medical school tuition is involved. I am puzzled why any medical school would not have tuition-free education as its goal. If it is not their goal, I would like to know why.

Let us hope that one day, all medical schools will be tuition free. Thank you, NYU. —



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

Dr. Richard J. Gimpelson

are most welcome and may be sent to editor@slmms.org.



All in the Family

Daughter follows father as physician, SLMMS Council member

By David M. Nowak, SLMMS Executive Vice President

A career in medicine often runs in the family. The children of physicians often follow in the footsteps of their parents in the practice of medicine. The Lund family of St. Louis is no different. Herluf G. Lund, Jr., MD, a plastic and reconstructive surgeon, followed his father, an uncle and his grandfather into the field. His daughter, Samantha, is now on the same path as a second-year medical student at Washington University School of Medicine.

But is service to the profession through organized medicine also part of the Lund genetic code? Apparently so. This past January, when Samantha was appointed as the medical student liaison from Washington University to serve on the SLMMS Council for 2018, she took a seat at the same table where her father sat nearly 20 years ago. Dr. Herluf Lund served as a SLMMS Council member from 1997-2000, including one year as treasurer (1999) and one year as secretary (2000). A member since 1991, Dr. Lund remains active in SLMMS, serving on several committees and as a Third District Delegate from SLMMS with the Missouri State Medical Association.

Both father and daughter completed their undergraduate degrees at Tufts University in Boston; interestingly, both waited three years before enrolling in medical school; and like her father, uncle and grandfather, Samantha was accepted into the program at Washington University. While Herluf Sr. pursued a specialty in urology, and Herluf Jr. chose plastic surgery, Samantha does not see herself selecting either specialty, but that decision will be made later.

The Lunds also share a mutual commitment to community service and to the betterment of the practice of medicine. This lesson Samantha learned early, as it was modeled by her father. "I was able to witness first-hand his commitment to standing up for what you believe in, whether it be health improvement or another important cause," she said.

"You can easily see and feel the impact of organized medicine," says Dr. Lund. "You have the power to help bring about change through collaboration with the larger group. You can't be nearly as influential by yourself."

Getting involved with SLMMS, as well as the Washington University chapters of the AMA and MSMA, has already



Herluf Lund, Jr., MD,
and his daughter,
Washington University
medical student
Samantha Lund.



opened doors for Samantha. Over the past year and a half, she's had the opportunity to meet several elected officials and participate in meaningful conversations about issues in health care. She is quick to attribute her inclination to volunteer and get involved, even with a busy class and study schedule, as influence from her father. This past March, father and daughter attended their first conference together—the Missouri State Medical Association's annual convention.

Both enjoy comparing and contrasting their medical school experiences, an activity certain to continue as Samantha pursues her training. "Thirty years ago, we all went to class and you saw your fellow classmates regularly," noted Dr. Herluf Lund. "Now, many classes are streamed online, and students individually view on their own schedule, reducing time together. Their interaction is much different."

As a result, Samantha feels her father is much more team-oriented and works well with groups. "But our curriculum is providing more opportunities to facilitate team-based work, to break down those barriers," she added. She also feels the outlet of participating in organized medicine offers some great team experiences as well.

"Today's medical school curriculum is also much more interested in the well-being of the student," Dr. Lund observed. "That's a positive change—reducing burnout and keeping students engaged and motivated." Samantha agrees, and points out that Washington University has been receptive to curricular changes and improving the student experience.

Perhaps blood is thicker than water. In the Lund family, shared commitments make for strong connections.

"I'm very proud of my daughter and her interest in organized medicine," adds Dr. Lund. "I believe that wherever she lands in medicine, she will have a positive impact on her profession and her fellow doctors." Right now, SLMMS and organized medicine are benefiting from their volunteerism and advocacy. —

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