Public Health
At the Forefront: KC's Public Health Agencies
Physicians, Health and the Community

Features
Meet KCMS 2017 President
Joshua M.V. Mamman, MD
Toward a New Medical Society
Prescription Drug Monitoring for KC
Big Pharma & the Opioid Epidemic
Making Time, Making a Difference
Are you an integrative healthcare practitioner? If so, we invite you to attend a special three-day workshop for practitioners in our hometown of Kansas City! This workshop will provide in-depth information about some of our most popular and clinically useful tests, so you can better incorporate them into your practice and create better health outcomes for your patients. Tests covered in this workshop include: Organic Acids Test, GPL-TOX (Toxic Non-Metal Chemical Profile), Glyphosate Test, GPLSNP1000 (DNA Sequencing Profile), GPL MycoTOX Profile, IgG Food Allergy Test, and more! You will learn about key markers in the tests, why they are relevant, how to interpret results, how to use the tests in tandem, and you will review possible treatment options that have been effective. Registration for this workshop will be limited, so reserve your place now!

**FEATURED SPEAKERS**

**WILLIAM SHAW, PHD**
LABORATORY DIRECTOR
THE GREAT PLAINS LABORATORY, INC.

**KURT WOELLER, DO**
DIRECTOR
INTEGRATIVE MEDICINE ACADEMY

**MATTHEW PRATT-HYATT, PHD**
ASSOCIATE LABORATORY DIRECTOR
THE GREAT PLAINS LABORATORY, INC.

**RICK SPONAUGLE, MD**
MEDICAL DIRECTOR
SPONAUGLE WELLNESS INSTITUTE

**DAY 1 | THE HEALTH IMPLICATIONS OF MICROORGANISMS**

- Intro To The Organic Acids Test & Why It Is So Important In Clinical Practice
- The Link Between Invasive Candida & Various Health Issues
- The Link Between Clostridia Bacteria Toxins & Various Health Issues
- The Hidden Threats of Mycotoxins
- Case Studies & Treatment Options for Mycotoxins
- Oxalate Metabolism: Risks and Treatments

**DAY 2 | THE HEALTH IMPLICATIONS OF METAL & NON-METAL TOXINS**

- Non-Metal Toxic Chemicals & Their Effects on Health
- Glyphosate, 2,4-D, GMO Foods, & the Microbiome
- Genetic Testing: The Route to Personalized Medicine
- How Genetics Affects the Detoxification of Drugs & Environmental Toxicants
- Case Studies and Treatment Options for Environmental Toxicants
- Heavy Metals & Their Role in Chronic Health Disorders

**DAY 3 | THE INFLAMMATORY BASIS OF DISEASE**

- Methylation: How Methylation Affects Mental Health, Cardiac Health, & Detoxification
- Neurochemical Imbalances & Quinolinic Acid Toxicity
- Understanding the Risks for Developing Mental Health Disorders & Possible Interventions
- The APOE Gene
- How Peptides Affect Chronic Health Issues
- IgG Food Allergy Testing: Scientific Evidence of its Validity in Chronic Illness
- PLA2: The Possible Root Cause of Many Inflammatory Disorders

Attendees receive a FREE Organic Acids Test, worth $299!
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ON THE COVER:
Kansas City-area public health directors, seated from left: Tiffany Klassen, Cass County; Lougene Marsh, Johnson County; Bridgette Casey, Jackson County. Standing from left, Andrew Warlen, Independence; Rex Archer, MD, Kansas City, Mo.; Terry Brecheisen, Wyandotte County/Kansas City, Kan.; Mary Jo Vernon, Platte County; Gary Zaborac, Clay County. Learn more about Greater Kansas City’s public health efforts starting on page 23. (Photo by Mike Curtis)
New Book Explores Near-Death Experiences


Dr. Hagan notes that this is the first scientific study of near-death experiences (NDEs) in peer-reviewed literature.

“As many as 9 million to 20 million Americans are estimated to have NDEs; perhaps 10% of successful cardiac arrest patients have a NDE. Physicians and health care professionals need to know how to recognize NDEs and how patients, especially children, should be treated after this frequently life-altering event occurs,” he said.

The foreword and chapter one are by Raymond Moody, MD, PhD, who coined the name NDE and has sold over 20 million books on the subject. The book also contains the personal account of her own NDE by former UMKC ophthalmologist Jean Hausheer, MD. The experience occurred in 1977 when she was 20 years old; it was not reported publicly until her article was published in *Missouri Medicine* in 2014 (read her account starting on page 34).

The *Science of Near-Death Experiences* book is available on Amazon.com; the publisher is the University of Missouri Press. The book was featured March 17 in the *Kansas City Star.*

All profits from the book are being returned to Missouri State Medical Association.

KCMS Moves to New Office

The Kansas City Medical Society is relocating its office to the new Plexpod Westport Commons building. The new address is 300 E. 39th St., Kansas City, MO 64111. The telephone number remains the same, (816) 531-8432. Besides office space at a more favorable lease rate than the previous Plaza Medical Building office, the Plexpod facility offers conference rooms, meeting space and other amenities. The Westport location remains central and easily accessible from physician offices and hospitals throughout the region.

The Kansas City Medical Society is relocating its office to the new Plexpod Westport Commons building. The new address is 300 E. 39th St., Kansas City, MO 64111. The telephone number remains the same, (816) 531-8432. Besides office space at a more favorable lease rate than the previous Plaza Medical Building office, the Plexpod facility offers conference rooms, meeting space and other amenities. The Westport location remains central and easily accessible from physician offices and hospitals throughout the region.
Physicians, Health and the Community
PUBLIC HEALTH EFFORTS TO PREVENT DISEASE BEGAN IN LONDON WITH DR. JOHN SNOW IN 1854
By Michael L. O’Dell, MD, MSHA, FAAFP, Editor, Kansas City Medicine

There are many great stories of the impact of a physician acting with intellect and courage on behalf of the larger community. Dr. John Snow’s services to the SOHO district of London in 1854 is such a famous tale. Dr. Snow’s work involved careful reasoning, represents the first uses of disease mapping, and is considered a foundational work in public health and epidemiology. Dr. Snow’s interruption of a London cholera epidemic by simple but dramatic action is a sentinel event in the history of fighting epidemics. Please consider Dr. Snow while reading about the work of our public health departments in this issue.

In 1854, London was in the grips of a terrible epidemic of cholera. Dr. Snow carefully mapped each case of cholera in the area (Figure 1). This map remains a venerated display, such that Edward Tufte in his remarkable book *Visual Explanations*, chose it as one of his best examples of a visualization leading to clear thinking. Today, we see similar mapping being called hot spotting and we celebrate the remarkable genius of such mapping. As a profession and within our institutions, we are adopting and expanding upon Dr. Snow’s techniques, now over 163 years old. Dr. Snow’s method is evolving into the new realm of population health. This use and expansion of Dr. Snow’s methods brings new value to our professional activities.

Dr. Snow’s map alone did not decipher the locus and source of the 1854 London cholera epidemic. It was Dr. Snow’s and Rev. Henry Whitehead’s reasoning that led to the answer. The cluster of cholera cases involved those that drew their water from the Broad Street pump. The finding that the workers at the nearby Broad Street Brewery were unaffected posed an anomaly. Discovering that these workers’ hydration came from their daily beer allowance allowed dismissal of the anomaly: the brewing process had...
eliminated cholera transmission for these workers. Today, we might describe the findings of unequal disease affliction under the rubric of social determinants of health. Here in Kansas City, disease and death are no less related to socioeconomic and geographic circumstances, albeit now not related to cholera. Perhaps the Missouri Hospital Association graphic on diabetes (Figure 2) will be a similar guide to Kansas City’s epidemic of diabetes as Dr. Snow’s map was for 1854 London. Visualizing and knowing are essential to learning. Action completes the necessary conduct of the profession. Dr. Snow acted: he convinced the local governing officials of his findings. The Broad Street Pump was disabled by removing the pump handle. The cholera epidemic quickly abated. Many of us are seeking to eliminate the causes of illness and death in our community. Our health departments and the profession are much like Dr. Snow and Rev. Whitehead, working together to improve the health of our community.

Our public health departments daily perform the investigative work of collecting, mapping, and analyzing the health of our community. These departments contain colleagues and peers who are focused on helping our profession and community succeed in health. Some issues can be contentious: I suspect that many of those living on Broad Street in 1854 London took a dim view of Dr. Snow and challenged the removal of their water source. His action saved countless lives, perhaps even an entire community. As physicians, what steps will we personally and collectively take in confronting health challenges in our community today?

Michael L. O’Dell, MD, MSHA, FAAFP, is chair of the Department of Community and Family Medicine at the University of Missouri-Kansas City School of Medicine, and associate chief medical officer for the Truman Medical Centers Lakewood campus. He can be reached at Michael.O’Dell@tmcmem.org.

REFERENCES
3. Gawande, A. The hot spotters: can we lower medical costs by giving the neediest patients better care? The New Yorker. 2011; 40-51.
As the story goes, Canute, king of England and Denmark around 1035 AD, had a sizeable court. Now, that wasn’t unusual. Court functionaries were the bureaucrats of medieval kingdoms, and actually ran the place while the king did … well, kingly things. But Canute’s courtiers, in the manner of government hangers-on today, thought that the king could do virtually anything. And of course, each courtier wished to have that supposedly vast power used to benefit his particular concerns. Tiring of their flattery and demands, Canute moved his throne to the edge of the sea, and commanded the tide to hold where it was, and not to advance. Of course, his shoes were shortly very wet. He then pointed out that he had no power over nature, that only God was all powerful. It is not recorded whether this silenced his courtiers.

The story was told by Henry of Huntingdon, a 12th-century historian of Anglo-Saxon-Danish England. It may even be true. But true or apocryphal, it contains a lesson for today.

For the last 10 years, we have been engaged in a national effort to re-configure the health care system. We are now entering a new phase of that effort. Let me say that the effort has achieved some worthy goals, particularly by decreasing the numbers of uninsured citizens. But nobody seems very happy. Rural hospitals are closing in large numbers, doctors are discouraged, medical practices are snarled in red tape, and costs are continuing to rise. Patients are covered, but the premiums and co-pays continue to rise. The public seems to be ambivalent at best, and hostile at worst.

The assumption has been that by providing insurance coverage and tweaking the rules, we can re-order the health care system to our liking. But … are we really accomplishing something, or are we just watching the tide come in?

The health care system isn’t precisely like the tide coming in, though. It is, after all, a human system. One can certainly argue that if people put the thing together, other people can take it apart and fix it. Really? Let’s see. During the Progressive Era, Prohibition was the Right Thing to do. Recall how well that worked? It was a disaster. Other than giving secure employment to a brigade of FBI agents, of course. More recently, remember the War on Poverty? Well-intentioned, perhaps even helpful. But poverty remains stubbornly with us. Just because people can create a problem is no reason to assume that people can un-create it, or even change it.

Indeed, once a system becomes sufficiently complex, changing it may be akin to changing the tides. For the last 50 years, or so, the march of globalization has promised to make nation-states irrelevant. But recent events here, and in Britain, and across Europe, express a contrary opinion. Human institutions are constantly in a dynamic balance among many forces, pulling them in differing directions. Changing that balance is not carried out by the wave of a pen, whether the pen is wielded by a king, or a President, or even (gasp!) Congress.

So, the relevant question is, just how much power does the government have over the practice of health care? The assumption has been that by providing insurance coverage and tweaking the rules, we can re-order the health care system to our liking. But … are we really accomplishing something, or are we just watching the tide come in?

DISSATISFACTION WITH EHRS

Health care is a bit large for a short essay. So, let’s focus on one aspect. Take the Electronic Health Record. (Please!) We have all been subject
to Meaningful Use requirements to incorporate the EHR into our practice. And we now know from a number of surveys, notably one by the Rand Corporation, that the EHR is a major source of dissatisfaction for physicians.1 How did we get here?

Between 10 and 20 years ago, a number of people, inside and outside of health care, began a major push to bring information technology into health care. These advocates saw no downsides. Putting patient information into electronic form would streamline health care, cut costs, improve quality, and provide portability and transparency of health records. There would be some initial expense and ongoing maintenance, but surely the system would pay for itself over time. The Leapfrog Group, a consortium of major companies, was especially vocal. It may be worth noting that of the 150 members of the Leapfrog Group at that time, about 50 were information technology companies. Anyway, based on the hope that IT would improve health care, the Health Information Technology for Economic and Clinical Health Act (HITECH), was passed by Congress as part of the American Recovery and Reinvestment Act in 2009. As directed, the Centers for Medicaid and Medicare Services (CMS) created rules, and thus we wound up with Meaningful Use.2 It was supposed to be introduced in three phases starting in 2011, leading to greatly improved outcomes by 2016.

Now, it's 2017. Meaningful Use has been abandoned. More precisely, it is now folded into MACRA and MIPS. MACRA is the Medicare Access and CHIP Reauthorization Act of 2016.3 The idea was to manipulate reimbursement rates for Medicare patients, in order to encourage the use of EHRs. MIPS, or Medicare Incentive Payment System, is supposed to do the manipulation, financially rewarding good physicians, and penalizing bad physicians. And of course, the insurance industry is expected to fall in line. As we all know, similar requirements were laid upon hospitals.

What about all of those objectives? Well, most of them are pretty much abandoned, as well. CMS is now just into penalizing physicians if they don't meet a laundry list of requirements, without much regard for whether those requirements will improve outcomes or not. We should give credit here to the AMA, whose negotiations with CMS have considerably moderated the requirements and reduced the penalties. But the requirements and penalties still exist, and our government is counting on them to change our practices.

Meanwhile, EHRs have become a major problem for physicians. The Rand survey of 2013 showed that the EHR was a major source of dissatisfaction, entirely aside from the other aspects of increased paperwork and surging bureaucracy. The Physician Foundation's biennial Physician Survey of 2016 noted that the EHR was number three on the list of things that physicians found least satisfying about practicing medicine. (In case you were wondering, number one was regulatory and paperwork burdens.) That same survey showed that 52% of physicians were pessimistic about the current state of health care, and 63% about its future.4

The federally-mandated drive to bring the wonders of information technology to health care has resulted in widespread dissatisfaction and disillusionment among physicians. More physicians than ever are planning to retire early, and more of them limiting their practices. Granted, we do have a lot of EHRs available. But they haven't produced the wonders that were anticipated.

Managing information in the health care system is difficult, and simply cannot be reduced to computer-friendly algorithms. We can track inventory, do accounting, and generate bills. Past those, we're into territory that is considerably more difficult than was ever dreamed by the Leapfrog Group. The same treatment doesn't produce the same result in a different patient. Or, often, in the same patient at a different time. An abnormal lab test may be important, unimportant, irrelevant, or wrong, depending on circumstances. Many things are time-sensitive, many are not. Some systems promote transparency, some advertise their proprietary nature as enhancing security. For that matter, we can't even agree on whether we want transparency or security of our data.

Requiring the use of computer systems in this environment has become an exercise in futility. But there remains faith in the effort, inside the Beltway, and in most state legislative chambers. An instructive example was an action, a few years ago, by the Massachusetts state legislature. Any EHR used in the state must be transparent, allowing data sharing. Of course, it didn't happen. An edict by the state government resulted in … nothing.

The government has mandated EHRs. But the technology wasn't, and isn't, ready. Computer systems in their present form are entirely adequate (continued)
Editorially Speaking

for tracking airline reservations, or managing huge retail operations, or maintaining manufacturing inventories. Certainly, they can keep track of much of our data. They can put x-rays online. They can interface with laboratory equipment, ranging from chemistry labs to sophisticated devices for measuring vision. But at the level of clinical medicine, these systems are a very poor fit. They do not, and frequently cannot, make meaningful differentiations. A patient with abdominal pain may have a life-threatening intestinal perforation, or simply a bellyache. “Decision support” in most EHRs is either irrelevant or misleading. Worse, use of EHRs interferes with interactions between patients and their doctors, their nurses, and others who care for them.

It’s safe to say that the king’s shoes are pretty well soaked, the hem of his robe is sopping, and his throne is becoming waterlogged. King Canute was wise enough to know his limitations, and to stop ordering the tide to halt. Our present leaders, evidently, are not. Canute is dead, but the descendants of his couriers are alive and well today.

Charles W. Van Way, III, MD, is editor emeritus of Kansas City Medicine and is emeritus professor of surgery at the University of Missouri-Kansas City, and director of the UMKC Shock Trauma Research Center. He can be reached at cvanway@kc.rr.com.

REFERENCES


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MEET 2017 KCMS PRESIDENT
JOSHUA M.V. MAMMEN, MD, PHD, FACS

By Jim Braibish, Kansas City Medicine

KCMS is privileged to have as its 2017 president, Joshua M.V. Mammen, MD, PhD, FACS, from The University of Kansas Medical Center. Dr. Mammen is an ideal choice to lead the Society during the transition year as we join forces with the Wyandotte-Johnson County Medical Society, of which he also is a member. In the following interview, Dr. Mammen shares insights into his background and his thoughts on KCMS and the medical profession.

Tell us about your practice.

I am a surgical oncologist at the University of Kansas. In caring for patients, I see them in clinic, perform operations, and care for them while they are hospitalized after surgery. In addition, I offer my patients the opportunity to try techniques and improve cancer care by participating in innovative clinical trials.

Why did you choose to go into medicine? Why did you choose oncologic surgery?

I am incredibly grateful that I have been given the opportunity to work in such a noble profession. As a physician, I am given the opportunity to make a concrete difference in an individual’s life. The trust that patients put in their physicians is humbling. I had the opportunity to observe physicians throughout my childhood (most importantly my father, who is a surgeon in a small town in Louisiana).

There is little doubt that observing the impact that they were able to make in the lives of others led me to this profession.

Surgical oncology attracted me for several reasons. First, I found that I could make a large difference in the lives of my patients with treatments that we have available. Secondly, I enjoy working with a team. The care of cancer patients requires a tremendous amount of coordination with a variety of other physicians (radiation oncologists, anesthesiologists, medical oncologists, radiologists, plastic surgeons, pathologists), but also other key team members like nurses and physical therapists amongst others. I enjoy working in such collaborative environments. Third, I enjoy the intellectual aspect of a field in which you not only need to know your own specialty, but enough in order to ensure that your patients get the best care in the correct order. Finally, surgical oncology is an area of exciting (continued)
new advances. I enjoy being able to offer our patients the newest strategies for diagnosis and treatment as well as working with others to create these new techniques and strategies.

**What aspect of your work do you find most satisfying?**

Without any hesitation, taking care of patients is my number one priority and what I value most about my job.

**Tell us about your family.**

I have been married to my wife, Julie, for 14 years. We have five children: Joshua (10), Ann (9), Therese (8), Isabel (5), and Rachel (4).

**What accomplishment(s) (personal or professional) are you most proud of?**

A recent accomplishment that was truly a group effort, but something that I was able to play a small part in, is the passing last year of a law in Kansas that prohibits commercial tanning facilities from serving children. The law took nearly four years of work, but it shows that a group of interested citizens, patient advocates, physicians and lawmakers can make real changes.

**What are your goals and priorities for KCMS this year?**

I have several issues that are important for the Medical Society this year.

An important one is that the KCMS and the Wyandotte Johnson County Medical Society will merge to create one voice for physicians in the Kansas City area. I am excited to participate in this transition. A unified medical society will allow us to advocate more effectively for our patients. An additional priority is to ensure that physicians are able to care for their patients. There are numerous stakeholders in the health care environment including payers, regulators, hospitals and other health care workers with whom we need to work to ensure that we are able to care for our patients in the best possible way. A third major priority is ensuring that physician collegiality (which has long been an important function of local and regional medical societies) is fostered. I want physicians to know each other as colleagues, not competitors, regardless of the health care environments. Finally, I want the KCMS to continue to work to advocate for our patients at local and regional levels.
BIOGRAPHY

PRACTICE: The University of Kansas Medical Center
- Associate Professor of Surgery and Molecular & Integrative Physiology
- Division Chief for Surgical Oncology, Department of Surgery
- Vice Chair, Department of Surgery

EDUCATION: B.A., History and Medical Science, Boston University; M.D., Boston University; M.B.A, Marketing and Management, University of Cincinnati; Ph.D., Molecular and Cellular Physiology, University of Cincinnati; Master’s in Education, University of Cincinnati

MEDICAL ORGANIZATIONS: Kansas City Medical Society, president, 2017; director, 2011-present; chair, Advocacy and Government Affairs, 2013-2015; Kansas Medical Society and Wyandotte Johnson County Medical Society, member; American Medical Association, member; Kansas City Surgical Society, president, 2017; board member, 2012-present; American College of Surgeons, YFA Governing Council, 2013-present; American College of Surgeons Kansas Chapter, president, 2015-2016; Association for Academic Surgery, councilor 2015-present; Catholic Medical Association, Cosmos and Damian Kansas City Chapter, board member, 2009-present; Kansas Cancer Partnership, chair, colorectal cancer action team, 2012-present

What is your biggest concern about the future of the medical profession?
I am most concerned about the tendency to become cynical. When we become cynical, we adopt a defeatist attitude and stop trying to improve ourselves and our environment. Though there are many challenges (and there always will be), I hope we adopt a practical optimism, a sporting spirit.

What would you ask individual physicians to do this year to support the Medical Society?
I would like to encourage colleagues to join us and share their ideas and enthusiasm. There is much that can and should be done. We all have other very important obligations, but I hope that the Medical Society can have some of your valuable time to make Kansas City better for our colleagues and patients.

KU Surgeon Was First WWI Casualty

Born on April 18, 1889, in Burlington, Kan., Dr. Fitzsimons graduated from the KU School of Medicine in 1912. He trained in surgery at Roosevelt Hospital in New York City, and volunteered for the U.S. Medical Reserve Corps and served for a year in England and Belgium. In 1915, he returned to Kansas City and joined the KU faculty. However, after the U.S. entered the war, his unit was called to duty in France.

His death sparked shock and grief throughout Kansas City and the nation. Memorials to Dr. Fitzsimons are placed in Kansas City at the intersections of 12th Street and the Paseo and 47th and the Paseo, and on the KU campus. The Army hospital in Aurora, Colo., was named in his honor in 1920. He is remembered as a good soldier on a mission of mercy.

On Sept. 4, 1917, Lt. William T. Fitzsimons, MD, a University of Kansas School of Medicine graduate and faculty member, became the first American officer killed in World War I enemy action. A German air raid on Base Hospital No. 5 near Dannes-Camiers in Pas-de-Calais, France, killed Dr. Fitzsimons and seriously injured others in the medical unit.
Toward a New Medical Society for Greater Kansas City
KANSAS CITY AND WYANDOTTE-JOHNSON COUNTY MEDICAL SOCIETIES JOINING FORCES

The Kansas City Medical Society and the Wyandotte-Johnson County Medical Society are finalizing the creation of a new medical society that will serve the entire Kansas City metropolitan area. The new society will begin operations in August.

The major benefit of the new society is that it will create a unified advocacy voice for patients and physicians across the metro area. It also will enable the joining of charity care activities through the two organizations’ respective foundations.

KCMS currently has 3,600 members and covers Jackson, Clay, Cass and Platte counties in Missouri. Wy Jo has about 600 members in its two Kansas counties. Some physicians are members of both societies.

A transition team composed of the three most recent presidents of both societies has been working out details of the new society, including the leadership and governance structure.

Following are FAQs about the proposed structure of the new medical society.

HOW WILL THE NEW BOARD AND OFFICERS BE ELECTED?

Both the Kansas City Medical Society and the Wy Jo Medical Society have selected six of their current voting Board members to serve on the new Board. After the start date of the new society, the board members will elect officers.

HOW WILL LEADERSHIP BE SELECTED GOING FORWARD?

Officers—A Nominations Committee will put out a call for nominations to the membership. The Nominations Committee will vet the list and recommend a slate of officers to the Board. This recommended slate will be shared with the membership and the members will be encouraged to comment or nominate (or self-nominate) additional candidates. The Board will have final approval of this slate of officers.

Directors at Large—The Nominations Committee will put out a call for nominations for open Director at Large positions each year in late summer. The committee will then vet the list and submit a candidate slate to the Board. Once approved by the Board, this candidate slate will be sent to the membership for a vote. The members with the majority of votes will be appointed as Directors at Large.

WHAT IS THE LEADERSHIP COUNCIL?

The Leadership Council is a larger, representative group that will meet approximately quarterly to do the following:

- Discuss physician advocacy issues
- Discuss patient advocacy and access issues
- Share ideas on strategic priorities of the organization
- Give feedback to the board on planned and completed programs and projects

WHO IS ON THE LEADERSHIP COUNCIL?

The Leadership Council is a group of volunteer leaders, with representatives from area physician organizations, medical staff organizations and ACO/CINs. The Leadership Council will also include Kansas and Missouri state medical society leaders from the Kansas City area (Councilors from MSMA and Trustees from KMS) as well as AMA representatives from the Kansas City area.

Both Boards and a Transition Team are working hard on more details. Check www.kcmmedicine.org for more information in the blog section, particularly regarding the medical society foundations and the membership requirements for the new society.
Thoughts from the Transition Team Leadership

WHAT IS THEIR VISION OF THE NEW SOCIETY? HOW WILL IT BENEFIT PHYSICIANS AND THE COMMUNITY?

A team of six current and recent presidents of the Kansas City and Wy Jo medical societies has spent many hours working out the details of joining the two societies and their foundations into a new, regional effort. Why do they feel this is an important move for the greater Kansas City area? How will it benefit physicians and the community? How will it strengthen the charitable care programs of the societies’ foundations?

Transition team members Mark Brady, MD; Joshua Mammen, MD; Sheila McGreevy, MD; Michael O’Dell, MD; Stephen Salinski, MD and Gregory Unruh, MD share their thoughts and their vision of what the new medical society can become.

WHY IS THIS MERGER IMPORTANT FOR THE SOCIETIES?

(Brady) We see this as a win-win for both organizations. On the Kansas side, we bring the largest collection of physicians in the KC metro area and a strong and supportive advocacy team at the state level through the Kansas Medical Society. Our team in Topeka has long advocated for Kansas physicians and they maintain a steadfast presence in our state capitol. The efficiencies obtained by the merger along with the willingness of KC metro physicians to work together for patient safety, care and advocacy will lead to a strong medical society.

(Mammen) Our patients rely on us to advocate on their behalf with payers, health care organizations, regulators and lawmakers. With a unified medical society, we will be able to do so more effectively. Additionally, physicians have long interacted with their colleagues on both sides of the state line. Having a unified medical society, our structure will now reflect the reality that already exists.

(McGreevy) Having two medical societies in one geographic area dilutes and diminishes our ability to effectively advocate on behalf of both our physician members and the patients we serve.

(O’Dell) Our medical societies are recognizing that the Kansas City metropolitan area is a regional presence not defined by state lines. I am proudly wearing an article of clothing proclaiming: “KC: Too Much City for One State.” As the city recognizes its regional oneness, the boundary of the state line diminishes in importance. The transition team’s motivation derives from this sense of community and the desire to acknowledge and associate with our colleagues across this great city.

(Salanski) The Kansas City metro area has an artificial dividing line at State Line Road. Physicians practice in both states. Our patients live in both states. The Medical Society must speak for all patients and physicians, not just those on one side of State Line Road.

(Unruh) Both societies see energy and activity in synergism. We believe
a combined society will have strength from numbers, be able to recruit more members effectively and vault the combined society to a more prominent and visible position in Kansas City.

WHAT BENEFITS WILL THE COMBINED SOCIETY YIELD FOR KANSAS CITY-AREA PHYSICIANS AND THE COMMUNITY?
(Brady) Our joint venture will lead to more patient education and advocacy and better patient care.

(McGreevy) For physicians: First, it brings clarity. We will get rid of the confusion and competition between the societies that had a chilling effect on participation. Secondly, it brings strength. Whether we are advocating regarding a legislative issue or planning an educational or social event, I believe this new society will have robust participation from a wide geographic area. For the community: We are planning for one foundation associated with the society which will provide us with a vehicle for community engagement, including, importantly, our efforts toward charitable health care for the most vulnerable patients in our community.

(O’Dell) A unified medical society serving Kansas City will speak with increased authority, advocating for patients and the physicians serving them. In prior years, such influence coming from the Medical Society provided Kansas City with the Community Blood Bank and founded Kansas City’s Blue Cross, among other accomplishments. Our combined society can expect future such attainments.

(Salanski) As one society, our combined voice for physicians and patients in the Kansas City area will be much stronger. Together, we will represent the entire region instead of just part of it. There also will be economic benefits from the merger by combining resources. The new governance structure we are developing will be streamlined through a smaller, more functional board of directors supported by a larger council that continues representation from local providers and organizations.

(Starr) Physicians will be able to make their individual voices heard at the society, and the society can then make the collective physician voices heard at medical staffs, regulatory agencies and state medical societies, and provide advocacy for both physicians and our patients.

HOW WILL THE MERGER BENEFIT THE KCMS AND WY JO FOUNDATIONS?
(Brady) The foundations will combine the primary care components of the Missouri side and the specialty care provided on the Kansas side. Our partnership should result in better funding and therefore more effective patient care. Those served by our foundations are among the most vulnerable in the metro area, and all efforts to continue our present success should be exceeded with the merger.

(Mammen) Both medical organizations have foundations that have different areas of strength. The Wy Jo foundation has focused on caring for indigent patients and has been tremendously successful due to the strong physician leadership. The KCMS foundation has concentrated on physician education and specific policy related topics (diabetes education and vaccination promotion). The merger of the two foundations will have tremendous synergy.

(McGreevy) It will strengthen and improve on the work of the current foundations. You will see the new foundation associated with the new medical society doing lots of good work for the community, especially for the most vulnerable people who live in our area. Over and over in my 10 years of association with the Wy Jo foundation, I have witnessed the amazing generosity of area physicians, whether through serving on a vaccination task force or donating time to see uninsured patients. This foundation will provide a strong vehicle for us to continue to serve our community.

(O’Dell) A single medical society enhances the work of the affiliated foundations. By merging, the scope and effort of serving the underserved become more comprehensive, and there is a reduction of effort and duplication in fundraising. The medical
care of those in need will undoubtedly remain the top priority, but the unified foundation’s scope will likely grow to include other good work, such as assisting medical students in need.

(Salanski) The work of MetroCare and Wy Jo Care will be merged, giving us a larger bank of physicians, hospitals and ancillary services with which to assist patients. Our funders, including the Health Care Foundation of Greater Kansas City and the REACH Foundation, welcome the more efficient use of resources. Eventually, we hope this will enable the foundation to expand into such activities as physician education and physician leadership development.

(Unruh) Consolidation of programs and impetus to better serve our patient/clients. Responding more effectively to our funding (grant) agencies and foundations to provide more and better benefits for our patient/clients.

**WHAT IS YOUR LONG-TERM VISION OF THE NEW SOCIETY?**

(Brady) In the future, I’d love to see a well-funded foundation that can take care of all medical needs of the indigent— including primary, specialty, mental and preventive services— eventually being recognized as one of the best in the region in the care of those less fortunate. Guided by the Medical Society, the foundation will serve as a beacon for other organizations. The same medical society will engage physicians in promoting medicine in the legislature, provide educational opportunities for members and the public, and also allow physicians to network in social settings.

( McGreevy) I want to build an organization that allows the voice of physicians to be heard. Why?
- So our voice—our perspective—is a factor in the changing landscape of health care
- So we support and encourage one another and build on shared experiences
- So we develop leaders within the larger health care community
- So in an environment of competing interests and goals, we keep the focus on the health and well-being of the patient.

(O’Dell) What I see in our new society represents the outcomes of being better together. One outcome is enhancing the sense of community that has fostered and is driving our transition (continued)
team’s work. Another outcome is a heightened member knowledge of the work, skill and professionalism of their Kansas City colleagues. A lively and respectful competition to the top of knowledge, skill and attitudes toward medical and surgical care will be encouraged by this collegial familiarity. And, present in the leadership of the society and our professional community, a sense of accountability and responsibility for the health of the entire Kansas City community.

(Salanski) We will see ourselves as Kansas City metro physicians, and less as being from Kansas or Missouri. State distinctions will become less significant—although still recognizing the importance of involvement with the Missouri State Medical Association and the Kansas Medical Society. (Unruh) All physicians in the Kansas City area will want to join and be active in the combined society because of the benefits to them professionally and to their patients.

**WHAT HAS MOTIVATED THE TRANSITION TEAM THROUGH THIS PROCESS?**

(Brady) This transition team saw the need to combine in order to enhance the success of our foundations by better funding, but also to add value to two societies which see the partnership as a key to growth. Members of the team were motivated to be successful in providing care for the indigent while at the same time giving doctors an organization they can be proud to be part of because of its local benefits.

(Mammen) The transition team was motivated by a desire to ensure that physicians were represented by a unified organization. The Royals, Chiefs, and Sporting are great models for our physician organization! Regardless of the state line, we support them.

(O’Dell) Like many physicians in Kansas City, I have had the privilege and honor of serving patients from across our community residing in both states. Similarly, I have practiced in and taught at hospitals and academic institutions in both states claiming our community. The constant here is Kansas City.

(Salanski) Those in leadership see the value of the two societies joining together and how this benefits both patients and physicians, as well as how this benefits MetroCare and Wy Jo
Physicians have long interacted with their colleagues on both sides of the state line. Having a unified medical society, our structure will now reflect the reality that already exists.

Leadership

Care through merging the foundation boards. We know the end goal is so important.

(Unruh) All of the above plus we’re already feeling the surge of enthusiasm through thinking proactively about the future.

WHAT WOULD YOU LIKE TO ADD?

(Salanski) The leadership of both societies has been unanimous in their support of the merger. Our discussions have been extremely productive and collegial. We share a common vision. I also thank Angela Bedell, KCMS executive director and CEO—and who also directs the Wy Jo Medical Society (by contract with KCMS)—for the continuity and legwork she has provided. I thank the Health Care Foundation of Greater Kansas City for the grant funds to hire a consultant to help with the MetroCare/Wy Jo Care merger and foundation board restructuring.

Kansas City Orthopaedic Institute Breaks Ground on Hospital Expansion and Renovation

Kansas City Orthopaedic Institute broke ground in February on a major expansion project to its facility on College Boulevard in Leawood, Kan.

Plans include adding more than 22,000 square feet of new hospital space to the south side of the building, as well as renovations to approximately 32,000 square feet of existing space. In addition to all new, modern inpatient rooms (which will nearly double in number), the hospital is adding three new surgical suites and creating expanded clinic space for the three orthopedic physician practices located inside the institute.

“The expansion project demonstrates our ongoing commitment to providing high-quality orthopedic care for all who need it,” said Charles Rhoades, MD, CEO of Kansas City Orthopaedic Institute and KCMS member. “Adding more beds, rooms and amenities further enables us to meet growing consumer demand for specialized orthopedic care with enhanced comfort and convenience.”

Expansion plans also include a new, dedicated space for Ortho Urgent Care, which opened at Kansas City Orthopaedic Institute in November 2016. Once construction is complete, Ortho Urgent Care will extend its hours to include weekdays as well.

Kansas City Orthopaedic Institute is a physician-owned specialty hospital and a joint venture with Saint Luke’s Hospital. As the area’s first and only hospital dedicated exclusively to orthopedics, the institute provides comprehensive orthopedic care, from diagnostic imaging to inpatient and outpatient surgery, pain management services, and rehabilitation therapy.
Prescription drug addiction and abuse have exploded metropolitan Kansas City over the past decade. Heroin use continues to grow, with some emergency departments seeing heroin overdose and naloxone rescue on a daily basis. Four of five heroin users start with prescription medications.

A Prescription Drug Monitoring Program (PDMP) is the backbone of a community effort to battle opioid and heroin addiction. It was first discussed in the Missouri Legislature in the 2004 session. During each session from 2004 to 2008, I sponsored a PDMP bill, with some success moving it through the legislative process. Unfortunately, it never received final passage.

Over the past 12 years, every state has adopted this program except Missouri. We remain the only state in the union that does not have this program in place through state legislative action. Missouri remains in the top five states for opioid consumption per capita and prescribes more opioid medications than any other state in the Midwest, earning the reputation as “America’s Drug Store.”

In the spring of this year, I successfully sponsored a bill in St. Louis County to create our own PDMP, with an option to allow other county and large city jurisdiction to subscribe for a nominal cost of $7 per prescriber or pharmacy. St. Louis County Executive Steve Stenger has been a strong supporter of this legislation. His nephew struggled with prescription drug and heroin addiction before losing his life to a fatal overdose in 2014.

Our program was built on the PDMP Center of Excellence at Brandeis University—the resource for all state-run PDMPs. Physicians, dentists and anyone licensed to prescribe scheduled medications will soon have the opportunity to access this database for patients under their care.

To date, St. Louis City, St. Charles County, Kansas City, Independence and Jackson County have passed bills to join our program. Columbia is in the process of joining as well. In October 2016, representatives of 11 rural southeastern Missouri counties attended a meeting with St. Louis County public health leaders to discuss joining the program. For other jurisdictions to join, it only requires passing of an enabling bill and then signing a user agreement with St. Louis County. The system will be HIPAA compliant and is subject to all local, state and federal privacy laws and regulations. Sharing with other states is built into the structure of this program and is a second-step function that will be added once the program is operational for a few months.

HOW THE PROGRAM WILL WORK

St. Louis County has contracted with Appriss, the PDMP vendor in 25 states. The PDMP concept has a long multi-state track record of privacy and security in the other 49 states where it functions. St. Louis County hopes to begin the data collection phase in January, and be available for use by physicians (and all other prescribers) and pharmacists in April.

Some PDMPs are built as a law enforcement tool, and some are built as a public health tool—in reality an extension of an electronic medical record. The St. Louis County PDMP (with optional statewide participation) is a public health tool. Law enforcement access is granted with a court order for an ongoing investigation of a specific prescriber or patient. Prescribing patterns that generate concern, by standards set by the PDMP technical advisory committee, will be referred to the appropriate licensing board for investigation by that body. Patients may also request a copy of their own prescribing history. De-identified data will be made available for community reporting and research purposes.

The PDMP database is populated by automated transmittal of Schedule II though IV prescription information as a copy of information sent to third party payers when a prescription is filled. The pharmacist does not manually enter additional data. In the 25 states where Appriss provides PDMP operational services, no additional switch fees are charged to participating pharmacies.

Some states have made physician participation in PDMP mandatory.
In St. Louis County we do not require physicians to check the PDMP prior to writing a controlled substance, but referring to this database is prudent, especially in light of medical liability associated with scheduled medication. Physicians do not enter data into the PDMP. Only filled prescription data from a pharmacy is automatically reported to the PDMP.

The best answer continues to be a PDMP that covers the entire state of Missouri, through state legislative action. State Rep. Holly Rehder (R-Sikeston), the sponsor of state legislation to create a PDMP for Missouri (HB 90), is continuing to pursue this legislation and should continue to receive medical community support. Senator Dave Schatz (R-Sullivan) has filed a companion bill (SB 314) with identical language. House and Senate leadership have indicated continued support for this solution as well.

The unique approach taken by St. Louis County to affiliate with each county in Missouri is cumbersome, but unfortunately the only way to accomplish the task at hand in the current legislative environment. We have concerns that patients with addiction disorders or drug-seeking behavior will migrate from the participating urban areas to nonparticipating and non-reporting counties.

Once passed, the state program will require two to three years to become functional, depending on appropriation of adequate funding and development of supporting regulations. When the state finally passes a PDMP built on best practices that are equal to or greater to the St. Louis County PDMP, our intention is to roll our county collaborative system into the statewide program.

Please email your questions and suggestions to me at spage@stlouisco.com. As this program is adopted we hope to give physicians another tool in the fight against opioid addiction, diversion and abuse. This is a work in progress and we will depend on the active engagement and participation of the members of the medical community in Kansas City and throughout Missouri.

Sam Page, MD, is a physician anesthesiologist at Mercy Hospital St. Louis and a St. Louis Metropolitan Medical Society member since 1996. He is a member of the St. Louis County Council representing the 2nd District. He served in the Missouri House of Representatives from 2003-2009. Dr. Page is a graduate of the UMKC School of Medicine and a former KCMS member.

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Because of the fear of addicting patients, physicians seldom prescribed opiates until the mid-1980s and early 1990s. At that time, “medical experts” and “thought leaders” led by the neurologist and pain specialist Russell Portenoy, MD, proclaimed that the risks of addiction to opioids were minimal and that not treating pain was cruel and even amounted to medical negligence. Pain was to be considered the fifth vital sign.1 To this day in most American hospitals, nurses on their daily rounds ask patients to rate their pain on a scale of one to ten and then may administer a narcotic accordingly.

Portenoy once had an impeccable reputation. He wrote numerous articles and book chapters on pain and has won many accolades and awards. He was known as the “King of Pain.” He was the chairman of pain medicine and palliative care at Beth Israel Hospital in New York. Portenoy and other “thought leaders” had been so influential in promoting the safety of opioids that regulatory agencies, such as the Joint Commission which accredits hospitals and the Federation of State Medical Boards, wrote guidelines and rules for the treatment of pain. In many cases, hospital lawyers warned physicians that their patients could sue them if they did not treat their pain adequately.1

Portenoy and his acolytes wrote articles and gave lectures to physicians about the safety of narcotics. They repeatedly cited a study by Porter and Jick in The New England Journal of Medicine that stated that only 1% of patients treated with narcotics became addicted. Time magazine described the one-paragraph letter to the editor. The lead author, Hershel Jick, MD, has repeatedly stated that his letter to the editor has been misinterpreted. It was based solely on hospitalized patients and did not apply to patients after they left the hospital.2

Recently and belatedly, Portenoy has backtracked and admitted he was wrong about the addictive properties of opioids. He stated: “I gave innumerable lectures in the late 1980s and 1990s about addiction that weren’t true.”1 Incredibly, the much discredited Portenoy remains chairman of the pain clinic and palliative care clinic at Beth Israel Medical Center.

Based on false statements about the addicting properties of opioids and the assertions that leaving pain untreated might constitute malpractice, the genie was out of the bottle. As of 2011, 75% of the world’s opioid prescriptions were in the United States which comprises 5% of the world’s population. Opioid overdose is the most common cause of preventable death in America today—a horrifying and shameful statistic!3 It is estimated that 50% of opioid overdoses resulting in death are from physicians’ prescriptions. From 1999 to 2014, opioid prescriptions quadrupled and there were more than 165,000 deaths related to opioid overdose.4 (See Figure 1.)

But statistics on death do not tell the whole story. Thousands of lives have been destroyed by opioid ad-
diction and a like number of families have been devastated and disrupted, never to see their loved ones return to a normal productive life. In his book *Dreamland: The True Tale of America’s Opiate Epidemic*, investigative reporter Sam Quinones documents the prescription drug problem in America. He writes that drug addiction crosses all social strata, affecting white middle class families from all walks of life including families of doctors, lawyers, judges, business people, politicians and police.²

**“FOLLOW THE MONEY”**

In attempting to understand the role physicians and researchers with financial conflicts played in creating the drug problem, it is essential to follow the money. Dr. Portenoy and his pain center have received millions of dollars of funding from many pharmaceutical companies including Purdue Pharma, the manufacturer of oxycodone, as well as numerous other well-known drug manufacturers such as Mallinckrodt, Wyeth, Baxter, and Pfizer. Portenoy has admitted to having financial relationships with more than a dozen companies, most of which produce opioid pain killers. Portenoy defends himself with the statement: “My viewpoint is that I can have these relationships [and] they would benefit my research mission and to some extent they can benefit my own pocketbook, without producing in me any tendency to engage in undue influence or misinformation.”¹ (emphasis added)

When drug companies fund research published in prestigious medical journals or give money to physician or PhD speakers at medical meetings or at upscale restaurants, practicing physicians should be very skeptical and hyper-critical of their findings and recommendations. The conflicts of interest are real and their conclusions are frequently suspect.

The American Medical Association has addressed this problem as have academic medical centers and scholarly medical journals. Their solution is currently that simply disclosing conflicts of interest is sufficient. It is left up to physicians and researchers to determine whether the research is valid. In the case of opioid prescribing, this “buyer-beware” strategy has been a disaster. Busy doctors are in no position to evaluate shoddy research.

Purdue Pharma has paid over $600 million in fines for misrepresentation of the addictive properties of oxycodone and three of their chief executives were criminally charged.¹ But does that restore the lost or ruined lives of the tens of thousands of victims and their families? And what has happened to Portenoy and the other “experts” and “thought leaders” who falsely promoted the safety of opioids? What happened to the Joint Commission and the Federation of State Medical Boards and hospital lawyers, all of whom played “follow the leader,” climbed on the opioid bandwagon and advised doctors they had better treat pain with opioids or possibly face sanctions or malpractice claims? The answer is a resounding nothing.

Physicians believed the false message of Portenoy and the other industry-compensated “thought leaders” on the safety and the non-addictive properties of opioids. And now these physicians are being blamed for their role in causing the opioid epidemic—deservedly so in my opinion.

New studies show that opioids are not effective in most non-cancer chronic conditions causing pain. Such studies were available in the past but were ignored. The Centers for Disease Control and Prevention (CDC) has issued new guidelines against opioid (continued)
prescriptions for chronic pain.\textsuperscript{5} It is well recognized that patients receiving opioids long term can develop both tolerance and hyperalgesia or increased sensitivity to pain.\textsuperscript{6}

The industry-financed and physician-led, physician-driven opioid disaster proves, like no other example, that the policy of simple disclosure of conflicts of interest do not work. Probably nothing will be done about the problems of conflicts of interest. There is simply too much money at stake in our commercialized health care system for those who profit from these conflicts of interest: drug companies, academic medical centers, hospitals, researchers, medical education programs, and finally some physicians.

The commercialization of Medicine is the result of a little-known 1972 unanimous Supreme Court decision known as \textit{Goldfarb}. This decision ruled that Medicine (and Law) were no longer to be considered learned professions but were to be considered “ordinary purveyors of commerce.”\textsuperscript{7} Right after the Goldfarb decision, the Federal Trade Commission sued the American Medical Association successfully and removed one of its most important Principles of Medical Ethics, which was a restatement of the Hippocratic Oath.\textsuperscript{8} Both of these Supreme Court decisions were intended to lower health care costs. Ironically they did not lower costs. Health care costs have increased dramatically since their enactment.\textsuperscript{9}

When the practice of Medicine loses its ethical foundation and operates by the rules of the marketplace rather than ethical standards, one can expect that disasters like the money-driven, physician-caused opioid epidemic to occur again. Physicians should be very skeptical and extremely careful in analyzing research by physicians and researchers who are compensated by pharmaceutical companies. They ought to avoid attending lectures given by physicians with blatant conflicts of interest. If these ethical bright lines had been honored with regard to opioid prescribing, a great American tragedy might have been prevented.

\textbf{REFERENCES}


8. \textit{American Medical Association v. FTC} (421 U.S. 676 [1975]).

Every day, in every part of our community, people rely on public health agencies, yet may not be aware of the role public health plays in our routine activities. Public health agencies have an impact on the quality of water that comes from your faucets, the food you buy at local groceries or restaurants, the safety of public facilities you visit and your resistance to viruses or bacteria you may be exposed to throughout the day.

The Kansas City region is served by 11 local public health agencies that work together to improve the health and well-being of residents in all of our communities.

Public health departments have a unique role in the health care system. While they offer some services such as immunizations to individual patients, especially low-income patients, much of their work is focused on disease prevention at the community level. In a region like Kansas City, with nine counties, 119 cities and two million residents on both sides of the state line, this takes high levels of cooperation and coordination.

**THE ROLE OF PUBLIC HEALTH DEPARTMENTS**

The U.S. Centers for Disease Control outlines 10 essential functions that form a guiding framework for public health systems:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.¹

Health departments in the Kansas City region operate under different models, most as departments within city and county governments. Some, like Clay County Public Health, operate as independent entities; and the Jackson County Health Department is managed and operated by Truman Medical Center. All local public health agencies work directly with their respective state health departments—Missouri Department of Health and Senior Services and Kansas Department of Health and Environment—with funding from the CDC, other federal agencies, state government, local government and other sources.

While services vary among the 11 local public health agencies, based on community needs, most offer immunizations, testing (for pregnancy, sexually transmitted diseases and tuberculosis) and health education. Some also offer clinical and dental services for low-income residents. Many provide environmental health services, such as food safety inspections, testing for lead, inspections of public pools and lodging facilities, and controlling pests that may carry disease such as mosquitoes and rats.

**REGIONAL COOPERATION**

For nearly three decades, public health directors in the Kansas City region have been working together through MOHAKCA, the Metropolitan Official Health Agencies of the Kansas City Area. The group meets bi-monthly at the Mid-America Regional Council (MARC) conference center to discuss public health issues and share best practices.

“This group’s long history of cooperative accomplishments makes the bistate Kansas City region unique among metropolitan areas,” said Terry Brecheisen, director of the Unified Government Health Department and current chair of MOHAKCA. “We’ve (continued)
Public Health

built strong relationships among the health department directors and our professional staff that help us approach public health issues not just from the perspective of our own communities, but with a regional view."

**SPEAKING WITH ONE VOICE**

In any public health crisis—from seasonal flu that occurs every year to suddenly emerging issues like the Zika virus—unified messaging is critical to ensure that residents across the region get accurate information to protect themselves and their families.

In 2006, MOHAKCA established a process for all 11 health departments to send a single news release to area media outlets when an important public health issue arises. Any department can initiate a regional public health news release and share it among the department directors. If directors whose combined departments represent at least two-thirds of the region’s population approve of the release, MARC issues the release to all area media outlets on behalf of all 11 departments.

Regional public health releases typically describe the situation, such as an outbreak of measles, mumps or other communicable disease; offer tips to protect people from contracting the disease; provide information on symptoms to watch for; and offer advice on when to seek treatment.

When the region experienced a significant number of cases of H1N1 influenza in 2009 and 2010, MOHAKCA members went beyond issuing news releases and pooled funding provided by the CDC to sponsor an advertising campaign with television, radio and print ads encouraging residents to get
vaccinated. Local public health departments also collaborated on a flu shot campaign in 2008, hosting vaccination clinics all across the region on the same day.

“When we share advertising costs, everybody wins,” said Lougene Marsh, director of Johnson County’s Health and Environment Department. “We’re able to stretch our limited funds and reach far more people than any one department could do alone.”

Public health departments are also able to share unified messages through a regional preparedness website, www.preparemetrokc.org, and Twitter feed, @PrepareMetroKC, both operated by the Metropolitan Emergency Managers Committee. “Websites and social media have become a critical part of our outreach efforts,” said Marsh. “We all post information on our own sites, but having access to these regional sites just strengthens the message.”

DISEASE SURVEILLANCE

Monitoring for signs of a communicable disease outbreak is a critical public health function that is made more challenging by the bistate nature of the Kansas City region. Typically, doctors and laboratories report incidence of certain diseases to their states, which notify local health departments. These departments, working in cooperation with their state health departments, look for higher numbers of cases within a given geographic area to facilitate early detection of a disease outbreak.

But in a bistate region like Kansas City, disease surveillance can be a challenge. “It would not be at all uncommon for a resident in Grandview, Mo., to see a doctor in Overland Park, Kan., who might send specimens to a lab in Kansas City, Mo.—or any other combination across city, county and state lines,” said Tiffany Klassen, director of the Cass County Public Health Department. “One report might end up at KDHE in Topeka, while another might go to MoDHSS in Jefferson City, making early detection much more difficult.”

Recognizing this challenge, local public health departments invested in a common surveillance software platform called X-Sentinel that simplifies notification, case management and surveillance across jurisdictional boundaries.

PREPARING FOR EMERGENCIES

Since 2003, local public health departments have worked with the Regional Homeland Security Coordinating Committee to plan, prepare, train and exercise emergency response capabilities. Staff from all public health agencies train together to activate point-of-dispensing locations and procedures in situations that might require widespread distribution of antibiotics, such as an anthrax threat.

(continued)
When emerging threats arise, the relationships built during routine training and exercise pay off.

Caches of equipment and supplies are kept ready so that agencies can mobilize a speedy public health response for a wide range of disasters, from tornados to terrorism. “In Platte County, we’ve used our free, drive-through flu shot clinics to exercise our ability to dispense medication to a large number of people quickly,” said Mary Jo Vernon, director of the Platte County Health Department. “We provide an important community service at the same time we prepare for large-scale public health emergencies.”

When emerging threats arise, such as the Ebola cases that made their way to the U.S. in 2014 and, more recently, concerns about the spread of the Zika virus, the relationships built during routine training and exercise pay off. In both of these cases, health officials were able to quickly organize and share information through established networks that connect public health agencies with area hospitals, emergency medical services, emergency management agencies and local government public information officers.

“By sharing accurate information with our network of emergency response and public information partners as quickly as possible, we can help them understand the issues so they can help us help the community,” said Vernon. “With Ebola, the actual risk to our residents was very low, but concerns were high. We were able to provide clear information and allay some of the fears.”

PROMOTING HEALTHY ACTIVITIES AND DISCOURAGING RISKY BEHAVIORS

MOHAKCA has been a driving force in encouraging healthy behaviors and providing resources for people to quit risky behaviors. For example, local public health agencies provide information about healthy eating habits that can help prevent obesity and diabetes, and in recent years health departments have become more actively engaged in promoting physical activity.
Public health campaign aimed at young parents to encourage them to protect their children from secondhand smoke. In 2015, local public health agencies threw their support behind Healthy KC’s Tobacco 21 initiative, which focuses on raising the minimum age for purchase and sale of tobacco products, e-cigarettes, vapor products and paraphernalia to 21. Studies have shown that approximately 90 percent of today’s adult smokers started smoking before they reached age 18. Today, 24 percent of high school students in Kansas and 23 percent in Missouri use tobacco, at a time when their adolescent brains are still developing and are uniquely sensitive to nicotine addiction.

Studies cited by Healthy KC estimate that Tobacco 21 would reduce smoking among 15- to 17-year-olds by 25 percent, and fewer smokers under the age of 18 will lead to fewer long-term smokers. To date, 21 cities in the region, with a combined population of more than 1.4 million, have adopted Tobacco 21 regulations, and several other local governments are actively considering them.

FACING PUBLIC HEALTH CHALLENGES

Prescription drug overuse—Local public health agencies are working together to face emerging issues. One such public health issue is overuse of prescription drugs. Through the leadership of Kansas City, Mo., Health Department, a regional steering committee began work in 2016 to address education, surveillance, public policy and treatment for the increased use of opioids and related deaths in the region. The committee has worked to educate around proper prescribing, support state and local policy around a prescription registry and collect data to build understanding about the extent of the problem and how to best target interventions.

Food deserts—Food deserts are another public health challenge. “In urban neighborhoods, many residents don’t have easy access to full grocery stores with fresh produce and other options for healthier eating, so they rely on convenience stores that sell primarily packaged, processed foods,” said Bridgette Casey, director of the (continued)
Missouri and Kansas rank near the bottom among all states in per capita general revenue spending on public health.

Jackson County Public Health Department. In 2011, MARC received a CDC community transformation grant to work with the health departments in Jackson County, Independence and Kansas City, Mo., to address this problem. “Part of this grant focused on helping corner groceries and convenience stores introduce more fresh produce into their inventory. We also held cooking demonstrations and provided recipes to encourage families to eat healthier diets.”

Infant mortality—Infant mortality is another key public health issue. While infant mortality rates declined significantly over the last decade, several counties in the region remain above the Healthy People 2020 goal of no more than six infant deaths per 1,000 live births. Several local public health agencies provide comprehensive prenatal services to help improve outcomes for both mothers and infants. Many also operate WIC clinics (Women, Infants and Children) to provide supplemental nutrition assistance, and offer nutrition education programs, breastfeeding support and car seat safety clinics.

Health Disparities—In a 2015 Regional Health Assessment, MARC and the REACH Healthcare Foundation found several positive trends in public health. Preventable hospitalizations are down, and so are mortality rates for major diseases. Although obesity and diabetes continue to increase, the rate of increase for obesity has slowed. But not everyone in the region is experiencing these improvements. While declining overall, preventable hospitalizations are on the rise for minority populations. Mortality rates vary widely, with rural and urban counties experiencing much higher incidence of premature death than suburban counties. Also, obesity prevalence is significantly higher for blacks and Hispanics than for whites, and the mortality rate from diabetes is twice as high as that for whites.

Numerous national studies have shown that one’s ZIP code can be a strong indicator of health. In a 2013 health assessment, MARC found a clear correlation between average household income in a particular ZIP code and death rates. Using a sample of nine ZIP codes across the region, the study found that high-income ZIP codes ($79,291 to $86,669) experienced death rates of 400 per 100,000 population, while low-income ZIP codes ($22,248 to $26,624) had a death rate of more than 1,200 per 100,000 population.

By targeting funding and public health initiatives to minority and low-income residents, local public health departments can help improve health outcomes for those most in need.

Shrinking funds—Since 2002, state general revenue funding for local public health in Missouri has fallen by 66 percent. Missouri now ranks 50th among all states in per capita general revenue spending on public health. Kansas does not fare much better, standing at 47th among 50 states.

“State general revenue now provides less than 1 percent of budgets that support public health at the local level in Missouri,” said Gary Zaborac, director of the Clay County Public Health Center. “With prevention funding that abysmal, it is no coincidence that Missouri has some of the higher rates in the nation in childhood obesity, heart disease, diabetes, high blood pressure, unintentional injuries and sexually
transmitted diseases.”

PUBLIC HEALTH AND THE MEDICAL COMMUNITY

Public health agencies can help medical practices, and medical practices can help public health. Working together, we can all make progress toward our common goal—healthier people in healthier communities.

“We encourage physicians to get to know their local public health departments and use us as a resource,” said Rex Archer, MD, director of the Kansas City, Mo., Health Department. “If you haven’t already, consider signing up for CDC’s Health Alert Network at https://emergency.cdc.gov/han.”

Physicians and labs can also help keep our communities safe and healthy with timely, accurate reporting on communicable diseases. Reporting procedures vary by state.

IN KANSAS:
Links to a list of reportable diseases and all reporting forms are online at www.kdheks.gov/epi/disease_reporting.html. Non-urgent reports should be faxed to (877) 559-4212 or mailed to the KDHE office; when an immediate report is required, call (877) 427-7317.

IN MISSOURI:
Missouri’s list of reportable diseases can be found online at http://health.mo.gov/living/healthcondiseases/communicable/communicabledisease. During business hours, physicians and labs with an immediate report should contact their local own health department. (If the patient lives in another jurisdiction, the health department will transfer the case to that health department.) After hours, call the state emergency/disease reporting line at (800) 392-0272.

Once a report is made for a communicable disease, the local health department will follow up with the medical office if needed and then contact the patient. Using a standard questionnaire for the particular disease, health department officials will gather information that might include symptoms, case history, recent travel, and recent food or water sources. Health department staff will also offer guidance to try to prevent secondary transmission to the patient’s family or others in close contact. When the situation requires it, the health department has the authority to establish isolation or quarantine of a patient or family.

If a health department begins to see abnormal incident levels for a particular disease, staff might reach out to other health departments to see if they have had the same experience. If so, they will look for commonalities, such as places patients have visited or foods they have eaten recently. Health departments will also share information using the X-Sentinel software platform.

“Without assistance from the medical community, our capacity to monitor disease would be severely limited,” said Andrew Warlen, director of the Independence Public Health Department. “No one likes additional paperwork, but the reports doctors and labs are required to submit really are critical to protecting public health.”

Medical practices and public health agencies may have different approaches—a focus on individuals, diagnosis and treatment in medical offices, compared to a focus on the community and prevention in public health—but both are critical components of the health care system. By raising aware-
Practicing medicine is demanding mentally and time-wise. However, today’s physicians are more likely to want to balance the mental demands with time left for their families and other interests. These interests often include activity in organized medicine.

Three members of the Kansas City and Wyandotte-Johnson County medical societies share their stories of how they prioritize their time and stay true to their professional and personal goals and priorities.
Planning the Month Ahead

CAROLE FREIBERGER-O’KEEFE, DO, AND PATRICK O’KEEFE, MD

ADVICE TO ASPIRING LEADERS: (Dr. Freiberger-O’Keefe) Definitely pursue leadership roles, but don’t overcommit. Choose one area that you are passionate about and give it your all. But don’t overextend by choosing multiple projects if it infringes on family and personal time.

CHILDREN: Son Liam, 8; daughter Zoey, 7.

DR. FREIBERGER-O’KEEFE

AGE: 47

PRACTICE: Critical care, Cardiovascular Intensive Care Unit, Saint Luke’s Hospital of Kansas City and assistant professor, University of Missouri-Kansas City.

YEARS IN PRACTICE: 8

MEDICAL SCHOOL: A.T. Still Kirksville College of Osteopathic Medicine

PROFESSIONAL ACTIVITIES: Member, KCMS board of directors. At Saint Luke’s Hospital, head of the Donor Advisory Council, chair of the Code Blue Committee, and member of the Critical Care EPT. Member, Saint Luke’s Health System Code Blue Committee.

PERSONAL ACTIVITIES: Girl Scout leader and past Cub Scout den leader; school volunteer; chapter president, PEO International, a philanthropic women’s club; volunteer with Harvester’s Back-Snack program that delivers food packs to elementary school children; taking guitar lessons.

DR. O’KEEFE

AGE: 43

PRACTICE: Radiologist, North Kansas City Hospital

YEARS IN PRACTICE: 10

MEDICAL SCHOOL: Southern Illinois University

PROFESSIONAL ACTIVITIES: Member, KCMS.

PERSONAL ACTIVITIES: Tennis and paddle tennis, movies, planning family vacations.

With her practice as a hospital intensivist requiring long shifts that vary by week, Carole Freiberger-O’Keefe, DO, says the family has to plan the month ahead. She and her husband, radiologist Patrick O’Keefe, MD, work together to balance their schedules.

“My job requires a week long commitment of long days and a very busy weekend once or twice a month. That week requires a great deal of advance planning and some help with before and after school sitters,” she said. “The weeks I am on nights are easier, as I can coordinate with Pat to be home before I go to work, and I still get to pick up the kids from school and spend time with them.”

During other weeks when she is not seeing patients, she performs non-clinical duties and has more family time. She also tries to attend group exercise classes three or four times a week, and take walks with the family on the weeks she’s not on day service.

“Pat and I work at coordinating our schedules. We stagger weekends so we are not on call at the same time,” she noted. Family vacations are planned as much as a year ahead.

Without family in town, the O’Keefes utilized a nanny to help with the children when they were younger. “This relieved the day-to-day stress tremendously. But the kids are in school now and we manage things well with help of two sitters a few days a month,” Dr. Freiberger-O’Keefe said.

Despite the complex scheduling, the family is doing well. Dr. Freiberger-O’Keefe concluded, “By maintaining balance, I continue to love my job and don’t mind giving it my all when I’m on service. I’m worn out at the end of my busy weeks, but I do get to recharge and pursue what I love. Which makes me excited to come back and do it again.”

(continued)
Confident in Managing Time

THOMAS LOVINGER, MD

ADVICE TO ASPIRING LEADERS: Initially say yes to leadership roles but as you grow as a physician and person, learn what you are excited about and focus your efforts on those organizations. We all have a responsibility to participate in some committee or board to help advance medicine.

AGE: 33
PRACTICE: Family Medicine, Saint Luke’s Medical Group-Lee’s Summit
YEARS IN PRACTICE: 3
MEDICAL SCHOOL: University of Missouri-Kansas City
FAMILY: Wife Kate Lovinger, DDS; dogs Ellie and Duke.

PROFESSIONAL ACTIVITIES: Member, KCMS board of directors. Secretary, Missouri State Medical Association Young Physician Section. Member, Saint Luke’s Hospital-East Quality Improvement Committee.

PERSONAL ACTIVITIES: Travel, skiing, watching Chiefs and Royals, meat smoking, yard work.

Thomas Lovinger, MD, and his wife Kate Lovinger, DDS, are both from medical families and are familiar with the challenges of work-life balance. First, they recognize the demands of each other’s practices. “She understands when I have to stay late finishing paperwork or spend time on call,” he said.

His father is Nevada, Mo., internist Warren Lovinger, MD, who is 2017-18 Missouri State Medical Association president; his sister is internist and KCMS member Sarah Lovinger Florio, MD, also with Saint Luke’s Medical Group-Lee’s Summit.

With a history of organized medicine running in the family, he has advocated for the interests of young physicians through service on the KCMS board of directors and the Missouri State Medical Association Young Physician Section which serves physicians under the age of 41 and who are in their first five years of practice.

“YPS focuses on issues that are important to physicians at an early stage in their careers. In addition, it gets young physicians interested in organized medicine and allows us to interact with colleagues,” Dr. Lovinger said.

About the KCMS board, he explained its benefits: “Being on the KCMS board has been a privilege and afforded me the opportunity to network with many of Kansas City’s leading physicians. It has given me insight into issues that other physicians are facing across the metro area. As an employed physician, I gain a broader perspective on the medical community outside of Saint Luke’s.”

Dr. Lovinger and his wife make time for their life together. “I chose a job that lends itself to regular business hours which allows me to be home for dinner every night,” he said. He works in clinic from 7 a.m. to 6 p.m. four days a week, and then spends a few hours on his day off and the weekends reviewing labs and finishing paper work.

He described their time away from work: “We try to exercise together even if it is just a quick workout on the elliptical after dinner. Most of the time we don’t work weekends so this lends itself to being able to go to church and do things around the house.”

He accepts balancing time as part of the medical lifestyle. “Most physicians are fairly good at balancing their time as it is a skill you learn through medical school and residency,” he noted.

“Initially I said yes to everything I was asked to be a part of, but as my practice has gotten busier, I am trying to find organizations with long-term goals parallel to my own. That being said, I think we all have the responsibility to sit on at least one committee or board that advances medicine and the care of our patients,” he continued.

Maintaining balance makes him a better physician: “My patients like to know I have a regular life with hobbies and family outside of patient care; it allows me to relate. Work-life balance also prevents burnout, which lends itself to poor patient care.”
AGE: 46
PRACTICE: Pediatrics at Johnson County Pediatrics, Merriam, Kan.
MEDICAL EDUCATION: University of Kansas
YEARS IN PRACTICE: 17
FAMILY: Husband, David White; daughters Chloe, 14, and Caroline, 11.
PERSONAL ACTIVITIES: Walking for exercise, reading, spending time with family, volunteer work with my daughters at Great Plains SPCA.

About a year ago, pediatrician Christine White, MD, started taking off work on Thursdays. That made a big difference in achieving better work-life balance.

“As a partner in an independently owned practice, I’m fortunate that I can control my schedule more than many employed physicians,” Dr. White said. She currently works full days Monday, Wednesday and Friday, and a half day on Tuesday.

“Having off Thursdays has allowed me to stay sane. I can relax, exercise, run errands, read, sleep, watch Netflix—just feel like a human. When I was working five days a week I felt like a hamster on a hamster wheel,” she explained.

Finding the Right Schedule
CHRISTINE WHITE, MD

ADVICE TO ASPIRING LEADERS: Think about what you are passionate about, what you want to change, who you want to help. Find out who is doing that and join them. If there isn’t anyone doing what you want to do, start a new group on your own. You have a good mind, a good heart, and good ideas. Take a little bit of your time and start to chip away at something that needs fixing.

Attending to a full book of patients all day is mentally demanding, she noted. “On those evenings when I work, it’s hard to give my best to my family. Having a shorter day on Tuesday and Thursday off allows me to be present, and more patient and kind—at least on those two days a week,” she said.

The right balance also helps her as a physician and overall. “I am more present with each patient, more empathetic and sympathetic. I am kinder to my staff. I am kinder to my family. I am kinder to myself.”

Also a big help is her husband David—a full-time dad, and former public relations specialist and now a bicycle mechanic at a nearby shop. He handles most of the driving of the girls to their competitive dance five days a week. Dr. White also thanks her group of physicians and office staff at Johnson County Pediatrics for their support.

One other suggestion she offers is knowing when to say no. “I have become better at recognizing opportunities for leadership or volunteer work that allow me to accomplish what I am passionate about,” she said.

Dr. White also is making more time for leadership and advocacy roles, through committee service at Shawnee Mission Medical Center since 2011, and by joining the Kansas Medical Society last summer and the Wy Jo Medical Society board of directors in October. Maintenance of certification is a particular area of concern for her.

“Physicians have to stop complaining about the aspects of health care that we don’t like and start doing something to change things for the better. Either we will shape and control our futures as physicians and the future of care for our patients—or administrators, governments and insurance companies will.”
During the summer of 1977, at age 20, I experienced an extraordinary and transcendent event. I have come to understand that it is best described as a “near-death experience (NDE).” The insights of my brush with death altered my understanding of the meaning and purpose of life, forever extinguished my fear of death, and confirmed the ineffable wonder and joy of an afterlife.

The series of articles on near-death experiences in *Missouri Medicine* address an important topic that has been sadly neglected in the medical literature and, for the most part, ignored by medical schools and the physicians they train. Accordingly I have chosen to go public and share my NDE with the *Missouri Medicine* readership.

**THE EVENTS THAT LED TO MY NEAR DEATH EXPERIENCE**

My family and most of our friends love open water. Many glorious summers involved sun-drenched days and cool starry nights at Lake Pomme de Terre. Activities included swimming, fishing, water-skiing, and racing over the glassine green water in our powerboats.

Summer was always a wonderful break from the rigor and stress of academics. In 1975, upon graduation from Truman High School, at the age of 17, I had entered the six year program at the University of Missouri-Kansas City (UMKC) School of Medicine. Academics were rigorous and physically demanding. We went to school eleven months per year for six consecutive years. The first two years’ basic sciences dominated the curriculum. Clinical rotations started the third year. Although I was robust and vigorous, my parents carefully monitored my physical and emotional health mindful of my young age and the stress that my studies and clinical work created.

Their concerns seemed justified in the summer of 1977 when, at the lake with my family, I developed what seemed to be a rather ordinary upper respiratory infection. My physician father (obstetrics-gynecology) had me rest and use a decongestant for my runny nose.

On a Saturday, two weeks after the onset of my ‘cold,’ I returned to UMKC to take an all-day standardized multiple-choice exam. Our entire class took these tests quarterly. In the first hour, unexpectedly and unexplainably, I developed very troubling intermittent double vision. With considerable difficulty, I completed the exam by shutting one eye then the other. By the time I completed the test, the diplopia was constant and bilateral ptosis was evolving. I called my father to report my difficulty. He was sufficiently alarmed to send me directly to an emergency room. Dad met me at the Independence Sanitarium Hospital (now renamed Independence Regional Hospital). Meanwhile he arranged for a stat neurological consultation. My mother developed multiple sclerosis at the age of 36. My father and I both wondered if this could be the first manifestation of MS in me at age 20.

I drove to the hospital with one eye closed, where I was examined by a hastily assembled team of physicians. They decided to admit me. I was developing additional neurological deficits including severe bilateral upper lid ptosis. This situation continued to progress over the next several days with a descending paralysis. My physicians narrowed the diagnosis to two possibilities: a Jacksonian variant of Guillain–Barre Syndrome or myasthenia gravis.

As the paralysis advanced, I developed severe respiratory distress as part of the descending paralysis. Breathing became an exhaustive activity. Because of this dire situation I was sent to the pulmonary department for testing. They performed a physostigmine challenge. Unfortunately, the amount I received was an overdose of medication. Precipitously I was in iatrogenic acute respiratory failure.

**MY NEAR DEATH EXPERIENCE**

I just quickly slipped away as if in a dream. The last thing I heard was the therapist calling ‘code blue.’ Immediately prior to departing my body I recall telling her I just couldn’t
breathe anymore; it was just too hard and difficult.

I saw, as if from above and apart, like watching a television drama, emergency resuscitation efforts frantically start over my body laying on the floor. I viewed the frenetic activities around my dying body with detached interest. My essence, my soul, my consciousness, my being, my spirit - whatever the non-corporeal quintessence of being should be called - was at peace and serene. Now I had no need for a physical body. Matter and gravity were no longer barriers to movement. Ahead emerged a wondrous, brilliant ball of the unimaginably whitest light from which emanated perfect love and peacefulness. Despite its infinite luminosity, the light was pleasing and caused my eyes no discomfort or photophobia.

As I departed, there was never recognition that what lay below was my dying body. It was not a part of me and the surrounding medical drama was not my concern. It seemed natural to disregard, and rapidly, leave the limp form behind.

This radiant ball of loving light initially appeared at a distance and rapidly surrounded my soul during my journey. The light sourced from a beautiful central ball-like brilliance that far exceeded that of diamonds. I became aware that this source of transcendent light was a peaceful, living, loving thing. From it originated the most tremendous transference of pure love and acceptance, far beyond human imagination. Very naturally and effortlessly, I was drawn to this living ball of loving light. As I moved towards the light the quicker it surrounded and insinuated itself within my soul. The love source and my soul merged within the light. We become one and the same.

Twice during this rapidly occurring experience, I realized my earthly body was dying and the loving light field was my soul’s destination. Being only 20 years old, each time I thought about dying young, I could only think of one word: “No.” As quickly as I would think this to myself, the movement to the light would halt like being suspended mid-thought. During each of these two ‘episodes of choice’ there was a sharp contrast between this ball of living, loving light and the darkness from where I came on earth. The decision of whether to return to my life on earth or move towards and into the light was very difficult for me. It fascinated me that I felt I was being provided a choice.

This living ball of light that emanated amazing amounts of the purest love totally surrounded me. Who I am and who this source of light was became one and the same. It was a welcoming home, as if the loving light source was now whole again, and so was I. Analogous to merging two mists into one. The darkness from where I originated and its unpleasant feelings were totally gone. The second time I said, “No,” I felt that I was being given a choice to proceed on or to return back to the darkness here on earth. The process halted again on the second decision point I was provided. A voice spoke to me. The voice wasn’t male or female, was audible and came from within this amazing living ball of lighted love. The voice surrounded me. The voice said directly to me, “Don’t worry. It’s not your time yet. Return!”

Faster than my journey to the ball of living, loving light, I suddenly awoke on a respirator in the intensive care unit at the Independence Hospital. I could see and hear all these people busy scurrying around trying to save me. I could hear them talking about how they noticed I was waking up. They were concerned that I would need emergent cardio-pulmonary resuscitation again. Of course I now had first-hand information; I knew I was going to survive. The voice had powerful lasting meaning and finalized my continued earthly existence. Once I got my hands on pen and paper, I wrote out an explanation to my father of my near-death experience. I told him that I knew I was going to be fine and my life was no longer in danger from this illness. I now knew my purpose here on earth was yet to unfold. Now was not my time to die. My father observed how happy I looked. There was no wiping the smile off my face. I was at total peace.

I spent the next month in intensive care working hard to recover from this post-viral Jacksonian variant of Guillain-Barre syndrome. It took me a year to recover, including relearning (continued)
Insights

how to walk and build strength and endurance back to normal. Over time my diplopia cleared. In spite of doubts about my ability to return to medical school, I was able to graduate with my class in spite of missing many classes.

HOW THIS NEAR-DEATH EXPERIENCE HAS CHANGED MY LIFE

I was forever changed by this experience. I was thrilled to have felt the wonder and beauty of the amazing love-light source that awaits us beyond life here on earth. I believe and choose to call this love-light source God. I will never again fear death for myself or others.

I’ve thought a lot, but talked little, about my NDE experience over the years. I share with you this conclusion. In the act of dying we are offered the opportunity of accepting and joining the ineffable light of pure and unconditional love. I’ve heard people concerned about the death of loved ones who didn’t have a relationship with God. They fear their loved one traveled to eternal darkness. Because of what I experienced, my view differs on this topic. At the time of transition from ‘here to there,’ I was allowed to choose to be one with this peaceful loving ball of amazing light. At the time, I was a Christian, and had a building and growing relationship with God, but was still a greenhorn novice by all means.

October 10, 1993, I was privileged to suddenly and unexpectedly be at the bedside of my dying father, as he experienced an evolving myocardial infarction and severe cardiogenic shock. His face indicated immense pain and fear (probably worried about leaving our mom more than anything else). He was fighting for his life. I told him I loved him and would always take care of mom for him. I said I would miss him very much. While his ailing heart was still beating, his face changed to an expression of total peace and comfort. That’s when I knew his essence had transitioned away from his body. I looked upward, waved goodbye, blew a kiss and told him again I loved him. The medical staff took his ‘living’ body with a beating heart to the cardiac cath lab where they later pronounced him dead. I knew differently. I sensed and knew exactly when his spirit left his body.

I have been with a number of other family members and patients at the time of their deaths. I have seen their faces suddenly become peaceful with all pain and anguish gone. I know what they are experiencing. I know fully where they are traveling. I’ve been inclined to look up and wave goodbye to them. I am certain they’ll choose to be one with the peaceful loving ball of light.

THE UNFOLDING OF MY PURPOSE IN LIFE

I am profoundly grateful I was given an opportunity to return to this earthly existence. My life is full and rich with many blessings. I went on to internship and ophthalmology residency at the Mayo Graduate School of Medicine in Rochester, Minn. I returned to Kansas City where I practiced from 1986 through 2011. I’m a healthy, happy 57-year-old practicing ophthalmologist. I have two amazing children and four stepchildren, each happily married to wonderful people. My husband Jim Meyer and I are the blessed grandparents of five grandsons and one granddaughter. My near death experience allowed me to feel, see, and experience the profound joy when our soul post-death becomes one with the source of all love, peace, and light.

It is indeed an amazing journey to restoration with God the Father, who is the source of all light, love, and peace. Walls and ceilings have no boundaries to us beyond earth. Our bodies are not necessary beyond earth and are irrelevant after death. Our spiritual essence while here on earth is what really matters. Nevertheless, we should take good care of our assigned bodies in our earthly journey. As physicians we serve in a noble profession working to maintain or restore physical and mental health to our patients.

I look forward to again meeting God the Father and my earthly father someday. What a wonderful reunion this will be.

Jean Renee Hausheer, MD, FACS, is the former head of the ophthalmology residency program at the University of Missouri-Kansas City. Since 2011, she has been dean of the McGee Eye Institute of the University of Oklahoma School of Medicine. She can be reached at dr.jean.hausheer@gmail.com.
Two years ago the Keane Insurance Group and your Society agreed to partner and offer an affinity professional liability program to members. The program became effective Jan. 1, 2015 and is available to every member of the Society at no cost, and the benefit is a 15 to 25 percent credit. This credit is above and beyond what you would otherwise be eligible for through normal underwriting guidelines. In order to have a successful program we needed the participation of an insurance carrier who desired to increase their business presence in the Kansas City marketplace. NORCAL Mutual was the carrier that we chose.

Over the last few years the program has proved a success and through it we have been able to assist KCMS physician members in a number of ways. We have been able to provide significant savings to numerous physicians, many of whom had been with a carrier for several years and believed that they had a good rate until they were able to compare with what this program could offer. These savings have been up to 50 percent of what the physicians had previously been paying.

Some members have benefited in ways other than just moving to the affinity program. In some cases we have provided quotes through the affinity program but have found that the program was not as competitive in the market as we needed so we have accessed other carriers and been able to save the groups significant money along with providing quality coverage. In this partnership we are truly working for your best interest. In one case we were able to bring a $40,000 annual savings to the table, but the group got their existing carrier to lower their rate and match the savings. Now in this case, the physicians still won. Although we did not end up providing them coverage, the competition that the program introduced led to savings for those doctors. The shame was that their existing broker had not been working for them because the savings had been available for several years prior. So, one way or another, the physicians are winning as a result of this program.

**IN SUMMARY WE HAVE:**
- Moved several physicians to the program saving them up to 50% from their previous rate—physician win!
- Quoted some through the program but placed them with other carriers and saved them substantial money—physician win!
- Provided $40k in savings by quoting an account but their existing carrier matched rate—physician win!
- Each insured account has access to a national group purchasing program at no cost to the client—physician win!
- We provide access to 24/7 human resources support at no cost to the client—physician win!

In today’s marketplace, you have so many things putting pressure on you. Your professional liability rates have been stable so they are out of mind, but it’s worth your while to think about them long enough to compare what this program can provide to what you’ve currently got. Who knows what we might be able to do for you!

Keane Insurance Group is a national brokerage specializing in the health care field; we are licensed to write business in all 50 states. We can assist with any of the insurance needs for your practice. In addition, we offer life and disability coverage for physicians including lump sum disability income coverage designed specifically for physicians.

For more information, contact Tom McNeill at tom.mcneill@keanegroup.com, (816) 474-4473, or cell (573) 808-1571.

Tom McNeill is health care specialist with Keane Insurance Group in Lee’s Summit. He has over 30 years’ experience in the health care industry including serving in hospital and physician practice management, and most recently as COO of the Missouri State Medical Association Insurance Agency. Physicians look to Tom for resources such as medical professional liability insurance through NORCAL Mutual Insurance Company, physician disability insurance, cyber and regulatory liability coverage, and HR guidance.
Learn the latest treatments and play an important role in the care of Soldiers and their families. As a physician on the U.S. Army Reserve health care team, you’ll continue to practice in your community and serve when needed. You’ll work with the most advanced technology and distinguish yourself while working with dedicated professionals. You’ll make a difference.

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