SPRING 2018

Kansas City MEDICINE

JOURNAL OF THE NEW KANSAS CITY MEDICAL SOCIETY

GERIATRIC MEDICINE: SPECIAL NEEDS, GROWING DEMAND

Training Geriatric Physicians

Interdisciplinary Group Addresses Aging Issues

KU Alzheimer's Disease Center

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Physicians: Knowing When to Say "When"

FEATURES

Oncologist Launches Concierge Practice

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FROM THE *Editor*

MEDICAL SOCIETY *News*

Editorially SPEAKING

Profiles

Special FEATURE

ON THE COVER: *Margaret Fensom, left, of Independence, enjoys an active life at the age of 82 with the help of knee replacement surgery she received from Thomas McCormack, MD, at Truman Medical Centers Lakewood campus. She typifies the desire of elder adults to contine busy and fulfilling lives.*

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Trust in Physicians: An Aging Issue

By Michael L. O'Dell, MD, MSHA, FAAFP, Editor, *Kansas City Medicine*

Trust in the medical profession, in general, has been declining for the past few decades. Trust by a specific patient of their specific physician continues to remain high. Much of this issue of *Kansas City Medicine* is dedicated to caring for the elderly. It may seem odd to raise the issue of trust for such an issue. However, a closer read of the contents will explain this apparent leap.

Surprisingly, there is no universal definition of trust. The trust for physicians in general by the public is based on five domains: fidelity, competence, honesty, confidentiality, global trust.[1,2] General trust is expressed by patients' willingness to seek care, disclose private information, and submit to treatments particularly when these treatments are not well understood. General trust is important to the profession as such trust lessens debate about the profession, lessens the likelihood of additional regulation of the profession, and enhances the intrinsic worth and value of professional activities.

Jon Dedon, MD, writes in this issue about training geriatricians and, more important to the general trust of medicine as a whole, the failure to meet the challenge of our ever-enlarging population of geriatric patients. Charles Van Way, III, MD, provides an editorial about the flow of money in the profession and its uneven benefit to patients. Sukumar Ethirajan, MD, explains how his concierge practice returns trust as a defined doctor-patient relationship unencumbered by health system or insurance payment interferences. Joan McDowd and Kelli Wright have contributed pieces about the importance of community services and engaging these services, with volunteers and others occupying important roles in health delivery. Jeffrey Burns, MD, highlights advances in the treatment of Alzheimer's disease, perhaps the illness where general trust by family and community is most needed for care of a patient.

General trust is important to the profession as such trust lessens debate about the profession, lessens the likelihood of additional regulation of the profession, and enhances the intrinsic worth and value of professional activities.

John Hagan, III, MD, has written what many will find the most poignant and trust-building piece in this issue. He outlines the difficult decision to give up the joy of operating as a surgeon advancing in his own years. This voluntary and thoughtful act, which many physicians face each year, is proof of holding the patient's interests above his own. And the act is proof of the trustworthiness of the profession.

Are we, as physicians, to be trusted? Thankfully, as individual physicians, the answer remains yes for our own patients. But collectively, are we trusted? This question and response underlie the importance of organized medicine remaining strong and vibrant, speaking not so much in the self-interest of the individual physician, but in the interests of patients. How we respond collectively to physician shortages, increasing costs, regulation, and our ongoing skill and competence is what drives the trust we enjoy and from which our patients benefit.

Your Editor,
Dr. Michael O'Dell

Michael 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@tmcmed.org.

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New KCMS Foundation Will Focus on Serving Those in Need

FOUNDATION WILL SPONSOR PROJECT ACCESS, PROVIDE MEDICAL STUDENT SCHOLARSHIPS AND TARGET PUBLIC HEALTH EFFORTS

By Michael L. O'Dell, MD, MSHA, FAAFP, Editor, *Kansas City Medicine*

The new Kansas City Medical Society Foundation is off to a great start. The predecessor organizations of Wy Jo Care, MetroMed and the former KCMS Foundation are now merged. This merger allows the Foundation to engage in good work across the metro area.

The Foundation will facilitate and sponsor Project Access, medical scholarships and public health activities across the metropolitan area. This work will allow us to have a direct impact on patients in need, future physicians, and the health and well-being of our community at large. Two-thirds of the Foundation board are physicians, but the remaining one-third will provide much-needed voice of the lay community. Also, we will reach out to members of the lay community to engage in committee work steering future projects.

Project Access will likely comprise the bulk of the work of the Foundation, at least initially. This work matches patients in need with physicians, hospitals and other treatment facilities to gain needed care. Much of the funding for this work is from the Health Care Foundation of Greater Kansas City and the REACH Healthcare Foundation. Their assistance of and confidence in the Foundation is greatly appreciated.

Wy Jo Care's focus has been specialty and advanced care, whereas MetroMed's focus has been more primary care oriented. In joining forces, we can now be more comprehensive in our approach to patients. Many members of the governing boards of the prior organizations worked diligently and long to form this new Foundation and several have been seated on the new board. NorthlandCare for the time has not combined forces with the new Foundation but will continue to work collaboratively with the Foundation. Following is a list of the members of the Board and the staff supporting the Foundation.

Members of the Kansas City Medical Society can be proud of the new Foundation. In addition to pride though, we hope that your generous sharing of time, talent and money will steadily grow in support. So many in our community have unmet needs, and so many in our medical community strive to give what they can in response. Giving back to our community provides enormous gratification to our nobler wishes and efforts in healing.

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Call for Nominations: Medical Society Leadership Council

By Joshua M.V. Mammen, MD, PhD, FACS, Medical Society President

The Kansas City Medical Society is seeking nominations of independent physicians for two positions on the new Medical Society's Leadership Council.

The 42-member Leadership Council meets quarterly and helps set the Medical Society's agenda and develop its programming in leadership, education and advocacy.

Historically, both the Kansas City Medical Society and the Wy Jo Medical Society had representatives on the Board of Directors from local medical staff organizations. When the new combined organization was formed, the officers wanted to incorporate best practices in governance, which meant a smaller board to handle day-to-day activities. Yet we do not want to limit leadership and involvement opportunities, or ideas. Since physicians now organize in many ways outside of traditional hospital medical staffs (ACOs, etc.), the Leadership Council is inclusive of all practice types and settings.

The Leadership Council is composed of:

- The 14 members of the Board of Directors
- Representatives from each medical staff organization of the area's major hospitals
- A representative of each ACO or CIN (i.e., the Kansas City Metropolitan Physicians Association)
- Physicians serving on the board of the Kansas Medical Society
- Physicians serving as councilors with the Missouri State Medical Association
- Physicians from independent groups

Please consider nominating a physician or volunteering yourself to serve in this important role. Your Medical Society relies on the active involvement of physicians from around the metropolitan area. Please make your voice heard about who will help set the Medical Society's agenda.

See the governance structure chart of the new Kansas City Medical Society on the next page.

KANSAS CITY MEDICAL SOCIETY

LEADERSHIP COUNCIL NOMINATION FORM

NAME OF NOMINEE _____

PRACTICE/ORGANIZATION _____

ADDRESS _____

PHONE _____

EMAIL _____

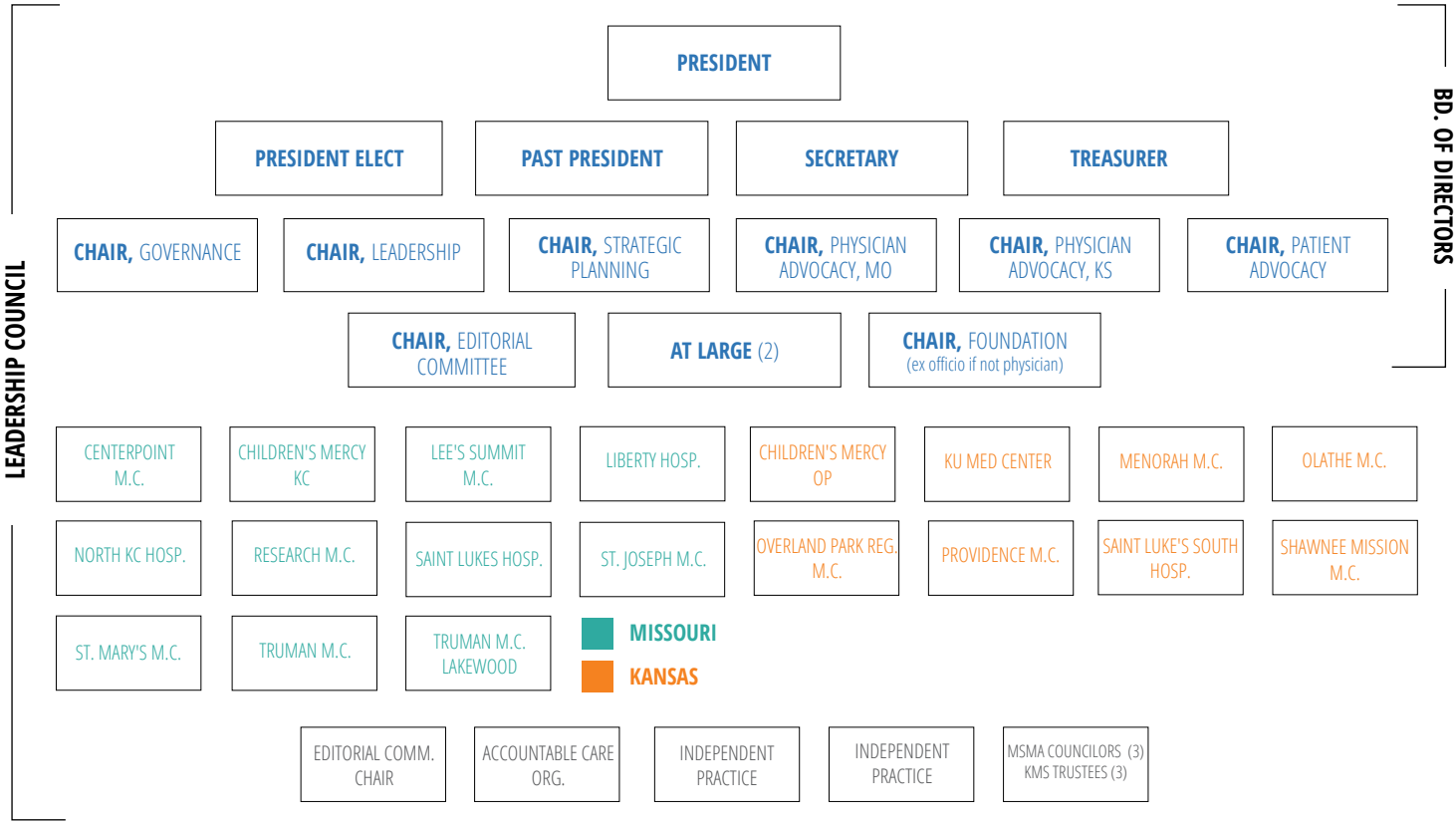
NOMINATED BY *(if different than self)* _____

PHONE _____

EMAIL _____

To submit a nomination to the Leadership Council, or self-nominate, please complete this form or send this information to Angela Bedell, Medical Society Executive Director and CEO, at abedell@metromedkc.org, or mail it to her at 300 E. 39th St., Kansas City, MO 64111.

New Medical Society Governance Structure



Honored for Lifetime Achievement

Displaying their awards are Charles M. Lederer, MD, middle left, with his wife Marilyn, and Carl V. Migliazzo, MD, with his wife Beth.

Bradley S. Thedinger, MD, right, accepts the award from Robert D. Cullen, MD.

The Kansas City Ophthalmology & Otolaryngology Society presented its annual Hal Foster Lifetime Achievement Awards in February. Receiving the award for otolaryngology was Bradley S. Thedinger, MD, of the Otologic Center. Co-recipients of the award for ophthalmology were Carl V. Migliazzo, MD, recently retired from the Kansas City Eye Clinic, and Charles M. Lederer, MD, of Associated Ophthalmologists of Kansas City. The Hal Foster Award was developed in 1991 and is presented to members of the Society who have demonstrated exemplary dedication and service to the Society and the local medical community.

Where Does the Money Go?

ANALYZING THE INCREASE IN HEALTH CARE SPENDING; CAN IT BE SLOWED?

By Charles W. Van Way, III, MD, Editor Emeritus, *Kansas City Medicine*

"We have met the enemy, and he is us."
~ Pogo (Walt Kelley)

The whole country seems to be intensely concerned about just how to lower the cost of health care. It's a little uncertain exactly why that should be so. After all, few people want to lower costs in, say, the auto industry. Or the electronics industry. Folks want to grow those, don't they?

But the health care industry is 18% of the U.S. economy, most of the new jobs, largest employer in America's small towns, one of the fastest-growing economic segments. What's not to like? Wanting to cut it back seems counterproductive. Of course, what people really want is to lower the cost of their health care.

Health insurance for a family of four is now well up into five figures, which gets the attention of nearly everyone. Many people just don't make enough to pay for that, or have it paid by their employers. Then too, despite Medicare for the old and Medicaid for the poor, a whole lot of Americans can't get insurance, and can't pay for their care. They still get care, but unreliably. Even then, hospitals and docs have to soak up the cost.

You know, putting it this way makes it look as if we don't have a problem with health care costs. We have a problem with health care economics. Or to put it more simply, we have not been smart enough to figure out how to pay for our collective health care. It's very refreshing to see a recent piece in *JAMA* by a group of researchers from Seattle,[1] who have actually looked at health care spending over the last 15-20 years.

From 1996 through 2013, total spending increased from $1.2 to $2.1 trillion. The authors analyzed five fundamental factors which contribute to the increase. About 23% of the increase was due to simple population growth. Another 12% was due to aging of the population. So, about a third was due to inherent population factors. Changes in disease prevalence overall were associated with a small spending reduction of around 2.4%. Naturally, some diseases increased (e.g., diabetes) and some decreased (e.g., cardiovascular disease), but the overall effect was close to nil. Changes in service utilization, interestingly, did not cause increased spending. But changes in service price and intensity accounted for 50% of the increase.

We have a problem with health care economics. Or to put it more simply, we have not been smart enough to figure out how to pay for our collective health care.

No, they don't add up to 100%. There are other factors, and the analysis was not designed to explain everything.

What was the money spent on? The biggest increase was in ambulatory care, with hospital care second, and pharmaceuticals third. We've been trying to shift more care from hospitals to the ambulatory setting, but it seems that we've succeeded in increasing both. Other contributors with smaller increases include nursing facility care, emergency departments and dental care. Percentage-wise, emergency departments increased the most of any of the six sites of care. This supports the general perception that emergency department use is increasing dramatically. ED spending rose 6.4% per year over the entire period, the highest of any component. Over the study period, spending rose 3.5% per year over and above inflation.

Starting sometime before the passage of the Affordable Care Act, most of the "Big Thinkers" in health care began talking about "bending the cost curve." I should define the group. Big Thinkers are located in major universities, usually have PhDs in economics, are never practicing physicians, and (most importantly) are politically well-connected. Few of them know anything about health care delivery to actual patients. Why we should pay attention to these amateurs is beyond me, but we do. It's sort of like picking Army generals from a group of conscientious objectors. But I digress.

"Bending the cost curve" is one of

those phrases which seems to mean something, but is sufficiently vague as to mean pretty much anything. The generally accepted meaning is slowing the rise in health care spending. Given that a third of the rise in health spending is due to population growth and aging, and is pretty much unavoidable, slowing the increase is pretty much all we should be able to hope for.

If we look at the five fundamental factors, we can't do much about disease incidence. Or more accurately, we're already doing as much as we can. Surprisingly, service utilization didn't factor in to the spending increases. Price and intensity appear to be the major areas in which spending might be cut. But this introduces some uncomfortable questions.

Just how do we go about doing that? What are our options?

Rationing? Perhaps each hospital should have a cap on ICU days. Or hospitals should have a fixed budget for expensive items, like artificial joints or pacemakers. "Sorry, Mr. Baker, we've used up our quota. You'll just have limp for a while. We'll see about a new hip joint next January." Actually, hospitals in Canada and Great Britain do have these kinds of limits. It's doubtful whether Americans would support such a system. Canadians, at least, can always head south.

Incentives? Let's pay doctors less, and they'll order fewer tests, and do fewer procedures. Well, we've tried that. It didn't work. Partly as a result, more and more doctors now work for health systems. And surprise! Health systems aren't getting paid less. They're being paid more. Even Medicaid is fairly decent reimbursement for hospitals. Health systems and hospitals have been more effective in lobbying Congress than physicians.

Centralization? We're fairly far along that road, and it hasn't lowered health care spending. If anything, forming larger and larger health care systems over the last 20 years has been associated with increased costs. Things like steel, automobiles and computers all have economies of scale. Unit costs get less as organizations get bigger. That's not true in health care.

Taking out someone's gall bladder requires a surgeon, an anesthesiologist, nurses, an operating room and an hour or so of time. That doesn't change for a health system which does a thousand cholecystectomies per day. But the health system puts layers of management and bureaucracy on top of the surgeon and the operating room, so that costs may actually be higher in a large system. That's a very politically incorrect thing to say, but political correctness and truth have a very uneasy relationship with one another. Especially in health care.

But the health system puts layers of management and bureaucracy on top of the surgeon and the operating room, so that costs may actually be higher in a large system.

Medicaid? It's a very important program, but it has major problems. Another politically incorrect truth is that poor people are more expensive to care for than most other people. They have more diseases, are more often disabled, and have fewer resources to care for themselves. If we were to recognize that caring for the poor is an expensive thing to do, perhaps we could design our systems, including Medicaid, to do a better job of it. But we are committed to the proposition that the poor are like everyone else, just with less money and no insurance.

Competition? We have a very competitive medical market place, but it doesn't seem to have lowered expenditures. Of course, that's because much of the competition is in the form of new buildings, or shiny new treatment programs. "Come to our heart center!" "Look at our cancer center!" "Our stroke center is the best in the state." And so on. Folks, all of these things cost money. That's exactly what is meant by "service intensity." And all of those buildings and new programs tend to produce a rise in price in order to pay off the bond issues and pay the salaries of the new clinical workers.

Maybe we could close more hospitals. There actually have been a fair number of hospital closures over the years, as hospitals become unable to attract patients and go out of business. But each one has produced great public distress. Certainly, closing non-productive facilities is a legitimate and effective way to cut costs. But the reason hospitals close is that patients are already going somewhere else. And that means that the spending is simply happening somewhere else.

Limiting the supply of physicians? We did that 20 years ago, when Congress capped the number of resident slots. The

result? We have a physician shortage right now, and people are trying to find advanced practice nurses and physician assistants to stretch the existing physician supply and otherwise fill the gap. We're actively trying to increase the number of physicians. In truth, we have several thousand more physicians than we have training positions, if you count U.S. citizens who are trained in other countries. Rather than cutting the supply, we actually need to increase it. In particular, we need to increase the number of residency positions.

Better organization? Accountable Care Organizations are the current cure-all being pushed by the Big Thinkers. Previous ones included managed care, group practice, managed competition and capitated payment schemes. While all of these things had at least a few virtues, none of them succeeded in lowering costs. Do we think that ACOs will succeed where managed care failed? Sure, we do. We always prefer hope to experience. The reason history repeats itself, as someone once said, is that nobody listens the first time. Big Thinkers rarely look back.

Pharmaceutical costs? Well, yes. These affect hospital care, ambulatory care and pretty much all other aspects of the health system. There seems to be a consensus that drug prices are out of control. For example, doxycycline has been around for decades. It's off patent and generic. But the current price has been raised from $0.03 to $5.00 per dose over the last few years. Wholesale prices rose 8,000%. The polite term for this sort of thing is "market failure." The less polite is "price gouging."

Getting drug prices under better control would seem to be an effective way to control spending. Just how to do that is another question. Controlling drug prices is currently being debated in Congress. Anything may happen.

Speaking of Congress, it's clear by now that the Affordable Care Act has not really made health care more affordable. Not only has spending continued to rise, its rate hasn't slowed since, briefly, during the so-called Great Recession. Some fine tuning is in order. Improving Medicaid would be an obvious first step. But with one party wanting to repeal the whole thing and the other party defending every line of it, "fine tuning" is not going to happen.

And one of our big problems is that we spend too much on administration. As anyone who works in a hospital knows, administrative overhead adds up. A 2014 paper by Himmelstein et al.[3] pointed out that the U.S. has not only the highest health care costs in the world, but also the highest percentage of administrative costs—25.3% of hospital expenditures. Another paper by Jiwani et al.[4] estimated that billing and insurance-related costs across the entire health system amounts to about 18% of expenditures. Both papers are directed towards making a case for a government-run or single-payer system, so their objectivity may be questioned. Still, we should be able to provide health care with far fewer administrators than we presently do, and with a far less complex billing system.

While the study by Dieleman et al.[1] ended in 2013, total annual spending has since risen to $3.2 trillion and 18% of the economy in 2015.[5] Note that this figure includes some things which were not included in the study. In any case, there has actually been a modest acceleration in the rise in spending.

Paradoxically, as we wring our collective hands about health care spending, an increasingly large number of us actually make our living in the system. It will probably reach 20% of the U.S. economy sometime in the next decade. It's futile to ask whether health care "should" be that large a part of the economy. The real question to ask is, why is it not more affordable for the average citizen? As the food industry has centralized and grown, food has become less expensive. The computer and electronics industries are the same. Health care, like education, professional sports and other people-intensive industries, has become more expensive.

One major factor, oversimplified though it may be, is that we require a large number of well-educated people to run the health care system. Such people are very expensive—including, I should point out, doctors. Yes, indeed, we are part of the problem. Will it be hard for us to be part of the solution? Perhaps so. But if we are not heard on this issue, we won't like the results.

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. He can be reached at cvanway@kc.rr.com.

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A Personalized, Holistic Approach to Cancer Care

LONG-TIME ONCOLOGIST AND HEMATOLOGIST LAUNCHES CONCIERGE PRACTICE; STRIVES TO BE "COUNTRY DOCTOR" FOR PATIENTS

By Jim Braibish, *Kansas City Medicine*

Dealing with a cancer diagnosis is a traumatic and confusing time for patients. Providing the patient with a better and more streamlined experience through the cancer journey is the goal of Overland Park medical oncologist and hematologist Sukumar Ethirajan, MD.

He is one of a handful of oncologists across the nation who have started specialty concierge practices. In both the concierge practice and his practice with Kansas City Urology Care, Dr. Ethirajan utilizes a holistic approach integrating traditional cancer therapies with genomics and other personalized medicine. He also strives to incorporate the patient's social and psychological factors in the treatment plan.

DR. E.T.'S CONCIERGE CARE

Dr. Ethirajan launched the concierge practice, Dr. E.T.'s Concierge Care LLC, in February 2016. Patients pay Dr. Ethirajan a flat fee or hourly rate for services not covered by insurance. As part of the concierge arrangement, patients have direct access to him by text and cell phone. He is available for house calls if necessary.

"Patients receive my time and my ability to listen to their concerns without the constraints of the appointment schedule," Dr. Ethirajan said. "We can talk things through. My goal is to be their 'country doctor'—similar to the TV character 'Marcus Welby, MD.'"

In the concierge practice, Dr. Ethirajan serves patients with all types of cancer. Besides a listening ear, he functions as a patient advocate and care navigator. "I try to be the patient's main advocate, and give them options to make the decision best for them."

His patients utilize hospitals and outpatient facilities across the Kansas City metropolitan area. "I can help save the patient money by directing them to less costly sites for radiology, labs and other services," he noted. "This is especially helpful to a self-employed person or a self-insured business with a high-deductible plan. One or two hours of my concierge time can save them thousands in out-of-pocket expenses."

He added, "In a system that is still volume-oriented, we work to link the patient with the best mix of resources for their needs, the best value. Our goal is to give the patient the best experience possible."

To date, he has served about 375 patients in the concierge practice. He likes to keep a panel of 50 to 100 full-service patients at any given time. The hourly rate is $395 and the flat fee is $2,000 per year for non-covered services. The only insurance he accepts are Medicare and Blue Cross Blue Shield.

"This is a high-value proposition for the patient," he said. "It is good medicine and I expect it will be good business." He has not advertised the practice; all patients have come through referral.

About the concierge practice, he said, "You're really practicing medicine. This is a lot more fun. When the patient calls or texts, I am there as their doctor. This is the reason we got into medicine."

He continued, "I would like to do this as long as I can."

TREATING THE PERSON FIRST

Through both practices, Dr. Ethirajan says, "We are treating the person with a disease first, not the disease."

Besides the normal medical evaluation, Dr. Ethirajan also notes the patient's various psychosocial factors, something which often is not well covered in a patient's chart. This might include:

- Life expectations. "Do they have education or employment goals? Do they want to spend more time with a grandchild?"
- Access to care—transportation, insurance, etc.
- Lifestyle—fitness, pets. "We document the names of their pets."
- Spiritual factors
- Other factors, e.g., if a caregiver for someone

"All of these factors can influence what will be the most effective and appropriate treatment for the patient," Dr. Ethirajan said. "We must consider the whole person."

He mixes this person-centered approach with the increasing array of treatment options available to cancer patients today. Besides traditional surgery, chemotherapy and radiation, these can include genomic therapies as well as hormone therapy, immunotherapy and others. Using these targeted approaches is termed "precision" or "personalized"

cancer care.

Precision cancer care is currently defined as "the right treatment for the right patient at the right time."

BENEFITS AND LIMITATIONS OF GENOMIC THERAPY

Genetic testing enables the physician to learn the exact genes where cancer mutations or expressions are occurring. This makes it possible for the physician to prescribe a medication that attacks the problem gene, rather than using traditional chemotherapy which impacts the entire body. Just over 20 medications have been approved for genomic treatment of cancer.

In the case of leukemia, genetic therapy has become the standard of care, Dr. Ethirajan said. Chronic Myelogenous Leukemia and the Philadelphia chromosome are personal for him. In medical school in the early 1980s, it was a professor's prompting about the Philadelphia chromosome that sparked his interest in oncology as a specialty.

Then, in the 1990s while now working in Kansas City, "My good friend with whom I played recreational basketball was diagnosed with CML," says Dr. Ethirajan. "At that time the only treatment available was a bone marrow transplant, and though he did receive one, his remission was short-lived and he passed away. Just a year later, an oral genomic treatment was available to help treat CML."

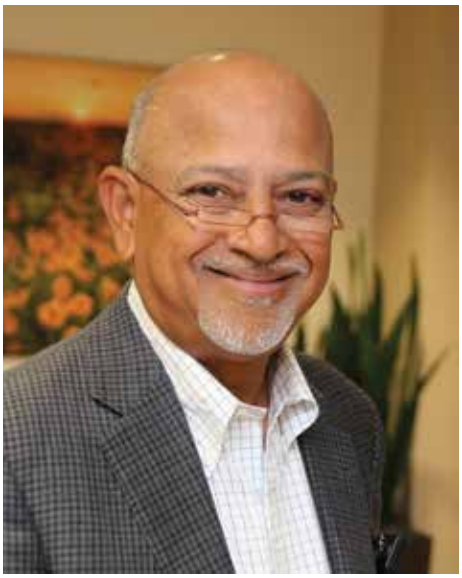
While the new genomic treatments can be effective, they are not the answer for everyone. In a July 2017 presentation to a Center for Practical Bioethics forum, he gave examples of three patients having genomics-based treatments.

One patient had gone through radiation and chemotherapy unsuccessfully for lung cancer, but started the EGFR target drug in 2009. The 83-year-old responded successfully for five-plus years until entering hospice care for other issues.

The second, a 47-year-old, was diagnosed with breast cancer in 2009 and it became metastatic in 2011. Various targeted treatments have been tried unsuccessfully. The third was a 48-year-old breast cancer patient where blood testing was negative for the BRCA gene but tumor testing suggested a germline mutation.

"Genomics is a good tool, but we can't overpromise," Dr. Ethirajan said. He noted several studies presented at the American Society of Clinical Oncology 2017 annual meeting showing that a relatively small percentage of patients are benefiting from the therapies. In one study, for example, ProfiLER out of France, of 2,490 patients with advanced cancer, 1,826 had tumors studied, with 940 showing "actionable" genetic mutations or expressions for which therapies exist. Of those, 101 initiated a recommended treatment. Of the 940 actionable,[2] (2.3%) showed complete recovery. While the ProfiLER study also demonstrated improved survival rates among those receiving treatment, the actual numbers remain small.[1]

Also at the Center for Practical Bioethics presentation, Dr. Ethirajan pointed out several ethical issues that have arisen with genomic therapies. One is the provider's "duty to inform" the patient of any unrelated results that genetic testing reveals, or inform family members of potential genetic risks. Such findings can be lifesaving, but also can lead to uncertainty and distress if they are unexpected or identify conditions for which no effective treatment is available. This is particularly sensitive since much of testing occurs in clinical trial research settings.



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Case law in this area still is being defined, Dr. Ethirajan said, although related cases in genetic testing show that physicians are obligated to inform patients of incidental findings.

A 2013 report from the Presidential Commission for the Study of Bioethical Issues advises physicians to seek informed consent from patients about incidental findings prior to genetic testing. The report said, "All practitioners should anticipate and plan for incidental findings so that patients, research participants, and consumers are informed ahead of time about what to expect and so that incidental findings are aptly communicated if they are found."[2]

Another issue is the ownership of genetic information. The U.S. Supreme Court has ruled that researchers and pharmaceutical companies can't "own" genetic information since they are discovering something that already exists.

"All of these are issues that society needs to talk about, and I am addressing these on the board of the Center for Practical Bioethics," Dr. Ethirajan said.

SERVING KANSAS CITY SINCE 1993

Dr. Ethirajan has earned his reputation for passion and compassion over 24-plus years of oncology practice in the Kansas City area. Prior to launching Dr. E.T.'s Concierge Care and joining Kansas City Urology Care in 2016, he practiced with the Sarah Cannon Cancer Institute at Menorah Medical Center from 2011 to 2015. Previously, he was with Kansas City Cancer Center for 11 years.

Obtaining his medical degree from University of Madras in 1982, he continued to pathology and internal medicine training at Boston University and Harvard affiliated hospitals. He then completed his hematology/oncology fellowship at University of California and a medical oncology fellowship at the University of Minnesota in 1993.

Dr. Ethirajan served as Kansas City Medical Society president in 2004. Besides board membership with the Center for Practical Bioethics, he was a founding member and board vice-chair for MetroCare which is now part of the Kansas City Medical Society Foundation. He was vice chair of the Midwest Institutional Review Board for HCA Midwest Health, and currently is a member of the Kansas City Blue Cross and Blue Shield Health Collaborative. In oncology, he is a past president of the Kansas Society of Clinical Oncology and has been a member of the American Society of Clinical Oncology clinical practice committee.

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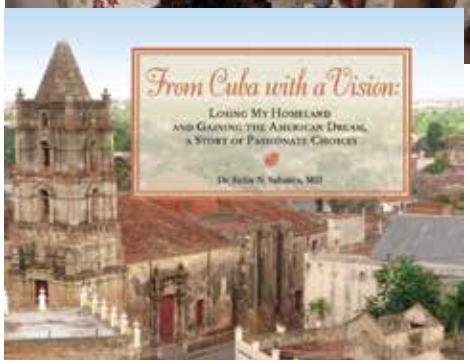
From Reluctant Immigrant to Leading Retinal Surgeon and Educator

FELIX N. SABATÉS, MD, HAS WRITTEN A BOOK CHRONICLING HIS LIFE GROWING UP IN CUBA AND DEVELOPING THE UMKC OPHTHALMOLOGY PROGRAM

By Jim Braibish, *Kansas City Medicine*



(Above) Dr. Felix Sabatés with his wife Carmen. ***(Left)*** The cover of Dr. Sabatés coffee-table-size book.

Noted Kansas City ophthalmologist and KCMS Life Member Felix N. Sabatés, MD, has published a memoir summarizing his life growing up in Cuba, training under leading eye surgeons, and eventually settling in Kansas City where he founded the University of Missouri-Kansas City Department of Ophthalmology.

The book, *From Cuba with a Vision: Losing My Homeland and Gaining the American Dream, a Story of Passionate Choices,* is a large-format, coffee-table-sized volume filled with many photos. It is an easy and fascinating read.

The story of Dr. Sabatés' early life, medical training and career is intertwined with the social and political history of Cuba. After liberation from Spain, by the early 20th century Cuba had developed a strong economy and was a popular tourist destination. But by the 1950s, Cuba had become an unstable dictatorship. When Fidel Castro overthrew Batista in 1959, it altered the direction of Dr. Sabatés' life and that of his family.

Growing up the youngest of 10 children, Dr. Sabatés and his siblings all learned the jewelry business that their father ran. "This gave us the fine hand skills for surgery," Dr. Sabatés writes in the book. He planned to practice medicine in Havana.

He graduated from the University of Havana Medical School in 1955 and then trained in New York under corneal transplant pioneer Ramon Castroviejo, MD. Before beginning a two-year residency at Kings County Hospital in Brooklyn, he married his fiancé from Cuba, Carmen, and they returned to the United States. He then obtained a fellowship at the Massachusetts Eye and Ear Infirmary under pioneering retinal surgeon Charles Schepens, MD, his primary mentor and lifetime friend.

Since Dr. Sabatés and Carmen originally planned to return to Cuba, they never applied for U.S. citizenship, instead staying on temporary visas.

But one day in 1960, a year after Castro took power, his father called him while on fellowship in Boston, and told him, "You can't come home. Castro is a communist."

After the failure of the Bay of Pigs invasion in April 1961 and his fellowship near its end, it became urgent that he find a way to remain in the U.S. and obtain a medical license. While sitting for an oral exam in Chicago, one of the examiners was John Buesseler, MD, chairman of the University of Missouri-Columbia's new department of ophthalmology. Dr. Buesseler invited him to come to work at UM-Columbia.

To get a medical license, it eventually

(*continued on page 15)*

LETTER TO THE EDITOR

Stress and Burnout in Residency

I was pleased to see that the medical societies on both sides of the state line have finally joined into one. When I was president of the Metropolitan Medical Society back in the 1980s we attempted that union but were unsuccessful. Congratulations!

I write to comment on the issue of burnout and depression particularly in the post-graduate years. I may be old and retired but I can still remember the eight years of internship, general surgery, pediatric surgery and cardiothoracic training that were free of work hour restrictions and electronic medical records. I cannot recall a single instance of dropout or suicide among the many fellow house staff that I worked with. True, we were all depressed at times because we had little or no leisure time. Our wives were more depressed because they bore the brunt of raising the family and working because our resident pay was adjusted to keep us from being eligible for welfare assistance. A few of the peers' marriages didn't work out but strangely they were mostly in those areas where the house staff did not have to work as long hours as the surgical residents did. It seemed that the "civilian" divorce rate was about the same but I have no data to support that contention.

I have an idea that it is the work-hour restriction that has caused the most problem among the house staff. A resident "owns" the patient and having to sign out in the midst of a workup or operation is not the way to provide continuity of care. Residents are stressed but this is a stressful profession. We wouldn't want it any other way. I was surprised by Charlie Van Way's statement that 75% of general surgical residents opt for a fellowship now. Part of that may be due to the restricted work hours resulting in insufficient education.

I was one of the three pediatric surgeons at Children's Mercy when we started the residency training program there. The first eight residents arrived on July 1 and some didn't leave the hospital for seven or eight days. They signed on for two years and they stayed. Then we went to one resident per year for the two-year fellowship and we got the most complaints from the guy who missed out on the good cases because they occurred on his time off. All of those fellows stayed in practice—some past their "sell-by" date.

I suppose (again, no data) that some of the dropouts are people who really went into the profession or specialty even though they didn't want to put in the effort. As residents we heard from the staff the tales of their training which made ours seem almost luxurious. By comparison we were damned lucky to have gotten the privilege of a spot on the house staff. That still is the case.

I don't have any answers to the burnout or dropout problem but it may have something to do with perceived roles. Women residents are particularly conflicted by maternal instincts both during training and in abbreviated practice hours or shortened careers. Some of us old timers were terribly fortunate to have spouses who took care of the details of life and family while we enjoyed specialty training. Perhaps there is some battery of tests that could sort out the dropouts before they had to dropout.

Keith W. Ashcraft, MD
Shawnee Mission

Joshua M.V. Mammen, MD, PhD, FACS, Elected to Board of National Certifying Body

KCMS President Joshua M.V. Mammen, MD, PhD, FACS, has been elected to the board of directors of the American Board of Surgery, the certifying board in the field of surgery, effective July 1. Dr. Mammen represents the Association for Academic Surgery. He will serve a six-year term.

Dr. Mammen is associate professor of surgery and molecular and integrative physiology at the University of Kansas Medical Center. He serves as vice chair of the Department of Surgery and division chief of surgical oncology. He is a Fellow of the American College of Surgeons and past president of the Kansas chapter.

Betty M. Drees, MD, Joins Stowers Institute for Medical Research

Betty M. Drees, MD, FACP, has been appointed president of the Graduate School of the Stowers Institute for Medical Research. An endocrinologist, Dr. Drees served as dean of the University of Missouri-Kansas City (UMKC) School of Medicine from 2001 to 2014. Dr. Drees also will continue at UMKC as Dean Emerita and a professor in the Department of Internal Medicine and the Department of Biomedical and Health Informatics.

In addition to her work at Stowers and UMKC, Dr. Drees will continue with the study she is leading on community interventions to prevent type 2 diabetes mellitus.

The Graduate School of the Stowers Institute for Medical Research trains predoctoral researchers from around the world for the pursuit of innovative and creative investigations in the biological sciences. It provides researchers with mentorship and hands-on experience to refine their abilities to carry out independent biological research. The Graduate School welcomed its first class in the fall of 2012, and in 2016 the first predoctoral researcher completed the PhD program.

University Health Clinic at YMCA Mates Primary Care and Fitness

Truman Medical Centers in March opened a University Health primary care clinic inside the Linwood YMCA on Kansas City's east side.

The 7,000 square-foot clinic will serve YMCA members and those in the surrounding community. Four physicians and a nurse will see patients for a full range of primary care.

SABATÉS *(continued from page 13)* took the university lobbying U.S. Sen. Stuart Symington to introduce an Act of Congress in 1962 making Dr. Sabatés a U.S. citizen—ironically signed by President Kennedy in the midst of the Cuban missile crisis.

Once licensed, Dr. Sabatés began practicing part-time in Kansas City as the university started an affiliation with the former Kansas City General Hospital. In 1966, he moved here to direct the hospital's eye department, continue training residents, and start a private practice. In 1971, the program became part of the new UMKC School of Medicine.

A major milestone was creation of the Kansas City Eye Foundation and the building of its first outpatient surgery center which opened in 1987. It installed one of the nation's first laser devices for refractive surgery in 1989. The affiliated private practice became Sabates Eye Centers.

Dr. Sabatés speaks out for the value that immigrants bring to American society. He writes, "The melting pot aspect of the United States is one of our greatest strengths and is reflected in the enrollment and faculty of our medical school."

An advocate of healthy lifestyles, he prohibited smoking at his offices as far back as the 1960s and encouraged patients not to smoke. He would swim laps at his home pool in the evening after long workdays.

Dr. Sabatés, 87, and Carmen have celebrated their 60th anniversary. Their three children are: Carmen Maria; Felix Jr., a neuro-ophthalmologist in Texas; and Nelson, who also is a retinal surgeon, and succeeded his father as president and CEO of Sabates Eye Centers and ophthalmology chairman at UMKC. Nelson also trained in retinal surgery in Boston under Dr. Schepens.

From Cuba With a Vision is available on Amazon.com.

William White, MD W. Abraham White, MD

Restoring and Protecting Vision Where the Need is Great

FOR OVER 15 YEARS, KANSAS CITY OPTHALMOLOGISTS HAVE LED MEDICAL MISSIONS TO HAITI

By William L. White, MD with W. Abraham White, MD

Editor's Note: William L. White, MD, and his son W. Abraham White, MD, are key partners in a twice-annual ophthalmology mission to the northwestern Haiti city of St. Louis du Nord. It is part of a larger mission operated by the Northwestern Haiti Christian Mission, which also has missions in six other Haitian communities. Dr. William White started the ophthalmology mission there in 2002; Dr. Abe White joined in 2005 while he was in medical school at the University of Missouri-Kansas City. A team of about 30-60 people including 6-15 physicians goes on each mission, seeing an average of more than 1,000 patients and performing over 200 surgeries. An eye clinic and surgery center was built there for the team in 2006.

Haiti is the poorest nation in the Western Hemisphere. It is still reeling from the effects of a 7.0 earthquake that struck the southern region in January 2010 killing 300,000 people and displacing 1.5 million people. While the earthquake did not damage northwestern Haiti, the economic impact was felt throughout the country. Further damage was wrought by Hurricane Matthew in October 2016.

My first trip to serve medically in Haiti was inspired by two individuals. The first was Henry Tiemann, MD, a family physician formerly of Kansas City, who served for many years as a camp doctor at various sites across the United States for a week a year, and later with our mission. The second was a young person from the Kansas City metro area, Lori Trowbridge, who was serving with a mission in Haiti and sent word back they had a need for an eye team and thought we could assist there.

Thus, we were connected with the Northwest Haiti Christian Mission in St. Louis du Nord, a city of almost 70,000 residents. This mission, established in 1979, is one of seven run by Northwest Haiti Christian Mission. The mission arranges for all transportation, lodging and provisions for those who are willing to provide care onsite. With no prior medical missions experience whatsoever, the adventure for us began.

EARLY TRIPS

Jennifer Stienstra, a surgical nurse from Kansas City, went in on the first trip. She thought about all of the extras that we as physicians presume are going to be present where services will be delivered. From sterile irrigation solution to intraocular lenses, if you didn't bring it, you may not have it. We learned there is no grace from the airlines when packing. You get 50 pounds for each of two checked pieces of luggage, period. The weight and volume restrictions made it seem like we were traveling into space, we were going so light.

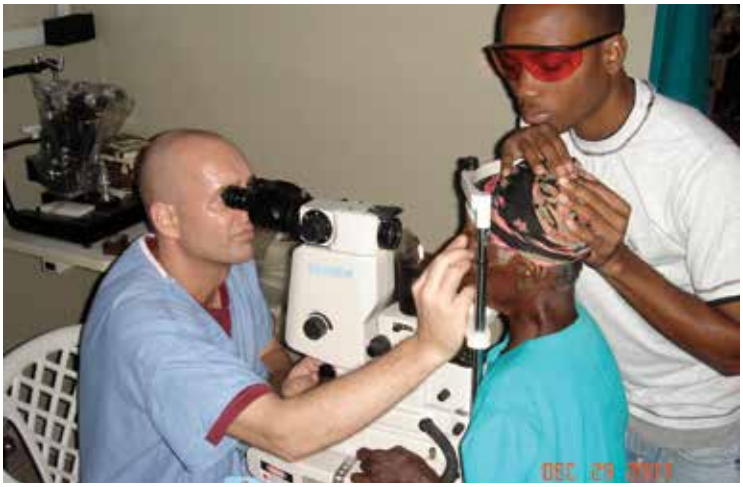
Initial surgeries were quite challenging. The climate was brutal. Beans and rice got a bit old. But in 2002 the groundwork was set. The needs were monumental in terms of numbers of patients with preventable vision loss from glaucoma and surgically reversible vision loss from cataracts. There would be no looking back as it would have been ethically unconscionable to not return.

The initial plan was for annual trips of 12 days during the winter months, which worked out best for the mission as they hosted student groups during the summer. There were ophthalmology residents in the community who were interested in missions, and they aided in the provision of care considerably during those first few years of service. Scott Morledge-Hampton, MD, and Scott Hickman, MD, both from the UMKC program, made several trips with the team and helped establish some of the customs of care that we would carry forward.

Dr. Hickman had served in the Peace Corps prior to medical school, and brought with him a volume of knowledge that books cannot contain. The fact that he was fluent in French did not hurt either. Creole is the language of the common man in Haiti, but French is frequently spoken. Speaking French was a necessity for Dr. Hickman during his Peace Corps time serving in Francophone Africa. He described the Haitian landscape as just like Africa without the large mammals.

LOGISTICAL CHALLENGES

It took a tremendous amount of coordination of supplies to pull off the capacity to provide medical and surgical eye care along with dispensing eyeglasses. When we tried to ship supplies, which typically took place by boat, they often would be indefinitely delayed and occasionally lost altogether. It would ordinarily take 12-18 months for a successful shipment to arrive onsite. Planning for equipment needs a year and a half away was interesting. That was the only way at the time we could transport




(Clockwise from top left) Dr. Scott Hickman performs a YAG capsulotomy. The ophthalmology clinic under construction in 2006. Dr. William White on a 2005 trip to Haiti. Dr. Sheila Alton with one of her smaller patients.

the bulk of our heavy equipment, such as phacoemulsification machines, operating microscopes and ophthalmic chairs with their attached stands and such.

Ophthalmology in general necessitates the use of many instruments and appliances, most of which are quite fragile. The climate and conditions within the country were hard on all of our devices, which meant that we needed a continuous flow of instrumentation even under the best circumstances. We would later benefit from learning the value of equipment used in the mobile delivery of ophthalmic services, which has made this process easier over time. Many in the community have also donated instruments and supplies to assist in our efforts over the years.

When we started, the mission provided us with a small room to use for our clinic. It was no more than 15 by 20 feet. Patients were lined up outside that room farther than the eye could see. And this was after they lined up outside the mission before sunrise. It was a bit intimidating to know that your patients were lining up waiting for your services while you were sleeping.

We learned early on that a station approach to the provision of care was much more efficient than the general model we use here in the states. Each team had health care personnel with different provider sets and a mixture of first time travelers and those with prior onsite experience. Thus, in every trip the patient screening operation was a little bit different. It was an annual lesson in creativity and flexibility to put the process together.

EYE CLINIC CONSTRUCTED

The realization came pretty early on that if we were going to be able to provide care for a larger number of patients—the supply of which seemed almost limitless—we would need a more spacious facility from which to work. An opportunity arose to purchase land and build an eye clinic adjacent to the mission which would allow us to expand our operation considerably.

Back in Kansas City, at a meeting

Dr. Andy Moyes performing cataract surgery.

of Ophthalmology and Otolaryngology Society, we discussed the mission and what was anticipated in the future. Following this meeting, many members of the Kansas City medical community came forward with financial support for the clinic building including Drs. Joe Parelman, Steve Unterman, Steve Byars, Charles Lederer, James Garner, Frank McKee, Louis Monaco, Luther Fry, Joel Leibsohn, Sara O'Connell, Peter Shapiro, William Godfrey, David Dyer, Larry Piebenga, Brad Kwapiszeski, Andy Moyes and John Hagan. Substantial donations also came in from outside the state.

A video was produced about what we were doing to share with our donors. Nothing professional, just real life. It was to be a thank you of sorts for all those aiding in our efforts. Probably the most pivotal event in this entire experience then took place. It would radically impact both the number of patients we were able to see and surgeries provided.

MORE PHYSICIANS JOIN THE MISSION

Andy Moyes, MD, an ophthalmologist in the Northland whom I had not personally met, but who had previously provided assistance to the operation, watched the video with his family. Not only was Dr. Moyes interested in personally becoming involved, but his whole family was. The course of the whole operation changed.

The biggest ophthalmic surgical need in Haiti is for cataract extraction. I am not a cataract surgeon. I was trained in cataract surgery in residency, but save for 200 cases prior to 1994, the only subsequent cataract surgeries I had done were those cases in Haiti. Andy was a cataract surgeon, and a stellar one at that. Additionally, he had connections with other ophthalmologists across the country that I do not have. The lion's share of the success of this operation in surgically restoring vision can be traced directly to Andy. He has personally been responsible directly or indirectly for thousands of Haitians having vision restored through cataract surgery.

There are many side stories here that involve the local medical community. During my first trip in, they had me assist in delivery and resuscitation of newborn infants. While ophthalmology and obstetrics are close to each other in the dictionary, the skill sets could hardly be more different. That initial experience reinforced both the need for primary care in the Haitian community and the assistance primary care physicians

could render us in providing ophthalmic services.

Henry Tiemann, MD, the physician who initially challenged my personal involvement, and Sheila Alton, MD, a Kansas City emergency room physician, joined the team and since have both served many times. Sheila has been on countless trips and typically brings in one or two of her three daughters every time she travels with us. From repairing machete wounds to broken bones and septic joints, she has been as busy as any of the team. Sheila has also "taken it on the road" to provide health care at a prison close to the mission.

Another aspect of this operation that is easily overlooked is anesthesia. We have done one trip with no anesthesia support, so retrobulbar anesthetics were then administered with no sedation. We had one patient who observed the person in front of them receive their block and subsequently climbed out a window in the operatory to avoid befalling the same scenario. CRNAs from the Kansas City area have generally formed the core of our anesthesia providers, including Karen Parker, Connie Carlson, Tricia Jester, Colleen Killian, Mike Kneller and Stacy Quick all making multiple trips with the team. Doug Hagan, MD, an anesthesiologist from Kansas City, has also been in with the team and has been a great resource to tap for questions as Doug has done surgical mission work around the globe.

The second generation of our family, W. Abraham White, MD, made his first trip to Haiti while in medical school at UMKC in 2005. Following graduation from residency, he has been a regular member of the eye care team. Much, but certainly not all of the groundwork, was laid at that point.

This was also about the time that

Dr. William White, left, and Dr. Abe White.

Our vision for the future is to bring education and training to the island sufficient in magnitude and scope that our personal skills are no longer required to restore and protect vision.

efforts were made to come to the island twice a year to serve. To make it easier on our families at home, we staggered our trip with one of us going in the late fall and the other to go during the more established winter trip. Our skill sets are different clinically, and there is no doubt that the skills of a comprehensive ophthalmologist such as Abe are much more in need where we serve.

The number of eye care providers from Kansas City who have served with our team is quite large. They include Drs. Larry Reed, Robert Thompson, Jamie Paauw and Matt Recko. Many have also traveled with their children or spouses including Drs. Brad Kwapiszeski, Scott Olitsky, Brett Dawson, Blake Cooper, Steve Stechschulte, Tami Soriano and Ajay Singh. Scott Murphy, MD, from St. Joseph, has made many trips with the team including one where he brought his wife and son, who is mobile only with the aid of a wheelchair. Elliot was an inspiration to all who were on that trip as his energy was seemingly limitless. There have also been dozens of ophthalmologists from around the country who have traveled with us, bringing ingenuity and diversity to our teams as we serve.

HURRICANES AND THE 2010 EARTHQUAKE

For an island as small as Haiti, it seems that it has more than its share of geographic excitement. We have had two major hurricanes pass through the area where we work, among several that have impacted other parts of the island. An earthquake in 2010, centered on the opposite end of the island from the mission, radically impacted the entire country. Haiti celebrated its 200th anniversary in 2004 with significant demonstrations and we learned the communication value of blocking the roads with burning tires.

There have also been microbiologic experiences, some of which have been quite personal. Traveler's diarrhea eventually impacts just about everyone who does this type of work and is more of an inconvenience than anything else. We learned about malaria and the importance of prophylaxis. The cholera outbreak after the earthquake was devastating to the island, but global

(continued on page 23)

AGING IS A journey

OF ADAPTING
TO NEW CIRCUMSTANCES

Geriatric Medicine: Special Needs, Growing Demand

AS THE NATION'S ELDERLY POPULATION GROWS SHARPLY IN THE NEAR FUTURE, SO WILL THE DEMAND FOR PHYSICIANS KNOWLEDGEABLE IN HOW TO CARE FOR THEIR SPECIAL NEEDS

For some patients, the changes may be minor. They can maintain active lives with a little help such as a hip or knee replacement. Other patients may see more severe changes. Mobility problems, a history of falls, use of a cane or walker. Severe effects of chronic conditions such as diabetes and COPD. Managing multiple medications. Dementia and Alzheimer's. The patient may have difficulty hearing or understanding the doctor, so a son or daughter also comes to the appointment.

The need for care and the complexity of care grow as patients age. Physicians find themselves discussing not just health issues, but also advising patients on community support resources and optimum living situations.

To care for our aging population, we will need more geriatric medicine physicians, and all physicians will need greater understanding of the special needs of elderly patients.

This issue of *Kansas City Medicine* provides insights from some of our region's experts on serving an aging population:

- **Jon F. Dedon, MD,** discusses geriatric physician training programs at the University of Missouri-Kansas City Department of Community and Family Medicine, including the nationally acclaimed geriatric fellowship program.
- **Joan McDowd, PhD,** describes an interdisciplinary faculty group at UMKC that is addressing aging issues across departments ranging from pharmacy and law to engineering and nursing.
- **Jeffrey Burns, MD, MS**, provides an update on leading-edge activities at the University of Kansas Medical Center's Alzheimer's Disease Center to find new ways to prevent and treat this disabling disease.
- **Kelly Wright, MA,** explains community resources available to seniors from the American Cancer Society, typical of the supports that can be accessed from various disease-specific organizations.
- **John C. Hagan, III, MD, FACS,** shares his story of when he decided it was time to "hang up the scalpel" and continue his work in clinical ophthalmology.

Training Doctors to Care for the Elderly at the UMKC Department of Community and Family Medicine

NATIONALLY RECOGNIZED PROGRAM INCLUDES FELLOWSHIP AS WELL AS TRAINING FOR RESIDENTS AND STUDENTS

By Jon F. Dedon, MD

The U.S. is aging, with the movement of the baby boom generation into the geriatric age range expected to have one in five Americans eligible for Medicare within 12 years. By 2030, 19-20% of U.S. citizens will be 65 and older, and by 2040, 25% of the U.S. population will be 65 and older.

The older population consumes health care resources in a disproportionately heavy manner: it is expected that the geriatric age range population will consume 60% of the trillions of dollars that will be spent on health care in America in 2030. Caring for this expanding population of patients who often have multiple chronic conditions and multiple medications will continue to be a challenge.

Currently there are just over 7,000 physicians certified as geriatricians in the United States, with a projected need for 30,000 geriatricians in 2030.[1] It is clear that we cannot train enough geriatric medicine specialists to meet this need, and we must train primary care physicians well in geriatric medicine to ensure high-quality care for older Americans.

The Department of Community and Family Medicine of the University of Missouri-Kansas City School of Medicine, based at Truman Medical Center Lakewood, has made teaching geriatric medicine a priority for decades. Current department chairman Mike O'Dell, MD, continues to support and encourage development of the geriatric medicine teaching programs of the department.

GERIATRIC MEDICINE FELLOWSHIP

Accredited by the American Council for Graduate Medical Education, the department's Geriatric Medicine Fellowship has trained 44 Geriatric Medicine Fellows over the last 20 years. The doctors are providing high-quality medical care to older adults in the Kansas City region and locations all over the U.S.

The Geriatric Medicine Fellowship trains family medicine and internal medicine physicians to be experts in primary care geriatrics, consultation and academic geriatric medicine. Fellowship graduates are providing patient care and teaching at locations ranging from Research Medical Center in Kansas City to the Mayo Clinic in Rochester, Minn., and many others nationwide.

The Geriatric Medicine Fellows train in the well-regarded 188-bed academic long-term care facility at Truman Medical Center Lakewood, where long-term care has been provided continuously since 1908. The Fellows experience outpatient clinic, Geriatric Assessment Clinic, hospice care and post-acute rehabilitation at Truman Medical Center Lakewood, and help teach many other levels of medical learners. The Fellows learn interdisciplinary care working with nurses, dieticians who specialize in and are certified in long-term care dietary expertise, along with physical/occupational/speech therapists and social workers.

The Fellows have weekly case study teaching sessions, weekly audiovisual lectures and monthly Geriatric Medicine Journal Club research reviews led by Steve Griffith, MD, who is certified in geriatric medicine by the American Board of Family Medicine and is immediate past department chair. Dr. Griffith also supervises the Geriatric Medicine Fellows in their outpatient geriatric medicine clinic each week. This author is fellowship-trained and board-certified in geriatric medicine and also has been a research fellow in geriatric clinical pharmacology. We always stress the importance of appropriate prescribing for older adults, using the Beers Criteria of Potentially Inappropriate Medications for Older Adults as a basis for teaching.[2]

RESIDENT TRAINING

Besides the Fellowship program, educating primary care doctors in geriatric medicine is a priority. Each of the resident doctors in the family medicine, internal medicine and med-peds programs has a required block rotation on the geriatric medicine service at Truman Medical Center Lakewood. They also participate in many educational programs along with the Geriatric Medicine Fellows.

Our goal is to give them exposure

and training in geriatric medicine, geriatric clinical pharmacology, long-term care and geriatric assessment clinic. Family Medicine faculty attending physician Steven Foote, DO, draws from his long-term care experience using the latest geriatric medicine electronic references and apps to assist the residents.

For decades, Michael Silvers, MD, Department of Community and Family Medicine vice chairman, has supervised the required monthly participation of family medicine resident doctors in teaching sessions with an outpatient older adults' community group at The Shepherd's Center in Lee's Summit. Family Medicine resident doctors have a required weekly Tuesday afternoon teaching session under the supervision of Miranda Huffman, MD, Department of Community and Family Medicine vice chairman for education, often featuring geriatric medicine topics. Family Medicine resident doctors also have a requirement to follow a panel of nursing home patients regularly in the Truman Medical Center Care Center over their three-year residency.

The teaching of all the learners has been facilitated by the supervision of Beth Rosemergey, DO, Family Medicine Residency program director, and immediate past Family Medicine Residency program director Todd Shaffer, MD, and by the outstanding academic support team that has included Octavia Jones, education manager; Gayle Price, medical student coordinator and current Geriatric Medicine Fellowship coordinator; and Kimberly Sixkiller, long-time Geriatric Medicine Fellowship coordinator. Over the last 26 years, over 1,000 primary care resident doctors and over 3,000 medical students have learned geriatric medicine via the Department of Community and Family Medicine.

PHYSICIAN ASSISTANT TRAINING

The School of Medicine has established a master's-level physician assistant training program. This competitive program is two and one-half years long. Each of the yearly class of 18 PA students has a required block rotation on the geriatric medicine service of the Department of Community and Family Medicine and participates in the same teaching experiences as the Geriatric Medicine Fellows and resident doctors.

MEDICAL STUDENTS

Our program participates in the teaching of geriatric medicine to UMKC medical students in several ways. Each first-year UMKC medical student has a required spring semester course that features geriatric medicine. The students meet with older adults who live in the community to gain their perspectives. The students have weekly teaching sessions about geriatric medicine topics, led by family medicine faculty including Steve Griffith, MD, and this author. The course is directed by and much of the teaching is done by Department of Community and Family Medicine faculty member Christina Crumpecker, MD.

The department also teaches geriatric medicine to fourth-year UMKC medical students during their required clerkship in family medicine at Truman Medical Center Lakewood. These students participate in a game of geriatric "Jeopardy," learning geriatric medicine and gerontology in a fun format. If a UMKC medical student has a strong interest in geriatric medicine, he or she can also serve a month-long clerkship in geriatric medicine at our department. They experience a week of geriatric medicine during their month-long family medicine elective rotation.

The Department of Community and Family Medicine also serves students from other medical schools who have an elective rotation in geriatric medicine for a month or an elective rotation in family medicine which includes a week of geriatric medicine. These students are interested in careers in family medicine and geriatric medicine. They come from as far away as Virginia, Texas and California.

The Department of Community and Family Medicine will continue to serve as a focal point in the UMKC School of Medicine for the training of physicians and physician assistants in the care of the increasingly important geriatric-age population. The care of many millions of older Americans will depend on the ability and availability of physicians in primary care and subspecialties to provide care that is appropriate for their health and age range.

Jon F. Dedon, MD, associate professor at the University of Missouri-Kansas School of Medicine, is founder and program director of the Geriatric Medicine Fellowship. He also is medical director and attending physician for the nursing home patients at Truman Medical Center Lakewood and Swope Ridge Geriatric Center, and for the UMKC Geriatric Assessment Clinic. He can be reached at dedonj@umkc.edu. For more information about the fellowship, visit http://med.umkc.edu/fm/geriatrics-fellowship/.

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REQUIREMENTS OF GERIATRIC TRAINING

Physicians training in geriatrics must meet unique requirements compared to other primary care specialties. According to the Accreditation Council for Graduate Medical Education (ACGME), each physician in a fellowship training program must have (supervised) clinical experience in the care of elderly patients, which includes management of:

- **Direct care for patients in ambulatory, community, and long-term care settings, and consultative and/or direct care in acute inpatient care settings;**
- **Care for persons who are generally healthy and require primarily preventive health care measures; and,**
- **Care for elderly patients as a consultant providing expert assessments and recommendations in the unique care needs of elderly patients.**

For further information, visit www.acgme.org

RESTORING VISION

(continued from page 19)

experience with that disease allowed relatively rapid accommodations for treatment within the country. The cholera treatment facility for our zone in Haiti was at the mission, which allowed us a significant educational experience with another disease that we previously just knew from textbooks.

Traveling back to the same area regularly for medical missions allows you to impact lives in ways that are pretty much impossible if you continuously vary your location of service. On my first trip in 2002, I met an 8-year-old boy who told me he wanted to be a doctor. Somewhat taken aback, I told him I would help him achieve that goal if that is really what he wanted to do in life. What child of that age really knows what they want to do in life? He never forgot that conversation. He completed his medical education earlier this year, passing the same National Board of Medical Examiners test that medical students take here in the U.S., and will begin his year of national service on the island this fall.

Editor's Note: *Dr. White and his wife funded the boy's medical education at Windsor University on the Caribbean island of St. Kitts.*

MEETING ADDITIONAL NEEDS

We still plan on twice-annual excursions occurring in the fall and winter of 9-10 days each. We would like to add a third team, but are limited at present by both personnel and supplies. We see upwards of 1,000 patients on a typical trip and perform over 200 surgeries. It is becoming increasingly clear over time, however, that the long-term answer for the needs such as we are trying to address is most likely to come through education and training of indigenous medical personnel who can provide continuous care. We are incorporating such teaching in our trips and plan to do even more going forward. Our vision for the future is to bring education and training to the island sufficient in magnitude and scope that our personal skills are no longer required to restore and protect vision. That said, we are still many years away from achieving that goal.

If you have ever had an interest in international medical work and have a sense of adventure, we have a place for you on one of our teams. Some of our most valuable volunteers over the years have been people with no medical experience, but who saw a need and worked to meet it. It is our hope that through increased involvement of U.S. medical teams and the development of local talent that we will someday be able to control preventable blindness in northwest Haiti.

William L. White, MD, practices ophthalmic plastic and reconstructive surgery with Associated Ophthalmologists of Kansas City. W. Abraham White, MD, is an assistant professor of ophthalmology at the University of Kansas Medical Center. To learn more about the mission, contact Dr. William White at wmlwhite1958@yahoo.com or Dr. Abe White at docabe@gmail.com. The Northwest Haiti Christian Mission website is www.nwhcm.org.

UMKC's Consortium for Aging in Community: Everything Old Is New Again!

INTERDISCIPLINARY FACULTY GROUP ENGAGES STUDENTS AND COMMUNITY MEMBERS IN EFFORTS TO ADDRESS THE NEEDS OF OLDER ADULTS

By Joan McDowd, PhD

Kansas City has a long history in the study of adult development and aging. Expanding on that tradition today is the UMKC Consortium for Aging in Community, a group of some 30 faculty members collaborating to improve the lives of older adults in the Kansas City area.

HISTORY OF AGING PROGRAMS

Interest in aging began formally in the Kansas City area in the early 1950s when the Kansas City Studies of Adult Life were initiated with support from the Carnegie Foundation and later the National Institutes of Mental Health. The goal of these studies was to understand psychological adaptations to aging as well as the role of a particular social milieu in determining how one ages. These were large-scale data collection efforts, organized out of the Institute for Community Studies which was created in part to support the project. The Institute became part of UMKC in the 1970s, with Aging Studies eventually becoming a program of the College of Arts and Sciences.

Over time, Aging Studies morphed from a program housed in the Department of Sociology to an interdisciplinary consortium of faculty from almost every unit within the university. This evolved into the Consortium for Aging in Community, founded in 2012 as a grassroots organization of faculty with research, teaching and/or service interests in aging.

Because of the nature of academic disciplines, people who study aging often operate in silos in their separate departments. However, aging is by nature an interdisciplinary phenomenon, and no single disciplinary approach can fully understand or explain it. Most people who study aging understand this, and so look around for colleagues or collaborators to enrich their work. This desire for interdisciplinary colleagues was the impetus behind the creation of our Consortium for Aging in Community.

CREATING COLLABORATIONS

The Consortium is made up of approximately 30 faculty members from the schools of Arts & Sciences, Engineering, Nursing, Law, Business, Dentistry, Pharmacy and Medicine. The goal of finding interdisciplinary colleagues is frequently met. Collaborations have joined nursing and engineering faculty to study the biomechanics of balance and falls in older adults. Psychology and engineering faculty are studying the application of Internet technology to monitoring and assessing older adults in their homes. Pharmacy and law faculty are addressing public need for health care information. These examples are a few of many illustrating the richness that interdisciplinary collaborations can bring to the study of aging.

The Consortium has also taken to heart the mission of our urban-serving university to be a good partner and neighbor to our surrounding communities. Our members have shared their expertise with community groups on topics ranging from legal issues for grandparents to Medicare and Medicaid, to providing music lessons at a senior center. Another recent collaboration involves faculty mentors along with law and real estate students working with neighborhood groups on revitalization of distressed neighborhoods—an issue that is particularly important for older adults aging in place. Issues of safety, neighborhood conditions and property values are directly related to quality of life for older adults. In addition to these larger issues, we have organized events with students and faculty such as raking leaves for seniors—a simple act that can mean so much, and build good will in the community.

INVOLVING STUDENTS

The involvement of students is motivated by our goal of exposing them to some of the realities of aging in the community. Given the current demographic realities in our society, almost any career that a student chooses will involve older adults. This is true not only for the health or helping professions—it is also true of business professions among others. Consortium faculty have gotten together to offer a general education course called "Innovation and the Aging Population." Led by faculty from UMKC's Regnier Institute for Entrepreneurship and Innovation in collaboration with additional Consor-

tium faculty, the course gives students the opportunity to learn the particular needs of people as they grow older, and then to develop a product or service that addresses these needs. Early on in the class, students interview older adults to get ideas for products or services, and then at the end of the class present their products or services to a panel of older adults for evaluation. Again, the goal of the Consortium is to prepare students to find the best ways to meet the needs of our changing population.

Another initiative newly adopted by the Consortium is the Age-Friendly University. This is an international initiative that is being taken up by universities around the country. There are 10 tenets that have been identified as describing an age-friendly university, such as encouraging the participation of older adults in a variety of university activities, promoting intergenerational learning, to engage the university's own retired community, to partner with organizations representing older adults, and to increase access to educational opportunities for older adults. We are undertaking a review of our current activities to see how we are already addressing these tenets, and we are thinking creatively about how to develop programs to go further in achieving them. Our goal with this initiative is twofold: the first is for the university to be a good citizen in our community, and the second is to involve more people in the life of the university—to enrich the experience for both young and old.

In sum, the activities of UMKC's Consortium for Aging in Community are designed to engage faculty colleagues, students and community members in creative endeavors to meet the needs of people growing older. Perhaps the essential nature of the Consortium is captured by a series of social events we host called "Random Collisions." Consortium faculty invite collaborators from outside the Consortium, community partners with whom they collaborate or would like to collaborate, or anyone else with interests relevant to aging, to a social hour where any number of ideas and partnerships might develop. The common interest in aging brings people together, conversations tend to be wide-ranging, and the resulting synergy often stimulates new partnerships and projects. Sound interesting? Contact us and we'll invite you to the next one!

Joan McDowd, PhD, is professor of psychology and director of the UMKC Consortium for Aging in Community at the University of Missouri-Kansas City. She can be reached at 816-235-2490 or mcdowdj@umkc.edu.

Earns Joint Commission Certification for Hip and Knee Replacement

Truman Medical Center (TMC) Lakewood has earned The Joint Commission's Gold Seal of Approval for its hip and knee joint replacement programs by demonstrating compliance with The Joint Commission's national standards for health care quality and safety in disease-specific care.

"With TMC Lakewood earning Joint Commission certification, the first in the Kansas City area for hip and knee joint replacement, it shows the significant investment in quality and excellence of care our orthopaedics program makes," said TMC orthopaedic surgeon Tom McCormack, MD.

To achieve this certification, TMC Lakewood underwent a rigorous on-site review in June 2017. A Joint Commission expert evaluated these programs for compliance with standards of care specific to the needs of patients and families, including infection prevention and control, leadership and medication management.

JOINT REPLACEMENTS HELP CONTINUE ACTIVE LIVES

More and more people in their 70s and 80s are leading active lives with the help of hip and knee replacements.

About seven million Americans are living with a hip or knee replacement, and retain mobility despite advanced arthritis, according to a study published in 2015 in *The Journal of Bone and Joint Surgery.* An estimated 4% of people ages 70-79 are living with a total hip replacement, and 8.8% with a total knee replacement in that age group, the study found. The prevalence of hip and knee replacements approximately doubled in each age group 50 and over between 1990 and 2010, according to their data.

More than one million total hip and total knee replacement procedures are performed each year in the United States. With the aging of the "baby boomers," higher rates of diagnosis and treatment of advanced arthritis, and growing demand for improved mobility and quality of life, the number of procedures is expected to grow.

KU Alzheimer's Disease Center Prepares Region for the Rising Tide of Alzheimer's Disease

NATIONALLY RECOGNIZED CENTER PROVIDES RESEARCH, TRAINS PHYSICIANS AND SCIENTISTS AND DEVELOPS INNOVATIVE MODELS OF CARE

By Jeffrey Burns, MD, MS

Since receiving designation from the National Institute of Aging (NIA) in 2011 as one of the country's 31 Alzheimer's centers, the KU Alzheimer's Disease Center has made tremendous strides in preparing the region for the rising prevalence of Alzheimer's disease. Our vision for the KU ADC is to impact the lives of every patient and family dealing with Alzheimer's in the region through our research, education and clinical care. This takes key investments in the backbone of both our research and medical care delivery enterprise to transform the region to be "dementia-capable" and "research-ready."

WHERE ARE WE NOW?

Currently in the fight against Alzheimer's disease, our tools are limited but it is important to stress two points:

- Doctors can make an accurate and early diagnosis in life.
- We have proven medications that help slow the decline.

Thus, we can think of Alzheimer's as a treatable condition right now. At the same time, however, we must strive to improve our limited diagnosis and treatment options. Even the most specialized centers misdiagnose 15 to 20 percent of patients whose cognitive decline is related to conditions that mimic Alzheimer's. Moreover, our current treatments do not yet stop, reverse or cure the disease. The best effect of the currently available drugs is to only partially slow the inevitable cognitive decline that occurs with the disease.

WHERE ARE WE HEADED?

The KU ADC is hard at work to better diagnose the disease and develop a cure. We believe the day will come when doctors will recognize the disease years before the onset of its earliest symptoms and in time to start new drugs that will stop, reverse, or cure the disease before it starts. We believe it is no longer a matter of if we will be able to do this, but it is a matter of when.

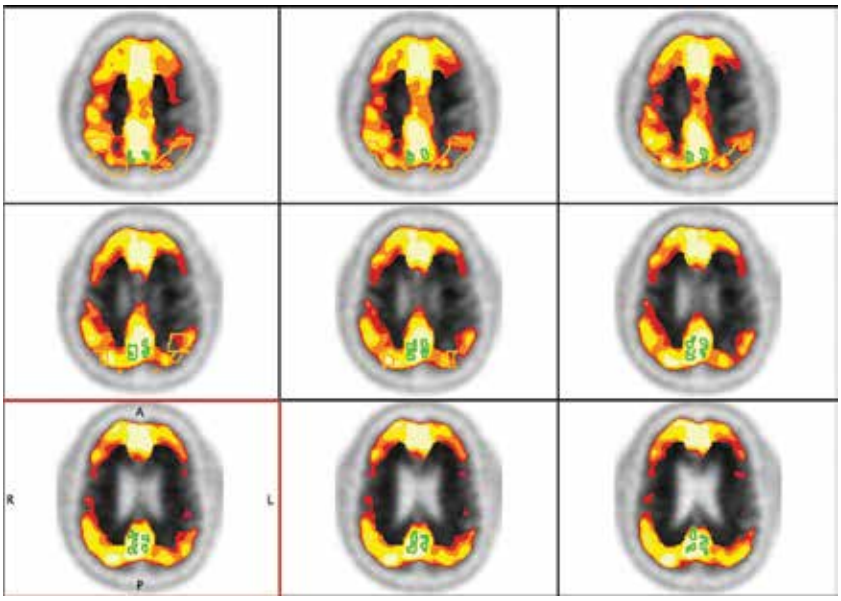
Why do we believe this? Rapid advances in PET scanning now allow us to see microscopic changes linked with Alzheimer's disease—amyloid plaques and neurofibrillary tangles. Before this, we could only see these changes by examining the brain under the microscope after someone had died. This new technology works using FDA-approved tracers that are injected into the bloodstream, cross the blood brain barrier, and bind to their target, the amyloid plaque. PET scanners detect the tracer's radioactivity, allowing us to measure the presence, location and burden of amyloid. A similar technique to detect neurofibrillary tangles is now widely used in the research arena, including at the KU ADC.

Amyloid PET scanning is available in the clinic, though its wide use is deterred primarily by expense and lack of reimbursement coverage. Without clear evidence that using these scans provides benefits to patient care beyond a routine clinical interaction, the use of these scans will remain limited. To determine whether it should foot the bill, Medicare recently completed enrollment of 18,000 patients around the country, including here in Kansas City, into a study testing whether amyloid PET scanning benefits clinician decision making and patient outcomes. Early results from that study (called the IDEAS study) should be available in 2018.

This entirely new vision into the brain is likely to have broad implications in the future fight against Alzheimer's. First, our ability to more accurately diagnose the disease should improve as amyloid PET scans are incorporated into the routine diagnostic algorithm. Second, these imaging techniques may play a role in choosing specific therapies targeting these molecular pathologies for individual patients in the future as we enter an era of more personalized medicine.

DRUG DEVELOPMENT EFFORTS

The KU ADC is at the forefront of clinical trials, currently running over 25 clinical trials testing a variety of approaches to stop or slow the disease. As one of 35 national sites selected to be part of the NIA's Alzheimer's Clinical Trial Consortium, we bring the most



(Left) A patient undergoes testing with an exercise research coordinator.
(Above) Nine brain scan images show amyloid plaques.

innovative and cutting edge trial opportunities to Kansas City. For example, we are testing approaches that target amyloid through the immune system (anti-amyloid antibody infusions), enzyme inhibitors that block the creation of amyloid, and a combination of these two approaches to potently reduce amyloid in the brain. We are also testing new approaches that may stop the spread of tangles via anti-tau antibody infusions. And, we are most proud of our own drug development efforts testing the metabolic hypothesis that increasing metabolism of brain and body cells could have an impact on Alzheimer's disease.

We have made key investments in our clinical trial infrastructure to speed the time it takes to achieve a cure. We have partnered with the Global Alzheimer's Platform to deploy innovative recruitment tools to address the single biggest slowdown of finding volunteers to participate in our trials. Our centralized recruitment team now triages patients and participants more quickly into trials of interest. Additionally, we seek to provide value to participants through a growing educational program for caregivers and those interested in the latest on prevention. Our goal is for everyone to benefit from our program, regardless of their eligibility for a trial. Our efforts are paying off. Our enrollment into studies has increased nearly five times from a year ago, and the time it takes to enroll someone into a trial has decreased by 50 percent. Our approach is recognized nationally as a model to be imitated.

NEW FIELD OF PREVENTION SCIENCE

These advances in drug development and molecular imaging have led to the emergence of an entirely new field of prevention science. We have known for some time that amyloid plaques are present up to 10 to 15 years before changes in memory can be detected. A remarkable one out of three healthy older adults without signs of cognitive decline have the presence of amyloid buildup in the brain, suggesting they are at higher risk of ultimately developing the disease (importantly, however, not all will). We have ongoing studies testing various approaches—from study drugs to physical exercise—to reduce the long-term risk in these higher-risk individuals. Though it is still early, we are well on the way to testing whether these approaches may one day prevent the disease.

We have also created an Alzheimer's prevention program called LEAP! (Lifestyle Empowerment for Alzheimer's Prevention). LEAP! provides exercise and nutrition strategies that empower people struggling with AD risk factors to reduce their risk for AD through healthy eating, exercise, cognitive engagement and better management of sleep and stress. We have offered our LEAP! Foundations course at seven retirement communities and reached over 250 individuals. We also have a rural program that has delivered 25 events across Kansas and Missouri. Not only are we spreading information on the latest in AD prevention, we are building collaborations and bridges to benefit more and more people through both states. The ultimate validation of this program came

earlier this year in the form of a five-year grant from the NIA to test the LEAP! approach through the Kansas City YMCA network. In this study, we are providing physicians who are struggling to leverage lifestyle, diet and exercise with a tool for their at-risk patients that reduces their chance for AD.

Russell Swerdlow, MD, center director, and Jeffrey Burns, MD, center co-director.

DEVELOPING INNOVATIVE MODELS OF CARE: MYALLIANCE FOR COGNITIVE HEALTH

Nationally and here in Kansas City, the field is struggling to provide optimal care to the growing population of people affected by Alzheimer's. That is why we are launching MyAlliance for Cognitive Health (MyAlliance), an effort designed to extend the reach of our care to every patient in the Kansas City region.

MyAlliance will use proven educational programs to train primary care providers with the skills and tools for optimal diagnosis and treatment. MyAlliance will also provide direct support to primary care providers by streamlining access to social services through a navigator program. And, we are developing a new collaborative care clinic. This model will deploy dedicated nurse practitioners and social workers to co-manage patients alongside primary care physicians in the community who are struggling to deliver the needed care and counseling. Although, we continue to grow our highly specialized memory clinic with additional neurologists, we do not believe the answer to the rising tide of Alzheimer patients is to simply expand the number and size of specialized clinics. MyAlliance represents an innovative model for extending our reach to more efficiently distribute the most appropriate levels of care to the right patients.

This early effort to align physicians in the Kansas City region has started successfully. We have 20 physicians who are part of our alliance and they have referred over 100 patients to our research program. In 2018, our alliance clinicians will have an exciting research opportunity to test an innovative cognitive screening program with research referral to the KU ADC (as opposed to clinic referral) in collaboration with the Global Alzheimer's Platform. We believe that a public health crisis of this magnitude requires a unified community approach that aligns all the key stakeholders, with primary care physicians being at the forefront.

TRAINING THE NEXT GENERATION OF SCIENTISTS AND CLINICIANS

Lastly, more experts dedicated to fighting this disease are needed to truly transform the Kansas City region. Our training programs are successfully launching young physicians and scientists into the fight. Our first physician trainee, Megan Baumgardner, DO, joined our practice full time in July. In the last year, three of our young scientists received prestigious career development awards from the National Institutes of Health, with two more expected in 2018. Other young scientists are on the verge of winning career-defining grants that would not have been possible without the KU ADC.

Thanks to the support of the Kansas City community, we are speeding the pace of discovery and shortening the path to a cure by improving the way clinical trials are conducted, training the next generation of Alzheimer's researchers, and developing innovative ways to deliver better patient care. With continued community support, we can continue to be a model for the country in how to fight this disease.

Jeffrey Burns, MD, MS, is the Edward H. Hashinger Professor of Neurology at the University of Kansas Medical Center. He is co-director of the KU Alzheimer's Disease Center and also directs the Frontiers Clinical and Translational Science Unit and the Alzheimer and Memory Clinic. He can be reached at jburns2@kumc.edu.

In an Aging World, the American Cancer Society Is Ever Relevant

FROM AN ARRAY OF PSYCHOSOCIAL PROGRAMS, TO INFORMATION AND ASSISTANCE, TO ACCESS AND FINANACIAL SUPPORTS, THE ACS IS A CONSTANT PARTNER TO THOSE DEALING WITH CANCER, A MAJORITY OF WHOM ARE OLDER ADULTS

By Kelli Wright, MA

With its 105-year history, the American Cancer Society (ACS) is a granddaddy of an institution in the world of health-related nonprofits. Not surprisingly, the ACS enjoys a 96 percent recognition rate among the general public. Given its history and reputation, what is surprising is how often I get asked what the ACS does.

As an ACS health systems manager for the state of Missouri, I interface with a wide variety of health professionals and agencies as well as community members. Most people know that the ACS both conducts and funds important cancer research, and many are familiar with the crucial advocacy the ACS does through its extensive Cancer Action Network. But, the ACS does much more. From an array of psychosocial support programs, to information and assistance, to access and financial supports, the ACS is a constant partner for those dealing with cancer and its aftermath as well as for the families and caregivers of those affected by cancer.

Having come to the ACS from a career in aging spanning over 15 years, I am acutely aware of the relevance of ACS programs and initiatives to our aging world. To be sure, the ACS serves the interests of anyone dealing with cancer, from the youngest of children to the oldest among us. Yet when we consider that 87 percent of cancer diagnoses happen in people over the age of 50,[1] coupled with the fact that the population of people over 60 has tripled since 1950[2]—and the population of people 65 and older is expected to double between 2025 and 20503—we see the relevance of the ACS to our aging communities.

"Unmet needs" is an issue that comes up time and again for an aging population. Access is key among these needs and covers a lot of territory: access to information and referral and access to psychosocial supports are typical in the "unmet needs" category as are transportation and financial assistance. The ACS responds to these needs. Following are some of the ways the ACS helps.

ACCESS TO INFORMATION AND REFERRAL

Since 1997, the ACS has offered easy-to-access information and referral services to cancer patients, caregivers and health care workers through its National Cancer Information Center (NCIC). The NCIC is staffed with specially-trained cancer navigators who empower patients and caregivers to participate in decision making, communicate with their treatment teams, and cope with myriad issues that arise along the cancer journey. They are available 24 hours a day, seven days a week.

Through a vast database of national, statewide and local resources, NCIC navigators can provide cancer patients with the latest information on their cancer type and current treatments; coordinate patient rides to and from treatment appointments; arrange lodging for patients who must pursue treatment away from home; and connect them to programs that help manage the appearance-related side effects of cancer as well as programs that offer emotional support.

The NCIC also offers assistance in matching cancer patients to the most appropriate cancer clinical trials for the patient's medical and personal situation. In addition, they can also help identify and remove barriers to participating in those trials. Oncology nurses also support NCIC navigators by assisting with more medically complex questions. In doing so, they provide information that can lead to better outcomes for patients. Patients, caregivers and health care workers have unlimited access to the NCIC by calling 1-800-227-2345, or through online chat at cancer.org.

PSYCHOSOCIAL SUPPORTS

Having moments of feeling vulnerable, isolated or disheartened is not unusual for people dealing with cancer. Yet, maintaining a positive sense of self and connection to community is essential for them to effectively face their challenges and move toward their future. The ACS seeks to encourage people in their journey by empowering them to find the inspiration and comfort they need.

Following are a couple of ACS programs that do just that. For more information on these programs, or to schedule a workshop or appointment, contact the ACS NCIC.

LOOK GOOD FEEL BETTER®

For women and men dealing with appearance-related side-effects of cancer treatment, the ACS offers the Look Good Feel Better program (LGFB).

The LGFB group workshop is a two-hour, hands-on workshop run by volunteer cosmetology professionals. It includes demonstration of a 12-step skin care and makeup program, along with instruction on options relating to hair loss and nail care. It also offers helpful suggestions on clothing as well as ways to camouflage areas of concern during cancer treatment. All cosmetology volunteers attend a four-hour certification class to become a LGFB volunteer.

For those who cannot attend a workshop, a free, one-time, individual consultation may be available in the patient's area. The LGFB program also offers at-home materials for patients who prefer to learn on their own. The at-home materials are available for free by calling 1-800-395-LOOK (5665). An at-home video can also be found at lookgoodfeelbetter.org. Materials specifically for men can be found at lookgoodfeelbetterformen.org.

REACH TO RECOVERY®

For more than 45 years, the American Cancer Society's Reach To Recovery program has been helping people cope with their breast cancer experience. Through face-to-face visits or by phone, Reach To Recovery volunteers provide support to individuals at all stages of their journey; from those who are facing a possible breast cancer diagnosis to those with advanced-stage breast cancer.

Volunteers are trained to give support and up-to-date information, including literature for spouses or partners, children, friends and other loved ones. Volunteers can also review American Cancer Society resources that may be able to help with a patient's experience, concerns and questions.

TRANSPORTATION AND FINANCIAL ASSISTANCE

Transportation is a huge access issue for older adults. Many may no longer be able to drive or maintain a car. Often, the realities of a fixed income further limit access to transportation as well as to other important needs. The ACS seeks to lessen these limitations through some special programs.

ROAD TO RECOVERY®

Every day thousands of cancer patients need a ride to treatment or a follow-up appointment. Yet, some may not have a way to get there, and may lack the funds for taxi services. The ACS Road To Recovery program provides transportation to and from treatment for people who otherwise do not have it. Depending on the patient's needs and what is available in a particular area, the ACS will coordinate a ride with a specially trained ACS volunteer or with a local organization that partners with us to provide transportation, and can also provide referrals to local transportation resources.

HOPE LODGE®

For patients who must travel away from home for treatment, the ACS offers lodging programs, including the Hope Lodge. Hope Lodge provides a nurturing, home-like environment where guests can retreat to private rooms or connect with others. Free to patients and their caregivers, Hope Lodge helps lessen the financial and emotional burden during an already challenging time. Currently, there are more than 30 Hope Lodge locations throughout the United States and Puerto Rico—one of which is in Kansas City.

Patients and caregivers who need lodging in areas that do not have a Hope Lodge can contact the ACS about hotel lodging. The ACS has partnered with hotels across the country to provide free and reduced-rate overnight stays for those who must travel for outpatient treatment.

Meeting the needs of cancer patients and their caregivers, family members and health care providers is the chief priority in serving the American Cancer Society's mission to save lives, celebrate lives, and lead the fight for a world without cancer. To do so, the ACS strives to be pertinent and accessible to anyone dealing with cancer by making sure that all our initiatives, programs and services reflect the real world we live in. Our focus on responding to unmet needs found in our communities—those often experienced by older adults, a rapidly growing constituency—makes us ever relevant in an aging world.

Kelli Wright, MA, is health systems manager for Missouri for the American Cancer Society. She can be reached at 816-218-7271, email kelli.wright@cancer.org.

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Hanging Up the Scalpel: Knowing When to Say "When"

"In 2001, during an acute flare-up of my back and after finishing eight hours of pain-wracked, but complication-free surgery, I decided to end my surgical career."

By John C. Hagan III, MD, FACS

Reprinted with permission from Missouri Medicine, January-February 2007

In the early epoch of human development, mankind learned to shape and sharpen wood, stone and metal objects to facilitate plunging them deep into other humans' chests, abdomens, skulls and eyes in the ultimate form of conflict resolution.

Over tens of thousands of years, other less pugilistic and more compassionate humans crudely—but later artfully—insinuated an increasingly sophisticated array of implements into the human corpus to cure diseases, repair injuries, beautify the body and deliver newborns. At some glorious moment, the cut-upon (or their clan/kin) began to pay the cutters for their skills and services with salt, fur, livestock, foodstuffs or other valuable "in kind" thingamajigs.*

In recent times, due to the inexorable force of etymological evolution, the cutters are now called "surgeons" and their craft "surgery." (It is alleged that trial lawyers refer to the former as "targets of opportunity" and the latter as "where to look for the next payment on the yacht.")

As lucre in its various iterations became the coin of the realm, it became more practical to pay the surgeon with money rather than, say ... beaver pelts. This begot "fee for service" and inaugurated the figurative and literal golden age of surgery. How surgery devolved into a less than golden age under assault by insurance companies, HMOs, Medicare, Medicaid, hospitals, the federal and state governments, surgeon pretenders and the plaintiff's bar is in the purview of common knowledge.

This highly truncated presentation summarizes how "assault with a deadly weapon" slowly but benevolently morphed into the demanding and noble profession of surgery.

Not every physician is cut out (pardon the obvious pun) to be a surgeon. The ideal surgical persona is a unique conflation of intelligence, manual dexterity, self-confidence, good judgment and the stamina of a draft horse. In recent years the distinction between surgeon and non-surgeon has blurred as interventional techniques have developed in radiology, cardiology, gastroenterology and other specialties. This editorial addresses all physicians doing invasive procedures.

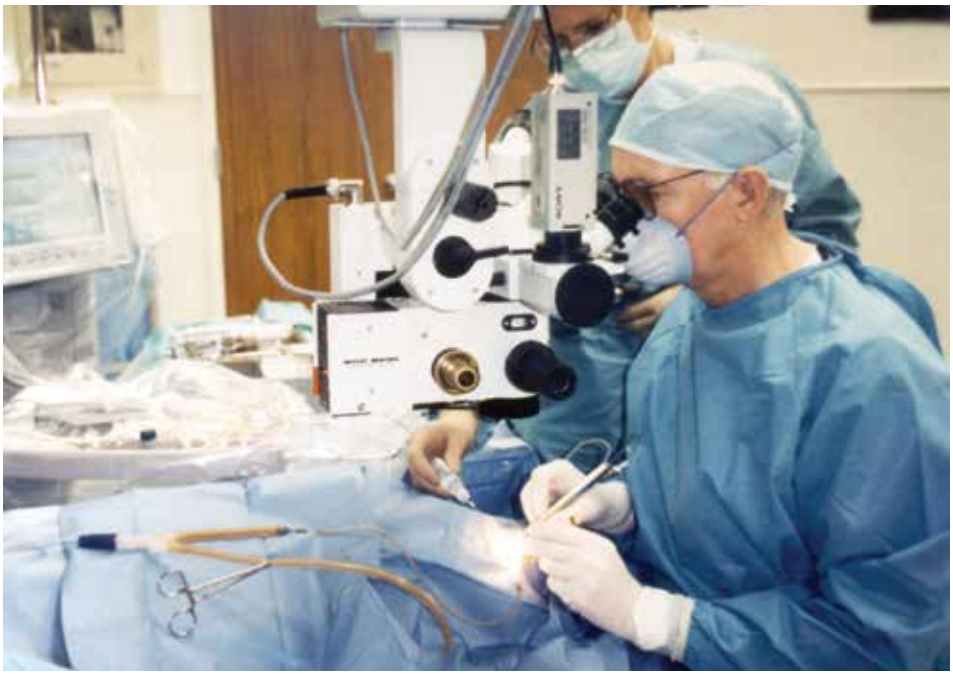
As a third-year medical student, I was uncertainly weaving back and forth on the road to a medical or surgical specialty. I veered into the surgical lane and a satisfying career in ophthalmic surgery.[1]

This brings me to the crux of this discourse. The two most difficult decisions I've had to make in my professional career have been: Do I want to do surgery? And 11,000 surgeries and 30 years later—Do I need to stop doing surgery?

I did not suddenly ask myself this latter question as I approached my 60th birthday. Every surgeon should inventory and evaluate their surgical skills from the first day of their internship. Some surgical residents realize early on that they are not suited to the operating room and transfer to a medical specialty. It is estimated that between 10% and 20% of surgery residents struggle with achieving surgical competency.[2,3] How program directors deal with this issue has been discussed in detail.[3] This has become ever more germane as some surgical boards have required residency programs to certify their graduates' surgical competency.[3]

After satisfactorily finishing a residency or fellowship, a newly minted surgeon will find that their practice situation will afford the opportunity of doing some procedures frequently and others infrequently. For example, due to geographic circumstances and the complexities of the referral process, a surgeon may do a great deal of trauma or major cancer surgery or these cases may be few and far between.

Early in my career, I determined that I would refer retinal detachments, corneal transplants and major oculo-plastic surgery. I believe some intricate surgery should best be done by ophthalmologists with formal fellowships and a surgery specific referral practice. The parallels to all surgical fields are obvious. Practicing surgeons must constantly reassess their



surgical skills, the number of cases that must be done and new techniques mastered to maintain procedure specific proficiency. Also, if they should do highly complex types of surgery, learn difficult new techniques or determine whether the patients' interests are best served by referral. One's ego and income must be disregarded in this assessment.

In medicine's version of Moore's Law, the standard of surgical care is constantly changing as new skills, techniques and procedures must be mastered at an ever-accelerating pace. The process of change and how surgeons react in their practices has been extensively studied. At the vanguard of surgery are the "innovators" that develop and proselytize new forms of surgery. Close behind them are the "early adopters" that adjust relatively easily and quickly to surgical innovation. As the benefits and superiority of new surgery are recognized, first the "early majority" then the "late majority" of surgeons make the transition. At the caboose of this process are the "laggards."

These laggard surgeons may fail to recognize the superiority of new surgery over the old surgery that they feel comfortable performing. Or they may lack the dexterity or temperament to keep up with their peers. This is especially painful and prevalent when a sea-change development threatens to obsolete much of the laggards' surgical repertoire.

There are many other ongoing threats to remaining a competent surgeon. Abuse of drugs and/or alcohol is often a cause of incompetency. A chaotic personal life or untreated mental illness may be the culprit. Acute or chronic health problems, aging and senescence are problems all surgeons must eventually confront.[4] In one study, general surgeons retired at an average age of 63 and disability was the primary factor in 14%.[5] A steadily increasing morbidity, mortality and complication rate may be harbingers of erosion of competency.

The surgeon may fail to recognize his or her problems or intentionally try to keep the problems sub rosa. In many instances, for hospital-based surgeons, staff quality and safety committees will identify the problem surgeon and, through a variety of rehabilitation pathways, correct the situation.

In other instances, the problem will be apparent first to the surgeon's associates, colleagues, or family. With the safety of patients at stake, we must not cast a blind eye to our fellow surgeon's problems. A "conspiracy of silence" exists only in the pejorative lexicon of the malpractice lawyer. Much reporting of impaired or incompetent surgeons is by fellow physicians.

The Missouri State Medical Association has a nationally known program for dealing with impaired physicians, the Missouri Physicians Health Program. I personally initiated an intervention on a colleague I found to be abusing drugs and alcohol. When intervention was resisted by two other incompetent surgeons, I reported them to the Missouri Board of Registration for the Healing Arts. One was surgically incompetent due to advanced age and the other was a middle-aged clumsy, unskilled bungler. Both "retired" after the board completed their investigations.

Surgeons that operate using microscopes have an increased incidence of musculo-skeletal disorders as they age.[6,7] Over the past decade, I developed a burgeoning amalgam of these afflictions including osteoarthritis of the knees and hips, degenerative back disease, torn shoulder rotator cuff and tendonitis of the hands and elbows. Performing surgery became excruciatingly painful and prevented me from incorporating new techniques like temporal corneal incision into my practice. In 2001, during an acute flare-up of my back and after finishing eight hours of pain-wracked but complication-free surgery, I decided to end my

surgical career due to disability. I merged my practice into a large, top-quality ophthalmology group, refer my surgical patients to our younger surgeons and do only office surgery, laser and medical ophthalmology. I have never regretted or second-guessed my surgery-ending decision.

With regard to age, some of the finest surgeons in Missouri and the United States are in their mid or late 60s, some even in their 70s or 80s. Michael DeBakey, MD, arguably the most renowned surgeon of the late 20th century, retired from cardiac surgery voluntarily at age 90, having done over 60,000 operations. At 96, he was deeply involved in research and surgical education. Dr. DeBakey died in 2008 just two months short of age 100. Conversely, there are incompetent and impaired surgeons in their 20s and 30s.

There is age discrimination and it must be avoided. Perhaps surgeons should be impartially assessed at age 70 and regularly thereafter. Or maybe the age issue should be enfolded into the broader issue of periodic re-certification and re-assessment of surgical skills. This is evolving as a leading frontier of medical education.

As for me, I'm happy and proud that I stopped picking up the scalpel before I started cutting myself doing so.

*** Archaeologists in Saqqara, Egypt recently unearthed the mummified remains of a doctor named "Qar" that practiced more than 4,000 years ago. Included in his sarcophagus were numerous bronze surgical instruments, a round limestone tablet (accounts receivable?) and 22 bronze statues (401-K account?). (*Kansas City Star,* Dec. 7, 2006, as reported by Associated Press)**

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Presents on Near-Death Experiences to Audience in Santa Barbara, Calif.

John C. Hagan III, MD, FACS, FAAO, discussed the topic, "Tunnel Vision: The Common Medical Syndrome of Near-Death Experiences" before a standing-room audience of physicians at Santa Barbara, Calif., Cottage Hospital. Pictured with Dr. Hagan, left, is Stephen Hosea, MD, chief of medical education and head of infectious diseases at the hospital. Also while in Santa Barbara, Dr. Hagan addressed the Santa Barbara International Association for Near-Death Studies. The lecture was based on his book *The Science of Near-Death Experiences,* and has been presented previously at the Kansas City University of Medicine and Biosciences, North Kansas City Hospital and Audrain County Medical Center. Profits from book sales are being donated to the Missouri State Medical Association.

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