LOUISVILLE MEDICINE
GREATER LOUISVILLE MEDICAL SOCIETY
1892
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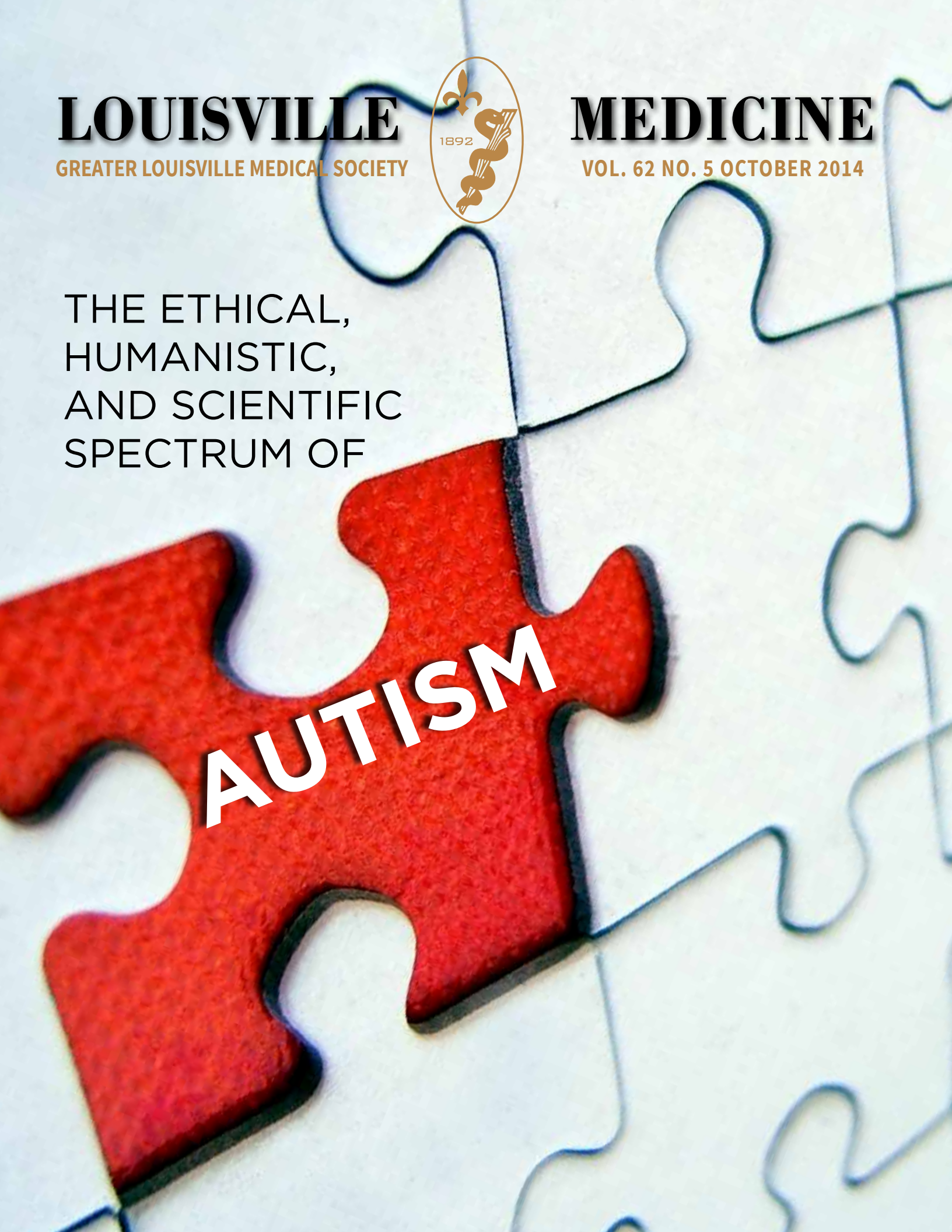

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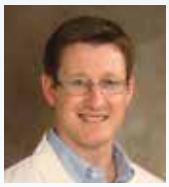

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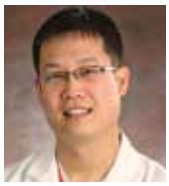

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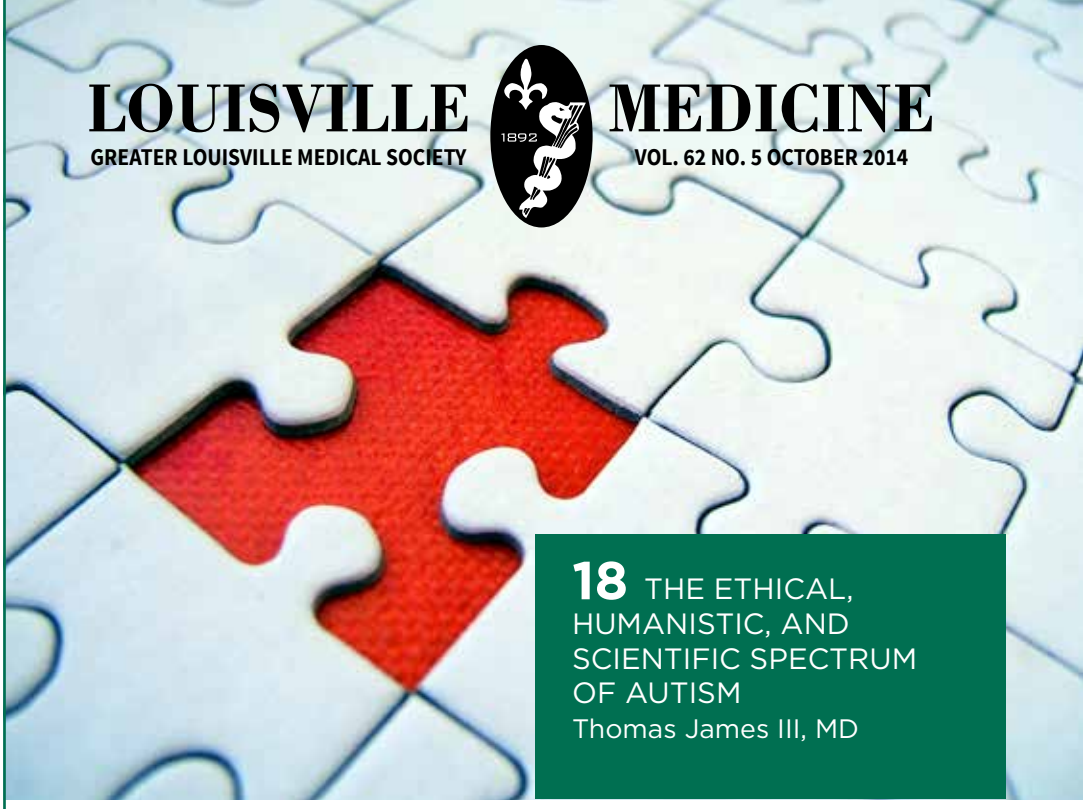

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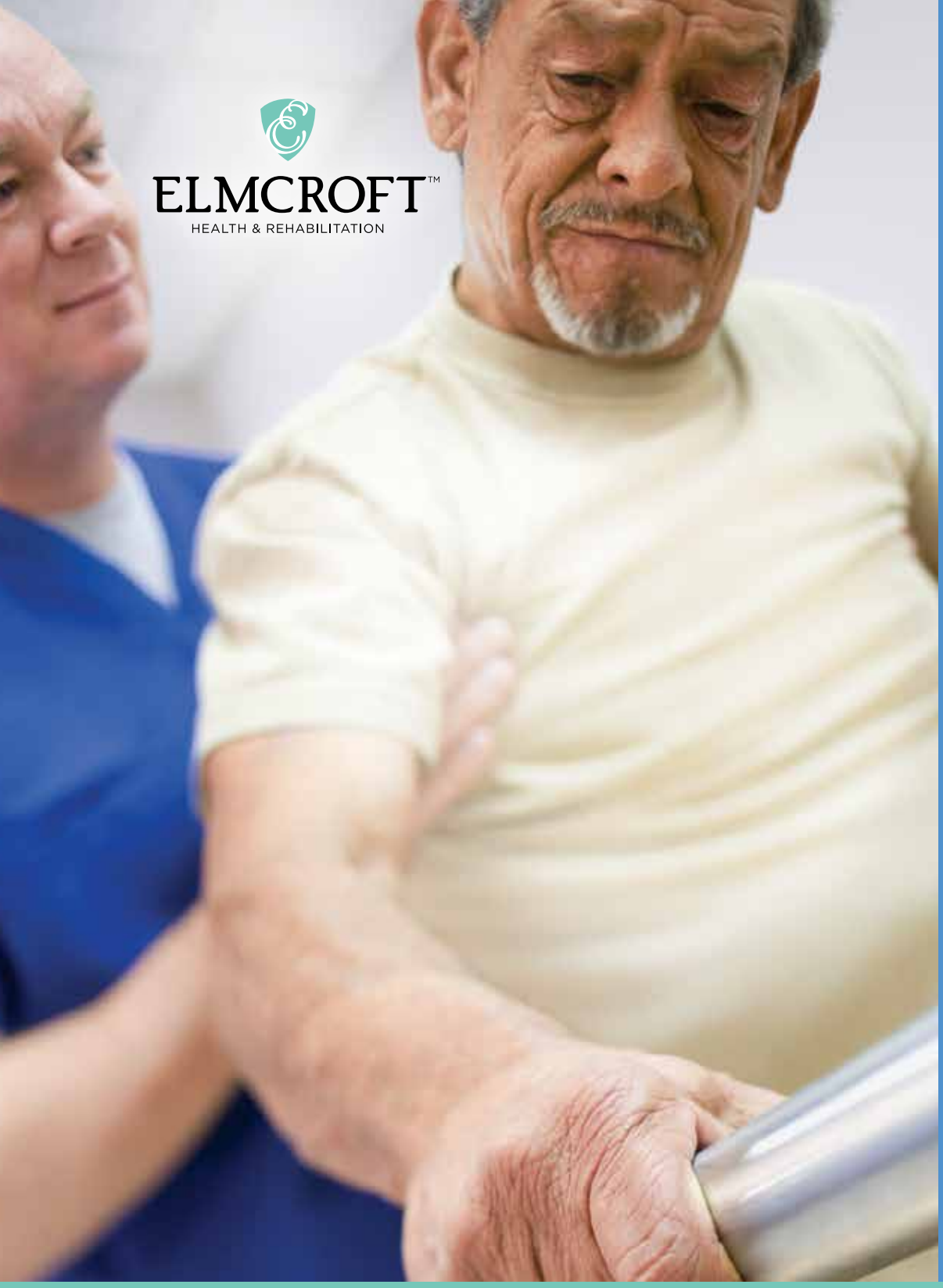

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From the President

BRUCE A. SCOTT, MD
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FOCUS ON THE PATIENT NOT THE COMPUTER

A few years ago, a long-practicing general surgeon told me he had decided to retire. I inquired as to the motivation behind his decision, that although reasonable given his chronological age seemed premature given his continued vitality, mental capacity and surgical skills. He told me that he had examined thousands of patients with inguinal hernias over his years in practice, and that by reviewing his notes he would clearly have an image of a given patient and their condition. When a patient returned years later or if he was ever asked in a court of law he could confidently recall the details of his care. He went on to tell me that his practice, acquired by a hospital system, had implemented an Electronic Health Record (EHR) system, and that now he had four choices to select from to describe an inguinal hernia. Finding this unacceptable he typed detailed descriptions rather than succumb to the temptation of the template, but his productivity suffered and he wasn't meeting the "quota." Rather than compromise the care he provided and potentially the reputation he had built over the years, he elected to retire.

A recent study by the RAND Corporation, sponsored by the American Medical Association, reviewed factors affecting physician satisfaction. The author, Mark Friedberg, MD, noted, "Physicians described feeling stressed and unhappy when they see barriers preventing them from providing quality care." In the study, physicians complained that EHRs require physicians to spend too much time doing clerical work, time that could be better spent caring for patients. There is no question that data entry is an inefficient use of physician time and yet this is exactly what we are increasingly forced to do. The study found EHR systems were a major driver of physician frustration and dissatisfaction.

Beyond inefficiency and physician unhappiness the study had even more concerning findings. We know that high quality physician documentation is critical to patient care, and it was thought that electronic documentation would result in more thorough clinical documentation. Contrary to this goal, the RAND study found that physicians were convinced there was degradation of meaningful clinical documentation because of EHR. How often have you seen multiple pages of electronic cut and paste garbage that adds nothing to patient care? Physicians are trained as independent thinkers who believe every patient is unique, but templates and "drop down box choices" can make every patient look alike. Potentially even worse, the prepopulated template is automated to the point that I fear we are sometimes not aware of the misinformation that is perpetuated. In addition, it was thought that electronic records would facilitate research to improve care protocols and outcomes. Sure it will be easier to search the record database, but how meaningful are the results if the records are not accurate? As one physician recently told me, "I type the shortest note possible and then click the boxes." He concluded, "There is nothing about any of this that improves patient care; it's all so the payers, lawyers and administrators can monitor and critique us."

Perhaps most concerning, the RAND study found that physicians felt the EHR interfered with face-to-face interactions, creating a barrier, and potentially harming the patient-physician relationship. There are a variety of suggested methods for physicians to hopefully reduce this obstacle, but the concern remains. I have heard it said that in the past when you wanted to find a nurse you went into the patient's room; now you look behind the computer. Unfortunately, I fear the same fate may befall physicians. In this day of time-challenged physicians driven to produce more RVUs, is time looking at the computer time taken away from looking at the patient?

Several months after implementing an EHR system in our six physician group, we identified many of the same concerns noted in the RAND study. Our response was to hire and train "scribes" to input clinical documentation into the computer, returning our physicians to the practice of medicine. Although we did not do any true accounting or scientific study, four years later we continue to believe that the increased labor expense out of our pocket is offset by improved physician efficiency, continued patient satisfaction, maintained quality of our clinical documentation and enhanced physician happiness.

Leading hospitals and physician groups around the nation are reaching the same conclusion and are using scribes or other innovative methods to overcome the discovered negatives of EHR. Locally, however the hospitals mandate that physicians do the data entry. We have all experienced the computer entry taking longer than the surgery or the patient encounter. Perhaps at some time in the future one or more local hospitals will decide that physicians' time is better spent caring for patients rather than replacing the transcriptionist. As health care continues to evolve we, the physicians, need be the ones to demand that the focus remains on the patient.

Reference: RAND. "Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy." Mark Friedberg, et al. 2013.

Dr. Scott, board certified in Otolaryngology-Head & Neck Surgery, is the president of Kentuckiana Ear, Nose, and Throat, PSC.

LOUISVILLE'S START THE HEART PLANS FOR THE FUTURE

Aaron Burch

The Greater Louisville Medical Society Foundation welcomed the Start the Heart Foundation's William C. Dillon, MD, to The Old Medical School Building on Thursday, Aug. 14 for an informational seminar and compression-only CPR demonstration. Dr. Dillon, an interventional cardiologist with the Baptist Medical Associates - Louisville Cardiology Group, founded the Start the Heart Foundation to educate Louisville community members about the dangers of cardiac arrest and the simple ways in which an ordinary person can save a life.

In 2013, eight Louisville residents died from fires and fifty-one died in homicides, but a staggering 750 people suffered from cardiac arrests and 90 percent lost their lives.

"You hear almost nothing about this. Cardiac arrest doesn't discriminate. It will kill anyone, anywhere at any time," said Dr. Dillon. He pointed to particularly troubling statistics for the city of Louisville, which has one of the lowest cardiac arrest survival rates in the country, behind only four other major metropolitan areas: Detroit, Chicago, New York City and Los Angeles.

"In our community, only about 20 percent of residents receive bystander CPR training. In Seattle, for example, 70 percent receive BCPR training and the city has a 50 percent cardiac arrest survival rate," said Dr. Dillon (Louisville's ranges from six to fourteen percent).

With these statistics in mind, Dr. Dillon began the Start the Heart Foundation with the goal of drastically increasing compression-only CPR knowledge in Louisville. "We can't save everyone, but we can be doing a lot better than we are right now," he said. The goal of the foundation this year is to improve cardiac survival rates by teaching CPR to every ninth grade student in Jefferson County. There are 10,000 ninth graders in Louisville across 32 schools, so Dr. Dillon has a big job in front of him. However, he's not working alone.

Joining the Start the Heart Foundation are three high school interns who assist Dr. Dillon in teaching each session. The students received professional CPR training from Louisville Metro EMS CEO Neal Richmond and the CPR Center's Janice Morgan. Over the summer, the group taught approximately 1,700 community residents. "We tried to start small. We knew we'd have a lot to learn, we'd make some mistakes," said Dr. Dillon.

With the first steps taken, Start the Heart is ready to expand going into the 2014-2015 school year. New interns will be joining with the start of a new school year. But the task before them can still appear daunting. To assist with this project, Start the Heart Foundation is looking for a few retired physicians who are willing to dedicate time to become compression-only CPR facilitators.

Any physicians interested may find more information at www.startheheartfoundation.org.

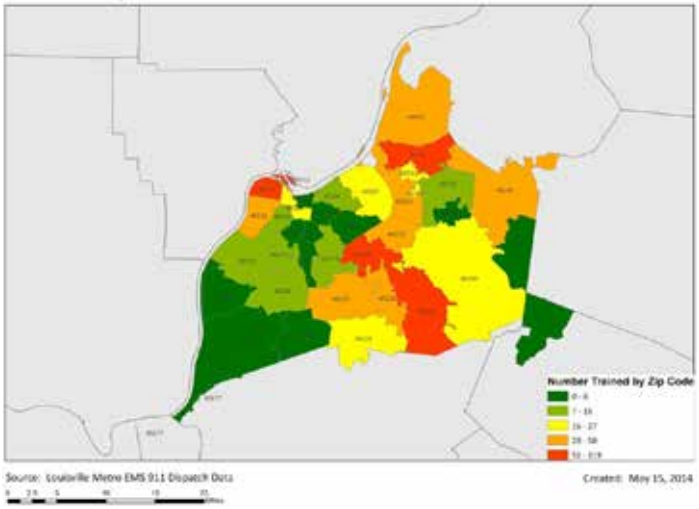
The foundation has received donations from Norton Healthcare and Baptist Healthcare as well as the University of Louisville, Kentucky One and more.

Concluding the seminar, Dr. Dillon said, "If we could teach all the ninth graders in Louisville for five years, we would reach 50,000 people. Over time, we can make a real impact and improve survival."

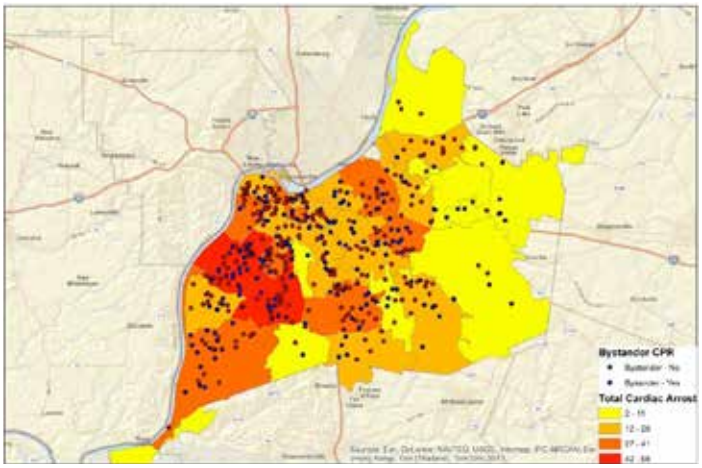
Aaron Burch is the communications specialist for the Greater Louisville Medical Society.

START the HEART FOUNDATION

Number of Individuals Trained in CPR
Jefferson County, KY



2013 Out-of-Hospital Cardiac arrest by Zip Code
Bystander CPR



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IT IS TIME

Teresita Bacani-Oropilla, MD

A couple of nicely dressed elderly physicians were patiently awaiting to board a 7 a.m. flight to St. Louis. Awake and busy since 4 a.m. to be on time for the preflight security screening, they were told at the last minute that their plane had mechanical trouble and they had to be rebooked. In dismay, they realized that if they missed their connection, they would miss the long-planned opening luncheon reunion with classmates of 58 years ago. So much depended on precise timing on this occasion, yet there were myriads of other occasions when time stretched out as a limitless commodity that could be frittered away with impunity.

As the modern world progresses, however, we live by the clock. We do not have the luxury of sleeping like a Rip Van Winkle while the world goes by and expect to awake and resume life. Rather, tick tock, tick tock, "Don't miss the beat or you'll miss the boat, the bus, the train, or the plane."

Would we want that this could be otherwise? If so, the alternative would be to live in parts of our world where time still blends with the temperament of the people, where ceremonies, happy or sad, can last hours or even days. There, people are prepared, nay, expect to wrest enjoyment or emotional satisfaction from a milestone, an engagement, a wedding, a reunion, a promotion, or even from the proper mourning of their dead. Time is at their command, not the other way around.

Or, we could wish that like the idyllic Scottish village in the musical, Brigadoon, we can preserve the status quo of what we consider ideal, only to reappear unchanged every 100 years? But is there such a place or condition that we would like to perpetuate at this time?

Time is so precious, so evanescent, here now, to make use of, or it marches on and is gone forever.

Which brings us back to the elderly couple awaiting their plane. Rebooked south via Atlanta, instead of north via Detroit, they arrived in St. Louis on time to join 40 other octogenarian classmates for days of reminiscing, touring, dining, and dancing. Then time not only stood still, it regressed to more than half a century ago, when youthful lads and maidens courted, studied, and looked to a bright future at the College of Medicine, University of Santo Tomas, Manila, Philippines in 1956. And that future was now and the intervening years in between.

Free of encumbrances of self consciousness, sure of their worth, and happy with what they had become, these young "olds" confided about their crushes, remembered their fears of being failed by once formidable professors now long gone. Reliving their struggles and successes with training, tests, and practice, their combined stories were a kaleidoscope of academia, long term practice among the needy, brave stints with the military, and the joys and pains of raising families in an adopted land, the USA. Interspersed were the sadness and loss of beloved lifetime spouses and family members both here and in the land of their birth. Most significant, however, were the successes of their children and grandchildren, a new American generation. These had become of prime importance for these veterans of life who had started to pass on the future to them. Now was the Time.

Note: Dr. Oropilla is a retired psychiatrist.

TWILIGHT OF PRIVATE PRACTICE

Gregory Ciliberti, MD

For early humans, medical care was provided by the priest or the shaman, relying on uncertain divinity or simple superstition. The ancient Greeks invented empirical medicine – one can still see the tools of these early physicians at the temple of Asclepius in Epidaurus, where metal catheters and primitive forceps remain on display till this day. The Greeks also established the profession of medicine with its tenets of dedication to learning, respect for one's teachers, commitment to patient benefit and privacy, and abstention from mischief and corruption. Most historians consider Hippocrates the "Father of Medicine." The *Corpus Hippocraticum* compiled in Alexandria after his death includes not only his famous Oath, but also a series of aphorisms. The first of these concludes: "The physician must not only be prepared to do what is right himself, but also to make the patient, the attendants, and externals cooperate." On this basis a 2500 year tradition of the ethical, autonomous, professional physician began.

After two and a half millennia, that profession faces a conundrum – a future of continued autonomy versus one of employment. When I began practice in the 1980s, nearly all physicians in our community and around the country were in independent practice. At that time, most physicians felt that insurance companies were the greatest danger to private practice. They controlled not only the money, but also were taking ownership of hospitals and employing physicians. By the early 1990s, that strategy was faltering, and the insurers abandoned the practice of medicine, leaving a void that was quickly filled by hospitals. By the middle of the decade, consolidation was increasing. Vulnerable hospitals (e.g. St. Anthony's and Methodist in Louisville) failed or were absorbed by entities no longer called hospitals, but rather systems. Next these systems began to acquire primary care physicians – no longer valued mainly as professionals or leaders in health care, but rather more as a commodity, the source of a reliable stream of patients. Not surprisingly, many major specialties dependent on their referrals followed. In the competitive environment of the times, hospitals might be excused for self-preservation, but physician complacency is more difficult to explain.

Young physicians starting their careers may not be fully aware of this history while perhaps others see all of this as inevitable. After all, most non-health care businesses have consolidated into fewer and larger enterprises: restaurants, groceries, gas stations, and so forth. However, none of these fields so deeply affects the lives of their customers or entails such perilous conflicts of interest. It is not hard to see that given the current trajectory, within a few decades, perhaps 3-10 national systems will dictate standards of care, decide on winning technologies, control medical education, and even write the textbooks. There is not enough space here to offer a critique of that outcome.

Rather my immediate concern is for our own community where very shortly three hospital system CEOs may, in effect, control the medical care provided to a million people. This is the very concern many physicians have articulated, and recent events substantiate the legitimacy of their unease: the waning of medical staff meetings and input, limitations on outside referrals, penalties for hospital employees and families for seeing non-owned physicians, the firings of physicians for business rather than clinical reasons, and so forth. A striking example appeared in a recent GLMS journal article by an employed physician bemoaning forced changes to patient scheduling at the expense of time spent with patients and potentially even quality of care. Worse still is the fragmentation and conflict in our previously collegial medical community, something that is being chronicled daily in the lay press.

Interestingly, state law is an imperfect guide to the conflicts inherent in the evolving environment. Kentucky does not appear to have a specific law addressing the Corporate Practice of Medicine, but my limited research shows that cases from the last century most importantly *Kendall v. Beiling (1943) and Johnson v. Stumbo (1938)* seem to proscribe it. One ruling reads "a corporation cannot

(continued on page 12)

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EQUAL HOUSING OPPORTUNITY

(continued from page 10)

lawfully engage in the practice of medicine, and the great weight of authority is that neither a corporation nor any unlicensed entity may engage in the healing arts through licensed employees." However, statements published in 1993 and 1995 by the Kentucky Board of Medical Licensure clearly sanction physicians as full time employees of hospitals. The AMA Code of Ethics only briefly addresses the issue in Section 4.6.

The supposed cause of the decline of private practice and the employment of physicians is their own shortcomings as business people in an environment of over-regulation, rising practice expenses, and decreased payments. (The question of physician greed is too odious to address here.) While larger organizations my have some advantages in contracting, I have yet to see evidence that hospitals run more efficient outpatient practices than physicians, and the contracting advantages only add to rising cost without concomitant improvements in care. Furthermore the evidence points to lower productivity by employed physicians which contributes to the shortage of some physician care in the community. But there is a greater price: starting-out physicians may no longer see private practice as a viable option, either because of the false security and temporary pecuniary advantages of working for a hospital or because there are no private groups to join in their chosen specialty (e.g. Cardiology in Louisville). It is a dishonor to our young colleagues that after all their years of training, they feel compelled to answer to an administrator and miss out on the adventure of owning and running a prosperous business. In my preferred business guide, Clinical Practice Management, the author, a non-physician, closes the text by exploring the joys of private practice, noting "most people work their whole lives for other masters. Making the decision and accepting and meeting the challenges and responsibilities of running your own business can give you the sense of freedom that many strive for in our society but few ever experience." Such entrepreneurial pride and fulfillment may unnecessarily disappear from the profession forever.

In closing, the great second century Roman physician, Galen said: "The best physician is also a philosopher." Working from that perspective, I suggest we consult Immanuel Kant who built his ethical system on the concept of the categorical imperative – an ethical mandate that applies at all times under all conditions. In medicine the categorical imperative has always been "first do no harm." Does employment with its requirement to follow management's rules and answer to a supervisor facilitate or impede this moral obligation? And do we have a responsibility to "do no harm" to the profession itself - a celebrated profession we inherited from others and should feel obliged to transmit intact to the next generation? The answer seems to me to be "yes," but at a minimum the question merits deep personal reflection. It is not too late to revisit an earlier decision, and with effort and yes, even personal hardship, nearly every physician can return to the independent practice of medicine- for patients, not systems, and for a time-honored tradition, not a paycheck.

Note: Dr. Ciliberti practices Internal Medicine with Greater Louisville Internal Medicine PSC.

2014 DOCTORS' BALL HONOREES

By: Damian "Pat" Alagia, MD
Chief Physician Executive and Chief Medical Officer, KentuckyOne Health

Dr. Ardis Dee Hoven

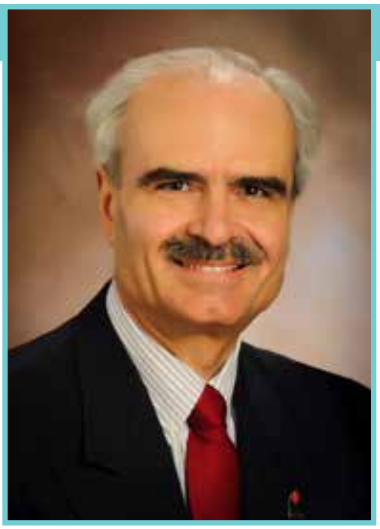
EPHRAIM MCDOWELL PHYSICIAN OF THE YEAR

Dr. Ardis Hoven says her career is defined by her work with HIV/AIDS patients in Lexington in the late 1970's and early 1980's. As an infectious disease specialist at the Lexington Clinic, she was one of the first physicians in central Kentucky to see the devastating disease. Inspired to become a doctor by the medical missionaries she saw as the child of a minister, Hoven's fascination with microbiology led her to specialize in infectious disease, eventually confronting the frustrations and setbacks of AIDS.

Treatment improved, but when fear and misinformation about AIDS seeped into public policy, Hoven began advocating for patients. Her focus on health care policy expanded, and Hoven rose through the ranks to become President of the Kentucky Medical Association, and in 2013, President of the American Medical Association, serving as political point person for more than 200,000 doctors nationwide. It was a natural progression from a clinic packed with patients to the halls of the United States Capitol, where Hoven testified before Congress dozens of times.

Dr. Alice C. Thornton, Chief of Infectious Diseases at the University of Kentucky Medical Center, cites Hoven's ability to command respect, speaking out on behalf of uninsured patients before that was widely done. Traveling the country for the AMA, Hoven was often challenged to explain the organization's support for the Affordable Care Act. She would argue that the needs of patients and doctors are interconnected, and persuaded many physicians that the ACA was, in her words, "the right thing to do."

In her speech as outgoing AMA President, Hoven said, "If I've learned anything from my days fighting HIV, it's that giving up is not an option." For Hoven, who found her calling at the intersection of medicine and politics, not giving up comes down to what's best for patients. "At the end of the day," Hoven says, "I'm a doctor."



Dr. Roberto Bolli

EXCELLENCE IN RESEARCH

Dr. Roberto Bolli has dedicated his research to saving the human heart. He led the SCIPIO clinical trial at the University of Louisville, supported by a multi-million dollar National Institutes of Health grant, to explore the use of adult stem cells to repair heart muscle damaged by a heart attack. It's named for Bolli's favorite ancient Roman general, who is said to have saved not only the empire, but his own father wounded in battle.

SCIPIO has been termed "groundbreaking." With 600,000 patients each year in need of heart transplants and only about 3,000 transplantable hearts a year available, Bolli and colleagues sought a way to repair the heart and restore its function more efficiently than expensive and potentially problematic mechanical cardiac assist devices.

Mike Jones, now 71, was the first patient to undergo cardiac stem cell infusion in the SCIPIO trial. In severe heart failure as the result of a heart attack, the retired Louisville building contractor was barely able to walk without becoming short of breath. Five years after receiving an infusion of his own cardiac stem cells, Jones' heart function has improved enough that he says he can now do just about anything he wants to. Other SCIPIO patients have likewise shown marked improvement. Advanced clinical trials are needed before the procedure can be widely used, but the results inspire Bolli to press on with research.

As Editor-in-Chief of *Circulation Research*, the international cardiovascular research journal, Bolli also draws attention to questions that prompt clinical trials like SCIPIO around the world. San Diego State University Distinguished Professor of Biology Dr. Mark Sussman notes that Bolli, "bridges the gap between basic science and understanding how that can change people's lives for the better."

Dr. Morton Kasdan

EXCELLENCE IN EDUCATION AWARD

Surgeon Dr. Morton Kasdan credits his mentor, the late Dr. Harold Kleinert, with teaching him never to give up. In 1991, Stephen Powell experienced Kasdan's skill and tenacity when the Centre College glass artist accidentally pushed his hand through a window, and Kasdan helped motivate him following successful surgery. The artist regained full use of his hand, and says he owes his career to Kasdan, who became a friend. "I look up to him as an artist," Powell says, because of his approach to surgery, and to life, with skill, creativity and compassion.

About 15 years ago, Kasdan noticed that medical students weren't being taught how to hold surgical instruments or how to handle tissue, so he started offering weekly Sunday suture workshops at his home. Now, about 100 students apply through a lottery each year for four to six slots per four-week session. The students learn not only how to handle a surgical needle, but how to handle themselves as doctors. Kasdan gives them his own printed "Advice You Won't Find in Medical Textbooks," which begins, "Professionalism does not arrive with your white coat; it is a behavior, an attitude that requires effort."

Kasdan also teaches University of Louisville medical students and residents at the Louisville Veteran's Administration Medical Center, where Chief of Surgery Dr. Earl Gaar, who worked for Kasdan as a college grad, also considers him a mentor. "He's not just influenced me," Gaar says. "He's influenced hundreds of people." Lexington surgeon Dr. Theo Gerstle, one of Kasdan's original Sunday suture workshop students, credits Kasdan with his decision to become a plastic surgeon. Of the trim and diminutive Kasdan, Gerstle says, "It's hard to quantify how huge a human being he is."

Dr. Rosemary Ouseph

COMPASSIONATE PHYSICIAN AWARD

Dr. Rosemary Ouseph says she was attracted to nephrology as a medical specialty because it enables a physician to do "total patient care." It's clear that what Ouseph means by "total patient" goes beyond an individual's physical health.

In her role as Director of the Clinical Transplantation and Kidney Disease Program at the University of Louisville, Ouseph oversees some 70 kidney transplants a year, and is as concerned about the emotional well being of patients as she is about the physical challenges, which can include the potentially deadly risk of organ rejection. Ouseph is so skilled at handling the effects of any sort of transplantation on the lives of patients that she also works with U of L's hand transplant program.

Dr. George Aronoff, former Chief of U of L's Division of Nephrology, explains that transplantation, starting with getting on the waiting list for a kidney, through surgery and follow-up care, is extremely complex. Patients need an indefatigable advocate, he says, "and Rosemary is that."

The recipient of two kidney transplants, Andreas Price, 49, says Ouseph's "calming spirit" put him at ease when he came under her care some 20 years ago. Price knows a thing or two about spirit: He's an ordained minister, and says Ouseph gives patients and their families the time they need to understand and get comfortable with the long, potentially risky process of transplantation.

Ouseph relishes the transformation of a patient's life when a successfully transplanted kidney can take the place of dialysis, which patients must undergo multiple times a week. "People are putting their whole faith that you will take care of them," she says. "Taking care of kidney transplant patients is the best of all worlds."

THE DOCTORS' BALL

The Doctors' Ball will be held on Saturday, October 18th at The Louisville Marriott Downtown. The event begins with cocktails and silent auction at 6:30 p.m., followed by dinner, awards, and dancing until midnight with Body & Soul. Tickets are $250. The charity event benefits the Jewish Hospital & St. Mary's Foundation, which focuses on enhancing patient care, funding medical research, improving access to quality health care, and educating future caregivers. To make your reservation, call (502) 587-4543 or visit kentuckyonehealth.org/doctorsball.

SHABTAI ZVI
THE MAN WHO BELIEVED HE WAS MESSIAH

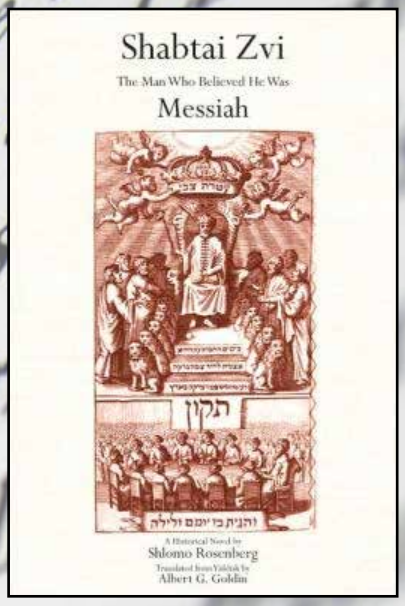
By Shlomo Rosenberg

Published by Hamenorah Publishing House, Tel Aviv, Israel, 1965

Translation from Yiddish to English by Albert G. Golden, MD

AuthorHouse, Bloomington, Indiana, July 2007

Reviewed by
M. Saleem Seyal, MD, FACC, FACP



Ani Ma'amin, I believe with a full heart in the coming of the Messiah, and even though he may tarry, I will wait for him on any day that he may come."

Moses Maimonides (12th Article of Faith)

When you are close to approaching your 90th birthday you don't, in general, embark on a translation project from Yiddish to English that lasts two years, with no help from the original publisher (not in business any longer) or the author (deceased). However, that is exactly what a senior member of the Greater Louisville Medical Society did quite successfully. Dr. Albert Goldin, a semi-retired internist from Louisville, completed translation of a historical novel about Shabtai Zvi, a controversial figure in the annals of Jewish history. At the age of 40 in 1666 he proclaimed that at long last, he was the long-expected redeemer and messiah. He was able to convince a large segment of the Jewish diaspora and developed a significant following. This Sabbatean Movement reached its peak when he sailed from Izmir to Istanbul hoping to take the crown from the Ottoman ruler, but he was promptly arrested, jailed and ended up becoming a Muslim (under duress) along with a large number of his followers who accepted Islam. Despite his conversion to Islam, many continued to believe that he was the true messiah and remnants of these believers (ma'aminin) who are called *donmeh* (Muslim descendents of Jews) still exist in present day Istanbul in Turkey.

Dr. Albert Goldin was born in Lima, Ohio in 1922 in a Yiddish-speaking immigrant family from Belarus, Russia. After graduating from The Ohio State University, he completed an internal medicine residency followed by a year of cardiovascular fellowship at the University of Louisville. He went away to Japan and Korea as part of his military service and on his return got married to Anita, a Louisville native, made Louisville his home, and started his private practice in internal medicine. He retired from full-time practice many years ago but still sees patients once a week. He has been quite active at the Jewish Community Center and has taught spoken Yiddish for many years to interested citizens. His brother, a radiologist in Bronx, New York, received a copy of the original book in Yiddish from the author Shlomo Rosenberg, which he then gave to his mother. Dr. Goldin received the book from his mother and enjoyed reading the story of Shabtai Zvi, an enigmatic, fascinating but ultimately a tragic and reviled figure in Jewish history. Dr. Goldin decided to translate it verbatim without any editing.

The result is a book of intrigue in a rather original flowery language with interesting insight into the pervasive religious milieu of messianic fervor, weaving cohesively Shabtai Zvi's psychiatric travails with episodes of "illuminations" punctuated by bouts of depressive spells. He surrounded himself with many of his sycophants and propagandists who produced tracts, documents and authentic looking "vintage" parchments proclaiming that Shabtai Zvi was the real thing. He went along with the roller-coaster ride of mystic messianism and convinced himself about the role that he'd been grooming himself to play since adolescence in Izmir. In his preface to the book, Dr. Goldin quotes Rabbi Yisroel ben Eliezer (1700-1760) also called Baal Shem Tov / Master of the Good Name (a Jewish mystical rabbi and founder of Hasidic Judaism) who wrote these comments about Shabtai Zvi, "He had within him a Holy Spark

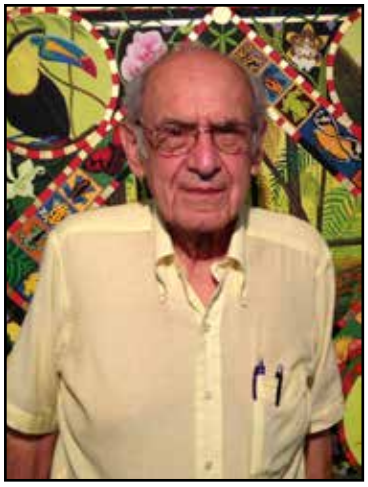
but he fell into Satan's net."

From his childhood, Shabtai Zvi was a peculiar individual who studied the usual Jewish books but his main interest was the study of Kabbalah, Jewish mysticism. He had a few like-minded friends but most of the time he was a recluse, disappearing in his room or in the wilderness for days immersed in prayers, repentance, cleansing himself by immersion in the sea and by self-inflicted pain. The book opens with Shabtai Zvi and his friend Moshe Pinharo taking a stroll on the beach on an early morning in their home town of Smyrna (Izmir in current Turkey) on the coast of the Aegean Sea, in the early part of the 17th century. They talked about the sad situation of the Jewish diaspora, the recent horrible massacre of Jews in Poland, and theimminence of a messiah's arrival – a messiah who would be the redeemer and deliver the oppressed and scattered Jews to the land of Israel, bringing peace to all. On his wedding day to the beautiful Rachel, daughter of a prominent rabbi in town, he experienced visions of sitting on a heavenly throne, and was utterly indifferent to the wedding festivities around him. The marriage eventually remained unconsummated because Shabtai saw himself as the messiah and therefore had renounced worldly pleasures. including union with his bride. This was a major embarrassment for the families of both the groom and the bride. There are descriptions of phantasmagoric dreams, illuminations and visions, and rumors were rife that the young Shabtai might be the awaited messiah.

There are many other intrigues well narrated in this absorbing book, including his friend Moshe Pinharo's lust for Rachel (who annulled her pointless marriage and eventually married Moshe instead). The "strange behavior" of Shabtai included his utter dedication to sacred books (becoming a *poresh*), and his taking of the Torah as his "bride" with another conventional, though weird, wedding ceremony. For this unusual behavior and for calling out the name of God in the form that is prohibited, he was declared a heretic by the rabbinate and and asked to leave Smyrna. After his exile and excommunication from Smyrna, he went to Constantinople, and his warm welcome by both Jews and non-Jews is described in detail.

Here Abraham Hikhini entered the picture and with striking cunning and intrigue, he became Shabtai's right-hand man and propagandist par excellence. He concocted an interesting story about finding a parchment with ancient writing of "The Wisdom of Solomon" purportedly vouching for the messiahship of Shabtai Zvi, which fueled Shabtai's chosen role of redeemer/messiah. He was received warmly in Constantinople's Jewry by the synagogue members, but their leaders, the rabbis, were wary and suspicious, and asked him to appear before them. Consequently, after stormy sessions in front of these scholars, Shabtai Zvi left Constantinople. He sailed to what is now Israel after an encouraging letter from Nathan of Gaza, a well-known kabbalah scholar who confirmed that Shabtai Zvi was indeed the messiah and would become his personal "prophet." He was later sent from Jerusalem to Cairo to solicit money for the huge taxes levied on the Jews of Jerusalem by the Turkish authorities.

Next, he tells the story of Sarah, a Jewish survivor of the Polish massacre who was raised by a Christian family in Amsterdam,



Dr. Albert Goldin translated the book

where she was sexually abused. She escaped and lived a life of disrepute for a while. She had visions and delusions of becoming the messiah's wife and so Shabtai married her in Cairo, Egypt. Sarah's subsequent sexual liaisons were considered legendary and they happened reportedly with Shabtai's full knowledge. After many years of wanderings, he returned to Smyrna with Sarah and was received warmly in his home town. When he finally and officially proclaimed himself as the long-awaited messiah, there was jubilation among the Jews of Smyrna. There was much commotion and many celebrations and then loud talk of Shabtai going to ask the Ottoman Sultan to relinquish his crown. The Ottoman authorities thus decided to banish Shabtai from Smyrna. He went to Jerusalem where he was received with much pomp and circumstance, but met the man called Nehemiah HaCohen, a self-proclaimed prophet from Poland, who would eventually cause Shabtai's downfall.

By this time, Shabtai's reputation as man of God had spread widely among the Jews, and he could just taste the rulership of the world. He was so delusional with imminent grandeur that he proceeded to parcel out the "kingdom" among his 26 friends. The fervor and insanity spread widely among the Jews of the world. Shabtai now decided that time had come to sail again to Constantinople and face the Sultan, boldly asking for his crown. He was immediately arrested on arrival, though the authorities were initially lenient and he was able to receive his devotees. Eventually his jailers tired of his antics and offered him the choice of death Islam – one or the other. He chose the latter and for the next 10 years, he remained a duplicitous individual who was ostensibly Muslim all the while secretly practicing Judaism with his many devotees (also Muslim only in name). Eventually he was banished to Albania and died there in 1676, ten years after arriving in Constantinople.

The book is very well written with a beautiful translation by Dr. Goldin. The narrative is intriguing and describes an important though notorious epoch in Jewish historiography.

Note: Dr. Seyal practices with Floyd Memorial Medical Group-River Cities Cardiology, specializing in Cardiovascular Diseases.

THE ETHICAL, HUMANISTIC, AND SCIENTIFIC SPECTRUM OF AUTISM

Thomas James III, MD

She was worried. Her four year old son was clinging to her and avoiding me altogether. My patient was a young, artistic woman who had moved to town from a rural community where she had been labeled as "different." So often magical thinking provides people in discomfort the solace that a new environment will change the underlying problems; but on coming to town she had found herself more isolated. She was much better able to communicate with others by writing, and did that so well that she won local honors for her work. That writing skill allowed her the ability to communicate with others on the internet. But she still had anxiety in talking with groups or individuals. Even being in crowds like the supermarket made her feel uncomfortable, as though she stood out, and people looked too long at her. So she found work in doing jobs that others would not do. Ultimately her old boyfriend moved to the city, and they had a child — the one before me, who was now completely avoiding me. Through emails to me, my patient had recounted how preschool workers had arranged for social service workers and for psychological testing for the young boy. My patient was against all this. She worried that her child would have a label attached to him, a diagnosis that would become a barrier for him, in the way being labeled as "different" had been for her.

Having a medical or a behavioral health diagnosis may assist the clinician in developing a treatment pathway, but for the patient it is the label by which he or she is known, and can become the person's new identity. She had heard the social workers and psychologists use the word "Autism" and this was a word that seemed to her to box in, to imprison, to diminish a person. She had read more about Autism Spectrum Disorder (ASD) and so she began to put that label on herself. But is this word "Autistic" reflective of the stereotype that both clinicians and society use to establish their approach to an individual? Or is it a banner that an individual can use for identifying and placing oneself in a certain group?

In the new Diagnostic and Statistical Manual (DSM-5), published by the American Psychiatric Association, Autism, Asperger's, and Pervasive Developmental Disorders are now all rolled up into Autism Spectrum Disorder. Thirty years ago this was considered an unusual disorder characterized by complete inability to relate to others or the environment. Even as recently as the year 2000, the

CDC reported prevalence was 1 in 150 children. Today, because of greater awareness with earlier diagnosis, the prevalence is reported to be 1 in 68 children. ASD is found equally in all racial or ethnic groups, but it is five times more common in boys. Nearly 83 percent of children with ASD have a comorbid neurologic or developmental disorder. Some one in ten children with ASD may have psychiatric disabilities. But nearly half of children with ASD have average or above average intelligence, yet because of communication disability, they may originally be diagnosed with intellectual impairment or psychiatric dysfunction.

Autism Spectrum Disorder is the phenotypic expression of a pervasive neurologic disorder, thus the etiology is not singular. Spectrum is the key word: actual behavior and life experiences vary considerably. The individual with ASD may be considered "high functioning" i.e. able to integrate into society, learning the areas of communication that are best avoided. Or he may be very withdrawn, needing physical as well as emotional support. Just as with other conditons, there may be a combination of genetic and external factors causing the expression of ASD, including social influences. Genetic conditions such as Fragile X syndrome (ASD, intellectual impairment, and large ears) have a distinct genetic component. ASD is more commonly found in children with tuberous sclerosis or idiopathic seizure disorder than in the general population. On the other hand, in children who are identical twins, there is variable expression of the symptoms of ASD. The disorder is felt to be a life-long condition that impacts the individual's capacity to communicate orally, interact socially, and manage repetitive behaviors. People with ASD are more likely to have seizure disorders, as ASD is among the more common neurobehavioral comorbidities of children with active epilepsy. Children with ASD are more subject to sleep disorders and gastrointestinal symptoms. Drug therapy does not improve the ASD, but may be appropriate for any secondary medical conditions.

While there is no cure for ASD, there are an increasing number of studies that demonstrate early intervention by a multidisciplinary team of family members with pediatricians/family physicians, specialized behavioral health experts, and geneticists may result in overall better outcomes. This team with the family may pursue a "medical path" or a "social path." Within the Autism community, there are those who define themselves as "people with autism" and those who call them themselves "Autistic people."

The advocacy group, Autism Self-Advocacy Network (autisticadvocacy.org) recognizes the label "autistic person" is a way of self-identification. Advocacy groups then promote the individual's recognition of the condition and functioning in life with it. This is the social and behavioral response to the label in a fashion similar to advocacy groups for LGBT or ethnic minorities. This allows the individual to feel a part of a virtual community—something that is more difficult for them to achieve in a physical environment. Matt Cottle of Arizona's Stuttering King Bakery (stutteringkingbakery.com) has developed high success on social media as he has celebrated his label in cooking, just as my patient has in writing. For many individuals this is the better approach to life as an autistic individual. As she told me, "It is a wonderful relief to have a name for a part of yourself that you were not sure what to call. We are proud to be Autistic."

There are others who prefer "people with autism" in recognition that they are people first and that they have a neurologic condition. This carries ASD to the medical model - establish a diagnosis and develop a therapy path. Living here in Philadelphia, I have developed a working relationship with the Genetic Clinics at Geisinger Medical Center in Danville, Pa. and with their counterparts at Children's Hospital of Philadelphia, where I trained. Both centers recognize that genetic testing for specific conditions such as Fragile X as well as with micro array analysis can achieve as high as 30% percent accuracy in predicting future ASD expression in infants where there is high degree of concern. Families accepting of this medical model and having genetic testing may not fully benefit unless they get their child into a multidisciplinary team approach that includes the family. That team must respect the cultural values of the family but cannot have all of the therapeutics dictated by the family. Studies show that by use of practice guidelines developed through the American College of Medical Genetics, that there can be improvement in clinical outcomes.

AS SHE TOLD ME, "IT IS A WONDERFUL RELIEF TO HAVE A NAME FOR A PART OF YOURSELF THAT YOU WERE NOT SURE WHAT TO CALL. WE ARE PROUD TO BE AUTISTIC."

As a primary care physician, the early role is gaining trust so as to better have the conversation with the patient with ASD. What are their goals? Do they prefer autonomy, and the label of autistic person? If so, then guiding them toward support or affinity groups may be more helpful from a social perspective, leaving the physician to manage any of the neurologic or other medical comorbidities. On the other hand, the individual who adopts the medical model may need more direction from the physician in terms of accurate diagnosis and direction into a treatment plan.

With most conditions a physician manages there is not the option of moving primarily down a social/educational direction or a medical management model. This puts the physician into a space that may be uncomfortable, especially since "cure" is not the goal but social integration, at the level which makes the patient most comfortable. It is not the goal of management to meet some preconceived cultural norm, unless that is in fact the goal of the patient. The ethic of allowing patient decision-making is further stretched when the child is under two years of age, but as with any very young child, parental choices are paramount. Since we are now dealing with a highly prevalent condition and one that now encompasses adults as well as children, it is important for all of us to become more aware. Most of us have taken care of (and some of us are) higher-functioning people with autism. Understanding their challenges is conducive to good patient care (and no ice buckets required).

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(continued from page 19)

DIAGNOSTIC STATISTICAL MANUAL V CRITERIA FOR THE DIAGNOSIS OF AUTISM SPECTRUM DISORDERS

A. Deficits in use or understanding of social communication and social interaction in multiple contexts, not accounted for by general developmental delays, and manifest by all 3 of the following:

1. Deficits in nonverbal communicative behaviors used for social interaction; ranging from poorly integrated verbal and nonverbal communication, through abnormalities in eye contact and body-language, or deficits in understanding and use of nonverbal communication, to total lack of facial expression or gestures.

2. Deficits in social-emotional reciprocity; ranging from abnormal social approach and failure of normal back and forth conversation through reduced sharing of interests, emotions, and affect and response to total lack of initiation of social interaction.

3. Deficits in developing and maintaining relationships appropriate to developmental level (beyond those with caregivers); ranging from difficulties adjusting behavior to suit different social contexts through difficulties in sharing imaginative play and in making friends to an apparent absence of interest in people

B. Restricted, repetitive patterns of behavior, interests, or activities as manifested by 2 of the following:

1. Stereotyped or repetitive speech, motor movements, or use of objects; (such as simple motor stereotypies, echolalia, repetitive use of objects, or idiosyncratic phrases); OR

2. Excessive adherence to routines, ritualized patterns of verbal or nonverbal behavior, or excessive resistance to change; (such as motoric rituals, insistence on same route or food, repetitive questioning, or extreme distress at small changes); OR

3. Highly restricted, fixated interests that are abnormal in intensity or focus; (such as strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests). OR

4. Hyper-or hypo-reactivity to sensory input or unusual interest in sensory aspects of environment; (such as apparent indifference to pain/heat/cold, adverse response to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects).

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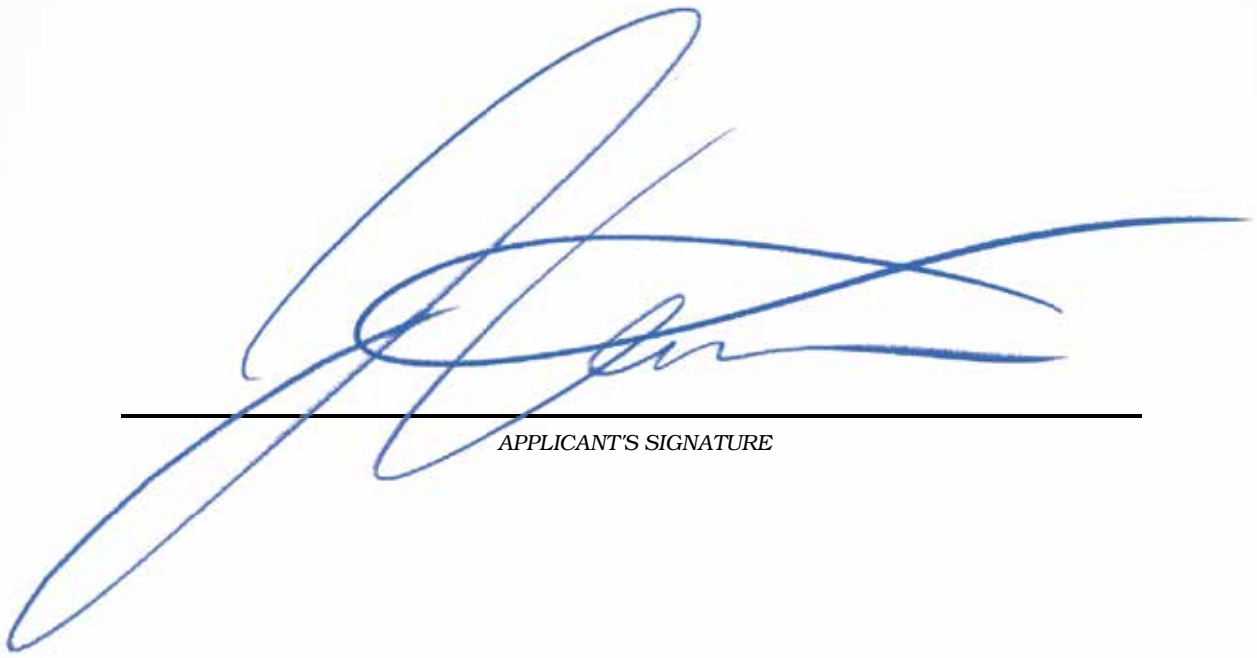
Note: Dr. James is the Corporate Medical Director of Clinical Policy at The AmeriHealth Caritas Family of Companies in Philadelphia. He has a part-time practice within Main Line Healthcare in Philadelphia.



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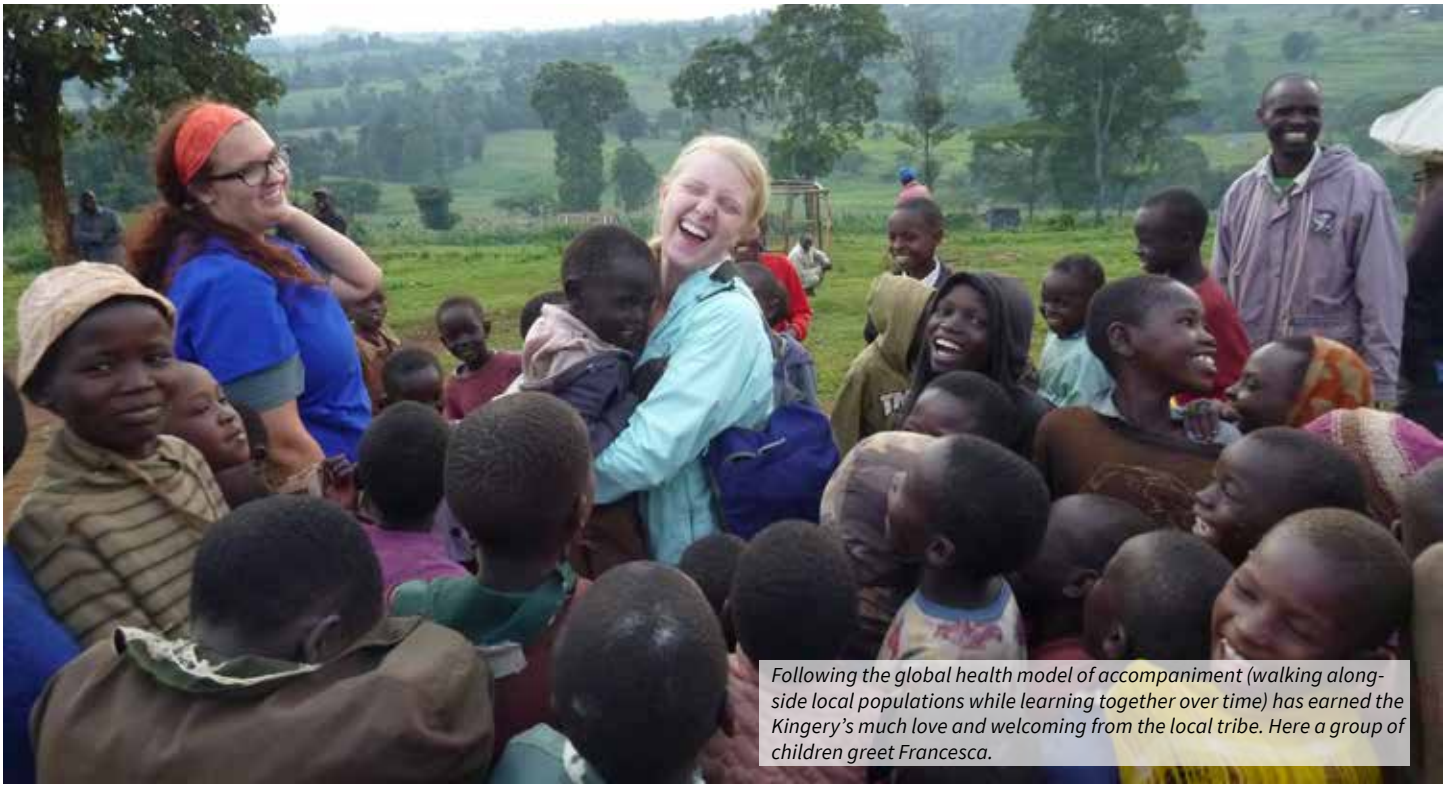
THE KINGERYS IN KENYA
TAKING THE FIRST STEPS TOWARD GLOBAL HEALTH

Aaron Burch



Following the global health model of accompaniment (walking alongside local populations while learning together over time) has earned the Kingery's much love and welcoming from the local tribe. Here a group of children greet Francesca.

On a dirt road lined with mud huts, two Louisville residents walk with native Kenyan villagers. The road slopes up, heading to the peak of Mount Elgon on the Kenya/Uganda border.

As the group walks, families peer out from doors and windows. Some invite the Americans in for tea or offer milk, high praise in the village. In the past, the visitors have accepted chickens from some of the poorest Kenyan villagers in thanks for saving the life of a family member. Although their skin is different, their accents are different and their background is different, Justin and Francesca Kingery have been accepted by the villagers as two of their own.

This trust and acceptance comes from more than two years of diligent community work by Francesca and Justin. The couple, who celebrated their third year of marriage in August, have given months of their time to helping people thousands of miles from the place they call home.

In that time, they've helped make deliberate, positive changes to the average Kenyan resident's way of life. Education, water and access to medical care have been their primary focuses, but the Kingerys are looking at the entirety of life and culture in Kenyan society and the best ways to help those in need.

"Justin and I wanted to get involved in certain areas, not just jump around the globe. We wanted to focus on global health as a couple and as a career," said Francesca.

Justin, MD, an Internal Medicine resident at U of L and Francesca, LMC 4, have partnered with Kenyan Parliament member, record setting marathon runner and U of L graduate Wesley Korir and his family as well as Dr. Bill Smock, forensic surgeon for the LMPD and medical director with Waterstep, a Louisville based organization dedicated to bringing clean water to underprivileged areas worldwide. Each year, Dr. Smock brings a small group of U of L students with him to Kenya for medical assistance and other work such as water treatment.

"It's an annual trek," said Dr. Smock, who also took a group of fellow police officers to repair and renew water pumps in the area. "The students come back changed. They realize how fortunate they are to live in the US and live somewhere with clean water. Louisville has some of the safest water in the world."

For Dr. Smock, the student trip to Kenya is an annual event, but the Kingerys hope to visit every four to six months, rotating with Dr. Smock as available. "We usually get there a little more frequently," said Justin. "Right now, Francesca's a student at U of L and I'm a resident. So I use my vacations and she uses her time off to go. We do it when we can. We try to rotate so that we don't all go one time in July and then no one's there."

Using Wesley Korir as a touchstone, Dr. Smock and the Kingerys have been able to affect Kenyan life for the positive in a variety of ways. Dr. Smock came first to Kenya, focusing on water and treating

those villagers in remote areas who were most in need of surgery. Francesca visited Kenya initially as a student in Dr. Smock's group, and was soon picked out by Korir who is said to have a distinctive eye for people genuinely interested in making a difference.

"Wesley said what he does, when students and physicians visit Kenya, is he sits back and tries to observe who is really interested in their culture as opposed to just being on a trip," Justin said. "And so he pegged Francesca out pretty early, which was a good observance on his part. He took her under his wing and pointed her out to Bill and some other people. Now she's done such great work, they've promoted her to being on the Kenyan Kids Foundation's Board of Directors."

Mr. Korir and his wife, Tarah, founded the Kenyan Kids Foundation in 2010, sponsoring children to attend school in Kenya, which costs approximately $350 American dollars per student each year. Because Kenyan residents are generally affected by poverty, a household with several children might only be able to send one or two to school each year.

After Francesca's initial visit, she returned with Justin in March of 2013 during the election which would send Wesley Korir to the Kenyan Parliament. "Once we saw how this could really be a strong relationship, we decided to do a community needs assessment," said Francesca, whose group chose a methodology known as Photo Voice, where cameras were given to 13 Kenyan women in the region so that local residents may articulate their own struggles.

"We asked them to portray barriers to their health in their community. After they collected photographs, we did individual and group interviews to determine the themes of those barriers," said Francesca, who returned after the two month assessment process to help the group rank the issues they felt took precedent.

Number one was the cost of school fees. Number two was the need for fresh water, which Dr. Smock and Waterstep have been helping to provide. The rankings gave the Kingerys as well as the Kenyan government a direction for the issues the average Kenyan citizen felt demanded the most attention. The Kenyan women's group has now continued its efforts and been given community organization status to approach the government to fix societal needs. "This is a women's group in a tribal area of Kenya. For them to have this ability is a major deal," said Justin.

In addition to the two focal points of education and clean water, the Kingerys began working in numerous other problem areas throughout the region involving health and logistics. When Kenyan residents were having difficulties with local health dispensaries, the global health team worked to educate the inhabitants on other nearby health options. "Maybe they don't know there are options a few miles away. In Kenya, there are six or seven different levels of health care which are very structured, and it's actually a pretty good system though it's underfunded," said Justin.

Another issue developed from the remoteness of the region the Kingerys work in, on the border of Kenya and Uganda. So far away from major cities, professional Kenyan physicians are few and far between. "Sometimes you need to go to the hospital. So we've managed to get an ambulance for the region. We're training what we believe may be the first actual paramedic in the country of Kenya," said Justin.

"Real global health is hearing the stories and empowering people

(continued on page 24)

Justin teaching the local boys what a stethoscope does. They're always very interested to learn what it means to be a doctor, and he's always interested to learn what it means to be a kid in Kenya.

Francesca earning the trust of a baby with the only toy in sight, her stethoscope.

(continued from page 23)

Francesca plays games with the local children after Sunday church service. The welcoming nature of the Kalenjin tribe is undoubtedly their best of many great qualities.

and them empowering me to go on and do something good in the world. Global health is really the stories of the kids that no one hears about. If we lay all the cards on the table: does the medical care help? Yes. Does the water help? Yes. But the real issue is that we're gaining as much from them as they are from us. I don't think you can be good in global health until you realize that you're gaining as much from other people as they are from you," he said.

One of the most striking stories came from the Kingerys' translator, Timothy, who quickly became close friends with the visiting couple. From a self-described "rough" tribe in Kenya, Timothy was taken in by the Korir family and sent to school with their help.

"Timothy is the definition of a global health inspiration story," said Justin, who talks with him on the phone every day. "He has become the most multi-talented person you'll ever meet in your life. Every time a group goes with water or engineering or medicine, Timothy is the new expert on that field."

One of Timothy's primary interests was American professions. Accounting, managing, the requirements of being a doctor, nothing was off limits. In May, Timothy passed his SAT. Now, with the help of Justin and Francesca, he is planning to attend the University of Charleston in West Virginia where he received a near full scholarship thanks to his SAT scores and natural abilities as a long distance runner.

"Justin and Francesca have done a lot of things," said Timothy, speaking from Kenya via e-mail. "In their first trip last year, though short, they managed to see over 500 patients and treat all of them. This year at the end of February, Justin came and he did a brilliant job. We rode on an ambulance and we were able to save more than 20 lives delivering mothers and unborn kids."

On his latest visit, Justin also visited the Kenyan Ministry of Health to discuss forward thinking ways of preventing different diseases such as diabetes and high blood pressure. "Justin is the first American doctor to be given a license to work in Kenya," Timothy said. "A week later, Francesca came accompanied with two medical students from Louisville. They were able to carry out clinics in Geta, Motosiet, Wiyeta and Benon dispensaries and Cherangany Health Centre. They treated over 1,000 patients. All people love Justin and Francesca in Kenya, and they wish them to come back."

There is still much work to be done. Kenya has 2,000 public physicians in a nation of more than 40 million people. Outside of major cities, the houses are typically mud huts. Villages are centered on farming, particularly corn. There is still no water in many places, and no electricity. Roads are beginning to be paved but the remoteness makes it a slow process.

"I thought going into global health that I had a good perspective on what it means to be privileged, and what it means to be from America. But, going abroad to other cultures and other countries you see just how privileged you are, exponentially, and what you should do about that. Should you challenge yourself to use that privilege to help others - to change policies because you see people who want to go to school so badly?" asked Francesca.

As Francesca continues a five-year program in medicine and bioethics, Justin is entering his third year as an internal medicine resident at U of L. Still, they plan on continuing their education and using Louisville as a base of operations for their goals in Kenya.

"We love that Louisville understands the world better than a lot of places," said Justin. "We think the med school here and the departments are really primed to do great things in global health. If we can be on board and help out, that's what we'll do. But we want to continue to develop the Kenyan relationship because the number one goal for us is the relationship. It's not a bounce around the globe and have fun issue."

It was this relationship that encouraged Timothy to pursue a college education and come to America. "I want to be known as a great learner and athlete in the world," Timothy said. "I will transform my 'everything' to help less fortunate people because I believe my purpose being on Earth is to help those, orphans and other people in the society."

By happenstance, the region in which Justin and Francesca visit is responsible for 60-80 percent of the world's long distance running gold medals since the mid-1980s. Each morning around 6 or 7 a.m., some of the best runners in the world take to the dirt roads near Mount Elgon. Because he's part of the tribe now, Justin has had the opportunity to run with some of the best runners in the world.

"The term 'run' for me is used very lightly," laughed Justin. "Because you're running while the kids are going to school, you may be surrounded by 50 children trying to talk to you. People are waving and cheering because they know you're a horrible runner compared to the others. But what they tell me is that it's the attitude, not the legs. Just to be out there with them, the sun coming up over the hills, the kids behind you, you'll never do that again in your life."

(The will to run appears to have a lot in common with the will to help others. The attitude determines the success.)

"Global health is not only health care. It's about randomly finding and meeting people and just trying to do the best you can with each other. And so that's what we're trying to do," Justin said. "We all have the same goal. The goal is to learn from each other."

Francesca agreed, "If you make the decision that you want to do something, then it's your will and you can go forward. We're not making any extraordinary bends in our life to do it. We just do it."

Aaron Burch is the communications specialist for the Greater Louisville Medical Society.

THE COUCH

Aaron Burch

Drs. Ora Frankel (left) and Debbie Thomas sit in the lobby of The Couch, the immediate mental health care facility which the pair opened in early 2014. The two physicians agree their work has been a labor of love.

Ora Frankel, MD, designed The Couch, Kentucky's first privately owned urgent mental health care facility with a simple premise in mind: when a person needs mental health assistance, they need it now.

"Most people don't come in for a psychiatric wellness check, they only come when they're in crisis," said Dr. Frankel, sitting in her office near Brownsboro Road. Across a two lane street sits The Couch, her newly opened labor of love which opened on January 15, 2014 after more than three years of research and preparation.

"I knew the need for an alternative was there. Just in my own office's experience, there are a limited number of patients I can see. If I've been seeing a patient every three months but some crisis happens and they want to come in early, I know how hard it is for me to get them in," said Dr. Frankel, who has practiced in Louisville for 20 years after moving here with her husband in 1994.

"So the idea came to me, 'If I can't get my patient in, I'd much rather they go to an urgent care facility and see someone really good and qualified then go to the ER," she said. With this thought, The Couch began to take shape.

To begin her research, Dr. Frankel asked how possible was it to find mental health care for patients in a state of emergency. "We called 42 psychiatrists in the region. Only one was taking patients earlier than six to eight weeks away," she said.

Dr. Frankel, masquerading on the phone as a patient in need of assistance, was told by multiple psychiatric offices to contact the University of Louisville's Emergency Psychiatric Services. They said, "That's your only real option.'"

"So I did. I called EPS, got a machine, left a message, nobody called me back. I kept calling, and eventually they picked up. They said a doctor could see me today but I would have to wait a while."

In addition to the University of Louisville, Baptist Hospital East has a 24-hour psychiatric service in its emergency room. Dr. Frankel, however, doesn't believe it matches the possibilities of an urgent care facility based outside of an ER. "Their facility is great, but the job of a psych ER is triage: does this person need in-patient, out-patient or intensive out-patient treatment? If you need in-patient or intensive out-patient, they can get you going. But the great majority of people only need out-patient - at which point they'll say you need to call and make an appointment with a psychiatrist - back to square one."

In Dr. Frankel's opinion, an ER is among the worst places for the patient to seek assistance for several reasons, not the least of which is the cost. "On average, a visit to the ER costs somebody approximately $1,800, whether it's the patient, the insurance company or the hospital. The doctors and nurses have to cover all their bases, they have to do several checks and tests. It doesn't matter what's going on. $1,800 is a ton of money to go and be told to make an appointment with a psychiatrist somewhere. It's a huge waste of resources."

In her eyes, the solution was a private facility where community residents could walk in or schedule appointments as they see fit. Dr. Frankel envisioned a facility with extended hours for working men and women with inflexible schedules and perhaps children

needing help after school, staffed by psychiatric nurse practitioners who can spend a worthwhile amount of time with each patient. After years of planning and preparation, a location was found, rented, stocked and staffed in time for the start of 2014. As luck would have it, a location presented itself just across the street from Dr. Frankel's private practice on Lime Kiln Road.

Today, the Couch's waiting room is decorated with modern chairs and sofas sporting intricate patterns and lacking arm rests. On the walls hang bright paintings as well as photos taken by Dr. Frankel's husband during a visit to Peru. An electric fireplace adorns the front desk. While I was inside The Couch for just a few moments, a woman in her early 20s came in without an appointment, gave her information, and sat for a moment before being called back to speak with a psychiatric nurse practitioner.

"I think nurse practitioners are much more holistic in their approach. They're taught in nursing school to think of the whole patient and be a patient advocate," said Dr. Frankel.

The Couch is also under the supervision of Dr. Frankel's friend and business partner, Dr. Debbie Thomas, Ed.D, APRN, who serves as the facility's Medical/Clinical Director.

"Urgent mental health care is a no-brainer," said Dr. Thomas, a nursing professor who operates her private practice, Here & Now Psychiatric Services, out of the same building. "With some of the changes in the Affordable Care Act and lack of enough psychiatric in-patient and out-patient facilities, there is a huge gap in access to mental health care. Often patients are discharged from a hospital, and there is no one for them to follow up with. They shouldn't have to wait anywhere from 3 to 12 weeks to get an appointment.

Dr. Thomas also serves as Assoc. Professor and Coordinator of the University of Louisville School of Nursing Graduate Psych Nurse Practitioners program. The program has enjoyed a 100 percent overall pass rate for the past seven years of her involvement.

"A psychiatrist friend said to me years ago, 'Primary care providers are the foot soldiers in the field for psychiatric mental health care.' That has rung in my ears many times. … This just isn't a role of the primary care provider, and I think many of them who are friends of mine would be the first to say that. They want to refer to Psych but no one is taking new patients or they can't get them in fast enough."

"Debbie and I are good buddies, and she was incredibly helpful as I was working on the idea for The Couch," said Dr. Frankel. "So she moved her private practice, and periodically brings graduate psychiatric nurse practitioners in to shadow her." These graduates work under the supervision of an experienced senior nurse practitioner at all times as well as the direction of Drs. Thomas and Frankel.

"It was no small thing to move my thriving private practice from Crescent Hill to The Couch," Dr. Thomas said. "I decided it made sense and helped us to really forge a system conducive to good program oversight and good communication. I like how we focused on the environment being a calm and comfortable place."

Treatment at The Couch is typically divided into two sections based on the needs of each patient. Visitors can pay for a 30-minute medication check or an hour long psychiatric evaluation for $110 or $225 respectively. Those times aren't set in stone however. "I don't like rushing people in and out. That idea bugs me. So if there's nobody in the waiting room, and you're seeing the nurse practitioner, they may spend 90 minutes with you. The people we have like to do therapy. They like to talk to patients. If anything, I'm having to be the bad guy to reign them in," laughed Dr. Frankel.

The Couch is not within an insurance network, but has forms available so patients may submit out of network coverage to insurance companies. "Some people think without insurance coverage they shouldn't come at all, but the truth is that deductibles are upwards of $1,000. Even if they visited psychiatrists covered by insurance, they'd likely be paying out of pocket anyway."

Patients vary widely from adults to grade school age. Diagnoses naturally follow a similarly wide swath. Dr. Frankel notes the most common issues her patients face are anxiety, depression, panic attacks, and suicidality. Parents may bring in their children if there are behavioral issues, perhaps stemming from Attention Deficit Disorder or social issues.

The Couch is open until 8 p.m. on weekdays and Saturday from 10 a.m. to 4 p.m. which Dr. Frankel explains as a simple way to decrease the stress of patients attempting to get proper care. "We wanted to create hours that would accommodate working people. I think of The Couch as a bridge. It's for those who can't get in to see their psychiatrist or for a one time issue where a person just needs to talk to someone professionally and privately."

So far, the experiment seems to be working. The Couch is already drawing as many as a dozen visitors per day. There are currently two nurse practitioners on staff with enough room for four operating at any given time. There has been zero paid advertising so far, with all business has come from Facebook, television interviews and word of mouth. "I think the word is spreading. Certain schools, certain therapists are starting to send us a lot of business."

Despite the increased demand, Dr. Frankel firmly stated she isn't interested in competing with other psychiatric offices. "I don't see us as competition," she said. "I see us as a resource for them. When a patient calls urgently and you can't see them, consider sending them to us. We do electronic records we can then fax those to you the same day. We are never going to try to take patients from other psychiatrists."

Dr. Thomas agreed, "It's clear there is a huge need to provide access to care for displaced or marginalized patients in our community. I think this should serve as a model for other centers to provide access to patients in need who may not have insurance or other means to pay."

Aaron Burch is the communications specialist for the Greater Louisville Medical Society.

WE WELCOME YOU

GLMS would like to welcome and congratulate the following physicians who have been elected by Judicial Council as provisional members. During the next 30 days, GLMS members have the right to submit written comments pertinent to these new members. All comments received will be forwarded to Judicial Council for review. Provisional membership shall last for a period of two years or until the member's first hospital reappointment. Provisional members shall become full members upon completion of this time period and favorable review by Judicial Council.

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U of South Florida 91

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U of Minnesota 91

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Pediatrics 89
U of Louisville 84

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Pediatrics 81
U of Louisville 76

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NOTE: GLMS members' names appear in boldface type. Most of the references have been obtained through the use of a MEDLINE computer search which is provided by Norton Healthcare Medical Library. If you have a recent reference that did not appear and would like to have it published in our next issue, please send it to Jennifer Howard by fax (502-736-6363) or email (jennifer.howard@glms.org).

DOCTORS' LOUNGE

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PROPER JOB

Mary G. Barry, MD
Louisville Medicine Editor
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In Cornwall that's a compliment (mostly) and also the name of a locally brewed St. Austell IPA (bleah). For us, in our August jaunts around the Penwith peninsula, a proper job meant a happy day's travel, enough clotted cream to solidify our most pristine arteries, and something - a sign, a comment, a place - that was quintessentially British.

We had no pirates to contend with. But on August 16th, after several earthquakes, the Bardarbunga volcano in Iceland erupted, and, remembering the complete meltdown of the European airspace after Eyjafjallajokull in 2010, we braced ourselves for disappointments. Luckily my husband made it over the ocean first to collect his mother Dr. Hertha, and I a day later, after several more eruptions and upgrades from Iceland air authorities to the "red alert" stages. We met at Heathrow on a lovely cool Friday morning, toured around, paid our respects to Sir Alexander Fleming, and rolled out Saturday from London Paddington for the 300 mile Great Western Railway ride to Penzance.

There are very few things I love more than riding on a train in a window seat, peering into backyards, pastures and vegetable plots, speed-birding, reading, and eavesdropping, which was lively. It was the final weekend before British primary schools started back, and we were headed to the coast. Children were cited for "moaning" and "being chippy" and "hanging about," and parents for being both "beastly slow" and "prodding." Farther west, at every port people crowded the sands, perched on the seawalls, and stared at the Channel.

We drove (left-handed, with significant co-piloting) to our cottage in Lelant Downs above St. Ives. It sat in dripping woods, with a super rope swing, an antique cannon in the front yard, and a near-total lack of internet connection (spotty, slow, cellular, no computer cables, only working at odd "low traffic over the airwaves" hours). Half our family was unmoved, but the American half was crestfallen. Thenceforth began our quest for wi-fi, and our gradual appreciation of the particular history of Cornwall and her ancient and modern communications.

All over the world from the dawn of time, people have built shrines, monuments to power, memorials for their dead, and temples to their own glories. Everywhere visitors climb over ruins, tour cathedrals, circle pyramids and queue up for castles. Cornwall settlements go back to at least the Bronze Age; the Romans made inroads; the saints arrived from Ireland about the 5th century AD. Each tiny church for every headland and hamlet has a parish vicar listing usually going back to the mid-1200s, in an unbroken line. But we wanted real, real old, so we searched for stone circles.

The famous ones are easier to find, but weren't on the family routes for the day. Goetz and I had to detour (after a stop at the one and only wi-fi close, the Hayle McDonald's, to download maps, newspapers, mail, the BBC and the latest volcano alerts: new earthquakes and now, lava had begun to flow). We found Boscawen-Un on the map – sort of - between several farms and two roads, near the village of St Buryan (famous church said to have the heaviest bells in the world). We drove both the roads, up and down, and the very narrow lanes with tall stone hedgerows each side, so tall that we could not see over them – no signs. We thought, "It is out there in some field, and not, we hope, a field with bulls." We stopped at the gas station. I took the map inside (in England, I am the Speakita of the family) but the young woman with pierced nose and tattoos had never heard of it. The old man at the counter, drinking tea and reading The Guardian, overheard me. He wore a cardigan with Exeter crest, had enormous eyebrows, and spoke with a low, cracked voice. "It's aye by the Carn Euny but before you crest the hill." The mechanic nodded, and said, "You go up the long hill, down the short, and just before you get to the top, look for the sign."

Sign? Hmmm. We backtracked. We drove into the Cairn Erth on the Public Footpath (took us aback the first time, to drive on a walkway, but that is common, in Cornwall). This involved a 30 minute expedition only to find some old prehistoric camp foundations, where an Army guy and his sweetie were huddled over a picnic. We survived numerous close calls, managing not to tear out the bottom of the rent-a car. We returned to

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(continued from page 31)

the village and asked a lady picking blackberries. She said, in the manner of helpful natives who have a vague idea, "Go straight and then right."

We retraced our steps. I drove, and G. tried to get an overlay on his I-pad from Google Earth and the county map. No dice. But on Google Earth, when we coned way down, we could clearly see a circle, at the intersection of several long hedgerows. We guessed, and took a likely lane, and found a young curly-headed farmer up to his ankles in pigs. He said, "You"ve gone too far. Go back, left, look for the wooden gate, the path is there."

We went back. We saw a metal gate but with wooden posts and a tiny sign that said, "Boscawen" and we hooted in delight, squeezed the car off the road but not quite into the ditch, and took to the fields. We saw no bulls, but there stood a single ten foot tall stone with no runes. There were many cowpats, many magpies, but no circle. Goetz climbed the hedgerow and took my binoculars and scanned the horizon: no circle. There came two very nice cows who sorely needed to be milked, and started toward us, bleating. We retreated.

But we felt closer. We had eliminated one lane and searched for the next, tiny, unmarked farm track, and finally saw a gate made entirely of wood. We parked illegally downhill from it ("Downhill – a good sign," I said). Next to the gate, hidden by the gorse, six inches from the ground rested a small plaque that read, "Boscawen-Un Quoits." Jackpot!

Thank God there are no chiggers in Cornwall, or we'd still be itching. We felt that the Druids had hidden their sacred circle from heathen eyes. We pushed our way through chest high ferns, corn, weeds, and then thornbushes for about a quarter-mile, following a faint track. It was humid, misty, and dank, and I had visions of snakes ancestrally set to guard the stones. Finally G. rounded the edge of the field, and shouted, and there they were, over the next wall, nineteen blocky, bulky stones, shaped like mallet-heads, with one giant slanted stone in the center.

The circle was eerie. It lay at the top of the hill, the coast a few miles below us, overlooking a great sweep of green fields and dark hedgerows. If fires were lit on the coast path near the Merry Maidens circle, it was said, they could be seen from this circle. The two were perfectly aligned, although we knew not to what – the patterns of certain stars, or the solstice, or to math we could not ken. Yet our circle was hidden from all eyes by tall trees, overgrown walls, and guardians of thorn. I walked around its outer perimeter, touching each stone and saying a private incantation. We had a victory kiss, and then wound our way back out through the jungle field.

When we got in the car, we found that the batteries on our I-devices had suddenly drained to less than 20%.

That made us slightly hysterical. But we pressed on – to the wondrous telegraph and undersea cable station at Porthcurno, to the cliff where the hang-gliders were taking off, to the M&S for beer (a Greenwich Ale aged all of four months in bourbon barrels – hah!), and then home, to cook the fish that our family had caught the day before. We thanked the Druids for our dinner, and our safe passage, and checked our I-devices several times, from superstition. But they were back to normal, though the cell reception was not.

We hope one day to go back to Cornwall; so many places remain to be explored. On the London train we had "Disruptions," and unruly passengers who crowded on at Plymouth, and "late-running," inspiring a conductor who rivaled John Cleese in his epic apologies, and two sisters who sparred over the last carrots. It was practically proper in every way.

Note: Dr. Barry practices Internal Medicine with Norton Community Medical Associates-Barret. She is a clinical associate professor at the University of Louisville School of Medicine, Department of Medicine.

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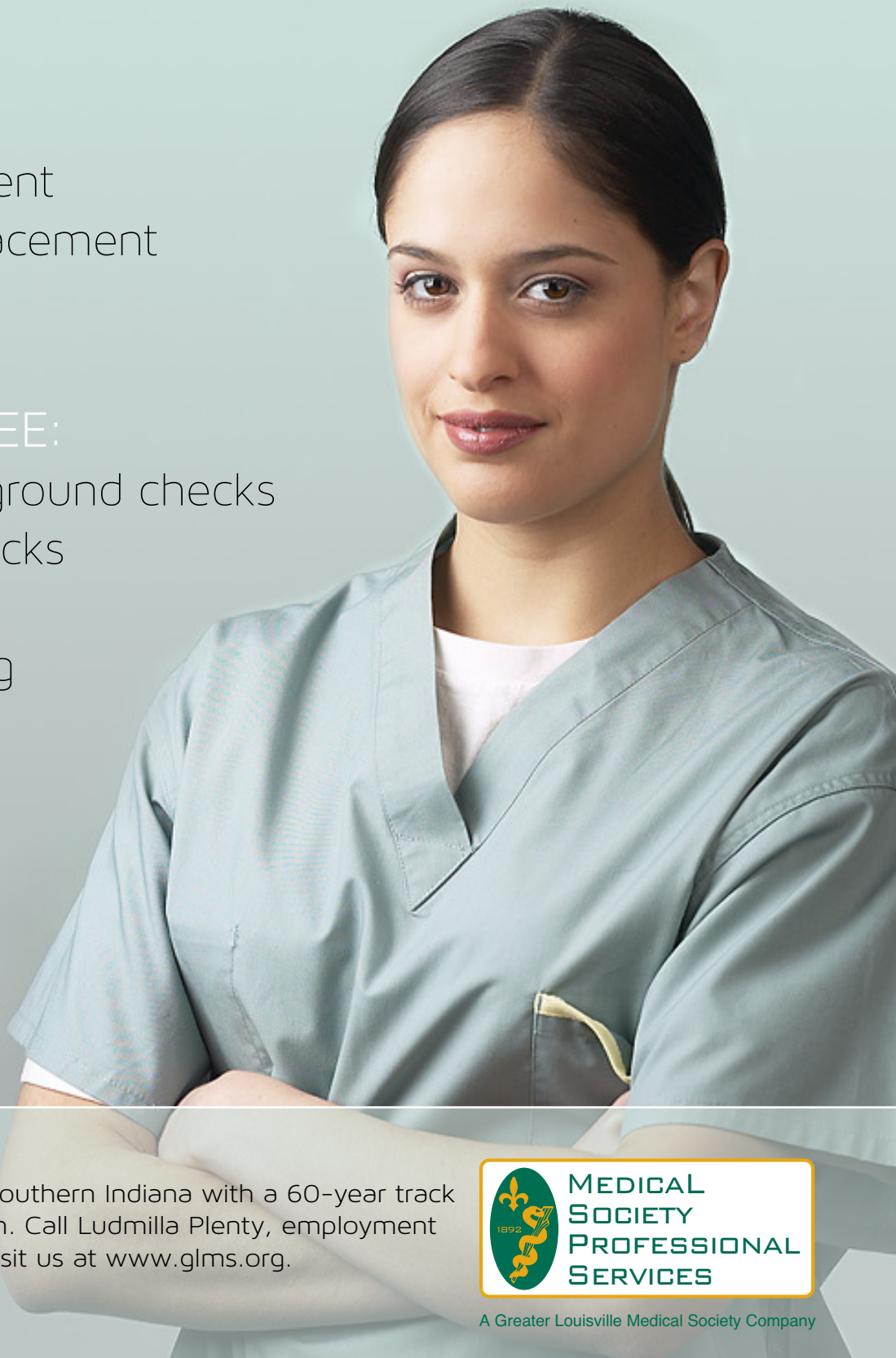

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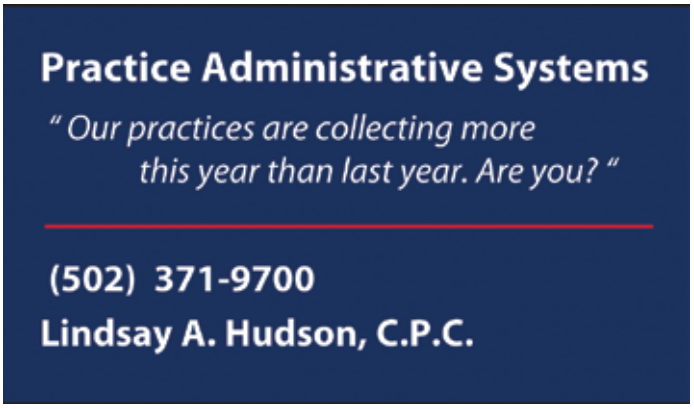

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