SPRING SUMMER
ISSUE 2017
VOL 20
NO 1

The HIPPOCRATIST

The Official Journal of the Ouachita Medical Society

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The HIPPOCRATIST
Spring Summer
ISSUE 2017
VOL 20
NO 1

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OUACHITA MEDICAL SOCIETY

MISSION STATEMENT

The Ouachita Medical Society is a service organization of physicians dedicated to the ideal of a community that is mutually beneficial to physicians and patients.

THE SOCIETY COMMITS ITSELF TO THESE GOALS:

1. To pursue and maintain access to quality medical care
2. To promote public education on health issues
3. To provide value to members by the representation and assistance of member physicians in the practice of Medicine

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We all realize the increasing pressures of day to day practice but, as these articles make clear, now more than ever is the time for physician led advocacy.

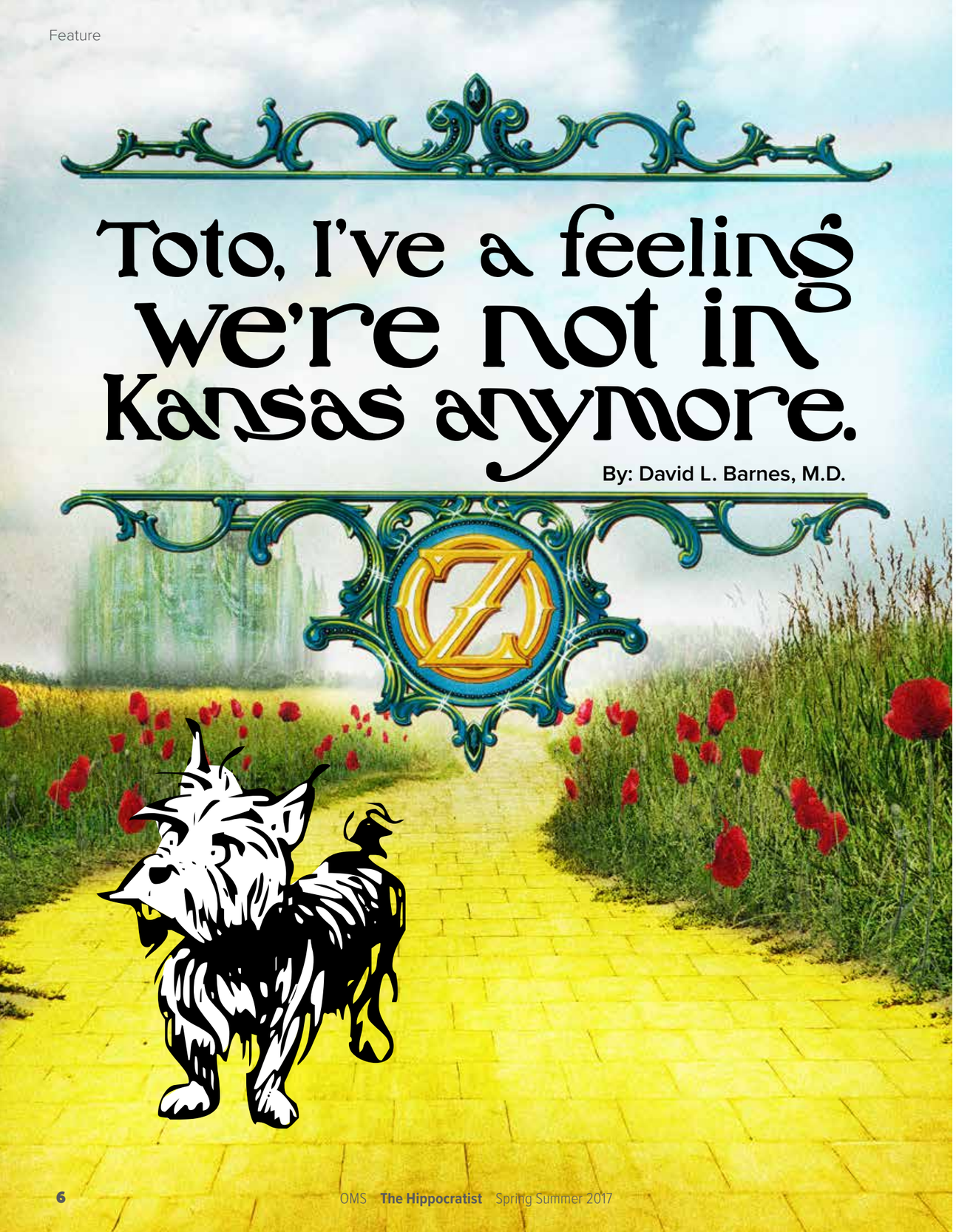
Greetings!

This edition of the Hippocratist addresses issues in healthcare that have been expanding at an accelerated rate over the last couple of decades. As you will read, there are many forces that have become increasingly influential factors in healthcare. From governmental interference, expanding non-physician scope of practice and the increased intrusion of “the business” of medicine, the assaults on the practice of medicine are numerous, growing and constant. The articles by our physician members outline a few of the sentiments and arguments made by physicians today and are by no means an exhaustive list. We all realize the increasing pressures of day to day practice but, as these articles make clear, now more than ever is the time for physician led advocacy. Dr. Shemwell and Dr. Napoli’s articles hopefully will encourage engagement for those of us in “our busy practices” to support those fighting on our behalf legislatively. Dr. Barnes’ article challenges our younger “millennial” colleagues to get involved and regain what we are losing, namely physician led healthcare.

Marty Luther, MD

Toto, I've a feeling we're not in Kansas anymore.

By: David L. Barnes, M.D.



The following is an open letter to my millennial colleagues concerning physician led medicine.

It will be 34 years in July that I began practicing Family Medicine as only the second Board Certified Family Practice Physician in Ouachita Parish. I vividly remember Dr. Roy Ledbetter, one of the founders of the Orthopedic Clinic, visiting me at my office to respectfully ask me about the basic closed fracture management I had requested on my Glenwood hospital privileges form. Satisfied with my answers my privileges were approved. Whether one had the knowledge and skill to practice medicine was of paramount importance to the physician leadership in our community at the time. The "Physician led" medical team was alive and well and under the sacred guardianship of the leaders of the Ouachita Medical Society.

Back then the "Physician led" medical team was led by physicians practicing out of their offices. **It was composed of the physician, his or her nurse, local pharmacists, hospitals (including their nurses and ER physicians), physical therapist, dieticians, nursing homes, home health agencies, etc.** When a patient was seen in the office he or she received an order or prescription to be carried to one of the above "team members". Probably two of the most important team members at the time were the pharmacists and hospitals. Most pharmacies were privately owned and you always knew these pharmacists "had your back". These were the days when prescriptions were all hand written. If you inadvertently wrote the wrong strength or very similar sounding medication you could "bet your bottom dollar" that you would get a call from the pharmacist pointing this out. The error was corrected over the phone and your patient got the correct dose of medication. If you referred your patient to a specialist, a detailed letter of the patients past medical history and reason for referral accompanied the patient. If your patient was admitted to the hospital or nursing home, you routinely rounded on the patient, consulting the appropriate specialists if needed, and were in constant contact with the family and the nurses who were caring for your patient

Fast forward to today. The medical team is "physician led" in name only. Everyone wants "Primary Access" to the patient and the ability to "write orders" for patient care. The "team" now has many "stakeholders" lead by the government, health insurance companies (including pharmacy benefit plans), "Big Pharmacies", and "Big Employers" with their "practice guideline recipe driven" nurse practitioner clinics. In many of these clinics there is little or no true physician supervision or leadership . Unfortunately, large medical clinics are doing much of the same. Many of these teams seem more concerned with what the patient looks like "on paper" correction, "in the computer", than what they look like "in one's office". We now test our patients due to protocol requirement vs their health care needs. Today when you write a prescription, the pharmacy may refuse to fill it for a sometimes-bizarre reason and not even pick up the phone to call the physician first.

When a patient is referred to a specialist the specialist receives a 40 page electronic medical records document. Buried somewhere in this document is the reason for referral. When your patient is admitted to a hospital or a nursing home they are seen by a rotating group of hospitalist physicians/nurse practioners or a nursing home based physician/nurse practitioner who are not familiar with the patient's history or family dynamics. Of course, this problem was supposed to be resolved by the transition of medical records from paper to computer (not).

In our current healthcare system everyone wants to be a doctor, but no one wants to go to medical school. All allied health fields now offer doctoral degrees. You think great, more education for my team members! Not so fast my millennial friends! Their goals are political, not educational. They are trying to influence state legislatures every session to give them authority to practice medicine. Physicians have lost their rightful place to decide who is qualified to practice medicine. The following is an excerpt from a letter I wrote to every member of the Louisiana House of Representatives last year concerning the difference in nurse practioner training, 700 hours of advanced nursing education and M.D. education, a minimum of 20,000 hours of medical training.

"I think this becomes clearer if you use the Jet Pilot analogy. Aviation Maintenance Technicians know a lot about Boeing 757's and are important members of the aviation team. But you cannot legislate them into Jet Pilots, even with "limited authority" to fly Jets. With all the on-board computer technology, an "Advanced" Aviation Mechanic may can get a jet down the runway and into the air. But what happens when birds unexpectedly fly into the jet engines? What happens when the computer malfunctions shutting the engines off? Do you want to be on that plane with the "Advanced" Aviation Mechanic in the pilot's chair? After all he took 4,000 hours of extra Aviation Mechanic training. Do you want your children or grandchildren to be on that plane? Of course not! You want a pilot to be in the pilot's chair. No amount of extra training by an Aviation Technician will make him a Jet Pilot. You want someone who went to flight school, not to "Advanced" Aviation Maintenance School. You want someone sitting in that chair whose judgment and decision making under pressure have been well tested.. Only a select few individuals have the training, fortitude, and perseverance it takes to fly a jet, and that's the way it should be. After all human lives are at stake! It is that same training that separates the Physician from the Nurse. No extra amount of nursing training can ever bridge that gap, neither 4,000 hours nor 100,000 hours of "nursing training" can make you a Physician. There is no short cut. There is no substitute for the grueling training and experience of medical school and residency. There should not be. After all, human lives are at stake."

So, to all my millennial colleagues, you have heard the interchangeable phrases "Physician led" or "Patient Centered" ad nauseam. Let's just call them what they are, a "Mirage".

The challenge is upon you. It is up to your generation to restore Physician leadership and true Patient Centered medical care to the "House of Medicine". You cannot "just" practice medicine. You have got to become active in the politics of Medicine.

Good luck. I'm confident you are up to the task.

as for me...

"I'm off to see the Wizard"

82
Pb
Lead
207.2

THE PROBLEM WITH LEAD

By: Shelley C. Jones, MD, MPH

On December 16, 2016, Governor John Bel Edwards issued a Public Health Emergency for the Town of St. Joseph in Tensas Parish, Region 8 northeast Louisiana. Residents were advised to use an alternative source for drinking water.

Routine water tests conducted by the Louisiana Department of Health-Office of Public Health on December 15, 2016 revealed levels of both lead and copper that exceeded federal safe drinking water guidelines. The town of St. Joseph has experienced water problems for years because of the poorly maintained and deteriorating water distribution system. Frequent breaks in the water distribution system provide a potential health risk because of the drop in water pressure.

Out of an abundance of caution, **the Louisiana Department of Health recommended that residents use an alternative source of water for personal consumption, including making ice, brushing teeth or using it for preparing food (including mixing baby formula), and rinsing of foods.**

The Governor also directed the Louisiana Department of Health (LDH) to collect water samples from every residence in the town of St. Joseph. This collection began on Tuesday, December 20th, 2016. The following article on Lead, its clinical effects, levels, prevention and follow-up was written by Alean Frawley, DO, MPH with Louisiana Office of Public Health Infectious Disease Epidemiology Section.

What is lead?

Lead is a soft heavy metal commonly used in building construction, bullets, lead-acid batteries and as a component of solders and fusible alloys. Common sources of human exposure are age dependent; in children the most common source of lead exposure is leaded paint from houses built before 1978 1,2 adult exposure is typically occupational[1].

What are the clinical effects of lead exposure?[1]

Lead exposure can affect every organ system and exposure is dangerous for everyone. Children tend to develop symptoms at lower blood lead levels (BLLs) than adults and the neurological effects of lead differ based on age of exposure. The other effects of lead exposure are similar across ages, see Table 1.

Is there a safe amount of lead exposure?

There is no safe BLL above zero. Lead exposure in children is associated with permanent neurological damage and behavioral disorders even with a BLL less than the current threshold of 5 µg/dL2.

Clearly lead exposure is harmful, is screening mandated? [3, 4]

Louisiana Sanitary Code mandates blood lead screening for all Louisiana children between the ages of 6 and 72 months but only 18.3% of Louisiana's children <6 years of age were screened in 2014. The Occupational Safety and Health Administration (OSHA) mandates employers to provide medical surveillance for employees with specific occupational exposures to lead. Often patients do not realize they have been exposed to lead, therefore collecting an occupational history is an important part of adult primary care visits.

How do I report BLL when I check it? [3, 4]

The Louisiana Sanitary Code also requires medical providers and laboratories to report all BLLs ≥ 10 µg/dL in all children within 24 hours, to the Louisiana Healthy Homes and Childhood Lead Poisoning Prevention Program (LHHCLPPP) in the Office of Public Health.

Fax the laboratory testing results to **(504) 568-8253**

The original lead case reporting form, available at http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/genetic/LEAD/LeadCaseReportingForm.pdf, should be mailed within 5 business days to:

LHHCLPPP, Office of Public Health
PO Box 60630
New Orleans, LA 70160

Table 1: Clinical Effects of Lead Exposure by Organ System and Patient Age1

Organ system	Effects in children		Effects in adults	
	Very high level exposure (≥70 µg/dL):	**Lower levels of exposure:**	**Very high level exposure (460 µg/dL):**	**Lower levels of exposure (40 to 120 µg/dL):**
Nervous *most sensitive target in both children and adults*	• Seizures • Coma • Death	• Decreased IQ • ADHD • Hearing and peripheral nerve impairment	• Encephalopathy	• Dizziness • Fatigue • Depression • Irritability • Impaired concentration • Forgetfulness
Renal	• Acute nephropathy • May cause decreased renal function in adulthood		• Chronic nephropathy such as chronic interstitial nephritis • Saturnine gout	
Hematology *Lead inhibits hemoglobin synthesis; often will see basophilic stippling on RBCs*	• **Acute high level exposure (≥25 µg/dL in children, ≥50 µg/dL in adults):** Hemolytic anemia • **Chronic exposure:** Hypochromic, and normo- or microcytic anemia with reticulocytosis			
Endocrine *Lead hinders vitamin D conversion impairing extra-and intra-cellular calcium regulation*	**Impaired:** • Cell growth • Tooth development • Bone development			
Gastrointestinal	**Severe lead poisoning:** • Severe cramping abdominal pain possibly mistaken for acute abdomen or appendicitis			
Cardiovascular	• Increased risk of hypertension in adulthood		• Elevated blood pressure • Increased risk of hypertensive heart disease	
Reproductive			**Current exposure (≥40 µg/dL):** • Decreased sperm count • Increased abnormal sperm **Chronic exposure (independent of current BLL):** • Diminished sperm concentration and total count • Decreased sperm motility	
Maternal Exposure during Pregnancy	**Possibly:** • Decreased fetal viability • Poor development • Increased risk of low birth weight and premature birth		**Exposure of BLL 5-9 µg/dL:** • Spontaneous abortion 2-3 times more likely than in women with BLL <5 µg/dL	

** Agency for Toxic Substances and Disease Registry. (2016, Aug). Lead Toxicity: What are the Physiologic Effects of Lead Exposure. Retrieved from https://www.atsdr.cdc.gov/csem/csem.asp?csem=7&po=10s

Laboratories are required to electronically report all BLLs for children under 72 months (6 years) irrespective of the level.

The Louisiana Sanitary Code requires medical providers and laboratories to report lead exposure in adults to the Office of Public Health Environmental Epidemiology & Toxicology Section, by fax to (504)568-8149, within 5 days of the lab result.

What advice can I give to my patients to prevent residential lead exposure?[5]

- Eliminate access to peeling paint or chewable surfaces, such as windowsills or toys, painted with lead-based paint
- Regularly wash children's hands and toys
- Wet-mop floors and wet-wipe window components every 2-3 weeks
- Remove shoes when entering the house to avoid introducing lead contaminated soil into the home
- Prevent children from playing in bare soil
- Avoid using glazed pottery, traditional medicines and cosmetics made outside the United States
- Do not eat candies imported from Mexico

How do I treat elevated BLL in a child?[6]

Always confirm capillary blood testing results with a venous blood level and refer all children with elevated lead to the Office of Public Health LHHCLPPP. Observe trend of BLLs to insure they are consistently decreasing until the BLL is below 5 µg/dL. In addition to lead exposure reduction counseling, for children with initial BLL of

- 10–14 µg/dL: test venous BLL every 3 months
  15–19 µg/dL: test venous BLL every 2 months
- 20–44 µg/dL: test venous BLL monthly, check hemoglobin and treat low iron
- ≥45 µg/dL: test venous BLL monthly, check hemoglobin and treat low iron, chelation therapy

What does the Office of Public Health do for children with elevated BLLs?[6]

- Children with BLLs 5–9 µg/dL: Letter mailed to parents requesting re-testing in 3 months and follow up BLL monitoring
- Children with BLLs 10–44 µg/dL: Follow up BLL monitoring, environmental investigation, lead education and nutrition counseling
- Children with BLLs ≥45 µg/dL: Follow up BLL monitoring, environmental investigation, lead education and nutrition counseling and referral for developmental screening

F.Y.I.

- CDC will likely reduce the BLL upper reference threshold for normal BLL from 5 to 3 µg/dL in the near future.
- Louisiana Office of Public Health's Lead Toolkit for parents and providers is available at http://dhh.louisiana.gov/assets/oph/Center-PHCH/Center-PH/genetic/LEAD/NewsandUpdates/ToolkitforProviderandParent20162018finalrevision.pdf

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F.D. MISTRY LEGACY SCHOLARSHIP

SCHOLARSHIP

The Ouachita Medical Society will be awarding two PGY2 University Health-Conway Residents with monetary scholarships. The monetary prizes may be used completely at the discretion of the winners. The winners will be announced and awarded at the September OMS General Meeting.

In order to qualify, residents must:

- be entering the PGY 2 phase of their residency at University Health-Conway (Monroe, LA)
- submit in-service exam scores
- complete the scholarship application
- complete the essay questionnaire
- submit a staff recommendation letter
- appear for a final interview before the OMS Executive Committee

1st Prize
$1000

2nd Prize
$500

MARK YOUR CALENDAR!!!

Thursday, September 7, 2017 at 6:30pm

Bayou Desiard Country Club, Monroe

OUACHITA MEDICAL SOCIETY'S

STATE *of* HEALTHCARE

EVENT

Expansion projects, aggressive physician recruiting, robotic technology additions… these are just a few of the topics that will be discussed at the upcoming "State of Healthcare" event.

The Ouachita Medical Society is inviting healthcare leaders from across Northeast Louisiana to have a candid discussion with physicians on local changes to the medical care landscape. Hospital CEOs, large physician group administrators, health insurance providers, and local/state legislators are all invited to attend.

No cost to attend

This meeting is open to all physicians in Northeast Louisiana and their spouses.

Door prize drawing Valued over $500.

Must be present to win.

RSVP Today! Seating is limited:

director@ouachitams.org

GENERAL MEETING

A PHYSICIAN'S KEYS TO LOCKING OUT LAWSUITS

The Ouachita Medical Society held its May 2017 General Meeting on Thursday, May 4th. Physicians and their spouses enjoyed delicious food and wine prepared and served by our friends at Vieux Carre in Monroe all while earning CME credit. Physicians, Ralph Armstrong, MD, Clyde Elliott, MD and Russ Greer, MD (not pictured) were each honored for having achieved the milestone of 50 years in medicine. David Gibb, Sr. VP with Legally Mine, Inc. spoke on Lawsuit Prevention and Tax Reduction. Gyanendra Sharma, MD won the evening's door-prize: a pair of tickets to the Auburn/LSU football game in October valued at over $700!! **Special thanks to our meeting's sponsor, Legally Mine.**

UPCOMING EVENTS

State of Healthcare event

Thursday - September 7th at BDCC

Beers with Peers

October - TBA

OMS Christmas Party

TBA

*dates/times subject to change-check

www.ouachitams.org

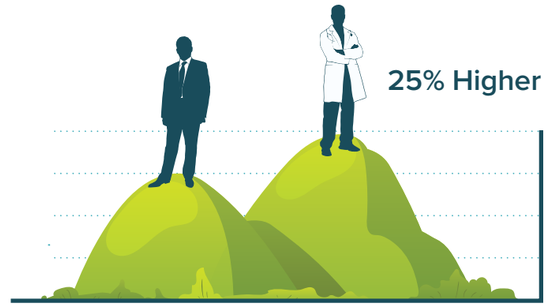
for the most up-to-date information

SUB PRIME HEALTH:

Finding Physician Leadership in the DYAD MODEL

By: Mark Napoli, MD

Last year a colleague of mine told me about a row he had had with his hospital. Just as the public was becoming aware of our rampant opioid abuse crisis through sensational reports of the deaths of celebrities like Prince and Phillip Seymour Hoffman, our government was relaying its plans to tie reimbursement to patient satisfaction.



Physician-run hospitals quality scores are approximately 25% higher than manager-run hospitals.[1]

The hospital administrator asked my friend to stop by for a friendly chat. They said his post surgical satisfaction scores had a few too frowny faces. He was several percentage points below the average patient reported pain control scores. He argued that his outcomes were excellent, his length of stay lower (likely from faster bowel recovery times), and readmissions were almost non existent. He expressed his concern for more aggressive pain control to alleviate any possible patient discomfort could jeopardize these meaningful metrics and possibly increase cases of narcotic addiction.

His hospital boss listened intently and replied that they really needed those pain satisfaction scores to improve. So just work on that please.

Recently I was on duty for the Ouachita Parish Acute Myocardial Infarction Interventional call schedule when I was notified that I would not have surgical backup. Although rare, this was not unheard of. I accepted the news easily until I sought assurance the hospital was not accepting transfers for STEMIs. In house or community emergencies are ubiquitous and uncontrollable, but certainly the hospital would not want to invite disaster by accepting unstable critically ill transfers from outside hospitals while not equipped to handle the need for bailout cardiac surgery.

As a matter of fact, the nursing director had decided just that. And the reason for the call was not to have a discussion about the pros and cons of such a decision nor to ask for my input, but merely to inform me of the situation because there was actually one such critically ill unstable patient in route from a nearby rural parish hospital that the nursing supervisor had accepted. *Good luck!*

profitable hospitals are led by physicians. They seem to be able to lead groups of providers both by example and by authority to make a complex chaotic hospital system work. According to research published in 2011, analysis of the top 100 US hospitals showed that hospital quality scores are approximately **25% higher** in physician-run hospitals than in manager-run hospitals[1]

Docs think long term, lifetime health, patient experience, reputation building, word of mouth. Physician led hospital requires MD with both these clinical and vocational traits, as well as high level business acumen and above all commitment to service.

Some of the most highly regarded and most profitable hospitals are led by physicians.

But hospital administrators have similar frustrations with trying to maintain a profitable hospital serviced by groups of self interested physicians. I've been told managing doctors in a hospital is like herding cats who think they are famous actors. No one complies with Meaning Use (because it's ridiculous). There are so many doctors that don't adhere to guideline directed best practices. And mention Length of Stay and Appropriate Use Criteria to some physicians, they look at you like you are speaking a Swahili.

So is there some solution here? Some of the most highly regarded and most

They bring their personal moral and avocational patient-centered code into the administrative realm.

From the Harvard Business Review in December 2016: "The Mayo Clinic is America's best hospital, according to the 2016 US News and World Report (USNWR) ranking. Cleveland Clinic comes in second. The CEOs of both — John Noseworthy and Delos "Toby" Cosgrove — are highly skilled physicians. In fact, both institutions have been physician-led since their inception around a century ago. Might there be a general message here?"[2]

The sad fact is that there are very few physicians with the skill set required to achieve success running a hospital. Most physicians struggle to maintain a profitable private practice. I suspect it may be that the long term caring positive attributes that make doctors good caregivers actually get in the way of making the day to day hard business decisions that hospital leaders require.

The Dyad Model

The term dyad simply means pair, two people in “an interactional situation, for example, patient and therapist, husband and wife”, or in this case physician leader and administrator.

In the case of hospital administration, the dyad concept creates management teams consisting of a clinical member paired with an administrative member. Each dyad partner brings specific expertise in clinical and/or business operations to the team with the goal of leveraging each other’s strengths to advance organizational performance and maximize cost efficiencies. This model differs from other existing concepts like co management agreements in that the physician involvement is not merely incentivized by cost savings through performance of clinical duties with a diminishing return as those savings are wrung out, but paid and held accountable for results like any other administrator.[3]

On the clinical side, the physician leader is responsible for ensuring quality, evidence-based care; minimizing variations and gaps in care; maximizing standardization without sacrificing individualized care; encouraging teamwork; maximizing the productivity of the clinical team; and overseeing clinician-driven resource utilization and staffing. Meanwhile, financial and supply-chain management, market-share analysis, and capital planning and deployment are the responsibilities of the administrative partner. The organizational chart is comprised of these pairs from the top down.

Advantages of the Dyad model include better communication, greater transparency in processes , and a more rapid and lasting respect between team members. Once members of the organizational structure recognize their common goals, they hopefully will reach true vertical integration and achieve those goals.[4] Clinicians may be more likely to strive for better compliance and professionalism if one of their own is leading, reporting results, and creating innovative methods of rewarding performance in the world of Quality Payment Program (QPP) under the Medicare and the CHIP Reauthorization Act (MACRA) of 2015. Hospital administrators will benefit from physicians becoming true stakeholders by reaching quality benchmarks and overcoming barriers to achieving efficiencies and profitability.[4] Kevin Nolan, MBA managing director for Navigant Consulting, Inc., in Washington, DC, said recently at a leadership summit that those hospitals and health systems that “realize healthcare is a team sport are going to do very well.”

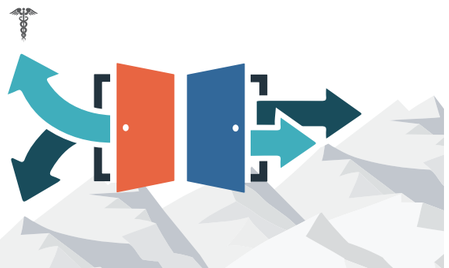
The dyad model may fail if physician involvement does not occur from the very start. Physicians are not necessarily trained to be team players. Mid level teams may be easy to implement, but buy-in from the top tier of hospital and health system management is also key. Fear of loss of power and control at the C-suite leadership is a major barrier to success.

A Case of Need

Healthcare is an increasingly toxic and irrational marketplace. Manipulation of the marketplace by government has led to the emergence of medical oligarchies. Oligarchies create inequities. Left to business people alone, winners will be shareholders and owners with the health of quarterly earnings holding primacy over the health of people. Losers will be providers and patients from lack of choice, lack of autonomy, and erosion of benefit. With true physician partners, hospitals stand to preserve doctor-patient sacrament, clinical voice, long term success, and ultimately profit and sustainability.

Consider how much time, money, and energy has been wasted on the struggle in our community to achieve goals within our respective silos. Quality clashes with cost. And technology can erode humanity. Shouldn’t we capitalize on a time of crisis and change to experiment with a new model? Fear of loss should no longer hold us back from boldness. We are all losing anyway.

We are trapped in a sub prime market with only two choices: *continue the doomed separate paths we currently follow, or forge a new path together.*



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Melton, Stuart - MD
Metoyer, Kenneth Paul Jr. - MD
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Noble, Jack C. - MD
O'Neal, Teri Barr - MD
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Proctor, Gwendolyn - MD
Raulerson, Robert Mac Kinnon - MD
Ross, Theresa J. - MD
Sharma, Gyanendra - MD
Stockstill, James Dean - MD
Sunkireddy, Nandini - MD
Thapa, Trishna - MD
Tirumanisetti, Pavana Naga
Gopi Krishna - MD
Uprety, Subodh Bhakta - MD
Winters, Harry H. III - MD
Woods, Ronald - MD
Wootton, James Leonard III - MD
Yarbrough, David - MD
Yembe, Enaka M. - MD

Gastroenterology
Coon, Clayton C. - MD
McHugh, J.B. Duke - MD, PhD
Richert, Arthur E. - MD
Seegers, Robert - MD
Smiarowski, John S. - MD

General Surgery
Alley, Jo Ann - MD
Clay, Roy Jr. - MD
Cummings, Russell O. Jr. - MD
Ferguson, William T. - MD
Liles, William Bartling - MD
Long, Stephenie R. - MD
Minor, Claude B. - MD
Sanfiel, Francisco J. - MD
Sartor, Walter M. - MD
Smith, James Patrick - MD
White, Robert K. - MD
Zizzi, Henry C. - MD

General Surgery/ Bariatric Surgery
Marx, Daryl S. - MD

General Surgery/ Vascular Surgery
Sartor, Frank B. - MD

General Surgery/ Wound Care
Lolley, Russell T. Jr. - MD

General, Thoracic & Vascular Surgery
Rizzo, Frank P. Jr. - MD

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Bryan, David G. - MD
Clark, Dellie H. Jr. - MD
Hall, Peyton Randolph III - MD
Jackson, Phyllis Gwenn - MD
Vines, Richard Sr. - MD
Williams, Adrienne M. - MD

Internal Medicine
Adams, Alyce - MD
Cavell, Richard M. - MD
Ewing, Robert C. - MD
Ford, Ladonna - MD
Hammett, Donald - MD
Harter, Herschel - MD
Hebert, David A. - MD
Joyce, Charles B. Jr. - MD
Koirala, Prashanta - MD
Lawson, Michael R. - MD
Mason, Charles - MD
Matthews, William - MD
Morgan, Charles G. Jr. - MD
Navarro, Priscilla J. - MD
Olinde, Kurt D. - MD
Ponarski, Roland - MD
Rangaraj, Uma - MD
Rodgers, Julia S. - MD
Sampognaro, Michael J. - MD
Shroff, Pankajrai S. - MD
Smith, Richard D. Jr. - MD
Smith, William D. Jr. - MD
Thadur, Anuradha R. - MD
Turpin, Corbin J. Jr. - MD

Internal Medicine + Pulmonary and Sleep Medicine
Irby, Marshall S. - MD

Internal Medicine-Pediatrics
Bruyninckx, Kyle B. - MD

Interventional Cardiology
Homan, David - MD

Neonatal Perinatal Medicine
Payne, Carmen Sanudo - MD

Nephrology
Anumele, Nkeekam - MD
Archie, Michael W. - MD
Hand, Michael R. - MD
Lee, Frederick B. - MD
O'Donovan, Richard M. - MD
Yount, Nelson - MD

Neurological Surgery
Greer, Carlton Russ - MD

Neurology
Boykin, Michael E. - MD
McCarty, Garland Edward - MD
Olinde, Melanie P. - MD
Thompson, Lowery - MD

Neurosurgery
Alvernia, Jorge - MD

Nuclear Radiology
Wilder, William M. - MD

OBGYN/Phlebology
Belsom, William B. - MD

Obstetrics/Gynecology
Armstrong, Rafael B. - MD
Caire, Michael J. - MD
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Klug, Sara J. - DO
LeBleu, Laurie - MD
Lee, Won S. - MD
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Pennebaker, Dawn W. - MD
Petty, Laura Rush - MD
Shemwell, Amber - MD
Smith, J. Wayne - MD
Truly, James A. - MD
Tugwell, Terence R. - MD
Wilson, Jason B. - MD

Oncology/Hematology
Barron, Scott Morris - MD
Gammage, Coy W. - MD

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Barron, Joseph - MD
Cooksey, John C. - MD
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Read, W. Jason - MD

Orthopedic Surgery
Bailey, Myron B. Jr. - MD
Bailey, Sidney L. - MD
Brown, Douglas C. - MD
Bulloch, R. Brian - MD
Counts, Jeffrey R. - DO
DeGravelle, Martin J. Jr. - MD
Dona, Grant - MD
Gavioli, R. Louis - MD
Graves, White Solomon IV - MD
Hand, Charles R. - MD
Houseworth, Stephen W. - MD
Liles, Douglas N. - MD
McClelland, Scott K. - MD
Sirmon, Kristopher C. - MD
Soeller, Clemens E. Sr. - MD
Spires, Timothy Davenport Jr. - MD
Spires, Timothy Davenport Sr. - MD
Sutton, Fletcher S. Jr. - MD
Taylor, Randolph H. - MD
Trettin, David M. - MD

Otolaryngology
Barham, Wilson - MD
Danna, Lawrence - MD
Fields, Thomas H. Jr. - MD
Metts, Brent A. - MD, PhD
Mickey, Lauren - MD
Miller, Lee A. - MD
Norris, Joel W. - MD
Taliaferro, Henry Van Jr. - MD

Pain Management
Forte, Vincent R. - MD
Gordon, James H. - MD

Pain Management / Anesthesiology
Ledbetter, John - MD

Pathology
Armstrong, John - MD
Blanchard, Richard J. Jr. - MD
Blanchard, Stephen P. - MD
Elias, Abdalla L. - MD
Liles, William Jerome Jr. - MD
Nawas, Soheir - MD
Pankey, Lee R. - MD
Wright, Howard W. III - MD

Pediatric Cardiology
King, Terry D. - MD

Pediatric Medicine
Bimle, Cynthia P. - MD
Bivens, Marilyn G. - MD
Bodron, Milhim A Jr. - MD
Bulloch, Russell H. - MD
Soler, Marc De - MD
Dyess, Bonita H. - MD
Eason, Margot Bell - MD
Everist, Jane - MD
Fichter, Elaine - MD
Grino, Marie Michelle - MD
Jones, John Bolling III - MD
Jones, Shelley Coats - MD
Malmay, Kim - MD
Ricks, Barry - MD
Rosales, Joaquin - MD
Yusuf, Munira Abdullah - MD
Zukowski, Nancy Lynn - MD

Pediatrics
Stanley, Gary - MD

Phlebology
Barr, James L. - MD

Physicial Medicine / Rehabilitation
Morstead, Rolf Daniel - MD
Potts, James M. - MD

Plastic Surgery
Antrobus, Stephen David - MD
Mickel, Timothy - MD
Worthen, Eugene F. - MD

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Ragsdill, Roy - MD
Robertson, Gerald M. - MD
Sherman, J. Rahn Jr. - MD
Walker, Calvin Cecil - MD
Zentner, Scott David - MD

Pulmonary Diseases
Gullatt, Thomas - MD
Hammett, Ronald F. - MD
Maran, Antti G. - MD

Radiation Oncology
Bland, Ross E. - MD
Jr., Robert Ebeling, - MD

Radiology
Abraham, Ralph III - MD
Broyles, Michael - MD
Davidson, Dan B. - MD
Davis, John A. - MD
Erikson, Christopher J. - MD
Golson, Robert - MD
Green, Warren J. - MD
Halsell, E Anne - MD
Halsell, Robert David - MD
Hollenberg, Henry - MD
Lawrence, David R. - MD
Pate, Steven - MD
Worley, Emery E. II - MD
Yatco, Reynaldo - MD

Rheumatology
Hull, John E. - MD
Mallepalli, Jyothi R. - MD
Robicheaux, Rochelle - MD

Therapeutic Radiology
Zollinger, William D. Jr. - MD

Thoracic Surgery
Borders, Blaine - MD
Jones, Thomas - MD

Urological Surgery
Humble, Robert Lee - MD

Urology
Cage, John M. - MD
Dean, Odell J Jr. - MD
Edgerton, Edwin III - MD
Johnson, Jon B. - MD
Liles, Arthur - MD
Liles, William B. - MD
Marx, Don F. - MD
Marx, Robert - MD
Rutland, Edward - MD

GOING THE FULL DISTANCE

By: Amber Shemwell, MD

Several years ago, I ran a few half-marathons. I was very proud of my accomplishment, but never before or since have I ever desired to run an ACTUAL marathon… TWENTY SIX and TWO TENTHS MILES!

I don't think I COULD do it. I don't think that I am physically or mentally strong enough. And I certainly don't hold myself in the same esteem as I do those who I know have put in the time, effort, and sacrifice to actually run a REAL marathon.

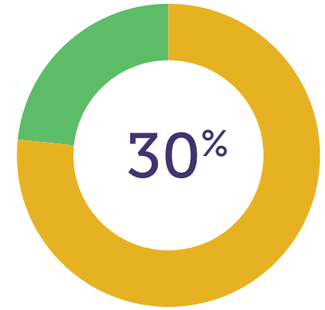
I have heard a similar analogy regarding the few mid-level providers or advanced practice clinicians (APC's) or physician-extenders (nurse practitioners, physician's assistants and certified registered nurse anesthetists) who feel that they should be allowed to practice independently, without physician oversight or collaboration. Some want the same respect, responsibility, reimbursement, and seat at the table, but they haven't run the same race. Most of the ACP's I know don't have a desire to work alone. On the same token, most of the physicians I know would not want to practice medicine WITHOUT their NP's/PA's/CRNA's.

My own practice uses 4 very qualified women's health nurse practitioners to increase our patients' access to care. Our patients can see NPs for urgent visits, follow up of chronic conditions, low risk obstetric care, and preventive services. Our NPs do not have their own patients because we prefer that every patient in the practice have a primary physician. Our preference is based more on logistics (because we are a 13 physician group) than our judgment of the NPs' ability to manage patients. However, some of our patients take matters into their own hands and ensure that they see their chosen nurse practitioner for any and all of their care. I don't view that as a threat but see it as an affirmation that we have a team of very competent NPs that patients feel comfortable seeing. Some patients, on the other hand, refuse to see anyone but a physician. That is their choice. When they request an appointment, we make clear who they can see and let our patients make the decision. We (the physicians and the nurse practitioners) have decided to put our own ambitions and pride in front of what really matters, the patient.

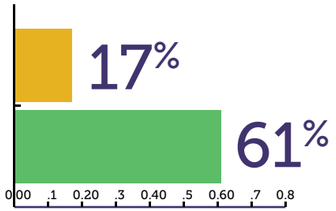
We are all intelligent. We are all well-trained. We all have a distinctive role to play. There is a mutual respect and trust between us because we both fully understand our roles. Our nurse practitioners (most of whom have been practicing for WAY longer than I have) can handle the majority of cases on their own, including the complex ones. But they know when to ask for help. They are humble enough and care about their patients enough to trust the physicians in the group to seek help, when they need it. This is how collaborative practice and physician-led medicine is supposed to work.

When we work together it is cost-effective and it is good for the patient. Which is the whole point right? If it isn't, why are we even doing this? When the physician and mid-level collaborate as a team, the way it was always meant to be, both sides will benefit, as will the patient.

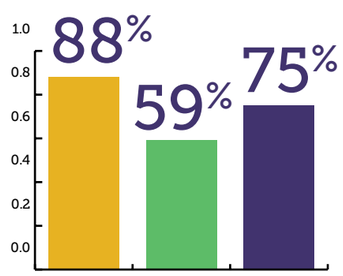
This brings me to the real topic that no one wants to speak out against…independent practice of mid-level providers (it seems so un-PC and we don't want to offend those with whom we work closely and regard as "work family"). I could cite several studies to support my assertion that patients DESERVE a physician-led healthcare team.



Hughes and colleagues from the Health Policy Institute found that APCs order 30% more imaging than primary care physicians[1].



Sanchez and colleagues found that antibiotics were prescribed 17% and 61% more frequently during visits involving NP/PA visits compared with physician-only visits, when accounting for overall visits and acute respiratory infection visits, respectively[2]



Wiklund and colleagues from the Mayo Clinic found an 88% reduction in cancellation of surgical procedures for medical reasons, 59% reduction in costs of pre-operative medical testing, and a 75% reduction in medical consultation requests when physician anesthesiologists led the team of anesthesia providers compared to certified registered nurse anesthetists providing care independently[3]

6.9 / 1,000

Silber and colleagues found that physician anesthesiologists' presence as leaders of the anesthesia team prevented 6.9 excess deaths per 1,000 cases in which an anesthesia or surgical complication occurred[4].

Yes, there is a primary care shortage that is expected to grow as the population ages. But the answer cannot be to substitute care. Most of us believe the answer is more physicians and more nurses working together in integrated, coordinated, physician-led health care teams. This model has proven to increase the quality of care for patients and improve cost-effectiveness. So far, independent practice of physician extenders has not solved the primary care access issues or improved health outcomes at lower costs in those states that now have it. It is not the solution. These NP's/PA's/CRNA's/DNP's have focused expertise and most are good at what they do. They are critical players on the health care team -- but they are not physicians. Some APCs may claim that they are better and faster "runners," and are just as capable or more capable of practicing independently, but it still matters that they've run a shorter race. The broad base of knowledge and resulting diagnostic ability that comes from a range of 11 to 16 years of higher education and training gives each of us physicians a unique ability to live up to the noble calling that is that of being a medical doctor.

Partners and colleagues practicing what they preach

Left Photo: (l-r) Sara Klug, MD, Dawn Pennybaker, MD, Amber Shemwell, MD

Top Right: (l-r) Sara Klug, MD, Dawn Pennybaker, MD, Amber Shemwell, MD

Bottom Right: (l-r) Amber Shemwell, MD, Sara Klug, MD

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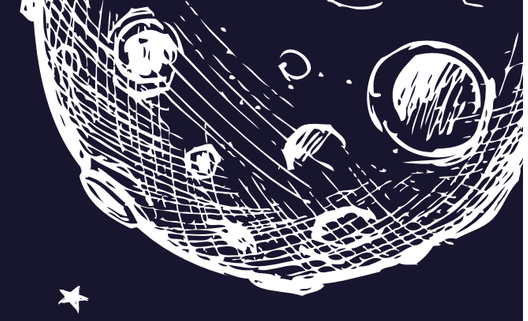
HOLD MY BEER. WATCH THIS.

By: Zeke Wetzel, MD



"Any man who thinks he can be happy and prosperous by letting the government take care of him, better take a closer look at the American Indian."[i]

It was an unusually slow night for emergency surgeries, given that it was a full moon. Those unfortunate enough to endure night shifts in medicine are woefully aware that full moons often bring out the werewolves and other associated freaks of nature and trauma that no doubt are influenced by the gravitational changes induced by the movement of heavenly bodies. Maybe it is the additional glow that inspires the dim-witted to consume to excess the right concoction of opiates, benzodiazepines, and ethanol which leads them to attempt the type of lunacy that often begins with, "Hold my beer. Watch this."

In this case, the injury wasn't induced by trauma, although intoxicants were certainly involved. The middle-aged male was shy about telling exactly how the foreign object came to be located where it was, but the radiologist's report left no uncertainty, " ... cylindrical foreign body located in the sigmoid colon. Batteries noted. Clinical correlation recommended." Apparently the device had long since ceased its motion, suggesting the object had become embedded some time ago. Given the amount of perirectal trauma, there had been some misguided attempts at dislodging the device prior to his presentation to the ER.

Many grand plans begin with vigorous motion and emotion, leading ultimately to uncomfortable situations. The passage of the Patient Protection and Affordable Care Act[ii] was certainly a grand plan that has led to such a condition. Although it was conceived with the best of intentions, and no doubt a smidge of opiates, benzodiazepines, and ethanol, it has since become lodged in a very uncomfortable place for both Americans and the house of organized medicine. Recent attempts to dislodge it have been misguided, leading to unnecessary trauma. A piece of legislation that fundamentally changes the American landscape should never be championed with, "We have to pass the bill, so that you can find out what is in it."[iii] This is the political equivalent of "Hold my beer. Watch this."

A government unable to carry out a function as basic as recovery and cleanup after a natural disaster[iv] certainly lacks the competence to address an entity as complex as the American healthcare system. PPACA inserts a legion of middle-men and bureaucrats, all of whom draw a taxpayer-funded salary, into the doctor-patient relationship. How can costs be expected to decrease, access be expected to increase, and quality to improve when minions with only vague regulation to follow, unchecked authority, and no understanding of medicine are allowed to govern patient care? Those who think a government-run system is the solution should look to the cost, access, and quality provided by the single-payer system that already exists in the US – the VA. At the VA, the government has already proven that it fails spectacularly the very mission it is attempting to force on the American public through the PPACA. Successful patient care has continued to elude the VA despite the presence of a ubiquitous EMR that existed long before the government made its use a condition of full reimbursement for healthcare delivery.

The bottom line is money, and the old adage, "You get what you pay for," applies. A government that forces cost controls on an American industry begins to fundamentally change our capitalist society to a socialist society. Many elements of socialism already exist: Our teachers, police force, firefighters, and yes, our military are all representative of the quality of socialist elements incorporated into our society. Those of us who grew up before millennial idealism were taught that true success was the result of hard work, trophies were not awarded for participation, and it takes strength and character to lose, as well as to win, with grace. And nothing good comes for free.

Fortunately for our friend with the concealed foreign body, doctors were able to safely remove it. The question remains as to whether doctors will be allowed to safely manipulate the PPACA, or whether politicians will attempt more of the same, "Hold my beer. Watch this."

References : i Attirbuted to Henry Ford, ii Obamacare iii, Then Speaker of the House, Nancy Pelosi, March 2010, iv See Hurricanes Katrina and Sandy

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