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NO 1

# The HIPPOCRATIST

The Official Journal of the Ouachita Medical Society

# WEED IN OUACHITA


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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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**Colleagues,**

**This edition of the "Hippocratist" marks the final edition during my tenure as your president. The subject of medical marijuana is timely as its use is now arriving in Louisiana. The first distribution centers are being named by the Louisiana Board of Pharmacy and soon we will likely be addressing questions from our patients.**

As I read through the articles in this issue I remain surprised at the level of anecdotal evidence on which marijuana relies and the lack rigorous scientific studies available to support its use. This is especially true when you consider that it is estimated that cannabinoids have been used for as long as 5,000 years. I hope you enjoy reading them as much as I did and perhaps it will provide you with a bit of information as you weigh its use in your practice.

This edition of the "Hippocratist" also marks the final edition overseen by our Executive Director, Krystle Medford. It is with heavy heart that I inform you that we must say our goodbyes as she will be relocating to Colorado and taking a position with the Colorado Medical Society. I offer my congratulations for a well-deserved recognition of her abilities and work effort. She has been the driving force behind the scenes at OMS for the last decade and helped keep OMS one of the most active and represented societies in the state. I thank her for all she has done and wish her and her family nothing but the best.

As one chapter closes for the OMS, another opens. I am happy to report that OMS has identified a new Executive Director. Ms. Jennifer Mills has accepted this position and I am excited for her as she builds upon Ms. Medford's successes.

As always, I remain optimistic for medicine in Ouachita Parish and I thank OMS for the privilege to serve as your president. Again, thank you Ms. Medford for helping me look good and welcome Ms. Mills.

The future is bright!

**Euil E. "Marty" Luther, M.D.**


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# LEGALIZED MEDICAL MARIJUANA

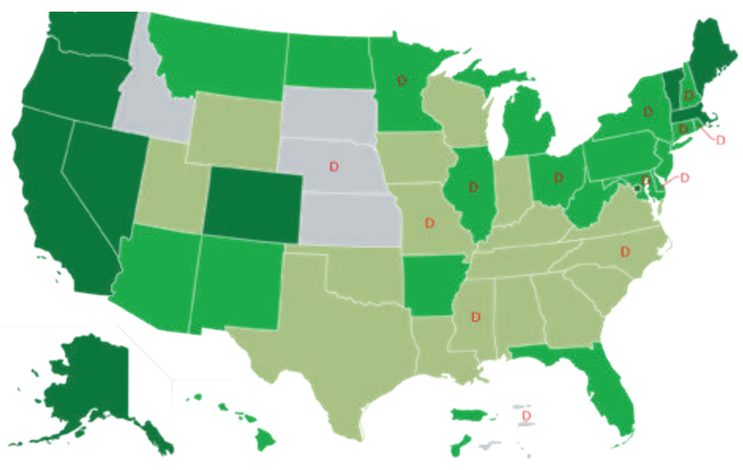
By Ron Ellis, MD

*I was asked to write an article regarding the impact of legalized medical marijuana on my practice and the care I provide my patients. The short answer is "not really very much, if any". But first I would like to provide some background. In the course of conducting my research for this article I discovered some interesting facts which I want to share with you.*

I learned that Louisiana was actually the first state to have a law that legalized medical marijuana. This was in 1978 when then Governor Edwin Edwards signed the bill allowing doctors to prescribe marijuana for treatment of certain medical conditions. Unfortunately, it is a federal offense to prescribe a Scheduled I controlled substance, so this law was never implemented and thus faded into history.

There are now 30 states (and the District of Columbia) with laws allowing medical marijuana, with Louisiana being #25 after ACT 261 was passed in 2015. More recently in 2016 Governor John Bell Edwards signed into law two bills: SB 271 which amended the existing law to allow doctors to "recommend" medical marijuana, something First Amendment freedom of speech protections allow, as opposed to "prescribing" marijuana, which under federal law can expose physicians to the risk of losing their licenses to prescribe all medications. The second bill, SB 180, amended criminal statutes providing protections for patients and their caregivers for possession and consumption of therapeutic cannabis. However, this bill did not specifically extend these protections to growers, pharmacies, or their employees, putting the entire program at risk. There will likely be further amendments to correct this.

The Louisiana system is scheduled to be up and running by summer 2018, although not all of the marijuana dispensaries will likely be open statewide by then. A Board of Pharmacy selection committee in January of this year interviewed applicants for each of the 9 regions that will have a medical marijuana pharmacy. The board is slated to issue 9 permits, one for each of the designated regions throughout Louisiana, plus a 10th later in a high demand area.



The actual plants will be grown by the LSU and Southern University agriculture departments, which must produce marijuana with the "lowest acceptable therapeutic levels available through scientifically accepted methods" under a tightly controlled system. The plants will then be processed by third-party companies into forms that cannot be smoked or vaporized. This will include oils, pills, sprays and topical ointments. Louisiana law is not going to permit any unprocessed raw plant material that can be smoked or vaporized. It is also not permitting any home cultivation for medical use. Louisiana plans to be able to track the marijuana "from seed to sale".

The LSBME and Louisiana pharmacy board have compiled a list of debilitating (or qualifying) medical conditions that will be eligible for treatment with medical marijuana. At the current time this list includes cancer, HIV/AIDS, cachexia/wasting syndrome, seizure disorder/epilepsy, Crohn's disease, muscular dystrophy and multiple sclerosis. Interestingly one of the main indications for medical marijuana in other states is chronic pain, which current Louisiana law does not allow. However, two bills that won approval in the House on April 5, 2018 would enable more patients access to medical marijuana. House Bill 579 by Rep. Ted James, D-Baton Rouge, would add glaucoma, severe muscle spasms, chronic pain and posttraumatic stress disorder to the conditions currently qualifying. House Bill 627, by Rep. Rodney Lyons, D-Harvey, would add autism to the existing conditions. These bills are now headed to the Senate.

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**"lowest acceptable therapeutic levels available through scientifically accepted methods"**

For practicing Louisiana physicians in good standing to qualify for recommending medical marijuana for their patients several things have to be done. First, physicians will need to obtain a therapeutic marijuana registration (TMR) permit. To do this you will need to complete an application found on the LSBME website. Before submitting this application you will need to successfully complete the online therapeutic marijuana rules course and quiz, after which you will be issued a certificate of completion. Also don't forget the $75 nonrefundable fee for the permit. Then, before recommending therapeutic marijuana you must obtain a Schedule I authority designated for therapeutic marijuana by the Louisiana Board of Pharmacy. Failure to do so within 60 days after issuance of the TMR permit will put the licensee at risk for disciplinary action. Also, that will cost you another $45.

Once you are finally set up to be a bona fide physician who can legally recommend medical marijuana to their patients you will need to obtain copies of the physician recommendation form. This form can be found at the end of Chapter 77 of the discipline specific rules for physicians on the LSBME website. Please note that this form not only requires you to check the qualifying condition that the patient has but also the recommended dose of marijuana for their condition. I personally have no idea how much marijuana it takes to treat these qualifying conditions. I assume that there are CME courses that can provide this information.

In wrapping up this article I would like to address the issue of medical marijuana as it relates to opioid use. A number of studies have been published over the last several years that suggest medical marijuana patients use fewer opioids as well as other drugs such as antidepressants, sedatives and alcohol. A study published just last Monday in the Journal of the American Medical Association found that states with medical marijuana and recreational laws had less opioid prescriptions among Medicaid beneficiaries. The study found that between 2011 and 2016 opioid prescribing rates decreased by 5.88% in states with medical marijuana laws and by 6.38% in those with adult-use (recreational) laws.

*Is it possible that, according to the study authors, "marijuana liberalization may serve as a component of a comprehensive package to tackle the opioid epidemic"? As a physician who specializes in pain management and legitimately prescribes opioids on an almost daily basis, I certainly hope so.*


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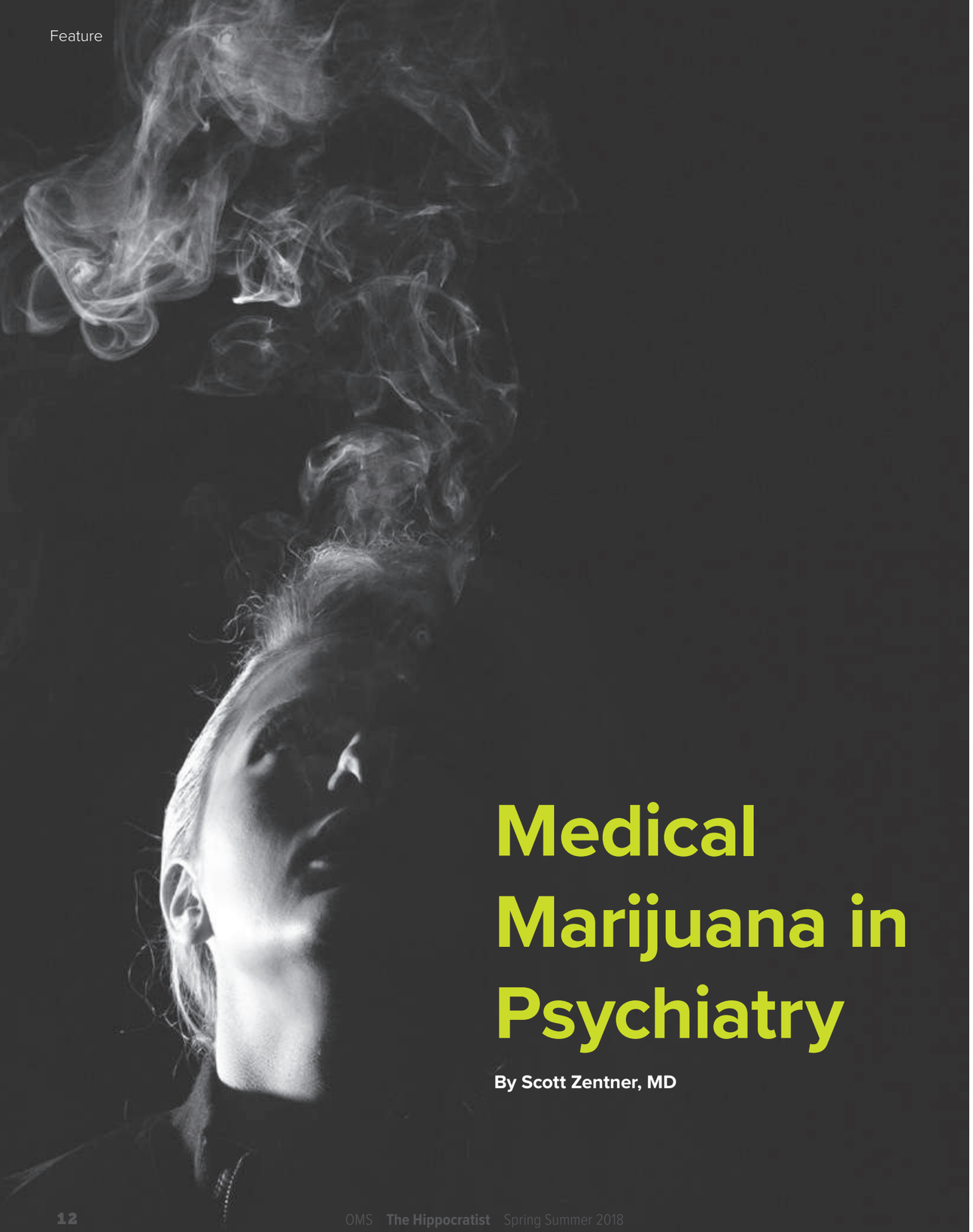


# Medical Marijuana in Psychiatry

**By Scott Zentner, MD**

**“Marijuana in its natural form is one of the safest therapeutically active substances known to man. By any measure of rational analysis, marijuana can be safely used within a supervised routine of medical care. It would be unreasonable, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record.”**

DEA Chief Administrative Law Judge Francis L. Young
*Ruling in the matter of Marijuana Rescheduling Petition, September 6, 1988.*

Cannabis has been used for medicinal purposes throughout the world for at least 5000 years. It was used extensively in Western medicine during the late nineteenth century, but fell into decline after potent synthetic medications were introduced in the early twentieth century. Marijuana was also vilified in thepopular media, such as in the movie Reefer Madness, an anti-marijuana propaganda film released in the late 1930s.

In recent decades, many proponents of medical cannabis have reemerged, particularly the powerful Marijuana Policy Project, which has been responsible for most of the major state-level marijuana policy reforms. They and others advocate the use of the plant in a smoked or otherwise inhaled form and the cultivation of strains with high concentrations of delta-9 tetrahydrocannabinol (THC) that are claimed to be effective for various ailments. Even an esteemed judicial representative of the DEA has adopted an ardent stance in favor of medical marijuana..."Marijuana in its natural form is one of the safest therapeutically active substances known to man. By any measure of rational analysis, marijuana can be safely used within a supervised routine of medical care. It would be unreasonable, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record."- DEA Chief Administrative Law Judge Francis L. Young, Ruling in the matter of Marijuana Rescheduling Petition, September 6, 1988.

Back to THC...It is the principal psychoactive chemical in cannabis and responsible for the pleasurable effects of relaxation, euphoria and laughter, as well as the negative effects of distorted perception of time and distance, loss of coordination, paranoia and cognitive impairment. Unfortunately, federal regulations, such as the classification of THC as a schedule I controlled substance, as well as the rapid and largely unscientific promotion of medical marijuana nationwide, or what some have called “medicine by popular vote”, have resulted in a scarcity of good scientific evidence on the reputed medicinal benefits of smoked marijuana.




Around the country, medical marijuana cards are routinely given to people suffering from **anxiety, depression, insomnia, ADHD, autism** and **other mental health syndromes**. The internet is replete with a growing number of gushing testimonials of successful symptom alleviation through cannabis, including people diagnosed with mood and psychotic disorders such as bipolar and schizophrenia.

Despite these anecdotal reports as well as misleading advertisements spread by legalization supporters, the reality remains that most of these claims are misguided and unsubstantiated. Sadly, they risk endangering the lives of the very patients they profess to help. Furthermore, no cannabinoid drug has been approved for any psychiatric indication, as the effects of THC are simply too unpredictable to assure any consistent therapeutic response.

To the contrary, several studies have linked marijuana use in its unprocessed plant form to an increased risk for psychiatric disorders, including schizophrenia, depression, dissociative states, IQ and memory impairment, and substance use disorders, but whether and to what extent it actually causes these conditions is not always easy to determine. The amount of drug used, the age at first use, and genetic vulnerability have all been shown to influence this relationship. The strongest evidence to date concerns links between marijuana use and other substance use disorders and between marijuana use and psychiatric disorders in those with a preexisting genetic or other vulnerability.

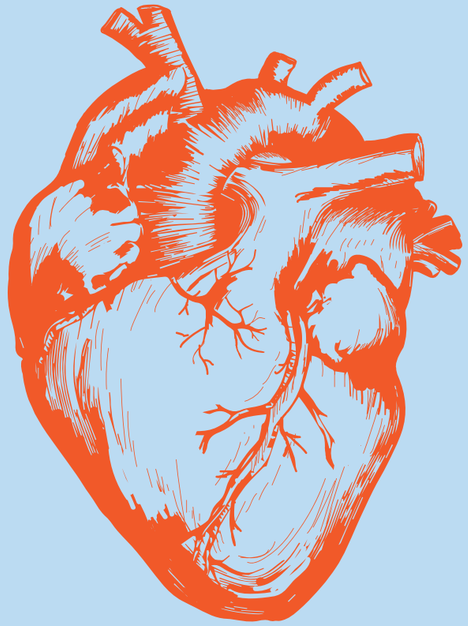
Interestingly, the antipsychotic effects of cannabidiol (CBD), one of 85 cannabinoids in the Cannabis sativa plant but lacking the psychoactive effects of THC, have been demonstrated in animals and in humans, and supported by functional MRI studies. Additionally, CBD may have potential therapeutic value in PTSD, due to its ability to block “reconsolidation”, in which memories of painful life events are enhanced by exposure to conditioned stimuli. CBD has also been shown to have anti-emetic and anti-inflammatory effects, as well as possible neuroprotective properties.

In closing, claims for the medicinal usage of marijuana in treating psychiatric disorders are myriad despite the relatively weak medical evidence. However, the potential consequences, especially in young adults, are numerous. Notwithstanding, the human cannabinoid system is widespread and involved in the regulation of several physiological mechanisms, some of which may be beneficial. Targeted pharmacotherapies based on specific cannabinoids found in marijuana, such as CBD, may hold promise in the treatment of psychiatric and other illnesses, if politics can be put aside in the interest of advancing solid medical research. Wishful thinking, I suppose.

**“Furthermore, no cannabinoid drug has been approved for any psychiatric indication, as the effects of THC are simply too unpredictable to assure any consistent therapeutic response.”**

# MARIJUANA
## — and —
# Coronary Heart Disease

By Mark Napoli, MD



Cannabis research is challenging since it remains illegal in most countries and research-grade samples are difficult to obtain – which may be a moot point given that research-grade plants in the US are thought to be very low potency and inferior quality.

Of greatest interest to the cardiology community is evidence that inhaled cannabis has adverse cardiovascular consequences. Couple that with its increasing use and decriminalization, it's not just blowing smoke to say that pot-related acute coronary syndrome cases will likely become more prominent.

Besides myocardial infarction, marijuana use has been temporally related to cardiac arrhythmias, sudden cardiac death, cardiomyopathy, stroke, transient ischemic attack, and arteritis.

The cardiology community has done little clinical or bench research on the cardiovascular effects of marijuana, but what exists is mostly related to smoking it.

Also, careful evaluation of the cardiovascular effects of marijuana inhalation is complicated by the fact that it is often used in combination with other drugs, such as alcohol or cocaine. Additionally, in many parts of the world, marijuana is smoked in conjunction with tobacco, making it difficult to separate the specific cardiovascular effects of each substance.

However, reports of myocardial infarction after acute exposure to the synthetic cannabinoid K2 suggest that the deleterious effect is likely secondary to cannabinoid exposure rather than 1 of the other nearly 500 chemical components that make up the cannabis plant. (Mir, A., Obafemi, A., Young, A., and Kane, C. Myocardial infarction associated with use of the synthetic cannabinoid K2. Pediatrics. 2011; 128: e1622-e1627)

2001, Mittleman et al. addressed this relationship. there was a 4.8-fold elevated risk of MI over baseline in the 60 minutes after marijuana use. Similarly, a 4.2-fold increased risk of mortality was seen in regular marijuana users compared with nonusers following MI.

Emilie Juoanjus, PharmD, PhD, and colleagues at the Centres d'Evaluation et d'Information sur la Pharmacodependance-Addictovigilance in France, presented a large case series that offers a little more insight into the link between marijuana use and serious CV complications. In total, just 1.8% of all cannabis-related reports were CV complications (35 of 1,979 events). In nine of 35 cases (26%), the event led to death. None of those who died made it to the hospital, but were rather found dead or unconscious, with cannabis use indicated by toxicology or bystander report. Concluded Joaunjus et al.: "Despite the known underreporting, the rate of cannabis-related cardiovascular complications reported steadily rose during the past 5 years...The majority consisted of acute coronary syndromes and peripheral arteriopathies," consistent with previous findings and strengthening the conclusion that "cannabis use may be responsible for serious complications, in particular on the cardiovascular system.

## KEY POINTS

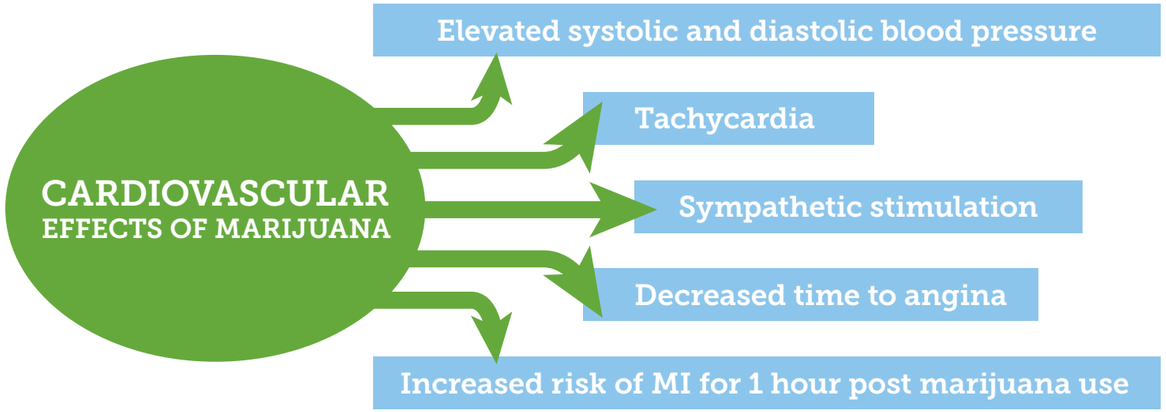
There are at least 33 known carcinogens in marijuana smoke.

Marijuana smoking is associated with cancer, respiratory problems and cardiovascular disease.

When legalized, policies should prefer safer modes of consuming marijuana over smoking.

Widespread smoking of marijuana in public may risk renormalization of smoking in general.

**"There is definitely a need for more serious research in this area—basic science research, observational studies, and controlled studies looking at the acute and chronic effects of marijuana on the structure and function of the heart and the vasculature—because there hasn't been much done," he stressed.**




## Target for Research

Tetrahydrocannabinol (THC) has been increasingly associated with agitation and cardiotoxicity, while cannabidiol (CBD) has been associated with neuroprotective, inhibitory states

Among cannabinoid receptors, CB1 receptors are pro-atherogenic, and CB2 receptors are anti-atherogenic. Studies are currently underway to develop molecules targeting CB1 and CB2 receptors to alter the course of atherosclerosis. There are no clinical data to suggest any definite relationship between chronic recreational marijuana use and atherosclerosis. Marijuana causes tachycardia and decreased exercise time to angina and increases the risk of triggering an ACS in the short term. Long-term, large sample size studies have failed to show an increase in cardiovascular mortality related to chronic marijuana use. However, marijuana use can precipitate an acute event in susceptible patients, and its use may be associated with increased mortality in patients with history of MI.

Sep 22, 2016 | Ajoe Kattoor, MD; Jawahar L. Mehta, M.D., Ph.D., FACC

## Edible cannabis products

Edible marijuana products are sold as brownies, cookies, and candies, which may be indistinguishable from counterparts without marijuana and are palatable to children and adults. The consumption of an entire product containing multiple dose-units may result in overdose.

Researchers also suggest that increasing concentrations of THC seen in cannabis concentrates such as “dabs” may cause agitation and end-organ damage through sympathomimetic and serotonergic pathways.

Edible marijuana exposures are increasing and may lead to severe respiratory depression. But as of yet, there’s little evidence of acute cardiac effects of edible marijuana products. Concerning is the lack of regulation of safe levels of cannabinoids in these products, especially the home-made varieties. Calls to poison control centers are increasing every year. The highest number of calls comes from states which have decriminalized marijuana usage.

## Figure:

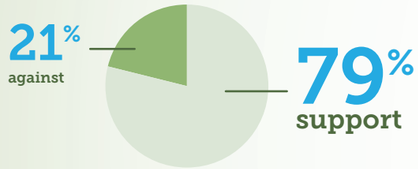
*Journal Clinical Toxicology*
*Volume 55, 2017 - Issue 9*

*Shannon S. Rickner, Dazhe Cao, Kurt Kleinschmidt & Steven Fleming*

*Pages 1011-1013 | Received 27 Feb 2017, Accepted 18 Apr 2017, Published online: 23 Jun 2017*

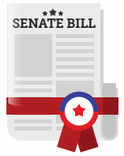

# LOUISIANA
## MEDICAL MARIJUANA LAW

### People in Louisiana support the idea of medical marijuana




**2015** First failed effort to legalize medical marijuana

**2016** Edwards signed Senate Bill 271 to amend the 2015 literature




- [x] Passed
- [ ] Now Act no. 96

**Flaw with Act no. 96:**
Doesn't protect patients, growers, and distributors from prosecution

## MEDICAL MARIJUANA USAGE IN LOUISIANA


The LSU AgCenter holds one of two licenses granted by the state for medical marijuana

### Marijuana-based Medicine must be a liquid

- Oil or Spray
- Pills
- Edible Dosages
- Topical Applications
- Trans-dermal Patches
- Suppositories

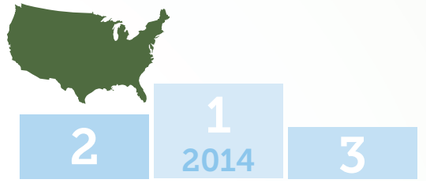
## HOW THE RECOMMENDATION FOR MEDICAL MARIJUANA WILL WORK


**30 DAYS** The certification for medical marijuana is good for 30 days and must return back to doctor for evaluation

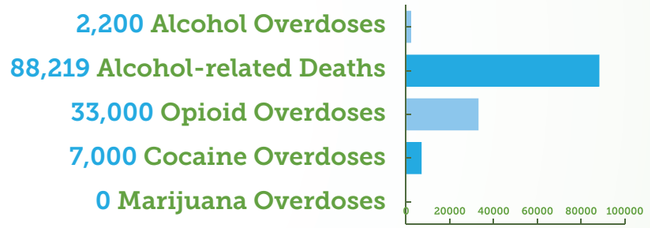
Physician then can recommend the patient a certification for another month



# NEWSWEEK
## CANNABIS COUNTRY INFO




**Data from 2014, ranks the US as 2nd in per capita cannabis-use worldwide**




**San Diego State University and Cornell University have performed studies that link medical marijuana to increased physical activity and a 2-6% decrease in obesity**

Due to medical marijuana alleviating chronic pain


Choosing cannabis over alcohol

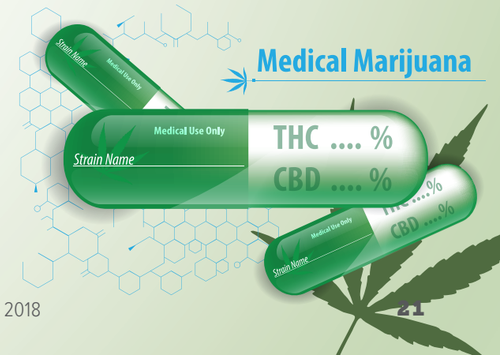
Helps fight against heart disease, inactivity, and poor-health

### Medical Marijuana Users

- Middle-aged Americans are more likely to use cannabis than their children
- This is due to older age experiencing chronic pain and aches
- Many seek alternative methods of pain relief and alternative cures rather than use heavy doses of pharmaceuticals
- Medical marijuana increases quality of life in older individuals
- Medical marijuana laws being passed has seen an increase in workforce participation in the older generations
- Senior citizens who do not respond well with pharmaceuticals are more likely to try medical marijuana

### Biological effects of cannabis

- Research shows possible link between a runner's high and a cannabis high
- Due to a series of receptors in our brain and nervous system, known as the endocannabinoid system
- Cannabinoids (i.e. THC and CBD) bind to this receptor
- Research has shown a runner's high depends on the cannabinoid receptors
- High levels of naturally produced endocannabinoids seen in mice bloodstream
- What is assumed to be behind the runner's high




I know that this **"WEED IN OUACHITA"** issue of The Hippocratist is primarily concerned with medical marijuana, but generally, once medical marijuana becomes accepted, recreational use is not far behind. Soon we will be like Colorado, where there are more pot shops than there are Starbucks. Or, as recreational use becomes accepted nationwide, we are at risk of losing our motivation, of tamping down our collective American drive and can-do spirit. We will become a bland, also ran in the world community — like Iceland – the highest percentage user of cannabis worldwide. Anyone ever remember any earth shaking, life changing advances coming out of Iceland?

I have to admit, when it comes to marijuana, I am a neophyte. Show me a face, and I will point out a score of subtle asymmetries. But when it comes to smoking, baking, eating or vaping dope, I am a rookie.

**WELL, NOT A COMPLETE ROOKIE. THERE WAS ONE EPISODE AFTER MY SENIOR YEAR IN COLLEGE.** I was headed to New Orleans for medical school in the fall, but decided to stay in Nashville for the summer and I took a job waiting tables at a restaurant called "The Sail Maker". Aside from decent food, one of the main attractions of this place was that all of the wait staff dressed up as fictional characters – Minnie mouse, Batman, Zorro, etc. The manager decided that since I was going to be a doctor, I would dress up as Ben Casey, which took no imagination on my part – I just wore scrubs and a cap and mask to work everyday.

One evening before work, one of my roommates – a lanky, business major from Tuscaloosa nicknamed **"NECK"**, who in his four years of college was stoned so often that it gave new meaning to the term **"HIGHER"** education, decided that I needed to experience the effects of THC before I went off to medical school. I laughed and told him that drugs didn't affect me much and besides, it was 4 o'clock and I had to be at work in an hour. With that, he sat across the table from me and while I ate, he lit up a chubby, hand rolled, left-handed cigarette that we passed back and forth. We chatted amicably for a while, and I told him I couldn't feel anything and that I knew I wouldn't. He handed me the rest of the joint and rocked back in his chair.

I wasn't irritated at him for holding me up while I was trying to get to work, in fact, I felt a growing, vague sense of amusement – **LIKE THE WORLD WAS A KINDER, HAPPIER, FUNNIER PLACE THAN I HAD EVER REALIZED** – and that he was a really nice guy for sharing his dope with me.

I was no longer interested in the meatballs I was eating, but I was really hungry for crackers or chips or something sweet like cookies or a Hostess Twinkie. I didn't usually eat this stuff so it made me giggle. I kept giggling, then I started laughing, then I saw a candy bar called a "ZagNutt" sitting on the counter and the laugh became a convulsive belly laugh – the kind that makes you lose your entire tidal volume and become a little hypoxic. I said, **"NECK, WHO NAMES A CANDY BAR ZAGNUTT? AND WHAT THE HECK IS A ZAGNUTT, ANYWAY?"** I waited, but he didn't answer. Then I realized that he was gone and I had been up in my little kitchenette giggling and guffawing to myself over meatballs, Twinkies and ZagNutts for the past 15 – 20 minutes and I was going to be late for work.

I slid into my car still convinced that marijuana had no effect on me. I was just happy. In fact, I was so happy to

be alive, accepted to medical school and on my way to a fun summer job, that I wanted to drive slowly, so I could enjoy the Nashville cityscape and wave at people on the sidewalk. If I were a little late for work, everyone would understand. A guy behind me honked and sped around. I could see his mouth moving aggressively so I flipped him the peace sign. He flipped me half of it back.

I made it to work just in time for the team meeting before the diner shift and by now, I was so tickled with life

in general that every single thing was the funniest thing I had ever seen: Tony Beretta's fake parrot wouldn't stay on his shoulder and kept falling into plates on his waiter's tray, Minnie Mouse had a big blob of whipped cream on her rear end from walking too close to the desert table and the newest waiter was a young Iranian guy who played Superman but had the wrong voice for the role. It didn't take long for Mother Hubbard, an older woman of 30, with two children whose husband was a graduate student, to notice something wasn't right with me. **"DR. CASEY, ARE YOU STONED?"** She asked.

**"BAHAAA, YES."** I said.

She promised to keep an eye on me.

In my euphoria, I had left home without my waiter's check book, so I borrowed a pen from a gentleman at my first table and took their order on my pants leg. I gave everyone at the table a pitcher of water and a basket of bread and when their food came out, I couldn't remember who ordered what, so I let them just get up and claim their own plate from the tray – all of which I thought was pretty doggone funny. Mother Hubbard, however, had seen enough. She relegated me to a chair in the kitchen, told me not to move, told my table **"DR. CASEY HAD AN EMERGENCY"** and took over my station for the rest of the night.

As I sat in the chair, alone, I became aware that I was different from the other characters. Snow White would hardly look at me. Don Diego de la Vega, (aka Zorro), acted aloof, haughty, arrogant, disgusted. Marshall Dillon gave me a wise, fatherly look, as if a shot of whiskey and a good night in jail would straighten me out. I was convinced they were all in the next room talking about me. Probably plotting to tell the manager and get me fired so they could take over my station. Or worse, they might leak out news of my attempt to serve dinner while impaired – news that might trickle down to New Orleans and the state board of Medical Examiners. My dream of going to medical school would go up in smoke!

Neck was right. I did need to smoke some dope before I went to medical school. Sure, things were funny, I was mellow, and life seemed rosy. But I learned first hand about the lack of motivation, loss of situational awareness, inability to sequence or multitask and the very real feeling of paranoia that can come from using marijuana (not to mention the munchies). I learned first hand that in the right setting, it could be a good buzz, but it wasn't my buzz.

I look back on that night often, and I laugh. Not an uncontrollable paroxysm of belly laughter, but a chuckle that springs from wisdom, experience and the assurance of divine providence. Thank God for Mother Hubbard and thank God that my first and last night with Mary Jane came to an uneventful end.

Even though the statue of limitations has run, the concept of **"NO HARM, NO FOUL"** probably applies, Mother Hubbard may be senile, deceased or living in Colorado and recreational use of marijuana is currently legal in 9 states and the District of Columbia, everything contained in this piece is fictional. Resemblance of any of the characters in this story to real persons, alive or dead, is purely coincidental. That's my story and I'm sticking to it.

Good luck trying to depose Batman, Superman, Mother Hubbard, Snow White, Beretta or Zorro.

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**The Executive Committee of the Ouachita Medical Society is proud to introduce Ms. Jennifer Mills as the new Executive Director of the Ouachita Medical Society. Please join us in welcoming her.**

Jennifer has over 15 years of experience in the nonprofit, healthcare and pharmaceutical industries. She began her pharmaceutical career in 2003 promoting gastrointestinal medications. In 2005, she joined the American Cancer Society as the Executive Director for Northeast LA where she was responsible for overseeing the administration, programs and strategic plan of the organization. Her other duties included fundraising, marketing, community outreach, and managing a team responsible for multiple events. Jennifer was tasked with merging the Shreveport and Monroe markets, which resulted in instrumental growth of income and volunteer engagement. She built relationships with various community organizations and directed a Leadership Council.

After 12+ years with the Society, when the local office closed, Jennifer returned to pharmaceutical sales as a Territory Manager with Salix Pharmaceuticals. In this role, she presented healthcare providers with the most current information on IBS-D and OIC medicines and treatments.

Jennifer specializes in event organization, fundraising, donor relations, and utilizing the strengths of others in a team environment to accomplish a goal. She is ready to bring her experience and enthusiasm to the Ouachita Medical Society and is looking forward to meeting its members.

A lifelong resident of Monroe, Jennifer is a graduate of ULM and St. Frederick. She and her husband Heath have three children – Lauren, a student at Louisiana Tech, and Bailey and Liam, both at Sterlington Elementary. They are members of Jesus the Good Shepherd Catholic Church. She enjoys gardening, interior design and architecture, and being actively involved with her church and the ACTS community.

### 15 Years of Experience

*Nonprofit, Healthcare, and Pharmaceutical Iindustries*

### American Cancer Society

*Executive Director for Northeast LA*

### Salix Pharmaceuticals

*Territory Manager*

### Speciality

*Event Organization, Fundraising, Donor Relations*

### Graduate

*ULM and St. Frederick*

### Personal

*Member of Jesus the Good Shepherd Catholic Church*

*Enjoys gardening, interior design and architecture, and being actively involved with her church and the ACTS community*




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