FALL WINTER
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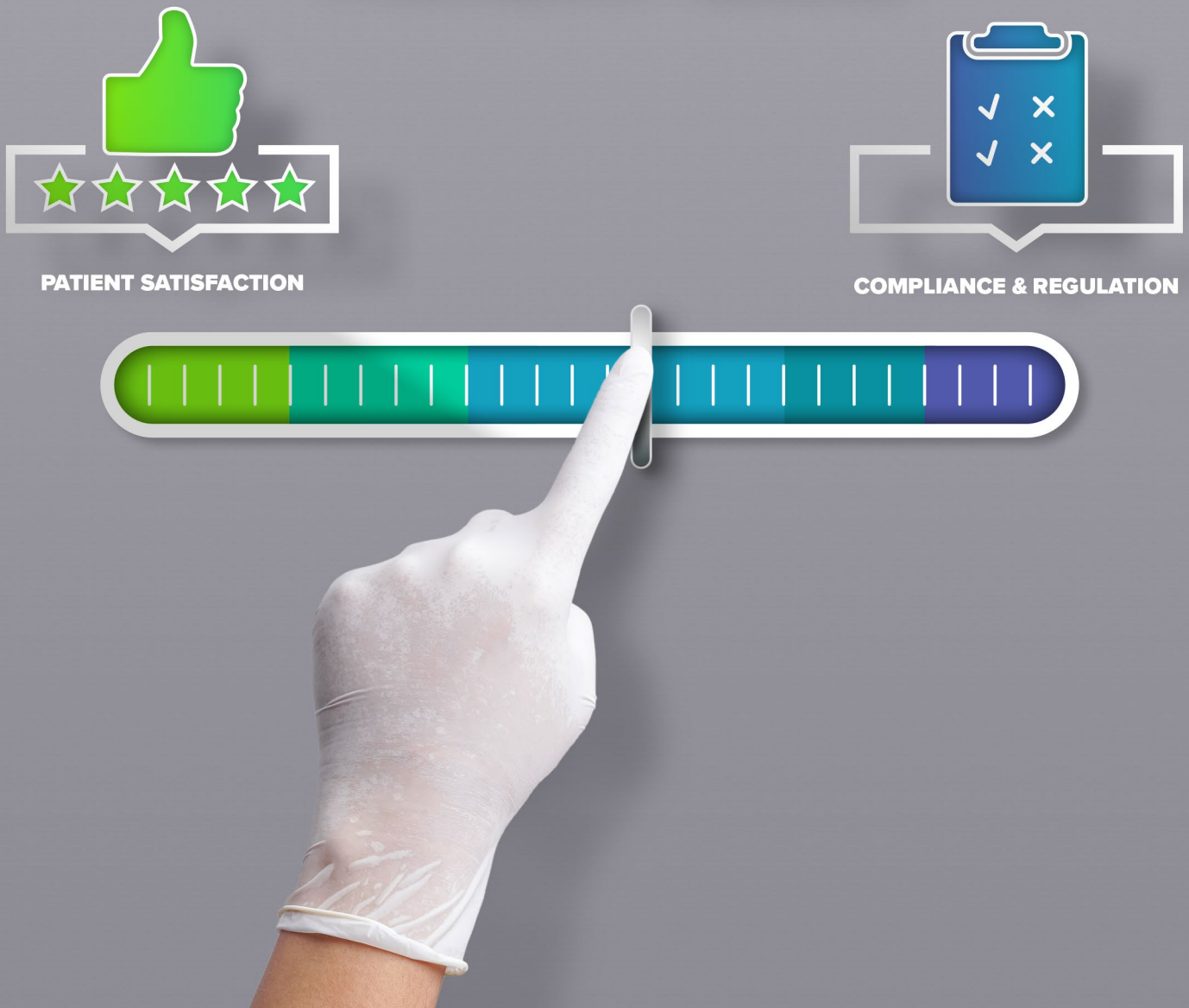
NO 2

The HIPPOCRATIST

The Official Journal of the Ouachita Medical Society

BALANCING PATIENT SATISFACTION AND PATIENT CARE



Fee-Based Financial Guidance

Fee-based investment is an investment account in which the advisor's compensation is based on a set percentage of the client's assets instead of on commissions. Contrast this to commission-based investment, in which the advisor makes money based on the amount of trades made or the amount of assets sold to the client.

Reference: investopedia.com

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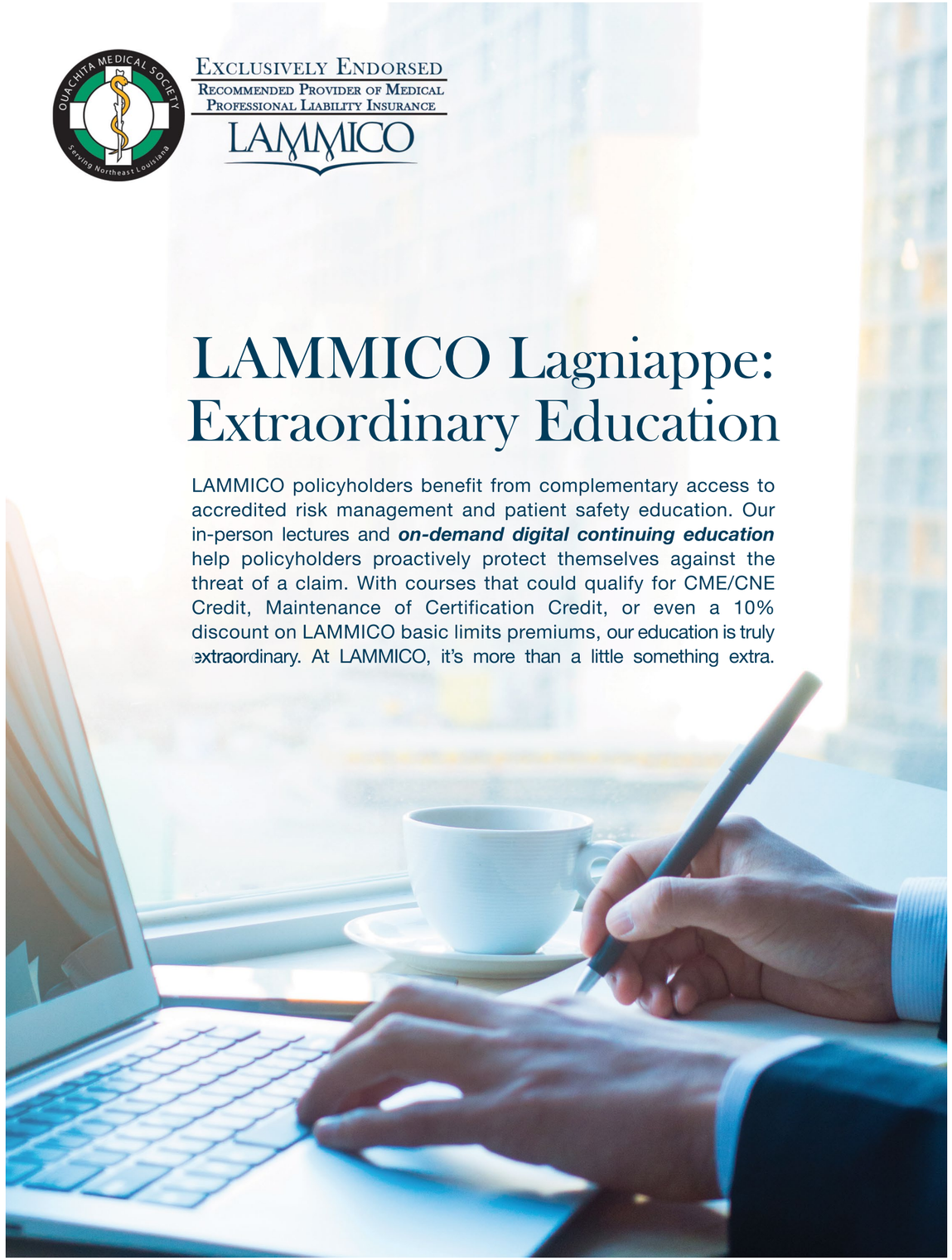

OUACHITA MEDICAL SOCIETY

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

OMS EXECUTIVE COMMITTEE

2018-2020

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– PRESIDENT'S PAGE –

WELCOME TO THE FALL/WINTER ISSUE OF THE HIPPOCRATIST, 2019-2020!

THE TOPIC FOR THIS ISSUE IS "BALANCING PATIENT SATISFACTION AND PATIENT CARE".

I WOULD LIKE TO THANK ALL OF OUR AUTHORS FOR SHARING THEIR

OPINIONS AND SENTIMENTS ON THIS SUBJECT.

Van Taliaferro, Jr., MD
Affinity Ear, Nose & Throat Clinic

Our fall meeting at Bayou DeSiard Country Club on "The State of Healthcare" was a real treat for both our members and guests. St. Francis Medical Center and Kristin Wolkart, President of SFMC, have our sincere appreciation for sponsoring this wonderful event.
Representatives from hospitals, surgery centers, physician groups, insurance companies and Acadian Ambulance Co. gave updates on expansions, new services and visions for the future of medicine in our area.

Those contributing information for the evening were: Kristin Wolkart representing St. Francis Medical Center, Jeremy Tinnerello representing Glenwood Regional Medical Center, Michael Echols representing Affinity Health Group and Vantage Health Plan, Linda Holyfield representing Specialty Management Services of Ouachita, Blake Kramer representing Franklin Medical Center and Delta Regional Authority, and Taylor Richard representing Acadian Ambulance.

An update on the Edward Via College of Osteopathic Medicine, Louisiana Campus, located at ULM was given by Dr. Ray Morrison, Founding Dean. He informed those attending that the first class is set to start in August of 2020.

Our year is shaping up nicely with our Christmas Party scheduled for Thursday, December 12th. Dr. Amber Shemwell, and her husband, Clay, have again offered to open their lovely home as the venue for this occasion.

The Mardi Gras Oyster Party, which is always a treat, is scheduled for Thursday, February 20, 2020 to be held at Bayou Landing!

I would encourage our members to invite at least one physician to join the OMS so that we can continue our great tradition of representing the physicians of our area.

Also, the Louisiana State Medical Society has announced that the House of Delegates (HOD) is scheduled for January 24-25, 2020 in Baton Rouge. Anyone interested in attending should contact Jennifer Mills at the Ouachita Medical Society.

Dr. H.G. "Van" Taliaferro

– FEATURE –

OUTPATIENT ANTIBIOTIC PRESCRIBING

BOOSTS PATIENT SATISFACTION SCORES... REALLY?!

BAD MEDICAL PRACTICE IS REWARDED!?!?

Amber Shemwell, MD
The Woman's Clinic

A November 2018 JAMA study evaluating the link between patient satisfaction ratings and antibiotic prescribing for respiratory tract infections (RTIs) confirmed what every busy clinician already knows: Many patients seeking care for RTIs expect to receive an antibiotic.

When they get one, they're happier than if they don't.

Among 8,437 patients seeking care for an RTI through a direct-to-consumer telemedicine service, 66% received an antibiotic prescription. The rate of prescriptions prescribed by physicians ranged from 19% to 90%, showing that these were not exactly evidence-based decisions. Not surprisingly, receipt of any type of prescription (antibiotic or nonantibiotic) was strongly associated with patients rating their care 5 stars, further implying that patients want any type of prescription vs. none.

It's even worse if you realize that NONE of the MDs in the lowest half of prescribers exceeded the 75th percentile for patient satisfaction.

> **"Few physicians achieved even the 50th percentile of satisfaction while maintaining low rates of antibiotic prescribing. To reach the top quartile, a physician had to prescribe antibiotics at least half the time; almost all physicians above the 90th percentile had a rate of antibiotic prescribing greater than 75%."**

Sample Characteristics and Adjusted Odds of Rating Physicians 5 Stars vs. Fewer Than 5 Stars*

Characteristic	Encounters, No./Total No. (%)	AOR (95%CI)
Prescription outcome		
None	1548/8437 (18.3)	1 [Reference]
Antibiotic	5580/8437 (66.1)	3.23 (2.67-3.91)
Nonantibiotic medication	1309/8437 (15.5)	2.21 (l.80-2.71)

This isn't the first time we've seen these results. In a June 2005 JAMA study that compared immediate vs. deferred vs. no antibiotic (along with a patient education intervention), patients with the immediate antibiotic prescription were significantly more likely to be very satisfied with their care, even though clinical outcomes were, not surprisingly, THE SAME!

I used to argue that it is physician communication (time spent talking with patients) that most powerfully drives patient satisfaction. If you would just spend time educating your patient, they would "get it"! And when they "get it," they'll rate you well, right? Maybe. But, undoubtedly, some patients would consider the counseling and education piece way too time consuming.

Many of us feel a pressure to perform and produce and see more patients/hour. We are not immune to the world we exist in. We live in an action-driven society. It's doing "something" (antibiotics, pain relievers, sleep aids, MRIs, etc.) rather than "nothing" (observation). It takes energy and time to explain why the latter is often the right choice.

All of this leads to our internal wrestling and justification to go ahead and prescribe the antibiotic.

- placebo works
- it's SO low-risk
- it's anti-inflammatory
- just this one time, even though I know it's not bacterial

Many of us know that it isn't prudent, yet we do it anyway. The pressure to be "liked" persists from our middle school days, despite our education and training beyond these years. So, what are we going to do about it???

Timothy Daven Spires, Jr., MD
North Louisiana Orthopaedic
and Sports Medicine Clinic

– FEATURE –

ENJOYING THE DANCE

What is patient satisfaction?

This seems like a rather simple question. So, should the answer be simple? In my personal and professional experience, it is a decided "no". There are so many variables going into what provides a satisfying experience. It can be very subjective, and objective standards to address it may leave a good number of patients feeling "unsatisfied". The other part of the equation is the quality of the patient care. Patient satisfaction and the quality of the care provided may actually be at significant odds. Asking patients to make drastic changes in lifestyle, diet, and medications to effect meaningful health improvements can leave them with a bitter taste in their mouths. Add to that the worry and dread of the pain and debility associated with surgery, and it may be even more difficult to produce a sense of "satisfaction" in our patients.

If we look from an empathic perspective, what is the patient seeking? Have they come to your office for treatment of a particular ailment or perhaps for a well visit?

For those with an acute medical issue, the timeliness and accuracy of diagnosis, the availability of effective treatment, and the ability to convey and provide both to the patient are critical components of their satisfaction and the quality of the care provided. Patients coming for a general physical have a whole other set of concerns. "Am I healthy?" "Is he going to ask me to give up dessert?" "Do I have diabetes?" They are hoping for positive news, for affirmation of good lifestyle choices, for a "I'll see you back in a year!" There are completely different circumstances behind both types of patient encounters. A patient with an immediate need for symptom relief is much more likely to be satisfied when you provide such symptom relief. A patient confronted with the revelation that his blood sugars are too high, his cholesterol is through the roof, and his diastolic pressure is holding steady at 105, not so much. Especially if he just came to see you because his wife kept "nagging" him because he snores too loud!

Are there ways we can improve the overall patient experience? Of course, but how meaningful are they?

This becomes a question of available resources and their subsequent allocation. You can build a beautiful building. You can employ a host attentive staff and assistants. You can put a flat screen tv in the waiting room with "educational" content to stimulate the minds of your patients as they wait. You can provide a ton of ancillary services on site. But this costs a tremendous amount of money to provide. For the provider, the questions become what are you willing to give up financially and professionally to practice medicine in such an environment, and does such an environment improve the patient "satisfaction" enough to justify it? This is a tough decision and not to be made lightly.

Another intangible component to a patient's perception of quality care and their subsequent satisfaction is the tone and timbre of their interaction with the doctor.

Are we kind and compassionate with the right balance of knowledge and sternness to make the patient feel heard and motivated to proceed with the recommendations? What they do not appreciate is the thirty other patients before them, the hospital calling your nurse to say your privileges are suspended because you did not sign a verbal order from a PA, you have seven discharge summaries to dictate, the deposition you forgot about at 5 pm, and now you have got to call your spouse to let them know you will miss the piano recital! We all strive to have as good a "bedside manner" as possible, but it only takes one unhappy patient to ruin a hundred good patient encounters, and they will surely let you and all of Facebook know about it! It's no wonder we have a crisis of physician burn-out in this country.

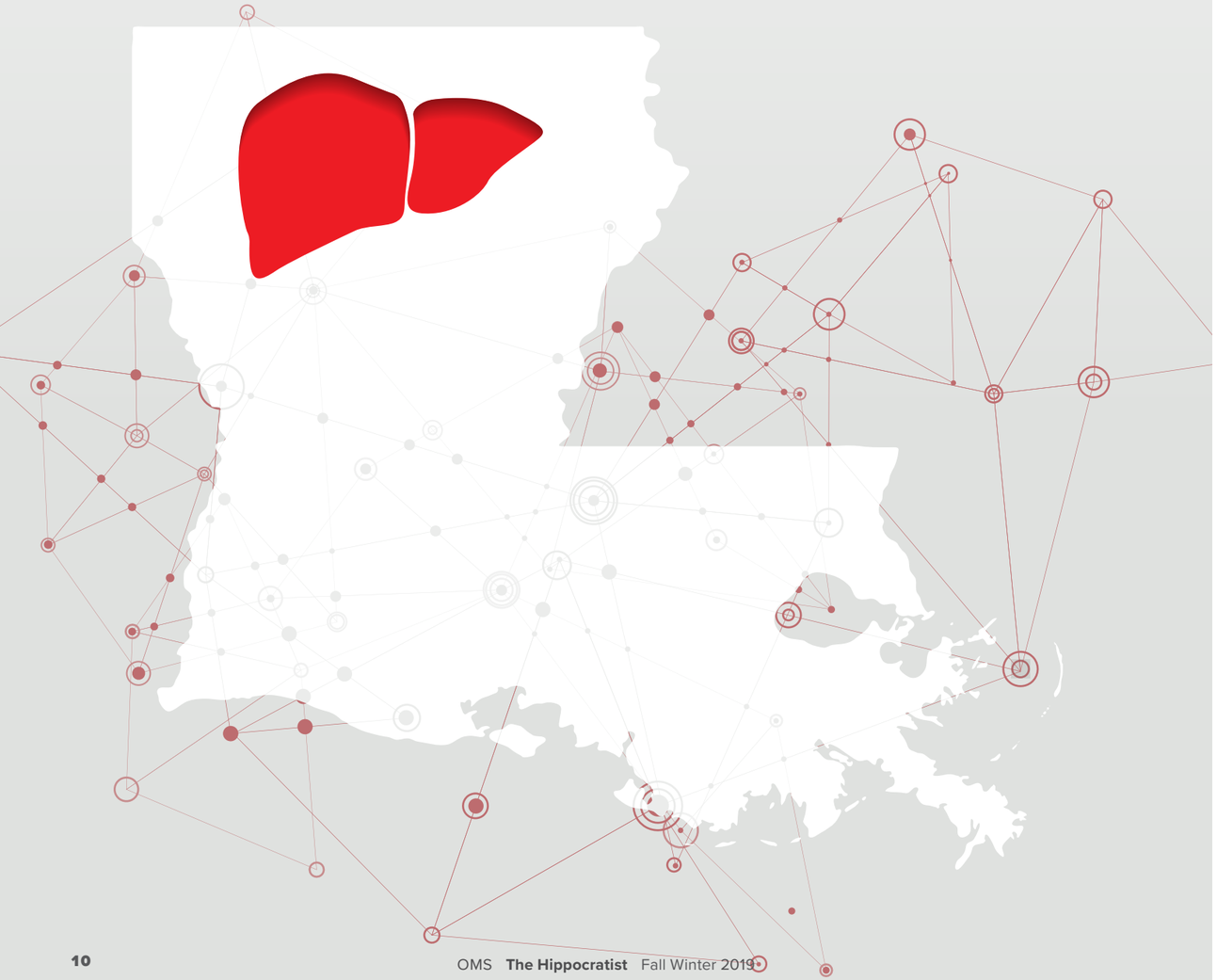
The practice of medicine is definitely an art. Art does not necessarily obey the rules of science. We learn to walk the edge between satisfying patients as best we can while providing the appropriate care they need. I love what I do. I love helping people in such a meaningful way. It would be nice if every patient had a very satisfying encounter and every outcome measure was met to perfection. Finding our own satisfaction in successful patient care can only improve the odds they will find it satisfying as well. Enjoying the dance can make even tough encounters rewarding!

– FEATURE –

UPDATE ON THE HEPATITIS A OUTBREAK IN LOUISIANA

Stephen Hill, PharmD, BCPS
Clinical Assistant Professor, ULM College of Pharmacy

Abby Thibodeaux and Lindsay Ferguson
PharmD Candidates 2020



After a downward trend in Hepatitis A (HAV) cases in the early 2000s, the number of cases reported nationwide has risen significantly within the last 2 years. Certain states have seen nearly a 500% increase in reported cases. In 2017, California reported the largest outbreak in over twenty years with 650 cases, including 417 hospitalizations and 21 deaths. Since then, many other states are experiencing a similar rise in Hepatitis A outbreaks, including Louisiana. The CDC contributes outbreaks to:

- foodborne transmission from contaminated food
- person to person contact, especially within the homeless population
- drug users sharing needles
- men who have sex with men

Since 1999, the CDC has supported routine vaccinations in children, which led to yearly reported cases of HAV drastically decreasing from 200 cases in 1999 to 7 cases in 2017 in Louisiana. According to the Louisiana Department of Health, only 9 cases per year were reported over the last decade. However, from January 1, 2018 to September 13, 2019, 532 cases have been reported in Louisiana, with 57% of cases requiring hospitalization and one death reported. Livingston Parish leads the state in most reported cases, with East Baton Rouge, Ouachita, Ascension, and Morehouse parishes trailing right behind.

WHAT IS HEPATITIS A?

Hepatitis A is a contagious viral infection that affects the liver and is usually ingested from food or drinks that are contaminated with an untraceable amount of feces from an infected person. The virus can also spread through personal contact and can be passed from person to person with symptoms emerging two to seven weeks after infection. The first signs of infection are usually nausea, fatigue, fever, weight loss, and abdominal pain. Within a few weeks, those infected may notice dark urine and/or pale stools lacking bilirubin pigment, followed by jaundice, pruritis (70% of patients), and hepatomegaly. Symptoms usually last between 2 to 6 months. Laboratory abnormalities include elevations of serum aminotransferases (often >1000 international units/dL), serum bilirubin (typically ≤10 mg/dL), and alkaline phosphatase (up to 400 U/L). Hepatitis A can lead to liver failure and death, with the highest prevalence of complications occurring in individuals over fifty years of age or with a previous diagnosis of liver disease.

The best way to prevent Hepatitis A is with the vaccine.

A CASE OF HEPATITIS A IN LOUISIANA

Gyanendra Sharma, MD

A 47-year old man, recently released from incarceration, previous history of drug abuse and homelessness, was diagnosed with Hepatitis A through an emergency room of a charity hospital in Louisiana. On reviewing his history, he would hang out with his “buddies” for fun, as life was already hard. He would eat when he could from handouts of kindhearted people. He vehemently denied any injectable drug use, but admitted consuming alcoholic drinks offered by his mates.

A few days after this incident, the Office of Public Health announced that there is an outbreak of Hepatitis A in North Louisiana. There were reports of Hepatitis A in a local correctional center as well.

WHO SHOULD GET THE HEPATITIS A VACCINE?

All children at the age of 1 year

Travelers to countries where Hepatitis A is common

Family and caregivers of adoptees from countries where Hepatitis A is common

Men who have sexual encounters with other men

Recreational drug users, whether the drug is injected or not

People with unstable housing, or the homeless

People with chronic or long-term liver disease, including Hepatitis B or C

People with clotting-factor disorders

People with direct contact with others who have Hepatitis A

Any person wishing to obtain immunity

WHO SHOULD NOT GET THE HEPATITIS A VACCINE?

Those who have had a serious allergic reaction to the Hepatitis A vaccine, or who are known to be allergic to any part of the vaccine

Infants under the age of one year

The antibodies produced from the Hepatitis A vaccine protect against the infection, and provide lifetime immunity. The brand names of the Hepatitis A vaccine are Havrix and Vaqta, and the vaccines are 2 shots given 6 months apart. For full protection from Hepatitis A, both shots are needed.

Also, a combination of Hepatitis A and B vaccine is available, and the brand name for this vaccine is called Twinrix. It is only given to adults 18 years of age or older, and it is a 3 shot series given over a 6-month period. Similar to the Hepatitis A vaccine series, it is important to get all three shots for complete protection. The virus is inactivated, so people with compromised immune systems or those around people with compromised immune systems are okay to get the vaccine.

The incidence of Hepatitis A infections is on the rise in Louisiana, and over 50 cases have already been reported in Ouachita Parish.

The Hepatitis A vaccine is safe and effective. It is an easy way to protect you and your loved ones from the Hepatitis A virus! The vaccines can be administered anywhere that vaccines are given (health clinics, retail pharmacies, and doctor's offices).

– INFOGRAPHIC –

As consumers demand more personalized and less divided healthcare experiences, health system executives are reassessing how they engage with their patients. Rather than just focusing on patients' clinical interactions, the focus has expanded to include how to predict their needs so their entire care process is easier and more efficient.

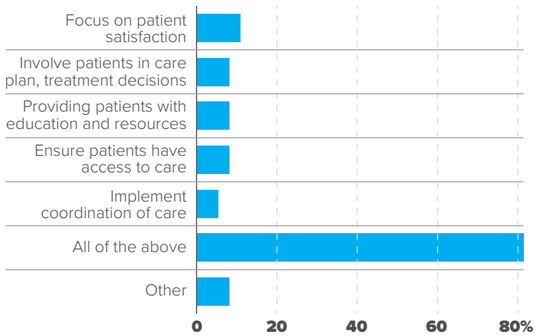
Rethinking patient-centered care

As a consumer-driven approach takes greater hold, systems are redefining the term while increasing implementation

For many respondents, the definition of patient-centered care has changed in the last five years

Formally training all employees to be more patient-centered, including front-line staff?

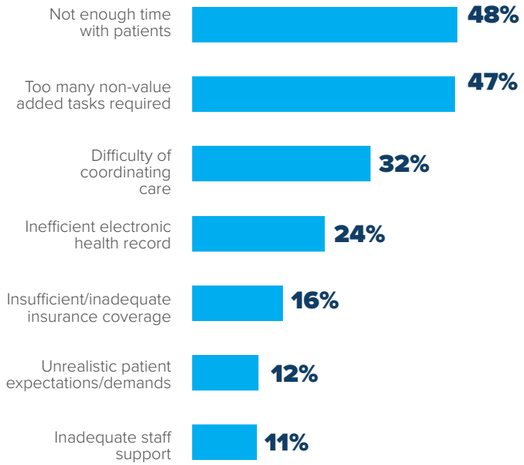
How organizations define patient-centered care



https://www.modernhealthcare.com/article/20180915/NEWS/180919978/ceo-power-panel-health-systems-focus-on-patient-centered-care-as-consumerism-takes-hold

Barriers to Providing an Outstanding Patient Experience

What are the top two biggest barriers today to providing an outstanding patient experience?



Base= 544 (multiple responses)
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

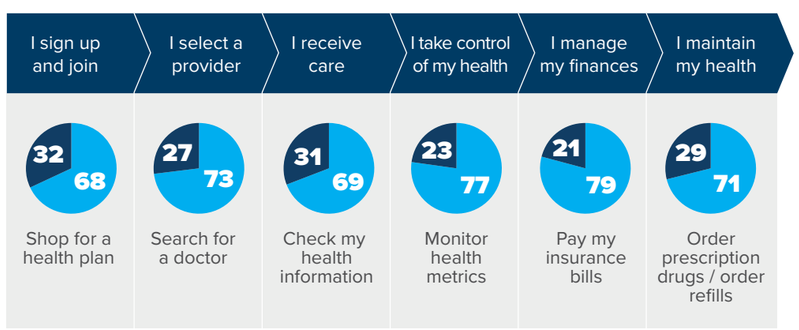
https://catalyst.nejm.org/buzz-survey-report-patient-experience/

- The healthcare consumer landscape is changing.
- Consumers want to be known and understood in order to get a personalized healthcare experience.
- There is a growing demand for more engaging digital experiences in healthcare. In fact, an Ernst & Young survey found that both patients and physicians are ready for increased digital engagement.

About 70% of consumers prefer digital healthcare solutions

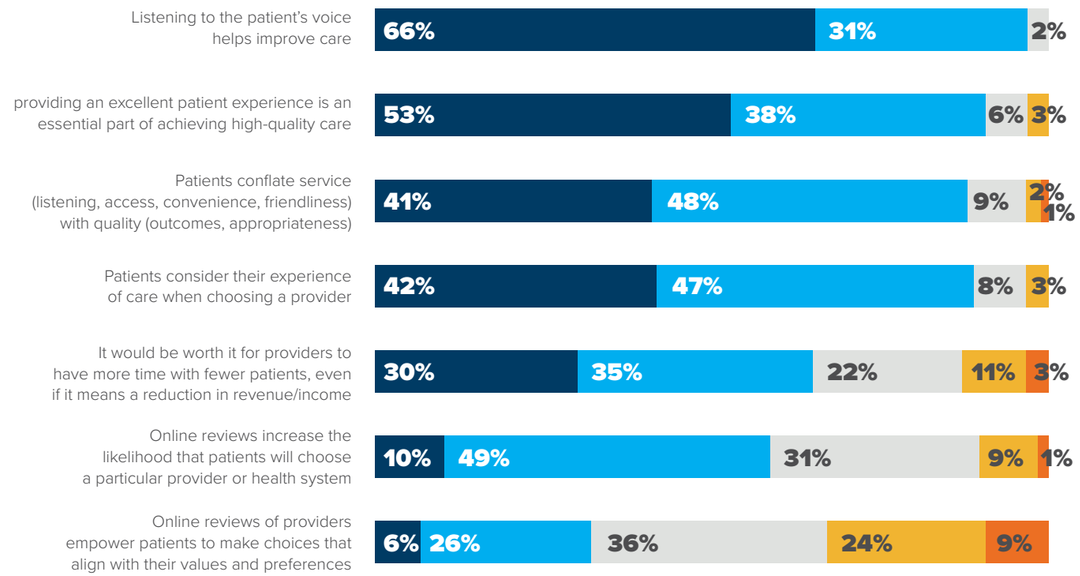
Respondents who prefer digital solutions to phone/in-person solutions for their health needs

Consumer journey %



https://liquid-state.com/engaging-the-healthcare-consumer-the-key-to-success-in-2019/

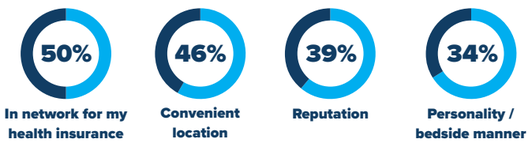
Please indicate to what extent you agree or disagree with each of the follow statements



https://catalyst.nejm.org/buzz-survey-report-patient-experience/

When searching for a new doctor or medical professional, consumers are most concerned with convenience, cost, and reputation

Survey question: When you are searching for a new doctor or medical professional, which of the following do you consider most important?



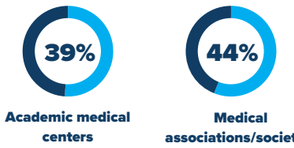
Other Sources

32%	Convenient hours and accessibility	**16%**	Medical school/training of the physician
31%	Price I have to pay / my out-of-pocket expenses	**10%**	High quality ratings from a magazine or ranking website
27%	Affiliation with my local hospitals	**8%**	Use of technology for other services, such as getting test/lab results
25%	A friend or family member's recommendation	**5%**	Use of technology for scheduling and payment
20%	High user reviews from other patients	**4%**	Offers telemedicine/ virtual visits

Note: Percentages Indicate respondents who ranked the factor as one of their top four.
Source: Delitte 2018 Survey of us Health Care Consumers,

Hospitals and medical societies top the list as trusted sources of reliable information on effective/safe treatments

Survey question: If you wanted information about the most effective and safe treatment(s) for a certain health condition, how much trust would you have in the following sources to provide reliable information?"



Other Sources

41%	Community hospitals	**27%**	Patient forums, blogs, or websites that address specific health issues
39%	Pharmacies	**26%**	Employers
35%	Independent health-related websites	**25%**	Pharmaceutical, biotech, or medical device / product manufactures
31%	Health insurance companies / health plans	**18%**	Social networking sites

*Chart shows percentage of respondents who answered 8,9, or 10 on a 10-point scale, where 1 Is "no trust" and 10 is "complete trust."
Source: Deloitte 2018 Survey of US Health Care Consumers.

https://www2.deloitte.com/us/en/insights/industry/health-care/patient-engagement-health-care-consumer-survey.html

– FEATURE –

PATIENT SATISFACTION: ARE WE ALL SATISFIED?

Billy Branch, MD
Glenwood Internal Medicine & Pediatrics

I believe that the day to day goal of most physicians is patient satisfaction. We are a singular group of people called to dedicate our lives to the care of others. At its foundation, our profession and plan for each patient carries a need to satisfy the ultimate desire of our patient: health. In recent years, patient satisfaction has shifted to using a set of data to gauge a number of patient experiences and their impact upon medical care. In turn, these metrics have become involved in a wide variety of aspects of the medical field, from reimbursements to helping with a patient's knowledge of services to helping providers give a higher quality of care.

The transformation of these subjective matters into a data point has, in many ways, devalued the primary goal for us as physicians and all providers. I, steadfastly, feel that the best care I can give my patients on any given day includes giving them the best explanation of what I believe to be their medical condition and treatment plan. I see numerous hospital follow-up patients, and by a wide margin their biggest complaint is that they either did not understand any of the care that was provided to them or the reason that the care was given. Truth be told, that does not indicate that their care was less than substandard, and in the majority of cases, they have been given excellent care. It falls on us to find ways to do a better job of stopping and explaining to these patients as much as we can to allow them to feel empowered over their decision making with us as a functional team.

> **Often in the clinic setting, I am confronted with:**
>
> **"I need a shot to get better."**
>
> **"I never get better unless you give me this like my last doctor."**
>
> **Or my new favorite "Google says I need this!"**

These are difficult times with patients having a vast knowledge base at their fingertips, and with higher expectations than ever. Overcoming this has become one of my greatest daily tasks, and I find myself needing to spend extra time explaining only to still be questioned if I am sure that I have chosen the best treatment plan. I do the best I can to tell my patients why I believe their treatment plan is correct and will work, and what we will do if it does not work. Still, and quite frequently, I am called back shortly afterward asking if I am certain we have done the right thing. It is hard at times, but I like to convey my confidence and give hope which shows my patients I am doing my very best for them.

A confounding factor that I frequently run into difficulty with is care controlled by insurances. Recently, a patient of mine with long-term diabetes was in need of insulin refills. His long acting insulin coverage was demanded to be changed by his insurance company, and then his short acting insulin was changed as well. After his short acting insulin was forced to be changed by his insurance, the patient became irate and began to call patient advocates along with anyone else he could get on a phone to tell them, in detail, how I was trying to kill him. Similar insulin, covered by his insurance plan, had been sent in many days prior for him to fill. Eventually, a nasty letter to the insurance company cleared his initial prescription, but not until after multiple complaints over a situation out of my control had been filed against me and my staff. The subjective nature of patient satisfaction is very hard in these types of circumstances because my patient had been given no drop off or step down in his care; however, he was very angry because he could not have what he wanted, which was out of my control. At that time, I learned that patient satisfaction unfortunately, with some patients, is never going to be attainable, no matter the time cost.

From my perspective, patient satisfaction surveying holds major benefits, as it has been shown that higher satisfaction rates correlate with a higher likelihood for patients to be adherent to our plans and follow through with their care. In the business of taking care of patients, we must strive to have our patients be both satisfied and well cared for, and in the end, one is typically the result of the other. Their satisfaction, in turn, leads to a busier business, the ability to provide better care, and a stronger ability to reach our common goal: a healthy life. Patient satisfaction should remain a primary focus in our work, but to me, it is a far too easily skewed metric; as a patient receiving the very best of care certainly does not always remain satisfied.

OUACHITA MEDICAL SOCIETY
SEPTEMBER GENERAL MEETING
STATE OF HEALTHCARE

On Thursday, September 12th, members of the Ouachita Medical Society and their spouses enjoyed an evening at Bayou Desiard Country Club. Guest speakers updated attendees on projects they've tackled over the last year, and what we could expect in the months to come.

Special thanks to our "State of Healthcare" event sponsor:

St. Francis Medical Center

Representing St. Francis Regional Medical Center:
Kristin Wolkhart, CEO

Representing Ochsner LSU Health Shreveport:
Charles Daigle, CEO

Representing Glenwood Regional Medical Center:
Jeremy Tinnerello, CEO

Representing Vantage Health Plan & Affinity Health Group:
Michael Echols, Director of Business Development

Representing Specialty Management Services of Ouachita:
Linda Holyfield, CEO

Representing Franklin Medical Center & Delta Regional Authority - LA Strategic Planning Committee:
Blake Kramer, Administrator

Representing Acadian Ambulance Service:
Taylor Richard, Operations Manager – Ouachita Parish

Representing the LA Campus of the Edward Via College of Osteopathic Medicine:
Dr. Ray Morrison, Founding Dean

FD MISTRY LEGACY SCHOLARSHIP

In an effort to support medical students completing their residency at Ochsner LSU Health here in Monroe, the Ouachita Medical Society Executive Committee voted to award two monetary scholarships to PGY-2 Residents. The purpose of this scholarship offering is to promote the practice of medicine in Ouachita Parish by supporting local medical students during their time of study, and to encourage them while they are new to their career to engage with their local medical society. The Ouachita Medical Society commits itself as a resource to young physicians in our area.

This year's winners were: 1st place: **Dr. Obioma Ilouga**
2nd place: **Dr. Sylvester Yari Mapoh**

MEMBER SPECIALTY INDEX

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Hopkins, Janine O. - MD

Emergency Medicine
Asbury, Ralph G. - MD
Guillory, Clinton C. - MD
Joiner, Sharon K. - MD
Najberg, Christopher J. - DO

Family Practice
Abraham, Ralph L. Jr. - MD
Anders, Kerry L. - MD
Barnes, David L. - MD
Beard, Barbara L. - DO
Belue, J. Michael - MD
Breard, Erin Robinson - MD
Brown-Manning, Cynthia L. - MD
Calhoun, Brian Keith - MD
Coleman, Edward O. - DO
Daniel, Warren A. Jr. - MD
Depa, Sreekanth R. - MD
Donald, Albert - MD
Elliott, Clyde E. - MD
Ghanta, Sumatha - MD
Givler, Donald N. Jr. - MD
Givler, Amy M. - MD
Green, Gregory R. - MD
Guinigundo, Noli C. - MD
Gujjula, Rajesh - MD
Hayward, Michael T. Sr. - MD
Jones, Patrick Gary - MD
Jones, Tammy V. - DO
Kintzing, William E. - MD
Lapite, Oladapo - MD
Lodgen, Kelly Reed - MD
Luther, Euil - MD
McMahan, Steven H. - MD
Melton, Stuart L. - MD
Meyers, Owen - MD
Oglesby, Leslie H. - MD
O'Neal, Teri Barr - MD
Poole, Charla - MD
Raulerson, Robert Mac Kinnon - MD
Ross, Theresa J. - MD
Scott, E. Benson II - MD
Sharma, Gyanendra K. - MD
Stockstill, J. Dean - MD
Thapa, Trishna - MD
Tirumanisetti, Pavana Naga
Gopi Krishna - MD
Twitchell, Daniel W. - MD
Uprety, Subodh Bhakta - MD
Williams, Norman B. - MD
Woods, Ronald - MD
Yarbrough, David A. - MD

Gastroenterology
Coon, Clayton Collins - MD
McHugh, J. B. Duke - MD, PhD
Richert, Arthur E. - MD
Seegers, Robert - MD

General Practice
Walters, Kermit L. Jr. - MD

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

Hematology/Oncology
Barron, Scott M. - MD
Gammage, Coy W. - MD
Weinberger, Benjamin B. - DO

Internal Medicine
Adams, Alyce R. - MD
Archie, Michael W. - MD
Branch, Billy G. - MD
Bruyninckx, Kyle B. - MD
Cavell, Richard M. - MD
Ewing, Robert C. - MD
Ford, Ladonna - MD
Hammett, Donald K. - MD
Harter, Herschel - MD
Mason, Charles W. - MD
Morgan, Charles G. Jr. - MD
Ponarski, Roland - MD
Rangaraj, Uma - MD
Rodgers, Julia S. - MD
Sampognaro, Michael J. - MD
Smith, William D. Jr. - MD
Thadur, Anuradha R. - MD
Turpin, Corbin J. Jr., - MD

Neonatal Perinatal Medicine
De Soler, Marc - MD
Payne, Carmen S. - MD

Nephrology
Anumele, Ekam - MD
Hand, Michael R. - MD
Lee, Frederick B. - MD
O'Donovan, Richard M. - MD

Neurology
Guerre, Jenny - MD
Thompson, Lowery L. - MD

Obstetrics/Gynecology
Armstrong, Rafael B. - MD
Belsom, William B. - MD
Caire, Michael J. - MD
Coffman, Leslie R. - MD
Gullatt, Erin M. - MD
Hunter, Tonya Hawkins - MD
Klug, Sara J. - DO
LeBleu, Laurie R. - MD
Lee, Won S. - MD
Luther, Sherry G. - MD
Pennebaker, Dawn W. - MD
Petty, Laura Rush - MD
Shemwell, Amber M. - MD
Smith, J. Wayne - MD
Tugwell, Terence R. - MD
Wilson, Jason B. - MD

Ophthamology
Barron, Joseph B. - MD
Haik, Raymond E. Jr. - MD
Humble, Joseph Elgin - MD
Parker, Thomas Guy Jr. - MD
Read, W. Jason - MD

Orthopedic Surgery
Bailey, Myron B. Jr. - MD
Bailey, Sidney L. - MD
Brown, Douglas C. - MD
Bulloch, Robert Brian - MD
Bunn, Kevin J. - MD
Counts, Jeffrey R. - DO
DeGravelle, Martin J. Jr. - MD
Dona, Grant - MD
Extine, James H. - DO
Gavioli, R. Louis - MD
Graves, White Solomon IV - MD
Liles, Douglas N. - MD
McClelland, Scott K. - MD
Nipper, Elliott B. - MD
Sirmon, Kristopher C. - MD
Soeller, Clemens E. Sr. - MD
Spires, Timothy Davenport Jr. - MD
Taylor, Randolph H. - MD

Otolaryngology
Barham, Wilson T. - MD
Danna, Lawrence J. - MD
Mickey, Lauren J. - MD
Miller, Lee A. - MD
Norris, Joel W. - MD
Taliaferro, Henry "Van" Jr. - MD

Pain Management
Ellis, Ronald L. - MD
Forte, Vincent R. - MD
Gordon, James Hardy - MD
Ledbetter, John L. - MD

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

Pathology, Anatomic
Geisler, James W. - MD

Pediatric Cardiology
King, Terry D. - MD

Pediatrics
Bimle, Cynthia P. - MD
Bivens, Marilyn G. - MD
Bodron, Milhim A Jr. - MD
Bulloch, Russell H. - MD
Dennison, Sarah - MD
Dyess, Bonita H. - MD
Eason, Margot Bell - MD
Frost, Kadie Bimle - MD
Jones, Shelley Coats - MD
Malmay, Kim R. - MD
Ricks, Barry -, MD
Rosales, Joaquin P. - MD
Stanley, Gary E. - MD
Zukowski, Nancy Lynn - MD

Phlebology
Barr, James L. - MD

Physicial Medicine & Rehabilitation
Morstead, Rolf D. - MD
Potts, James M. - MD

Plastic Surgery
Mickel, Timothy - MD

Psychiatry
Ragsdill, Roy R. Jr. - MD
Robertson, Gerald M. - MD
Walker, Calvin C. - MD
Zentner, Scott David - MD

Pulmonary Diseases
Gullatt, Thomas - MD
Hammett, Ronald F. - MD
Maran, Antti G. - MD
Smith, James Garland Jr. - MD

Radiation Oncology
Bland, Ross E. - MD
Zollinger, William D. Jr. - MD

Radiology, Diagnostic
Abraham, Ralph "Lee" III - MD
Barraza, J. Michael - MD
Broyles, Michael O. - MD
Davidson, Dan B. - MD
Davis, John A. - MD
Erikson, Christopher J. - MD
Green, Warren J. - MD
Halsell, Robert David - MD
Halsell, E. Anne - MD
Hollenberg, Henry G. III - MD
Pate, Steven W. - MD
Wilder, W. Mitchell - MD
Worley, Emery Edward II - MD
Yatco, Reynaldo L. - MD

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

Surgery, Cardiovascular/ Thoracic
Borders, Blaine M. - MD
Donias, Harry W. - MD

Surgery, General
Alley, Jo Ann - MD
Clay, Roy G. Jr. - MD
Cummings, Russell O. Jr. - MD
Ferguson, William T. - MD
Hebert, Jacob M. - MD
Liles, William Bartling - MD
Lolley, Russell T. Jr. - MD
Marx, Daryl S. - MD
Morrison, Ray L. - DO, FACOS
Norman, David W. - MD
Rizzo, Frank P. Jr. - MD
Sartor, Frank B. - MD
Sartor, Walter M. - MD
Smith, James Patrick Jr.- MD
Zizzi, Henry C. III - MD

Surgery, Neurological
Greer, Carlton Russ - MD

Surgery, Thoracic
Jones, Thomas Keith - MD

Urology
Cage, John Michael - MD
Dean, Odell J. Jr. - MD
Edgerton, Edwin III - MD
Humble, Robert Lee - MD
Johnson, Jon Bradley - MD
Liles, W. J. Burchall Sr - MD
Marx, Don F. - MD
Marx, Robert D. - MD
Murphy, Paul G. - MD
Rutland, Edward H. - MD

UPCOMING **EVENTS**

Christmas Party
Thursday, **December 12th** at 6:30 p.m.
Home of Clay and Amber Shemwell
2805 Pargoud Blvd., Monroe

2020 LSMS House of Delegates Meeting
January 23-25, 2020
Baton Rouge, LA

Mardi Gras Oyster Party
Thursday, **February 20**, 2020 at 6:30 p.m.
Bayou Landing
7805 Desiard Street, Monroe

www.ouachitams.org
for the most up-to-date information
*dates/times subject to change-check

KNOWING WHEN AND HOW TO SAY NO?

Obioma Ilouga, MD
PGY 2 Family Medicine Resident, LSU (Shreveport) Monroe Family Medicine Residency Program

Pain is a common complaint that patients present with, both in the outpatient and inpatient setting. Some patients may hurt a little but would describe their pain intensity as severe, while others may hurt a lot but would describe their pain as mild or manageable. I would guess that the reason for this is because, just as humans are different, as expected, the patients we take care of also have different thresholds for pain. My focus for this discussion would be my experience mostly in the outpatient setting.

A lot of patients that present to the clinic complaining of pain probably do experience pain that affects their activities of daily living (ADLS) and may indeed need analgesics to ease their pain. However, in this era of opioid abuse and dependence, healthcare providers need to be cautious when managing pain in these patients.

> **Let us look at some statistics in order to appreciate the gravity of the problem: according to the American Society of Anesthesiologists and the National Institute on Drug Abuse (opioid overdose crisis; NIDA, 2019), about 2 million Americans abuse opioids and more than 130 Americans die daily from opioid overdose. The economic burden of prescription opioid misuse is $78.5 billion per year (NIDA, 2019). This is indeed a national crisis. The statistics are alarming and suggest that there is an opioid use "epidemic".**

There are a lot of effective options other than opioids for pain control. Part of the problem that I have experienced lies in the fact that some patients only want specific opioid medications and even suggest specific doses. I have managed a lot of patients that state that no other medication relieves their pain other than opioids. Some of these patients become aggravated when other forms of pain management are suggested. That may be the time when a "NO" answer to a patient would be the right thing to do. The patient may become unsatisfied with the response, but a bigger problem would have been solved.

As a medical student, I was the school president of a student organization (Christian Medical and Dental association, CMDA). CMDA has a motto that states, "Caring for the whole man, spirit, soul and body". This means that health care providers should focus on caring for all aspects of the patient's health and think of both the short and long term consequences of medical interventions and prescriptions. This means that it is okay to say "NO" to a patient requesting opioids or any other medication if there is suspicion that there may be a problem with abuse/addiction or other adverse outcomes. The manner of saying "NO" becomes important in these situations. We should explain our reasons for refusal to the patient in a professional and empathetic manner, and provide other evidence based alternatives.

The Prescription Drug Monitoring Program (PDMP/PMP) is an important tool that helps health care providers track a patient's opioid use and make an informed decision in assessing who may be at risk for opioid abuse. It should be used by all providers before prescribing opioid medications.

In conclusion, knowing when and how to say "NO" is an important aspect of the care we provide to patients, even when these patients may seem to be unsatisfied with the answer. In the long run, it will ensure the safety of the patients and will be a big step towards solving the opioid use epidemic.

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