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FALL/WINTER
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The HIPPOCRATIST

The Official Journal of the Ouachita Medical Society

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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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The Changing Landscape Of Healthcare

written by: **Jason Read,** MD President

Even though a presumed Supreme Court review looms on the horizon, physicians must adapt to the Patient Protection and Affordable Care Act of 2010 as written. Healthcare in Louisiana, as well as the fiscal wellbeing of our state will be tested. There is still much to be decided. Who will receive waivers? Who won't? Why? Why not? Fee-for-service or bundled payments? Let the political games begin.

A significant aspect pertaining to the southern states is the changes in Medicaid. The Department of Health and Hospitals has credited the increasing utilization of Medicaid as a "stress" to the program. However, the federal expansion of Medicaid scheduled for 2014 will surely stress if not fracture the program. Despite the fact that a large number of physicians no longer accept Medicaid, it is only logical that the current tactic of physician-cuts will accelerate that trend. Whether you accept Medicaid or not, we will all, at least indirectly, be affected. The PPACA expands Medicaid to all individuals and families with incomes up to one hundred thirty three percent of the poverty level. Nearly eighteen percent of Louisianans live below the poverty level while the national average is fourteen percent. Something has to give.

With all the challenges of healthcare reform, it sometimes seems the weakest voice is the provider.

Physicians need a legitimate seat at the table if we plan to solve the problems. The once powerful American Medical Association is a shadow of its old self. According to Forbes, thirteen percent of doctors agree with the AMA's support of PPACA. Only seventeen percent of doctors are AMA members. The Louisiana State Medical Society still has a prominent voice in state issues, but cannot be expected to have a significant national impact. Hopefully, AMA will reconsider its current stance and live up to its motto "Helping Doctors Help Patients". Physicians must have representation while our government makes critical choices at this healthcare crossroad. Do your part. Make your voice heard.

The Newest Members Of The OMS

OUACHITA MEDICAL SOCIETY
Serving Northeast Louisiana

Prashanta Koirala, MD
Internal Medicine
E.A. Conway Hospital
4864 Jackson Street
Monroe, LA 71210

Henry C. Zizzi, MD
General Surgery
Surgery Associates
102 Thomas Road, Suite 203
West Monroe, LA 71292

Frederick B. Lee, MD
Nephrology & Internal Medicine
Northeast LA Kidney Specialists
711 Wood St. Suite A
Monroe, LA 71201

From The Battle Of Manassas

written by: **Robert Hendrick**, MD

This issue, I thought I would like to look at life on the front line through the eyes of a physician. But we will not be hearing about life at an MASH unit in Iraq or Afghanistan. Instead we will be hearing about life on the front lines during the Civil War.

I am fortunate enough to have an ancestor's letter that was written to his wife while serving in the Civil War. This would be Dr. Edwin Tracy Edgerton. While I am related to him through his wife's family, he is the great grandfather of one of our local physicians, Dr. Ed Edgerton.

Dr. Edgerton was born in 1827 in South Carolina. He married in 1851 and migrated to Bienville Parish Louisiana in the 1850's. (Today their homestead is preserved as the Caroline Dorman Nature Preserve, also known as Briarwood.) Dr. Edgerton was already practicing medicine before arriving in Bienville Parish and established a thriving practice. When the war between the states broke out, he enlisted as a private in the infantry. By July of 1861, he was stationed in Richmond, Virginia. What follows is the contents of the letter he wrote home to his wife on July 21, 1861.

Richmond VA.
July 21st 1861

My Dear Ann,
A bloody battle was been fought at Manassas Junction, & a brilliant victory achieved. General Beauregard was attacked on last Thursday by the Lincolnites & not withstanding that their number was superior to his, he stood his ground manfully & cut them down by the wholesale. The number of killed is not yet known. A prisoner owns that fact that 900 fell at one fire. Beauregard fired 3 times to one. The commander of the enemy sent our General a flag of truce, begging time to bury his dead. It is very likely that his loss was several thousand. The loss on our side did not exceed 70 in killed wounded & missing. Beauregard took a great many prisoners & from 4 to 6,000 stand of arms. The Washington artillery from New Orleans & the Louisiana volunteers did the work. General Beauregard prefers troops from the West. As soon as he heard that our regiment was at Richmond, he requested President Davis to send us on and we were ordered yesterday evening, while on dress parade, to proceed to Manassas as fast as we could be transported. We will start early in the morning, perhaps late this evening if cars can be got. The distance from here is 60 or 80 miles. General Scott will, it is thought, advance upon Manassas in a few days with a very large force. General Johnson at Winchester will move down at once to assist Beauregard with his whole force & Yorktown will send in 20,000 troops at the same time. So with what Beauregard already has & those that will be sent, from this place, it is very likely that we will have not less than 200,000 soldiers at Manassas in less than 24 hours. A large body of mounted men rode into our camp about sundown yesterday from South Carolina. They went on this morning to Manassas. The opinion prevails here, that the progress of the war will depend in a great measure upon the next battle, which will certainly take place at Manassas in a few days.

In order to convince you that I am not yet tired of Camp life & that I am sill willing to continue a private in the service of my country, I will simply say that I was very strongly solicited today to remain here & take charge of the Richmond hospital, for which I would receive a large compensation & be entirely free from the performance of military duty. Here too the yellow flag is always waving, which among civilized nations, protects the inmates from the horrors of war. But I respectfully informed the officers who kindly offered me the situation that I had come to serve my country upon the field of battle & not in the capacity of a physician or surgeon. I also told them that I hoped they would not resort to measures which would compel me to remain, and when I finished my remarks, they gave me three cheers for being willing to make what they considered a great sacrifice, very readily excused me.

General Davis rode into our camp yesterday evening on his fine white horse. He is a very ordinary man in appearance & has a striking resemblance to Mr. Joshua Prothro. He was well pleased with his soldiers. He is determined that Scott shall never surprise Richmond, inasmuch as he keeps mounted guards stationed 21 miles around the town.

Congress opened here yesterday. Nothing of importance however, has yet been transacted. The president's message cuts down Lincoln as much as Beauregard cut down his army.

If we drive Scott away from Manassas, he may give up his notion of subjugating the South & in all probability the U.S. Congress will direct Lincoln to remove his men from the field. This is the opinion of many, and it is very important to send in strong reinforcements to General Beauregard. If Scott should prove himself victor, he will immediately attack this place & if successful here, he will keep on further South. But he never will be victorious while we are so strongly fortified & have so many troops. I saw yesterday several soldiers who were pressed into service. Some of them told me that they never expected to see home again. I told them when men were forced into service they always stood in more danger than volunteers, which did not seem to console them much. We're all getting along finely. Darling Babers is down with measles, but is not very sick. The ????? at this place is delightful, and although so many soldiers are here everything is kept clean. We have a beautiful parade ground. I wish Bud could see our whole force on parade & listen to the fine music. When he grows up, I would like him to turn his attention to military tactics.

I will write again soon if I have an opportunity. Perhaps at Manassas my chance will not be so good as here, and if you should not hear from me in a long and read of a bloody battle at Manassas, don't imagine that I am killed or badly wounded. If you should even see my name published in the list of killed, don't believe it, for I do not believe that I will get scratched, although in less than 3 days from now, a cannon ball may send my head in one direction & my body in another. Kiss all the young ones & tell them I will see them when the war is over.

Yours very affectionately, E. T. Edgerton

Since writing the above, we have orders to go right off. The cars are waiting for us. I will mail this at Richmond or on my way to Manassas. The battle commenced there again last night & is yet going on.

Farewell, E. T. Edgerton

I also have a letter written by him to his home in Louisiana on September 25, 1861. Due to its condition, it is very difficult to transcribe. In the letter he writes of that fact that he was away from home for his tenth wedding anniversary. He writes of having been ill, but seems to be recovering at that time. He closes by remarking that two of his wife's Sweatt relatives had been wounded. He evidently found out about it in a letter from home even though they were with him in Virginia. He said he would have sought them out if he had known.

I hope you have enjoyed this glimpse at life on the front lines more than one hundred and fifty years ago. It helps us appreciate the blessings we have today.

Meet the next $600 wrench...

The Affordable Care Act

written by: **David Barnes**, MD Vice President / Finance Chair

Our government has a tendency to create big things. Many have been very beneficial, like the Constitution, the Bill of Rights, the Department of the Treasury, and the city of Washington DC. But what of more recent endeavors… huh… NASA maybe? These programs, while designed with good intentions, have not fared so well over time, such as Social Security, Medicare, and Medicaid. Some would add the Department of Defense to that list. How many times have you heard of a defense contractor over-charging the government for a minor item of little value such as a wrench? Expanding coverage and bureaucracy, while losing efficiency and oversight has been the Achilles heel of government programs. Add the all-important variable of human nature to the mix and costs increase exponentially.

Let's look at the Social Security Act, which is facing more than $20 trillion in unfunded liabilities. It was signed into law by President Franklin D. Roosevelt in 1935 to pay workers age 65 and older a continuing income after retirement. One has to wonder why there were not some adjustments placed into the program initially since the average life span of Americans had increased by more than 10 years between 1900 and 1930. That seems to be a problem with many government programs, when theory meets reality. Social Security disability benefits were added to the program in 1956 to provide income support to individuals aged 50 to 64 who were permanently disabled. As typical with government programs, eligibility and benefits were greatly expanded over the subsequent decades. This program was funded by a 1.8% payroll tax on all workers, yet was recently described by the Congressional Budget Office as not financially sustainable. There is now a whole industry out there to help people qualify for disability who don't meet the criteria. This is the usual track record for big government programs. They become more inclusive over time with little or no adjustment in monetary methods to cover the costs of the expansions.

As Ronald Reagan used to say "there you go again". The government has designed another theoretical program, a brand new bureaucracy, requiring a "pot load" of money.

So meet the next $600 wrench …The Patient Protection and Affordable Care Act. As Ronald Reagan used to say "there you go again". The government has designed another theoretical program, with a brand new bureaucracy, requiring a pot load of money. At the forefront of this government mandated reform is the Accountable Care Organization. The purpose of this new government structure is to create a healthcare entity that allows physicians, hospitals, and other health care providers to provide lower cost, efficient, accountable care for a defined population of patients while sharing monetarily in any cost savings they achieve. It can be created by independent physician practices, multispecialty clinics, hospitals with employed or affiliated physicians, or a combination of the above. It must be a separate legal entity with its own tax identification number. The Affordable Care Act mandates that the Medicare ACO program be operational by January, 2012. The CMS wants the Office of the Inspector General, Department of Justice, the Federal Trade Commission, and the IRS to offer guidance on tax and legal concerns. Business estimates show that setting up ACO's will be an 80 billion dollar expense. The ACO will be required to measure and report 65 quality indicators to the government. Does this sound like low cost, efficient medical care?

After millions are spent forming this new healthcare model, businesses will form to profit from the new government regulations. Accountable Care Organizations, Insurance Exchanges, and numerous new administrative boards and bureaus will be where the power and money will be, not the doctor and his patient. In return, the doctor gets more paper work, more committee meetings, more malpractice risk, and less time with his patient; all in the name of shared savings, supposedly generated by this complex medical entity. The new buzz word summarizing this theoretical model is Pay-for–Performance. But can I tell you a dirty little secret? There is little evidence to date that this model for healthcare will create savings. So why are we spending Trillions of dollars creating this program?

"The great achievements of civilization have not come from government bureaus. Einstein didn't construct his theory on order from a bureaucrat. Henry Ford didn't revolutionize the automobile industry that way."

The proposed Medicare rule includes 65 performance measures.

A few of these measures include the following:

1. Timely care, appointments and information.
2. Helpful, courteous and respectful office staff.
3. Patient's rating of doctors.
4. Admissions for uncontrolled diabetes.
5. Percentage of physicians meeting meaningful use requirements.
6. Meeting preventive health requirements.
7. Defining and implementing best practice guidelines for selected target populations such as the elderly and morbidly obese.

The Affordable Care Act is one big bureaucratic mess, destined to achieve the opposite of its original intent. We need a simpler, more flexible healthcare system that uses delivery models presently available in the market place. They need to focus on service, efficiency, information technology, malpractice reform, and evidence based medical care. Better service and increased efficiency is key to increasing access. Malpractice reform and practicing evidence-based medicine is key to lowering costs. We need Primary Care and Specialists from the private and public sector working together driving the changes, not Washington, D.C. We need to get the technology of EHR in place and we need a little time. Some thirty years ago Nobel Prize winning Economist Milton Friedman was interviewed by Phil Donahue. It's an interview worth viewing on the internet. Friedman said, "The great achievements of civilization have not come from government bureaus. Einstein didn't construct his theory on order from a bureaucrat. Henry Ford didn't revolutionize the automobile industry that way". You cannot revamp the entire healthcare system overnight and the last thing we need is another government conceived, theoretical program that has no chance to achieve what it was designed to do.

$600 wrenches anyone? Make that $6000.

$600 wrenches anyone? Make that $6,000.

The Northeast Louisiana Virtual Clinic **thanks** all our **volunteers**!!

Northeast Louisiana VIRTUAL CLINIC
Dental & Medical Care Made Easy

The Northeast Louisiana Virtual Clinic, better known as the NLVC, is a non-profit organization that provides comprehensive healthcare services to the low income, working uninsured in northeast Louisiana.

Although the NLVC is funded by a grant from the Living Well Foundation, the grant covers only the administrative expenses associated in running the program. The program itself only truly functions by the donations of time and service from our generous volunteers. This includes, doctors, dentists, nurse practitioners, hospitals, labs, radiologists, and pharmacies.

We have been accepting patients for one full year as of July 2010. To date we have provided health and dental care to 186 patients. We currently have 14 dentists and 14 physicians volunteering to see patients.

As our program continues to grow, we are in great need of physicians, dentists and nurse practitioners to provide care to our patients in Ouachita Parish. Volunteering to see at least one patient per month would be a great help in maintaining our program. Our goal for Ouachita Parish is to enroll 150 patients each year. If you already volunteer, thank you! If not, please consider doing so!

In addition to recruiting physicians, we are also working on our first fundraiser. Please join us Saturday, November 12, 2011 for the NLVC "Historic Building Tour". Tour times will begin at 1:00 p.m., 1:30 p.m., and 2:00 p.m. Come learn the history of St. Matthew Catholic Church, The Francis Hotel, Masur Museum, Central Bank Building and the Wellspring Building (Luther B. Hall and Keller homes). Refreshments will be served.

Northeast Louisiana Virtual Clinic Historic Building Tour

November 12, 2011

Tickets $30 *limited number available*

Tour Times: 1:00p.m.
1:30 p.m.
2:00 p.m.

For more information, please contact the NLVC office:

email: NLVC611@gmail.com
phone: 318.329.8490

Volunteer Today!!

If you have any questions or would like to volunteer, please contact our office at **318.329.8490**, or visit our website at **www.NLVConline.org**.

OMS Membership Service / Value

Advocacy for physicians in political, regulatory and economic arenas.

Legal Advice providing guidance and assistance to members on a number of Medical-Legal issues affecting physician practices and organized medicine.

Friends of the OMS program, offers discounts on products and services to all active members of the OMS and OMSA. Here are a few of our participating businesses for 2011:

LAW OFFICES
NELSON, ZENTNER,
SARTOR & SNELLINGS, L.L.C.

Connectivity through special membership activities such as the Oyster Party, the Christmas Party, Doctors Day Reception, Valentine's Social, General Meetings and Executive Committee Meetings.

Business-Over-Breakfast allows office managers / business managers from each member's practice to attend a quarterly breakfast where key speakers will cover topics that address areas of concern when managing a medical practice. Everything from medical billing to personnel issues, from fiscal responsibility to safety. We'll cover it all.

If your business is interested in applying for the "Friends of the OMS" program please contact the OMS office at:

director@ouachitams.org
318.512.6932

Upcoming Events

Nov 11, 2011 | 7:45am
Business Over Breakfast for Practice Managers
Medicaid Representative as our Guest Speaker

Dec 1, 2011 | 7:30
OMS Christmas Party
At the Home of Dr. Walter and Sue Sartor

Jan 27-28, 2012
LSMS House of Delegates Meeting
Hilton Capital Center in Baton Rouge

Feb 17, 2012
OMS/OMSA Valentine's Party
At the home of Dr. Scott and Nicole Barron

Feb 23, 2012 | 6:30
Oyster Party

For more information on these events, contact: Krystle Medford, Director
318.512.6932 | director@ouachitaMS.org

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WHO IS OCTAPHARMA PLASMA?
Octapharma Plasma, Inc. is dedicated to improving the health and lives of people worldwide by providing quality plasma products to our customers. OPI owns and operates plasma collection centers throughout the United States critical to the development of life-saving patient therapies utilized by thousands of patients all over the world.

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OMSA
OUACHITA MEDICAL SOCIETY ALLIANCE

The executive board is made up of:

Kim Read
President

Nicole Barron
Secretary

Lana Forte
Programs

Amy Taylor
Vice-President

Heather Trettin
Treasurer

Carolyn Barnes
Chaplain

The Ouachita Medical Society Alliance is off to a great start this year!

The executive board is made up of Kim Read (President), Amy Taylor (Vice-President), Nicole Barron (Secretary), Heather Trettin (Treasurer), Lana Forte (Social Chairman), Carolyn Barnes (Chaplain), and Debby Edgerton and Dee Ledbetter (Cares and Concerns). The board met over the summer and came up with some new and exciting ideas for the year. We are looking forward to continuing the renewed interest in the Alliance…our goal is to have all of the Ouachita Parish physicians' spouses become active members!

Our first meeting was held at Genusa's restaurant in September. We enjoyed a delicious lunch with over 30 physician spouses in attendance! It was great to see so many familiar faces and catch up from the summer. President Kim Read presided over the meeting. Her husband Jason is the current OMS President, and we are looking forward to working closely with the OMS on community projects, social activities, and promotion of the medical community's interests in Ouachita Parish. Krystle Medford, Executive Director of the OMS, spoke about upcoming OMS events. She is very excited about the upcoming year and is always a great help to the OMSA board.

The next Alliance event will be the joint OMS/OMSA Christmas party to be held in the home of Dr. and Mrs. Walter Sartor on December 1st. Mrs. Norma Sherman and Mrs. Judy Marx will host our January OMSA meeting at the Sherman's home on January 19, 2012. They are both exceptional hostesses, so you won't want to miss this meeting!

Children's Museum Update

Katharine Spires gave us an update on one of our community projects this year. We will be giving the medical corner at the Northeast Louisiana Children's Museum a much-needed "facelift". Katharine and her team have enlisted the help of the design students at Louisiana Tech, and they will be working on our project as part of their classroom experience. They are very excited about it and will be updating us with information about all the ways we can contribute very soon.

The OMS/OMSA Valentine's Party will be held in the new home of Dr. and Mrs. Scott Barron on February 17th, 2012. We are always so grateful to those who open their beautiful homes to us!

In these changing political and economic times, it is more important than ever to work together towards a unified medical community. There are many unique challenges and rewards involved in being married to a physician. The OMSA is a great way to give and receive support that can only come from those facing these same challenges. The OMSA is a great way to renew old friendships, make new ones, and support each other in our personal and community endeavors. Participation in the Alliance is just what the doctor ordered! Please contact us through the OMS office if you are not receiving correspondence from the OMSA and would like to.

Participation in the Alliance is just what the doctor ordered!

If you are not receiving correspondence from the OMSA and would like to please contact us:

alliance@ouachitams.org
318.322.4895

The Future of Medicine

written by: **Mark C. Napoli,** MD FACC

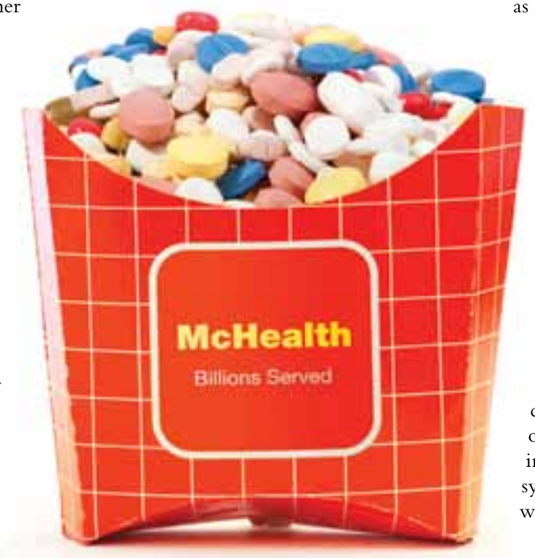
The title of this article arrogantly implies that I, or anyone else, could reliably predict what we can expect from the next few years in the realm of healthcare. I have asked seasoned Washington politicians, sage elder physicians, and cunning healthcare business people with much more experience and insight than me, pointed questions on the topic and received little satisfaction. Paradoxically, this frees me to make any wild prediction I please, with little consequence.

As providers, most of us are exquisitely aware of the dreary challenges that lay ahead. The uncertainty of our future, gives most of us who hold priority in remaining steadfast in our vocation, the same unsettled feeling as standing under a century old sweetgum tree in a strong wind. Rationality and irrationality collide. There is an impulse to break and run from one's position under the fragile branches but to do so makes manifest one's fear and lack of mastery of his surroundings. Especially if the consequence of one's actions only brings a new set of perils.

No one has the specifics of how healthcare reform will change delivery or reimbursement but one thing is certain. The current mindset of the nation will allow large changes to occur like no other time. Whether or not the healthcare reform act remains legislation, a significant loss in provider autonomy through financial or regulatory restriction will take place.

Austerity is the new buzzword. Anyone earning top dollar is scrutinized and resented. Reimbursement for intangible components of care such as talent and expertise are in jeopardy. I believe large corporations that have replaced small accountable local business, have also relentlessly devalued service as a numerated aspect of business. From retail to service, to banking there are simply few remaining who will accept responsibility for consumer complaints. Outrage has been replaced with resigned acceptance and consumers have shifted their focus to the reliability and consistency of the product. As do these parts of life change, so probably changes the practice of medicine.

As for predictions, I am willing to make several specific statements. The first is that Accountable Care Organizations are stillborn. Explaining the details of the reform measure is beyond the scope of the article and the ability of the author. But, in broad terms, the reason why it is dead, is because ACOs require accountability from only a few of the participants. ACOs will pay providers depending on how cheaply they provide the best outcomes. This assumes providers operate in the system independently from the remainder. So long as health illiterate or apathetic patients are not held to answer financially to their fellow consumers for their behavior, there cannot exist true accountability. So long as some health insurance companies relentlessly raise rates, irrespective of true costs, there cannot exist true accountability. So long as lawyers inscrutably smother our society with baseless malpractice claims, without the least personal consequence to livelihood or reputation, despite their collectively abysmal success rate, there cannot exist true accountability. I feel so confident about the non-existence of Accountable Care Organizations in the future as a healthcare delivery system, I submit the reader has wasted his time on the paragraph.



The next prediction is based on a sad fact that I have seen little evidence to contradict it. The government's role in our industry, has clearly been defined as continuing to provide funding for the system as a whole but to do so in the least costly manner. They aim to slow growth in healthcare spending, while expanding the number of those who depend on it. Even though costs of individual services have declined for years based on reimbursement rates, the volume of services provided has steadily escalated. The fact is this: there are only two ways to decrease spending in healthcare.

So long as health illiterate or apathetic patients are not held to answer financially to their fellow consumers for their behavior, there cannot exist true accountability.

The first is to incentivize consumers to engage in behaviors that lead to a decrease in utilization of services, thus driving down volume.

The other is simply to deny care.

Ask yourself dear reader, if you were part of the American political machine, which option is more feasible to your reelection? Would you force and monitor your constituents to stop smoking, take regular exercise, eat less and healthier, or face negative consequences? Or would you restrict the services for which the government is willing to pay and lay the blame and risk at the feet of an easy scapegoat: the provider? You would quickly realize first option is bad for politics, just as most private health insurance has realized its bad for business. Medicare and Medicaid will increasingly manage to deny services to its participants without physician input.

Declining incomes, rising costs, heavier risks and regulations, and increasing outcomes scrutiny will surely have an impact on the provider landscape. There is already a well-described physician shortage looming in the future, as the population ages. There are already decreasing numbers of traditional physicians willing to accept or participate in government sponsored healthcare. But, I believe, to have a better glimpse of future medical practice, one must look to the past of what has happened to our related healthcare providers.

They aim to slow growth in healthcare spending, while expanding the number of those who depend on it.

Nearly gone are the independent practitioners of pharmacy. The franchised megaliths algorithmically dropped on major

continued on 18

intersections across the nation, eclipse them. Despite pharmacist's increasing years in training and higher degrees, they are hostage to the computers in front of them, dictating which drugs to substitute and what advice they can administer. There is little hope in corporate reality of entrepreneurship beyond rolling pills. Productivity is buoyed by pharmacy techs. Personal relationships with customers are limited, buffered by automated calling menus and shift work. Incentives are based on productivity, volume, and efficiency rather than depth of caring or accountability. That is not to say pharmacy is not a gratifying, lucrative, and secure vocation. But it has evolved quite a bit.

I can easily imagine my future medical practice at the Wal-Clinic McHealth Medigoogle outlet.

Before gender equality reached its current levels in the workplace, there were few organized career paths most women could pursue that provided stable and appropriate levels of income, better than nursing. As a result, nursing generally attracted the best of self-motivated and intelligent women. The older model for nursing was total patient, care from the most mundane, to the most specialized. Presently, there are of course more opportunities for bright and ambitious women across the spectrum of professions. Certainly nursing still includes the brightest and most hard-working women and men comparable to any occupation. But the number of willing workers drawn to other careers, creates a void that is filled by not only those perhaps not the caliber of past standards but also by allied health specialists, with narrower focus. That is not to say nursing is not a gratifying, lucrative, and secure vocation. But it has evolved quite a bit.

So, I can easily imagine my future medical practice at the Wal-Clinic McHealth Medigoogle outlet. I have an elderly greeter at the door, giving the illusion of welcome warmth. The patients have already typed their complaints into their electronic tablets and the Watson supercomputer churns out lean, clinically efficient solution after solution. I sit, with a keen eye, supervising the mosaic of images on my 56-inch LED screen, showing the thirty-seven physician extenders under my supervision, passing a handheld Apple iPET scanner over the endless line of patients trundling along the conveyor belts. And I wonder, what I will have for dinner when my shift is up and the Licensed Physician Associate with a two-year degree from the Delta Community Medical School comes in to relieve me.

Fighting the impulse to close my laptop here and jump off of it, I remember that we, as physicians hold, a unique place in society. We can and must maintain the intimate relationships with patients, because it is truly our only reliable tool to accomplish good work. Instead of waiting for technology to usurp our position, we can utilize it to improve lives better and more cost effectively. We can find ways to improve public health and health literacy and at the same time earn a good living. Just like most of our patients, our destiny and outcomes are largely determined by the choices we make and our conviction.

We have the ability to remain relevant. But we will, undoubtedly, have to evolve quite a bit.

General Meeting

Of The Ouachita Medical Society

The summer evening was filled with the sounds of laughter, clinking glasses and a warm breeze blowing through the vineyard. September 1, 2011 marked the second general meeting of the Ouachita Medical Society this year.

Approximately 80 physicians, their spouses and candidates running in the upcoming November election attended this general meeting at the Landry Vineyard in West Monroe. Jennifer Marusak gave an update from LAMPAC on the political actions taken and supported by the LSMS. The food catered by Chef Eric Johnson was exceptional and the West Monroe-produced wine from Landry Vineyard was outstanding. The evenings' door prizes were a large Landry wine basket donated by Bancorp South and a cash prize of $250 donated by Todd Blanchard with Ultimate Business Systems.

Join us for our next General Meeting in May 2012!

“Go therefore….” Matthew 28:19

written by: **J. Larry Barr,** MD FACS

In today’s medical climate of third party interference, malpractice litigation, unending red tape, and immeasurable stress, I would recommend a getaway. Most of us went into medicine with the desire to serve others through a very noble profession. Regrettably, that seems like a long time ago. Someone has said that medicine is the most scientific of the humanities and the most humane of the sciences. This is how it should be.

This spring Dr.’s Joe Barron, Brad Johnson, and myself, led by Dr. Mike Walker completed a mission trip to remote Honduras. The purpose of the trip was two-fold: to bring much needed medical care to an area with really no access to care, and to introduce or advance the gospel. Dr. Walker’s grandson, Alban, also accompanied us.

After our commercial flight from Houston to Tegucigalpa, Honduras, we were met by missionaries Marlon and Trish Munoz, and their two-year-old daughter Madison. They had made all the arrangements for the rest of the trip and had selected the areas to visit. The following day after loading all supplies into duffels and crates, we departed for a four hour truck ride, one hour boat ride (a hollowed out large tree trunk), and half hour uphill hike to our first destination. This consisted of a small village of about nine families, all with the same parents. Each small shelter was packed with children of all ages, cows, dogs, pigs, and chickens (North American roosters crow at dawn-Honduran roosters crow all night). Word that the medical missionaries were coming must have spread rapidly, as people came from a 25 mile radius, either on foot or horseback.

Medicine is the most scientific of the humanities and the most humane of the sciences.

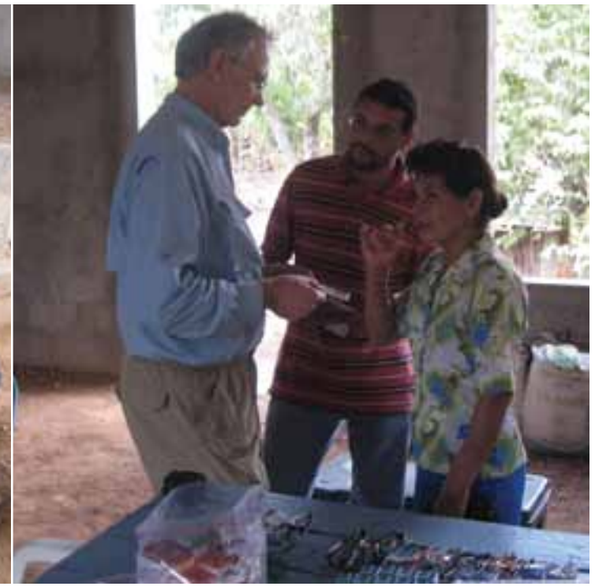
The clinic at the first village consisted of an open-air tent which we set up on arrival. Dr. Walker saw dental patients and pulled teeth, while Dr. Barron, Dr. Johnson, and myself saw medical patients. Most common ailments were parasites, joints pains, upper respiratory ailments, etc. There were lots of young mothers so peri-natal vitamins were in big demand. Poor is not a strong enough word to describe these people, but all were most grateful for the care and anxious to pay you with a smile or hug.

At night, the tent was transformed into a theater where a Jesus-related DVD was shown by a projector powered by a portable generator supplied by the missionary. Sleeping quarters were either under the tent or on a concrete floor with air mattress and sleeping bag. Other than a few mosquitoes and tarantulas, insects were not bad.

After three days in this village we headed back down river and conducted a one-day clinic in the village of Santa Maria. Here, we saw approximately 200 patients with similar problems.

The entire trip lasted 7 days and was truly ‘chicken soup for the soul’. Many people were aided by our presence, but none, blessed so much as us. I would encourage every physician to consider such a trip. If you are ever asked to donate supplies or samples for a trip, items that always seem to be in short supply include parasite meds, antibiotics (especially pediatric), pediatric decongestants/antihistamines, antifungal cream, asthma meds, ibuprofen, Tylenol, antihypertensives, etc. Remember, these people have nothing, so anything is appreciated.

If you ever get the chance,
“Go therefore….”



Controlling Health Costs:

written by: **Lowery L. Thompson,** MD

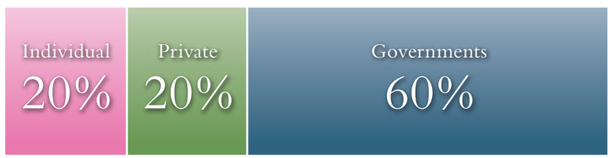
The United States of America has the highest per capita cost ($8,160) for healthcare expenditures, which equates to the highest percentage of the Gross Domestic Product (GDP), of any nation worldwide. There is also a very real concern that we are not getting the best value for our money, as The United States lags behind even some third world countries in certain population health outcome measurements—e.g., infant mortality rate. There are life style factors which impact these statistics, which are not under the direct control of healthcare providers—e.g., obesity generating dietary intake. The percentage of uninsured individuals seems to increase monthly (now about 45 million persons) and most of us would be under-insured, if confronted with a catastrophic illness.

Option One:

One option would, be to make healthcare a strictly free market commodity without governmental (read taxpayer) subsidy. Anyone could obtain the healthcare for which they were able to pay, but nothing more. There is some sentiment in this country for this approach. During the Republican presidential candidate debate recently held in Florida, Wolf Blitzer (moderator) interrupted Congressman Ron Paul (candidate) to ask: "Are you saying society should just let him (a poor, critically ill man) die?" None of the eight candidates replied, but according to The Kansas City Star there were cries of "Yeah!" from many in the audience. Under such a free market system, healthcare expenditures would decrease. If you favor this approach, perhaps you should read no further, as the proposal to follow, will surely aggravate you.

Who pays now in the current US healthcare system?

Governments using taxpayer revenues: 60%
Private employment based insurance plans: 20%
Individual direct out of pocket expenses: 20%



A Two Tier Healthcare System For The United States Of America

If one accepts the premise that the healthy and wealthy will always have to subsidize to some extent healthcare for the sick and poor, the question becomes how to accomplish that goal at an acceptable cost. A modest proposal follows:

Tier One: Free market system

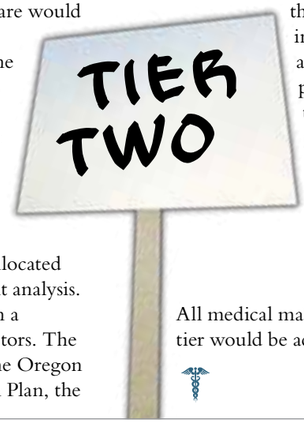
Every individual would be free to pay cash for health care services and/or to purchase any available healthcare insurance policy they could pay for. There would not be any employer mandate to purchase health insurance for their employees, but employers could purchase such insurance as a benefit of employment, if they so wished, but without any direct or indirect federal subsidy. All federal income tax deductions for healthcare insurance and expenses would be eliminated. Market forces would directly determine prices and availability of services in the free market tier without federal interference or taxpayer support.

Tier Two: Federal Universal Access System

Develop a federal universal access system which by definition covers everyone based on hospitals, clinics, and long term care facilities which would be located locally and regionally located based on rational medical demographic factors. Some of these jurisdictions (e.g., 15) would contain parts of more than one state and some states would have more than one jurisdiction. In addition, there would be a few (e.g., 4) mega-jurisdictions which would have the capacity to provide complex and/or experimental therapies in the context of randomized, controlled studies, but there would be clear referral lines to these mega-jurisdictions with more specialized resources. Funding would be from a federal health tax on an individual's or family's adjusted gross income. These monies would flow directly to the universal access system and could not be diverted to any other federal fund. No monies could be borrowed by the federal government to support the universal access healthcare system and no monies could be transferred to the universal access system from other federal funds. Healthcare would become a separate, clearly identifiable line item of the federal budget. Congress would determine the amount of the tax to be paid to support this universal access system. How much would the tax be? I would suggest a tax that would collect 10.8% of the GDP which is near the amount of healthcare expenses paid currently with tax dollars.

The monies available to this system would be allocated to various healthcare needs based on cost benefit analysis. Rationing of finite resources would be based on a combination of medical, social and financial factors. The Oregon Plan is an example currently used by the Oregon Medicaid system in the U.S. Under the Oregon Plan, the state legislature is informed of the amount of money which will be available for Oregon Medicaid for the next two years. A prioritized list is consulted to decide how far down the list the state can afford to go. On September 23, 2009, "pregnancy" was number one on the list and "gastrointestinal conditions with no or minimally effective treatments or no treatment necessary" was number 680 (last) on the list. These terms are defined by ICD-9 and CPT/HCPCS pairing. There will never be enough money to provide everything for everybody. Rationing must occur. All programs that are currently funded by federal tax dollars (e.g., VA, DOD, Medicare, Medicaid, and Tricare) would be included in this system.

Any member of a household, the income of which was less than twice the then current federal poverty level, would receive free care in the universal access system which would provide prescription medications. There would be a sliding scale fee schedule from that point upward for anyone who elected to use this system instead of the free market system.



No one would be forced to use the universal access system if the free market system without government interference or subsidy met their medical needs and desires. Any family unit's annual out of pocket cost for healthcare expenses incurred in the universal access system would be limited to 10% of the adjusted gross income on the applicable Federal Income Tax Return from the previous year. Expenditures in the free market tier would be unlimited, but not subsidized directly or indirectly by federal tax revenues.

All medical malpractice claims involving the universal access tier would be adjudicated under the federal tort statutes.

References will be provided if requested by any reader who is still speaking to me:

Lowery L. Thompson, MD
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The Affordable Care Act

written by: **Henry Hollenberg,** MD

The 100 year war waged on the American Economy and the 45 year war waged on American Medicine have taken their toll.

As we struggle to maintain control of our heavy workloads and strive daily to provide quality care for our friends and neighbors, we watch, incredulously, as the ACA is deftly thrust down the nation's throat. Of course, the ACA is billed as a panacea that will cure limited access, ever expanding costs and increasingly questionable quality. During the debate leading up to the bills passage, the ills of the American Medical System were of course exaggerated and the benefits of the ACA were grossly overblown. Already premiums that the ACA was supposed to drive down have gone up, in many cases dramatically. In light of the fact that the really harsh provisions of the ACA have not even been implemented yet, I believe we can safely predict a bumpy road ahead.

IF IT'S NOT BROKEN DON'T FIX IT.

We were told repeatedly by somber politicians and reliable main stream media outlets that the United States had "the lowest life expectancy of any industrial nation" or "US life expectancy lags or falls behind", yet all to often no hard numbers are offered upon which to reflect. Allow me to clutter the argument with a few facts.

The average life expectancy in the U.S. is age 78. This statistic includes an African-American population of 13% with a life expectancy of 74yrs and significantly smaller categories including Asian at 4%, American Indian/ Eskimo at 1% and Pacific Islanders at 0.2%. The Hispanic category represents a cross section of multiple races of various national origin including Mexican, Cuban, Puerto Rican, Dominican, Spanish and Central/South America. Clearly Americans are quite a diverse group. And our life expectancy statistics actually fair well when compared to less racially diverse populations. For example, the life expectancy in Canada is 80.3, Britain 78.7 and Germany 79 on the higher end and Uganda 51.7, Somalia 48.8 and Angola 37.6 on the lower end. That is not to say that diabetes, hypertension and atherosclerosis are not endemic within our borders and we certainly have room for improvement in diagnosis, treatment and prevention of these diseases. But perhaps the situation is not so dismal as the sound bites would have us believe.

POOR OUTCOMES, UNNECESSARY MAMMOGRAMS AND $50,000 DOLLAR AMPUTATIONS. BUT WAIT, THERE'S MORE!

We were accused of performing unnecessary procedures and delivering poor results. Again let us look at a few facts, for instance cancer therapy:

Breast Cancer Survival:

Britain	US
54%	75%

Prostate Cancer Survival:

Britain	US
43%	81%

Somehow, these statistics don't seem to support the complete failure of healthcare delivery in America we were sold. And the golden age of socialized medicine to come, already enjoyed in Great Britain, does not seem to bear close inspection.

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TROUBLE IN PARADISE.

But all is not well:

COST: Medical costs are high and most patients find it impossible to afford medical care without insurance. At 15% of GDP, medicine consumes a large amount of the nation's resources and the average American's wages.

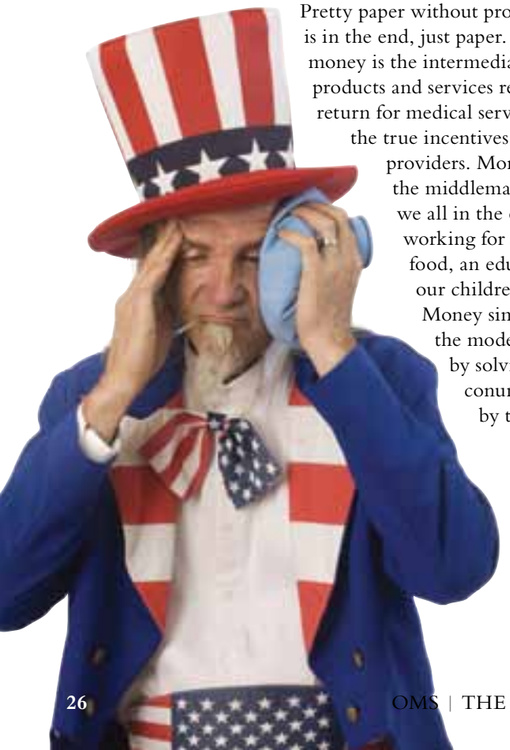
CHOICE: Patient's find it's difficult to switch jobs and not jeopardize their healthcare insurance. This leaves them vulnerable to becoming trapped in a dead-end job, and strips them of one of their primary negotiating tools, the option to quit a job and offer their services elsewhere.

QUALITY: As margins have been squeezed, healthcare is increasingly delivered by corporations more interested in the bottom line, than quality. Meager reimbursement for the considerable labor and skill involved, has effectively removed the Independent Primary Care Physician from regular hospital rounds. The principle patient advocate in the hospital, the physician, is no longer anchored by the Independent Primary Care Physician with their own office and staff but a physician employee of the hospital. This critical role is now often filled by a shift worker, who no longer takes primary responsibility for a patient from admission to discharge and has little or no input into staffing levels, equipment or formulary. Far from being an effective advocate for the patient, the typical hospital employed physician is "out of the loop".

IT'S A FINE MESS YOU'VE GOTTEN US INTO NOW, OLLIE.

A careful analysis invariably leads to the conclusion that more government is not the cure for medicines ills but actually represents the malady itself.

COST: While multiple factors, such as an aging population, are certainly at play in the high cost of medicine, one primary factor overrides all others. America is jobless and broke. Is it any surprise that America is having trouble paying it's medical bills?



Don't be distracted by green paper. Pretty paper without production is in the end, just paper. While money is the intermediary, it's the products and services rendered in return for medical services that are the true incentives to medical providers. Money is just the middleman. Aren't we all in the end really working for a home, a car, food, an education for our children, travel etc. Money simply facilitates the modern economy by solving the conundrum posed by the double (or quadruple?) coincidence of barter. After we do our day's work as physicians and lay our product on the table what do our fellow Americans have to lay on the table in return? Is steel still made in America? Cars? Computers? Cell Phones? Oil? As our government prints an avalanche of green paper to distribute to an ever increasing entitlement class, American production is in decline. While green paper without matching production may buy one more round of votes, this debauched currency leaves Americans virtually empty handed as they shuffle up to the counter of commerce. Since the non-medical sectors of the American Economy produce less and less, that means an ever greater proportion of that same meager production must be used to balance the scales of payment for medical services. In my judgement, it's not so much that the real expenses of medicine are dramatically increasing but rather the production of the American Economy is precipitously dropping. So how has the government wrecked the American Economy? By debauching our currency. Without a stable dollar every economic transaction becomes a crap shoot. Saving, honest labor and a retiree's fixed income are all punished. Fiat dollars created out of thin air are thrown in dizzying quantities at every scam and get-rich-quick scheme hopelessly diluting every honestly earned dollar. Tragically, the dollar of 1913 is now worth about one cent. More shocking still, this tale of woe occurs just after the gold-backed dollar doubled in value, (between 1800 and 1900), and America became an economic superpower. Just as locks keep honest men honest, a currency fixed in quantity by gold seems to be the only way to muzzle our government lest it consume us all. The "fiat" dollar instituted in 1913 has proved a powerfully destructive weapon waged against the American Economy. Perhaps one day sanity will return.

CHOICE: Tying healthcare to employment was the bright idea of our government in World War II. Once again instead of making things better, the government's interference in the private sector has made things much worse. The insurance company caters to the business and not to the patient. The patient has become a sort of fifth wheel, to whom none owe allegiance. With no "skin in the game", patients are left to stumble thru the healthcare maze without advocate or voice.

QUALITY: For the last 45 years, the government has become even more heavily involved in medicine as a third party payer with the Medicare and Medicaid programs. After years of disconnecting the producer and consumers of medical services from one another, the market signals of price and consumption have been hopelessly distorted. No medical business in America has the slightest idea what the true cost of their product is. No medical consumer has any rational basis to judge the price tag on a medical service. Any hope to communicate market signals between producer and consumer are dashed by the FTC's position of implied guilt in respect to physicians. The FTC assumes any publication of medical fees by a provider is, by default, an attempt to collude and fix prices with other medical providers. So the government's standard operating procedure is to treat physicians, the traditionally most respected members of any community, as mafia racketeers. It seems that somewhere between the Philadelphia Convention and the end of the Cold-War our government has come to the conclusion that it's greatest threat is the American people. To rein in and control the Independent American Spirit, our friends in Washington have pursued a strategy of criminalizing behavior. All of it. And the forms and customs of the practice of medicine are now squarely in their sights. CMS bounty hunters roaming the countryside like goblins? Are we living in a Harry Potter movie? After years of government interference and economic disruption, we have become an industry of razor thin margins and ever more cut-throat practices. Rather than promptly and cordially seeing a consult, we now all too often see attempts to dodge a patient encounter. A new consult has simply become a heavier workload, another malpractice exposure and now the opportunity to do jail time for ever more anemic fees.

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No medical business in America has the slightest idea what the true cost of their product is. No medical consumer has any rational basis to judge the price tag on a medical service.

EASIEST THING IN THE WORLD

With 10 square miles in Washington D.C. wreaking such havoc for the last 100 years in the American Economy and the last 45 years in medicine, the obvious solution is of course.....more government! Who else but a bureaucrat could come up with this answer. While there is currently a hard look being taken at the state of America, activists seem to be divided. The Tea-Party coalition representing the conservative viewpoint is most critical of the central government and the Left is focusing their ire on Wall Street. In my opinion, they are both fighting opposite ends of the same dragon. The fiat money system is at the root of Wall Street corruption and is the sine quo non of a massive, oppressive central government. The good that might be accomplished by the central government's re-instituting real money is in real jeopardy of being overlooked by the Tea-Party. And the millions of hard working businessmen providing legitimate goods and services (such as physicians) are in danger of being inappropriately labeled as the "evil rich" by the Left in their zeal to punish the crony-capitalists. Obviously, any one producing wealth by creating copious goods and services through voluntary exchange is not to be castigated. They are in fact super-producers and as such should be looked upon as valuable societal assets and not as social parasites. As leaders in our communities, becoming conversant with these principles and consistently articulating a rational position must be our paramount concern.

The fiat money system is at the root of Wall Street corruption and is the sine quo non of a massive, oppressive central government.

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When Family Medicine Went To the Dogs

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I don't know about yours, but in my family of origin, the pecking order has never budged. It doesn't matter that I have acquired two initials behind my name – I am still Franny's little sister. Always have been, always will be.

For a decade or two, Franny, who is an artist, didn't hold much confidence in my hard-won medical degree, or my family practice board certification, or my years of medical practice. After all, how much could her little sister really know?

This is the story of when all of that changed.

It was approximately 15 years ago that I was in Rhode Island, where my parents live, with my three young children. Franny was there, which was great, and so was her dog Juxo, which was not so great.

Don't get me wrong. I love my sister. It's just that I have not, over the years, loved her dogs. This dog in particular was just not my friend. Juxo was an Alpha Male dog who, it would be more accurate to say, owned Franny, rather than the other way around.

Now, I am very much a dog lover. I have always owned a dog and I love to interact with other people's dogs. But not Juxo. He was a large chocolate lab, with shaggy hair that always reeked of the various items he regularly rolled in. Drool dripped from his open mouth, which bothered me because he was at eye level with my youngest son. He clearly didn't like any of my children, and bumped into them, hard, emitting a guttural, threatening hum whenever he was around them. Our own dog slinked away when Juxo approached.

But Franny didn't seem to notice any of that, and in the interest of family harmony I decided to just stay vigilant to keep my kids and Juxo apart.

So I was glad the day Franny took Juxo for a long walk. I was upstairs when she returned, and I heard her run into the house, calling frantically for me.

"Amy, Amy! Juxo can't walk. It's like his hind legs are paralyzed. And I think it's getting worse."

I started to run downstairs, but then something peculiar happened. Time slowed down. It was one of those moments when I was able to think a series of clear, focused thoughts in the few seconds it took me to get to Franny. I suppose this is one benefit that comes from rushing to countless codes during medical training.

"One: Juxo – previously healthy – is paralyzed.

Two: Ticks are everywhere here in Rhode Island. I suspect this is tick paralysis. (I am amazed, in retrospect, that I thought of this relatively-rare diagnosis instantly. But my brain, as I said, was working on overdrive.)

Three: All Juxo needs is for the tick to be removed.

Four: (long pause) Should I tell Franny?"

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That last thought I am not proud of. Juxo was a beloved member of Franny's family. I told myself this. Then I told it to myself again.

When I reached Franny, she had carried Juxo out of the car and onto the grass. He looked up at me with a fearful, whimpery expression.

I thought it would be immature to sneer at him the way he had always seemed to sneer at me, back before the tables were turned. So I faced Franny.

"I suspect there's a tick somewhere causing this," I said. Notice that I was declining the opportunity to bury my own hands in his damp coat, which was particularly odiferous that day. "Find the tick and remove it, and he should get gradually better."

She dropped to her knees and began to search. In a few minutes she had found a tick, and, sure enough, within an hour he was moving his legs, and within a day he was back to his old self again. But not quite. He was a chastened Juxo, a kinder Juxo. He stopped bumping into my kids and actually responded to my "sit" command once in a while. At any rate, we seemed to have an understanding.

And Franny? Well, let's just say that ever since that day I have been her "go to" person whenever she needs medical information or health advice. Maybe you're thinking I wouldn't welcome this, but I do. As a little sister, it feels pretty good. Yes, it feels pretty good, indeed.

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