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The HIPPOCRATIST

The Official Journal of the Ouachita Medical Society

ADVANCEMENTS IN MEDICAL TECHNOLOGY

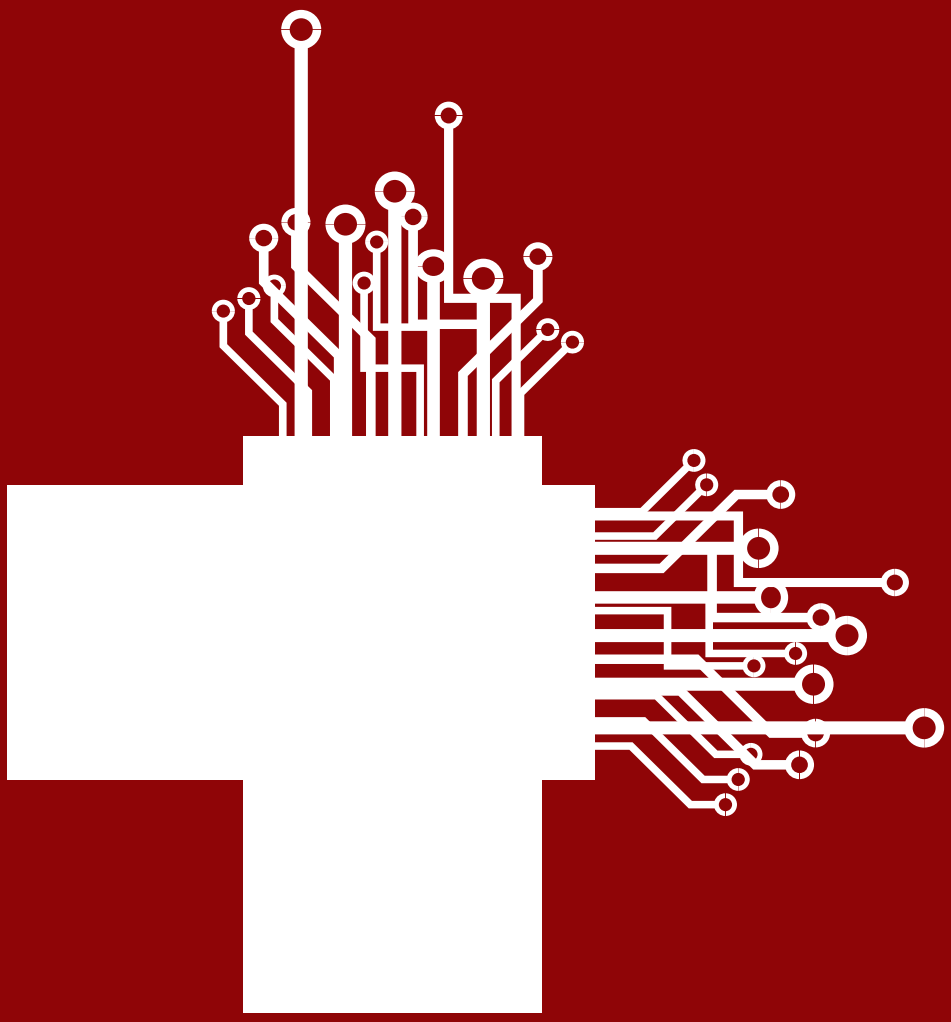

TABLE OF CONTENTS

Featured In This Issue:

In Every Issue:

Advertisers:

The HIPPOCRATIST

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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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Doctors United

By: David L. Barnes, MD

In preparation for my last Presidents page I read my first three President's pages. Two out of the three seemed somewhat depressing and nostalgic. So I think it is time for some good news. I feel the issues of today are uniting physicians as they have not been united since the advent of managed care in the 1980's.

No challenge has ever been greater for the Ouachita Medical Society and its parent organization, the Louisiana State Medical Society than that which is before us today. The passage of the Patient Protection and Affordable Care Act, the restructuring of Medicaid, the privatization of the Louisiana State Charity Hospital System, and the attempt by non-medical school graduates to expand their licenses beyond their training show the importance of having a strong voice in Washington, D.C. and Baton Rouge.

These issues have energized the Ouachita Medical Society and Louisiana State Medical Society and galvanized physicians.

We are now again focused on what binds us together as physicians. But while we have been busy practicing medicine and trying to adapt to all the changes, special interest groups with hired lobbyists in Washington and Baton Rouge have been hard at work undermining our authority to speak for Medicine. I sense a renewed purpose in our membership across all specialties in insuring that those practicing medicine today are properly trained, properly licensed, and held to a high ethical standard for the great responsibility of caring for patients. We are seeing a renewed interest in our social functions as well, as we again seek and enjoy time visiting with our colleagues that we no longer see in our daily practice routines. If you missed our last Ouachita Medical Society Oyster Party you missed the largest turnout for an Ouachita Medical Society function in the last 10 years. Mark your calendar as soon as next years date is announced, spread the word, and come early!

But we must be united and speak with one voice on the national level. This brings me back to the subject of my favorite Presidents page "Can I get An Amen Somebody?".

Dr. Ben Carson, the former head of Neurosurgery at Johns Hopkins, has emerged as a voice for practicing physicians that were left out of the Health Care debate. I recently received my first letter from a national organization urging Dr. Carson to run for President. In his book, America the Beautiful, he lays out the values that shaped America's past and must shape her future. He has a chapter entitled "Is Health Care A Right?". At the end of this chapter he writes…

"As we continue to try to improve health-care access and quality for everyone, we might do well to ask ourselves the question, if the Golden Gate Bridge fell down, who would we get to rebuild it---structural engineers or people who like to talk about building bridges? In like fashion, we would be wise to put health-care reform in the hands of the people who know the most about health care---those providing the care and those receiving it."

So if you are still dreaming of a better health care system, if you are like me and know we can do better, then speak now! Join LAMPAC today and join the legislative action committee of your specialty society! We cannot have too many voices in Washington and Baton Rouge advocating for our calling. If we don't, there will be only time for fond remembrances and wishful thinking. Fond remembrances of when you went to see a doctor and not a clinic, and wishful thinking… if we had only had the courage to make a change "back then".

The major challenges noted above remain, but there is strength in numbers and a unified sense of purpose. I see cohesiveness among the Louisiana State Medical Society and the component specialty societies on the state level, and the disastrous rollout of the Affordable Care Act has left an opening for the "House of Medicine" to take back the leadership role in health-care reform from the Washington politicians and bureaucrats.

So as my time as President of the Ouachita Medical Society comes to a close, I will leave you with three up lifting words that give me hope that Medicine's best days are still ahead.

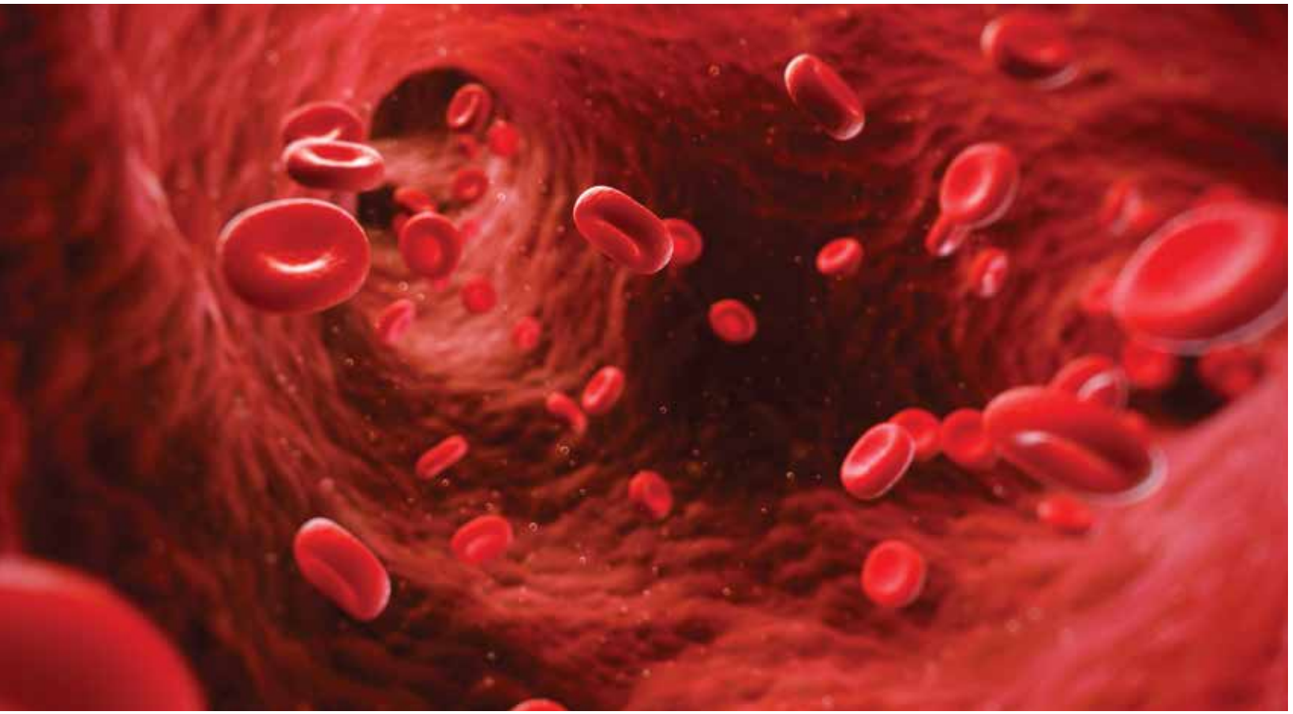
"Run, Ben, Run."

I hope you enjoy this issue of the Hippocratist.

David L Barnes M.D.
President, Ouachita Medical Society

LESS INVASIVE SURGICAL TREATMENT OF AORTIC ANEURYSMS

By: Blaine Borders, MD



New technology in the medical field always enters the market in phases. Development and testing always precede introduction of new technology, followed by advances in initial design and structured use.

The safe use of new technologies requires a studied and careful implementation strategy by the adopting physician. In Ouachita Parish, this has occurred in the specialty of vascular interventions.

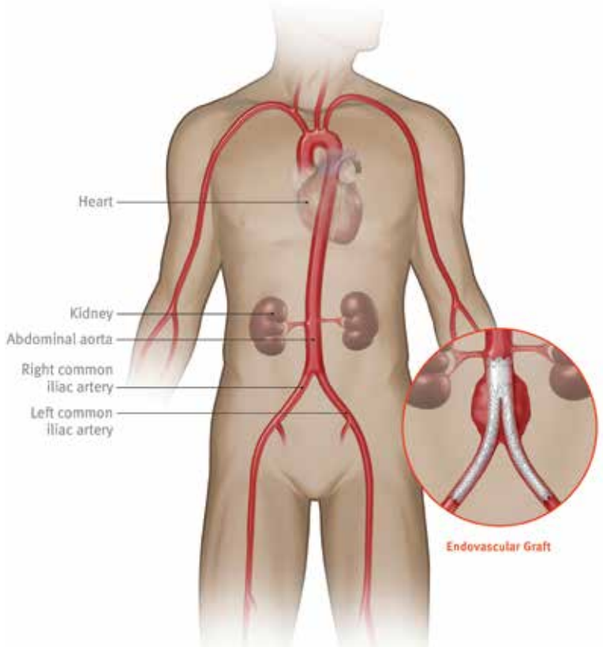
Minimally invasive or endovascular approaches to vascular disease covers a variety of specialties. The local specialists include the fields of cardiovascular surgery, vascular surgery, interventional cardiology, and interventional radiology. Each has its own distinct skill sets and the merging of the fields has led to local proficiency of minimally invasive vascular procedures. These procedures are referred to as endovascular procedures because the technology for treating aortic pathology is from within the lumen of the vessel. We are fortunate to have a diverse group of physicians performing endovascular procedures

Endovascular aneurysm repair (EVAR) was first introduced into clinical practice in 1991. Since that time EVAR has increasing become the preferred treatment for aortic

aneurysms. Thoracic aortic pathology, aneurysm and now dissection, can as well be treated from an endovascular approach. Thoracic aortic grafts (TAG) were used initially for thoracic aneurysms, but have expanded into aortic dissection and aortic transection therapies. Type B aortic dissection, dissection beginning beyond the aortic arch, now has an FDA approved treatment with TAGs as of 2013.

Infrarenal Abdominal Aortic Aneurysm (AAA)

Endovascular aneurysm repair has gained popularity and the initial concerns about long term results now demonstrate that it is a safe and durable procedure. The ongoing discussion centers on re-intervention rates. EVAR has a substantial mortality advantage, but does have need for re-interventions for progressive distal disease or neck or sac expansion. Open aneurysm repair has similar disadvantages with neck expansion and distal arterial disease progression as well as incisional hernias and intrabdominal post procedure complications.



EVAR has moved from expert centers into community practices.

With this progression in the treatment of AAA, the understanding of how and what to expect with minimally invasive aortic repair has become more defined.

Endovascular aneurysm repair requires rather large sheaths and in my practice I use an open femoral approach for access. The open approach is two small groin incisions for the exposure of the common femoral arteries. The working sheaths and catheters are becoming smaller and totally percutaneous approaches are used. The technique is similar with either access approach. Large bore working sheaths are placed in the common femoral arteries and diagnostic angiography is performed. Once the anatomy of the abdominal aorta and iliac arteries are defined, a covered stent graft is positioned under the renal arteries ostiums and the graft is deployed. In the most commonly used devices, an additional extension is placed in the contralateral iliac system to bring the aortic flow from the level of the below renal arteries to the common iliac arteries. The result is an exclusion of the aortic aneurysm sac from direct aortic pressure.

Following the procedure the patient is extubated and transferred to a post-surgical telemetry unit for observation and early ambulation. The typical length of stay is two or three days, depending on the complexity of the graft. The patient is commonly ambulating and eating a regular diet on the afternoon of surgery.

As experience has grown, more technically challenging cases are being undertaken. These cases can include placing branch covered stents in the renal arteries to "snorkel" the renal arteries and in the case of thoracic grafts the celiac artery can as well be "snorkeled". This preserves flow into the "snorkeled" vessel and allows more complex aneurysm to be treated.

After discharge, patients are seen as routine post-surgical patients and as a general rule in uncomplicated cases a post procedure CTA (CT Angiogram) is performed three months following the procedure and then yearly for two years. If the aneurysm sac is decreasing and no endoleaks are identified the yearly evaluation can be with abdominal aortic ultrasound.

The less invasive and early ambulation is greatly appreciated by the patients, doctor, and staff. Early return to work and activities of daily living are expected. The lack of abdominal surgery morbidity has greatly increased the patient's acceptance of the procedure.

Thoracic Aortic Graft

Thoracic aortic grafting (TAG) was first introduced for thoracic aneurysms in 2005 and has gained wide acceptance. It is similar to the EVAR, often requiring an open femoral approach and contralateral percutaneous sheaths. The hospital stay is similar to EVAR and patient acceptance is as well similar. As with all thoracic aortic procedures, paraplegia is a concern and similar treatment protocols exist to minimize or treat this possible complication. Type B descending aortic dissection is currently treated in my clinic with TAG placement when the patient fails initial medical management with blood pressure control and beta blockade.

Ouachita parish is fortunate to have several physicians participating in the described procedures for our patients. Patients who once had to leave town or undergo extensive open procedures now have up to date choices being provided by experienced and well-reasoned practitioners.

OMS Membership

SERVICE / VALUE

Advocacy
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.

Connectivity
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.

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 2014:

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director@ouachitams.org
318.512.6932

Upcoming Events

OMS General Meeting
Thursday, May 8, 2014

Landry Vineyard, West Monroe

(CME)-Affordable Care Act / Evolving Reimbursement Models

Bruce Miller of Baylor Health-Dallas

LSMS Alliance Day At The Capitol
Wednesday, May 14, 2014
7:30am - 1:30pm

LSMS Headquarters

OMS General Meeting
Thursday, September 4, 2014

Bayou Desiard Country Club

Meet the Candidates Event

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

NOT SO FAR BACK IN THE DAY

By: Robert Hendrick, MD

Since this issue's topic is advances in healthcare, I thought I'd look at some of the changes that have taken place just in the time I have been in and around the medical field-both concerning the field of anesthesia and other areas of medicine.

The first job I had was working as an orderly in surgery in 1972. Before I went to work I had to buy special conductive shoes because explosive anesthetic gases had not been phased out yet. Shortly thereafter, they were removed from the operating suites allowing the widespread use of electrocautery units for the control of bleeding. It also allowed the entrance into the surgery suite of other advanced equipment like operating microscopes to robotic surgery equipment. At the same time, the monitoring for anesthesia was quite archaic. The routine use of EKG monitors was not standard. On many shorter cases all that was done was listening to breath and heart sounds with a precordial stethoscope and BP were taken using manual blood pressure cuffs. One hardly had enough hands to do all the tasks needed to be done.

In my field, anesthesiology, the advances that have been made have been breathtaking and really made a difference in saving lives. The pulse oximeter was not even widely available until the mid 1980's. It uses a relatively simple technology to measure the saturation of the blood with oxygen on a real-time basis. Before this, during surgery there were times that a dramatic, life-threatening drop in the oxygen level occurred before it became evident. Now with pulse oximetry, interventions can be made before oxygen saturation drops to a dangerous level.

There was a time that there was no good way to breathe for a patient when they had severe lung disease, paralysis or were having major surgery. Think of the days of the "iron lung" when polio patients had to be in large metal boxes (except for their heads) that used negative pressure to help them breathe.

The advent to positive pressure ventilation obviated that. With mechanical ventilation with endotracheal tubes and positive pressure ventilation has allowed many patients to undergo advanced, life saving surgery to recover from acute episodes of severe lung disease.

The end-tidal carbon dioxide monitor has been as revolutionary as the pulse oximeter. These monitors became widely available in the 1980's. They allow for the detection of carbon dioxide. This provides unequivocal proof that artificial airways are placed appropriately in the trachea. It also provides a way to monitor the adequacy in ventilation. Several studies over the last 20 years have shown that both devices have lead to a decrease in mortality and morbidity in surgical patients.

And it is not just in the field of anesthesia that there have been remarkable changes and advances. There are many surgical procedures that were quite commonly performed that are rarely done today. Removal of part of the stomach for bleeding ulcers was a fairly common procedure that was done 20-30 years ago that we rarely see today thanks to the advances in gastroenterology. An open operation to remove the gallbladder used to be the only viable option for removal along with its 6 week recovery time. With the advent of laparoscopic surgery it has now become a same day procedure in some cases with a one week recovery time. The advent of extracorporeal lithotripsy has virtually ended open operations to remove kidney stones. Medical therapy has also made the transurethral removal of the prostate gland a rare operation. Non-invasive approaches for many vascular procedures have also led to the reduction in the number of open operations for such things as carotid artery obstruction, peripheral artery obstruction, aortic aneurysms and intracerebral vascular disease. And let's not leave out all the advances made in laparoscopic to robotic surgeries. They have led to reductions in morbidity and recovery time.

So you see, you don't have to look back 100 years to see remarkable advances. Many have been made in the last 20-30 years.

It makes one wonder what advances we will see in the next 30 years.

MEDICAL TECHNOLOGY

THE NEW FRONTIER

By: Jason Read, MD

I was asked to write an article about technology in medicine. As one might imagine, it is a subject that frequently arises in my field of ophthalmology. Patients want to be assured that their doctor is "on the leading edge" of technology. Whether on Facebook or at social gatherings, some patients view the latest medical care as a status symbol.

As physicians, we must carefully balance our desire to learn and develop new treatments with potential unintended consequences.

Consequently, new technologies must be approached with caution. The Hippocratic oath charges physicians to never do harm.

The past decade has undergone many ophthalmic advancements including a new type of corneal transplant surgery called DSAEK (Descemet's Stripping Automated Endothelial Keratoplasty) and the anti-VEGF intraocular injections. DSAEK is a partial cornea transplant in which the donor's endothelial layer is transplanted instead of a full-thickness graft. It has proven to have quicker recovery, greater safety, and less refractive error. Anti-vascular endothelial growth factor injections have been a miracle to some macular degeneration and diabetic patients. The injections can reverse the damaging effects of neovascularization and has led to exponential growth of these medications among retinal specialists. On the other hand, some promising procedures have not met the same fate. Conductive keratoplasty, laser thermal keratoplasty, and sclera expansion surgery were three treatments for presbyopia that have all gone the way of the Dodo bird. They each had favorable early results, but were not able to maintain it for any significant length of time. It would be difficult to find an ophthalmologist who still performs those surgeries.

Our patients depend on us to decide which technology is worth the hype and which isn't. I approach new technology with a few questions.

The medical sales representatives often incite the rampant hype that accompanies emerging procedures. They relay the propaganda from headquarters and are ready to educate physicians how their new gadget can lead to increased reimbursement in order to offset its "new technology" price tag. Medical technology, like consumer electronics, will have hits and misses. Some procedures or inventions will have the success of the iPhone, while others will flop like 3D television or Betamax.

First: Is it better than the status quo?

This question seems obvious but frequently lost in the ballyhoo with the rollout of new instruments. Lens implants are currently available in 0.5 diopter steps. Spectacles and contact lenses are available in 0.25 diopter steps. Some enterprising company developed 0.25 diopter implants and marketed them as more accurate. Due to physics/optics properties that I won't discuss here, there is no significant advantage of a 0.25 step lens implant over the current standard. Good marketing, yes. Good science, no.

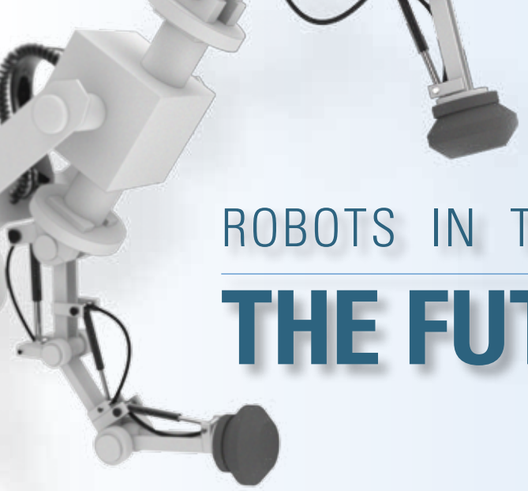
Next: Is it worth the costs?

Affordable Healthcare Act or not, cost is always an issue. The cost of expensive equipment is one of the biggest hurdles for clinicians. Some technologies may lead to increase revenue and can easily be calculated. Others may not make sense economically but clearly benefit patients, thus they are purchased as a "cost of doing business". Patients also have decisions to make regarding new elective procedures. Multifocal lens implants, astigmatism implants and some laser surgeries are not covered by insurance and may be a significant out-of-pocket expense for patients. Remembering that all patients want "the best" but all come from different means, it is crucial for the physician to help them make an informed decision regarding the true benefits. We are not the sales rep. We provide evidence based medicine and the patient decides.

Last but not least: Is the supporting data and research consistent with evidence based medicine?

Two of the primary players in the anti-VEGF market are Avastin (bevacizumab) and Lucentis (ranibizumab). Lucentis is FDA approved for the treatment of neovascularization and macular edema. Avastin is not. Lucentis is $1,500 per dose; Avastin is $40. Many retina specialists have used Avastin "off label" with a patient waiver. Despite the lack of FDA approval, there were multiple randomized, double-blind, placebo-controlled trials that confirmed its effectiveness. This decision is usually made by the physician not the patient.

Whether by laser, by robot, or by new pharmaceutical, it is our responsibility to use new technology wisely. Inform the patients. Use evidence based medicine. Stay away from marketing gimmicks. Never do harm.



ROBOTS IN THE OPERATING ROOM?

THE FUTURE IS NOW

By: Daryl Marx, MD

When we imagine what future technology may bring, we may think about hovering vehicles, teleportation, and even time travel. I think about operating rooms. What might they look like? As a young operating room technologist at North Monroe Hospital in the early 90's, I witnessed the remarkable ability of good surgeons using scalpels and silk ties to get the job done. A surgeon's hands and a few instruments could accomplish the most simple and most complicated operative procedures. Within a short period of time, however, the arrival of laparoscopic equipment was added to the rooms, and use of these quickly became the "new" way to do surgery. I observed many of our Ouachita parish surgeons learn these new techniques. The use of this equipment changed the way surgeons could see, touch, and move around in an abdomen, benefiting patient and doctor. Laparoscopy demonstrated its superior role rather quickly in cholecystectomies and hernia repairs. Laparoscopic colon, anti reflux and bariatric surgery soon followed. The learning curve was steep, however, and some surgeons were wary and unsure of it. It was a totally foreign way of operating. It seemed so radical to use instruments inside a closed abdomen. But the new technology changed surgery and the surgeon's ability to improve patient outcomes like never before. I remember thinking - **the future is now!** I want to be a part of this. So started my medical career.

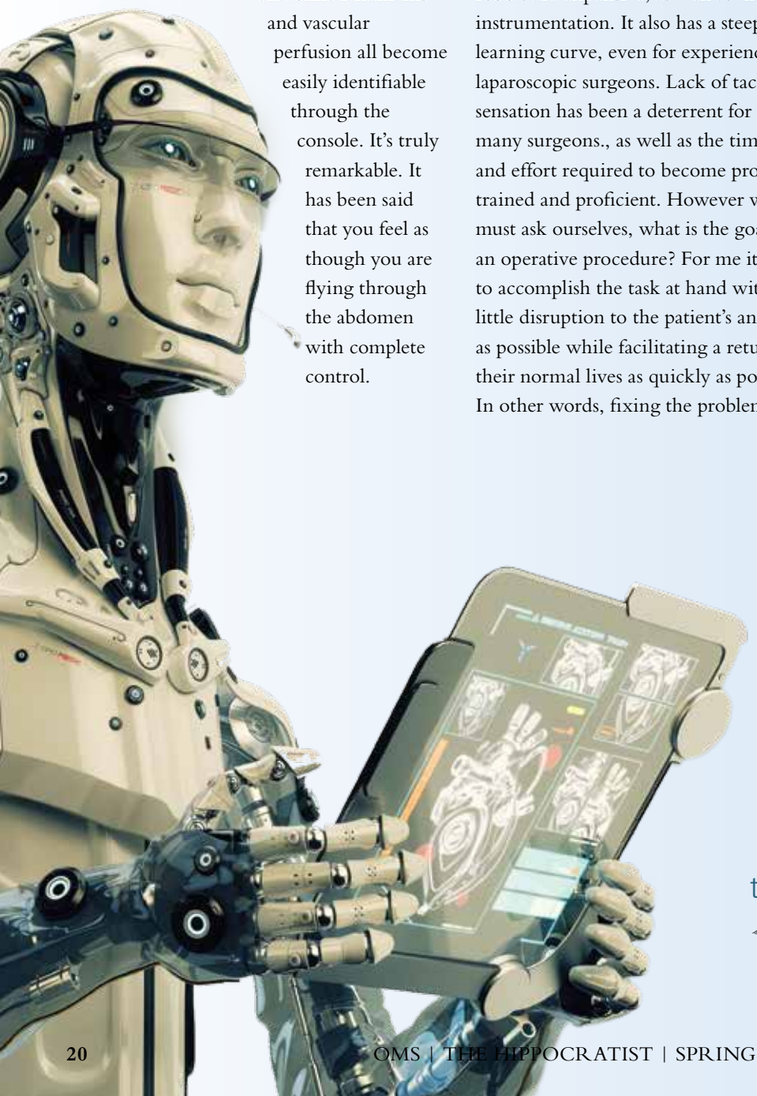
Fast foreword to April 2012 (only about 20 years later): The first surgical robot arrives in Ouachita Parish. What? They say it has three dimensional stereoscopic views and wristed instruments that can turn 360 degrees within an abdomen. What a quantum leap!

Robotic surgery was originally developed by the military for surgical use in remote areas where surgeons were not available. The idea was that the doctors would be able to operate on soldiers while being in another location, with just the robot being at the patient's bedside. The doctors would remotely direct the robot's movements. However, the delay in transmission of information over long distances proved ineffective for real use. In 1992, the technology was introduced into a standard operating room (with the doctor present) in performing a prostatectomy. This was the beginning of proving its dominance in urology. Now, more that 1.5 million prostatectomies have been completed worldwide assisted by the robot. Urologic surgeons have seen the operative advantage of robotics, especially when faced with the confines of the narrow pelvis. Gynecologists have also realized the ease of maneuvering in the pelvis, sewing in a more normal fashion and faster recovery.

Acceptance of the robot into general surgery has been slow. Some surgeons have been slow to accept the advanced laparoscopy despite the overwhelming data in the literature to support the technology. The benefits of the robotic platform are numerous. The ability to control all aspects of the laparoscopic procedure is far superior than traditional laparoscopy. In traditional laparoscopy, an assistant maneuvers the camera, a second

assistant controls additional instruments, and the surgeon performs the surgery using another two instruments. With the robot, the surgeon can manipulate the camera and arms all at once. The surgeon is in complete control of the entire operation. The instrumentation is so superior, that a surgeon can now manipulate, dissect and sew with a precision that standard laparoscopy cannot offer.

The 3D visualization allows the operating surgeon to see the anatomy unlike ever before. Nerve plexus, anatomic landmarks and vascular perfusion all become easily identifiable through the console. It's truly remarkable. It has been said that you feel as though you are flying through the abdomen with complete control.



The technology that the robot offers is transforming the operating theater.

So much more than standard laparoscopy did back in the 90's. And you thought that the doctor on Star Trek had the coolest instruments.

This, technology, however, does come with a price. Da Vinci robots are expensive, as well as the instrumentation. It also has a steep learning curve, even for experienced laparoscopic surgeons. Lack of tactile sensation has been a deterrent for many surgeons., as well as the time and effort required to become properly trained and proficient. However we must ask ourselves, what is the goal of an operative procedure? For me it is to accomplish the task at hand with as little disruption to the patient's anatomy as possible while facilitating a return to their normal lives as quickly as possible. In other words, fixing the problem and leaving things better than you found them. If technology develops a better way for me to do my job, then it's my responsibility to try it out for myself and see what I think. Learning the latest techniques, exploring ideas with other colleagues, thinking outside the box, daring to go where no man has gone before, has been the mindset of our kind since the first medical practitioner starting practicing medicine.

Should this new technology be in our operating rooms? Yes. Traditional laparoscopy has, in my opinion, evolved to the extent that it can. Robotic surgery has so much more to offer. Is Robotic surgery just a temporary phase in our fasciation with the latest gadgets? No. Robotic surgery is being incorporated into hospitals, outpatient centers, not just in our country-but all over the world. Surgeons are beginning to finish their residency fully trained in Robotics.

Where will this new technology take us? I don't know for sure but if history gives us any indication, I think it will be another useful tool in our mission to help others.

Now I'm the old guy learning the new tricks. Maybe some young scrub in my operating room is watching and thinking –**"the future is now"** This is so cool, I want to be a part of this. So starts their medical career.

★ 2014 ★

LSMS ALLIANCE DAY AT THE CAPITOL

WEDNESDAY, MAY 14, 2014
7:30AM - 1:30PM

LSMS HEADQUARTERS

6767 PERKINS ROAD SUITE 100, BATON ROUGE, LA 70808

★SCHEDULE OF EVENTS

7:30 am Welcome & Breakfast
7:40 am Grassroots Advocacy Training
8:15 am LSMS Legislative Update
8:30 am Committee Assignments

TRANSPORTATION TO AND FROM THE CAPITOL WILL BE PROVIDED FOR ALL PARTICIPANTS

★REGISTRATION

Contact Vicki Krupala to register
By Phone: 225-757-0931
By Email: jvkrupala@cox.net
Online: http://lsms-day-at-the-captiol.eventbrite.com

REGISTRATION IS FREE!

Ouachita Medical Society's 2013

Oyster Party















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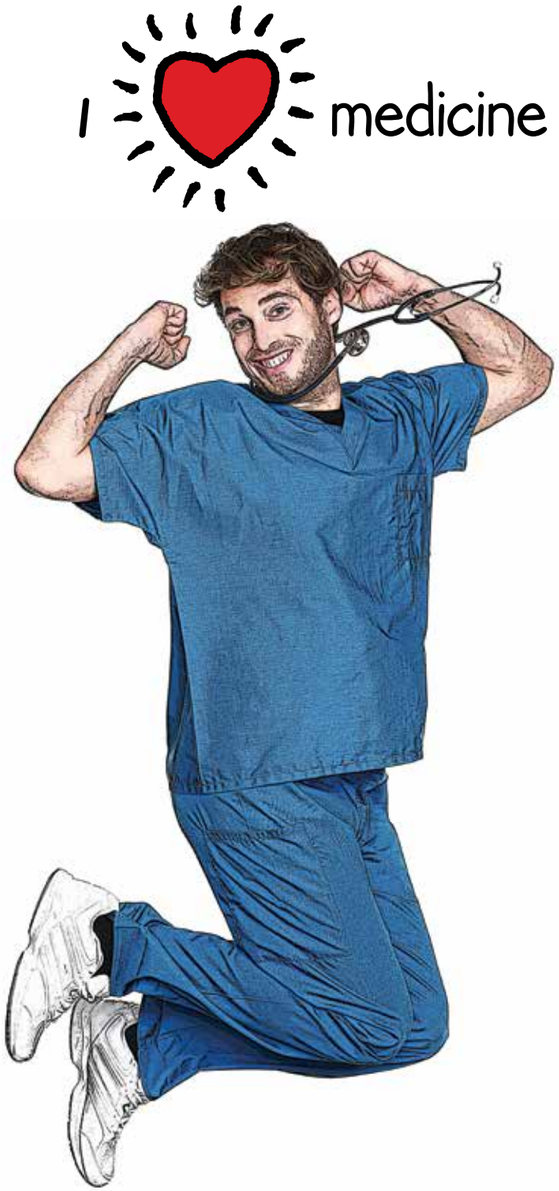
Things I Love About Medicine . . .

By: Daven Spires, Jr., MD

As I reflect on the current state of the medical field, I try to maintain a positive attitude. Thank-you Tony Robbins! I have decided to put together a verbal collage of things I most dearly love about medicine in general and my practice in particular. I am looking at this as a type of quasi-therapy. The goal is to just get it out and off of my chest. While this is my perspective, I am fairly confident that others can see where I am coming from. The hope is that some of you can relate enough that this catharsis can be communal. Hmm, now let's see, what I love about medicine . . .



With ObamaCare hanging over everyone's head (which I love), it is nice to know that our local hospital system has my (our) back. When the first provisions of the new law began to roll out a few years ago, we were treated to a fantastic seminar where certain "facts" were revealed. The first was this: because there are going to be fewer funds available a miracle is going to occur. The money they are going to be spending will be worth more than its actual value. They are going to "increase the value of the healthcare dollar."

I was ecstatic to find out I am going to be paid less but actually be paid more?

This was combined with an enthusiastic reminder that we will eventually be reimbursed based on outcomes and that we need to spend more time with every patient, but we also need to be ready for the significant increase in patient volume. The next "fact" we learned was that doctors need to accept the reality they are no longer the "driver" of the car, but are just part of the "pit crew." My eyes were shining with the joy of such a revelation. Who would have thunk it, the doctor changing tires . . .

Another thing I've been loving of late is the transition to an electronic medical record (EMR). There are few things more satisfying than checking over a patient note that is five pages long to find the one line that actually tells you something. But the overload of added information of dubious benefit is only part of the story. The real joy came when I actually started using an EMR myself. I had been looking for ways to avoid spending time with my kids, of staying out

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of the outdoors during daylight hours, of, well, just letting the rest of the world pass me by. With a grateful heart, I had found the EMR. Being someone who was trying to do it right and get all the "meaningful use" information placed, I was rewarded by prolonging my workday by hours. It's amazing how the EMR has so improved our efficiency that my office has hired a myriad of new employees to help us walk the narrow, but worthwhile, path of compliance. With a guilt-heavy heart, I must confess, I have returned to the idolatrous practice of speaking into the magic box that mysteriously produces a patient note heavy on the narrative (at least on page 4!).

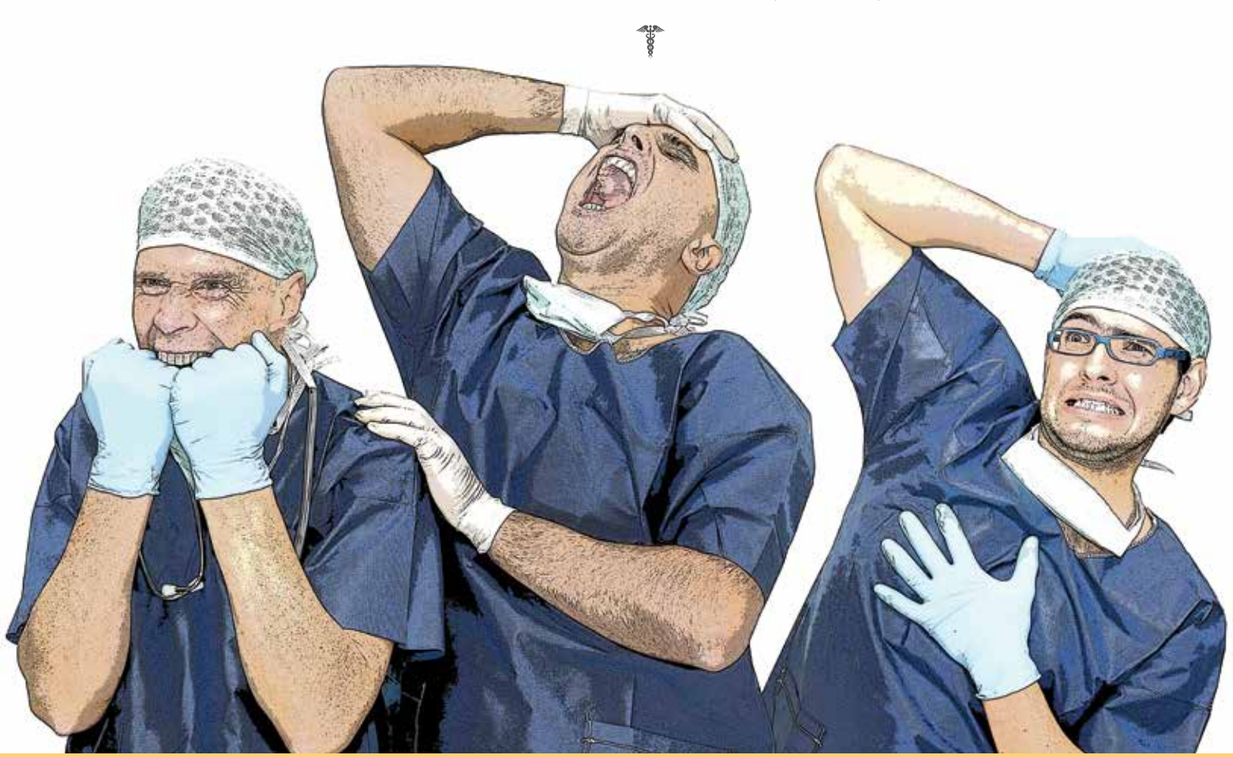
Quick! Do something, lil' Johnny is experiencing discomfort.

With several encounters fresh on my mind, I have been loving the parents who cannot stand the idea of their child experiencing any pain. Can I get an "amen"? They are so worried that his broken bone may discomfort little Johnny, that they generously apply any and all narcotic pain medicines to sooth him.

The end result is that one in a million child who is in moderate pain, constipated, and completely disinhibited.

The look in his eye, the twitch of his mouth, and the mother whose first question is "can we get him some more pain medicine?" brings a smile to my face. I brace myself for the sweet song that is about to spring forth from his mouth as I reach towards his leg. After giving the happy news that we are going to encase him in a long leg cast (and my cast tech pops the earplugs into his ears) I walk away in triumph. The eye of every other patient is on me as the heavens are shattered by the angelic cries, tears of joy standing ready to fall. I just can't get enough of it!

I think I'm going to stop here. I can only stare into the heart of darkness so long before it begins to stare back at me!



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