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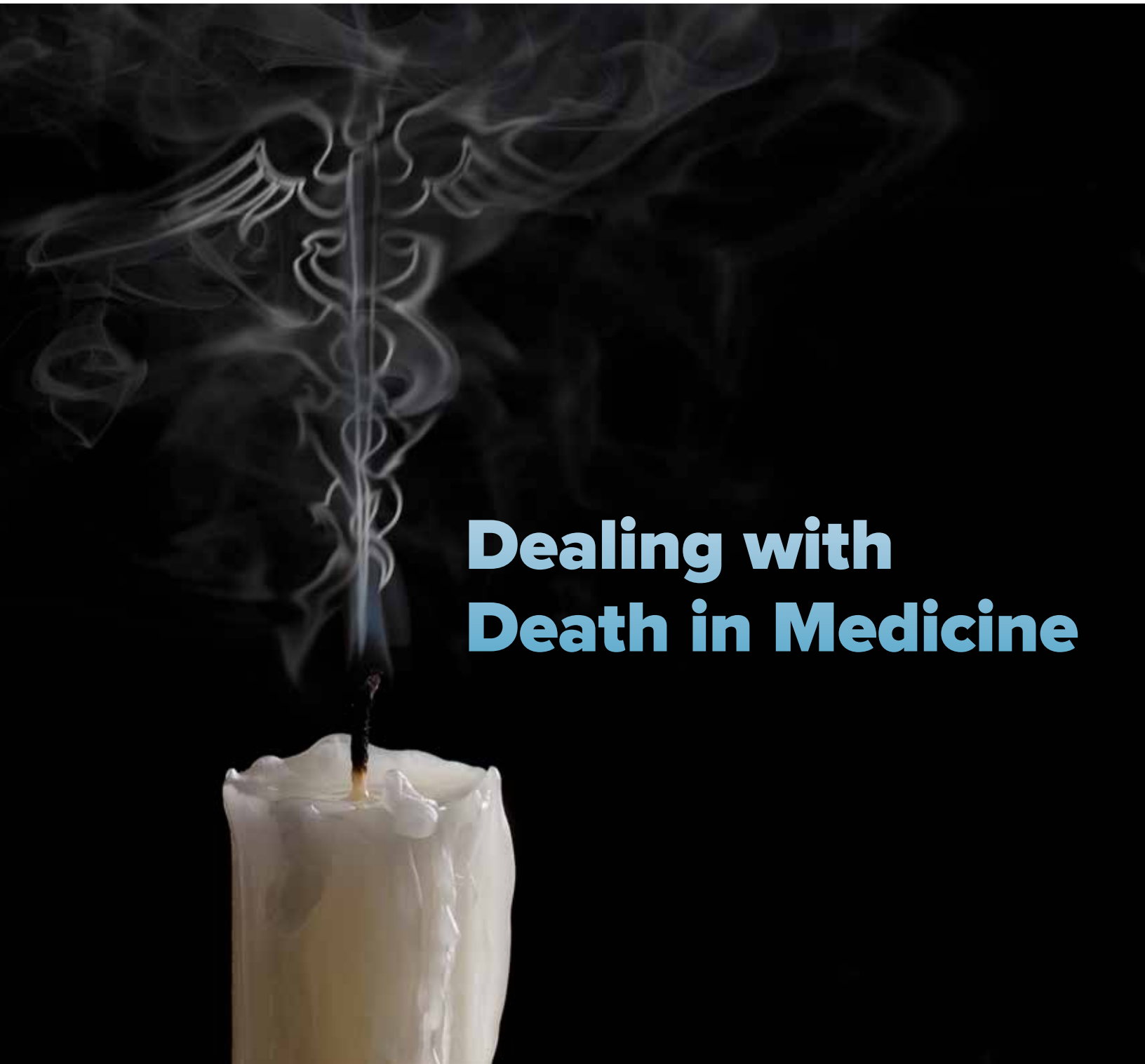
The Official Journal of the Ouachita Medical Society



Dealing with Death in Medicine

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- Weight Loss Surgery
- Women's Services

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

THE SOCIETY COMMITS ITSELF TO THESE GOALS:

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

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2014 – 2016

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Greetings!

I am very happy and excited to begin my term as President of the Ouachita Medical Society. I am hopeful that during my term we shall increase the value of your medical society for you, your practice and your patients. In achieving this, I believe that our secondary goal will also be realized, namely an increase in enrollment and participation in medical society activities. I would also like to re-vitalize the OMS Auxiliary to its once vibrant state. We cannot achieve any of these goals without the ideas and active participation of our current membership, so please look for upcoming events and participate. Suggestions and ideas are always appreciated.

I want to give you some facts about Ouachita Medical Society. According to the US Census Bureau, Ouachita Parish is the 8th largest parish in Louisiana by population. In spite of this, OMS is one of the largest medical societies in the state, ranking 4th. In order to achieve this, we have the highest participation rate in the society of physicians residing in the parish compared to other parish medical societies. This participation translates into increased representation in other organizations, such as the LSMS. So please get involved, remain engaged, recruit a colleague and nudge your spouse toward participation in the OMS Auxiliary.

Please get involved, remain engaged, recruit a colleague and nudge your spouse toward participation in the OMS Auxiliary.

This is the first edition of "The Hippocratist" during my tenure. While there is an uplifting and inspiring article about a medical mission trip to Kenya, there are several articles on issues surrounding death and dying. One of my colleagues recently shared with me a blog, penned by a physician, on "How We Used to Die."[a] This article seems to highlight, that in this age of advanced technology, sometimes the humanism of the patient is overshadowed and lost. It has been anecdotally reported that when physicians face end of life issues, we tend to eschew much of the available treatments and technology that are so often embraced by less informed patients and families. It highlights the importance of physicians having these difficult, awkward discussions with their patients before these difficult decisions must be made by the patient or the otherwise well-intentioned family.

I look forward to seeing you at our next general meeting.

Marty Luther, MD

a. http://exopermaculture.com/2016/01/19/how-we-used-to-die-how-we-die-now/

DO NOT RESUSCITATE ORDER:

MYTHS AND REALITY FOR DYING WITH DIGNITY

By: Gyanendra Sharma, MD

Initiating the conversation about end of life care is difficult for any physician or patient. However, it is also important to have this discussion when providing comfort care becomes more important than providing cure. Death is an inevitable truth of life, something that individuals and families of a critical patient find difficult to accept. While medical advancement can offer a long and healthy life, the aggressive measures aren't always successful; health conditions of a patient can deteriorate irreversibly. Therefore, under these conditions, medical care should not solely be used for prolongation of life.

Most people would like to benefit from the medical advancement going on in this world. However, we need to understand the limitations of prolongation of life or going for "everything possible". Heroic treatments during the end of life may result in a poor outcome and a poor quality of life before death, in addition to insurmountable economic burden to the families. Do Not Resuscitate or DNR is one of the rational decisions that individuals can make when they or their loved ones are not in distress. This will prevent individuals from making hasty decisions in emergent situations and regretting them later.

What is DNR?

DNR is a part of advance directives centered on the principles of your right to die and death with dignity. With an advance directive, you can express how much or how little you want done for you when you are no longer able to make these decisions. In Louisiana, patient or their medical surrogate can choose one or all of the following as a part of DNR.

1. **Hold Chest Compression or Cardiac Defibrillation when Heart Stops**
2. **Hold Endo tracheal Intubation and mechanical ventilation when one stops or has inadequate breathing**
3. **Hold life prolonging medication or intravenous feeding.**

Facts

DNR does not mean the withholding of pain medications or other comfort measures. The living will is a way to express your wishes for medical treatment and, if the situation warrants, die with dignity. Pain medication and comfort measures are provided whenever required to minimize suffering and make the dying as comfortable as possible.

You can withdraw, change, or revoke your DNR order at any time you choose.

The laws regarding DNR and advance directives vary from state to state. Legal experts agree, however, that most states will honor an out-of-state advance directive if it meets legal requirements in the state that it was executed.

Give copies of your advance directive to people who may be called on to act as or identify your surrogate.

You can designate information regarding organ donation in most advance directive documents.

In the untimely event of a medical emergency, those closest to you will need to know where the papers are in order to provide them to the medical personnel.

Without legal paperwork, emergency personnel must do everything possible to attempt to revive someone.

A lawyer may be helpful with the completion of these matters, but one is not required.

DNR **does not mean the withholding of pain medications** or other comfort measures

Myths

Myth: Choosing DNR as an advance directive will hasten dying.

Many people believe that advance directives are only contemplated when facing death. However, you can fill out an advance directive at any time – including when you're relatively healthy. And although end of life decisions can be uncomfortable to talk about, doing so in no way correlates to early mortality. However, you should let everyone know if you've made (or plan to make) an advance directive, including family members, doctors, and auxiliary health care providers.

Myth: A DNR means choosing euthanasia.

No, no, no. Euthanasia is the premature ending of a person's life in order to prevent pain and suffering. However, through an advance directive you may order healthcare practitioners to take whatever measures necessary to prolong your life – including extraordinary ones. These measures are specifically designed to prevent early mortality (i.e., the exact opposite of euthanasia). Many people elect to forego these measures in order to avoid the pain associated with the end-stage of their medical conditions. However, that decision is entirely up to you. By completing an advance directive, you can request a passing consistent with your values, beliefs, and preferences.

Myth: An Advance Directive or DNR means "Do not treat."

An advance directive can express both what you want and don't want. Never assume it simply means "Do not treat." Even if you do not want treatment to cure you, you should always be kept reasonably pain free and comfortable.

Myth: DNR is only for old people.

It is true that older, rather than younger, people use advance directives, but every adult should have one. Younger adults actually have more at stake, because, if stricken by serious disease or accident, medical technology may keep them alive but insentient for decades. Some of the most well-known "right to die" cases arose from the experiences of young people (e.g., Karen Ann Quinlan, Nancy Cruzan) incapacitated by tragic illnesses or car accidents and maintained on life support.

Dr. Gyanendra Sharma, MD, MSC
Assistant Clinical Professor for Family Medicine,
Louisiana State University Health Science Center-
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NO REGRETS

By: Don Givler, MD

"I believe that if we don't do this, **I will look back in the future and I will regret that we didn't."**

"I believe that if we don't do this, I will look back in the future and I will regret that we didn't." The year was 2002, and I was explaining to Dr. Rick Cavell, my supervisor at E. A. Conway Medical Center, why my wife, Amy, and I wanted to spend the better part of a year working at a mission hospital in Africa. I uttered those words long before the concept of a "bucket list" was popular. But the idea was the same. Professionally, it made no sense. It was complicated and disruptive. The prospect of taking three young children (ages 9, 11, and 12) halfway around the world was almost overwhelming. I, personally, don't like change, and yet I was contemplating irreversible changes to our comfortable and predictable life. What in the world was I thinking?

I was thinking, "We need to do this. I don't want to live with regrets."

There are many honorable motivations for compassionate service. For Amy and me, our involvement in part-time missions work in Africa over the past 15 years has been a natural expression of our Christian faith. As the Proverb says, "Do not withhold good from those to whom it is due, when it is in your power to do it." Jesus spoke of "the least of these", which encompasses the needy here in the US and also abroad. Over the years Amy and I have looked for ways to serve the poor in both places. As physicians, the opportunities to help those in need are literally endless.

The timing of our work in Kenya in 2003-2004 was intentional. We wanted our children to be old enough to remember the experience and to be changed by it. As it turned out, they do remember, and they were changed. One of our daughter's college application essays summed it up. She wrote not about the experience of going to Africa, but the experience of coming home. "We were Americans, returning to America. How hard could coming home be?" she asked. The answer is: it was much harder for all of us than we had anticipated. We had made close African friends, including long-term missionaries, and we had seen first-hand the challenges of life in sub-Saharan Africa. Living cross-culturally was not always easy, and while we were there we faced personal challenges both as individuals and as a family. When we returned we were different, and it was hard for us to explain to our friends and family in the U.S. what we had experienced.

We have slept in **grass huts,** hand pumped **water from a well,** endured hours on the **poorly-maintained Kenyan roads,** and enjoyed the **amazing hospitality of our Kenyan hosts.**

Since 2004 we've been back to Kenya several times. For the past 2 years we have worked in rural western Kenya with groups of medical students and residents from LSU-Shreveport. We have slept in grass huts, hand pumped water from a well, endured hours on the poorly-maintained Kenyan roads, and enjoyed the amazing hospitality of our Kenyan hosts. We work cooperatively with a Kenyan faith-based ministry that has done community health work for over 20 years. It is a joy to teach tropical medicine to the students and residents, and to help them process the cultural differences that they experience. Even so, we are constantly reminded that we are students ourselves, that we have much to learn from the Kenyans, that our goal is to support and encourage them in their ongoing work, and that we will invariably gain more from our time in Kenya than we can possibly contribute.

Hopefully Amy and I can continue to do this type of work for some years to come. Perhaps one day we will "retire" to a mission hospital in Africa, or we may instead work in Africa several months per year. Our exact path isn't clear to us at this point. But we are glad that, at least for this one aspect of our lives, we have "no regrets".

Our exact path isn't clear to us at this point. But we are glad that, at least for this one aspect of our lives, **we have "no regrets".**

GENERAL MEETING

On Thursday, September 1st members of the Ouachita Medical Society and their spouses enjoyed an evening hearing privately from several of the candidates running in the U.S. Senate election: Caroline Fayard, Foster Campbell , Cong. John Fleming, MD, Troy Hebert and Rob Maness.

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WANT TO LEARN MORE...?

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Frontline by PBS "Facing Death"
http://www.pbs.org/wgbh/pages/frontline/facing-death/

LISTEN
Podcast by Radiolab "Playing God"
http://www.radiolab.org/story/playing-god/

READ
Book "Knocking on Heaven's Door" by Katy Butler
http://www.simonandschuster.com/books/Knocking-on-Heavens-Door/Katy-Butler/9781451641981

UPCOMING EVENTS

OMS Christmas Party:

Thursday, December 8, 2016
At the home of Dr. John and Dee Ledbetter

Louisiana State Medical Society Annual Meeting

Thursday - Saturday, February 2 - 4, 2017
At the Hilton Capitol Center, Baton Rouge

Oyster Party

Thursday, February 23, 2017
TBA

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

PHYSICIAN ASSISTED SUICIDE

By: David L. Barnes

Physician-assisted suicide and euthanasia have been profound ethical issues confronting doctors since the ancient days of Greece and Rome. In the United States the terms are defined as follows:

physician-assisted suicide ~ In physician-assisted suicide the physician supplies a death-causing agent, such as narcotics or benzodiazepines, but the patient performs the act that brings about death.

euthanasia ~ In euthanasia the physician performs the death-causing act after determining that the patient indeed wishes to end his or her life.

Neither term applies to a patient's refusal of life-support technology, such as a respirator or artificial nutrition, or a patient's request that it be withdrawn; these have had ethical and constitutional sanctions in our nation since the Karen Ann Quinlan case in 1976. And neither term applies to what is sometimes called indirect euthanasia, where the administration of drugs primarily for pain relief may have the secondary effect of causing death, as the physician is well aware. This practice, too, is ethically and legally sanctioned.

The “Modern” euthanasia debate reemerged in the 1870's because of the Enlightenment inspired shift in human thought away from the belief that all human life had intrinsic value simply because it was human. Those who favored euthanasia coupled this philosophy with the discovery and use of new drugs like morphine and chloroform to advance their cause. Samuel Williams, an English school teacher, in a speech to the Birmingham (England) Speculative Club used this claim to redefine the term euthanasia and argued that it be permitted “in all cases of hopeless and painful illness” to bring about “a quick and painless death”. This issue was carried to our shores and debated by prominent Americans including one of the great American orators of the late 19th Century, euthanasia proponent Robert Ingersoll. The debate culminated in 1906 with the Ohio legislature taking up “An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons”- a bill to legalize euthanasia. The merits of the act were debated nationally for months and were covered extensively in the pages of The New York Times, which vigorously opposed legalization, and in medical journals. The Ohio legislature overwhelmingly rejected the bill, effectively ending this chapter of the euthanasia debate in America.

Fast forward to the 1990's and physician-assisted suicide was again brought to the public's attention with the highly publicized cases of Dr. Jack Kevorkian. Dr. Kevorkian assisted over 40 people in committing suicide in Michigan. His first public assisted suicide involved a 54-year old woman diagnosed with early-onset Alzheimer's disease in 1989. He was charged with murder, but charges were dropped on December 13, 1990 because there were no Michigan laws outlawing suicide or the medical assistance of it, so he was not in violation of a law.

Years later, Kevorkian crossed the line from assisted suicide to euthanasia by actively killing a patient himself. Kevorkian videotaped himself giving a man a lethal injection and aired the tape on 60 minutes. He was found guilty of second-degree murder and served eight years of a 10-25 year sentence. He was released in 2007 and died on June 3, 2011.

In 1994, the State of Oregon presented Ballot Measure 16, a citizen initiative, to Oregon voters. Ballot Measure 16 provided for the enactment of the Oregon Death with Dignity Act. This law required that patients of sound mind request a prescription for a lethal dose of medication. Two physicians must confirm a diagnosis of terminal illness with no more that six months to live. Two witnesses, one non-physician, unrelated to the patient, must confirm the patient's request, and the patient must make a second request after 15 days. This ballot measure passed narrowly with 51.3 percent of the vote. In 2008 a Washington state law passed that closely modeled the Oregon law. Since 2008, more states have taken up debate of this issue with very limited success until Vermont passed The Patient Choice and Control at End of Life Act in 2013. This law was based on, but less restrictive than, the Oregon law.

Bills on physician-assisted suicide continue to come before state legislatures. Efforts to pass assisted suicide legislation came before the California State Legislature in 1999, 2005 and 2006. All failed due to bipartisan opposition including major disability rights organizations across the state, the California Medical Association and the California League of United Latin American Citizens. However, it again came before the California legislature in September 2015, passed and was signed into law by Governor Jerry Brown on October 5, 2015. The law went into effect in June of this year.

1870's
shift in human thought away from the belief that all human life had intrinsic value

1906
An Act Concerning Administration of Drugs etc. to Mortally Injured and Diseased Persons

1990's
Dr. Kevorkian assisted over 40 people in committing suicide

1994
Oregon Death with The Patient Choice and Control at End of Life Act

2015
physician-assisted suicide bill passed in california

Most of the arguments made today to justify - or condemn - physician assisted suicide closely mirror the basic arguments of the late 19th Century. If you go to the Physician Assisted Suicide Web Page you will find this current list of Pros and Cons.

PROS

- The patients' tremendous amounts of pain and suffering will end.
- The patients die knowing that it was their choice.
- The patients can die with dignity rather than a shell of their former selves.
- Health care costs can be reduced.
- The nurse or doctor can move onto another patient that has a chance at living instead of spending their time helping a terminally ill patient.
- Pain of the patient's family can be reduced.
- Vital organs can be saved and used to save other patients.
- Without physician assistance people may commit suicide in messy, horrifying, or traumatic ways.

CONS

- It would violate the doctor's Hippocratic oath.
- It decreases the value of human life.
- It could open the floodgate to non-critical patient suicides and other abuses.
- Many religions believe that if you commit suicide you are sent straight to Hell. Therefore, it is harder for the families.
- Doctors and families may be prompted to give up on recovery much too early
- Government and insurance companies may put undue pressure on doctors to avoid heroic measures or recommend the PAS procedure.
- Doctors' could be given too much power

For me, physician assisted suicide is not an option. My faith informs me that there is a Designer of the Universe, who is conscious and has purpose. He revealed to me that he has built into our universe A Moral Law that is separate from our instincts. It is not just a social convention, but an ultimate truth that says all human life has intrinsic and sacred value. But in the realm of the sanctity of life lies also the process of dying.

We, as physicians, know that dying can be sudden or slow and include many conditions where pain is inevitable, but dying in comfort must be the paramount goal for all end of life care.

I believe we can do three things that could go far in alleviating our patients fear of suffering while dying. First we can discuss with our patients how one physiologically dies, what that process looks like and possibly feels like. Second we can give adequate relief from pain and anxiety whenever needed. And third, we can engage Hospice Care for our patients and their families to support them through the dying process.

As Physicians it would not hurt any of us to review the history of this debate and meditate on the ancient way of “Victus quoque rationem ad aegrotantium salutem pro facultate, judicioque meo adhibebo, noxamvero et maleficium propulsabo” or in Latin short hand “Primum non nocere”. **Our patients deserve it and will surely benefit from it.**

A LOOK AT THE NUMBERS

Based on a study in The New England Journal of Medicine of 6,972 elderly people who survived in-hospital cardiac arrests between 2000 and 2008 gives some answers.

1 A year after exiting the hospital, 58.5 percent of these older patients were still alive. Of this group, **48 percent** had little or no neurological impairment, while **52 percent** had moderate or severe neurological damage.

2 **40 percent** of older patients who survived CPR returned to life at home; the remaining **60 percent** went to nursing homes, rehabilitation facilities or hospices."

3 About **two-thirds** of older patients who survived cardiac arrest ended up readmitted to a hospital within one year.[a]

little or no neurological impairment

moderate or severe neurological damage

returned to life at home

went to nursing homes, rehabilitation facilities or hospices

readmitted to a hospital

Hospital Do-Not-Resuscitate Orders: Why They Have Failed and How to Fix Them

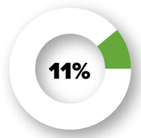
1 Beginning in the 1980s, however, studies showed that the average survival rate to hospital discharge for all patients undergoing CPR in the US was only **10-15 percent**. This rate has not measurably improved over the last 20 years.

2 A study of 500 patients who suffered from a cardiac arrest showed that **76 percent** of these patients with DNR orders were incapacitated to make decisions at the time a DNR order was discussed.

3 However, only **11 percent** were impaired at the time of admission. Only **22 percent** of patients participated in the decision about their DNR order.

survival rate to hospital discharge

patients with DNR orders were incapacitated to make decisions



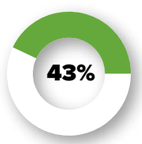
were impaired at the time of admission

patients participated in the decision

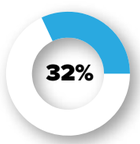
4 In one survey of 155 medicine and surgery residents, **43 percent** would withhold blood products and **32 percent** would not give antibiotics to a patient with a DNR order.

5 Tulsky and colleagues' analysis of tape-recorded DNR discussions led by medical residents found that only **4 percent** of residents discussed the chances of survival after CPR, and only in vague, qualitative terms.

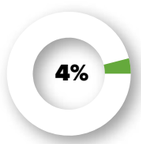
6 In one study, more than **80 percent** of respondents over the age of 70 believed that the survival rate to hospital discharge after CPR was at least **50 percent**.[b]



43% would withhold blood products



32% would not give antibiotics



4% of residents discussed the chances of survival after CPR

believed that the survival rate to hospital discharge after CPR was at least 50%

How do medical residents discuss resuscitation with patients?

1 The physicians often did not provide essential information about cardiopulmonary resuscitation (CPR). While all the physicians mentioned mechanical ventilation, only **55 percent** mentioned chest compressions and **32 percent** mentioned intensive care.

2 Only **13 percent** of the physicians mentioned the patient's likelihood of survival after CPR, and no physician used a numerical estimate.

3 The physicians initiated discussions about the patients' personal values and goals of care in **10 percent** of the cases, and missed opportunities to do so.[c]

mentioned chest compressions

mentioned intensive care

physicians mentioned the patient's likelihood of survival

missed opportunities

a. http://newoldage.blogs.nytimes.com/2013/03/14/healthy-rate-of-survival-for-elderly-saved-by-cpr/
b. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3138592/
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Worley, Emery E. II - MD
Yatco, Reynaldo - MD

Emergency Medicine
Asbury, Ralph G. - MD
Eppinette, James - MD
Twitchell, Daniel W. - MD
Williams, Norman B. - MD

Family Practice
Abraham, Ralph Jr. - MD
Anders, Kerry - MD
Barnes, David L. - MD
Beard, Barbara - DO
Calhoun, Brian K. - MD
Courtman, Sol - MD
Dahal, Ruma - MD
Daniel, Warren A. Jr. - MD
Donald, Albert - MD
Ellerbe, William Michael - MD
Elliott, Clyde E. - MD
Ghanta, Sumatha - MD
Givler, Amy M. - MD
Givler, Donald N. Jr. - MD
Green, Gregory R. - MD
Guinigundo, Noli C. - MD
Gujjula, Rajesh - MD
Hayward, Michael Sr. - MD
Hutton, Daniel E. - MD
Jones, Patrick Gary - MD
Jones, Tammy - DO
Kintzing, William - MD
Lapite, Oladapo - MD
Luther, Euil - MD
McMahan, Steven H. - MD
Melton, Stuart - MD
Metoyer, Kenneth Paul Jr. - MD
Meyers, Owen - MD
Mistry, Fulvantiben Dahyabhai - MD
Momah, Tobe - MD
O'Neal, Teri Barr, MD
Palla, Shireesha - MD
Proctor, Gwendolyn - MD
Raulerson, Robert Mac Kinnon - MD
Ross, Theresa J. - MD
Sharma, Gyanendra - MD
Stockstill, James Dean - MD
Sunkireddy, Nandini - MD
Thapa, Trishna - MD
Tirumanisetti, Pavana Naga
Gopi Krishna - MD
Uprety, Subodh Bhakta - MD
Winters, Harry H. III - MD
Woods, George R. - MD
Wootton, James Leonard III - MD
Yarbrough, David - MD
Yembe, Enaka M. - MD

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

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

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

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

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

Gynecology
Hall, Peyton Randolph III - MD
Jackson, Phyllis Gwenn - MD
Shemwell, Ronald E. - MD
Vines, Richard Sr. - MD

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

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

Internal Medicine-Pediatrics
Bruyninckx, Kyle B. - MD

Interventional Cardiology
Homan, David - MD

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

Neurological Surgery
Greer, Carlton Russ - MD

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

Neurosurgery
Alivernia, Jorge - MD

Nuclear Radiology
Wilder, William M. - MD

OBGYN/Phlebology
Belsom, William B. - MD

Obstetrics/Gynecology
Armstrong, Rafael B. - MD
Bryan, David G. - MD
Caire, Michael J. - MD
Clark, Dellie H. Jr. - MD
Coffman, Leslie R. - MD
Hunter, Tonya Hawkins - MD
Jarrell, Robert G. - MD
Klug, Sara J. - DO
LeBleu, Laurie - MD
Lee, Won S. - MD
Luther, Sherry G. - MD
Moreau-Shemwell, Amber - MD
Pennebaker, Dawn W. - MD
Petty, Laura Rush - MD
Smith, J. Wayne - MD
Truly, James A. - MD
Tugwell, Terence R. - MD
Williams, Adrienne M. - MD
Wilson, Jason B. - MD

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

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

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

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

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

Pain Management / Anesthesiology
Ledbetter, John - MD

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

Pediatric Cardiology
King , Terry D. King - MD

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

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

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

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

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

Radiation Oncology
Ebeling, Robert Jr. - MD

Radiology
Abraham, Ralph III - MD
Broyles, Michael - MD
Davidson, Dan B. - MD
Davis, John A. - MD
Erikson, Christopher J. - MD
Green, Warren J. - MD
Halsell, Robert David - MD
Pate, Steven - MD

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

Therapeutic Radiology
Zollinger, William D. Jr. - MD

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

Urological Surgery
Humble, Robert Lee - MD

Urology
Cage, John M. - MD
Edgerton, Edwin III - MD
Johnson, Jon B. - MD
Liles, William B. - MD
Marx, Don F. - MD
Marx, Robert - MD
Rutland, Edward
Tennis, Paul R. - MD

HOW DO DOCTORS DIE?

KILLED BY PIRATES

By: Mark Napoli, MD

Bartholomew Roberts (Black Bart, The Dread Pirate Roberts), was a Welshman Third mate on the ship, *the Princess* in 1719 when it was captured by pirates led by Howell Davis aboard the Royal James. Davis slaughtered most of the Princess' crew and forced the remaining few to join his band of pirates. The captain, also a Welshman, quickly recognized Roberts' navigation skill and charisma and came to confide in him and rely on him as second in command.

Within six weeks of Roberts' capture, Captain Davis was killed in a battle with the Portuguese and Roberts became the new pirate captain through election by the crew. Roberts went on to become arguably the most successful pirate during the so-called "golden age". He states of his rationalization to accept a life of outlaw piracy, "Better to be a Commander than a commoner."

Posthumously referred to as Black Bart, he was also glamorously immortalized in the book The Princess Bride, by William Goldman. The book was later adapted to film by Rob Reiner and Goldman.

Explaining his rise from farm boy to pirate extraordinaire, the protagonist, Wesley, explains, "I am not the real Dread Pirate Roberts". He too was captured by pirates and forced to serve after pleading for his life. The captain set him to work sparing him only a day at a time. Each night casually mentioning he would meet his end most likely the next day. Eventually the captain reveals he was only grooming Wesley to become his replacement and inherit his moniker, terrorizing him endlessly in the process.

The film, one of the best ever made in my opinion and highly recommended, contains a scene that I think provides a perfect analogy to the conditions under which physicians live and practice:

"Good work, Wesley, sleep well. I'll most likely kill you in the morning."

Doctors classically believe early on in their education that they will eventually complete training and sail on the calm seas of practicing medicine. We hope to reap the noble rewards of gratification, respect, and financial success. I'm not sure of any of my colleagues who have not experienced the shock and frustration of nonsensical interference from insurance companies, hospital administrators, and the government promising us only more red tape and less remuneration for our exemplary work. We stand agape when our patients explain in exquisite detail why they plan to reject our medical advice based on anecdotes from what their sister's cousin's neighbor's girlfriend's father's college roommate read on a MySpace account posted by a lawyer that worked for a company run by a man who retweeted a post he read on Susan Sarandon's dog's blog. We cringe at the purposefully diminutive mention of our collective title, "provider", and feel the gut punch at being lumped in with chiropractors, midwives, podiatrists, holistic healers, psychologists, herbalists, and yoga instructors. Good work doctor, fill out these forms, click these boxes, we will most likely cut your reimbursement in the morning.

We doctors are all naive farm boys who have been broadsided by pirates.

The question is, do you plead for your life? Do you hope to be spared and made part of the pirate crew? Will you justify your actions in your own head?

To my fate I will quote another scene in the story in which our hero finds himself against impossible odds facing the business end of the sword of his opponent:

Prince Humperdink:

"Surrender!"

Dread Pirate Roberts:

"Do you mean you wish to surrender to me? Very well, I accept."

PH:

"I give you high marks for surviving this far, don't make yourself a fool. I say again, Surrender!"

DPR:

"Death, first!!"

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