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At the October 31 meeting of the AMS Board of Trustees, the Board approved a new “exclusive sponsorship” agreement with State Volunteer Mutual Insurance Company. The AMS requested proposals from five of the major medical malpractice carriers in the state, received proposals from three of those carriers and selected SVMIC who submitted a proposal that was substantially superior to the competitors.

This endorsement solidifies a relationship that has been building for 25 years. SVMIC is the state’s largest writer of physician coverage with over $1 billion in assets and $500 million in reserve. Over the past 25 years SVMIC has contributed over $455,000 to support AMS and its related programs; placed three Arkansas physicians on their Board of Directors; utilizes a nine member Arkansas physician advisory committee to review claims and make underwriting decisions; and returned over $13.5 million to Arkansas physicians in the form of dividends. SVMIC is a physician owned and physician managed professional liability carrier headquartered in Tennessee. Arkansas premium rates are based 100% on actual loss and expense data from Arkansas policyholders.

SVMIC will work together with AMS and AMS Benefits to bring value-added services to Arkansas physicians including practice management support and a variety of insurance products. In return, the carrier will be considered an exclusive sponsor of AMS with exclusive rights to promote its professional liability product in AMS publications (print and web-based), trade shows, and other AMS events. AMS
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A recent trip to New York City gave me the time to reflect on the current status and fears related to the Ebola outbreak. I would be less than honest if I did not confess harboring some of the same concerns and worries that I felt back during the early days of HIV and the Anthrax scares following the 9-11 Attacks. With a son in the city who regularly rides the “1” train to football practice, and with a physician in quarantine at Bellevue being treated for Ebola, my relative sense of security in traveling through DFW was replaced with personal and parental angst. Why is it that we get so worried about something that is certainly very dangerous yet much less likely to do us harm than the upcoming flu season? Let’s start by looking back at a couple of historical precedents.

Perhaps the first pandemic of historic proportions occurred during the medieval period from 1346 to 1353, when the “Black Death” plagued Europe. The plague probably originated in China, and in what was arguably the first biological warfare, bodies infected with Yersinia Pestis were catapulted over the walls of Caffa in the Crimea, by the conquering Mongol army. The plague took off from there, with infected rats being transported on galleys arriving in Genoa and other cities. The pandemic that ensued ultimately killed over 100 million people and reduced the world’s population by about 20%.

In 1918, World War I was winding down, and most of us are aware that almost an entire generation of young Europeans died during that conflict. What we don’t realize is that the number of combat related deaths pales in comparison to deaths related to the deadly concomitant Flu Pandemic of 1918. An H1N1 variant was responsible for somewhere between 50 to 100 million deaths, infecting over 500 million people. A disproportionate number of young people (many of them soldiers) died because of their overwhelming cytokine response, in contrast to the usual expected deaths in the elderly and immuno-compromised. This pandemic was labeled the “Spanish Flu” in part because of the protracted, well publicized illness of the King of Spain, Alfonso XIII.

Ebola first made its’ appearance in 1976, in the Sudan and in Zaire from two different species of the filovirus. The virus was named for the Ebola River, where one of its first victims, Mobala Lokela, a schoolmaster, had been visiting before contracting the disease. Over 300 people died during the first outbreak in which approximately 600 or more individuals were infected. Dr. Peter Piot, at that time of The Institute for Tropical Medicine, and his team identified the virus and were responsible for containing the first epidemic. The current outbreak began in December of 2013, and represents the fifth and largest expression of the disease. As of November 4, some 13,000 people have been infected with over 5,000 deaths. Doctors Without Borders has sent 700 physicians to Africa, with about 300 remaining there at present.

Three of these DWB have become infected, including Dr. Spencer from Columbia-Presbyterian in NYC. Asymptomatic upon his return to the U.S., his movement about the town on the “1” train, lunch at the “Meatball Shop,” and bowling in Brooklyn, combined to create the aura of concern that was felt on our own trip to New York last weekend. Even though it appears that the epidemic is still in a logarithmic growth phase in West Africa, it is unlikely that we will see this illness on anything approaching that scale in this country. However, as pointed out by James Surowiecki in a recent article in the New Yorker magazine, “The real problem is that irrational fears often shape public behavior and public policy. They lead us to over investing in theatre (such as airport screenings) and to neglect simple solutions (such as getting a flu shot).”

An attempt to put this into perspective is necessary. Keep in mind that, on an annual basis, the flu accounts for over 200,000 hospital admissions, over 40,000 deaths, and around 80 billion dollars in cost. It is particularly important as we face the upcoming flu season that we recognize the public is at much greater risk from the flu than they are from the Ebola outbreak. Unfortunately, the symptoms of both are similar. We have already seen a couple of false alarms in Fort Smith, one of which initiated full donning of PPE before the situation clarified. It is imperative we prepare for the possibility of a patient with Ebola, as we remain calm and educate our patients, friends and families about Ebola and how it is transmitted. We should remember that of the 9 cases treated in the U.S., including the 4 cases that were diagnosed here, all have survived with the exception of the Dallas patient, Thomas Duncan. None of his family or contacts contracted the illness, which thankfully is a good thing. We will persevere through this just as we have done previously in hard times and other diseases. Let us all hang in there.

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References
www.cdc.gov Ebola outbreak in West Africa;
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A COMMUNITY FIXTURE OF HEALTH HAS CLOSED ITS DOORS
Where Does That Leave Area Physicians and Patients?

Author’s Note: My thoughts and prayers are with the residents of West Memphis who are without their local hospital as of this writing. I rarely dip into first person, but I’d like to share a recent experience that brought this topic home for me.

If ever there was a place where the devil could lay an easy snare, it was in that perilous chunk of Interstate 40 between West Memphis and Memphis. Or so I thought as I drove toward Tennessee (to attend a workshop), this month’s assignment already churning in my head.

I had made tentative plans to stop in West Memphis to take photos for this story (which was in the early research stages). However, as I drove through pre-construction and construction zones, I saw no sun ... no photo opportunities. There was only cold rain, an overcast sky, and an aura of claustrophobia as I navigated my Rav4 through a narrow lane. In those seconds, encased by a cement wall on one side and a semi-truck on the other, those thoughts of devil-ish traps filled my mind.

Suffice it to say, my next thought was one of empathy. Who would want to be a patient in an ambulance trying to get to a Memphis emergency room because their closer West Memphis ER had closed?

My road-weary observation was noteworthy, I learned later. Just moments after I escaped unscathed, others behind me did not. It made the November 5th newscasts – a fiery crash with semi-trucks, a van, and massive flames leaping unbelievably high. Two people died and others were injured on the outskirts of the construction zone I had just squeezed through.

... Now, back to third person.

This month, The Journal shares the story of an Arkansas community that has lost its local hospital – the closing, the aftermath, and a look at the future.
A YouTube video posted just six months ago (in June 2014) emphasized the necessity of Crittenden Regional Hospital to the community it had served for the past 62 years. The hospital closed its doors not long after.

"Having services here is not a matter of is it necessary? We have to have services for the citizens of eastern Arkansas," CEO Gene Cashman stated gravely in the hospital’s public relations video, which explained county citizens’ reliance on the facility. It provided acute care services, primary care clinics, specialty clinics, ER, ICU, inpatient/outpatient rehab services and more.

“I don’t know what people would do without it right in their back yard,” said Beth Toleson in the video. (Toleson, a physical therapist, was among the hundreds of employees who lost their jobs when the hospital closed.)

Unfortunately, people are beginning to experience life without a nearby hospital. The CRH emergency room closed its doors first, on August 27, 2014. The remainder of the hospital and its properties shut down on September 7, and by September 12, the hospital had filed for Chapter 7 Bankruptcy protection.

“It’s almost unbelievable,” said Crittenden County Judge Woody Wheeless, reflecting on the blow to the community — including a fallout that, as it unfolds, has poured out worse news upon already bad. “I would never have believed that we would have at that point today where we’re talking about the community it had served for the past 62 years. The hospital closed its doors not long after.

In the months since the CRH closing, accusations have flown. Many take aim at the hospital for alleged mismanagement and misappropriation of employees’ money. “There are horror stories and lawsuits,” said Dr. Ferguson, who described the main issue behind many of the suits. “The hospital is accused of withholding money from employees’ checks and then not using it for its intended purpose — to pay insurance costs.”

Attorney Denny Sumpter filed one such suit. Originally filed on behalf of his mother, Deloris Sumpter, who worked at CRH for more than 36 years, the suit is against the Crittenden Hospital Association (CHA, which controlled the hospital) and has grown to include more than 175 plaintiffs — all of whom are hospital employees or family members of employees. Plaintiffs say they were required to pay toward plan premiums through their paycheck checks. Allegedly, CHA intentionally used plaintiffs’ money by the individual employee/patient through the insurance plan.

Sumpter’s mother and others lost various benefits in addition to the medical insurance issues. It is unclear how their retirement will be affected.

The lawsuit has brought the matter to light, a positive step, according to Sumpter. “There has been positive movement,” he said. “Crittenden was an affiliate of Methodist Hospital. To its credit, bills outstanding that traced back to employment at Crittenden have been waived for the most part. There is a lot of relief that the employees have already gotten as a result of the activity that has been filed.”

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What Happened?

The hospital’s financial woes were not exactly hidden (though the extent of them was a surprise to many). The hospital suffered from a declining patient load, reduced physician staffing, and even two fires in recent months. Still, the closing shocked hospital employees, physicians and county citizens who just two months prior, had overwhelmingly passed (85.7%) a county-wide sales tax to bail the hospital out of debt.

There’s the rub. Voters did what was asked of them, and, perhaps, would have done even more. “That is the anger in the community,” said Scott Ferguson, MD, who practices in West Memphis and is committed to maintaining his practice there. A former state representative, Dr. Ferguson and his wife, Rep. Deborah Ferguson, have long been active in community affairs. “We passed a tax to keep it open and everyone was exuberant! We saved our hospital! We saved our jobs! And then less than two months later, it closes all of a sudden.”

Circuit judge Victor Hill has since placed a temporary injunction on the tax, and the voters who passed the tax back in June are being asked to repeal it on December 9. (This vote will be taken after press time.)

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Waived bills are not enough, according to Sumpter. “I don’t want to diminish the fact that there is relief for some folks. My mother is one of them, but there are a whole lot of folks that are not out of the woods yet, and we don’t want to say everything is okay until it’s truly okay and all the bills are taken care of.”

Meanwhile, the “other” side (the hospital’s attorneys) argues that claims were paid, to a third-
party provider. “The argument is that there are two third-parties administrators,” Sumpter explains. “The hospital had a self-funded insurance plan. Until January (2014), that plan was administered by Simplify and at some point in time the hospital became delinquent in paying medical claims that were being turned from providers who had given services under the health insurance plan to the employee/patients. It seems to have occurred while Simplify was still the third party administrator.

“At the beginning of this year Cigna became the third party administrator. As of today there has been no claims paid by Cigna for any employee for a medical healthcare claim. So, the simple evidence is claims left to be paid. Until you can’t say that anymore, we’re going to have a case.”

The Aftermath

As dramatically as the closing is affecting hospital employees and patients, it is also stretching an already-thin community of West Memphis physicians. Some have chosen to leave the area. Others, like Dr. Ferguson, are working longer hours to care for sicker patients with less to work with.

“We’ve added two employees and I think we’re going to add another. Except for those who have to go to the ER, we are picking up the slack,” said Dr. Ferguson, the only x-ray and radiology provider left in West Memphis without CRH. “I’ve talked to physicians in town. Most, like me, are backlogged with patients that are more complex. They’re sicker, and they take longer. We are trying to take care of everybody, but we are without laboratory services.

“The ambulance service is stressed. They have to add new ambulances because they are used to this smaller hospital. They could make a run, drop them off, and make another run. Now they have to go to Memphis. We have a lot of construction on the bridges, and they are talking about closing one of our two bridges for two years. When we have wrecks and accidents, you can’t get there.”

The increased volume has led to added stress on physicians and other health care professionals. However, the real critical issue, indicated Dr. Ferguson, is the vulnerability of West Memphis residents. Without a local hospital – and particularly without emergency services – patients are at risk. “It’s tough to get to Memphis,” he said. “As a result, you lose that ‘golden hour’ when patients need to be treated.”

Another concern is pregnant patients. “Dr. Chin is an obstetrician in the area who wants to stay here. He is currently taking his patients to Forrest City and Blytheville to deliver,” said Dr. Ferguson, referring to colleague Robert Chin, MD, who was unavailable for comment at press time. “His patients are not going to do that forever, and 75% of his revenue is from delivering babies. I’m afraid we’re going to lose him if we don’t get services up and running. Without him, you have a pregnant patient that’s ready to deliver … and where is she going to go?”

The hospital’s financial woes have proven particularly challenging also to Internal Medicine physician Ken Nadeau, MD. Dr. Nadeau has been caring for West Memphis patients since 1981, when he and his wife moved there with plans to leave after fulfilling a short-term commitment for public health. They never left, said Dr. Nadeau. “There was a need in the community. Our two-year commitment became a 33-year career.”

In 2010, Dr. Nadeau left private practice to become a hospitalist for CRH. “In 2008 it became clear that EMR was going to be the future,” he said. “Dr. Webb and myself did not want to take the economic risk involved with starting the required advancements despite Medicare’s promise to help pay for the system. We helped recruit physicians to replace us and sold the practice for a nominal fee.”

As a hospital employee, Dr. Nadeau worked part-time on a monthly basis. Partially retired, he and his wife settled into their dream home in Tellico Village, Knoxville, Tennessee. The hospital salary came with medical benefits and malpractice insurance – both of which were necessities for this couple. “We needed benefits from a large group because my wife had a melanoma resected in 2008,” he explained.

Cheryl Nadeau had no melanoma recurrences and did well until February 2014, when she was diagnosed with multiple myeloma. She received care locally in Knoxville and tertiary care at Vanderbilt University. “I continued to work and became aware that Crittenden Hospital was self-insured and behind in their payments,” said Dr. Nadeau, adding that he still had hope at that point that a $100,000 stop loss policy (for medical care for participants with bills exceeding $100,000) would kick in. “Cheryl required inpatient chemotherapy twice with complications afterwards. She was admitted for a stem cell transplant in Nashville on August 25, 2014, the same day the hospital announced bankruptcy.

“The bankruptcy left Cheryl’s treatments uncovered. I have been told that the stop loss only goes into effect after the insured entity has paid the initial treatments expense. As you may imagine, this has been a costly burden for us.”

Thankfully, some related bills were waived or reduced, and the couple has since secured in-
The elimination of pre-existing illness restrictions has prevented a possible personal bankruptcy for us,” said Dr. Nadeau. “We have been savers our entire lives and are able to pay for Cheryl’s care this year. Many other employees are not so fortunate.”

Cheryl Nadeau will undergo reevaluation in early December, and he plans to be at her side. “I have had a fulfilling career. With my wife’s illness and the closing of the hospital, I have decided to retire. I may do volunteer work but have not yet made specific plans.”

A County Trying to Move Forward

In response to the closing, Crittenden County officials are working hard toward their goal of restoring hospital services in some form or fashion. “We’re working with the bankruptcy judge and the lawyer and we’re looking at early December to start selling some of the property,” said Wheeless. “The bankruptcy Judge (Jan Thomas) has hired an auctioneer to start auctioning off some of the properties owned by the Crittenden Hospital Association.”

“Properties” to be auctioned off do not include the hospital, the two-story professional building next to the hospital or the Schoettle Center Educational Complex. These belong to the county.

As for what happens next, the County is open to a number of options that include selling or leasing the facility. “This county needs a hospital,” said Wheeless. “We see that every day since the hospital’s closed. We are working hard to land somebody to come in here and open it up. We have shown it to several different agencies, but nobody at this particular point has made an offer.”

A stand-alone emergency room is not out of the question, but no one has stepped up as of yet to establish one. Rather, potential buyers have shown concern over the age and location of the property. “The property is 63 years old,” said Wheeless, “and it sets a good ways from I-40/I-55.”

For the time being, the county has picked up about $100,000 per month in costs related to the property — security, maintenance personnel, and picking up insurance. “The quorum court allowed us to do that through the end of the year. Beyond that, we’re not sure. We would hate to demolish it, but it may be something we have to take a look at.”

The Future

“I can say there’s not one positive thing about CRH closing,” said Wheeless, who considers himself a positive person by nature. “This hurts the community, not only from a medical standpoint, but also from the standpoint of employment … of vendors. It’s a trickle-down effect in a negative way for our county, and we are concerned with the potential of not being able to land future businesses here without a hospital here.”

What Cashman said in the Crittenden Regional Hospital video — however unwittingly at that time — seems to be right on the mark. That is the perception of Judge Wheeless, Dr. Ferguson and others who still believe strongly that a hospital — in some form or fashion — is a necessity for the citizens of Eastern Arkansas.

“It is vital that we find a way to get this hospital back open again, and my office is dedicated to working as hard as we can to make that happen,” said Wheeless. “We haven’t given up and we’re not going to give up. We’re going to keep fighting until, hopefully, we can find that right fit for our county.”

Referenced CRH video: https://www.youtube.com/watch?v=EdZnsPShBEo
Medicare added hospice services for its beneficiaries’ end-of-life care in 1982 and since then the hospice industry has rapidly expanded. In 2010, approximately 1.5 million patients received hospice care from more than 3,500 Medicare-certified hospice organizations.

Under the Medicare hospice benefit, patients agree to forgo curative treatments aimed at prolonging life, and receive palliative medications and treatments focused on comfort and quality of life. Specially trained physicians, nurses, social workers and others provide this care. The patient’s family also receives support. In most cases, patients are cared for in their home but care can occur anywhere, including hospice centers, hospitals, nursing homes and other long-term care facilities.

To qualify for hospice care, two physicians must certify that a patient has less than six months to live if his or her disease runs its natural course. The patient’s treating physician and a hospice physician usually provide this certification. Medicare Part A pays an all-inclusive daily rate depending on the hospice patient’s level of care. The rate is paid for each day the beneficiary is in hospice care, regardless of the number of services furnished. Under Medicare provisions, the first six months of the hospice benefit is divided into two 90-day benefit periods. At the end of these two periods, the hospice team will evaluate whether the patient continues to have a prognosis of less than six months to live. Following these two 90-day periods, the hospice is then required to evaluate more closely and will review every 60 days. When a hospice provider re-certifies a six-month or less prognosis, the judgment is not made based upon the start of hospice, but rather on the patient’s current status.

There are four primary levels of hospice care: routine home care, continuous care, general inpatient, and respite care. All Medicare-certified hospices are required to offer each level of care.

- Routine home care is the most common level of hospice care provided in a patient’s home, nursing home or assisted living facility.
- Continuous care is provided for patients who are experiencing severe symptoms and in need of temporary extra care. Under this care level, a minimum of eight hours a day of hospice support is provided for short periods of time.
- General inpatient care is an intensive level of care provided in a contracted hospice bed in a nursing facility, hospital or in a freestanding hospice facility for patients experiencing severe symptoms requiring frequent interventions from the hospice team.
- Respite is brief care provided for a hospice patient if a family member is in need of a “break” from caregiving.

Many healthcare providers wait to recommend hospice care until they are absolutely certain of a terminal prognosis or until all treatment options are exhausted. As a result, the majority of patients are referred to hospice in the very end-stages of their diseases. The median length of service in 2011 was 19.1 days, a decrease from 19.7 in 2010. The average length of service increased from 67.4 days in 2010 to 69.1 in 2011.

It is difficult to predict if a patient has an expected prognosis of less than six months and sometimes patients live longer. Hospices experience this difficulty as well and, while most patients are in a hospice program for a short time, approximately 19 percent receive hospice services for longer than six months, according to the Medicare Payment Advisory Commission.
Another issue is that many hospice patients are discharged alive. Recent Medicare statistics show that between 2000 and 2012, the overall rate of live discharges increased from 13.2 percent of hospice discharges to 18.1 percent in 2012. A study, published in the Journal of Palliative Medicine, based on a 2010 analysis of more than one million records of Medicare patients found that more than 182,000 hospice patients were discharged alive.\(^7\)

However, a comprehensive review of the hospice data reveals that about 33 percent of hospice patients used the benefit for less than seven days, and nearly 66 percent spent less than 30 days in hospice care. Of all hospice beneficiaries, 90 percent received less than 180 days of hospice care in 2012.\(^8\) A recent study found that 33 percent of the patients who were discharged alive from hospice died within six months of ending their hospice care, signifying ongoing appropriateness for this care. This suggests that patients discharged from hospice should be evaluated frequently, especially within the first weeks to months after discharge, for changes in status and potential need for hospice readmission.

Local coverage determinations are guidelines intended to help a physician determine appropriateness for the hospice benefit. However, they are not regulations and should not be used solely to determine hospice eligibility. Certification or recertification is based upon a physician’s clinical judgment. Prognostication is not an exact science, and it takes time to determine the trajectory of the disease. Congress made this quite clear in Section 322 of the Benefits Improvement and Protection Act of 2000 (BIPA), which says that hospice certification of terminal illness “shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.”

If a patient does not meet criteria for hospice or chooses not to receive it, he or she can receive palliative care to manage symptoms and improve quality of life.\(^9\) Palliative care, like hospice, addresses the symptoms associated with an illness or complications of treatment, involving a broad range of concerns, starting with treatment of physical symptoms such as pain, nausea and breathlessness.\(^10\) Examples include the use of anticonvulsants to treat pain, antipsychotic medications to treat nausea, and opioids to treat dyspnea.\(^11\)

Palliative care also addresses the psychological, social or spiritual issues that frequently occur in conjunction with physical symptoms. Some examples are fears about the future, loss of independence, worries about family and perceiving themselves as a burden. While some patients will want to discuss psychological or spiritual concerns and some will not, it is fundamentally important to assess each individual and his or her family’s need for support.\(^12\) Philosophy of care and treatments are similar between hospice and palliative care. The biggest differences are the patient’s wishes regarding curative treatment and his or her current illness trajectory.

It is appropriate to provide palliative care along with curative treatment at any stage of a serious illness.\(^10\)

Dr. Garner is a dual-boarded physician in geriatrics and hospice and palliative medicine and works at the VSN 16 Geriatric Research, Education and Clinical Center for the Department of Veterans Affairs and the Arkansas Foundation for Medical Care.

**REFERENCES**

The Paris Hospital now stands empty. The Smith physicians who founded it and kept it alive until 1971 were remarkable men; local accounts of their accomplishments, particularly those of Dr. Jim Smith, the founder, and his nephew Dr. John sometimes push the bounds of credibility. The Paris Hospital in Paris, Arkansas, provided high quality care during its existence from 1910 to 1971, offering a prepaid health care plan from 1920 to 1971. Three generations of Smith doctors were its nucleus, subsidizing the annual losses of the hospital and providing care to all, regardless of ability to pay. The hospital was a community unto itself for the nurses who lived, trained, and worked there. A unique family in the history of medicine in Arkansas, the Smith physicians were well trained, altruistic, compassionate, and conscientious, exemplifying the traditional values of twentieth century medical practice.

The first generation: Dr. Jim and Dr. Mack

Arthur F. Smith homesteaded land near Chismville, Arkansas, in 1860, then died in 1863 in the Civil War. His oldest son J.J., later known as “Doctor Jim” (1854-1941), attended a nearby one-room school and then taught school and took care of the farm in order to earn enough money to attend medical school at Vanderbilt University.1 He purchased what is now a long-deserted log cabin near Chismville for himself and his new wife in 1880, and there he established his practice of medicine.2 Having taught his younger brother Arthur McDaniel Smith (1863-1930), later known as “Dr. Mack”, to read and write, he provided funds for him to attend medical school at Vanderbilt. When Dr. Mack returned and established his practice with his brother, Dr. Jim went to Jefferson Medical College in Philadelphia for further study. After Dr. Jim’s return, Dr. Mack completed his medical studies at Tulane.

Their widespread rural practice was the stuff of legend. They rode out in different directions each morning; a sheet hung out of a window told them which houses needed their services. Dr. Jim left his saddle and bridle on his fence so he could saddle up as fast as possible for night calls. He took a pistol with him on his rounds, using it once to shoot a pig when his brother Frank yelled at him to stop a pig that he couldn’t catch. “Stopped it,” Jim said as he holstered his pistol.2 They performed surgery within a fifty-mile radius from Charleston to Dardanelle. On more than one occasion they treated young boys kicked in the head by mules with elevation of the skull and insertion of a metal plate. One of these young lads survived into his seventies with the plate in place. They also performed laparotomies at least as early as 1900, draining an appendiceal abscess on one occasion and later removing the appendix. Surgery was usually performed on the kitchen table or under a shade tree, depending on the weather. They continued to occasionally perform surgery in the home through the 1920s. Dr. Jim performed much of the surgery until his late seventies when he assisted his brother. Dr. Mack, taller and quieter than his older brother, had a more calm and deliberate manner; yet the nurses stood in awe of him.

Dr. Jim moved his practice from Chismville to Paris in 1899, and Dr. Mack joined him in 1901. They opened a hospital in 1910 in the old Potts Paris Hospital between 1913-1923. They opened a hospital in 1910 in the old Potts

ABSTRACT

The Paris Hospital provided high quality care during its existence from 1910 to 1971, offering a prepaid health care plan from 1920 to 1971. Three generations of Smith doctors were its nucleus, subsidizing the annual losses of the hospital and providing care to all, regardless of ability to pay. The hospital was a community unto itself for the nurses who lived, trained, and worked there. A unique family in the history of medicine in Arkansas, the Smith physicians were well trained, altruistic, compassionate, and conscientious, exemplifying the traditional values of twentieth century medical practice.
home and then completed construction of a new hospital on a hill in 1913, having to pump water up
the hill from Dr. Mack’s house. A three-story annex was added to the hospital in 1923, equipped with
a three-story elevator and increasing the hospital’s capacity to thirty rooms.

In order to provide affordable health care for the coal miners, the two brothers established a prepaid system called the People’s Hospital Association in 1920, charging each family a dollar a month, later extending the benefits and cost to two dollars a month in 1926. They participated in the formation of the Colonial Hospital in Fort Smith in 1928, operating on the same basis of two dollars per family per month, later increased to three dollars a month with extra charges for a private room. Eventually they expanded the plan by offering it to the public. Though the American Medical Association did not object to prepaid medical care for specific groups such as miners, the AMA forbade provision of such a plan to the public. Dr. Jim accordingly relinquished his membership in the AMA. The Smiths sold their interest in the Colonial Hospital in 1930; it finally closed in 1952. (Holt-Krock Clinic began using the Colonial Hospital building in 1953.) No patient was turned away from the Smith Hospital because they couldn’t pay. The Smiths routinely allowed the hospital to run at a loss, covering these losses with funds from other business interests. Though the mines closed, the public prepaid plan lasted until the hospital closed in 1971.

SECOND GENERATION:
DR. JOHN, DR. CHARLES, DR. JAMES

Dr. Jim had no children, and all three doctors in the second generation were sons of Dr. Mack. John (1901-1960), the oldest, joined the clinic in 1925, Dr. Charles (1905-1979) in 1927, and Dr. Jim Paris Hospital. Undated.

Dr. John Smith is a second generation physician at Paris Hospital. He is a brother to Dr. Charles Smith. Dr. John Smith lost his left arm to cancer that resulted in an amputation. He was fitted with a prosthesis. The cancer may have been due to his practice of positioning patients under fluoroscopy with his left hand for many years.

The operating room of the former Paris Hospital is long abandoned, but in its day, life-saving operations could be performed in this part of the facility.

The steam autoclave was a vital instrument in the old Paris Hospital.
(1913-1994) in 1939. Dr. John became the administrator of the clinic. Having trained in pathology at Tulane, he had a basement dug for the hospital laboratory and personally directed its operations, sometimes staying until 4 a.m. to examine surgical specimens. Townspeople repeated many stories of his surgical prowess, some surely exaggerated. However, nurses affirmed numerous anecdotal accounts of his having successfully reattached the chopped-off digits of farmers and miners. Operating on a victim of a stabbing, he once found and successfully sutured a laceration of the heart. Wiry and muscular, he went down into the coal mines to rescue injured miners. On one occasion he climbed a 150 foot wall, in suit and tie, with hat and lamp, to reach an injured miner. His domestic life was neglected for his work; he customarily left home at 4 a.m. and didn’t return until 9 p.m. Occasionally he would go to the local movie theater for a nap, leaving a young friend to come get him if there should be a call.

Dr. John was almost overwhelmed by the volume of the practice during World War II when his two brothers Dr. Charles and Dr. James served in the military. Use of his left hand to position patients for x-rays resulted in cancer that started in the hand and required amputation. He used a hook on his forearm for the last years of his life. When he became terminally ill, he drove himself to the hospital where he occupied the otherwise vacant third floor and stayed there until he died, never seeing his wife again.

The hospital was an isolated institution unto itself. Dr. John found female companionship there. His brother Dr. Charles married into the hospital in his own way. Geneva Campbell came to the hospital as a red-headed sixteen year old student nurse. Full of energy, she had many dates, none with Dr. Charles. Yet when she was twenty-two, and he thirty-two and father of two children, there was a divorce and he married her.

The hospital had loosened its rules for nurses by the time Geneva arrived. Until World War II nurses and students had to be single. They lived in the nurses’ home and if they had dates, they had to be in by a certain hour. Young girls in their teens usually started work at this secular nunnery, where the head nurse was often called “Sister,” with no previous health care experience or training. They took classes under the doctors and head nurses at night; during the day they received on the job training. Nurses did the janitorial and housekeeping jobs; they were paid thirty dollars a month, plus room, board, and laundry.

Some of the nurses became legends themselves. “As much a part of the hospital as the walls,” Neecy Bradshaw was head nurse for many years, living first in the hospital, then in the nurses’ residence, and finally in her own house south of the hospital, purchased with the help of the doctors. She was the hospital anesthetist during the forties; after her retirement, all anesthesia...
was given by one of the doctors. Wilna Schnitzius Lawson (known as “Lawson”) worked there until the hospital closed, as head nurse of the surgery unit and the doctors’ office.

Dr. Mack died in 1930 at age sixty-six, Dr. Jim in 1941 at age eighty-seven, after retiring in 1936. Dr. James, youngest of the second generation, joined the clinic in 1939. A skilled observer, he once passed by Dr. John’s examination room, looked in at the patient, and said, “Black widow spider bite.” Indeed it was, but Dr. James’s own bite could be intimidating. Sometimes described as gruff and cantankerous, one patient said, “Aw, he barks some, but that’s about all. He don’t bite.” Though he complained of the time consumed in obstetrics, Dr. James delivered 1,246 babies before his retirement in 1990.

With changes in economics and delivery of medical care, doctor-owned hospitals became a dying breed, and although the second generation of Smiths continued to subsidize the hospital personally, the brothers were obliged to close its doors in 1971. Dr. Charles and Dr. James continued to use the building as an office.

THIRD GENERATION: DR. JOHN CHARLES (J. C.)

John Charles Smith (1948-), son of Dr. James, began work at the Smith Clinic in 1981, two years after the death of his Uncle Charles, who was killed in an automobile accident. John Charles had trained in surgery at the University of Oklahoma and was certified by the American Board of Surgery. He worked with his father until Dr. James retired in 1990; he continues to practice surgery in Paris and Ozark.

REFERENCES

Much of the information in this paper is from personal recollections of family stories by one of the authors (J. C. S.). Several of the sources listed below were used extensively. Comprehensive page citations are available and may be obtained from the author.

Central Line Placement in the Presence of a Ventriculo-atrial Shunt

By Joshua D. Dilley, MD; M. Saif Siddiqui, MD; Sidney Dassinger, MD; M-Irfan Suleman, MD

1Department of Anesthesiology, University of Arkansas for Medical Sciences
2Department of Pediatric Anesthesiology, University of Arkansas for Medical Sciences, Arkansas Children’s Hospital
3Department of Pediatric Surgery, University of Arkansas for Medical Sciences, Arkansas Children’s Hospital

Venous access can be a critical component of any surgery. The presence of a central venous catheter (CVC) can allow a physician to deliver maintenance fluids, blood products, or lifesaving medications. However, if the CVC is placed incorrectly it may result in complications including bleeding, pneumothorax, and potentially death. In this report, we describe the placement of a CVC in the presence of a ventriculo-atrial (VA) shunt that minimized the risk to the shunt and the patient.

An 18-year-old female presented for a posterior spinal fusion. Her relevant surgical history was noteworthy for a ventriculoperitoneal (VP) shunt converted to a VA shunt secondary to peritonitis. Once an adequate depth of anesthesia was achieved, general surgery physicians arrived for placement of a left subclavian CVC. A CVC was chosen in this case due to the potential need for high volume of resuscitation through a secure access point, and the likely need for delivery of vasopressor drugs. Much consideration was given to the placement of the CVC because of the desire to leave the shunt undisturbed and to minimize the potential for complications, given the location of the shunt. The VA shunt utilized the right internal jugular vein as a path to the right atrium. In order to avoid disturbance of the VA shunt, the left subclavian vein was chosen. Using fluoroscopic guidance, the catheter was positioned 2 cm proximal to the VA shunt, per neurosurgery recommendations (See figure).

Placement of a CVC using radiologic techniques is safe and efficient with a high technical success rate and a low complication rate. Evidence supports not only the performance of a CVC for this case, but also the site used and method of placement. Aside from the potential complications related to placement of the CVC catheter alone, other adverse outcomes include those related to the VA shunt itself, including, but not limited to, compromising the integrity of the VA shunt, the placement of the shunt tip, and introducing a nidus of infection. In this case, the subclavian site and the use of fluoroscopy to place the CVC resulted in good outcomes in a patient with a VA shunt in place.

The surgery proceeded without any anesthetic complications. The CVC was used extensively throughout the surgery. An estimated 2 liters of blood loss occurred, requiring cells saver blood, donor packed red blood cells, crystalloid, and albumin. After the surgery, the patient was extubated and transferred to the pediatric intensive care unit. The CVC and arterial line were removed the following morning. After an uneventful hospital stay, she was discharged home 4 days later. At the 2-week follow-up, there were no signs of complications from the surgery or from the CVC placement. She remained aseptic, and the VA shunt continued to function properly.

Figure: Straight Arrow: Ventriculoatrial (VA) shunts. Curved Arrow: Tip of catheter positioned at the junction of Brachiocephalic vein and left subclavian vein, which is 2 cm away from VA shunt

References
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to the following physicians who are celebrating 10, 25, 50 and 65+ years of continuous membership in the Arkansas Medical Society.
We appreciate your support!

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Son,

I am proud that you choose to study medicine and apprentice in my field. Medicine, as with all things, is easy if you approach it with ease. "Do no harm" is the first dictum. "Do unto others as you have them do unto you" and "love thy patients as you love yourself for they are your neighbors" are higher principles.

It is easy to become a 9-5 “health care provider,” set up a drive through practice, prescribe pills, make an incision and use the patient’s trust and dependence to run a business. It is easy to memorize a few cranial nerves, rattle them trippingly off the tongue and remember or forget them after graduation. It is easy to be seduced by time pressure, frustration, your own emotional needs, anger and arrogance and fool yourself. It is easy to order lab tests, pass pills, inject or operate and think yourself a doctor. It is easy to become a victim of pseudoscience, science by popular acclamation, anecdotes or market forces. It is not easy to be a physician. Soft and hard commercial predations will carve and steal from you and your patient. Science will always be a work in progress. Know the established principles but be open to change.

"Physician know thyself" is the second dictum. The doctor is at once a shaman, an actor, an entire cast and the director on the patient’s stage. To be on that stage, he/she must read and understand himself. It is only then that he can open and read the text that is the patient. To that end you must train yourself with books, practicums, labs and lectures that are required. Despite all the learning, understand and accept your own limitations. That is, be smart enough to know that you will never be smart enough.

To function well, society demands ever increasing efficiency. Individuals are infinitely malleable. Polis vs. person is a moving and inconsistent intersection. The physician balances him/herself at that corner. Like a street performer, the physician juggles all that must be managed in defense of his/her patient.

Pathos expresses itself in many ways. The physician looks through the presenting illness and sees the face, the tilt of the head and the seemingly irrelevant gesture and reads the patient and her/his fears and frustration, his anger, pain and desires. Then, he/she with interest, an appropriate gesture, a slight pause and well-placed hesitation, or a deliberate half sentence open his way into the patient. All the necessary clues will be there.

Nothing in life is greater than the gift of life. When a patient permits you to enter her/his body, she/he tacitly grants you the permission to enter her/his soul and sacred being. Keep your covenant. Honor yourself by honoring them. Enter with humility. Use the best tools at your disposal, which includes yourself, to improve her/his condition.

Compassion is the physician’s most effective tool. All his other tools depend on it. So while in training, fill your black bag with a stethoscope, clamps, medicines, needles, scalpels and knowledge. Then add to them a soft or firm touch; a judicious frown or smile; a word or a necessary silence; humor; a meaningful gesture, realistic hope and all the sincerity you can muster. Use them as needed (prn). Learn to see and hear them with your third eye and ear. Continue to refine these techniques. You will always be a work in progress.

“Oh, by the way, Doctor ...” may be the last, yet the most important phrase that your patient may utter. This may be the most important clue to her inner pain. Often small voices from deep inside speak the loudest. Take your hand off the door knob; turn around and listen. Your knowledge and expertise is not as important as her/his perception. Before you leave, make sure you have made sense to your patient. When you leave them, leave them a bit happier, more at ease and confident, and with realistic hope and expectation. A smile on the patient’s face never hurts.

Empathize but do not identify with your patient, and please do not call Ms. Smith, “the ovarian cancer case” or “room 308.” She deserves her dignity and you must keep yours by honoring hers. Remember that the bed you attend to today is the very same bed that you will sleep in later. Take your time and make it well.

The white coat you wear is a privilege and an honor which your patients and not your professors or your paper credentials bestow. It is an honor and a sacred trust that you must earn every day from each one of them. You are and will be as good as your last case.

“Physician heal thyself” is another dictum. You must have enough passion to put your pa-
tients before yourself. True, you will often have
your own doubts, frustration and even pains.
Remember, your patients are not there to make
you feel better. They come to you for your help.
Touch, feel, listen and learn, and take care of
them well. In the process you will find that they
help you cure yourself.

If it is your destiny to be a doctor, welcome.
You are at the start of your journey. It will be hard
and often confusing. Despite all his/her failings,
mediocrity is not in the nature of the physician.
Take yourself out of the equation. Know the dif-
ference between urgent and important. Learn
the difference between the wheat and the chaff.
When you hear hoof beats, first think of horses
then zebras. The gift of many lives, is a rare
privilege to have. Your patients will eagerly of-
er them to you. Accept them with love, care
and humility. If not length, they add breadth to
your life.

While in med school, the day will inexorably
seize you. Go with the flow. Cultivate yourself
in many fields. Growth and wisdom are noth-
ing more than experience consumed and well
reflected upon. You will find your soul’s meaning
and the remedy we all, knowing or unknowingly
we all seek. A journal entry every now and then
will help. Once you achieve this goal, you can-
not help seizing every minute of every day. Then
you will see that I was right, so many years ago.
There is nothing boring in life, not even bored
and boring.” At the very end, our magnum opus,
our only opus, whether great or small, will be
who we are.

In residency, when you make an incision,
remember traction, counter-traction; when you
close with a suture, approximate, do not stran-
gulate. Practice tying knots. Be sharper than the
scalpel in your hand and more potent than the
medicines you prescribe. As I was told when I
was young, when you see food eat it, when you
see a chair sit in it. When you see a bed, sleep
in it. When you see a bathroom, use it. You will
never know when you will get your next chance.
When you study pathology, medicine or psychol-
ogy, you may feel that you have every disease
which you study. Don’t worry. You are normal.

Finally for better unsolicited advice, read
Polonius in Hamlet who told his son Laertes, “…
to thine ownself be true…” (Shakespeare, as
you know, is a good read.)

I know your independent mind is asking
“are you a doctor or a label dad?” You always
challenged me. Thank you. After forty years of
science, medicine and excursions into art, my
professional and personal journey is winding
down. At times I am certain, at times I remember
my failures and have doubt. The Platonic ideal is
an abstraction in mathematics and fantasy. You
best ask this question from my patients.

I do get occasional phone calls and remind-
ers that make my day. “I want you to know,
the nine-pounder you delivered at 3 in the morn-
ing, just made me a grandmother.” “The preemie
twins that we worried over so much are graduat-
ing from college.” Sometimes I get a newspaper
clipping or a note with a picture. “My son is
a high school teacher.” “I wanted you to know
my daughter passed her surgery boards. Here
is her picture.” There are chance encounters on
the street, in a grocery store or at the gas station.
“This is my girl. She is a cheer leader.” “Hey

Memorial Resolution

WHEREAS, the members of the Pulaski County Medical Society are deeply saddened by
the recent death of an esteemed colleague, Junius Bracy Cross, MD; and
WHEREAS, he graduated from Little Rock High School, the University of Arkansas and UAMS;
and,
WHEREAS: he served his country as a medic during World War II; and
WHEREAS, his public health career included almost 50 years as a practicing Ophthalmologist
in Little Rock, Chief of Staff at Doctor’s Hospital and Jones Eye Institute Advisory
Board, and served as a pioneer for the building of the Doctor’s Building and Doctors
Hospital; and,
WHEREAS, he loved the outdoors and was the state 12 Gauge Skeet Shooting Champion several
times; and
WHEREAS, his devotion to patients, and the practice of medicine will remain a source of
inspiration to all who knew him; and

BE IT THEREFORE RESOLVED:
THAT, this resolution be adopted and placed in the permanent files of the Society; and
THAT, a copy be sent to Dr. Cross’ family as an expression of our heart-felt sorrow; and
THAT, a copy be made available to the Journal of the Arkansas Medical Society for
publication.
Adopted: By Order of the Memorials Committee
September 2014, Tracy Baltz, MD, President
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OBITUARIES

LITTLE ROCK – Wayne Bryant Glenn, MD. 82 died October 31, 2014. Dr. Glenn was an Associate Professor at UAMS for fourteen years. He then joined Little Rock Anesthesia Group at St. Vincent Infirmary and remained there for 30 years until his retirement. He had a wonderful retirement. He loved his farm and had a plentiful vegetable garden and had a workshop and after retirement, made lots of rustic furniture giving much of it to Ferncliff Camp and his family.

His professional affiliations were the Arkansas Medical Society, the Pulaski County Medical Society, the Arkansas Society of Anesthesia and the American Society of Anesthesia. He was board certified in Anesthesia. He is survived by his wife, Mary Ann Glenn; three daughters, Melissa Glenn, Johanna Gillenwater (Price) and Leah Glenn (Lance Mattson) and seven grandchildren.

HOT SPRINGS – Gary N. Meek, MD, passed away November 7, 2014. Dr. Meek is survived by his wife, Mary Julia Meek, his two sons, Greg P. (Catalina) and David G., and three grandchildren, Adam C. Meek, Brooks P. Meek, and Ellen M. Meek. Dr. Meek grew up in Hot Springs, AR. After completing his training as a surgeon at UAMS, he served his country (Under The Barry Plan) and spent the remainder of his tour of duty in Northeast Thailand where he helped many members of the armed services and locals native to the area. Dr. Meek was awarded the rank of Major in the United States Airforce, The Bronze Star, and The Order of The White Rose from the Laotian Military. Upon his return from the war, he returned home to join Vernon Sammons, M.D. and Robert Hill, M.D. at Surgery Associates of Hot Springs for over thirty five years. He touched many lives over the years, and said, “To be a surgeon required having the heart of a lion and the hands of a lamb.” After Dr. Meek retired, he volunteered at a clinic for those in need, and at the Quapaw House. He said those years were some of the best in his medical career. Dr. Meek was a member of the Arkansas Medical Society and a member of the Fifty Year Club.

Group Membership Program for Clinics
AMS group membership eliminates the burden of collecting individual renewal statements each year with one, itemized statement for your entire clinic. The program also connects clinic administrators and staff directly with the Society, providing exclusive benefits and direct access to the information and resources they need. Group memberships are available at no extra cost to groups with 5 or more physicians and require 100% physician participation in the Society. If you would like more information on getting your group involved, please contact Courtney@arkmed.org or apply online at www.arkmed.org/group.

Congratulations!
While AMS has many friends in the legislature, we wish a special congratulations to some of our closest friends for their recent re-election to serve in the 90th Arkansas General Assembly, convening January 12, 2015: State Senator Cecilie Bledsoe (Rogers), State Representative Deborah Ferguson, DDS (West Memphis), State Senator Missy Thomas Irvin (Mountain View), and State Representative Stephen Magie, MD (Conway).

Also, being elected to their first term to the Arkansas General Assembly, AMS congratulates and looks forward to working with two new members with close ties to the Arkansas physician community: State Representative-elect Michelle Gray (Melbourne) and State Representative-elect Ken Henderson (Russellville).
YOU HELP PATIENTS FEEL BETTER. WE HELP YOU BANK BETTER.

At First Security, we appreciate the many health care professionals who take such great care of Arkansas. And we’re happy to return the favor. From personal banking and wealth management to trusts and public finance, the First Security team is ready to take care of you. Stop by today and get banking well soon.
Proudly Serving
Arkansas Physicians
for
25 Years

SVMIC is celebrating its 25th year of providing medical professional liability coverage to physicians in The Natural State. We are rated “A” (Excellent) by A.M. Best Company and, since 1990, have returned more than $13 million in dividends to Arkansas physician policyholders. Our Arkansas Advisory Committee is comprised of nine physicians from various specialties and cities across Arkansas who review claims and make underwriting decisions for Arkansas physicians on behalf of SVMIC. Three of those members sit on our Board of Directors. Combine that with three professionals based in Arkansas to directly serve the needs of local policyholders, and it’s clear that SVMIC is the right choice for you. Simply put, your interests are our interests.

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