

# THE Journal

OF THE ARKANSAS MEDICAL SOCIETY

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MARCH 2020

## Improving Doctor-Patient Communication

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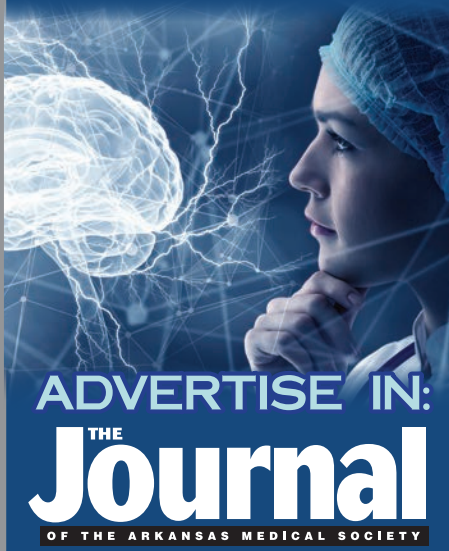
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## WHAT HAVE WE DONE FOR YOU LATELY?



# The Eyes Have It

BY **DAVID WROTEN**  
EXECUTIVE VICE PRESIDENT

**P**rior to the 2019 legislative session, Arkansas optometrists launched a massive (and successful) grassroots campaign to convince legislators to pass legislation to allow them to perform certain surgical procedures on the eye and eyelid. That legislation became Act 579 of 2019.

Legislators were misled into believing that what optometrists wanted to do was only a few “minor” procedures that they were properly trained to perform. Well, that wasn’t true. Legislators were misled into believing that passing this legislation would increase access to vision care. Well, that wasn’t true either. Despite polling that clearly showed overwhelming public opposition, the Legislature passed the bill and the governor signed it into law.

Optometrists are good at what they do, but they are not medical doctors. They do not go to medical school, and they are not residency trained. It boggles the mind to suggest that attending a weekend course in laser surgery is adequate to provide the high-quality care provided by a residency-trained ophthalmologist.

The value of your medical education and training, regardless of your specialty, is clearly under attack by the stream of legislation proposing to expand the scope of practice by lesser trained providers. But you have an opportunity in this case to stand up for your patients and your profession.

Safe Surgery Arkansas (SSA) is a coalition of patients and physicians formed in response to

Act 579. SSA has secured 64,027 valid signatures to place a referendum on the November 2020 ballot. A referendum gives the public an opportunity to vote on the legislation. A “no” vote in the election will be a vote to repeal Act 579. Furthermore, because the signatures were turned in to the secretary of state prior to the effective date of the Act, the legislation cannot be implemented pending the outcome of the election.

This is the first time, in any state, that a scope of practice expansion will be decided by voters rather than politicians. If we are successful, it will set a new (national) standard for opposing inappropriate scope of practice expansions. Do the voters value the education and training of physicians? Apparently, they do. Do voters believe that non-medical doctors should be performing surgery? Absolutely not. A recent poll conducted by SSA shows that nearly 90% of voters are likely to vote against Act 579.

But we have a lot of work to do between now and November. Because of the national ramifications of this repeal effort, you can expect optometrists to raise massive amounts of money from their out-of-state colleagues. They have already tried legal action to keep the referendum off the ballot, and we can expect them to do more.

Physicians cannot allow our state’s ophthalmologists to fight this battle alone. Act 579 threatens patient safety and is an attack on the value of medical school and residency training for all physicians. You will be hearing more over the next few months about how you can help. Meanwhile, you can donate to Safe Surgery Arkansas to help raise the necessary funds that will be needed to get out the vote in November.

Donations can be made to Safe Surgery Arkansas, PO Box 56170, Little Rock, AR 72215 or online at [safesurgeryarkansas.com](http://safesurgeryarkansas.com). Donations can be personal or corporate, unlimited in amount, are not tax deductible, and are subject to reporting requirements (by SSA). Give generously! Next time, it could be your specialty.

**Do voters believe that non-medical doctors should be performing surgery? Absolutely not. A recent poll conducted by SSA shows that nearly 90% of voters are likely to vote against Act 579.**



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## COMMENTARY

BY TOBIAS VANCIL, MD, FACP



# Our Patients are Talking. Are We Listening?

I've wanted to write some kind of commentary about the effects of the EMR on provider-patient relationships for some time. Within the last two weeks, a couple of things happened that have given me some inspiration. The first occurred while working with a student one afternoon in my clinic. The student had been reading in the EMR about the patient they were about to go see; they were actually looking ahead because of an apparent "no-show." As I was off to see a patient with another student, the late patient arrived. Knowing that not seeing them now meant an over-book later, we triaged the patient. I casually told the student to change gears and go see the late patient. They looked at me oddly and said, "I haven't had a chance to look over the chart, what should I ask them about?" Now, this very bright individual will no doubt go on to have a successful career as a physician, but through no fault of their own, they had asked a trivial question. My answer was simply, "just go ask them why they are here."

The second thing that happened was the timely publishing of an article in the *Annals of Internal Medicine* regarding the time spent by physicians using an EMR/EHR in an outpatient setting. This was looking at PCPs and ambulatory medical subspecialists, but I think any provider who works regularly with an EMR can use this article as a way to be reflective about its effect on their practice. In summary, the study included data from approximately 100 million patient encounters with about 155,000 physicians from 417 health systems. It found that physicians spent an average of 16 minutes and 14 seconds per encounter using EHRs, with chart review (33%), documentation (24%), and ordering (17%) functions accounting for most of the time. This certainly is not the first article of its kind, but it disturbs me that the most time spent was on chart review. Certainly, there are ways the EMR can help with more accurate order/medication entry and the adaptive documentation options are vast, but why are we spending so much time in chart review? My fear is that we enter a patient's room with a pre-conceived bias about the purpose for that day's visit. Based on prior issues/co-morbid conditions noted in the chart, we may not be ready to listen to the actual chief complaint of the day. There is abundant data that shows either missed or delayed diagnoses due to diagnostic suspicion/provider bias based

on a too-narrow differential diagnosis framed by pre-conceived notions. A basic example would be assuming all patients who present with pain with a sickle-cell disease history are having a pain crisis. It is not that I feel chart review is not helpful, but we need to ask ourselves what's more important: the information in the EMR or the patient sitting right in front of us?

The challenges with using an EMR while still maintaining tactful provider-patient communication divides clinicians into two groups. The first includes those of us who trained mostly without an EMR or at least using a hybrid system with computers for order entry or data retrieval. The problem is that most of our training and prior practice involved sitting face-to-face with the patient and/or family, looking them eye-to-eye, and maybe intermittently jotting down notes while absorbing the story of their current worry. In clinical practice, we must transition to a model that now involves splitting time between a computer screen and our patient, with some compromise of our clinical assessment skills. These skills, for most of us, have significant reliance on the non-verbal communication from our patients.

The second group encompasses the newer challenge of teaching interpersonal communication skills to new trainees who have never lived without computers and are more dependent on digital communication than their analog elders. Medical education has been diligently focusing on strategies to teach more enhanced provider-patient communication skills to our trainees. Over at least the last decade, this has become a more thought-provoking endeavor due to more dependence on the EMR. These students' first patient experience very likely is now a provider-patient-computer encounter. This can be a change for even the most seasoned veteran of clinical practice.

I am not "against" the EMR and I do see the promise of a clinical workflow that is more efficient by a well-designed computerized system, but let us not lose sight of the importance of the human role in health care delivery. The information contained within these databanks can assist patient care delivery, but we always need to keep in mind that clicking a mouse is not the same as listening.

# LISTEN. LEARN. SHARE.

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Check back often to see additional topics!

# Improving Doctor-Patient Communication

**H**ave you ever considered communication to be one of the necessities to being a successful physician?

“Most people believe they are effective communicators,” said SVMIC Vice President of Medical Practice Services Stephen A. Dickens, JD, FACMPE. “The key is not that *you* understand what you’re talking about, but that the person you’re talking to understands what you’re trying to tell *them*.”

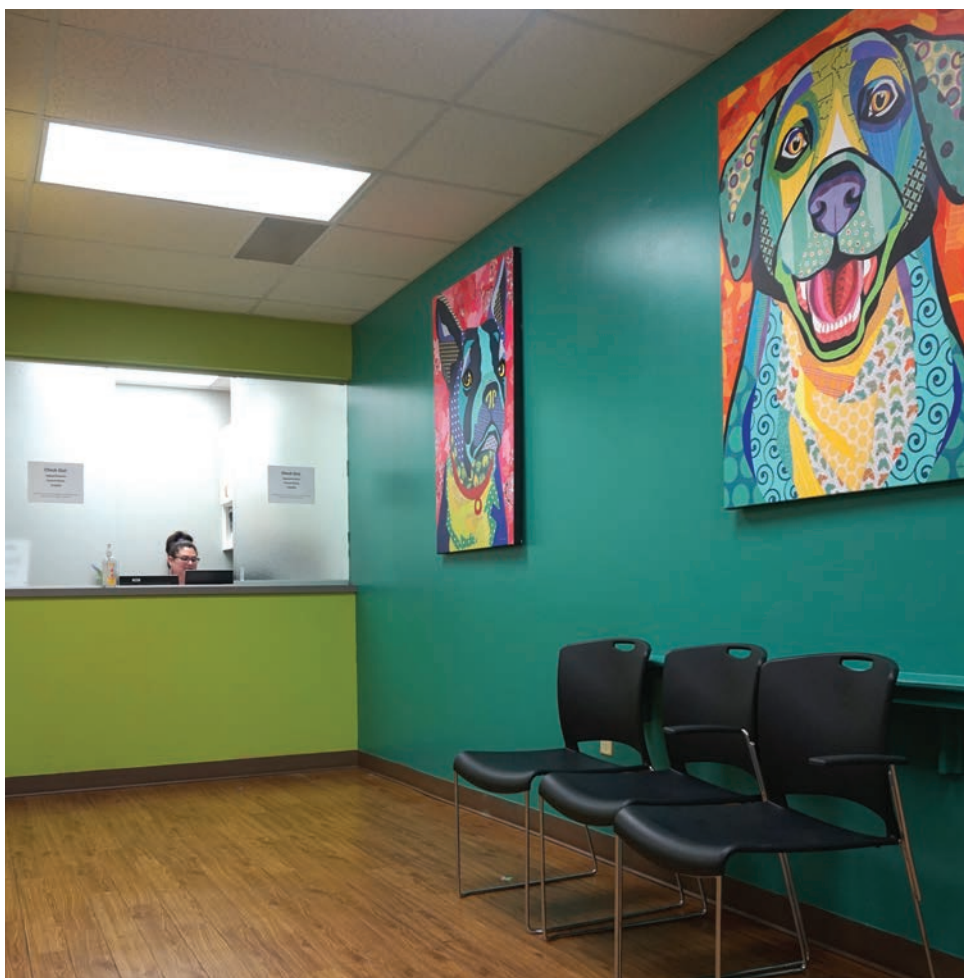
Whether you are in private practice or an employed physician, there are ways to improve communication and thereby your practice, according to Dickens. “Physicians are at a disadvantage when it comes to communicating with patients,” he explained. “You don’t speak the same language as your patients, you’re in a hurry to start because of the many burdens put upon you, and electronic medical records have done nothing to help.

“However, you need to understand that effective communication doesn’t take any longer than ineffective communication. In the long run, it saves time. To put it in context, think about a patient who leaves without understanding what they’re supposed to do. It results in phone tag, increased frustration for both parties, or, at worst, the patient not getting the care he or she needs.”

To help you evaluate and improve doctor-patient and staff-patient communication, we visited at length with Dickens, who speaks and advises regularly on the subject. Our conversation follows.

**AMS: How can physicians make sure patients understand what they’re telling them?**

**In the exam room, you want to make eye contact, introduce yourself, and call the patient by name, understanding that no matter what you say, most of your communication with the patient comes from body language or tone of voice.**



LITTLE ROCK PEDIATRIC CLINIC'S WAITING ROOM IS INVITING AND PATIENT FOCUSED.

**Dickens:** You must meet patients where they are. When patients enter the clinic, they are likely apprehensive, uncertain of what’s expected of them, and concerned about costs and health outcomes. Patients may decide what’s wrong with them before they come in. It’s important that they understand why a physician is doing something – particularly if the physician is contradicting their self-diagnosis. You can say things like, “Actually, you *don’t* have this, this is why, and this is what I think you have.”

Patients need to know that you’re engaged and listening. If not, they’ll assume you didn’t care – and that you ignored their concerns. Reflective listening can help. For instance, you can paraphrase back to the patient what she has told you ... “Okay, so you’re dizzy in the evening than you are in the morning?”

**AMS: What are some other tips for improving communication in the exam room?**

**Dickens:** Approach conversations from a positive perspective by telling patients what you *can* do as opposed to what you *can’t* do. How physicians phrase things is important. Often, they come into the exam room and say, “What can I do for you?” or “What brings you in today?”

That’s an ice breaker, and many doctors call it a cognitive test. In other words, they want patients to tell them in their own words what they’ve already told the nurse. It isn’t a bad question, but there’s a better way to ask it. Instead of asking “What brings you in today,” walk in and say, “I’ve read what you’ve told my nurse Suzy, but I really want to hear from you what’s going on.”

It's the same question, but you've sent some subliminal messages to the patient: you're prepared, you trust Suzy and therefore so can they, and you value what they have to say.

### AMS: In your advice to clinicians, why do you stress the importance of personally connecting to patients?

**Dickens:** I encourage everyone on staff to make initial contact with each patient that comes in. When a patient approaches the front desk, they need eye contact from the person behind the desk. They can see that the receptionist is busy or on the phone, but they still need someone to acknowledge their presence.

I'm the patient. When you enter the exam room, and you're looking at the chart when you speak to me, you've missed an opportunity to connect on a personal level. If you *then* try to be social, that really doesn't work. In the exam room, you want to make eye contact, introduce yourself, and call the patient by name, understanding that no matter what you say, most of your communication with the patient comes from body language or tone of voice.



LITTLE ROCK PEDIATRIC CLINIC'S CALL CENTER IS COMPLETELY SEPARATE FROM ITS WAITING ROOM.

Since we've moved to electronic medical records, we've learned so much more about body language. What happens now is that we're missing the subtle physical cues patients are giving when we ask them a question—and they're missing our sincerity because we're focused on the tablet. I get it that we must use

EMR, but let the patient know that you're still there by saying things like "What you said is important, I want to get this in the computer."

Also, if you knock on the door, wait for a response before you enter. If you can sit down and converse with the patient at eye level, that

>>CONTINUED ON PAGE 202.



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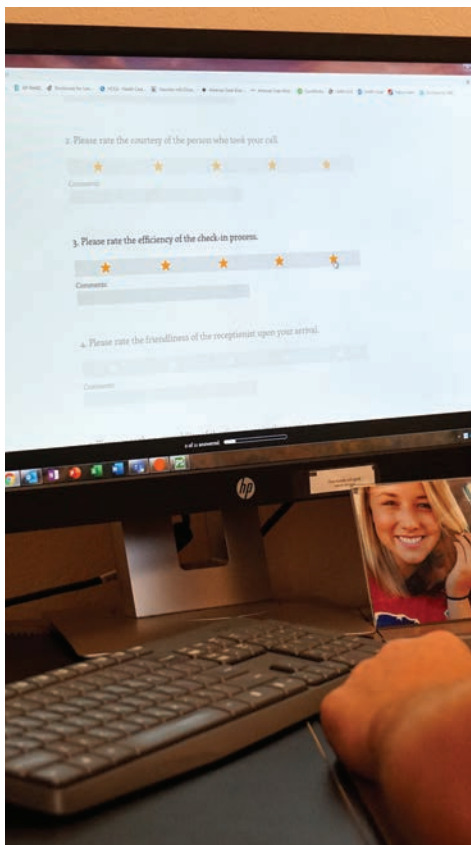
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PATIENT SURVEYS ARE ONE OF MANY TOOLS FOR EFFECTIVE PATIENT COMMUNICATION.

is helpful. The act of sitting requires more effort but conveys that you are more invested in the encounter and gives the impression it lasted longer. Move away from the door once you're in the exam room.

### AMS: How do clinic phone systems affect communication, satisfaction, and outcomes?

**Dickens:** Clinics should approach phones from a patient's perspective. Physicians, you or someone you trust should call in randomly to see what your clinic's phone process sounds like. If it frustrates you, it's going to frustrate your patients. Phone trees can be necessary, but I call so many that have too many options, or the options are so odd, that I'm left wondering what button to push. Say I'm not returning a call, I don't need an appointment, I don't need a prescription refill ... is there not just a general information or call-back message option?

You and your staff should be trained on phone etiquette because all you've got on the telephone is tone of voice. While patients can't see your body language on the phone, good body language while you're talking — smile, have good posture — will come through in your tone of voice.

When an employee answers the phone, he or she needs to be ready for whatever their job is and should answer promptly — by the third to fifth ring — and should tell the patient who they are! You'd be amazed how many offices I call, where employees are afraid to give their name because they're afraid someone will call back and ask for them. That's their job.

If you ask someone to hold, you should stop and wait for the answer. Calls should not be randomly transferred around. I call it "flipping the booker," ... "I don't know what to do with you, so I'm going to give you to somebody else." Well, by the time I've talked to three or four people, I'm angry. If you take a message for a call-back, don't just get a number. Get a good message so that when I call them back, I can have an answer and avoid starting a game of phone tag. A proper response if you cannot answer the question is, "No, Mrs. Jones, I'm not sure how to answer this, but I'm going to find out and call you by 4 p.m. tomorrow."

Finally, when returning a call to a patient, realize that they are busy, too. You may not have caught them at an appropriate time, so be willing to work with their schedule.

### AMS: What can employed physicians do to improve communication within their organization?

**Dickens:** Employed physicians can improve their face-to-face time with patients just as private-practice physicians would. As for impacting policies, there are arguments they can make to those who are in charge. Most payors are at some phase of measuring patients' experiences. Patient evaluations are being used to rate physicians. So, an employed physician may validly argue that any poor communication practices will eventually impact the organization's evaluation ratings, and therefore, its bottom line.

### AMS: How can physicians help patients do their part in effective doctor-patient communication?

**Dickens:** To help patients help you, make sure your processes are consistent and patient friendly. As you did with the phones, walk through the process yourself to assess, is it clear, simple? Also, plan procedures for the masses. I see clinics that, rather than dealing individually with one or two problem patients, will adopt policies that negatively affect all patients.

Help patients understand the processes you're dealing with. For the patient that's waiting on an insurance company to approve something ... "Mrs. Jones, I want to let you know we're going to get the paperwork in for you, but it's Blue Cross Blue Shield that requires this, so we'll be waiting to hear from them."

One of the best ways to help patients understand what you need from them is the teach-back method, which ensures understanding in a non-confrontational manner. Most likely done by support staff after the physician leaves the room, it is a technique to fight low health literacy. One should not ask if the patient can read or write. It is not about illiteracy, but about whether the patient has trouble remembering or comprehending. Be empathetic and affirm that health care is difficult. For example, "Mrs. Jones, the doctor has instructed you take your prescription three times per day. Can you tell me how you will do that?" Or, "Mr. Williams, Dr. Anderson scheduled you for your procedure next Thursday. Can you tell me where you are supposed to go and how you will prepare for that?"

### AMS: Patients and caregivers are often in different age brackets. Could you speak to generational differences and their effects on communication?

**Dickens:** Generational differences are real. The way my mother wants to be communicated with is different from my daughter's [preferred method]. Elderly patients, especially, need routine and consistency. One of the challenges of taking care of older patients is that you likely have their children or grandchildren in the room with them. You've got to communicate on multiple levels.

Patients of every generation value communication, privacy, and trust. You can work to provide that by creating a patient-friendly process, connecting to the patient, approaching things from a positive, talking to patients in terms they can understand, and assessing their understanding before reinforcing where you need to. These things are not going to work with all patients, but if they work with 20-30% of them, that takes a burden off the practice.

**What about you? Do you believe you communicate effectively with your patients, or do you feel challenged as to how (or if) you're reaching them? Write to AMS with your comments at [lhaywood@arkmed.org](mailto:lhaywood@arkmed.org).**

# Good Communication Put in Practice

## Administrator Jo Lynn Varner

BY CASEY L. PENN

Little Rock Pediatric Clinic was the first pediatric clinic in Arkansas to be recognized by The National Committee for Quality Assurance as a Patient-Centered Medical Home for its use of evidence-based, patient-centered processes that focus on highly coordinated care and long-term, participative relationships. With seven physicians, one nurse practitioner, and approximately 14,000 patients who make more than 29,000 office visits annually, doctor-patient communication can be an administrative challenge.

LRPC Clinic Administrator Jo Lynn Varner has been on the job for 16 years. She shares insight into her clinic's approach to effectively handling doctor-patient and staff-patient communication.

### AMS: As clinic administrator, how do you approach good patient communication?

**Varner:** Communication with patients is hard. We focus on providing as many access points as we can for patients. We have a website and Facebook page, and we were one of the first pediatric clinics to set up a patient portal. Our portal allows for patients to send secure messages and photos to our staff. Last year, we started using secure emails through Outlook. However, you can have all of that, but without doctors and staff that support that, it isn't going to work. Our doctors and staff ensure that when a patient sends something our way, we respond. You have a lot of parents of children who don't know if something their child is experiencing is normal, so it's so important to get back with them promptly.

### AMS: What about people who prefer a direct approach over patient portals or other online conduits?

**Varner:** With grandparents raising their grandchildren, our physicians today counsel a variety of age groups. But age aside, we have a fair number of patients and caregivers who simply don't want to be on the patient portal. For those people, we have a dedicated phone nurse. Our scheduling and billing are in house; in each area, we have a dedicated person to take phone calls. If patients have questions about their bills,



KEEPING THE FRONT DESK FOCUSED ON CONNECTING TO PATIENTS.

for instance, we have a live person ready to pick up the phone.

### AMS: Phone systems have been a point of contention and frustration for many a patient. Tell me about yours.

**Varner:** First, I don't have the front desk people in the phone tree. The front desk is focused on people coming in the door. The phone team is not patient-facing and completely behind the scenes. We believe that the people in the waiting room should not hear a lot of phones ringing or people answering phones. Anyone answering the phone is, for the most part, in a restricted area. Second, we have tiered groups answering the phone. If the main phone group is full, calls roll over to the secondary group, and then to the third tier.

### AMS: How do you help patients leave the clinic knowing what's expected of them?

**Varner:** We offer a lot of handouts. We've found that patients *want* to leave the clinic with something in hand. If it's not a prescription, then something. So, we have a lot of illness-specific handouts. We give them developmental milestones to look for in the next year. We give them an updated shot record with information on when the next shots will be due. Doctors give them patient-education articles.

### AMS: Patient satisfaction is a big part of LRPC's success. How do you know patients are satisfied?

**Varner:** We have targeted questions on our patient experience survey. All clinics participating in Medicaid or Blue Cross are asking comparable questions to ours (it's required). One of our questions is, "How confident are you filling out medical forms by yourself?" That's in their registration and is answered periodically. As we identify folks who need help with that, we have referral options for Literacy Councils and other resources. Also, on our post-visit experience survey, we ask, "How well do you feel your physician listened and answered your questions?" Together, these are sort of a double check for us. We think we're doing well at patient communication, but this lets us know if we really are. And this is something we get consistently high scores on.

We serve parents of growing children, so they're coming to the doctor often. We change up survey questions annually since people tire quickly. We try different things, too. For instance, we had a patient family advisory group that met quarterly to get some face-to-face feedback. Over time, participation dwindled. We're thinking about trying something like that again in a more virtual way to accommodate busy patients. We'll see how it works. Communication is a continuing struggle. You must go at it from different angles and hope something sticks.

# Update on Antimicrobial Stewardship Efforts in Arkansas

MARSHA F. CRADER, PharmD

Seven years after the first guideline recognizing antimicrobial stewardship (AS) was introduced in 2007, the Centers for Disease Control and Prevention (CDC) released the first AS core elements, outlining the personnel and practices needed for successful antimicrobial stewardship programs (ASPs).<sup>1</sup> CDC's core elements were followed by the Joint Commission and Centers for Medicare & Medicaid Services (CMS) AS requirements within hospitals, hospital clinics and nursing homes. In January 2020, the Joint Commission began requiring hospital outpatient departments to implement stewardship practices: determine an annual goal, provide education to improve usage, and track and report.

Pharmacists' vital role in these regulatory requirements is evidenced by pharmacist leadership in hospital ASPs, especially those without infectious-diseases physicians. According to 2018 National Healthcare Safety Network (NHSN) hospital survey data, 85% of hospitals' ASPs have pharmacist leadership, specifically, 59% are co-led by pharmacists and physicians; 26% have pharmacist-only-led stewardship programs.<sup>2</sup> CDC specifically recognized the efforts and critical role

of pharmacists when it replaced the "Drug Expertise" section with "Pharmacy Expertise" in the 2019 update.<sup>2</sup>

## ROLE OF PHARMACISTS IS CHANGING

Pharmacists throughout the United States are improving their knowledge in order to be an essential part of AS teams. There are limited residency positions for pharmacists to receive post-graduate training in infectious diseases. Pharmacists have been obtaining AS training certificates to demonstrate advanced training. The Society of Infectious Diseases Pharmacists and Making a Difference in Infectious Diseases are the certificate programs currently available. Most require a quality improvement project after completion of continuing education programs. During Arkansas' 2018–19 AS state collaborative, 60 certificate program scholarships were awarded to pharmacists practicing in hospitals and nursing homes. CDC also has an antibiotic training series for health care professionals, including more than 10 hours of free continuing education hours. CDC's training modules meet certain requirements for the CMS Merit-Based Incentive Programs and

can be useful to physicians wanting to learn more about AS.

Multiple opportunities for education have been made available. The Arkansas Department of Health has been a partner with both AS state collaboratives. The first collaborative was led by the Arkansas Hospital Association and the Arkansas Association of Health-System Pharmacists. During the 2015–16 AS collaborative, pharmacists were trained in the basics of hospital AS and shared ideas to meet the CDC's core elements for AS. The 2018–19 state AS collaborative was led by the Arkansas Foundation for Medical Care (AFMC). Education was expanded to include additional health care disciplines from hospitals and nursing homes. Participants were provided with basic and advanced AS and infection prevention education as well as opportunities to share stewardship intervention successes.

## COLLABORATION BOOSTS IMPROVEMENTS

AS collaboration is key to Arkansas' successful work in this vital area. Providing general AS education to different disciplines is important but understanding each discipline's unique role and thought processes can lead to

greater AS success. Collaborative participants learned from one another's success and failures, and what could be useful in their practice settings.

Following the first AS collaborative, Arkansas hospitals meeting all seven of the CDC's hospital AS core elements increased from 43% in 2015 to 63% by 2016. Improvement continued in meeting all hospital AS core elements during the second AS collaborative, increasing from 67% in 2017 to 79% in 2018.<sup>3</sup> Based on the 2019 pre- and post-assessment results of 57 facilities that participated in the second AS collaborative, 72% reported gaining needed education and planned to implement some aspect of what they learned. The same percentage of participants reported implementation of at least one intervention to improve AS within their facilities.

## IMPROVING ANTIBIOTIC USAGE

### 1. Limit antibiotic duration by

reassessing patient's improvement at 72 hours for evidenced-based duration of therapy. Pharmacists can collaborate with physicians to determine if these lengths of therapy can be considered based on clinical improvement:

- Skin and soft tissue infections: 5 days<sup>4,5</sup>
- Urinary tract infections: 5-7 days<sup>4,5</sup>
- Community-acquired pneumonia: 5 days<sup>4,6</sup>

**2. Verify penicillin allergy.** Although 10% of the population reports a penicillin allergy, less than 1% has a true allergy. Pharmacists can assist physicians to determine if a beta-lactam antibiotic is appropriate<sup>4,7</sup> by assessing patients' allergy history and previous antibiotic usage.

**3. Avoid treatment of asymptomatic bacteriuria (ASB).** A urine culture

positive with or without pyuria alone does not indicate a urinary tract infection (UTI) and could be ASB if no symptoms are present.<sup>4,8-9</sup> Pharmacists can discourage unnecessary urine cultures when no UTI symptoms are present, and unnecessary antibiotic usage when ASB is determined.

- 100% of patients with a chronic urinary catheter will grow an organism from a urine culture with or without a UTI.<sup>4,9</sup>
- A change in urine cloudiness or odor alone does not indicate a UTI.<sup>4,8-9</sup>
- Delirium should be interpreted with caution since delirium alone has a low specificity for UTI.<sup>4,9</sup>

### 4. Avoid duplicative anaerobic coverage.

Unnecessary duplicate anaerobic coverage is usually encountered when one of the following combinations is ordered unless Metronidazole is needed for treatment of *Clostridioides difficile*: Piperacillin/tazobactam + Metronidazole, Meropenem + Metronidazole, Ertapenem + Metronidazole, Ampicillin/sulbactam + Metronidazole, Amoxicillin/clavulanate + Metronidazole, etc. When Clindamycin is utilized instead of Metronidazole for anaerobic coverage in one of these combinations, it is also considered inappropriate unless Clindamycin is added to reduce toxin production in necrotizing infections. Pharmacists can inform physicians when unnecessary duplicate coverage is prescribed.<sup>4</sup>

### 5. Re-assess antibiotic therapy including anti-Methicillin-resistant *Staphylococcus aureus* (MRSA) antibiotics.

Pharmacists can alert physicians when new culture information is available to de-escalate antibiotics. An important consideration for de-escalating anti-MRSA

coverage is based on negative cultures with clinical improvement, negative MRSA nasal screen in patients with community-acquired pneumonia, etc.<sup>4,6,10</sup> Reasons to continue anti-MRSA antibiotics may exist when certain types of infection require a longer duration of therapy or cultures are not available.

Physicians should be encouraged by the involvement of Arkansas pharmacists who have furthered their AS education. Pharmacists can assist in improving patient care and outcomes, education, patient and ASP interventions, and leadership skills to fulfill AS requirements. ▲

*Dr. Crader is associate professor of pharmacy practice at UAMS and co-leads St. Bernard's AS program.*

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MARCH 2020

# Massive Hepatomegaly with Gastric Compression

**A** 40-year-old female without prior medical history presented with upper abdominal pain, postprandial nausea, and early satiety for a week. Her vitals were stable. Physical examination revealed massive hepatomegaly, with the lower edge of the liver 3 cm below the costal margin. Laboratory data were normal including liver function tests. A CT scan of the abdomen is shown (Figure 1). The patient underwent laparoscopic deroofing of the large liver cysts including the left liver 15 cm cyst that was compressing the stomach (Figures 2-4). No post-procedure complications were noted.

The diagnosis is adult polycystic liver disease (APLD). The CT scan shows multiple cystic

masses with a large cyst in the left lobe of liver compressing the stomach causing the patient's symptoms.<sup>1</sup> Only a minority of patients develop advanced liver disease or signs and symptoms of massive hepatomegaly or large cysts causing compression of surrounding structures. Patients with large-size cysts and advanced liver disease rarely respond to medical therapy. Operative management for large symptomatic liver cysts includes aspiration, sclerotherapy, laparoscopic or open parenchyma-sparing de-roofing of the cyst or fenestration, and marsupialization of as many of the large cysts as possible.<sup>2,3</sup> Liver transplantation for a severe polycystic liver disease has been described and remains the only curative therapeutic option.

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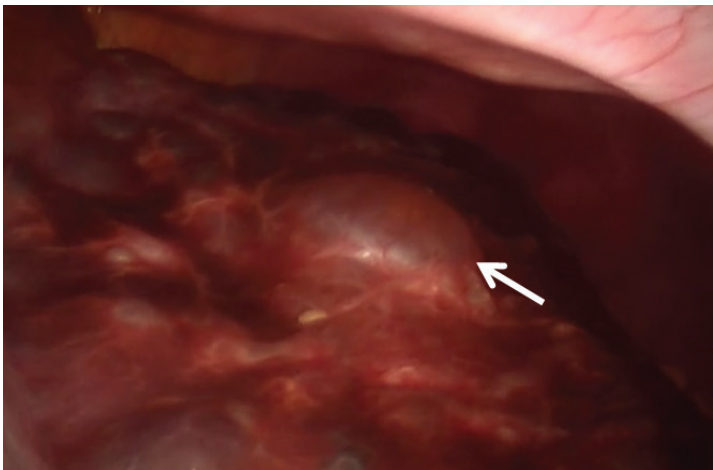


FIGURE 1.

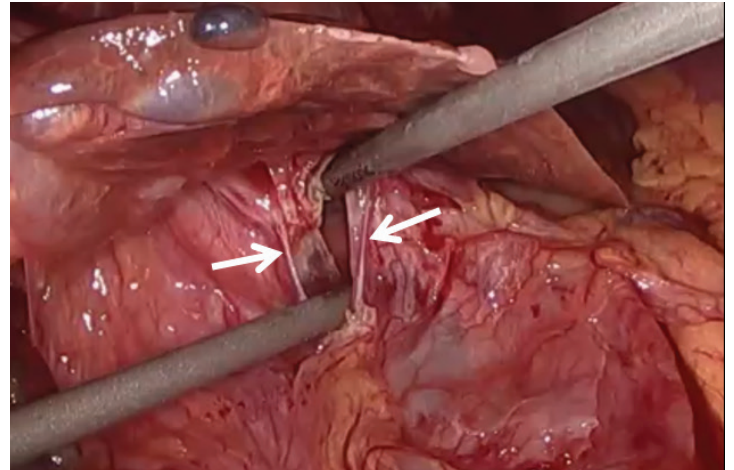


FIGURE 2.

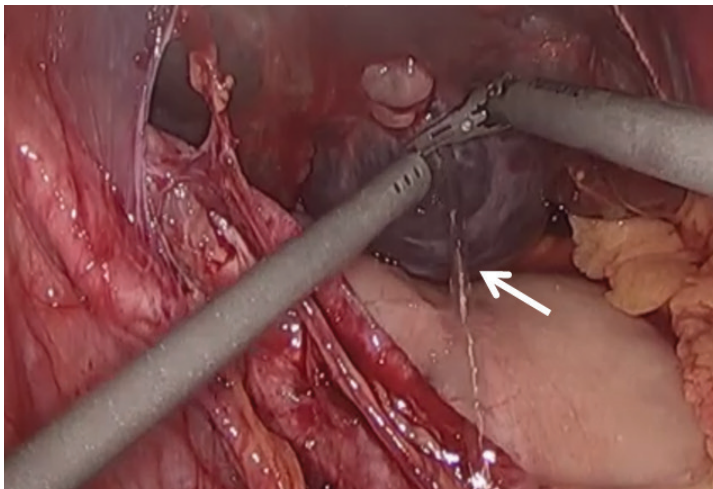


FIGURE 3.

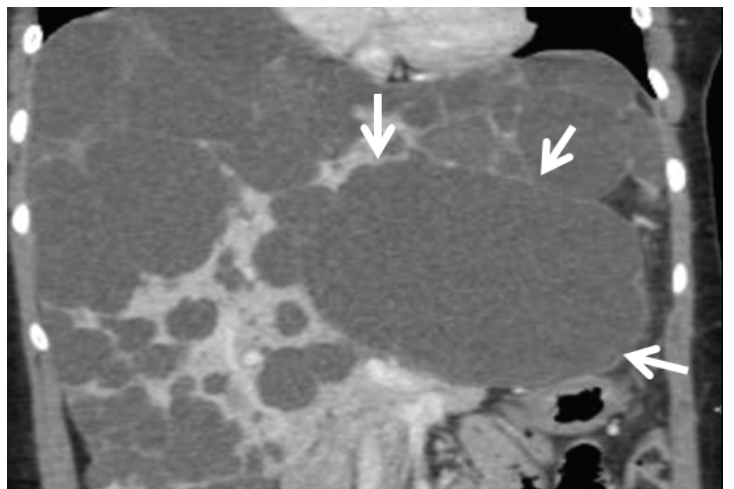


FIGURE 4.

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# Changes in Smoking Behavior and Lung Cancer in Arkansas Since 1972



**Disclaimer:** Opinions expressed in this paper are those of the authors and not the Arkansas Department of Health or UAMS.

## Abstract

Lung cancer remains the leading cause of cancer death in Arkansas and is largely determined by historical smoking patterns. This paper examined smoking behaviors over time, policy reforms since the Tobacco Settlement Proceeds Act of 2000, and patterns in lung cancer incidence and mortality in Arkansas. Results showed that as the cigarette excise tax increased, the number of cigarette packs sold decreased over time. Findings also showed that the risk of developing lung cancer has decreased among men and increased among women. Solutions include targeting cessation programs towards women and increasing the excise tax on tobacco, a tax that has not increased since 2009.

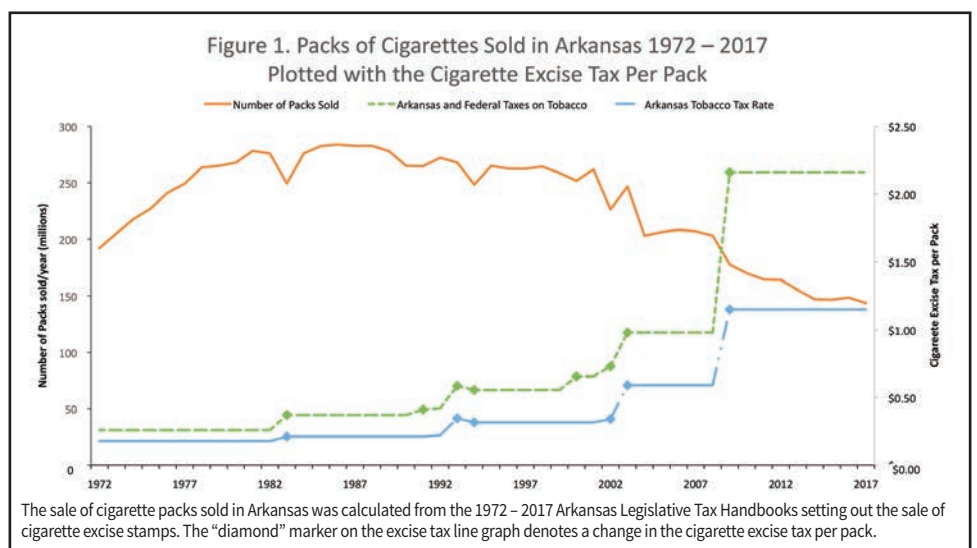
## Introduction

Lung cancer is largely determined by historical smoking patterns and remains the leading cause of cancer death in Arkansas.<sup>1</sup> Even 25 years after quitting smoking, former smokers have a threefold higher risk of developing lung cancer than those who have never smoked.<sup>2</sup> There has been a progressive decline in lung cancer incidence and mortality over time in the U.S., a trend associated with decreases in smoking patterns since the early 1960s.<sup>3</sup> In Arkansas, the trends are declining, but at a slower pace.<sup>1</sup>

Cigarette smoking peaked during the 20th century despite health warnings as early as 1929 by Surgeon General Hugh S. Cumming and later from the 1964 Surgeon General’s Report.<sup>3</sup> It was reported that the increase in technology for mass production, together with the extraordinary scale of advertising, created a consumer culture that fueled the smoking epidemic.<sup>3</sup>

Marketing of tobacco products to men and women impacted cigarette smoking as early as the 1920s. The U.S. entrance into World War II fueled male use rates by providing soldiers cigarettes as part of the K-ration food package, while women at home were introduced to gender-specific branding featuring femininity.<sup>4</sup>

Product marketing towards women increased in the 1970s when Philip Morris began marketing Virginia Slims as containing less tar and being a “healthier” alternative for smokers who were worried about their health. These marketing campaigns resulted in increased smoking among adult women and adolescent girls. Women were again targets of tobacco marketing in the 1990s, when Philip Morris introduced the 1996 revamped Virginia Slims campaign “It’s a Woman Thing” and the 1999 “Find Your Voice” campaign.<sup>5</sup> From 1995 through 1998, total domestic advertising and promotion of cigarette use increased by 37.3%, from \$4.90 billion to \$6.73 billion.<sup>6</sup>



From 1996 to 2010, cigarette use steadily declined in Arkansas due to actions associated with the Master Settlement Agreement (MSA) of 1998, as well as changes in public policy.<sup>7</sup> The MSA mandated that the companies pay damages to the states to counteract the economic burden associated with the harmful effects of tobacco use. The Tobacco Settlement Proceeds Act of 2000, initiated by the citizens of Arkansas, appropriated funds annually to promote public health initiatives such as the creation of the Tobacco Prevention and Cessation Program (TCP); this was operated and maintained by the Arkansas Department of Health, the formation of the UAMS Fay W. Boozman College of Public Health, funding for tobacco related research, and other programs.<sup>7</sup>

Policy reform has reduced the use of cigarettes by enacting laws and imposing excise taxes on tobacco products. The Arkansas Clean Indoor Air Act of 2006 and the Arkansas Protection from Secondhand Smoke for Children Act of 2006 restricted the use of cigarettes in areas deemed “public spaces” and in vehicles with passengers under the age of 14, respectively.<sup>7</sup> In addition, U.S. Federal District Court Judge Gladys Kessler ruled that the tobacco companies lied to the public about dangers of smoking in 2006.

Excise taxes have been an important and effective approach to reducing cigarette use. Arkansas began taxing cigarettes as early as 1929 at \$0.04 per pack with marginal increases throughout the years.<sup>8</sup> In 2009, the cigarette excise tax increased to \$1.15 per pack and is the current tax amount.

The purpose of this report is to describe the change in smoking behavior and lung cancer incidence and mortality patterns in Arkansas.

### Methodology

Lung cancer incidence was defined using the International Classification for Diseases for Oncology (ICD-O), Third Edition, using standard primary site and histology codes for years 1997 to 2015, the most recent year of complete data available. Lung cancer mortality was defined using International Classification of Diseases and Related Health Problems (ICD-10), Tenth Edition, standard codes from the CDC WONDER Compressed Mortality file from the Centers for Disease Control and Prevention for years 1999 to 2015.

Smoking prevalence rates were obtained from the Behavioral Risk Factor Surveillance System (BRFSS) responses to surveys from 1995 to 2017.<sup>9</sup> In 2011, BRFSS had substantial methodological changes; therefore, data from 1995 to 2010 are not comparable to subsequent years.

>>CONTINUED ON PAGE 210.



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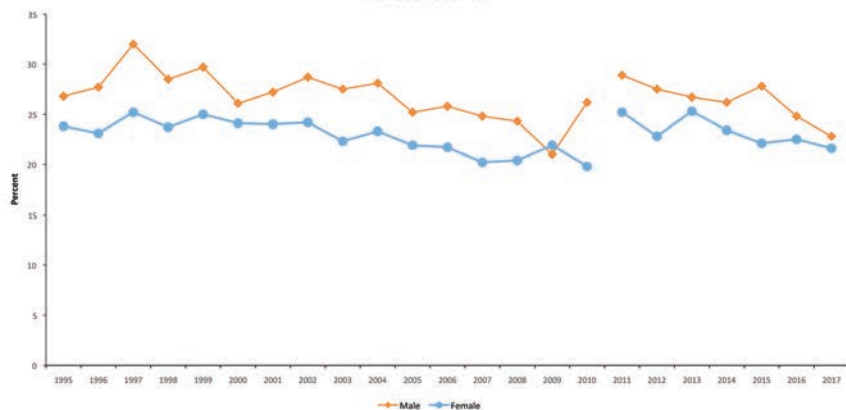
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**Figure 2. Current Cigarette Smoking among Adults by Gender  
Arkansas 1995-2017**



Respondents who report having smoked 100 cigarettes in their lifetime and currently smoke every day or some days. In 2011 BRFSS had substantial methodological changes; 2011 and subsequent years are not comparable to years prior to 2011.

Source: Behavioral Risk Factor Surveillance System (BRFSS)

Lives saved from lung cancer were calculated using methods from DeLongchamp et. al.<sup>3,10</sup> Lung cancer treatment costs were calculated using Surveillance, Epidemiology, and End Results (SEER)/Medicare analysis results from Cipriano et. al.<sup>11</sup>

The annual number of cigarette packs sold in Arkansas was calculated from 1972 to 2017 using data obtained from the Arkansas Legislative Tax Handbooks.<sup>8</sup> Per capita consumption rates were calculated by dividing the number of cigarette packs sold each year by the number of adult Arkansans age 18 and over for the corresponding year; population estimates were obtained from the National Cancer Institute, SEER Program.

## Results

### Trends in Tobacco Packs Sold

It is important to note that as the state and federal tax rate increased during years 1993, 2003, and 2009; the number of cigarette packs sold decreased during corresponding years. As shown in Figure 1, approximately 284 million packs were sold during the peak consumption time period in 1986 compared to 144 million in 2017, the period when the lowest number of cigarette packs were sold. This decrease means the number of packs of cigarettes sold per-adult per year declined from approximately 167 per-adult in 1986 to 62 in 2017.

### Trends in Smoking Prevalence

In 2017, 22.8% of men and 21.6% of women in Arkansas smoked tobacco (Figure 2). The percent of men who smoked tobacco peaked in 1965, and the percent of women smokers peaked 25 years later in the 1990s.<sup>6</sup> This lag time of peak tobacco use among women explains their continued increasing risk of lung cancer.

### Lung Cancer Incidence and Mortality

Lung cancer incidence and mortality since 1997, when the Arkansas Department of Health

began collecting population-based cancer data, is set out in Figure 3. Incidence trends closely parallel mortality, only 7% survive more than ten-years following diagnosis.<sup>4</sup> Rates in males are roughly double that of females. From 1997 to 2015, the age-adjusted lung cancer incidence rates declined in men (1.45 fewer cases per 100,000 per year,  $p < 0.0001$ ) and increased in women (0.27 more cases per 100,000 per year,  $p = 0.018$ ) (Figure 3).

Lung cancer mortality increased in Arkansas from 1970 until 1992 and then began a slow decrease through 2015 (Figure 4). This decline is entirely due to decreasing rates among males. Lung cancer mortality rates in females have increased since 1970 and show no evidence of a decreasing trend (Figure 4).

### Lives Saved from Lung Cancer Deaths

In 2017, Arkansas's smoking prevalence was the fifth highest in the nation and 23% higher than the U.S. prevalence.<sup>9</sup> If the state-smoking prevalence was the same as the U.S., an estimat-

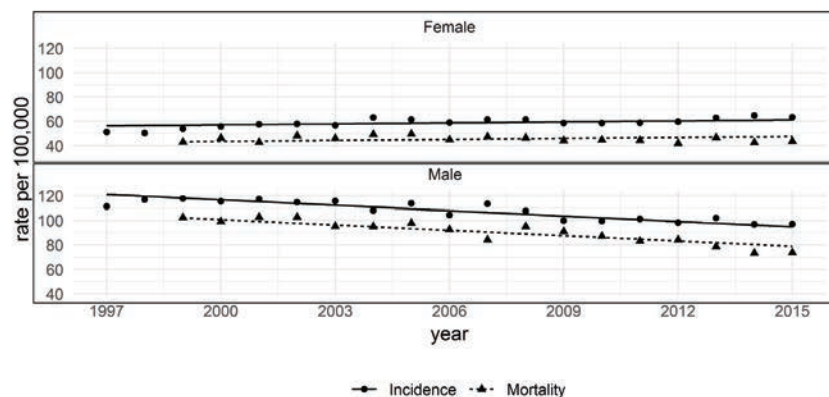
ed 403 Arkansas lives could be saved from lung cancer each year. This decline in deaths would lead to approximately \$26 million per year in savings in direct lung cancer treatment costs.<sup>9,11</sup>

## Discussion

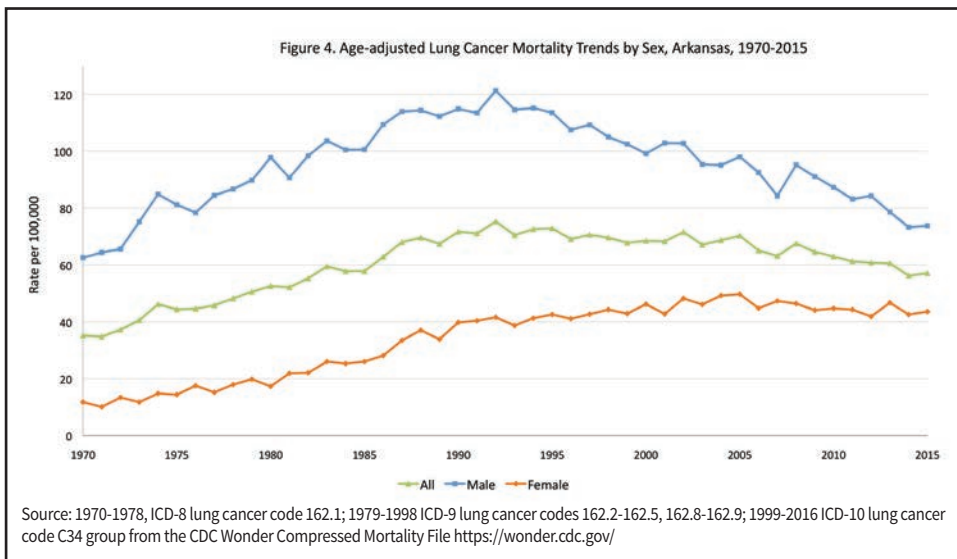
In 1986, cigarette packs sold per-adult per-year peaked in Arkansas at 167 packs, and sales steadily decreased to reach 62 packs in 2017. The decline in the number of cigarette packs sold annually is an indicator that Arkansas smokers, as a group, are smoking fewer cigarettes per year. Although any number of cigarettes smoked will increase disease risk and the Arkansas smoking prevalence is in need of improvement, some of the successes since 2000 can be attributed to continual increases in the tobacco excise tax and the Clean Indoor Air Act of 2006 as well as reforms made possible by the Tobacco Settlement Proceeds Act of 2000.<sup>7</sup> During the recent 2019 legislative session, the Arkansas Legislature approved an Act that will raise the minimum age to purchase tobacco products from 18 to 21 over time. The bill will also remove border excise tax exemptions, which will raise the excise tax for cities located on or near the Arkansas border. These areas will collect the current excise tax, \$1.15 per pack. Removing border zone taxes will increase excise taxes in Arkansas cities that border Louisiana, Missouri, and Tennessee. Additionally, the bill limits local cities and municipalities from enacting tobacco regulations that are more restrictive than state laws or rules regarding the manufacturing, sale, storage, or distribution of tobacco products.

According to the 2014 U.S. Surgeon General's report, smokers are more likely to develop cancer because of changes in the levels of carcinogens in cigarettes and the use of ventilated filter cigarettes that cause smokers to inhale more deeply, drawing more carcinogens into the lungs.<sup>3</sup> Although the number of cigarette packs consumed

**Figure 3. Age-adjusted Lung Cancer Incidence and Mortality Trends, Arkansas, 1997 - 2015**



Source: Incidence from the Arkansas Central Cancer Registry, ICD-O-3, C34 group, 1997-2015 and mortality from the CDC Wonder Compressed Mortality File, ICD-10, C-34 group, <https://wonder.cdc.gov/>



per individual is declining, the risk of developing lung cancer and dying from the disease has increased over the last 50 years.<sup>3</sup> Sadly, a female in Arkansas was more likely to die of lung cancer in 2015 than in 1970.

In general, the rise in lung cancer incidence in women is troubling. Lung cancer incidence in women increased after targeted-marketing campaigns that began in the 1960s and 1970s.<sup>3,12</sup> While the risk of lung cancer has increased in women, lung cancer incidence among men has steadily declined since 1997. This is associated with the fact that women began smoking in large numbers about 25 years after men were smoking heavily.<sup>6</sup> In Arkansas, female adult smoking prevalence peaked in 2013 – an indication that lung cancer incidence and mortality rates have yet to peak in women and will continue to rise. Recent mortality trends, 1999 to 2015, show that lung cancer deaths are decreasing in men, but not yet in women.

## Conclusion

Smoking is the leading preventable cause of lung cancer, and while great strides have been made to reduce tobacco use in Arkansas, lung cancer remains the leading cause of cancer death in both men and women.<sup>1</sup> Even when heavy smokers quit smoking, the risk of developing the disease remains threefold higher than those who have never smoked cigarettes.<sup>2</sup> If Arkansans had the same smoking rate as the U.S., we could save 403 lives per year from lung cancer and save approximately \$26 million per year in direct cancer treatment costs.<sup>9-11</sup>

Thus, the challenge continues to reduce the use of tobacco products, including novel electronic devices that deliver nicotine by inhalation. Cessation programs should target women since their risk of developing lung cancer continues to increase. The most effective public policy to reduce cigarette consumption would

be to increase the excise tax on tobacco. The federal and Arkansas taxes on tobacco have not increased since 2009.

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## Tinea Faciei

A 23-month-old girl presents with a six-week history of worsening, erythematous, annular, and scaling plaques of the face. The patient's mother applied an over-the-counter anti-fungal cream for three days without resolution. They then visited their pediatrician, who prescribed triamcinolone 0.025% cream. The patient's mother has been applying the cream twice a day for four weeks. The rash has continued to spread.

Provided this clinical image and photomicrograph of a potassium hydroxide (KOH) mount, what is the most appropriate next step in management of this patient?

- A) The KOH test is negative. A skin biopsy should be taken and autoimmune serologies should be drawn, as this patient most likely suffers from neonatal lupus erythematosus. Evaluate the mother for autoantibodies and the child for heart block.
- B) The KOH test is positive. The patient has tinea faciei. The triamcinolone should be discontinued, and oral antifungal therapy initiated.
- C) The KOH test is equivocal. Given the failure of the mid-potency corticosteroid, a stronger, Class 1 topical corticosteroid, should be prescribed, as the patient likely suffers from granuloma annulare.
- D) The KOH test is positive. This patient suffers from perioral dermatitis. Discontinue the use of triamcinolone and begin oral erythromycin and topical metronidazole cream.

Answer: B.

Although erythematous annular plaques are characteristic of granuloma annulare and neonatal lupus erythematosus, the KOH

mount depicted is positive which indicates a fungal infection. This proves the diagnosis to be tinea faciei. Granuloma annulare (GA)

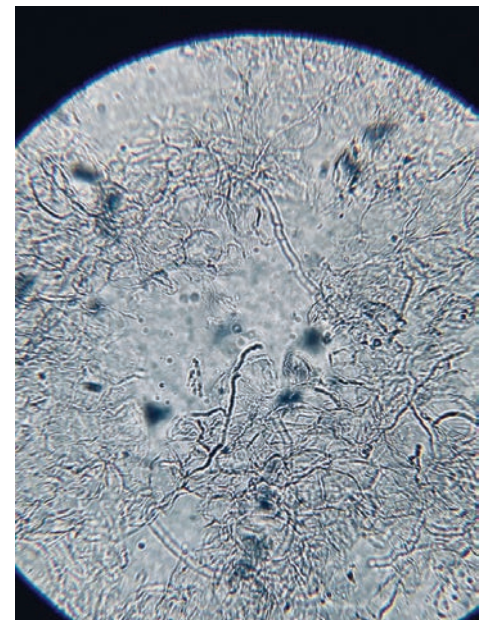


has a predilection for the extensor surfaces of the joints, rarely presents on the face, and does not have surface scale. Neonatal lupus has a similar clinical appearance but presents at birth or within the first few weeks of life. In nearly every case of neonatal lupus, the mother is found to have autoantibodies of the Ro/La family. Children with neonatal LE are at high risk for developing heart block and should be followed closely. The rash of perioral dermatitis is not annular and would have a negative KOH result. However, like tinea faciei, perioral dermatitis is worsened by using topical corticosteroids.

When dermatophyte fungal infection occurs on the face, it is called *tinea faciei*. Most commonly, the fungus will be the anthropo-

philic organism, *Trichophyton rubrum*. When history shows the patient had contact with other species, especially kittens or cats, *Microsporum canis* is the zoophilic organism that should be considered. The distinguishing characteristics of tinea faciei are spreading, erythematous, scaling, annular plaques with a positive KOH test.

A common mantra in dermatology is "if it scales, scrape it." When a scaling rash is seen and tinea is a possibility, a skin scraping for a KOH test is taken from the scale on the leading edge of the advancing border of the rash. The KOH test is used to determine if the rash is fungal in origin. KOH dissolves keratinocyte skin cells in order to better expose the dermatophyte hyphae for microscopic diagnosis. Early or less severe cases of tinea may be managed with topical antifungals whereas more severe or widespread cases are best treated with oral antifungals. When treated appropriately, tinea faciei typically resolves without scarring.



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## OBITUARIES

**M**ichael Neill Moody, MD, 73, passed away December 15, 2019. Dr. Moody graduated from Salem High School and attended Arkansas College in Batesville on a basketball scholarship. When ball practices interfered with pre-med biology lab, he transferred to Arkansas State University to pursue his dream of attending medical school and becoming a family doctor in his hometown of Salem. He did just that, graduating from UAMS and practicing in Salem for more than 45 years. A board certified family practice doctor until 2013, “Doc Moody” is best known for delivering and taking care of multi-generational families. As a physician, he served in a number of leadership roles with the Arkansas Medical Society, the Arkansas Academy of Family Physicians, and their national affiliates. He was medical director of the Arkansas Foundation of Medical Care for 20 years and continued as a board member until his illness. Of all his many accomplishments and accolades, his true passion was medicine. He was known at the

state Capitol as the champion for rural medicine, being sought out by legislators and regulators for his expertise. As one of the first four graduates of UAMS’s Family Practice Residency, he spent his entire career advocating for patients. One of his proudest successes was the passage of Any Willing Provider legislation, which grants patients the freedom to see the doctor of their choice. Dr. Moody is survived by his wife Barbara of Salem; three children Scott Moody of Salem, Melissa Moody of Little Rock, and Karla Moody McBride of Kalamazoo, Mich.; three grandchildren; and his nurse of 29 years Sheila Cochran.

**Nathaniel Fay Austin, MD, 75,** passed away November 2, 2019, at his home in Russellville. He is survived by his partner, Judy Rae Lawton; daughters Allison Nicole Austin, Keely Rochelle Austin, and Laila Mae James; son-in-law, John Puhr; and grandchildren Alex and Evan Austin-Puhr. Dr. Austin attended college at the University of Arkansas in Fayetteville, UAMS in Little Rock, and had a private medical practice for over 32 years in Russellville. He was a generous father and friend, an avid golfer, an artist, and dedicated doctor and surgeon.

**Allie Eldon “A.E.” “Doc” Andrews, Jr., MD,** passed away December 16, 2019. He graduated from Arkansas State University and from the UAMS after serving in the U.S. Navy during World War II. Dr. Andrews enjoyed a successful career as a doctor, specifically of radiology, in Arkansas, Tennessee, and Texas. He interned at Arkansas Baptist Hospital in Little Rock and worked at a family practice in Paragould. His career included appointments as chief of staff and other positions at Arkansas Methodist Hospital, Saint Michael Hospital, and Texarkana Community Hospital. He was a past president of the Arkansas Medical Society and a member of the Fifty Year Club as well as president and officer of Greene-Clay County Medical Society, Miller-Bowie County Medical Society, and serving as Arkansas representative delegate of the American Medical Association. Dr. Andrews is survived by his children Susie Williams and husband Don, Jenny Cope and husband Brad, and David Andrews and wife Jane; five grandchildren; and four great-grandchildren.



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