ARKANSAS MEDICAL SOCIETY

JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY

WINTER **2024** VOLUME **120** NUMBER **3**

OBESITY, ADDICTION, AND ALL MENTAL HEALTH DISORDERS *ARE* CHRONIC MEDICAL DISEASES

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Established 1880, the Journal of the Arkansas Medical Society is owned and edited by the Arkansas Medical Society and published quarterly under the direction of the AMS Board of Trustees.

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10 Corporate Hill Dr., Ste. 300, Little Rock, AR 72205
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ARKMED.org/thejournal

DISTRIBUTION: The Journal of the Arkansas Medical Society (ISNN 0004-1858) is published quarterly by the Arkansas Medical Society, 10 Corporate Hill Drive, Suite 300, Little Rock, AR 72205. Subscription rate: $30.00 annually for domestic; $40.00, foreign; $3.00, single issue.

Periodicals postage is paid at Little Rock, AR, and at additional mailing offices. The Journal is printed by Walsworth Press Inc., Fulton, MO 65251.

Postmaster: Send address changes to:
The Journal of the Arkansas Medical Society,
P.O. Box 55088, Little Rock, AR 72215-5088.

Editor Emeritus: Alfred Kahn Jr., MD (Deceased)

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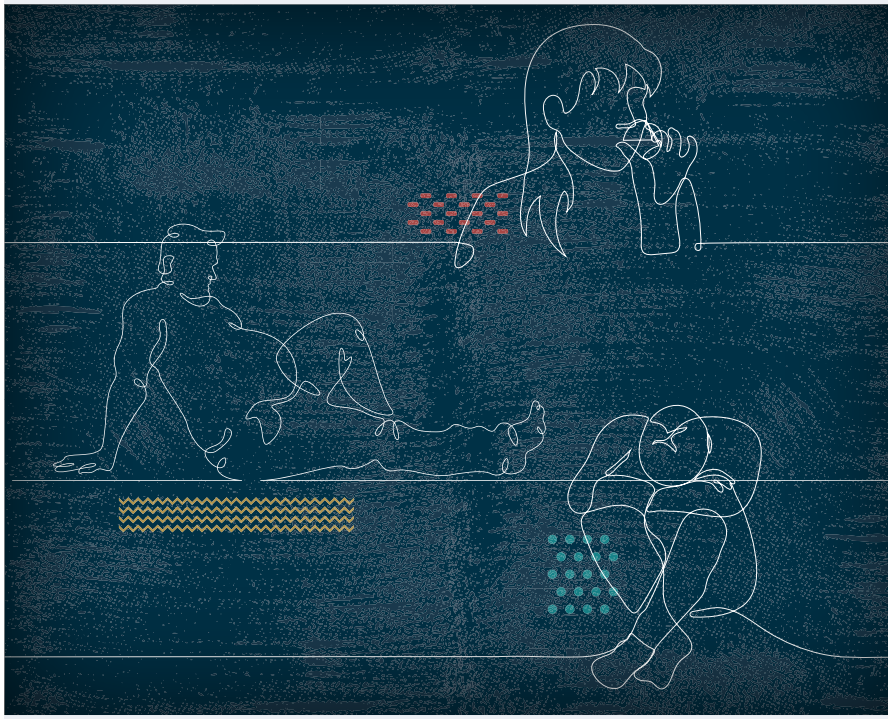

FROM THE PRESIDENT

IT IS GROUNDHOG DAY AGAIN

ANTHONY JOHNSON, MD
2023-2024 AMS PRESIDENT

Every day in the clinic, with at least one of my patients, just like Bill Murray in the movie Ground Hog Day, it is the same story just one year later. This week it was a 17-year-old, weighing 335 pounds. His last clinic visit was a year ago and he has gained another thirty pounds since then. When I looked at last year's clinic note, we discussed his weight gain, recommended exercise and a diet with more fruits and vegetables and less carbs. His cholesterol and blood sugar were normal and Hemoglobin a1c was 5.5%. I had recommended another office visit to follow up on the lifestyle changes we had discussed but he did not show.

He says he tried to make some changes but got frustrated when he did not see any benefit. When I looked further back in his chart, either I or one of my partners have had similar discussions every year since he was in elementary school. Now he is a junior in high school, about to outgrow our clinic. We had the same discussion and I ordered labs.

I called mom with his lab results the next day, cholesterol and blood sugar were normal, but his Hemoglobin a1c was up to 5.9%. I told mom he would now be considered prediabetic and treatment options other than lifestyle changes might be in order, but his mom said she would like to continue to address this the natural way and she did not think his insurance would cover some of the treatments we discussed. She promised to come back to see me in a couple of months to follow up.

This story repeats itself too often, especially here in Arkansas, where we usually rank in the top 5% in the U.S. for obesity. Dr Mike McClurkan, an obesity specialist who practices in Jonesboro, brought this concern to the AMS Board of Trustees meeting this past May, stimulating significant discussion. At our November meeting of the Board of Trustees, we approved a statement regarding not only obesity, but also addiction and all mental health conditions. The increased incidence and limited access to the treatment of these conditions represents a true public health crisis. One of the goals of our efforts is to increase the recognition, prevention, and treatment of these chronic medical diseases. We plan to do this by advocating for changes in education, payment, and policy.

My goal is that at some point in the future when a young man presents like this, things will be different in that his parents, the public, and the entire medical system will recognize that rather than a personal failing or just bad habits, he has a chronic medical disease and we can readily treat with accessible, evidence-based treatment options, just as if he had asthma, diabetes, or Crohn's disease.

I hope he does return for his appointment next month; I would like to have another crack at him.

FEATURE STORY

OBESITY, ADDICTION, AND ALL MENTAL HEALTH DISORDERS *ARE* CHRONIC MEDICAL DISEASES

RECENT AMS POLICY STATEMENT CALLS FOR RESPECT AND COVERAGE FOR THESE COMMON CONDITIONS

CASEY L. PENN

A NEW POLICY STATEMENT ADOPTED NOVEMBER 1, 2023, BY THE ARKANSAS MEDICAL SOCIETY BOARD OF TRUSTEES MAY SEEM TO RESTATE THE OBVIOUS. EVEN SO, IT'S THE STAND THE BOARD DEEMED NECESSARY TO ADVANCE AND PROTECT EFFORTS RELATED TO TREATMENT AND COVERAGE FOR OBESITY, ADDICTION, AND MENTAL ILLNESS.

Initiated by AMS President Tony Johnson, MD, the statement puts in writing the Society's endorsement of obesity, addiction, and mental health disorders as chronic medical conditions. It goes on to stress that since these are recognized illnesses, and have been for some time, they should be treated and viewed as such, not only by physicians, policymakers, and the public, but also by public and private payors as related to coverage for accepted and available treatments. "The Mental Health Parity Act and other things have been attempts to help, but it's still hard to get the needed treatments for these disorders," said Dr. Johnson. "When a patient is diagnosed with diabetes, that's a tough diagnosis, but we have a definite path we can send them on, and we know they're going to get good care and whatever is available to treat that. The child with obesity or the adult with substance abuse or a mental health disorder is not getting that same assurance."

To further efforts related to realizing adequate acceptance, access, and coverage of treatments, the policy statement shares goals of raising awareness and thereby increasing overall advocacy. And to work toward these goals, the statement puts forward tangible first steps. These include bringing together experts to define the gaps and opportunities; engaging with public health colleagues and sister medical societies to gain broader support in these efforts; and developing strategies to educate the public, the medical community, third-party payors, and government leaders and policy makers.

Efforts based on the newly adopted policy are in preliminary stages. With goals clarified, Dr. Johnson is working with AMS staff and colleagues and has put together an initial workgroup on obesity, addiction, and mental health. Current members represent specialization in key areas and include Dr. Johnson; Michael B. McClurkan, MD; Nihit Kumar, MD; Patty Gibson, MD; Olivia Tzeng; and Bala Simon, MD, MPH, DrPH.

FROM A SINGULAR TO MULTIFACETED APPROACH

Dr. Johnson credited Dr. McClurkan, an obesity specialist practicing at The McClurkan Clinic in Jonesboro, as the initial spark to form and adopt this policy. Dr. McClurkan is boarded in obesity medicine and Ob/Gyn and is a fellow of the Obesity Medicine Association. In his presentation on obesity at the Society's Board of Trustees meeting in May 2023, Dr. McClurkan challenged his audience, and Dr. Johnson was listening. ***"He wanted us to step up and say that the treatment of obesity is something we're not doing well and something we need to do better,"*** said Dr. Johnson. "***He pointed out that insurance is not covering a lot of medications and procedures that actually work for obesity and that there aren't enough people treating it."***

After that presentation, Dr. Johnson began thinking about how to act on Dr. McClurkan's challenge. He took the subject to the AMS Executive Committee for further discussion, and the group decided a policy statement was in order, but one that went beyond the subject of obesity. ***"It didn't make sense to me to focus only on obesity. Instead, I felt we should expand this because it's not just obesity [that we could do better on], it's the treatment of addiction, of substance abuse disorder, and pretty much all mental health problems. We need to recognize and reiterate that these are diseases."***

Regarding the actions taken by the Society in response to the call of his presentation, Dr. McClurkan shared mixed feelings. ***"I've worked on advocacy in the state and nationally for obesity treatment, and I had thought if we could get the Medical Society to take a stance on obesity, it would add weight to conversations with payors about treating obesity effectively. They took my statement and expanded it to include mental health and substance abuse disorders. I wasn't crazy about that at first, but I'm glad AMS has taken up a formal position. Obesity does share some similarities to substance abuse disorders and mental health disorders in that they are chronic problems with a high relapse rate."***

Dr. McClurkan looks forward to working with colleagues in the workgroup on educational opportunities for physicians in Arkansas. Further, he hopes the workgroup can come together to strongly urge coverage for obesity medicines by all payors in the state. He said, ***"I'm anxious to look at barriers to treatment – availability of medication, stigma, physician education, those types of things – and possible remedies to those barriers."***

Another obesity specialist here in Arkansas, Samuel Bledsoe, MD, serves as board secretary for AMS and practices as a bariatric surgeon with the Bariatric and Metabolic Institute at Arkansas Heart Hospital. While not a part of the current workgroup, Dr. Bledsoe shared excitement about the policy and the awareness that could result from it. ***"Obesity is an area of medicine where there's a real disconnect between what the public and even many clinicians perceive, and what's really going on,"*** he said. ***"Hopefully, we can achieve better public perception of treatments and find ways to improve access and funding. I'd like to see universal coverage for bariatric surgery and other medical treatments for obesity. Around 50%***

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WHEN A PATIENT IS DIAGNOSED WITH DIABETES, THAT'S A TOUGH DIAGNOSIS, BUT WE HAVE A DEFINITE PATH WE CAN SEND THEM ON, AND WE KNOW THEY'RE GOING TO GET GOOD CARE AND WHATEVER IS AVAILABLE TO TREAT THAT. THE CHILD WITH OBESITY OR THE ADULT WITH SUBSTANCE ABUSE OR A MENTAL HEALTH DISORDER IS NOT GETTING THAT SAME ASSURANCE.

AROUND 50% OF INSURANCES IN ARKANSAS DON'T COVER BARIATRIC SURGERY AND PROVIDE NONE TO NOMINAL COVERAGE FOR MEDICAL WEIGHT LOSS TREATMENTS.

of insurances in Arkansas don't cover bariatric surgery and provide none to nominal coverage for medical weight loss treatments. I would hope that one thing that would come out of this would be universal and adequate coverage for obesity-related diseases, extending to addiction and behavioral health."

MORE FROM WORKGROUP MEMBERS

On the mental health and addiction front, psychiatrists Dr. Kumar and Dr. Gibson will help identify gaps in care and how to fill them. Dr. Kumar is board certified in addiction (child and adolescent) and adult psychiatry. Through his work at Positive Recovery (Little Rock), he treats adolescents with addiction and has been involved with research and teaching in Arkansas and nationally. Expressing his appreciation for the statement and the founding of the workgroup, he commented, ***"I'm glad that AMS has focused on mental health and addiction as part of the overall outreach. My physician colleagues in the state, when they hear that I'm a psychiatrist, are excited because they see the need for this in their own patients. Shedding light on this issue is a huge step forward."***

Dr. Gibson is board certified in psychiatry, addiction medicine, and anesthesiology and is currently the medical director for Behavioral Health for Arkansas Blue Cross Blue Shield and president of the Arkansas Psychiatric Society. As someone with experience integrating behavioral health into primary care practices, Dr. Gibson shared enthusiasm about what such a bold policy statement can achieve, ***"A statement like this is consistent with what you're seeing across the country as medical groups are coming together and laws are leaning toward increased parity. Good steps are being taken, and the good news is that health is bipartisan. Figuring out how to solve it is what gets sticky."***

Pointing out a barrier to solutions, Dr. Gibson explained, ***"Not only do we separate treating physical health and mental health, but traditionally, we also treat mental health and substance use separately. Separate facilities, separate training. So, it's relevant that in their statement, AMS brought together obesity, addiction, and mental health. By that, we can try to overcome that stigma of getting treatment and move toward changing our health system. We need to treat the whole person, the whole kid, the whole family.'***

"Change is complicated, but to get to a solution, this statement is a necessary piece. Dr. Johnson has brought together a good group, even including a medical student and the Arkansas Department of Health. I'm optimistic and happy to be involved."

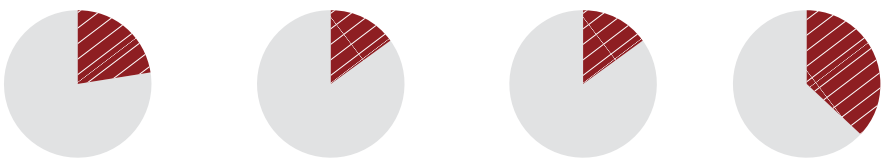
Representing ADH, Dr. Simon brings a public health perspective and expertise to the workgroup. He shared related statistics* in Arkansas and stressed the importance of examining the context of individual patient choices in these areas.

According to Dr. Simon, 22.6% of Arkansas adults have some form of mental illness; 15% of Arkansas youth have had at least one mental/depressive episode in the past year; about 15% of Arkansas adults use some form of substance (illicit or overuse of prescription medications) to cope. In addition, obesity prevalence is over 37% in Arkansas and when counted with overweight, prevalence is more than 70%.

Dr. Simon also noted, ***"The World Health Organization definition puts it well, that health is a state of complete physical, mental, and social wellbeing … so, in public health, we look at this from a socioecological approach."*** Considering the socioecological model is important because, as studies have shown, only 20% of health is determined by health care. The other 80% is affected by what happens outside the health care setting, including individual choices, physical environment, and social determinants of health.

"When I see patients with diabetes, hypertension, heart failure, they may be on ten medications, but they may not take them," summed Dr. Simon. ***"Unless I address their mental health, they will not address their physical health. It's critical***

ARKANSAS STATS



22.6% HAVE SOME FORM OF MENTAL ILLNESS

15% YOUTH HAVE HAD AT LEAST ONE MENTAL/DEPRESSIVE EPISODE IN THE PAST YEAR

15% OF ADULTS USE SOME FORM OF SUBSTANCE TO COPE

37% OBESITY PREVALENCE

ONLY 20% OF HEALTH IS DETERMINED BY HEALTH CARE. THE OTHER 80% IS AFFECTED BY WHAT HAPPENS OUTSIDE THE HEALTH CARE SETTING, INCLUDING INDIVIDUAL CHOICES, PHYSICAL ENVIRONMENT, AND SOCIAL DETERMINANTS OF HEALTH.

to approach obesity in the context of the socioecological approach. It is important to have mental health parity. If we start addressing that, I think that some of the issues with addiction will be addressed, too, to prevent people from moving in the mental health spectrum to a place where they need something unhealthy to help them cope with their mental health."

Referencing the whole picture of health is in line with the new AMS statement, which calls on payors, public and private, to "cover evidence-based prevention and treatment for these disorders;" governmental and philanthropic institutions to "accelerate research funding for prevention and treatment;" and public policy to "mitigate socioeconomic and clinical risk factors leading to the development of these disorders."

On the educational side, the policy states ***"education and training of medical students and physicians should have a more dedicated focus on the causes, opportunities for prevention, and varied treatment for these disorders, which are stigmatized and disproportionately affect the most vulnerable and least empowered populations in Arkansas and across the nation."***

With this policy statement, AMS has boldly challenged physicians, payors, medical training institutions, policymakers, and other stakeholders to look closer at the whole picture of health and work toward better outcomes in relation to obesity, addiction, and mental illness. As meetings get underway, Dr. Johnson will continue to reach out to specialty groups for participation and education. With his colleagues in the workgroup and the AMS staff, he hopes to keep spreading the word on these efforts and to begin strategizing and jumping into the hard work necessary to change the landscape. Are you ready to take up the challenge as well? To learn more and see what you can do to help, reach out to Dr. Johnson at **tjohnsonfaap@gmail.com** or contact AMS at **501-224-8967**.

*Sources, Arkansas Statistics

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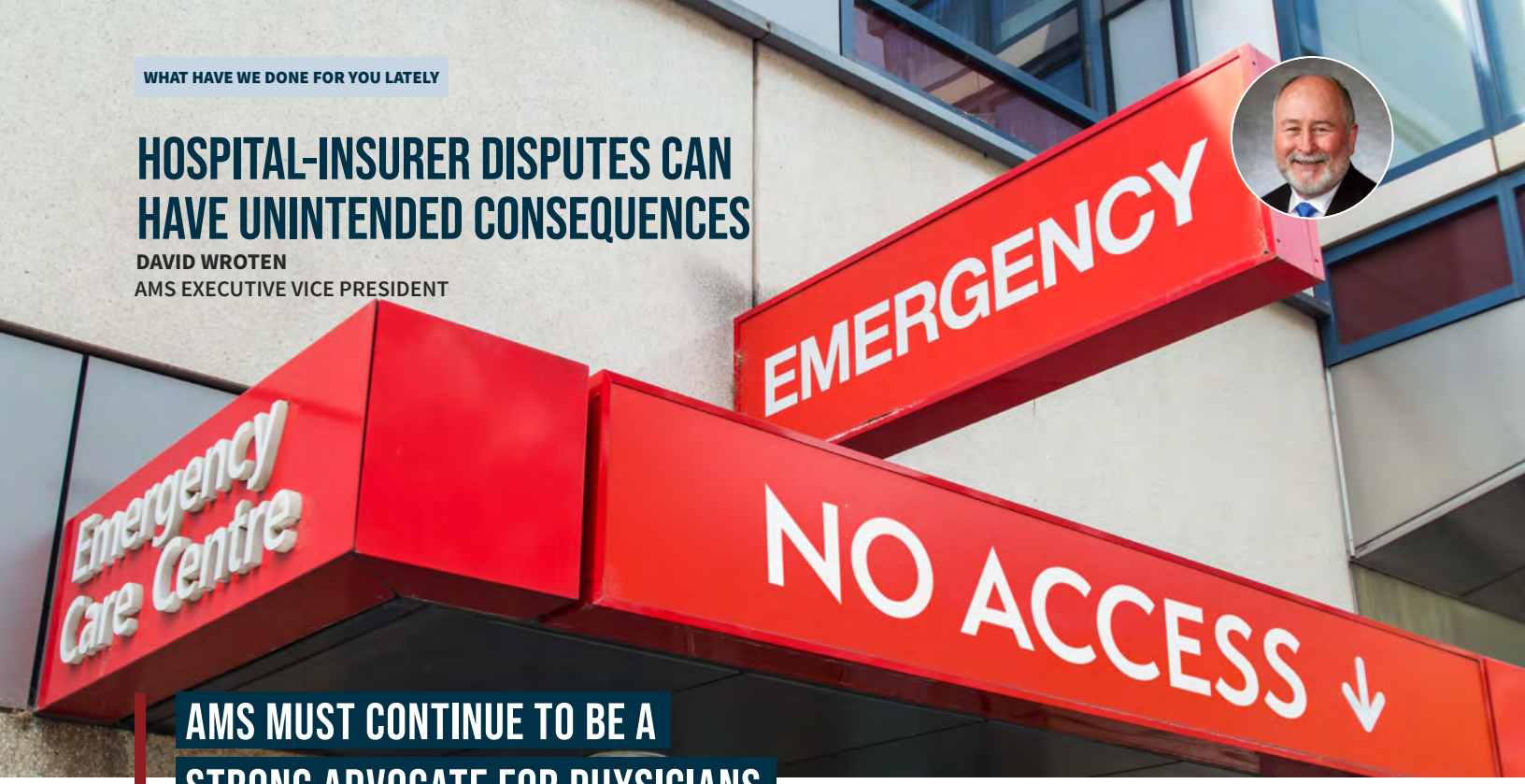
HOSPITAL-INSURER DISPUTES CAN HAVE UNINTENDED CONSEQUENCES

DAVID WROTEN
AMS EXECUTIVE VICE PRESIDENT



AMS MUST CONTINUE TO BE A STRONG ADVOCATE FOR PHYSICIANS AND THEIR PATIENTS.

Two weeks before Christmas AMS received several calls from physician offices concerning a letter they received from Cigna. The letters were addressed to network physicians whose sole hospital affiliation is a Baptist Health facility. At the time, Baptist and Cigna were at odds over their provider contract which was scheduled to end December 31, 2023.

The letter provided notice that Baptist Health may no longer be in their commercial network as of 1/1/24. To remain in network, the letter went on to state that the physician must obtain admitting privileges at another participating hospital or make arrangements with another network physician to admit patients to another participating hospital. If not, you would be removed from Cigna's Commercial Network effective January 1, 2024.

AMS STAFF REACHED OUT TO A REPRESENTATIVE OF CIGNA AND RAISED THE FOLLOWING CONCERNS ABOUT THE LETTER AND THE POTENTIAL HARM TO PATIENTS THAT WOULD CERTAINLY OCCUR IF THIS HAPPENED.

1. Timeliness – The letter was dated December 1st but many physicians, if not most, did not receive the letter until around the 14th or 15th; leaving less than two weeks, during a major holiday, for physicians to comply with the requirements. Cigna's provider agreements require at least 30 days' notice.

2. The provider agreement also contains a provision that physicians terminated from the network must wait two years to reapply. AMS is unsure if Cigna would wave this requirement if, sometime after January 1, (a) they successfully enter into a new contract with Baptist, or (b) the physician complies with the directions in the letter.

3. At least four of the 10 Baptist facilities named in the letter are in counties with only one hospital. There are no other local facilities to which you could admit patients, even if you wanted to.

4. This is a much larger issue than a hospital contract. Most patients never need to be admitted to a hospital. If a Cigna policyholder lives and works in Stuttgart, for example, and all the local physicians are suddenly terminated from the network, this will place an untenable burden on those patients.

It is understood that AMS does not have a position regarding the contract negotiations between Cigna and Baptist Health. However, AMS must continue to be a strong advocate for physicians and their patients. In that regard, AMS asked Cigna to consider these concerns and take whatever action is necessary to address them in a way that minimizes the disruption of the provision of medical care to patients insured through Cigna.

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SCOTT FERGUSON, MD
AMA BOARD OF TRUSTEES

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Our physician workforce, both here in Arkansas and across our nation, is a vitally important resource. But the vitality and overall effectiveness of that resource continues to be threatened by the unrelenting crisis of physician burnout.

A whole host of factors drive burnout, and its fallout is felt by both physicians and the patients we care for. Reducing burnout is one of the five pillars of the AMA Recovery Plan for America's Physicians, along with enacting Medicare payment reform, stopping scope creep, supporting telehealth and fixing the prior authorization process.

Cutting into the enormous administrative burden posed by excessive prior authorization requirements is a great place to begin reducing physician burnout and improving patient outcomes. I am proud to report that, with input from the Arkansas Medical Society and other stakeholders, our state's lawmakers have helped set the pace for prior authorization reform in recent years. Even so, more work remains to be done both here and at the national level to eliminate this obstacle that insurance companies often use to delay or deny necessary patient care.

The roots of physician burnout point to systemic issues in our health care system that have long been ignored: increasing administrative burdens that cut into our time with patients; poorly functioning electronic health records; inadequate physician support in practice environments; a sense that physicians are powerless to correct the problems we face; disinformation campaigns designed to undermine trust in science and medicine; and third-party interference in the patient-physician relationship.

Aggravating this situation is that fact that physicians are often reluctant to seek help for our mental health and wellness needs. Many of us fear that it will jeopardize our licenses or employment, given the outdated and stigmatizing language on medical board and health system application forms that ask about a "past diagnosis," or require peer references to give their opinions about an applicant's mental health status.

The solution involves shedding the cultural stigma that still surrounds the act of seeking assistance for mental health concerns.

We need to ensure that physicians and our colleagues in health care can access the care we need when encountering stress and anxiety, or whenever we might feel powerless to overcome the frustrations and challenges that are part and parcel of modern medicine.

The AMA is working tirelessly at both the state and national levels to strip away stigmatizing language on licensing and credentialing applications. We support the position that a physician's mental health should only be considered in a licensing or credentialing decision when it imposes a current adverse effect on that physician's ability to practice medicine competently, ethically and professionally.

The AMA is also dedicated to establishing and sustaining a culture of wellness that allows physicians to deliver high-quality patient care in every situation. An important aspect of this effort is the AMA's Joy in Medicine Health System Recognition Program, which focuses on reclaiming physician fulfillment in caring for patients. A total of 72 health systems, hospitals and medical groups were cited as 2023 Joy in Medicine recognized organizations. Each recognized organization has demonstrated competency in the six distinct areas: commitment, assessment, leadership, teamwork, efficiency of practice environment, and support.

Every health care organization in Arkansas would benefit from a thorough self-assessment of its own competency in these areas, and by making a firm commitment to improving physician satisfaction through policies and programs that actively support well-being, promote cooperation and teamwork, and boost operational efficiency. Doing so will promote wellness across an organization's entire workforce while strengthening the patient-physician relationship that lies at the center of effective health care delivery.

I AM PROUD TO REPORT THAT, WITH INPUT FROM THE ARKANSAS MEDICAL SOCIETY AND OTHER STAKEHOLDERS, OUR STATE'S LAWMAKERS HAVE HELPED SET THE PACE FOR PRIOR AUTHORIZATION REFORM IN RECENT YEARS.

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HEALTHCARE PROFESSIONALS AND WELLNESS

TEREASA HOLMES, CMPE
AMS DIRECTOR OF PRACTICE AND HEALTH POLICY

When a patient seeks healthcare from a physician, the subject of wellness and lifestyle is always addressed. Most employers offer wellness and healthy lifestyle programs and often reward employees who participate in the programs. Implementing a wellness program is an investment in the health and productivity of your employees, organization, and your community.

"Healthy citizens are the greatest asset any country can have."
- Winston Churchill

One may think having an organized wellness program within a healthcare setting is foolish, yet it is one of the best places to offer this. As in other occupations, healthcare workers take immense pride in their position. Placing the patients and their needs first is their top priority. They are fully aware of the long-term effects of tobacco use, inadequate exercising, poor nutrition, obesity, and unhealthy living. Yet often, the staff overlook their own personal health. Healthcare professionals have some of the nations' highest health risks, such as obesity.

Most workers spend a substantial portion of their waking hours on the job. While displaying posters and resources on walls and waiting rooms is good, this is only a fraction of a wellness program. People are more likely to succeed in healthier lifestyles when they have a supportive environment.

Building a healthy program includes physical and mental well-being. Healthy lifestyles are personal, it is not a 'one type fits all" program. This first step is to poll your employees and customize the wellness program to include what is most beneficial to them.

A wellness program may include onsite workout equipment or discounts to fitness center, scheduled lunch and learn sessions, and/or weekly healthy tips. To promote wellness, involve the staff with initiatives, such as monthly challenges – walking, exercise, drinking water. Reward your staff for their accomplishments. Regardless of the size. personality, and work demands of your clinic, a plan for your staff is essential.

"A healthy lifestyle is the most potent medicine at your disposal."
- Sravani Saha Nakhro.

Source for Chart

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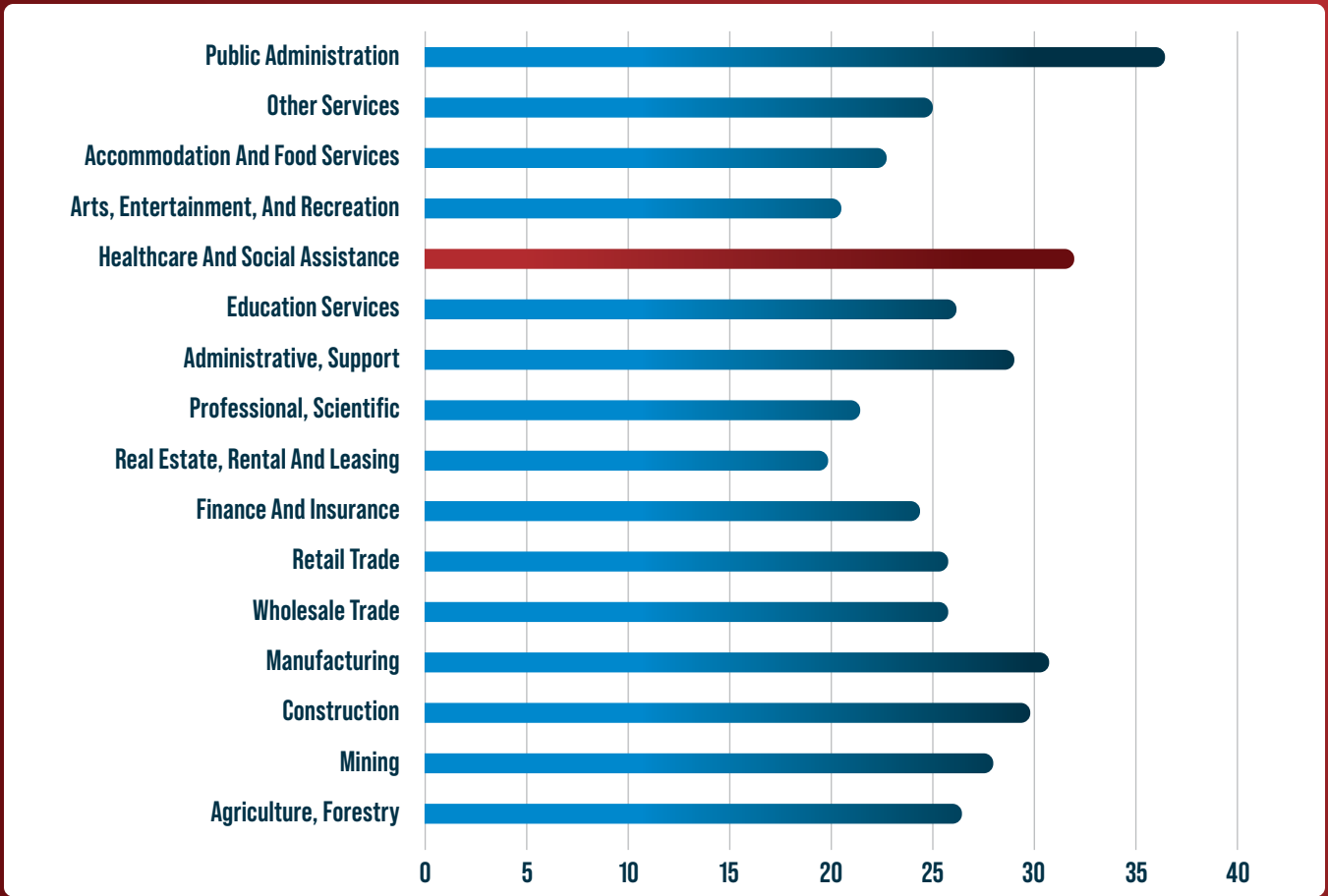

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H. SCOTT SMITH, JD
AMS DIRECTOR OF GOVERNMENTAL AFFAIRS

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WHAT'S AT STAKE?

Who defines the practice of "medicine" and determines who can practice it? Don't you need a medical degree and a license from the medical board to practice medicine in Arkansas? One would hope so.

In reality, the definition of the practice of medicine and who can practice it is established by the Arkansas state legislature, just like all other state legislatures around the country. Each legislature has the power to define the various scopes of practice. They let whoever they say practice within that expanded scope (whether the expansion is actually practicing medicine or not). So, the legislatures are the gatekeepers to patients in their states and a person does not necessarily have to have a medical degree and a medical license, but only needs their preferred legislation to pass.

DON'T BELIEVE ME?

Advanced Practice Registered Nurses (APRNs) have been practicing independent of physician interaction in about half the states around the country for years. Psychologists can prescribe medicine independent of physician interaction in a few states. Optometrists continue to win some legislative fights to perform limited laser surgery in states around the country…including here in Arkansas.

These state legislative victories for APRNs, psychologists and optometrists had nothing to do with patient safety or demonstrated competency (optometrists claim that 32 hours of laser surgery "training" over two weekends is all that's needed). Instead, some legislators claim without supporting evidence that these expansions will help increase access to care.

You and I know that most of these APRNs, psychologists and optometrists are fine people, but we also know they aren't qualified just because a non-scientific, non-medical legislative body suddenly declares them so. Unfortunately, all around the country, patients can and do rely upon such licensure or "blessing of the state" when visiting non-medically trained people, and that reliance can be detrimental.

Why it is important to continue defending against bad legislation and bad policy? Let me share just how far this could go within an elected body that doesn't truly value your medical school training and patient safety. Within the last few years, two different state legislators said the same thing on different occasions. They both said, "I would vote FOR licensing WITCH doctors if given the chance."

JUST TO MAKE SURE I CLEARLY UNDERSTOOD WHAT I THOUGHT I HAD JUST HEARD...I ASKED, "WHICH DOCTORS...WITCH DOCTORS?" YES ... WITCH DOCTORS.

While extreme, this is precisely the direction some elected officials would take us, and why it is so important to help elect medicine-friendly legislators. It's this simple … the more medicine-friendly legislators we elect in Arkansas and in DC, the safer your patients will be. That is not an overstatement. If you truly believe in the value of your medical training and the importance of patient safety, you should be concerned whether the legislators elected also believe in the value of your medical training and patient safety.

The good news is … you can help elect medicine-friendly candidates very easily and quickly.

Joining AMS is important, but it's not the only action needed to help.

YOUR AMS DUES ARE USED TO HELP PAY FOR DIRECT ADVOCACY EFFORTS IN LOBBYING THE ARKANSAS LEGISLATURE AND OUR

CONGRESSIONAL DELEGATION … BUT THOSE AMS DUES ARE NOT ALLOWED TO BE USED TO SUPPORT CANDIDATE CAMPAIGNS IN THEIR EFFORTS TO BE ELECTED TO PUBLIC OFFICE, NEITHER AT THE STATE NOR FEDERAL LEVEL.

Financial support to these campaigns for public office is limited to individual contributions and contributions from Political Action Committees (PACs). ArkMed-PAC needs your financial assistance in addition to your AMS membership.

To be most effective, AMS must have medicine-friendly legislators in Little Rock and in Washington, DC. To get elected and re-elected requires funding expensive campaigns, sometimes VERY expensive. A campaign for the Arkansas House of Representatives can cost well over $100,000 and state House races generally are the least expensive of all legislative races. You can help these medicine-friendly candidates quickly with a small contribution of less than $1 a day.

A contribution of $300 (only 82 cents a day), will help the non-partisan board of physicians from all around the state fund those medicine-friendly candidates. The board provides guidance and listens to all ArkMed-PAC contributors when making decisions on where to deploy funds…but we need sufficient financial resources to deploy to be most effective in defending the patients of Arkansas AND defending the value of your medical education and practice.

Please take a few minutes and join ArkMed-PAC today.

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Healthy **Communities.**

A CLOSER LOOK

Age and Medicine

CHAD T. RODGERS, MD, FAAP, CHIEF MEDICAL OFFICER, AFMC; PARTNER AND PEDIATRICIAN, LITTLE ROCK PEDIATRIC CLINIC

When is it time? It is hard not to highlight the life and accomplishments of Dr. Joseph Bates, whose recent passing leaves a huge hole in the health landscape of Arkansas. His obituary included details of a successful career as a physician and educator at UAMS. But then it went on to describe another 25 years of work after retirement and his significant contributions to our state's public health. I attended his visitation and was struck by the attendance of many "rock stars" of medicine. Among them were the very young to the very, let's say, seasoned practitioners and health care leaders.

The national discussion has highlighted the "age-old" topic of the mental and physical capacity of older individuals in jobs of vital importance. An aging congressional body and now the oldest United States President in history has raised the question of when someone in such a critical decision-making role may be beyond the expected age to have the capacity to serve and make crucial decisions. The mandatory retirement age for airline pilots has recently increased from 65 to 67 years old.

The practice of medicine also includes this question of concern. There is no mandatory or recommended age of retirement for physicians. When does an individual reach an age that is beyond their expected abilities for their age group? We know from science and our practice of medicine that every patient's ability is different.

According to the National Institutes of Health, approximately two out of three Americans experience some level of cognitive impairment at an average age of approximately 70 years. We would expect they should not be in a decision-making role to ensure the safety and well-being of themselves and others. But what if you are the other one out of three? The complexity of the determination of capacity or ability includes genetics, lifetime wellness, physical and mental capabilities, personal choices, and the elements of the job and skill required to perform certain functions.

Many physicians plan to retire as early as age 60, but most work until age 69, and others well into their 70s and 80s. Thanks to advances in medicine, many of us live active and vibrant lives well into our later years. Preventive measures and medications improve the function of our minds and bodies.

Hospitals and other health care entities often struggle to define an appropriate physician retirement age. Again, there is no mandatory age for physicians in practice. A seasoned physician with a wealth of knowledge and experience provides an invaluable resource to the health care system. The development and growth of a younger population

depends on that resource to become the next generation of leaders and providers. Young leadership has its value in innovation, energy, and capacity to perform at a competitive level to sustain and advance medicine. The optimal practice age varies for every institution and across the health care landscape.

The most challenging task is that of the individual to realize and decide when it is time to shift gears and move into other lanes of health care and their personal life. For many physicians, medicine is a calling to serve and gives a sense of purpose, making it difficult to come to closure professionally. There is also the reality that some must continue working for financial or other reasons beyond when they hoped to retire. Others struggle with their identities and what they have left to offer as physicians and individuals in this modern high-tech world.

As advances in medicine and longevity increase, we must continue to evaluate and re-evaluate this question of age and capacity. Our culture needs to recognize and value the work of those ahead of us in life while making room for the next generation. In their early career, physicians focus on building a practice, finding a cure for diseases, promoting innovative concepts, and making up for lost time in training to grow professionally and financially. Many are starting practices and families and getting involved in hospital roles and community and family activities. At that point, most believe they will always have the capabilities they have well into their mid-life. Despite what we know about aging, we think it doesn't apply to us. However, like our patients, we also get older, and our body and mind ages even with optimal health. Knowing when to retire is a difficult personal and professional decision.

So when should one retire? This remains a very personal choice but also has limits that our profession dictates to be necessary for optimal health and well-being for us and our patients. You would think physicians and other well-informed professionals should have determined or at least considered the best age to retire. Cognitive testing and evaluation of motor skills is helpful in this determination, but what the "practice of medicine" may require ultimately varies from specialist to specialist.

There are countless opportunities to transition from one's current practice into another area of medicine or into a new profession altogether. There are a growing number of fields identified where physicians can make significant contributions. A plan to acquire new skills or increase involvement in areas of interest may grow a new career for a physician. Pursuing interests outside of medicine is also an excellent opportunity to find fulfillment. ▲

Dr. Rodgers is a board-certified pediatrician and physician at Little Rock Pediatric Clinic. He received his medical degree from the University of Arkansas for Medical Sciences and completed his residency at Arkansas Children's Hospital, also serving as Chief Resident of Pediatrics. He has served as president of the Arkansas chapter of the American Academy of Pediatrics and on the board of directors of the Arkansas Medical Society. Dr. Rodgers served on AFMC's board of directors from 2011 until 2015 when he resigned to become AFMC's chief medical officer.

UAMS STUDENTS ATTEND AMA INTERIM MEETING IN MARYLAND

At the recent AMA Interim Meeting, Arkansas Medical Society Medical Student Section delegates provided testimony for the American Medical Association Medical Student Section Region 3 (Ark., Kan., La., Miss., Okla., Texas) on various issues. After serving as primary reviewers for resolutions leading up to the interim meeting, the delegates spoke on behalf of Region 3 to advocate for specific positions on policy, including Native American voting rights and other important resolutions.

Throughout the meeting, the delegates voted on each policy brought forward by the assembly in either support or opposition. The delegation worked to make the goals of Region 3 move forward to the AMA House of Delegates. On issues that were brought up during the assembly, they worked together to determine the best decision for the UAMS chapter.

These decisions included language changes to policy and amendments brought forth by their colleagues.

The delegation also attended a lunch outreach session in which they learned more about ways to encourage participation at their home school. They collaborated with other medical students from all over the country to make policy decisions in real time.

Top Right: Clara Puente presents her research poster to students and physicians. Bottom Left: Jordan Myers, AMS-MSS delegate, Madi Nichols, AMS-MSS alternate delegate, representing the UAMS chapter. Bottom Right: Jordan Myers with Humam Shahare, AMA outreach leader for the UAMS chapter.

MEMBER NEWS

CANDIDATE APPLICATIONS NOW BEING ACCEPTED FOR 2024-25 BOARD OF TRUSTEES

The Arkansas Medical Society is now accepting candidate applications for District Trustees. The deadline is February 1, 2024. District Trustees are elected by AMS members in each of 10 geographic districts. Voting will take place from February 14 – March 1, 2024.

Any member interested in serving on the AMS Board of Trustees, or wishing to nominate someone, please visit **https://www.arkmed.org/about/physician-leaders/nominate/** to fill out the online form. Board of Trustee qualifications can be viewed at **https://www.arkmed.org/news/2022/11/nominations-applications-open-for-ams-board-of-trustees/**. You can also call the AMS offices at 501-224-8967, or email Mary Ann Mansfield at mamansfield@arkmed.org with your submission.

The Board of Trustees consists of the primary officers of the AMS and district trustees representing 10 geographic areas of the state. There are currently 36 district trustees, which can fluctuate based upon the number of AMS members in each district.

The Board of Trustees sets policy and is responsible for the business and financial affairs of the AMS. The Board meets quarterly with meetings generally lasting about 2 hours.

Terms are for two years, beginning Spring 2024, with a limit of four consecutive terms. Those elected will be notified after March 1 and will be installed at the Annual Membership Meeting held May 17-18, 2024, to be held at the Embassy Suites in Little Rock.

MEMBER NEWS

2024 MEMBERSHIP DUES STATEMENTS HAVE BEEN SENT OUT

Your 2024 membership dues statements were emailed & mailed in December to the default or preferred address in your membership record. Per AMS bylaws, members who have not paid by March 1 are considered a delinquent for the current calendar year. You can log into your AMS account and update your info or pay online at **www.arkmed.org/membership/**.

Why is being a member so important and beneficial? As a member, you can actively participate in shaping the legislative landscape that impacts the practice of medicine. Through your AMS membership, you gain a collective voice in the state Legislature, influencing the creation of laws and regulations that affect the medical profession.

AMS offers valuable educational resources designed to support your professional development. Stay informed about the latest research, advancements, and best practices through access to conferences, workshops, and publications that keep you at the forefront of your field.

In summary, being a member of AMS goes beyond mere affiliation—it provides a platform for professional growth, advocacy, and a support system that enhances your career and the state of Arkansas.

First Year in Practice in Arkansas
$100.00

Active Member
$400.00

Retired Member
$200.00

Associate or Affiliate Member
$200.00

Student/Resident
Fee Waived

Retired Member:
This is for fully retired members who have not been a consistent member of the Society during all their years of practice in Arkansas. If you are fully retired and have been an AMS member for 10+ years, please contact the AMS office regarding exempt from dues status.

Associate Member:
If you are a full member of a joining state's medical society. Affiliate Member: If you are in full-time military service.

EDWARD "E.J." JONES, MD, FACOG

EDWARD "E.J." JONES, MD, FACOG

OUTPATIENT CHIEF MEDICAL OFFICER FOR WHITE RIVER HEALTH SYSTEM

Specialty:
Obstetrics and gynecology

City:
Batesville

County Medical Society:
Independence

AMS Member Since:
1983

Why are you an AMS member?
AMS is the best policy advocate for Arkansas physicians and a great resource.

Who or what inspired your career in medicine?
My father was a physician and he always tried to help his patients regardless of time or day.

What do you like most about being a doctor, or your specialty?
I recently stopped obstetrics but always enjoyed delivering babies. It's great to participate in what is usually a very happy time in people's lives. Obstetrics and gynecology allows you to provide primary care but have a specialty practice. Very unique.

What is the best professional advice you have received?
Choose a branch of medicine that interests you and a place to live that fits your personality.

What advice do you have for young people considering a career in medicine?
Consider being self employed. Autonomy is important for personal happiness.

What is the most critical health care issue facing Arkansas today?
Obesity and addictive disorders

Do you have a personal motto or favorite quote?
Primum non nocere (First, do no harm)

What do you like to do on your days off or weekends?
Spend time with my grandson. I have several hobbies: amateur radio and astronomy are two main interests.

What is an important cause to you?
Women's health

What is my favorite restaurant?
I can't say I have one. I'm not a very picky eater so I usually find something I like on most any menu.

Dream Car?
Any 4-wheel drive pickup truck.

What is something surprising or interesting about you?
I play piano and upright bass. Really enjoy playing in music groups.

RILEY LIPSCHITZ, MD

RILEY LIPSCHITZ, MD

Specialty:
Internal Medicine

City:
Little Rock

County Medical Society:
Pulaski

AMS Member Since:
2017

Why are you an AMS member?
I believe that physicians must engage in advocacy to promote the health of Arkansans and support the practice of medicine within the state.

Who or what inspired your career in medicine?
My dad – he was an ardent advocate of his patients, always encouraging people to be empowered consumers of healthcare.

What do you like most about being a doctor, or your specialty?
I love practicing primary care. I consider myself a specialist in chronic disease management – so it allows me to help patients navigate the long journey to lifelong health.

What is the best professional advice you have received?
First and foremost, be a good communicator.

What advice do you have for young people considering a career in medicine?
Learn about the future of value-based care.

What is the most critical health care issue facing Arkansas today?
Unmet health related social needs. 40% of Arkansans are "ALICEs" - asset limited income constrained employed. They are one health crisis away from financial catastrophe. Arkansans face hunger, poverty, and chronic toxic stress – all of which contribute to poor health outcomes.

What do you like to do on your days off or weekends?
Play with my kids at the barn. I'm passing down my lifelong love of horses.

What is an important cause to you?
Population health and value-based care

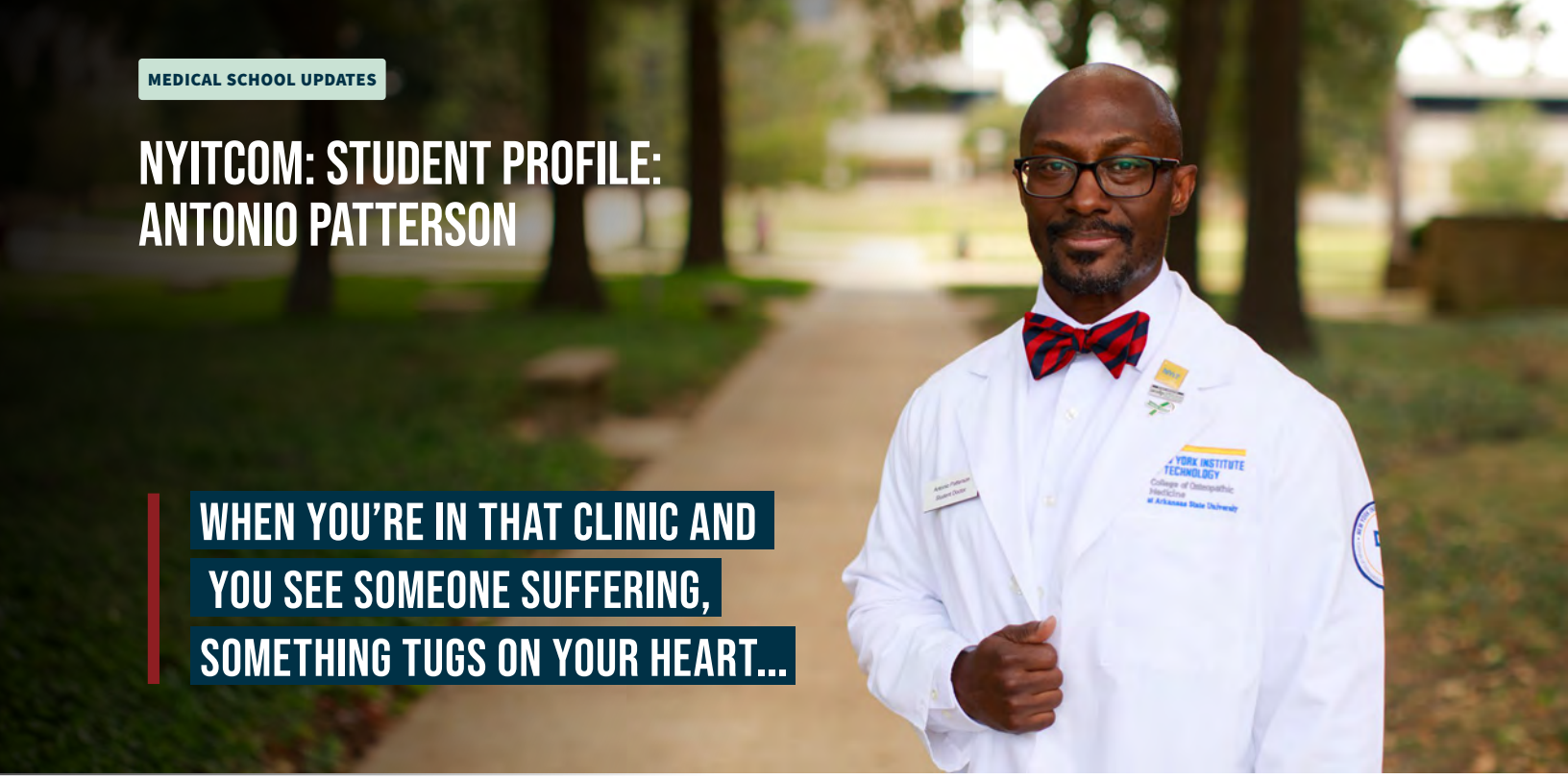
What is your favorite restaurant?
Taj Mahal

Dream Car?
My horse

What is something surprising or interesting about you?
I used to live in China and speak Mandarin.

Dr. Lipschitz with her children.

NYITCOM: STUDENT PROFILE: ANTONIO PATTERSON



WHEN YOU'RE IN THAT CLINIC AND YOU SEE SOMEONE SUFFERING, SOMETHING TUGS ON YOUR HEART...

Antonio Patterson can recall a number of times throughout his life where he felt a pull towards medicine, but one moment in particular in 2016 led the now 50-year-old medical student to finally pursue his dream.

Patterson, who is an ordained minister, was on a medical mission trip in Haiti when his team was visited by a young boy who had been badly burned in a fire.

"When you're in that clinic and you see someone suffering, something tugs on your heart," said Patterson, who is now in his second year at NYIT College of Osteopathic Medicine at Arkansas State University. ***"He was just wailing, crying so hard. I was praying for him and trying to comfort his family, but I said to myself, 'Why can't you use your hands to physically help him?'"***

It was on that trip that Patterson circled back to a dream that began to take shape as a student at Ethel High School near Jackson, Miss.

Growing up, Patterson wanted to either play in the NFL or follow in the footsteps of his father and 11 uncles by pursuing a military career. But during his sophomore year, Patterson suffered a heart attack following a football game, and that medical condition derailed both of his preferred career paths.

"I buckled down and got into the books," Patterson said. ***"I really grew to love biology."***

Patterson attended Tougaloo College, a small university in Jackson, and studied biology. A short time later, he felt called to ministry, which led him to focus more on theology than his original course of study.

Over the next two decades, Patterson pastored churches and used his biology degree to teach junior high and high school science. He also held part-time positions as an x-ray tech and medical assistant, which kept medicine close to mind.

Shortly after his trip to Haiti, Patterson moved to Bentonville to be close to his wife's family. Approaching 50 years old with a wife and three kids, Patterson spent much of his spare time studying for the MCAT after his days of teaching at Lincoln Junior High School.

Soon, his principal encouraged him to pursue a master's program that would allow him to get into educational administration. The program was at Arkansas State University, which provided another moment of what Patterson believes was divine intervention.

"I got to Jonesboro and learned that there was a medical school on the A-State campus," Patterson said. ***"I was grateful for the opportunity to study to be a principal, but I knew medicine was my calling at this point."***

He was particularly drawn to NYITCOM at A-State's rural focus, and he reached out to the school's leadership to express his interest. After completing NYITCOM's Master of Biomedical Sciences program in 2021, Patterson was accepted into the DO program in 2022, more than 30 years after he graduated high school.

Patterson wants to pursue family medicine because of the many hats the specialty allows a physician to wear. While his journey is unique, Patterson believes he's much more focused than he would have been had he started medical school when he was younger.

"I feel crazy some times," Patterson jokes. ***"I think it's more about the timing that life has for you. You can't get around that. I'm at a point where I'm thinking about my legacy, and I want it to be one where I fulfilled my calling and was able to help others through medicine. I'm very grateful for an opportunity to pursue that."***

ARCOM STUDENTS ENGAGE IN MASS CASUALTY DRILL ON CAMPUS

The Arkansas College of Osteopathic Medicine (ARCOM) recently conducted a Mass Casualty Drill on its campus, aiming to enhance the crisis management skills of medical students through invaluable training. This immersive initiative was planned and organized by the Arkansas Colleges of Health Education (ACHE) Center for Clinical Skills Development (CCSD). The drill was specifically centered around simulating an active shooter scenario, offering students a realistic and hands-on experience to better prepare them for emergency situations.

The event saw active participation from ARCOM medical students, as well as nursing students from the University of Arkansas – Fort Smith. The collaboration extended to include crucial partnerships with local emergency management entities such as the Sebastian County Emergency Management, Sebastian County SWAT Team, Fort Smith Police Department, Mercy Lifeline, Mercy family medicine residents, Baptist ER physicians and fellows. Together, they engaged in a realistic simulation involving live actors and mannequins to mimic the chaos of a mass casualty incident.

The primary objective of this comprehensive exercise was to enhance the skills and coordination of future healthcare professionals. By immersing themselves in a simulated active shooter scenario, students had the opportunity to work seamlessly alongside local emergency responders and law enforcement agencies. This hands-on experience proved invaluable in preparing them to respond effectively to unforeseen emergencies that may arise in their future healthcare careers.

The drill was a multi-faceted learning experience that provided students with exposure to the complexities of managing a mass casualty incident. From triage and medical interventions to efficient communication and collaboration with other healthcare providers and law enforcement, participants gained practical insights that are challenging to simulate in a traditional classroom setting.

BY IMMERSING THEMSELVES IN A SIMULATED ACTIVE SHOOTER SCENARIO, STUDENTS HAD THE OPPORTUNITY TO WORK SEAMLESSLY ALONGSIDE LOCAL EMERGENCY RESPONDERS AND LAW ENFORCEMENT AGENCIES.

UAMS: STUDENTS HOST HEALTHY COOKING CLASSES – WITH HELP FROM MEFFA

Turkey roulade with apple cider gravy. Browned butter mashed potatoes. Pumpkin roll cake.

Those were just a few of the things whipped up by UAMS College of Medicine students at a cooking class hosted by the Integrative Medicine Interest Group just before Thanksgiving.

One might never guess the dishes all had a healthier twist, were it not for the tips provided by the instructor from the UAMS Culinary Medicine Program and the student group's mission to help fellow students, future patients and others live more healthful lives.

The group's mission was aided by a $2,500 grant this year from the Medical Education Foundation for Arkansas (MEFFA) to relaunch the interest group's nutrition-conscious cooking series, which also has received past support from MEFFA. The student group followed up the Thanksgiving-themed event with a class in December featuring traditional holiday recipes from Latin America, and future classes will focus on other healthy cuisine from around the world.

"Our group is very excited to bring back our cooking classes," said College of Medicine senior and group President Sairi Zhang. "We were last able to do these classes in 2020, and they were very popular with medical students. Unfortunately, COVID put a temporary stop to things."

"Thanks to MEFFA, we were able to restart the series," Zhang said. "*The classes are a great way for medical students to unwind while learning about healthy cooking, which they can use in the future to educate the patients in their care."*

The UAMS Culinary Medicine program has expanded substantially in recent years. In 2021, UAMS opened its own state-of-the art teaching kitchen on the first floor of the Donald W. Reynolds Institute on Aging. The facility provides ample space for events such as the Integrative Medicine Interest Group's cooking series as well as interprofessional education courses, an elective for fourth-year medical and pharmacy students, and culinary medicine education that has been integrated into the third- and fourth-year medical school curriculum.

"The grant for the cooking series is just one example of the countless ways the Arkansas Medical Society and MEFFA have supported medical education and enriching experiences for our students over many decades," said James Graham, M.D., executive associate dean for academic affairs in the UAMS College of Medicine. *"We are profoundly grateful."*

MEFFA has supported innovative faculty teaching initiatives, visiting lectures, student scholarships and more. MEFFA is also a sponsor of UAMS' annual "Teach the Teacher" conference for faculty, which will be held for the 15th year in January, showcasing educational research and sessions focusing on the theme of cultural intelligence in health education.

UAMS medical students prepare multiple dishes for a healthier holiday dinner. Pictured (front to back) are freshman Amber Alzufari, junior Vanessa Weidling and freshman Urooj Hudda.

Sophomore medical student Emily Joy Seminara cracks eggs for a pumpkin roll cake

Freshman medical students Reyna Gomez (front) and Leo Cooper receive guidance from UAMS Culinary Medicine Instructor Alyssa Frisby while preparing a turkey roulade. Down the counter are sophomore Safi Alsebai and junior Humam Shahare, while freshman Megan Hunter works at the other counter.

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PRESERVING HISTORY

HISTORY OF HEALTH AND DISEASE AND THE VARIOUS HEALING PROFESSIONS IN ARKANSAS

SAM TAGGART, MD

WITH THIS ARTICLE WE ARE BEGINNING A SERIES LOOKING AT THE HISTORY OF HEALTH AND DISEASE AND THE VARIOUS HEALING PROFESSIONS IN ARKANSAS. IT IS IMPORTANT TO PUT OUR HISTORY INTO PERSPECTIVE BOTH FROM A REGIONAL AND WORLD BASIS.

THOSE WHO ASSIST THE SICK AND DYING HAVE A HAVE A LONG AND COMPLEX HISTORY. THE IMPULSE TO PROVIDE NOURISHMENT AND HEALING FAR PREDATES THE PRESENCE OF THE HUMAN SPECIES IN THE PLACE WE CALL ARKANSAS.

Photo: Sloan Site in East Arkansas

THE PICTURE THAT IS EMERGING IS THAT MANY IF NOT MOST OF THE COMMON DISEASES WE FACE TODAY HAVE THEIR ORIGIN IN THIS DISTANT PAST.

In all probability, there were isolated hunting parties that roamed this part of the Mississippi Valley as early as 12,000 BCE. The first documented evidence of permanent inhabitants is a small graveyard in east Arkansas on a bluff above the Cache River called the Sloan Site. Dated at 8500 BCE, it was discovered in 1974 and is one of the oldest known cemeteries in the western hemisphere. These late Paleo or early Archaic peoples clearly were continuing the traditions established by their distant ancestors.

Who were these people? What kind of problems did they face? What tools did they have to face those problems? How did they respond? With the advent of carbon dating and DNA-sequencing the answers to these questions are emerging. If this text is re-written in twenty years many of the answers might well be different.

There do not appear to have been any human inhabitants in the Central Mississippi Valley prior to 14000 years ago but the evidence that is slowly being brought to light about earlier human activity in Africa, the Middle East, Europe, and Asia give strong hints to the evolution of human nutrition, the religious impulse, and their fellow traveler—healing and health. Most authorities agree that the priest/healer emerged as one person. In many cultures these individuals were women. This makes good sense when we look at the nature of work distribution in hunter/gatherer societies.

There is a great deal of controversy as to what these healers were called. The term Shaman is a term that had its beginnings in the peoples of Siberia. Icons with religious/fertility/healing significance in Western Europe, Central Europe, the Levant region in the Middle East, India, China, and Siberia have been well documented. The Virgin Statues of Fertility in France and Austria have clear mixed religious and fertility messages. A well-preserved female Shaman skeleton buried with a variety of tools and icons of the trade was found just in the last few years in the near Middle East dating to 12,000 years ago.

It is reasonably clear that we began as a species that partook of low-hanging ripe fruit and carrion. At some point, we picked up a stick to protect ourselves. We eventually began to use it as a tool and a weapon; this greatly extended the range of usable environments. As population density increased, the human populations began to extend; estimates are that, based on the available food stuffs in an environment, hunting/foraging/gathering peoples required on average 3.5 square miles per person to sustain themselves.

The history of the human species extends through a series of Ice Ages; with waves of population growth waxing and waning as the sheets of ice allowed. It was during the last of these Ice Ages that humans appear to have made their trek across Beringia and into what would be the Americas.

So, what type of health problems would these primitive people have faced? The seeds of destruction are built into our systems. Diseases of wear and tear that we label as degenerative were present in dinosaurs and other living creatures long before we emerged. With changes in DNA comes the emergence of cancers. Archaebacterial agents that are the ancestors of common bacteria and viruses we face today were present millions of years ago. The picture that is emerging is that many if not most of the common diseases we face today have their origin in this distant past.

Throughout the Archaic Period (8500BCE-600BCE), there were small numbers of humans living in the Central Mississippi Valley, Ozark, and Ouachita mountains. For most of this time, these small bands of people were egalitarian with each man an encyclopedia of survival. By the Late Archaic period, population numbers had begun to increase, sedentism and agriculture with trade were emerging. It is reasonable to speculate that the first people to identify themselves as full-time healers evolved in this same timeframe. It was during this time that stone effigies and tools used by healers around the world began to appear in the Mississippi and Ohio River valleys. Archeological artifacts such as a hollowed out human femur thought to have been used as a sucking or blowing pipe, stone smoking pipes, effigies of humans taking on the form of protective animals are all indications of efforts to intervene in health and disease.

With no written records, it is difficult to be certain about timing but by the mid-17th century CE, the indigenous people of the people of the Central Mississippi Valley had developed a complex pharmacopeia and a number of surgical/orthopedic procedures that evolved over time. They had at their disposal a variety of biologic simples (herbs) and crude surgical techniques such as the opening of carbuncles, scarification of infected wounds, trepanation, amputations, and the setting of fractures. It is hard to date but the use of mineral-laden waters and clays were probably used as therapeutic tools as well.

When the Europeans arrived, they brought with them a variety of different tools and treatments. Over several centuries, the two groups borrowed freely from each other.

Photo: Reprinted with the permission of the Arkansas Archeological Survey.

BOARD MEETING MINUTES

MINUTES OF THE ARKANSAS MEDICAL SOCIETY BOARD OF TRUSTEES MEETING

Wednesday, November 1, 2023 | VIA Zoom

The Arkansas Medical Society Board of Trustees met via zoom on November 1, 2023. AMS Board Members and Past President's attending were Drs. Seth Barnes, Dale Blasier, Sam Bledsoe, John Bouldin, Willard Burks, George Conner, Anthony Davis, Jacob Dickinson, Candace Franks, Matthew Haustein, James Hunt, Anthony Johnson, Edward Jones, Shaletha Jones, Sujit Kotapati, Riley Lipschitz, Randy Maddox, Issam Makhoul, Nirvana Manning, Tim Paden, Naveen Patil, Mark Ramiro, Carolyn Reeves, Jeremiah Rutherford, Alan Schumacher, Courtney Sick, Bala Simon, Kathryn Stambough, Olivia Tzeng, Tobias Vancil, Randy Walker, Mark Wren, Stacy Zimmerman, Omar Atiq, Amy Cahill, David Jacks, Chad Rodgers and Danny Wilkerson. AMS staff present were David Wroten, Scott Smith, Mary Ann Mansfield, Alanna Scheffer, Laura Hawkins, Tereasa Holmes, and Nicole Richards. AMS Legal Counsel present was Mike Mitchell.

Chairman, Dr. Seth Barnes called the meeting to order and the following business was received and transacted:

1. The Chair greeted everyone and called for an Executive Session to review the AMS Finance and Audit Committee Recommendations. The Chair asked everyone who is not a trustee or a past president to leave the meeting. The recommendations of the committee were approved.

2. The Chair welcomed everyone back to the board meeting and reminded all in attendance of their responsibility to declare and disclose any conflicts of interest.

3. Dr. Barnes presented the minutes of the August 23, 2023 meeting and asked for a motion to approve. There was a second, and the minutes were approved as presented. Dr. Barnes also asked for a motion to approve two separate Executive Committee Actions (attachments #3 and #4). There was a second, and these actions were approved as presented.

4. Shaletha Jones, MD was nominated to fill Dr. Mimo Lemdja's unexpired term in District 5. Dr. Jones' term would begin immediately and last until May of 2025. There was a second, and the nomination was approved.

5. Dr. Barnes called on Mr. David Wroten, Executive Vice-President, to present his report. David mentioned that AMS would be celebrating its 150th anniversary in 2025 and called for a committee to be formed to plan activities. Several board members were interested. AMS staff will follow up. The Executive Vice-President's report was accepted as presented.

6. Dr. Barnes called on AMS President Dr. Tony Johnson to present the proposed policy statement – Obesity, Addiction, and Mental Health Disorders. Following discussion there was a motion to adopt the policy as a statement of the Arkansas Medical Society. There was a second, and the motion was approved.

7. Dr. Barnes called attention to upcoming meetings of the AMS Board of Trustees. The next meeting will be February 7, 2024 at 5:30 via zoom. The AMS Annual Session is scheduled for May of 2024 in Little Rock.

8. Seeing no other business, Dr. Barnes adjourned the meeting.


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AMS EXCLUSIVE MEDICAL MALPRACTICE PARTNER: SVMIC

CLOSED CLAIM ANALYSIS: TRUST THE PROCESS

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As an avid sports fan, I routinely hear athletes mention that they need to "trust the process." The origin of "trust the process," as used ubiquitously in sports, apparently goes back to 2013 when the Philadelphia 76ers' new general manager, Sam Hinkie, advocated an emphasis on process over outcome in his first speech with the team. The 76ers' fans coined the phrase during a rough time for their team and it essentially means, "things may look bad now, but we have a plan in place to make it better." Dr. Wexler* had to be reminded to "trust the process" when he faced his first health care liability action in the same year "trust the process" was coined by the 76ers' fans.

The patient in Dr. Wexler's lawsuit was a 75-year-old female who had an MRI that showed a high-grade partial thickness tear of the tendon in the right shoulder. Based on the results of the MRI, Dr. Wexler recommended and performed a right shoulder hemiarthroplasty. Dr. Wexler encountered a bleeding vessel during the surgery, which he chose to tie off with a suture. There was a small amount of blood loss, but the rest of the surgery was uneventful. Dr. Wexler, per his routine, checked the patient's pulses before he left the operating room. Nursing notes that were charted immediately after the surgery recorded brisk capillary refill and strong pulses. The patient's radial pulses were also checked by the nursing staff repeatedly throughout her hospital admission following the surgery. The patient was discharged from the hospital three days following the surgery with no circulation issues documented in the medical chart.

A circulation problem was first documented twenty-eight days later, at which time the patient presented to her primary care physician, Dr. Green. Dr. Green referred the patient to Dr. Sunderland, an interventional radiologist. Dr. Sunderland ordered a CTA and angiography, which showed an occlusion of the axillary artery at the axillo-brachial junction with collaterals. Dr. Sunderland concluded that the patient had a chronic occlusion of the axillo-brachial junction and referred the patient to Dr. Castro, a cardiovascular and thoracic surgeon.

Dr. Castro performed a right axillary exploration on the patient. Dr. Castro's operative note indicated that there was a large amount of scar tissue at the point of transition for the brachial to the axillary artery, and he also noted that a silk stitch was "through the artery" approximately 4 mm proximal to this. The artery was noted to be completely occluded and scarred down for approximately 1 cm. Dr. Castro performed an end-to-end anastomosis and circulation was restored by the graft. Unfortunately, the patient later developed a thrombus.

The patient then had another CTA of her right upper extremity, which showed that the right axillary artery was again occluded. To address this, Dr. Castro performed a thrombectomy of the axillo-brachial, ulnar, and radial arteries by axillary incision, and a brachial-to-brachial bypass with cryopreserved vein. Following the surgery, Dr. Castro described an excellent radial pulse.

The patient later commenced a health care liability action against Dr. Wexler alleging that Dr. Wexler deviated from the standard of care, in part, "by placing a stitch/suture in/through the axillary artery at the axillo/brachial junction with collaterals." The patient claimed she had significant loss of sensation and diminished use of her right arm and hand as a result of the alleged damage to the vessel.

Defense counsel for Dr. Wexler reported that upon first meeting with Dr. Wexler, he seemed to have the impression that he would be automatically liable simply for placing the stitch. Defense counsel discussed with Dr. Wexler that the occurrence of the complication itself does not establish negligence; instead, the circumstances of his placement of the stitch would dictate whether the placement was negligent. In other words, Dr. Wexler needed to "trust the process." Although things looked bad from Dr. Wexler's personal view, his defense counsel was already developing a solid defense plan.

It was apparent, however, that Dr. Wexler was anxious about the litigation process. Upon recommendation of defense counsel, a witness consultant was engaged to assist Dr. Wexler in preparing for his deposition and trial testimony. After first meeting with Dr. Wexler, the witness consultant noted that he was completely "crazed" about the lawsuit and that he had a hard time thinking since he was so anxious about the case. The witness consultant noted that Dr. Wexler, more than anything, needed confidence, hope, and a plan. Again, he needed to "trust the process."

DEFENSE COUNSEL ARGUED THAT ALTHOUGH THE STITCH MAY HAVE ACCIDENTALLY ENTERED A PORTION OF THE AXILLARY ARTERY, DOING SO WAS NOT A DEVIATION FROM THE STANDARD OF CARE.

The case eventually proceeded to trial. During trial, the patient's counsel attempted to prove that Dr. Wexler placed the stitch through the lumen of the axillary artery and tied down the stitch, which caused the axillary artery to occlude. Defense counsel argued that had Dr. Wexler placed a stitch through the lumen of the axillary artery and tied down the stitch, the occlusion and patient's circulation problem would have been apparent almost immediately; instead, the first documentation of any circulation problem was twenty-eight days after the patient was discharged from the hospital. The proof offered by the defense showed that Dr. Wexler encountered bleeding from a collateral branch vessel off the axillary artery that was avulsed by use of a retractor during the procedure. Defense counsel argued that Dr. Wexler, consistent with the standard of care, placed a suture around the branch vessel to control the bleeding. Defense counsel conceded that the stitch did, in fact, lead to the occlusion of the axillary artery twenty-eight days later; however, the occlusion was not due to a placement of the stitch through the lumen of the axillary artery as argued by the patient's counsel. Defense counsel argued that although the stitch may have accidentally entered a portion of the axillary artery, doing so was not a deviation from the standard of care. The source of the bleed was deep within the surgical site, visibility was limited, and the suture unfortunately encountered the axillary artery despite the best efforts of Dr. Wexler to avoid doing so. Furthermore, with the assistance of defense counsel and the witness consultant, Dr. Wexler performed admirably and confidently on the stand at trial in defending his care and treatment of the patient. The jury deliberated for one-and-a-half hours and returned a verdict in favor of Dr. Wexler.

Being accused of medical negligence is almost always stressful for a healthcare provider. Although the litigation process is painfully slow, it can quickly wear down a healthcare provider both mentally and physically. For Dr. Wexler, the anxiety from being sued escalated quickly as he believed he was liable simply for placing the stitch. You should be mindful, however, as defense counsel discussed with Dr. Wexler, that an injury alone does not raise a presumption of negligence. Although things seemed bad from Dr. Wexler's perspective when he was served with the patient's Complaint, his defense counsel formulated a defense plan to make things better. Ultimately, defense counsel secured a verdict in favor of Dr. Wexler because Dr. Wexler trusted his defense counsel, trusted his defense counsel's plan, trusted the witness consultant's plan, and trusted his own care and treatment of the patient – the process worked.

To learn more about SVMIC's strong legal defense, contact Sharon Theriot at Sharon.Theriot@svmic.com or 870.540.9161.

TRUST THE PROCESS

AMS CORPORATE SPONSOR: PANACEA FINANCIAL

DO STUDENT LOANS AFFECT MY ABILITY TO BECOME A PRACTICE OWNER? TO BECOME A PRACTICE OWNER?

As a bank that lends specifically to doctors, we at Panacea Financial often get asked, "Will my student loans prevent me from buying or opening my own medical practice?"

Physicians often take on a lot of student debt, graduating with an average of about $241,600[1] in debt, which can take a considerable amount of time to pay off.

Because of high debt, many physicians don't consider practice ownership to avoid taking on even more debt. In reality, student loans don't prevent you from becoming a practice owner, and practice ownership could help you pay down your debt faster.

WILL STUDENT LOANS PREVENT ME FROM OWNING A PRACTICE?

To answer simply, no. Student loans won't prevent you from owning or partnering in a practice, but they do play a role in loan approval because of debt-to-income ratio and credit score, which are used to determine lending eligibility.

HERE'S HOW THESE FACTORS IMPACT LENDING ELIGIBILITY:

IMPACT OF STUDENT LOANS ON DEBT-TO-INCOME RATIO

A debt-to-income ratio is a financial measure used by lenders to compare a borrower's debt payments to their income. The lower a borrower's DTI ratio, the more attractive they will appear to a lender. A high monthly student loan payment can increase your DTI, making you a less appealing candidate for a practice loan.

To decrease your DTI, consider reducing your monthly student loan payment through options like enrolling in an income-driven repayment plan[2] for federal loans.

Refinancing[3]* is another option that may lower payments but isn't suitable for everyone. New graduates often consider refinancing federal loans, but it can increase both monthly payments and the debt-to-income ratio.

**If you're aiming for Public Service Loan Forgiveness or income-driven repayment, avoid refinancing federal student loans.[3]*

IMPACT OF STUDENT LOANS ON CREDIT SCORES

Another element that affects a lender's assessment of your creditworthiness is your credit score. Credit scores are categorized as: excellent (850 to 800), very good (799 to 740), good (739 to 670), fair (669 to 580), and poor (579 to 300). If you have a low credit score, you may be denied a loan, be offered a higher interest rate, or be given less favorable terms.

Timely payments on student loans can positively impact your credit score, but missing payments may lead to a decrease. To increase or maintain your credit score, be sure to make on-time payments.

If your score has suffered due to missed payments, it usually takes a minimum of six months of on-time payments to see improvement. Setting up automatic payments could help you avoid missing payments.

Maintaining a strong score keeps your financial options open, allowing you to open a practice if you decide to.

SHOULD I TAKE ON MORE DEBT TO OWN A PRACTICE?

When becoming a practice owner, you may be hesitant about taking on more debt in addition to your existing student loan debt, but incurring debt for practice ownership is not necessarily a bad thing.

Both student loan debt and a practice loan are investments in your future. Having a clear business plan and a student loan repayment plan are essential to managing your debt load well.

Additionally, becoming a practice owner could help you pay off your debt quicker. Becoming a medical practice owner means you will likely receive additional cash flow, giving you the leeway to pay off student loans, save for retirement, or achieve other financial goals.

WORK WITH A LENDER WHO UNDERSTANDS DOCTORS

Though practice ownership can be intimidating, there are lenders who work specifically with physicians and understand the complex financial challenges that doctors face. Panacea Financial works exclusively with doctors to help them achieve their financial goals – including practice ownership!

Find AMS member-exclusive discounts on practice loans at **https://panaceafinancial.com/our-partners/ams-members/**.

Sources

1. https://educationdata.org/average-medical-school-debt
2. https://panaceafinancial.com/resources/refinancing-medical-dental-vet-school-loans/
3. https://panaceafinancial.com/resources/a-doctors-guide-to-refinancing-student-loans/

ADDITIONAL

MENTAL HEALTH SCREENING PROGRAM AVAILABLE FOR HEALTHCARE WORKERS

The Arkansas Medical Foundation and the Arkansas Medical Society announce the availability of a new mental health screening program for physicians and other healthcare workers. The Interactive Screening Program (ISP) connects individuals to mental health services before crises emerge. This is a no cost, anonymous, voluntary screening program.

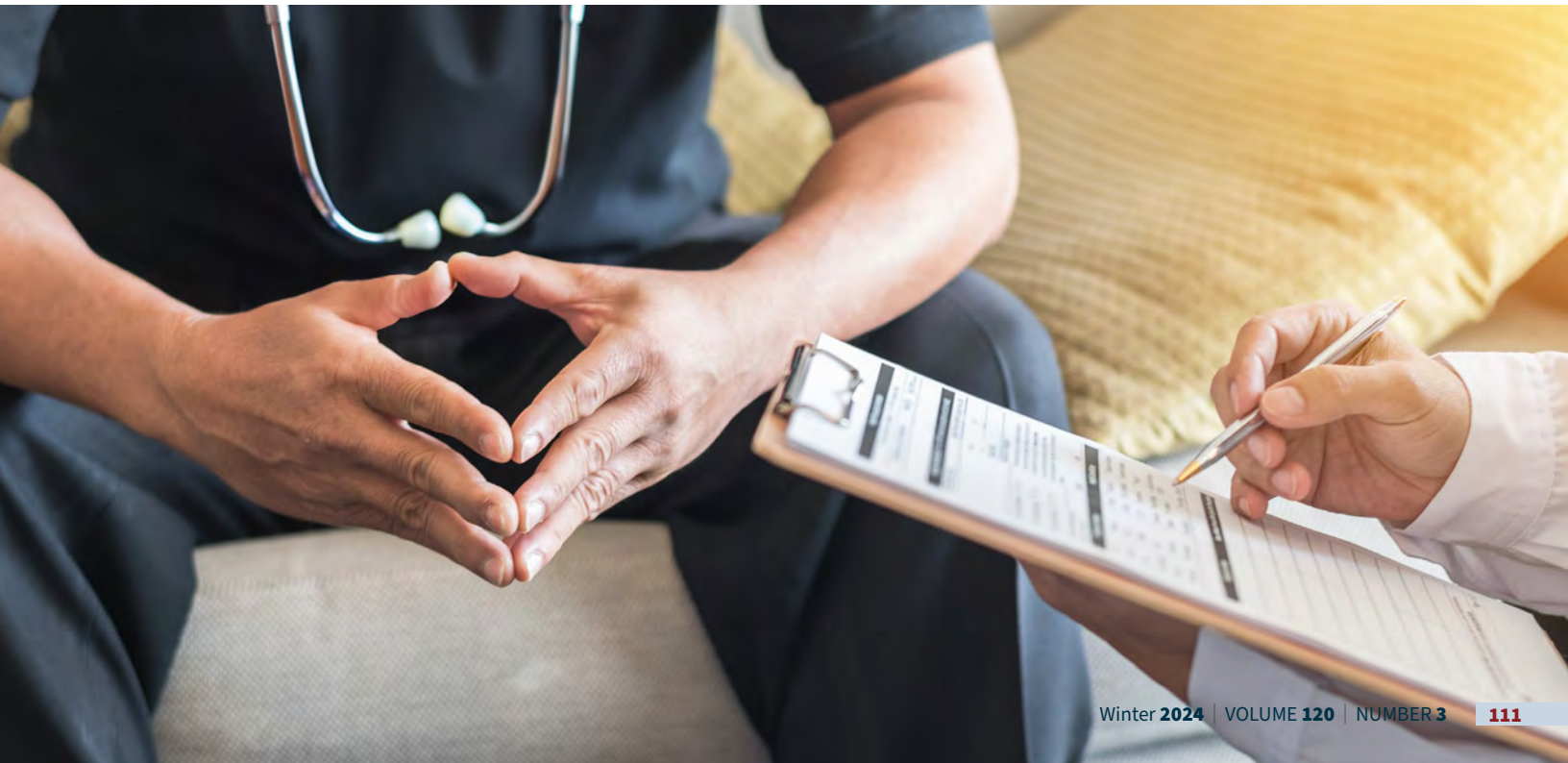
The Arkansas Professional Screening Questionnaire is available at no cost to licensed healthcare professionals or healthcare professionals in training in Arkansas. The first step is a voluntary and completely anonymous questionnaire designed to help you assess your current state of mental health and well-being.

Once completed, a licensed mental health professional will review your questionnaire and provide you with a personalized response that includes, should you be interested in pursuing them, vetted services that are available throughout Arkansas. Taking this questionnaire cannot and will not result in any licensure board investigation or action.

Stress, anxiety, and the pressures of day-to-day life affect us all. Sometimes those pressures can negatively affect our happiness and disposition, our relationships with others, our job satisfaction, and even our feelings and beliefs about ourselves.

This is not an emergency response system or crisis intervention service. If someone is in crisis, they can call or **text 988**, chat **988lifeline.org** or utilize the additional crisis resources.

FOR MORE INFORMATION, GO TO HTTPS://ARKANSAS.PROVIDERWELLNESS.ORG OR SCAN ON THE QR CODE



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Get a quote at www.svmic.com

Together, we go further.

The practice of medicine is full of unforeseen challenges, and an experienced, proactive partner will help navigate them. As a premier provider of medical malpractice insurance, our in-house attorneys and unique array of tailored services are always at the ready to help you be prepared for what lies ahead.