JOURNAL
OF THE ARKANSAS MEDICAL SOCIETY
FALL **2025** VOLUME **122** NUMBER **2**

ANTIBIOTIC STEWARDSHIP IN ARKANSAS:

WE KNOW YOU KNOW... BUT DID YOU KNOW *THIS?*





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FROM THE PRESIDENT

IT'S BEEN AN EXCITING YEAR ALREADY!

As we head into fall, the Society is actively preparing for the year ahead. From planning next year's annual meeting to continuing our advocacy efforts and growing our membership, there is much to look forward to.

As we begin to build on the Society's 150-year legacy, I hope we can remain focused on our core mission: empowering physicians and improving medicine in Arkansas—for the benefit of the patients we serve. In working toward that mission, every voice matters and membership is a top priority. We encourage you to share the value of AMS with your colleagues, both members and prospective members. Let's grow this year into an even stronger, more connected medical community.

Also in this issue, we take a thoughtful look at antibiotic stewardship, a topic that is personal to us and our patients. This month's cover story doesn't point fingers; rather, it highlights the role of misinformation or lack of knowledge of current data in prescribing practices. It's a reminder that good information leads to better care. We invite you to read the article and consider how awareness can support better outcomes for everyone.

BRADLEY BIBB, MD, MBA
2025-2026 AMS PRESIDENT



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Omar Atiq, MD
30-year AMS Member
Past President

"I completed my medical training out of state, and I have appreciated the opportunity to get to know and subsequently collaborate with providers in Arkansas through AMS."

Kate Stambough, MD, FACOG
Current AMS District Trustee

WHAT IS YOUR "WHY"?

Feel free to send your testimonial to **ams@arkmed.org.** You may see it in a future issue of The Journal or in other member or prospective member communications.

ANTIBIOTIC STEWARDSHIP IN ARKANSAS: WE KNOW YOU KNOW … BUT DID YOU KNOW *THIS?*

A FRESH LOOK AT PRESCRIBING, PATIENT EXPECTATIONS, AND THE PHYSICIAN'S ROLE IN IMPROVING OUTCOMES

CASEY L. PENN



ANTIBIOTIC RESISTANCE IS AN INCREASING THREAT TO PATIENT SAFETY. WHILE IT MAY FEEL LIKE PREACHING TO THE CHOIR TO SAY THAT TO YOU—THE PHYSICIANS OF ARKANSAS—THE SOCIETY BELIEVES IT'S IMPORTANT TO SHARE HOW SIGNIFICANTLY THE DATA HAS SHIFTED IN RECENT YEARS. THE LATEST STATISTICS REVEAL A MORE TROUBLING PICTURE OF ANTIBIOTIC RESISTANCE AND PRESCRIBING PATTERNS IN OUR STATE—INFORMATION THAT COULD INFLUENCE YOUR PRESCRIBING DECISIONS AND YOUR APPROACH TO PATIENT EDUCATION.

"Antibiotics are powerful tools in the treatment of infections," wrote Kelley Garner, epidemiology manager for the Arkansas Department of Health. "However, after only 80 years of use, their effectiveness is beginning to wane. Antibiotic resistance has been identified as a major public health threat … the CDC estimates that in the U.S., there are more than three million resistant infections and that 48,000 of those affected will die as a result."

As an associate professor of medicine in the UAMS Infectious Diseases Division and medical director of the UAMS Antimicrobial Stewardship Program, Ryan Dare, MD, has developed a deep understanding of antimicrobial resistance. Having been instrumental in stewardship efforts focused on inpatient care – resulting in a 20% reduction in antibiotic exposure at UAMS and the Baptist systems – he is now turning his attention toward outpatient clinics with the goal of educating his fellow physicians and other providers in Arkansas.

According to Dr. Dare, the biggest challenge isn't knowing there's a problem. "Physicians are acutely aware of the threat of antimicrobial resistance," he said. "There's plenty of publicity on the impact of superbugs and a worry that all providers have that one day we may not have antibiotics that work."

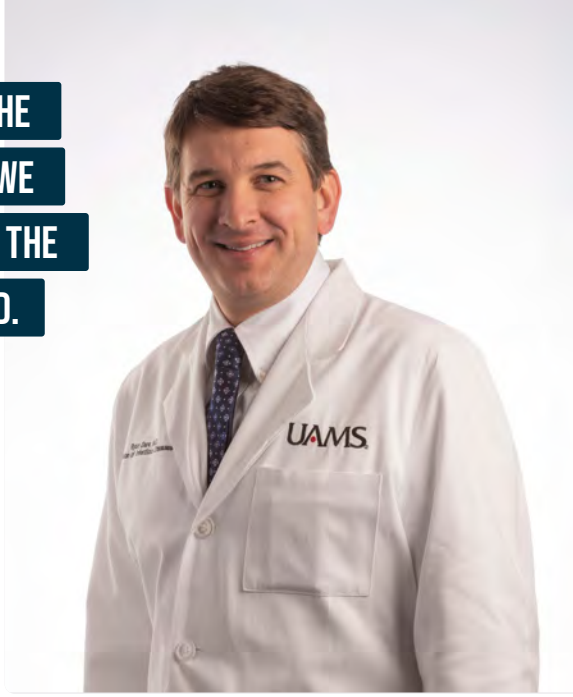


Rather, he proposed, "It's about understanding the gravity of the problem so we can take action to improve the odds and reduce the spread."

A PROGRESSING CHALLENGE – GLOBALLY AND IN ARKANSAS

Resistance has increased rapidly in the past decade. "Ten years ago, less than 1% of certain gram-negative bacteria living in our gut would resist basic antibiotics like cephalosporins," Dr. Dare explained. "Now we're at about 20% cephalosporin resistance. In our most effective class of antibiotics, carbapenems, there was zero resistance to them 10 years ago. We're at about 3% now. Within 10 years, we've been forced to change what we must use and we're seeing infections that we truly don't know how to treat."

IT'S ABOUT UNDERSTANDING THE GRAVITY OF THE PROBLEM SO WE CAN TAKE ACTION TO IMPROVE THE ODDS AND REDUCE THE SPREAD.



The CDC reports that physicians and other providers in Arkansas collectively prescribe 1046 antibiotic prescriptions per 1000 Arkansans, a statistic that is far above the national average. "On average, every Arkansan gets at least one antibiotic prescription per year," said Dr. Dare, using himself to illustrate this scenario. "I haven't had an antibiotic in eight years. To balance me out – and I don't think I'm an outlier – there's someone who's had more than eight antibiotic prescriptions this year alone. We're 45th in the country in terms of prescribing per capita, making us an epicenter of resistance and antibiotic overuse for the country."

Lest we feel too badly about ourselves, he added that we're "in good company with our SEC brethren," with similar health metrics to Louisiana, Mississippi, Kentucky, Alabama, and Tennessee.

Like these states, Arkansas has fewer providers per capita, less access, and higher comorbidities, which leads to more severe infections and, in turn, more antibiotics. Noting how these challenges affect the culture and overall approach to patients, Dr. Dare said, "With fewer providers, it's further for patients to drive. If they drive two hours to see us, we're likely to prescribe more than when they come in from a block away."

It could also be that we're too polite about it. "In the Northeast, someone comes in and says, 'I need an antibiotic,' and the provider says, 'No. Next patient,'" supposed Dr. Dare, referencing research linking Southern hospitality to higher antibiotic prescribing. "In the South, we're more like, 'I hate that. Let me help. I got you.'"

Other studies suggest that older providers are more likely to prescribe antibiotics than younger providers. "In Arkansas, we struggle to recruit physicians and keep our graduating physicians in the state, and we have an older provider population," said Dr. Dare. At just 44, he lumps himself into that "older" population, since antimicrobial stewardship and resistance are contemporary issues. "I graduated from medical school in 2011 and residency in 2014. I never heard the term antimicrobial stewardship until my third year of residency. Previously, everything was, 'Have an antibiotic? Give it as much as possible.' The risks were not as obvious as they are now."

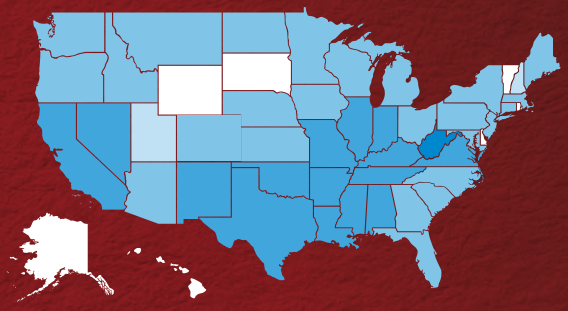
Sharing the risks associated with antibiotic exposure is a primary goal for Dr. Dare as he visits outpatient settings across the state, "We must appreciate that it's not a theoretical or international risk. It's a local and an individual patient risk. Giving a single patient an unnecessary broad-spectrum antibiotic can easily turn on resistance patterns in their microbiome that will then make those conditions more difficult to treat."

THE PRESCRIBER'S AND THE PATIENT'S ROLES

When asked, "Where does the buck stop?" Dr. Dare noted that stewardship isn't solely the responsibility of infectious disease physicians or advocates like himself; it lies with everyone who writes prescriptions—physicians, nurse practitioners, physician assistants, and others – and patients bear some accountability as well.

"It's easy for a third party to say, 'Don't prescribe just because patients ask,'

INPATIENT ANTIBIOTIC UTILIZATION (MEDIAN SAAR*) - 2023



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.988

ARKANSAS (46)
1.082

*STANDARDIZED ANTIMICROBIAL ADMINISTRATION RATIO

but when a patient comes in and says, 'I need an antibiotic and I'm not leaving without one,' it's difficult to refuse. Explaining why an antibiotic may not be appropriate and the growing data on side effects and risks can be nearly impossible when 30 other patients are waiting, you're behind schedule, and your kid's baseball game is at 4:30."

Elaborating on satisfaction as a determinant, Dr. Dare added, "The weight in that room is heavy. My incentives are tied to satisfaction scores, so there's pressure to keep everybody happy. I might want to acquiesce, thinking, 'What's really going to happen? You're probably going to be fine.'

"Even so, it's on all of us prescribers to carry the weight of prescribing appropriately. That includes not only when to prescribe, but also what and for how long. And then there's a responsibility for us as a community to help educate our patients. It can't just be one at a time in the exam room."

TOOLS FOR JUDICIAL PRESCRIBING AND A CLOSER LOOK AT DURATION

There are alternatives to routinely prescribing antibiotics. "There are tools to help us prescribe more safely than just saying 'No' or 'Less,'" said Dr. Dare, referencing the CDC's recommendations for delayed prescribing or callbacks. "As physicians, we're aware that 90% of upper respiratory infections are viral and don't need antibiotics. Telling patients to "come back" can seem unempathetic after missed work or school. Instead, tell them, 'This is viral. Antibiotics won't help—but here's what we can do: if you're not better in three days, call me and I'll call it in,' or 'Here's a prescription—fill it Saturday if you need it, not today.' Instead of, 'You have a viral infection, call me if you don't get better,' try: 'You have bronchitis. Here's your prescription for guaifenesin or a nasal spray for symptomatic relief.'

"Studies show that delayed prescribing and prescribed callbacks reduce antibiotic use while keeping satisfaction scores high. It's a small extra step that reduces unnecessary exposure."

When antibiotics are warranted, accurate duration is key. A 2021 meta-analysis published in Clinical Microbiology and Infection found that each additional day of antibiotics increases the risk of adverse events by about 4%. "Side effects include nausea, diarrhea, kidney injury, C. diff infection, and antibiotic resistance," said Dr. Dare. "As a healthcare community, we grossly overprescribe in duration. Most prescriptions are 10 or 14 days, while newer societal guidelines recommend three to five days. The American Academy of Pediatrics, American Academy of Family Practice, The Infectious Diseases Society of America, the American Thoracic Society, and the Pediatric Redbook all have recommendations for common outpatient infection treatment periods. At UAMS, we've been supporting a 'Five for Five' campaign, which recommends five days for these five common infections: urinary tract infections, skin soft tissue infections, pneumonia, bacterial sinusitis, and bacterial otitis media infections. Some infections do need 10 days, but when the five most common should be treated in five days, 10 days is doubling the risk of resistance and adverse events in our patients, in whom we have ingrained the message, 'Always finish your antibiotics.'"

For more on duration and comparison studies, Dr. Dare recommends the research and findings of Brad Spellberg, MD, an infectious disease physician who has made "shorter is better" his mantra and mission. "Dr. Spellberg's beautiful website (bradspellberg.com/shorter-is-better) is one long table that lists hundreds of randomized, controlled trials," he said. "When they started comparing duration for pneumonia, for example, they compared 14 days versus 10 and determined that 10 did as well as 14. Then they compared 10 versus eight, eight versus five, and even five versus three. It's amazing that we have randomized controlled trials doing all of that. What if somebody had just thought to compare 14 versus three to begin with, you know?"

5 FOR FIVE

CONSIDER 5 DAYS FOR 5 INFECTIONS

1. URINARY TRACT INFECTIONS
2. ACUTE RHINOSINUSITIS
3. OTITIS MEDIA
4. COMMUNITY ACQUIRED PNEUMONIA
5. CELLULITIS

BE ANTIBIOTICS AWARE
SMART USE, BEST CARE

Antibiotics aren't always the answer when you're sick. Ask your doctor how you can feel better.
For more information on antibiotic prescribing and use, visit **www.cdc.gov/antibiotic-use.**

CUE THE BILLBOARDS! AND OTHER IDEAS ON PATIENT AND COMMUNITY EDUCATION

When it comes to education and associated publicity, Dr. Dare would like to see Arkansas – and the nation – give antibiotic stewardship the weight that's been given to opiate awareness. "There is a parallel in our community between statistics related to opiates and antibiotics. In the U.S., there are three million multi-drug-resistant infections per year, with [nearly] 50,000 deaths," he explained. "There are also three million active IV drug, opiate, and fentanyl abusers, and 50,000 associated deaths each year.

"Where we have billboards preaching the dangers of taking, sharing, and, for providers, prescribing opiates, we don't have that same push for antimicrobial stewardship. If our patients, and Arkansans as a whole, could appreciate that taking an antibiotic unnecessarily, while not anywhere near injecting fentanyl, is something that, similarly, has a risk to hurt you and a further risk of killing you or somebody else, that would be effective. And it does. That's what our numbers say. We are losing patients to these infections, and what we do to patients with these fourth-line treatments is dangerous."

While we may not have a billboard campaign in Arkansas promoting antibiotic stewardship, there are, at least, a few tools available to help physicians educate patients. The CDC offers clinical resources that include posters for waiting rooms, letters of commitment to patient health, and other tools. (See sidebars and additional reading for more on toolkits.)

Curbing antibacterial resistance is clearly a daunting task for all prescribers, but Dr. Dare's progress and that of others proves that real change can be effectuated with education and concerted action. He is proud to be part of Arkansas's efforts to promote stewardship in outpatient clinics. "This outpatient focus is unique to Arkansas," he said. "We are leading this effort compared to other states. Add to that the support of the Arkansas Department of Health and the involvement of the Arkansas Medical Society, and Arkansas is making meaningful progress in antibiotic stewardship."

The AMS, with support from the Arkansas Department of Health, brings you this information as part of an ongoing Antibiotic Stewardship Campaign. If you'd like to be involved in spreading the message in your area, contact Mary Ann Mansfield at (501) 224-8967.

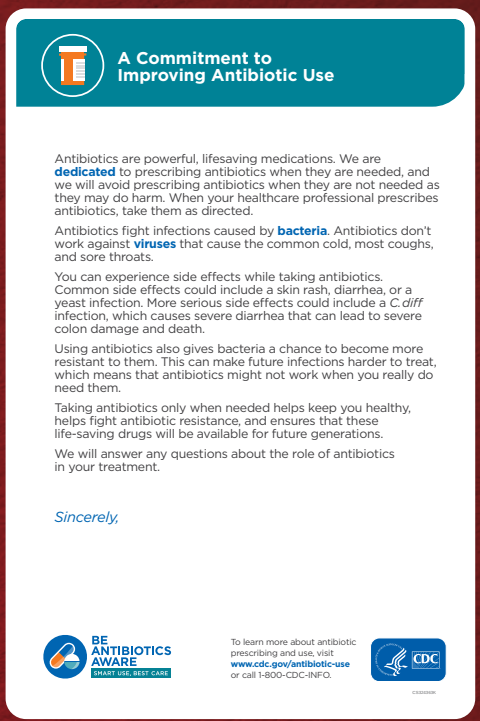
ADDITIONAL READING

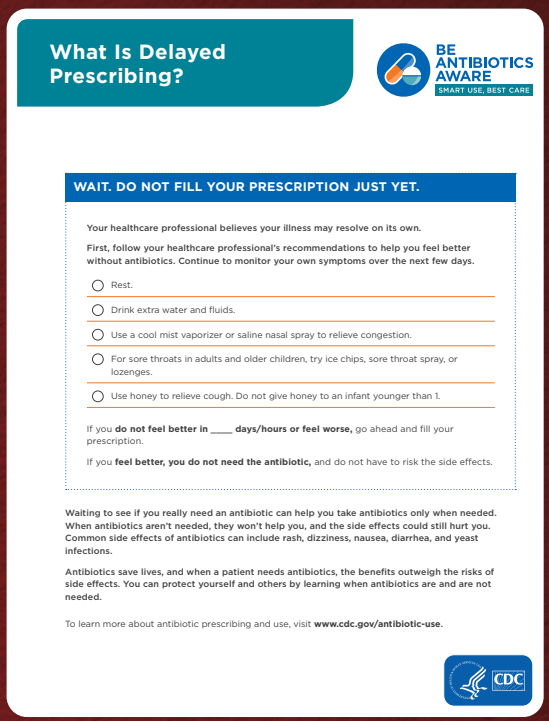
Schmidt ML, Spencer MD, Davidson LE. **Patient, Provider, and Practice Characteristics Associated with Inappropriate Antimicrobial Prescribing in Ambulatory Practices.** Infection Control & Hospital Epidemiology. 2018;39(3):307-315. doi:10.1017/ice.2017.263

Be Antibiotics Aware Partner Toolkit
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- **Corporate/Clinic ($5,000):** Recognition in the AMS Journal and on the AMS website, invitation to a legislator event, and four admissions to the Diamond Club Dinner with plaque.

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Please join today—before it's too late.

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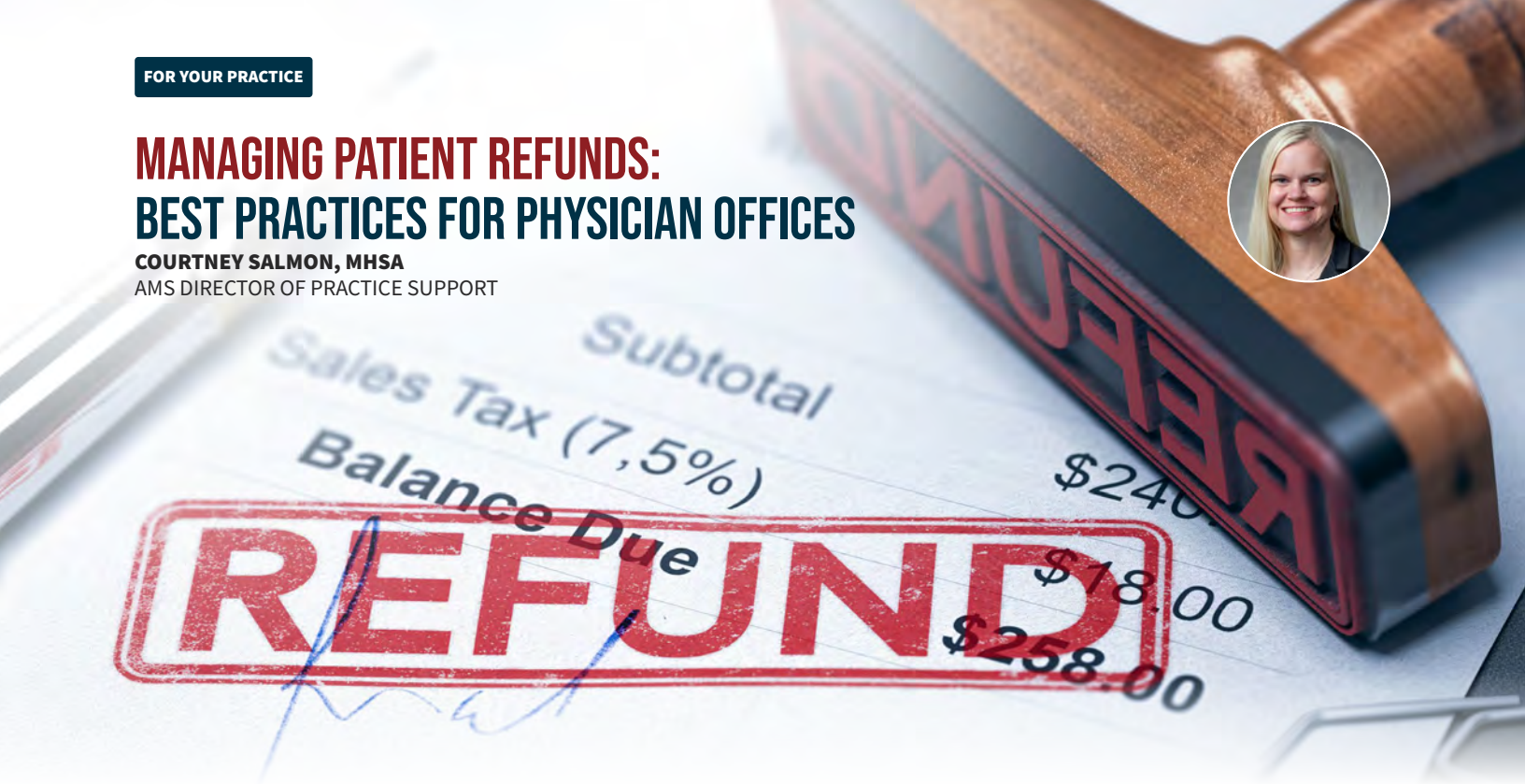
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FOR YOUR PRACTICE

MANAGING PATIENT REFUNDS: BEST PRACTICES FOR PHYSICIAN OFFICES

COURTNEY SALMON, MHSA
AMS DIRECTOR OF PRACTICE SUPPORT



THE HEALTHCARE REIMBURSEMENT PROCESS IS OFTEN COMPLICATED, LEADING TO CHALLENGES IN DETERMINING ACCURATE PATIENT FINANCIAL RESPONSIBILITY. AS A RESULT, OVERPAYMENTS ARE COMMON. WHILE PHYSICIAN OFFICES ARE RESPONSIBLE FOR ISSUING REFUNDS, INCONSISTENT OR DELAYED REFUND PROCESSES CAN NEGATIVELY IMPACT PATIENT SATISFACTION. THIS ARTICLE OUTLINES COMMON CAUSES OF PATIENT OVERPAYMENTS AND PROVIDES BEST PRACTICES TO ENSURE TIMELY, TRANSPARENT, AND EFFICIENT REFUND PROCESSING IN PHYSICIAN OFFICES.

WHY DO REFUNDS HAPPEN IN HEALTHCARE?

The healthcare revenue cycle process is characterized by a high degree of complexity, with multiple variables affecting patient balances—contracted rates, deductibles, coinsurance, copayments, coordination of benefits, and more. Given these intricacies, it is not uncommon for patients to overpay for services, either at the point of care or after receiving a bill.

PATIENT OVERPAYMENTS MAY ARISE FOR SEVERAL REASONS. SOME OF THE MOST COMMON INCLUDE:

- **Insurance claims processing sequence:** Claims from hospitals or other providers may be processed before the physician's, resulting in a change to deductible or out-of-pocket limits.
- **Front office miscalculations:** Staff may overestimate the patient's responsibility due to errors in benefit verification or a misunderstanding of plan design.
- **Coverage changes**: Patients may experience a change in insurance coverage between the time of service and claim adjudication.
- **Duplicate payments:** Patients may accidentally pay a balance more than once, especially when managing multiple statements or using automated payment systems.
- **Billing errors:** Coding or data entry mistakes can result in incorrect charges or balances.

THE IMPACT OF REFUND DELAYS

Although issuing refunds is a standard part of revenue cycle operations, the timeliness and transparency of this process can significantly impact patient trust. In some cases, refunds take months—even years—to process. This delay not only frustrates patients but also erodes their confidence in the physician's office.

To draw a parallel: if a retail company like Amazon took 12 months to issue a refund for a returned item, customer loyalty would suffer. Healthcare consumers today expect the same level of responsiveness from medical providers.

BEST PRACTICES FOR ISSUING PATIENT REFUNDS

1. VERIFY THE CREDIT

Before issuing a refund, billing staff should validate the credit balance to ensure it is accurate and not due to an unapplied payment, pending claim adjustment, or insurance refund request. Proper reconciliation is essential.

IF A RETAIL COMPANY LIKE AMAZON TOOK 12 MONTHS TO ISSUE A REFUND FOR A RETURNED ITEM, CUSTOMER LOYALTY WOULD SUFFER.

2. CLEAR DOCUMENTATION

Each refund should be accompanied by clear internal documentation that explains the reason for the credit. Staff should be able to confidently and accurately communicate this to patients, reinforcing transparency and professionalism.

3. LIMIT REFUND APPROVAL AUTHORITY

Establish internal controls defining who can authorize refunds, especially those over a certain dollar amount. This reduces the risk of error or fraud and maintains consistency in the refund process.

4. PRIORITIZE ELECTRONIC REFUNDS

When possible, use electronic payment methods to return funds to the patient. This method is faster, more secure, and generally preferred by patients over receiving a paper check. Leveraging technology also improves tracking and reporting of refund activity.

5. SET TIMELINES FOR PROCESSING

Establish internal timelines for refund issuance—ideally within 30 days of identifying the overpayment. Make this part of your billing department's standard operating procedures and monitor compliance regularly.

CONCLUSION

Issuing patient refunds is more than simply an administrative obligation. It's a reflection of a practice's integrity and commitment to service. By implementing clear protocols and prioritizing transparency and efficiency, physician offices can turn a potentially negative situation into a positive patient experience. In today's consumer-driven healthcare environment, this can make all the difference.



BY IMPLEMENTING CLEAR PROTOCOLS AND PRIORITIZING TRANSPARENCY AND EFFICIENCY, PHYSICIAN OFFICES CAN TURN A POTENTIALLY NEGATIVE SITUATION INTO A POSITIVE PATIENT EXPERIENCE.



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A CLOSER LOOK

Nobody Likes a Shot

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

If you want to get a pediatrician or other pediatric care health provider stirred up today, ask them about immunizations. We just had our annual state meeting of the American Academy of Pediatrics, and it was a central topic of people's conversations, many expressing their frustrations with increasing challenges. I recently attended Immunize Arkansas' annual meeting, which focused on addressing dis- and misinformation around vaccines. There is an overall grave sentiment about what is happening to immunizations. But what is also bothersome is what is happening with the perceptions of medical providers and our relationships with patients.

Nobody likes shots. I get that. I close my eyes and take a deep breath when I get my flu shot. I even turn my head the other way. Most of the time, I do not even feel it, but I often feel achy and more tired for the day. Although I get anxious, it is nothing too significant. But despite my firm belief in the tremendous benefits of getting an annual flu shot, I still get this child-like queasiness every time. I would prefer not to get a shot, but it's essential to my health and longevity, as well as others' good health. The flu shot reduces the spread, reduces the severity of disease, reduces complications from the flu, and reduces deaths. It prevents a missed day from work and decreased productivity for me, benefiting the greater economy. The benefits far outweigh the minuscule risk.

We believe in science. Science is so foundational to the practice of medicine that it is hard to understand the growing distrust of science. What played out in the early days of the pandemic, with not fully knowing how to control the spread, resulted in drastic interventions. Later in the pandemic, when the collection of sufficient data over time led to changes in recommendations thanks to gaining greater knowledge of the virus, to the rapid response in the development of vaccinations and medications, and to having clearer hindsight after the long months that became years, it becomes easier to see the public perception of science. The scientific method builds knowledge and experience and depends on independent and non-biased data review, leading to changes in older concepts and the introduction of new concepts, which all lead to a result that is something better. And when we know better, we do better. This results in better cancer treatments, new and innovative procedures with better outcomes, and new and effective interventions in prevention.

The truth is that imunizations have had one of the most powerful impacts on healthcare in the last century. The significant impact on saving lives and reducing morbidity by reducing preventable diseases has increased our lifespan and contributed to improved health. It has been so successful that the collective memory of these diseases has faded. The success of vaccines is now contributing to the growing disbelief in their safety and effectiveness among young parents.

When I started practicing pediatrics, I occasionally had a family that would push back on vaccines. In general, it tended to be families with above-average education. Most just wanted to discuss and sometimes wanted to pursue a delayed or alternative schedule. Few outright refused. Conversations were beneficial and led to a greater relationship with concerned families who came from a place of love for their child and fear of harm. Now, almost daily, I am confronted with families with

outright refusal of vaccines and a refusal to discuss. It comes from complete distrust of vaccines and medical providers. Maintaining that relationship of trust with families is hard, and it ultimately disrupts the entire doctor-patient relationship. Sometimes I wonder why those people even come to the doctor if they are not coming to us for advice and treatment. And it's no longer the most educated or knowledgeable of parents. Parents just hear so much that's bad and scary when it comes to vaccination. The amount of dis- and misinformation in the news, social media, and discussions with friends and family is overwhelming.

We know that a strong recommendation from a trusted physician is one of the best ways to ensure a family will vaccinate. This takes time and is taking longer to listen and address concerns with vaccine-hesitant families. Empathy goes a long way. But we must take some care of ourselves. Vaccine refusal or hesitancy isn't up to you alone to change. We must continue working to get good information out to patients through those avenues, as they get bombarded daily with opposing messages. We must accept that we do our best and keep moving forward. Change takes time, and we will experience some unfortunate tragedies as well. But getting mad or frustrated and arguing with people who refuse vaccines is not helping us move the needle (no pun intended). Continuing to build that trusted doctor-patient relationship is key.

The battle appears hard and at times feels unwinnable. Having a better understanding of how we got where we are now, we need to stick together to figure out where we go next. Professional organizations are now our primary source of medical information and treatment recommendations. What used to be "trusted" sources of information and health data are being dismantled. Never has it been more important for physicians to be involved in healthcare, participate in and support their professional associations, and participate in the political process.



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.









Son Keaton (20), daughter Kendall (14), husband Jeremy (married 26 years)

KASEY HOLDER, MD, MBA, MS

SPECIALTY:
Family Medicine

CITY:
Jonesboro

AMS MEMBER SINCE:
2000

WHY ARE YOU AN AMS MEMBER?
I became involved in the Arkansas Medical Society as a medical student to learn about healthcare policy, its potential impact on my future practice and patients, and how I could advocate for the health of our communities. As a family medicine physician, I have had the privilege of practicing in ambulatory, academic, and hospital-based settings in Arkansas. Now, as a physician executive for a healthcare system, I carry those experiences with me with the broader goal of shaping and improving systems of care. Regardless of the setting, the importance of physician advocacy remains. AMS provides a critical platform for physicians across the state to have a unified voice, influence policy, support one another, and advocate for our profession and patients.

WHAT ADVICE DO YOU HAVE FOR YOUNG PEOPLE CONSIDERING A CAREER IN MEDICINE?
Medicine is a rewarding career, but it can also be emotionally taxing. I would advise that people considering a career in medicine understand their "why" and practice self-care and stress management. Clarity of purpose and resilience are key to a successful and joyful career in medicine. I would also suggest that they pursue leadership training even if a formal leadership role is not desired or anticipated. This training will equip them with skills that foster more effective communication and collaboration with patients, families, colleagues, and the systems in which they will practice, ultimately increasing their impact as a clinician.

WHAT IS THE MOST CRITICAL HEALTHCARE ISSUE FACING ARKANSAS TODAY?
A number of serious and interconnected healthcare challenges face Arkansas today. Most critical is probably maternal and infant health. Unfortunately, Arkansas has some of the poorest outcomes in the country in this regard. This is largely a result of care access gaps related to provider shortages and insurance challenges. I am hopeful the recent legislation, funding, and support programs implemented will have a substantial impact in addressing these challenges.

DO YOU HAVE A FAVORITE QUOTE?
"How you do anything is how you do everything."

This reminds me to be intentional, set high standards, and bring consistent effort to all aspects of my life. That consistency creates discipline and habits that are, hopefully, the foundation for overall success and excellence.

WHAT DO YOU LIKE TO DO IN YOUR FREE TIME?
We like to travel. As a family, we enjoy NYC, Universal Studios, and snow skiing. I like to read, watch movies, and exercise (spinning, lifting) in my free time.

FAVORITE RESTAURANT:
An Italian restaurant in NYC—Piccola Cucina.

A SURPRISING FACT ABOUT YOU:
At 5'5", it might be surprising that I played Division 1 volleyball. Pound for pound, I was the second strongest on the team.

PRESERVING HISTORY

ARKANSAS HOSPITALS

PART 1

SAM TAGGART, MD



Helena Civil War Military War Hosptial

IN 1804, THE PLACE WE CALL ARKANSAS WAS AN UNPOPULATED WILDERNESS. EARLY ON, WHAT PASSED FOR COMMUNITIES WERE NOTHING MORE THAN WAYSTATIONS WHERE THE TRAILS CROSSED A RIVER OR STREAM. MOST OF THE MEN WHO CALLED THEMSELVES DOCTORS RODE CIRCUITS IN THE SPARSELY POPULATED COUNTRYSIDE SURROUNDING THESE SMALL COMMUNITIES. DURING THE FIRST HALF OF THE 19TH CENTURY, THE POPULATION DOUBLED EVERY 10 YEARS, AND BY THE BEGINNING OF THE CIVIL WAR, THERE WERE 438,000 PEOPLE IN THE STATE.

Before the Civil War, hospitals in the wilderness were often nothing more than pesthouses (plague houses or fever sheds) where the sickest were sent to die. These were used as a form of quarantine and were established during epidemics such as yellow fever, smallpox, and cholera. There are several newspaper references to temporary hospitals established in Little Rock in the 1830s and 1840s, dealing with smallpox and cholera. As late as the 1890s, Hot Springs established a pesthouse and cemetery, south of the city, along Hot Springs Creek, during a smallpox epidemic. A second form of hospital was established at Fort Smith in 1819 as a part of the military post. As a part of the original structures of the fort, a small hospital barracks (staffed by a nurse matron and a series of nurses) was established to deal with soldiers who were ill with malaria. The nurses were male soldiers who were recovering from illness themselves.

The first recorded civilian hospital in Arkansas was in the early 1820s and was composed of a series of huts in the side yard of Nathan Smith, MD's home in Southwest Arkansas. Dr. Smith had ascended the Red River to Hempstead County near the site of Old Washington. He built the cabin hospital as an attempt to keep the sickest patients from having to travel as they recuperated from a variety of illnesses.

In the 1850s, the U.S. Marine Service built a series of Navy hospitals up and down the Mississippi River. One such hospital was built in Napoleon, Arkansas, near Arkansas Post. The multi-story building was short lived because, like the community of Napoleon, it was consumed by the flood waters of the Mississippi River during the Civil War.

In the 1850s and 1860s, several monumental international changes occurred that dramatically changed the nature of hospitals in the wilderness. In the Crimean War of the 1850s, Nurse-Administrator Florence Nightingale began accumulating information on sanitation and changing hospital practices. She was able to demonstrate to the commanders that clean, well-fed soldiers healed faster and were able to get back to battle quicker.

With the outbreak of the Civil War, the Federal and Confederate Armies established Sanitary Commissions. The Federal Commission had a significant impact on the fighting abilities of the Union armies. The command structure of the Confederate Army was more challenging to convince. It is important to remember this was before the acceptance of the germ theory. **Military hospitals were generally considered hellholes. Most soldiers believed that admission to the hospital meant certain death.** There has been a good deal written about the horrible reputation of the military hospital in Helena. There were other military hospitals in towns like Fort Smith and Little Rock; there was a substantial facility on the grounds of St. John's College in Little Rock.

In the second half of the Civil War, freedman hospitals were established around the state for the freed slaves. Supplies were meager, medicine was nonexistent, and sanitation was atrocious. Records indicate that death rates were exceedingly high, and eventually these facilities were abandoned.

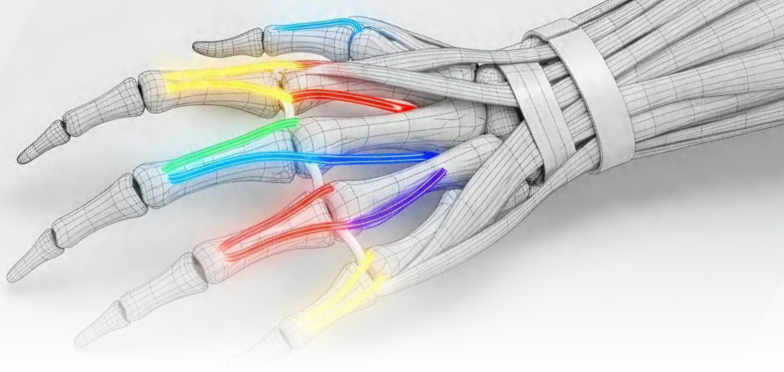
The end of the Civil War, the acceptance of the germ theory, and the move toward professionalism in the practice of medicine slowly changed the nature of hospitals.

Stay tuned to the Winter 2025 Journal for Part Two of this series of articles.

Napolean Hosptial



ARCOM STUDENTS LEARN FROM RESEARCH EXPLORING THE LASTING IMPRINT OF MOVEMENT



RESEARCHERS AT THE ARKANSAS COLLEGE OF OSTEOPATHIC MEDICINE ARE UNCOVERING HOW A LIFETIME OF MOVEMENT LEAVES LASTING MARKS ON OUR SKELETONS—INSIGHTS THAT COULD TRANSFORM HOW WE UNDERSTAND BOTH MODERN AND ANCIENT HUMAN ACTIVITY.

This innovative study is being led by ARCOM faculty members Lucyna Bowland, PhD; Joanne Peterson, PhD; and Caitlin Yoakum, PhD. In addition, a team of Doctor of Osteopathic Medicine (DO) students is investigating entheses—the sites where muscles attach to bone. "Because soft tissue doesn't preserve over time," Bowland explained, "scientists rely on these sites to reconstruct physical activity. These clues can even reveal traits like handedness in long-deceased populations."

To explore these patterns, the ACHE team uses 3D scanning technology to create precise digital models of hand muscles and their attachment points, especially those tied to thumb movement. Their goal is to answer this key question: Do larger or more prominent bone markings really reflect how often or how intensely a muscle was used?

This meaningful project blends research and education. Students take part in dissections, data collection, and digital modeling, thereby gaining hands-on experience that deepens their understanding of anatomy while contributing to fundamental scientific discoveries.

"This project deepened my understanding of anatomy by using 3D scanning to study how movement shapes our bones," said Joseph Howard, a second-year student and participant in investigations surrounding the study. "Collaborating with faculty strengthened my connection to ACHE's research community and built skills for my medical career. Our work shows how precise digital models can enhance education, preservation, and the study of human history."

"This project exemplifies the ACHE mission," said Bowland. "Our students are not just learning anatomy—they are contributing to scientific discoveries that connect human movement today with stories written in the bones of the past."

Findings could refine how clinicians assess skeletal injuries and help archaeologists more accurately interpret remains, offering a clearer view of lives lived centuries ago. For more information, visit **www.achehealth.edu.**

photos: Courtesy of ARCOM

OUR STUDENTS ARE NOT JUST LEARNING ANATOMY—THEY ARE CONTRIBUTING TO SCIENTIFIC DISCOVERIES THAT CONNECT HUMAN MOVEMENT TODAY WITH STORIES WRITTEN IN THE BONES OF THE PAST.





MEDICAL SCHOOL UPDATES

GETTING TO KNOW ALICE L. WALTON SCHOOL OF MEDICINE'S INAUGURAL CLASS



AWSOM Inaugural Class Members



AWSOM White Coat Ceremony

Alice L. Walton School of Medicine in Bentonville, Arkansas, welcomed its inaugural class of 48 medical students on July 14, 2025. During their first two months, students have learned fundamentals of medical education through active learning sessions, participated in community engagement activities across Northwest Arkansas, and gotten to know the faculty and career mentors who will guide them through the next four years.

The first week of class culminated in AWSOM's inaugural White Coat Ceremony, where students donned white coats for the first time and pledged to serve future patients with competence and care. At the ceremony, students heard from AWSOM Founder Alice Walton and AWSOM Founding Dean and CEO Sharmila Makhija, MD, MBA, about the school's vision for healthcare transformation in Arkansas and beyond.

AWSOM's inaugural class represents 19 states and 38 undergraduate institutions. One-third of students are from Arkansas, while 20% come from bordering states, and 15% are from rural areas. In a Time magazine profile by Alice Park, students shared what drew them to AWSOM, including the school's emphasis on nutritional health, novel technologies, and helping underserved populations.

AWSOM's curriculum integrates the arts, humanities, and whole health principles into a traditional allopathic medical education. The first class is building vital communication and observation skills through art-based education sessions at Crystal Bridges Museum of American Art, which AWSOM shares a campus with. Students are also learning the structure of the human body and developing clinical skills in the Anatomy Resource Center, Simulation Center, and other robust educational spaces.

AWSOM is currently accepting applications for the Class of 2030 through the American Medical College Application Service. AWSOM's public spaces, including a gallery, café, and rooftop park, will open to the community on November 3 of this year.

photos: Courtesy of AWSOM

MEDICAL SCHOOL UPDATES

A-STATE, NYITCOM PARTNERSHIP REMOVES BARRIERS FOR ASPIRING PHYSICIANS



(L to R) Eva Wilk, Kayne Wilson, and Madeline Farris are among several current medical students at NYITCOM who earned their undergraduate degrees at Arkansas State University. NYITCOM and A-State recently announced a new partnership that aims to increase the number of future physicians studying at both institutions.

Arkansas State University and NYIT College of Osteopathic Medicine (NYITCOM) at A-State recently announced the launch of the Freshman to Physician Pathway, a new opportunity for Arkansas students to secure early admission to medical school.

The initiative is designed to grow the number of physicians serving rural and underserved areas of Arkansas. To qualify, students must maintain a 3.5 GPA in science and overall coursework, complete all required pre-med classes, receive a favorable recommendation from A-State's premedical committee, and pass an admissions interview with NYITCOM faculty.

Students who meet these criteria will not be required to take the MCAT, significantly reducing the cost and complexity of applying to medical school.

"The path to medical school is challenging; however there are hurdles that can be overcome when we have strong academic partners at the collegiate level that are preparing the students for the rigor of medical education," said Dr. Shane Speights, dean of NYIT College of Osteopathic Medicine at Arkansas State. "Leveraging our higher education relationships creates a stronger university, medical school, and most importantly, future physicians."

Since opening in 2016, NYITCOM has graduated approximately 650 physicians, a large number of whom are now practicing as physicians in Arkansas.

"This is a game-changer for the health of Arkansas," said Todd Shields, chancellor of Arkansas State University. **"By eliminating traditional barriers and offering early admission assurance, we're making medical education more accessible for high-achieving students who want to stay and serve right here at home. This is about investing in the next generation of healthcare leaders — and in the well-being of every corner of our state."**

For more information, visit **AState.edu/FreshmanToPhysician**.

MEDICAL SCHOOL UPDATES

UAMS MD/PHD STUDENT RECEIVES FELLOWSHIP FROM NATIONAL CANCER INSTITUTE



UAMS MD/PhD student Sydnye Shuttleworth will continue her pursuit to become a physician and cancer researcher with support from a highly competitive fellowship award from the National Cancer Institute. (Image by Jaison Sterling)

The impact of cancer on her family set UAMS MD/PhD student Sydnye Shuttleworth on the path to becoming both a physician and cancer researcher.

A prestigious fellowship award from the National Institutes of Health National Cancer Institute is bringing that path into focus for the Beebe native.

"My grandfather died from colon cancer before I was born, and I watched my grandmother fight triple-negative breast cancer," said Shuttleworth. "Those experiences inspired me to pursue a career in oncology, where I can care for others facing the same challenges and work to develop new immunotherapies."

Shuttleworth has completed the first two years of medical school and the first of an anticipated three to four years of research toward a doctorate in philosophy. She will then complete her final two years of school before continuing with postgraduate clinical and research training.

The Ruth L. Kirschtein National Research Service Award provides four years of funding for tuition, a stipend, and an institutional allowance to support Shuttleworth's research training. Shuttleworth joins an elite group nationally and a small group from UAMS who have received NRSA awards from one of the NIH institutes.

Shuttleworth is an affiliate trainee member of the UAMS Winthrop P. Rockefeller Cancer Institute working in the lab of Brian Koss, PhD, an assistant professor of biochemistry and molecular biology. Her research focuses on engineering immune cells to be more effective and efficient at eliminating cancer cells — an area that could transform how immunotherapies are used to treat cancer.

"Sydnye is driven, deeply committed, and always thinking about how her work can make a real impact," said Koss. "That kind of focus is exactly what you want in a future physician-scientist.

> THOSE EXPERIENCES INSPIRED ME TO PURSUE A CAREER INONCOLOGY, WHERE I CAN CARE FOR OTHERS FACING THE SAME CHALLENGES AND WORK TO DEVELOP NEW IMMUNOTHERAPIES.

AMS EXCLUSIVE MEDICAL MALPRACTICE PARTNER: SVMIC

RISK MATTERS: TREATING FAMILY MEMBERS

JEFFREY A. WOODS, JD
DIRECTOR OF RISK MANAGEMENT, SVMIC
REPRINTED FROM THE SVMIC SENTINEL





In general, physicians should not treat themselves, members of their own family, or people with whom they have an intimate relationship. There are specified limited exceptions such as in emergency settings, where there is no other qualified physician available, and for short-term, minor problems. See AMA Code of Medical Ethics, 1.2.1 Treating Self or Family. In addition to the AMA, individual state medical boards have enacted forms of this ethical prohibition, which can vary from state-to-state.

Recently, there has been an uptick in the number of state board investigations related to physicians treating themselves and family members. Many, but not all these investigations, result from physicians prescribing controlled substances to themselves, family members, and/or intimate partners. These types of investigations can lead to suspension or loss of license to practice medicine, fines, and other costs.

Physicians should be familiar with the AMA Code related to this subject as well as the requirements of the state in which they practice.

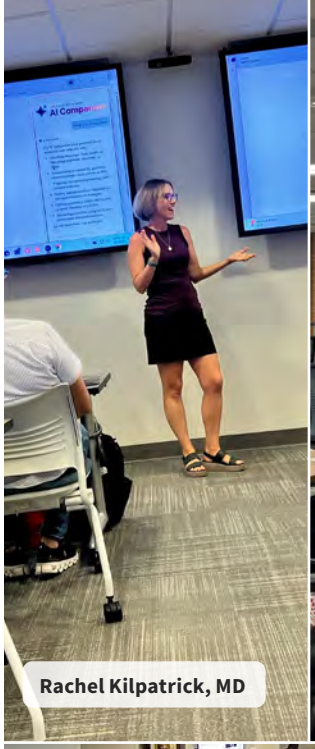
MEMBER NEWS

MEDICAL SOCIETY BOARD OF TRUSTEES VISIT WITH MEDICAL STUDENTS

Members of the Arkansas Medical Society board of trustees visited with medical students from the Little Rock and NWA campuses of UAMS and ARCOM as the new semester begins.

AMS District 8 Trustee **Amanda Novack, MD**, from Little Rock, and AMS District 9 Trustee **Rachel Kilpatrick, MD**, from Fayetteville, spoke to first year medical students about becoming members of the Society. AMS Medical Student Trustee and Student Section Chair (UAMS) **Megan Schutte**, talked about section activities for AMS student members.

AMS District 10 Trustee **Bryan Clardy, MD**, from Fort Smith, discussed membership benefits and encouraged ARCOM medical students to join the Society. AMS Medical Student Trustee and Student Section Chair (ARCOM) **Allie Dew**, spoke with students about becoming both an AMS and AMA student member.



Rachel Kilpatrick, MD



Amanda Novack, MD, speaking to M1s about AMS



Megan Schutte and Dr. Novack



Bryan Clardy, MD, presenting at ARCOM

IN MEMORIAM: MEGAN HERRALD, 39 | HANNAH FORD, 31

The AMS extends its deepest sympathies to the families of two medical students who died in a vehicle collision in July. The late Megan Herrold, 39, and Hannah Ford, 31, both of Fort Smith, Arkansas, were pronounced dead at the scene of an accident that left five others also injured.

Herrold and Ford were osteopathic medicine students in the class of 2026 at The Arkansas College of Osteopathic Medicine, one of five programs offered at the Arkansas Colleges of Health Education in Fort Smith.



NEW CONTACT INFORMATION?

New Contact Information? Have you recently moved your home and/or your practice location?

Help the AMS staff keep your information updated. Call **501-224-8967**. Ask for **Rebecca or Casey**.



BOT MINUTES

BOARD OF TRUSTEES MINUTES

AUGUST 20, 2025

JACOB DICKINSON, MD
AMS CHAIRMAN OF THE BOARD

The Arkansas Medical Society Board of Trustees met on August 20, 2025, via Zoom. AMS board members and past presidents were Drs. Ahmed Abuabdou, Ahmed Ali, Omar Atiq, Brad Bibb, Dale Blasier, Sam Bledsoe, Willard Burks, Bryan Clardy, George Conner, Scott Cooper, Allie Dew, Jacob Dickinson, David Dobies, Thejovathi Edala, Sarenthia Epps, Scott Ferguson, Candace Franks, Amy Galdamez, Kasey Holder, James Hunt, David Jacks, Anthony Johnson, Shaletha Jones, Natthew Kincade, Zachary Lewis, Stephen Magie, Issam Makhoul, Nirvana Manning, Matthew Nix, Ashley Norse, Ezinne Nwude, Naveen Patil, Carolyn Reeves, Chad Rodgers, Daniel Roubein, Alan Schumacher, Megan Schutte, Eugene Shelby, Courtney Sick, Jerakaycia Smith, Michael Smith, Kathryn Stambough, Danny Wilkerson, and Mark Wren. AMS staff present included Attorney Mike Mitchell, David Wroten, Scott Smith, Mary Ann Mansfield, Alanna Schaffer, Courtney Salmon, Laura Hawkins, Casey Penn, and Nicole Richards.

AMS BOARD CHAIRMAN, DR. JACOB DICKINSON, OPENED THE MEETING AND ASKED FOR ANY DISCLOSURES. BUSINESS INCLUDED:

1. Dr. Dickinson informed the board that there was an omission from the attendance of the May 31 meeting. He instructed that Dr. Mark Ramiro be added to the minutes. He asked for a motion to approve the minutes as amended. It was moved, seconded, and approved.

2. Dr. Dickinson welcomed the new student trustees from ARCOM and NYIT, Allie Dew and Stuti Chatterjee, respectively. Dr. Dickinson thanked Dr. Patil for his efforts in getting this done.

3. Dr. Dickinson offered two recommendations for district trustee vacancies. For District 5, Dr. Ezinne Nwude has been put forward and for District 8, Dr. Amy Galdamez has been put forward. Dr. Dickinson asked for a motion to approve these recommendations. It was moved, seconded, and approved.

4. Dr. Dickinson called on David Wroten to give the executive vice president's report.

5. Dr. Dickinson continued with committee appointments to the Finance and Audit Committee. He appointed Drs. Shannon Cooper, Courtney Sick, Kate Stambough, and Ashley Norse. He asked for a motion to approve. It was moved, seconded, and approved.

6. Dr. Dickinson called on AMS attorney, Mike Mitchell, to give an update on the Brandt v. Rutledge case.

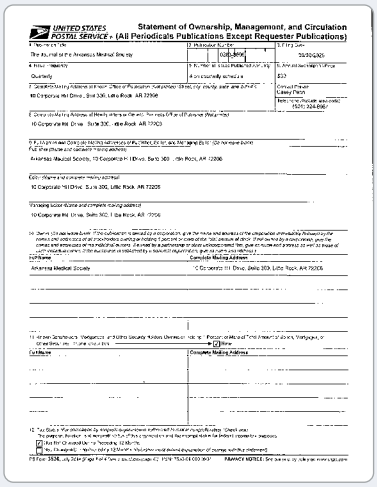
7. Dr. Dickinson called on AMS president, Dr. Brad Bibb, to discuss the Strategic Planning Process.

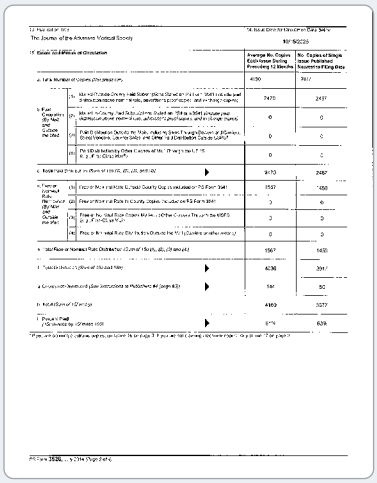
8. Dr. Dickinson asked the board to review their board packets for informational items.

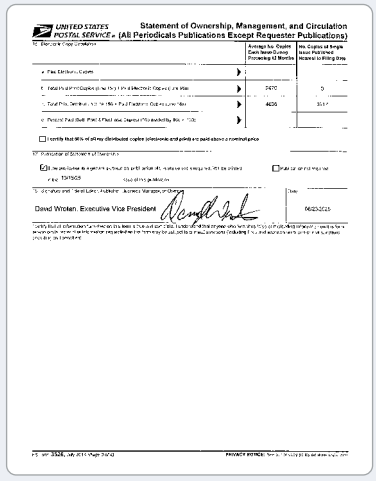
9. Dr. Dickinson called everyone's attention to the upcoming board meetings on Wednesday, November 5, 2025; February 4, 2026; and the annual meeting on Friday/Saturday, April 10-11, 2026.

10. Seeing no other business, the meeting was adjourned by the chair, Dr. Jacob Dickinson.

2025 STATEMENT OF OWNERSHIP


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UNITED STATES POSTAL SERVICE® Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

David Wroten, Executive Vice President

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AS OF SEPTEMBER 15, 2025

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MOORE, SAMUEL, DO
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