Key talking points regarding H.3078 and H.3508

Bills addressing physician supervision of APRNs currently being considered by the SC House of Representatives

Physicians value APRNs as important members of a team of health care providers. APRNs, as well as Physician Assistants (“PAs”), are critical to improving access to care. Their skills should be fully and effectively utilized.

Physicians support a team-based approach to care, but the physician must remain the leader of the team because the physician is the clinician with the most comprehensive education, training, and skill. Physician leadership is critical in assuring quality of care and cost-effective care. Physicians and APRNs are both important team members, but they are not interchangeable.

Physician organizations would like to reach an appropriate compromise with the APRNs, as we did with the PAs in 2013. We cannot, however, support the approach taken by H. 3078 which provides for full independent practice by APRNs with no physician supervision or oversight.

Physicians support H. 3508 (Murrell Smith, Henderson, and others), a bill that will revise certain limitations on APRNs to allow their skills to be more fully utilized but would maintain appropriate physician supervision and oversight of APRNs.

Become informed on the issue and contact your representative to show your support for H3508. You can access the complete legislation at the web address: www.scstatehouse.gov

On the Cover: 2015 Society President Wesley H. Frierson, MD. Dr. Frierson is an Emergency Medicine physician with Lexington Medical Center. A native of Summerton, SC, Dr. Frierson is a 2004 graduate of the USC School of Medicine.
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EDITOR:
C. Warren Derrick, Jr., MD
Columbia, SC 29201
Telephone: 803.765.1498

EDITORIAL OFFICE:
Nancy C. Walborn
1214 Henderson St.
Columbia, SC 29201
Telephone: 803.765.1498
FAX 803.254.2993
nancy@columbiamedicalsociety.org

EDITOR EMERITUS:
Charles N. Still, MD

On the web at www.columbiamedicalsociety.org

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PRESIDENT'S LETTER

Wesley H. Frierson, MD

Several years ago, while in undergraduate training, I met a physician who had been in the business for many years. He asked about my plans after graduation and I told him it was my dream to become a physician. He looked at me with much concern and quickly informed me that he would not do it again if he had known then what he learned over the years of practice.

This proclamation puzzled me and I began to wonder why he would respond in that way to my aspirations. I reflected on that moment multiple times while in medical school and residency training. It didn't deter me from my goal, but I took it as something to consider as I moved forward.

I have seen many difficult days and situations while in medicine and am grateful for the lessons learned from these events. I have endured heartbreak from delivering bad news and enjoyment when I was able to deliver encouraging words or relieve suffering. During that time, I didn't come to the conclusion that I made a bad choice in choosing my profession.

Soon after residency I joined the Columbia Medical Society, not really knowing what to expect. I slowly found myself fully involved in the organization. It has been thrilling to meet other like-minded people and to learn from the wisdom of those who came before me. I am hopeful to continue learning from the experience while contributing something valuable in return.

These are difficult times for many physicians and physician practices, with increased workloads and increasing requirements for compensation. The job can become overwhelming and leave many of us feeling like the physician I mentioned. I contend that these matters don't have to have a negative impact on the way we feel about what we do. There is still room for significant satisfaction.

I am convinced involvement with the Columbia Medical Society is a great way to start. It provides a platform to voice concerns in an ever-evolving workplace. Individual input and collective collaboration can effect change in
positive ways, allowing for increased satisfaction for all of us. The alternative provides a bleak outlook on the future of our profession.

I strongly encourage all physicians to join and actively participate in the Society’s activities. New suggestions for providing a better experience are both expected and encouraged from our members. At this time, one of the most important responsibilities we have is advising our legislators on issues that affect all physicians in the state. This involves face-to-face meetings, letters and phone calls from those in the trenches who truly understand how changes in legislation directly impact patient care.

Do not allow yourself to fall into the trap of being complacent and thinking things will never get better. Instead, consider becoming fully engaged with the profession by becoming an integral part in the Medical Society. It would be a tragedy to end up dissatisfied and unfulfilled like the gentleman I met many years ago.

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**We Want Your Submissions**

Do you have an article, editorial, story, poem or photograph you’d like to submit to *The Recorder* for publication? Please send them to us. You may do so by writing to Dr. Warren Derrick, Editor, 1214 Henderson Street, Columbia, SC 29201. You may also email your submissions to nancy@columbiamedicalsociety.org. We’d love to hear from you.
EDITORIAL

Taking on the Big Boys
C. Warren Derrick, Jr., MD

Are we on the verge of a major upheaval in our health care financing? A number of indicators point to just that.

The hue and cry from a number of sources about our dismal health care statistics compared with those of other developed countries has alerted everyone to the fact that we pay way too much for our health care and get much less in return. Unlike our Canadian neighbors and our European friends, we are the only country that doesn’t offer universal health care. And many say, therein lies the rub.

There are many reasons we don’t have universal health care in this country including distrust of government and funding issues. But the biggest reason is the insurance industry and its lobby. Most attempts at changing our health insurance system are stymied at every turn by insurance lobbyists pandering to our legislators with more and more money. Bill Clinton and George Bush’s attempts to change our health care industry went nowhere, and look at the beating Obamacare is currently taking. You take on Big Insurance and Big Pharma at your peril. Too bad because, currently, more than 30% of our health care dollars are spent (? wasted) on health care administration—not on patient care.

The system is too entrenched to ever change. Or is it??? Recently, a number of different attempts to undercut the health insurance industry have surfaced with more to come. A chink in the armor? Perhaps. Let’s take a look:

Hospitals Unite. Building on the Kaiser Permante success, this all-encompassing managed care system is being emulated in larger metropolitan areas across the country. Large hospitals are merging, buying physician practices, and offering their own health insurance plans at lower rates than the “big boys”. The Cleveland Clinic and New York-Presbyterian are two examples along with the Geisinger Health System in Pennsylvania and the University of Pittsburg Medical Center. All of these integrated systems are
thriving and are already affecting the bottom line of competing private insurance companies (the Blues, United Health Care, etc.). Some are expanding into storefront clinics and exploring expansion into smaller, rural areas. Many of them purport to save as much as 20% of the health care bill by being their own insurer. Obviously, there are concerns such as excess profits and monopolies, which will have to be addressed, but doing away with multiple insurance companies is a dream come true for most physicians.

Can this integrated system be implemented in smaller metropolitan areas such as Columbia? Well, Palmetto Health and USC School of Medicine are in the process of integrating. And talks are ongoing with Florence, Grand Strand Hospital and Tourney in Sumter. Who knows?

**Concierge Medicine.** Started as a form of boutique medicine for the well-heeled, entrepreneurial physicians provide convenient health care including home visits, same day appointments, email response, etc., for a significant monthly fee. Now, physicians are beginning to scale down the monthly fee (some as low as $50/month) to attract middle class patients. You will still need insurance for hospitalizations and catastrophic events but your monthly fee provides routine and acute care. Obviously, this is still in its infancy, but who knows the potential.

**Universal Health Care.** Still around, the universal health care buzz just won’t go away. Physicians for a National Health Program continues to grow and now boasts a membership of over 18,000 physicians and medical students. Others are talking about expanding Medicare to cover everyone not just the elderly. And still others are proposing a universal health care system like France’s using existing insurance companies as the intermediary but with government control over pricing.

Whether any of these will take off remains to be seen. But when Insurance executives like the CEO of Blue Shield California makes $4.6 mil a year, and our country spends over 30% of our health care dollars on administration, people are taking notice. What we do know is that universal health care saves lives and money, and we would be foolish not to embrace it.
An interview with Charles S. Bryan, M.D.
Distinguished Professor of Medicine
U.S.C. School of Medicine

Editor's Note: Dr. Charles Bryan is the Heyward Gibbes Distinguished Professor of Internal Medicine at the USC School of Medicine. An infectious disease specialist by training, Dr. Bryan was educated at Harvard, Johns Hopkins and Vanderbilt. A charter faculty member of the USC SOM, he served as Director of the Division of Infectious Diseases and Chair of the Department of Medicine. He is currently the Director of the Center for Bioethics and Medical Humanities. He has published more than 100 peer-reviewed articles in the field of infectious diseases and medical history as well as six books. His most recent book is Asylum Doctor: James Wood Babcock and the Red Plague of Pellagra.

Your latest book, “Asylum Doctor” seems to be two books in one: 1) A history of the early search for the cause of pellagra and 2) the history of the embattled mental health administration in SC in the early 20th century—and the role Dr. James Babcock played in each. Why did you pick these topics to write about?

As related in the preface, my new book (Asylum Doctor: James Woods Babcock and the Red Plague of Pellagra) began with the commonly—and erroneously—related biographical clip that Babcock was the first person to describe pellagra in the United States. This was not the case, and indeed whenever anybody gave him such credit Babcock quickly pointed out that although he’d been unaware of previous accounts of highly-endemic pellagra in the U.S., he’d been preceded in this regard by Dr. George Searcy of Alabama, who’d published his results a few months earlier. A summer project with a medical student (Shane Mull, who is now a member of the faculty of the Department of Family and Preventive Medicine at USC) evolved into a 15-year obsession, perhaps worthy of a doctoral dissertation. It became increasingly apparent that the full story of pellagra in the United States prior to February 1914, when Joseph Goldberger of the U.S. Public
Health Service became involved, has never been told. (Alan Kraut, author of Goldberger’s War, acknowledged this to me.) But equally fascinating was the role Babcock played as asylum superintendent during an era of our state’s history that most people would like to forget about.

Despite your busy and distinguished career as an infectious disease expert, you have managed a parallel career as an accomplished medical historian. Why the interest in medical history?

I probably would have become a historian, and spent my career teaching somewhere at a small college, had it not been for early acceptance into medical school. I decided after my freshman year of college to be a pre-med major. The fall semester of my sophomore year I signed up for a course in southern history—popularly known as “mint juleps”—as a counterweight to organic chemistry. I loved it. The second semester of my sophomore year I took a course under the famous sociologist David Riesman and wrote a term paper on slavery on a South Carolina rice plantation. Meanwhile, my father had told me about a five-year program at Johns Hopkins whereby one shaved off a year of college and got both degrees (B.A. and M.D.). I applied and was accepted. The first year was a transition year with courses at both the Homewood campus and the School of Medicine campus. I approached David Donald, who went on to become a very famous American historian, about the possibility of developing my paper on slavery into a senior thesis, to which he kindly agreed. Then I approached Owsei Temkin, one of the world’s top medical historians, about the possibility of a summer project in the history of medicine. He suggested a project on bloodletting and obtained NIH funding, which was plentiful back then. This led to my first publication. I’ve been fortunate to have been able to maintain these parallel interests.

As one of the charter faculty members of the USC School of Medicine in 1977, you obviously have a great affinity for the school as underscored by your generous endowment to establish the “Charles S. Bryan History of Medicine Room” in the medical school library. What was the motivation for this history room?
It’s my recollection that the Development Office of the School of Medicine approached me to fund the history room. It was not my idea. They had already approached the late Michael Craig to design the cabinets and furniture for the room. (Tragically, Michael, whom I knew when he was a young boy, was killed in an automobile accident in London not long after completing his work for the room.) Numerous friends of the School of Medicine had previously donated old medical books, some of them rare, to the school, and the special room provided them with a home. My current dream is that the School of Medicine would also develop a room given to the secondary literature in medical history, as a place where scholars could access material pertaining to the more important topics.

Dr. William Osler is obviously one of your heroes. How has he impacted your life and your medical career?

At Johns Hopkins everyone learned about William Osler, since he was of course one of the “big four” among the charter faculty (the others were pathologist William H. Welch, surgeon William S. Halsted, and obstetrician-gynecologist Howard A. Kelly). Osler was the best-known and most-celebrated physician in the English-speaking world at the turn of the twentieth century. He was best known in his day for his textbook of medicine, but is now best known for his inspirational essays. I regard Osler much as he regarded his own heroes—a person who is to be admired in numerous ways, and whose positive traits we should try to emulate or internalize while, at the same time, not losing sight of the obvious fact that he was human like the rest of us. I was very fortunate to find a publisher (Oxford University Press) for Osler: Inspirations from a Great Physician (1997), in which I develop Osler’s message (as gleaned from his biography, his writings, and a huge secondary literature on Osler) into practical advice for everyone. Thus, the eight chapters deal successively with time management, career development, mentoring, maintaining a positive attitude, caring, learning and teaching, communicating, and striving for a balanced life. Members of the American Osler Society—likeminded souls interested in the humanities as they related to medicine—have been since 1993 my major peer-reference group outside of Columbia. My papers pertaining to Osler include one subtitled “The Ideal of Idealism.” But many of my papers on Osler stress that he, like the rest of us, had his
foibles and shortcomings.

Your accomplishments are vast and way too many to recount here. What do you consider your most cherished accomplishment?

You’re very kind. From my father I internalized the idea that whatever one does, it’s important to do it well. I can’t point to a single “cherished accomplishment,” since to me the most important thing (and Osler emphasized this repeatedly) is the satisfaction of doing the day’s work well. I still get great pleasure from doing a good infectious diseases consultation, which involves spending time with the patient, thinking through the problem, making sure I’ve brought the latest medical literature to bear on the problem at hand, and writing a good note. A few years back I was asked by a high school student somewhere in the Midwest, “How do you go about getting a book published?” I gave him some general advice, and then cautioned him that you’ll always find that your greatest accomplishments were not without their flaws. Someone asked me recently how it felt to see Asylum Doctor in print, and I replied that it probably gave me about as much pleasure as a child gets from a new pair of shoes. I’ve pretty much defined my adult life as a seamless series of projects. There’s always the next hill.

Despite earning the right to retire many times over, you don’t seem to be slowing down a bit. What drives you and what is left for you to accomplish?

Some years ago, I made the mistake of giving up several productive hobbies (woodworking, winemaking, photography) for what turned out to be a mediocre golf game. I still enjoy practicing medicine and interacting with physician colleagues and others in the health care environment.

Using your crystal ball, how do you view the future of medicine in this country and globally? Are you optimistic or pessimistic about medicine’s future?

I’m extremely optimistic about the future of medicine as a public good. I’m a bit pessimistic about the future of the medical profession in the United States and globally. We’ve lost much and perhaps most of our
autonomy—the ability to control our individual destinies. I've written a fair amount of this, and most of my thoughts are summarized in a piece I wrote for the Texas Heart Institute Journal (2011: 38: 465-470) entitled “Medical professionalism meets generation X. A perfect storm?” Each generation of physicians, I contend, must define what is meant by “the medical profession” and “medical professionalism” on its own terms and in the context of the society (both nationally and globally) in which doctors find themselves. I’m also concerned about the high cost of medical education, the extent to which students must incur debt for an uncertain future. More generally, I’m concerned about the extent to which power and influence in just about every sphere of life is becoming increasingly concentrated in the hands of a few. Those who come into such power must decide whether to use their power for self-aggrandizement or for the public good. Like others I’m concerned about the devaluation of an honest day’s work. I’m glad to have lived when I've lived. Still, the digital age holds out the opportunity for today's medical students and young physicians to make the world a better place in ways we cannot even imagine.

Any final thoughts?

Stay positive, and, as Osler put it, “Start at once a bedside library and spend the last half-hour of the day in communion with the saints of humanity.”
BRAVE NEW WORLD: TWITTER

Amelia Bischoff

The Columbia Medical Society is marking our presence in the world of social media via Twitter (@ColaMedSociety). Through an effort to keep you abreast of important information, national/local trends and news updates that directly impact you, we are now utilizing Twitter as a powerful platform to expand and enhance our communication possibilities.

What is Twitter?

Twitter is an online social networking service that enables users to read and send short 140-character messages called “tweets.” Users access Twitter through the website interface or mobile device application where you receive a live feed of tweets from the Twitter accounts in your network. Users can also opt to receive push notifications on their devices allowing for real-time updates. You can read, comment, respond or even write your own tweets for posting. Twitter has more than 100 million medical professional users and is described as “text messages of the internet”.

With that said, healthcare related matters on social media pose unique challenges, including but not limited to HIPAA and litigation concerns. A majority of these fears are provoked by the reality of health care as it is practiced today. There is a fine line between caution and fear. It is the fear of change so common in health care that we hope medical professionals will overcome. Twitter may be a proving ground of how we can overcome our fears, satisfy our cautions and extend the reach of our health care system with web-based technologies and communities. It’s the 21st century: let’s be innovative and determined.

Who is Twitter for? You!

You, the physician who is tired of chasing information that should be at your
finger tips.

You, the advanced practice provider who wants legislative and policy updates.

You, the resident who wants to network with peers and periscope for the latest advances in medicine.

You, the leader of a health care entity who wants to know what’s being said and what can be done about it.

Twitter’s simplicity of design, speed of delivery and ability to connect two or more people around the world provides a powerful means of communication and collaboration. As your new Social Media Advisor, I will listen and curate information that you, our Columbia medical professionals, find important, relevant and interesting.

Follow @ColaMedSociety on Twitter or contact Amelia at ameliabischoff@gmail.com or by phone (803)-296-5355 for any questions and interest in starting your Twitter account.

Letter to the Editor:

1/15/15

Dr. Derrick,

I was quite intrigued with your essay in this month’s Recorder, “The Solution to Poverty: Get Married.” It’s a position that I’ve not thought of. I do feel the beginning of the cycle of poverty in my community started with the de-emphasizes on the family unit. I’ve long believed education is pivotal but interventions must start early, in elementary school. Something happens when the young African American male enters the third grade. I hope this is the beginning of a dialogue. Key stakeholders need to examine the barriers to education.

Again, thank you for addressing this multidimensional problem.

Patricia W. Witherspoon, MD
WELCOME NEW MEMBERS

ALVIN L. DAY, MD
USC 2014
Palmetto Health IM Residency PGY-1
1801 Sunset Drive
Columbia, SC 29203
PH: 803.422.1218

KIMBERLY B. WILLIAMS, MD
MEDICAL COLLEGE OF GA 1999
Family Medicine Centers of SC
1721 Horseshoe Drive
Columbia, SC 29223
PH: 803.788.7884

TARIQ HORANI, MD
AMERICAN UNIVERSITY of the
CARIBBEAN 2012
Palmetto Health
2 Medical Park Drive
Columbia, SC 29203
PH: 803.434.7000

PAYAM YOUSEFIAN, MD
ST. CHRISTOPHER’S COLLEGE OF
MEDICINE 2006
Family Medicine Centers of SC
813 Leesburg Road
Columbia, SC 29209
PH: 803.779.1420

ALEJANDRO J. LUIS, MD
UNIVERSIDAD DE CIENTAS MEDI
CAS DE CENTRO AMERICA 2006
Palmetto Health Surgical Specialists
9 Richland Medical Park Dr., Ste. 450
Columbia, SC 29203
PH: 803.434.8800

“Health Care? I say, ‘If it ain’t broke, don’t fix it!’”