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Many times the most important member of the patient care team – the physician – is the most neglected, leading to “burnout.”

“We want people who are competitive, driven who can excel at everything that they do. What do they do when they get into practice? They try to do everything and they have this complex which also says they must succeed at everything,” commented T. Jock Murray, MD, director of the Medical Humanistics program at Dalhousie University in Halifax.

Burnout can manifest in many ways: fatigue, exhaustion, inability to concentrate, depression, anxiety, insomnia, and sometimes lead to substance abuse. These symptoms are not unique to physicians; many other professionals can experience them. However, they can have devastating effects on patient care.

According to a study by Johns Hopkins School of Medicine in 2000, only one-third of physicians have a personal physician. Taking care of yourself is not part of the physician’s professional training and usually is low on the list of priorities. Physicians do not usually admit they are under stress and may need help. It is not only the stress of the complex nature of today’s medicine, but the administrative burdens, quality and reporting targets, learning EMR systems, concerns on volume targets, and changing coding environments. Is it no wonder physicians feel frustrated and out of control?

Dr. Murray reminds physicians that “your whole life is not medicine. Medicine is a very important part of your life, that’s your professional life, but there’s also a personal life and a community life.”

A 2001 study in Western Journal of Medicine found that physicians have five major categories of self-protective practices: relationships, religion or spirituality, self-care, work, and approaches to life (being positive or finding balance in life between work and personal life).

It is important to the people around you and your patients that you take care of yourself. Listen when someone suggests that you may be tired or not as attentive. Listen and answer honestly when someone asks how you are. Remember you were a person before you became a doctor. It is when you are healthy that you are at your best as a physician.

I would invite you to take time this May – Friday and Saturday, May 30 and 31 – to join your colleagues for the 2014 SDSMA Annual Meeting in Rapid City. This is a great chance to spend time with colleagues and relax, a time to recharge and reinvigorate yourself. We will install Dr. Mary Milroy as our new SDSMA president. Hope to see you there.

Book Recommendations This Month

Where Have All the Leaders Gone? By Lee Lacocca with Catherine Whitney

The Greatest Generation by Tom Brokaw

The Grand Design by Stephen Hawking and Leonard Mlodinow

“Self-love, my liege, is not so vile a sin as self-neglecting”

– Henry V, Act 2, Scene 4
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February is American Heart Month, but heart health should be a huge issue every month of the year. In the U.S., one woman dies every minute from a cardiovascular event. Many women are actually unaware that heart disease is the leading cause of death for women, claiming more lives than all cancers combined. The American Heart Association tells us that one in four women in our country die from heart disease, while one in 30 die from breast cancer, the form of cancer most feared by women. Equally sobering is the news that two-thirds of women who have a heart attack fail to make a full recovery. Almost 25 percent of women die within one year of having a heart attack.

As serious as these facts are, heart disease is often a treatable and preventable condition. All women can take steps to lower their risk of developing heart disease. First, identify your personal risk factors, which might include: 1) having a family history of coronary artery disease; 2) being 55 or older; 3) having high blood pressure, high cholesterol, or diabetes; 4) being post-menopausal; 5) having had a previous heart attack or stroke; and 6) choosing to smoke.

This year marks 50 years since the U.S. Surgeon General first announced the strong link between smoking and heart disease with these words spoken by Surgeon General Luther Terry in 1964: “There is a very strong relationship, and probably a causal relationship, between heart disease and cigarette smoking.”

It would do our hearts, literally, to examine just this one risk factor. First, we need to acknowledge the positives we are enjoying after 50 years of anti-smoking education initiatives. Nearly 70 million people smoked in 1964 when the population of the U.S. was not quite 192 million. Today, with a population of 315 million or so, there are about 43 million smokers in the U.S., so we have made significant gains. And over half of those smoking today want to quit. In fact, quitting smoking is in the top 10 for 2014 new year’s resolutions, and has been for years. What we need is the heart to quit.

Picture what the world would be like if we eliminated smoking once and for all. Robin Koval, president and CEO of Legacy, the nation’s largest public health foundation devoted to the issue of tobacco use prevention and cessation, tells us: “Over time, 443,000 people each year could live instead of die from tobacco-related disease. That’s more than half the population of San Francisco. In this new world, we’ll be on our way to reducing the nearly $97 billion loss in annual productivity costs due to smoking. We’d eventually save $193 billion in annual smoking-attributable costs. Tobacco product manufacturing facilities would no longer release the estimated 902,000 pounds of toxic chemicals that are currently released every year. And the most-littered item in the U.S. – cigarette butts – would slowly disappear, saving our communities from costly clean-ups, and the risk of toxins leaching into the soil and water would not longer threaten our wildlife.

Our children and pets would be free of exposure to deadly secondhand smoke, and eventually, the incidence of our No. 1 cancer killer – lung cancer – would plummet and it would once again become the rare disease it was before the modern cigarette era. Our lives would be longer, our air cleaner, our bodies healthier. Our economy and public health would benefit dramatically.”

So, have a change of heart for your heart. Get started on a healthier lifestyle. If you smoke, quit. Research shows that women can lower their heart attack risk over 80 percent by lifestyle changes. Doctors advise: 1) seeing your doctor to identify your family history and personal health risks; 2) changing your diet by reducing your intake of saturated fats and increasing your consumption of fresh fruits, vegetables and oily fish; 3) starting an exercise routine – even walking 30 minutes a day can lower your risk of heart attack or stroke; and 4) having the heart to quit smoking!

Last month we were reminded that Alliance members would be in Pierre for our annual Day at the Legislature during this legislative session. The first Day at the Legislature was held in 1977 in conjunction with the winter Board of Director’s meeting in Pierre. The idea of using our knowledge to influence politics took bold steps when the American Medical Association organized a Political Action Committee (AMPAC) in the early 1960s. The SDSMA soon followed suit with the establishment of SDSMA PAC to raise money to support selected candidates, and began to encourage doctors and their spouses to enter into the political arena. Do you know what year SDSMA PAC began?
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Recently, my father-in-law Francis referred to an oak board as having lavish grain. I was struck by the somewhat unusual adjective he chose but not surprised as he has a facility for coming up with just the right word or phrase. For instance, he taught me that “easing the edges” with a plane lends a finished appearance to a board and that “angle of repose” is the natural shape sand or grain assume when dumped onto a flat surface.

Prompted by Francis’ eloquence, I have found myself first considering the adjective “lavish” and then proceeding to ponder a “lavish life.” This term has appeal, offering both alliteration and nuance. It lacks the implications generally attributed to the phrase “lavish life style” which connotes, in my mind, excessive opulence and indulgence. In contrast, a “lavish life” can suggest something different – a richness of purpose and meaning, as well as a conscious gratitude.

A life in medicine can be, in many ways, both lavish and hugely rewarding. Indeed, thinking about a life in medicine as lavish strikes me as particularly important in a time when many physicians are vocal about professional frustrations. Of course, unhappiness can exist about long hours, insufficient time for clinical encounters, institutional demands for productivity and frustrations with the electronic medical record. Many of us have heard reports that occasional physicians tell students and residents that, given the chance to do things over, they would not again choose to go into medicine.

In my judgment, at least on a good day, such comments and attitudes have it all wrong. In fact, being in medicine can offer almost unparalleled opportunities for satisfaction and self-fulfillment. Each of us in medicine has the opportunity to experience a lavish life. Webster’s Dictionary defines lavish as “very generous or liberal in giving or spending, often extravagantly so.” And indeed, in medicine we are given countless opportunities to expend the talent and learning we have acquired. We are part of a high-stakes drama. Fragile lives often hang in the balance. Mystery and challenges abound as diagnoses are made and therapeutic interventions implemented.

Perhaps we need to remind ourselves of the privilege we are bestowed as we acquire medical experience and then enter into the private lives and vulnerabilities of patients. The famous physician and author, William Carlos Williams, captured this sentiment in his short story Ancient Gentility. He was called to the apartment of an elderly couple to assess the wife’s illness. Williams noted, upon entering the bedroom, “What a thrill I got.” In fact, Williams was reveling in the healing opportunity he was granted.

Most physicians in South Dakota are provided an additional, unique occasion to celebrate a lavish life through teaching. Our community-based medical school depends on physician mentors throughout the state. Being actively involved in teaching is a privilege that many physicians in other regions of the country may not be accorded. Teaching challenges clinicians to consider new data and practices. For example, our current students’ immersion in quality and safety issues can enhance faculty/student discourse in unanticipated ways. And the enduring influence of a physician who teaches may be evident throughout a student’s professional career and beyond, as each student becomes a potential future mentor.

A person’s life is lavish only if she or he perceives it to be. There is much in the world beyond our control. Calamity can befall any of us. But those variables that we do control can shape our attitudes and destiny. Francis, who is now in his 92nd year, has confronted sorrow and adversity in his life but would much prefer to focus on the happiness he’s encountered and the gratitude he feels. Clearly, one does not need be in medicine to enjoy a lavish life. But in medicine, it seems to me, we are given unique opportunities to fashion a life that is lavish in the best sense of the term. We are given a chance to be generous with our time and liberal with our talents. We are given the chance to make a difference in the lives of those we touch, whether patients or students. I am confident that William Carlos Williams, had he been asked, would have agreed that his life in medicine was lavish. He said it simply, “What a thrill ...”

REFERENCES

Celebrating Excellence

Outstanding Teaching

Matthew Jahraus, DO
Assistant Professor, USD Sanford School of Medicine
Hospitalist - Internal Medicine
Sanford USD Medical Center
Clinical Faculty Teaching Award

Tamera Sturm, DO
Clinical Assistant Professor, USD Sanford School of Medicine
Hospitalist - Internal Medicine
Avera McKennan Hospital & University Health Center
Academic Faculty Teaching Award

Both Physicians were chosen by the Residents of the Internal Medicine Residency Program to receive faculty teaching awards from the Department of Internal Medicine “in recognition of excellence as a teacher and clinician.”
Introduction
Abdominal compartment syndrome is a condition in which a pathological process leads to end organ affect secondary to significantly increased intra-abdominal pressure. Most cases occur due to injury or disease in the abdomen or pelvis, sepsis, fluid overload and numerous other conditions. The most common form of treatment is decompressive laparotomy, and without treatment, the prognosis is poor. We report an unusual case of a 77-year-old male brought to the emergency department with a chief complaint of abdominal pain diagnosed with abdominal compartment syndrome (ACS) that was secondary to a sigmoid volvulus with later perforation. A review of abdominal compartment syndrome follows the case.

Case Report
A 77-year-old man presented to our tertiary center with abdominal pain of two days duration. He had not eaten anything and had been drinking alcohol every day. He stated he had not had a bowel movement for two days and had “vomited a little.” The patient’s medical history includes chronic obstructive pulmonary disease (COPD), hypertension, type 2 diabetes mellitus, hypothyroidism, and alcohol and tobacco abuse. He had no prior abdominal surgeries. The patient’s original vitals were: blood pressure 146/97; pulse 88 beats/minute; respirations 20; O2 sat 97 percent on room air. On exam the patient’s abdomen appeared massively distended, firm, tympanic, and the skin was taught and pale. Bowel sounds were hypoactive. He had a Foley-catheter placed with very little urine output and had been intubated at a previous facility. Chest and abdominal radiographs were taken, which revealed markedly dilated loops of bowel consistent with possible sigmoid volvulus. The patient arrived at our tertiary hospital for further evaluation of the volvulus and surgical consult. The patient’s systolic pressure was now only in the 70s despite two vasopressors, heart rate was 80 beats/minute with frequent premature ventricular contractions (PVC), and respirations were controlled at 14 on a ventilator.

The patient continued to be oliguric. He was diagnosed with a surgical abdomen, hypotension and tension pneumoperitoneum ultimately leading to abdominal compartment syndrome by the on-call surgeon. The patient was taken to the operating room (OR) for exploratory laparotomy. Upon arrival to the OR, the patient remained hypotensive and his tidal volumes were low. After the initial midline incision, a significant amount of air escaped and the patient’s tidal volumes, blood pressure and urine output improved. A perforation was discovered in the mid sigmoid colon. No inflammatory changes consistent with peritonitis, as well as no fecal material or fluid, were noted in the peritoneal cavity. The sigmoid colon was resected and an end-colostomy was created. The patient’s blood pressure and ventilation were markedly improved following surgery.

Definition
Abdominal compartment syndrome (ACS) is defined as intra-abdominal pressure (IAP) above 20 mmHg with evidence of organ failure. This pressure increases suddenly and by definition lasts for at least six hours. A new measurement has been recently described when defining
ACS called abdominal perfusion pressure (APP). APP is measured by subtracting IAP from mean arterial pressure (APP = MAP – IAP). Many organ systems are affected by increased IAP including cardiac, pulmonary, neurological, renal, gastrointestinal, abdominal wall and ophthalmic. The GI tract is the most sensitive to ACS and is the first organ system to be damaged.1

Diagnosis
To best diagnose ACS, IAP is measured either directly or indirectly. Direct measurement is accomplished with the use of drains connected to a pressure transducer postoperatively. Several different methods have been employed to indirectly measure IAP. The most studied of these is the transvesical method, which uses urine as the transducing medium and measures the height of the fluid column in the catheter to estimate IAP.2 Abdominal compartment syndrome can also be diagnosed clinically; however, clinical diagnosis is non-specific. Clinical diagnosis includes increased alveolar pressure, decreased urine output and a tense abdomen on physical exam.1

This particular case report is not a typical presentation for ACS. However, there have been other cases described in which ACS presented in a similar fashion with perforation occurring during a colonoscopy. This rapidly resulted in abdominal pain, abdominal distension, tachycardia and hypotension. With colonic perforation, ACS has been described as abdominal distension, increased abdominal pressure, inadequate ventilation and renal dysfunction.3 Our case illustrates these findings as the patient complained of abdominal pain, had a greatly distended abdomen, was tachycardic and hypotensive and had decreased renal function in the form of oliguria. Furthermore, the continuous leak of air into the peritoneal cavity from the perforation can lead to tension pneumoperitoneum, which some authors have added to the list of causes of ACS.1

Types
There are four types of ACS: primary, secondary, recurrent and open. Primary ACS is associated with disease or injury in the abdominopelvic region such as abdominal trauma, intra-abdominal hemorrhage or pancreatitis. Secondary ACS is associated with conditions not originating from the abdominopelvic region such as sepsis, capillary leak, burns and conditions requiring massive fluid resuscitation. Recurrent ACS develops after previous treatment of primary or secondary ACS. Open ACS occurs in patients during the recovery period.6

Complications and Risk Factors
Elevated IAP can cause decreased preload, which leads to decreased cardiac output and stroke volume, and increased systemic vascular resistance.6 Other complications include increased peak airway pressure and thoracic pleural pressure, which compromises ventilation. Risk factors for ACS include but are not limited to ruptured abdominal aortic aneurysm, intra-abdominal infection, tumors, peritonitis, gastroparesis, gastric distention, ileus, volvulus, acute pancreatitis, hemorrhage and trauma.7 Ertel et al. found persistent intra-abdominal/retroperitoneal bleeding was associated with ACS in patients with severe abdominal or pelvic trauma. They defined ACS as respiratory compromise, renal dysfunction, hemodynamic instability and rigid or tense abdomen.

Treatment and Prognosis
Treatment for increased IAP and ACS can consist of both medical and surgical intervention. Medical treatment includes positioning the patient supine, crystalloid resuscitation to correct hypovolemia, and drainage of intra-abdominal fluid accumulation. If these conservative measures fail to improve IAH, or there are signs of end-organ failure, then surgical intervention must be considered through decompressive laparotomy.8 Percutaneous catheter drainage of fluid, air or blood is a less invasive technique than laparotomy, and it is performed under ultrasound or CT scan guidance.9 This technique is generally used when the IAP rises above 20 mm Hg or the APP is less than 50 mm Hg. In one study, there was an average decrease in IAP of 8 mm Hg. Serial IAP measurements are needed to confirm the effectiveness of percutaneous catheter drainage.10 Several complications following decompressive laparotomy can occur including fluid loss through the open abdomen, difficult wound dressings, risk of infection or fistula, cost and longer hospital stay.2 The decision to perform catheter drainage vs. laparotomy comes down to timeliness of diagnosis. An earlier diagnosis of ACS allows clinicians to use a less invasive method of treatment, such as percutaneous catheter decompression.9 The prognosis for patients with ACS is quite poor, with reports of mortality ranging from 63 percent to 72 percent. Patients who have undergone decompressive laparotomy have an improved prognosis with mortality around 49 percent.6 Prognosis also improves with earlier diagnosis.9

Discussion
Abdominal compartment syndrome is a serious condition that can quickly lead to the deterioration of the patient.
ACS, defined as IAP above 20 mmHg with evidence of organ failure, can damage the heart, lungs, kidney and gastrointestinal tract among others.

Patients with a vast number of conditions warrant close observation for ACS, including acidosis, hypothermia, multiple transfusions, coagulopathies, sepsis, bacteremia, liver dysfunction, mechanical ventilation and pneumonia. Additionally, patients with recent abdominal surgery or trauma to the abdomen should be evaluated for ACS³. Patients at risk need to be closely monitored with IAP measurements using either direct or indirect methods. Prompt diagnosis, monitoring and intervention are vital in decreasing the mortality of abdominal compartment syndrome. The case study is an unusual presentation for ACS in that it occurred due to volvulus leading to perforation of the colon. The physician should always have suspicion for ACS with any patient presenting with abdominal pain, abdominal distension, hypotension, tachycardia and renal dysfunction. Management for any similar case should be decompressive laparotomy to ensure the best possible outcome for the patient.

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NP vs. PA: What Is The Difference?

By Samuel W. Carlson, MSI; and Walter O. Carlson, MD

Abstract

The recent passage of the Affordable Care Act (ACA) has highlighted the need for more primary care providers. One solution to increase the primary care provider base is the increased utilization of nurse practitioners (NPs) and physician’s assistants (PAs). Differences exist in the educational background, board examinations and licensing requirements of NPs and PAs. In addition, their practice patterns, recertification and types of supervision are different. Moreover, changes in the NP educational pathway leading to a doctoral degree will create new challenges regarding collaboration agreements currently required by South Dakota statute. This paper discusses the differences and similarities of NPs and PAs to gain a better understanding of these professions.

Introduction

The current consensus in the U.S. is that a shortage of primary care physicians exists and will worsen in the next 10 years. Factors cited as a cause for this shortage include a growing population, an aging demographic and an expansion of health insurance coverage as a result of the Affordable Care Act (ACA). According to the Association of American Medical Colleges, the shortage of physicians providing primary health care will surpass 100,000 physicians by 2025. As a result of these anticipated physician shortages, the concerns for access to health care and managing the cost of health care are worsened. Another factor decreasing the supply of primary care physicians is the desire for a balanced work life by the next generation of providers. Many young doctors are taking salaried jobs, working fewer hours, often working part-time, and choosing specialties based on family reasons. For these doctors, their choices lead to more control of their personal lives, but for our health system, these changes further add to the shortage of primary care providers.

Various solutions to the problem of a shortage in primary care physicians have been discussed. A change in the way clinicians deliver care, to include the use of teams or pods, information technology, sharing of data and the use of non-physicians, has the potential to offset the perceived increase in demand for physician services while improving access to care. The implementation of care delivered by nurse practitioners (NP), certified nurse midwives, and physician assistants (PA) is often cited as a solution to the predicted surge in demand for health care in the next decade.

The goal of this paper is to define and clarify the difference between the NP and the PA in terms of education, licensure, scope of practice, practice types, clinical outcomes and legal implications in South Dakota. This paper will also address future trends in implementing the skills advanced practice providers offer the health care system to offset workforce shortages.

Definition of Nurse Practitioner and Physician Assistant

One factor contributing to the confusion is that each state specifically defines the NP and PA and variability exists in the definitions. South Dakota Codified Laws define an NP as “a provider duly authorized under this chapter to practice the specialty of nurse practitioner as defined in Section 36-9A-12.” In addition, this law specifies the word collaboration, to be the act of communicating pertinent information or consulting with a physician licensed pursuant to South Dakota Codified Law 36-4, with each provider contributing their respective expertise to optimize the overall care delivered to the patient.

According to South Dakota Codified Laws, a PA is defined in Section 36-4A-1 as a health professional who meets the
qualifications defined in this chapter, is licensed by the South Dakota Board of Medical Examiners, and acts as an agent of a supervising physician. In Section 36-4A-1, the law defines supervision as the act of overseeing the activities of, and accepting responsibility for, the medical services rendered by the physician assistant. Thus, in South Dakota, NPs and PAs are defined as health care professionals with legal authority to provide patient care. The difference between the terms “collaboration” and “supervision” creates the difference in professions. Although South Dakota requires both the NP and the PA to work directly with physicians, throughout the country NPs define themselves as nurses with a broad scope of practice and do not define themselves as physician-supervised professionals in many other states. Alternatively, PAs practice under the supervision of a physician in all states.

**Education**

Prior to studying at the graduate level for certification as a NP or PA, both fields require specific undergraduate preparation. Admittance into the South Dakota State University (SDSU) NP program requires the applicant to have a Bachelor of Science in Nursing (BSN), a 3.3 cumulative GPA, a registered nurse (RN) license, and 1,500 hours of experience as a RN. The PA program at the University of South Dakota (USD) requires the applicant to have a bachelor’s degree with two semesters of biology with lab, two semesters of chemistry with lab, biochemistry, microbiology, normal and abnormal psychology, and two semesters of anatomy and physiology. None of these pre-PA courses can be survey courses, whereas survey courses are accepted in RN programs. Additionally, the PA program requires a 3.2 cumulative GPA, a preferred science GPA of 3.2 and health care experience (average 5,510 hours). Once admitted to the graduate level of training, the NP must complete a master’s level curriculum in a “nursing model” and a PA must complete a master’s level curriculum in the “medical model.” After the fall of 2009, all students entering SDSU for a NP degree will spend 3.5 years studying to obtain the doctor of nurse practitioner degree. The PA program requires 104 graduate level credits and on successful completion of this course of study, the master of science degree will be awarded.

The differences between the medical model and the nursing model relate to the focus and structure of the educational experience of the two respective professions. In comparing the respective training, the medical model of the PA training more resembles aspects of medical school for physicians without the in-depth coursework in pathology and the length of clinical rotations. In addition, no post-graduate training, such as an internship or residency, is required. The nursing model focuses on a more holistic approach to medical care without as much physician shadowing.

**Licensure**

The pathway to NP and PA licensure is unique to each profession in the state of South Dakota. In South Dakota, a NP is subject to the joint control of the South Dakota Board of Nursing and the South Dakota Board of Medical and Osteopathic Examiners.

The initial requirements to be licensed as a NP in South Dakota include being currently licensed by the Board of Nursing as a RN and the completion of a NP course of study. Additionally, there are numerous voluntary NP certifications available through organizations such as the American Nurses Credentialing Center and the American Academy of Nurse Practitioners. In contrast, PAs are licensed solely by the South Dakota Board of Medical and Osteopathic Examiners.

Several organizations provide credentialing resources to fulfill this requirement for NPs, including, but not limited to, the American Academy of Nurse Practitioners and the American Nurses Credentialing Center. As defined in SDCL 36-4A-8, PAs must have successfully completed an accredited educational program for PAs and pass the Physician Assistant National Certifying Exam. In South Dakota, recertification of NPs and PAs is based on the requirements of the original certifying organization’s requirements. In the case of the PA, 100 hours of continuing medical education every two years and sitting for a recertification test every six years is required. NP's typically must complete 75 hours of continuing education every five years and renew their certification every five years.

**Scope of Practice**

The scope of practice for the NP and PA are clearly defined in the South Dakota Codified Laws. NPs are regulated by a collaborative agreement, which is a written agreement authored and signed by the NP and the physician with whom the NP is collaborating. This collaborative treatment includes the scope of advanced practice nursing and medical functions as defined by the board. The PA is an agent of the supervising physician in the performance of all practice-related activities. Therefore, a PA may provide those medical services that are delegated by the supervising
physician pursuant to SDCL 36-4A-1.

By 2015, there will be 200 nursing schools offering the doctor of nurse practitioner degree and the American Association of Colleges of Nursing wants the doctoral degree to replace the master’s degree as the standard qualification for new advanced practice nurses. Advocates for this change in training claim the doctorate degree will give advanced practice nurses the extra clinical experience they need to independently treat patients with complex needs in a variety of settings. Thus, the need for collaboration as defined by South Dakota law will likely be challenged by the advance practice nursing profession.

Interestingly, a nursing group, the Council for the Advancement of Comprehensive Care, collaborated with the National Board of Medical Examiners to create a voluntary exam, which is based on a section of the medical licensing test that measures how well people apply medical knowledge to patient scenarios. This step by the National Board of Medical Examiners has created controversy within the medical profession as stated by the American Medical Association in a 2006 resolution warning that the quality of care rendered by individuals with a nurse doctorate degree is not equivalent to that of the physician. Not only does the nurse doctoral degree give nurses the extra clinical experience they need to independently treat patients with complex needs in a variety of settings, but it is hoped that doctoral nurses passing a national exam will also see an increase in reimbursement commensurate to physicians. There is no current evidence that the educational pathway for the PA is seeking a doctoral level of training at this time.

Practice Types

Because PAs practice under the license of a physician and never independently, they are truly physician extenders and are found in primary, specialty and surgical practices. Therefore, the scope of a PA’s practice, and the type of practice, corresponds with the supervising physician’s practice with the understanding that the supervising physician will handle the more complicated medical cases.

NPs define themselves as nurses with a broad scope of practice and do not define themselves as physician-supervised professionals. As a result, the types of clinical settings in which a NP works is extremely variable. NPs/PAs function under the collaboration/supervision of a physician in South Dakota in various fields of primary care, hospital-based practices, retail clinics, mental health clinics and neonatal care units. The growth of NPs has outpaced the population growth in the principal primary care tracks with adult health, pediatrics, family health and gerontology accounting for 85 percent of NP graduates’ practice focus. In addition, NPs can provide care for at least 60 percent of the patients needing primary care with outcomes comparable to those achieved by physicians. Similarly, “PAs work in a number of specialties, including internal medicine, family medicine, pediatrics or surgery...the exact duties of PAs are dictated by [their] supervising physicians.”

Clinical Outcomes

There is a significant pool of data suggesting that primary care NPs are licensed to provide up to 90 percent of the care provided by their primary care physician counterparts, while providing a level of care comparable to or better than that of a physician. Another study compared patient satisfaction and quality between NPs, PAs and physicians and found that NPs and PAs provided care that was as good as, or better than, the care provided by physicians and at a lower cost, in a nursing home setting. This study further documented a significant difference in satisfaction with care among rural patients treated by an NP and those treated by physicians or a PA. Six aspects of care, including technical quality, personal manner, communication, the natural aspects of care, time spent with the doctor and accessibility of care were studied. The results of this study discovered that more patients were satisfied with care provided by NPs than by physicians or PAs.

Legal

As the role of the NP and PA changes, and with current efforts on the part of advanced practice nursing organizations for more independence, the potential for an increase in the number of lawsuits involving NPs is likely. According to the article by Burkle, one prominent medical malpractice insurer has reported an increase in the number of lawsuits involving NPs. In addition to the fact that there is an increase in the number of NPs practicing today, this article suggests other causes of increased liability risk include: the absence of proper policies and procedures, lack of written practice guidelines, inadequate physician supervision, failure of NPs to properly refer to or collaborate with a physician, and NPs taking on excess independent clinical responsibility. In situations such as in South Dakota, where NPs and PAs work in collaboration or under supervision of a physician, the physician is liable for their actions. However, with the increased interest in independent practice by NPs, there may be an increased legal risk experienced by the independent NP.
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Michael Jaff, DO, Massachusetts General Hospital Vascular Center, Boston, Mass.
Jeffrey Olins, DO, Mt. Sinai School of Medicine, New York, N.Y.
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Conclusion

Various studies project our country will face a shortage in excess of 130,600 primary care doctors by 2025. To meet this projected shortfall, an increase in the utilization of NPs and PAs is anticipated. South Dakota currently provides licensure for both NPs and PAs under the collaboration or supervision of a practicing physician. New initiatives for more independence by NPs with doctorate degrees are developing in South Dakota. Other states have recognized the quality of care provided by these physician extenders and have provided licensure pathways for this independent practice. PAs are not seeking a change in the scope of practice or moving to a doctorate degree at this time. With such changes, consideration regarding quality of care and medical liability will likely surface. These concerns will be balanced against the needs of South Dakota to increase access to healthcare for rural populations and decrease health care costs. It is clear from a review of the literature that increasing the use of physician extenders and increasing their scope of practice is one likely solution. On the other hand, physician resistance to this change has been documented. One option might be to train family physicians over a four-year period rather than three-year period allowing the family physician to earn a master’s in business administration with a health care focus. This would provide the physician with the needed management skills to supervise four or five physician extenders in a new model of collaboration and teamwork consistent with the proposed medical home as encouraged by the ACA. In the end, quality patient care and quality outcomes is the goal; collaboration and teamwork among health care providers is the best way to achieve this desired outcome.

REFERENCES


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Walter O. Carlson, MD, Orthopedic Institute, Sioux Falls.
Tooth Decay Is Preventable!

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Partnership to Decrease Antipsychotic Medication Use in Nursing Homes: Impact at the State Level

By Jane R. Mort, PharmD; Ryan Sailor, MBA; and Lori Hintz, RN

Abstract
In 2012, the Centers for Medicare & Medicaid Services (CMS) established a partnership among stakeholders to decrease the percentage of residents in nursing homes receiving an antipsychotic agent by 15 percent. This goal emanated from concerns including the large percentage of residents taking antipsychotic agents, the questionable use of antipsychotics (e.g., off-label use), the high cost of inappropriate antipsychotic use, and toxicity in patients with dementia (e.g., black box warning regarding mortality). The successful achievement of this goal is evaluated via quality measures, which are greatly influenced by changes in exclusion of residents from the population examined. The partnership is focused on optimizing use of antipsychotic agents by training clinicians on non-pharmacologic approaches, educating on the dangers of antipsychotic medication use and sharing data on antipsychotic medications. In South Dakota, these efforts have yielded a 12 percent relative reduction (21.3 percent to 18.7 percent) in the percent of residents prescribed antipsychotic agents from the second quarter of 2012 to the second quarter of 2013. Future efforts in South Dakota include a Nursing Home Quality Care Collaborative that involves the majority of facilities across the state learning from peers and national experts. The South Dakota Dementia Coalition includes 17 stakeholders who guide education activities and communicate these opportunities to their constituents.

Introduction
A national focus on reducing antipsychotic medication use in nursing homes has yielded positive results in South Dakota. In May 2012, the Centers for Medicare & Medicaid Services (CMS) announced the creation of a partnership “among federal and state partners, nursing homes and other providers, advocacy groups, and caregivers” with the national goal of decreasing antipsychotic medication use by 15 percent in nursing homes by the end of 2012. Multiple reasons support the pursuit of this goal.

First, there is a high level of antipsychotic medications prescribed in nursing homes. One study examined antipsychotic medication use and found that 14 percent of 2.1 million Medicare residents in 2007 had a claim for an atypical antipsychotic agent. A separate study found that 22 percent of 1.4 million residents served by Omnicare Pharmacies in 2008-2009 were prescribed an antipsychotic agent. Second, antipsychotic use has been questioned based on concerns regarding inappropriate use of antipsychotic agents for dementia-related behaviors. In addition, evidence indicates use of antipsychotic agents is often not in compliance with the CMS standards. For example, in May 2011 the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services published data showing that 22 percent of atypical antipsychotic agents claims for Medicare nursing home residents were out of compliance with CMS standards, which require residents to be free from unnecessary drugs (i.e., excessive dose, excessive duration, without adequate monitoring, without adequate indication, or with adverse effects that indicate the need for reduction). Most often the problem was excessive dose, followed by excessive duration and inappropriate indication. Third, the OIG report estimated the cost of antipsychotic medication use that was not compliant with CMS standards at more than $63 million over a six-month period. Finally, in April 2005 the “Food and Drug Administration (FDA) required manufacturers of these drugs (atypical antipsychotics) to include a boxed warning regarding the increased risk of mortality when these drugs are used for the treatment of behavioral disorders in elderly patients with dementia.” All of these factors led to a national commitment to reduce antipsychotic
medication use among nursing home residents.

Quality Measures and Antipsychotics Use

CMS has sought to evaluate and report use of antipsychotic medications through quality measures that are publicly reported through the Nursing Home Compare website at www.medicare.gov/nursinghomecompare, and utilized by nursing homes and surveyors via the Certification and Survey Provider Enhanced Reports (CASPER) system. One important aspect in establishing a measure for use of antipsychotic medications is the creation of exclusions to the population examined for appropriate use. Given the debate surrounding appropriate antipsychotic use, this has not been an easy task. Currently, exclusion of residents with appropriate indications for the Nursing Home Compare and CASPER antipsychotic medication quality measure includes having a diagnosis of schizophrenia, Tourette's syndrome and Huntington's disease. The CASPER system had previously utilized a much broader set of exclusion criteria, which caused CASPER quality measure results to be different from the quality measure results reported on Nursing Home Compare, which used more restrictive exclusion criteria.

Partnership Approach and Outcomes

The CMS partnership involves training clinicians on optimal use of antipsychotic medications, dangers associated with antipsychotic agents, sharing data on use patterns in nursing homes and educating clinicians on non-pharmacologic alternatives to antipsychotic agents. State quality improvement organizations (e.g., South Dakota Foundation for Medical Care [SDFMC]) are actively involved in helping to achieve these goals. Since June 2012, SDFMC has helped to focus health care providers on this issue by recruiting coalition members, providing and sponsoring education sessions, distributing educational information and facilitating group sharing on the issue (Table 1).

Antipsychotic medication use has declined in South Dakota nursing homes over the last four quarters (See Figure 1). Specifically, more than a 12 percent relative reduction was observed in the data from quarter two of 2012 to quarter two of 2013 in South Dakota. While not meeting the high goal of 15 percent reduction, it is a meaningful shift for such a short time period.

Directions for the Future

SDFMC plans to continue to work toward the goal of reducing antipsychotic medication use through providing educational opportunities to health care professionals around this important initiative. In addition, the newly formed South Dakota Nursing Home Quality Care Collaborative will focus on reducing unnecessary antipsychotic medication use and optimizing non-pharmacological approaches to dementia care. Currently 75 percent of South Dakota’s nursing homes have signed on for this 18-month collaborative, joining more than 4,200 nursing homes from across the country. Participants in the collaborative will have access to and learn from some of the highest performing nursing homes across the U.S. and national experts in geriatrics and long-term care. To support the national goals of reducing antipsychotic use and improving dementia care, SDFMC has helped local partners form the South Dakota Dementia Coalition. This is an ad hoc group of 16 stakeholders from across the state who are promoting the initiative by communicating educational opportunities to their constituents. Members of the South Dakota Dementia Coalition are listed in Table 2.

Table 1. Activities of SDFMC to Reduce Antipsychotic Medication Use in the Second Half of 2012

- Formed South Dakota Nursing Home Quality Care Collaborative.
- Formed South Dakota Dementia Coalition.
- Provided articles to South Dakota Association of Health Care Organizations (SDAHO), South Dakota Health Care Association (SDHCA), South Dakota Medical Directors Association and members of the CMS Partnership.
- Sponsored or provided presentations on antipsychotic medication use for nursing home residents at the SDHCA conference, via regional webinar, at the SDAHO Annual Convention, and to 10 local nursing homes.
- Distributed educational materials on the management of residents with dementia.
- Facilitated a listserv discussion on issues related to antipsychotic medication use.

Figure 1. Average Percent of Long Stay Nursing Home Residents Prescribed Antipsychotic Medications in South Dakota Nursing Homes*  

- **Exclusion criteria – schizophrenia, Tourette’s syndrome and Huntington’s disease.**
Appropriate use of antipsychotic agents remains a concern. Efforts are underway to address these concerns through partnerships utilizing national, state and local resources. Only through a concerted effort by all involved health care providers will progress be made on this important initiative.

Table 2. Members of the South Dakota Dementia Coalition

<table>
<thead>
<tr>
<th>Organization</th>
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<tbody>
<tr>
<td>Avera Behavioral Hospital</td>
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<tr>
<td>CMS Central Office and Regional Office representatives</td>
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<tr>
<td>Omnicare of South Dakota</td>
</tr>
<tr>
<td>South Dakota American Association of Retired Persons</td>
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<tr>
<td>South Dakota Association of Health Care Organizations</td>
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<tr>
<td>South Dakota Alzheimer’s Association</td>
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<tr>
<td>South Dakota Culture Change Coalition</td>
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<tr>
<td>South Dakota Department of Health Survey and Licensure</td>
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<tr>
<td>South Dakota Division of Adult Services and Aging</td>
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<tr>
<td>South Dakota Foundation for Medical Care</td>
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<tr>
<td>South Dakota Health Care Association</td>
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<td>South Dakota Human Services Center</td>
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<tr>
<td>South Dakota Medicaid Agency</td>
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<tr>
<td>South Dakota Medical Directors Association</td>
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<tr>
<td>South Dakota Nurses Association</td>
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<tr>
<td>South Dakota State Ombudsman</td>
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<tr>
<td>South Dakota State University College of Pharmacy</td>
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REFERENCES


Please note: Due to limited space, we are unable to list all references. You may contact South Dakota Medicine at 605.336.1965 for a complete listing.

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Lori Hintz, RN, Nursing Home and Drug Safety Program Manager.

This article was prepared by the South Dakota Foundation for Medical Care (SDFMIC), the Medicare Quality Improvement Organization for South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. C54060201-13-386
The American College of Cardiology (ACC)/American Heart Association (AHA) recently published their much anticipated guidelines for the treatment of cholesterol to reduce the risk of atherosclerotic cardiovascular disease (ASCVD), also known as the Adult Treatment Panel (ATP)-4 report.¹ With one in three Americans dying from cardiovascular disease, these treatment guidelines are a welcome tool in the fight against the leading cause of death in the U.S.

While previous guidelines have traditionally offered a comprehensive approach to the detection, evaluation and treatment of hyperlipidemia, this time the panel chose to concentrate their efforts on addressing a few key questions. These questions focused on which patients stood to benefit the most from treatment, which medications offered the strongest evidence for reducing cardiovascular events, and what intensity of treatment was most appropriate for a given population. Due to this change in methodology, the resulting recommendations reflect a drastically different approach for treating cholesterol to reduce the risk of cardiovascular disease.

One of the biggest changes that will be noticed is how lipid-lowering medications are dosed. The expert panel found no scientific evidence to support the traditional practice of titrating doses to a specific LDL-cholesterol goal. They explained that traditional target numbers were originally derived from patients who had already experienced cardiovascular events; these numbers were then extrapolated to healthy populations. Additionally, most of the trials used to establish the role of cholesterol medications in improving cardiovascular outcomes utilized fixed rather than titrated doses. Because of this change, follow-up lipid levels are now recommended as a means to assess treatment adherence rather than to guide dosage adjustments. The new recommendations also focus on those medications with a proven cardiovascular benefit, namely the 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitors, otherwise known as statins. While other cholesterol medications are effective at improving the lipid profile, there is insufficient evidence that they reduce cardiovascular events. Because of this, non-statin therapies are now only recommended for high-risk patients who have a less than expected response to statins, or who are intolerant of statin therapy. The new guidelines also appropriately recognize the superiority of intensive treatment for those at high risk, and attempt to match the intensity of treatment with the patient’s predicted level of cardiovascular risk.

One thing that hasn’t changed in the guidelines is the continued emphasis on lifestyle modifications, including a heart healthy diet and regular exercise, as the foundation for all preventative efforts. The new recommendations are intended to address the treatment of adults aged 21 and older; they specifically exclude some patients such as individuals older than 75 years (unless they have ASCVD), those on chronic hemodialysis and patients with heart failure (NYHA class II through IV) as trials in these populations did not show evidence of a reduction in cardiovascular event rates. The main focus of treatment is on four “statin benefit groups” which represent those individuals who are most likely to benefit from treatment (Tables 1 and 2). The first three benefit groups consist of patients deemed to be “high risk,” including those with known cardiovascular disease, an LDL cholesterol greater than or equal to 190 mg/dl, or diabetes. Patients are placed into the fourth benefit group if their estimated 10-year ASCVD risk score is 7.5 percent or higher.

It was the panel’s method of estimating this risk score that has raised the most controversy amongst clinicians. Previous guidelines used the Framingham risk score, but the expert panel felt this scoring system underestimated cardiovascular risk in certain populations such as women, younger adults and African Americans. Because of this, the expert panel opted to develop their own risk assessment calculator based on the Pooled Cohort Equations for predicting ASCVD risk.² This tool provides a 10-year and a lifetime risk assessment for patients aged 40 to 79 by taking into account factors such as age, sex, race, total cholesterol, HDL-cholesterol, systolic blood pressure, history of diabetes and current smoking status. For the first time in a major guideline, the risk assessment takes into account the risk of stroke as well as the risk of heart attack, and it also provides estimates that are applicable to African Americans. The calculator is available as a smartphone app and online at www.americanheart.org.² Even though critics agree that the new recommendations are a step in the right
direction, they argue that the new calculator greatly overestimates risk, up to two-fold in some database comparisons. They express great concern that under the new guidelines, up to 31 million additional Americans might be candidates for statin therapy. Additionally, they point out that the risk calculator has never been prospectively tested for validity.

The expert panel acknowledges that these and other uncertainties remain. There will always be individuals who don’t fall neatly into one of the four treatment categories, but may still benefit from treatment. They emphasize that the guidelines are intended to serve as a starting point for decision making, and are not meant to replace clinical judgment. All such decisions call for a candid discussion between the physician and the patient, including a review of the patient’s cardiovascular risk, the relative risks and benefits of treatment, and the patient’s preferences for treatment. For those individuals in whom treatment decisions are less than clear, additional markers may be used to enhance decision making. These factors include: LDL greater than or equal to 160 mg/dl or other evidence of genetic hyperlipidemia, family history of premature CVD (onset in a first degree male relative younger than 55 years, or a first degree female relative younger than 65 years), high-sensitivity C-reactive protein greater than or equal to 2 mg/dl, coronary artery calcium score greater than or equal to 300 Agatston units (or greater than or equal to 75th percentile for age, sex and ethnicity) and ankle brachial index (ABI) less than 0.9. Additional clinical trials are needed to further address all of these uncertainties.

Cardiovascular disease continues to be the No. 1 cause of death and disability in the U.S. The latest cholesterol guidelines represent a novel approach that promotes the use of statin therapy in individuals who are most likely to benefit. Even though extensive efforts were made to ensure that only the highest quality of scientific evidence was utilized to build the guidelines, many clinicians are still skeptical of the results and worry about the potential impact of placing millions of more Americans on statin therapy. Only time will tell whether this seemingly more aggressive approach will calm those fears by improving clinical outcomes.

### Table 1.

<table>
<thead>
<tr>
<th>Statin Benefit Group</th>
<th>Recommended Treatment</th>
</tr>
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<tbody>
<tr>
<td>Group 1</td>
<td>Known clinical cardiovascular disease (e.g., coronary heart disease, stroke/TIA, peripheral arterial disease) High-intensity statin unless age over 75 years or intolerant, then use moderate-intensity statin</td>
</tr>
<tr>
<td>Group 2</td>
<td>LDL &gt; 190 mg/dl (primary prevention) statin High-intensity statin unless intolerant, then use moderate-intensity statin</td>
</tr>
<tr>
<td>Group 3</td>
<td>Age 40 to 75 with diabetes and LDL 70 to 189 mg/dl (primary prevention) Moderate-intensity statin unless 10-year risk is 7.5 percent or higher, then use high-intensity statin</td>
</tr>
<tr>
<td>Group 4</td>
<td>Age 40 to 75 years with LDL 70 to 189 mg/dl and an estimated 10-year risk of 7.5 percent or higher (primary prevention; no diabetes) Moderate to high-intensity statin; may consider a moderate-intensity statin if 10-year risk is 5 to 7.4 percent</td>
</tr>
</tbody>
</table>

### Table 2.

<table>
<thead>
<tr>
<th>Statin*</th>
<th>High-intensity</th>
<th>Moderate-intensity</th>
<th>Low-intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atorvastatin (Lipitor)</td>
<td>On average lowers LDL by 50 percent or more</td>
<td>On average lowers LDL by 30 to 50 percent</td>
<td>On average lowers LDL less than 30 percent</td>
</tr>
<tr>
<td>Rosuvastatin (Crestor)</td>
<td>40-80 mg</td>
<td>10-20 mg</td>
<td></td>
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<tr>
<td>Simvastatin (Zocor)</td>
<td>20-40 mg</td>
<td>10-20 mg</td>
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<tr>
<td>Pravastatin (Pravachol)</td>
<td>20-40 mg</td>
<td>10-20 mg</td>
<td></td>
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<tr>
<td>Lovastatin (Mevacor)</td>
<td>40 mg</td>
<td>20 mg</td>
<td></td>
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<tr>
<td>Fluvastatin (Lescol*)</td>
<td>80 mg XL or 40 mg BID</td>
<td>20-40 mg</td>
<td></td>
</tr>
<tr>
<td>Pitavastatin (Livalo*)</td>
<td>2-4 mg</td>
<td>1 mg</td>
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</table>

* All statins are available as generics except for rosuvastatin and pitavastatin. # Initiation of 80 mg dose is no longer recommended due to increased risk of rhabdomyolysis.

### REFERENCES


About the Author:
Kim Messerschmidt, PharmD, Professor, Department of Pharmacy Practice, SDSU College of Pharmacy.
Medical Record Handling

The medical record is a critical vehicle of communication, both in treating patients and in defending malpractice claims. Proper maintenance and handling of medical records is essential to ensure that important medical information is not lost or overlooked.

Appropriate systems and processes for the release and retention of records and accounting of disclosures protect against charges of breach of confidentiality and guarantee that records are readily available if they become an issue in a lawsuit.

Release of Medical Records

Releasing patient information is a significant risk within a health care organization. Staff must familiarize themselves with the basic concepts and protections relating to the release of patient information, as well as the appropriate set of records to release within the legal health record.

Absent an individual’s authorization to allow a provider to disclose protected health information (PHI), privacy rights are granted to individuals through a combination of state law and the Privacy Rule mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, certain disclosures of PHI, following “minimum necessary” guidelines, are permitted without authorization as in the circumstances listed below:

1. Treatment, payment and health care operations.
2. Public interest and benefit activities.
   a. Reporting to public health authorities.
   b. Law enforcement to prevent or lessen serious threats to health or safety.
   c. Reporting suspected abuse or neglect.
3. Required by law or for law enforcement purposes.
   a. In response to law enforcement officials or court orders to assist in criminal investigation.
   b. Judicial or administrative proceedings.
4. Regarding decedents, such as disclosures to funeral directors, coroners, and medical examiners.
5. Regarding cadaveric donations to facilitate donation and transplantation.
6. For purposes of research.
7. Essential government functions including health care oversight agencies during investigation.
8. Workers compensation.

Subject to specific exceptions, release of medical records may be authorized by the individual through written consent containing certain required provisions. Personal representatives and parents or guardians of unemancipated minors may be required to execute such an authorization on the individual’s behalf.

In order to be valid under federal privacy rules, an authorization must include the following:

- A description of the information to be used or disclosed.
- The person, or class of persons, authorized to make the requested use or disclosure.
- The person, or class of persons, to whom the covered entity may make the requested disclosure.
- The purpose of the requested use or disclosure. The statement “at the request of the individual” is sufficient when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose.
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statements “end of the research study,” “none,” or similar language is sufficient if the authorization is for the use or disclosure of PHI for research, including for the creation and maintenance of a research database or research repository. “End of case” or “end of lawsuit” is also acceptable.
- Signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative’s authority to act for the individual must also be provided.

In addition to the required elements listed above, an authorization must include statements that address the following:

- The individual’s right to revoke his or her authorization in writing and either 1) the exceptions to the right to revoke and a description of how the individual may revoke authorization, or 2) reference to the provisions of the covered entity’s Notice of Privacy Practices relating to revocation.
- Notice of the covered entity’s ability or inability to condition treatment, payment, enrollment, or eligibility for benefits on the authorization, including research-related treatment, and, if applicable, consequences of refusing to sign the authorization.
- The potential for the PHI to be re-disclosed by the recipient and no longer protected by the privacy rules. This statement does not require an analysis of risk for re-disclosure but may be a general statement that the privacy rules may no longer protect health information.
- For marketing or sale of PHI, statements must be included disclosing payments received by provider as a result of marketing or sale. Marketing is defined as communication about a product or service that encourages recipients to purchase or use the product or service.

This article includes material originally published by MMIC, MMIC is the largest policyholder-owned medical liability insurance company in the Midwest and is always thinking ahead to find ways to protect clients through risk financing, improving patient safety and physician well-being, and reducing the risks associated with information technology.
Estate planning is a dynamic process that should not only be thought of in hindsight following a possibly life-threatening health condition or passing of a loved one. It should begin immediately and continue throughout your lifetime.

Individuals should set in motion arrangements for the future of their assets and employ an array of strategies to ensure that those assets go to the intended parties and that their survivors are supported financially.

**Transfer of Assets**

Multiple vehicles are available for distributing your property following the end of your life.

If you pass “intestate” – without leaving a will – state law will determine how your property will be distributed. While officials often attempt to do this fairly, it may not satisfy your intentions and may be a lengthy and cumbersome process for your loved ones.

A will names recipients and an executor of your estate. It is a legal document prepared under state law to ensure there are no ambiguities about your wishes. Following your passing, a court-supervised distribution of your assets – known as probate – will occur, unless your estate planning documents and beneficiary designations are constructed so that all of your property is distributed without need of probate. This can reduce costs and allow for a more timely and confidential settlement of your estate.

Trusts may be used for transferring some of your assets. An individual or corporate entity is named as the trustee, who is responsible for managing the assets transferred to the trust for your benefit or for your designated trust beneficiaries. There are various types of trusts, each with their own advantages and uses.

Many people own assets as joint tenants with rights of survivorship. As such ownership will automatically transfer to the surviving owner under operation of law.

In the case of certain assets, like qualified retirement plans and life insurance policies, you will name beneficiaries to receive your account balance and policy death benefits.

**Caring for Survivors**

Estate planning should take into account your survivors, including your spouse, children and other dependents.

Some of your assets may require gradual liquidity, such as funds distributed to minor children. Guardians should be designated to care for any children who may be under 18 years of age in the event that both you and your spouse pass prematurely. Life insurance can also be used as a means of establishing an estate to support your family.

**Minimizing Transfer Costs**

Effective estate planning incorporates measures to minimize taxes and legal costs so you can distribute as much as possible to your heirs.

Trusts can be used to avoid the expenses associated with probate. Strategies such as charitable giving, bypass trusts, marital deduction and lifetime gifts can all be employed to limit estate taxes.

Once measures are put in place for the transfer of your assets, you should review your estate planning documents and beneficiary designations annually to make any needed changes.
Quality Focus:
Future Quality Improvement Work

By Stephan D. Schroeder, MD, Medical Director,
South Dakota Foundation for Medical Care

On Dec. 5, 2013 the Centers for Medicare & Medicaid Services (CMS) released a request for proposal for the QIO 11th Scope of Work (SOW), which is scheduled to begin on Aug. 1, 2014. The Quality Improvement Organization (QIO) program is the federal government’s largest coordinated effort for improving health care at the community level. South Dakota Foundation for Medical Care (SDFMC) is currently the designated QIO for the state of South Dakota.

The 11th SOW will be structured differently than prior scopes of work in that CMS is requiring QIO contractors to be responsible for a minimum of three states up to a maximum of six states. Quality improvement efforts will continue to be conducted on a local or statewide level, but will also include a regional component to facilitate collaboration with providers in other states. Additionally, case review and beneficiary protection activities for South Dakota will be performed under a regional QIO contract. CMS has stated that the goal of these changes is to bring efficiencies to the program and support the spread of best practices across state borders.

The following table summarizes the aims, goals and activities of the 11th SOW.

<table>
<thead>
<tr>
<th>Aim</th>
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<th>Description</th>
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Contract awards for the 11th SOW will be announced in July 2014 and after that time we will let providers know how they can participate in our quality improvement opportunities. Please keep up the good work of providing the best care for your patients, and let me know if there is anything SDFMC can do to be of assistance.

"Quality Focus" is a monthly feature presented by SDFMC, South Dakota’s Quality Improvement Organization. For more information about the SDFMC, visit their website at www.sdfmc.org or SDSMA’s website at www.sdsm.org.
SDBM O E Board News

By Margaret B. Hansen, PA-C, MPAS, Executive Director
South Dakota Board of Medical and Osteopathic Examiners

SDBM O E Member Update
Gov. Dennis Daugaard has re-appointed Mary S. Carpenter, MD, and appointed Laurie B. Landeen, MD, and Ms. Deborah Bowman for three-year terms as members to the Board of Medical and Osteopathic Examiners.

Renewal Cycle for South Dakota Medical Licenses Continues Until March
If you are experiencing difficulties with your online renewal application, please contact the SD BM O E staff for assistance. The staff is also collecting feedback regarding the renewal application in an effort to make improvements in the future. The following information was published in last month’s article and is being reprinted as it contains helpful renewal material.

The South Dakota Board of Medical and Osteopathic Examiners (SDBM O E) is requesting additional data with licensure renewal applications this year. This effort is part of a state and nationwide effort to identify information about health care professionals including academic training history, where and what services are provided to patients as well as other demographic information. Gov. Dennis Daugaard made improving the availability of health care providers in rural South Dakota a key provision of his South Dakota Workforce Initiative (SD WIN S).1 This effort has been approved by the South Dakota Legislature.2

A recent Associated Press story also highlights the problem in South Dakota. Nineteen of South Dakota’s 66 counties lack a primary care physician.3 Information gathered by the SD BM O E from the new questions on the renewal applications may provide assistance in determining how effective the rural recruitment efforts have been, and how to adjust those efforts to meet anticipated needs. The SD BM O E will ask the questions of all their regulated professions to provide a more detailed look at which health care personnel are available to serve the needs of South Dakotans.

Frequently Asked Questions (FAQ) that the Board Staff is fielding this year:

Q: You already have my medical school information. Why do you need it again?
A: The academic training information is not yet available in an electronic format; therefore, for this year, licensees will need to provide the month and year of completion for medical school and post graduate training.

Q: How do I answer the “how many weeks worked” question?
A: Use the actual number of weeks worked. For example, if you took two weeks of vacation, the answer would be 50 weeks.

Q: The “Please provide more details…” box comes up after one of my answers. If I made a mistake, can I type: “I hit the incorrect answer” in the explanation field?
A: Yes, that would be an appropriate response. If more details are needed for this or any other explanation, you will be contacted.

Q: The individuals that I supervise are not correctly listed. What do I do to change this?
A: Please send an email with the necessary corrections and the board staff will assist you. You can see who you are supervising at any time by doing a Licensee Look-Up on the Board website.

Q: Why are you only asking about the American Board of Medical Specialties (ABMS) board certification? Shouldn’t the American Osteopathic Board (AOA) certification be asked as well?
A: At this time, only the ABMS is being requested as it is the only board certification organization mentioned in the South Dakota medical practices act. Also, this question was already part of the information technology (IT) system so it was relatively easy to include in the renewal application. Next year the ability to ask about AOA certification may be available.

REFERENCES
2. SDCL 34-12G.
Don’t forget to send in your favorite scenic photo for South Dakota Medicine front cover consideration. Send photos to ereiss@sdsma.org.

Child & Adolescent Neurology
Jorge D. Sanchez, MD

Complete care for children and adolescents, treating:

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Jorge D. Sanchez, MD
Greetings to you and a belated happy new year. We have “hit the ground running” here at DAKOTACARE already in 2014, mostly with the ever-changing rules associated with the Patient Protection and Affordable Care Act (PPACA) as company CEO Kirk Zimmer expanded upon in last month’s article. I’m sure you are equally, if not more, confused and frustrated as you attempt to follow and identify which of these changes will impact your patients and your practice. I have the privilege to work with many intelligent, energized and highly ethical individuals in this company, all working together to ensure we provide unsurpassed health care coverage to our members. We will continue to serve as your advocate and attempt to help you better understand the new health care landscape as it revolves around the payer-provider landscape.

The title of my article hopefully interested you enough that you have continued to read at least this far. A new year sparks interest for many to introspectively evaluate where we’ve been and establish goals to where we plan to go in the future. I have a few of my own goals which I’ll point out later, but first I wanted to promise you that DAKOTACARE’s Strategic Goal has not and will not waiver:

To differentiate itself from other managed care organizations and achieve long-term success by focusing on truly effective medical management and highly efficient processes in order to provide the highest quality, cost-effective health care to its members in a manner that recognizes, respects, and enhances the primacy of the patient/physician relationship.

Perhaps you were not aware of this company strategic goal. It is lofty, but attainable. More importantly, it requires a constant focus upon our core values of Integrity, Initiative, Innovation, Accountability, and Community Involvement. These values are based upon the principles (e.g., a moral rule or belief that helps you know what is right and wrong and that influences your actions) of the company founders 25-plus years ago. They may seem passé in the “new age” of health insurance, undermined by current political and market conditions; however, I wanted to reassure you that we remain firmly committed to all of these values. If you ever have concerns about our business practices, I encourage you to contact me directly.

If you happen to visit our company office in Sioux Falls – and I encourage you to – you will see the following Four Marks of Value posted on the wall in our public conference room:

1. Our ability to make health care easier for you; and
2. Our solid plan features and options;
3. Our investment in quality care for you; and
4. Our stability and financial strength.

All of our efforts related to the operations of this company need to reflect these values. Hopefully you can identify these values within the aspects of DAKOTACARE which impact you, your family or your patients. Our Executive Team has studied the health care landscape carefully and prioritized our goals into major business initiatives of regulatory compliance (necessary in this new era), product delivery enhancement, network/reimbursement transformation, increasing focus on communications (to members and providers) and well-being, and expanded decision support for our internal provider quality measurement. These may seem mundane, but I can guarantee you these are vital in the transformation of this company to stay competitive.

When is the last time you thought deeply about your personal values, principles or professional/personal goals? Have they deviated from medical school/residency training days when we were all so very focused on altruistic patient care? Have the “privileges” described in the quote at the top superseded your principles? Hopefully not, but it is very easy during the day-to-day multiple responsibilities you balance to forget to re-focus and be sure your professional goals and principles continue to be properly aligned with your personal ethics. This new year is a perfect time to re-examine and reflect.

I promised at the beginning of this article to share some of my own goals. Wearing my CMO hat I will be focusing much more this year on helping to direct this company toward increased emphasis on value-based reimbursement models. DAKOTACARE has already begun discussions with various provider groups to transform compensation models, while fully understanding this area continues to be a “process in evolution.” Enhancements in contracting and provider quality measurements will be necessary to support this initiative. Stay tuned here; you will be hearing much more from me on this topic in the year(s) ahead. On a personal note, I am striving to be a better listener and more intentional in my recreational reading, with much assistance from my wife. I hope to share more insights into those areas in the near future as well.

I would be remiss if I didn’t recommend some jazzy notes to soothe your winter doldrums: DOTERO is a contemporary smooth jazz group from Colorado who take their name from a small mountain town in the Rocky Mountains, meaning “something unique” according to Ute Native American legend. Enjoy!
Extenuating Circumstances

Earl Rose, MD, JD – A Personal Recollection

By Steven P. Olson, MD

As has been heavily covered in the media, last fall (November 2013) marked the 50th anniversary of John Kennedy's assassination. Anyone who was born before 1958 or so has the events of that day seared in his or her memory. We baby boomers were just children then, and for many of us, this was our first exposure to death, violence and loss. I have often wondered what the psychological effects of that day had on the members of my generation, just as I suspect the events of 9/11 may have damaged the psyche of my children's generation.

On Nov. 22, 1963, I was in third grade and living in Ottumwa, Iowa. It also happened to be my 9th birthday. I recall the principal coming into our room around 12:45 and saying, “I think you children are old enough to understand this, but the president has been shot.” Of course we were dumbfounded. About a half-hour later he leaned in the room, said, “The president is dead,” and walked out. No further explanation. My grandfather and teenage uncle happened to be visiting us that day. Everyone tried to put on a brave face as we celebrated my birthday that evening but I am sure my parents were devastated, as was the rest of the nation. I never would have imagined as a young boy that a person central to the events that day would someday be my mentor and friend.

Earl Rose was from western South Dakota. He grew up on a ranch near Eagle Butte on the Cheyenne River Indian Reservation. He served in the U.S. Navy in World War II in the submarine service. He went to Yankton College, also the school my mother attended. She has told me she knew of him but did not know him personally as he was an upper-classman. Earl went on to attend medical school for two years at the University of South Dakota and finished at the University of Nebraska. He was in general practice in Lemmon, South Dakota, and later completed pathology residencies at Baylor University and DePaul Hospital. He went on to complete a forensic pathology fellowship at the Medical College of Virginia and later earned a law degree from Southern Methodist University. On Nov. 22, 1963, Dr. Rose was Dallas County medical examiner and based at Parkland Hospital.

Eighteen years later I began a residency in pathology at the University of Iowa. Dr. Earl Rose was on the faculty. I had contact with Earl one time prior to starting residency. In my first year of medical school, it was common for various members of the medical faculty to give lectures to the students about some aspect of their practice. One day Earl came and talked to us. I don’t remember the topic, probably something related to medical-legal issues. Dr. Rose said to the class, “You are all planning to become family doctors in rural Iowa, aren’t you? That’s what you all put on your application to medical school!” Of course everyone laughed since very few students at that time were interested in such a career, with most thinking about specializing. Earl looked at us with a grin. I would learn in later years this was typical Earl Rose humor.

The word in the pathology department was that Dr. Rose had been in Dallas on that day many years ago but it was a subject that was off limits. I don’t think any of the residents ever broached the subject with him. Earl (the department was very informal; we called all the faculty members by their first names) was known as a specialist in autopsy pathology, cytology and cardiac pathology. Although board certified in forensic pathology and by that time also possessing a law degree, medical-legal death investigation was not a major focus of his academic practice. Earl had appointments in both the College of Medicine and the College of Law and taught courses in both disciplines. He additionally gave guest lectures to medical students at USD.

As a pathology resident, I interacted with Earl often, signing out surgical pathology cases, cytology specimens and autopsies. I quickly came to respect and appreciate him. He was a “hands-on” teacher, often making you do things outside your comfort zone. When you were looking at a specimen, he would say, “Hey, look what you found here!” when in fact he had found it and was pointing it out to you. I think it was his way of encouraging the residents and making us feel smarter than we were.

One case in particular has stuck with me. It was a Sunday morning and I was on call to do autopsies. I received a call from the hospital mortician that we had a murder case to deal with. They had called Dr. Rose to come in and help even though he was not on call and didn’t do much forensic work anymore. Nonetheless he came in and, to my eternal gratitude, helped me with the case.

The story was very unfortunate. A young couple had been to a Halloween party the night before. We had access to
pictures taken at the party. The young lady was dressed in a rather sexy outfit. Her boyfriend, a black belt in karate, wanted to go home. She decided to stay and went home alone. When she returned home there was a jealous altercation. He grabbed her by the hair and pounded her head against the wall. They went to bed and hours later he woke up and found her unresponsive. He called for an ambulance and she was transported to University of Iowa Hospitals where she was pronounced dead in the emergency department. The cause of death was head trauma and the manner of death was homicide.

Needless to say the young man was charged with murder and the case was scheduled for trial. Earl and I met with the prosecutor. I assumed that Earl would take the lead given his experience. To my surprise, he volunteered me to testify. He told me with typical enthusiasm, “Steve, you need to give a deposition and go testify in court. I told the prosecutor to subpoena you.” And that was what happened. I gave a deposition to the defense attorney and testified in court. Intimidating to a 20-some year old novice, yes, but what an education. I have always been grateful to Earl for that. The young man was found guilty and sentenced to life.

One day I was talking to Earl about forensic pathology. He said, "It gets boring after awhile. Plus it is very political. You are always asking for funding and equipment. Also, you need the right facilities. It should never be practiced in a hospital setting. When you get a badly decomposed body the smell can be very powerful and spread all over the place.” I said the smell would be one thing I would never get used to. His response was, "Oh, you can learn a lot from the smell!" He was completely serious. I indicated I would have to take his word for it.

Earl was always full of stories and pearls of wisdom. One of his comments was, "the guy who pounds his fist on the table hardest is the one who is right." In pathology, interpreting the slide and deciding what disease process is present has a certain subjective character, especially in that era when many of the current immunohistochemical and molecular techniques were unavailable. This was Earl's way of saying when the diagnosis is uncertain, the pathologist who is "correct" is the one with the most publications or is generally recognized as an authority. I have reflected on this idea on numerous occasions over the years when faced with a tough case that required consultation with an “expert.”

Earl would occasionally relate an episode from his forensic career. Prior to going to Dallas, he had worked as a medical examiner in Virginia. One time a body was found submerged in a canal. The decedent was tied to a weighted chair and a shotgun was present on the canal bank. The individual had suffered a shotgun blast to the chest. Murder, right? No – the manner of death was suicide. The person had tied himself to a weighted chair on the canal bank and fired the shotgun into his chest. When he died and lost all muscle tone the weight pulled him and the chair into the canal. Apparently he wanted to commit suicide but did not want to be found afterward. Despite clever planning, it didn't work out that way.

Earl was always good humored and approachable. I only saw him get angry one time. One of his areas of expertise was cardiac pathology. Congenital defects of the heart can be very complex and difficult to visualize. It requires an ability to picture the abnormal heart in three dimensions and being able to dissect very small structures – skills I never mastered. Whenever the residents had to do an autopsy on an infant that had died of congenital heart disease, Earl was always the one to help figure it out. One day I was in the morgue and Earl was helping a pathology extern perform a dissection of an abnormal infant heart (externs were medical students who took a year off from school to work in the pathology department and performed duties similar to the residents). Earl specifically told the extern not to make a cut at a certain site, which the extern promptly did. Earl absolutely exploded. I was glad his temper was not directed at me that day!

Earl never talked about November 1963, and no one asked him. In later years, his story became more public. In 1992 a then-retired Dr. Rose gave an interview to the Journal of the American Medical Association. The journal was doing a story on the Kennedy assassination and interviewed the doctors who treated the president at Parkland Hospital and the military pathologists who performed the autopsy at Bethesda, as well as Earl. Additionally, in 2005 he donated his personal papers regarding the assassination to the University of Iowa. These accounts describe how Earl went nose to nose with the Secret Service in the Parkland Hospital emergency room. Earl noted that a murder had occurred in Dallas and it was the medical examiner's responsibility to perform the autopsy. A judge was called but he was too terrified to argue with the Secret Service. Finally Earl had to back down. In his words, “I had no minions, no armies to enforce the will of the medical examiner.” The body was taken back to Washington on Air Force One. Earl was embittered that the law, which was clear, didn't apply to an individual who was exempt due to status or the wishes of his famous wife. There is no federal statute regarding murder, and at that time, there was no federal law regarding assassination of a president. The jurisdiction was clearly with the State of Texas. The Secret Service that day had no right to take the president's body away. One can only imagine the depth of their shame that day. The president had been killed on their watch – the ultimate failure. I suspect the behavior of the federal agents that day was motivated largely by this – as well as by grief.
President Kennedy’s autopsy was performed in Bethesda, Maryland, at the Naval Medical Center. It was performed not by trained forensic pathologists, but by hospital pathologists. Similar to what I do, their focus was on handling tissue specimens from living patients for diagnostic purposes. Hospital autopsies are generally limited to patients who die from disease, not medical-legal cases. The Bethesda pathologists did not have the training or equipment to properly perform such a complex case. Furthermore, they did not have access to the president’s clothing or to the treating physicians – absolutely critical information. Their lack of this material led to misinformation, particularly regarding the president’s neck wound. Unbeknownst to the pathologists, the Parkland doctors had performed a tracheostomy through the neck exit wound. This led to all kinds of unnecessary confusion regarding what happened to the bullet (it had passed through Kennedy and hit Governor Connolly). This would have been a non-event if the autopsy had been performed in Dallas. Dr. Rose would have had face-to-face communication with the ER doctors, and this would instantly have cleared up any confusion. The Navy pathologists did the best they could, but their report is universally regarded as sub-optimal. No single set of events has fed conspiracy theories more than the mishandling of the president’s body and autopsy. Had the law been followed and the Dallas medical examiner performed the autopsy, many of the nonsensical conspiracy theories would never have arisen.

What if Oswald had not been murdered? A trial would have been held in Dallas. Nothing is more important in criminal cases than maintaining the chain of evidence, and the decedent’s body is the most important piece of evidence. The actions of the Secret Service that day totally corrupted the process. At trial, Oswald’s defense attorney would have had a field day claiming that the body had been tampered with on the trip to D.C. or that the Navy pathologists had somehow altered the wounds. Reasonable doubt could have been raised and perhaps Oswald would have been acquitted. We will, of course, never know.

Earl was personally attacked for his role in the events of that day. The most prominent criticism came in William Manchester's book, *Death of a President.* He described Earl’s actions that day as inappropriate, obstructionist and insensitive to the Kennedy family. In retrospect, the feelings of the Kennedy family at that time were of no consequence. A murder had been committed and there was a proper procedure that needed to be followed. Manchester was completely wrong in his criticism of Earl. Dr. Rose was the only man in the room thinking clearly that afternoon about what needed to be done. Over the years, Earl received all kinds of hate mail and death threats because of this book. It is probably the main reason he ended up in Iowa City – a place to carry on his career with some degree of anonymity. Although he carried some bitterness, he never let it show. He was always the consummate professional and teacher. And history has shown that he was in the right that day in Dallas.

Earl did perform several other high-profile autopsies related to the assassination. He autopsied Officer J.D. Tippit and Lee Harvey Oswald. Several years later, he performed the postmortem examination on Jack Ruby who died in prison from cancer. Years later, a British writer hypothesized that it really wasn’t Oswald who had been killed in Dallas but a Soviet agent that was impersonating him. Part of the theory was based on discrepancies between findings at Oswald’s autopsy and his physical exam when he was in the Marines. One of the discrepancies was that Oswald was described as having a scar behind one ear on his Marine Corps physical, and this was not mentioned in the autopsy report. I recall a local reporter asking Earl about this. He responded, “I probably missed it.” I can just imagine the grin on Earl’s face. Ultimately the body was exhumed and needless to say it was quickly proven that indeed Lee Harvey Oswald was in the grave. One more conspiracy theory down the drain.

Unfortunately, I did not keep in touch with Dr. Rose over the years since I finished my pathology residency and for that I am regretful. He attended the 50th anniversary of his graduation from USD medical school. The last time I saw him was about 10 years ago when I attended a retirement dinner for another faculty member from the University of Iowa Pathology Department. At that time Earl looked great and hadn’t changed at all. Unfortunately, he later developed Parkinson’s disease and he and his wife moved to a retirement home. He died in 2012 at age 85.

Despite all the controversy, Earl was in total agreement with the findings of the Navy pathologists. He reviewed all the forensic evidence and was convinced that President Kennedy was killed by two bullets fired from behind. There was no evidence of a second shooter. When asked about all the conspiracy theories, Dr. Rose’s response was, “The defamers of the truth can only be confronted and defeated by the truth. Do not attribute to conspiracy what can be explained by distrust, inexperience or ineptitude.” Amen, Earl.

**REFERENCES**


**About the Author:**

Steven P. Olson, MD, Pathologist, Physicians Laboratory, LTD, Sioux Falls.
Why does the female breast get so much attention?

Why has the female organ, which has evolved to feed her newborn child become Madison Avenue’s sure-fired way to sell almost anything to men and women?

Is it because of the infant memory most of us have of the calming, unconditional caring nature of Mama, and of the nutritious and life-sustaining milk coming from her breast?

Or is it because breasts are usually covered, or partly hidden from public view? Is it the fact breasts are forbidden fruit, and it is the social allure of the taboo that has made them so interesting? Jerry Seinfeld said that, “If women kept their heads covered instead of their breasts, we’d all be heading down to the corner store to pick up the latest copy of Heads Illustrated.”

I think the answer to our question runs deeper than juvenile musings or the appeal of a prohibited peek. Evolutionary psychologists speculate that breasts are what attracted ancestral males seeking a healthy partner with whom to make children. It is therefore no surprise that the human female is the only primate that possesses fully formed breasts even when not pregnant.

Is it also because of breasts that humans are the only mammals that mate in the frontal, facing-each-other, more interactive manner? And is it true what anthropologists suggest, that the consequence of that female-to-male, face-to-face, caring to competitive interaction, that has lead to a more compassionate and just nature of our societies allowing for social progress instead of war?

And yet with all this interest, the breast can turn cancerous and become a source for fear, loss and suffering. It is appropriate and even glorious that we have advanced our medical and surgical knowledge to discover breast malignancy, to remove the destructive tumors, and to repair and reconstruct the breasts back to their original shape and consistency. Think how devastating to lose them, and not be able to get them back.

A woman’s breast is at once the origin of intimacy, the nourishing gift of mother’s milk, perhaps the foundation for civilization, and then after all this nurturing, to become such a potential source for individual suffering. No wonder breasts get all that attention. They deserve it.
Syphilis: Physician’s Guide

Syphilis is a systemic, sexually transmitted disease (STD) caused by the Treponema pallidum bacterium.

SYPHILIS TRANSMISSION:
- Person to person via vaginal, anal, or oral sex through direct contact with a syphilis chancre.
- Person to person during foreplay, even when there is no penetrative sex (much less common).
- Pregnant mother with syphilis to fetus.

SIGNS and SYMPTOMS
If left untreated, syphilis progresses in stages.

PRIMARY SYphilIS:
- One or more chancres (usually firm, round, small, and painless) appear at the site of infection (most often the genital area) 10 to 90 days after infection.
- The chancres heal on their own in 3-6 weeks.
- Patient is highly infectious in the primary stage.

It is very important for people who test positive for HIV and other STDs to get tested for syphilis, since transmission of HIV is enhanced by syphilis and other STDs.

SECONDARY SYphilIS:
- Rashes occur as the chancre(s) fades or a few weeks after the chancre heals.
- Rashes typically appear on the palms of the hands the soles of the feet, or on the face, but also may appear on other areas of the body.
- Sometimes wart-like “growths” may appear in the genital area.
- Rashes and syphilitic warts tend to clear up on their own within 2-5 weeks but may take as long as 12 weeks.
- Patient is highly infectious in the secondary stage.

EARLY LATENT SYphilIS:
- Patient is seroreactive within one year of onset of infection, but has no symptoms.
- Patient is potentially infectious.

LATE LATENT SYphilIS:
- Patient is seroreactive more than 1 year after onset of infection, but has no symptoms.
- Patient is not infectious in late latent stage.

LATE (TERtiARy) SYphILIS:
- Manifestations in the skin and bones (gummas), central nervous system, and cardiovascular system.
- Patient is not infectious in late stage.

DIAGNOSIS
- Syphilis diagnoses are made using two types of blood tests: 1. nontreponemal tests (VDRL and RPR) and 2. treponemal tests (FTA-ABS, TP-PA, various EIAs, and chemiluminescence immunoassays).
- The definitive diagnostic method is by darkfield microscopy, which is rarely used any more.
- Examine patient thoroughly and obtain sexual history, as many patients do not notice the signs and symptoms of syphilis because chancres can be hidden in the vagina, rectum, or mouth.
- Contact the health department for information and help with partner notification. Report all presumptive and confirmed cases of syphilis within 3 days of diagnosis (Secure web at sd.gov/diseasereport or call 800-592-1861).

TREATMENT www.cdc.gov/std/treatment/
- Primary, Secondary, or Latent <1 year. 2.4 million units IM of Benzathine Penicillin G in a single dose
- Latent >1 year, latent of unknown duration, late cardiovascular, gumma. 2.4 million units IM of Benzathine Penicillin G in 3 doses at 1 week intervals (7.2 million units total)
- Pregnant women. Treatment during pregnancy should be the penicillin regimen appropriate for the stage of syphilis (See CDC Treatment Guidelines)
- Neurosyphilis. 3 to 4 million units IV of Aqueous Crystalline Penicillin G every 4 hours for 10-14 days (18-24 million units/day)
- Penicillin allergies. See CDC Treatment Guidelines

Note: For treatment information on congenital syphilis and syphilis in children (early, primary, secondary, latent [both <1 year and >1 year or of unknown duration], late latent and HIV co-infection) please see CDC Treatment Guidelines.

Full diagnosis and treatment guidelines, educational, visual and epidemiologic resources at www.cdc.gov/std/syphilis or call the South Dakota Department of Health 800-529-1861.
Member News

Visit www.sdsma.org for the latest news and information.

For Your Benefit:

Membership Services

Your membership is voluntary, and we appreciate it. SDSMA Membership Services works hard to ensure that you have the programs and services you want and need, as well as marketing the SDSMA to potential new members. We want to hear from you if you have questions, concerns or ideas on how we can serve you better, or if you know of a potential new member. It’s your association and we’ll work with you to make it the best it can be.

We still haven’t told you about all the benefits of your membership in SDSMA, so stay tuned! If you’d like more information about Membership Services give us a call at 605.336.1965, visit the SDSMA website at www.sdsmoa.org, or email Laura Olson at lolson@sdsmoa.org or send an email to membership@sdsmoa.org.

We never take your membership in SDSMA or your input and activism for granted. Thank you.

“For Your Benefit” is the SDSMA’s monthly update on programs and services available to physicians through their affiliation with the SDSMA.

Medical Records Privacy – Disclosures Without Patient Consent

Patient health information is protected from disclosure under both state and federal law and privacy rules mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, law provides for circumstances where a patient’s health information may be disclosed without his or her consent.

The federal privacy rules provide for the disclosure of protected health information without the patient’s consent in certain circumstances as described below:

• Administrative or judicial proceedings pursuant to an order of the court of administrative agency, or pursuant to a subpoena;
• Law enforcement and criminal investigations and related court orders, warrants, subpoenas, or summons issued by a judge or grand jury;
• Protection of the health or safety of others;
• Treatment, payment and other health care providers for the purposes of a referral or coordination of treatment;
• Investigative or oversight agencies for regulatory activities such as audits, investigations, inspections, licensure or disciplinary actions;
• Reporting suspected abuse or neglect of children, disabled adults and the elderly;
• Public health activities for the reporting of statistical data;
• Parents or guardians of a minor or adult subject to a guardianship; and
• Workers’ compensation claims or proceedings.

For more about medical records privacy, download the SDSMA legal brief Medical Record Privacy – Disclosure Without Patient Consent at www.sdsmoa.org. Through the SDSMA Center for Physician Resources, the SDSMA develops and delivers programs for members in the area of practice management, leadership and health and wellness.

Source: SDSMA staff

New HHS Regional Director

Kim Gillan has been appointed Region VIII director of the U.S. Department of Health and Human Services.

Gillan served in both the Montana House of Representatives and Senate. She most recently served as Director of Workforce Development & Training Programs at Montana State University, where she was responsible for the strategic and operation direction of workforce-related programs for the university.

Source: HHS

SDSMA President Completes Visits to Districts

SDSMA President Daniel J. Heinemann, MD, has completed his travels to each of the 12 district medical societies, with the final meeting on Jan. 20 hosted by Seventh District Medical Society.

Dr. Heinemann and physicians attending the meetings discussed issues facing patients and physician practices, the challenges faced in health care in South Dakota and nationwide, and ways physicians can work together toward common goals. Members also discussed Gov. Dennis Daugaard’s fiscal year 2015 budget proposals and the SDSMA’s advocacy issues for the 2014 legislative session. Read more about the SDSMA’s 2014 Advocacy Agenda in this issue’s Member News feature, “The Issue Is…”

Source: SDSMA staff
The governor said in approaching the federal government, his goal would be to get approval to cover South Dakotans earning below 100 percent of the federal poverty level.

In addition, the SDSMA has long been an advocate for increased funding for medical education as the state’s need for physicians will only increase as our population ages. The SDSMA is pleased that Gov. Daugaard proposed to expand medical school slots by 44 students over the next four years at the Sanford School of Medicine of the University of South Dakota, and looks forward to continuing work with the governor and legislature to address the state’s shortage of physicians to ensure access to high-quality care for South Dakota patients.

With the expansion of medical school class size, the number of slots available in South Dakota for residency training must also be looked at. Currently, the state has 225 medical students and only 137 residency training slots.

The SDSMA’s 2014 Advocacy Agenda is available at www.sdsmua.org under Advocacy.

Source: SDSMA staff and Argus Leader

Sound Medical Record Documentation Webinar

On Feb. 20 at 7 p.m. CT, the SDSMA Center for Physician Resources will present a webinar, “Sound Medical Record Documentation.”

This presentation is the second of six programs designed to offer physicians and medical students information on mitigating risk in clinical practice. The free program is being offered as part of the Center’s Practice of Medicine education series and will provide key information about how physicians can protect themselves against liability claims by identifying and mitigating risk. Don’t miss this information on key ways to:

- Mitigate risk with accurate and complete documentation;
- Avoid documentation pitfalls that can be used against you in a claim; and
- Conduct a self-assessment of documentation practices.

Upcoming SDSMA Center for Physician Resources programs will include topics such as patient communications, how to avoid a HIPAA security breach, supervisory responsibilities, and more.

To register for the webinar, visit www.sdsmua.org.

Source: SDSMA staff
DAKOTACARE Approves Class C Stock Redemption and Reserve Payment

The DAKOTACARE Board of Directors met in early January and approved both a redemption of Class C stock and payment of contingency reserve balances to physicians.

Approximately $2.3 million in contingency reserve balances previously withheld, marking the 21st return of contingency reserves in the 24 years since repayment began in 1988, were distributed on Jan. 10. Letters were sent to providers and clinics announcing the repayment and amounts. Any questions on the contingency reserve repayment may be directed to the Provider Relations Department at DAKOTACARE.

The Board also approved a redemption of additional shares of Class C stock under the redemption plan approved by shareholders in October 2011. An original redemption of 20 percent of its Class C shares carried out in February 2012 was followed by another redemption of 20 percent of the original number of shares in February 2013. The current redemption approved will redeem an additional 23 percent of outstanding shares, or 14 percent of the original shares, of Class C stock. Shares will be redeemed at the established redemption price of $20,500 per share, plus a consumer price index adjustment. After this third redemption, only 46 percent of the company’s original Class C shares will remain outstanding.

Shares to be redeemed will be selected by a random process set forth in the approved redemption plan, and affected shareholders will be notified by letter in March 2014. Shareholders whose shares were not selected for redemption will also receive a letter informing them. April 22, 2014 has been established as the redemption date.

Although there is no guarantee when, or if, Class C shares will be redeemed, the DAKOTACARE Board is authorized to carry out future redemptions of the Class C stock based on the financial performance of the company as well as minimum regulatory capital and working capital requirements, and will continue to annually consider future redemptions.

As part of an amendment made to DAKOTACARE’s Articles of Incorporation in October 2011 which authorized the stock redemptions, an additional class of common stock, Class S, was created. One share of Class S stock was issued to the SDSMA. Once all of the shares of Class C stock can be redeemed in the future, the SDSMA would hold all of DAKOTACARE’s outstanding capital stock and could receive any dividends or distributions from DAKOTACARE that may exist.

Class C shareholders with questions about the plan or their shares should contact DAKOTACARE Shareholder Relations at 605.334.4000.

– Kirk Zimmer, DAKOTACARE CEO

Risk Pool Will Continue Another Year

Gov. Dennis Daugaard will not propose the elimination of the South Dakota Risk Pool during the 2014 Legislative Session.

However, no new participants will be enrolled unless they do not qualify for coverage elsewhere. In addition, the Risk Pool will be communicating with current enrollees that open enrollment for private coverage continues until March 31, and to evaluate obtaining such coverage prior to the inevitable closing of the Risk Pool plan.

Those with questions may contact the South Dakota Risk Pool Office at 605-773-3148, email riskpool@state.sd.us, or visit http://riskpool.sd.gov/.

Source: South Dakota Risk Pool

Memorial Service Held for SDSMA Past President Duane B. Reaney, MD

A memorial service was held on Dec. 27 at United Church of Christ in Yankton for Duane B. Reaney, age 90, who passed away Dec. 22.


A tribute to Dr. Reaney will be published in an upcoming issue of South Dakota Medicine.

Source: SDSMA staff and Yankton Press & Dakotan
CME Events

Continuing Medical Education events which are being held throughout the United States (Category 1 CME credit available as listed)

February 2014

Feb. 5
Internal Medicine Grand Rounds:
“Novel Immunotherapies in Oncology: An Overview for Clinicians”
12-1 p.m.
Sanford School of Medicine HSC
Room 106
Sioux Falls
AMA PRA Category 1 Credit(s)” available
Register online: www.usd.edu/cme

Feb. 19-22
“Acute Care for the Complex Hospitalized Patient for NP/PAs”
Mayo School of Continuous Professional Development
Rochester
AMA PRA Category 1 Credit(s)” available
Register online: www.mayo.edu/cme

Feb. 26-March 1
Mayo Clinic 17th Annual Endocrine Update
Westin Kierland Resort
Scottsdale
AMA PRA Category 1 Credit(s)” available
Register online: www.mayo.edu/cme

March 2014

March 5-8
Internal Medicine Recertification Course
The Westin Gaslamp Quarter
San Diego
AMA PRA Category 1 Credit(s)” available
Register online: www.mayo.edu/cme

March 19-22
“Pain Medicine for the Non-Pain Specialist”
Mayo School of Continuing Medical Education
Rochester
AMA PRA Category 1 Credit(s)” available
Register online: www.mayo.edu/cme

April 2014

April 24-25
“Ethics Problem Solving and Consultation: The Mayo Approach”
Leighton Auditorium, Siebens Building, Mayo Clinic
Rochester
AMA PRA Category 1 Credit(s)” available
Register online: www.mayo.edu/cme

DO YOU HAVE A CME EVENT COMING UP? WOULD YOU LIKE TO HAVE IT LISTED HERE?
Contact: Elizabeth Reiss,
South Dakota Medicine,
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2014 SDSMA Annual Meeting

SAVE THE DATE

FRIDAY, MAY 30 – SATURDAY, MAY 31
Best Western Ramkota Hotel & Conference Center
Rapid City, South Dakota
For more information, go to www.sdsma.org.
Thank you for putting the ‘CARE’ in DAKOTACARE

In 1986, the physicians of our state created DAKOTACARE because they believed a health care plan should be locally owned and directed. Today, DAKOTACARE continues to improve on making healthcare coverage and services provided by South Dakota physicians a seamless process.

Your involvement is critical to making DAKOTACARE a success. Many South Dakota physicians are currently participating through various committees, work groups or in other capacities, helping to guide the business decisions of our organization. DAKOTACARE’s Medical Management Department, staffed with knowledgeable physicians, pharmacists and nurses work with you to provide quality health care to your patients.

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