John W. Herbst

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Sioux Falls, SD 57105

*May be tax deductible
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NEXT MONTH
Splenic Abscess: Two Case Reports

About the Cover
"Cottontail Rabbit Sitting in Snow." Photographed by professional photographer,
John W. Herbst. Dr Herbst is a South Dakota physician, who has given up private
practice to spend more time with his family and photography. He is the Director
of Physicians Networking at Rapid City Regional Hospital. Dr Herbst is primarily
an outdoor and nature photographer. He and his family live in Keystone, SD.
Our best wishes to you throughout the

NEW YEAR!

South Dakota Blue Shield
1601 W. Madison, Sioux Falls, SD 57104
National Health Care: "It’s Going to be GREAT!"

Let’s look at the good side of National Health Care for a moment. The good side of National Health Care, of course, would only involve the doctors, not the patients that will be seeking medical care, so you will have to put aside your deeply ingrained moral and ethical standards for a moment in order to fully understand the great benefits that will be ours when National Health Care is instituted!

First off come the hours that we’d have to practice our profession. As of now, you know, the hours are long and at times truly unhealthy! But just think, with the implementation of National Health Care we would see a dramatic change: ie, 7 1/2 hours daily with a full hour for lunch, even possibly an hour and a half! No weekend office hours and at least a half day off for paperwork each week! Of course this would be accomplished under the guise that a well rested physician would better serve the patient. I forgot to mention the daily coffee breaks we’d also be entitled to!

Then comes vacation and time off for CME, no worry about any patients you may be following because with National Health Care there could be no continuity of patient care. Can’t you just imagine a vacation where you aren’t constantly tempted to call your office or the hospital to see how Mrs Brown is doing or if the blood pressure of a close friend has indeed responded to the medicine you placed him on just before you left town?

And it goes without saying that you wouldn’t have to be concerned about the cost of the vacation or the CME courses etc., because you’d be drawing full salary while attending. There would be, of course, a seniority clause that would completely eliminate nights on call after, say, five years of service, and the doctors would be divided into those that would practice in the hospital and those who would rather have a clinic practice. Reimbursement would, of course, be commensurate with your education and expertise; however, this training would be paid for by the government and also while you are in the training program you would receive your usual and customary salary.

Another side of this that would be great is the billing process! Just think, no worry about whether or not your patient can afford the medical care because it would all be costless! Also, the present hassle with insurance claims, third party payors, second opinions and preadmission certification would be completely eliminated. Referral patterns would also become less of a headache for us in that the referrals would be to the designated hospital or specialty clinic and we’d not have to worry about the qualifications of the specialist, or the lack of same! There would, of course, be absolutely no worry about equipment or supplies, and the quality thereof. Those decisions would be made by someone else and if it was not of the best quality or in the best interests of the patient, so what, you gave that right/concern up when National Health Care took over. Big brother always know best!

No more 30 or 40 patients a day either; you’d be able to set your own pace! Those physicians that are hospital based would be assigned a certain number of beds, and if you wanted admission that day you would have to discharge someone. Again, working at your own pace!

Other problems that as of now continually frustrate us such as rural health, access to health care, immunizations, AIDS testing, laboratory regulations, employment benefits for clinic personnel and mandated health insurance benefit laws to abide by would be non-existent! Also I would suspect, there would be a manual of regulations to tell you exactly how to practice medicine, ie, anyone with chest pain over the age of thirty-five will have an EKG! It would, of course, cover your responsibilities from AIDS to bald-headed women and flexibility of treatment would be completely denied! We would not have to worry about the cost of medications we might prescribe or the lab tests we might deem necessary; that’s someone else’s department. Get me started and I could go on and on!

However, and here’s the crux, there probably is not a physician out there that would tolerate such a practice because it completely and totally destroys the very tenets we all avow, which includes the best medical care possible, rendered by a kind, caring, dedicated physician that has, above all else, the "Humane Factor" as the foundation upon which his/her practice of medicine is firmly embedded!

You know, rather than continue to fight against government interference with the practice of medicine, we perhaps should continue to spread the word about how great National Health Care is going to be for all us doctors! Who knows, they may deny us all of these benefits and rule that we should continue to practice medicine as we have been! Believe me, stranger things have come out of Washington! For instance, I just read that (although they continue to take away our rights) "Son of Sam" will indeed receive any profits from books, movies, etc because it has been ruled that his first amendment rights were denied!

I told you, strange things continue to happen! #

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1991 - 1992

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  Washington, DC 20510

- **PRESSLER, LARRY (R)**  
  Office: Hart 133  
  Telephone: 202-224-5842

  Committees: Banking, Housing & Urban Affairs;  
  Commerce, Science & Transportation; Foreign Relations; Small Business; Special Aging  
  Term Expires: 1996

- **DASCHLE, THOMAS A. (D)**  
  Office: Hart 317  
  Telephone: 202-224-2321

  Committees: Agriculture, Nutrition & Forestry;  
  Finance; Select Indian Affairs  
  Term Expires: 1992

**UNITED STATES REPRESENTATIVES**

- **House Office Building**  
  Washington, DC 20510

- **JOHNSON, TIM (D)**  
  Office: Cannon 513  
  Telephone: 202-225-2801

  Committees: Agriculture; Interior & Insular Affairs  
  Term Expires: 1992

**SOUTH DAKOTA GOVERNOR**

- **MICKELSON, GEORGE**  
  Office: State Capitol, Pierre, SD 57501  
  Telephone: 773-3212

**SOUTH DAKOTA SENATE**

- **State Capitol, Pierre, SD 57501**

<table>
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<tr>
<th>Lieutenant Governor</th>
<th>Capitl Telephone</th>
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<td>Walter D. Miller</td>
<td>773-3661</td>
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<td>President Pro Tempore</td>
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<td>Harold W. Halverson (R)</td>
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<td>Sen. Henry Poppen</td>
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All other Senators can be reached during the Legislative Session by calling the Senate Lobby at 773-3821.

**SOUTH DAKOTA REPRESENTATIVES**

- **State Capitol, Pierre, SD 57501**

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<td>Allen, Carrol V. &quot;Red&quot; (D)</td>
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<td>Yankton 665-1315</td>
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<td>Rep. Jim Hood (R)</td>
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<td>Speaker Pro Tempore</td>
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(PLEASE SAVE THIS DIRECTORY FOR FUTURE USE)
Appropriations
Rep. Janice Nicolay (R) 773-5352 332-6481

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Abbott, James W. (D) 19  Yankton  665-2225
Becdow, Jean T. (D) 21  Mitchell  996-1753
Caselli, Robert E. (D) 12  Sioux Falls  338-8138
Cerny, William F., Jr (D) 29  Burke  775-2300
Christianson, T. Loren (R) 6  Astoria  832-4131
Cutler, Steve K. (R) 25  Claremont  294-5232
Diedtrich, Elmer (R) 5  Minne  225-3333
Dusbury, Robert N. (D) 17  Wessington  458-2582
Edelen, Mary B. (R) 10  Vermillion  624-4760
Flatt, Elmer E. (D) 23  Custer  673-2333
Foshie, Douglas G. (D) 27  Huron  352-3573
Frederick, Randall (R) 8  Hayti  783-3710
Gabriel, Larry E. (R) 26  Cottonwood  457-3161
Gleason, David (D) 1  Claire City  652-4631
Good, Janet (D) 27  Long Valley  462-6347
Greseth, Mona (R) 1  Claire City  652-4667
Gullickson, Alvin (R) 10  Colman  495-2465
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Hagg, Rexford A. (R) 5  Rapid City  434-0079
Haller, Pat (D) 23  Huron  352-4909
Ham, Donald J. (R) 34  Rapid City  428-1506
Hillard, Carolee (R) 32  Rapid City  429-7979
Hillard, Joyce E. (R) 8  Lake Preston  847-4716
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Hood, Jim (R) 31  Spearfish  642-7498
Howell, Dale L. (D) 4  Watertown  882-2192
Hunt, Roger (R) 14  Brandon  582-3865
Ingalls, Marie C. (R) 26  Mud Butte  748-2121
Johnson, Carol A. (R) 5  Franklin  472-1296
Johnson, Joel S. (R) 9  Parker  297-3708
Kane, Patrick J. (D) 15  Sioux Falls  334-5508
Kennedy, Howard L. (R) 16  Beresford  763-5529
Kloucek, Frank J. (D) 18  Scotland  583-4468
Kocer, Albert J. (D) 20  Wagner  384-3285
Koskan, John (R) 29  Wood  452-3448
Krautschin, Harvey C. (R) 31  Spearfish  642-4276
Kundert, Alice (R) 25  Mound City  955-3518
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Lucas, Larry (D) 28  Mission  856-2439
Mater, Charles Q. (R) 35  Belle Fourche  892-4262
McKillop, Malcolm C. (R) 22  Ariesian  527-2360
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Michelson, Gordon (D) 20  Platte  337-3780
Moore, Garry A. (D) 19  Yankton  665-2301
Munson, David R. (R) 12  Sioux Falls  336-6987
Neggstad, Richard B. (R) 7  Volga  826-4385
Nystad, Janice R. (R) 16  Sioux Falls  332-6481
O'Connell, Michael W. (D) 16  Alcester  253-2838
Olson, Edwin W., Jr (R) 21  Mitchell  996-0099
Pederson, Gordon R. (D) 20  Wall  279-2610
Pilcher, Patricia A. (D) 11  Sioux Falls  336-1072
Putnam, J. E. (Jim) (R) 18  Armour  724-2541
Reedy, John J. (Joe) (D) 17  Vermillion  624-2210
Rentschler, Jack G. (R) 13  Sioux Falls  336-7544
Roe, Robert (R) 7  Brookings  692-8784
Sandness, William J. (R) 11  Sioux Falls  361-2666
Schauemier, Craig D. (D) 3  Aberdeen  229-1393
Schreiber, Lola Eae (R) 24  Gettysburg  258-2103
Sears, John D. (R) 32  Rapid City  342-0236
Shah, Michael H. (R) 24  Pierre  224-4079
Solum, Burdette C. (R) 4  Watertown  886-3808
Timmer, John (R) 14  Sioux Falls  332-8932
Vanderlinde, Mary (D) 15  Sioux Falls  338-6501
Van Overschelde, Dennis (D) 22  Salem  425-2050
Viken, Linda Lee M. (D) 33  Rapid City  341-7053
Wagner, Michael D. (R) 9  Baltic  529-5682
Waltman, Alfred (D) 2  Aberdeen  229-0233
Weber, Robert R. (R) 6  Strangburg  676-2471
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Involvement - A Choice?

The practicing physician has a great many demands on limited time including active practice, continuing education, committee work for local quality assurance, family demands and a certain time for rest and diversion to prevent premature burnout.

Be that as it may, involvement in local or state politics or direct or indirect contact with our representatives to Congress and State Legislature is another demand which must be met.

Medicine like every other facet of our society is undergoing change whether we like it or not. It is easy to become frustrated and say there is little that can be done. Although every individual will not achieve exactly what they want, our political process is still a democratic system but it, by definition, requires active participation and that means time. The question is how to turn limited time into an effective way of having legislators understand our views.

Let us concentrate on two areas - local and state representatives and national representatives. There are a lot of advantages in living in a small state. During my 27 years in the state, I have personally met everySenator and Representative to the National Congress. This is in spite of the fact that my political involvement has been much less than it should have been and more locally than nationally focused. With the same level of involvement in most populous states, I might have been fortunate enough to briefly meet one or two. The importance of this is that if you have met your representatives, correspondence or conversation at appropriate times is apt to be much more effective, especially if prior contact is mentioned in the letter containing your reasoned views on a particular issue.

As to influencing members of the State Legislature, the problem is easier. If you have one as a patient, I believe this opportunity should be exploited to develop a relationship so that basic medical issues can be discussed.

However, I do not believe this is enough because the points made must be pertinent to present issues and be concise. How can we achieve our goal? I believe every medical district should have a district committee, which periodically meets with their legislators so that an ongoing dialogue can be established. Members of the district should periodically plan what is to be discussed at these meetings and what viewpoints are to be promoted. This is best done by contacting the office of the State Medical Association so that opinions on specific issues can be coordinated whenever possible. Discordant views between physicians and their representative organizations are a formula for defeat.

This grassroots approach should bear fruit over time if consistently applied.

Lastly, I would like to apologize to, and recognize those physicians who have done much more in the way of political activism than I, and particularly express my gratitude to those who have actually represented us in Pierre.

#

John F. Barlow, MD
Editor

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JANUARY 1992
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The State of South Dakota's Child: 1991

Ann L. Wilson, Ph.D

Editorial Note:
The University of South Dakota School of Medicine has been very pleased over the past year to work with the State Department of Health and the Tribal Chairmen to successfully pursue funding for a variety of new programs that will enhance training opportunities for students in the health professions and service for mothers, infants and children in our State. The need for these new programs is well portrayed in this year's "State of South Dakota's Child" report. While we are gratified by the outcome of our efforts over the past year to assist in ascertaining new funding for maternal and child health care, we challenge all involved in these new programs to persevere in working collaboratively so that innovative approaches developed will be successful in addressing the unique needs of citizens of South Dakota.

R.C. Talley, MD, Vice President/Dean
USD School of Medicine
Sioux Falls, SD

ABSTRACT
This annual report describes the continuing trend of a decreasing birth rate in South Dakota. Infant mortality data show that South Dakota's neonatal mortality rates continue to be below those of the nation and post neonatal mortality rates exceed those of the United States. A very high Native American post neonatal mortality rate persists. Low birth weight contributes to approximately three quarters of newborn deaths and has declined by approximately 1% over the past two and one half decades. Descriptions of preterm labor prevention programs are presented with an emphasis upon the need for education of pregnant women and communities about its risk factors and warning signs. A review of a variety of new programs that aim to improve maternal and child health in South Dakota is provided.

This annual contribution to the Journal will report upon infant mortality in South Dakota. Special attention in this article will be given to low birth weight as a contributor to infant mortality and morbidity. Various new initiatives that have begun to address maternal and child health care in South Dakota will also be discussed.

In 1989, use of a new birth certificate was initiated and will ultimately provide more data than previously have been available. The use of this certificate, however, has slowed the availability of final data from the National Center for Health Statistics. For this reason, 1989 and 1990 data for this report will be from the Center for Health Policy and Statistics of the South Dakota Department of Health and provisional 1989 data from the National Center for Health Statistics for the United States will be used.

Birth Rate

In 1988, for the first time since 1970 South Dakota's birth rate dropped to a rate lower than that of the United States. As can be noted in Figure 1, this trend continued in 1989 with the state's birth rate of 15.5 below that of the United States' rate of 16.2. Data from the State's Department of Health show that in 1990 there were 10,987 resident live births in South Dakota. This number represents a 17% decline in births since 1980 and reveals a very clear trend of a diminishing cohort of births to residents in our state. The trend of a declining cohort of births to South Dakota residents has various implications for policy development and the
the State were born to residents of Minnehaha and Pennington counties. In 1980 this was true of 28% of all births.

Over the past decade, the percentage of Native American births in South Dakota has increased from 12% to 15%. In recent years there have been approximately 150 annual births of babies with a background that is neither Native American nor white.

Infant Mortality

Infant mortality data are expressed per 1,000 live births and with the state’s increasingly small base of births small variations in the number of deaths have a noticeable impact on yearly mortality rates. In 1989, 106 babies died in South Dakota before the end of their first year of life yielding an infant mortality rate (IMR) of 9.6 per 1,000 live births. This is the lowest rate of infant death that the state has ever experienced. For the white population, the infant mortality rate was 7.0, but for the Native American population, it was more than three times higher at 22.8. The South Dakota rate is comparable to the United States’ 1989 total infant mortality rate of 9.7. Data from 1990, however, show that South Dakota’s overall IMR has increased slightly to 10.1 with 111 infant deaths during the past year.

Over the past decade (1980-89) in South Dakota and the United States there has been a slowing decline in the rate of mortality for infants. While over the 1970s the slope was fairly steep for the trend of declining mortality, in the 1980s this slope flattened with South Dakota’s rate of decline decreasing less than that observed nationally. This general slowing decline of South Dakota’s IMR can be better analyzed when differences in neonatal mortality (deaths occurring between 0 to 27 days of age) and post neonatal mortality (deaths occurring between 28 and 365 days of age) are reviewed.

Figure 2 compares neonatal mortality data from 1965 to 1989 for the United States and South Dakota. What can be seen in this graph is that, over the past decade, South Dakota has generally had a lower neonatal mortality rate than has the nation as a whole. In 1989, the total rate was the lowest ever for South Dakota at 4.6 (3.7 for whites and 8.9 for non whites) which compares quite favorably with the total rate of 6.3 for the United States. South Dakota data for 1990, however, show that this rate rose to 5.3. Overall, progress in decreasing the neonatal mortality rate in South Dakota slowed in the 1980s compared to what was observed in the 1970s and to what has been observed nationally over the past decade. Progress has most clearly slowed for the whites and the trend of declining neonatal mortality rates actually reversed, over the past decade, for the non white population.

Contrary to the general picture portrayed in neonatal data is the pattern of post neonatal mortality rates also presented in Figure 2. What is seen in these data is this
rate's very modest decline in the 1980s and recent persistence in being higher than that for the United States. Data from 1989 continue this trend with South Dakota having a rate of 5.0 compared to the United States' rate of 3.5. In 1990, South Dakota's post neonatal mortality rate dropped slightly to 4.8 per 1,000 live births. While the trend of the white post neonatal mortality rate is slightly higher than that for whites nationwide, most dramatic is the rate for Native Americans that tends to be double that for non whites of the entire nation.

More specific analyses of the disparity in white and the Native American infant mortality rates are additionally meaningful in interpreting data from South Dakota. While 15% of all births for the past five years (1985-1989) were Native American babies in South Dakota, 23% of neonatal deaths and 40% of post neonatal deaths were Native American babies. These figures reflect how a strikingly disproportionate number of post neonatal deaths are Indian babies. Another way of examining South Dakota data with reference to specific findings for the white and non white populations is to compare the distribution of infant deaths by when they occur during the first year of life. Notably, among both the white and the Native American population groups in South Dakota there has been a shift over time with an increasing percentage of infant deaths now occurring in the post neonatal period. Currently, however, approximately two thirds of all Native American infant deaths occur following the first 27 days of life while alternately this is true of less than half (41%) of all deaths for the white population.

Post neonatal deaths are typically associated with socio-economic factors that affect daily lives and represent a complex interaction between health, social supports and stressors. Such complexity defies simplistic responses but requires comprehensive and culturally relevant attention that will address the needs of families as they nurture young children. (For a more specific discussion of the causes of these deaths see the "State of South Dakota's Child - 1990".)

In September 1991, President Bush announced that the Aberdeen Area Tribal Chairmen's Health Board was one of fifteen recipients of a five year "Healthy Start" multi-million dollar grant to decrease by one half infant mortality. The Aberdeen Area includes South Dakota, North Dakota, Nebraska and Iowa with 10 of the 19 tribal groups and approximately two thirds of the infants to be served residing in South Dakota. The Healthy Start Project has begun by assisting communities as they determine how the needs of their young families can best be addressed with the new resources that will be available. This is an opportunity to develop responses to the complex problems associated with the high mortality rates for Native American babies.

Low Birth Weight and Infant Mortality

Low birth weight is a major contributor to infant mortality. Between the years 1986 and 1990, 53% of all infants who died in South Dakota had birth weights of less than 2500 grams. When infant deaths are broken down into those occurring in the neonatal and post neonatal periods, different patterns emerge. Figure 3 shows that for newborns who did not survive, 72% had birth weights of less than 2500 grams. Nearly half (47%) of these babies had birth weights of less than

![Figure 3](image1)

![Figure 4](image2)
1,000 grams. In contrast, only 24% of all infants that died after the first 28 days of life weighed less than 2500 grams at birth, with only 4.5% of them having birth weights of less than 1000 grams. This observation indicates that improving the survival of extremely low birth weight infants does not contribute substantially to post-neonatal mortality.

A comparison of infant deaths by birth weight between the first and second half of the decade of the 1980s shows that very little change in these data occurred. Analyses that compare these data for the white and non-white populations also reveal minor variations with both groups having similar profiles in the distribution of deaths by birth weight categories.

Though currently nearly three quarters of all newborns that die have birth weights less than 2500 grams, an examination of mortality of these newborns shows that progress has been made in increasing their chances of survival. Figure 4 presents data that illustrate the changing rates of survival between the years 1981-1985 and 1986-1990 for low birth weight newborns.11 Noted in these data is the observation that among the weight cohorts of low birth weight infants, the greatest progress has been made among the group of babies with birth weights of 500 to 999 grams and 1000 to 1499 grams with 57% and 88% of newborns with these weights now surviving. Over 96% of all newborns with birth weights over 1500 grams are currently surviving. While these data reveal progress, important to their interpretation is a recognition that morbidity increases as birth weight decreases12,13 and that preventing the need for neonatal intensive care is fundamentally critical to improving the ultimate outcome of pregnancy.

This observation is reinforced when the 25 year neonatal mortality and low birth weight data in Figure 5 are examined. Noted in this graph of South Dakota data is very little change in the percentage of newborns with birth weights of less than 1500 grams who currently contribute to 56% of all neonatal deaths. Specifically, between the years of 1965-1969, the mean incidence of these very low birth weight (less than 1500 grams) newborns was .90,14-18 and it increased to .93% during 1985-1990.1,19-21 While these South Dakota data reveal little progress, they have been consistently lower than those representing the incidence of very low birth weight for the nation. The mean percent of very low birth weight for the United States (1.23%) has been identical for the years 1965-1969,14-18 and 1985-1988.1,19-21 The pattern of South Dakota’s neonatal mortality rate also plotted in Figure 5 is quite different from that observed with low birth weight. Contrasting with our fairly consistent incidence of low birth weight, is our declining neonatal mortality rate that has decreased by two thirds since 1965. Comparisons of these data clearly demonstrate how progress in assuring survival of newborns has far surpassed success in preventing the birth of babies with low birth weight.

Table I presents these data in a different format that reinforces the need for low birth weight prevention efforts. Listed in this table are 1985-1988 mean percentages of newborns in 500 gram birth weight cohorts for the white and non white populations of the United States and South Dakota and neonatal mortality rates. The white/non white composition of the total population of births for South Dakota (83/17%) and the United States (79/21%) is comparable with 15% of South Dakota’s non white births being...
Native American and 17% of the United States' non white births being Black.\textsuperscript{1,19-21} What is observed, however, is a 44% lower incidence of low birth weight for the non white population of South Dakota than that observed for non whites nationwide. This observation is helpful in interpreting South Dakota's non white neonatal mortality rate that is 33% lower than that for non whites of the United States. Native American babies in South Dakota are more likely than non white babies nationwide to be born larger and are more likely to survive the first 28 days of life. For the white population, South Dakota's percent of low birth weight newborns is 12% lower than that for all whites nationwide. South Dakota’s white neonatal mortality rate is also 4% lower than that for all whites of the United States.

These observations highlight how our state's neonatal mortality rate parallels our incidence of low birth weight and contributes to an understanding of the State's favorable mortality rate for newborns. Data presented in Table I may also partially address why progress in reducing the neonatal mortality rate has slowed. Interestingly, South Dakota, compared to the United States, has a slightly higher percentage of white newborns in the two smallest weight cohorts (less than 500 grams and 500-999 grams) that have the highest mortality.

Data presented in Table II provides information that may also address this observation. A comparison of the mean incidence of low birth weight during the years 1965-1969\textsuperscript{14-18} with the recent years of 1985-1988\textsuperscript{17,19-21} show that there has been a slightly greater than a 1% decrease in the percentage of low birth weight newborns in both the United States and South Dakota. For South Dakota, this percentage amounts to 124 fewer low birth weight newborns per year. However, over 90% of this decrease may be attributed to declining incidence of newborns with birth weights of 2000 to 2400 grams whose rate of death is less than that for the smaller low birth weight newborns.

Of further interest are weight group specific data presented in Table II showing that between 1965-1969 and 1984-1988 the percentages of all newborns with birth weights less than 500 grams and between 500 to 999 grams have actually increased, thus affecting progress in decreasing neonatal mortality. The increase in the percentage of these tiny newborns may be attributed to a greater likelihood in recent years of issuing birth certificates to them, to changes in obstetric care that may bring more babies to viability or to other factors. A minimal decrease in South Dakota of approximately 1% has been noted in the birth weight cohorts of 1000 to 1499 and 1500 and 1999 grams. Advances in neonatal care continue (for example surfactant therapy) and ongoing efforts to assure access to tertiary care are essential. Yet, without a further decrease in the incidence of very low birth weight newborns, declines in the neonatal mortality rate may be limited.

While progress in decreasing the incidence of low birth weight newborns may not have been dramatic, we must not fail to consider how very slight changes in percentages do make very important differences to the lives of those they reflect. In the case of newborns with weights of 1000 to 1999 grams, in South Dakota the decrease observed over the past two decades represents 24 fewer babies a year born among this weight group. Each birth of a baby with this low birth weight represents the need for considerable investment in human and financial resources. Since most of these infants now survive, and approximately 10% to 30% of those with weights less than 1500 grams will have a need for developmental or special educational assistance\textsuperscript{12,13} (the percentage increases with declining birth weight) even very small shifts in decreasing the percentage of very low birth weight represent successful efforts.

**Low Birth Weight Prevention Efforts**

Data presented so far show that the majority of newborns who die are born with a low birth weight and that little progress has been made in decreasing the incidence of newborns with weights less than 2500 grams. Further, data show that advances in neonatal care has increased the likelihood of survival of tiny newborns but that overall progress in decreasing the neonatal mortality rate is slowing. These observations lead to questions about preterm labor, its etiology and how it may be prevented.

Estimates show that approximately 20-25% of all preterm births occur because of fetal or maternal complications of pregnancy such as diabetes or hypertension that require a preterm delivery. Alternatively, approximately 75%-80% of all preterm deliveries result from either a spontaneous labor or premature rupture of the membranes.\textsuperscript{22} Different strategies must be employed to respond to the needs of these two groups of pregnant women. While the first group requires medical attention to the underlying...
Table III
Risk Screening for Preterm Labor

Major Risk Factors

**History:**
- Previous Preterm labor (birth)
- DES (in utero exposure)
- Cone Biopsy
- Uterine Anomaly (including fibroids)
- More than or 2 second trimester abortions
- Cocaine use

**This Pregnancy:**
- Cervix < 1 cm long
- Cervix > 1 cm dilated (internal os)
- Cerclage this pregnancy
- Polyhydramnios this pregnancy
- Abdominal surgery this pregnancy
- Multiple Gestation

Minor Risk Factors

**History:**
- More than or 3 first trimester abortions
- 1 second trimester abortion

**This pregnancy:**
- Febrile illness (>102 degrees)
- Pyelonephritis
- Cigarettes (more than or 10 a day)
- Bleeding after 12 weeks
- "Street" drug use
- High Risk = One major or two minor factors

This risk screening protocol is available from the South Dakota Department of Health

A joint effort of the South Dakota Department of Health, South Dakota Perinatal Association, University of South Dakota School of Medicine, and March of Dimes has supported two training workshops on preterm birth prevention for 11 communities in South Dakota in 1990 and 1991. A third training workshop is scheduled for six more communities in February 1992. At these intensive two day workshops, communities are represented by a physician, office nurse, hospital nurse and community health nurse. Information on how a preterm labor prevention program may be implemented is provided and participants have the opportunity to plan how they will implement their program in keeping with the unique nature of their community and mutual working relationships.

It is hoped that all communities interested in this training will have the opportunity to become involved in developing a community based program of prevention. Two aspects of this program, the risk screening instrument and warning signs of preterm labor, will be presented here as they may be readily implemented in any clinical setting.

The risk screening instrument used in the South Dakota programs is presented in Table III. Data from various programs show that 5% to 15% of all pregnant women are identified as at high risk for preterm labor (11% in Worthington). In Worthington 60% of the potentially preventable preterm newborns come from this group of pregnancies. Other investigators report that approximately 2% to 3% of women in the low risk categories develop spontaneous preterm labor without their risk identified in advance or that approximately half of preterm labor patients come from the population of patients who come from those who are screened

Table IV
Warning Signs of Preterm Labor

Menstrual Like Cramps
(constant or come and go, just above the pubic bone)

Low, Dull Backache
(constant or comes and goes)

Pressure
(feels like the baby is pushing down; feels heavy)

Abdominal Cramping
(with or without diarrhea)

Increase of Change in Vaginal Discharge
(mucousy, watery, light or bloody)

Fluid Leaking from the Vagina

Feeling Bad

Uterine Contractions That Are 10 Minutes Apart or Closer
(may be painless)

This patient education teaching sheet is available from the South Dakota Department of Health

causes of a preterm delivery, the second group requires broad based educational efforts, identification and education of women at increased risk for prematurity, increased provider awareness of preterm delivery, frequent evaluation of women at risk and prompt and aggressive treatment when preterm labor occurs. In addition, recent data suggest the possibility of using biochemical markers to predict preterm delivery.

In the 1980s various programs in Europe and the United States have examined the efficacy of screening and educational approaches to preterm labor and have demonstrated their effectiveness. Though variation exists in the outcomes of these programs, they generally show decreases in the incidence of preterm delivery. Barbara Yawn, MD, a family practitioner from Worthington, Minnesota conducted a two year project of intensive screening, education, support and treatment of pregnant women and her findings are particularly relevant to South Dakota. Before the initiation of this program, only 56% of patients presenting with preterm labor were successfully treated with delivery occurring at term gestation. By the end of the two year program, 98% of women with preterm labor were successfully treated yielding an economic savings of approximately a half a million dollars over two year's time in short term perinatal related hospital costs.

SOUTH DAKOTA
as "low risk". These observations point to difficulties with the sensitivity and specificity of risk assessments and underscore the need for all, not just the women identified as high risk, to receive ongoing education regarding the warning signs of preterm labor and how to respond to them.

Table IV presents a list of the warning signs that pregnant women are helped to recognize. A written handout on these warning signs of preterm labor is available through the South Dakota State Department of Health and may optimally be given to women on their first prenatal visit and then reviewed with them at 20, 28 and 32 weeks gestation. It is suggested that women who are high risk for preterm labor receive at least one individual education session so that their understanding of the signs of preterm labor and the appropriate response to them is assured. Further, it is generally believed important that high risk patients and any other patient who develops signs or symptoms of preterm labor be seen weekly by their physician after 24 weeks gestation. These weekly visits typically include a pelvic examination to ascertain cervical dilatation and effacement, station of the presenting part and thinning of the lower uterine segment. In addition, these visits offer an opportunity to review with the patient how preventable risk factors (smoking) may be modified or minimized and to review warning signs of symptoms and procedures to follow if they are recognized. (For information regarding the medical treatment of these patients see Clinical Obstetrics and Gynecology, September 1988).

To optimize an approach to decreasing preterm labor, entire communities need to be involved in broad based public education efforts that emphasize that preterm labor is treatable. This educational effort needs to reach not only the broad spectrum of health care providers that may be in contact with pregnant women for prenatal or other health care needs (physicians, school nurses, industrial health nurses, emergency room nurses, operating room nurses), but must also reach community members with whom the pregnant woman interacts on a daily basis. Supervisors in the work place, teachers, school principals, social acquaintances, friends and family need to be aware of the pregnant woman's need to respond to warning signs and receive necessary medical attention. Community and family support for the woman facing the potential for preterm labor is also critical for a woman to comply with special care measures that may be necessary to prevent the birth of a preterm baby.

The educational efforts that are suggested as a means of decreasing potentially preventable preterm delivery are relatively inexpensive. They, however, must be coupled with a broad based perception that preterm labor is often treatable if its signs receive a prompt response by the pregnant woman and her health care providers. On occasion, in spite of the most valiant efforts that may be taken to prevent a preterm delivery, tiny babies may be born early. The families of these babies most certainly need support as they adapt to the needs of their newest family member and attention needs to be given to ease their likely feelings of failure.

Comments

The year 1991 brought new resources to South Dakota through major new funding for maternal and child health care. Already mentioned is the new Healthy Start program that will be administered through the tribal chairmen to decrease infant deaths among the Indian people. The Interdisciplinary Center for Disabilities at the University of South Dakota also received funding for the training of professionals who will provide services to children who reside in rural areas with special health care needs. The State Health Department has received new funding to promote efforts to prevent alcohol related development disabilities. In addition, the Center for Disease Control selected Rapid City as one of six cities nationwide to serve as a model for community collaboration to increase to 90% the number of children under two years of age who are fully immunized.

Each of these newly initiated projects reflects the dedicated efforts of those who pursued their funding and are administering their efforts. Their success, however, will demand the collaborative efforts of entire communities of service providers and citizens. This collaboration is a true test of citizenship and a willingness to commit efforts for the welfare of infants, children and families. Infant mortality has always been recognized as an indicator of a society's care and concern for its citizens. Babies are dependent upon those who surround them with care and protection. Their parents, too, need this care and protection, especially if they are vulnerable to the miseries of poverty and social isolation.

While financial resources enable ambitious plans and collaborative efforts, we must be challenged not to forget that it is human caring connections that render healing in a most profound way. Reaching out in a warm, accepting and nurturant way to parents who are suffering from life's ills may help in immeasurable ways to foster life for the new baby who represents our future.

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REFERENCES

"If I Were Queen of the World" is a game I played as a child (and as recently as last week)! It was magic thinking and wishful thinking too. It went something like this...I'd say, "If I were Queen of the world, I'd get rid of war!", or..."If I were Queen of the world, I'd have the most beautiful palomino horse in the world. I'd be the only one who could ride him. He'd hate everyone but me. I'd have long, blonde straight hair, and it would fly behind me as I rode, my legs astride his strong and supple back...running along the beach at night...the moon bright and the crashing of the breakers the only sound except for the solid, thudding sound of his hooves on the packed sand!

As you can see, I really got into it! I still do, but the scenario has changed somewhat. I have noticed that all of the above are not possible. I even know that there are no oceans in South Dakota! Even with my enlightenment, I still play on occasion. For instance, if I were Queen of the world, the first thing I'd do is get rid of January! I hate it! It is dark, cold, busier than I want to be right after Christmas, etc! Who needs it?

Then I'd go to work on the awful things that are happening to the adolescents of today. I would not do it just because Tommy and I have two of them, but because it is chilling to consider the things that are threatening the health of future generations...some members of which are our children and yours. A partial listing of these scourges includes: teen sexuality (AIDS, STD's, pregnancy), suicide, substance abuse, accidental death, depression, eating disorders, violence, abuse, tobacco use, steroid use (yes, I know that tobacco and steroids are included in the category of drugs, but I think they should be listed separately because of the alarming new trends concerning their use), and many others.

An alarming series of articles in the Rapid City Journal reported on surveys of youth in South Dakota. Among other things, it suggested that we in South Dakota deny that we have the problems facing other areas of the country that we so often identify with the prevalence of the above threats to teens. I can't go into all of them, but I want to tell you some of the most frightening in the hopes that you will have open eyes as you look around you, and perhaps find ways to do some good in the fight against them!! Are you sitting down? If not, I suggest that you do.

The survey suggests that half of South Dakota teens have had sex. Half of those had sex at 14 or 15 years of age. Five percent had sex in their pre-teen years! One-fourth of all the sexually active teens used no form of birth control or precautions against disease. Only 12% of those surveyed said they had never drunk wine, beer or liquor. Eight percent said they began drinking alcohol before the age of 9!! Over half of them began drinking between the ages of 11 and 14!! About one-third said they had considered suicide in the previous year. Half thought about ways to kill themselves. Ten percent said they actually tried it, and 2% said they injured themselves!!

Half of the students surveyed had ridden in a car in the previous month with someone who had been drinking or using other drugs. Twenty-seven percent said they had driven after using alcohol or other drugs!! Thirteen percent of the teens said they had taken a weapon, such as a knife or gun, to school in the previous month. About 7% reported being in fights during that time in which they or another person required medical treatment! Had enough? This is only the tip of the iceberg!!

The AMA Auxiliary is trying to make a difference! It is educating the public by way of over 2,000 programs and services in an effort to curb this destruction and devastation. Please find a way to add your support! It would really make me feel like a Queen!!

I recommend the AMA's publication called, AMA Profiles of Adolescent Health. Volume I, America's Adolescents: How Healthy Are They? by Janet E. Gans, Ph.D. Order #NLO12690. Call 1-800-621-8335 for credit card orders.

Mollie O. Krafla
Quality Review Determination

SDFMC, the physician peer review organization for South Dakota, reviews medical records to assess quality of care. Appropriate quality of care includes performance of the following actions:

- Conducting an appropriate history and physical evaluation.
- Evaluating and developing a treatment plan for a defined problem or diagnosis which prompted the episode of care.
- Recognizing, stabilizing, and monitoring clinical signs and symptoms.
- Obtaining, evaluating, and monitoring appropriate laboratory studies.
- Instituting timely and appropriate clinical management of complication and/or comorbidities.
- Initiating appropriate rehabilitation and discharge planning.

Failure to perform these actions may result in some common quality of care problems such as:

- Failure to order/repeat diagnostic studies.
- Failure to order appropriate medications.
- Medically unnecessary procedure.
- Failure to appropriately stabilize before discharge.
- Failure to obtain an adequate history and physical.
- Untimely intervention.
- Failure to appropriately interpret, address, and/or initiate treatment related to diagnostic studies.
- Failure to provide appropriate discharge instructions and follow-up.
- Failure to identify the problem.

SDFMC, through the physician peer review screening process, determines if the right care was provided. The medical record should describe an orderly progression of care and response to care, revealing appropriate and timely responses to all unexpected events.
Ethics For The Surgeon

H. Phil Gross, MD

ABSTRACT

Guidelines are helpful in analyzing the process of ethical behavior in the surgical arena. In this paper, three guidelines will be considered: Action, Disposition, and Structure. Action deals with the surgeon's conduct relative to ethical principles. Disposition refers to the character of the surgeon, and virtues relevant to character are considered. Structure is the environment in which medical treatment and diagnosis takes place.

Relative to these above guidelines, the case of a 79 year old lady with a fractured hip is discussed.

While medical ethics are often voiced in decisions of life and death, they can also be raised in the process of the surgeon's day to day practice. It is not only in matters like euthanasia and assisted suicide that ethical issues must be considered. The common practice routines must also follow an ethical framework.

The paradigm for this daily ethical behavior can be divided into three classifications:  

A. Actional  
B. Dispositional  
C. Structural

Actional traits are related to what we as physicians do in a given situation. The dispositional traits refer to what physicians are as they relate to the patient. And the structural function of this triad refers to the circumstances under which this encounter between physician and patient takes place. There are no absolutes as to conduct under any of these categories, but a knowledge and constant realization of their existence is helpful for ethical behavior.

ACTION

There are certain duties which are essential to ethical conduct between patient and physician. These duties can be clarified by ethical principles which include: autonomy, beneficence, non-maleficence, and justice.  

Autonomy is giving the patient enough information and freedom to enable him/her to make a rational decision concerning their own health care. This should include all the options without being biased. The choices must be based on sound medical judgment with definite outcomes in mind. The patient must not only be informed of the immediate response to therapy, but what the long term effects will be as well. The information must not be coercive in order that the patient must meet the desires of the physician.

Beneficence is a treatment plan that will benefit the patient. It must also meet the expectations of the patient. While we think of most forms of therapy as beneficial, some may have only preventative effect such as vaccines. Others may have more social value than functional, such as certain types of plastic surgery. And some, such as a placebo, may have no specific value to the patient, but may help the community at large in investigating whether or not a treatment modality is helpful.

Non-maleficence simply means "Do the patient no harm". Whatever the treatment plan, it is important to insure that the benefit outweighs the detriments. There are times that withholding treatment can be harmful, and others when the usual and customary form of therapy will do more harm than good. Surgeons do not think of a surgical assault on the body as harmful, but the patient may not fully share this view.

Justice is giving to each his or her due. This is best expressed in terms of fairness. It can also mean the distribution of medical resources on the basis of need, effort, contribution, merit, or even free market exchanges (i.e., those who can afford it!). While most issues of justice in the medical arena are described in the monetary terms of fair distribution of goods, emphasis need also be given to compassion. To have compassion while still maintaining good medical judgment is difficult, but it is possible and will emphasize the issue of justice.

1. Retired orthopedic surgeon who practiced in Sioux Falls. Now resides in Ross, CA, attending the Univ. of California and the Graduate Theological Union in Berkeley.
DISPOSITION

This concept deals with who the physician is, not what he or she does. Perhaps "character" is a more descriptive word. While there are many virtues that define the ideal physician, this essay will deal with only three of these virtues: trustworthiness, prudence, and veracity.

Trustworthiness is an ideal virtue for the professional person. He/she is trusted with things of great value, such as confidential material or even the patient's own life. The patient would be able to trust his/her own doctor to show care, concern, and fairness in the management of the case. This trust does not materialize in the brief time of a routine history and physical, but takes a more concerted effort. The time spent in discourse with the patient may seem wasteful on occasion, but it engenders trust between the two parties and is well worthwhile.

Prudence is the virtue of thoughtful stance, in contrast to trustworthiness, which is the virtue of being. It is the ability to weigh all the options of a treatment regimen and to choose the best of the lot, rather than the knee jerk response of choosing a certain treatment program because it is the favorite of the physician. This is the contemplative stance that should precede any action.

Veracity is truth telling. This may seem evident, but there are times when half-truths, shaded truths, or words left unsaid are felt to be necessary for the good of the patient. Techniques must be developed to deal with the patient in a truthful, forthright manner without invoking anxiety or mental anguish.

The dispositional factors of trustworthiness, prudence, and veracity will all speak as loudly to the patient as will the action taken. The image presented to the patient often assumes more importance than the course of outlined therapy.

STRUCTURE

The structural factors that surround the patient are so commonplace to the practicing physician that they may go largely unnoticed. But they are recognized by the patient, and the physician must be cognizant of their existence.

The hospital or clinic is an imposing structure with its sanitized, decontaminated environment. The sterile stainless steel containers, the polished surfaces, the hypodermic needles and the cast saw are all detracting. They are designed to deliver good, efficient medical care, but nevertheless cost the patient his/her autonomy. These surroundings cast an authoritarian aura over the patient, much as the cathedral does to the humble parishioner. The white coats of the doctors, and the crisp white nurses' uniforms are another means of setting the medical profession apart from the patient. Even the language used among the professionals can be interpreted by the patient as a signal that there is information being withheld from them and lead to paranoia.

Because these structural entities are constructed and maintained for the good of the patient, they cannot be ignored. But every attempt should be made to recognize their existence, and allay the patient's fears. Usually only a word or two explaining the necessity of a certain restriction on their autonomy is all that is necessary.

A case report from the author's files will be used to illustrate the outline mentioned above.

CASE REPORT

C.J., a 79 year old white female, fell at the nursing home and injured her right hip. She was taken to the emergency room where x-rays were obtained. The emergency room doctor made a diagnosis of fractured hip, advised the patient of the diagnosis, and suggested that she be admitted to the hospital under the care of an orthopedist.

The patient was admitted to the orthopedic ward and the surgeon notified. On the way to the orthopedic ward, the surgeon stopped by the x-ray department and looked at the x-rays. He commented, at the time, to his assistant that this was an intracapsular fracture of the right hip, and that the patient would be a good candidate for a bipolar prosthesis, which was, at that time, considered "state of the art".

Upon encountering the patient, a brief history and physical exam were obtained. The patient was a frail lady, appearing her stated age of 79, with no significant past history. Her activity had been limited in the nursing home due to a variety of aches and pains which she ascribed to old age.

The patient was told by the surgeon that she needed an operation, namely a prosthesis to replace the broken "ball" in her hip. Before the operation, an internal medicine consultation would be obtained, mainly because of her age, to make sure she could tolerate the operative procedure. Meanwhile, she would be placed in traction to give some degree of comfort.

The medical consult was completed, and on the second day after admission, a bipolar prosthesis was inserted. The patient recovered without incident, and by the seventh post-operative day was transferring from bed to wheelchair with the help of physical therapy.

She was then returned to the nursing home where she continued her wheelchair existence with help transferring. At 18 months after operation, she had gained no additional mobility.

CRITIQUE

To review this case from an ethical point of view, we have only to go through the list of attributes and principles enumerated in the first portion of this paper. This will clearly establish that life and death issues are not the only factors in ethical behavior.

First, an analysis will be made of the actional paradigm dealing with basic principles.
1. Autonomy: The patient was not informed of the multiple choices available in her medical management. Instead, she was told what was felt to be best for her. While patients in this age group may still tolerate this paternalistic approach, this patient was of sound mind and could have entered into the decision making process. By denying her this right she was deprived of her autonomy.

2. Beneficence: This treatment helped the patient. But what were her expectations? These were never fully explored. Would she be able to walk again? Even though a treatment may help the patient, if it does not fully meet his or her expectations, it is regarded as a failure.

3. Non-maleficence: The patient had two assaults on her body while in the hospital. The first was placing her in traction and the second was the operation. Both were painful initially, but then gave favorable results. This initial pain can be eased by explaining the course of events and the intended outcome.

4. Justice: As mentioned before, justice is usually described as the allocation of scarce medical supplies or services so there will be plenty for all. In this case, the most expensive prosthesis was used, whereas another basic femoral head replacement, costing one fourth as much, would have given the same result. All too often, surgeon’s preferences take precedence over the strict medical indications.

This concludes the analysis of the principles as they pertain to the behavior of the surgeon in this case. As noted above, each of them could have been fulfilled to a greater degree.

A second perspective is gained from the dispositional paradigm analyzing the character of the surgeon.

1. Trustworthiness is a relationship of trust between people that is necessary for fruitful interaction. Trust takes time to develop and a hasty history and physical exam are hardly the setting to develop this trust. History taking is the ideal time to spend on this virtue. The patient can teach the physician a great deal if only the time is given in a relaxed atmosphere with regard given to the patient’s family, past history, likes, dislikes, prejudices and desires.

2. Prudence was certainly not shown in the reflex manner the decision was made for treatment immediately upon x-ray review. Careful thought as to the long term needs of the patient was not exercised. What is termed a medical indication is oft times more a preference of the surgeon. This preference can become so dominant that it precludes thinking of any other possibility, unless the prudent mind is allowed to exercise itself.

3. Veracity could be challenged more in the things not said rather than in those that were said. Truth telling is said to be the respect we owe to others as well as the obligation of fidelity or promise keeping. The surgeon played it safe by not saying anything he could not guarantee. Patients can be made aware that medicine is an inexact science and will accept these facts if presented in a forthright and truthful manner.

From the standpoint of the third perspective, the structural paradigm, factors such as being in a hospital, using technical language, being in the company of strangers, were all taken for granted by the physician. No attempt was made to explain to the patient how the ropes and balances of traction or that traction may create difficulties in toilet and hygiene care. The surgeon is often helped in this regard by the nursing staff, but to rely entirely on this nursing input is to shirk responsibility.

SUMMARY

The physician has certain duties of action that he/she must carry out in an ethical manner. The physician must not only show the ethically correct action, but must also be of ethical character, exhibiting trustworthiness, prudence, and veracity. This is all carried out in a structural setting that promotes dominance and coercion and loss of the patient’s autonomy. This must be recognized and rectified in every instance. To be sure, what is outlined here is the ‘Impossible Possibility’ referred to by Niebuhr. But physicians are called to keep striving toward a more positive way to act at all times and under all circumstances. It is in the endeavor that ethical conduct will be acquired.

REFERENCES

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The Council of the South Dakota State Medical Association met September 27, 1991, in Sioux Falls, and again on November 22, 1991, in Pierre. Following are highlights from these meetings:

1. LEGISLATION FOR 1992 -

SDSMA Sponsored Bills

A. Bill to ensure confidentiality of patient records when a doctor retires or dies or a hospital closes.
B. Amendment to Medical Practice Act to exempt physicians permanently licensed in another state from obtaining a SD license if they are members of 1) an organ harvesting team 2) on-board an air ambulance 3) providing one time consultation or teaching assistance not to exceed 24 hours 4) providing consultation or teaching assistance approved by the Board to charitable organizations.

SDSMA Endorsed Bills

A. Bill to establish a risk pool for uninsurables - $1.5 million allocation (SDSMA supports this provided the funding comes from the general fund).
B. Amendment to Durable Power of Attorney law which will extend immunity to physicians when acting in good faith.
C. Establishment of a physician assistant program at USD. The estimated cost for this program, utilizing some USD School of Medicine faculty and facilities is $165,000.

SDSMA Opposed Bills

A. Licensure of additional allied health personnel.

2. BYLAW AMENDMENT - An amendment to the SDSMA bylaws will be considered at the June 1992 House of Delegates meeting. This amendment will increase the size of the Council so that every district with fifty members or less will have two councilors. Larger districts with more than fifty members will have one councilor for every fifty members or fraction thereof as now stated in the bylaws.

3. HEALTH INSURANCE AVAILABILITY AND COST FOR SOUTH DAKOTANS - This is a priority item previously identified by the Council and referred to the Commission on Medical Service for study and recommendations. Recommendations submitted by the Commission and action taken by the Council includes:

   A. Encourage people to purchase health coverage with higher deductibles and copays (when people are partially responsible for paying their medical bills, it encourages more careful utilization of services).
   B. Physicians should become more aware of the costs for various procedures.
   C. Physicians should offer to discuss costs with their patients.
   D. In conjunction with SDSMA’s public relations program a bill stuffer be prepared for use by physicians in expressing concern about the increased costs of health care and suggestions for holding the line on these costs.
   E. Make available to the public information on the cost of defensive medicine.
   F. Recognizing that hospital costs are increasing at a rate of about 20% per year.
   G. Directing the executive office to develop a list of 20 or more most ordered tests outside the hospital and what those tests cost for distribution to the membership.

4. HONORARY LIFE MEMBERS - The following have been elected to honorary life membership in their district and the State Medical Association: Si Gaph Lee, MD, Sioux Falls; E.F. Kalda, MD, Platte; Peter Carter, MD, Aberdeen; George Flora, MD, Sioux Falls; Patrick McGuigan, MD, Rapid City; Marion Cosand, MD, Pierre; Paul Dzintars, MD, Rapid City, C.S. Roberts, MD, Brookings, B.J. Desai, MD, Watertown; John Janis, MD, Sioux Falls; Marion Thompson, DO, Watertown; and Loyd Wagner, MD, Sioux Falls.

5. AIDS POLICY - The Council recommended that any state legislation relating to AIDS and HIV testing and reporting be based on the guidelines adopted by the Center for Disease Control and the AMA.

6. ANNUAL MEETING - For the first time in many years individual tickets for the various events will be sold. The scientific program for the 1992 meeting will include three half-hour concurrent sessions on updates of high tech/current topics, a two hour seminar for physicians and spouses on co-dependency and how it affects the physician and the family and a SoDaPAC sponsored lunch hopefully with Senator Daschle and his Republican opponent. #
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Tenth Annual Park City Multidisciplinary Eye & Facial Plastic Surgery Conference, Olympia Resort Hotel and Conv Ctr, Park City, UT, Feb 1-4. CME hours avail. Contact: Brenda Ram, Staff Assistant, CME, U of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (402) 559-4152.

Creighton Medical School Centennial Symposium, Student Ctr, Omaha, NE, Feb 4. CME hours avail. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton U, CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Domestic Violence: A Focus on Adult Women, Educ Bldg Amphitheater, St Paul-Ramsey Med Ctr, St Paul, MN, Feb 7. Fee: $100. 7 hrs AMA Category 1 & AAFP credit. Contact: Registrar, St Paul-Ramsey Med Ctr, CME, 640 Jackson St, St Paul, MN 55101. Phone: (612) 221-3992.

Advances in Diagnosis and Management of Cardiovascular Disease, Omaha Marriott, Omaha, NE, Feb 8. CME hours avail. Contact: Brenda Ram, Staff Assistant, CME, U of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone (402) 559-4152.


Obstetrical and Gynecologic Update for the Primary Care Physician, Hyatt Orlando, Orlando, FL, Feb 10-14. Contact: Postgraduate Courses, Section of Cont Educ, Mayo Foundation, Rochester, MN 55905. Phone: (800) 323-2668.

Distinguished Lecture Series - Claude J. Lenfent, MD, Boys Town Natl Research Hosp Aud, Omaha, NE, Feb 12. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton U, CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

National Conference on Prostate Cancer, Hyatt Regency San Francisco Airport, San Francisco, CA, Feb 13-15. Fee: $250. 18 hrs AMA Category 1 credit. Contact: Natl Conf on Prostate Cancer, American Cancer Society, 1599 Clifton Road, NE, Atlanta, GA 30329-4251. Phone: (404) 329-7604.

Fourth Annual Presentation Health System Perinatal Conference, Ramkota Inn, Sioux Falls, SD, Feb 27-28. Contact: Kathy Miles, Educ Dept, McKennan Hospital, Sioux Falls, SD 57101. Phone: (605) 339-7739.

March

Advanced Laparoscopy Course, St Joseph Hosp and Creighton U, Omaha, NE, Mar 5-6. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton U, CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Autologous Transfusions: New Perspectives, Boys Town Nat'l Research Hosp Aud, Omaha, NE, Mar 7. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton U, CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

ENT Ski Conference, Keystone, CO, Mar 8-13. Contact: Brenda Ram, Staff Assist, CME, U of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (402) 559-4152.


April

Annual Obstetrics & Gynecology Update, St Paul-Ramsey Med Ctr, St Paul, MN, Apr 2-3. 12 hrs AMA Category 1 credit. Contact: Off of CME, Ramsey Foundation, 640 Jackson St, St Paul, MN 55101. Phone: (612) 221-3992.

ENT Update, St Paul-Ramsey Med Ctr, St Paul, MN, Apr 3. 7 hrs AMA Category 1 credit. Contact: Off of CME, Ramsey Foundation, 640 Jackson St, St Paul, MN 55101. Phone: (612) 221-3992.


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IMPORTANCE OF DOCUMENTATION
FOR AMBULATORY SURGERY RECORDS (ASC)

SDFMC has been reviewing selected ambulatory surgery cases to assure that quality care is provided, that procedures are performed when medically necessary and in the appropriate setting, and that billed CPT codes reflect the procedures performed.

A consistent problem found from the review of ASC records has been the lack of adequate documentation. SDFMC staff have been working closely with hospitals and ASC centers to improve the ASC recordkeeping. SDFMC encourages complete documentation and recordkeeping of all pertinent information by physicians and hospital personnel.

The following is an outline of HCFA ASC generic screens utilized by SDFMC in reviewing the quality of care provided to Medicare beneficiaries.

1. Adequacy of preoperative assessment.
   a) Appropriate history and physical examination not completed timely (i.e., within 30 calendar days prior to the procedure) or no results in the medical record, and no evaluation note by the operating surgeon. The note is to include information (including location) about the operative site.
   b) Laboratory, EKG, and x-rays (necessary/relevant to the patient’s health status and for the procedure being performed) not completed or no reports available at time of surgery.
   c) No blood pressure, pulse, respiration, and temperature taken and recorded prior to surgery.
   d) Abnormal results in 1.b) and/or c) above not addressed or resolved and the record does not explain why they are unresolved.

2. No appropriate and timely interventions during surgery for significant and sustained deviations or adequate explanation.
   a) Abnormal blood pressure
   b) Abnormal pulse
   c) Respiratory difficulty and/or decrease in saturation of arterial oxygen (SA O2)
   d) Abnormal blood loss
   e) Abnormal temperature

3. Issues related to the provision of postoperative care.
   a) Abnormal temperature
   b) Abnormal blood pressure
   c) Abnormal pulse
   d) Respiratory difficulty or observance of hypoxia
   e) Abnormal bloody drainage from wound or sign(s) of internal bleeding
   f) Significant change in physical status
   g) Adverse drug/transfusion reaction(s) and/or Medicare error (1) with potential for harm or (2) resulting in measures to correct
   h) Significant change in mental status

4. Lack of appropriate documented discharge plan including patient education and provisions for follow-up care.

5. Care or lack of care resulting in serious or potentially serious complications that could or did place the patient at risk.
SCIENTIFIC ARTICLES

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Donald B. Graham, MD

USD School of Medicine
Hearing Aids and Assistive Listening Devices
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Hand Lacerations of the Combined Interdigital-Intermetacarpal Region (Split Hand)

About the Cover
Photographed by professional photographer Charles M. Lewis, Sioux Falls, SD.
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Splenic Abscess: Two Case Reports

Paul Gisi, MS IV
Donald B. Graham, MD

ABSTRACT

Two cases of splenic abscess are presented. Both patients presented similarly with fever and abdominal pain. Diagnostic and treatment approaches to splenic abscess are discussed.

INTRODUCTION

Abscess of the spleen is a rare condition. Less than 400 cases have been described in the world literature.

Most cases of splenic abscess are due to an infectious process occurring elsewhere in the body which seeds the spleen with infective organisms. A smaller percentage of cases have an initiating etiology that is noninfectious in nature. These noninfectious etiologies include trauma, hemoglobinopathies, and contiguous disease spread.

We present here two cases of splenic abscess of differing etiologies followed by a discussion.

Case 1

A 57 year old white male presented with a ten day history of fever, chills, and left upper quadrant pain. He had been diagnosed four years previously with mixed cell non-Hodgkin's lymphoma, stage III. Despite intensive chemotherapy and consolidating radiation therapy, he had several remissions and relapses.

Ultrasound performed in the physician's office showed a hypodense region in the spleen. Air was also noted in the region and splenic abscess was suspected. Patient was admitted to the hospital that same day.

The patient's most recent course of chemotherapy and radiation had been 14 days before this illness developed. During that chemotherapy he had been hospitalized and suffered left upper quadrant abdominal pain. A computerized tomography scan (CT) of the abdomen at that time showed a hypodense region in the spleen which at the time was attributed to his lymphoma. He was discharged after the pain subsided.

Laboratory data on hospital admission were reported as follows: White blood count was $1600 \times 10^9/L$, hemoglobin was 10.6 g/dl, hematocrit was 29.1, platelets were measured at $170,000 \times 10^9/L$. Blood cultures drawn on admission were negative after seven days. CT studies of the thorax and abdomen were obtained. A hypodense region of the spleen was demonstrated. This was noted by the radiologist to be consistent with splenic abscess. Also noted on CT contrast studies was a gastrosplenic fistula from the fundus of the stomach to the abscess in the spleen. Surgical treatment consisting of splenectomy and fistula resection was determined to be the treatment of choice. Due to the patient's neutropenia, which was attributed to his recent chemotherapy, surgery was delayed one week.

During the week preceding the surgery, the patient received hyperalimentation for nutritional support, intravenous (IV) antibiotics for infection control, and two units of packed red blood cells to stabilize his hemoglobin. Two days prior to surgery, upper endoscopy was performed. The gastrosplenic fistula was visualized, but no other lesions of the stomach were seen.

By the time of surgery his white count had risen to $4900 \times 10^9/L$ and his hemoglobin was 11.2 g/dl. During the operation, the abscess was found to have ruptured and was walled off in the upper left abdominal quadrant. The spleen was removed. A proximal gastrectomy and anastomosis was performed. A Nissen wrap of the stomach was performed to prevent gastric reflux. The spleen and the portion of resected stomach were sent for pathology to evaluate. The patient tolerated the surgery well.

Cultures of the abscess grew a large amount of Candida Albicans, and a small amount of Group D.

1. Fourthyear medical student, USD School of Medicine, Sioux Falls, SD.
2. Clinical Assistant Professor, Department of Surgery, USD School of Medicine, Sioux Falls, SD.

FEBRUARY 1992
streptococci. The pathology report described a 332 gram spleen which was widely affected by infiltrating large cell pleomorphic non-Hodgkin's lymphoma. The portion of the stomach resected was also infiltrated with lymphoma. The patient was treated for eight days postoperatively with IV antibiotics, and did not suffer any recurrence of abdominal pain or fever during this hospitalization.

Case II
A 73 year old white male had been suffering from fever and generalized abdominal pain of two weeks duration. As a result, he was hospitalized at his local hospital and treated with IV antibiotics for probable pneumonia. He did not respond well to this therapy, and an abdominal ultrasound was performed. A splenic mass was seen on ultrasound. On CT scan a low density region was seen at the center of the spleen, and the splenic outline was noted to be distorted by what appeared to be inflammatory changes and/or an abscess in the spleen. The patient also had an increase in number and size of periaortic retroperitoneal lymph nodes. He was transferred to a surgeon's care, and preparations were made for an exploratory laparotomy.

The patient's pertinent recent medical history includes having been hospitalized 11 months earlier for necrotizing pneumonitis of the right lower lung lobe. Also of note, is the fact that the patient did have a difficult tooth extraction for a broken tooth two weeks prior to becoming ill. The patient reported that he did take two days of prophylactic antibiotics prior to the extraction. His only medication on admission was digoxin for chronic atrial fibrillation.

Physical examination on admission showed a well nourished elderly man who was alert and cooperative, and seemed to be in mild distress. His blood pressure was 146/78, his pulse was 86, and his temperature was 101. On heart auscultation a grade II, harsh pansystolic ejection murmur was heard at the left sternal border. This was consistent with past physical examination performed since his myocardial infarction in 1979. On abdominal examination the spleen was not palpable. No masses or organomegaly were noted. Bowel sounds were normal. There were no other abnormalities noted on exam.

The result of laboratory tests performed on admission were as follows: white blood count was 11,800 x 10^9/L with a differential showing 75% segmented neutrophils, 14% neutrophilic bands, 14% lymphocytes, and 10% monoocytes. Hemoglobin was 15.6 g/dl. Hematocrit was 46.9. Blood cultures were negative after 7 days.

The patient was taken to surgery on December 13. Exploration of the abdomen revealed normal liver, pancreas, bowel, and pelvis. The spleen was visualized and appeared to contain an abscess. This process occurring in the spleen was walled off by omentum and the splenic flexure of the colon, and was eroding through the abdominal wall into the abdominal muscles. The spleen was bluntly mobilized off the abdominal wall and removed.

Cultures were obtained and the spleen was sent for pathology to evaluate. The patient tolerated surgery well, and did not suffer any complications initially.

Cultures of the abscess grew alpha hemolytic streptococci. The pathology report described the spleen as weighing 345 grams with significant fibrosis and inflammation. He was treated post operatively with antibiotics sensitive to this organism.

The patient initially did well postoperatively, but in the weeks following surgery he developed an intra-abdominal abscess in the vacated splenic bed. This was treated successfully by percutaneous drainage and IV antibiotics.

DISCUSSION
The spleen functions to remove foreign macromolecules and particulate matter from the circulation. Arteries supplying the spleen are "end arteries" terminating in the splenic tissue. Consequently, occlusion of these arteries is likely to produce infarction of the spleen. It is evident then that the high exposure of the spleen to infectious agents and its susceptibility to infarction are important factors in the development of abscess.

Splenic abscess occurs mostly in males, with the mean age of occurrence being 37. A bimodal distribution of splenic abscess has been described by Nelken and colleagues: those under 40 years of age and those older than 40 years of age. The younger patients are more likely to be drug users, to have cancer, and/or to be immunosuppressed. The abscess formation in this group is more likely to be multilocular in nature and caused by fungal organisms. The older group of patients is described as being more likely to be suffering from diabetes or nonendocardial metastatic infection with unilocal abscess being more common.

Chun's classification of splenic abscesses emphasizes predisposing causes and is widely accepted. The four predisposing causes are described as: primary pyogenic infection, splenic trauma, hemoglobinopathies, and contiguous disease affecting the spleen.

Pyogenic infection is the most common condition predisposing to splenic abscess. The mechanism being bacteremia or septic embolization from a septic focus in the body which results in sequestration of organisms in the spleen. The most common infectious process leading to abscess formation is bacterial endocarditis. Other common causes are listed in Table I.

Trauma and hemoglobinopathies can result in splenic abscess. The infarcted or damaged spleen can serve as a nidus for blood borne organisms. Abscesses can occur in the spleen as the result of contiguous spread of disease processes occurring elsewhere in the
Table I
Factors Predisposing to Splenic Abscess

<table>
<thead>
<tr>
<th>Etiology</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infections</td>
<td></td>
</tr>
<tr>
<td>Endocarditis</td>
<td>15.3</td>
</tr>
<tr>
<td>Urinary Infection</td>
<td>7.1</td>
</tr>
<tr>
<td>Otitis</td>
<td>3.3</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>2.8</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>2.8</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>2.3</td>
</tr>
<tr>
<td>Lung Abscess</td>
<td>2.3</td>
</tr>
<tr>
<td>Malaria</td>
<td>1.9</td>
</tr>
<tr>
<td>Diverticulitis</td>
<td>1.9</td>
</tr>
<tr>
<td>Urological Surgery</td>
<td>0.95</td>
</tr>
<tr>
<td>Amebiasis</td>
<td>0.95</td>
</tr>
<tr>
<td>Miscellany</td>
<td>11.9</td>
</tr>
<tr>
<td>Septic Syndrome</td>
<td>11.9</td>
</tr>
<tr>
<td>Noninfectious Etiology</td>
<td>31.2</td>
</tr>
<tr>
<td>Trauma</td>
<td>16.7</td>
</tr>
<tr>
<td>Hemoglobinopathies</td>
<td>11.9</td>
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<tr>
<td>Contiguous Diseases</td>
<td>23</td>
</tr>
</tbody>
</table>

Table II
Bacteriology of Splenic Abscesses

<table>
<thead>
<tr>
<th>Etiology</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Streptococcus</td>
<td>15.6</td>
</tr>
<tr>
<td>Staphylococcus</td>
<td>14.6</td>
</tr>
<tr>
<td>Salmonella</td>
<td>7.3</td>
</tr>
<tr>
<td>Other Gram Negative</td>
<td>21.4</td>
</tr>
<tr>
<td>Anaerobes</td>
<td>12.1</td>
</tr>
<tr>
<td>Fungi</td>
<td>2.4</td>
</tr>
<tr>
<td>Sterile Cultures</td>
<td>26.6</td>
</tr>
</tbody>
</table>

gastrointestinal tract. Such diseases include cancer growing in the gastrointestinal (GI) tract, perihepatic abscess, and diverticulitis. The proposed mechanism for this type of abscess formation is erosion and thrombosis of the splenic artery leading to secondary bacterial infection and abscess formation.

Fever is the most commonly reported symptom in splenic abscess, occurring in 93-95% of patients. The second most common symptom reported is abdominal pain, described as being diffuse and of varying intensity. In less than one half of the patients abdominal pain was localized to the left upper quadrant.

Chest pain can occur in up to twenty percent of patients. Splenomegaly appears in a little more than one half of the reported cases. WBC as reported on 100 patients reviewed by Chun ranged from 2400 x 10^9/L to 41,000 x 10^9/L, with a mean of 15,631 x 10^9/L. Chun reports positive blood cultures in 43 of 72 patients where cultures were obtained in cases that he reviewed.

Streptococcus has consistently been identified as the most common etiological organism of splenic abscess, with staphylococcus a close second. Table II lists the most common causative agents. Although not apparent from this table, an increasing number of splenic abscesses are being caused by fungal organism. Nelken reports that fungal abscesses, almost unheard of before 1978, have made up nearly 26% of the reported cases of splenic abscesses since 1978. This phenomena can be explained by the fact that fungi are opportunistic pathogens and the increased use of immunosuppressive agents to treat seriously ill patients (i.e., cancer patients) has increased the population at risk for development of splenic abscess.

The best diagnostic methods for splenic abscess are radiologic. Computerized tomography has a sensitivity of 96%. Ultrasound is effective also, having a sensitivity of 76%. Chest radiographs can also be helpful as they may show nonspecific abnormalities such as a mass effect in the left upper quadrant, or elevation of the left hemidiaphram. Untreated splenic abscess is fatal with the most common cause of death being abscess rupture causing acute peritonitis. Treatment of choice consists of splenectomy with adjunct antibiotic therapy. Antibiotics effective against gram positive cocci and gram negative aerobic bacteria are effective. When evidence exists for infection by anaerobic organism, antibiotics such as imipenem, chloramphenicol, metronidazole, and clindamycin should be used. Antibiotic therapy for two weeks following surgical therapy, unless underlying medical conditions calls for longer therapy, is indicated.

An alternative treatment to surgery in select patients with abscess is percutaneous CT-guided drainage. Percutaneous drainage is indicated when patients are seriously ill, postoperative, or when the risks of general anesthesia or surgery are substantial. Percutaneous drainage should only be attempted on unicellular abscesses that have discrete walls without internal septations.

COMMENTS
We have presented two cases of splenic abscess of differing etiologies. The first patient was immunosuppressed as the result of the chemotherapy he was receiving for his lymphoma which involved the stomach. It spread to the spleen causing an abscess which was fungal in nature and consistent with Nelken's observation that immunosuppressed individuals are susceptible to fungal abscess formation in the spleen. He did well
following splenectomy, although he still suffered from lymphoma.

The second patient developed a splenic abscess following a tooth extraction. The causative organism was alpha hemolytic streptococci. This is consistent with the fact that streptococci is the most common organism isolated in splenic abscesses. The patient probably did not have endocarditis since he was evaluated for this on his second hospitalization and found to be free of that disease. The most likely explanation for the abscess formation is that the patient became bacteremic following the tooth extraction he underwent two weeks prior to becoming ill. The bacteremia most likely seeded the spleen and led to abscess formation. Streptococcus viridans, an alpha hemolytic streptococci indigenous to the oral cavity and a known human pathogen, was the most likely causative agent. He also received a splenectomy, followed by postoperative antibiotic therapy. His recovery was complicated by subsequent abscess for-

mation in the vacated splenic bed. He did well following percutaneous drainage of the abscess and antibiotic therapy.

REFERENCES
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The omission of all or any part of the President's Page because of: act of God; inevitable accident; fire; labor dispute; act of government or governmental instrumentality; failure of technical facilities; illness or incapacity of any important contributor, or other cause of similar or different nature beyond the President's control, shall not constitute a failure of performance on the part of the President; provided, however, that if no part of such President's Page is printed, subscriber shall not be obligated to make any payment to the State Association!

Legal interpretation: I couldn't find the time to get said President's Page together! However, last month's page was so long I should have made it a continued story!

Sorry about that, watch this space next month!  

\[#\]

Mark your Calendar---
Plan to Attend!

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1992 Annual Meeting
South Dakota State Medical Association
June 4 - 6, 1992
Howard Johnson Motor Lodge
Rapid City, SD

<table>
<thead>
<tr>
<th>Thursday, June 4:</th>
<th>Friday, June 5:</th>
<th>5. Ethics</th>
</tr>
</thead>
<tbody>
<tr>
<td>First House of Delegates Meeting</td>
<td>Concurrent Scientific Sessions on:</td>
<td>6. AIDS in South Dakota</td>
</tr>
<tr>
<td>Reference Committee Meetings</td>
<td>1. Advances in Cardiology</td>
<td>followed by a 2 hour program for doctors and spouses on &quot;Co-dependency&quot;</td>
</tr>
<tr>
<td>Golf and Trap Shoot</td>
<td>2. Sudden Death</td>
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<tr>
<td>Doctors’/Exhibitors’ Party</td>
<td>3. Overview of Geriatrics</td>
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<tr>
<td>AMA-ERF Event</td>
<td>4. Osteoporosis</td>
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SoDaPAC Lunch
Specialty Society Meetings or Free Afternoon
Annual Banquet and Entertainment

Saturday, June 6: Second House of Delegates Meeting
Second Council Meeting
Adjourn by Noon

---

Mark your Calendar---
Plan to Attend!

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FEBRUARY 1992

41
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Therapeutic Interventions: What Really Works?

Virtually all physicians would agree that ineffective treatment should not be employed. Historically, however, there have been numerous differences of opinion and debate about what constitutes truly effective treatment and how the efficacy of a given treatment should be proven. All too often in the past, treatment decisions have been based on anecdotal experience and report, noncontrolled studies, and sometimes on clinical judgments which have, in essence, been "the gut feelings" of practitioners.

Recently, increasing emphasis has been placed on only utilizing treatments with clearly demonstrated efficacy. The call for this type of scientific rigor has come from a number of sources, including the American College of Physicians. In the ACP’s Annals of Internal Medicine, for instance, recent articles have discussed the development of publicly available standards of medical practice and the development of clinical guidelines to help determine a given technology's efficacy and cost. In these and other articles, emphasis has been given to the importance of subjecting our treatments and biases to close scrutiny. One way to do this is through the use of "consensus conferences" in which recognized national experts join in making recommendations as to what represents proven, effective therapy. Certainly, it seems likely that in our current climate of escalating health care costs, the government (i.e. Medicare/Medicaid), and insurance companies are going to become increasingly insistent that the treatments which are used be of well established benefit.

One could look to many different areas of medicine to find examples of how empirically used treatments have either ultimately proven to be effective or, conversely, how widely used treatments have ultimately proven ineffective. An area of medicine which readily lends itself to this type of analysis is cerebral vascular disease.

Carotid endarterectomy has, of course, been widely used throughout this country for many years. The feeling has been that an endarterectomy in a patient who has a transient ischemic attack (TIA) or stroke might be more effective than medical treatment in terms of preventing future strokes. While a number of papers and articles have addressed this topic, properly controlled, double blind comparisons of medical vs. surgical management have been lacking. This circumstance changed with the August 15, 1991, New England Journal of Medicine article entitled "Beneficial Effect of Carotid Endarterectomy in Symptomatic Patients with High Grade Carotid Stenosis." This study does demonstrate that carotid endarterectomy is highly beneficial to patients with recent TIA's or minor strokes. A second example of fairly definitive and helpful information is seen in the recent article, "Stroke Prevention in Nonvalvular Atrial Fibrillation." This article consists of a compilation of transcripts from a symposium held at Stanford University Medical Center in 1990. It summarizes nicely the current evidence that long term, low dose Warfarin therapy appears to be beneficial for most patients with chronic atrial fibrillation. These studies suggest a substantial reduction in the incidence of strokes, and a relatively low rate of bleeding complications, when Warfarin is appropriately used.

Equally instructive are studies which have demonstrated that widely used therapies are ineffective and should not be employed. Vascular medicine examples in this category can also readily be found. In the article, "Failure of Extracranial - Intracranial Arterial By-Pass to Reduce the Risk of Ischemic Strokes," it was demonstrated that this type of anastomosis was not effective. This type of surgery was being done regularly prior to this study. Initially, the procedure seemed to make good sense, especially for persons with a completely occluded internal carotid artery on one side and continued TIA's from that ipsilateral hemisphere. A second example of research which clearly challenged accepted therapy concerned the use of dipyriramole to prevent strokes. In the 1985 American-Canadian Cooperative Study Group it was shown that for patients taking aspirin following TIA, the addition of Persantine conferred no benefit.

Surely it is imperative for the medical profession to continue to look critically at the treatments and options we offer our patients. To the extent possible, we need to focus on those measures of proven efficacy and be willing to discard measures of doubtful benefit. This is not always easy to do. Especially as patients become more medically sophisticated, they may insist on measures which are not proven to be beneficial or could even, possibly, be harmful. For instance, I have had patients and families argue strenuously for a prompt carotid endarterectomy after a major stroke or in the presence of a completely occluded carotid artery, even though most authorities would agree that the potential morbidity/mortality of these types of surgical interventions outweigh any benefit.

By continuing to insist that the medical interventions we employ have established efficacy and benefit, we
enhance our creditability as care givers whose principle focus and energy are devoted to the good of our patients. We must continue to remind ourselves and our colleagues to strive for this ideal.

Jerome W. Freeman, MD
Editor

REFERENCES

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Hearing Aids and Assistive Listening Devices

Priscilla F. Bade, MD

ABSTRACT

Hearing impairment is common. However, many people, physicians included, are unaware of the practical aspects of owning a hearing aid. This article explains how to obtain a hearing aid. It also describes the different types of hearing aids including assistive listening devices, hearing aid maintenance and factors which affect acceptance of a hearing aid.

INTRODUCTION

Hearing impairment is one of the most common chronic health problems in the elderly, affecting as many as 40% of persons over the age of 65.1 Far from being a benign consequence of old age, hearing impairment has been associated with adverse effects on physical and psychosocial function. It can lead to social isolation and withdrawal as well as symptoms of depression, and has been associated with cognitive dysfunction.2,3 Of course, hearing impairment can affect younger persons as well, with adverse effects on school performance and employment opportunities if communication problems are not addressed appropriately. Hearing aids and other electronic devices can improve the quality of life for many hearing impaired people.4 However, health care professionals often have little experience with these devices. This lack of familiarity may adversely affect patients' attitudes toward hearing aid use, both in the initial purchase of a hearing aid and in making optimal use of hearing aids and assistive listening devices.

Types Of Hearing Aids

Hearing aids are of three basic types: in-the-ear (ITE) aids, behind the ear (BTE) aids, and body aids. Selection of a hearing aid for a given patient will depend not only on its cosmetic appeal but also on the aid's power output and the presence of features such as telephone coil switch(es). Hearing impaired persons should work closely with a hearing aid specialist to choose the appropriate hearing aid.

A hearing aid is essentially a device to amplify sound. It consists of four basic components: a microphone which picks up sound from the environment and turns it into an electrical signal, an amplifier, a receiver to change the electrical signal back to sound waves, and a physical channel to direct the amplified sound to the ear. This channel may be very short in the case of an ITE aid, or may consist of an earhook and a tube which passes through an earmold to reach the ear (for BTE aids). The maximum power output and the frequency response of the aid (i.e. whether it amplifies high-pitched sounds more than low-pitched sounds) depend on the amplifier circuitry, but can be adjusted by hearing aid specialists.

Hearing aid controls vary from one aid to the next, but almost all aids have a volume switch. There may be a separate on-off switch, or the aid may be switched off by opening the battery compartment. Some hearing aids have a remote-control device to improve the ease of manipulating the controls; this may be useful for patients with impaired manual dexterity. Many aids have a telephone coil (telecoil) switch, which can be used to listen to the telephone while eliminating background noise. This telecoil switch is also useful for FM loop assistive listening devices, which are available in some public auditoriums. Some hearing aids have a directional microphone feature, which can improve hearing in noisy situations.

1. Portions of this article were published in the American Geriatrics Society Fellows-in-Training Newsletter, Summer 1991, Volume III, No. 4. We have permission to reprint from Robert Hawkins, Editor of the newsletter.
2. Graduated from the USD School of Medicine Internal Medicine Residency Program. Is completing a fellowship in geriatrics, Medical College of Wisconsin in Milwaukee and then she will be joining the USD School of Medicine faculty in the summer of 1992.

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Canal aids or ITE aids fit into the ear canal, and have a custom-made case which fits into the patient’s ear. Arthritic patients may have difficulty with the small controls. Power output is limited not only by the aid itself, but also by acoustic feedback (“whistling”), caused by leakage of sound around the earmold when the aid is used at higher volume settings. Canal aids are suitable for mild losses. ITE aids are the most popular hearing aid for mild to moderate losses, but may lack features available in BTE aids.

BTE aids are worn behind the patient’s ear and are connected to an earmold which is purchased separately from the aid. BTE aids are somewhat less cosmetically acceptable but allow greater power output. They may have added features such as a telcoil switch.

Body aids are worn in a pocket or in a body harness, and wires connect the aid to a receiver, which plugs into an earmold. Because of cosmetic reasons, noise from clothing, and the fact that body aid microphones are at chest level instead of ear level, these aids are rarely used except for profound hearing losses.

Other, less common types of hearing aids include eyeglass aids and bone conduction aids. Eyeglass aids have the hearing aid built into the earpiece of the eyeglasses. The main disadvantage is that if one component needs repair, the other (glasses or hearing aid) will be unavailable to the patient. Bone conduction aids provide less sound fidelity than ITE, BTE or body aids, but may be useful for patients who cannot tolerate an earmold in the ear canal.

Cochlear implants may be beneficial for selected patients who cannot hear adequately with an external hearing aid. During the cochlear implant procedure, a transducer is implanted within the temporal bone. This device stimulates the auditory nerve, which sends impulses to the brain. However, this surgical procedure does not restore normal hearing and is reserved for patients with profound impairment. Patients who are considering this operation should work closely with their otolaryngologist and audiologist.

Purchasing A Hearing Aid

How should someone obtain a hearing aid? The U.S. Food and Drug Administration requires that patients undergo a physician’s examination to rule out reversible causes of hearing loss. Patients may sign a waiver refusing the examination, but this is inadvisable unless they have been examined recently. Primary care physicians play an important role in referring patients to either an otolaryngologist or audiologist when a hearing problem is suspected. It is recommended that all hearing-impaired patients be seen by an otolaryngologist, who can determine the cause of the hearing loss and treat reversible causes of hearing loss such as otitis media and otosclerosis.

The need for a hearing aid is determined by an audiometric examination. Although hearing aids cannot be fitted with the same precision as eyeglasses, a person must be individually fitted for the optimum hearing aid. Aids vary in their maximum power output and in their frequency response, as well as in optional features such as telephone coil switches. Furthermore, hearing aids of the same model can differ in sound quality, so that ideally a person should be fitted with the same aid that he will purchase.

A hearing aid is chosen based on the patient’s need for a given amount of amplification and the pattern of hearing loss in certain frequencies. For example, patients with presbycusis need greater amplification for high frequency sounds. Hearing aids can be purchased from hearing aid specialists; private dealers or audiologists. Private dealers are licensed by individual states, usually after passing an examination; there is no minimum educational requirement in South Dakota. Audiologists must obtain a master’s degree in audiology as well as state licensure. Their training includes not only the techniques of audiometry and hearing aid fitting but also auditory rehabilitation. They may be certified by the American Speech-Language-Hearing Association after an additional year of experience.

One major problem in supplying hearing aids to the elderly population is the cost. A single hearing aid can cost several hundred to a thousand dollars. The price of the aid may vary considerably from one source to the next. Patients should shop carefully before they make their final purchase. The cost of the hearing aid generally has to come out of the patient’s own resources, since most insurance plans (including Medicare) do not pay for hearing aids. In some instances, Medicaid will cover aids. The Department of Veterans Affairs provides aids to eligible veterans, including those in VA nursing homes who need an aid to help with rehabilitation.

Many states require a thirty-day trial period during which the aid can be returned if it is not satisfactory, no matter where it was purchased. South Dakota does not have such a law, so patients should inquire about such a provision before making a purchase. Warranties and repair policies should also be investigated. Patients may have to pay a service fee for the hearing aid fitting and for a custom-fitted earmold, but in general they should not pay more than $100 until they decide whether or not to keep the aid.

Hearing Aid Maintenance

Hearing aids do require maintenance. Batteries need to be replaced every one to three weeks, depending on the power requirements of the aid (this is the most common reason for malfunction of a hearing aid). Zinc-air batteries last longer than mercury batteries and are safer for the environment. Hearing aids, like most electronic devices, do not like to get wet, and should not be worn while showering or swimming. During vigorous exercise, moisture may build up in the earmold tubing.
of behind-the-ear aids. It can be expelled by removing the earhook and forcing air through the tubing. Cerumen buildup inside the mold can be removed gently with a sewing pin. Cerumen impaction in the ear canal can interfere with hearing and should be removed using cerumen-dissolving drops or by a health care professional.

Sometimes there are physical or mechanical problems with the aid. An ill-fitting earmold can cause ear discomfort or even sores in the ear. If the mold is too loose, acoustical feedback will cause "whistling". This limits the volume at which the patient can use the hearing aid. A hearing aid specialist can modify or retake the earmold to improve the fit. A few patients have difficulty with recurrent ear infections and will need to work closely with an otolaryngologist for this problem.

Hearing Aid Acceptance

How can the physician tell whether the patient will accept a hearing aid? Often, the only way to know is for him or her to try it. However, there are several important factors to consider. First the patient has to recognize that an aid is needed. The person who thinks the whole world is mumbling and there's nothing wrong with his ears, even after seeing his audiogram, is unlikely to accept and use a hearing aid. Denial of hearing loss is common; many people seek help for hearing loss only after intimate conversation becomes difficult. Secondly, demented patients may be unable to cooperate with testing or to adjust to using a hearing aid. Thirdly, many people have heard their friends complaining about their aids. Some complaints are realistic; hearing aids do whistle at inconvenient times, and they are not a substitute for normal hearing. Patients with presbycusis may have difficulty with speech discrimination even with amplification. This is analogous to correction of refraction error in someone who also has symptomatic macular degeneration. He or she will see better with glasses than without them, but will not have normal vision.

Counseling is important to encourage realistic expectations. Someone who expects to hear perfectly with an aid under all circumstances will be disappointed. They need to realize that a hearing aid is just that—an aid. It is not a cure-all for situations with background noise, speakers who really do mumble, or speech discrimination problems. In these situations, the hearing-impaired person should use communication techniques to improve his or her understanding of speech. People who have had a gradual onset of hearing loss may be upset because they are now hearing all the noises (traffic, screaming children, kitchen clatter, etc) that were lost to them during the years of diminished hearing. The new aid user needs to wear the aid on a regular basis to allow the brain to adjust to those noises again. This person should begin using the aid in quiet areas at first, and in noisy areas later.

What about the person who has a hearing aid but keeps it in a dresser drawer instead of using it? Ask him or her how much it helps. The individual may not feel he or she needs it, or may be disappointed with the quality of sound from the aid. The aid may need to be repaired, or may need a new battery. Reassessment by an audiologist can determine if the aid is appropriate for the individual's hearing loss—perhaps a more powerful aid is needed.

Audiologists are helpful in providing counseling to hearing aid users. They can instruct patients to use good communication techniques to supplement the help their hearing aids provide. Physician encouragement can make a difference; reminding patients to wear their aids to appointments shows them that you think it is important. Patients in nursing homes may need assistance in using their hearing aids; nursing staff should learn how to help them. Physicians and other health care professionals should also use good communication techniques, which can improve patient satisfaction and compliance.

Assistive Listening Devices

There are two basic types of assistive listening devices: personal amplifiers and systems used by public places such as churches and auditoriums. Other devices, such as TTD (telecommunication device) telephones and closed captioning, make use of the printed word to enhance communication.

Pocket amplifiers can be helpful for the patient with mild to moderate loss who doesn't have a hearing aid. Many speech pathology departments keep them on hand for hospitalized patients. If you see many hearing-impaired patients, consider purchasing one for your office. They are available from electronics supply stores for less than a hundred dollars. Battery-powered telephone amplifiers fit over the telephone receiver or plug into the telephone. These can be purchased from telephone or electronics supply stores. Amplified telephone handsets can be purchased for private phones; some public telephones are equipped with amplifying buttons. Pay telephones which are useable with a telephone coil are usually marked with a blue rubber tube at the end of the handset cord.

Another variety of assistive listening device is found in public places such as churches, concert halls, and some theaters. There are several different types, from an earphone wired directly to the sound system, to an infrared system which can be worn around the neck, to an FM-loop system which connects to an FM input found on certain hearing aids. A given system may work better for one individual than for another. Encourage your patients to make use of these devices rather than forgo activities they enjoy.

SUMMARY

Hearing aids can improve the quality of life of many hearing impaired persons. However, they are quite...
expensive, and should be fit carefully to the individual. Anyone who is considering a hearing aid purchase should consult a physician to rule out reversible causes of hearing loss, and should have his or her hearing evaluated by an audiologist. Hearing aid purchasers should shop carefully and discuss the terms of purchase with the hearing aid specialist before they buy. Counseling is important for making the optimum use of a hearing aid. Assistive listening devices can be useful but whether they work well for a given individual is a matter of trial and error. Health care professionals should be aware of the different types of hearing aids and their limitations as well as their benefits.

REFERENCES


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Telephone: (605) 665-7841 (call collect)
Extenuating Circumstances

Legislative Contacts: Maximizing Your Efforts For Organized Medicine

Dave Gerdes¹
Dennis Duncan²
Dean Krogman³

Introduction

The State Legislature meets annually on the second Tuesday of January at the State Capitol in Pierre, with a session of 40 legislative days in odd-numbered years and a session of 35 legislative days in even-numbered years. Currently, there are 105 legislators, the House of Representatives consisting of 70 members and the Senate consisting of 35 members.⁴ Each Legislative District contains two members of the House and one Senator.

A legislative bill typically faces five or six hurdles which it must successfully negotiate before becoming law. When a bill is introduced, upon first reading it is assigned by the presiding officer of the house of origin to a committee.⁵ By legislative rule, all bills must receive final action, meaning that each committee must act on all bills referred to it. To move a bill to the floor, a committee has essentially three options: do pass, do not pass or without recommendation. The latter two options require a majority vote of the members-elect⁶ of the House considering it to place the bill on its calendar; otherwise the bill dies. A bill is killed in a committee by a successful motion to table, or to defer to a legislative day beyond the end of the session (e.g., a motion to defer a bill to the 41st legislative day in a 40-day legislative session). Many bills also suffer a de facto death by amendment.

The second step of a bill toward becoming law is passage by the house of origin upon a second reading, by a majority of the members-elect in the case of most legislation, and by a two-thirds majority of the members-elect in the case of appropriations or emergency measures.⁷ Following passage by the house of origin, the same process occurs in the second house. Passage by the house of origin by no means assures passage of controversial bills in the second house. Also, mistakes or misapprehensions can occur in the house of origin, and scrutiny by the second house assures a second perspective on all pieces of legislation, especially those which might be controversial or novel.

If the second house passes the bill in the same form as the house of origin, the bill then goes to the Governor. However, if the bill is amended in the second house, it must be returned to the house of origin for its agreement with the amendment. If the house of origin concurs, the bill then goes to the Governor. If the house of origin does not concur, conference committees⁸ consisting of three members from each house are appointed to resolve the differences between the houses. If the two houses cannot agree, the bill will die.

The last step in the process occurs when the bill is delivered to the Governor. He or she approves the bill by a signature, or the Governor may veto the bill, which can only then become law by passage by a vote of two-thirds of the members-elect of both houses over the Governor's veto.

Most legislators view themselves as being representatives of the constituencies from which they are elected. While lobbyists can present issues to committees, poll individual legislators and identify strengths and weaknesses in bills, most lawmakers respond best to contacts from their constituencies, "the folks back home." Certainly all legislators carry with them the experiences and opinions of a lifetime which may precondition them on some issues. However, on a close issue contacts from their constituencies have the best chance of dictating their final vote.

Contacts from constituents are significant and will be considered by legislators. Beyond that, however, it is the "quality contacts" that have the greatest impact on

1. Dave Gerdes is a lawyer practicing in Pierre with the law firm of May, Adam, Gerdes & Thompson. He has practiced law in Pierre since 1968. He has been general counsel, and a lobbyist, for the South Dakota State Medical Association since 1972.
2. Dennis Duncan is a partner in the Parker law firm of Zimmer, Duncan & Deadrick. Dennis has practiced law since 1973 and has been a lobbyist for various clients since 1975. He is general counsel to Dakotacare.
3. Dean Krogman is a realtor from Brookings and began serving as a contract lobbyist for the Association and Dakotacare during the 1991 legislative session. Dean served in the South Dakota House of Representatives from 1984 to 1989. While in the Legislature he served on the Taxation, Health and Welfare, and Commerce Committees.
4. The Constitution permits the Legislature to establish the membership of the House to be not less than 50 nor more than 75 members, and to establish the membership of the Senate to be not less than 25 nor more than 35 members. Article III, Section 2.
5. Both the House and the Senate have the following standing committees: Agriculture and Natural Resources; Appropriations; Commerce; Education; Government Operations & Audit; Health & Human Services; Judiciary; Legislative Procedure; Local Government; Retirement Laws; State Affairs; Taxation and Transportation.
6. Required votes by "members-elect" as opposed to "members present" can be significant. As a practical matter, this means that on any affirmative proposition those not present constitute "no" votes.
7. Two types of emergency measures are recognized by the Constitution: laws necessary for the immediate preservation of public peace, health or safety, and laws necessary for the support of the state government and its existing public institutions.
8. Typically, the presiding officer will appoint to a house's conference committee two members who voted on the prevailing side of an issue, and one member who voted on the other side of the issue. Also, the presiding officer will attempt to have bipartisan representation on each conference committee.
individual legislators. Generally speaking, these are contacts from a constituent who has a prior relationship with the legislator, whom the legislator respects, who has pertinent or significant information on a particular issue, or who is part of a group with whom the lawmaker has a significant relationship or affinity. In a close vote, quality contacts have the best chance of securing a legislator's vote.

Legislators ran for the office which they hold and expect to represent their constituents. Thus, they expect to be contacted by their constituents and they generally enjoy discussing the concerns of their constituents with them. Whether you believe it or not, they consider themselves to be neutral and like to be treated that way. Remember that they must listen to all sides of an issue to fulfill what they perceive to be their responsibility to those whom they represent. Most legislators will appreciate a succinct, logically presented argument on a particular issue. However, if a particular legislator indicates disagreement with you, it is a mistake to be offensive, tenacious or overbearing. If you lose one with your senator or representative, he or she will undoubtedly be looking for a way to vote with you in the future, and you don't want to alienate that legislator. If you remain on speaking terms, he or she might very well be your biggest booster on the next issue that comes along.

Prior to the Session

Even though the members of our Legislature are distinctly part-time, in a sense they are on the job 365 days of the year. In addition to attending the annual legislative sessions and perpetually running for re-election, they attend interim committee meetings to study subjects of legislation for ensuing sessions. As we have mentioned, they expect to discuss legislative issues with their constituents throughout the year. Therefore, most legislators will not be put off by your desire to discuss legislative issues with them most any time it is convenient.

You should try to develop a relationship with each of the legislators in your district. This has a tendency to foster the quality contacts which are necessary to bring about favorable votes. A good way to develop a personal relationship with a legislator is to become acquainted with him or her during the election campaign. Pick out candidates with whom you agree philosophically and develop a relationship with them. While a campaign contribution is always appreciated by a candidate, there is no substitute for personal contact or personal involvement to develop a potential quality contact. For example, you can:

- Get acquainted by introducing yourself to the legislator (or candidate) at local sporting events, on the golf course, at the tennis court or at other public meetings.
- Offer, along with your family, to help the legislator during the campaign by stuffing envelopes, going door-to-door or accepting yard signs.
- Offer to introduce the legislator to your colleagues and friends.
- Host or help with a fund-raiser.
- Offer your expertise—most legislators greatly appreciate a professional who will act as a resource person to help the legislator understand and analyze complex or technical issues.

Generally speaking, you cannot expect a legislator to agree with you on every issue. However, a healthy relationship will develop a rapport which the lawmaker will appreciate. Over the years you will find that this rapport will translate into more agreements than disagreements on issues.

Most importantly, your relationship with your legislator should be on a year-round basis. They will tend to shy away from"fair-weather"relationships that occur only during the legislative session. It is important to develop a habit of contacting your legislator periodically and sounding him or her out on issues. Every contact doesn't have to be an in-depth discussion of all issues. Also, legislators appreciate your concern with their problems from time-to-time, which can easily translate into their concern for your problems on other occasions.

During the Legislative Session

Typically, your contacts with your legislators during the session will be in one of two general scenarios. It may be that, for one reason or another, you are not well acquainted with the legislator. It is not always possible to start out making quality contacts based upon a long-standing personal relationship, and a contact from a concerned constituent is far better than no contact at all. The second scenario involves your contact as a constituent when you know the lawmaker socially or have had a professional relationship with the lawmaker. In either instance, you should know the subject matter of the bill and be prepared to intelligently discuss its pros and cons. If the legislator is not well acquainted with you, and your presentation is weak, he or she will tend to discount it. On the other hand, if you are well acquainted with the legislator and your presentation appears weak or ill-informed, he or she will not be uncomfortable voting against you because he or she knows you well enough to know that if you felt strongly about the issue you would be better informed.

In making legislative contacts during the session, you should be prepared to accommodate his or her situation. Legislators literally see hundreds of people every day, and it is sometimes hard to keep track of names. You can help him or her out by introducing yourself, even if you feel the legislator should know you. They will appreciate it.

Legislators deal with between 600 and 700 bills in a legislative session. Therefore, you should refer to the bill and what it does, rather than launching into a dissertation based only on the bill number. For example, don't say, "How are you voting on House bill 1001?" You have immediately put your legislator on the defensive and he or she now has to ask you what the bill is about. You should begin your discussion in an educational manner, such as, "I want to visit with you about House
Bill 1001, which would prohibit clocks in operating rooms."

It also helps to establish a time frame for the legislator, for instance by telling him or her that the bill will be in committee tomorrow morning, or the bill is up for the floor action this afternoon. Because of the number of bills handled by the legislature, those being of immediate concern to the legislators will get their first attention. It is also helpful to volunteer special information or experiences relevant to the bill which you may have had, such as, "I had an experience where the presence of a clock in an operating room saved the life of my patient, and there appears to be no good reason to prohibit clocks in operating rooms."

Here are some other significant legislative dos and don'ts:

- Never lie or shade the truth. That legislator will likely be talking to a number of people on the issue that you are discussing. If he or she gets the idea that you have been playing fast and loose with the facts, you will have lost his or her vote forever. In the process, you may very well have created a perpetual and dedicated advocate for the other side of your profession's issues.

- Be prepared to admit the weak points of your position. Above all, legislators appreciate candor. Be prepared to state logically and succinctly why these weak points should not affect your legislator's vote.

- If you are asked, and if you know it, state your opponent's position as you understand it. This is also a matter of candor. Of course, you should also indicate why you think that this position is ill-informed or in error.

- Do not be afraid to ask the legislator for his or her support. Try to get a commitment -- some will make a commitment and some will not make a commitment. Generally speaking, if they say something like, "I understand your position and I will listen to the debate," you won't get their vote.

- As we have previously mentioned, don't burn your bridges just because this legislator is not with you on this vote. It is a certainty that you will want to ask him or her for a vote in the future.

- Keep in mind that legislators are dealing with hundreds of bills and hundreds of people in the course of a session. Try to keep your presentation succinct and to the point.

- Finally, remember that almost without exception, all legislators are trying to do what they view is best for their constituents. They view themselves as trying to do a good job. If you have a complete inability to make any headway with a legislator after a fair number of tries, your remedy lies at the ballot box and with a different candidate at the next election, not to berate or antagonize that particular lawmaker. There is no point in creating a dedicated adversary.

Conclusion

Quality contacts based upon a personal relationship are the best contacts. Failing that, well-reasoned, well-informed contacts by a concerned constituent are universally appreciated by legislators. We know you are busy and it is difficult to find the time to do as much as you want to accomplish. However, with a good plan and with periodic contacts, you can develop a relationship with a legislator which will prove to be helpful over the years. Not only that, you will likely establish a meaningful friendship.

We hope that the points that we have raised in this article are helpful to the members of the Medical Association in developing significant long-term legislative contacts. We've each been involved in the legislative process for a number of years and find it to be challenging and exciting. When concerned citizens become involved, the system works quite well. Undoubtedly, our system of government has flaws. However, when we look around the world, we hope you will agree with us that the system which we have in this country is far superior to that found in any other country. We all have to keep working to make it better.

The following letter is from the Steering Committee of the South Dakota Drug Evaluation and Education Program explaining the mandated program. I feel good about it since it might have been antagonistic but instead it will be educational. It might have been a "negative" but instead it really should cause improvement. Please if you have problems with it, write me or Dave Helgeland, whose address is at the end of this article.

Richard Holm, MD
Brookings Clinic
Brookings, SD 57006

Introducing: The South Dakota Drug Evaluation and Education Program

In June 1991, most of you should have received a letter from us explaining the Drug Evaluation and Education Program (DEEP). Over the past several months, the implementation process has progressed to the point where we are starting to officially review data. We think it is an appropriate time for us to give you a brief review of DEEP and let you know what to expect should you be contacted by the program.

In 1990, Congress mandated that a retrospective review of prescription drug use by Medicaid patients be conducted on an ongoing basis in each state. The South Dakota Department of Social Services contracted with the South Dakota University College of Pharmacy to administer our program. A steering committee com-
posed of three members from Social Services, two physicians (Bruce Lushbough and Rick Holm), and two faculty from the College of Pharmacy will oversee the activities of the program.

Another committee will confidentially review data on Medicaid prescriptions. This evaluation committee, consisting of practicing physicians and pharmacists, will set parameters for drugs or drug categories based on common reference material and current medical literature. The parameters may be set for over-utilization or under-utilization of drugs, contraindicated drug combinations, drug-drug interactions, and other areas. If a drug falls outside of the parameters, the particular patient’s drug profile will be evaluated by the committee. Should the evaluation suggest that the drug therapy could present a clinical risk to the patient, the physician(s) and/or pharmacist(s) involved with that patient will be notified and a copy of the profile sent. We would ask that you then send any comments you have on that particular case back to us in a postage paid return envelope which we will provide.

We realize that we do not have the complete clinical picture, the first hand knowledge, or your history and expertise with your patients. DEEP is simply educational to help providers become aware when potential problems in their patients’ therapy might exist. If problems can be prevented or care improved, then the Medicaid patients in South Dakota will be receiving even better quality care than you are already providing. That is the major intent of this program.

The DEEP Steering Committee appreciates the support of physicians who provide quality care to Medicaid patients in South Dakota. We are confident that we can count on your continued cooperation as this educational program gets underway. Please do not hesitate to contact us if you have any questions or comments. South Dakota State University, College of Pharmacy, Box 2202C, Brookings, SD 57007-0197, (605) 688-4240.

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February is a bleak month in many ways. It is right smack dab in the middle of winter, and the days are still short, but it does have Valentine’s Day going for it! Valentine’s Day is all about love, and if you work it right, love can keep you warm...right? Ah love, sweet love!

**************
PONDERING JUST WHAT LOVE IS ABOUT,
THOUSANDS OF WRITERS HAVE WISDOM TO SPOUT!
EARLY ON THE BIBLE HAD THIS TO SAY —
(IT’S NOT OUT OF STYLE; IT’S GOOD STUFF FOR TODAY):

Love is very patient and kind, never jealous or envious, never boastful or proud, never haughty or selfish or rude. Love does not demand its own way. It is not irritable or touchy. It does not hold grudges and will hardly even notice when others do it wrong. It is never glad about injustice, but rejoices whenever truth wins out. If you love someone you will be loyal to him no matter what the cost. You will always believe in him, always expect the best of him, and always stand your ground in defending him...there are three things that remain — faith, hope, and love — and the greatest of these is love. 1 Corinthians 13:4-7, 13

SHAKESPEARE SAID HOW CRAZY LOVE IS IN AT LEAST TWO EMPHATIC QUOTES OF HIS!

Love is a madness most discreete.
Love is merely madness.

'bout love, songwriters have written a "ton"!
Think for a bit...what's your favorite one?
The course of true love is difficult, true.

Worst highlights this in a poem for you.

It's hard to love
The tallest girl
When you're the shortest guy.
For every time
You try to look
Your true love in the eye
You see
her bellybutton.

There are strange and wonderful things we see
As I love you and you love me!
"We love someone because. We love someone although."

What would it be like if there were none?
"Without love (life) would be like the earth without sun."

We examine love. Are we doing it right?
When we find that we're not, we should all be contrite.

"Do I love things and use people or love people and use things?"

About love, Buscaglia writes entire books.
At a quote (R.D. Laing's), he tells us to look.
We think much less than we know. We know much less than what we love.
We love much less than what there is. And to that precise extent, we are much less than what we are.

Now I'll end with one of my favorite ones —
Of the miracles the love of a child has done.

"Real isn't how you are made," said the Skin Horse.
"It's a thing that happens to you. When a child loves you for a long, long time, not just to play with, but really loves you, then you become Real. It doesn't happen all at once. You become, it takes a long time. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby.

But these things don't matter at all, because once you are Real you can't be ugly, except to people who don't understand." (The Velveteen Rabbit) #
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New Physicians

The following physicians recently began practicing medicine in South Dakota.

Health Professionals for Western South Dakota announced that Terry M. Graber, MD, joined the staff at Family Healthcare Clinic and Custer Community Hospital. Born in Kingman, Kansas, Dr Graber received his medical degree at the University of Illinois, Urbana in 1987. He completed his family practice residency in 1990 at St. Thomas Medical Center, Akron, Ohio. Dr Graber was a staff physician at Pine Ridge Hospital as part of a full-time sharing agreement between the Indian Health Service and his employer, the Veteran's Administration Medical Center in Hot Springs.

He and his wife, Marcia, have one daughter, 19 months old.

Dr Graber also joined the Yankton Medical Clinic as a specialist in general surgery. She was born in Winnipeg, Canada, with US citizenship. She graduated from the University of Minnesota with a Bachelor of Arts degree in Russian and a Bachelor of Science degree in microbiology. In 1985 she received her Doctorate of Medicine degree from the University of South Dakota School of Medicine. She completed her internship in general surgery at Highland General Hospital, Oakland, California, in 1982. From 1982 to 1985, she was a member of the Commissioned Corps with the United State Public Health Service and in general practice in northeastern South Dakota. In 1989, she completed the Integrated Program in General Surgery at Michigan State University. She and her husband, Dr Dan Johnson, have been married for 16 years.

The Brookings Clinic announced the association of E. W. Filler, MD, a family practice physician. Dr Filler was born in Hawaii. After serving in the army from 1978 to 1982, he completed his Bachelor of Science degree in biological science at the University of North Dakota, graduating Summa Cum Laude in 1984. He continued his education at the University of North Dakota Medical School receiving his medical degree in 1988. He completed his family practice residency with the Cedar Rapids Medical Education Program in Cedar Rapids, Iowa, in 1991.

Dr Filler and his wife, Sue, have two children.

Dr Daniel C. Johnson recently joined the staff of the Yankton Medical Clinic as a specialist in orthopedics. He was born in Chadron, Nebraska, and graduated from Edgemont High School, Edgemont, South Dakota, in 1973. He graduated with honors from Oregon State University in 1977 with a Bachelor of Science degree in zoology. In 1981, he received his medical degree from the University of South Dakota School of Medicine. He completed his internship in flexible surgery at Highland General Hospital, Oakland, California, in 1982. He was in general practice in northeastern South Dakota from 1982 through 1985. In 1991, he completed his orthopedic residency at McLaren General Hospital in Flint, Michigan.

He and his wife, Dr Mary Milroy, have three children. They reside in rural Yankton.

Dr Mary Milroy also joined the Yankton Medical Clinic as a specialist in general surgery. She was born in Winnipeg, Canada, with US citizenship. She graduated from the University of Minnesota with a Bachelor of Arts degree in Russian and a Bachelor of Science degree in microbiology. In 1985 she received her Doctorate of Medicine degree from the University of South Dakota School of Medicine. She completed her internship in general surgery at Highland General Hospital, Oakland, California, in 1982. From 1982 to 1985, she was a member of the Commissioned Corps with the United State Public Health Service and in general practice in northeastern South Dakota. In 1989, she completed the Integrated Program in General Surgery at Michigan State University. For the past two years, Dr Milroy has been a member of the Michigan State University faculty as assistant professor in the Department of Surgery. She became board certified by the American Board of Surgery in 1990.

She and her husband, Dr Dan Johnson, have three children.

Orthopedic surgeon, Mark McKenzie, MD, has joined the St. Joseph Hospital medical staff. Dr McKenzie, a native of Burke, South Dakota, received his premed education and his medical degree from the University of South Dakota School of Medicine in 1986, where he was a member of the AOA Medical Honor Society. He completed his residency in orthopedic surgery at the University of Kansas School of Medicine, Wichita, and St. Francis Regional Medical Center and Affiliated Hospitals in Wichita, Kansas.

Dr McKenzie and his wife, Francine, are the parents of two sons.

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Future Meetings

March

Sixth Annual Center on Aging Postgraduate Symposium. The Older Adult, Special Issues: In Hospital and Out, Battenfeld Aud, Univ of Kans Med Ctr, Kansas City, Mar 6. Fee: $125. 6 hrs AAFP & AMA Category 1 credit. Contact: David Baldwin, U of Kans Med Ctr, Office of Cont Educ, 3901 Rainbow Blvd, Kansas City, KS 66160-7108. Phone: (913) 588-4488.

Occupational Medicine Update: Selected Topics in Occupational Medicine, Minneapolis Metrodome Hilton, Minneapolis, MN, Mar 20. Fee: $135. 6.5 hrs AAFP & AMA Category 1 credit. Contact: Midwest CME for Occupational Health & Safety, Cont Educ, 640 Jackson St, St Paul, MN 55101. Phone: (612) 221-3992.

Risk Factor Modifications, Omaha Marriott, Omaha, NE, Mar 21. CME credits avail. Contact: Brenda Ram, CME, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (402) 559-4152.


Management Strategies in Complex Congenital Heart Disease, Phoenix, AZ, Mar 29-Apr 1. AMA Category I credit avail. Contact: Postgraduate Courses, Section of Cont Educ, Mayo Foundation, Rochester, MN 55905. Phone: (800) 323-2688.

Family Practice Review, U of Neb Med Ctr Campus, Omaha, NE, Mar 23-Apr 3. CME credits avail. Contact: Brenda Ram, CME, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (402) 559-4152.

April


Current Concepts in the Care of the Longterm Mechanically Ventilated Patient, Neb Ctr for Cont Educ, Univ of Neb, Lincoln, NE, Apr 10. Contact: Sally O'Neill, PhD, Assoc Dean, Creighton U, CME Div, 2500 Calif St, Omaha, NE 68178. Phone: (800) 548-2633.

1992 Central Plains Clinic Symposium, Topics in Clinical Medicine, Ramkota Inn, Sioux Falls, SD, Apr 10-11. 10+ hrs AMA Category 1 credit. Contact: Michael R. Ferrell, MD, Med Dir, Central Plains Clinic, Ltd, 2727 S Kiwanis Ave, Sioux Falls, SD 57105. Phone: (605) 331-3490.

Bone & Soft Tissue Tumors, Hilton Beach & Tennis Resort, San Diego, CA, Apr 27-29. CME credits avail. Contact: Postgraduate Courses, Section of Cont Educ, Mayo Foundation, Rochester, MN 55905. Phone: (800) 323-2688.

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In numerous occasions, procedures have been cancelled for the welfare of the patient due to physical abnormalities. In some instances, the brief elective IV sedation surgical procedure has been cancelled in order that the patient undergo a percutaneous transluminal coronary angioplasty or coronary bypass surgery in an otherwise asymptomatic patient.

Patients receiving IV sedation should be treated as though they would be receiving a general anesthetic. The reason for this is that in some patients IV sedation is not enough, and the patients need to receive general anesthetic. Some patients may react to the IV sedation and have complications such as cardiorespiratory arrest, convulsions, aspirations, etc. So the same criteria for IV sedation patients would apply to general anesthesia patients. Preoperative heart and lung auscultation is in the best interest of the patient.

*Prepared for SDFMC by Dr Edward Anderson.
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NEXT MONTH
HIV Associated Risk Factors: A Survey of a Troubled Adolescent Population

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President's Page

Richard I. Porter, MD, President, South Dakota State Medical Association

Well, here it comes! It seems that every candidate running for a political office this year has his or her own brand of nationalized medicine on their agenda! I just can't believe it. Even our animal control officer here in Yankton has this as part of his platform!

Winston Churchill once said in all seriousness that the United States was the only country he knew of that continuously attempts to tax itself into prosperity!

We all know the gross inequities and major flaws that continue to plague Medicare and Medicaid, and now we are being told that "womb to the tomb" nationalized medicine will be better? That's like giving a juggler with hyperthyroidism one more ball to keep in the air! Paul Harvey said it best when he likened national medical care to giving yourself a blood transfusion from your left arm to your right arm and spilling half of it in the process. No matter which nationalized form of health care you are talking about, none will survive financially, and that's a "gimme". You just need to look at Medicare and Social Security and the progressive lack of funding thereof to understand this!

I fully realize the cost of medicine today is 12% of the gross national product, but one must take into account that our gross national product has become stagnant over the last several years and that alone contributes greatly to the problem.

Lately the politicians sound as if they are at an international bizarre (the misspelling is deliberate) hawking the German plan, the British plan, and Canadian plan, and now someone has come up with the "American plan" based upon a mixture of all the others. What great originality! Let us pray that this guy gets re-elected! (Prayer, by the way, is about the only thing that still works, is highly effective, produces sometimes amazing results, and, as of this writing anyway, has not been taxed!)

In discussing this very problem with a colleague of ours, he told me of his brother who is an orthopedic physician practicing in Canada and is now in the process of leaving because of the overwhelming problems with the health care system there. Now, at first, one might think that the problem may have been related to the low reimbursement schedule or the almost overwhelming paperwork or the impersonal bureaucracy that forced him to make this monumental change in his (and his family's) life. But no, his decision was based on the pain, suffering, and death of many of his patients and the utter frustration of knowing there was absolutely nothing he could do to change this scenario! The nationalized health care that Canada has, placed all people on waiting lists for hip surgery and many other procedures that are life-saving and pain-relieving, and because of the nature of the "beast," people continue to suffer and die! The reason — cost!

Now Canada is not, by any stretch of the imagination, a third world country and yet the morality of its health care system would make any third world country blush with shame!

I know I'm preaching to the choir when I say this, but the United States does not need less medical care on an untimely, uncering basis, brightly repackaged, made artificially palatable, and served up by self-serving bureaucrats who are telling us we can't afford the real thing! (Talk about your truth in labeling!) Personally, I feel that medicine has more than adequately balanced the books in this regard over the years.

Many of us remember how far, indeed, medicine has come — from C.C. Floc and thymol turbidity tests to 44 panel blood studies — from blood gases calculated by a complex formula I never could comprehend, to almost instantaneous accurate readings — from tracheostomies and Morck respirators (remember those?) to the most advanced pulmonary labs of today — from major, sometimes disabling, surgery for bleeding ulcers and gallbladder stones to drug therapy with Zantac and Carafate and same-day surgery for cholecystectomies along with other procedures for inflections that previously were not only insufferable, but incapacitating and disabling!

MARCH 1992
When was the last time a power failure happened at your hospital and, if it did, were your first thoughts of where the location of the polio ward was because all those iron lungs needed to be operated manually?

How about whole floors of the hospital, or, for that matter, whole hospitals dedicated to the care of a single illness, such as tuberculosis!

CAT scans, MRIs, laser, physical therapy, intensive care units dedicated to pediatrics, cardiac, trauma, etc. The list is almost unending. But the bottom line in our ledger is the tremendous relief of pain, suffering, and the patient’s return to a healthy, long, and productive life.

Now, it doesn’t take a mental giant to figure out that society profits immensely from this in the form of better health, less disability, and less longterm care, and when you even whisper "profits," the politician immediately thinks "taxes!"

I, therefore, propose to you that medicine has, indeed, more than paid its own way! I cannot in all good conscience say the same for our bloated bureaucratic system which continues its "search and control" mission!

PS: Each and every physician in South Dakota deserves a pat on the back. For each of you, in your own way, has made the quality of medicine in the United States the envy of every other country in the world!

---

South Dakota Society Of Pathologists

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Where Is The Waste In Medical Waste?

When debris, including tubes of blood and syringes, washed up on coastal beaches in the late 1980's, galvanized by the already widespread fear of AIDS, Congress passed the Medical Waste Tracking Act of 1988 (MWTA). This affected four eastern coastal states and Puerto Rico and has expired in June 1991, but the concept of the MWTA is being promoted as a Federal law. The tracking plan in MWTA applies to any physician office, hospital, or laboratory, etc, which generates over 30 pounds of "regulated medical waste" per month to keep detailed records from origin to disposal of such material. This is backed up with stiff fines. Is this justified?

First, we better define "regulated medical waste" which is potentially infectious waste generated by treatment of patients which may possibly transmit disease. Next we should point out that there is no evidence medical waste is a source of infection in the community. Even potential for infection exists almost entirely with sharps (contaminated needles and scalpels) which are already regulated. There is no evidence that other medical waste is anymore than a remote potential danger. Sharps disposal is a relatively small amount of waste which can be handled with puncture proof containers and/or incineration.

Secondly, most hospitals and many medical facilities already comply with existing regulations for safe disposal of waste.

Thirdly, a large category of medical waste including some sharps are not covered. An example is home use of diabetic syringes. This latter point becomes important when one realizes only approximately 1% of the "coastal debris" was identifiable medical waste and this was never traced to illegal dumping and may have been due to sewer malfunction.

Fourthly, prestigious government agencies such as the CDC (Center for Disease Control), the NIH (National Institute of Health) as well as APIC (American Practitioners of Infection Control) all experienced in the study of transmissible infectious hazards are opposed to the legislation since adequate regulations exist and sufficient hazard does not.

Lastly, investment of more of the already shrinking health care dollar in non-productive pursuits is another straw on the camel's back.

John F. Barlow, MD
Editor

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Hand Lacerations of the Combined Interdigital-Intermetacarpal Region (Split Hand)

Robert E. Van Demark Sr, MD

ABSTRACT

Longitudinal lacerations involving the finger commissures and adjacent intermetacarpal clefts (including the adjacent tendons, the intrinsic muscles, the deep transverse metacarpal ligament, adjacent arteries, nerves, bones and joints), present multiple problems not seen in the usual hand lacerations. Thorough cleansing, delayed closure, accurate repair of all injured structures with prompt appropriate rehabilitation results in excellent appearance and early function.

Continuous longitudinal lacerations of both the interdigital and intermetacarpal areas have received no recognition in recent textbooks in discussion of open wounds of the hand. Discussion is given to the late repair of the interdigital commissures which is only one facet of this multi-injury problem. The combined injury splits the distal hand into two parts.

Review of the current literature of the past twenty years reveals no reference to this combined injury as contrasted to other open wounds.

The nature of this combined injury, the problems, treatment and rehabilitation are presented in the following.

CASE REPORT

A white tree trimmer, age 25 (SVH 2 259 173), was seen in the emergency room on June 25, 1991, with a through-and-through laceration of the cleft between the ring and long fingers, incurred two hours previously when a chain saw kicked back, lacerating his left hand. (Figure 1)

Physical examination revealed a contaminated irregular laceration involving the entire interdigital and intermetacarpal cleft to the bases of third and fourth metacarpals.

Roentgenographic examination reported multiple small fragments of bone arising from the metacarpal cortex.

Figure 1
Contaminated, through-and-through chainsaw laceration left hand incurred on June 25, 1991, involving the interdigital-intermetacarpal region.

Following one gram of intravenous cefazolin sodium and a general anesthetic, the fourth metacarpal was found to be loose at its base, permitting easier cleansing of the proximal area of the wound. The wound was thoroughly cleansed and debrided of all destroyed and devitalized tissues. Six thousand cc of normal saline was used for pulsating jet lavage in the wound which was packed open with a fine meshed nonadherent dressing and a volar plaster splint applied. The intravenous cefazolin sodium was repeated at eight hour intervals.

Post-operatively the patient remained afebrile. On examination of the wound two days later (Figure 2) it was clean, with negative routine smears and cultures.

subsequently. A Kirschner wire was placed transversely through the third and fourth metacarpals for stability, after repair of the lacerated median digital nerve of the cleft under loupe 4.5 magnification. Repair was then carried out of the deep transverse metacarpal ligament, the intertendinous slip of the extensor digitorum communis and the skin. Careful reconstruction of the torn commissure between the ring and long finger was followed by nonadherent pressure dressings and a volar plaster splint.

The immediate post-operative course was uneventful. The Kirschner wire was removed on July 23, 1991, followed by removal of all sutures. An interdigital abduction splint was used to prevent post-operative contracture of the web.

An intrinsic extension contracture of the long finger responded promptly to elastic splinting. (Figure 3)

The patient received daily hand therapy and by August 20, 1991, had recovered a full range of motion in the hand, as subsequently demonstrated. (Figure 4)

Return of the digital nerve sensation was progressing satisfactorily when last seen. Fingertip sensation of the ring and long fingers from the adjacent digital nerves was normal.

DISCUSSION

These contaminated wounds require extremely thorough cleansing and debridement as the primary procedure. Soap and water have been most valuable in cleaning dirty wounds, followed by pulsating jet irriga-
tion with copious amounts of normal saline. The addition of antibiotics to the solution has not been clearly proven to be of increased value, in contrast to intravenous antibiotics.

Delayed closure of contaminated hand wounds is a well recognized principle. Maximum function can be achieved if no infection occurs and wound repair is not unduly delayed. Prompt wound closure is appropriate in an afebrile patient with a clean wound and negative smears and cultures.

Thorough structural assessment of the wound prior to operative repair, with effective tourniquet control of hemostasis, is desirable. Examination is difficult in the depths of the wound, where injury to the deep branch of the ulnar nerve may occur. Only after a thorough assessment of all injuries is repair desirable.

With injury to the dorsal and volar interosseous and lumbrical muscles, intrinsic muscle problems may be anticipated and promptly treated.

Stability of bony structures is best secured by minimal use of transverse Kirschner wires. Repair of the deep metacarpal ligament is dependent on this stability.

Garcia-Elias, Bishop, Dobyns, Cooney and Linscheid have given an excellent presentation of the carpal-metacarpal dislocations which may occur in this type of injury.

Repair of the commissure requires accurate approximation with supplemental full thickness or local pedicle grafts as needed.

REFERENCES


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MARCH 1992
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Overdosage: Clinical trials showed no evidence of an antidote due to nizatidine. Imipramine and debrisoquine were reported with similar frequency. Treatment of overdose in the absence of nizatidine and other H2-receptor antagonists has not been reported. Patients should be observed for at least 24 hours following ingestion of Axid. A gastric lavage is recommended. Axid is not removed by charcoal. Oral activated charcoal and peritoneal dialysis do not alter the pharmacokinetics of Axid. Hemodialysis has been reported as hazardous. If necessary, supportive treatment should be instituted.

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Clark W. Likness, MD* Watertown

October
Michael P. Elston, MD Rapid City
George R. Hanson, MD* Deadwood
Scott K. Ross, MD* Sioux Falls
Jerry L. Simmons, MD*

November
Thomas M. Cink, MD* Sioux Falls
Herman A. Dobbs, MD* Hot Springs

*members of the South Dakota State Medical Association

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Early Detection of Adolescent Mood Disorders

Vinod S. Bhatara, MD

ABSTRACT

Adolescent depression remains significantly underdiagnosed despite its official recognition since 1975 and its association with high morbidity and mortality. With the exception of teachers, physicians are the professionals most likely to see depressed youngsters. This article attempts to increase the physician’s awareness of adolescent depression.

Early detection can be life saving for many diseases. This, in my view, is certainly the case with adolescent major depressive disorder. Although the estimates vary with criteria used, studies have found a population prevalence of depressive disorders of 4.7% in 14 to 16 year old adolescents. (The population prevalence of depression in prepubertal children is estimated to be only 1.8%, although the prevalence sharply increases after puberty.) A recent National Mental Health (NIMH) study found that teenagers between the ages of 15 and 19 are at special risk for developing depression.

Depression in young people is associated with high mortality. Suicide is the third leading cause of death among 15 to 24 year olds in the United States. Over 90% of young people who commit suicide have an associated psychiatric disorder, most commonly a mood disorder, such as bipolar illness. They may also have a conduct disorder, substance abuse and psychoses. These conditions often coexist which increases lethality. Therefore, if suicide in young people is to be prevented, depression should be detected as early in life as possible, and cases at high risks for suicide need to be identified.

Although the NIMH has officially recognized childhood and adolescent depression since 1975, depression in youngsters is still significantly underdiagnosed. Diagnostic criteria for a major depressive episode (Table I) and dysthymia (Table II) are defined in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, Revised (DSM-III-R).

According to DSM-III-R, "Although the essential features of major depressive episode are similar in children, adolescents, and adults, there are some differences." Table III outlines adolescent age-specific features of depression that often coexist with the signs and symptoms listed in Table I and II.

### Table I

<table>
<thead>
<tr>
<th>SIMPLIFIED - DSM III-R Diagnostic Criteria for Major Depressive Episode Duration - At Least 2 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential Criteria</td>
</tr>
<tr>
<td>1. Dysphoric mood (adolescents and children tend to have irritable rather than sad mood. Dysphoric mood can be inferred from a persistently sad facial expression.)</td>
</tr>
<tr>
<td>2. Loss of interest (look for apathy and decreased activity and sometimes restless overactivity.)</td>
</tr>
<tr>
<td>Optional Criteria (4 of remaining 7)</td>
</tr>
<tr>
<td>1. Insomnia/hypersomnia (uncommon in children and adolescents)</td>
</tr>
<tr>
<td>2. &gt; 5% weight loss or gain and/or change in appetite (in children consider failure to gain expected weight)</td>
</tr>
<tr>
<td>3. Concentration problems and indecisiveness</td>
</tr>
<tr>
<td>4. Agitation or retardation</td>
</tr>
<tr>
<td>5. Guilt or worthlessness</td>
</tr>
<tr>
<td>6. Diminished energy</td>
</tr>
<tr>
<td>7. Suicidal thoughts, plans, attempts</td>
</tr>
</tbody>
</table>

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1. Associate Professor and Acting Director, Child and Adolescent Psychiatry, USD School of Medicine, Sioux Falls, SD.
Health care professions should be aware of the discrepancy between the above misconceptions, and demonstrable facts regarding adolescent depression. Offer using survey studies (more than 30,000) of boys and girls between ages 13 and 19, found that about 20% of adolescents experience constant turmoil. Therefore he stresses the crucial need to recognize conflict and turmoil as a sign of a psychiatric disorder, rather than a developmental phase. Similarly, Rutter et al found that no more than 10% of all adolescents had such serious difficulties as: 1) withdrawal from the rest of the family, 2) serious altercations with parents, 3) parent-youth communication difficulty, and 4) rejection of the parents. The difficulties listed above were more likely to be present in psychically disturbed adolescents. Several authors have demonstrated continuity of depression from prepuberty to adolescence, and from adolescence to early adulthood in many patients, thus reinforcing the need for early diagnosis and treatment.

**PROTOCOL FOR ADOLESCENT DEPRESSION EVALUATION**

In the following section, our comprehensive and interdisciplinary approach at the USD Mood Disorders Clinic is described.

I. Multiple sources of information, and description of behavior from several different settings is necessary for accurate diagnosis.

Information should be obtained from parents, teachers and peers. Teachers and peers are often able to detect adolescent depression before parents do. While adolescents are cognitively mature and are the most important source of information, their emotional immaturity of aberrant beliefs (mistrust of adults, fear of hospitalization, exaggerated loyalties, a distorted understanding of personal independence and negativism) may prevent them from cooperating fully in the interview. Of course, not all forms of mood disorders of adolescence have either a classical presentation or are easy to diagnose. In such atypical cases or when there is moderate or high risk of suicide or a serious comorbidity, a comprehensive and interdisciplinary evaluation is indicated. Sometimes, a firm and final diagnosis can only be made after a period of inpatient observation or longitudinal outpatient follow-up and observation.

Because conditions such as attention deficit hyperactivity disorder and learning disorders may be evident only in one setting (school) and not in another (physician's office) data from several settings, including the home should be collected.

II. Physical and laboratory tests

Because there are a number of physical disorders (diseases or drugs) that can mimic adolescent depression, the following baseline workup is sug-

---

Table II^4

**Dysthymia**

**Essential Criteria**

1) Dysphoria (irritable mood in children and adolescents is common)
2) 1 year duration

**Optional Criteria: 2 of the Remaining 6**

1) Insomnia/hypersomnia
2) Poor appetiteovereating
3) Decreased energy and fatigue
4) Low self-esteem
5) Poor concentration
6) Hopelessness

Table III^4

**DSM-III-R Age-Specific Associated Features of Depression in Adolescents**

1. Negativistic or antisocial behavior
2. Oppositional and defiant behavior
3. Feeling of wanting to leave home
4. Feeling of being not understood
5. Restlessness and grouchiness
6. Aggression
7. Sulking, reluctance to cooperate
8. Withdrawal
9. School difficulties
10. Neglect of personal appearance
11. Rejection sensitivity
12. Increased emotionality
13. Substance abuse especially alcohol abuse

**AWARENESS AND EARLY DETECTION**

The first step in the early diagnosis of adolescent depression is to increase awareness of its existence. The most likely reasons that health care professionals underdiagnose adolescent depression are: 1) a misconception about adolescent development and depression (and its etiological factors), and 2) the high frequency of comorbid psychiatric disorders such as borderline syndrome, attention deficit hyperactivity disorder, anxiety disorder, conduct disorder and substance abuse. The diagnosis of adolescent depression may be missed because of unwarranted generalizations about adolescent development as: 1) "all adolescents have mood swings" i.e. mood swings are not only considered "normal" but necessary for adolescent development, and 2) a "hands-off approach is best because this is just a stage they are going through". Similarly there are misconceptions about presentations of depression and mania. Irritability in adolescence is often dismissed as a normal reaction to stress. Early detection of juvenile bipolar disorder or mania is possible only if a high index of suspicion is maintained for bipolar depression, particularly in cases with a positive family history. Adolescence is now believed to be a common age of onset for bipolar depression, although its presentation in the form of irritable and/or mixed mood states can be confusing.
gested for a comprehensive evaluation of mood disorders.

A. Complete blood count with differential to investigate for infections and anemia. Because lithium can cause neutrophilia, and carbamazepine use may cause suppression of white cells, CBC with differential should also be done prior to starting lithium or carbamazepine.

B. Thyroid profile (including TSH) to rule out hypo- or hyperthyroidism. Since lithium can cause hypothyroidism, thyroid functions should also be done prior to starting lithium.

C. BUN, creatinine, urinalysis and serum electrolytes to rule out renal disease and electrolyte abnormalities, particularly hyponatremia which can mimic depression.

D. Liver function tests to look for hepatitis and drug-induced enzyme elevations.

E. EEG to help rule out a seizure disorder, especially when the history is suggestive of an episodic disturbance, such as an intermittent explosive disorder or an episodic dyscontrol syndrome.

F. An EKG prior to starting a tricyclic antidepressant in children or adolescents since youngsters may be more sensitive to certain cardiovascular side effects of tricyclics.

G. Dexamethasone supression test (DST) can be, "helpful in confirming a clinical diagnosis" of major depression, and "also may prove useful in monitoring treatment response during followup." The overall sensitivity of DST is 70% in prepubertal children and 47% in adolescents.

H. Drug abuse screen when substance abuse is suspected. Alcohol, cocaine and amphetamines are among the common substances of abuse associated with depression or mania.

I. Pregnancy test in sexually active adolescents and in cases of impulse behavior secondary to mania or in some cases of borderline personality syndrome.

J. Testing for sexually transmitted diseases (syphilis, gonorrhea and HIV serology) may be indicated in sexually active adolescents.

K. Additional testing as needed, for example, serum lead level when there is an associated cognitive deficit or evidence of attention deficit hyperactivity disorder.

III. Aids to data collection

At the USD mood disorders clinic, we use the following methods of data collection.

A. History from multiple sources and settings

1. Questionnaires: Self reports and ratings by others. A global questionnaire such as the parent version of Child Behavior Checklist (CBCL) is helpful. The teacher and youth self-report versions may also be used in selected cases.

2. The Beck Depression Inventory (BDI) for adolescents and its childhood adaptation, the Children's Depression Inventory, are used as measures of severity of depression. Because of the high rate of false positives and false negatives that occur in association with self-reports, BDI is not considered a diagnostic test for depression. However, serial BDI measurements can be useful in monitoring treatment response.

3. To investigate comorbid conditions appropriate questionnaires, such as the Connors' Rating Scale and the Revised Children's Manifest Anxiety Scale (RCMAS), may be used respectively. The RCMAS is available in both parent and adolescent versions. The Connors' scale has several forms, and should be completed by both the parents and teachers.

B. Diagnostic interview

Structured diagnostic interviews 10 such as Diagnostic Interview for Children and Adolescents-Revised (DICA-R), Kiddie-Schedule for Affective Disorder and Schizophrenia (K-SADS) and Diagnostic Interview Schedule for Children (DISC) are helpful for the diagnostic assessment of mood disorders. Unlike the Beck Depression Inventory, these paraprofessionally administered interviews are symptom oriented. Since there is face-to-face interaction with the youngster in these structured interviews, an adolescent who does not understand a question can ask for clarification. Similarly, the interviewer, aided by direct behavioral observations and follow-up questions intended to clarify and monitor responses, is able to interpret interview data in a more meaningful manner. Therefore, shortcuts such as BDI should not be used to make a diagnosis of depression since there is high likelihood of a false positive or false negative diagnosis. At the Health Center for Children, we are currently using DICA-R for interviewing both the parents and the youngsters.

C. Psychosocial testing

A psychological consultation is needed to individualize selection of appropriate psychometric tests in each case. Some of the common psychological tests include the Million Adolescent Personality Inventory (MAPI),
Wechsler Intelligence Scale for Children-Revised (WISC-R), and the Minnesota Multiphasic Personality Inventory (MMPI). These tests can be particularly helpful to clarify the nature of psychopathology and to look for such comorbid conditions as borderline syndrome and learning disorders.

D. Family evaluation

Using a family systems approach, the clinician may look for the following etiologically relevant factors:
1. Identification with a depressed adult
2. Unresolved grief
3. Interference with normal development by an overprotective and enmeshed parent
4. Reaction to family stress
5. A family history of mood disorders, alcoholism, and other psychiatric disorders

CONCLUSION

Adolescent depression is a well defined disorder. It is relatively common. A physician familiar with the diagnostic criteria presented here can usually diagnose it. When an adolescent has an atypical presentation, mixed mood states, an associated psychiatric comorbidity, or is moderately or severely suicidal, the primary care physician may wish to refer the youngster to a specialized clinic for evaluation and treatment.

REFERENCES

2. Burke KC, Burke JD, Regier DA, Rae DS: Age at onset of selected mental disorders in five community populations. Arch Gen Psych 1990; 47:511-518
Happy Doctor's Day!! Having said what I want this whole, March article to say in three words at its beginning, I will (hopefully) reach more physicians with my wish. I have a vague notion that doctors are busy people, and some understanding of the fact that it is likely that many of them are too busy to wade through my entire article to find out what in the heck I'm trying to say. My thinking runs on to the possibility that seeing that this particular article is about them...they might read on. If I am correct (and I hope I am), then I will have the opportunity to say more good stuff about them. I intend to make each reader feel "warm fuzzy" feelings in the time that it takes him or her to read to the end of this.

In case you missed the facts of your day, March 30 was officially proclaimed Doctor's Day in 1990 by President Bush. As Jackie Slingsby pointed out last year in her article about your day, auxiliaries across the nation worked long and hard to make it happen so you would be recognized for the invaluable contributions you make by caring for individual patients and promoting the health and well-being of all people! She went on to point out that the date for your day was chosen because on that date in 1842, Dr Crawford Long, who was from Georgia, first used ether as anesthesia and painlessly removed a tumor from the neck of one of his patients. The red carnation was chosen to symbolize your day because of its association with the qualities of love, charity, sacrifice, bravery and courage! Doctor's Day was first observed in 1933, in the small community of Winder, Georgia. South Dakota "joined the crowd" in 1989 due to the efforts of Jacquelyn Gunnarson, the President of the SDSMAA, at that time.

Facts are all well and good, but I am more at home with the feeling that the celebration embodies! It is the feeling that will be dispensed when the districts of the SDSMAA (sometimes in concert with other organizations) find ways to honor you for all you do! It seems to be more important to express the gratitude and love, because today's world seems to be loaded with assailants as often as it is with advocates of yours! Do take time out of your busy day to savor the expressions of those people who are aware of the realities of your lives, and want to stress the more positive side...appreciation and admiration! I wish that I could thank each of you personally for what you do! I can't imagine life in this world without physicians like you. In fact, I can think of a couple of times in my 44 years that I might well have lost my life were it not for members of your ranks! I would like to be able to thank those people in person too, because I love life very much! As that is not possible, I am pleased to think that somewhere, someone may be doing it for me.

TRASH sings a song at most performances that is appropriate for Doctor's Day. It is set to the tune, "The Rainbow Connection", and includes the following ovation to what you do...It is amazing that they can continue to deal with it day after day. They are not perfect, just perfectly human. They don't know a better way. So they go on with the tools they have, just day to day doing their best. Someday they'll find it-the cure to all illness, and doctors will cheer with the rest!

It reminds me of a story one doctor who is very close to me told me. It is about a tough old geezer who had a tumor obstructing his ureters. The question was whether or not to do anything, but the decision was made to do a nephrostomy in the hopes of buying him an extra couple of months. The story came to my attention when that doctor read the man's name in the obituaries...5 years later! No doubt you have many such stories as this. On March 30th, take a moment to recall a couple, as they are the essence of what the practice of medicine is about. March 30, with all its warmth and good feeling will come and go, but recalling times when you have made a difference can take place anytime and anywhere. It can, even more than the recognition you all deserve, really make a doctor's day!!

I want to say a special THANK YOU to all the physicians who have touched my life and the lives of my family in our times of need!!

Mollie O. Krafska, President, South Dakota State Medical Association Auxiliary

MARCH 1992
John W. Donahoeh (Jack), MD, 73, died February 7, 1992, in Sioux Falls. Dr. Donahoeh, a Sioux Falls native, received his medical degree from Georgetown University School of Medicine in 1944 and completed a three-year fellowship in internal medicine at the Mayo Clinic. He served in the Army as a captain. In 1952 he married Joan Bolenkamp. He was co-founder of Central Plains Clinic, originally the Donahoeh Clinic, in Sioux Falls, and served on the staff of Sioux Valley and McKennan Hospitals. He was past president of McKennan staff; an associate clinical professor of Internal Medicine at the University of South Dakota School of Medicine and an active teacher in the Family Practice Residents Program. For 13 years he served as Medical Director of Midland National Life Insurance Company. Dr. Donahoeh was past president of the O’Gorman Foundation, and served on the Board of Directors and as vice president of the South Dakota Symphony. He was a member of the Seventh District Medical Society and the South Dakota State Medical Association. He was a former Eagle Scout and had been active in Boy Scouts of America. He was a member of St. Mary’s Catholic Church, Knights of Columbus and Sioux Falls Rotary Club.

Survivors include his wife; six sons: Stephen, Englewood, Colo; John Jr., Boston, Mass; David, Sioux Falls; Mark, Minneapolis, Minn; Michael, Chicago, Ill; and Patrick, Sioux Falls; a daughter, Mrs. Jeffrey (Joan) Walline, Idaho Falls, Idaho; and six grandchildren.

Lawrence L. Massa, DO, long-time general practitioner in Sturgis, died November 30, 1991, at the age of 77. He was born in Iowa in 1914.

Dr. Massa received his Osteopathic degree from Kirksville College of Osteopathy and Surgery in Kirksville, Missouri in 1936. He established his medical practice in 1937 in Sturgis soon after his graduation from osteopathic college. He practiced medicine in Sturgis and the surrounding area for 54 years and he was the guiding force behind the construction of the Sturgis hospital—twice—now named the Sturgis Community Health Care Center. He served on the Sturgis City Council, the city park board, the volunteer fire department and was past president and secretary of the State Board of Medical Examiners. In 1987 he received his 50 year pin and certificate from the South Dakota State Medical Association. He was a long time member of the Black Hills District and the South Dakota State Medical Association.

He is survived by his wife, Shirley, and seven adopted children.

William A. Bormes, MD, Aberdeen surgeon, died December 7, 1991, at the age of 65, from injuries received in a car accident.

A native of Beardsley, Minnesota, Dr. Bormes came to Aberdeen in 1964, from National Jewish Hospital in Denver, where he was a clinical instructor in surgery at the University of Colorado’s Medical School. He received his medical degree from the Marquette University School of Medicine in 1957, and served a one year residency at St. Joseph’s Hospital, Denver, in 1958.

He was a member of the Aberdeen District Medical Society, the South Dakota State Medical Association, and the American College of Surgeons and served as president of the Northwestern South Dakota Mental Health Center.

Anthony Petres, MD, died January 3, 1992, in Sioux Falls, at the age of 84. Dr. Petres, who practiced medicine in Salem for 33 years, is a native of Transylvania, Hungary. He graduated from the University of Budapest School of Medicine in 1933. He then earned a masters degree in Public Health at the John's Hopkins in Baltimore in 1937. He returned to Hungary and married Maria Fritz in 1942 in Budapest.

In 1950, he moved his family to Sioux Falls and joined the staff at McKennan and Sioux Valley Hospitals. In 1975, Dr. Petres was appointed to the State Board of Medical and Osteopathic Examiners by Governor Kneip. He was a member of the Seventh District Medical Society and the South Dakota State Medical Association and the Royal Order of Physicians.

He is survived by his wife, Maria; two daughters: Anne Marie Waggoner, Rapid City; and Veronica Hufford, Tucson, Ariz; two adopted sons: Peter Stephens, Pittsburgh, Penn; and Emery Stephens, Stamford, Conn; three grandchildren; and one sister: Ann Petres, Sovato, Romania.

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Dr. Robert E. VanDemark, Sr., of Sioux Falls, was honored for his lifetime commitment and dedication to the betterment of health services for the community by being chosen as the Sioux Valley Hospital's Community Health Service Award recipient.

The award was established by the Foundation to recognize the continued contributions of a person to the area's health care arena. Dr. VanDemark has practiced medicine and taught medical students for over 40 years. As an orthopedic pioneer, he has also been instrumental in molding the medical community by helping establish the Crippled Children's Hospital and School as well as many other important community health programs including developing the orthopedic specialty area at Sioux Valley Hospital.

Three members of the St. Luke's Midland Regional Medical Center in Aberdeen, have been elected to top staff positions: David Wachs, MD, family practice, is now president; Jean Gerber, MD, general surgeon, is vice president; and Sanjeevi Giridhar, MD, psychiatrist, is secretary-treasurer. Others who will assume leadership positions are Karl Kosse, MD, chairman of the surgical section; Harvey Hart, MD, chairman of the family medicine/obstetrics-gynecology/pediatrics section; and John Vidoloff, MD, chairman of the medical section.

Sioux Falls family physician, Loren H. Amundson, MD, has been appointed to a three-year term on the National Advisory Council for the National Health Service Corps (NHSC). Dr. Amundson is a professor of family medicine at the University of South Dakota School of Medicine and director of the South Dakota Office of Rural Health. He was appointed to the 15 member Council by U.S. Secretary of Health and Human Services, Louis W. Sullivan, MD.

Stephan Schroeder, MD, of Miller, was awarded the first ever Rural Health Achievement Award in recognition of his "dedication, enthusiasm and leadership in the field of Rural Health, advancement of Rural Health Care delivery and demonstration of community awareness and involvement." Dr. Schroeder has been a practicing family physician since 1980 and is currently president of the SD Academy of Family Physicians. Dr. Schroeder has recently been appointed as a Rural Health Representative on the Presentation Health System's Physician's Advisory Council.

Sioux Falls physician, Donald Humphreys, MD, who specializes in infectious disease, was honored at the Sixth Annual South Dakota Rural Health Conference for his contribution to public and rural health issues. Dr. Humphreys received the 1991 C.B. Alford Award for his involvement with public health concerns in South Dakota. He is recognized throughout the state for his expertise in infection control and has worked closely with the Department of Health on health issues ranging from tuberculosis and AIDS to measles immunization. He is a professor of medicine in the University of South Dakota School of Medicine Department of Internal Medicine and serves on the infection control committees at McKennan, Sioux Valley and the Veterans Administration in Sioux Falls. He is also current president of the South Dakota Chapter, American College of Physicians.

Dr. John A. Malm, Gregory and Dr. Warren Golliher of Spearfish, have been recertified as diplomats of the American Board of Family Practice, after passing a recertification exam.

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Future Meetings

April

Gastrointestinal Motility Disorders in Children and the Role of Intestinal Transplantation, Red Lion Hotel, Omaha, NE, April 3-4. Contact: Sally C. O'Neill, PhD, Assoc Dean, CME, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Contact:

Current Concepts in The Care of Ventilator Dependent Patients, UNMC, Neb Ctr for CME, Lincoln, NE, April 10. Contact: Sally C. O'Neill, PhD, Assoc Dean, CME, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

1992 Central Plains Clinic Symposium, "Topics in Clinical Medicine", Ramkota Inn, Sioux Falls, SD, April 10-11. 10+ hrs AMA Category 1 credit. Contact: Michael R. Ferrell, MD, Med Dir, Central Plains Clinic, Ltd, 2727 S. Kiwanis Ave, Sioux Falls, SD 57105. Phone: (605) 331-3490.

Sixth Annual Critical Care Update Course in Critical Care Medicine, Hyatt Regency-Capitol Hill, Washington, DC, April 22-26, 35 hrs AMA Category 1 credit. Contact: Svetlana Lisanti, Conf Adm, Center for Bio-Medical Comm, Inc, 80 W Madison Ave, Dumont, NJ 07628. Phone: (201) 385-8080.

Breast Cancer: Issues in Prevention and Care, Minneapolis Convention Ctr, Minneapolis, MN, April 24. 5.75 hrs AMA Category 1 credit. Contact: Gloria O'Connell, Abbott Northwestern Hosp, 800 E 28th St at Chicago Ave, Minneapolis, MN 55407-3799. Phone: (612) 863-4801.

Distinguished Lecture Series - Samuel Z. Goldhaber, MD, Boys Town Nat Research Hosp Aud, Omaha, NE, April 29. Contact: Sally C. O'Neill, PhD, Assoc Dean, CME, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Family Practice Review, UNMC campus, Omaha, NE, April 27-May 8. Contact: Brenda C. Ram, UNMC, Cont Educ, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (402) 559-4152.

May

Clinical Issues in Diabetes Management, Howard Johnson's, Rapid City, SD, May 8. Contact: Laura L. Bates, Exec Dir, American Diabetes Assoc, PO Box 659, Sioux Falls, SD 57110. Phone: (605) 335-7670.

Fourth Annual Black Hills Cardiac Symposium - "The Everyday Challenges", Rushmore Plaza Civic Ctr, Rapid City, SD, May 8. Fee: $25. CME credit avail. Contact: Lorna Ogle, Coord, Networking Dept, Rapid City Regional Hospital, PO Box 6000, Rapid City, SD 57709. Phone: (605) 341-8013.


Family Medicine Update, Lake Okoboji, IA, May 22-24. Contact: Sally C. O'Neill, PhD, Assoc Dean, CME, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.


June

Advanced Laparoscopy Course, Creighton Univ, Omaha, NE, June 4-6. Contact: Sally C. O'Neill, PhD, Assoc Dean, CME, Creighton U, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Fifty-First Annual Ob-Gyn Conference, Omaha, NE, June 4-5. Contact: Brenda C. Ram, UNMC, Cont Educ, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (402) 559-4152.

Tenth Annual Maurice Grier Symposium, Student Center, Creighton U, Omaha, NE, June 6. Contact: Sally C. O'Neill, PhD, Assoc Dean, CME, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

The Eleventh Annual Cornhusker Canadian Clinical Conference, Lynn Lake, Manitoba, Canada, June 20-27. Fee: $150. Contact: Sharlene Knippelmeyer, RN, BS, Educ and Staff Development, Lincoln Gen Hosp, 2300 S 16th St, Lincoln, NE 68502. Phone: (402) 473-5638.

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**Postural Hypotension:** Hypotension, including some cases of syncope, can occur following the initial dose or during therapy with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease.

**Renal Function:** ACE inhibitors administered to diabetic patients with moderate to severe renal impairment (creatinine clearance less than 60 mL/min) have resulted in deterioration of renal function (see DOSAGE AND ADMINISTRATION). ACE inhibitors have been associated with oliguria and/or severe, acute renal failure, including renal tubular necrosis and death, in patients administered diuretics and in patients whose renal circulation was compromised by volume contraction (e.g., dehydration).

**Hypotension:** Hypotension has been reported in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease. Postural hypotension may occur in patients treated with ACE inhibitors, including those with bilateral renal blood vessel disease.

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About the Cover
South Dakota still has many working ranches (with real cowboys), especially in the
western part of the state. (Photo courtesy of the South Dakota Department of Tourism)
Herbert A. Saloum, MD, was appointed to the Commission on Quality and Scope of Practice of the American Academy of Family Physicians (AAFP) at their recent meeting. Dr Saloum is a family practice physician in Tyndall.

*****

Dr Robert Van Demark, Jr recently served as a faculty member for the Regional Review Course in Hand Surgery. Sponsored by the American Society for Surgery of the Hand, the course was held in Rochester, Minnesota. Dr Van Demark spoke on tenosynovitis of the upper extremity and compression neuropathies of the arm and hand.

*****

Hiroo Kapur, MD, chairperson of the board of trustees for Huron University, is one of two South Dakotans with East Indian background selected to receive the highest award of the National Federation of the Indian-American Associations. Dr Kapur was born in Poona, Maharashtra state of India; completed her medical degree at the SMS Medical College in Jaipur, India in 1973; and completed her pediatric residency at the New Jersey Medical School. She and her family then moved to Huron where she has been engaged in private practice since 1979. Dr Kapur is a fellow of the American Board of Pediatrics, and a clinical assistant professor in pediatrics with the University of South Dakota School of Medicine.

*****

Dr Loren Amundson, Sioux Falls, has been appointed as a member of the Skin Phototrauma Foundation’s (SPF) Advisory Board. SPF is an educational foundation formed in 1990, by a distinguished group of physicians and professionals specializing in dermatology, photobiology, meteorology, immunology, family practice and patient education, to support healthcare professionals in their efforts to educate the public about photodamage and its potential medical consequences.

*****

Martin physician, Larry Weitenkamp, MD, has completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians.

*****

Dr Robert Rietz of Brookings completed a mini-fellowship in pediatric ear, nose and throat surgery. He worked and trained with a pediatric ENT group in western Tennessee at LeBonheur Children’s Medical Center in Memphis, where he had an opportunity to perform endoscopic sinus surgery in addition to many other ear, nose and throat surgeries on pediatric patients. He is a board-certified otorhinolaryngologist with the Brookings Clinic.

*****

Dr Richard Hieb of Brookings attended the Obstetric Review for Primary Care Physicians at the Mayo Clinic. Dr Hieb is a board-certified family practice physician at the Brookings Clinic and a member of both the South Dakota Academy of Family Physicians and the American Academy of Family Physicians.

*****

Watertown orthopedic physician, Terry Seeman, MD, was inducted as a fellow of the American Academy of Orthopaedic Surgeons during their 59th annual meeting in Washington, DC.

*****

Dr Tom Dean, Wessington Springs, was recently appointed to the Secretary’s Advisory Committee on Infant Mortality by Dr Louis Sullivan, Secretary of the Department of Health and Human Services. The committee is composed of health care providers, researchers and administrators from across the country. Dr Dean is currently Medical Director of Tri-County Health Care in Wessington Springs and is past president of the National Rural Health Association. In addition, he serves as Chairman of the Advisory Committee to the South Dakota Office of Rural Health and is a member of the Infant Mortality Workgroup of the South Dakota Department of Health.

*****

Governor, George S. Mickelson, appointed Dr James Wiggs to the Victims Compensation Commission.

Dr Wiggs also participated in his sixth annual two-day seminar for graduate nurses at the Barton County Community College in Great Bend, Kansas. He has been a part of this program since 1985.

*****

Dr K-Lynn Paul of Sioux Falls was appointed, by Governor Mickelson, to the Mental Health and Coordinating Advisory Board effective immediately. Dr Paul is an Associate Professor of Psychiatry and Director of the Psychiatry Residency Program at the USD School of Medicine in Sioux Falls.
Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

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  - Current dosages/frequency of medications not listed
  - Pre-op vital signs not recorded

- Acute Care
  - Bowel elimination not recorded
  - Vital signs at discharge not recorded
  - No recorded results of tests ordered by the physician
  - No care plan for confused patient

Physician Quality Concerns:

- ASC
  - Heart and lung auscultation not recorded
  - Reason for procedure not recorded
  - Current health status not recorded
  - Inadequate discharge plan

- Acute Care
  - Unaddressed abnormal patient findings/complaints
  - Medications prescribed with no recorded indication
  - Unaddressed abnormal urinalysis
  - Unaddressed abnormal electrolytes
  - Unaddressed abnormal hemoglobin/hematocrit
  - Inadequate discharge plan
HIV Associated Risk Factors: A Survey of a Troubled Adolescent Population

Geri Loecker, RN, MA, David A. Smith, MD, Leah Smith, RN, BSN, Patricia Bunner, MD

ABSTRACT

The incidence of Acquired Immunodeficiency Syndrome (AIDS) in young adults and the typical incubation period for AIDS suggest that exposure to this disease often occurs in adolescence, a period of life during which risk-taking behavior is particularly common. The population of adolescents with mental or behavioral problems and substance abuse problems at the South Dakota Human Services Center were studied by questionnaire and by human immunodeficiency virus (HIV) screening to assess the current prevalence of seropositivity and the potential for HIV transmission in these troubled youths. Sexual behavior, number of partners, prior incarceration, history of sexual abuse, drug and alcohol use, and knowledge about HIV transmission were examined. While no cases of HIV seropositivity were discovered, the authors are disturbed by the prevalence of known and suspected correlate behaviors and historical traits for HIV infection in this population. Implications for intervention and education are discussed.

INTRODUCTION

A total of 179,136 cases of AIDS and 113,426 deaths due to AIDS have been reported to the Center for Disease Control (CDC) from January 1981 to July 1991. White males age 20-39 account for the largest segment of these figures. More specifically, South Dakota has had a total of 144 human immunodeficiency virus positive (HIV +) patients, and 27 deaths due to AIDS in this time period. Obviously, South Dakota lags far behind in HIV + and AIDS cases, however, 103 of the 144 positive patients have been identified in the last four years.

New knowledge regarding latency period (1 to 10 years from HIV positivity to AIDS) infers that exposure of these young adults to the disease occurred during the teen years. This knowledge, coupled with troubled teens' sometimes poor judgment and risky behavior (i.e., sexual experimentation, alcohol and drug use), makes the work of the health care professional particularly challenging.

In an effort to define the problem and assess educational needs, a survey to determine the risk factors relative to HIV infection was undertaken in the adolescent psychiatry and substance abuse population at the South Dakota Human Services Center.

METHODS

From January 1, 1990, to April 1, 1991, all patients on the adolescent unit at the South Dakota Human Services Center were surveyed regarding AIDS education and risk factors for exposure to HIV infection.

Admission to the unit is seldom voluntary and exact statistics on this survey's population were not explored and are not available. Generally, patients arrive on the unit following voluntary consent by the guardian, mental health commitment, court order, or voluntarily if over 18.

The survey questionnaire was developed by the Chief of Medicine and the Infection Control Nurse of the South Dakota Human Services Center. The survey was administered verbally to the patients during the first week of admission by the attending physician during the required admission history and physical exam. The survey history included questions regarding HIV risk factors and behaviors associated with those risk factors (i.e., age, alcohol use, physical abuse). Table I outlines these factors.

| TABLE I |
| Behaviors/Traits That Impact on Risk for HIV Infection |
| Unprotected anal and vaginal intercourse |
| Sharing needles in IV drug use |
| Male homosexual activity |
| Prostitution |
| Sexually transmitted diseases |
| Multiple sex partners |
| Incarceration |
| Alcohol use |
RESULTS

A total of 93 patients were surveyed or 100 percent admission to the adolescent unit for a 15 month period (January 1990 to April 1991). The 93 patients ranged in age from 12 to 18; 60 (64.5%) were Caucasian; 33 (35.5%) were Native American; 49 (52.6%) were male; and 44 (47.4%) were female. Number and age ranges are illustrated in Figure 1. In addition to routine history and physical, voluntary consent for HIV testing was requested if the patient had any of the following criteria: three or more sexual partners; IV drug use; history of sexual abuse; homosexual activity; or patient request.

A total of 61 HIV tests were completed during the first two weeks of admission. It is not surprising that this was the first time testing occurred for 60 of these patients since the frequency of testing in South Dakota is low. Thirty-two of the total patients were not tested for the following reasons: 23 were determined not to be at risk by the above criteria, and 9 refused in spite of admitted high risk behavior (4 of the 9 refused because of testing within the last year with negative results). All of the 61 tests performed returned negative. Other identifiable risk factors included sexual behavior. Seventy-three (78.5%) of the 93 were sexually active. While 76 (81.7%) stated they understood safe sex, only 10 (10.8%) reported using condoms regularly, and 20 (21.5%) sometimes. Thirty (32.2%) denied condom use at any time. These activities are illustrated in Figure 2. A pregnancy and abortion history was not obtained. Of interest, 6 cases of sexually transmitted diseases (other than HIV) were diagnosed during the routine gynecologic screening. When each of the participants were asked about number of partners, 20 refused to answer. The remainder admitted from one to over 25 partners. (See Figure 3.)

Other psychosocial variables of possible relevance to HIV infection are as follows:

--Jail

As of October-November 1989, a total of 5,411 confirmed AIDS cases had been reported among inmates across the federal, state, and county correctional systems. However, due to inconsistencies in record keeping and testing procedures, the percentage and exact number of HIV/AIDS cases in prisons is unknown. It is reasonable to predict higher rates in correctional populations than in the population at large because of the over representation among inmates of individuals with histories of high risk behavior, particularly IV drug use.

In our population of 93 participants, 50 (53.7%) had been previously incarcerated.

(See Figure 3.)
Number of Partners

<table>
<thead>
<tr>
<th>Participants</th>
<th>No Answer</th>
<th>1</th>
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Admitted number of partners. N = 93

--Abuse

The relationship of HIV risk to a history of sexual abuse is an unknown, but probably germane issue. Of the 93 participants, 21 (22.5%) reported on admission to being previously sexually abused. This includes four cases of rape, and six cases of homosexual contact.

In some cases, sexual abuse information was not shared until later in the patient stay, so this 22.5% is probably an under estimate.

--Chemicals

Of the 93 patients, 90 (97%) denied IV drug use and 3 (3%) admitted to using IV drugs.

--Alcohol

Of the 93 patients, 14 (15%) denied any alcohol use. The remaining 79 (85%) admitted to using a variety of alcoholic beverages.

--Education

Twenty-one (23%) denied having any form of AIDS education. Seventy-two (77%) stated they had participated in previous formal AIDS education programs. The content and dates of these programs were not assessed.

DISCUSSION

The exact numbers or percentages of teenagers who are sexually active is not really known. Researchers put the figure at 50% to 70% for 14 to 19 year olds.4,5,7,11 Health care workers view this with some dismay and alarm. Teenagers cite various reasons for their sexual activity. Social pressure is the number one reason given for not delaying sexual activity. "Everyone is doing it," "curiosity," "being in love," "wanting to feel grown up," are less frequent reasons.

Precise data on condom use is difficult to obtain. Some researchers believe condom use is increasing, but is at only about 50% currently.9 Others place use at 25% to 38%.4 Teens give many reasons for non-use: "Intercourse - just happened" (single most important reason); "had wanted to get pregnant and didn't care if they did"; "costs"; and "inaccessibility."5 Teenagers also say some of their peers "just prefer not to use it"; "don't think about it"; "don't know about it"; "do not have access to"; "safe without"; and "pregnancy won't happen to them."5

In a survey6 conducted at a California health clinic, knowledge that condoms prevent disease was not associated with motivation to use. Conversely, physician counseling about AIDS did increase condom use in Massachusetts teens.11 Short term considerations such as ease of use and discomfort with use were more closely associated with teen motivation.

Although many teens have had AIDS education,2,5,10 Massachusetts investigators reported in 1987 that students have a limited understanding of AIDS, modes of transmission and prevention. A small percentage reported changing their behavior and of those that did, few used effective methods.

In 1990, the CDC reports that most (88% to 98%) American teenagers10 are aware of high risk behaviors that lead to HIV/AIDS, but this knowledge does not translate into behavior change. Forty percent have 4 or more sexual partners within a year, 2% to 5% report injecting illegal drugs, and 3% reported sharing needles. Teens see HIV/AIDS as a disease of "other people" and do not see it as a threat to themselves. Teens seldom volunteer disclosing their high risk behaviors and seldom request information about AIDS unless the physician introduces the subject.12

CONCLUSION

Disadvantaged youths have been determined to be at higher risk for AIDS and our special population, though free of seropositive cases, similarly showed a high prevalence of risk factors.13 However, this data should not be generalized to unselected teen populations. In a study such as ours, it is important to keep in mind the usual bias that accompanies self reporting.
information, i.e., threats to both internal and external validity.

The CDC has determined that unprotected intercourse and sharing needles place a person at highest risk for HIV infection. Alcohol/chemical use, sexual experimentation, abuse, trouble in school and with the law all contribute to low self esteem in the teen. This, in turn, can lead to personal, social and behavioral problems. The teens in this survey demonstrate all of these factors.

The educator can play a critical role in working to change teens' behaviors. Misinformation and confusion regarding HIV/AIDS transmission, prevention and risks still exists in some teen populations. Many teens do not have the cognitive ability or life experiences to understand prevention and risks in order to alter behavior. Therefore, the goal of the educator should be not only to share knowledge, but also to be a resource person for change and a role model. The educator may utilize such strategies as group discussions and role playing regarding health issues. Simultaneously, efforts can be made to address decision making skills, assertiveness, communication, and strategies to improve self esteem.

Another valuable adjunct to the education process can be peer instruction. This can be used to provide current and factual information and to reinforce the importance of avoiding promiscuous sexual activity, alcohol and drugs.

Currently at South Dakota Human Services Center formal education regarding HIV infection and risks consists of a total of nine hours. The class is assembled twice monthly for 1 to 1 1/2 hours each session. Methods of teaching include: lecture, videos, group and one-on-one activity and discussion groups. This course was initiated in 1988. The content includes a pretest on knowledge, terminology, facts and symptoms of HIV, risk factors, methods of transmission, methods of prevention, and post test. Approximately 80 to 90 students attend annually. All 93 of the survey participants completed the course sometime during their hospital stay.

Fortunately, no cases of HIV seropositivity were detected in this study. However, the prevalence of behaviors and historical traits that place the teens of this study at increased risk of HIV infection is disturbing.

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SOUTH DAKOTA
Reflections of an Easter Past

As I started to write this month’s page, (late as usual, as it is now March 24th) I happened to glance back at my diary for this date one year ago and thought you might enjoy hearing about just a few of the 145 truly dedicated medical people that it was my privilege to have served with while in Iraq during Desert Storm.

The roster includes nurses, medics, laboratory and x-ray technicians, mechanics, cooks, truck drivers, and a multitude of other people—all, I might add, professionals.

The sheer number of individual acts of heroism and self-sacrifice precludes any attempt on my part to relate to you each one’s part in the overall mosaic. However, since this is to be a page dedicated to physicians, I would plead your indulgence for a moment as I attempt to give to you a thumbnail sketch of the South Dakota physicians involved in what was thought, at the time, as the "Mother of all Wars"! Remember that Saddam was equipped with biological, (anthrax, botulism), chemical, (nerve and blood agents), air burst "flash" bombs, and as rumored, atomic weapons. Add to this the Elite Republican Guards, as we thought at the time, and you have a fairly good scenario!

Major John Ottenbacher, MC, is in private practice in Selby, South Dakota. A fellow physician, graduated from USD Medical School, with 12 years of military experience behind him, and yet since he was and is the only physician in the area really could have remained home, but duty called, and thank God he answered! It was through John’s leadership that his platoon was able to convoy half-way across Iraq during the third night of the ground war, through fog, rain, (not to mention enemy territory) and without the aid of radio communications, to establish a forward medical triage station. Far forward I might add!

Captain Pat Mitchel, MC, is another one of our own graduates from USD Medical School. Pat was in his third year of family practice residency in Minot, North Dakota, and had already paid his dues in Viet Nam, returning as a highly decorated Special Forces Medic. Nonetheless he volunteered to return to the 730th and active duty for what we all thought to be for at least a year! Pat volunteered to accompany the 2nd Armored Calvary Regiment after our intelligence forces told of this unit having the most hazardous position of an end run to cut off the Republican Guard fleecing Kuwait and that the casualty rate was expected to reach 40%! I am certain that the mission was a success in no small part to Pat’s extensive prior combat experiences!

Col. Kenneth Pavlik, MC, is in private practice in Verdigre, Nebraska, but so close to South Dakota that if the meandering Missouri River had not been harnessed, he might well be practicing in Verdigre, South Dakota, today!

Ken was my age, my tentmate, my sounding board, my psychiatrist, my sanity control officer, and one of the closest friends I have had in my life! Having to spend five months in the same tent with me automatically qualifies him as extremely understanding, compassionate and totally accommodating; or, as I many times suspected, suffering from intermittent bilateral 8th cranial nerve palsy!

Ken volunteered, (refusing my advice to the contrary) to accompany his platoon into Iraq that night with Doctor John, and spent nine hours in the back of a deuce and a half truck without a break!

"Captain Jack" Glidden, MC, is our very own anesthetist from Sioux City, Iowa, whose courage and commitment to duty never once failed throughout the "Storm". Unofficial morale officer for the whole unit, Jack also was absolutely fearless in requisitioning badly needed supplies. In fact, towards the end I seriously thought that he was "borrowing" some of those supplies directly from Iraq’s Republican Guard!

W-3 Jim Freck, PA, tried his very best, as we all did, to stay with the unit but we lost him to another unit in Texas that was also heading for the Gulf. Jim and his family suffered all the more because of all the uncer-
tainties that arose! Jim and his expertise were sorely missed, and I'm sure I speak for everyone when I say that they could have pulled anyone else from our unit and not have caused as much anguish! I only hope Jim realizes that he was indeed with us "ALL THE WAY!"

This story could not be complete, however, without telling you that a year ago it was Palm Sunday and our beloved Chaplain Father Joe Holzhauser of Kimball, South Dakota, said Mass and made a special request of God to have us out of Saudi Arabia by Easter. As Father will be the first to tell you, we did get out of Saudi Arabia by Easter, but ended up back in Iraq! Next time, Father, be sure to include your destination in your travel request!

I would be remiss if I did not also tell you of the heroism and bravery of three other physicians, Major Robert Swan, MC, who came to us from Fort Leavenworth, Kansas; Captain Steve Buckles, MC, from Fort Rucker, Alabama; and Captain Carlos Torres, MC, from Devils Lake, North Dakota, who had just received his United States Citizenship, and paid his dues many times over! And a special thanks to Major Larry Wilcox, HMC, who fits all of the above, who made it all happen and made it happen right (with a lot of help from 144 great people)! It is to all the members of the 730th that these REFLECTIONS are dedicated, for each reflects the high moral fiber that is weaved into the very fabric from which the mantle of medicine was cut!

Abraham Lincoln once said, "We have been the recipients of the choicest bounties of heaven; we have been preserved these many years in peace and prosperity; we have grown in numbers, wealth, and power as no other nation has ever grown.

But we have forgotten God. We have forgotten the gracious hand which preserved us in peace and multiplied and enriched and strengthened us, and we have vainly imagined, in the deceitfulness of our hearts, that all these things were produced by some superior wisdom and virtue of our own.

Intoxicated with unbroken success, we have become too self-sufficient to feel the necessity of redeeming and preserving grace, too proud to pray to the God that made us."

To all of you of the 730th, Stand Tall, for we have not FORGOTTEN, nor will we ever FORGET!
The True Joy of Easter to All!

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The Trojan War, Humanities, and the Medical Student

Recently, a first year resident and I met with a group of third year medical students to discuss neurologic diseases. Coincidentally, shortly before the meeting, I had learned that the resident had a special interest in the ancient Greeks and particularly in the Trojan War. Our dialogue on these subjects continued as we sat down with the students, and we included them in a discussion of why the Trojan War took place and why it has such literary and historic significance. Interestingly, the students knew almost nothing about this topic. They did not know that Helen was "the face that launched a thousand ships", how the Trojan Horse figured in the battle, or any of the heroes of this epic, such as Agamemnon, Achilles, Hector or Ulysses.

Now admittedly, this single gap in the students' knowledge of the classics may be of minor import. Indeed, it is not very surprising in a group of students who all had largely scientific (as opposed to liberal arts) backgrounds, and whose current educational efforts are devoted almost entirely to mastering the scientific data of disease processes and the technologic capabilities of medicine.

On the other hand, this incident does serve as an excuse to reflect on the role that humanities can play in medical education. The argument has been made that despite the already incredible competition for curricular time in medical school, efforts can and should be made to broaden the students' perspectives beyond the strict science of medicine. A past issue of Academic Medicine was devoted entirely to the topic of teaching medical ethics and the humanities in medical schools. This issue consisted of discussions from a variety of medical schools as to how humanities and ethics programs had been implemented. In one of these articles, Miles et al talk about a "broad curricular effort to develop physicians' values, social perspectives and interpersonal skills for the practice of medicine". For a number of schools, this effort consists of teaching about medical ethics, with focus on the value questions and judgment issues inherent in medicine. A few medical schools, like Loyola University of Chicago, have developed a broader mission, and implemented a formal medical humanities program. At Chicago, during all four years of medical school, the students are exposed to a range of readings and discussions dealing with medicine, ethics, law, social sciences and humanities. Clinicians from a variety of disciplines are very active in this teaching.

Perhaps one of the greatest contemporary advocates of the humanities in medicine is Edmund Pellegrino, MD of Georgetown University. He is an internist, ethicist and classics scholar. He believes that teaching the humanities is important because they are a vehicle for teaching the liberal arts. He defines the liberal arts as "the skills most commonly associated with being human – the capability to think correctly and critically, to read and understand language, to write and speak clearly, to make moral judgements, to recognize the beautiful, and to possess a sense of continuity between the present and the past which it inherits." He goes on to note, "The physician's thinking is not solely scientific. To be sure, scientific and actuarial logic are crucial in diagnosis, prognosis, and therapeutics. But in deciding what ought to be done, the physician is often required to analyze an ethical dilemma and make moral judgement...the cognitive skills of the liberal arts are what make the physician's decision more than the simple application of diagnostic algorithms or decision trees." He argues that teaching the humanities is an especially effective way to foster skills in the liberal arts. Such educational efforts are germane, I think, to the question of how medical schools work to try to ensure that their future physicians are well rounded and of good character, as well as, capable of technical excellence. This is a complex issue. It is notoriously very difficult, in the medical school selection process, to reliably identify applicants who are honest, compassionate, ethical and self sacrificing. Some cynics argue that these and similar character traits are learned well before one starts post graduate education and that qualities such as these cannot be taught. Others, like Pellegrino, take the more optimistic stance that indeed, the teaching of values and ethics does make a difference in students' future behaviors and attitudes. In a similar vein, Miles et al argue for this type of education. They note, "There is increasing evidence that ethics education humanizes medical education, enhances physicians' understanding of their values and social responsibilities, enhances physicians' ability to identify value conflicts in medical care, and enables physicians to address more successfully ethical dilemmas with patients and other professionals."

Certainly, discussing ethical/value issues with medical students seems to sharpen their analytical and problem solving abilities. Using Pellegrino's model, such education in medical ethics can help medical students develop one important facet of liberal arts skills. When education is done in the broader context of exposing students to a wide range of the humanities as they relate to medicine, the student is, arguably, still better equipped to deal with the social and personal intricacies that daily confront the physician in medical practice. Through the perspectives offered in the
humanities, students can enrich their skills in all of the liberal arts and in so doing, become more empathetic physicians for their patients.

Moreover, excursions into the humanities are fun. They can be a welcome respite from the tedium of technologic medicine and can serve to invigorate students, faculty members, and practitioners with heightened awe and enthusiasm for the incredible layers of complexity in human life and interaction. Besides, it's rather satisfying, even for beleaguered medical students, to know enough about the Trojan War and the collapse of Troy to realize that the poet William Butler Yeats is referring to Helen's conception when he notes that her parents' coupling "engenders there the broken wall, the burning roof and tower and Agamemnon dead."^6

Jerome W. Freeman
Editor

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5. Miles SH et al Ibid.

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As the editorial in this issue suggests, medicine and the humanities can readily be companions. Dr Winston B. Odland, former president of the South Dakota Medical Association, has exemplified such a perspective for many years. Included below is a poem from his book “Material Souls”. Dr Odland notes: “the arts belong with the science in that they soften and illuminate the lives which are touched by it, making it ‘good medicine.’” In addition to his poetry, Dr Odland is also a painter.

Physicians Proposal

Come out thou chambered nautilus
Look for the change not sought
Protect the innermost securities
Protect thy favorite thought.

Join in approbations
Enjoin the sublimations
Of hyper personalizations
To form the heartfelt Corps.

What greater motivation
Could bring your own salvation
In terms of face not lost
That to join, not face conscription
To face the gain-not cost.

Defeat is not agreement.
Concession is not loss.
Refinement is not possession
Possession has its flaws.
Unity is welded purpose
Selfness serves but one
Oneness is most defenseless
Defense is stay, not run.

Take heart, thou beleaguered doctor
For change has not changed you
You carry mankind’s scepter
Entwined with serpent true.
What you have to offer is timeless.
When all the changes happen
You will still be you.

Dr Odland notes: this painting “is to me, as all visual artists, an impressionistic form with its exaggerations, compressed clouds, and angulated wing feathers—kind of a Chinese effect—why not a Chinese ringneck?”

APRIL 1992 99
Of all the H₂-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, 150 mg b.i.d., relieves heartburn in 86% of patients after one day and 93% after one week.¹
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Contraindications: Known hypersensitivity to the drug. Known hypersensitivity to any component of the formulation. Because cross-reactivity in the class of compounds has been observed, H₂-receptor antagonists, including AXID, should not be administered to patients with a history of hypersensitivity to other H₂-receptor antagonists.

Precautions: General—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests or unexplained malarial may occur during therapy. No interactions have been observed with theophylline, chlorpromazine, lidocaine, phenytoin, and warfarin. AXID does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,000 mg/d) aspirin in daily, increased serum levels were seen when nizatidine, 150 mg b.i.d., was administered concomitantly.

Cardiovascular, Metabolic, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 350 mg/kg/day (about 60 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (EC) cells in the gastric mucosa of rats. In a 2-year study in mice, there was no evidence of a carcinogenic effect in mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of AXID (350 mg/kg/day, about 300 times the human dose) showed a statistically significant increase in hyperplastic liver nodules and hepatic nodules. Inhibiting effects on liver weight in any of the other dose groups or the rate of hepatic fibrosis at this dose level were within the historical control limits seen for the strain of mice used. The mouse females were given a dose of acetaminophen (10 mg/kg/day) as a negative control. It is not possible to determine whether these changes were caused by nizatidine.

Hematologic—Anemia, a common pharmacologic effect noted with other H₂-receptor antagonists, was observed. AXID was not mutagenic in a battery of tests performed to evaluate its potential genotoxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Holding rates in elderly patients were similar to those in younger age groups and rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,500 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only 2.3% of patients (vs 2.0% in placebo) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between AXID and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported. It was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >3,000 IU/L. The incidence of elevated liver enzymes is generally 2% in patients. In most cases, the elevation of liver enzymes was reversible. There were no cases of jaundice or other evidence of cholestasis. Other cases of cholestatic or overt hepatitis, and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of AXID therapy. In clinical pharmacology studies, short episodes of symptomatic, venoocclusive, biliary tract changes occurred in 2 individuals administered AXID and in 3 uninfected subjects.

DOS—Rare cases of reversible mental confusion have been reported.

Postoperative—Clinical pharmacology studies showed no evidence of anti¬androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency in patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Facial thrombocytopenia was reported in a patient treated with nizatidine and another by placebo. There were no other cases of thrombocytopenia in the trials. There was no evidence of a thrombocytopenic purpura association. Hypersensitivity—No other H₂-receptor antagonists are reported with eosinophilia following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, leukocytosis, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hypersensitivity unassociated with post-necrotizing enterocolitis was reported. Eosinophilia, fever, and rash related to nizatidine have been reported.

Overdosage: Overdosage of AXID has been reported rarely. If overdose occurs, activated charcoal, irrigation, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been adequately documented; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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The Yankton Model Program

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ABSTRACT
Changes in medical education towards a student-centered, problem-based learning, with continuity care experience in ambulatory settings have been recommended. The University of South Dakota School of Medicine has developed such an educational model for third year medical students named the Yankton Model Program and is herein described.

INTRODUCTION
Changes in medical education have been recommended by the leaders in medical education, the GPEP report, the Macy Foundation Report, and the Commission of Medical Education. These recommendations reflect changes in the modern practice of medicine with a shift from hospital to ambulatory-based treatment, shorter hospital stays, a reduction in numbers of medical students choosing primary care careers and the increased responsibilities of physicians to their patients and community. Leaders of American medical education suggest that teaching in an ambulatory setting emphasizes the role of the student in self-education, provides a continuity experience and an opportunity for problem-based learning.

South Dakota has witnessed all the national changes in the practice of medicine and use of hospitals. The mission of the University of South Dakota (USD) School of Medicine is to provide the opportunity for South Dakota residents to receive quality broad-based medical education with an emphasis on primary care. In keeping with these goals, the Yankton Model Program was developed to provide third year medical students with an ambulatory-based, student-centered, continuity care experience. A required one year clerkship at the junior level with these goals would offer considerable improvement over the current educational programs for beginning clinical students and would demonstrate the joys and strengths of primary care to students. The following is a description of the USD School of Medicine Yankton Model Program which began June 1991.

The curriculum of the USD School of Medicine is based on the traditional department and section approach. Fifty students are admitted to the school each year. The first two years are spent mostly on the Vermillion, South Dakota, campus while the students study the basic sciences including anatomy, biochemistry, microbiology, physiology, pharmacology and pathology. There has been some integration of clinical material into selected segments of the curriculum via small groups. However, most of the education in the first two years is instructor-based lectures. The student chooses their third year clinical site in either Sioux Falls or Rapid City, South Dakota, for the traditional clinical clerkships in internal medicine, family medicine, ob/gyn, pediatrics and adolescent medicine, psychiatry and surgery. Community and private hospitals and the Veterans Administration hospitals are used for clinical teaching since the University does not operate a health care facility. Students are divided into four groups on each campus and rotate through the six departments during required block rotations. Ten students were self-selected to participate in the Yankton Model Pro
program during the 1991-92 academic year. A traditional program also was offered in Yankton until this year.

The Yankton campus was selected for this program for several reasons. A single clinic comprised of 35 physicians with two satellite clinics in Hartington, Nebraska, and Vermillion, South Dakota, provide the primary care for the community of 12,703 people and the surrounding area. There is also only one 144 bed acute care hospital serving the Yankton community. The Yankton campus has a USD School of Medicine campus dean, an enthusiastic faculty, and a strong educational coordinator. Also, the Yankton campus is only 25 miles from the basic science campus in Vermillion, and basic science input at the coordinator and facilitator levels of this course is strongly desired.

The philosophy for the Yankton Model Program is to deliver an education program which is ambulatory-based, allows continuity of care...

The first discussion of the program began in 1988, between Yankton clinical faculty and the dean of the School of Medicine. Interaction continued until January 1990, when a Coordinating Committee was developed. The Curriculum and Evaluation Committee of the medical school approved the program in the fall of 1990. The members of the Coordinating Committee are the authors of this paper and have been the innovative force for the program since its beginning.

The philosophy for the Yankton Model Program is to deliver an educational program which is ambulatory-based, allows continuity of care, is problem-oriented, and is student-centered. This philosophy was implemented by locating the entire twelve months of the required junior year clerkship at an ambulatory center, the Yankton Medical Clinic. Affiliated clinics include Rosebud Public Health Service, Wagner Public Health Service, and Lewis and Clark Mental Health Center. In the ambulatory care clinic, students are assigned to individual faculty members in six specialty areas (family practice, internal medicine, pediatrics, surgery, psychiatry, and ob/gyn). The students attend the clinic daily throughout the junior year. Each student is introduced to patients in the clinic and continues to follow those patients during hospitalizations and clinic follow-up visits throughout the year in order to provide a continuity experience. The student may also follow a patient when a referral is made to a subspecialty clinic. The student has a specific responsibility to be the coordinator for the patient's health care and to assure provision of the patient's health needs. The student will not be "on" a given specialty a specific number of weeks; but indeed, is "on" all primary care specialties throughout the year.

The clinic schedule has been designed so the students are in their assigned clinic for a two-hour period in the morning and two hours in the afternoon, except Friday afternoons. Friday afternoons are set aside for chart audit, bedside clinical skills evaluation (OSCE), journal club and student educational programs as requested by the students. Two hour clinic time blocks were selected to allow the student two hours of unscheduled time each morning and each afternoon. This allows students time to follow their patients to subspecialty clinics, observe procedures in the hospital or at the clinic, and have their own study time. The students are assigned to each clinic in teams of two in order to provide cross coverage for each other. The patients serve as the stimulus for the problem-based education. The patients' health and social problems are the focus of small group discussions.

The program is student centered since the student is responsible for the method and pace at which the objectives of the clerkship are met and patient problems are solved. The faculty is responsible for providing the setting and situation for the student to learn, for guiding the student to reach the student's learning issues, for providing the resources for the student learning, and for teaching the student to use the various resources available. In order to achieve this end, students are provided with computer capabilities and instruction in their use, library facilities, textbook facilities, and faculty for interaction and direction to obtain resources to solve the learning issues identified by the students.

The students must also conduct one community project during the junior year.

In order to enhance goals of both student-centered and problem-oriented education, the students are divided into groups of five. Each group meets with a faculty facilitator twice a week for a two hour period. For the first seven weeks of the year, a prepared patient case was presented to the students and the students determined the learning issues relevant to the case. They had two days to research the learning issues and discuss them during the follow-up session. After the first seven weeks, the students present one of their own patients to the group. The students specifically discuss the methods of preventing the illness, the pathophysiology of the illness, the presentation and natural history with and without therapy and appropriate diagnostic evaluation. The mix of students and facilitators for the groups change every six weeks. Facilitators are from both clinical and basic science disciplines and from the Yankton, Sioux Falls and Vermillion campuses.

In addition to objectives specific to the program developed by the coordinators, the standard departmental junior clerkship objectives of each
academic department are required. The students have the entire year to achieve these objectives at their own speed, by their own methods. For each of the program's objectives, methods of evaluating the student achievement also have been developed. A patient log kept on a computer database is required of all students. This allows students to interact with computers and provides the coordinators of the Yankton Model Program a method of instantaneous access to the students' clinical experience throughout the year. The database contains each significant patient interaction and is used to establish not only the students' patient and procedure experiences, but allows evaluation of the students' continuity experience and the types of patients seen by a particular student.

All students have "on call" responsibility to care for patients involved in the teaching program when they are seen after hours in the emergency room. During this on call time, the students also may see other patients in the emergency room and may select patients to follow the remainder of the year.

The students also must conduct one community project during the junior year. The purpose of this requirement is to introduce a sense of community responsibility to the students. The students may design their own community project. The only guideline is that the project must be consistent with the goals and objectives of the Yankton Medical Clinic and the medical community.

Management and Evaluation of the Program

The program is managed by a Coordinating Committee composed of the Dean of Academic Affairs, the Yankton campus dean, an educational coordinator, five clinical physicians, one basic scientist and two students who are participating in the program. Formal approval or changes in objectives must be approved by the USD School of Medicine Curriculum and Evaluation Committee, but must originate with the Yankton Model Program coordinators. Changes in the Yankton Model Program student schedules and responsibility are reviewed by the Coordinating Committee. Since the program is student-centered, students can request changes which are then reviewed by the Coordinating Committee.

Student evaluation is ongoing throughout the year. The student is provided with input concerning performance weaknesses and strengths by one of the physician coordinators who is assigned to interact with an individual student throughout the year. Students are evaluated by objective testing and clinical evaluation for each of the junior year objectives.

The objective tests consist of the standard departmental discipline specific examinations for all junior clerkships of the school of medicine and the National Board of Medical Examiners Part II and a portion of the departmental discipline specific examination every three months so the identification of weaknesses and accumulation of knowledge may be monitored throughout the year. The students are required to achieve scores determined by the departments to successfully complete the junior year. In addition to these standard tests, the students are tested four times a year by using a modified McMaster's "Triple Jump" exercise. The objective of this exercise is to identify the student's problem-solving ability as well as self-directed learning knowledge and the student's self-assessment ability. The student is presented with a clinical problem and is asked to identify important issues, what critical pieces of information are missing and to determine what steps need to be taken to solve the clinical question. Two hours are allowed to research the priority questions and prepare a synthesis. The student then meets with the faculty and reports on the research, final assessment and proper approach to the patient's problem. The student is asked to assess his or her overall performance in addition to the faculty evaluation. The coordinators are the faculty for this exercise.

...the students are tested four time a year by using a modified McMaster's "Triple Jump" exercise.

The students maintain a computer database on all their patients which include the presenting problem, the patient's problem/diagnosis and procedures done. The coordinators review the database periodically and direct the student as to his or her experience.

Physical diagnosis skills are evaluated during Friday afternoon bedside clinical sessions. The educational coordinator chooses a patient with a specific history or physical finding. A faculty member takes five students at a time to the bedside and observes the student doing the examination, discusses the examination with the students and demonstrates appropriate techniques and procedures.

Ambulatory care and interpersonal skills are evaluated by the clinic staff and nurses using a checklist of interpersonal skills. These skills include: dependability, leadership qualities, ability to work as a team member and ability to communicate and educate patients. Patients interacting with the students are given an evaluation form which address the following areas: the student's response to the patient, awareness of the patient's concern, instructions to the patient, verbal communication skills, physical examination management and professional attitude. The attending staff at the Yankton Medical Clinic are asked to evaluate the students on the following categories of clinical performance.
1. specific clinical skills of history taking, physical examination, oral and written communication, technical skills and interpretation of laboratory test results.
2. interpersonal skills; that is, relationships with patients, faculty members, staff, peers and interest in patients.
3. clinical judgment and problem solving which include clinical reasoning, use of resources, diagnostic formulation, development of a treatment and/or management plan.
4. fund and application of knowledge.
5. physician related characteristics of responsibility, initiative, attendance and dependability.
6. personal characteristics related to leadership potential, educational initiative, maturity and understanding.
7. use of the medical literature.

Continuity of care is evaluated by the student's computer database which contain the number of interactions and places of interaction with each individual patient.17 The following areas of knowledge are considered part of continuity of care:
1. The student must have an understanding of the natural history of illnesses and the current status of the patient in that natural history.
2. The student should be able to develop therapeutic plans for relevant areas.
3. The student should be able to provide patient education including specific instructions as when the patient should return, what referral or consultation should be sought over time and who is responsible for identifying the provider of appropriate care. The student's charts are reviewed in peer groups every two weeks in order to assess the student's charting ability and if appropriate follow-up is being undertaken for the patients. One of the coordinators acts as faculty for these sessions. All hospital History & Physicalls done by the students are sent to course coordinators for evaluation.

Small group skills are evaluated by the use of forms which are used by the students to evaluate themselves and to evaluate their peers. The form is also used by the facilitators to evaluate the students. Areas addressed are as follows: acquisition and integration of knowledge, communication skills, interpersonal and group skills, assessment skills, learning prescription and a summary of strengths and weaknesses.

Evaluation of the Program

Program evaluation as to the effect both financially and upon the quality of patient care at the Yankton Medical Clinic are important areas of evaluation. Relatively few articles have been published as to the financial effect of medical students training in a fee for service setting.12-16 Using all these sources and making a number of assumptions, calculations of the effect will be a part of the program evaluation. The authors feel secure the quality of care at the clinic will continue at its current high level and in fact may be even higher due to the program.

The Coordinating Committee meets every two weeks to evaluate the program and make changes when necessary. The Coordinating Committee will be challenged to make changes that meet the needs of students and faculty. The students have already requested a course in adult cardiac life support which will be instituted by the Coordinating Committee. One or two students have been asked to keep a journal of their experiences throughout the year in addition to their patient logs. The students will also have the opportunity to evaluate the program, the facilitators and the attending staff.

The authors are excited and enthusiastic about this new and innovative teaching program. Results of our experience will be reported.

REFERENCES

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Let's see...what is it that they say about April? Oh, I remember. "April showers bring May flowers." I've always interpreted it as meaning (among other things) that although it is dreary, soggy and gray now, if a person can just hang in there, good stuff will come from it. It's like May is the silver lining to the dark cloud of April. Are you with me so far?

My next-to-last communication with you has to do with the dark cloud of violence gathering over families in our country. "This year 4 million homes were wracked with intrafamily violence. Approximately 2 million to 4 million children suffered abuse or neglect at the hand of a parent; as many as 1 million senior citizens were mistreated by their caregivers; and 1.8 million women were battered by their partners." So states an article in the American Medical News. It goes on and on and, yet all the statistics that are so completely appalling in and of themselves probably understate the magnitude of the problem because reliable data are so hard to come by.

The highlights — rather the lowlights — of another article on the subject include the following atrocities: One-sixth of all homicides were committed by a member of the victim’s family. Half of the cases of battery against women were committed by spouses. From 200,000 to 500,000 children were sexually abused by parents and relatives. Are you physically ill yet? It would appear that our society is!

The same issue of AM News says that family violence refers to people who are beaten, slapped, punched, shaken, kicked, burned, raped, sodomized, starved, abandoned, thrown down stairs, stabbed, shot, bludgeoned, choked and killed...male or female. It covers people who are subjected to verbal abuse, threats against themselves and those they love, abuse of pets, destruction of property and forced isolation. It extends to people who are denied access to money, food, transportation, medical care and other necessities of life. It includes people who are deprived of rights, and those who are forced to watch or listen as others in their families are abused.

It is nauseating to read and consider once, but the awful realities of abuse and violence reverberate in our society for generations. It has been reliably suggested and observed to have such far-reaching effects as substance abuse, sexual activity, suicide, various criminal behaviors and other anti-social behaviors among those abused. It has even been shown to be a factor in the development of eating disorders. It had been cited as a cause in the profile of mass-murderers. It also is a well-known fact that the abused often go on to abuse others.

The human costs are unfathomable. The dollar costs are estimated to be $5 to $10 billion a year!! In 1987 alone, the estimated health care costs of the violence were $44 million (egad!), and the incidence appears to be rising. What can we do?

We all have a responsibility to keep our eyes and ears open, but physicians, I am told, must learn how to ask and what to ask in order to identify victims from among their patients. We must insist that medical education include family violence curriculum. In a 1987-88 survey of US and Canadian medical schools, it was reported that half of such schools provided no education on this grisly topic. We must all take action in 1991. The AMA Auxiliary launched a program to educate the public, support the victims of family violence and provide physicians with resource materials for patients who are victims of family violence. In our state, each district has been charged with the same goals! All are trying to find a way to help.

Yes, these are showers-torrential rains in April and other months, but if we dedicate ourselves to the fight against family violence in all its forms, flowers will bloom in the form of families that will be what they were intended to be...safe and nurturing places in which to bloom and grow all year around!!!

**************

APRIL IS CHILD ABUSE PREVENTION MONTH!!! Please help!

The March issue of FACETS focuses on family violence. Take a look!
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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine’s peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity... It is to be noted that in male sexual performance, erection is offset by alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by α-adrenergic receptors. Its effect on blood pressure, if any, would be lower; however, no adequate studies are at hand to quantify this effect in terms of Yohimbine dosage.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, genitaiic or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.1,2,3,4 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.3

How Supplied: Oral tablets of Yocon® 1/12 gr., 5.4 mg in bottles of 100’s NDC 53159-001-01 and 1000’s NDC 53159-001-10.

References:
1. A. Morales et al., New England Journal of Medicine, 1221, November 12, 1981.

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May

Advances in Gastroenterology: New Developments for Primary Care, Off of Academic Affairs, Hennepin County Med Ctr, Minneapolis, MN, May 1. Contact: Hennepin County Med Ctr, Dept of Int Med, 701 Park Ave, Suite 4512, Minneapolis, MN 55415. Phone: (612) 347-3533.

* * *

Common Infectious Disease Problems in Primary Care: Focus on the Pediatric Patient, Marriott Hotel, Omaha, NE, May 1. Fee: $35. CME hrs avail. Contact: Univ of Neb Med Ctr, Ctr for Cont Educ, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

* * *


* * *

Fourth Annual Black Hills Cardiac Symposium: Everyday Challenges, Rushmore Plaza Civic Ctr, Rapid City, SD, May 8. CME hrs avail. Fee: $25. Contact Lorna Ogle, Coord, Networking Dept, Rapid City Reg Hosp, PO Box 6000, Rapid City, SD 57709. Phone: (605) 341-8013.

* * *


* * *

Advanced Laparoscopy for the General Surgeon, Wohl Aud, Washington Univ School of Med, St. Louis, MO, May 15-16. 15.75 hrs AMA Category 1 hrs. Fee: $2,750. Contact: Off of CME, Washington Univ School of Med, PO Box 8063, St. Louis, MO 63110-1093. Phone: ((800) 325-9862.

* * *

Distinguished Lecture Series - Pedro A. Jose, MD, Ph.D - Pathogenesis of Salt-Dependent Hypertension, Boy Town Nat'l Research Hosp Aud, Omaha, NE, May 20. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

* * *

Controversies in Women's Health Care, Acapulco Princess Hotel, Acapulco, New Mexico, May 20-23. Fee: $395. 16 hrs AMA Category 1 credit. Contact: Susan Hughes, Off of CME, Scott and White, 2401 S 31st St, Temple, TX 76508. Phone: (817) 774-4083.

* * *

Primary Care Treatment for Pressure Sores, Hennepin County Med Ctr, Minneapolis, MN, May 21-22. Contact: Off of Academic Affairs, Hennepin County Med Ctr, Dept of Surgery, Div of Plastic Surg, 701 Park Ave, Suite 4512, Minneapolis, MN 55415. Phone: (612) 347-3533.

* * *

Family Medicine Update, Village East Resort, Lake Okoboji, IA, May 22-24. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

* * *

A Review of Orthopaedics and Orthopaedic Pathology, Criss II, Creighton Univ, Omaha, NE, May 28-31. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

* * *

Symposium on Fluorescein Angiography and Retinal Diseases, Mahoney State Park, Ashland, NE, May 30. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

June

41st Annual Obstetrics and Gynecology Conference: Update in Office Gynecology, Marriott Hotel, Omaha, NE, June 4-5. Contact: Ctr for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

* * *

Advances in Aesthetic & Reconstructive Breast Surgery, Ritz-Carlton Hotel, St. Louis, MO, June 4-7. Fee: $680. 18.75 hrs AMA Category 1 credit. Contact: Off of CME, Washington Univ School of Med, PO Box 8063, St. Louis, MO 63110. Phone: (800) 325-9862.

* * *

Advanced Laparoscopy Course, Creighton Univ, Omaha, NE, June 5-6. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

* * *

10th Annual Maurice Grier Symposium, Student Ctr, Creighton Univ, Omaha, NE, June 6. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

* * *

Conea and Contact Lens Course, Ritz-Carlton Hotel, St. Louis, MO, June 11-13. Fee: $300. 13 hrs AMA Category 1 credit. Contact: CME, Washington Univ School of Med, PO Box 8063, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

* * *

New Approaches in the Diagnosis and Management of Patients with Hyperlipidemia, Mahoney State Park, Ashland, NE, June 12-13. Contact: Ctr for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

* * *

Lipids/Cardiology Program, Mahoney State Park, Ashland, NE, June 12-13. Contact: Univ of Neb Med Ctr, Brenda C. Ram, Staff Assist, CME, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

July

Advanced Laparoscopy Course, Creighton Univ, Omaha, NE, July 24-25. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.
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**BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see Warnings), hypotension (systolic pressure < 90 mm Hg or cardiogenic shock, sick sinus syndrome if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control mild heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Deaths of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypertension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 50% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of accessory bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Diureptor should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of foscarnet and verapamil may have additive effects on myoccardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lidocaine and verapamil may result in a lowering of serum lidocaine levels or increased sensitivity to lidocaine. Patients receiving both drugs must be monitored carefully. Verapamil may increase carboxyhemoglobin concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of methyldopa and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (paraquat-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorgenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use. Adverse Reactions: Constipation (3.7%), diarrhea (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia, HR < 50/min (1.4%), AV block: total 1:2, 3:1 (1.2%), 2:1 and 3:1 (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive ileus-like ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, aortoarteriosclerotic dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (leucocytoclastic), syncope, diaphoresis, dry mouth, gastrointestinal distress, gingival hyperplasia, eczema or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, anorexia and rash, xanthema, hair loss, hyperkalemia, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence. 4/11/91 • P19CA6277V


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POLICY/RECOMMENDATION ON TURP

South Dakota Foundation for Medical Care (SDFMC) is responsible for assuring that appropriate care is provided to Medicare/Medicaid beneficiaries. On a regular basis, SDFMC’s Quality Assurance Committee reviews cases identified through the physician peer review program where there is a potential for significant adverse effects on the patient and where a quality problem exists that has resulted in significant adverse effects on the patient.

It has come to the attention of the Quality Assurance Committee through the physician peer review process, that primary TURPs are, in some instances, being performed on an ambulatory surgical care basis. Although SDFMC recognizes that physicians may have different approaches to treating patients, it appears to be a standard of care in the surrounding states to perform primary TURPs on an overnight inpatient basis.

The Quality Assurance Committee recommends that primary TURPs be performed on an acute inpatient basis or a stay of at least 24 hours. When extenuating circumstances do exist where exceptions are to be made, the medical record should clearly be documented to reflect the patient’s unique situation to ensure the best possible care for all patients.
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Richard J. Backes, MD

USD School of Medicine
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Defending Defensible Doctors
President's Page

Richard I. Porter, MD, President, South Dakota State Medical Association

Acts 19, Verse 32

The Apostles in the above noted title well describe the workings of Washington today!

One of the oldest dictums of medicine, "The less the indication, the greater the complications," should be heeded by our politicians! I keep hearing that our health care system is broken and needs "comprehensive reform" (whatever that means?). Well, the health care system wasn't "broke" before the federal government got into the business!

The million dollar question, (cheap at today’s prices), is how we can provide excellent health care to everyone in this nation and not go bankrupt? Simple answer, we’re already bankrupt! Congress continues to spend more than it takes in, and that to me is bankrupt in its truest sense.

If I were to go to a banker (excluding the HOUSE BANK), show him the ledger and then ask if his depositors (TAXPAYERS) would finance such a program, a prudent banker would ask me if I had a name for my fairy tale! However, who ever said that the federal government was prudent! After all, these are the same people who gave us the luxury tax recently enacted, which costs the government $5 to collect $2 in taxes! A lot of jobs were lost, but I'm told we will make it up on the volume! Trying to understand their logic is about as frustrating as attempting to play plastic spoons!

I firmly believe that if we as physicians do not, however, address the medical problems that face this great country of ours, then surely the federal government will attempt to do so for us, and in the process, destroy the greatest medical system in the world today and bankrupt the country trying!

One idea that might be of significant value would be to offer up a year's service after finishing our training. I feel deeply that everyone owes something back to this great nation, (YOU CAN EITHER DRINK THE WATER THAT'S IN THE CUP OR USE IT TO PRIME THE PUMP) and those of us in medicine have such a tremendous amount to give back that a year after completion of our training, or possibly during our training, to practice our specialty in an area that is sorely in need of some could help stem the tide, so to speak! Also, physicians that are thinking of retiring might get involved as well! It might well include all health care fields—laboratory technicians, radiology techs, nurses at varying levels, psychologists, podiatrists, optometrists, etc.

Much of the needed system is already in place. The Armed Forces, the Army in particular, have or will have closed at least 24 hospitals. Many times these are in the most remote poverty stricken areas of our country. I don't know that much about the Public Health Service, which already attempts to provide care in many of these areas, but they could also be included in this voluntary, but nonetheless, rewarding idea! Adequate reimbursement financially would be commensurate with the level of training and the genuine overwhelming satisfaction inherent in so doing might just make it work! It’s worth a try! We need to rekindle love of country and the axiom, "Duty, Honor, Country" as a part of our profession!

Medicine has always been a calling, if you will, a deeply ingrained desire to help others less fortunate and to advance the fight against disease, pain and suffering. If we were to somehow make this work, then surely what is often quoted from Ecclesiastes would continue to be reaffirmed!

"A generation goes, and a generation comes, but the earth remains forever. The sun rises and the sun goes down, and hastens to the place where it rises. The wind blows to the south, and goes round to the north; round and round goes the wind, twisting back and forth, getting nowhere! The rivers run into the sea, but the sea is never full, and the water returns again to the rivers and flows again to the sea."
"All things are full of weariness and tiresome. No matter how much we hear, we are not content; no matter how much we see, we are never satisfied;

So I saw that there is nothing better than that a man should enjoy his work, for that is his lot; who can bring him to see what will be after him?"

This will be my last President's Page, and not to share with you the gratitude, pride and humble good fortune that has been mine by your allowing me this honor, I would be remiss indeed, but I cannot put it to words well enough!

Most importantly, however, to Marlys, who understood when I couldn't; throughout Fort McCoy, Desert Shield, and Desert Storm; brief periods of insanity when political aspirations ran amuck; my driver (both ear and mind), organizer, proof-reader and critic, I'd like to say HAPPY 30TH ANNIVERSARY? Thank God the really good things in life never change.

#
Stress Echocardiography
Richard J. Backes, MD

ABSTRACT

Stress echocardiography is a relatively new imaging modality that is rapidly becoming the preferred technique to evaluate patients for and with coronary artery disease. This article will review how the procedure is performed, its diagnostic accuracy, its clinical role, and its advantages and disadvantages as compared to other imaging modalities.

INTRODUCTION

Coronary artery disease is the leading cause of morbidity and mortality in this country. As such, the detection of significant coronary artery disease prior to the development of its complications including myocardial infarction, congestive heart failure, or sudden death is a major goal of diagnostic cardiology today. Exercise electrocardiography has traditionally been the standard method to diagnose ischemia and there is a vast experience regarding its prognostic significance. However, the realization of a number of limitations to electrocardiographic stress testing lead to the development of numerous nuclear imaging techniques including radionuclide ventriculography, thallium scintigraphy and most recently technetium scintigraphy which have increased the sensitivity and specificity of detecting significant coronary ischemia. 

The most recent imaging modality to be used in diagnosing coronary artery disease has been stress echocardiography. Although first described as a diagnostic technique in 1979, it has only recently passed from the investigational stages to have now become a very practical and often preferred alternative in the evaluation of patients with coronary artery disease.

TECHNIQUE

Numerous forms of stress may be utilized in conjunction with echocardiographic imaging. These include: standard treadmill exercise testing and bicycle ergotamine as exercise modalities, or dipyridamole, dobutamine, or adenosine as pharmacologic stressors. If at all possible, standard exercise testing to at least 85% of predicted maximal heart rate is the preferred stressor and the pharmacologic modalities are only utilized when a patient cannot exercise.

When using the treadmill stress test multiple two dimensional tomographic images are first obtained with the patient at rest. The patient then exercises to greater than 85% of maximal predicted heart rate. The patient is then reimaged within a time window of 90-120 seconds post exercise. Recent technological advances utilizing real time digital frame grabbers and continuous loop recording techniques have vastly improved the recording of wall motion abnormalities and allow multiple views of a single cardiac cycle to be displayed simultaneously, thus eliminating noise due to respiration.

The normal left ventricular response to exercise is for wall motion to become hyperkinetic with increased wall thickening and a decrease in cavity size. Abnormal responses include dyskinesis, akinesis, and hypokinesis which represent varying degrees of exercise induced ischemia. Wall motion is broken down into various segments that correspond to a particular coronary artery territory and a wall motion score algorithm has been generated to semiquantitate the degree of ischemia.

ACCURACY

Several studies have examined the diagnostic sensitivity and specificity of stress echocardiography. In studies utilizing cardiac catheterization to verify results, sensitivity and specificity have in general ranged from 80-90%. In two small studies exercise echocardiography has been directly compared to radionuclide techniques. In 41 patients studied by Limacher, sensitivity and specificity levels for exercise echocardiography were 92% and 88% versus 71% and 80% for radionuclide ventriculography. In 36 patients studied by Mauer and Nando, sensitivity and specificity levels for exercise echocardiography were 80% and 92% respectively versus 74% and 92% for thallium 201 imaging. The major causes of diagnostic inaccuracy have recently been well described by Marwick and include: 1) performance of a submaximal exercise test; 2) the presence of single vessel coronary
disease; 3) moderate coronary artery disease, i.e. a 50-70\% stenosis. 13

**CLINICAL ROLE**

The most obvious role of exercise echocardiography is in the patient who requires exercise testing, but has either an abnormal resting electrocardiogram or is on digoxin, i.e. similar indications where nuclear imaging is advisable. 14-16 Other clinical applications have recently been studied including using stress echocardiography as a prognosticator post myocardial infarction or post reperfusion therapy with either thrombolytics or balloon dilatation. 17,18 The advantage of stress echocardiogram is the ability to look at LV function and LV wall thickening.

**ADVANTAGES/DISADVANTAGES**

There are a number of advantages and only a few disadvantages to this imaging technique. The first disadvantage is a successful imaging rate of 90-95\% in unselected patients. Causes of poor images include, patient obesity, musculoskeletal deformities, or significant chronic obstructive lung disease, however, with improved technology, the number of patients that cannot be adequately imaged continues to decline. 19 Another disadvantage is the need for both skilled and properly trained technicians to perform the study and skilled and properly trained physicians to interpret the images. 20

The advantages to this technique begin with its cost. Because of the cheaper equipment outlay, the study can be performed for 1/2 to 2/3 the cost of radionuclide imaging. It is a totally non-invasive test and does not expose the patient to radiation. It is a single, simple test to perform, in that it is easily adapted to the clinic setting and can be performed in less than one hour. Finally, it allows an assessment of left ventricular function and myocardial thickening in addition to evaluating for myocardial ischemia. 15,19

**CONCLUSION**

Stress echocardiography is a convenient and cost effective alternative to plain treadmill exercise testing and nuclear imaging modalities in the evaluation of coronary ischemia. It allows an assessment of both perfusion defects and regional wall motion abnormalities that parlay significant diagnostic and prognostic importance to the patient. As such, this technique is rapidly becoming the procedure of choice in the evaluation of patients with presumed or known coronary artery disease.

**REFERENCES**


**AUTHORS**

Richard J. Backes, MD is a Cardiologist in Sioux Falls, SD.
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Drug Interactions

Concomitant diuretic therapy: With either ACE inhibitor, patients on diuretics, especially those on diuretics for congestive heart failure, should be treated cautiously (see PRECAUTIONS). ACE inhibitors can produce severe, and even life-threatening, hypotension in patients who are volume-depleted, especially those who are on diuretics. (see PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS). ACE inhibitors should be used with care in patients who have had a myocardial infarction in the last 2 months, because severe, and even life-threatening, hypotension may occur in such patients. ACUPRIL therapy should be started at the recommended dose under close medical supervision. These patients have been shown to have lower blood pressures than other patients in clinical trials, because the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

Hyponatremia: Symptoms of hyponatremia were rarely seen in uncomplicated hypertensive patients treated with ACUPRIL, but, in some patients, it has been seen in diastolic volumes of patients, especially those who are on diuretics or use diuretics. (see PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS). These patients should be monitored closely and the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

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Elderly: Elderly patients who had increased diurnal plasma potassium levels following treatment had a greater reduction in diastolic volume than younger patients (see PRECAUTIONS, Drug Interactions, and ADVERSE REACTIONS). These patients should be monitored closely and the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

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Freedom of Choice in Medicine — "It makes me feel better"

When government undertook the responsibility of medical care for a significant segment of the populace, it follows that it would be able to control medical practice by the Golden Rule, i.e. he who has the gold makes the rules. As the government only represents the public, it follows that the public should be intimately involved in the decision making process of health care policies. With the growth of government in medicine, there has been the acceptance by most politicians and a large number of voters that health care is a right. Because of the above convictions, the concept has arisen that the individual patient as well as the public should have input into diagnostic and therapeutic options in the control of their own health. This is where problems start to occur. First, physicians often stress the point that choice implies the patient or collective patients must take more individual responsibility in determining their own health by cessation of smoking, temperance in the use of alcohol, and following good dietary habits. The patient may look on the new freedom as a right to dictate the choice of diagnostic or therapeutic procedures. A conflict is bound to arise in that the options may be limited somewhat like a multiple choice examination in which you have to pick the "best" answer of those given but the choices which are most desirable are not present.

What's more, does the freedom of medical choice mean the patient can demand therapies which are unproven and/or potentially harmful? If you can prove harm, it would seem that the answer is no. However, if the procedure is relatively or even completely safe and makes the patient feel better, should it be promoted? The danger, of course, is that the process of whether it be cancer or atherosclerosis, our most common lethal entities, may proceed unchecked until standard therapy is much less effective or ineffective. There is also the problem of wasting the shrinking health care dollar on unproven therapies.

In general, when legislative bodies are concerned with deliberations in any area, they usually consult with authorities in the area. Boards concerned with natural resources, mining or medicine, or their representatives, are consulted. While one might agree that no board is above the purview of the legislative body, does this mean that an active group of constituents of legislators can dictate the use of an unproven therapy? Chelation therapy in this last legislative session was such an issue.

Somewhere the complexity of determining which medical treatments are effective must be stressed to our legislators, most of whom are dedicated and work in the public interest. A harmless therapy is not innocuous. It would be detrimental to call it a right.

The placebo effect has been known for a long time and plagues most medical statisticians in assessing the effectiveness of a drug or procedure. This fact must be appreciated as well as the fact that each therapy must be subjected to numerous comparisons before its proper place in the practice of medicine is known.

There are several cancer groups which rigorously try to evaluate methods of treatment for malignancy. It is a painstaking and slow process. Sometimes, methods thought to be effective are not. However, over a period of years the results for cancer therapy have improved. They have not improved as much or as quickly as one would like but use of treatments not subjected to serious scrutiny or use of anecdotal cases only leads to chaos. "It makes me feel better" is not necessarily a criterion for a successful therapy. Just think if any group of people could demand a drug or a procedure because it made them feel better, we might be in store for some serious problems.

John F. Barlow, MD
Editor

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Neuropsychiatric Manifestations of Vitamin B12 Deficiency in the Absence of Anemia or Macrocytosis: A Case Report

Hany Shanody, MD, Anthony G. Salem, MD, from the Medical Service, VA Medical Center and Department of Medicine, USD School of Medicine.

ABSTRACT

We describe an atypical case of a young adult who had the acute onset of neuropsychiatric symptoms consistent with vitamin B12 deficiency despite a normal hematocrit, a normal MCV, a normal peripheral blood smear, a normal bone marrow biopsy, a normal Schilling test but abnormally low serum vitamin B12 levels. The patient responded quickly to parenteral vitamin B12 therapy but had mild residual symptoms at the time of his last clinic visit.

Neuropsychiatric manifestations of vitamin B12 deficiency may be present in the absence of megaloblastic anemia. We describe a patient without anemia or macrocytosis who developed acute onset of neuropsychiatric manifestations of vitamin B12 deficiency.

CASE REPORT

Mr S. W. is a 34 year-old male without any contributory past medical history except a mild hearing loss secondary to acoustic trauma while in the military. The patient was seen in the outpatient clinic with a 10 day history of severe dizziness which was initially thought to be secondary to viral labyrinthitis. (In retrospect, it appears that he had ataxia and not true vertigo.) He was treated with meclizine HCl and pseudoephedrine. He was instructed not to drive. He returned to the clinic two days later with the complaint that he was feeling worse. He was instructed to drink lots of fluid and transcutaneous scopolamine was prescribed. This provided no relief. He was admitted to the hospital the next day for evaluation of his persistent dizziness.

Additional history revealed that he was unable to maintain his balance while walking for the two days prior to admission and that the dizziness increased with sudden movement of his head or with sudden standing from a supine position. He also complained of increased fatigue, weakness and intermittent numbness in his hands and feet during the two months prior to admission. His wife noticed a change in speech (dysarthria) prior to admission. Psychiatric history revealed mood swings, irritability and lack of concentration.

Physical examination revealed a 34 year-old well developed, well nourished male in no acute distress. Blood pressure 120/70 without orthostatic changes, pulse rate 80, respiration rate 18, temp 98.1 F. HEENT: Unremarkable except for mild nystagmus when looking to the right but not to the left. Pupils reacted slowly to light. His tympanic membranes were normal when seen in the clinic. Neck: No carotid bruises were noted. Examination of the lungs, heart, abdomen, extremities, genital urinary system and skin were unremarkable.

Neurology examination revealed a cooperative patient who readily answered questions and followed commands well. He did not appear anxious or depressed. CN II-XII were grossly intact without any apparent focal deficits. He had intact sensations and diminished reflexes in the lower extremities. He moved his arms and legs very slowly and deliberately. He appeared to have a very mild lower extremity weakness, slight hypotonia, a stumbling gait, a positive Romberg sign and dysarthria. He was unable to walk without assistance. He could stand without assistance with his
feet spread apart, but could not stand on a narrow base. The finger to nose test was very slow with his eyes open. There was some dystaxia with his eyes closed. Proprioception of both the upper and lower extremities was normal.

Laboratory studies revealed the following values: WBC, 7,600/cu mm; hemoglobin, 16.5 g/dl (14-18); Hct, 47.4% (42-52); platelets, 245,000/cu mm; MCV, 91.6 cu um (80-94); MCH, 31.9 pg (27-31); MCHC, 34.8 g/dl (33-37). Folic acid, 2.8 ng/ml (2.5-20). Electrolytes and serum chemistries including SGOT, bilirubin, and LDH were normal. Chest roentgenogram was unremarkable.

The patient was admitted to the hospital and an extensive work-up was undertaken. The initial differential diagnosis included a posterior column lesion, a cerebellar tumor, myasthenia gravis, multiple sclerosis or a "viral labyrinthitis". The neurology consultant suspected early multiple sclerosis, but the visual evoked potential study and the MRI of the brain were normal. A lumbar puncture was also normal with no evidence of oligoclonal bands. The rest of the work up included a VDRL, HIV serology, Lyme antibody titer, serum prolactin level, thyroid function studies, a serum lead level and a urine screen for heavy metals. These tests were all normal. Vitamin B12 levels obtained on three different days and sent to two different labs showed low levels at 177 pg/mL, 186 pg/mL and 191 pg/mL (200-1000). A bone marrow biopsy including a peripheral blood smear and a Schilling test were normal. Anti-parietal cell antibodies were negative. Stool for ova and parasites and an upper GI series with a small bowel follow through were normal.

A tentative diagnosis of vitamin B12 deficiency was made based on the clinical history (ataxia; hyporeflexia, muscle weakness and hypotonia of the lower extremities; positive Romberg sign; dysarthria; dystaxia with finger to nose; mood swings; irritability and fatigue) and low serum vitamin B12 levels despite a normal bone marrow, a normal Schilling test and a negative anti-parietal cell antibody level.

The patient was given vitamin B12 injections of 1000 meg IM every day for ten days. He showed remarkable improvement with vitamin B12 injections. He felt less dizzy, his Romberg sign and finger to nose tests became normal with muscle strength improved and his ataxia resolved. He could walk without assistance after five days of vitamin B12 injections. He still had some residual neuropsychiatric manifestations such as mood changes and fatigue. He was discharged from the hospital after ten days of vitamin B12 injections. He has been followed in the outpatient for six months. At the time of his last visit, he had mild residual problems with muscle weakness, hyporeflexia, dysarthria, fatigue and mood swings. He will receive vitamin B12 injections every month for life.

DISCUSSION

Vitamin B12 deficiency typically is seen in elderly people (mean age of onset of over 60 years of age) and is usually accompanied by a macrocytic anemia. Neuropsychiatric manifestations occur in about 50% of the cases. These include sensory (paresthesia and diminished proprioception, vibratory and cutaneous sensation), motor (weakness), reflex (hypo or hyper-reflexia), gait disturbances (ataxia and abnormal Romberg sign) and mental impairment (dementia, memory loss, decreased attention span, depression, psychosis, etc).1

Although we traditionally think of vitamin B12 deficiency only in the context of macrocytic anemia and hypersegmented neutrophils, neuropsychiatric manifestations may occur in the absence of both anemia and macrocytosis.1 4

Lindenbaum, et al reported 141 consecutive patients with neuropsychiatric abnormalities due to vitamin B12 deficiencies. The hematoctrit was normal in 34 patients (24%), the MCV was normal in 25 patients (18%) and both the hemoglobin and MCV were normal in 19 patients (13%). Twenty-six of 28 patients with normal hematocrits and normal MCVs had hypersegmented neutrophils (one six-lobed or more than five five-lobed granulocyte per 100 neutrophils) on their peripheral blood smear.7

Utilizing the same patient population as Lindenbaum, et al, Healton, et al published similar data regarding 153 episodes (some patients had more than one episode of vitamin B12 deficiency). In 42 episodes of 153 episodes (27%) of B12 deficiency, the patients had normal hematocrit. In 31 of 135 episodes (23%) the MCV was normal and in 22 of 135 episodes (16%) both the hematocrit and MCV were normal. Hypersegmented neutrophils were noted in 137 of 139 peripheral blood smears (98.6%). Bone marrow aspirate in 78 patients including 15 with either a normal hematocrit, a normal MCV or both revealed megaloblastic anemia.1

In their series, Healton, et al demonstrated that the severity of the neuropsychiatric manifestation of vitamin B12 deficiency correlated directly with the duration of symptoms before treatment and indirectly with the level of hematocrit (i.e., patients with a normal hematocrit were worse than patients with a low hematocrit).1 The latter finding probably relates to the failure to diagnose vitamin B12 deficiency in the absence of anemia. Failure to treat vitamin B12 deficiency expeditiously may lead to permanent sequelae.1

SUMMARY

Neuropsychiatric manifestations of vitamin B12 deficiency in the absence of anemia and macrocytosis is not uncommon. A serum vitamin B12 level should be
obtained when the clinical setting warrants it. Vitamin B12 deficiency can be treated easily and usually results in dramatic improvement of the patient, particularly if diagnosed early.

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REFERENCES

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The contact person at the Journal office is Jeri Spars, (605) 336-1965.
This HELLO is a good-bye! Where does the time go? It is truly amazing to me that this is the last of the articles that I will write for the South Dakota Journal of Medicine. It is especially shocking to me because at the beginning of the year, the articles loomed large, obstacle-wise, as I looked forward to the 1991-1992 Auxiliary year!

Now I'm about to be "outta here"! I'm history! That is good news! By that I mean that being part of the history of the "Oldest Continuous Medical Association Auxiliary in the United States" is an honor. Wow! I'm feeling older by the minute.

I have enjoyed my opportunity to write for our fine Journal. It challenged me in a number of ways that have been beneficial for this year, and will continue to benefit me. What I'm struggling to say is that I have learned much. As many of you may have guessed, the biggest challenge for me was/is to limit myself to the 500 or so words I'm allotted — to shut up! The awful truth about me (I cannot tell a lie) is that if six words will do nicely, I use 6000! Oh well. We each have strengths and weaknesses.

I want to thank a bunch of people who have helped to take care of Auxiliary at the "grass roots level" so to speak. Thanks to the woman who made me what I am today! That is you Jackie Slingsby. Did you guess that I was talking about you? Jackie got me warmed up and in the "starting blocks", so that when the gun sounded, I knew in which direction to run! I am sure that she was tempted to slap me the last few times I asked her to explain the budget to me, but she didn't!

The Board of Directors has my deepest gratitude. Many of them did double and triple duty this year, and each held up her end of the deal. I would like to express my sincere appreciation to the folks at the SDSMA office for their assistance. I would like to thank Tommy, who only rolled his eyes 4,242 times this year when I bounced ideas off of him! His patience was a big help.

Kudos to the district officers and members who did the day-to-day work under the direction of both State and National! They did a lot of good and made us all look good in the process. I was impressed with the way they did what was asked of them. If they grumbled, I did not hear it! I am thankful to the staff at the AMAA National headquarters for their quick response to my needs and requests. I am truly a lucky person!

To all, thank you for your efforts and patience with me. I hope to see you all at the Annual Meeting in Rapid City! The convention committee is a great group. They too are humoring me! Come see Ruth Parry take over the reins of the SDSMAA. I can tell you that she will definitely be able to clean up after me and add much of value to our organization.

I urge you to continue to do good things in the areas of family violence, and teen health issues (including the fight against substance abuse, the prevention of suicide, teen sexuality, preventing teen pregnancy, AIDS education and prevention of eating disorders).

I entreat you to pay your dues each and every year. The return on your investment will be beyond measure. I hope you will continue to:

- Take care of yourself!
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- Support AMA-ERF!
- Support health care legislation which protects what is good about our system while correcting that which needs work!
- LOOK FOR HUMOR!

Parting is such sweet sorrow! I don't know what in the heck it means, but it does end my year on a classy note, doesn't it? Tricky, huh? #
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Council Meeting Highlights

The Council met on April 3, in Sioux Falls. Following are highlights from that meeting.

1. PUBLIC RELATIONS PROGRAM - Craig Lawrence from Lawrence and Schiller, the marketing firm under contract with SDSMA since October, reviewed activities undertaken by the firm to date and outlined their recommendations for responding to proposals dealing with health reform plans, publicizing the ShareCare program and developing brochures for display and distribution in doctors' offices. The Council accepted this report and directed Lawrence and Schiller to proceed and to provide an update at the time of our annual meeting.

2. LOCUM TENENS SURVEY - The Council directed that a survey be prepared and sent to certain South Dakota doctors to determine if there is a need for locum tenens physicians in South Dakota; if so, how extensive the need is and if the SDSMA should serve as a resource and clearinghouse for this activity.

3. STATE HEALTH DEPARTMENT GUIDELINES FOR HIV INFECTION AND HEALTH CARE WORKERS - The AIDS Task Force reviewed the guidelines submitted by the Health Department and made several recommendations. The Council, in turn, approved the recommendations of the AIDS Task Force and directed they be sent to the Health Department for consideration.

4. HEALTH ACCESS SOUTH DAKOTA - A report based on the Council's study and discussion throughout the year on health access issues will be prepared and submitted to the House of Delegates at the 1992 annual meeting. Problems identified deal primarily with Title 19 patients, the disabled and those with chronic diseases.

5. SDSMA BYLAW AMENDMENT - An amendment to the SDSMA Bylaws will be considered by the House of Delegates at the annual meeting. This amendment increases the size of the Council by allocating to each district at least two councilor representatives.

6. SODAPAC BOARD OF DIRECTORS - The following were elected to serve three year terms on the SoDaPAC Board effective June 1992-1995: Marie Hovland, Aberdeen; Thomas White, MD, John Sall, MD, Sioux Falls; Richard Porter, MD, Marlys Porter, Yankton; John Barlow, MD, Dennis Nesbit, MD, Rapid City; and Robert Goodhope, MD, Fort Meade. It was noted there are still a number of vacant positions on the SoDaPAC Board. Anyone interested in serving should contact your local councilor or the executive office.

7. ENDOWMENT BOARD OF DIRECTORS - Re-elected to the Endowment Board for a one year term are: Joseph Hamm, MD, Sturgis; Warren Jones, MD, Robert Giebink, MD, Sioux Falls; Howard Saylor, MD, Huron; Bruce Lushbough, MD, Brookings; T. H. Sattler, MD, Yankton; and Bruce Allen, MD, Rapid City.

8. SDSMA HONORARY LIFE MEMBERS - The Council elected the following to honorary life membership in the SDSMA: David Seaman, MD, Bernard Gerber, MD, Aberdeen; Richard Gere, MD, Donald Weatherill, MD, Mitchell; Tom Wilcoekson, MD, Yankton; R. C. Jahraus, MD, Pierre; and Richard N. Smith, DO, Huron.

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15th Annual Black Hills Seminar, Advances in Clinical Pediatrics, Golden Hills Resort, Lead, SD, June 17-19. Contact: Debbie Meyer, USD School of Medicine, PO Box 5039, Sioux Falls, SD 57117-5039. Phone: (605) 333-5210.

Distinguished Lecture Series - Thomas J. Brady, MD - 'Functional Magnetic Resonance Imaging of the Brain', Boys Town Nat'l Aud, Omaha, NE, June 18. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.


Clinical Applications of PET in Psychiatry and Neurology, Red Lion Inn, Omaha, NE, June 19-20. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

July

22nd Annual Sports Medicine Symposium, Sheraton Hotel, Atlantic Beach, NC, July 3-5. Fee: $75. 6 hrs AAFP & AMA Category 1 credit. Contact: Alan Skipper, North Carolina Medical Society, PO Box 27167, Raleigh, NC 27611. Phone: (919) 833-3836.


Advanced Laparoscopy Course, Creighton Univ, Omaha, NE, July 24-25. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

August

Basic Laparoscopy Course, Creighton Univ, Omaha, NE, August 14-15. Contact: Sally C. O'Neill, Ph.D, Assoc Dean, Creighton Univ, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.


January


The AMA Financing & Practice Services and the AMA Investment Advisers are offering workshops throughout the summer (April - September) to help you with personal or business financial problems and decisions. Call the AMA (800) 366-6968 for more information on these meetings. The names of the meetings and the fees are: Financial Strategies for Successful Retirement - $275; Gearing Up for Retirement - $275; Successful Money Management - $275; Starting Your Practice - $335; Joining a Partnership or Group Practice - $160; Insurance Processing and Coding - $195; ICD-9 Coding for Doctors' Offices - $195; CPT Coding for Doctors' Offices - $140; Medical Collections Management - $140; The Business Side of Medicine -$195.

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Several times each summer, the Sioux Indians of South Dakota don their native costumes and hold pow wows all over the state. Their costumes are beautiful with the colored bead work and colorful feathers. (Photo courtesy of the South Dakota Department of Tourism)
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Special Report

On The Consensus For Primary Care: Reflections On The First National Primary Care Conference

Loren H. Amundson, MD

FOREWORD

Primary care was first defined and addressed in the Millis report of 1966, following the post World War II expansion of specialization. This and other commissions provided the grist for the emergence of the specialty of family practice (1969), America's 20th recognized medical specialty. Dr. John Fry, venerable English general practitioner and clinical researcher (present at the conference), spoke of levels of care in 1972. In 1978, the Institute of Medicine (IOM) published the concepts of accessible, comprehensive, coordinated, continual care by accountable providers of personal health services. The World Health Organization (WHO) first emphasized community (fusion of primary health care and community medicine) through efforts of Dr. FitzHugh Mullan in the late 1970's. These concepts were crystallized by Dr. Sidney Kark in the early 1980's by creating the practice of Community Oriented Primary Care (COPC).

The primary care thrust waned most of the remainder of the decade as medicine was placed in the hands of the market place (technology, managed care), only to be revived at the beginning of the 1990's. Reasons abound, and include the presence of a non-health care system, widespread citizen discontent regarding access and costs, failure of the market place to control those costs, current dysfunctional medical training (undergraduate and graduate), and the need for a new paradigm.

PRECIS

While primary care is a need whose time has come—again, the primary care community is not readily identifiable. While somewhat diffuse, and in need of structure, the primary care "framework" must include a strategy for organizing the health care system; a set of activities; a process for an entry level of care; and a philosophy that embodies an explicit social contract between society and the health professions. Primary care (individual, biomedical, unselected patients with unselected problems, emergency care, acute and chronic care, cost effective) must be integrated with primary health care (public health, health promotion, disease prevention, surveillance, profiles and standards, improved medical records, patterns of care, systems to provide research data and statistics) to insure reasonable access to quality, affordable health care for all citizens. This new infrastructure would provide "the care people get for most of their problems most of the time."

The medical education system, defined by many as entrenched and a laggard, has been targeted by major foundations (Kaiser, Kellogg, R.W. Johnson, Pew) and government to enhance the number of keystones physicians for an expanded primary care focus in America. Conventional notions must be cast aside and medical education needs to become a paradigm for patient care. Implications for schools of medicine include changes to insure increased primary care curriculum, faculties and practices; less dependence on non-primary care residents and fellows; and increased community based and ambulatory education. Integration of "primary care" specialties (defined as family practice, general internal medicine and general pediatrics) is the thrust of a new R.W. Johnson "generalist physician initiative" now underway. America is looking for a new dawn of accountability for primary care, a re-focused balance of care. To the medical schools, the question might be asked, "why are we training three types of generalists?" Training of mid level professionals (MLPs), such as (family) nurse practitioners (FNP), physicians assistants (PA) and certified nurse midwives (CMN) is an achievable goal for "Departments of Primary Care." Four ways to increase generalists include:

1. New knowledge (what generalists do, what MLPs do, what non-primary care specialists do, outcomes).
2. Attitudes (public acknowledgement and appreciation).
3. Enhance attractiveness (change structure of GME, financial reimbursement incentives, market opportunities).
4. Reform of academic medical centers (entrance criteria, preclinical experiences, clinical clerkships, primary care residencies more closely linked with clinical practices, faculty development and research support).

Obstacles loom and include lack of acceptance of the prevention model, coming to grips with marginal costs (what is an additional month of life worth), acceptance
by all citizens of a primary care provider, and lack of recognition of non-medical interventions (failures in housing-homeless, education-teenage gang wars and shootings, and job systems-alcoholism).

At the practice level, "organ system" lobbying for pieces of the Resource Based Relative Value Scale (RBRVS) pie must be muted, although "it's never over" in Washington, D.C. Medicaid, "the other current national health insurance program", needs restructuring to insure support for appropriate types and levels of care to the right people and reimbursement for that care. The legal environment likewise should not be immune to necessary change. Barriers must be overcome to serve the needs of people by moving to more efficient and effective models. It will take some risks! Resistance is ever present ("it may take a generation to resolve/solve the primary care problem" - AMA).

Implications for government include more student incentives to enter primary care, more Primary Care Area Health Education Centers (AHECs) and enhanced graduate training grants keyed to support ambulatory graduate medical education (GME) which occurs while caring for underserved populations in settings such as Community Health Centers (CHCs) and Rural Training Tracts (RTTs). Government must de-emphasize (limit) funding of non-primary care specialty GME. Medicare direct and indirect graduate medical education reimbursement to teaching institutions ($5.2 billion - the real educational policy) must be leveraged in favor of primary care training in a real and meaningful way. The National Institutes of Health (NIH) pour $4 billion into medical schools for biotechnology while its primary care counterpart, the Agency for Health Care Policy and Research (AHCPR), struggles with $200 million, only $40 million of these dollars currently dedicated to primary care-another cause of the continued focus on the biomedical model. Reimbursement adjustments can likewise limit services provided by the "hidden system of primary care," that care provided by non-primary care specialists who lack training, experience and demonstrated competence to accent necessary primary health care. On these important issues resides the fulcrum about which specialty and geographic (re)-distribution turn.

Health care reform is overdue and necessary throughout the system—to "re-tilt the playing field." Financing is wrong for all the wrong reasons. The market place "lacks discipline." Explosive, uncontrolled growth of the medical complex prevents any progress towards a balanced federal countenance. The fear is that the American medical system will remain "typically American—expensive and complicated." The paradigm shift must create a health care system where now there is only a medical care system. It must empower the people and their communities to roll up their sleeves and address local problems by appropriate application of resources while realizing that change is not the enemy. Structural reform can create the milieu to bring it all together.

CLOSURE

Primary care is at the core of the health care reform debate. Inadequate care today increases costs tomorrow. Primary care fuses access, quality and cost. Winston Churchill said, "You can always bank on the Americans to do the right things, after they have expended all other ideas." During the conference, Nutting said, "We're in the right town at the right time talking about the right issues with the right people." Let's go for it!

POSTSCRIPT

Governor George S. Mickelson of South Dakota gave the keynote address at the opening session of the first National Primary Care Conference. Louis W. Sullivan, MD, Secretary of Health and Human Services, gave the closing address and highlighted President Bush's Access to Care Plan for health care reform.

Governor Mickelson, co-lead governor on health for the National Governor's Association, shared perspectives of the nation's governors about national health care reform and South Dakota's experiences in addressing rural health issues, including financing and delivery of primary care services. His presentation was well received by the large audience in attendance, and set the tone for a productive meeting on primary care.

ACKNOWLEDGEMENTS

This Precis includes excerpts from presentations by: Budetti, PP; Elders, MJ; Grace, HK; Kadison, WD; Graham, R; Green, L; Inglehart, JK; Lee, PR; Mickelson, GS; Mullan, F; Nutting, F; Schroeder, SA; Shine, KL; Smith, MD; Todd, JS; Vernon, T; Wartman, SA.

DEFINITIONS

Primary Care: Primary care is a type of medical care delivery which emphasizes first contact care and assumes ongoing responsibility for the patient in both health maintenance and therapy of illness. It is personal care involving a unique interaction and communication between the patient and the physician. It is comprehensive in scope and includes the overall coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of effective primary care (American Academy of Family Physicians, 1990).

Family Practice: Family practice is the medical specialty which provides continuing and comprehensive health care for the individual and the family. It is the specialty in breadth which integrates the biological, clinical and behavioral sciences. The scope of family practice encompasses all ages, both sexes, each organ system and every disease entity. Family practice is the continuing and current expression of the historical medical practitioner and is uniquely defined within the family context (AAFP, 1986).

AUTHOR

Loren H. Amundson, MD is Director, South Dakota Office of Rural Health, and Professor, USD School of Medicine.
Medical Director’s Message

T. H. Sattler, MD

At this time your Foundation for Medical Care is completing the last month of the "Third Scope of Work" contract with HCFA (Health Care Financing Administration). It is encouraging that the program has remained quite stable, thus enabling us to concentrate on the primary goal of improvement in quality of care.

We need to make note of the significant gains in documentation made by the medical profession, which helps to demonstrate clearly the patient’s health status at every stage of the patient’s health care. The allied members of the health team—especially the medical records and utilization and review members—have been vital in the documentation improvement. These are major contributions to the patient’s welfare.

South Dakota physicians have reason to be proud of their worthy accomplishments through their peer review program. However, I do wish to suggest a challenge to all of our members. The new contract with HCFA will offer an opportunity to take major steps in a continuum of improved health planning and care. It will be possible to direct emphasis toward the goal and the right of the medical profession to monitor and regulate itself. The signs of such attitudinal emphasis are encouraging. Local hospital review is the key to success!

We are extremely proud of the dedication of South Dakota peer review physicians, who have always kept foremost the goal of continuous improvement in quality of care.
New SDSMA Members

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In mice, rats, and rabbits, a number of abnormalities including visceral organ hypoplasia and skeletal defects resulted from treatment with ACE inhibitors (see Table 1). In rabbits, renal artery stenosis and/or coarctation of the aorta were noted, as were other cardiovascular abnormalities. These effects also occurred in mice treated with AcUPRIL. In rats, renal artery stenosis and/or coarctation of the aorta were noted, as was other cardiovascular abnormalities. These effects also occurred in rabbits treated with AcUPRIL. 

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Hypertension is a disease of chronicity and requires long-term therapy. Therefore, laboratory tests should be performed on a regular basis and correlated with patient history and physical examination in order to assess the overall effectiveness of treatment. 

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The other morning at my early morning coffee group, which includes a local lawyer, I mentioned that I had been called for jury duty for this quarter. Being proud of the fact that no excuse had been made to be removed, I did ask how to notify the court if I had to be out-of-town for a few days. My lawyer friend said don't worry you won't be chosen anyway, your too strong willed. We don't want people who have strong ideas. We want to be able to convince a jury. This is exactly the reason we need some type of arbitration by medical minds who understand a situation and can decide in a fair and unbiased manner.

This is only one area that needs our input. There are many areas which we deal with that are taken for granted as far as thinking that the rest of the membership is informed. You can tell by questions asked at district meetings that we have failed in some areas. Hopefully this can be improved upon.

I would like to thank the House of Delegates and the Council for giving me the chance to represent this fine organization this year and will be relying on the expertise of past leaders, the Council, the Executive Committee and our CEO. Hopefully, we will get some positive feedback from our numerous new members.

M. George Thompson, DO, President
South Dakota State Medical Association

The magnitude and responsibility of being president of this organization have never been underestimated by me. As spokesman for the South Dakota State Medical Association, the president and all officers must be able to sometimes forget their personal opinions, especially on major issues and espouse the beliefs of the majority. This will be quite easy for me as nearly all stands of the Association coincide with mine.

This office has the job of relaying to the rest of the members what the organization stands for. This is especially true in the area of legislation. One physician testifying in opposition to our majority opinion can have a great impact on the outcome. It seems some legislators, because of small but vociferous groups back home, are always looking for an excuse to appease these people. An example of this is the chelation bill in the last session.

The governor this year has decided to put emphases on tort reform. I understand he has notified the bar of his intentions we must be ready to take an active role.
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About Our New President

M. George Thompson, DO was born in Sioux Falls, South Dakota in 1935, and grew up in Watertown. He earned his bachelor of science degree in chemistry at South Dakota State University in 1957. He then received his osteopathic degree at the College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 1961. After completing his internship at Normandy Osteopathic Hospital in St. Louis, Missouri, in 1962, Dr. Thompson returned to South Dakota where he has been a family practitioner for the past 30 years—practicing in Watertown for the past eight years.

He was a member of the Board of Basic Sciences for six years; has been a member of the South Dakota State Board of Medical and Osteopathic Examiners for the past six years; a member of the Foundation for Medical Care Board for six years; and a member of the Dakota-Care Board since its inception. Dr. Thompson was treasurer for the South Dakota State Medical Association for five years before becoming vice president and then president-elect. Prior to becoming treasurer, he had served as a delegate and also a councilor for the State Medical Association. He also served as a delegate for the Federation of National Boards.

Activities in civic organizations keep him very busy. He has been on two school boards and is a member of the Watertown Rotary, the Elks and the Shrine.

Dr. Thompson and his wife, Judy, have three children: Vance is an ophthalmologist in Sioux Falls; Misty is a general manager with the Ramkota Corporation; and their son Chris, who was just married in May, works as a surgical technician for an ophthalmology group.

For hobbies, he enjoys the “big three”—golf, hunting and fishing.

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Alternately, I am amazed and alarmed to discover what I don't know about medicine and life. Of course, the scope of human knowledge is now so vast, and expanding so rapidly, that even a wistful reflection about wishing one could "know everything" seems hopelessly far-fetched. I once heard that Goethe was the last human who may have had the intelligence and education to know everything there was to know in his time. Since then, the explosion of human endeavor and knowledge has been exponential. Presumably the likes of Einstein and Whitehead only grasped a fraction of what "there was to know" world-wide during their lifetimes. Even when one narrows one's focus to a single discipline, like medicine, the depth and array of knowledge and information is staggering.

In this regard, certain disciplines are particularly quick to foster my own discomfiture. Immunology is a good example. The other day, one of my residents was expounding on superantigens and the human response, and it made me think that virtually everything that is known about immunology has substantially changed since I was a medical student 18 years ago. For that matter, the drugs in cardiology, oncology, and infectious disease are changing and expanding entirely too rapidly for my contentment.

Genetics also readily fits into this dastardly category of being too mutable and complex. This circumstance was forced upon my attention, recently, when I was invited to attend lectures of the Great Plains Clinical Genetics Society, which held its annual meeting in Sioux Falls this April. The language employed there had informational accents which seemed distressingly foreign to me.

But such erstwhile reflections on my intellectual finitude are not the real reason I have been gradually steering this piece toward genetics. In fact, I was fascinated by the two lectures I heard on legal/ethical issues in genetic testing. One of the speakers, Rebecca Anderson, JD, MS, readily acknowledged that she was raising more questions than providing answers. She noted that all humans have genetic liabilities. For instance, she estimated that everyone carries 6-8 "bad" recessive genes and 12-14 "bad" dominant ones. Anderson speculated that this knowledge can prompt humans to better develop a sense of shared fate and tolerance. However, such knowledge can certainly readily prove to not be "value neutral". It can challenge our ideals of social equality and our self-image. Important questions will arise as to whether a person in the future will feel an obligation to know his or her genetic makeup, and who else might have a right or desire for this information (such as other family members, adoption agencies, school admission committees, insurance companies or the courts). Obvious legal questions will arise dealing with privacy and confidentiality. Questions of discrimination will exist, not only for individuals with expressed genetic conditions, but also for individuals who have presymptomatic ones (i.e., someone who is asymptomatic but has the gene for Huntington's Disease).

Furthermore, troublesome questions arise when one ponders the prospect of gene manipulation or repair. If this is done prenatally, for instance, who decides what genetic features are clearly worthy of altering and which ones are of borderline significance, but tolerable?

Certainly, the field of medical genetics is an excellent example of why the ethical and value problems we confront in medicine are going to continue to be complex and demanding. Increasingly, it may prove easier to expand our scientific knowledge than to know how to use the information gleaned.

As a respite from such ethical quagmires and quandaries, there was also much fascinating factual information provided at these lectures. The speakers frequently mentioned the Human Genome Project. The scope and implications of this research are astounding. Because I suspected that many of our readers, like myself, are not well versed on this topic, I have asked Dr Virginia Johnson to briefly describe the Project and its implications in the "Extenuating Circumstances" portion of this issue. Dr Johnson hosted the April genetics meeting, as she is currently president of the Great Plains Clinical Genetics Society. She is also a professor of Medical Genetics with the USD School of Medicine.

#

Jerome W. Freeman, MD
Editor

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South Dakota State Medical Association sincerely appreciates the support of all the sponsors for our 1992 Annual Meeting.
Extenuating Circumstances

A periodic column of personal, ethical, and socioeconomic reflections on medicine.

Human Genome Project

Virginia P. Johnson, MD

Genome n.[gene plus chromosome] the complete set of chromosomes containing all of the genes of an organism. For man this set of 46 per cell stretches to 6 foot strand of DNA. Within this string of 3 billion nucleotide bases are 100,000 genes. Utilizing a 4 letter alphabet (Adenin, Guanine, Cytosine, Thymine), genes provide the blueprint for the amino acid sequence of structural protein (cell membrane, connective tissue, etc) or functional protein (hormones, enzymes, transmitters, etc). DNA replication guarantees exact gene copies and chromosome melosis and crossing over guarantees varied gene combinations. This forms the basis for the similarity and the diversity of all of humankind; the similarity needed to perpetuate successful genes and the diversity needed for genes to respond to the weeding out process of evolution.

The Human Genomic is a collaborative effort of the National Institute of Health's (NIH) National Center for Human Genome Research (NCHGR) and the Department of Energy (DOE) to map out genes and sequence the DNA of all 46 chromosomes. Mapping the chromosomes is anticipated to take the first 5-10 years and DNA sequencing all through the 15 year project. Other agencies involved include the National Science Foundation (NSF), the United States Department of Agriculture (USDA) and the Howard Hughes Medical Institute.

Advances in the last two decades in molecular biology and computer and laser technology are critical in locating, identifying, sequencing and manufacturing gene probes and gene products. It is now established that Huntington Disease (HD) is on the short arm of chromosome #4; Neurofibromatosis, on the short arm of chromosome #17; and Cystic Fibrosis, on the long arm of chromosome #7. The localization of genes on chromosomes is dependent upon linkage studies of large multiplex families with several affected individuals. Naturally occurring bacterial enzymes cut DNA at specific sites with a particular nucleotide base sequence. The number and location of such RFLP (restriction fragment length polymorphism) sites varies between individuals and can thus serve as markers. Markers that are close to the gene or are within the gene are likely to be inherited. Markers far from the gene are likely to be randomly segregated. In an HD family study, of the four marker haplotypes (A,B,C,D), one may be able to show the C haplotype segregating with HD and the non-C with the normal gene. These markers are usually anonymous non-gene segments of DNA. Since they do not function as genes coding for a specific protein product, they can collect mutations through millennia without any deleterious effect. These polymorphisms (many forms) of DNA RFLP sites, differentiate individuals within and between families or ethnic groups.

The main goal of the Human Genome Project is to facilitate localization of genes within the human genome by establishing markers along the strand of DNA within a chromosome, much like the creation of a physical map. A useful analogy is localizing towns and cities on the interstate system. Interstate 80 runs from New York City to San Francisco with major cities, Des Moines in the middle, Salt Lake City to the west, and Cleveland to the east. A genetic linkage map would suggest certain cities on I-80 to be closely linked (Omaha and Council Bluffs, IA; the Quad cities, Davenport and Bettendorf, IA, Rock Island and Moline, IL) and certain cities to be far from each other (Reno from Chicago or the above major cities) by virtue of the frequency of recombination (the chance at which they are inherited together or separately). Physical mapping requires placing these cities upstream or downstream of each other and identifying distances in between. Mapping of genes could be greatly expedited if milestones (DNA markers) could be established along the length of the highway (chromosome). Looking for a village (gene) along this highway is expedited by identifying the milestone (DNA marker) with which it segregates.

Genetics is currently in the forefront of medicine with the recognition of well over 4000 gene-based. These disorders include common conditions such as diabetes, heart disease, cancers, psychiatric disorders, alcohol dependency, and Alzheimers disease, which have a strong genetic predisposition. Knowledge of the nature of the gene and its product (following DNA sequencing) should lead to an understanding of pathogenesis and, hopefully, treatment and cure. Use of DNA probes for linkage studies or for direct gene analysis could identify a predisposition to, or provide a presymptomatic diagnosis of, a condition. Pharmaceutical products derived from genes are a boon to humankind. Well known examples include insulin, interferon, growth hormone, tissue plasminogen activator, and erythropoietin. The potential is limitless.

As in all human endeavor, assets are always accompanied by liabilities, rights by responsibilities. Numerous questions and issues come to fore:

- questions of fairness in the use of genetic information with respect to insurance, employment, the criminal justice system
- impact of genetic information on the individual; stigmatization, ostracism, psychological stress
- privacy, confidentiality, and ownership of genetic information
- genetic counseling issues in prenatal testing, presymptomatic testing, carrier status testing, population screening
- philosophical implications including concepts of health and disease, problems of determinism and reductionism, concepts of personal identity and responsibility
- questions regarding commercialization of information derived as it pertains to intellectual property rights (copyrights, trade secrets) and impact on candor of scientific collaboration
- use and misuse of genetics in eugenics

It is for these very issues, that were raised by NCHGR, that an Ethical, Legal and Social Implications working group was convened. Public forums on the Human Genome Initiative are being conducted nationwide, hopefully to provide for solutions before problems arise.

Man is the only creature who has sought to analyze himself. Now that we have the tools, we should attempt to answer these questions. The benefits to humankind are enormous since all things eventually harken back to the gene.

REFERENCES:
NCHGR Office of Communication, NIH 91-3190.

AUTHOR
Virginia P. Johnson, MD, is Professor, Medical Genetics, Depts. of OB/GYN, Pediatrics and Laboratory Medicine, USD School of Medicine, Vermillion, SD.

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**Director**
**Physician Assistant Program**

**POSITION**
The University of South Dakota School of Medicine is seeking an individual to fill the joint position—Director of the Physician Assistant Program and Medical Director of the Physician Assistant Program. The program will be located at Yankton, South Dakota.

**RESPONSIBILITIES**
The Director of the Physician Assistant Program will be responsible for administering the program developing, implementing and directing the curriculum. The director will be active in securing faculty, achieving and maintaining accreditation and recruiting students. The director will serve as the representative for the program at appropriate meetings. The director will also be responsible for interacting with the Nurse Practitioner Program at South Dakota State University and providing medical direction as requested. The director must support the mission of the University of South Dakota School of Medicine. The director will report directly to the Dean of Health Sciences.

**QUALIFICATIONS**
The candidate must have an MD degree from an LCME accredited medical school, board certification in family practice, a valid license to practice medicine in the United States and be licensable in South Dakota, and be willing to travel often and throughout South Dakota. Candidates must have demonstrated good communication skills with colleagues, students, the public and other health professionals.

Preference will be given to candidates who have experience with physician assistant educational programs, experience working with physician assistants, experience in rural health, and experience on the faculty of a medical school.

**SALARY/COMPENSATION**
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**APPLICATION PROCEDURES**
Send a current curriculum vitae and three (3) letters of reference to:
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University of South Dakota School of Medicine
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Preference for applications received by July 15, 1992.
As my thoughts continued with concern about this line, I began to realize that another statement may actually better describe the situation: the more collaborative thought that "We are all in this together."

Throughout my lifetime, I have never become particularly focused on a single issue, but I have attempted to maintain a commitment to several worthy causes simultaneously. It is doubtful that the effectiveness was always satisfactory...in fact a more focused individual could undoubtedly have accomplished more.

A moment of enlightenment for me was the realization that nearly all of these important causes in my life have gradually blended together to become a single focus. This occurred partially by the similarity of mission and partially by the cross-over of individuals who were equally committed.

As health care providers and spouses, we do not have to always draw a line in our lives. We can join with others in our communities and in our professions to underscore that..."We are all in this together." Responsibility belongs to all of us and collectively we will accept it. We can become financial supporters and benefactors of the arts and various social service agencies. We can become informed and active participants in the political process. We can make our talents and skills available to assist as leaders and followers in community service ventures. We are all in this together. 

At a recent meeting of a non-profit board of directors on which I serve, a rather frustrated board member asked the somewhat rhetorical question..."Where do we draw the line?" His concern dealt with the difficulties of providing services while being faced with diminishing resources.

The question has echoed in my head for several days. Perhaps, it is because I know it is being asked in so many different situations and by many different people. In our medically related lives we consistently deal with this question as well. Just "where do we draw the line" with...health care costs, health care provisions to employees, delivery of health care to the under-insured, and providing health care to the rural areas of the state.

If someone could easily tell us where to draw the line, it would already be drawn. It probably would not be a straight line either, but rather it would be a line that zigs and zags as an attempt is made to meet many needs in a variety of ways. In fact, that line need never become a clearly defined division, and may be more like a membrane that allows movement back and forth from one situation to another.
Soon, your practice could be run from here.

Most people agree that the U.S. health care system needs significant change. And if a single-payor, national system is adopted, it will change.

Some proposals under consideration would put the government in charge of America's health care. That kind of radical change could affect your freedom to make decisions in administering patient care. It could affect the way you're compensated. And how you use medical technology.

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American Medical Association

Physicians dedicated to the health of America
The following South Dakota family practice physicians have completed continuing medical education requirements to retain active membership in the American Academy of Family Physicians, the national association of family doctors: Drs David J. Halliday, Jr, Custer; Arthur P. Reding, Marion; Lonnie Waltner, Bridgewater; Mark P. Mogen, Aberdeen; Kathy Wimmer, Miller; Buron O. Lindbloom, Pierre; Michael W. Justice, Dell Rapids; G. Robert Bell, DeSmet; Lambert W. Holland, John B. Jones, and Gary P. Van Ert, Chamberlain; Mark Belyea, Huron; Victoria L. Andersen, Hot Springs; Kevin L. Bjordahl, Webster Harold J. Fletcher, Yankton. The requirements call for members to complete a minimum of 150 hours of accredited continuing medical study every three years.

Robert E. McWhirter, MD, orthopaedic surgeon from Mitchell, attended the Campbell Clinic Orthopaedic Symposium, in Scottsdale, Arizona. The course involved a complete review of current techniques in orthopaedic surgery.

Dr Sandro Visani, a Mitchell urologist, has recently returned home after spending a month in Saint Lucia, an island in the Caribbean, where he volunteered his medical services at a hospital that was "somewhat primitive". He said that "the equipment, supplies and ancillary services were definitely quite a bit less than what we're used to having here. Over here, things that I could do very easily with virtually no risk there became major undertakings. But I was still able to help a lot of people."

Dr Visani and his wife, Brenda, stayed in rooms provided them at the hospital which were also very primitive. They had hot water about 3 or 4 days a month and there were lots of lizards.

Pierre physician, Dr Brent Lindbloom, has successfully complete the requirement for board certification in OB/GYN. Dr Lindbloom completed an OB/GYN residency in Yankton and has been in practice in Pierre since 1989.

John D. Barker, Jr, MD, a Sioux Falls internist and gastroenterologist, assumed office as Governor for the South Dakota Chapter of the American College of Physicians (ACP) during the College's 73rd Annual Session in San Diego. He was elected by ACP member internists in the South Dakota Chapter. ACP is the nation's largest medical specialty society. Dr Barker is in private practice in Sioux Falls and is clinical professor of Internal Medicine at the University of South Dakota Medical School.

Board certified internal medicine specialist, David T. Malters, MD of Mitchell, recently completed a pediatric medicine review course in Minneapolis. The course was designed to study various aspects of the elderly population.

Mike Davies, MD, internal medicine physician at Fort Meade VA Medical Center, has been appointed acting chief of Rehabilitation Medicine Service. Dr Davies, a Bridgewater native, is board certified in internal medicine.

Dr Eberhard H. Heinrichs, 65, died May 10, 1992, in Dakota Hospital, Vermillion. Dr Heinrichs was born November 22, 1926, in Berlin, Germany. He was a medic in the German navy during World War II. He received his medical degree at the University of Goettingen, Germany in 1953 and moved to the United States in 1957. He became a United States citizen in 1963, and then served as a pediatric specialist at Bartron Clinic in Watertown from 1961 to 1977. He moved to Vermillion in 1977, and was the physician for the Coyote football team, director of Student Health at the University of South Dakota and professor of pediatrics, adolescents and family medicine at the University. He was affiliated with Dakota Hospital in Vermillion and Sacred Heart Hospital in Yankton.

Dr Heinrichs was a member of the American Medical Association, the American Academy of Pediatrics, and the South Dakota State Medical Association (SDSMA). He received the Distinguished Service Award in 1977, from SDSMA, the Larry Annis Award in 1984 and the Rotarian Paul Harris Award in 1989. He was an active member of Vermillion Child Protection Team and St. Paul's Episcopal Church.

He married Josephine Simmons Kahler in 1985 in Vermillion.

Survivors include his wife; one daughter, Kristinn Heinrichs of Charlottesville, VA; one stepson, Daniel Kahler at home; two stepdaughters: Jennifer Kahler and Jeanette Kahler, both at home; one brother, Gunther of Aachen, Germany; and one sister, Gisela Schunerman of Hamburg, Germany.
Dr Brooks Ranney, Yankton, is writing a brief history of the Yankton District Medical Society, dating from the beginning of the territory (1861) and ending in 1950. Dr Ranney, a long-time physician in Yankton, specializes in obstetrics and gynecology.

The American Medical Directors Association, the professional association representing long term care physicians, recognized the charter group of Certified Medical Directors of a Long Term Care Facility (CMD) at its 15th Annual Symposium in Denver. David Smith, MD, of Yankton, was one of four people who received special recognition for their ongoing contributions to the development of the Certification Program.
The following physicians recently began practicing medicine in South Dakota.

**Howard O. Thompson, MD, Sioux Falls**, is a maternal/fetal medicine specialist. He received his medical degree from the Medical College of Wisconsin, in 1984 and he completed his OB/GYN residency at Providence Hospital in Southfield, Michigan, in 1988. He completed a maternal/fetal medicine fellowship at the University of Rochester, New York, in 1990. In addition to the practice of his specialty, Dr. Thompson will continue his research on the importance of environmental factors and the developing baby and be involved in medical education with USDSM. He will practice as a perinatologist with University Physicians, Sioux Falls.

*****

**Lonnie J. Nedved, MD, Mitchell**, is an obstetrician and gynecologist. He received his medical degree from Creighton University in Omaha, in 1981, and completed his obstetrics and gynecology internship and residency at the David Grant Medical Center at Travis Air Force Base in California, in 1985. He has joined the Dakota Women's Clinic, in Mitchell.

*****

**Mary Watson, MD, Canton**, specializes in family practice. She received her medical degree from the USD School of Medicine, in 1986, and completed a pathology residency at Sioux Valley Hospital, in Sioux Falls, in 1990, and also completed a family practice residency. She has joined Canton Family Physicians, Ltd.

*****

**Daniel J. Megard, MD**, specializes in internal medicine, in Yankton. He received his medical degree from the USD School of Medicine, in 1988, and completed his internal medicine residency in 1991. He has joined the Yankton Medical Clinic, PC.

*****

**Riyad Mohama, MD, Sioux Falls**, is a specialist in internal medicine and cardiology. He received his medical degree from University of Damascus, Syria, School of Medicine, in 1977. He completed a residency in internal medicine at Georgetown University Medical Service at the District of Columbia General Hospital, Washington, DC; a fellowship in cardiology and a fellowship in nuclear cardiology at Deborah Heart & Lung Center, Browns Mills, New Jersey; a fellowship in electrophysiology and ablation therapy at University of British Columbia Hospital, Vancouver, B.C., Canada. Dr. Mohama has joined the USD School of Medicine in the Cardiology Section of the Department of Internal Medicine.

*******

**Barry Smith, MD, Deadwood**, specializes in family practice. He received his medical degree from Tufts University School of Medicine, Boston, in 1975. He completed a residency at the University of Iowa Hospital, in 1976, and took an aerospace medicine course while in the Air Force. He has joined the Black Hills Medical Center.

*******

**John C. Schwartz, MD**, is a radiologist in Watertown. He completed his medical degree, in 1978, at St. Louis University School of Medicine in St. Louis, Missouri. He completed his residency in diagnostic radiology at St. Louis University School of Medicine, in 1982, and Balboa Naval Hospital, San Diego, California, in 1986. He completed a fellowship in nuclear medicine at Bethesda Naval Hospital, Bethesda, Maryland, in 1984. He has joined Diagnostic Medical Imaging, PC.

*******

**H. Ouranos, MD, Gettysburg**, is a family practice physician. He received his medical degree from the University of Tehran School of Medicine, in 1968. He came to the United States, in 1972, and completed his internship and residency, in 1977, at Mount Sinai Hospital Medical Center, Chicago. He has joined the Gettysburg Medical Center.

*******

**Dionisio Ramirez, MD, Hoven**, is in general practice. He received his medical degree from the University of Santo Tomas, in Manila, in 1960. He emigrated to the United States, in 1964, and completed a rotating internship at St. Joseph Hospital in Paterson, New Jersey, in 1965. He has joined the medical clinic in Hoven.
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JUNE 1992
Future Meetings

July
22nd Annual Sports Medicine Symposium, Sheraton Hotel, Atlantic Beach, NC, July 3-5. Fee: $75. 6 hrs AAFP & AMA Category 1 credit. Contact: Alan Skipper, North Carolina Medical Society, PO Box 27167, Raleigh, NC 27611. Phone: (919) 833-3836.


Advanced Laparoscopy Course, Creighton Univ, Omaha, NE, July 24-25. Contact: Sally C. O’Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

August
Basic Laparoscopy Course, Creighton Univ, Omaha, NE, Aug 14-15. Contact: Sally C. O’Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.


September

American College of Physicians South Dakota Scientific Meeting, Holiday Inn, Brookings, SD, Sept 10-12. Fee: TBA. CME: TBA. Contact: John D. Barker, MD, 111 W 39th St, Sioux Falls, SD 57105-5794. Phone: (605) 331-4050.


Advanced Laparoscopy Course, Creighton Univ, Omaha, NE, Sept 18-19. Contact: Sally C. O’Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Emergency Medicine Review, Univ of Neb, Omaha, NE, Sept 21-26. Contact: Center for CME, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

November
60th Annual Postgraduate Assembly, Omaha Mid-West Clinical Society, Red Lion Hotel, Omaha, NE, Nov 5-7. Contact: Lorraine Seibcl, Exec Sec, Omaha Mid-West Clinical Society, 7389 Pacific St, #229, Omaha, NE 68114. Phone: (402) 397-1443.

January

The AMA Financing & Practice Services and the AMA Investment Advisers are offering workshops throughout the summer (April - September) to help you with personal or business financial problems and decisions. Call the AMA (800) 366-6968 for more information on these meetings. The names of the meetings and the fees are:

- Financial Strategies for Successful Retirement - $275;
- Gearing Up for Retirement - $275;
- Successful Money Management - $275; Starting Your Practice - $335; Joining a Partnership or Group Practice - $160;
- Insurance Processing and Coding - $195; ICD-9 Coding for Doctors' Offices - $195; CPT Coding for Doctors' Offices - $140;
- Medical Collections Management - $140; The Business Side of Medicine - $195.

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NEXT MONTH

Transactions of the South Dakota State Medical Association 111th Annual Meeting, June 4-6.

About the Cover

The Cleopatra Mine was reached in 1951 by hiking up Squaw Creek in the Northern Black Hills. This painting was done from a sketch the artist made sitting on the bank of the creek and looking up. The building was deteriorating, but still entirely standing. The machinery inside was immense and impressive. Below on level ground remains of dwelling places could still be seen. It was a place to wander and consider the courage and perseverance of the early entrepreneurs of the Hills.

The artist is Jean Bailey of rural Brandon, SD. Her work is represented by the Dakota Galleries in Sioux Falls.
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The primary purpose of the South Dakota Medical School Endowment Association is to provide low interest (6%) loans to medical students who are attending the University of South Dakota School of Medicine. In the past few years we have increased available loan money from $35,000 to $70,000 for 1992-93. Student needs are increasing each year, reflected by the increase in the number of loans from 35 to nearly 60. More contributions are needed to ensure continued growth in our loan assistance.

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All contributions are used to provide loans to South Dakota’s medical students unless you specify otherwise.

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Odontoid Fracture in the Elderly: A Case Report of the Screw Fixation Technique

Wilson T. Asfora, MD, Thomas W. Free, DO, Jorge H. Johnson, MD

ABSTRACT

The case of a type II, highly unstable, odontoid fracture in a 92 year old patient is reported. This fracture was treated by a new technique for anterior odontoid screw fixation with excellent results. The authors discuss this technique and treatment options for odontoid fracture in the elderly.

INTRODUCTION

Treatment of type II odontoid fractures in the elderly is often problematic. External immobilization, such as a Halo vest, is not well tolerated in the elderly population, and is associated with a very high non-union rate, up to 100%\(^1\) in some reported series. The surgical technique most frequently employed has been posterior wiring and fusion between the arch of C1 and C2, sometimes involving the occiput or C3 if the posterior arch of C1 or C2 is also fractured. Although results of this operative technique have shown a high degree of successful union, especially when coupled with an additional period of external immobilization,\(^2\) the disadvantage of using this approach is that it is associated with a high morbidity and mortality rate in the elderly.\(^3,4\) It also eliminates the normal rotatory motion between C1 and C2.\(^2,5\) We have recently treated a 92 year old patient with type II odontoid fracture by placing a fixation screw directly across the fracture site. This proved to be an effective and expeditious procedure, was very well tolerated by the patient, provided immediate stabilization obviating the need for halo immobilization, and spared the normal rotation between C1 and C2.

CASE REPORT

This 92 year old man was transferred to our institution after sustaining a hyperextension injury to his neck. He apparently had fallen down some stairs at his nursing home while in a wheelchair. His past history was positive for a previous right hemispheric stroke, organic brain syndrome, prostatic carcinoma, and atherosclerotic heart disease. He was on numerous medications. His physical examination revealed a forehead laceration which had been sutured; marked cognitive impairment; no motor or sensory deficits; and deep tendon reflexes slightly brisker on the left side, probably related to his old stroke.

Cervical spine x-ray (Figure 1) revealed a totally, posteriorly displaced type II odontoid fracture associated with fracture of the posterior arch of C1.

The patient was placed in cervical traction (five pounds) and the fracture was successfully reduced. Treatment options were discussed with the patient’s family and it was decided to proceed with anterior screw fixation of the odontoid. This procedure was done uneventfully, using Apfelbaum’s technique\(^6\) and instruments. During surgery two C-arm fluoroscopic units were used for simultaneous anteroposterior and lateral imaging to monitor screw insertion. The screw entry site was at

![Figure 1](https://example.com/figure1.jpg)

Lateral cervical spine x-ray shows a fracture across the base of the odontoid (type II). The dens appears to be located completely posterior to the body of C2. There is also an associated bilateral fracture of the posterior arch of C1 which is displaced upwards.
the anterior-inferior margin of C2, and the screw was advanced across the fracture and extended through the cortex at the tip of the odontoid to obtain cortical purchase by the threads of this lag screw. Following screw placement, flexion and extension views of the cervical spine observed under lateral fluoroscopy revealed no movement of the odontoid, confirming immediate stability. The postoperative cervical spine films were satisfactory (Figures 2A & 2B). In view of this patient's organic brain syndrome and for added safety, we decided to keep him in a Philadelphia collar postoperatively. The patient did well and was discharged back to his nursing home three days postsurgery. At follow-up three months later, the patient was doing very well and cervical spine x-rays revealed satisfactory fusion of the odontoid.

**DISCUSSION**

The most widely accepted classification of odontoid fractures was proposed by Anderson and D'Alonso based on the anatomical level and configuration of the fracture. They classified the fractures as type I, type II, and type III, where type I fractures present as an oblique fracture of the tip of the dens; type II fractures are through the odontoid base; type III fractures extend through the body of C2.

Odontoid fractures occur in 10 to 15% of all cervical spine injuries in adults and compose 75% of cervical spine injuries in children. Type II fractures are the most common in both groups, comprising at least two-thirds of all odontoid fractures.

A type I odontoid fracture is a very rare injury, is a stable fracture and frequently heals without any specific treatment. Type III fractures, in view of the relatively broad cancellous surface of this fracture, is generally treated by cervical immobilization with a high union rate. Type II odontoid fractures, however, frequently fail to heal in patients treated by external neck immobilization. Factors that contribute to this high nonunion rate are disruption of the precarious blood supply of the odontoid, marked instability with free-floating of
the fractured odontoid, and limited contact between the two cancellous surfaces of the fracture. Apuzzo, et al found that if displacement is greater than 4 mm, the nonunion rate could be up to 88% versus 16% for nondisplaced fractures. In patients over 65 years old nonunion has been reported to be very high, while younger patients fared much better. Overall, nonunion rates have varied from 710 to 100% in reported series. Prolonged skeletal traction in the aged is complicated by an unacceptable incidence of respiratory insufficiency, pneumonia, or both.11 Braakman and Penning12 also noted that elderly patients were often restless and confused during prolonged bed rest and did not tolerate plaster immobilization. They reported that five out of eight elderly patients treated with plaster immobilization and bed rest died. Halo apparatus is currently the best external orthosis, but it is always difficult to fit and maintain the jacket on an elderly patient. Special factors to be considered are impaired respiratory function in a snug fitting vest, frequent presence of a prominent dorsal kyphosis, frailty and difficulty ambulating in a cumbersome device.1111

Posterior wiring and fusion of C1 and C2 has been the operative procedure most commonly employed for either early intervention or failure to achieve bony union with external immobilization. However, this procedure carries a high morbidity and mortality in the elderly and debilitated patients. This approach eliminates the normal rotatory motion and flexion-extension between C1 and C2 (more than half of the normal axial rotation of the spine is between C1 and C2). If a concomitant C1 fracture is present, as in our patient, fusion should include the occiput and this would further limit neck flexion and rotation. This procedure also requires a postsurgical period of additional external immobilization.

Anterior screw fixation of the odontoid was first described by Europeans. Their approach, however, often involved a rather extensive neck dissection. Geisler modified the European approach and this was further refined by Apfelbaum. Dr Apfelbaum developed new instrumentation which simplified the procedure greatly, making it quick and safe. He states he has obtained satisfactory stabilization in his patient with no late failures or surgical complications.

CONCLUSION
In the elderly patient who is not able to tolerate prolonged bed rest, Halo vest, or a posterior fusion, anterior screw fixation of the odontoid appears to be the procedure of choice for treatment of type II odontoid fracture. It carries less morbidity, provides immediate stabilization without the need for external fixation, restores normal spinal biomechanics sparing normal rotation between C1 and C2, and the patients have brief hospitalizations. It is a technique which may also be considered in any case where the odontoid is displaced more than 4 mm, or when the patient is unwilling or unable to accept external immobilization.

ACKNOWLEDGEMENTS
Dr R I Apfelbaum (professor of Neurosurgery, University of Utah Medical Center, Salt Lake City, Utah) for the use of his set of prototype instruments for this procedure. Mr A Hutchinson, (Mid-West Aesculap representative), for arranging delivery of the instruments required for this procedure. Ms R Moffet for the typing of this manuscript.

REFERENCES

AUTHORS
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Thomas W. Free, DO; Section of Neuroradiology, Sioux Valley Hospital, USD School of Medicine, Sioux Falls, SD.
Jorge H. Johnson, MD: Assistant Professor, Section of Neurosurgery, USD of School of Medicine, Sioux Falls, SD.
Medical Record Discharge Summary

South Dakota Foundation for Medical Care offers this as a suggested format for a medical record discharge summary.

A discharge summary is a conclusion made of the patient’s hospital stay.

The summary includes the provisional diagnosis or reasons for the admission, the principal and secondary diagnosis, a final progress note, and when appropriate, the autopsy report.

The summary includes all relevant diagnoses established by the time of discharge as well as all operative procedures performed.

The summary includes the recapitulation of the reasons for the hospitalization, the significant findings, including laboratory and x-ray, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient/family. Consideration should be given to instructions relating to physical activity, medication, diet, disposition, and follow-up care. Lab work still awaiting report at the time of discharge should be noted as well as any unstable conditions present at discharge.

Often times physicians consider a final progress note substituting for the discharge summary when there is a brief hospital stay of less than 48 hours. Whether a progress note or a discharge summary is used, the patient’s medical record should include the physician’s impression of the patient’s response to treatment.

Your suggestions are always appreciated. If SDFMC can provide further information, please let the Foundation know.
An association, according to what I learned at the National Leadership Conference, is described as a group of people who voluntarily come together to solve common problems, meet common needs and accomplish common goals. An effective association is one that recognizes and focuses on the common self-interests of its members.

These goals can be met only with active volunteerism, especially in a nonprofit organization such as ours. My goal this year is to stimulate interest by those who up to now, either have not been motivated, feel that others will watch out for their well being or feel it is not important until it’s too late. When a physician accepts an appointment to a commission, a board, or office, he or she should at a minimum attend the meetings.

Any constructive ideas will not only be readily accepted but also gratefully appreciated. I feel that any constructive criticism should be accompanied by an alternative solution.

Volunteers are the foundation of this association. The more volunteers and the wider the involvement can only lead to success in removing the obstacles which interfere with our common interests.

Nonprofits used to say, "we don't pay volunteers so we cannot make demands upon them". Now they say, "volunteers must get far greater satisfaction from their accomplishments and make a greater contribution precisely because they do not get a paycheck". This is a quote from the Harvard Business Review.
Correspondence

To our dear friends of the SDSMA and Spouses!

We want you to know how much it means to us to be a part of your annual meetings! It is like "going home" to be with family! When we look out at a room where you are gathered, we feel the energizing and validating power of your positive feelings! Without the support of "family" it would be impossible to "keep on keepin' on" as we spread fun and laughter and try to be good P.R. for organized medicine and more specifically for the people who are organized medicine!

Thank you for being behind us! We count on it!

If you've been "moved" by this letter, send your donations to...! Just Kiddin'!

Love
Mollie O. and other TRASH

The very attractive 50 year plaque and pin were forwarded from my Sioux Falls address to my summer address on Bad Medicine Lake (what a name for an MD's address) near Itasca Park in Northern Minnesota. I wish to thank the South Dakota State Medical Association for the plaque and pin and for the recognition of the 50 years that I have been licensed. However, because of a hip problem, I have had less than half that time in active practice.

I thank you for your letter and wish you the best for the future.

Sincerely,
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Once is Not Enough
Rational Use of the Blood Culture

The demonstration of microorganisms in the bloodstream (bacteremia) is an excellent indicator of the cause of infectious disease and serves as a significant prognostic factor and guide to therapy. However, we must understand how to effectively procure blood cultures and how to utilize the information we obtain.

Since the commonly used blood culture methods will detect rapidly growing bacteria and fungi, we will include the latter in the definition of bacteremia realizing that many fastidious bacteria, viruses, and other microorganisms require special methods for isolation or cannot be detected.

We will also define a blood culture as a single venipuncture regardless of how many tubes, bottles, or plates are inoculated. We will confine ourselves to the practical questions of how many blood cultures to obtain, and when, and not discuss the many excellent techniques.

If we are going to suggest guidelines, we must convince the reader of the rationale. The first ground rule is, if possible, obtain blood cultures before empiric antimicrobial therapy is administered.

The second ground rule is obtain more than one blood culture which means between 2 and 4 usually. Once is not enough, but why?

There are three categories of bacteremia:

a) Transient bacteremia - this may be clinically significant but is usually benign and self limited, and occurs when a colonized area is manipulated as during endoscopy or during dental procedures. We are usually not interested in detecting transient bacteremia.

b) Intermittent bacteremia - this form occurs in severe localized infections such as pneumonia, meningitis, or genitourinary tract infections. The bloodstream is seeded periodically but bacteria are not continuously detectable. This is quite common.

c) Continuous bacteremia - seen in intravascular infection such as endocarditis.

The obvious point is that in order to detect intermittent bacteremia more than one blood culture would often be required. However, it has been shown that more than one culture (2 or 3) are usually necessary to give best yield for detection of continuous bacteremia as well.

In addition, the percentage of positive blood cultures increases with the volume of blood drawn up to 30 to 40 ml in adults. Since the volume of tubes or bottles is often about 5 or 10 cc, more than one culture is often necessary to reach the desired volume even if more than one tube is drawn at a single venipuncture.

There is one more reason to draw more than one blood culture and it concerns the interpretation as to whether an organism isolated from the blood is clinically significant or a contaminant. Certain organisms such as Escherichia Coli or beta hemolytic Streptococcus are almost always clinically significant pathogens. However, there has been a rise in incidence of bacteremias due to Staphylococcus albus or aureus. These are also common skin flora and can be contaminants. If any organism is isolated from more than one blood culture, it is less likely to be a contaminant.

The timing or interval between cultures would seem to be important but there is no good data to determine the desired interval between blood cultures so the interval used in the guidelines will be determined on clinical urgency.

Guidelines For Obtaining Blood Cultures

1) Acute infections: (bacterial pneumonia, meningitis, or suspected septicemia from an unknown focus). Immediately obtain two separate blood cultures (separate venipunctures) before starting empiric antimicrobial therapy.

2) Fever of unknown origin in an otherwise stable patient: Obtain two blood cultures over several hours. If after 1 or 2 days of incubation, these cultures are negative and the patient’s clinical status continues to suggest an infectious etiology, then obtain two more blood cultures. If these remain negative, then bacteremia is unlikely.

3) Acute infective endocarditis: Obtain three blood cultures during the first hour or two and begin empiric antimicrobial therapy.

4) Subacute infective endocarditis: Obtain three blood cultures during the first 24 hours. If these remain negative after 2 days of incubation, then obtain 2 or 3 more blood cultures.

5) Suspected infective endocarditis in patients who have received prior antimicrobial therapy during the weeks immediately preceding evaluation: Obtain 2 to 3 blood cultures on the first day of evaluation. If these remain negative, obtain 2 or 3 additional cultures daily on the second and third days of evaluation.

John F. Barlow, MD
Editor

REFERENCE

MARGARET WILSON RECEIVED HER DOCTOR'S BILL TODAY. AND SHE'LL PAY IT...JUST AS SOON AS SHE FIGURES IT OUT.

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REFERENCES: Should be listed in the order in which they appear in the article and should not be more than 20. They should be complete and accurate and include the authors' names and initials, title of article, abbreviated name of Journal, volume number, pages and year of publication. References to books should include authors, title, location and name of publisher, year of publication, edition and page numbers.

ILLUSTRATIONS: Satisfactory photographs or drawings should be supplied by the author. Each illustration, table, etc., should bear the author's name on the back. Photographs should be clear and distinct 5"x7" glossy prints. Drawings should be made in black India ink on white paper. Used illustrations are returned after publication if requested.

The contact person at the Journal office is Jeri Spars, (605) 336-1965.
At the 1992 South Dakota State Medical Association and Auxiliary annual meeting in Rapid City, we were privileged to combine a fund-raising event for AMA-ERF with a tribute to a wonderful auxiliary leader, Virginia Stoltz. Virginia, as a district, state, and national auxiliary president, has long been a proponent for support for medical education and is extremely deserving of the recognition.

As members of the South Dakota State Medical Association Auxiliary, we have been fortunate to have had the wonderful leadership of individuals such as Virginia and Bertie Van Demark. They have been energetic workers, visionary leaders and loyal supporters of the Auxiliary and its goals. Each of these women have served tirelessly on committees at all levels of the organization and continue to encourage and enable current leadership.

In addition, both Virginia and Bertie have been responsive to needs in their own communities. Virginia has expended a great deal of creativity and energy in promotion of the arts, specifically theater, in Watertown. She also entered the political arena and served on the Watertown Board of Education. Her vision included the promotion and building of the Watertown community swimming pool. Although the focus on family violence has only recently become a highly visible issue for the American Medical Association Auxiliary, Bertie had the foresight to work toward intervention and prevention of domestic violence nearly two decades ago, as she persevered to enable parents to become more effective and to provide shelter for victims of domestic violence. The Children's Inn was part of that vision and has now become an integral part of the social service agencies in Sioux Falls.

How appropriate that their dedication, commitment and effort resulted in a visible structure in the two communities. In just that same way, Virginia and Bertie have become symbols of leadership in Auxiliary. It is their presence and support that enables each of us to reach a little farther and work a little longer.

In her inaugural address in Chicago on June 19, 1963, Virginia stated, "Few of us are leaders of high competence, but each one has a potential for growth and development, especially if we will take advantage of high caliber leadership and stretch the resources of mind and heart." That statement still rings true. Virginia and Bertie, you have provided that high caliber leadership. We will stretch our personal resources of mind and heart.

Ruth Parry, President, South Dakota State Medical Association Auxiliary

JULY 1992
BC/E family practitioners, do yourself a favor and take a look at this model of what family practice is meant to be.

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JULY 1992
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Death Demands a Reason

It was 8:30 Christmas Eve many years ago when I cleaned off my desk. A card and letter were there from an appreciative medical student who had spent a month studying and observing here. The rough draft of the answer I penned that evening turned up in my files recently. Some edited excerpts from that letter (with the use of a pseudonym) are as follow:

Dear Susan:
I just left the hospital after checking a "bad coronary". I was also busy arranging the transfer of a lady with a cerebral aneurysm. The vessel later ruptured on the operating table in Sioux Falls and the patient died.

We take the good with the bad. I am thankful to be a part of the drama. A physician and surgeon must understand what is happening, what to expect, what may help, and what is useless, along with the ability to put anxious people at ease. That is the Art of Medicine.

You mention in your letter how thankful you are to have become acquainted with some Indians. The Native Americans are a people whose ancestors lived majestic lives. (I can’t think of a more adequate word.) Their complete philosophy was sharing. He who shared the most was the most. Your opportunity to get acquainted with some of the Native Americans is something to cherish.

Follow as many cases as you can to the autopsyt table. (Learn to think out of this body rather than out of a book.) You are a scholar and will be a credit to the profession.

Speaking of autopsies and sharing, a wonderfully sensible lady of immediate South German ancestry asked me to do an autopsy on her elderly bachelor brother’s body (as you know, I had completed a pathology residency at Ancker Hospital and I had no reservations about doing the examination). The man had died shortly after he had been brought to our hospital from his farm home. I found that he had died as the result of acute cholecystitis and peritonitis.

After the funeral the sister came for the result. When I told her what I had found she sat very straight, looked directly into my face, and with tears trickling down both cheeks, she said "Death Demands A Reason".

#

Rooseo Dean, MD
Wessington Springs, SD

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—NEEDED: NOMINATIONS—
In the ongoing spirit of rural health care championed by Dr Bob Hayes, an annual award will be presented to an outstanding rural health care provider.

This award will be based upon nominations citing the attributes that make that provider an exceptional health care worker. Among those features necessary to be considered for this award is a compassionate, caring nature Doc Hayes so epitomized. All health care providers in rural South Dakota from emergency care to home health to mid-level practitioners and physicians shall be eligible for this honor.

Please send letters of nomination to:
SDAPA
c/o Jan Hines, PA-C
8326 N Blucksberg Mtn Rd
Sturgis, SD 57785
by no later then September 30, 1992.
The first DR ROBERT HAYES MEMORIAL AWARD will be presented at the annual SD Rural Health Conference November 4-6.
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JULY 1992
Future Meetings

August

AO/ASIF Workshop for the Operative Treatment of Fractures, Univ of Neb, Omaha, NE, Aug 5-8. CME credits avail. Contact: Center for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

Clinical Allergy for the Practicing Physician. Ritz-Carlton Hotel, St. Louis, MO, Aug 6-8. Fee: $225. 20 hrs AMA Category 1 credit. Contact: Off of CME, Washington Univ School of Med, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

Basic Laparoscopy Course, Creighton Univ, Omaha, NE, Aug 14-15. CME credit avail. Contact: Sally O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Summer Pulmonary Symposium, Mahoney State Park, Ashland, NE, Aug 15. Fee: $25. CME credit avail. Contact: Center for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

Use of Non Steroidal Anti-inflammatory Agents in a Clinical Practice, Brookings Hospital/Brookview Manor conf room A&B, Aug 19. No fee. 1 hr AMA Category 1 credit. Contact: Phyllis Sander, Brookings Hospitals, 300 22nd Ave, Brookings, SD 57006. Phone: (605) 692-6351.

American College of Physicians South Dakota Scientific Meeting, Holiday Inn, Brookings, SD, Sept 10-12. Fee: TBA. CME: TBA. Contact: John D. Barker, Jr, MD, 111 W 39th St, Sioux Falls, SD 57105-5794. Phone: (605) 331-4050.

Recent Advances in the Management of CHF, Marriott Hotel, Omaha, NE, Sept 12. CME credit avail. Contact: Center for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

Advanced Laparoscopy Course, Creighton Univ, Omaha, NE, Sept 18-19. Contact: Sally O'Neill, Ph.D, Assoc Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.


Dealing with Parkinson's Disease: A Short Course for the Non-Neurologist, Henry Doorly Zoo, Omaha, NE, Sept 19. CME credit avail. Contact: Center for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

10th Annual Occupational Health & Safety Institute, St. Paul-Ramsey Med Ctr, St. Paul, MN, 20-30 hrs/course (16 courses) AMA Category 1 credit. Contact: Off CME, Ramsey Foundation, 640 Jackson St, St. Paul, MN 55101. Phone: (612) 221-3992.


October

Interactions Medical Staff Leadership Program, Marriott Downtown, Chicago, IL, Oct 2-3. Fee: $495. 16 hrs AMA Category 1 credit. Contact: Dept of Registration Services AB17, AMA, 515 N State St, Chicago, IL 60610-9986.

New Concepts in Diagnosis and Treatment of Vascular Disease, Marriott Hotel, Omaha, NE, Oct 9. CME credit avail. Contact: Center for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

Emergency Medicine Review, Univ of Neb Med Ctr, Omaha, NE, Oct 12-17. Fee: $700. CME credit avail. Contact: Center for Cont Educ, Univ of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5915. Phone: (800) 642-1095.


November

60th Annual Postgraduate Assembly, Red Lion Hotel, Omaha, NE, Nov 5-7. Contact: Lorraine Selbel, Exec Sec, Omaha Mid-West Clinical Society, 7389 Pacific St, #229, Omaha, NE 68114. Phone: (402) 397-1443.

South Dakota State Osteopathic Association Annual Meeting and Family Practice Update, Ramkota Inn, Pierre, SD, Nov 13-14. Fee: $100. 15 hrs AOA Category I and 14 hrs AAP credit applied for. Contact: Lorin Pankratz, PO Box 89202, Sioux Falls, SD 57105-9302. Phone: (605) 361-6004.
Published Monthly by the South Dakota State Medical Association
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Outpatient Observation

What single word has wrought the most utter confusion in today's hospitals, threatened to snap the last thread of hospital-to-medical staff communication links, and launched daily debates over whether a hospital patient is "in," "out," or just "hanging around?" Probably nothing related to Medicare has been so maligned and misunderstood as the novel concept of "observation status," born in the spring of 1989.

It was at this time that HCFA announced that there was no hourly limit to the length of time a Medicare patient could be observed as an outpatient. Heretofore unheard of, a patient could now stay in the hospital overnight and still be considered an outpatient. Furthermore — and someone forgot to tell most doctors — patients could be observed anywhere—not just in a holding area adjacent to the emergency department. So, now we can (theoretically at least) have outpatients in what used to be inpatient beds on the regular nursing floors. Even ICU, you might ask? And we can have "outpatients" at the hospital for literally days since there is no automatic limit to outpatient observation. Obviously, these "observations" are far-fetched, but not so far from some of the things we hear.

**IT IS TRUE THAT THERE IS NO HOURLY LIMIT ON HOW LONG A MEDICARE PATIENT MAY BE CONSIDERED AN OUTPATIENT. UNTIL THE PHYSICIAN FEELS CONFIDENT THAT THE PATIENT WILL LIKELY NEED MORE THAN APPROXIMATELY 24 HOURS OF HOSPITAL CARE, OBSERVATION ON AN OUTPATIENT BASIS IS APPROPRIATE TO FURTHER DETERMINE THE PATIENT'S NEEDS, INCLUDING THE POSSIBLE NEED FOR INPATIENT ADMISSION. THIS IS WHAT HCFA MEANT IN SAYING THAT PHYSICIANS SHOULD USE A "24-HOUR BENCHMARK" IN DECIDING WHETHER TO "ADMIT" A PATIENT OR TO "OBSERVE" HIM/HER ON AN OUTPATIENT BASIS.**

SECONDLY, physicians must realize that there is no distinct hospital licensure or any other requirement for "observation beds" to be so designated, or even that they be located in the same area of the hospital. All Medicare-participating hospitals can file claims for outpatient services, which is exactly what "observation" is; they can even charge for the hours (units) of observation services received, with some limitations.

One such limitation is for so-called observation following minor outpatient surgery. Observation charges by the hospital are non-covered in such instances, because hospitals are paid partially based on the global surgery package, which includes postoperative recovery. Should complications arise after outpatient surgery that are likely to require substantially more than 24 hours of hospital care—the benchmark again—then inpatient admission should be ordered.

**THIRD, hospital care is hospital care—whether it is provided to an inpatient or to an outpatient. Both patients can appropriately receive an "acute" level of care. Again, the benchmark for judging the decision to admit (or not) is generally the 24 hour expectation of care. The actual length of time an individual patient remains hospitalized does not alter the facts surrounding the admitting decision once this decision has been made. Once a patient is admitted by the physician, the patient is an inpatient, and is not switched back to outpatient status because of an unexpectedly short hospitalization.**

Note that (except for courts) non-physicians cannot make admission decisions, as only physicians are granted such authority. You should therefore be explicit when ordering inpatient admission versus outpatient services. Avoid vague orders such as "observe". Do search out and follow your hospital's protocol and use terminology that will be consistently understood by everyone in the hospital—from the patients to the nursing, admissions, billing, medical records, lab, and radiology departments, etc.

Your hospital is always available to work with you in addressing this highly misunderstood "observation status".
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NEXT MONTH

Research In Context

About the Cover
Hikers enjoy the challenge of climbing Harney Peak. It is the highest point east of the Rockies and is located in the Black Hills of South Dakota. (Photographer is D. J. Arnold. Photo courtesy of the South Dakota Department of Tourism)
BECOME A "SPONSORING" MEMBER OF THE SOUTH DAKOTA MEDICAL SCHOOL ENDOWMENT ASSOCIATION

You can be a "Sponsor" by contributing $100 or MORE in a calendar year to the Endowment Association.

Your contributions may be tax deductible and the money is very much needed to make low interest (6%) loans to medical students who are attending the University of South Dakota School of Medicine.

In the last few years the number of loans granted by the Association has increased to nearly 60 annually and the total amount loaned annually has increased from $35,000 to $70,000. This is a substantial increase which means we need more contributions.

WON'T YOU PLEASE HELP?

Send your contributions to:
South Dakota Medical School Endowment Association
1323 S. Minnesota Ave.
Sioux Falls, SD 57105
Fear of the unknown, surprised, impressed, rewarding and proud can all be used to describe how it feels to attend your first AMA convention.

Unknown, because of comments by some that the AMA is filled with old men who run the organization with outmoded, inefficient ideas and everything is cut and dried before voting takes place.

Surprised, at the amount of hard work performed by our delegates and others. The meeting started by 6:30 or 7 am and at least one reference committee went until 11 pm.

Everyone has a choice to voice an opinion in the reference committees, including outsiders. On the House floor, every delegate who wants to speak is recognized. This is true no matter how far out their ideas. The North Central Medical Conference has a very active role and seemed to be a stabilizing force throughout the meeting.

The young physicians group is also becoming an important force in determining the course of the AMA. Again, South Dakota’s representatives did a great service.

Rewarding, because you know you made a difference. One vote on an important commission was a tie with 424 votes cast. As the voting delegate on the floor at the time, it felt like South Dakota, with its lone vote, was able to determine the winner.

Becoming friends with people who are involved. These are not politicians but men and women with active practices who are willing to take their time to work for our interests. I noted that we are not alone after learning about the problems in other states.

Proud, because of the way our State Medical Association is looked to for guidance. We met with a delegation from another state that wants to start a company like DAKOTACARE, and they asked for our help because we have the only successful HMO, started by a state medical association, in the United States.

The College of Surgeons, after years of disagreement with the AMA, has once again sent its delegate to the meeting. It seems their disagreement has taken a back seat to the problems we all face. Don’t those of you who are non-members of the AMA think you should also forget your differences and make the AMA, which is really our only force, stronger and even more effective.

#
The Mithradates Mandate: Know Thy Pharmacopoeia

Mithradates was an ancient king, a contemporary of Julius Ceasar. He was, apparently, very interested in the subject of poisoning and antidotes. His studies were part of early progress to separate medicine from magic and religion.1 The poet, A. E. Housman, suggests that Mithradates lived in a time when kings were frequently poisoned to death, and that to avert this possibility, Mithradates reputedly developed a tolerance for poisons by taking them in very small, but gradually greater, quantities. Housman describes Mithradates' enemics thusly:

They put arsenic in his meat
And stared aghast to watch him eat;
They poured stychnine in his cup
And shook to see him drink it up;
They shook, they stared as white's their shirt;
Then it was their poison hurt.2

Mithradates' fascination with chemicals and poisons render him a fitting personage to lend his name to the "mandate" alluded to in the title of this essay (i.e. the mandate to know the benefits and toxicities of drug therapies). Today's pharmacists have the potential for achieving remarkable benefit, as well as, for causing serious morbidity.

Such meandering reflections are intended to herald the principle intent of this editorial—the introduction of a new monthly column in the Journal, "Pharmacology Focus". Surely, one of our most difficult tasks in medicine is understanding the uses and side effects of the large array of drugs we possess in our medical armamentarium. Unfortunately, studies have shown that mistakes are easily, and frequently, made with drug prescribing. Problems can include errors in dosage, failure to recognize drug interactions, inadequate length of therapies, and inappropriate drug usage.3 As an example of the potential magnitude of this problem, Soumerai and Ross-Degnan note that 30% of drugs used in pediatrie patients are antibiotics, and that one-half of antibiotic usage may be inappropriate (based on clinical and economic criteria).4

It is our hope that the essays presented in "Pharmacology Focus" will prove helpful to the practicing physician who is constantly immersed in the urgencies and complexities of drug therapy. Future columns will be written by faculty members of the College of Pharmacy at South Dakota State University. The pieces will be brief and clinically based, and will cover topics such as the therapeutic monitoring of drugs, reviews of classes of drugs, and perspectives on new pharmacologic agents.

The Department of Clinical Pharmacy at SDSU has eleven faculty members, all of whom have doctorates in Pharmacology. Most Pharm.Ds are clinical pharmacists and experts in information-oriented activities, such as the teaching of health professionals, patient teaching, and the monitoring of patients on certain pharmaceuticals. Generally, a Pharm.D has either taken two to three postgraduate years of study following a five year Bachelor of Science degree, or has enrolled directly at the college level in a six to seven year degree program. In addition, Pharm.Ds usually take an additional residency year of training following their college study if they intend to be active participants in the clinical realm. Pharm.Ds, as well as their clinical pharmacy colleagues with B.S. degrees, generally spend much more of their time on patient care units interacting directly with physicians, nurses and patients than in the pharmacy itself. As both a medical student and a resident, I had the good fortune to be at institutions which had well developed Pharm.D programs. Thus, I have had the advantage of learning firsthand, and over a number of years, the extraordinary assistance which the clinical pharmacist can render to the physician.

The first essay in this series is written by Dr Brian Kaatz who is an associate professor and head of the Department of Clinical Pharmacy at SDSU. He will be helping to coordinate and edit future essays. Ultimately, it is hoped that this monthly column will assist all of us in our observance of the "Mithradates Mandate", to optimally use the range of drugs at our disposal.

Jerome W. Freeman, MD
Editor

REFERENCES
**Transactions Of The South Dakota State Medical Association**

**111th Annual Meeting**

**June 4-6, 1992**

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<td>James Hovland, MD</td>
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<td>Second District (Watertown)</td>
<td>James Larson, MD</td>
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<td>Third District (Brookings-Madison)</td>
<td>Curtis Wait, MD</td>
<td>Brookings</td>
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<td>Fourth District (Pierre)</td>
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**Eighth District (Yankton)**

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<td>Larry Meyer, MD</td>
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<td>Bruce Mannes, MD</td>
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<td>Carol Ziciike, MD</td>
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<td>Stephen Haas, MD</td>
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<td>Richard Renka, MD</td>
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<td>John Malm, MD</td>
<td>Gregory</td>
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<td>James D. Collins, MD</td>
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<tr>
<td>Kevin Bjordahl, MD</td>
<td>Webster</td>
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**ALTERNATE COUNCILORS**

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<tr>
<th>District</th>
<th>Name</th>
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<tr>
<td>First District (Aberdeen)</td>
<td>David Seaman, MD</td>
<td>Aberdeen</td>
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<td>(1993)</td>
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<td>Second District (Watertown)</td>
<td>Stephen Gehring, MD</td>
<td>Watertown</td>
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<td>Third District (Brookings-Madison)</td>
<td>Richard Holm, MD</td>
<td>Brookings</td>
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<td>Fourth District (Pierre)</td>
<td>Thomas Huber, MD</td>
<td>Pierre</td>
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<td>Fifth District (Huron)</td>
<td>Jeffrey Hanson, MD</td>
<td>Huron</td>
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<td>Sixth District (Mitchell)</td>
<td>James Gaede, MD</td>
<td>Mitchell</td>
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<td>Seventh District (Sioux Falls)</td>
<td>Loren Tschetter, MD</td>
<td>Sioux Falls</td>
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<td>D. G. Ortmie, MD</td>
<td>Sioux Falls</td>
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<td>Lawrence Finney, MD</td>
<td>Sioux Falls</td>
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AUGUST 1992
Eighth District (Yankton)
Julie Stevens, MD (1995) ................ Vermillion
Robert Thompson, MD (1994) ............... Yankton

Ninth District (Black Hills)
Dave Johnson, MD (1994) ................ Rapid City
Craig Hansen, MD (1995) ................ Rapid City
John Barlow, MD (1993) ................ Rapid City
Tenth District (Roscud)

Eleventh District (Northwest)
James Wunder, MD (1994) ................ Mobridge (1993)

Twelfth District (Whetstone Valley)
Alan Bloom, MD (1994) ................ Webster (1993)

1992-1993 COMMISSIONS

COMMISSION ON LEGISLATION AND GOVERNMENTAL RELATIONS
Melvin Thomas, MD (1993) Sioux Falls, Chairman
Gary Bruning, DO (1993) Flandreau
Richard Smith, DO (1993) Huron
Catherine Gerrish, MD (1993) Watertown
Jean Gerber, MD (1993) Aberdeen
John Sall, MD (1994) Sioux Falls
Laura Larsen, MD (1994) Sioux Falls
James Wiggs, MD (1994) Yankton
John Barlow, MD (1994) Rapid City
Patricia Malters, MD (1994) Mitchell
O. Myron Jerde, MD (1995) Rapid City
Vance Thompson, MD (1995) Sioux Falls
J. Michael McMillin, MD (1995) Sioux Falls
Steven Feeney, MD (1995) Watertown
Thomas Olson, MD (1995) Vermillion
Annie Wiggs, Auxiliary
Chuck Rose, Clinic Manager

COMMISSION ON INTERNAL AFFAIRS,
COMMUNICATIONS AND LIAISON
Ken Peterson, MD (1994) Watertown, Chairman
John Jones, MD (1993) Chamberlain
Martin Christensen, MD (1993) Mitchell
Brent Lindbloom, DO (1993) Pierre
Kevin Bjordahl, MD (1993) Webster
Herb Saloom, MD (1993) Tyndall
Anthony Salem, MD (1994) Sioux Falls
Dennis Stevens, MD (1994) Sioux Falls
Dan Heinemann, MD (1994) Canton
Julie Stevens, MD (1994) Vermillion
John Griffin, MD (1995) Sioux Falls
John Davis, MD (1995) Sioux Falls
Milton Mutch, MD (1995) Sioux Falls
Paul Kuck, MD (1995) Sioux Falls
Brian Tjarks, MD (1995) Mitchell

COMMISSION ON MEDICAL SERVICE
Robert Harms, MD (1994) Sioux Falls, Chairman
Jerome Freeman, MD (1993) Sioux Falls
Bernard Linn, MD (1993) Pierre
Cynthia Weaver, MD (1993) Rapid City
Henry Travers, MD (1993) Sioux Falls
David Jenny, MD (1993) Yankton
Jerome Bentz, MD (1994) Platte
Richard Sample, MD (1994) Madison
Jeffrey Hanson, MD (1994) Huron
Ed Gerrish, MD (1994) Watertown
Timothy Moore, MD (1995) Sioux Falls
Tad Jacobs, DO (1995) Flandreau
Thomas Estes, MD (1995) Sioux Falls
R. Maclean Smith, MD (1995) Sioux Falls

COMMISSION ON SCIENTIFIC MEDICINE
Curtis Buchholz, MD (1993) Huron, Chairman
Roger Carter, MD (1993) Watertown
Gregg Tobin, MD (1993) Winner
Ronald Anderson, MD (1993) Mitchell
Thomas Luzier, MD (1993) Aberdeen
Edward Zawada, MD (1994) Sioux Falls
James Ryan, MD (1994) Sioux Falls
Anthony Javurek, MD (1994) Sioux Falls
John Frank, MD (1994) Yankton
Kevin Whittle, MD (1994) Sioux Falls
Michael Keppen, MD (1995) Sioux Falls
Michael Brown, MD (1995) Spearfish
Jose Teixeira, MD (1995) Sioux Falls
Angelina Trujillo, MD (1995) Sioux Falls
Kevin Kavanaugh, MD (1995) Sioux Falls

COMMISSION ON PROFESSIONAL LIABILITY
Mitchel Rydberg, MD (1995) Dell Rapids, Chairman
Calvin Roseth, MD (1993) Watertown
John Sternquist, MD (1993) Yankton
John Robbins, MD (1995) Sioux Falls
Robert VanDemark, Jr, MD (1995) Sioux Falls
Lori Hansen, MD (1994) Yankton
Douglas Traub, MD (1994) Rapid City
Billy Fields, MD (1994) Sturgis

CREDENTIALS COMMISSION
AND EXECUTIVE COMMISSION
M. George Thompson, DO, Watertown
Thomas Krafka, MD, Rapid City
James Reynolds, MD, Sioux Falls
Mary Carpenter, MD, Winner
Robert Ferrell, MD, Rapid City
Michael Pekas, MD, Sioux Falls
James Engelbrecht, MD, Rapid City
Stephan Schroedter, MD, Miller
Richard Porter, MD, Yankton

GRIEVANCE COMMISSION
Robert L. Ferrell, MD (1993) Rapid City, Chairman
Frank Messner, MD (1994) Yankton
Michael Pekas, MD (1995) Sioux Falls
J. A. Eckrich, Jr, MD (1996) Aberdeen
Richard I. Porter, MD (1997) Yankton

ARCHIVES AND HISTORY COMMISSION
John Hoskins, MD (1993) Sioux Falls, Chairman
Carol Hohn (1993) Auxiliary
Nathaniel Whitney, MD (1993) Rapid City
Joseph Ham, MD (1993) Sturgis
Brooks Ranney, MD (1993) Yankton

MEDICAL-LEGAL COMMITTEE
Jerry Walton, MD (1993) Sioux Falls, Chairman
Daniel Kennelly, MD (1993) Sioux Falls
Walter Carlson, MD (1993) Sioux Falls
Herb Saloum, MD (1993) Tyndall
James Larson, MD (1993) Watertown
Ray Birkenkamp, MD (1993) Mitchell
David Hoversten, MD (1993) Sioux Falls

DEPARTMENT OF SOCIAL SERVICES
MEDICAL ADVISORY COMMITTEE
Thomas Krafla, MD (1993) Rapid City

FETAL ALCOHOL SYNDROME ADVISORY
COMMISSION, SD HEALTH DEPARTMENT
Michael Crandell, MD (1993) Kennebec

SHARECARE COMMITTEE
Tony Berg, MD (1993) Winner, Chairman
Michael Ferrell, MD (1993) Sioux Falls
Ted Jacobs, DO (1993) Flandreau
Thomas Huber, MD (1993) Pierre
James Reynolds, MD (1993) Sioux Falls
Howard Saylor, Jr, MD (1993) Huron
Robert Suurmeyer, MD (1993) Aberdeen
Robert Westaby, MD (1993) Rapid City
John Healy (1993) Clinic Manager
Ed Arshem (1993) Clinic Manager
Robert Chleborad (1993) Clinic Manager

AIDS TASK FORCE
Bruce Lushbough, MD (1993) Brookings, Chairman
Donald Humphreys, MD (1993) Sioux Falls
Jerome Freeman, MD (1993) Sioux Falls
Thomas Huber, MD (1993) Pierre
Alfred Hartmann, MD (1993) Sioux Falls
Michael McVay, MD (1993) Yankton
Wendell Hoffman, MD (1993) Sioux Falls
Richard Belatti, MD (1993) Madison

CONTINUING MEDICAL EDUCATION COMMITTEE
Robert Raszkowski, MD (1995) Sioux Falls, Chairman
James Caede, MD (1995) Mitchell
James Larson, MD (1994) Watertown
Thomas Luzier, MD (1994) Aberdeen
Henry Travers, MD (1993) Director of CME
McKinnan Hosp.
Jerome Freeman, MD (1993) Director of Medical Education, Sioux Valley Hosp.
James Engelbrecht, MD (1993) Director of Medical Education, Rapid City Regional Hosp.
Richard Holm, MD (1993) Director of Medical Education, Brookings Hosp.
Michael Ferrell, MD (1993) Director of Medical Education, Central Plains Clinic
David Bean, MD (1993) Director of Medical Education, Charter Hosp.
Willis F. Stanges, MD (1993) Director of Medical Education, Yankton CME Consortium
William Ogston, MD (1993) Director of Medical Education, Fort Meade Veterans Administration

REPORT OF THE
BUDGET AND AUDIT COMMITTEE MINUTES
5:00 pm Jefferson/Roosevelt Room
Wednesday Howard Johnson
June 3, 1992 Rapid City, SD

The meeting was called to order by Chairman Ken Peterson, MD. Those present included Drs. Peterson, Richard Porter, M. George Thompson, Thomas Krafla, Mary Carpenter, Michael Pekas, James Reynolds and James Engelbrecht, and staff, Robert Johnson and Jan Anderson.

The minutes of the previous meeting were approved as printed and distributed.

Mr. Johnson reviewed the audit prepared by McGladrey & Pullen for the members' information. Dr. Pekas moved to approve the audit as presented. The motion was seconded and carried.

The meeting then convened as a meeting of the Executive Commission. Mr. Johnson presented a request from Governor Mickelson for three physicians to represent the State Medical Association on work groups for the "Summer Forum on Health Care Reform". The work groups were: 1) Health care cost containment, 2) Indigent health care, and 3) Medical liability. It was decided that this would be deferred to the Saturday Council meeting for final action.

There being no further business the meeting adjourned at 5:30 pm.

MINUTES
FIRST COUNCIL MEETING
3:00 pm Jefferson/Roosevelt Rooms
Wednesday Howard Johnson
June 3, 1992 Rapid City, SD

The meeting was called to order by James Engelbrecht, MD, Chairman at 3:10 pm. Those present were Drs. Richard I. Porter, James Hayland, M. George Thompson, D.G. Ortmeier, Thomas Krafla, Mary Carpenter, Robert L. Ferrell, Michael Pekas, Ken Peterson, James Engelbrecht, James Reynolds, James Larson, Curtis Wait, Phillip Hofsten, Stephen Schroeder, Jeffrey Hagen, Rodney Parry, Guy Tam, Lowell Hyland, C. Roger Stoltz, Robert Raszkowski, Daniel Kennelly, Larry Meyer, Duane Reaney, Carol Zieliwe, J. Geoffrey Slingby, Stephen Haas, Richard Renka, John Malm, James Wunder, Kevin Bjordahl, and staff, Robert Johnson, Jan Anderson and Donna Sievers.

The minutes of the previous meeting were approved as printed and distributed.
REPORT OF THE AD HOC COMMITTEE TO STUDY SENATOR DASCHLE'S HEALTH REFORM PLAN - Dr. Thomas Krafla reported to the Council regarding the meetings of the Ad Hoc Committee to study Senator Daschle's Health Reform Plan on May 9 and June 3.

MINUTES
AD HOC COMMITTEE ON RESPONDING TO SENATOR DASCHLE'S AMERICAN HEALTH SECURITY PLAN

10:00 am Harney Peak Room
Wednesday Howard Johnson
June 3, 1992 Rapid City, SD

The meeting was called to order by Thomas Krafla, MD, Chairman. Those present included: Drs Krafla, Robert Ferrell, Richard Holm, Phillip Hoffsten, James Larson and C. Roger Stoltz, and staff, Jan Anderson.

The Committee carefully reviewed the minutes from the first meeting held on May 9, and after making several amendments and additions, submits the attached report to the Council for their consideration and action.

The Committee considered the attached resolution. Dr Larson moved that this resolution be submitted to the Council for consideration and possible submission to the AMA's House of Delegates. The motion was seconded and carried.

There being no further business the meeting adjourned at 11:20 am.

A motion was made by Dr. Pekas that Resolution #3 and the report of the Ad Hoc committee be submitted to the House of Delegates for approval. (See minutes of the First House of Delegates' Meeting.)

Upon approval, a formal report will be sent to Senator Daschle, expressing the Ad Hoc Committee's willingness to meet with him or his committee for ongoing dialog and also expressing the State Medical Association's desire to cooperate and to be involved in the development of the American Health Security Plan. The motion was seconded and carried.

A motion was made by Dr. Larson that the following Resolution #4 be submitted to the House of Delegates:

RESOLUTION #4

TO: SDSMA House of Delegates
FROM: SDSMA Council
SUBJECT: Calculation of "Health Care Costs"

WHEREAS, the expense of the custodial portion of long-term care is not a medical expense but is included in the calculation of the "cost of medical care," and

WHEREAS, this expense is a major component in the "cost of medical care," and

WHEREAS, this is one of the reasons United State's health care costs are perceived to be high, therefore

BE IT RESOLVED, that the American Medical Association should calculate "health care costs" without the expense of the custodial portion of long-term care included and should influence the government and media to do the same.

The motion was seconded and carried.

OLD BUSINESS:

Discussion on Development of SDSMA Mission Statement - Dr. Raszkowski discussed development of a formal mission statement by the State Medical Association. A motion was made by Dr. Ortmeier that Dr. Raszkowski chair a committee which will study this further and prepare a mission statement for consideration at the next Council meeting. The motion was seconded and carried.

Proposed Report on Health Access South Dakota - The Council reviewed the report regarding Health Access South Dakota, which identifies several problems encountered in South Dakota. Dr. Krafla reported to the Council regarding his meeting with the Department of Social Services' Medical Advisory Committee in Pierre concerning the gap in coverage for the disabled. A motion was made by Dr. Larson that the report regarding Health Access South Dakota be submitted to the House of Delegates. The motion was seconded and carried. (See minutes of the First House of Delegates meeting.)

Response from SD Academy of Family Physicians Regarding Joint Annual Meeting - The Council reviewed a letter from Mary K. Stoddard, Executive Director of the South Dakota Academy of Family Physicians, indicating the SDAFP would not be able to participate in a joint 1993 meeting. The Council wished to suggest to the SDAFP that although they cannot work this out for 1993, the State Medical Association remains interested in looking at coordination of these meetings in the future.

Nominees to Serve on the SD Advisory Committee on Health Care - The Council discussed H.B. 1329, to create an Advisory Commission on Health Care. The Governor has asked that the names of three nominees be submitted, after which he will choose one to serve on this advisory commission. The Governor also asked the Association to name three representatives to serve on subcommittees on Health Cost Containment, indigent Health Care and Medical Liability for his special "Summer Forum on Health Care Reform". A motion was made by Dr. Krafla that this be deferred to the second Council meeting. The motion was seconded and carried.

Report from Lawrence & Schiller - Robert Johnson reported to the Council regarding the status of the SDSMA public relations program. Lawrence & Schiller is updating the present ShareCare brochure and developing public service announcements on the SDSMA's ShareCare program. This was accepted for information.

NEW BUSINESS:

Appointments to SoDaPAC Board of Directors - A motion was made by Dr. Pekas to appoint Dr. James Reynolds and Dr. C. Roger Stoltz from the Seventh District, to the SoDaPAC Board of Directors for two year terms. The motion was seconded and carried.

Summary and Proposed Resolution Regarding Clinical Data Abstraction Centers and the PRO - The Council discussed the significant negative impact the creation of a Clinical Data Abstraction Center would have on local physician peer review in South Dakota. Dr. Pekas moved that the resolution on Clinical Data Abstraction Centers be
submitted to the House of Delegates with the Council’s recommendation to adopt this resolution. (See minutes of the First House of Delegates’ Meeting)

The motion was seconded and carried.

Opening for Medicare Medical Director - The Council reviewed a notice from Blue Cross Blue Shield of North Dakota that the executive position for Medicare Medical Director is open. This was accepted for information.

Medicare Claims Committee - Dr. Kraftka reported to the Council concerning the Medicare Claims Committee. This was accepted for information.

Letter from Dr. Bean - The Council reviewed a letter from Dr. Bean regarding state employee coverage for hospital psychiatric services. A motion was made by Dr. Raszkowski that the matter be referred to the Commission on Medical Service. The motion was seconded and carried.

DAKOTACARE Update - Robert Johnson reported to the Council concerning the DAKOTACARE Board meeting and action taken by the Board. This was accepted for information.

There being no further business, the meeting adjourned at 4:55 pm.

SECOND COUNCIL MEETING
11:15 am Lincoln/Jefferson Rooms
Saturday Howard Johnson
June 6, 1992 Rapid City, SD

The meeting was called to order by James Engelbrecht, MD, Chairman. Those present for roll call were: Drs. M. George Thompson, Thomas Kraftka, Richard Holm, James Reynolds, John Barlow, Mary Carpenter, Robert Ferrell, Michael Pekas, Stephan Schroeder, Ken Peterson, James Engelbrecht, Richard Porter, James Hoyland, James Larson, Phillip Hoffsten, Lucio Margallo, Jeffrey Hagen, Guy Tam, C. Roger Stoltz, Daniel Kennelly, Bruce Mannes, Carol Zielike, J. Geoffrey Slingsby, Richard Renka, James Collins, Kevin Bjordahl, and staff, Robert Johnson, Jan Anderson and Donna Sievers.

A motion was made to dispense with the reading of the minutes of the previous meeting. The motion was seconded and carried.

BUSINESS:
Seating of New Councilors - Dr. Engelbrecht introduced the following newly elected and re-elected councilors:

Aberdeen District #1 - Winston Oland, MD (3 years)
James Hoyland, MD (1 year)

Watertown District #2 - James Larson, MD (3 years)
Pierre District #4 - Phillip Hoffsten, MD (3 years)
K. Gene Koob, MD (3 years)
Rodney Parry, MD (3 years)
Robert Raszkowski MD (3 years)
Daniel Kennelly, MD (1 year)

Yankton District #8 - Bruce Mannes, MD (3 years)
James Engelbrecht, MD (3 years)
Stephen Haas, MD (3 years)

Black Hills District #9 - James Collins, MD (2 years)

Northwest District #11 -

Dates for 1992-93 Council Meetings - The Council reviewed and confirmed the following dates for the 1992-93 Council meetings:

Friday, September 25 - Sioux Falls
Friday, November 20 - Pierre
Friday, April 16 - Sioux Falls

This was accepted for information.

Election of Council Chairman - Dr. Larson nominated James Engelbrecht, MD, as Chairman of the Council and moved that nominations cease and a unanimous ballot be cast for Dr. Engelbrecht. The motion was seconded and carried.

Nominees to Serve on the SD Advisory Committee on Health Care and Subcommittees on Health Cost Containment, Indigent Health Care and Medical Liability for the Governor’s special “Summer Forum on Health Care Reform” - A motion was made by Dr. Eckrich that the names of Drs. Thomas Kraftka, John Barlow, C. Roger Stoltz, Phillip Hoffsten, James Larson and Stephen Schroeder be considered by the president as representatives of the State Medical Association to serve on the Governor’s Advisory Committee on Health Care and on the subcommittees on Health Cost Containment, Indigent Health Care and Medical Liability for the Governor’s special “Summer Forum on Health Care Reform”. The motion was seconded and carried.

SoDaPAC Update - A motion was made to appoint the following members to the SoDaPAC Board of Directors:

Robert Raszkowski, MD (District 7)
Lucio Margallo, MD (District 6)
Kevin Bjordahl, MD (District 12)
Chris McGann (Auxiliary - District 7)
Tacy Braithwaite (Auxiliary - District 7)
Scott Peters (Auxiliary - District 7)
Chris Kuck (Auxiliary - District 7)
Robbin Airlin (Auxiliary - District 9)
Tom Graslie (Auxiliary - District 9)

The motion was seconded and carried.

There being no further business, the meeting adjourned at 11:35 am.

South Dakota
DRUG INFORMATION CENTER
1-800-456-1004
OPEN EVERY DAY
8:00 am - 4:30 pm

For questions on:
- Availability
- Identification
- Drug Interactions
- Dosing
- Drugs of Choice
- Side effects
- Stability
- Safety
- Therapeutics
- Pharmacokinetics

AUGUST 1992

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MINUTES
FIRST HOUSE OF DELEGATES MEETING
9:30 am Washington Room
Thursday Howard Johnson
June 4, 1992 Rapid City, SD

The meeting was called to order by James Reynolds, MD, Speaker of the House. Those present for roll call were Doctors: Richard Porter, George Thompson, Thomas Kraft, Mary Carpenter, Robert Ferrell, Michael Pekias, James Reynolds, Jerome Eckrich, James Howland, James Larson, Curtis Wait, Phillip Hofsten, Stephan Schroeder, Lucio Margallo, Jeffrey Hagen, D. G. Ortmeyer, Rodney Parry, Guy Tam, Lowell Hyland, C. Roger Stoltz, Robert Raszkowski, Daniel Kennelly, Larry Meyer, Duane Reaney, James Engelbrecht, Carol Zielle, Richard Renka, Craig Hansen, John Barlow, John Malm, Kevin Bjordahl, Roger Carter, Steven Feeley, Ken Peterson, Richard Holm, Ted Jacobs, Brent Lindbloom, Ken Bartholomew, Mark Belyea, Curtis Buchholz, Jerome Howe, Thomas White, James Ryan, Robert Talley, Wm. Rossing, David Hoversten, Karla Murphy, C. F. Gutch, Russell Harris, John Sall, Robert Thompson, David Smith, Jem Hof, T. H. Sattler, Robert Goodhope, Thomas Hermann, Charles Hart, Cynthia Weaver, Robert Preston, James Rud, David Sandvik, Reuben Bareis, H. Lee Ahrlin, Eugene Bolliger and James Collins.

Dr. Meyer moved to approve the minutes of the previous meeting as printed and distributed. The motion was seconded and carried.

Dr. Reynolds announced the appointment of the following to serve on the Nominating Committee: Drs. James Howland; Ken Peterson; Curtis Wait; Brent Lindbloom; Stephan Schroeder; Lucio Margallo; Jeffrey Hagen, Chairman; Robert Thompson; Craig Hansen; Eugene Bolliger; James Collins; and Kevin Bjordahl.

Dr. Reynolds announced the appointment of the Reference Committees as follows:

Reference Committee on Credentials, Resolutions and Memorials and Reports of the Officers and Councilors: Drs. David Smith, Chairman; T. H. Sattler; Guy Tanz; J. Geoffrey Slingsby; Thomas White; Allen Nord; Roger Carter; James Rud; and James Ryan.

Reference Committee on Reports of Commissions on Medical Service; Legislation and Governmental Relations: Drs Robert Goodhope, Chairman; Kenneth Bartholomew; O. Myron Jerde; John Malm; Martin Christensen; Jem Hof; H. Thomas Hermann; C. Roger Stoltz; Robert Talley; William Rossing; and David Hoversten.

Reference Committee on Reports of Commissions on Scientific Medicine; Internal Affairs, Communications and Liaison; and Professional Liability: Drs Carol Zielle, Chairman; Mark Belyea; Cynthia Weaver; Stephen Haas; John Barlow; Phillip Hoffsten; E. Paul Amundson; Karla Murphy; and C. F. Gutch.

Reference Committee on Reports of Special Committees and Miscellaneous Business: Drs Lowell Hyland, Chairman; Curtis Buchholz; Robert Preston; Richard Renka; Richard Gere; Dave Johnson; Duane Reaney; Russell Harris; and John Sall.

Dr. Reynolds referred the reports of the officers and councilors to Reference Committee #1.

Dr. Reynolds called for the introduction of resolutions from the Council which have not been published in the Delegates' Handbook. Dr. Krafta read the report from the Council on Health Access South Dakota. Dr. Reynolds referred this report to Reference Committee #1.

REPORT TO THE SDSMA HOUSE OF DELEGATES REGARDING HEALTH ACCESS SOUTH DAKOTA

Pursuant to the 1991 House of Delegates meeting the Council, as directed, has considered health care access for South Dakota. Each Councilor was asked to discuss this with members of his/her district and all district secretaries and presidents were provided with background information and asked to discuss this at one of their district meetings, with response coming back to the Council. After deliberations the Council has identified the following access problems and proposes some resolution to these problems:

1. For disabled patients, the period of time when they have no health care coverage. This is the waiting period between the ending of disability coverage and acceptance by the Medicare program. (Dr. Krafta will discuss this matter at the May meeting of the Department of Social Services Medical Advisory Committee and report to the Council.)

2. Title 19 patients. Some physicians do not accept Title 19 patients and this has been identified as a problem with regard to access of care. The Council refers this to the House of Delegates for further discussion and resolution.

3. Some patients have been forced to drop their group insurance because the deductible is so low, making the premium too high. (This problem has been addressed by Blue Cross/Blue Shield and DAKOTACARE which now offer higher deductible policies, and the SDSMA encourages other insurance companies to make similar changes.)

4. Title 19 patients. Some are income eligible but they are owners of non-productive land so they cannot qualify for Title 19 benefits. (The Council recognized that an attempt to resolve this situation might compound the problem.)

5. Title 19 patients. In rural areas some patients have no transportation so they cannot get to the physicians they need. (The Council recommends that the State Office of Rural Health and the Department of EMS look at this matter for possible solutions.)

6. Physicians are not able to give a discount and are forced by Medicare to collect the deductible and co-payment. (The Council identified this as a problem and indicated patients should be informed physicians are mandated to collect the deductible and co-payment. It is noted that patients eligible to participate in the ShareCare program are exempt from this requirement.)

7. When a young person with a chronic disease reaches employment age, frequently they are uninsurable. (The Council identified this as a problem and reiterates the SDSMA's support for a pool for the uninsurable.)

This report was accepted at the Second House of Delegates meeting with the recommendation that the seven problem areas be assigned to the appropriate Association commissions or committees for extensive study and specific recommendations for action and/or policy statements.

SOUTH DAKOTA
Dr. Engelbrecht introduced Resolution #3, a Response to Senator Daschle's American Health Security Plan, from the Council. Dr. Reynolds referred Resolution #3 and the Ad Hoc Committee report to Reference Committee #4.

RESOLUTION #3

TO: House of Delegates South Dakota State Medical Association

FROM: Council South Dakota State Medical Association

SUBJECT: Response to Senator Daschle's American Health Security Plan

REFERRED TO: Reference Committee #4 - Reports of Special Committees and Miscellaneous Business

WHEREAS, Senator Tom Daschle has developed the American Health Security Plan, and

WHEREAS, Senator Daschle has requested review and input by the South Dakota State Medical Association, and

WHEREAS, an Ad Hoc Committee of the Council of the South Dakota State Medical Association has carefully considered Senator Daschle's proposal and developed a response, therefore, be it

RESOLVED, the South Dakota State Medical Association submit the attached report, with recommendations, to Senator Daschle, and further, be it

RESOLVED, the South Dakota State Medical Association specifically requests the opportunity and responsibility to help develop a basic health care benefits plan.

Resolution was adopted at the Second House of Delegates' meeting.

REPORT TO HOUSE OF DELEGATES REGARDING SENATOR DASCHLE'S AMERICAN HEALTH SECURITY PLAN

Prepared by: Ad Hoc Committee
Drs Thomas Krafla, Chairman; Lowell Hyland; Robert Ferrell; C. Roger Stultz; Steve Haas; Phillip Hoffsten; Richard Holm; and James Reynolds

After general remarks and surveying the group for interest, the bill summary was reviewed step by step and the following points and recommendations came out of this discussion for Senator Daschle. In general it should be noted that the spirit of the committee was to praise Senator Daschle for taking a step forward in a very difficult area and that our recommendations are not meant to be criticisms for his plan but constructive feedback in an effort to encourage him to go forward in a positive way fulfilling the needs that he has outlined. Indeed, we concurred that 1. All Americans must have access to basic medical care. 2. Costs must be maintained at a level that society is willing to spend. 3. We must find ways to reduce the administrative costs of providing medical care. 4. We must make sure that the medical care that is provided in this country is medically necessary. 5. We must strengthen our efforts to assess the effectiveness and cost effectiveness of existing and emerging technology.

6. We must enact policies to reduce the bureaucratic hassles of the existing insurance system.

Response to details of the plan are as follows:

I. Eligibility enrollment. We agreed with A, B, and C.

II. Benefits.

A. We would recommend standardization of benefits from state to state. We thought there was potential problem with this area in that it may involve some cost sharing, distortion and exclusions if state to state there is some variation.

B. Long-term care. Our committee recommended separating the basic living costs of long-term care from the health problems. The expense is primarily not medical but is dumped into the medical expenses in America. We feel this should be a separate issue and carefully approached by a different group of experts. We do not want to ignore it, but would like to have it dealt with separately.

III. Federal and state administration
A, B, C: No disagreement.

D. State Programs

1. Medical experts and scientists must be involved.

2. Greater than 50 percent or a significant representation of MDs/DOs should be required.

3. Each state should be entitled to at least one intermediary located within their state.

IV. Health budget
A. National Health Budget

1. This should be determined on a basis of actual costs and needs and not be capped.

2. We want to see this always a fixed ratio for all states, e.g. 15 percent state money, 85 percent national money.

B. State Payments

1. Payments to facilities. It is vital that hospitals have adequate funding to provide services. We are concerned with the potential inequities that may arise with individual negotiations between this board and hospitals, nursing homes and other medical facilities depending on their size and political clout.

2. Capital. These budgets should be examined by a board but not dictated. The Certificate of Need concept has been tried already and it failed.

3. Health training. We recommended that the distribution of funds should be negotiated according to the needs of individual states.

4. a. Practitioner payments and non-physician practitioner payments. These should be determined by each state. The American Society of Internal Medicine competitive pricing proposal enclosed is an option which allows freedom for a practitioner to bill in a competitive manner. (See enclosed outline, #1 and the full ASIM proposal.)
b. Payments to non-physician practitioners should be paid through a supervising physician since a physician must oversee and be held responsible for the quality and appropriateness of care delivered.

c. Mandatory assignment:

1) We think this will not encourage growth or motivate research but would, in fact, discourage the same.

2) The pressure of the market place should be allowed to be a factor; mandatory assignment destroys that.

3) No one wants total mandatory assignment when the control of the payment is left to the state. For example, it is not working for the State Employees Program in West Virginia.

4) One possibility would be to use the American Health Security Plan as structured to provide a "basic benefits plan." Mandatory assignment then should be required only for low income patients and in instances where the patients are unable to exercise choice of physician (e.g., real emergencies).

C. Revenue, the federal health trust fund. It was our general reaction that this health program should be funded adequately and fairly and from the general fund. We would suggest not taxing businesses which would result in taking away the competitive edge for U.S. businesses.

V. Congressional consideration. No problem.

VI. A&B Okay.

C. Limits on private insurance. We would agree, but consider allowing insurance to cap the max personal loss at, for example, $2,000.

VII. Underserved areas. Our group would like to see incentives for rural health care considered.

VIII. Malpractice reform. We would suggest going to the AMA's Health Access America Program. A variety of opinions came forth, but ideally it was our committee's opinion that the court costs should be picked up by the person suing the physician if the lawsuit is lost; thus, preventing unfair expense resulting from inappropriate lawsuits.

Again, we represented as a committee a unity of opinion supporting the AMA's Health Access America Plan and would encourage consideration in general for that 16 part proposal.

* Basic Benefits Plan: The South Dakota State Medical Association requests the opportunity and the responsibility to help develop a basic health care benefits plan.

#1 Outline of American Society of Internal Medicine Competitive Pricing Proposal

1. Uses RVS from RBRVS

2. Each physician (or group) would determine an annual conversion factor

3. Government programs would negotiate an annual conversion factor for reimbursement

4. Private third party payors would also reimburse via a conversion factor

BC/E family practitioners, do yourself a favor and take a look at this model of what family practice is meant to be.

Canby, Minnesota has a modern - economically strong clinic, hospital and long-term care system nestled in a community where old fashioned values merge with a progressive spirit. Join two BC family practitioners, physician assistant, and the area's best consulting physicians and services to care for today and shape the future of Midwest health care.

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5. Limits would be placed on balance billing for patients with low income and inability to choose their physician.

6. National Health Care Objectives Board would set conversion factor for government programs and also approve RVS changes.

See the complete ASIM proposal.

Report was adopted at the Second House of Delegates meeting.

Dr. Engelbrecht introduced Resolution #4, Calculation of Health Care Costs, from the Council. Dr. Reynolds referred Resolution #4 to Reference Committee #3.

RESOLUTION #4

TO: SDSMA House of Delegates
FROM: SDSMA Council
SUBJECT: Calculation of "Health Care Costs"

WHEREAS, the expense of the custodial portion of long-term care is not a medical expense but is included in the calculation of the "cost of medical care," and

WHEREAS, this expense is a major component in the "cost of medical care", and

WHEREAS, this is one of the reasons United State's health care costs are perceived to be high, therefore

BE IT RESOLVED, that the American Medical Association should calculate "health care costs" without the expense of the custodial portion of long-term care included and should influence the government and media to do the same.

Resolution #4 was rejected and replaced by Substitute Resolution #4 which was adopted at the Second House of Delegates' meeting. (Substitute resolution is printed in minutes of the Second House of Delegates.)

Dr. Holm introduced Resolution #5 on Clinical Data Abstraction Centers from the Council. Dr. Reynolds referred Resolution #5 with the summary to Reference Committee #2.

SUMMARY

HCFA has released for comment a draft statement of work to create Clinical Data Abstraction Centers (CDACs). CDACs would be established for the purpose of abstracting data from hospital records into the Uniform Clinical Data Set (UCDS) system, essentially regionalizing this activity instead of contracting with local PROs.

It would seem reasonable to regionalize those peer review activities which cannot be as efficiently performed at the local level. For example, pattern analysis of Medicare data would most effectively be performed on a database comprising Medicare claims from many states in order to increase the statistical reliability of the results. However, HCFA has provided no evidence to suggest that a peer review activity such as UCDS data abstraction would be more effectively performed by a regional entity than a local physician organization.

HCFA's Health Care Quality Improvement Initiative proposes to impact quality of care by providing practitioners educational feedback from statistical analysis of clinical data. Expert opinion and published research both support the view that the success of the health care quality improvement model is highly dependent on the extent to which the local medical community can actively participate and feel a sense of ownership of the clinical database and the practice guidelines that are being used to compare their practice behavior. HCFA's proposed regionalization of UCDS will divorce both the UCDS database and the UCDS clinical algorithms from the local community. We have seen in the past the suspicion with which the South Dakota medical community approaches data generated by entities outside the state, such as the recent HCFA Mortality Release.

Regionalization of a function as critical to physician peer review as the collection of clinical data leads many to question HCFA's commitment to local peer review. Many believe that the decision to centralize one PRO function is the signal of future strategies that may lead, eventually, to regionalized physician peer review. This HCFA proposal will impose national criteria on the local community while regionalizing the entire review screening function. If not countered at this juncture, local peer review may eventually be lost or at the very least, significantly weakened.

The HCFA proposal does not require credentialed, expert personnel to conduct the data abstraction function. Movement in the direction of non-nurse abstractors will mean the loss of clinical judgment at the case screening level. Such expertise has demonstrated, both in traditional and UCDS review, an ability to identify quality and utilization concerns separate from whatever cases are flagged by traditional medical criteria or UCDS clinical algorithms. How valid will be future published profiles generated from data abstracted by non-credentialed personnel?

This proposal is a transparent strategy to circumvent the Peer Review Organization statute. The current statute clearly states that HCFA must contract with the PRO for all functions related to peer review and the providers must release records only to the designated PRO in their state for review purposes. The Clinical Data Abstraction Centers (CDAC) screening function not only identifies cases for physician review, but certifies the remainder of cases as to the medical quality, necessity and appropriateness. The PRO statute is clear that only the PRO entity can make such determinations. HCFA proposes to circumvent the statute by requiring every PRO to subcontract with HCFA's designated CDAC, and therefore, skirt these statutory provisions by having Medicare trust fund dollars and hospital medical records literally "pass through" the PRO to the CDAC.

This proposal will have significant negative impact upon local physician peer review in South Dakota. Now is the time to comment upon it officially to HCFA. I would appreciate any assistance you could provide in helping to rescind this proposal before it is finalized.

RESOLUTION #5

TO: House of Delegates
FROM: SDSMA
SUBJECT: Clinical Data Abstraction Centers
WHEREAS, the Health Care Financing Administration (HCFA) has announced its intention to implement a modified Uniform Clinical Data Set (UCDS) as
WHEREAS, HCFA has announced its intention to establish regionalized Clinical Data Abstraction Centers (CDACs) in place of local PROs in order to collect the detailed medical record data necessary for UCDS, and

WHEREAS, CDACs would be responsible for data abstraction and clinical database development activity in isolation from the local community, making it difficult for the local medical community to participate in the clinical database that will ultimately be used to compare and evaluate local practice patterns and behavior; and

WHEREAS, HCFA has provided no evidence that the establishment of CDACs will meet their stated policy goal of collecting more reliable data than would be the case if this data abstraction function remained the responsibility of the local PROs, and these centers (CDACs), in addition to the data abstraction function, would be responsible for determining which cases should be flagged for physician review, as well as certifying the remainder cases as to medical necessity, quality, and appropriateness, thus moving the physician peer review activity away from the local PROs to a regional center; therefore be it

RESOLVED, that the South Dakota State Medical Association encourage the AMA to oppose implementation of a Uniform Clinical Data Set (UCDS) and Patient Care Algorithm Systems (PCAS) until HCFA can demonstrate from field trials by local peer review entities that this process is statistically reliable and effective at detecting problems in patient care, and be it further

RESOLVED, that the AMA oppose Clinical Data Abstraction Centers (CDACs) and other processes that would remove important functions that are an integral part of the local peer review process and structure, and be it further

RESOLVED, that the AMA support the local peer review process with renewed emphasis on education of physician providers.

Resolution was adopted at the Second House of Delegate’s meeting.

Dr. Reynolds called for introduction of resolutions from district medical societies which have not been published in the Delegates’ Handbook. Being none, he called for the introduction of resolutions by individual members which have not been published in the Delegates’ Handbook. There were no additional resolutions introduced.

Dr. Reynolds referred pages 1-15 of the Delegates’ Handbook to the Reference Committee on Credentials, Resolutions and Memorials; and Reports of Officers and Councilors.

Dr. Reynolds referred pages 16-20, including Bylaw Amendment #1, to the Reference Committee on Reports of Commissions on Medical Service; and Legislation and Governmental Relations.

Dr. Reynolds referred pages 21-26, including Resolution #1, to the Reference Committee on Reports of Commissions on Scientific Medicine; Internal Affairs, Communications and Liaison; and Professional Liability.

Dr. Reynolds referred pages 27-33, including Resolution #2, to Reference Committee on Reports of Special Committees and Miscellaneous Business.

Dr. Reynolds announced the various corporate body sessions which are scheduled to follow the House of Delegates and he gave a brief overview of the remaining annual meeting sessions.

There being no further business, the meeting adjourned at 10 am.

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**SOUTH DAKOTA**
MINUTES OF THE SECOND HOUSE OF DELEGATES

10:00 am

Washington Room
Saturday
June 6, 1992

The meeting was called to order at 10:05 am, by James Reynolds, MD, Speaker of the House. Those present for roll call were Doctors Richard I. Porter, M. George Thompson, Thomas Krafla, Mary Carpenter, Robert L. Ferrell, Michael Pekas, James Reynolds, Jerome Eckrich, James Howland, James Larson, Phillip Hoffsten, Stephan Schroeder, Lucio Margallo, Jeffrey Hagen, Rodney Parry, Guy Tam, Lowell Hyland, C. Roger Stoltz, Daniel Kennelly, Duane Reaney, James Engelbrecht, Carol Zieleke, J. Geoffrey Slingsby, Richard Renka, Roger Carter, Steven Feeney, Ken Peterson, Richard Holm, Tad Jacobs, Brent Lindbloom, Ken Bartholomew, Mark Belyea, Curtis Buchholz, Jerome Howe, Martin Christensen, Richard Gere, Dave Bean, James Ryan, Wm. Rossing, Karla Murphy, C.F. Gutch, Russell Harris, John Sall, David Brechtelsbauer, Paul Kuck, Robert Thompson, David Smith, Jem Hof, Robert Goodhope, John Barlow, David Sandvik, Craig Hansen, Cynthia Weaver, O. Myron Jerde, James Rud, Eugene Bolliger and James Collins. A quorum was present and the meeting was declared competent to proceed.

A motion was made to dispense with the reading of the minutes of the previous meeting inasmuch as they will be printed and distributed. The motion was seconded and carried.

Dr. Hagen read the Report of the Nominating Committee.

REPORT OF THE NOMINATING COMMITTEE

The Nominating Committee submits the following recommendations for the consideration of the House of Delegates:

OFFICERS

President Elect: Thomas Krafla, MD
Vice President: James Reynolds, MD
AMA Delegate: Robert L. Ferrell, MD
AMA Alternate Delegate: Michael Pekas, MD
Speaker of the House: Stephan Schroeder, MD

COUNCILORS

Aberdeen District #1: Winston Odland, MD (3 years)
James Howland, MD (1 year)

Watertown District #2: James Larson, MD (3 years)

Pierre District #4: Phillip Hoffsten, MD (3 years)

Sioux Falls District #7: K. Gene Koob, MD (3 years)
Rodney Parry, MD (3 years)
Robert Raszkowski MD (3 years)
Daniel Kennelly, MD (1 year)

Yankton District #8: Bruce Mannes, MD (3 years)

Black Hills District #9: James Engelbrecht, MD (3 years)
Stephen Haas, MD (3 years)

Northwest District #11: James Collins, MD (2 years)

ALTERNATE COUNCILORS

Watertown District #2: Stephen Gehring, MD (3 years)

Pierre District #4: Thomas Huber, MD (3 years)

Mitchell District #6: James Gaede, MD (2 years)

Yankton District #8: Julie Stevens, MD (3 years)
Robert Thompson, MD (2 years)

Black Hills District #9: Robert Goodhope, MD (3 years)
Craig Hansen, MD (3 years)

ANNUAL MEETING SITE

1993 - Sioux Falls, SD, June 10-12, 1993
1994 - Rapid City, SD, June 9-11, 1994
1995 - Sioux Falls, SD, June 8-10, 1995
1996 - Rushmore Plaza Holiday Inn, Rapid City, SD

Respectfully submitted,

NOMINATING COMMITTEE

Jeffrey Hagen, MD, Chairman
James Howland, MD
Ken Peterson, MD
Curtis Wait, MD
Brent Lindbloom, DO
Stephan Schroeder, MD
Lucio Margallo, MD
Robert Thompson, MD
Craig Hansen, MD
Eugene Bolliger, MD
James Collins, MD
Kevin Bjordahl, MD

A motion was made that the Report of the Nominating Committee be approved. The motion was seconded and carried.

AMA President Dr. John Ring, addressed the House of Delegates concerning the AMA’s efforts in the areas of health care reform and the Health Access America program. The AMA does not support a healthcare system run by the government and urges physicians to keep pushing for workable, realistic reform. Dr. Ring also discussed the subject of physician professionalism and asked that physicians adopt guidelines on self-referral, stressing care in the acceptance of gifts from pharmaceutical companies.

Dr. David Smith read the Report of the Reference Committee on Credentials, Resolutions and Memorials and Reports of Officers and Councilors.

REPORT OF THE REFERENCE COMMITTEE ON CREDENTIALS, RESOLUTIONS AND MEMORIALS AND REPORTS OF OFFICERS AND COUNCILORS

The following delegates, alternate delegates, officers and councilors of the South Dakota State Medical Association were present: Doctors Richard Porter, M. George Thompson, Thomas Krafla, Mary Carpenter, Robert L. Ferrell, Michael Pekas, James Reynolds, Jerome Eckrich, James Howland, James Larson, Curtis Wait, Phillip Hoffsten, Stephan Schroeder, Lucio Margallo, Jeffrey Hagen, D.G. Ortmeyer, Rodney Parry, Guy Tam, Lowell Hyland, C. Roger Stoltz, Robert Raszkowski, Daniel Kennelly, Larry Meyer, Duane Reaney, James Engelbrecht, Carol Zieleke, Richard Renka, John Malm, Kevin Bjordahl, Roger Carter, Steven Feeney, Ken Peterson, Richard Holm, Tad Jacobs, Brent Lindbloom, Ken Bartholomew, Mark Belyea, Curtis Buchholz, Jerome Howe, Thomas White, James Ryan, Robert Talley, William Rossing, David Hoverson, Karla Murphy, C.F. Gutch, Russell Harris, John Sall, Robert Thompson, David Smith, Jem Hof, Robert Goodhope, Thomas Herrmann, Charles Hart, Cynthia Weaver, Robert Preston, James Rud, Eugene Bolliger, James Collins, Craig

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The Reference Committee reviewed a report from the South Dakota State Medical Association Council regarding Health Access South Dakota involving seven identified proposed problem areas. By unanimous vote the Reference Committee validated these problems and recommends that the seven problem areas be assigned to the appropriate South Dakota State Medical Association Commissions or Committees for extensive study and specific recommendations for action and/or South Dakota State Medical Association policy statements.

Respectfully submitted,
REFERENCE COMMITTEE ON CREDENTIALS, RESOLUTIONS AND REPORTS OF OFFICERS AND COUNCILORS
David Smith, MD, Chairman
Guy Tam, MD
James Rud MD
J. Geoffrey Slingsby, MD
Roger Carter, MD
James Ryan, MD
Thomas C. White, MD

A motion was made to accept the Report of the Reference Committee on Credentials, Resolutions, and Memorials and Reports of Officers and Councilors. The motion was seconded and carried.

Dr. Robert Goodhope read the report of the Reference Committee on Reports of the Commission on Medical Service and the Commission on Legislation and Governmental Relations.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF THE COMMISSION ON MEDICAL SERVICE AND THE COMMISSION ON LEGISLATION AND GOVERNMENTAL RELATIONS

The Reference Committee reviewed Resolution #5 regarding Clinical Data Abstraction Centers. Following discussion, the committee moved to recommend adoption of this resolution.

The Reference Committee reviewed the report of the Commission on Legislation and Governmental Relations and recommends acceptance of the report as published and requests that the Commission specifically address the issue of the uninsurable pool and explore alternative sources of funding for that pool. The Committee also recommends that if an amendment to the Physical Therapy Practice Act is reintroduced which would allow employment of physical therapy assistants at locations removed from the supervising physical therapist, such amendment should specify the frequency of on-site supervision.

The Reference Committee reviewed the report of the Commission on Medical Service and recommends acceptance of the report but requests a review as to the reasoning for South Dakota statute dictating the release of workmen's compensation records without patient consent and the physician liability thereby incurred. The Committee also recommends that the South Dakota State Medical Association remain pro-active in the decision to deal with the availability and cost of health insurance in South Dakota.

The Committee reviewed Bylaw Amendment #1 and recommends acceptance of this Amendment.
BYLAW AMENDMENT #1

TO: House of Delegates
South Dakota State Medical Association

FROM: Council
South Dakota State Medical Association

SUBJECT: Amendment to Bylaws

ARTICLE VII Officers

Section 1. Designation and Terms

a. Designation--The officers of this Association shall be the President, President-Elect, Vice-President, Speaker of the House of Delegates, Secretary-Treasurer, and one Councilor for every fifty (50) members or fraction thereof from each component society (((with fifty-one or more members and two Councilors from each component society with fifty members or less))). The Council may employ an Executive Secretary who need not be a physician nor a member of the Association who may act in an ex-officio capacity at the direction of the Secretary-Treasurer.

c. Terms of Officers--The House of Delegates at its regular meeting shall elect the following officers to serve the terms indicated: (1) President-Elect, one year; (2) Vice President, one year; (3) Speaker of the House of Delegates, one year; (4) one Councilor for a three year term from one-third of the districts and where a district has more than one member only one such member (((only one member from each district))) shall stand for election in any given year, provided that if a district has four or more members, more than one may then stand for election in such a manner to provide for staggered election of equal number of council members from any one district; (5) the Council shall elect a Secretary-Treasurer to assume office at the close of the last general session of the meeting to serve for three years. All of the officers shall serve until their successors are elected and installed, and each officer assumes office at the close of the last general session of the annual meeting at which they were elected, and shall serve until the corresponding period of the next annual meeting following their election, except in the case of the councilors and the Secretary-Treasurer, and they of the third annual meeting next following their election. At the close of the last general session of the annual meeting next following his election, the President-Elect shall assume the office of President, and serve as such until the corresponding period of the following annual meeting, or until his successor assumes office at the next annual meeting.

e. Initial Appointment of Additional Council Members--In districts authorized more than one ((two)) councilor member(((s))), such additional members (((shall be elected by the Council to serve until the annual meeting when the House of Delegates elects the Council members whose initial terms will))) be determined by the Nominating Committee of the House of Delegates, based upon the length of term remaining for present councilors for such districts to effectuate the provision of staggered years of election set forth above (Article VII, Section c. (5.). ((, and thereafter for full three year terms.))

ARTICLE VIII Council

Section 5. Alternate Councilors

Alternate councilors shall serve with the same powers, duties and responsibilities as councilors, and as voting members of the Council, in the absence of the councilor to whom they are alternates. In district societies with more than one councilor, if (((district))) the alternate councilor for the absent councilor is unable to act, another alternate councilor from that district may act in the stead of the absent councilor.

Bylaw amendment was adopted at the Second House of Delegates’ meeting.

Respectfully submitted,
Reference Committee on Reports of the Commission on Medical Service and the Commission on Legislation and Governmental Relations
Robert Goodhope, MD, Chairman
Kenneth Bartholomew, MD
O. Myron Jerde, MD
John Malm, MD
Martin Christensen, MD
Jem Hof, MD
H. Thomas Hermann, MD
C. Roger Stoltz, MD
Reuben Bareis, MD

A motion was made to accept the report of the Reference Committee on Reports of the Commission on Medical Service and the Commission on Legislation and Governmental Relations. The motion was seconded and carried.

Dr. Carol Zielike read the report of the Reference Committee on Reports of the Commissions on Scientific Medicine; Internal Affairs, Communications and Liaison; and Professional Liability.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF THE COMMISSIONS ON SCIENTIFIC MEDICINE; INTERNAL AFFAIRS, COMMUNICATIONS AND LIAISON; AND PROFESSIONAL LIABILITY

The Reference Committee reviewed the report of the Commission on Scientific Medicine. The Reference Committee recommends that at least one member of the committees for which reports are being reviewed be appointed to the reference committee in order to answer questions encountered in the review of such reports. The Reference Committee also recommends that the SDSMA update Committee prepare and mail to the membership a brief updated summary, outlining the goals and objectives of the Office of Rural Health. This would be for informational purposes. The Reference Committee recommends acceptance of the balance of the report.

The Reference Committee reviewed the report of the Commission on Internal Affairs, Communications and Liaison. The Reference Committee recommends acceptance of this report.
The Reference Committee reviewed the proposed budget for the fiscal year 1992-93. The Reference Committee recommends acceptance of the budget.

The Reference Committee reviewed the report of the Commission on Professional Liability. The Reference Committee recommends acceptance of this report.

The Reference Committee reviewed Resolution #1, concerning Excessive Expense of JCAHO Accreditation.

RESOLUTION #1

TO: House of Delegates
South Dakota State Medical Association

FROM: Black Hills District Medical Society

SUBJECT: Excessive Expense of JCAHO Accreditation

WHEREAS, in 1965, Congress mandated accreditation as a prerequisite for hospitals to receive payment under Title 18 and Title 19, and

WHEREAS, in 1965, the majority of hospitals in the country had achieved and were maintaining the minimal Joint Commission Standards, this Congressional mandate was not then onerous, and

WHEREAS, in 1966, the Joint Commission Board, with good intentions, made a major decision to undertake a complete revision of the standards to reflect an optimal achievable rather than a minimal essential level of care, and

WHEREAS, the law of eventually diminishing economic returns which states that 80 percent of the benefit comes from 20 percent of the effort (the Pareto Principle) began then to operate upon the results, and

WHEREAS, over the next 25 years, the annual direct and indirect costs of compliance with the optimal achievable JCAHO standards rose into the billions of dollars, while measures of the comparative health of the U.S. population stagnated or declined in part due to economic barriers to access, and

WHEREAS, if for economic reasons, Congress unmandates accreditation for hospitals as it has for HMO's, the JCAHO's role as the definor of the minimal acceptable level of hospital care may be usurped by the government, therefore be it

RESOLVED, that the South Dakota State Medical Association ask the American Medical Association to consider the optimal achievable standards of the JCAHO as uneconomical, readily reversible contributing causes of the health care cost crisis in the United States of America, and be it further

RESOLVED, that the South Dakota State Medical Association ask the American Medical Association to direct the JCAHO board members to begin a return to minimal

WHEREAS, over the past 25 years, the annual direct and indirect costs of compliance with the optimal achievable JCAHO standards rose into the billions of dollars, while comparative health of the U.S. population has not changed accordingly,

The Reference Committee recommends acceptance of this resolution with the following change to the fifth WHEREAS paragraph:

WHEREAS, that the South Dakota State Medical Association ask the American Medical Association to consider the optimal achievable standards of the JCAHO as uneconomical, readily reversible contributing causes of the health care cost crisis in the United States of America, and be it further

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Resolution was amended to change the fifth whereas as recommended by the Reference Committee and this amended resolution was adopted at the Second House of Delegates’ meeting.
TO: SDSMA House of Delegates  
FROM: SDSMA Council  
SUBJECT: Allocation of Financing of Long-term Care as a Health Care Expense  

WHEREAS, long-term care is a vital need for many elderly and it is projected the need will increase with changing demographics and increased real costs, it is vital this need be addressed directly, and  
WHEREAS, the major aspect of long-term care is to meet personal needs of the recipient including food, shelter, and personal hygiene and the social goal that the elderly be cared for with dignity, and  
WHEREAS, the needs currently are inappropriately allocated as health care rather than social costs of daily living and this allocation is a major and increasing distorting factor on national health care costs, and  
WHEREAS, states are mandated to fund long-term care through Medicaid budgets impairing their ability to fund appropriate health care needs of the Medicaid recipients, therefore,  
BE IT RESOLVED, that funding of long-term care be removed from health care calculations; Medicaid funds not be mandated to be expended on long-term care; and that Federal and State officials directly address long-term care and other social needs of the elderly through separate and independent social legislation regarding budgeting, financing, and administration, and  
BE IT FURTHER RESOLVED, that the SDSMA submit this resolution to the AMA House of Delegates.

Respectfully submitted,  
REFERENCE COMMITTEE ON REPORTS OF THE COMMISSIONS ON SCIENTIFIC MEDICINE; INTERNAL AFFAIRS, COMMUNICATIONS AND LIAISON; AND PROFESSIONAL LIABILITY  
Carol Zielike, MD, Chairman  
Cynthia Weaver, MD  
Daniel Kennelly, MD  
John Barlow, MD  
Phillip Hoffsten, MD  
Charley Gutch, MD  
Steven Feeney, MD  
Karla K. Murphy, MD  
James Engelbrecht, MD  
Richard Holm, MD  

A motion was made to accept the Report of the Reference Committee on Reports of the Commissions on Scientific Medicine; Internal Affairs, Communications and Liaison; and Professional Liability. The motion was seconded and carried.

Dr. Lowell Hyland read the Report of the Reference Committee on Reports of Special Committees and Miscellaneous Business.

REPORT OF THE REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES AND MISCELLANEOUS BUSINESS

The Reference Committee considered Resolution #3, Response to Senator Daschle’s American Health Security Plan, along with the Ad Hoc Committee report. The Reference Committee recommends adoption of Resolution #3 and adoption of the Ad Hoc Committee report.

The Reference Committee considered reports of the Continuing Medical Education Committee, the Budget and Audit Committee, the ShareCare Committee, the Grievance Commission, the South Dakota Political Action Committee, the Physicians HELP Committee and the Archives and History Commission and recommends approval of these reports.

The Reference Committee considered the report of the Board of Directors, South Dakota Medical School Endowment Association and recommends that the Board continue to explore utilizing the USD Foundation’s investment program.

The Reference Committee considered the report of the AIDS Task Force and recommends that the Task Force consider new AIDS tests which are becoming available and formulate recommendations concerning the use of such tests for the physicians of South Dakota.

The Reference Committee considered the report of the Special Medicare Committee noting with concern that the Committee was disbanded and requests that Dr. Reynolds comment to the House of Delegates why the Committee felt this action was necessary.

The Reference Committee considered Resolution #2, the Goals of Medicine, and recommends that Resolution #2 be rejected.

RESOLUTION #2

TO: House of Delegates  
FROM: Robert C. Goodhope, MD, MBA  
SUBJECT: The Goals of Medicine  
WHEREAS, "this new ability to keep patients alive has raised legal questions about when doctors may stop administering the therapy and let the patient die. And who should make the decision," and  
WHEREAS, "if medicine takes aim at death prevention rather than at health and relief of suffering...then it is tacitly asserting that its true goal is bodily immortality," and  
WHEREAS, in 1989, the AMA Council on Ethical and Judicial Affairs opined. "The social commitment of the physician is to sustain life and relieve suffering," thereby tacitly perpetuating bodily immortality as a goal of medicine and rendering impossible a medical determination of futility where futility is defined as the inability to achieve the goals of medicine, therefore be it  
RESOLVED, that the independent and overriding goals of medical intervention should be
RESOLVED,

that the South Dakota State Medical Association submit this resolution to the American Medical Association House of Delegates.


Resolution was rejected at the Second House of Delegates' meeting.

Respectfully submitted,
REFERENCE COMMITTEE ON REPORTS
OF SPECIAL COMMITTEES AND
MISCELLANEOUS BUSINESS
Lowell Hyland, MD, Chairman
Curtis Buchholz, MD
Robert Preston, MD
Richard Renka, MD
Richard Gere, MD
Duane Reaney, MD
Tad Jacobs, DO

Richard Holm, MD
Russell Harris, MD
John Sall, MD

A motion was made to accept the report of the Reference Committee on Reports of Special Committees and Miscellaneous Business. The motion was seconded and carried.

Dr. Thomas Stolte, Minnesota Medical Association President addressed the House of Delegates concerning Minnesota's Health Right Act.

Dr. M. George Thompson was installed as president of the South Dakota State Medical Association and briefly addressed the House of Delegates. The presidential address was followed by introduction of the new officers.

There being no further business, the meeting adjourned at 11:15 am.

PRESIDENTIAL OATH OF OFFICE

I SOLEMNLY SWEAR THAT I shall carry out the duties of the President of the South Dakota State Medical Association to the best of my ability. I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving health standards and to the task of bringing increasingly improved medical care to the people of South Dakota. I shall uphold the Constitution and Bylaws of the AMA and the South Dakota State Medical Association. I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans.

I do solemnly swear that I will discharge the duties of this office to the best of my ability, so help me God.
REPORT OF THE PRESIDENT AND CHAIRMAN
OF THE EXECUTIVE COMMISSION

"It's lonely at the top", someone once said, and I'm certain that in many instances that would ring true, but thanks to a myriad of understanding people that was not an experience I was to have during my year as your president!

A debt of gratitude (which can never be fully repaid) is owed Mr Robert Johnson, whose fait accompli of getting yours truly through this year will be recorded in the annals of one of, if not the most, Herculean tasks ever performed! A special thanks to Bob's wonderful family for their support to both Marlys and myself throughout this tenure, and especially for opening their home to allow an old soldier and his forever young (but just as weary) wife in for a most rejuvenating respite between battles!

Thanks to Mrs Jeri Spars, the Managing Editor of the South Dakota Medical Journal, I was not placed in chains and driven from the land, although this fate was more than richly deserved, for not once was the President's Page submitted on time. To Mrs Jan Anderson goes a special thank you, for having the courage and fortitude to continue to answer the phone each time I called with one more dumb question! Through Jan and the always professional staff, not only is it all put together, but it's kept together!

And a thank you to all of you out there whom I've had the privilege of meeting and to those I have not yet met, for allowing me the honor of being a part of your professionalism! As your president this year you have given me the liberty of traveling around this great state of ours, visiting each of the districts with Bob Johnson our CEO. Reflecting back, I feel we came away from these thought-provoking meetings with 100 messages:

TOO much government intervention, manifested mainly through bureaucratic regulations that would keep a compulsive archivist extremely happy for years, which in turn has led to the second message.

TOO little time left after dealing with this "hassle factor" to spend caring for our patients!

However, as an old Sergeant Major used to say, "there are not problems, only opportunities!" and it is reassuring to know that each district has HALLMARKED!, i.e. sent their very best people, to represent their views on the Council and in the House of Delegates so that these "opportunities" might be collectively addressed. I am absolutely certain that these "opportunities" will be resolved, not only because of the excellence of your representatives but most of all because we have at the very heart of our deliberations the health and welfare of our patients!

Bob Johnson and myself, along with your AMA delegate, Robert L. Ferrell, MD, (anyone who would drive from Rapid City to Minneapolis during the worst snowstorm of the year to attend the North Central meeting not only tells you of his dedication, but reflects the wisdom of the Council in their choice!), and your alternate delegate Michael Pekas, MD (an equally wise choice on the part of the Council, for not only is Mike quite knowledgeable and capable of precisely expressing that knowledge, but reticence in so doing is not his strong suit!), attended the Annual AMA meeting in Chicago, and the Interim meeting in Las Vegas, where a little luck and a little government were nowhere to be found!

I came away from these meetings convinced now more than ever that as physicians we all have the same goals, and it is crucial that our unity be made crystal clear! The road ahead demands that we speak with but one voice which will be heard, starting as a whisper at the district level, becoming amplified at the level of your State Association, to be delivered with a SHOUT from YOUR American Medical Association! THE BEST MEDICAL CARE IN THE WORLD WILL BE PROVIDED BY THE BEST PHYSICIANS IN THE WORLD TO AS MANY AS HUMANLY POSSIBLE ONLY IF WE ALLOWED THE FREEDOM TO DO SO!!

Respectfully submitted,
Richard J. Porter, MD
President and Chairman
Executive Commission

The Reference Committee reviewed the Report of the President and Chairman of the Executive Commission and recommended it be accepted as submitted.

REPORT OF THE PRESIDENT ELECT

Having been involved in the South Dakota State Medical Association as well as DAKOTACARE and the Board of Medical and Osteopathic Examiners for many years, I feel this can bring some continuity to the office of president of our Association. During the past year I also attended the AMA leadership conference in Los Angeles, which all future officers should attend. Visiting with leadership from other states leads me to believe that we have an enviable situation in South Dakota by being led by a CEO such as Bob Johnson and his staff. I also congratulate Dr Porter, the Executive Commission and the Council for a very successful year. All such years are made possible by the hard work which also comes from our commissions. As this is our election year we will all have to work extra hard to protect our rights and that of medicine.

Respectfully submitted,
George Thompson, DO
President Elect

The Reference Committee reviewed the Report of the President Elect and recommended it be accepted as submitted.

REPORT OF THE VICE PRESIDENT

After being the Chairman of the Council, the vice presidency is somewhat of a letdown -- a job Dan Quayle could love. I have enjoyed continued involvement by attending Council and Executive Committee meetings.

Respectfully submitted,
Thomas L. Krafka, MD
Vice President

The Reference Committee reviewed the Report of the Vice President and recommended it be accepted as submitted.

REPORT OF THE SECRETARY-TREASURER

The Council has spent time this year trying to make the South Dakota State Medical Association more responsible to our members and to provide a greater service to them. We are exploring several ways that we can provide help to the membership both as individual physicians and as an entire group. We are looking at increasing the representation on the council for each district. This will increase involvement in the decision making for our Association.

I have also continued to be involved with the Young Physicians Section. We continue to encourage involvement by the young physicians, both on a state and national level.

SOUTH DAKOTA

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We need your support and input to continue improved service to our members.

Respectfully submitted,
Mary S. Carpenter, MD FAAFP
Secretary-Treasurer

The Reference Committee reviewed the Report of the Secretary-Treasurer and recommended it be accepted as submitted.

REPORT OF THE CHAIRMAN OF THE COUNCIL

I was honored to be elected Chairman of the Council at the June 8, 1991 Council Meeting. It has been a privilege to serve the Council and the State Medical Association in this role. The year has been challenging on many fronts. Your Council continues to meet and respond to the challenges as outlined below.

Officers elected and Councilors seated:
Chairman of the Council - James Engelbrecht, MD
Secretary-Treasurer - Mary Carpenter, MD
Seated Councilors - Daniel Kenelly, MD
Stephen Haas, MD
James Wunder, MD
Julie Stevens, MD

The Council considered and took action as follows:

Developed general policy on AIDS testing and recommended the SDSMA AIDS Task Force be the Medical Association's representative to the State Health Department's AIDS coalition. The Executive Commission and Council continue to be involved in AIDS policy development.

Reiterated support of the ShareCare program recommending enrollment in the program to not require membership in the South Dakota Association of Senior Centers and Citizens nor any special enrollment fee.

Approved format for the 1992 annual meeting with the addition of individual event tickets as an alternative to an all inclusive registration.

Reviewed and accepted reports from the AMA student section and the young physicians section.

Appointed Dr Raszkowski and Dr Malm as the representatives of SDSMA to the SDSU College of Nursing Rural Health Care Enhancement project.

Approved a joint marketing plan of the AMA-HIV insurance proposal to the SDSMA membership.

Approved a resolution supporting the general concept of a new family practice residency in the west river area.

Reviewed a proposal from Dakota Hills Homestead regarding payment of "finder fees." This issue was reviewed from a legal and ethical standpoint and the Council reinforced the feeling that this was unethical and a letter stating such was sent to the physicians potentially affected by this proposal.

Supported the Auxiliary resolution on eating disorders which was submitted to the AMA Auxiliary as a potential national project.

Endorsed the Governor's Council on Physical Fitness and Sports and submitted Dr McKichan's name for consideration of appointment to that council.

Established and approved the 1992 legislative agenda.

Elected Endowment Association and SoDaPAC directors. Reviewed DAKOTACARE reports. Solicited nominees for the South Dakota Drug Policy Board.

Reviewed the mental health code and amendments regarding commitment procedures. Several problems were identified and a resolution outlining these problems and recommending appropriate revision was approved.

Prior to the 1991 Annual Meeting the Council held a "goal setting" session identifying five priorities for the SDSMA. These priorities were then sent to the appropriate committees for further review. The Council continues to receive reports on these and will develop appropriate responses. This process is also laying the foundation for the development of a formal mission statement.

The House of Delegates resolved that the Council review Health Access problems in South Dakota and then develop a plan to address these problems. This report is to be submitted to the 1992 House of Delegates. The Council has solicited input and has developed recommendations as submitted to the House of Delegates.

Received reports and reviewed initial public relations activity from Lawrence and Schiller.

Elected Distinguished Service Award and Community Service Award recipients.

Elected the following members to honorary membership:

Si Lee, MD
Peter B. Carter, MD
Patrick McGuigan, MD
Paul Dzintars, MD
B. J. DeSai, MD
Marion Thompson, DO
Loyd R. Wagner, MD
David Seaman, MD
Donald Weatherill, MD
R. C. Jahraus, MD
Richard N. Smith, DO

E. F. Kalda, Sr., MD
George Flora, MD
Marion Cosand, MD
C. S. Roberts, MD
John B. Janis, MD
E. S. Palmerton, MD
R. G. Belatti, MD
Richard Gere, MD
Thomas Willcockson, MD
Bernard C. Gerber, MD

I appreciate the opportunity to serve as Council Chairman. This task is truly made possible by the commitment and support of the SDSMA staff with special recognition of the efforts of Jan Anderson and Bob Johnson.

Respectfully submitted,
James Engelbrecht, MD
Chairman of the Council

The Reference Committee reviewed the Report of the Chairman of the Council and recommended it be accepted as submitted.

REPORT OF THE AMA DELEGATE

Thank you for the privilege of serving in the American Medical Association House as your delegate. The annual meeting was held as usual in Chicago in June and the interim meeting in Las Vegas in December. I attended both as delegate and Mike Pekas did so as your alternate delegate. The material presented, discussed, and voted upon at these sessions is sufficiently complicated and detailed that having so willing an alternate as Mike helps in keeping order to all that is going on.

Having become acquainted with the goals and processes
of the AMA, it is impossible not to be impressed with the strength, intelligence, and vigor with which the best interests of our profession are pursued by the AMA. Actions by the AMA House of Delegates daily touch the lives of each and every physician in this country. I admit it is difficult to appreciate this in such times of over-regulation, character assassination, and downright organized cheating carried on by the Federal Government but believe me, our plight would be unrecognizable were it not for the efforts made on our behalf through the AMA.

Detailed reports of the actions of both House of Delegates meetings have been sent to you under separate cover.

It behooves us to continue our support to keep the AMA strong.

Health Access America is continuing its goal of access to quality medical care for all Americans. This continues to be our primary and overriding concern.

The "final" rules for physician office laboratory regulation, while having been modified, did not come down as promised so there will hopefully (and with continued AMA effort) be a significant delay in implementation so that some common sense may prevail before our patients suffer more harm at the hands of poorly guided federal regulators.

I have been chosen Chairman of Reference Committee C for the annual meeting in Chicago in June, an honor that most assuredly would have been bestowed upon our friend Woody Lang who represented us so well had he been able to defeat his cancer. I shall try to conduct this committee in the manner he would have.

Our organization must remain alert to ever increasing demands on our profession and counter those demands not in the best interest of our patients. We remain the patient's true advocate and while this carries awesome responsibilities it also carries with it the highest honor that can be bestowed upon this planet.

Respectfully submitted,
Robert L. Ferrell, MD
AMA Delegate

The Reference Committee reviewed the Report of the AMA Delegate and recommended it be accepted as submitted.

REPORT OF THE AMA ALTERNATE DELEGATE

I was elected as your alternate delegate to the AMA at the last annual meeting in June of 1991. I attended the AMA annual meeting in June in Chicago as well as the interim meeting this past December in Las Vegas. The American Medical Association and its federation of state medical societies and associations was never more important than it is today. The changes that face organized medicine in the form of health care reform require a unified front from organized medicine so that the result of this health care reform will be continued access to quality health care for our patients. I have attended all of the Council and Executive Commission meetings since my election to this office and before that served as councilor at large and immediate past president of the South Dakota State Medical Association.

I look forward to serving you in this important position. Please feel free to contact me at any time concerning your views, with regard to organized medicine so that I can represent you in the North Central Medical Conference and the American Medical Association the most effective way that I can. I am proud to serve as your alternate delegate to the AMA.

Respectfully submitted,
Michael W. Pekas, MD
AMA Alternate Delegate

The Reference Committee reviewed the Report of the AMA Alternate Delegate and recommended it be accepted as submitted.

REPORT OF THE SPEAKER OF THE HOUSE

The annual meeting of the South Dakota State Medical Association will be held in Rapid City, South Dakota, from June 4-6. We are again looking forward to the House of Delegates meeting. The House of Delegates plays a vital role in the functioning of the State Medical Association. Resolutions can be submitted from the district medical societies, as well as individuals, at the time of the state meeting. The resolutions become the focal point of the House of Delegates through the reference committees. Last year all members of the House of Delegates were assigned to reference committees. The function of these committees is to allow for smaller group interaction on the resolutions.

A reference committee consensus report, and if needed, a minority report will be submitted to the second House of Delegates meeting for full discussion by the House of Delegates.

The House of Delegates continues to be a forum in which the problems facing medicine can be discussed. I am looking forward to a profitable House of Delegates assembly. I would encourage any guests or visitors to attend the House of Delegates sessions, as this is a good way for new South Dakota physicians to become involved with the State Medical Association.

Respectfully submitted,
James R. Reynolds, MD
Speaker of the House

The Reference Committee reviewed the Report of the Speaker of the House and recommended it be accepted as submitted.

REPORT OF THE COUNCILOR AT LARGE

Over the past year as Councilor at Large, I was privileged to attend the meetings of the Executive Commission, the House of Delegates, and the Council. I am grateful for the continuing opportunity to serve our organization in my capacity as Councilor at Large. There seems to be a never ending series of new problems which face organized medicine and it is certainly incumbent on all of us to remain vigilant and meet the challenges with which we are presented daily. I have thoroughly enjoyed my years in the Association as both a member and officer and will continue to maintain an interest in the functions and activities of the State Medical Association and hope to be able to participate in any way deemed appropriate by the membership. I am most grateful to the members of our organization for the excellent leadership which our organization enjoys and for all of the help and support that I have received from the membership at large and from the administration of the State Medical Association over the past many years.

Respectfully submitted,
J. A. Eckrich, MD
Councilor at Large

The Reference Committee reviewed the Report of the Councilor at Large and recommended it be accepted as submitted.

SOUTH DAKOTA
REPORT OF THE CHIEF EXECUTIVE OFFICER

To say that the American health care system is under intense public and political scrutiny would truly be an understatement. I doubt that any candidates for high political office will run their campaign without some statement calling for health care reform.

It goes without saying that our present system has its short-comings and needs improvement, but to throw it out and replace it with a dusted off version from some foreign country doesn’t make any sense and would be a tragedy for the American public.

The AMA has recommended changes through their Health Access America program, and your State Association is customizing Health Access America for the unique needs of South Dakota. These efforts are a positive and proactive way of improving our health care system without destroying the many strengths of our current system.

Throughout this past year, the Commission members and Councilors have once again given generously of their time and talents to establish a long range public relations program, a responsible position on AIDS, a positive legislative package, improved physician involvement in the Association, and as previously discussed, positive improvements in our current health care delivery system. An expression of thanks seems almost inadequate for all their efforts, but needless to say, their efforts, along with that of all members, are deeply appreciated.

This past year has given me the unique opportunity to get to know both Marlys and Richard Porter better. What a delightful couple. To Dr. Porter, our outgoing President, I salute you for your courage, compassion, and commitment to achieving lofty goals. You have truly represented the profession you love so much in an outstanding way.

As we look ahead to the coming year, I expect it will be challenging and there will be great frustration as the real debate on health care reform develops in earnest. I feel confident that we are prepared to meet the challenge. It will, however, require the unified support of the entire membership. Like never before, we must pull together, as the outside forces calling for change will try to pull us in many different directions.

Respectfully submitted,

Robert D. Johnson
Chief Executive Officer

The Reference Committee reviewed the Report of the Chief Executive Officer and recommended it be accepted as submitted.

REPORT OF THE FIRST DISTRICT COUNCILOR

Since June 1991, the time of the last annual meeting of the Medical Association, District 1 has had a year full of activity in the practice of medicine, the real core of our existence. The Aberdeen District Medical Society met each month with emphasis on professional programs having a series of guest speakers on a variety of medical subjects.

It has been a time of change with many new faces choosing Aberdeen as a place to practice. Sadly, some of our old faces are absent. Dr. William Bornes was mortally injured in an auto accident. His passing left a large practice to assimilate. Dr. Peter Carter retired pursuing a life style to relieve some of the risk of a chronic heart problem. Dr. David Seaman announced his retirement last fall. Dr. Bernard Gerber has recently announced his retirement. These individuals have contributed an immeasurable service to the people of this area.

Several physicians are relocating, soon to be here, bringing new services previously not available on a full time basis. St. Luke’s Midland Regional Medical Center has begun the execution of an ambitious expansion of the hospital bringing new operating room facilities, out-patient surgery and services. The adaptation to the two hospital consolidation has taken place in a timely fashion producing a cohesive attitude in the hospital environment.

The Aberdeen District Medical Society Auxiliary has been active in their projects of fundraising and presence in the political and governmental procedures with style and effectiveness.

While our attendance and business agendas have at times been light, the District will be more active in organizational affairs as the need and opportunities present. We must accept some changes, but we have no desire to be devoured by the uninformed influence of politics and government.

We have asked our patient constituency to re-evaluate their access to medical care and have stood ready to assist them when help and direction are needed.

Respectfully submitted,

Winston B. Odland, MD
First District Councilor

The Reference Committee reviewed the Report of the First District Councilor and recommended it be accepted as submitted.

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AUGUST 1992
REPORT OF THE THIRD DISTRICT COUNCILOR

This district has continued its meetings during 1991. The meeting in February was held in Brookings. Dr Curtis Wait was elected Councilor of the Third District. Delegates to the South Dakota Medical Association were Dr Richard Holm and Dr Richard Hibb. Alternate delegates were Dr Gary Bruning and Dr Tad Jacobs, Dr Keith Burnes, an ophthalmologist, spoke to us.

The district met again in April in Brookings. The discussion regarding the oblique face of medicine and what we could do about it was very interesting.

The meeting of June 20 was held again in Brookings. A presentation of cardiovascular care and what's new was given to us.

On August 22, 1991, the meeting was held in Brookings again. A lecture by Dr Backus regarding geriatric cardiology was given as well as an interesting general business meeting.

On October 24, 1991, the meeting was held in Brookings. The Doctor of the Day program was discussed. Dr Bruce Lushbough discussed problems with reimbursement of EKGs. Dr Filler and Dr Johnson were approved for membership in the Third District. Dr Roberts was approved for honorary life membership. Dr Rick Holm gave an update on RBBVS.

December 18, 1991, the meeting was held in Madison. Dr Porter gave us an update of the state of medicine in South Dakota. Jan Anderson discussed various legislative matters. New officers for 1992 are: John Ramsay, MD, president, Gary Bruning, DO, vice president and Merritt Warren, MD, secretary.

Respectfully submitted, Curtis Wait, MD
Third District Councilor

The Reference Committee reviewed the Report of the Third District Councilor and recommended it be accepted as submitted.

REPORT OF THE FOURTH DISTRICT COUNCILOR

The Fourth District Medical Society held their annual meeting in January, 1991.

The business portion of the meeting consisted of election of officers. Dr Brent Lindblom was elected president of the district medical society and Dr Eldon Becker was elected as the secretary. Dr Phillip Hoffsten continues as a councillor from the Fourth District with Dr Huber as alternate councilor. Delegates for 1992, will be Dr Brent Lindblom and Dr Ken Bartholomew. Alternate delegates will be elected at a later time.

Dr Richard Porter was present for the Fourth District meeting. He made a presentation and discussion followed. The continued success of DAKOTACARE was again noted.

The Fourth District Medical Society in conjunction with the Continuing Education Department at St. Mary's Hospital sponsored the following CME programs:

<table>
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<tr>
<th>Date</th>
<th>Topic</th>
<th>Presenter</th>
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<tbody>
<tr>
<td>January 15, 1991</td>
<td>Rehabilitation of the Stroke Patient</td>
<td>Dr Steven Goff</td>
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<tr>
<td>March 19, 1991</td>
<td>New Perspectives in the Treatment of Anxiety and Depression</td>
<td>Dr Frederick W. Engstrom</td>
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April 16, 1991  Hepatitis B Treatment and Prevention - Dr Gary Bochna
May 21, 1991  Modern Concepts of Menopause and Estrogen Replacement - Dr Thomas Pruse
June 18, 1991  Gestational Diabetes - Dr J. Michael McMillin

September 17, 1991  Medical Aspect of Rheumatoid Arthritis - Dr James A. Engelbrecht

The membership of the Fourth District Medical Society has changed substantially in the past year. We all mourned the death of Dr Mark Werpy who passed away in October, 1991. Dr Curtis Jahrus retired after 38 years at Medical Associates Clinic in February, 1992. Dr Marion Cosand retired in November, 1991, and has moved to Arizona. Fortunately additions to our medical staff include Dr Ken Bartholomew who relocated from Faulkton, South Dakota to Pierre where he will continue in family practice. New additions to the medical staff are anticipated in the next year as our recruiting efforts continue.

Respectfully submitted,
P. E. Hoffsten, MD
Fourth District Councilor

The Reference Committee reviewed the Report of the Fourth District Councilor and recommended it be accepted as submitted.

REPORT OF THE FIFTH DISTRICT COUNCILOR

The Fifth District Medical Society continues to meet in Huron on a quarterly basis. New district members include: Dr Lois Truh, Dr Sonja Wyckoff, Dr Jeff Wheeler and Dr Shirrang Lele, all of Huron. Dr Richard Smith is retired from active practice.

New officers for the district include Dr Mark Belyea, president; Dr Stephan Schroeder, vice president; and Dr Knute Landreth, secretary.

The district meetings continue to be held in conjunction with medical education programs at Huron Regional Medical Center. Dr Richard Porter visited the district in October.

A Committee has been formed in the district to decide on potential scholarship programs to be awarded from fifth district contributions.

Respectfully submitted,
Stephan Schroeder, MD
Fifth District Councilor

The Reference Committee reviewed the Report of the Fifth District Councilor and recommended it be accepted as submitted.

REPORT OF THE SIXTH DISTRICT COUNCILORS

Since the last report the Sixth District Medical Society has met several times. On May 1, 1991, E. Steeves Smith discussed living wills vs. durable power of attorney. On August 28, 1991, the district met in Chamberlain and Daniel Hilleman, Pharm D. presented a program on the "Effect of Food on the Bioavailability of Certain Cardiac Drugs." On December 5, 1991, Dr. Richard Porter, president of the State Medical Association, made his official visit to the district along with Bob Johnson, State CEO. At the January 30, 1992, meeting Richard J. Barth, MD gave a presentation on "Diabetes and Hypertension."
New members accepted into the district during the past year include Doctors: Phillip Barker of Parkston, Robert Kundel of Chamberlain, Mark McKenzie and Lonnie Nedved of Mitchell. Members who have retired from practice and who were elected to honorary life membership include Richard Gere, MD and Donald Weatherill, MD. District officers for 1992 are president, Lucio Margallo, MD; vice president, Patricia Malters, MD and secretary/treasurer, Ronald Anderson, MD.

Respectfully submitted,
Lucio Margallo, MD
Walter Baas, MD
Councillors, Sixth District

The Reference Committee reviewed the Report of the Sixth District Councillors and recommended it be accepted as submitted.

REPORT OF THE SEVENTH DISTRICT COUNCILORS

The Seventh District Medical Society continued to meet monthly except during the summer. Since the time of the last report, Dr Robert Raszkowski has completed his term as president, and Dr John Sall began his presidency in January. The other officers for 1992 are Dr Robert Vandemark, Jr, president-elect; Dr Dan Blue, secretary; and Dr Karla Murphy, treasurer.

In September, Dr Mary Carpenter met with the Young Physicians before the regular meeting. Later she described the Young Physicians movement within the AMA to the membership who voted to provide financial support for a Young Physician member to attend their annual meeting. The program on the RBRVS was presented by Sandy Sherman, Senior Health Policy Analyst of the AMA. In October, the meeting centered around a discussion of the two-ambulance issue in Sioux Falls and Minnehaha County.

After the election of officers for 1992, and the election of Dr Dan Kennelly as the eighth councilor because of membership growth, Dr Talley presented his annual report on the status of the Medical School at the November meeting. He discussed the multiple new educational initiatives in South Dakota (PT, OT, PA, Yankton Model Program, and the Rapid City Family Practice Program) and the construction of a new building for the Medical School and associated health sciences library.

In December, members and spouses met with area legislators and members of the South Dakota Health Department's AIDS Coalition to hear presentations on AIDS in South Dakota by Drs Don Humphreys and Wendell Hoffman. The program served to heighten awareness, with an extensive and frank discussion following the formal presentations.

The January and February meetings were presentations by area hospital administrators who presented a wide variety of health care perspectives. In March, the annual president's visit was held. Following Dr Porter's remarks, Bob Johnson presented an overview of the recently completed legislative session. The topic for the April meeting was the Federal Trade Commission law and health care. This topic was presented by Mr. Michael Ile of the AMA's Office of General Counsel.

The councilors, officers, and the membership congratulate the Seventh District Auxiliary on their highly successful "Sawbones vs. Jawbones" basketball game with the Second Judicial Bar Association. Proceeds from the first game were used to help present educational seminars last fall on "Reclaiming Youth at Risk" and "Parenting Courageous Children." This year, the auxiliary plans to continue their "Children at Risk" series with AIDS as the focal point. The district is proud of their efforts and takes this opportunity to publicly thank them.

Respectfully submitted,
Robert Raszkowski, MD
Jeffrey Hagen, MD
Rodney Parry, MD
C. Roger Stoltz, MD
K. Gene Kody, MD
Guy Tan, MD
Lowell Hyland, MD
Daniel Kennelly, MD
Seventh District Councillors

The Reference Committee reviewed the Report of the Seventh District Councillors and recommended it be accepted as submitted.

REPORT OF THE EIGHTH DISTRICT COUNCILOR

The Eighth District Medical Society met on four occasions during 1991 and 1992. Beginning in April of 1991, with a presidential visit by Dr Eckrich and Executive Officer, Bob Johnson. New members elected at the April meeting were Dr Jem Hof, Dr James Ruggles and Dr Charles Yelverton. Officers for the 1991/1992 year were President, Larry A. Meyer, MD, Vice President, Max Farver, MD, Secretary-Treasurer, Lori Hansen, MD.

Delegates to the State Medical Association meeting were selected including: Jem Hof, MD, Charles Yelverton, MD, Frank Messner, MD, Morris Radack, MD.

Alternates were: Ted Sattler, MD, Harold Fletcher, MD, Art Reding, MD, John Sternquist, MD.

Duane Reaney, MD, was selected as the representative to the nominating committee and Larry A. Meyer, MD, was selected as a councilor for the following three years.

Our second meeting of the year was held in July, 1991, aboard the Far West Excursion Boat. New members elected at that meeting included: James Kerr, MD, George Pasewitz, MD, E. F. Kuld, Sr., MD, of Platte was also elected to Honorary Life membership.

Julie Stevens, MD, was selected as an alternate councilor at the July meeting.

In October, the District Eight Society met with the following business conducted. Bruce Manns, MD, was approved for membership and legislative contacts were included David Smith, MD, for Senator Red Allen. Willis Stanage, MD, was selected as a nominee for the South Dakota State Medical Association Distinguished Service Award and a program was presented by Dr Richard Porter about his experiences the previous year in Operation Desert Storm/Desert Shield.

Our final meeting of the year, prior to this report, was held on January 8, 1992, with the following business conducted. Daniel Megard, MD, was selected as a new member as well as Gordon Field, MD. Delegates for the 1992 annual meeting were selected including: Robert Thompson, MD, Frank Messner, MD, David Smith, MD, Jem Hof, MD James Wiggs, MD and Ted Sattler, MD will serve as alternates.
Nominating representative for the 1992 Annual Meeting, Larry A. Meyer, MD. SoDaPAC Board of Directors, Dr Richard and Marlys Porter were selected to continue in this capacity.

Nominating Committee was selected for annual officers as well as selection of a councilor and alternate councilor.

We look forward to our final meeting prior to the state meeting in June with a presidential visit by Dr Richard Porter and Executive Secretary, Robert Johnson in early April.

Respectfully Submitted,
Larry A. Meyer, MD
Eighth District Councilor

The Reference Committee reviewed the Report of the Eighth District Councilor and recommended it be accepted as submitted.

REPORT OF THE NINTH DISTRICT COUNCILORS

The Black Hills District Medical Society retained much of the focus of the last two years. We have continued to be active politically through the ministrations of our legislative committee. As in the prior year, two dinners for legislators were held, including the social event in November and the "cracker barrel" session in April. We discussed both past legislation and anticipated issues. Throughout the year, legislative issues were discussed during society meetings. In that way, the membership was kept abreast of events in the state.

Vigorous efforts to maintain or increase the membership have continued. We are proud to announce the addition of 11 new members. At the same time, three were granted honorary status as they entered retirement.

Programs this year included presentations on the durable power of attorney by Dave Sandvik, MD. A "growing up healthy" program was put on by the State Department of Health. This concerned immunization of children. Dr Goodhope gave an informative presentation on Medicare issues. Toward the end of the year we heard about estate planning from a certified public accountant. In addition, a medical risk management seminar was arranged and presented at Regional Hospital.

The auxiliary was very active as always. Two auxiliaries went to the AMA Auxiliary conference in Chicago. The auxiliary has continued to attend MADD as part of our institutional membership. They contributed voluntary efforts to the Children's Miracle Network. A veritable flood of rubber duckies released on Rapid Creek helped raise money for this endeavor.

Dr Ferrell was appointed to the Nursing Education Advisory Committee within the last year.

Charities were well supported by the Medical Society. We contributed to the Robert Hayes Memorial Scholarship Fund for physicians assistants. We contributed the major prize for the local "fun run", an event which promotes health and physical fitness. A significant sum was given to Storybook Island, a playground for children in Rapid City.

Throughout the year we have been quite focused on the Health Access America issues. Some ideas were forwarded to the Council from the Ninth District.

Dr Tom Hermann, MD, is the new president-elect for 1992-93.

Respectfully submitted,
James Engelbrecht, MD
Stephen Haas, MD
Richard Renka, MD
Geoffrey Slingsby, MD
Carol Zielike, MD

Ninth District Councilors

The Reference Committee reviewed the Report of Ninth District Councilors and recommended it be accepted as submitted.

REPORT OF THE TENTH DISTRICT COUNCILOR

As District 10 councilor I would like to update our report on our district medical meeting. We were able to have a limited district meeting with Dr Bolliger, Dr Nemier, Dr Clark and Dr Kafka present from Gregory, as well as Dr Berg, Dr Carpenter and Dr Tobin present from Winner. The original meeting was scheduled with Dr Porter and Bob Johnson, but a blizzard hit that night and it had to be cancelled. The official yearly meeting has not been held as of this date.

Elections were held and officers are as follows:
President - Melanie Schraun, DO
Vice President - Robert L. Steihl, MD
Secretary-Treasurer - E. P. Sweet, MD

Discussion was held regarding the availability of medical services in the area regarding ultrasounds and some difficulties with getting these interpreted. This issue is being addressed and updating of the equipment for the various sites in the district were identified. In addition, discussion was carried out regarding the current legislative issues. General support of the official medical association positions were voiced by the majority of the members present. An official meeting is to be planned later in the spring or summer. Hopefully we can coordinate this with the visit from Mr Johnson and Dr Porter. The district membership would also like to congratulate Dr Melanie Schraunn on the arrival of her bouncing baby boy born on March 22, 1992.

Respectfully submitted,
John A. Malm, MD
Tenth District Councilor

The Reference Committee reviewed the Report of the Tenth District Councilor and recommended it be accepted as submitted

YOUR CONTRIBUTION IS NEEDED TO THE SOUTH DAKOTA MEDICAL SCHOOL ENDOWMENT FUND
REPORT OF THE ELEVENTH DISTRICT COUNCILOR

During the past year we have had several meetings of the Eleventh District Medical Society at which time scientific sessions were presented on various topics with outside consultants. In January of 1992, we met with the officers of the South Dakota State Medical Association prior to the legislative session beginning in Pierre.

During the March, 1992, meeting new officers for the Eleventh District Medical Society were elected and they are as follows: Ben Henderson, DO - President, J. D. Collins, MD - Vice President, L. M. Linde, MD - Secretary, J. D. Collins, MD - Delegate, L. M. Linde, MD - Alternate Delegate, James Wunder, MD - Councilor, J. D. Collins, MD - nominating committee member.

Respectfully submitted,
James F. Wunder, MD,
Eleventh District Councilor

The Reference Committee reviewed the Report of the Eleventh District Councilor and recommended it be accepted as submitted.

REPORT OF THE TWELFTH DISTRICT COUNCILOR

The Whetstone Valley District Medical Society had its customary three meetings in 1991. The spring meeting was held in Webster and consisted of a scientific program and a business meeting. The summer meeting was held in Rosholt at the home of Dr. Joseph Kass and was attended by the CEO and Dr. Richard Porter, president of the Medical Association, for an update on State Medical Association affairs. Our fall meeting was held in Milbank and the feature presentation was by a Medicare representative to answer questions regarding Medicare changes.

Newly elected officers for the 1992-1993 year include:

Joseph Kass, MD, Rosholt - President and Secretary
David Oey, MD, Sisseton - Vice President
Kevin Bjordahl, MD, Webster - Annual Meet. Delegate

Dr. Kevin Bjordahl, Webster, is the current councillor from the Twelfth District, and has two years remaining on his term.

Respectfully submitted,
K. L. Bjordahl, MD
Twelfth District Councilor

The Reference Committee reviewed the Report of the Twelfth District Councilor and recommended it be accepted as submitted.

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COMPANY ________________________ SPECIALTY ________________________
ADDRESS ________________________
CITY ________________________ STATE __________ ZIP __________
TELEPHONE ________________________ BEST TIME TO CALL __________

Business Resources Ltd., 620 South Cliff Avenue, Sioux Falls, SD 57104

AUGUST 1992
REPORT OF THE COMMISSION ON LEGISLATION AND GOVERNMENTAL RELATIONS

The Commission on Legislation and Governmental Relations met on October 24, 1991. At that time the Commission considered numerous legislative issues and made recommendations to the Council of the SDSMA concerning a legislative program for 1992.

The Commission recommended that legislation be drafted and introduced by the State Medical Association to ensure confidentiality and appropriate storage for both doctor and hospital records when a physician closes his practice or dies and when a facility closes. This bill subsequently passed the 1992 Legislature.

This Commission also recommended that the State Medical Association introduce an amendment to the Medical Practice Act to exempt physicians permanently licensed in another state and eligible for licensure in South Dakota from obtaining a license if they are members of 1) an organ harvesting team, 2) on-board an air ambulance, 3) providing one time consultation or teaching assistance not to exceed 24 hours; or 4) providing consultation or teaching assistance approved by the Board to charitable organizations. Again, this bill was introduced and did pass the Legislature.

Following is a listing of other legislation which the Commission recommended the SDSMA endorse:

1. Establishment of a state insurance pool for uninsurables, provided the funding comes from the general fund.

2. Amendment to the Physician Assistant Law which would extend the 48 hour limit on prescribing controlled substances to a reasonable time to be determined by the physician assistant's supervising physician.

3. Establishment of a physician assistant program at the University of South Dakota in conjunction with the medical school, with an estimated cost of $150,000.

4. Amendment to the Durable Power of Attorney law which would extend immunity to physicians when acting in good faith.

Several other legislative items were considered including a corporate practice law which would allow hospitals and other facilities to employ physicians directly rather than requiring contract or other arrangements as is now necessary. This will be considered further at the fall 1992 meeting when representatives from the Hospital Association can be present and when information on Montana's experience with this law is available.

The Commission received a request to endorse an amendment to the Physical Therapy Practice Act which would allow physical therapy assistants to be supervised by a licensed physical therapist who is not on-site. The Commission asked to review a draft bill before the Medical Association took a position; however, this was never provided and the bill was not introduced into the 1992 session.

The Commission members were encouraged to participate in the legislator contact program set up for the 1992 session, to get in touch with their local legislators and establish a line of communication with them.

The Commission also considered the Number 3 priority as established by the Council of the State Medical Association which is "paraprofessional relationships." Some discussion was held; however, it was decided this would be considered in depth at their next meeting and a recommendation developed at that time.

Respectfully submitted,
Thomas H. Olson, MD, Chairman
Commission on Legislation and Governmental Relations

The Reference Committee reviewed the Report of the Commission on Legislation and Governmental Relations and recommended acceptance of the report as submitted with the request that the Commission specifically address the issue of the uninsurable pool and explore alternative sources of funding for that pool. Also, if an amendment to the Physical Therapy Practice Act is introduced which would allow employment of physical therapy assistants at locations removed from the supervising physical therapist, such amendment should specify the frequency of on-site supervision.

REPORT OF THE COMMISSION ON MEDICAL SERVICE

The Commission on Medical Service met twice in 1991. The first meeting took place on May 23, 1991, with seven members present.

The primary purpose of this meeting was to consider the 10% Medicaid increase for physicians and to recommend how this increase be allocated to South Dakota physicians fairly. We noted the growth in Medicaid services for maternal and child health care. The Commission made several recommendations including:

1. That well child (EPSDT) exams be increased to $33.00.

2. That several of the more commonly used office codes be increased by 10% for 1992.

3. That ER physician reimbursement for hospital based physicians be equitable to the same level of service provided by non-hospital based physicians providing ER services.

We also discussed worker's compensation in South Dakota and the possibility of a tax on physician and hospital services which would be earmarked for Medicaid.

The Commission met again on November 18, 1991, with five members present. We reviewed correspondence from a South Dakota physician concerning insurance reimbursement problems. We affirmed the physician's right to submit his full charges to the insurance carrier.

We reviewed a physician rebuttal letter developed by the Indiana State Medical Association. The letter, addressed to the insurance carrier, asks the company to rephrase its message to the insured to correctly reflect that the company is not paying for the physician's usual charges rather than stating or inferring that the physician is overcharging. We asked the SDSMA legal counsel to review it and if appropriate, distribute it to SDSMA members for information.

We again discussed worker's compensation items which included:

1. South Dakota statute requires physicians to release patient records to the Department of Labor and the employer even without the patients' consent.

2. Industries' concern that physicians allow too much time off from work for injuries and don't understand the actual job involved.

SOUTH DAKOTA
3. Physician liability is greatly increased if a patient is allowed to return to work and is reinjured.

4. South Dakota statute allows patient to choose physician - this increases costs to industry.

5. Physicians and industries need better communication.

6. We expressed our interest in meeting with a representative from the Industry and Commerce Association.

7. We suggested that employers contact physicians about patients' progress and what light duty work is available.

8. We suggested that worker's compensation information be included regularly in the Grab Bag and that the SDSMA and the Industry and Commerce Association jointly develop an informational brochure for physicians and industry.

We noted that the Federal Occupational Safety and Health Administration (OSHA) will issue new guidelines December, 1991, that will affect medical employers - including physicians. We asked the executive office to review these and provide appropriate information.

We then discussed our priority assignment "health insurance availability and cost for South Dakota." Insurance accessibility is less of a problem in South Dakota than nationwide, but the cost for health care coverage is equal to the rest of the nation.

The Commission recommended that:

1. People be encouraged to buy insurance with higher deductibles and co-pays - when patients are partially responsible they're more careful with utilization.

2. Physicians be more aware of costs of procedures.

3. Physicians discuss costs with patients.

4. SDSMA develop a bill stuffer expressing physicians' concern for costs of health care and how to keep it down.

5. SDSMA inform the public that physicians tend to provide care regardless of whether patients have insurance or not.

6. Executive office develop a list of the 20 most ordered tests outside of the hospital, and their cost and provide this information to the members.

Respectfully submitted,
Jerome W. Bentz, MD, Chairman
Commission on Medical Service

The Reference Committee reviewed the Report of the Commission on Medical Service and recommended acceptance of the report as submitted but requests a review as to the reasoning for South Dakota statute dictating the release of workers' compensation records without patient consent and the physician liability thereby incurred. The Reference Committee also recommended that the State Medical Association remain proactive in the decision to deal with the availability and cost of health insurance in South Dakota.

At the September 1991 meeting the program for the scientific session at the South Dakota State Medical Association meeting for June 1992 was planned. The proposed rules for the state cancer data collection system were reviewed.

At the December 1991 teleconference several aspects of rural medical care in South Dakota were discussed. Guest presenters were Dr. Tom Dean and Dr. Barbara Fetters who are members of the Rural Health Advisory Committee. They gave an update on activities of the Office of Rural Health Advisory Committee and reviewed several of the issues of medical care in rural South Dakota. The Office of Rural Health has developed 11 priorities. It has addressed primarily the first 5 which include:

1. Rural hospitals
2. Underserved population
3. Emergency medical service
4. Primary physician availability
5. Mid-level practitioner availability

Three major concerns that could be addressed by the State Medical Association include:

1. Physician and mid-level practitioner recruitment for rural areas
2. Locum tenens coverage for rural physicians
3. Continuing medical education for rural physicians

Currently, the Office of Rural Health has printed some brochures and promotional material for physician recruitment. The medical school is working on a locum tenens program and for the long-term the medical school is trying to encourage physicians to stay in South Dakota, preferably in small communities. Continuing medical education programs are available through the USDSM teleconference programs and also the USDSM is proposing a state-wide library that would be available to all doctors in the state on a 24-hour per day basis.

Dr. Anthony Jawurek discussed problems with the emergency medical services system in the state and he discussed pending legislation to provide continuing education for EMS personnel. A report was also reviewed from Barbara Smith, Secretary of Health for the state of South Dakota. This report highlighted accidental deaths in the state. She also reported a need for physician involvement in the EMS system in South Dakota. In addition a report from Maynard Konechne, president of the EMT Association of South Dakota, was discussed. Problems that have been identified in their association include:

1. Need for education and training
2. Legislative funds to provide training
3. Support of the seat belt law

The committee did recommend that the State Medical Association support legislation to provide funding for EMS training and support a law for mandatory use of seat belts.

Respectfully submitted,
Curt Buchholz, MD, Chairman
Commission on Scientific Medicine

The Reference Committee reviewed the Report of the Commission on Scientific Medicine and accepted the report as submitted. The Reference Committee recommended that at least one member of the committees for which reports are being reviewed be appointed to the reference committee in order to answer questions encountered in the review of such report. The

REPORT OF THE COMMISSION ON SCIENTIFIC MEDICINE

The activities of the Commission on Scientific Medicine for 1991-1992 were as follows:
Reference Committee also recommended that the executive office prepare and mail to the membership a brief summary outlining the goals and objectives of the Office of Rural Health for informational purposes.

REPORT OF THE COMMISSION ON INTERNAL AFFAIRS, COMMUNICATIONS AND LIAISON

The Commission reviewed the Doctor of the Day Program for the 1992 legislative session. The plans for the Doctor of the Day office for the 1992 session included assigning a number of physicians from each district based on the number of physicians in that district. It was also recommended that a letter of explanation be sent to each doctor serving as the Doctor of the Day to remind them to bring their own prescription pad and stethoscope and they should bring their own sample of medications if they plan to give out samples while they are serving as Doctor of the Day.

Craig Lawrence and Ann Metli from Lawrence and Schiller, the public relations firm employed by the South Dakota State Medical Association, made recommendations that the South Dakota State Medical Association designate one spokesperson for the South Dakota State Medical Association and recommended that spokesperson be Bob Johnson, the CEO. Other issues addressed by Mr Lawrence included a response to negative press stating the South Dakota State Medical Association's position on specific subjects such as AIDS and HIV testing, the use of survey results to generate positive press, and to inform the SDSMA membership on the position taken by the Association prior to holding press conferences. After discussion, Dr Holm moved to recommend that the SDSMA designate Bob Johnson as the spokesperson and as an alternative using the SDSMA President as the secondary spokesperson. Dr Saloum moved that the staff arrange for appropriate training for the spokesperson on an annual basis for the SDSMA President-Elect and for the CEO as needed.

The Commission also considered the position of the Executive Commission regarding HIV testing.

The South Dakota member physicians deceased during the preceding year include the following:

Robert Hayes, MD  Wall, SD
Parry S. Nelson, MD  Watertown, SD
Lloyd C. Vogelgesang, MD  Gregory, SD
John C. Rodine, MD  Aberdeen, SD
Ronald Price, MD  Armour, SD
Mark Werpy, MD  Pierre, SD
Dennis Johnson, MD  Sioux Falls, SD
Harry Bartron, MD  Watertown, SD
Lawrence L. Massa, DO  Sturgis, SD
William A. Bormes, MD  Aberdeen, SD
Anthony Petres, MD  Salem, SD
John W. Donahoe, MD  Sioux Falls, SD

Respectfully submitted,
Kenneth B. Peterson, MD, Chairman
Commission on Internal Affairs, Communications and Liaison

1992-1993 BUDGET

SOUTH DAKOTA STATE MEDICAL ASSOCIATION

GENERAL FUND

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1992-1993 BUDGET

JOURNAL OF MEDICINE

INCOME

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SOUTH DAKOTA
State Medical Association are always appreciated. You can contact either Jan Anderson at the South Dakota State Medical Association, 1323 S. Minnesota Avenue, Sioux Falls, SD 57105, or myself at 111 E. Tenth St., East, Dell Rapids, SD 57022.

Respectfully submitted,
Mitch Rydberg, MD, Chairman
Commission on Professional Liability

The Reference Committee reviewed the Report of the Commission on Professional Liability and recommended acceptance of the report as submitted.

REPORT OF THE CONTINUING MEDICAL EDUCATION COMMITTEE

The resurveying of accredited sponsors has remained active during the past year with surveys conducted at McKennan Hospital, Rapid City Regional Hospital and Brookings Hospital. Also, since the last annual report Central Plains Clinic, Fort Meade VA Hospital and the Yankton Medical Education Consortium (composed of the Lewis and Clark AHEC, Sacred Heart Hospital, the Human Services Center and the Yankton Medical Clinic) have received their initial accreditation. There are now seven institutions accredited through the South Dakota State Medical Association to provide AMA Category I programs for the physicians of this and the surrounding states, in addition to the USD School of Medicine which is accredited directly by the Accreditation Council for Continuing Medical Education (ACCME).

In September the CME Committee met with site surveyors who visited on behalf of the Committee for Review

---NEEDED: NOMINATIONS---

In the ongoing spirit of rural health care championed by Dr Bob Hayes, an annual award will be presented to an outstanding rural health care provider.

This award will be based upon nominations citing the attributes that make that provider an exceptional health care worker. Among those features necessary to be considered for this award is a compassionate, caring nature Doc Hayes so epitomized. All health care providers in rural South Dakota from emergency care to home health to mid-level practitioners and physicians shall be eligible for this honor.

Please send letters of nomination to:
SDAPA
c/o Jan Hines, PA-C
8326 N Blucksberg Mtn Rd
Sturgis, SD 57785

by no later than September 30, 1992.

The first DR ROBERT HAYES MEMORIAL AWARD will be presented at the annual SD Rural Health Conference November 4-6.
and Recognition (CRR) of the ACCME. Their report was subsequently reviewed by the ACCME, and the South Dakota State Medical Association was granted continued recognition for the maximum length of time, which is four years.

The accreditation process continues to change nationally, as noted in this report a year ago. The requirements for the Physicians Recognition Award, which were modified at the AMA Annual Meeting in 1990, to give increased importance to Category 2, remain controversial. The Kansas Medical Society succeeded in having this issue referred to the Board of Trustees who are due to report their findings to the House of Delegates at the 1992 AMA Annual Meeting.

The second major change is the result of the Food and Drug Administration's interest in regulating industry-sponsored CME. A significant amount of CME funding for both national and local programs comes from pharmaceutical and medical device manufacturers. The initial FDA proposal was for a tough set of federal regulations aimed at preventing any corporate influence on CME programming. These regulations, as initially proposed, would have virtually eliminated this significant source of CME funding. The FDA is apparently now rethinking its position if the ACCME will increase the monitoring of sponsors. This will almost certainly raise the cost of the accreditation process significantly. Thus governmental involvement in a voluntary accreditation process, which was begun by physicians to improve the quality of their lifelong learning and thereby improve patient care, will require more documentation and an increased expense. Why does that sound familiar?

Respectfully submitted,
Robert Raszkowski, MD, Ph.D., Chairman
Continuing Medical Education Committee

The Reference Committee reviewed the Report of the Continuing Medical Education Committee and recommended acceptance of the report as submitted.

REPORT OF THE BUDGET AND AUDIT COMMITTEE

The Budget and Audit Committee met January 17, 1992, prior to the Executive Commission meeting. Mr. Robert Johnson reviewed the budget item by item and the proposed budget was approved by the Committee.

The Committee also recommended that the Executive Office contact clinic managers in clinic groups where some physicians are members of the State Medical Association and others are not, explaining to the group the problems this creates for the clinic with regard to DAKOTACARE participation and group health insurance, and to encourage the physicians in their group to join the District and State Medical Association.

Respectfully submitted,
Kenneth B. Peterson, MD, Chairman
Budget and Audit Committee

The Reference Committee reviewed the Report of the Budget and Audit Committee and recommended acceptance of the report as submitted.

REPORT OF THE SHARECARE COMMITTEE

During 1991, there were no meetings held by the ShareCare Committee. The program continues to function well with no complaints or requests for changes by the participants. Prospective enrollees continue to receive the application forms from senior citizens' groups, county health nurses and physicians' offices as well as being distributed to all Medicare recipients in South Dakota. At the present time 545 ShareCare cards have been issued through the office of the South Dakota State Medical Association and there are approximately 2300 senior citizens enrolled within the state of South Dakota. South Dakota has 588 physicians currently participating in the program.

If anyone has any recommendations to make for the ShareCare program, please feel free to contact one of the committee members.

Respectfully submitted,
Tony L. Berg, MD, Chairman
ShareCare Committee

The Reference Committee reviewed the Report of the ShareCare Committee and recommended the report be accepted as submitted.

REPORT OF THE GRIEVANCE COMMISSION

The Grievance Commission convened at the time of the annual meeting with all members present. All past and pending matters were reviewed. A consensus opinion was obtained from the members on several pending issues allowing closure of the 1990-1991 case load.

Although there has not been an appreciable increase in the number of grievances brought to the Commission over the past 12 months, those which have been reviewed have again highlighted the need for physicians to make additional effort in the sphere of doctor-patient communications, and increase the level of sensitivity to the anxiety and apprehension which are so much a part of an individual's psyche during the stress of illness.

Many thanks to Jan Anderson and her staff for assistance provided the Commission throughout the year. I would also like to express appreciation to the other members of the Commission for their thoughtful and prompt responses on all matters brought before us.

Respectfully submitted,
William O. Rossing, MD, Chairman
Grievance Commission

The Reference Committee reviewed the Report of the Grievance Commission and recommended the report be accepted as submitted.

REPORT OF THE SOUTH DAKOTA POLITICAL ACTION COMMITTEE

This has been a year of building for SoDaPAC. It appears to be more and more difficult to convince the membership of the State Medical Association that the value of a strong political action committee is so important to the future of medicine. We still have a lot of vacancies on the Board of Directors of the South Dakota Political Action Committee and in general need a lot more participation on the part of the membership of the Medical Association.

In order to elect and re-elect legislators that are sympathetic to medicine and support our concerns, we need a strong political action committee to support these legislators in their election and re-election campaigns. Until some type of reform occurs in our political system, political action committees will continue to play an active and very important role in deriving the needed support from legislators to aid in our goal of delivering, economically and efficiently, the finest health care in the world.
The SoDaPAC officers and board members alike need your support so that we can carry on this job which is so vitally important. As your board, we support candidates who listen to our concerns for better government and quality health care for our patients regardless of their political party affiliation. Please make it one of your top priorities to join SoDaPAC and support the activities of SoDaPAC so that we can continue our commitment to impact major medical legislative issues in this critical election year.

Respectfully submitted,
Michael Pekas, MD
SoDaPAC Chairman

The Reference Committee reviewed the Report of the South Dakota Political Action Committee and recommended the report be accepted as submitted.

REPORT OF THE BOARD OF DIRECTORS OF THE SOUTH DAKOTA MEDICAL SCHOOL ENDOWMENT ASSOCIATION

The annual meeting of the Board of Directors of the South Dakota Medical School Endowment Association convened at 8:00 am on Friday, June 7, 1991, at the Ramkota Inn, Sioux Falls, South Dakota. Present for roll call were Drs Robert Giebink, Joseph Hamm, Warren Jones, Howard Saylor, T.H. Sattler and Bruce Allen. Guests included Dr Ray Lynn, Dr Robert Talley and Mr Ken Grover as well as staff members, Robert Johnson and Jan Anderson. The minutes of the previous meeting were approved as printed and distributed.

Nominations were in order for officers for 1991-92, and the following were elected: Robert Giebink, MD, president; Warren Jones, MD, vice president; and Bruce Lushbough, MD, secretary.

The Board reviewed the year end 1990 financial report and a report for the first four months of 1991. The Board received information on the USD Foundation's investment program utilizing a Chicago firm. The executive office was directed to get an opinion from the Endowment's accounting firm regarding this investment program, to find out if Endowment funds can be segregated from other funds; and if there would be insurance coverage for Endowment funds invested and report back to the Board at the 1992 meeting. In 1991 the Endowment Association received donations totaling $62,642.64 and memorials in the amount of $700, for a grand total of $63,342.64. This included $13,625 in response to a mailing sent in March, 1991, to all USD alums and $26,364.64 from the USD Foundation of which about $25,000 were bequests from two wills. The remaining $22,653 in contributions was received throughout the remainder of the year in response to letters and personal contacts made by individual Board members to their colleagues in South Dakota. There was a total of 181 contributors with 46 being from out of state.

The Board determined that for 1991 there would be two major solicitation efforts; the first being in early fall and the second in early spring 1992. The fall solicitation would be from individual Board members to physicians in assigned districts. The executive office was directed to notify each Board member of donations received and then the Board member would contact all physicians who have not yet made a donation by letter or personal contact. Then in early spring the president of the Board would prepare a letter to be sent to all alums and all other practicing and retired physicians in South Dakota. This spring letter has been composed and sent. I thought it best to send it out on
Orthopedic Associates stationery so perhaps the recipients would be more likely to read it.

Because of donations received during the past year we were able to provide $70,000 to the USDSDM for loans to students. The Board voted to provide 90 percent of its income for student loans and to maintain 10 percent as reinvestment. Also, the Board determined that the interest rate should remain at 6 percent. In addition, the Board decided to provide two $1,500 grants from the Wulber's' fund to students at USDSDM. The Wulber's' Fund was a bequest of $31,203.34, and the interest from this fund is given to the most deserving medical school students based on information received from the school and from the candidates.

I have again enjoyed the privilege and honor of serving as president of the Board of the Endowment Association. Again, Jan Anderson has done a terrific job of running the program, and I would like to thank Jan as would the Endowment Association Board for all that she has been doing during the past several years. This coming meeting in June of 1992, I will not be able to attend because I will be attending the 50th anniversary of my graduating class from the University of Minnesota Medical School. I regret not being able to attend the Medical Association meeting and the Endowment meeting, but I guess my 50th anniversary more or less takes precedent. I will look forward to hearing what has transpired at the State meeting and at the Endowment Association meeting.

Respectfully submitted,
Robert R. Giebink, MD, President
South Dakota Medical School Endowment Association, Board of Directors

The Reference Committee reviewed the Report of the Board of Directors, South Dakota Medical School Endowment Association, and recommended that the Board continue to explore utilizing the USD Foundation's investment program.

REPORT OF THE PHYSICIANS HELP COMMITTEE

The committee met at the annual meeting in June 1991 in Sioux Falls. We were pleased to have Dr William Fuller accept our invitation to join the committee.

We are pleased to note that a seminar will be given by Dr Joseph and Sharon Cruse on issues of the medical family at the annual meeting in Rapid City this coming June. There have been several requests for information and for assistance to the committee during the year. The outcome of these referrals generally has been very satisfactory. I want to thank the committee members who have assisted me with these referrals. The committee continues to offer its assistance in any way possible to the impaired physician, family or friends. Referrals can be made directly to the committee or the executive office. I am pleased to announce that there are now six members from the state of South Dakota belonging to the American Society of Addiction Medicine, four of whom are certified.

Respectfully submitted,
Neil Elkjær, MD, Chairman
Physicians HELP Committee

The Reference Committee reviewed the Report of the Physicians HELP Committee and recommended the report be accepted as submitted.

REPORT OF THE ARCHIVES AND HISTORY COMMISSION

The Archives and History Commission did not meet this year, but has continued to encourage physicians to contribute articles to the South Dakota Medical Journal regarding family histories if three or more members of the family had been involved in medicine in the state of South Dakota. That has led to the publishing of a very interesting book titled VanDemark Family History in South Dakota Medicine Beginning in 1907. This was authored by Robert E. VanDemark, Sr., and was published under the auspices of the Center for Western Studies, Augustana College, Sioux Falls.

South Dakota. This excellent volume should be on the reading list of anyone interested in the history of South Dakota, particularly in medicine in South Dakota.

Respectfully submitted,
John H. Hoskins, MD, Chairman
Archives and History Commission

The Reference Committee reviewed the Report of the Archives and History Commission and recommended the report be accepted as submitted.

REPORT OF THE AIDS TASK FORCE

On September 27, 1991, the Council of the South Dakota State Medical Association designated the AIDS Task Force to be the State Medical Association's representative to the State Health Department Coalition representing the Medical Association's views on HIV testing and AIDS policy.

On March 12, 1992, the AIDS Task Force met to review a near-final draft of the South Dakota State Health Department's "Recommendations on HIV Infection and Health Care Workers."

The AIDS Task Force recommended several changes to the above mentioned "Recommendations..." These recommendations were forwarded to the Council of the State Medical Association for consideration at the Council's April, 1992 meeting.

All members of the South Dakota State Medical Association benefit from the work done by the members of the AIDS Task Force. We all owe them our sincere thanks.

Respectfully submitted,
Bruce C. Lushbough, MD, Chairman
AIDS Task Force

The Reference Committee reviewed the Report of the AIDS Task Force and recommended that the Task Force consider new AIDS tests which are becoming available and formulate recommendations concerning the use of such tests for the physicians of South Dakota.

REPORT OF THE SPECIAL MEDICARE COMMITTEE

The Special Medicare Committee met on April 8, 1991. At this meeting the topics reviewed were:

1. The differential in reimbursement between physician home visits and home health nursing service visits.
2. Medicare's policy on consultations.
3. Reimbursement for cardiovascular stress testing.
4. Psychologist services.
5. Certification of facilities providing mammography.
6. The problem of inability to get information from our carrier when requested.
7. Reduction in funding for Medicare's provider and customer relations services.

There were no further meetings called of the Special Medicare Committee. I resigned as chairman of the committee on November 25, 1991. The State Medical Association Executive Committee decided to disband this committee on January 17, 1992. Dr. P. M. Riisager of the North Dakota Blue Cross Blue Shield was notified of this decision on February 2, 1992.

Respectfully submitted,
James R. Reynolds, MD
Special Medicare Committee

The Reference Committee reviewed the Report of the Special Medicare Committee noting with concern that the Committee was disbanded. The Reference Committee requested that Dr. Reynolds comment to the House of Delegates why the Committee felt this action was necessary. (Dr. Reynolds addressed this issue at the Second House of Delegates meeting.)

ANNUAL MEETING MINUTES SOUTH DAKOTA FOUNDATION FOR MEDICAL CARE

June 4, 1992 Howard Johnson Motor Lodge 9:50 am Rapid City, SD

The 17th Annual Meeting of the South Dakota Foundation for Medical Care was held on Thursday, June 4, 1992, at 9:50 am, at the Howard Johnson Motor Lodge, Rapid City, South Dakota.

The meeting was called to order by Chairman Charles Hart, MD. The roll call was taken with the following members being present: Drs Richard Porter; M. George Thompson; Thomas Kraftka; Mary Carpenter; Robert Ferrell; Michael Pekas; James Reynolds; Jerome Eckrich; James Howland; James Larson; Curtis Wait; Phillip Hoffsten; Stephan Schroeder; Lucio Margallo; Jeffrey Hagen; D. G. Ortemeier; Rodney Parry; Guy Tam; Lowell Hyland; C. Roger Stoltz; Robert Raszkowski; Daniel Kennelly; Larry Meyer; Duane Reaney; James Engelbrecht; Carol Zieliik; Richard Renka; Craig Hansen; John Barlow; John Malm; Kevin Bjordahl; Roger Carter; Steven Feeney; Richard Holm; Tad Jacobs; Brent Lindblom; Ken Bartholomew; Mark Belyea; Curtis Buchholz; Jerome Howe; Thomas White; James Ryan; Robert Talley; William Rossing; David Hoversten; C. F. Guth; Russell Harris; John Salt; Robert Thompson; David Smith; T. H. Sattler; Robert Goodhope; Thomas Hermann; Charles Hart; Cynthia Weaver; Robert Preston; James Rud; David Sandvik; Reuben Bareis; Eugene Bolliger; and James Collins.

The Chairman declared a quorum present for the purpose of conducting business of the corporation.

The Chairman called for consideration of the minutes of the last annual meeting. He referred the membership to the Foundation minutes in the printed manual furnished to each member. It was moved and seconded that the minutes be accepted as published and the reading thereof waived. Upon voice vote the same was approved unanimously.

Dr. Hart reported that the following persons were elected to serve three year terms on the Board of Directors: John Willocockson, MD; Stephen Gehring, MD; Thomas Dean, MD; Michael Schurrer, MD; and Charles Hart, MD.

Dr. Hart called for consideration of the corporate financial report. He noted that the financial report was published in the Handbook which was furnished to each member of the body. Dr. Hart asked the membership if there were any questions, qualifications, or corrections. There being no comments, the financial report was accepted as published.

Dr. Hart referred the membership to the written report made by the President, and published in the Handbook, and also the written report contained therein of the Foundation's Medical Director. He asked if anyone had any questions on the operations of the Foundation. There being none, he noted that the reports would be filed with the records of the Foundation accordingly.

In honor of Dr. T. H. Sattler's retirement, Dr. Hart presented Dr. Sattler with a plaque in appreciation for his work and dedication as SDFMC's Medical Director for the past 15 years.

Dr. Hart then asked for any comments from the floor. There being none, the meeting was adjourned at 10 am.

ANNUAL MEETING MINUTES SOUTH DAKOTA STATE MEDICAL HOLDING COMPANY, INC.

June 4, 1992 Howard Johnson Motor Lodge 10 am Rapid City, SD

The 4th Annual Meeting of the South Dakota State Medical Holding Company, Inc., was held on Thursday, June 4, 1992, at 10 am at the Howard Johnson Motor Lodge, Rapid City, South Dakota.

The meeting was called to order by Chairman Robert Ferrell, MD. The roll call was taken with the following members being present: Drs Richard Porter; M. George Thompson; Thomas Kraftka; Mary Carpenter; Robert Ferrell; Michael Pekas; James Reynolds; Jerome Eckrich; James Howland; James Larson; Curtis Wait; Phillip Hoffsten; Stephan Schroeder; Lucio Margallo; Jeffrey Hagen; D. G. Ortemeier; Rodney Parry; Guy Tam; Lowell Hyland; C. Roger Stoltz; Robert Raszkowski; Daniel Kennelly; Larry Meyer; Duane Reaney; James Engelbrecht; Carol Zieliik; Richard Renka; Craig Hansen; John Barlow; John Malm; Kevin Bjordahl; Roger Carter; Steven Feeney; Richard Holm; Tad Jacobs; Brent Lindblom; Ken Bartholomew; Mark Belyea; Curtis Buchholz; Jerome Howe; Thomas White; James Ryan; Robert Talley; William Rossing; David Hoversten; Russell Harris; John Salt; Robert Thompson; David Smith; Jem Hof; T. H. Sattler; Thomas Hermann; Charles Hart; Cynthia Weaver; Robert Preston; James Rud; David Sandvik; Reuben Bareis; H. Lee Ahrlin; Eugene Bolliger; and James Collins.

The Chairman declared a quorum present for the purpose of doing business of the corporation.

The Chairman called for consideration of the minutes of the last annual meeting. He referred the membership to the SDSMHIC minutes in the printed manual furnished to each member. The minutes were accepted as published and the reading thereof waived.

Dr. Ferrell highlighted the financial report as published in the Handbook. He also apprised the corporate body members concerning the status of DAKOTACARE's relationship with North Dakota Blue Cross/Blue Shield and DAKOTACARE's future operating objectives.

Dr. Ferrell reported on the election results. It was reported that the following persons were elected to serve
three-year terms on the Board of Directors: Robert Ferrell, MD; M. George Thompson, DO; Gerald Tracy, MD; and Bruce Lushbough, MD.

Dr. Ferrell asked for any comments or further business from the floor. There being none, the meeting was adjourned at 10:10 am.

MINUTES OF
SOUTH DAKOTA MEDICAL SERVICE, INC
CORPORATE BODY MEETING

10:15 am Howard Johnson Motor Lodge
June 4, 1992 Rapid City, SD

Chairman Rossing called the meeting of the Corporate Body of South Dakota Medical Service, Inc. to order at 10:15 am, June 4, 1992, at the Howard Johnson Motor Lodge, Rapid City, South Dakota.

On roll call vote, the following members of the Corporate Body of the South Dakota Medical Service, Inc. were present: Drs. Richard Porter, M. George Thompson, Thomas Krafla, Mary Carpenter, Robert L. Ferrell, Michael Pekas, James Reynolds, Jerome Eckrich, James Howland, James Larson, Curtis Wait, Phillip Hoffsten, Stephan Schroeder, Lucio Margallo, Jeffrey Hagen, D. G. Orntmeier, Rodney Parry, Guy Tam, Lowell Hyland, C. Roger Stoltz, Robert Raszkowski, Daniel Kennelly, Larry Meyer, Duane Reaney, James Engelbrecht, Carol Zielike, Richard Renka, John Malin, Kevin Bjordahl, Roger Carter, Steven Feehey, Ken Peterson, Richard Holm, Ted Jacobs, Brent Lindblom, Ken Bartholomew, Mark Belyea, Curtis Buchholz, Jerome Howe, Thomas White, James Ryan, Robert Talley, William Rossing, David Hoversten, Karla Murphy, C. F. Gutch, Russell Harris, John Sall, Robert Thompson, David Smith, Jim Hof, Robert Goodhope, Thomas Hermann, Charles Hart, Cynthia Weaver, Robert Preston, James Rud, Eugene Bollinger, James Collins, Craig Hansen, John Barlow, Richard Gere, T. H. Sattler, David Sandvik, Reuben Bareis, and H. Lee Ahrlin.

A quorum being present, the Chairman declared the annual meeting of the membership of the Corporate Body of the South Dakota Medical Service, Inc. to be duly in session for the transaction of business.

Dr. Stoltz moved that the reading of the minutes of the last meeting of the Corporate Body, being the 1991 annual meeting, be waived, the same having been published and mailed to each member previously. Such motion was seconded by Dr. Carter. Upon voice vote, the same was approved unanimously.

Chairman Rossing presented the chairman’s message to the Corporate Body. He noted the retirement of Mr. John Zimmer, who served as the legal counsel for South Dakota Medical Service, Inc., for 27 years. Dr. Rossing commended Mr. Zimmer for his years of service and counsel to Blue Shield. He then introduced to the Corporate Body, Mr. William Janklow, Blue Shield’s new legal counsel. Dr. Rossing related the high degree of satisfaction and confidence the Board of Directors has expressed in the selection of Mr. Janklow in this capacity. Dr. Rossing also presented a brief history of the incorporation of South Dakota Blue Shield. It was noted that the complete chairman’s message was printed in the Delegate’s Handbook.

No action being necessary on the chairman’s report, none was taken.

Chairman Rossing called upon President Ben Johnson to review the 1991 Annual Report. Mr. Johnson noted that each of the members were sent a copy of Blue Shield’s annual statement for 1991 prior to this meeting. He highlighted certain items contained therein. He specifically mentioned that the Blue Shield 1991 premium income of $58,999,263 and claims paid of $3,768,000 shows that 91.1% of premium income was paid back to our subscribers. The previous year’s payout was 92.2%. Blue Shield’s underwriting gain in 1991 was $752,212 or 1.3% of premium income, and its investment income was $1,616,179. After deducting $499,850 federal income taxes, the net gain to surplus was $1,868,541 or 3.2% of income. In 1990, Blue Shield processed 831,377 claims. In 1991, Blue Shield processed 9,093,353 claims.

With no questions being addressed from the floor, Mr. Johnson concluded his report.

Chairman Rossing, at this point of the meeting, stated the next order of business was the election of directors. He asked Dr. Thomas Krafla to present the report of the Nominating Committee. Dr. Krafla reported as follows:

The Nominating Committee appointed by the Blue Shield Board of Directors recommended current directors Don Ham of Rapid City; Thomas J. Huber, MD of Pierre; James C. Larson, MD of Watertown; and Glenn Walterm of Freeman be re-elected to the Board of Directors.

The Nominating Committee also recommended and nominated Ronald R. Tesch, MD of Brookings for election to the Blue Shield Board of Directors.

The Chairman called for nominations from the floor. Dr. Ryan moved that the nominations be closed and the current directors be re-elected to the Blue Shield Board of Directors. Dr. Margallo seconded the motion. Upon voice vote, the same was approved unanimously.

Dr. Rossing then reviewed the nomination and election procedures, as set forth in the By-Laws, and the enabling legislation of South Dakota Medical Service, Inc, which state all physicians and surgeons on the Board of Directors must hold participating contracts with Blue Shield.

Dr. Holm moved that Dr. Tesch be elected to the Board of Directors. Dr. Peterson seconded the motion. Upon voice vote, the same was approved.

Chairman Rossing called for any further business to come before the Board. There being none, he called for a motion to adjourn the Corporate Body meeting. Dr. Reaney moved that the meeting be adjourned. Dr. Tam seconded the motion. Upon voice vote, the same was approved unanimously.

Philip M. Davis
Secretary
DISTINGUISHED SERVICE AWARD

Started in 1951... T. F. Riggs, MD, Pierre (deceased)
1952... H. Russell Brown, MD, Watertown (deceased)
1953... Guy VanDemark, MD, Sioux Falls (deceased)
1954... C. Ohlmacher, MD, Vermillion (deceased)
1955... R. G. Mayer, MD, Aberdeen (deceased)
1956... C. Ohlmacher, MD, Vermillion (deceased)
1957... W. E. Donahoe, MD, Sioux Falls (deceased)
1958... Drs. J. C. Hagin (deceased), M. W. Pangburn (deceased), and James DeGeest, Miller
1959... J. F. Brennan, MD, Superior, WI (deceased)
1958... Mrs. Agnes Holdridge, Madison
1959... Walter L. Hard, PhD, Vermillion
1959... Rev. and Mrs. Robert O. Bates, Sturgis
1959... R. M. Kilgward, MD, Watertown (deceased)
1960... L. J. Pankow, MD, Sioux Falls (deceased)
1961... Gregg M. Evans, PhD, Custer
1962... Edward Shaw, PhD, Vermillion (deceased)
1963... Arthur A. Lampert, MD, Rapid City
1964... John C. Foster, Phoenix, AZ
1965... A. P. Reding, MD, Marion
1966... Mrs. C. Rodney Stoltz, Sioux Falls
1967... Mrs. William Fish, Watertown
1968... G. J. Bloemendaal, MD, Ipswich (deceased)
1969... F. W. Haas, MD, Yankton (deceased)
1970... Paul Bunker, MD, Aberdeen (deceased)
1971... E. T. Lietzke, MD Beresford (deceased)
1972... C. B. McVay, MD, Yankton (deceased)
1973... G. E. Tracy, MD, Watertown
1974... J. A. Muggly, MD, Madison (deceased)
1975... Harvey Wollman, Hitchcock
1976... R. H. Quinn, MD, Spearfish
1977... E. H. Heinrichs, MD, Vermillion (deceased)
1978... John Olson, Sioux Falls, and Evans Nord, Sioux Falls (deceased)
1979... Helen Jane Hare, MD, Rapid City
1980... Warren Jones, MD, Sioux Falls
1981... Saul Friefeld, MD, Brookings
1982... G. Robert Barton, MD, Watertown
1983... Oscar J. Mahoe, MD, Mitchell
1984... Karl Wegner, MD, Sioux Falls
1985... William R. Taylor, MD, Aberdeen
1986... R. E. VanDemark, Sr, MD, Sioux Falls
1987... Bruce C. Lushbough, MD, Brookings
1988... John J. Stransky, MD, Watertown
1989... John Barlow, MD, Rapid City
1990... Durward Lang, MD, Sioux Falls (deceased)
1991... Russell H. Harris, MD, Sioux Falls
1992... Joseph N. Hamm, MD, Sturgis

COMMUNITY SERVICE AWARD

1961... R. A. Buchanan, MD, Yankton (deceased)
1962... Roland F. Hubner, MD, Yankton (deceased)
1963... George W. Mills, MD, Wall (deceased)
1964... John C. Hagin, MD, Miller (deceased)
1965... Alonzo P. Peeke, MD, Volga
1966... Hugo C. Andre, MD, Vermillion (deceased)
1967... G. Robert Barton, MD, Watertown
1968... M. M. Morrissey, MD, Pierre (deceased)
1969... N. J. Sundet, MD, Kadoka (deceased)
1970... W. H. Saxton, MD, Huron (deceased)
1971... R. E. VanDemark, Sr, MD, Sioux Falls
1972... R. H. Hayes, MD, Wall (deceased)
1973... B. F. King, MD, Aberdeen (deceased)
1974... M. C. Tank, MD, Brookings (deceased)
1975... Karl Wegner, MD, Sioux Falls
1976... John T. Fleson, MD, Rapid City
1977... W. F. Stanage, MD, Yankton
1978... C. S. Roberts, Jr, MD, Brookings
1979... C. J. McDonald, MD, Sioux Falls (deceased)
1980... E. A. Johnson, MD, Milbank
1981... J. A. Muggly, MD, Madison (deceased)
1982... Robert R. Gibbink, MD, Sioux Falls
1983... Theodore H. Sattler, MD, Yankton
1984... Paul Holum, MD, Huron
1985... George Mangulis, MD, Philip
1986... Richard Friess, MD, Sioux Falls
1987... Melford B. Lyso, MD, Sioux Falls
1988... Brooks Ranney, MD, Yankton
1989... Willaim R. Taylor, MD, Aberdeen
1990... Reuben Bareis, MD, Rapid City
1991... O. Myron Jerde, MD, Rapid City
1992... Duane Reaney, MD, Yankton

AESCULAPIUS AWARD

1966... Paul R. Leon, MD
1968... Walter Miller, MD, Aberdeen
1968... H. Phil Gross, MD, CA

FIFTY YEAR CLUB MEMBERS

C. V. Auld, MD, Plankinton (deceased)
Harold Adams, MD, Huron
Thomas Billim, MD, Sioux Falls
G. J. Bloemendaal, MD, Ipswich (deceased)
Henry Borgmeyer, MD, Rapid City
W. C. Brinkman, MD, Sisseton (deceased)
R. A. Buchanan, MD, Huron (deceased)
John L. Calene, MD, CA (deceased)
Myrtle Carney, MD, TX (deceased)
Bernard S. Clark, MD, Spearfish
J. C. Clark, MD, Sioux Falls (deceased)
F. L. Class, MD, Huron (deceased)
M. E. Cogwell, MD, Wolsey (deceased)
E. H. Collins, MD, Gettysburg
J. Cook, MD, Bonesteel (deceased)
G. I. W. Cutta, MD, Sioux Falls (deceased)
Harold L. Crane, MD, CT (deceased)
S. A. Donahoe, MD, Sioux Falls (deceased)
W. E. Donahoe, MD, Sioux Falls (deceased)
J. A. Eckrich, Sr, MD, Aberdeen (deceased)
V. W. Embree, MD, Pierre (deceased)
W. D. Farrell, MD, Aberdeen (deceased)
R. B. Fleeger, MD, Lead (deceased)
R. R. Fisk, MD, Flandreau (deceased)
R. W. Freyberg, MD, Mitchell (deceased)
E. E. Gage, MD, Sioux Falls (deceased)
D. A. Gregory, MD, MT (deceased)
E. H. Grove, MD, Arlington (deceased)
M. Stuart Grove, MD, Sioux Falls
J. C. Hagin, MD, Miller (deceased)
Lyle Hare, MD, Spearfish (deceased)
John F. Hill, MD, Yankton (deceased)
Emil Hofer, MD, Huron
J. A. Hohf, MD, Yankton (deceased)
F. S. Howe, MD, Deadwood (deceased)
A. H. Hovne, MD, Salem (deceased)
Roland Hubner, MD, Yankton (deceased)
A. S. Jackson, MD, Rapid City (deceased)
R. J. Jackson, MD, Hot Springs (deceased)
J. A. Jacotel, MD, Milbank (deceased)
G. T. Jordan, MD, Vermillion (deceased)
F. F. Keene, MD, Wessington Springs (deceased)
H. O. Kittelson, MD, Sioux Falls
Arthur A. Lampert, Sr, MD, Rapid City
Ray Lemley, MD, Rapid City (deceased)
Bernard Lenz, MD, Huron (deceased)
J. H. Lloyd, MD, Mitchell (deceased)
O. J. Mabee, MD, Mitchell
Lawrence L. Massa, DO, Sturgis (deceased)
P. V. McCarthy, MD, Aberdeen (deceased)
Murlin Merryman, MD, Rapid City
G. W. Mills, MD, Wall (deceased)
B. C. Murdy, MD, Aberdeen (deceased)
T. F. O'Toole, MD, Rapid City (deceased)
Gordon S. Owen, MD, Rapid City
N. T. Owen, MD, Rapid City (deceased)
L. L. Parke, MD, Canton (deceased)
C. C. Pascale, DO, Centerville
A. P. Peeke, MD, Volga
M. O. Pemberton, MD, Deadwood (deceased)
R. J. Quinn, MD, Sioux Falls (deceased)
F. J. Radusch, MD, CA (deceased)
T. B. Ranney, MD, Aberdeen (deceased)
Arthur P. Reding, MD, Marion
T. F. Riggins, MD, Pierre (deceased)
Maurice Rousseau, MD, Watertown (deceased)
I. R. Salladay, MD, Ft. Meade (deceased)
W. H. Saxton, MD, Huron (deceased)
H. L. Saylor, MD, Huron (deceased)
C. S. Schad, DO, Rapid City
C. E. Sherwood, MD, Brookings (deceased)
Arthur W. Spiry, MD, Mobridge (deceased)
Myron Tank, MD, Brookings (deceased)
F. J. Tobin, MD, Mitchell (deceased)
Leonard W. Tobin, MD, Mitchell (deceased)
J. S. Tschetter, MD, Huron (deceased)
Paul Tschetter, MD, Huron
F. W. Valkenaar, MD, Chancellor (deceased)
G. E. VanDemark, MD, Sioux Falls (deceased)
Cleo L. Vogele, MD, Aberdeen
H. P. Volin, MD, Lennox (deceased)
C. H. Weishaar, MD, Aberdeen (deceased)
J. R. Westaby, MD, Madison (deceased)
G. E. Zimmerman, MD, MT (deceased)

C. B. ALFORD AWARD
1974 . . . Roscoe Dean, MD, Wessington Springs
1975 . . . Gerald Tracy, MD, Watertown
1976 . . . Robert Westaby, MD, Hot Springs
1977 . . . Robert VanDemark, Sr, MD, Sioux Falls
1978 . . . Howard Saylor, Jr, MD, Huron
1979 . . . J. D. Bailey, MD, Rapid City
1980 . . . John T. Elston, MD, Huron
1981 . . . T. H. Sattler, MD, Yankton
1982 . . . Bedford T. Otey, MD, Flandreau
1983 . . . Robert H. Quinn, MD, Spearfish

1984 . . . Granville Steele, MD, Aberdeen
1985 . . . Robert Hayes, MD, Wall (deceased)
1986 . . . Leonard Linde, MD, Mobridge
1987 . . . Richard Sample, MD, Madison
1988 . . . Willis Stangme, MD, Yankton
1989 . . . Reuben Bareis, MD, Rapid City
1990 . . . Rodney Parry, MD, Sioux Falls
1991 . . . Donald Humphreys, MD, Sioux Falls

SPECIAL PRESIDENTIAL AWARD
1979 . . . G. Robert Bartron, MD, Watertown
1983 . . . Gerald E. Tracy, MD, Watertown
1986 . . . Russell H. Harris, MD, Rapid City
1991 . . . Robert E. VanDemark, Sr, MD, Sioux Falls
1991 . . . Dennis L. Johnson, MD, Sioux Falls (deceased)
1991 . . . Parry S. Nelson, MD, Watertown (deceased)

MCKENNNAN HOSPITAL
8th Annual CLINICAL UPDATE
A Symposium for Physicians

Modules in:
Pediatrics/Neonatology
Rheumatology/Orthopedics
Endocrinology
Topics of Current Interest

Friday and Saturday Contact: Marvie Swanson
December 4 and 5, 1992 800 E 21st
Holiday Inn City Centre Sioux Falls, SD
Sioux Falls, SD 57117-5045
(605) 339-8117

SOUTH DAKOTA
Drugs Related Problems

Brian Kaatz, Pharm D., Sioux Falls, SD

It is my pleasure this month to write the first of a series of columns on contemporary issues of drug therapy. These articles will be written by practicing faculty members from South Dakota State University's College of Pharmacy. We will attempt to explore pertinent topics on new drugs, adverse effects and monitoring of drugs, some cost issues and, perhaps, some philosophical insights. We hope to provoke your thoughts and interest.

Improved, more potent, and more target specific drugs produced by manufacturers in the last few years have not been without problems. Indeed, the literature is replete with summaries of adverse events associated with these potent drugs. Sources such as Healthweek (8/8/88) tell us that as much as $7 billion in health care costs can be attributed to drug-related morbidity yearly. Much of this results from new or unusual interactions, unexpected adverse events, and non-compliance. Depending on the demographic group, 10% or more of hospitalizations are due to these same drug related problems. Accrediting agencies and third parties are stressing, more than ever, the need for "drug utilization" studies, both for hospitalized and ambulatory patients. Familiar categories of drugs like the angiotensin converting enzyme inhibitors and nonsteroidal anti-inflammatories are being added to continually by new entities, some with subtle changes and improvements, some not. Keeping abreast of all the complexities has become a daunting task.

Traditional pharmacy services have not always contributed what they might have to contend with these complexities. Too often pharmacists have been satisfied with dispensing an accurately filled prescription and have been less concerned with patient outcome. Thus, what was being done was being done very well, but not necessarily always in the best interests of the patient. An accurately filled prescription for a drug that the patient did not take, or that interacted with another drug from a different prescriber, did not help the patient. In keeping with this concern for patient outcome, the pharmacy profession and pharmacy students now are recognizing the importance of doing their part to detect or prevent drug related problems.

The mission of pharmacy practice is to help people make the best use of their medications. If this is accomplished through effective communications between prescribers and pharmacists, patients will greatly benefit.

60th ANNUAL POSTGRADUATE ASSEMBLY

Omaha Mid-West Clinical Society

November 5, 6, and 7, 1992
(Thursday, Friday, and Saturday)

The Red Lion Hotel
Omaha, Nebraska

For information, please contact:
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<td>*Westaby, Robert S.</td>
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Anderson, Wayne J...........Spearfish
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Vanadurongvan, Vichit.......Milbank

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Cancer! Malignancy! Metastasis! Terminal Illness!

These words are often part of the health care giver's vocabulary, but once again our family is hearing the terminology directly. Fourteen years ago my father lost a valiant fight to a malignancy. Presently my other Dad, who has been part of my life since our marriage in 1967, is facing similar circumstances.

Grandpa, as he is known to all of us, has provided me with fresh sweet corn and tomatoes each summer. He has walked through cold, November corn fields to collect the harvest decorations that I needed for church. With the assistance of Fisher-Price magnetic letters, he taught the alphabet to his 3 year old grandson. He has shot firecrackers and pulled the toboggan. He and his mount, Cinnamon, led the trail ride in the Rocky Mountains. Just as he bottle fed the newborn lambs, he has faithfully adopted the chickens, ducks, geese and kittens when they outgrew the box in my garage. His love of nature has been an important focus for our family activities.

Our younger son once made the assumption that his two grandfathers were brothers. That amusing perception is nearly an accurate one. These men shared a vocation, shared similar values and personal characteristics, and most significantly shared a family.

Physicians also share a common vocation. The shared value of the work ethic is also present. In addition the traits of compassion, kindness, and understanding are common. Our family is aware of the support and encouragement which has been readily given to us by members of the medical community, and we are most appreciative. The families of countless numbers of patients around the state undoubtedly echo that response.

My challenge to each physician and spouse is to ask that you give even more...this time to your own family. During these last weeks of summer, I urge you to take the time to interact with another generation. Teach someone a skill that you feel is important to know. Visit the grandchildren. Go to the zoo. Share a movie. Pack a picnic. Pick some flowers. Take in a ball game. Make a memory. Say "I Love You".

Ruth Parry, President, South Dakota State Medical Association Auxiliary

Auxiliary News

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September


* * *

American College of Physicians' South Dakota Scientific Meeting: Holiday Inn, Brookings, SD, Sept 10-12. Fee: TBA. CME: TBA. Contact: John D. Barker, Jr, MD, 111 W 39th St, Sioux Falls, SD 57105-5794. Phone: (605) 331-4050.

* * *

Pain Management for the Primary Care Physician, Hennepin County Med Ctr, Minneapolis, MN, Sept 18. Contact: Office of Academic Affairs, Hennepin County Med Ctr, 701 Park Ave, Suite 4512, Minneapolis, MN 55415. Phone: (612) 347-3533.

* * *


* * *

Prostate Diseases: Benign and Malignant, Ritz-Carlton Hotel, St Louis, MO, Sept 19. 4 hrs AMA Category 1 credit. Contact: CME, Washington Univ School of Med, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

* * *


* * *

Update on Current Management Strategies for Chronic Granulocytic Leukemia, Westin Crown Ctr Hotel, Kansas City, MO, Sept 25. 2.5 hrs AMA Category 1 credit. Contact: Mary Boyd, Publications/Promotions Coord, Off of Cont Educ, U of Kansas Med Ctr, 3901 Rainbow Blvd, Kansas City, KS 66160-7108. Phone: (913) 588-4488.

* * *

Contemporary Cardiothoracic Surgery: General Thoracic, Transplantation, Cardiovascular, Ritz-Carlton Hotel, St Louis, MO, Sept 30-Oct 2. 20.75 hrs AMA Category I credit. Contact: CME, Washington Univ School of Med, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

October

Treating the Addicted Patient in Primary Care Medicine: Smoking, Alcoholism and Drug Abuse, Battenfeld Audit, U of Kansas Med Ctr, Kansas City, KS, Oct 2. Fee: $50. 6 hrs AMA Category 1 & AAFP credit. Contact: Mary Boyd, Publications/Promotions Coord, Off of Cont Educ, U of Kansas Med Ctr, 3901 Rainbow Blvd, Kansas City, KS 66160-7108. Phone: (913) 588-4488.

* * *

Update in Ophthalmology, Washington Univ Med Ctr, St. Louis, MO, Oct 2-3. Contact: CME, Washington Univ School of Medicine, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

* * *


* * *

Anxiety: The Interface Between Biology & Behavior, Minneapolis Metrodome Hilton, Minneapolis, MN, Oct 16. Fee: $125. 6.5 hrs AMA Category 1 credit. Contact: Registrar, CME, St. Paul-Ramsey Med Ctr, 640 Jackson St, St. Paul, MN 55101. Phone: (612) 221-3992.

* * *


* * *


November


* * *

Sixteenth Annual Postgraduate Assembly, Red Lion Hotel, Omaha, NE, Nov 5-7. Contact: Lorraine Seibel, Exec Sec, Omaha Mid-West Clinical Society, 7389 Pacific St, Suite 229, Omaha, NE 68114. Phone: (402) 397-1443.

* * *

Update in Cardiovascular Diseases, Mayo Foundation, Rochester, MN, Nov 7-8. CME credit avail. Contact: Postgraduate Courses, Section of Cont Educ, Mayo Foundation, Rochester, MN 55905. Phone: (800) 323-2688.

* * *

South Dakota State Osteopathic Association Annual Meeting and Family Practice Update, Ramkota Inn, Pierre, SD, Nov 13-14. Fee: $100. 15 hrs AOA Category I and 14 hrs AAFP credit applied for. Contact: Lorin Pankratz, PO Box 89302, Sioux Falls, SD 57105-9302. Phone: (605) 361-6004.
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SCIENTIFIC ARTICLES

Research in Context
(or If You Want to Study How Fox and Chickens Relate, Go To The Hen House, Not The Zoo)

Michael V. Bloom, PhD; and Timothy J. Moore, MD, MS

USD School of Medicine
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Atlantoaxial Instability in Down's Syndrome:
A Case Report and Review

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Research in Context
(or If You Want to Study How Fox and Chickens Relate, Go To The Hen House, Not The Zoo)

Michael V. Bloom, Ph.D., Timothy J. Moore, M.D., M.S.

ABSTRACT

The context in which the research is carried out frequently is as important as the research question being investigated. The fact certainly is the etiology for many of the problems practicing physicians face when applying traditional research findings to clinical practice. The recent development of a family practice research network in South Dakota brought the investigators face to face with divergent views on this issue. This article provides some insight into different research philosophies.

A new drug hits the market, touted by drug representatives armed with reams of research evidence to back them up, that it is the answer to any physician's dreams. It is promoted as far more efficacious than any drug presently being used for the problem, with a far superior side-effect profile. Those physicians who have not yet become cynical of such expectations, and who want to be on the leading edge of medical practice, eagerly embrace the new treatment. Only later do they find that the (usually much more expensive) new treatment is, if anything, only slightly better than those of the past. How is it with such excellently designed doubled-blinded studies, the epitome of excellent clinical research, can this story repeat itself so frequently? We would suggest that our recent experience in developing a research project as part of the development of a research network can shed some light on this pattern.

About three years ago the South Dakota Foundation of Family Medicine made the decision to encourage the development of family practice oriented research in South Dakota. The Ambulatory Sentinel Practice Network (ASPN) was chosen as a model of research which could be adapted to fit South Dakota's needs (several other states now have this type of network as well). ASPN (pronounced aspen) is an affiliation of family physicians and academicians who investigate research questions which are best investigated at the level of the practicing primary care physician rather than the usual research "lab"—a large university medical center. In response to the Foundation's solicitation of interest, more than a dozen family practices expressed interest in joining the "South Dakota Research Network". These physicians were then polled as to what research questions they had interest in, with the Network finally settling on the investigation of antibiotic usage in respiratory illness in children.

Briefly, the research was aimed at investigating what criteria physicians use to prescribe an antibiotic for children suffering from coughs or sore throats, and what effect, if any, the antibiotics have on the symptoms from the perspective of the patients and their parents. After seeing those patients, the protocol required physicians to fill out a questionnaire that queried for information and findings from the history, examination and laboratory/radiology studies (if performed) along with any antibiotic prescribed. The patients were also given a questionnaire dealing with symptoms resolution to be returned within ten days. Given the number of variables involved, the research will need 500 patients to yield statistically significant data.

Eight physicians ultimately agreed to be involved in the study. After the protocol and budget were developed, the South Dakota Foundation of Family Medicine agreed to support the study with the proviso that consultation would be sought prior to commencing the study from "experienced researchers" to assist with the study design, etc. We chose to request feedback on our proposal from two types of researchers, i.e. experienced network researchers and those experienced in large university settings. For us, one of the most interesting results of this consultation process was the difference in the feedback from these two different groups.

The consultants from the academic background saw strengths in the research proposal but also had some poignant criticism, summarized generally in the area of it not being seen as rigorous enough. Specifically they had concerns about using practicing physicians as an
accurate way to judge antibiotic efficacy. As one reviewer put it, "The investigators need to consider the use of physician criteria for sole decision of antibiotic use or not. This may severely hamper any interpretation of their results. Without an assessment of interrater reliability on symptom ratings, assessment of symptoms resolution based on two sources of information is problematic." They also questioned the use of physician decision making as far as prescribing the antibiotic, recommending instead the blinded use of antibiotics and placebos thus eliminating "physician bias."

On the other hand, the Network consultants were much more sensitive to the goals of our research. They suggested that what we were really studying was not antibiotic efficacy but physician prescribing behavior. Our initial reaction to their suggestion was agreement, however, upon further reflection, we concluded that this was not quite what we were after either. What we were really after is much more difficult to investigate but important. Our investigation was aimed at the interaction between the doctors' perception of the problem, the treatment prescribed, and the results as perceived by the patient. From this perspective each one of the elements could not be seen as separate from the others. Certainly the research results which we receive may not be the same as those in a double-blinded, interphysician agreement study in an academic setting, but is it any less useful?

The "academic reviewers" implied that the results are not the same when you take the antibiotic variable away from interinvestigator reliability and put it in the hands of practicing physicians. But which study would yield results that are more relevant to practicing physicians? Our Network study would likely give the practicing physician a different, yet valuable perspective on the use of antibiotics with these patients that the "academic study" could not provide. The information obtained is not more or less valuable, but different because it comes from a different context. As the great physicist Werner Heisenberg is quoted as saying "...what we observe is not nature itself, but nature exposed to our method of questioning." 4

This brings us back to the question we raised at the beginning of this article, why is it that so many new drugs that show promise in the academic research environment, achieve such a different result in the real practice of medicine? The answer just may be that the method of investigation usually used in the large university medical setting does not really reveal the whole picture of how efficacious the new treatment will be when used in the everyday practice of medicine.

For example, the results from research settings for tricyclic treatment of depression are tremendous. Studies have reported that 70% of patients benefit from these medicines. 5 Yet what is frequently found in everyday primary care practice is that tricycles are far less effective than that in the treatment of depression. One explanation for this is based on a chart review of 400 inpatients and is typical of the rational often given for this discrepancy. This study concludes that non-physicians are not rigorous enough in their use of tricycles. They state, "...little attention is directed toward ensuring optimal antidepressant therapy."

However, the authors' review of thousands of videotapes (note the different method of inquiry) of residents' encounters with patients has resulted in a quite different explanation. Frequently higher doses are not prescribed in this setting because patients would be even less likely to comply with higher doses. The physicians involved in treating these patients are, in many cases, thoroughly discussing treatment options quite knowledgeably, resulting in patients declining to take antidepressant medication or refusing to increase their dosage.

But those academic research studies often show that when a psychiatrist prescribes tricyclics, it yields better results—why? Most family physicians know the reason. Psychiatrists see only a subset of the patients a family physicians sees, in fact, only those willing to receive a referral to a psychiatrist, thus eliminating a large number of patients, leading to a significant selection bias. So the academic university studies seeming to demonstrate the effectiveness of tricycles may in part be irrelevant to what goes on in the family physician's office. To gain an understanding of the efficacy of antidepressants in the family physician's office research in that setting is required. Herein lies the necessity of promoting primary care networks.

CONCLUSION

We are not suggesting that research in large academic settings be abandoned. However, we are suggesting that gathering information about clinical practices in primary care settings can also provide valuable and useful information. Neither information is more true, but to paraphrase Heisenberg it is true within the context of the "method of questioning." Part of the purpose for writing this article is to promote the idea that practicing physicians can make an important contribution to medical research. Through network research participation one can participate in the development of medical science without being a member of a prestigious academic center. Furthermore, editors of journals will have to learn to acknowledge this source of contribution. Since most editors come from large academic settings and are there because they are believers, this will certainly test their openness to alternatives. Journals such as, the Family Practice Research Journal and Family Systems Medicine, were started in part because of resistance of established editorial boards to this type of research. Hopefully, this resistance will lessen in the future.
Those interested in joining the South Dakota Research Network, please contact us at the Sioux Falls Family Practice Residency, 2300 S Dakota Ave, Sioux Falls, SD 57105, phone: (605) 339-1783.

REFERENCES

AUTHORS
Michael V. Bloom, Ph.D, Director of Behavioral Science, Sioux Falls Family Practice Center, Sioux Falls, SD.
Timothy J. Moore, MD, MS, Associate Director, Sioux Falls Family Practice Center, Sioux Falls, SD.

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South Dakota Society of Pathologists

SEPTMBER 1992
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South Dakota Blue Shield
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By the time this letter has gone to press you can be assured that the DAKOTACARE board has done all in its power to reach an agreement in regard to the well publicized cost differential between certain hospitals. The purpose of DAKOTACARE has and always will be to serve its enrollees with quality care at the lowest possible cost without causing major problems for its physicians and other providers. This is a delicate situation as you can well imagine.

DAKOTACARE has gone the extra mile in allowing a 30 day cooling off period. This was decided after considerable debate and thought. The people of South Dakota have shown great support and realize the State Medical Association is working for them.

On August 12, the Board of Medical Examiners will be holding a hearing in Pierre in regard to chelation therapy. This is probably a no-win situation for the profession, but the health of the people of the state must be considered on medical evidence rather than political pressure. The Board asks that you get as many facts as possible to answer your patient's questions intelligently.

On a brighter note, the pheasant, duck and goose population appears to be up this year.
New Macrolide Antibiotics
Debra Farver, Pharm.D., Yankton, SD

Erythromycin was the first macrolide antibiotic to be used in clinical trials. Since 1952, this antibiotic has effectively treated streptococcal pharyngitis, atypical pneumonias, and cutaneous infections. There have been some limitations of erythromycin, such as poor oral bioavailability in an acidic medium necessitating enteric coating or changes in formulation, gastrointestinal adverse effects, and only intermediate activity against Hemophilus influenzae. A renewed interest in the macrolide antibiotics has resulted in recent FDA approval of clarithromycin (Biaxin by Abbott Laboratories) and azithromycin (Zithromax by Pfizer Pharmaceuticals). The new macrolides may provide some improved microbiologic and pharmacologic properties.

With all new antibiotics, the most commonly asked question is, "Is this drug better than the old, less expensive drug?" Based on minimum inhibitory concentrations, these new antibiotics do have some subtle differences in their spectrum of activity compared to erythromycin. Compared to erythromycin, lower concentrations of the new macrolides are sufficient to inhibit Moraxella catarrhalis, Mycoplasma pneumoniae, Legionella species, and Chlamydia pneumoniae. The activity against Streptococcus species with all three antibiotics is comparable. Azithromycin has an advantage over erythromycin in that it is more active against Hemophilus influenzae by four to eight times. What is truly unique to clarithromycin and azithromycin is their potential to inhibit organisms such as Mycobacterium avium, other Mycobacteria, and Toxoplasma gondii.1,2

Clinical trials have proven that the new macrolides are effective in treating lower and upper respiratory tract infections and uncomplicated skin and skin structure infections. Comparison trials with other classes of antimicrobials will help to better establish their role in treating infectious diseases. Resistance may become a concern with overuse of the new macrolides. In Europe, resistant strains of streptococci and staphylococci are occurring.3

Overall, although the macrolides appear to be one of the safest groups of antimicrobials, gastrointestinal disturbances have been notorious with erythromycin. The incidence of this varies with various formulations and doses, but has been estimated to be between 7% to 40%. The incidence appears to be less with clarithromycin (2% to 10%) and azithromycin (2% to 8%). Another adverse effect that is similar between these drugs is an elevation in serum liver enzyme concentrations.1,2

To summarize, subtle differences in microbial and pharmacologic properties exist between the macrolide antibiotics. A less subtle difference may exist between the new antimicrobials and generic erythromycin in cost. A cost comparison should be done by local pharmacies to add to the final evaluation in the use of this class of drugs.

References
Editorial

It's Back

The title of the above editorial could also be "When the Stigma is Gone II" employing a Hollywood principle of following any production which was successful by a sequel. The comparison of alcoholism with tuberculosis which Dr Cruse has given us in "When the Stigma is Gone" appearing in this issue of the Journal is compelling and I cannot improve upon its message.

I would, however, like to make some points about tuberculosis or the white plague which Osler called the Captain of the Men of Death. Clearly, in the past this dreaded infectious disease has made outcasts of its sufferers. There was always fear of the progressive disability and ultimate death which a diagnosis of tuberculosis meant. There was fear of banishment to a sanatorium away from friends and family and the resulting loss of productiveness.

When INH (isonicotinic acid hydrazine) was discovered in the 1950's and other effective antimicrobial agents were found to treat tuberculosis, sanatoria closed and tuberculosis has been treated like a curable chronic infection. We even found by using tuberculin testing as a detection of early infection the disease could be prevented.

It might be pointed out at this point that although tuberculosis has been a treatable and curable disease for several decades, it has always remained a leading cause of death and disability in many parts of the world where early diagnosis and treatment are not readily available.

In the 1980's AIDS exploded upon the scene as a new plague which rivaled tuberculosis and syphilis of previous centurie. Now we have found that as the incidence of HIV infection rises, our old enemy tuberculosis has found a new alley and is responsible for significant morbidity and mortality in AIDS patients. The most frightening fact is that noncomplying drug abusers who have contracted tuberculosis and HIV have multiple drug resistant variants which have caused numerous outbreaks. It's back. Tuberculosis is back and the antimicrobial resistant forms may turn back the pages of history. This gives us pause to reflect on the transient nature of medical successes, such as antibiotics which some said would eliminate infectious disease as a significant problem. If one notes the increasing number of antimicrobial resistant forms of many other microorganisms, one can only ask, what is next?

John F. Barlow, MD
Editor

SEPTEMBER 1992
Overview of PRO

Twelve Month Extension

The Health Care Financing Administration (HCFA) has announced plans to change the federal review program to make the national review process more consistent and more useful in aiding hospital and medical staffs to meet their objective of continuous quality improvement. For South Dakota, some of these changes began July 1, 1992, with SDFMC's signing of a contract for a twelve month extension.

The following is a comparison of significant changes for SDFMC’s next twelve month extension, July 1, 1992 through June 30, 1993:

<table>
<thead>
<tr>
<th>Third Scope of Work</th>
<th>Twelve Month Extension</th>
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<tr>
<th>South Dakota PRO selects sample of cases subject to review.</th>
<th>Primarily HCFA selects sampling of cases subject to review.</th>
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</thead>
<tbody>
<tr>
<td>Preauthorization was initially required, later phased out.</td>
<td>No provision for preauthorization.</td>
</tr>
<tr>
<td>Ambulatory surgery sampling 5%.</td>
<td>Ambulatory surgery sampling 3%.</td>
</tr>
<tr>
<td>No provision for outcome/pattern analysis.</td>
<td>South Dakota PRO will be performing outcome/pattern analysis.</td>
</tr>
<tr>
<td>Quality review process allows only physicians to determine generic screen failures are not a quality problem.</td>
<td>Quality review process allows nurse reviewer to determine screen failures are not a quality problem.</td>
</tr>
<tr>
<td>Only a physician can determine that a problem does exist.</td>
<td>Only a physician can determine that a problem does exist.</td>
</tr>
<tr>
<td>Physician/hospital identifiers not available to HCFA.</td>
<td>Physician/hospital identifiers available to HCFA.</td>
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Pine Ridge IHS Primary Care Resident Rotation

H. Bruce Vogt, MD and O. Myron Jerde, MD

ABSTRACT

With the support of the Oglala Sioux Tribe and the Aberdeen Area Indian Health Service, the University of South Dakota School of Medicine initiated development of a primary care resident rotation at the Pine Ridge IHS provider site. The rotation was conceived in an effort to help address the problem of recruitment and retention of physicians at Pine Ridge in the long term, while offering a unique educational experience for residents. It is a cooperative effort of four neighboring medical schools in South Dakota, North Dakota and Nebraska. Similar relationships between tribes, the Indian Health Service, and medical schools are encouraged, with the belief that such endeavors will assist in stabilizing professional staffs at provider sites, and lead to improved health care of the Indian people.

INTRODUCTION

Indian health care has been a concern in the state of South Dakota for many years. A significant problem has been the difficulty experienced by the Aberdeen Area Indian Health Service in recruiting and retaining well qualified physicians at provider sites. Turnover has been unacceptably high.

Medical schools are always interested in augmenting their curriculum, particularly to be able to offer their students and residents unique educational opportunities. In addition, many educators strive to stimulate a desire in their students and residents to provide community service during the course of their education. Indeed, such a recommendation was made in the published proceedings of the Josiah Macy Jr Foundation’s National Seminar on Medical Education.¹

The Pine Ridge Primary Care Resident Rotation was conceived in an effort to help address the problem of recruitment and retention of physicians at the Pine Ridge Indian Health Service provider site in the long term, while offering a unique educational experience for residents. Initiated by Dr Robert C. Talley, Dean of the University of South Dakota School of Medicine, it was planned with the support and cooperation of the Aberdeen Area Indian Health Service and the Oglala Sioux Tribe. The latter adopted a resolution in support of this endeavor July 25, 1990. The project is a cooperative effort of the University of South Dakota School of Medicine (USD), the University of North Dakota School of Medicine (UND), the University of Nebraska College of Medicine (UN), and the Creighton University School of Medicine (CU).

PINE RIDGE RESERVATION AND THE INDIAN HEALTH SERVICE

The Pine Ridge Reservation is the home of enrolled Oglala Sioux tribal members, Indians from other tribes, and other ethnic groups. It has a population of approximately 22,000. Major health problems include: ischemic heart disease, diabetes mellitus, hyperlipidemia, tuberculosis, malignancy, tobacco and alcohol abuse, accidental death and perinatal mortality.

The Indian Health Service (IHS) has its origin in treaties dating back to 1784, and was established through the Indian Health Care Act of 1954. The Aberdeen Area was established to serve the Indian tribes in North Dakota, South Dakota, Nebraska and Iowa. It brings health care to approximately 94,000 Indians living in the area. The Pine Ridge Hospital is one of 13 in the Aberdeen area. In addition, there are community health centers.

The 58 bed hospital in Pine Ridge is the largest in the Aberdeen area. Construction of a new 45 bed facility has begun with completion expected in 1993. There are health centers in Kyle, Manderson, Allen and Wanblee. The modern facility in Kyle was completed in 1989, and
a new building is planned for Manderson. IHS physicians also provide patient care one day per week in the community controlled health clinic in Porcupine.

The full-time physician staff includes specialists in family practice, internal medicine, pediatrics and obstetrics and gynecology. A faculty member from the USD Department of Obstetrics and Gynecology and two private practicing general surgeons from Gordon, Nebraska are in Pine Ridge two days per week. Radiology and pathology support is also provided by physicians from other communities who travel to Pine Ridge.

PROGRAM DESCRIPTION AND GOALS

The program offers a rotation for two primary care residents (family practice, general internal medicine, and general pediatrics) each month. The general structure of the rotation was developed by both a Site Governance Committee and a Program Governance Committee described below. The goals of the program are listed in Table I.

| TABLE I |
|-----------------|-----------------|
| Program Goals   |                 |
| 1. To improve the health care of the Indian people at the provider site. |
| 2. To instruct residents in primary care medicine. |
| 3. To instruct residents in the primary care model of the Aberdeen Area Indian Health Service. |
| 4. To provide for the interaction and instruction of residents in the Indian people's health related philosophies. |
| 5. To recruit primary care physicians to a career in the Indian Health Service. |
| 6. To retain current and future providers through their involvement in the teaching program. |
| 7. To involve residents in the health education of the Indian people at the site. |
| 8. To establish a teaching site for future medical student rotations. |

Goals which relate to resident education are accomplished during the course of the rotation, and we also believe the residents favorably impact the provision of health care and the health education of the Indian people immediately. The improved recruitment and retention of physicians are obviously long term goals and directly relate to goal number 1, "to improve the health care of the Indian people at the provider site". It is our belief that the presence of residents at the Pine Ridge site will increase its attractiveness to physicians with an IHS commitment and improve retention of physicians on the site. Additionally, it is hoped that the rotation will stimulate some residents to pursue a career in the IHS, thereby improving the recruitment of physicians.

ADMINISTRATION/GOVERNANCE

The key administrative personnel are the program director, who has ultimate administrative responsibility, the associate program director, and the clinical director at Pine Ridge. Two committees, the Site Governance Committee (SGC) and the Program Governance Committee (PGC), are responsible for program governance. The SGC is comprised of four members selected by the tribe, one member from the Aberdeen Area IHS, one member from the IHS at Pine Ridge, the program director and the associate program director. The SGC has policy and programmatic authority. Specific curricular responsibilities include supervision of the education of residents as to the tribal people and their health related philosophies, and direction of the health education for the Pine Ridge community to be delivered by the residents. It also has responsibility for the overall evaluation of the program.

The PGC is the academic committee and the membership is comprised of the program director, the associate program director, the Pine Ridge IHS clinical director, and representatives from each participating residency program. The PGC is responsible for curriculum development and evaluation of the academic program.

THE ROTATION

Residents are on rotation for a one month block of time. Specific learning objectives are listed in Table II. Residents provide inpatient and outpatient care in Pine Ridge under the supervision of the IHS physician staff. Hospital rounds are made daily. They see patients in selected Pine Ridge clinics three to four days per week. These include: the general medicine clinic, pediatric general clinic, OB/GYN clinic, surgery clinic, diabetes clinic, chest clinic (TB), and podiatry clinic. Residents see patients at a selected outreach facility (Manderson, Kyle, etc) up to two days per week again under the supervision of an IHS physician. They participate in the on-call schedule with the IHS physicians.

While on rotation, residents spend two to three days learning about the tribal culture, the Sioux people's health philosophies, and the IHS (in particular the Aberdeen Area and Pine Ridge provider site). Activities over the course of the month include a car tour of the reservation, informal didactic presentations, interaction with a Lakota Medicine Man, and other activities. It is hoped that residents will be invited by tribal families to powwows, sweats, and other cultural activities. The opportunities for cultural education and exchange are deemed highlights of the rotation.
Residents provide health education to the Pine Ridge community at least once during the rotation. Possibilities include, but are not limited to a presentation to high school students about a career in medicine or a health concern (e.g. drug abuse), a presentation about a particular disease process to affected individuals (e.g. diabetes education), or a radio call-in program.

For residents interested in performing a "mini" research project, a computer is available to support such endeavors.

Residents complete an evaluation of their attending physicians and the rotation as a whole. Similarly, the attending physicians evaluate resident performance. In addition to the rather standard questions asked of residents on evaluation forms, we are specifically interested in the cultural aspects of the rotation, and whether the resident had any interest in a career in the Indian Health Service prior to the rotation or following completion of the rotation.

During the developmental stages, an internal medicine resident from USD and a family practice resident from the CU/Ottutt Air Force program completed a "pilot" rotation. The first resident to arrive for the formally established rotation was from the UND-Bismarck Family Practice Residency program in January 1992. Four others completed the rotation through June 1992, and several residents are scheduled for the 1992-93 academic year.

CONCLUSION

The Pine Ridge Primary Care Resident Rotation offers a unique educational opportunity for primary care residents. The rotation is a challenging and rewarding experience, both personally and professionally. The resident is part of a minority group within a sovereign nation. The cultural experiences, values, and traditions encountered and the professional experience gained are invaluable.

We believe the relationship between academic medicine and the Indian Health Service is a very positive one which can continue to grow, and ultimately assist in stabilizing the professional staffs at provider sites leading to improved health care of the Indian people. It is hoped through the enthusiasm generated by all involved—the tribal community, participating residents, the medical schools, and the Pine Ridge IHS—this educational program can become a model for other IHS provider sites in the nation.

REFERENCES


AUTHORS

II Bruce Vogt, MD, Professor, Family Medicine. Dean, Graduate Medical Education, USD School of Medicine, Sioux Falls, SD. O. Myron Jerde, MD, Professor, Internal Medicine. Dean, West River Campus, USD School of Medicine, Rapid City, SD.
New Physicians

The following physicians recently began practicing medicine in South Dakota.

**Greg Fehr, MD, Sturgis**, is a board certified emergency room physician. He received his medical degree from the University of Alberta, in 1976, and completed an internship at Royal Alexandra Hospital in Alberta, Canada in 1977. He has joined the Sturgis Medical Center.

Anna Krishnamoorthy, MD, Faulkton, specializes in obstetrics and gynecology as well as family practice. She has also had training in anesthesia in Canada. She received her medical degree in Madurai, India in 1961. In 1967 she immigrated to Canada and practiced there since 1969. Dr Krishnamoorthy has joined the Faulkton Clinic.

Raymond Polizzi, MD, Hot Springs, is a board certified surgeon in laser and laparoscopic surgery. He received his medical degree in 1963 and completed a residency in surgery at the Jackson Memorial Hospital in 1967. Dr Polizzi relocated to the Southern Hills General Hospital in Hot Springs.

**Mark S. Perpich, MD**, is an orthopaedic surgeon at the Prairie Lakes Hospital in Watertown. He is a native of Wisconsin and received his medical degree from the University of Wisconsin Medical School in 1977. He completed a residency in orthopaedic surgery at the University of Wisconsin University Hospital.

Mark E. Bubak, MD, Sioux Falls, is certified in internal medicine and allergy and immunology. He received his medical degree from the University of South Dakota in 1986. Dr Bubak completed an internal medicine residency at the Mayo Graduate School of Medicine in 1989. He has joined the Central Plains Clinic, Sioux Falls.

Craig Hedges, MD, Sioux Falls, is a board certified physician in otolaryngology - head and neck surgery. He received his medical degree from the University of Illinois School of Medicine in Chicago in 1983, and completed an internship and residency at the Mayo Clinic. He has joined Ear, Nose and Throat, PC.

Douglas M. Holum, MD, specializes in family practice. He received his medical degree from the University of Minnesota Medical Schools of Duluth and Minneapolis in 1985. He completed a family practice residency at Riverside Medical Center and was in private practice in St. Cloud, MN. Dr Holum joined the Mitchell Clinic.

**Dennis Leland, MD, Mitchell**, is a native of Minnesota and specializes in general surgery. He received his medical degree from the University of Minnesota, Minneapolis, School of Medicine in 1987 and completed a general surgery residency at the VAMC in Des Moines, IA in 1992. Dr Leland recently joined Dakota Medical Specialists.

Timothy R. Waterman, MD, Aberdeen, an internal medicine specialist, completed his medical degree at the University of South Dakota in Vermillion in 1989. He completed an internal medicine residency at Abbott Northwestern Hospital in Minneapolis. Dr Waterman is an Aberdeen native and began his practice at Internal Medicine Associates.

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17th Annual South Dakota Perinatal Association Conference

"Healthy Perinatal Environment - NOT!"
October 19-20, 1992
Ramkota Inn, Pierre, SD

Guest faculty include: James Hanson, MD, University of Iowa, Maureen Reeves-Horsley, RN, BSN, Emmetsburg, IA and Elizabeth Thomson, MS, RN, University of Iowa. Continuing Medical Education for physicians and nurses will be available.

For further information contact:

Debbie Meyer
SD Perinatal Association
1100 S Euclid
Sioux Falls, SD 57105
(605) 333-5210

SOUTH DAKOTA
Extenuating Circumstances

A periodic column of personal, ethical, and socioeconomic reflections on medicine.

When the Stigma is Gone
(Is This Alcoholism?) A Parable

She had been concerned about him for a long time. He was acting differently, he was missing more work, he had lost his vim and vigor, he was quick to snap at the kids, and most distasteful, in bed at night he would sweat profusely, waking her with his mumbling, restlessness. She would confront him the next day and he would absolutely deny it for he had no recollection. On occasion, she sent him to their dear friend, the physician, who would back up his allegation that "he had the flu again".

On one occasion, she confronted him with her diagnosis and he absolutely exploded and, for the first time in their marriage, hit her. Later she would realize that he hit her out of his own fear rather than through actual anger. She was petrified at the thought that one or more of the children would end up the same way. They took a trip they could ill afford to Colorado and she feared he would be worse, but true to his predictions, he was better, and her hopes soared. He even became somewhat physically attractive to her again.

Their daughter, Sue, was engaged to the son of a very prominent family in town. Here again if anyone in her family had suspicions about his disease, they weren't talking. It was a foregone conclusion that should the future in-laws become aware, there would be no marriage, and though Sue had gone with the young man for a long period of time prior to their engagement, and she felt she could confide in her finance about almost anything, she dare not mention her father's suspected illness. She was beginning to wonder if she should move out prematurely as things seemed to be getting worse between her and her father. Strangely, he had stopped hugging her.

His was the greatest fear, and the sense of relief he felt after visiting his dear friend, the physician, could not be measured because the creeping thoughts that he might have "it" were becoming more and more frequent.

If it were true and he did have that disease ... no! He couldn't even think of it. Those people lost their jobs, their families, and have to be sent away to one of those places for "the cure", and there are no funds or insurance to pay for it. The thought was so totally abhorrent to him that he only considered it for fleeting moments from time to time. Besides, he was too strong a man.

The boss had approached him only last week and stated that he had had concern for the past year regard-
disease of alcoholism in certain of our societies. Chopin was taken to Spain from Paris by George Sand. When his consumption became serious, the Spanish required that he be isolated in Majorca in the country and she had to travel to the village to do all the shopping as no one would work for them. He returned to Paris still infected, coughing blood and again was busy with high society attending concerts, receptions, etc. So, while Chopin could reasonably, if a bit cruelly, be isolated on Majorca, he could not be isolated in Paris. For if he had been quarantined, a good third of the city would have had to join him. This is probably the same case in countries which have difficulty dealing with alcoholism and alcohol problems. When a significant number have and hold on to the problem, and when the social stigma is so great, and when denial or unawareness is the major symptom, that society will not address the problem face on. This history of an attitude toward TB suggests a principle concerning disease in general. Where there is any choice, society accepts only those facts it finds least disturbing.

If necessary, it sets itself in opposition to science in an effort to stave off the threat implicit in the truth. In the case of tuberculosis, the burden of evidence won out in time, and society was forced to deal with the facts as they really were - but before giving in, TB and society had won a 200-year delaying act.

Quote - William Osler, MD, 1911 - "The disease is distinctively a social problem. As long as science looks upon it (its spread) as a behavioral problem, it holds out small hope of recovery to the stricken one. It is merely a family affair, calling for whatever fortitude can be summoned to endure the inevitable suffering of one's self and relatives, making at the most only one demand, rarely heeded, in the interest of society, that laws not be broken. But the discoveries of the last twenty years have laid heavy responsibilities on society, for they have made the prevalence of this disease known, and have given ground for believing that man has it in his power to recognize and treat it in its earlier stages. And perhaps even prevent it. This will take a major change in social common sense."

Tuberculosis has been the most lethal disease in history and its incidence is re-increasing. Its story has much to say about the future, as well as the past. TB's story fits alcoholism like a glove. We are responsible to our patients and our stricken colleagues to recognize and intervene on this progressive and eventually fatal disease of alcoholism and its related disorders. The impact of alcoholism and other addictions requires a change in our own social and professional common sense. We have it in our power "to recognize and treat it in its earlier stages and perhaps even prevent it". #

Joseph R. Cruse, MD, Member
SDSMA Physicians HELP Committee
Rapid City, SD
Auxiliary News

Ruth Parry, President, South Dakota State Medical Association Auxiliary

What's In A Name?

Delegates to the Annual Conference of the American Medical Association auxiliary recently gave approval to change the name of the organization to the American Medical Association Alliance. The vote to accept the recommendation followed a year-long study which included a survey sent to more than 500 auxiliary leaders, members, young physicians' and resident physicians' spouses, AMA member and non-member physicians, young physicians, and medical society executives. The survey was designed to gauge feelings and perceptions of the word "auxiliary" and its relevance in today's world.

In addition, the tag line "Physicians' spouses dedicated to the health of America" was approved to accompany the new name. The majority of the delegates and members stated that this change was a timely step for the 70-year-old organization to take to be responsive to the physicians' spouses of today and the future.

Although the name will not officially change until June 1993, at which time the Bylaws Amendments are presented to the 1993 House of Delegates, we must begin to consider the use of new vocabulary. No longer will the name Auxilian be appropriate. It appears that physicians' spouses who belong to the national organization in the future will simply be Alliance members.

Does this change of title also mean a change in description? From my perspective, it certainly does not. As I have gained knowledge and familiarity with this group, I realize that the name does not describe the membership. Instead, the accomplishments of the organization provide the means of identification. Auxiliaries throughout the 70 year history have demonstrated enduring commitment to medical education as they promoted AMA-ERF. They have promoted physical wellness and prevention with "Growing Healthy" and inoculations. They have been concerned about children of every age and situation. There has been concern about alcohol and drug abuse, teenage pregnancy, and family violence.

These concerns will not change. As physicians' spouses, we will continue to demonstrate commitment and caring for our families, our communities, and our country. Perhaps, the most significant descriptor might be the tag-line which would always have been most appropriate, "Physicians' spouses dedicated to the health of America".

As we look to the future, we in South Dakota may choose to also make a change in title from Auxiliary to Alliance. We may also choose to retain our current organizational name. That name is not the focus of our group. It is our commitment and concern about health issues which will be our catalyst.

#

Ruth Parry

SEPTEMBER 1992

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**MCKENNNAN HOSPITAL**

8th Annual
**CLINICAL UPDATE**

A Symposium for Physicians

**Modules in:**
Pediatrics/Neonatology
Rheumatology/Orthopedics
Endocrinology
Topics of Current Interest

Friday and Saturday  Contact: Marvie Swanson
December 4 and 5, 1992  800 E 21st
Holiday Inn City Centre  Sioux Falls, SD
Sioux Falls, SD  57117-5045
(605) 339-8117

---

**Family Practice**

Interlakes Medical Center, PC is seeking a family practitioner to practice in Madison, South Dakota with Richard Sample, MD, Mary Beecher, MD, and Wayne Wetzarger, MD. We offer a competitive salary, benefit, and retirement package, a reasonable call schedule, and a busy practice opportunity in a relaxed environment.

Madison is a progressive southeastern South Dakota community of 6,200 located in a region offering abundant opportunities for recreation, education, and various cultural events throughout the year.

If you are interested, please contact one of the above or Scott Jamison, Business Manager, at 605-256-6951. Interlakes Medical center, PC, 903 N Washington Ave, Madison, SD 57042.

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**Nephrology Update in Clinical Practice**

January 14-15, 1993
rushmore Plaza Holiday Inn
Rapid City, SD

Fourth Annual Conference Sponsored By:
Department of Internal Medicine
USD School of Medicine
and
Rapid City Regional Hospital

Program includes:
1. Acid/base symposium
2. Common nephrology lab tests review
3. Symposium on renal diseases in the extremes of age
4. Symposium on dialysis and transplantation
5. Clinical/pathologic review of common glomerular diseases
6. New drugs in renal patients/detoxification

Physicians, Nurses, Pharmacists, Students,
Dialysis Nurses & Technicians, Dieticians
Contact:
Brian Hurley, MD
Department of Internal Medicine
USD School of Medicine
PO Box 5046
Sioux Falls, SD  57117-5046

---

**Internal Medicine, Family Practice and Obstetrics-Gynecology Practice Opportunities**

Rural Lake Country Community is seeking the above practitioners to join an active 13 physician multispecialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits.

Send curriculum vitae or inquiries to:
Lake Region Clinic, PC
Attn: Joel Rotvold
PO Box 1100
Devils Lake, ND  58301
or call collect at (701) 662-2157 for further information.
60th ANNUAL POSTGRADUATE ASSEMBLY
Omaha Mid-West Clinical Society

November 5, 6, and 7, 1992 (Thursday, Friday, and Saturday)

The Red Lion Hotel
Omaha, Nebraska

For information, please contact:
Miss Lorraine E. Seibel
Omaha Mid-West Clinical Society
7389 Pacific Street, #229
Omaha, NE 68114
(402) 397-1443

OTOLARYNGOLOGIST NEEDED

A third otolaryngologist is being sought by two busy otolaryngologists, the leading ENT partnership in a Midwest city. Each doctor sees 200 patients/week in the office, and each does 20 surgeries/week in the two large nearby hospitals. The office, 4,500 square feet with 12 examination rooms, has three audiologists.

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The area, having four colleges and one major university with a medical school, is culturally alive and medically sophisticated.

For more information for yourself or someone you know, please contact:
Walter F. Smith, PhD
E.G. Todd Physician Search, Inc.
915 Broadway, Suite 1101
New York, NY 10010
800-221-4762

MEDICAL DIRECTOR

South Dakota Foundation for Medical Care (SDFMC), the Peer Review Organization (PRO) for South Dakota, is accepting applications for the position of Medical Director.

Qualifications:
- Licensed doctor of medicine or osteopathy engaged in active practice at least 20 hours per week.
- Admitting privileges in one or more South Dakota hospitals.
- Admits and prescribes treatment for Medicare beneficiaries on a routine basis. Previous experience as a PRO physician reviewer.
- Medical administration experience and/or education preferred. Primarily, the Medical Director would be in the SDFMC office 1-2 days per week.

Duties:
- Responsible for coordinating quality review and utilization review functions.
- Represents SDFMC and creates liaison with medical staffs throughout South Dakota as related to medical practice.
- Directs communications to physicians regarding PRO review process.

Send letter of application along with CV by October 1, 1992, to the following address:

South Dakota Foundation for Medical Care
Attn: Mark Hoven
1323 South Minnesota Avenue
Sioux Falls, SD 57105
(605) 336-3505
CME Conferences

CME Conferences being held on a regular basis at various health care facilities throughout the state of South Dakota.

(1 hour AMA Category 1 Credit Available Unless Otherwise Specified)

SEPTEMBER 1992


September 23  Geriatrics Grand Rounds - 12:00 noon, Sioux Valley Hospital - Mtg Room A, Info: Edward Zawada, MD, 339-6790.

September 24  Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

September 24  Cardiac Cath Conference, 7:30 am, McKennan Hospital Auditorium, Info: Tom Kenyon, 339-7677.

September 24  Pediatric Grand Rounds - 7:30 am, Ann Berdahl Hall, Sioux Valley Hospital, Info: Larry Wellman, MD, 333-7175 (Cathi).

September 25  Tumor Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.


September 30  "Topics in Clinical Medicine" - audio teleconference series, 12:30 pm (CT/CDT), Topic: "The Cholesterol Crusade: Is It Worth It?", Speaker: William P. Castelli, MD, Info: Connie Kleinsasser, USDSM, 339-6638.

OCTOBER 1992

October 1  Cath Conference - 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glibas, 333-7266.

October 1  Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

October 2  Psychiatry Grand Rounds - VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Topic: "Family Therapy", Speaker: Michael Bloom, PhD, Info: Douglas J. Soule, PhD, 339-6785.

October 2  Morbidity/Mortality Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.


October 7  "Topics in Clinical Medicine" - audio teleconference series, 12:30 pm (CT/CDT), Topic: "Ocular External Disease and Cornea", Speaker: Michael Pekas, MD, Info: Connie Kleinsasser, USDSM, 339-6638.

October 8  Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

October 8  Cardiac Cath Conference, 7:30 am, McKennan Hospital Auditorium, Info: Tom Kenyon, 339-7677.

October 8  Pediatric Grand Rounds - 7:30 am, Ann Berdahl Hall, Sioux Valley Hospital, Info: Larry Wellman, MD, 333-7175 (Cathi).

October 9  Psychiatry Grand Rounds - (Special Grand Rounds) VAMC, 11:00 am to 1:00 pm, VA Regional Bldg - Training Room, Topic: "Child Psychiatry", Info: Douglas J. Soule, PhD, 339-6785.

October 9  Pathology Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

October 14  Internal Medicine Grand Rounds - 7:30 am, McKennan Hospital Auditorium, Topic: "High Resolution CT Chest Scans", Speaker: Tom Cink, MD, Info: Brian T. Hurley, MD, 339-6790 (Barb).

October 14  Geriatrics Grand Rounds - 12:00 noon, Sioux Valley Hospital - Mtg Room A, Info: Edward Zawada, MD, 339-6790.

October 14  "Topics in Clinical Medicine" - audio teleconference series, 12:30 pm, (CT/CDT), Topic: "Sinusitis: Primary Care Perspective and Meeting the Goals of Therapy", Speaker: Paul A. Cink, MD, Info: Connie Kleinsasser, USDSM, 339-6638.

October 15  Cath Conference - 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glibas, 333-7266.

October 15  Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

October 16  Psychiatry Grand Rounds - VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Info: Douglas J. Soule, PhD, 339-6785.

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SOUTH DAKOTA
October 19  
**CPR Certification/Recertification** - 7-10 pm, Brookings Hospital. Info: Phyllis Sander, RN - 692-6351.

October 20  
Endoorna (Endocrinology Conference), 7:30 am, Sioux Valley Hospital. Info: J. Michael McMillin, MD - 334-8387.

October 21  
**Internal Medicine Grand Rounds** - 7:30 am, Sioux Valley Hospital Auditorium. Topic: "Hypertensive Nephropathy: Where do we Stand with Diagnosis and Therapy?". Speaker: Stanley S. Franklin, MD. Info: Brian T. Hurley, MD - 339-6790 (Barb).

October 21  

October 21  

October 22  
Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus. Info: Norma Wise, 339-8568.

October 22  
Cardiac Cath Conference, 7:30 am, McKennan Hospital Auditorium. Info: Tom Kenyon, 339-7677.

October 22  
**Pediatric Grand Rounds** - 7:30 am. Ann Berdahl Hall, Sioux Valley Hospital. Info: Larry Wellman, MD - 333-7175 (Cath). 

October 23  
Tumor Conference - 12:30 pm, Brookings Hospital. Info: Phyllis Sander, RN - 692-6351.

October 25  

October 26  
**Tumor Board** - Fort Meade VA. Info: Vickie Netterberg - 347-2511, ext 284.

October 28  

October 28  
Geriatrics Grand Rounds - 12:00 noon, Sioux Valley Hospital - Mtg Room A. Info: Edward Zawada, MD - 339-6790.

October 29  
Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus. Info: Norma Wise, 339-8568.

**MISCELLANEOUS MEETINGS**

**OCTOBER**

October 2-3  
Laparoscopy - Assisted Vaginal Hysterectomy Course, Creighton Univ, Omaha, NE. CME credit avail. Contact: Sally C. O'Neill, PhD, Associate Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

October 9  
Annual Contemporary Issues in Dialysis Therapy, Hennepin County Med Ctr, Minneapolis, MN. CME credit avail. Contact: Office of Academic Affairs, Hennepin County Med Ctr, 701 Park Ave, Minneapolis, MN 55415. Phone: (612) 347-2075.

October 12-17  
Emergency Medicine Review, Ctr For Cont Educ, U of Nebraska Med Ctr, Omaha, NE. Fee: $700. CME credit avail. Contact: Ctr for Cont Educ, U of Nebraska Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

October 15-16  
Trauma and Critical Care Conference, Hennepin County Med Ctr, Minneapolis, MN. CME credit avail. Contact: Office of Academic Affairs, Hennepin County Med Ctr, 701 Park Ave, Minneapolis, MN 55415. Phone: (612) 347-2075.

October 19 & 26  
**ACLS Provider Course**, Sioux Valley Hospital Meeting Room B, Sioux Falls, SD. 20 hrs AHA Category 1 credit. Contact: HealthInformation, Sioux Valley Hospital, 1100 S Euclid Ave, Sioux Falls, SD 57105. Phone: (605) 333-4444.

October 30-31  

October 31  
Pediatric Immunology and Rheumatology for the Practitioner, Ritz-Carlton Hotel, St. Louis, MO. 6.75 hrs AHA Category 1 credit. Contact: CME Washington Univ Sch of Med, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

October 31  
**Recognition and Management of Parkinson's Disease for the Primary Care Physician**, Holiday Inn Crowne Plaza, Kansas City, MO. Fee: $40. 3.75 hrs AAFP & AHA Category 1 credit. Contact: Office of Cont Educ, U of Kansas Med Ctr, 3901 Rainbow Blvd, Kansas City, KS 66160-7108. Phone: (913) 588-4488.

**NOVEMBER**

November 2  
**ACLS Provider Course**, Sioux Valley Hospital Meeting Room B, Sioux Falls, SD. 20 hrs AHA Category 1 credit. Contact: HealthInformation, Sioux Valley Hospital, 1100 S Euclid Ave, Sioux Falls, SD 57105. Phone: (605) 333-4444.

November 4-6  
1992 SD Rural Health Conference: Helping Communities Help Themselves, Ramkota Inn, Sioux Falls, SD. Contact: SD Office of Rural Health, 2501 W 22nd St, Sioux Falls, SD 57117-5046. Phone: (605) 339-6541.
November 5-7  Sixteenth Annual Postgraduate Assembly, Red Lion Hotel, Omaha, NE. Contact: Lorraine Seibel, Exec Sec, Omaha Mid-West Clinical Society, 7389 Pacific St, Suite 229, Omaha, NE 68114. Phone: (402) 397-1443.

November 12-14  Strategies in Primary Care Medicine, Holiday Inn, East, St. Paul, MN. Fee $245. 16.5 hrs AMA Category 1 credit. Contact: Registrar, CME, St. Paul-Ramsey Med Ctr, 640 Jackson St, St. Paul, MN 55101. Phone: (612) 221-3992.

November 15-16  SD State Osteopathic Association Annual Meeting and Family Practice Update, Ramkota Inn, Pierre, SD. Fee: $100. 15 hrs AOA Category 1 & 14 hrs AAFP Category 1 credit. Contact: Lorin D. Pankratz, PO Box 89302, Sioux Falls, SD 57105-9302. Phone: (605) 361-6004.

November 19  Practical Review and Update of Infectious Disease, Allis Plaza Hotel, Kansas City, MO. Fee: TBA. 7 hrs AMA Category 1 credit & AAFP: TBA. Contact: Mary Boyd, Promotions Coord, Off of Cont Educ, U of Kansas Med Ctr, 3901 Rainbow Blvd, Kansas City, KS 66160-7108. Phone: (913) 588-4488.


DECEMBER

December 3-5  Annual Cardiopulmonary Medicine Update, St. Paul-Ramsey Med Ctr, St. Paul, MN. 16 hrs AMA Category 1 credit. Contact: Registrar, CME, St. Paul-Ramsey Med Ctr, 640 Jackson St, St. Paul, MN 55101. Phone: (612) 221-3992.

December 3-5  Obstetrics and Gynecology Conference, Bally's, Las Vegas, NV. Fee: $250. Contact: Ctr for Cont Educ, U of Neb Med Ctr, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

December 4-5  Eighth Annual Clinical Update, Holiday Inn City Ctr, Sioux Falls, SD. 9 hrs AMA Category 1 credit. Contact: Marvie Swanson, McKennan Hospital, 800 E 21st St, Sioux Falls, SD 57105. Phone: (605) 339-8117.

December 4-5  Children with Brain Injuries: Can We Make a Difference?, Sheraton Midway Hotel, St. Paul, MN. CME credit avail. Contact Off of Academic Affairs, Hennepin County Med Ctr, 701 Park Ave, Suite 4512, Minneapolis, MN 55415. Phone: (612) 347-3533.

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SOUTH DAKOTA
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Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a “V” formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on.

Cooperation and support for the group.

The same is true of The Doctors’ Company. We work with our doctors, not against them, by providing the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more South Dakota physicians are joining our flock. The Doctors’ Company has the financial strength and support of more than 15,500 members nationwide. But unlike the migrating geese, we’re in South Dakota to stay. We’ve never left a state to which we’ve committed service.

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Goatsbeard (looks like a large dandelion). The radiance is the sun directly behind the flower. Photographed in 1970. Joel Strasser, well-known South Dakota photographer, lives near Canton, SD.
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Atlantoaxial Instability in Down’s Syndrome: A Case Report and Review

R. G. Briggs, MD, W. O. Carlson, MD, and D. L. Johnson, MD

ABSTRACT

Down's syndrome is the most common autosomal chromosomal abnormality in humans and is associated with a number of well known clinical findings. Atlantoaxial instability is a less recognized, yet potentially significant, manifestation of Down’s that has gained importance because of the widespread participation of Down’s syndrome individuals in athletic events.

Early recognition and appropriate management of patients with atlantoaxial instability can significantly reduce the morbidity and mortality associated with this condition and guide patients and their parents toward continued safe participation in athletics.

CASE REPORT

A. L. was a thirteen year old white female with Down’s syndrome who presented to this clinic following a routine screening for Special Olympics participation. Her initial outside examination revealed radiographic abnormalities of the cervical spine. She was subsequently referred for further evaluation.

The patient’s history, obtained by questioning the patient and her foster parents, revealed that she had been relatively asymptomatic despite the radiological evidence of cervical pathology. An occasional mild headache upon arising in the morning was her only complaint which possibly related to her radiographic findings. Her parents described her as being exceptionally active, and especially enjoying gymnastics and football. Her expressed interest in these potentially dangerous activities required that she be thoroughly evaluated and a course of management determined.

Physical examination revealed a well nourished, adequately developed, white female with facies and other stigmata of Down’s syndrome. The examination was unremarkable and noncontributory with regard to her present condition. She was neurologically intact without any localizing signs. Deep tendon reflexes were brisk, and motor strength was bilaterally symmetrical. The patient demonstrated no gait disturbances or problems with coordination.

Lateral cervical spine flexion and extension films were taken (outside films were neutral) and revealed significant pathology. These views showed widening of atlanto-dens interval with flexion from one millimeter to four millimeters (Figure 1 & 2). These radiographic findings represented a significant abnormality for an individual of her age group. In light of her atlantoaxial instability and participation in strenuous physical activity, it was determined that surgical stabilization of the cervical spine was warranted.

Shortly thereafter, A. L. was taken to surgery for open reduction, internal fixation, and posterior fusion of the occiput to C2. Intraoperative findings revealed a one centimeter gap posteriorly in the midportion of the C1 ring consisting only of ligamentous material with no bony or cartilaginous analage present. A marked laxity of the ligament of C1 and C2 (transverse odontoid ligament) was also seen. Reduction and fixation was obtained by passing a wire through holes drilled through the occiput and arch of C2. Fusion was accomplished using autologous bone graft from the patient’s iliac crest.

The patient’s postoperative course was excellent and she was discharged four days following the procedure wearing a SOMI brace for support. Four months later the brace was discontinued, and the patient was allowed to resume limited physical activity.

Final evaluation of A. L. occurred eleven months postoperatively. Radiographs revealed solid fusion from the occiput to C1, and the presence of pseudoarthrosis from C1 to C2 (Figure 3). There was no progression of the atlanto-dens interval and motion at the C1 and C2 interface was prevented by the posterior bone graft. At this time, it was judged that A. L. possessed a functionally adequate atlantoaxial joint and, therefore, was allowed to resume all activities including...
those specified as high risk by the Special Olympics Committee.

**DISCUSSION**

The clinical findings associated with Down's syndrome were first fully described by John Langdon Down in 1866. While these patients display a broad range of phenotypic expression, the more common findings include a small anteroposteriorly flattened skull, short flat-bridged nose, epicanthal fold, short phalanges, and widened space between the first and second digits of the hands and feet, accompanied by varying degrees of mental retardation. Congenital heart defects, bowel abnormalities, and an increased incidence of leukemia also occur.¹

Lax joints, including laxity of the atlantoaxial articulation have more recently been described. Atlantoaxial instability is thought to result from ligamentous laxity and associated joint instability, especially of the transverse odontoid ligament and atlantoaxial articulation. It is not known why individuals with Down's syndrome have ligamentous laxity. Some believe intrinsic defects of the collagen fibers that form the ligaments are responsible and that atlantoaxial instability can be correlated with hyperextensibility of other joints.² Others believe that congenital weakness of the ligaments and superimposed endogenous trauma causes spondylitis leading to atlantoaxial dislocation.³

The odontoid of the axis is held secure against the anterior arch of the atlas by the transverse ligament. It is the integrity of this positional relationship that is responsible for the articulation of the C1 and C2 vertebrae. Atlantoaxial instability occurs because of laxity of the transverse ligament alone, or in combination with abnormalities relating to the odontoid. These odontoid abnormalities range from odontoid dysplasia, hypoplastic odontoid, os odontoideum, ossiculum terminale or a "third condyle" (a manifestation of an occipital vertebrae).⁴⁻⁷

The prevalence of atlantoaxial instability in the Down's syndrome population has been determined radiographically to be 12%-20%. Martel and Tishler reported radiographic evidence of increased atlantoaxial dissociation in 14 (20%) of 70 Down's patients.³ Pueschel conducted some of the larger patient studies and found 59 (14.6%) of 404 Down's patients that displayed atlantoaxial instability.²

To determine if atlantoaxial instability exists radiographically, lateral views of the cervical spine are taken in the flexion, extension, and neutral positions. Atlantoaxial instability is then determined by measuring the atlanto-dens interval. The atlanto-dens interval is the shortest distance between the posterior/inferior aspect of the anterior arch of the atlas, and the adjacent anterior aspect of the odontoid process. Normally, the atlanto-dens interval is 2.4 +/-0.7 mm. Atlantoaxial instability exists when the atlanto-dens interval is greater than, or equal to, 4 mm (3-5 mm intervals have been used as defining criteria).

All three (lateral, neutral, and extension) views are necessary for a complete radiographic exam. Maximal atlantoaxial instability is generally seen on the flexion films.⁵ However, there have been cases where the flexion films were normal while the extension films revealed atlanto-dens intervals greater than 5 mm.²

The prevalence of atlantoaxial instability in Down's syndrome is significant (12%-20%), but the frequency of neurologic symptoms is relatively low. Neurological symptoms related to atlantoaxial instability has a prevalence of 1%-3% in the Down's syndrome population.²,⁶,⁸

Clinically, manifestations are related to spinal cord compression by the odontoid process of C2 anteriorly or by the arch of C1 posteriorly. Frequently, these patients present with complaints of torticollis, neck pain and/or headache, weakness of at least one limb, abnormal gait, progressive clumsiness, spasticity, and hyperreflexia. Occasionally, the signs and symptoms can be more severe, such as neurogenic bowel and
bladder, spastic hemiparesis, paraparesis, quadriaparesis, and even death.8-11

A thorough neurological examination is an essential part of screening for atlantoaxial instability. Most cases that result in serious neurologic damage are preceded by abnormal neurologic symptoms and signs.10,12,13 Any Down's syndrome patient who presents with neurologic symptoms requires a complete work-up for atlantoaxial instability regardless of a previous negative screen. There are reported cases where individuals with initial normal radiographic evaluations have later shown evidence of atlantoaxial instability on subsequent exams.2

The increasing participation in athletic events by persons with Down's syndrome and the possibility of severe consequences resulting from atlantoaxial instability have led to greater emphasis on early recognition of this condition. The United States Special Olympics Committee has mandated that all Down's syndrome individuals participating in events with the potential to stress the head and neck must first be evaluated for atlantoaxial instability.14 Gymnastics, diving, pentathlon, diving starts in swimming, high jump, soccer, and warm-up exercises placing stress on the head and neck were specified as potentially dangerous activities. Persons participating in these events are required to verify that physical examination, and neutral lateral, flexion, and extension roentgenograms of the cervical spine demonstrate no instability or neurologic disorder.

RECOMMENDED GUIDELINES

Despite the institution of these mandates, there remains considerable confusion regarding the role of primary care physicians in screening Down's patients prior to athletic competition. Routine screening and appropriate management of high risk individuals can reduce morbidity and mortality. This does not, however, mean that all children with Down's syndrome need extensive evaluations to rule out an admittedly infrequent symptomatic condition. Various authors have described guidelines to determine those most likely to benefit from screening and further evaluation. After reviewing the current literature, the guidelines adapted from Orthopedic Consultants of Cincinnati, Inc.15 appear to be most reasonable. These guidelines are reprinted with the hope they will assist primary physicians in providing a comprehensive care program for active Down's syndrome individuals.

1. Children exhibiting symptoms of increased clumsiness, walking fatigue, sudden preference of sitting, change in gait, change in bowel or bladder function, change in neck posturing, neck pain, limited neck motion, weakness of any extremity, spasticity, or hyperactive reflexes, should be seen, screened, and evaluated for cervical spine instability. This evaluation should include a thorough examination as well as AP, flexion/extension laterals and odontoid views of the cervical spine. Odontoid views only need to be completed once.

2. For any child with Down's syndrome who is involved in sporting activities which involve flexion and extension of the cervical spine or is involved in contact sports where such an injury could occur, screening for pre-existing cervical instability is recommended. Local educational programs may, or may not, require such examination prior to participation in sporting activities.

3. Activities categorized by the Special Olympics Committee as "high risk" include gymnastics (tumbling, trampoline), diving, butterfly stroke in swimming, high jump in track and field, soccer, and all warm-up exercises placing pressure on the head and neck muscles. Participation in these "high risk" activities may be restricted temporarily by local programs until screening has been performed.

4. A permanent restriction on participation in certain "high risk" activities is recommended for those individuals found to have symptoms of atlantoaxial instability and/or with x-ray evidence of atlantoaxial instability.

5. Clinical examination and x-ray studies of children with Down's syndrome should be performed by physicians (primary care physicians, orthopedists, radiologists, or neurologists) who are familiar with the historical and physical findings associated with atlantoaxial instability. X-rays can be adequately performed by private radiologists, hospital radiology departments, or orthopedic offices.

6. Physicians required to sign medical release forms indicate by signing that there are no present symptoms of cord compression and that radiology report indicates no x-ray evidence of instability on that particular examination. This does not mean, however, that cervical instability may not develop at a later time.

SUMMARY

Atlantoaxial instability represents a relatively uncommon problem in children with Down's syndrome. Our concern has been heightened by recent medical investigation and the Special Olympics policy. The establishment of certain guidelines raises questions of medical and legal implications for the patient, the parents, the physician, and the educational center. These guidelines are an attempt to provide these groups with a logical approach, based on current medi-
REFERENCES


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Walter O. Carlson, MD, Orthopedic Surgeon and Clinical Instructor, USD School of Medicine, Sioux Falls, SD
Dennis L. Johnson, MD, now deceased, was an Orthopedic Surgeon, and Clinical Associate Professor and Head of the Section of Orthopedic Surgery, USD School of Medicine, Sioux Falls, SD.

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SOUTH DAKOTA
Women in Medicine

September was designated as women in medicine month. There is no doubt women have made great gains in numbers. They have always had quality. I was told that over half of the new class at the USD School of Medicine was women and this may be true for years to come.

Women make up 16.9% of all physicians and are expected to increase to 30% by 2010. Women in medical schools comprised 38% of the student in 1990-91. In 1970, women represented seven specialties. They are now in fifteen but two-thirds are still in the seven which include internal medicine, pediatrics, family practice, obstetrics, gynecology, anesthesia, and pathology.

The AMA at its 1992 meeting decided to use gender neutral language in all bylaws, policies, procedures and publications and they encourage state, district and medical specialty societies to do the same.

The only problem is that even though the number of women in medicine has doubled in the past ten years, the number in organized medicine has increased by only 15%. South Dakota has done much better. As of August 1992, there were 112 women licensed. Seventy four are SDSMA members with several applications pending. There is, of course room, for improvement.

Along with any increase in representation comes an increase in responsibility. We do not need a separate women in medicine group. Beware of those individuals who work to divide. My advice to women in medicine is to be proud of your success, enjoy the accolades and continue to increase your goals. At the same time join the federation of medicine.

M. George Thompson, DO, President
South Dakota State Medical Association

OCTOBER 1992
South Dakota Foundation for Medical Care (SDFMC), the physician Peer Review Organization for South Dakota, utilizes explicit written criteria in conducting the initial screening for Medicare reviews. The criteria is designed to identify for the nurse reviewers when a physician should be contacted for a medical determination. The criteria does not represent standards of care but serves only as a referring tool.

Copies of all screening criteria were provided to each hospital in April 1989 and September 1992. The following is a listing of the criteria utilized by SDFMC in conducting the initial screen for Title 18 cases subject to PRO review.

**ADMISSION NECESSITY**
- Rehab Criteria — SDFMC Board Approved
- Skilled Level Care Criteria — HCFA Developed
- Inpatient Acute Care Criteria Severity of Illness/Intensity of Service — InterQual Developed, SDFMC Adapted and Board Approved

**DIAGNOSIS VALIDATION**
- Invasive Procedure Criteria — Developed Nationally by Physicians, SDFMC Board Approved

**QUALITY OF CARE**
- Inpatient Acute Care Generic Screen — HCFA Developed
- Inpatient Psych Care Generic Screen — HCFA Developed
- Outpatient Department Generic Screen — HCFA Developed
- Outpatient Surgery Generic Screen — HCFA Developed
- Skilled Level Care Generic Screen — HCFA Developed
- Home Health Department Generic Screen — HCFA Developed

If you wish to obtain a copy of any of the above criteria, please let your physician Peer Review Organization know by calling 1-800-658-2285.
Editorial

On Commencements

The uses of the word "commencement" are of interest. It means "to begin" or "start", of course, but it is also regularly employed as a term for the graduation ceremony (and the new beginning that completing a course of education signifies). The fittingness of this dual usage was brought home to me this spring and summer when, in the space of two months, I attended the USD School of Medicine (USDSM) graduation and then, the orientation activities for the incoming first year medical students. At these convocations, the symbolism and reality of "new beginnings" was evident. In both settings, the students collectively evoked images of scientific power and eager resolve, juxtaposed against visions of the inevitable uncertainties and struggles in medicine. John Stone, MD evokes such sentiments in his poem, "Gaudeamus Igitur", which he delivered to the graduating class of Emory University School of Medicine in 1982. He notes:

"For you will not be superman
For you will not be superwoman
For you will not be Solomon

But you will be asked the question nevertheless
For after you learn what to do, how and when to do it
the question will remain whether..."

Certainly, this message seems equally appropriate for the "beginnings" of both first year medical students and graduating seniors.

The USDSM May commencement was the sixteenth since the first class of the new four year school graduated in 1977. The graduation ceremony was moving, especially, perhaps, for a student turned teacher. I found that the ceremony triggered many images and emotions of my own medical school days. The gathering of medical students and their families and the faculty together seemed to endorse Hippocrates' adage, "To hold him who has taught me this art as equal to my parents and to live my life in partnership with him...". 2 Feelings of generational community and continuity were amplified by Dr. Robert Giebink, Sr who noted that the USDSM graduation of his son, Bob, coincided with the fiftieth anniversary of his own medical school graduation.

Not surprisingly, perhaps, the emotion, optimism, and fears of this summer's other commencement—the beginning of fifty new medical school careers—closely paralleled those evident at the graduation ceremony. This year at USDSM, the incoming students were provided with an expanded two and a half day orientation. The first two days were convened in Sioux Falls, the third in Vermillion. An effort was made to introduce the students to various aspects of clinical and professional life. The activities included: "grand rounds" sessions featuring both clinicians and basic scientists as discussants; small group sessions dealing with ethical and value quandaries of medicine; and a reception designed to introduce the incoming students to faculty members and practicing physicians. Efforts were made to allay the students' burgeoning apprehensions and to welcome them into the community of medicine. Emphasis was given to the importance of intertwining both the science and the human art of medicine in one's practice. Despite the conviviality and excitement, the daunting challenges lying ahead for these students seemed to lurk as a background premonition. As Stone also noted in his graduation address to the Emory students:

"For this is the day you will know too little
Against the day when you will know too much".

Very appropriately, I think, both of these 1992 commencements concluded with a reading of the "Affirmation of the Physician". The May graduates formally took the pledge; the incoming first year students were invited to ponder it's prospects while it was read to them by Dean Robert Talley. To the best of my knowledge, this oath was last printed in the South Dakota Journal of Medicine in the April 1977 issue (which was dedicated to articles by, and about, the new graduates). 3 In this season of beginnings, it seems appropriate to again consider it's challenge:

Affirmation of the Physician

Now being admitted to the high calling of the physician, I solemnly pledge to consecrate my life to the care of the sick, the promotion of health and the service of humanity.

In the spirit of those who have inspired and taught me, I will seek constantly to grow in knowledge, understanding and skill and will work with my colleagues to promote all that is worthy in the ancient and honorable profession of medicine. My professionalism and intellectual curiosity will be laced with compassion for the individual in an impersonal world.

The health and dignity of my patient will ever be my first concern. I will hold in confidence all that my patient relates to me. I will not permit considerations of race, religion, nationality, or social standing to come between me and my duty to
anyone in need of my services. Compensation for my services will be fair and tempered by individual needs.

This pledge I make freely and upon my honor.

*****

Jerome Freeman, MD
Editor

REFERENCES

AMA Physician Recognition Award

Congratulations to the physicians in South Dakota who have earned the AMA Physician Recognition Award in the months of April, May, June, July, and August, 1992.

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Tuberculous Peritonitis: A Case Report and Literature Review

Usha R. Ganga, MD and Larry Schafer, MD

ABSTRACT

We present a case of tuberculous peritonitis in the setting of alcoholic cirrhosis with ascites. A young American Indian male with alcoholic cirrhosis and ascites presented with low grade fever and weight loss. A diagnosis of tuberculous peritonitis was made by laparoscopic guided peritoneal biopsy. He was treated successfully with isoniazid and ethambutol for 24 months. The diagnosis of tuberculous peritonitis should be entertained in high risk populations such as American Indians, Asians, alcoholics, chronic ambulatory peritoneal dialysis patients and AIDS patients in the appropriate clinical setting. Definitive diagnosis can usually be made by laparoscopic guided peritoneal biopsy.

A
fter a long period of decline, the incidence of tuberculosis has been increasing in recent years because of its association with acquired immunodeficiency syndrome (AIDS). Tuberculous peritonitis is the most common form of abdominal tuberculosis. It is difficult to diagnose because of its variable and nonspecific clinical presentation. The incidence of tuberculous peritonitis ranges from 0.4% - 1% of all reported cases of tuberculosis. However, its incidence is much higher (38%) in patients with tuberculosis complicating AIDS. Overall tuberculous peritonitis accounts for approximately 3% - 11% of all cases of extra-pulmonary tuberculosis. Tuberculous peritonitis is more common in women than men (2:1) and in alcoholic patients. It is important to make a definitive diagnosis since the prognosis of the disease depends on institution of appropriate treatment. The mortality rate was 49% in the preantibiotic era and is now 7% with appropriate anti-tuberculous chemotherapy.

CASE REPORT

A 33 year old American Indian male with a long history of alcoholism and alcoholic cirrhosis with ascites was admitted to a university hospital in California with a low grade fever, weight loss, malaise and weakness. A presumptive diagnosis of spontaneous bacterial peritonitis was made. The patient was treated with a course of triple antibiotics with some improvement and was discharged home. However, he was readmitted to the same hospital, shortly thereafter, with a recurrence of his symptoms. At that time ascitic fluid showed 2000 WBC/mm³ and bacterial cultures were negative. The patient signed out against medical advice and returned to Rosebud, SD. The patient continued to have a low grade fever and anorexia despite antibiotics. Subsequently, he was admitted to Sioux Valley Hospital for reevaluation.

Neither the patient nor his family had a history of tuberculosis. He was not taking any medications other than antibiotics. He quit drinking alcohol two months prior to admission. Physical examination was essentially normal except for a slightly distended abdomen with no shifting dullness and a few spider nevi on the upper chest. CBC revealed normal WBC count with 10% - 18% bands and normocytic, normochromic anemia. Serum bilirubin was high at 4.4 mg/dl but serum transaminases, glucose, total protein, BUN and creatinine were normal. PT and PTT were high at 15.0 sec and 40.0 sec respectively. Blood sputum and urine AFB smears and cultures were negative. Hepatitis B core and E antibodies were positive and Hepatitis A serology was negative. Serum ceruloplasmin, ferritin and alphafetoprotein levels were normal. Chest roentgenogram revealed loculated right pleural effusion. CAT scan of the abdomen showed ascites with splenomegaly. Ascitic fluid analysis showed 4200
WBC/mm$^3$ with 90% monocytes and 3.9 gm/dl of protein. Ascitic fluid AFB smears were negative.

The patient continued to have a low grade fever with a base line temperature of 100$^\circ$F and daily late afternoon spikes to 101-102$^\circ$F. This suggested a diagnosis of tuberculosis. The patient underwent laparoscopy with peritoneal biopsies. A large volume of ascitic fluid was removed. The peritoneum was studded with granulomas. Histology of biopsy specimens revealed fibro-connective tissue with multiple small granulomas and acid fast bacilli. Ascitic fluid AFB smears also revealed occasional acid fast bacilli.

The patient responded slowly to a regimen of isoniazid and ethambutol. He became afebrile and regained his appetite. He was discharged home on isoniazid and ethambutol and was instructed to return to his personal physician for follow up. He was continued on the above regimen for twenty four months.

DISCUSSION

The tuberculous bacilli gain entry to the peritoneal cavity by one of three mechanisms, transmurally from diseased bowel, from tuberculous salpingitis or from the blood stream. The most common pathogenesis of tuberculous peritonitis is reactivation of a long latent tuberculous focus in the peritoneum. Concurrent active pulmonary tuberculosis is uncommon, unless a patient has miliary tuberculosis.

Peritoneal tuberculosis is a disease of young adults. The average age of patients is 31 years. This figure varies from series to series and from country to country. In India it is 21-35 years, whereas in developed nations it is 40-55 years. Compared with non-Hispanic Whites, the overall risk of developing tuberculosis is 5.3 times greater for Hispanics, 4.7 times greater for American Indians, 6.4 times greater for non-Hispanic Blacks and 11.2 times greater for Asians and Pacific Islanders. Tuberculous peritonitis presents with vague abdominal symptoms. The physician must have high index of suspicion to make the diagnosis.

Tuberculous peritonitis manifests itself in two ways, the exudative or moist type and the plastic or dry type. The exudative type occurs in 95% of cases of tuberculous peritonitis and presents with ascites. The dry type presents with the typical doughy abdomen. Often the clinical picture is confusing and suggests an occult malignancy or ascites with cirrhosis. It is particularly difficult to diagnose tuberculous peritonitis in alcoholic patients since physicians tend to attribute ascites to alcoholic cirrhosis. Generally, patients present with abdominal symptoms of a week or longer duration. Usual symptoms include abdominal pain (70%-90%), abdominal swelling (72%), fever/night sweats (57%), anorexia (44%) and weight loss (55%). Coexistent pulmonary tuberculosis increases the frequency of fever and night sweats.

Laboratory studies are of little help and are nonspecific. Skin tests are positive in 70%-89% of patients. Tuberculin skin testing is often negative in the face of substantial disease and in immunocompromised patients. Anemia is a common finding, 48%-80%, and is usually normochromic normocytic. Relative lymphocytosis was noted in 20%-32% of cases in one series. An elevated ESR was found in 80%-90% of cases, but only 12.5% of patients showed an ESR of more than 100 mm/hr. Typically peritoneal fluid is straw colored with a protein content equal to or greater than 3.0 gm/dl. However, transudates have been described, particularly with coexistent cirrhosis. In one series, ascitic fluid was found to be a transudate in 29% of patients. The white cell count is variable (100-4000/mm$^3$) with lymphocytes usually constituting 70% of the cells. In contrast, in the majority of chronic ambulatory peritoneal dialysis (CAPD) patients with tuberculous peritonitis, polymorphonuclear cells predominate in the peritoneal effluent. Acid fast bacilli are rarely found in the ascitic fluid, especially when small volumes of ascitic fluid are examined. AFB cultures are positive in 43%-66% of cases, although the sensitivity may rise to 83% when a liter of fluid is used for bacteriologic diagnosis. Since AFB cultures usually take 4-6 weeks, the diagnosis will be delayed in the majority of cases.

The activity of adenosine deaminase (ADA) in ascitic fluid is useful in the diagnosis of tuberculous peritonitis. This test is easy to perform and relatively inexpensive. In one series, the mean ascitic fluid ADA was 112.6 U/l in patients with tuberculous ascites and 16.3 U/l in those patients with ascites of other causes. It has a sensitivity of 100% and specificity of 96% in discriminating tuberculosis from other causes of ascites. Measurement of ascitic fluid ADA is especially helpful in diagnosing tuberculous peritonitis in endemic areas and in high risk population, although it does not replace the standard histological and microbiological methods. This test should be interpreted with caution in alcoholic patients since there are conflicting data regarding the diagnostic accuracy of the test in this population.

Rapid and accurate diagnosis can be made with the laparoscopic guided peritoneal biopsy. Culture and histologic examination of biopsy specimen raise the diagnostic sensitivity to 75%-100%. In a recent retrospective study from South Africa, which included 145 patients with tuberculous peritonitis, peritoneal biopsy specimens revealed granulomata with caseation in all patients. Acid fast bacilli were found in 73.8% of patients. In the same study, typical peritoneal tubercles were found by peritoneoscopy in 98% of patients and in the remaining 2%, only mild peritoneal erythema was observed. Interestingly, biopsies of these erythematous lesions showed acid fast bacilli. The
authors emphasized the need to take biopsy specimen of these lesions when they are found.

In conclusion, tuberculous peritonitis is an underdiagnosed and misdiagnosed illness. The diagnosis of tuberculous peritonitis should be entertained, particularly in American Indians, Asians, alcoholics, CAPD patients and AIDS patients, in the appropriate clinical setting. Ascitic fluid ADA levels provide a presumptve diagnosis in many cases. A definitive diagnosis can usually be made by laparoscopic guided peritoneal biopsy.

ACKNOWLEDGEMENT

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REFERENCES


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SOUTH DAKOTA
Pediatric Pain Management

Helen B. Fiechtner, Pharm.D
Sioux Falls, SD

Children experience pain. Sadly, there has been a lack of treatment of this pain, resulting in both long and short term negative consequences for these young patients. Reasons for inadequate pain treatment are many. "Myths" about pain in pediatric patients include: children do not experience pain, they tolerate pain better than adults, children do not remember pain, and opioid analgesia should be used only sparingly in children. All these beliefs have been refuted by recent study.

One of the leaders in the treatment of pediatric pain summarizes:

"The single greatest problem lies in the provision of inadequate doses of opioids at infrequent intervals via the noxious intramuscular route. Simple provision of nearly constant opioid levels via a painless route (intravenous, oral, and so forth) would dramatically improve the care of children following surgery."

Effectively managing pain in the pediatric patient is more than knowing what medication to give. Important also is the starting dose, the best method of administration, and titration of the dose to response, based on frequent assessment and reassessment of the patient's pain, pain relief, and side effects.

The gold standard and pediatric opioid of choice for parenteral use is morphine. A frequent problem with morphine, however, is itching and a rash caused by a non-allergic histamine release. Unfortunately, this reaction can progress to more serious symptoms. The mild histamine reactions can be treated with diphenhydramine (Benadryl) or by changing opioids. Meperidine (Demerol) is a drug that is also commonly used in pediatric patients, and can be safely used on a short term basis (a few days). This drug has potential for adverse reactions with repeated use, especially in patients with renal dysfunction. Normeperidine, a metabolite of meperidine, accumulates and may produce an excitatory syndrome with hallucinations, seizures, agitation, irritability, nervousness, tremors, twitches and myoclonus. The short term use (a few days) of meperidine is an alternative to morphine. Other parenteral opioids have been used with success as well.

The main routes of administration in children should be intravenous and oral, and usually not intramuscular. The intravenous route can be used until the patient tolerates oral administration. The intramuscular route is not liked by children because it hurts. Since the relief from pain is not immediate after the "shot", many children do not correlate the injection pain with their ultimate pain relief. Children will deny pain to avoid receiving another "shot", and use of intramuscular injections may make some children afraid or distrustful of nurses and physicians. According to the new guidelines for acute pediatric pain management from the Agency for Health Care Policy and Research, intramuscular injections are recommended only under exceptional circumstances.

Opioids can be given intravenously as a continuous infusion, intermittent doses, PCA (patient controlled analgesia) or PCA with a background continuous infusion (basal/PCA). This article will only address the first two methods.

Intermittent morphine administration using a "Buretrol" is a simple method. The dose of morphine is diluted in the Buretrol with enough fluid to deliver the drug to the patient over 20 to 30 minutes. By infusing morphine over this time period, the high serum peak concentration often seen with IV push administration is avoided. This decreases the risk of respiratory depression that can be seen with higher serum concentrations. To prevent patients (over 6 months) from experiencing the valleys in pain relief, the opioid should be given every 2 hours around the clock. This method may be preferred for the child who is expected to need only a few doses of the IV drug.

Continuous infusion of morphine allows a uniform level of pain control. The infusion can be easily titrated to the response of the patient. Patients on continuous infusion will have their average level of pain met by the infusion, but they may need small added doses of the narcotic when they have an increase in pain (e.g. physical therapy, bed transfers, or whirlpool). This method takes less nursing time and is especially useful in the patient requiring opioids for more than one or two days.

Successful pediatric pain management relies on careful and frequent assessment of the patient for pain relief and adverse effects. No single assessment tool can be used in all pediatric patients, but a combination of self-report, behavioral observation, and physiological measures allows the nurse and physician to tailor therapy for the individual patient.

A word of caution needs to be made about the infant less than 3 to 6 months old. The very young are more sensitive to the respiratory depressant effects of opioids and they may not metabolize the drug as well as other.
children. Infants at this age vary greatly in how they metabolize opioids. The safest way to dose opioids in this age group is to start with a low dose and increase it quickly, as needed to treat the infant's pain. More drug can be given if needed but it is sometimes difficult to reverse too much. Children under 6 months need to be monitored more closely for respiratory depression and the use of monitoring equipment is necessary, but as with older children, it is not desirable for the infant to experience pain.

# REFERENCES


Edited by Brian Kaatz, Pharm.D.
more aware of the positions on this issue as the term, health care reform, echoes around the country.

In addition, we will also be deciding on ballot questions which deal with environmental and economic issues. Referred Law #1, if passed, will allow the siting, construction and operation of the Lonetree solid waste disposal facility. Initiated Measure #2 deals with acreage regulation and reclamation incentive for large-scale gold or silver surface mining. Initiated Measure #3 seeks, by its passage, to repeal some sales tax and reduce property taxes by the imposition of a personal and corporate income tax. The intention of Initiated Measure #4 is the repeal of the video lottery system.

Your personal vote on these candidates and issues will be significant. The SDSMAA has placed a great emphasis on voter registration. That is only the first step in the political process. Continue the walk of democracy by participating on election day. Do not abstain and passively allow others to make a decision for you.

#

Ruth Parry

Ruth Parry, President, South Dakota State Medical Association Auxiliary

Get Out and Vote

In just a few short days, the citizens of America will be entering voting booths throughout the country and making decisions—decisions that can impact our future even more than we may now realize. As South Dakotans, we will be electing a president/vice-president, a senator, and our lone member of the House of Representatives. We also will be electing legislators from the various areas of our newly redistricted state.

It is our responsibility to enter that booth and make a decision. It is also our responsibility to be certain that the decision is an informed one. Although it is difficult to know all of the candidates equally well, we must study the positions which the candidates do take on a specific issue. All of us have concern about the environment, the economy, education and taxation. As physicians and spouses we have a dual concern about health care provision and costs. We must make ourselves even
Extenuating Circumstances

A periodic column of personal, ethical, and socioeconomic reflections on medicine.

A Condom Sense Approach to AIDS Prevention: A Historical Perspective

The lowly condom has never occupied a place of status in the world until the AIDS epidemic thrust it into the spotlight in the early 1980s. Dr C. Everett Koop, the former surgeon general of the US, is considered by many to be the modern day father of the condom because of his unabashed promotion of condom use for "safe sex.

The condom has a long but checkered history. It has two essential functions—to prevent the spread of sexually transmitted diseases (STDs) and to prevent conception. Both functions have received considerable attention over the years.

Egyptian art of more than 3000 years ago shows the god Bes wearing a penile sheath. The Chinese made condoms of oiled silk paper two thousand years ago. Romans soldiers reportedly made condoms from muscle sheaths of their slain enemies.

Gabriello Fallopio (of the tube fame), writing in the 1560s, provided the first written description of the condom. He advocated the use of linen sheaths to prevent the spread of STDs, particularly syphilis.

In the 1700s, legend has it that Charles II of England knighted an English physician, Dr Condom (some say Colonel Cundum) for inventing the lamb cecum condom that permitted the King to have his pleasure but not his progeny.

The fame and usage of the condom spread during the 1700s although there remained concern about their reliability and quality. Casanova called the condom "the English riding coat...the English vestment that puts one’s mind at rest". Despite these endearments, he reportedly tested their quality by filling them with air. History does not record if he filled them with water and threw them off the balcony of the local movie theater, a practice popular during my youth.

In the mid-1700s, two enterprising women, a Mrs Perkins and a Mrs Philips were the major wholesalers of condoms in London. No doubt Mrs Perkins and Philips were DBAs ("doing business as"). By the end of the 1700s, Mrs Philips boasted of 35 years in the condom business supplying condoms to "ambassadors, foreigners, gentlemen, and captains of ships going abroad" with "the best goods in England on the shortest notice and at the lowest price". In 1952, several condoms dating back to Mrs Philips' era were discovered in the muniment room of an English mansion. These heirlooms were donated to the British Museum but are not considered fit for public viewing.

The 19th century was a red letter century for condom consumers. The 1840s brought the vulcanization of rubber that made it possible to mass produce a reliable and inexpensive condom. This opened the condom market to the proletariat. The development of seamless condoms tickled everyone's fancy except the French. Some clever entrepreneurs developed the novelty condom. Soon the English working class was decked out in condoms that bore the portraits of Queen Victoria and her minister, William Gladstow.

In 1873, Anthony Comstock pushed a bill through the US Congress that made it obscene to provide information on the "prevention of conception". In the early 1900s, Prince Morrow founded the American Society for Sanitary and Moral Prophylaxis. The expressed purpose of the organization was to "prevent the spread of diseases that have their spread in the social evil". He further stated, "I have always felt that the doctrine of consequences should be fully expounded as a fear of infection will sometimes restrain men from an evil life when educational or moral considerations fail. As a matter of fact, all hygienic precepts are based upon the consequences which result from the infraction of nature's laws". (A not dissimilar approach to present day concerns about AIDS.) Thus the late 19th century and early 20th century was a low point in the life of the condom.

Venereal disease took on an international flavor during W. W. I. Shortly after the US entered the war in Europe, General John J. Pershing issued General Order No. 6, which mandated lectures on the evils of VD as well as periodic medical inspections to find untreated infections. The Army's decision to stress continence rather than condoms resulted in the loss of almost 7 million days of active duty secondary to VD.

The latex condom was introduced in the mid-1930s, in the years between the big wars. The Food and Drug Administration (FDA) promulgated the first quality control standards for condoms in 1938.

Condoms really hit their stride during W. W. II. The Army, having learned about human nature in W. W. I, began promoting the condom for the prevention of STDs. This caused "condommonium" in lay and church groups. Bishop John F. O'Hara was particularly concerned that condoms would also prevent conception. The Surgeon General assured the Bishop that "there is no inclination on the part of the War Department to minimize the importance of the moral aspects of the
venereal disease problem". He further advocated "the use of mechanical and chemical prophylactics, not as contraceptives, but solely as an effective procedure for the prevention of infection". (A brilliant bit of doublespeak.)

After W. W. II, condoms were again relegated to a lowly status since their war-time use made them a symbol of prostitution and infidelity. The introduction of oral contraceptives and changing mores in the 1960s further devastated the condom market. Causal sex became commonplace, despite the increase in STDs.

In the 1980s, AIDS resurrected the condom. It is now considered by many to be the "great rubber hope".

Many groups are befriending the condom today. For example, Mexico introduced an animated condom dressed in a soccer jersey at the world cup games several years ago. Sweden and Thailand have Proud Pete, a human "penis" wearing a condom. Clergymen of many denominations, as well as AIDS activists, have distributed condoms to their congregation or to people on the street. Many schools distribute condoms to students. The stories are many and interesting.

Contrary to popular belief, condoms do come in different sizes. Class I condoms are a minimum of 2 inch’s flat-width (1/2 the circumference) and 7.1 inches in length. Class II condoms are a minimum of 1.93 inches flat-width and 6.3 inches in length. They are made of either latex or lamb eecum (the latter is also called natural membrane or skin condoms).

Since natural membrane (lamb eecum) condoms are porous, they are not recommended for the prevention of human immunodeficiency virus (HIV) transmission, although they are probably adequate for contraception. Approximately 95% of condoms are made of latex and only 5% from lamb eecums. Natural membrane condoms are usually more expensive than latex condoms since you get only one condom per lamb. Latex condoms are relatively thin, but wall thickness varies from brand to brand. There are at least 108 different brands of condoms, some of which were reviewed at the "first annual condom-rating contest", sponsored by the Stanford AIDS Education Project held in February 1987. For example, a classy condom named "Blacky" (made by Fuji Latex) was voted "most versatile — formal wear to swim wear". In the 1987 contest, 6,300 condoms (7 condoms per participant) were distributed to 900 participants. By 1990, the contest had spread to six California campuses with 161,000 condoms distributed to 23,000 participants. The 1990 overall favorite was "Skin Less Skin Crown". A few of the many condoms readily available on the market include: Duke, Arouse, Dixie Deluxe, Mentor, Prince, Bareback, Bikini, Hugger, Slim, and Rough Rider.

Condoms may be either blunt-ended or reservoir-ended; dry or lubricated; straight-sided or contoured; smooth or textured; clear or colored; and have spermicide or no spermicide. Many special features are more decorative than functional. The most common spermicide used is a mild detergent, nonoxynol-9, a nonionic surfactant that is also available as a hand soap. Some of the lubricants, perfumes, and even the latex itself may cause "consort contact dermatitis", an embarrassing but nonfatal disease. To prevent the embarrassment of latex dermatitis, one author recommended that you query your sexual partner. "Can you wear rubber gloves without itching?" An affirmative answer usually means that, dermatologically speaking, it’s safe to have safe sex.

Since 1976, condoms have been regulated by the FDA under the Medical Device Amendments of the Federal Food, Drug, and Cosmetic Act. Within the FDA, the Center for Devices and Radiological Health is responsible for assuring the public that condoms are not defective. The FDA began testing latex condoms in the spring of 1987. (The FDA does not test natural membrane condoms.) The FDA uses a water-leak test in which a condom is filled with 300 ml of water and checked for leaks by use of a blower. In any batch of condoms, there cannot be more than four leaky condoms per 1000. Batches exceeding this standard are barred from sale. It is encouraging to know that the average failure rate (i.e., leaky condoms) is 2-3/1000. Data from February 1988 revealed that the FDA had studied 430 batches of condoms and over 102,000 condoms had been tested. Of 165 batches of domestic condoms, 12% of the batches failed to meet FDA standards. As a result, four domestic manufacturers were required to conduct 16 condom recalls. Of 265 foreign-manufactured batches, 21% failed. Thus seven foreign manufacturers were unable to sell condoms in the US. Because of enhanced federal inspection, condom quality has improved since 1987.

Theoretically, condoms used correctly should be 100% effective when used as either a contraceptive or a prophylactic. Unfortunately theory does not always meet reality. The failure rate for the prevention of contraception is between 10% to 15%, but the rate is user dependent. Motivated couples who use condoms correctly and consistently have a lower failure rate than those who do not.

Data regarding the effectiveness of condoms in preventing the spread of STDs are not as hard. A study in England, reported in 1977, demonstrated that male patients attending a venereal disease clinic who used condoms "properly and invariably" had a lower incidence of gonorrhea when compared to those men who did not use condoms or used them improperly. Various other studies have demonstrated a protective effect of condoms, but its difficult to quantitate how much.

In vitro techniques have shown that latex condoms block the passage of both large and small viruses such as cytomegalovirus (150-200nm), herpes simplex virus
(150-200 nm) and hepatitis virus (42 nm), while natural membrane condoms (lambs cecum) allowed the passage of hepatitis B virus only. Also, scanning electron microscopy demonstrated pores up to 1.5 nm (HIV is 100 to 120 nm) in natural membrane condoms and no pores in latex condoms.

There are no firm data that conclusively prove condoms prevent the transmission of HIV. However, there are at least six studies, one in vitro study and five epidemiological studies, that suggest condoms reduce the risk of acquiring HIV. The first study used condoms filled with a solution of HIV submerged in a beaker containing sterile culture media. A 12 cc plastic syringe was inserted in the condom and repeatedly aspirated and expelled with the HIV solution. HIV could not be grown from the culture media that bathed the condoms. Other investigators have confirmed these findings. A second retrospective study in Zaire looked at a population of 377 prostitutes. Eight prostitutes reported that more than half of their clients used condoms. All were seronegative for HIV. Of 77 prostitutes whose clients used condoms less than one half the time, 34% were seroconverted for HIV. A third prospective study followed 45 heterosexual couples in which one partner had AIDS. Of the couples that continued to have unprotected sex, 12 of 14 of the spouses became seropositive; of the 8 couples who abstained from sex, none seroconverted; and of the 10 couples who used condoms, only 1 couple seroconverted. Two other couples who claimed to use condoms were seropositive before the study. Three other studies, one in Holland, one in West Germany, and one in the US, demonstrated that prostitutes who use condoms are less likely to be seropositive for HIV than those who do not use condoms.

The future of the condom is secure and innovation continues. Wisconsin Pharmacal Co. of Jackson, Wisconsin is seeking FDA approval for the "female condom." The new condom is a lubricated polyurethane sheath with flexible polyurethane rings on each end. The sheath is closed at one end and is the same length as a male condom. One ring is inserted into the vagina similar to a cervical diaphragm. The condom can be inserted minutes to hours before sexual contact. The female condom reportedly appeals to women with multiple sexual partners, women who are allergic to latex, and women who wish to share responsibility for contraception or disease prevention with their partners.

**SUMMARY**

Condoms have come a long way since their use in ancient Egypt three millennia ago. Their benefit is well established for the prevention of both contraception and STDs. Although AIDS has revitalized the condom, we must remember that condoms do not prevent the spread of HIV infection, people do. Everyone must take personal responsibility to avoid high risk behavior (e.g.; IV drug use, promiscuous sex, casual sex, etc). If one does engage in high risk sexual behavior, he/she should at least use condom sense.

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* * * * *
Requiem of Fall

When the Great Blue Herron croaks his last goodbye;
And the Satyrs of the night,
In their winged lust fly by;
When the solitary Bluebill is lying dead,
And all forms of life forget the springs,
Forgotten falls become white with Hoarfrost instead of gentian red,
The quaking dead reeds Break and fall to their knees
Giving up their frizzled tails.

To winters wind propelling
Grey and scudding clouds.
Past the rock strewn points,
Where clusters of striving buck brush bend.
The Sumac tosses its windshorn head
In affirmation of the ancient and the newly found dead.

Terminal grey after sunset envelopes all;
In this final declaration, the Requiem of Fall.

Winston Bryant Odland

(C)

Author's note:
To these calamitous sounds and sights of termination,
I commend the life and the soul of the hunter,
Once described so succinctly in our passing time,
The tenure of one generations Wildfowl Association.
With its historical Nimrods and human camaraderie Clustered with individual delight in all of this.

Winston Bryant Odland

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Again thank you for supporting me in my pursuit and I hope that you have a rewarding year.

Tiffany Kay Bee
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**Future Meetings**

CME Conferences being held on a regular basis at various health care facilities throughout the state of South Dakota.

(1 hour AMA Category I Credit Available Unless Otherwise Specified)

**CME CONFERENCES**

**NOVEMBER 1992**

**November 4**
Internal Medicine Grand Rounds - 7:30 am, McKennan Hospital Auditorium, Topic to be announced, Speaker: George DeVault, MD, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

**November 4**
"Topics in Clinical Medicine" - audio teleconference series, 12:30 pm (CT/CDT), Topic: "Hypertension and the Diabetic", Speaker: Mark Houston, MD, Info: Connie Kleinsasser, USDMS, 339-6638.

**November 5**
West River Internal Medicine Grand Rounds - 2:00 pm, Hot Springs VA Hospital, Topic: Cardiology, Speaker: John Davis, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagley).

**November 5**
Cancer Conference - 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

**November 5**
Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

**November 5**
Cath Conference - 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Gribas, 333-7266.

**November 5**
Tumor Conference - Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

**November 6**
West River Internal Medicine Grand Rounds - 11:00 am, Ft. Meade VA Hospital, Topic: Cardiology, Speaker: John Davis, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagley).

**November 6**
Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

**November 6**
Morbidity/Mortality Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

**November 6**
Psychiatry Grand Rounds - VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Info: Douglas J. Soule, PhD, 339-6785.

**November 9**
CPR Certification/Recertification - 7-10 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

**November 9**
Tumor Board - Fort Meade VA, Info: Vickie Netterberg - 347-2511, Ext 284.

**November 11**
Dermatopathology Conference - 7:30 am, LCM, Info: Richard Schultz, MD, 339-1212 (Joan Cleveland).

**November 12**
"Topics in Clinical Medicine" - audio teleconference series, 12:30 pm (CT/CDT), Free Program, Topic: "NSAID Gastroopathy", Speaker: Cynthia Weaver, MD, Info: Connie Kleinsasser, USDMS, 339-6638.

**November 12**
Pediatric Grand Rounds - 7:30 am, LCM, Info: Richard Schultz, MD, 339-1212 (Joan Cleveland).

**November 12**
Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

**November 12**
Cancer Conference - 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

**November 12**
Tumor Conference - Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

**November 12**
Cardiac Cath Conference - 7:30 am, McKennan Hospital Auditorium, Info: Cardio Pulmonary Dept, 339-7677.

**November 13**
Pathology Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

**November 13**
Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

**November 17**
Endorana (Endocrinology Conference) - Sioux Valley Hospital, Info: J. Michael McMillin, MD, 334-8387.

**November 18**

**November 18**
"Topics in Clinical Medicine" - audio teleconference series, 12:30 pm (CT/CDT), Topic: "Multiple Sclerosis Update", Speaker: James Wiggs, MD Info: Connie Kleinsasser, USDMS, 339-6638.

**November 18**

**November 18**
Geriatric Forum - 7:30 am, East Auditorium, Rapid City Regional Hospital, Info: Med Staff Office - 341-8107.

**November 19**
Cancer Conference - 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

**November 19**
Tumor Conference - Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

**November 19**
Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.
November 19
Cath Conference - 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glirbas, 333-7266.

November 19
Geriatrics Grand Rounds - 12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.

November 20

November 20
Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, 341-8107.

November 20

November 23
Tumor Board - Fort Meade VA, Info: Vickie Netterberg - 347-2511, Ext 284.

November 25
Internal Medicine Grand Rounds - 7:30 am, Sioux Valley Hospital Auditorium, topic & speaker to be announced, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

November 27
Tumor Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

November 27
Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, 341-8107.

DECEMBER 1992

December 2
"Topics in Clinical Medicine" - audio teleconference series, 12:30 pm (CT/CDT), Topic: "Hypertension Update", Speaker: Louis Tobian, MD, Info: Connie Kleinsasser, USDSTM, 339-6638.

December 2

December 3
Cath Conference - 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glirbas, 333-7266.

December 3
Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

December 3
Cancer Conference - 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

December 3
Tumor Conference - Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

December 4
Psychiatry Grand Rounds - VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Info: Douglas J. Soule, PhD, 339-6785.

December 4
Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, 341-8107.

December 4
Morbidity/Mortality Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

December 9

December 9
Geriatrics Grand Rounds - 12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.

December 9

December 10
Pediatric Grand Rounds - 7:30 am, Ann Berdahl Hall, Sioux Valley Hospital, Info: Larry Wellman, MD, 333-7178 (Joan).

December 10
Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

December 10
Cancer Conference - 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

December 10
Tumor Conference - Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

December 10
Cardiac Cath Conference - 7:30 am, McKennan Hospital Auditorium, Info: Cardio Pulmonary Dept, 339-7677.

December 11
Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, 341-8107.

December 11
Pathology Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

December 14
CPR Certification/Recertification - 7-10 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

December 14
Tumor Board - Fort Meade VA, Info: Vickie Netterberg - 347-2511, Ext 284.

December 15
Endorama (Endocrinology Conference) - 7:30 am, Sioux Valley Hospital, Info: J. Michael McMillin, MD, 334-8387.

MISCELLANEOUS MEETINGS
OCTOBER

October 28
Cardiology Update, Sioux City Convention Ctr, Sioux City, IA. 5 hr AAFP & AMA Category 1 credit. Fee: $45. Contact: St. Lukes Regional Med Ctr, Staff Development, 2720 Stone Park Blvd, PO Box 2000, Sioux City, IA 51104. Phone: (800) 541-2304.

October 30
Third Annual Rush Symposium on Hepatic and Biliary Disease, Rush-Presbyterian-St. Lake's Medical Center, Chicago, IL. Contact: Suzanne Buss, Phys Relations Coor, Rush-Presbyterian-St. Lake's Medical Center, 1653 W Congress Pkwy, Chicago, IL 60612. Phone: (312) 942-6242.
NOVEMBER

November 4-6  1992 SD Rural Health Conference: Helping Communities Help Themselves. Ramkota Inn, Sioux Falls, SD. Contact: SD Office of Rural Health, 2501 W 22nd St, Sioux Falls, SD 57117-5046. Phone: (605) 339-6541.

November 5-7  Sixtieth Annual Postgraduate Assembly, Red Lion Hotel, Omaha, NE. Contact: Lorraine Seibel, Exec Sec, Omaha Mid-West Clinical Society, 7389 Pacific St, Suite 229, Omaha, NE 68114. Phone: (402) 397-1443.

November 5-6  Medical Intensive Care Conference, Hennepin County Med Ctr, Minneapolis, MN. CME credit avail. Contact: Off of Academic Affairs, Hennepin County Medical Center, 701 Park Ave Mail Code 867A, Minneapolis, MN 55415-1829. Phone: (612) 347-2075.

November 6-7  Front Line Neurology, Marriott City Ctr, Minneapolis, MN. CME credit avail. Contact: Abbott Northwestern Hospital, CME Off, Tim Schuh, 800 E 28th St at Chicago Ave, Minneapolis, MN 55407-3799. Phone: (612) 863-5461.


November 12-14  Strategies in Primary Care Medicine, St. Paul Ramsey Med Ctr, St. Paul, MN. 16 hrs AMA Category 1 credit. Contact: Off of CME, Ramsey, 640 Jackson St, St. Paul, MN 55101. (612) 221-3992.

November 13-14  South Dakota State Osteopathic Association Annual Meeting and Family Practice Update, Ramkota Inn, Pierre, SD. Fee: $100. 15 hrs AOA Category 1 and 14 hrs AAFP credit applied for. Contact: Lorin Pankratz, PO Box 89302, Sioux Falls, SD 57105-9902. Phone: (605) 361-6004.

November 13-14  Lasers in Orthopaedic Surgery, Abbott Northwestern Hospital, Minneapolis, MN. CME credit avail. Contact: Abbott Northwestern Hospital, CME Off, Tim Schuh, 800 E 28th St at Chicago Ave, Minneapolis , MN 55407-3799. Phone (612) 863-5461.

November 13-14  Update on Inflammatory Bowel Disease, Mayo Foundation, Rochester, MN. CME credit avail. Contact: Postgraduate Courses, Section of Cont Educ, Mayo Foundation, Rochester, MN 55905. Phone: (800) 323-2688.


November 19  Update in Ultrasonography, Marriott Hotel, Omaha, NE. CME credit avail. Contact: Sally O'Neill, Ph.D, Asso Dean, Creighton Univ CME Div, 2500 California St, Omaha, NE 68178. Phone: (800) 548-2633.

Nov 27-Dec 4  Seventy Eighth Scientific Assembly and Annual Meeting of the Radiological Society of North America (RSNA), McCormick Place, Chicago, IL. Contact: RSNA, 2021 Spring Road, Suite 600, Oak Brook, IL 60521. Phone: (708) 571-2670.

DECEMBER

December 3-5  Cardiopulmonary Medicine, Holiday Inn East, St. Paul, MN. 16.75 hrs AMA Category 1 credit. Fee: $255. Contact: Registrar, CME, St. Paul-Ramsey Med Ctr, 640 Jackson St, St. Paul, MN 51101. Phone: (612) 221-3992.

December 12  Management of Hypercholesterolemia: Goals and Strategies, Adam's Mark Hotel, St. Louis, MO. 4.5 hrs AMA Category 1 credit. Contact: CME, Washington Univ School of Medicine, Campus Box 8063, 660 S Euclid Ave, St. Louis, Mo 63110-1093. Phone: (800) 325-9862.

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For more information, write to: National Council on Patient Information and Education (NCPIE) 606:Eleventh Street, NW Suite 810 D Washington, DC 20001

To fax your request — (202) 638-0773
The Hospital Medical Staff Section
Twentieth Assembly Meeting
December 3 - 7, 1992
Opryland Hotel
Nashville, Tennessee

Highlights of the Interim Meeting will include an educational program on:

A highly recognized consultant in health care issues will provide his perspective of the factors that will influence the reform of the health care system in the decades to come. Having painted a picture of Health Care 2000, the futurist will respond to questions of a reactor panel which will focus on:

- the role of organized medicine in framing the future health care delivery system,
- the role physicians will play in shaping the future and assuring adequate access to high quality health care services, and
- the impact that anticipated changes in the health care delivery system will have on the hospital medical staff's relationship with the community outside the hospital setting, including the payers.

The relation of the hospital with members of its medical staff will be substantially impacted by the forces that are shaping national health care policy and the health care delivery system of the future. The HMSS Representatives will learn:

- what some states are doing to serve as "laboratories" for alternative health care delivery systems,
- what the AMA is doing to study and advise physicians on the appropriateness of various physician / hospital organizations, and
- what one consultant anticipates will ultimately be the prognosis for organizational relationships between health care providers.

For information contact:
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American Medical Association
515 North State Street
Chicago, IL 60610
Phone / 312 464-4754 or 464-4761

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Physicians dedicated to the health of America
Millions Victimized by Family Members Every Year!

Are you concerned about the effects of family violence and victimization within your community?

Become an advocate within your community for the prevention of family violence.

Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a National Coalition of Physicians Against Family Violence. Through the Coalition the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assault, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the National Coalition you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

Through the Coalition you will:
• be informed about local contacts and referrals
• become aware of local and regional resources
• be provided with information regarding model educational programs
• become aware of treatment guidelines and protocols.
• have access to newsletters, public education materials and other publications
• receive an official membership card and frameable poster alerting your patients of your interest in and concern for this problem.

The only cost to you is your commitment to help curb this problem. Simply complete the membership application form below and mail to the Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610.

Yes, include my name in the Coalition's membership

Name ____________________________________________

Address __________________________________________

City/State/Zip ___________________ Telephone # ________

Specialty __________________________________________

Auxiliary Member □ Yes □ No Other ___________________

Area of interest within Family Violence: □ Child Abuse □ Sexual Assault □ Domestic Violence

□ Elder Abuse □ Other ___________________

American Medical Association
Physicians dedicated to the health of America
December is

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* May be tax deductible
Did you know that wild geese have an instinctive spirit of cooperation and support for the flock? For example, by taking off together it creates an updraft that lifts the flock up. By flying in a "V" formation it breaks up the wind resistance enabling the flock to make 50% more progress. And if one bird falls due to injury or exhaustion, two others will follow it to the ground and stay with it until it is able to move on. Cooperation and support for the group.

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Physician Peer Review Organization
Screening of History and Physicals

South Dakota Foundation for Medical Care, the physician Peer Review Organization for South Dakota, reviews medical records to assure that services are:

- Provided economically and only when, and to the extent, they are medically necessary;
- Of a quality that meets professionally recognized standards of health care; and
- Supported by the appropriate evidence of medical necessity and quality to assure the practitioner or other individual is meeting these obligations.

When a history and physical or complete admit note is not recorded preoperatively, SDFMC refers the case to a reviewing physician for peer review. History and physicals not completed or not completed timely are potential quality concerns.

The potential for inaccuracies often stems from the practice of writing or dictating the history and physical long after the examination has been conducted. Specifically, the medical record must contain documentation of a pertinent physical examination including applicable health history. Most hospitals have their own bylaws addressing their hospital’s minimal requirements.

When history and physicals are conducted prior to the patient’s admission, copies of that information should be maintained on the patient’s current hospital medical record. Either a complete history and physical, or a copy of a recent history and physical that includes still pertinent past history, or a note that includes changes since the last history (especially including medications), should be included on the patient’s medical record.

All history and physicals should be based on the patient’s unique health care situation. Failure to obtain or document an adequate history and physical can result in avoidable patient care oversights with a potentially adverse outcome for the patient.
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NEXT MONTH
Groin Infection Following Cardiac Catheterization: A Case Report

About the Cover
"Fall Colors Along a Black Hills Stream" was photographed by John W. Herbst of Keystone, SD. It is from his Fall Scenics series.
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M. George Thompson, DO, President
South Dakota State Medical Association

After reviewing my past monthly president pages, it became apparent that there was too much lecturing. This month I would like to tell a story about an episode with an elderly patient of mine which left me with many different emotions.

An 88 year old, never married, very nice lady has been worried about dying for the past two decades. Every little symptom leads to a telephone call, mostly to my home, telling me she probably won't live until morning. Even though her major problem is the too frequent bites from her small but just as nervous dog, every cough, sneeze, gurgling in her stomach or missed bowel movement is life threatening. Each symptom has been thoroughly checked and no major problem has ever been found.

Finally last month, as a last resort, I tried to explain to her that we all are going to die. She will die, I will die, we all are going to die someday. I also told her that at her age she may die before some others much younger since she is far past the life expectancy. She agreed but ended with the following statement which brought on those emotions I mentioned earlier, "I know I'm going to die but I want you to go with me so you can take care of me".

The first emotion was laughter and of course it made me feel good that she thought so much of me, later it made me think of my own mortality, which most of us don't consider. Disease, injury and death are for others. This Thanksgiving season let us be grateful to be in a profession where we are still appreciated and respect these little old ladies and gentlemen even if not all their requests.
The Council of the South Dakota State Medical Association met on Friday, September 25, in Sioux Falls. Business transacted at that time includes:

1. **SEATING OF NEW COUNCILORS** - Three new councilors were seated; Tom Huber, MD, Pierre District; Gregg Tobin, MD, Rosebud District and Ben Henderson, DO, Northwest District. Each represents the second councilor from their district as directed by the amended Bylaws.

2. **LOCUM TENENS SURVEY** - The executive office, as directed by the Council, has prepared and mailed a survey to all member physicians asking if they would serve in a locum tenens capacity. This information will be compiled and a report prepared for the November Council meeting. If feasible, the SDSMA will establish a listing of locum tenens available and provide this to members needing temporary coverage. The intent is to establish a clearinghouse of information and contacts, not to be involved in the employment in any way.

3. **YOUNG AT HEART AWARD** - The Council approved a proposal from the Young Physicians Section to establish a Young at Heart Award. The award will be given at the annual banquet to a physician, selected by the Young Physicians Section, who has been a role model or who has greatly supported the Young Physicians of South Dakota.

4. **MEDICARE PHYSICIAN ADVISORY COMMITTEE** - In a close vote the Council determined that the SDSMA not formally participate in the Medicare Advisory Committee at this time because of past problems encountered by individual members of a similar committee. The executive office was directed to send this information and decision to our congressional delegation, and to the Wyoming and North Dakota State Medical Associations. In addition, this will be discussed again at the November Council meeting.

5. **MEDIA AWARD** - A Media Award is to be established for South Dakota based on criteria similar to that established by the AMA.

6. **PROFESSIONAL LIABILITY COMPANIES** - Information, including major companies writing professional liability insurance in South Dakota with their A.M. Best ratings, will be published in the Grab Bag on a regular basis.

7. **CONTRACT WITH PUBLIC RELATIONS FIRM** - A one year contact with Lawrence and Schiller expires in October 1992. The Council directed Mr Johnson to meet with representatives of the firm, to review the past year's activities and to determine the best way to proceed with a public relations program for the SDSMA.

8. **HONORARY LIFE MEMBERS** - The following physicians were elected to honorary life membership in the SDSMA:
   - T. H. Sattler, MD Yankton
   - Lloyd Sweeney, MD Sioux Falls
   - Michael Ferrell, MD, Sioux Falls (effective 1-1-93)

9. **RESOLUTION ON LONG TERM CARE FUNDING** - The resolution on allocation of financing of long-term care as a health care expense which was adopted at the June 1992 meeting of the SDSMA House of Delegates has been submitted to the North Central Medical Conference for consideration. This resolution asks that "funding of long term care be removed from health care calculations; Medicaid funds not be mandated to be expended on long-term care; and that Federal and State officials directly address long-term care and other social needs of the elderly through a separate and independent social legislation regarding budgeting, financing and administration". This resolution was also submitted to the AMA.

---

**U.S. Savings Bonds Make Great Gifts.**

A public service of this magazine
INR and ISI - A Step Forward!

The one stage prothrombin time (PT) has been used as a means to monitor anticoagulant by warfarin for decades. However, the test is deceptively simple because of the variability in rabbit brain thromboplastin, the major reagent used in this test. Since thromboplastins differ so much, PT times performed in different laboratories are not comparable. The same PT time reported in seconds or reported in a ratio to the control can represent different anticoagulant intensities when reported from different laboratories. Therefore, different likelihoods of therapeutic anticoagulant effect and different risks for bleeding complications occur. The above also implies that trying to utilize therapeutic levels as reported in the literature is not possible since the levels reported are based on PT tests not comparable to other laboratories.

Even if a physician uses the same laboratory when that laboratory changes thromboplastin lots, the PT values reported in seconds will not necessarily be equivalent to previous values obtained with the old lot of thromboplastin.

The above has been the case for years and helps explain why warfarin anticoagulant therapy has been associated with so many complications and has been difficult to evaluate.

There is now a way to avoid the above confusion by the use of a reporting method called the International Normalized Ratio or INR which employs the International Sensitivity Index or ISI.

The ISI of an international reference thromboplastin has been established at 1.0 and various lots of commercial thromboplastin can be compared to this standard. A value greater than 1.0 indicates a less sensitive thromboplastin and a value less than 1.0 would be a more sensitive thromboplastin than the reference thromboplastin. The range of ISI values of the of the commonly used commercial thromboplastins in USA is 1.3 - 2.9. Values of PT based on such thromboplastins represent much more anticoagulant than PT based on thromboplastins with ISI values closer to 1.0. This more intense anticoagulation was actually recognized in the 1980's when studies in Europe showed less common hemorrhagic complications than parallel studies in North America. The reason for this was that thromboplastins used in Europe had ISI values closer to 1.0 than those used on this side of the Atlantic. The adjustment for this was to reduce the previously recommended ratio used to target anticoagulant effect from 2.0 to 2.5 times the control value to 1.2 to 1.7 times the control value. (This is not the INR ratio below).

Even is the above adjustment is made, it still does not solve the problem of comparing PT based on different thromboplastins. However, this can now be done by reporting PT not in seconds but by the INR or International Normalized Ratio which utilizes the ISI as follows:

The INR not only allows the physician to compare

\[
\text{INR} = \frac{\text{Prothrombin time}}{\text{Mean of Normal}}
\]

PT performed in different laboratories but it is necessary to use the INR to utilize the new recommended therapeutic ranges indicating two levels of anticoagulant intensity for different clinical conditions. It is important to realize that these ratios indicated below are INR ratios and not the previously reported PT to control value ratios or R ratios.

Therapeutic Ranges Using the INR for Warfarin Therapy

<table>
<thead>
<tr>
<th>INR Range</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0 - 3.0</td>
<td>1. Treatment of deep venous thrombosis</td>
</tr>
<tr>
<td></td>
<td>2. Prevention of deep venous thrombosis</td>
</tr>
<tr>
<td></td>
<td>3. Prevention of systemic embolism from atrial fibrillation</td>
</tr>
<tr>
<td></td>
<td>4. Prevention of systemic embolism from tissue prosthetic heart valves</td>
</tr>
<tr>
<td>3.0 - 4.5</td>
<td>5. Prevention of stroke after myocardial infarction</td>
</tr>
<tr>
<td></td>
<td>1. Prevention of systemic embolism from mechanical heart valves</td>
</tr>
<tr>
<td></td>
<td>2. Reduction of recurrence or mortality after myocardial infarction (controversial)</td>
</tr>
</tbody>
</table>

I do, however, believe that the PT should be reported in seconds with normal range as well as an INR value. The INR is useful only to follow patients on stable warfarin anticoagulation. There are other uses of the PT including detection of congenital coagulation factor deficiency, acquired Vitamin K deficiency, and coagulation abnormalities in acute or chronic liver disease.

# J. F. Barlow, MD
Editor
THERE ARE THOUSANDS OF MALPRACTICE ATTORNEYS OUT THERE. WHO COULD BLAME YOU FOR FEELING A LITTLE PARANOID?

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Management of the Do-Not-Resuscitate Patient Undergoing Anesthesia and Surgery

Edward F. Anderson, MD and Jerome W. Freeman, MD, FACP

ABSTRACT

Some unique questions and concerns arise when a patient with do-not-resuscitate orders is taken to surgery. This issue is discussed in the context of current data on cardiopulmonary resuscitation and ethical decision-making strategies.

INTRODUCTION

In the past twenty years, experts in medicine and medical ethics have placed much emphasis on the patient's autonomy. The principle of autonomy sanctions the patient's right to be actively involved in decisions affecting his or her health care. At times, a patient's autonomy may appear to conflict with other principles such as the health care provider's desire to help the patient (beneficence) or to avoid harm to the patient (non-maleficence).

One of the important manifestations of patient autonomy is seen in the realm of "do not resuscitate" (DNR) orders. Since the advent of external cardiac massage in 1960,1 the use of cardiopulmonary resuscitation (CPR) has become prevalent for both in-and out-of-hospital cardiac arrests. Because of the frequency with which this technique is employed, both health care providers and patients/families have begun to look somewhat more critically at the CPR technique, attempting to determine when this intervention is warranted and potentially life saving, and when it is intrusive and only prolongs the dying process. Certainly a consensus exists in this country that a patient's autonomy does enable the individual to decide whether or not CPR is desired if a cardiac arrest occurs. If the patient is unable to speak for himself or herself, the importance of surrogate decision making has been emphasized (e.g. as through family members). In an effort to maximize the patient's ability to have a voice in these matters, much emphasis has been placed on so-called "advance directives". That is, through an instrument like a durable power of attorney or a living will, a competent patient can decide, in advance, if he or she desires certain medical interventions such as CPR. Recent impetus to the emphasis on advance directives was provided by the Omnibus Budget Reconciliation Act of 1990 which stipulated that, as of December 1, 1991, health care institutions are required to inform patients, upon admission, of their right to consent to, or refuse, treatment; and also, institutions need to determine whether a patient has an advance directive for health care.

Despite this concern for patient autonomy, CPR issues, and advance directives, little emphasis has been placed on the specific question of how DNR orders should be handled in an intraoperative setting. Specifically, debate exists as to whether a patient with a DNR preference should have that status temporarily suspended during a surgical procedure. This question can arise with surprising frequency. It has been estimated that up to 15% of patients with DNR orders undergo some type of surgical procedure.3,4 In this essay, we wish to discuss and analyze the question of whether DNR orders should be temporarily suspended during anesthesia/surgery or whether they should always remain in force.

ANALYSIS OF CPR DATA

The purpose of CPR is to prevent sudden, unanticipated death from such causes as coronary artery disease, malignant arrhythmia, drowning, and electrocution. As with most medical interventions, there are times when CPR is helpful and appropriate, and instances when it is not likely to be of benefit. One of the latter times is 'the case of the terminally ill patient for whom no further therapy for the underlying disease process remains available and for whom death appears imminent'.5

Studies have suggested that the immediate success of in-hospital resuscitation is in the range of 30%-40%. Approximately one half of these patients survive to discharge.6 In analyzing the appropriateness of CPR as a medical intervention, Jonson, et al, note that survival after CPR is much reduced with certain conditions such as pre-existing hypotension, renal failure, sepsis, pneumonia, acute stroke, metastatic cancer, AIDS and...
age (over 70 years old). Given this data, it is certainly important for physicians and patients to critically assess whether employing CPR for a patient is likely to have benefit, or whether the overwhelming probability is that the technique will prove to be a burdensome, and ultimately futile, intervention. It has been stressed that in making the determination about whether or not to attempt resuscitation, the physician certainly has no medical or ethical duty to employ futile or useless treatment measures.

In the past, physicians have not always done an optimal job of discussing options concerning CPR with hospitalized patients. In their series, Bedell and Celbano note that only 19% of patients had discussed resuscitation, prior to their arrest, with a physician; and only 33% of families were consulted in advance. In another series, Evans and Brody found that when a DNR decision was made, the family and/or patient were involved 83% of the time in the decision. However the family/patient were much less frequently involved (25% of the time) if a decision was made to resuscitate or in instances where no specific decision was made. It is anticipated that the Patient Self Determination Act will heighten awareness of the ethical importance of involving patients and their surrogates in this type of decision making, and will lead to a higher degree of patient/surrogate involvement in the future.

**DNR ORDERS IN SURGERY**

As part of an increasing medical and societal sophistication with CPR issues, appropriate emphasis is frequently given to the fact that "no CPR" does not mean "no treatment". Indeed, there are instances when it may be judged medically appropriate to utilize invasive technologies in order to achieve some palliation or comfort for the patient. This is emphasized by the fact that, as noted above, it is not unusual for patients with DNR orders to undergo a type of surgical procedure. Such surgeries, typically, might include tracheostomy, gastrostomy, repair of a pathologic fracture, insertion of a urinary drainage catheter, or placement of a venous access catheter.

Despite the fact that numerous articles have been written about DNR ramifications, surprisingly little discussion has taken place, until recently, relative to the issue of DNR orders during surgery. Indeed, Truog noted in a March 1991 article that his literature review did not find prior report of discussion of the question of DNR orders during anesthesia and surgery. Since his article, several other excellent discussions of this issue have appeared. However, the Joint Commission on Accreditation of Health Care Organizations, which requires DNR policies, still makes no specific mention of DNR patients who require surgery. Moreover, the Council on Ethical and Judicial Affairs of the American Medical Association, which recently updated its guidelines for the appropriate use of DNR orders, did not specifically mention the issue of DNR patients requiring surgery (although the option of withholding CPR because of patient preference or futility is mentioned).

The issue of what to do with DNR orders in the operating room remains potentially troublesome and divisive. Anesthesiologists have the primary responsibility for intraoperative resuscitation and Truog notes, "While most believe it is acceptable to allow a patient to die from a terminal disease, many feel it is inappropriate for a patient to die as a direct result of an anesthetic complication." He asserts that this issue is particularly relevant since patients who have DNR orders are frequently at higher risk for surgical complications. Despite this circumstance, many hospitals in the United States have not specifically addressed this issue. In a recent survey of 156 hospitals in the contiguous United States with residency programs in anesthesiology, only 53 of 99 respondents have an existing DNR policy for the surgical patient. Of these 53, 42 programs suspended the DNR policy at the time of surgery. Of the programs who did not have a DNR policy, 16 indicated they were planning to initiate one. In another survey of 187 anesthesiologists, 59% noted that they would assume a patient's DNR order was suspended for surgery, and only 51% indicated that they would discuss this issue with the patient or family. In still another study, it was noted that if a DNR patient arrested because of anesthetic (i.e. iatrogenic) complications, 68% of 125 anesthesiologists would perform a full resuscitation. Of this group, 87% also concurred with the statement that, "The surgeon preparing to do the surgery on a patient with DNR status should always inform the anesthesiologist preoperatively in time to discuss the matter with this patient and/or proxy".

In addressing this issue, Truog notes three arguments that can be used to justify the suspension of DNR orders during surgery and anesthesia. First of all, since anesthetic drugs may produce apnea and moderate hemodynamic instability, in effect a consent for anesthesiology implies a consent for resuscitation. By this reasoning, a consent for anesthesia is incompatible with an intraoperative DNR order. Secondly, a difference exists between a spontaneously occurring cardiopulmonary arrest and one that occurs secondary to iatrogenic intervention. The argument can be made that every arrest that occurs during anesthesia could be considered to be in this latter category and, thus potentially reversible. Thirdly, the patient undergoing surgery naturally desires the optimal benefit of anesthesia. Anesthesia can promote cardiovascular instability. If an anesthesiologist is limited by a DNR order, the anesthesiologist might opt for less anesthesia and greater hemodynamic stability, but in so doing, might occasion more discomfort for the patient.

Cohen and Cohen suggest that when a DNR patient goes to surgery, a reconsideration of this/her DNR status should be required of the patient and the caregivers. It is these authors' contention that, most of the time, this dialogue will result in a "negotiated suspension" of the DNR orders during surgery, with later
reinstatement when appropriate. It is noted that, in the operative setting, the only two therapies generally available for cardiac arrest are external cardiac massage and cardiac countershock. They argue that a cardiac arrest resulting from the use of an anesthetic is generally fairly easily reversed and would ordinarily not result in adverse consequences to the patient. Indeed, they note: "When the arrest was related to the anesthesia, the recovery rate was 92%." 17 The fact is pointed out that if a patient with a DNR status has an untreated arrest in the operating room, the physicians and operating staff may feel responsible for the death because of failure to intervene. While Cohen and Cohen indicate a willingness to adhere to the wishes of a patient or the appropriate surrogate, their recommendation generally is that DNR orders be suspended in the perioperative period. Other recent articles seem to support this position, suggesting that if physicians carefully discuss intraoperative resuscitation with patients, most of them will agree to suspend a DNR status during their surgery.18,19

On the other hand, Walker argues more aggressively for allowing the patient or surrogate to maintain a DNR status during surgery. He points out that even though anesthesia might hasten death in the case of such arrest, this would not be the intention of the treating physicians. Using the "double effect" argument, he asserts that the reason for surgery and anesthesia would clearly be to benefit the patient and that if death was hastened, that would be a secondary (but not the desired) outcome. He also contends that the DNR patient/surrogate may reasonably opt to assume the risk of an intraoperative cardiac arrest just as they could agree to accept the potential morbidity/mortality of any intervention.

CONCLUSION

Certainly one can make a strong argument for the fact that the physician and patient/surrogate specifically need to address this question of perioperative resuscitation prior to surgery. When this discussion takes place, it can enable a case by case determination of whether or not DNR orders should be suspended during surgery. Institutions should endorse and adopt protocols to help insure that this dialogue takes place.

Depending on the nature of the patient's illness and preferences, either suspending or maintaining DNR orders during surgery might well be morally and medically defensible. If a DNR patient/surrogate opts to not rescind DNR orders during surgery, it is important for the surgeon and operating room staff to realize that they are not culpably responsible for hastening a patient's death should an intraoperative arrest occur and go untreated. Discussing this issue explicitly with the surgical staff in advance may be of assistance, although the emotional difficulties the staff may encounter in the face of an untreated cardiac arrest should not be underestimated.

Certainly, the patient's prerogative to maintain DNR status, even in surgery, is consistent with contemporary ethical thought that emphasizes patient autonomy. Further, it is consistent with the thrust of the Patient Self Determination Act. Good communication between the patient/surrogate, the surgeon, and the anesthesiologist is clearly critical in this process of trying to make the best judgment in each individual patient's case. Even when this discussion takes place, and when the benefits and risks of a proposed procedure are clearly explained and accepted, this type of decision making is never "easy". It serves as a powerful reminder that the technologies of medicine must be continually seen as inextricably tied to the difficult ethical and value judgments that inevitably arise in medical practice.

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AUTHORS

Edward F. Anderson, MD, Medical Director, Department of Anesthesiology, Sioux Valley Hospital, Sioux Falls, SD.
Jerome W. Freeman, MD, Chairman, Department of Neurosciences, USD School of Medicine, Sioux Falls, SD.
The South Dakota Drug Education and Evaluation Program (DEEP) is a retrospective drug utilization review program for Medicaid patients, and has been reviewing therapy for nearly a year. To get started, the Medicaid patients initially reviewed were mostly residents of nursing homes. This fall we plan to begin reviewing all Medicaid patients in South Dakota. We will begin by reviewing H-2 antagonists, and will later move to other drugs and therapeutic categories. As with the nursing home patients, we will identify therapeutic situations that fall outside of "normal" parameters. We also expect to identify situations where patients have used multiple health care providers and problems have resulted. While it is not the primary focus of the program, we also expect to identify some patients having problems with drug abuse.

The DEEP Evaluation Committee, consisting of physicians and pharmacists, sets review parameters using common references, current literature, and advice from medical specialists in South Dakota. After an initial computer screening, therapy is reviewed by the evaluation committee. Letters are then sent to the physicians and pharmacies involved with those patients whose therapy may be problematic. If you receive a letter from us, we ask that you take a look at the therapy and change the therapy only if you think a change is appropriate. We do ask that you drop us a very short note letting us know if you are making a change or not (we provide the stamp!).

Congress mandated this program in OBRA 1990. The reviews must take place. We have developed a program which is based on the standards of practice in South Dakota, and is overseen by physicians and pharmacists in South Dakota. Since its inception DEEP has been and will remain informative and educational. If you have any questions, please do not hesitate to contact us, or contact Dave Helgeland, the program director, at the SDSU College of Pharmacy.

Thank you for your understanding and cooperation.

Richard Holm, MD
Bruce Lushbough, MD
DEEP Steering Committee

Dear Dr Barlow:

Just a note to thank you for the editorial in the September issue of the Journal regarding tuberculosis.

We appreciate your help in alerting physicians to the problems of TB today. We cannot let our guard down now!

Kathy Wiebers
South Dakota Lung Association

Medical Malpractice Support Group—Realizing that medical malpractice suits can be devastating to a physician and the physician's family, the Commission on Professional Liability recommended that SDSMA establish a support group of physicians and spouses who have endured a malpractice suit with all its implications and emotional stress. This is not intended to be a formal group but rather a contact, by telephone or in person, would be available to listen and empathize with a physician and/or spouse who are experiencing or being threatened with legal action. The executive office will maintain a list of physicians and spouses available as a support group. Then when a member encounters a suit and needs to share this with a colleague, we can give the physician names and telephone numbers from the support group. If you or your spouse would like to be a part of this support network, please notify the executive office—(336-1965—Jan).

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Auxiliary News

As I traveled the South Dakota countryside during the summer and fall, I was impressed by the wide variety of color. Instead of the usual brown mutation, the abundant rainfall created many shades of vibrant green during the summer. This same green then remained as a contrast for the oranges, reds and yellows during the weeks of autumn. The visual splendor of the seasons seemed to be enhanced this year, either as a result of the acts of nature or through my greater sense of observation.

Although the frequent rainfalls and moderate temperatures were feared to decrease an interest in outdoor activities, tourism fared well. The abundant moisture in actuality has provided a truly bounteous harvest.

The year has also been a productive one for those involved in health care in South Dakota. Hospitals have continued to grow and develop. Clinics have expanded and moved to larger facilities. Plans for additional educational space for USDSM were announced.

Educational programs for health care support staff and technical assistance are increasing in our vocational schools. The number of physicians in our state has reached 1040.

In general, the economic woes of much of the United States are not a major problem for urban South Dakota. We are fortunate that much of our society has a healthy, colorful appearance not unlike the rich green tone of the natural countryside. However, this same society is not without the various colors that we also see in nature. Just as leaves of a particular plant may change color and fall to the ground too early, signifying a vulnerability in nature; so some individuals may exhibit a vulnerability.

I encourage each of you to analyze your personal situation during this harvest season. Just as the first settlers shared food and bounty at the times of the early harvest festivals of Thanksgiving, sharing can be done with those in need. You may choose to share your harvest locally, nationally, or globally. Perhaps your family could plan together to help another family or individual in a special way. Perhaps you care personally about an environmental or health care issue and wish to share resources by helping in this way. There are also deep concerns for the victims of natural disasters such as the hurricanes in Florida and Hawaii which have impacted life dramatically in these areas. You might be moved by the famine victims of Somalia or war-torn Yugoslavia. For each of us there is an opportunity and there is a choice. I urge you to share your harvest generously.

Ruth Parry, President, South Dakota State Medical Association Auxiliary

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Enteral Nutrition: Past, Present and Future
Janet Fischer, Pharm.D., Sioux Falls, SD

Enteral nutrition (EN), as a therapeutic modality, is a relative newcomer in general medical practice. Tube feeding was used in the 1960's and 1970's, but tissue irritation and damage from the rigid tubes limited its use. It became widely accepted only after the development of a flexible, weighted tube in 1976. In the past two decades, significant improvements have been made in techniques, equipment, and products used for EN. As a result, EN has been used successfully in hospitals, extended care facilities, and the home.

Enteral feeding is the preferred nutritional treatment for all patients with functioning gastrointestinal (GI) tracts when oral intake is impossible, inadequate, or contraindicated. This may include patients with neurologic impairment, swallowing difficulties, anorexia, and even abnormalities of the GI tract. Currently there are a variety of tubes available to access the GI tract. The nasogastric tube is often the initial tube placed, and is now available as a small bore, flexible tube designed specifically for EN. For patients with poor gastric emptying, weighted tubes can be manipulated to terminate in the duodenum or jejunum. For patients undergoing surgery of the upper GI tract, very small bore needle catheter jejunostomy tubes can be inserted for feeding while the surgical site heals. For long term tube placement, a gastrostomy or jejunostomy tube is usually used. The gastrostomy is preferred in patients with adequate gastric emptying and can often be placed endoscopically under light sedation. Later it can sometimes be replaced with a skin level tube to provide convenience to the patient. For patients with poor gastric emptying or significant reflux, the jejunostomy tube is preferred.

Currently there are nearly 100 EN products available, but many of them are nearly identical and therefore interchangeable. In general, the majority of products are lactose-free; contain electrolytes, vitamins and minerals; and have a concentration of 1-2 cal/ml. Usually, it is most cost effective for institutions to carry a single "workhorse" product, such as Isocal or Osmolite, that is isotonic, lactose-free, contains intact protein, and has a caloric density of 1 cal/ml. There are several fiber-containing products currently on the market which are nearly identical to the intact protein products, with the addition of approximately 13-14 grams of fiber per 1000 calories. These products may be useful in patients with either diarrhea or constipation. An elemental product is preferred for patients with severe malabsorption or those with needle catheter jejunostomies, which require a less viscous product. These preparations are hyperosmotic, however, and can induce diarrhea. Several high density products containing 1.5-2 cal/ml are available for use in fluid restricted patients. They are all lactose-free and contain intact protein, but also tend to be hyperosmotic.

Recent years have seen the development of specialized products for specific disease states. Hepatic formulas, which are higher in branched-chain amino acids and lower in aromatic amino acids, are better utilized by the diseased liver and allow the provision of higher protein with less risk of encephalopathy. Renal formulas provide lower amounts of protein in the form of essential amino acids in an attempt to minimize uremia in the pre-dialysis patient. High fat, low carbohydrate formulas can be utilized in the respiratory failure patient to minimize CO2 production. In addition, there are specialty products designed specifically for the diabetic patient, trauma or stressed patient, dialysis patient, and malabsorbing patient. These specialized products may offer some benefit to selected patients, but tend to be much more expensive and should be utilized only in those patients who require them.

Current research in this fast moving field is centered upon "nutritional pharmacology"—the use of specific nutrients in pharmacologic doses to alter or enhance cell and tissue function. Probably the best studied of these is glutamine. Recent research indicates that glutamine is a preferentially utilized fuel by rapidly proliferating cells such as enterocytes and lymphocytes. Glutamine-enriched EN solutions have been shown to maintain the integrity of the bowel mucosa better than those devoid of glutamine. Studies in humans indicate improved nitrogen balance with glutamine supplemented EN. Arginine is another amino acid undergoing considerable study. Arginine supplementation has been shown in various studies to improve nitrogen balance, enhance reparative collagen synthesis, and improve T-cell function. Other nutrients being investigated include short chain peptides, nucleotides, omega-three fatty acids, and short chain fatty acids. Short chain peptides may be more efficiently absorbed and promote better nitrogen retention than free amino acids in patients with malabsorption. Nucleotides appear to be necessary for T-cell maturation and may aid in maintaining immune function. Omega-three fatty acids have been shown to decrease inflammation and improve immunity. Short chain fatty acids, liberated from the digestion of soluble fiber, have
been shown to improve water and electrolyte absorption and may play a role in maintaining the integrity of the GI tract. These nutrients all require further study of their effects and safety before widespread use can be advocated.

Enteral nutrition in acute and chronically ill patients has become increasingly utilized in the past two decades. The use of specific nutrients to augment cell and tissue function may become a treatment modality for specific diseases states in the future. The expertise of multidisciplinary nutrition support teams can assist physicians in providing the best possible nutrition for patients.

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Best time to call is
George W. Smith, MD, Sioux Falls, Died June 19, 1992, at the age of 71. Dr Smith was born September 8, 1920 in Ethan, where he grew up and graduated from high school.

He received his pre-med degree and attended two years of medical school at the University of South Dakota School of Medicine. He received his medical degree from the Loyola University School of Medicine in Chicago, in 1944. He completed his internship at St. Ann's Hospital in Chicago, in 1945 and a residency in neurological surgery at the Cook County Hospital in Chicago followed by a fellowship in neuropathology at the University of Illinois Fellowship Laboratory.

He entered the Army and served in the Percy Jones Army Hospital in Battle Creek, Michigan. In 1949, he married Mildred P. Craig in 1949 in Battle Creek. After his discharge in 1953, they moved to Sioux Falls, where he pioneered neurosurgery and had a private practice until retiring in 1980.

He was assistant chief of surgical services at Royal C. Johnson Memorial Veterans Hospital and professor of neurosurgery and coordinator of surgical specialties at the University of South Dakota School of Medicine. He held these positions until his death. During his career, he helped train emergency medical technicians of rural ambulance and fire departments in emergency medical procedures.

He was a member of Christ the King Catholic Church; honorary member of the South Dakota State Medical Association; a member of the AMA; Congress of Neurological Surgery; and the American Association of Neurosurgeons.

Survivors include: three sons: Bill of Ft. Worth, Texas, George S. and Mike of Osage Beach, Missouri; three daughters: Pat Lehrer of Sioux Falls; Teri Hildebrand of Hurst, Texas; and Mary Smith of Minneapolis; and 10 grandchildren.

Dr Everett R. Maresh, Sioux Falls, died on July 9, 1992, at the age of 77. He was born and raised in Cedar Rapids, Iowa. He graduated from high school in 1932 and received a bachelor of science degree in 1936 from the University of Iowa. He received his doctor of medicine degree in 1938 from the University of Iowa School of Medicine, and completed a surgery internship and residency program in Detroit, Michigan. In 1941, he married Katherine Ziskovsky.

In 1942, he accepted a commission in the Army Medical Corps and was assigned to the 21st Medical Hospital Ship Platoon and served at medical stations in North Africa until the end of World War II. After resigning his commission as captain, he returned to Detroit to complete his surgical residency training. In 1949, he accepted the position of chief of surgery at the newly built Royal C. Johnson Veterans Memorial Hospital in Sioux Falls.

He was a certified Diplomate of the American Board of Surgery in 1950 and continued his practice until retiring in 1979. He continued to assist in providing care to veterans in outpatient clinics at the request of the chief of staff until 1987. Throughout his career, Dr Maresh worked with medical students, interns and residents and continued his involvement with medical and surgical education.

Dr Maresh was a member of the YMCA Gray-Y program and was awarded a Certificate of Merit for 23 years of volunteer service. He served as sponsor for many activities of the Boy Scouts. He was a member of Asbury United Methodist Church; many civic organizations; and the South Dakota State Medical Association and the AMA.

Survivors include, his wife; three sons: Dr James, Evansville, Ind; Dr. John, Long Lake, Minn; and Joseph, Scottsdale, Ariz.; a daughter, Janet Bowersox, Seattle; and 10 grandchildren.

William T. Sweeney, MD, died July 5, 1992, at the age of 76 in North Bend, Oregon. Dr Sweeney was born and raised in Cleveland Heights, Ohio.

He received his medical degree at the Loyola University School of Medicine in Chicago, in 1943. He completed a one year internship at Cleveland City Hospital in 1944.

He was a honorary member of the SD State Medical Association and a member of the AMA. After he retired in 1986, he moved to North Bend, Oregon.

He is survived by his wife, Mary Jane.

YOUR CONTRIBUTION IS NEEDED TO THE SOUTH DAKOTA MEDICAL SCHOOL ENDOWMENT FUND

NOVEMBER 1992
David Halliday, MD, died July 16, 1992, at the age of 65. He was a family practice physician in Custer. He was born in Kenmare, North Dakota, graduated from Kenmare High School and then served in the Army.

He graduated from the University of North Dakota with a pre-med degree in 1952, and from the University of Nebraska at Omaha in 1956, with a medical degree.

In 1955, he married Dorothy Strand. He practiced medicine in North Dakota until moving to Lake Preston in 1982 and then moved to Custer in 1989. They had recently moved back to Lake Preston. He had served in the National Guard in North Dakota and South Dakota; and was a member of the South Dakota State Medical Association.

Survivors include his wife; one son, David James of Las Vegas, Nev; one daughter, Elizabeth Ann Halliday of Minneapolis, Minn; and two brothers: D. Ross of Scottsdale, Ariz; and Hugh John of New Mexico.

Charles A. Stern, MD, 75, died August 16, 1992, in San Diego, California. He was born October 14, 1916, in Sioux Falls. He graduated from the University of Chicago in 1939, and completed his basic science in medicine at the University of South Dakota in 1942. He received his medical degree in 1944, from the University of Tennessee-Memphis and completed his internship at Grace Hospital, New Haven, Connecticut. He married Doris Seigman in 1945, in Memphis, Tennessee.

He practiced Ob-Gyn in Sioux Falls until he moved to California in 1967. He was active in training University of South Dakota medical students and participated in local and state medical societies. He was assistant professor of Ob-Gyn at USD Medical School and he was instrumental in the early development of McKennan Hospital Internship and Residency training programs. He moved to San Diego where he was the director of Maternal and Child Health Care program for San Diego Department of Public Health and was a professor at San Diego University School of Public Health.

Survivors include his wife; one daughter, Gwyn Enright, of San Diego; and two sisters: Barbara Kay of Long Island, NY and Mitzi Russick of Sioux Falls.

John Vidoloff, MD, Aberdeen, was elected president at the first annual meeting of the South Dakota Chapter of the National Head Injury Foundation which was recently held in Pierre. Dr Vidoloff specializes in physical rehabilitation medicine and is medical director of St. Luke’s Midland Rehabilitation Center in Aberdeen.

Alonzo Peeke, MD, 91, died September 23, 1992, in St. Cloud, Minnesota.

Dr Peeke was born July 19, 1901, in the southern island of Kyushu, Japan. He attended the Shanghai American School in China for two years and returned to the United States to attend Park Academy and Park College in Parkville, Missouri.

He received his medical degree from the University of Minnesota Medical School in 1929, interned at St. Luke’s Hospital in Duluth and received his fellowship in the American College of Surgeons in 1938.

He married Roma Barlow in 1932 and began his practice in Volga. He was president of the board and chief of staff at the Volga Hospital from 1945 to 1962. He served as president of the South Dakota State Medical Association (SDSMA) in 1956-57. He was voted “Doctor of the Year” in 1960 and 1961. For 18 years, he trained medical students in connection with the South Dakota Medical School’s Preceptor Program. In 1965, he received the SDSMA’s A. H. Robins Award for outstanding community service.

He was inducted into the South Dakota Cowboy and Western Heritage Hall of Fame in Pierre.

He served as South Dakota’s representative to the National Rural Health Conference for 15 years. He served on the American Medical Association’s Committee for Religion and Medicine and was a member of the Board of Ecumenical Missions and Relations for the Presbyterian Church.

He was preceded in death by his wife, Roma.

Survivors include three sons: Alonzo Richard of Lynchburg, Virginia; James Barlow of Overland Park, Kansas; and Raymond Bryan of Olathe, Kansas; three daughters: Cheryl Edelen of Newton, Connecticut; Caroline Johnson of St. Cloud; and Becky Wilson of Wayne, Nebraska; 15 grandchildren; four great-grandchildren; and two sisters: Harriet Pawley and Olive Pawley, both of Riverside, California.

Wesko Man nursing home, an office he still holds. The event took place during National Nursing Home Week. Dr Dean was one of those instrumental in starting the nursing home.

Jenkins Methodist Home is pleased to announce that Dr G. Robert Bartron was recognized by the American Medical Directors Association, the professional association representing long term care physicians, as a member of the charter group of Certified Medical Directors. This recognition took place at the organization’s 15th Annual Symposium in Denver, earlier this year.

Dr Bartron has been medical director of Jenkins Methodist Home since 1979. He also serves as medical director of Prairie Lakes Nursing Home in Watertown, the Clark Care Center in Clark, and the Lake Norden Care Center in Lake Norden.
Yankton pediatrician, Dr Rich Kaplan, was elected to the Board of Directors of the South Dakota Perinatal Association for a three-year term. Dr Kaplan has been a member of the Pediatrics Department at the Yankton Medical Clinic since 1990.

*****

Dr Bernard Gerber, a physician at St Luke’s Midland Regional Medical Center who retired earlier this year, was honored by the South Dakota Hospice Organization at its annual meeting held in Sioux Falls. He was recognized for service and contribution to the work and continuing development of the hospice program.

*****

Vermillion physician, Dr William Dendinger, was named the recipient of the Edward J. Batt Memorial Award as outstanding University of South Dakota School of Medicine clinical faculty member of the year. Dr Dendinger, a family practice physician at Medical Associates, has been involved in teaching medical students from freshman through senior years. He is a diplomate of the American Board of Family Practice.

*****

James Engelbrecht, MD, rheumatologist, is the new chief of the medical staff at Rapid City Regional Hospital. Dr Dave Johnson, internal medicine, has been elected vice chief of staff. Charles Hart, MD, an emergency physician, is the board chairman and Elmo J. Rosario, MD, a pulmonologist, and John Bedingfield, MD, a surgeon, are also members of the board.

*****

Bruce Lushbough, MD, Medical Director, Brookview Manor and United Retirement Center, Brookings, was awarded a master of science degree in administrative medicine at the University of Wisconsin Medical School.

Dr Lushbough was one of 20 participants to successfully complete requirements for the two-year program. Since its inception 13 years ago, the master’s degree in administrative medicine at UW Medical School has become a nationally recognized program for training physicians and nurses in health care management.

*****

Dr Robert Van Demark Sr attended the Comprehensive Hand Review of the American Society for Surgery of the Hand, held in Dallas, Texas.

*****

Sioux Falls family practice physician, Dr Lawrence Finney has been named Family Doctor of the Year by the South Dakota Academy of Family Physicians (SDAFP). Dr Finney joined the Central Plains Clinic, then the Donahoe Clinic, in 1973. He will become the clinic’s medical director at the end of the year.

Dr Finney, a board certified family physician, is a native of Iowa. He received his medical degree from the University of Iowa College of Medicine in 1972, and completed a one year internship at McKennan Hospital in Sioux Falls in 1973. He is a member of the SDAFP, SD State Medical Association and the AMA.

*****

Dr Frank Bieberly has passed the geriatric medicine examination as presented by the American Board of Internal Medicine. He is now certified as a diplomate in geriatric medicine through the year 2002. He is associated with the Community Clinic in Chamberlain.

*****

Richard W. Honke II, MD of Parkston was elected Vice President of the South Dakota Academy of Family Physicians at its annual meeting in Rapid City. He has been very active in SDAFP serving on various committees. He has also been active with the Department of Health Preterm Birth Prevention Program. A member of the AMA and the South Dakota State Medical Association. He served on the board of the South Dakota Foundation for Medical Care, and is currently director of the South Dakota Foundation of Family Medicine.

*****

Mike Davies, MD, is the newly appointed chief of medical service at Fort Meade VA Medical Center. He is a board certified internist and has been at the hospital since 1987. He was serving as acting chief of rehabilitation medicine service from April of this year until his promotion.

*****

Raymond Nemer, MD has celebrated 30 years of medical practice in Gregory. He graduated from Gregory High School and went on to attend Creighton University and later Creighton Medical School in Omaha. He completed a rotating internship at Ramsey County Anchor Hospital in St. Paul.

Shortly after his internship, he was drafted in the United States Navy. Following his discharge from the Navy Dr Nemer decided to return to his hometown to establish a family practice.

He notes that there have been many changes in medicine in those 30 years. He commented that when he delivered a second generation baby he felt, for the first time, that he had been in the medical field for a long time.

He and his wife, Elyane, have three children and two grandchildren.

*****

Dr. Thomas Krafka, has been appointed to Governor George S. Mickelson’s 11-member commission to recommend health care reform strategies for South Dakota. The state's first Health Care Advisory Commission's recommendations will be the basis for a health reform package to be introduced in the 1993 legislative session and in future years. Dr Krafka, a radiologist from Rapid City, is president-elect of the South Dakota State Medical Association.
The following physicians recently began practicing medicine in South Dakota.

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeanne Bennett, MD</td>
<td>IM</td>
<td>University Physicians, PO Box 113, Gettysburg, SD 57442</td>
</tr>
<tr>
<td>Shawn Culey, MD</td>
<td>FP</td>
<td>Dell Rapids Medical Clinic, 111 Tenth St, E, Dell Rapids, SD 57022</td>
</tr>
<tr>
<td>Robert F. Dorsey, MD</td>
<td>GS/VS</td>
<td>Tschetter-Hohm Clinic, 455 Kansas, SE, Huron, SD 57350</td>
</tr>
<tr>
<td>Gregg Drabek, MD</td>
<td>GS/VS</td>
<td>PO Box 2623, Rapid City, SD 57709</td>
</tr>
<tr>
<td>Paul Eckrich, MD</td>
<td>U</td>
<td>Urology Associates, 201 S Lloyd, #290, Aberdeen, SD 57401</td>
</tr>
<tr>
<td>Kenneth Kirton, MD</td>
<td>FP</td>
<td>Rural Medical Clinics, 804 S Walnut, Freeman, SD 57029</td>
</tr>
<tr>
<td>David Krohn, MD</td>
<td>FP</td>
<td>Yankton Medical Clinic, PO Box 706, Yankton, SD 57078</td>
</tr>
<tr>
<td>Lori Krome, MD</td>
<td>FP</td>
<td>Dell Rapids Medical Clinic, 111 Tenth St, E, Dell Rapids, SD 57022</td>
</tr>
<tr>
<td>Nathan Loewen, MD</td>
<td>FP</td>
<td>433 Kansas Ave, SE, Huron, SD 57350</td>
</tr>
<tr>
<td>Rudolf Loperena, MD</td>
<td>FP</td>
<td>Wagner Family Care Clinic, PO Box 638, Wagner, SD 57380</td>
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<tr>
<td>Mark Mabee, MD</td>
<td>FP</td>
<td>Yankton Medical Clinic, PO Box 706, Yankton, SD 57078</td>
</tr>
<tr>
<td>Clifford Matushin, DO</td>
<td>IM</td>
<td>115 16th St, NW, Huron, SD 57350</td>
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<tr>
<td>Raymond McFadden, MD</td>
<td>GP</td>
<td>201 S Lloyd, Aberdeen, SD 57402</td>
</tr>
<tr>
<td>Douglas Prochaska, MD</td>
<td>FP</td>
<td>Mobridge Medical Clinic, PO Box 520, Mobridge, SD 57601</td>
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<tr>
<td>Nancy Roberts, DO</td>
<td>OTO</td>
<td>201 S Lloyd, Aberdeen, SD 57402</td>
</tr>
<tr>
<td>Faith Sarfarazi, MD</td>
<td>OPH</td>
<td>Yorks6r Clinic, 2311 Yorkshire Dr, Brookings, SD 57006</td>
</tr>
<tr>
<td>Kari Rae Sikkink, MD</td>
<td>FP</td>
<td>Tschetter Hohm Clinic, 455 Kansas, SE, Huron, SD 57350</td>
</tr>
<tr>
<td>Matthew Simmons, MD</td>
<td>N</td>
<td>5327 Waxwing Lane, Rapid City, SD 57702</td>
</tr>
<tr>
<td>Janet Smith, MD</td>
<td>U</td>
<td>3701 W 49th St, #104, Sioux Falls, SD 57106</td>
</tr>
<tr>
<td>John Van Erdewyk, MD</td>
<td>AN</td>
<td>Queen of Peace Hospital, 5th and Foster, Mitchell, SD 57301</td>
</tr>
<tr>
<td>Robert Van Steenkiste, DO</td>
<td>IM</td>
<td>PO Box 439, Redfield, SD 57469</td>
</tr>
<tr>
<td>Rodney Vizcarra, MD</td>
<td>GS</td>
<td>Medical Associates Clinic, 772 E Dakota Ave, Pierre, SD 57501</td>
</tr>
<tr>
<td>James Wallace, MD</td>
<td>PD/PUD</td>
<td>University Physicians, 3701 W 49th St, Sioux Falls, SD 57106</td>
</tr>
<tr>
<td>Scott Weber, DO</td>
<td>FP</td>
<td>Wagner Family Care Clinic, PO Box 638, Wagner, SD 57380</td>
</tr>
</tbody>
</table>

SOUTH DAKOTA
One day, behind an alcohol treatment center in Rapid City, South Dakota, I saw a grand, rusty old car pull up with an obvious patient in the back seat. I left to do some errands, but the entire family scene of Ma, Pa, son, and car was on my mind all that afternoon.

I was preoccupied with the way all family members are affected, changed, and afflicted by chemical dependency or co-dependency. I had to write "The Heap".

The Heap

A lot of people buy big, old cars and then drive and drive them until they are much older. The definition of "old" is 120,000 miles. They get so old that it's really hard to tell them apart outside or inside. But they get the job done again and again. They gain respect, a place in the family, and even understanding for an occasional breakdown.

If you work in an alcohol treatment center, the sight of an old family automobile delivering a patient is common. Once they are there, the driver hurriedly goes inside with, "I got him this far; somebody help!"

Cars rust. Rusting must start inside somewhere. Then it just pops out in spots through the paint. Once it starts, it goes fast, from a speck to many specks to a whole part.

It's the same with alcoholics...

Rusty cars are hard to remember new. Their charm and their vexations blot out the memory of their own particular shiny model year. It takes concentration to call up the original image.

It's the same with alcoholics...

The rusting 12-year-old auto with 180,000 miles on it brought the blond, blue-eyed young man with the effects of 12 years of drinking on his body to the door of the treatment center. (The car and the young man had started their rusting at the same time.) Dad tried to get the 210-pound body out of the back seat, but only succeeded in getting his son turned onto his stomach with his hairy legs sticking stiffly out the back door.

He went inside for help...

Mom sat in the front staring straight ahead, hearing, but not listening to, the half-anesthetized slobbering snore. There was an occasional grunt or a moan...which was it? She couldn't tell...

She didn't dwell on it...

She was half-thinking on the sad curiosity of times and...events that rust people.

When did the first spots appear?

When did the decay set in?

When did the child's acceptance turn to rebellion?

When did the blue in the eyes become matched with red instead of white and perhaps next yellow?

When did the tiny, soft pink, kicking feet become rough, variegated, and dirt-imbedded?

When did the coarse, dirty black hair replace the smooth, curving, velvety, kissable skin of thighs, legs, and backside?

When did the smell of baby powder and baby lotion turn to the odor of the unbathed body and second-hand whiskey?

When did spit-up turn to throw-up?

When did wet diapers turn to wet undershorts?

Sad, so sad...the baby is still in there...with a rusting body and a short-circuited brain to deal with whatever life is left. She blinked, and her "whens" turned to "whats".

What happened to the adventuresome youth whose methodical searching of a curious world...became an intense panic for another drink, another fix, another free fast meal or fuzzy-memories fornication?

What happened to the athlete whose gazelle-like gait became a device to stay ahead of trouble, accountability, and responsibility?

What changed innovation to deception? Persuasiveness to manipulation? An authoritative nature to bullying?

What became of the energy, the schedules, and the numerous small jobs that were replaced by lethargy, wanderings, and "big deals"?

What happened to the many noisy friends whose visits to the house were replaced by whispered phone calls to just a few?

She blinked again, but her "whats" did not turn to "whys".

Spending days such as this, many days over, was not unusual in her life. Wasting time is normal, interruption is normal, angry is normal, broken promises and no plans are normal.

She came from an alcoholic family. She married an alcoholic. Now her son is an alcoholic. She cannot
question the "why" of normal!

Not even the why of "How come all these heaps around me are alcoholic and not me? Why am I spared? Why am I not more upset and even now myself drinking over the death and disappearance of my baby lying on the back seat?"

These things are too sad to ponder, she decides, as she shifts her own 210 pounds so as to reach the glove box and her stashed Twinkies behind Dad's pint.

And the bra strap over her giant breast prosthesis breaks again...

"Why are all of you such rusting heaps?" She reflects without emotion once again as she bites into the spongy cake..."Oh, well..." Before her teeth meet the creamy center, she already feels that familiar surge of comfort and excitement...that will last a few minutes...

"Oh, well..."

And the gurgling, rusting baby on the back seat continues his death rattle.

Joseph R. Cruse, MD, Member
SDSMA Physicians HELP Committee
Rapid City, SD
Family Practice

Interlakes Medical Center, PC is seeking a family practitioner to practice in Madison, South Dakota with Richard Sample, MD, Mary Beecher, MD, and Wayne Wetzbarger, MD. We offer a competitive salary, benefit, and retirement package, a reasonable call schedule, and a busy practice opportunity in a relaxed environment.

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December 4 & 5, 1992

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Contact: Lorna Ogle
Rapid City Regional Hospital
353 Fairmont Boulevard
Rapid City, SD 57701
605-341-8013

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8th Annual CLINICAL UPDATE

A Symposium for Physicians

Modules in:
Pediatrics/Neonatology
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Topics of Current Interest

Friday and Saturday Contact: Marvie Swanson
December 4 and 5, 1992 800 E 21st
Holiday Inn City Centre Sioux Falls, SD 57117-5045
Sioux Falls, SD (605) 339-8117

Nephrology Update in Clinical Practice

January 14-15, 1993
Rushmore Plaza Holiday Inn
Rapid City, SD

Fourth Annual Conference Sponsored by:
Department of Internal Medicine
USD School of Medicine
and
Rapid City Regional Hospital

Program includes:
1. Acid/base symposium
2. Common nephrology lab tests review
3. Symposium on renal diseases in the extremes of age
4. Symposium on dialysis and transplantation
5. Clinical/pathologic review of common glomerular diseases
6. New drugs in renal patients/detoxification

Physicians, Nurses, Pharmacists, Students,
Diagnosis Nurses & Technicians, Dieticians

Contact: Brian Hurley, MD
Department of Internal Medicine
USD School of Medicine
PO Box 5046
Sioux Falls, SD 57117-5046
CME CONFERENCES

CME Conferences being held on a regular basis at various health care facilities throughout the state of South Dakota.

(1 hour AMA Category 1 Credit Available Unless Otherwise Specified)

CME CONFERENCES
DECEMBER 1992

December 2  "Topics in Clinical Medicine", audio teleconference series, 12:30 pm (CT/CDT), Topic: "Hypertension Update", Speaker: Louis Tobian, MD, Info: Connie Kleinsasser, USDMS, 339-6638.


December 3 Cath Conference, 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glirbas, 333-7266.

December 3 Cancer Conference, 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

December 3 Cancer Conference, 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

December 3 Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

December 4 Physicians Continuing Education, 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

December 4 Morbidity/Mortality Conference, 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.


December 9 Geriatrics Grand Rounds, 12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.


December 10 Cancer Conference, 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

December 10 Cancer Conference, 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

December 10 Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

December 10 Cardiac Cath Conference, 7:30 am, McKennan Hospital Auditorium, Info: Cardio Pulmonary Dept, 339-7677.

December 11 Physicians Continuing Education, 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, 341-8107.

December 11 Pathology Conference, 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

December 14 CPR Certification/Recertification, 7-10 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.


December 15 Endoroma (Endocrinology Conference), 7:30 am, Sioux Valley Hospital, Info: J. Michael McMllin, MD, 334-8387.

December 16 Geriatric Forum, 7:30 am, East Auditorium, Rapid City Regional Hospital, Info: Med Staff Office - 341-8107.

December 16 Internal Medicine Grand Rounds, 7:30 am, Sioux Valley Hospital Auditorium, Topic: Clinical Pathology Conference, Speaker: Dr. Peter Frohner, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

December 16 "Topics in Clinical Medicine", audio teleconference series, 12:30 pm (CT/CDT), Topic: "Practical Approach to the Diagnosis of Anemia", Speaker: Loren Tschetter, MD, Info: Connie Kleinsasser, USDMS, 339-6638.

December 17 Cancer Conference, 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

December 17 Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

December 17 Cancer Conference, 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

December 17 Cath Conference, 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glirbas, 333-7266.

December 18 Physicians Continuing Education, 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

December 23 Internal Medicine Grand Rounds, 7:30 am, Sioux Valley Hospital Auditorium, topic and speaker to be announced, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

December 23 Geriatrics Grand Rounds, 12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.
### January 1993

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 7</td>
<td>Morbidity/Mortality Conference</td>
<td>12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.</td>
</tr>
<tr>
<td>January 6</td>
<td>Psychiatry Grand Rounds</td>
<td>VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Info: Douglas J. Soule, PhD, 339-6785.</td>
</tr>
<tr>
<td>January 6</td>
<td>Internal Medicine Grand Rounds</td>
<td>Rotate between Sioux Valley &amp; McKennan Hospitals, Info: Brian T. Hurley, MD, 339-6790 (Barbara).</td>
</tr>
<tr>
<td>January 7</td>
<td>Cancer Conference</td>
<td>11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).</td>
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<td>Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.</td>
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<td>January 7</td>
<td>Cancer Conference</td>
<td>12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.</td>
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<td>January 7</td>
<td>Cath Conference</td>
<td>7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Giibas, 333-7266.</td>
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<td>January 7</td>
<td>West River Internal Medicine Grand Rounds</td>
<td>2:00 pm, Hot Springs VA Hospital, Topic: Cardiology, Speaker: Robert Talley, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagley).</td>
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<td>January 8</td>
<td>Pathology Conference</td>
<td>12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.</td>
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<td>January 8</td>
<td>Physicians Continuing Education</td>
<td>7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.</td>
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<td>January 8</td>
<td>West River Internal Medicine Grand Rounds</td>
<td>11:00 am, Ft. Meade VA Hospital, Topic: Cardiology, Speaker: Robert Talley, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagley).</td>
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<tr>
<td>January 11</td>
<td>CPR Certification/Recertification</td>
<td>7-10 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351</td>
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<td>January 13</td>
<td>Dermatopathology Conference</td>
<td>7:30 am, LCM, Info: Richard Schultz, MD, 339-1212 (Joan Cleveland).</td>
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<td>January 13</td>
<td>Internal Medicine Grand Rounds</td>
<td>Rotate between Sioux Valley &amp; McKennan Hospitals, Info: Brian T. Hurley, MD, 339-6790 (Barbara).</td>
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<td>January 13</td>
<td>Geriatrics Grand Rounds</td>
<td>12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.</td>
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<td>January 14</td>
<td>Cancer Conference</td>
<td>11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).</td>
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<td>January 14</td>
<td>Tumor Conference</td>
<td>Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.</td>
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<tr>
<td>January 14</td>
<td>Cardiac Cath Conference</td>
<td>7:30 am, McKennan Hospital Auditorium, Info: Tom Kenyon, 339-7677.</td>
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<td>January 14</td>
<td>Cancer Conference</td>
<td>12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.</td>
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<td>January 14</td>
<td>Pediatric Grand Rounds</td>
<td>7:30 am, Ann Berdhall Hall, Sioux Valley Hospital, Info: Larry Wellman, MD, 333-7718 (Joan).</td>
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<td>January 15</td>
<td>Physicians Continuing Education</td>
<td>7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.</td>
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<td>January 15</td>
<td>Psychiatry Grand Rounds</td>
<td>VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Info: Douglas J. Soule, PhD, 339-6785.</td>
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### MISCELLANEOUS MEETINGS

#### DECEMBER

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<th>Date</th>
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<tr>
<td>December 4-5</td>
<td>Emergency Symposium, sponsored by Rapid City Regional Hospital, Holiday Inn Plaza Hotel, Rapid City, SD. 8 hrs AMA Category 1 credit.</td>
<td>Contact: Networking 341-8013.</td>
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</table>

NOVEMBER 1992

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December 4-5 Eighth Annual Clinical Update, sponsored by McKennan Hospital, Holiday Inn City Center, Sioux Falls, SD. 9 hrs AMA Category 1 credit. Contact: Marvie Swanson, McKennan Hospital, 800 E 21st, Sioux Falls, SD 57117-5045. Phone: (605) 339-8117.

December 5 Hypertension, The Ritz-Carlton Hotel, St. Louis, MO. Contact: Washington Univ School of Medicine, Cathy Caruso, Off of CME, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

December 12 New Perspectives in the Management of Congestive Heart Failure, sponsored by U of Kansas Med Ctr, Dept of Int Med, Ritz-Carlton Hotel, Kansas City, Mo. 4 hrs AAFP and AMA Category 1 credit. Fee: $25. Contact: Off of Cont Educ, U of Kansas Med Ctr, 3901 Rainbow Blvd, Kansas City, KS 66160-7108. Phone: (913) 588-4488.

December 12 Management of Hypercholesterolemia: Goals and Strategies, Adam's Mark Hotel, St. Louis, Mo. 4.5 hrs AMA Category 1 credit. Washington Univ School of Medicine, Cathy Caruso, Off CME, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

JANUARY

January 14-15 Nephrology Update in Clinical Practice, Rushmore Plaza Holiday Inn, Rapid City, SD. 18 hrs AMA Category 1 credit. Contact: Brian Hurley, MD, USD School of Med, Dept of Int Med, PO Box 5046, Sioux Falls, SD 57117-5046. Phone: (605) 339-6790.

January 21 Clark Lecture-Research in Clinical Practice Utilizing Sentinel Practice Sites, Marriott Hotel, Omaha, NE. Contact: Sally C. O’Neill, Ph.D, Assoc Dean, CME, Creighton Univ, California at 24th St, Omaha, NE 68178. Phone: (800) 548-2633.

Jan 28-Feb 3 1993 Update in Clinical Neurophysiology, Mayo Clinic Campus, Rochester, MN. Contact: Postgraduate Courses, Section of Cont Educ, Mayo Foundation, Rochester, MN 55905. Phone: (800) 323-2688.

FEBRUARY

February 6 Advances in the Diagnosis and Management of Cardiovascular Disease, Marriott Hotel, Omaha, NE. Contact: U of Nebraska Med Ctr, CME, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

February 18-20 Advanced Gynecologic Surgery - 1993, Disney's Yacht and Beach Club Resorts, Lake Buena Vista, FL. Contact Postgraduate Courses, Section of Cont Educ, Mayo Foundation, Rochester, MN 55905. Phone: (800) 323-2688.

February 19 Burn Care Today, St. Paul-Ramsey Medical Center, St. Paul, MN. 7 hrs AMA Category 1 credit. Contact: Off of CME, Ramsey, 640 Jackson St. St. Paul, MN 55101. Phone: (612) 221-3991.


February 27 Colon and Rectal Disease Conference for Primary Care Physicians, Marriott Hotel, Omaha, NE. Contact: Sally C. O’Neill, Ph.D, Assoc Dean, CME, Creighton Univ, California at 24th St, Omaha, NE 68178. Phone: (800) 548-2633.

February 27 Women and Men in Health Care, Washington Univ Med Ctr. Contact: Cathy Caruso, Off CME, Washington Univ School of Med, Campus Box 8063, 660 S Euclid Ave, St. Louis, MO 63110-1093. Phone: (800) 325-9862.

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The same is true of The Doctors' Company. We work with our doctors, not against them, by providing the finest in professional liability insurance. Our competitive rates, responsive service, interest-free quarterly payments, and outstanding risk management program are just some of the reasons why more and more South Dakota physicians are joining our flock. The Doctors' Company has the financial strength and support of more than 15,500 members nationwide. But unlike the migrating geese, we’re in South Dakota to stay. We’ve never left a state to which we’ve committed service.

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It is a joy this Holiday Season to extend to you our sincere thanks for your cooperation and to wish you a happy and prosperous New Year.

From All of Us at the South Dakota Foundation for Medical Care
SCIENTIFIC ARTICLES
Groin Infection Following Cardiac Catheterization: A Case Report
Brenda DeLong, MD

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Legislative Directory 1993-1994
Editorial
Confidentiality: Jaded Ideal or Relevant Aspiration
Jerome W. Freeman, MD 
 Editor
Pharmacology Focus
The INR: Friend Not Foe in The Anticoagulation Jungle
Brad Wallenberg, Pharm.D

Auxiliary News
New SDSMA Members
Physician's Directory
Index Volume 45
Directory of Advertisers
CME Conferences

NEXT MONTH
Bartholin Cyst Presenting as Inguinal Hernia

About the Cover
Snow and Shadow. Photographed by Joel Strasser, well-known South Dakota photographer. He lives near Canton, SD.
The staff at South Dakota Blue Shield wishes each of you a safe and joyous holiday season.

South Dakota Blue Shield

* Registered Service Mark of the Blue Cross and Blue Shield Association
As we travel around the state our objective is to bring the districts up to date on what is happening in various areas of medicine. Lately it has become clear that the questions refer to national health insurance and our role in regard to its final design. According to Stormy Johnson, Speaker of the AMA House of Delegates, we have two main questions. 1. Is there a problem? 2. Do we want to help solve the problem? The answers to both are, of course, "yes". Some of the problems we don't always relate to are things like people losing their insurance when they change jobs; insurance companies cancelling group policies or raising rates out of sight because of a catastrophic illness in the group; self insured companies cutting benefits at any time, legally according to recent Supreme Court ruling. All this does is transfer costs to the rest of the private sector.

The government uses the term cost containment. It should be called money management. The bureaucrats can think of only one solution and that is to lower fees of physicians and decrease payments to hospitals. They want to add the questionable number of 37 million people to the insurance roles and keep the cost the same and at the same time maintain benefits. They can't understand that the patients and their part in being responsible in their expectations should be part of the formula. If it is entirely free they will never hesitate to utilize the system to its maximum.

New laws are needed and I'm sure the medical profession will do its part if they are equitable to all, even if there is some pain.

I could go on and on and discuss various plans being offered and the problems with each but after all this is the holiday season. Let me therefore close by wishing you all happy holidays and better times ahead.
Season's Greetings

WITH EVERY GOOD WISH

FOR THE NEW YEAR!

From the Staff

SOUTH DAKOTA STATE MEDICAL ASSOCIATION
LEGISLATIVE DIRECTORY
1993 - 1994

UNITED STATES SENATORS
Senate Office Building
Washington, DC 20510
PRESSLER, LARRY (R)
Office: Hart 133
Telephone: 202-224-5842
Committees: Banking, Housing & Urban Affairs; Commerce, Science & Transportation; Foreign Relations; Small Business; Special Aging
Term Expires: 1996
DASCHLE, THOMAS A. (D)
Office: Hart 317
Telephone: 202-224-2321
Committees: Agriculture, Nutrition & Forestry; Finance; Select Indian Affairs
Term Expires: 1998

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Washington, DC 20510
JOHNSON, TIM (D)
Office: Cannon 428
Telephone: 202-225-2801
Committees: Agriculture; Interior & Insular Affairs
Term Expires: 1994

SOUTH DAKOTA GOVERNOR
MICKELSON, GEORGE
Office: State Capitol, Pierre, SD 57501
Telephone: 773-3212

SOUTH DAKOTA LIEUTENANT GOVERNOR
MILLER, WALTER D.
Office: State Capitol, Pierre, SD 57501
Telephone: 773-3661

SOUTH DAKOTA SENATE
State Capitol, Pierre, SD 57501

All Senators can be reached during the Legislative Session by calling the Senate Lobby at 773-3821.

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<th>Senator (Party)</th>
<th>Dist.</th>
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SOUTH DAKOTA REPRESENTATIVES
State Capitol, Pierre, SD 57501

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(PLEASE SAVE THIS DIRECTORY FOR FUTURE USE)
Minority Whips
Rep. Pat Haley (D) 352-4969
Rep. Garry Moore (D) 665-2301
Rep. Dennis VanOvershede (D) 425-2650

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VanSickle, R. Lee (D) 5 Watertown 886-7373
Volesky, Ron J. (D) 21 Huron 352-0493
Wagner, Michael D. (R) 9 Baltic 529-5682
Waltman, Alfred (D) 3 Aberdeen 229-0355
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Editorial

Confidentiality: Jaded Ideal or Relevant Aspiration

The poet, T. S. Elliot, describes an ineffectual J. Alfred Prufrock who struggles with decisions. Prufrock reflects:

"In a minute there is time
For decisions and revisions which a minute will reverse". 1

While there are times in life when words and deeds may be disowned or repudiated, there are certainly other instances when conduct has irrevocable consequences. Issues of patient confidentiality frequently fall into this latter category.

Certainly, patient confidentiality has long been an important tenant of medical practice. Ethically, confidentiality arises in part from the patient's right to autonomy and from the precept that the physician should act primarily in the patient's best interest. The patient's right to confidentiality and privacy has long been an integral part of the doctor/patient relationship, and indeed is alluded to in the Hippocratic Oath: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about." 2 Certainly, most patients approach the doctor/patient relationship with the expectation that the content of that interaction will not be unnecessarily divulged to others.

And yet, while confidentiality is a long-standing ideal, it was probably much easier to maintain in the medical practices of prior decades than it is today. Indeed, there are so many forces in today's health care delivery system that work against confidentiality, that many cynics view complete confidentiality as more of a myth from the past than a reality. This is not to imply that confidentiality is never stressed. In some contexts, such as AIDS, the issue is much debated. Emphasis is given to protecting the patient (as well as the physician) from unwanted disclosure of HIV status.

Nonetheless, the occasions for violating patient confidentiality abound. Increasingly, insurance companies seek specific patient information which can be computerized and, potentially, widely disseminated. The physician's office staff are regularly privy to considerable data about patients, including the diagnosis, the content of the office chart, and billing/financial information. Employees of the physician's answering service deal with patient information as they provide messages dealing with patient admissions, consultation requests and laboratory data. In the hospital, it seems, it is even more difficult to maintain a semblance of patient confidentiality. Multiple care givers and other individuals have valid access to a patient's chart. These individuals may include a primary physician and multiple consultants, numerous nursing personnel from each hospital shift, pharmacists, respiratory therapists, and dieticians. Any of these individuals might, either deliberately or even inadvertently, discuss some aspect of a patient's care with parties beyond the treating team. The better known patient in a community or the more unusual or spectacular the illness (e.g. AIDS), the more likely that the content of such disclosures will spread through a widening circle of people. Unlike Prufrock's dilemma, which apparently gave him time to consider and reconsider the ramifications of action, once confidentiality is breached and private information begins to be spread, the damage often cannot be undone. The disclosed information theoretically, and practically, is irretrievable. Of course, the patient might not even know about such a breach of privacy, but that does not render the disclosure any less grave.

Clearly, today's complex, many-tiered health care system makes it difficult to maintain the ideal of confidentiality. Inevitably, there will be times when this ideal is eroded. Nevertheless, I would submit that the nature of the doctor/patient relationship and the ethics that attend it demand that we attempt to maintain patient privacy and confidentiality to the extent possible. In this regard, it certainly is important for physicians to take a proactive role in educating office and hospital staff to the importance of confidentiality. Moreover, I believe we physicians need to continue to emphasize to each other the importance of confidentiality. In my experience, it is not infrequent to hear a patient's name and diagnosis mentioned in casual conversation between physicians. Such comments might seem fairly innocuous and could include a passing remark about an individual's recent surgery, hospitalization, or diagnosis. Such disclosure might take place in a physician's lounge, or worse, at some social setting outside the hospital. Frequently, I believe, physicians may make such comments without even realizing that any potential breach of confidentiality exists — especially if the discussion is between two physicians.

In medicine, our therapeutic options and treatment decisions have to be precisely chosen and are often irrevocable once implemented. Similarly, a breach in patient confidentiality is potentially irrevocable in a sense that would baffle and terrify Prufrock. Confidentiality is important to our patients and to physicians who
constitute a distinguished and beneficient profession. We should strive to promote this ideal among ourselves, to our staff, and certainly to the medical students who come under our influence.

Jerome W. Freeman, MD
Editor

REFERENCES

Groin Infection Following Cardiac Catheterization: A Case Report

Brenda DeJong, MD

ABSTRACT

A 56 year old female with insulin dependent diabetes mellitus developed a severe wound infection after a cardiac catheterization. The clinical features and treatment of progressive bacterial synergistic gangrene and necrotizing fasciitis are discussed.

CASE REPORT

A 56 year old female with insulin dependent diabetes mellitus underwent a cardiac catheterization on 10/15/91. Eight days later (10/23) she noticed several small black specks on her right groin near the catheterization entry site. Over the next few days this area became hard, raised, erythematous, and slightly tender. The black lesions enlarged to 2 cm x 1 cm. The skin broke down on two of the lesions and a serous drainage began on 10/26. Still, these lesions were not very painful, so the patient waited until after the weekend (10/28) to consult her physician. By this time, the erythema had spread to her right buttock laterally; medially it spread over the pubis and right labial areas; and it extended to the left anterior thigh. The third lesion continued to enlarge, and the overlying skin appeared to be on the verge of break down. She was afebrile.

Her family doctor admitted her to the local hospital. Wound cultures were taken and gram stain revealed gram positive cocci. Because she was allergic to penicillin, intravenous (IV) Axtrenon, Metronidazole, and Clindamycin were started. Wound cultures grew Staphylococcus aureus and Streptococcus, Group A. Blood cultures were negative. She did not respond to the initial antibiotics and on 10/29 she was transferred to a tertiary care center for further evaluation. Debate ensued as to whether she had a cellulitis or a necrotizing fasciitis.

Surgical and Infectious Disease Consults were obtained. It was felt that surgical exploration was indeed necessary to fully determine the extent of tissue involvement and continued aggressive IV antibiotics were needed. Her antibiotics were changed to IV Vancomycin, Clindamycin, and Gentamycin. Although she was not clinically toxic, she had significant risk factors for a necrotizing fasciitis—the recent invasive procedure, diabetes, a presentation of necrotic skin lesions, and erythema possibly spreading along facial planes—that mandated prompt, aggressive treatment.

At surgery, it was determined that a large area of subcutaneous tissue had become necrotic over the right groin area. However, the underlying fascia was not affected. Debridement of a 10 cm x 3 cm area over the right groin was performed until healthy tissue was encountered. A second debridement a few days later extended this area to include the right labia and several centimeters over the right hip. A skin graft was placed when all signs of infection were gone and granulation tissue had formed. The patient was discharged on oral Ciprofloxin and Clindamycin 25 days after admission.

DISCUSSION

At surgery, our patient was considered to have a progressive bacterial synergistic gangrene with extensive soft tissue loss, rather than necrotizing fasciitis. Synergistic gangrene, or sometimes called "Meleney's ulcer", is a slower developing, less toxic entity than necrotizing fasciitis. It can be caused by several bacteria including streptococcus and staphylococcus, and requires similar treatment. This patient was treated as though she did indeed have a fasciitis because of her risk factors, the potential for rapid dissemination of the infection, the high mortality rates associated with fasciitis, and because it actually was not clear early in her clinical course how extensive the infection was.

Necrotizing fasciitis is a rare condition with approximately 1000 cases in the USA per year.1 It is a rapidly progressive, often fatal soft tissue infection involving the superficial and deep fascia. There is secondary involvement of the overlying skin as thrombosis of nutrient vessels occurs. The underlying muscle is spared until its entire facial envelope is affected late in the process.

There is no significant age or sex predilection. Clinically severe pain, swelling, and ill-defined cellulitis develop early. Nutrient vessels to the skin are
destroyed, causing the characteristic dull blue-gray areas, and blisters filled with hemorrhagic fluid. The bacterial infection becomes well established in the subcutaneous space where necrosis of the superficial fascia and fat takes place. The muscle remains unaffected. The overlying skin anesthetizes because of cutaneous nerve necrosis. By the fourth or fifth day the skin becomes frankly gangrenous and by the tenth day the skin may slough. Signs of severe systemic toxicity such as fever, encephalopathy, septic shock and evidence of septic emboli to other sites in the body accompany the local findings. Most untreated patients die and there is a very high mortality even in aggressively treated patients.

Tissue examination demonstrates widespread undermining of the skin, gray attenuated fascia, and pockets of serosanguinous fluid. Although the precise mechanisms are not known, the liquefactive necrosis is believed to be a result of bacterial enzymes, especially hyaluronidases and lipases which degrade fascia and fat, respectively.

Many organisms can cause necrotizing fasciitis. Streptococcus alone or in combination with Staphylococcus is common. However, many organisms have been isolated in fasciitis including gram positive, gram negative, and anaerobes, or combinations of these microbes. Clostridium with its gas production in an especially difficult microbe to isolate and treat. Diabetes are very susceptible to anaerobic infections because of small vessel disease, altered leukocyte function and increased tissue glucose level. These conditions create an environment rich in nutrients and low in oxygen tension where anaerobes thrive.

The diagnosis of fasciitis is made at surgery. Only if there is significant gas formation from an anaerobic infection will an x-ray be helpful in diagnosis. Treatment consists mainly of surgical debridement and fasciectomy with frequent reevaluation for evidence of further extension of the disease. Medical treatment consists of incorporating adequate antimicrobial coverage with supportive care. Correction of electrolyte imbalances and anemia, as well as fluid support is essential. Underlying conditions such as diabetes mellitus, renal insufficiency, or heart problems deserve even closer surveillance as patients with these conditions can decompensate rapidly.

Hyperbaric oxygen therapy has been also incorporated in treatment of necrotizing fasciitis. It is felt that the increase in oxygen tension provided by the hyperbaric oxygen tank and the increase in oxygen free radicals produced by leukocytes while in the tank both work to destroy anaerobic organisms. Niinikoski and Aho, Ellis and Mandel, and others have seen decreased morbidity and mortality when using hyperbaric oxygen as adjunct therapy. They found that fewer and less radical amputations of extremities were required as well as fewer debridements. It was noted, however, that care must be given when using hyperbaric oxygen on diabetics because hyperbaric oxygen stimulates glucose metabolism which can produce hypoglycemia that in turn can cause seizures. Regardless of whether the treatment includes hyperbaric oxygen or not, the most crucial component of treating necrotizing fasciitis is how quickly surgical and medical treatment is initiated. It is imperative to begin treatment as soon as one suspects fasciitis because extensive spread and death can occur in just a few hours. Even with aggressive surgical and medical treatment, mortality is still 20%-40%.

**SUMMARY**

The patient presented in this paper was problematic. She had a typical presentation for a severe infection, but it was unclear how close she actually was to a necrotizing fasciitis. She had many features of necrotizing fasciitis, but was not febrile and at surgery it was determined that the infection involved only the subcutaneous tissue, not the actual fascia. However, this could only be discerned upon surgical debridement. It is essential to treat such a patient aggressively because the mortality of this type of infection is potentially so high.

**REFERENCES**


**AUTHOR**

Brenda DeJong, MD is a family practice resident in Sioux Falls, SD. She received the C. B. McVay Award from the SD Chapter of American College of Surgeons with this article.
The INR: Friend Not Foe in the Anticoagulation Jungle

Brad Wallenberg, Pharm.D
Associate Professor of Clinical Pharmacy, SDSU College of Pharmacy, Brookings, and Clinical Pharmacist, VAMC, Sioux Falls, SD

The 3rd ACCP Consensus Conference on Antithrombotic Therapy as published in CHEST Supplement (October 1992) prods medicine in North America to accelerate acceptance of the INR (International Normalized Ratio) for the laboratory control of oral anticoagulant (warfarin) therapy. This 'corrected' prothrombin time (PT) ratio is well on its way to full adoption worldwide except in North America. Acceptance and adoption of the INR will benefit the patient and provider by making the therapeutic range comparable and the safety (bleeding risk) margin wider without regard to which laboratory or clinic performed the PT test. Today in South Dakota as elsewhere, there is no comparability between different laboratory reported PT's. A PT value of 18 seconds from two labs can represent either desired therapeutic range and safety or an elevated PT with an increased risk of bleeding. Impossible? Not at all.

Thromboplastin is the culprit which causes the need for adoption of the INR. This naturally occurring phospholipid-protein tissue extract triggers the clotting cascade in vivo and in the PT test. The most responsive thromboplastin is derived from human brain and is the international standard against which all animal source thromboplastins are compared. Over the last 40 years the use of animal source thromboplastins replaced human brain thromboplastin. The loss of responsiveness by the new reagents was subtle and not recognized until the 1970's. The problem was not discussed or published widely in the US until the early 1980's. This resulted in two rather consistent findings in comparable studies done in Britain and the US. First, the average dose to achieve the desired anticoagulant effect in the US was significantly higher than in Britain. Second, the incidence of clinically significant bleeding was higher in the US studies than in the British. The latter resulted in some indications for anticoagulation therapy being abandoned because the risks outweighed benefits. The recognition of this laboratory control problem and the change of anticoagulation intensity has led to re-evaluation of some previously discarded indications. Of note is the recent initiation of warfarin in post MI studies. Warfarin post MI was common in the 1950's and 1960's but was deserted due to the bleeding risk. A further problem continues because of non-standard reporting of anticoagulation control. As a result, apparently similar warfarin studies in the literature are not comparable because of significant differences in efficacy and/or safety.

The INR will standardize the clinical control of anticoagulation therapy. The less responsive thromboplastins will be compared to the World Health Organization human brain standard thromboplastin and be assigned an ISI (International Sensitivity Index). The calibration system is based on the linearity of the logarithm of the PT obtained with the reference and test thromboplastins. This calibration is used to convert PT ratio of the local thromboplastin into the INR. Using a calculator with a (y^x) function the INR can be calculated as follows:

\[
INR = \frac{(Patient\ PT/Control\ PT)^{ISI}}{\text{ISI}}
\]

Human brain and the most responsive thromboplastins have an ISI of 1.0. The rabbit brain thromboplastins available in the US have ISI's that range from 1.8 to 2.8. The therapeutic INR's recommended by the CHEST Supplement (October 1992), consist of two INR ranges:

- INR 2.5 to 3.5 Mechanical Prosthetic Heart Valves
- INR 2.0 to 3.0 All Other Indications

Thromboplastins with the following ISI's of 1.8, 2.3, and 2.8 respectively yield the following PT ratios, which correspond to the above recommended INR's:

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<td>1.7 - 2.0</td>
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If a control PT of 10 seconds is assumed, a PT value of 18 seconds may represent safe therapy if the ISI = 1.8, but may put the patient at an increased risk of bleeding if the ISI = 2.8. By calculating the INR from the local results and ISI, patient's intensity of anticoagulation, safety and efficacy can be maximized. Adhering to the recommended INR's will become a standard of practice.

The time has come to recognize the problem with anticoagulation control and to implement standardized reporting of INR for the management of oral anticoagulation patients. It is recommended that labs and clinics not use thromboplastin reagents which do not report the ISI in the kit or have it readily available on request. This decade of expanding indications for oral anticoagulant therapy, such as non-valvular atrial fibril-
lations and potentially, post-MI patients, demands we standardize control methods to minimize risk, optimize efficacy and insure increased comparability in published literature reports. An added benefit in our decidedly rural state, would be the interlab discrepancies would be minimized and patients could be consistently monitored at more than one site.

Edited by Brian Kaatz, Pharm.D.

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As we approach the start of another new year, we once again analyze our lives and re-establish priorities. Perhaps, this is the year that you will change a particular behavior or make a modification in your life style. You may even be one of those task oriented individuals who, having achieved a particular goal, need only to maintain current practices to be successful.

The SDSMAA, in its relationship to the national auxiliary, established several priorities at the annual meeting in June. The end of the calendar year serves as our mid-year reference point as we assess our achievement and evaluate our progress.

In this significant presidential election year, a great emphasis was placed on voter registration of physicians, spouses, and health care professionals. Thanks to the committed legislation committee and the cooperation of local hospitals; at least ten different registration events were scheduled around the state which resulted in more than 200 registrations. GOOD WORK, EVERYONE!!! This enthusiasm for the political process must now continue into the legislative session.

Our membership emphasis will continue to be retention of the federated member. South Dakota was one of ten states in which auxiliary membership increased during 1991-1992, and Helen Owens and Mary Ann Harris have developed a campaign which focuses on the perennial member. Each district will receive a perennial bulb for each member who joins the federation (district, state and national) during 1992-1993. It is suggested that these bulbs be planted at a local hospital or non-profit community agency as a lasting reminder of our auxiliary dedication to community. Mid year reports show that districts are working on membership retention, and we are approaching numbers equal to 50% of last year’s total membership. Again, I applaud your good work.

It is in reaching our goals for health issues that cooperation between spouse and physician is most critical. Immunizations for all children before age two is a national priority and a major emphasis of the South Dakota Department of Health. Concerns about adolescent eating disorders must continue to be addressed. The issues of nutrition and exercise are significant factors in the lives of all. A special emphasis on women’s health deals extensively with promoting regular breast self-examination and an annual exam by a physician. The AMA Auxiliary in encouraging all members of all physician families to obtain a base line mammogram during this year. Encourage your family to be part of this success.

Again, I challenge you to look at your life as we begin the new year. In order to foster and achieve successful programs for preventive health practices in the general population; we must first establish these behaviors in our own families. Make good health a high priority in 1993.

Drew Parry

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South Dakota State Medical Association
CME Conferences

CME Conferences being held on a regular basis at various health care facilities throughout the state of South Dakota.

(1 hour AMA Category 1 Credit Available Unless Otherwise Specified)

CME Conferences

January 1993

January 6


January 6

"Topics in Clinical Medicine", audio teleconference series, 12:30 pm (CT/CDT), Topic: "Birth Control Update", Speaker: David Gearhart, MD, Info: Connie Kleinsasser, USDMS, 339-6638.

January 7

Cancer Conference, 11:00 am, St Luke’s Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

January 7

Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

January 7

Cancer Conference, 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

January 7

Cath Conference, 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glirbas, 333-7266.

January 7

West River Internal Medicine Grand Rounds, 2:00 pm, Hot Springs VA Hospital, Topic: Cardiology, Speaker: Robert Talley, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagley).

January 8

TURP Follow-up Care - 12:30 pm, Brookings Hospital, Speaker: R.C. Johnson, Urologist, Info: Phyllis Sander, RN - 692-6351.

January 8

Physicians Continuing Education, 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

January 8

West River Internal Medicine Grand Rounds, 11:00 am, Ft. Meade VA Hospital, Topic: Cardiology, Speaker: Robert Talley, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagley).

January 11


January 12

CPR Certification/Recertification, 7-10 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

January 13

Dermatopathology Conference, 7:30 am, LCM, Info: Richard Schultz, MD, 339-1212 (Joan Cleveland).

January 13

Internal Medicine Grand Rounds, 7:30 am, McKennan Hospital Auditorium, Speaker: to be announced, Topic: to be announced, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

January 13

Geriatrics Grand Rounds, 12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.

January 13


January 14

Cancer Conference, 11:00 am, St Luke’s Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

January 14

Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

January 14

Cardiac Cath Conference, 7:30 am, McKennan Hospital Auditorium, Info: Cardiopulmonary Dept, 339-7677.

January 14

Cancer Conference, 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

January 14

Pediatric Grand Rounds, 7:30 am, Ann Berdahl Hall, Sioux Valley Hospital, Info: Larry Wellman, MD, 333-7178 (Joan).

January 15

Physicians Continuing Education, 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

January 15

Psychiatry Grand Rounds, VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Info: Douglas J. Soule, PhD, 339-6785.

January 19

Endorama (Endocrinology Conference), 7:30 am, Sioux Valley Hospital, Info: J. Michael McMillin, MD, 334-8387.

January 20

Internal Medicine Grand Rounds - 7:30 am, Clinical Path Conference, Sioux Valley Hospital Auditorium, Topic: to be announced, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

January 20

Geriatric Forum - 7:30 am, East Auditorium, Rapid City Regional Hospital, Info: Med Staff Office - 341-8107.

January 21

Cancer Conference, 11:00 am, St Luke’s Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

January 21

Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

January 21

Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

January 21

Cath Conference - 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glirbas, 333-7266.
Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

Pathology Conference, 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.


Tumor Board - Fort Meade VA, Info: Vickie Netterberg - 347-2511, Ext 284.

Internal Medicine Grand Rounds, 7:30 am, Sioux Valley Hospital Auditorium, Speaker: Richard McAllister, MD/Michael Bloom, PhD, Topic: Preventative Intervention for Patients at Risk for Chronic Pain, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

Geriatrics Grand Rounds - 12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.

Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

Cancer Conference, 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

Cardiac Cath Conference, 7:30 am, McKennan Hospital Auditorium, Info: Cardiopulmonary Dept, 339-7677.

Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

Pediatric Grand Rounds - 7:30 am, Ann Berdahl Hall, Sioux Valley Hospital, Info: Larry Wellman, MD, 333-7178 (Joan).

Tumor Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

FEBRUARY 1993

February 3

Internal Medicine Grand Rounds - 7:30 am, McKennan Hospital Auditorium, Speaker: Marvin Bittner, MD, Topic: Emerging Pathogens of the 90's, Info: Brian T. Hurley, MD, 339-6790 (Barb).udden.

March 3


February 4

Cancer Conference, 11:00 am, St Luke's Midland Regional Medical Center, Aberdeen, Info: Dr. Roy Burt, 662-5194 (Rhonda).

February 4

Tumor Conference, Dakota Midwest Cancer Institute - noon, McKennan Campus, Info: Norma Wise, 339-8568.

February 4

Cancer Conference - 12:00 noon, West Auditorium, Rapid City Regional Hospital, Info: Cancer Registry - 341-8705.

February 4

Cath Conference - 7:30 am, Sioux Valley Hospital Auditorium, Info: Alice Glibaras, 333-7266.

February 4

West River Internal Medicine Grand Rounds, 2:00 pm, Hot Springs VA Hospital, Topic: Gastroenterology, Speaker: Robert Raszkowski, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagle).

February 5

Ophthalmology/Orthopedic Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

February 5

Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

February 5

Psychiatry Grand Rounds - VAMC, 12:00 noon to 1:30 pm, VA Regional Bldg - Training Room, Info: Douglas J. Soule, PhD, 339-6785.

February 5

West River Internal Medicine Grand Rounds, 11:00 am, Ft. Meade VA Hospital, Topic: Gastroenterology, Speaker: Robert Raszkowski, MD, Info: Donald Humphreys, MD, 339-6790 (Barb Wagle).

February 8

CPR Certification/Recertification - 7-11 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

February 10

Internal Medicine Grand Rounds - 7:30 am, McKennan Hospital Auditorium, Speaker: to be announced, Topic: to be announced, Info: Brian T. Hurley, MD, 339-6790 (Barbara).

February 10

Geriatrics Grand Rounds - 12:00 noon, Meeting Room A, Sioux Valley Hospital, Info: Edward Zawada, MD, 339-6790.

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Cardiac Cath Conference, 7:30 am, McKennan Hospital Auditorium, Info: Cardiopulmonary Dept, 339-7677.

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February 12

Pathology Conference - 12:30 pm, Brookings Hospital, Info: Phyllis Sander, RN - 692-6351.

February 12

Physicians Continuing Education - 7:30 am, West Auditorium, Rapid City Regional Hospital, Info: Med Staff Office, - 341-8107.

MISCELLANEOUS MEETINGS

JANUARY

January 14-16

Nephrology Update in Clinical Practice, Rushmore Plaza Holiday Inn, Rapid City, SD. 18 hrs AMA Category 1 credit. Contact: Brian Hurley, MD, USD School of Med, Dept of Int Med, PO Box 5046, Sioux Falls, SD 57117-5046. Phone: (605) 339-6790.
January 16-23
Topics in Hematology and Oncology, St. Martin, French West Indies. Contact: John F. Vargo, George Washington Univ Med Ctr, Off of CME, 2300 K St, NW, Washington, DC 20037. Phone: (202) 994-4285.

FEBRUARY

February 2
Common Infectious Disease Problems in Primary Care: Focus on the Pediatric Patient, Bloomington Marriott Hot, Minneapolis, MN. Fee: $35. Contact: Univ of Neb Med Ctr, Ctr for CME, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

February 6
Psychiatry Department Winter Update, Sioux Falls, SD. 8-12 AMA Category 1 credit. Contact: USDSM, Office of CME, Kate Naylor. Phone: (605) 339-6785.

February 25-27
Black Hills Neurology Seminar, Advances In Clinical Child Neurology, Holiday Inn of the Northern Black Hills, Spearfish, SD. Contact: K. Alan Kelts, MD, 2929 5th St, Suite 240, Rapid City, SD 57701. Phone: (605) 341-3770.

Feb 28 - Mar 2
13th Annual Keystone ENT Conference, Keystone Resort, Keystone, CO. Fee: $400. Contact: Univ of Neb Med Ctr, Ctr for CME, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

MARCH

March 3
Heartland Risk Reduction Society, The Clinical Importance Lipoprotein(a) [L.P(a)], Plaza Club, Kiewit Plaza, Omaha, NE. No charge. Contact: Univ of Neb Med Ctr, Ctr for CME, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

March 7
Selected Topics in Internal Medicine, Hotel del Coronado, San Diego, CA. Contact: Postgraduate Courses, Section of Cont Educ, Mayo Found, Rochester, MN 55905. Phone: (800) 323-2688.

March 5-6
State of the Art-Medical Therapeutics, Marriott Hotel, Omaha, NE. Contact: Univ of Neb Med Ctr, Ctr for CME, 600 S 42nd St, Omaha, NE 68198-5651. Phone: (800) 642-1095.

March 11-12

March 18-20
Spring Break for CME, PGA National Resort and Spa, Palm Beach Gardens, FL. Fee: $385. 18 hrs AMA Category 1 credit. Contact: Karen Barnum, Meeting Coor., Florida Medical Association, PO Box 2411, Jacksonville, FL 32203. Phone: (904) 356-1571.

March 26
11th Annual Toxicology Conference, McKennan Hospital Aud, Sioux Falls, SD. 4 hrs AMA Category 1 credit. Contact: Kathy Miles, (605) 339-8096.

Family Practice

Interlakes Medical Center, PC is seeking a family practitioner to practice in Madison, South Dakota with Richard Sample, MD, Mary Beecher, MD, and Wayne Wetzberger, MD. We offer a competitive salary, benefit, and retirement package, a reasonable call schedule, and a busy practice opportunity in a relaxed environment.

Madison is a progressive southeastern South Dakota community of 6,200 located in a region offering abundant opportunities for recreation, education, and cultural events throughout the year.

If you are interested, please contact one of the above or Scott Jamison, Business Manager, at 605-256-6951. Interlakes Medical center, PC, 903 N Washington Ave, Madison, SD 57042.
WE COULD LOOK AT YOU LIKE ANY OTHER DOCTOR, BUT THEN YOU'D LOOK AT US LIKE ANY OTHER INSURANCE COMPANY.

Doctors have different specialties and consequently, different levels of risk. Which is why you need a different kind of insurer. One who sees you as an individual, not as just one more physician in a large, homogeneous group.

As a company founded and owned by physicians, MMIC is by nature more empathetic to your concerns.

Thus we’ve worked to revise the industry classification system to one that more fairly evaluates the risks of each practice. Creating more rate classes has enabled us to reduce our premiums. In many cases, MMIC policy holders are paying lower rates than they paid in 1988.

That’s just one example of the differences you’ll find at MMIC. For another, you’ll always have a voice in the litigation process. We work closely with you in building a strong case for your defense. And in those limited cases, we make every effort to expedite the settlement process.

Looking at issues from your perspective has helped us build assets in excess of $140 million, serving the finest physicians and clinics in the midwest. To learn more, call (612) 922-5445. Or outstate, call (800) 328-5532.
New Humulin 50/50 is the tailor-made answer to individual patient needs. A unique combination of equal amounts of Regular human insulin and NPH human insulin, it will be useful in situations in which a greater initial insulin response is desirable for greater glycemic control.

Like Humulin 70/30, new Humulin 50/50 offers the convenience and accuracy of a premix. And it can be used in conjunction with an existing 70/30 regimen.
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