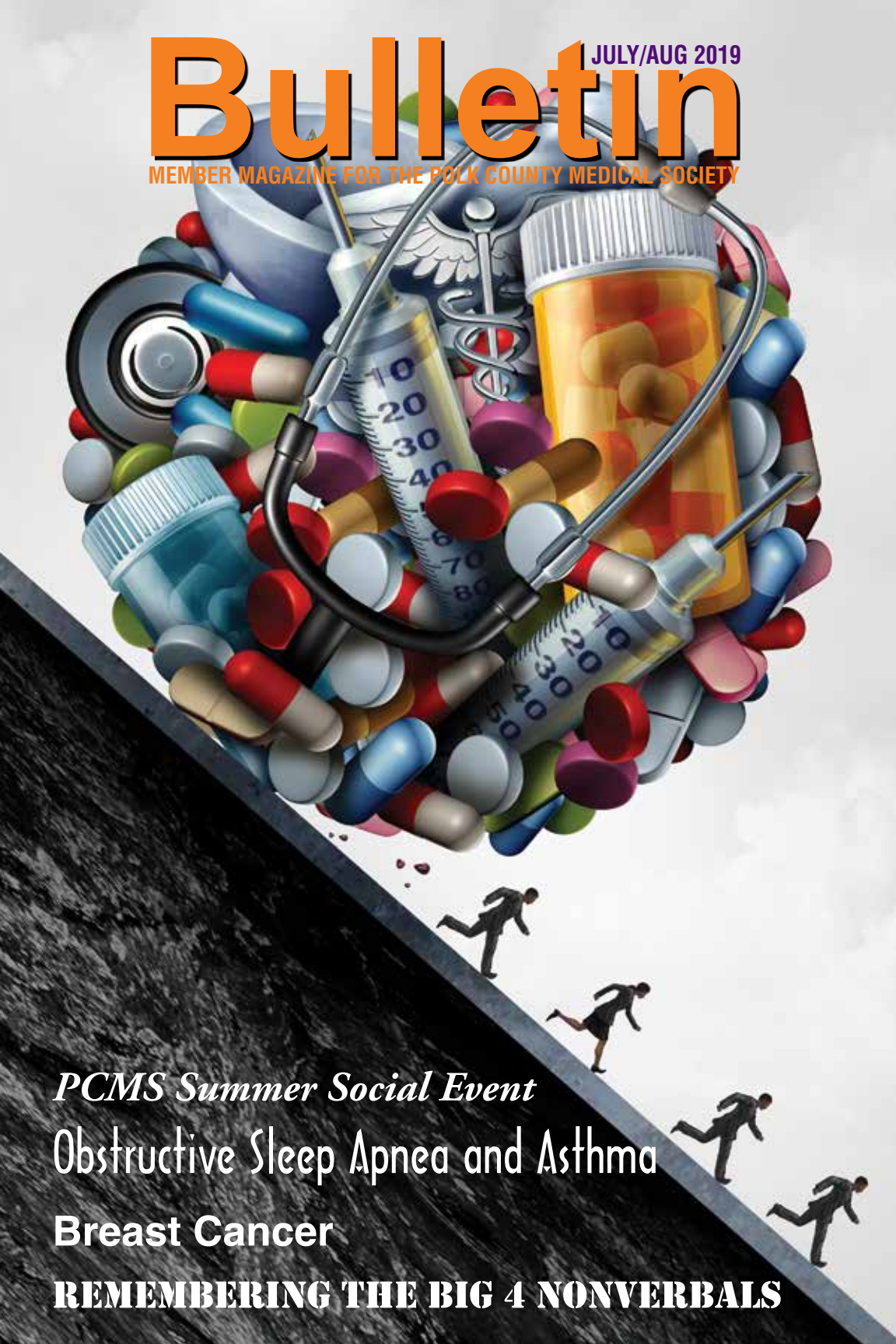
JULY/AUG 2019

Bulletin

MEMBER MAGAZINE FOR THE POLK COUNTY MEDICAL SOCIETY



PCMS Summer Social Event

Obstructive Sleep Apnea and Asthma

Breast Cancer

REMEMBERING THE BIG 4 NONVERBALS

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THE POLK COUNTY MEDICAL SOCIETY

Official Publication of the Polk County Medical Society

VOLUME 91 No. 4

Des Moines, Iowa
July/August 2019

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Bulletin

MEMBER MAGAZINE FOR THE POLK COUNTY MEDICAL SOCIETY

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Feature Articles

Monthly Articles

Articles and editorial inquiries should be directed to:
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TAKING CARE OF OUR
Medical Profession in Iowa

By: Doug Massop, M.D.

Dear Colleagues,

In the last Bulletin, I talked about physicians being leaders in caring for Mother Earth. I continue to feel this is one of the most important issues of our time. We, as professionals, need to continue to be advocates for the health of our environment. We need to challenge our patients, our peers and political leaders to make this a high-level priority for the generations to come.

We live in a wonderful community here in central Iowa that is consistently getting National Level accolades. This is made possible by the citizens of the community at large, businesses and their leaders, the greater Des Moines Partnership and a whole host of other individuals and groups that contribute to "the good life" in Iowa.

We need to strive to make our metro a beautiful place to attract young talented physicians to our respective practices. This is particularly challenging in Iowa since most training programs are in large urban centers outside our immediate microcosm.

Fortunately, the residency training programs we have here throughout Iowa are strong and many of the trainees do stay here in Iowa. Recruitment of young physicians continues to be a challenge and will become more difficult with time. The American Association of Medical

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Colleges predicts that the country will be severely short of physicians by 2030 (somewhere between 40,000 to 105,000 by then).

I had recent conversation with a couple of young physician trainees considering coming to Iowa. One of their significant concerns was whether we had undergone some effective level of tort reform. I have growing concern about the increasing number of large malpractice settlements here in Iowa—there are now several over 10 million dollars.

The costs of malpractice claims, both direct and indirect, takes a large toll both on the caregivers (physician, clinics, and hospitals) involved and the insurers who support them. Further, when those dollars are consumed with inflated settlements, the cost of practice and the ability to support the community with growth of quality facilities and charitable activity by all is challenged.

I have read with great interest the saga of tort reform in Texas. The statistics in the 1990s are unbelievable. At that time, one out of four physicians EVERY YEAR had a malpractice claim filed against them. The good new is that well over 85% of these claims failed to reach a courtroom, but the average defense costs were on average over $50,000 per case.

The result of this was that by 2003, the number of malpractice insurers decreased from 17 to 4, premiums were increasing yearly at over double-digit rates, Texas had the lowest number of physicians per capita of any state in the country (100 counties with no pediatricians and 154 counties with no obstetricians).

Finally, Governor Rick Perry declared this to be a state of emergency in Texas. Several common-sense reforms were written into HB4 and passed and enacted. This bill was described by "The Wall Street Journal" as a "model bill" for many states to consider.

The main reforms included:

- **Noneconomic damages should be capped at $250,000 for any and all doctors with an additional cap of $250,000 for each of up to two medical institutions.**

- **A medical report written by a physician within the same or similar field as the physician being sued will be submitted**

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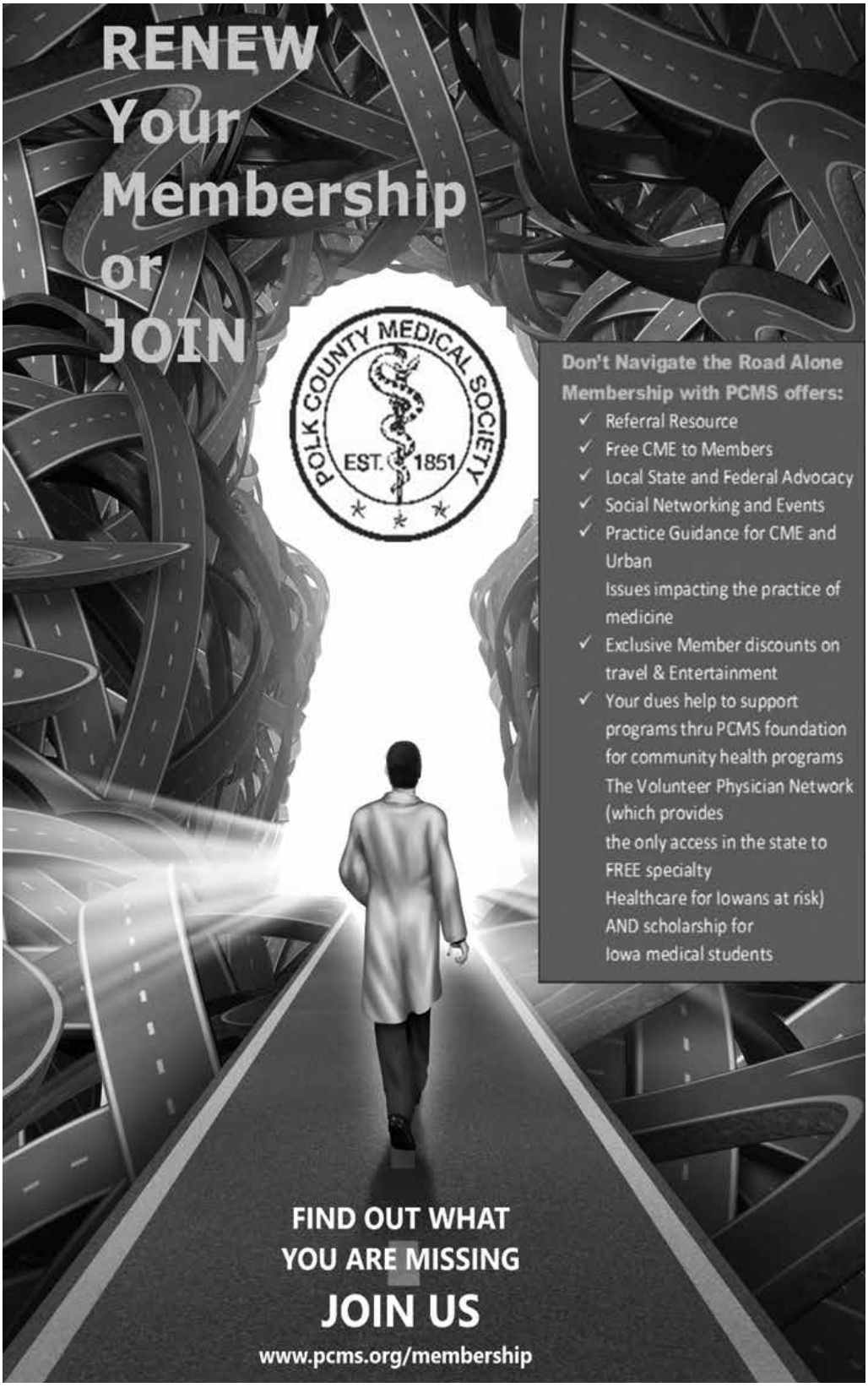
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within 120 days of the filing of the lawsuit, clearly identifying the appropriate standard of care, how it was violated, and the damage that resulted.

- **Juries should hear more evidence about who may really be at fault.**
- **Only those individuals who cause harm should pay and then only to the extent of their own fault.**
- **Damages should be limited to what the plaintiff paid or incurred or what someone paid on their behalf, thereby limiting "phantom damages."**
- **Other procedural and substantive devices, such as forum shopping, used to tilt scales of justice would be eliminated.**

The net result over the next several years was that there was a 60 percent decrease in the number of claims and a 30 percent decrease in the payout per claim settled. Even the president of the Texas Trial Lawyers at the time was quoted as saying that probably one half to two-thirds of cases should probably have never been filed.

The important downstream effect of this was that over the next 10 years: the number of physicians in the state approximately doubled, malpractice insurance costs went down, and more patients had access to timely care.

I think the time is now to contact your state level representatives and senators to encourage them to again consider this legislation that was nearly passed her in Iowa a few years ago. The whole state needs to realize that this is important not just for fair treatment of physicians and healthcare providers but also for the overall health of the state, in terms of recruitment and maintenance of services.

Please use the listings below to make your voices heard!
https://www.legis.iowa.gov/

All the best,
Doug Massop MD
PCMS President
Ref: www.heritage.org/research/reports/2013/07/ten-years-of-tort-reform-in-Texas-a-review

FOSTER GROUP

Money and Emotions

BRITTANY HEARD, CFP®, CKA®, *Lead Advisor*

It has been said that death and taxes are the two certainties in life, but I would argue there are many more! Here are two additional and seemingly unrelated certainties: you will spend money and you will experience emotion. Research reveals that 90% of money decisions are made strictly emotionally (The Emotional Aspect of Sound Money Decisions, Rick Kahler, kahlerfinancial.com).

Most of us make emotional money decisions based on our money scripts, an underlying assumption or belief about money that is only partially true. These scripts are developed in childhood and are unconsciously followed throughout adulthood. Usually, our money scripts are based on a series of powerful events associated with money early in life and are passed down from generation to generation. These money scripts shape our financial behaviors and most of us have one or more money script we can associate with (Financial Therapy: Theory, Research, and Practice, Klontz, Britt, and Archuleta).

Money Avoidance is when a person avoids dealing with money and often rejects personal responsibility for financial health. He may blame others or believe money is bad. This person often labels the wealthy as greedy and could respond by either underspending, overspending, or giving money away.

A person with the **Money Worship** script believes more money equals more happiness. Her needs are never met, and she always believes another item can improve happiness. She focuses on earning, saving, or spending and often spends money to show love. This belief about money could lead to hoarding or workaholism.

Money Status is when a person associates self-worth to net-worth. He relates money to a socioeconomic class and always needs to own the newest big-ticket item to display wealth to others. He may be interested in gambling to increase net worth could become a workaholic. This person tends to overspend and take excessive risk.

Money Vigilance is when a person is watchful, alert, and concerned about her finances. normally pays off credit card balances monthly and thinks that saving is important. She may suffer excessive wariness and anxiety around money and can be distrustful of others. This person does not want handouts and could potentially suffer from workaholism.

You likely associate with one or more of these money scripts. The first step to managing emotions in financial decisions is to understand the script or story you are telling yourself about money. Was there a significant event in your childhood relating to money? What thoughts and feelings did your parents have about money?

If you would like to know more about your money scripts and the emotions impacting your financial decisions, an advisor can often help you identify these, consider how they affect your financial life, and think more objectively.

Congratulations to Hijinio Carreon, D.O. who was named interim chief medical officer (CMO) at MercyOne Des Moines and West Des Moines medical centers.

Dr. Carreon joined MercyOne in 2007 and served as co-medical director of the department of emergency medicine, at MercyOne Des Moines and West Des Moines and CMO of MercyOne Newton Medical Center.

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Screening Indications for Obstructive Sleep Apnea *in Difficult to Control Asthma*

By: Fadi Alkhatib, D.O.

Obstructive sleep apnea (OSA) is a condition with upper airway obstruction that causes apneas (brief period of breathing cessation) and hypopneas (marked reduction in airflow) episodes during sleep. OSA is associated with multiple physiologic processes that effect both respiratory and cardiovascular diseases including vascular disease, hypertension, pulmonary HTN, congestive heart failure (CHF), asthma, COPD, and GERD.

One recent association of study is is asthma's relationship to OSA that is often comorbid in a significant number of patients. It has been noted in multiple prior studies that symptoms of asthma improve with treatment of OSA regardless of the asthma severity.

Recent evidence has shown that OSA may be an independent predictor for difficult to treat asthma and controlling OSA might prove to be beneficial for the patient with difficult to treat Asthma. This review article discusses the association between asthma and OSA, as well as the impact of CPAP on asthma symptoms.

The prevalence of OSA has been on the rise for the past decade. This is partially due to informed physicians testing patients for OSA and mostly due to increasing obesity in the USA. More than one third of Americans (34.9%) are obese, an increase from 30.5% in 2000, with obesity defined as BMI of 30 or greater from National Health and Nutrition Examination Survey (Cynthia L. 2014 JAMA). OSA is 10 times more prevalent in patients with BMI >40. Patients noted to have symptoms of OSA including snoring, waking with gasping or choking, excessive daytime sleepiness or observation of sleep cessation during sleep should be referred for a sleep study.

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Similarly, the number of patients with asthma has also been rising. Asthma affects 25 million, with 70% being adults (NCHS data 2012). According to Center of Disease Control, 8% of adults have asthma with 14 million office visits for asthma related diagnosis, while 1.8 million emergency visits for asthma as primary diagnosis occurs annually.

The association between OSA and asthma has been well established with multiple studies showing increased risk of asthma in patients with OSA. Asthma diagnosis was noted to be up to 39% in a cross-sectional study for OSA patients. The risk for developing OSA seem to be doubled in asthmatic compared to non-asthmatic patients in a recently published cross sectional study.

Population based studies to determine the prevalence of OSA in asthma patients have not been conducted. However, a recent observational and prospective clinical population study found that the risk of OSA in asthmatic is about 28% to 39%. In addition; OSA is an important comorbid condition in patients with uncontrolled asthma. Patients with uncontrolled asthma have higher prevalence of OSA.
In a prospective study of 80 patients with difficult to control asthma, OSA was found to be a major independent factor regardless of GERD, nasal disease including obstructive rhinitis and obesity. Patients with asthma and high risk OSA were 3 times more likely to have difficult to treat asthma than those with low risk for OSA.

Asthma and OSA share common factors that influence them, such as systemic inflammation, obesity, GERD, severe nasal obstruction, and rhinitis. It has been described that both disease entities affect each other through varies mechanisms.

Potential mechanism for OSA worsening asthma include neural stimulation and refluxes through pressure build up, increasing vagal tone during apnea episodes, increased bronchial hyperresponsiveness as a results of increased chronic systemic inflammatory cytokines from repeated hypoxia, and increased leptin production from increased obesity. Potential mechanism for asthma worsening OSA include reducing the cross section area of the upper airway during asthma attacks as well as through chronic steroid use. Other factors aggravating asthma that indirectly worsens OSA includes; rhinitis, GERD and obesity.

The impact of using CPAP on asthma symptoms:

Since both diseases are related and affect each other, it is expected that treating one might prove beneficial to the other. Multiple small studies have examined the effect of CPAP on asthma symptoms prospectively. Nocturnal CPAP use has been shown to decrease nighttime symptoms of asthma patient. It has also been shown to decrease daytime symptoms in a prospective cross-sectional study by Teodorescu et al 2013. However; this study failed to show improvement of nighttime symptoms that the previous studies showed.

Does asthma severity matter?
We have noted that using CPAP has positive effect on patients with OSA and asthma as it decreases the night and daytime

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symptoms discussed above. Patients with difficult to treat asthma possess a unique challenge as many exacerbating factors could be contributing to their control of symptoms.

Identifying the patient that would benefit from CPAP would be significantly beneficial in improving their quality of life. A study of 16 patients who had nocturnal symptoms despite maximum medical management with OSA were studied using CPAP for 2 months. There was no change in PFT before or after CPAP use, However there was significant improvement of nighttime asthma symptoms and improved quality of life.

In a larger cohort of patients examining the association of OSA risk with asthma control in adults, patients with the highest OSA risk were significantly associated with uncontrolled asthma independent of known asthma aggravators. These results were even more prominent when examined for older adults >65 years of age, with OSA being the only diagnosis strongly associated with severe asthma. Treating OSA helped reduce the likelihood of severe asthma more in the older adult than in the younger asthmatic population.

In conclusion, multiple studies have been done pertaining to CPAP use in patients with OSA and asthma showing improvement in symptom control. However, the effect of CPAP on bronchial hyperresponsiveness with methacholine challenge test has been inconsistent.

In addition, the use of CPAP has been shown to induce hyperresponsiveness in non-asthmatic and should be used vigilantly. Most of these studies were small in number. Even in the large cohort studies data collection was through chart review for CPAP use, and many confounders could play a role in finding a differences in asthma control.

Confounders like patient compliance with treatment and behavioral habits might play a role for the difference found. A more compliant patient with CPAP would probably be more compliant with medication and certain behavioral habits reducing their exacerbation and improved control of their symptoms. Thus, more large studies are needed to investigate the benefit of CPAP in patients with difficult to control asthma and its long-term effect.

Dr. Alkhatib is joining Ahmad Al-Shash, M.D. at the Allergy Institute in West Des Moines, as their newest medical provider.

PCMS SOCIAL *Summer Event 2019*

The PCMS/Foster Group co-sponsored the third annual social summer event for PCMS members and guests at Juniper Moon Conversation Lounge, on August 7, 2019. All came out to enjoy conversation and collegiality with colleagues and staff of PCMS and our long-time sponsoring partners The Foster Group.

The weather was beautiful and a full kick off celebration to start the upcoming Iowa State Fair was well attended by almost 100 PCMS members and guests. If you haven't had an opportunity to join in this fun event every year, please make on your calendar to save the date for August 6, 2020!

L-R: Steven Halm, D.O. the new Dean of the Osteopathic College at Des Moines University discusses strategic vision with PCMS President Doug Massop, M.D.

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L-R: PCMS Members Craig Mahoney, M.D., Michelle Mahoney, Dana Wortman and Will Wortman, M.D., reacquaint as family and friends.

L-R: Jason Brown, Tom Benzoni, D.O., Noreen O'Shea, D.O., and Mark Stadtlander talk about the benefits of PCMS Social Events.

L-R: Christy Benson, D.O. and Dermot Noonan share a laugh together.

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Members of PCMS and guests enjoy the social surroundings of Juniper Moon.

L-R: Reed Rinderknecht and Craig Mahoney, M.D. stop for a photo during the event.

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L-R: Michelle Mahoney, Kate Massop, M.D., and Noreen O'Shea, D.O. share a moment celebrating women in medicine.

PCMS Sponsor discussions at the event with all members and guests.

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PCMS Staff Members and guests enjoy great weather and a fun evening together.

L-R: Christy Benson, M.D. and Alex Batani discuss upcoming Iowa State Fair.

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L-R: Evelyn Mintzer and Albert Mintzer, M.D. enjoy food from Gusto and specialty drinks at the event.

L-R: Bret Ripley, D.O., Marti Dowie, Mark Stadtlander, and Mitsi Lizer share a moment together.

L-R: Ethel Condon, M.D., Janie Hendricks, D.O. and Marcus Miller love the charcuterie.

BREAST CANCER *in Younger Women*

By: Carlos Alarson, M.D., M.P.H.

Breast cancer is the most common cancer in women and the second-leading cause of cancer death for women in the United States. Breast cancer is also the most common cancer diagnosed in women ages 15 to 39. In younger women, breast cancer tends to be diagnosed in its later stages, and is often more aggressive. Young women are more likely to have metastatic breast cancer at the time of initial diagnosis and are at higher risk for metastatic recurrence.

Because mammograms are not recommended for women under 40 with average risk, it is important to increase women's knowledge of breast self-awareness; the importance of early detection and healthy behaviors and; understanding breast cancer risks.

Some young women are at a higher risk of getting breast cancer at an early age compared with other women their age. Your patients may have a higher risk for breast cancer if they:

- Have close relatives who were diagnosed with breast cancer before the age of 45 or ovarian cancer at any age.

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- Have certain breast cancer genes (BRCA1 and BRCA2), or have close relatives with these genes.
- Are of Ashkenazi Jewish heritage.
- Were treated with radiation therapy to the breast or chest in childhood or early adulthood.
- Have dense breasts.
- Had breast cancer or certain other breast health problems, such as lobular carcinoma in situ (LCIS), ductal carcinoma in situ (DCIS), atypical ductal hyperplasia, or atypical lobular hyperplasia.

Clinical breast exams are an important part of early detection. The National Comprehensive Cancer Network (NCCN) recommends women start having clinical breast exams at age 25 and continue after they begin having mammograms.

The American College of Obstetricians and Gynecologists (ACOG) continues to encourage clinical breast exams annually for women over age 19.

Clinical breast exams offer an opportunity to discuss the importance of breast self-awareness with patients and identify breast lumps and/or other changes for further evaluation.

Clinical breast exams, as performed by a trained healthcare provider, check for lumps, physical changes and other abnormalities that need to be further examined with testing and imaging such as a diagnostic mammogram.

Clinical breast exams are a relatively noninvasive service that can find enough evidence of abnormal tissue to seek imaging and detect cancers in women who would not yet receive mammography routinely. Radiologists also use information from a provider's clinical breast exam to focus diagnostic imaging on the specific areas of concern.

The clinical breast exam is also an opportunity to explain to women the importance of knowing how their own breasts normally look and feel.

Women, especially young women, should be very familiar with how their breasts look and feel so they are readily able to identify changes. Encourage your female patients to report any breast changes to a health care provider immediately.

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REMEMBERING THE BIG FOUR NONVERBALS

By: Steven J. Halm, D.O.

I am privileged to have been invited to join Des Moines University's College of Osteopathic Medicine, and I have been reinforcing a message with our medical students that I learned in my medical journey. This message also aligns with our University's mission, "to improve lives in our global community by educating diverse groups of highly competent and compassionate health professionals."

I am referring to four principles of nonverbal interaction we can have with patients and other people from all walks of society. These are nonverbal actions that I use with patients and others I meet with in any setting to help set the foundation of compassion that can build strong relationships and trust. They are reminders of the value of humanism in our professional calling.

1. **Smile appropriately.** There is nothing more infectious and refreshing than engaging with someone who is genuinely positive and happy to be in our presence. The smile must be appropriate to the moment, but it will make all the difference in the moment.
2. **Make eye contact.** Too often, I've noticed care givers engrossed in the electronic health record or heart monitor. Those are important actions, but never forget to keep the patient engaged and making sure they understand what you are doing and saying. Eye contact shows interest and care.
3. **Shake hands.** Of course, in some cultures a handshake is taboo, so we must be sensitive and understand the patient's background. But, when appropriate, a sensitive handshake, either firm or gentle, permits important contact and engenders a sense of compassion and interest.
4. **Listen actively.** Sir William Osler, often called the father of modern medicine, one of the four founding professors of Johns Hopkins Hospital and the first to bring medical students out of the lecture hall for bedside clinical training, once said, "Listen to your patient; he is telling you the diagnosis." In most cases, how the patient describes their condition and history contains the information for us to form an accurate diagnosis. Careful listening leads us to the proper tests for validation if needed.

Certainly, the world of medicine continues to evolve with new technologies, advanced techniques and therapies at an ever-accelerating pace. But, in the process of this vital evolution, there is also growing literature underscoring the importance of maintaining humanistic qualities within our science-based profession. Truly connecting with patients allows us to establish the trust that is vital to the most effective patient care. Compassion is a universal quality; it is what makes us human. It is what makes us excellent care providers.

As the population in our region, and Polk County in particular, continues to grow increasingly diverse, we may be challenged on how to interact with patients. And, while we might not be able to apply all of the big four nonverbal actions in every case, we can nonetheless show our interest and care by engaging genuinely with fellow human beings.

Steven J. Halm, DO, FAAP, FACP is the Dean of the College of Osteopathic Medicine, Des Moines University.

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Breastcancer.org offers a neighborhood model to help women better distinguish what's normal in different areas of their breasts. Women can think of the breast as having different 'neighborhoods' that may feel differently. The upper, outer area, which is near the armpit tends to have the most prominent lumps and bumps. The lower half of the breast can feel like a sandy or pebbly beach. The area under the nipple can feel like a collection of large grains. Another part might feel like a lumpy bowl of oatmeal.

This neighborhood analogy is a helpful way for patients to know what's normal in different parts of their breasts and to be better prepared to notice breast changes. Is there a rock on the beach that isn't normally there? Has one breast changed in size or shape? Is there pain in one spot that doesn't go away? Is there pulling at the nipple or other parts of the breast? Is there swelling, warmth, redness or darkening of the breast? Does the area that used to feel like oatmeal have a hard lump in the middle now?

Breastcancer.org also suggests that patients keep a journal where normal findings are written down. This journal can be like a small map of their breasts, with notes about what they see or feel in the different neighborhoods in their breasts.

Especially as young women begin to pay attention to how their breasts look and feel, a journal may help your patients document and remember what is normal for their breasts and notice changes more readily.

The Susan G. Komen website at https://ww5.komen.org/BreastCancer/WarningSigns.html provides a list of breast cancer warning signs that women should know. Not all warning signs of breast cancer will be the same for all women, which is why women should know their own normal and report changes in their breasts to their provider.

Make sure to educate your patients that if they notice a change in their breast or breast health that they should inform a health care provider right away. Women can help to lower their risk of breast cancer by taking care of their overall health. To reduce breast cancer risks, the CDC recommends that women:

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- Keep a healthy weight
- Exercise regularly, at least four hours a week
- Don't drink alcohol or limit alcoholic drinks to no more than one per day
- Avoid exposure to chemicals that can cause cancer (carcinogens)
- Breastfeed
- Discuss the risk and best options for oral contraceptives or hormone replacement therapy with a provider

For additional information on clinical breast exams and breast health education, please visit these websites:

1. https://www.nccn.org
2. https://ww5.komen.org
3. www.cdc.gov
4. http://www.breastcancer.org/

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Colletier, Philip J., M.D.

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Gehrke, Jon C., M.D.

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Mintzer , Albert J., M.D.

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Poudyal, Shardul, M.D.

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Trible, John, M.D.

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Paul, Robert K., M.D.

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Polk County Medical Society wants to know what's new! Have you been appointed to a board, received an award, volunteered for a medical mission? Email us at pcms@pcms.org.

What's new: _____

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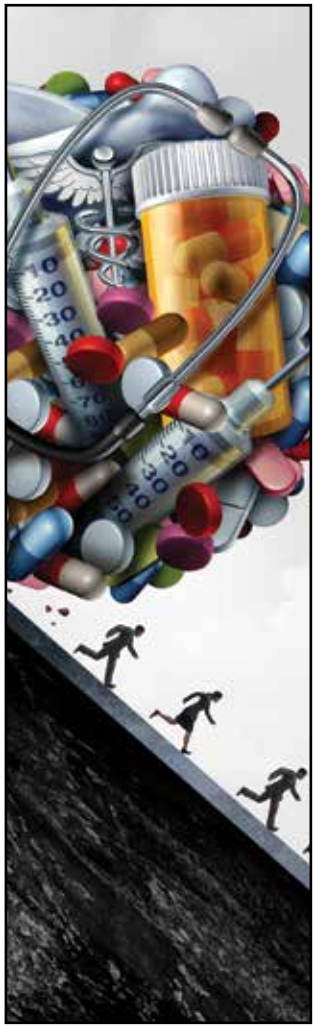

Bulletin

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