

The Consult

Summer 2011

Directory

Physician's Name	Suite #	Practice Name
Aymond, James K., M.D.	Suite 200	Orthopaedic Specialists of Charleston
Bariatric & Metabolic Services	Suite 208	Bariatric and Metabolic Services
Boatwright, H. Wade, MD	Suite 304	Coastal Gynecology and Obstetrics
Caldwell, Kenneth M., M.D.	Suite 200	Orthopaedic Specialists of Charleston
Cheek, DeAnna E., MD	Suite 307	Palmetto Kidney & Hypertension
Dennis, William A., M.D.	Suite 306	William A. Dennis, M.D.
Hong, Charles, M.D.	Suite 205	Carolina Kidney & Hypertension
John, Egie, M.D.	Suite 205	Pulmonary Diseases Care, PA
John M. J., M.D.	Suite 200	Orthopaedic Specialists of Charleston
John K., M.D.	Suite 205	Pulmonary Diseases Care, PA
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Inside:

The Business of Medicine

Benefits of Cancer Center Accreditation

A Safer Route to the Heart

ROPER
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HEALTHCARE

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RSFH

LEADERSHIP

Dear Colleagues,

The practice of medicine has always been dynamic. Our understanding of human biology and treatment of disease changes as science, research and technology evolve. Yet other factors also impact how we practice the art and science of medicine, namely cultural trends, population shifts and changing economic realities.



In this issue of *The Consult*, we examine how Roper St. Francis Healthcare is positioned within the new medical landscape, why we as a leading health system have embraced physician employment, and the pros and cons of this trend from a physician's perspective. We welcome your feedback on this important topic and hope these articles might lead to creative and useful dialogue on how Roper St. Francis can continue to deliver the best possible care in an increasingly challenging market.

As always, *The Consult* also brings you updates on new procedures, research and protocols at Roper St. Francis that may be beneficial to you and your patients. In this issue, we also highlight radial catheterization and our accredited cancer center. I welcome your input and feedback for topics for future issues.

A handwritten signature in black ink that reads "Steven D. Shapiro M.D." The signature is written in a cursive, professional style.

Steven Shapiro, MD
VP of Medical Affairs
steven.shapiro@rsfh.com



The Business of Medicine

The Trend Toward Physician Employment



By Douglas Bowling
CEO, Roper St. Francis Physician Partners
VP and Chief Strategy Officer for Roper St. Francis Healthcare

If there is one word that sums up why many physicians are seeking the sanctuary of employment by a healthcare system, it is complexity. We are generations away from the era when a physician evaluated and treated a patient, sent a bill to one of a half dozen insurance companies and could expect payment in reasonably short order. Today, doctors must contract with dozens of payers, each with different requirements, levels of payment and restrictions.

The business side of practicing medicine has become incredibly complex and fraught with legal pitfalls and risks. Further concerns and restrictions loom on the horizon as practices are faced with new “meaningful use” requirements related to information technology and the government’s use of Recovery Audit Contractors in order to recapture alleged inappropriate Medicare payments.

This continually increasing complexity, coupled with the physician’s desire to stabilize personal income while focusing more on treating patients and less on business issues, is driving a national trend toward employment and away from independent private practice. At a recent business development conference of the top 50 not-for-profit healthcare systems in the nation, members

predecessors were at the outset of their careers. Further, to hire a successor into the practice can seriously and negatively impact the incumbent physicians’ incomes at a time they can least afford it, just ahead of retirement. Growing a practice also presents financial challenges. In the past, when the existing doctors in a practice decided they were just too busy and needed to add a partner, they took it on the chin, recognizing that their own income would suffer for a period of time as the new partner grew a practice. With declining reimbursement and increased expenses, this solution to practice growth is becoming impractical.

The reasons hospitals and healthcare systems have returned to employing physicians are much different. From the late 1980s through

At a recent business development conference, 47 of the nation’s top 50 not-for-profit healthcare systems indicated physician employment was a priority.

were asked, “Who of you are actively employing physicians as part of your growth strategy?” Forty-seven of the 50 systems indicated physician employment was a priority.

Other physician concerns also play a role. One of the significant issues across our region is low reimbursement. The Charleston area has historically had one of the lowest reimbursement rates for physician services in the Southeast, due largely to the tendency for area physicians to practice in small groups that have little or no negotiating clout with the large insurance companies. The result is that private practicing physicians in Charleston receive as much as 50% less for the same service as their counterparts in the Upstate and North Carolina.

Another factor is the significant number of Baby Boomer physicians now approaching retirement, which makes succession planning for the practice a serious economic concern. Few recent medical school graduates have a desire to buy into or earn their way into an established private practice. Most are more interested in a guaranteed paycheck and a balanced lifestyle than their

the mid ‘90s, many hospitals employed physicians with, in many cases, disastrous results. Misaligned incentives and unreal financial expectations resulted in resentment, mistrust and ultimately the unwinding of most arrangements. A few systems decided to restructure their arrangements with physicians rather than unwind and have prospered as a result. The most notable in our region is Carolinas Health System (CHS), based in Charlotte. As a managing, founding member of the Roper St. Francis Healthcare System, CHS now employs more than 1,200 physicians in North and South Carolina. It has helped them gain and maintain the position of market share leader in their area.

The protection of market share is one of two main reasons healthcare systems are trying to better align with physicians through employment. Market share protection includes the healthcare system’s ability to retain key physicians, recruit new physicians in order to grow existing practices, establish practices in new geographic areas and develop new programs and clinical services.

The healthcare system's desire to hardwire quality improvement also drives the employment model. It is difficult to ask private practicing physicians to participate in difficult and time consuming quality improvement initiatives that take them out of the office or operating room. Under an employment model, a doctor can be compensated not only for productivity but also for participation and achievement in quality measures. In looking at the future of healthcare, it is clear that physicians and hospitals are going to be compensated by a method that recognizes outcomes more than it does volume. It is critical that the healthcare system put in place a structure with strong physician participation that

enables us to continue to excel in quality improvement and reward physicians for their effort.

Not all physicians will move toward the employment mode, and it is probably best for the healthcare system that they not. Certain subspecialties and practice sites maintain an advantage by remaining independent, and the healthcare system ultimately benefits from their independence by reaching a broader base of patients. Physicians will have to conduct a careful analysis of their practice and patient population in order to determine if employment or independence best suits their needs.

Success of the Patient-Centered, Private Primary Care Practice



By Hugh Durrence, MD

"A quiet revolution is transforming how medical care is delivered in this country, and it has very little to do with the sweeping healthcare legislation that President Obama just signed into law." – New York Times, 2010

Depending on whom you ask these days, physicians like me represent either a dying breed or a growing trend. It has become increasingly difficult for an independent physician practice to succeed financially and more and more physicians are opting to give up autonomy and become employed by hospitals. On the other end of the spectrum, "concierge" physicians are rejecting interaction with health insurance companies so they may be "unencumbered by insurance company policies, provider-network constraints, and the misaligned incentives that have infected our healthcare system," according to the American Academy of Private Physicians (AAPP.org).

As a private practice primary care physician in Charleston, SC, I have gained an appreciation for the rewards and benefits of being a small, independent practitioner, and learned that bigger isn't always better for me, my staff or my patients. As a small business owner, I recognize that practice efficiency, employee morale and the

ability to provide personal service and care to my patients goes a long way toward ensuring financial success and personal job satisfaction. Though the private practice model has become more challenging in the current healthcare business environment, I believe the challenge is worth the reward. There are three major reasons why this model continues to work best for me in delivering quality patient care and reducing healthcare costs.

First, my primary goal is to keep my patients healthy, and ideally, out of the hospital. Hospital systems rely on practice referrals and inpatient admissions to meet financial benchmarks. While the healthcare system's and private physician's goals are not necessarily at cross purposes, I prefer to treat my patients without the added stress of knowing that my practice could represent a financial loss to my employer. Until the financial incentives of the health system are aligned with my patient's, I will remain independent.

In addition, I have the flexibility and independence to make business decisions and implement office policies that are in the best interest of my patients and employees and result in improved efficiency and patient satisfaction.

Second, my patients benefit from the continuity of care and increased efficiency I am able to provide. In my experience as an independent physician, my patients are more involved in the decisions regarding their treatment. This joint effort increases the quality of care by putting the decision back in the hands of the patient and the physician. According to a March 2010 *New York Times* story by Gardner Harris, "A patient who chooses a doctor in private practice is more likely to see that same doctor during each office visit than a patient who chooses a doctor employed by a health system." Maintaining a single point of contact for patients reduces duplication, thereby improving efficiency, safety and satisfaction.

Third, Health Information Technology (HIT) has enabled all physicians to offer their patients the benefits of better coordinated, high quality care. When Congress passed the economic stimulus plan early last year, \$20 billion was included to spur the introduction of electronic health records and help make this technology more affordable. Private practice physicians are able to implement these systems without joining a large health system. Newer HIT systems allow patient records to pass seamlessly from doctor to specialist to hospital, helping improve safety and efficacy and hopefully reduce system costs.

As more and more physicians adopt these systems, we will have to work with policymakers to ensure we preserve the physician-patient relationship. Electronic prescribing will have to be designed to allow us to promote the highest quality of care, with the right dose to the right patient at the right time. This is a crossroads that can revolutionize healthcare delivery in South Carolina, and it is crucial that medical decisions remain in the doctors' hands.

Announcing RSFH Physician Partners Affiliate Program

A new opportunity is now being offered for active and community-active physicians on the Roper St. Francis Healthcare medical staff who do not wish to be employed but would like a more formal affiliation with Roper St. Francis Physician Partners (RSFPP).

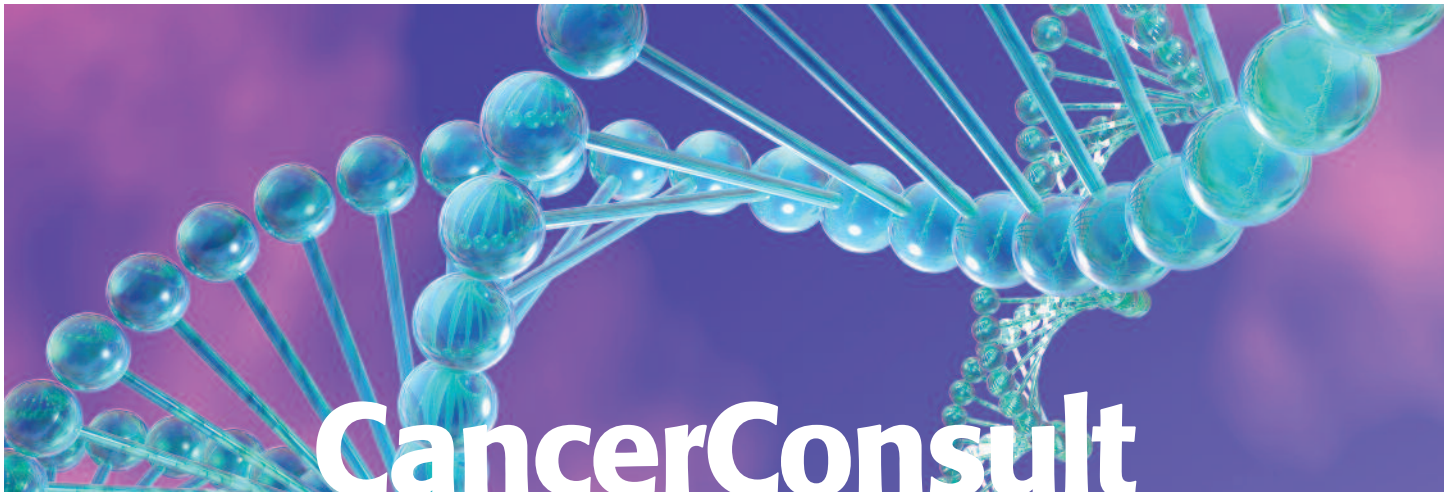
Roper St. Francis Healthcare is now accepting applications for its new Physician Partners Affiliates program.

RSFPP Affiliate status was developed with the aim of improving continuity of healthcare services, providing better access to those services, improving clinical quality and ensuring a higher level of satisfaction for physicians and patients.

The new distinction will offer an array of benefits including, but not limited to:

- Affiliation with RSF Physician Partners
- Invitation to become part of the Coastal Choice, a local insurance solution that can benefit Lowcountry employers and providers through the use of an exclusive network encompassing all Roper St. Francis facilities
- Additional benefits, such as malpractice insurance, are being explored

Applications are available online at www.rsfh.com/affiliates.



The Significance of Being an Accredited Cancer Center

At present, the number of cancer centers accredited by the Commission on Cancer (CoC) of the American College of Surgeons is just short of 1,500 throughout the United States and Puerto Rico, which represents between 25% and 30% of hospital programs. Accreditation is granted only to those facilities that have voluntarily committed to provide the best in cancer diagnosis and treatment and comply with high CoC standards.

Roper St. Francis Cancer Care (RSFCC) has been accredited since 1995 and continues to hold the designation of an Accredited Comprehensive Community Cancer Program, with consistent commendations in many areas of performance. RSFCC is well positioned to be awarded the highest recognition from the Commission on Cancer at our next survey in July 2011.

According to Robert Flanigan, MD, FACS, vice chair of the CoC accreditation committee, accredited programs tend to be the dominant facilities in their region. The CoC's standards promote the best quality of care, which begins with a comprehensive multidisciplinary team approach to care, given that the vast majority of cancers (lung, colon, breast, etc.) require multimodal therapy. The CoC has a diverse membership, representing 47 organizations and disciplines that address every potential facet of cancer care that a patient could require.

“Simply put, I feel we are in a better position to take care of our patients because of the steps we have taken as an accredited program.” Scott Broome, FACHE

Hallmarks of Success

RSFCC upholds the five key elements of successful CoC-accredited programs:

1. Clinical services provide state-of-the-art pre-treatment evaluation, staging, treatment and follow-up for cancer patients seen at RSFCC for any phase of care.
2. Our Cancer Committee leads the program through setting goals, monitoring activities, evaluating patient outcomes and improving care.
3. Our regular Cancer Conferences provide a forum for treatment plan development in a multidisciplinary setting and contribute to physician education.
4. A quality-improvement program is the mechanism for evaluating and improving patient outcomes.
5. Our cancer registry and database is instrumental in monitoring the quality of care and measuring outcomes.

Benefits of Accreditation

Accredited institutions have access to the National Cancer Database (NCDB). The database, a joint project of the CoC and the American Cancer Society developed in 1989, is currently the largest cancer database in the world, containing nearly 25 million records from hospital cancer registries across the United States and Puerto Rico. With web-based, password-protected access, accredited cancer programs can use the database to access almost 8.3 million case reports of patients diagnosed between 2000 and 2007. The institution can generate reports showing data reported to the NCDB, aggregated by hospital system, state, region or at the national level. Users can also compare their program data with data from other NCDB user programs to determine performance relative to a number of variables.

Commission-accredited programs can access Comparison Benchmark Reports and other password-protected tools to compare their quality of care and improve performance based on nationally recognized quality measures and standards of care. Survival data are available on 51 cancer sites, allowing institutions to compare their data with other institutions in the same accrediting category for an apples-to-apples comparison. Roper St. Francis Cancer Care publishes a comparative analysis of its data versus state and NCDB datasets for a select tumor site each year, assessing variables such as stage, histology, first course treatment and 5-year overall survival.

Another benefit is data analysis and participation in CoC special studies that are developed to address important issues in cancer care.

“A majority of the care provided to cancer patients in the United States is provided in the non-academic, community hospital setting,” notes Scott Broome, FACHE, service line director for RSF Cancer Care. “It follows that a majority of patients enrolled in clinical trials in the United States are from community hospital cancer programs. As care becomes more targeted and appropriate for the less acute setting, this trend will continue. The CoC process is quite thorough with sufficient rigor to demand excellence from accredited organizations,” Broome notes. “Simply put, I feel we are in a better position to take care of our patients because of the steps we have taken as an accredited program.”

Roper St. Francis Cancer Committee:

Angus Baker, MD.....	<i>Hospice and Palliative Medicine</i>
Paul Baron, MD.....	<i>General Surgery</i>
Amy Bethea, MD.....	<i>Diagnostic Radiology</i>
Charles Bickerstaff, MD.....	<i>Gastroenterology</i>
Walter “Bo” Blessing, MD.....	<i>General Surgery (Community Outreach)</i>
Frank Brescia, MD.....	<i>Hematology/Oncology</i>
William Carter, MD.....	<i>Urology</i>
Elizabeth Christian, MD.....	<i>Hematology/Oncology</i>
Mary Decker, MD.....	<i>Radiation Oncology</i>
Aaron Domm, MD.....	<i>Gastroenterology</i>
David Ellison, MD.....	<i>Hematology/Oncology</i>
George Geils Jr, MD.....	<i>Hematology/Oncology</i>
George Geils Sr, MD.....	<i>Hematology/Oncology</i>
Chris Hawk III, MD.....	<i>General Surgery</i>
Scott Jennings, MD.....	<i>GYN Oncology (Quality Improvement)</i>
Raymond Kaplan, MD.....	<i>Otolaryngology</i>
George Keogh, MD.....	<i>Hematology/Oncology</i>
Elizabeth Kline, MD.....	<i>Thoracic Surgery</i>
Jorge Lagares-Garcia, MD.....	<i>Colorectal Surgery</i>
Heather Newlin, MD.....	<i>Radiation Oncology</i>
David Peterseim, MD.....	<i>Cardiothoracic Surgery</i>
Gene Saylor, MD.....	<i>Hematology/Oncology (CoC Liaison)</i>
Steven Shapiro, MD.....	<i>Medical Genetics</i>
Stanley Wilson, MD.....	<i>General Surgery</i>
Frederick Worsham, MD.....	<i>Pathology (Cancer Registry Data Quality Coordinator)</i>

Research Corner

RSF Cancer Care maintains an active oncology research program. The following clinical trials are open and now enrolling new patients. For more information or to refer a patient, please contact Elizabeth Strojny, RN, at (843) 720-8386.

NSABP P-5 (Colon Cancer Stage I or II)

For a resected colon cancer Stage I or II - A randomized placebo controlled double blind trial of rosuvastatin for the prevention of adenomatous polyps of the colon or rectum, metachronous colorectal carcinoma, and colon cancer recurrence among colon cancer patients treated for cure. Participants will take oral Rosuvastatin 10 mg or placebo daily for 5 years. Patients must have had a surgical resection with curative intent within 1 year prior to randomization and must have completed any adjuvant treatment prior to randomization. Colonoscopy requirements within 180 days prior to randomization and may be either pre-operative or post-operative (documented colonoscopy to cecum or small bowel anastomosis) with all observed polyps removed. Follow up colonoscopies required at 12, 36 and 60 months following randomization. Statin use within 30 days prior to randomization or hyperlipidemia with clinical indication for statin use are conditions for ineligibility.

NSABP FB-7 (Neoadjuvant HER2-Positive Breast Cancer)

Locally advanced HER2-Positive Breast Cancer with Palpable Mass \geq 2cm in breast or axilla or inflammatory breast cancer. To determine the pathologic complete response rate in breast and axillary lymph nodes for patients with HER2-positive locally advanced breast cancer following neoadjuvant therapy. If determined eligible submission of fresh tumor is a requirement for patients with a palpable breast or axillary mass prior to randomization. Participants are randomized to receive either ARM 1 Paclitaxel 80mg/m² IV on Days 1, 8 and 15 every 28 days X 4 cycle plus Trastuzumab IV weekly beginning on Day 1 of Paclitaxel for a total of 16 doses. Followed by AC every 21 days X 4 cycles. Or to ARM 2 Paclitaxel 80mg/m² IV on Days 1, 8 and 15 every 28 days X 4cycles plus Neratinib PO beginning on Day 1 of Paclitaxel continuing through Day 28 of the final Paclitaxel cycle (for a total of 16 weeks). Followed by AC every 21 days X 4 cycles. Participant then proceeds to surgery. Post-operatively all patients will receive Trastuzumab IV every 3 weeks to complete a total of 1 year of targeted therapy. Other post-operative therapy will include radiation therapy if clinically indicated as well as endocrine therapy in patients with ER + and or PR + tumors.

CALGB 40603 (Neoadjuvant Hormone Receptor Poor/HER2 Negative Resectable Breast Cancer)

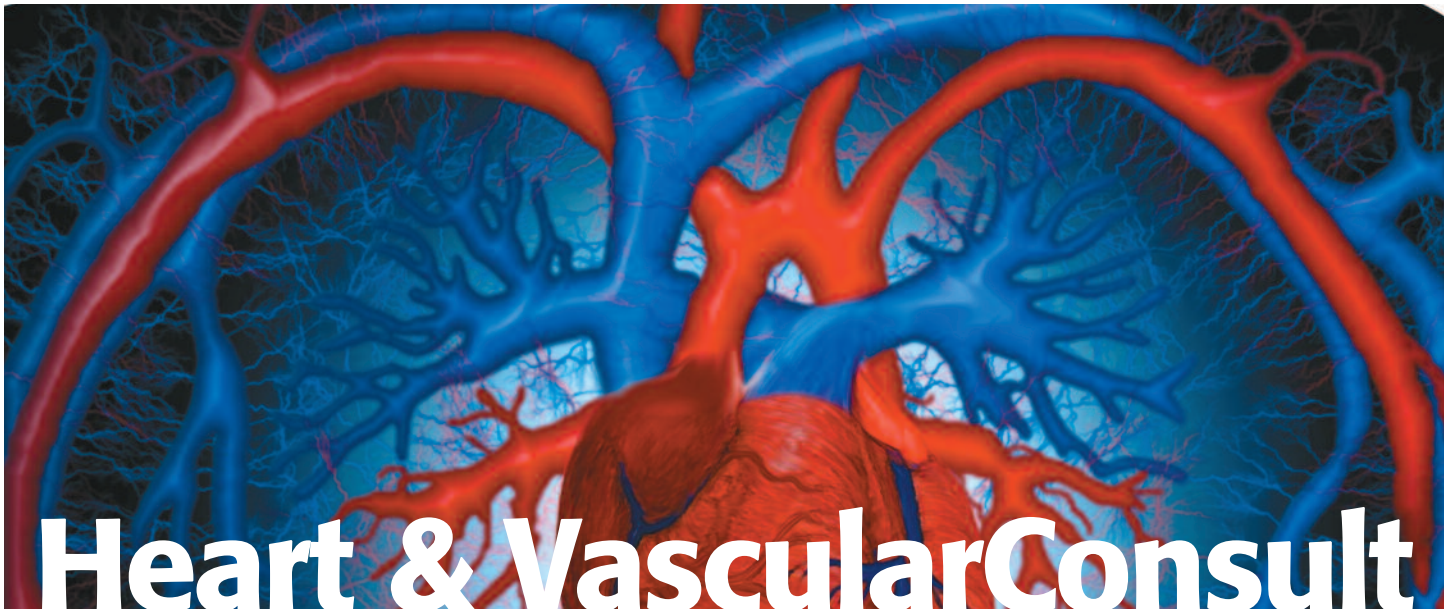
Randomized Phase II 2x2 Factorial Trial of the addition of Carboplatin plus or minus Bevacizumab to neoadjuvant weekly Paclitaxel followed by dose dense AC in hormone receptor poor HER2 Negative Resectable Breast Cancer. The criterion for ER and PR expression is negative or $\leq 10\%$ of invasive cancer by IHC. Clinical Stage II or III invasive breast cancer (measurable disease of target lesion $\geq 1\text{cm}$ either clinically or radiographically) with intent to perform surgical resection after neoadjuvant therapy. Patients with inflammatory breast cancer are not eligible. Patient must agree to undergo pretreatment research biopsies. Patients are randomized to one of four treatment groups: Group 1 - Weekly Paclitaxel X 12 weeks followed by AC every 2 weeks X 4. Group 2 - Weekly Paclitaxel X 12 weeks followed by AC every 2 weeks X 4, Bevacizumab every 2 weeks beginning with Day 1 week 1 of Paclitaxel X 9 *Bevacizumab is not given with the last dose of AC. Group 3 - Weekly Paclitaxel X 12 weeks with Carboplatin every 3 weeks X 4 followed by AC every 2 weeks X 4. Group 4 - Weekly Paclitaxel X 12 weeks with Carboplatin every 3 weeks X 4 followed with AC every 2 weeks X 4, Bevacizumab is given every 2 weeks beginning on Day 1 week 1 of Paclitaxel X 9. Bevacizumab is not given with the last dose of AC. Definitive surgery is to be done between 4 and 8 weeks following completion of neoadjuvant therapy with appropriate management of the axilla unless the patient is now considered inoperable or surgery is medically contraindicated.

CALGB 80701 (Pancreatic Neuroendocrine Tumor)

Randomized Phase II Study of Everolimus versus Everolimus plus Bevacizumab in patients with locally advanced or metastatic Pancreatic Neuroendocrine Tumors. Must have a histologically documented well or moderately differentiated neuroendocrine tumor with evidence of pancreatic as the primary site and is locally unresectable or metastatic with evidence of disease progression within the past 12 months. Patients are randomized to either ARM A: Everolimus 10 mg orally daily plus Octreotide LAR every 4 weeks or to ARM B: Everolimus 10 mg orally daily plus Bevacizumab 10 mg/kg IV every 2 weeks plus Octreotide LAR every 4 weeks. Duration of treatment: continue treatment until unacceptable toxicity, disease progression, or symptomatic tumor progression following one or more cycles.

ECOG E 1505 (Non-Small Cell Lung Cancer)

Stage IB ($\geq 4\text{cm}$) - IIIA Phase III Randomized Trial of Adjuvant Chemotherapy with or without Bevacizumab for patients with completely resected Stage IB ($\geq 4\text{cm}$)- IIIA At the discretion of the investigator all patients will be assigned to one of the four chemotherapy regimens listed and must be determined prior to registration and randomization to the study. Chemotherapy Regimen 1: Vinorelbine 30mg/m² IV push on Days 1 & 8, Cisplatin 75mg/m² IV day 1 immediately following Vinorelbine. Chemotherapy Regimen 2: Docetaxel 75mg /m² IV , Cisplatin 75mg/m² IV Day 1 immediately following Docetaxel Chemotherapy Regimen 3: Gemcitabine 1200mg /m² IV days 1 & 8, Cisplatin 75mg/ m² IV day 1 immediately following Gemcitabine Chemotherapy Regimen 4: (non squamous histology only) Premetrexed 500 mg/m² IV day 1, Cisplatin 75mg/m² day 1 immediately following Premetrexed. Patients are randomized to either ARM A 1 of the 4 chemotherapy regimens (no Bevacizumab) or ARM B 1 of 4 chemotherapy regimens plus Bevacizumab 15 mg/kg. Each cycle is 21 days and chemotherapy will be given for 4 cycles and if assigned to ARM B Bevacizumab will continue for up to 1 year from first day of protocol treatment.



Heart & Vascular Consult

Radial Artery Catheterization: A Safer Route to the Heart



By Troy Bunting, MD, FACC
Coastal Cardiology

One of the most common procedures in cardiology, cardiac catheterization, is getting a new makeover. Cardiac catheterization is a procedure in which coronary angiograms are performed to detect blockages in the coronary arteries during myocardial infarction and stable angina. During a catheterization, stents may be placed in the coronary arteries to restore blood flow to the heart muscle. Traditionally, cardiac catheterization has been performed through accessing the common femoral artery in the groin and threading the wires, catheters, and stents up through the abdominal and thoracic aorta to reach the coronary arteries.

With over one million cardiac catheterizations performed annually in the U.S., a new approach through the radial artery has been developed to provide a safer, more comfortable, and more cost-effective procedure. Multiple studies have shown that a radial approach reduces access complications such as hematomas, pseudoaneurysms and retroperitoneal bleeds; decreases length of hospital stay; are more cost effective; and generally more preferred due to comfort by patients.



Cardiac catheterization through the radial artery was first described by Dr. Lucien Campeau in 1989 and the first angioplasty and coronary artery stents were placed through this approach in 1993 by Dr. Ferdinand Kiemeneij. Cardiologists in the U.S. have been very slow to adopt radial artery catheterization as a preferred approach over the traditional femoral artery approach due to conventional training and reluctance to change. Only eight percent of the cardiac catheterizations in the U.S. are through the radial approach, says Sunil Rao, a leading interventional cardiologist at Duke University. This stands in stark contrast to countries such as France and Japan where radial artery catheterization is performed in 50-70% of cases.

Over the last one to two years, radial artery catheterization is making a major change in cardiac catheterization laboratories as U.S. cardiologists are realizing the benefits of the new technique. At Roper St. Francis, cardiac catheterization has been performed via the radial approach since 2007 and now is dramatically increasing in its usage.

Why the switch?

Traditionally, angioplasty, stenting and diagnostic cardiac catheterization had bulkier sheaths and tubing requiring a large access artery such as the femoral artery. This site required the patient to lie flat quietly for at least 4-6 hours after the sheath was pulled. In obese patients often the access site in the femoral artery was difficult to compress and to stop bleeding it required heavy pressure. Often internal bleeding could occur at the site which was not immediately visible. Advances over the last several years in sheath and catheter technology have enabled the tubing to shrink, thus allowing routine access of smaller arteries such as the radial artery in the wrist. The radial artery is easily compressible with a wrist band device allowing the patient to literally jump off of the catheterization lab table and into a wheel chair where they can be comfortably escorted to their room for rest and a meal.

Bleeding complications from cardiac catheterization is not a benign event and causes an increase in the patient's mortality and recurrent cardiac events. In a study by Dr. Rao, the serious bleeding risk of the traditional femoral approach was 1.8% while the radial artery approach was 0.8% which is a relative risk reduction of 58%. Given the need for multiple anticoagulants during myocardial infarction with emergency stenting and elective stenting, bleeding complications are always a prominent concern among the interventional cardiologist. A minor bleed can extend a hospital stay by an extra 1-2 days costing thousands of extra dollars, while a serious bleed can increase cost by more than \$10,000. Patients at Roper St. Francis who have had both radial and femoral artery catheterization are amazed at the ease and comfort of the radial approach.

Who is eligible?

Almost any patient is eligible for the radial artery catheterization provided they have an intact palmar arch. Prior to radial artery access, a modified Allen's test is performed to access the competency of the palmar arch and the dual arterial supply to the hand by the ulnar and radial artery. If this is intact, then even if the radial artery becomes occluded after the procedure, there will be no clinical significance. Patients who tend to receive most benefit from the procedure are women and the obese, both of whom have increased bleeding risks. Also elderly patients and patients with orthopedic problems benefit from the increased comfort of being able to sit up immediately. Patients who may have their radial arteries harvested for bypass surgery or hemodialysis patients should still have the traditional femoral approach so as to preserve the artery for other usages.

Roper St. Francis is providing radial artery catheterization for eligible patients undergoing cardiac catheterization. State-of-the-art catheters and techniques allow out patients to undergo this procedure in a safer, more comfortable, and more cost-effective method. Radial artery catheterization will eventually be the default method for all cardiac catheterizations in the U.S. and Roper St. Francis is leading in these advances.



Roper St. Francis Mount Pleasant Hospital Offers a Wide Variety of Specialists

The following specialists are now seeing patients at the Medical Office Building at Mount Pleasant Hospital.
3510 Highway 17 North • Mount Pleasant, SC

For more information, call 727-DOCS.

COLORECTAL SURGERY

Jorge Lagares-Garcia, MD

GASTROENTEROLOGY

Jeffrey Joyner, MD
William Marsh, MD
Paul Yantis, MD

GENERAL SURGERY

Chad Eustis, MD

GYN

Elaine Eustis, MD

OB/GYN

Susanne Bradford, MD
Lauri Bullen, MD
Robert Flowers, MD
Kenosha Gleaton, MD
Karen Hallmark, MD
Meghan Lynch, MD
Olumide Mughelli, MD
Eleanor Oakman, MD
Phyllis Rogerson, MD
Delinda Terry, MD

ONCOLOGY/HEMATOLOGY

Aruna Reddy, MD
Robert Wall, MD

ORTHOPEDECS

Kenneth Caldwell, MD
William Carroll III, MD
John MacIlwaine, MD
Robert Schoderbek, MD

OTOLARYNGOLOGY (ENT)

Eugene Brown, RPh, MD
Mark Ghegan, MD
Michael Noone, MD
Matthew Scarlett, MD

PODIATRY

Jeff Armstrong, DPM
John Marino, DPM
Rahn Ravenell, DPM

PLASTIC SURGERY

Seung-Jun O, MD

PULMONOLOGY

Jason Huet, MD
Tal Klatchko, DO

UROLOGY

Jon Donaldson, MD
Stanley Hall, MD
Dennis Kubinski, MD

VASCULAR SURGERY

Thomas Appleby, MD
Edward Morrison, MD
Britt Tonnessen, MD



Roper Rehab Hospital is the only hospital in the Lowcountry to be awarded Adult Inpatient Rehabilitation accreditation.

Roper Rehab Hospital Receives National Commission Awards

Roper Rehabilitation Hospital has again been recognized among the nation's top facilities for stroke specialty and adult inpatient care. The Commission on Accreditation of Rehabilitation Facilities (CARF), a private, not-for-profit organization that promotes quality rehabilitation services internationally, has reaccredited Roper Rehab Hospital for another 3-year period for its Adult Inpatient Rehabilitation Hospital and Stroke Specialty programs. To receive a CARF accreditation, a rehab facility must meet stringent requirements of staff knowledge, operational procedures, safety and effectiveness.

“These accreditations mean that Roper Rehab’s programs meet internationally recognized standards of patient care, and that our patients and their families can be confident of our commitment to quality,” said Matt Severance, CEO of Roper Hospital, home of the Rehabilitation Hospital. Roper Hospital is presently the only hospital in the Lowcountry and one of only six in South Carolina to be awarded the Adult Inpatient Rehabilitation accreditation, and one of only three in the state to be awarded the Stroke Specialty accreditation.

The CARF survey, based on a site visit conducted in December 2010, commended the rehab hospital’s enhanced stroke support group meetings, as well as the hospital’s bed reserve agreement with MUSC, which ensures that Roper Rehabilitation Hospital always has 15 beds available for MUSC patients.

For more information about Roper Rehab Hospital, or to refer a patient, please call (843) 724-2842.

Medical Society of South Carolina

Founded in 1789, the Medical Society of South Carolina is the fourth oldest medical society in existence and has been influential in promoting healthcare excellence for almost 320 years. Its history is long and proud: in 1824, the Medical Society founded the Medical College of South Carolina (known today as the Medical University of South Carolina) for teaching and research, and in 1852, with a bequest from the will of Col. Thomas Roper, the Society established Roper Hospital "to treat all sick and injured people without regard to complexion, religion, or nation," and to serve as a teaching hospital for the Medical College. Today, members of the Medical Society of South Carolina remain dedicated to improving the health of our community through clinical excellence, support and participation in Roper St. Francis Healthcare and other endeavors.

The Medical Society of South Carolina is the majority owner and a founding member of the Roper St. Francis Healthcare System. The Society provides funding for state-of-the-art equipment and other capital needs. These important initiatives positively impact the quality of medical care that Roper St. Francis provides in the community.

Membership in the Society is considered an honor and is open to any physician on the active medical staff of a Roper St. Francis Healthcare facility. An application and two recommendations from Society members are required.

If you would like more information about joining the Medical Society, please call (843) 789-1789.

New Physicians

Roper St. Francis Healthcare welcomes the following board certified physicians to its active medical staff:

Greg Barabell, MD	Pediatrics
Robert Bartlett, MD.....	Anesthesia
Matthew Davis, MD	Pediatrics
Leonard Forest, MD	Physical Medicine and Rehabilitation
Mark Netherton, MD	Pain Management
Nihar Patel, MD	Hospitalist
James Rawls, MD	Anesthesia
Blane Richardson, MD.....	Pain Management



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