Writer’s Needed
Paul Harrison, Executive Director, Wake County Medical Society

Knowledge is Power—and a Healthier NC
By Robert W. Seligon, CEO, North Carolina Medical Society

Project Access of Wake County: A View from a Community Nurse Case Manager
By Pam Carpenter, Project Manager
Project Access of Wake County
By Tara Jaworski, RN, BSN
Community Nurse Case Manager
WakeMed Health & Hospitals

A Heart Doctor in the Heart of Smithsonian Institution
By Assad Meymandi, MD, PhD, DSc (Hon)

Mystique of the Cave Man
By L. Jarrett Barnhill, MD

WCMS New Members

Join WCMS
“Leadership College provided something I could not get anywhere else. Specifically, it put like-minded, forward-thinking people from many walks of medicine together in a room working toward a series of common goals. It opened my eyes to the experiences of different specialties, different practice models and different provider levels.”

Jeremy Pyle, MD - Class of 2012

For more information or to apply to this prestigious program contact Kristina Natt och Dag at TNattochDag@ncmedsoc.org or Erin Grover at EGrover@ncmedsoc.org.

www.ncmedsoc.org/KIPL
Assad Meymandi, MD, PhD, DSc (Hon) is an Adjunct Professor of Psychiatry, University of North Carolina School of Medicine at Chapel Hill, Distinguished Life fellow American Psychiatric Association; Life Member, American Medical Association; Life Member, Southern Medical Association; and Founding Editor and Editor-in-Chief, Wake County Physician Magazine (1995-2012). He serves as a Visiting Scholar and Lecturer on Medicine, the Arts and Humanities at his alma mater the George Washington University School of Medicine.

Robert W. Seligson, CEO North Carolina Medical Society for the last 20 years, Robert W. Seligson has served as Executive Vice President, CEO of the North Carolina Medical Society, the largest and oldest professional association in the state, representing nearly 13,000 physicians and physician assistants throughout North Carolina. He also serves as CEO of the North Carolina Medical Society Foundation, the philanthropic arm of the Medical Society.

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Pam Carpenter, Program Manager, Project Access Wake County attended Los Angeles Harbor College and Loma Linda University where she studied business and nursing. She worked for fifteen years at Fluor Engineers in the Project Management Department and with The Fluor Foundation in Irvine, California. Pam relocated to Raleigh in 1995 and was hired as Wake County’s first Project Access Coordinator in 2000; she has grown the program tremendously over the years. She now supervises a staff of two and increases participating providers as well as the range of specialties offered each year.

Tara Jaworski, Community Nurse Case Worker, WakeMed Health & Hospitals is a Licensed Nurse Case Manager on WakeMed’s Community Case Management team since March of 2015. She holds a Bachelor’s Degree in Nursing and received certification from The North Carolina Coalition to End Homelessness as a SOAR worker. Tara has worked with the uninsured and homeless population for four years and has assisted many uninsured patients with connection to healthcare services while assisting many homeless in obtaining disability benefits.
The Wake County Medical Society is inviting its members to write articles for upcoming issues of the Wake County Physician Magazine. Wake County Medical Society members wishing to write an article for publication are asked to submit a brief five sentence proposal.

Proposed article summaries could focus on your first person accounts of the personal side of practicing medicine (e.g., a patient overcoming all odds and achieving a positive outcome, experience with grief/overcoming grief, your best day practicing medicine, or care management success stories, etc.) or any other human interest story that might appeal to our readership—keeping in mind that anything resembling promotion of a current practice or practitioner, or taking a political stance would not be usable, with the final say on such matters resting with the editorial board. Please email your brief proposal to Paul Harrison, editor, by Sept. 16, 2016 at pharrison@wakedocs.org.

We would like to include your article in our next publication—October 2016, which will be posted on our website. Thanks!
As a physician you recognize that the more information you have about a patient the better able you are to care for them effectively. A Health Information Exchange (HIE) is, at its core, a streamlined way to share information about a patient - their allergies, prescriptions, vaccinations, test results, labs etc. Ideally, with all the data at your fingertips, there would be fewer repeat tests and procedures; fewer medical errors and improved patient safety and outcomes. All of which could ultimately make patient care more efficient and cost-effective.

This is the ideal the North Carolina Medical Society (NCMS) has been striving for over the years. We continue to work with a variety of stakeholders to create an HIE that truly meets the needs of physicians to get and share the clinical information you need about your patients in a secure, cost-effective, seamless and timely manner. The NCHIE is a private, encrypted network that adheres to all federal and state privacy and security laws.

We are increasingly optimistic we will reach this ideal thanks to recent legislation and the work of our new NC Health Information Exchange Authority (NCHIEA). The sharing of health information also is essential to the success of our state’s Medicaid reform initiative.

What is Health Information Exchange?

Health Information Exchange (HIE) is technology that allows a secure electronic exchange of health-related information between healthcare professionals that provides the ability to access and securely share vital medical information.

Visit HIEA for more information →
With that in mind, last fall the North Carolina General Assembly created the NCHIEA, and fully funded it for two years. This new entity will oversee a statewide, secure computer system allowing any connected physician to share information electronically and better coordinate patient care. The legislation also requires all physicians who treat Medicaid patients to be connected to the HIE by Feb. 1, 2018 in order to continue to be in the Medicaid program.

In its first six months the new HIE authority has been working diligently with them to establish a new connection.

Based on the feedback from those who were connected previously, the authority also has identified enhancements to the HIE platform that will bring more value to physicians such as providing access to public health data, lab reporting and immunization and chronic disease registries as well as offering a statewide provider directory.

The technology behind connecting to the HIE is complicated and labor intensive. The HIEA is working to standardize the process as much as possible and to develop proper training to help users fully understand and utilize the system.

As the HIEA states on their blog: “It is our goal to make the NC HIEA a relationship-based, technology-focused entity that will include you - our stakeholders - in all stages of the development of the HIE. Together, through collaborative efforts, we can meet the mandates set out by the North Carolina General Assembly and will improve health care outcomes for the citizens of North Carolina.”

Much work needs to be done to ensure that doctors, hospitals and health systems are all able to tap into the HIE in order to submit and retrieve information on behalf of patients. The NCMS will continue to work on your behalf to make sure the NCHIE is a secure, cost-effective and accessible way to share information. You, as physicians, need this information to make sound clinical decisions in this value-driven climate. Ultimately, success will mean a healthier bottom line for the state’s Medicaid program and, most importantly, a healthier population. §

The NC HIE enables participating organizations to:

- Have improved care coordination, higher quality of care and better health outcomes
- Facilitate more informed treatment decision-making
- Save time and reduce paperwork

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**North Carolina Medical Society**

Leadership in Medicine
PROJECT ACCESS of Wake County (PAWC) is a physician-referral program serving the uninsured population where qualified enrollees can access care that they may not otherwise have been able to receive. PAWC grew out of our physician community’s desire to more appropriately deliver healthcare to the low-income uninsured residents of Wake County. Modeled after a Buncombe County (Asheville, North Carolina) program, PAWC helps members of our community stay out of the emergency room and receive the myriad benefits associated with having a long-term medical home. The program launched in late 2000 with the leadership of local physicians and the support of the Wake County Medical Society. Physician and staff involvement are key to PAWC’s ability to help our neighbors in need. PAWC is structured pro bono care with an infrastructure that provides local volunteer physicians an easy way to ensure that their donated care is going to help the neediest members of our community.

When physicians sign up with Project Access, they agree to a certain number of commitments, or new clients, they will accept in a given year. PAWC then provides a list of participating providers to the safety-net primary care clinics for the purpose of referring appropriate clients to these physicians. In 2015, over 2300 people received medical specialty care through the compassionate care of our physician volunteers. The generosity of these volunteers, along with the generous support of Duke Raleigh Hospital, UNC-Rex Healthcare, and WakeMed Health & Hospitals generated over $16 million in donated care. Below is a story of one individual who received much needed medical services through the CapitalCare Collaborative, Project Access and other partners. Together we can make a difference, one life at a time!
A 42-year-old veteran and a father of four children injured his lower back while working. This was his third injury to the same exact location of two previous injuries and this time, he had no financial assistance to help him with his medical needs. The third injury sent him on a very painful journey, both physically and emotionally. He lost his ability to be gainfully employed, suffered from depression, and became homeless. Healthcare for the homeless does not provide pain management for many reasons and often times; individuals suffer in silence utilizing emergency rooms and street drugs to soothe their pain.

Through a CapitalCare Collaborative case manager’s referral to Project Access, this individual was able to receive treatment from an orthopedic doctor. This doctor considered performing a spinal fusion to alleviate his pain and fix his spine. A major surgery like this presents challenges for the homeless population because their treatment often stops once they leave the hospital. Shelters are typically unable to provide hands-on assistance of any kind and without insurance, homeless individuals do not have access to a rehabilitation facility. In addition, this individual experienced opiate addiction after his first surgery.

After exploring options, the doctor proceeded with a non-surgical treatment plan. The case manager reached out to Project Access again for guidance and their staff fast tracked his UNC Charity Application for Rex Pain management. The case manager and individual felt that if his pain could be controlled, he would have some quality of life and could do a more sedentary job. After a consult, follow-up, and careful review of his MRI, his pain doctor strongly recommended he have surgery and referred him to a Neurosurgeon. The individual and case manager left the office that day surprised that surgery was being put back on the table as an option and relieved that he would receive treatment that eventually resulted in a successful spinal fusion and stay in a rehab facility post-surgery for recovery. While this individual was in the rehab facility, the case manager received a long-awaited call from The Veterans of America notifying her of an opening for an apartment. The individual was discharged from the rehabilitation center into a furnished apartment with many services he could access. Currently, this former Project Access enrollee remains in housing since his surgery, is off all pain medication, and is working with vocational rehab to prepare to return to work.

According to this case manager, “I honestly believe with Project Access, their services, and appreciation for urgent healthcare needs, this man would have spiraled back into addiction to treat his pain and missed out on treatment and housing.” §

For more information about Project Access of Wake County, please contact Pam Carpenter, Program Manager at (919) 819-6281 or via email at: pcarpenter@wakedocs.org.

Project Access website: http://projectaccess.wakedocs.org
A Heart Doctor in the Heart of Smithsonian Institution

By Assad Meymandi, MD, PhD, DSc (Hon)*

Smithsonian

Reprint courtesy of Dr. Meymandi | “Monday Musings” for Monday June 6, 2016 | Volume V, No. 23/283

From ancient days, going back to Hippocrates (460 BC-370 BC—died at age 70), Galen (130 AD-201 AD—died at age 71), Avicenna (980 AD-1037 AD—died at age 57), to more recent physicians of note William Harvey (1578 AD-1657 AD—died at age 79), practice of medicine has been referred to as both science and art. I submit that medicine is more than science and art. Medicine encompasses ethics, theology and philosophy. Medicine is a calling. Medicine is priesthood. It is a privilege to be a physician, and to be of service and help to one’s fellow beings.

But going back to the notion that medicine is science and art has been elevated to an unprecedented peak. Recently, the governing board of the Smithsonian Institution chose Dr. David J Skorton, a former Cornell University President, and former Cornell University Medical School Professor of Cardiology, to be the new Director/Chief of The Smithsonian Museum. The awesome responsibility of managing the world’s largest art institution is mindboggling. Smithsonian Institution, the “attic of the world”, is a stupendously large place. It consists of 19 museums, nine science research centers and the National Zoo. This is the first time ever; a physician has been given the responsivity of directing the complex and behemoth organization. Congratulations to all of the physicians of the world. Before we explore the function(s) of Director Skorton, a few words about him:

Dr. David J. Skorton

David Skorton was born in Milwaukee on November 22, 1949 (age 67). His parents moved to Los Angeles when he was 9. He comes from Russian ancestry. His father was a Russian immigrant who did not finish high school. In Los Angeles, the gentleman started a family shoe store and made a success of the business. David’s mother wanted to be an architect but had no means to do so. She ended up working as a designer in an architect’s office. As an aside, to all the xenophobes who want to build a wall around America and keep the immigrants out, David Skorton’s parents and family are a good example of the extent of immigrant’s contribution to the enrichment of quality of life in our beloved America. I once tallied the Nobel Prize winners since its inception (in 1895, the first prize in Physiology or Medicine was awarded in 1901), more than 80% are either foreign born or are first generation Americans.

Kelly Crow, a reporter for the Wall Street Journal who interviewed Dr. Skorton quotes the newly appointed director: “Both my parents had artistic abilities. My dad sketched—I still have a couple of his drawings at home—and in the late 1950s, he and my mom made a mosaic wet bar top from glass and ceramic tiles. I never forget how he drew the shape of a genie coming out of a cocktail glass...” Also, his parents encouraged him to play a musical instrument. He took up the saxophone at age 9 and learned to play the flute at age 14. He is considered an excellent jazz saxophonist. While not a rival to James Galway, he is also an accomplished flutist/flautist.

David was a very bright student. After high school, he studied at the University of California at Los Angeles (UCLA) where in 1970 he was awarded a bachelor’s degree in psychology. In 1974, he received his medical degree from Northwestern University Medical School. He returned to UCLA where he completed his medical residency. He was chief resident before fellowship in cardiology.

In his nine years tenure as the President
of Cornell, he has committed his time as an administrator to advance the integrity of research, fundraising, and progressive stance on issues affecting his institution. Among his accomplishments are the growth of Cornell University onto Roosevelt Island, via Cornell NYC Tech, and $4 billion in fundraising for the University. He not only belongs to America, he belongs to the world.

In the person of David J. Skorton, we have a giant of intellect, a giant in motivating others and a giant in raising the ethical bar in the conduct of faculty and administration of institutions of higher learning throughout the world. David Skorton has become a role model for physician-servant-leader aspirants. He and his wife, Professor Robin Davisson, Professor of molecular physiology at Cornell, live in Washington, DC.

Below: Staff and invited guests filled the historic Arts and Industries building for the installation of Dr. David J. Skorton.

*The writer is Adjunct Professor of Psychiatry, University of North Carolina School of Medicine at Chapel Hill, Distinguished Life fellow American Psychiatric Association, and Founding Editor and Editor-in-Chief, Wake County Physician Magazine (1995-2012). He is a Raleigh writer and dramaturge.
The Neanderthal legacy provides another good example of our penchant for imaginative thought. It also demonstrates how some errant ideas are hard to replace. We will explore three aspects of this phenomenon.

1. Neanderthals were stoop-shouldered, dim-witted, brutish savages, and the quintessential cave people. This artistic misinterpretation was based fossilized remains of an old arthritic Neanderthal who became the poster child for the species. Another opined that this specimen was a Cossack left behind in the Napoleonic Wars. These interpretations were congruent with Victorian views but in spite of the many inaccuracies the artistic rendering has remarkable staying power.

2. Neanderthals lacked the creative intelligence of anatomically modern humans. This theory hinges on the apparent conservatism of the Neanderthals— they just didn’t see the need to change. Newer discoveries however reveal a different scenario. We may have underestimated to creativity of Neanderthal, especially higher levels of technological skills; the emergence of self-decoration with ochre and eagle claws, and emerging evidence suggestive of ritual and burial practices.

3. The Neanderthals disappeared within 20,000 years of the apparent entrance of anatomically modern humans migrated into Europe. The explanations for their disappearance range from paleo-colonialism and genocide to a prototype for Social Darwinism.

A Revision of the story

The discovery of more fossils, new archeological evidence and the addition of genomic studies suggest a different view of Neanderthals. They turned out to be large brained, robust people who managed to survive for nearly 200,000 years in frequently inhospitable times. They do appear to be quintessential cave people (or at least that’s where we find them). But who were they? Our best hypotheses suggest that Neanderthals diverged from a population of Archaic peoples around 450-600,000 BCE. Future Neanderthals migrated out of Africa and into Eurasia and along the way most likely crossed paths with earlier immigrants— their distant cousins. In backwater Europe, relative geographic and genetic isolation along with small population size set the stage for their specialization as an adaptation to a new homeland.

The Archaic peoples who stayed behind in Africa managed to survive the great droughts and climate changes associated with the advancing ice sheets in the Northern Hemisphere. They were dabbling in art, self-decoration, new technologies and a more diversified diet. They were also hunters who had periodic contacts with Neanderthals in the eastern Mediterranean during glacial advances.

The completion of the Neanderthal genome awakened other possibilities. The most intriguing is that Neanderthals and Denisovan (another cousin species) interbred with anatomically modern humans. New evidence from molecular genetics suggest that except for modern Africans our genomes contain between 1-4% of our genes are derived from Neanderthals and Denisovans. The Neanderthal genome also reveals the presence of the modern FOXP2 gene associated with expressive language and adaptions that included fair skin, red hair, and vulnerability to some forms of skin cancer. Interbreeding devotees point out that Neanderthals bequeathed their Major Histocompatibility Complex /Leukocyte antigens
(regulate and initiate adaptive immune responses) to us. More on this a bit later.

**Extinction and Myth Making**

There are several “extinction-event” tales. One focused on an extermination scenario- the smarter and technologically more advanced peoples out hunted and outgunned the less sophisticated “natives”. Other theories hold that Neanderthals never disappeared, but inbred with other modern humans in Europe and Asia. A third holds that the Neanderthals time was up. They overspecialized in terms of hunting styles and a fundamentally carnivorous diet that did not exploit more diverse food sources. Climate change did them in. But some of their conservatism may have been related to low population densities. Limited contact with other Neanderthals most likely restrained innovation- low population densities reduced opportunities for exchange of new ideas and technologies.

Oddly there are very few references citing modern humans as the source of new infectious diseases among the immunologically naïve Neanderthals. Population density may have also limited the spread of infectious diseases- scaled down version of the catastrophic epidemics among Native Americans after their first contact with white Europeans. Low population densities scenario may have been protective to some degree. The untimely deaths of 2 or 3 extended family members from infection might have had the greater impact on small isolated pockets of Neanderthals. There were fewer available mates.

Population geneticists are warming to the idea of interbreeding and perhaps hybridization. Some note that interbreeding is more likely to occur at the interface between invading and indigenous populations. But there were multiple migrations at various points in our evolutionary history. As far back as *H. ergaster* and *erectus*, our ancestors were wayfaring strangers. Waves of migration inched their way into Asia and Europe. By 40-50,000 years ago indigenous Australians (Aborigines) were isolated from other Asians and Melanesian peoples who reaped the benefits of interbreeding with Neanderthals and Denisovans respectively. But there are forces that stand in the way of successful interbreeding. The greatest challenge lies in our definition of species as genetically closed systems that produce infertile cross-species offspring.

So if these matings did occur with any frequency, how did they influence the emerging modern gene pool- selective advantage for survival for either the indigenous and immigrant populations? Neanderthals had nearly 150,000 years in Europe to adapt to diseases, parasites and other pathogens. Perhaps we owe our survival in Eurasia to the Neanderthals who bequeathed us their innate and adaptive immune functions.

**Mythmaking at Its Best**

In the Descent of Man Darwin argued that females selected their mates, leaving males to compete- analogous to the modern bar scene or romantic comedy. Cultural and behavioral differences may have had a greater impact than strictly defined genetic/ biological factors. Maybe most Neanderthal men were just too short and ugly or too
“Neanderthal” for modern women. Perhaps the invading Africans were too dark or tall to pick up local Neanderthal girls at the cave side watering hole. But just imagine a new genre of Sci-Fi movies starring newly cloned Neanderthals searching for mates- Paleo World or Neanderthal Night Fever might finally replace our obsession with Zombies. Obviously, we have no evidence other than extrapolating modern cultural ideas about beauty, social conventions and language to help us understand what restrictions or taboos applied to mate selection. Mythmaking can be fun and exciting. §

The last of our discussions involves the greatest detective story in the history of paleo-anthropology the Piltdown Man Hoax.

Wake County Medical Society welcomes our newest members

Lisa B. Gardner, DO
Heather P. Lampel, MD, MPH, FACOEM

WCMS will be moving to its new office location at the end of July 2016. Our new address is:

Wake County Medical Society
4207 Lake Boone Trail #100
Raleigh, NC 27607
CURRENT PROGRAMS

Project Access - A physician-led volunteer medical specialty service program for the poor, uninsured men, women, and children of Wake County.

Community Care of Wake and Johnston Counties CCWJC has created private and public partnerships to improve performance with disease management initiatives such as asthma and diabetes for ACCESS Medicaid recipients.

CapitalCare Collaborative - The CCC program is a membership of safety net providers working corroboratively to develop initiatives to improve the health of the region’s medically underserved such as asthma and diabetes for Medicaid and Medicare recipients.

WHY JOIN

Membership in the Wake County Medical Society is one of the most important and effective ways for physicians, collectively, to be part of the solution to our many health care challenges.

A strong, vibrant Society will always have the ear of legislators because they respect the fact that doctors are uniquely qualified to help form health policies that work as intended.

It’s heartening to know the vast majority of Wake County physicians, more than 700 to date, have chosen to become members of the Wake County Medical Society.

HOW TO JOIN

To become a member of the Wake County Medical Society contact Deborah Earp, Membership Manager at dearp@wakedocs.org or by phone at 919.792.3644

A portion of your dues supports to the volunteer and service programs of WCMS. Membership is also available for PA’s. There is even an opportunity for your spouse to get involved by joining the Wake County Medical Society Alliance.

WCMS MISSION

To serve and represent the interests of our physicians; to promote the health of all people in Wake County; and to uphold the highest ethical practice of medicine.
The Wake County Medical Society (WCMS) is a 501 (c) 6 nonprofit organization that serves the licensed physicians and physician assistants of Wake County. Chartered in 1903 by the North Carolina Medical Society.

**BENEFITS OF MEMBERSHIP**

Service Programs - The spirit of volunteerism is strong in Wake County. Hundreds of local physicians volunteer to help our indigent. The Society coordinates several programs that allow low income individuals access to volunteer doctors and to special case management services for children with diabetes, sickle cell anemia or asthma.

Publications - Members receive the peer-reviewed The Wake County Physician Magazine four times a year, and we keep you informed regularly via pertinent emails. The magazine focuses on local health care issues in Wake County, the Wake County Medical Society and the WCMS Alliance, a companion organization composed of physician spouses and significant others.

Socializing with your physician colleagues - Many physicians feel too busy to do anything except work long hours caring for patients. But, the WCMS provides an opportunity for physicians to nourish relationships through social interaction with one another at our dinner meetings featuring prominent speakers and at other events.

Finally, joining the WCMS is plain and simple the right thing to do - Physicians and the community benefit from our membership and our leadership in local affairs.
Please join our Advocacy effort

The Wake County Medical Society
Legislative Advocacy Committee

NEEDS YOUR SUPPORT AND NEEDS YOU TO JOIN IN!

The WCMS Legislative Committee advocates for Wake County Physicians with the Wake County Delegation to the NC General Assembly. The Committee will be active now and through the 2016 legislative session.

Key issues include:

1. Maintain physician led and local quality care initiatives
2. Support the NC Community Care Program and its care management activities
3. Address Medicaid reform issues
4. Prevent “scope of practice” legislation that would allow non-physicians the right to practice medicine.
5. Work in concert with the NC Medical Society’s legislative advocacy agenda

INTERESTED?

Please contact
Paul Harrison, WCMS Executive Director
(919) 923-2442 or by email at pharrison@wakedocs.org