

ST. LOUIS METROPOLITAN
MEDICINE

VOLUME 31, NUMBER 3

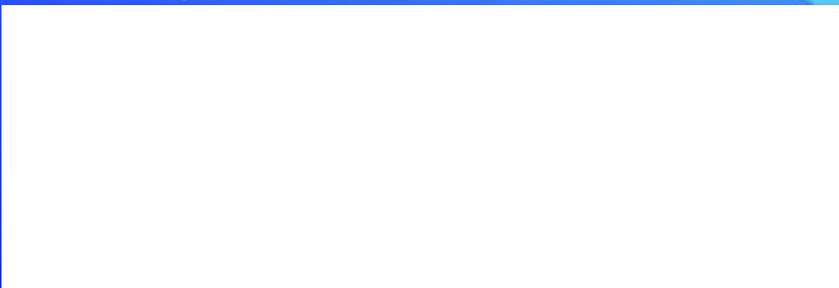
MAY / JUNE 2009



Twenty-First Century Epidemics:

Obesity, Diabetes, Cardiovascular Disease

page 18



Behind the lectern: how to leave
a good impression *page 6*

Health-care reform: elements to consider
page 14

Using dashboards to manage
accounts receivable *page 26*

**St. Louis Metropolitan
Medicine**

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St. Louis Metropolitan Medicine, official bulletin of the St. Louis Metropolitan Medical Society (SLMMS), (ISSN 0892-1334, USPS 006-522) is published bi-monthly by the St. Louis Metropolitan Medical Society; 680 Craig Rd., Ste. 308; Saint Louis, MO 63141-7120; (314) 989-1014, FAX (314) 989-0560. Printed by Messenger Printing Co., Saint Louis, MO 63122. Periodicals postage paid at St. Louis, MO.

Established 1880. Owned and edited by the St. Louis Metropolitan Medical Society and published under the direction of the SLMMS Council.

Advertising Information: *SLMM*, 680 Craig Rd., Ste. 308; Saint Louis, MO 63141-7120; (314) 989-1014.

Postmaster: Send address correspondence to: *St. Louis Metropolitan Medicine*; 680 Craig Rd., Ste. 308; Saint Louis, MO 63141-7120.

Annual subscription rates: Members, \$10 (included in dues); nonmembers, \$45. Single copies: \$10.



Volume 31

Number 3

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COVER FEATURE:

18 Twenty-First Century Epidemics: Obesity, Diabetes, Cardiovascular Disease
Lifestyle choices, a culture of abundance and technological conveniences are spawning rampant obesity and related health problems. What can physicians do?

Features

6 Behind the Lectern
How to leave a good impression when you speak or moderate a panel
By Tom Watters, CAE, SLMMS Executive Vice President

14 Elements to Consider in Health-Care Reform
Crafting a system that serves our patients, our profession and our nation
By William M. Fogarty, Jr., MD, FACP

23 Do You Let Your Ego Dominate Investment Decisions?
By Bill Bender, Mason Road Wealth Advisors

26 Using Dashboards to Manage Accounts Receivable Results
Identify key measures to keep a pulse on the practice
By Jerrie K. Weith, FHFMA

Columns

4 President's Page: Elie C. Azrak, MD, FACC, FSCAI
Brace for the Pandemic! Obesity, diabetes and cardiovascular disease are 21st century threats

1 SCAM-Q: Richard J. Gimpelson, MD
Delay of Game

News

10 SLMMS Call for Nominations - 2010

11 Honored for Service

12 Science Fair Winners Recognized

17 SLMMS Resolutions Advance

25 Letters to SLMMS

29 Employers Must Use Revised I-9 Form

29 H1N1 Flu Resources Available

32 Toolkit Helps Navigate Medicare Enrollment

34 Members Elected to MSMA, AMA Posts

Departments

1 Harry's Homilies

28 Newsmakers

30 Alliance

32 Calendar

33 Minutes of the SLMMS Council

35 Obituaries

36 Birthdays

37 Welcome New Members

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Brace for the Pandemic!

Obesity, diabetes and cardiovascular disease are 21st century threats



Medical Society President
Elie C. Azrak, MD

If you thought for a moment that I am alluding to the recent outbreak of the H1N1 flu virus – the so called swine flu – spreading across international boundaries in all continents, causing panic in many societies, to the point of disrupting lives, causing hundreds of deaths, threatening the productivity of many nations, and paralyzing entire economies due to illness and death, if you thought for a moment

that I was really talking about the swine flu, you would be mistaken!

Have no doubt, nonetheless, that the H1N1 strain of the flu virus threatens to reach pandemic proportions in short time if public health measures such as public education, preventive lifestyle changes and immunizations are not undertaken.

Does this analogy sound familiar? What I am really trying to do here is bring home the point that our global human community of the 21st century, among other threats, already faces certain outbreaks of pandemic proportions, disrupting lives, threatening the productivity of nations, and paralyzing entire economies: those threats are called cardiovascular disease, diabetes, and obesity – the 21st century epidemics!

I am a cardiologist, and I experience first hand as a matter of routine in my daily practice, the devastating effects of these conditions on individuals, families, communities and society. Unfortunately, the terms young and unhealthy are no longer mutually exclusive: sudden cardiac death, stroke and major disability due to cardiovascular disease are commonplace in medical practice, with alarming incidence in younger individuals.

To appreciate the extent of the problem, it would be sobering to learn that according to the American Heart Association's most re-

cently available data, the total prevalence of cardiovascular disease in American adults of age 20 and older, is over 36 percent. That exceeds one-third of the adult population! Likewise, it is estimated that over 10 percent of the same population of American men and women over 20 have full-blown diabetes mellitus, and another 26 percent are "pre-diabetic!"

On a similar note, and while the devastating effects of diabetes on the heart are well established, there is also an overwhelming prevalence of obesity in our society, which certainly adds an alarming dimension as well. The American Heart Association also estimates that 67 percent of adults 20 years or older have a body mass index (BMI) of over 25, and 34 percent have a BMI of 30 or more! The findings are no less alarming in children.

If the above statistics do not represent pandemic proportions, what does?

In this issue of *St. Louis Metropolitan Medicine*, I invite you to examine the realities of these conditions, their impact on the health and well-being of our communities, the toll they threaten to take on our productivity, and consequently on the health of our economy.

On a personal note, I want to take the opportunity in this president's column to thank the members who contributed via e-mail to the issues discussed in the March/April publication of this journal, and acknowledge that many of the ideas brought forward in recent correspondence are helping the leadership position the Medical Society for maximum

value to our members, plan future programs that are relevant, and focus on issues of importance for discussion.

As usual, the magazine editorial staff and I personally welcome your comments and e-mails, and any suggestions you may have on the content and format of this publication. Your input allows us to reflect on the work of the Medical Society and respond to the needs of the membership. Let us hear from you at president@slmms.org.

“Unfortunately, the terms young and unhealthy are no longer mutually exclusive: sudden cardiac death, stroke and major disability due to cardiovascular disease are commonplace.”

Behind the Lectern

How to leave a good impression when you speak or moderate a panel

By Tom Watters, CAE
SLMMS Executive Vice President



**Medical Society
Executive Vice President
Thomas A. Watters, CAE**

Physicians are typically people who want to get to the point. They don't like to waste time, and as a result, sometimes are a bit abrupt with the amenities and formalities. This is especially true when it comes to presentations. They have information, the audience wants it, so let's get it done and move on, right?

In my several years with SLMMS, I've had the pleasure of observing a good many of you on the podium. As a physician, you are viewed with respect and as a person

of knowledge. You can often get away with skipping the formalities. However, you may also be asked to moderate a session, speak in settings more formal than the teaching arena, or maybe even serve as a toastmaster in an unrelated setting. For more formal settings, a few basic podium skills can be invaluable.

Preparing for Your Speech

When my career in association management began, I found that I had to become a better speaker, and I quickly learned there were tricks of the trade. I picked up some of these in Toastmasters, but learned many through traumatic trial and error. I thought I would pass a few of these tips along.

First keep in mind you aren't the only person who gets butterflies when it's time to step up to the lectern. Everyone goes through pretty much the same thing. Some people just hide it better. Just jumping into your information without first getting organized, thanking the moderator and recognizing the audience doesn't help. In this case, doing the proper thing gives you a chance to get organized, relaxed and take a few much-needed breaths.

Second, prepare. The better you're prepared, the easier it is. If you plan to wing it, don't expect much. Every time I try to wing it not only do I do a poorer job, but I'm more anxious about the whole thing, both before and while I'm doing it. And don't underestimate the need to take short presentations seriously. Most speakers find that if they're going to get anxious, it will be during the

first minute or two they speak. Therefore, if you have just a two- or three-minute presentation, you may be nervous through the whole thing. By the time you work through it, it's over. So actually, you need to prepare more, not less, for brief presentations. It's like a good short story – much more difficult to write than a novel.

Third, do what you do best. Some people can wing it. If you're good at that, more power to you. But most of us need to work from notes, and some people are best off working from a complete script. If that's what you need, do it. All the books will tell you to use an outline and speak naturally and never look down. That's great advice for someone who's a professional speaker, or someone aspiring to be one, but most likely you're just trying to do a good job. Most of you aren't professional or seasoned speakers so don't get caught up trying to be something you're not. If you have to use a script and read it, do it. All I encourage you to do is practice it a lot before you use it and make it as natural as possible.

There are some tricks to using a script. Write it the way you talk, not the way you write. If you want to sound natural put your contractions right in your script. If you'd drop a letter off the end of a word when you normally say it, write it that way. If you don't want to sound like you're reading, don't write it so it sounds like you're reading.

Type your presentations in big, bold type so it can be read easily and double-space them. Don't type too near the bottom of the page; use only about the top two-thirds of each page. It's easier to maintain eye contact if you're not looking toward your belt buckle.



Fold the upper right-hand corner of each page in advance so you're not fighting with the paper each time you move on, or worse, skipping an entire page by turning two at a time.

Whenever you can, use visual aids and handouts. Not only do they help your audience, they also help you. They give you a break now and then – some time to get your breath, to think for a few seconds, to regroup. Good overheads don't just help your listeners, they act as your outline – and help keep you on track.

Anticipate your audience. Ask in advance about the size and the makeup of the group. There's nothing worse than going to a meeting prepared to speak to one audience and finding out it's made up of people you didn't expect.

Be brief. The less time you're on the podium the less exposure you have. The wordier you get, the bigger chance for problems. Being longer doesn't make you sound better. As the old adage says – "Be brief, be concise, be quiet." Another one I like is "Stand up, stand out, sit down." Say what you need to say, but the fewer words, the better.

Finally, be yourself, be friendly, be fun. If you're naturally funny, then use it. If you're not, don't try to be. Be yourself. I think the best advice I ever received as a speaker was that everyone in the audience was there to hear what I had to say. They all want you to succeed. (And I always like to add, that if they could do a better job ... they'd be up there!)

Podium Protocol for Speakers

Now, here are a few things that will help you be more comfortable, and look better, when you're on the podium doing your thing as a speaker.

The first thing you have to do is take charge. When you come



“As the old adage says –
“Be brief, be concise, be quiet.”
Say what you need to say, but the
fewer words, the better.”

into a room and you're one of the speakers, don't take anybody's word for anything. Don't be bashful; in fact, you need to be aggressive. If you're not, some day you'll pay for it. Trust me – I know.

If someone tells you they just checked the microphone, check it yourself anyway. I can't tell you how many times I've saved myself a problem by finding out that it may have worked 15 minutes ago, but it doesn't work now!

Always arrive early and check the equipment. Know where the switch is on the microphone. Be sure that you can move it where it needs to be for you. Know who's ahead of you. Are they shorter or taller? Will you have to make major adjustments at the podium when you're introduced?

Make sure there's enough light for you to see, and be sure your papers don't slide off the podium. If you're in charge of the meeting, be sure you know who the audiovisual person at the facility is, and where they'll be if you need them in a hurry. Write down their cell number. **Never** trust AV equipment!

Never put your notes up on the lectern in advance. People will even tell you to leave them there; sometimes they even get stubborn about it. Obviously they have never had their notes disappear! I'll bet at least a dozen times I've seen a speaker come to the podium to speak, only to find out that a previous speaker has accidentally carried their notes away. There's nothing wrong with carrying your notes to the podium.

And here is the most common mistake made – never, ever, desert the lectern. Nothing looks worse, and nothing is ruder to your audience, yet you see it done all the time. When *you're* done speaking, wait for the chair to come back and thank you. If the chair isn't coming back, wait for the next speaker. Regardless, stand

continued on page 8

Behind the Lectern *(continued from page 7)*

there until someone comes and shakes your hand no matter how long it takes. “Never leave until you’re relieved!”

Podium Protocol for Chairs and Moderators

If you happen to be the chair or moderator of a meeting, the same thing goes about deserting the lectern. If you’re the chair, don’t leave until you’ve introduced the next speaker, waited for them to get to the lectern, and shaken their hand.

If you’re making a presentation, anticipate. Give it with your left hand so you can shake with your right. If you’re on the receiving end, accept it with your left so your right hand’s free.

Coping with waiters after a meal is always an issue. When you can, you want to let them do their job, and you have to sometimes compromise to keep your meeting on schedule. But there’s a point where they can be obtrusive, and if so, you need to let them know it.

If the doors in the back are open, close them, especially if there’s noise outside. (This is also a good way to let your waiters know that you’re starting your program. If you ask them to shut the doors, then they’ll know you’re getting down to business and it’s time to be quiet.) Don’t forget – you’re in charge!

As a chair, you have a responsibility to keep the meeting on schedule. If you have a speaker scheduled for 30 minutes and they decide to talk for an hour, what should you do? First use your judgment. Is there time in the schedule, which allows for you to be flexible? Is the audience really “into” what the speaker’s saying? If so, you may want to be lenient. There’s nothing worse than trying to stay on schedule just to be on schedule. But, when it’s going to affect your later speakers, or make your audience run late to their next obligation, it’s your responsibility to cut the person off. Remember, you’re not being rude – *they’re* being rude to your entire audience.

It’s always a good idea to have a couple of cards handy you can hold up that say “Five Minutes Left,” “One Minute Left,” and finally, one that says “Time’s Up.” If you don’t have cards, pass a note. If worse comes to worse, you may have to stand up and move



around behind them. Eventually they’ll get the hint. The purpose of a schedule is to have an effective meeting.

Dealing with questions from the audience can sometimes be challenging. Don’t let a person get up and make a statement that you *know* is incorrect without challenging it. There’s nothing worse than the entire group going away from a meeting thinking what they just heard someone say was true, when in fact it was all wrong.

Consider using cards to manage Q&A sessions. Pass them out in advance or ask people to write their questions on a piece of scratch paper and put them in a special spot during the course of the meeting. Then you can filter out questions that are just individual issues, or may be intentionally disruptive. This also allows you to think the answer through in advance, or have the right person in mind you might call on to answer the question.

There aren’t many of us who will become a Winston Churchill or a Barack Obama, but we can at least avoid looking awkward while we’re doing our best. You don’t expect less of yourself anywhere else – why would you expect less when you’re behind the lectern?



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Elements to Consider in Health-Care Reform

Crafting a system that serves our patients, our profession and our nation

By William M. Fogarty, Jr., MD, FACP

We are again approaching health-care reform at the national level. In the 16 years since the failure of the last attempt, the system has become more dysfunctional. Many of the stakeholders who opposed reform in 1993 now see its merits. Whether they will all stay on board as the debate develops remains to be seen.

Some elements to consider as we approach comprehensive reform are:

1. Cost control and quality improvement
2. Coverage and access
3. Primary care and prevention
4. Systems in other countries

Cost Control and Quality Improvement

Health-care costs have put the economy on a collision course with disaster. Increases have outpaced inflation by two to three times for years and are unsustainable. The reasons are complex and include the aging of the population, increases in the cost of and the use of technology, escalating drug costs, lack of primary care, overuse of care (especially at the end of life) and many other factors.

I would like to illustrate the complexity of the cost problem with some examples:

For patients who have had or are at risk for a heart attack or a stroke, an anti-platelet drug is usually recommended. Aspirin is commonly used, is effective and is very cheap. Another drug, clopidogrel, is said to be more effective but is much more expensive. When the two drugs were compared in a clinical trial, its advantage was very small. The estimated cost of one year of quality life gained with clopidogrel and aspirin combined was \$250,000 whereas, using aspirin alone it was \$11,000. Is this a reasonable extra expenditure?

Biopharmaceuticals and chemotherapeutic agents for the treatment of various autoimmune diseases or malignancies can cost tens of thousands of dollars and we are promised “custom designed” treatments from stem-cell and genomic research of unknown cost. How should these be used and paid for? Should there be limits on what insurance should pay? Should those who can afford to pay privately for these super-expensive therapies be allowed to do so? How will politically powerful groups, such as breast-cancer or rare-disease treatment advocates influence decision making? These are some of the very tough questions that we, through our elected representatives, are being called upon to answer.

Another element in the debate is Comparative Effectiveness Re-



search. For years, agencies such as the Joint Commission, the Food and Drug Administration and the Agency for Health Care Quality and Research have gathered data on best practices and the utility of new drugs and technology. The knowledge gained has advanced medical science. However, this concept is now being vilified by opponents (often with vested interest in the status quo) who characterize this research as a way to ration care and to limit physicians' ability to care for their patients. On the contrary, this research is essential if we are to avoid adopting measures which add greatly to cost with no, or only marginal, improvements in quality.

To ensure objectivity, in my opinion, these studies should be done in government or university laboratories and paid for by the government and not by manufacturers *before* these innovations are released for widespread use. In a recent paper, The Commonwealth Fund, a public policy institute, estimates that the creation of a center for comparative effectiveness could save \$634 billion over its first 11 years.

The quality of care delivered in the U.S. is highly variable. For many years the Dartmouth Atlas has compared the care delivered in various parts of our country and has demonstrated that some areas have markedly lower costs and better outcomes than others. Shouldn't we adopt practices that are demonstrably superior as our standard of care? Some say that that would be the forced adoption of “cookbook medicine” and would “hamper doctors' ability to treat their patients.” We pride ourselves on being an evidence-based profession. That claim is not always borne out by the facts.

President Obama, during the campaign, offered a plan for reform. Some of the major elements of that plan are:

1. Cover more children by expansion of the Children's Health Insurance Program. (This has been enacted and signed into law covering four million additional children.)
2. Cover the uninsured by requiring larger employers to provide coverage to their workers or contribute to the cost of a public insurance program very similar to Medicare.
3. Forbid insurers to deny coverage because of pre-existing conditions. The plan, however, doesn't state whether that mandate includes “community rating” without which coverage will be available but unaffordable.
4. Cost control would be supported by widespread adoption of health information technology, technology assessment, chronic disease management and adoption of best practices. These innovations are said to offer the potential for huge cost savings but

whether that will be the case remains to be seen.

5. Coordinated and preventive care, the mainstays of primary care, offer the potential for cost savings and improvement in health outcomes.

Coverage and Access

At this time, there are more than 46 million U.S. citizens who lack health-care coverage (a number projected to rise to 62 million over the next few years), and many additional millions who are “underinsured.” The inclusion of all citizens must be an element in the design of comprehensive reform. Those who lack coverage do access the system through emergency rooms at great cost to *all* of us. The Commonwealth Fund estimates that a universal system will *decrease* overall expenditures by \$432 billion over its first 11 years.

Coverage, however, does not guarantee access as has become evident in Massachusetts. Since their plan was activated, more than 300,000 additional citizens have “coverage” but shortages of physicians, especially in primary care, have left many of these people without “access.” Serious reform must address both.

Primary Care and Prevention

In any reform plan the crisis in primary care must be addressed. In the last match, fewer than 2,700 of 17,000 graduates chose internal medicine. Of those about 90 percent will sub-specialize. Thus, fewer than 300 U.S. graduates will enter general internal medicine practice in three years; far fewer than the number who will be leaving practice. Similar statistics apply to family practice and pediatrics. The gap will be closed to some extent by foreign medical graduates. Is it ethical for the U.S. to rely on foreign countries to supply us with physicians that they need themselves?

The shortage of primary care has great implications for care quality and cost. Numerous studies here and abroad have shown that areas with a strong primary-care base have lower costs and better outcomes. A study comparing cost of care for matched Medicare patients showed that costs were 2.6 times higher in Miami than in Minneapolis and that the outcomes were better in Minneapolis. This difference was attributed largely to heavy reliance on specialist care in Miami and a robust primary-care base in Minneapolis.

Seventy percent of health-care expenditures go for the care of 10 percent of the population, primarily those with chronic illnesses. Preventive care and the coordinated care of chronic illnesses offer the potential of reducing costs and improving outcomes.

Medical Care in Other Countries

In the January 1, 2008 issue of the *Annals of Internal Medicine* a comparison was made of the U.S. system and those of 12 other

“ We face a health-care crisis in this country that we must confront for moral, humanitarian and economic reasons. ”

industrialized countries. All of them spend a much lower percentage of their GDP on health care, cover *all* of their citizens and have better outcomes. None of these other systems are directly transferable to the U.S. for a variety of reasons both practical and

political, but we can learn much from them. The editors of the *Annals* have extracted some key elements from an analysis of these systems and recommend that they be included in any reform. These are:

1. *All* residents must have access to affordable health care. This can be done by either a government run, single-payer system or a mix of public and private funding.
2. Budgets can restrain costs but do not provide incentives for improved efficiency unless that budget is targeted at small groups such as an individual practice or hospital.
3. The use of government power to negotiate prices can achieve cost savings but can result in shortages, delays, cost-shifting and creation of parallel private-sector markets.
4. Co-pays and other types of cost-sharing must be designed so that low-income individuals pay little or nothing out-of-pocket to assure that they have access to services.
5. Societal investment in professional medical education can achieve a balanced health-care workforce. Scholarships or loan forgiveness for graduates entering specialties that are in short supply or serving in underserved areas might increase the numbers taking those career paths.
6. Physician payment systems must support primary care, incentives for quality improvement and care coordination. The income of physicians in primary care is about 55 percent of the average earnings of specialists and that percentage is *decreasing*. Medical students are graduating with a median debt of more than \$150,000 precluding many of them from entering lower-paying fields of practice.
7. Uniform billing systems and electronic claims processing save administrative expenses.

In Conclusion

We face a health-care crisis in this country that we must confront for moral, humanitarian and economic reasons. The recent election and the current economic situation offer an opportunity to move toward long-term solutions with many believing that comprehensive revision of our health-care system is a vital part of economic revitalization. The Commonwealth Fund projects savings of \$3 trillion and a reduction of the percentage of the GDP spent on health care from 21 percent to 18 percent over the first 11 years if their comprehensive plan were put into effect in 2010.

As medical professionals and as citizens, it is in our best inter-

continued on page 16

Elements to Consider in Health-Care Reform *(continued from page 15)*

est to become knowledgeable about these issues and to keep pressure on our elected officials to enact meaningful reform that benefits all. I urge all of you to use your e-mail and telephone to contact your legislators at the state and national levels. Our goal should be to craft a system that well serves our patients, our profession and our nation. If that is to happen, you must get involved.



Dr. William Fogarty is an internist and endocrinologist. He has served as chairman of the Health and Public Policy Committee of the Missouri Chapter of the American College of Physicians since 1991 and on the National HPPC of the College from 1995 to 1998. He has lobbied Congress on health care issues annually for more than 15 years. Since retiring from Southwest Medical Center in 2001, he has volunteered at La Clinica in St. Louis and with HELPS International in Guatemala.

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4. **The Obama Health Care Plan.**

<http://www.barackobama.com/issues/healthcare/>

5. **The Commonwealth Fund.** An excellent source of information on health care policy. Particularly recommend are two recent papers, one by Karen Davis: **You Can Get There from Here: Mapping the Way to a Transformed U.S. Health System** and a second by the Commission on a High Performance Health Care System: **The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way.**

<http://www.commonwealthfund.org/>

6. **Missouri Foundation for Health.** This excellent organization has contributed greatly to the fund of information available on health care in Missouri. <http://www.mffh.org/>



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Twenty-First Century Epidemics: Obesity, Diabetes, Cardiovascular Disease

By Jim Braibish

St. Louis Metropolitan Medicine



growing rapidly. The number of Americans with diabetes increased by over 12 percent in just the past two years. The death rate from diabetes has increased by 45 percent since 1987.

Also linked to obesity is cardiovascular disease. Blood pressure, cholesterol, triglycerides and other indicators all are higher among those who are overweight. Although advances in treatment and surgical procedures have reduced deaths from cardiovascular disease, there is concern that progress could be reversed by the ongoing swell in waistlines.

Diabetes

“Diabetes has become the greatest public health crisis of this quarter century,” said Kevin Blinder, MD (SLMMS), of the Barnes Retina Institute at Washington University School of Medicine. He also is president of the American Diabetes Association St. Louis chapter.

“Nearly 24 million Americans are affected by diabetes, an increase of three million in the past two years alone, according to the most recent statistics from the Centers for Disease Control. Close to six million people are undiagnosed. An additional 57 million Americans have pre-diabetes, placing them at increased risk for developing type 2 diabetes.”

Diabetes is the seventh leading cause of death – killing more people than AIDS and breast cancer combined each year. Those who live with diabetes may suffer serious, lifelong complications such as heart disease, stroke, blindness and kidney failure. Diabetes is the most common cause of blindness in the young adult population each year.

If current trends continue, Dr. Blinder said, one in three children born in the year 2000 will develop diabetes in their lifetime. And the ratio is even greater for minority children, with one in two developing the disease some time in their lives.

If it were reported that a viral epidemic had struck 145 million American adults and another 10 million children, there would be public outcry.

Yet these are the real numbers today of Americans whose lives and health are threatened by obesity and overweight and their related lifestyle-influenced disorders, cardiovascular disease and diabetes.

Over two-thirds of American adults – 145 million – are overweight, with a body mass index (BMI) of 25 or higher. Nearly a third of adults – over 72 million – are obese with a BMI of 30 or more.

What is even more shocking is the growth in obesity among children. Nearly one in six children are overweight, more than triple the number in 1980, setting the stage for later health disorders.

Obesity often leads to diabetes, of which the incidence is



Frank Bleyer, MD



Kevin Blinder, MD



Kathleen Killion

Lifestyle choices, a culture of abundance and technological conveniences are spawning rampant obesity and related health problems.

What can physicians do?



“Type 2 diabetes has risen dramatically in our children due to their sedentary lifestyles of computer games and fast food,” Dr. Blinder said.

Diabetes is costly, he added, with the 2007 related expenses amounting to \$174 billion. One of every five health-care dollars is spent on caring for someone with diagnosed diabetes, while one of every 10 health-care dollars is attributed to diabetes. In 2007, indirect costs of diabetes resulted in 15 million work days absent, 120 million work days with reduced performance, six million reduced productivity days for those not in the workforce, and an additional 107 million work days lost due to unemployment disability attributed to diabetes.

Cardiovascular Disease

Some 80 million American adults – more than one in three – have one or more types of cardiovascular disease. Nearly half of these are age 60 and over. In addition, over 73 million people have high blood pressure, defined as a systolic reading of 140 or higher and/or a diastolic reading of 90 or higher, or taking antihypertensive medication.

According to the American Heart Association, nearly 2,400 Americans die of cardiovascular disease each day, an average of one death every 37 seconds. The estimated direct and indirect cost of cardiovascular dis-

continued on page 20

Obesity Facts

- 66.3% of U.S. adults ages 20 and older are overweight or obese (BMI of over 25) (Centers for Disease Control)
- 32.2% of adults are obese (BMI of 30 or higher) (CDC)
- Obese prevalence has more than doubled since 1980, when it was 15% (CDC)
- Obesity causes at least 300,000 deaths each year in the U.S.
- Black and Hispanic populations appear to be at a higher risk for being overweight

Overweight in Children and Adolescents

- 18.8% of children ages 6-11 were overweight in 2004 compared to 6.5% in 1980 (CDC)
- Type 2 diabetes, previously considered an adult disease, has increased dramatically in children and adolescents. (U.S. Surgeon General)
- 31.8% of females and 18% of male students in grades 9-12 did not engage in 60 minutes of moderate-to-vigorous physical activity even once in the previous seven days (American Heart Association)
- More than one fourth of all the students spent three or more hours per day outside of school time using computers or watching television (American Heart Assn.)
- In Missouri, 39.4% of students ages 5-11 who participated in a 2000-01 nutritional screening were overweight or at risk of being overweight, up from 36.6% just a year before (Mis-

souri Dept. of Health & Senior Services)

- In the same study, French fries were the second-largest contributor to most of the students' total fat and caloric intake; soft drinks were the second-largest contributor to their total carbohydrate intake (Mo DHSS)

Diabetes Facts

- 10.7% (23.5 million) of adults age 20 and over have diabetes
- 57 million have pre-diabetes
- Diabetic retinopathy causes 12,000 to 24,000 new cases of blindness each year making diabetes the leading cause of new cases of blindness in adults 20-74 years of age.
- Diabetes is the leading cause of kidney failure, accounting for 44% of new cases in 2005.
- About 60% to 70% of people with diabetes have mild to severe forms of nervous system damage.
- Almost one-third of people with diabetes have severe periodontal disease

(American Diabetes Association)

Cardiovascular Disease Facts

- 80,000,000 American adults (over 1 in 3) have one or more types of cardiovascular disease, of whom 38,000,000 are estimated to be age 60 or older
 - 73,600,000 have high blood pressure (140 and/or 90 or higher, or taking antihypertensive medication)
 - Estimated direct and indirect cost for cardiovascular disease in 2008 is \$475.3 billion
- (American Heart Association)

Twenty-First Century Epidemics: Obesity, Diabetes, Cardiovascular Disease

(continued from page 19)

ease for 2008 was \$475.3 billion.

Since the 1960s, steady progress has been made in reducing death rates from cardiovascular disease through more aggressive treatment. However, there is concern among physicians that progress may not continue.

“Over the past five years this decline seems to be blunted. The problem may be the increase in obesity and metabolic syndrome,” said Frank Bleyer, MD, a cardiologist and Saint Louis University faculty member.

Metabolic syndrome is a term used to describe obesity appearing in combination with other cardiovascular risk factors. It shows how all the risk factors work in combination with obesity as a preliminary condition for atherosclerotic cardiovascular disease (ASCVD) and type 2 diabetes.

A person who has metabolic syndrome shows three of the following five risk factors:

- abdominal girth greater than 40 inches in men and 35 in women
- HDL cholesterol less than 40 in men and 50 in women
- elevated blood pressure greater than 130/85
- elevated triglycerides greater than 150
- fasting blood sugar greater than 100

For a person with diabetes (fasting glucose greater than 126), only two of the above risk factors need to be present.

“This is the result of living in an industrial society. We have plentiful supplies of inexpensive food and sedentary jobs,” Dr. Bleyer said. “In other parts of world where people are not so sedentary and food is not so plentiful, obesity is not so much of a problem.”

Another contributor to obesity is the aggressive marketing and advertising of food through grocery products and fast-food restaurants.

The most serious type of obesity, he said, is



fat around the abdomen. This fat can wrap around organs inside and be metabolically active, helping to lead to glucose intolerance, elevated triglycerides and hypertension.

“This type of fat is the first lost when we lose weight and exercise. That’s why weight loss and exercise can have a tremendous effect on metabolic syndrome.”

Battling Obesity

Getting people to slim down takes more than just telling them to diet and exercise. If it were that simple, there already would be fewer overweight people. Ask anyone who has tried to diet or start an exercise program and only see it fizzle.

Dealing with obesity must involve the whole person and consider all the factors influencing their lives, said Kathleen Killion, executive director of health literacy for BJC HealthCare.

“We must understand the connection between obesity and a person’s mental health, the culture they are part of, and various stresses in their lives,” she said. “Food is an addictive behavior like cigarettes or alcohol. People trade one stress reliever for another.”

When dealing with stress, people often turn to traditional “comfort” foods that are often are high in fat and salt, which contribute to obesity, hypertension, diabetes and other health risks.

Ms. Killion also expressed concern that the current economic crisis could cause diet and exercise to go on the back burner. “There is a correlation between financial health, physical health and mental health.”

Dr. Bleyer noted that orthopedic conditions, depression and other medical problems such as asthma can be barriers to exercise. It can be hard to find time to exercise between demands of family and work.



continued on page 24

Twenty-First Century Epidemics:

Obesity, Diabetes, Cardiovascular Disease

(continued from page 20)

Children and Physical Activity

The growth in obesity among children is one of the most alarming trends. More than three times as many children are overweight today as there were in 1980 – just 29 years ago. This is attributed in large part to a lack of physical activity.

According to data reported by the American Heart Association, 32 percent of female and 18 percent of male students in grades 9-12 did not engage in 60 minutes of moderate-to-vigorous physical activity even once in the previous seven days. Rates of inactivity were highest among black (42%) and Hispanic (35%) females.

Among children ages 9-13, over 60 percent do not participate in any organized physical activity during the nonschool hours, and 23 percent do not engage in any free-time physical activity, according to data reported by the Heart Association.

Daily enrollment in physical education classes dropped from 42 percent to 25 percent among high school students between 1991 and 1995, as the emphasis increased on core subjects of reading, math and science.

Computers and television take a large portion of young people's out-of-school time. More than one fourth of all the students spend three or more hours per day outside of school time using computers or watching television, reports the American Heart Association.

Finding Solutions

All interviewed agreed that solutions must involve work at the societal level.

"As a group, physicians and others should educate the public about the significance of this problem. We need to get into the school systems and bring back physical education, and remove the soda machines and fast food," Dr. Bleyer said.

Ms. Killion said, "We need to attack the disease where people congregate – at schools, in the workplace, in congregations, at sports venues, and more."

BJC offers programs to its employees and the community to promote healthy lifestyles. Services include educational presentations, screenings, support groups and other programs delivered through employers, churches and other community



sites. BJC partnered with the St. Louis Science Center on the BJC SportsWorks exhibit, and also has partnerships with the St. Louis Cardinals and St. Louis Blues.

Dr. Blinder encourages physicians to get involved with advocacy and education groups such as the American Diabetes Association. "By affiliating with a well-structured organization, we can help educate the public and raise money for patient care and research."

Advice for Physicians

There are a variety of ways physicians can address obesity and the other 21st Century epidemics with their patients.

Be more aggressive in treating patients with

metabolic syndrome, says Dr. Bleyer. "Make sure blood pressure is adequately treated, and aggressively treat lipid problems." He advised physicians to utilize a test for the number of non-HDL particles; the more particles, the greater likelihood of metabolic syndrome.

Along with maintaining proper glucose, blood pressure and cholesterol levels, Dr. Blinder suggests annual dilated eye exams and routine foot exams. He offers the ABCs of care:

- A for A1C test for blood glucose, twice a year
- B for blood pressure check, at every visit
- C for cholesterol, at least once a year

Ms. Killion encourages physicians to talk frankly in plain terms with patients about the risks of obesity, diabetes and cardiovascular disease. "Explain the meaning of the numbers and how they could impact the patient's life. Don't scare the patient, but give the facts."

Also important, she added is completing the conversation on a positive note. "Help the patient leave with hope and a game plan."

Physicians should have a "toolkit" of referral resources to provide to patients, ranging from nearby workout centers to dietitians to mental health or financial counselors, she said.

All noted the wealth of literature available from the American Heart Association, the American Diabetes Association and other groups.

