Bulletin

Editor: John W. Snead, M.D.
March 2019 • Volume 43 Issue 3

LEE COUNTY MEDICAL SOCIETY INC.

Physicians Caring for our Community

LEE COUNTY MEDICAL SOCIETY INC.

Bulletin

13370 Plantation Road, Ste. 1
Fort Myers FL 33912

The Lee County Medical Society Bulletin is published monthly with the June and August editions omitted.

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LCMS **Disclosure Policy**

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Lee County Medical Society
Mission Statement

The mission of Lee County Medical Society is to advocate for physicians and their relationships with patients; promote public health and uphold the professionalism of the practice of medicine.

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March Inserts: Patti Testa, Realtor
Joan Crompton, Realtor
Elmquist Eye Group

Lunar Eclipse January 2019

A total lunar eclipse lit the night skies with an eerie red glow between Sunday, January 20 and the early hours of Monday, January 21. This is due to light refraction, filtering out all colour hues apart from those on the red spectrum. This lunar phenomenon is a sight to behold. **Photo by Howard Sheridan, M.D. from his Fort Myers residence.**

Events RSVP online at www.lcmsfl.org

Friday, March 8, 2019 - Tacos & Tequilas
Combined Cocktail Hour with Collier County Medical Society
10952 Eagle Village Dr., Ste 425D
Fort Myers, FL 33913
6:00 p.m. to 8:00 p.m.

Saturday, March 16, 2019
Second Annual Fun Run
Registration begins at 7:30 a.m.
5k Race at 8:45 a.m.
Walk at 9:00 a.m.

Friday, April 5, 2019
Shopping at Chico's
4:00 p.m. to 5:30 p.m.
To register by March 29, 2019 visit www.lcmsfl.org

Wednesday, April 17, 2019
LCMS General Society Meeting
6:00 p.m. to 8:00 p.m.
FSW Medical Museum

Membership News

NEW APPLICANTS

Melanie Coombs-Bynum, M.D. – Dr. Melanie Coombs-Bynum received her medical degree from the University of Miami School of Medicine, Miami, FL from 8/92 – 5/96. She completed an internship and residency at Children's Medical Center of Dallas, Dallas, TX from 7/97 – 6/99 in Pediatrics. Dr. Coombs-Bynum is in practice at Physicians' Primary Care of SW FL, 9350 Camelot Drive, Fort Myers, FL 33919. Tel: 239-481-5437 Fax: 239-481-0570. Board Certified: Pediatrics

Marlene Moulton, M.D. – Dr. Marlene Moulton received her medical degree from the Meharry Medical College, Nashville, TN in 2003. She completed an internship at Mayo Clinic in Rochester, MN from 6/2003 – 6/2004 and a residency at the Mayo Clinic, Rochester, MN in Otolaryngology from 6/2004 – 12/2004 and a second residency at the University of Miami, Jackson Memorial in Internal Medicine from 6/2005 – 5/4/2008. Dr. Moulton is in practice with The Listening Doctor, PLLC, 13421 Parker Commons Blvd. Ste 101, Fort Myers, FL 33912. Tel 239-985 2600 Fax: 239-985-0103.

Tanweer Memon, M.D. – Dr. Tanweer Memon received his medical degree from Ltaquat Medical College, Jamshoro Sindh, Pakistan from 2/1984 – 6/1991. He completed an internship and residency in Internal Medicine at Kings Brook Jewish Medical Center in Brooklyn, NY from 7/1994 – 7/1997. Dr. Memon is in self practice at, 2852 Tamiami Trail, Ste #5, Port Charlotte, FL 33952. Board Certified: Internal Medicine

Mark Droffner, D.O. – Dr. Mark Droffner received his Doctor of Osteopathic Medicine at University of Osteopathic Medicine & Health Science College, in Des Moines, IA from 8/1980 – 6/1984. He completed a residency in Family Practice & Geriatrics at Memorial Hospital of Burlington County, Mount Holly, NJ from 7/1984 – 6/1987. Dr. Droffner is in self practice at, 260 Milus St., Punta Gorda, FL 33950. Tel: 941-637-0911 Fax: 941-637-9153. Board Certified: Family Medicine

New Phone and Fax number for the Florida Radiology Consultants Tel: **239-331-5566** Fax: **239-274-5791**

Matthew Assing, M.D.
Christopher Conner, M.D.
Cory Duffek, M.D.
Christopher Johnson, M.D.
David Johnson, M.D.
Jamal Ksar, M.D.
Heidi Lewis, M.D.
Louis Magas, M.D.
Gregory Michaels, M.D.
Geoffrey Negin, M.D.
Tom Presbrey, M.D.
Nikhil Rajadhyaks, M.D.
Sharik Rathur, M.D.
John Rodriguez, M.D.
Mai Saif, M.D.
Gail Santucci, M.D.
Jeffrey Sonn, D.O.
Joseph Tienstra, M.D.
Michael Weiss, M.D.

MEMBER NEWS

We are requesting that if you have information that you would like to share regarding yourself or your practice, to please e-mail kris@lcmsfl.org. You will be featured in our upcoming Membership Spotlight section.

Become a 5K Fun Run Honor Roll Physician Sponsor

Current 2019 Honor Roll Physicians:
F. Rick Palmon, M.D. at Southwest Florida Eye Care
Dean Traiger, M.D. at Physicians Pimary Care of SWFL
Shari Skinner, M.D. at Associates in Dermatology

Honor Roll sponsorships available - $250 $500 $1000
Your name on race day banner

www.lcmsfl.org

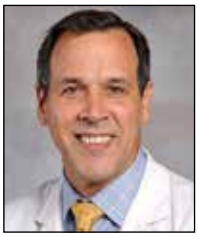
President's Message
By Daniel de la torre M.D.

Are doctors still relevant?

I recently read an article entitled "It's time to fire your doctor" about the inexorable march of consumer-based medicine in the age of the "gig economy". Anyone who's been around long enough knows that if such predictions were accurate, we would be getting around in flying cars by now. Still, this article discussed new technologies in medical care (The "Uber" model of medical care) and ended with the statement "the revolution is coming. But not from your doctor." Granted, I am not exactly in a position to know the state of the art in primary care. As an employed hospitalist, most of my "clients" have no choice in the matter. Nonetheless, the implications for medical practice in general are disturbing.

The idea that a physician is less trustworthy than an app is by itself disturbing

Already, the proliferation of web-based medical advice and even app-based medicine is alarming. Insurers have been quick to jump on board, recognizing the obvious cost savings. A number of insurance providers offer discounts for web based "visits" such as Anthem Blue Cross' LiveHealth. Telehealth is taking off. To make matters worse, when I address the occasional patient who comes to me with a preconceived diagnosis based on their Google search or smart phone app, I am sometimes accused of wanting to charge them more for unnecessary work up or treatment. (The idea that a physician is less trustworthy than an app is by itself disturbing). While medical websites all carry disclaimers of risk, few seem to take it seriously.



The reasons are many, and not trivial. The time and cost savings are obvious. Waiting for an appointment and taking time off work might be a reasonable option if you have insurance coverage, but after the co-pay and the inevitable insurance denial, how much is that really worth? And if you're one of the (many) uninsured, the incentive vanishes all together. It's no wonder that Internet-based medicine has gained so much traction. If it were not for our older, medically needy, non-Internet savvy population, I suspect the trend would have accelerated even faster.

What's missing of course is the personal touch. Even relatively younger healthier patients benefit from having a primary care physician. In my own case, I would never have been diagnosed with thyroiditis had a skillful primary care doctor not uncovered it. The time needed to make that personal connection has become exceedingly scarce. Burdened by economic and regulatory factors, primary care physicians find themselves stretched thin. Patients often tell me they have not seen their PCP in years; just the nurse practitioner. With competition from web-based services mounting, all primary care physicians clearly need to adapt quickly. But they should also focus on the one thing that no Internet service can provide: personal face time and the relationship it affords. My patients don't thank me for diagnosing or treating their elements, they appreciate that I care. Let's face it. Your smart phone really doesn't care about you.

LCMS EVENT!

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chico's

Keeping Families Close . . .
By Laura Ragain

Since 1996, the Ronald McDonald House® in Fort Myers has welcomed thousands of families from Lee, Collier, Charlotte, Glades and Hendry counties while their children are undergoing medical treatment at Golisano Children's Hospital of Southwest Florida. Our "home-away-from-home" means a great deal to those we serve. Our family-centered programs make a difference by improving the clinical outcomes and experience for the children and their families. Our support efforts were further enhanced with the addition of a Ronald McDonald Family Room® in the new Golisano Children's Hospital. There, all families with a child in the hospital can stop by for a sandwich, a quick snack, a cup of coffee or just close their eyes for a few minutes without having to be far from their child's bedside.

Ronald McDonald Family Room®

You may not be aware that Ronald McDonald House Charities (RMHC) also serves children far beyond the hospital walls. Through our partnership with Healthcare Network of Southwest Florida, the Ronald McDonald Care Mobile® brings medical and dental services to over 3,000 children annually in Collier County, right in their own neighborhoods. In partnership with Golisano Children's Hospital, autism screenings are performed onboard the Care Mobile one day a month in Lee County.

Ronald McDonald Care Mobile®

Thanks to grant funding from RMHC Global, our Southwest Florida Chapter added a second Ronald McDonald Care Mobile to provide medical and dental treatment to the unserved and underserved children in Lee, Charlotte and Hendry counties. Family Health Centers of Southwest Florida is our partner in providing services that include dental screenings, sealants and varnishes to children at Title 1 schools. This expanded program was launched in January of 2018 and has provided services to more than 5,000 children in its inaugural year.

Ronald McDonald House®

RONALD MCDONALD HOUSE CHARITIES®

Need help with life's difficulties?

Please visit our website at:

www.lcmsfl.org

The Pendulum Has Swung Too Far

By Linda Brookes, M.Sc., Medical Writer

"In the war on opioids, the main casualties are usually identified as the people who misuse or abuse the drugs and are at increased risk of dying from an overdose. However, since regulators tightened opioid prescribing rules in the United States, another group of victims has emerged: the so-called "legacy patients," often elderly, with non–cancer-related chronic pain."

In the war on opioids, the main casualties are usually identified as the people who misuse or abuse the drugs and are at increased risk of dying from an overdose. However, since regulators tightened opioid prescribing rules in the United States, another group of victims has emerged: the so-called "legacy patients," often elderly, with non–cancer-related chronic pain that was successfully managed with a regular dose of a prescribed opioid analgesic. Many of these patients have had their medication reduced or even withdrawn, often with distressing and sometimes tragic consequences.

Stories abound of patients unable to tolerate a forced tapering of their dose. Other are cut off from their medication completely by physicians or pharmacies who face pressures to change opioid prescriptions.

"These patients are undoubtedly discriminated against," says Charles Vega, MD, clinical professor of family medicine at the University of California, Irvine. "They are viewed as drug-seekers, whether they have drug-seeking behavior or not, and it makes them ashamed. There is a psychological toll."

The plight of these patients has provoked reactions from organizations as disparate as Human Rights Watch, which issued a report about patients feeling abandoned and stigmatized by the healthcare system, to the TV channel Fox News, which screened a series of programs highlighting the overlooked victims of America's opioid epidemic. Patient groups, such as Don't Punish Pain, have been formed to protest the "arbitrary restrictions" on opioid medications introduced by the US government.

Chronic Pain Patients Are Not All Created Equal

"We have a crisis that has precipitated a set of policy responses that many clinicians adhere to in almost a religious kind of way without acknowledging variation at the patient level," says Cary Reid, MD, PhD, associate professor of geriatrics at Weill Cornell Medical College, New York, New York.

Vega agrees, noting that although only a minority of patients really need opioid therapy, "we are painting with such broad strokes now in this crisis mode that they are negatively affected by it."

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The Pendulum Has Swung Too Far - Treating Pain in Primary Care

By Linda Brookes, M.Sc., Medical Writer

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He recalled the case of a 72-year-old retiree with chronic degenerative disease of the spine. "She also had stage IV chronic kidney disease, hypertension, and diabetes, all fairly stable and well-controlled. It would be a huge mistake to put her on chronic anti-inflammatory drugs; acetaminophen doesn't do enough, and she has trouble accessing physical therapy, he explained. What really sets her free is tramadol once a day, which she takes in the morning. And then she uses acetaminophen the rest of the day. When I last wrote her the usual prescription, the pharmacy denied it, saying she didn't have a chronic condition and was at risk for overdose. They didn't notify me and she went 10 days without therapy. She finally called me, asking why I had withheld her medicine, and I didn›t know what she was talking about.

"That is the environment we are living in, and it is a real shame. I understand the value of safety regulations," he stresses. "I stay away from opioids in most patients, even for acute treatment, because I am really worried about the path toward addiction — but not for 72-year-olds who have become accustomed to them and have used them for a long time, and in whom we've tried everything else and nothing else works."

"That is the environment we are living in, and it is a real shame. I understand the value of safety regulations," he stresses.

Brad Fox, MD, chairman of the Department of Medicine at Saint Vincent Hospital, Erie, Pennsylvania, is also concerned that the regulations treat every patient as equivalent. He cited the case of an 80-year-old patient who had been taking hydrocodone 2.5 mg every 6 hours for 12 years. He hasn't asked for more; he doesn't take them more frequently; and he calls me every 30 days and gets 120 tablets, which the guidelines see as a bad addiction. I really don't care if he may be addicted to it; he functions very well on his current medications, Fox declared."If there is ever a case for patient-centered care, it is probably the chronic pain patient, especially the older chronic pain patient," Vega suggests.

Prescription Opioids Are Not the Main Culprit

No one disputes the role that prescription opioids played early on in the opioid epidemic, which the US government has called "the worst drug crisis in history." The odds of dying from an accidental opioid overdose are greater than dying in a motor vehicle crash. The increase in opioid prescription rates in the early 1990s was accelerated by both increased use and the launch of the American Pain Society's Fifth Vital Sign campaign.

The now-notorious launch and marketing of OxyContin (Purdue Pharma) alone accounted for over 7 million prescriptions in 2001. Opioid prescriptions peaked in 2010, a year in which enough prescriptions were dispensed to supply 4 out of every 5 US citizens. Although not a surprise in hindsight, that increase was paralleled by a dramatic increase in deaths due to opioid overdose, particularly associated with higher doses.

The overall national opioid prescribing rate has been declining since 2012. That year, just under one fifth of the US population was prescribed one or more opioid prescriptions annually; fewer than 1 out of 10 was for a high dosage.

Death rates involving prescription opioids have remained high, albeit stable, since 2016, even though the rate of overdose deaths involving all opioids has been on the rise since 2012. Although these deaths were initially due to heroin, since 2013 most deaths have been due to illicitly manufactured fentanyl and fentanyl analogues. Prescription opioids now account for about one third (36%) of all opioid overdose deaths. That percentage is projected to continue to decline.

Are Guidelines Up To the Task?

Guidelines for management of chronic pain issued around 10 years ago recommended opioids as the drugs of choice. Reid, who participated in the panel that authored the American Geriatrics Society guidelines for chronic pain management in older adults told Medscape that we knew that nonsteroidal anti-inflammatory drugs (NSAIDs) had not only significant adverse cardiovascular but also nephrotoxic effects. Because pain is difficult to treat in an 80- or 90-year-old with multiple clinical conditions, opioids appeared to be a more appropriate choice for

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2019 Member Installation

Names of LCMS Past Presidents from left to right:

2019 Daniel de la Torre, M.D.
2018 F. Rick Palmon, M.D.
2016 Shari Skinner, M.D.
2011 Shahid Sultan, M.D.
1997 George Kalemeris, M.D.
2014 Peggy Mouracade, M.D.
2017 Jon Burdzy, D.O.
2015 Andrew Oakes-Lottridge, M.D.

2019 Board of Governors Oath given by Jon Burdzy, D.O. Left to Right: Stu Bobman, M.D.; Ryan Lundquist, M.D.; Joanna Carioba, M.D.; Rick Palmon, M.D.; Daniel de la Torre, M.D.; Elizabeth Cosmai, M.D.; Annette St. Pierre MacKoul, M.D.; Asif Azam, MD; Gamini Soori, M.D.; Imtiaz Ahmad, M.D.

The Pendulum Has Swung Too Far -Treating Pain in Primary Care

By Linda Brookes, M.Sc., Medical Writer

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patients with severe pain that could not be managed by other means. I would say in hindsight, our understanding of the potential harms of this strategy was not what it should have been. A evidence base demonstrating harm associated with prescription opioid use emerged after release of the guideline."

The idea of don't prescribe an opioid, don't prescribe drugs, just prescribe nondrug modalities' is fine until it comes face to face with the reality that in many communities, it is simply not viable.

Concerns about increases in opioid prescribing and abuse led the Centers for Disease Control and Prevention (CDC) to issue a guideline in 2016 on use of opioid medications for adults with chronic noncancer pain. Although the publicly released draft was generally supported by most US health organizations, the final version raised concerns.

Canada did not adopt the CDC guideline because of several "important limitations" said Jason Busse, DC, PhD, associate professor in the Department of Anesthesia Research, McMaster University, Hamilton, Ontario, Canada, and lead author of the Canadian guideline published the following year. As far as we could tell, the CDC panel included individuals who were on record as being fairly critical of opioids for chronic noncancer pain," Busse said.

He also criticized some of the guideline's recommendations. "One was to prescribe opioids only if the benefits are anticipated to exceed the harms. Who is not doing that?" he asked rhetorically. "What clinicians need is specific guidance on the circumstances where the harms will exceed the benefits," he declared.

In a commentary in the *New England Journal of Medicine*, Thomas Frieden, MD, MPH, then CDC director, and Debra Houry, MD, MPH, director of the CDC's National Center for Injury Prevention and Control, opined that nearly all prescription opioids were "no less addictive than heroin" and that "for the vast majority of patients, the known, serious, and too-often-fatal risks far outweigh the unproven and transient benefits."

MACRA 2019 Changes Address Physician Concerns

By Kim Hathaway, MSN, CPHRM, Health Quality Patient Safety and Risk Consultant, The Doctors Company

Centers for Medicare & Medicaid Services (CMS) is taking steps to ease regulatory burdens by removing process measures, developing more outcome measures, changing the fee schedule to support telemedicine technology, and focusing on EHR interoperability. That's because CMS listened to stakeholder input before releasing the final changes to the Quality Payment Program (QPP). The changes were effective on January 1, 2019.

This marks the third year of the QPP, which was established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Highlights of the changes made to MIPS for 2019 include:

1. Category weights have changed for two categories. The category changes include:
   - Quality: 45 percent (down from 50 percent in 2018).
   - Cost: 15 percent (a 5 percent increase from 2018).
2. Important general MIPS changes for performance year 2019 include:
   - The performance period for the third year of the QPP/MACRA is the calendar year 2019. Performance for 2019 will affect payment in 2021.
   - The performance threshold increases in 2019 from 15 MIPS points to 30 MIPS points.
   - The exceptional performance bonus increased to 75 points (up from 70 points in 2018).
   - The total amount of Medicare reimbursement at play for 2019/2021 has increased.
   - The five bonus points added to the final score of clinicians in small practices (Tax Identification Numbers - "TINs" with fewer than 15 associated National Provider Identifier - "NPIs") increases to six points.
   - Eligibility has been adjusted to allow more clinician participation in MIPS, even by providers excluded based on the low-volume threshold criteria.
   - Eligible clinician types have expanded
3. The MIPS Quality category has:
   - Separated collection types from submission types.
   - Added eight and removed 26 measures.
   - Made claims-based measures available only to groups with fewer than 15 physicians.
4. MIPS Advancing Care Information category changed in 2018 to Promoting Interoperability. The Promoting Interoperability changes for 2019 include:
   - Four aims clinicians must meet: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange.
   - Any unreported measure or no answers to a yes/no measure will result in a zero Promoting Interoperability score.
   - MIPS-eligible clinicians are required to use the 2015 Edition of Certified Electronic Health Record Technology (CEHRT) if they report in this category and must submit evidence to CMS.
   - The Promoting Interoperability reporting period will remain a minimum of a continuous 90-day period.
   - Scoring is now solely based on performance and the base.
   - Security risk analysis is still required, but no points will be assigned.
   - Two new measures are added for the e-Prescribing objective.
5. MIPS Improvement Activities category changes include:
   - Removal of the 10 percent Promoting Interoperability bonus for using a CEHRT to complete the Improvement Activity.
   - Clarification of the criteria for "high-weighted" classification.
6. MIPS Cost category changes include:
   - Eight episode-based Cost measures have been added. The same two core measures for Medicare Spending per Beneficiary and Total Per Capita Cost remain.
   - All cost measures have the same weight.
7. Alternative Payment Models: More specialty-related models will be developed.

Practices that find these changes overwhelming may want to reach out for expert help with industry-leading best practices to maximize Medicare payments. Visit Medical Advantage Group (medicaladvantagegroup.com) for more information. For resources on MACRA and success in optimizing reimbursement, go to MACRA Resources for Medical Practices (thedoctors.com/MACRA).

And You Were There

By Roger Scott, M.D.

(Previously Published September 1997)

This early June, as the weather began to get warmer, I was thinking about Polio in summers past and wondering what had happened to our old iron lung at Lee Memorial. Low and behold, within two days the iron lung was on display in the lobby of Lee Memorial. This hadn't been out of its closet for some years, I thought, but a sign attached stated that it was given to the historical Museum and remained on display there. Finding this lung reinforced my thought to write the following article

It was a hot summer in June 1953, when the U.S. Air Force stationed me with my family on TDY (temporary duty) in Montgomery, Alabama. The city was under siege by a Polio epidemic (most commonly called Infantile Paralysis), with eighty-one cases occurring. Throughout the nation in the summers when Polio would begin to appear, public gathering of children was forbidden and swimming pools, theaters, camps, etc. were closed to try to avoid this dread disease. The National Infantile Paralysis Foundation, working with the U.S. Government, decided to use Gamma Globulin (GG) in a mass inoculation trial for the disruption of the epidemic. GG had been used sporadically and apparently had shown beneficial results with exposed cases but never had a mass inoculation program been given.

Alabama Editors Vote the Top Story of 1953

First Anti-Polio Injection Given
During the massive polio epidemic 35,000 children were given gamma globulin injections in the first mass trial for polio prevention. Edward Cripple, 5, was given the first injection by Dr. Roger Scott of Gunter Air Force Base staff and medical history was made.

This article appeared June 30, 1953 in the Montgomery *Alabama Journal*.

(Photo by Kraus) Archive of the Museum of Medical History Collection

We were asked to volunteer to give the Gamma Globulin, and I had the honor of giving the first injection given in the U.S. for this mass prophylactic. I was really a celebrity, with my face posted all over the front page of the newspapers of the county (better there than in the post office!), but the fame was short-lived. Six hundred volunteers (including about 90 physicians, a number of nurses, aides, and clerks) participated in the program, but all injections had to be given by the physicians.

Gamma Globulin is a very viscus fluid and the dosage for each child was calculated based on weight. The dose was quite high for even the smallest of children and injecting this large quantity of viscus liquid yielded a profound number of blisters on all fingers and hands at the end of each day. The Foundation had obtained 67 gallons of GG, most of the total U.S. supply, amounting to approximately 250,000 cc's, which was expected to be given during this epidemic. The first day (the 82nd and 83rd cases appeared, and 3 deaths had occurred) 9,216 shots were given with 39,562 cc's being utilized. In four days, 31,000 children received GG.

Each day we worked from 8 AM to 8 PM, but in the end all turned out well. The epidemic was stopped. Ironically, my two children were not allowed to receive the shots because we were transients in Montgomery and not residents! The authorities are still looking for the 20 cc's of Gamma Globulin disappeared from my table.

After leaving Montgomery I was stationed in New Mexico and in 1954 Dr. Salk's first licensed Polio Vaccine (formalin and heat inactivate virus) was made available for limited use in the country. We were able to obtain this vaccine and give it to the children of our base; however, it was later reported that the Cutter Company who supplied our vaccine had supplied contaminated vaccine, with some active virus. We had one or two cases of Polio on the base but everybody else got by without a problem.

Didn't hear much more about Polio until 1962 when Dr. Albert Sabin produced the attenuated live virus vaccine. The LCMS had three Sabin Polio Sundays with members donating their time to administer this oral vaccine. Type 1 was given on one Sunday, and Type 2 and Type 3 on later Sundays, as three immunizations were required. Altogether, it was my understanding that 65,000 people, including some adults, in Lee County received this vaccine in 1962. This was free of charge to the public; however, a basket with a sign was placed to ask people to contribute 35 cents if they could to cover the cost of the vaccine. More than enough money was obtained, as some people were very generous, and the excess funds were contributed to ECC Library. There hasn't been a case of Polio in Lee County since the vaccine was given in 1962.

The most famous person to have Infantile Paralysis (Polio) was Franklin D. Roosevelt, the 32nd President of the U.S. He contracted Polio at age 39 and had very little use of his lower extremities, using a wheel chair and crutches. Instead of exposing his disability as I would expect someone to do today, President Roosevelt would hide his disability as much as possible by appearing in a seated position, or if he were standing, by wearing a cape that draped around his crutches. Politically correct in his day, but politically incorrect in our day of persons with disability

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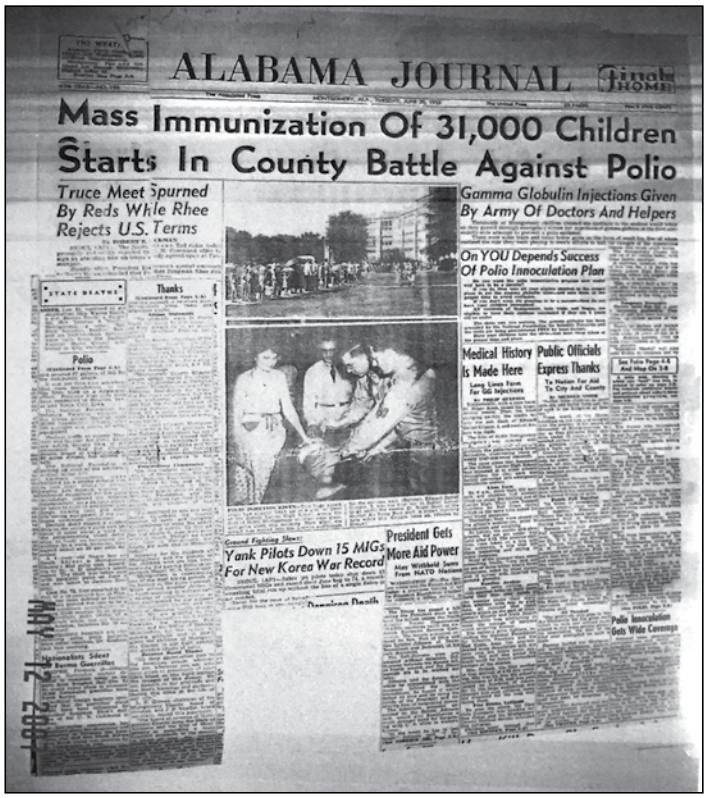
And You Were There

By Roger Scott, M.D. (Previously Published September 1997)


ALABAMA JOURNAL

Mass Immunization Of 31,000 Children Starts In County Battle Against Polio

Truce Meet Spurned By Reds While Rhee Rejects U.S. Terms

Gamma Globulin Injections Given By Army Of Doctors And Helpers

On YOU Depends Success Of Polio Innoculation Plan

Medical History Is Made Here

Public Officials Express Thanks

Yank Pilots Down 15 MIGs For New Korea War Record

President Gets More Aid Power

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rising well above their disability. President Roosevelt was the greatest one to ever rise above his disability.

Of note and comic relief is information that Dr. Cox had developed an ineffective vaccine for Polio before Dr. Sabin's. Dr. Cox's vaccine was also orally administered and was mixed into the ingredients of suckers (lolly pops). Each child got a sucker which was comically named in honor of Dr. Cox. If you do not understand the comedy speak to me personally, please.

It has been a distinct pleasure to have been present at the beginning of the eradication of a major disease in this country and as best that I have been able to find, the last case of Polio was 1991 in the U.S. It still occurs throughout the world but is diminishing, and it is hoped that by the year 2000 there will be no more Polio.

This article is reminiscent of an old program regarding historical events called "AND YOU WERE THERE". Now you have been there in one disease in history.

In January 1954, the Alabama editors declared the Polio News the top news story of 1953.

Doctor: Fight To Regain the Title That Is Rightly Yours

By Michele Luckenbough (Patient - January 10, 2019)

As we have moved into the 21st century, we have witnessed a deterioration in our perception of our doctors of medicine. This has been a gradual, eroding process, quite possibly by the design of those in powers of authority in our government, health insurance corporations and the plethora of health care corporations. The assumption might have been to make these changes in the mode of operation gradually so that they would go unnoticed by the general population. An analogy would be to compare the process to that of a volcano which has been simmering for decades and then finally erupts. It's hot, molten lava flows surreptitiously over everything in its path choking out life. One might say this is a wild exaggeration on my part, but just stop and consider what the practice of medicine was like even 20 or 30 years ago when doctors had the autonomy to make decisions on how they would conduct the practice of medicine and when the family doc actually knew his patients and was able to give them the time and care they needed.

Do we want to place that label on those individuals who are responsible for our health and our very existence?

Governmental mandates have placed an immense burden upon our physicians and how they spend their workday. It seems the concern now has transferred from viable doctor/patient interactions to inputting data into electronic health records for the purpose of fee determination. Often a patient will leave an office visit to his doctor with only having answered yes or no to a series of directed questions off a computer screen. The doctor-patient relationship is being severely damaged by these so-called technical advancements in medicine. Our doctors want to hear their patients concerns but feel overwhelmed by the time constraints often placed upon them. As a result, the patient leaves the exam room feeling underwhelmed.

Individual primary care practices have almost gone the way of the dinosaur. They have been absorbed by health care corporations which offer potential financial security for the physician but at what cost? These corporations refer to our doctors as "providers," a vague term which in my opinion belittles the years of preparation and sacrifice to acquire the title of medical doctor. This terminology should stir up discontent among all members of the health care profession such as nurse practitioners, physician assistants, nurses, etc. who are referred to as "mid-level providers." I have many so-called providers in assisting me in the course of living in today's world. The term provider is defined by Merriam-Webster "as a group or company that provides a specified service." For example, I have a provider who disposes of my trash weekly; I have a provider who supplies internet service, etc. Do we want to place that label on those individuals who are responsible for our health and our very existence?

As a patient, I have witnessed the sacrifices made by my doctors on my behalf. Not only do most put in long and hard hours during their workday, but for many, this extends well beyond the normal 9 to 5 time frame. Additional hours are necessary to input patient notes, update medical records and contact patients with lab results. Most of this goes unnoticed from those on the outside. The bottom line: Often times the physician's concern for their patients extends well beyond the office visit.

So in reparation for their personal sacrifice of time away from family, for the huge financial burden to acquire a medical degree, for the years spent in preparation to practice, for the stress placed upon them to make life and death decisions regarding our health care, we have slapped the label "medical provider" upon them. The primary care doctor, once a revered position and a core position in the practice of medicine, is now struggling to stay in existence. Many are taking an early retirement or leaving due to burnout. This profession, has to a large extent, evolved into merely a cog of the well-oiled machine we call medicine in today's world. The practice of medicine has morphed into visits to urgent care centers or visiting a "virtual" doctor on the internet. Although these alternatives may lessen the burden of the shrinking number of primary care doctors, it is only a band-aid for the problem.

A stand must be taken to prevent the disappearance of the family doctor. A good doctor-patient relationship is the basis for maintaining the health for those served. Without it, health care is doomed. Doctors: You are our heroes; you are our healers. Fight to regain the title that is rightly yours. If the current medical associations that you are members of have fallen short of their responsibility to you, then form new ones who will get the job done. We, doctor and patient alike, all have a stake in this troubling state of affairs.

Michele Luckenbaugh is a patient.

LCMS Retiree Luncheon — February 26, 2019

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