Bulletin

Editor: John W. Snead, M.D.
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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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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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Oak Alley Plantation is a historic plantation located on the west bank of the Mississippi River, in the community of Vacherie, St. James Parish, Louisiana, U.S. Oak Alley is named for its distinguishing visual feature, an alley (French allée) or canopied path, created by a double row of southern live oak trees about 800 feet (240 meters) long, planted in the early 18th century — long before the present house was built. The allée or tree avenue runs between the home and the River. The property was designated a National Historic Landmark for its architecture and landscaping

Photo by Peter Sidell, M.D.

Events RSVP online at www.lcmsfl.org

Thursday, May 2, 2019
Women's Event at Jennifer's
The Design Center
13251 McGregor Boulevard, Suite 111-1, Fort Myers
Between the Melting Pot and First Watch

Friday, May 10, 2019
LCMS Cocktail Hour
6:00 p.m. – 7:30 p.m.
Square 1 – 5031 S Cleveland Ave, Fort Myers

Thursday, June 27, 2019
FSU/LH Residency Reception
6:30 p.m. – 8:30 p.m.
FineMark National Bank & Trust
12681 Creekside Lane
Fort Myers, FL 33919

Save The Date

Friday, September 20, 2019
Annual Medical Service Awards

Membership News

Moving Out of Area: Douglas Henricks, M.D.

New Applicants

Claudio Ferreira, M.D. – received his medical degree at the Medical University of Vassouras, Rio de Janeiro, Brazil in 1992. Dr. Ferreira completed an internship in General Surgery and a residency in Ophthalmology from King Drew Medical Center, Los Angeles, CA from July 1, 2000 - June 30, 2004. Dr. Ferreira also completed a fellowship in Vitreoretinal, Ophthalmology, at university of Virginia, Charlottesville, VA and University of Tennessee, Memphis TN from July 1, 2004 – June 30, 2006.

Dr. John Thompson – received his medical degree at Lake Erie College of Osteopathic Medicine, Bradenton, FL in 2013. Dr. Thompson completed an internship at Rowan University, Glassboro, NJ from June 2013-June 2014, and a residency at Memorial Hospital, York, PA in Orthopedic Surgery from July 2014-June 2017. He also completed a fellowship at Rubin Institute for Advanced Orthopedics at Sanai Hospital, Baltimore, MD in Adult Reconstruction Fellow from August 2016-July 2019.

Rebecca Kimpel, M.D. – received her medical degree at Hahnemann University College of Medicine in 1987. Dr. Kimpel completed an Internship in Internal Medicine at Dartmoouth-Hitchcock Medical Center, Hanover, NH from 1987 - 1988. Dr. Kimpel also completed a residency in Internal medicine at Guthrie Medical Center, Sayre, PA from 1988-1990.

Membership SPOTLIGHT

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.

Dr. Trevor Elmquist of Elmquist Eye Group has once again been honored as one of the region's Top Doctors by Castle Connolly Medical Ltd., a research and publishing company created to help consumers identify the best health care providers. Since 2011, Elmquist has been included annually in Castle Connolly's regional directory of "Top Doctors" for ophthalmology, which recognizes the top 10 percent of primary and specialty care physicians within their chosen field after a doctor-led research team completes an extensive review of nominations, credentials and interviews. Learn more: https://www.elmquist.com/news.html

Allison Yee, M.D. – received her medical degree at Indiana University, Indianapolis, IN in 2006. Dr. Yee completed an internship in Transitional Medicine at St. Vincent's Hospital, Indianapolis, IN from July 1, 2006-June 1, 2007. She completed a residency in Ophthalmology at the University of Indiana, Indianapolis, IN from July 1, 2007-June 1, 2010, and a fellowship in Oculoplastic Surgery at Indiana University, Indianapolis, IN from July 1, 2010-June 1, 2012.

Juan Fernandez de Castro, M.D. – received his medical degree at Universidad El Bosque, Bogota, Colombia in 2001. Dr. Fernandez de Castro completed an internship in General Surgery and a residency in Ophthalmology at the University of Louisville, KY from 2013-2017. Ocular Pathology and Molecular Ophthalmology from the University of Iowa from 2008-2010.

New Members: January through March 2019

Melanie Coombs-Bynum, MD
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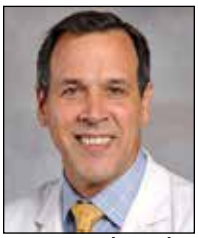

The new drug war

Those have been paying attention may have noticed the battle lines forming. Drug prices have always been a matter of concern, but with the next election cycle well in progress, they have become a major political issue. The idea of buying drugs from Canada is not a new idea but has gained steam as a politically easy work around for getting cheaper drugs. Several states including Vermont and Colorado have already enacted laws to import Canadian drugs (if the FDA will allow it). In Florida, it's no secret that importing Canadian drugs has long been a favorite part of our new Governor's healthcare agenda. A bill allowing the importation of drugs from Canada has passed the Florida house, and is on its way to the Senate for a full vote. Despite criticism, Governor Ron DeSantis recently re-committed to his plan, insisting that is the best path to creating a safe and affordable supply of medications for all Floridians.

Putting aside the political Considerations (is this a free market solution, or gaming the system?), the plan raises more questions than it answers. First of all, is this plan even feasible? Canada is a country of 37 million people. Florida alone has over 21 million citizens. Is it reasonable to expect that Canadians will willingly part with over half their supply? If not, would drug companies, knowing that the drugs were being funneled to the US, willingly increase their supply of drugs to Canada at Canadian prices? Also, it's unclear to what extent this would actually be a cost savings. Studies have shown that 9 out of 10 prescriptions are generic, and direct comparisons have shown that many Canadian generic drugs are more expensive than their American counterparts. Finally, there is the regulatory aspect. Any drugs imported from outside of the country must be approved by the FDA. The FDA has already stated that they will not approve any importation of drugs they cannot guarantee are safe, and have noted there is no way to guarantee imported Canadian drugs will not include counterfeit drugs.

Ultimately, this begs the question: why are drug prices so high in the US? Many factors have been examined. FDA regulations for production of generic drugs practically guaranteed limited competition and supply bottlenecks. The most politically potent factor is the apparent drug company policy of selling drugs to single payer countries at artificially low prices and passing along the indirect cost to the US market.

While I don't pretend to understand the intricacies of contracting with drug suppliers, I do know about supply and demand. I (and apparently much of the US consumer market) find it hard to believe that a market with such high demand could not command better drug pricing from suppliers. Perhaps a better strategy would be to form some sort of cooperative to get better prices from suppliers. Florida's population alone would seem to command a good deal of buying power. At the very least, it may incentivize the drug companies to make their prices more uniform. If we are willing to be the patsies for the rest of the world, we deserve to pay higher prices.

LCMS General Membership meeting was held at the Florida South Western College Medical Museum on April 17, 2019. Presentations were done by Dr. Jacob Goldberger and Dr. Roger Scott. Dr. Scott presented an award to Susan Lien for Appreciation for the Countless Unique Donations as well as Gifted Restoration of Artifacts from 2001 to the present. The Medical Museum was open for tours throughout the evening.

Dr. Roger Scott and Susan Lien.

Susan Lien, Dr. Jeff Elsberry, Dr. Roger Scott, Dr. Valerie Dyke, John Miksa, Dr. Jacob and Margar Goldberger

Ramirez Report
By Julie Ramirez, Executive Director

At the beginning of April, Valerie and I attended a software conference in Savannah, Georgia. Savannah is known for its history and southern charm. To me, Savannah is very unique. You have ocean bearing container ships floating down the river right next to the cobblestoned historic section of Savannah. You have fighter jets from the nearby military bases flying overhead doing maneuvers while you gaze over the marshlands during low tide. I am a total nerd watching these machines in action and took lots of pictures and videos for my family to see. Besides the show of industry, Savannah is largely supported by its tourism industry because of its deep history.

I am not one to let time just waste away, during a 4-hour break, Valerie and I drove 15 minutes out of town to a historic site called Wormsloe Plantation. I would have had no idea this plantation existed, if it hadn't had been for the marketing book in our hotel with a gorgeous picture of a tree-lined drive. Little did I know that a visit to this 1700's property would educate me on how the owners of this property would tie into the local county medical society!

Back in 1733, and Englishman named, Noble Jones, arrived with 114 other colonists in what is now downtown Savannah, GA. In 1736, Mr. Jones started leasing an area of 500 acres of land south of town and named it Wormslow. Many battles and invasions happened in this area due to the major water route and Mr. Jones began building his home and fort to protect it. Parts of the remains of this building are still standing. In 1756 he was able to gain ownership of the property due to a royal grant. Mr. Jones had a son named Noble Wimberly Jones who would eventually inherit the property. Unlike his father, Mr. Wimberly Jones, the son, was quite the revolutionary! He was part of the Second Continental Congress and part of a patriot group that stole from the British. Once his revolutionary days were over and he was released from prison after 3 years, he came back to the Savannah area and resumed his medical career. Jones became a respected physician and helped form the Georgia Medical Society. Dr. Jones was the first President of this county medical society.

Incidentally, in 1828, Noble Wimberly Jones' son George Jones, started construction on a two-story dwelling on the property that is currently owned and still occupied by the Jones' family. Noble Wimberly Jones' great grandson, Wymberley Jones De Renne, is credited to planting the 400 live oak trees that line the alley today.

Membership – New Members

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When Treating Children Avoid These Risks

By Darrell Ranum, JD, CPHRM, Vice President, Patient Safety and Risk Management, The Doctors Company

When Treating Children, Avoid These Risks

A study of malpractice claims against physicians in 52 specialties who treat children reveals that while there are common elements in allegations, the types of problems experienced by pediatric patients—and that lead to malpractice claims—change as they age.

The Doctors Company studied 1,215 claims (written demands for payment) filed on behalf of pediatric patients that closed from 2008 through 2017.

The study focused on four groups: neonate (less than one month old), first year (one month through 11 months), child (one through nine years), and teenager (10 through 17 years). It included all claims and lawsuits except dental claims, regardless of how the cases were resolved (denied, settled, or judgment at trial).

Claim and Lawsuit Payments

Of the claims, 446 (37 percent) resulted in a payment to the claimant. The mean indemnity payment was $630,456, and the mean expense was $157,592. The median indemnity payment was $250,000, and the median expense to defend these claims was $99,984.

Neonates had the highest mean indemnity ($936,843) and median indemnity payment ($300,000). The mean expense paid to defend these cases was also the highest ($187,117), as was the median expense paid ($119,311).

The median number may be a more accurate representation of the amount of indemnity in paid claims. The median eliminates the impact of very high or very low indemnity amounts, giving a better idea of a typical value.

The patients represented in these claims and lawsuits were treated by a variety of specialties. Obstetricians were most frequently involved with neonatal patients. Pediatricians, orthopedic surgeons, emergency medicine physicians, and family medicine physicians were most frequently named as defendants for children older than one month.

The top 10 physician specialties named as defendants were: obstetrics (24%), pediatrics (15%), orthopedics (7%), emergency medicine (6%), family medicine (6%), radiology (3%), general surgery (3%), anesthesiology (3%), otolaryngology (3%), and psychiatry (2%). These specialties represented 72 percent of all the claims.

Allegations

Diagnosis-related allegations were the most common allegation in all but the neonate age group. Patients older than neonates experienced diagnosis-related claims in 34 to 44 percent of all claims and lawsuits.

The most common allegation for neonates was obstetrics-related treatment for injuries that occurred during labor and delivery (63 percent).

Factors Contributing to Patient Injury

To prevent injuries, it is essential to understand the factors that contributed to patient harm. Categories of contributing factors include clinical judgment, technical skill, patient behaviors, communication, clinical symptoms, clinical environments, and documentation. Physician experts identified factors that contributed to patient harm and evaluated each claim to determine whether the standard of care was met.

The most common factor contributing to injury in neonates was selection and management of therapy. This issue refers to decisions about vaginal birth versus cesarean section. Other factors included patient assessment issues and lack of communication among providers.

The most common factors contributing to patient harm for age groups other than neonates were patient assessment issues and communication between the patient or family member and provider. Inadequate patient assessments were closely linked to incorrect diagnoses. Incomplete communication between patients or family members and providers affected clinicians' ability to make correct diagnoses.

Risk Mitigation Strategies

The following strategies can assist physicians in preventing some of the concerns identified in this study:

For Neonates

1. Become familiar with the National Institute of Child Health and Human Development nomenclature. Physicians and nurses should participate together in regular fetal monitoring learning activities.
2. Respond without delay when a nurse requests a physician assessment.
3. Conduct drills to ensure 30-minute response times for emergency cesarean section deliveries and carry out simulations of low-frequency/high-severity obstetric emergencies.
4. Estimate and document fetal weight when considering vacuum-assisted vaginal delivery. Plan the exit strategy, such as calling the cesarean section team in advance in case the extraction is unsuccessful.

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When Treating Children Avoid These Risks

By Darrell Ranum, JD, CPHRM

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For Children Ages One Month to 17 Years

1. Ensure quality documentation. Documentation is essential for coordinating quality care and defending a claim that may not be filed until years after the alleged injury.
2. Conduct careful reevaluations when patients return with the same or worsening symptoms. If no new information comes to light, consider a second opinion or referral to a specialist.
3. Ensure an adequate exchange of information. Utilize translations services if communication is difficult.
4. Provide parents with information to help them recognize when a sick child requires emergency care. Train office staff to recognize the types of concerns raised by parents during phone calls that should prompt immediate assessment and treatment.

Conclusion

This study showed that neonates and infants in their first year of life were more vulnerable than older children. Children less than one year of age experienced high-severity injuries at almost twice the rate of children older than one year. Neonates may experience complications due to difficult labor and delivery. They also face congenital conditions that may not be readily diagnosed and treated.

Children older than one year experienced more injuries from trauma, communicable disease, and malignancies. Teenagers experienced trauma and illness, and teenaged females may also face the dangers of pregnancy and childbirth.

This wide spectrum of development adds to the challenges of diagnosing and treating pediatric patients and shows that clinicians need the assistance of reliable systems to help prevent these errors.

These issues and additional data are addressed in more detail at **thedoctors.com/childmedmalstudy**.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

As I Recall . . .

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

"Skeeters"

In 1845, Congress was considering Florida (a territory) for statehood and speaking against this was James Randolph of Virginia stating that Florida was "a land of swamps, frogs, quagmires, alligators and mosquitoes; would never amount to anything; couldn't possibly be developed, and as a matter of fact it just wasn't a fit place for people to live" U.S. life expectancy was 43, but in Florida, it was 34 primarily due to yellow fever, malaria, and other diseases. Were we there in 1845, we could tell Mr. Randolph "you ain't seen nothin' yet".

The railroads, both on the west and east coast of Florida, helped to populate the state and a very major factor in allowing people to live here was the control of mosquitoes. The first state involvement in mosquito control was in 1923 – in a very limited manner. Unfortunately, the politicos in Tallahassee directed most of the funding for counties to the east coast and it was not until the early 50's that any major effort was made to control mosquitoes in Lee County. In WWII, the military did a great deal to control the skeeters in this area but the "pest" ones (the bad biters) are from salt marshes and little was done to control these "beasts". In September 1951, a mosquito trap captured 165,000 skeeters which gives Lee County the World's Record for the most mosquitoes captured in one night in a single trap. When I came to town in 1958, this part of the state was much as Congressman Randolph had stated in 1845. At night during skeeter season, one would hesitate to venture outdoors until after the truck spraying DDT fog went down the street, otherwise we would be covered with pesky skeeters.

In 1956, Wayne Miller was brought to town as Director of the Mosquito Control and for 38 years served well in this capacity. He states that if the skeeters can be caught as larvae rather than adults, the task of control is greatly diminished. It is only when the larvae hatch and skeeters spread over the county that aerial and land fogging are used. Sanibel salt marsh skeeters have been known to fly as far as LaBelle (bet they were tired little bugs)! Larval control can be done by ditching but this was stopped in 1969 by the EPA and no permits have been issued since that time. More recently emphasis has been placed on larvaeciding using insecticides but these are gradually being withdrawn from the market as their patents and such expire. Lee County is the first in the world now utilizing widespread biological control (biological warefare). Time is of the essence because the mosquitoes hatch from larvae to adult in 3 to 5 days. The original aerial fogging began in 1960 with two DC-3's (C-47 airplanes), but it was extremely difficult to get these cleared by the Federat Aviation Authority because it was necessary to drop 20 gallons of diesel fuel with DDT (combustible) a minute into the exhaust to create a fog over the terrain. There were twelve DC-3's utilized for fogging but the most in flight at one time was seven and this was rare. These planes would fly as low as 25 feet above the TV antennas spraying a DDT oil cloud over everything and everybody.

Hancock Creek was originally named Yellow Fever Creek and thanks to skeeter control we don't see bumper stickers "My Child is on the Honor Roll at Yellow Fever Creek Elementary"!

The Lee County Mosquito Control now has six C-47's, six UH-1H choppers, and seven Bell Helicopters. They fly out of their base at the old Buckingham Air Base. The choppers are primarily utilized for larvaeciding.

The Mosquito Control has done an excellent job over the years and you can rest assured that your tax dollars allocated to them are vital to this community and to your health. You cannot imagine how difficult it was during "skeeter season" in years past, and I would suspect that many of you would have turned around and returned to a less blood-thirsty environment.

Hancock Creek was originally named Yellow Fever Creek and thanks to skeeter control we don't see bumper stickers "My Child is on the Honor Roll at Yellow Fever Creek Elementary"!

For many years the Fort Myers News-Press newspaper had in the right upper corner the following quotation: "Mr. Edison said There is only one Fort Myers and one million people are going to find out about it." We are close to the million mark in Lee County!

Teaching, Rural Hospitals Gain from CMS Readmission Changes

By Maria Castellucci, ModernHealthcare.com

The CMS' Hospital Readmissions Reduction Program hit academic and rural hospitals with lower penalties in 2019 compared to 2018, after the agency made changes to the program, according to a new study.

The research, published Monday in JAMA Internal Medicine, found 44.1% of teaching hospitals and 43.7% of rural hospitals experienced a lower penalty in 2019 compared to 2018 from the readmissions program. The smaller penalties were the result of changes made to the readmissions program this year in which hospitals were separated into five groups by similar proportion of patients who are dually eligible for Medicare and Medicaid.

As a result of the changes, the study estimates that average penalties for teaching hospitals will drop from $287,268 to $283,461.

The changes, mandated by Congress through the 21st Century Cures Act, were made to address complaints from hospitals — safety-net hospitals in particular — that they are unfairly penalized in the readmissions program because of their complex patient case mix.

It appears the changes have achieved their intended effect, said Dr. Karen Joynt Maddox, lead author of the study and assistant professor of medicine at Washington University School of Medicine in St. Louis.

"This is a reasonable start and I think it has good face validity," she said.

A Modern Healthcare analysis last October found similar results as the JAMA study with specialty hospitals hit harder with penalties than teaching hospitals this year after hospitals were divided into the five groups.

As a result of the changes, the study estimates that average penalties for teaching hospitals will drop from $287,268 to $283,461. The figures are an estimate because hospitals are still reporting claims for fiscal year 2019, Maddox said.

For rural hospitals, their average penalties are estimated to decline from $55,268 to $53,633.

The study found that about 22% of teaching hospitals and 22.5% of rural hospitals were in group five, or the group with the highest proportion of dual-eligible patients.

Hospitals in group five will likely see a decrease in penalties of $22.45 million overall in fiscal year 2019 while hospitals in peer group one, or those with the least number of dual eligible, will see an increase in penalties by $12.3 million, according to the study.

There are 577 hospitals in group one and 604 hospitals in group five with vast differences in dual eligibility populations, the study shows. Group one hospitals have as much as 13.7% of their patients classified as dual eligible while hospitals in group five have between 31% to 93.8% of their patient population dual eligible.

Regarding the differences between the two groups, Maddox said, "It isn't appropriate to expect the same outcomes among hospitals who have vastly different patient populations."

Maria Castellucci covers safety and quality topics for Modern Healthcare's website and print edition. Castellucci is a graduate of Columbia College Chicago and started working at Modern Healthcare in September 2015.

Thursday, June 27, 2019

FSU/LH Residency Reception

6:30 p.m. – 8:30 p.m.
FineMark National Bank & Trust
12681 Creekside Lane
Fort Myers, FL 33919

❖❖❖

SAVE THIS DATE TOO

Friday, September 20, 2019

Annual Medical Service Awards

CDC Issues Clarification on Guideline for Prescribing Opioids for Cancer-Related Pain

By Zachary Bessette, Associate Editor, Journal of Clinical Pathways

The Centers for Disease Control and Prevention (CDC) issued a key clarification, stating that their guideline on prescribing opioids is not meant to limit access to appropriate pain management in individuals with cancer and sickle cell disease.

The clarification regarding CDC's Guideline for Prescribing Opioids for Chronic Pain—which was issued in a letter to the American Society of Clinical Oncology (ASCO), the American Society of Hematology (ASH), and the National Comprehensive Cancer Network (NCCN)—is a result of a collaborative effort to clarify the guideline in an attempt to ensure safe and appropriate access for patients with cancer, survivors of cancer, and patients with sickle cell disease.

"This clarification from CDC is critically important because, while the agency's guideline clearly states that it is not intended to apply to patients during active cancer and sickle cell disease treatment, many payers have been inappropriately using it to make opioid coverage determinations for those exact populations," said Clifford A Hudis, MD, FACP, FASCO, chief executive officer, ASCO, in a press release (April 9, 2019).

The clarification letter also noted that clinical practice guidelines addressing pain control for survivors of cancer (ie, ASCO Clinical Practice Guideline on Management of Chronic Pain in Survivors of Adult Cancers and the NCCN Clinical Practice Guideline in Oncology: Adult Cancer Pain) provide important guidance on considerations when using opioids to control pain in survivors of cancer without worsening the current opioid "crisis."

"Our guidelines help clinicians to assess the risk of inappropriate substance use, while still ensuring people with cancer do not suffer unnecessary, severe pain," stated Robert W Carlson, MD, chief executive officer, NCCN. "CDC's acknowledgment that clinical decision-making should be based on the relationship between physicians and their patients is important and in the best interest of people with cancer and sickle cell disease."

These results come from a meeting among ASCO, ASH, CDC, and NCCN representatives to discuss concordance and variation among current guidelines for chronic pain management as well as to develop a strategy to resolve inconsistencies. Additionally, the organizations discussed issues related to the CDC guideline and agreed to seek clarification regarding applicability to patients with cancer and sickle cell disease.

CDC has developed materials for providers as an emphasis that the guideline is intended for primary care physicians for the treatment of chronic pain. Among these resources are Assessing Benefits and Harms of Opioid Therapy and Applying CDC's Guideline for Prescribing Opioids, a training series. To read article on line:

http://bit.ly/jcp040919

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CHANGE SERVICE REQUESTED

Spring is a wonderful Time of Year!