Bulletin

Editor: Ellen Sayet, 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.

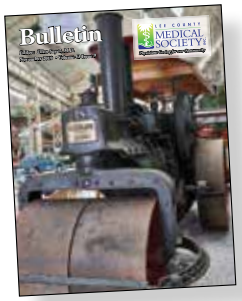
LCMS Disclosure Policy

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.

Table of Contents

The picture was taken at the Techniks museum in Speyer Germany. Speyer is close to Mannheim Germany. There were many fascinating exhibits, including WW II technology of German origin - including spring wire bicycle wheels designed to eliminate the need for rubber tires and tubes during the war and German jet airplanes. There was also a model of the Eagle - the US moon lander, and of a Russian version of the Space Shuttle. One of the reasons I took the photo is that the name Mannheim Steamroller evokes for me the music of Chip Davis who formed a music label with the name Mannheim Steamroller. Apparently the term Mannheim steamroller refers to a musical crescendo. Seeing an actual Mannheim steamroller brought a smile to my face as well as memories of the music. Mozart spent time in Mannheim adding to its musical fame. ***Photo by Peter Sidell, MD***



Events RSVP online at www.lcmsfl.org

Saturday, November 2
LCMS FAMILY BBQ
3:00 PM-6:00 PM at Lakes Regional Park
featuring Gator John's BBQ, Southern SnoBalls, and tons of fun games for the whole family!
BBQ will be served from 3:30-5pm and the Snowcones will be served around 5pm.
This event is for LCMS Members and their families.

Non-physician members are $25 each.

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Join us for our November Cocktail Hour
hosted by
ELMQUIST EYE GROUP
2nd Floor
7970 Summerlin Lakes Drive, Fort Myers, FL 33907
Friday, November 8
6:00 P.M. - 7:30 P.M.
Feel free to bring a guest!

❖❖

Membership Meeting
Thursday, November 21
Cocktails 6:30 p.m. - 7:00 p.m.
Program at 7:00 p.m.
FineMark National Bank and Trust
Agenda:
Welcoming New Members
Topic on Financial Wellness
sponsored by FINEMARK NATIONAL BANK & TRUST

Membership News

NEW APPLICANTS:

Dr. Michael Antiporda received his medical degree from Ohio State University School of Medicine, Columbus, OH in 2012. Dr. Antiporda completed an internship in Preliminary Surgery at Ohio State university, Columbus Oh from 2012 - 2013, and a residency in General Surgery at Mayo Clinic in Jacksonville, FL from 2013 - 2018. Dr. Antiporda completed a Fellowship in Advanced GI & Minimally Invasive Surgery at Providence Medical Center, Portland, OR from 2018-2019. Board Certified: Surgery

Dr. Elie Balesh received his medical degree from Harvard University, Cambridge, MA in June 2017. He completed an internship in Internal Medicine, and a residency in Diagnostic Radiology & Integrated Fellowship in Cardiovascular Imaging at Massachusetts General Hospital - Harvard Medical School, Boston, MA. Dr. Balesh completed a Fellowship in Interventional Radiology at the university of Texas Southwestern Medical Center, Dallas TX. Board Certified in Radiology

Dr. Maria Becka received her degree at Chicago College of Osteopathic Medicine in 1996. Dr. Becka completed an internship and residency in Internal Medicine at Quillen College of Medicine, Johnson City, TN. Board Certified: Internal Medicine.

Dr. Shauna Berry received her Osteopathic degree at Nova Southeastern College of Medicine in 2012. Dr. Berry completed an internship and residency in Ophthalmology at Larkin NSU Community Hospital, South Miami from 2012 - 2016, and a fellowship in Ophthalmology at Houston Methodist Hospital from 2016-2017

Dr. Dustin Begosh-Mayne received his medical degree at the university of Florida, Gainesville, FL in 2016. Dr. Begosh-Mayne completed an internship and residency in Internal Medicine at university of Florida, Gainesville, FL from 2017 - 2019.

Dr. Drew Bienvenu received his medical degree from Louisiana State university, New Orleans, LA in 2015. Dr. Bienvenu completed an internship in Emergency Medicine and a residency in Ultrasound at Orlando Regional Medical Center, Orlando, FL from 2015 – 2019. Board Certified: Emergency Medicine

Dr. Silvia Caswell received her Osteopathic Medicine degree at Campbell University School of Osteopathic Medicine, Bules Creek, NC. Dr. Caswell is currently in the FSU Family Medicine Residency Program @Lee Health.

Dr. William Cutting received his medical degree at the University of Miami Leonard M. Miller School of Medicine, Miami, FL in 2012. Dr. Cutting completed his internship and residency in Internal Medicine and Fellowship in General Cardiology at University of Florida in Gainesville, FL. Board Certified: Internal Medicine - Cardiology

Dr. Farhan Rashid received his medical degree at the Chicago Medical School at Rosalind Franklin University of Medicine & Science, North Chicago, IL in 2016. Dr. Rashid then completed his residency in Pediatrics at Loma Linda University Pediatric Residency Categorical Program, Loma Linda, CA.

Dr. Doron H. Finn received his medical degree at the University of Oklahoma College of Medicine, Tulsa, OK in 1983. Dr. Finn also completed his internship in 1984 and residency in 1988 at University of Oklahoma College of Medicine in Tulsa, OK. Board Certified: Surgery

Dr. Michael Horowitz received his medical degree from University of Rochester School of Medicine, Rochester, N.Y. in 1984. Dr. Horowitz completed his internship in General Surgery from 1984 - 1985 and residency in Neurological Surgery from 1985 - 1994 at University of Pittsburgh Medical Center, Pittsburgh, PA. He then completed his Fellowship in Neuroendovascular Surgery/Interventional Neuroradiology at UT Southwestern Medical Center, Dallas, TX from 1994 -1996. Board Certified: Neurosurgery

Dr. George Kopidakis received his medical degree from New York Medical College, New York, NY in 1988. Dr. Kopidakis then completed his internship from 1988-1989 and residency from 1989-1993 in surgery at St Vincent's Hospital and Medical Center, New York, NY. Board Certified: Surgery

Dr. Sergey Kozyr received his medical degree from Ross University School of Medicine in 2013. Dr. Kozyr completed his internship in 2015 and residency from 2015-2018 in General Surgery at Kern Medical Center, Bakersfield, CA. Dr. Kozyr then completed his Fellowship in Trauma/Surgical Critical Care from 2018 - 2014 at University of Florida Health Shands, Jacksonville, FL.

Dr. Salomon Levy Miranda received his Medical degree at Universidad Central De Venezuela Escuela de Medicina Luis Razett, Venezuela, Medico Cirujano from June 1995 – March 2002. Dr. Levy Miranda completed a Preliminary Internship/General Surgery – and a Liver & Multivisceral Transplant Internship from Jackson Memorial Hospital, Miami, FL from June 24, 2005 – June 30, 2007. Board Certified: General Surgery

Dr. Claude Lieber received his Medical degree at Katholieke Universiteit Leuven (Ku Leuven) Faculteit Geneeskunde. 1973. Board Certified: Surgery

Dr. Eve MacLean received her medical degree from Western University Health Science, Lebanon, OR on June 2015. Dr. MacLean then completed her residency in Internal Medicine at Palmetto General Hospital, Hialeah, FL on June 2018. Board Certified: Internal Medicine

Dr. Marte Solange received her medical degree and completed her internship from Pontifica University Catolica Madre Y Maestra (PUCMM) Fac de Cien de la Salud, Dominican Republic in 2009. Dr. Solange then completed her residency in 2018 from Lincoln Medical Center, Bronx, NY.

Cont'd on next page

Membership News

Dr. Juliana Odetunde received her medical degree from University of Kentucky College of Medicine in Lexington, KY in 2015. Dr. Odetunde completed her internship and residency from 2016-2019 in Family Medicine at the University of Pittsburgh Medical Center in Pittsburgh, PA. Board Certified: Internal Medicine

Dr. Gustavo Prada received his medical degree at Universidad El Bosque, Columbia in 2003. Dr. Prada completed an internship in Family Medicine at IU Methodist Hospital, Indianapolis, IN in June 2012. He completed an internship and residency in Family medicine at IU Riggs Community Health Care, Indianapolis, IN from July 2012 - June 2014.

Dr. Patricia C. Subnaik received her medical degree from Nova Southeastern University College of Osteopathic Medicine, Davie, FL in 2012. Dr. Subnaik completed her internship and residency from 2012 - 2015 in Pediatrics at the University of Louisville School of Medicine, Louisville, KY. Dr. Subnaik then pursued a fellowship in Pediatrics Gastroenterology from 2016-2019 at University of Florida/ Orlando Health Arnold Palmer Hospital for Children, Orlando, FL.

Dr. Erin H. Ward received her medical degree from the Marshall University, Huntington, WV in 2012. Dr. Ward then completed her internship and residency in Ob/GYN from 2012-2016 at the University of Florida in Gainesville, FL. Board Certified: OB/GYN

Dr. Lori Williams received her medical degree from Hahnemann University College Of Medicine, Philadelphia, Pennsylvania, PA and graduated in 1993. Dr. Williams completed her internship in Internal Medicine at Keesler AFB in Biloxi, MS from 1993-1996. Board Certified: Internal Medicine

Dr. Matthew Young received his OS degree at Western University of Health Science from August 2003 – May 30, 2007. Dr. Young also completed an Internship and a Residency in ER Medicine at Arrowhead Regional Medical Center, Colton, CA from July 2007 - July 15, 2012. Board Certified: Family Medicine.

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

LCMS CLASSIFIEDS

Out of medical practice due to retirement or handicap? But miss the interaction that comes with seeing patients and your ability to provide relief and healing? We have positions open for physicians in our Naples and Ft. Myers offices. Please call Dr. Brueck at (239) 202-0606.

PHOTO CORRECTION & ADDRESS UPDATE

Syed Sher, DO
Physicians Primary Care of Southwest FL
1304 SE 8th Terrace
Cape Coral, FL 33990
Tel: 239-482-1010 **Fax:** 239-481-1481
Board Eligible

NEW PHONE & FAX NUMBERS

Southwest Florida Urologic Associates
Tel: 239-424-2030 **Fax:** 239-343-4116
James Borden, MD
Paul Bretton, MD
Blake Evans, MD
Jasper Rizzo, DO

CHANGE OF ADDRESS

Dr. Amanda Danley
Physicians' Primary Care of Southwest FL, PL
1255 Viscaya Parkway #200
Cape Coral, FL 33990
Tel: 239-574-1988 **Fax:** 239-574-1435

Nominations for 2020 Officers

Lee County Medical Society Nominations for 2020 Officers

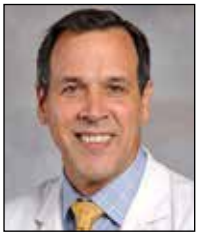
The following slate of nominations for the 2020 officers of the Lee County Medical Society is presented for your consideration. The membership will vote at the November 21, 2019 Annual Membership Meeting. If you wish to nominate someone else for an office, please be sure to have that person's approval before nominating him or her from the floor

Board of Governors
President: Elizabeth Cosmai, MD
President-Elect: Annette St. Pierre MacKaoul, MD
Treasurer: Tracy Vo, DO
Secretary: Ryan Lundquist, MD
Past-President: Daniel de la Torre, MD

Newly nominated Members-at-Large:
Arie Dosoretz, MD (2022)
Janette Gaw, MD (2022)

Cont'd on next column

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



Up in smoke

I remember the first time I heard about vaping; thinking what a great potential tool this could be for my patience struggling to quit cigarettes. As vaping became more main stream, I began to suggest it to my patience as a smoking cessation tool, or at least a more benign alternative to cigarettes smoking. In a number of cases I was able to claim victory, as some of my patients transitioned from cigarettes to vaping.

Given that nearly half 1 million Americans die every year from cigarette smoking, is a complete ban the wisest advice?

And so was (with an added sense of horror at my complicity) that I've watched vaping evolved from an alternative to tobacco, to a new and particularly harmful "epidemic". Initial reports raised the specter of hundreds of vaping related illnesses. Was I inadvertently contributing to a national healthcare crisis? I watched sadly as some of my "victories" reverted to cigarettes out of fear. Like Manny in the medical community, I found the story with great interest: what was suddenly causing so many to fall ill from vaping?

As of late October the CDC reports 33 deaths and 1479 confirmed or probable cases of vaping related illness, The majority appear to be related to use of non-traditional e-cigarette products; an area which is not legally regulated. Public health officials have pointed out that most such products have been on the market for a long time, making it highly unlikely that traditional e-cigarette products have caused any significant number of the sudden lung problems. In fact, it's now been determined that the majority of the cases were caused by the use of THC or CBD products, typically mixed with vitamin E and provided by unregulated street vendors. A prominent theory holds that such products, largely insoluble in water (unlike nicotine) led to cases of a condition called lipoid pneumonia or pneumonitis in which oil droplets delivered to the lungs causing acute inflammation and lung failure. Of course, many of the cases do involve traditional e-cigarette products. A significant number are due to practices such as "dabbing"and "dripping"; in which users "free base" substances of their own making in ways vaping device manufacturers never intended. Investigations are still ongoing.

It now appears that the epidemic is largely due to the rush to market of new products to take advantage of this relatively novel delivery system. What is clear is that vaping is neither universally harmful nor helpful: much like most modern therapeutics. Politically the rush is on to apply heavy-handed restrictions. Some appear reasonable, but all regulation has potential for unintended harm. Witness the recent spate of regulations to address the opioid epidemic. How many people now struggle to obtain adequate treatment of chronic pain?

Unfortunately, in the setting of unknown risks, this has led the AMA to recommend that everyone avoid ie-cigarettes at this time. That warning seems to conflate vaping as a form of harm reduction versus recreational use. Given that nearly half 1 million Americans die every year from cigarette smoking, is a complete ban the wisest advice? What of former cigarette smokers currently vaping as an alternative to cigarettes? The principle of relative risk would seem to apply. It seems the CDC is bowing more to media hype and political pressure than to medical science.

For now, the recent events have at least thrown cold water on what was becoming a dangerous form of teen recreation. The evidence about vaping remains unclear. What seems clear is that vaping has potential benefit for reduction of smoking related illness. I will continue to follow the story with great interest. I just hope that fear and sensationalism does not continue to drive it.

Nominations for 2020 Officers

Cont'd on previous column

Previously elected Members-at-Large:
Gamini Sorri, MD (2021)
Asif Azam MD, (2021)
Justin Casey, MD, (2021)
Scott Caesar, MD (2020)
Imitiaz Ahmad, MD (2020)
E. Trevor Elmquist, DO (2020)
Joanna Carioba, MD (2020)

Ex-Officio
Legislative Committee
Stuart Bobman, MD, Chair
Committee on Ethical & Judicial Affairs
Ryan Lundquist, MD, Chair
FSU Family Medicine Residency Program at LH
Jaime Hall, MD
John Schmidt, DO
Grievance Committee
R. Thad Goodwin, MD, Chair

Why Many Doctors Live Paycheck to Paycheck

By Cory Fawcett, M.D.

Wealth seems to be an elusive dream for many people. They desire to become wealthy, but feel they don't earn enough money to reach that goal, as if earning more would make the difference. A study of 10,000 millionaires presented in Chris Hogan's new book, Everyday Millionaires, showed that 69% of these millionaires reached that level of affluence on a household income of less than $100,000 a year. If all it took was money to become wealthy, then the average physician, who makes $200,000 a year, should have no problem reaching millionaire status.

Rather than becoming wealthy, many doctors today are HENRYs: High Earners, Not Rich Yet. Many doctors feel the need to spend all, or more than all, of their income. They worked hard to become doctors, and now they want to reap the benefits by spending their earnings. They are the "working rich." They only appear rich as long as they are working. If they were to stop working, they would be broke.

I recently wrote about a family that was earning $750,000 a year and had been doing so for some time. They had a net worth of near zero. (You can read this article here.) How can one earn so much, yet have so little? It's because every dollar they earned was spent on their very nice lifestyle. Nothing was set aside for saving and investing. They needed all their earnings to "get by." This is laughable to those who "get by" on only $100,000 annually and still become millionaires.

Everyone seems to want to be rich, and by next Tuesday, please. No one wants to follow through with the savings it takes to become truly wealthy, which takes a long time to achieve. The formula is simple and readily available to everyone.

1. Spend less than you earn.

2. Save and invest the difference.

3. And do it for a long period of time.

I learned this magic formula when I was in high school. I have been saving and investing money since my very first full-time job, as an intern. Even before that, I saved everything I earned each summer, to pay for college for the rest of the year. But today, so many physicians hear about my retirement from medicine at age 54 and say "It's because you were a specialist. If I had chosen something other than primary care, I could retire early too." That thinking didn't work out so well for the family making $750,000 a year. It's not about the money you make; it's about what you do with the money you make.

During my residency, my wife and I maxed out both of our IRAs and the hospital 403(b) plan. Upon our marriage in October of my internship year, we vowed to live on half of our combined income and save the rest for our future. We began saving for a down payment on a house and put about $1,000 a month into retirement accounts. Unfortunately, I could only talk one other resident into funding their retirement. All of the other residents chose to postpone their retirement savings. They reasoned that they needed all their money right now, but they would start saving when their income increased as attendings.

According to statistics, physicians earn plenty of money to become wealthy, or at least millionaires. Doctors seem to take one of two paths. One that leads to becoming wealthy (Dr. Timex). The other, the life of a HENRY, which does not lead to wealth accumulation (Dr. Rolex).

Many specialists are wealthy and many who live paycheck to paycheck. Many primary care doctors are wealthy and many who are not. A high income is not the common denominator to becoming wealthy. One of the top three jobs of people who have become millionaires, according to Hogan's book, is a teacher. Teachers are known for their low income. If they can become millionaires, then having a high income is not the key to wealth accumulation. By the way, engineers and accountants are the other two on the top three list. Doctors didn't make the top three professions to become millionaires.

So what does make the difference if it's not money? Attitude about money makes the difference. Those who accumulate wealth feel that saving for the future is not only important, but it's a priority. Pay yourself first is a common motto. Out of each paycheck, save for the future first, then live on the remainder. Those who never reach the status of becoming wealthy spend all of their money for current wants and needs, no matter how much they earn.

The attitude about debt is another difference between the wealthy and the HENRYs. The wealthy tend to avoid personal and consumer debt. They also avoid that dreaded second mortgage. I was saving well for the future, but I also got caught up in the doctor lifestyle when I started my practice and went from near zero debt to over $500,000 of debt in just three years. I needed a little attitude adjustment back then. That adjustment changed my future.

The wealthy also tends to drive cars purchased with cash, and they own them for a long time. HENRYs often borrow money to buy very expensive cars and trade them in before they are paid off to borrow for newer cars. Perpetual debt contributes to preventing the HENRYs from acquiring wealth.

The good news is that accumulating wealth is a learnable skill. With less than the effort it took to learn the Krebs Cycle, most physicians can learn to accumulate wealth. With just an attitude adjustment, one can start on the path to becoming wealthy. It's not too late to change your attitude. You can teach an old doc new tricks.

How has your attitude about debt, saving, and investing shaped your current financial position? If you were to look ahead, can you see that your current path is placing you where you want to be financially? Or will you be making major cutbacks in your lifestyle when you stop earning your high income? Would you consider yourself a HENRY?

As I Recall . . .

By Roger Scott, M.D. (Previously Published October 1959)

Calvert Courier

What a surprise to find the following editorial appearing in the CALVERT COURIER October 1957 in Baltimore Maryland!

"Speaking of credit, who should deserve it more than Dr. Roger Scott who terminated his tour of duty at this hospital September 30th. Weekdays, Saturdays, Sundays, holidays, morning, noon, or night, that's when he was on duty — anytime and all the time. In the few months he was here, his name became a byword. As a surgeon, he performed frequently and well, and for this his many patients will be everlastingly grateful. As a cheerful and friendly person with an unfailing send of humor, he brought much that we will all remember. Good luck to you, Doctor, wherever you go and whatever you do."

I felt especially honored by this "horn tooting" that was published in the monthly newspaper by the inmates of the Maryland State Penitentiary in Baltimore on Calvert Street. A rat packer I am (while I frequently mistype, I meant packer) & just recently uncovered this "keepsake" from my youth. Few people know that I was in the "Pen" for four months!

Maryland Penitentiary, Baltimore

The prison hospital with about 14 beds & a nice operating room had just been built within the massive dark & dreary granite walls of the prison. The University Hospital thought it would be good to assign a Chief Surgical Resident to the pen so that all prisoner surgery could be performed there instead of at the University Hospital. I was chosen for the first trial of four months to be THE surgeon for the entire penal system of the state. The salary was about $250 a month, which was a boon as that doubled my chief resident's salary.

Life in the pen was totally different & here are a few remembrances. All the prisoners decried "not guilty" except for our great X-Ray technician, a former insurance salesman. He admitted guilt at having shot & killed (in his own bed) his wife and her lover. Most of the inmates seemed grateful to have me there. I had no fear of a malpractice suit, but of a shiv (knife) in the back.

One week all the post-op patients needed more & more narcotics and still complained of pain. They all enjoyed a "fix", but all at one was unusual. I had the medical examiner's toxicologist analyze all the injectable narcotics & found mostly H2O with a trace of narcotic! Well, off to solitary confinement for my now untrusted trustee ward clerk for stealing the narcotics.

The last hanging in the state of Maryland occurred during my tour, and the warden (also the happy hangman) asked me to be present and pronounce the prisoner dead. I declined this invitation as I always felt it was my job to sustain life. The warden did show me the gallows and explained that a proper hanging causes fracture of the cervical vertebrae with transection of the spinal cord rather than strangulation or avulsion of the head from the body. The weight and height of the victim are used to calculate how far he must drop when going through the trap door. A sandbag of the victim's weight hangs from the gallows to stretch the new rope for about a week before the execution.

The warden was exceedingly proud of his expertise and as this was the last hanging, he kept the hangman's knot as a trophy but one day it "disappeared" from his office. Furiously he searched the prison but failed to retrieve his trophy!

The first cyanide execution also occurred during my time, and again I declined. The expert hangman became the incept "gaser" due to a comedy of errors. The execution chamber was airtight to prevent leakage of cyanide gas into the witness room. The victim was strapped in the chair and the airtight door to the gas chamber was sealed. Nitric (?) acid was then released into a basin beneath the victim's chair, and then using an airtight connection, the cyanide crystals would drop into the acid to create the cyanide gas to fill the chamber. The nervous executioner (his first time with this process) erroneously released the cyanide tablets into the pan and then opened the valve to allow the acid to flow. Before anybody realized what was happening, the cyanide gas escaped through the open valve into the witness room and there was a rapid emergency evacuation. Sure glad I didn't attend that one either. Fortunately, only the victim perished.

Years later we saw a great movie, AND JUSTICE FOR ALL, with Al Pacino, filmed in Baltimore. The final scene of hostage taking & shootout was done in my Maryland State Pen Hospital! Thanks inmates for the nice send off. It was both an interesting & educational experience. I learned much about an unusual group of people in an unusual environment with the realization that there was no future for some & great expectation for others in a new life outside those walls.

To Extinguish Burnout, Bring Back Physician Autonomy

By Christina Dewey, M.D. / Physician | www.kevinmd.com

"Medical education needs to stop burning out students — now," Augustine Choi suggests the culture of medical education is responsible for increasing numbers of depression and burnout among medical students, and suggests that more programs are needed to address self-care and wellness in order to build resilience.

While I agree that mental health treatment should be readily available and easily accessible to those in need, I'd argue that medical students and physicians are already some of the most resilient individuals alive today. I submit the real cause of "burnout" or "moral injury" can be linked to the correlating rise of "health care" over the past 20 years.

The loss of physician autonomy plays a huge role in feelings of hopelessness and frustration that many of us experience. And I believe that health care — intrusion of third parties into the practice of medicine — is to blame for much of the distress, unhappiness, and frustration we see among physicians and those aspiring to practice medicine. Instead of adding more programs about wellness and resiliency to the medical school curricula, let's recognize the root causes of systemic burnout — those which exist across the entire profession of medicine today — and empower both students and physicians with the skills necessary to advocate for and bring about needed change.

Factors playing a role in the loss of physician autonomy:

1. Insurance companies dictating and questioning our orders for treatment of our patients, including but not limited to: prior authorizations for prescriptions, diagnostic tests, therapies — in short scientifically evidence-based medicine proven to help our patients — is being limited, impeded, or outright denied, all in the name of profit. Legislators tout the need for universal single-payer insurance, the hypocrisy of which is that having insurance does not equate to access to or the receiving of actual medical care, nor does it help reduce the underlying causes of skyrocketing health care costs.

2. Middlemen PBMs and GPOs are driving up the cost of prescription medication and supplies, corralling physicians into prescribing what is on their formularies, and directly causing shortages of basic medicines in hospitals throughout the country. Our hands are tied into treatments decided by these third-party middlemen, creators of contracts with ever-increasing partnering monopolies limiting choice and the free market and receiving legalized kickbacks (aka rebates) for doing so — the only instance in which these kickbacks

Cont'd on page 10

To Extinguish Burnout, Bring Back Physician Autonomy

By Christina Dewey, M.D. / Physician | www.kevinmd.com

Cont'd from page 9

are legalized due to the Safe Harbor Act of 1987, which exempted PBMs and GPOs. Such kickbacks are illegal in all other businesses. Coupled with government interference/restraint of the free market and inability to pass legislation that would actually lower health care costs, both physicians and patients remain chained, unable to break free in order to create real needed change.

3. EHRs the mandated integration of the electronic health record was highlighted and pitched as the ability to integrate & share needed health information across systems for the benefit of our patients and those caring for them. No longer were we going to have to search for charts or transfer information between offices/hospitals/clinics. All important patient health records would be easily and immediately accessible for those physicians caring for the said patient — a universal system of access when we needed it most. Instead, EHRs became the bane of our livelihood: time-consuming never-ending clicks, without interoperability, degrading patient interactions and exorbitantly expensive. EHRs are neither for the patient nor the physician; they are a data source for coding and billing for insurance companies, to the detriment of patient care.

4. Government-mandated reporting and pay for performance instituted as a way of improving public health, has instead become unnecessary busywork with no proven benefit in improving health outcomes. In fact, the Minnesota Medical Association has recently withdrawn from the board of MN Community Measurement due to Minnesotans' health actually declining since its inception.

5. Physician replacement by lesser trained / qualified/experienced individuals — this trend is happening across the country and patients are being harmed. Don a white coat, call yourself a doctor — and the public is none the wiser. Physicians spend years and countless hours earning the privilege to be allowed to care for patients.

We are competitive, driven, resilient individuals that overcome countless obstacles, excessive testing, and years of supervised training, prior to being allowed to care for patients independently. We are assessed, tested, questioned, and made to complete multiple steps prior to being licensed to practice medicine and surgery.

The term "provider" began being used by administrators to lump us all together, obscuring our training and confusing our patients & the public. It is deceitful and done in the name of profit, increasing revenue for hospital/business entities at the expense of patient safety. Billed as "cost-saving and increasing access" for patients, this trend of physician replacement is causing undue harm, morbidity, and mortality. The ability to safely practice the science and art of medicine is earned through education, not legislation. When placed in charge of life or death decisions, above all else, training matters.

Maintenance of certification (MOC) was created by medical boards, starting with the ABFM in the 1960s, with all 24 American Board of Medical Specialties participating by 1990, as a means to increase revenue.

Administrators who are non-physicians turning medicine from a learned profession into a for-profit business, usurping control from physicians at the expense of our patients. Dictating how and what we physicians may or may not do within a hospital system – all in the name of cutting costs, often to the detriment of our patients. We now spend more time worrying about how many patients we need to see in designated time slots, checking boxes, running behind, doing never-ending non-physician required tasks than we do on patient outcomes, discussing interesting cases, learning from one another, sharing, teaching, and inspiring each other to hone our skills in the art and practice of medicine. Collaboration, connection, teaching, individual physician expertise and spending time with our patients developing relationships, is now deemed less important than productivity and following the dictated — and often nonsensical — rules. And if we dare disagree, speak up or suggest an alternative method, we are labeled as disruptive, troublesome, threatened with dismissal/termination and often replaced, leaving our patients without their trusted caregiver.

Patient satisfaction scores being tied to promotion/advancement. My job as a physician is to diagnose and treat my patients, often with an illness or treatment that they may very well not want to hear. We try our best to partner with our patients, run on time, provide acceptable options/treatment plans, but medicine is not an exact science, nor are patients one size fits all. There is an art to medicine. Schedules are imperfect. Patients may be scheduled for one thing, yet have another more pressing matter that needs to be addressed. Emergencies happen. Babies need to be delivered. A physician may not be readily available at the exact time the patient desires. Life happens. As physicians, we are not providing a service for customers; we are caring and treating our patients as we know best, in hopes of bettering their health and wellness. This practice may lead to less satisfaction at times by some, but in no way means we are less deserving of being promoted, paid, advanced, or treated with respect. We try our best to do the best we can for our patients, and we put our patients first, always.

If we wish to bring back our learned profession of medicine, inspire others to become physicians and help guide, mentor and encourage them along the way, I argue we must change the system, not the individuals. We must activate, value, and put physicians back in control of medicine rather than the above mentioned third-party contributors that over the past 20 some years have created for-profit healthcare. We must bring back and respect physician autonomy. We, as physicians, have the power to do so, and standing together we can, and we must bring back medicine.

Christina Dewey is a pediatrician.

Advanced Practice Provider Closed Claims: What Can We Learn?

By Howard Marcus, M.D., FACP & Susan Shepard, MSN, RN, Senior Director, Patient Safety Staff Education

The Doctors Company analyzed 649 claims against two types of advanced practice providers (APPs): physician assistants (PAs) and nurse practitioners (NPs).

The analysis revealed that the most common patient allegations in both PA and NP claims were related to diagnosis.

Case Example: PA

A 59-year-old female underwent redo quadruple coronary bypass grafting surgery. Her WBC was 13.9 prior to discharge.

When the patient was next seen, the sternal wound was healing well.

The patient's spouse subsequently testified that his wife complained of neck and shoulder pain during the visit. He called the physician's office two days later and spoke with a PA, who advised him to increase the patient's pain medication.

The spouse reported contacting the physician three days later and was again directed to the PA. He reported a continued complaint of pain.

The following day, the patient was experiencing chest pain with movement and deep breathing. She was instructed to report to the ER. An EKG was unremarkable. Her WBC was 14.8. The patient was discharged with a diagnosis of "chest wall pain."

The physician admitted the patient, and she underwent surgery for a ventral epidural abscess. The patient was rendered an incomplete C6 quadriplegic.

The following day, the patient again phoned the physician. She was instructed to continue taking the pain medication. The patient sought care from a chiropractor, who noted a reddened, swollen area at the incision site.

That evening, the patient called the physician and was directed to a PA. She was given instructions to continue the pain medications. The patient's spouse testified that he called the physician five times the following day, demanding that the patient be seen. The physician admitted the patient, and she underwent surgery for a ventral epidural abscess. The patient was rendered an incomplete C6 quadriplegic.

Case Example: NP

A 41-year-old male presented with complaints of fever and abdominal pain with bright red clots from the rectum. The NP noted recent antibiotic therapy.

The NP suspected Clostridium difficile colitis. and prescribed Flagyl. The stool tested positive for Clostridium difficile toxin.

Four days later, the patient returned with complaints of bloody diarrhea and abdominal pain. The NP recommended continuing Flagyl and a repeat urinalysis.

One week later, the patient presented with bright red blood from the rectum and a moderate amount of abdominal pain. The NP recommended continued antibiotics.

One month later, the patient presented with complaints of persistent abdominal pain. The NP noted the abdomen was soft, and no further treatments or testing was ordered.

Two months later, the patient was seen for bloody diarrhea and abdominal pain. The NP ordered a stool culture. It is unknown whether testing for Clostridium difficile was repeated. The NP recommended that the patient avoid dairy products and take probiotics.

The patient continued to be seen over the next year with similar complaints.

One year later, due to persistent diarrhea, the patient was referred for a colonoscopy, which revealed a large sigmoid mass positive for Stage IIIA cancer.

Risk Mitigation Strategies

1. The following strategies can help avoid issues revealed by the claims analysis:
2. Develop written guidelines and protocols that specify an APP's responsibilities.
3. Delineate under what circumstances the physician must personally assess the patient.
4. Review and evaluate APP medical record documentation.
5. Track and document incoming telephone calls, including the provider's responses.
6. Engage the patient as part of the team.

The guide, Advanced Practice Provider Liability: A Preventive Action and Loss Reduction Plan, includes additional strategies.

The guidelines suggested here are not rules, do not constitute legal advice, and do not ensure a successful outcome. They attempt to define principles of practice for providing appropriate care. The principles are not inclusive of all proper methods of care nor exclusive of other methods reasonably directed at obtaining the same results. 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.

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