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

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

Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and endorsement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.

All LCMS Board of Governors and Committee meetings minutes are available for all members to review.

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Cover Photo by Thomas Logio, MD Flower statue of West Highland Terrier, Guggenheim Museum, Bilbao, Spain

Calendar of Events

rsvp online at www.lcmsfl.org or call 239-936-1645

Friday, Nov. 4, 2016 A Casual Dinner
(Formerly known as Potluck in Paradise)
Lee County Medical Society Alliance invites you
Friday, Nov. 4, 7p-9m to the home of
Dr. Gary & Mrs. Robin Correnti
11351 Compass Point Drive, Fort Myers, FL 33908
Please RSVP by Oct. 26th to Vicki Sweet
email: president@lcmsainc.org
$45.00 per person
New members please be our guest!

HONOR OUR VETERANS!
November 11, 2016 - Cocktail hour in the Cape
Ford's Garage - 6:00 - 7:30pm
719 Cape Coral Pkwy E, Cape Coral, FL 33904

November 17, 2016 - General Society Meeting
Fiddlesticks Country Club 6:30pm Social -7pm Dinner
15391 Cannongate Dr., Fort Myers, FL 33912
Speaker: Jeff Lindsay, Author of the Dexter Series

December 5, 2016 - LCMS Annual Holiday Party
Gulf Harbour Yacht & County Club 7pm - 10 pm
14500 Vista River Dr, Fort Myers, FL 33908

January 27, 2017 - Annual Service Medical Awards

Membership News

NEW APPLICANTS

Amanda Avila, MD- Dr. Avila received her MD degree from the University of Vermont, Burlington, VT. She completed an internship at Brown University, / RI Hospital, Providence, RI from 2006-2007 and a residency at Brown University / RI Hospital, Providence, RI. Dr. Avila completed a fellowship in Movement Disorders at the University of Florida, Gainsville, FL from 2010-2012. She is in Group practice with Telespecialists, LLC & Virtual Neurology, LLC, 15050 Elderberry Lane, Ste 3, Fort Mers, FL Tel: 239-208-2206
Board Certified: Psychiatry and Neurology

MEMBERSHIP NEWS

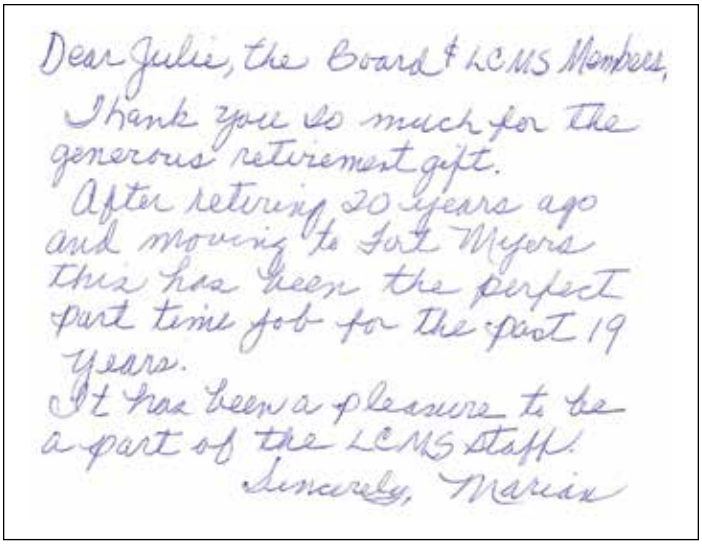
New Location
Michael McCleod, D.O.
Frank Rodriguez, M.D.
Florida Cancer Specialists
8260 Gladiolus Drive
Fort Myers FL 33908
Tel: 239-437-5775
Fax: 239-437-5776

Practice Name Change
Eye Health of Fort Myers is Now
Quigley Eye Specialists
6091 South Pointe Blvd.
Fort Myers, FL 33913
Tel: (239) 466-2020

CORRECTION: Listed incorrectly in the July Bulletin:

NEW MEMBERS

Chadwick S. Leo, DO
LPG Obstetrics and Gynecology
1628 NE Pine Island Road
Cape Coral, FL 33909 Tel:
239- 424-1600
Fax: 239-343-2301
Board Certified: Obstetrics and GYN



Dear Julie, the Board & LCMS Members,
Thank you so much for the generous retirement gift.
After retiring 20 years ago and moving to Fort Myers this has been the perfect part time job for the past 19 years.
It has been a pleasure to be a part of the LCMS staff!
Sincerely, Marcia

LCMS Member Dues

The 2017 LCMS membership dues are payable by January 1, 2017. You or your group can pay at http://www.lcmsfl.org/en/join or call 239-936-1645. To pay your FMA dues, go to flmedical.org, and to pay your AMA dues go to ama-assn.org .

President's Message

By SHARI SKINNER M.D.

By the time this gets published, we will have elected a new President of the United States. As of this writing, the smart money is on Hillary Clinton to win. If that outcome arrives, we can expect health care in Lee County and elsewhere to continue its current trends, namely: prices will rise, access of patients to physicians will decrease as the shortage of physicians increases relative to demand for services, and control of the market will be further consolidated into government hands, at least at the federal level. She can also be counted on to take more steps toward a "single-payer" government-run health care market. If her opponent wins, anybody's guess is as good as mine – he's a wild card.

In every edition of the President's Message this year, I've written about the relationship between physicians and our patients. We Lee County physicians have a sacred duty to our patients that is becoming more difficult to perform, and the reason for that sad fact is: perversion of the health care market by government interference in it. All the good intentions in the world do not overcome nature's laws, and every time economic interference in a market by government is tried, it produces terrifically bad results. In a critical market such as health care, it produces dire results. So, in this strangest of political years, I've been looking at the state of American medicine from a slightly different perspective: a macro-economic one.

Most federal laws are titled to market them to the public at large, and the Affordable Care Act of 2010 is no exception. It has certainly made health care less affordable for most people, not more, as have all health care laws that I reviewed for this essay. Those who were paying attention saw it coming, and the fact that the ACA was intended to raise prices was confirmed by its architect (and the man behind its predecessor Romneycare in Massachusetts), Jonathan Gruber. In several videos in 2014, he admitted that the bill was essentially a way for the federal government to take money from healthy people and funnel it through the health care system in order to pay for new insurance plans for the unhealthy and poor (most certainly as a step toward an even more collectivized system). The administration believed that Americans would not accept a new tax for this purpose if it were proposed forthrightly, and they were probably correct, given their track record in handling our tax money. Gruber said that the American voter is stupid, and that he wrote the law to be incomprehensible in order to further policy goals. The main goal was clearly more control by the federal government over the health care market. This has been a goal for many for decades; remember Hillarycare?

For all the money that the ACA has and will cost the productive economy of this country, we could have simply given "free health care" cards to everyone who needed them, and allowed them to use the cards like charge cards at any hospital in the country – and had billions left over (this would have worked for the VA, too, but then many government jobs would have gone uncreated). Clearly the goal was not simply to provide health insurance to more people, and especially not to everyone, as promised. And as millions of our patients have learned, President Obama's promise of getting to keep your insurance plan if you liked it was a lie. Another lie was told by Ezekiel Emmanuel (Rohm's brother), and others, who wrote in Annals of Internal Medicine on 24 August, 2010, "These reforms will unleash forces that favor integration across the continuum of care." Yet even now the administration is suing to block to mergers of Anthem & Cigna and of Aetna & Humana insurance companies. The "forces of integration" apparently weren't what they were after at all. It seems that disintegration is a more likely goal. It seems obvious to me that removing artificial barriers to buying and comparing health insurance, such as the prohibition from buying insurance across state lines, for example, would tend to drive the price down, but this simple step was not included in the giant ACA bill, probably as a conciliatory measure to insurance companies.

Time and again, government's good (and bad) intentions have driven prices up in a market where innovation, immigration and increased efficiency should have driven them down. Certificates of Need were implemented as federal law in 1974, though thankfully that law has been repealed. But now 36 states and the District of Columbia still operate under this absurd restriction due to laws at the state level. The stated theory behind Certificates of Need is that by limiting the number of hospitals by law, the fewer hospitals that are allowed to operate in a geographical area would gain increased profitability. This turns out to be true. The theory further posits that the monopoly profits granted by Certificates of Need would impel hospitals to provide indigent and low-income and uninsured care to those who need it. Guess how that worked out? In the end, prices rose, some people found it difficult to obtain or afford health care, and along came more laws. Should charities really have to ask permission to treat the poor? One wonders what would happen to the price and availability of gasoline if only one gas station were allowed per intersection. We could even stipulate that they would have to provide discounted gasoline to the poor with their inflated profit. Of course, a new bureaucracy would be required to dole out the benefits and regulate the gas stations, and this would cut into those profits – but, the intentions are good!

Medicine is a unique responsibility, but this special field is not immune to the law of supply and demand. The customer is not really the patient any more. Though we as physicians care about the needs of our individual patients, they are not the ones we bill. We get paid for our services by insurance companies, Medicare and Medicaid – not necessarily in that order. Prices billed often

have virtually no relation to their items' true cost, especially in hospitals. The patient, and often the physician, has no price transparency, and without price's function, it is impossible to tell how best to allocate resources. When we misallocate resources, perversions in costs, and in supply and demand, are the inevitable result. Some things will be underutilized and others will be overused relative to their actual availability and value. Add to that the inane coding requirements which have created a new specialty job - Coder - and millions of hours and dollars are wasted every year with no increase in patient outcomes or satisfaction, and our patients can often feel like they're on a health-care assembly line, like numbers not names. At the very least, customer service can suffer. That term is not normally on our radar, but it should be.

Treating the needy is something we physicians take for granted – for most of us, we are going to do it whether the government helps us or hurts us. Those technocrats and politicians with good intentions and grand plans often have an ulterior motive, usually power over the lives of others. We mostly just want to help our patients and practice medicine. I keep coming back to the relationship between physician and patient. Anything that interferes with that is bad for everybody, and the current trend is toward more interference, not less. As the profession and art of the physician shifts away from independent practice and toward shift work as the inevitable "integration across the continuum of care" proceeds, I wonder whether we will be allowed to treat our patients more directly, with more personal care, or less.

Nevertheless, things in many ways are getting better. We should celebrate those good things, which brings to me our November General Membership meeting with New York Times bestselling author Jeff Lindsay author of the Dexter novels and hit TV show and our next social event honoring our Veteran Colleagues on Veterans Day at Ford's Garage in Cape Coral. Please join us – we always have fun, and you can tell me how much you agree or disagree with this month's Message!

Lee County Medical Society Nominations for 2017 Officers

The following slate of nominations for the 2016 officers of the Lee County Medical Society is presented for your consideration. The membership will vote at the November 17, 2015 General 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: Jon Burdzy, DO (elected 2016)
President-Elect: F. Rick Palmon, MD
Treasurer: Daniel de la Torre, MD
Secretary: Elizabeth Cosmai-Cintron, MD
Past President: Shari Skinner, MD

Newly elected Members-at-Large:
Joanna Carioba, MD (2019)
Arie Dosoretz, MD (2019)
Ryan Lundquist, MD (2019)

Prevously elected Member-at-Large:
E. Trevor Elmquist DO (2018)
Tracy Vo, DO (2018)
Alexander Pogrebniak, MD (2018)
Cherrie Morris, MD (2017)
Alejandra Miranda-Sousa, MD (2017)

GRIEVANCE COMMITTEE
President: Jon Burdzy, DO (elected 2016)
R. Thad Goodwin, MD, Chair
President-Elect: F. Rick Palmon, MD
Secretary: Elizabeth Cosmai-Cintron, MD

LEGISLATIVE COMMITTEE
*Stuart Bobman, MD

COMMITTEE ON ETHICAL & JUDICIAL AFFAIRS
*Darius Biskup, MD, Chair (2018

Previously elected EJA Members:
Krista Zivkovic, (2019)
Craig Sweet, MD (2018)
Tracy Vo, DO (2018)
Steven Guterman, MD (2017)
Jacob Goldberger, MD (2017)

DELEGATES / ALTERNATES TO THE 2017 FMA ANNUAL MEETING

2017 FMA Delegates
F. Rick Palmon, MD, Chair
Stuart Bobman, MD
Jon Burdzy, DO
Joanna Carioba, MD
Stefanie Colavito, MD
Daniel de la Torre, MD
Elizabeth Cosmai-Cintron, MD
Raymond Kordonowy, MD
Peggy Mouracade, MD
Alexander Pogrebniak, MD
Alternates: Cherrie Morris, MD
James H. Fuller, MD

The Executive Board of the Lee County Medical Society recommends the following By-Law changes. (Deletions in red and additions in green)

Article III- MEMBERSHIP

Section. 2 CLASSIFICATIONS

This Society shall be composed of Active, Associate, Resident, and Retired members. ~~and Associate/Retired, and Life members.~~ Any member granted Life membership prior to 2016 shall be grandfathered and allowed to keep this status for the duration of their membership.

ACTIVE MEMBERS shall be licensed doctors of medicine or osteopathy in active practice in Lee County, Florida, who have met all eligibility requirements.

ASSOCIATE MEMERS shall be doctors of medicine or osteopathy not active in practice in Lee County, Florida. ~~but may include the following:~~

~~(1) Interns or resident physicians.~~

~~(2) Doctors of medicine or osteopathy in full-time career status with the United States Army, Navy, Air Force, Coast Guard, Public Health Service, Veterans Administration, Indian Services, and other governmental agencies that do not hold active membership in another state or county medical association.~~

~~(3) Retired/Semi-Retired Members- Physicians who have fully retired or semi-retired from practice in Lee County or from another county/state.~~

~~(4) An Active Member of another Society may become an Associate member of Lee County Medical Society and pay the required Active Member Dues.~~

RETIRED MEMBERS shall be physicians who have fully retired from practice in Lee county or from another county/state.

RESIDENT MEMBERS shall be intern or resident physicians in Lee County, Florida

Section. 3 RIGHTS AND PRIVILEGES

Membership in the Society confers no vested right to the holder thereof, but is a conditional privilege revocable for cause. Each doctor of medicine or osteopathy, by accepting membership in the Society, becomes subject to all provisions of these bylaws, and subject to disciplinary proceedings authorized hereunder. No member of this Society, whether officer or not, nor any agent or employee, shall incur, nor shall be able to impose, any indebtedness against the Society or spend any Society funds without proper authority as set forth in these bylaws. Any member violating this provision shall be personally responsible for such indebtedness or expenditure and shall reimburse the Society for any expense it may incur on account thereof.

ACTIVE MEMBERS shall have full rights and privileges, including the right to vote and hold office.

ASSOCIATE, RETIRED, AND RESIDENT MEMBERS shall attend Society activities unless unavoidably prevented but they shall not vote or hold office unless approved by the board of governors.

~~Life Members shall be active members who after having been an active member of the Society for thirty-five (35) consecutive years or having been President of the Florida Medical Association. Life Members will pay dues as set by the Board of Governors.~~

LCMS Secretary, Daniel de la torre

Article VIII- FUNDS AND EXPENSES

Section. 2 DUES

ANNUAL DUES- The annual dues shall be determined yearly by the Board of Governors, and shall be payable on January 1 of each year. Members not paying by February 1 shall be delinquent. Members who fail to pay annual dues by April 1 shall be suspended without other action by the Society. Members suspended for non-payment of dues shall be restored to full membership on payment of all indebtedness. Members shall be reinstated only upon payment in full of the indebtedness. All members are required to pay dues and assessments except as provided in the bylaws. The Board of Governors may excuse a member from paying dues or assessments if there is a hardship.

MEMBERS EXCUSED FROM DUES- Members advanced in age or disabled to a degree which interrupts temporarily or partially their ~~professional activities and for whom payment of dues would result in financial hardships as determined by the Board of Governors may be excused from payment of dues by the Board of Governors. Similarly, members fulfilling obligatory tours of military duty may be exempted until their return to non-military practice. Any member who has been on active status in this Society for 35 years shall automatically qualify to become a "Life Member." Active members whose practices have been temporarily suspended for additional professional training, not to exceed four years, may be excused from dues payment by the Board of Governors.~~

~~DUES FOR ASSOCIATE MEMBERS- The annual dues for Associate members will be the same as active member or the cost of the years meals at the County Society meetings, provided meals are included in the annual dues. Associate members may be granted dues exempt status bt the Board of Governors. Associate member cannot vote or hold office.~~

~~NEW MEMBER DUES- When meals are included in the dues, the cost of the meals may be prorated for the number of meetings which the new member will be eligible to attend. The remainder of the fee must be paid in full regardless of how much of the fiscal year remains.~~

LIFE AS A RESIDENT

BY KENNETH O'DELL, MD., FSU/LMHS MEDICAL RESIDENCY PROGRAM

It's not like I didn't have fair warning. My wife told me that there were wasps by our gate when she asked me to take out the trash. However, feeling brave, or to be more honest tired, and somewhat lazy after a long day at work I decided I could just grab the trash can and make a run for curb rather than spraying the wasps and waiting. So I grab the trash can, open the gate, and WHACK. I get stung in the eye. Any neighbors that were watching would have been highly entertained, I start swatting, running, and doing some awkward bobbing as I furiously attempt to get the can to the curb. I succeed and go inside to see my left lower eyelid starting to swell. Luckily my wife passed on the opportunity to say "I told you so". Unfortunately, it gets worse. The next day I had to bring the trash back up to the house. Yet again I'm tired, I'm in a hurry, and I figure that my luck couldn't possibly be bad enough to get stung again. I'll spare you the details but I ended up getting stung twice on the cheek, with more of that awkward running and bobbing motion. But hey, at least the trash wouldn't have to be taken out for another week.

I'll be honest, I feel sort of embarrassed to tell all of my co-workers and peers about this but I think it is applicable to our daily life. If I was smart, listened to my wife, or stopped to do the proper thing and spray the wasps, I would have avoided being stung in the face three times. Of course, I didn't do any of that. I felt it was more important to save some time and just get the job done. We find similar pressures daily at work. We have many patients, with many problems, piles of paperwork, and limited time to manage it all.

This problem will only be further exacerbated as it becomes "season" in our area and the population balloons. The patient lists buckle with new patient names, the rooms fill, and beds start spilling out into the halls. In order to keep afloat, our desks become littered with caffeinated beverages. To make it through in one piece we all must increase our efficiency, but we must do so carefully. We must not skip important steps or lose focus of what should be done as we deal with this increased stress. Rather than swollen eyes from wasps we may get sunken eyes from fatigue, but we must resist the urge to hurry.

MILLENNIAL MEDICINE: PERSPECTIVES FROM THE ETHOS OF THE MILLENNIAL GENERATION

BY CLAY DUVAL, MD

Recall your first semester of medical school. In front of you lies a behemoth of a textbook - perhaps Gray's Anatomy. It is a formidable opponent to be sure, but to read it in its entirety is a reasonable goal to set, and mastering its content is a tested ritual of medical education. Learning the marvels of human anatomy is a rewarding experience, especially since the truths of human anatomy will not change within the lifespan of any one physician. For millennial physicians, however, medical education has become unfathomably more daunting. Humanity's cumulative medical knowledge is expanding at an ever-accelerating pace. In fact, some literature suggests that the rate at which medical knowledge doubles has increased drastically: from every 50 years in 1950, to every 7 years in 1980, and to every 3.5 years in 2010. By 2020, the doubling rate of medical knowledge is estimated to approach 0.2 years - which is only 73 days!

The entire human genome has now been sequenced. The rules of genetics that we used to view as static facts are now being modified as we come to understand the implications of epigenetics. Cytokine pathways which were once thought to be within the purview of only immunologists and molecular biologists are now the very drug targets of many of our most modern medicines. Long-standing therapies and indications for therapies that we have acted upon for decades are now being assessed more vigorously, and some of them are found lacking. Finally, as if there weren't enough to grasp within the realm of human biology for the modern physician, we are now learning that the biology of the microflora of our GI tract may be key regulators and modulators of human health in ways in which we had never before expected.

In the context of this enormous surge in cumulative medical knowledge, the millennial physician certainly has big shoes to fill. In addition to learning the material that our predecessors had to learn during their 7 or more years of medical education, we now are faced with the onerous responsibility to incorporate the latest and most cutting-edge evidence into clinical practice - some of which had not been discovered yet when we began our medical journeys!

Luckily, humanity has also experienced a concomitant surge in the power and ubiquity of technology. Like many of our non-medical peers, the millennial physician is often seen seemingly "glued" to an electronic device of some kind. Although many seasoned physicians may decry the constant use of smartphones and computer-based resources by millennial physicians, it is precisely the efficient use of such technologies that allows us to accelerate our learning process, to distill the essentials from the non-essentials and to streamline our clinical decision making.

As a Family Medicine resident, I like to step back and see the big picture - and what I'm seeing in contemporary medicine is that everything is becoming amplified in scope. On the one hand, we can see that there are burgeoning health care costs and a veritable pandemic of chronic diseases - not to mention a looming boom of the geriatric population which will require unprecedented levels of medical care (no offense, baby boomers). And yet while the challenges we face are indeed amplified, I believe our strengths as physicians have never been greater.

Extraordinary leaders across all specialities and within primary care are working tirelessly to equip our generation of physicians; Jaw-dropping technologies, teaching modalities and strategies are being put in place to educate the best and brightest of the millennial physicians; targeted medicines are being approved which are stopping many diseases in their tracks! It's almost as if our profession is in the midst of a grand crescendo transitioning from one epoch of medicine to the next. Much moving forward remains a mystery but one thing remains certain - what the next epoch will hold in store is up to us now. No pressure, right?

CMS ANNOUNCES FLEXIBILITY FOR MACRA'S FIRST YEAR: WHAT YOU NEED TO KNOW

BY JARROD FOWLER, FMA

On Sept. 8, CMS Acting Administrator Andy Slavitt announced that physicians would be granted additional flexibility in the first year of MACRA's Quality Payment Program. The announcement, though scant on details, appears to be a positive development. While CMS did not announce any plans to delay MACRA's implementation, it is planning changes that should make the law temporarily less onerous. According to the announcement, physicians will now have the opportunity to exempt themselves from penalties under MIPS in the first year of the program by complying with any one of three newly created participation options. The upshot is that as a result of this development, physicians will now have the opportunity to avoid the risk of penalties in the first year of MIPS through data reporting alone. Further, physicians will now have more choice in terms of how they report data to CMS. Prior to this announcement, more than 90 percent of physicians were expected to be subject to the full program requirements of MIPS in 2019, and about half of those physicians were expected to receive a penalty. In addition, prior to this announcement, reporting data under MIPS was not enough by itself to avoid potential penalties. So while it's important to caution that the precise impact of these changes will be impossible to assess until CMS releases more details, this added flexibility could potentially spare thousands of physicians from a Medicare pay cut in 2019. The FMA and its allies in organized medicine have consistently advocated for implementing MACRA in a way that increases flexibility for physicians. At face value, this announcement appears to be a small step in the right direction. Providing temporary flexibility to physicians under a deeply flawed program certainly doesn't address the many problems that physicians still face under MACRA, but it could be a sign that CMS is at least paying some attention to the grave concerns voiced by the medical community. We'll know for sure once a final rule is published and the details of this development have been fully released. A more in-depth look at what this announcement means is provided below.

However, taken at face value, this announcement represents a small step in a positive direction. The FMA will continue to monitor this development and will keep you updated.

Physicians will now have more options to avoid penalties under MIPS. CMS has announced three new participation options that physicians can comply with in order to avoid penalties in the first year of MIPS. The announcement states that physicians who comply with any one of these three options will not be penalized in the first year of the program. While the full details surrounding these options likely won't be available until a final rule is published, here's what we know: The first option available to physicians who want to exempt themselves from penalties under MIPS will be to "test" MIPS by reporting "some" data during the calendar year. CMS describes this option as a way to prepare for "broader participation" in subsequent years. Although it's enormously tempting to want to interpret the word "some" to mean "any whatsoever," no specific details were provided, so it's not clear exactly how much data one will need to report in order to fulfill this requirement. Notably, unlike the second and third options described below, CMS does not mention whether it will be possible to earn any payment bonuses under this participation option. The second option is to report data under MIPS for "a reduced number of days" instead of throughout the entire calendar year. This option will also allow physicians to begin reporting data after the originally scheduled Jan. 1 start date. Further, CMS states that it will be possible for physicians to qualify for "small" bonuses under this option. The third option will be to report data under MIPS throughout the entire calendar year, beginning Jan. 1. CMS states that physicians who choose this option may qualify for "modest" bonuses. However, unless there is an actual difference in the size or availability of the bonuses offered under this option, it's unclear what incentive there would be to choose it. The fourth option, which existed prior to the announcement, is to participate in an advanced alternative payment model (A-APM). Physicians who receive a certain proportion of their Medicare Part B payments or patients through an A-APM will be exempt from MIPS and will also receive a 5-percent lump sum payment bonus in 2019. However, there are currently very few A-APMs available to choose from. Yet, many unanswered questions must be addressed. More details are needed before we can fully assess the impact of these changes. Again, the announcement is scant on details, which likely won't be available until a final rule is published around November. For example, we've yet to learn the exact details of the reporting requirements under each option, how physicians will elect their preferred option, how bonuses will be determined under the second and third options, and whether CMS is planning to modify any other aspect of the proposed rule. Finally, regardless of what CMS announces in its final rule, MACRA will still require careful implementation and statutory amendments in order to minimize its burden to physicians and protect access to care. However, taken at face value, this announcement represents a small step in a positive direction.

The FMA will continue to monitor this development and will keep you updated. Jarrod Fowler, M.H.A., is FMA Director of Health Care Policy and Innovation.

Shared Responsibility for preventing malpractice suits-patient interaction

Submitted By Susan Shepard, MSN, RN and Carol Murray, RHA, CPHRM The Doctors Company

Each member of a healthcare team plays an important role in reducing the number of incidents that cause patient dissatisfaction.

Why Do Patients Sue?

The basic emotions leading to any medical liability action are surprise, disappointment, and anger. These reactions can be triggered by a wide variety of causes that include miscommunication and medication errors.

Communication Errors

Remember that patients may experience uncomfortable emotions, including uncertainty, embarrassment, shyness, and fear. A failure to respond appropriately can create negative feelings that have serious consequences and trigger a chain of events ending in litigation. By contrast, comforting words, gestures of kindness, or simple expressions of caring will often evoke positive patient reactions and promote favorable relationships.

Telephone Conversations with Patients

For many members of a professional medical or dental staff, the telephone is often the primary mode of patient communication. All medical and dental professionals should note the following points:

- Be courteous and maintain professionalism. Remember that you cannot read your patients' nonverbal cues. Use your best listening skills.
- Make sure that any member of your healthcare team who has the slightest doubt about giving instructions or advice to a patient first checks with the provider. If the provider is not immediately available, the staff member should assure the patient that his or her call will be returned as soon as possible and should verify later that the patient's call was returned.
- Make sure that staff members obtain as much detailed information as possible on a patient's health problem and its degree of urgency before conveying it to the provider for evaluation.
- Establish procedures in your practice for providers and patient care staff to effectively manage urgent problems, scheduling difficulties, and unexpected visits.
- Ensure that patient requests, problems, and issues received by telephone are addressed in a timely manner.

Face-to-Face Encounters

The following tips can help you and your staff develop and maintain therapeutic interactions with patients:

- Initiate personal contact with the patient by expressing cordial, individual attention.
- Make a favorable impression through your demeanor. Any interaction with any member of the team may represent the patient's first, last, and most enduring impression of the provider, hospital, or office.
- Explain unavoidable delays in the office schedule to the patient. If appropriate, offer to reschedule the appointment. Most patients will appreciate being informed.
- Maintain strict confidentiality. Do not discuss any patient problems outside the hospital or office practice. Even when discussing a matter pertaining to a patient with another staff member, do not do so in a public area or within hearing range of other patients.
- Staff should always alert providers to disgruntled or hostile patients so that the situations can be defused immediately. Patients frequently share information with healthcare support staff that they will not tell providers, so be sure providers are informed of any significant statements.
- Staff members should never give advice beyond their competencies or scopes of practice. Assure any patient of a prompt response to an inquiry and follow through as soon as possible to ensure the patient gets the appropriate information or referral.
- Encourage patients to write down their questions for providers or questions regarding the provider's instructions. Studies have shown that patients remember only a small portion of what they are told. Furnish written instructions or educational information to patients for review at home.
- Incorporate Ask Me 3 into your practice. This technique, which encourages patients to participate in their healthcare, has been shown to improve communication. Download free educational materials at www.npsf.org/askme3.

Methods to Enhance Consent

Although obtaining informed consent is the provider's responsibility, staff members often become involved in assisting or answering additional questions from patients. Everyone involved in obtaining consent should follow these guidelines:

- Be supportive and reassuring, but do not promise too much when dealing with anxious patients.
- Take time to answer questions. Informed patients are less anxious and more cooperative.
- Remind patients of their instructions by using preprinted fact sheets for commonly performed procedures, tests, or treatments, including preparation requirements and instructions following discharge.

Steps to Avoid Medication Mistakes

Avoidable medication errors can result in severe patient injury. These steps can help reduce the risk of errors when administering medications:

- Review all current medications with a patient at each visit and reconcile any discrepancies.
- Double- check the vial or bottle label against the order before drawing up a substance. Never use unlabeled vials or bottles
- Make sure you understand the amount of the dose ordered. Fifteen and 50 sound similar, but the difference in dosage can be catastrophic
- Ask a patient if he or she has an allergy to the drug or drugs to be injected or ingested before administering any medication by any route—even when there is no indication of drug allergy in the patient's chart.
- Know the location and proper use of oxygen and other resuscitative equipment and drugs for emergent conditions.
- Develop guidelines to manage prescription calls and refills, and always record the calls with the date and time in patient's charts.
- Ensure that all healthcare personnel who deal directly with patients are trained in cardiopulmonary resuscitation.
- Always verify the "six rights": the right drug, right date, right dose, right route, right frequency, and the right patient.

Summary

Improving office or hospital procedures and communications in healthcare are the responsibility of all personnel. By following the guidelines in this article, you can make a vital contribution to safe patient care.

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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 in light of all circumstances prevailing in the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

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