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

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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 & 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:
Mermaid Lake in the Italian Dolomites.
Richard Keown, MD

Calendar of Events

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

Cocktail Hour at Cru
September 8, 2017
6 p.m. - 7:30 p.m.
RSVP to www.lcmsfl.org

Sponsored by the Bank of the Ozarks

Bell Tower Shops
13499 S. Cleveland Ave, Ste 241
Fort Myers, FL 33907

September General Membership Meeting
September 14, 2017- Crown Colony Golf & Country Club
See insert for more information

LCMSF Wellness 5k and 2k Fun Run / Walk
September 16, 2017 Lakes Regional Park

Registration - 7:30 a.m.
See page 13 for more inforamtion

SAVE THE DATE

October 13th - Cru Cocktail Hour
October 24th - Gentlemen's Night Out!
November 10th - Cru Cocktail Hour
November 16th - General Society Meeting
December 4th - LCMS Holiday Party
December 8th - Cru Cocktail Hour

All RSVP's can be made online at *www.lcmsfl.org*

Membership News

Retired
Patrick M. McGookey, MD

Practice Name Change
A Kagan & T Atkinson Orthopedics & Sports has changed to:
Advanced Orthopedic & Sports Medicine of SWFL
Todd Atkinson, MD
Thomas Laporta, MD
8710 College Parkway
Fort Myers, FL 33919
Tel: 239-482-8788

Corrections
NEW PRACTICE:
Omar Benitez, MD
Complete Care Urology
13770 Plantation Road, Ste 3
Fort Myers, FL 33912
Tel: 239-204-9855

April Bulletin
Omar Benitez, MD was incorrectly listed as resigned. He remains an active member of the LCMS.

Corrections Cont'd
New Location
Daniel Bendetowicz, MD
6840 International Center Blvd.
Fort Myers, FL 33912
Tel: 239-985-1050
Fax: 239-985-1060
www.doctorben.net

July Bulletin
Phone number was incorrectly listed, their phone/fax number remains the same as before move.

Brian Krivisky, MD
Pictorial Directory
Dr. Krivisky's photo was incorrectly placed in our 2017 Directory. Below is the correct photo.

New Applicants

Melissa Bacchus, MD – Dr. Bacchus received her medical degree from the University of West Indies, Kingston, Jamaica in 2002. She completed a Pediatric residency at WVU School of Medicine, Charleston, WV from 2004 – 2007. Dr. Bacchus is in practice with Physicians' Primary Care of Southwest Florida, 1261 Viscaya Parkway, #101, Cape Coral, FL 33990.Tel: 239-573-7337 Fax: 239-574-5883.
Board Certified: Pediatrics.

Jennifer Carrion, MD - Dr. Carrion received her medical degree from University of South Florida Morsani College of Medicine, Tampa, Florida in 2017. She is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

Sarah Churton, MD - Dr. Churton received her medical degree from Marshall University Joan C. Edwards School of Medicine, Huntington, WV in 2010. She completed an Internal Medicine internship at University of Cincinnati, Cincinnati, OH from 2010-2011. She also completed a Dermatology residency and Dermatology Research fellowship at University Hospital's Cleveland Medical Center, Cleveland OH from 2011-2017. Dr. Churton is in practice with The Woodruff Institute, 23471 Walden Center Dr., Ste 300, Bonita Springs, FL 34134. Tel: 239-498-3376 Fax: 239-498-3379.
Board Certified: Dermatology

New Applicants *(cont'd)*

Arieal Felix, MD – Dr. Felix received her medical degree from Meharry Medical College, Nashville, TN in 2017. She is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

Shayna Klein, MD – Dr. Klein received her medical degree from Michigan State University College of Human Medicine, East Lansing, MI in 2017. She is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

Robert Kopp, MD – Dr. Kopp received his medical degree from SUNY Upstate Medical University, Syracuse, NY in 2012. He completed an Otolaryngology residency at SUNY Upstate Medical University, Syracuse, NY from 2008-2012. Dr. Kopp is in practice with ENT Specialists of FL, 39 Barkley Circle, Fort Myers, FL 33907. Tel: 239-936-0939 Fax: 239-936-0837.
Board Certified: Otolaryngology

Murilo Lima, MD - Dr. Lima received his medical degree from American University of the Caribbean, Cupecoy, St. Maarten in 2017. He is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

Danielle Matta, DO – Dr. Matta received her medical degree from Virginia College of Osteopathic Medicine, Blacksbury, VA in 2011. She completed an Osteopathic Medicine internship at Philadelphia College of Osteopathic Medicine, Drexel Hill, PA from 2011-2012 and a Diagnostic Radiology residency at Cooper University Hospital, Camden, NJ from 2012-2016. She also completed an Abdominal Imaging fellowship at Emory University Hospital, Atlanta, GA from 2016-2017. Dr. Matta is in practice with Radiology Regional Center, 3660 Broadway, Fort Myers, FL 33901 Tel: 239-936-2316 Fax: 239-425-4798.
Board Certified: Radiology.

Hazem Matta, DO – Dr. Matta received his medical degree from Philadelphia College of Osteopathic Medicine, Philadelphia, PA in 2011. He completed an internship at Philadelphia College of Osteopathic Medicine, Philadelphia, PA from 2011-2012 and a Diagnostic Radiology residency at Penn State Health Milton S. Hershey Medical Center from 2012-2016. He also completed an Interventional Radiology fellowship at Emory University School of Medicine, Atlanta, GA from 2016-2017. Dr. Matta is in practice with Radiology Regional Center, 3660 Broadway, Fort Myers, FL 33901 Tel: 239-936-2316 Fax: 239-425-4798.
Board Certified: Radiology.

John Neiner, MD – Dr. Neiner received his medical degree from the Medical College of Georgia, Augusta, GA in 2012. He completed an Otolaryngology residency at Louisiana State University HSC, from 2012-2017. Dr. Neiner is in practice with ENT Specialists of FL, 39 Barkley Circle, Fort Myers, FL 33907. Tel: 239-936-0939 Fax: 239-936-0837.
Board Certified: Otolaryngology

Christine Norton, MD – Dr. Norton received her medical degree from Wayne State University School of Medicine, Detroit, MI in 2017. She is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

Cont'd on page 4

New Applicants
Cont'd from page Three

Kristen Noud, MD - Dr. Noud received her medical degree from FSU College of Medicine, Tallahassee, FL in 2017. She is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

Guillermo Philipps, MD – Dr. Guillermo Philipps received his medical degree from St. Louis University School of Medicine, St. Louis, MO in 2006. He completed a Pediatric internship and residency at Miami Children's Hospital, Miami FL from 2006-2008 and a Child Neurology residency at University of Chicago, Chicago, IL from 2008-2011. Dr. Philipps is in practice with Golisano Children's Hospital, 15901 Bass Rd.# 108, Fort Myers, FL 33908. Tel: 239-343-6050 Fax: 239-343-6051.
Board Certified: Psychiatry and Neurology.

Jaime Realsen Hall, MD – Dr. Realsen Hall received her medical degree from Ross University School of Medicine, Portsmouth, Dominica, West Indies in 2017. She is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

Hannah Schrubbe, MD - Dr. Schrubbe received her medical degree from University of South Alabama College of Medicine, Mobile, AL in 2017. She is a Family Medicine resident through the FSU College of Medicine Family Medicine Residency Program at Lee Health.

President's Message
By Jon Burdzy, D.O.

May I never see in the patient anything but a fellow creature in pain. -Maimonides Oath

Writing a companion piece to Dr. Liu's masterful article (page 6-7) was not an easy task. The questions he raises are difficult and uncomfortable. And as with most complex problems there is no simple answer. There are many actors in this play: physicians, patients, hospitals, pharmacies, drug manufacturers, government agencies, law enforcement, criminal syndicates and professional societies. All bear some of the responsibility for our current opioid epidemic.

Physicians who trained at the turn of the century were indoctrinated with the idea of pain as the fifth vital sign and were taught to address, "poor pain control as unethical, clinically unsound, and economically wasteful." So said JCAHO and AHCA, so said our attendings, so we too came to believe, assuming we were practicing evidence-based medicine and adhering to validated practice guidelines. Too much faith was placed in agencies, pharmaceutical companies, and their spokespeople. We were taught the risk of addiction to prescription opiates was low and over prescribed them in the belief we were helping our patients. A few grievously commoditized our prescription pads and created pill mills.

The pendulum then swung the other way. Pill mills were raided and shut down. Physician outliers lost their licenses; some were convicted and jailed. Important lessons were learned about the nature of the newer opiates. The sobering statistics Dr Liu cites, as well as our personal experiences in treating patients with chronic pain, reinforces their dangers.

In response the majority of us have changed our practice patterns. We have expanded the use of non-pharmaceutical and lifestyle based therapies in treatment plans for pain. We increasingly utilize physical and other manual therapies. We have become more likely to prescribe non-opiate analgesics, recommend diet, exercise, mindfulness, and other lifestyle methods. We refer to pain management physicians who offer non-opiate interventions and are experienced in the management of opioid dependent patients with complex pain syndromes. Physicians have become more critical of guidelines and government pronouncements as to the delivery of care, and also of the pharmaceutical company sales reps and the doctors who speak for them.

Better tools to address prescribing opiates are now available. eForcse works remarkably well as a prescription monitoring program and is routinely queried. Pharmacies and insurers are more forthcoming when they learn of patients filling opiate prescriptions from multiple providers. REMS (Risk Evaluation and Mitigation Strategy) courses are now a part of CME meetings, and physicians are increasingly implementing these strategies.

But barriers remain. Cost, access, time, and of course desire. It is faster and easier for the doctor to prescribe a medication than to explain a lifestyle change. It is simpler for the patient to take a pill than implement these changes. Insurers contribute to the problem by limiting coverage of non-pharmaceutical interventions and cognitive based therapies, but are willing to pay for opiate prescriptions. Change will require shifting the behaviors on both ends of the prescription pad. Patients need to accept that some degree of pain is a part of life and physicians need to be more judicious about prescribing opiates. We need to think critically. An ankle sprain does not require Percocet and Motrin does not generally provide adequate relief for renal colic or pancreatitis.

Some patients with chronic non-cancer pain require long-term opiate analgesia. They may have kidney disease or take anticoagulants that render NSAIDs a poor treatment choice. Others suffer chronic pain from a trauma, medical condition, or surgical procedure gone wrong that does not respond to more conservative measures. These are the patients who require the most attention. We need to treat them, but also do all we can to prevent them from becoming addicts.

But this only scratches the surface. How can we prevent people from becoming addicted in the first place? We have crude tools to aid in assessing a patient's risk of opiate abuse, but they are easy to manipulate and often inaccurate. Ample evidence shows some patients have a genetic predisposition to addiction, but we lack an accurate way of identifying them. Population medicine demonstrates opiate addiction is most problematic in areas that lack primary care physicians and have high levels of unemployment and poverty. These issues need to be addressed by our society and government, not only by physicians. Opiate abuse is not purely a medical problem.

Help must be made available to those who have become addicted. With the current regulatory and political climate it is easy to demonize them. We must resist this impulse, keep our focus on their humanity, and try to help them, recalling our profession has abetted some patient's addiction. None of this however removes responsibility from those who have misused or abused opiates; but as with any condition resulting from poor choices (obesity, tobacco use, etc.) we have an obligation to aid in its treatment.

Unfortunately, addiction treatment is often difficult to obtain. There are few outpatient detox and treatment programs available. Many are not well covered by insurance plans. Primary care physicians, with few exceptions, lack the training and skills to add addiction treatment services to the others we offer. We are overburdened with treating metabolic, neurologic, musculoskeletal, obesity related problems, acute illnesses and psychiatric problems, not to mention providing preventative care. Also there are simply not enough of us. It is estimated that by 2025 we will have a deficit of at least 250 primary care physicians in southwest Florida. We need better access to those skilled in treating addiction.

Echoing Dr. Liu's article, I'll end with some questions. Where do we go from here? How do we decrease demand for opiates (prescription and from the street)? How do we provide the resources for those who are addicted? How do we create a culture where people accept that pain, physical and psychic, is an inevitable part of life? How do we address the underlying problems of poverty and unemployment that often lead to addiction? And finally, who is to take responsibility? At least to this last question I have a simple answer - all of us.

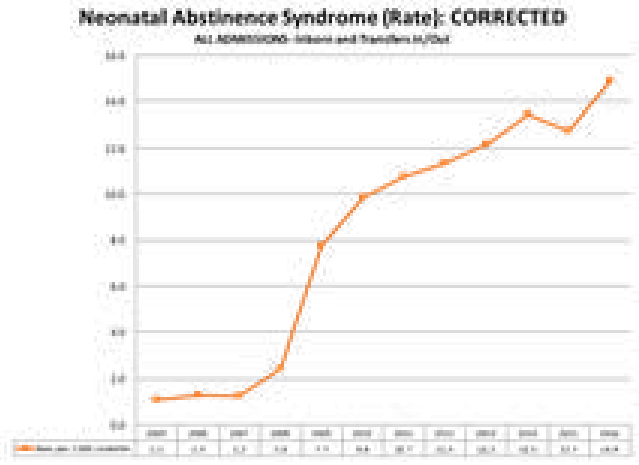
Our rising NAS rates and the Opioid Epidemic: a look backward and forward

By William Liu, M.D.

Unless you have been disconnected from the grid, you are probably very aware of the continued drum beats warning us of a growing narcotic drug epidemic impacting all members of our society (see NIDA or CDC websites). This is validated by acknowledgement of an opioid "state of emergency" by President Trump.

In 2005-8 we began to see an upward trend in prescription drug abuse, and from the perspective of a neonatologist, we saw a concurrent increase in the number of babies being admitted to our NICU's for neonatal abstinence syndrome. I reflected on this in a Bulletin article back in 2010 when we were seeing a 7-9-fold increase in our NAS admissions, and the adult world was noticing a dramatic proliferation of "pill mills," with prescription drugs becoming the drugs of choice for abuse. 2009-2012 saw a recognition of this problem as well as a concerted effort to address it: we saw (1) a National policy statement (National Drug Control Policy, National Institute of Drug Abuse and CDC statements); (2) a national medical community response (Florida Board of Medicine supported improved education, physician drug monitoring program development), (3) legislative actions (stronger laws created and implemented targeting sources of prescription drugs, e.g. "pill mills"), as well as (4) an increased enforcement of existing laws, and a crackdown on illegal sources of prescription medications. In 2010, the DEA- ARCOS database listed Florida as the place of residence of the 98 out of the top 100 prescribers of oxycodone; by 2012, there were zero Florida prescribers included in this notorious top 100 list! By 2011-12, our State-wide statistics suggested a decreasing trend in oxycodone related deaths, and in Lee County, I reported a flattening of our total number of patients with NAS. There was increased awareness, action and results (a national PDSA cycle).

Reason for optimism? There was a flattening in many indicators locally and nationally, especially in indicators of prescription opioid use and death, even as heroin related deaths began to skyrocket. 2016 marking our highest NAS rates ever (Corrected by Chart review) and reflect a 12-fold increase from 2005.



The relative numbers of our mothers on a medication assisted treatment program remain at about 50%, and although we are indeed seeing less mothers abusing prescription drugs, its The relative numbers of our mothers on a medication

assisted treatment program remain at about 50%, and although we are indeed seeing less mothers abusing prescription drugs, its seems they have found other narcotic sources including heroin, abuse of methadone and buprenorphine, dilaudid, fentanyl, and other street sources of synthetic opioids.

Although I remain, as does the entire pediatric community, very engaged in understanding and refining the specific strategies that allow us to improve the identification and treatment of babies with NAS, this remains a "pay me later" approach, and does not address the root cause.

NAS is the unintended consequence of a larger dynamic. In any human population, there will be some significant percentage of us that will become addicted to drugs. As with most medical conditions, there is a nature/nature equation. NIDA estimates 40% of the propensity towards addiction is genetic (psychologic vulnerability, genetic variation in drug metabolism). So just as every garden has the potential for pesky weeds (and yet some have more than others), it is our uniquely fertile soil that is nurturing our societal garden's infestation. What is this nurture component? Addiction has most likely been an inherent part of our genetic potential even before we first cultivated the poppy seed in 3,400 B.C. Are there other epigenetic triggers? Possibly so, and maybe the future will allow us to identify and nullify our genetic tendencies. But until then, I am more inclined to focus most upon understanding and modifying the environmental exposures or triggers.

The 2016 CDC guideline for prescribing opioids now acknowledges the highly addictive nature of this family of medications, and has now recognized the need to control its use.

With a fall in our recent prescription drug epidemic, we are now seeing a compensatory growth in illicit drug abuse. According to the most recent Florida Department of Law Enforcement statistics, opioids - the class of drugs that includes heroin and prescription painkillers - were directly responsible for the deaths of 3,896 Floridians in 2015. Back in 2012, SAMHSA data noted that only 4% of pain relievers were obtained from a drug dealer or stranger. Almost all the rest were obtained by direct prescription or second-hand from others who had indirect access to this prescribed source. In 2015, over 1/3 of all Medicare patients were given physician prescribed opioids, and more than 20% of this population were drug abusing. Are we, the physician, directly or indirectly, by prescribing or making available a highly addictive product to our patients, providing the "trigger" for addiction?

In 2000 JAMA, JCAHO came out with their mandate to address "poor pain control as unethical, clinically unsound, and economically wasteful." As with most complex systems, attempts to mold health care policy must consider these unintended consequences, but policy makers sometimes are unable to have this foresight. In addition, the pharmaceutical companies that produced this product were naturally motivated to perpetuate or reinforce any actions that would favor the consumption of their products (OxyContin/PurduePharma was FDA approved in 1995). From 1991-2010 there was a 6-fold increase in opioid prescriptions. Physicians faced a knowledge-based error cycle that was perpetuated in a perfect storm of positive feedback loops… So, from 2000-2012, more begat more. Retrospectively, we helped to provide the fuel for a prescription drug epidemic; we were the environmental trigger for those genetically vulnerable individuals in our society who have a propensity towards addiction.

It is now 2017, and I am seeing, at least anecdotally, a shift in "drugs of choice" for women of child-bearing age who are narcotic-dependent, become pregnant, and subsequently deliver an opioid-dependent baby. Women of child-bearing age are of most interest to the neonatologist, but once they are addicted, it is often too late. As I understand the challenges of addiction management- a potentially life-long struggle utilizing acute medication-assisted treatment and ongoing behavioral counseling- our society is most efficiently served by developing effective prevention strategies. We are trying to better understand the age and gender-specific motivational factors that increase the risk of drug abuse.

I will end with several questions that I believe you, my colleagues are best equipped to answer: What is the role for the primary care physician who must educate and advise their? How might we best utilize screening tools such as eForce? Are the SBIRT model, and other screening strategies effective? Can we better define the multifactorial exposure risks, and can we then diagnoseand modify treatments based upon this risk profile, for each of our patients?

And here is the low-hanging fruit- questions that may have actionable answers: Are there new paradigms for pain management? The CDC has said as much. What is the role of non-opioids in chronic pain management?

We are indeed holding on at the front line, but do not be discouraged by the daunting challenge we now face. There are exciting, emerging research solutions that may stem the tide, and many of these were recently summarized by Nora Volkow (NEJM, July 27, 2017). These involve overdose prevention and reversal including stronger opioid antagonists; treatments of addiction including novel opioid receptor agonists (6-mo Probuphine implants), development of selective reward circuit antagonists (lofexidine, loraserin), and even vaccines that induce antibodies protecting the CNS from powerful bloodstream borne opioids e.g. heroin, fentanyl… and for treatment of chronic pain: development of non-addicting opioid anlagesics, novel analgesics targeting non-opioid pain pathways (endocannabinoid system, dopamine D3 antagonists), as well as non-pharmacologic approaches (brain-stimulation technologies- high-frequency repetitive transcranial magnetic stimulation) and the use of gene therapy.

Ramirez Report
By Julie Ramirez, LCMS Executive Director

It's amazing how fast a summer can fly by. At the end of July, I took my husband and two kids with me to Minneapolis, Minnesota for the Annual American Association of Medical Society Executives' Conference. This 4-day conference for fellow medical executives like myself is packed full of information and ideas that helps keep medical societies vibrant and relevant. Here are just a few of the topics that we touched on. The idea of physician wellness continues to gain momentum throughout the country. One of our fellow county medical societies in Kentucky started their Physician Wellness Program (PWP) 18 months ago. Since they are a similar size in membership, I have watched them closely to glean ideas and take notes on their success. It is interesting to note, in the past 18 months since they started, they have had 12 physicians and over 74 residents use their PWP. Those are amazing and encouraging numbers. We operate very similarly to them in that the Society has very little involvement besides promoting the program and paying the bill. Our program has seen 6 physicians since our start in February. This is very exciting news in the fact we are fulfilling a need for our member physicians. There's no shame in talking with someone about issues in our lives.

One of the keynote speakers for the conference came from the School of Public Health at the University of Minnesota. I highly doubt anything that she taught about would surprise you. 325 million Americans are served by 16 million healthcare providers at an expense of $3.2 trillion dollars. Our problems for care delivery and providers include changing payer mix, access to providers, and investment into payment models. For hospitals in states with expanded Medicaid, uncompensated care costs were lowered on average by $2.9 million. ACO's show a modest success in reducing spending, but not necessarily proving to be the magic bullet with long term success. Physician led groups are doing better than others. 10 states currently have Medicaid ACO's. Uncertainty in the health market is leading to higher insurance premiums. Our speaker offered up multiple solutions and gave her experience working during the Obama administration but the one comment at the end of the speech left me stunned: Politics always trump Policy. *sigh*

One of the classes I enjoyed the most was on Forging Productive Professional Relationships. Work is not just what you know and who you know, but how well you work together. Avoid relationship sabotage by maintaining a relationship—talking human to human. Don't take things too personally—You are focusing TOO much on yourself. Sometimes it's just business. Don't dominate or be dominated. Others around you must feel valued. If you are doing almost all the talking, you are dominating. Don't limit yourself with cliques. It's in the excluding others kind of way. Break the cliques, because not only you but they will also benefit. Communication can make or break a professional relationship. Men and women are different in communicating. Always think about who is on the receiving end of the communication. And communication is a 2-way street—make sure you stop to listen. Communication is 3 dimensional ---it is both verbal and non-verbal. Of the 3 types of communication – verbal, tone and physical—which do you think has the most impact? Physical has a 55% impact on your communication! Tone was 38% impact with Verbal being 7% impact. A good tip is to try to use as much of the 3 types of communication – verbal, tone and physical—as possible.

I barely touched the surface on the information that I learned. I must add that Minneapolis and the state of Minnesota is beautiful……in the summer! As a native Michigander, my childhood memories flooded back as I watched my children climb rocks, splash in the 60-degree Lake Superior waters and marvel at the large cargo carrying lake freighters. For us the weather was perfect, the people in the downtown Minneapolis area were friendly and the state was easy to navigate. So, if you have the chance to visit, I would highly recommend it---in the summertime!!

Gregory G. Young, M.D.
December 8, 2016

Dr. Gregory G. Young, 87, of Bonita Springs, FL passed away at Hope Hospice on December 8, 2016. The oldest of four children of George and Marguerite Young.

Dr. Young graduated from University of Dayton and the University of Cincinnati, College of Medicine. Dr. Young was a Psychiatrist with a private practice in Dayton, Ohio and practiced in Fort Myers, Florida.

He is survived by Sheila Young, his wife of 60 years and his children, Colleen Cusick, Lisa Sublett and David Young, along with his grandchildren, and great-grandson.

He will be remembered for many things: his towering intellect; his kindness to all he encountered; and his devotion to his family are chief among them. Dr. Young joined the Lee County Medical Society in September of 1999.

Lee County Medical Society expresses their deepest sympanthy to his family and friends.

Summer Event Photos

LCMS hosted a FSU / LMHS Family Medicine Residency Program Welcome Reception June 29, 2017
Sponsored by: FineMark National Bank & Trust

Women's Manicure & Martinis Event
August 17, 2017
Sponsored in part by - Leading Edge Benefit Advisors

2017 Florida Medical Association (FMA) Annual Conference

August 4, 2017 FMA Delegate Dinner

August 5, 2017 FMA Installation Dinner

Reference Committee Joanna Carobi, MD

1st row Left to right - 2017 Delegates, Michael Katin, MD; Joanna Carioba, MD; Stewart Bobman, MD; F. Rick Palmon/ Valerie Dyke; *2nd row left to right* Ray Kordonowy, MD; Stephen Hannan, MD; Rich Macchiaroli, MD; Jon Burdzy, DO; Stefanie Colavito, MD; and Daniel de la Torre, MD *Absent from photo is:* Scott Caesar, MD; Elizabeth Cosmai, MD. Andres Laufer, MD

2017 FMA Reference Committee: Valerie Dyke, MD

2017 FMA Reference Committee: F. Rick Palmon, MD

"Do No Harm"

By Thomas M. Mouracade, CEO The Kimberly Center

Daily we are barraged with a sea of information regarding the opiate crisis. Who is to blame? How do we fix it? Is it a national emergency? What is the best course of action? How do we save these lives?

I would ask you to think critically about one option being encouraged as a viable solution, that of Suboxone. Ask yourself, can I trust a pharmaceutical solution to an epidemic that was created by pharmaceutical companies, (who are among the most profitable entities in history). Pain as the fifth vital sign? An argument can be made that the same guys who provided the poison are now offering the antidote. A moment's pause is warranted; there is another option that will do no harm, that of Abstinence Based Recovery. Treating narcotic addiction with narcotics can be compared to dousing a fire with gasoline.

The responsibility of any Health Care Professional is to promote wellness and ease suffering. Of course, there are levels of physical pain which warrant the use of powerful narcotic medications. But at what cost? Does a Physician ease suffering at the expense of the overall health and wellness of the patient? Not intentionally. As an individual in long term abstinence based recovery who lives with chronic pain, I received lifesaving advice which very simply stated, "No one has ever died from being in pain, but addiction will kill you". Non-narcotic Pain Management is a viable option.

> *"Does a Physician ease suffering at the expense of the overall health and wellness of the patient?"*

When used as a taper, Suboxone serves a legitimate purpose. In my experience, opiate withdrawal is excruciatingly painful. Yet, it is not medically dangerous. If it can ease the suffering of opiate withdrawal, perhaps there is no harm in a multi-day taper of Suboxone. However, when used as a maintenance medication, it becomes the new Methadone. Suboxone clinics are reimbursed handsomely by insurance companies. Maintenance narcotic medications such as Suboxone and Methadone are the most cost-effective way for insurance companies to "Deal with" the opioid Crisis. As a Treatment Provider, I can assure you that there are individuals in treatment today for Suboxone. Their collective statements have been that it is harder to get off Suboxone then Heroin.

Suboxone is an easy fix, we can check the box and move to the next patient feeling that we have done a good job. As Bill Wilson, the co-founder of AA, is quoted, "The good is all too often the enemy of the best." A Physician strives for the best, and is accountable to fellow Physicians and Patients to provide the very best. The other co-founder of AA is Dr. Bob. In his last public address before his death, this recovered Alcoholic, and Physician, addressed a World Convention of AA with these simple words, "Recovery is about love and service. We all know what love is, and we all know what service is". As you fought the insurance companies on behalf of your patients to insure they received better care, you can put this into practice and advocate they support Abstinence Based Recovery.

I have come to know many of you over the last decade, and I believe we agree care should be delivered in a manner which is loving and compassionate, while humbly being of service to those who are in our care. As a Treatment Provider, , The Kimberly Center considers medication as a last resort, and never as a first line of defense. We will help those who wish to get off Suboxone, and realize their full potential. The PRN Program for physicians with substance abuse problems discourages the use of Suboxone, except in extreme cases. This approach has produced an 85% success rate over 5 or more years of follow-up (Alexis Polles, MD, Medical Director, Florida Professionals Resource Network) There is good reason for this. A physician on maintenance medication, such as Suboxone, is impaired in their ability to deliver care. Do not those entrusted to your care deserve the same consideration as your colleagues?

Finally, I would ask that we make the distinction between sustaining life and truly living. Maintenance Medications do lower the mortality rate of those of us suffering with the Disease of Opiate Addiction. Consider the quality of life. Abstinence based recovery does provide a solution which encourages the individual to meet and even exceed their potential. I have experienced this myself over the past 15 years, and counting.

Tom Mouracade is the CEO of The Kimberly Center, Fort Myers, Florida. The Kimberly Center is a holistic evidence based treatment center for substance use disorder with a focus on wellness. www.kimberlycenter.com

Burned out? Just say no and teach others to as well

By N. Bande Virgil, MD Columbus Regional Medical Group

Without question, the interconnectivity created by social media is a plus when it comes to talking about physician burnout, suicide and policies affecting our practice of medicine. We are no longer in independent silos with the surgeons suffering in one corner and pediatricians elsewhere. Physicians are no longer isolated contemplating if what they are experiencing is just unique to them. We are developing collective voices. It is incredible to believe a profession that requires some of the top academic performers and minds of any field is struggling with basic concepts of control, equity and justice in the workplace — but we are.

As we have advanced the discourse externally about the collective pressures we face, we are simultaneously paving a path for students and residents who enter the workforce that will hopefully look different than the highly regulated and micromanaged medical world we currently practice in. But collective work is not enough. As individual attending and seasoned physicians, we must mirror balance in our professional lives. To defend against burnout and physician abuse, we must teach our new physicians the art of saying no. Helping our new residency graduates and medical students recognize these abusive work environments, prioritize their happiness and values so that they can avoid pitfalls is essential. In order to do so, we must recognize the role we as attendings play in perpetuating physician abuse and burnout. We are part of the problem.

"You cannot teach what you do not know," so the saying goes. As attending physicians, many of us are still learning how to say no. When we graduate residency many of us are straddled with considerable debt from student loans. We are used to working long hours that are out of our control. For a finite time, shorter for some trainees than others, we are beholden to hospital schedulers, program directors, and ACGME requirements. However, this period passes, even during the longest training process. Then, one is left with life after training. This is the life we have worked hard for, made promises to our significant others and family that it would be better. However, if one does not prioritize the things that matter to you outside of medicine, create boundaries, by saying no to unreasonable requests, it will not be better. This is where the dream is deferred, and many of us find ourselves hopeless and disappointed. Mastering the art of no is important for physician well-being.

There are many of us out in practice, those who are seasoned, who have not yet figured out how to create professional boundaries for themselves. Our residents and students look to us for mentorship and leadership. We sit on hospital boards and committees but do not speak up. If we do not continually advocate for ourselves, they are left uncertain of their capability to do it. In my work with those in training, many are overwhelmed by the culture of negativity that surrounds us.

While we continue to practice heroic measures in our fields, we are clinical innovators; we are academically astute, and the work-life balance perils in our personal lives are blatantly apparent. This generation of upcoming future physicians needs us to stand up and be accountable. While, as mentioned, there are many collective improvements, on a daily basis we falter in the decisions for personal wellness that we fail to make. It is a disservice to our profession and those behind us.

Residents who work with physicians who have an antiquated perspective of extreme self-sacrifice become indoctrinated in a negative culture. The expression of professional success has long been sacrificing one's well-being for patient care or medical service. We criticize our colleagues who recognize their need for rest, who prioritize special moments in the lives of their family members. We continue to make it difficult for mothers who are working, fathers who want to spend time with a newborn. These are physician culture issues as much as they are institutional problems. Therefore, it is imperative that we stop affirming this malignant perspective and say no. While those who choose to work in this manner make a decision to do so, others should not feel bullied or pressured into a physician-led culture such as this.

There is nothing more troubling than watching a senior physician who has lost grip and control over the most precious commodity of their own time. Work does not define you unless that is your choice. We can all pursue excellence and be the best physicians we can for our patients but still take care of ourselves. It is a difficult balancing act but one that matters as much as completing charts and attending CME. It is the great juggling task of our profession. The more we as attendings and seasoned physicians model this behavior, normalize balance and disavow the culture where physician personal needs are unimportant the easier it will be to transform the landscape of medicine from the external pressures we face. We must humanize the way in which we work as colleagues and physicians if not for our own benefit, then let's do it for those behind us.

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Millennial Medicine
By Clay Duval, MD

It was early on a Saturday morning when we picked up the donuts. At the age of 8 years old, my usual Saturday morning routine was to wake up and watch the cartoons on TV. But this Saturday morning was different - I was going to get to go to work with my Dad, an Emergency Room doctor. I don't really remember the circumstances surrounding why that was necessary. What I do remember are the donuts and my intrigue that my father was buying 2 dozen donuts. You can imagine that this had me pretty excited. "Dad, are those all for me?" I asked, enthralled at the prospect. "No, son", he answered. "These are for the nurses at the hospital." With that all-too-familiar tendency of children to continue their lines of inquiry ad infinitum, I continued with "But dad, why do they need so many? Are they starving?". My dad looked at me with a smile and then seemed to furrow his brow pensively for a moment as if reflecting on his own motives. After a brief moment, he responded with something that impacted me enough to make me remember it to this day: "I don't buy the donuts because they are hungry for food, Clay; I buy them because they are hungry to be appreciated. I do it so they know I am thankful for all their hard work - and to make them feel happy."

The question I pose for us all to ponder on today as physicians is not a medical one but rather a personal one: Is there anyone in your life right now who is hungry for your appreciation? The answer for so many of us is a resounding "Yes". And it's not without reason. As physicians, we have so many balls to juggle and plates to spin. Many times we ourselves don't feel appreciated for the hard work and sacrifice that we put forth on a consistent basis. Nonetheless, if we are going to be effective leaders, both in medicine and also more generally in life, we must be cognizant of the morale of the teams we lead and those in which we participate.

The beauty of speaking words of kindness, appreciation and affirmation is that it costs us nothing but yields us an enormous harvest of long-term benefits. This is even more true when they are spoken in high-stress and high-stakes environments like those we encounter daily in the healthcare field. Yet for various reasons, those benefits are not always realized. When as physicians our stress levels are maxed out or when we feel that the efficiency or execution of tasks by other team members is lacking, there are generally two modes that we can go into: Reactivity or Proactivity. The problem with a reactive leadership/communication style is that while it can often feel cathartic to be overly assertive, blunt or sarcastic in the moment, it is hard to live with the results over the long-term. This method of leadership is fear and intimidation-based, and over time it erodes at team morale. It leads to a more poorly functioning team dynamic which then requires ever increasing levels of assertiveness and reactive communication to maintain. By contrast, a proactive leadership/communication style which is kind, considerate and patient can be very difficult to commit to in a moment of exhaustion, frustration or workplace tension, but it creates an atmosphere in the long-term that pays dividends. Consistently holding one's tongue in the moment, pausing thoughtfully and communicating a request clearly, respectfully and in a grateful tone of voice may initially feel like an endeavor which is slow and tedious, but the more often it is done, the more fluid and jovial the environment becomes. Even the most rag-tag team can achieve all-star performance when everyone is committed to a proactive, unwavering resolution to kind communication. And the longer this communication occurs, the more its benefits manifest.

Years later after that initial donut run, I joined my father as a high-school and the later as a college student to shadow him in the emergency room. It was a surreal experience. Nurses, respiratory technicians, social workers all gathered to meet me. I felt like a celebrity. They all shook my hand or greeted with me with exclamations like "You're Dr. Duval's son?". One by one, as the day of shadowing went forward they told me how kind, considerate and professional my father was. They told me stories of the way he would react in various intense situations in the emergency department over the years. They told me how he always used to bring donuts until they asked him to stop because they were gaining weight. But the over-arching message was that they didn't just respect my father, they loved my father. It wasn't for his medical acumen; it wasn't for charting efficiency. It wasn't anything else except for his consistent, persistent kindness. That was a defining moment for me. That day I decided that I wanted to be the kind of doctor that my staff talks about like that when I am further along in my career. What I've realized since then, however, is that I have to remind myself to continually re-affirm that decision, daily. I used to think of kind communication as something that requires an intrinsic capacity for compassion and empathy. Luckily, what it really requires is intentionality, commitment and humility. If we as physicians start bringing metaphorical donuts to those we work with more often; if we begin to prioritize not just accurate communication but proactively kind communication - then I know the sky is the limit. It can seem like a daunting task to change a culture of communication, but it is actually quite simple. It is changed one "donut" at a time.

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Healthcare Business Operations: When Medicare Knocks, You Better Be Home!

By Dave Davidson, Esq, Florida Healthcare Law Firm

A recent decision by a Health and Human Services appellate panel emphasizes how strictly the government will interpret its rules and the disingenuous results that can sometimes follow when healthcare business operations best practices are less than optimal. Although the case referenced below involves a home health agency, the panel's application of the rules applies to all Medicare providers. The resulting loss of the agency's participation in Medicare serves as a sobering reminder that total compliance with all conditions of participation is crucial.

Vamet Consulting & Medical services was a Medicare-enrolled home health agency based in Houston, Texas. On July 14 and 15, 2014 the company conducted training for its office staff at its primary location. The training meant that all the agency's staff would be in the back of the office, either in training or working, so the company locked its front door.

Unfortunately for Vamet, an investigator under contract with CMS made an unannounced visit to the Vamet office during the early afternoon of July 14. The investigator noted that the door was locked, and no one responded when he knocked. He looked in through the door, but could not see any activity. There was a sign on the door, noting the agency's office hours, the telephone number, and instructions to call 911 in the event of an emergency. The investigator left without calling the office telephone number.

The investigator returned the next day, in the late morning. Since the staff was still working or training in back, the door was once again locked. Again, no one answered his knocks. The investigator did not call the office number. However, he took photographs of the site and reported to CMS that the home health agency was not operational.

On March 30, 2017, the panel handed down its final decision, affirming the revocation of Vamet's participation in Medicare. The panel noted that Vamet had sufficiently proved that it was properly stocked and equipped, with healthcare business operations fully ramped and that it was adequately prepared to submit claims to
Medicare. In fact, there was no evidence whatsoever that the investigator would have found any deficiencies had he been admitted to the office.

However, the panel held that Vamet could not prove the threshold requirement that it be operational, since the door was locked and no one answered. The panel noted that the presence of the phone number was not sufficient, since the sign did not say to call the number to gain access. That instruction might have made a difference, but the panel then wondered what would happen if the person seeking entry did not have a phone. Vamet therefore lost its contract with its primary payor simply because no one answered a knock at the door!

Every provider enrolled in Medicare should take note of this decision and focus on healthcare business operations best practices. Loss of the ability to participate in Medicare is usually the death penalty for a provider. Every provider's Medicare Enrollment Application must be kept up-to-date. A change in location, in leadership, or in ownership must be reported. If there is even a slight discrepancy between the Application and what is found by an investigator, there could be harsh penalties, jeopardizing continued participation in the program.

CMS requires that a Medicare provider "has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered), to furnish these items or services." A lot of effort goes into making sure those conditions are met through healthcare business operations best practices. Just make sure the government can get in to your office so you can prove it.

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