Lee County Medical Society

Bulletin

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Details on page 11

3Q 2022 • Volume 46 • Issue 3

LEE COUNTY MEDICAL SOCIETY INC.

BULLETIN

Lee County Medical Society is a Virtual Operation
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Lee County Medical Society Mission Statement

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

CONTENTS

The cover photo was taken by: **Peter Sidell, MD**

Members are encouraged to submit photos to be considered for the Bulletin *cover. Must be large format/300dpi. Email photos to valerie@lcmsfl.org*

LCMS is currently updating its Bylaws. If you would like to review them before a final version is adopted on November 17, 2022, please go to www.lcmsfl.org/publications.

CALENDAR OF EVENTS

AUG 26th
6:30PM
Family Fun Night
Pop Stroke
5531 Six Mile Commercial Court, Fort Myers, FL

FRIDAY, SEPT 9th
6:00PM
LCMS Cocktail Hour
Sponsored by: GenesisCare
Fancy's Southern Café
8890 Salrose Lane, Fort Myers, FL

FRI & SAT,
OCT 7th-8th
LCMS Physician Retreat
Hyatt Regency Coconut Point Resort & Spa
5001 Coconut Road, Bonita Springs, FL

FRIDAY, OCT 14th
6:00PM
LCMS Cocktail Hour
Florida Cancer Specialists
8981 Colonial Center Drive, Fort Myers, FL

FRIDAY, NOV 4th
6:00PM
LCMS Cocktail Hour
TBD

FRIDAY, DEC 9th
LCMS Holiday Party
Forest Country Club
6100 Club Blvd. SW, Fort Myers, FL

RVSP to LCMS events at www.lcmsfl.org

NEW MEMBERS AS OF AUGUST 17, 2022

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Sait Barlas

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You Hernandez-Castillo

Ross Huff

Arunima Jose, MBBS

Katarzyna Karpinska

Gautam Maddineni

Stefan Milutinovic

Ambar Marie Morales-Rodriguez

Juan Carlos Perez

Kelsey Theriault

THE ART OF THE MOTIVATIONAL INTERVIEW

PRESIDENT'S MESSAGE: Tracy Vo, DO

We all know education is a must and vital for the care of every patient. Health care providers have an opportunity to teach all patients about healthy living and making controllable changes for disease prevention. The last thing patients want from their doctor is to be "lectured to" on healthy living.

More and more, doctors are being graded on "performance," with increasing pressure to demonstrate patient achievement on various goals such as A1c reduction, statin use, alcohol and smoking cessation.

Primary care physicians are being held accountable for improving patient health parameters, even though outside of our short interaction with patients with each visit. We have no control over our patients' behaviors and life choices. In a 10-minute visit, we are expected to fulfill a list of criteria for third-party payers to review. They will in turn compare us to other physicians and provide reimbursement cuts if we don't measure up.

Those of us that resort to lecturing patients to improve their lifestyle for better health will be disappointed with the results. The problem is that lectures don't work. **The use of guilt and threats are terrible motivators and will not get the desired responses from our patients.**

I came across an article that highlighted some good suggestions on motivational patient education. An example was given on approaching a patient with elevated LFT's and the need for cutting back on alcohol drinking. Instead of being accusatory and going straight to suggesting medication or AA meetings, we should try **motivational interviewing**.

The technique is to have the patient come up with his or her own possible solutions. We can ask: **"What would be the first step you could take to cut back on drinking?"**

The example response was she would drink tea at lunch instead of vodka. This would also help with her husband not to nag her about her drinking.

The physicians response: **"Sounds like things would be much more pleasant around your house if you cut back on drinking."** This was a small positive change for this patient that would hopefully progress to more long term improvement to her health.

This example would be good for any poor behavior that affects overall health such as smoking, diet choices and a sedentary lifestyle.

The positive office visit interaction above worked due to intrinsic motivation. Patients and doctors discover what will motivate them internally to succeed, and to determine the best steps that they can take to realistically achieve that success.

What I find to be very productive is to include patients to find their own reasons for change by eliciting their ideas and feelings using open-ended questions, and reinforcing these motivators with **reflective listening and empathy**. If the patient demonstrates a willingness to change, we should help them think through their own solutions and then come up with a plan.

While the value of motivational interviewing may not be apparent yet to insurers, we can apply these practices to patient care to get better results and make our office visits more efficient.

LCMS DELEGATION ATTENDS FMA ANNUAL CONFERENCE

A delegation from LCMS attended the annual Florida Medical Association meeting on August 6-7 and participated in many sessions including reference committees and House of Delegates.

Pictured front to back are: Dr. Andres Laufer, Dr. Scott Caesar, Dr. Fadi AbuShahin, Dr. Peggy Mouracade, Dr. Rick Palmon, Dr. Jessica Rogers and Dr. Jon Burdzy.

THE BENEFITS OF LEADING WITH EMPATHY

THE RAMIREZ REPORT: Julie Ramirez, CAE, LCMS Executive Director

Towards the end of July I had the privilege of attending two conferences – one for Medical Society Executives, and one for Association Executives. Kinda like you attending a specialty society and vocational society conference. I am a note taker and I have pages of notes from the excellent speakers. One speaker has had me thinking about her lecture since, so I am sharing what I learned with you.

Leading with Empathy

Ever get frustrated that a coworker isn't doing their job right? Dropping the ball? Not engaged? Snarky in their responses?

Our normal response is frustration, anger or talking behind their back. But what if there is something more to their story. Are we really too busy that we ignore the human?

As leaders, we are to have a servanthood mentality and lead with empathy. Empathy is a skill. Step one is to attempt reflection. You need to understand who you are and know your power within yourself. Learning who you are, you can understand better.

Step two is listening. The people we are around don't always have the bravery to come up to you and tell you their story. Don't write someone else's story for them, read it. Yes, assuming is easier than learning about someone. But life is not a one way street; you need to connect.

Sharing is the third strep. Sharing who you are in this world as a leader can be difficult. Everyone is looking to you. Leaders are expected to be "fine" all the time. To borrow from the movie, "The Italian Job," fine means **f**reaked out, **i**nsecure, **n**eurotic, and **e**motional.

I believe that most of us are really experiencing that definition when saying "I'm Fine".

"We can't learn things from people who are perfect. We can only learn from people who are imperfect."

– James Rubilotta

Do you really trust perfection? Imperfection makes us real humans. It bonds us. And by sharing our stories with each other, we can relate and comfort.

I'll leave you with the story that the speaker told attendees that illustrates the importance of empathy:

When the speaker was a senior in college, she was the leader of six students for a class project. For the whole year, she had this team of six. She loved being the leader, but the thorn in her side was a teammember named Jonathan.

Jonathan was late for EVERY deadline. Oh, he always turned in his work, but it came with a lame excuse. The late assignments irritated her to her last nerve. She was so glad to finally graduate because she didn't have to deal with Jonathan's lateness and excuses anymore.

Six months later she saw Jonathan's name in the alumni newsletter. His mother had passed away from a two-year long battle from cancer. Jonathan was her sole caregiver.

Talk about feeling like dirt. A simple conversation 18 months ago before first or second assignment was late could have revealed the immense pressure Jonathan was facing. The lesson for all of us: Lead with Empathy.

LCMS Executive Director Julie Ramirez, CAE was presented with a plaque recognizing her work as the Chairperson of the Conference of Florida Medical Society Executives

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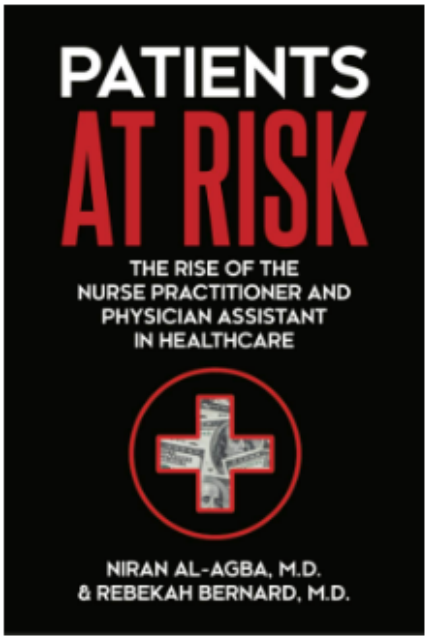
LCMS MEMBER AUTHORS BOOK ON RISKS OF SCOPE CREEP

Rebekah Bernard, MD, an LCMS member, 2020 President of the Collier County Medical Society, and co-author of the book *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare* was featured in a recent AMA article "Physician authors explore what rise of NPs, PAs, means for patients," to discuss how care from nonphysicians is dangerously being promoted as "just as good" as that provided by doctors—despite the huge differences in education and training requirements.

Fighting scope creep is a critical component of the AMA Recovery Plan for America's Physicians. As stated, the AMA asserts that "patients deserve care led by physicians—the most highly educated, trained and skilled health professionals." The AMA vigorously defends the practice of medicine against scope-of-practice expansions that threaten patient safety.

"Unfortunately, most Americans have remained dangerously unaware of this revolution in health care," says Bernard in her book. And, "if patients do wonder about being treated by a non-physician, they are reassured that their nurse practitioner or physician assistant is 'just as good' as a doctor, an idea reinforced by multimillion-dollar direct-to-patient advertising campaigns."

A nurse practitioner graduates with a minimum of 500-1,500 hours of clinical experience, while a physician will have completed 15,000 hours of training before permitted to treat patients independently.



Dr. Bernard said her passion for the scope-of-practice issue is "about making sure that patients have the right quality of care and making sure that we're going to have the care for ourselves because, ultimately, we're all going to be patients someday."

PrEP: ARE YOU PrEPARED?

by: V. Chokkavelu MD, FACP, Board Certified: Infectious Diseases

In the February 5, 2019 State of the Union address, President Donald Trump announced his administration's goal to end the Human Immune Deficiency Virus (HIV) epidemic (EHE) in the USA within 10 years. The U.S. Department of Health and Human Services (DHHS) has proposed the goal of reducing the number of incident new HIV infections by 75% in 5 years and by 90% within 10 years[1].

In the year 2019, 34,800 new HIV cases were reported, more than 50% of all these new cases occurred in the southern USA. Forty-eight high burden counties in the country accounted for 50% of the new HIV infections during the year 2016-2017, seven of these counties were in the state of Florida. This is happening despite more than a decade of evidence that PrEP, with antiretrovirals, protects greater than 90% of at-risk persons from HIV infection, if taken daily along with consistent, correct latex condom use.

Only 23.4% of the at-risk eligible patients have received the PrEP nationally and an even lesser percentage of 17.9 have received PrEP in the State of Florida.[2] Some of the reasons for the low uptake of PrEP are many physicians have not embraced the PrEP as effective and safe, and healthcare providers are reluctant to discuss or prescribe PrEP.

This is occurring despite the Grade A recommendation of PrEP by the USPSTF and endorsement by the CDC and WHO. There is also considerable difference in the rate of acceptance and usage of PrEP in different racial/ethnic groups. Usage in whites is 60.7%, Hispanics/Latinos 14.6%, and lowest in Blacks/African Americans of 8.4%.

How may a healthcare provider help in the epidemic effort? We should screen our sexually active patients at least once for HIV between the ages of 15 to 65 US Public Health Services Task Force (13 CDC).

PrEP is for people without HIV who are at risk of HIV acquisition from sex or injection drug use. Basically, any one who asks for PrEP should be offered PrEP unless they have contraindications.

Before prescribing PrEP, ensure the patient has a documented negative HIV test result, no signs/symptoms of acute HIV infection, normal renal function (think of F/TAF if eGFR is <60 but >30), and no contraindicated medications.

F / TDF Generic TRUVADA: This drug has the longest experience and safety profile. The cost is very reasonable, even for the uninsured. The only limitation is that it is approved only for persons with baseline eGFR greater than 60.

F / TAF DESCOVY: This drug has no generic equivalent so the cost is high at approximately $2,000 per month. Only advantage of Descovy, F / TAF over the cheaper generic F/ TDF is that it can be prescribed in individuals with lower than 60 eGFR.

Both F / TDF and F / TAF may be given as two tablets on the day of high-risk sexual exposure or activity and one pill daily for the next two days. This On-Demand PrEP is not FDA approved, but is discussed as an option by CDC experts on PrEP, though they can not officially endorse it due to lack of FDA approval. On-Demand PrEP is approved and recommended by the WHO.

Cabotegravir 200mg/ml extended release injectable (APRETUDE): This has no generic option available. It is given once a month for two doses then once every two months IM. Since resistance may develop if used in HIV positive individuals as a single drug, screening and confirming negative HIV infection is paramount. Major adverse effect is cost, approximately $3,700 per shot.

Dr. Chokkavelu, MD, is an LCMS member and can be reached at 740-359-0337. Email: vchokkavelu33@gmail.com

1. JAMA 321;(9):844-45, Feb 7-2019.
2. NEJM 386;22: page 2064-66, June 2,2022.

WHAT WE OWE LONG COVID PATIENTS

by: Dr. Zijian Chen, Assistant Professor of Medicine at the Icahn School of Medicine at Mount Sinai, and Peter A. Kolbert, Senior Vice President of Claim and Litigation Services for Healthcare Risk Advisors, part of TDC Group

When Gov. Andrew Cuomo shut down New York City in March 2020, we knew little about treating COVID-19. While treatment has improved considerably, most dialogue has focused on two types of patients—those with severe, even lethal illness, and those with milder symptoms. Yet there is a third category of patients: those suffering from long COVID, whose symptoms linger for an extended period or mysteriously reappear months after their original infection.

Clinicians recognized the existence of these long COVID patients early in the pandemic. May 13, 2022 marked the two-year anniversary of the opening of the Mount Sinai Center for Post-COVID Care in New York City, a first-of-its-kind unit in the U.S. Since then, long COVID has emerged as one of the biggest but least-addressed medical concerns. Anywhere from 10% to 30% of those who contracted COVID-19 suffer chronic aftereffects, some lasting many months after the initial diagnosis. These patients face increased risk of thromboembolic disease, cardiovascular complications, hepatic and renal impairment, and systemic inflammatory response syndrome.

While most of the U.S. has returned to "normal" (or at least a new version of it), these long COVID sufferers, through no fault of their own, have been left behind. They may have avoided the most serious outcomes of COVID-19 initially but are missing out on the return to life as they knew it. And while these patients struggle, so do their healthcare providers—many of whom suffer from long COVID themselves after fighting on the front line as intensive care units and morgues exceeded capacity.

According to the AMA, anywhere from 10% to 30% of those who contracted COVID-19 suffer chronic aftereffects...

Long COVID presents varying and unpredictable symptoms and has no known cure, so with very little information, healthcare providers are facing an uphill battle when it comes to providing adequate care to these patients. The absence of a standard set of interventions leaves caregivers vulnerable to liability risks stemming from misdiagnoses—either by not recognizing that the patient has long COVID or by diagnosing long COVID when, in fact, the patient has another serious disease.

Medical errors do happen; in fact, diagnostic error is the No. 1 cause of serious harm, making it the top concern for preventing patient injury. In light of these findings, patients need to present clinicians with the full range of symptoms and ask for comprehensive diagnostic tests to be run in order to identify if it's long COVID or another ailment.

In return, health-care providers need to bring experts from varying fields together. Forming a strong multidisciplinary care team, communicating clearly and often with patients, keeping detailed chart notes, conducting exploratory testing, following up frequently with the patient and proactively referring to specialists are all essential elements of effective long COVID care.

If a patient suspects they suffer from long COVID or presents a variety of symptoms after having COVID-19, their assembled care team—which often starts at the office of their primary care provider—should first rule out a separate underlying illness. Health-care professionals need to find a balance whereby they maintain, when appropriate, a high index of suspicion for long COVID, without letting long COVID become a catchall diagnosis.

Knowing that long COVID can present as more than 200 symptoms affecting 10 organ systems, health-care providers find it challenging to pinpoint which ailments, if any, were a direct result of COVID-19. With so many individual symptoms, patients may see a range of specialists, calling for a high degree of collaboration between providers.

That there are other ailments masquerading as long COVID emphasizes the importance of seeing patients quickly and providing a thorough evaluation. Common long COVID symptoms like chest pain and heart palpitations could also be the presentation of some other, more emergent condition. As frustrating and debilitating as long COVID can be, it can mask worse diseases that might lead to costlier medical

bills and a more rapid decline in a patient's health—as well as a higher chance for litigation against physicians if these diagnoses are missed.

When signs of long COVID emerged in the summer of 2020, many doctors were skeptical. Even now—two years later—skeptics remain. Consequently, many patients feel that medical professionals are failing them. In the early 1990s, given limited research, some health-care providers did not yet believe that chronic Lyme was a real disease. Similar doubts have been expressed about long COVID. When health-care providers struggle with doubts about long COVID, they should remember that COVID-19 can result in something other than short-term symptoms or death. There's another scenario—a third category of COVID-19 patients—and we need to accept that reality.

This work first appeared in The New York Daily News and online at www.nydailynews.com.

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

Links in this article can be accessed in the online edition of this magazine at lcmsfl.org/publications.

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PHYSICIAN WELLNESS PROGRAM

The **Physician Wellness Program (PWP)** provides a safe harbor for active LCMS physicians to address normal life difficulties in a confidential and professional environment. Our program works with two independent, local psychology groups that provide member-physicians with up to three visits per calendar year.

This is a confidential and free member benefit. No insurance will be billed and LCMS will not be given any personal information about those who use the program. LCMS pays a monthly bill based on the number of sessions provided. Full details on how to enroll or donate to this program can be found at www.lcmsfl.org/our-programs.