LEE COUNTY MEDICAL SOCIETY

Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 24, NO. 5

FORT MYERS, FLORIDA
DANIEL R. SCHWARTZ, M.D., EDITOR

SEPTEMBER 2000

LEE COUNTY MEDICAL SOCIETY 2000 MEMBERSHIP MEETINGS

SEPTEMBER GENERAL MEETING

The Lee County Medical Society/Alliance
&
Collier County Medical Society/Alliance
Invite you to participate in the

ELECTIONS 2000
TO
MEET YOUR CANDIDATES

Monday, September 18, 2000
At
Fiddlesticks Country Club
15319 Canongate Drive
6:30 p.m. – Social Time
7:00 p.m. – Dinner
R.S.V.P. by September 12th – 936-1645
Guests and Spouses – $25.00

November 20, 2000
Royal Palm Yacht Club

The Wonderful World of Retirement? Is it for me? If Dr. Lee Howington can find his way back, he will share his adventure with us.

Fifth Annual Legal/Medical Golf Tournament

The Fifth Annual Legal/Medical Challenge was held Saturday, July 8, 2000 at the Lexington Country Club. The event was a success. We raised $10,000 for the Lee County Breast Screening Program. Everyone had a great time, and the lawyers won the cup.

We want to thank everyone that participated in this event, a special thank you to Dr. John Petersen, Dr. Scott Harris and Ms. Ann Wilke of the Lee County Medical Society. We would also like to offer a special thank you to Mr. Ken Jones, Ms. Kathy Wittman, and Ms. Celeste Ford of the Lee County Bar Association.

In This Issue...

PRESIDENT'S MESSAGE

Where is Our Next Crisis?

Bruce J. Lipschutz, D.O.

Over the past several decades, medicine has been challenged by many crises – both medically and politically. In the early part of the 20th century, there were flu epidemics, rampant infections, pre-antibiotic crisis, and futile medical regimen crisis. And certainly, there have been many more recent medical crises such as AIDS, antibiotic resistance, and the inability of many people to obtain access to medical care. On the plus side, we have had many medical successes throughout the years, too many to mention here. Political crisis have been equally daunting, rising medical costs, the rising population of the elderly, continued inaccessibility to medical care–especially for the uninsured, and overcrowded emergency rooms.

Our most current crisis, which has been brewing for many years, is now at hand in our community as it is in so many other communities. Of course what I am talking about is the psychiatric care crisis, which includes the closing of Charter Glade and the impending closing of G. Pierce Wood Hospitals. These closings have caused a domino affect, hitting both the medical and lay communities. Primary care physicians, emergency room physicians, nurses, hospital social workers, psychiatrists, police, EMS, legislators, and the general public are all affected when our source of inpatient (children, adult, and geriatric) psychiatric facilities are no longer available in our county. The medical and lay communities are forced to make difficult decisions in the care and well being of people requiring inpatient care. Transfer to alternative facilities out of county, is mandatory in many instances. This causes numerous other problems for families and for physician continuity of care.

The Ruth Cooper Center, The Salvation Army, and SWFL Addiction Services are feeling the bulk of this crisis. Since the closure of Charter Glade Hospital during early June of 2000, more than 50 children and adults in need of crisis stabilization for mental health have been transferred to Sarasota or Collier Counties. Ruth Cooper Center has been forced to close many of its outpatient rehabilitation services in order to maintain the crisis stabilization unit in Lee County. It has recently reinstated its mobile crisis unit, which had previously been closed due to lack of funding. This service is a team of mental health clinicians who perform onsite assessments and link patients with appropriate community based services including crisis stabilization.

The psychiatric crisis is long and widespread; to this end I felt it important that the Lee County Medical Society attempt to begin to help in a solution. On July 28, 2000 key members of the medical and non-medical psychiatric community were invited to the Medical Society office to discuss the issues and potential solutions. A wonderful turnout including Southwest Florida Regional Medical Center's CEO **Steve Royal**, along with Lee Memorial Health System's **Chuck Krivenko, M.D.** and **Davy Crockett** - Vice President of Patient Care Services - attended, **Steve Machlin, M.D.** and **Raymond Johnson, M.D.** represented the psychiatric community, **Judith Hartner, M.D.** from Lee County Health Department attended. A variety of other related fields were represented: **Stan Applebaum** of the Human Rights Advocacy Committee, **Ann Arnall** and **Karen Hawes** with the Lee County Department of Human Services, **Meg Geltner** of The Salvation Army, **Fran Gibbons** with the Department of Children and Families, and **Kevin Lewis** with SWFL Addiction Services. **Jan Eustis**, CEO of the Ruth Cooper Center, represented our only source of inpatient facility and was a key member to this group. Unfortunately, other invitees including emergency room physicians, hospital administrators, and concerned physicians were unable to attend due to scheduling conflicts. Following two hours of discussion it was acknowledged that at this time citizens of Lee County have no choice in their inpatient facilities as Ruth Cooper represents the only available facility. There are no geriatric beds available anywhere, there is no backup facility supporting Ruth Cooper (such as Charter Glade). Only 26 acute psychiatric beds exist at the present time at Ruth Cooper Center. Many patients continue to require transfer by way of police escort to Sarasota, Charlotte, and Collier counties for inpatient care. This takes police away from duties here in Lee County. It was clear that children, adult and geriatric units are the three areas of the "psychiatric pie" that are needed the most. Currently, geriatric patients being treated in nursing homes including those with dementia, confusion, and/or delirium are aggressively sedated but would be better served in inpatient geriatric psychiatric facilities to improve their quality of life. Adults are not receiving inpatient workup and evaluations. Therefore, the potential for inadequate care being rendered increases due to the unavailability of inpatient facilities. Finally, children from ages 5 – 18 are being underserved due to a bed deficit in Lee County.

The solutions are extraordinarily difficult. Reimbursements for care, government money and donations are limited. Despite the problems LMHS and SWFRMC are entertaining possible hospital inpatient solutions.

Whatever the short term to long term solutions will be, the Lee County Medical Society, which represents over 500 physicians in this community, plays an integral role in organizing and bringing together the major players in this problem. The psychiatric crisis in our community represents a problem both on a national and local scale that must be solved. It is not only a medical problem but also a societal problem. The Lee County Medical Society represents the leaders in our community and must insist from our legislators as well as bospitals and other community leaders to end this terrible problem before tragedies occur. I urge every physician to become involved and interested in this problem over the next several months. The Lee County Medical Society will continue to explore solutions and work with key players to help solve this devastating issue.

AS I RECALL...

The Lockbox

Roger D. Scott, M.D.

It's only an 8.5x5.5x4 inch khaki colored metal lock-box with high school and college decals upon it. I purchased this box on going to military school in 1941 and carried it through college as a safe haven for small valuables. The box disappeared and was forgotten for 45 years but just 2 days after the last article (Cheekeen Soup) was submitted for publication, this box was found in an old storage container. Well, speak of the devil; believe it or not, stranger than fiction (these are old expressions of the unbelievable), when the locksmith opened the box, treasures galore appeared. The oldest was something really special i.e. my first drivers license. Hopefully you will remember my wish in Cheekeen Soup that I had kept my first drivers license and this statement was made not knowing that I did still have it. Obviously I have become so psychotic (oops! a malapropism) I mean psychic that I must have known that this was going to appear so perhaps I should see a psychiatrist or join the Psychic Hotline Staff.

The most recent item found was a Customs Decoration (Oh! Not again, I mean Declaration) on another trip from Mexico dated March 24, 1955.

The 1940 Drivers License was the second year of issuing drivers license in the state and it expired 10/1/40. I was 130 pounds, 5'8" tall, and 13 years of age. Fred P. Cone was the Governor and the license number was 31-4173. During WWII we didn't bother with drivers licenses, but in order to obtain a gas ration card one had to register the serial numbers of the car tires with the ration board. A second license issued in 1946 and expired 10/1/1947 number 82517, now 6'2" tall, 160 pounds, and Millard F. Caldwell was the Governor.

A letter from the President of the United States to me dated 12/9/44 advising that I was to report for induction physical in the Armed Forces of the U.S. at Camp Blandings, Fla. on 12/20/44 (Merry Xmas!). Along with this letter was another one (of dubious honor) appointing me as Assistant Leader of "a contingent of Select Men" (these were all North Florida Rednecks) who, along with the Leader, got drunk on the bus on the way to the induction. It was freezing in December so they pulled the planks off the building and burned them in the stove, practically tearing the barracks down.

Two Draft Registration Cards, 1944 & 1948, and three Draft Classification Cards.

Receipt for medical books dated 11/15/47 for *Grant's Atlas of Anatomy* $10, *Bailey's Textbook of Histology* $6, *Grant's Method of Anatomy* $6, *Schaefer Textbook of Anatomy* $8, and others.

The National Board of Medical Examiners receipt dated 5/12/49 in the amount of $15 for Part I Examination.

Certificate for Efficiency in Basic Sciences from the Florida State Board of Examiners in Basic Sciences #2553 undated but was 1949.

The June 24-26, 1951 Florida State Board of Medical Examiners examination papers with the list of questions asked on the exam that I took. Rules and Regulations for the States Board of Medical Examiners of Florida 1951.

A receipt from the Seminole Hotel ("Jacksonville's leading hotel") for my room 6/24 and 6/25/1951 in the amount of $4.50 + .14 tax for each night that I stayed there while taking the State Board.

Florida State Board of Health Bureau of Narcotics registration 1952, 1953, and 1955.

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The editors welcome contributions from members. Opinions expressed in the *Bulletin* are those of the individual authors and do not necessarily reflect policies of the Society.

PRINTERS Distinct Impressions

Membership Activities

TRANSFERRED TO COLLIER COUNTY
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NEW PRACTICE
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Inserts

1. **SEPTEMBER MEETING NOTICE**
2. **MEDICINE AS A PROFESSION – SOROS ADVOCACY FELLOWSHIP FOR PHYSICIANS**
3. **LEE COUNTY HEALTH DEPARTMENT – SECOND QUARTER ENTERIC AND SEXUALLY TRANSMITTED DISEASE REPORT**
4. **ADVISORY BULLETIN – LAWS REGARDING SPLIT FEE AND SELF REFERRALS**

LCMS Stats

JUNE 22, 2000 - AUGUST 11, 2000

	Current	YTD
Total Phone Calls Received	490	2494
From Physicians and Office Staff	159	755
For Referrals	34	231
For Background Checks	21	154
Filing Complaints	6	41
Regarding Non-Members	14	92
Regarding Alliance	13	89
Regarding CMS, FMA, and AMA	34	181
Miscellaneous Calls	209	951
Meetings	15	63
Attended on behalf of LCMS	10	42
Society Meetings	5	21
Applications Sent to Physicians	8	39
Pictorial Directories Distributed	9	34

LCMS Alliance / Foundation News

Respectfully submitted by Victoria Sweet, LCMS Alliance President

2000 CHARITY BALL SUMMARY - "NY2K"

We would like to thank all of the Charity Ball Committee members for their dedication, hard work, long hours and talent to the "NY2K" Charity Ball. A wonderful and memorable evening was had by all!!

Our sincere thanks go to our very charitable Underwriters and Sponsors who have once again shown their support for our Foundation! The Foundation raised a record amount that will greatly benefit the Southwest Florida Children's Fund along with the Foundation's Mini-Grants Program.

On behalf of the Lee County Medical Society Alliance Foundation and the Southwest Florida Children's Fund, Inc., we would like to thank the following Underwriters and Sponsors for their generous and ongoing support of this grand event.

Underwriters

Southwest Florida Regional Medical Center, East Pointe and Gulf Coast Hospitals, Lee Memorial Health System, Nemours Children's Clinic, Shelton Jaguar/Audi, Northern Trust Bank, Bank of America, Northwestern Mutual Life, Atlantic States Bank, Sprint, SunTrust Bank, Lexus of Fort Myers, Devonwood Development Inc., Markham Norton & Stroemer.

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Contributing
Canterbury School; Children's Specialists of Florida; DSI Laboratories; ENT Specialists of Florida; Kagan, Jugan and Associates; Lee County Medical Society; Lee Memorial Dept. of Neurological Surgery; LIPA/ Lee Independent Physicians Association; Merck & Company; Dr. & Mrs. James O'Mailia; Retina Consultants of Southwest Florida; Drs.. David and Mary Reardon; Southwest Florida Neurosurgical Associates, P.A., Southwest Florida Urologic Associates

Sustaining
Associates in Pulmonary Medicine; Anesthesia & Pain Consultants of Southwest Florida; Dr. Ken and Sue Backstrand; Batson, Carnahan & Company, P.A.; Kevin M. Burns & Associates; Cape Coral Ear Nose & Throat Center; Foot and Ankle Care of the Island Coast; Fort Myers Toyota; Med Tech Diagnostic; Radiation Therapy Regional Centers; Searle; Specialists in Healthcare; Surgical Associates of Southwest Florida

MEDI-BAGS

Medi-bags is a statewide project that involves collecting personal hygiene and toiletry items for the homeless or those in need. Due to the spectacular job last year's co-chairs Maria Galang and Maria Del Sol completed, the project will not need to be as intensive this year. The LCMS will still be collecting your toiletries and the drop off point will be at the LCMS office, located at 3805 Fowler Street. Victoria Sweet will then distribute the toiletries to those organizations that may be low on inventory. For more information or if you would like to help with this project, contact Victoria Sweet at 481-5797 or Vsweet@LNCServices.com

Separating the Wheat from the Chaff

By Frank C. Bozeman, Esq.

Must doctors accept and/or continue to treat all patients who seek medical care? What doctor hasn't had patients who were uncooperative, disruptive, wouldn't follow advice, wouldn't keep appointments, wouldn't pay their bills, or who were threatening and abusive to the office staff? This article will explore some practical and legal ramifications of refusing to treat such patients.

Physicians' offices have been judicially defined as "places of public accommodation," the result of which is that their practices are subject to both state and federal civil rights laws. There have been successful lawsuits alleging discrimination and violation of the Americans with Disabilities Act when physicians refuse to accept certain people as patients. These cases are both thorny and potentially more costly than a "standard" malpractice suit because usually malpractice insurance does not cover alleged illegal acts. Therefore, physicians may find themselves without coverage in the defense and payment of such discrimination suits.

The U.S. Supreme Court has ruled that health care providers may not refuse to treat, or to continue to treat, people with asymptomatic HIV, who are protected by disability laws, for fear of contagion; there must be a sound medical reason, apart from discrimination, for refusing to accept such a patient. Moreover, the AMA's position is that physicians may not decline to accept patients because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, age, or any other basis that would constitute "invidious discrimination." This includes patients with gay and lesbian lifestyles.

Must a physician accept as a patient someone who walks into the office in a Klu Klux Klan robe with a swastika on it? Anti-discrimination laws do make some exceptions. A physician is not required to treat everyone who walks in the door so long as he is not discriminating based on any of the classes protected by the law. Moreover, no physician is required to perform a procedure that conflicts with his religious beliefs.

Similarly, a physician may refuse treatment for someone he dislikes for any personal reason, as long as it is not discriminatory under the law. In the late 1980's a group of OB/GYN physicians in Brunswick, Georgia refused to treat the spouse of any lawyers involved in litigation against any physician in the group. In a case, which achieved national attention (if not notoriety) after the doctors were sued by the attorneys whose wives sought treatment from them, the court ruled in favor of the physicians.

Continued on Page 3

AS I RECALL...

(Continued from Page 1)

A variety of ID cards: two Student Athletic U.VA., Medical and Chirurgical Faculty of Maryland 1952 (for your electrification – not another malapropism! – I mean edification, chirurgical is surgical), U. of MD. Student Activities, ATO Fraternity Card #44215 dated 11/23/44 (annual dues $3.50), Marriage Certificate, U.S. Invasion Currency for Japan, and others.

Now here's another antidote (Oh! Another malapropism), I mean anecdote. About two weeks after finding the lockbox, I was thumbing through some of my old stamp collection books and found a postcard that I wrote from Mexico in 1940 addressed to our cook in Live Oak, and the last sentence was "please have plenty of good ole home cooking for me when we get home". Admittedly, I am a Certified Pack Rat with all of the junk that I collect, but just think where medicine would be without CPR.

Best of luck to Robin C. Brown, M.D., and Jan in your retirement, you have been a credit to our profession and community.

Correction to "Chee-keen Soup": I was driving my father all over the state at age 10 and driving alone everywhere at age 12.

Bob Boudreau, M.D. our first dermatologist died in July.

THE QUESTION MAN
OPINIONS – EDITORIALS
LETTERS TO THE EDITOR
John W. Snead, M.D.

September's Question:

"What is the Most Important Action the Government Could Take to Repair the Health Care System?"

Lawrence Schoenfeld, M.D.
Urology

"Please be advised I haven't got a clue. I think the biggest problem the government has gotten us into is allowing for third party payers to assume the cost liability for patients' medical care. Medicare and private insurance companies have promulgated this general problem. The only way to bring market forces to bear would be to have the patients in part or primarily responsible for their own decision-making process and for their medical bills. For instance, if I were to be evaluating for a renal tumor, I might give the patient the option of having an MRI with perhaps a 95% specificity, a CT scan with 90% specificity, or a renal ultrasound with 80% specificity. The MRI might cost $1,000, the CT scan $800, and the renal ultrasound $150. Now, since the patient is not paying, he would certainly choose the MRI, whereas, if he had to make the decision he might decide that he would take the chance of a small percentage error in exchange for the $800 difference in the tests.

Perhaps medical saving accounts for all might be a partial answer, although I am realistic enough to know that the government will not, and probably no longer can, give up the reigns for controlling costs for health care.

I do not believe that private sector health maintenance organizations are doing a good job, and I assume that ultimately, in the future, the government will have to have nationalized medicine. I do not look forward to a nationalized medical system, and I think it would deliver worse care at increased expense, but I suspect that a future national health policy will be enacted.

In response to the initial question as to what would be the most important action the government can take to repair the health care system, my answer would be to get out of the health care business entirely (I know this will never happen).

October's Question:

"CURRENTLY, IS THE MOST IMPORTANT ISSUE FACING HEALTH CARE QUALITY, QUANTITY OR COST?"

Send your comments to the Medical Society. The *Bulletin* deadline is the 10th of each month... we want to see you in the print media.

Draft 2000 E&M Documentation Guidelines

Glenda Henderson, Medical Economics/ Managed Care Coordinator

Yet another draft of the Evaluation and Management (E&M) Documentation Guidelines has been released from HCFA stating that they feel they have an obligation and a duty to make clear, straightforward E&M Guidelines. Implementation is not expected until 2002. Pilot testing of two version of the draft will be done later this year.

In the meantime, physicians should continue to use either the 1995 or the 1997 guidelines, whichever is more beneficial to the physician.

It has been reported that several companies are "selling" these guidelines. There is no need for physicians to pay for the draft guidelines. Free copies of the draft can be obtained by visiting the HCFA website at www.hcfa.gov or FMA members can obtain a free copy by contacting Glenda Henderson in the FMA Managed Care/Medical Economics Department at ghenderson@medone.org or call her at 800-762-0233. A flier is attached that can be reproduced and distributed to your membership if you desire.

Remember, these guidelines are a draft only and should not be implemented at this time.

New Member Applicants

APPLICATION FOR MEMBERSHIP

Active members are requested to express to the Committee on Ethical and Judicial Affairs or Board of Governors any information or opinions they may have concerning the eligibility of the applicants.

GARY SCOTT ALLEN, M.D. – CARDIOTHORACIC SURGERY
Medical School: Albany Medical College (1987-91)
Internship/ Residency: University of Texas Health Science Center, Houston (1991-93)
Fellowship: University of Utah, Salt Lake City, UT (1993-95)
University of Utah, Salt Lake City, UT (1998-00)
Dr. Allen is an associate with Cardiac Surgical Associates
at 2675 Winkler Avenue Ste 440, Fort Myers.

KEVIN CARROLL, M.D. – DIAGNOSTIC RADIOLOGY
Medical School: Georgetown University School of Medicine, Washington, DC (1986-90)
Internship: Washington VAMC/ Georgetown University, Washington, DC (1990-91)
Residency: David Grant USAF Medical Center, Travis AFB, CA (1993-97)
Fellowship: Duke University Medical Center, Durham, NC (1999-00)
Board Certification: American Board of Radiology
Dr. Carroll is in group practice at Radiology Regional Center
at 3680 Broadway, Fort Myers.

MICHAEL FLETCHER, M.D. – PAIN MANAGEMENT/ ANESTHESIOLOGY
Medical School: University of Louisville, Louisville, KY (1987-91)
Internship: Florida Hospital, Orlando, FL (1991-92)
Residency: University of Miami School of Medicine, Miami, FL (1992-95)
Fellowship: Univ. of FL School of Medicine/ Shands Hospital, Gainesville, FL (1999-00)
Board Certification: American Board of Anesthesiology
Dr. Fletcher is in practice at The Pain Management Center at Bonita Springs
at 26800 South Tamiami Trail, Suite 220, Bonita Springs.

WILLIAM B. HEARN, D.O. – DIAGNOSTIC RADIOLOGY
Medical School: University of Health Sciences, Kansas City, MO (1981-85)
Internship : University of Medicine And Dentistry, Camden, NJ (1985-86)
Residency: University of Medicine And Dentistry, Camden, NJ (1986-89)
Board Certification: American Osteopathic Board of Radiology
Dr. Hearn is in group practice at Radiology Regional Center
at 3680 Broadway, Fort Myers.

SAIFUL ISLAM, M.D. – FAMILY PRACTICE
Medical School: Sind Medical College, Karachi, Pakistan (1976-1983)
Internship : Abbasi Shaheed Hospital, Karachi, Pakistan (1984-85)
Illinois Masonic Medical Center, Chicago, IL (1989-90)
Residency: Quincy Family Practice Program, Southern Illinois Univ., Quincy, IL (1992-95)
Board Certification: American Board of Family Practice. Board eligible nuclear medicine.
Dr. Islam is in practice at Lee Convenient Care
at 2776 Cleveland Avenue, Fort Myers, FL 33901

THAD C. KAMMERLOCHER, M.D. – GENERAL/VASCULAR SURGERY
Medical School: University of Oklahoma, Oklahoma City, OK (1988-92)
Internship : Baptist Medical Center, Birmingham, AL (1992-93)
Residency: Orlando Regional Medical Center, Orlando, FL (1993-98)
Fellowship: Vanderbilt University, Nashville, TN (1998-99)
Board Certification: American Board of Surgery in General Surgery and Vascular Surgery
Dr. Kamerlocher is an associate at Associates in General and Vascular Surgery
at 21 Barkley Circle, Fort Myers.

SEPARATING THE WHEAT FROM THE CHAFF...

(Continued from Page 2)

What about discharging current patients? The manner in which physicians say goodbye is very important. Frequently there has already been some breakdown of confidence or trust, express or implied, when the physician gives serious consideration to termination of the relationship. Risk managers and malpractice defense attorneys almost universally recommend attempts at conciliation, which may also involve the physician's office employees in their handling of the patient. Sometimes the relationship can be repaired and thrive thereafter as a result of a candid discussion. Regardless, all discussion with the patient, as well as reasons for the discussion, should be thoroughly documented in the patient's chart. A caveat, however, relates to managed care patients; this will be treated below.

There comes times, nevertheless, when physicians decide that an existing doctor-patient relationship should be officially terminated despite genuine efforts to repair it. The manner in which the good-bye is delivered can make a big difference in whether the recalcitrant patient later sues the physician for abandonment, or perhaps even for discrimination. There are ways to accomplish an effective termination of the physician-patient relationship, which minimize the chance of a later successful suit by the former patient. It almost goes without saying that discharging a patient should be a last resort after repeated efforts for conciliation have failed.

Under the general law prevailing throughout the country, the traditional doctor-patient relationship is essentially a two-party contract, and both parties must cooperate in order for it to work. Generally, a physician has a duty to follow the patient and give proper instruction and treatment to the patient. The physician's employment continues until ended by mutual consent or dismissal of the physician by the patient, or until the physician's services are no longer needed. Before a physician may withdraw from a case without substantial threat of liability, he must give sufficient notice to the patient of the intention to withdraw and offer to provide care for a designated period of time until a stated termination date, or in the event of an emergency, and help provide the patient with information for securing the services of another physician.

There are developed protocols and recommended sample letters which physicians can use in order to lower their risk of a lawsuit. Termination should be accomplished by a certified letter, return receipt requested, which should also mention medication requirements and reinforce prior medical recommendations given to the patient. If the certified letter is returned as having been refused, many suggest that the letter be re-dated and sent by regular mail after putting the original unopened certified letter in the patient's chart. Of course, sometimes letters are returned because a patient has moved, and in such an instance diligent efforts should be made to determine the patient's present address and to send a newly dated certified letter.

Many suggest that the discharge letter avoid referring the to-be-discharged patient to a specific physician. Instead, the doctor may recommend that the patient contact a referral organization, such as those which hospitals advertise on television. After all, the discharging physician does not want to pass his problem patients to colleagues, nor does he wish to be included in a later lawsuit alleging negligent referral if the physician he selects for referral commits malpractice.

It is also important that the physician offer to transfer the patient's records promptly once a written authorization to do so has been received. Upon transfer of records, the original or a copy of the records should be retained in the patient's chart. Naturally the office staff should be advised of the termination, as well as the continuing duty to treat for a designated time period. After all, some manipulative patients get back on the schedule even after receiving a discharge letter. This could be construed as re-establishing an unwanted doctor-patient relationship.

How a discharge letter is phrased can be very important, since a physician does not want to provoke a dissatisfied patient or push him or her over the edge and invite a lawsuit for abandonment or discrimination. It is generally suggested that discharging letters be factual in order to avoid later confusion and focus on a breakdown in the necessary trust which is the cornerstone of such a relationship. Above all, the patient should never be attacked in a discharging letter. In every instance the patient's chart should be thoroughly documented.

Dismissal of managed care patients complicates the process, as this involves a three-party agreement. Some managed care plans limit a physician's ability to act unilaterally because most plans require physicians to accept all patients who choose them from a panel and have established protocols for discharging patients. The contract between the physician and the managed care organization should be reviewed carefully and complied with. In addition, most plans require assignment of a new primary physician before the discharging doctor can be relieved of responsibility. At the same time, most doctor-patient relationships in the managed care arena typically terminate by the patient asking that another physician be assigned. Still, the contract with the managed care plan must be complied with.

Interestingly, the genesis of Florida law relating to abandonment arises out of a Pensacola case dating back to the mid 1930's. Mr. Saunders sued Dr. Lischkoff for abandonment. The names of the witnesses in the case will be familiar to or at least ring bells with "senior" members of the Medical Society: Dr. Lischkoff, Dr. McLane, Dr. Bryans, and Dr. Quina, all of whom were members of the Medical Society, The Florida Supreme Court decision, in ruling in favor of Mr. Saunders, stated the standard of care then existing: "The custom prevailing in Pensacola among physicians was that the physician should visit his patient when the patient was not physically able to go to the physician's office.

The 1930's custom of house calls has changed, of course, but the law of abandonment is continuing to evolve. The present focus is on discrimination against protected classes. Whether refusal to accept a new patient or to continue treating an existing patient constitutes abandonment or discrimination turns on specific facts, sometimes with no predictable answer.

Reprint with permission
June 2000/ Escambia County Medical Society

Playing it Safe: Recognizing Legal Risk

By Jeffrey L. Cohen, Esq.

With all of the healthcare regulations and increasing governmental enforcement activity, it is important to recognize key "warning signs" and know how to respond to them. Warning signs are not, by themselves, necessarily violations of anything. Like chest pain, they are simply events that should trigger further investigation or some other response.

FRAUD AND ABUSE WARNING SIGNS

What they are:

Fraud and abuse warning signs include:

1. Any agreement, written or otherwise, between you and any health care business (including another physician), which involves payment or receipt of anything of value in return for referral of patients. This includes leases and employment agreements that pertain to your medical practice.
2. Any agreement, written or otherwise, between you and any person or entity, which involves referral of patients or the enhancement of your medical practice. This especially includes agreements where compensation is percentage based.
3. Any governmental inquiry concerning Medicaid or Medicare billings or any professional or business activity.

What to do:

A Tell the person that anything you discuss is subject to review by legal counsel and that you want to be sure not to violate any law.

B Discuss the proposed arrangement with legal counsel who understands healthcare regulations, hopefully even before it is reduced to writing.

C Do not play lawyer or treat any investigator as your friend. They have a job to do, and that can have very serious consequences for you. Contact a lawyer who has a lot of experience handling such matters. Do not ask a nephrologist to do the job of a cardiologist.

MALPRACTICE WARNING SIGNS

What they are:

Malpractice warning signs include:

1. Receiving a Notice of Intent to Initiate Litigation
2. A patient complains about the care they received or did not receive.

What to do:

Immediately contact your professional liability insurer and let them know about the potential suit. If you delay, you may jeopardize your insurance coverage since you are required to let them know of such things in a timely fashion. Even if a Notice of Intent has not been provided to you, your insurer may direct you to legal counsel to assist you or might have their own risk manager work with you to handle the situation. You should also promptly obtain copies of the medical records in question, and prepare a medical chronology showing what was done at each stage of the patient's care.

AHCA WARNING SIGNS

What they are:

AHCA warning signs include:

Being contacted by an investigator from AHCA.

What to do:

A Notify your professional liability insurer. Some have "free" coverage for such matters. Be sure to check out the expertise of the lawyer, in any, who is appointed to defend you. Some insurers will permit you to designate a qualified lawyer to represent you if you think the other lawyer will be better able to handle your case and he or she works out the business arrangements with the insurer. Regardless, the lawyer you select should have significant experience handling administrative hearings before your licensing board. Finally, remember that the Fifth Amendment does generally apply to administrative actions. As such, you are under no obligation to speak with the investigator, and in fact you should never do so without legal representation.

CONCLUSION

Understanding complicated laws can be frustrating, particularly when they change often as healthcare laws do. While it is reasonable to expect lawyers to closely track changes in law and to have many resources that help them interpret those laws, it would be unfair to expect clients to do the same. Nevertheless, clients who have a good grasp of "warning signs" are more likely to avoid liability.

*Under state and federal law, "designated health services" are clinical lab services; physical therapy services; comprehensive rehabilitative services; occupational therapy services; radiology services and radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; inpatient and outpatient hospital services.

The foregoing does not purport to be a complete list of issues, which should give rise to a certain response. Mr. Cohen is a partner with the Delray Beach/Ft. Lauderdale law firm of STRAWN, MONAGHAN & COHEN, P.A. He is Board Certified by the Florida Bar as a Specialist in Health Law and may be reached at (561) 278-9400.

Hydrocodone Issue

By Francesca Plendl - FMA, Associate General Council

SUMMARY:

Last session CS/HB 2085 was passed by the Legislature–it has subsequently been signed into law. Pursuant to the bill, effective October 1, 2000, there will be a major change in how products containing hydrocodone can be prescribed.

THE ISSUE:

Under current law, hydrocodone is a Schedule II drug EXCEPT THAT substances containing lower levels of hydrocodone are exempted and are instead Schedule III drugs (see Section 983.03, Florida Statutes). CS/HB 2085 strikes the language regarding the lower levels so now ALL substances containing hydrocodone will be Schedule II drugs. There are approximately 200 substances sold that contain hydrocodone. These include commonly prescribed substances such as Lortab, Lorcet, Vicodan, and certain cough syrups. CS/HB 2085 is a criminal justice bill. The change in schedules was sought due to the need for higher penalties in cases involving hydrocodone. The implications for the health care community were not addressed before this bill passed.

THE PROBLEM:

Section 893.04(l)(f), Florida Statutes provides that Schedule II drugs may only be dispensed pursuant to a written prescription and cannot be refilled.

THE RAMIFICATIONS:

Because of the two statutes mentioned above, patients will have to visit a physician's office each time they need a refill of a substance containing hydrocodone. This has serious implications for chronic pain patients and severely ill patients who may have trouble coming to the physician's office that often. Physicians are reluctant to write prescriptions for larger amounts of hydrocodone due to Final Orders that have been issued by the Board of Medicine disciplining physicians for overprescribing.

FMA RESPONSE TO THE PROBLEM:

The FMA is meeting with the Florida Retail Federation and other groups on this issue on July 19th. We are also working with the Department of Health and the Board of Medicine to arrive at a solution to this problem. FMA General Counsel John Knight will be working on this issue over the next couple of weeks–he can be reached at jknight@medone.org or 850-224-6496.

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