A MUST READ: THE KING OF TORTS
BY JOHN GRISHAM

LEE COUNTY MEDICAL SOCIETY

Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 27, NO. 04

FORT MYERS, FLORIDA
John Snead, M.D.

JULY 2003

GENERAL MEMBERSHIP MEETING

NO MEETINGS JULY AND AUGUST

SEPTEMBER MEETING
Thursday, September 18, 2003
PREVENTION OF MEDICAL ERRORS
2 Hours Mandatory CME Credits
Royal Palm Yacht Club
2360 West First Street
Downtown Fort Myers
6:00 p.m.–Dinner/7:00 p.m.– Program
Speaker: Cliff Rapp, Vice President
Risk Management, FPIC

These activities have been planned and Implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Florida Medical Association and First Professionals Insurance Company. The Florida Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Florida Medical Association designates activities for a maximum of 2 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each Physician should claim only those hours of credit that he/she actually spent in the educational activity.

NOVEMBER MEETING
Thursday, November 20, 2003
HIV/AIDS AND DOMESTIC VIOLENCE
2 Hours Mandatory CME Credits
Royal Palm Yacht Club
2360 West First Street
Downtown Fort Myers
6:00 p.m. – Dinner/7:00 p.m. – Program

DECEMBER
Monday, December 8, 2003
ANNUAL HOLIDAY PARTY
Veranda Restaurant
2122 Second Street
Downtown Fort Myers
7:00 p.m. – 11:00 p.m.

Inserts

1. **HIPPOCRATIC OATH**
2. **AAPS NEWS**
3. **PORTER, WRIGHT, MORRIS & ARTHUR…HEALTH CARE ALERT**
4. **ADVERTISEMENT: PMCI**

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President's Message

OUR LEE COUNTY MEDICAL SOCIETY ALLIANCE

Ralph Gregg, M.D.

As I sit down to write this, I have only recently recovered from the Lee County Medical Society Alliance Foundation Gala. If you weren't there, you missed a great evening. The event was held on the lawn of the Edison estate in view of the Caloosahatchee River. In addition to great food and libations, there was a live band, which included members of our own medical community. Before things could get out of hand, we were taken in carriages to reputable downtown establishments for nightcaps. I cannot vouch for anything that happened after that, but seriously, this was a wonderfully successful event that raised over $39,500.00 for the Foundation's projects. Thanks to President Cheri O'Mailia who worked so hard to make this Gala possible.

Since its inception in the mid forties, the Lee County Medical Society Alliance has played a vital role in our medical community as well as our community as a whole. In addition to the monies raised at this year's Gala, the Alliance has raised over a million dollars for local health related charities. Our Alliance Foundation's many award-winning projects touch many every single day. Bucklebear, for example, is a child safety seat education program which has traveled to virtually all of Lee County's public and private primary schools and has been seen by thousands of children. Our Alliance has been nationally recognized for its Bullies and Victims prevention project, which over a three-year period will have trained dozens of public and private school counselors on how to stop and prevent violence in our middle schools. In the past, the Alliance's Charity Ball and Mini-grant program benefited many by making large and small donations to local health related programs such as A.C.T., Salvation Army, Hope Hospice, and many more. Every effort is made to keep these resources helping members of our local community.

Perhaps less recognized but equally important are the political activities of the Alliance. Our Alliance participates in fundraising for medical friendly candidates. They lobby in Washington and Tallahassee in support of medicine and they participate in developing grass-roots support. Very often, while the Lee County physician is working in the office, his or her spouse is working the phones or traveling to Tallahassee to lobby for what we need.

The Lee County Medical Society Alliance, despite its wonderful success, does not exist in a vacuum. Just as the members of our Medical Society are under economic and professional stress, our family members, and thus the Alliance is under stress as well. Like the Medical Society, our Alliance is under pressure to maintain membership and is struggling with issues of burnout among its active members. Like us, our Alliance is fighting the good fight and needs our support. Please ask your spouse to join or join as a benefactor if you do not have a spouse. As President of the Lee County Medical Society, I would like to thank the Alliance for all their efforts and letting us shake it on the dance floor at the Gala.

A DAY AT THE CAPITOL

Larry Hobbs, M.D.

In March of this year, I had the privilege of serving as the Florida Medical Association's "Doctor of the Day". I first reported to the FMA headquarters in Tallahassee and attended the morning conference meeting that outlines the legislative agenda for that day. I was then escorted to the clinic at the Capital and introduced to the two nurses who work there. To my surprise, one of the nurses at the clinic was a nurse I knew from 10 years ago. She had worked in the ICU at Southwest Regional and had since moved to Tallahassee. She gave me a tour of the two room clinic. Most of the "patients" were legislative personnel having their BP checked or getting Advil or Tylenol. I only saw two patients during the day, one with dizziness that resolved and one with borderline hypertension that subsided with rest. One of the Senators had an extremely high blood pressure the day before and was transported via EMS to the nearest hospital. In general, the clinical obligation is minimal.

The real advantage of serving as "Doctor of the Day" is your access to the legislative floor. My legislative sponsor was Rep. Carole Green. Rep. Green is a friend and has toured our ED at Southwest Regional. Now I had the unique opportunity to visit her place of work on the floor of the House of Representatives. She introduced me to the Speaker Byrd, Rep. Bense (the next Speaker) and other prominent Representatives. And as luck would have it, I witnessed first hand the passage of the Medical Malpractice Bill including the $250,000 cap. Witnessing the discussion and passage or rejection of all the Amendments was very enlightening. The bipartisan distribution of the process was very evident. The minority Democrat Representatives were seated toward the rear of the House. When an issue came for a vote, Rep. Bense and the House majority whip would stand to give a thumbs up or down for the other Republican members to see. The vote on sovereign immunity for all physicians caring for emergency patients (for which I was lobbying for three days prior) was tabled during the day. Rep. Green and Rep. Harrell, who sponsored the amendment, assured me this was politically necessary for the survival of this provision. As "Doctor of the Day" you are forbidden to lobby for any Bill. But, during the course of the day I was given words of encouragement from many key House leaders on their support of our issue with medical malpractice reform.

I was given a beeper by the Clinic nurses to page me if they needed me during my day on the House floor. After not having any pages, I returned to the Clinic later that afternoon, saw one patient with borderline hypertension and called it a day at 4:00 PM. I felt my experience to witness the legislative process first hand was invaluable. It helped me start to understand a very complex process especially now when I meet with legislators to try to convince them to see issues my way. I think if we in medicine are to affect change in how different laws influence our practices, serving as "Doctor of the Day" is an excellent primer of how the Legislature works.

Dr. Hobbs is an emergency room physician at Southwest Florida Regional Medical Center.

As I Recall…

Roger D. Scott, M.D.

OLD GLORY

June 14th, Flag Day, & July 4th have just passed so I thought it might be meaningful to write about our flag and tweak your memories of the past. Can you answer the following ten questions? How many rows of stars? How many stars in each row? How many red stripes? How many blue stripes? What is the name of the blue field? What is the star color? What color stripes does the blue field begin & end on? What color are the first and last stripes? Who was Dr. William Beanes? What was Francis Scott Key's occupation? You see the beautiful flag every day, but how many of these little things do you recall? Here are the answers! Has there ever been a more beautiful sight than our Star Spangled Banner waving in a soft breeze just before sunset or shortly after sunrise? It was just such a sight, but many times more awesome, with bombs bursting in air over Fort McHenry (Baltimore harbor) that inspired Francis Scott Key (an attorney) as he viewed the huge (42x30 foot) American flag to write a poem called the *Star Spangled Banner* in 1814. Hardly believable is that an American attorney was aboard a British warship (during the bombarding of Ft. McHenry) in an effort to get Dr. William Beanes (an American physician) released from British imprisonment. (I've always said there must be some good attorneys in this world!) The verses were soon set to the tune of "Anacreon in Heaven" & became our unofficial national anthem, but not to be officially adopted until March 3, 1931 (117 years later)!!! Incidentally, the original Star Spangled Banner flag may be viewed at the Smithsonian. Its stars are 2 ft. tall & each stripe 2 ft. wide & could be seen from a great distance.

The 1814 flag had 15 white stars for the 15 states and 15 red & white stripes, changed to 13 in 1818 to commemorate the original 13 colonies. As each new state was added to the Union, a new star was added on the following Fourth of July. In 1916 Arizona became the 48th State; therefore, the flag had 48 stars (six rows of 8 stars with single point up) when I started learning about the flag in 1932 in the first grade. (The 49th star represents Alaska in 1959 followed by the 50th star for Hawaii in 1960 with the stars being rearranged to five rows of six stars and four rows of five stars). We would begin our school day with " good morning dear teacher", then the Pledge of Allegiance ("under God" added 1954). Further flagucation (Could I have coined a new word?) came with four years in the Boy Scouts of America followed by three years at military school. I learned that the American flag represents our living country and in itself is considered a living thing to be respected. It is never to touch the ground; it is never to be flown in inclement weather & is to be displayed above all others except on a level with the flag of another country. It should never be flown when damaged, but should be ceremoniously destroyed by burning when possible. The flag should be raised briskly in the morning after sunrise and lowered slowly at retreat before sundown. Each time it is removed from the staff, it is to be stored after folding it in a tricorn manner with the union (blue field and stars) covering the remainder of the folded flag (this was much harder for me to learn than how to apply an Ace bandage with Velcro in the proper manner). For many years the only place that the American flag could fly 24 hours a day was the U.S. Capitol, but in 1948 President Truman proclaimed that it could fly at Fort McHenry at all times. More recently it has been allowed to fly over the grave of Francis Scott Key constantly and at any site overnight if illuminated. Did you know that on Memorial Day the flag should be displayed half-staff only until noon and then raised to full staff? Whenever the flag is to be flown at half staff, it should first be raised to full staff & then lowered to half staff; when taking it down, it should again be raised to full staff and then lowered slowly. These are but a few of the many customs for courtesy to our flag. I believe you'll find all of your questions answered except one that was sneaky; there are no blue stripes.

Our greatest of thanks to our warriors who have fought for our nation and its flag. You are so greatly appreciated that words fail to express the degree.

With the realization of how much suffering and at what sacrifices have been made by men and women so we may freely fly out beautiful flag, it is inconceivable how any American can burn our flag in a protest to any of the occurrences in our country. I certainly do not object to protest (freedom of speech), but strongly feel that the burning of the American flag is an act of sedition and should be a federal offense.

I finished this article on 5/25 & the newspaper came out on 5/26 with a full-page spread on some of the same facts, but you're still privy to many others. Coincidence?

LEE COUNTY MEDICAL SOCIETY BULLETIN
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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.

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MEMBERSHIP ACTIVITY

New Members
Barry Blitz, M.D., Urology
Paul D. Fuchs, D.O., Orthopedic Surgery
A. Eric Gioia, M.D., Neurosurgery
Edward Humbert, D.O., Orthopedic Surgery
Craig MacArthur, M.D., Pediatric Hematology/Oncology
John [illegible]lik, M.D., Orthopedic Surgery
Joh[illegible]uez, M.D., Radiology

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Fax: 573-3226

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3501 Health Center Blvd.
Bonita Springs, FL 34135

Dropped
Richard Liu, M.D.
Peter New, M.D. (No longer in area)
John Young, M.D.

LCMS STATS

April 16, 2003 - June 13, 2003

	Current	YTD
PHONE CALLS RECEIVED	**902**	**3118**
From Physicians and Office Staff	200	687
For Referrals	274	1101
For Background Checks	39	145
Filing Complaints	4	22
Regarding Non-Members	31	114
F[illegible]g Alliance	14	52
R[illegible]g CMS, FMA, and AMA	37	121
Miscellaneous Calls	303	876
APPLICATIONS SENT TO PHYSICIANS	**3**	**30**
MEETINGS	**11**	**33**
Attended on behalf of LCMS	7	10
Society Meetings	6	23
DIRECTORIES DISTRIBUTED	**15**	**70**

LEE COUNTY MEDICAL SOCIETY ALLIANCE NEWS

Lee County Medical Society Alliance Wins National Award For Health Awareness Promotion

The Lee County Medical Society Alliance was awarded the 2003 AMA Alliance Health Awareness Promotion (HAP) Award for **SAVE/"SAVE Today"** for its project *"Bullies & Victims" A Proactive Approach to Stopping School Violence.*

Alliance members sponsored a three-day workshop to train school guidance counselors, social workers, mental health care counselors and Alliance members to facilitate anti-violence and anti-bullying programs. Over 30 participants were certified to facilitate "Bullies and Victims Interactive Student Workshops." Facilitators are visiting local elementary classrooms on an ongoing basis, and another workshop to train more facilitators is being planned.

The Bullies & Victims workshop was one of 82 entries in five categories reviewed by the HAP Awards committee. The Lee County Medical Society Alliance was recognized for their achievement at the 2003 AMA Alliance Annual Session on Sun., June 15, at The Drake hotel in Chicago. Outgoing AMA Alliance President Patti Herlihy and outgoing President Yank D. Coble Jr., MD, presented the award to Nancy Barrow and Barbara Rodriguez, Co- Chairs SAVE Lee County.

Initiated in 1989 by the AMA Alliance, the HAP Awards recognize excellence in the health programs and projects of county Alliances nationwide. Five county Alliances are recognized annually for their work in community service, education and awareness, fund-raising (effective planning and implementation, not amount of money raised), SAVE and SAVE Today (support of the Stop America's Violence Everywhere program) and Resident Physician and Medical Student Spouses (efforts of these individuals in any category).

The American Medical Association Alliance, Inc., is the largest, most influential grassroots organization representing physicians' spouses nationwide. As the proactive volunteer voice of the American Medical Association, the Alliance is dedicated to promoting better public health, ensuring sound health care legislation, and fund-raising for medical education.

2003 LEGAL/MEDICAL GOLF CHALLENGE

The Lee County Medical Society and Lee County Bar Association teed off at the 8th Annual Legal/Medical Golf Challenge on May 10, 2003 at Cypress Lake Country Club. It was a close tournament this year 34 teams played, with Ken Jones of the lawyer's side tying the game with his final putt. Because of this being a Ryder Cup format the lawyers will retain the cup for the fourth year in a row.

We would like to thank the following sponsors for their support:

- Fort Myers Court Reporting
- Capital Appraisal Services, Inc.
- Culler's Copy Corner
- Oswald Trippe and Company
- Jay Calvert Cooper Law Offices
- Garvin & Tripp, P.A.
- Von Ahn Associates, Inc.
- Orthopedic Specialists of SW Florida
- Southwest Florida Regional Medical Center
- Radiology Regional Center
- Florida Radiology Consultants
- Henderson, Franklin, Starnes & Holt, PA
- Travis Legalgraphics
- DSI Laboratories
- Hill, Barth Y King, LLC
- Lexis Nexis
- Reflection Mortgage
- Thomas Carrasquillo, M.D.
- Verandah/Bonita Bay Properties, Inc.
- Rubenstein & Holz, P.A.
- Eyetopian Optical, Inc.
- Comp Options
- Nolen-Martina Court Reporting
- Cape Coral Elks Lodge, #2596
- Lee Memorial Hospital

The Tournament helped to raise $12,000 for Partners for Breast Cancer Care. To date this yearly tournament has raised over $60,000 for Lee County charities. Thank you to all who played this year you really are making a difference in our community. We would like to send an extra big thank you to Bruce Lipschutz, D.O. Co-Chair of the Legal/Medical Challenge Cup and Committee Members Saurin Shah, M.D., and Hal Bozof, DPM, for the time and effort they put into this tournament to make it such a success.

3RD ANNUAL LEGAL/MEDICAL TENNIS CHALLENGE

The Lee County Medical Society and the Lee County Bar Association met on the Courts of the Oasis Tennis Club, Saturday, May 31, 2003 for the 3rd Annual Legal/Medical Tennis Challenge.

The Medical Society won the trophy for the 3rd time. We would like to thank all the 40 lawyers and physicians that participated and would like to congratulate the Lee County Medical Society's first place winners Michael Gross, M.D. and Karen Kovaz. We would like to thank **Westlaw** for donating water and coozies for the tournament. We would also like to send a very special thank you to the following people for their hard work: Dinah Leach, Executive Director Lee County Bar Association; Jim Neel, Co-Chair Legal/Medical Tennis Tournament; Dr. Linda Gardiner, Co-Chair Legal/Medical Tennis Challenge; and Jonas Kushner, Team Coordinator.

ODDS AND ENDS

Medicare providers must qualify and register to continue receiving Medicare B update! In hardcopy format

Effective June 1, 2003, Medicare providers will no longer receive hard copies of the Medicare B Update! Unless you have a valid reason for not utilizing the electronic publication available on the Internet. A valid reason might be lack of a personal computer with Internet access, or some other technical barrier. Medicare publications are posted on the Florida Medicare Website at www.floridamedicare.com and can be downloaded free of charge. Online publication will have enhancements such as hyperlinks to each article making it easy to go to a particular article of interest and links to third-party Web sites reference in articles if you believe that you meet the criteria and wish to receive hardcopies, you must complete a registration form that can be found in your Third Quarter 2003 *Medicare B Update!* You will be required to re-register annually. If you have a paid subscription, you will continue receiving a hardcopy of the *Medicare B Update!* through you subscription period.

HIPAA Reminder

Just a reminder that October 16, 2003, is the deadline for compliance for all electronic healthcare transactions and code sets. The Administrative Simplification Compliance Act requires entities who received a one-year extension to start testing their systems no later than April 16, 2003. If you have not tested your system with your business partners, you should begin testing immediately.

Letter to the Editors...

The May 2003 issue of our Bulletin contained two messages, one from Dr. Ralph Gregg, President, and another from Dr. Annis, former President of the AMA. The subject, as if you didn't notice, was the governmental intrusion into the practice of medicine. On one hand, we are advised not to strike for fear of criminal penalties. In another advice to the down trodden, the best weapon available was "making our case to our patients".

No one in the practice of Medicine needs to be told of our present dilemma. We are fully aware of the onerous laws that prohibit joint protest. We are equally cognizant of our future prospects in terms of change in the law. What to do?

Dr. Annis urges an appeal to our patients, however he expects the ordinary citizen to understand the Constitution which limits the powers of the federal government. Forget it! Our appeal to the populations should be Charity Based. If every practitioner in this county would offer one day a month of FREE CARE and present those who advanced themselves of this unusual opportunity with both a Good Samaritan release and a copy of a "Physician's Bill of Rights" to be signed and sent (at our expense) to the federal government, (HHS, CMS), we would accomplish two worthy objectives. Namely, dedication to our patients welfare, and secondly, unlike attorneys and HMOs our bottom line is not financial reward. We must convince our patients that fee for service will provide quality care, whereas government management is a recipe for socialistic chaos.

Burton Rubin, M.D.

PHYSICIANS PROVIDE FREE SPORTS PHYSICALS FOR HIGH SCHOOL ATHLETES

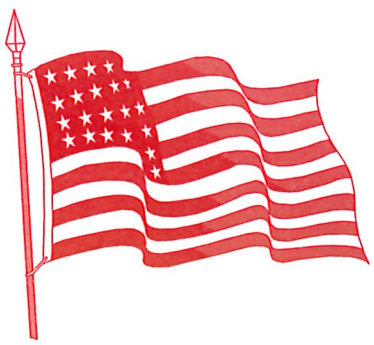
A group of physicians provided 122 free sports physicals to high school athletes May 31, 2003 at Bishop Verot.

The Lee County Medical Society would like to thank the following physicians for donating their time to provide free high school sports physicals:

Dr. Stephanie Beck
Dr. Jeff Comer
Dr. Travis Gresham
Dr. Steven Hannan
Dr. Michael Haupt
Dr. Abbott Kagan
Dr. Richard Lane
Dr. Chris Marino
Bruce Patzwahl, P.A.
Dr. Doug Savage
Dr. Timothy Underhill

CONGRATULATIONS!!

Congratulations to Cheri O'Mailia and the Lee County Medical Society Alliance Foundation for the Success of "The Best of Times" Gala 2003. It was a beautiful evening that helped raise $39,500 for the Lee County Medical Society Alliance Foundation Reaching Out Program.



McCOURT SCHOLARSHIP FUND HELPS LOCAL CHILDREN

The Lee County Medical Society McCourt Memorial Scholarship Fund will sponsor four children – Angelena Lopez, 14; Melissa Murr, 13; Scott Grazier, 13; and Forrest Mettaver, 9 – for full scholarships to the Florida Camp for Children and Youth With Diabetes in the amount of $1800. This camp is very important in helping children learn to treat their diabetes in a controlled and fun atmosphere.

W[illegible]ld like to thank all our members who donated to this fund in their yearly dues. Please carefully con[illegible]nating in next year's dues.

Dear Lee County Medical Society:

On behalf of the children from Lee County who will attend the Diabetes Camp in 2003, I want to thank you for the donation of $1,800.00 from the McCourt Memorial Scholarship Fund. We appreciate having scholarship money available to help our campers.

The goal of our programs is simple: provide children with diabetes and their families with a fun camping experience in a medically supervised environment and teach hem good diabetes management skills. The long-term complications of diabetes can be avoided through good nutrition, exercise and proper insulin adjustment. Our diabetes educators work with the children to give them the necessary skills to manage their disease and our volunteer staff helps them to achieve the self-esteem and belief that "they can handle it"! Over two hundred volunteers including physicians, nurses and educators give their time to help these children. All children can attend the camp regardless of the family's ability to pay the fees which cover the food and campground rental. Nearly 2/3 of our campers need financial aid. Therefore sponsorships from caring individuals and organizations are critical to our ability to serve these children.

We appreciate the continued support of the Lee County Medical Society in assuring that children from the area can benefit from our programs. Thank you again and best wishes.

Sincerely Yours,
Rosalie Bandyopadhya
Executive Director
Florida Camp for Children and Youth with Diabetes, Inc.

Letter from one of LCMS sponsored children:

This sends a world of thanks to you!
Thank you for sponsering me the money. I look forward to having fun at camp. I will send you another note. I can't wait to go exploring with some friends and cannoing. Forrest

RECREATIONAL WATER ILLNESSES

By Michael Barnaby, Public Information Officer, Lee County Health Department

Summer swimming can lead to patients entering the office with gastroenteritis and dermatitis caused by a number of common, and uncommon, agents. The June 2003 edition of MMWR discusses a recent report in which over twenty thousand swimming pool inspections were studied from six areas nationwide (the vast majority – over nineteen thousand – were in Florida). The MMWR notes editorially that "The increasing number of reported pool-associated outbreaks of gastroenteritis underscores the need for proper pool maintenance is an important public health intervention. Approximately one fourth of these outbreaks involved chlorine-sensitive pathogens (e.g., *Escherichia coli* O157:H7 and *Shigella* spp.), which causally implicates inadequate pool maintenance and disinfection." In one recent week, twelve confirmed cases of shigella were reported to the Lee County Health Department.

In Florida, as elsewhere, many reportable organisms are "missed" simply because stool specimens are not taken for confirmation. The public health would be greatly served if testing was routinely done for patients presenting with acute diarrhea. Testing should include stool cultures, stool for O & P, and viral studies, and can be sent to the state laboratory in Tampa where testing is performed for little or no charge to the patient.

Among agents responsible for gastroenteritis, the following appear most frequently:

- *Shigella,* a bacteria that can cause diarrhea, stomach cramps, fever, nausea and vomiting.
- *E. coli* O157:H, *a strain of Escherichia coli* bacteria that can cause severe illness. Symptoms can include severe bloody diarrhea and stomach cramps.
- *Giardia*, a parasite that can cause diarrhea, abdominal cramps, bloating and gas, found in ponds and swimming holes.
- *Cryptosporidium*, another parasite that can cause diarrhea, stomach cramps, fever, and nausea.

Naegleria fowleri, although rare – less than 200 cases have been reported worldwide, with fewer than 20 reported in Florida - PRIMARY Amebic Meningoencephalitis (PAM) can be fatal to humans. A survey conducted in the early 1970s found that over 46% (12/26) of all lakes surveyed in Florida have the pathogenic ameba and it is believed that more extensive sampling would result in recovery of the ameba from most Florida lakes.

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.

DIEGO ANDRADE, M.D. – ANESTHESIOLOGY
Medical School: Central University of Ecuador, Quito, Ecuador (1986-94)
Internship: Social Security Hospital (1993-94)
Residency: Cook Count Hospital, Chicago, IL (1999 - 2003)
Dr. Andrade is in group practice with Medical Anesthesia and Pain Management Consultants at 4048 Evans Avenue, Fort Myers, FL 33901.

DAVID BALDINGER, M.D. – RHEUMATOLOGY
Medical School: St. George's University School of Medicine, Grenada, West Indies (1981-85)
Internship: Laguardix Hospital, Affiliate Cornell University Medical College, New York, NY (1985-86)
Residency: East Tennessee State University, Johnson City, TN (1986-89)
Fellowship: George Washington University Hospital (1989-91)
Board Certification: American Board of Internal Medicine in Internal Medicine and Rheumatology
Dr. Baldinger is in group practice with Internal Medicine Associates at 2675 Winkler Avenue #300, Fort Myers, FL 33901.

MICHAEL COLLIER, M.D. – INTERNAL MEDICINE
Medical School: Autonomous University of Guadalajara, Guadalajara, Mexico (1979-83)
University of Maryland, Maryland (1983-85)
Internship & Residency: South Baltimore General Hospital, Baltimore, MD (1985-86)
Board Certification: American Board of Internal Medicine
Dr. Collier is in group practice with Internal Medicine Associates at 1528 Del Prado Blvd, Cape Coral, FL 33990.

HOLLACE LEPPERT, D.O. – INTERNAL MEDICINE
Medical School: Philadelphia College of Osteopathic Medicine, Philadelphia, PA (1985-89)
Internship: St. Joseph's Hospital, Philadelphia, PA (1989-90)
Residency: Hospital of Philadelphia of Osteopathic Medicine (1990-93)
Board Certification: American Osteopathic Board of Internal Medicine
Dr. Leppert is in group practice with Internal Medicine Associates at 16251 N. Cleveland Avenue #13, North Fort Myers, FL 33903.

STEVEN LONGOBARDI, M.D. – CARDIOLOGY
Medical School: Semmelweis University, Budapest, Hungary (1987-89); New York Medical College, Valhalla, NY (1989-91)
Internship & Residency: Memorial Hospital, Pawtucket, RI (1991-94)
Fellowship: Miriam Hospital, Providence, RI (1994-97)
Board Certification: American Board of Internal Medicine in Internal Medicine and Cardiovascular Disease.
Dr. Longobardi is in group practice with Florida Heart Associates at 1550 Barkley Circle, Fort Myers, FL 33907.

MARY BETH SAUNDERS, D.O. – INFECTIOUS DISEASE/INTERNAL MEDICINE
Medical School: University of Health Sciences Kansas City, MO (1988-92)
Internship & Residency: Garden City Hospital, Garden City, MO (1992-95)
Fellowship: Botsford General Hospital, Farmington Hill, MI (1995-97)
Board Certification: American Osteopathic Board of Internal Medicine
Dr. Saunders is in group practice with Internal Medicine Associates at 2675 Winkler Avenue #300, Fort Myers, FL 33901.

MICHAEL STENS, D.O. – INTERNAL MEDICINE
Medical School: Kirksville College of Osteopathic Medicine, Kirksville, MD (1996-2000)
Internship: Suncoast Hospital, Largo, FL (2000-01)
Residency: Suncoast Hospital, Largo, FL (2001-03)
Dr. Stens is in group practice with Internal Medicine Associates at 12700 Creekside Lane #201, Fort Myers, FL 33919.

CANADIAN DRUGS AND PRESCRIPTIONS

The FMA Legal Department has been getting questions lately about whether it is legal for a prescription written by a U.S. physician to be filled in Canada.

Canadian law does not allow a Canadian pharmacist to fill a prescription written by a physician licensed only in the United States. A Canadian physician must issue the prescription (in fact, the Canadian province may require that the physician be licensed in that province.)

Some Canadian physicians have been signing off en masse on U.S. issued prescriptions that are being brought to Canada. Canadian medical authorities have started investigating the Canadian physicians who are doing this without adequate examination of the patient. While it is not illegal for a Florida physician to write a prescription that the patient is going to have filled in Canada, Florida physicians should refrain from giving any advice on the matter to their patients.

The following information regarding Canadian drugs comes from Jay Fisher, JD, Legislative Analyst with the American Academy of Orthopedic Surgery:

It is a violation of the Food, Drug and Cosmetic Act (21 USC) to import drugs into the United States from Canada by or for individual US consumers [21 USC]. The reason for this is that FDA approvals are "manufacturer-specific" and "product-specific," and they include many requirements relating to the drug including location, formulation, source and specifications of active ingredients, processing methods, manufacturing controls, container/closure systems and appearance. If a specific drug was originally manufactured in the US and then exported, it is permissible for it to be imported back to the States, but only if the importation is done by the US manufacturer [21 USC Section 381 (d) (1)]. In the view of the FDA, virtually all shipments of prescription drugs imported from a Canadian pharmacy will run afoul of the Act. If parties are involved in violations of the Act, there are many potential avenues of liability. A court can enjoin violations of the Act. A person who violates the Act can also be held criminally liable. Those who can be found civilly and criminally liable under the Act include all who cause a prohibited act. Those who aid and abet a criminal violation of the Act, or conspire to violate the Act, can also be found criminally liable. FDA's "personal importation policy" is used in connection with importations of drugs by individuals for their personal use only. Under this policy, the Agency allows individuals and their physicians to bring into the United States small quantities of drugs sold abroad for the consumers' treatment for which effective medication is not available domestically. The Agency makes it very clear that its "personal importation policy" is not intended to allow importation of foreign versions of drugs that are already approved in the U.S. (FDA is apparently of the opinion that foreign versions of US-approved drugs are what Canadian pharmacies often sell to US consumers unbeknownst to them.) The Catch 22 situation, of course, is that if the drug is not a foreign version of a US drug (that is, it was manufactured in the US according to FDA guidelines and then exported), under the Food, Drug and Cosmetic Act it can only be imported back by the original manufacturer; that is, not an individual or a doctor. See above. FDA has further emphasized that its policy is not something that is formally permitted under federal law; it's simply a matter of "enforcement discretion." While the Agency acknowledges it has not often prosecuted individuals and providers importing illegal drugs into the US from Canada, it reserves the right to do so if it so chooses.

HOUSE MEDICARE BILL MOVING

From the AMA Division of Political and Legislative Grassroots

House Bill

Late Wednesday afternoon, June 11, staff from the House Energy & Commerce and Ways & Means Committees reported that the House Medicare bill would include a provision to correct the Medicare payment update problem for two years and make underlying changes to the GDP portion of the formula.

Energy & Commerce Committee plans to mark-up the bill on Tuesday (6/17) and we expect the Ways & Means Committee to mark-up on Tuesday or Wednesday (6/17 or 6/18). Committee staff said that the language would provide updates for physician and health professional services of "no less than +1.5%" in 2004 and in 2005. They indicated the main change that could cause the updates to be above 1.5% would be Administration action such as removing drugs from the Sustainable Growth Rate (SGR) pool. The positive updates are a temporary measure that would be funded by negative updates in later years. They also indicated that effective in 2006 the bill will change the GDP factor in the SGR on a permanent basis to a 10-year rolling average GDP instead of annual GDP. Few details were provided about other aspects of the larger bill, such as what steps will be taken to address the concerns of rural physicians. Also, staff has not provided a CBO score on this provision.

The committee staff made it clear that getting the update fix passed into law will be a difficult process. They asked for letters of support from the medical community and others affected by the recent cuts. The AMA is extremely pleased that the two committees plan to address the pending update crisis. We expect to send a letter of support once we have reviewed actual bill language and confirmed that it is acceptable. Because the committees are seeking multiple letters of support, we will not be circulating a sign-on letter at this time. To facilitate your development of individual letters of support, however, we do plan to send a draft of our letter around as soon as possible.

Senate Bill

The AMA yesterday released a press statement applauding Senate Finance Committee Chairman Charles Grassley and Ranking Member Max Baucus for providing a prescription drug benefit and expanding private plan options in their Medicare reform bill. The AMA also applauded Senate Majority Leader Bill Frist for his demonstrated leadership in moving the process forward.

While a prescription drug benefit is clearly important for America's seniors, we are disappointed that the bill does not address impending cuts in Medicare physician payments that threaten seniors' access to care. Without action by Congress, the government predicts physician payment cuts of 4.2 percent in 2004. This is in contrast to the 2.5 percent increase recommended by MedPAC, Congress' own advisory committee on Medicare.

The AMA appreciates the Finance Committee's inclusion of important regulatory relief provisions that will ease the bureaucratic burden on physicians and the commitment to improving health care in rural America.

Please have your grassroots members use the *AMA Hotline* at (800) 833-6354 or the *AMA in Washington* web site (www.ama-assn.org/grassroots) to urge their Senators and Representatives to stop the projected 4.2% cut in Medicare physician payments in 2004.

FLORIDA MEDICAL ASSOCIATION AGREES WITH AETNA SETTLEMENT

Lisette Gonzalez Mariner
Director of Communications
Florida Medical Association

Tallahassee, Fla. – May 22, 2003 – Aetna and representatives of over 700,000 physicians and state medical societies, including the Florida Medical Association, announced at a press conference in New York that physicians and Aetna have settled a national class action suit which is pending in federal court in Miami. This agreement, pending the acceptance by the court, would conclude Aetna's involvement in the class action suit filed against four other Florida for-profit health insurance plans. The other plans include Humana, Inc., Cigna, United Health Care and Prudential Insurance Company of America. This suit is currently being reviewed in the Southern District of Florida before U.S. District Judge Federico Moreno.

"With this proposal, Aetna is leading the industry in improvements to business practices that have hindered the physician's ability to practice medicine," stated Robert E. Cline, M.D., Florida Medical Association President. "The changes will reduce administrative hassles that will enable our staff to spend time doing what they need to do – take care of our patients," continued Dr. Cline.

The agreement includes industry-leading improvements to physician-related business practices that set new levels of efficiency in paying claims, including a National Advisory Committee of Practicing Physicians to provide advice to Aetna on issues of importance to physicians. It also establishes an independent foundation dedicated to improving the quality of health care in America. The agreement will streamline communication between physicians and Aetna, reduce administrative complexity in the claims payment system and help improve the quality of the health care system.

"This is not about money, not about compensation. It is about open and honest dialog between the HMO and the physician," stated Sandra Mortham, Florida Medical Association Executive Vice President and CEO. "We hope that other HMOs will take Aetna's lead in change," continued Mrs. Mortham.

CLASS ACTIONS AGAINST MANAGED CARE PAYORS IN THE NEWS

Jeffrey L. Cohen, Esq.

May was a big month for actions against managed care payors for being bad citizens. Various medical societies and other representative class members entered into a multi million dollar settlements with Aetna to rectify their shenanigans; and United Healthcare fired back in its lawsuit with the AMA.

The Aetna lawsuit is a monster class action, representing all providers who treated Aetna insureds between August 4, 1990 and May 22, 2003. The allegations include such things claims as automatic downcoding, routinely drawing out the precertification process, and not paying claims in a timely basis.

So what did the Aetna plaintiffs win? Plenty, including:

1. A requirement that Aetna invest $5-1 0 million dollars over the next twelve months to facilitate the automatic adjudication of claims',
2. A requirement that Aetna invest $8-15 million over the next twelve months into enhancing the ability of physicians to register referrals, into precert procedure, claims submission and eligibility determinations;
3. Standardization of precert requirements;
4. A physician dispute resolution procedure that is designed to be streamlined;
5. Payment of $5 million to qualifying physician offices;
6. Mandatory educational programs for physicians;
7. Elimination of the practice of requiring physicians to participate in all Aetna products;
8. Elimination of automatic downcoding; and
9. Payment of $100 million into a Settlement fund

The plaintiffs understandably believe that they have won significant, concessions from Aetna. Some experts, however, believe that Aetna has merely agreed to do what they were already inclined to do.

United Healthcare took a different route this month by fighting back against the class action aimed at it by the AMA and various other class representatives. The underlying claims in the United suit are very similar to the Aetna case. United's response took the form of a counterclaim against the plaintiffs, claiming for instance, that the plaintiffs are violating antitrust law in maintaining the suit. The counterclaim arises in response to the plaintiffs' attempts to obtain information which United claims is confidential and proprietary. The gist of the counterclaim is that the AMA's real aim is to dampen United's competitive spirit and to raise the rates that physicians are paid. It is an interesting attack, one which will be closely watched by other litigants in actions against payers around the country.

Mr. Cohen worked as Associate General Counsel to the Florida Medical Association from 1989 to 1993. He is a shareholder in the Delray Beach law firm of Strawn, Monaghan & Cohen, P.A. and is Board Certified by the Florida Bar as a specialist in Health Law. Mr. Cohen may be reached by calling (561) 278-9400.

Please Update Your Medical Society With Current Info On Your Practice - 936-1645

Medical Expert Witness Report Online Now

Medicalexpertreport.com is now online. The website is currently a database of reformatted public records dealing with physicians providing expert witness testimony in cases of Florida medical litigation. The database was created in order to better educate healthcare professionals about their medical legal climate and currently represents a collection of the medical legal cases that have been made public. It is the desire of its developers to greatly expand the database in the near future to include educational aspect as well as a repository of expert witness depositions. Medical expertreport.com will also provide a chat room and a mechanism for feedback from viewers. Additionally, there are plans to add forms on the site for those who wish to provide information that might be posted on the site.
www.medicalexpertreport.com.

HOW GOING BARE CAN BE A GOOD BUSINESS DECISION

Negotiating Settlements for Bare Physicians

Marc Singer, MBA, CFP

Many physicians are currently considering or have recently "gone bare" (selfinsure). The first group of doc[illegible] self-insure did so in 1986 during the past Florida malpractice crisis. Many of them have not carried insu[illegible] since that time 17 years ago. There are no numerous physicians who have experienced a lawsuit while self insuring. In instance where bare physicians were sued, virtually all cases reached a favorable conclusion. The following are some lessons we have learned.

Initially, bare physicians approached lawsuits as if they were insured, essentially mounting a full legal defense. The average case now costs approximately $85,000 to defend through trial. If the case was won, there was no concern. However if they lost, then they would have a malpractice judgment to contend with. At that point, an attempt would be made to settle the judgment for a reasonable and affordable amount. Many times this could be accomplished, especially when the plaintiffs understood that here was no deep pocket (the physicians had no malpractice coverage and all their assets were well protected).

In the event that a reasonable settlement could not be reached, some doctors found it beneficial to declare voluntary bankruptcy. Contrary to popular belief, bankruptcy is not a dirty word, but rather a process in which the physician can retain all their protected assets and have their malpractice judgments discharged. It essentially wipes the slate clean. Unlike a malpractice case, which takes 4-6 years and is psychologically grueling for a physician, a voluntary bankruptcy can be completed in 30-60 days. Of course, we always attempt to settle cases without going to bankruptcy. It should be noted that in most cases, where doctors went through bankruptcy, the $250,000 financial responsibility was discharged by the court and the physician was able to retain their medical license. This concept will be explored in detail in a future article.

As everyone now realizes, our malpractice insurance system in Florida has essentially melted down. Over the years, we learned that being prepared to declare bankruptcy is actually the best way to fight a malpractice claim. We believe that plaintiff attorneys are primarily motivated by their ability to get awards for their clients, and thus be compensated through the contingency system. It can be very effective in some cases to argue the financial reality of a case rather than the medical merits. We do this in certain cases by retaining bankruptcy attorneys to conduct negotiations rather than using traditional defense lawyers. A bankruptcy attorney presents the case from the perspective that the physician has no insurance and no available assets to pay a judgment, should the plaintiff be successful in their lawsuit.

To summarize the economics of going bare, take the example of an obstetrician who went bare in 1986. The premiums would have averaged $125,000 per year for $250/$750 coverage. Cumulatively, over $2.1 million in premiums would have been paid over that time. The highest amount we are aware of any obstetrician paying out in total claims and legal fees during this entire period is only $300,00. The reality is that going bare has been shown to be a much better business decision than carrying coverage.

Of course, every case is unique and must be evaluated individually. It is of crucial importance that, prior to being sued; a physician has taken adequate measures to protect their personal and PA assets. A physician's Financial Advisor should be experienced in asset protection strategies and be in a position to assist in the negotiating process. Bankruptcy attorneys will not bluff; one has to be 100% protected prior to them being willing to negotiate.

Marc Singer, MBA, CFP is a certified financial planner and partner of Singer Xenos Wealth Management with offices in Coral Gables and Tampa. The firm specializes in money management and asset protection services for physicians. 888-289-0060 www.SingerXenos.com

LEE COUNTY OUTPATIENT MARKET OVERVIEW 90K+ PROCEDURES 2001

Peter Young

Health Care Strategic Issues

Here are the outpatient volumes as reported to the Agency for Health Care Administration for 2001. 2002 data will be available in about a month. This report is a high level overview identifying the top volume specialties. 2001 was the first year of reporting certain outpatient data and not all data was reported to the State.

The reported data indicates just over 90,000 reportable outpatient encounters for Lee Co. I suspect the number to be under-reported by 10,000 based on it being the first year and errors in reporting or not reporting can occur.

Outpatient encounter per population – Our county population was roughly 440,000 and this equates to roughly 24% of population utilization rate of reportable outpatient procedures.

Population growth – The challenges of recruiting additional physicians to Lee Co. given the growth. Our 2010 population will be near 550,000 or an increase of just over 100,000 people in seven years. It took Cape Coral 30 years to reach 100,000 and the growth in our county will do so in 7 years. In rough ballpark terms, based on current utilization it seems likely the 100,000 population increase in conjunction with the significant increase in healthcare consumers in the higher utilization ages 50+ will result in a conservative additional 25,000 outpatient visits per year by 2010.

One of the likely problems facing our physician community will be meeting their individual practice growth demands.

Lee County - All Specialties

Specialty	Total # of Cases	Specialty	Total # of Cases
Gastro	21704		
Opthal	16528	Vasc Surg	348
Orthopedic	15012	Endocrine	260
Other	10436	Pulmonary	201
Gen Surg	4648	Dentistry	171
Dermatology	2846	Neurosurgery	111
Rheum	2153	HIV	8
Gen Med	2152	Psych	8
Neurology	2138	Newborn	7
Otolaryn	2070	**TOTAL**	**90777**
Or[illegible]y	1988		
G[illegible]ogy	1759	Market Share Report	
Nephrology	1345	Case Type:	All
Thor Surg	1121	Geographic:	FL-Lee
Urology	1096	Hospital:	All
Hematology	1013	Payor:	All
Obstetrics	856	Demographic:	All
Cardiology	798	Product Line:	All

THE ELEMENTS OF PREMISES RISK MANAGEMENT

By Cliff Rapp, LHRM, Vice President of Risk Management, FPIC

Professional liability companies also encounter claims involving premises risks. These are usually not high dollar loss cases, but are frequent in number. One example is a slip or fall within examination rooms or waiting areas. Someone should be assigned to go through the office at least twice a year to look at the office with a critical eye to detect possible safety risks to the patients and staff members. As with medical risk management the goal is to prevent an event from ever happening in the first place.

A particular list of items to check include the following:

- Are floors clean and nonskid? Are any carpet seams fraying, or does carpet need restretching to eliminate bulges, which can be tripped over?
- Are equipment, boxes, supplies, etc., out of the way of foot traffic?
- Are chairs and furniture stable, sturdy, and without sharp edges or splinters?
- Are stairs, handrails, and steps safe and sturdy?
- Is your office wheelchair accessible?
- Are hallways free of obstacles?
- Are there loose tiles on the ceiling or anything on the walls that can fall off and injure patients?
- Are pieces of art safely suspended/attached to the wall?
- Does your office present unsuspected risks for visually or hearing-impaired patients?
- Are prescription blanks left in exam rooms?
- Are outdated drugs and supplies checked and rotated?
- Are chemical solutions, and undiluted and diluted medications clearly labeled?

When treating children it is important to keep sharp instruments and swallowable objects out of possible reach of children. In addition drug samples should be kept in closed closets and out of reach of children.

In case of power failure, it is important to have backup lighting. During office surgery, you would not want to interrupt a procedure due to lack of light. Battery pack auxiliary lighting is a good investment.

Set up a system to track the number of times an instrument is used. Also check sterilization methods at appropriate recommended intervals.

Avoid having staff drive patients home or to the hospital. Involvement in an automobile accident is an added risk. If necessary, call an ambulance.

Emergency Risk Management Plan

Are you and your staff prepared to handle an emergency situation? Physicians performing any invasive procedures in a non-hospital setting should review and comply with all state regulations with respect to facilities, equipment, and staff required for performing certain procedures. Even the most benign procedures conducted in your office may be considered office surgery by your state laws. Please review all state laws on performing office surgery or the use of anesthesia in your office to determine emergency equipment requirements.

The following is a list of criteria your office should have in place for a patient emergency situation:

- Is emergency equipment/crash cart available in the office?
- Is your clinical staff trained on how to use the emergency equipment/crash cart?
- Does all your staff know the location of your emergency equipment/crash cart?
- Is staff trained and certified in CPR?
- Is the crash cart purged and updated regularly according to an established schedule? Do you record cart checks?
- Does your office have a written emergency plan:
  - Who will call 911?
  - Who will start CPR?
  - Who will notify the doctor?
  - Who will get the emergency equipment/crash cart?
  - Who will call the hospital ER?
  - Who will watch for the EMTs?
  - Who will notify the patient's family?

Your office should have a fire drill plan and posted evacuation route(s). Practice fire drills throughout the year.

The following is a list of fire emergency suggestions for your office:

- Does all your staff know the locations of the fire extinguishers?
- Is your office equipped with smoke detectors? Is this equipment checked on a regular basis?
- Are fire drills conducted in your office?
- Does all your office staff know the locations of the emergency exits in your office?
- Who will notify all the patients in the treatment rooms about the emergency and help escort the patients out of the building?
- Who will call your answering service to notify them of the emergency?
- Who will notify all your staff?
- Who will take a copy of the schedule and check that all patients who had appointments at the time of the fire got out safely?
- Who will get a printout from the computer of the patients scheduled for appointments and notifies them of the emergency?
- Who will notify other physicians who are away from the office of the emergency and tell them not to come to the office?
- Who will call the fire department?

Every office should be prepared for any form of an emergency situation (e.g., patient emergency, fire, and a natural disaster). Your office should have a plan for each one of these emergencies.

Information in this article does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. FPIC recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.

From the American Medical Association

MONKEYPOX OUTBREAK

INTERIM INFECTION CONTROL GUIDANCE: MONKEYPOX OUTBREAK – JUNE 2003

General Principles

Persons seeking medical care with fever or rash should be asked about possible exposure to small mammals, especially pet prairie dogs and Gambian giant rats. If a patient with suspect monkeypox infection is seen as an outpatient or admitted to the facility, a combination of Standard, Contact, and Airborne Precautions (http://www.cdc.gov/ncidod/hip/isolat/isolat.htm) should be applied in all health-care settings. These include:

1. Hand hygiene after all contact with an infected patient and/or the environment of care;
2. Use of gown and gloves for any contact with the patient and/or the environment of care;
3. Eye protection (e.g. goggles or face shield) if splash or spray of body fluids is likely;
4. Respiratory protection including a NIOSH-certified N95 filtering disposable respirator for entering the room or patient care area (http://www.osha.gov/SLTC/etools/respiratory). If N95 respirators are not available for health-care personnel, then surgical masks should be worn;
5. Airborne isolation room with negative pressure relative to the surrounding area. If a negative pressure room is not available, place the patient in a private room;
6. Contain and dispose of contaminated waste (e.g., dressings) in accordance with facility-specific guidelines for infectious waste or local regulations pertaining to household waste;
7. Use care when handling soiled laundry (e.g., bedding, towels, personal clothing) to avoid contact with lesion exudates. Soiled laundry should not be shaken or otherwise handled in a manner that may aerosolize infectious particles;
8. Handle used patient-care equipment to prevent contamination of skin and clothing;
9. Ensure that procedures are in place for cleaning and disinfecting environmental surfaces in the patient care environment. Any EPA-registered hospital detergent-disinfectant currently used by health-care facilities for environmental sanitation may be used.

Outpatient Management

Segregate the patient from others in the reception area, preferably in a private room with negative pressure relative to the surrounding area. Place a surgical mask over the patient's nose and mouth. Cover exposed skin lesions (sheet and/or gown on patient).

Monitoring Exposed Healthcare Personnel

- Health-care workers who have unprotected exposures to patients with monkeypox need not be excluded from duty, but should undergo active surveillance for symptoms, including measurement of body temperature at least twice daily for 21 days following the exposure.
- Health-care workers who have cared for or otherwise been exposed to monkeypox patients while adhering to recommended infection control precautions should be instructed to be vigilant for fever and other symptoms, including measurement of body temperature at least twice daily for 21 days following the last exposure to a monkeypox patient.

Duration of Isolation Precautions

Isolation precautions, either in health-care facilities or home settings, should be continued until all lesions are crusted.

Asymptomatic Contacts

- Asymptomatic contacts to animals or humans suspected to have monkeypox must be placed under symptom surveillance for 21 days after their last exposure.
- Asymptomatic contacts may continue routine daily activities (e.g., go to work, school) but should remain close to home for the duration of surveillance. However, it may be prudent to exclude pre-school children from daycare or other group settings.

Contacts must monitor their temperature twice daily. In addition, they must maintain daily telephone contact with designated health department personnel. If resources permit, closer monitoring is desirable.

Submission of Specimens from Patients with Suspected Monkeypox

Procedures recommended for collection of samples of diagnosis of potential monkeypox disease are essentially the same as those for diagnosis of the related orthopoxvirus diseases, vacccinia and smallpox. For information regarding collection of serum specimens and lesions, please refer to the smallpox laboratory testing guidelines at http://www.bt.cdc.gov/agent/smallpox/lab=testing. Consultation with the state epidemiologist (http://www.cste.org/members/state_and_territorial_epi_asp) and state health laboratory (http://www.aphl.org/public_health_labs/index_cfm) is necessary for submission instructions before sending specimens to CDC.

INTERIM CASE DEFINITION: MONKEYPOX OUTBREAK – JUNE 2003

Clinical Criteria

Rash (macular, papular, vesicular, or pustular; generalized or localized; discrete or confluent).

Other signs and symptoms:

- Temperature ≥ 99.3° F (≥ 37.4° C)
- Headache
- Backache
- Lymphadenopathy
- Sore throat
- Cough
- Shortness of breath

Epidemiological Criteria

- Exposure (ie. living in a household, petting or handling, or visiting a pet holding facility) to an exotic mammalian pet (eg. prairie dogs, Gambian giant rats, and rope squirrels) obtained on or after April 15, 2003, with clinical signs of illness (e.g., conjunctivitis, respiratory symptoms, and/or rash).
- Exposure to an exotic mammalian pet with or without clinical signs of illness that has been in contact with a case of monkeypox either in a mammalian pet (living in a household, or originating from the same pet holding facility as another animal with monkeypox) or a human
- Exposure to a suspect, probable, or confirmed human case.

Laboratory Criteria

- Isolation of monkeypox virus in culture
- Demonstration of monkeypox virus DNA by polymerase chain reaction testing in a clinical specimen
- Demonstration of virus morphologically consistent with an orthopoxvirus by electron micros copy in the absence of exposure to another orthopoxvirus
- Demonstration of presence of orthopox virus in tissue using immunohistochemical testing methods in the absence of exposure to another orthopoxvirus.

Case Classification

Suspect Case:

- Meets one of the epidemiologic criteria
- Rash OR two or more other signs or symptoms

Probable Case:

- Meets one of the epidemiologic criteria
- Rash AND two or more other signs or symptoms

Confirmed Case:

- Meets one of the epidemiologic criteria
- Rash and two or more other signs and symptoms
- Meets one of the laboratory criteria

For the Latest Information

The following infection control information was summarized from the Centers for Disease Control and Prevention (CDC) on June 12th, 2003. For the most up-to-date information on monkeypox infection control, please visit the CDC web site at: http://www.cdc.gov/ncidod/monkeypox/infectioncontrol.htm.

For the most up to date information on this outbreak, please visit the CDC's monkeypox web site at:http://www.cdc.gov/ncidod/monkeypox/.

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