December 2006
Volume 30, Issue 7

DECEMBER 4, 2006
HOLIDAY PARTY
VERANDA RESTAURANT

LCMS General Meetings

January 18, 2007
Installation of Officers
Royal Palm Yacht Club
2360 West First Street
Downtown Fort Myers
6:30 p.m.—Social Time
7:00 p.m.—Program

Reservations:
LCMS, PO Box 60041, Fort Myers, FL 33906
Tel: 936-1645 Fax: 936-0533

2007 General Meetings
Royal Palm Yacht Club
2360 West First Street

January 18, 2007
March 15, 2007
May 17, 2007
September 20, 2007
November 15, 2007

Inserts

- Holiday Fruit Baskets
- Proclean Authority Advertisement
- Office Space Available Ad

Inside this issue:

LEE COUNTY MEDICAL SOCIETY

Bulletin

Editor: Mary C. Blue, M.D.

President's Message

Your 2007 Officers Julio Rodriguez, M.D.

As I write my final president's message, the holidays approach. It seems we just finished Thanksgiving and the race for the holiday season has begun. This is the time of year when we stop and reflect on our many blessings. We are blessed to be a community rich in tradition, values, and friendships. This past year confirmed what I already knew. The Lee County Medical Society is filled with kind, devoted and brilliant members, and staff. Indeed, together we grieved the loss of a beloved colleague, Dr. Alan Siegel, tried to make sense of the new hospital acquisitions, united to elect pro medicine candidates, and celebrated with friends during the Holiday Party at Verandah. As the year wraps up your new board is ready and eager to lead the way. I urge you to give them the support and friendship you have shown me this past year.

Your newly elected officers are:
President: **M. Erick Burton, M.D.** a Cardiologist with The Heart Group. Erick graduated from Emory University School of Medicine in 1987.
President-elect: **Dean Traiger, M.D.** who practices Family Medicine with Physicians Primary Care. Dean graduated from Medical School at Technion University, Israel Institute of Technology in 1997.
Secretary: **Larry Hobbs, M.D.** an Emergency Medicine physician with SWFL Emergency Physicians, PA. Larry graduated from the University of Miami School of Medicine in 1982.
Treasurer: **Cherrie Morris, M.D.** an Obstetrics/Gynecology physician with Lee Physicians Group. Cherrie graduated from New Jersey Medical School in 1994.

Members-At Large:
Howard Barrow, M.D. is an Otolaryngologist with ENT Specialists of Florida. Howard graduated from Cornell University Medical College in 1987.
Stuart Bobman, M.D. a Radiologist with Radiology Regional Center. Stu graduated from Duke University School of Medicine in 1985.
Michael Kim, M.D. a Plastic Surgeon with Associates in Cosmetic Surgery. Michael graduated from New York University School of Medicine in 1987.
Shahid Sultan, M.D. is a Neonatologist with Associates in Neonatology. Shahid graduated from King Edward Medical College in 1975.
Craig Sweet, M.D. a Reproductive Endocrinologist with Specialists in Endocrinology. Craig graduated from Southern Illinois University Medical School in 1985.
Kenneth Towe, M.D. is a Cardiologist with Florida Heart Associates. Ken graduated from University of Miami School of Medicine in 1992.
Stephen Laquis, M.D. an Ophthalmologist with The Institute for Ophthalmic and Facial Plastic Surgery. Steve graduated from New York Medical College in 1996.
Stephen Schroering, M.D. is an Orthopedic Surgeon in solo practice. Stephen graduated from Medical School from the University of Louisville in 1985.

On a personal note I wish to extend a sincere thank you to Richard Murray, M.D. and Raymond Kordonowy, M.D. They will be leaving the Board after several years of dedicated service. I would also like to thank the Medical Society staff who work so hard on our behalf. After 32 years of service Ann Wilke, Executive Director, is still the glue that holds us all together. Administrative Assistants Marian McGary and Cynthia Greenfield joined Ann in the summer of 1997. Together they channel all correspondence, numerous phone calls, e-mails, plus any task assigned in a courteous and professional manner. These ladies are an integral part of our Medical Society and we are fortunate to have them.

It has been an honor and a privilege to serve and work alongside so many gifted individuals. You have my best wishes for a safe and peaceful holiday season.

Together we are stronger!

LEE COUNTY MEDICAL SOCIETY BULLETIN
P.O. Box 60041
Fort Myers, Florida 33906-0041
Phone: (239) 936-1645
Fax: (239) 936-0533
E-Mail: awilke@lcmsfl.org
www.leecountymedicalsociety.org

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

CO-EDITORS
Mary C. Blue, M.D.
John W. Snead, M.D.

EDITORIAL BOARD
PRESIDENT
Julio Rodriguez, M.D.
PRESIDENT ELECT
M. Erick Burton, M.D.
SECRETARY
Cherrie Morris, M.D.
TREASURER
Dean Traiger, M.D.
PAST PRESIDENT
Richard Murray, M.D.
MEMBERS-AT-LARGE
Larry Hobbs, M.D.
Raymond Kordonowy, M.D.
Craig Sweet, M.D.
Howard Barrow, M.D.
Stuart Bobman, M.D.
Kenneth Towe, M.D.
Michael Kim, M.D.
Shahid Sultan, M.D.

MANAGING EDITOR
Ann Wilke, 936-1645

DESIGNER
Cynthia Greenfield

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. Advertisements do not imply sponsorship by or endorsement of Lee County Medical Society.
© 2006 LCMS.

PRINTERS
Insta-Print, Inc.

We would like to thank Ironstone Bank for Sponsoring our 2006 Annual Holiday Party and for Contributing a beautiful basket to be raffled with proceeds to benefit the Lee County Medical Society Alliance Foundation.

Membership Activity

NEW MEMBERS
Carol Barekman, M.D.-Pathology
Carlos Cuello, M.D.-Cardiology
Ariel Figueredo, M.D.-Ob/Gyn
Russell Gilchrist, D.O.-Physical Med/Rehab
Evan D. Gross, M.D.-Nephrology
Timothy Hughes, M.D.-Ob/Gyn
Ann Lord-Tomas, M.D.-Ob/Gyn
Tinerfe Tejera, M.D., D.M.D.-Oral Maxillofacial Surgery

REACTIVATION
Brian Martin, D.O.—Internal Medicine
Robert Sharkey, M.D.—Emergency Medicine

RETIRED
Mario Petrini, M.D.

NEW ADDRESS
James Conrad, M.D.
Robert Grohowski, M.D.
Michael Lee, M.D.
Brian Taschner, M.D.
Coastal Cardiology
16261 Bass Road Ste 300
Fort Myers, FL 33908
Tel: 239-274-8866
Fax: 239-274-8867

Leonard Benitez, M.D.
Lehigh Medical Group
13100 Westlinks Terrace, Unit 10
Fort Myers, FL 33913
Tel: 239-938-7474
Fax: 239-938-7475

New Member Applicants

Veronique Fernandez-Salvador, M.D.—Dr. Fernandez-Salvador attended Southwestern Medical School and obtained her M.D. in 2001. She completed her internship and residency at Washington University in St. Louis, MO from 2001-06. Dr. Fernandez-Salvador is with SWFL Urologic Associates at 507 Del Prado Blvd, Cape Coral, FL 33990.

Patrick Guadiz, M.D.—Dr. Guadiz attended St. Lukes College of Medicine in the Philippines where he obtained his M.D. degree in 2001. He completed his internship and residency at the University of Massachusetts from 2002-2005. He is board certified by the American Board of Family Medicine. Dr. Guadiz is in solo practice at Guadiz Medical at 1530 Lee Blvd Ste 1800, Lehigh Acres, FL .

Joseph Magnant, M.D.—Dr. Magnant attended the Medical College of Virginia and obtained his M.D. in 1985. He completed his internship and residency at the Medical College of Virginia from 1985-90 and a vascular surgery fellowship at Dartmouth-Hitchcock Medical Center from 1990-92. He is certified by the American Board of General Surgery and Vascular Surgery. Dr. Magnant is in solo practice at Vein Specialist at Royal Palm Square at 1510 Royal Palm Square Blvd, Fort Myers, FL 33919.

Life Members

We would like to thank our two new life members for 35 years of continued membership in the Lee County Medical Society and Florida Medical Association and for their many years of service to our community.

Jack C. Carver, M.D.—Internal Medicine
Ellen Sayet, M.D.—Oncology

As I Recall...

Roger D. Scott, M.D.

The Christmas House

I believe it was 1994, actually August 1994, when I decided to build a house for Christmas. Beginning at this time should be adequate time despite my busy work schedule, but could I in this brief period of time complete it for Christmas? I had previously built two fairly simple large houses and one smaller detailed house in about the same amount of time; however, this was going to be a more elaborate large house.

I purchased a kit and plans for the basic building; oh! incidentally I forgot to tell you that this was going to be a doll house. Perhaps we should go back to the beginning so here goes.

When my oldest daughter, Susie, was a child, I was so busy during the last year of residency and then beginning private practice that I didn't have enough time to build one for her. It seems that I was at the office or hospital, (actually there were two hospitals, Lee Memorial and Jones Walker) most of the days, nights, and weekends so she only got commercial doll houses. Later in life I had time to build one shared complicated house & two large uncomplicated keepsake dollhouses for my two younger daughters (Lara and Shane).

Susie's daughter (Olivia, my granddaughter) was about 12 years old in 1994 when there was time in my life alone to undertake the construction of a "masterpiece" for Olivia that Susie could also enjoy.

The hobby shop had a large kit that could be made into a three-story Victorian style home with a "captain's watch" (an area on the roof where wives could stand and watch for the arrival of their husband's ship). Little did I realize that this would be the biggest dollhouse making undertaking that I had ever faced. There were unpainted pre-cut 1/4 & 1/2 inch thick plywood walls & roofs to build a split level with two major roofs & a small roof over the front porch. All of the windows (including a large full-length bay one for the first-floor living room), two stairways, four front door steps & doors had to be constructed from the unpainted materials included in the kit.

All of the materials and tools needed (including a few surgical instruments) were set up on a card table on the left, a six-foot long table on the right, and an old typewriters swiveling stand in the center creating a U-shaped workbench with a swivel secretary's chair in the center of this work area. Most components had to be painted prior to assembly. The major color was a very pretty blue with white windows & molding trim, but some moldings including the gingerbread were dark crimson. The roof was a light tan.

The three walls (the back wall was left open) were assembled (using hot glue) on the large table, but then despite following the directions, I had messed up. (With previous assembly of children's toys I found that plans were often ambiguous.). The assembled parts didn't fit so it was necessary but difficult to take down the basic construction and rebuild correctly using hot glue and nails for extra strength. The house was then placed on the typewriter table for rotation to add the windows, doors, steps, and stairs all of which had been constructed from the materials in the kit. The previously built four steps were then anchored in place at the front porch. Many trips were made to the shop during the construction to obtain "gingerbread" trim for all the edges of the roofs and much trim and bric-a-brac for other portions of the house.

A miniature carved wood "MERRY CHRISTMAS" was hung over the front door from the porch ceiling. A white flower box with red trim and many small red roses was on the front porch and a larger similar wall mounted flower box containing many small red roses was placed on the left side wall. A white trellis covered with miniature red roses was on the right side of the house. All of these decorations were handmade by me. Two wooden seagulls were perched upon the captain's walk and on its four walls were placed small carved wooden wreaths & candy canes. There were several other little wooden decorations and trim applied to the house to make it more Christmassy.

Previously a two inch high board had been placed completely around the base of the house to raise it up off the "ground". I desired to make this into a stone base, but declined the only material the shop had to make "fake" stones that could be painted. It occurred to me that the stones used in aquariums might be just right and these were found at the pet store. After about the fourth or fifth attempt to adhere the stones to the wood, I found a substance that would simulate white cement and would adhere the stones in position. (They are still adhering today!) Altogether one thousand hand selected stones were mounted to completely cover the base except for a small area in the center back where a painted wood carved Santa Claus is on the left and a carved wood painted angel on the right of a red plaque reading:

OLIVIA'S CHRISTMAS HOUSE
Built By Grandaddy Scott 12-25-94

The house was so big & pretty that it should not set on the floor so I made a blue top wooden table with red molding & brown legs (colors to match house) about the size and height of a card table. No one got to see the house till Christmas.

It hardly seems possible that I could've spent 750 hours and around $1000 in this venture, but I did with love. It was fun and worth it to build a keepsake which hopefully will each Christmas remind the descendents of Grandaddy Scott.

This article comes to you with best wishes and happiness for Christmas, Hanukkah, & other non-Christian holidays. GOD BLESS AMERICA! Remember Pearl Harbor!

Lee County Medical Society Alliance & Foundation News

Pediatric Immunization: A Priority in the Fight Against Serious Influenza Complications

Les Tice, Deputy Director of Public Health, sanofi pasteur

As a health-care professional (HCP), imagine being asked to prevent a disease that results in high rates of serious illness, complications, and hospitalizations among young children.[1,2] Now imagine that there is a simple and inexpensive way to prevent this disease in children; *would you consider such prevention to be optional*?

When it comes to preventing influenza, one of the most infectious viral diseases, there are many who feel that annual immunization is an option they don't have to take too seriously—even during influenza season.

HCPs themselves can underestimate the potential for influenza complications: the Centers for Disease Control and Prevention (CDC) estimates that influenza vaccination coverage of health-care workers in the United States (US) in 2004 was approximately 36%.[3] Influenza vaccination coverage for young children 6-23 months of age was 48.4%, and for those 2-17 years of age coverage was 34.8%.[3]

Due to the immense health and economic burden of influenza, the CDC recommends influenza vaccination for persons in high-risk groups such as infants and young children, the elderly, and any person with known compromised health. The CDC also recommends influenza immunization for all children 6-59 months of age, as well as children of all ages with certain medical conditions.[4] In 2006, the CDC's Advisory Committee on Immunization Practices (ACIP) voted to recommend an expansion of influenza immunization to also include children 24 months up to 59 months of age, as well as their caregivers.[2]

Being proactive can reduce the influenza disease burden

Several approaches can be taken by HCPs and parents to help reduce the overall burden of influenza and, in particular, the burden from influenza faced by young children.

One method is for HCPs to immunize patients throughout the entire influenza season, as recommended by the CDC. Influenza season generally runs from October through March.

To improve vaccination coverage, the CDC recommends that influenza vaccine should continue to be offered in December and throughout the influenza season as long as vaccine supplies are available, even after influenza has been documented in the community.[4] This is a longer span of time than is currently recognized by most people.

References:

1. Centers for Disease Control and Prevention (CDC). Influenza. In: Atkinson W, Hamborsky J, McIntyre L, Wolfe C, eds. *Epidemiology and Prevention of Vaccine-Preventable Diseases. The Pink Book*. 9th edition. Washington, DC: Public Health Foundation, 2006;233-253.
2. CDC's Advisory Committee recommends expanded influenza vaccinations for children [press release]. CDC; February 23, 2006.
3. CDC. Estimated influenza vaccination coverage among adults and children—United States, September 1, 2004-January 31, 2005. *MMWR*. 2005;54:298-324.
4. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*. 2006;55(RR-10):1-43.

Lee County Black/White HIV/AIDS Ratio—Greater Than 10:1

Michael Barnaby, Lee County Health Department

More blacks in Lee County live with HIV—or are already dead from AIDS—than any other racial or ethnic group. Statewide, in 2005, 1 in 58 black males and 1 in 83 black females were living with a diagnosed case of HIV/AIDS. This compares with 1 in 310 white males, 1 in 1,625 white females, 1 in 148 Hispanic males, and 1 in 553 Hispanic females.

HIV/AIDS gaps exist between blacks and whites and between Hispanics and whites, but the black-white gap is widest by far. These terrible statistics are reported in *"SILENCE IS DEATH - The Crisis of HIV/AIDS in Florida's Black Communities"*, a recent study by the Florida Department of Health.

Evaluating an individual's risk for HIV infection and offering HIV testing on a voluntary basis should be a routine part of primary health care. Florida law carefully structures the manner in which health care providers may perform HIV tests, and includes a requirement that providers obtain informed consent prior to testing for HIV. ***Note that consent need not be in writing provided there is documentation in the medical record that the test has been explained and the consent has been obtained.***

The physician must confirm positive preliminary results with a supplemental test before informing the test subject of the result, and ensure that all reasonable efforts are made to notify the patient. Should a positive patient reveal the name of any sex or needle sharing partner(s), the physician is legally protected if they do not inform those partners, under confidentiality laws. However, if the practitioner elects to inform those partner(s) of the patient's status, they are also legally protected, if they follow approved protocol.

Although the law no longer requires pre-test counseling, it is recommended that testing be preceded by a pre-test counseling session consisting of the following:

- Purpose of the HIV test;
- Indications for testing (medical indication and/or information obtained from the risk assessment);
- The possible need for retesting;
- Information on how to avoid contracting and transmitting HIV infection;
- Potential social, medical, and economic effects of a positive test result;
- Options for eliminating and/or reducing risk behavior;
- The availability of support services for those awaiting test results (e.g., hotlines, health care professional's name and telephone number, county health department number); and,
- Scheduling a specific date for receiving test results. (It is recommended that positive results always be disclosed during a face-to-face post-test counseling session.)

Regarding pregnant women, Florida statutes state that physicians and midwives are mandated to test for sexually transmitted diseases, including HIV. If a woman objects, a written statement of objection, signed by the woman, needs to be placed in her medical record. Testing is recommended at first visit and again at 28-32 weeks into the pregnancy.

REPORTING

HIV Cases: A confirmed positive HIV test must be reported to the Florida Department of Health by every laboratory, as well as by any physician who diagnoses or treats a case (since July 1997).

AIDS Cases: All persons who diagnose or treat an AIDS case must report it to the Florida Department of Health (since 1983).

- *Approximately 90% of all diagnosed HIV/AIDS cases are reported, which is the highest completeness rate of all diseases.*
- *Through 2005, nearly 137,000 HIV/AIDS cases have been reported in Florida; 55,000 have died.*

PLWHA: Person living with HIV/AIDS at a given time (reported case).

- Through 2005, there were 81,585 PLWHA in Florida.
- Blacks account for 51% of all PLWHA, but only 14% of the population.
- HIV/AIDS is the leading cause of death among black males and black females aged 25-44 years.

One-in Statements Among Persons Living with HIV/AIDS (PLWHA) by Race/Ethnicity / Top 20 Counties, Florida, Through 2005*

Whites: County	One in...	Blacks: County	One in...	Hispanics: County	One in...
Monroe	119	St. Lucie	35	Monroe	179
Miami-Dade	143	Palm Beach	42	Miami-Dade	182
Broward	207	Miami-Dade	44	Broward	216
Orange	284	Collier	55	Orange	237
Hillsborough	375	Broward	58	Palm Beach	252
Pinellas	439	Monroe	60	Manatee	298
Duval	456	Manatee	70	Pinellas	298
Palm Beach	503	**Lee**	**72**	Hillsborough	309
Escambia	539	Hillsborough	85	Brevard	351
St. Lucie	701	Duval	88	Volusia	353
Volusia	729	Orange	90	**Lee**	**359**
Alachua	737	Sarasota	92	Collier	366
Sarasota	743	Pinellas	98	Duval	369
Lee	**768**	Volusia	104	St. Lucie	430
Brevard	777	Polk	117	Seminole	431
Manatee	797	Brevard	119	Sarasota	465
Polk	803	Alachua	120	Polk	524
Seminole	990	Seminole	148	Escambia	572
Collier	1140	Escambia	150	Leon	668
Leon	1358	Leon	162	Alachua	870

"SILENCE IS DEATH - The Crisis of HIV/AIDS in Florida's Black Communities", documents the disproportionate impact of HIV infection in minority communities. *"SILENCE IS DEATH,"* reports some of the underlying factors contributing to these racial disparities:

1. Amount of HIV already in the community
2. Late diagnosis of HIV or AIDS
3. Access to and acceptance of diagnosis and care
4. Stigma and denial, including fear of disclosure of HIV-positive status
5. Discrimination and homophobia, including fear of disclosure of being an injection drug user (IDU) or a man who has sex with men (MSM)
6. Poverty and unemployment
7. Delayed prevention messages (long considered a gay, white male disease)
8. Non-HIV sexually transmitted diseases in the community
9. HIV/AIDS conspiracy beliefs, reflecting mistrust of the health care system
10. Sexual and needle-sharing behaviors
11. Incarceration
12. Many complex factors related to socioeconomic status

Destination: Antarctica

Dean Traiger, MD

Indiana Jones went to exotic places to retrieve treasures and artifacts from ancient ruins. In this real life movie, I went on a treasure hunt to the bottom of the world.

The Preparation

Preparation for the journey began long before we set foot in Antarctica. The trip was 16 months in the planning. Coming from Florida, we were lacking the correct clothing so several months were spent researching different outfitters and choosing the correct extreme cold apparel. A physical exam and certificate of health was needed from our physicians to reduce the chances of a medical emergency while on the remote continent. As part of my research, I studied the history, fauna and flora and looked at maps of Antarctica. I found the history fascinating and several times found myself wondering why I was never taught this in school. I also discovered that there are very few good maps of Antarctica available (for free) on the Internet, so I purchased the Lonely Planet series book: *Antarctica* which was just what I needed. I highly recommend this book to anyone who plans to visit the continent.

The Beginning

Every thousand mile journey begins with the first step. In this case, the first step was going to Miami. From Miami we took a red-eye flight (about 8 ½ hours) to Buenos Aires, Argentina. Sadly, this was just a quick stop and little time to explore the city was available. The next flight was (4 ½ hours) to Ushuaia, Argentina. It is the southern-most city on Earth and is know as "Fin del Mundo" – literally the end of the world. Ushuaia is a beautiful city with an interesting history. It is a port on the Beagle Canal, on Ushuaia Bay. Settled in the 1870s by English missionaries, it was taken over by Argentine naval forces in 1884. The city was known for having a large national prison – and convicts guilty of serious crimes, many for lifetime or long sentences were sent there.

The Professor Molchanov

Even 5,700 miles from home we still had 2 days at sea before we would reach the Antarctic peninsula. The *Professor Molchanov*, a Russian vessel, was built in Finland in 1982-83 for polar and oceanographic research and carries a maximum of 48 passengers. With an ice-strengthened hull and passive stabilizers (aka no stabilizers) it is able to navigate scenic areas for smooth sailing where many other vessels cannot. The ship comprised of 33 passengers, 20 crew members and 10 expedition staff. An American, 2 British, a Scotsman, a Dutch chef and "John the doctor". This was our home for our 9 day voyage to Antarctica.

The Drake Passage

The Drake Passage has earned a place in history as having some of the roughest sea weather on the planet. The Drake Passage occurs where the fast flowing southern ocean waters are squeezed between the continental land masses of South America and Antarctica. Storms frequently whip the ocean into a dark grey turbulent, heaving mass of water, renowned for sinking many a ship. Satellite images show a cyclonic low of basically hurricane strength travels through the Drake Passage on the average of once every three weeks. The Drake Passage is referred to as either the "Drake Lake" or the "Drake Shake" depending on the roughness when you travel. The Professor Malchanov was ice strengthened and thus had a very shallow hull, which caused it to roll quite a bit in the open seas. In the 'Drake Shake' the ship usually rolled between 20 and 35 degrees. Every now and then, a rogue wave would roll the ship up to 42 degrees! When it did, there was nothing to do but hang on!

As the Drake's turbulence calmed down, we spotted some humpback whales very close to the ship. They are the first real Antarctic wildlife we encountered besides the albatrosses and the cape petrels and other birds that follow the ship. But these are huge graceful whales - and they are very impressive. They surface and blow, and glide so effortlessly back under water. We observed a group of 4 whales feeding on a shoal of fish and playing together.

The Antarctic

Finally, 3 straight days of traveling and 6,500 miles from Florida we reached the calm waters of the South Shetland Islands. Our first stop was on Half Moon Island, a small chinstrap penguin rookery with about 2,000 penguins. The chinstraps were going about their chinstrap business. The level of activity in a penguin colony never ceased to amaze me. You'll never see anything like that in a zoo. Yes, they really are that cute in person but the thing that you don't appreciate from pictures, television or movies is the ***smell*** of 2,000 penguins making guano. They were all nesting on their eggs and since they can't leave the nest to go find the little penguin's room, they will just lift tail and aim at their nearest neighbor. I guess that is payback for their mates stealing stones from each others nests all day long. Another interesting fact is that since penguins eat mostly krill (small pink shrimp-like sea creatures), they produce pink guano!

Baily Head

I thought a colony of 2,000 chinstraps was impressive until we visited Baily Head which has a colony of 200,000 chinstraps! The sights! The sounds! The smells!

Baily Head is a rocky headland on the south east coast of Deception Island. It was named after Francis Baily, the English astronomer who reported on Foster's magnetic observations at Pendulum Cove. The site comprises the southern end of a long linear beach which runs along most of the eastern side of Deception Island, and a narrow valley that rises steeply inland to a semi-circular ridgeline, giving the impression of a natural 'amphitheatre'. It is bounded to the north by a large glacier and to the south by the cliffs of Baily Head. A substantial melt-stream runs through the center of the valley during the austral summer. It clears of snow and ice early in the summer and provides optimal breeding grounds for the chinstrap penguins who must nest on dry ground.

Deception Island

The approach to Deception Island is almost certainly the key to its name. Deception Island is a dormant volcano with its peak imploded, forming a caldera that is now flooded by seawater that enters via Neptune's Bellows. Amid a stiff, whistling breeze, our ship slowly and precisely came about, lining itself up with a navigation marker now visible just inside the bay. A picture of concentration, the captain, flanked by his officers at the radar and depth-sounder, threaded the ship through the eye of the needle that is Neptune's Bellows, a narrow chink in the encircling cliffs that form a natural bowl for the port.

We put ashore in front of the ghostly buildings weathered, not just by time, but by the ravages of several fierce eruptions in the late 1960s that ultimately led to the evacuation of the old facility. The station was evacuated temporarily on Dec 5, 1967 after volcanic eruptions. It was evacuated permanently after Feb 21, 1969 when further eruptions damaged the station buildings. Originally set up at the turn of the century to shelter whalers and sealers, it quickly grew into a full-scale, if grossly inefficient, processing factory. Early whaling was messy and wasteful, and at one time it was reckoned that about 6,000 partly butchered, putrid beasts floated in the bay.

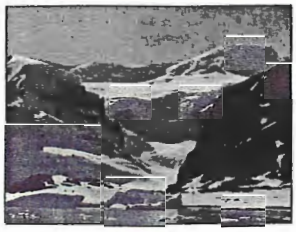
Our small party set out to explore what was once an Operation Tabarin base. A precursor to the British Antarctic Survey, Operation Tabarin was a secret British wartime activity that secured allied control of the southernmost regions and kept a lookout for Nazi killer whales and fascist penguins.

Black lava covers the beaches. Hiking on the beach felt like we were on another planet -- firstly the terrain was totally different from anything else we'd seen, and secondly because we were all in our goofy water/wind/rain/cold-proof getups that made us look like astronauts or something. Along the hike everyone took their turns unwittingly walking through the territory of a couple of Antarctic terns. They didn't appreciate the invasion, so they dive-bombed everyone who trespassed.

The other favorite activity of Deception Island is the swimming. "Swimming" is a generous term. The water was plenty warm right on the edge of the shore, but quickly cooled off as you wandered out into the bay. As a result, if you wanted to avoid freezing you had to lie on the edge of the shore where the water just covered your body. If you started to get cold, all you had to do was plunge your hands into the sand to release more heat. A few stalwart people did swim out to a near-by iceberg.

Port Lockroy

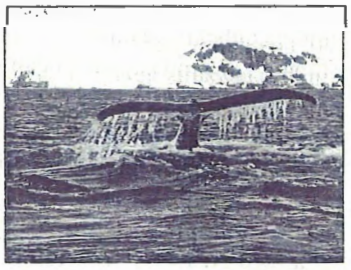
Port Lockroy is the site of the Penguin Post Office. Port Lockroy was established on 16 February 1944. The station was thus the first permanent British Antarctic station in Antarctica. Today the station is a tourist hive with museum, gift shop and post office. The station is now operated only in the summer season and staffed by 3 people. The 3 staff sleep, cook and live in a single room, leaving the rest of the station intact. In order to limit potential damage, they also have no heating, not even in their room. Besides serving the tourists, some research is done on the effect that tourists have on penguins, as there is a large Gentoo colony on the island, some even nesting in the doorway. Results to date have shown little effect on the penguins, which is good news for Port Lockroy as it is now the most visited site in Antarctica by tourists.



Petermann Island and Pleneau Bay

Our most southern plunge in this white world of wonderment. We had reached the point where we needed to start back to our society of insanity and complexities. In our pre-landing briefing we learned that this island is the home of 2,000 mixed Gentoo and Adele penguins, nesting Blue-Eyed Shags and 3 humans. Part of the island was off-limits to us since it was an active research area for the 2 American women and 1 British man who were living on the island for the past month. They lived in tents with the barest of amenities. No showers, a porta-potty and when they completed their research and left the island, they would take everything with them leaving the area as pristine as it was when they arrived. Pleneau Bay is just south of the Lemaire Channel. Here we boarded our Zodiacs for an iceberg tour. Large tabular icebergs as big as office buildings have been cast aground in the shallow bay. We saw many penguins in the water swimming by us and were visited by a pair of curious Minke whales. Usually Minkes are shy and avoid boats, however on this day they came right up to our boats to look at us. Imagine you are in a 15 foot rubber raft with a 30-35 foot whale weighing several tons putting his nose up to your boat. It was astonishing and more than a bit intimidating. We looked each other in the eyes for over a minute and then ever so gently he/she passed under our boat.

Melchior Islands



The Melchoir Islands are a group of many low, ice-covered islands lying near the center of Dallmann Bay in the Palmer Archipelago. A favorite hangout of whales. Again we boarded our Zodiacs and toured the islands. One of the drivers spotted a pair of humpback whales and off we sped for a closer inspection. What a sight to behold having two 45-ton creatures calmly coming up for air. The Zodiac engines were off as we waited for them to come up again. Suddenly one surfaced 10 feet from my boat. All you could hear for miles around when they surfaced was the force of air shooting out of their blowholes. And then the camera shutters. A couple of surfacings later and they went for the deep dive exposing their flukes as they pointed their heads straight down into the water.

Drake Passage

Sadly, we turned northward back into the dreadful Drake. However, this time there was much joy and merriment on the way back as we all shared our photos and video clips. One talented passenger even gave us a slideshow presentation of her best photos set to music that left us all teary-eyed. Soon, we docked in Ushuaia, hugged our new friends good-bye and returned to our regular lives. Reflecting on our journey, I think we all left Antarctica with a greater appreciation of the world we live in and a new found yearning to return to the white continent.

Total miles traveled 12,800 miles (round-trip)
From North 26° to South 66° **and** West 081° to West 059°

Hospital Peer Review Tips

Jeffrey Cohen, Esq.

Being investigated by the peer review committee of a hospital is one of the most stressful things a physician can experience. Yet, knowing a little law and exercising some common sense can help dramatically.

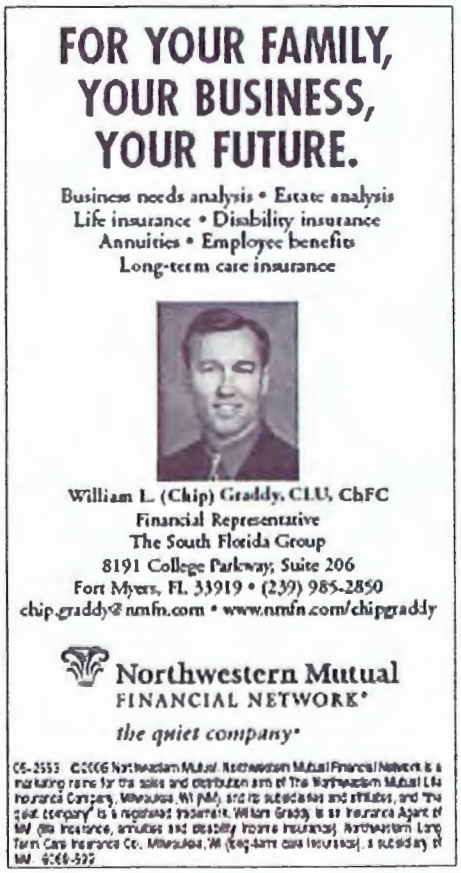
Peer review activity is authorized by both federal and state law. The reason for the laws is to ensure that patients are well cared for in licensed healthcare facilities. As such, the laws make peer review fairly simple for the reviewing facility. For instance, facilities must provide the affected physician written notice and afford the physician a "fair hearing" with certain procedural benefits like the right to examine and cross examine witnesses and also the right to submit a written statement upon the close of the hearing.

The laws cloak the process in confidentiality in hopes that this will encourage participants to be honest and feel free to actively participate in the process. And if the facilities provide the affected physician a fair hearing by following the procedural requirements of the laws, the facilities and those who testify in the process are immune from liability for antitrust violations. Peer review is intended to resolve quality concerns on an intraprofessional basis. Moreover, it is easy for the healthcare facility to comply with the applicable laws. Finally, lawsuits against healthcare facilities in connection with peer review have rarely, if ever, been successful. From the affected physician's perspective, the reviewing facility has a huge advantage.

In truth, practically speaking, peer review is a last resort. It arises typically after multiple committees have reviewed the concern and usually after many discussions with the affected physician. A matter goes to peer review usually out of the medical staff's perception that their quality concerns are not being heard or taken seriously by the affected physician.

Nevertheless, affected physicians have a great deal of control in the matter; and the outcome will depend largely on how they view the process and participate in it. For instance, if the doctor views the process as a personal attack, it will be difficult to participate meaningfully and positively. The trick for the affected physician is to not take the process personally. If the physician takes the position of "You're wrong; and I'll fight you," the process will be adversarial and the outcome will be painful. If instead, the affected doctor takes the position of "Help me to understand and address your concerns," the process can be smooth and the outcome can be positive, even beneficial. This is not to say that affected physicians should simply lie down. In fact, that will be as unhelpful as being combative. Instead, seek to understand and communicate.

Many physicians are motivated in the peer review process by fear associated with a report to the National Practitioner Data Bank ("NPDB"). NPDB reporting is basically triggered by peer review activity that involves quality issues. If, however, the doctor allows the fear of an NPDB report to control him or her, it will typically lead to the physician hardening his position in the process. In other words, the fear of an NPDB report often causes a physician to lose his or her best advantages: an open mind and willingness to discuss and compromise. In truth, an NPDB report is not a death knell to a physician's professional career. In fact, the doctor has the right to respond to an NPDB report, and the response will be available to those who query the NPDB. Affected physicians should remember that nearly every doctor who has been sued or who settles a claim has been reported to the NPDB, no matter how ludicrous the claim may be. Still, NPDB reports can raise questions and are upsetting. As such, affected doctors should address the medical staff's concerns at the earliest opportunity. In fact, the best way to avoid NPDB reporting is to simply address the medical staff's concerns before the matter rises to the level of peer review.



Odds & Ends

CMS STRENGTHENS EMERGENCY PREPAREDNESS COMMUNICATION—The Centers for Medicare & Medicaid Services (CMS) is working to strengthen its emergency preparedness communications infrastructure for the nation's health care providers. As part of this emphasis, CMS is encouraging all health care providers to subscribe to their contractor's listserv in order to remain informed in case of either a regional or national emergency.

You may access First Coast Service Options, Inc. (FCSO) *eNews* mailing lists through the provider educational website (*www.floridamedicare.com*). Click on the "eNews" on the top navigational menu of the home page. Select "FCSO eNews Lists/Interest Groups" on the FCSO eNews Electronic Mailing List Service main page, or use the following link:
http://lb.bcentral.com/ex/manage/subscriberprefs.aspx?customerid=8380

Providers should have a designated employee subscribed to monitor the Florida Medicare listserv and a contingency plan in effect on how to deliver the necessary information throughout the provider's organization. CMS also recommends that there be at least one alternate employee who also subscribes to serve as a backup.

This communication tool is an effective and rapid way to disseminate critical information in the case of a regional or national emergency.

MAINTAINING CONTROL OF YOUR PATIENT RECORDS—Florida law requires physicians to maintain adequate patient records for each patient. There is no requirement that these records be stored in a paper format, so electronic records meet the requirement. However, physicians should be careful to ensure that they are able to access those records. A Florida company recently made national news when it was accused of cutting off doctors' access to electronic patient files over a dispute relating to payment of higher tech support fees. Unfortunately, there is no current federal or state law to prevent a company from doing this. Make sure that whatever method you use for storing patient records allows you access to the records now and in the future.

MEDICARE PROVIDER ENROLLMENT BACKLOG—The FMA has received calls regarding delays in obtaining Medicare provider numbers. The FMA is working with First Coast Service Options, Inc., (FCSO) to identify and correct the problems that exist. FCSO currently has about a 30-day backlog on provider enrollment applications. They are hiring and training new people to help with this backlog, and hope to be caught up in about 60 days. They are processing clean applications within the 60-day time period allotted by CMS.

What Providers Can Do To Prevent Delay In Applications:
1) Be sure that you notify FCSO of any change in address, or other status. If your checks are going into the Do Not Forward (DNF) file because you have not provided FCSO with a change of location or other changes, nothing can be entered into your profile until the DNF has been corrected, that takes 45 – 60 days, then another 60 days for a clean provider enrollment application. 2) Be sure you read the instructions provided with the application before you fill it out. FCSO is not allowed to "walk" a provider through the application process. 3) Go slowly when filling out the application—be sure it is complete, and be sure all of the attachments are there. If the application is not complete when it comes in to FCSO, a development letter will be sent to you, and you will have 60 days to get the information back to FCSO, then the process and time frames start over when they receive it. CMS says the average time for filling out a provider enrollment form is about six hours, so take the time frames into consideration when you start the process. 4) If you have hired a consultant to do your applications for you, be sure that consultant is qualified to handle the job you have asked them to do.

IMPORTANT ADVICE CONCERNING YOUR NATIONAL PROVIDER IDENTIFIER (NPI)—Take control of your NPI. If you are a billing provider, your NPI will be your billing number for life. Your NPI does not belong to your employer or to any health plan, even if your employer or a health plan obtained it for you by bulk enumeration. It is the one number that identifies you as a health care provider in standard transactions with other health care providers, health plans, and health care clearinghouses.

2007 SYMPOSIA:

- **Cutting Edge Diagnosis & Treatment: A Course for the Practicing Physician**
  February 8-10, 2007 at Naples Beach Hotel and Golf Club, Naples, Florida. Director: Ronaldo Carneiro, MD
- **6th Annual Otolaryngology Symposium**
  March 15-17, 2007 at Naples Beach Hotel and Golf Club, Naples, Florida. Director: David Greene, MD
- **Geriatrics Update: Contemporary Geriatrics for the Practicing Physician**
  March 22-24, 2007 at Naples Beach Hotel and Golf Club, Naples, Florida Director: Leela R. Bolla, MD

The meetings listed are upcoming CME activities sponsored by Physicians Regional Medical Center (formerly Cleveland Clinic). For further information, please contact Teri A. Antonucci at 239-348-4366.

Florida's Insurance Assessment Funds

Angie Nykamp, FPIC

First Professionals Insurance Company announced recently that it filed for a base rate decrease of 8 percent. If not for an assessment by the Florida Insurance Guaranty Association (FIGA), those rates would have gone down by an additional 2.2 percent.

The assessment was made, as required by state law, because of the insolvency of the insurance subsidiaries of the Poe Financial Group (Poe). Even though Poe did not write medical malpractice, all licensed property and casualty insurers in Florida are required to pay the FIGA assessment. FIGA is state-created and is funded by assessments against property and casualty insurers in Florida. In the event a licensed property and casualty insurer in the state goes bankrupt, its losses are paid by FIGA, which helps to further protect Florida policyholders.

The FIGA assessment should not be confused with the CAT Fund assessment, which applies strictly to hurricane losses. The CAT Fund is essentially a vehicle for reinsurance within the state of Florida, typically less expensive than market reinsurance, for insurers who pay hurricane losses.

Medical malpractice insurers were given an exemption from the CAT Fund for hurricane years 2004, 2005 and 2006. Unless the legislature renews that exemption, medical malpractice insurers will return to the CAT Fund with the hurricane year beginning June 1, 2007.

A CAT Fund assessment is a straight pass through. The current assessment percentage (from which medical malpractice insurers are exempt) is 1 percent. It is estimated to be paid by Florida policyholders for the next seven years to cover the cost of the bonds sold to pay hurricane losses in 2004 and 2005.

If you have any additional questions please feel free to contact me via e-mail or by phone at (800) 741 3742, Ext. 3071.

Senior and Retired Physicians Association

Jim Dougherty, MD, SARPA Founding President

Ten years ago at the suggestion of Ann Wilke, a small group of retired doctors seeking full or part time retirement in Lee County formed an organization which we called "Senior and Retired Physicians Association (SARPA)". What motivated us, all physicians of diverse specialties from any areas of the country, was shared desire to remain connected to medicine in some way. How better to do it than to make new friends in this new environment, socialize with them and their spouses as full members (only $25 annually per household). Recruitment was largely by word of mouth.

We grew from the initial 16 doctors to a combined membership last year of 210. SARPA holds monthly meeting from November through April including 1 luncheon, a holiday dinner dance, and 4 evening events. Our programs are not technical. Rather we endeavor to have speakers on subjects of general interest. They are held at local country clubs, the Royal Palm Yacht Club and usually a season ending river cruise. It is worthy of note that should a doctor member predecease his/her spouse the survivor remains a member with no dues obligation other than the cost of meals at meetings. Thus, close relationships are maintained, and indeed, this has proven to be the case in the past.

Our original service objectives have come to pass with voluntary activities through Lee Memorial, Disaster Defense Corps, We Care support with several school activities, CME programs, speakers for civic organizations upon request. Several of us were instrumental in lobbying the legislature for limited licensure to do volunteer work for the medically disadvantaged.

However, our main objective remains social, bringing retired physicians and spouses together socially. It has been received enthusiastically judging by our steady growth. We have failed, unfortunately, in only one respect — getting retired Lee County doctors to come aboard. Please give it some thought and contact our membership chair Dr. Lynn Boynton (239-395-1443) or our President, Dr. Bill Graham (230-283-4151). We want your participation as new friends and colleagues.

Henderson Franklin's Health Law Group represents the interests of health care providers and health care related businesses.

Henderson|Franklin ATTORNEYS AT LAW

The hiring of a lawyer is an important decision that should not be based solely on advertising. Before you decide, ask us to send you free written information about our qualifications and experience.

Fort Myers • Bonita Springs • Sanibel
239.344.1100 • www.henlaw.com

Why Medically Defensible Claims Get Settled

by Cliff Rapp, Vice President, Risk Management, FPIC

Frequently, physicians assume that when an otherwise medically defensible claim is settled, economy was the reason. Before making that assumption, consider that First Professionals Insurance Company (First Professionals) does not make economical settlements in non-meritorious cases merely to avoid the cost of a defense. Moreover, from a purely economic standpoint, the average malpractice settlement far exceeds the average cost of a defense. The fact of the matter is that there are a number of reasons why settlements are made, and sometimes necessitated, in claims which the care and treatment is perfectly acceptable.

Often the reason necessitating settlement can be traced to inadequate risk management practices that facilitate claims and undermine defensibility. Other factors that explain why medically defensible claims get settled include:

- *Inadequate coverage.* This is best illustrated when damages exceed policy coverage limits. Can the physician afford the risk of personal financial exposure?
- *Factual discrepancies.* Issues of law are decided by the judge; however, issues of fact are determined by a jury. Consequently, the composition of the jury is tantamount to prevailing on questions of fact.
- *Documentation.* Does evidence in the form of medical records support the defense?
- *A defendant's witness potential.* Essentially, will the jury like the doctor?
- *A plaintiff's witness potential.* Is the non-physician jury more likely to identify with the patient than the doctor under the circumstances?
- *Supportive testimony.* Will prior and subsequent treating physicians support the defense or inure to the plaintiff?
- *Sympathy factors.* Will the nature and extent of the plaintiff's injury overwhelm the jury?
- *Case venue.* What is the bias of the county towards defendants and in particular, physicians?
- *Plaintiff attorney.* What is the caliber of opposing counsel? Has the attorney achieved good courtroom results in similar cases?
- *Applicable case law.* What influence will applicable case law or previous court rulings have upon the defenses raised?
- *Punitive damages.* What is the likelihood of punitive damages being awarded?
- *Claim Experience.* Does the physician have a history of claims? Can the history be used against the physician?
- *Unfavorable rulings.* Has the judge ruled unfavorably for the defense during discovery of the case? How likely will subsequent rulings during trial favor the plaintiff's case?
- *Publicity factors.* Will a trial result in detrimental publicity or media coverage?
- *Impact of an adverse verdict.* What impact will an adverse verdict have upon the doctor's future ability to practice medicine?

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. First Professionals 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.

First Professionals Insurance Company is Florida's Physicians Insurance Company and the endorsed carrier for professional liability insurance.

Medicare Advantage Plans Record Retention for 10 Years

100.4—Provider and Supplier Contract Requirements (Rev. 79, Issued 02-17-06, Effective Date 02-17-06)

Contracts or other written agreements between MA organizations and providers and suppliers of health care or health care-related services must contain the following provisions:

- Contracting providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records;
- Contracts must specify a prompt payment requirement, the terms and conditions of which are developed and agreed-to by the AM organizations and its contracted providers and suppliers;
- Contracts must hold Medicare members harmless for payment of fees that are the legal obligation of the MA organization to fulfill. Such provision will apply, but will not be limited to insolvency of the MA organization, contract breach, and provider billing;
- Contracts must contain accountability provisions specifying: That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist and provide information as requested, and maintain records a minimum of 10 years.

Lee County Medical Society

3805 Fowler Street Ste 2
PO Box 60041
Fort Myers, FL 33906-0041

PRSRT STD
US POSTAGE
PAID
FT MYERS, FL
PERMIT NO 534

It Pays To Be a Member
of the Lee County Medical Society

Florida-based First Professionals Insurance Company (First Professionals) is the official provider of professional liability insurance for LCMS members.

Members in good standing with the LCMS are eligible for a 5 percent discount on malpractice premiums. LCMS members may also be eligible for additional claims-free discounts for even greater savings up to 25 percent.

We are Florida's Physicians Insurance Company℠

For more information visit our Web site at www.firstprofessionals.com or contact Angie Nykamp, Director of Society Relations, FPIC, 800-741-3742, ext. 3071 or by e-mail at angie.nykamp@fpic.com

FPIC®
First Professionals Insurance Company