July 2008
Volume 32, Issue 2

LEE COUNTY MEDICAL SOCIETY

Bulletin

Editor: John W. Snead, M.D.

2008 LCMS General Membership Meetings

NO MEETINGS FOR THE SUMMER MONTHS OF JULY AND AUGUST

Thursday, September 18, 2008
Royal Palm Yacht Club
2360 West First Street
Fort Myers, FL
6:30 p.m.

Thursday, November 20, 2008
Royal Palm Yacht Club
2360 West First Street
Fort Myers, FL
6:30 p.m.

Make reservations to:
Lee County Medical Society
239-936-1645

Pictorial Directories Available

2007-2008 LCMS Pictorial Directories are available for your office and patients at no charge. They can be picked up at our office at:
3805 Fowler Street, Ste 2
Fort Myers, FL 33901

Insert

- **How to Appeal Inappropriate Health Care Claim Denials**
- **Special Needs Shelter Sign Up**

Inside this issue:

President's Message

Disaster Preparedness Part 1

Are We As Prepared As We Think?

Dean Traiger, M.D.

At the previous Medical Society meeting in May, we were privileged to have Dr. Anna Marie Pou, MD and Richard T. Simmons, Esq. speak to us about their experiences regarding the medical, ethical and legal challenges of natural disasters.

The New Orleans surgeon was accused of administering lethal painkiller injections to four elderly intensive-care patients at Baptist Memorial Medical Center in New Orleans three days after the landfall of Hurricane Katrina in that city.

Let's revisit August 29, 2005 - Hurricane Katrina makes landfall in New Orleans battering the coast with 135 mile-an-hour winds. Just the day prior, the mayor of New Orleans ordered a mandatory evacuation of residents, however there was no mandatory evacuation for hospitals. They were expected to ride out the storm and the hospital administrators thought they had an adequate plan. The levees protecting the city breeched, and the city flooded. On August 30th, 85% of the parish (county) was underwater, up to 10 feet in places.

The patients whom Dr. Pou was accused of killing were patients of a company called Lifecare, which ran a long-term acute care facility for the extremely ill. Dr. Pou and other medical staff were caring for these patients after the doctor assigned to care for them did not appear.

The hospital conditions were greatly overcrowded. Not only were they sheltering the patients and the staff, but the families (and about 120 pets) of the staff as well of some of the families of the patients were also sheltered at the facility. The generator for the hospital was constructed in the basement so when it flooded they had no electricity. No fresh or running water was available. It was August; therefore the heat and humidity were intense. Food and supplies were limited. The bathrooms were non-functional, so personal hygiene was an important issue. The morgue was not working without electricity and was also underwater, so dealing with where to place the 34 deceased was also a problem they confronted. There was no communication with the outside world, other than what they could get from people on the street or occasional helicopter that eventually came to start evacuating the hospital. Doctors could hear gunshots in the vicinity of the hospital but despite the danger to their patients, officials told the doctors that evacuating Memorial was not as high a priority as evacuating citizens stranded on rooftops.

Why were they so isolated? FEMA and state agencies had no organized plan for hospital evacuations (government officials assumed that hospitals would be self-sufficient for 5-7 days). All local, state and federal authorities were overwhelmed. Also there were no coordinated efforts between governmental agencies; they were the victims of their own operational and communication unpreparedness.

When rescue finally came to Memorial Hospital, it was not quick and efficient. Sporadic helicopters would arrive once or twice a day and there were boats that would come and go. Those that could walk were evacuated by boat and those that could not by helicopter.

Pets were not evacuated. The most critical patients, those that were not expected to survive, were left behind to die. This was a huge shock to the families and medical staff, who did not understand and were not mentally prepared to deal with the reality.

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LEE COUNTY MEDICAL SOCIETY BULLETIN
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Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and enforcement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.

All LCMS Board of Governors and Committee meeting minutes are available for all members to review.

Membership Activity

If you have a new physician in your practice or know a new physician coming to town, please contact the Lee County Medical Society at 936-1645 and we will send them an application.

New Address

Carmen Barres, MD
Lee Physician Group
1303 Homestead Road
Lehigh Acres, FL 33936
Tel: 239-303-0926

Stephen Kaskie, MD
10915 Bonita Beach Road
Bonita Springs, FL 34135
Tel: 239-947-4100

Brian Kurland, M.D.
13685 Doctors Way Ste 310
Fort Myers, FL 33912
Tel: 239-936-8575

Michael Verwest, M.D.
Charlotte County VA Clinic
4161 Tamiami Trail Unit 4
Port Charlotte, FL 33952
Tel: 941-235-2712

Juan Domingo, M.D.
Salvatore Lacagnina, D.O.
Dirk Peterson, M.D.
Bharath Radhakrishna, M.D.
Lee Physician Group
1682 NE Pine Island Road
Cape Coral, FL 33909
Tel: 239-424-1600

Edward LaMotta, M.D.
600 Tarpon Bay Road
Sanibel, FL 33957
Tel: 239-395-2444

Katie Drake, D.O.
517 Tamiami Trail
Punta Gorda, FL 33950
Tel: 941-575-9845

Reactivation

H. Lee Adkins, D.O.

Dropped for Non-Payment

Lewis Chaikin, M.D.
Earl Gurevitch, M.D.
Fred Liebowitz, M.D.
Richard Liu, M.D.
Douglas Newland, M.D.
Linda Yarris-Ewert, M.D.

Moved Out of Area

Richard Boothby, M.D.
Richard Fernandez, M.D.

New Practice

William Wittenborn, M.D.
Wittenborn Plastic Surgery
6811 Porto Fino Circle
Fort Myers, FL 33912
Tel: 239-561-2313

New Phone & Fax Numbers

Associates in Neonatology
Tel: 239-343-6906
Fax: 239-343-6915

Closed Office

Angel Pietri, MD

Members in the News

This section is for Lee County Medical Society members' accomplishments. Please send in your newsworthy items to the Medical Society office to fax 936-0533 or email awilke@lcmsfl.org.

Joseph O'Bryan M.D., has retired from medical research at The Heart Group. Prior to medical research Dr. O'Bryan was an internist in Lee County from 1968-1997.

Joseph Walker M.D. and Paul A. Raskauskas, M.D., were named Gulfshore Life Magazines' *"Top Doctors of 2008"* for the third year. Dr. Walker and Dr. Raskauskas are ophthalmologists who specialize in the treatment of the retina and the vitreous. Their practice Retina Consultants of SWFL is located at 6901 International Center Blvd Ste 101, Fort Myers—939-4323.

New Member Applicant

Syeda Khan M.D.—Dr. Khan attended Osmania Medical College in Hyderabad, India where she obtained her MD in 1999. She completed her internship/ residency at Temple University Hospital in Philadelphia, PA (1999-2005). She completed a fellowship at Temple University Hospital in Philadelphia, PA (2005-7). Dr. Khan is board certified by the American Board of Internal Medicine in Internal Medicine and Nephrology. She is in practice with Associates in Nephrology at 7981 Gladiolus Drive Fort Myers, FL 33908.

As I Recall...

Roger D. Scott, M.D.

Golden Anniversary

It was July 1, 1958 (50 years or 600 months or 18,262 days [38 years of 365 days plus 12 years of 366 days] or 438,288 hours or 26,297,280 minutes and approximates 21,037,000,824,400 heartbeats @ 80 per minute [however my heart has been fibrillating for about 18 years and sometimes only 40 per minute so that may be inaccurate] and 315,567,360 respirations assuming 12 per minute which is possibly also erroneous as I frequently hold my breath for long periods of time) that I first opened my office in Fort Myers for the practice of general surgery. There are few sentences that rival the length of that first one!

This is the 133rd *As I Recall* article (and its 13th anniversary) so you may possibly find duplications, but most likely you will have already forgotten them from previous articles!

When coming directly to private practice from residency my greatest fears were whether this semi-hostile (medically speaking) small isolated Southwest Florida community was the proper place to locate, and was I competent. Well one of the beauties of aging and experience is knowing my fears were unwarranted. The people over the years have proven to be beautiful and good. The territory was wonderful and beautiful but is now rapidly deteriorating into a concrete jungle. Guess this must be considered progress but so many changes have occurred in this community making us a semi-metropolitan area.

The medical community rapidly became less semi-hostile and accepted me nicely. I always worked hard and was available days, nights, and weekends (including the emergency room), and my practice of general surgery expanded rapidly without practicing any general medicine.

For those of you who may have forgotten, general surgery included all phases of surgery and in the early days here it was necessary for me to cover all the sub-specialties except for ophthalmology (except when Leland Glenn was unavailable), urology, and gynecology. As each new sub-specialists came to town they could take over their part from me. Bill Dakos (ENT) arrived in 1960, and how relieved I was at not having to do tonsillectomies, nosebleeds etc. Jack Warnock returned from orthopedic residency in 1959, but he didn't especially like doing emergencies so I continued to practice orthopedics until about 1972 or so. Vascular surgery was still in its infancy. Synthetic arterial grafts were quite new, but I had done a few while in training, but were unsatisfactory until a few years later when improved grafts were developed. Vascular surgery was rapidly developing, and I quit doing it in the 1970's. I only did neurosurgery in life threatening emergencies when patients could not safely be transported to Tampa or Miami (no helicopters) and the same for thoracic surgery. There were no designated "Trauma Surgeons" for many years. Gradually the field of general surgery narrowed down to abdominal surgery, hernias, ano-rectal problems, breast diseases, lumps, bumps, and such.

The first operation I did was a Lumbar Sympathectomy (the first one ever performed here) for Peripheral Vascular Disease. I had done about 80 of these in training as this was one of the few operative procedures that was available for P.V.D. The second operation was an Abdomino-Perineal Resection (APR), but I had only performed one or two in training. This was a big and scary procedure, and it went slowly but well. So it was that the first two patients survived and didn't put a black mark against me in the community. (Everybody knew everybody else's business in this small community.)

Very commonly occurring peptic ulcers were thought to be due to acid hypersecretion and now today we know it's due to a Bacillus! The indications for emergency surgery on peptic ulcers were: uncontrolled or recurrent hemorrhage, obstruction, or perforation. The indications for elective surgery were primarily chronicity and pain. There were several surgical procedures utilized for ulcers. In 1958, the procedure of choice was a subtotal gastrectomy (removal of 75% or more of the stomach with anastomosis of the gastric pouch to the small intestine). Unfortunately ulcer patients were usually obese as they had ingested large quantities of Half-and-Half (milk and cream) to try to neutralize the hyper-acidity). Obesity increased the difficulty of an already difficult surgery especially when emergent in the middle of the night. A few years later Hemi-Gastrectomy with Vagotomy (removal of 50% or less and removal of a small segment of the left and right Vagus nerves) was in vogue. Other procedures were also recommended later on, but it was the arrival of Tagamet (medication) that practically obliterated gastric procedures for ulcers. Today these are extremely rare operations.

It was late 1958 or early 1959 that one on the internists admitted a 17 or 18-year-old migrant female worker with severe hemorrhaging from a suspected peptic ulcer, and that night I was asked to see her. She continued bleeding profusely and was not responding to any therapy so; therefore, we went to the operating room immediately. Fortunately she was thin and without any symptoms of ulcer disease prior to this episode so it was easy to open the duodenum and find a large ulcer with a large pulsating artery in its base. I turned to get a suture, and upon looking back there was no further bleeding. I asked the old nurse anesthetist how the patient was, and she said "fine", but there was no pulse palpable in the abdominal aorta indicating that the patient had a cardiac arrest. Cardiac massage performed by compressing the heart through the diaphragm failed to render a palpable pulse and so I rapidly opened her chest and did open cardiac massage. After about 17 or 20 minutes of massage with anesthesia discontinued and the patient getting only oxygen, her heart beat resumed in normal function. The nurse anesthetist was unaware that the patient had been over anesthetized! I went ahead and sutured the now again bleeding ulcer, repaired the duodenum and closed the incision (No indication for gastrectomy as this was an acute, not chronic, ulcer.). The patient recovered uneventfully and amazingly had no obvious brain damage but did wonder why she had to have two separate incisions. There was a big article in the newspaper (and boost for me) about this being the first "heart surgery" done in Fort Myers. You young physicians possibly wonder why in the world the patient could have had a cardiac arrest as you just don't have arrest in the operating room these days. The answer is that it was 1958-59 before the improved anesthesia era. The patient and my reputation were both saved by the grace of God.

In looking back in history I am certainly glad of being a physician and even more so of being a surgeon. It has been very rewarding to be of service to mankind.

Give thanks to all those who have sacrificed to allow us to have a Happy Fourth of July!

National Rabies Vaccine Shortage

Michael Barnaby, Lee County Health Department

As most of you are aware, the rabies vaccine supply has been limited since last fall due to manufacturing problems. This shortage is expected to last for the next 6 months. In the past the Florida Department of Health State Central Pharmacy provided rabies vaccine to county health departments. They are no longer able to do this. The Lee County Health Department is currently out of vaccine. We will order vaccine on a case-by-case basis.

The Lee County Health Department will continue to treat high-risk cases. The county reports over one thousand yearly bites, and normally the Lee County Health Department treats between eighty and a hundred post-exposure prophylaxis cases annually.

There may be the necessity of referring individuals who have started rabies vaccine back to the emergency room or their private physician if their bite history does not fall into the high-risk category. Cases that will not be included for post exposure prophylaxis are bites from small rodents such as squirrels, and bites from animals that are available for quarantine and/or testing.

Physicians may order *Imovax Rabies Vaccine* from Sanofi Pasteur at (800) 822-2463 if you need to start or complete a vaccine series on your patient.

Please call the health department before referring bite cases to us. Robert South, PhD, MPH, PA-C – Biological Administrator - (239) 332-9580.

Michael Barnaby is the Public Information Officer for the Lee County Health Department.

FMA on Your Behalf

Managed Care Legislation 2008

Karl Altenburger, M.D., Florida Medical Association President

A major cause of the enormous pressure facing physicians today is the continuing efforts by insurers to intrude into the clinical decision making authority of physicians and to deny, reduce or take back reimbursement for care rendered. During the 2008 Legislative Session, the FMA sought, fought and won legislation to end three unfair managed care organization policies, which impact on physician's ability to practice medicine.

After an unprecedented journey of eight committee stops and determined opposition from every insurance company licensed to do business in Florida, SB 1012 passed. This bill balances the playing field between physicians and managed care organizations (MCO) by reducing the "look back" period from 30 months to 12 months for MCOs to demand refunds for overpayment. This bill also makes silent PPOs transparent by requiring MCOs to notify network physicians any time the MCO sells or leases their discounted physician fee information to another entity. Lastly, this bill requires MCOs to directly pay in-network physicians for services provided, rather than sending the payment to the patient.

It is important to note, this bill would not have passed without the remarkable dedication and hard work of the sponsors, Sen. Don Gaetz (gaetz.don.web@flsenate.gov) and Rep. Bill Galvano (galvano.bill@myfloridahouse.com). Every FMA member should let them know how much they appreciate their efforts.

Note: This information is taken from FMA Monday Morning by Dr. Altenburger.

"Pendulums swing and seasons change"

Disciplinary Process—Summary of the Chapter 456

The mission of the Department of Health (Department) is to promote, protect and improve the health of all people in Florida. The Legislature created a comprehensive regulatory process that provides a number of tools for the Department to use in accomplishing its mission.

The health care Boards and the Department have shared responsibility for the disciplinary process. Most health care Boards are responsible for determining probable cause through a probable cause panel and for taking final disciplinary action. A common misconception is that the Boards handle complaints, conduct investigations and direct how cases are prosecuted. This is not correct. The first time that a full Board ever considers a disciplinary case is after prosecution by the Department.

Disciplinary complaints follow a five-step process: complaint analysis, complaint investigation, probable cause review, prosecution, and tracking compliance with the penalties and restrictions imposed. The Department's Consumer Services Unit is responsible for complaint analysis and for handling many minor complaints through mediation, notice of non compliance, or citation. Complaints originate from many sources including patients, other licensees, other regulatory agencies, hospitals, risk managers, etc. The Department's Investigative Services Unit conducts investigations and inspections. The Department's Office of the General Counsel, Prosecution Services Unit, prepares cases for probable cause review and conducts prosecution of complaints in which the panel directs the filing of an Administrative Complaint. The State Surgeon General provides overall policy guidance and issues Emergency Suspension or Restriction Orders (ESO/ERO) in matters that concern an immediate and serious threat of harm to the public.

The first step in the process is to analyze complaints and reports for legal sufficiency. Legally sufficient complaints are then forwarded to one of 11 offices for investigation. Department legal staff review completed investigations. In-house and outside subject matter experts further review quality of care complaints. After the complaint has been investigated for regulatory, medical and legal issues, they are presented to a probable cause panel for consideration. Probable cause panels are composed of both professional and consumer board members. The panel members review each case and then vote to decide which complaints are dismissed and which complaints will be prosecuted. If the panels direct disciplinary action be taken, a formal charging document, an Administrative Complaint, is filed. The Administrative Complaint sets out specific factual allegations and specific alleged violations of the relevant health care practice act. This Administrative Complaint and the entire investigative file, except patient identifying information, is a public record. Although the Board determines the final action on the Administrative Complaint, the licensee may elect a hearing before an Administrative Law Judge of the Division of Administrative Hearings (DOAH). The process also provides the licensee with the opportunity to appeal the Board's actions to a District Court of Appeal. The patient, or person who filed the complaint if not the patient, are advised of this process and of the opportunity to participate if they wish to.

The Department and the Boards ensure public safety with a dedicated Compliance Management Unit that tracks licensees who are required to restrict practice, complete rehabilitation efforts, pay fines and costs, or comply with other penalties imposed by the Board.

To learn more about the disciplinary process, health care boards, and the Department, please visit: www.flhealthsource.com.

President's Message Continue from Page 1

In a disaster situation, reverse triage is used and the priority is on saving the un-injured and the mild-moderately injured, those that can be treated and are expected to survive. Those with more severe injuries are not treated nor evacuated.

In the aftermath, Louisiana Attorney General Charles Foti arrested Dr. Pou, along with two nurses, accused of being "a principal to second-degree murder" in the deaths of four patients at Baptist Memorial Medical Center. The affidavit says Pou and the nurses "intentionally killed" 4 patients in the Lifecare unit by administering lethal doses of morphine sulphate and/or midazolam (Versed). A year after her arrest in July 2006, the grand jury opted not to indict her on second degree murder charges, thus clearing her of criminal charges. Several civil suits however are still pending.

As incredulous as this story sounds, it could easily happen here. There are many low lying areas in Lee County that would flood easily, even with a much lesser hurricane than Katrina. Even though we have no levees to fail; we have nothing to stop the encroaching sea.

Next month, I'll discuss the issues of preparation and dealing with the ethics and legalities of disasters.

LCMS Volunteers Perform Student Athlete Preparticipation Physicals

Abbott Kagan, II, MD

On Saturday, May 10, 2008, volunteers from Lee County Medical Society donated their time to perform student athlete pre-participation physical examinations for the 2008 – 2009 school term at Bishop Verot High School. As in previous years, a nominal fee was charged for each athlete, and the monies collected were donated to the school athletic department.

Standing, left to right: Michele Petrites RN, Tom Underhill, Todd Atkinson MD, Don Moyer MD, Paul Liccini MD, Larry Black DO, Steve West MD, Tim Underhill OD, Stu German PA, Travis Gresham OD, Doug Savage MD, Mark Petrites MD.
Kneeling, left to right. Bo Kagan MD, Gina Fair RN, Chris Marino MD, Lorraine Rizzo ARNP, Alex Lozano MD

This year we examined 157 student athletes. There were 103 males and 54 females. The exams took about four hours to complete, but additional time was required to review the results and make decisions about further referrals. This time requirement does not include setup time for the facility, nor does it include clerical and administrative time.

In all, we cleared 140 student athletes for sports participation, but referred seventeen (five females, 12 males) for further evaluation or follow-up. Referrals were made to:

Neurology /Neurosurgery—two for headaches, one for upper extremity numbness, one for nystagmus, and one for syncope
Cardiology—one for murmur workup.
General Surgery—2 for hernias
Urology—one for hydrocoele
Orthopedics—7. Most already under active care for existing problems were referred back to their treating physician for clearance
Family Medicine—One for evaluation of abdominal pain.
Finally, twelve students were referred to the school nurse for further monitoring of high blood pressure noted at exam time.

We are thankful for being able to offer eye exams as part of our physicals. For many years, Travis Gresham OD and Tim Underhill OD have brought equipment to measure not only visual acuity, but also stereoscopic visual function which is extremely important for skill athletes. My most sincere thanks to all the physicians who graciously gave their Saturday morning to help these student athletes, and special thanks to Jim Marshall (Athletic Trainer) who coordinates these exams every year.

Dr. Kagan is an orthopedic surgeon with A. Kagan Orthopedics and Sports Medicine at 8710 College Parkway, Fort Myers.

Florida Court Upholds Medical Malpractice Binding Arbitration Agreement

The enforceability of a mandatory binding arbitration agreement in the context of a medical malpractice claim was recently tested in a February 2008 decision by Florida's Second District Court of Appeal (Court) in Jonathan M. Frantz, MD, PA vs. Shedden (Frantz). The Court found that the arbitration agreement was valid and that the patient had a meaningful opportunity and ability to know and understand the terms of the agreement before signing it and that the terms of the agreement were reasonable and fair. In a separate analysis the Court also commented that the patient failed to identify any public policy or statutory right that was violated by the agreement. The Court reviewed the terms and the manner in which an arbitration agreement was entered into which were both very similar to the arbitration agreement and program developed by First Professionals Insurance Company (First Professionals) for its insured. First Professionals' arbitration program has previously and continues to be structured in a way that is very similar to the facts presented in the Frantz case. Upholding the validity of such agreements will assist physicians in managing their exposure to medical malpractice judgments.

First Professionals' Binding Arbitration Program
When medical malpractice claims arise, an alternative to the courtroom is binding arbitration. First Professionals has developed a binding arbitration program (Program) for its Florida policyholders. The objectives of arbitration are to reduce legal costs and facilitate speedier resolution of claims. Binding arbitration means that physicians and patients agree to litigate—outside the court system—any claims that may arise from rendering or failing to render medical care and treatment before an arbitration panel. The arbitration panel is required to follow Florida law and their decision is binding upon the parties except in very limited circumstances. Binding arbitration affords potential benefits to both physicians and patients including:

Lower legal costs for both parties;
Lower indemnity payments through the use of an arbitration panel that, relative to a jury pool, will likely make a more well-reasoned and educated decision based upon the medical facts of the case; and
A more prompt resolution of claims.

How Arbitration Works
When the patient and the physician agree to arbitration they agree to give up their constitutional right to have any potential medical malpractice claims resolved in court. The process begins when one party sends a notice demanding arbitration to the other party.

Upon receipt of the notice, the patient and the physician each name one person to serve as an arbitrator. These two arbitrators then pick the third arbitrator. First professionals claims staff will select the arbitrator for its policy holder. Ideally this arbitrator will be someone who is:

A well qualified physician expert in the same specialty as the defendant;
Someone who is savvy about the legal process;
Experienced in testifying in legal proceedings; and
Effective in analyzing and explaining medical issues.

The arbitrators function as judges, in that they listen to the evidence presented by both sides and they collectively render a decision as to liability and damages. The panel of three arbitrators sets up rules about the witnesses and evidence to be presented. If necessary, the arbitrators can issue subpoenas to compel witnesses to appear at the hearing or to obtain documents.

Each party is represeneted by his or her own attorney at the arbitration hearing. First Professionals provides its policyholders with an attorney and defense just as it does for claims it defends in a traditional court. Each party has the opportunity to submit evidence and to present and cross-examine witnesses.

Implementing Arbitration into a Physician Practice
First Professionals offers its policyholders two alternative arbitration agreements. They are the same, except for one key provision:

> The "Form A" agreement requries patients to sign the arbitration agreement as a prerequisite to treatment; whereas the Form B agreement permits a patient to terminate the agreement for a period of 30 days from their date of signature.

For policyholders who choose to particpate in the Program, First Professionals will provide at no charge the arbitration agreement forms, along with a video or DVD in both English and Spanish. These tools allow physicians to effectively inform their patient about the purpose and fundamentals of the arbitration agreement.

Provided that a patient is not in an emergent or urgent condition, physicians present the arbitration agreement to patients (or their representatives and provide an area where they can view the video or DVD, which lasts approximately five minutes. The patients and/or their representatives are asked to sign the agreement, a copy is given to them and the originals are placed in the patients' medical records.

Once a First Professionals policyholder completes the order form and signs the arbitration participation agreement, First Professionals will mail an arbitration contract and video within 10 business days. For additional information concerning particpating in the Program, please contact Stephany Carter in the Marketing Department at 800-741-3742 ext.3064 or carter@fpic.com. For legal issues concerning the Program please contact Rob Wortelboer, First Professionals General Counsel and Vice President at 800-741-3742 ext 3281 or at wortelboer@fpic.com.

Would you be interested in learning more about becoming a mediator for Binding Arbitration. Please email us at awilke@lcmsfl.org or call our office at 239-936-1645.

Collaborative Family Law Saving Families, One At A Time - Part 2

Sheldon (Shelly) E. Finman

I would submit **the filing of initial court papers is not reasonably necessary in the vast majority of cases**. The lawyer who is initially consulted can inform the client of an optional process in order to determine if the client is comfortable in attempting to engage the other side without filing initial court papers. I find most consulting clients choose to opt out of the court system and not file initial court papers. The client and lawyer discuss ways in which to engage the other side informally. It is important that the lawyer not in any way coerce or "sell" the client, but rather the client must be comfortable and feel secure.

If both sides have consulted or retained lawyers and no court papers are filed, both sides can discuss the particular problem-solving model or process with which they would be most comfortable. At this point, the parties and attorneys normally would choose between a cooperative process or a collaborative process, with the understanding that the lawyers and any neutral experts would withdraw if the collaborative model is engaged. (Another form of conflict resolution, mediation, may be employed at a later time when the parties have engaged their lawyers. However, mediation may be a preferred option at the outset, if both parties would wish to work with one conflict-resolution specialist and consult with their attorneys.)

If the parties choose the collaborative process, the parties and lawyers sign a **Participation Agreement**, which defines the process, sets forth the roles of the parties and the attorneys, and further provides a code of conduct and expectation how each of the parties and attorneys will conduct themselves throughout the process. The Participation Agreement may further refer to a valuation date/cut-off date, preservation of assets and not altering the financial status quo, provide for engagement of neutral experts, provide for payment of professional fees, provide for termination of the process and disqualification of the professionals and other such provisions.

After the Participation Agreement is fully signed by the parties and the lawyers, the parties then begin to work with their lawyers and each other at attorney/client joint meetings. The parties and lawyers meet normally at one of the attorneys' offices approximately every two to three weeks for two to three-hour blocks of time. In between sessions, information is gathered, communication between the parties and between attorneys occur, an agenda is prepared for the upcoming joint meeting and summary minutes are reviewed from the past meeting. Meetings are structured whereby the process proceeds in an orderly, efficient and productive manner.

There may be occasional deviations from the stated agenda. Perhaps, an incident occurred since the last joint meeting which either warrants discussion and/or something occurred which sparked unresolved feelings. Questions and concerns frequently crop up which require discussion. Voiced concerns over emotional matters should be addressed in a sensitive and caring manner. It is important everyone feel secure and comfortable. Everyone understands this process allows open discussion on all matters. Ground rules require all such discussions be respectful. Venting of feelings and frustrations can surface during attorney/client joint meetings. These deviations from the stated agenda could significantly challenge the ongoing status of the process. It is, therefore, helpful to deal with these matters as they arise in session. Depending upon the intensity of feelings, I might suggest a "time out" in order for the client to talk with the attorney outside of the meeting room in private. Sometimes, a walk outside is helpful to break from the charged atmosphere. The client needs to be heard and have an opportunity to regain composure.

Depending upon the emotional stability of the parties and their ability to communicate with each other, I may suggest the engagement of a mental health "coach". This neutral professional is a psychotherapist. However, the "coach" does not treat the client (s) or give therapy. The parties, either or both, may already have their own therapist. The "coach" guides the parties and helps them learn how to communicate better with each other. The "coach" attends the joint meetings and observes, takes notes and at appropriate times, may intervene with comments and observations, intended to be constructive.

During the duration of time between joint meetings, the parties' subconscious mind is at work. By the third or later session (if required), most parties have learned or realized that their feelings, actions and comments can empower them in ways never before understood. In this way, a problem-solving process can be therapeutic, spiritual, but mostly a learning experience whereby the client can learn how to be a better person.

Every client has an opportunity to learn about himself/herself going through a divorce. Many clients are so overwhelmed by grief, sadness, anger, frustration and fear they lose touch with their own feelings. Moreover, the sooner the client can understand their feelings and attempt to set aside blame attributable to the other spouse's actions, the more quickly that client will be able to move on. Fault finding based upon feelings is rarely helpful to one's ability to learn and move on. Perhaps, the other spouse deemed to be at fault by a grieving or angry spouse may be able to recognize the power of acknowledgment (hearing) and validation (apology). Simple apology, when appropriate, may not be effective.

To be continued, this article is part 2 of a 3 part series.

Shelly Finman is a Florida Bar Association Board Certified Marital and Family Law Attorney, a Supreme Court Certified Family Law Mediator, and in addition to having practiced in Southwest Florida for over 30 years, has lectured and trained other legal professionals all over the country in non-adversary family law. Shelly is also raising awareness in Southwest Florida of the adaptation of collaborative family law to medical malpractice and errors. Shelly can be contacted at (239) 332-4543; PO Box 1380, Fort Myers, Florida 33902; and maintains his offices at 2134 McGregor Boulevard, Fort Myers, Florida 33901.

Going Bare Talking Points

Information provided by FPIC

1. Buying coverage is really about indemnity AND defense costs. FPIC provides experienced litigation management to minimize expenses in defense of a case. The defense costs are very expensive and can run higher than the indemnity payment. The attorney hourly rates that FPIC negotiates for its insureds would be very different than the rate an attorney would charge an individual physician. A physician may not have the resources to battle a claim and, as a result, may be forced to enter into a settlement. In addition, FPIC provides some reimbursement for lost earnings as a result of the physician being away from his or her practice.
2. Going bare is not a one-time event for a physician. There is a lot of time and planning involved in maintaining the status of a bare physician. Every time a bare physician obtains a new asset, it has to be determined how to protect that asset. The expense involved in ongoing asset protection may be greater than the professional liability insurance premium.
3. Bankruptcy is a real possibility for bare physicians who experience a substantial verdict in favor of a plaintiff. The new bankruptcy law may create problems for physicians who seek to discharge a medical malpractice claim. Even if a physician successfully discharges a claim there may be a negative effect as a result of their patients who receive letters from court appointed receivers who are seeking direct payment of co-payments.
4. Even if a bare physician qualifies for bankruptcy, new bankruptcy laws impact the applicability of the homestead exemption for a physician's personal residence.
5. In the event a physician decides to appeal, a bond must be posted for any judgment. The bond requires collateral that a physician may not have after paying for attorney fees.
6. If the physician does not pay a court judgment, arbitration award, or settlement arising from a malpractice judgment, a physician risks a suspension of their medical license by the Florida Board of Medicine.
7. Bare physicians must comply with the financial responsibility reporting requirements of the Board of Medicine as a condition of licensing. The failure to timely report may lead to disciplinary action against a physician's license to practice medicine.
8. There is no insurance for licensure investigation expenses. Even a simple complaint that is defensible from a competitor or patient can run into thousands of dollars to defend. Disciplinary action against a physician's license could have more of an impact on a physician's career than a medical malpractice claim.
9. Premiums previously paid will not cover claims reported after the claims-made coverage has expired. However, a bare physician will likely not be able to purchase tail coverage exposing the physician for all past incidents.
10. Hospitals that allow physicians to go bare may not end up paying for the physician's losses. Under Florida's Uniform Contribution Among Tortfeasors Act, any defendant in a lawsuit has the right to settle the case and pursue any party, whether they are named or unnamed in the litigation, in a subsequent action. In other words, the hospital can sue the bare physician(s) for losses sustained.
11. A bare physician is *always* asked to testify against insured co-defendants by the plaintiff attorney. The bare physician(s) must then make the difficult decision to either go against colleagues or be forced to pay a settlement.
12. Referring physicians may feel uncomfortable referring to a bare physician fearing that they will become the target in any medical malpractice claim.
13. The bare physician is all alone. A bare physician only has the support of a lawyer who, and it must be noted, is charging for every call and action taken on behalf of the physician. Insurance carriers provide not only a defense lawyer and team, but also experienced claims handlers, as well as attentive and sympathetic risk managers.

Physicians Take a Lesson From the Three Little Pigs

Jeffrey Cohen, Esq.

In the Three Little Pigs story, there were three pigs who each built a house of a certain material, each doing their best to ward of the Big Bad Wolf. It is great instruction for today's physicians.

Pig #1 ("Ernie") built his house of straw, but it was no match for the Wolf. Pig #2 ("Bernie) built his house of sticks and it was not match for the wolf. Pig #3 ("Deepok") apparently attended PU ("Pig University") where he earned a degree in mechanical engineering and architecture. He built his house of bricks and the wolf was thwarted. The story is used to teach about intelligence, ingenuity, planning and such. But there is another way to see it.

Each pig alone was unable to deter the wolf. And the wolf was each pig's worst fear, the fear of being eaten. No single pig alone could deter the wolf, not even two of them. It was only when they stood together that victory was possible. Now that's a powerful story!

Physicians today feel hunted, some would say attacked, by many things—managed care, hospital administration, the government payers. One by one, they do their best. They shave costs. They look for new revenue sources. They hire lawyers and other consultants for things they used to handle on their own. The scramble to see more patients and to earn less. They're stressed, and so are their families. Their passion for medicine, for making a difference is often overshadowed by these "realities." Though they often love what they do and how it changes people's lives, it isn't as fun and energizing as it once was.

In my view, the community of physicians has never been so fractured. And, sadly, when there is a connection among them, it is often to focus on their frustrations, their commonality has become draining and disempowering. In archetypal terms, they have become the warrior that does battle and gets beaten up in the process each day. But there is another way.

Years ago, medical staff meetings were packed. Departmental meeting were packed. Medical staffs absolutely controlled the quality of care provided in their hospitals, and many other things as well. They walked with respect for themselves and each other. Hospital administration had a respectful and symbiotic relationship with them which required communication and cooperation.

Today there are stresses and events that did not exist years ago. And over time physicians have begun to tell a different story about themselves and about their profession, one that casts them as "little pigs," as targets, and hospitals and managed care payers as the big bad wolf. They are "at war." They are the beaten warrior and their strength being drained is affecting no only them, but their patients and communities. As they lose their power, their enjoyment, the quality of medical care is threatened.

The clear thing about Ernie, Bernie and Deepok is that there was a complete shift when they stood together, It is not an easy task, to be sure. Everyone is a little different in their look, their values, their thinking and two people respecting and valuing each other's differences is sometimes hard. It requires an overriding ethic or vision, a vision of compassion and respect, in essence "spirituality." It was easy for the pigs because, well, they are just pigs. But what we didn't hear is that once Ernie called Bernie a bad name, that Deepok took Bernie's parking space. In other words, they've had their challenges with one another too. But the end result is the same: try to survive alone and fail or work together despite the apparent differences and live. Take a step further: Create a new vision that is energizing and enjoyable and everyone wins.

Physicians have a challenge that is similar to the pigs. In short, it comes down to vision, creating a new story, not just personally but collectively. Everyone knows the dominant story, the one that doesn't work. What story can physicians tell instead? What inspires them? What parts of what they do inspire them? Those are the pieces that will inform that new vision. They have to come together to start that process. And the process can't be connected or a reaction to what they don't like today, since that's just another way to connecting to what doesn't work. In a sense, they have to cut the strings that bind them and create a new vision without those limitations. Work on the vision first and the particulars will become apparent. You will know what to do about managed care payers. You will know what to do about hospital administration. Once the vision becomes enlivened (as it once was), physicians will know what to do. But focusing on the particular problems here and there and then reacting does not take physicians anywhere. In fact, it leaves them digging themselves deeper into situations and problems, with no apparent way out because there is no greater vision that guides them to a better, more fulfilling and more powerful way.

Physicians have to stop looking for quick fixes. There is no lawyer or consultant that can do it for them. A lawyer reviewing medical staff bylaws, though useful, is valueless if the medical staff members will not work together. Physicians have to be flexible with the way the world is today. They cannot insist medicine be exactly the way it was. Technology is different. People are different. Patients have a greater need for information and often want to play a more active role in their care. And they are more open to things that may be confusing to physicians. If physicians are to enjoy practicing medicine again, and if communities will be better off for that, then it will be because physicians themselves have together reestablished themselves. And that requires time, commitment, flexibility, a lot of interaction and humor. In short, they have to show up...again.

This article presented for educational purposes only and should not be taken as a substitute for legal advice which should be obtained from personal legal counsel.

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IN MEMORIAM

J. FRANK RAWL, M. D.

10/13/29– 6/11/2008

Our friend and colleague, J. Frank Rawl, M. D. passed away on Wednesday, June 11, 2008.

Dr. Rawl came to Fort Myers in 1960 as the 2nd internist in Lee County and served our community for many years. He was with the practice of Bryan, Rawl, Gore, Butler, Agnew and O'Bryan. He served as President of the Lee County Medical Society (1971) and President of the Lee Memorial Medical Staff.

Odds and Ends

Supervising Physicians must notify Council on Physician Assistants of any PA status change

Please visit the Lee County Medical Society website at leecountymedicalsociety.org for a link to forms. Below is the rule as seen in the Florida Administrative Code.

64B8-30.004 Change in Employment Status.
(1) The supervising physician of any physician assistant who is terminated from employment or otherwise ends employment as a physician assistant shall notify the Council in writing within 30 days of such occurrence.
(2) Each physician assistant shall submit changes to the Department on the form approved by the Council and Boards, and provided by the Department within 30 days of any change in employment status.
(3) Upon any change in employment status the licensed physician assistant's prescribing privileges shall immediately be stayed until such time as a new written agreement is entered into pursuant to Rule 64B8-30.007 or 64B15-6.0037, F.A.C., and a new form is filed with the Department.

"33rd Annual Seminars in Family Practice"

The Florida Osteopathic Medical Association District 11 will hold their Annual Seminars in Family Practice at the Sundial Beach Resort on Sanibel from Thursday, October 30th through Sunday, November 2nd. They will offer 22 credits hours in CME Courses. On Sunday will be the Florida Mandatory Courses for D.O.'s of:

- Risk Management in the Critical Care Arena
- Prevention of Medical Errors (2 hrs) - This is also required of M.D.'s
- Laws Regulating Use and Abuse of Controlled Substances
- 2008 Florida Laws and Rules Update

Please call (239) 898-9616 for more information.

Office Manager Email List

The Lee County Medical Society is putting together an email list of all our members' office managers and administrators so that we can send out important information that will affect you and your practice. Included in our emails will be updates on new laws and regulations such as what's going on with the Medicare cuts.

If you haven't done so, but would like to be included or would like your office manager included in our email list, please call the LCMS office at 936-1645, fax 936-0533 or send an email to cynthia@lcmsfl.org.

Special Needs Shelter Sign Up

We are one month into Hurricane Season. Do you have patients with special needs? Do they have a place to go during and after the storm? If you have patients with special needs that do not have a place to stay during and after the storm, please fill out the enclosed form. The Lee Emergency Operations Center (Lee EOC) is taking applications for the Special Needs Shelters. You can also visit their website at leeeoc.com for more information.

Lee County Medical Society

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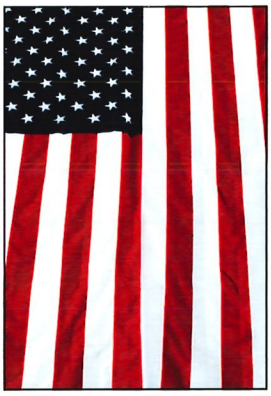
Fort Myers, FL 33906-0041



Happy 4th of July!

Together We Are Stronger