LEE COUNTY MEDICAL SOCIETY INC

Physicians Caring for our Community

Bulletin

Volume 356 Issue 1 | Editor: John W. Snead, MD | April 2012

2012 Meetings and Events

LCMS General Membership Meeting

May 17, 2012
Cypress Lake Country Club
6767 Winkler Road
Fort Myers, FL 33919

Speaker:
Jonathan Fleece, Esq

Co-Author
New Health Age

Sponsor:
Markham, Norton, Mosteller & Wright Company

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Inserts

Museum of Medical History
May Meeting Notice
Alliance—Spring Fling
Hope Healthcare Services

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President's Message

The Independent Payment Advisory

Richard Macchiaroli, MD

The Independent Payment Advisory Board (IPAB) is the primary cost containment mechanism of the Patient Protection and Affordable Care Act (PPACA), otherwise known as Obamacare. The IPAB was created pursuant to section 3403 of PPACA, and, when made into law in 2010, was not well understood. The IPAB is a 15 member panel of presidential appointees designed to make cost reduction recommendations to Congress for Medicare. One of the primary goals of PPACA is future Medicare cost containment, and the IPAB is the designee to control costs.

Section 3403 of PPACA states that proposals made by the IPAB "shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums… increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and co-payments), or otherwise restrict benefits or modify eligibility criteria." The IPAB will be tasked with developing proposals to reduce per capita Medicare spending if the chief actuary of the Centers for Medicare and Medicaid Services (CMS) determines that the projected growth rate in Medicare spending exceeds the target growth rate from one year to the next. These goals indicate that the IPAB is tasked with Medicare cost-cutting without either reducing beneficiary eligibility or raising premiums or deductibles. This primarily leaves reducing physician and hospital reimbursement as the main cost containment mechanism. It is also likely that the reduced physician reimbursement will be amplified by private insurers, as they have traditionally followed CMS's lead on reimbursement.

Previously, only Congress had the power to change Medicare reimbursement rates. Going forward, the IPAB will make annual recommendations regarding Medicare cost containment to Congress. These annual recommendations will automatically become law unless two thirds of the House and Senate vote against them.

This means that a supermajority in Congress is needed to overturn IPAB recommendations. The first set of IPAB decisions will be detailed in a report due for release in July, 2014. The ultimate result of IPAB recommendations is that bureaucrats will be creating legislation that will reduce physician reimbursement, severely limit Medicare beneficiaries' access to care, and promote rationing of care.

The IPAB recommendations also are not susceptible to the normal judicial review process. Subsection 3403(e) states that "actions of the IPAB are not reviewable by the judiciary branch of government." This is an unprecedented abuse of the constitutional checks on the executive branch. Basically, the IPAB is part of the executive branch of government, creating legislation, without the ability to exercise proper control by the Congress, or judiciary branch. Additionally, any resolution to abolish the IPAB can only be introduced in Congress after Feb 1, 2017, and must be enacted by Aug. 15, 2017, but cannot take effect until 2020.

The IPAB can only be summed up as an ultimate travesty of justice. By some estimates, the IPAB, under Obamacare, will reduce physician reimbursement by 30 to 50 percent over a 10 year horizon. The IPAB is Obamacare at its most arrogant, bypassing all of the checks and balances that our democracy has spent centuries creating and maturing. Recent efforts in the U.S. House of Representatives have produced a bill to repeal the IPAB which has passed overwhelmingly in a bipartisan fashion through the House Energy and Commerce Subcommittee on Health with a 17 to 5 vote on February 29, 2012. This bill is now scheduled to move forward through the usual legislative process. We can only hope that Congress will recognize the inherent injustices of the IPAB and repeal it before it begins. Please contact your U.S. Representatives and Senators to relay your feelings about this atrocity, known as the IPAB.

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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 News

Relocated

William Dakos, MD
13831 Metropolis Avenue
Fort Myers, FL 33912

SPRING TIME 2012

Physicians in the News

Dr. DiGiorgi Named Obstetrics Director

LCMS wishes to congratulate Dr. Sarah A. DiGiorgi of Physicians' Primary Care of Southwest Florida for being named Medical Director of Obstetrics for Cape Coral Hospital, Gulf Coast Hospital and HealthPark Medical Center,

In addition to her duties at the three hospitals, Dr. DiGiorgi practices obstetrics and gynecology with Physicians' Primary Care of Southwest Florida at the Park Royal OB/GYN Office at 9021 Park Royal Drive in Fort Myers and at the Lehigh OB/GYN Office at 3507 Lee Blvd. Lehigh Acres.

Dr. DiGiorgi also recently earned certification to perform daVinci robotic surgery in gynecological procedures, such as hysterectomies, which result in minimal scarring and faster recovery than more traditional methods.

New Applicants

Stacey Gorovoy-Kunc, MD— Dr. Gorovoy-Kunc received her MD degree from Brown University Medical School, Providence, RI 2002-2006. She completed her intership at University of Massachusetts Medical School Hospitals 2006-2007. She did a residency (2009-2011) and a fellowship (2011-2012) at Tulane University, New Orleans, LA. Dr. Gorovoy-Kunc is in group practice with Gorovoy M.D. Eye Specialists—12381 South Cleveland Ave, Ste 300, Fort Myers, FL 33907—Tel: 239-939-1444.

Manish Shah, MD— Dr. Manish Shah received his MD degree from NHL Municipal Medical College, Gujarat University, India 1986-1992. He completed his residencies at East Tennessee State University, Johnson City, TN (2005) and Suma Health System, Akron, OH (2005-2009) with a fellowship at Inova Fairfax Hospital, Falls Church, VA (2009). Dr. Shah is in group practice with Lee OB/GYN Associates, Fort Myers, FL 33908—Tel: 239-343-7100.

Michael D. Smith, MD— Dr. Michael Smith received his MD degree from Indiana University School of Medicine, Indianapolis, IN 1983-1987. He completed his internship at Baylor College of Medicine, Houston, TX (1987-1988) and a residency at University of Texas Medical Branch, Galveston, TX (1988-1989). Dr. Smith also did a residency at Baylor College of Medicine, Houston, TX (1989-1991). He is in group practice with Premiere Oncology—955 10th Avenue North Naples, FL 34102—Tel: 239-325-1440.

As I Recall...

Roger D. Scott, M.D.

DADDY

April 28, 2012 marks the 32nd anniversary of the death of Thurber Talmage Scott just 32 days before his 93rd birthday (May 27, 1887). To many he was known as Mr. Scott, Mr. T.T, and to his close friends as T.T. , but he was always **Daddy** to me, and so you will know a little bit more about him from this article. His grandfather was a New Hampshire physician who migrated to Georgia in 1840 and settled about 18 miles east of Americus and was remembered for having treated the Yankee prisoners at Andersonville Military Prison with what little medications that were available. Daddy's father (Joseph) was a farmer and merchant and gave Daddy the name Thurber to honor Mr. Thurber who owned the company that supplied his merchandise. Then his mother bestowed upon him the Talmage name in respect for a famous New England preacher. So you now know the explanation for this unusual name for a future destined to be great.. I'll use TT instead of Daddy intermittently throughout this article.

TT's former schooling ended at fourteen years of age after finishing the sixth grade, and he started what he termed "The School of Hard Knocks" beginning with the construction of a railroad at $25 a month. After 3 months he was promoted to Superintendent of Construction at $50 per month. He saved his money and one year later he began his first company for cutting cross-ties (the large square wooden poles placed under the train rails for support). The reputation & friendships he made were his later salvation during his life. He bought his first small sawmill in 1907 for $1,000 and then a larger mill, but lost it all in the 1907 panic. Daddy then got a contract to build wooden bridges for the county in 1907 as the automobiles appeared and they could not go through streams as did horses & buggies. He continued to grow in the lumber industry and moved from Georgia to north Florida in 1915. Sawmillers usually worked from dawn to dusk and for many years Daddy was in the middle of all phases of the business. Much of Florida in those days was a vast forest of virgin pine & cypress trees. His mills became larger until his was the largest individually owned one in Florida and shipped lumber all over the world with two lumber yards in Spain and two in England. During World War I his mill cut large timbers for the Navy and the Navy employed him to encourage mills in Georgia, Alabama, & Florida to do the same, but he refused a salary except for one dollar & a citation. Daddy did the same thing (except he no longer had a mill) during World War II, but he never received his two dollars or certificates!

Well Daddy proved his "smarts" by purchasing over the years the controlling interest in the First National Bank of Live Oak, Florida, the fifth oldest national bank in Florida. In 1932 we left the sawmill and moved to Live Oak where TT became president of the bank and also maintained interest in lumbering. It was then that I as the youngest realized what a great gift I had in having been born into such a loving family of parents & siblings. We learned from our parents honesty, obedience, work, respect and regards for others especially those less fortunate. We received punishment as needed and rewards when won. The bank flourished with many out of town and other states lumber accounts because Daddy understood the lumbering processes. I spent some time running errands at the bank, making sure the ink wells were filled, ink pens had proper points and blotters were available. In 1936 TT opened the Hamilton County Bank in Jasper, Florida. Daddy was a very generous man.

He gave much to all the charities, churches, Harry-Anna Crippled Children's Home and the Children's Home Society of Florida. He gave large amounts to both his & my Mother's families when they were in need. The following is quoted from a 1927 letter to his brother Joe "I will help you or divide anything I have with you". He was a profound believer in education and supported his five children's education producing a dentist & two Doctors of Medicine. He "lent" money to many, especially farmers, that he knew would probably not be repaid. He server gratis on the Florida State Board of Control (University of Florida, Florida State College for Women (FSU now), Florida Agricultural.& Mechanical. College, Florida Deaf & Blind School) under three Governors. He donated heavily to Lakeland's Florida Southern College from which he received an Honorary Doctor of Law degree The 1942 Florida Southern College yearbook with an 8 x 10 photo was dedicated "In recognition of distinguished service to the field of education, in honor of the Chairman of the Florida Southern College Founder's Week and a Member of the Board of Control for the State Institutions of Higher Learning, and in open admiration for the embodiment of the spirit of our Alma Mater, we respectfully dedicate the Interlachen for 1942 to Mr. T.T. Scott." Daddy was exceedingly proud of the educational accolades he received en lieu of a formal education. TT was forever campaigning for a Medical School in Florida as we had none, but he did help get the Hill-Burton Act passed & Live Oak got the first hospital under that act.

He was a member of the Elks Club and was a Lifetime Honorary Rotarian. There's much more to the Daddy's story with knock downs but always rebounding. I don't mean to be boasting only giving a just tribute to a pioneer who has given so much to Florida and its citizenry by his generosity monetarily and personally. Daddy was a great great gentleman of whom I am extremely proud and whose achievements could only have been possible in our United States of America. I often think of him and wish that I had spent more time with him. That is a suggestion for you young folks who still have your seniors around. Someone who had know Daddy well told me that I reminded them of Daddy, and I consider that the greatest compliment I ever had. Well before long I'll be saying "Yes sir" again to my Daddy.

We regret the untimely passing of Orthopedic Surgeon, James L. Otis, D.O.

Why Do Pharmacists Refuse To Fill Some Prescriptions?

Rich Lawrence, PharmD, Fort Myers Prescription Shop

I am certain that you all are acutely aware of the issues that our patients face in getting their prescriptions for controlled substances filled. There have been numerous reasons for this difficulty over the past several months. The supply issues with controlled substances continue and in many ways have actually gotten worse.

We, as pharmacists, are currently forced to turn patients away and not fill their prescriptions out of fear of losing our DEA licenses or being cut off by our suppliers. The DEA has placed pressure on the distributors of controlled substances to reduce the quantity of narcotics that pharmacies purchase but have not shared with them what is the goal or target purchase limits. Through my own research, I have developed an idea of what those limits are. We are able to purchase, without much hassle, up to 3-5 thousand combined dosing units of any products that contain oxycodone (i.e. Percocet, OxyContin and Roxicodone) and up to 3-5 thousand combined dosing units of all other controlled substances. That is not very much, especially in the light that CVS has publically announced that they will not fill narcotic prescriptions (a few other chains have internal policies of the same nature) and several independent pharmacies have lost their DEA licenses and/or closed in recent months. Additionally, a high percentage of cash paying customers (those without any kind of insurance) is a red flag to the DEA and wholesalers. (That target is approximately <7% of sales in dollars.) Basically the DEA, through the distributors, is forcing us to discriminate against patients in pain, especially those without insurance or who live in chronic pain and don't have additional medical problems.

To add to the issues, there are a few medications that are legitimately not available right now. Those include Opana (due back in the market later this month), generic Adderall, generic Ritalin, and generic Dextrostat. With any luck those supply issues should be resolved in the relatively near future.

You can help our patients by communicating with pharmacists before prescriptions are written to ensure that they have the desired medications. Also, the DEA's focus is the immediate release products (i.e. Roxicodone, MS IR, and Percocet) as they are the ones that are most easily abused. By writing for a regimen of long-acting medications (i.e. MS Contin, OxyContin, and Duragesic patches) with a smaller, more appropriate quantity of the immediate release medications you can make it easier and more comfortable for the pharmacists to fill the prescriptions all the while providing better pain control for our patients. If all chronic pain patients were placed on such a regimen it would alleviate the majority of the current situation's stresses. You can also employ alternative medication therapies such as topical patches, creams and gels such as combinations of gabapentin, lidocaine, diclofenac, ketoprofen and amtiptyline.

Network Improves Patient Safety

PDR® Drug Alerts

Medical liability protection requires that you are well-informed about patient safety issues quickly and reliably. PDR® Drug Alerts through the Health Care Notification Network (HCNN) offer immediate, electronic delivery of FDA-approved, specialty-specific Drug Alerts and safety information for The Doctors Company/FPIC members.

HCNN is a network to deliver drug safety alerts online to U.S. physicians to replace the decades-old system based on paper and U.S. mail. The HCNN is free to all licensed U.S. physicians and is solely used for patient safety alerts that are product-related and mandated by the FDA. It ensures the most rapid and effective delivery of important alerts to physicians, thereby improving patient safety and office efficiency while reducing liability and paperwork. It may also be used to notify physicians in the event of national public health emergencies or bio-terror events.

If you have not yet registered to receive electronic PDR Drug Alerts, please do so at www.fpic.pdr.net. Your e-mail or fax number will only be used to send and administer Drug and Device Alert services, FDA-approved drug labeling information, and other clinically relevant PDR services/information. If you do not register to receive PDR Drug Alerts, you will not receive them immediately by e-mail or fax but may view the information at www.PDR.net.

Why should I register for PDR Drug Alerts?

- Improved patient safety
- Reduced professional liability
- Immediate receipt of important clinical information
- Increased convenience for practices
- The ability to have patient safety alerts also sent to other members of your office staff
- Reduction in office paperwork and mail
- The ability to get more information about a specific patient safety alert

You may also contact a risk management consultant at The Doctors Company/FPIC if you have questions or to obtain additional details at (800) 741-3742, extension 3016, or rm@fpic.com.

MUSEUM OF MEDICAL HISTORY

David Bernstein, M.D. Memorial
Edison State College

The Museum of Medical History provides an array of fascinating information. It gives you the opportunity to step back into time and look first hand at how much medicine has advanced over the years.

The Medical Museum found a home within the Edison State College. The museum holds only a small amount of the artifacts from the past in their collection. The rest of the collection is maintained in storage.

The Medical History Museum needs the financial support of its medical community to help defray the cost of maintenance.

Please come by the museum and take a tour with their curator, Dr. Roger Scott, to see and hear all about the past years in medicine. Please consider supporting the museum with a contribution today. Museum Medical History Flyer included in the Bulletin for your convenience.

Museum of Medical History
Roger Scott, MD, Curator
8099 College Parkway
Fort Myers, FL 33919

When and How to Discharge a Problem Patient

By Terry Salz, CEO, International Medical Billing Management & Consulting Inc.

PUT YOUR POLICY IN WRITING AND PRACTICE IT CONSISTENTLY
Your dismissal policy must be in writing so that staff understands what constitutes a reason for dismissal. Make sure you apply your own rules with consistency as not to have any legal ramifications.

WARNING SIGNS: Fail to comply with a recommended plan of care, including subsequent appointments

NO SHOWS

Although no-shows create a loss of revenue there is something more important with the handling of these patients and their continuation of care. When you find that this is an ongoing issue taking action is critical. If the patient continues to schedule appointments and fails to show up for them you may also put your malpractice carrier on notice once dismissal has been determined. The reason for this is if this patient has a serious medical problem in the future you do not want a lawsuit claiming abandonment. As tedious as it may seem thorough documentation of your actions prior to dismissal is crucial. Documentation of office actions and attempts in a resolution is something that should be the protocol of all offices regarding patient's activity. Just as insurance company's state if there is no documentation then it did not happen, you don't want the legal system to use this in their defense should one be needed.

ABANDONMENT
Patient abandonment occurs when a physician fails to provide for necessary medical care to a current patient without adequate justification. Once a physician patient-relationship is established, a physician has an ongoing responsibility to the patient until the relationship is terminated, therefore, a protocol established to complete termination without legal issue is needed. A physician can discharge a patient for a number of reasons, including non-payment, noncompliance, threatening behavior, and an ineffective physician-patient relationship if done according to guidelines.

VIOLENCE
Staff should be able to hear if a situation is escalating and call 911 immediately. A false alarm is better than a tragedy. Normally there is frequently escalating events that occur before violent acts occur. It is critical and of importance that your staffs not try to handle them but know how to recognize them. Training and having an emergency response plan will eliminate staff acting chaotically in the face of a threatening situation. A plan in place and training to recognize urgent and not urgent should be in your training. Should you or staff ever feel that your life is at risk leave immediately. Dismissal of these patients should be handled with immediate notifications of the proper authority and your malpractice carrier.

DISCRIMINATION
If you have standards and protocols this is less likely to become an issue. If the staff does not have guidelines and they are using their own judgment it could create a legal concern. Never discharge a patient based on age, religion, gender or ethnicity. When your discharge practices are known and if you have standards and protocols this is less likely to become an issue. If the staff does not have guidelines and they are using their own judgment it could create a legal concern. When your discharge practices are not consistent your acts could be considered discrimatory.

NON-PAYMENT
We must take into consideration that failure to pay the bill could occur for a number of reasons. Non-payment is often an early warning sign that a patient is unsatisfied with his or her outcome or it could be due to lack of funds but both must be considered. It is important to first determine why the patient is unwilling to pay. This can be difficult and uncomfortable and should be handled by a staff member with excellent communication skills. Patients with financial hardship appreciate being given the opportunity to make arrangements to honor the financial obligation. Patients that are voicing an issue with care should be referred to the physician, who should seek risk management assistance from his or her professional liability carrier. Patients often are confused or angry about their responsibility to pay co-payments and deductibles and, mistakenly feel that physicians can waive these at will, need to understand that they have an obligation to the physician for service rendered and also an obligation according to the contract with their insurance carrier may also be applicable.

We must be realistic in the fact that this will happen many times in a Practice for many reasons. The goal is be prepared and handle it with professionalism and this in turn will mitigate any issues for liability in the future.

Cont'd on page 7

FMA PRESIDENT REPORT

By Miguel Machado, FMA (Florida Medical Association) 2012 President

As physicians, we are taught to "first do no harm." The 2012 session of the Florida Legislature, which ended on Friday, March 9 at midnight, can be described in much the same way. There were many harmful initiatives that the FMA prevented from passing this year. Some of these bills, such as legislation that would have allowed health insurance companies to fix prices on physician services in the hospital setting, would have had devastating effects on the economic viability of many medical practices in Florida. Fortunately, we were able to stop these bad bills from passing.

At the beginning of this year's legislative session it was very clear that few major bills would pass as members of the House and Senate dealt with redistricting and the state budget. In addition, with 2012 being an election year, we knew that there was little appetite in the Legislature for controversial issues. Only 149 bills passed out of more than 2,000 bills filed during the 60-day legislative session. This was the fewest number of bills passed during a legislative session in recent history. Furthermore, the session was defined by internal power struggles and independent factions in the Florida Senate that made it extremely difficult to advance any issues. These dynamics worked in our favor as we engaged in efforts to defeat unfavorable legislation, but they hurt our attempts to pass meaningful medical liability reforms that would have lowered insurance premiums and reduced health care costs.

On the positive side, the FMA defeated several bills that would have been harmful to physicians and the patients we serve. As previously mentioned, one of the FMA's top priorities was to defeat a bill that would have permitted insurance companies to fix prices for physicians who treat PPO patients, even those physicians who do not have a contract with the PPO. This bill would have limited the charges of a physician providing ER services to PPO patients to the arbitrary amount set by the patient's insurance plan and would have unfairly restricted physicians from recovering fees for non-emergency services provided in a hospital to PPO patients. I am pleased to report that this proposal was defeated thanks to the tenacious efforts of the FMA's lobbying team, which worked closely with several of our specialty society partners to educate legislators on the negative impact this bill would have on access to care for patients in the hospital and emergency room settings.

In addition, because of the FMA, the following bills did not pass the Florida Legislature this year: mandatory biannual fingerprinting of physicians; suspension or limitation of a physician's license based on an arrest or suspected illegal conduct; expansions in scope of practice for advanced registered nurse practitioners; expansions in scope of practice for electrologists; mandatory requirement for physicians to check the prescription drug database; decentralization of the Department of Health to county health departments; and elimination of limits on recovery under the wrongful death statute.

The FMA was able to favorably influence several other important issues, including: reforms to Florida's Personal Injury Protection insurance laws that will not adversely affect the practice of medicine or your ability to receive reimbursement for services rendered; legislation authorizing pharmacists to administer vaccines for shingles and pneumonia in a manner that will protect patient safety; needed clarifications to laws governing registration requirements for prescribing controlled substances; reorganization of the Department of Health; protections for physicians when public hospitals are sold or leased; youth athlete "return to play" requirements following a concussion or head trauma; and protection of existing physician Medicaid reimbursements in the state budget..

This legislation (SB 1506 sponsored by Sen. John Thrasher, SB 1316 sponsored by Sen. Don Gaetz, and HB 385 by Rep. Matt Gaetz) included important provisions that would have significantly improved the medical liability climate in the state of Florida.

The bills would have helped level the playing field in medical liability cases by allowing defendant physicians equal access to interview a plaintiff's other treating physicians and by increasing the burden of proof in cases involving the failure to order supplemental diagnostic tests. In addition, the legislation would have extended the state's sovereign immunity protections to physicians rendering care in an emergency room. Finally, the bills would have clarified the authority of physicians and patients to enter binding arbitration agreements that include a cap on damages. The sovereign immunity provision was determined to have a multi-million dollar fiscal impact on the state's budget and was subsequently removed from the bill. Legislators remain interested in ways to protect physicians from liability threats in the ER, however, and the FMA will help them find ways to do this while minimizing the fiscal impact to the state. The arbitration provision was dropped out of the bills after the United States Supreme Court issued a ruling that upheld the general use of such agreements, which appears to trump any state law or court decision to the contrary.

We generated tremendous momentum this year in advancing our medical liability reform agenda and we are optimistic that we can pass these issues in the future. However, we should never underestimate the strength of the plaintiff attorney lobby. We must be unified if we are going to successfully win these important legislative battles.

On a personal note, every member of the FMA should be proud of the outstanding professional staff we have at the FMA. Our lobbying team, led by Vice President of Governmental Affairs Rebecca O'Hara and General Counsel Jeff Scott, is one of the most dedicated and respected groups in Tallahassee. They work extraordinarily hard on our behalf. I also want to thank all of the physicians who came to Tallahassee during the past two months to advocate for our profession.

In addition, I would like to recognize the efforts of the county medical society executives and others who helped with grassroots phone calls and emails in support of medicine's legislative agenda this year. Finally, I want to thank the FMA's Council on Legislation Chairman, Neal Dunn, M.D., who has selflessly given his time and talents to the physicians of Florida. All of us owe Dr. Dunn a debt of gratitude for his work on behalf of the physicians of Florida.

Now we will shift our focus to the political process. The opportunities to improve the makeup of the Florida Legislature, particularly the Florida Senate, are abundant as term limits will force many legislators to leave. In the Florida Senate alone, 11 out of 40 members will not return to Tallahassee next year. We need to ensure that pro-medicine legislators are re-elected, and work to replace unfriendly legislators. Of course, this is only possible if we have the necessary financial resources and grassroots support. If you care about these legislative issues but are not engaged in the political process, there is no better time to get involved and truly make a difference than over the next eight months.

Some doctors say that cheerful people resist disease better than grumpy ones, The surly bird catches the germ.

Admiral Hyman Rickover, U.S. Navy

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The Defendant Physician…A Personal Experience.

By: Shahid Sultan, M.D.

Tort reform is one item that is always on the minds of physicians. In addition to financial ruin that can be associated with a lost malpractice suit, it is the mental anguish, which lasts for months and years and can take an even bigger toll on the physician. Different organized physician groups continually attempt to get the legislators to impose a limit on the economic damages but very little, if any, thought has been given to the disturbance in the emotional equilibrium of the accused physician. Most medical errors are never pursued in the courts and majority of claims don't result in any payment. Even though direct and indirect cost of such suits is only 2.4 percent of total health care costs, we are still talking $55 billion a year and that is without saying anything about the social and mental cost to the physicians of litigation.

Recently, I went through this process as a result of an unanticipated outcome. I was named a defendant in this case on totally baseless merits. After going through the lengthy interaction with lawyers, giving statements and losing sleep over the outcome the plaintiff decided to drop the case. Actually, they asked for my insurance company to settle out of court but after looking at the merits of the case, which was based on a single abnormal lab test that had no bearing on the unfortunate outcome, my insurance company decided to fight it. At that point the plaintiff decided to drop the case all together. It was a welcome outcome for me but the mental anguish associated with the episode was almost too much to bear.

My initial response was typical of those that accompany any major untoward life event. There were feelings of anger, frustration, inner tension; loss of concentration, and at times loss of sleep. According to Sara C. Charles, Professor of Psychiatry, University of Illinois School of Medicine, incidence of depressive disorder, after a law suit is initiated, is 27%-39%, of adjustment disorder 20%-50% and onset or exacerbation of a physical illness range from 2%-15%. Emotional detachment, a low sense of accomplishment and even thoughts of suicide have been described. Fewer than 2% acknowledge drug or alcohol abuse. These effects figure prominently in deciding to settle the case or taking an early retirement by the physician. I was fortunate that plaintiff's case was weak and I was spared of any of the above listed maladies but loss of concentration and to some extent of confidence were two of the more noticeable effects. I questioned my decisions and at times ordered more tests than what may have been necessary. Others have refused to take care of complicated patients as a safeguard against litigation. Burnout is a common occurrence resulting in fatigue, errors and more claims…a vicious circle.

One way to break this negative circle is to improve communications between the patient and the physician. The patients should be aware of the problems that may arise despite the best efforts by the treating doctor. These conversations need to continue even after an error has occurred. Both public and the government are demanding more patient involvement in their healthcare decisions. This involvement should not be limited to the choice of a therapy but there needs to be an environment that will allow doctor and patient to continue this conversation and resolve unwanted issues together and directly. We need to look at malpractice reform in a different way as well. The reforms, if there are any, should not only give weight to economic impact but also weigh in the emotional burden on the physician and his relationship with the patient, medical community and society in general.

We, doctors, work under tremendous pressure and are well adapted to every day stress but when some of our actions result in undesirable outcome it is foreign to us. A lawsuit results in loss of control and disturbs the feeling of equilibrium that is of colossal importance to function in an already stressful environment. An understanding of the litigation stress and the coping mechanism will diminish the stress and will bring back the sense of control and equilibrium. The goal is to continue to function as a competent physician and member of the society in this lengthy and unwanted process.

Alleviating the Stress of a Malpractice Claim

The Doctors Company, the nation's largest insurer of physician and surgeon medical liability, goes beyond a superior legal defense for members facing a claim. We created regional Litigation Education Retreats to help members who are involved in a malpractice claim.

Each retreat provides a safe and supportive environment for physicians and their spouses to become familiar with the litigation process and to learn constructive methods for alleviating stress and anxiety. It's also a valuable opportunity for them to meet others experiencing a claim.

To learn more about our unique program and how attending a Litigation Education Retreat helped one physician, visit www.thedoctors.com/ler watch our six-minute video, or visit www.thedoctors.com. Participating physicians may also be eligible for up to 6.5 CME credits.

MEMORIAM
JAMES L. OTIS, DO
NOVEMBER 12, 1950 — MARCH 14, 2012

On March 14th, 2012, Dr. James Otis, my partner for the last 22 years, passed away. Dr. Otis came to me from the Tampa Orthopedic Institute after serving a fellowship in foot and ankle trauma. Dr. Otis was blessed with an abundance of intelligence, mechanical skills with his hands, and compassion to take care of patients as if they were his own family. Dr. Otis was the valedictorian of the first medical school class at Nova Southeastern University. He stayed on the East Coast to do his rotating internship at Humana Hospitals of the Palm Beaches, then traveled north, to do his 4 year orthopedic residency at Grandview Hospital, in Dayton Ohio. Before settling down to do his private practice, he decided to do a fellowship in the foot and ankle subspecialty, which was one of his favorite areas of the human body.

Dr. Otis enjoyed so many different types of activities. He was an accomplished sailor, a gardener who knew how to grow and maintain fragile orchids, and he was an excellent marksman with a vast knowledge of many different types of guns. He took great pride in his music collection which many of us were able to enjoy in the surgical suite as he did his trade as a bone setter and reconstructive expert of the musculoskeletal system.

Dr. Otis was also a very fine athlete. In college he played football and lacrosse. He was a golfer with a very low handicap which many physicians and pharmaceutical representatives found out the hard way, as he would methodically embarrass them in many charitable events. In the early years of our practice, we would play basketball and tennis together, and once again, he was able to hold his own. He was also an accomplished water and snow skier.

When I looked back, over 22 years in practice together, I will remember him most for the superior skills that he possessed in the field of orthopedic surgery, and how much his patient's loved his approach to their orthopedic problems. He was able to develop a loyalty that very few physicians know how to create in our present fast-pace, number-driven, medical environment.

Edward R. Dupay, Jr., D.O.
Orthopedic Associates of Southwest Florida, P.A.

LCMS Partner Education Event
Thursday, April 12th, 2012
Medical Equipment Financing

The Club at Renaissance
12801 Renaissance Way
Fort Myers, FL 33912

Time 6:00 PM Social Time (Wine)
6:30 PM Dinner (Surf & Turf)

Physicians only **RSVP Required 936-1645**

ALLIANCE NEWS

Mariquita Anderson, LCMS Alliance President

JOIN THE ALLIANCE

Dues for 2012 were due March 31. If you'd like to join, please send a check for $85 Regular (Membership to the LCMS Alliance and FMA Alliance) or $35 Retired (You or your physician spouse are retired.) to

LCMS Alliance, c/o Mariquita Anderson, 17920 Grey Heron Ct
Fort Myers Beach FL 33931-3031

You will receive a 2012 LCMS Alliance Directory if you join now! This is only available to current LCMS Alliance members.

Not sure of your membership status? E-mail Mariquita at lcmsa@lcmsalliance.org. Thank you!

ANTI BULLYING UPDATE

The next Anti Bullying Task Force Meeting is Wed, April 18, 4:30 PM at the LCPEC, 2855 Colonial Blvd, Fort Myers, FL 33966.

All are welcome to attend.

SPRING FLING

Join us on Sat, April 14, 7-10 PM, at the beautiful home of Sara and Brian Krivisky for the LCMS Alliance's Spring Fling!
Sara and Brian Krivisky's home, 15361 River By Road, Fort Myers, FL 33908

RSVP with check for $45/person made payable to:

LCMS Alliance, c/o Mariquita Anderson, 17920 Grey Heron Ct
Fort Myers Beach FL 33931
RSVP by March 31, 2012

If you are interested in sponsoring this event, please contact lcmsa@lcmsalliance.org. $750 to sponsor Invitations, Flyers, and Postage $500 each for the following: live music, hors d'oeuvres, beverages and desserts. For the most current information about Spring Fling, visit http://www.lcmsalliance.org/content/spring-fling.

IMMUNIZATIONS COMMITTEE

For more information about the Immunizations Committee, please contact Mariquita Anderson at lcmsa@lcmsalliance.org.

This committee is newly formed to answer the need for immunizations for students who are beginning or returning to school in the Fall. We will meet with Dr. Judith Hartner, Director of Lee County Public Health, at a time yet to be determined.

Your commitment can be as brief as one day in midsummer or it can span several meetings and a day, it's up to you! We hope this new program will benefit moms with young children, high school students who need community service hours, or physicians who want to help their community. As a new committee, anyone who joins now will help shape its mission. http://www.lcmsalliance.org http://twitter.com/lcmsalliance

MEMERSHIP DUES ARE CONSIDERED PAST DUE. MEMBERS THAT HAVE NOT PAID THEIR DUES BY APRIL 1, 2012 ARE SUBJECT TO REVIEW AND DROPPED FROM MEMBERSHIP.

When and How to Discharge a Problem Patient Continued

Steps to Take to Discharge

State your reason for dismissal – be objective

Give a 30 day (recommended) continuance of care.

Send a copy of your medical records transfer for the patient to fill out for the new physician to have all information to give continuing care without delay.

> Offer to send medical records to the new physician, whether the patient has an outstanding balance with you or not. Be sure to obtain a written request for the release of a copy of the medical records. If you elect to charge your patients for the copy of the medical records, inform your patient.

Give a referral for other physicians- never suggest a specific physician.

Send the discharge letter – regular mail and certified mail- keep all documentation.

Occasionally a letter of dismissal does not reach a patient. Legal counsel has indicated that a physician cannot be held responsible indefinitely for a patient because the physician has been unsuccessful in notifying the patient of dismissal via certified mail. When the certified letter is returned undeliverable, the physician should mark on the envelope the return date and attach the letter and envelope to the patient's chart. Once a termination letter is sent certified mail to a patient who has moved and left no forwarding address or to a patient who has refused to accept the letter, the physician is no longer responsible for the patient's care. Should the patient subsequently return to the area and request the physician's medical attention, the Physician should agree to treat the patient if it is a genuine emergency. If it is not an emergency, the physician should inform the patient diplomatically but firmly that their physician-patient relationship is irretrievably damaged, refer to the letter previously sent, and indicate:

Willingness to assist the patient to find another physician and transfer their medical records. This should be documented on the patient's record, and a letter confirming the conversation should be sent that day to the patient at the new address, with a copy of the original letter of dismissal enclosed.

Check your insurance carrier contract regarding discharge and if you have any responsibilities to them in the process.
If you are the patient's primary care physician, send a copy of the discharge letter to the HMO or PPO and indicate in the patient chart. Urge the patient to select a new physician from the current panel without delay!

Check your responsibility to you Malpractice Carrier.

Documentation of all correspondence of discharge should be a policy in place in all Medical offices and carried out without exceptions other than direct orders from the physician.

We must be realistic in the fact that this will happen many times in a practice for many reasons, the goal is be prepared and handle it with professionalism and this in turn will mitigate any issues for liability in the future.

CS/CS/HB 751: Prescription Drugs

GENERAL BILL by Health and Human Services Committee; Health and Human Services Quality Subcommittee; Brandes; (CO-INTRODUCERS) Ahern; McBurney

Prescription Drugs; Revises definition "addiction medicine specialist" to include board-certified psychiatrists; defines "board eligible"; excludes board-certified physiatrist as addiction medicine specialist; includes American Board of Medical Specialties as recognized certification entity; exempts specified board-eligible health care providers from application of certain provisions; adds American Board of Pain Medicine as recognized board-certification entity for purposes of exemption from application of certain provisions; permits rheumatologist to own pain-management clinic without registering clinic; recognizes American Board of Pain Medicine, American Association of Physician Specialists, & American Osteopathic Association as board-certification organizations for purposes of determining board-certified pain medicine specialist as owner of pain-management clinic; exempts from out-of-state prescription drug wholesale distributor permit requirements intracompany transactions or sale of prescription drugs from out-of-state distributor to distributor in this state if both distributors conduct wholesale distributions under same business name, etc.

Senate Committee References: Health Regulation (HR), Children, Families, and Elder Affairs (CF), Budget (BC)
Last Action: 03/05/2012 Referred to Health Regulation; Children, Families, and Elder Affairs; Budget -SJ 846
Effective Date: July 1, 2012