"All politics are local"

LEE COUNTY MEDICAL SOCIETY Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 26, NO. 4 | FORT MYERS, FLORIDA | Mary C. Blue, EDITOR | JULY 2002

NO MEETINGS IN JULY AND AUGUST

NEXT GENERAL MEETING
SEPTEMBER 19, 2002
Medical Myths of Chronic & End of Life Care
Royal Palm Yacht Club
2360 West First Street
Dinner: 6:00 p.m.
Program: Promptly at 7:00 - 9:00 p.m.
Cost: LCMS Members - $25
Applicants/Spouses/Retired Members- $25
Non-Members- $50 (Includes Dinner)
Reservations Required

Continuing Medical Education Credits:
"This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Florida Medical Association and Lee County Medical Society. The Florida Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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

Inserts

1. **Watch Out For "The Bundle and Drop"**
2. **15 Steps to Protect Your Practice**
3. **Communicable Disease Surveillance Report 1997-2001**
4. **News Release Flash Comp. Options**
5. **Medicare on the Front Burner**

In This Issue. . .

President's Message

"S.O.S - SAVE OUR SYSTEM"

Eliot Hoffman, M.D.

During the previous several months and continuing until the November election, there will be ongoing discussion and debate regarding the planned referendum for a half-cent sales tax to fund emergency and trauma services throughout Lee County. This growing crisis was initially discussed with the Lee County Commissioners in December 2001 and subsequently a multidisciplinary task force was formed to identify the scope of the problem and to evaluate potential solutions.

Although the starting point was "trauma services", it became rapidly apparent that the entire system of emergency service delivery countywide is in a crisis stage. The entire state of Florida and Lee County's rapid growth is fueling the problem: 600 people a day move to Florida, and Lee County is growing 60% faster than the rest of the nation. Over 7 million visitors come to Southwest Florida annually, and most have no family physician locally, and frequent the emergency room for regular medical care. The aging population is also straining the system, expected to grow from 2.9 to 5.5 million seniors by 2025. These elderly patients use health care services 2-4 times more frequently than younger groups, and utilize emergency services more than all other age groups combined. Unfortunately, as we all know, 25% of emergency patients are uninsured and many more are underinsured. The emergency and trauma services task force has identified an enormous need for funding these services which include $26,533,672 in unfunded hospital and professional emergency services rendered at all six Lee County hospitals, as well as $9,105,958 in unfunded hospital and professional trauma services rendered at all six emergency departments county-wide. This does not include funding for mental health crisis stabilization and urgent primary and outpatient services to reduce the inappropriate utilization of emergency rooms or support for services such as The Phoenix Center's Rape Crisis Program.

The task force recommendations do recognize and include these services and others as appropriate and mandatory elements in addressing the emergency care needs of the citizens of Lee County. The total cost, obviously, is well above the $33-40 million a half-cent sales tax would be expected to generate annually, but would be adequate to ensure that these services continue to be available to the county residents.

The physicians of Lee County must provide a leadership role in educating the public regarding what they will LOSE if this referendum is not passed. They need to be educated to appreciate the fact that preventable trauma deaths in the first "golden" hour after injury is reduced from 30% to less than 5% by a "mature" trauma system, and in fact, Lee County is blessed with a system with a "preventable" death rate of approximately 3%. The public needs to be educated to realize that without this system, the "golden" hour will be spent being "triaged" in the closest emergency room and then transported to either Tampa or Miami. This "preventable" death rate for Lee County citizens will therefore immediately rise 10-fold back to 30%! The public must be educated to recognize that many subspecialists will likely withdraw from hospital emergency room coverage and therefore will not be available at all if this tax is not enacted. They must be educated to the fact that the only surviving trauma systems, e.g. Tampa, West Palm Beach, and Broward-Dade counties in south Florida, are all supported by tax dollars. If this referendum fails, we all lose – big time.

As I Recall...

"SUMMER OF '39"

Roger D. Scott, M.D.

The summer of 1939 Daddy advised that we would head north to the big city of New York, New England, and who knows where else. I would invite you to take this first time north of North Carolina trip with the 12-year-old country boy from a small north Florida town.

Return with me to Suwannee County (Live Oak) with a population of 16,500 people. Only 1,700,097 people resided in Florida! Our three largest counties: Dade (Miami) 250,000, Duval (Jax) 200,000, and Hillsborough (Tampa) had 178,000. We frequently traveled to Miami and Jacksonville but rarely to Tampa. These all seemed like monstrous cities to me.

We began our trek on the two lane US #1 (no Interstates or A/C cars) through GA, SC, NC, and VA. Crossing the Potomac and entering Washington, D.C. was when my love of history really began. All through school I had seen pictures of the Washington Monument, the White House, and the Lincoln Memorial. The Museum of Natural History displayed a Brontosaurus skeleton that was truly amazing as was a "stuffed" whale. The Air Museum contained the "Spirit of St. Louis" (Col. Lindbergh's plane in which he flew solo across the Atlantic just twelve years before). All of my studies were coming to "life"!

Most memorable about Baltimore was Ft. McHenry where the Star Spangled Banner was flying during the War of 1812 when Francis Scott Key wrote his poem that was later put to music and adopted as our National Anthem. Again, more of my reading and lessons coming to life. We ate at Miller Brothers, the oldest and most prestigious restaurant in downtown Baltimore. Everyone ordered lobster, crab, and other fine dishes and were aghast when I ordered a "ham-sammich". The waiter brought out a massive tray with all types of hams, cheeses, pickles, tomatoes, lettuces, etc. that would have made a Dagwood Sandwich seem small. (Do any of you remember Dagwood?)

Philadelphia and Independence Hall were next. We were allowed to touch and (if no one was looking)

See AS I RECALL, page 3

CELEBRATE FLORIDA MEDICINE

By Sandra Mortham, EVP/CEO

The "2002 Celebration of Florida Medicine" is just around the corner. You will not want to miss this fun-filled annual meeting weekend, August 29 – September 1. We have chosen the Wyndham Palace Resort & Spa in Lake Buena Vista, Florida conveniently located inside the Walt Disney World® Resort. You and your family won't have to go far to enjoy free transportation to all Disney theme parks, dining with Disney characters, access to the championship Disney golf courses and more. Universal Studios® and Sea World® are also just minutes away. We invite you to bring the family and enjoy the entire Disney experience! For those wishing to stay-over Sunday, we have extended the special group room rate of $139 per night. So relax, take your time, and have fun!

We will kick-off this year's celebration with "A Taste of the World Reception" event on Thursday evening featuring fine wines and gourmet delights from around the world as well as musical entertainment and door prizes. All proceeds will benefit the Florida Medical Foundation to help support educational activities. Don't forget to be prepared for the FMF Silent Auction during the reception as well as in the exhibit hall on Friday.

Our exhibit hall is twice the size of last year's! Now, more than ever, you will have the opportunity to visit prominent medical vendors while enjoying fun activities and participating in prize giveaways. As always, be sure to visit the FMA booth and register for the grand prize giveaway.

Since the 2002 elections are guaranteed to be an exciting part of this year's meeting, we want to provide you with the perfect opportunity to meet the FMA and AMA candidates running for office this term. Our very first "Old Fashioned Candidate Meet & Greet" in the exhibit hall during lunch on Friday will be your chance to talk to the candidates face to face. Of course, you can count on many of the same events from last year. The Creole Family Festival on Friday evening, the Good Government Luncheon, featuring incoming Senate President Jim King, the 2nd Annual FLAMPAC Golf Tournament, and the Installation Ceremony and Dinner all taking place on Saturday.

The highlight of the weekend will be our featured keynote speaker, Dr. Edward R. Annis. The Florida Medical Association is truly honored to have Dr. Annis address our members during the opening session of the House of Delegates beginning at 3:00 p.m. on Friday. Dr. Annis, Past President of the AMA (1963-64), began his private practice in Tallahassee in 1938 before relocating to Miami in 1946. He is also a Past President of both the World Medical Association and the United States Section of the International College of Surgeons. Dr. Annis is nationally and world renowned for his prowess and skill as an orator and debater and continues to be one of our best ambassadors and statesmen on behalf of quality health care in a free enterprise system. We know everyone present at our Annual Meeting can greatly benefit by hearing words of wisdom from a proven leader in American medicine.

Go ahead and mark your calendars today for the FMA 2002 Annual Meeting and the "2002 Celebration of Florida Medicine." For more information about the meeting, please visit the FMA website at www.fmaonline.org. I look forward to seeing you at the "Celebration" in August.

LEE COUNTY MEDICAL SOCIETY BULLETIN
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MEMBERSHIP ACTIVITY

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Joseph Zeterberg, M.D.
Patrick Cullen, M.D.

Dropped for non-payment

Joseph Dallessio, M.D.
Larry Farmer, D.O.
Edward Laird, M.D.
Jack Lomano, M.D. (Retired)
Neil Pauker, M.D.
Quinnon Purvis, M.D.

Name Change

Lee Radiology Physicians Group have changed their name to Florida Radiology Consultants. The new Administrator is Dee Sanders.

LEE COUNTY MEDICAL SOCIETY ALLIANCE NEWS

Ann Shah, PhD, Corresponding Secretary

Installation of 2002-2003 Officers

The 2002-2003 Lee County Medical Society Alliance and Foundation Officers were inducted on May 8th at the historic Murphy-Burroughs Home in Downtown Fort Myers. American Medical Association Alliance President Liz Kagan returned to her Lee County roots to officiate the installation ceremony. Fort Myers Mayor Jim Humphrey was also on hand to welcome our new leadership. Please join us in congratulating next year's officers:

President - Cheri O'Mailia
Co-Presidents Elect - Lynne Bacon and Linda Chazal
Vice President - Karma Marino
Recording Secretary - Jillinda Duerbeck
Corresponding Secretary - Ann Shah
Treasurer - Tami Traiger
Parliamentarian - Lynne Gorovoy

Please also support our health-related endeavors in the year ahead. The Alliance, the Medical Society and the most honored profession of Medicine — we are in this together!

Largest Membership in Florida

The Lee County Medical Society Alliance and Foundation currently has a record-breaking 215 members! This is an amazing increase of over 10% from last year. Having surpassed Broward County's 208 documented members, Lee County now has the largest Medical Society Alliance in the state of Florida!

7th ANNUAL LEGAL/ MEDICAL GOLF TOURNAMENT

By Bruce J. Lipschutz, D.O.
Chair, LCMS Legal/Medical Golf Committee

On May 11, 2002, I had the pleasure, as co-director with Ken Jones, JD, to participate in the Jaw Bones versus Saw Bones Seventh Annual Legal/Medical Golf Tournament at West Bay Golf Club in Estero. West Bay was selected for its excellent golf and playing conditions. The golf tournament benefited Partners For Breast Cancer Care and was an overwhelming success, raising upwards to $13,000. Unfortunately, the lawyers were successful in their challenge against the doctors. Next year will prove to be even more exciting as the physicians strive to overcome the attorneys. There was wonderful participation with over 60 players combined. Sponsorship was excellent, and I personally thank all members of both the Lee County Medical Society and Lee County Bar Association committees as well as the players who helped to make this event successful.

If anyone is interested in participating in organizing next year's event, please do not hesitate to call 239-936-1645. Next year the doctors will win! I know because I am beginning to practice my swing now.

SPORTS MEDICINE COMMITTEE FREE SPORTS PHYSICALS THURSDAY, MAY 30, 2002

Larry S. Eisenfeld, M.D.
Chair, LCMS Sports Medicine Committee

LCMS physicians in conjunction with many volunteers coaches, school nurses, and administrators performed high school physicals on over 500 athletes on May 30, 2002 at Lee Memorial Hospital. The LCMS would like to thank Drs. Larry Eisenfeld and Ed Dupay (Orthopedics), Dr. Thad Goodwin (Ophthalmology), and Drs. Diana Young, Michelle Candelore, and Barry Sell (FP/IM) for donating their time and expertise for our county athletes.

The list of volunteers from the doctor's offices, high school nurses, athlete directors, coaches, administrative aides, LMH Security, and all the other volunteers whom I do not know personally have the gratitude of LCMS, Lee County and over 500 athletes coming their way. Without the time and efforts of everyone involved, this endeavor would not have been successful.

We would really benefit next year if more physicians, office and school staffers would get involved in this program. That would allow more of us the joy of contributing to our high school athletes and our community.

Thanks again to all of the volunteers.

THE QUESTION MAN
OPINIONS-EDITORIALS LETTERS TO THE EDITOR

John W. Snead, M.D.

JULY'S QUESTION: "WHAT WOULD BE YOUR SUGGESTIONS FOR FUNDING EMERGENT CARE IN LEE COUNTY, AND DO YOU FEEL LEE COUNTY RESIDENTS WOULD BE WILLING TO HELP DEFRAY THE COSTS OF A TRAUMA CENTER?"

Gary Correnti, M.D.
Neurosurgery

"The current proposal for ½ cent tax is the solution. This will spread the cost to visitors and not burden the property owners only. It also funds trauma care done outside of the trauma center and funds mental health care which puts a tremendous burden on the emergency rooms now."

Larry Eisenfeld, M.D.
Orthopedic Surgery

"Lee County's size and growth requires the presence of a trauma service for the well being of our community. A sales tax is a fair and reasonable way for all people using services and buying goods in Lee County to fund this service. We cannot afford to lose this service, lives will be lost if that happens – Might it be you or your loved one that does not survive the trip to Tampa or Miami?"

Kurt Markgraf, MD
Anesthesiology

"As a participant in the Emergency and trauma services task force, I support the current sales tax initiative. Sales tax, rather than a property tax was felt to be fairer, as visitors as well as all residents would share the cost of emergency services. Will Lee County residents support this tax? That is anyone's guess. Certainly it is an up hill battle. As state law dictates that this tax should support all emergency services, not just the trauma center, the voters will be that more reluctant to vote yes."

Richard Murray, M.D.
Obstetrics/Gynecology

"Lee County residents have been resistant to sales tax increases. Surcharges on fuel, hotels, new and used auto sales make more sense. Furthermore the $10,000 requirement for helmet-less motorcyclists is vastly insufficient. We will need a crisis to solve this issue just like we will need a crisis to solve our malpractice issues. Moreover, we have impact fees for schools; why can't we have them for trauma centers? Yes the trauma center needs funding, however I do not know if sales tax is the best way."

GOOD TELEPHONE HABITS INCREASE PATIENTS' PATIENCE

Barbara Harty-Golder, M.D., J.D.

The first impression your medical practice gives is on the telephone, and yet, few physicians pay much attention to phone matters. Good telephone habits encourage patient communication, and enhance your ability to care for your patients. Poor habits – often undetected – can cause enormous problems in patient care. Take a few minutes to review how your office uses the telephone, with these hints in mind.

1) Most people VASTLY prefer a human voice to a computer. Although computer answering services have become the "standard," they present real problems for the medical practice. In a community such as ours, many elderly patients are either flummoxed by the menu system, can't hear the options, or aren't fast enough (especially with a cordless phone) to enter the option and get the receiver back to the ear to hear the next prompt. Result? Angry patients, or those who decide calling just isn't worth it – even when there is a real medical issue. Make every attempt to have your telephone answered, at least during business hours, by a living, breathing person.
2) Too many offices have too few lines for the amount of telephone traffic they get. Few messages are more off-putting than "All of our receptionists are busy; either call back later or leave a message." Getting an interminable busy signal is even worse. This is most often a problem in large group practices, and again, presents a real impediment to communication and care. Remember how angry you get when you can't contact an insurer to get authorization for treatment because there are too few lines and they are always busy? Your patients have same complaint about you.
3) If you have a computerized message, the first thing it says must be emergency directions. Otherwise, a patient may call in an after hours emergency and, out of desperation or anger, fail to wait through the office hours-and-ad information to get instructions for emergency coverage.
4) Make sure those who do answer the phone – either in your office or at your after hours service – have excellent phone manners and communicate your concern for your patients. Make an occasional call yourself to see how well they do, both in answering calls and in forwarding messages.
5) Encourage "alternative" phone uses. Many elderly patients may find it easier to fax a message than to wade through your phone menu and wait for a call back, especially if it is simply to ask for routine prescription refill or notify you that they will not make an appointment. If fax traffic is a problem in your office, consider using computer fax option: for a small monthly fee, you can obtain an 800 number for faxes that will convert the messages to e-mail and send them directly to your computer (efax.com). That spares telephone line snarls, cuts down on paper use, and permits you to store the faxes in a computer file for future reference.

This publication is intended to provide education information about medicolegal and risk management subject. It is published with the understanding that it is not intended to provide legal or other professional advice. If legal or other professional advice is needed, the services of a competent professional should be sought.

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CALIFORNIA "IPAs" DON'T WORK EITHER

Jeffrey Cohen, Esq.

The Federal Trade Commission recently settled a case against OB/GYNs in Napa Valley. The FTC alleged that every OB/GYN with staff privileges at the two general acute care hospitals in Napa County fixed fees and boycotted payers.

The FTC complaint alleges that the OB/GYNs were part of an IPA (Independent Physicians Association) that shared risk, but then broke off and formed their own IPA. In particular, the OB/GYNs allegedly agreed on non-risk fees to charge payers and refused to negotiate with health plans other than through their own IPA. As a result, the FTC alleged, some health plans ceased providing HMO coverage in Napa County.

Rather than litigate the charges for eternity, the doctors agreed to a consent order wherein they will not:

*negotiate on behalf of physicians with any payer or provider;

*agree to deal or refuse to deal with any payer or provider; or

*agree with any payer on any term on which physicians deal or are willing to deal.

The California case merely underscores once again the clear and timeworn prohibitions of applicable antitrust law. It also harkens back to the days of intense IPA activity and the frustrations experienced through that time.

Applicable antitrust law forbids, among other things: (1) two or more physicians to agree to charge specific fees for certain procedures in their respective, independent practices, and (2) two or more physicians to agree not to do business with a particular payer. If doctors want the benefits of market share they must demonstrate that they share substantial economic risk through such things as capitation and economic integration to the degree that is typically found in an integrated medical practice. A loose affiliation of competing doctors will never suffice for purposes of obtaining managed care agreements.

But all of this begs the question concerning the effectiveness of IPAS. The problem with IPAs is that they create some very unrealistic expectations for physicians. Though IPAs can have a greater purpose than simply procuring and negotiating risk based managed care agreements, they usually confine themselves to that task. Moreover, even the loosening up of the antitrust laws via the revised *Statements of Antitrust Enforcement* Policy in Health Care issued by the Department of Justice are not particularly helpful. For instance, though they expand the role of the "messenger" in contracting on behalf of physician networks like IPAS, physicians do not obtain the benefits they want by using messengers in the first place.

In truth, the very nature of most IPAs is self-defeating. Most are physician owned, and do nothing more than keep capitated fees in place. They often fail to conduct meaningful utilization management and quality assurance, which in turn adversely affects their ability to obtain and maintain even pure cap agreements. To obtain fuller risk contracts is usually out of the question for such organizations, particularly single specialty organizations.

Still, there is an opportunity for IPAs whose members understand that, at the end of the day, the more economically integrated they are, the more value the IPA will deliver. Does this mean the only benefit is the formation of a group medical practice? Not necessarily, though it remains the Cadillac model in terms of market power, economies of scale and revenue enhancement. An IPA can deliver meaningful benefits short of full integration, usually in the form of (1) benefits obtained through well managed risk agreements, and (2) MSO (back office) type functions.

That is, it is becoming clear to most IPAs that capitation without more risk is of nominal value. Linking economic benefits to outcomes, patient satisfaction, etc. is meaningful, but requires internal systems and compliance activity. Simply outsourcing claims adjudication, which is what many IPAs do, does not deliver useful information that doctors can use to optimize outcomes or cost.

Perhaps the most that can be expected from an IPA is the provision of administrative (a/k/a "management") services, such as scheduling, billing and collection, etc. But even that is only as useful as the physician's willingness to implement and rely on those systems. If they mirror the ones the physicians have in place, they will only be of significant economic value if the ones in place are replaced by centralized services.

Making an IPA useful is hard work. Paying consultants to form one, and adhering to the limited vision of simply maintaining capitated agreements will disappoint and frustrate physicians. At the end of the day, there is still a direct relationship between risk, effort, vision and reward. And IPAs are usually at the low end of all of those things.

Mr. Cohen is a partner with the Delray Beach/Ft. Lauderdale law firm of STRAWN, MONAGHAN & COHEN, P.A. He is Board Certified by the Florida Bar as a Specialist in Health Law and has formed and represents numerous IPAS. He may be reached at (561) 278-9400.

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IS IT WAR?

Steven R. West, M.D.

Talking with physicians throughout Florida the practice of medicine is becoming increasingly difficult. We face more regulations. Our patients expect more and are aware of the newest technology or therapy often before it is of proven benefit. Certainly, before I have heard of it. The therapies of proven benefit are challenged and seeking alternative medicine patients demonstrate a reluctance to adhere to effective treatment. The rising cost of prescription drug make it very difficult if not impossible for many of our patients to afford their medication. We are experiencing substantial reductions in Medicare reimbursement of 10 percent or more for cardiology. Florida's Medicare carrier First Coast aka Blue Cross and Blue Shield due to a "transition period" is extremely slow in paying Medicare claims. First Coast is so slow that many practices are borrowing money to meet expenses.

Managed care organizations for years have negotiated aggressive contracts with physicians with notoriously low reimbursement rates. Once the contract is signed the agreed to rates and terms of the contract are not honored, often unilaterally changed without notice, and medical decisions are made by the HMO clerks. Laws are sponsored by physician groups to correct problems with HMO contracts as well as restricting the managed care organization practice of medicine. The laws are ignored or loopholes are taken advantage of requiring new laws to be sponsored, lobbied and passed year after year. Finally, the Florida Insurance Commissioner fines fifteen of the thirty-two Florida HMO's for breaking the Prompt Pay law. Due to larger jury settlements, malpractice insurance is becoming unaffordable forcing physicians to limit their practices, move out of the state or retire. It is increasingly difficult to recruit new physicians to Florida. ***Our practices are under attack. We are at war with our political opponents!***

David Horowitz is a political activist that has written extensively on the "Art of Political Warfare". There is **Six Principles of Political Warfare** according to Mr. Horowitz.

1. Politics is war conducted by other means.
2. Politics is a war of position.
3. In political war, the aggressor usually prevails.
4. Position is defined by fear and hope.
5. The weapons of political war are symbols that evoke these emotions.
6. Victory lies on the side of the people.

We must position ourselves as patient advocates as well as reaffirming our role as the providers of health. Victory lies on the side of our patients. Physicians must realize that in political war the aggressor usually prevails. We want to position ourselves as patient advocates, as caring physicians who provide good care relieving pain and suffering. This is a message of hope. Our opponents desire to limit our ability to be there for our patients when they are sick and suffering. This is the image we wish to stick but to do this we must become the aggressor. We must strike first defining physicians as the friend of patients and our adversaries as the uncaring profit seeking HMO or trial attorney.

We are under attack from various fronts. In the state of Florida, three weapons need our aggressive support. The Florida legislature has passed the Florida budget in the second special session called this year. During the first special session the Prompt Pay bill was passed. The business community and the insurance industry fought hard to defeat the Prompt Pay bill. **The Florida Medical Association** overcame these very powerful special interests passing this bill that will close many of the loopholes allowing insurance companies to avoid payment for medical services rendered. If you are not a member of the FMA and your county medical society, **JOIN.**

The Florida Medical Political Action Committee (FLAMPAC) needs support. FLAMPAC endorses candidates for the state legislature that are pro-medicine and pro-patient. Make out your check ($150.00 individual membership, $250.00 family membership) to FLAMPAC, P.O. Box 10269, Tallahassee, FL 32302.

The 1000 Club is a committee of FLAMPAC. Members of the 1000 Club pledge a thousand dollars per two-year election cycle to pro-medicine candidates who are involved in a close race and need an infusion of cash to win.

Citizens For Tort Reform is a committee created by the Florida Medical Association to raise the approximate $15 million for a constitutional initiative or amendment to place a cap on non-economic damages. The FMA TASK FORCE ON TORT REFORM studied the malpractice crisis for several months. The Task Force found that in Florida a constitutional amendment is the only vehicle that would provide meaningful tort reform. Checks can be sent to Citizens for Tort Reform, 6675 Weeping Willow Way, Tallahassee, Florida 32311.

Dr. Edward Annis a retired surgeon from Miami, former President of the AMA and author of the book **"Code Blue"** has it right. When asked about the current mess medicine is in by a colleague, Dr Annis replied "Politics, politics, politics got us into this mess and politics, politics, politics is going to get us out of this mess." ***Please support the war effort.***

NEW MEMBER APPLICANTS

Application for Membership

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

PAUL ENGEL, M.D. – FAMILY PRACTICE

Medical School: University of Florida, Gainesville Florida (1995-99)
Internship & Residency: University of Florida, Gainesville Florida (1999-02)
Dr. Engel is in group practice with Physicians Primary Care, 1304 SE 8th Terrace, Cape Coral.

GEORGIA ROCHA-RODRIGUEZ, M.D. – PEDIATRICS

Medical School: Universidade Federal De Goias/Brazil (1989-1996)
Internship & Residency: University of Miami/Jackson Memorial Hospital (1997-00)
Board Certification: Dr. Rodriguez is Board Certified by the American Board of Pediatrics.
Dr. Rodriguez is in group practice with Physicians Primary Care, 9350 Camelot Drive, Fort Myers.

STEVEN STRICKLER, M.D. – RADIOLOGY/NEURORADIOLOGY

Medical School: Des Moines University, Des Moines, IA (1986-90)
Internship: Botsford General Hospital, Farmington, MI (1990-91)
Providence Hospital, Southfield, MI (1991-95)
Residency: University of Florida Shands Teaching Hospital (1995-96)
Board Certification: Dr. Strickler is Board Certified by the American Board of Radiology. He is currently in solo practice, Diagnostic Radiologists of South Florida, and is contracted by Bonita Community Health Center.

AS I RECALL from page 1

gently gong the Liberty Bell.

As we rolled into New York City I was awed by the buildings, especially the Empire State Building (constructed in 1931) that was 1,250 feet tall and the world's tallest building. We took a ride to the top (I recall it having 101 floors – did they skip the 13th floor?) and on the observation deck there was a very minimal guardrail rather than the screen enclosures that are present today. The view was unbelievable, but only a few skyscrapers as compared to today. The Statue of Liberty was majestic. I ran all the way up the stairs inside the statue and into the arm up to just below the torch (later closed because of a fracture in the metal). It was fantastic going outside the arm, onto the torch base, and looking down at the statue from 306 feet above the ground (remember there were no choppers & minimal aviation in '39). Daddy told me that as a young man in the sawmill business, he made a number of the crossties used for the subway, and we could still see his mark on some of them (the pieces of heavy wood that are placed under and perpendicular to the two rails for trains and three rails for subways).

The N.Y. Worlds Fair of 1939-40 was a lengthy portion of this summer adventure and will be a future article. There was so much of interest and amazement for this youngster.

New England where the people talked really "funny" was our next stop. We visited President Calvin Coolidge's home and saw his tennis court where his son developed a blister on his heel that became infected and killed him.

We just kept going north and headed west into Canada to Montreal, Toronto, and across Lake Ontario on a car ferry that was big enough to hold a "bunch" of cars. Wow! What a boat! We visited Niagara Falls and Mark Twain's (Samuel Clemens) home in Elmira, N.Y.

Well it was good to return to home cooked meals and lots of ham sammiches.

Physicians practicing in Lee County (population 17,488) in 1939: Harry Allen, Fred Bartleson, Ernest Bostelman, William Grace, Arthur Hunter, M. F. Johnson, H. Q. Jones Sr., Harry Kehoe, Guy Longbrake, Gordon Merrick, M. Seiler (not sure but I think this was Myrtle), Harvie Stipe, Edward Velasco (the only colored physician), Baker Whisnant, Archie Byle in Alva, J. Menefee in Bonita Springs, and Robley Newton at Ft. Myers Beach. Eight of these physicians were still in practice and personally known to me in 1958.

Didyano: "Miss Liberty" is on the $1,000,000 bill?

Correction: Dr. Otis D. Brungard's License should read 1921 instead of 1931.

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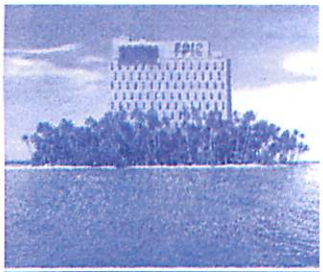

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ANTHRAX AS A BIOLOGICAL WEAPON

By Michael Barnaby, Public Information Officer Lee County Health Department

Anthrax as a Biological Weapon is part of a continuing series designed to give, in very abbreviated form, an overview of biological agents that have the potential to be used as terrorism weapons. All materials are excerpted from the JAMA website at http://jama.ama-assn.org, where the full consensus papers for each are available for viewing and downloading at no charge.

HISTORY OF CURRENT THREAT

For centuries, *B anthracis* has caused disease in animals and serious illness in humans. Research on anthrax as a biological weapon began more than 80 years ago. Most national offensive bioweapons programs were terminated in the early 1970s; the US offensive bioweapons program was terminated after President Nixon's 1969 and 1970 executive orders. However, some nations continued offensive bioweapons development programs despite ratification of the BWC. In 1995, Iraq acknowledged producing and weaponizing *B anthracis* to the United Nations Special Commission. The former Soviet Union is also known to have had a large *B anthracis* production program as part of its offensive bioweapons program.[8] A recent analysis reports that there is clear evidence of or widespread assertions from nongovernmental sources alleging the existence of offensive biological weapons programs in at least 13 countries.

The anthrax attacks of 2001 have heightened concern about the feasibility of large-scale aerosol bioweapons attacks by terrorist groups. It has been feared that independent, well-funded groups could obtain a manufactured weapons product or acquire the expertise and resources to produce the materials for an attack. Al Queda also has sought to acquire bioweapons in its terrorist planning efforts although the extent to which they have been successful is not reported.

In the anthrax attacks of 2001, *B anthracis* spores were sent in at least 5 letters to Florida, New York City, and Washington, DC. Twenty-two confirmed or suspected cases resulted. The anthrax attacks of 2001 used 1 of many possible methods of attack. The use of aerosol-delivery technologies inside buildings or over large outdoor areas is another method of attack that has been studied.

An aerosol release of *B anthracis* would be odorless and invisible and would have the potential to travel many kilometers before dissipating. Aerosol technologies for large-scale dissemination have been developed and tested by Iraq and the former Soviet Union. Few details of those tests are available.

In 1970, the World Health Organization estimated that 50 kg of *B anthracis* released over an urban population of 5 million would sicken 250 000 and kill 100 000. A US Congressional Office of Technology assessment analysis from 1993 estimated that between 130 000 and 3 million deaths would follow the release of 100 kg of *B anthracis*, a lethality matching that of a hydrogen bomb.

EPIDEMIOLOGY OF ANTHRAX

Naturally occurring anthrax in humans is a disease acquired from contact with anthrax-infected animals or anthrax-contaminated animal products. The disease most commonly occurs in herbivores, which are infected after ingesting spores from the soil. Animal vaccination programs have reduced drastically the animal mortality from the disease. However, *B anthracis* spores remain prevalent in soil samples throughout the world and cause anthrax cases among herbivores annually.

Anthrax infection occurs in humans by 3 major routes: inhalational, cutaneous, and gastrointestinal. Naturally occurring inhalational anthrax is now rare. Eighteen cases of inhalational anthrax were reported in the United States from 1900 to 1976; none were identified or reported thereafter. Most of these cases occurred in special-risk groups, including goat hair mill or wool or tannery workers; 2 of them were laboratory associated.

Cutaneous anthrax is the most common naturally occurring form, with an estimated 2000 cases reported annually worldwide. The disease typically follows exposure to anthrax-infected animals. In the United States, 224 cases of cutaneous anthrax were reported between 1944 and 1994. One case was reported in 2000. The largest reported epidemic occurred in Zimbabwe between 1979 and 1985, when more than 10,000 human cases of anthrax were reported, nearly all of them cutaneous.

Although gastrointestinal anthrax is uncommon, outbreaks are continually reported in Africa and Asia following ingestion of insufficiently cooked contaminated meat. Two distinct syndromes are oral-pharyngeal and abdominal. Little information is available about the risks of direct contamination of food or water with *B anthracis* spores.

Inhalational anthrax is expected to account for most serious morbidity and most mortality following the use of *B anthracis* as an aerosolized biological weapon. Given the absence of naturally occurring cases of inhalational anthrax in the United States since 1976, the occurrence of a single case is now cause for alarm.

CLINICAL MANIFESTATIONS

Clinical Presentation, Inhalational Anthrax

Early diagnosis of inhalational anthrax is difficult and requires a high index of suspicion. Prior to the 2001 attacks, clinical information was limited to a series of 18 cases reported in the 20th century and the limited data from Sverdlovsk. The clinical presentation of inhalational anthrax had been described as a 2-stage illness. Patients reportedly first developed a spectrum of nonspecific symptoms, including fever, dyspnea, cough, headache, vomiting, chills, weakness, abdominal pain, and chest pain. Signs of illness and laboratory studies were nonspecific. This stage of illness lasted from hours to a few days. In some patients, a brief period of apparent recovery followed. Other patients progressed directly to the second, fulminant stage of illness.

This second stage was reported to have developed abruptly, with sudden fever, dyspnea, diaphoresis, and shock. Massive lymphadenopathy and expansion of the mediastinum led to stridor in some cases. A chest radiograph most often showed a widened mediastinum consistent with lymphadenopathy. Up to half of patients developed hemorrhagic meningitis with concomitant meningismus, delirium, and obtundation. In this second stage, cyanosis and hypotension progressed rapidly; death sometimes occurred within hours.

2001 Attacks Data

The anthrax attacks of 2001 resulted in 11 cases of inhalational anthrax, 5 of whom died. Symptoms, signs, and important laboratory data from these patients are available at http://www.jama.ama-assn.org. Several clinical findings from the first 10 patients with inhalational anthrax deserve emphasis. Malaise and fever were presenting symptoms in all 10 cases. Cough, nausea, and vomiting were also prominent. Drenching sweats, dyspnea, chest pain, and headache were also seen in a majority of patients. Fever and tachycardia were seen in the majority of patients at presentation, as were hypoxemia and elevations in transaminases.

Importantly, all 10 patients had abnormal chest x-ray film results: 7 had mediastinal widening; 7 had infiltrates; and 8 had pleural effusions. Chest computed tomographic (CT) scans showed abnormal results in all 8 patients who had this test: 7 had mediastinal widening; 6, infiltrates; 8, pleural effusions. Data are insufficient to identify factors associated with survival although early recognition and initiation of treatment and use of more than 1 antibiotic have been suggested as possible factors. For the 6 patients for whom such information is known, the median period from presumed time of exposure to the onset of symptoms was 4 days (range, 4-6 days). Patients sought care a median of 3.5 days after symptom onset. All 4 patients exhibiting signs of fulminant illness prior to antibiotic administration died. Of note, the incubation period of the 2 fatal cases from New York City and Connecticut is not known.

Clinical Presentation, Cutaneous Anthrax

After the anthrax spore germinates in skin tissues, toxin production results in local edema. An initially pruritic macule or papule enlarges into a round ulcer by the second day. Subsequently, 1- to 3-mm vesicles may appear that discharge clear or serosanguinous fluid containing numerous organisms on Gram stain. Development of a painless, depressed, black eschar follows, often associated with extensive local edema. The anthrax eschar dries, loosens, and falls off in the next 1 to 2 weeks. Lymphangitis and painful lymphadenopathy can occur with associated systemic symptoms. Differential diagnosis of eschars includes tularemia, scrub typhus, rickettsial spotted fevers, rat bite fever, and ecthyma gangrenosum. Noninfectious causes of eschars include arachnid bites and vasculitides. Although antibiotic therapy does not appear to change the course of eschar formation and healing, it does decrease the likelihood of systemic disease. Without antibiotic therapy, the mortality rate has been reported to be as high as 20%; with appropriate antibiotic treatment, death due to cutaneous anthrax has been reported to be rare. Following the anthrax attacks of 2001, there have been 11 confirmed or probable cases of cutaneous anthrax.

The only published case report of cutaneous anthrax from the attacks of 2001 is notable for the difficulty in recognition of the disease in a previously healthy 7-month-old, the rapid progression to severe systemic illness despite hospitalization, and clinical manifestations that included microangiopathic hemolytic anemia with renal involvement, coagulopathy, and hyponatremia. Fortunately, this child recovered, and none of the cutaneous cases of anthrax diagnosed after the 2001 attacks were fatal.

LABORATORY

Given the rarity of anthrax infection, the first clinical or laboratory suspicion of an anthrax illness must lead to early initiation of antibiotic treatment pending confirmed diagnosis and should provoke immediate notification of the local or state public health department, local hospital epidemiologist, and local or state public health laboratory. Several preliminary diagnostic tests for *B anthracis* can be performed in hospital laboratories using routine procedures. *B anthracis* is a gram-positive, nonhemolytic, encapsulated, penicillin-sensitive, spore-forming bacillus. Confirmatory tests such as immuno-histochemical staining, gamma phage, and polymerase chain reaction assays must still be performed by Department of Health laboratories.

Nasal swabs were obtained in some persons believed to be at risk of inhalational anthrax following the anthrax attacks of 2001. One patient who died from inhalational anthrax had a negative nasal swab. Thus, the CDC advised in the fall of 2001 that the nasal swab should not be used as a clinical diagnostic test. Persons who have positive nasal swab results for *B anthracis* should receive a course of post exposure antibiotic prophylaxis since a positive swab would indicate that the individual had been exposed to aerosolized *B anthracis*.

Antibodies to the protective antigen (PA) of *B anthracis*, termed *anti-PA IgG*, have been shown to confer immunity in animal models following anthrax vaccination. Given the lack of data in humans and the expected period required to develop an anti-PA IgG response, this test should not be used as a diagnostic test for anthrax infection in the acutely ill patient but may be useful for epidemiologic purposes.

Postmortem findings are especially important following an unexplained death. Thoracic hemorrhagic necrotizing lymphadenitis and hemorrhagic necrotizing mediastinitis in a previously healthy adult are essentially pathognomonic of inhalational anthrax. Hemorrhagic meningitis should also raise strong suspicion of anthrax infection. However, given the rarity of anthrax, a pathologist might not identify these findings as caused by anthrax unless previously alerted to this possibility.

If only a few patients present contemporaneously, the clinical similarity of early inhalational anthrax infection to other acute febrile respiratory infections may delay initial diagnosis although probably not for long. The severity of the illness and its rapid progression, coupled with unusual radiological findings, possible identification of *B anthracis* in blood or cerebrospinal fluid, and the unique pathologic findings should serve as an early alarm. The index case of inhalational anthrax in the 2001 attacks was identified because of an alert clinician who suspected the disease on the basis of large gram-positive bacilli in cerebrospinal fluid in a patient with a compatible clinical illness, and as a result of the subsequent analysis by laboratory staff who had recently undergone bioterrorism preparedness training.

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