LEE COUNTY MEDICAL SOCIETY INC.

Physicians Caring for our Community

Bulletin

Volume 33, Issue 2 | Editor: Mary C. Blue, M.D. | May 2009

2009 Meetings and Events

LCMS General Meeting
Thursday, May 21, 2009
6:30 p.m. Social Time
7:00 p.m. Dinner

Royal Palm Yacht Club
2360 West First Street
Fort Myers, FL 33901

Speaker:
Peter E. Dans, M.D.

Topic: "Hollywood's View of Doctors: 1931 - Present"

1 Hour CME Credit

Hollywood's portrayal of doctors from 1931 to the present. Invite your spouse to attend with you.

RSVP Medical Society Office
LCMS, PO Box 60041, Ft Myers 33906
Tel: 936-1645 Fax: 936-0533

Inserts

- May Meeting Notice
- Special Needs Shelter Sign up
- Red Cross Shelter Sign up
- McGregor Reserve Advertising

Inside this issue:

President's Message

Patient Advocacy

Larry Hobbs, M.D.

Reflecting back to this past season, I would like to comment on what I feel is a disturbing trend. As medical director of a local emergency department (ED) and as president of the Lee County Medical Society, I have had the unfortunate task of fielding numerous patient complaints over the past few months. Essentially, these folks are not too happy about the medical care they received. So why am I bringing this up in this format? A few disgruntled individuals might outwardly seem trivial. But, after talking with these patients and many of our colleagues, I have noted a real change occurring on how healthcare is delivered in Lee County.

I feel this change stems from our collective failure as patient advocates. Both physicians and hospital administrators are responsible for this trend. In the past, if a patient presented to his primary care physician (PCP) with a medical problem, the PCP would arrange diagnostic testing and necessary follow up within a short period of time. If the condition required, the PCP would contact his favorite specialist describing the patient's relative history and findings and arrange for prompt consultation. If hospitalization was necessary, the PCP would call the hospital, arrange for a bed, give orders and follow the patient after seeing his office patients to care for that patient in the hospital. Consultation would be made as needed and the patient would be cared for and be happy. If an emergent condition was noted by the PCP, he would arrange for transportation to his favorite hospital ED alerting the ED staff of the patient's history and condition. Again the patient was cared for and was happy.

Today we have a much different and disconnected process for patient care. The PCP no longer goes to the hospital. His relationships with the specialty consultants have faded. He is unable to achieve prompt diagnostics due to limiting factors such as pre-approval of insurance coverage or scheduling conflicts. This PCP, maybe in frustration because of lack of time, tells the patient to go to any ED. No call is made to the ED staff. Maybe a scribble is made on a prescription pad stating, "patient is weak, work up and admit". The PCP's involvement then ends. The patient arrives at an extremely busy ED (and they all are) exclaiming his doctor sent him but the patient doesn't know exactly why. Because of the overcrowded ED, the patient has to wait sometimes for hours until seen. He is evaluated sometimes having diagnostic studies he just completed through his PCP's office. But because of the disconnect in communication or inability to obtain the outpatient study results these studies are repeated. The patient is admitted to a physician who does not know him. Multiple consultants visit the patient in the hospital without any significant explanation of why. He is treated and discharged without complete knowledge of what was found. He presents back to his PCP weeks later without a clue about what happened and is unhappy.

Maybe the PCP wanted to be more involved in his patient's care and instead of sending him directly to the hospital ED he calls his favorite specialist to see if he can admit the patient directly to the hospital. The PCP is told that all the hospitals are full and admitted ED patients are waiting for beds. After numerous calls to nursing supervisors and administrators without success, the PCP resorts to sending the patient to the ED. Again the patient experiences significant delays and possible duplication of studies.

Time and time again we cannot or will not properly advocate for our patients. The excuses for this change in how healthcare is delivered are numerous but usually because of lack of funding. PCPs can do better seeing patients in their offices rather than seeing them in the hospitals. The payers pay more for office visits than hospital visits and the physician sees more patients in his office than in multiple hospitals. This led to the advent of hospitalists. A hospitalist is an internist or family practitioner who only sees patients in the hospital. By definition, they do not have outside practices and devote their time seeing hospitalized patients. But for hospitalists to obtain a decent

President's Message continued on page 4

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Lee County Medical Society Mission Statement & Disclosure Policy

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

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

Membership Activity

New Practice/Address
Juan Domingo, M.D.
Internal Medicine
900 SW Pine Island Road #208
Cape Coral, FL 33991
Phone: 673-9861

Ariel Figueredo, MD
Obstetrics/Gynecology
Complete Women's Care
602 SE 16th Place
Cape Coral, FL 33990
239-573-7222

Stephen Kaskie, M.D.
Family Medicine
Bonita Family Practice LLC
9500 Bonita Beach Road #111
Bonita Springs, FL 34135
Phone: 947-4100

Christine Mackie, M.D.
Family Medicine/Hospitalist
IPC
13650 Fiddlesticks Blvd.
Fort Myers, FL 33912
Phone: 597-5638

Keith Susko, M.D.
Physical Medicine & Rehab & Pain Mgt.
Pain Relief & Physical Rehab, Inc.
13470 Parker Commons Blvd., #105
Fort Myers, FL 33912
Phone: 226-0077

New Satellite Office
Howard Eisenberg, MD
Pulmonary Disease/Sleep Medicine
9671 Gladiolus Drive Unit 109
Fort Myers, FL 33908

Brian Fabian, MD
Dermatology
7451 Gladiolus Drive
Fort Myers, FL 33908

New Phone /Fax
John Bishop, MD
Wound Care and Hyperbaric Medicine
Phone: 939-8345 Fax: 939-8202

Moved out of Area
Phillip Roland, M.D.

Resigned
George Mestas, M.D.
Rob Simmons, M.D.

ATTENTION MEMBERS…

Your Medical Society has some great marketing ideas. Here are just a few affordable ways we can help you get your message out:

- Direct Mail Labels
- Links from our website
- Public speakers Bureau
- Advertising in the Bulletin
- Advertising in the 2009-10 Pictorial Directory.

What are you doing about Electronic Medical Records?

Dear Physician,

The American Recovery and Reinvestment Act of 2009 (ARRA) will provide approximately $19 billion for Medicare and Medicaid HIT incentives over five years. The bill provides financial incentives through the Medicare program to encourage physicians and hospitals to adopt and use certified electronic health records (EHR) interoperatively and in a meaningful way. Early adopters (2011 or 2012) will be eligible for an initial incentive payment. Incentive payments will be reduced each year. After 2015, physicians who do not adopt/use a certified HIT system will face reduction in their Medicare fee schedule. E-prescribing penalties will sunset after 2014. The bill requires HHS to adopt standards for qualified EHRs by December 31, 2009 (H.R. 1 stimulus bill, AMA, 2009).

IPALC, Lee County Medical Society and LMHS would like to get a better idea of the attitudes and needs of the physician community regarding EMR. We are especially interested in input from physicians who are not currently using EMR. One of our goals is to determine how we can facilitate effective adoption of EMR. Please go to the IPALC web site (www.ipalc.org) and follow the link to the survey. Please visit the Electronic medical records page for more current information regarding EMR. Results will be posted on the IPALC web site. We appreciate your participation.

This survey is a joint effort of IPALC, Lee County Medical Society and LMHS.

Thanks
James W. Penuel, Jr., M.D.

As I Recall...

Roger D. Scott, M.D.

"WHUPPIN"

"Love is a boy by poets styl'd; then spare the rod, and spoil the child." So wrote Samuel Butler (1612-1680) in *Hudibras*, and that was one of the guides for rearing of children extending into the early 20th century and practiced by my father. Please note that I dearly loved my father, and I do not believe that he was malicious or unjust in his discipline, but he felt that a "**whuppin**" (whipping, spanking) was indicated in certain instances. A verbal or physical incident such as being disrespectful, not performing a task, not keeping one's word or following parenteral orders would precipitate a whuppin. My older brother, Joe, was a "devilish" boy and did get many whuppins, but my oldest brother, Frank, and I got into less trouble and consequently received less punishment. I remember Joe intentionally throwing a thick glass telephone insulator from a pole to hit Frank in the head causing a laceration, and that was good reason for his whuppin. In a family usually the father was the punisher and the mother the comforter (like the modern bad cop-good cop). Daddy used a bamboo stalk (not the massive Philippine type but the smaller American variety) as a switch for whuppin. I was about 10 years old when I did something that I felt wasn't so bad, but Daddy felt it was bad and directed me to go in the yard and get a bamboo switch to be whipped with. I picked out one of the smallest stalks I could find and also partially broke it in several places so that it would not be rigid. I leaned over and Daddy tried to whip me, but the switch almost folded up in his hand and he laughed, threw the switch away, and said "Bud (that's me), you're too old to whip," and that was the last one for me I thought.

I would like to interject a little information and an anecdote regarding bamboo. Bamboo is a very unusual plant of the grass family and it appears in many varieties from very small plants to the timber bamboo of 80-100 feet. What's most remarkable is that eight -inch diameter 60 to 80 foot tall bamboos have reached that height in one growing season, which might have been as short as two months. It is known to grow 12-24 inches in one day! Its sprouts are eaten by both man and animal, and the larger plants are used in many ways such as construction of furniture, dwellings, bridges and such.

In about 1947, Dennis O'Keefe (acting as a DEA agent) appeared in a movie regarding drug smuggling called *To The Ends Of The Earth.* O'Keefe captured the villain smuggler as he was eating lunch of "bamboose livers", and therefore he would not be taken alive. I kept asking friends about bamboose livers but nobody had an answer for me. Many years later I saw the picture on TV and by listening carefully during that scene it was apparent that the man was eating bamboo slivers that would cause multiple perforations of his intestines and death and not bamboose livers! Remember I was a country boy and not an epicurean.

In June 1944, I attended the University of Florida where freshmen were dubbed "Rats" and had orange and blue rat caps. I joined (pledged) the Alpha Tau Omega (ATO) fraternity and for the first year was required to wear the rat cap most all of the time. In addition we rats had to make our own paddles for (believe it or not) **whuppin**. The paddles had to be approximately 30 inches in length, 1 inch thick and 3 or 3 1/2 inches wide. If a rat did anything that a fraternity brother (full-fledged member) deemed incorrect, the brother applied the paddle to the rat's posterior. Punishment was meted for such things as not wearing the rat cap, not flushing the toilet, not cleaning a room, not sweeping the floors, not saying good morning, or any whim of the brother's. The number of strokes depended upon the brother's desire. Sometimes a brother was just having a bad day and decided he wanted to beat on someone. The week before Christmas vacation the rat had to visit each member who would spell M-E-R-R-Y C-H-R-I-S-T-M-A-S and optionally A -H-A-P-P-Y N-E-W Y-E-A-R (each letter represented a blow to the rear by the paddle)! Fortunately most members were not sadistic and would tap lightly, but some would really "lay it on" and after so many blows, one might have bloody underpants. Obviously these were real whuppins, but I fortunately avoided most of the bad ones. This was true hazing which was practiced in all of the fraternities at that time at the University of Florida.

It was indeed great to proceed to the initiation and become a full-fledged member (brother). I believe that I mentioned the initiation in a previous article years ago, but you have probably forgotten the episode. The brothers took all our clothes off except for our underpants, put us in the trunk of cars, and took us some miles away from Gainesville (in a cold December) in the woods and turned us loose to get back to Gainesville the best way we could. I guess the people around Gainesville and Alachua County were used to seeing college freshmen running around almost nude in the woods. We were able to find some clothes on a clothesline and in our makeshift garb we were able to "thumb" (hitchhiker) back to Gainesville. It was indeed great to become a full-fledged member (brother), but I pledged that I would not "whupp" any of the new pledges.

A few months after becoming a "brother", I transferred to the University of Virginia as I was not getting a pre-medical education at the University of Florida for there were no medical schools in the state of Florida.

The University of Virginia (UVA) was a totally different experience. All students wore seersucker suits and ties on campus. I was invited to join the ATO chapter there and was delighted that no hazing was allowed. Virginia was an exceedingly nice experience because of the historic significance bestowed by President Thomas Jefferson's involvement in its formation and development. He was the architect himself and could observe the campus through a telescope some miles away at his hill top plantation, Monticello. I did make up the lack of premedical education by doubling up on scientific courses and matriculated to the University of Maryland School of Medicine.

Robley Dunglison Newton, M.D. (As I Recall November 2001*)* was the father of James Newton, a prominent Ft. Myerian and *Uncommon Friends* founder. Dr. Newton's granddaughter (also named Robley) told me that she thought Dr. Newton had been named for Dr. Robley Dunglison who had been President Thomas Jefferson's physician. A year ago I received a leather-bound "Bicentennial of the University of Maryland School of Medicine" and to my surprise it pictured Dr. Robley Dunglison as Dean of my medical school 1834-36 and he was also dean at Jefferson Medical College in Philadelphia. He founded the UVA Medical School in 1825 at Thomas Jefferson's request. The book also confirmed that Dr. Dunglison was the personal physician to President Jefferson and ALSO to Presidents Monroe, Madison, and Jackson. He was a noted prolific medical writer. The Museum of Medical History has *Human Physiology (1843)* written by Dr. Dunglison (& dedicated to James Madison) and also Dr. Robley Newton's true sheepskin 1896 Pennsylvania medical diploma and 1895 Pharmacology Diploma. Once again it's a small world!

Lee County Medical Society Alliance and Foundation News

Mary Macchiaroli, President
Lee County Medical Society Alliance

Happy Spring! The Alliance year is drawing to a close. We have exciting things planned for the month of May. First will be the installation of officers. It will take place on Wednesday, May 20th. The location is being finalized as I write this, but it will be lovely, I promise!

On May 30th, we will host our last Supper Club of the season with dinner at the Blue Coyote Business and Social Club at 7 PM. Please join us! We would love to see as many of you as possible. Come with your great ideas regarding what the Alliance should do next year!

Back to the installation for a moment…We will again be governed by a committee of leaders in 2009-2010, rather than a traditional president or co-president. Thank you to Nicole Laquis, Anne Wittenborn, Lynne Gorovoy, Sherri Zucker, Betty Rubenstein, Robbin Sonn, Barbara Rodriguez, and Nancy Barrow for agreeing to serve in that important role next year! Also, thank you John Miksa for returning to his throne as Supper Club Czar, and helping us plan the upcoming one on May 30th.

We are in the planning stages for next year's events, such as the Welcome Brunch and Potluck in Paradise. Let us know if you like to host either at your beautiful home!

Thank you all for coming out and mingling at the happy hours this year. We will continue them next year.

Presidents Message

Continued from front cover

salary, he/she needs to care for a large number of patients. This sometimes does not allow for a lot of patient contact thus further frustrating patients. As for the hospital, the increasing number of uninsured and underinsured puts an increasing financial burden on the hospitals. They are less likely to expand and provide more inpatient services or patient beds. But this does not mean that there aren't significant changes the hospitals can affect in order to free up more patient care areas during the seasonal crunch.

Although these are some of the obvious reasons for this trend, I feel there is another culprit. In general hospitals and physicians have become complacent and accepting of this trend. The hospitals are increasingly distracted with preserving and growing market share while cutting expenses and services in order to preserve their financial viability. Although important, this diminishes from the focus of why they exist; to take care of patients. I think that a policy that should be sought by those who operate the hospitals is to provide enough hospital services for accessibility as well as quality to those patients that need it especially during the busy times. Hopefully no one's family member or friend would have to experience the significant delays and lack of services we are seeing today.

Physicians, as a group, have also become less effective as patient advocates. These pressures to see more patients in order to make ends meet have driven some to provide less than optimal care. We have collectively lost that collegial relationship with other physicians and are sometimes viewed as "dumping" our difficult patients over to the specialist or surgeon. Or, simply we tell these patients to go to the ED if you need a particular diagnostic study or specialist referral. This is not optimal patient advocacy. This is not, if we were the patient, what we would want for ourselves or for our families. We need to take back the responsibility for patient care regardless of the time required or financial burden that plagues healthcare delivery today.

I may sound a bit altruistic and even though there are no simple answers, this trend of healthcare delivery must be changed. Simple physician to physician communication when referring patients, the development of a community electronic health record system and an improved connection for hospital administrators with the inpatient clinical services they are responsible for could help reverse this trend. The LCMS Board of Directors recently discussed this issue and shared experiences. We feel a dialog with LMHS needs to begin to improve our patient's accessibility to the hospitals. Patient care and advocacy is what we as physicians should provide. Let us own up to that calling and work to improve healthcare in Lee County.

Health Care Providers: The Unvaccinated

Barbara Fernandez, RN, PHR
Visiting Nurses Association of SW Florida, Inc.

According to the US Department of Health and Human Services (HHS), less than 50% of health care providers (HCPs) got a flu shot in 2007. This is a slight improvement over the 2006 rate of 42% but there is still work to be done to reach the goal of 60% for *Healthy People 2010*. It's a goal important enough to bring together some of the agencies with which we are familiar: HHS, CDC, FDA, NFID, IDSA, and JCAHO.[1]

For years, we've heard people tell us they had "a touch of the flu" or "stomach flu" and, perhaps, it is this broad use of the term flu that has softened us against a virus that once killed an estimated 21 million people worldwide in one year's time.

It has been some time since the last pandemic, but the current numbers are not to be dismissed. The CDC reports that 26 children in the US have died from flu complications this season. It is estimated that 36,000 people die annually from the flu and that over 200,000 are hospitalized. Surprisingly, although the flu is hardest on the elderly who represent over 90% of flu-related deaths, 57% of hospitalizations are for people younger than 65.

With these hard-to-ignore figures, why is it that health care providers then are so hesitant to get a flu shot?

Excuse: *"I don't ever get sick"*
Rebuttal: It's not all about you.

- One study shows that, while nearly 26% of unvaccinated HCPs had documented serologic evidence of influenza infection, 42% of these individuals could not recall having had a febrile respiratory illness. [2]
- Studies show a correlation between increased HCP vaccination rates and a marked decrease in nosocomial infections in hospital patients. [3]
- In a nursing home setting, there is correlation between increased HCP vaccination rates and a decreased mortality rate among patients regardless of the patient's vaccination status. [4,5]

Excuse: *"The shot will give me the flu."*
Rebuttal: Injectable flu vaccines cannot give you the flu.

- Injectable influenza vaccines cannot give you the flu because that virus has been killed.

Excuse: *"I hate needles!"*
Rebuttal: Other options are available.

- While it's a live, attenuated vaccine, intranasal vaccine is an effective alternative to injectable vaccine if you are between the ages of 2 and 49 and in good health.

Excuse: *"I'm allergic."*
Rebuttal: The vaccine is safe for most people.

- Unless you have had a severe allergic reaction to eggs or a previous flu vaccination or a history of GBS, flu vaccines are safe. The most common side effects of injectable vaccines are minor. There are even preservative-free options.

Excuse: *"It doesn't do any good."*
Rebuttal: The flu vaccine definitely makes a difference.

- The vaccine has been found to prevent the flu in 70%-90% of healthy people younger than 65 years of age. Effectiveness depends on whether there's a good match between the vaccine and the prevalent strains and the age and health status of the person receiving the vaccine.

Excuse: *"I don't have time."*
Rebuttal: You have even less time to be sick or to take care of sick family members.

- It takes just minutes to complete a simple consent form and roll up your sleeve. It takes two weeks or more to fully recover from the flu.

Excuse: *"I can't afford it."*
Rebuttal: A flu shot is a good investment in your health and the health of your loved ones.

- The estimated lost earnings to workers in 2003 related to the flu reached $16 billion.[6]

Excuse: *"I forgot and now it's January."*
Rebuttal: It's not too late!

- Although the ideal vaccination months are October and November, you can still get a flu shot December through March. Flu activity usually peaks around mid February.

It is time to plan for the coming flu season which will take us into 2010 and our deadline to improve immunization amongst HCPs. Part of our planning needs to include a personal commitment on the part of every health care provider to get vaccinated. A commitment to refuse not only to be easy prey for these viruses, but to refuse to be a vehicle of transmission to vulnerable patients and family members.

[1] Mootrey, et al. Influenza Vaccination of Health-care Personnel: Disease, Vaccine, Beliefs, Barriers, and Recommended Strategies to Improve Vaccination. CDC. **www.cdc.gov**. Accessed March 2009.
[2] Wilde et al., JAMA 1999;281:908—13
[3] Salgado et al., Inf Cont Hosp Epi 2004;25:923-8
[4] Carman et al., Lancet 2000;355(9198): 93--7
[5] Potter, et al., J Infect Dis 1997;175:1--6
[6] Bridges CB, Thompson WW, Meltzer MI, et al. Effectiveness and cost-benefit of influenza vaccination of healthy working adults: A randomized controlled trial. *JAMA*. Oct 4 2000;284(13):1655-1663.

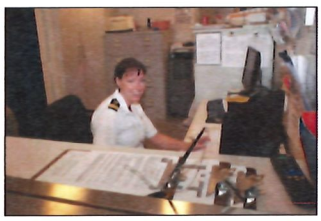
Ship's Physician

All of us are physicians, and many of us have been on cruises. What is it like when these two activities are joined? For the most part it's relaxing and the medicine is not too challenging. The culture of cruise ships however, can make it frustrating especially in the beginning.

As well as taking care of the episodic needs of the passengers (about 20% of your patients) you are also the family doctor to all of the crew (about 80% of your patients). About 90% of your encounters would be typical of a doctor or clinic office (back pain, rashes, and URIs) about 10% are standard ER fare - lacerations, acute coronary syndromes, fractures, and GI bleeds. The physician best suited for cruise ship medicine is one double boarded in Emergency Medicine and Family Practice. A physician really needs to be comfortable in both arenas. When things go bad on a ship 24 hours from port, that ER experience is invaluable. But it takes more than ER experience; you wear every specialist's hat aboard ship. After you stabilize the MI then you're the cardiologist. You're the guy that needs to put in the central line and the chest tube; there is no ICU or intensivist upstairs.

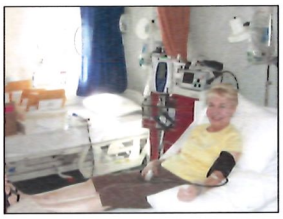
Our ICU

We have a surprising array of resources to assist us in our infirmary. On most ships today we have digital plain radiography, point-of-care lab (why can't we have that in the ER?), slit lamp, ventilators, as well as a complete pharmacy with nearly any drug you could ask for, including thrombolyics. We do have limitations, of course. We don't have a CT scan, and often don't have access to one in certain ports. We can't do surgery. If you're out at sea and a geriatric patient presents in shock with severe back pain, he's going to die of his AAA. Other than IV saline, vasopressors, and analgesics, there's just nothing else to be done. (We do have a morgue.) For a suspected appendicitis we give IV fluids and antibiotics and speed the ship up to our next port. For an active GI bleed we give IV saline, vasopressors, speed up, and pray. Sometimes we get a patient off the ship by tender-boat close to a port; not so easy in rough seas or at night. It's rare that we use helicopters for evacuation anymore. That maneuver is extremely dangerous to both the helicopter and the ship. Cruise ships are not built with an open space safe for a helicopter to land.



Gabby the Nurse

In addition to the physical tools in the infirmary we are blessed with an experienced crew of nurses. Mostly from Great Britain, New Zealand, and South Africa; they have years of emergency and ICU experience. They are incredible and, in fact, make the cruise pleasant for the physician. I'm not used to this luxury in the ER, maybe it's common in a doctor's office, but on-ship they deal with three-fourths of what comes in the door and over the phone. They will, of their own accord, go up to guest's cabins and administer IM Reglan for seasickness, and then tell you about it the following morning. They are also knowledgeable about the arcane corporate and seafaring bureaucracy. I couldn't do this job without their expert help.



IV therapy for pneumonia

Undoubtedly the biggest challenge is dealing with the bureaucracy of a cruise ship from a large corporation that sails to many nations. From international maritime law, to local laws, to environmental regulations, to corporate regulations, to officer hierarchy, everything is new and different. One thing we don't have is COBRA/ EMTALA laws like in the US. What that means is that, unlike a U.S. emergency room, the guests are required to pay for their visits to the infirmary. There's one fee to see the nurse, or a larger fee to see the doctor. This fee goes on your account just like your bar drinks. We don't take insurance, but we provide records for the passengers to submit. One of my favorite stories about cruise ship medicine involves a geriatric patient who came in demanding to see the doctor for a cough. When he was told it would be $80, he shouted, "Well, I have Medicare!" The nurse nodded and said it would still be $80. He then asked how much a bottle of cough syrup was and paid the five dollars. I actually wrote up that episode as an editorial to the News-Press. (And we wonder why Medicare is going broke!) Crew members are different, we don't charge to see them, but if they continue to come to the infirmary and get time off from work for things like back pain, they will just be released from Carnival. That serves as a deterrent.

We frequently encounter language barriers aboard. Most of the staff is from Italy, Eastern Europe, India, Indonesia, the Philippines, Honduras, etc. They may have a working knowledge of English for their particular job, but not enough to convey their symptoms in the infirmary. This can become extremely frustrating. Even the nurses from England, Scotland, or New Zealand can be equally difficult to understand, especially when they give you a phone report.

Doctor's Office

So is it worth it? It is for me. But not for the money. The cruise lines can recruit English-speaking physicians from England, South Africa, and India who are used to much less compensation than we enjoy in America, so there is no reason to pay us more than the going rates for those countries. However your room and board and transportation are provided. And you are a senior officer, which makes a huge difference aboard ships. Unfortunately it is difficult to bring your spouse along for anything more than an occasional cruise, so like the rest of the crew, this is a job better suited for someone who's not married. But if you enjoy the sea, enjoy seeing various ports, enjoy working with people of different nationalities, and can feel comfortable dealing with whatever medical malady that can present itself, it's a pleasant diversion from the medicine you're used to practicing.

Hurricane Season—Again

Judith Hartner, MD, MPH

When my son was in elementary school we had a joke about the two seasons in Florida – tourist and hurricane. It is May and the season is changing, so once again we need to refresh hurricane preparedness basics:

- Do you have a disaster plan for your family? Where will you shelter? What will you take? Don't forget to consider the children's needs, your pets, your valuables, and your documents. If you don't have a plan yet, check out http://www.floridadisaster.org/.
- Do you have a disaster plan for your practice? How will you secure or backup your medical records? How will you communicate with your staff post storm? If your building is destroyed, can you temporarily open your practice at another location? The FMA offers more planning information at http://www.fmaonline.org/pages/knowledge/disaster_prep.html.
- Do you have responsibilities for coverage at the hospital or a nursing home? Do they know how to contact you or where you will be sheltering during the storm?
- Can you volunteer to help either during or after the storm? There are several opportunities to help – Medical Reserve Corp (http://swflmrc.org/) or the Lee County Chapter of American Red Cross are two of many organizations that will need assistance during and after the storm. *(Sign up for special needs shelters enclosed)*
- Do you ask your patients about their disaster plans – especially the elderly, disabled and medically dependent patients? *(Enclosed is a special needs shelter sign up for patients)*

We are still haunted by the stories and images from Hurricanes Charley, Katrina, and Hurricane Ike. Each disaster provides lessons for emergency managers to incorporate into their plans. Our hospitals, county emergency operations center and state disaster managers actively review and revise their plans. No one is truly ready for a catastrophe – almost by definition – but good plans are in place to guide our response and recovery.

An important part of recovery will be to bring our health care services – emergency departments, hospitals, and outpatient care – back as quickly as possible. Thoughtful consideration now can make that more possible if the need should arise.

Dr. Hartner is the Director of the Lee County Health Department, 3920 Michigan Avenue, Fort Myers, FL 33916.

Important Phone Numbers and Websites

Be Prepared! Hurricane Season begins June 1st and runs through November 30th

American Red Cross	278-3401
Cape Coral Emergency Management	573-3022
Cape Coral Police Department	574-3223
Fort Myers Police Department	334-4155
Lee County Animal Services	432-2083
Lee County EMS	335-1600
Lee County Emergency Op Center	477-3600
Lee County Health Department	332-9501
Lee County Sheriff's Office	477-1000
Lee County Storm Hotline (When Article)	477-1900
Salvation Army	278-1551
Sanibel Police Department	472-3111
Florida Power and Light	1-800-4OUTAGE
Lee County Electric Coop	1-800-282-1643

Please visit the following websites for more information on preparing for a disaster.

www.lee-county.com—Official website of the Lee County Government

www.leeeoc.com—Website offers information on the special needs program and transportation for the infirm. Also offers latest hurricane updates and the county's response level.

www.fema.gov—Website offers a lot of information on all aspects of disaster planning

www.nhc.noaa.gov—National Hurricane Center website for the National Weather Service

www.intellicast.com—Website offers weather information and forecasts

www.floridadisaster.org—This website helps individuals make family and business plans, it is a site of the Florida Division of Emergency Management.

What's New with the Board of Medicine

Advertising Your Services

Crystal Sanford, CPM, Program Operations Administrator, Florida Board of Medicine

This portion of the *Top 10 Tips to Avoid Problems with Your License* series is about advertising. What is the big deal about advertising? Did you know there are restrictions on advertising? If you didn't, you should because your competitor probably does and will report you. What do competitors look for in your advertisement? They look for accuracy, board specialty certifications and statutory disclaimers.

Board Rule defines "advertisement" or "advertising" as any statements, oral or written, disseminated to or before the public or any portion thereof, with the intent of furthering the purpose, either directly or indirectly, of selling professional services, offering to perform professional services or inducing members of the public to enter into any obligation relating to such services. Now that you know what advertising is, what are the restrictions?

There are limitations in advertising yourself as a "specialist" because the Florida Board of Medicine does not recognize every specialty recognizing agency. The Board recognizes the following organizations only:

- American Board of Medical Specialties
- American Board of Facial Plastic & Reconstructive Surgery, Inc.
- American Board of Pain Medicine
- American Association of Physician Specialists, Inc.

There are some common sense rules about advertising, such as the dissemination of any advertisement which may be false, deceptive or misleading. Rule 64B8-11.001, Florida Administrative Code, outlines what the Board considers to be false, deceptive or misleading.

Although there are exemptions to this requirement which are outlined in section 456.062, Florida Statutes, all advertisements for free or discounted services require the following disclaimer in capital letters:

> THE PATIENT AND ANY OTHER PERSON RESPONSIBLE FOR PAYMENT HAS A RIGHT TO REFUSE TO PAY, CANCEL PAYMENT, OR BE REIMBURSED FOR PAYMENT FOR ANY OTHER SERVICE, EXAMINATION, OR TREATMENT THAT IS PERFORMED AS A RESULT OF AND WITHIN 72 HOURS OF RESPONDING TO THE ADVERTISEMENT FOR THE FREE, DISCOUNTED FEE, OR REDUCED FEE SERVICE, EXAMINATION, OR TREATMENT.

Regarding the possibility of HIV transmission from healthcare workers, although not common, some physicians want to advertise that he/she is HIV negative. This is not permitted. Rule 64B8-11.002, Florida Administrative Code elaborates on the proper way to advertise HIV negative test results.

One last point, in 2006, the Legislature passed a law that requires disclosure of licensure status to patients. Rule 64B8-11.003, Florida Administrative Code outlines the methods in which a health care professional can disclose his/her licensure status. This includes wearing a name tag, wearing an article of clothing which identifies the licensee, by orally disclosing licensure status, by providing a business card or by placing a notification in the waiting area identifying the licensees.

Where do you find the laws and rules?
Florida Statutes (laws): http://www.leg.state.fl.us/statutes/index.cfm
Florida Administrative Code (Rules): http://www.leg.state.fl.us/statutes/index.cfm

The Board of Medicine's *Web Board* has changed. The old site is no longer available. For a no-cost, automatic e-mail of every new item put on the Board website, you can subscribe and unsubscribe by going to this web site:
http://flems.doh.state.fl.us/mailman/listinfo/boardofmedicine

Happy Mothers' Day
May 10th

&

Happy Fathers' Day
June 21st

New Member Applicants

Jonathan Jay, M.D., attended the University of Michigan, Ann Arbor, MI and obtained his M.D. degree in 1991. He completed his internship/residency at Henry Ford Hospital/Univ of Michigan (1991-97) and a fellowship at Harvard Medical School, Boston, MA (1997-98). He is certified by the American Board of Urology. Dr. Jay is in practice with Specialists in Urology, 28930 Trails Edge Blvd #200, Bonita Springs, FL 34134.

Guillermo Narvarte, M.D., attended the Universidad Peruana Cayetend Heredia and obtained his M.D. degree in 1999. He completed his internship/residency at the University of Texas, Houston, TX (2002-05). Dr. Narvarte is in practice with Bonita Family Practice LLC, 9500 Bonita Beach Road #111, Bonita Springs, FL 34135.

Rolando Rivera, M.D., attended the University of Puerto Rico, San Juan, PR and obtained his M.D. degree in 1996. He completed his internship at Brooke Army Medical Center, San Antonio, TX (1996-97) and residency at Shands Medical Center (2000-2005). He is certified by the American Board of Urology. Dr. Rivera is in practice with Specialists in Urology, 28930 Trails Edge Blvd #200, Bonita Springs, FL 34134.

David Wilkinson, M.D., attended Wright State University School of Medicine, Dayton, OH and obtained his M.D. degree in 2002. He completed his internship/residency at University of Kentucky Chandler Medical Center (2002-07), He is certified by the American Board of Urology. Dr. Wilkinson is in practice with Specialists in Urology, 28930 Trails Edge Blvd #200, Bonita Springs, FL 34134.

Physicians Provide a Booster Shot to Florida's Economy Even During Challenging Times Reveals FMA Economic Impact Study

TALLAHASSEE, Fla. (March 31, 2009) - Today, the Florida Medical Association (FMA) Center for Health Policy released findings from its study on the Economic Impact of Private Practice Physicians in Florida. The study, conducted in partnership with the Florida State University Center for Economic Forecasting and Analysis, provides an in-depth look at the contributions of private practice physicians to Florida's state and local economies.

"While many studies have addressed how the economy impacts the healthcare industry, few have taken a closer look at how physicians impact Florida's economy," says FMA President, Steven R. West, MD. "In the current economic climate, these critical dynamics are important to understand."

"Private practice physicians contribute to Florida's economy in many ways: they create jobs and income through employment, purchase goods and services from local businesses, and generate considerable tax revenue for government at all levels," says Timothy J. Stapleton, FMA Executive Vice President. "These factors lead to increased household spending and greater economic activity in every community."

The FMA/FSU study estimates that in 2009:

- Private practice physicians' offices in Florida support approximately 451,500 jobs, which represents a striking 5 percent of total state employment.
- These jobs create $22 billion in real personal disposable income ("income"), which includes the income of individuals employed by and through the economic activity of physicians' offices.
- Private practice physicians' offices generate $56 billion in total economic activity and $3 billion in government revenues
- Each private practice physician in Florida supports an average of 19 additional jobs, $913,000 in "income", and $2.3 million in total economic activity.

The study also describes the projected economic impact of private practice physicians. For example, in 2020, private practice physicians are expected to create almost 650,000 jobs, $41 billion in personal income, $93 billion in total economic activity, and $6 billion in government revenues per year.

"These widespread benefits to Florida's economy by private practice physicians cannot be taken for granted," says Dr. West. "Like the nation, Florida faces a growing shortage of physicians. While the consequences of this shortage are clear in terms of dwindling access to care, we cannot overlook or underestimate the economic implications of this shortage as well."

The FMA/FSU study demonstrates the benefits of alleviating Florida's physician shortage, both in terms of raising the ratio of physicians per Floridian and by creating additional Graduate Medical Education (GME) residency positions. The study found that

- Increasing Florida's ratio of physicians to meet the national average, by 2012, would create an additional 50,000 jobs, bringing with it $3.6 billion in personal income and $6.5 billion in greater total economic activity.
- Likewise, expanding Florida's ratio of GME positions to the national average, by 2012, would create an additional 34,000 jobs, bringing with it $2.4 billion in personal income and $4.3 billion in total economic activity.

"There are several factors that contribute to Florida's physician shortage, many relating to the policy and regulatory environments in which physicians practice medicine," says Stapleton. "This study discusses these issues in detail and presents a case for why the economic impact of physicians should be a strong consideration for lawmakers when addressing healthcare system reforms."

The study is available on the FMA website <www.informz.net/z/cjUucD9taT03NTYwMDImcD0xJnU9NzcxMTU0MjImbGk9Mjk5NzA4OA/index.html . For more information about the study, contact Karen Halperin Cyphers, Director of Health Care Policy, at kcyphers@medone.org or email: kcyphers@medone.org.

Note: Lee County Workforce did a survey of Charlotte, Lee And Collier Counties.

Odds and Ends

FMAPAC Membership

As FMAPAC closes out the first quarter of 2009, we wanted to give you a brief update on FMAPAC membership. The bad news is that FMAPAC is down 90 members year-to-date in 2009. The good news for our us is that Lee County is up 11 members for 2009 from the same time last year.

We still need your help. Please visit the FMA PAC website (**http://www.fmaonline.org/fmapac**) and join today.

Red Flags Rule Guidance Material Available for Physicians

The Federal Trade Commission (FTC) continues to assert that physicians who regularly bill their patients (including co-payments and coinsurance) are considered creditors and so must develop and implement written identity theft prevention and detection programs for their practices by May 1, 2009, in order to be in compliance with the FTC's Red Flags (Rule). The American Medical Association strongly disagrees with the FTC's broad interpretation of the term "creditor." We are continuing our efforts to delay the compliance deadline and to get FTC to re-publish the Rule so that medicine will have an opportunity to explain why this Rule is not applicable to physicians.

In the interim, the AMA has developed guidance material to help physicians comply with the Red Flags Rule, which can be accessed on the AMA website at http://www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml

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