LEE COUNTY MEDICAL SOCIETY INC.
Physicians Caring for our Community

Bulletin

Volume 35, Issue 5 | Editor: John W. Snead, M.D. | October 2011

President's Message

Surviving the Uncertain Times

Shahid Sultan, M.D.

A few weeks ago the senior management of Lee Memorial Health System came to the HealthPark Facility Executive Committee meetings to give us their view of the national economy and its impact on health care in general and on the hospitals and the physicians in particular. The picture they painted was not pretty (no secret there). John Weist, CFO of the system very bluntly told us that the country is bankrupt (it was soon after the downgrade of the US credit rating by Standard and Poors and budget debate in the Congress) and there is no money to go around and there is no way health care payments will not be cut. According to him, in the recent past, the hospital has been hit twice with cuts of about 11% and he expects more to come. The Health industry has gone through these difficult times before but in time has recovered, but not this time. The downward spiral is not limited to the US, it is the economy of the world which is suffering and a quick turn around is not in the near future. Tough times are the new norm and we should get used to them. He also refuted the notion that LMHS has a pot of gold stashed somewhere for rainy days. They do have money but that has been invested and helps to pay the debt payment incurred when the Gulf Coast Hospital was acquired.

Jim Nathan echoed his sentiments and reassured us that the system will survive but it has to position itself to get more efficient, cost conscious and react to the changes in a positive way. The reporting of outcome data, infection rates, readmission rates and numerous other measures reporting of which is voluntary at the moment will become the basis for reimbursement and if we do not measure up to the standards, payments will be cut. Jim conveyed that the system has to make these changes to keep its accreditation as without it their bond rating will degrade increasing the interest rate on the debt. He asked us to work with the hospital in being proactive in implementing the changes. Actually, he really did not give us a choice; he asked those of us, who disagree, not to be obstructive. The change is coming whether we agree or not.

Concerns were raised that the changes are not what most people object to rather it is the way they are implemented by the middle managers who do not work in patient care areas and have very little knowledge how things work in the real world. Larry Antonucci agreed and he again asked us to work with him to smooth out these wrinkles and give suggestions on implementing changes in a more palatable fashion.

In short the message by the administration was, the change is here and the question is how to respond to it. Whether it is the Affordable Care Act or the Republican plan in the form of Rep. Paul Ryan's budget proposal, there will be cost reduction. In order to survive, the health industry, hospitals, doctors and all other affiliated entities will have to work together to come up with the solution. The Medicare Advisory Payment Commission who presently is responsible for suggesting cost cutting measures to the Congress, but whose suggestions become effective only if Congress concurs with them, will be replaced by Independent Payment Advisory Board (IPAB) whose suggestion will automatically become policy unless Congress overrules it.

The new healthcare law also includes new experimental payment methods by Medicare, including bundling of the payments encouraging team based, more cost effective and efficient health care. The team based approach is an integral part of Accountable Care Organizations. No one really knows how effective this approach will be but cost reduction while providing efficient care is the goal.

Meanwhile, the Republican plan effectively changes Medicare from a fee for service based plan to a purveyor of vouchers which the beneficiaries will use to buy health insurance, thereby limiting Medicare's exposure to increasing health care premiums.

No matter whose plan is in effect, one thing is certain: both hospitals and physicians will be paid less. Therefore, it is in our vital interest to cooperate and devise ways to survive together in this inhospitable situation. LMHS needs physicians as much as the physicians need the system. We are in it together and the only way to save the day is to work together. As Jim Nathan said, contrary to general belief he does not stay up at night figuring out ways to make physician life miserable. There are forces greater than him altering the playing field. I for one believe him. These are changing times, no one likes a change especially the one which will affect us in a negative way but unfortunately I don't see another way. Therefore, the more we each get involved in the process the more control we will have on shaping the end product and hopefully we will the survive rest of our professional lives half-way intact.

Meetings and Events

General Membership Meeting

November 17, 2011

FineMark National Bank & Trust

12681 Creekside Lane
Fort Myers, FL 33919
6:30 PM Social/7 PM Dinner

Speaker: Robyn Bonaquist
"Marketing Medical Practices"

Board of Governors Meeting
October 11, 2011
6:30 P.M.

Inserts:

Rx Medication Misuse

FL Vital Statistics

November Meeting Notice

Inside this issue:

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

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

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

Membership News

Relocated
David Sudderth, MD
Athletic Orthopaedic Reconstructive Center
3210 Cleveland Ave
Fort Myers, FL 33901
Phone: 239-275-6690

Edward T. Humbert, DO
Dennis O. Sagini, MD
Jon P. Kimball, MD
Joint Implant Surgeons of Florida
7331 College Parkway, Ste 300
Fort Myers, FL 33907

Pictorial Directory Corrections

We apologize for any errors that were made in our membership directory and will publish corrections as needed.

Robert Pascotto, MD, Retired,
Incorrectly listed as:
Robert Pascotto Jr., MD
Cardiothoracic Surgery

Address Correction
Thomas Presbrey, MD
John Rodriguez, MD
8791 Conference Drive
Fort Myers, FL 33919

A. Aurora Badia, DO
13691 Metropolis Ave.
Fort Myers, FL 33912

Add Website
Associates in Dermatology
www.associatesinderm.com

New Members

Martin Barrios, MD - General Surgery
Florida Incisionless, LLC

Robert Casola, MD - Orthopedic Surgery
Orthopedic Specialists of SWFL

Christopher Dawson, MD - Orthopedic Med
Orthopedic Specialists of SWFL

Jon Kimball, MD- Orthopedic Surgery
Joint Implant Surgeons of SWFL

Freddy Montero, MD - OB/GYN
Maternal Fetal Medicine of SWFL

Jason Nemitz, MD - Orthopedic Surgery
Orthopedic Specialists of SWFL

Francesca Swartz, DO - Orthopedic Surgery
Orthopedic Associates of SWFL, PA

Steven Woodring, DO - Anesthesia
Mobile Anesthesiologists of Florida, LLC

SAVE THE DATE
LCMS ANNUAL HOLIDAY PARTY
DECEMBER 5, 2011
BY INVITATION ONLY

Physicians in the News

Judith Hartner, MD, MPH attended a CDC event at the Community Reception Center, Orlando, Florida. Theme for the CDC Drill was "In the Event of Intended Exposure to Radiation". Drills were conducted with procedures for screening and decontamination and in determinations being made as to whether further treatment would be necessary. The set up time in case of a massive radiation exposure is 6 hours. Local hospitals and fire stations are equipped to handle some cases of exposure to different elements including radiation.

PRESCRIPTION MEDICATION MISUSE:

PREVENTION, RECOGNITION, RESOURCES FLYER

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Enclosed flyer courtesy of LiveFree!
Substance Abuse Coalition Pinellas County.
http://www.findtreatment.samhsa.gov/

As I Recall...

Roger D. Scott M.D.

KIDS

My **Webster's New World Dictionary of the American Language** (July 1983) defines **Kids** as children of goats; however, my generation (to the best of my knowledge) define them as children. It seems as the parents get older their offspring remain **kids** (children) regardless of their age. I think this is probably a universal thought in America, but maybe it is only used in the South. Those of you who are childless will see from this article what harrowing experiences you might have missed! There may be some redundancy with portions of this article and the one hundred & sixty-four or so previous *As I Recall* articles over sixteen years, but perhaps you will not remember these "turning hair gray" episodes even though my hair is only slightly gray. It is always amusing to me when someone tells me "Gee I really enjoyed your last article" but they can't remember what it was about! Hopefully all of this will appear to be new material to those with short memories.

My oldest kid (62) was born in Miami (My Am Ah) on September 1, 1949 that was appropriately Labor Day, and all through his childhood he seemed to be trying to turn my hair gray. Examples: We drove from Alamogordo, New Mexico to Mexico City and went to visit the Pyramids of the Sun there. As the guide was telling us about the tall pyramid, my four year old son was running up the steps when the guide saw him and excitedly ran to catch him. We then held his hand for the remainder of the distance up the pyramid to the top and saw the immediate drop off from the top to the ground that would have killed the boy had he gone all the way by himself. We really were not negligent parents; he was old enough not to have to hold his hand while we were just viewing the base of the pyramid. About a year later as I looked out the window I saw this same child walking on the top beam of a tall swing set. I suspected that he would fall, and so he did and sustained a supracondylar fracture of his humerus ! Many of this type of fractures are very difficult to treat because they are very unstable fractures and we did not do open fixation of fractures in children. Fortunately his fracture was stable and he did well with a long arm cast (I did at that time orthopedics as a general surgeon.). This same child during his Pre and early teens "picked on" his younger brother (born March 25, 1951in Baltimore, unfortunately not a native Floridian) so much that I made a partition ceiling to floor of thick cardboard in the backseat of the car to separate the two boys. He never really did anything bad, just little things of annoyance frequently.

The younger boy was almost 3 years old when a foreign body embedded in the cornea of his eye one Sunday when I was a resident in training. I took him to my room at the hospital and phoned the only visiting private ophthalmologist for our hospital. I explained about the foreign body and the doctor said he would be in to take care of the problem. I put the boy on the top deck of the double-decker bed for a nap, and while my back was turned he rolled off the bed and hit the floor sustaining a simple, non-displaced fracture of his forearm. I took him to the emergency room and applied a cast. We waited several hours and made several phone calls for the ophthalmologist who never appeared so back to the ER we went. My son was cooperative enough so that I was able to remove the foreign body using a #11 scalpel blade. (I had used this technique many times previously on adults when working in the E.R. and later used the technique in private practice to the astonishment of the local ophthalmologist as the #11 blade is so very pointed and might cut the eye but I never did.) My wife was not happy about the cast but delighted about the eye. A previous *A.I.R.* article told about this kid's exploits as a teenager when he didn't return home from sailing. He lost his paddle and had to use his hands to paddle his pram (small sailboat, but no wind) all the way from the F.P. & L. plant down the river back to the Royal Palm Yacht Club while several of us (sheriff's posse) in boats at night were frantically searching for him in the river and the sloughs (pronounced slews) that made up Cape Coral's waterfront before the seawalls and landfills. He really was rarely any trouble.

I was praying that the third child (born April 28, 1957-another Marylander!) should be a girl, and she was indeed a little beauty. I got to go home from my residency training on a Saturday when she was six weeks old. My wife stated that the baby was sick, but I only thought she had a cold as the two boys were also sick with a flu-like illness. I went to the hardware store to get something and was gone about an hour, and when I returned an ambulance and our pediatrician were at the house. He said that the baby was in heart failure and had to be on oxygen and go to the hospital by ambulance. An EKG showed that she had a nodal, not sinus, tachycardia which was a bit unusual and was in significant heart failure. My wife stayed with her during the day, and I was relieved as chief resident at night to stay with her. Senior student nurses ran the floors at night so I checked before each dose of medication was given to my daughter. On the second or third night I noticed the student nurse brought in a rather large syringe filled with medication. I questioned her and she said it was Digoxin and I questioned the dosage. The nurse had prepared a larger dose than would have been given to a 150 pound adult rather than an 8 pound baby. Thanks to God I was there as my wife would not have known any different when the baby had died from "heart failure" rather than an overdose of heart medicine. The student nurse almost had heart failure because of her mistake that she almost accidentally killed a baby. When our baby was discharged the cardiologist suggested that we see Dr. Helen Taussig (world's most famous and the first pediatric cardiologist(1930) in the world) at Johns Hopkins Hospital. Dr. Taussig was instrumental in the correction of the Tetralogy of Fallot (Blue Baby Syndrome), very nice and confirmed our cardiologist's diagnosis and treatment. The oral heart medications were Quinidine four times a day for six months and Digitalis daily for a year. The "baby" is now a super wonderful grandmother.

Space does not permit me to write about episodes with my two youngest daughters, but perhaps that will be covered in the future. This article may sound like it's bad to have children, but to the contrary I could write a book on the special and wonderful joys, events, and love of children. This must be a true statement on my part or I must have needed sex education!

Ten years ago today (September 11, 2001) someone came in the operating room and said a plane had hit one of the Trade Center buildings. I had just finished the case and went into the lounge in time to see the second plane hit the tower and the beginning of active war between radical Islam and the United States. Today (9-11-2011) I have mostly followed the stories on TV and have reviewed the 10-year-old 100-plus pictures and stories taken from the Internet that I have kept. **God bless America and continue to protect us.**

New Applicants

Peter M. Denk, MD — Dr. Denk received his MD degree from University of Michigan Medical School in Ann Arbor, MI in 2001. He completed his internship/residency at University of South Florida, Tampa FL ((2001-2001). Dr. Denk specializes in General Surgery and Bariatric Surgery. Dr. Denk is in practice with Florida Incisionless, LLC at 4881 Palm Beach Blvd, # 100, Fort Myers, FL 33905 - Tel: 239-433-3504.

Melissa A. Lee MD — Dr. Lee received her MD degree from the Medical College of Georgia, Augusta GA in 2007. She completed her residency at the Winnie Palmer Hospital for Women and Babies, Orlando, FL (2007-2011). She is in group practice with LPG/Women's Health Professionals, 9981 S. HealthPark Dr. Ste 283, Fort Myers, FL 33908—Tel: 239-343-6100.

Henry W. Zimmerman Jr. MD — Dr. Zimmerman received his MD degree from Eastern Virginia Medical School, Norfolk VA in 2001. He completed his internship/residency at Allegheny General Hospital, Pittsburgh, PA, (2001-2004). Dr. Kimball is board certified by the American Board of Emergency Medicine. He is in group practice with Lee Memorial Emergency Physicians, 2776 Cleveland Ave, Fort Myers, FL 33901 - Tel: 239-343-3695.

Tal Ben Hazan, MD — Dr. Hazan received his MD degree from the St. George University of Grenada, West Indies in 2003. He completed his internship and residency at the Providence Hospital, Southfield, MI in (2003-2009). He completed his fellowship at St. Luke's Hospital in Milwaukee, WI in (2009-2010). Dr. Hazan is in group practice with Gastroenterology Associates of Southwest Florida, 4790 Barkley Circle, Building A, Fort Myers, FL 33907 Tel: 239-275-8882.

September General Membership Wine Tasting Social

Liability Issues Associated with Electronic Physician-Patient Communication

By Cliff Rapp, LHRM Vice President Risk Management First Professionals Insurance Company

Information in this article does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. First Professionals recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.

The Internet continues to open new avenues for communicating. Over forty-million Americans access the Internet for healthcare information and services.[1] Recent data further evidences the growing demand by patients for specific healthcare information and directives as well as increasing expectation for online interactivity.

In tandem with the benefits of electronic communications are emerging liability issues and sobering legal concerns. To date, legal waters are largely untested. Consequently, it is important for physicians who communicate electronically to address fundamental risk management issues evolving for Internet-based communication entailing patient privacy, confidentiality of patient information, security and encryption, parental informed consent, use of disclaimers, opportunities for patient education, and the implications of website linkage.

Electronic communication systems encountered in the healthcare delivery system are fairly abundant and include practice-based Internet web pages, electronic prescribing systems, wireless personal data, drug formularies, e-mail transmission, voice mail, and internal, intranet web sites. Approximately four-million patients communicate with their physician via e-mail and over three-million Americans access physician office-based websites.[2]

There are many advantages in communicating electronically with patients. Electronic transmission of information is faster than traditional modalities, and in some cases, instantaneous. In addition to meeting growing expectations for quick and precise information exchange, electronic communication has the advantage of informing and educating patients, confirming delivery of information exchange, provides automated follow-up, enhances informed consent, facilitates compliance with treatment regimens, and documents the sequence of communication. However, such advantages are not without consequences liability-wise.

The inherent risks in communicating electronically include online malpractice exposure, unintended creation of a physician-patient relationship, inadvertent extension of the physician-patient relationship, and inappropriate disclosure of confidential patient information under potentially draconian HIPAA and civil monetary penalties. Courts have ruled that when used in connection with patient care and treatment, electronic communication is a medical record. Seemingly intangible electronic communication is likely to become evidence should a legal proceeding arise. In this context, consider whether the communication would support a defense or facilitate a malpractice claim against the physician? Such evidence could include notes that you author, records made by others, correspondence, e-mail transmissions, answering service records, staff notations, the content of websites and their links as well as messages and insurance and billing statements.

Meeting ever increasing expectations for online interactivity should be coupled with a modicum of risk management foresight and savvy.

Do You Have A Website?

As we move more into a world of technology, patients are looking to websites to find information on physicians. Our website has the ability to link to your website. With one click a patient may access all your information as provided by your office.

Click to check it out,

go to: www.lcmsfl.org

If you have not already done so, please submit your practice website information to our office at valerie@lcmsfl.org

When Doctors Become Patients

By Eric D. Manheimer

FRANK SINATRA'S greatest hits album, filtered through the jet engine noise of the Varian linear accelerator, was not what I felt like hearing at 9 a.m. I made a mental note to bring a Steely Dan CD for my next appointment.

I was strapped to a hard metal sheet, and the technician had just bolted my head down using a black mask that had been heat-molded to the contours of my face. The sheet and I would slide first up and then back in an overhead arc that would send high-energy electrons into my head and neck from computerized data sets outlining my throat cancer and its spread into adjacent lymph nodes.

I wasn't a doctor anymore. I was a patient.

That was almost three years ago. This spring, the Archives of Internal Medicine published a much-discussed study that showed that doctors might recommend different treatments for their patients than they would for themselves. They were far more likely to prescribe for patients a potentially life-saving treatment with severe side effects than they were to pick that treatment for themselves.

Understandably, people are worried that this means doctors know something they're not telling their patients. But my own experience with illness taught me a simpler truth: when it comes to their own health, doctors are as irrational as everyone else.

I had squamous cell carcinoma of the throat, a pea-size lesion first, then the cancer spread to my lymph nodes. I knew that this was a bad actor; I'd seen the disease and its consequences many times while wearing a white coat, a stethoscope dangling from my neck, at a patient's bedside.

At the beginning, I knew intellectually what was in store for me. I allowed myself to be a patient, to trust my doctors and let them lead me through the treatments and complications and side effects that rolled out with alarming regularity. I submitted to a brutal treatment regimen that had not changed in over 40 years. Two thousand units of radiation a day for 35 days, with high doses of platinum chemotherapy, followed, a year later, by a dissection of the right side of my neck to remove the lymph nodes in which the cancer had reappeared.

I soon realized I had no idea what kind of rabbit hole I had fallen into.

For my doctors, it was all about the numbers, the staging of my cancer, my loss of weight and strength. For me, too, it was about the numbers: the six feedings I pushed through the syringe into the plastic tube in my stomach every day; the number of steps I could take by myself; how many hours I had to wait before I could grind up the pill that allowed me to slip into unconsciousness.

But it was also about more: my world progressively shrinking to a small, sterile, asteroidal universe between the interminable nausea and the chemobrain that left my head both empty and feverish, between survival and death.

Survival was a percentage, and not a horrible one — 75 percent if I completed the treatment regimen, by the reckoning of my physicians. But more and more I found myself thinking about what would happen if I was in that 25 percent. If I completed the regimen and the tumor came back, there were no other treatment options. It was morphine and palliative care. I was 58 years old. Death was a 100 percent certainty, eventually. So did it matter?

During one particularly desperate hospitalization, after receiving blood transfusions and a drug to stimulate my white cells, I decided that I had had enough. I refused further radiation and chemotherapy. I lay in my bed and watched the events around me — the distress of my family, the helplessness of my doctors — without anxiety, comfortable that I had made the correct decision.

My doctors couldn't override it or persuade me to change my mind, but, luckily, my wife, Diana, could and did. From my mental cocoon in the hospital bed, I could sense Diana at my side. "You're going to finish the treatment," she said softly. I did not have the energy, or perhaps the will, to disagree. She wheeled me down herself to finish my radiation treatments in the basement of the hospital.

My dreams of dying were not the products of anxious moments of terror. The life force had simply slipped away and made me ready to die. It had also rendered me incapable of making the right decision for myself. My disease was treatable and the odds were favorable. My doctors were professional and gentle but ultimately could not decide for me. When neither doctor nor patient can make the right decision, it is vital to have a caring family — though even here the legal and ethical issues are complicated.

Next week it will be three years since I first noticed the hoarseness that was a symptom of cancer, and I am back to work and a busy life. But my illness has changed me profoundly as a physician. Even having lived through this illness, I'm not sure that I would be any better prepared if I had to relive it again. No amount of doctoring can prepare you for being a patient.

If anything, it's that recognition of vulnerability as well as expertise that makes me a better doctor today.

 Eric D. Manheimer, the medical director of Bellevue Hospital Center, is the author of the forthcoming memoir "Twelve Patients."

Facebook© and Social Networking—Friend of Foe?

By Joseph Putz, LHRM, FPIC Rish Management Consultant

The information below does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained herein are generalized and may not apply to all practice situations,. First professionals recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.

Social networking and blogging are increasingly popular forums in our society. Facebook© currently has over 600 million active users, a phenomenal number considering the fact that it was launched just seven years ago. Other social networking services have experienced similar growth. All of these services are increasingly becoming an integral part of the lifestyle of our society.
Along with the growth and popularity of social networking sites comes the issue of the risks associated with their usage. The sites offer individuals the ability to share information and communication with family and friends. Privacy issues thus become a key concern, centering on the placement of personal information on the site and the ability to view and share this information by others. Communications intended for a limited audience can be seen by "friends" who might take a comment out of context or draw the incorrect conclusion based on that comment. Once something is posted, it never can be totally removed or eliminated.

Physicians and other healthcare providers have an even more unique dilemma. Should they participate in networking, and should they "friend" patients? The answer to these questions is not an easy one, since there are both benefits and risks associated with networking. The most obvious benefit involves increased communications between doctors and patients, which can enhance the physician-patient relationship. The risks include the previously mentioned issue of privacy, and the potential for confidential information to be posted (or the perception of confidential information). Sachin H. Jain MD, MBA recently wrote an article for the New England Journal of Medicine, "Practicing Medicine in the Age of Facebook©." In this article, Dr. Jain tells the story of a caregiver who posted her experience involving her interaction with a difficult (unnamed) patient, forgetting the fact that one of the patient's family members had been a recent addition to the caregiver's network of "friends".

Throughout their medical education, doctors are taught the importance of maintaining a professional relationship with their patients. This implies the need to maintain a professional distance between themselves and their patients. The posting of comments and pictures to a social networking site can blur these lines and may expose personally held opinions and beliefs to the general public. Additionally, pictures and comments posted to a social network, which previously were private, can subsequently be utilized in ways that could be to the doctor's detriment. Just as employers may search social networking sites for information on prospective employees, prospective patients may take the same approach when selecting a physician.

Social networking can be a useful tool for certain activities and efforts. However, its usage in a professional setting should be carefully considered and very specific guidelines should be developed should the decision be made to participate in these activities. Remember, the only way to completely avoid liability for comments or postings on networking sites is to not use those vehicles at all.

News: HHS announces new lab/HIPAA rules, new OCR director

Patients may have easier access to lab results under a **proposed rule** announced by Department of Health & Human Services (HHS) Secretary Kathleen Sebelius during the first-ever HHS Consumer Health IT Summit in Washington, DC. September 12.

The proposed rule would allow patients to access test results reports directly from labs, which would provide such information directly to patients or their personal representatives, according to an HHS press release.

"When it comes to healthcare, information is power. When patients have their lab results, they are more likely to ask the right questions, make better decisions and receive better care," Sebelius said.

CMS, the Office for Civil Rights (OCR), and the Centers for Disease Control and Prevention (CDC) drafted the proposed rule. It would amend the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations and HIPAA privacy regulations to strengthen patients' rights to access their own laboratory test result reports, according to the HHS press release.

Sebelius also announced Monday the appointment of Leon Rodriguez as the new director of OCR. Rodriguez brings Department of Justice experience to HHS. He replaces Georgina Verdugo. OCR did not immediately return an e-mail Monday about the status of Verdugo.

"Consumers need to know that private and secure access to their health information is a given," OCR Director Rodriguez said in the HHS release. "The privacy and security of health data will be a top priority for OCR during my tenure."

Sebelius also unveiled a voluntary Personal Health Record (PHR) Model Privacy Notice, which creates an easy-to-read, standardized template allowing consumers to make informed decisions based on their privacy and security policies and data practices about PHR products.

The new template is similar to Nutrition Facts Labels in that it presents certain complex information in a simple way to improve transparency and consumer understanding about data practices. By making this Model Privacy Notice available, PHR companies can help build greater trust in PHRs, according to the HHS press release.
For more information about the proposed amendments to the CLIA and HIPAA Privacy Rule, please visit https://www.cms.gov/apps/media/fact_sheets.asp.

Empowering our Students: BullySafe Training in Lee County Schools

by Mariquita Anderson

The BullySafeUSA Training led by SuEllen Fried on September 7-9 was a big hit in Lee County schools. Thirty participants attended the 3-day training session. Among the participants were a high school principal, a media specialist, counselors, and social workers. All schools - private, public, and charter - were invited. Topics in the 3-day training session included the following:

- confidentiality
- profiles of bulliers
- child abuse
- passive vs active targets
- bullying hotspots: the bus, playground, recess, or P.E. class
- inclusion of ancillary staff in a bullying situation
- speaking to parents about bullying without mentioning the word "bully"
- different types of bullying: physical, verbal, emotional, sexual, and cyber
- the power of witnesses.

SuEllen introduced her training to participants with presentations to a fourth grade class at Colonial Elementary and a fifth grade class at Dunbar Middle where the participants were the students and the fourth and fifth graders were the teachers. When SuEllen asked, "How long does it take to heal a broken heart?", answers ranged from "a day" to "until someone says they're sorry" to "never." As SuEllen was leaving Dunbar Middle, one student thanked her for coming and asked her to visit again next year!

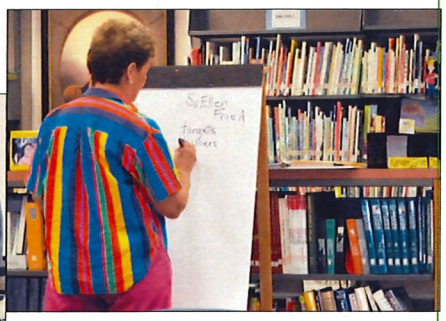
These presentations were the basis for the bully prevention training. By the third day, everyone gave a presentation to a class at a school in Lee County. Presenters from the Alliance included Vicki Sweet and Mariquita Anderson with help from Dixie Dakos.

All of the classroom students were taught the types of bullying and asked why they thought people bullied others. Responses to why people bullied included "to look cool", "because they're being bullied at home", "they have problems at home", and "to be popular." Everyone learned that bulliers cast a wide net and, by the end of the year, had narrowed their selection of targets. Classroom students were given ways to help a target in a bullying situation:

- challenge the bullier
- don't give bulliers power
- get a group to challenge the bullier
- befriend a troubled bullier
- tell an adult
- include a target in your activities, and
- talk to a target in private.

The conclusion of the presentation taught the meaning of empathy: to put one's self in someone else's shoes. Then the class was asked for volunteers who'd like to apologize to someone they had bullied. Most of the classes had volunteers who apologized to their targets. One person apologized to her teacher. All that was required of a volunteer was an apology: a restatement of the offense was highly discouraged or not allowed.

One of the most powerful statements about bullying was a short video called, _The List_. It is the result of a reaction of school faculty after they surveyed their students about bullying. The Alliance has a copy of the video if anyone would like to view it.

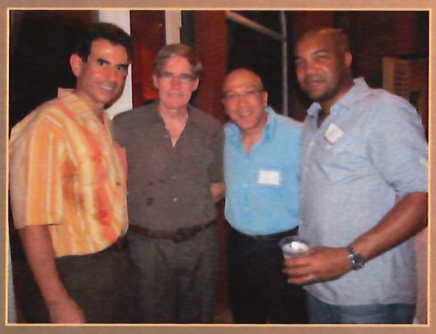


Potluck in Paradise

September 10, 2011

John and Traci Mehalik, hosted the Annual LCMSA Potluck in Paradise in their lovely home. LCMS members and new physicians to Lee County were among the guests that enjoyed an end of summer celebration with great music and wonderful cuisine provided by Jordan Webster of Webster's Catering. If you weren't there you missed out! Lots of fun!









Potluck in Paradise

LEE COUNTY MEDICAL SOCIETY

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