LEE COUNTY MEDICAL SOCIETY INC.

Physicians Caring for our Community

Bulletin

Editor: Mary C. Blue, M.D.

Volume 37 Issue 5

May 2013

2013 Meetings & Events

General Membership Meeting
May 16, 2013

FineMark National Bank & Trust
12681 Creekside Lane
Fort Myers, 33919

Speaker:
Timothy Norbeck, CEO
The Physician Foundation

"The Physicians Foundation, the challenging physician practice environment"

RSVP to:
Lee County Medical Society
13770 Plantation Road, Ste 1
Fort Myers, FL 33912
Tel: 936-1645
Fax: 936-0533
(Limited Seating)

Florida Medical Association Annual Meeting

July 26-28, 2013
Hilton Bonnet Creek
Orlando, FL

Delegates representing LCMS:

Cy Anderson, MD	Stuart Bobman, MD
Stefanie Colavito, MD	Daniel de la Torre, MD
Valerie Dyke, MD	Larry Hobbs, MD Chair
Richard Macchiaroli, MD	Jeffrey Neale, MD
F. Rick Palmon, MD	James Rubenstein, MD
Shari Skinner, MD	Shahid Sultan, MD

INSERTS
ICD-10
DocbookMD
May 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 meeting minutes are available for all members to review.

About the Cover:
Royal Poinciana on McGregor Boulevard (Fort Myers)
By Ed Guttery, M.D.

The Lee County Medical Society expresses our condolences to Joseph K. Isley, MD with the passing of his wife, Nancy J. Isley on March 21, 2013.

Membership News

Moved

Ralph Garramone, MD
12998 S. Cleveland Avenue
Fort Myers, FL 33907
Tel: 239-482-1900

Charles Bisbee, MD
Charles Homolka, Jr., MD
Simeon Manalili, Jr., MD
Joseph Nicotra, MD
Sally Palmon, MD
Bernard Shucavage, MD
Robert Turner, MD
Henry Venable, MD
Anesthesia & Pain Consultants
12511 World Plaza Lane
Bldg 50
Fort Myers, FL 33907
Tel: 239-939-2622

Terese Taylor, MD
4202 Del Prado Blvd S
Cape Coral, FL 33904
Tel: 239-540-9918

No Longer Practicing In Florida

Brian Kim, MD

Moved

Stefanie Colavito, MD
FMA Hospitalists
13691 Metropolitan Pkwy S
Ste 130
Fort Myers, FL 33912
Tel: 239-210-4247

New Practice

Reggie Augusthy, DO
Trinity Spine & Joint Care
8851 Boardroom Circle
Fort Myers, FL 33919
(239) 433-7400

Practice Phone Change

Ivan Abril, MD
Deogracias Caangay, MD
Mohamed Faisal, MD
William Liu, MD
Kultar Singh, MD
Shahid Sultan, MD
Pediatrix Medical Group of FL
9981 S HealthPark Drive
Room 30618
Fort Myers, FL 33908
Tel: 689-5681
Fax: 689-5768

Resigned

Richard DeIorio, MD (retired)
James Dougherty, MD (retired)

Members dropped for non-payment

Matei Andreoiu, MD
Washington Baquero, MD
Robert Casola, DO
Julio Pabon, MD
John Prater, DO
Jose Colon, MD

New Applicants

Brad A. Snead, MD – Dr. Snead received his MD degree from University of Alabama School of Medicine, Birmingham, AL 2005-2009. He completed his internship at Baptist Health System, Birmingham, AL 2009-2010. Dr. Snead did his residency at Georgia Regents University, Augusta, Georgia 2010-2013. He is in group practice with Snead Cataract, 4790 Barkley Circle Bldg C, Unit 103, Fort Myers, FL 33907. Tel: 239-936-8686.

Recruit three new members & your 2014 dues will be free of charge.

If you have changed locations, added a new physician to your practice, or changed office managers, please call the Medical Society office. It's important to keep us up-to-date so that you receive the patient referrals and office communications for your practice from the Medical Society.

President's Message: Will eVisits Be Primary Care Physicians' Answer to the Retail Clinic Trend?

Audrey Farahmand, M.D.

On April 4th, Walgreens announced that its 300+ Take Care Clinics would be the first to diagnose and manage chronic conditions such as asthma, diabetes, high blood pressure, and high cholesterol. In the past, Walgreens along with its competitors Target and CVS managed already-established chronic illnesses. The Nurse Practitioners (NPs) and Physician Assistants (PAs) staffing these retail clinics also provide testing and treatment for minor short term illnesses like strep throat.[1]

Retail clinics have seen tremendous growth over the last decade. The first retail clinics opened in the year 2000 and by 2010 have numbered close to 1,200. Americans have made 6 million visits to these clinics in 2009 alone, clearly showing that retail clinics are meeting a need.[2]

The appeal is obvious: Convenience, better access to care through longer hours and more locations, no appointments, and short wait times (more than 44 percent of retail clinic visits take place when physician offices are typically closed). Price transparency and low costs may be particularly attractive for people without insurance.

The concerns of this model have included fear of over-prescription of antibiotics, lost opportunities for preventative care, and disruption of existing physician-patient relationships.

It would not be wise to bet against Walgreens as it has proven to be an undisputed expert at data collection, analysis, customer service, and sales. It would also not be wise to bet against NPs' and PAs' ability to diagnose and manage the above-listed chronic conditions. One can opine that a primary care physician's motivation for the health and well being of patients probably exceeds that of the retail chain giant.

We must acknowledge that this growing trend represents a need that traditional primary care clinics were not fulfilling and we can and should learn from their experiment.

Electronic visits (eVisits) could help traditional primary care clinics improve convenience and customer service while lowering costs. For eVisits, non-emergency patients log on through a patient portal and select a topic such as cold symptoms, back pain, depression, bronchitis, etc. Then, they fill out a tailored questionnaire to provide the doctor with medically relevant data in a structured format. A physician, PA, or NP gets back to them in a few hours (often minutes) with treatment advice.[3] A study in JAMA did show that patients who were treated online were prescribed more antibiotics than those that were treated in the office setting. Otherwise, this study that looked at the treatment of sinus infections and urinary tract infections suggested that misdiagnosis and treatment failure were not any higher with patients who were treated online.[4] As most primary care clinics have adopted patient portals and EHR, eVisits can be integrated with these softwares. Although more studies would be helpful to define the strengths and weaknesses of the program, many healthcare clinics have already seen growth and cost-cutting while utilizing eVisits and have payers on board for reimbursement. The success of these programs would also depend on extended hours of staffing to answer the inquiries.

Although the majority of patients still prefer the traditional office visit and face-to-face physician-patient interaction, physicians can develop strategies to capture and maintain those patients who prefer speed and convenience.

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[1]Chronic Care at Walgreens? Why (Not)?, Ishani Ganguli

[2]Rand Health. Special Feature: Retail Clinics Play Growing Role in Healthcare Marketplace.

[3]Healthcare Informatics. Making the eVisit work. Jennifer Prestigliacomo. April 27, 2012.

[4]JAMA Internal Medicine. Online January 14, 2013

Empowered By ACA, Old Fraud Law Puts New Scrutiny On Physicians

By Alicia Gallegos - amednews staff

With the Affordable Care Act giving the government more power and dedicating more money to improving federal efforts against health care fraud, waste and abuse, physicians' business practices are under the microscope like never before.

How to stop False Claims Act violations before they start

Doctors increasingly have become the targets of False Claims Act investigations by the federal government. Experts say practices can prevent such violations by developing strong compliance programs:

- Know general compliance rules and industry-specific ones. Understand that general rules include implementing written compliance policies and procedures, and designating a compliance officer.
- Identify risk areas. Know that each industry has its own dangerous areas for noncompliance; for many physicians, these include coding and medical necessity issues.
- Document a compliance program. Detail how issues are investigated and resolved, and describe compliance expectations.
- Create a code of conduct. State principles and values of the company, and include a commitment to compliance and lawful conduct.
- Communicate policies. Distribute procedures and conduct standards to employees within 90 days of hiring, every time there are updates, and annually. Practices should ask for a written acknowledgement of the policies.
- Promote a culture of compliance and transparency. Identify and address conflicts of interest, ensure regular compliance training and report potential violations to the appropriate authorities.
- Conduct internal auditing. Create an audit plan and update it regularly, review issues proactively and establish corrective plans.
- Respond promptly. Establish a system to respond quickly to any possible FCA issues, make reasonable inquiries into potential violations and communicate with the person who reported the issue, if appropriate.
- Maintain and evaluate records. Track potential issues and their resolutions, and disclose issues to the government if necessary. Evaluate and measure program effectiveness regularly.
- Impose standard discipline. Establish disciplinary procedures and clear consequences for violations, make sure employees are aware of any discipline and apply rules uniformly across the entire practice.

Sources: "A 12-step Program to Better Compliance: A Practical Approach," American Health Lawyers Assn.'s Physicians and Physician Organizations Law Institute, February

LCMS Welcomes Our Newest "Friend In Medicine" Attorney Linda R. Minck, PL

Florida licensed attorney Linda R. Minck provides legal counsel to area physicians and businesses with a focus on formation of entities, agreements among owners, contracts, employment agreements, buy-in/buy-out agreements, stock and asset purchase agreements. Ms. Minck is uniquely familiar with the legal challenges facing health care practices with regard to compliance and health care regulations such as HIPAA, Stark and Medicare Anti-kickback Rules. Formerly with Porter, Wright, Morris & Arthur, Ms. Minck opened her own practice in March 2013, and will continue to help clients meet their day-to-day legal needs as she has done for over 20 years.

Linda Minck practiced law in Ohio before relocating to Florida with her family in 2001. She maintains licensure in Ohio. Ms. Minck supports several charities and causes including the American Cancer Society. She also contributes her knowledge by conducting educational presentations at area hospitals and medical societies and on behalf of Florida Gulf Coast University. Before embarking on her legal career, Ms. Minck served in the National Guard, earning the rank of Staff Sergeant.

Linda R. Minck earned her B.S. in business from Franklin University, and J.D. from Capital University Law School, Columbus, Ohio. Linda began practicing law in 1990, and since 1997 practiced at Porter Wright Morris & Arthur, first in their Columbus, Ohio office, and then at their Naples, Florida office.

Ms. Minck is a member of The Florida Bar, Collier County Bar Association, Southwest Florida Medical Managers Group, Collier County Women's Bar Association, Medical Management Association of Collier County, American Health Lawyers Association, Columbus Bar Association, Ohio State Bar Association, The Childhood League, Collier County Medical Society Circle of Friends, and Lee County Medical Society Friends of Medicine.

The law office of Linda R. Minck, PL is located at 5633 Strand Boulevard, Suite 314, Naples, FL 34110, (239) 260-5827 or email Linda@Minck-Law.com.

LINDA R. MINCK, PL

OIG Shoots Down Physician Owned Distributorships (PODS)

By: Jeffrey L. Cohen - The Florida Healthcare Law Firm

Physician owned distributorships (PODs) have been the source of considerable controversy for years. A couple years ago, they caught the attention of Congress. Now, the Office of Inspector General of the Department of Health and Human Services ("OIG") has issued a Fraud Alert making clear their dislike of PODs and sending a clear shot across the bow of those who are in that industry.

PODs distribute various things, most commonly surgical implants and devices, that are reimbursed by insurers. A patient needs a spinal rod, a surgical implant/device company makes it and a distributor rep distributes it. Device/implant companies usually contract with distributorships to sell their products. Distributorships contract with reps who are paid commissions for sales. Surgeons who actually order the devices sometimes think "Since I'm the one doing the surgery and ordering all this stuff, why can't I earn something from that? I'm not ordering anything I don't need or that I don't think is good for the patient." PODs are one way for physicians to financially benefit from the sales of devices and items their patients need, but they have never been more controversial than now.

Conceptually speaking, PODs are controversial because government regulators think physicians who have an economic stake in health care items or services will tend to over utilize them. Moreover, there is a specific concern that allowing physicians to profit from the devices their patients need violates federal anti kickback laws or the Stark prohibition on compensation arrangements. That's exactly what the OIG thinks; and physicians who are owners of PODs can expect to be investigated by the feds.

In 2006, the Office of the Inspector General of HHS and CMS expressed major concerns about PODs, and cited concerns about "improper inducements." At that time, the OIG stopped short of prohibiting them, but called for heightened scrutiny. CMS itself has stated that PODs "serve little purpose other than providing physicians the opportunity to earn economic benefits in exchange for nothing more than ordering medical devices or other products that the physician-investors use on their own patients."

Implantable medical devices are unusual in the way they come into use. Unlike DMEPOS, for instance, medical devices are not sold to distributors. They're sold from the manufacture to the medical facility where the surgery will take place. So, the argument goes, physicians are not actually in a position to drive the sales volume of the implants. The counter: physicians invested in a POD can leverage their hospital admissions to influence the device choice of hospitals and surgery centers.

The biggest legal hurdle for PODs is the federal Anti Kickback Statute, which carries both criminal and civil penalties. Simply put, if even one purpose of an arrangement is to pay for patient referrals, the law is violated. So, the law is arguably violated if one purpose of the POD is to induce physicians to order implants for their patients. Looked at another way, the law is violated if one purpose of a hospital doing business with a POD is to ensure patient referrals by the physician POD investors.

A 1989 OIG Special Fraud Alert on fraudulent physician joint ventures is especially interesting on the fraud and abuse issues in pointing out that the following would indicate unlawful intent to induce patient referrals—

Investor choice. If the only investors chosen are surgeons with an opportunity to refer and if they lack any business or management expertise, the arrangement appears to be a cloaked way to incentivize unlawful referrals (i.e. ordering implants). The key question is whether the business, in selecting investors, is looking to raise capital or to lock in referral sources.

Risk. If the POD investment involves little or no financial risk, the OIG would likely take issue with it.

The bottom line seems to be that if there isn't a real business, with real financial risk and qualified investors, a POD will likely be viewed as a suspicious arrangement based on locking in patient referrals or physician admitting pressure by physician investors.

In its June, 2011 Inquiry "Physician Owned Distributors (PODs): Overview of Key Issues and Potential Areas for Congressional Oversight," the U.S. Senate Finance Committee Minority Staff, the Committee reports "A number of legal and ethical concerns have been identified as a result of this initial inquiry into the POD Models." The Committee reviewed over 1,000 pages of documents and spoke with over 50 people in preparing its report. The Committee cited long-held concerns regarding PODs, and leaned heavily on the 2006 Hogan Lovells (previously Hogan & Hartson) law firm's anti-POD analysis.

It is clear now that the OIG has accepted the Hogan Lovells anti-POD reasoning. In particular, the OIG, on March 26, 2013, issued a Special Fraud Alert regarding PODs. In it, the OIG recounts the reasoning of the Anti Kickback Statute and also reminds readers of the concerns raised by Congress on the 2011 Senate Finance Committee Report. The Fraud Alert goes further than any governmental pronouncement on PODs than ever before, keying in on such things as (1) "corruption of medical judgment", (2) "overutilization" and (3) "unfair competition." The OIG continues: "We do not believe that disclosure to a patient of the physician's financial interest in a POD is sufficient to address these concerns." Calling PODs "inherently suspect under the anti-kickback statute," the Fraud Alter specifies eight areas of particular concern, including:

- "The size of the investment offered to each physicians varies with expected or actual volume or value of devices used by the physician;" and
- "The POD is a shell entity that does not conduct appropriate product evaluations, maintain or manage a sufficient inventory in its own facility, or employ or otherwise contract with personnel necessary for operations."

The OIG has gotten more proactive than ever by stating that the eight specified areas of concern are not intended to be used as a defense by those who structure PODs in such a way that responds

continued...

cont'd from page 6

to those concerns. For instance, those structuring a POD in a way that the size of the physician investment does not vary on the basis of expected or actual volume or value of devices used by the physician will likely find the OIG unimpressed by the distinction. Instead, the OIG invites parties to engage in the OIG Advisory Opinion advisory process. They are saying "Don't do it. If you think you can put together a POD that won't violate the law, show it to us and we'll tell you if we think you got it right."

Is this the death knell for PODs? Probably not, but the stakes are remarkably higher now that the OIG has presented clear prosecutorial intent. Those physicians committed to developing a POD need to take more seriously than ever (1) the legal risks, (2) the cost of investigation and enforcement, and (3) engaging in the advisory process.

With almost 25 years of healthcare law experience following his experience as legal counsel for the Florida Medical Association, Mr. Cohen is board certified by The Florida Bar as a specialist in healthcare law. With a strong background and expertise in transactional healthcare and corporate matters, particularly as they relate to physicians, Mr. Cohen's practice involves him in regulatory, contract, corporate, compliance and other healthcare law related matters. As Founder of the Florida Healthcare Law Firm, Mr. Cohen can be reached at 888-455-7702 or online at jcohen@floridahealthcarelawfirm.com.

Spring has returned.
The Earth is like a child that knows poems.
~ Rainer Maria Rilke

How to Talk About Hospice Care

By: Susan M. Block, MD – www.amednews.com

The discussions are trying for everyone involved. But there are concrete strategies to make these end-of-life care talks go more smoothly.

"Hospice is the gold standard for end-of-life care for most people. "Yet for many patients, that first conversation about hospice is the first time anyone has told them that their disease wasn't going well. It's just too much to take that in. … We want people to be prepared with the first hospice conversation before it's a crisis."

Talks about hospice should not come without context. Instead, experts say, they should emerge from a series of discussions about the patient's care, values and goals.

- Identify other decision-makers. "Who in the family should be there with us when we discuss the results?"
- Assess understanding of prognosis. "What have other doctors told you about your condition? … From what you know, do you think that over the next month your cancer will get better or worse, or stay the same?"
- Define the patient's goals for care. "What do you hope for most in the next few months? … Is there anything you're afraid of?"
- Reframe goals. "I wish we could guarantee that we could keep you alive until your daughter's graduation, but unfortunately we can't. Perhaps we can work together on a letter for her to read on that day, so she will know you are there in spirit in case you cannot be there."
- Identify needs for care. "It can be very difficult to care for a family member at home, and no one can do it alone. Have you thought about what kinds of help you might need?"
- Summarize and link goals with care needs. "So I think I understand that your main goal is to stay at home and spend time with your family. To do that, we will need to help you in several ways, for instance, by sending a nurse out to your home and giving you both some help around the house. Is that right?"
- Introduce hospice. "One of the best ways to give you the help that you will need to stay at home with your family is a program called hospice. Have you heard of hospice? … Hospice can provide more services and support at home than most other home-care programs, and the hospice team has a lot of experience caring for seriously ill patients at home."
- Acknowledge emotional response. "You seemed surprised to learn how sick you are. … I can see it's not easy for you to talk about hospice."
- Legitimize reaction. "Many people are understandably upset when they learn how ill their loved one is and that hospice is a possibility."
- Empathize. "I can imagine how hard this is for both of you; you care about each other so much."
- Explore concerns. "Tell me what's upsetting you the most."
- Explain hospice goals. "Hospice doesn't help people die more quickly; it helps people die naturally, in their own time."
- Reassure. "Hospice's goal is to improve your quality of life as much as possible, and to help you and your family make the most of the time you have left."
- Reinforce commitment to care. "Let's think this over for a day or two; you know I will continue to care for you whatever decision you make."
- Recommend hospice. "Hospice could be very helpful to you in the ways that we've talked about, but I realize it's a big decision. I'd like to arrange for a hospice nurse to visit you so you can decide for yourself whether hospice is right for you."

Physician Leadership Key To National Quality Collaborative

By James Palermo, MD, MSMM, FACS
Physician Consultant, Florida Hospital Association HEN

In April of last year, the Department of Health and Human Services (HHS) launched the national Partnership for Patients (PfP) initiative to make healthcare safer and less costly by targeting and reducing the thousands of preventable injuries and complications that occur from healthcare acquired conditions (HAC).

The PfP, under the direction of the U.S. Center for Medicare and Medicaid (CMS) Innovation, then launched a nationwide public-private collaboration called the Hospital Engagement Network (HEN), which has brought together leaders of major hospitals, employers, physicians, nurses and patient advocates along with state and federal governments in a shared effort to identify and create innovative solutions designed to reduce patient harm and improve care coordination.

The PfP established two specific goals for the HENs:

- Reduce hospital acquired conditions by 40%, and
- Reduce preventable hospital readmissions by 20% by 2013

The HEN approach to reducing HACs and readmissions is not just a database of process measures and outcomes, but is structured as a true national "collaborative." The focus is on aligning and accelerating the work by affording participating clinical improvement teams direct interaction with their network counterparts through national, regional and state conferences, as well as online communication where content experts, many of whom are physicians, share successful approaches to system improvement, leadership commitment, physician and staff engagement, teamwork development and culture transformation.

In December of 2011 CMS awarded two-year HEN contracts to 26 national, regional, state, and hospital system organizations. The Florida Hospital Association HEN has by far the largest number of participating hospitals in the state with 77, which includes all of the Lee Memorial Health system hospitals.

Since May of 2012, participating HEN hospitals have been engaged in a wide array of initiatives and activities to spread established, effective interventions and rapidly improve patient safety in hospitals. They are focused on more efficient and effective care in 10 core areas that include: adverse drug events; catheter-associated urinary tract infections (UTI); central line-associated blood stream infections; injuries from falls; adverse obstetrical events; pressure ulcers; surgical site infections; ventilator-associated pneumonia; venous thromboembolism; and preventable hospital readmissions.

As a front-line physician you may already be familiar with the HEN initiatives in your hospital and be actively involved in the evidence-based clinical strategies unique to your domain that contribute to preventing HACs. In fact, it is clear that front-line physician involvement is imperative to identify system defects and establish solutions that improve quality and mitigate safety risks.

However, no matter which HEN core area or other clinical domain you may be focused on, to ensure the highest level of excellence and productivity, your clinical team requires your knowledge and understanding of the initiatives, your awareness of the aims and data, and a clear expectation set by you that all members of the team take ownership of the clinical process and its outcome.

The Health Research and Educational Trust (HRET), the educational arm of the American Hospital Association, has partnered with the Florida Hospital Association in administering their HEN. Information on upcoming HRET-HEN events can be found at www.hret-hen.org, and presentations related to all 10 topics from previous events are available at www.hret-hen.org/resources.

The FHA HEN is also in the progress of developing online on-demand physician educational/training programs focused on evidence-based practice and your role as an effective team leader in the HEN improvement initiatives. These programs are free to all staff at FHA HEN hospitals, and upon completion, CMEs will be available.

For more information related to the FHA HEN, please contact Kim Streit, FHA VP of Healthcare Research and Information, at 407.841.6230 or kims@fha.org.

Trauma Care: Yesterday, Today and Our Choice for Tomorrow

By Roger D. Scott, M.D.

The following article was written October 22, 2002 by Roger D. Scott, MD. Lee County's Trauma Center continues to grow with the support of the community.

Imagine yourself as a victim in a major automobile crash, but you are conscious. The ambulance arrives, and you note that it is a hearse from one of the local funeral homes. You are placed upon a stretcher by the two attendants, who are morticians, and further note that the only equipment within the "ambulance" is an oxygen tank. No first-aid is given on the scene and you're transported to Lee Memorial Hospital, but there is no radio communication to the hospital, so the hospital staff doesn't know that you're about to arrive.

After being brought into the small Emergency Room that has only two stretchers, a registered nurse checks your vital signs. The nurse can administer oxygen (but can't start an IV because nurses are not allowed to do so-only a physician can do this). The nurse then calls the "on call physician", requesting him to come to the emergency room to treat you. The physician might be an eye doctor; a pediatrician; ear, nose and throat specialist; ob-gyn specialist; family practitioner; internal medical specialist; a urologist; or if you're fortunate, a surgeon.

Each physician on the hospital's medical staff has to rotate on a daily basis (regardless of specialty) and cover emergency room patients. The physician on call might be either in his office (packed full of waiting patients), delivering a baby, with a patient in the operating room, or during the night at home asleep. It is the obligation of the physician, regardless of his ability to manage trauma, to render your care. In most instances the physician on call, who has no experience with trauma, does try to obtain the services of a more qualified surgical person. Sometimes you may be delayed a few hours in the emergency room awaiting arrival of that doctor who is tied up in another situation. In such a case, the nurses and the physician on call may only render first-aid rather than giving rapid, defined care. Even if a surgeon can be obtained, it is frequently necessary to await the availability of an operating room and to obtain anesthesia for the necessary surgery. Lee Memorial Hospital only has two operating rooms and during the day these are busy, and at night the staff has to be called out to set up the emergency cases. Of course, all of this is taking quite a bit of time. From the time of your accident until you receive the necessary operation, two to four or more valuable hours are lost- and perhaps even your life.

All of the above may seem a ridiculous scenario to you; however, this was the way trauma was managed in 1958 when I came to Fort Myers.

Gradually over the years, this scene has changed greatly, first by the establishment of a very fine Emergency Medical Service (at the taxpayers expense), with always-improving skills. Patients then could be managed safely in the field and transported to the hospital, increasing your chances for survival. Even more was done to increase your safety by establishing departmentalization of the emergency room on call and hiring true, well-trained emergency room physicians who specialize in this phase of medicine (paid by Lee Memorial Hospital). So now you would arrive safely in the emergency room, and the well-trained emergency room physician would evaluate your injuries and call the appropriate specialist for your treatment, thus increasing your chances of survival. The problem that we surgeons sometimes had was in obtaining operating room time as all operating rooms and anesthesiologists were busy, especially on weekends.

As more time passed Lee Memorial Hospital established a Trauma Center. The development of the center was not an easy nor inexpensive process, but as all requirements were fulfilled, the program was certified. Remember that Lee Memorial Hospital has the only trauma center between Tampa and Miami (I occasionally used to have to transfer critically injured patients by ambulance to these centers- not a fun trip!)

Today, all major trauma is directed to Lee Memorial Hospital's Trauma Center. There is a dedicated operating room reserved only for trauma cases and that room often sits idle throughout the day and night, but when needed it is readily available. It is the same room all the time and is equipped with the necessary instruments and other equipment that are most commonly used by the trauma surgeons. No other surgery can be done in this room and while it is not being used, revenue is lost, but that's some of the cost of the Trauma Center. A full operating room crew is available and in the hospital at all times, 24 hours a day, as is an anesthesiologist. A full staff of general surgeons especially trained in trauma surgery must remain within very few minutes of the hospital, if not in the hospital, 24 hours every day.

Your chances of surviving major trauma in this area are so greatly improved by having a trauma center to serve us. I still remember patients from the past who might have survived in today's "setup." What a shame it would be to lose this vital medical care benefit for all of us. The person whose life is saved may be your loved one, your friend, or just a stranger, but it's still a life that has been saved. While I personally hate the very thought of a tax increase, though it be only one-half percent of sales (this is not a property tax that would lay the burden on just us citizens), I must vote for this tax increase. There is a special feeling that one has who participates in an ill person's recovery, and I invite you to vote yes with me and share in that special feeling. I've had the pleasure of treating citizens in this area for 44 years and continue to do so (but not trauma) now because of the special feeling. If this issue fails, we will not go back to what we experienced in 1958 trauma care, but we certainly won't be at the 2002 level without the Trauma Center. Surely some of you will call me biased or prejudiced. Your assumption is correct; however, this letter is purely my thoughts and is not prompted by anything except for everyone's benefit. I have known and respected Jim Nathan for many years and feel that were there a better way to fund the emergency and trauma services network in our county, he would have used it.

Respectfully submitted,
Roger D. Scott, M.D.

HURRICANE PREPARATION GUIDE

Hurricane Season: June 1 - Nov. 30

Lee County is a tropical paradise, but along with Florida's year-round sunshine comes the risk of hurricanes. If you haven't created your Family Emergency Plan[1] for hurricanes, now is the time to get started. It's easy with Lee County's tips on what to do before, during and after a hurricane.

Emergency Management's Emergency Operations Center[2] is the command center for official Lee County emergency information when a hurricane becomes an imminent threat. We've also provided useful resources from other county departments, plus links to outside agencies.
And remember, a hurricane's high winds can cause power outages that last for days, even weeks. Print copies of must-have reference materials and download those apps now to help protect your family and property.

Family Emergency Preparedness

Before hurricane season is the time to develop and practice your emergency plan. The **Family Emergency Plan** is a great tool to help you to create a plan that is specific to your family's needs.

Some things to consider when preparing for hurricane season are:

- Know your risks
  - What Storm Surge/Evacuation Zone do you live in?
  - Are you in a flood zone?
  - Do you live in a mobile or manufactured home?
  - What year was your house built?
  - Does your home have storm shutters?
- Prepare several evacuation or sheltering options for your family.
  - Shelter at home if it is safe from winds and flood waters.
  - Shelter outside of the evacuation area, with a friend or at a hotel.
  - Go to a Public Shelter if you have no other safe place to go.
- Prepare your Emergency Supply Kit before the start of hurricane season
  - Have ample supplies for each person in the family
    - Infants and children
    - Seniors
    - Persons with disabilities
    - Pets
- Secure items in and around your home before tropical storm force winds arrive
- Be sure all family members know who to call or where to gather if you become separated.
- Let family or friends in other locations know your evacuation plans

Please visit the links below for more information on what to before, during and after a Hurricane.

Links:
1. Family Emergency Plan: http://www.leeeoc.com/Preparedness/Pages/familyhurricaneplan.aspx
2. Emergency Operations Center: http://www.leeeoc.com/pages/default.aspx

Hurricane Preparation Guide: http://www.lee-county.com/Pages/hurricane.aspx

LCMS CALENDAR OF EVENTS

MAY

16 **LCMS General Membership Meeting**
FineMark National Bank & Trust
12681 Creekside Lane, Fort Myers, FL 33919

17-19 **FMA Spring Board of Governors & Council Days**
Hilton Bonnet Creek, Orlando, FL

21 **LCMS Board of Governors Meeting**

JUNE

15-19 **AMA Annual Meeting**
Hyatt Regency Chicago, Chicago, IL

JULY

26-28 **FMA Annual Meeting**
Hilton Bonnet Creek, Orlando, FL

SEPTEMBER

17 **LCMS Board of Governors Meeting**

20 **LCMS General Membership Meeting / Wine Tasting**
Robb & Stucky International
13170 S Cleveland Ave, Fort Myers, FL 33907

Lee County Medical Society

13770 Plantation Road, Ste 1
Fort Myers, FL 33912

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