The Bulletin

OF THE HILLSBOROUGH COUNTY MEDICAL ASSOCIATION
July/August 2016

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The Bulletin

OF THE HILLSBOROUGH COUNTY MEDICAL ASSOCAITION

The Bulletin is the official publication of the Hillsborough County Medical Association, Inc., 606 S. Boulevard, Tampa, Florida 33606.

Executive Council Meetings
6:00 PM @ the HCMA Office

September 20, 2016
November 22, 2016

HCMA Dinner Meeting
September 12, 2016
Centre Club

Watch your email for more details

Advertising

Got Something to Say?

To submit an article, letter to the editor, or a photograph for *The Bulletin* cover, please contact Elke Lubin, Managing Editor, at the HCMA office. All submissions will be reviewed by Bulletin Editor, David Lubin, M.D. We encourage you to review *The Bulletin's* "Article Guidelines" which can be faxed or emailed to you.

The Bulletin is YOUR publication. You can express your views and creativity by participating.

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The Bulletin: *July/August 2016*

ABOUT THE COVER

On a recent trip "down unda," Dr. Michael Cromer snapped this issue's cover photo. The picture is of "Ninety Mile Beach" in New Zealand, taken from a private six passenger plane with Dr. Cromer's IPhone. Ninety Mile Beach is on the western coast of the far north of the North Island of New Zealand. It stretches from just west of Kaitaia towards Cape Reinga along the Aupouri Peninsula. Read Dr. Cromer's "Travel Diary" - page 13.

Features

HCMA BENEFIT PROVIDER

Hillsborough County Medical Association, Inc.
Established 1895

Building and Protecting Your Income and Your Practice

Building a sound financial foundation sometimes takes help. Our goal is to be your financial resource now, and in the years to come. Together, we analyze, design and implement strategies that address the financial needs and challenges physicians face. We believe the key to meeting your needs is earning your trust.

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* Creation and funding of Kai/Tri Zen is arranged by an independent third party specialist.

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No More Free Stuff

President's Message

"OVER 30 YEARS" – that was the answer I gave my new patient, whom I have subsequently come to know very well and will call "Pops," when he asked me how long I was in medical practice.

"Well," he said, "I was in the medical practice myself just about 30 years ago, I retired early due to medical reasons; just about the time you entered practice." He went on to tell me that once he left medical practice he never looked back. He never read a medical journal, scientific article, or paid any attention to the goings-on in the medical field. After a few years out of medical practice, he went on to say, "I felt as if I was never a physician." Then he asked me what I felt was a most interesting question, "Over the past 30 years of medical practice, what do you think has changed in your day-to-day practice?" I very politely told him that I really didn't have time during busy office hours to discuss this with him, but I would think about his question and get back to him. He told me he understood this and we went ahead and completed our first office visit and subsequently many more visits.

It has been well over a year but, last month the question surfaced again. "Ok Pops," I replied, "read the 'President's Message' in the HCMA Bulletin and get my answer."

He replied, "I haven't picked up any literature regarding medicine in over 30 years – but I will now."

Well Pops, here it is. Enjoy! Three things have changed:

EHR – have patients actually gotten better care since its widespread adoption? I really don't know; I am sure you can find a study to support either position. Here is my reality. Each day I spend an average of one and a half hours more completing patient charts than when I used paper charts. Can we now jump to the conclusion that patients are better cared for? Maybe, when one considers the records are now legible, probably better organized, contain more information, and are more easily and quickly available to other healthcare providers. Personally, as my EHR system is internet based, I can work on my charts wherever I have secure, non-public, internet access. Furthermore, on nights and weekends when the office is closed, I have immediate access to patient charts in case of a medical issue while on-call.

So Pops, bottom line, I'll give the implementation of EHR a thumbs-up, with the caveat that work still needs to be done to improve "ease of use" issues and interoperability.

INSURANCE COMPANIES - where do I begin? Referrals/Pre-Authorizations, "Step-Care" policy for certain medications, not to mention the almost yearly double digit increases in our own health insurance premiums, with little or in most cases none of this money "trickling down" to the ones actually taking care of patients - physicians.

When I think of all this negativity, I channel my positive thoughts into knowing that organized medicine, the HCMA and FMA, are our friends and protectors, representing physicians and working with us to have a better position when negotiating with insurance companies.

PHARMACEUTICAL REPS - Remember the pads and pens? How about the clocks, doormats, and coffee mugs? My favorite was the emergency car kit. It had the logo of a very popular P.P.I. on the cover of the box - remember which one? It contained fix a flat, jumper cables, flash light, and emergency road flares; what a life saver! How about the trips to Orlando, professional sports games, and dinners at fine restaurants? Well, I guess, the "powers that be" determined that we physicians have no morals or scruples and are easily influenced by such things, and banned them. Also, the cost of pharmaceuticals was supposed to decrease with all the money not spent wooing doctors – decide for yourself if this has actually happened.

I chuckle to myself when I remember those days. My response – I increased my office budget for pads, pens, and incidentals. I enjoy sporting events and meals in fine restaurants on my own dime, and with my own guest list.

Patient care and prescribing habits - no effect at all!

So much for my light-hearted journey down memory lane. I love being a physician and taking care of patients. I can't imagine doing anything else. The past 30 years has been great and I am still good for a few more. Working within organized medicine, I'll be well prepared for any changes coming down the pike and together we will fight to protect physicians' rights and autonomy. I invite all physicians to join me on this exciting journey!

Fred Bearison, MD
drfredb1@gmail.com

Cocktails & Camaraderie!

HCMA Member Appreciation Reception

You are cordially invited to attend a membership appreciation reception hosted by HCMA Benefit Provider, The Legatus Group. The complimentary reception will be held at the prestigious Palma Ceia Country Club on Thursday, September 22nd, from 6:30-8:00 PM.

The HCMA values your membership. Join your colleagues and allow us the opportunity to express our appreciation for your continued support.

RSVPs are required.
Please call the HCMA office: 813.253.0471

We look forward to seeing you at Palma Ceia!

Thursday **September 22, 2016** **From 6:30pm to 8:00pm**	**Palma Ceia Country Club** **1601 S. MacDill Ave.** **Tampa, FL 33629**

Still in touch

Editor's Page

I thought when I retired from private practice in December 2013, that I'd be pretty much done with medicine, except for my own health care and visits to the my own doctors. But after seven months of owning the Swann Ave. Market and Deli, medicine is still crisscrossing in front of me.

Shortly after I bought the Market in October, a Channel 28 reporter walked in and wanted to know if anyone had a comment about the World Health Organization's report that bacon and processed meats were carcinogenic. I introduced myself to her as Dr. Lubin, and also the owner of the Market, so I wasn't sure which side of the story she was interested in. Nonetheless, I told her that with all that was going on in the world… fires, floods, earthquakes, terrorism…an occasinal piece of bacon would probably do no real harm. She aired about three seconds of what I said; however, our turkey/bacon/cheese melt is still our #1 seller, followed closely by Lubin's Reuben.

Over the past few months I've met many people, new customers to the Market. Many are patients who live outside Tampa but come here for cancer treatments or to go to TGH for various reasons. One woman had a son with a serious seizure disorder who was followed by a neurologist at TGH; they stopped in for lunch.

It's nice when colleagues stop in to see me in my new milieu and I appreciate them taking the time to come in. I've also had a number of repeated orders for lunch deliveries from many of the doctors' offices in South Tampa. Former patients are also finding their way to the Market. Some of their names I remember, some have slipped away, but there are some who saw me over 15 years ago, saw the articles in the paper about the Market, and have come to visit. To me that's special. One former, and favorite, patient came in with two of her girlfriends. She had lost 100 pounds, something I was unable to get her to do while I was in practice and constantly nagging her about. She was told by the orthopedist, that to have her knee operated on, she'd have to lose the weight. Being diabetic, with hypertension to boot, that wasn't a bad idea. Well, she lost the weight, but is doing so much better, even ambulating without a cane, that she has forgone surgery and takes a diabetic pill every other day. Good for her!

And then one day, a medical issue really struck home…or Market. I was making a delivery when I received a call, at about 10 AM from the Market, that one of the cooks in the deli had a seizure. I was seconds away and when I arrived, he was lying on the floor, obviously postictal, with his hand being held by a PA who happened to be in the Market. Fire rescue came and took him to TGH, where tests were negative, and he was discharged on meds. He had a history of seizures, but had not had one in years. This occurred on a Friday and he, thankfully, was back to work on Monday. The only problem was that he and the 3 other guys in the kitchen were in the middle of preparing a 16 platter catering delivery due at 11 AM. We called the company and explained what happened and they graciously accepted the delivery a bit later. We also had to cancel a small USF catering job, but they also understood the situation.

As much as I'm involved with the Market, I still try to keep my pulse on what's happening in medicine. It's not as easy as it used to be since I'm not around my colleagues to discuss issues and to be honest, those issues involving the practice of medicine don't tweak my interest very much, since they're still the same issues that "forced" me out.

But I do peruse the paper and news magazines (*The Week* is my favorite), and what I'm reading can be mindboggling (along with politics). For instance…

We've all probably known that loneliness is unhealthy, both emotionally and physically. A meta-analysis of 23 studies involving 181,000 people, as reported in *Heart,* revealed that poor social relationships could actually hurt your heart. Being lonely or socially isolated appeared to be associated with a 29% increase in risk of heart disease and a 32% increase in risk of stroke. Lonely people are also more apt to smoke, get less exercise, follow a healthy diet, or visit their doctor.

"Just plain Tylenol." Turns out it just might not be so plain. A 2013 study revealed that acetaminophen could reduce anxiety in addition to relieving pain. This was considered to be a positive effect. But in a study with 200 college students, participants who took 1000mg of acetaminophen displayed less empathy for people who were en-

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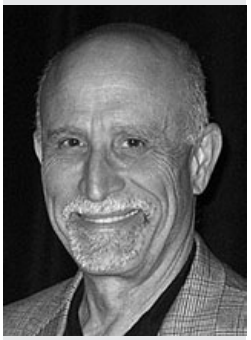

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during an emotionally or physically painful experience. One study author said, "If you are having an argument with your spouse and you just took acetaminophen, the research suggests you might be less understanding of what you did to hurt your spouse's feelings."

Maybe we've found the etiology of "irreconcilable differences."

So I guess it's still advisable to give the advice to "take two aspirin and call me in the morning." At least your patient might still care.

Connect with the Hillsborough County Medical Association

HCMA Website

Scan the QR Code to be connected with the HCMA website! Peruse *The Bulletin,* pay your dues, find an HCMA Benefit Provider, and much more...

HCMA Facebook Page

Find Legislative Updates, event photos, seminar and social invitations. Connect with your colleagues. Like us on Facebook and receive a voucher for a free drink at an HCMA dinner meeting!

HELP ELECT PHYSICIAN-FRIENDLY CANDIDATES!

It is of utmost importance that all physicians become pro-active and support "friends of medicine." HILLPAC (Hillsborough Political Action Committee) conducts interviews and will support the campaigns of pro-medicine candidates.

Please join HILLPAC today: DUES ARE ONLY $75

YOUR SUPPORT IS NEEDED AND GREATLY APPRECIATED!

Contact Debbie Zorian, HCMA Executive Director, at 813/253-0471 or DZorian@hcma.net for more information concerning HILLPAC and other legislative endeavors implemented throughout the year.

Please mail your contribution to:

HILLPAC
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Or securely donate online: http://www.hcma.net/Donate-HILLPAC.html

High Hopes and Joint Efforts…Up in Smoke?

My cousin, Sheryl, and I spent much time together during our childhood years even though her family lived in Denver and mine in Chicago. Being the same age made us very close. By the age of ten, we devised a strategy on how we were going to live together (in California) and become stewardesses (now flight attendants) after we graduated from high school.

As life's realities unfolded, we both married, became young mothers, and neither one of us ever worked for an airline. I moved to Florida while Sheryl remained in Denver. The last time we saw each other was in 1997. We decided a visit was way overdue, so a short but cherished reunion took place recently as we tried to cram 19 years of "catch up" into five days. During one of our conversations, we began discussing the impact of legalizing recreational marijuana in Colorado. Over two hours later…

Being a Denverite all her life, Sheryl can validate how the legalization of marijuana has, in many ways, negatively affected the city in which she lives. A subject that I didn't consider when I wrote a past article regarding this issue was how legalization could affect the housing market. Sheryl informed me that her monthly rent doubled last year. Doubling the rent increased it to an amount unaffordable for her family, so house hunting began. She quickly came to find out that no matter where they looked, the monthly rents had skyrocketed in every nook and cranny in the Mile High City.

While legalization of marijuana has created massive economic growth in Colorado, it appears it hasn't been without a cost for numerous Coloradans. During the initial stages of legalization, housing prices were relatively affordable. Now, people are flocking to Denver from other states and chomping at the bit for housing. Skyrocketing prices are potentially transforming the city into one that only the uber-wealthy can afford. And there is no need for sellers or landlords to worry about needed renovations. People are buying and renting homes "as-is, no questions asked." Competition is fierce and includes an influx of out-of-staters who buy houses with cash to establish legal grow operations.

At many a street corner, my cousin shared that you can expect lines of people, wrapped around several blocks, waiting to make purchases at pot dispensaries. She often has to "make her way through" to stores, pharmacies, etc., when running errands.

Sheryl also told me that the homeless population has increased dramatically. How much of the increase is due to unaffordable housing is uncertain, but a good majority of homeless from other states have flocked to Denver to legally seek out the drug that can allow them to experience the euphoric sensation it is touted to bring. In a nutshell, it appears that rising home prices coupled with an influx of "Marijuana Refugees" and a reduced number of homeless shelters (also due to increased industrial space needed for grow houses) have all exacerbated the homeless population problem.

Brian Freeland, founder of the LIDA Project – an experimental theater company that was once housed in a warehouse located in the RiNo Arts District – openly states that, "Colorado hasn't planned for the successes or the failures of their boom and bust economy and will ultimately pay the price of not having the foresight of planning. Denver is treading water: trying to regulate growth it didn't plan for, and reaping benefits of cannabis sales without studying the long-term effects."

Colorado has become a national magnet for people who not only suffer from painful and debilitating diseases, but also for pot smokers who don't want to deal with drug dealers, and young people (many below the age of 18) who like the idea of blending into a population where pot is not only accepted, it's expected. It's evident that a younger population is moving to Colorado simply because pot is legal.

Just this month, the U.S. Department of Health and Human Services released a survey showing that Colorado now ranks number one for regular marijuana use among youth. "Edibles" often intentionally resemble candy or cookies and are marketed as an innocuous or appealing snack, garnering youth attention. Surveys

(continued)

Executive Director's Desk

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have shown that there is a direct correlation between the availability of marijuana and teen usage. I can attest first-hand to the unrepairable destruction pot can cause, even when it wasn't readily available. My older brother whose physical and mental health has been completely destroyed due to a lifetime of drug use… and my stepson who was under the heavy influence of drugs the night he took his own life in 2011, both began smoking pot while in their early teens. When the effects of pot no longer satisfied their need to experience the high they craved and counted on, other drugs came into play and further took hold of their once healthy minds and bodies. As this may not be the case for all pot smokers, I strongly believe a great deal of drug addicts started out "only smoking pot." It has undoubtedly served, in my opinion, as a gateway to life threatening drugs and destructive behaviors.

I'm also a strong believer that marijuana usage is not only detrimental for its addictive characteristics but also for its long-term effects on the adolescent brain even when other drugs are not sought out. THC, the main chemical in marijuana, is stored in the body where it can remain for days or weeks and impair cognitive ability for enduring periods of time. The president of the American College of Pediatricians, Dr. Michelle Cretella, notes that, "Long term effects are most worrisome as marijuana's impact on the teen brain leads to increased risk of motor vehicle accidents, sexual victimizations, academic failure and permanent loss of IQ, psychopathology, addiction, and psychosocial impairment."

Another supposed reason for legalization in Colorado was to eliminate the marijuana black market. My common sense tells me that will never happen. According to my online research, drug traffickers are growing pot among the state's sanctioned pot warehouses and farms, then covertly shipping it elsewhere and pocketing millions of dollars from the sales. Many examples I read confirmed an increase in illegal trafficking to other states which was a longstanding fear of marijuana opponents.

There are also many statistics on how the crime rate is rising rapidly in Denver. Aggravated assaults, murder, and forcible sexual offenses (to name a few) have skyrocketed since legalization. A coincidence? I think not. The empirical evidence, combined with what science tells us about the harmful psychological effects of marijuana use, strongly suggests that the social fabric is starting to unravel in Colorado's capital. While supporters applaud America's new cash cow, perhaps they should ask themselves whether this newfound flow of revenue should be hoarded at the expense of America's youth, the marijuana martyrs, and society in general. During a recent news media report, Colorado's own governor cautioned other states from legalizing marijuana. I'm quite certain I'm not alone in hoping they will take heed.

At this time, future visits to Denver are not high (sorry) on my list. The thought of being amongst a herd of people with impaired and distorted judgement, altered perceptions, lackadaisical attitudes, not to mention slower reaction times behind the wheel of a car, does not appeal to me. I may change my mind if a trip to Denver is the only available option to see my cousin. Until then, we plan on future visits right here in the Sunshine State.

Editor's Note: Ms. Zorian's column reflects her own opinion and not necessarily those of The Bulletin, or any members or officers of the HCMA. Comments concerning this highly controversial topic are welcome.

Traveling Down Unda'

Travel Diary

My wife, Carol, and I, were able to take a trip of a lifetime to Australia and New Zealand in February of this year. For those of you who have been, you already know how amazing these two countries are. For those of you who haven't been, I urge you to go sometime in your life if at all possible.

We decided that we were going to do as much as we could by taking a 16-day cruise on Oceania Cruise Line. This is a top notch cruise line with slightly smaller ships, and excellent food and service. We had taken a cruise with them last year to Singapore, Thailand, Vietnam, and Hong Kong.

Of course the most arduous part of the trip is the 30 hours of traveling to get to Sydney. We immediately took a plane north to the city of Cairns, which lies in the middle of the 1200-mile-long Great Barrier Reef. Carol and I love to dive and didn't want to pass up the opportunity to dive on the most famous reef in the world. Our impression was that the reef was huge and very beautiful, and the marine life was as beautiful as you will see anywhere. The area reminded us of Hawaii, and it was a great experience to start our trip.

We flew back to Sydney and spent two full days touring this magnificent city. It is definitely in our top 10 cities. While there, we took a city bus tour, a harbor dinner cruise, and did the climb to the top of the 440 ft. Bay Bridge. This used to be the widest long-span bridge in the world and from the top you have plenty of time to marvel at the iconic Opera House and the Sydney landscape. They have a wonderful zoo that sits on a hill that winds down to the harbor. They have all of the animals that are unique to Australia, and a lot more.

Dr. Michael and Carol Cromer on the Sydney Harbour Bridge with the Opera House below.

One of the highlights of our time in Sydney was a morning backstage tour of the Sydney Opera House. We toured the four theaters, orchestra pits, saw the dressing rooms, the prop mechanics, and heard the stories about what makes this such a unique place. We toured the Chinese Botanical Gardens and, of course, we indulged in good food with strong English and Asian influences. Getting around Sydney was very easy and the dollar was definitely in our favor. It finally came time to board the Oceania Marina and start our cruise.

Our first three stops took us to Eden, Geelong, and Melbourne, all harbor towns along Australia's East and South coast. We began to see how much farming plays a part in the economy of Australia. They have more cows and sheep than they do people. We went to a wildlife reserve and petted the kangaroos and Koala bears and we took a private plane ride across the beautiful southern coast line and saw the rock formation, The Twelve Apostles. Google this if you get a chance, the scenery is like nowhere else.

We went on down to Hobart, Tasmania and saw an oyster farm. 25% of the world's oysters come from Australia. Oh, by the way, there are real live Tasmanian devils. They're ugly! After this, it was sailing across the Tasman Sea to New Zealand.

Our first encounter with New Zealand was Milford Sound. This is an area of glaciers and fiords that arrive steeply at the water, with water falls cascading down and seals sunning themselves on the rocks. Truly gorgeous. After this, our first harbor stop was near Christchurch. This large city had experienced earthquakes in 2010 and 2011, and still had evidence of damage, demolition, and construction. We had lunch at a winery and after a 60 mph jet boat ride down a river we headed back to the ship.

Picton, New Zealand, is in the middle of the

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Marlborough district, which is known for its 120 wineries. No, we didn't experience them all, but we sampled our fair share with most of the wineries offering free tastings. A little different from Napa. We did like their Sauvignon Blancs and Pinot Noirs, which they are most known for.

In Akaroa, we were able to see the geysers and mud pools, as well as learn more about the indigenous Maori tribes that had settled in Northern New Zealand. The next stop on the north island was the Bay of Islands, located a little northwest of Auckland. From here we rented another private plane and took off out of a cow pasture to head up to the northern tip of New Zealand where Cape Reintga is located. This is where a lighthouse sits on New Zealand's northernmost point and overlooks where the Tasman Sea intersects with the Pacific Ocean. They are also known for their 200 ft. sand dunes. Of course we had to partake in the sand dune surfing and boogie boarding that the area is known for.

In front of the Dunedin Train Station in New Zealand.

After 16 days of cruising, we arrived in Auckland, the country's largest city. We took two extra days to enjoy the city and partake in two more adventures. First was the cave exploring adventure. New Zealand has about 300 caves in the north island. This particular cave has an unground river running through it. The adventure consisted of rappelling down 100 ft. into the Abyss, zip lining down another 90 ft. in pitch black darkness, and then tramping through muddy cold (55 degrees) water for four hours. The cave consisted of spiders, bats, and maggots with fluorescent poop hanging from the ceiling (they call them glow worms to make them sound more welcoming), and "friendly" eels nipping at our wet suits. This adrenaline adventure also included shimmying through narrow crevasses, climbing up water falls, and crawling in the mud through very tight spaces. I felt like it was all worth it when they gave us some Tootsie Rolls and warm Tang to warm us up. My wife said she would never do this again and she gave me some rather unique nicknames along the way.

Last, but not least, we went bungy jumping off of the Auckland bridge. New Zealand is, after all, the birthplace of bungy jumping. I was the oldest and the heaviest in the group, so for various reasons, I got chosen to go first. No problem, I had done it twice before. I waved to the cameras, and dove off the platform, and went waist deep into the water 120 feet below. What a thrill it was, and my wife repeated the feat a few minutes later.

Even though the trip does take about 30 hours of travel, I would recommend seeing this beautiful part of the world if you ever have the chance. We are now planning where our next travel adventure will be. It certainly will be difficult to beat this one.

Dr. Cromer bungy jumping off the Auckland Bridge in New Zealand.

Please tell the advertiser you saw it in the *HCMA Bulletin!*

Please Consider Making a Donation

The Foundation is the charitable arm of the HCMA. Through the Foundation, grants were provided to medically related organizations and medical student scholarships. In order to accomplish this, donations to the Foundation, as well as participation in our annual fundraising event, are essential.

As a result of the 2015 Foundation Charity Golf Classic, we were able to award grants and a scholarship to:

Michael Manasterski, USF MCOM medical student

Frameworks

Hillsborough Water Safety Team

Judeo Christian Health Clinic

MoreHealth

Outreach Clinic Brandon

SJH Foundation/Craniofacial New Patient Welcome kits

Voices for Children

The 20th HCMA Foundation Charity Golf Classic is being held Thursday, October 13th at the Carrollwood Country Club. We hope you will join us for a great day of golf, camaraderie, and fundraising!

Visit: http://www.hcma.net/Docs/Golf-INFO-FACT-SHEET-2016.pdf

And please consider donating to YOUR Foundation. Call the HCMA office 813.253.0471 or visit www.hcma.net/About-HCMA-Foundation.html

MARK YOUR CALENDAR!

We don't care HOW you play... JUST PLAY!

HCMA Foundation, Inc.
20th Charity Golf Classic
Thursday, October 13, 2016

Lunch & Registration: 11:30am
Shotgun start: 1:00pm
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Single Golfer: $150

Call Kay or Elke at the HCMA for more information: 813.253.0471.

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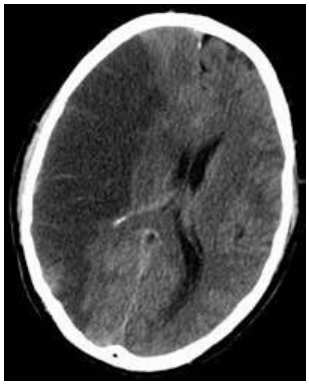
Stroke is a Brain Attack

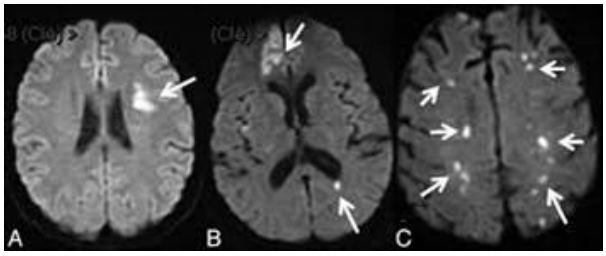
The Evolution of Stroke

Stroke as a cerebrovascular disease has been evolving with new classifications, syndromes with a different therapeutic modalities. It is a neurological emergency which required a series of changes in our healthcare system, utilizing new diagnostic imaging and techniques and new therapies and neurovascular intervention provided by vascular neurologists, neuro-radiologists and vascular neurosurgeons. Stroke is known to all of us as a suddenly occurring, most disabling chronic neurological disease which strikes our patients and leaves the stroke survivors among them with residual cognitive, functional, social, and financial burdens. It impacts the stroke survivor's families, caregivers, and our society. It is one of the most common preventable devastating chronic illnesses, and most of the advancement in cerebrovascular diagnostic imaging technology and stroke therapies have been seen only in the last two decades.

Hippocrates was the first to recognize stroke over 2,400 years ago. At this time stroke was called apoplexy, which means in Greek "struck down by violence." This was due to the fact that a person developed sudden paralysis and changes in well-being. Doctors had little knowledge of the anatomy and function of the brain, the cause of stroke, or how to treat it. In the mid-1600s, Jacob Wepfer found that patients who died with apoplexy had bleeding in the brain. He also discovered that a blockage in one of the brain's blood vessels could cause apoplexy. In 1928, apoplexy was divided into categories based on the cause of the blood vessel problem. This led to the term stroke or "cerebral vascular accident (CVA)." CVA was used by most healthcare providers until last year when ICD-10 was introduced. The term "Brain Attack" was used amongst stroke neurologists in 1995, as recommended by the National Institute for Neurological Disorder and Stroke (NINDS) to refer to a stroke caused by a lack of blood supply to the brain, very much like a heart attack is caused by a lack of blood supply to the heart. The term brain attack also conveys a more urgent call for immediate action and emergency treatment.



Time Lost – Brain Lost



Little Strokes Fell Great Oaks, Prevent It!

Nearly 800,000 people in the United States have a stroke every year, with about three in four being first-time strokes. Stroke is the No. 5 cause of death in the United States, killing nearly 130,000 people a year. That's one in every 20 deaths. Someone in the United States has a stroke every 40 seconds. Every four minutes, someone dies of stroke. Stroke is a leading cause of long-term disability and the leading *preventable* cause of disability. More women than men have strokes each year, in part because women live longer. Estimates of the overall annual incidence of stroke in U.S. children are 6.4 per 100,000 (0 to 15 years), with approximately half being hemorrhagic strokes. Eightyseven percent of strokes are classified as ischemic. An ischemic stroke occurs when a clot or a mass blocks a blood vessel, cutting off blood flow to a part of the brain. African-Americans are more impacted by stroke than any other racial group within the American population today.

When ischemic brain tissue is at risk "The Penumbra" time is of the essence to save neurons from ischemic injury. Every second counts in reducing neurological disability. A national call by the American Stroke Association on recognizing stroke symptoms and the time of symptoms onset using the term FAST (Face, Arm, Speech and Time of onset) is to help patients access emergency therapy for acute stroke, which is time dependent. EMS personnel are trained on emergency prehospital stroke protocol as part of ALS certification and Stroke Code became a standard ED protocol to all hospitals throughout the United States.

(continued)

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The Evolution of Stroke (continued)

Certified Primary and Comprehensive Stroke Centers are granted their designation by JACHO based on their level of specialized stroke care and their access to vascular/stroke neurologists and interventional neuro-radiologists and neurosurgical coverage. These hospitals have established standard stroke code with stroke team and protocols to reduce door to needle time where:

Door to physician	≤10minutes
Door to stroke team	≤15minutes
Door to CT initiation	≤25minutes
Door to CT interpretation	≤45minutes
Door to drug	≤60minutes
Door to stroke unit admission	≤ 3 hours

Wait and see care in acute stroke is no longer acceptable. It does starts with providing the (ABC) Airway, Breathing, and Circulation in the field by EMS, to the ED stroke center where Stroke Code and stroke teams are activated and stat laboratory tests and stat neuroimaging studies such as CT and CTA, MR and MRA, CT perfusion or MR diffusion and perfusion–weighted imaging are initiated, to IV tPA thrombolytic therapy, and for selected patients to the cath lab where cerebral angiography and endovascular stroke therapies are provided. Then finally to the stroke critical care unit, where stroke trained nurses and house staff will monitor and treat stroke patients per post-tPA or per procedure protocols. Stroke patients eligible for IV tPA, where benefit is time dependent, should be treated as quickly as possible. The door to needle time (time of bolus administration) should be within 60 minutes from hospital arrival. The time to treat is only 3-4.5 hours from symptoms onset. Furthermore, all anti-platelets therapy such as aspirin, Plavix, Aggrenox, Ticlid are only for stroke prevention have no benefit in treating acute ischemic stroke.

The good news is that 80% of all strokes are preventable. It starts by all of us managing risk factors of stroke including hypertension, atrial fibrillation, hyperlipidemia, diabetes, cigarette smoking, obesity, and physical inactivity. As a result of our relatively improved efforts in managing stroke risks, the good news is that in the last five years stroke fell from number 3 to number 5 most common cause of death in the United States.

Gastro-Esophageal Reflux Disease: Treat the reflux, not the acid

Practitioners' Corner

Excessive reflux of gastric contents to the esophagus is referred to as gastroesophageal reflux disease (GERD). Its prevalence is as high as 10-20% in the Western world. The most dreaded complication of GERD is esophageal adenocarcinoma, the incidence of which has increased 56-fold between 1984 and 2010, according to data from the Surveillance, Epidemiology, and End Results (SEER) Program. Common symptoms of GERD include heartburn, regurgitation, chest pain, bronchospasm, laryngitis, and chronic cough. Dysphagia is an ominous symptom as it may be the first indication of cancer. However, GERD can be asymptomatic until complications reflecting advanced disease occur. Complications of undertreated GERD include erosive esophagitis, esophageal strictures, and Barrett's esophagus, in which metaplastic columnar epithelium replaces the squamous epithelium that normally lines the distal esophagus, predisposing to the development of esophageal adenocarcinoma. In addition, extra-esophageal complications may develop, including asthma, chest pain, hoarseness, chronic cough, recurring pneumonia, chronic sinusitis, and voice changes.

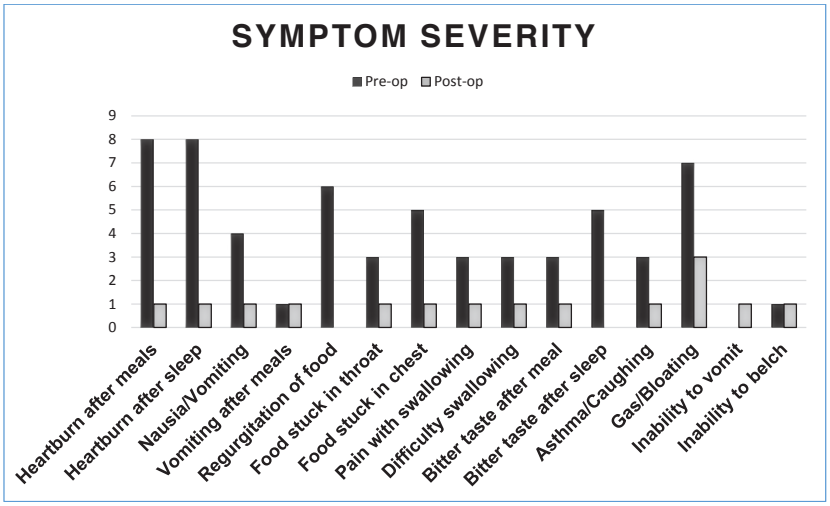

Figure: Symptom severity scores as reported by GERD patients before (dark bars) and after (light bars) anti-reflux surgery performed by our group.

Based on a convincing clinical presentation with a good response to anti-acid therapy, the diagnosis of GERD can be made empirically. Testing is recommended and needed to objectively confirm the diagnosis and severity of GERD, to assess for complications of GERD, or to establish alternative diagnoses. Endoscopy should be undertaken for patients with GERD that have "alarm features" (e.g. dysphagia, odynophagia, gastrointestinal bleeding, anemia, weight loss) and for patients who have not responded to an empirical trial of PPI therapy. Ambulatory pH monitoring is a "first-line" and "gold standard" test to confirm or rule-out GERD and should be undertaken before employing open-ended therapy.

After the diagnosis of GERD is made, lifestyle and dietary modifications are recommended, including weight loss, elevation of the head of the bed, avoidance of meals 2-3 hours before bedtime, selective elimination of dietary components that cause a relaxation of the gastro-esophageal sphincter (e.g fatty foods, caffeine, chocolate, alcohol, peppermint), as well as smoking cessation. The next step in treatment usually involves anti-acid medications; the most commonly used include antacids, which neutralize gastric acid, surface agents, which adhere to and protect the gastric mucosal surface, histamine-2 receptor antagonists (H-2 blockers), which decrease the secretion of acid by inhibiting the histamine-2 receptor on the gastric parietal cells, and proton pump inhibitors (PPIs), the most potent inhibitors of gastric acid secretion, which work by irreversibly binding to and inhibiting the hydrogen-potassium (H-K) ATPase pump of the parietal cells.

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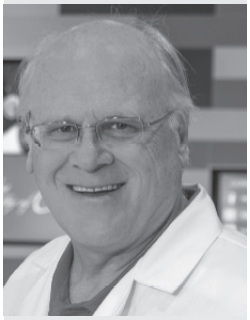

Alexander Rosemurgy, MD
arosemurgy@hotmail.com

Traditionally, definitive control of reflux through surgical and/or endoscopic interventions has been reserved for patients with complications of reflux such as recurrent or refractory esophagitis, stricture, Barrett's metaplasia, persistent symptoms despite acid suppression, GERD-induced asthma, as well as for patients unable to tolerate medications, noncompliant with medications, or unwilling to take medications life-long. The most commonly used endoscopic interventions are Transoral Incisionless Fundoplication (TIF) and Stretta. We use these techniques selectively in patients that are not good surgical candidates because of serious medical comorbidities, that have a notable history of abdominal/gastric operations, and for those meeting strict eligibility requirements (e.g., a hiatal hernia of ≤ 2cm).

Laparoscopic anti-reflux surgery (e.g., laparoscopic Nissen fundoplication) is associated with very encouraging and durable results when undertaken by experienced surgeons. We have undertaken more than 2,000 of these operations over 25 years and have been very pleased by their efficacy, durability, and low complication rate. Our preference is a "scarless" laparoscopic approach: Laparo-Endoscopic Single Site (LESS) surgery. This approach allows for conventional laparoscopic operations to be undertaken through only one 12mm incision at the umbilicus, itself a scar. This approach has been very well received and results in less pain and a quicker recovery with a truly superior cosmetic outcome. Symptom control after LESS fundoplication is salutary, significant, and durable (note figure). We pioneered and embraced this approach very early and have undertaken more antireflux operations using this approach than any other center in the United States.

The proven efficacy of PPI's in decreasing acid secretion has led to the common practice of employing them in an open-ended fashion, and overlooking their downsides. Although PPI's are effective in eliminating gastric acidity, the reflux of gastric contents, which contain bile salts, continues, as PPIs do not affect structural, mechanical, and functional abnormalities at the gastroesophageal junction responsible for gastroesophageal reflux. With PPI therapy, patients do not reflux acid, but rather bile salts and conjugated acids, which can cause persistent heartburn, esophageal injury, and some of the aforementioned extra-esophageal complications of reflux, such as asthma, pneumonia, laryngitis, chronic cough, and hoarseness.

In addition, long-term PPI therapy is associated with several complications, such as pneumonia, community acquired colonic Clostridium difficile infections, magnesium and calcium malabsorption with an associated increased risk of osteoporosis, vitamin B12 malabsorption, iron malabsorption and iron-deficiency anemia, acute interstitial nephritis, dementia, drug interactions with other medications metabolized via hepatic cytochrome P450 enzymes, including warfarin, diazepam, clopidogrel and phenytoin, and a decrease in the absorption of certain HIV protease inhibitors and other medications. It is this persistent non-acidic reflux that may be the driving force in the path to developing adenocarcinoma at the gastroesophageal junction. Recently, several reports have linked long-term PPI use to chronic kidney disease, end stage renal disease, dementia, and myocardial infarctions. Multiple lawsuits have been filed against drug companies manufacturing PPI's, accusing them of knowing about some of these deleterious effects and failing to warn users about them. Last but not least, it is estimated that 11 billion dollars are spent annually on PPI's in the U.S, with a large proportion of the patients taking these drugs lacking objective documentation of excess gastroesophageal reflux.

Therefore, objective testing for excessive acid reflux should be undertaken before prescribing "open-ended" PPI therapy. After documentation of excessive reflux, the focus of treating GERD should be directed toward definitive treatments that cease the reflux itself. For patients failing to minimize their excessive acid reflux through weight loss and other salutary measures, anti-reflux surgery, either endoscopic or laparoscopic, especially LESS, is underutilized: it is efficacious, durable, and salutary.

This article was co-authored by Forat Swaid, MD and Sharona Ross, MD.

Sacred Pepper - Hot, But Not So Sacred

Restaurant Review

When you walk into the fabulous Sacred Pepper restaurant on North Dale Mabry you expect it to be a "Special Occasion" place. Very modern and obviously outfitted with one-of-a-kind beautiful chandeliers, bubbling walls at the bar, and tall comfy booths, it is a delight for the eyes. And "Hot" it is. Lively and crowded, the restaurant is booming.

But "Sacred" it is not. The food has not, during our two visits, matched up to a "Special Occasion" place. It's more of a "Tuesday or Wednesday" night place as far as the food goes. With multiple televisions tuned to sports that seem out of place with the surroundings, it is the fanciest sports bar in town.

Not to say the food is bad—it just doesn't match the setting. The appetizers were the best. The "Honey Goat Cheese Baklava" was different and good. The "baklava" looks like a layered tiramisu or baklava, but consists of a sweet fig reduction in pastry with mayonnaise, honey, and pistachios. It could be a yummy dessert. The "Sacred Meatballs" are soft, tender, and tasty. They have a ricotta marinara sauce on them - the same sauce as the polenta appetizer and, I assume, the Pappardelle pasta entrée which we did not have. The Hungarian Hot Peppers and Fontinella dish was spicy, savory, and good. On a crisp grilled flatbread, the accompanying sauce with black olives and fontinella cheese could be spooned to monitor the spiciness. The Brie L.T. also was good. It is served as a quartered sandwich with Nueske bacon, gooey brie, and mild shishito peppers. However, the "Crispy Polenta" was crispy on the outside but mushy on the inside and bland. So most of the appetizers were worthy of a very nice restaurant. Perhaps they should substitute some of the entrees with larger portions of the appetizers. Both evenings unfortunately went downhill after the appetizers.

The Sacred Pepper house salad was plated nicely and sounded delicious. With lettuce, hearts of palm, feta, cukes, onions, and a white balsamic dressing, we were expecting something unusual, but despite the description it turned out to be pretty standard fare. The Knuckle Head salad with lobster, corn, Marcona almonds, and lemon zest dressing sounded fantastic but was not nearly as spectacular as described. There was adequate lobster but more almonds and herbs would make it exciting.

Entrees were a mix of chicken, pastas, steaks, fish, a pork chop, and a burger seemingly to satisfy any hunger, but the variety made it hard to decide. Often it is so hard to decide in a nice restaurant what to choose because you want to try them all. Unfortunately, here it was hard to choose because they all seemed to be standard fare that one could get in a nice chain restaurant. We settled on the Short Rib Cavatelli, the Honey Truffled Buttermilk Chicken, the Oak Grilled Norwegian Salmon, the Grilled Pork Chop, and the Filet with Lobster and Crab Rotolo. I could go into great detail on each one but all ten of us independently agreed we could have had these entrees at a moderately priced local neighborhood chain.

The braised short ribs were good, tender, moist, and flavorful; they seemed as though they had been cooking for hours. The cavatelli was "handmade" - does that mean in house or by somewhere else and purchased? All in all, it was good. The chicken was a huge flat slab of breast fried to a crisp accompanied by sweet creamed corn. It was good, but again not special. The salmon was decent, not special, the pork was tough, the filet was chain quality, and the rotolo was tasteless.

For dessert we had a large four-layer chocolate cake that was average. The DIY ice cream sundae was good but how could you mess that up?

Sacred has a very good "Black Widow" cocktail, among others, and a reasonably priced wine and beer list.

(continued)

Taste Bud

Restaurant Review (cont.)

SUMMARY:

	CUISINE 1/2	AMBIENCE 1/2	SERVICE 1/2
PLUSES + + +	• Nearly scoring a touch-down on the appetizers	• A beautiful restaurant, invition and unique	• Service was mostly attentive and friendly on both visits
MINUSES - - -	• Fumbling on the entrees	• TV's seemed out of place but the owners are sports people so "there you go" • Quiet at first, the place was louder than a stadium by eight thirty	• There were delays on one visit, some lapses on the second with refreshing water, removing finished plates and by serving tiny appetizer plates although we ordered many large appetizers

Sacred Pepper, 15405 North Dale Mabry, 813 609 8000,www.sacredpepper.com

Restaurants are rated from one to five stethoscopes.

HCMA Welcomes New Interns and Residents!

In-Training Membership – USF (28):

Adam Barnathan, DO (EM)
Muhammad Chughtari, MD (ID)
Alison Cullinane, MD (PD)
Elissa Engel, MD (PD)
Karl Kasischue, MD (N)
Jibran Khan, MD (EM)
David Lindsay, II, MD (PDA)
Byron Markel, MD (EM)
Daniel Mathew, MD (IM)
Adithya Mathews, MD (IM)
Christopher Matson, MD (ORS)
Sayeef Mirza, MD (IM)
Natalie Moreo, MD (N)
Kathleen Murray, MD (N)
Lynh Nguyen, MD (PTH)
Daniel Nolan, DO (OPH)
William Pearce, MD (IM)
Marijan Pejic, MD (R)
Yilmarie Resado-Acevedo, MD (PD)
Colby Richardson, MD (N)
Darrell Ritchey, Jr., MD (EM)
Savan Shah, MD (IM)
Eric Shamas, MD (EM)
Carissa Simone, MD (PD)
Andrew Smith, MD (EM)
Misbahuddin Syed, MD (IM)
Zain Tariq, MD (EM)
Dwayne Wilson, MD (OM)

In-Training Membership – Brandon Regional Hospital (22):

Rameez Ahmad, MD (IM)
Mohammad Awad, MD (IM)
Muhammad Ayyaz, MD (IM)
Mahin Bahadovani, MD (IM)
Anuradha Bharsar, MD (IM)
Preet Cheema, MD (IM)
Nishant Dagli, MD (IM)
Ramon Docobo, MD (IM)
Marcos Freeman, MD (IM)
Shitaldas Pamnani, MD (IM)
Rikesh Patel, MD (IM)
Zarin Pirzada, MD IM)
Zulfiqar Qutrio Baloch, MD (IM)
Trisha Saha, MD (IM)
Feras Shalabi, MD (IM)
Santosh Shivanna, MD (IM)
Anurag Singh, MD (IM)
Rajeshkumar Sonani, MD (IM)
Jesse Suarez, MD (IM)
Padiuarshyamanand Tantry, MD (IM)
Zaw Tun, MD (IM)
Dalia Zakri, MD (IM)

REGISTER FOR HCMA FOUNDATION GOLF

We don't care HOW you play – JUST PLAY!

HCMA FOUNDATION, INC.
20th CHARITY GOLF CLASSIC
October 13, 2016

Carrollwood Country Club
13903 Clubhouse Dr.
Tampa

Format: Four-Person Scramble
11:30 AM: Registration and Boxed Lunch
12:45 PM: Call to Carts
6:00 PM: Social/Reception, Awards, Prizes, and Raffle
Cost: $150.00 per golfer (Includes cart, greens fee, goodie bag, lunch, and dinner)

Contest Holes – Door Prizes
SUPER TICKET - Raffle Prizes!

To register: complete the form below, enclose your check for $150 per golfer **made payable to HCMA Foundation**, and mail it to the HCMA, 606 S. Boulevard, Tampa, Florida 33606 or fax registration to: 813.253.3737.

DEADLINE TO REGISTER: Monday, October 10, 2016

Please - only one golfer per registration. Feel free to make copies of this registration form!

Name: _____ **Handicap:** _____

Phone #:_____Fax:_____

Email: _____

I'd like to play in a foursome with:

1) _____
2) _____
3) _____

Only $150 per golfer!

Is this foursome a hospital team? Hospital name: _____

A PRIZE WILL BE AWARDED FOR THE BEST SCORING REGISTERED HOSPITAL TEAM

SPONSORSHIP OPPORTUNITIES ARE AVAILABLE – CALL THE HCMA TODAY FOR MORE INFORMATION!

Any questions? Call Elke or Kay at the HCMA office, 813/253-0471
No refunds after seven days prior to tournament.

Hillsborough County Medical Association, Inc.
Established 1895

BECOME AN HCMA MEDICAL STUDENT MENTOR OR NEW MEMBER AMBASSADOR

GET INVOLVED

Medical Student Mentor

Allow medical students to shadow you in your office. The frequency and number of students is up to your discretion.

Dinner Meeting Mentor

Escort up to three medical students during the social hour of an HCMA dinner meeting and invite them to sit with you and your colleagues during dinner. Medical students are eager to learn and receive guidance from practicing physicians regarding the medical environment.

New Member Ambassador

Welcome a new member to the HCMA. You will be provided with names and contact information. Invite the new member to lunch or meet them at a dinner meeting to introduce yourself and colleagues.

To get involved in any of the programs, please see an HCMA staff member or complete a sign-up sheet. You will be contacted and provided with appropriate information to participate in your chosen program(s).

Thank you for your participation!

Florida Stifles the Responsible Behavior of Men

Legislative Repercussion

As of July 1, 2016, uninsured low-income Florida men will find it more difficult to be responsible about family planning.

In March, the Republican-controlled Florida legislature passed, and Gov. Rick Scott signed, a bill that strips Planned Parenthood (**PP**) of all public funds as of July 1. Federal funding of abortion has been prohibited for years [section 1008 of Title X (Public Health Service Act), 42 U.S.C. §300a-6], but the new HR 1411 blocks provision at Planned Parenthood clinics of ALL services that are publicly funded. This includes services funded by Title X ("Ten"), a program established by President Nixon and Congress in 1970 to help low-income men and women in the United States pay for family planning (**FP**). Title X funds are federal funds (not monies generated by state taxes) distributed to Title X providers by the Office of Population Affairs within the US Department of Health and Human Services. The largest Title X provider in Florida is the Florida DOH. These federal funds are re-distributed by the DOH central office in Tallahassee to the 67 county health departments who then either provide FP services or contract with individual FP providers. The rationale of the legislature was that any income that helps PP cover their operations costs (electric bill, maintenance, etc.) enables PP to continue to provide safe and legal abortion care.

For 20 years, I have provided vasectomy services under Title X at a variety of locations: county health departments, private offices, and Planned Parenthood clinics. I did not learn of Title 10 until I had been urologist for 13 years, but in 1996, I became a Title X vasectomy services provider in Hillsborough County. I am now the contracted provider for over 30 counties in Florida. These are uninsured patients whom few other doctors wish to serve. Reimbursement through Title X is on a par with the lowest of the insurance companies with whom I have contracts. These patients have no insurance coverage for potential complications (e.g. OR drainage of a scrotal hematoma), so doctors fear a lawsuit over the resultant hospital bills. But many of these families are on other entitlement programs (WIC, food stamps, etc.). And many have experienced the failure of less dependable forms of contraception, resulting in either more recipients of those entitlement programs or the very abortions that the legislature is trying to prevent.

My service locations in Southwest Florida have long been the Planned Parenthood clinics in Sarasota, Fort Myers, and Naples, and I have contracts for vasectomy services with Collier, Lee, and Charlotte counties. Unless another provider in SW Florida offers to provide vasectomy services under the program at his or her private office, Title X patients from those counties will now have to drive to my office in Tampa for their vasectomies, rather than attain them locally when I am at SW Florida PP clinics serving insured and self-pay patients. (My income will be negligibly affected, as Title X is only about 5% of my practice, and at this stage, I would be delighted to taper.) In fact, since the county contracts are with my practice itself, Planned Parenthood receives from me nothing more than a facility fee. But I am simply not allowed to provide Title X services in a Planned Parenthood facility whether I pay PP a facility fee or not. Does it make sense to ask the low income farm worker in Immokalee to drive all the way to Tampa when he can obtain the same service in Fort Myers or Naples? Will the long drive be such a barrier that many low-income men opt out of getting a vasectomy, thereby increasing the risk of more unwanted pregnancies? Did Florida state legislators and Rick Scott consider that when they enacted the new law?

In their determined efforts to make safe and legal abortion unavailable, our Republican legislators have also made it more difficult for men to do the responsible thing to avoid siring children they cannot support financially or emotionally.

Local legislators who voted for HR 1411 include Jeff Brandes, Dana Young, and Tom Lee, all Republicans and all of whom received financial support from HILLPAC in the past.

The funds contributed by HILLPAC to political campaigns are generated from HCMA members' contributions to HILLPAC. The HILLPAC Board interviews candidates and endorses and/or contributes to those believed to be "friends of medicine." It always amazes me that as patient advocates, many physicians support candidates whose

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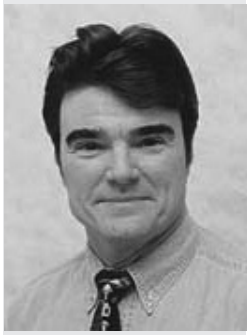

Douglas Stein, MD
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agendas can make it more difficult for patients to acquire services that would make us a healthier society.

Planned Parenthood is providing options guaranteed to all Americans by United States law. Because Republican Florida lawmakers disagree philosophically with one of those services, they have denied payment of federal government funds to PP for all other services. Will the next step be to forbid payment of our personal funds to Planned Parenthood because private funds also help PP cover operations costs? Given the current political climate and the party that is in power in Tallahassee, I wouldn't be surprised.

Editor's Note: Dr. Stein's column reflects his own opinion and not neccessarily those of The Bulletin, or any members or officers of the HCMA or HILLPAC. Comments concerning this debatable topic are welcome.

Mark Your Calendar!

Featured Speaker: Anna Pou, MD
http://www.drannapou.com/

HCMA Dinner Meeting
Monday, September 12, 2016
6:30pm – Social/7:30pm - Program
The Centre Club
Urban Center – 8th Floor
123 S. Westshore Boulevard

"Disaster Medicine: Ethical, Legal, & Psychological Repercussions"

In the days following Hurricane Katrina's landfall in New Orleans on August 29, 2005, Dr. Anna Pou and 2,000 others endured "third-world" like conditions at Memorial Medical Center in Uptown New Orleans as they waited to be rescued. By the time evacuations were complete, 45 critically ill patients had died. Dr. Pou was left with painful memories; in addition to accusations of "helping" four of those patients die peacefully. Louisiana's former attorney general, Charles C. Foti, charged Dr. Pou and two nurses with second-degree murder. Charges were dropped in 2009, and now she reflects on her experience during one of the deadliest disasters in U.S. history.

Watch your email for your invitation. If you have any questions, please do not hesitate to contact the HCMA office: 813.253.0471.

Ensuring Informed Consent, Addressing Payment Concerns

Risk Management

Payment concerns are becoming more prevalent due to high deductible payment plans, uninsured patients, and lower reimbursement rates—and the importance of informed consent is undiminished no matter the situation. Help ensure your practice addresses both issues effectively.

Informed Consent

A patient's absolute right to make informed decisions regarding his or her medical care is the foundation of informed consent. The American Medical Association states, "Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients."

Informed consent as a legal requirement began in earnest with a New York lawsuit back in the early 1900s. Justice Cardozo of the New York Court of Appeals stated, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body…"[1] This Appeals Court decision laid the framework for our modern-day informed consent laws and rules.

Over the years, case law relating to informed consent has evolved—with some states introducing statutes governing consent requirements for healthcare providers.

Informed consent laws differ by state in the amount of information a healthcare provider is required to disclose to the patient. Some states employ a "reasonable physician" standard, meaning a healthcare provider must provide the amount of information a reasonably prudent physician would provide in the same or similar circumstances.[2] Other states use a "reasonable patient" standard, requiring that a physician provide information that a reasonable patient would need to make an informed decision.[3]

Generally speaking, physicians do well to provide patients with enough information to make a fully informed decision about medical care. Exceptions to the informed consent requirement can be made for emergencies where the patient is unconscious and arrives at a facility needing a life-saving procedure. Be sure to check your state's laws so you know what is required for your informed consent discussions with patients.

Refusing Treatment Due to Financial Issues

If you have self-pay patients, you may implement a pre-pay policy to ensure payment prior to rendering services. Difficulty may present when a patient requires an expensive diagnostic test or procedure that they cannot afford. Depending on the situation, consider establishing a policy addressing financial hardship and an associated payment plan for expenses that cannot be paid in one lump sum. If you choose to do this, ensure payment arrangements are in writing; this will help if you have payment issues.

A more challenging scenario occurs when a patient refuses to consent for a critical test or procedure because he or she cannot afford it. These are particularly concerning in potentially life-threatening situations. An example is a woman in labor who adamantly refuses a C-section because she cannot afford it—even after being told she, or her baby, may die if vaginal delivery is continued.

Avoiding Medical Battery, Obtaining Pre-Approval

Medical battery is a very real issue with real consequences. The most likely scenario for a medical battery claim is when the patient expressly refuses treatment and the physician performs the treatment over the patient's objection. The C-section situation above is an excellent example.

If a patient is asked to consent to a C-section and expressly refuses, the physician's hands are tied unless he or she can get the patient to change her mind. Certain situations require you or your practice to obtain pre-approval for a test or procedure from a third-party payer. These pre-approvals sometimes may be denied. If a third-party payer denies a pre-approval, you have two options: either appeal the denial or ask the patient to pay for the test or procedure.

If you decide to appeal the denial, each third-party payer has an appeals process you must follow. If the appeal is unsuccessful, you may try call-

(continued)

Jeremy A. Wale, JD
ProAssurance Risk Resource Advisor

Risk Management (continued)

ing the payer directly, asking to speak with a physician reviewer. Once all efforts are exhausted, it's time for a documented conversation with the patient to explain the situation.

If a patient accepts responsibility for the cost of a test or procedure, consider a written agreement. If your practice offers financing, you may wish to have a written document outlining both parties' expectations.

Communication is key to the consent process and addressing payment concerns. If you have any questions, please contact your healthcare professional liability insurer.

This article, courtesy of HCMA Benefit Provider, ProAssurance, was authored by Jeremy Wale, JD, ProAssurance Risk Resource Advisor. ProAssurance Group provides healthcare malpractice insurance and is rated A+ (Superior) by A.M. Best. Mr. Wale is a licensed attorney in Michigan. He has authored numerous articles about mitigating medical professional liability risk. Mr. Wale also conducts loss prevention seminars to educate physicians about new and emerging risks.

[1] Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129 (1914).

[2] Thaw v. North Shore Univ. Hosp., 129 A.D.3d 937, 939 (2015).

[3] Janusauskas v. Fichman, 264 Conn. 796, 810 (2003).

IN MEMORIAM

It is with much sadness that we report the following member of our medical family has passed away…

Luke Glover passed away unexpectedly on June 3, 2016. Luke is survived by his companion, Lis Lissabet; brother, HCMA member **Dr. Matthew Glover** and his wife Cecilia; sisters, Denise (Gaspar) Monte, Susan (Patrick) Glennon, Barbara (Allan) Lette; cousin, Mark (Renee) Dupuy; several nieces and nephews. In lieu of flowers, please consider a donation to Metropolitan Ministries or The Humane Society of Tampa Bay.

Our heartfelt condolences go out to the family and friends of Dr. Glover.

Personal News

A 40 year career and 7,357 babies

On Saturday, July 2nd, HCMA Past President, Dr. Bruce Shephard, donned the front page of the Tampa Bay Times. On June 28th Dr. Shephard delivered his last baby, a boy named Angel. Times Staff Writer, Lane DeGregory, wrote a touching story about Dr. Shephard and his 40 year career. Dr. Shephard's story has also been reported in TBO, on local radio stations, in FMA News, and will be a feature in the September issue of Florida Medical Magazine. Congratulations on such a remarkable career and the well-deserved recognition, Dr. Shephard!!

Olivia Butler competes in the Miss Florida Pageant

A recent Tampa Bay Times article featured the daughter of HCMA Past President, Dr. Madelyn Butler and HCMA Alliance President, Bill Butler. Olivia Butler competed in the 81st Annual Miss Florida Pageant in June and was among the Top Ten Finalists. While she did not win the title, she prevailed in the talent competition and was chosen to receive the Quality of Character award by her fellow contestants. Olivia is an advocate for victims of sexual assault and domestic violence and helps to raise awareness through Girls Empowered Mentally for Success (GEMS) in Tampa. Her experience and work with GEMS was part of her platform for the competition. Well done, Olivia!

Need a Meeting Space?

The HCMA's Executive Board Room is the perfect place for your next meeting. The board room table seats fifteen very comfortably and can be arranged classroom style to accommodate up to 30.

HCMA members can reserve the board room with a $100 donation to the HCMA Foundation.

To confirm availability, please contact the HCMA office (813-253-0471).

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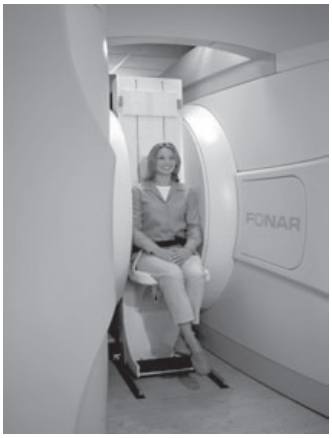

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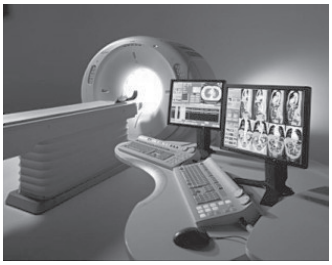

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CHOOSE A WAY THAT IS RIGHT FOR YOU!

Attend an Executive Council Meeting
The HCMA Executive Council is the governing board of the Association. The meetings are held bi-monthly at 6pm at the HCMA office and are open to all HCMA members. RSVPs are required. Call the HCMA office for a list of meeting dates.

Attend a Dinner Meeting
The HCMA holds four dinner meetings per year. The meetings offer an excellent opportunity to socialize with colleagues, meet HCMA partners, and enjoy a variety of interesting speakers. Dinner meetings are held at The Centre Club in Tampa.

Legislative Activity
The HCMA's political arm, HILLPAC, meets with legislators and interviews candidates to determine friends of medicine. The HCMA Legislative Committee hosts an annual Legislative Luncheon, and reaches out to legislators to educate them on important issues that affect physicians and their patients.

Become an HCMA Delegate to the FMA
The HCMA Delegation prepares resolutions to be submitted at the FMA Annual Meeting which is held annually. At the meeting, resolutions are discussed by the FMA House of Delegates and, if approved, may result in proposed legislation or FMA policy.

Medical Student Mentor
Allow medical students to shadow you in your office. The frequency and number of students is up to your discretion.

Dinner Meeting Mentor
Escort up to three medical students during the social hour of an HCMA dinner meeting and invite them to sit with you and your colleagues during dinner. Medical students are eager to learn and receive guidance from practicing physicians regarding the medical environment.

Join our Editorial Board
The HCMA's bi-monthly publication, *The Bulletin,* is the voice of our members. Submit an editorial, travel journal, photo diary, or relay an experience you believe would interest your colleagues. Submissions are always considered and suggestions welcome.

Call the HCMA for information concerning any of the opportunities listed (813.253.0471) or email Debbie Zorian, Executive Director (DZorian@hcma.net).

Be sure to provide us with your email address so you can be kept apprised of pertinent information, urgent legislative updates, and to receive our monthly "Enews" and CME correspondence.

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