

The Bulletin

OF THE HILLSBOROUGH COUNTY MEDICAL ASSOCIATION

May/June 2017



Fred Bearison, MD
2017-2018 HCMA President

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Tuesday, June 20, 2017

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1601 S. MacDill Ave., Tampa, FL 33629

5:30-6:00pm: Registration
6:00-6:45pm: Active Shooter Experts
6:45pm: Panel Discussion and Q&A

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HCMA Members/Staff: Complimentary
Non-Members & Staff: \$25 per person (max 2 per office)

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Executive Council Meetings

6:00pm at the HCMA Office

July 18, 2017

September 19, 2017

November 21, 2017

Foundation Charity Golf Classic

11:30am at Carrollwood Country Club

October 12, 2017

Workplace Violence Seminar

5:30pm at the Palma Ceia Country Club

June 20, 2017

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HCMA Dinner Meetings

6:30pm at the Westshore Grand

September 12, 2017

November 7, 2017

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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.

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May/June 2017

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This year Dr. Fred Bearison was re-installed as HCMA President, he graciously volunteered to serve a second term as HCMA President, upon the request of the HCMA Leadership. Debbie Zorian, HCMA Executive Director, presented Dr. Bearison with a “mini-me” bobble head to recognize his success in recruiting the most new members (48!) in 2016!!



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President's Message

No Change For Me

Fred Bearison, MD
drfredb1@gmail.com



When I first sat down to write this article, I planned to recap my year as your President and say "Good Bye" to the office. I wanted to highlight my accomplishments and discuss my vision for our future. I have been honored to serve as your president over the past year. However, as the adage goes, "The only thing that is constant is change" which won't describe my upcoming future with the HCMA.

As I am sure most of the membership is aware, I have been asked by the leadership to serve a second year as President. After careful consideration (and some "prodding" from a few unnamed sources), I have agreed to remain in this role. I am, again, honored and also humbled that you have entrusted me with this position. In addition, I would also like to formally recognize Dr. Thomas Bernasek whom I have asked, and who has graciously agreed, to remain in his position as President Elect for a second year.

Working together, along with our new Vice President and Chairman of the Membership Committee, Dr. Jayant Rao, we will strive to continue to grow our membership. I am proud to report that over this past year we have almost 50 new members from the Brandon area as well as 100% membership of the Brandon Regional Hospital residency staff. In addition, we have new members countywide. These physicians joined the HCMA because they realize the importance of organized medicine. Furthermore, they understand the value of political and professional advocacy, networking with colleagues, and the enhanced Benefit Provider program the HCMA offers. In addition, included with membership, HCMA's quarterly dinner meetings provide interesting guest speakers and regular organized medicine updates.

Looking forward, I would like to re-introduce the HCMA health plan through Florida Blue. My medical group has participated in the plan for nearly five years and is extremely satisfied with the benefits, costs, and plan administration - compared to the other plans we have had in the past. Specific information regarding the plan will be forthcoming in the near future via email and direct personal contact. I urge members to take a serious look at the plan to see if it would work for your practice. I find it to be one of the HCMA's most beneficial tangible benefits. I will personally be actively involved to ensure the continued success of this program - this is my goal during the 2nd year of my Presidency.

I would personally like to thank the HCMA staff: Debbie, Elke, Kay & Jean for their hard work and dedication to our Association.

No one could ever imagine what they do behind the scenes to make every meeting, and the daily activities of the HCMA a success. Thank you, also, to the Executive Council for all their hard work.

A special thanks to Dr. David Lubin, who despite being retired, spends countless hours of his own time serving as our official photographer and Editor of *The Bulletin*.

I truly look forward to serving as your President for another year. I have a great team behind me: the Board of Trustees, the Executive Council, and our administrative staff. I am confident that working together we will again increase new memberships and make the HCMA health plan a success.



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Editor's Page

It's probably true - doctors make the worst patients.

David Lubin, MD
dajalu@aol.com



At the end of my last *Bulletin* column I hinted that I would tell you more about hospital gowns. For now I'm going to say that probably for longer than the 43 years since I've been in medicine, gowns still open and tie in the back. And wearing one is about as much fun as splitting an English muffin with a fork.

We had a wonderful wine tasting at the Swann Ave. Market on Friday, February 17th, and then I went out to dinner

with Elke and my daughter, Leah, splitting another bottle of wine three ways. Things were fine until 3 AM when I awoke for one of my 3-4 trips to the bathroom. I felt a flutter in my chest, took my pulse, and diagnosed myself with, apparently, my first episode of atrial fibrillation. I tried a couple of Valsalva maneuvers to no avail and at 3:30 nudged Elke, trying not to startle her. "Am I snoring?" she asked. No, but she'd have to take me to the hospital since I had an irregular heartbeat. She took it better than I thought she would. She even suggested St. Joe's North, where we arrived about 4 AM to a completely empty ER waiting room.

Editor's note: This is an opportune time to give you this bit of information. The Valsalva maneuver is named after Antonio Maria Valsalva, a seventeenth-century physician and anatomist from Bologna whose principle scientific interest was the human ear. He used the Valsalva maneuver to clear Eustachian tubes.

I filled out all the necessary paperwork and was taken to an ER exam room where nurses came in for vitals; I got an EKG, chest x-ray, blood work, etc. The doctor came by after all that was done and concurred with my own bedside, or in bed, diagnosis.

I wasn't scared, since I knew it wasn't that uncommon, but I was just wondering "Why?" But I pretty much knew what lay ahead.

When I arrived in my room I received my new wardrobe, although I did bring some apparel from home. Hospital apparel is not from any fine clothing store, but is still comprised of those gowns that are open and tie in the back. They should at least have the opening in the front since it would have been easier to do my echocardiogram. Not a big deal, but you would think...

The echo tech was a young lady who also worked for a South Tampa cardiologist and had actually sampled sandwiches from my Market. Her interpretation of my echo was somewhat reassuring, although not official.

Soon after the echo was done it was lunchtime. You can get your meals routinely delivered three times a day, or you can order them through "room service." You call food services and order off the menu, just as if you were at the Don Cesar. Problem is, the food is still from the hospital. Not terrible, but still "hospital" food.

Finally, later in the afternoon, the hospitalist came in and we discussed my case. I'd have to go on warfarin, which I figured I would. I wasn't sure what the plan would be long term, but he was going to leave it up to the cardiologist. When the cardiologist came in, we had another discussion. He was concerned about my rate having spiked to 130 so he stopped my Bystolic (for hypertension) and started Cardizem to lower my rate. He also ordered my first dose of warfarin that afternoon (Saturday).

Later on, very, very early Sunday morning, there was a knock at the door and a nurse asked Elke if I was ok. She thought so, but we both had been sleeping, or at least she thought so. Now she was alarmed. "Why, what's wrong?" My heart rate had dropped to 40 on the Cardizem...so later that AM we all agreed to go back on the Bystolic and forego the calcium blocker.

Then at 5 AM, another knock. "Vital signs," the nurse said. "Ok," I mumbled. She took my BP and temperature (I still don't know why), and then asked me if I would mind standing for a weight. I declined. You would have too.

Then half an hour later there was another knock. "Blood work," she said. I asked what she was drawing. She said, "BMP, CBC, protime, and INR." I politely said, "No, you're not. I came in yesterday, without any bleeding issues, and my electrolytes and CBC were normal. I just started warfarin 12 hours ago, so a protime and INR will be useless." I'm not sure if she knew I was a physician, but maybe it's true--we might make the worst patients. She tried again at 7:30 and again I refused. Since I was wide-awake, I dialed up room service and had a delightfully lukewarm breakfast.

I was anticipating getting out of the hospital later Sunday AM since I was stable. At about 10 AM, I went into the bathroom, for a "sit-down." When I was done, Dr. Valsalva's maneuver had performed a miracle. I was now in sinus rhythm; I went out to the nurse's station and asked that someone document it for the record. That presented me with a whole new significance of "Physician, heal thyself."

When the cardiologist returned, we again discussed the future. I didn't want blood tests every week and have to watch my greens

(Continued on page 11)



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Executive Director's Desk

A Prevalent Health Risk

Debbie Zorian

DZorian@hcma.net



My last column focused on how I felt the rapid paced, progressive technology of today was having a tremendous impact on the dwindling of human compassion. It also included my stance regarding the way society misuses what technology offers every time someone snaps photos on their smartphone during horrible situations, including the beatings and deaths of innocent people.

Unfortunately, another crime has transpired and has been shared via social media. As of this writing, it has been three days since the tragic, inconceivable murder of Robert Godwin Sr., a father of 10 and grandfather of 14. Neither he nor his family knew Steve Stephens, the man who randomly shot Mr. Godwin as he innocently walked a residential area of Cleveland, collecting cans, in the middle of the afternoon on Easter. His own statements regarding his intent to kill, and the actual murder itself, was recorded by Stephens and posted to his Facebook page.

Online research specified that it took two hours and 11 minutes for Facebook to remove the horrific video. Another source quoted nearly three hours. Nonetheless, the video was viewed 1.6 million times. The victim's grandson pleaded with users on social media to stop sharing the video. Other live videos that captured the attention of media outlets, across the globe, included a confession by Stephens and one in which he was laughing about the murder and claiming he had killed more than a dozen others because he was angry with his former girlfriend. Fortunately, his claim of taking other lives has proven to be false thus far. Hopefully, his own life was the last to be taken by his own hand.

The coldblooded killing rekindled the dispute about violence in the Internet Age. It prompted outrage and questions over Facebook's responsibility in policing content on its global platform. According to online information, "The world's largest social network has had to contend with this issue more frequently as it has bet big on new forms of media like live video, which gives it a venue for more lucrative advertising. Facebook does not want to be a media company that overly arbitrates what is posted on its site, but the more reluctant it is to intervene or the slower it is to respond, the more it may open itself to the posting of killings, sexual assaults, and other crimes."

Many remember the death of a Minnesota man shot by police during a traffic stop last summer. It was broadcast by the man's girlfriend live across Facebook. In January of this year, three men

in Sweden were arrested on suspicion of raping a woman and streaming the assault live to a private Facebook group. In February, two radio journalists in the Dominican Republic were fatally shot during a Facebook Live broadcast. Sadly, examples are numerous.

The job of scrutinizing social media videos is enormous. Facebook handles more than a billion uploads per day and YouTube users upload hundreds of hours of video every single minute! It makes one wonder the amount of work or family commitments that have fallen by the wayside, replacing the time needed to engage in social media.

In referring to the heartbreaking video posted by Stephens, Justin Osofsky, vice president of Facebook, was quoted as saying, "The company is working to ensure that such content and reports of it can be flagged faster, including through the use of artificial intelligence and a better review process. We know we need to do better."

The question begged, "What about in the meantime?"

The fact is, although the video of Robert Godwin's tragic murder was removed, it continued to be shared across social media. That brings up questions I have had, and will continue to have, regarding the prurient interests of many in our society. I personally know someone who watched the video and I became instantly upset when told. It's difficult for me to imagine a person purposely or inadvertently viewing such a video...thus, my curiosity why some people have morbid curiosities. Yet, when we stop and think about all the ways technology has provided unhealthy forums, for society in general, it's easier to understand how humanity can become desensitized to almost any subject matter.

When my children were young, I remember video games such as PAC Man and Mario Brothers. Those types of games pale in comparison to those that are now played which include violence and killing. How many times can an adolescent play these games before they become desensitized to acts of such violence? Adolescent psychiatrists throughout the country believe that children's exposure to media violence plays an important role in the etiology of violent behavior and aggression. It is my opinion, the plethora of harmful exposure to violence included in television, video games, music, and social media, will continue to warp the minds of our youth and those who are suffering mental health issues.

I was surprised when reading information from the American Academy of Pediatrics which referred to "interpersonal violence, as victim or as perpetrator, now being more of a prevalent health risk than infectious disease, cancer, or congenital disorders for

(continued)

Executive Director's Desk (Cont.)

children, adolescents, and young adults. Merely being exposed to violence has been linked to chronic disease, mental health problems, lower quality of life, and increased risk of perpetrating violence." As viewing online violence is considered "exposure," and one that obviously cannot be regulated at this time, health risks will continue to rise among young and old alike.

If the harmful effects of social media violence begin to surpass the wonderful benefits social media was meant to offer, I cringe at the enormous grief that will be bestowed upon society.

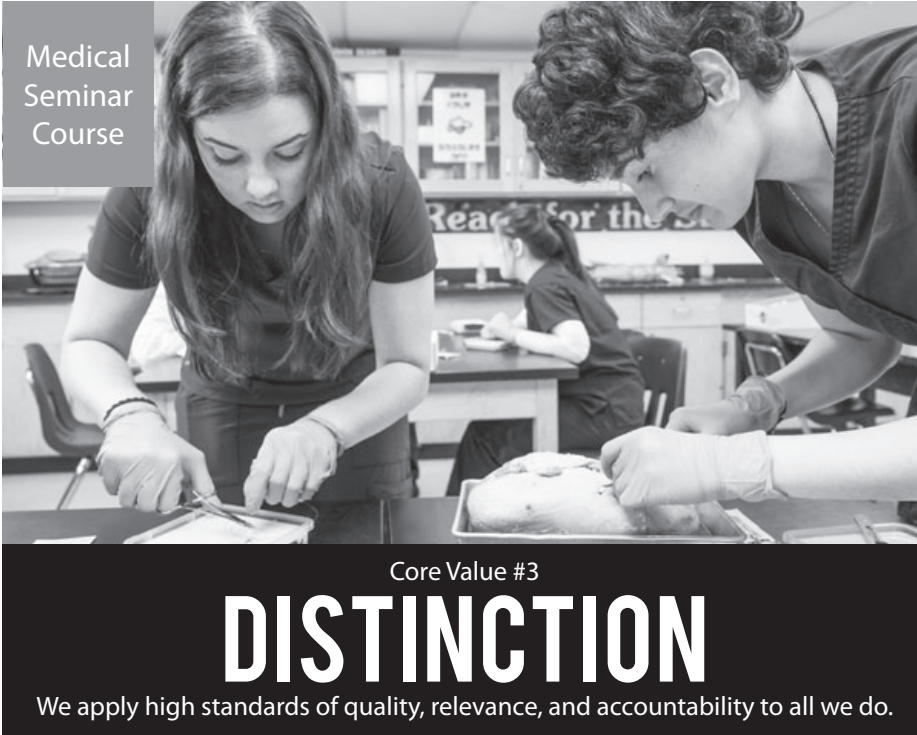
I wish Steve Stephens was deprived of his audience of 1.6 million.

Editor's Page (Cont.)

on warfarin, so I would later get Xarelto, even without a prescription plan, and started that. Still wondering how my AF was triggered, he told me about the "Holiday Heart" syndrome. People would head over to Mexico for a weekend of drinking and come back with arrhythmias. I'm not a lush, but we might split a couple bottles of wine a week with dinner and my beer consumption has increased. HEY, I own a beer and wine store for crying out loud. So, less alcohol and I agreed to stay on Xarelto for 5-6 months, monitor my pulse closely, and even do a Holter for a few weeks at the end of 6 months. If completely clear, I can come off meds.

Another issue, I realized, was going to be how Medicare handled my hospitalization. When I was actively admitting patients, I remember "24 hour observation" patients who were considered as outpatient. Now, apparently, it's been extended to 48 hours, and you have to be in the hospital for two midnights. Well, I was admitted after midnight and stayed through only one, Saturday night/Sunday morning. So now all the providers are billing me under part B, rather than the hospital filing under Part A. It probably doesn't amount to much more money, but just more bills from various providers.

So I'm doing ok...no return of the AF. I've cut back my alcohol, and I never want to dress in hospital garb again.



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Photo Gallery

HCMA Officers & Representatives

On May 9th, Dr. Fred Bearison was reinstated as HCMA President, serving a second term. It was also announced that the members listed below will serve the HCMA in the following capacities:

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President
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Thomas Bernasek, MD
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Orthopaedic Surgery



Jayant Rao, MD
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Clinical Notes

Doctor of the Day

Michael Cromer, MD
drmcromer@gmail.com



I recently had the opportunity to serve as Doctor of the Day for the Florida Legislature. I was sponsored by Rep. James Grant (District 64) and went to Tallahassee on Friday April 7th. The Doctor of the Day program started in the 1960s by a former Florida House member, Representative Walter Sackett, MD, from Miami. This program, which is administered by the Legislative Clinic, delivers a vital professional service to the members of the Florida Legislature, all legislative employees, and the Capitol staff.

Even though neither the Senate nor the House was in session that day, the clinic nurse told me that there still would be some duties to perform at the Clinic. Upon my arrival at 8:30, I was met by Cathy and Dana, two registered nurses who had a half a century of experience between them. My first “patient” of the day actually happened to be Cathy, the nurse. She had evidently gotten bit on the neck the night before by a beetle while carrying a load of turnip greens in to her house. Application of a steroid cream would be all the treatment that the bite would need, but I learned more about the grape flea beetle than I ever thought I would.

On busy days, when the Legislature is going full steam, the clinic can be quite busy. Between the two nurses and the doctor, it is not unusual to see over 50 people in the clinic. Many of the visits are for simple things like supplying a Band-Aid or dispensing ibuprofen. But occasionally, there can be some interesting things. Just the day before the doctor of the day had sent a male patient to the hospital for probable appendicitis. I was very impressed with how well the clinic is supplied. There were three exam rooms and among the rooms there was an EKG machine, a defibrillator, an oxygen tank, a nebulizer, suture supplies, and various over-the-counter medicines. There is a nominal one dollar fee for any services or supplies that are dispensed.

The nurses are definitely the source of whatever information needs to be circulated between the buildings. Many people use the clinic to get their daily weight or blood pressure checked. Since the clinic was not busy the day that I was there, it allowed me time to scout out the highlights of the building. I toured the former Capitol building, which has been converted to a museum that highlights Florida history. There were school groups taking field trips and getting their group pictures taken. I went up to the twenty second floor of the present Capitol and thoroughly enjoyed the 360 degree view. You could see all the way to the southern coast of the panhandle and barely see the lighthouse that is located southwest of Tallahassee.

Rep. Grant was not in the building since the House was not in session but I was able to meet with his legislative aide, Trent Phillips. He was very informative, sharing with me what a typical day of a legislator consists of and what an important role the aide plays in helping “push” bills through. There are 40 Florida state senators and 120 Florida state representatives. In a building as big as the Capitol, it was surprising to see that about 8 representatives and their staffs are crowded into each wing that is only about 1500 sq. ft. Before I left for the day, I was given a tour of both the House and Senate floors and was able to get my picture taken as a souvenir of my day.

I rounded out my trip by paying a visit to the headquarters of the Florida Medical Association. Jarrod Fowler, the FMA Director of Health Policy and Innovations, met me and gave me a tour of the building and I was able to meet some of the people that I had only communicated with by occasional emails. It was gratifying to see how many qualified people there are at the FMA going to work every day for us, protecting the best interests of our profession and the patients that we serve. I would recommend volunteering as the “Doctor of the Day” and visiting the FMA headquarters to anyone who wants to get a behind the scenes look at how things develop that are shaping our future.

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Murie Rothman Bldg. Owls Den
Tampa, FL 33620

Saturday, June 17, 2017, 10:00 AM - 12:00 PM
Univ. of South FL - Area Health Education Center
3515 E. Fletcher Ave. Suite MDT 1400
Tampa, FL 33612

Wednesday, June 21, 2017, 10:00 AM- 12:00 PM
Suncoast Community Health Center -Ruskin
2814 14th Ave Se
Ruskin, FL 33570

Thursday, June 22, 2017, 6:00 PM - 8:00 PM
Palm River Family Services
7454 Palm River Rd.
Tampa, FL 33619

Monday, June 26, 2017, 6:00 PM- 8:00 PM
St. Joseph's Hospital Tampa -Medical Arts Bldg.
3001 W. Dr. Martin Luther King Jr. Blvd.
Tampa, FL 33607

Wednesday, July 5, 2017, 10:00 AM- 12:00 PM
Suncoast Community Health Center- Brandon
313 S Lakewood Drive
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Photo C Installation Dinn



Drs. Rebecca Johnson, Kelly Devers, Karin Hotchkiss, Anne Champagneaux, and Alejandra Kalik.

This year's Annual Installation dinner had a twist. Dr. Fred Wallenda was honored and performed by FMA President, Dr. David Becker. Dr. Bearison graciously accepted the award upon the request of the HCMA Leadership.

The evening's guest speaker, high-wire artist and daredevil, Nik Wallenda, performed with his wife, Gayle Sierens. Mr. Wallenda recounted his family's history, dating back to the 1800s, and hinted that a "walk on the rope" over an active volcano may be in the future.

Many thanks for the generosity and support of The Bank of America, The First Group, and ProAssurance for making the evening possible.



FMA President, Dr. David Becker (L), performed the re-installation of Dr. Fred Bearison as HCMA President.



Dr. Richard Lockey, Michael Kelly, and Dr. Malcolm Root.



Drs. David Becker, Michael Caire, Lacey Bernard, Savan Shah, Jayant Rao, and Jose Jimenez.



Gayle Sierens and Nik Wallenda share the stage.



Dr. Ralph and Kathy Rydell with Dr. Glenn and Carole Hooper. Drs. Hooper and Rydell are both HCMA Past Presidents.

Gallery

er May 9, 2017

Bearison was re-installed as HCMA President, the honor previously volunteered to serve a second term as HCMA President,

Wallaenda, shared the stage with local media personality, Gayle to the 1700s, and the family's current projects and goals. Nik his future.

Tampa, Brandon Regional Hospital Medical Staff, the Legatus



In lieu of an honorarium, Gayle Sierens asked that Dr. Bearison present Kelly Bell, Executive Director of the Judeo Christian Health Clinic, with a donation to support the Clinic.



Dinner sponsors, The Legatus Group, The Bank of Tampa, and Brandon Regional Hospital Medical Staff were represented by Mr. Joe Yagar, Mr. Corey Neil, and Dr. David Lorch, respectively.



Mr. Corey Neil, EVP of The Bank of Tampa and dinner sponsor, Judge Katherine Essrig, and her husband, Kevin Napper.



Dr. Dennis and Ellen Laffer.



Drs. Jimmy Vargas and Roberto Garcia.



Mr. Wallenda's credo: Never Give Up!



Drs. Peter Radice and Adam Cohen.

Risk Management

Mitigating Risk - Five Key Areas of Focus

Jeremy A. Wale, JD

ProAssurance Risk Resource Advisor



Healthcare liability insurers cannot tell physicians or midlevel providers how to better practice medicine or avoid surgical mistakes - but can offer guidance that can help you mitigate risk. Here are five key areas to focus on that can help protect your practice.

Use Technology with Caution

Healthcare looks very different than it did 25 years ago. Physicians are using tablets, smartphones, interactive apps, and other electronic means to provide efficient healthcare to patients.

According to several sources, between 75 and 85 percent of physicians use a smartphone or tablet for professional purposes.¹ Uses include email, research, EMR entry, x-ray review, telehealth, and more. While electronic devices have many benefits, their use presents new risks.

Chief among these risk exposures is the increased possibility of a HIPAA violation. While a HIPAA violation is not the same as a malpractice claim, it can still negatively impact you and your practice, staff, and patients.

HIPAA concerns arise in several areas of electronic device use. Losing a device may allow an individual access to protected health information (PHI) stored on the device. If the device is not properly encrypted or secured, an individual may access PHI through apps, email, or hacking into a system using the device's connectivity.

Another risk arising from mobile electronic devices involves app usage. There are approximately 26,000 healthcare apps available, and 7,400 of those apps are marketed to physicians.² Somewhat surprisingly, the FDA has only approved 10 healthcare apps as of July 26, 2016.³

One physician wrote about a blood pressure app he was using that gave inaccurate readings. When he contacted the app's developer, he was told the app was in the "beta-testing stage" and intended for "entertainment purposes only." Despite this information, the developer was selling the app to end-users—without any disclaimers or mention of its test status.⁴

Healthcare providers need to be vigilant when deciding whether to use certain apps. Research the app's usage and do preliminary testing to ensure its accuracy. Use the app, then verify the results with traditional testing until the physician is satisfied the app's results are accurate. Another suggestion is to contact the app's developer and

request testing/clinical trial results on its accuracy.

Use of smartphones, tablets, laptops, etc., in healthcare becomes more main stream every day. Be sure you are proactive in mitigating the accompanying risks. You may need to contact an IT security specialist to help ensure you are managing potential risks as effectively as possible.

Track and Follow up on Your Tests

Missed or delayed diagnosis is one of the most often litigated allegations in medical malpractice.⁵ These claims often result from tracking and follow-up procedure failures.

Lab testing is one of three key areas (the others are referrals to specialists and missed/canceled appointments) where tracking and follow-up are vitally important. A retrospective study researched the frequency of patients not being informed of test results, concluding there was a 7.1 percent failure rate.⁶ Tracking and follow-up procedural safeguards can be implemented and have a large impact on potential liability claims.

A reliable test tracking and follow-up system ensures the following steps occur:

1. The test is performed.
2. The results are reported to the practice.
3. The results are made available to the ordering physician for review and sign-off.
4. The results are communicated to the patient.
5. The results are properly filed in the patient's chart.
6. The results are acted upon when necessary.

Here are some suggestions for improving your process:

- Route all test results to the ordering physician for review. Procedures to ensure the ordering physician receives each and every test result can help lessen the risk of a result "falling through the cracks." Something as simple as a log book or email notification can help facilitate physician review.
- Ask the ordering physician to review and sign off on each ordered test result. Physicians order lab tests for specific reasons; physicians are encouraged to sign or initial each test result following review.
- Notify your patients. Several practices notify patients only when there is an abnormal result. Some practices choose to send a letter for normal results and call the patient for abnormal results. Others call patients with all results. In today's technology-driven world, an email may be appropriate for normal results,

(continued)

Risk Management (Cont.)

or an email directing patients to a portal where results can be reviewed. Patient notification of all test results is advised—however your practice chooses to do so.

Ensuring all tests ordered by your physicians are handled a consistent manner will help avoid tracking and follow-up errors.

Set and Review Policies and Procedures

A policy and procedure manual is an important tool for defining practice operations. In well-run practices, there is one set of rules every staff member understands and follows. The alternative is risky—procedures that vary from physician to physician or between staff members make it easy for errors or omissions to occur.

Develop a comprehensive manual of specific policies and procedures that explains how tasks are performed in your office, and make it readily available to all staff. It's important for staff to review and initial that they have read and are aware of these policies and procedures.

The following is a list of suggested topics to address in your policies and procedures manual:

1. Clinical Protocols/Patient Care
2. Patient Relations and Confidentiality
3. Health Information Management (Medical Records)
4. Laboratory (Test Tracking and Follow-up)
5. Radiology
6. Appointment Scheduling
7. Patient Tracking and Follow-up
8. Infection Control
9. Human Resources
10. Practice Operations
11. Special Procedures
12. Safety

You may need to add or subtract certain topics to best address the specific areas of your practice. **Maintain Accurate Medical Records**

A medical record is crucial to the defensibility of a case; occasionally it can be the biggest hurdle. The primary purpose of a medical record is to provide a complete and accurate description of the patient's medical history. This includes medical conditions, diagnoses, the care and treatment you provide, and results of such treatments. A well-documented medical record reflects all clinically relevant aspects of the patient's health and serves as an effective communication vehicle.

The medical record also has a critical secondary function: it is the most important piece of evidence in the successful defense of a medical professional liability claim. On average, a medical malpractice lawsuit takes five years to resolve.⁷ Most physicians cannot recall specific patient encounters from several years ago—so it is important to have accurate, thorough, and timely documentation of all your patient encounters.

Good medical record documentation may help prevent a lawsuit. Your defense team may be able to disprove a patient's assertions if the physician has thoroughly and accurately documented the patient encounter.

Good medical record documentation includes, but is not limited to, the following elements:

1. Legible – If your handwriting is not legible, consider dictating your notes.
2. Timely – Most electronic medical record systems document the date and time of all entries. If you still use paper records, note the date and time of each entry, with an accompanying signature or initial. It is best to chart patient encounters either contemporaneously or shortly after the visit for more accurate and thorough documentation.
3. Accurate – Ensure your documentation accurately reflects what occurred during a patient encounter.
4. Chronological – Documentation is more easily understood when it is sequential by date and logical in process. The SOAP (subjective, objective, assessment, plan) format, or something similar, is suggested when documenting patient encounters. A logical, clear thought process is compelling evidence to present to a jury.
5. Thorough – The old adage “if it's not documented, it didn't happen” still applies today. It is challenging to show something happened if there is no documentation to support that assertion.
6. Specific and objective – Make documentation as specific as possible (e.g. using actual measurements rather than descriptors such as “small” or “large” in size).

Additions, corrections, or addendums may be pertinent in certain situations, but altering a medical record is strongly discouraged. It will destroy your credibility in the eyes of a jury and cast doubt on the legitimacy of the entire chart. Alterations include modifying accurate information for fraudulent or self-serving reasons.

To properly correct a written chart, strike a single line through incorrect information, leaving it readable. Then make the correction or addition as needed. Be sure to authenticate the change with a time and date, along with your initials or signature. In the event of litigation, be prepared to be questioned about any changes made to the patient's chart—especially if they occurred after the incident in question or suit was filed.

Follow the same authentication principles in electronic records; consider using a “~~strikethrough~~” function rather than deleting information. Making any corrections or additions to a medical record after a claim or lawsuit has been filed—or after receiving notice a claim or lawsuit may be filed—is strongly discouraged. These actions will likely be viewed as self-serving and could severely undermine your defense.

Keep Your Team Trained and Informed

Office staff is a critical component of a medical practice. Patients often have more interaction with staff than physicians. Properly trained and educated staff can be strong protection against a professional liability claim. Consider the following risk tips for office staff issues:

- Prepare written job descriptions for all staff. Review each staff member's job description at his or her annual performance evaluation to determine whether the description accurately reflects the individual's responsibilities and capabilities.

(continued on page 22)

Reflections

This Is Us: A Lesson in Dying

Peter Radice, MD
DrRadice@aol.com



I realize it is unusual to write a *Bulletin* article about a TV program. The story line is complex, twisting between small vignettes about an extended family. Randall finds his biological father and brings him to live with his wife Beth and their two children. Over eight episodes, we are able to follow the emotions generated by William's decline and death from pancreatic cancer. The storyline exemplifying, Ira Byock's *Good Death*, teaches the viewers how palliative care

and hospice can prepare the patient and family for the treacherous path of dying.

Family friend, Olivia: How does it feel to be dying?

William: It feels like all these beautiful pieces of my life are flying around me . . . and I'm trying to catch 'em . . . And soon what was my granddaughter's breathing and my son's laughing, there will be (pause) nothing . . . Catch the moments of your life, catch them while you are young, and quick because sooner than you know it you'll be old . . . and slow.

As Christmas approaches, William explains to his partner, Jesse,

"Cause the holidays are hard times. But tonight I'll go back to my son's house, have Christmas with his beautiful family, and stay up late enough to feel Christmas Eve turn into Christmas day, one last time."

In feeling the cancer is getting worse, despite treatment, William does not want to be a burden on his newfound family.

William: I can feel it now, Randall. This cancer is coming for me sooner than later. Jesse is taking me to some of the best state-funded nursing homes, trying to find a good place to go before this gets really bad . . . I will not put this on you, Randall. I won't do that to your family.

Randall: Look, this is your home now. You've lived in this home, and if it comes to that, you can die in it. You're not going to be crawling underneath someone else's porch like some dog.

As with most patients with pancreatic cancer the realization of treatment failure sinks in.

William: The medication isn't working anymore. It just makes me feel sicker.

Randall: Do you want to stop the chemotherapy, William? (softly) Yeah.

Okay . . . It's okay . . . Everything's going to be okay.

Stopping treatment lets William's symptoms improve, giving everyone false hope.

William: Am I okay? "Okay" does not do justice to how I feel. I feel better than I've felt in months. I feel like sex, I feel like magic, I feel like music . . .

Beth: Uh Chemo boost. Happened to my dad when he stopped his treatment. His energy's not being zapped anymore.

William realizes there are things he wants to accomplish before he dies. He has the proverbial "bucket list."

William: I was hoping to drive your car . . . Driving a cool car, drinking my favorite drink, listening to my favorite record. Something I always wanted to do before I die . . . I think I'm getting the hang of this, Randall.

As they drive the 750i BMW around in a circle in the parking lot.

William's oncologist has been open to William's desire to honestly estimate his survival. Hospice is called in to help support William but Randall, representing many other family members of the dying, doesn't understand and is hostile.

Hospice admissions officer: The oncologist estimates he's only got a few more months, which is why you guys were right to seek palliative care. Our focus is making him more comfortable, whether that is pain management or nutrition or getting you access to hospice nurses.

Randall: Should we start digging his grave now or should we wait until there's an actual body?

But as expected the symptoms come roaring back.

William: It's just my body doesn't work right anymore. My fingers don't bend. My knees can't support me. I can't get warm. It's like every day it's something new, something I never had to think about before . . . gives out from under me and I just . . . I don't know how much longer I can do this.

William and Randall take a last road trip to Memphis to revisit William's past and have his son share his roots. After seeing his cousin, saying he was sorry, and paying back his debt, he was still able to "jam" with his cousin's band. The next day he woke up short of breath and Randall had to take him to the hospital.

Doctor: It's a bit of a miracle he was able to make the trip.

Randall: I need to get him home, where he'll be comfortable.

(continued on page 22)

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Risk Management (Cont.)

- Ensure each staff member works within the boundaries of state laws regarding appropriate job functions.
- Provide clear instructions to your staff on the amount and type of advice they may relay to patients and limitations on such advice.
- Establish a formal orientation period for new employees. Include a review of administrative practices, emergency medical procedures, and clinical skills and responsibilities.
- Establish procedures to ensure professional staff are credentialed.
- Educate all employees on patient confidentiality and have them sign a confidentiality agreement annually.
- Document employee training, including clinical competency, credentialing, performance evaluations, and annual reviews in employees' personnel files.
- Conduct regular staff meetings with designated agendas.
- Provide frequent feedback (both positive and negative) to staff.
- Ensure tasks are delegated to staff with the appropriate education, training, and experience to perform the task.

While the risk of a medical malpractice claim can never be eliminated, the information provided herein will help you reduce your practice's risk of a claim. If you have a specific question regarding your practice, please contact an attorney.

Mr. Wale is a licensed attorney in Michigan where he works as a Risk Resource Advisor for HCMA Benefit Provider, ProAssurance. 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.

Reflections (Cont.)

Doctor: Mr. Pearson, I'm sorry, but he's looking at hours here, a day or so at best.

Randall: no . . . no . . . He's, he's got months, maybe more even... There's an experimental drug that...we're waiting for FDA approval.

Doctor: His organs are shutting down rapidly . . . You asked me to be direct . . . your father is not leaving this hospital. I need to confirm, are you the medical decision maker? Standard procedure is comfort and care, pain medication at maximum levels. No intubation, no resuscitation.

Randall speaking to William: You knew you weren't coming home.

The last episode deals with William's wake and memorial and the bereavement of his family. Beth was angry and hurt that she never had a chance to say goodbye.

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⁵ "PIAA Closed Claims Comparative: A comprehensive analysis of medical professional liability data reported to the PIAA Data Sharing Project," 2015 Edition.

⁶ Casalino, L.P., et al., "Frequency of Failure to Inform Patients of Clinically Significant Outpatient Test Results." *Archives of Internal Medicine* 169 (2009): 1123-9.

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Randall at the end of the memorial gives Beth a postcard that had been sent by William from Memphis.

"Told you I'd send you a postcard. Good-bye, my dearest Beth. The daughter I never had. Love, William."

Throughout his dying all the common benchmarks were examined. The emotions ranging from very high to very low were viewed. The best moments came as everyone shared an openness in facing the changes of the disease process in their lives.

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Practitioners' Corner

Improved Access to Healthcare Could Mean Delayed Care

Erfan Albakri, MD

ealbakri@floridastroke.com



A Sam's Club eye clinic exam by an optometrist may not be the place to diagnose but to rather miss a brain aneurysm.

Biannual or yearly eye exams, various prescription glasses, and visits to the Sam's Club eye clinic did not help my patient's deteriorating vision. After several years, she was referred to an ophthalmologist who ordered a brain imaging study which showed a large inoperable cerebral aneurysm. Among the many thousands of my

neurological patients, when asked, probably more than 80% could not differentiate between an optometrist and an ophthalmologist. Obviously, many patients benefit from the services that optometrists provide. However, when patients experience visual symptoms, they require immediate emergency physician care with access to neurological or ophthalmological care and treatment. Such care is needed in the case of acute stroke from retinal artery occlusion or optic neuritis from demyelinating disease, where any delay in treatment would lead to lifelong disability. "The eyes are the windows to our brain," and as a neurologist, I have learned to ask all my patients about their visual symptoms, examine their vision and visual pathway, and ask if they have seen an eye doctor.

The delay in seeking the appropriate medical care could be the result the patient's source of information, education, and the misinformation available on the information highway. Neurological disorders and symptoms can be very confusing to many patients, especially when they look them up on the internet to ask "Dr. Google." Every headache is a migraine and a tension headache could be a brain tumor. Memory loss could be Alzheimer's dementia or it could be age related. Stroke symptoms could be seen as a "sugar problem." A gait disorder with bladder incontinence might be related to aging and arthritis, and dizziness to an ear problem. As a result, when patients experience neurological symptoms, they rarely seek a neurological evaluation independently. Therefore, most of my patients probably see many healthcare providers before they see a neurologist. Patients with spinal, cervical, thoracic, or lumbar disease are commonly seen by a chiropractor or orthopedic surgeon before they see a neurologist.

I believe that years of medical training, with academic and clinical experience, has a special value which our patients would appreciate. Access to better healthcare is the patient's right, which I strongly support and fight for every day. So when a patient I see experiences suboptimal care I move to adjust the clinical pathway for a positive

outcome. The opportunity to have been trained in neurology at New York University Medical Center, particularly at Bellevue and Manhattan VA Hospitals, then at Yale University and West Haven VA Hospital, and 23 years of work at USF and Tampa General Hospital, has taught me a lifelong lessons where the experience, not the title, is what helps my patients.

Recently, I received an email asking to reach out to our state representatives and ask them to vote NO on healthcare bills HB1037 and HB7011. The first bill would allow optometrists to perform laser and non-laser ophthalmic surgery as well as give optometrists the power to prescribe controlled substances. The other healthcare bill would allow ARNPs to open practice independently, without physicians' oversight.

An Advanced Registered Nurse Practitioner (ARNP) is defined according to Rule 64B9-4.010(1), Florida Administrative Code, as such: "An Advanced Registered Nurse Practitioner (ARNP) shall only perform medical acts of diagnosis, treatment, and operation pursuant to a protocol between the ARNP and a Florida-licensed medical doctor, osteopathic physician, or dentist." The aforementioned two bills were introduced to deprive our patients from skilled physicians' medical services, delay their access to better care, and allows the less experienced healthcare providers to deliver services which they are less qualified, less experienced, and less trained to perform. I do believe in improving access to basic healthcare services to all, but unless this access is paired with well trained and qualified healthcare providers, patients will suffer from delayed and suboptimal care. Access to quality healthcare should not be achieved only through relying on retail healthcare clinics without the support of primary and family physicians, that is, not by walking into Target, Walgreens, Walmart Care Clinic, Little Clinic operated by Kroger grocery stores, or the CVS Minute clinics where a federal health benefit is be used for a Pilot program. The Program was recently announced to treat minor illnesses and injuries for some ailing veterans, probably in an attempt to reduce the long wait-time our veterans have experienced in order to see a physician.

Improved healthcare access for our patients, with the help of increasing numbers of physician extenders, is clearly valuable if it is standardized with physicians' involvement and supervision. However, patient knowledge and education of the qualifications and the experience of their healthcare providers would not only help them receive better care, it would establish a trust for the source of their healthcare information, and improve compliance and the outcome of their care.

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Mushrooms



She wanted to serve her guests mushroom-smothered steak, but she had no mushrooms and no time to buy them. Her husband suggested, "Why don't you go pick some of the mushrooms that are growing wild down by the stream?"

"No, some wild mushrooms are poisonous."

"Well, I see squirrels eating them and they're OK."

So she picked a bunch and washed, sliced, and sautéed them for her dinner. Then she went out on the back porch and gave Spot, their dog, a double handful. Spot ate every bite.

All morning long, she watched the dog. The wild mushrooms hadn't affected him after a few hours, so she decided to use them.

The meal was a great success. After everyone had finished, her daughter came in and whispered in her ear, "Mom, Spot is dead."

Trying to keep her head about her, she left the room as quickly as possible, called the doctor and told him what had happened. The doctor said, "That's bad, but I think we can take care of it. I'll call for an ambulance and I'll be there as quickly as I can. We'll give everyone enemas and we'll pump out their stomach and everything will be fine. Just keep them calm."

Before long they started to hear the sirens as the ambulance tore down the road. The paramedics and the doctor had their suitcases, syringes, and a stomach pump. One by one, they took each person into the bathroom, gave them an enema and pumped out their stomach. Well after midnight, after the last one was done the doctor came out and said, "Everything will be okay now," and with that he left.

The hosts and the guests were all weak and exhausted sitting around the living room when the daughter came in and said to her mom... "I can't believe that guy!"

"What guy?"

"You know, that jerk who ran over Spot. He never even slowed down."

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Benefit Providers

A Testimonial

Tessa Wigger, MD
tessawigger@gmail.com



Ray Carapella, Dr. Tessa Wigger, her husband Mark, and Joe Yagar at a recent HCMA dinner meeting.

"The Legatus Group was so helpful to us. They offered more than we expected and really took the time to get to know us so they could assist us in what we felt was important."

~ Tessa Wigger, MD

For more information about The Legatus Group, financial services specialists, please contact Joseph Yagar, MSFS, CES, RIS, Yagar_Joe@nlvmail.com, (646) 898 3562 or Raymond Carapella, Carapella_Raymond@nlvmail.com, (813) 526-2619.

Committee Happenings

Editorial Board, The Bulletin

David Lubin, MD
dajalu@aol.com



The *Bulletin's* Editorial Board met March 28th to plan the 63rd volume. The dinner at Donatello Italian Restaurant was graciously hosted by board member Dr. Michael Foley. In addition to the writing assignments, the board members approved the September/October issue being dedicated to the environment. Dr. Lynn Ringenberg will serve as guest editor for the issue. And, as you can see, we've changed the layout and format to freshen it up a bit. We hope everyone likes the changes! Feel free to send comments to me.

The *Bulletin* is YOUR publication and we are always accepting submissions. Topic ideas/submissions include:

- Interesting cases
- Interaction with patients
- Interesting vacation
- Movie/book review
- Personal opinion relating to the practice of medicine
- Hobby/Leisure time
- Photos
- Topic ideas are welcome!

Please notify Elke Lubin, *Bulletin* Managing Editor (ELubin@hcma.net) if you are interested in submitting an article for *The Bulletin*. The article guidelines and deadlines for the year are available upon request. Remember, you can submit at any time - write when the urge strikes you and if space and content allows, we will include your submission in the next available edition of *The Bulletin*.

Pictured: Back row: Elke Lubin (Managing Editor), Drs. Rodolfo Eichberg, Erfan Albakri, William Davison, and David Lubin (Editor). Front row: Debbie Zorian (Executive Director), Drs. Michael Foley, Husain Nagamia, and Peter Radice.

Restaurant Review

The Reading Room...Food is Allowed in this Library!

6001 Central Avenue, St. Petersburg, Florida 33710, rrstpete.com, 727-343-0052.

The Taste Bud



The Reading Room was exactly that...a former Christian Science “Reading Room” now turned into a small (nine tables plus bar sitting) box-like restaurant on Central Avenue in St. Pete.

After hearing about this restaurant that is in the midst of St. Petersburg, our group was excited to visit. A group of women from a restaurant in Asheville came south and opened the Room. With good culinary experience, they creatively prepare an interesting range of dishes fit for foodies. With four sections to the somewhat limited menu, customers can stop in for a tapas-like snack or a full and satisfying meal.

First, and perhaps the best part, is the bread. Bread in Tampa Bay is fairly standard and fairly tasteless. The bread here, milled and created daily by the staff, is flavorful, soft in the middle, mildly crusty on the outside, and is served with home seasoned butter. It is perhaps the best bread in any restaurant in the area. It is worth the six dollars they charge, you get what you pay for. Along with the great bread in the first menu section are cheeses. We had a sharp blue brought with a honeycomb and tiny marinated veggies. Boiled peanuts are also listed in the same first menu section. They were the usual mushy tasteless pile, in my opinion, but enthusiasts of this ‘treat’ may love them.

On to the second section: salads and veggie starters. We had the Caesar which had an unusually tangy dressing and crunchy cooked anchovies. They were not as strong tasting as raw and one wonders why they aren’t served this way always...they would be much more popular. Oh - the salad also has hard boiled square eggs...cooked in a mold for another unique touch.

The burrata, with spring vegetables and an almond vinaigrette, was not worth the fifteen dollars and needed more seasoning. At least it needed some salt and pepper but unfortunately the restaurant must feel everything is seasoned perfectly as they do not stoop to provide those condiments on the table.

The third and fourth sections of the menu were more the “entrée” sections with the smaller section “III” ranging from \$14 to

\$18 and section “IV” from \$22 to \$26. The “Clams and Mussels,” one of the more popular dishes, consists of a pile of tender mussels and clams in a seasoned broth with bacon pieces and herbs topped with a crusty bread just begging to sop up every drop of the savory broth, which we did.

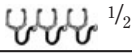
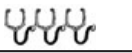
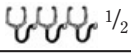
Ahhhh! The pork on a skewer. I had heard about this one and it did not disappoint. Since, now according to our watchful government, we are “allowed” to cook pork to a lower temperature, it is much better and this pork was no exception. Marinated, exquisitely tender, and encrusted on the surface, it was the best entrée of the evening. The only suggestion is that they add another skewer and make it one of the larger “IV” offerings, maybe trading with the rather skimpy chicken dish and making that one of the smaller dishes. Whoops...another suggestion...the whipped potatoes, served with the pork, need some nonexistent salt. Not that I’m bitter about it not being on the table or anything...

Speaking of the chicken, there were small rolled rounds about the size of “chicken bites” with dark meat in the center and white in the periphery of each. The bites were simple and tasted simple. Accompanied by tender mushrooms and a chicken juice, it was not worth twenty-four dollars and seemed to be sized to be little more than an appetizer.

We tasted three deserts which were nothing special. The brown butter cake was dry and needed more sauce, perhaps a caramel. The chocolate pave with some almond sorbet was okay but not as rich or tasty as some chain restaurant offerings. The weird “Lime Pie” was not a pie, it was a fluffy lime froth atop a strawberry puree and lime cream.

The Room offers some unique cocktails made with wines or vermouth, they do not have a full liquor license. The “No Strings Attached” of vinho verde, lime juice, honey, and cayenne was an unusual combination that was sweet and mildly spicy. They have a few craft beers, ales, and a few wines, including some wine “on tap” that is sold by the glass or carafe. The beverage list sticks to the reading room theme - the list is cleverly inside the authentic “Yale Shakespeare” book.

The Room is a good addition to an area of St. Petersburg that has a paucity of such restaurants. Those of us in Tampa have the fortune of having multiple similar eateries, especially along Seminole Heights, which may limit the reason to travel across the bay.

	CUISINE  1/2	AMBIENCE 	SERVICE  1/2
PLUSES + + +	<ul style="list-style-type: none"> Creative dishes Variety caters to every taste 	<ul style="list-style-type: none"> Casual and friendly, a comfortable place locals can visit frequently Cute hangings from the ceiling 	<ul style="list-style-type: none"> Generally, the server knew how to describe the dishes
MINUSES - - -	<ul style="list-style-type: none"> Going to similar places in Tampa avoids the travelling to St. Pete I enjoy old fashioned ice in the water and salt on the table, which you do not get here unless you ask 	<ul style="list-style-type: none"> A rather stark setting- essentially just a “room” The cacophony of happy voices and no noise abatement may be annoying 	<ul style="list-style-type: none"> Average service was given

Restaurants are rated from one to five stethoscopes.

Personal News

In Memoriam



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

Augustine "Gus" Smythe Weekley Jr., MD, JD, 87, was born in Tampa April 12, 1930. He died April 12, 2017 at Melech Hospice House. He was the only child of Dr. A. S. Weekley Sr. and Ruby Weekley. He lived in the same house from his birth to the time of his death. Dr. Weekley had been an HCMA member since 1960.

Dr. Weekley is survived by his wife, Marilyn Mancuso. He is also survived by JoLynn Sherouse Weekley, their daughter, Alexandra Weekley Rico and her two sons, Jean Paul and Christopher Rico, all of New Orleans; his second wife, Aldona Mary Weekley, R.N., moved to Tampa from Boston with Dr. Weekley and they opened his first medical practice together. They had two sons - Augustine S. Weekley III and Paul Marshall Weekley. Dr. Weekley is also survived by four grandchildren.

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

A Word on TrumpCare



In a recent editorial, which appeared in the March 9, 2017 issue of *Doctors Life Magazine*, "TrumpCare and You: How the New Administration's Healthcare Policy May Affect Your Practice," HCMA Past President, Dr. Christopher Pittman reflected on how "TrumpCare" will have little to no impact on how physicians are paid.

Dr. Pittman is clear that although there is a new captain at the helm, the ship will remain heading the direction it was already going: away from the fee-for-service payment model and toward a fee-for-value payment model.

To read the article in its entirety, visit doctorslifetampabay.com and enter "Pittman" in their search option.

HCMA Benefit Provider, Full Circle PR, seeks out HCMA members for quotes and opinions on issues affecting physicians, their patients, and the community at large. For more information about Full Circle PR, please contact Michele Krohn, President, 813.887.3277 ext 101, or Michele@FullCircle-PR.com.

Technology in Medicine



A recent BayNews 9 report, *Florida Hospital Tampa uses 'Surgical Theater' virtual tech to help remove tumors*, featured HCMA member Dr. Sharona Ross.

"The Florida Hospital in Tampa is the first in the nation to use a virtual technology called "Surgical Theater" to help surgeons remove tumors, which is the only cure for pancreatic cancer, according to Dr. Sharona Ross..." To read the article in its entirety, visit baynews9.com and enter "vr technology" in their search option.

Our Philanthropic Family



A recent feature in the Tampa Bay times, written by Amy Scherzer, included the April 7th Island Paws Party. HCMA member, Dr. Thomas Newman, and his wife Nancy hosted the event in their home, hoping to find forever families for 20 of the Humane Society's "adoptables." The event raised over \$67,000 for the Human Society.

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
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
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