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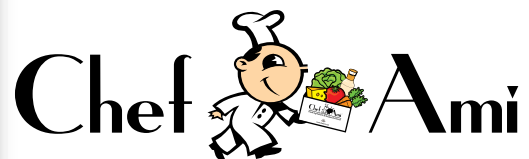
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My Legislative Community

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Cherylle Hayes, MD
Radiation Oncology

Dr. Hayes earned her undergraduate degrees in Nuclear Medicine Technology and Health Physics and became a Physician's Assistant. She went on to earn her Medical Degree at Medical College of Georgia. While there, she completed her residency in Radiation Oncology. Prior to coming to the North Florida Radiation Oncology Team, Dr. Hayes served at the University of Florida as an Assistant Professor. Dr. Hayes is also very concerned about a growing number of women diagnosed with cancer in one breast who choose to have the other breast removed even though, in their cases, doing so is not medically necessary.



Irene Estores, MD
Integrative Medicine

Dr. Estores serves as Medical Director of the Integrative Medicine Program at the University of Florida. She completed her Integrative Medicine fellowship at the University of Arizona Center for Integrative Medicine. Her physical medicine and rehabilitation (PM&R) residency training was completed at the Sinai Hospital - Johns Hopkins Hospital. She received her initial acupuncture training at the University of Miami Center for Complementary and Integrative Medicine and has applied this to the management of both musculoskeletal and neuropathic pain. She completed an Integrative Healthcare Leadership program at Duke University with its Center for Integrative Medicine.



Scott Medley, MD
Retired Family Physician

Dr. Scott Medley practiced family Medicine for 20 years before becoming the Chief Medical Officer at NFRMC. He served as President of the ACMS and of the Florida Academy of Family Physicians, and as Chair of the Gainesville Area Chamber of Commerce. He received the Gainesville Sun Community Service Award in 1987 and was chosen Florida Family Physician of the Year in 1992. He currently is retired and Volunteers at Haven Hospice. Dr. Medley has served as Executive Editor of *House Calls* for the past 19 years, and has authored over 80 editorials and articles for this publication.

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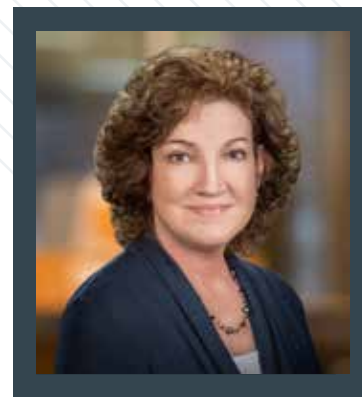
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From the Desk of the EVP



The 2018 Legislative Session

Jackie Owens, ACMS Executive Vice President



The Regular Legislative Session for the State of Florida convenes a little early this year – January 9, 2018 and concludes March 9, 2018. Due to this earlier schedule, we are presenting “Your Legislative Community” in this issue of House Calls magazine. There are several issues that will affect organized medicine in the upcoming session. The Conference of Florida Medical Society Executives (CFMSE) - of which we are a member, is a professional organization consisting of more than 50 medical society executives representing and supporting physicians in state of Florida. They, along with the Florida Medical Association (FMA), support and/or oppose the following upcoming bills:

Support:

Appropriate Utilization of Opioids -

SB 8 (Benacquisto) HB 21 (Boyd) - SB 458 (Bean)

One of the greatest challenges facing communities across the country is the crisis with opioid use and treating dependency. The CFMSE supports restrictions in the supply of opioids. Component organizations are engaged across the state educating physicians on appropriate prescribing of these highly addictive medications. County Medical Societies have been active locally working with elected officials, medical professionals, and law enforcement to educate the public and protect our communities. Our CFMSE does have concerns with the potential ramifications to the health of some patients that may need opioids to recover from major trauma or for end-of-life care.

Direct Primary Care – Less Paperwork, More Care –

SB 80 (Lee) and HB 37 (Burgess)

One of the most promising developments in health care delivery in recent years has been the Direct Primary Care (DPC) movement. A growing number of primary care physicians nationwide are adopting this innovative model because they are frustrated by the excessive paperwork and regulatory burdens imposed by insurance companies. They are attracted to direct

primary care because of their desire to spend more time with patients.

DPC is an alternative to the traditional fee-for-service model in which patients are charged a simple, affordable flat monthly fee for comprehensive coverage of all primary care services. DPC physicians have been able to control costs by preventing chronic illnesses and reducing administrative expenses. A growing body of evidence suggests that DPC leads to better patient care at a lower cost. The CFMSE strongly supports legislation which would allow DPC to grow by defining direct primary care agreements as a medical service outside the scope of insurance regulation.

Right Medicine, Right Time –

SB 98 (Steube) HB 199 (Harrison)

The CFMSE supports efforts by patient advocates to ensure that appropriate prescriptive treatments are based on a physician's recommendation. Each year, thousands of Floridians are subjected to “fail first” protocols, whereby insurance companies impose their own treatment decisions ahead of treating physicians' medical judgment. This causes delays in care that can lead to unnecessary hospitalizations and sometimes devastating consequences for patients.

Florida needs legislation that allows physicians and patients to override step-therapy protocols when deemed medically necessary and in patients' best interests. In addition, if a patient is currently stable on a drug, step-therapy should not be required to continue usage of that drug because of changes in a health care benefit or plan. Finally, the FMA supports shortening the amount

2018 Legislative Session

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of time for a step-therapy override to be granted. It is time to stop insurance companies from practicing medicine and getting in the middle of the patient-physician relationship.

Retroactive Denials – SB 162 (Steube) HB 217 (Hager)

The CFMSE supports legislation that eliminates the ability of insurance carriers to retroactively deny claims when they have provided a physician with authorization and the physician renders that service in good faith.

Oppose:

Scope of Practice Expansions – SB 524 (Brandes) and HB 431 (Plasencia)

The CFMSE is concerned with proposals that either have already been filed, or likely will be filed for debate in the upcoming legislative session that would expand the scope of practice for non-physicians. SB 524 and HB 431 have already been filed which will enable pharmacists to

diagnose and treat the flu and strep infections under protocols developed by a physician. We also anticipate legislation that will enable optometrists to perform laser surgery.

As you can see, contacting your Senator and Legislative Representative with your views is crucial. We have included contact information on your legislative community so that you may talk with them about your priorities for organized medicine that are being discussed and evaluated during the upcoming session - specifically regarding Retroactive Denial, Appropriate Use of Opioids, Direct Primary Care and Scope of Practice. If you visit their websites, you will be able to email them directly.

To get further involved, join the ACMS as a Delegate this summer at the annual FMA meeting August 3 - 5, 2018 at Loews Sapphire Falls Resort at Universal Orlando. Here physicians formulate a listing of policy positions and directives to be adopted by the FMA House of Delegates and FMA Board of Governors for presentation to the legislative bodies in the state of Florida. This is where your outreach begins.

ACMS We Care Physician Referral Network

The We Care Physician Referral Network is a community-based initiative that coordinates volunteer physicians, dentists, hospitals, and ancillary providers to meet the medical and dental needs of uninsured and poor Alachua County residents. It is a partnership of public and private institutions, agencies, and individuals that responds to the health care needs of the community's under-served population. A health care board provides guidance to the program in response to community health issues and evaluates the efficacy of the agency's programs. The initiative started over twenty-five years ago in response to an overwhelming need for medical services for low income, uninsured residents of Alachua County.

Since 1990 the program has received over 25,000 requests for volunteer medical and dental care. More than half of those requests were met by volunteer professionals. The cumulative total of volunteer medical and dental services provided exceeds \$300,000,000.

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In Memoriam

It is with much sadness that we report that a beloved member of our medical family passed away....

Robert Gerard Mullee, MD

(September 25, 1933 – August 18, 2017)



Dr. Mullee was born September 25, 1933 in New York City. He received his medical training at the University of Florida and worked as an OB/Gyn in Gainesville for over 43 years, practicing at both Alachua General and North Florida Regional Hospitals. One of his greatest loves was, when out in the community, he would be greeted by former patients. He would also often meet their child, whom he had brought into the world. Dr. Mullee contributed untold numbers to the Gainesville community while he served as an OB/Gyn.

He served for several years in the United States Air Force. He enjoyed boating, fishing, running, biking and swimming. He was born Catholic. He and his wife were married and worshipped at Highlands Presbyterian Church.

INTEGRATIVE MEDICINE AND HEALTH



CREATING, SUPPORTING AND EMBODYING HEALTH

Irene Estores, MD
Director, UF Health Integrative Medicine

Personal Observations

One of the ways I observe health trends is by noticing how hospitals are named. When I was a medical student and resident, I trained in “hospitals” or “clinics”. As I progressed in my practice, I noticed that I was working in medical centers that then became integrated health care systems. Most of these systems have since dropped the word “system” and simply refer to themselves as XXX Health. I find this a bit ironic because most of our health care systems are mostly disease management systems, in spite of the name change. But I also see an encouraging subtle, steady shift in thinking about health and how it can be created, supported and embodied.

Are health systems now paying more attention to disease prevention and whole person care because we cannot sustain the costs of the disease management model? We spend more on health care than any other country, estimated to be about \$3.2 trillion in 2015.¹ Are health systems doing this because our patients are more aware of the need for this change to disease prevention and choose to use this? Data from the 2012 National Health Survey of 89,000 adults and 17,000 children conducted by the National Center for Health Statistics, show a third of the persons surveyed used health services and/or products outside their doctor’s office in conjunction with conventional care and 5% used alternative medicine solely.² I now see the terms integrative medicine, complementary and alternative medicine, functional medicine and holistic medicine mentioned more frequently in recent years, no longer in hushed tones. This growing interest may stem from its potential

impact on health care costs, patient satisfaction, health outcomes, symptom management and improvement of functional status, an area of active study with promising preliminary data.³

Are integrative medicine, complementary and alternative medicine, and holistic medicine, really new developments, or simply a reclaiming of older philosophy and practice? When asked to define integrative medicine, I use the description from the Academic Consortium for Integrative Medicine and Health, an organization of academic medical centers and health systems in the US, Canada and Mexico. “Integrative medicine and health reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic and lifestyle approaches, healthcare professionals and disciplines to achieve optimal health and healing.”⁴ To integrate means “to join together or unify disparate components or elements into a coordinated or harmonious whole.”⁵ Integration can occur at different levels. It can occur at an individual level, where the patient’s physical, emotional, mental and spiritual health needs are assessed and addressed. It can occur at a practice level, where health care professionals, regardless of specialty and training, adopt this philosophy in their practice. At an institutional level, it can take the form of coordinated programs and processes to promote health and wellbeing and to manage disease. I notice an interesting parallel between

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these degrees of integration to the processes of creating, supporting and embodying health.

Creating health

As physicians, we are quite familiar with the term pathogenesis: the origin, development and resultant effects of a disease.⁶ In most cases, we seek to understand how disease develops so we can treat or cure it. Although we are now aware of health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity,”⁷ we have little understanding of how health is created.

Research on salutogenesis, or the creation of health, by Antonovsky in the 1970s, sought to find out why some persons remain healthy in the midst of disease-promoting circumstances.⁸ David Rakel describes salutogenic-oriented sessions (SOS), and how they can be incorporated in primary care settings as a clinical visit.⁹ With short clinic visits, mandatory use of EMR, and increasing complexity and chronicity of medical conditions, we are focusing on disease management in spite of our best intentions to practice whole patient care. Rakel suggests a practical strategy using an apt mnemonic RELIEVE: Relationship-centered care built on Empathy and trust creates a positive environment where the clinician can Listen to a complicated story that creates Insight into a problem and results in an Explanation that is consistent with the patient’s Values leading to Empowerment and action towards health. Salutogenesis is a concept that can also extend to a health system and a community.¹⁰

Supporting health

Unfortunately, in a disease-based and disease management system, “health does not pay”! But with research demonstrating the impact of lifestyle-based integrative health programs on coronary artery disease and diabetes prevention, we are seeing a shift in policy. Medicare now reimburses the Ornish Program for Reversing Heart Disease¹¹, and plans to reimburse services for Medicare Diabetes Prevention Programs in 2018.¹² There are innovative models such as the ideal medical practice, a micro-practice model developed in an effort to improve the patient-physician relationship, restore physician autonomy, eliminate cuts and improve

health outcomes.¹³ There are direct primary care and integrative clinics and hybrid integrative medicine practice models with revenues generated from insurance and membership fees fueled by the desire to make health care more health-focused, accessible, and relationship-centered. These models are still navigating treacherous financial waters. Even after initial success, large practices, such as Turntable Health, Beth Israel Continuum for Health and Healing, and the University of Arizona Integrative Primary Care Clinic, have ceased their operations. We still need to find ways to “make health pay!”

Embodying Health

Integrative health practitioners are admonished to be “models of health and healing, committed to the process of self-exploration and self-development.”¹⁴ This admonition should apply to all physicians and must go beyond the cliché “Physician, heal thyself”. We see epidemic rates of burnout not only because we have not paid attention to our self-care, but also as a result of massive changes in health care that have robbed us of the joy and meaning of medicine as a practice and a calling. Health care systems should also embody health by creating a culture of wellness and caring within their organizations. Improving work environments and processes to improve efficiency of practice complement these two domains of self-care and culture change, all three being key drivers of health and wellbeing.¹⁵

Closing Observations

I am encouraged and challenged by what I see, hear and read from my patients, peers, colleagues and teachers, leaders, neighbors and friends since I moved to this city. We all desire to have meaningful and productive lives, and health is the key that opens this door for us.

References available upon request.

INTEGRATIVE MEDICINE, ONCOLOGY, AND BEYOND

Cherylle Hayes, MD
NFRMC: The Cancer Center



How many of your patients are taking vitamins, supplements or eating chia seeds with every meal? How many come in with a long list of problems and medications for each problem? How about utilizing some form of complementary medicine? From where are they gathering their information?

Research has shown that between 38-60% of cancer patients are using complementary medicine without informing their healthcare team. This means patients are gathering information from friends, relatives, and the internet while not including their healthcare team in the process. This is one of the most important reasons why integrative medicine is critical to incorporate into oncology care at the time of diagnosis. We have a habit of helping patients when they feel they are at a point where their daily life has somehow failed them. I have many patients ask me about Curcumin (turmeric root) on a routine basis. It is a very well researched anti-inflammatory, but do patients understand the difficulty of absorption or the amount required for benefit or that it requires fat and pepper for improved bioavailability? Not to mention the individuality of their ability to absorb this substance.

Both functional medicine (FM) and integrative medicine (IM) are the future of conventional medicine. They seek to identify and address the root causes of the real drivers of disease and view the body as "one integrated system, not a collection of independent organs divided up by medical specialties". They look at mechanisms of "WHY" disease occurs and address the functional systems of the body. Lifestyle and environment affect our individual genomes leading to Imbalances of the basic biologic systems. How do we address multiple phenomena that cross multiple medical specialties like inflammation, oxidative stress, toxicity and energy problems in the cells that make up your body. Labeling imbalances in the network of biologic systems as "symptomatic disease" and giving the disease

a pill may not address the root cause of the disease. It is estimated that 81% of Americans take at least one medication a day. Let's not stop there- this is not just an American problem - it is a global problem. We have seen China move towards the obesity epidemic as well. Worldwide the number one medication is an anti-cholesterol medication. Drugs obviously are not the only answer to treating disease. As many of you know, we are raising the first generation of Americans who are going to live sicker and die younger than their parents. I ask myself what is the definition of insanity? Doing the same thing over and over and expecting a different result.

Top worldwide causes of death are heart disease, diabetes and cancer and are the result of the top six risk factors for death including high blood pressure, tobacco use, high blood glucose level, physical inactivity, obesity and high cholesterol levels. It has been quoted that "Global deaths will account for more than 50 million people dying from preventable and often curable chronic diseases caused by toxic stress and diets washing over our genes creating new diseased phenotypes." Is this going to be our new norm?

In my family I have seen the suffering as most of you have, too. I've personally suffered as well, which forced me to take a deeper look into the "why" chronic diseases occur. We have come to accept a whole list of complaints as normal. To name a few "joint pain, skin disorders, back problems, high cholesterol, bloating, fatigue, reflux, diabetes, headaches, trouble sleeping, anxiety, high blood pressure, etc. The majority of health care utilization and costs in middle-aged and older adults are for chronic conditions. Nearly $\frac{3}{4}$ of Americans are overweight, one in two will have heart disease and one in three children born today will have diabetes, one in four

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will have major depression, one in five children will have a mood or behavioral disorder and one in 10 of us over the age of 65 will have dementia. The World Economic Forum reported that the global spread of chronic disease is one of the biggest threats to global economics. It is reported that 78% of health care costs (~\$2.1 trillion) are driven by lifestyle and environmentally-related preventable chronic disease (as per the Congressional Budget Office) resulting from what we eat, our sedentary lifestyle, chronic stress and environmental toxins. "Peeling the onion" of chronic disease and putting ourselves back together cell by cell or system by system may help us to prevent, treat and even reverse the global epidemic of chronic diseases, which quite frankly we cannot afford.

Integrative medicine creates this trusted source for patients to gather evidence-based information regarding complementary therapies to maintain a high quality

of life through the cancer process. The Society of Integrative Oncology created the first clinical guidelines for Integrative Oncology in 2009. Discussing the effectiveness found through research for mind-body techniques (mindful-based stress reduction, meditation, Tai Chi), acupuncture, massage, diet, exercise, yoga, and nutritional supplements.

For FM and IM to flourish, it requires a multi-layered approach which includes physician acceptance, an integrative practitioner with strong biomedical understanding, and empowered patients. I locally work with JJ Williams, AP, DOM, and have had the appreciation for celebrity physicians who have helped bring the field of integrative medicine and functional medicine to the forefront - namely Drs. Andrew Weil and Mark Hyman.

References available upon request.

In Memoriam

It is with much sadness that we report that a beloved member of our medical family passed away...

Betty Lou Bottoms Grundy, MD **(January 3, 1940 – June 11, 2017)**

Betty Lou Bottoms Grundy, MD, age 77 of Gainesville, passed away Sunday, June 11, 2017.



Betty attended medical school at the University of Florida. She graduated near the top of her class in 1963, one of the first women graduates from the College of Medicine.

A pioneer for women in medicine, Betty first worked as the company doctor for the Homestake Gold Mine in South Dakota — hired after being told, "we don't really want a woman doctor, but we're desperate." She completed her anesthesiology residency in Boston and entered private practice in Saginaw, Michigan. After assistant professorships at Case Western Reserve and the University of Pittsburgh School of Medicine, in 1982 Betty was appointed as the chief of anesthesiology at Oral Roberts University School of Medicine in Tulsa, Oklahoma — one of the first female department chairs in the country. Betty returned to the University of Florida in 1984, as a professor in the Department of Anesthesiology and Chief of Anesthesia Services at the Veterans' Administration Medical Center.

Betty contributed immensely to the specialty of neuroanesthesia. She led numerous research studies and generated a prolific list of publications, contributing to preserved brain function in thousands of patients today. She also passionately taught resident anesthesiologists throughout her career, serving as an examiner for the American Board of Anesthesiology and as a visiting professor at anesthesia departments throughout the country. She retired in 1994 from the University of Florida. Betty is survived by her husband Dave of Gainesville; her daughter Jennifer (Ream) Stokley; and her son, Tom of Nevada City, California.

AN EXPANDED TOOLKIT FOR ALZHEIMER'S

Christopher L. Bray, MD, PhD
NFRMC Internal Medicine



Dementia, like most non-communicable chronic diseases that plague our country, is a frustratingly common and debilitating condition which leads to significant disability and increased healthcare costs. For families caring for a patient with severe Alzheimer's, the overall burden is best described as crushing. As physicians, our dementia toolkit is often viewed as frustratingly small and inadequate. Most of the hundreds of drugs targeting the presumed biochemical basis of Alzheimer's have been expensive failures. As physicians, we recognize that lifestyle determinants contribute to risk, but feel inadequately trained to engage in meaningful lifestyle discussions and behavioral modifications. This training deficit has driven some physicians, especially at the front-lines of patient care in primary care, to seek additional training through integrative medicine training programs. In this article, I explore an integrative medicine toolkit that could be used in treating a patient suffering from or concerned about the cognitive decline of Alzheimer's.

Background on Alzheimer's

Alzheimer's (the biochemical diagnosis) causes approximately 60% of all dementia (the clinical diagnosis). This neurodegenerative disorder results in loss of synaptic connections, disruption of functional networks and ultimately brain atrophy. The Alzheimer's pathology is characterized by a presence of amyloid plaques with neurofibrillary tangles with increased phosphorylated tau protein deposits in the brain, particularly in the hippocampus. Genetics and environmental triggers synergize in this pathologic dance. The synaptic failure ultimately leads to cognitive and behavioral impairment. The loss in occupational productivity, social connectivity and functional disability results in high emotional and financial consequences for the patient and caregivers.

While ranked by the CDC as the sixth leading cause of death with 93,541 attributable deaths for 2014 (PMID:28542120), other analyses have challenged this estimate. A reanalysis of the same data showed rates of Alzheimer's attributable death as 6 times higher than CDC statistics based on overlooked connections in death certificate reporting (PMID:24598707). If accurate, this would make Alzheimer's the third leading cause of death. Furthermore, the prevalence of dementia is increasing at a staggering rate. A study published just recently found that while the incidence may be declining, the prevalence will still more than double by 2050 (PMID: 28873124). By that time, the yearly cost of Alzheimer's is expected to rise to \$1.2 trillion. It is estimated that an intervention able to delay onset by 5 years would reduce Medicare costs by \$283 billion.

Alzheimer's is classically described as incurable with a long period of preclinical disease. Clinical diagnosis traditionally relies on a careful history and neurocognitive testing. Newer diagnostics, not used in routine clinical practice, include detection of elevated tau and depressed amyloid in the cerebrospinal fluid. MRI has sometimes been a part of the evaluation to rule out masquerading neurologic conditions. Early diagnostic approaches have used new volumetric MRI studies of the hippocampus as well as FDG-PET amyloid scans.

Unfortunately, despite a large research investment, drug development for Alzheimer's has been disappointing. Current FDA approved therapies involve symptomatic treatments that modulate neurotransmitters acetylcholine or glutamate - cholinesterase inhibitors or partial NMDA antagonists. Of the cholinesterase inhibitors (donepezil, rivastigmine, galantamine), donepezil is the most commonly prescribed treatment. A Cochrane Review from 2006 analyzed the available

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trials, compared 10mg of donepezil versus placebo and found a 1.3 point improvement in MMSE from baseline after 12 weeks, 1.5 points after 24 weeks and 1.8 points after 52 weeks (PMID:16437430). At 24 weeks, donepezil showed a 3% improvement on the ADAS-Cog, another neurocognitive test often used in Alzheimer's research. The clinical relevance of these improvements was not as well reflected in an assessment of global clinical state, where most of the benefit was scored in the no change or 'minimal' improvement range. Donepezil was unfortunately not found to affect patient-rated Quality of Life. The efficacy of our best treatment is remarkably underwhelming.

The Search for Alternatives

When I was in training, physicians delivered evidence-based medicine by learning the details of drug trials and using that as ammunition to start or change medications on patients with a defined diagnosis. In some cases, it was challenging to persuade patients or family to absorb the expense and inconvenience of adding medications when patient-valued outcomes were marginal. "I can improve your MMSE score by two points after 52 weeks of treatment with this \$300 per month medication," I might have advocated. It worked most of the time because I had nothing else to offer a patient concerned about their deteriorating memory. Fast forward to today's empowered patient, the hope of lifestyle modifications and the promises from supplement manufacturers is widespread in direct-to-consumer health advertising. Patients either expect their physicians to be the expert in all health-related knowledge or instead flip the channels to their most popular internet blogger or slick salesperson with a new book or infomercial. I face this interaction frequently in clinic practice. In fact, after a while, I eventually became an expert at dismissing these self-help treatments proposed by my well-meaning patients. After my dismissal, I continued my jovial path of righteousness until patients started trickling back to report to me their success with some new diet fad or some peculiar alteration in their lifestyle. Slowly, I started seeing that for certain motivated patients, they could lose 80lbs or drop their A1c by 6 points or fix their once-thought-refractory IBS symptoms or reverse their need for thyroid replacement – all with strategies not discussed in my textbooks and guidelines. And those observations, while not part of a randomized-controlled trial, were still a type of evidence that nagged at my thoughts.

Curiosity led me to dive into the peer-reviewed literature for data that supported my clinical observations. Shockingly, I was usually able to find a reasonably robust pool of literature supporting lifestyle interventions for the prevention and treatment of chronic disease. Obviously, the research is plagued (from a clinician's perspective) with observational studies that can be inappropriately interpreted as causative, small poorly designed studies with inappropriately broad conclusions, and in-vitro or animal studies that may not have any relevance to human therapies. But after sifting through the chaff, there are still countless studies that have been underappreciated and underutilized by clinicians.

The intrigue of having a patient ask about a lifestyle intervention and then having an evidence-based answer was fulfilling for me. Ultimately, this led me to educational talks by integrative medicine physicians like Dr. Andrew Weil. The content was not one of magical alternative medicine treatments with spectacular promises and little evidence, but rather evidence-informed and common-sense approaches involving lifestyle changes to combat the escalating rates of chronic disease. I started to realize that I had informed my patients a thousand times to "eat better, stay away from fatty fried foods, exercise more, and watch your weight." But few of them made any significant changes with that simple advice, so I usually resorted to heroically starting a life-saving medication very quickly. Until I reviewed the lectures and books of the early leaders in integrative medicine, I didn't really see the nuances in listening, communication, and motivational change that would more significantly impact the health of the individual patient sitting in front of me. That's what started my interest and formal training in integrative medicine.

Now, when a patient comes to me with concerns, I can pull from a broader range of evidence-informed therapies to help them. My toolkit has expanded. Not only is this attractive to patients who feel more involved and empowered with steering their health, it is more fulfilling for the physician. Patients might be interested in prevention of Alzheimer's because they were traumatized seeing their parent suffering. Or patients that are showing early signs of dementia might want to know what can they do to delay what is perceived as an inevitable decline in their cognitive performance. In

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either case, I can always discuss the standard-of-care options with a patient, but additionally feel comfortable discussing lifestyle interventions that have shown promise. In many cases this inspires hope by giving the patient tangible tasks rather than just helplessly waiting for the disaster of Alzheimer's (or other chronic disease) to unfold. Integrative medicine is not formulaic in its delivery. If a patient shows no interest in discussing lifestyle interventions, we have no obligation in torturing someone with pedanticism. If a patient can't do one type of exercise because of physical limitations, then we can discuss alternative exercises. If patients can't imagine themselves eating fish, then we don't prescribe a diet that includes fish. Just like the uniqueness of our patient, our treatment plan must also be unique. This often makes an inflexible application of randomized-controlled trial data problematic and strikes fear in the heart of a novice or rigid clinician. However, this nuance and subtle weighing of risk and benefit in the setting of uncertainty and complexity is what elevates the profession of medicine from methodical to artistic, from robotic to humanistic. In the next section, I will explore a few tools in the integrative medicine toolkit used with patients battling Alzheimer's.

Diet

Recent research presented at the 2017 Alzheimer's Association International Conference (AAIC) in London showed convincingly that a Mediterranean diet or the low-sodium DASH diet can improve aging cognition by 30% (www.aaic2017.com). The key features of the Mediterranean diet include eating primarily plant-based foods, such as fruits and vegetables, whole grains, legumes and nuts. Butter is replaced by olive or canola oil. Herbs and spices replace salt. Red meat is limited to only a few times per month. In the classic definition of the Mediterranean diet, fish and wine are encouraged. However, in some component analyses (PMID:20502015), fish and wine did not contribute to the cognitive benefits of the overall dietary intervention. In comparison, the DASH diet is one high in fruits and vegetables and low in overall fat and saturated fat. The DASH diet is rich in potassium, magnesium and calcium. The design of the DASH diet was based on plant-based foods which had been found to significantly lower risk for cardiometabolic disease. The study diet added a degree of flexibility as to better engage the palate of the average American. The MIND (Mediterranean-DASH Diet

Intervention for Neurodegenerative Delay) diet has been studied rigorously showing substantial slowing of cognitive decline with age - equivalent to being 7.5 years younger (PMID: 25681666). Like the Mediterranean diet, the MIND diet emphasizes a high intake of vegetables, berries, nuts, olive oil, beans, whole grains and fish. It minimizes butter, cheese, red meat, fried foods and pastries / sweets.

While macronutrient manipulation has shown promise in reducing dementia, another form of dietary modification that has shown promise is intermittent fasting (IF) or time-restricted eating (TRE). There is mounting evidence that Alzheimer's dementia is a metabolic disease and that IF or TRE, important tools in battling metabolic disease, result in suppression of the mTOR pathway (involved in aging) and enhancement of BDNF (brain-derived neurotrophic factor – a critical factor in upregulating synaptoblastic activities). Similar to fasting, nutritional ketosis has also become a popular therapy for dementia. It is believed that MCT (medium chain triglycerides), a component of Axona, a prescription medical food for Alzheimer's patients, may function by harnessing the metabolic flexibility of neurons to use lipids as an alternative fuel source, as also occurs during the fasted state. MCTs, specifically caprylic acid, comprise a popular nutritional supplement popularized for cognitive enhancement called Brain Octane™. Another likely benefit from IF, TRE or nutritional ketosis has to do with a reduction in the reactive oxygen species associated when switching to a non-glucose cellular fuel source.

It is important to note that the Greek origin of the word diet "dieta" translates to the phrase "way of life." The scope of a diet in medical discussions is often limited to a patient's food choices, however, food choices are inextricably linked to other lifestyle choices as well. In the case of a Mediterranean diet, meals are typically eaten socially with friends and family and physical activity is a regular part of one's life. It is interesting to recognize that at the time Ansel Keys studied the health benefits of the original Mediterranean diet, many of the observed participants were also engaged in religious fasting rituals. Hence, to prescribe a "Mediterranean diet" may actually encompass more than instruction on food choices.

Specific targeted dietary interventions that have

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shown promise for supporting normal cognitive function involve normalizing levels of DHA (docosahexaenoic acid, a type of omega-3), Vitamin D, Vitamin B12 and Vitamin E. Anti-inflammatory foods like curcumin and plant bioflavonoids also have evidence of reduced Alzheimer's progression - perhaps through reduction in the damage caused by reactive oxygen species. Unfortunately, some environmental nutrient exposures may also worsen or contribute to the pathology of Alzheimer's. Excess copper or other heavy metals like mercury may be important factors in triggering brain inflammation and Alzheimer's plaques. Large predatory fish, like swordfish, shark, and tuna have notably high levels of mercury as reported by both the EPA and NRDC. So, it is prudent to be cautious with these exposures.

Exercise

With the plague of inactivity from our increasing dependence on electronic devices and fossil-fuel-burning vehicles, our investment in physical activity is shrinking. Encouraging more physical activity and exercise among our patients should be high on our list of priorities. Marc Hamilton, PhD, an inactivity researcher at Pennington Biomedical Research Center, declared sitting as "the new smoking." In addition to the physical strength and endurance enhanced by exercise, there is reasonable evidence that exercise is critical to maintaining cognitive health as well. Indeed, work from Barnes and Yaffe (PMID:25030513), found that physical inactivity was the most significant modifiable risk factor for Alzheimer's disease from among the seven that were analyzed (diabetes, hypertension, obesity, physical inactivity, depression, smoking and low educational attainment). Although dietary factors were not included in the analysis, these seven factors were still estimated to cause at least half of Alzheimer's cases. A recent meta-analysis analyzing the role of exercise on cognitive function in 35 studies with 3,113 participants (PMID:28546744) found significant improvements from low to moderate aerobic exercise on cognitive function and preventing cognitive decline.

It is recognized that exercise results in a reduction of inflammatory signals IL-6 and TNF-alpha as well as a significant increase in BDNF. While exercise is a mild stress on the physiology, the net effect of exercise also lowers the stress hormone, cortisol. Exercise enhances the ability of the circulatory system to provide oxygenated blood and nutrients for brain repair, angiogenesis and synaptogenesis. Exercise additionally provides a complex

stimulation of the nervous system (gardening, dancing and Tai Chi) all involve a complex interplay between subtle sensory, high-level processing and subtle motor neurons). When it comes to brain health, the saying "use it or lose it" is quite applicable. Physicians should strive to be in harmony with the World Health Organization recommendations of 150 minutes of moderate-intensity aerobic exercise weekly.

Sauna

The role of sauna use in chronic disease prevention, including all-cause mortality, cardiovascular disease, and Alzheimer's disease is a fairly recent, but nevertheless, a remarkable observation. Regular sauna use was associated with a 65% risk reduction in Alzheimer's (PMID:27932366). The same research team in 2015 published that regular sauna use was associated with 48% reduction in fatal coronary heart disease and a 40% all-cause mortality reduction (PMID:25705824). While most of the expected confounding variables were controlled in these studies, causation cannot be definitively ascertained without Randomized Controlled Trials (RCTs). It is interesting to conjecture whether this regular sauna use is lowering the risk via a direct endothelial mechanism, a benefit similar to exercise, or because sweating is reducing some toxin (such as a heavy metal). Further studies are needed, but in the meantime, there are relatively few risks to sauna use in the typical patient trying to prevent cognitive decline.

Chronic Stress

We are all aware from the cardiovascular literature that stress is an important causative factor in cardiovascular disease, particularly acute events. One striking example is Takotsubo cardiomyopathy. Stress can also cause transient vascular vasospasm and microvascular dysfunction, contributing to acute vascular events. Based on animal research, we recognize that stress similarly has effects on neurocognitive function with a reduction in BDNF. Design of human studies to confirm the role of stress - to consistently and appropriately induce chronic stress and to provide a one-size-fits-all treatment approach to experimentally lowering stress - are challenging. Human studies causally linking the effects of chronic stress on dementia are lacking, but obviously strongly suspected based on observational studies.

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Stress can be both beneficial and destructive. Intermittent doses of stress can motivate one's mind and body to grow and strengthen. However, chronic unrelenting stress can function to tear one's mind and body down. Learning a new language or a musical instrument can be viewed as an acute stress, but usually functions to enhance our cognitive abilities. Chronic stress, such as an abusive marriage, is unfortunately associated with brain atrophy and progressive cognitive decline. Other lifestyle factors further confound the impact that stress has on our brain health, including diet, exercise, sleep and mood. So, in the setting of a poor diet, low physical activity, poor sleep and depression, even potentially beneficial stressors could generate a toxic response for an individual patient.

Physicians are often presented with the difficulty of seeing the negative effects of stress on their patients. While encouraging patients to remove a stressful influence is sometimes feasible, many times it is not. For patients unable to exclude stressful influences, despite a thorough evaluation of their core values, the next step for the physician would be to encourage the patient to lessen the persistent "focus" on those stressful influences. It is very popular these days to recommend mindfulness strategies for stress and anxiety reduction. Many times, these mindfulness strategies have already been a part of the patient's life, but in a less prescribed manner. Petting an animal, immersing in restorative music, hugging a loved one, taking a stroll in nature, engaging in prayer or meditation, relinquishing some elements of work or home responsibility – can all help patients better cope within a stressful environment through mindfulness. This is where physician common sense and empirical wisdom may trump lack of clinical data from a randomized control trial.

Concluding Remarks

In September 2017, the American Heart Association (AHA)/American Stroke Association (ASA) issued a new "presidential advisory" to promote brain health which included seven steps, called "Life's Simple 7." The seven steps include 1) nonsmoking status, 2) physical activity at goal, 3) body mass index less than 25 kg/m², 4) healthy diet consistent with guidelines, 5) untreated BP less than 120/80 mmHg, 6) untreated total cholesterol less than 200 mg/dL, 7) fasting blood glucose less than 100 mg/dL. These factors highlight the interplay between obesity, metabolic syndrome and cardiovascular risk factors which

have clearly been found associated with dementia in population studies. As a healthcare provider, regardless of our specialty, we should incorporate these prevention strategies in our toolkit for patients at risk or suffering from Alzheimer's. The health promotion benefits of smoking cessation are obvious to all, but yet we do not have a human RCT showing that smoking cessation prevents Alzheimer's, just observational data. Why then should we avoid health promotion in the realms of diet, exercise, sauna use and stress mitigation? This is where an integrative medicine provider would say – what's the risk of promoting these lifestyle factors with a receptive patient?

There is currently a 2-year \$20 million clinical trial (US POINTER - US protect through a lifestyle intervention to reduce risk) studying a set of lifestyle interventions on prevention of Alzheimer's. This study will start in 2018 and involve 2500 older adults with no cognitive symptoms. Similar lifestyle intervention trials have been or are being conducted in other countries around the world – FINGER, SINGER, MYB trial, and MIND-AD. The FINGER (Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability) trial studied the randomized intervention of nutritional guidance, physical exercise, cognitive training and social activities, and management of vascular risk factors (versus regular health advice) on the cognitive function of 1,260 60-77 year-olds from Finland (PMID:25771249). There was on average, a 25% higher performance in the intervention group versus control on a comprehensive neuropsychological test battery after 2 years. These trials are remarkable, because they involve multidomain interventions.

Dale Bredeesen, MD, a neurologist with training from Duke and UCSF, has been leading a similar multimillion dollar research project on multidomain lifestyle interventions to slow and reverse cognitive decline. Preliminary peer-reviewed results using his ReCODE protocol are remarkable (PMID:27294343), sometimes reversing disabling Alzheimer's in individuals enough to allow them to regain employment. Dr. Bredeesen conjectures that there is a balance between synaptoblastic and synaptoclastic factors in the brain, much like those controlling bone density. A loss of synaptoblastic factors (like essential nutrients and hormones) or an increase in synaptoclastic factors (stress, inactivity, heavy metals) can accelerate the pathological changes of Alzheimer's.

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The present article is as much about dementia as it is about integrative medicine. In September 2017, a \$200 million-dollar grant was gifted to UC Irvine to help foster an integrative medicine approach to chronic disease. Howard Federoff, MD, PhD, a researcher in neurodegenerative disorders and UC Irvine's new vice chancellor for health affairs stated "It is becoming clear that the existing modern focus on specific disease sites is unsuitable to meet the needs of entire populations beset by chronic conditions. We are reaching a tipping point in which a holistic approach is required." Integrative medicine is defined by the Academic Consortium for Integrative Medicine & Health as "the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals, and disciplines to achieve optimal health and healing."

Unfortunately, there is a stigmatized label around the practice and use of integrative medicine. Integrative medicine has its share of advocates that promote incorrect or unsubstantiated and risky ideas as truth - or even worse - as conspiracy. The so-called "quacks" and "quackery" are indeed real scourges of the entire medical system, requiring a vigilant guard. Pseudoscience can be used to drive unscrupulous people and companies to gain profit. The explosion of probiotic supplements is one example, in my opinion. While the idea of microbiome manipulation is exciting and as radical as discovering a new organ of the body, our interventional studies using specific strategies with specific strain combinations are still notoriously limited. Similarly, prescribing an herbal product or other supplement without a system to insure consistency, integrity and purity of those products is frustrating at best and dangerous at worst.

Labels in general are often excuses to elevate or denigrate unfairly. In my humble opinion, instead of seeing integrative medicine as a separate entity, we should be simply calling good medicine as good medicine. It is as much good medicine for a primary care physician to control hypertension as a cardiologist or a nephrologist. Similarly, it is just good medicine to incorporate low-risk, high-value, and effective lifestyle education into our treatment recommendations for patients with chronic disease. The cost of chronic disease in this country is literally bankrupting our healthcare system. The RCT studies of

lifestyle interventions will not catch up fast enough to curb the voracious growth of our healthcare costs from lifestyle-associated non-communicable chronic disease. Gaining skill and nuance at influencing our patients to adopt healthy lifestyles only makes common sense at this point in time. The label of integrative medicine is unlikely to go away because residency training programs are necessarily limited in time and there will always be people that want to learn more about the power of lifestyle changes in influencing the course of chronic disease. However, at least in the case of Alzheimer's, all physicians should consider adding some of these discussed low-risk, high-value tools into the toolkit.

The occupation of a doctor (definition: a teacher) is one based on love and compassion for our fellow human. It is our responsibility to teach and empower the patient to better themselves through healthy behaviors first and then to administer treatments second. "The young physician starts life with 20 drugs for each disease, and the old physician ends life with one drug for 20 diseases." – Sir William Osler (1849-1919).

References available upon request.



See it First on Facebook!
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Medical Society at
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Contribute to the Robb House Endowment Fund



ROBB HOUSE MEDICAL MUSEUM

This Victorian cottage built in 1878 became the home and medical office of doctors Sarah Lucretia and Robert Robb. Sarah Lucretia was the first woman physician in Alachua County. She practiced medicine from 1884 to 1917.

Help Us Put on a New Roof!

It's been 30 years since the Robb House roof was replaced, and we need your help. Please make your contributions to the Robb House Endowment Fund through the ACMS Foundation.

Robb House Endowment Improvements To Date:

- Carpet Replacement
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- Electrical Work
- Insulation Replacement
- Porch Repairs
- A/C Repairs

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HAPPEN

ACMS



Matheen Khuddus, MD, ACMS President; Fan Ye, MD; and David Winchester, MD, ACMS Past President.



L to R: Robert Balbis, DO; Arthur Lee, MD; Ms. Olivia Lee; and Ilie Barb, MD.

ACMS Tap Room Tuesday Loosey's Haile August 22, and September 26, 2017



L to R: Norman Levy, MD, ACMS Past President; Roslyn Levy, Alliance Past President; and Harry Meisenbach, MD.



L to R: Thomas R. Beers, MD; Ronald C. Jones, MD; and Evelyn K. Jones, MD winning the Community Bank & Trust door prize.



L to R: NFRMC Resident Physicians Pritam Brar, MD; Eddie Murgasen, MD; and Priyanka Kapoor, MD.



L to R: Eduardo Marichal, MD; Mr. John Roberts, VP Commercial Banking, Community Bank & Trust of Florida; and Mrs. Nida Marichal.



Ira Gessner, MD, and Keynote Speaker
Timothy Flynn, MD.

**ACMS October Dinner Meeting and Fall
Vendor Show**
UF Hilton Conference Center
October 10, 2017



Jackie Jackson, MD and
Ms. Corinne Gelfand Lipnick.



L to R: Mr. Jeff Sims; Ms. Dana Nemenyi, UF
Health Business Development and
Charles Riggs, MD.

UF Homecoming Parade
Community Bank & Trust of Florida
October 6, 2017



L to R: John Roberts, VP, Community Bank and
Trust of Florida and Caroline Rains, MD.



Scott Medley, MD, and Carl Dragsted, DO.



L to R: Howard Noble, MD; Mr. Lloyd Alford; and
Judith Lightsey, MD.

HAPPENINGS

ACMS



Norman Levy, MD and Lindsay McCullough, MD, UF Resident Physician.

ACMS Tap Room Tuesday Loosey's Haile October 17, 2017



Ronald Jones, MD and
Glenn Rousseau, MD.

Practice Management Network Luncheon Napolitano's Restaurant November 2, 2017



From L to R: Jay Hutto, CPA, James Moore CPAs; Ms. Candice Rogers; Ms. Darla Williams; and Mr. Richard Fiorello with Real Time Medical Billing; Ms. Jackie Owens, ACMS EVP; and Speaker Mr. Mike Smuts, Chief Cannabis Operations Consultant, The Green Solution.



Ms. Dana Nemenyi, UF Health Business Development and Mr. Ed Jimenez, CEO, UF Health Shands.



Mrs. Sandy Fackler

Grand Opening Celebration: UF Health Heart & Vascular Hospital and UF Health Neuromedicine Hospital Gainesville Florida, November 2, 2017



L to R: Michael Good, MD, Dean, UF Health College of Medicine; Mr. Russ Armistead; and Henry Baker, PhD.



Mrs Chris Riggs and Charles Riggs, MD.



L to R: Mrs. Joyce Stechmiller, PhD; Bruce Stechmiller, MD; Norman Levy, MD, PhD; and Mrs. Roslyn Levy.

L.A. ADDENINGS



L to R: Matheen A. Khuddus, MD, ACMS President; Keynote Speaker Kristy Kramp, JD, LHRM, with MedMal Direct; and Ronnie Lamb, Medical Relationship Manager, SunTrust Bank.

ACMS November Dinner Meeting Plantation Hall at Haile Village Center November 14, 2017



L to R: Robert Ashley, MD; Scott Medley, MD; and Christopher Bray, MD.



L to R: Mrs. Ellen Gershow; Michael Lukowski, MD; and John Shahan, MD.



Jean Cibula, MD, and Albert Robinson, III, MD.



L to R: Michael Wiggins, MD; Meera Nair, MD; and Livio Pardi, MD.



Livio Pardi, MD and
Brandon Hogue, SunTrust Bank.

ACMS November Dinner Meeting Plantation Hall at Haile Village Center

November 14, 2017



L to R: Cherylle Hayes, MD; Keynote Speaker Kristy Kramp,
JD, LHRM; and Elias Sarkis, MD.



L to R: Dale Syfert, MD; Richard Neyberger, MD; Howard Noble, MD;
and
Mrs. Barbara Noble.



L to R: Betsy Beers, MD; Thomas Beers, MD; Rogers Bartley, MD; Mrs. Shannon Ashley and Robert Ashley, MD.



Dr. Medley is a retired Family Physician
Volunteers at Haven Hospice

A Note from our Editor

24/7/365, JUST LIKE US

SCOTT MEDLEY, MD

House Calls Executive Editor

[I don't like clichés. I'm tired of hearing, "We're going to give 110%," or, "We're going to take this to the next level." And I really don't like overused clichés (I guess that's redundant) such as, "We're going to think outside the box." Well, I'm sorry, because this issue of HOUSE CALLS featuring Integrative Medicine is, indeed, "outside the box" of traditional Medicine. It follows, then, that the following Editorial is also "outside the box"-interviewing the principals of a company that has little to do directly with Medicine. The similarity is that-like physicians and hospitals-this company must provide excellent, reliable service 24 hours a day, 7 days a week, 365 days a year, including Holidays and "through all kinds of weather".

BUT LET ME BEGIN WITH A TRUE STORY ABOUT OUR HOME INVASION. It was Wednesday, November 27th, 1987-the day before Thanksgiving. Sleeping soundly at our home here in Gainesville, I was rudely awakened at about 5 AM-it was still very dark outside-by the sound of loud music emanating from our kitchen area. Thinking that one of our children, then ages 9 and 6, had inadvertently set the music alarm on our counter-top radio, I stumbled down the hallway toward the kitchen and the loud music. **THEN I STOPPED COLD!** I heard the unmistakable sound of someone in our nearby living room! Turning on my heels, I headed back to our bedroom, startling my sleeping wife with cries of "Where's my damned baseball bat? There's someone in our house!" That's when I heard our front door slam, as the intruder loudly exited our home! Our children-thank goodness- continued to sleep through this ordeal. Of course, we phoned the police, who came

immediately and found a jimmied-open window with footprints outside, where the intruder had entered our home. The courteous and respectful policemen informed us that this was probably the work of the "Cat Burglar", who recently had been burglarizing several houses in the Gainesville area, often while the residents were in the home! He apparently had been attempting to steal the radio in our kitchen-"lifting" small appliances was his specialty-when he accidentally turned on the radio, waking me. As is the case with anyone experiencing a home invasion, we felt shaken and violated.

We did not at that time have a home alarm system. That's where our guests from Crime Prevention Security Systems (CPSS) enter this issue. We, of course, phoned them on that same Wednesday, but with the Thanksgiving Holiday already upon us, we could not schedule our alarm system installation until the following Monday. Needless to say, during that long weekend we spent a few sleepless nights ever vigilant, clutching "weapons" such as baseball bats and hatchets. My dear late Grandmother would have said that "we were as nervous as two long-tailed cats in a room full of rocking chairs". (We subsequently experienced another home invasion in another residence, but that's a story for another day.) Then on Monday the alarm system was installed, expertly and professionally, by the CPSS personnel. And that system has functioned flawlessly, giving my family and me a great sense of security and peace of mind for the past 30 years!]

Recently I sat down with the founder, owner, and CEO of

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CPSS, John Pastore (JP); and with his daughter, Jorgia McAfee (JM), VP of Development at CPSS.

Editor (Dr Scott Medley): “Please tell me how your company became established.”

JP: “Actually, I was doing research in Rheumatoid Arthritis, considering going to medical school. Interested in technology, I was fooling around with a device called a ‘sound discriminator’. In July of 1975, about 42 years ago, I became aware of the need for residential and commercial alarm systems in our community. We established CPSS, and I guess the rest is history. We remain a family owned and operated business. And, we also own and operate Custom Home Entertainment.”

Editor: “How many employees did you have then and now?”

JP: “We started with myself and one other employee, plus my wife Randi Elrad (now the V.P. Of sales) worked with us part-time. Those first few years, I was personally crawling around in attics, hard-wiring alarms. It got pretty hot in some of those attics in the summertime here!”

Editor: “I understand that your company has experienced terrific and sustained growth.”

JM: “Yes, we now have 124 employees in our four locations-Gainesville, Orlando, Jacksonville, and Atlanta. We have about 12,000 customers, but we monitor calls for about 65,000 total customers.”

Editor: “I know that, like medical practices and hospitals, you must have someone available to answer your phones 24/7/365.”



John Pastore, founder, owner and CEO of Crime Prevention Security Systems.

“We have excellent relationships with the police and Sheriff’s departments in all our locations. We work very closely with them”.

JP: “Yes, we receive about 1,000 high priority alarm signals per day-of course, some of these are false alarms, but we manage about 30-60 ‘real’ serious events every month.”

Editor: “Is it difficult to find responsible employees to work all those shifts and odd hours?”

JM: “Actually, we have been very fortunate to continue to find and retain excellent employees. Some employees have been with us for as long as 28 to 35 years. We have a number of great UF students working here, especially during our evening shifts.”

Editor: “Where are your calls answered?”

JP: “We have a ‘secure room’ where our calls are answered. We must be very conscious of security.”

Editor: “Kind of like the CIA or the Pentagon?”

JM: “Not quite that secure and protected, but almost.”

Editor: “How do you work with Law Enforcement?”

JP: “We have excellent relationships with the police and Sheriff’s departments in all our locations. We work very closely with them”.

Editor: “What have been some of your biggest challenges over the years?”

JP: “Certainly, the storms wreaking havoc on our equipment. We dealt with the 4 hurricanes here in 2004. Just this fall, hurricane IRMA was a real challenge for us, because it caused problems in all of our locations-Orlando, then Gainesville,



Jorgia McAfee, Vice President of Development at CPSS.

“Like the hospitals, during a major storm our staff may have to stay here constantly for several days. We are always stocked with food, water and other essentials.”

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then Jacksonville, and finally Atlanta.”

Editor: “How did you manage that?”

JP: “Mainly through our redundant systems with our two central stations. When our monitoring center in Gainesville experienced heavy traffic, we were able to route calls through our monitoring station in Atlanta, and by that time IRMA had progressed north. Once Atlanta had high call volume due to the storm, Gainesville was able to carry the majority of alarm calls.”

Editor: “How do you staff during these storms?”

JM: “Like the hospitals, during a major storm our staff may have to stay here constantly for several days. We are always stocked with food, water and other essentials.”

Editor: “Do you have difficulty convincing your staff members to remain at their stations all that time?”

JP: “Not really. Our staff is very committed to their mission, and we folks in senior management often stay here, too. We try to ‘lead by example’. Our team is trained to perform in emergency situations, and our operational technology is state of the art. Again, we focus on redundant systems. We have industrial backup generators, as well as redundancy in all of our servers. Monitoring our customers is too important to be put at risk with a storm, regardless how big.”

Editor: “Do you have a server in your garage, like Hillary Clinton?”

JP: “No, fortunately we do not!”

Editor: “How has your business changed with the coming of the ‘digital age’?”

JM: “In a word-phenomenally! Our home and business camera installations have increased remarkably over the past few years. A good example: when a ‘latch-key kid’ arrives home from school, we can automatically take a photo of the child entering the home and text that reassuring snapshot to his parents!”

Editor: “What about the elderly, like me?”

JP: “We also perform ‘medical alert’ type monitoring, remaining on the phone with the patient while we call

911. Also, for elderly patients living alone, we can place sensors in areas where the person performs their usual ADLs-activities of daily living. So if the elderly person does not open that bathroom door, or medicine cabinet, or kitchen cabinet as usual, we can alert their designated family member or neighbor!”

Editor: “What are a few of the awards your company has won?”

JP: “Let me list a few for you”

1. One of the Best places to work in Florida from Florida Trend Magazine
2. Business of the Year from the Gainesville Area Chamber of Commerce
3. Ethics in Business Award from the Gainesville Rotary Club
4. One of the Top 100 Security System Companies In the US from SDM Magazine, the leading publication For the security industry.

Editor: “Wow! Very impressive. This has been fascinating. Thank you for meeting with me today and also for keeping my home safe 24/7/365 for the past 30 years!”

JP and JM: “Thank you!”

[Post script: The “Cat Burglar” mentioned above was killed in a gunfight with police in the Midwest several months after ‘visiting’ us, making us even more glad that I had not actually confronted him in our home, and that we continue to regularly use our CPSS alarm system!]

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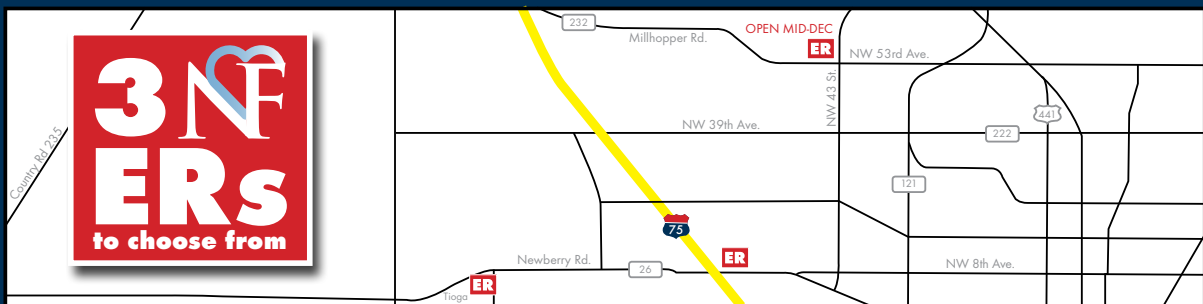
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