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House Calls

WINTER 2019

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From the President's Desk

Matheen A. Khuddus, MD,
ACMS President

Recently a physician colleague told me that he "dreamed of walking away" from medicine, a statement I found both shocking and disturbing. For those of you who have attended an ACMS dinner program or discussed the role of the ACMS with me, you know that I feel strongly about the Medical Society taking the lead in representing and advocating for physicians in our community. Addressing the multitude of challenges facing physicians today is almost always a part of that conversation and is the focus of this edition of *House Calls*. While these issues remain an important part of the conversation related to physician burnout and should continue to be a focus of our advocacy efforts, I have recently become concerned that the extensive discussion surrounding these challenges is overshadowing and detracting from the many positives associated with a career in medicine.

Growing up as the son of Cardiologist in South Florida, I had a pretty good idea of what a career in medicine involved. My dad was one of the hardest working, most dedicated and compassionate doctors I have ever seen. He had only one partner for the majority of his career, alternating call nights and weekends, a structure almost unheard of in Cardiology today. He didn't have a laptop with EHR access that he brought home at night, but would spend extra time in the "chart room" to complete hospital charts. He would work on medical talks with a slide projector, not PowerPoint. Nobody ever faxed or texted him an ECG, he would drive into the hospital when he was needed. He read echocardiograms on tape and angiograms on old fashioned film, a process that is much more inefficient than what is available today. Treatment options for patients with complex conditions such as acute coronary syndrome, valvular heart disease or cardiogenic shock were also more limited and caring for these patients was associated with a greater emotional toll when compared to today. Despite all of this, there was no mention of dissatisfaction or talk of burnout and my father's passion for medicine remained for his entire life.

As busy physicians, we very frequently overlook the many rewarding aspects of our job and we have a tendency to view the extraordinary as just ordinary. I recently saw a patient in the office who has followed up with me regularly since he was first diagnosed with heart failure several years ago. When we first met, he was admitted to NFRMC with decompensated heart failure that was secondary to a hyperthyroid state. During that admission, he asked me to call his daughter in Pennsylvania, a medical student at that time. I explained his condition and treatment plan to her while she politely listened and asked a few questions. At every visit following that admission, he would update me on her career in medicine. At his most recent visit, he informed me that she was completing her fellowship, starting a new job and had gotten married. After showing me the pictures of her wedding, he reminded me that when we first met he told me he had to live to walk his daughter down the aisle at her wedding. As he thanked me, with tears in his eyes, it occurred to me that a "regular day" for anyone of us has an impact on our patients and their families that we too often forget.

Despite all the challenges in Medicine today, being a doctor for me remains the most satisfying and rewarding career I could ever imagine. I am in no way suggesting that the challenges facing physicians today are trivial or should be ignored. The challenges are formidable but they are surmountable. We will and should always work to repair the problems in Medicine but let's not lose sight of the incredible privilege we have to help our patients, impact the lives of others and advance healthcare and medical science. It is with a passion and appreciation of our careers, that we will be best suited to advocate for change as new challenges arise.

From the Desk of the EVP

Professionals Resource Network

Jackie Owens, ACMS Executive Vice President

Recent studies show that physicians have higher rates of burnout, depression and suicide risk than the general population and that they are also more likely not to seek treatment for these problems(1). Professionals Resource Network (PRN) is an important resource through which physicians may receive the appropriate intervention and treatment needed due to addiction, psychiatric illness or depression.

PRN is a private non-profit 501(c)3 organization whose mission is to support the health and integrity of Florida's healthcare professionals, and also the health, safety and welfare of the general public. It is considered one of the premier programs for impaired health care professionals in the United States and is designated as the State of Florida's Impaired Practitioners Program for physicians. Though originally created to serve physicians, it has grown to serve a wide range of health care professionals and other participants. It is an alternative to the Department of Health/Department of Business & Professional Regulation disciplinary process and is designed to assist in the recovery of practicing physicians and to allow them to restore/maintain their licensure. Participation in the program may be voluntary or statutorily mandated.

The program relies on referrals from the impaired professionals themselves, a friend/family member of the professional, or their employer. The goal of intervening is to make sure a problem is recognized and dealt with for the well-being of the professional and to assure safe practice in the workplace. PRN assessments are based on current impairments of the professional and not on any past impairments that may have occurred.

The first step in receiving assistance is recognition of indicator signs, symptoms and behaviors resulting from problems that could impact a professional's ability to practice safely. Chemical dependency is a primary disease with signs and symptoms and a specific course that can be identified, documented and treated(2).

Physical and Behavioral Indicators of Alcohol or Drug Addiction and Psychiatric Illness (source - PRN):

- Observable decline in physical or emotional health
- Atypical weight changes
- Deteriorating personal hygiene
- Personality and behavior changes
- Inability to mentally focus and keep track of a conversation
- Shakiness, tremors of hands, agitation
- Unsteady gait, falls
- Unsatisfactory documentation performances and/or illegible written communication
- Defensive if questioned or confronted
- Alcohol on breath with attempts to cover with mints or mouthwash
- Missed deadlines and/or sporadic punctuality
- Questionable practice judgment
- Increased interest in patient pain control
- Frequent unexplained absences or illness or trips to the bathroom
- Inaccessibility to patients and staff
- Decreased workload or workload intolerance and declining performance

The PRN website also provides "The Medication Guide for a Safe Recovery." This is a guide to maintaining sobriety while receiving treatment for other health problems. It outlines drug safety classifications from Class A (generally safe to take), Class B (with addiction medicine Specialist/Doctor approval only) and Class C (high risk of triggering relapse), and provides a list of common household products that, when taken or exposed to, could produce a false-positive on testing for substances.

The following are Frequently Asked Questions from the PRN website:

What is Impairment?

Impairment is defined as the condition of being unable to perform one's professional duties and responsibilities in a reasonable manner consistent with professional standards. Cognitive function, judgment, reaction time, and ability to handle stress are increasingly affected. As impairment progresses the potential for compromised patient care increases.

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PROFESSIONALS RESOURCE NETWORK

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Impairment may result from dependence or use of mind or mood altering substances; distorted thought processes resulting from mental illness or physical condition; or disruptive social tendencies.

Coworkers and Staff of impaired Professionals often feel frustrated and helpless. Staff morale and performance tend to deteriorate while the impaired professional becomes more impaired. Associated problems usually stay unresolved without effective intervention and treatment of impairment and it's cause.

How does the evaluation process work?

Upon referral of an individual with a suspected illness, and given sufficient evidence, the individual is required to undergo an independent evaluation with a Department Approved Provider (DAP) coordinated by PRN. Such providers have been approved by the Department of Health (DOH), due to their credentials, expertise in treating healthcare practitioners, and the diverse services they offer. PRN will offer the referred individual three (3) options for evaluators based upon the suspected impairment, the intensity/severity of the situation and the geographic location. Evaluations will vary from one hour in-office assessments to 4-7 day inpatient evaluations. A second opinion evaluation by a DAP, and also coordinated by PRN, is always allowed if the practitioner disagrees with the original recommendations.

How is treatment provided?

In those cases where there is a recommendation for treatment following evaluation, PRN will again offer three options for a DAP. This selection will be based on the illness identified, the type of treatment needed, the intensity of treatment required and the geographic location. Treatment modalities will vary from office follow-up for medication management and/or therapy to extended residential treatment for several months.

What are the costs for PRN services?

PRN is a non-profit organization funded through a contract with DOH to implement the statutorily mandated Impaired Practitioners Program (from licensure fees) and through charitable contributions. Participants are not charged for PRN services. The Program has no financial relationship with any evaluator, treatment provider or facilitator. PRN does not provide medical services; therefore, participants pay directly to the providers.

Likewise, in the monitoring phase, the participant pays directly to the provider for urine toxicology screening, for ongoing psychotherapy and to the facilitator of the regional PRN group they attend as a requirement of their contract.

Can a participant still practice?

Initially, the participant may be required to refrain from practice during evaluation and any resulting treatment. The participant may resume practice when given authorization to do so by PRN. The approval for a return to practice is based upon recommendations from approved treatment providers in consultation with PRN staff. Practice limitations are often required during the early phase of return to practice.

Does PRN protect the Practioner's license?

The Professionals Resource Network routinely supports participants in the Program who are in compliance with the recommendations of the Program in the evaluation, treatment and/ or monitoring phase. PRN will work with hospitals, practice partners, insurance carriers, HMO's, disability carriers, DEA, criminal courts, other state impairment programs and other state licensing agencies; and offer support for participants if they are deemed impaired.

As Consultant to the Department of Health, Department of Business and Professional Regulation and the Licensing Boards, PRN supports compliant participants who have disciplinary investigations, complaints, or action taken against their license. Participation in PRN is often used as mitigation in disciplinary cases charging impairment and PRN will speak in support of those in compliance.

To Contact PRN, call (904) 277-8004 from 8:30am until 4:30pm, Monday through Friday. Referral forms are available online at www.flprn.org/referrral. PRN may also be contacted via fax (904) 261-3996 or email to admin@flprn.org.

Volunteer at We Care!

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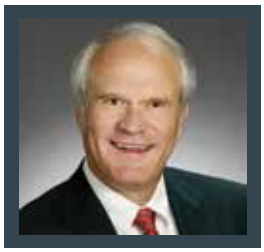
The Challenge of Electronic Health Records

An Informal, Unscientific, Anonymous Poll



Scott Medley, MD
House Calls Executive Editor

I believe that this issue of *House Calls* about Challenges Facing Physicians Today would not be complete without at least a brief piece about Electronic Health Records (EHRs). Complaints surrounding this subject are by far the most common that I hear from physicians. Much has been written, discussed, and "cussed" about EHRs. But I thought I would go directly to the source and ask a dozen of my physician colleagues who are still in practice in various specialties in private practice and in academia how they feel about EHRs.

Following are the answers I received to the question, "Tell me briefly what you think about EHRs.":

"They are a lot of bad, but probably more good than bad. They sure have helped with the legibility issue."
- -- From a Hospitalist

"They are horrible. I must begin my day at 5:30 a.m. just to keep my EHRs up-to-date."
---From a Surgeon

"They are awful. But they have been forced on us, so I just have to 'go with the flow'."
---From a Subspecialty Internist

"They are actually very useful. Now that I'm finally used to them, they're very helpful."
---From a Pathologist

"They're gradually getting better. The technology dragged along for awhile, but it's finally beginning to catch up."
---From an Internist

"I think they are terrible. They are all-consuming. Some weekends I spend 30 hours just trying to keep up with the requirements". ---From a Surgeon

"I realize that they are necessary and I'm reluctantly getting used to them. Many times the 'voice to text' software can be very frustrating". ---From a Radiologist

"He doesn't like to complain, but many days he is working on his EHRs at 5 a.m. and again at 9 p.m. They're very difficult for him". ---From the wife of a Subspecialty Internist

"I think that the EHR has helped in communication about the overall patient's care. However, the lack of different EHRs integrating with each other makes it difficult to achieve the initial goal of making the required EHR necessary. What we really need is a system that allows us to access the records of patients at other institutions".
---From an Internist

"I think EHRs have been helpful only in requiring us to have the correct documentation so that we can do our coding and billing. The patient progress notes are 'cut and pasted' so that about 90% of them are useless 'fluff', so that I only look at the bottom few lines.'
---From a Surgeon

"EHRs have been a positive game-changer in OB. We no longer must rely on paper charts which we had to carry from the office to the hospital and were often misplaced. I'm in favor of them."
---From an OB-GYN

"I hate them. I'm in solo practice so I still have paper charts. I have to pay a fine every year, but the fine is much less than the cost and the hassle of instituting EHRs"
---From a Subspecialty Internist

Doctor Lifeline: Preventing Physician Suicide

Steven A. Reid, MD, FAANS
Spine and Neurosurgery, A Division of SIMEDHealth

"There is but one truly serious philosophical problem and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy". -- Albert Camus

The Problem

About 400 doctors per year die of a fatal but largely preventable malady in our country -- suicide. That's three times the size of the entering class at the University of Florida College of Medicine. These deaths deprive about 1 million Americans of their doctors annually. Almost every practicing physician personally knows one or more colleagues who have taken their own lives.

Doctors die by suicide at a rate twice that of active duty military members. The American Foundation for Suicide Prevention reports that the suicide rate for male doctors is 1.41 times higher than the general population, and for female doctors it's 2.27 times greater. We need to urgently identify and correct the oppressive elements in modern practice environments that lead these caring healers to take their own lives.

Contributory Factors

The largest single factor contributing to physician suicide consists of untreated depression. Depression generally includes sadness, pessimism, sinking mood, aversion to activity, and loss of the ability to experience pleasure. In the general population about one in ten males, and two in ten females, have depression. About 10 percent of depressed patients attempt suicide. Because of their specialized knowledge physicians succeed in suicide at a much higher rate than the general population.

Depression

Depression probably originates from genetic, biological, environmental, and psychological factors. Genes supply about 40% of the risk. The success of pharmacologic and electroconvulsive therapies implies significant neurochemical and neurophysiologic contributions to depression's underlying etiology. The success of cognitive behavioral therapy argues for a psychological contribution as well. In other words, depression has relevant etiologic factors spanning multiple conceptual levels of organization, from molecules to minds.

Environmental factors significantly contribute to depression in physicians. The stresses doctors experience on a daily basis can equal those of military personnel in combat. Emergency rooms can resemble war zones. Doctors often find themselves at the intersection of competing interests -- they experience pressure from countless parties with differing agendas and feel pulled in several directions. Well-meaning but naive bureaucrats pile regulations which do nothing to promote health upon already overburdened physicians. Electronic health records, better suited for billing than for patient care, perplex and frustrate doctors in most practice environments. Administrators try to direct, command, and cajole doctors into actions benefiting the corporation more than the patient.

Changes in social stature can contribute to depression. Most medical students earned rankings at the top of their class as undergraduates in college. In medical school they find themselves surrounded by other stellar performers, and realistically may need to self-assess as "average". They may find such a reappraisal demoralizing. Medical education demands many sacrifices, often including the sacrifice of attention to personal health and relationships.

Physicians who have practiced many years may also feel demoralized as a result of changes in social stature. The forced adoption of coding systems requiring pigeon-holing of diagnoses, cookbook conformity to ever-expanding "guidelines", and imposed limitations on available treatment options has stifled creativity and turned the practice of medicine from a profession into a trade. Employers, agencies, and health care systems now refer to "providers", making little distinction between doctors, physician's assistants, and nurse practitioners. Hospitals appear to consider doctors as interchangeable, based on filling specialty slots, rather than identifying the strengths and talents of individual physicians and encouraging them to flourish.

"One must follow and understand this fatal game that leads from lucidity in the face of existence to flight from light". -- Albert Camus

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PREVENTING PHYSICIAN SUICIDE

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To the general public, it may appear puzzling that physicians often ignore depression, suffering in silence, until they reach a point of crisis and willfully end their lives. Why would anyone knowledgeable of the dangers of untreated depression not seek treatment? The answer to this question involves personal fears and cultural mores.

Cultural Factors

The culture of medicine affords low priority to the mental health of physicians. Doctors must confront human pain and suffering every time they go to work. Such exposure exacts an emotional toll. Everyone, including doctors, "buys into" the image of the physician as being strong and resilient. In many medical circles, it is taboo to discuss the physician's own emotional issues. Many doctors have no place to discuss or vent their distress.

Personal Fears

Even if a doctor recognizes the seriousness of her depression, fear can override the desire for treatment. Such fear is not irrational. Medical communities are close-knit, and gossip travels quickly. Doctors reasonably fear stigmatization, damage to their reputations, loss of collegial esteem, and indelible marks on their records affecting future employment opportunities. For example, the Florida Board of Medicine Medical Doctor Licensure Application asks, "In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?" After dedicating a large part of one's life to training and the practice of medicine, anything that might interfere with licensing is a major threat.

Other fears blocking a decision to seek treatment include taking the necessary time off, financial concerns, loss of referrals, and loss of privileges.

Doctors, by nature, selection, and training are intelligent problem solvers. Unfortunately, with depression you can't think yourself out of your situation.

"Physicians are smart, tough, durable, resourceful people. If there was a way to MacGyver themselves out of this situation by working harder, smarter, or differently, they would have done it already".

-- Simon G. Talbot and Wendy Dean

Pitfalls Despite Treatment

Psychiatry is not an exact science. Even with psychiatric treatment some physicians will nevertheless proceed with suicide. Some patients respond well to particular medications while others prove ineffective. The period shortly after initiating antidepressants is particularly hazardous with regard to suicide. The suicidal doctor may trivialize the depth of his despair and convince the psychiatrist that his depression is not that bad. The psychiatrist may not ask tough questions out of deference to a colleague. The psychiatrist might withhold stronger medications or ECT because of concerns regarding cognitive effects on the physician-patient. The depressed doctor may cleverly provide just the right answers to short-circuit cognitive therapy. Reasons like these can result in less than optimal psychiatric treatment for physician-patients compared to the general population.

Even after treatment, the physician must return to the environment that contributed to his depression in the first place. Hence, relapses are common.

Doctor Lifeline

Many organizations have begun to notice the prevalence of suicide amongst doctors. There are a few, such as the American Foundation for Suicide Prevention, that aggregate resources addressing the problem of suicide in general. There are almost none specifically organized to counter the problem of physician suicide.

We started Doctor Lifeline, Incorporated, as a Florida nonprofit corporation dedicated to preventing physician suicide.

We intend to identify and correct the factors influencing the high rate of physician suicide. Some of these include a culture discouraging doctors from seeking help for burnout or depression. Others include increasingly hostile workplace environments, loss of societal stature, excessive documentation and regulatory demands, anxiety over litigious patients, inflexible poorly designed electronic health records, insurance company preemption of clinical decisions, and a general feeling of increasing powerlessness.

We intend to apply for 501(c)(3) status with the IRS. We are seeking experts to fulfill our education, intervention, and advocacy missions. We welcome collaboration with other suicide prevention organizations and professional societies.

Please visit www.DoctorLifeline.org for further information.

Beyond Burnout Prevention: Promoting a Culture of Wellness

Lisa J. Merlo, PhD, MPE
UF Health Psychiatry

In 2007, the Institute for Healthcare Improvement introduced the "triple aim": a somewhat radical proposal to work on: improving the patient care experience, improving population health, and reducing health care costs all at the same time. Though ambitious and well-intentioned, this initiative nonetheless introduced some unintended consequences to physicians, who bear the primary burden for implementation of the three goals. Indeed, as Robert Wachter, MD observed, "Physicians are the only high-level professionals who do the majority of production, customer service, and clerical work." Not surprisingly, in the past decade, we have continued to see a rise in burnout among physicians across all specialties.

"Burnout" is typically characterized by emotional exhaustion, depersonalization/detachment, and feeling lack of efficacy or low personal accomplishment at work. The consequences have been well-documented, and include: negative impacts on quality of work, increased medical errors, decreased empathy with patients and colleagues, decreased job satisfaction, and increased symptoms of depression and substance use disorders. In response to this concern, in 2014, Thomas Bodenheimer, MD and Christine Sinsky, MD introduced a revised "quadruple aim," which adds an emphasis on improving the work life experience for physicians and other clinical care providers.[1] In addition, many professional organizations, healthcare institutions, and medical centers have begun to consider "physician well-being" an important priority.

However, most proposed solutions have fallen short of their goal to decrease physician stress, primarily because they ignored systemic and environmental problems within the workplace, and instead focused on encouraging physicians to add healthy behaviors into their already busy lives. The implicit message being that physicians themselves are responsible for their burnout and could improve their own wellness by eating healthier, exercising, meditating, sleeping, and/or taking breaks. This approach back-fired to some extent. Rather than feeling supported, physicians were left feeling guilty and more overwhelmed by the new burden of figuring out how to fit "wellness" into their lives.

Then, in 2016, the Stanford Medicine WellMD Center introduced a new model. They recommended focusing on a goal of "professional fulfillment," which they define as "happiness or meaningfulness, self-worth, self-efficacy, and satisfaction at work." Importantly, rather than placing all responsibility for wellness on physician self-care, the model posits that professional fulfillment is supported by 3 primary components:[2]

1) **Culture of wellness:** which refers to organizational values and actions that promote personal and professional growth, self-care, and compassion for ourselves, our colleagues, our trainees, and our patients
2) **Efficiency of practice:** which refers to workplace systems, processes, and practices that promote safety, quality, effectiveness, positive patient, trainee, and colleague interactions, and work-life balance
3) **Personal resilience:** which refers to individual skills, behaviors, and attitudes that contribute to physical, emotional, and professional well-being

Perhaps the most important contribution of this model is the recognition that there are many contributors to workplace wellness, and that the most effective approach to combatting burnout and promoting professional fulfillment will require effort and input from the institution, leadership, team members, and individual clinicians. This means that ALL members of the health care system can contribute to the culture of wellness and help to promote professional fulfillment in themselves and their colleagues.

With this in mind, it is recommended that physician wellness initiatives take into account the following major contributors to workplace wellness:

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BEYOND BURNOUT PREVENTION

- **Leadership:** The tone is set from the top, and leaders should present a strong message regarding the importance of a positive, collaborative work environment. Their actions are particularly important, as they can serve as a role model for healthy work-life integration. In addition, it is important that leaders support efforts to improve workplace conditions through allocation of time, talent, and funding. Equally important is the recognition that any member of the health care team can take the lead in improving the culture (just as any member can take the lead in destroying it).

- **Values Alignment:** Objective discussion of the metrics for evaluating performance may help to uncover issues that lead to burnout. Most physicians did not choose a career in medicine because they wanted to bill for the most services. Rather, they were driven by a desire to connect with others and to help people. If the metrics for "success" conflict with the goal of providing the best patient care, moral injury can result. This promotes frustration and cynicism, and may lead to a decrease in empathy as a method of self-preservation. Recognizing and valuing physicians for the quality (rather than the quantity) of care provided will help to prevent burnout.

- **Voice/Input:** The number of healthcare administrators in the U.S. grew 3200% between 1975-2010, compared to just 150% growth in the number of physicians. More recently, many physician practices have been bought out by corporations. As a result, many physicians are now salaried employees who take direction from non-physicians. Losing this measure of control over their practice can be very challenging, particularly if physicians feel that the decisions being made are not in the best interests of patients or the health care team. Efforts to elicit input from physicians are likely to pay dividends by identifying solutions that will help to improve both the patient care experience and job satisfaction for physicians.

- **Peer Support:** For decades, the expectation has been that doctors would "suck it up" and continue working, even if their own health suffered as a result. We now recognize that physicians cannot provide their best care if they are struggling themselves from a physical, mental, or psychological condition. However, physicians are notoriously "bad patients" and may attempt to self-medicate or have difficulty acknowledging when they need help. As a result, it is important for physicians to give a colleague (or two) explicit permission to intervene if they are concerned. Given the grim statistics on physician suicide, this is a necessary step and can be life-saving.

- **Meaning in Work:** When physicians start to burn out, one of the first positive emotions to fade is the experience of awe—of wonderment regarding life's possibilities and the impacts of our work. Too often, the health care system focuses on errors, "near misses," and poor outcomes. We forget to acknowledge--and celebrate—the successes. Taking time to reflect (as an individual or with your team) on the positive impact of your work can help to sustain you through more difficult experiences.

- **Fostering Community:** Loneliness is a key contributor to poor health, and changes to the health care environment and technology have led to decreased interpersonal interaction and increased isolation among physicians. Investing the time and effort to form connections, share life experiences, and develop positive relationships (with colleagues, patients, and staff) can help to counteract this unfortunate trend.

- **Appreciation:** Gratitude is an effective antidepressant for both the giver and the receiver. Expressing appreciation (in person, via email/text/note), acknowledging contributions through "employee of the month"-type recognition, and/or setting up a gratitude board in a central location will boost the morale of team members. Similarly, taking the time each night to document 3 good things that happened will help to improve your perspective throughout the day.

- **Flexibility:** Many physicians have perfectionistic tendencies, which may have been somewhat helpful in their academic and professional pursuits. However, excessive rigidity or obsessive-compulsive personality features can reduce creativity in problem-solving. Mindfulness and meditation strategies can help physicians become more open-minded and accepting, which may help them revise policies and procedures in order to improve practice efficiency and team satisfaction.

-

- **Culture of Compassion:** Traditionally, physicians are among the most compassionate people on earth. Yet, they tend to lack self-compassion, and are prone to judging themselves more harshly than others would. Criticism resonates much more strongly than praise, so care must be taken when providing feedback to team members. In addition, setting more realistic expectations for oneself and one's colleagues will help to create a more supportive work environment.

Most importantly, we must all remember that each of us contributes to the culture of wellness in our work environment. As Mother Teresa said, "I alone can't change the world. But, I can cast a stone across the waters to create many ripples." If each person commits to making just one small change, the effects will add up to create waves of positive change.

References available upon request.

Bobby Brown - A Physician Challenges Baseball

Thomas Lau, MD

Bobby Brown, MD autographing a baseball for General Douglas MacArthur.

Without open fields for traditional baseball, we Brooklyn schoolboys had only "stickball," played with a broomstick and an amazingly lively pink rubber "spalldeen". We played without fielding and without base running. We chalked a strike zone on an apartment wall, and the batter tried for distance. A fly ball to the next street was a home run! To add fun, we adopted the identities of major league players. I pretended I was the 1950 "Damn Yankees" with a line-up that included the "Murderer's Row" of Yogi Berra, Joe DiMaggio and Johnny Mize, followed by "Doctor Bobby Brown".

But wait! What is this about "Doctor Brown"?

Seventeen thousand men have played Major League Baseball, but only one physician! Remarkably that one, Bobby Brown, attended Medical School while he played third base for the New York Yankees. Bobby's father, Bill, helped him "workout" with the minor league Newark Bears when his "Golden Boy" was just 13 years old!

At Stanford University, "The Belting Sensation" was enjoying a day at San Gregorio Beach (about 30 miles south of San Francisco) when Bobby saw a Navy seaplane crash about 400 yards offshore. Bobby entered the extremely chilly and rough surf to save the injured crewman thus earning the prestigious "Silver Coast Guard Life Saving Award."

Starting in 1946, playing for the New York Yankees, he won five World Series and achieved the highest Series batting average of 0.439 (you can look it up)!

He enlisted in WWII in 1943 and the Navy gave him a deferment to pursue his career in Medicine. The military called him to serve in the Korean War in 1952. There, during a year in a combat-filled hospital, Bobby helped patriots such as one of his own medics "with blood pouring out of his right ear." After treatment in Japan, that soldier returned to medic duty.

Bobby and Joe DiMaggio played together for the Yankees and both attended the same San Francisco High School. When Joe married Marilyn Monroe, the newlyweds sought a honeymoon site far from "news hounds". Marilyn selected Asia! Joe sought out Dr. Brown and his wife Sarah to join him and Marilyn in Japan and Korea. Then the foursome toured the area together.

1952 Bobby Brown New York Yankees Baseball Card

BOBBY BROWN, MD

Continued from Page 14

After Medical Residency at the University of California – San Francisco and a cardiology fellowship at Tulane, Bobby practiced in Fort Worth, Establishing the "Coggans-Brown Heart Center".

In 1984, noticing Bobby's effectiveness with the Texas Rangers, the owners selected him to lead the American League. At that time, the majors initiated an "Athlete Through with Chew" national anti-tobacco campaign with a video narrated by the famous sportscaster, Mel Allen, strike out ace Nolan Ryan and Bobby Brown. Typical of Dr. Brown, he "went the extra mile" to arrange the funding to show their video in "every United States High School".

Bobby's father, Bill, once told a reporter, "My son is not the greatest ball player in the world, but he is the best son!"

Bobby Brown (center) with Cincinnati Reds' Bobby Mattick (left) and Jimmy Gleeson in 1941 when Brown worked out with Reds before his career with the Yankees.

Bobby Brown, MD C.V. and Timeline: **New York Yankee Baseball Player, WWII and Korea War Veteran, Cardiologist and President of the American League**

1924	Born in Seattle, Washington
1937	"Works out" with the Newark Bears
1938	High School in San Francisco with Joe DiMaggio
1941	"Works out" with Yankees and Reds
1942	Stanford University Baseball "Belting Sensation." Awarded the United States Coast Guard Silver Lifesaving Medal.
1943	Enlisted in the Navy R.O.T.C.
1944-1945	U.C.L.A. War Time Navy Program with 5 years to finish Medical Program
1946	Signs as Yankees third basemen for a record $52,000 Bonus and continues Tulane "off season" medical studies until 1950. Yankees finish in third place.
1947	Jackie Robinson joins Brooklyn Dodgers
1948	Yankees Third Place
1949	Yankees World Series Championship over Brooklyn Dodgers
1950	Yankees win World Series against Philadelphia Phillies. Marries Sarah French (Tulane Homecoming Queen). Interns at Southern Pacific Hospital, San Francisco
1952	Yankees win World Series against Brooklyn Dodgers - Brown plays in 29 games. Serves in Korea in M.A.S.H. Unit at "Chornon."
1953	Tokyo Army Hospital. "Honeymoons" with DiMaggio and Marilyn Monroe.
1954	Yankees (Bobby played 28 games) Second place.
1955-1956	Medical Residency, San Francisco County Hospital
1958-1973	Cardiology Practice, Fort Worth, Texas
1974	Vice President, Texas Rangers
1975-1983	Cardiology Practice - Coggans and Brown Heart Center, Fort Worth, TX
1984-1994	President, American League
1995	Retired, Three children, Ten grandchildren
2018	Currently resides in Fort Worth Texas.

SIMEDHealth: Built on Guiding Principles

An Interview by Scott Medley, MD
with Daniel Duncanson, MD

Dr. Medley

Dr. Duncanson

[**EDITOR'S NOTE:** I have known Dr. Dan Duncanson for over 15 years. He has always been known as a highly respected internist and physician leader. A few years ago, he assumed the role of CEO of SIMEDHealth, now by far the largest private practice multi-specialty group in this region. I recently had the opportunity to visit with Dr. Duncanson to learn more about SIMEDHealth. As we strolled through the halls of the huge complex on Newberry Road, a few things became obvious. The place was filled with patients and friendly support staff. There were many beautiful, striking paintings and photographs displayed, through a relationship with the Gainesville Fine Arts Association. Then a large rather rough-hewn plaque hanging on the wall caught my attention. In bold letters it stated simply: FAIRNESS, RESPECT, TRUST, EXCELLENCE. I thought that this might be one of those "usual inspirational slogans" until I later realized that every one of these values came up in my conversations with Dr. Duncanson, indicating that this was more than an empty slogan – it represents the guiding principles by which SIMEDHealth operates and continues to grow.]

Editor (Dr. Scott Medley): Thank you for meeting with me today. How many providers does SIMEDHealth currently have and in how many locations?

Dr Duncanson: We have 81 physicians and a total of 130 licensed providers of care including physicians, APRNs, PAs, Psychologists, Pharmacists, etc. We have five locations: Gainesville, Ocala, Chiefland, Lake City, and the Villages and we see over 1,200 patients per day practice- wide.

Editor: Does SIMEDHealth have many specialties represented?

Dr. Duncanson: We have 26 specialties, from primary care to hand and spine surgery, psychiatry to podiatry, and allergy to urology. We also have many services integrated into our practices such as physical therapy with massage and aquatic therapy, and sleep medicine, diagnostic imaging, laboratory, etc.

Editor: Under your continued leadership, SIMEDHealth has achieved remarkable growth. To what do you attribute this success?

Dr. Duncanson: We don't consider ourselves successful because we grew, nor is it defined by profits. We are successful because of relationships that are developed between physicians, patients, management, staff, and others. We try to treat people fairly and with respect... this builds trust. This combined with a constant push for excellence has drawn like-minded people to us and allowed us to grow.

Editor: You continue to recruit excellent physicians, both established and new....what's your secret?

Dr. Duncanson: When we are recruiting we are "selling" our decades of successful independent practice, our decades of successful co-existence of physicians and management, and our relationships. The most powerful message we deliver is that we all get along quite well.

Editor: With an organization this complex, you must have an excellent support staff?

Dr. Duncanson: Absolutely! We are fortunate to have several MBA's working here. We recruit nationally for our physicians and our administration. As with any practice our employees are the face of our organization. In the last few years we've totally revamped our training and initiated development opportunities to hopefully better prepare them for the changing dynamics in healthcare.

Editor: I assume that, as with all rapidly expanding organizations, you've experienced some "growing pains"?

Dr. Duncanson: We have, but "growing pains" are opportunities for learning. Our administrative team has a ton of experience integrating and on-boarding physicians and their staff. While there are similarities among all of them, they are each unique in their own way. The challenge we love to figure out is how to best incorporate the benefits and efficiencies of our larger multi-specialty system while preserving the features of their practice which allowed them to be high quality physicians prior to integrating

Editor: In keeping with the theme of this issue of *House Calls*, what are some of the main challenges facing physicians today?

Dr. Duncanson: We experience similar challenges faced by other physician groups. Our size doesn't allow us to escape the issues. As we get larger it is somewhat more difficult to perpetuate our culture so we continue to cultivate this. We have group meetings with all physicians and management six times a year. A portion of these meetings are dedicated

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to helping our physicians develop efficiencies and manage stress. Hopefully this allows our physicians to successfully navigate their challenges.

Editor: What main challenge do you think individual physicians face today?

Dr. Duncanson: Generally, across the board, physicians don't know where to turn to get trusted and accurate business information. Physicians don't have a "business apprenticeship" nor any significant business leadership training. As a profession we historically abdicated this role to non-clinicians. What other profession has done this? I'm encouraged that physician executives have begun emerging over the last decade, and a high percentage of the successful hospitals, accountable care organizations (ACOs), and multispecialty health systems have strong physician leadership throughout these organizations. We expect our physicians to be clinicians, however we try to fill the healthcare business void for them with regular educational opportunities. You can join SIMEDHealth and "just be a doctor" if you want, while we handle the administrative aspect for you. However, by osmosis our physicians learn the language and culture required for healthcare business success.

Personally, I still consider myself first, a physician. I practice in our clinic here on Fridays and I still take SIMEDHealth hospitalists call at HCA/North Florida Regional Medical Center. But my "spare time" is dedicated to our development of SIMEDHealth into a high-performing health system.

Editor: I think that is great. There's nothing like establishing continued physician practice credibility with your group.

Dr. Duncanson: I certainly agree.

Editor: Most physicians are challenged by Electronic Health Records (EHR). What do you think about that development?

Dr. Duncanson: While many were reluctant to get into EHR, I don't know of anyone trying to get out of it. Our patients have one electronic chart. You and I both remember the days of crating around paper charts from location to location. I haven't heard anyone calling for those days again. There's still too many clicks, and the software still has a long way to go to incorporate the physician's thought process and decision making during an encounter. The problem was EHR was forced upon us by the government, and the software was rushed to meet the required items for meaningful use certification. The next step of software development focused on the patient experience – electronic connectivity with our patients. Now the software is getting around to the health care provider experience.

Editor: What can you do about "physician burnout"? Are your physicians somewhat shielded from this problem just because they are in SIMEDHealth?

Dr. Duncanson: We've had some struggles with "burnout". Physicians are pulled in more ways than ever but, we let our physicians know "We've got your backs." Again, the relationships we're developing are a very important aspect in helping physicians cope with the stressors. This along with us addressing the topic during our meetings and bringing them ideas and tools to help them. It's important they know they are not alone – this comes back to respect and trust.

Editor: I understand you have on-site a pharmacy, lab, and imaging, which are very convenient for your patients.

Dr. Duncanson: Indeed, these services are very convenient for our patients. We feel that the more familiar patients are with our services, the more compliant they will be. We consider these integrated services, not ancillaries. We have essentially all imaging modalities except nuclear and PET scans. Incidentally, we have physical therapy services at four of our sites and we have our own Sleep Lab in Gainesville with five physicians board certified in sleep medicine. We also are involved in clinical research, with ongoing level II and III studies which are open to anyone, not just our patients.

Editor: Any plans for future growth?

Dr. Duncanson: Our growth is all about keeping SIMEDHealth relevant. We are currently expanding services in Chiefland, and we think that the Ocala area is ripe for growth. I don't know what relevant will look like in five years, but I don't think it will be smaller. Therefore we keep an eye open for horizontal and vertical growth opportunities.

Editor: Is SIMEDHealth doing anything to develop physician leaders?

Dr. Duncanson: We have a development group of physicians that our physician leadership has been working with the last couple years. We meet regularly and bring to them real life practice administration issues. Our meetings and retreats also have a physician development aspect to them. We attempt to improve physician satisfaction by surrounding our physicians with other physicians and administration who are motivated towards high performance and development. Within our employees we are developing leadership through our SIMEDHealth Academy. This is a year-long curriculum designed to help a select group of staff gain personal insight and managerial skills - all of which improves our health system.

Editor: Thank you very much Dr. Duncanson. This has been fascinating. We wish you continued good fortune with SIMEDHealth.

Dr. Duncanson: Thank you very much.

Welcome New Members

Fall 2018 New Members: Welcome to the ACMS Physician Community!

Torben Becker, MD, PhD, RDMS
UF Emergency Medicine

Victoria Bird, MD
Urologic Integrated Care

Allison Buel, DO
SIMEDHealth
Pulmonology

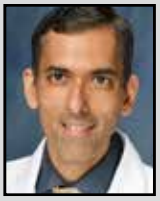
Lawrence J. Caruso, MD
UF Health
Anesthesiology

David Crabb, MD
UF Emergency Medicine

Gabriele DeMori, MD
SIMEDHealth
Internal Medicine

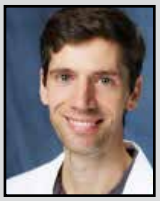
Christopher E. Estel, MD
The Cardiac &
Vascular Institute

Mohamed Foda, MD
Women's Group of
North Florida, LLC



Hans Ghayee, DO
UF Health
Endocrinology

Eric Grieser, MD
UF Health
Ophthalmology



Grant Harrell, MD
UF Health
Family Medicine

Ariane Harris, MD
SIMEDHealth
Interventional Pain
Management

Patricia Hess, MD
Hess Child
Psychiatry

Ronald C. Lee, MD
Digestive Disease
Associates

Mauro Lodolo, MD
UF Health
Pediatric Neurology

Amy L. Nance, MD
Florida Cancer
Specialists

Mary Patterson, MD,
UF Emergency
Medicine

Roja C.
Pondicherry-Harish, MD
The Cardiac &
Vascular Institute

Jeffery Schulman, MD
Women's Group of
North Florida, LLC

Sandra Sullivan, MD
UF Health Pediatrics

Jasmin Tanaja, MD
UF Emergency
Medicine

Meredith Thompson, MD
UF Emergency
Medicine

Sanjeev Y. Tuli, MD
UF Health Pediatrics

Justin Yancey, MD
SIMEDHealth
Neurology

Mark and Mary Barrow Day:

A Proclamation by the City of Gainesville, Florida

Remarks by: Joseph Cauthen, MD

We are honoring two of Gainesville's most remarkable people today for their significant contributions to the preservation of architecture and history in our community: Mark and Mary Barrow.

Matheson Museum and Robb House Medical Museum

The Barrows have made many contributions to the Matheson History Museum and the Robb House Medical Museum over the years. This former physician's office and residence commemorates the life and times of Drs. Robert and Lucretia Robb in our city in the mid-to late 1800s. Lucretia was refused entry by American medical colleges since it was unusual for women to become physicians during that time. Not to be deterred (very much like Mark and Mary Barrow), Gainesville's first female physician completed her medical training in Germany prior to coming here.

Thanks to Mark and Mary, this Late 1800s physician's residence and former medical office is now the permanent home of the Alachua County Medical Society. If you make time to visit the Robb House on second Avenue, it will be an unforgettable experience for you.

North Florida Regional Medical Chief of Staff

When the pressing need for more hospital beds and updated diagnostic equipment arose in Gainesville in 1965, a group of community physicians led by Richard Cunningham formed an alliance with the Hospital Corporation of America, and The North Florida Regional Medical center was built. 10 years later in 1975 Mark Barrow became the chief of the medical staff contributing to its emergence as one of the outstanding centers of medical excellence in our region.

L to R: Ken McGurn; Linda McGurn; Mark Barrow, MD; and Mrs. Mary Barrow.

Paul McKnight, the first administrator of the hospital recalls that there was a significant dispute between Dr. Barrow and himself about cigarette machines in the hospitals. Dr. Barrow was successful in having them all removed after quite a few spirited discussions.

As a leading hospital of which Mark was a strong proponent, North Florida Regional has recently announced a $110 million building program to continue its reputation for medical leadership. Again, thanks must go to Mark Barrow and his medical colleagues .

Scientific Interests, Leading Edge Medical Care and Highest Level of Empathy

Mark grew up in Crestview Florida and earned a Bachelor of Science degree from the University of Florida in 1956, graduating with high honors. When the University of Florida School Of Medicine opened its doors in 1956, Mark began a four-year course of study, again graduating with honors in 1960. As a lifelong learner, Mark went on to earn his PhD in Anatomy at the University of Florida in 1968.

Mark's scientific contributions include research and scholarly papers in infectious diseases, cardiology, genetics, and cardiac resuscitation.

Mark has been the trusted personal physician for many patients for many years in this region. I am one of those privileged to have been under his care. Empathy, extensive knowledge and careful guidance have been the hallmarks of his medical practice. He has been the consummate physician throughout his lifetime.

Mary Barrow earned her Bachelor of Arts degree at the University of Florida, and became a teacher in the Alachua County school system in 1958.

Over the next 20 years, Mary undertook the task of raising five outstanding children and overseeing the restoration of 16 homes of historical importance in Gainesville.

Mary transformed The Bailey house, Gainesville's oldest residence, into our first significant assisted living facility. Additionally, she provided leadership in historic preservation as an early officer in the Florida Trust for Historic Preservation, assisting in the opening of Fort Lauderdale's Bonnet house to the public.

Thank you, Mark and Mary Barrow, for your collective 60 years of outstanding service to our community.

In Memoriam

Robert John Baker, MD

(1940 – 2018)

Dr. Robert Johnson (John) Baker, Jr., passed away on September 24, 2018 at the Haven Hospice E.T. York Care Center in Gainesville, Florida

Born in Mt. Lebanon, Pennsylvania, Dr. Baker attended Temple University School of Medicine and Temple University Skin and Cancer Hospital, becoming a physician with Board Certification in Dermatology and Dermatopathology. He had a private dermatology practice in Gainesville for 26 years.

Dr. Baker was a regular LifeSouth blood donor, and served as a Rockin' Reader with the Alachua County School Volunteer Program. He was a long-time member of the Rotary Club of Gainesville. Dr. Baker enjoyed all things nature-related, especially walks and outdoor adventures with his grandchildren, riding his bike, working in his garden, and photographing flowers. In their retirement, John and Marge were able to enjoy their love of travel.

Dr. Baker is survived by his wife Marge Baker; his two daughters, Barbara Marcille (Tom) of Portland, OR and Kim Harless (Derek) of Jacksonville, FL; and his six grandchildren.

Arthur Nesmith, MD

(1933 – 2018)

Marsh Arthur Nesmith, MD, passed away peacefully October 16, 2018 at his home after a long battle with cancer.

Dr. Nesmith was born in March 1933 in Springhead, Florida, growing up on the family farm. He was a high school football star and received a football scholarship to the University of Florida. He graduated from Medical School at Duke University, and returned to Gainesville, where he completed a General Surgery residency at the University of Florida.

In 1967, soon after beginning his General Surgery practice, he was drafted into the Army during the Vietnam War. The family spent two years in Augusta, Georgia where he served at Fort Gordon. He was honorably discharged as a Major and then returned to his General Surgery practice in Sanford, Florida. Two years later it was back to Gainesville for a Cardiothoracic fellowship. Dr. Nesmith practiced Cardiac and Vascular surgery at North Florida Regional Medical Center and Alachua General Hospital. Dr. Nesmith served on the Board of Trustees at NFRMC for many years.

He is survived by his wife, Carolyn Campbell Nesmith; five children, Rick (Connie Gruenwald), Patsy (Breck) Weingart, Susie (Larry) Smith, Marsha (Mac) Hall, and John (Kelly); 16 grandchildren and 11 great-grandchildren.

In Memoriam

Carolyn M. Hopkins, MD

(1949 – 2018)

Carolyn M. Hopkins, MD, passed away November 11, 2018 at her home near Gainesville, Florida.

Dr. Hopkins was born June 14, 1949 in St. Louis, Missouri. Upon the completion of her medical degree from the University of Missouri, Columbia, she enlisted in the U.S. Navy. After residency, she was stationed at the US Naval Air Station in Jacksonville, Florida, where she attained the rank of Lieutenant Commander before her discharge from active duty in 1982. She was a staff Pathologist at Alachua General Hospital for many years and also served as an Associate Medical Examiner for the 8th Medical Examiner District.

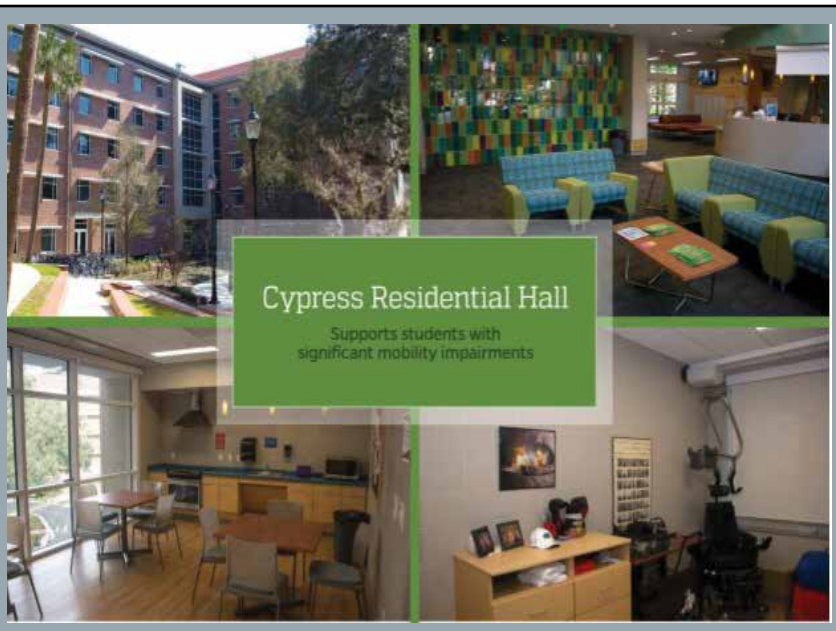
Dr. Hopkins was the first female Chief of the Medical Staff at Alachua General Hospital. In 2006, Dr. Hopkins joined the faculty in the Department of Pathology, Immunology and Laboratory Medicine at the University of Florida College Of Medicine where she served as a Clinical Associate Professor of Pathology for two years. After leaving the academic medical community she established her own private practice of diagnostic pathology providing services for numerous medical group practices in north central Florida and beyond.

Dr. Hopkins is survived by her husband John and stepdaughter Michelle.

Cypress Hall is equipped with the capability of supporting 35 students with significant mobility impairments.

Cypress Hall offers the following:

- **Enhanced rooms that include SureHands lift systems to aid in the transportation of students throughout their residence hall rooms;**
- **Flexible restroom configurations, including zero entry showers, adjustable sinks and grab bars, and bidets;**
- **State of the art system for controlling access to residence hall room, video/audio equipped doorbell, window blinds, and lights and**
- **Adequate workspace for multiple personal care attendants to attend to each individual's needs.**



For further information please contact Jenna Gonzalez, Associate Director, at the University of Florida Disability Resource Center at (352)392-8565 or JGonzalez@ufsa.ufl.edu.

University of Florida, Disability Resource Center
Division of Student Affairs
drc.dso.ufl.edu
Tel: 352.392.8565; Fax: 352.392.8570; Toll Free: 800.955.8771
1310 Museum Road, PO Box 114085, Gainesville, Florida 32611

ACMS

HAPPENINGS

ACMS October Dinner Meeting and Vendor Show

Hilton UF Conference Center; October 23, 2018

David Hall, MD and Jesse Lipnick, MD.

Renata Wajsman, MD and Ellen Gershow.

William Driebe, MD and Robert Newman, MD.

L to R: Scott Medley, MD, *House Calls* Executive Editor; John Leibach, MD, and Preston Green, MD.

L to R: Amy Nance, MD; Phalyka Oum, MD; and Lynn Findley, MD.

L to R: Sergeant First Class Garcia, Caroline Rains, MD; Howard Nobles, MD; and Staff Sergeant Rendon with the US Army.

Priyanka Vyas, MD and Himesh Vyas, MD.

L to R: Mohamad Foda, MD; Karen Harris, MD; and Jeffrey Schulman, MD.

Mrs. Mary Barrow and Mark Barrow, MD.

Thomas Beers, MD and Charles Sninsky, MD.

L to R: Vijay Patel, MD; Cherylle Hayes, MD; Cole Dooley, MD; Nicole Bodlack; and Brandon Bodlack, DO.

Rigoberto Puente-Guzman, MD and Eric Rush, MD.

ACMS HAPPENINGS

ACMS October Dinner Meeting and Vendor Show

Hilton UF Conference Center; October 23, 2018

John Leibach, MD and Nancy Worthington, MD.

L to R: Nicole Bodlak; Arthur Lee, MD; and Ronald Lee, MD.

L to R: Yogi Patel, MD; Vijay Patel, MD; and Brandon Bodlak, DO.

Mary Hurd, MD and Amy Nance, MD.

Glenna and Billy Brashear, MD

L to R: Mrs. Barbara Noble; Tyler Murphy; and Forrest Clore, MD.

Keynote Speaker Jay Hutto, CPA, and Partner with James Moore CPAs.

L to R: ACMS Past Presidents Norman Levy, MD, PhD; and James Garlington, MD

L to R: Dan Duncanson, MD; Wendy Garlington, MD; and Jay Hutto, CPA.

John Roberts, VP Community Bank & Trust of Florida with the door prize winner,

L to R: Madeleine Mills, VP, Community Bank & Trust; Stacy Joyner, CPA, James Moore CPAs; Jay Hutto, CPA, James Moore CPAs; Jackie Owens, ACMS EVP; John Roberts, VP Community Bank & Trust; and Blanca Millsaps, ACMS Graphic Designer.

Practice Management Network Luncheon

November 1, 2018 at Napolatanos Restaurant
Sponsored by: Community Bank & Trust of Florida

HARBEN HOS

L to R: Ann Marie Mauceri; Arlene Colon, ACMS Alliance President; and Cherise Bartley.

Cynthia Bush, MD and Jeffrey Catlin, MD.

Dean McCarley, MD and Andrew Smock, MD.

Burton Silverstein, MD and Janet Silverstein , MD.

Steven Reid, MD and Jerry Cohen, MD.

Patricia Hess, MD and Mark Andreozzi.

ACMS November Dinner Meeting
at Haile Plantation Hall, November 13, 2018

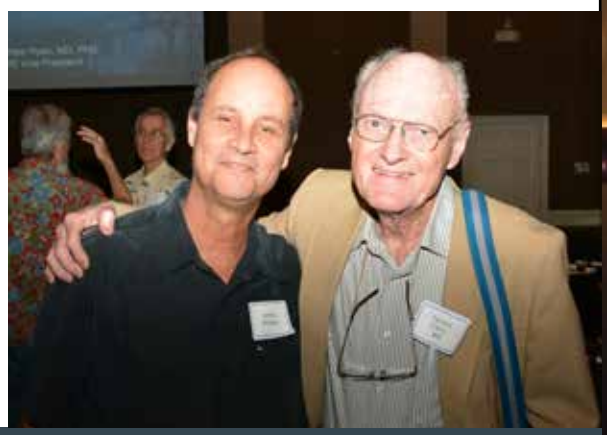
Pryanka Vyas, MD and Caroline Rains, MD.

Selden Longley, MD and Anne Longley.

Thomas Burkart, MD and John Meuleman, MD.

Arlene Colon, ACMS Alliance President; John Colon, MD, ACMS Past President; and Blanca Millsaps.

ACMS November Dinner Meeting at Haile Plantation Hall, November 13, 2018



Jimmy Millsaps and Forrest Clore, MD.

Arthur Mauceri, MD; Ann Marie Mauceri; and Rudy Gertner, MD.

ACMS HAPPENINGS

Comprehensive Women's Health Grand Opening, November 8, 2018

L to R: Scott Medley, MD, *House Calls* Executive Editor; Amy Million, MD; and Mrs. Faye Medley.

Eduardo Marichal, MD and Hugh Dailey, CEO/ President, Community Bank & Trust of Florida.

Blanca Millsaps and Judith Yancey, MD.

L to R: David Hall, MD; Phalyka Oum, MD; and Richard Brazzel, MD.

Kelly Chamberlain, MD and Jackie Owens, ACMS EVP.

L to R: Lauren Lewis, RN; Amber Paxson, RN; Eduardo Marichal, MD; Betty Bobe, Diane Reddish; and Nikki Osteen of Comprehensive Women's Health. Congratulations to all on your new space!

L to R: Jerry ; son; and Tracey Botha, MD.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, September 4, 2018

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, September 4, 2018 at The Cardiac and Vascular Institute.

Approval of Minutes: The minutes of the May 1, 2018 meeting were presented. Dr. Jones moved approval, seconded by Mr. Tyson to approve the minutes. The minutes were approved by the Board.

Secretary's Report: Dr. Dragstedt presented the following names for membership: Torben Becker, MD, PhD, RDMS; Allison Buel, DO; David Crabb, MD; Eric Grieser, MD; Jonathan G. Harrell, MD; Ariane Harris, MD; Patricia Hess, MD; Mary Patterson, MD, MEd; Jasmin Tanaja, MD; Meredith Thompson, MD; Justin Yancey, MD; Judith Banks, MD; Charles Bush, MD; Carolyn M. Hopkins, MD; Alan M. Lessner, MD; James W. Lynch, Jr., MD; Dean L. McCarley, MD; John S. Shahan, MD; Herbert E. Ward, MD; and NFRMC/UCF Resident Sardar M. Alamzaib, MD. Dr. Levy moved approval of the new members, seconded by Dr. Dragstedt.

Treasurer's Report: Dr. Dragstedt presented the July 31, 2018 (12 months) Balance Sheet and P & L statement for the ACMS and the ACMS Foundation.

President's Report: Dr. Khuddus discussed the year in review, with positive feedback from the Board / members concerning Dinner Meeting programs, the ACMS Gator Angioclub, the Delegate representation at the FMA Meeting, the Research Poster Symposium, the Annual Awards Dinner and the Annual Spring Party. The Board discussed possible events and programs they would like to see in the coming year including charitable foundation promotion for causes the ACMS endorses, more discussions on Physician Burnout and a greater presence on social media. Also discussed were nominations for the ACMS Board, which will be presented at the October Board Meeting. The annual evaluation for the EVP will be completed at the next meeting.

EVP Report: Ms. Owens announced that Resident Representatives Lindsay McCullough, MD; and Fan Ye, MD; are accepting Fellowships out of town and will be resigning from the Board. The ACMS will send out requests for applications to fill these positions for discussion at the next meeting. Ms. Owens reported that the CME course for Prescribing Controlled Substances will be offered to members on October 23rd. Registration is open early as the venue is expected to sell out.

There being no further business, the meeting was adjourned at 7:15p.m.

Alachua County Medical Society - Board of Directors Meeting Minutes, October 2, 2018

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, October 2, 2018 at The Cardiac and Vascular Institute.

Approval of Minutes: The minutes of the September 4, 2018 meeting were presented. Dr. Skidmore moved approval, seconded by Dr. Riggs. The minutes were approved by the Board.

Secretary's Report: Dr. Khuddus presented the following names for membership: Victoria Bird, MD; Vincent Bird, MD; Lawrence Caruso, MD; Christopher Estel, MD; Mohamed Foda, MD; Hans Ghayee, DO; Ronald Lee, MD; Roja Pondicherry-Harish, MD; Jeffery Schulman MD; Janet H. Silverstein, MD; Sanjeev Tuli, MD; Jose Llinas, MD; Faraz Afridi, MD. Dr. Levy moved approval of the new members, seconded by Dr. Skidmore.

Treasurer's Report: Dr. Khuddus presented the Year-to-Date Balance Sheet and P & L statement (2 months) for the ACMS and the ACMS Foundation. The report was motioned for approval by Dr. Jones, and seconded by Dr. Levy.

President's Report: Dr. Khuddus discussed the nominations for new Board members and asked for additional suggestions from the existing Board. He also announced that the charitable cause to be presented at the October Dinner Meeting would be for the Phoebe Louise Dooley Foundation. The Board also discussed the EVP annual evaluation and presented it to Ms. Owens afterwards. The EVP received an excellent overall rating and was asked to continue to increase the ACMS presence in social media.

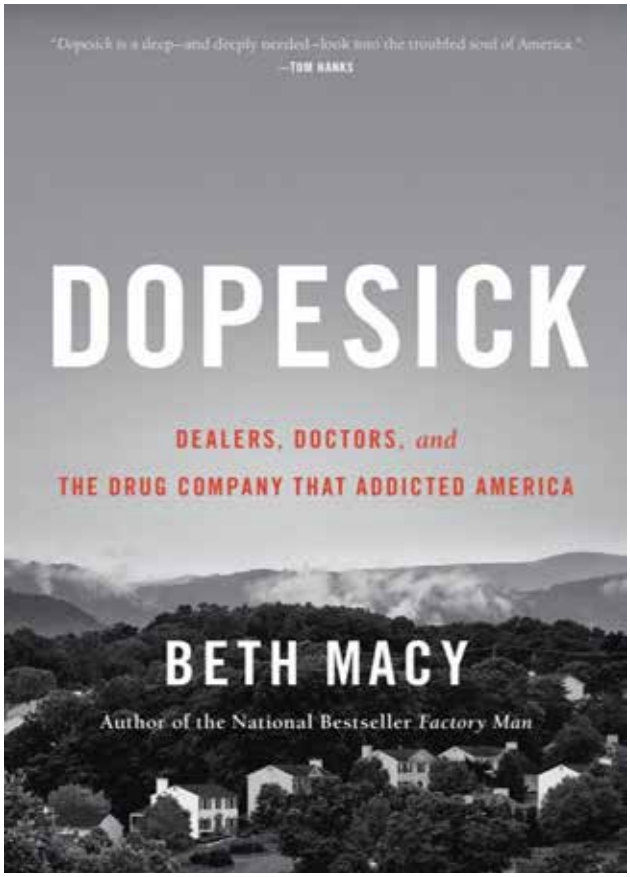
EVP Report: Ms. Owens stated that we have received applications to fill the vacated Board seat of Lindsay McCullough, MD; who accepted a fellowship out of state and recently resigned. These will be presented at the next Board meeting for consideration. All Board members were invited to attend the City of Gainesville celebration of the Mark and Mary Barrow Day, recognized for their contributions to historic preservation in the City of Gainesville. Ms. Owens mentioned that the FMA President Corey Howard, MD; would like to visit the ACMS within the next few months.

There being no further business, the meeting was adjourned at 7:00p.m.

Dopesick* -- A Book Review - Sort Of

SCOTT MEDLEY, MD
House Calls Executive Editor

This non-fiction account of the OPIOID EPIDEMIC captured my interest for 3 main reasons: 1) It explores the history of, reasons for, and progression of one of the most serious and confounding challenges facing our country—and our physicians—today. Or, as actor Tom Hanks endorses, "DOPESICK is a deep—and deeply needed—look into the troubled soul of America."; 2) Much of it takes place in Lee County, Virginia, which adjoins the rural county in Kentucky where I was born and raised; and 3) I read it so our busy ACMS members don't have to! The book is mostly about the crushing heartbreak of families dealing with this all-pervasive epidemic. Story after true story depicts how bright, promising young people—some as young as "ages 22, 19, and 15" lose their dreams and ambitions, their families, and, too often, their lives to addiction to opioid drugs and their devilish partner, heroin. In fact, "four out of five heroin addicts come to the drugs through prescribed opioids."



THE "HEROIN HIGHWAY" BRINGS THE END OF INNOCENCE

This is a tale not of drug abuse in the big cities, but of how the scourge spread into smaller, once-innocent communities. Yes, the "heroin highway" indeed begins in Baltimore, Maryland, where "with the highest per capita heroin use in the country, Baltimore residents were six times more likely to die from an opioid overdose than the national average." It is just a short jaunt west from Baltimore to Interstate 81, which runs northeast to southwest through West Virginia and Virginia and near Lee County, the southwestern-most county in Virginia. I-81 became the main corridor for opiates—and heroin—as the drug dealers and unscrupulous pharmaceutical companies found fertile ground for their products in small, economically depressed communities. Or, as the author Beth Macy puts it, where there was "the real perfect storm fueling the opioid epidemic...the collapse of work, followed by the rise in 'disability', and the flood of painkillers."

I-81 passes through Martinsburg, West Virginia, where "the synchronous thud of two Little League parents who had fallen from the bleachers after overdosing at their daughters' softball practice, their younger children running around frantically screaming, 'Wake up! Wake up!' " The I-81 "highway to hell" also passes through the "comparatively staid" city of Roanoke, Va., (where Beth Macy reported for the Roanoke Times) and where, in the city's most affluent high school " attended by the children of doctors and lawyers", there was "evidence implicating fifty...kids they'd been selling heroin to." How does so much heroin use in kids with loving, caring parents go undetected? "Because heroin is a depressant, people kind of withdraw; they go in a corner, shoot up, and sit there in the dark, in a fetal position. They weren't out there committing crimes like with crack or meth. It was a largely invisible and isolated group."

SOME HISTORICAL PERSPECTIVE

Opium, derived from the poppy plant, has been around for centuries. Laudanum, containing opium and

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DOPESICK

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alcohol, was said to be used "in 1804 to ease the pain of Alexander Hamilton, as he lay dying from a gunshot wound sustained during a duel." Around 1820, the active ingredient inside the poppy was isolated and named "morphium (now morphine) after the Greek god of dreams." In northern Virginia, also along I-81, lies the town of New Market, also affected by the opioid crisis and home to a famous 1864 Civil War battle. Macy points out the irony of "the women who grew poppies (in this area) for the benefit of wounded soldiers, harvesting morphine from the dried juices inside the seed pods." The scientific name for the poppy plant is Papaver Somniferum, quite appropriate it seems to me! The following sums it up nicely: "a quote from a seventeenth-century English apothecary: Among the remedies which it has pleased Almighty God to give man to relieve his suffering, none is so universal or efficacious as opium."

DOPESICK DETAILS SOME STARTLING STATISTICS YOU MAY ALREADY KNOW

- " Drug overdoses (took) the lives of 300,000 Americans over a fifteen-year period (from about 1998 to 2013), with more people than that expected to die over the next five years."
- "Drug overdose is now the leading cause of death for Americans under the age of fifty, killing more people than guns or car accidents, at a rate higher than the HIV epidemic at its peak."
- In 2017, "the annual death toll...had climbed to 64,000."
- "...by the year 2017...the financial toll (of the epidemic) was $1 trillion as measured in lost productivity and increased health care, social services, education, and law enforcement costs."
- "Between 1998 and 2005, the abuse of prescription drugs increased a staggering 76 percent."
- "In 2012, for every one opioid overdose death, there were 130 opioid-dependent Americans who were still out there, still using drugs."
- "...drug users are arrested four times more often than those who sell the drugs."
- "Big Pharma shipped nearly nine million hydrocodone pills to a single pharmacy in a town of just 392 people, giving Mingo County (in rural West Virginia) the fourth highest prescription opioid death rate of any county in America."
- In a statement about collateral damage of this "tsunami of misery", Macy writes "the number of children entering foster care due to parental opioid abuse, and the cases of children born with neonatal abstinence syndrome (increased at) roughly five times the previous year's rate."

CONNECTION TO DRUGS FOR ADHD?

And speaking of children, the author-- and many experts she quotes—firmly believe that drugs for Attention Deficit Hyperactivity Disorder (ADHD) are "vastly overprescribed," and that the use of these drugs in children often "become a gateway" for the use –and abuse—of "harder drugs into adulthood." She states, "that was true for almost every addicted young adult I interviewed for this book." "Between 1991 and 2010, the number of prescribed stimulants increased tenfold among all ages, with prescriptions for ADHD tripling among school-age children between 1990 and 1995 alone."

"On college campuses, Ritalin and Adderall were not just a way to pull an all-nighter...they also allowed a person to drink alcohol for hours on end without passing out. That made them a valuable currency, tradable for money and/or other drugs." "So it went that young people barely flinched at the thought of taking Adderall to get them going in the morning, an opioid painkiller for a sports injury in the afternoon, and a Xanax to help them sleep at night, many of the pills doctor-prescribed. So it went that two-thirds of college seniors reported being offered prescription stimulants for non-medical use by 2012—from friends, relatives, and drug dealers."

SO WHAT'S THE ANSWER?

Macy spends little time writing about preventive measures such as Prescription Drug Monitoring Programs (PDMPs), like the one recently strengthened in Florida by new laws enacted just this year. She spends much more space writing about treatment and rehab programs. She is a strong proponent of the controversial medication-assisted treatment (MAT) programs, as opposed to "abstinence-only" programs, stating, "Fewer than ⅓ of heroin addicts who receive abstinence-only counseling and support remain clean

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2 or more years. The recovery rate is higher, roughly 40 to 60 percent, among those who get counseling, support group, and MAT such as methadone, buprenorphine, or naltrexone." "Opioid addiction is a lifelong and typically relapse-filled disease. Forty to 60% of addicted opioid users can achieve remission with MAT, according to 2017 statistics, but sustained remission can take as long as 10 or more years. Meanwhile, about 4 percent of the opioid-addicted die annually of overdose."

She states flatly that "indefinite (and maybe even lifelong) MAT is superior to abstinence-based rehab for opioid disorder." And about the difficulties with rehab, "a Harvard researcher told me....What happens is it takes about 8 years on average after people start treatment, to get one year of sobriety...and 4 to 5 different episodes of treatment for that sobriety to stick. And many people simply do not have 8 years." Also a month of rehab treatment in a private facility may cost as much as $30,000 and these facilities often demand their payment "up front." "Only about 10 percent of the addicted population manage to get access to care and treatment for a disease that has roughly the same incidence rate as diabetes"

CONCLUSION

So would I recommend this book? The answer is yes—if for no other reason than the unique perspectives Macy brings to this topic. For instance, she presents a couple of interesting anecdotes that kind of summarize the problem. From an EMT in rural Wise County Virginia, "Last week I narcanned the same person for the fourth time. There's communities where we are like the ice cream truck." And from a farmer in Lee County, Virginia—the county that adjoins my hometown county—"OxyContin had stolen everything from (me), nothing's more powerful than the morphine molecule and once it has its hooks in you, nothing matters more. Not love, not family, not sex, not shelter, the only relationship that matters is between you and the drug." And, finally, from a "dislocated coalminer from Grundy, Virginia confessing that OxyContin had become more important to him than his family, his church and his children. It became my God, the man said. "

DOPESICK*—Dealers, Doctors and the Drug Company That Addicted America. By BETH MACY. Copyright 2018. Little, Brown and Company. 308 pages plus extensive Notes.

Congratulations on the Establishment of the FSDB Thomas M. Zavelson, MD Endowment for Student Achievement!

Dr. Tom Zavelson of Gainesville recently received a special honor in St. Augustine, Florida. The Lastinger Family Foundation presented the Florida School for the Deaf and the Blind with a check for $250,000 to fund The Thomas M. Zavelson, MD Endowment for Student Achievement. Dr. Zavelson has been a board member at the school for nine years. This gift was made in recognition of his efforts to enhance the education and healthcare of the students.

Dr. Zavelson stated "This award is about our incredible students. I want to use this endowment opportunity to empower both teachers and students to excel to the highest skill level. This school has an amazing student body and staff and I am looking forward to creating new horizons and programs with them."

Dr. Zavelson is best known in Gainesville for the large pediatric practice he founded, managed, and practiced in for many decades. He was instrumental in establishing the Pediatric Service at NFRMC and the Pediatric After-Hours Clinic, providing care for children at night.

The endowment is a Matching Funds endowment. For more information contact:
FSDB.K12.fl.us/index.php/donate/

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