Cutting edge medicine - innovation - treatment - solutions - advances - cure

ALACHUA COUNTY MEDICAL SOCIETY

House Calls

FALL 2019

Trends in Emergency Care

Connecting practices to

EMERGING TRENDS.

We're taking the mal out of malpractice insurance.
In an ever-evolving healthcare environment, we stay on top of the latest risks, regulations, and advancements. From digital health innovations to new models of care and everything in between, we keep you covered. And it's more than a trend. It's our vision for delivering malpractice insurance without the mal. Join us at **thedoctors.com**

THE DOCTORS COMPANY
medical ~~mal~~practice insurance

When physicians reference Florida's #1 research hospital, they're talking about us.

Home to the state's #1 research hospital, UF Health is consistently ranked among the best in the nation by U.S. News & World Report. Our discoveries advance care for millions of patients each year. So, it's not surprising that physicians send patients to UF Health from every county in the state and every state in the nation, and from dozens of countries around the world. We conduct landmark translational research that changes lives and moves medicine forward with innovative treatments.

Best in Florida for pediatric cardiology and heart surgery

Trauma and emergency patients transported to UF Health from all 67 Florida counties

More than 7,200 patients from 32+ countries treated at the UF Health Proton Therapy Institute

More lung transplants than any other Florida hospital

More than 1,000 patients with movement disorders treated with deep brain stimulation

Milestones such as these are made possible by unmatched research advances at UF Health — with 8 hospitals, 9 research centers and institutes, 1,400 College of Medicine faculty physicians and a comprehensive team of health care professionals. The quest for answers begins here. Put the power of research to work for you and your patients.

UFHealth

UNIVERSITY OF FLORIDA HEALTH

UFHealth.org

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.

The dedication of the AGH facade was a huge success. Thanks to Florence Van Arnam, Glenna Brashear and Carla Van Arnam, who did a great job planning the event. Special thank you to the ACMS Alliance for their $8K grant to the Robb House Endowment Fund! The funds have been used to rebuild the front porch steps, paint the exterior and install a new HVAC system. In the coming year, we are seeking funds to replace the roof. All contributions are tax deductible. Please donate today!

Robb House Endowment Improvements To Date:

- Rebuild Steps, Porches and Exterior Railings
- Roof Patching, Carpet Replacement
- Paint Interior/Exterior, Electrical Work
- Foundation Insulation Replacement and Repair
- HVAC Replacement, Tree Removal

Robb House Endowment Donors

A Special Thank You to our Generous Donors below!

The ACMS Alliance
Dr. John Andrews
Dr. Mark and Mary Barrow
Dr. Thomas and Dr. Betsy Beers
Dr. Billy and Glenna Brashear
Dr. Cynthia Bush
Dr. George and Constance Caranasos
Dr. Joseph and Virginia Cauthen
Dr. Jean Cibula
Dr. Forrest and Kathy Clore
Dr. Chris Cogle and Ms. Alisa Guthrie
Colonial Dames XVII Century-
Abraham Venable I Chapter
Mrs. Joanne Cullen in Honor of Oliver Cullen
Dr. Laurie K. Davies
Dr. Lee Dockery
Dr. Carl and Alissa Dragstedt (Grins and Giggles)
Dr. Leonard and Libby Furlow
Dr. Ann Grooms
Dr. Cherylle Hayes and Gary Schneider
Dr. Robert and Shari Hromas
Dr. and Mrs. Orvin Jenkins
Dr. Evelyn and Dr. Ronald Jones
Dr. Marie A. Kima
Mrs. Barbara Kirby in Memory of Dr. Taylor H. Kirby
Dr. Thomas Lau
Dr. Norman and Roslyn Levy
Dr. Judith Lightsey
Dr. Larissa A. Lim
Dr. Michael and Judith Lukowski
Dr. Terry and Jean Marshall
Dr. Thomas Martinko
Dr. Richard and Mary Neiberger
Mrs. Shirley and Mr. William Matthews
Dr. Scott and Faye Medley
Dr. Walter and Barbara Probert
Dr. Nicole Provost
Dr. Eric Rosenberg
Dr. Glen Rousseau
Dr. Gerold Schiebler
Dr. Rick and Pat Tarrant
Florence Van Arnam
Dr. Justine Vaughen Fry
Dr. BJ & Eve Wilder

CONTENTS

02 **Robb House Endowment Fund**

04 **Contributing Authors**

06 **From the President's Desk**
Matthew Ryan, MD, PhD

07 **From the Desk of the EVP**
Jackie Owens, ACMS EVP

09 **Welcome New Board Members**

Featured Articles

10 **Freestanding Emergency Departments**
Gary Gillette, MD
D.J. Martin, MD, FACEP

12 **Delivering Effective Learner-Centered Feedback**
Matthew Ryan, MD, PhD.
Henry Young, MD

15 **Alternatives to the Emergency Department**
Calvin Martin, MD

Medical Community

19 **2019 Health & Wellness Advocacy Award**
Nancy Hardt, MD

20 **Ryan Luevanos, MD**
NFRMC Emergency Medicine GME Program

21 **2019 Outstanding Clinical Practice Award**
Florida heart and Lung Institute

2019 ACMS Awards and Annual Meeting 26

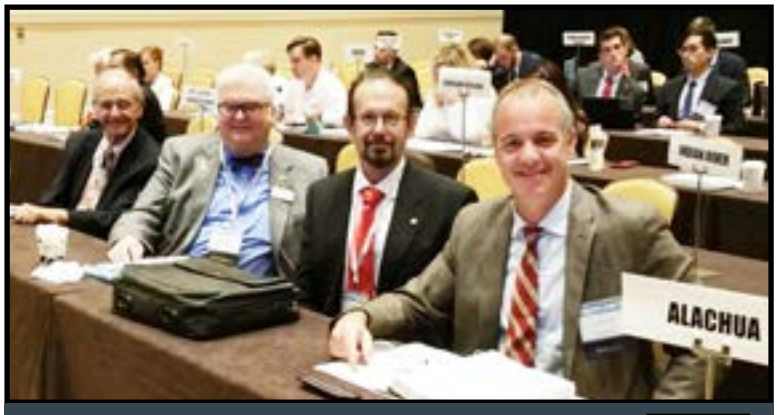
22 **In Memoriam**
George A. Dell, Jr., MD
Jose J. Llinas, MD

24 **ACMS Happenings**

30 **ACMS Board Highlights**

31 **A Note from Our Editor:**
New Drug Name Collusion
Scott Medley, MD

32 **In Memoriam**
James Talbert, MD



FMA Annual Meeting 2019 29

CONTRIBUTING AUTHORS

Calvin Martin, MD

SIMEDHealth First Care

Dr. Martin, Jr., is a 5th generation Florida native who practices Urgent Care/ Occupational Medicine at SIMEDHealth's First Care in Gainesville, FL. He completed his BS at Davidson College and his M.D. at the University of Florida College of Medicine. He completed his Family Medicine residency at the University of Florida and served on the faculty at UF working with the residents before discovering his professional passion in urgent care.

Gary Gillette, MD

NFRMC Emergency

Dr. Gillette graduated from Baylor College of Medicine in 1998. He completed his residency at Orlando Regional Medical Center and is currently Medical Director of NFRMC Emergency Department. Currently serves as Associate Clinical Professor at UCF College of Medicine. Dr. Gillette is Board Certified in Emergency Medicine.

Matthew F. Ryan, MD, PhD

UF Health Emergency Medicine

Matthew Ryan, MD, PhD, currently serves as chair of UF Health Emergency Medicine. He joined the UF faculty in 2008 after completing his residency training in Emergency Medicine at Orlando Regional Medical Center. Dr. Ryan received his medical degree from University of Indiana School of Medicine. Prior to medical school, Dr. Ryan was an Associate Professor of Chemistry of Purdue University Calumet. Prior to Purdue, Dr. Ryan held Postdoctoral Fellowships at York University, Department of Chemistry with Dr. A.B.P. Lever in Toronto, Canada and at the Technical University of Berlin, Institute for Organic Chemistry with Dr. Helmut Schwarz in Berlin, Germany.
His interests include medical education, public health, basic and applied research.

Scott Medley, MD

Retired Family Physician

After graduating from the University of Kentucky College of Medicine, Dr. Scott Medley served in the U.S. Army, completing his Residency in Family Medicine and attaining the rank of Major. He entered Private Practice in Gainesville, establishing Gainesville Family Physicians. After 20 years in Private Practice, Dr. Medley became a Hospitalist and later acted as Chief Medical Officer at NFRMC. He served as President of the ACMS and of the Florida Academy of Family Physicians. He was given 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 21 years, and has authored over 90 editorials and articles for this publication.

CONTRIBUTING AUTHORS

Henry Young, MD

UF Health Emergency Medicine

Dr. Young was born in the small town of Cordele, Georgia. He became interested in a career in medicine after watching his father serve his community as a Family Physician for several years. He attended Georgia Southern University where he majored in Biology. Following college, he attended the Medical College of Georgia. He completed Emergency Medicine Residency at the University of Florida where he served as chief resident in his final year. After graduation, Dr. Young joined the University of Florida Emergency Medicine faculty where he serves as Assistant Medical Director. His interests include emergency cardiology, resident education, and sickle cell disease.

Ryan Luevanos,MD

NFRMC

Medical School: Eastern Virginia Medical School Undergraduate: University of California, Santa Barbara Hometown: La Jolla, CA. Dr. Luevanos looks forward to balancing his community EM career with his outside passions. He spends his time traveling abroad, visiting his other home in San Diego, enjoying live music, going to the beach, as well as camping and golfing.

D. J. Martin, Jr.,MD, FACEP

NFRMC Emergency

Dr. Martin graduated from Marshall University Medical School in 2005. He completed his residency at Orlando Regional Medical Center in Emergency Medicine. He is certified in Emergency Medicine and currently serves as Medical Director at NFRMC West End Emergency Department.

Physicians & Office Managers

Please advise the ACMS of any changes in your practice.
Thanks.
352-376-0715 or
acmsassist@acms.net

Alachua County Medical Society, 235 SW 2nd Avenue, Gainesville, FL 32601.
Ph: (352) 376-0715;
Fax: (352) 376-0811;
www.acms.net

House Calls is a quarterly publication of the Alachua County Medical Society, Inc., Gainesville, Florida.

From the President's Desk

Matthew F. Ryan, MD, PhD, ACMS President

In 1941, President Roosevelt presented his four freedoms to congress which he believed were intrinsic rights for all. He stated everyone has basic freedoms that transcend the laws of the land: freedom of speech, freedom of worship, freedom from want and freedom from fear. To the third freedom Roosevelt added "translated into world terms, means economic understandings which will secure to every nation a healthy peacetime life for its inhabitants - everywhere in the world." This freedom specifically means economic viability for all and that no one should go hungry, go without shelter or lack access to an otherwise healthy life: Freedom from want is synonymous with freedom to be healthy.

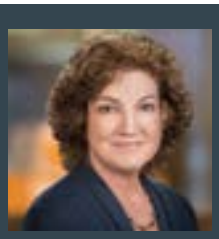
Health itself can be an odd thing because we often do not notice or appreciate it until it is at risk or until we become unhealthy. A health scare is among the most emotionally challenging experiences anyone can face. Most of us see this every day we work: good health and its maintenance are vital to our well - being and our sense of purpose. For those who have to manage a major health issue or a chronic medical problem day in and day out, the emotional toll adds up. So given how important health is, why don't we see health as a fundamental human right? Why is the issue of health and by extension healthcare so divisive?

There are many answers to these knotty questions. Consider, healthcare is expensive and requires tremendous resources: so who pays and who gets coverage and how much coverage and how do we make funding sustainable and control costs.? Moreover, what of controversial issues such as end of - life - care, pre-existing conditions and birth control/ family planning.? This last one is important because women's health is still not on equal footing with other healthcare issues.

Currently, the existing federal policy, e.g., the Affordable Care Act, provides coverage for millions who would otherwise not have access to healthcare. However, the ACA is quite imperfect and overly complex – premiums and deductibles are increasing and the number of participating insurers is decreasing. Recent attempts to initiate new national healthcare policies have failed to be enacted into law and a comprehensive bipartisan plan continues to elude our nation's leaders. Some want blanket coverage for all, while others are willing to accept people losing coverage for concerns regarding unprecedented costs. The middle ground is often hard to find. For example, how do you expand coverage to all, eliminate the pre-existing coverage clauses and fold in financial solvency without casting some to the side.?

We have a constitutional right to free speech and assembly and protection from religious persecution. Still, we have no constitutional right to food or to healthcare and most states-as well as the federal government-do not recognize healthcare as a right, but as a privilege, similar to a driver's license. Yet the two issues - nutrition and health - are deeply intertwined. Food insecurity is still a problem is this nation – consider school lunch programs – and many still lack access to basic health care and thus live with the associated fear of either getting sicker or encumbering exorbitant bills increasing their own food insecurity. We live in a great nation and we have continually adapted to overcome great adversity. Yet, it is hard to move forward when so many of our marginalized, our vulnerable, our at-risk, and our torn remain unmended.

Trends in Emergency Medicine



Jackie Owens, ACMS Executive Vice President

Emergency medicine physicians are dedicated to the diagnosis and treatment of unforeseen illness or injury for all who seek care, regardless of ability to pay. This process includes the initial evaluation, diagnosis, treatment, and coordination of care among multiple providers, while assessing the disposition of any patient requiring expeditious medical, surgical or psychiatric care. Today, emergency medicine is practiced in a variety of physical locations, including hospitals, freestanding emergency departments, urgent care clinics and express care clinics. Mobile locations include emergency medicine response vehicles, disaster sites and the use of telemedicine.[1]
Emergency Department (ED) use has been increasing over the last few decades, at a rate faster than population growth, and is expected to continue this trend into the future. This development has caused concern for policymakers as EDs have relatively high treatment costs compared with other care settings. Overcrowding is also a concern, as EDs struggle to keep up with the ever-increasing demand for their services.[2,3] A 2017 study by the University of Maryland School of Medicine found that nearly half of U.S. medical care is delivered in EDs. ED visit rates reached a 10-year high for all age groups in 2015, with patients aged 45-64 having the largest percentage increase from 2006 to 2015. Figure 1 shows the rate of ED visits per 100,000 population by age group.[4]

A partial explanation for this increase in ED visit rates, in addition to aging demographics and expanded wait times to access a doctor, is more frequent referrals to the ED from primary care physicians and the increase in ED visits for opioid overdoses.[2] In many healthcare settings other than EDs, the physician will typically not see a patient quickly without an appointment. An NIH study in 2013 found that 22 percent of non-urgent ED patients had tried but failed to access primary care first.3 In addition, opioid overdose visits have increased steadily over the last 10 years, rising an additional 30% in the US from July 2016 through September 2017.[4]

Figure 1

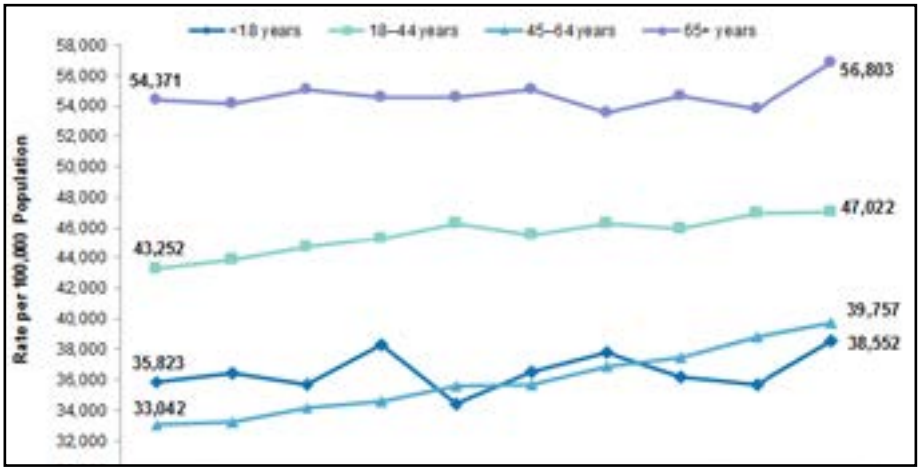


Figure 1: Rate of ED visits, per 100,000 population by age group, 2006-2015; Data source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets. Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2006-2015.[4]

Figure 2

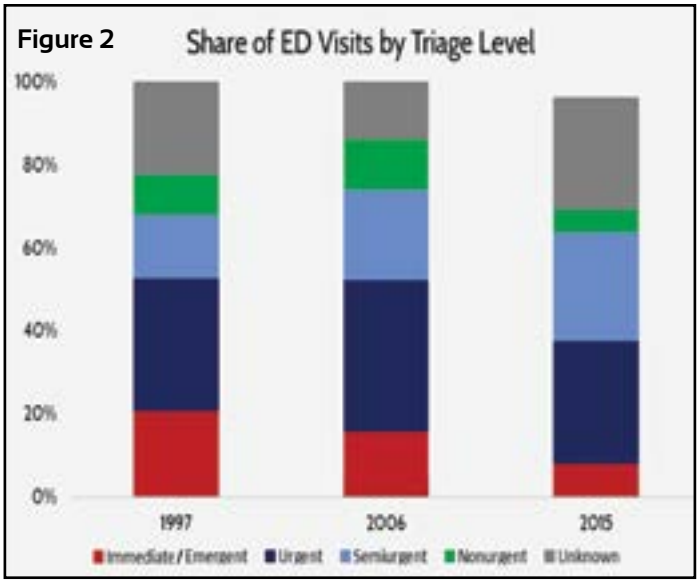


Figure 2: Share of ED Visits by Triage Level; Data source: Primer: Examining Trends in Emergency Department Utilization and Costs, American Action Forum, O'Neill Hays, November 2018.[3]

Figure 2 shows ED visits by Triage Level[3,5] A review of Triage Levels indicates that low-acuity visits to EDs have decreased by 36 percent, despite an overall increase in the number of low-acuity visits across all acute care venues of 31 percent. Visits to non-ED care venues (urgent care centers and retail clinics) increased 140 percent during the same time period, indicating that people are utilizing non-ED sites when they are available. High intensity visits have become more common in EDs and are mostly attributed to the large aging population group utilizing Medicare. In addition, ED wait times have declined over the last ten years, as hospitals are

Continued on Page 8

Continued from Page 7

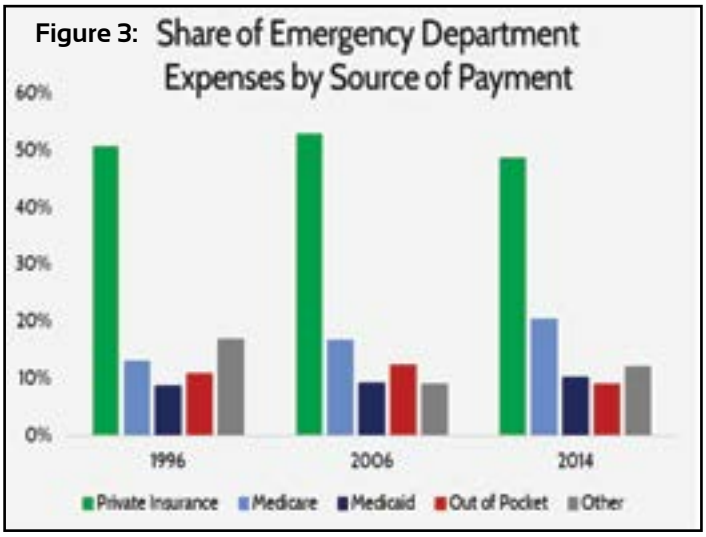


Figure 3: Share of Emergency Department Expenses by Source of Payment - Data source: Primer: Examining Trends in Emergency Department Utilization and Costs, American Action Forum, O'Neill Hays, November 2018.[3]

managing to increase efficiencies and process triage assessment at faster levels.[5] The growing category of "unknown" triage, however, leaves a degree of uncertainty in drawing conclusions from this analysis.

Source of Payment

The share of ED expenses by source of payment (private insurance, Medicare, Medicaid, Out-of-Pocket) shows a slight decline in private insurance payment from 1996 to 2014, with an increase in Medicare as a payment source. This shift is primarily due to the aging population of baby boomers reaching Medicare qualification. Medicaid as a payment source shows a slight increase over this period with most of that increase coming from patients aged under 18 years. For the under 18 years-of-age sector of the population, Medicaid as the primary source of payment rose from 45% in 2006 to 62% in 2015.[6] Overall, out-of-pocket expenses as a source of payment have declined over the same period (figures 3 and 4).

Figure 5 shows the share of ED expenses paid out-of-pocket broken down by poverty status. Following the passage of the Affordable Care Act (ACA), there has been a decline in the share of out-of-pocket ED expenses paid by all ED visits, with a significant decline for people near or below the poverty line.[3]

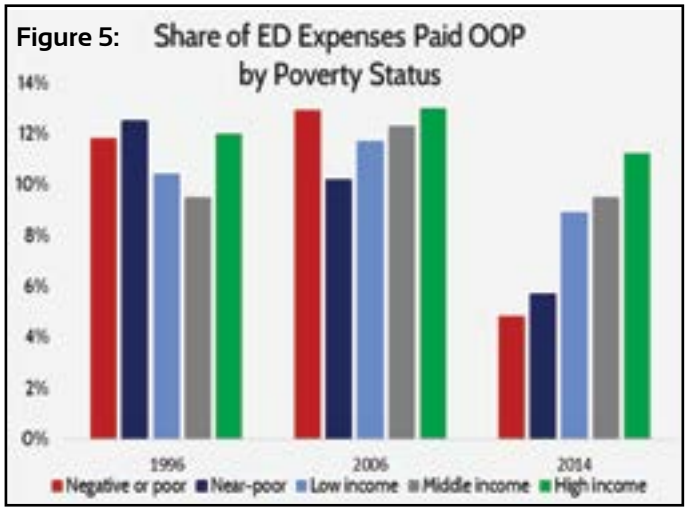


Figure 5: Share of ED Expenses Paid OOP by Peverty Status Data source: Primer: Examining Trends in Emergency Department Utilization and Costs, American Action Forum, O'Neill Hays, November 2018.[3]

Figure 4

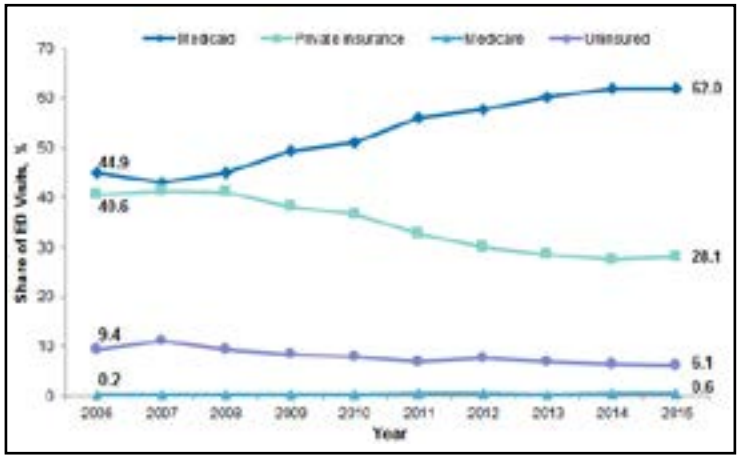


Figure 4. Trends in primary payer among all ED visits for patients under age 18 years, 2006-2015 - Data source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets. Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2006-2015.[4]

Increasing ED utilization has created problems for both policy makers and hospitals in keeping up with the costs and demand. The emergence of non-ED venues has relieved much of the non-urgent demand, yet the overall usage of ED services continues to increase in the general population. The passage of the ACA has made significant strides in providing insured ED services to people at or near the poverty line, particularly for children under the age of 18. However, there is still much to be done to reduce the overuse of the ED as a first-point of primary care for all demographics. A more comprehensive program improving access to primary care, with emphasis on preventive care and disease management needs to be implemented to allow the ED to serve as the name implies, a place to seek medical assistance for a true emergency.

References available upon request.

ALACHUA COUNTY MEDICAL SOCIETY

Thanks

Matheen A. Khuddus, MD, FACC

For his outstanding leadership as ACMS President, 2017-2019

ACMS is pleased to announce Officers for 2019-21

President
Matthew F. Ryan, MD, PhD

Matthew Ryan, MD, PhD, currently serves as Chair of UF Health Emergency Medicine and is an Associate Professor of Medicine at the University of Florida, Department of Emergency Medicine. He joined the faculty after completing his residency training in Emergency Medicine at Orlando Regional Medical Center, and receiving his medical degree from the University of Indiana School of Medicine. His general interests in medicine include medical education and public health and epidemiology.

Vice President
Carl Dragstedt, DO

Dr. Dragstedt is a Cardiologist at the North Florida/South Georgia VA Medical Center in Lake City, Florida. He was raised in the Boston area and attended Bates College in Lewiston, Maine. He graduated from Nova Southeastern University College of Osteopathic Medicine in 2004, completing his internship, residency and Chief Residency in internal medicine at the University of Florida (UF). He stayed on at UF to complete fellowships in Cardiovascular Diseases and Interventional Cardiology. Dr. Dragstedt is board certified in Internal Medicine, Cardiovascular Diseases, and Interventional Cardiology. He is a recent graduate of the FMA Physician Leadership Academy and is the ACMS Delegate Liason to the FMA. Dr. Dragstedt is married with two children. He enjoys spending time with his family, attending his children's activities, and traveling.

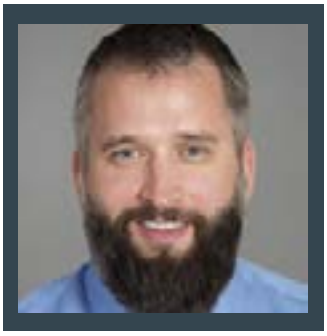
Secretary/Treasurer
Ann Tong, MD

Dr. Tong graduated Magna cum Laude from the combined accelerated BA/MD Program from Boston University. Dr. Tong is certified by the American Board of Internal Medicine, with a specialty certificate in Cardiovascular Disease. Prior to relocating to Gainesville, Dr. Tong held faculty appointments at MD Anderson at The University of Houston, Baylor College of Medicine, and Tufts University School of Medicine. She joined The Cardiac & Vascular Institute (TCAVI) in 2009. Her areas of clinical interest include Congestive Heart Failure, Heart Disease in Women, Echocardiography and Valvular Heart Disease. As Director of Echocardiography and the Congestive Heart Failure Clinic, Dr. Tong oversees TCAVI's outpatient and inpatient Echocardiography Laboratory and Heart Failure Clinic.

Freestanding Emergency Departments

Gary Gillette, MD, NFRMC Emergency Department
DJ. Martin, Jr., MD, NFRMC Emergency Department

Gary Gillette, MD

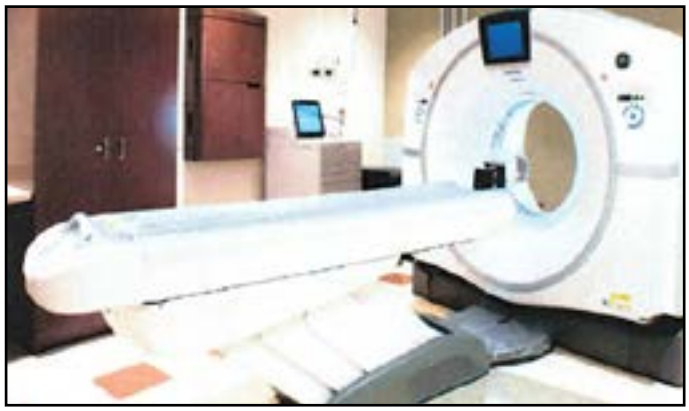


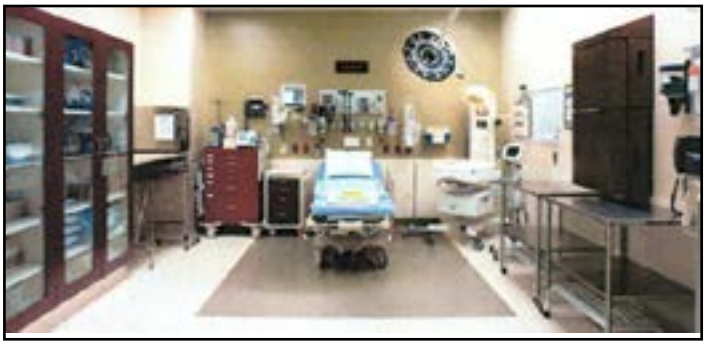
D. J. Martin, Jr., MD, FACEP

Off - site emergency departments-better known as freestanding emergency rooms- (FSEDs) is a quickly expanding trend in healthcare. Despite what appears to be a new trend, freestanding emergency rooms are not a new concept, as they have been around since the 1970s as a result of the need for emergency care in rural or other underserved regions of the eastern United States. Some of the first FSEDs have now expanded to full hospitals, while others have remained freestanding facilities. In 2002 Florida began its pilot FSED program.

At that time it was determined that hospitals could have certain off - site outpatient facilities that could be listed on the hospital license. This new requirement allowed FSEDs to operate on the same license as the parent hospital and to have virtually no regulations on new construction. The first FSED in Florida therefore opened in 2002 and continues to operate as a FSED today. In 2003, the Florida state legislature passed a bill that placed a moratorium on construction of new FSEDs in the state. As late as the beginning of 2008 there were only 2 freestanding emergency departments operating in the state, but the moratorium was lifted in 2007 when a bill to extend the moratorium was vetoed by the state's governor. Fast-forward just over a decade and there are now 59 freestanding emergency departments in Florida as of June 2019.

Comparing FSEDs across the country is not like comparing apples to apples. There are state - specific regulations for FSEDs. Regulations can be as strict as in California, which has legislation that indirectly eliminates FSEDs, to as lenient as in Texas and Colorado where there are few regulations and





the majority of FSEDs are independently owned and not affiliated with a hospital. The Florida regulations for FSEDs fall somewhere in the middle of these two extremes. According to the Agency for Healthcare Administration (AHCA), any Florida licensed hospital which has a dedicated emergency department, may provide emergency services in a location off of the hospital's main campus. The off-site emergency department must be under the same direction, offer

Continued on Page 11

FREESTANDING EMERGENCY DEPTS

Continued from Page 10

the same services and comply with the same regulatory requirements as the emergency department located on the hospital's main campus. There are no additional rules or standards specific for emergency departments located off the premises of the licensed hospital.

Despite a constant expansion of the size of the emergency department at North Florida Regional Medical Center over the previous decade, it was determined that the number of ER visits was outpacing the hospital's ER capacity. This situation led to the need for new access points to the ER for patients. Therefore, in 2017 North Florida Regional Medical Center (NFRMC) opened two FSEDs.

The first-West End FSED-opened in April 2017 at 12311 W. Newberry Rd on the corner of Parker Rd and Newberry Rd. This FSED is an improved access point for the ever - expanding western portion of Gainesville-particularly west of I-75-and the citizens in the counties to the west of Alachua County.

The second, Millhopper FSED, opened in December 2017 at 4388 NW 53rd Ave. at the corner of Millhopper Rd and 43rd St. This FSED is an improved access point for the northern part of Gainesville and for the neighboring city of Alachua.

NFRMC FSEDs offer a full range of capabilities, from pediatric to adult care, and provide the same level of excellent emergency care as the main campus emergency department, with significantly shorter wait times. Like NFRMC's main ER, the West End and Millhopper FSEDs offer 24/7 access to an Emergency physician, an emergency nurse, moderate complexity blood testing, and a radiology department with advanced imaging such as x-rays and CT scans along with ultrasound procedures. The same physician group that staffs the main ER, Gainesville Emergency Medical Associates (GEMA), staffs both of NFRMC's FSEDs.

The NFRMC FSED's provide care for the full spectrum of emergency medical conditions. The FSEDs have a stroke alert program in place with the ability to start TPA for stroke patients prior to transporting to the main campus. The providers at the FSED have the ability to call a "STEMI alert" or cardiac alert for heart attack patients who are then transferred from the FSED directly to the main campus cath lab for intervention. Patients with trauma such as lacerations, sprains, and fractures are typically treated and referred for subsequent outpatient follow-up. The FSED's can provide conscious sedation for conditions such as joint reductions.

Most patients who present to the FSEDs are discharged home with either primary care physician or specialist follow-up. The same specialists who provide referral services for the main NFRMC campus provide referral services for the FSEDs. Patients that need to be admitted to the hospital have the admission process arranged from the FSED and the patient is transported via Alachua County Fire Rescue directly to their inpatient bed at the main campus. The overall stay at the FSEDs is up to an hour shorter for both discharged patients and for admitted patients, despite having to be transported from the FSED to the main campus. This efficient and quality care leads to patient satisfaction scores that are very high at both facilities.

Delivering Effective Learner-Centered Feedback

Matthew Ryan, MD, PHD, Chair UF Health Emergency Medicine
Henry Young, MD, Assistant Medical Director
UF Health Emergency Medicine

Matthew Ryan, MD, PhD

This is an important method we use for training our ER house-staff and students at UF Health.

Henry Young, MD

With the new academic year beginning, it is important to recognize providers have a responsibility to provide both the best patient care while still delivering foundational educational experiences. We describe herein why feedback is amongst the most important tools in our educational arsenal and describe some ways op optimizing who to give feedback and best practices.

Hattie's Tables of Effect Sizes, derived from a massive meta-analysis of what works and why in education, lists formative feedback as the most influential aspect of teaching. Feedback is what we as students respond to greater than any other aspect of a wide arsenal of education tools. Look where testing resides on this list. Anything below 0.4 is considered a wash in effectiveness.

Consider a moment when a teacher or professor or colleague took you aside to give feedback, especially negative feedback. I bet you remember the tone and content of the conversation if not the exact words. Feedback, direct, well-timed, well conceived, based on concrete observations and facts is the best tool in medical education we have.

FEEDBACK DISSECTED. Feedback is specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance. Feedback is an assessment for learning rather than an assessment of learning and some basic guidelines apply. Effective feedback is specific (formative) and not summative. Effective feedback is a conversation between the learner and the teacher used to analyze actions and explore their underpinnings which entails a learner's

Hattie's Tables of Effect Sizes

Influence	Effect Size		Source of Influence
Feedback	1.13		Teacher
Student's Prior cognitive ability	1.04		Student
Instructional quality	1.00		Teacher
Direct instruction	0.82		Teacher
Acceleration	0.72		Student
Remediation/feedback	0.65		Teacher
Student's disposition to learn	0.61		Student
Class environment	0.56		Teacher
Challenge of Goals	0.52		Teacher
Peer tutoring	0.50		Teacher
Mastery learning	0.50		Teacher
Homework	0.43		Teacher
Teacher Style	0.42		Teacher
Questioning	0.41		Teacher
Peer effects	0.38		Peers
Advance organizers	0.37		Teacher
Simulation & games	0.34		Teacher
Computer-assisted instruction	0.31		Teacher
Testing	0.30		Teacher
Instructional media	0.30		Teacher

Continued on Page 13

Continued from Page 12

emotions, skills, knowledge, perceptions and experiences.

WHY GIVE FEEDBACK. Feedback provides information to the learner about their progress towards a goal with a purpose to improve performance in the future, develop expertise and promote self-assessment. Effective feedback can shed light on the underlying drivers of performance gaps; subsequent discussions are focused on teaching what is meaningful to learners. Feedback should attempt to seek a learner's frame thus ascertaining why a certain path was chosen, a rule was adhered to or a task was completed a certain way. Once the frame is identified, we can understand a learner's beliefs and philosophies and hopefully correct knowledge gaps to thus correct performance gaps. Results stem from actions and frames; incorrect or suboptimal results stem from incorrect actions and from misaligned frames which need to be realigned through feedback.

WHAT HAPPENS WITHOUT FEEDBACK? The absence of feedback is tantamount to missed learning opportunities. Good performance is not reinforced and poor performance remains uncorrected. Moreover, learners are left to self-assessment in the absence of expert opinion and observation. Even worse, learners may assume that all is well which may lead to insecurity or overconfidence in abilities. Further, trainees may have to guess their level of competence, based on how well they are coping or rely on unsubstantiated information from colleagues. Even worse, trainees may have to learn by trial and error at patients' expense which is of course unacceptable. This last reason is why well-conceived, timely feedback in medical education is so important: poor outcomes stem from poor decisions and misaligned frames.

LIMITATIONS TO GIVING FEEDBACK. Patient volume and acuity, time constraints, and interruptions combined with limited direct observation of the learner are barriers to providing effective feedback. Other key factors especially for trainees assessing other learners include uncertainty about standards or benchmarks and lack of training in feedback methods. Providing effective feedback is complicated and additional training in the optimal delivery of this feedback to the learner would greatly enhance the learning environment. Further, concerns exist regarding the consequences of negative feedback: learner self-esteem, retribution via learner evaluation of faculty as well as complex-and-not-to-be-disregarded cultural, institutional, personal, situational, temporal issues.

SOME ABCs OF FEEDBACK. The timing of feedback is important. In a critical situation, feedback too soon will not work because learners will not be prepared. Simply stating we are about to have a discussion about an event will overcome this barrier. Also, consider the situation for which feedback is given. If you tell me my essay on

Continued on Page 14

Continued from Page 13

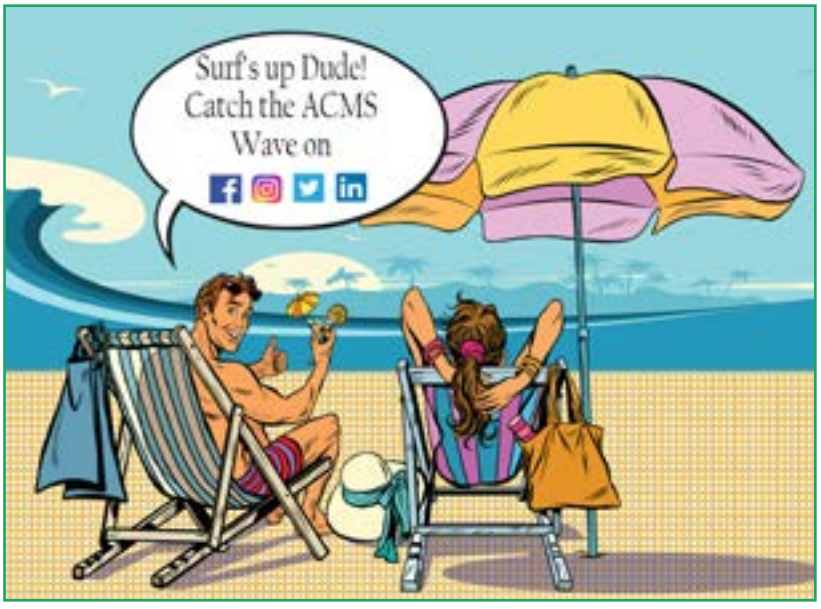
Self Regulation Theory: Prevention versus Promotion

PREVENTION	PROMOTION
• Fear of retribution	• Associated with reward
• Requires vigilance	• Requires eagerness
• Obligations, meetings, specific tasks	• Hobbies, interests, opportunities
• Relief when completed	• Seeks praise when completed

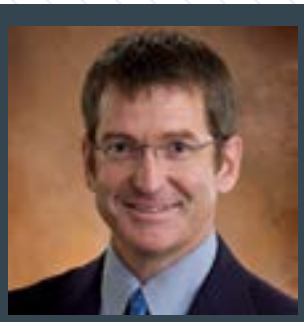
Kuger and Dijk, Med Educ. 2010:44; 1166-1174

feedback was awful, something I created with care and thought, I may be devastated. If you tell me my essay was submitted late, I will be more vigilant. The difference is in prevention versus promotion modes. For the most part clinical medicine is lived in prevention mode, we seek to avoid mistakes, and we are observant and ever mindful of mistakes. Nonclinical work (papers, research, conference presentations) falls under the umbrella of promotion mode where we seek reward. In prevention mode negative feedback works. We file our taxes on time, show up early for work, and complete our charts because of preventative repercussions. Basically, provide the negative feedback constructively, with highly specific examples and a plan moving forward. Say chest x-ray is misinterpreted. The feedback would discuss the error, what the error was and why it is important and a performance plan such as some online modules or further reading and then a follow up with the learner to assess outcomes.

CLOSING COMMENTS. Feedback by definition is an emotionally charged process regardless of experience, situation or level of training of participants. Moreover, who assesses the assessors of feedback? Those who develop feedback methods and plans may not see the limitations in their plans. We often attempt to curb our emotions yet we are human and thus filled with emotions that can be too strong to ignore. I encourage you to embrace this, provide feedback based on your experiences with thoughtfulness, based on clear observations ("I saw", "I heard", "I noticed") and with an understanding no other tool we possess will carry a greater impact in learner training.



Alternatives to the Emergency Department



Calvin Martin, MD
SIMEDHealth First Care

There are many options in our area to address urgent/emergent medical issues. We have traditional in-hospital emergency departments designed to address Level 1 traumas and other truly life-threatening emergencies. We also have hospital-affiliated free standing emergency departments that can handle more ambulatory emergent issues and transfer patients, when appropriate, to their respective hospitals. Though these facilities provide necessary care, this comes at great financial cost to the medical system as well as to the individual requiring care. Increasing attention is being paid to the cost of emergency department services, as well as to the costs and health risks associated with frequent, and possibly unnecessary, admissions to the hospital. The National Hospital Ambulatory Medical Care Survey from 2016 reported over 145 million emergency department visits of which less than 10 percent resulted in admission to the hospital. Costs for even the simplest emergency department visits are estimated by many sources to be from 10 – 20 times the cost of urgent care center visits. Now add to these concerns physicians being encouraged to go "at risk" with new contract models, and it becomes evident that other methods for evaluating patients emergently should be re-visited.

Though not all urgent care centers offer an extensive array of services, some offer a way to quickly and cost-effectively evaluate and treat many "emergent" medical issues. Generally, with medical providers on staff on any given weekday and some on weekends and holidays, urgent care centers can address a wide array of "emergent" medical issues from the very simple to the more complex.

Chest Pain

According to a 2018 paper from the Journal of the American College of Cardiology, approximately 7 million patients present to emergency departments yearly with a complaint of chest pain, though only 5.5% of these have a life-threatening condition (vol. 72, no.6). Many of these patients can be evaluated and treated effectively at an urgent care center resulting in significant cost savings. With skilled triage, the patient can be in a room and the initial evaluation completed in moments including vital signs and ECG followed promptly by history and physical exam. If further outpatient evaluation is indicated, urgent care centers often have the ability to process stat in-house labs, including initial cardiac enzymes. Most urgent care centers provide X-ray services and some, such as SIMEDHealth's First Care, even run CT/CTAs on an urgent basis. Countless unnecessary hospital admissions can be prevented in this way. If a more severe condition is diagnosed and admission to the hospital is warranted, direct admission is sometimes possible through hospitalists, bypassing the emergency department altogether.

Deep Venous Thrombosis (DVT)

DVT management has evolved to the point that many cases can safely be managed in an urgent care setting without the need for an emergency department visit or hospital admission. The release in recent years of advanced orally administered anti-thrombotic agents that do not require regular serologic monitoring have paved the way. The use of these drugs, carefully chosen with the aid of bleeding-risk calculators, allows for the outpatient management of many DVT presentations. Some urgent care centers have access to stat ultrasounds for diagnosis of the severity and extent of a thrombus. Some centers

Continued on Page 16

Continued from Page 15

also have the ability for rapid d-dimer measurement, as well as other clotting metrics, to further assess the causes of thrombus formation and risk stratification for potential complications of therapy. The patient is then scheduled for follow-up with the primary care provider for long-term management and further evaluation as indicated.

Abdominal/Pelvic Conditions

Pain of the abdomen and pelvis can similarly be evaluated thoroughly in an outpatient urgent care setting. A thoughtful history and exam can lead providers to successful outpatient treatments for conditions ranging from acute gastritis to urinary tract infections to diverticulitis. Again, appropriate STAT labs done in-house as well as indicated imaging in-house from ultrasounds to contrast-appropriate CT scans, aid in prompt and accurate diagnosis. Intractable nausea/vomiting as well as dehydration can commonly be addressed at urgent care centers with IV fluids and injectable medications.

Head Trauma

With an aging population, falls are a common occurrence-sometimes resulting in head traumas. This can lead to great concern for intracranial bleeding, especially given the increasing use of chronic antithrombotic therapies. With skilled triage, head traumas may be safely treated in an outpatient urgent care setting. A thorough history and exam may indicate the need for a non-contrast head CT which can provide a high degree of reassurance to the patient, family and healthcare provider. The patient and family are then educated about warning signs and symptoms that might suggest further emergency department evaluation and treatment is necessary or referral back to their primary care physician for continued outpatient follow-up.

Skin Trauma and Infections

Lacerations, punctures, abscesses, and skin infections can all be treated quickly and with minimal cost in an outpatient urgent care setting. At First Care, and many other urgent care centers, there is a dedicated procedure room well-stocked to address minor to moderately complex skin injuries with primary wound closure. Incision and drainage of abscesses can also be accomplished with wound packing as indicated. Throughout the healing process, patients can be set up to return to the urgent care center, follow-up with their primary care doctor, or be referred for more intensive wound care as needed. Given increasing issues with antibiotic-resistant organisms, wound cultures of infected sites and appropriate antibiotic therapy can be directed as indicated.

Respiratory Conditions

Urgent care centers are uniquely positioned to address respiratory conditions ranging from the common cold to more severe conditions such as asthma and COPD exacerbations, as well as pneumonia. With appropriate triage, patients with more severe conditions can be quickly assessed and treatments such as nebulized medications administered. Chest x-ray can be obtained with diagnosis determined by the attending health care provider, but then also confirmed quickly with a reading by an on-or off-site radiologist. Stat blood work can be performed as indicated to further assess severity of the presenting condition. Appropriate intramuscular/intravenous injection medications are commonly stocked at urgent care centers to initiate outpatient treatment for common conditions and then short-term follow-up with the primary care provider can be scheduled for ongoing care.

Orthopedic Injuries

Sprains, strains, minor dislocations and closed non-complex fractures can be effectively evaluated and treated in many urgent care centers. Stat x-rays, again with radiologist over-read, can help make an accurate diagnosis. Grade I and II strains are easily evaluated and initially managed in an urgent care setting. In the absence of any related neurologic or vascular compromise, Grade III sprains and closed fractures can be treated initially with temporary

Continued on Page 17

Continued from Page 16

splinting and management of pain and swelling. Following these initial treatments, the patient can then be scheduled for outpatient follow-up with the primary care provider or appropriate specialist.

Ophthalmologic Issues

A cause of great discomfort and worry, eye injuries and infections lead many patients to the emergency department. However, a skilled urgent care provider can address many of these issues in a more ambulatory setting. Using topical anesthetics and fluorescein dye, a thorough exam can identify many conditions such as corneal abrasions and small foreign bodies that can be treated in an urgent care setting. Patients can follow-up with their primary care provider to ensure healing or can be referred to a specialist as needed.

A key element to more utilization of urgent care centers for the above, and many other conditions, is better education for patients, but also for physicians and staff of primary care and specialty offices. It has become reflexive to advise patients to "go to the ER" when a physician's practice cannot provide services to handle the patient's immediate medical needs. However, as the various stakeholders become more comfortable with urgent care centers and the services they offer, a paradigm shift in acute health care delivery can be achieved, thus lowering the total cost of health care, and freeing the emergency departments to focus their care on truly life-threatening emergencies.

Learn Locally! (and save $$ too!)

ACMS Local Live CME Courses offered this Fall:

Prescribing Controlled Substances (Cost non-members: $175)
Prevention of Medical Errors (Cost non-members: $125)
Domestic Violence (Cost non-member: $125)

All courses are free to members!

Your membership supports the continuing operations of the We Care Clinic for underserved populations in Alachua County.

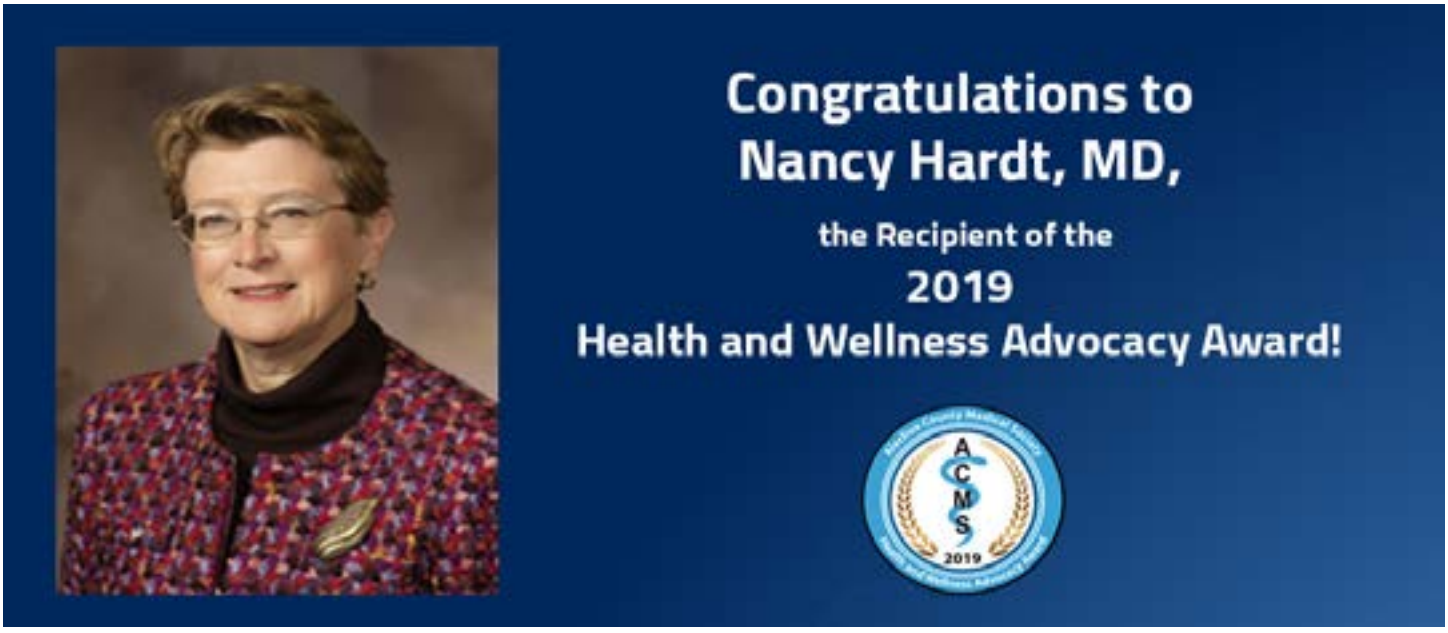
Invest in Your Physician Community!

CME Courses Offered this Year will Include:		Cost to Members:	Cost to Non-Members:
Prescribing Controlled Substances	10-15-19	$0	$175
Prevention of Medical Errors	11-12-19	$0	$125
Domestic Violence	1-14-20	$0	$125

Join the ACMS today and get free access to required CME courses this Fall. Members also receive a free listing in the Physicians Directory that has 47,000+ downloads annually in the Alachua County area.

Alachua County Medical Society

We're Working For You!



Nancy Hardt, M.D. is Professor Emerita of Pathology and Obstetrics and Gynecology at the University of Florida College of Medicine. Most recently she directed the Health Disparities and Service Learning Programs, including the Mobile Outreach Clinic. She co-founded the undergraduate minor in Health Disparities in Society which is now the most popular minor in the College of Liberal Arts and Sciences. She learned policy as a Robert Wood Johnson Health Policy Fellow during which time she worked as a health legislative advisor for Senator Jeff Bingaman of New Mexico and Speaker of the House, Nancy Pelosi.

In retirement, she collaborates with community leaders to address local health equity issues, specifically early childhood brain development as an important social determinant of adult health. A health report card for Alachua County was developed by Dr. Hardt, and key indicators were mapped, resulting in numerous community actions to respond to highlighted health inequities. She spearheaded the University response, the Mobile Outreach Clinic, in which an interprofessional team meets the needs of the underserved in neighborhoods throughout Alachua County. This effort resulted in a significant reduction in premature births and documented cases of child abuse and neglect.

She co-founded the innovative Intimate Partner Violence Clinic in conjunction with the College of Law, in which law and medical students learn together how best to meet the needs of victims. The law-medicine partnership led to formation of Peace4Gainesville which seeks to reduce trauma and enhance resilience for children and adults.

Thank you, Nancy Hardt, MD, for your contributions to the Health and Wellness of the Community!

NFRMC Emergency Medicine GME Program

Ryan Luevanos, MD
NFRMC Resident

In July of 2017, North Florida's Emergency Department Faculty welcomed their first class of Emergency Medicine Residents. North Florida Regional Medical Center is Alachua County's community hospital and, after years of preparation, began five residencies in the last few years- one of the newest programs being our 3-year Emergency Medicine residency. From the beginning, our residents have made a positive impression throughout every department with which we've had the pleasure to work. In the first year alone, our residents performed more intubations, central lines, and chest tube insertions than many other programs!

Fast forward two years to this July of 2019- we at last have 3 full classes of emergency medicine residents and we could not be more excited! Our residents continue to experience a wide range of training and exposure as they learn to serve the surrounding community in a busy and high-acuity emergency department. Our high-volume emergency departments have approximately 80,000 visits every year, with residents treating a high-acuity population where 44% of patients require hospital admission. Residents collaborate alongside a proficient interdisciplinary team which holds resident education of highest importance- by encouraging protected conference time with oral and written medical board preparation, and providing vast resources for research as well as for quality improvement projects. We also continue to invite medical students from across the country to take part in a unique and rigorous learning experience while working alongside our senior residents and dedicated attending faculty.

Our outstanding clinical faculty all offer unique insights in training our residents and students; our highly-involved Program Director Robyn Hoelle, MD, and Associate Program Director Tami Vega, MD, have gone to great lengths to ensure our residency "hit the ground running" smoothly and successfully. Our faculty also includes two Fellowship-trained Ultrasound Directors, a multi-county EMS Director, and a devoted Medical Director, to list a few.

Our fellowship-trained Ultrasound Director and Assistant Director, Diana Mora, MD, and Dakota Lane, MD, have successfully developed an unmatched ultrasound clinical experience! Utilizing top-of-the-line ultrasound machines in one-on-one scanning sessions, they've ensured that our ultrasound rotation is unlike anything else offered at other institutions!

An exciting EMS experience is offered by Amit Rawal, MD, who co-directs two local EMS systems and directs a flight medical service as well. The EMS rotation has been a great success as it offers a rare glimpse into the world of an EMS Director in addition to scheduled ground and air EMS "ride-alongs".

Our Emergency Medicine-focused Simulation director, Evan Stern, MD, has done an amazing job helping build our simulation program for our residency by receiving training at Harvard University on medical simulation and therefore ensuring that our state-of-the-art Simulation lab furthers our education and prepares us for medical encounters one can't train for anywhere else.

We also could not have been more excited with how well our research projects have been received! Our very own residents, Alex Waldman, MD, and Donovan Ginest, MD, presented a Top 100 presentation on opioid prescription reduction research at the SAEM meeting in Las Vegas. Zaza Atanelov, MD, was also one of the top resident presenters at this year's Alachua County Medical Society Research Poster Symposium-- We can't wait to share what our attendings and residents have planned for in the future!

From taking leadership roles on Intensive Care Unit teams to managing multiple resuscitations to maintaining a healthy work-life balance, you can see how well our residents will be trained and ready to serve beyond residency. We can't wait to see what's in store for the future of our program!

The establishment of Florida Heart and Lung Institute, under the leadership of Dr. Chuck Klodell in January 2017, culminated into a top quality, patient-centric clinical practice. They offer individualized care in a compassionate genuine manner. The attention to delivering quality care is of utmost importance within their practice. Florida Heart and Lung Institute initiated the following to focus on ensuring their patients are receiving excellent care:

- Development of Family Centered Rounds in order to facilitate patient/practitioner communication
- Initiation of monthly Morbidity and Mortality conferences and individual case reviews of any readmissions, mortalities, major morbidities, or blood transfusions
- Enhanced ICU coverage model to include 24-hour-a-day advanced practice clinician coverage of the postoperative patient
- Initiation of minimally invasive valve surgery including AVR/MVR/TVR/PVR
- MitraClip program was initiated with excellent outcomes
- Enrollment into the Apollo transcatheter mitral valve replacement trial (1 of 2 sites in the entire state Florida)
- Implementation of a multifaceted blood conservation strategy with dramatic reduction in blood utilization for cardiac surgery with a 42% intra/postoperative blood product usage in 2016 reduced to 12% in 2017.
- Initiation of daily multi-disciplinary rounding to include occupational therapy, advanced practice clinicians, pharmacy, and nursing.
- Implementation of monthly CV Surgery quality meetings with review of STS data and other quality metrics.
- Continued reductions in mortality, blood transfusion, readmission, reintubation, time to extubation and otherquality metrics, all made possible through close collaboration of all stakeholders and monthly meetings to review progress and maintain alignment on strategies for further improvement.

Congratulations!

In Memoriam

George A. Dell, Jr., MD

(March 29, 1928 – May 17, 2019)

Dr. Dell was born in Gainesville, Florida. Following his graduation from the University of Florida in 1948, he matriculated to St. Louis University School of Medicine, where he graduated in 1952. Dr. Dell completed his Residency in Pediatrics in 1957 at St. Christopher's Hospital for Children, Temple University School of Medicine in Philadelphia. His training included two years of service in the United States Air Force as the Chief of Pediatric Outpatients at Moody Air Force Base, Valdosta, Georgia.

During his career, he was President of the Alachua County Medical Society; Chairman of the Department of Pediatrics at Alachua General Hospital; Clinical Professor of Pediatrics, UF, College of Medicine, Department of Pediatrics Neonatology; Appointee Florida Children's Commission, and a Member of the Alachua County School Health Advisory Council.

He practiced as a pediatrician in Gainesville, Florida from 1957 and retired in 2003. During his career he was privileged to work with many excellent physicians and provide care to multiple generations of families.

Dr. Dell is survived by his three children, Claudia Dell Stolz (Richard Alan); Ann Dell Bzoch (Kevin); George Alexander Dell, III (Nannette); and his four grandchildren, Cali Dell Bzoch; Ann-Lorrayne Bzoch; George Alexander Dell, IV; and Elizabeth Parker Dell. Dr Dell was preceded in death by his wife, Shirley Allen Dell.

In Memoriam

Jose J. Llinas, MD

(August 10, 1928 – May 16, 2019)

Dr. Llinas graduated from Universidad de la Habana, Cuba with a doctor of medicine degree in 1954. As young newly-weds, he and his wife Maria made the decision for him to pursue further medical training in the United States. Dr. Llinas came to Gainesville in 1974, where he taught at the University of Florida College of Medicine and went on to head the newly-formed North Florida Community Mental Health Centers. Over the next forty-plus years, he served as Medical Director at Meridian Behavioral Healthcare and Vista Pavillion, penned the 'Your Mental Health' column for the Gainesville Sun, and cared for patients in private practice and at Alachua General Hospital. He closed his career as a staff psychiatrist at the Malcom Randall Department of Veterans Affairs Medical Center in Gainesville until his retirement in 2017. He received numerous awards and recognitions over his long career and was a Diplomat of the American Board of Neurology and Psychiatry. He was named a Distinguished Life Fellow of the American Psychiatric Association in 2003.

Dr. Llinas is survived by his wife of 65 years, Maria Gonzalez Llinas; his children, Joe Llinas (Terri), Tom Llinas (Robin), Madeleine French (Kevin), Margie Llinas (Michael Goodman), Jackie Llinas (David Drake), and Lizzie Anderson (Jim); seventeen grandchildren and seven great-grandchildren.

ALACHUA COUNTY MEDICAL SOCIETY HEALTH INSURANCE CO-OP

Now Available to Members:

ACMS Health Insurance Co-Op Plan

Underwriten by

Thomas Buss,

of Barrett, Liner & Buss, LLC

Join the ACMS Physician Health Insurance Co-op Plan and find out how Practices in Lake, Sarasota and Marion Counties are already lowering their health insurance cost by leveraging joint venture economies of scale, large group underwriting, and profit sharing with Florida Blue.

If you'd like more information email Jackie Owens at: evp@acms.net

BARRETT, LINER & BUSS, LLC

Florida Blue

HAPPENINGS

ACMS

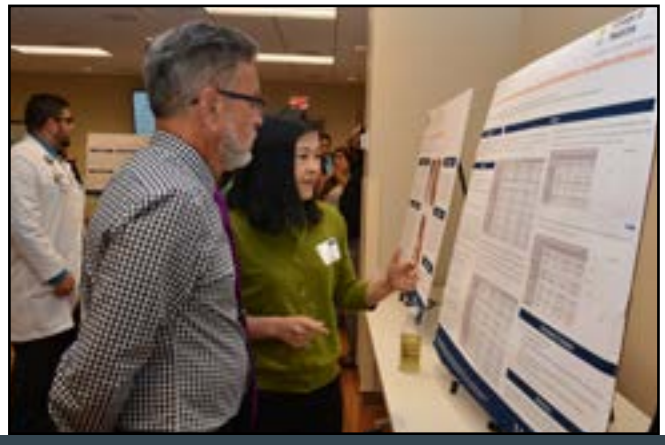
ACMS Research Poster Symposium

North Florida Regional Medical Center, South Tower, May 1, 2019

L to R: Matheen Khuddus, MD, ACMS President with the ACMS Research Poster Symposium Winners: Zaza Atanelov, MD; Parker Long, DO; and Rachel Fritz.

L to R: Charles Riggs, MD; Consuelo Soldevila-Pico, MD; Dhaval Upadhyay, MD; and David Tyson.

Madison Szar, UF Medical Student with Research Poster Symposium Presenters Vanessa Lewis, MD and Mar'Tina Reynolds, MD.



John Colon, MD, ACMS Past President and Hongchuan Coville, MD, Research Poster Symposium Presenter.

Group Photo of all Poster Symposium participants, sponsors and judges. Thanks to everyone for a most successful event!

ACMS Research Poster Symposium

North Florida Regional Medical Center, South Tower, May 1, 2019

Hale Toklu, PhD, and Matheen Khuddus, MD, ACMS President.

Alina Alvarez, MD presenting her project to Christopher Bray, MD and Joseph Thornton, MD.

UF Student Sara Khan with her Poster Presentation.

Syed Raza Shah, MD presenting his project to Carl Dragstedt, DO.

L to R: Jackie Owens, ACMS Executive Vice President; Mrs. Roslyn Levy; Norman Levy, MD, PhD; Christopher Vallandingham, JD; and Muhannad Bahrami, MD, Research Poster Symposium Presenter.

Fan Ye, MD and Ahmad Al dughiem, MD.

HAPPENINGS

ACMS

ACMS Awards and Annual Dinner Meeting

Mark's Prime Steakhouse, May 14, 2019

The induction of Matthew F. Ryan, MD, PhD, as ACMS President.

L to R: Ronald Giffler, MD, presenting the award for the ACMS Research Poster Symposium to the First Place Winners: Rachel Fritz and Stephanie Adamczak, MD

Katie Winter, MD, receiving the Health and Wellness Advocacy Award on behalf of Nancy Hardt, MD.

Mark Barrow, MD, Presenting the ACMS special award to Florence Van Arnam, Robb House Medical Museum Curator.

Charles Riggs, Jr., MD and Christine Riggs, President, UF Medical Guild.

Florida Heart and Lung Institute accepting the ACMS 2019 Outstanding Clinical Practice Award. L to R: Mark Martin; Nick Mignon; Kelly Chewning; Brian McCain; Brooke Haddix; Aubrey Hall; Thomas Zeyl, MD; Charles Klodell, MD; and presenting the award is Ann Weber, MD.

HAPPENINGS

ACMS

ACMS Awards and Annual Dinner Meeting

Mark's Prime Steakhouse, May 14, 2019

L to R: Blanca Millsaps, ACMS Graphic Designer; Jeff Sims ; and Madeleine Mills, CB&T Vice President.

Lloyd Alford and Judith Lightsey, MD.

Ki Park, MD, and Matheen Khuddus, MD, outgoing ACMS President.

L to R: Mrs. Cherise Bartley; Florence Van Arnam; and Justine Vaughen, MD.

L to R: Brittany Bruggeman, MD; Lauren Aycock; and Rachel Fritz.

L to R: Charles Riggs, MD; Donald Giffler, MD, FMA President-Elect; Matthew Crowley, FMA COO; Ki Park, MD; and Carl Dragstedt, DO, ACMS Vice President.

Robb House AGH Facade Dedication

Robb House Museum, June 1, 2019

Mark Barrow, MD and Mrs. Mary Barrow with the original AGH Facade as installed at the Robb House.

L to R: Mrs. Roslyn Levy; Leonard Furlow, MD; Norman Levy, MD, PhD; Mark Barrow, MD; and Mrs. Mary Barrow.

Joe Cauthen, MD.

L to R: Carla Van Arnam; Florence Van Arnam; and Mrs. Cherise Bartley.

L to R: Margaret Pisano; Diana Holder; and Helen Joan Croft (seated).

L to R: Thomas Hopkins, MD; Mrs. Mary Barrow; Mark Barrow, MD; and Speaking is Perry Foote, MD.

L to R: Caroline Rains, MD; Mrs. Doris Farmback; Scott Medley, MD, *House Calls* Executive Editor; and Justine Vaughen, MD.

HAPPENINGS

Congratulations to Karen Harris, MD, on her successful election as American Medical Association Alternate Delegate!

L to R: Norman Levy, MD, PhD; Charles Riggs, MD; Steven Reid, MD; and Carl Dragstedt, DO, ACMS Vice President, serving as Delegates at the 2019 FMA House of Delegates meeting.

2019 FMA Annual Meeting
Bonnet Creek Hilton - Orlando, August 9-11, 2019

David Tyson, UF Medical Student Delegate.

Scott Rivkees, MD, State of Florida Surgeon General (center) with UF Resident Physicians participating in the David Paulus Poster Symposium 2019.

Parker Long, DO, David Paulus Poster Symposium Presenter.

L to R: Charles Riggs, MD; Mrs. Christine Riggs, UF Medical Guild President; and Donald Giffler, MD, FMA 2019 President Elect at the President's Inauguration Dinner.

Congratulations to FMA President Corey Howard, MD on receiving the Gerold Schiebler, MD, Advocate for Medical Students Award 2019!

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, March 5, 2019

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, March 5, 2019 at The Cardiac and Vascular Institute.

Approval of Minutes: The minutes of the February 5, 2019 meeting were presented. Dr. Riggs moved approval, with a second by Dr. Colon. The minutes were approved by the Board.

Secretary's Report: Dr. Khuddus presented the following name for membership: Erick Perez Sifontes, MD, NFRMC GME Internal Medicine. Dr. Colon moved approval of the new member, seconded by Dr. Grow.

Treasurer's Report: Ms. Owens presented the Year to Date Balance Sheet and P & L statement (7 months) for the ACMS and the ACMS Foundation. Net Income was reported of $11.4K for the ACMS, with total grant payouts of $43.8K from the ACMS Foundation for the same period. The report was motioned for approval by Dr. Levy, seconded by Dr. Jones and approved by the Board.

President's Report: Dr. Khuddus recommended considering a new Board Member Named Haseeb Jabbar, MD/JD. He is a physician and attorney and may be able to assist with legal questions as they arise. Dr. Khuddus asked the Board to consider new ideas to encourage physician engagement. Dr. Bruggeman mentioned a Mentorship Program that would be a great help to students/fellows and Residents.

EVP Report: The Physician Burnout panelists were finalized with the Board to consist of Dr. Martha Brown, Dr. James Lynch, and Dr. Sarah Fayad, with Dr. Matt Ryan moderating. The group discussed a new bid for the Robb House roof replacement from TMT Roofing for $12.5K. The bid was approved by the Board with construction to commence at a later date to be determined. Ms. Owens announced that the ACMS Alliance has set aside approximately $8K for Robb House Improvements in the form of a charitable contribution to the ACMSF. These improvements will cover various projects including AC system replacement, improvements to the porches, railings, walkways, painting, and refinishing floors. Dr. Khuddus asked the Board to form a committee exploring options and future possibilities for the Robb House building and property to formulate a long-term plan for ongoing repairs and replacements. Dr. Riggs agreed to chair the committee and recruit committee members. The Marion County Medical Society proposed a Health Insurance Co-op arrangement with the ACMS and will make a presentation to the Board at the April meeting.

Alachua County Medical Society - Board of Directors Meeting Minutes, April 2, 2019

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, April 2, 2019 at The Cardiac and Vascular Institute.

A Special Presentation: Tom Bussing, MCMS Insurance, presented a proposal for a Health Insurance Co-op for private practice ACMS members. Dr. Ryan motioned to explore the concept further, with permission to move forward in discussions. The motion was seconded by Dr. Skidmore and approved by the Board.

Approval of Minutes: The minutes of the March 5, 2019, meeting were presented. Dr. Riggs moved approval, with a second by Dr. Ryan. The minutes were approved by the Board.

Secretary's Report: Dr. Dragstedt presented the following name for membership: Christine Mitchell, MD, Dermatology Specialists of Gainesville.. Dr. Riggs moved approval of the new member, seconded by Dr. Ryan.

Treasurer's Report: Dr. Dragstedt presented the Year to Date Balance Sheet and P & L statement (8 months) for the ACMS and the ACMS Foundation. Net Income was reported of $4.9K for the ACMS, with total grant disbursements of $44.9K from the ACMS Foundation for the same period. The report was motioned for approval by Dr. Skidmore, seconded by Dr. Riggs and approved by the Board.

President's Report: Dr. Khuddus discussed the upcoming ACMS Research Poster Symposium and encouraged all Board members to sponsor their Residents and Medical Students in the competition.

EVP Report: Ms. Owens discussed the upcoming FMA deadlines for the Annual meeting in August. The ACMS is actively recruiting Delegates for the meeting. Ms. Owens announced that the ACMS has (in addition to Facebook) recently established a presence on social media sites LinkedIn, Instagram and Twitter. She encouraged all Board members to visit the sites and follow our monthly postings. Members can now renew their membership online through these sites or at the acms website (acms.net). The Robb House and ACMS Alliance will be hosting a dedication of the AGH Façade mantel on June 1st at the Robb House from 2-4pm. All are invited to attend and take a tour of the Robb House.

New Drug Name Collusion

By Scott Medley, MD

After writing recent articles about such weighty subjects as medical marijuana and the opioid crisis, I thought it was time to return to a more frivolous topic—making fun of drug brand names. Our long-time loyal readers-both of them-will recall my previous columns about "drug name scrabble": (Spring 2001, "As Simple as XYZ"; Summer 2007, "More XYZs"; Winter 2015, "Even More Drug Name Scrabble"; and Spring 2017, "Even Yet Still More Drug Name Scrabble.") Many of these pieces dealt with the curious preponderance of the numbers of drug names containing rarely used letters such as X, Y, and Z. Examples cited were XANAX, ZOPENEX, ZORVOLEX and XELJANZ-XR. Two years ago, in my last column dealing with this subject, we also featured the mysterious rise of the "Q"—SOLIQUA, ELIQUIS, QYSIMIA, and EQUETRO. Also, as expected, many, many (mostly very expensive) new drugs have been introduced during the past two years. So, eschewing the time-worn scrabble theme, let's look at some of the curiosities of some of the new drug names. (Even after decades of careful investigation, I have no earthly idea about how the Marketing Departments of the pharmaceutical companies come up with these strange names, containing rarely-used letters.)

THE EMERGENCE OF THE "T"

Depending on the source one believes, the "T" is the second to sixth most commonly used letter in the English language. But it has not appeared so commonly in the past in brand drug names. Tis Truthfully and Technically Too Tedious and Tantalizing To Try to Tell you why the "T" has risen to such Terrific Tantamount prominence. Perhaps it is because the "T" reminds us of good experiences. Such as: for the golfer, Tee Times; or for the British, Tea Times; or our old comfortable T-shirt; or, for Native Americans, their homey Teepee; or our favorite dinosaur, the T-rex; or perfection-fit to a "T"; or for the former alcoholic, becoming a Teetotaler. Anyway, you get the picture.

Some of the "T" drugs: Trelegy (for COPD), Toujeo and Tresiba (diabetes), Triumeq and Tivicay (HIV), Tolsura (antifungal), Toviaz (overactive bladder), Trulance (constipation), and my favorite—Trintellix (depression). (You may feel like throwing a tantrum and getting toasted and tattooed when I connect the "T" to the "Z" later in this piece).

VALUE THE "V"

Verily I can Vouchsafe with some Veracity that Various drug companies still Value the Venerable and Virtuous V, even though it is one of the least-used letters in the English language---fifth from the least used.

Some "V" drugs include: Valcyte (CMV), Vabomere (UTI), Vascepa (hypertriglycerides), Vraylar (bipolar), Vemlidi (hepatitis B), Varubi (nausea), Verzenio (breast cancer), and my favorite—with two V's—Vosevi (hepatitis C).

"X" STILL MARKS THE SPOT

I've written before about the mysterious prominence of the letter "X" in brand name drugs. This little-used letter—fourth from the least used –somehow still finds its way into many drug names. A few examples beginning with X are: Xermelo (carcinoid diarrhea), Xultophy (diabetes), Xadago (Parkinson's), and Xoflusa (influenza). Hidden away in additional names: Rexulti (depression), Saxenda (weight management), Glyxambi (diabetes), and Dupixent (atopic dermatitis). "X" marks the spot at the end of drug names like Cosentyx (psoriatric dermatitis) and Shingrix (Zoster vaccine).

"Z" IS NOT LAST

Finally, to the much-derided "Z"–the poor misunderstood last letter in the English alphabet. In fact, the inventor of the telegraph, Samuel Morse (1791-1872) believed that "Z" was the least commonly used

Continued on Page 32

NEW DRUG NAME COLLUSION

Continued from Page 31

letter. More recent research reveals that it is actually third from the last in usage. {Next-to-last is "J", but there's still Jardiance (diabetes) and Juluca (HIV). Last in usage is "Q", which I featured in my last editorial, and still survives in Qtern (diabetes), Siliq (psoriasis), Triumeq (HIV), and Zynquista (diabetes)}

But back to the "Z". For starting letters we have: Zepatier (hepatitis C), Zontivity (coronary disease), Zinbryta (multiple sclerosis), Zerit and Ziagen (HIV), Zurampic (gout), and the aforementioned Zynquista. Surprisingly, there are many more drugs featuring the lowly "Z": Kevzara (rheumatoid arthritis), Namzaric (dementia), Prezcobix (HIV), Daclinza (hepatitis C), Sympazan (seizures), Imfinzi (lung cancer), Nuplazid (Parkinson's), Duzallo (gout), Ozempic (diabetes), and my two favorites- featuring not one but two "Z"s, back-to back even-Afrezza (insulin) and Ingrezza (tardive dyskinesia)!

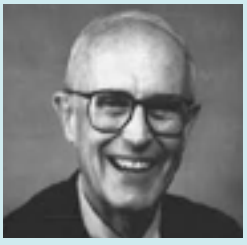
THE "T" PLUS "Z" CONUNDRUM

I hesitate to bring this to light, but one cannot but notice the large number of new drug names containing both a "T" and a "Z". Some of these names have been previously listed, but I give you: TaltZ and OTeZla (psoriatic dermatitis), ZynquisTa and VicToZa (diabetes), ZinbryTa (multiple sclerosis), and TrogarZo, ZeriT, TriZivir, and EvoTaZ (all for HIV). We have carefully researched this "T Z" conundrum, and the only person whose name we could find with these very same initials is my great good friend, the Eminent Gainesville Pediatrician (retired), Dr. Tom Zavelson! (How many people, my dear readers, do YOU know with the initials "TZ"?) Not to cry "conspiracy", but do you concur that this capricious discovery is not coincidence, but conclusive evidence of a covert and curious connection involving collusion with Dr. "TZ" being in cahoots with the pharmaceutical companies' cartels? I'm just sayin'..... Perhaps we should appoint a Special Prosecutor to investigate this possible collusion- it will only cost about $25 million and take about two years!

In the meantime, mind your "T"s and "Q"s –and "X"s and "V"s and "Z"s!

[Editor's note: Once again we have determined not to use the Registered Trademark ® symbol alongside the drug names in this piece. We list some 68 brand names, and the ® would add unnecessary clutter. Please do not let the copyright cops arrest us for this desperate infraction!]

In Memoriam



James Talbert, MD

(September 26, 1931 – July 1, 2019)

Dr. Talbert graduated from Vanderbilt's School of Medicine in 1956. Dr. Talbert was appointed as a Lieutenant in the United States Public Health Service and selected to serve as a Senior Assistant Surgeon at the National Heart Institute, and the National Institutes of Health, in Bethesda, Maryland. He was appointed as an Instructor in Surgery and Garrett Scholar in Pediatric Surgery and an Assistant Professor of Surgery and Pediatric Surgery at the Johns Hopkins University School of Medicine.

In 1967, Dr. Talbert became the first pediatric surgeon to be recruited by the Department of Surgery at the University of Florida College of Medicine and was appointed as its Chief of Pediatric Surgery. He remained the Chief of Pediatric Surgery from 1967 until retiring in 1998. He was actively involved in the establishment of Emergency Medical Services in Alachua County and served as Chairman of the Emergency Medical Services Advisory Council. He was awarded the University of Florida College of Medicine's Lifetime Achievement Award.

Dr. Talbert is survived by his wife Alice; son, William David Talbert II; daughter, Alison Whitney Talbert; and granddaughters, Olivia Grace and Adriana Elizabeth Talbert.

Learn to Drive

Behind the wheel lessons

www.ncfsc.com

"Hands on Driving Program"

We can make you a confident driver!

Intended audience:
1st time drivers, International students,
anxious drivers looking to improve

North Central Florida
Safety Council

Alachua County Medical Society
235 SW 2nd Avenue • Gainesville, FL 32601-6256

CHANGE SERVICE REQUESTED

PRSRT STD
US POSTAGE
PAID
PERMIT NO 507
GAINESVILLE FL
32601