Cutting edge medicine - Innovation - Treatment - Solutions - Advances - Cure

ALACHUA COUNTY MEDICAL SOCIETY

House Calls

SPRING / SUMMER 2025

Dermatologic Surgeon Charles Stoer, MD, Serving Gainesville for Over Forty Years

Legislative Issue

CONTENTS

HOUSE CALLS - SPRING / SUMMER 2025

In This Issue

Featured Articles

Our Medical Community

Advertising in *House Calls* does not imply approval or endorsement by the Alachua County Medical Society. All advertising is subject to acceptance by the Board of Directors. Send all advertising submissions to: **Alachua County Medical Society, 235 SW 2nd Avenue, Gainesville, FL 32601 Ph:(352) 376-0715;Fax:(352) 376-0811; Website: acms.net**

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

CONTRIBUTING AUTHORS

Scott Medley, MD

Retired Family Physician

Dr. Medley received his Medical Degree from the University of Kentucky, then served in the U.S. Army, where he completed his Residency in Family Medicine. He founded Gainesville Family Physicians, enjoying 20 years in Private Practice. He later served as a Hospitalist and Chief Medical Officer at North Florida Regional Medical Center. He is a Past President of the ACMS and of the Florida Academy of Family Physicians. Currently retired and volunteering at Haven Hospice, he has served as Executive Editor of *House Calls* for the past 26 years, for which he has authored over 110 editorials and articles.

Charles B. Stoer, MD

Gainesville Skin Cancer Center

Charles Stoer, MD has practiced Dermatology at the Gainesville Skin Cancer Center for the past 40 years. He received his Medical Degree from Louisiana State University, followed by an Internship there. He completed a Residency in Dermatology and Cutaneous Surgery at the University of Miami, and a Mohs Surgical Fellowship in Advanced Skin Cancer in 1985. He joined the faculty at the UF College of Medicine in Gainesville in 1985 and continues to retain a clinical appointment there today. His medical practice focuses on skin cancer and reconstructive skin surgery, along with light therapy for precancerous conditions.

Daniel M. Duncanson, MD, CPE

CEO, SIMEDHealth

Dr. Duncanson has over thirty years of experience as an Internal Medicine/ Primary Care physician, practice administrator, and independent practice owner. He serves as Chief Executive Officer of SIMEDHealth, LLC, a north central Florida independent multi-specialty healthcare system. He received his Medical Degree from the University of South Florida and completed his residency at the University of Florida. He is a past board member of the American Medical Group Association, and serves on the AMGA's Public Policy Committee, CEO Council, and Independent Medical Group Council.

Jackie Owens

ACMS Executive VP

Jackie Owens is the Executive Vice President of the Alachua County Medical Society. Previously, she served as the President of JOLA, Inc, a landscape architecture design firm in Gainesville, Florida and as Adjunct Faculty for the UF College of Design, Construction and Planning. Prior experience includes serving as Assistant Vice President and Credit Manager for First Union Bank of Gainesville and Credit Analyst for American Bank in Jacksonville, Florida. Ms. Owens received a Master of Landscape Architecture from the University of Florida and a Bachelor of Business Administration/Finance from the University of North Florida.

Christopher Clark

Florida Medical Association CEO

Chris Clark currently serves as the Chief Executive Officer of the Florida Medical Association (FMA). In his role as CEO, Mr. Clark oversees and manages the legislative agenda of more than 20,000 doctors statewide. He has worked with the FMA since 2014, previously serving as the Senior Vice President of Public Affairs. Chris served as Personal Assistant for Governor Jeb Bush and was the Governmental Affairs Director for the Florida Department of Corrections and as Legislative Affairs Director for The Florida Lottery, among other positions.

Daniel Kent Cassavar, MD, MBA

Director, The Doctors Company

Dr. Cassavar is the former President and Chief Medical Officer of ProMedica Physicians, a healthcare network of specialized hospitals, facilities, researchers, physicians, and advanced practice providers. Previously he was an interventional cardiologist with Heart Specialist of Northwest Ohio, a Founding Member of Cardiocare Consultants, and Clinical Assistant Professor of Medicine in the Department of Internal Medicine at the Medical College of Ohio. He is certified in Interventional Cardiology and Cardiovascular Diseases. He is also a Fellow of the American College of Physicians and the American College of Cardiology. He serves on The Doctors Company Board of Governors and is a member of its Patient Safety Committee.

Medical Academic Research and Proposed Budget Cuts

Jackie Owens, ACMS Executive Vice President

As part of an effort to reduce federal spending, it has been proposed that the National Institute of Health (NIH) grants be cut by $1.81 billion this past May, terminating 694 grants across 24 NIH institutes and centers, thereby reducing its total budget by 40%. According to the Journal of the American Medical Association (JAMA), that also included $544M in promised funding that has already been committed, but not yet disbursed to the researchers. These funds have, in most cases, already been spent by the research institution, which operates on a reimbursement basis. Budget cuts included grants researching neurodegenerative diseases, genomic medicine, aging, cancer, child health, diabetes, and mental health, to name a few. The National Institute on Minority Health and Health Disparities had approximately 30% of its budget cut. The Alzheimer's Research budget is to be cut by 39%, with the Cancer Research budget cut by 38%. This has disproportionately affected pediatric cancer research due to its often high costs and specialized needs. (1, 2, 3)

Next year, an additional $18 billion in cuts is planned. The Office for Long Covid Research is to be closed entirely. 10-26% of adults and 4% of children who had COVID-19 developed Long Covid. Several lawsuits have been filed challenging the budget cuts, and some of the proposed cuts have been temporarily blocked by federal judges. (4, 5)

In addition to the grant terminations, the budget cuts targeted "indirect costs" associated with academic research in general. Institutions are also challenging the federal cuts for Indirect Cost reimbursement (IDCs), arguing that these cuts would severely impact research capabilities. IDCs are used to cover overhead expenses like facilities, equipment (microscopes, centrifuges, etc.), supplies (test tubes, chemicals), and support staff (the researcher, lab techs, graduate students), utilities (electric, water, sewer), regulatory staff (safety, IACUC, accounting), IT infrastructure, and administrative salaries - expenses not associated directly with the research itself. It's impossible to conduct research without overhead and the elimination of all IDCs would shut down academic research almost completely, delaying advancements, and hindering the development of new treatments and technologies.(5, 6, 7, 8)

Currently available alternative funding sources are not a realistic substitute to cover these grants and essential costs, as organizations and private foundations typically restrict the use of funds towards IDCs. In addition, smaller private donors are usually not interested in sponsoring overhead expenses - preferring that their dollars go towards buildings, scholarships, colleges, and endowed chairs, for example. Biotech innovation is built upon academic research, and, as an alternative funding source, could not accommodate the cost of funding the associated research and still remain an ongoing concern. Those in the academic research field say industry and philanthropy are in no position to make up for the losses, and that relying solely on endowments, philanthropy, and internal funding is not a sustainable long-term solution. (6, 7, 9, 10)

Many long-term challenges are associated with academic research budget cuts - impacting research progress, patient care, the scientific workforce and the economy. Universities are currently navigating workforce challenges because of reduced funding, offering temporary relief to researchers whose projects have been disrupted in the short term. Many Universities are experiencing layoffs as a result of these cuts, thereby threatening ongoing studies, and delaying the development of new therapies. (7, 9, 10)

Scientists are currently leaving the U.S. for positions in other countries while universities are seeing fewer applications for research assistant positions. Europe, Canada and other countries are pursuing American scientists and researchers at an unprecedented rate. The Journal Nature recently reported that over 1200 American scientists said they were considering working abroad, with 32% more applications for positions overseas between January and March this year than during the same period last year. (6, 11)

Summary: Historically, academic medical research has been considered as an investment in the future. The system is currently facing significant challenges due to proposed budget cuts and restrictions at the National Institutes of Health (NIH). These cuts have led to the termination of numerous research grants, causing delays and disruptions in clinical trials and research projects. This will have far reaching consequences for scientific progress and innovation, with the potential loss of life and the overall quality of life.

Of course, as with most issues these days, the cuts are highly politically devisive. The proposed budget cuts to the NIH will be voted upon by Congress, however, the outcome is uncertain. Congress has the power to reject or approve the budget cut proposals, and many members have expressed concerns about the impact of the NIH cuts. Whatever your opinion, contact your congressional representative to let them know your position on the current academic research budget proposals. You will find their contact information on pages 13 and 14 of this magazine. (6, 13)

References available upon request.

ALACHUA COUNTY MEDICAL SOCIETY

Special Thanks to

Christopher Balamucki, MD

For his outstanding leadership as ACMS President, 2023-2025

ACMS is Pleased to Announce Officers for 2025-27

President
Brittany Bruggeman, MD

Brittany Bruggeman, MD is pediatric endocrinologist and physician scientist at the University of Florida. She completed all her studies and post-graduate training at UF - Go Gators! She is a leader in patient advocacy and policy within the American Academy of Pediatrics and American Diabetes Association and is the incoming President of the Alachua County Medical Society. Her current pursuits include the clinical care of diabetes and endocrine patients and research investigating the natural history, pathophysiology, and clinical care of type 1 diabetes, which is funded through NIH and foundational awards.

Vice President
Althea Tyndall-Smith, MD

Althea Tyndall-Smith, MD started her career in medicine at York Hospital, after graduating from Drexel University College of Medicine in Philadelphia. She then relocated to Gainesville to be closer to family and joined the University of Florida as a Clinical Assistant Professor in the Community Health and Family Medicine Department. In 2018, Dr. Tyndall-Smith co-founded Gainesville Direct Primary Care (DPC) Physicians to allow her to "get to know her patients and to develop strong and lasting relationships, which are the foundation of exceptional health care." She enjoys her Caribbean culture through travel, cuisine, and music. In her spare time, she participates in the praise and worship team at church, playing the piano, riding her bike, and sharing her life and dreams with her husband, two sons and a puppy named Buster.

Secretary/Treasurer
Gary Gillette, MD

Dr. Gillette currently serves as the Medical Director of the Free Standing Emergency Department at HCA North Florida Hospital and Core Faculty at HCA/UCF Graduate Medical Education Program. He received his Medical Degree from Baylor University, followed by his Residency in Emergency Medicine at Orlando Regional Medical Center. Dr. Gillette is Board Certified in Emergency Medicine. He enjoys the administrative side of emergency medicine and process improvement while teaching Residents. Dr. Gillette interests include spending time with his family, exercising and traveling.

Forty Years of Dermatologic Surgery: An Interview with Dr. Charles (Chuck) Stoer

By: Scott Medley, MD

[Editor's Note: I have known Dr. Chuck Stoer for 40 years. I am his patient, his colleague, and his friend. He has practiced Dermatologic Surgery in Gainesville for the past 40 years, 25 of them at the beautiful "Serenola Plantation" in south Gainesville. Recently, before he sat down with us to tell us about his amazing career, he gave us a brief tour of his 5000 sq. ft. building. In this stately home there are rooms after rooms packed with all sorts of fascinating memorabilia, mostly gifts from his obviously loving and loyal patients. Among the homemade clocks, "solar etchings" on wood – using only a magnifying glass -there are photos of his extended family – some dating back 100 years. There are also many trophies from his "big game hunting days" – elk, moose, turkeys, alligators, and even a huge 7-foot tall Brown bear!]

Editor (Dr. Scott Medley): Thank you for visiting with us today.

Dr. Stoer: I am very happy to do this Scott. And it is a special treat being "interviewed" by you.

Editor: And it's a special treat to "interview" you here on the comfy front porch of your "office building". Where were you born and raised? (As we say in Kentucky).

Dr. Stoer: I was born in New Orleans but we soon moved to Shreveport and we later moved to Tennessee. My father was a pathologist, an expert "microscopist", and a talented artist

Editor: Do you think you inherited those traits? They must come in pretty handy when you're doing delicate MOHS microscopic surgery.

Photo: Dr. Stoer's Grandmother (far left) - Geneva, AL - 1910

Dr. Stoer: I hope that I inherited some of those artistic traits. What I think I do have, is an ability to see proportion and symmetry in dealing with facial reconstruction and using simple approaches combined with natural healing to achieve that desired proportion and symmetry.

Editor: Please tell us about your education and training.

Dr. Stoer: High School in Trenton, Tennessee. Undergraduate at Tennessee- Martin. Med School at LSU Shreveport.

Editor: Oh, my goodness you aren't an LSU fan are you?
Dr. Stoer: Well, kinda, but I am a Gator Fan when they play the Gators. I did a flexible internship at LSU and did some trauma surgery in the ER. I then did a Residency and Fellowship at the University of Miami, where I was introduced to MOHS surgery.

Editor: So why did you choose Gainesville?

Dr. Stoer: Actually, Gainesville chose me. Dr. Frank Flowers was Chief of Dermatology at UF then, and needing a MOHS surgeon, he recruited me. So I was on the UF faculty in 1985. I was about the only one in Gainesville doing MOHS surgery at that time.

Editor: How about your beautiful office location here at Serenola Plantation? Tell us how this came about.

Dr. Stoer: At first my practice was in the old "720 building – the Ayers Medical Plaza".

Editor: I remember. The offices where we first established Gainesville Family Physicians in 1981 was about 1 block away from you.

Dr. Stoer: I felt very "confined" in the "720 building". I lived in Micanopy at that time, and when I was driving into Gainesville one morning I spotted an old cobweb-covered sign reading "PROPERTY FOR SALE". Being mostly curious, I checked out the 8.8 acres here and it struck me that this would be a great location for the large office building I had envisioned. So I bought the property and designed and built this 5000 sq. ft. building, complete with lots of rooms and a large front porch and back porch.

Continued on Page 6

Continued from Page 5

Editor: And the rest, as they say, "Is History".

Dr. Stoer: I guess so. We have been very happy here and our patients love it, which is the most important thing.

Editor: I hear that you have encountered some wildlife here on the property.

Dr. Stoer: Yes, there is an occasional alligator in our pond, and many wild turkeys, deer, and other creatures roaming around the property.

Editor: Regarding your MOHS surgery, I understand that it involves excising cancerous skin lesions and then looking at the specimen under a microscope, and then carefully excising skin as necessary until the "margins are clear" on the excised lesion, saving as much unaffected skin as possible.

Dr. Stoer: That is basically correct. We save as much "healthy" skin as possible, but the key feature is immediate mapping and complete analysis of the surgical margins by the surgeon. It's really important to know you have all the cancer before doing any complex repairs.

Editor: You were a pioneer with MOHS surgery here in Gainesville, and now it seems that many of the Dermatologists are performing it.

Dr. Stoer: Let's just say I am very thankful for and proud of my Fellowship training in MOHS.

Editor: Are there other changes that you have seen in the specialty of Dermatology in your many years in practice?

Dr. Stoer: There has been a big push lately for more cosmetic dermatology, but I like my "cancer" practice. Removing these cancers, especially on the face and ears, often involves fashioning creative skin grafts and flaps. I enjoy that.

Editor: When do you consider referring a patient to a plastic surgeon?

Dr. Stoer: If lesions are very large or if general anesthesia is required, I will refer the patient, but those cases are rare

Editor: I have had a few squamous cell skin cancers removed here myself – too much sun exposure in my youth, I guess. Do you mostly see basal cell and squamous cell cancers?

Dr. Stoer: Yes, mostly. But the incidence of Malignant Melanoma is rising. I think this is partly due to more sun exposure now as well as increasing awareness of this problem through community education. We are always preaching about avoiding excessive sun exposure. Thankfully, most melanomas we diagnose are in-situ and not invasive. As you know, invasive melanomas may metastasize widely and cause death.

Editor: I must admit that I had never heard of Merkel Cell skin cancer before the late, great, Jimmy Buffett's tragic death from it. Do you see much of that?

Dr. Stoer: Yes, unfortunately the incidence of this deadly disease is also rising. We now see several cases a year. It can at first look like an innocent nondescript purplish-red lesion. But it can metastasize into regional lymph nodes. We especially see it in immunocompromised patients who have had organ transplants, etc. We are also seeing more of another rare but deadly skin cancer – pleomorphic dermal sarcoma.

Editor: Thanks again for visiting with us today. This has been very instructive. Anything else you would like to add?

Dr. Stoer: Yes there is. I'd like to add some advice to younger physicians in interacting with their patients. Try to relate as much as possible as a peer-to-peer rather than as a parent-to-child interaction. Try to see their perspective and meet them where they are, as well as where your goals and therapeutic demands are. Simply put: be transparent and human. Always let the best interests of the patient exceed any goals you have for this relationship. I can honestly say that I have really enjoyed caring for my patients, and that treating them as "family" is rewarding for all concerned.

Editor: Well said. Thanks again.

[Editor's final note: We conducted this "interview "on the homey, comfortable front porch of Dr Stoer's unique office building. At the completion of the interview, I asked Chuck, "What is that pleasant fragrance I've enjoyed while sitting out here?" Chuck said, "Oh that's our grapefruit tree, let me pick you some." At that point Chuck went out among the beautiful blooming dogwoods and azaleas and picked a handful of grapefruits for me - payment, I guess, though none was needed, for this great experience!]

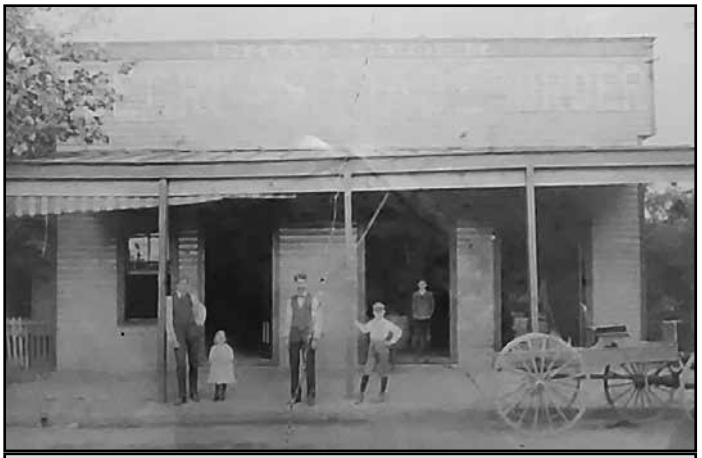

Photo: Dr. Stoer's Great Grandfather - the first ice cream store in Shreveport, LA - 1900

Beyond the Exam Room: Your Voice Has Power

By: Daniel M. Duncanson, MD, CPE

In the exam room, physicians are trusted stewards of patients' health. But outside those walls, in the halls of government, boardrooms of insurers, and offices of policymakers, decisions are made every day impacting how physicians can care for their patients. These decisions often lack input from those most qualified to guide them: patients and physicians themselves.

When physicians hear the word advocacy, they often think of lobbyists – individuals hired by large entities such as pharmaceutical companies, insurance companies, and conglomerate hospital systems. Over time, these organizations have contributed to the erosion of physician autonomy, leaving many doctors with a negative perception of advocacy work. Yet true healthcare advocacy is not the domain of hired intermediaries alone, nor is it a peripheral task for physicians — it is a vital responsibility. As healthcare systems grow more complex and the regulatory environment evolves, physicians are being pushed further from the decision-making process shaping patient care, and the future of the profession itself.

The Disconnect Between Policy and Practice

Many policies governing healthcare are written without direct input from practicing physicians. When physician input does occur, it is often from those graduated from the clinical space, and sometimes physician hired lobbyists who are there to satisfy their contracted mission. This disconnect from the clinical practice of medicine regularly results in regulations that are burdensome, impractical, or misaligned with clinical realities. Whether it's insurance reimbursement models, the uncertainty of telehealth, or public health mandates, these decisions can profoundly influence day-to-day patient care.

For example, prior authorization requirements imposed by insurers intentionally create extra steps resulting in delays for necessary treatments, while creating frustration for both patients and physicians. These requirements are implemented under the guise of ensuring evidence-based care, and cost-saving measures without the understanding of the clinical urgency involved in many cases. Physician advocacy has been pivotal in recent legislative efforts gaining momentum in several states and on Capitol Hill requiring payers to streamline or significantly reduce these burdens.

Why Physician Advocacy Matters

Physicians, including the healthcare professionals under their supervision, bring unmatched credibility and firsthand experience to policy discussions. They and their patients are the only two parties involved in every healthcare encounter! Lawmakers much prefer to hear directly from physicians, rather than lobbyists, as it permits them exposure to the real-world consequences of their decisions. Data may be persuasive, but stories from the front lines — about patients harmed by delayed care, clinics struggling under administrative burden, facilities reducing or ceasing services due to non-sustainable reimbursement — are what sparks legislative action.

Additionally, physician advocacy influences more than just legislation. It helps shape public perception, guide institutional policy, and strengthen the overall healthcare delivery system. We only have to go back a few years to know how influential the voice of physicians was during the COVID-19 pandemic. Physicians played a key role in public health messaging, vaccine promotion, and policy development at every level of government.

Forms of Advocacy: From Exam Room to Capitol Hill

Not every healthcare professional needs to run for office to make a difference. Advocacy takes many forms. Here are several avenues through which physicians can advocate effectively:

- **Legislative Advocacy:** Engaging with federal or state lawmakers by writing letters and emails, making phone calls, or attending meetings to discuss key issues.

- **Organized Medicine:** Medical societies and associations provide a collective voice and the resources to align and support impactful advocacy campaigns.
- **Media Engagement:** Writing op-eds, making yourself available for participation in interviews, or using social media platforms to share physician perspectives and elevate public understanding.

Continued on Page 8

Continued from Page 7

- **Institutional Advocacy:** Serving on committees, quality boards, or medical staff councils to improve care delivery and promote staff and patient safety.

- **Public Health Leadership:** Working with local health departments or school boards can influence decisions on community health initiatives, mental health resources, and vaccination policies.

Advocacy Successes: Real-World Examples

Physician-led advocacy has steered significant policy changes in recent years. Consider the following examples:

- **Medicare Reimbursement Cuts:** In the fourth quarter in each of the last 5 years, CMS has finalized reductions to the following year's Medicare Part B reimbursements. In November of 2023, the cuts approved for calendar year 2024 alone amounted to nearly a 10% reduction; in the fall of 2024, for 2025's performance year, the cuts were finalized at 6.8%! The voice of physician advocacy drove home to legislatures the devastating effects these cuts would have on our ability to provide patient care. Organizations such as the American Medical Group Association, composed of medical group leaders across the country representing over 140,000 physicians, along with many other medical societies and associations, urged Congress to prevent or greatly minimize these repeated cuts to Medicare Part B reimbursements. The collective advocacy efforts led to Congressional action preventing or lessening these cuts, preserving access to care for millions of Medicare beneficiaries.

- **Value-Based Care:** While preserving the current fee for service reimbursement model is vital to meet our immediate needs, sustainability of our healthcare system requires the development of alternative payment models focused on the patient experience, improved health outcomes, and being effective stewards of healthcare costs. Value-based care payment models have been developed based on advocacy efforts urged upon Congress of the need for financial stability and regulatory flexibility necessary to meet the care needs of patients.

- **Telehealth:** Telehealth has become an integral part of modern healthcare delivery. It is easy to forget, just five years ago, telehealth visits were limited to patients in rural clinics connecting virtually with specialists in distant locations. That limited model shifted dramatically during the COVID-19 pandemic when the urgent need for flexibility transformed telehealth into a widely accepted and essential mode of care. While not appropriate for every clinical situations, telehealth has proven effective and convenient for a broad range of services – and it has been embraced by both patients and providers. Despite its success, current telehealth flexibilities are temporary. Because of physician advocacy efforts, Congress has extended the pandemic-era telehealth policies five times, with the latest extension expiring on September 30, 2025. Ongoing advocacy efforts are vital to ensure permanent access, payment parity, and regulatory support for telehealth, so patients and providers can choose the care modality best fitting their needs.

These are just a few advocacy successes among many others underscoring that change is possible, especially when physicians act in concert.

Barriers to Physician Involvement

Despite the clear need and opportunity, many physicians hesitate to get involved in advocacy. The reasons are understandable:

- **Time Constraints:** We're busy. Between long clinic hours, call shifts, and administrative work, there is often felt to be little time left for advocacy.

- **Lack of Training:** Physicians receive little formal education in health policy, or the importance of advocacy, making it feel intimidating or out of reach.
- **Perceived Futility:** Some believe their voice is too small in the sea of legislative chaos, and won't make a difference, or that their advocacy efforts won't yield tangible results.

- **Concerns about Partisanship:** In polarized times, physicians may worry that their engaging in advocacy could be seen by others as political or divisive.

While these concerns are valid, they can be addressed. A quick phone call or email to your legislator's office, taking only a few minutes of time, can let them know your thoughts on an issue. Training and support are available through physician societies and associations, along with mentorship from experienced physician advocates providing encouragement, direction, and possibly an advocacy "buddy." And, perhaps most importantly, by centering advocacy on the patient experience, and outcomes and improvements in our system physicians can focus on issue-based, non-partisan topics. Who is better suited to provide this information?

Advocacy as Professional Duty

The American Medical Association's Code of Medical Ethics states physicians have a duty "to advocate for

Continued on Page 9

Continued from Page 8

social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being." This is not a suggestion; it is an ethical obligation. Just as we commit to do no harm in our clinical practice, we must also work to prevent systemic harms through advocacy.

As trusted members of society, physicians hold a unique position. According to surveys, doctors consistently rank among the most trusted professionals in the United States. This trust is a powerful tool - one that can be leveraged to influence decisions at every level of healthcare policy.

Getting Started: Steps Toward Advocacy

Physicians interested in becoming more involved in advocacy can start small. Here are a few actionable steps:

1. **Educate Yourself:** Read up on the issues affecting you in healthcare and your community. Attend webinars or conferences focused on health policy – many are available at no costs from medical societies and associations.

2. **Build Relationships:** Start by contacting the office of your local and federal representatives and senators. Their contact information is listed in this issue of *House Calls*. Introduce yourself to their staff and offer to serve as a resource on healthcare issues. Offer to visit with them when the legislator is in the community, or invite the legislator and staff to visit your practice site.

3. **Speak Up:** Whether it's writing an opinion editorial, sharing a story on social media or testifying at a committee hearing, your perspective matters.

4. **Join Medical Societies and Associations:** Local, state and national medical societies and associations are often the first point of engagement and offer facilitated opportunities to meet with lawmakers and participate in legislative days.

5. **Involve Others:** Encourage colleagues to participate. Introduce advocacy to residents and students. Collective action amplifies the message.

Conclusion: Advocacy is Care

In a healthcare environment shaped as much by policy as by science, physicians cannot afford to remain on the sidelines. Advocacy is not a detour from patient care — it is an extension of it. Whether fighting for patient protections, reducing administrative burden, or improving access to care, physicians have the insight, the expertise, and the moral authority to lead. Now, more than ever, the profession needs voices willing to speak up — not just in exam rooms, but in courtrooms, city halls, and capitols across the country.

The FMA 2025 Legislative Report

By: Christopher Clark, FMA CEO and the FMA Legislative Team

The FMA 2025 Legislative Report

The 2025 Legislative Session has been an intriguing one – and it's not over. Of the 1,982 bills that were filed, only 254 passed both chambers. However, the budget, which is the only constitutionally required action item, was not passed. The Legislature passed HCR 1631, a concurrent resolution extending the 2025 Regular Session of the Florida Legislature, until 11:59 p.m. on Friday, June 6, 2025.

BILLS THAT PASSED

Department of Health
(HB 1299 by Rep. Yarkosky and SB 1270 by Sen. Collins)
Every session there is a Department of Health package that often gets loaded up with several unrelated issues to the point where it dies of its own weight. This year, however, the House and Senate sponsors were able to get the bill across the finish line by jettisoning the most controversial provision in the original bill – a provision that would have prohibited physicians and hospitals from discriminating against a patient based solely on the patient's vaccination status.

The FMA was successful in having this provision narrowed to apply only to hospitals before it was removed entirely. The remaining provisions – which were either favorable or did not apply to the practice of medicine – include an extension of the repeal date for the definition of "messenger ribonucleic acid vaccine" from 2025 to 2027; add new institutions authorized to grant medical faculty certificates; update laws governing temporary certificates for physicians and physician assistants working in areas of critical-need areas; and eliminate background check requirements for officers and board members of medical marijuana treatment centers but maintains them for owners and managers.

Most notably, the bill helps further the goal of increasing access to care in Florida by amending last year's Interstate Mobility Act (SB 1600 by Sen. Collins). The change reduces the active practice requirement for licensure by endorsement from three years to two and allows licensure for applicants with a National Practitioner Data Bank report if the conduct that occasioned the reported adverse action would not have violated any statute or rule in Florida. The FMA was also able to get language included late in the session that will allow newly licensed residents in other states currently excluded from Florida licensure to qualify for licensure by endorsement.

Improving Screening for and Treatment of Blood Clots
(HB 1421 by Rep. Black and SB 890 by Sen. Yarbrough)
Named the "Emily Adkins Protection Act," this legislation requires hospitals and ambulatory surgical centers to develop policies and regularly train staff to screen for and treat venous thromboembolisms using evidence-based best practices. It creates a statewide venous thromboembolism registry to collect and track data from hospitals and generate reports to improve patient outcomes and compliance. Additionally, this legislation requires ALFs to provide residents with consumer information pamphlets containing certain information about venous thromboembolisms. This legislation was supported by the FMA and inspired by the Blood Clot and Pulmonary Embolism Workgroup, a state-established entity. Longtime FMA member Chris Pittman, MD, served on this workgroup.

Stem Cell Therapy
(SB 1768 by Sen. Trumbull and HB 1617 by Rep. Buchanan)
The proponents of this bill sought to ensure that certain stem cell therapies that have not been approved by the FDA are available and properly regulated in Florida. The FMA was extensively involved in the crafting of this legislation and sought to ensure that a proper balance was struck between protecting the public from bogus therapies and preventing physician overregulation. SB 1768 authorizes physicians to perform stem cell therapies that have not been approved by the FDA for orthopedics, wound care, and pain management and requires that all stem cells used be retrieved, manufactured, and stored in facilities registered with and regulated by the FDA and certified or accredited by approved organizations. Physicians must obtain signed consent from patients and must advertise that the therapies have not yet been approved

Continued on Page 11

Continued from Page 10

by the FDA. This bill excludes treatments that use fetal or embryo-derived cells from abortions and imposes felony penalties and disciplinary actions by the appropriate board if any provision is violated.

Refund of Overpayments Made by Patients
(SB 1808 by Sen. Burton and HB 1513 by Sen. Greco)
This bill was inspired by an experience the Senate sponsor had with her dentist in which a number of overpayments that she made were not refunded until she discovered the overpayments over a year later. SB 1808 requires any physician, healthcare practitioner, or licensed healthcare facility that bills the patient's insurer to refund to the patient any overpayment not later than 30 days after the date that the physician, healthcare practitioner, or healthcare facility determines that such overpayment was made. The FMA was able to correct an amended version of the bill on the issue of overpayment determination to clarify that the 30-day repayment obligation is only triggered when the physician determines that an overpayment was made.

Recovery of Damages for Medical Negligence Resulting in Death
(HB 6017 by Rep. Trabulsy and SB 734 by Sen. Yarborough)
For 35 consecutive years, the FMA has successfully defeated every attempt to legislatively expand the availability of noneconomic damages in wrongful death cases. This year, unfortunately, the Legislature passed HB 6017 despite the concerted efforts of the physician, hospital, insurance, and business lobbies. HB 6017, if signed by Gov. Ron DeSantis, will remove the prohibition on recovery of noneconomic wrongful death damages in a medical negligence case by the decedent's children who are 25 years of age or older and parents of a deceased child who was 25 years of age or older at the time of death. The governor is reportedly not in favor of this legislation, and the FMA is working with its coalition partners to ensure that he vetoes the bill and that any override attempt is unsuccessful.

BILLS THAT FAILED

Scope-of practice-expansion was a dominant issue this session. The FMA battled numerous bills that sought to expand the practice scope of allied health providers:

- **Acupuncture (HB 803 by Rep. Alvarez and SB 1722 by Sen. Wright)** Would have allowed acupuncturists to provide primary healthcare and treatment services and order clinical lab tests and diagnostic imaging.

- **Chiropractic Medicine (HB 849 by Rep. Tramont and SB 564 by Sen. Gruters)**
Would have expanded the chiropractic scope of practice to include ordering, storing, possessing, prescribing, and administering "articles of natural origin."

- **Autonomous Practice by Certain Psychiatric Nurses (HB 883 by Rep. Shoaf and SB 758 by Sen. Simon)** Would have given psychiatric nurses the ability to practice autonomously.

- **Autonomous Practice by a Certified Registered Nurse Anesthetist (HB 649 by Rep. Giallombardo and Sen. 718 by Rep. Rodriguez)**
Would have allowed CRNAs to practice autonomously without an established protocol with a physician.

- **Naturopathic Medicine (HB 533 by Rep. Smith and SB 470 by Sen. Rodriguez)**
Would have changed the practice of naturopathy to "naturopathic medicine" and would have allowed naturopaths to call themselves naturopathic physicians with the same scope of practice as a medical or osteopathic physician.

- **Optometry (HB 449 by Rep. Rizo)**
Would have given the Board of Optometry control over optometrists' scope of practice and would have allowed optometrists to perform laser procedures.

- **Physician Assistants (SB 1540 by Sen. Collins)**
Would have allowed physician assistants to practice without physician supervision.

- **Prescriptive Authority Certification for Psychologists (HB 23 by Rep. Franklin and SB 250 by Sen. Simon)** Would have allowed psychologists to prescribe certain medications, including controlled substances, after consultation with the patient's primary care physician.

The FMA was successful in ensuring that not a single scope-of-practice expansion bill passed. The fight will continue, however, as we expect these bills to be filed again next session.

Office Surgery Standards of Practice (HB 309 by Rep. Gentry and SB 424 by Sen. Gaetz)
As originally filed, these bills would have imposed

Continued on Page 12

Continued from Page 11

onerous new requirements and regulations on office surgery. The FMA was able to work with the bill sponsors early in the session and rewrite the legislation to address certain issues without unduly burdening the practice of medicine. Both bills ultimately died in committee without receiving a hearing.

Electronic Prescribing (HB 1297 by Rep. Partington and SB 1568 by Rep. Brodeur)
During the 2019 session, the FMA negotiated a compromise on legislation that would have required physicians to issue prescriptions electronically in all instances. The FMA was able to include provisions that allowed physicians to issue paper prescriptions when it would be impractical to do so electronically, and to allow patients to compare prices. HB 1297 would have removed these exemptions. The FMA worked with Sen. Brodeur on SB 1568 and was able to restore the exemptions on the Senate bill. The two chambers could not come to an agreement on the differing versions and both bills died late in the session.

Health Care Provider Referrals (HB 1101 by Rep. Albert and SB 1842 by Sen. Burton)
This bill was a major priority of the House, probably for negotiating purposes rather than the merits of the policy. For unknown reasons, the House decided that it was important to fix the problems with limited network insurance plans by requiring physicians to notify patients in writing when referring a patient to an out-of-network provider. This remedy completely ignored the fact that the physician is not a party to the contract between the patient and the insurance company and is not in a position to know the network status of all of the providers to whom they refer patients. Fortunately, the FMA was able to work with Sen. Burton to drastically limit the Senate bill's application. The two chambers were unable to work out the differences, and the bills ping-ponged back and forth on the final day and ultimately were withdrawn from consideration.

Parental Rights (HB 1505 by. Rep. Plakon and SB 1288 by Sen. Grall)
The Parent's Bill of Rights legislation passed in 2021, prohibited physicians from treating minors without parental consent unless otherwise provided by law. SB 1288 would have removed the "unless otherwise provided by law" provision with the result that it would have been illegal for physicians to treat minors without parental consent in a number of situations, including testing for and treating STIs. Physicians also would have been unable to provide treatment to minors in emergency situations, an issue the FMA specifically had to fix during the 2022 session. The FMA and our specialty society partners secured numerous changes to this legislation, but the bill ultimately died on the Senate floor.

Health Care Practitioner Identification (HB 1341 by Rep. Gonzalez Pittman and SB 172 by Sen. Burton and HB 1427 by Rep. Griffitts)
Originating after a Board of Nursing opinion that allowed a CRNA to refer to himself as a "nurse anesthesiologist," this legislation has been a session fixture for the last five years. Known as the "ology bill," a version actually passed both chambers in 2024, only to be vetoed by Gov. DeSantis. This year's version took a slightly different approach in that it restricted the list of protected titles to board-certified specialties and omitted such titles as "physician" and "doctor." After SB 172 was passed by the Senate, the bill language was added to HB 1427, a House train that unfortunately included several provisions the Senate opposed. Eventually, everything was stripped out of HB 1427 and a nursing education bill was substituted in and passed by both chambers. The "ology bill" will have to wait until next year.

BUDGET
The state's budget will be the sole focus of the extended session. Two key items to keep an eye on are SB 110, the Rural Renaissance Package, and the Florida Reimbursement Assistance for Medical Education (FRAME) program. The Rural Renaissance Package contains a $25 million grant program that would give $250,000 for a primary healthcare provider to set up a practice in a rural community. Additionally, FRAME was cut from $46 million to $16 million in the House version of the budget. The Senate retains the entire $46 million in its version of the budget. The FMA is advocating for full funding of this program, which is designed to encourage qualified medical professionals to practice in underserved areas of the state. It offers annual payments to offset loans and educational expenses incurred during the pursuit of medical, dental, mental health, or nursing degrees and licensure.

FMA
Florida Medical Association

Your Legislative Representatives

United States Senators

Rick Scott (R)
United State Senate
716 Senate Hart Office Bldg
Washington, DC 20510
Phone: (202) 224-5274

Jacksonville Office
1301 Riverplace Blvd,
Suite 2010
Jacksonville, Florida 32207
Phone: (904) 346-4500
Web: www.rickscott.senate.gov

U.S. Senator Rick Scott

Florida Governor

Governor Ron DeSantis (R)
Office of the Governor
State of Florida
The Capitol
400 South Monroe Street
Tallahassee, FL 32399-0001
Phone: (850) 488-7146
Website: www.flgov.com

Governor Ron DeSantis

United States Senators

Senator Ashley Moody (R)
United State Senate
SR-387 Russell Senate Office Bldg
Washington, DC 20510
Phone: (202) 224-3041

Tallahassee Office
402 S. Monroe Street,
Suite 2105
Tallahassee, FL 32399-6526
Phone: (850) 433-263
Website: www.moody.senate.gov

U.S. Senator Ashley Moody

U. S. House of Representatives

Congresswoman
Kat Cammack (R)
U.S. House of
Representatives
2421 Rayburn House Office
Bldg
Washington, DC 20515
Phone: (202) 225-5744
INFO@KATFORCONGRES.COM

Gainesville Office:
5550 NW 111th Blvd, Suite A
Gainesville, FL 32653
Phone: (352) 505-0838

Congresswoman Kat Cammack

The Florida Senate

Senator Jennifer Bradley (R)
District Office:
1845 East WestParkway, Unit #5
Fleming Island, FL32003 312
(904) 278-2085
Senate VOIP: 40600

Tallahassee Office
406 Senate Building
404 South MonroeStreet
Tallahassee, FL 32399-1100
(850) 487-5006
Senate VOIP: 5006

Senator Jennifer Bradley

Senator Stan McClain
(R)
District Office
315 SE 25th Avenue
Ocala, FL 34471
(352) 732-1249

Gainesville Office
5700 SW 34th St, Ste 225
Gainesville, FL 32608
(352) 264-4040

Tallahassee Office

Senator Stan McClain

404 South MonroeStreet
Tallahassee, FL 32399-1100
(850) 487-5009
Senate VOIP: 5009

Florida House of Representatives

Representative
Chuck Brannan (R)
Capitol Office:
317 The Capitol
402 South Monroe Street
Tallahassee, FL 32399-1300
Phone: (850) 717-5010

District Office:
1262 SE Baya Drive
Lake City, FL 32609-2865
Phone: (352) 264-4001
Email: chuck.brannan@flhouse.com

Representative Chuck Brannan

Representative
Yvonne Hayes Hinson (D)
Capitol Office:
House Office Bldg
402 South Monroe Street
Tallahassee, FL 32399-1300
Phone: (850) 717-502
Email: Yvonne.Hinson@flhouse.gov
District Office:
2815 NW 13 Street, Ste 202
Gainesville, FL 32609-2865
Phone (352) 663-1140

Representative Yvonne Hinson

Representative Chad Johnson (R)
Capitol Office
1302 The Capitol
402 South Monroe Street
Tallahassee, Florida 32399-1300
Phone: (850) 717-5022

Representative Chad Johnson

Jonesville Office:
105 Southwest 140th Court,
Suite 1
Jonesville, Florida 32669-3391
(352) 496-3700
Email: chad.johnson@flhouse.gov

HAPPENINGS

ACMS

ACMS Poster Symposium 2025

January 22, 2025 - UF Professional Park

L to R: Brittany Bruggeman, MD, ACMS Vice President; with the winners of the 2025 ACMS Poster Symposium: Nikita Shah, DO; Farigol Hakem Zadeh, DO; Tyler Kashuv; Mercedes Malone Galloway, MD; Xuban Palau Villareal; Grace Hey; and with Christopher Balamucki, MD, ACMS President.

Participants of the Poster Symposium with Judges Yvette Bazikian, MD (center with jacket); and Shyam Sabat, MD (far right).

Event Sponsor US Army Medical Recruiting Station with Mrs. Jones; Capt. Xavier Jones and SFC Halutz Parilla.

Thanks to All the Participants, Judges and Sponsors of the ACMS 2025 Research Poster Symposium!

HAPPENING ACMS

ACMS March CME Meeting
March 5, 2025, UF Professional Park

L to R: James Andrisin, UF Health Sponsor; Panelists Marsha Lewis, MD, MSc; Karen Harris, MD, MPH; and Julie Moderie, MPH. Thank you for an excellent presentation on Maternal Mortality Prevention!

ACMS April CME & Mentorship Program
UF Professional Park, September 24, 2025

L to R: Erin Black, MD; and Joy Kunishige, MD.

Mentor Nicholas Maldonado, MD; and Mentee Grant DuVall.

L to R: Althea Tyndall-Smith, MD; Karen Sem; and Brittany Bruggeman, MD, kicking off the Mentorship Program.

Sponsor Ana Mann; and Beth from Jazz's Wonderland.

Nikita Shah, DO; Victoria Bird, MD; and Farigol Zadeh, DO.

HAPPENINGS

ACMS

ACMS April CME & Mentorship Program Kickoff
UF Professional Park, September 24, 2025

L to R - Moderator Althea Tyndall-Smith, MD; with Panelists Byron Flagg, JD; Hunter Patrick, JD; Rupa Lloyd, JD of Gray|Robinson and Stefan Mann, MD. Thanks to Gray|Robinson for Sponsoring this informative presentation on Growing Your Practice!

L to R: Erin Black, MD; SFC Halutz Parilla; Althea Tyndall-Smith, MD; Blanca Millsaps, ACMS; and Jose Gilbert, UF Health.

ACMS Installation of Officers
May 20, 2025 - Mark's Prime Restaurant

L to R - Jackie Owens ACMS EVP; Brittany Bruggeman, MD ACMS Incoming President; Speaker and FMA President Lisa Cosgrove, MD and Brad Bruggeman, MD.

L to R - Charles Riggs, MD and Outgoing ACMS President Christopher Balamucki, MD.

Alan Lessner, MD and Erin Black, MD.

L to R - Michael Smith; Althea Tyndall-Smith, MD; Lisa Cosgrove, MD, FMA President; Brittany Bruggeman, MD and Sarah Marsicek, MD.

HAPPENINGS

ACMS Installation of Officers
May 20, 2025 at Mark's Prime Restaurant

L to R: Farigol Zadeh, DO, ACMS Board Member; Jackie Owens, ACMS EVP; Gary Gillette, MD, ACMS Secretary/Treasurer; Brittany Bruggeman, MD, ACMS President; Althea Tyndall-Smith, MD, ACMS Vice President and Christopher Balamucki, MD, ACMS Immediate Past-President.

L to R: Steven Reid, MD and Daniel Duncanson, MD.

L to R: Parker Gibbs, MD and Christopher Balamucki, MD, ACMS President.

L to R: Noelle Lucke-Wold and Brandon Lucke-Wold, MD.

L to R: Parker Gibbs, MD; Erika Griffith, Rhonda Tompkins and Tammy Lindsay.

HAPPENINGS

ACMS

ACMS Installation of Officers
May 20, 2025 at Mark's Prime Restaurant

L to R - Faye Medley; Scott Medley, MD; Carl Dragstedt, DO; Christine Riggs and Charles Riggs, MD.

L to R - Gary Gillette, MD; Karen Humphreys; Mindaugas Rackauskas, MD; and Adriana Zuniga, MD.

L to R: Roslyn Levy; Norman Levy, MD, PhD; and Jackie Owens. Nice tie, Dr. Levy!

Blanca and James Millsaps

L to R - Carolyn Carter, MD; Laurel Lingle with Gallagher Insurance and Jyoti Budania, MD.

In Memoriam

Melvin C. Dace, MD - (1936 - 2025)

Melvin (Muz) Dace, MD, passed away on March 30, 2025 in Gainesville, FL. Dr. Dace received his Medical Degree from Washington University. He began his Internship at the University of Florida and was then joined the Army, as a Captain and Medical Officer for 2 years. Afterwards, he completed his Residency and advanced training at Jay Hillis Miller Hospital at UF, (Shands Teaching Hospital). Dr. Dace became a Medical Internist specializing in Cardiology and joined a Private Practice Group in Gainesville. He lead the Gainesville Medical Group as CEO, and was a key member of the team that brought the (HCA) North Florida Regional Hospital to Gainesville where he would serve as its Chief of Staff for several years. He was passionate about golf and tennis and loved his Florida Gators. He is survived by his wife, Dottie, his two sons, John Sr and Doug, four Grandchildren and two Great Grandchildren.

James Garlington, MD - (1931 - 2025)

James Garlington, MD passed away October 2024. He served as a Past-President of the Alachua County Medical Society. Dr. Garlington received his Medical Degree from Yale University. He then joined the US Navy as a Medical Officer in 1956, serving two years in that capacity. Afterwards, he completed Residencies in Surgery and Otolaryngology both at the University of Florida. Dr. Garlington served as Clinical Professor of Otolaryngology at UF Health, while practicing at Alachua General Hospital. He was a founding Board Member of North Florida Regional Medical Center and later served as the ENT Division Chair at UF Health Jacksonville. In his retirement, Dr. Garlington enjoyed woodworking, flying model planes and sailing on Kingsley Lake. He is survived by his children.

Col. Craig Kitchens, MD - (1944 - 2025)

Col. Craig Kitchens, MD (USAR, Ret), aged 81, passed away peacefully in his home in March 2025. Dr. Kitchens grew up in Gainesville, FL. He received his Medical Degree from the University of Florida, his Internship at Duke University, followed by his Residency and Fellowship in Hematology and Oncology at Johns Hopkins University. He returned to Gainesville where he raised his family and became an instrumental faculty member and leader at the College of Medicine at the University of Florida as Vice Chairman of the Department of Medicine, Program Director for Internal Medicine Residency and Chief of Medicine at the Gainesville VAMC. Dr. Kitchens is survived by his wife, Dawn Grinenko, MD, two sons and four grandchildren.

William Thomas Hawkins, MD - (1941 - 2025)

Dr. William Thomas Hawkins, Sr., passed away January 27, 2025 at the age of 83. He was a Past-President of the Alachua County Medical Society, a retired Navy Lieutenant Commander, and a veteran of the Vietnam War. Dr. Hawkins was born at Alachua General Hospital in 1941 - where he would later practice Radiology. A committed community member, Dr. Hawkins led his family to donate land to Alachua County for the John Henry Thomas, MD Center and to the city of Gainesville for the Gainesville Technology Entrepreneurship Center. He is survived by his four sons, Will, Alan (Di), Matthew, and Thomas Jr. (Sara); by his grandson Rowan Hawkins; by his former wife Mary Lou Spates.

Sandy K. Sanders, MD - (1935 - 2025)

Dr. Sandy Kent Sanders passed away Monday, April 28, 2025 at the age 0f 89. Dr. Sanders' father was a professional photographer, so he and his family moved around a frequently, mainly around south Florida. Dr. Sanders proudly served in the United States Army where he was a Medical Technician. He attended the University of Florida medical school and graduated in 1964. Dr. Sanders was a Pediatrician in Gainesville for over 50 years, seeing generations of patients. He enjoyed photography, fishing, motorcycles and was a collector of pens, knives, music, and kites. He is survived by his children, a grandson, brother and sisters and their children.

EHR Interoperability and AI: Don't put the Cart Before the Horse

Guest Editorial By: Daniel Kent Cassavar, MD, MBA, FACC,
Medical Director The Doctors Company and TDC Group

Healthcare practitioners are ready to let AI lighten their loads—but first, we need to achieve EHR interoperability. AI can help us with that, too.

My checkout desk is run by an individual who has been with my practice for 20 years. I see her being more useful doing more important jobs, because we should be using automation to discharge patients and book their next appointments.

I am optimistic that tools powered by artificial intelligence (AI) can make our lives easier and more successful by relieving administrative burdens, streamlining workflows, improving patient safety, and making risk management easier to manage.

But first, we need to achieve interoperability for our EHRs. Fortunately, AI can help us with that, too.

Our AI Wish List

Most practitioners spend so much time swatting through clouds of administrative nuisances that we miss the experience of focusing on and advocating for patients.

The wish list of administrative and business operations functions that AI can help us with includes prior authorizations, billing, scheduling, and a host of front-desk and checkout tasks. Further, I'd welcome some automated assistance with certain essential items completed by medical assistants, like medication reconciliation, that take up precious, limited appointment time. Witnessing improvements in AI for healthcare, I'm looking forward to my slice of the assistance pie.

Here are the top three items on my personal AI wish list:

1. Booking: Many healthcare systems are already experiencing success with referral automation and other scheduling tools. These generate cost savings for practices and organizations while increasing healthcare access for patients. For example, a pilot program at Montage Health in California has shrunk their time from referral received to patient scheduled from 23 days to 1.6 days.

2. Emails: Generative AI can draft email responses to common questions like "What does this test result mean?" Sharing the inbox load—and preserving clinician attention for more complex patient situations—combats one of the primary sources of burnout.

3. Triage: After heart catheterization, a chatbot sifting a patient's answers to questions can refer a patient with signs of infection to a human clinician. Meanwhile, that chatbot can answer questions for patients with routine procedure aftereffects, reserving the attention of human clinicians for patients with pressing concerns.

Triage chatbots are already live and patient facing, with mixed results so far. It's early days—as developers make improvements, chatbots will help us more quickly distinguish between minor questions and major concerns. Already, chatbots providing patient support are one of the three generative AI use cases chosen for review by an expert panel at the IHI Lucian Leape Institute "as being broadly representative of anticipated clinical uses of AI in the next several years."

AI Can Help With Teamwork, Too

Back to that heart catheterization: Let's say I perform the procedure, but the next day, another practitioner is rounding. They don't need to know procedure details—they just need to know that the result was normal. AI's capability to slice and dice summaries, with varying degrees of complexity, can pull a lot of weight through transitions in care. Patient handoffs are charged moments for patient safety and practitioner liability, so AI's capacity for summation—if carefully integrated into

Continued on Page 22

Continued from Page 21

workflows—can elevate patient safety and bring relief to overburdened practitioners.

Other AI benefits to teamwork are harder to specify, but imagine how lifting administrative burdens can lift up teamwork: We all have more capacity to reflect and to interact in our best collegial manner when we reduce unnecessary hassles and stressors and recover some cognitive bandwidth.

Any of these wish list solutions must seamlessly integrate into the EHR, and they have to achieve better results than we're getting now. Not perfect results, but better than our present state.

Let's say my wish list of AI-powered tools becomes perfect and available for free tomorrow: My practice, like many, will still be hampered by interoperability challenges.

The Risks of Our Siloed Medical Records

When I complete an ultrasound here at ProMedica, the test result comes to my inbox. I can ask my nurse to call up the patient and say, "Your result was normal." But if my patient gets that test completed at the other local healthcare system, no notification reaches me. If I get a call months later from the patient, asking about their test results, this is less than ideal from the perspective of risk management, relationship management, patient satisfaction, or clinician satisfaction.

The other big hospital in Toledo, Ohio, where I practice, is an Epic shop, just like we are—but they use a different version, so we're still not interoperable. If my patient gets studies done at their hospital (perhaps their insurance demands it), I don't get those results until they are transcribed, printed out, faxed over, scanned in, and put into our records here. It's silly. And potentially dangerous.

The benefits of interoperability to test tracking alone will be, if we ever achieve it, a boon to patient safety and practitioners' protection from liability risks. For many practices and systems, test tracking is a chronic headache at best—and a safety and liability risk at worst.

In a mobile, high-tech society, patients should not have to leap over so many hurdles to see a practitioner outside their usual EHR, and healthcare should not still be doing this much printing, faxing, and scanning.

EHR Interoperability Is Table Stakes for AI

AI excels at digging through mountains of data, and it can help us wrangle our EHRs. Some healthcare systems have turned AI loose to find information lost in nondiscrete fields in their own EHRs. Elsewhere, researchers are using large language models to translate clinical data into standardized forms that are more easily transmissible across platforms.

Imagine the recovery of cognitive bandwidth and the benefits to professional satisfaction if we and our teams could spend less time chasing down records and more time practicing medicine.

Still, with all that we've learned about biases and other dangers inherent to AI for healthcare, developers have some trust building to do with clinicians. Part of that trust can be built by recognizing practitioners' priorities: As we consider our investments in AI wish list items, we can let developers know that AI has some basic table-stakes promises to fulfill, starting with EHR interoperability.

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