Thank you for a great year! Reflecting upon my year as your president, I think the most important thing we, as your board, worked on was the common goal to make our medical society relevant to you. We know that you have high expectations on getting value for your membership- how do we provide that value? We have realigned our resources to assist you by providing meaningful CME and services that you value and new opportunities to lead in today’s fast paced environment.

We must continue to provide efficient services and offer rapid and quality responses to specific member issues that we face. Multiple regulatory issues affecting physicians are impacting the physician-patient relationship and in many cases leading to burnout among young and old alike. Our medical society is working on creating a wellness program that would be available to all of us as members.

Now more than ever, active membership within organized medicine is needed. I urge all physicians to become involved and support the hard work of ECMS. Participating in events, like the Legislative Session, where we can express our views to our legislators, is one way to get involved in the issues that we face. Further, you can choose to write a resolution to try and change policy to help make relevant changes. You can join an action committee that was formed out of our strategic plan initiative as part of the rebranding of ECMS. Additionally, you can opt to become a FMA representative to actually vote to change FMA policy.

We had a great year and ECMS is in great hands with our new leadership. I want to extend my warmest wishes to ECMS’ 2018 President, Dr. Ellen McKnight, who is both a friend and a dedicated physician leader. Please lend your support to her and all the incoming ECMS officers for 2018. Thank you again for allowing me the honor of serving as your president this year. Our accomplishments would not have been possible without the input from our ECMS physician members and the outstanding efforts of our Medical Director, Erica Huffman.
True pediatric care is more than a colorful room with kid-friendly artwork and toys. Only one hospital has been caring for the region’s children for 48 years – The Studer Family Children’s Hospital at Sacred Heart.

Now, the families we serve can take comfort in the fact that the care Sacred Heart offers regionally is also backed by the most comprehensive academic health center in the Southeast — University of Florida Health, recognized among the nation’s best hospitals by US News and World Report in six children’s medical specialties.

Through our affiliation with University of Florida Health, Sacred Heart is staying on the leading edge of children’s healthcare providing access to the latest medical research with a local network of pediatric specialists, including:

- Pediatric Cardiology
- Pediatric Cardiology
- Pediatric Gastroenterology
- Pediatric Hematology/Oncology
- Pediatric Infectious Diseases
- Pediatric Nephrology
- Pediatric Neurosurgery
- Pediatric Orthopedics
- Pediatric Pulmonology
- Pediatric Surgery
- Pediatric Urology

To learn more, visit www.sacred-heart.org/childrenshospital.

The best care for children comes from the heart.
The Bulletin is a publication for and by the members of the Escambia County Medical Society. The Bulletin publishes six times a year: Jan/Feb, Mar/Apr, May/Jun, Jul/Aug, Sept/Oct, Nov/Dec. We will consider for publication articles relating to medical science, photos, book reviews, memorials, medical/legal articles, and practice management.

Vision for the Bulletin:

- Appeal to the family of medicine in Escambia and Santa Rosa County and to the world beyond.
- A powerful instrument to attract and induct members to organized medicine.

Mission:
Advancing physicians’ practice of medicine in our community.

NEW MEMBERS

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Baptist Medical Group
1000 West Moreno Street
Pensacola, FL 32501
(850) 469-7406 Fax: (850) 437-8283
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www.baptistmedicalgroup.org

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Family Medicine
Baptist Medical Group Primary at Airport
5100 North 12th Ave Ste. 201
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(850) 437-8485 Fax: (850) 437-8489
www.baptistmedicalgroup.org

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Baptist Medical Group Trauma
1717 North “E” Street Ste. 208
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Baptist Medical Group- Gastroenterology
1717 North “E” Street Ste. 401
Pensacola, FL 32501
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Events

ECMS Fall CME Conference and Vendor Fair

2018 Slate of Officers
President: Ellen W. McKnight M.D.
President-Elect: Brett Parra, M.D.
Vice President: Karen Snow, M.D.
Secretary Treasure: Nutan De Joubner M.D.

Members at Large
Kacey Montgomery M.D.
Casey Mickler M.D.
Michelle Grier-Hall M.D.

John Lanza M.D., Liaison, Director, Florida Department of Health in Escambia County
Paul McCloud M.D., Laisan, Dean, Florida State University College of Medicine, Pensacola Regional Campus
President-Elect Ellen W. McKnight, M.D. cordially invites you to join ECMS for the 2018 Annual Inaugural Ball (Cocktails & heavy hors d’oeuvres Reception)

Saturday, January 20, 2018
6:00 pm
Hilton Garden Inn on Airport Boulevard

Tickets $65 per person
Please mail your cash or check made payable to ECMS ($65 pp)
6706 North 9th Ave, #A8 Pensacola, FL 32504
To RSVP call 850-478-0706
Advance tickets must be purchased before January 12, 2018 (Room Rate Code: ECM call 479-8900)

Attire: Black Tie Optional (patriotic theme)
Music by: Adam B. Young Featuring Miss Ami Russ

SAVE THE DATE
We invite you to join the ECMS Foundation & Florida State University College of Medicine Pensacola Regional Campus for a fundraiser to benefit the Escambia/Santa Rosa County Medical Society Endowment!

Thursday, March 1, 2018
5:30pm
Bere’ Jewelers
$50 per person
Your ticket will enter you for a chance to win a $2000 piece of jewelry. Hors d’oeuvres & cocktails provided.

2018 MEMBERSHIP DUES
2018 ECMS Invoices have been mailed. If you did not receive a copy of your invoice please contact Erica Huffman at (850-478-0706).

Please remit payment for your dues prior to March 1st to be included in the 2018 ECMS Pictorial Directory.
The Escambia County Medical Society has moved!

Our new address is:
6706 North 9th Ave
#A8
Pensacola, FL 32504

The J. Hugh & Earle W. Fellows Foundation

providing educational loans for studies in medicine, nursing, medical technology and the ministry.

For more information, visit www.fellowsfund.org

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ECMS ADVANCEMENT TEAMS

Advocacy and Government Relations
Legislative Advancement Team (LAT)
Chair: Ellen W. McKnight
ECMS advocates for physicians and preserving the practice of medicine.

Member Value and Service Membership Advancement Team (MAT) and Education Advancement Team (EAT)
Chair: Hillary Hultstrand, M.D.
ECMS unites the profession through membership and delivery of value, service and relevance.

Trusted Community Resource Community Health Advancement Team (CHAT)
Chair: Hillary Hultstrand, M.D.
ECMS promotes a healthy community and favorable public image.

Medical Society Strength Executive Committee Officers
Chair: Karen Snow, M.D.
ECMS sustains the leadership and resources for a dynamic medical society.

SAVE THE DATE!

ECMS Inaugural Ball
Saturday, January 20, 2018 | Hilton on Airport Blvd.
ECMS Inaugural Ball
President-Elect Ellen W. McKnight
$65/per ticket!
Resurgence of Medical Practice Acquisitions in Private Equity

By: Jeff Cohen, Founder, Florida Healthcare Law Firm

Private money (e.g. private equity) is back chasing medical practice and medical business acquisitions. This is very different from similar activity in the 90s. Back then, the movement was public companies aggregating gross income dollars, which for a time drove stock prices. Today’s private money buyers are looking to maximize profitability through achieving efficiencies and aggregating large groups for leverage and the development of new income streams. Though stock (in the form of warrants and options or stock itself) if often on the table, it doesn’t have to be. Buyers are doing all cash deals, albeit to some degree on an earnings basis. If you want the full price, you have to remain involved and do what you can to maintain revenues and perhaps even drive them up.

Physicians especially have to know what they’re dealing with and then have at least a basic understanding of the issues that will drive these deals. To begin with, “private equity” simply means private investors (typically a group that pools their capital) that buy a portion or all of a company. Their investments are usually much larger than venture capital firm deals. They are not publicly traded entities. What do they want? To invest money in mature businesses, grow a company’s profitability and then “flip” their ownership to another buyer, typically in three to five years form their launch date. In contrast, venture capital firms usually invest in start-ups, buy 100% of the company and require control.

The up-front issues sellers ought to focus on include:

1. **Buyer experience.** How much experience does the buyer have in the space occupied by the seller? Since the buyer promises to grow the seller’s profitability, sellers need to know the buyer has experience growing the very sort of business being sold by the seller, and also need to see specifically how the growth will occur.

2. **Impact on the seller.** Sellers need to understand how the transaction will affect the seller. Will it hurt the seller’s culture? Will it mean big changes at the C Level? What sort of changes in control will the buyer require? Sellers would do well to speak with other sellers to see what life is like after the acquisition.

3. **Buyer plans.** Issues like timing of other rounds of investment are critical too, especially if there is any stock (stock, warrants, options) involved in the transaction. If the usual flipping period is 3-5 years and the buyer is in its first year of options, stock would likely have no value at all for several years (since the buyer is just buying and incurring debt for a while).

**Prepping for the Sale**

Sellers considering a sale need to get prepared to maximize value at least a year in advance. There may be loans on the books and other things that impair profitability. Since purchase prices are based on a multiple of earnings, sellers need to clean up their books to increase profitability. Similarly, there may be a variety of legal “clean up” that needs to be done to remove fears of the buyer. Are corporate documents in place and signed? What about state filings? Are there UCC-1s that need to get resolved? This is all early work that needs to be done with the seller’s accountant.

**Getting It Done**

The sale process usually begins with non-disclosure agreement signed between the parties. The NDA is designed to simply have the parties keep all information and documentation exchanged as confidential.

Next is the non-binding letter of intent. Sellers who think the terms of the LOI aren’t important (because it’s non-binding) will be stunned to learn that the entire transaction is actually driven off the LOI. That doesn’t mean changes can’t happen to the deal once the LOI is signed. It just means it’s often difficult for material changes to be made after that point. In fact, both parties tend to consider material changes after LOI to be a “bad faith” sort of move. Sellers must have input from their accountants and lawyers before signing the LOI, since seemingly innocuous things (e.g. stock vs. asset transaction and purchase price allocations) can have a big impact on the value of the transaction.

Due diligence is the period of time after an LOI is signed (30-90 days), during which time the buyer will dig through all aspects of the business to identify any issues. They are seeking to avoid upsetting surprises. And of course, these surprises are often used as leverage to reduce a purchase price.

Sculpting the deal is critical early on. How much will the buyer be required to reserve under the banner of “operating capital” (which is typically left on table for the buyer)? If a buyer isn’t careful, the buyer may claim that all the receivables are operating capital. Are the accounts receivable allocated to the buyer or reserved to the seller? If the buyer wants them, you will have to discuss their net value. Is real estate part of the transaction? If it is not contained in the Letter of Intent, or if it is not specified in the legal documents, it is not part of the deal.

Papering it up. Buyer typically propose all the legal documents in a purchase transaction. And of course it’s normal for all of the terms and condition to favor the party that drafted the agreements. For instance, the reps and warranties (promises made by the seller) will be extensive. But many of the things you will have to promise about your company are not even knowable. For instance, governmental or licensing board investigations are confidential. You won’t even know about them.

So how can you rep and warrant that there are none? Indemnification obligations can be “first dollar” and unlimited, which is a huge risk to the seller. Sculpting a proper indemnity threshold and cap is important. Sellers can expect at least three
rounds of changes to the proposed agreements, plus perhaps many discussions on the client level (between purchaser and seller representatives) and legal counsel level. Sellers need to understand that the buyer is most impacted by ensuring the seller (not their lawyer) is reasonably happy. As such, these deals do not typically get done at the lawyer level. Knowing which issues the client will carry and which ones the lawyer will carry is critical.

**Regulatory Climate**

All transactions occur against a backdrop of healthcare regulations. The Stark II law is a Federal self-referral law which requires each of the foregoing to be handled in a particular way. Practices with designated health services (DHS) like diagnostic imaging and physical therapy, DME and clinical lab services have to understand how profits will be allocated after a transaction. The Federal Safe Harbors describe ways of handling the transaction so that you will not violate the federal Anti-Kickback Statute. Medicare has peculiar regulations such as the “incident to” services requirement, for instance, that will impact certain core aspects of the purchase and compensation arrangements. And Florida (and many states) have fee splitting prohibitions that affect the way physician compensation can be paid. These are up front issues that often need to be thought about before an LOI is executed. Ask your healthcare lawyer and advisors to explain these things to you. If they cannot, you need to find professionals who understand these laws and how to apply them to your situation.

**Conclusion**

Selling your practice (or any healthcare business) is an exciting time, but not one where you want surprises. Your advisors will help you on that journey and will reduce the risk to you while maximizing the value you receive.
Cyberattacks Threaten Patient Safety

By Robin Diamond, MSN, JD, RN, Senior Vice President of Patient Safety and Risk Management, The Doctors Company

The recent WannaCry ransomware attack that crippled the United Kingdom’s National Health Service (NHS) showed how more than money and IT security are at risk—patient safety is also compromised by a cyberattack.

Hospitals and doctors’ offices in parts of England had to turn away patients and cancel appointments because their IT systems were infected with ransomware. Electronic health records (EHRs) were not accessible, and entire communities were advised to seek medical care only in emergencies. The same scenario could play out here in the United States.

Ransomware is not the only risk to patient safety. As the use of computerized medical devices continues to grow, hackers may target these devices. And because healthcare is the most frequently attacked form of business, more cyber threats to patient safety are certain to arise. Our nation’s healthcare providers must approach cybersecurity as an organizational risk management and quality-of-care issue. And they must do it now.

After WannaCry, I asked myself: Would physicians and hospital staff know how to respond to protect patient safety if all computer access suddenly vanished? With 79,000 member physicians nationwide, The Doctors Company has access to experts in specialties that might be most affected by a cyber attack: obstetrics, emergency medicine, anesthesiology, and surgery. So I reached out to some of these experts to share their concerns as well as their plans to protect patients. Their insights are a wake-up call to be prepared.

Some physicians have considered the potential danger and prepared a response, which is often a return to paper records when EHR systems go down. But that might not always be easy, or even possible. Paper copies of patient medical records may not always be available, a situation that could jeopardize patient care when clinicians must act without sufficient knowledge of allergies, medications, and past treatment.

This is why Marcus Tower, MD, director of gynecology at Hillcrest Hospital (part of the Cleveland Clinic Health System), always keeps a paper backup of patient records that can be accessed quickly in the event of a computer failure. While he said losing access to computer records would be devastating to patient safety, access to paper backups would enable him to continue seeing patients even if his system was offline. Without a computer system, Dr. Tower would keep notes with time stamps. Diligence with time stamping is particularly important in obstetrics, where so much hinges on exactly when decisions were made and care was provided.

Anesthesiologist Randolph Steadman, MD, MS, at the University of California, Los Angeles, said in case of computer failure, ordering labs, imaging, and other diagnostic tests would be done by paper form and transmitted within the hospital by fax and/or conveyed by phone with paper forms to follow. But that would only be a workaround. Patient care overall would be affected, with registration slowed, he noted. Many clinicians and staff would be challenged to adapt to non-digital processes, as happened in the March 2016 cyberattack on the MedStar Health system, which has 10 hospitals and more than 250 outpatient clinics. When hackers seized control of their computer data, senior staff had to assist their younger counterparts with learning how to use paper messages and recordkeeping.

The ER could be hit hard by a cyberattack, but the physicians and staff there might be best prepared to respond, says Roneet Lev, MD, FACEP, chief of emergency medicine at Scripps Mercy Hospital in San Diego, California, and president of the Independent Emergency Physicians Consortium.

“Emergency departments have all experienced downtime with computer systems,” Dr. Lev said. “At our facility, we call this ‘Code White.’ When we hear ‘Code White’ on the speaker system, we know to get out the white board and the markers, and that things will be slower. It’s annoying and no one likes it, but we’d manage by keeping track of patients the old-fashioned way.”

Even so, a “Code White” still leaves clinicians without a way to refer to any medical records that are stored electronically. Not knowing a patient’s allergies or medical conditions is not optimal, she said, suggesting that all patients should always carry a list of their medications, allergies, and pertinent medical history on paper or on their smartphone.

Workarounds can only accomplish so much, Dr. Lev noted. A cyberattack could affect all computer-related hospital activities such as labs, x-rays, patient tracking, operating room scheduling, access to previous medical records, and treatment recommendations.

“What while the emergency department would function using ‘Code White’ procedures, this is not sustainable for long-term operation of a hospital,” she said.

What these experts all seem to agree on is that in the face of an attack, the best way to protect patients is to return to practices that worked before computers.

As Ralph Gambardella, MD, orthopedic surgeon and president of the Kerlan-Jobe Orthopaedic Clinic (affiliated with Cedars-Sinai) in Los Angeles, so aptly stated: “Rather than relying on computers, I still believe that talking to—and communicating directly with—my patients is the best way to impact patient safety.”
Telehealth uses various technologies making it possible for a provider to deliver virtual medical, health and educational services to patients in other states. Medical services are delivered through a two-way interaction between the patient and a provider using audiovisual telecommunications technology.

The healthcare provider can use several modalities to diagnose and treat, coordinate care, monitor a patient or educate a patient from a distance. Providers use either real time live video, store and forward communication which uses a secure e-mail platform and is not in real time or remote patient monitoring. Currently, the most used and reimbursed method is live video.

How are these telehealth services reimbursed?

Both Medicare and private payors are reimbursing for telehealth services. However, Medicare has restrictions on where the patient is located at the time of service based on geography, type of provider and type of services that can be reimbursed. Medicare does not pay when a patient is in the home at the time of service. The patient must be in what’s known as an “originating site” located in rural professional shortage area or underserved metropolitan area. There are some discussions about change to these restrictions but today a patient must go to an originating site for a telehealth service to be reimbursed under Medicare. An originating site, for example, can be a provider’s office, hospital, rural clinic or skilled nursing facility. Although with an increasing Medicare population and focus on delivery of healthcare to the home, seniors would be well served if legislation develops for this site of delivery with protections in place for the patient to assure quality of care and to prevent over utilization of services. Private payors also reimburse telehealth services; however, they have their own set of limitations. A recent study completed in 2017 by the Center for Connected Health Policy on private payor laws found none of the payors had imposed a location or site limitation and many reimbursed for services in the patient’s home. Where private payors are limiting reimbursements is based on types of service and factors such as complexity in physician licensing, lack of appropriate billing codes, and contracting with a third party to provide telehealth services to their members rather than rely on in-network providers. CMS has adopted new place of service code for telehealth in the 2017 Physician Fee Schedule. This may make identification regarding telehealth place of service a little clearer. Also, patients are unsure what telehealth benefits are available under their own health plan.

As noted, out-of-state providers are providing services via telehealth to a patient in a state where they are not located. The location of the patient is the place of service and the distant site provider must comply with the rules and regulations of the state in which the patient is located. Each state has its own laws and regulations which creates many challenges for a physician and for billing and reimbursement for the transaction by the payor. Many states have proposed legislation directing licensure boards to establish standards for the practice of telehealth within their professions. There a limited number of states that issue special licenses or certifications related to telehealth. A license or certification in telehealth, along with place of service in a patient home and would lead to a large increase in the use of services by providers across the nation.
Doctors Examine Injury Risks with Malpractice Closed Claims

Robin Diamond, senior vice president of patient safety and risk management, The Doctors Company

Physicians are always seeking ways to enhance patient safety. Taking a close look at research into real-life malpractice claims and incorporating some of the findings into their practices is one way physicians are reducing risks of adverse events. Studies provided by The Doctors Company provide insight into thousands of closed claims and shine a light on preventive actions. The following are examples of doctors who learned from these malpractice closed claims studies and, as a result, took patient safety in their practices and hospitals to the next level.

Cardiology
• Doctor spotlight: Sandeep S. Mangalmurti, MD, JD, cardiologist at the Bassett Healthcare Network in Cooperstown, New York.
• Risk trend: The Cardiology Closed Claims Study outlines liability pitfalls of improper medication management. Cardiovascular medications have inherent risks even when used correctly.
• Solution: This risk led Dr. Mangalmurti to change his daily practice when managing certain high-risk medications such as anticoagulants. “Coumadin, in particular, is associated with high-liability risk because of the risk of bleeding and its narrow therapeutic window,” said Dr. Mangalmurti. To avoid medication mishaps or breakdowns in communication, he makes a point to be very clear about whether the general practitioner or cardiologist will manage the anticoagulant medication.

Emergency Medicine
• Doctor spotlight: Roneet Lev, MD, FACEP, chief of the emergency medicine department at Scripps Mercy Hospital in San Diego, California.
• Risk trend: The Emergency Medicine Closed Claims Study identified the need for rapid recognition of stroke patients and treatment for tissue plasminogen activator (tPA).
• Solution: Across the entire hospital system, Scripps Mercy Hospital now initiates its emergency protocol for potential strokes when the call is placed to 911. The patient is taken straight to the CT scan without stopping at an emergency department bed. This expedites patient care as they activate the stroke team.

Hospital Medicine
• Doctor spotlight: John D. Nelson, MD, internal medicine hospitalist at Overlake Medical Center in Bellevue, Washington.
• Risk trend: The Hospitalist Closed Claims Study reveals spinal epidural abscess—a disease relatively uncommon in the general population—is appearing in medical malpractice claims more frequently. A diagnosis-related error involving spinal epidural abscess can lead to dire consequences, including paralysis.
• Solution: “This study should serve as a strong reminder for hospitalists of the importance of maintaining a very high index of suspicion for spinal epidural abscess,” said Dr. Nelson. Problems with back pain, leukocytosis, and fever are red flags, but Dr. Nelson states the literature isn’t so simple. These symptoms alone do not equate with epidural abscess. It requires a great deal of judgment to decide which cases are deemed appropriate for this diagnosis. “If you think a patient could have it, and it’s worth pursuing, you should pursue it now rather than later. So, for example, get an MRI tonight rather than tomorrow.”

Internal Medicine
• Doctor spotlight: Howard Marcus, MD, internal medicine physician in Austin, Texas.
• Risk trend: The Internal Medicine Closed Claims Study found that 39 percent of claims resulted from a diagnosis-related allegation (failure, delay, or wrong).
• Solution: Dr. Marcus has conducted small group discussions with physicians in his multispecialty medical group of over 300 doctors to improve understanding of the underlying methodological reasons leading to cognitive error. “Diagnosis in medicine is often challenging. There are more than 8,000 diagnostic entities listed by the National Library of Medicine and every patient is unique. It is helpful to understand the effect that psychological biases such as ‘overconfidence bias’ or ‘anchoring bias’ may play in medical decision making,” said Dr. Marcus.

Obstetrics
• Doctor spotlight: Marcus Tower, MD, obstetrician at the Cleveland Clinic’s Hillcrest Hospital, Cleveland, Ohio.
• Risk trend: The most common patient allegation identified in the Obstetrics Closed Claims Study is delay in treatment of fetal distress—specifically, failure to act when presented with Category II or Category III fetal heart rate tracings.
• Solution: Upon learning of this trend, Hillcrest Hospital now offers physician and nurse classes, providing the opportunity to learn how to identify heart rate tracings in a wide spectrum of scenarios. “From [the classes] we had a standardization process. Everyone became a patient advocate. Everyone focused their attention on, for that moment, identifying something that could be ominous so that we could act in a very timely manner,” said Dr. Tower.
Orthopedics
• Doctor spotlight: Ralph A. Gambardella, MD, orthopedic surgery and sports medicine specialist with the Kerlan-Jobe Orthopaedic Clinic in Los Angeles, California.
• Risk trend: The Orthopedics Closed Claims Study reveals patient factors contributed to injuries in 29 percent of claims. It found that patient nonadherence was more likely when there was inadequate communication between the patient or family members and the physician. The study also notes that determining whether a patient is an appropriate candidate for a procedure is an important part of providing good care.
• Solution: With communication being a prominent pitfall, the practice identified two areas where it could influence behavioral change:
  1. Incorporating a smartphone application to improve doctor-patient communication.
  2. Having the patient work directly with a financial advisor in-office and at the hospital to better understand financial responsibilities.
The hospital also adopted a preoperative screening assessment to identify comorbidities, thereby improving the surgery selection process and lowering risk.

Plastic Surgery
• Doctor spotlight: Phillip Haeck, MD, a plastic surgeon at The Polyclinic in Seattle, Washington.
• Risk trend: The Plastic Surgery Closed Claims Study notes that 10 percent of claims against plastic surgeons involved miscommunication between the patient or family members and the doctor.
• Solution: Dr. Haeck presented the study to his six partners and 35 staff members where they reviewed communication practices. As a result, the practice administered changes to communication protocols among physicians, staff, and patients. It now has clear guidelines to identify each communication, when it took place, and what resulted. All communications—including social media exchanges between patient and staff—are now entered into the EHR to alert the surgeon of new communication.

By leveraging technology, implementing new protocols, and being better equipped to address scenarios that could negatively impact patient safety, these practices and hospitals are taking steps in advancing patient care. Further insights from doctors who are learning from malpractice claims are available in The Doctors Company’s Innovations in Patient Safety video playlist.

Contributed by The Doctors Company (thedoctors.com)
2017 Beer, Bourbon & Boil
October 19, 2017

On October 19th the ECMS Foundation hosted the Beer, Bourbon, and Boil on the Fish House Deck. With nearly 100 in attendance, guest enjoyed beer and bourbon tastings while eating a low country boil.

The ECMS Foundation was able to raise a little over $3500 at this event which will go towards some of our existing projects. A very special thank you to Dr. Robert Sackheim for providing such wonderful live music for this event!

We hope you will join us for our next fundraiser on March 1, 2018!

SAVE THE DATE

We invite you to join the ECMS Foundation & Florida State University College of Medicine Pensacola Regional Campus for a fundraiser to benefit the Escambia/Santa Rosa County Medical Society Endowment!

Thursday, March 1, 2018
5:30pm
Bere’ Jewelers
$50 per person

Your ticket will enter you for a chance to win a $2000 piece of jewelry. Hors d’oeuvres & cocktails provided.
We continue to grow our programs through your help! For all that attended the recent B,B & B (Bourbon, Beer and Boil), I think that you agree a great time was had by all, while helping to fund our programs. We have more upcoming programs and projects as below!

- The recent B,B & B raised $3500 to fund our ongoing projects below. Thanks again!
- Mark your calendars for March 1, 2018. We will be having a fundraiser at Bere’ Jewelry to benefit the ECMS Endowment through the Florida State University College of Medicine Pensacola. Details to follow!
- **The Blood Pressure Program** continues to supply cuffs to patients that cannot afford them. The program thus far has provided over 400 cuffs through Hope and Healing, Good Samaritan, Escambia Community Clinic and St. Joseph clinics.
- **The We Care Program** continues to expand, providing needed medical care to indigent patients.
- **The Go Senior Voucher Transportation Program** continues to provide transportation vouchers to doctors’ office visits.
- **The FSU Medical Student Scholarship Program** continues to be enabled through the Foundation.
- **Pensacola State College Endowment** is partnered with ECMS Foundation to award scholarships to students at PSC who pursue degrees in healthcare.

Again - mark your calendars for March 1, 2018 for the fundraiser!

As you know, these programs are enabled by your donations. As your end of the year tax planning progresses, make your Foundation a part of this, and consider a donation. They may be sent to 6706 N. 9th Ave. #A8, Pensacola 32504. Note our new address!

Personally,

Kurt A. Krueger, MD
President
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