PRESIDENT’S MESSAGE

The penalty for refusing to engage in politics is being governed by your inferiors

The title is a quote from Plato that despite being over 2000 years old is likely more applicable today than it was in ancient Greece. While I find politics generally underhanded and distasteful, health care is being ruled by our inferiors. Physicians themselves are rarely involved in politics which is readily seen by comparing the number of physicians in political office versus the number of lawyers in office. Physicians a group always complain that the attorneys and there cronies always get their way, there is a reason why.

We recently returned from the Florida medical Association annual meeting where delegates from our Medical Society work to help decide the future of health care in Florida. We help develop the policies of the Florida Medical Association and also decide what rules and legislation can be made to further advance the interests of physicians and help physicians practice medicine successfully. Unfortunately none of this is free. A resolution is meaningless until it becomes legislation and for it to become legislation it takes 100s of man hours from staff and FMA lobbyists and usually anywhere between $50,000 to 100s of thousands of dollars to make legislation a reality. The money to lobby our state legislature as well as the money to help elect legislators whose interests align with ours comes from the FMA PAC.

The FMA PAC is a bipartisan political action committee who helps provide money to lobby to legislature for the passage of pro physician legislation as well as help elect legislators who have our interests in mind. The FMA PAC is funded solely by physician fundraising and physician contributions. In 2015 the FMA PAC raised 2.5 million-dollars. While sounding like a considerable sum money it is a fraction of what the attorneys raised in the state of Florida.

So how would your life be different without the FMA and the FMA PAC (1)? Without the intervention of the FMA and the PAC, physicians would be required to be fingerprinted every 2 years. (How fingerprints change after 2 years is beyond me but this was legislation that was defeated.) The CAT fund exemption would expire, allowing a 10% premium on medical malpractice insurance if a major storm hit anywhere in Florida. Physicians would be unable to self insure and minimum liability would increase to 500,000-1.5 million. If you had 3 complaints against you with the board of medicine you would automatically have to appear in front of the board to defend your license. Assignment of benefits would disappear and insurance company payments would go directly to the patients. Immunity for volunteer work would disappear and likely so would volunteer work. Expert witness certificates would no longer be issued and any physician from any specialty could testify against you. The look back period for insurance companies to request refund money would be 30 months instead of 12 months. If you prescribed any amount of narcotics, even one pill, you would be legally obligated to check the prescription database. The Department of Health would be able to suspend your license for any suspicion of a crime without due process. Finally, ARNP’s would be able to practice independently in all specialties.

When I first learned about all the legislation that the FMA and the PAC helped pass and more importantly help prevent, I was astounded. Then I started thinking if we all truly contributed what could be accomplished. Physicians spend pennies on the dollar compared to lawyers trying to advance our political agendas. If every physician in Florida contributed $500 a year, we would raise over 30 million-dollars a year total (2). If every physician contributed $500 a year we would dominate the political landscape for health care in Florida.

Politics is the only sport where the spectator always loses. To become the masters of our own destiny we as a group need to become engaged. So I encouraged you to contribute to the FMA PAC, participate with your Medical Society and the FMA. If you have questions and/or would like to contribute please feel free to contact us at the Medical Society, and as always I look forward to seeing you at the next meeting.

1. Life without the FMA
2. A Q&A with FMA PAC president Dr. Christopher Pittman
Telluride, Colorado
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February 10-16, 2017

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(L-R) Samuel Criollo, MD; Juan Rondenos, MD; Matthew Pearson, MD; Lincoln Jimenez, MD, Charles Wolff, MD

Sacred Heart Hospital Pensacola
E.C.M.S. Bulletin

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:

The mission of the Escambia County Medical Society is to promote the art and science of medicine in order to improve the health of our community. | Tradition – Honoring the history of medical care in Escambia and Santa Rosa counties. | Service – Serving the needs of our community through the service of our members in the practice of medicine. | Leadership – Meeting the challenges of the future and safeguarding our community’s health through organized collaboration on the local, state, and national level.

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www.thegcpi.com

YOUNG PHYSICIANS SECTION MEETING

On August 9th the ECMS hosted our annual Young Physicians Section Meeting at V.Paul’s Italian Restaurante. The topic was Direct Patient Care and the 1.5 hour CME was given by Dr. Lee Gross. The room was filled with approximately 70 medical students and physicians interested in learning about the topic.

We want to thank our dinner sponsor, Regions Bank and two social sponsors Fisher Brown Insurance and ADP for helping to make this event possible.

SAVE THE DATE

February 4, 2017 | SAVE THE DATE | ECMS Inaugural Ball
New World Landing
President-Elect Hillary Hultstrand, M.D.
2016 FLORIDA MEDICAL ASSOCIATION ANNUAL MEETING

On July 29th the Escambia County Medical Society in Conjunction with Santa Rosa County took 9 delegates to the Florida Medical Association Annual Meeting in Orlando, Florida. On Friday evening our physician delegates met with delegates from Duval, Capitol, and Emerald Coast Medical Societies at a dinner social. On Saturday morning delegates from the Northwest Florida Caucus discussed resolutions in the FMA Handbook and gave testimonial at the reference committee meeting.

We want to thank the following physicians who served. For Escambia County Dr. Brian Kirby, Dr. Ellen McKnight, Dr. Hillary Hultstrand, Dr. Victor Hultstrand, Dr. Jennifer Miley, Dr. Coy Irvin, Dr. John Lanza and for Santa Rosa County Dr. Ken Long and Dr. Bach-Uyen Le Thi.

If you are interested in serving as a 2017 FMA Delegate through Escambia or Santa Rosa County please contact Erica Huffman 478-0706 x2 or director@escambiacms.org.

The Escambia County Medical Society sponsored four resolutions at the annual Florida Medical Association meeting, all of which passed. We feel our efforts at the FMA have advanced our mission to help physicians practice medicine. The title of each resolution and the final language that passed is as follows:

Resolution 16-401- End the Federal Policy of Imposing Maintenance of Certification upon Physicians through Medicare Payment Models, Quality Measures, and Future Alternative Payment System
Resolved, that the FMA opposes MOC mandates under all Medicare payment models, quality measures, and any future alternative payment systems.

Resolution 16-314- Declaration of No Confidence in the American Board of Internal Medicine and the Prevention of Further Interference by the American Board of Internal Medicine in the Practice of Medicine
Resolved, That the FMA stands committed to remove MOC mandates legislatively and will prohibit the interference of the ABIM/ABSM on the ability of the physicians to practice medicine in the State of Florida.
The FMA was not willing to declare no confidence in the ABIM/ABSM because they thought it would hurt the FMA’s stance going forward but remained strongly supportive of removing MOC mandates. The key is to move forward with legislation.

Resolution 16-402- Protecting the Right of Privacy and Access for the Medicare Patient and Preserving Solo/Small Practices
Resolved, that the FMA recognizes the importance of the survival and success of private solo, small group medical practices; and be it further
Resolved, That the FMA supports the right of the Medicare patient to see a physician of their choice who is committed to keeping their medical information private; and be it further
Resolved, That the FMA opposes a Medicare patient being penalized financially, which is presently done, if that patient chooses to see and opted out doctor in order to protect their access and privacy; and be it further
Resolved, That the FMA supports a change in federal policy which currently denies the rights of a Medicare patient to privacy and access, supports federal legislation allowing a Medicare patient to see an opted out physician, and supports the patient being reimbursed directly by Medicare, a fair contracted price for the services provided.

Resolution 16-411 Ensuring that Physicians have Access to the Safest Medications When Treating Pain in a Complex Regulatory Environment.
Resolved, That the FMA supports requiring insurance companies in the state of Florida to have multiple long-acting opioids with abuse deterrent technology on both their tier one and tier two level pharmacy benefit.

Congratulations
Dr. Ellen McKnight has been selected to serve on the Florida Medical Association’s Council on Legislation effective July 31st-August 5, 2017
Dr. Hillary Hultstrand has been selected to serve on the Florida Medical Association’s Council on Medical Education Science and Public Health
The U.S. has one of the safest drug and medication supply systems in the world, in part due to careful regulation in the face of globalization and increasing threats to the supply chain. However, according to the FDA, there is a growing network of rogue wholesale drug distributors selling potentially unsafe drugs in the U.S. market. To combat this threat, the FDA has launched the Know Your Source campaign to ensure physicians are aware of the problem and to help them play their part in protecting the integrity of the U.S. drug supply chain. In addition, the FDA is participating in a collaborative initiative targeting drug safety on a global level.

**Dangerous Drugs in the Supply System**

How real is the threat? There have already been cases where adulterated, diverted, stolen, unapproved, or counterfeit drugs made their way into the American drug supply system. Counterfeit Avastin made it into the U.S. in 2012. Altuzan, a non-FDA-approved drug equivalent to Avastin but only approved to be sold in Turkey, arrived in the country in a counterfeit form in 2013. In 2012 and 2015, counterfeit Botox was found in the U.S. The FDA has indicated that antidepressants, hormone replacement therapies, sleep aids, cholesterol medications, and seizure medications are reaching the U.S. as well.

What does this mean for patients? They may receive a medication containing harmful ingredients or they may receive medications containing no active ingredients at all. Issues include the purity of the medication, whether harmful ingredients have been added, or whether it contains active ingredients. In addition, many drugs must be stored and transported within specific temperature guidelines in order to maintain effectiveness—and rogue distributors do not follow these precautions.

In certain parts of the world, counterfeit or substandard anti-malarial drugs constitute one-third of the supply. The result is a malaria patient population that may not be receiving lifesaving treatment. Additionally, the counterfeit drug creates a situation in which the parasites become resistant to the real medications. Fortunately, the FDA has found a solution to this problem and is sharing that solution globally.

**Guide Patients to Safe Websites**

Rogue distributors have expanded their efforts to advertise FDA-approved prescription drugs on unofficial websites with familiar-sounding names. The clear intent is to fool patients into thinking they are dealing with trusted entities. In addition to health risks, patients who order from these websites are at risk of credit card fraud and identify theft.

Commonly ordered medications on these sites are:

- Avandaryl (a non-FDA-approved Glimperide).
- Non-FDA-approved Generic Celebrex.
- Levitra Super Force, a non-FDA-approved medication to treat erectile dysfunction.

The FDA has cooperated with Interpol to place a warning on such sites, but physicians are encouraged to educate their patients about the risks of these websites. Direct patients to the FDA’s resource for safe pharmacies: BeSafeRx: Know Your Online Pharmacy.

**What Doctors Should Do**

Which doctors are the main targets? While any specialty could be at risk, most of the counterfeit drugs in the U.S. targeted to physicians are expensive medicines, and the targeted specialties are often oncology, dermatology, plastic surgery, and dentistry.

Regardless of your specialty, these tips can help ensure that your practice is ordering safe medications:

- In situations where there is a medication in short supply, the FDA may authorize limited importation of such medications from approved international suppliers. When that occurs, information will be available on the FDA drug shortages website.
- Beware of e-mail blasts and faxes that advertise the option of buying expensive medications at a discount. Remember the adage, “If it sounds too good to be true, it probably is.”
- Emphasize to staff, especially those in charge of ordering medications for patients, that it is illegal and ill-advised to buy medications and drugs from outside the U.S. The FDA is often aware of practices that order drugs from outside the U.S. and may initiate contact with the practice in order to educate employees. The FDA’s involvement may also trigger contact from a state's Board of Medicine.
- “Know Your Source” means know that a supplier of drugs and medications is legitimate. Practices can verify this through the FDA. Select a state and click on the link to the agency that can verify that the supplier is legitimate.
Once you’ve verified a supplier, rechecking once a year is sufficient—as long as there are no changes in the name, address, and other information from the supplier.

- Keep the “pedigree sheets” that are shipped with the product. Under federal law, they should contain:
  - Proprietary and established name of the drug.
  - Dosage.
  - Container size.
  - Number of containers.
  - Lot or control numbers.
  - Business name and address of all parties to each prior transaction involving the drug, starting with the manufacturer.
  - The date of each prior transaction.
- Keep a log of drugs and medicines ordered, the supplier information, and when the legitimacy of the supplier was checked.
- Be sensitive to any complaints by patients that might indicate there is a problem with the integrity of a product.

The FDA also has extensive information on its website about protecting the U.S. drug supply chain.

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Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.
TREATMENT OF MINORS WITHOUT PARENTAL CONSENT

What are you bound by law to do when a minor presents for healthcare without a parent or legal guardian? Related laws are largely state-specific; however, there are instances for which a majority of states have similar laws.

One example is the provision of prenatal care to minors. Florida, for example, allows “an unwed pregnant minor [to] consent to the performance of medical or surgical care or services relating to her pregnancy—and such consent is valid and binding as if she had achieved majority.”

Another example is Virginia law, which states that a minor is “deemed an adult for the purpose of consenting to medical or health services required in case of birth control, pregnancy or family planning except for the purpose of sexual sterilization.” If your facility provides prenatal services or labor and delivery services, it is helpful to ensure familiarity with your state’s laws regarding these instances of care.

You also may be asked to provide alcohol and/or drug abuse treatment for minors. Much like prenatal care, many states allow healthcare providers to provide services to minors for alcohol and/or drug abuse treatment without parental consent. For example, Missouri law states a minor may consent “for himself [sic] in case of pregnancy, but excluding abortions; venereal disease; and drug or substance abuse.”

Caring for minors is part of many facilities’ services. Applying related state (and federal) law is an important element of your treatment.

1 Fla. Stat. § 743.065.

Authors: Vanessa Mulnix, RN, BSN, CPHRM, CPHQ, ProAssurance Senior Risk Resource Advisor, and Jeremy A. Wale, JD, ProAssurance Risk Resource Advisor.

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THE THREE OPTIONS IN A RANSOMWARE ATTACK: RESTORE IF POSSIBLE, PAY, OR LOSE PATIENT INFORMATION

by Craig Musgrave, Senior Vice President, Information Technology, The Doctors Company

The news made national headlines: Hollywood Presbyterian Medical Center’s computer systems were down for more than a week as the Southern California hospital became yet another victim of ransomware—an attack where a business or individual’s computer system is held hostage by cybercriminals until a ransom is paid. Hollywood Presbyterian Medical Center ended up paying $17,000 to restore its systems and administrative functions.

“The quickest and most efficient way to restore our systems and administrative functions was to pay the ransom and obtain the decryption key,” said Allen Stefanek, president and CEO of the medical center. “In the best interest of restoring normal operations, we did this.”

No healthcare provider wants to be in Mr. Stefanek’s position. Once ransomware is in your medical practice or hospital system, there are only three basic options:

1. If you have performed frequent backups, restore your system.
2. If you have not performed frequent backups, pay the ransom.
3. Put your system back to the default setting—and lose everything.

If before the attack you’ve performed incremental backups, you can restore the areas affected, with minimal data loss (for example, an hour). If you have point-in-time backups, you can restore with increased data loss (for example, a week). If you have no reliable backups, you can reset the technology back to its “out-of-box,” or default, state and lose all the data, if no paper records exist.

The only other option would be to pay the ransom.

The key to handling any type of attack is to stop the spread once it’s identified. For example, Ottawa Hospital in Canada took the right steps when four of its 9,800 computers were hit by ransomware.2 The hospital was able to find the virus, isolate it before it spread, and wipe the drives clean on the infected computers. The hospital was able to prevent loss of any patient information and avoid paying any ransom because it had saved critical data on servers instead of desktop computers.

Besides loss of business, inconvenience to patients, and damage to reputation, a ransomware attack also poses liability risks. The possibility of adverse events and subsequent claims for professional negligence increases when computerized systems necessary for various functions such as CT scans, documentation, lab work, and pharmacy needs are offline. If hospital systems are down for any significant period of time, certain patients should be transported to other hospitals.

Adverse events can occur when healthcare workers do not have access to EHR systems. However, if this type of case was litigated, the patient would have to prove that something in the records may have had a bearing on the treatment being provided. In the case of emergency care, the claimant would have to successfully argue that the staff should not have undertaken the care until the medical records could be accessed.

Another risk involves theft of patient records during the attack. If patients’ personal information such as social security numbers and addresses are stolen, the physician practice or healthcare facility may be subject to claims for damages due to identity theft. If a HIPAA violation occurs because patients’ healthcare information is compromised, the practice or healthcare facility would face an investigation by the federal government and could face fines.

Hospitals, medical practices, and businesses should take full precautions to prevent a hack that results in ransomware being installed. Prevention strategies include:

- Provide security awareness for all employees. Over 80 percent of attacks are made possible by human error or human involvement. Train staff members to avoid downloading, clicking on links, or running unknown USB on computer systems.
- Block the malware at the firewall, by using intelligent firewalls to stop the malware from downloading.
- Install intrusion detection software to monitor illegal activities on computer networks.
- Stop the malware from executing on desktop computers by installing application whitelisting software, anti-virus, or anti-malware.
- Perform regular system backups.
  - Ensure that critical systems and business data are backed up—even backed up hourly for critical systems.
  - oTest that the backup restore process works.
- Avoid relying solely on encryption. Encryption does not protect a business from a ransomware attack. If a cybercriminal has your login, encryption doesn’t do anything to stop the hacker.
- Perform penetration testing on a regular basis to determine any existing vulnerabilities that should be patched.

Much of the decision to pay or not to pay the ransom is based on the circumstances surrounding the attack, the extent to which all or part of the systems have been compromised, and the degree to which recovery or restoration of the system can be achieved. Any decision must be viewed in light of all of the information and made on a case-by-case basis.

References

Contributed by The Doctors Company. For more cybersecurity articles and practice tips, visit www.thedoctors.com/cybersecurity.
Chances are good that in your practice, you treat obese patients. Obesity continues to be a national crisis: Current research has found that 35 percent of men and 40.4 percent of women in the United States are obese. The obesity crisis not only contributes to growing health costs but also raises serious patient safety risks.

Patients who have experienced an adverse medical event leading to a medical malpractice claim are frequently noted to be obese (based on documented height and weight). A review of 7,065 claims from 2011 to 2013 by The Doctors Company, the nation’s largest physician-owned medical malpractice insurer, revealed that 28 percent were identified as having one or more comorbidities, and obesity was the most common (8.3 percent of total claims and 19.2 percent of total claims with a comorbidity). When closed claims were analyzed, 26 percent of claims that resulted in indemnity payments listed obesity as a comorbidity.

Increased Risks: Complications and Access Issues

Obese patients commonly have a variety of comorbidities. Many are associated with a metabolic syndrome, such as hypertension, dyslipidemia, and hyperglycemia, which increases the risk of stroke, ischemic heart disease, and diabetes mellitus. These patients also have increased risk of obstructive sleep apnea (which often contributes to opioid-induced respiratory depression), susceptibility to nosocomial and postoperative infections, and weight-associated wear and tear on joints that can lead to osteoarthritis. Additionally, bariatric surgery can be associated with both surgical and metabolic complications.

In addition to the risks of comorbidities, healthcare facilities also face risks if they are unprepared to accommodate obese patients. An inability to fit a morbidly obese patient into a conventional MRI machine or CT scanner is a unique problem necessitating use of an open MRI or CT. Healthcare facilities that are unable to accommodate morbidly obese patients in their MRI machine or CT scanner or if their MRI or CT isn’t available at night or on weekends should have transfer agreements with open facilities in place so there are no delays in urgent MRIs or CT scans. The failure to transfer an obese patient to a facility with an open MRI machine or CT scanner in a timely fashion may result in a delay of diagnosis and/or surgical treatment—and, ultimately, in a malpractice claim.

The following is an example of such a claim:

A 41-year-old female, 6 feet 2 inches tall, weighing 390 pounds, was initially seen by a neurosurgeon in November with complaints of neck and low back pain and tingling in her hands. She had no deep tendon reflexes in her arms and decreased sensation in her left hand. She had been diagnosed three years earlier with an L4-5 radiculopathy and spinal stenosis. An MRI two years prior had shown C3-4, C5-6, and C6-7 disc herniation with moderate cord compression at C3-4.

The neurosurgeon ordered an MRI and, based on the findings, performed an anterior interbody discectomy with fusion at C3-C4, C4-C5, C5-C6, and C6-C7 in January. Her symptoms improved following surgery.

In early February, she was readmitted through the ER with a six-day history of right-sided neck pain, fever, and a discharge from the surgical wound. Cervical x-rays were done, and an epidural abscess could not be ruled out. She was seen by an infectious disease specialist and started on empiric vancomycin and amikacin. The neurosurgeon debrided the wound with placement of a drain and noted that there was purulent material in the deep soft tissues. A culture revealed methicillin-resistant Staphylococcus aureus (MRSA). One week later—afebrile, moving all extremities, and ambulating well—she was discharged. Two weeks later, the wound was healing nicely without drainage, and she was continued on antibiotics.

On April 22, she was readmitted with complaints of not feeling well for three days, generalized body pain, and difficulty urinating. A hospitalist noted confusion. She reported being seen at another hospital and diagnosed with a urinary tract infection. She was afebrile.

On April 23, she was again seen by the neurosurgeon because her legs had given out and she had fallen several times. He suspected spinal epidural abscess and ordered a cerebral MRI. However, the MRI at this hospital could not accommodate a patient of her size, so it could not be done. The hospital did not have a transfer agreement in place with an open MRI facility. She was seen by the infectious disease specialist, who suspected a gram-positive bacteremia of unclear source. He ordered a blood culture and started her on IV vancomycin.

On April 24, the hospitalist made arrangements to transfer her to an open MRI facility. When he saw her again on April 25, he noted decreased strength in both upper extremities. Nursing notes indicated an unsteady gait and a limited range of motion.

On April 26, the neurosurgeon noted lower extremity weakness with bilateral loss of sensation. The blood culture came back...
positive for MRSA. The infectious disease specialist noted that the patient had left arm weakness and trouble moving her legs. His progress note stated “Needs MRI—if transfer is necessary to accomplish this, it should be done as quickly as possible.” The neurosurgeon again requested an MRI. However, two attempts on April 27 to transfer the patient by ambulance to outside facilities were unsuccessful because she was too large for the gurney. On April 28, the neurosurgeon was told that the MRI could not be completed (four days after he had ordered it), and on April 28 she underwent a CT myelogram—which showed significant anterior epidural compression extending from the L2-3 to the L3-4 vertebral interspace, a suggestion of compression of the lower cervical cord–thoracic cord junction, and flattening of the cervical cord from C6-T1.

On the morning of April 29, she developed decreased movement and sensation in both lower extremities. The next morning, the neurosurgeon performed a wide decompressive laminectomy from C3 to T1. Somatosensory-evoked potential monitoring during the procedure showed no activity in the lower extremities. Two weeks later, the patient was transferred to a skilled nursing facility with paraplegia and a neurogenic bowel and bladder.

**Steps to Accommodate Patients of All Sizes**

Practices should have appropriately sized furniture in the waiting areas and exam rooms to meet the needs of obese patients. They should also have equipment—such as blood pressure cuffs, needles, and wheelchairs—designed for obese patients.

Weight assessment tools are handy, and practices may want to consider providing weight education to patients. It’s key to understand the importance of talking about weight with patients—the conversation should take place early for better prevention and treatment. Many factors can arise that inhibit a practitioner from speaking frankly about weight with a patient. As obesity rates continue to increase, it is worthwhile for doctors and other healthcare professionals to recognize that they might have their own barriers to such communications.

Sensitive treatment of obese patients involves attending to their needs for comfort, safety, and respect. Obesity can be viewed as one of the many chronic health conditions afflicting patients. The person, not the obesity, should be the focus of treatment. As with any patient with a chronic health condition, a relationship with respectful caring forms the bedrock of medical care.

**Reference**


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The second Quarter of 2016 has been very active for the Escambia County Medical Society Foundation. The following are some of the accomplishments and future anticipated projects.

- The Blood Pressure Cuff Donation Program continues to provide BP cuffs to needy patients through the Health & Hope, Escambia Community, St. Joseph’s and Good Samaritan Clinics. Plans for a second donation of 100 cuffs are in the works.

- Mission Healthy Baby Shower Donations: For the past month the ECMS Foundation has collected donations to benefit the March of Dimes Mission Healthy Baby. This event was partnered between the Foundation, March of Dimes and Phillips Corporation. The donated items will benefit military moms-to-be. THANK YOU to all of the offices and individuals who donated items.

- Foundation Scholarships: The ECMS Foundation awarded 4 scholarships to students at Pensacola State College pursuing training in a medical health program. Scholarships are used for tuition, fees and books. Information can be obtained through the ECMS Foundation office.

- Go Seniors Program: This program provides vouchers for transportation to doctors offices. It continues to grow and fills a tremendous need to facilitate necessary patient visits.

- National Academy Disaster Preparedness: This preparedness event is being held on September 14th and is facilitated by the ECMS Foundation in conjunction with the Department of Health in Escambia County.

- Pneumonia and Shingles Vaccine: An exploratory committee has been formed to determine how the Foundation can help provide pneumonia and shingles vaccines to needy patients through the Escambia Community Clinic.

- Spring Wine Festival: Initial preparation is being made to host a Wine Tasting Gala in conjunction with the FSU College of Medicine Pensacola regional campus. This will help provide scholarships through the Escambia/Santa Rosa County Medical Society Scholarship Endowment Fund program. Watch for details!

All of these programs are made possible by your generous donations. Please remember that there is minimal overhead involved with your commitment to the Escambia County Medical Society Foundation. Donations may be sent to 8800 University Pkwy., Suite B, Pensacola, FL 32514.

Personally, Kurt A. Krueger, M.D., President

The many ways you could be wasting money on your malpractice insurance

Did you know that most doctors unknowingly waste money on malpractice insurance, which is one of the largest expenses in a medical practice each year? One of the most common ways doctors continually spend too much include:

#2. Not considering a deductible

Taking a deductible basically hedges your insurance bet. Your agent should perform a 10-year historical deductible analysis to give you a decision-making tool for this.

Isn’t it time you called Julie Danna, the med mal insurance expert?
SACRED HEART HEALTH SYSTEM

Medical Group Names President for Gulf Coast
Sacred Heart Medical Group has named Bob Murphy, RN, JD, as the new President of the Sacred Heart Medical Group in Pensacola and Providence Medical Group based in Mobile, Ala.

Murphy has worked as a nurse, paramedic, attorney, hospital administrator and hospital chaplain. For the past 10 years, he served as a senior leader and international speaker with the Studer Group based in Gulf Breeze. Many of his years in healthcare were spent at Baptist Healthcare in Pensacola where his roles included senior vice president, chief operating officer, Life Flight program director, and trauma nurse coordinator.

Murphy is also pursuing seminary studies and a master’s degree in divinity. He holds a bachelor’s degree in nursing from the University of South Alabama, a master’s degree in public administration from Troy University, and a law degree from Stetson University College of Law.

Sacred Heart Medical Group, which is part of Ascension and Sacred Heart Health System, is the largest network of primary care and specialty physicians in Northwest Florida. The network includes more than 150 board-certified primary care and specialty care physicians along the Gulf Coast from Gulf Shores, Ala. to Apalachicola, Fla.

Dermatologist Joins Sacred Heart Medical Group
Our Medical Group has expanded its specialized services with the addition of Dr. Rahul Chavan, a dermatologist with advanced training in Mohs surgery for skin cancer. Dr. Rahul Chavan obtained his medical degree from the University of South Florida College of Medicine. He earned his PhD in the biomedical and biological sciences at Emory University and completed his internship and residency training in Dermatology at the Mayo Clinic in Rochester, Minn. He then completed a fellowship in dermatopathology at the Mayo Clinic.

Dr. Chavan has special interests in the treatment of melanoma and other skin cancers in which he uses Mohs surgery, the most effective and advanced treatment for skin cancer today. He will practice in the Airport Medical Park.

Hand and Wrist Surgeon Joins Sacred Heart Orthopedics
Sacred Heart Medical Group welcomes Dr. David Fiedler, an orthopedic surgeon who specializes in hand and upper extremity surgery. Dr. David Fiedler earned his medical degree from the Medical College of Georgia in Augusta, Ga. and completed his residency training in orthopedic surgery at the Atlanta Medical Center. He completed a fellowship in hand surgery at New York University Langone’s Hospital for Joint Disease. Dr. Fiedler specializes in hand, wrist, elbow and shoulder surgery, including treatment of hand and wrist fractures, arthritis, tendonitis, nerve injuries, and tendon injuries.

He will practice at the Sacred Heart Hand Center at 4551 N. Davis Highway.

OB/GYN Joins Sacred Heart Medical Group in Pensacola and Pace
SHMG also has welcomed OB/GYN Dr. Benjamin Osterrieder to its regional network. Dr. Osterrieder graduated with his bachelor’s degree from Florida State University, and he received his medical degree from the University of South Florida. He completed his residency training in obstetrics and gynecology through the University of Florida College of Medicine program at SHHP.

Dr. Osterrieder has a special medical interest in minimally invasive and robotic surgery. He joins the practice of Dr. Shane Medlock with offices at SHHP and the Pace Medical Park.

Children’s Hospital Adds Pediatric Emergency Specialist
Pediatric Emergency Medicine Physician Kimberly Massey, MD has joined the medical staff of The Studer Family Children’s Hospital at Sacred Heart and will serve in the Pediatric Emergency Department.

Dr. Massey earned her medical degree from Ross University School of Medicine. She completed her residency training in pediatrics through the University of Mississippi Medical Center, and performed a fellowship in pediatric emergency medicine at Children’s of Alabama. She is a pediatric advanced life support instructor, a child passenger safety technician and has a special interest in injury prevention.

ECMS Executive Director Erica Huffman selected to serve as the 2016-2017 Conference of Florida Medical Society Executives (CFMSE) Chair. CFMSE is made up of executive directors from both county, specialty, and state societies. Huffman has been a member of CFMSE for 5 years and will serve as chair for a one year term. The mission of CFMSE is to serve in an educational capacity to bring best practices, new and updated information, and other relevant topics to the attention of members in order that they can maximize the benefits their member physicians receive from their organization.
E.C.M.S. Calendar of Events

Sunday, September 25, 2016 | Time: 12:30pm
Women in Medicine Brunch – Painting
Co-Sponsors: BBVA Compass Bank, Danna Gracey Insurance, & MAG Mutual Insurance

October 11, 2016 | Location: V.Paul’s Italian Ristorante | 5:30p
General Membership Meeting | Topic: “Deposition Training for Physicians”
1.5AMA PRA Category 1 Credit(s)™
Sponsor: MAG Mutual Insurance

November 12, 2016 | Hilton Garden Inn Airport Boulevard | AM start time
General Membership Meeting - FALL CME CONFERENCE | Topics: TBD
Vendors: Danna Gracey Insurance, Gilmore Services, MAG Mutual Insurance, Physicians Indemnity

February 4, 2017 | SAVE THE DATE | ECMS Inaugural Ball
New World Landing
President-Elect Hillary Hultstrand, M.D.

Member Benefit: The Health Care Attorney On Call Hotline (561) 306-5699