BURNOUT

The other day was a particularly difficult one for me. While not out of the ordinary that day seemed to affect me more than others. I had 2 severely overweight patients berate me because I could not make their back pain go away with a simple prescription. When I finished seeing patients I had a stack of paperwork, mostly FMLA forms and disability to complete. Then I had to review and sign off on my Meaningful Use metrics to make sure I wouldn’t be penalized Medicare payments. Shortly after signing my stack of forms, I went to a meeting to work on our capital budget. I arrived home to 2 sleeping children and an aggravated wife, who like me, was tired of me coming home late. I sat down on the couch tired, not physically tired but mentally tired. I was tired of the paperwork, the alphabet soup of MIPS, MACRA, FMLA etc. I wondered if there was something better, somewhere I could make a bigger difference. Fortunately, the next morning I walked into my first exam room and was greeted by a hug from a pain free rheumatoid patient and I quickly felt purpose and satisfaction again.

Honestly, this is not the first time I felt this way. Thoughts like these happened many times throughout my career, med school, residency, particularly internship as well as my current position. I know it happens others to, as I hear the cynicism, the complaints, and see good physicians leaving medicine. At least once a week I see an e-mail linking me to an article or discussion on physician burnout. I never really thought about it much, we were always training to handle stress, handle chaos but the stress and chaos that approaches now is different. It is not simply disease, it is the stress of business, government programs, EMR, administrators, clipboard nurses and the never-ending contradictions that patients get from Web M.D. and Dr. Google. We’ve tried to make changes, leave private practice, leave employed practice, move from a small group to large group and vice versa. While everybody has their ideal dynamic, there is always stress, always chaos.

Medscape survey several thousand physicians a year from multiple specialties. While the physician burnout rate has been high for several years, overall it has increased to 46% this year from 39% a year ago. While emergency room physician’s lead the way in physician burnout, primary care specialties, family practice and internal medicine are not far behind at just over 50%. Actually primary care, including family practice and internal medicine had the most rapid rise and physician burnout rate, 16% higher than it was the year before. While many physicians have moved from a self-employed to unemployed model to try and reduce stress, the burnout rate is actually accelerated in employed physician’s faster than self-employed.

Exhaustion, cynicism, and self-doubt that we make a difference are signs of physician burnout which at this time of year those feelings can be prevalent. We are often torn by the need to care for are patients, or practices and employees as well as our families especially around the holidays. Burnout is no more prevalent than it is around the holidays when schedule or chaotic and the need to spend time with friends and family is paramount.

While the state medical societies and the FMA work to help us practice medicine, this time I’m not going to ask for your support or encourage participation at meetings. I’m going to ask you to take time for yourself, your family and friends and reflect on all the good you do. Spend time with your family and friends during this holiday season, maybe take a vacation and relax. Happy holidays and as always I hope to see you at the next meeting.
Sacred Heart Hospital Pensacola has been named one of the Nation’s 50 Top Cardiovascular Hospitals by Truven Health Analytics.

The hospital was selected from more than 1,000 U.S. hospitals and recognized for top performance in cardiovascular outcomes, clinical processes, and efficiency for treatment of heart attack and heart failure.

Visit 100tophospitals.com for more information or call 416-4970 to make an appointment with a Sacred Heart cardiologist or cardiovascular surgeon.
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:
Advancing physicians’ practice of medicine in our community.

On October 11th Attorney J. Nixon Danielle spoke to ECMS physicians about deposition training at V. Paul’s.

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

Join us for our Installation of Officers

President-Elect: Hillary Hultstrand, M.D.
Vice-President: Karen Snow, M.D.

Secretary/Treasurer: Brett Parra, M.D.
Members at Large: Nutan DeJoubner, M.D.; Jennifer Miley, M.D.; and Casey Mickler, M.D.

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## ECMS ADVANCEMENT TEAMS

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**ECMS advocates for physicians and preserving the practice of medicine.**

I attended the FMA Council on Medical Education, Science, & Public Health on October 14 in Tampa. I didn’t know what to expect but was pleasantly surprised. All of the resolutions presented at the FMA delegation that did not officially get approved but got sent to the FMA Board of Governor’s, were then dispensed to the appropriate councils for review. As part of the FMA Council on Medical Education, Science, & Public Health, we reviewed and heard further from the authors of resolutions on issues such as Promoting better outcomes for meningitis, promoting immediate treatment for HIV, and Knowing when to refer to nephrology for Chronic kidney disease. The information reviewed was informative and helpful for me to take back to my own practice. Further, we discussed the quality and diversity of CME credits at the past Annual Meeting and chose the next meetings’ CME offerings based on direct input from FMA members’ surveys. The poster symposium at the Annual Meeting got great reviews by students and judges, given it is now all digital but there was discussion to create a more structured outline for presentees to follow. Lastly, we worked on reviewing old FMA policies to determine if they need reaffirmation or sunset.

**ECMS unites the profession through membership and delivery of value, service and relevance.**

The Florida Department of Health in Escambia County, in collaboration with the National Academies of Science, Engineering and Medicine and the Escambia County Medical Society, recently conducted a pilot project to determine the extent to which local organizational and community plans support health, resilience, and sustainability in the event of a disaster. On September 14th, 2016, over 30 emergency management and public health stakeholders assembled at the Hilton Garden Inn, Pensacola, to have a conversation about how they might take actions to infuse recovery planning with strategies that optimize community health. The meeting, entitled, “Rebuilding Healthy Communities after Disaster, was an interactive brainstorming session that brought together individuals from numerous sectors.” Next steps will focus on continued dialogue among stakeholders with an emphasis on revision of current long-term recovery plans in Escambia County. For more information please contact: Carla Chromik, Florida Department of Health in Escambia County at Carla.Chromik@flhealth.gov.

**ECMS promotes a healthy community and favorable public image.**

On 11-2, the committee met to update the bylaws.

**ECMS sustains the leadership and resources for a dynamic medical society.**

EAT/MAT met via phone conference to discuss relevance of CMEs to DOs. 2 DOs are on the committee - Dr Eric Branch and Dr Carrie Steichen. We have made a plan to get in touch with individual DO accreditation groups in Florida to find out specifics on the process to get our CMEs accredited under AOA (especially where there is cross over like medical errors). Our group will also review CMEs for the upcoming calendar year and try to make them relevant for all our members.

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"My knee still hurts after surgery, and I'm getting all these bills to pay that I didn't know about."

I thought it was going to be another typical day at my practice, but I found myself comforting an upset and frustrated patient who was still having a hard time returning to golf three months after having an arthroscopic medial meniscectomy.

“What had I done wrong?” I asked myself.

“Mr. Jones” had made an appointment to see me after twisting his knee trying to kick a soccer ball around with his grandson. He was 62 years old and already had been treated by his primary care physician with medicine and therapy but had remained symptomatic with a torn medial meniscus on MRI. He was miserable because he had not been able to play golf and couldn’t even keep up with his wife on their evening walks. He was overweight, with a varus knee and early osteoarthritis on weight-bearing x-rays and MRI.

Of course, his internist and friends had told him that he needed an arthroscopic surgery and after that he would be all better.

Despite counseling him that he might still have knee pain after a meniscectomy due to the underlying arthritis, we agreed that an arthroscopic surgery was in his best interest to try to improve his lifestyle. We discussed all the medical and surgical risks and postoperative rehabilitation program. I connected him to my surgery scheduling team after carefully and clearly explaining his medical diagnosis and treatment.

I thought I had done a good job—but I was wrong. I had neglected to make sure he had been advised of all the growing financial obligations that our patients face today.

When the pain didn’t resolve completely after surgery—and Mr. Jones was receiving bills he hadn’t expected—I had an unhappy patient.

Miscommunication Can Lead to Claims

Patient-physician miscommunication issues such as this one play a large role in contributing to malpractice claims. The Doctors Company, the nation’s largest physician-owned medical malpractice insurer, has studied thousands of closed claims in various specialties and found that poor communication between the provider and the patient or the patient’s family is one of the key factors behind lawsuits. This issue contributes to 12 percent of cases for hospitalists and 14 percent of cases for obstetricians and emergency medicine providers.

A key component of good communication with patients is a discussion about financial obligations for the medical services provided. Good communication up front can help, especially if a surgical outcome or treatment does not lead to a perfect outcome.

Increasing numbers of physicians are joining large medical groups with a business manager or becoming hospital employees, which typically decreases their involvement with the business portion of healthcare. Most major medical insurance companies continue to sell policies with varying deductibles, co-payments, and complex rules. Unfortunately, these factors have led to an increasing disconnect between the patient and the physician when it comes to discussing financial obligations.

The physician needs to be involved in making sure that the patient is informed and educated about the financial burden of surgical and medical treatments. Doing this before proceeding with treatment can help lower the risk of a malpractice claim even when the medical outcome doesn’t meet the patient’s expectations. Understanding the financial commitment up front allows patients to make a more informed decision for care.

How to Ensure Financial Disclosure

In our office, we have established a series of steps for our patients once the patient has decided to proceed with elective surgery. These steps can be adjusted for non-surgical specialties:

• At the time of the office visit, the office staff provides the patient with a surgical information packet that includes a direct telephone number to the physician’s care coordinator (PCC). The staff tells the patient to contact the PCC once he or she has decided to proceed with surgery.

• The patient and physician also complete three forms with information that a staff member then enters into our electronic medical record:
  1. Surgery procedure form, completed by the physician with the appropriate CPT and ICD-10 codes.
  2. Anesthesia medical questionnaire form, completed by the patient.
  3. Durable medical equipment (DME) form, completed by the physician.
If the patient then contacts the PCC to proceed with surgery:

1. The PCC contacts the insurance provider. If precertification is required, the office notes this and sends other data (MRIs, etc.) to the provider to authorize.
2. The PCC then confirms the provider authorization.

Once the insurance provider has certified surgery, the PCC will contact the patient to schedule a surgery date and ensure that, if needed, the patient will obtain an appropriate medical clearance by their primary care physician (or a local physician to whom the patient is referred if the patient does not have a primary care physician). The physician must complete the clearance by the time of the preoperative office visit. The type of medical clearance required, if any, is determined by the criteria set by the anesthesia medical questionnaire form.

The PCC then sends the correct surgical date, CPT codes, and ICD-10 codes to:

- **Office financial advisor**: This advisor will discuss the patient’s insurance plan, deductible, and co-pay; establish the surgeon’s fee based on the expected procedure; and require a patient deposit at the time of the preoperative office visit. The deposit amount is designed to minimize the need for patient refunds due to overpayment post surgery.
- **Surgery center**: The surgery date will be set and the surgery center financial advisor will contact the patient and discuss the patient’s insurance plan, deductible, and co-pay; establish the facility and anesthesia fees based on the expected procedure; and require another patient deposit prior to the date of surgery.
- **DME company**: A private DME company will contact the patient and discuss payment costs and options for the DME requested by the physician.

It is incumbent upon the physician to work with his or her entire office and, where applicable, the surgery center team to provide patients with both the medical and financial information they need to make an informed decision prior to an elective surgery or other medical treatment.

By paying attention to both the medical and financial details, we are more likely to have happier patients, physicians, and surgery centers. Realistic medical and financial expectations discussed prior to elective surgery or other medical treatment can result in better efficiency, better outcomes, and less litigation.

Contributed by The Doctors Company. Dr. Gambardella is a member of The Doctors Company’s Orthopedic Advisory Board. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.
CANDOR TOOLKIT: PHYSICIANS NOW HAVE THE RIGHT TOOLS TO DO THE RIGHT THING AFTER AN ADVERSE EVENT

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

In the past, hospitals and physicians could appear cold and distant after adverse events. The fear of malpractice lawsuits created a culture in which physicians were expected to avoid most contact with a patient or family who might have reason to sue—and physicians certainly weren’t supposed to accept blame.

Even when a well-meaning physician wanted to acknowledge the tragedy and express concern, hospitals sometimes discouraged the conversation because they were afraid the doctor’s comments would implicate the hospital in a malpractice case. The actual effect of this way of thinking was just the opposite of what hospitals and doctors desired. Rather than shielding them from liability, patients and family members perceived this culture of silence as callous and uncaring, in some cases encouraging them to file lawsuits.

That was then. Over the past decade the healthcare community has embraced the idea that saying “I’m sorry this happened,” or at least acknowledging that an unanticipated adverse event occurred with genuine sympathy and concern, can go a long way toward healing the relationship between the healthcare provider and patient. Physicians have moved progressively toward a culture that expects an adverse event—a medication error, for instance, or a death during routine surgery—to be followed by a full disclosure of the facts to the patient and family. Hospital administrators and physicians both can say they’re sorry for what happened and even acknowledge they made a mistake in some circumstances when a clear-cut error has occurred that could have been prevented.

This is not just the right thing to do; it also helps the hospital and physicians avoid malpractice litigation, especially the lawsuits motivated not by actual errors or substandard care but by patients and family members who were left angry and abandoned.

Now we have not just the right idea, but the right way to execute it.

When Bad Things Happen to Good Doctors

The Agency for Healthcare Research and Quality (AHRQ) developed the Communication and Optimal Resolution (CANDOR) Toolkit with the input of healthcare professionals who studied the different tools, policies, and procedures in use at various hospitals, including the disclosure resources offered by The Doctors Company. David B. Troxel, MD, medical director at The Doctors Company, served on the oversight committee, and I served on the technical advisory committee, which assessed expert input and lessons learned from AHRQ’s $23 million Patient Safety and Medical Liability grant initiative launched in 2009. The CANDOR Toolkit then was tested in 14 pilot hospitals across three U.S. health systems: Christiana Care in Delaware, Dignity Health in California, and MedStar Health in the Baltimore/Washington, DC, metropolitan area.

“CANDOR is one of the most important patient safety programs to be released in the last 10 to 15 years,” said David Mayer, MD, vice president of quality and safety at MedStar Health and one of the originators of the toolkit. “CANDOR promotes a culture of safety that focuses on organizational accountability; caring for the patient, family, and our caregivers; fair resolution when preventable harm occurs; and most importantly learning from every adverse event so our health systems are made safer.”

This tool is just as useful for doctors as for hospitals. When a hospital is sued, physicians who were involved in the case will likely be named in the suit, whether they are employed by the hospital or not. Even though the CANDOR Toolkit is designed for hospitals, physicians should become aware of the valuable resources available to them in this toolkit, such as the videos that demonstrate how to have an effective disclosure conversation and tools that help doctors assess their own interpersonal communication skills.

The toolkit facilitates communication between healthcare organizations, physicians, and patients while promoting a culture of safety, said John Morelli, MD, vice president of medical affairs at Dignity Health’s Mercy General Hospital in Sacramento, California. “The CANDOR Toolkit helps our caregivers improve how we rapidly communicate with patients and families when harm occurs. Consistent with our mission and values, we have always communicated with compassion and empathy; however, the toolkit provides a framework to respond quickly and in a learned manner to patients and families while also offering support to our caregivers.”

CANDOR calls for a prompt response and specific actions after an adverse event. Within one hour, specially trained hospital staff should:

1. Explain the facts, and what might still be unknown, to patients and family members.
2. Contact the clinicians involved and offer assistance, because the stress and grief of the healthcare professionals can easily be
overlooked in these incidents.

3. Immediately freeze the billing process to avoid further stressing the patient with a bill for the services that may have caused harm.

CANDOR calls for the hospital to complete a thorough investigation within two months, keeping patients and relatives fully informed along the way. When the investigation is complete, the patient and family are provided with the findings and engaged in a discussion of how the healthcare organization will try to prevent similar adverse events in the future.

**Encouraging Open Communication**

The investigation will not always find that the physician or other clinicians failed to meet the standard of care, and in those cases the patient and family members can still benefit from understanding what happened. In many cases, they will not sue despite their loss because they are satisfied that the hospital and physicians did their best and were forthcoming with information.

The Doctors Company encourages physicians to disclose and speak to patients about unanticipated events as early as possible. We also suggest they go to their hospital administration to find out what the hospital’s disclosure process is and how closely it follows the CANDOR plan, because a cooperative approach is ideal. Working in harmony with the hospital is easiest in a closed system, where the physician is employed and insured by the hospital. Even when the hospital and physician are in adversarial positions and limited in communication, both parties still can adhere to the best practices outlined in the CANDOR program.

The philosophy and actions outlined in the CANDOR Toolkit can help hospitals and physicians avoid malpractice litigation, but even when the matter cannot be resolved and goes to trial, the fact that the patient and doctor talked early on can make a huge difference in the outcome of the case. Patients tend to pursue litigation with a vengeance when they think the doctor doesn’t care, but they tend to be much more reasonable when they can see that the physician is a human being with emotions, regret, and sympathy for the patient.

Contributed by The Doctors Company. For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.
Key information can go missing during the multitude of handoffs that occur in a hospital on any given day. Communication among providers continues to be one of the most frequently cited patient safety and risk management issues found in our closed claims analyses. As the following case illustrates, miscommunication and missed opportunities resulting from hurried handoffs can produce fatal results.

A 37-year-old female presented at 9:11 PM to the community hospital emergency medicine department (EMD) complaining of nausea, vomiting, and numbness of the left side of her face and left arm. She had anxiety, difficulty swallowing, fever, chills, severe intermittent abdominal cramps, and abrupt onset of chest pain for a few hours prior to admission. The patient, who was five feet four inches tall and weighed 192 pounds, had a blood pressure of 190/120.

The patient reported a history of hypertension, but she had stopped taking her blood pressure medication approximately six months before due to financial problems. The emergency medicine (EM) physician ordered a complete blood count, chemistry profile, cardiac enzymes, and an electrocardiogram (ECG).

After receiving Vistaril and Phenergan, the patient’s nausea improved. Cardiac enzymes were within normal limits, however, her white blood count was 12,700 per mcL (normal 4,500–11,000 per mcL), blood urea nitrogen was 27 mg/dL (normal 7–20 mg/dL), and creatinine was 2.6 mg/dL (normal 0.5–1.5 mg/dL). The ECG (read by the computer) showed sinus bradycardia, left ventricular hypertrophy, and nonspecific ST and T wave abnormality.

The EM physician diagnosed dehydration and renal failure and contacted the on-site hospitalist for admission. The hospitalist admitted the patient for observation. She ordered intravenous fluids and a 24-hour urine test for creatinine and protein. The hospitalist later noted that because the EM physician had not communicated a sense of urgency, she planned to see the patient in the morning. Neither physician ordered any medications to treat the patient’s hypertension.

At 12:30 AM, the patient arrived on the nursing unit, and the emergency nurse gave a report to the floor nurse. According to the floor nurse, the emergency nurse mentioned that the hospitalist was aware of the elevated blood pressure and was going to “deal with it in the morning.”

The registered nurse assigned to the patient was fairly new and inexperienced. The patient’s blood pressure was 180/100 upon admission to the floor. At 1:00 AM, the patient’s skin was pale, and she complained of back pain.

The nurse called the hospitalist, obtained an order for Tylenol for the back pain, and administered it 30 minutes later. At that time, the patient’s blood pressure was recorded as 190/100. An hour and a half later, the nurse called the hospitalist again to report that the patient continued to complain of nausea and of back pain. There was no note to indicate that the nurse reported the elevated blood pressure.

The nurse later stated that because the blood pressure was unchanged from when the patient was admitted in the EMD, she did not consider reporting it. She understood that the hospitalist was already aware it was elevated. The hospitalist stated that she was not aware of the elevated blood pressure and, if she had been notified, would have seen the patient and ordered additional testing.

The doctor ordered Percocet and Compazine; the Percocet was given to the patient.

Forty-five minutes later, the licensed practical nurse working under the registered nurse was unable to obtain a blood pressure reading using a conventional cuff. She switched to a blood pressure machine, which recorded the pressure as 212/162. She reported this reading to the RN.

The RN, according to hospital policy, reported the elevated blood pressure to the nursing supervisor. The supervisor later stated that she thought the nurse reported the pressure as 212/106; when asked if the patient was symptomatic, the nurse said no. The supervisor testified that she decided not to call the doctor and did not direct the RN to call the doctor because the patient’s blood pressure was not significantly different from the reading taken in the EMD.

The patient continued to complain of chest tightness and back pain with no radiation. Her skin was warm and dry, and she was up to the bathroom. At 6:30 AM, the nurse noted that the patient was sitting quietly in the bedside chair with unlabored respirations and normal skin color.

While taking another patient to surgery at 6:55 AM, the nurse passed the patient’s door and noted the patient lying on the floor. Her color was dusky, and she was unresponsive. A code was called and resuscitation attempted, but it was unsuccessful. The patient was pronounced dead at 7:21 AM.

The autopsy listed the cause of death as cardiac tamponade caused by acute aortic dissection that had developed over hours. The autopsy also noted that aortic dissection was caused by “years of hypertensive cardiovascular disease” and that the heart was...
enlarged; it weighed 550 gm (normal 250–280 gm). The dissection extended from the root of the aorta to the iliac arteries—the full length of the aorta. Also noted were left ventricular concentric hypertrophy and arterionephrosclerosis.

**What Went Wrong**

Critical lapses in communication and in understanding what was being communicated were major factors in this case. The EM physician and the hospitalist gave widely divergent accounts of what was communicated during their handoff. Handoffs between providers—whether via an electronic template or a written or verbal exchange—need to be structured and consistent in order to standardize the information exchanged.

**Patient Safety Recommendations**

- Watch for human errors. Opportunity for errors is multiplied when workload, hour restrictions, or other factors increase or complicate handoffs.
- Implement a structured handoff protocol. Communicating required information in a consistent way will help decrease human error. Handle sign offs with care—actively listen and take notes.
- Ask about any anticipated patient care problems, including considered diagnoses, pending significant laboratory results, procedures, or consultations.
- Think about what else the problem could be—have a backup plan in place.
- Encourage staff to go up the chain of command until all concerns are addressed.
- Ask for critical information to be repeated back.
Looking to avoid risk?

WE CAN SHOW YOU THE WAY.

We’re taking the mal out of malpractice insurance. Thanks to our national scope, regional experts, and data-driven insights, we’re uniquely positioned to spot trends early. We shine a light on risks that others can’t see, letting you focus on caring for patients instead of defending your practice. It’s a stronger vision that creates malpractice insurance without the mal.

Join us at thedoctors.com
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:

#3. Not choosing your liability limits wisely

Some doctors prefer lower limits but think that they are restricted from lowering their limits by a hospital, managed-care company, research study group, or the like. Often, simply negotiating a bit will eliminate these concerns and allow a practice to lower to a much less expensive limit.

Isn’t it time you called Julie Danna, the med mal insurance expert?
WELCOME TO THE FAMILY!

On August 23 at 3:06pm Executive Director Erica Huffman and her husband Travis welcomed their first born child Madison Brielle Huffman! We appreciate all of the well wishes during the pregnancy and delivery.
Dear fellow physicians;

Wow. The third quarter sure slipped by in a hurry! The Escambia County Medical Society Foundation has been busy, and I wanted to bring you up to date on a few things.

Blood Pressure Cuff Program: the second round of blood pressure cuffs has been delivered to the clinics. These are dispensed by Hope and Healing, Good Samaritan, Escambia County and St. Joseph clinics to patients that cannot afford one on their own. They have been put to very good use - note the recent thank-you letters below.

We Care: the program whereby physicians donate time and services to indigent patients has been ongoing for many years. It continues to thrive and we look forward to recognizing those physicians again at the Medical Society Ball on February 4, 2017. Mark your calendars!

Go Seniors! The senior transportation program has been very helpful in facilitating seniors’ office visits through the voucher program. It is in the process of being refined, and thanks to Dr. Willis for meeting with the Fellows Foundation, a prime supporter of this program.

National Academy Disaster Preparedness Event; the ECMS Foundation recently partnered with the Florida Department of Health in Escambia County to facilitate the Preparedness Event. This was held on September 13 with more than a dozen multidisciplinary participants attending to maintain the regions preparedness for possible disaster scenarios.

FSU Wine Event; our Foundation will partner with the FSU College of Medicine in March 2017 for a wine tasting festival. proceeds will benefit the Escambia/Santa Rosa Scholarship Endowment Fund. Date TBD, so watch for details.

Pensacola State College Endowment; the ECMS Foundation awarded 4 scholarships in the amount of $1,042.88 this year to PSC students pursuing degrees in healthcare. This is an ongoing program which greatly helps supply needed medical personal to our area.

As the year comes nearly to a close, I want to thank the Board members for all of their time in making these programs possible. Thanks to Drs. Joanne Bujnosky, Brian Kirby, John Lanza, Jennifer Miley, Wayne Willis, and George Smith; and Erica Huffman, administrator.

And as you know, these programs are made possible by your generous donations. As the year closes, consider a donation to help support them. There is virtually no overhead involved with your commitment to the Foundation. Donations may be sent to 8800 University Pkwy., Suite B, Pensacola, FL 32514.

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

We have distributed all but 2 of the blood pressure cuffs. The patients have been grateful and ecstatic about receiving them. This has led some patients to make lifestyle modifications. Also our chronic disease case manager has received an increase in questions from the patients about better control which has prompted us to revisit offering a class on hypertension. Please tell the ECMS board that we are very grateful for the cuffs.

Clinical Director
Escambia Community Clinics, Inc
**BAPIST HEALTH CARE**

**Baptist Health Care First in Region to Offer Watchman Procedure**
Baptist Heart & Vascular Institute (BHVI) now offers a treatment that may reduce the risk for strokes in people with atrial fibrillation. The Watchman procedure often has the added benefit of eliminating the need for blood thinning medications. This first procedure was performed at Baptist Hospital in August.

“Baptist Heart & Vascular Institute is the first and only health care provider on the Gulf Coast to offer all three of today’s leading-edge technologies in structural heart disease treatment – MitraClip, TAVR and now Watchman. These procedures put us in the same league as major medical centers around the world and give our patients the ability to remain close to home for their heart care,” said Saurabh Sanon, M.D., structural heart disease expert and interventional cardiologist.

The procedure is performed under general anesthesia in the catheterization laboratory and usually lasts about an hour followed by a 24-hour hospital stay. Patients remain on warfarin for 45 days following the procedure. After that time, if the closure is successful, patients may be taken off warfarin completely.

Patients who may be considered for the Watchman procedure have non-valvular atrial fibrillation, have issues with long-term warfarin use and are at increased risk for stroke.

For more videos about Watchman LAA closure and other procedures available at the BHVI, visit http://www.ebaptisthealthcare.org/Heart/videos. For appointments call 850.484.6500.

**Baptist Medical Group Neurosurgeon Publishes Article**

The research article is titled “Recurrent Laryngeal Nerve Injury Following Reoperative Anterior Cervical Discectomy and Fusion: a Meta-Analysis” The objective of this study was recurrent laryngeal nerve (RLN) injury is one of the most frequent complications of anterior cervical discectomy and fusion (ACDF) procedures. The frequency of RLN is reported as 1%-11% in the literature. The rate of palsy after reoperative ACDF surgery is not well defined. This meta-analysis was performed to review the current medical evidence on RLN injury after ACDF surgery and to determine a relative rate of RLN injury after reoperative ACDF.

Dr. Gordon earned her medical degree from the University of Alabama at Birmingham and subsequently completed a general surgery internship and neurological surgery residency while there. She was honored with the title chief resident of neurological surgery in 2013/2014.

Dr. Gordon practices exclusively with Baptist Medical Group and welcomes new patients at her office located at the Baptist Towers, 1717 North E St., Tower 2, Suite 422 in Pensacola, Florida. To learn more about Dr. Gordon or to schedule an appointment, visit BaptistMedicalGroup.org or call 850.469.0642.

**SACRED HEART HEALTH SYSTEM**
Sacred Heart Health System and University of Florida Health have collaborated to launch a new kidney transplant program to benefit the thousands of individuals across the Southeast currently awaiting a life-saving transplant.

Throughout the southeastern United States, the average time on a wait list for patients needing a kidney transplant is 73 months, according to the Scientific Registry of Transplant Recipients. Previously, northwest Florida residents had to travel to Gainesville, Birmingham or New Orleans in order to undergo kidney transplant, including the required pre-surgery and follow-up care.

The new program is led by University of Florida kidney transplant surgeon Dr. Rick Brian Stevens and Renalus’ transplant nephrologist Dr. Douglas Scott Keith, who have a combined experience in kidney transplant of more than 40 years. For information, please call 850-416-1080 or visit www.sacred-heart.org/kidney-transplant.

Fellowship-trained Cardiologist Dr. Balraj Singh has joined Sacred Heart Medical Group Cardiovascular Specialists in Pensacola. Dr. Singh is board-certified in internal medicine, nuclear cardiology and echocardiography. Dr. Singh has a special medical interest in nuclear cardiology and specializes in treating coronary artery disease, heart valve disease and heart failure. For more information or to refer a patient, call (850) 416-4970.

Fellowship-trained Dermatologist Dr. Rahul Chavan has joined Sacred Heart Medical Group at Airport Medical Park in Pensacola. Dr. Chavan has special interests in the treatment of melanoma and other skin cancers, and he specializes in the use of Mohs surgery for skin cancer. Dr. Chavan completed his internship, residency and fellowship training at the Mayo Clinic in Rochester, Minnesota. For more information or to refer a patient, please call 850-416-1345.

Radiation Oncologist Dr. Veronica Carden has joined the Sacred Heart Cancer Center in Pensacola. Dr. Carden graduated medical school from Florida State University. She completed her residency training in radiation oncology from State University of New York (SUNY) Upstate Medical University. Dr. Carden is skilled in stereotactic body radiation therapy (SBRT). For more information, please call 850-416-6700.
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