



# THE FLORIDA INTERNIST

Newsletter of the Florida Chapter of the American College of Physicians

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Photos from the Awards Dinner October 23, 2004 at the PGA National Resort

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(more on the Chapter website: [www.acponline.org/chapters/fl](http://www.acponline.org/chapters/fl))

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## From the Governor

**Kay M. Mitchell, MD, FACP**

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It has been said that doors never really close, they are just opening on the other side. I find that life is similar. Projects are always opening as others end. I have just ended a 15 year career in the American Medical Association with leadership in Education. This was a hard, heavy door to close, but a new one has swung open. In April 2004, I started my four year term as your ACP Governor of the Florida Chapter and look forward to concentrating on Educational issues on all levels. I have been very excited to accept a position on the ACP Education Committee and I am on the Liaison Committee between the ACP and the ABIM. I look forward to these wonderful challenges!

I hope to help with innovative changes in our professional education and also in the primary education of our medical students and residents. In the first two years of my governorship, Education and Membership are my responsibilities. The last two years of my governorship involve advocacy issues.

What's wrong with our current system of medical education? Many feel that we have the best in the world, and we do, but many know there are problems with our system. If you start at the end with the practicing physician, we are faced not only with mandated CME for licensure but now face Maintenance of Certification (MOC) which is a daunting task. At the residency level we are struggling with resident work hours and new competencies mandated by the Accreditation Council for Graduate Medical Education (ACGME.) Our students are beginning a new test procedure, the Clinical Skills Assessment (CSA) which is tied to the United States Medical Licensing Examination (USMLE) and their licensure.

On top of these challenges, we all are faced with educating ourselves to prevent errors and to improve our practice through evidence based medicine. On the horizon through the development of a new Federal Office, the Office of Health Information Technology is the task of the computerization of all physician offices and hospitals with interoperative systems.

I know many of you have ideas on how our system can be made better and I will solicit your help. The first challenge that I'll pitch to you is Student Mentoring to increase the number of medical students choosing general internal medicine. I hope to plan with your help, a mentoring program at all of our medical schools with Chapter members in that area. I hope that I'll have this up and ready to run at our annual meeting and see if you catch the first pitch! Stay tuned! ❖



## Congratulations!

The College has notified us that Malcolm T. Foster, Jr., MD, FACP has been elected the ACP Governor-elect designee for Florida. Dr. Foster will assume office as Governor-elect at Annual Session in San Francisco for a one year term. He will become ACP Governor for Florida in 2006, serving as President of the Division of Education and Membership for two years and then assuming the office of President of the Chapter and President of the Division of Advocacy and Member Benefits for the two years thereafter.

Congratulations to Dr. Foster and to all the members of the Florida Chapter ACP!

## GOING BARE

**JOSE M. DELGADO, JR., MD, FACP**

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By now many of you are well versed in the details involved with going bare or self-insuring. For those of you who are facing that very difficult decision this year or for those of you who are past that critical point but would like to review and re-evaluate your situation, these are some points to consider. Please consult with your attorney/advisors before making any decision.

### **Should I Go Bare?**

The average Florida physician has a 10-15% chance of getting sued per year. If sued, there is a 46-48% chance of walking away without paying. If you lose, the average indemnity is \$247,000. In Florida, you are 20% more likely to lose a case and defense costs are much higher. Of course, these statistics are changing as more and more doctors go bare. Lawyers will be less likely to take a case where the physician has no malpractice insurance and physicians are more likely to hire competent counsel and fight cases as opposed to a quick settlement as occurs when the attorneys play the "bad faith game" with your insurance company.

Consider the costs and risks including being responsible for up to \$250,000 per claim on any judgment/settlement or risk losing your license. Six physicians in the State of Florida have lost their license so far and others have been placed on payment programs. There is also the risk of judgments in excess of \$250,000. Other costs include legal defense fees, expert witness fees, lost professional time, and mental duress. Without malpractice insurance you are now much more involved in the process.

It has been estimated that the breakpoint premium to consider going bare is approximately \$40,000 for primary care physicians. This is based on an average one lawsuit every five years and assuming \$200,000 in overall costs. This breakpoint premium may be higher or lower for you depending upon your own situation.

Other insurance options to consider: Going back to a first year rate with an insurance carrier, risk

retention groups, a self-insurance plan (i.e.- a captive insurance company or closely held insurance company), or legal defense insurance. Before your current malpractice insurance terminates, be sure to notify them of any potential claims.

### **Asset Protection**

The two most important points here are: 1. Do it irrespective of whether or not you have malpractice insurance, and 2. Do it now before anything happens or risk being accused of a fraudulent conveyance. Other than that, it would be critical to understand the Florida law with respect to personal assets that are exempt from creditors. With regards to business assets, protecting the accounts receivable as well as real estate would be prudent. Interview several asset protection attorneys as they vary from being ultra conservative to being overly aggressive. Ultimately, the choice you make will depend on how much you're willing to spend and the value of the assets you are trying to protect. The key here is to do something as opposed to nothing.

### **Risk Management**

It may seem obvious but probably the most important thing you can do in all of this is to simply not get sued! It will be time well spent focusing on patient satisfaction, proper documentation, following-up on abnormal results, and considering electronic medical records if you have not done so. Be more selective with the patients you accept and avoid high-risk situations. Hire a risk management consultant to review your office procedures.

Spending more time with your patients, communicating effectively, minimizing wait times in the "waiting" room and on the phone, returning your calls, improving access to patients who are sick, and having a caring office staff will make for happy, satisfied, non-litigious patients.



(l to r) Drs. Craig Kitchens and Kay Mitchell accept the 2004 Chapter Excellence Award from Dr. Cecil Wilson. The Chapter again exceeded standard criteria for chapter management.

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## From The President

Craig S. Kitchens, MD, FACP  
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### The Cognitive Consult: Something of Value

Value is worth divided by price. Little has been written about the value of cognitive thought processes in modern consultative medicine. Third party payers are quick to pay for any invasive procedure, imaging, or complex laboratory tests with hardly a question being asked. However, for a diagnostician to sit down, consult literature, and actually think and contemplate about a difficult problem rarely gets duly reimbursed without some type of hassle, and then, the fee is only a few percent of the fee generated by an invasive procedure. Not very long ago I saw a patient whose case I wish to share with you because it illustrates some of these points and maybe something about value.

He had a very long and complex history. He was being referred to me by a group of hematology/oncologists because they were afraid that he was developing a myelodysplastic syndrome (MDS) over the past year. He was referred to me for the primary intention of confirming that diagnosis using cytogenetics, flow cytometry, and bone marrow analysis, and for the second intention of exploring impacts on his renal transplant. The stakes were high.

He had had renal failure due to hypertension and had been on dialysis for a decade until he finally got a cadaveric renal transplant about 10 years ago. He was on the usual fare of renal transplant medicines. He had been under the care of his excellent medical community for some time which is both good and bad. I had the distinct advantage of being forced to think about him as a new patient. I was probably the first physician required to "start over" in several years.

Previously, his CBC had been rather typical for a renal transplant patient. However, by now his anemia had become more progressive and he actually had to be transfused a few times when his hemoglobin approached 6 gm/dl. It was also noted that his platelet count and white count began to fall. He had been diagnosed with gout and Probenecid was administered. As his hematocrit fell, a bone marrow was done and he was diagnosed as having pure red cell aplasia but tests for the Parvo B19 virus were negative. A statin drug had recently been administered but was stopped because of an increase in CPK and creatinine. He had undergone an upper endoscopy and colonoscopy in a search for

blood loss (fully paid for by third party).

When I saw him, his hemoglobin was 11 gm/dl but he had just received three units of blood in order to travel to Gainesville. His absolute reticulocyte count was inappropriately normal at 1% despite Epogen.

The white count recently had improved to 4000/mm<sup>3</sup> and the platelet count was 240,000/mm<sup>3</sup>.

Examination of blood smear did not show any abnormal red cells, no nucleated red cells, no shift to the left in white cells and no red cell changes suggestive of MDS. His physician thought all this was MDS possibly resulting from his transplant medicines. At the same time his renal function was decreasing and obviously his physicians were loathe to back off the transplant medicines for fear of losing the transplant.

Not knowing now what to do, I delved further into the history and physical. I had noticed from the flow-chart provided by his excellent hematologist that the white count and platelet count tended to be erratic and either low or normal with few points in between. I asked him how often his "gout" bothered him and he said it also was erratic. We then reviewed each medication on his extensive list and learned that the Probenecid dispensed by the pharmacy had "looked different" for the past year. We then determined that he was on a combination pill of Probenecid and colchicine. Although the colchicine was only 0.6 mg per day, that dose combined with his impaired renal function, seemed to explain his erratic CBC and worsening creatinine.

Accordingly my consultation was simply to stop the colchicine. He returned to his referring doctors. I received a note some month or two later stating that both his blood counts and renal function had vastly improved.

I wasn't as smart that day as I was lucky. My main advantage was not knowing what was going on so, starting at zero, I considered all possibilities. It would have been much easier and briefer to do all the bone marrow studies suggested and spend, without anyone batting an eyelid some \$5000 in tests. My total consultation was about \$300 (low price). I'd argue that this consultation may have saved his renal transplant viability (high worth). The cognitive approach to medicine certainly worked (had value) that time.

Third party payers should know more about this value and reimburse accordingly. "Thinking time" is often productive and can actually do more for a patient than ordering just another test. ❖



**Dr. Joe Lezama (l) accepts the Outstanding Teacher award for "outstanding leadership and dedication to medical education" from Dr. Kitchens.**

(Council continued)

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St Petersburg

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Michelle Rossi, MD receives the Key Contact Award. Dr. Rossi is a Council member representing Region A and utilized the Voter Voice interactive system as well as participated in legislative visits to Tallahassee and Washington DC.



Stuart B. Himmelstein, MD, FACP accepting the Internist of the Year Award from Dr. Mitchell. Dr. Himmelstein has just completed a term as President of the Palm Beach County Medical Society and recently assumed office as Treasurer of the Florida Chapter of the American College of Physicians.



(l to r) Drs. Craig Kitchens and Kay Mitchell accept the Evergreen Award from Dr. Cecil Wilson. The award was presented for "A Swiss Army Knife for State-Based Advocacy", a computerized, interactive system that enables the Florida Chapter to efficiently communicate information to its members and allows these members to easily and immediately advocate Chapter positions to legislators.



Szilvia Udvari-Nagy, MD (second from right) received the first Gary Izzo Scholarship Award. Dr. Udvari-Nagy is in her first year of fellowship training in geriatrics at the Cleveland Clinic Florida. Pictured with her are (left to right) Dr. Mitchell, Paula Izzo, Dawn Moerings, Patrick Ellis and John Langdon, MD, FACP.



Glenn R. Singer, MD, FACP (left) was selected the Outstanding Community Based Teacher Award. We regret that he was unable to be with us on the rescheduled date to honor his dedication to the education of medical students and residents. Dr. Singer is pictured above with his favorite referring internist, Karen B. Singer, MD, FACP.

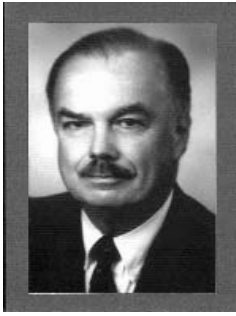


Chief Residents recognized at the Regional Meeting included (l to r) Drs. Sunil Lakhani, Mary Busowski, Lushantha Gunasekera, Kay Mitchell ACP Governor for Florida, Carlos Mercado, Elana Oberstein, Antonio Cano, Amy Zito, and Mike Diaz. Dr. Rotem Amir (far right) accepted the plaque for The Cleveland Clinic Florida.

**Congratulations!**

First Place Associates Clinical and Research Vignettes went to Dr. Elana Oberstein of the University of Miami program for "The Man with a Stiff Neck: An Unusual Presentation of Breast cancer in an HIV+ Man." She will present the case again as a poster at Annual Session.

Tolga Erim DO of Cleveland Clinic Florida took top honors in the poster competition with "Aortic Root Inflammation & Progressive Heart Block in a Patient with Symmetric Polyarthritis."



**2004 Florida Chapter Laureate  
JAMES E. MCGUIGAN, MD, MACP**

Dr. McGuigan was born in New Jersey in 1931 and received his MD degree from St. Louis University in 1956 graduating with Alpha Omega Alpha honors. He then interned at the Hospital of the University of Pennsylvania which was followed by three years of service in the Medical Corps of the United States Air Force in Tacoma, Washington. There he performed his first clinical investigation and published his first article in which he had the foresight to prospectively study "The effects of chloramphenicol, oxytetracycline and prochlorperazine in airmen during a salmonella outbreak of gastroenteritis." He then returned to his medicine training at the University of Washington in Seattle where he finished his residency. That was followed by two years of gastroenterology training at that same institution. At that juncture, Dr. McGuigan departed from the usual track of his GI colleagues and procured a two-year fellowship at Washington University School of Medicine in St. Louis where he was a special fellow in immunology, a decision which proved pivotal in his career as he was one of the very first clinical scientists to develop and use the immunoassay. He turned his attention toward gastrin and has spent a considerable amount of his investigatory career studying gastrin and its perturbations in health and disease. He stayed on as a clinical professor in gastroenterology in St. Louis for three years but by that time his success was noted by many recruiters to include the late Dr. Leighton Cluff of the new medical school at the University of Florida. Dr. McGuigan was recruited by Dr. Cluff to become chief of that division at the advanced age of 38.

Dr. McGuigan quickly developed the GI program in Gainesville from a nascent program to arguably one of the best divisions in the nation in both in clinical and investigative gastroenterology. His fellows have been spread throughout academia nationwide and worldwide.

He was appointed as Chair of the Department of Medicine at the University of Florida, a position he held until 1997 during which time he was Chair for essentially half the existence of that Department of Medicine and saw meteoric growth in the Department essentially tripling the

size of the faculty and even further multiplying grants awarded and papers published. Dr. McGuigan became Emeritus Chairman in 1997 and is still active in gastroenterology and especially teaching.

Dr. McGuigan, during his tenure as Chairman, while continuing his extraordinary bench research also developed, mastered, and promulgated excellence of clinical medicine amongst his multiple students. Indeed, to this day, he is still the most sought after Attending for general medicine amongst housestaff and students. He has an ease with patients that instills confidence in the system, soothes the anxiety of patients and their families, and proves to be a model of impeccable professionalism for students, house officers, and colleagues. These traits were duly recognized by his receipt of the coveted Mastership of the American College of Physicians in 1998.

Dr. McGuigan has published over 300 articles, the bulk of which are in investigative gastroenterology with a penchant for cross fertilization with surgeons, pharmacologists, and practitioners and investigators of every type. He wrote the sections on both peptic ulcer disease and gastritis for the 10<sup>th</sup>, 11<sup>th</sup>, 12<sup>th</sup>, 13<sup>th</sup>, editions of Harrison's Principles of Internal Medicine. Dr. McGuigan is an active member of a variety of academic organizations to include but not limited to American College of Physicians, Alpha Omega Alpha, American Society for Clinical Investigation, Association for Professors of Medicine, and the American Clinical and Climatological Association.

My only complaint about Dr. McGuigan is that he makes it all look too easy due to his incredible natural talents. Those of us who follow his lead know that it is not as easy as he makes it seem.

He is known as a warm but serious clinician and scientist. I hold him out to all who (including myself) are "students of internal medicine" as an ideal Laureate of the Florida Chapter of the American College of Physicians. ❖

—Craig S. Kitchens, MD, FACP



**Dr. Kitchens (r) presents the 2004 Laureate Award to Dr. McGuigan.**

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**STARK REGULATIONS AMENDED**  
***“Rent-A-Lab” Plans Face Tighter Scrutiny***  
***Christopher L. Nuland, Esq., General Counsel***

Confronted with scores of provider leases that it considered to be contrary to the spirit, if not letter, of the Stark law, the federal government has promulgated new rules that severely limit the ability of physicians to enter into part-time leases for designated health services such as clinical laboratories and MRIs.

Until July 26 of this year, it was common for a physician or group to rent a clinical laboratory and its technical staff for a few hours per week. Such an arrangement allowed the physician to perform a clinical laboratory test and bill globally for the service under the “in-office ancillary” exception to the Stark prohibition on self-referrals. Under the new regulations, however, such leases will not be eligible for the in-office ancillary exception unless they meet one of the following three criteria:

The referring physician or his/group practice has an office that is normally open to patients at least 35 hours per week and the physician or practice provides patient services in that office at least 30 hours per week, at least some of which are not related to the designated health service;

The patient receives unrelated services from the physician or group practice, the rented office is open at least 8 hours per week to patients, and the physician or group actually is present at least 6 hours per week, including at least some time providing patient services unrelated to the designated health service; or

The physician present and orders the designated health service during a patient visit, the rented office is open at least 8 hours per week to patients, and the physician or group actually is present at least 6 hours per week, including at least some time providing patient services unrelated to the designated health service.

The common element in all three scenarios is that the rented space must allow the physician or group to actually see patients at the site for a minimum of 6 hours per week, and at least some of those patient encounters must involve services unrelated to the provision of designated health services.

Because the new regulations do not “grandfather” existing leases, physicians are urged to re-examine their existing operations and to make necessary adjustments in order to comply with the new law. Those members having questions may contact the General Counsel’s office at [nulandlaw@aol.com](mailto:nulandlaw@aol.com). ❖