CAP SCAN

A CAPITAL MEDICAL SOCIETY PUBLICATION

SEPTEMBER EDITION, VOLUME 2013, NO. 9

2013 ANNUAL FMA MEETING

BY NANCY LOEFFLER, M.D., CMS PRESIDENT

The FMA Annual Meeting is our opportunity, each year, to influence the agenda of the Florida Medical Association for the upcoming year. I am proud to announce that our CMS Delegation was there in force! The meeting was held July 26, 27 and 28 in Orlando. Our FMA delegates, and those involved in their specialty societies, were all in attendance and active in the process. Congratulations to Dr. John Katopodis who was unable to attend, but was elected this year to the office of Secretary of the Florida Medical Association!

Many thanks go to:
John Bailey, D.O., County Delegate
Andrew Borom, M.D., County Delegate & FMA PAC Vice President
Michael Forsthoefel, M.D., County Delegate
Shakra Junejo, M.D., County Delegate
William Kepper, M.D., County Delegate
Alma Littles, M.D., County Delegate
Nancy Loeffler, M.D., County Delegate
John Mahoney, M.D., County Delegate
Christie Sain, M.D., County Delegate
Gary Winchester, M.D., County Delegate
Marc Inglese, M.D., FMA Board of Governors
John Katopodis, M.D., FMA Board of Governors
Avon Doll, M.D., Specialty Society Delegate
Andrea Friall, M.D., Specialty Society Delegate
Brence Sell, M.D., Specialty Society Member

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CMS AND SPECIALTY SOCIETY DELEGATES:

(FRONT ROW, L-R)
DR. SHAKRA JUNEJO, DR. ALMA LITTLES, DR. CHRISTIE SAIN, DR. ANDREA FRIALL, AND DR. NANCY LOEFFLER.

(BACK ROW, L-R)
DR. GARY WINCHESTER, DR. JOHN MAHONEY, DR. JOHN BAILEY, DR. BILL KEPPER, DR. MICHAEL FORSTHOEFEL, AND DR. MARC INGLESE, FMA BOARD MEMBER

CAPITAL MEDICAL SOCIETY 2013 MEETINGS CALENDAR

***SEPT. 17, 2013 @ 6 PM■**
"ATRIAL FIBRILLATION CONTINUUM OF CARE"
Farhat Khairallah, M.D.

***OCT. 15, 2013 @ 6 PM■**
**"PREVENTION OF MEDICAL ERRORS" - 2-Hour Required CME
Jesse Suber, Esq. & Scott Sellinger, M.D.

***NOV. 19, 2013 @ 6 PM■**
"CANCER GENETICS: THE FAST-MOVING FIELD OF GENETIC TESTING AND ITS IMPACT ON CLINICAL PRACTICE"
L. Kristin Parsley, M.D., FAAP, FACMG

DEC. 5, 2013 @ 6:30 PM
CMS FOUNDATION HOLIDAY AUCTION
Location: Florida State University Center Club

*INDICATES IT IS A CMS MEMBERSHIP & CME MEETING
**JOINT MEETING WITH THE LEON COUNTY DENTAL ASSOCIATION
■ INDICATES THE MEETING WILL BE HELD AT THE MAGUIRE CENTER FOR LIFELONG LEARNING AT WESTMINSTER OAKS

CAPITAL MEDICAL SOCIETY

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ARE YOU INTERESTED IN WRITING AN ARTICLE FOR CAP SCAN?

Please contact Dr. Charles Moore at cmoore5186@aol.com and Shannon Boyle at sboyle@capmed.org. All articles submitted will be reviewed by your peers prior to publishing.

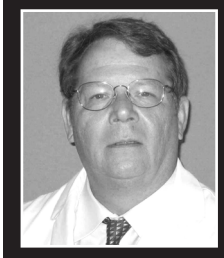
IN THIS ISSUE:

PROFESSIONAL NOTES:

AARON GUYER, M.D., an orthopedic foot and ankle surgeon with Tallahassee Orthopedic Clinic, was elected Chair of the Humanitarian Committee for the American Orthopaedic Foot & Ankle Society (AOFAS) in July 2013.

JOHN KATOPODIS, M.D., an interventional cardiologist with Southern Medical Group practicing at Tallahassee Memorial Physician Partners Cardiac and Internal Medicine Specialists, was elected as Secretary of the Florida Medical Association (FMA) at the FMA Annual Meeting in Orlando in July 2013.

RICHARD THACKER, D.O., an internist with Capital Regional Medical Group, was re-elected to the American Osteopathic Association (AOA) Board of Trustees at the organization's annual House of Delegates meeting in Chicago in July 2013.



Congratulations to **DALE WICKSTRUM, M.D.** on his retirement from North Florida Radiation Oncology Associates. Thank you for your service, Dr. Wickstrum!

"2013 ANNUAL FMA MEETING," CONTINUED FROM COVER

Several of our medical student members from the FSU COM were also in attendance presenting posters and participating in policy-making through the Medical Student Section.

With her years of experience, Dr. Alma Littles did a fabulous job of organizing and chairing the Northwest Florida Caucus Meetings – consisting of delegates from Capital, Bays, Escambia and Santa Rosa counties. Our CMS Delegates met twice before the annual meeting to review Resolutions submitted by county and specialty medical societies and individual FMA members. Each morning of the Annual Meeting - at the bright and cheerful hour of 6 a.m. - all twenty-five delegates from these counties met as a caucus to discuss a multitude of submitted Resolutions. As the conference proceeded, Delegates next attended any of four Reference Committee meetings, where we listened to individuals or Caucus representatives express concerns and/or support for various Resolutions to the Committee members. Our own Dr. Mike Forsthoefel skillfully chaired the Reference Committee on Finance and Administration. Dr. Christie Sain served as a committee member for the Reference Committee on Legislation. These Reference Committees spent the remainder of the day Saturday formulating reports to adopt, amend, or to refer/not adopt each Resolution. These reports were then distributed for discussion and final vote by the Delegates the following day.

Each and every FMA member - not only Delegates – had the opportunity to stand in support or opposition and voice their opinions at the Reference Committee meetings on Saturday and again before the full House of Delegates on Sunday. The process is fascinating and inclusive!

In addition to reaffirming the FMA's focus on tort reform and issues related to scope of practice, here are just a few of the highlights of resolutions that were adopted, instructing the FMA to:

- …study the feasibility of passing legislation which would allow physicians to submit active ABMS Board Certification as an alternative pathway for compliance with MD/DO Florida licensure and re-licensure continuing medical education requirements.
- …study the feasibility of contractually employed physicians forming a union or other appropriate organization.
- …seek legislation which automatically terminates the active provider-patient relationship three years from the date of the last provision of care; and further stating that the provider is not responsible for the provision of services to any patient that no longer has an active relationship with their provider.
- …maintain its policy that MDs and DOs are the only appropriate leaders in primary care and the patient centered medical home.

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SHANNON BOYLE WITH CMS PRESIDENT, DR. NANCY LOEFFLER, DURING A BREAK IN ACTIVITIES.

THE NORTH FLORIDA DELEGATION DINNER AT THE PUB IN ORLANDO.

"2013 ANNUAL FMA MEETING" CONTINUED FROM PAGE 3

- …support legislation amending current Pharmacy laws to prohibit the sale of tobacco products (including, but not limited to, cigarettes, cigars, pipe tobacco, hookah tobacco, snuff, chewing tobacco, dipping tobacco, bidis, or any other preparation), in establishments housing licensed pharmacies.
- …support legislation to further raise the excise tax on cigarettes to at or above $2/pack in order to further tobacco control efforts within the State of Florida.
- …determine if it is feasible to pass legislation that would ensure payment to physicians by all Medicaid HMO's for maternal and newborn care, regardless of contracting status.
- …support legislation requiring insurers to negotiate in good faith with any provider of office based services to contract higher levels of payment for services provided in the office.
- …support statewide expansion of Medicaid and further, support any statewide expansion of Medicaid into managed care only if such programs safeguard patient access to care while increasing all primary care physicians (internal and family medicine physicians, pediatricians and obstetricians and gynecologists) Medicaid rate payments to Medicare rates; and furthermore support such rates for specialists….

These are only a few of the issues critical to our profession that were discussed and debated. You can find more detail on each issue at the Members Only section of our website – go to: http://capmed.org/membersonly/fma-updates/ (you will need your username and password.)

We also heard from American Medical Association President, Ardis Dee Hoven, MD, about the importance of organized medicine and the work the AMA is doing on behalf of all physicians. And, we installed a new FMA President, Dr. Alan Harmon. Dr. Harmon will lead the FMA in 2013-14 as it promotes the issues voted most important by the membership in this annual meeting.

The FMA is clearly the most highly respected and recognized voice of physicians in our state. As testament to this, the Good Government luncheon speakers this year included Governor Rick Scott, Speaker of the House Will Weatherford, and Senate President Don Gaetz. If you feel passionately about an issue affecting the practice of medicine, I urge you to get involved. It is easy to do so! Frankly, the more voices heard, the more balanced the organization. The FMA presents an opportunity to be heard in the legislative arena, and to contribute to a process that directly affects our profession. CMS

CAPITAL MEDICAL SOCIETY LUNCH & LEARN
FALL 2013

CAPITAL HEALTH PLAN, 1491 GOVERNORS SQUARE BOULEVARD

A SEMINAR SERIES OFFERED BY THE CAPITAL MEDICAL SOCIETY.
For physician office staff (clinical and non-clinical), practice administrators, office managers and business office managers. CMS member offices only! Please join us this fall 2013 for a monthly luncheon series with topics that are designed especially for physician office staff – providing you with useful and current information to enhance your daily work life!

WEDNESDAY, SEPTEMBER 18, 2013
TRAIN YOUR BRAIN FOR RELAXATION AND POSITIVE RELATIONSHIPS
Speaker: Linda Miles, Ph.D.
Dr. Linda Miles draws on her 40 years of experience as a psychotherapist and extensive research on stress to give practical strategies for peace of mind and meaningful relationships in today's fast-paced world.
Sponsor: TMH Federal Credit Union

WEDNESDAY, OCTOBER 16, 2013
TEAM BUILDING, MENTORING, COACHING: SKILLS FOR SUPERVISORS
Speaker: Bert Mitchell, Workforce Plus
"What lies behind us and what lies before us are tiny matters compared to what lies within us." - Emerson
Coaching, teambuilding and mentoring have many common threads that complement each other. We all have various experiences with these 3 words and they have been a part of us our entire lives. We've been coached, we've been on teams and various mentors have impacted us. Now as a supervisor, the question is "How can I use what I know to become a better coach, build more effective teams and foster personal and professional growth through mentoring?" It's not how much you know; it's what you DO with what you know. Are you ready to take what you know to the NEXT LEVEL?
Sponsor: PMIS

WEDNESDAY, NOVEMBER 20, 2013
HIPAA/SECURITY RISK ASSESSMENT CHECKLIST
Speaker: Larry Allen, Director of IT Services, The Center for the Advancement of Health IT
What are your options for conducting a Security Risk Assessment (SRA), the importance of implementing security updates, and correcting security deficiencies as part of a comprehensive risk management process? Actively safeguarding patient health information, meeting HIPAA compliance and Meaningful Use requirements, and ensuring an audit-ready status; healthcare providers across our network are rapidly increasing and benefiting from their use of Electronic Health Records (EHRs). We will review the January HIPAA Final Omnibus Rule and why SRA's are important. Join us as we share from our experiences with collaborative SRA engagements with your healthcare colleagues, including budgetary approaches, identifying common risks, and utilizations of policy templates. Learn how your practice can have a Security Risk Assessment comfortably and affordably.
Sponsor: Copyfax

Time: 12 Noon to 1:30 pm (seminars start at 12:30 pm)
Place: CHP Auditorium, 2nd Floor - 1491 Governors Square Boulevard
$10 per seminar, per person. You can RSVP for all seminars, or one at a time! For more information, call Rosalie at 877-9018.

Registration Form (please print): Seating is limited, you must pre-register. Reservation must include payment.

Name/Office/Phone: _____

Email address: _____

Please register me for (check all that apply):

☐ September 18, Train Your Brain for Relaxation and Positive Relationships

☐ October 16, Team Building, Mentoring, Coaching: Skills for Supervisors

☐ November 20, HIPAA/Security Risk Assessment Checklist

Enclosed please find my check in the amount of $_____

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Editor's Note: The following article, kindly written by Scott Tetreault, M.D., is the result of my own ignorance and confusion about the general and specific topic he so well addresses. Maybe not for many of our readers, but for me the mystery of an oncological practice, the variety of drugs and their application in the treatment of various stages of cancer, remains forever obscure. Dr. Tetreault, a founding member of The Florida Cancer Specialists group, brings a wealth of involvement to this topic. His C.V., which includes his research experience, encompasses eight pages of accomplishment; leaving me unable even to attempt its summary here. Suffice it that Cap Scan much appreciates his having taken the time to enlighten us regarding this daunting topic, with a discussion of breast cancer as the paradigm.

STAGE IS THE RAGE:

ONCOLOGY MADE BRIEF

By Scott Tetreault, M.D.

There really are only two stages of any solid organ cancer (lung, breast, colon, prostate, kidney, bladder...): CURABLE and INCURABLE. Your patients are confused and terrified enough; don't add to it by confusing yourself. Of course, oncologists recognize 4 stages in almost all cancers but in reality, from a practical standpoint, when a patient asks the stage of her cancer, she wants to know if it is curable or incurable.

Generally, if the cancer is curable (Stages I, II, or III) then that means that VISIBLE disease-visible by scans or by palpation-is in a relatively localized area. Usually, cure in these cases involves surgery, chemotherapy, and radiation. It is crucially important that you know, and that the patient knows the purpose of the chemotherapy in these curable cases. Chemo is given to kill off the microscopic cells that may have escaped from the visible primary tumor and that may be hiding, just waiting to grow.

Please note that this can be a VERY difficult concept for "non-medical" patients and families to wrap their minds around. Here's what it looks like in the real world: Jane Smith develops a 2 centimeter breast cancer and the surgeon removes it. Of course, the surgeon tells the patient that she "got it all", but that the patient still needs to see the medical oncologist. The oncologist recommends nine weeks (or 18 weeks-it depends…) of chemo to attack this "micro-metastatic" disease but the patient says: "wait a minute; my lovely surgeon said she got it all and my scans are clean so why on earth do I have to have chemo??!!"

Oncologists call this "adjuvant chemotherapy" and patients often refer to it as "insurance policy" chemotherapy.

Another way of putting this that you might find useful is that in CURABLE situations, the actual type of chemo-the regimen of chemo, is easy to figure out: curative (adjuvant) regimens are in the recipe book and are standardized. It is the REASON for the adjuvant chemo that takes a lot of personalized thinking and personalized education with the patient.

In INCURABLE (stage IV) cancer, the opposite is true: the reason for the treatment is quite straightforward: to live longer. It is deciding on the type of chemo or exact regimen that requires the oncologist to really spend time getting to

CONTINUED ON NEXT PAGE

know the patient and her important life priorities so that they can work together to pick regimens that allow the patient to still enjoy life while fighting cancer.

So, in summary, there are two basic stages: curable and incurable. All the doctors involved in the patient's life must know the goals of therapy if they are to give useful advice. If the goal is cure, then we need to get it done, and get it done right, and get it done right now. The standard plans for these patients are very easy to look up on the computer at NCCN.org.

If the goal is not cure, but palliation and extending survival, then, by definition, there is no "right" single answer so the wise physician explores the patient's priorities and values-then picks treatments to match.

BREAST CANCER: CURABLE (Stage I, II, III)

In curable cancers, the chemo world moves slowly. Fifteen years ago, a high risk woman would receive Adriamycin plus Cytoxan for 4 cycles, then Taxol weekly for 12 weeks. Guess what? That is still the correct answer in 2013.

For women with less risk of micrometastatic disease, in other words, for women with small tumors without spread to lymph nodes, LESS chemo is OK too. Options include Taxotere plus Cytoxan for 9 weeks or even the very "old-school" CMF for 6 months.

But there have been two significant developments in the past several years that have really helped women with early breast cancer.

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"STAGE IS THE RAGE" CONTINUED FROM PAGE 7

First of all, not all breast cancers are created equal and we get better every day at figuring out the exact gene derangements that resulted in cancer in each individual patient. One in five women will over express the HER-2-Neu receptor on their breast cancer cells and the monoclonal antibody Herceptin (Genentech/Roche) attacks this receptor. So, for these women who are HER-2-Neu positive, a year of Herceptin is added to their chemotherapy. It sounds like a big deal, a whole year, but remember that this year of Herceptin significantly raises her cure rate and we really don't get many complaints from patients about Herceptin alone, it has minimal side effects, if any at all.

The second major advance in curative treatment is gene sequencing of the actual tumor with the goal of giving the patient and the doctor a more precise idea of just how "bad" the cancer is biologically. The experienced pathologist, looking at the cancer through a microscope, can tell us a lot of information about the cancer but that is a little like judging a book by its cover. These tests actually open the book and let us read the story inside. The ultimate goal is to use this information to tell the patient whether she needs any chemotherapy at all.

The two competing tests are Oncotype DX and Mamma print. Both use formalin-fixed tissue so they can be run any time after surgery. Now, these tests are only for breast cancers that express estrogen and progesterone receptor on their surface (which is the vast majority) and are only for cancers that have not spread to lymph nodes in the axilla already. But they can save many women from useless chemotherapy-and that's a good thing.

Of course, it has been true for 25 years that all women with estrogen receptor positive breast cancer receive 5 years of tamoxifen or tamoxifen-like pills (arimidex, aromasin, femara…). Us cancer doctors are currently arguing about whether it should be 5 years or 10 years-but it's all good...

"I KNOW, I HATE SAYING 'INCURABLE' TOO---AND I BELIEVE IN MIRACLES AND PRAY FOR THEM FOR EVERY PATIENT WITH METASTATIC BREAST CANCER-BUT YOU PLAY THE CARDS YOU ARE DEALT, AND IF THE DOCTORS START LYING TO THE PATIENT THEN ALL TRUST WILL DISAPPEAR."

INCURABLE BREAST CANCER (Stage IV)

I know, I hate saying "incurable" too---and I believe in miracles and pray for them for every patient with metastatic breast cancer-but you play the cards you are dealt, and if the doctors start lying to the patient then all trust will disappear.

The most exciting new treatments are in the Her-2-Neu positive world. As mentioned, Herceptin is a great drug and there are two new drugs that extend the range of Herceptin. Perjeta, is a HER2 dimerization inhibitor so it works along with Herceptin (and taxotere chemo) to improve remission rates. Patients like it because it works and doctors like it because it doesn't really increase the side effects of the Herceptin-taxotere combination. Kadcyla is another anti-HER 2 drug that is working well in my clinic. This one is pretty neat. It is basically the monoclonal antibody structure of Herceptin but attached to the molecule is a deadly cellular poison called emtansine. This drug attaches to the breast cancer cells and the emtansine is taken in-like a "Trojan horse" and voila, dead cancer cells.

There are lots more drugs, but I know you don't have lots more patience. So I'll close with a few important points about advanced breast cancer. This is almost totally an outpatient business. Many of you old-timers grew up when getting chemo meant staying in the hospital and getting sick. Today, it is about staying at home and living well. Our chemo/immunotherapy drugs are better and kinder, our supportive drugs are fantastic, and our doctors are much smarter about paying attention to the goals of the patient. We are shifting from the "chemo age" to the era of personalized cancer treatment where the patient's cancer is tested to find the driver-mutations and drugs known to target those mutations are tried first. Patients today can have a meaningful, joy filled life AND fight cancer too. CMS

PRESS RELEASE: TALLAHASSEE SURGEON EMBRACES

MEDICAL CHALLENGES IN VIETNAM

Aaron J. Guyer, M.D., reflects on gratitude of patients, dedication of Vietnamese surgeons

When orthopaedic foot and ankle surgeon Aaron J. Guyer, M.D., arrived in Vietnam last month for a two-week humanitarian trip, he found a challenging environment. Vietnamese clinics lack many of the modern surgical tools and equipment that are customary in the United States, and Guyer applied all of his skills as he managed orthopaedic conditions not commonly seen here. But applying his knowledge helped his patients and the local surgeons equally.

"It was fulfilling to see the gratitude the Vietnamese surgeons showed us as we taught them new techniques for treating orthopaedic conditions they see frequently," says Guyer, who is on staff at the Tallahassee Orthopedic Clinic.

Guyer was one of seven members of the American Orthopaedic Foot & Ankle Society (AOFAS), which has for 12 years organized the annual Overseas Outreach Project to Vietnam. Patients with untreated congenital deformities are common in Vietnamese clinics, and the AOFAS project provides corrective surgery without charge for both children and adults with lower extremity deformities caused by polio, cerebral palsy, clubfoot, trauma and other conditions.

AOFAS members volunteer their time and pay their own travel expenses to Vietnam. In-country expenses are supported by the Orthopaedic Foot & Ankle Outreach & Education Fund (OEF) with charitable donations from individuals and industry.

Guyer, together with J. Turner Vosseller, MD, of New York, worked several days in June alongside Vietnamese orthopaedic surgeons at the Orthopaedic Rehabilitation Center in Thai Nguyen, which is just north of Hanoi. In addition, Guyer spent several days at Viet Duc Hospital, the large teaching hospital in Hanoi. While Guyer focused on patient care, waiting Vietnamese family members focused on thanking him.

"One 8-year-old boy in Thai Nguyen had developed a type of nerve palsy as a result of encephalitis," Guyer says. "We performed a tendon transfer to allow his ankle to flex upward. As I passed through the waiting area, the father of the boy jumped up, shook my hand, and then bowed to me saying, 'Bless you for saving my son.' I will always remember his reaction."

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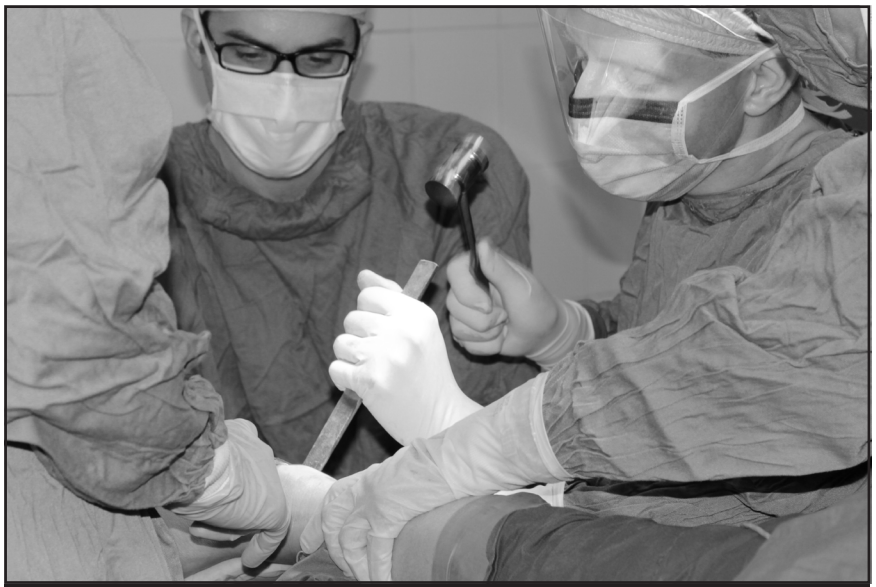
PATIENTS WAIT TO BE SEEN BY THE SURGEONS.



DR. GUYER USES TOOLS AVAILABLE IN VIETNAM FOR SURGERY.

"MEDICAL CHALLENGES IN VIETNAM" CONTINUED FROM PAGE 9

Other AOFAS member volunteers included Mario Kuhn Adames, MD, Florianapolis, Brazil; Paul S. Docktor, MD, Denver, Thomas A. McDonald, MD, Springfield, Mass.; Naomi N. Shields, MD, Wichita, Kan.; and Mark P. Slovenkai, MD, Boston. In addition to operating and teaching, AOFAS volunteers conducted seminars to share surgical advancements in the treatment of foot and ankle disease and deformity.

Since the first AOFAS outreach project in 2002, more than 1,000 patients have benefited from surgery performed without charge by AOFAS volunteers, and more than 2,400 patients have been seen in Vietnamese clinics. The Prosthetics Outreach Foundation (POF), partner with the AOFAS in the project, has provided prosthetic limbs to indigent Vietnamese children and adults without charge since the 1990s.

ABOUT THE AOFAS

The AOFAS promotes quality, ethical and cost-effective patient care through education, research and training of orthopaedic surgeons and other health care providers. The Society creates public awareness for the prevention and treatment of foot and ankle disorders, provides leadership, and serves as a resource for government and industry as well as the national and international health care communities.

ABOUT POF

The Prosthetics Outreach Foundation is a Seattle-based leader in orthopedic rehabilitation in developing countries. It creates opportunities for children and adults who suffer from limb loss and deformities to lead more fulfilling lives. POF staffers emphasize local capacity building through the training of medical professionals in the countries in which they work and the transfer of technologies that foster the local fabrication of mobility devices and their components. CMS

A PERSONAL ACCOUNT

By Aaron Guyer, M.D., Tallahassee Orthopedic Clinic

I have been fortunate to travel to Vietnam for the past two years with the American Orthopaedic Foot & Ankle Society's (AOFAS) annual Overseas Outreach Project. For one month each year, the AOFAS program sponsors American and international orthopedic surgeons with specialty training in disorders of the foot and ankle to work with patients throughout the Northern region of Vietnam. Two surgeons at a time spend one week each seeing patients in the clinic and performing surgery. These AOFAS volunteers work with Vietnamese surgeons who have identified patients in need of orthopedic care in advance. The breakdown of patients is typically 80% children and 20% adults, most of which suffer from complex deformities of the foot or ankle.

Ever since rotating in Kenya as a 4th year medical student, I have been interested in becoming involved in international humanitarian orthopedic endeavors. The AOFAS Vietnam program, however, provided me with a more personal connection to such outreach work. My wife, Hien, immigrated to the United States from Saigon, Vietnam in 1979. She still has family that lives there, and I felt that this would be a fulfilling opportunity to make a difference in the lives of people who share her heritage. The AOFAS program is well organized, and, as a result, I believe it allows surgeons to make a great impact on the lives of Vietnamese patients during the short time we are in the country.

This was my second year working in Vietnam and was even more special because Hien was able to accompany me and participate as well. Although her parents visit Vietnam yearly, this was her first time returning after 34 years. Her fluency in Vietnamese was quite helpful in communicating with patients, doctors, and staff which allowed the interpreters more time assisting the other American surgeons.

"For me personally, the trip was a humbling experience…one that makes you reprioritize what's truly important and appreciate what we have here in America. Witnessing Aaron using his skills to help improve the

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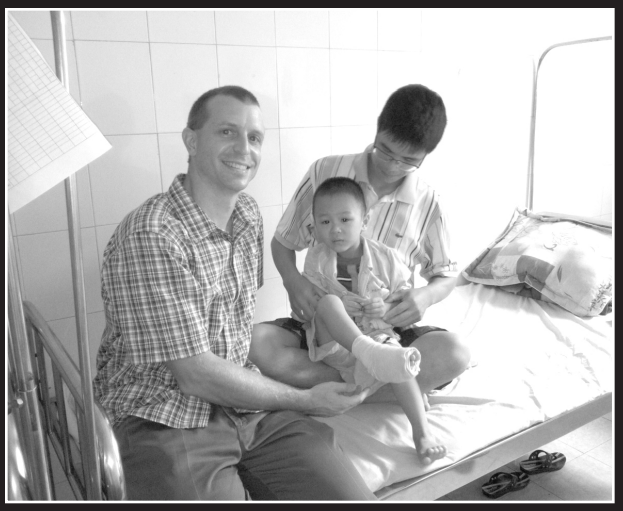
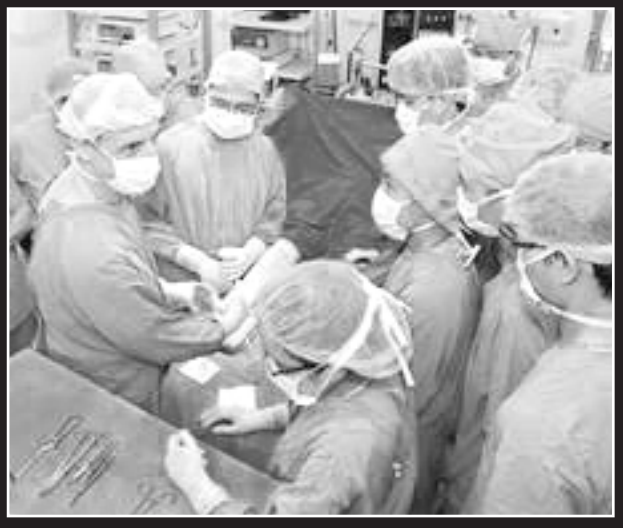




TOP TWO PHOTOS: DR. GUYER WITH PATIENTS IN VIETNAM.

BOTTOM PHOTO: DR. GUYER TRAINS VIETNAMESE ORTHOPAEDIC RESIDENTS.

"A PERSONAL ACCOUNT" CONTINUED FROM PAGE 11

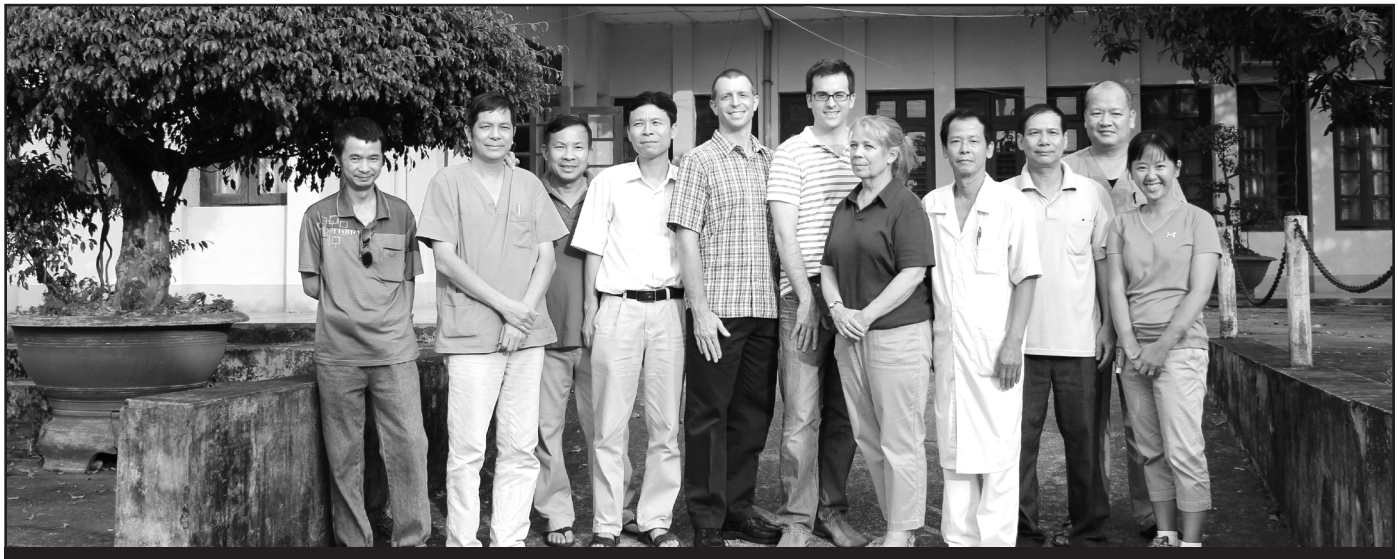
children's quality of life was amazing. I am proud of him for many reasons, but his enthusiasm for this project is indescribable," said Hien Guyer.

It was very moving to see how appreciative patients were of the services we provided. Many patients explained that they were surprised that American surgeons would take the time to travel thousands of miles to their small, rural cities to try and help them. It was also quite overwhelming at times to see how much effort some patients made to be evaluated by our team. For example, while in Dien Bien Phu, multiple patients showed up to be evaluated at the hospital unexpectedly on one of the days we had scheduled surgery. They had seen on TV that 2 American orthopedic surgeons were at the regional hospital for only a short time. Many patients had traveled 2 days by foot from their small villages in the mountains, sleeping on the road along the way, just to be seen by the American surgeons who may be able to help them or their children's orthopedic problems. It was humbling to realize just how fortunate we are in the United States to have ready access to any kind of medical care quickly and efficiently, while people in developing nations like Vietnam do not have this luxury.

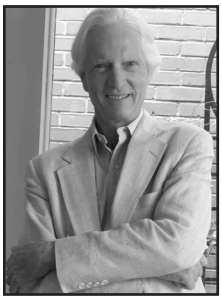
I really enjoyed working with the Vietnamese surgeons and nurses, who were eager to learn new techniques for treating orthopedic conditions they see frequently. While it was rewarding to be able to teach many of our Vietnamese colleague's surgical and clinical evaluation techniques in treating complex foot and ankle problems, these experiences also allowed me to grow as a surgeon. Having to think "outside the box" and be creative in how to accomplish a specific surgical goal without the tools or materials so readily available in the United States was a daily occurrence in Vietnam. This forced me to think back about basic orthopedic principals for diagnosing and treating foot and ankle problems, and rely less on the many modern implants, instruments, and imaging modalities we take for granted at home. For example, in America, we would use a saw to cut a bone during a surgery aimed at re-aligning a foot deformity, but in Vietnam, I had to use a drill and an osteotome, which is much more difficult and time consuming. Sadly, the lack of resources occasionally caused us to turn away patients that I knew I could have helped at home.

I thoroughly enjoyed my experiences in Vietnam, and look forward to participating in this and other outreach programs in the future.

MANAGING EDITOR'S NOTE: If you have been on a recent medical mission or done humanitarian work here or overseas, please submit your experiences to us. You can email it to Shannon Boyle at sboyle@capmed.org. We want to hear from you!



DR. AND MRS. GUYER OUTSIDE A RURAL ORTHOPEDIC HOSPITAL WITH SURGEONS AND STAFF.



EMBARKING ON BEER

By Charles Moore, M.D.

I had, the other day, perhaps stimulated by Angelina Cain's article in the issue-before-last of Cap Scan, a beer. This is a great rarity for me, who have probably averaged no more than one beer per year of my life. (We will not, by the way, address the subject of a martini.) It was not a rough beer, over-sized and advertised like a "Bud," but a simple, gentle little "Yuengling." No, the "Bud," with all those huge horses and myriads of good, goofy friends in front of TV sets cheering on their favorite team, was just a little too much for a tyro like myself. I had also thought about embarking on my beer drinking career (and at such a late age too!) with a "Newcastle Brown;" but I well-remembered the young Scot medical student, who spent a few months more or less apprenticed with me in the mid-nineties, telling me that the hospital wards in Glasgow were crammed with the livers of Newcastle Brownonians. No, a kind "Yuengling," thought I, would be a better place to begin.

It had, as well, a pleasant association with the beautiful young lady opposite whom I had found myself sitting at some luncheon event: she had ordered a "Yuengling," which she drank with impeccable stylishness and insouciance, while my own pretensions to manhood were forced to deal with the embarrassment of sipping on a mere Diet Coke. I felt suddenly singularly mouse-like, and so determined there and then to turn over a new dietary leaf.

But I have raced ahead of myself, as usual. You may be wondering how, possibly, Angelina Cain's article, and my serendipitous introduction to a "Yuengling" intertwine, and to what grander purpose. I rather wonder, too, at this doubtful point in this little essay. But, I assure you, all will unfold, the truth be revealed, the health of our nation improved, and everyone's BMI about 23. No more, please: I do not want the nation too skinny, you see. It is a personal aside, of course, with which some may legitimately take issue, but the fact is that I do not want ladies to look like "coat hangers," and as for gentleman, they should be roughly BMI-ed somewhere between Fred Astaire and Cary Grant. The question you will necessarily ask, and which I ask myself, is "how will beer lower our national BMI?" It is a good question. Some research was required.

I accordingly went first not to Google but my delightful friend, Bobby Brooks. He has been for all his life a connoisseur of beers of the highest and lowest sort, from every part of the world. He can go into a bar anywhere at all, in the roughest seaports on the south China or Apalachee coast, or even, as I have seen him do, in Newcastle itself, order a "Brown," and make everyone his friend instantly. I would guess that he has averaged in his lifetime 2.6 beers a day, excluding perhaps an intermittent day or so in the week, which comes

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out to roughly thirty-seven thousand, nine hundred and sixty beers. He is perfectly fit, too; never icteric; his ALT/ASTs handsomely where they ought to be; and lean (but never mean) without the least evidence of beer in his belly or fat in his liver, weighing just what he did in college. His trick, alas! is that having been a "Hall of Fame" long distance runner for FSU, he has kept up the habit. Running at least forty miles a week, he has in the last forty years or so run approximately eighty-seven thousand three hundred and sixty miles, which is three times around the planet, and more than half way to the silly moon. I am not sure we can expect this of the ordinary, beer drinking American public.

So what, becomes the next question, are we to do with all those calories beer so merrily contains. My further research tells me that Americans consume over fifty billion pints of beer annually, which amounts, at 205 calories/pint, to roughly ten trillion seven hundred and fifty billion calories. This seems to me a very great deal, even if it does exclude all the equally easy-going triple whoppers, double French fries, and potato chips that so beguilingly lurk on every street corner. Angelina Cain, let us note, has her work truly cut out for her.

So how do I justify my own embarkation on a beer drinking career, and by extension contrive to applaud its benefit to our national health? "An uneasy question?" you say. Never mind: I am determined to wrest from it a rational answer.

First of all, as a possible window to perception, let us note that the average American consumption of "soft drinks" is over 448 pints per year; in total some one hundred and twenty billion pints of this liquid are sold in the U.S. annually. If roughly half is a diet-cola then there is an equivalence, give or take a few billion, of calories consumed per person betwixt beer and cola.

CONTINUED ON NEXT PAGE

But no one, I gather, not the government, the FDA, the NSA, nor even the i-cloud knows quite for certain just what is in a diet cola: well, of course, 4-methylimidazole, not to leave out phosphoric acid, artificial coloring, and various other mysterious derivatives of this and that. There are people, certainly, who are certain that fizzy drinks in a can all contain an undisclosed "Compound X," put there probably by the government, or the CIA, or the Chinese in order to turn us into zombies or kill us with cancer.

On the other hand, we do know what is in beer, which is to its great advantage.

To be reasonably brief, there is starch leading to sugar, and from thence a refreshing touch of alcohol, some malted barley and wheat, a few hops and maybe some herbs. It is the world's most widely consumed beverage after water and tea. Its provenance predates antiquity, and the Code of Hammurabi has within it laws regulating beer parlors. It contains several B vitamins and antioxidants; it reduces the risk of kidney stones; may help with osteoporosis; assists in the prevention of heart disease; and because of the hops, which contain xanthohumol, has been shown to help prevent cancer, particularly of the prostate. At my age, I should clearly guzzle lots.

Now tell me: can a Diet Coke or Pepsi live up to any of that whatsoever?

No wonder my shame at luncheon. The young lady had got it right. Bobby has got it right, even though I, myself, never intend to run even a mile ever again unless chased by a bear. History has got it right, too, since at least the XII Dynasty, and doubtless well before. Nor to forget the aesthetics: the foaminess of it, the golden color, coming in every hue;

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"EMBARKING ON BEER" CONTINUED FROM PAGE 15

the different textures, fullnesses of flavor, the bon ami, the camaraderie, even the goofiness, etc.

As for Dr. Cain, I can't quite remember what she drank at the lunch I shared with her awhile back. I think it was chaste water, or something like that, with a bit of lemon for vitamin C. On the other hand, despite the cool sophistication of her aura, I can conceive her as remaining altogether uncompromised were she to partake of a decent beer under the right circumstances. I even hazard to think she would agree with me that, for at least some of the reasons above enumerated, a modest few gallons of beer per year is better than numberless gallons of diet-cola, which almost inevitably must come accompanied by the above noted double-whopper-double-fries combo.

Moderation, of course, in all things: that's the ticket. Which is to further say that Cap Scan thanks Dr. Cain for her article addressing our nation's greatest epidemic (obesity), and that we would love to hear from her again regarding whether or not she might occasionally, in fact, ever have a beer, aside from green tea, unsweetened lemonade, red wine, or a martini with an olive (to get the daily quota of "fruit").

Whatever! (as they now always say whenever…)

As for me, I am now well on my way to becoming some sort of beer connoisseur myself: I have already by this writing enjoyed a delicate little "Harp," and have risked a stunning advance even to a "Newcastle Brown," delighted to discover I am not in some hospital ward. Who knows to whence I go from here: for it is "Starship" time, and a galaxy of beers beckon, calling me forth.

I might one day even try a great big "Bud," and, of course, why not a huge motorcycle. CMS

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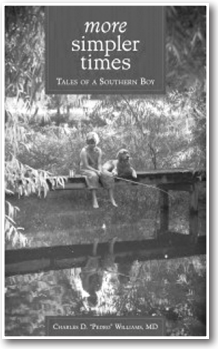
How to Buy Dr. Williams' **More Simpler Times**

By Shannon Boyle



We are very grateful to Dr. Charles Williams that he has decided to donate to the We Care Network, proceeds from the sales of his new book and sequel, More Simpler Times.

The cost is $20 per book.
You can buy copies of the book at:

- The CMS office – 1204 Miccosukee Road
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Or simply enter http://capmed.org/access-to-care-committee-starts-blogging-3/ and click on each Blog.

So far, the following have been published:

- "Enhancing Access to Care in the Community," by Dr. James Stockwell
- "Medicare Access in Tallahassee: Milestone or Millstone?," by Dr. Kenneth Brummel-Smith
- "Access to Care Dilemmas for Patients, Doctors and Families," by Dr. John Mahoney
- "Who will YOUR physician be in 20 years?," by Sarah-Ashley Robbins, 3rd year Medical Student

We are looking for a few good bloggers on the issue of access to care. If you have a story to tell, send your Blog to Sue Conte at sconte@capmed.org. CMS

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"TO A CARPENTER, EVERYTHING IS A NAIL"

By Jeff Cohen, Esq., President and CEO, The Florida Healthcare Law Firm

As change in the healthcare industry continues to unfold, keep in mind that one size does not fit all. Moreover, try to keep in mind that everyone selling solutions see things through a lens they are most familiar with and which may be financially beneficial to them, but not specifically tailored to meet your own needs.

When you look at ACOs, group practices, concierge opportunities and the rest of the options, you have to ask yourself two questions: (1) What do I want my life to look like in 3-5 years?; and (2) Will this help me get closer to that? There are so many strategies worth looking at. Seeing which one fits is far more complex, however, than theorists may appreciate. Knowing what you want, what is good for your family, how many years you want to work and how hard you want to work, being realistic about your health and financial situation are all part of the process. And the truth is that there is a tendency at this time to rush in, grab something and run, without sufficient analysis. That is in part driven by fear and also by the unique (and sometimes limited) perspective of advisors.

"To a carpenter, everything is a nail" is an apt saying for this time. Healthcare professionals and business people need to give proper time and attention in planning for the future. The sky is not falling. It is changing, always has and will. Being honest and thorough in your evaluations about what you want and what will be a good fit for you is a process that may take more time and energy than you think you have. Slow down. Investing the time and energy now will pay off bigger than rushing in. CMS

Reprinted from The FHLF Monthly – August 2013

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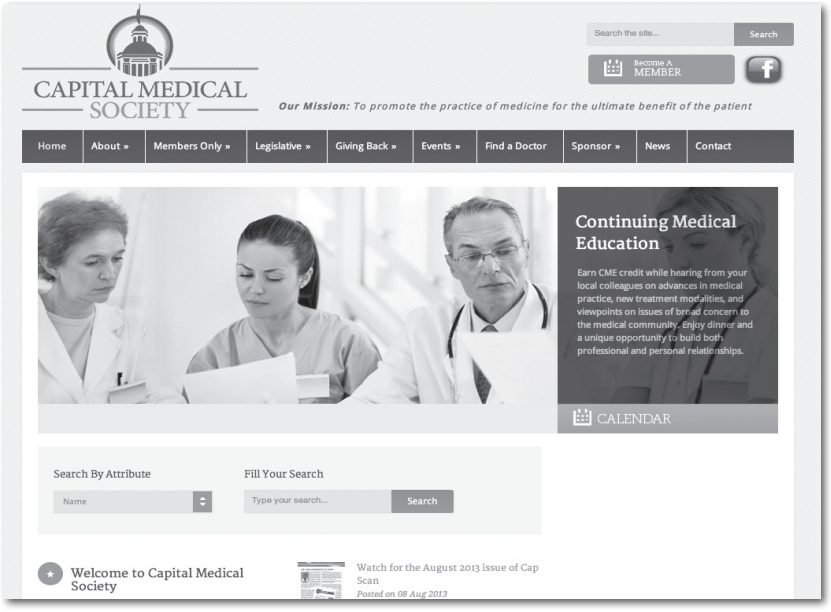

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