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**ALSO IN THIS ISSUE – Pages 16-23**

Northeast Florida Medicine from the Duval County Medical Society
The media loves to hype concerns about artificial intelligence: What if machines become super-intelligent and self-aware? How will humanity compete and survive? But artificial intelligence today is a far cry from a robot takeover. “AI” is a catch-all term that often refers to machine training or machine learning: There is an abundance of data, vastly more than the human mind can assimilate, being tagged, captured and stored. This systematic data processing requires methodologies that can put it in usable form and formats. While these new developments stoke fear in some corners, the ability to predict outcomes is generally seen as a good thing, as it can mitigate risks and even save lives.

The prospects and attempts toward artificial intelligence has been with us for decades. Only recently have the underlying technologies and infrastructure—including computer processing, storage, networking speed and advanced software platforms—become omnipresent. These technological advances enabled the implementation of data mining concepts and the subsequent advantages that were not feasible just a decade ago.

AI is fantastical by vision, evolutionary by experience, and disruptive upon reflection. In the world of health care, AI is already transforming research and clinical practice. We, collectively, want AI even though it is seldom expressed this way. What we, the patient population, patient advocates and caregivers, agree on and want is: (1) timely, precise and inexpensive diagnoses of our ailments, injuries and disorders; (2) timely, personalized, highly effective and efficient courses of therapies; and (3) expedited recovery with minimum deficits, complications and recurrence.

“Artificial intelligence and machine learning will impact healthcare as profoundly as the discovery of the microscope.”

Implicitly, we all are saying that we want our healthcare systems and clinicians to accomplish truly inhuman feats: to incorporate all sources of structured data (such as published statistics and reports) and unstructured data (including news articles, conversational analysis by caregivers, nuances of similar cases, talks at professional societies); to analyze the data sourced and uncover patterns, reveal side effects, define probable success and outcomes; and to present the best personalized course of treatment for the patient that addresses the ailment and mitigates associated risks. It is hard to argue against any of this.

In a recent published interview, Keith J. Dreyer, executive director of the Massachusetts General Hospital and Brigham
and Women’s Hospital Center for Clinical Data Science, says that “artificial intelligence and machine learning will impact healthcare as profoundly as the discovery of the microscope.”

But as AI helps physicians in profound ways, like detecting subtle lesions on scans or distinguishing the symptoms of a stroke from a brain tumor, we humans can’t get too complacent. Evolving AI platforms will provide more sophisticated sets of “tools” to address both mundane and complex medical challenges, albeit with humans very much in the mix and routinely at the helm.

Human beings are capable of a level of nuance and contextual understanding of complex medical scenarios and, consequently, do not appear endangered to be replaced anytime soon. These platforms will do some heavy lifting for sure and provide considerable assistance across the healthcare industry. But human involvement is crucial, as we are best at adaptive learning, cognition, ensuring accuracy of the data, and continually providing feedback to improve the machine learning components of the AI platforms that the health industry will increasingly rely upon.

The human/machine interface is not binary; there is no line in the sand. It is fuzzy and evolutionary, a synchronicity that we all will surely witness and experience. In the future, it may be possible that all recorded knowledge, including genetic, genomic and laboratory data, from structured and unstructured sources, can be at the fingertips of your clinician, and then factored into diagnosing your condition and prescribing your course of treatment. This is precision and personalized medicine on a grand scale applied at the micro level— you! But none of this will diminish the importance of doctors, nurses and all assortment of care providers. Though they all will undoubtedly become more effective with such awesome AI assistance, their job will always be to heal you with compassion, wisdom, and kindness, for the essence of humanity cannot be automated.

Steven Haley is a tech industry veteran and prolific angel investor. He is highly engaged at the leading edge of innovations through his company affiliations and in multiple capacities, which include advisor, operational roles, committee, and board member. He began his technology career working Numerically Controlled Systems (NC Machines), macro-assembler coding, applications hosted on mainframes and minicomputers, and broadband networking. Present-day initiatives relate to commercialization of software platforms. He has been involved in the healthcare sector for two decades serving on academic hospital boards, technology initiatives, and a medical investment advisory committee for a healthcare VC. He is also involved in numerous medical philanthropic activities, including establishing The BrainScience Foundation. His interest lie in adaptive learning software platforms, analytics, and the applications they support in healthcare, STEM education and enterprises.
Every time I call a friend, all I have for them is more work. I’ve never yet called to say: “I hope you’re having a great day. Why don’t you take a break and have some fun. You’ve worked enough.”

Nope. I only call to give them extra work. Whether it’s 2AM or 2PM, I need you to get away from your bed/lover/high horse and come take my patient. All, always, sick. The healthy ones I send home without waking you up.

Sometimes they’re not sick enough. My ortho friend says: “Are you crazy? Just because she has broken her wrists you think she needs to stay?”

“She walks with a walker. How’s she gonna walk? How’s she gonna wipe herself? How’s she gonna stay alive?”

He looks at me like I’ve lost it. He doesn’t do comfort or supportive care. The patients either need surgery or they don’t. It’s not rocket science. It’s not his problem. But then whose is it?

Sometimes they’re too sick. “Are you out of your mind? She’s 95, her systolic is 74 and you want me to admit her to the ICU? Call the hospitalist and make her comfort care.”

I’d be happy to, but it’s not my call. It’s hers. If she’s with it and she wants the intubation and the electricity and the broken ribs from CPR, in short she wants everything done, it’s her choice. She’ll get everything done, at whatever cost to herself, to her family, to society as a whole. I’m not entitled to make decisions for her even if I think I know better, even if I wouldn’t make those same decisions for myself.

It gets even worse when it’s the family’s decision. Her daughter who left home at 22 and hasn’t seen her in 50 years; her ex, who eloped with the babysitter and is now so sorry that he wants EVERYTHING done so he can confess—I mean apologize—and get it off his chest? They want it all, the rib-breaking CPR and the foley and the tubes, as many of them as her body can stand, and whatever other misery I can inflict on her as long as she gets to stay alive long enough for them to drop their load on her and be set free.

But I digress. I was talking about my friends, the ones I call when the going gets tough and I need help.

I call my cardiologist. “I have this 90-year-old with an EF of 25 who comes complaining of fatigue. Her troponin is ?.”

“Why are you calling me?”

“I thought you were the cardiologist.”

“So what? There’s nothing I can do for her. She gets admitted every week for something. There’s nothing I can do for her, why call me?”

I get angry. Very angry.

“She’s got a long cardiac history, chest pain, an abnormal EKG and a troponin of 7.” I say it softly, as softly as the hissing long fuse of a detonation cord after it’s been lit.

“She always makes troponin. She’s got to have some arrhythmia, she always makes troponin when she’s got an arrhythmia. What’s her EKG like?”

“It’s sinus at 110. I see no arrhythmia. I can take a picture of it and send it to you.”

“No need. I can access her EKG.”

Maybe you should.

“I’ll see her but I won’t admit her. Give her to the hospitalist.” Of course. If there’s anybody on the totem pole lower than me, getting shat upon every day by every specialty known to man, it’s the hospitalist.

They are smart and hardworking and always there. They are
the Cinderellas of medicine. Their ugly stepsisters piss on them whenever they get a chance. Not directly, no. Via me. I get to call them and get them to admit surgical patients and oncological patients and cardiology patients and any other patients. Soon enough I’ll call them to admit patients for the vet down the road. He’s a specialist too. “I have this 2-year old lizard…”

I call the hospitalist. She has an accent. She came here legally to practice medicine but the system didn’t allow her into the hot fields like dermatology, ENT or neurosurgery. She got to be a hospitalist in this after-life, whether she was a Nephrologist in Peru, an Endocrinologist in Romania, or an Oncologist in Bulgaria.

She’s smarter than I am— she’s an internist. They think long and act slow. I’m an ER doc. I think fast and act now. I’m the cowboy while she’s the judge. The house of medicine needs us both.

“Why do you think this patient needs admission?”

“Well, she can’t walk,” I say, feeling like a fraud.

“Did you try walking her?”

“No. She walks with a walker and now she has two broken wrists.”

Or a hip. Or a pelvis. Or something else that’s gonna stop her from going home to her previously marginal function. I can’t send her home, and nobody else wants her.

“She’s all yours.”

Still wondering why I have no friends?

Rada Jones, MD, is an Emergency Physician. She practices in Upstate New York where she lives with her husband Steve, her GSD Gypsy Rose Lee, and a deaf black cat named Paxil. She’s working on finishing her novel, “Overdose, an ER Thriller” where a lot of people die in unnatural but exciting ways. Find more at RadaJonesMD.com, Instagram RadaJonesMD and twitter @JonesRada.
When traveling in the fall, picturesque foliage isn’t the only reason to pick a destination.

Grape Harvest, Portugal
Fall brings grape harvest in the northern hemisphere, and there’s no better place for an oenophile to spend the season than in Portugal’s Douro Valley. In partnership with neighboring estate Quinta de Pacheca, the area’s Six Senses Spa & Resort invites guests to join the tradition by rolling up their sleeves, donning traditional straw hats and tobacconist scarves, and getting to work. Spend the day picking the year’s bounty and stomping the fruit in stone lagares, with breaks for a typical Portuguese lunch (think caldo verde and feijoada), a winetasting, estate tour, and glass of port.

Back at the hotel’s Wine Library, guests can choose from a series of daily tastings to delve deeper into the region’s diverse flavors, or opt for one of five intensive courses to become an expert in understanding wines beyond the area’s borders. Even the spa integrates the fruit of the vine into their treatments—don’t miss the rejuvenating body exfoliation, wrap, and massage using grape pulp, grapeseed oil, and other vineyard-based concoctions.

Peak Surf Season, Nicaragua
November in Nicaragua—the final month of the area’s green season—means both the smallest crowds and the biggest waves of the year. Guests of Mukul Beach, Golf, & Spa can take on the best swells the Emerald Coast has to offer with next-level, bespoke surfing adventures organized by luxury surf school and outfitter Tropicsurf.

Tour Historic American Homes & Gardens in Charleston
American architecture, design, and history buffs get a rare opportunity to snoop around some of the country’s most distinguished historic homes this fall, when Charleston’s choicest residences throw open their doors for one month only. Whether your penchant is for 18th-century Georgian or 20th-century Colonial Revival styles, the city’s Preservation Society offers upwards of 15 tours during their 41st annual fall event season (October 5–29).

Highlights include the Roper House at 9 East Battery, The Cleland Kinloch Huger House at 8 Legare, and 4 Logan Street, once the home of Preservation Society Founder, Susan Pringle Frost. For the full experience, the celebrated Planters Inn from Relais & Chateaux, located in one of the largest and most gorgeous historic districts in the nation, offers as homey and elegant stay.

Hunting, Butchering, and Cooking Class in Aspen
Hands-on cooking experiences might be a dime a dozen these days, but the Viceroy Snowmass goes above and beyond with a luxe culinary adventure set in the Colorado wilderness. With 28,000 acres of deep canyons, open meadows, and wooded rivers as the backdrop, hotel guests can traverse a world-class upland bird habitat to hunt dove, blue grouse, duck, pheasant, goose, and other seasonal fowl alongside the hotel’s executive chef, Will Nolan, and an expert from the prestigious Aspen Outfitting Company.
Post-hunt, the action continues in the privacy of guests’ rooms, where chef Nolan leads an in-depth butchering and cooking class. The grand finale, of course, is the chance to sit down in the comfort of your own suite to a feast that’s sure to top any farm-to-table dining experience in town.

**Truffle Hunting in Tuscany**

There’s more to peep in Tuscany’s woods than the color of the changing leaves. A hunting excursion in Siena encourages guests of Castello di Casole - A Timbers Resort to shift their gaze downstream to look for the area’s most prized treasures: black, white, and muscat truffles. The foraging adventure, complete with a guide and a fleet of Lagotti dogs, takes place on the property’s own natural wood reserve, which shares the 4,200-acre estate with a 41-suite boutique hotel and an additional 28 restored Tuscan farmhouses.

Once you’ve rounded up your bounty, the resort’s chef will demonstrate methods to conserve, clean, and prepare truffles in a three-hour cooking class. A three-course meal with wine pairings from the property’s winery follows as a well-deserved reward.

**Great Migration River Crossing in Kenya**

For a visceral experience that beats even the most up-close-and-personal moments captured in Planet Earth, book a front-row seat to The Great Migration in October and November, when more than one million wildebeest head north across Kenya’s muddy, crocodile-covered Mara River. Only a short drive from an optimal viewing site on the banks, &Beyond’s Bateleur Camp—a private concession that borders the Mara conservancy—makes a perfect home base. Designed with a nostalgic 1920s-‘30s aesthetic in mind, each of the lodge’s 18 glamorous tents comes with its own private butler, views over the Plains, and elegant accommodations, including an en-suite stone shower, hardwood floors, and silver and crystal accents. Before the wildebeest take off, guests can view the bustling Mara at sunrise from a hot air balloon; back on land, rangers—experts in the area’s flora and fauna and how to capture them on camera—escort guests to their place along the river to witness the spectacular event.

**Fall Foliage in the Ozarks, Missouri**

The Northeast isn’t the only place in the United States to catch the fall colors; the Ozark Mountains might be offering the very best vantage point for leaf peepers this season. Situated on more than 4,600 acres of southern wilderness, Big Cedar Lodge is smack-dab in the middle of the changing leaves. Spread across a range of lodges, cottages, and cabins—book the massive Western chalet-style Governor’s Suite for an over-the-top stay—the rustic-chic accommodations provide vistas of the colorfully wooded hills from both above and below.

Enjoy hikes through Dogwood Canyon Nature Park, adventures through the Lost Canyon Cave and Nature Trail, scenic drives to various lookout points, and sunset cruises on the adjacent Table Rock Lake, where guests can take in the crisp, colorful atmosphere from the deck of a custom-built 62-foot luxury yacht. Cruises are offered Wednesday and Saturdays, from September 1–October 31.

**A Celebration of Nelson Mandela in Cape Town**

Next July would have been the 100th birthday of South African activist and former president Nelson Mandela; and this fall, ahead of this milestone, Cape Town’s recently renovated Belmond Mount Nelson Hotel is offering a new package to honor his legacy.

Guests will be able to immerse themselves in both educational and experiential opportunities, like getting their hands on a complimentary copy of “Dare Not Linger: The Presidential Years,” a newly-released Mandela memoir unfinished at the time of his death (South African writer Mandla Langa continued where Mandela left off, reporting on the leader’s years in office from 1994-1999); a three-course meal inspired by Mandela’s favorite dishes, like oxtail soup; and an opportunity to speak with Christo Brand, one of the guards who looked after Mandela when he was incarcerated on the nearby Robben Island.

Guests can also reserve a two-hour guided walking tour to some of Mandela’s key historic sites, and have their portrait painted by Mandela’s portraitist (and Belmond Mount Nelson’s artist-in-residence) Cyril Coetzee.

**A Fall Food Festival in St. Bart’s**

Winter is considered the prime time to visit St. Bart’s, but the island also makes for a sumptuous fall getaway—especially for the culinary enthusiast. From November 2 - 5, a slew of top chefs take over the island for the annual Saint Barth Gourmet Festival.

This year’s theme is French gastronomy; its patron chef is Eric Frechon (of the Michelin three-starred restaurant Epicure at Le Bristol Hotel in Paris). Six more acclaimed French chefs will take up residence at six of the island’s most opulent hotels (Hotel Cheval Blanc St-Barth Isle de France, Hotel Christopher, Le Guanahani, Le Sereno, Le Barthélemy Hotel & Spa, and the Eden Rock Hotel).

Each will create three multi-course dinners at their respective properties for festival guests. Stay at the chic Hotel Cheval Blanc St-Barth Isle de France, located right on the pristine Flamands Beach—it will have just reopened after an end-of-summer refresh.
I was recently doing some home shopping in Target. It was peak time and fairly busy. After I was done, I walked towards the front of the store and approached the counter area to pay. But alas, there appeared to be hardly any manned registers. Lots of people were strolling up and down, trying to do the same as me—find a real person to help us check out. We were then informed that the store was trying to cut back on people at the cash registers, and instead, encourage people to use the “self-service” checkouts. There was a collective sigh. Most people, including myself, scurried to one of the nearest few manned registers, despite the line being longer.

So there I waited. I did not want the hassle of doing it all myself. I had both small and large items, didn't relish bagging everything, and simply wanted my usual check-out experience. The same one that I have had for over 10 years and was very happy with. I waited patiently for my turn as the several people in front of me were served first. The cashier was visibly getting frustrated with having to deal with the long line and being left out to dry by the organization.

I left the store later than anticipated owing to this unexpected delay and thought to myself as I was driving home: this experience shouldn't really be a surprise. It’s typical of the standard corporate modus operandi that pervades many industries, and is probably happening all over America in other stores too. A relentless drive to reduce manpower and maximize revenue by any means possible, regardless of the effect on the customer. The mentality is all about the bottom line and making a buck. That experience at Target represents everything that the bad side of corporations stand for: cost-cutting, depersonalization, and inflating shareholder profit. Customer experience is always shoved to the side, on the road to achieving this. I have since been back to the same Target a couple of times, and I can report that the situation was not a one-off—and continues to happen. Not enough manned registers and a desire to make us “check out ourselves”.

Sadly, the corporatization of healthcare over the last decade has brought this same basic approach to medicine. We see it every day in our nation’s hospitals and clinics. The departmental mergers, the staff cuts, the loss of that unique personal touch. It’s all about factory-like processes and dissecting illness down to numbers. In all of this, guess who loses the most? Yes, the patient.

A few years ago, I was speaking to a colleague who was rapidly climbing the healthcare administrative ladder. I was talking about improving healthcare quality and the patient experience. He remarked to me how he found his meetings really interesting, shook his head and said very honestly: “You know Suneel, you really don’t realize…in the meetings all I hear the top-level hospital people talk about is money, money, money. How can we cut things and increase profit? How can we make more savings and ramp up our numbers? I rarely hear anything about actually improving anything”. I will never forget the way he said that to me. In some ways, that’s what business is all about, so one can't blame the MBAs of this world for doing what they’re trained to do—especially after we’ve surrendered control to them.

I am a big reader of biographies, particularly about society’s most successful people. There’s so much to learn from these folks. A select few business geniuses really do understand that the above is the wrong approach. I read Walter Isaacson’s book about Steve Jobs several years ago. Despite being a notoriously difficult person to work with (okay, let’s be honest, he sounds like he was frequently an ass to work with!), Jobs was amazing at always putting the customer experience first. In fact, he was obsessed with it. An Apple store without him, would probably look just like any other standard shop—crammed with as much sellable stuff as possible. Another business genius, who has much more humility, is Sir Richard Branson, founder of the Virgin Empire. His latest book, Losing My Virginity, is the best book I’ve read this year. He describes his whole fascinating life story and thoughts on how to work with people and run a big organization. It is clear that Sir Richard also totally “gets it” when it comes to putting the customer experience first and not focusing solely on profits and the bottom line.
I have a lot of friends and family who have worked hard and reached very high level executive positions. Some have even founded companies themselves. I've also of course met many other senior level people in my own work. I would say there's probably a roughly 50-50 split generally between those who appear to understand the need to stay focused on the frontlines, and those who don't. That's not to say the ones who don't are bad people. It's just that they tend to lose sight of the fact that no organization is worth anything without this as the primary motivating force. Furthermore, out of those who do “get it”—the reality is that only a minority have the communication and execution skills to actually make a real difference. Eventually though, the right way of doing things usually always wins through in a competitive business environment (and in the long-term is actually much better for profits). It can just be painful to see things go wrong at first and the harsh lessons being learned.

I am cautiously optimistic we'll come full circle over the next few years, especially in healthcare. We are going to eventually realize that a bloated administrative C-suite approach that focuses only on the bottom line, at the expense of patient experience (and good clinical care), is going to implode. In the meantime, how can you help change things if you see situations like the one at Target? Well, one simple thing you can do is give immediate online feedback and write reviews about the suboptimal service you’ve received. Be ruthless about ensuring you do this! It’s often more effective than verbal point-of-contact feedback to someone who may or may not be able to take it further. You can be both polite and firm at the same time, while communicating the message succinctly. In today’s world, no company wants to receive bad feedback. Neither can any organization afford to ignore it. The lesson for healthcare is simple: the patient must always come first. Yet it’s seemingly so difficult for many in the corporate world to understand. As soon as you become a back end self-serving organizational behemoth—you’ve lost. Whether it’s Target or your local hospital, when those scales tip away from the frontline experience and towards that “spreadsheet and numbers” mentality, you’re going to be in trouble sooner or later.

Suneel Dhand is a physician, author and speaker. He is Co-Founder at DocsDox and Founder at DocSpeak. His latest keynote presentation is: “Using amazing everyday communication techniques to improve patient experience and healthcare outcomes.”

"Do something for somebody everyday for which you do not get paid."
-Albert Schweitzer
By inserting trailers between episodes, the streaming giant stated that its plan is to try help its subscribers discover new content they may be interested in. However, binge-watchers are balking at this idea. In-house trailers or not, these ads can ruin the flow of an extended marathon of your favorite show.

Fortunately, there’s a way to opt out of these test ads. Read on and learn how.

**How to opt-out of Netflix’s ad tests (for now)**

To opt out of the new ads (and Netflix’s feature preview tests, in general), you can turn off “Test Participation” on your account. This acts like beta tests for Netflix’s new features. Note: This is set to “On” by default to all subscribers.

1. Log on to your Netflix account on a web browser or your mobile app.
2. In your mobile app, tap the three horizontal lines on the bottom left labeled “More” or if you’re on a web browser, click your profile picture on the top right of the page.
3. Tap or click on “Account.”
4. Scroll down then tap or click on the section called “Test Participation.”
5. On the Test Participation page, simply toggle it to “Off” then tap or click “Done.”

For, this will turn off the in-between episode ads and it will also prevent Netflix from pushing other feature previews to your account in the future.

However, if the preview ads move beyond the testing phase, expect them to show up across the board even if you’ve opted out of test participation. With all the complaints we’ve been hearing about this feature, we’re hoping that Netflix will reconsider.

**IN RELATED NEWS, NETFLIX DOES AWAY WITH REVIEWS, BUT THAT DOESN’T MEAN YOU CAN’T FIND THEM**

Have you ever just logged into Netflix not knowing what you wanted to watch, figuring you would let fate decide for you? There are plenty of movies and shows to choose from, and chances are you will find something enjoyable.

For the less daring, reviews are helpful. Granted you don’t necessarily want to treat every comment and summary as
gospel, but getting opinions from others who have already seen the show or film certainly can’t hurt.

If you are the kind of person who crowdsourced your entertainment, however, Netflix is doing you no favors anymore. Beginning this past weekend, reviews are gone.

That’s right, you’re on your own

If you log into the site now you will notice that user reviews have been deleted. It does not matter if it was a show, movie or any other kind of content, because all of it is gone. Netflix has been looking into doing this for a while, and now it has finally come to fruition. Instead, the only help you will get when deciding is to look at the match percentage, which is what Netflix shows as a way to guess whether or not you would like a particular show or film. That number is based off your viewing history and whether or not you gave a particular show or film a thumbs up or thumbs down.

It’s not a particularly scientific method, nor is it all that in depth. If nothing else, user reviews provided a larger sample size, and therefore was pretty helpful. Yet according to Netflix the feature was removed because not enough people were using it.

Be that as it may, if you relied on reviews to help make decisions for you, Netflix is not helping.

There is another option, though

Just because Netflix will no longer show reviews does not mean they are not out there. Besides sites like IMDB.com, which provide plenty of information about pretty much anything that could show up on your screen, you can check out usa.newonnetflix.info.

Also known as "New On Netflix USA," it is billed as "the most complete source of what’s on Netflix in the USA."

On the site you will find all sorts of information, including expiration dates and removals as well as, you guessed it, ratings. They come courtesy of popular ratings sites like the aforementioned IMDB as well Rotten Tomatoes and some others. Already a pretty useful site, it will come in especially handy now that Netflix is no longer showing reviews.
I am where I am today because of so many who supported me along the way.

My family roots are pretty humble. My parents, grandparents, and great-grandparents lived and worked on ranches and farms and underground mines. With little spare money, my family spent vacations camping, hiking and lots and lots of fishing. I do not remember my first fish or picking up my first fishing pole – because I started fishing before I could walk. It was in my blood. With three brothers, we grew up on my Grandpa’s land, which was on the edge of the Wasatch Mountains in Utah. We climbed canyons and mountain peaks and fished the small streams. In Wyoming, where my Mother grew up, we would fish for rainbow and brook trout in small cricks (and yes that is how we spell them) in the Shirley Basin Mountains surrounded by the homesteads that my ancestors tamed outside of Casper. They were glorious days for sure. I was blessed to have had a wonderful family that put family first.

After graduation from high school, I decided I wanted to become a computer engineer. I had visions of one day working for Boeing or General Motors. I had a brother, however, who convinced me that I should go into medicine. He said that was what I was destined to do. I decided to pursue that goal of medical school but had also recently become engaged to a beautiful woman, Jolene, who disliked doctors. After long discussions she agreed to marry me and also support me in my quest for a medical career. I wasn’t sure I was cut out for a career as a doctor so I decided to volunteer in a pediatric cancer clinic, at Primary Children’s Hospital in Salt Lake City Utah. I figured if I could withstand the emotional ups and downs of working with cancer patients, then I could probably manage the emotional rigors of a medical practice. Not only did I manage, I loved working with pediatric cancer patients. They were resilient, tough and special. So, after completing a degree in Chemistry at the University of Utah, I entered Medical School, also at the University of Utah knowing that I wanted to be an oncologist.

I was doing research with a gynecologic oncologist. He asked what kind of a doctor I wanted to be. I said I wanted to be an oncologist. He said that if he had to do it over, he would be a radiation oncologist. At the time the radiation oncology department was about 3 floors below the main floor. After a few weeks rotation in the radiation oncology department, I knew that radiation oncology would be my next adventure. Radiation oncology was a very unusual specialty. In my medical school graduating class of 110, I was the only one who pursued this discipline.

During the match process, I had narrowed my search to Rochester, NY, Milwaukee, WI, and Minneapolis, MN. On the days I interviewed, the temperatures were respectively, 0 degrees, 20 degrees below zero, and 40 degrees below zero. Cold, colder and coldest. I matched with the Medical College of Wisconsin (MCW) in Milwaukee for my residency. By this time in my life my wife and I had 4 children, aged seven to six months. So, in 1991 we packed everything we owned in a small moving van and relocated to a small suburb of Milwaukee - the Village of Hartland. I didn’t know how lucky I was to have matched with one of the best Radiation Oncology training programs in the country. My attending physicians were caring and nice. They were great teachers and were very politically connected. Over the years since my graduation, two
of my attending physicians, Dr. Frank Wilson and Dr. Colleen Lawton, would become presidents of ASTRO (our discipline’s international professional organization). Four years later at graduation, I was well trained and felt ready to cure the world.

At that time in national politics, the president’s health care policies were attempting to change the medical system and almost every radiation oncology practice was not hiring as the future of health care seem very uncertain. I had assumed that I would return to the West. However, no one was looking for any new partners to join their group. As luck would have it, one of my attending physicians at MCW, Dr. Chris Schultz, trained with Dr. Scot Ackerman at Columbia University. On my behalf, he asked Dr. Ackerman if he had an opening in Florida…and he did. I interviewed and fell in love with Florida. How could you not! When I left in January, the temperature in Milwaukee was 10 degrees below zero and Jacksonville had a high temperature of 73 degrees! I called my wife after the first day and said, “I have found our new home!” After graduation in July 1995 I drove straight to Jacksonville.

Dr. Ackerman and I initially practiced at St. Vincent’s Medical Center in Riverside. In 1997 we opened a private facility in Mandarin and in 1998 added an additional location in Amelia Island.

I came to Jacksonville with a great interest in treating prostate cancers. Since there was no prostate seed implant program at St. Vincent’s, I spearheaded bringing seed implants to the hospital. I organized a group of urologists and myself to be trained in Seattle at the Seattle Prostate Institute. At the time, not many radiation oncologists had an interest or training in brachytherapy, which is the surgical implantation of radiation seeds inside of tumors. I was again blessed to join up with Dr. Ackerman who had a wealth of experience in brachytherapy. He also has a great knack of keeping on the cutting edge of radiation oncology technology and advancement. Ackerman Cancer Center is the world’s only private, physician-owned center to offer proton beam therapy. We were the 15th center to offer proton therapy in the United States when we began treating with protons in April 2015, and are currently one of 28 in the country.

I think that radiation therapy will continue to evolve in the future with smaller and more accurate beam arrangements. At Ackerman Cancer Center, we have already seen a significant reduction in side effects with the use of proton beam treat-
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ARTICLES IN THIS ISSUE

• DCMS Members Participate in FMA House of Delegates
• Why DCMS Membership is Right For You!
• CME: Polypharmacy; A Case-based Primer
Recently, the Jacksonville community lost a truly remarkable man, retired decorated Navy Commander, John Hunt, MD. He was an extraordinarily talented physician who served our community for more than 20 years. Dr. Hunt was a pain management and addiction medicine specialist who made it his mission to help as many people as possible throughout his career. He owned NexStep Integrated Pain Care prior to joining Coastal Spine and Pain Center. Dr. Hunt, a man who earned two Purple Hearts, saved thousands of patients from addiction and built a beautiful life with his wife Mary, will truly be missed. His legacy and work in medicine will continue to live on.
DCMS Members Participate in FMA House of Delegates

In August, more than 25 Duval County Medical Society (DCMS) members traveled to Orlando to serve as Delegates to the Florida Medical Association (FMA) House of Delegates. As in years past, the DCMS Delegation was one of the largest in the state. These Delegates represented not only the DCMS, but also several State Specialty Societies. Each year, these dedicated physicians come together to discuss important issues facing medicine.

During the House of Delegates, several DCMS members were elected to key leadership roles within the FMA. Dr. Tra’Chella Johnson Foy and Dr. John Montgomery were elected as FMA Delegates to the American Medical Association. Dr. Mark Dobbertien was elected to serve as the FMA Surgical Specialty Board Representative.

In an election year, it is also critically important that physicians step forward to support physician-friendly candidates. One way to do this is by contributing to the FMA Political Action Committee (FMA PAC). Each year at the FMA House of Delegates, the County Medical Society that raises the most money for the FMA PAC is awarded a trophy. This year we are pleased to announce that Duval County brought in the most contributions, raising more than $12,000. Your donations go a long way in ensuring we have the right leaders at the state-level. Please join us in supporting the FMA PAC by visiting fmapac.org to make a donation.

We know physicians have extremely busy schedules and limited free time, and we are so proud of our members for going above and beyond the call of duty to serve in these important roles within the House of Medicine. If you are interested in learning more about the FMA House of Delegates, or how you might be able to serve in the future, please feel free to reach out to me at stgeorgemd@stjohnsvein.com.
From the President’s Desk

Why DCMS Membership is Right for You

Founded in 1853, the DCMS has a long and storied tradition of helping physicians and patients locally and throughout the state of Florida. With over 1800 members strong, the DCMS serves as the leading and guiding force in healthcare for Northeast Florida.

First and foremost, the DCMS is here to serve all physicians. No matter if you are in private practice, work for a hospital system, a small group, or a large group, the DCMS is your source for practice and professional development. We strive to meet the demands and challenges of medical practice. From holding CME and informational sessions, to lobbying our state and national legislators, the DCMS is always working for physicians. Published monthly, the DCMS peer-reviewed medical journal, FNortheast Florida Medicine, serves to promote lifelong learning while providing physicians with FREE CME credits required for licensure. The DCMS also has developed the DCMS Leadership Academy to help our members become future leaders in an ever-changing medical environment.

Beyond the practice of medicine, the DCMS is committed to the mental welfare of our physicians. The LifeBridge: Confidential Physician Counseling program has been created as an anonymous way for members to get professional advice prevent burnout, improve work–life balance, and curb any possible risk for substance abuse or suicide.

The DCMS is also active in improving the health and welfare of our community through a variety of initiatives. The annual Future of Healthcare Conference, created by the DCMS and DCMS Foundation, brings together community and governmental organizations to help address the specific healthcare needs of the First Coast. DCMS physicians are also well recognized as community experts that local media outlets use for accurate and credible healthcare information. We volunteer our time at free clinics, doing sports physicals, and educating the community on improving their health and well-being.

I look forward to welcoming you as a new Duval County Medical Society Physician. The opportunities you have for your practice, medical knowledge, leadership skills, camaraderie, and mental well-being are just a small part of what DCMS can offer to you. If you have any questions please feel to reach out to me personally at ruplegalani@gmail.com.

Join now for 2019 and receive the rest of 2018 for FREE!
Polypharmacy; A Case-based Primer on the Practice in the Geriatric Population

Background:
The Duval County Medical Society (DCMS) is proud to provide its members with free continuing medical education (CME) opportunities in subject areas mandated and suggested by the State of Florida Board of Medicine to obtain and retain medical licensure. The DCMS would like to thank the St. Vincent's Healthcare Committee on CME for reviewing and crediting this activity in compliance with the Accreditation Council on Continuing Medical Education (ACCME).

This issue of Northeast Florida Medicine includes an article, “Polypharmacy; A Case-based Primer on the Practice in the Geriatric Population” authored by Michael J. Schuh, PharmD, MBA, FAPhA, Haya S. Kaseer, PharmD, Robert P. Shannon, MD, FAAHPM, and Jessica Peterson, PharmD, which has been approved for 1 AMA PRA Category 1 credit.™ For a full description of CME requirements for Florida physicians, please visit www.dcmsonline.org.

Faculty/Credentials:

Objectives:
1. Identify patients at high risk for complications associated with polypharmacy.
2. Be able to create a plan of care to mitigate the risk of drug-drug interactions on behalf of the patient.
3. Be able to evaluate and counsel the patient who needs additional comprehensive medication management pharmacy consultation.

Date of release: Sept. 1, 2018 Date Credit Expires: Sept. 1, 2020 Estimated Completion Time: 1 hour

How to Earn this CME Credit:
1) Read the “Polypharmacy; A Case-based Primer on the Practice in the Geriatric Population” article.
2) Complete the posttest. Scan and email your test to Kristy Williford at kristy@dcmsonline.org.
3) You can also go to www.dcmsonline.org/NEFMCME to read the article and take the CME test online.
4) All non-members must submit payment for their CME before their test can be graded.

CME Credit Eligibility:
A minimum passing grade of 70% must be achieved. Only one re-take opportunity will be granted. If you take your test online, a certificate of credit/completion will be automatically downloaded to your DCMS member profile. If you submit your test by mail, a certificate of credit/completion will be emailed within four weeks of submission. If you have any questions, please contact Kristy Williford at 904-355-6561 or kristy@dcmsonline.org.

Faculty Disclosure:
Michael J. Schuh, PharmD, MBA, FAPhA, Clinical Pharmacist, Assistant Professor of Family and Palliative Medicine, Assistant Professor of Pharmacy, School of Health Sciences, College of Medicine, Mayo Clinic, Haya S. Kaseer, PharmD, Mayo Clinic, Robert P. Shannon, MD, FAAHPM, Assistant Professor of Family and Palliative Medicine, Jessica Peterson, PharmD, Clinical Pharmacist, Maine Medical Center report no significant relations to disclose, financial or otherwise with any commercial supporter or product manufacturer associated with this activity.

Disclosure of Conflicts of Interest:
St. Vincent’s Healthcare (SVHC) requires speakers, faculty, CME Committee and other individuals who are in a position to control the content of this educations activity to disclose any real or apparent conflict of interest they may have as related to the content of this activity. All identified conflicts of interest are thoroughly evaluated by SVHC for fair balance, scientific objectivity of studies mentioned in the presentation and educational materials used as basis for content, and appropriateness of patient care recommendations.

Joint Sponsorship Accreditation Statement
This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of St. Vincent’s Healthcare and the Duval County Medical Society. St. Vincent’s Healthcare designates this educational activity for a maximum of 1 AMA PRA Category 1 credit.™ Physicians should only claim credit commensurate with the extent of their participation in the activity.
Abstract

Polypharmacy in the geriatric population is challenging for all caretakers involved. These patients often have a variety of comorbid medical conditions requiring numerous medications. On occasion, these medications are no longer consistent with the treatment goals and can cause serious side effects. Geriatric patients may benefit from the expertise of pharmacists who are well-trained in pharmacology, pharmacokinetics and pharmacodynamics working in collaboration with primary physicians in both the inpatient and outpatient setting. The authors present a case-based primer on the principles of polypharmacy in the geriatric population.

Introduction to Polypharmacy

Polypharmacy is simply defined as “the administration of multiple medications concomitantly or the administration of excessive medications.” Approximately 61 percent of individuals older than 65 take at least one prescription medication, and most are taking an average of three, exclusive of over-the-counter (OTC) medications or supplements.

Another recent analysis found the prevalence of polypharmacy in the United States (defined as ≥8 medications) was 15.7 percent; females had a higher rate of polypharmacy than males. Polypharmacy is most dominant in the southern region of the United States. Between 1988 and 2010, multiple medication use increased dramatically. The median number of prescription medications used in adults aged ≥ 65 has doubled, and the proportion of adults taking five medications or more has tripled from 12.8 percent to 39.0 percent.

Clinical practice guidelines often recommend several medications to treat chronic disease. Consequently, an elderly patient with at least two medical conditions, such as hypertension and diabetes, will often be on more than five medications.

Polypharmacy in the Elderly

Polypharmacy in the elderly is associated with increased healthcare expenses and emergency room visits. Geriatric patients are at increased risk for adverse drug events due to drug interactions, altered drug metabolism, or absorption from declining organ function. Medications also contribute to increased fall risk in geriatric patients. It is estimated that 1 in 3 older adults fall annually, associated with increased emergent care visits, increased cost, and death. Reducing polypharmacy can reduce the number of falls and subsequent debility.

Many elderly patients take medications without a clear indication. Often, drugs are not routinely assessed for continued need. Examples include long term use of proton pump inhibitors for a history of acid reflux, xanthine oxidase inhibitors for a distant episode of gout, and hormone replacement therapy in patients long past menopause. Studies of community-based older patients have documented an average of one unnecessary drug per patient, including drugs with no identifiable current indication or those that provide marginal benefit for the disease indication.

Additionally, the elderly often self-medicate, sometimes preferring supplements for health and medical conditions. A recent study showed analgesics, vitamins & dietary supplements are commonly self-administered by older adults. Dietary supplements may be viewed as benign by patients and providers, but can have major interactions with prescription medications. This view is problematic in the setting of polypharmacy and decreased organ function, and increases the risk for drug interactions and adverse effects.

Patient Centered Medical Home/Beers Criteria

The Patient Centered Medical Home (PCMH) is a healthcare delivery model recognized to improve the quality and efficiency of care while responding to each patient’s unique needs. This model focuses on a team approach, incorporating physicians, nurses, social workers, and pharmacists. The PCMH provides comprehensive, patient-centered care,
including acute care, chronic condition management, and preventative services to patients from childhood to end of life. The Beers Criteria is an evidence-based list of medications from The American Geriatric Society which helps identify the risk level of certain medications that can cause harm to elderly patients. The list includes common drug-drug interactions associated with harmful outcomes, and identifies drugs to avoid in patients with kidney impairment. A clinician can use this list to monitor medication use and recommend discontinuation, dose adjustments, and/or increased monitoring.

Pharmacy Medication Management: The Evolving Role of Pharmacist

Numerous studies demonstrate the benefits of clinical pharmacist interventions in the setting of polypharmacy. Medication therapy management (MTM) clinically integrates pharmacists in the PCMH in a variety of practice models. Physicians may be time-limited during office visits and unable to address polypharmacy or conduct comprehensive medication reviews. MTM is a comprehensive, patient-centered service that can enhance therapeutic outcomes while ensuring individualized care. MTM provides face to face patient education to review medication use, simplify medication regimens, and improve adherence.

MTM focuses on improving the quality of care in elderly patients, utilizing clinical guidelines and patient goals. The pharmacist reviews the patient’s medications, counsels the patient on proper administration and management of side effects, and educates the patient on non-pharmacological interventions. The pharmacist identifies potential concerns, and reviews the medical and relevant drug history to suggest a plan that meets the patient’s goals. After composing recommendations, the pharmacist discusses modifications with the physician to improve quality of life and prevent potential complications.

The role of the pharmacist is especially significant in chronic disease management. The pharmacist ensures that the patient understands short-term and long-term treatment goals, therapeutic monitoring, and possible adverse effects, and can alleviate patient knowledge gaps in understanding when complex treatments have been initiated by multiple physicians.

Medication Reconciliation

Medication errors frequently occur during transitions of care. Errors result when patients can’t recall home medications, and when records are unavailable. Medication reconciliation is a required process of creating a medication list for a patient during transitions of care. Medication reconciliation reduces the incidence and severity of medication errors during both prescribing and dispensing. Maintaining an up-to-date list and accounting for medication changes at every appointment helps to reduce inadvertent medication errors, and harm to the patient.

Screening tools are helpful in preventing medication errors in the elderly. The screening tool of older people’s prescriptions (STOPP) and screening tool to alert to right treatment (START) criteria recognize the dual nature of inappropriate prescribing by including a list of potentially inappropriate medications (STOPP criteria) and potential prescribing omissions (START criteria). Potentially inappropriate medications identified by STOPP criteria include digoxin, beta blocker with history of COPD, TCA with dementia, long-acting benzodiazepines, and prolonged use of first generation antihistamines. Potential prescribing omissions, defined as treatments indicated but not prescribed, by START criteria include ACE inhibitor following acute myocardial infarction, ACE inhibitor in chronic heart failure with no existing contraindications, statin therapy in patients with documented history of cardiovascular events, and ACE inhibitor or Angiotensin Receptor Blocker in diabetes with nephropathy. There is no evidence that using the START/STOPP criteria reduces morbidity, mortality, or cost in the geriatric population. However, these criteria may identify opportunities for better patient prescribing practices.

Comprehensive Geriatric Assessment

The geriatric assessment is a multidimensional tool intended to gather information on the medical, psychological, social, and functional abilities and restrictions of the elderly population. Areas to assess include current symptoms and their functional influence, current medications along with indications and effects, past allergies and medical conditions, recent life changes, current caregiver network, measure of cognitive function, nutritional status, and services required. It is important to inquire about demographics, patient’s chief complaint and present illness, past medical history, social history, daily nutritional health, physical activity, sleep hygiene, and recreational activities. It is useful to perform regular physical examinations and laboratory tests, and a thorough review of systems for every elderly patient.

Opioids and Controlled Substance Treatment Plans

Opioids are listed on the Beers Criteria due to increased risk
for falls, fractures, and potential interaction with other psychotropic medications. Despite this recommendation, elderly patients are frequently prescribed chronic opioids for nonmalignant pain. The use of prescription opioids has increased in older adults in the United States.\textsuperscript{26, 27, 28}

The elderly are at risk for adverse drug events due to opioid use, and they are not immune to opioid misuse and overdose. Compassionate care requires a delicate balance of undertreating pain and inappropriate prescribing. If opioids are deemed appropriate for long term use, providers must discuss benefits and risks, including side effects and potential for dependence or addiction.

Controlled Substance Treatment Plans should be formulated between the patient and physician, including goals of treatment, with a schedule for periodic evaluations. Non-pharmacologic treatments should be considered as alternatives or in conjunction with medications. Treatment plans should outline appropriate medication use and define medication misuse. Providers should address other medications that can interact with opioids and efforts should be made to minimize other central nervous system (CNS) modulating medications.\textsuperscript{28}

**Palliative Care**

Polypharmacy is common in patients at end of life. There is little guidance on appropriate discontinuation of medications in the setting of palliative care. The pharmacist and members of the palliative care interdisciplinary team should focus the conversation on the wishes of the patient and family, and create a plan of care consistent with the notion of “assess, anticipate and alleviate suffering.” All modalities aimed at comfort, including those on the Beers Criteria should be considered and offered; all other treatments should become elective or discontinued.\textsuperscript{29} Continuing unnecessary medications can increase harm to patients and add to the burden of polypharmacy, and providers should highlight the disadvantages of continuing medications.\textsuperscript{30} Medications such as aspirin or statins are particularly important in palliative care discussions.

**Specialty-based**

**Geriatrics:** Geriatric patients are often cared for by multiple specialists. When care is not coordinated between each provider, patients are at risk for polypharmacy, duplications in therapy, drug interactions and increased side effects.\textsuperscript{31}

**Oncology:** Cancer progression and treatment affect the overall quality of life, functioning, and life expectancy of older adults. Polypharmacy is a serious concern in cancer patients.\textsuperscript{32} Chemotherapy agents are associated with several adverse effects, including gastrointestinal abnormalities, peripheral neuropathy, hand and foot syndrome, and hypersensitivity reactions. In the setting of polypharmacy, toxicity and adverse effects may increase due to drug-drug interactions or metabolism-induced complications. This can lead to lack of adherence, treatment failure and suffering. A patient’s medications should be evaluated thoroughly to avoid therapeutic barriers and adverse consequences.

**Neurology & Psychiatry:** With each amendment of the Beers Criteria, there is a greater focus on antipsychotics, benzodiazepines, tricyclic antidepressants, opioids, and other CNS-impacting agents. Polypharmacy with multiple of these medications is risky and dangerous.\textsuperscript{28} When managing mental health and controlling pain in the elderly, it is imperative to evaluate each patient’s medications and ensure the use of CNS-impacting agents is limited to what is truly needed. Subjective assessment of a patient’s mental and pain status is essential to manage these medications, including listening to caregivers in patients with cognitive impairment.

**Cardiology:** Hypertension, atrial fibrillation, and heart failure are some chronic disease states commonly seen in the geriatric population necessitating the use of anti-hypertensives, nitrates, antiplatelets drugs, and anticoagulants. Cardiac medications have risks of bleeding, orthostatic hypotension, bradycardia, and falls that are often seen in the geriatric population. Therefore, polypharmacy requires special attention to ensure appropriate medications are prescribed, and adverse effects are managed. Patient education and monitoring are crucial to achieving treatment goals.

**Case Introduction**

Case #1

- Demonstrates the diversity of symptoms resulting from polypharmacy.
- Illustrates how fragmented care contributes to polypharmacy.
- Shows the “multiplier effect” of iatrogenic symptoms.

A 64-year-old female presented to her pulmonologist for evaluation of dyspnea. Her medications included diclofenac, cyclobenzaprine, and hydrocodone/acetaminophen from her chronic pain physician, clonazepam, nortriptyline, and...
Meet Ian Aguilar of Capital Analysts

Can you describe what Capital Analysts offers to the physician market?

We offer financial planning to younger physicians at a flat fee independent of their liquid assets, in an effort to grant them back more time, and elevate their values through the use of technology, open and clear communication, and advice around education-based expenses (i.e. student loan debt).

How does this benefit the doctors that use your services?

1. The flat fee offers comprehensive financial planning strategies to younger physicians who may not have a liquid portfolio large enough to garner a quality advisor elsewhere.

2. Our technology platform allows for seamless and real time financial planning, that brings peace of mind and ease of service.

3. Open & clear communication ensures that even though there is a different "language" in relation to financial terms, that everyone has a grasp of the overall financial plan, and that it jives with the clients wants & needs.

4. Education based expenses is a part of many younger physicians’ problem set. Whether it be for themselves via student debt, or planning college expenses for their children.

What are areas that doctors should pay attention to in the areas of financial planning that is particular to their profession?

Outside of the education piece, it’s the fact that many doctors are relied upon by many outside family members financially. The extent to which this happens and making sure that it doesn’t derail their own financial plans is a common issue.

I would never say don’t help out those who need it, but its hard to help others if your financial foundation isn’t sound.

What is your advice to doctors on what is important in handling their student loans?

I think it’s important to attack the issue as early as possible. If you are a resident you have a lot of options available to you that can help tremendously in order to set you up better over the long haul. Once you begin to make above a certain amount it becomes a little harder to do things creatively as it relates to financial planning.

Tell us about Capital Analysts, the firm.

We’re a small firm that is celebrating its 50th year anniversary this year. We pride ourselves on offering customized and objective advice and were part of the pioneering movement in Florida behind offering holistic financial advice rather than just financial products.

Why did you decide to focus on the MD market for your services?

I come from a physician household myself. My father, Jorge Aguilar, practices out at Jacksonville Beach, FL. I experienced first hand a lot of the predatory practices that financial professionals used to try and sell whatever they could. I wanted to offer physicians, particularly those in the first 10 years of their careers, sound advice that was meant to serve in their best interest over anything else.

How long have you been at Capital Analysts and what did you do before joining the company?

I joined Capital Analysts in the beginning of this year because they already served a large contingent of physicians and they understood the issues they face. They also serve in helping independent offices set up efficient retirement plans and employee benefits which wasn’t something I dealt with in my last job. Prior to joining Capital Analysts I worked as the lead investment advisor with a team at UBS that managed over a $1 billion in assets that was lead by Christopher Aitken, where we served around 40-45 Ultra High Net Worth families. In order to serve those who I felt a connection to most though, Capital analysts was the best fit for me.
What are the biggest differences in physicians using your service versus contacting other financial planning businesses?

I think thankfully our industry as a whole is moving towards comprehensive financial planning as the standard, and more and more individuals are garnering the Certified Financial Planning TM marks as time goes on which ensures that your advisor is legally required to work in your best interest and that they have certain level of competency. That is the low bar. But you always want to look for advisors who are attuned to your problem sets. Our fee schedule and services are geared towards doctors in their first 10 years of practice and I am well familiar with the common problem sets. I am well aware of the fact that time is held at a high premium for doctors, so gearing our service around that fact while still delivering top tier service is paramount.

How do you see your business and career evolving in the future?

We are a local group and we don’t view ourselves growing beyond our office here. We want to grow and cultivate relationships with a finite amount of clients and serve them to the best of our abilities. I view success as being able to grow clients into long term partnerships helping them achieve their long-term dreams. We also have a large focus on giving back to the community and would love to expand that aspect over time. We are currently gearing up for a 5k on Sept 29th supporting our local Dreams Come True organization which is dedicated to fulfilling the dreams of children with life threatening illnesses.

What is life like for you away from your business?

I’m a very family-oriented person. As I said previously my parents live here in town, as do my Wife’s parents so we often find ourselves spending our free time with both set of parents. I’m also a very avid Gators fan, along with being an even more avid Jaguars fan, so I find myself watching a lot of football on the weekends when I can. For those who are jaguar fans, “Myles Jack wasn’t down”.

Health Issues Linked to Hearing Loss...

CARDIOVASCULAR DISEASE
DEMENTIA & ALZHEIMER’S
DEPRESSION & ANXIETY
LONELINESS & ISOLATION
KIDNEY DISEASE
HOSPITALIZATION
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Voted Jacksonville’s #1 Diner
The past decade has seen an enormous upheaval in the practice of medicine. The private independent medical practice is in danger of extinction. Management overhead and red tape has skyrocketed due to government regulations and private insurance and pharmaceutical benefit rules. Added to that are multiple electronic medical records that need to be implemented, vary from one hospital to another, and often do not “talk” to one another. Thus, it would seem obvious that physicians are leaving their practices in large numbers. Perhaps. Perhaps not.

An April 5, 2017 Time Magazine article broke down retirement rates by professions. They charted the percentage of workers still working after age 65. It seems that this is an accurate yardstick to measure the issue. Topping the list of working professionals least likely to retire after 65, were tax preparers. 14.6 percent them were still working at age 66 and beyond. Pharmacists were at the bottom with only 4.3 percent. Although not near the top, physicians and surgeons were still in the top third at 8 percent. So why then do so many physicians resist retirement? I believe there are multiple reasons.

For many physicians, medicine is the only employment they have had in their adult life. Despite drops in salaries and autonomy, they still enjoy above-average wealth and income and may fear loss of this post-retirement. I fully retired three years ago. I have friends who still work and others who don’t. Illnesses play a role for sure. Some have few hobbies and fear boredom. That is a reasonable concern. Most of us are used to being respected by the public and inwardly fear that loss as well. My father, who had no hobbies, worked as an internist up until almost the day he died. Certainly, I am called “mister” a lot more these days than “doctor.” For me, however, there seemed to be a loss of “purpose.”

Victor Frankl’s famous 1946 book Man’s Search for Meaning has a great quote that goes something like this: “Your work is not your worth.” This is a concept that is difficult for many of us to accept and grasp. Although I spent most of my career in private practice, I always felt like a teacher. I would teach my patients, younger doctors joining the practice, nurses, and pharmacists. That all disappeared as soon as I retired. I write and read a lot. I like to fish and practice tai chi. I will soon become a tai chi instructor perhaps filling one need. A good fishing friend of mine who retired from sales and many years on the road and in the air, doesn’t understand why doctors are reluctant to retire. I don’t want to be judgmental, but for him he had a job. For many doctors, we feel as if we have a calling. For me, every other January is decision time. That is when my Florida medical license is up for renewal. Although the likelihood of me returning to active practice is low, the mere act of giving this up would mean that there really is no going back.

Lastly, the act of retirement brings into hard focus that this is indeed the “last stage” of one’s life. Although we deal with the death and dying of our patients daily, when it is “our” death and dying, well, that is a different matter. The hassles of corporate and industrialized medicine will continue to affect physician retirement rates. However, for many of those in the profession, the idea of life without medicine is just too scary to contemplate.

David Mokotoff is a cardiologist who blogs at his self-titled site, David Mokotoff. He is the author of The Moose’s Children: A Memoir of Betrayal, Death, and Survival.
A LOOK AT THE 2018 DCMS/NAVY DINNER

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KEYNOTE SPEAKER
Rear Admiral Bruce Gillingham, MD

CIRCLE OF EXCELLENCE AWARD
Alexandra Vance, PharmD

ADMIRAL PAUL KAUFMAN AWARD
Lisa Jones, MD
The air is just beginning to turn crisp. Cool air is slipping in to warn us of autumn's arrival. Cozy sweaters, crushed velvet and comfort food on the stove are overwhelmingly appealing to our senses. As fall drops its curtain bringing nightfall in its wake, evenings spent by a crackling fire with an exceptional glass of wine and your favorite socks are about all you have on your mind as you hasten out of the office, anxious to get home.

Yet not all evenings are whiled away in the quiet company of velvety red Bordeaux. The holidays are filled with grand sumptuous affairs that consume all of your November and December brain. Thanksgiving, Christmas, Hanukkah, and all the different festivities you may attend, or host, are crowding your calendar. Thankfully, we have the wine pairing survival guide to get you through.
**Creamy Pumpkin Alfredo by Yellow Bliss Road**

Heavier foods, like pasta and casseroles, pair well with acidic wines that can cut through the richness of the dish. Plates that you are dousing in gravy should be paired with unoaked Chardonnay from Chablis or red Gamay from Beaujolais. The acidity of these wines stands up to the richness of the meal and keeps the wine from going flabby under all the grease.

Side note on favoriting French regions - wines that hail from France lean towards more authenticity in representing the terroir they are extracted from. French standards are stricter than the United States and ensure the winemakers produce wines that represent the region, soil and weather. Over-extraction, over-oaking and pumping their vino with extra sugar are no-no's.

**I LATKES YOU A LOT: WINE PAIRINGS FOR SALTY FALL FOODS**

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**Fetta Zucchini Quinoa Fritters by Give Recipe**

Many of your holiday side dishes will be on the salty side and this is to your benefit. Salt and wine are a good match and salty dishes enhance many varietals. But you do want to ensure that the salt does not overtake the acidity in your wine. If you are heavy handed with the seasoning, then Champagne is the way to go. Champagnes are highly acidic and also refreshing when paired with foods that can balance them. If you're on the light side with salt then consider a Riesling. The sweet balances the salt and Riesling compliments spicy dishes as well, making it a great wine to have on hand.

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**Orange Honey Glazed Roasted Turkey Breasts by The Cozy Apron**

The main event and centerpiece of many holiday tables, turkey is a notoriously dry meat that, unless you fry it, will not be your juiciest dish. Therefore you want to avoid tannic wines with will dry out your mouth and procure the turkey’s sawdust taste elements. Zinfandel and Pinot Noir are classic pairings and granted, successful ones. But if you would like something a little bit off the beaten path, Austria has an under-appreciated red grape by the name of St. Laurent that produces smooth flavors of black raspberry and pleasant earthiness resulting in a lush red with low tannins. Drink young, as St. Laurent is not designed for aging.

Primitivo is another off-the-chart wine hailing from Southern Italy. If you look at the Primitivo family tree you will discover that it is actually related to Zinfandel through a Croatian grape called Crljenak Kastelanski. A fruit-forward wine, Primitivo beautifully showcases a taste profile of raspberry jam and earthy hints of clay.

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**Silky Smooth Pumpkin Pie by Smitten Kitchen**

Last but not least, dessert! This might be your easiest pairing as the main rule of thumb here is to pair sweet with sweet. Tawny Port is a great option as this incredibly sweet wine will completely change when you taste it next to an equally sweet desert. It bounces off the dish and becomes splendidly bitter in the most complimentary way. This pleasing bitter and sweet contrast is the same reason that black coffee also pairs well with dessert. (Not allowed until after wine by the way, as coffee diminishes your palate)

May all the food and wine you joyfully consume this season escalate your senses to new heights and provide your palate with a new appreciation for the science of food and wine pairing.
Pierre’s Eatery is a lunch and dinner spot with a unique story, an awesome partnership, and some delicious food, now open on the Southside at Butler and Phillips. Pierre himself hails from New York, from a neighborhood with a large Jewish and Muslim population. Pierre’s challenge in New York was to create delicious pizzas and pastas and strombolis without using any pork products at all. Not easy when we’re talking pepperoni, sausage, ham, and bacon! Luckily, Pierre found a small purveyor of all beef pepperoni and other pork free meats. Things were off and running at Pierre’s in New York. When Pierre moved to Florida and was opening a new restaurant he was faced with a conundrum. Should he find a new supplier for all his meats, or stick with the quality he knew he could rely on, even though pork would likely not be an issue? In the end, Pierre went with the quality pork free products he knew. It may seem like a non-issue, but Pierre’s pork free foods got him a golden opportunity. NAS Jax was looking for eateries for a food court style area on the base. The Navy is incredibly diverse with sailors of many religions and also food requirements. The fact that Pierre could run a restaurant with fresh, delicious pizzas and have everything be 100% pork free was a big draw for the Navy. So Pierre got the gig at NAS Jax. He also opened an eatery in downtown Jax, in Orange Park, and in the food court at the St. Augustine Outlets. Along the way Pierre’s Eatery joined forces with Jacksonville’s beloved Three Layers Cafe, formerly of Springfield. You can find fresh baked desserts and a coffee bar at the NAS Jax and St. Augustine Outlets Pierre’s Eatery locations, and now at the newest location on Phillips and Butler.

Pierre’s Eatery – Dinner is Served
No two Pierre’s Eateries are exactly alike, but there is always fresh dough made from scratch, simmered pizza and pasta sauce, fresh veggies, and pork free meats. We tried out the new Pierre’s location at Phillips and Butler and found it to be a great family friendly addition to the Jax restaurant scene. Its clean and streamlined layout was inviting, and we got a great sense of the ethos of Pierre’s from the decor. “Scratch made dough”, “No pork ever” and “Feed your soul” on the walls gave us a glimpse into the values of Pierre’s Eatery. We tried pizza, strombolis, salad, mac and cheese, and desserts. We saw some kids working their own dough, which the team then finished with sauce and toppings and baked into a pizza for the kidlets.

Pierre’s Eatery – Stuffed Pizzas and Strombolis
Let’s talk ‘scratch made dough’. We’ve eaten our share of pizzas around town. This dough was truly delicious. It had good flavor and a nice snap to it when you bit into a slice. We really loved the dough from the slice of pizza to the strombolis. The strombolis come with a cup of sauce for dipping, but you should ask for an extra cup because you’ll run out- it’s that good. We’ve had plenty of red sauces and this one was exceptional. It was rich and not bright tasting or tart as tomato sauces can sometimes be. One stromboli was “The Greek”- it had feta, spinach, mushrooms, and tomatoes. This was yummy and flavorful and great with the red sauce. The other stromboli was the pepperoni and sausage. It was fantastic. The saltiness of the meat was so nice with the gooey mozzarella and fresh dough.

Pierre’s Eatery – Greek Salad
So how was the pork free meat? Could we tell it wasn’t regular pepperoni? Well, we loved it in the stromboli, and we didn’t love it as much on the deluxe pizza. It was just more exposed on the pizza. It was noticeably less greasy than typical pepper-
oni, which most people would appreciate. The sausage was great on both the pizza and the stromboli. Would a restaurant draw me in by being pork free? It’s not something I’m particularly concerned about, but I’m just one person. There are plenty of people who would love to eat pork free pepperoni pizza, or a big ole meaty stromboli sans pork. Pierre’s Eatery is a great option and addition to Jacksonville.

Pierre's Eatery – Pizza By The Slice
We were delighted to see some of our favorites from Three Layers Cafe in the dessert case. We tried J Squares, which tasted exactly as sugary and gooey as we remembered. We tried Strawberry Cupcakes and Black and White Cupcakes, both of which thrilled us with yummy surprise fillings inside soft and luscious cake with rich frostings.

We savored all the offerings at Pierre's Eatery, from fresh pizzas and strombolis to a crisp salad to tasty desserts by Three Layers Cafe. This fast casual spot is great for lunch or a family friendly dinner, especially with its convenient location at the end of Butler Blvd on Phillips. We are so glad Pierre stuck to his guns on his supplier and is offering food nearly anyone in Jax can eat.

Pierre's Eatery – Dinner Spread
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