Strengthening the Doctor-Patient Relationship: A Spotlight on DCMS Member Dr. Linda Edwards

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Growing up in Jacksonville the older I get, the more I appreciate its diversity. Not only in culture, religion, and art; but in FOOD! On Saturday you can have Indian, Sunday Ramen, Monday Ethiopian, and on this fateful Tuesday my family and I were craving Irish food. For me there is only one place to go for Irish delights, and that is Culhane's Irish Pub & Restaurant. Luckily for us, and a good portion of Jacksonville residents, Culhane's just opened a second location, closer to me in the Tinseltown area; so on our way we went.

The original Culhane's is found near the beaches on Atlantic Boulevard, opened by four sisters straight from Ireland in 2005. The new restaurant resides in the old Tilted Kilt location and opened in October of last year. Being familiar with the first location, I was expecting much of the same food, aesthetic and atmosphere but I was pleasantly surprised walking through the heavy red painted wooden doors.

Culhane's is now a stand-alone building that packs a beautiful and unexpected surprise. The owners spared no expense when creating the new restaurant and you can feel it when you walk in. We stepped into a large open space and were greeted by the host. Right past the host stand is an ornate bar that could rival any establishment. There is plenty of seating and TVs are positioned above and throughout the restaurant to catch any sports game, be it futbol or football. Bottles upon bottles of alcohol line the walls behind the bar, backlit with a soft orange glow. I don't know if it was the anticipation of my future drink, or the actual beauty of the space, but it almost took my breath away.

We chose to sit at the regular tables in the middle of the packed restaurant. There were multiple games on and a TV in every corner. Our waiter was there in no time with a smile on his face and eager to welcome us. We started with a round of drinks, as always I got the Half & Half, which is Guinness and Harp. It took a few extra minutes to get our beverages, but I could tell how busy they were and understood. It just gave us spare time to decide what we wanted to order. The drinks arrived and mine had a beautiful separation of the dark rich stout on top and golden lager on the bottom. With a little more Guinness than Harp, it wasn't a perfect Half & Half, but I didn't mind.

Next we placed our order. With two appetizers to start, we got Karen's Scotch Egg ($9) and Lynda's Reuben Rolls ($10). Luckily the kitchen was on their A-Game and there was little wait for our first course. To tease my senses, I could smell the Scotch Egg well before it hit the table. Served on a square plate, the Scotch Egg perched atop a heaping mound of mashed potatoes swimming in a demi gravy. I could tell the demi was homemade, with no corners cut. No box gravy or bullion was used to make the sauce; you could taste the love put into it. It also had a nice kick from the hot mustard drizzle. Traditionally a Scotch Egg is a hard-boiled egg wrapped in sausage, breaded and deep fried. Unfortunately the hard-boiled egg in our appetizer was overcooked and slightly dry. The sausage
was still moist and full of flavor and bread crumbs were perfectly crunchy. Overall, I would order it again, as it is rare to find a Scotch Egg in Jacksonville, but only after I tried the other appetizers.

The Reuben Rolls were an interesting and delicious twist on a classic. Think of it as if an Asian eggroll and a Reuben sandwich had a baby. Gourmet corned beef, sauerkraut and Swiss cheese are expertly mixed and rolled into eggrolls. Served with Culhane’s famous hot mustard, these eggrolls were perfectly fried. Two eggrolls were cut in half, long ways served on the same square plate. Crispy, salty, spicy and full of corned beef deliciousness, this appetizer definitely outshined the Scotch Egg and I would order it again, no questions asked.

Culhane’s Irish Pub & Restaurant – Dingle Fish Pie
We were excited and ready for our main course. Our waiter was prompt and helpful, out with our dinner shortly after we were finished with our appetizers. We ordered the Banger’s N’ Mash ($14), Drunken Cheesesteak ($12) and Dingle Fish Pie ($15). I’ve enjoyed the Dingle Fish Pie before and find myself ordering it again and again. This “pie” consists of large flaky chunks of cod, salmon and shrimp bathing in a sea of parmesan cream sauce, peas and potatoes. A hearty layer of cheese is melted on top and served with toast points. This time I did find the sauce thinner than I remember it being, but still creamy and packed with seafood and veggies. The dish overall lacked salt for me, but I am known to prefer heavier salted foods. It was an easy fix to salt my own dish at the table. Although this time my Dingle Fish Pie was a little under seasoned and sauce thin, I would absolutely order it again, but only knowing this was probably due to the kitchen being busy on this particular night. For me, it has always been a completely satisfying dish: creamy, cheesy, and filling.

My sister ordered Culhane’s take on a Philly Cheesesteak, the Drunken Cheesesteak. Guinness marinated beef, sautéed mushrooms, peppers and onions are covered in cheese, nestled into a Cinotti’s hoagie. Served with steak fries, this sandwich didn't impress me much. The cheesesteak needed more aioli or some other element to elevate this plate. Otherwise, it was just the same ole meat and veggies in some bread. The thick cut fries were the best part (I also may enjoy ketchup too much). I understand they are trying to reach a broader audience and throw in some “familiar” dishes like a cheesesteak or burger, but Jacksonville isn’t Philly and a Philly Cheesesteak isn’t Irish. I completely respect what they are trying to do, but I didn’t come to an Irish restaurant to eat anything but Irish bites.

With few restaurants offering Irish fare in Jacksonville, my family has been going to Culhane’s Irish Pub & Restaurant for years. The second location is a welcomed addition to the Tinseltown area and when you have four sisters from Ireland running their team, it is sure to be a win. And although I appreciate offering approachable plates that will make even the fussiest of diners happy; the authentic Irish dishes are the way to go here. If a trip to Ireland isn't in the budget, the next best thing is their Banger’s N’ Mash, Shepard’s Pie or Corned Beef N’ Cabbage.

Culhane’s Irish Pub & Restaurant
9720 Deer Lake Ct
Jacksonville, FL 32246

Melissa Nolan was born and raised in Jacksonville, FL and graduated from Florida State University where she earned her Bachelor of Arts in Business Hospitality. From there she attended Johnson & Wales of Charlotte, NC and following an internship at Thomas Keller’s prestigious Per Se, graduated with her Culinary Degree. After New York she moved back home and currently works in the San Marco area.
Technology and medicine have gone hand and hand for many years. Consistent advances in pharmaceuticals and the medical field have saved millions of lives and improved many others. As the years pass by and technology continues to improve, there is no telling what advances will come next. Here are the top 10 new medical technologies in 2019:

10. Smart inhalers
Inhalers are the main treatment option for asthma and if taken correctly, will be effective for 90% of patients. However, in reality, research shows that only about 50% of patients have their condition under control and as many as 94% don't use inhalers properly.

To help asthma sufferers to better manage their condition, Bluetooth-enabled smart inhalers have been developed. A small device is attached to the inhaler which records the date and time of each dose and whether it was correctly administered. This data is then sent to the patients’ smartphones so they can keep track of and control their condition. Clinical trials showed that using the smart inhaler device used less reliever medicine and had more reliever-free days.

9. Robotic surgery
Robotic surgery is used in minimally invasive procedures and helps to aid in precision, control and flexibility. During robotic surgery, surgeons can perform very complex procedures that are otherwise either highly difficult or impossible. As the technology improves, it can be combined with augmented reality to allow surgeons to view important additional information about the patient in real time while still operating. While the invention raises concerns that it will eventually replace human surgeons, it is likely to be used only to assist and enhance surgeons’ work in the future. Read more about robotic surgery here.

8. Wireless brain sensors
Thanks to plastics, medical advances have allowed scientists and doctors to team up and create bioresorbable electronics that can be placed in the brain and dissolve when they are no longer needed, according to PlasticsToday.com. This medical device will aid doctors in measuring the temperature and pressure within the brain. Since the sensors are able to dissolve, they reduce the need for additional surgeries.

7. 3-D printing
If you haven't heard, 3-D printers have quickly become one of the hottest technologies on the market. These printers can be used
to create implants and even joints to be used during surgery. 3-D printed prosthetics are increasingly popular as they are entirely bespoke, the digital functionalities enabling them to match an individual’s measurements down to the millimetre. The allows for unprecedentedly levels of comfort and mobility.

The use of printers can create both long lasting and soluble items. For example, 3-D printing can be used to ‘print’ pills that contain multiple drugs, which will help patients with the organisation, timing and monitoring of multiple medications. This is a true example of technology and medicine working together.

6. Artificial organs
To take 3D printing up another notch, bio-printing is also an emerging medical technology. While it was initially ground-breaking to be able to regenerate skin cells for skin draughts for burn victims, this has slowly given way to even more exciting possibilities. Scientist have been able to create blood vessels, synthetic ovaries and even a pancreas. These artificial organs then grow within the patient’s body to replace original faulty one. The ability to supply artificial organs that are not rejected by the body’s immune system could be revolutionary, saving millions of patients that depend on life-saving transplants every year.

5. Health wearables
The demand for wearable devices has grown since their introduction in the past few years, since the release of Bluetooth in 2000. People today use their phone to track everything from their steps, physical fitness and heartbeat, to their sleeping patterns. The advancement of these wearable technologies is in conjunction with rising chronic diseases like diabetes and cardiovascular disease, and aim to combat these by helping patients to monitor and improve their fitness.

In late 2018, Apple made headlines with their ground breaking Apple Series 4 Watch that has an integrated ECG to monitor the wearer’s heart rhythms. Within days of its release, customers were raving about the life saving technology, which is able to detect potentially dangerous heart conditions much earlier than usual. The wearable devices market is forecast to reach $67 billion by 2024.

4. Precision medicine
As medical technology advances it is becoming more and more personalised to individual patients. Precision medicine, for example, allows physicians to select medicines and therapies to treat diseases, such as cancer, based on an individual’s genetic make-up. This personalised medicine is far more effective than other types of treatment as it attacks tumours based on the patient’s specific genes and proteins, causing gene mutations and making it more easily destroyed by the cancer meds.

Precision medicine can also be used to treat rheumatoid arthritis. It uses a similar mechanism of attacking the disease’s vulnerable genes to weaken it and reduce symptoms and joint damage.

3. Virtual reality
Virtual reality has been around for some time. However, recently, with medical and technological advances, medical students have been able to get close to real life experience using technology. Sophisticated tools help them gain the experience they need by rehearsing procedures and providing a visual understanding of how the human anatomy is connected. The VR devices will also serve as a great aid for patients, helping with diagnosis, treatment plans and to help prepare them for procedures they are facing. It has also proved very useful in patient rehabilitation and recovery.

2. Telehealth
In a technologically driven world, it’s thought that as many as 60% of customers prefer digitally-led services. Telehealth describes a quickly developing technology that allows patients to receive medical care through their digital devices, instead of waiting for face-to-face appointments with their doctor. For example, highly-personalised mobile apps are being developed which allow patients to speak virtually with physicians and other medical professionals to receive instant diagnosis and medical advice.

With oversubscribed services, telehealth gives patients different access points to healthcare when and where they need it. It is particularly useful for patients managing chronic conditions as it provides them with consistent, convenient and cost-effective care. The global telemedicine market is expected to be worth $113.1 billion by 2025.

1. CRISPR
Clustered Regularly Interspaced Short Palindromic Repeats (CRISPR) is the most advanced gene-editing technology yet. It works by harnessing the natural mechanisms of the immune system of bacteria cells of invading viruses, which is then able to ‘cut out’ infected DNA strands. This cutting of DNA is what has the power to potentially transform the way we treat disease. By modifying genes, some of the biggest threats to our health, like cancer and HIV, could potentially be overcome in a matter of years.

However, as with all powerful tools there are several controversies surrounding its widespread use, mostly over humanity’s right to ‘play God’ and worries over gene-editing being used to produce hordes of designer babies. CRISPR is still a first-generation tool and its full capabilities are not yet understood.
A self-described “country girl,” Dr. Linda Edwards grew up in a small town in North Carolina called Rural Hall with a population of about 2,000. It was during those formative years that she learned the importance of family, specifically during Sunday afternoons at her grandparent’s home.

“My grandmother, with the help of her daughters and daughters-in-law, would put on a big spread for Sunday lunch after church,” she recalled. “After those Sunday lunches, my cousins and I would play flag football or softball. I am thankful for my family and the love that we shared. My mom and dad enjoyed sports as well and would play with my cousins and me. Mom was a great left-handed basketball player and would challenge us to a game of HORSE. Dad loved volleyball and softball so those Sunday afternoon games usually had an adult sneak in to play!”

Now serving as the Senior Associate Dean for Educational Affairs and an Associate Professor for the Department of Medicine at the University of Florida College of Medicine in Jacksonville, you might be surprised to learn Dr. Edwards didn’t always plan to be a physician.

While she always had a strong interest in science (her undergraduate degree from UNC-Greensboro was in biology), she didn’t decide to pursue medicine until she was a junior in college. At that time, she was taking graduate level courses in microbiology and virology in anticipation of a career in the microbiology lab. Her advisor saw strong promise and suggested that she consider medical school.

“He shared with me that he thought that I would be more fulfilled interacting with patients than sitting in the lab “behind a microscope!” Dr. Edwards remembered. “So, I took his advice and took the MCAT and applied to medical schools.”

Turns out it was the right decision. Dr. Edwards was in the first class to graduate from the four-year medical school at East Carolina University in 1981. Her class at ECU was small, only 28 students.

“In one respect we were ‘in a fishbowl’ being scrutinized by many since we were the first class of a new school,” Dr. Edwards recalled. “However, because we were the first class and because many of the residency training programs that are part of medical schools were just beginning to recruit, we had a tremendous clinical experience.”

She remembers a fantastic learning environment with faculty and residents who were very involved in her training. As a student on surgical rotations, she was scrubbed in for numerous cases and given the opportunity to participate at the level a surgery resident would be allowed to participate.

“It was great! So, you might think that I would have pursued surgery as a career. But internal medicine was a better fit for me,” she said. “I certainly did not enter medical school with a pre-determined idea of what discipline I would pursue. I can honestly say that I enjoyed all of my clinical rotations as a third- and fourth-year student! When I look back, I think my choice was the right one for me and I would do it again!”

Upon graduation from medical school, Dr. Edwards moved to Jacksonville to complete an internal medicine residency and also served as chief medical resident from 1984-1985. The UF College of Medicine training programs in Jacksonville at that time were JHEP, Jacksonville Health Education Programs. Dr. Edwards completed her residency and chief residency and joined the faculty of the Department of Medicine at what was then JHEP. For many years, she served as program director for the internal medicine residency. In the 90s, she was appointed Chief of the Division of General Internal Medicine and she still continues in that role today! In 2013, she was also appointed Senior Associate Dean for Educational Affairs.
Medicine has changed a lot over the years, and technology, particularly the electronic health record, is one of the biggest changes. Dr. Edwards notes that it’s had both a positive and negative impact, particularly with the doctor-patient relationship, which is critical to patient care.

“The relationship develops trust between the provider and the patient and is critical to their care. This trust that develops impacts the patient comfort in providing necessary information to their provider and impacts patient compliance,” she said. “The introduction of the EHR has, in many instances, eroded that relationship. Physicians are so focused on checking the right box and picking the right "smart phrase" that they forget there is a patient in the room!”

“On the positive side is that information is literally at your fingertips. Providers have dashboards that allow them to compare their practice to others and against national quality metrics. They receive reminders to ensure that preventive measures are taken and immunizations are given. Nothing new here, but the EHR has contributed to physician burnout and frustration. We need to figure out how to make the EHR work for us!”

While it was not part of her medical or residency training, Dr. Edwards is thrilled about the use of simulation that now prepares students and residents for clinical scenarios they will encounter. Interprofessional team care has also become a critical component of the practice of medicine.

“Physicians are learning to not only be the leaders of teams but to be a member of the team when another professional is the more appropriate leader,” she stated.

In her role as Senior Associate Dean for Educational Affairs, Dr. Edwards is responsible for graduate medical education at UF. The College of Medicine has 35 ACGME (Accreditation Council for Graduate Medical Education) accredited programs and two CODA (Council on Dental Accreditation) accredited programs. There are approximately 350 residents and fellows completing their graduate medical education at UF in Jacksonville.

“It is a privilege to be involved in the training of the future physician workforce,” Dr. Edwards said. “But it is daunting as well, because of the evolving technology and the need to prepare our young physicians for their future practice. And as physician educators we must not only graduate competent and caring physicians but we must also ensure that the physician workforce is a healthy one as well, addressing physician well-being and burnout. Burnout and wellbeing were not issues that were addressed when I trained, although very likely an issue, just not one discussed or addressed.”

Dr. Edwards acknowledges that a variety of people influenced her medical career and still continue to inspire her today. Professionally, Dr. Malcolm Foster was Associate Chair of Medicine when she began her training in Jacksonville. Dr. Foster served as both a mentor and advocate throughout the years.

“Dr. Foster shared with me early on that it was important to give back to your community and to your family,” she said. “His insight has proven valuable over the years and I thank him for his counsel.”

Dr. Yank Coble also served as an advocate and mentor, particularly encouraging her to become involved in the Florida Society of Internal Medicine and the American Society of Internal Medicine, organizations that merged with the American College of Physicians several years ago. Dr. Coble was also instrumental in her appointment to the Residency Review Committee for Internal Medicine of the ACGME. More recently, Dr. Arshag Mooradian has become a valuable mentor, fostering her growth as a leader and providing encouragement and support in her various roles at UFCOM-Jacksonville.

Personally, Dr. Edwards’ brother has been a tremendous influence and role model.

“Although younger, I have always looked up to him,” she noted. “He is a humble servant leader.”

Perhaps most importantly, she is thankful for her husband who serves as a sounding board and a great source of strength and comfort.

“He is the levelheaded one in the family and offers great wisdom,” she said.
Although the majority of her work time is spent as Senior Associate Dean for Educational Affairs, Dr. Edwards also still has a limited practice. In 2005, she worked with pediatrician Dr. David Wood to establish a transition clinic for adolescents and young adults with chronic medical conditions, including intellectual and developmental disabilities. Out of that program, JaxHATS (Jacksonville Health and Transition Services), came a new program, Program for Adults with Intellectual and Developmental Disabilities (PAIDD). This is a primary care home for adults with ID and DD.

“This is an underserved patient population in our community, as well as nationally,” Dr. Edwards noted. “It is a very gratifying experience and I am humbled and honored to care for this group of adults. Since this is such a unique clinical experience, medical students form UFCOM Gainesville, as well as internal Medicine residents from our internal medicine residency spend time with me in this clinic. They too find the clinical experience to be a rewarding one and quite different from their usual primary care experience.”

Over the years, Dr. Edwards has been involved with a variety of organizations in the Jacksonville community. She has previously served on the board of Hubbard House and currently serves on the Pine Castle Board of Directors. The organization provides services for adults with intellectual and developmental differences and Dr. Edwards has found it very rewarding to advocate for these individuals.

No matter who your patient might be, Dr. Edwards lives by the notion that the doctor-patient relationship is key.

“That aspect of medicine is what keeps me going,” she said. “I have patients that I have taken care of for 35 plus years! As these patients and I say, ‘we’ve been taking care of one another for a long time!’”

When she’s not working, you’ll typically find Dr. Edwards enjoying the outdoors. She enjoys jogging, the opportunity to clear her head and stay in shape. She also describes herself as a beach person, a title she found after moving to Atlantic Beach just nine months after she first arrived in Jacksonville in 1981. Being near and on the water brings great joy.

“When I met my husband, one of our first dates was on his sailboat, a 31-foot Beneteau, named Cabernet,” she recalled. “We love to sail and have had several sailboats over the years. We currently have a Bavaria monohull that we keep in town on the river. Sailing on the Lizzie Marie, named after our mothers, is another way we decompress and enjoy the outdoors. We love getting friends together on the boat for Saturday or Sunday afternoon sails. And sunsets on the river are pretty spectacular!”

Drawing on her childhood, Dr. Edwards still loves being around her family. Her brother lives in Boone with his wife and she has a niece and two nephews. While her husband and her do not have any children, she loves being an Aunt and considers her residents and fellows as family, as well.

“I laugh and say that I have about 350 children from work,” she jokes. “I am pretty sure that they would not find this amusing!”

Loving your career is one of the best dreams you can have and Dr. Edwards is fortunate to be in that position. She plans to continue her involvement in graduate medical education, as well as continuing to serve adults with ID/DD.

“Being involved in training and preparing the next generation of physicians is so important and staying involved keeps me young!”
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Luxury Resorts + Kid-Friendly are not two words you often see together but thanks to millennial parents who value experiences over things & Gen Xer’s continuing to dominate the luxury family travel market top brands are taking notes and making changes with their youngest guests in mind. Recently, I asked 30+ top family travel experts, globetrotting families, and nomadic parents to tell me about their very favorite kid-friendly luxury resorts and here are the results.

Grand Wailea- Maui, Hawaii
I mean what could be better than a pool area that is 2,000-feet-long, 770,000-gallons of water and consists of nine pools on six different levels connected by waterslides? Get to the bottom and the world’s first WATER ELEVATOR will take you back to the top. YUP! It’s pretty great. This luxury resort is one of my personal favorites and it’s one of the munchkins favorites too.

Beach Club Villas- Orlando, Florida
Disney knocks it out of the park when it comes to luxury resorts for families. They have quite a few resorts in Orlando specifically that come to mind, but there is one in particular that we are suckers for, Disney’s Beach Club. An incredible sand-bottomed pool, the cute boats that transport it’s guests to both Epcot & Hollywood Studios (you can also walk to both parks from this resort), plus the cute little lake and boardwalk behind the resort & the over-accommodating staff wrapped up in an adorable cape cod aesthetic- it’s pretty hard to resist.

Terranea Resort- Palos Verdes, California
Terranea is classic California elegance at its best… but being near a beach it is also laid back enough for you to feel more than comfortable toting munchkins along. Our kiddos love the waterslides, pools, splash pad and unique kid's activity offerings like falconry.

They also have a fun brunch on the weekends where our little munchkins enjoyed freshly made doughnuts and a waffle bar complete with m&m's. Mom's don't forget to book a session at the spa its AH-MAZING!!

Margaritaville- Hollywood Fl.
One of the newest additions to this list is Margaritaville in Hollywood Fl. I was knocked off by this amazing resort. The grounds are absolutely stunning, there is a flow rider for the kids and the kids club is FREE!

In addition, I loved the location of this resort as it was right on the boardwalk, plus at Margaritaville, they have free bike rentals so you can cruise on down the boardwalk. For those who love food, Margaritaville had some of the best food I have ever had in a hotel. This place is definitely worth a visit and truly one of the best luxury resorts for families.

Biltmore Estate- Asheville, North Carolina
Leigh Powell Hines of HinesSightBlog states, “Biltmore Estate in Asheville, N.C is the state's largest tourist attraction. It's majestic. The food is farm-to-table fabulous, and the scenery is breathtaking. It's certainly a must-see for the first-time Asheville visitor, but it's also a place where North Carolinians and locals want to frequent often.

The estate offers horseback riding, biking, hiking, fly-fishing, Segway tours, fishing, and water activities. It's an 8,000-acre outdoor playground for all ages. Curators have made mansion tours...
fun for kids by creating a scavenger hunt and a special audio tour. With four distinct seasons that the estate promotes, it’s easy to visit this Asheville landmark all year. Antler Hill Village is especially fun for families because of the working farm and delicious creamery. The Inn at Biltmore and the Village Hotel offer complimentary shuttle around the estate.

Grand Hyatt- Kauai, Hawaii
Sara Wellensiek of MomEndeavors says, “Situated on Kauai’s driest south shore, the Grand Hyatt Kauai Resort & Spa is an idyllic place for families. Not only is Kauai, Hawaii a fabulous destination in itself, but the breathtaking hotel property really makes it feel like you’re in a luxurious tropical paradise.

There are lush gardens, tropical plants, and palm trees at every turn. In addition to beautiful flora, animal lovers will enjoy koi feeding, wildlife walks, and "parrot time" with one of the colorful hotel residents. Everyone in the family will love spending ample time at the variety of pools here – it’s really the star of this property.

Not only does the resort sit on 50 oceanfront acres (though swimming here isn’t recommended), there is an incredible system of pools and lagoons. This large water system features lava-rock lined lazy river pools, waterfalls, a 150-foot waterslide (for anyone over 42), and a massive 2 million gallon saltwater lagoon. It’s perfect for all kinds of family fun in a gorgeous tropical setting.

Boar’s Head Inn, a 3,000-acre resort in the foothills of Virginia’s Blue Ridge Mountains, is our family’s favorite. The resort takes full advantage of its setting, with nature trails for hiking and biking, a small lake for fishing and an Audubon-certified golf course. In the summer, take a hot air balloon ride! The award-winning racquet and fitness club and three pools provide more options to stay and play.

Four restaurants provide a variety of dining options — dinner at the Old Mill Room is a must! For busy parents, the full-service spa offers the ultimate in relaxation. What makes Boar’s Head Inn so special, though, is not the amenities but the staff. They offer warm hospitality, an appreciation for the history of this beautiful resort and expert knowledge to make every experience here special. Go. Play. Relax.

Four Seasons Scottsdale- Arizona
Colleen Lanin founder of TravelMamas recommends Four Seasons Scottsdale. She says, “Tucked away in the Sonoran Desert next to the Pinnacle Peak granite summit, Four Seasons Scottsdale is where to go to escape it all. The exquisite landscaping at this resort will make you fall in love with the desert’s beauty.

This hotel features three pools – one for tots, one for all ages, and one just for grown-ups. Plus, there is a whirlpool for soaking. Staff just may stop by these watery oases with complimentary homemade chocolate-dipped granola bar bites, frozen grapes, or strawberry smoothies. Up the luxe factor with a Deluxe Cabana, complete with a kid-friendly stocked bar, 40-inch flat screen TV, and selection of board games and reading materials.

On summer weekends, the resort plays family-friendly movies poolside so you can float while you watch. Kids for All Seasons will entertain children ages 5 to 12 while parents relax at the onsite spa, play a tennis match, or hit the links at the nearby Troon North Golf Club. There really is something for all ages at Four Seasons Scottsdale.”

Montage Deer Valley- Utah
Allison Dover Laypath of TipsForFamilyTrips states, “There are lots of fun things to do in Park City, Utah, but my family found so many activities during our weekend at Montage Deer Valley, we never left the resort. Montage Deer Valley is a ski-in, ski-out luxury resort that offers an impressive array of family activities. Kids are invited to choose a stuffed animal at check-in that represents the native species that live in the mountains surrounding the resort. During your visit, ask the concierge about the complimentary Montage Merits program where kids earn pins for participating in the resort and local activities like skiing, snow tubing, hiking, mountain biking, archery, and bowling.

This luxury resort is truly for families as it has its own bowling alley, video game arcade, indoor and outdoor pools, spa, restaurants, equipment rental and family marshmallow roasts. Montage Deer Valley is also an excellent choice for a romantic trip without the kids.”
Hello, and welcome to my periodic dig through the samples pile. I’m pleased to bring you the latest installment of Vinography Unboxed, where I highlight some of the better bottles that have crossed my doorstep recently.

This week included a really lovely riesling from the recently anointed Petaluma Gap AVA in Sonoma, just across the top of the San Francisco Bay. Made by Dutton Goldfield it has a wonderfully dry citrus crackle to it.

Dutton Goldfield also sent through one of their classic Chardonnays from their estate property in the Russian River. It’s pretty much a bullseye for those looking for the latest (more restrained) version of California Chardonnay.

Sticking with the Chardonnay theme, I’ve got a bottling from one of the Russian River Valley’s best vineyards, the Ritchie Vineyard, by Ten Acre. It’s a little awkward, but still a pleasurable glass of Chardonnay.

Headed towards red, let’s pause for an hour of sun on the porch with the Frescobaldi rosè named Alie, which begs to be ice cold and consumed in copious quantities. With the Tuscany IGT designation you might expect this wine, especially from a producer like Frescobaldi to be made of Sangiovese, right? But if you guessed that, as I did, you’d be dead wrong. It’s a blend of Syrah and Vermentino, of all the crazy combinations, and you know what? It’s fantastic. And with a bottle styled not unlike the Miraval rosé made by Brad Pitt and Angelina Jolie, my guess is that it is a hot commodity.

Moving on to red wines, this week featured two of Napa’s royalty, starting with the Cardinale Cabernet Sauvignon, showing its typical lush density thanks to the experienced hand of winemaker Chris Carpenter.

Next we had the Spottswoode Estate Cabernet, which is among my favorite Napa Cabernets for its impeccable balance and deep complexity.

This week also saw a couple of wines from the Aridus Wine Company in Wilcox, Arizona. One of them, a Syrah from Arizona, is quite pretty, while the other, an “American” designated Malbec made with New Mexico fruit has a surprising stony aspect. All these and more below.

2017 Dutton Goldfield “Chileno Valley Vineyard” Riesling, Petaluma Gap, Sonoma, California
Near colorless in the glass, this wine smells of tangerine zest and Asian pear. In the mouth, positively brisk flavors of Asian pear and mandarin oranges snap and crackle across the palate thanks to excellent acidity. A faint chalky flavor and texture emerges on the finish along with notes of citrus peel. Crisp and tasty. 13.5% alcohol. Score: between 8.5 and 9. Cost: $30. click to buy.

2017 Dutton Goldfield “Dutton Ranch” Chardonnay, Russian River Valley, Sonoma, California
Palest gold in color, this wine smells of buttered popcorn and cold cream. In the mouth, lemon curd and buttered popcorn flavors have a zippy crackle thanks to excellent acidity, and a nice
2015 Ten Acre “Ritchie Vineyard” Chardonnay, Russian River Valley, Sonoma, California
Pale gold in the glass with a slight haze, this wine smells of cold cream and melted butter. In the mouth, wonderfully saline notes of melted butter, cold cream and lemon zest have an almost searing acidity to them that leaves a citrus pith bitterness in the finish along with a little alcoholic heat. Feels slightly imbalanced. 14.4% alcohol. Score: around 8.5. Cost: $55. click to buy.

2017 Frescobaldi Tenuta Ammiraglia “Alie” Rosé, Tuscany, Italy
Palest baby pink in color, this wine smells of berries and tropical flowers. In the mouth, crisp and bright berry and watermelon flavors have a nice zing thanks to excellent acidity. Light and bouncy and quite delicious, this is everything you want in a rosé, with a kick of minerality in the finish. 12.5% alcohol. An unusual blend of Syrah and Vermentino. Score: around 9. Cost: $22. click to buy.

2015 Cardinale Cabernet Sauvignon, Napa Valley, Napa, California
Very dark garnet in the glass, this wine smells of rich cherry fruit. In the mouth, lush and bright cherry fruit has a wonderful aromatic sweetness and mixes with cola and cocoa powder. Dark chocolate notes linger in the finish along with dusty tannins. Very pretty and polished. 14.5% alcohol. Score: between 9 and 9.5. Cost: $295. click to buy.

2015 Spottswoode Estate Cabernet Sauvignon, St. Helena, Napa, California
Very dark garnet in the glass, this wine smells of cedar, tobacco, cherry and pencil lead. In the mouth, gorgeous flavors of pencil lead, cherry, cola and a touch of herbs are wrapped in a fleecy blanket of tannins that flex their musculature as the wine finishes with floral notes and great depth. Outstanding, and worthy of 5-15 years in the cellar. 14.4% alcohol. Score: around 9.5. Cost: $225. click to buy.

2014 Domaine de la Terre Rouge “Les Cotes de L’Ouest” Syrah, California

Medium garnet in the glass, this wine smells of bloody steak, dried flowers and cassis. In the mouth, cassis and black cherry have a wonderful deep earthy backbone and excellent acidity. Savory notes of herbs emerge on the finish that seems to ooze out of the felt-like tannins that coat the mouth. 14.5% alcohol. Score: between 8.5 and 9. Cost: $24. click to buy.

2017 Aridus Wine Company “Limited Production” Malbec, Arizona
Very dark garnet in color, this wine smells of earth and herbs and blackberries. In the mouth, blackberry pie flavors have a nice brightness to them thanks to excellent acidity as faint muscular tannins build strength through the finish. Only a tiny bit of bitterness betrays the 15.8% alcohol. Score: around 8.5. Cost: $37.
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3 - Do No Harm: Documentary on Physician Suicide Coming to Jacksonville

4-8 - CME: Response to Changes in HB21, Controlled Substance Prescribing

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Do No Harm: Documentary on Physician Suicide Coming to Jacksonville

By Bryan Campbell, DCMS Chief Executive Officer

Those three words are so simple: Do no harm. Yet the field of medicine and medical ethics is littered with examples of conundrums and difficult decisions. In fact, you might consider it ironic the amount of time and effort physicians and their institutions spend on those three little words, without looking inward at the effect on the physicians themselves.

It is no secret that physician burnout is at epidemic proportions. The Medscape National Physician Burnout, Depression & Suicide Report 2019 shows that 44% of physicians self-report as burned out, while 15% report that they are depressed. The list of factors range from bureaucratic tasks and electronic health records, to reduced reimbursement and noncompliant patients.

 Sadly, physicians are now at the highest risk of suicide of any profession in the United States. Physicians are twice as likely to commit suicide as the general population. Unfortunately, this trend doesn’t culminate from years of enduring the grind of the profession. Signs of burnout and suicide begin in medical school.

Documentary filmmaker Robyn Symon, a Florida native who grew up in a family of doctors, decided to explore the phenomenon of physician suicide starting with medical school. The result: a new film entitled Do No Harm: Exposing the Hippocratic Hoax. The film takes a look at the high-pressure culture of Graduate Medical Education in the United States and explores how some say it harms the very individuals that it’s meant to train.

Close to Home

The issue of physician suicide hits close to home here in Duval County. Five physicians in the community have taken their own life in the past two years. UF Health Jacksonville initiated a bold new initiative to create access to counseling for its physicians following the loss of a member of the medical staff in 2017. Additionally, the Duval County Medical Society (DCMS) Foundation has created the LifeBridge Physician Wellness Program, which has received national recognition.

That’s why UF Health Jacksonville, the DCMS, and Orange Park Medical Center have teamed up to invite Symon to screen Do No Harm here in Jacksonville on April 23rd. The screening will be free to anyone interested in attending. Please RSVP to David.Chesire@jax.ufl.edu. Following the screening of the film, there will be a question and answer session featuring Symon and leaders from the local medical community on how we can tackle this epidemic moving forward.

“I am so excited to be bringing DO NO HARM to my home state of Florida,” says Symon. “It is truly encouraging to see the leadership at UF Health Jacksonville, the Duval County Medical Society, and Orange Park Medical Center showcase this film and take the lead in making physician wellness a top priority in your community.”

Who: All Are Invited
What: Screening of the film DO NO HARM
When: April 23 at 6:00 pm
Where: UF Health Jacksonville, LRC Auditorium
Cost: Free
RSVP: David.Chesire@jax.ufl.edu

The issue of mental health in our medical community will also be a significant part of the 2019 Future of Healthcare Conference presented by the DCMS and DCMS Foundation. The annual conference is an opportunity for the medical community, local non-profits, and local government officials to actively address predominant public health issues facing our community.

Symon will be among those presenting at the Future of Healthcare Conference. Other notable speakers include Patrice Harris, MD, President of the American Medical Association, Ronald Giffter, MD, President of the Florida Medical Association, and many more.

The Future of Healthcare Conference will take place October 7-8 at the Prime Osborn Convention Center in downtown Jacksonville. Early bird registration is now open.

Our Mission

The mission of the Duval County Medical Society is “Helping physicians care for the health of our community.” That’s not just a saying, that’s what DCMS doctors have been doing since day one, May 27, 1853 when a group of doctors met at a small downtown office to discuss ways to tackle an outbreak of Dengue Fever.

Today, helping physicians gain access to resources which can deal with their stress and burnout is a perfect example of fulfilling our mission. It’s no secret that medical errors are the #3 cause of death in America. The Medscape report also shows that more than half of physicians dealing with depression say that it has impacted the quality of their care provided to patients.
A Committee-Based Systematic Response to Changes in Controlled Substance Law: The Example of House Bill 21 and UF Health Jacksonville

By Alberto E. Ardon MD, MPH, Brittany Johnson, PharmD, Brian Yorkgitis, DO, Joseph Cammilleri, PharmD, BCACP, Christopher B. Scudder, DO, FAAFP, Jeffrey G. House, DO, FACP, and L. Kendall Webb, MD, FACEP

UF Health Pain and Opioid Stewardship Committee at UF Health Jacksonville

Address correspondence to:
Alberto Ardon MD
University of Florida – Jacksonville
Department of Anesthesiology, 2nd Floor, Clinical Center
655 West 8th Street, C72
Jacksonville, FL 32209
Phone: 904-244-5431
Fax: 904-244-4908
Email: alberto.ardon@jax.ufl.edu

Abstract
Opioid abuse, overdose, and opioid-related mortality has steadily increased in the United States (U.S.) over the past decade, and the opioid overdose death rate of 14.6 per 100,000 in Florida presents a public health problem to the population of the state. Prescription opioid medications have been linked to these increasing trends; in 2016, the city of Jacksonville ranked 1st in Florida in hydrocodone deaths. Florida House Bill 21 “Controlled Substances” was signed into law in March 2018 and took effect July 1, 2018, it aimed to limit controlled substance prescribing for acute pain and require a review of patients’ prescription history.

Methods
From March to July 1 of 2018, the Pain and Opioid Stewardship Committee at UF Health Jacksonville utilized a multispecialty team-based approach to address preparation across three major themes: 1) Education, 2) Clinical Guidelines, and 3) Implementation and Logistics.

The committee’s most significant recommendations included a compulsory online and live educational program regarding the new law and analgesic management, a concurrent patient education effort, adoption of prescribing guidelines for both primary care and surgical services, a strengthening of naloxone prescribing, advocacy for electronic prescription printing, electronic prompts to aid in clinical decision making, a call for a clear organizational strategy for Prescription Drug Monitoring Program access, and an internal social marketing campaign to raise awareness about upcoming changes in practice.

Results
By the target date of July 1, 92 percent of physicians, midlevel providers, and pharmacists at UF Health Jacksonville had completed the online educational training. Outpatient and perioperative analgesia guidelines were developed and adopted for use by clinicians. An electronic medical record-based approach was utilized to facilitate review of patients’ controlled substance prescriptions and maximize provider compliance with the HB21 prescribing requirements.

Conclusion
In a span of 90 days, the Committee developed and implemented the above changes, facilitating the transition of practice to comply with this legislation. No major issues nor clinical workflow barriers have been elucidated since implementation of the above described measures.

Table 1: Summary of Florida House of Representatives Bill 21 “Controlled Substances” (Section 456.44(3)(d), F.S.), (HB21)

- The bill defines “acute pain” as “the normal, predictable, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness.”
- Excludes any pain related to cancer, a terminal condition, palliative care, or a traumatic injury with an Injury Severity Score >9
- Professional license boards must develop rules establishing guidelines for prescribing controlled substances for “acute pain.” Prescribers must follow these guidelines.
- Acute pain opioid prescriptions are limited to 3 days’ supply
- Extension to 7 days available upon proper documentation of need, diagnosis, and lack of alternatives
- If opioid prescribed for non-acute pain, must indicate “non-acute pain” on prescription
- Excludes any pain related to cancer, terminal condition, palliative care, or traumatic injury with Injury Severity Score (ISS) >9
- For the treatment of traumatic pain with an ISS >99, a prescriber must concurrently prescribe an emergency opioid antagonist such as naloxone
- Electronic prescribing explicitly authorized
- Prescribers (or designees) MUST review patient’s controlled substance history in the prescription drug monitoring program (PDMP) before prescribing a controlled substance for any patient age 16 or older.
- If PDMP not available, prescriber must document reason and may not prescribe more than 3-day supply
- Current exemptions from reporting to PDMP are maintained
  - One administration
  - Hospital, nursing home, ambulatory surgical center, hospice, etc
  - Emergency department
  - Age <16
  - One-time, 72 hour emergency resupply of a controlled substance
- 2 hours of board-approved continuing medical education (CME) on safe and effective prescribing of controlled substances (part of biennial license renewal)
Duval County ranked:
- 1st in hydrocodone deaths
- 2nd in fentanyl deaths
- 3rd in oxycodone deaths by age

Furthermore, responses to overdose incidents and concurrent use of naloxone had steadily increased in Jacksonville since 2015, and only recently have begun to show a downward trajectory (Figure 1). In 2017, approximately 24 percent of Jacksonville Fire and Rescue Department transports for ingestion/poisoning/overdose were to UF Health and UF Health North, more than any other health system in the city.1

While the reasons for the opioid crisis are indeed multifactorial, prescription medications have consistently and increasingly contributed to accidental deaths, both throughout the state and locally. From 2015 to 2016, accidental deaths caused by prescription drugs increased by 151 percent in Jacksonville, and those involved in deaths in combination with alcohol or illicit drugs increased by 74 percent over the same time period. In a response to the statewide crisis, Governor Rick Scott signed into Florida law House Bill 21 “Controlled Substances” (Section 456.44(3)(d)(F.S.), (HB21)),4 which established several significant changes to controlled substance prescribing for acute pain. The most significant changes involved with the adoption of this new law are described in Table 1. This law has a direct impact on outpatient opioid prescribing and implications for the clinical care of both opioid-naïve and opioid-tolerant patients. UF Health Jacksonville, being experienced in the care of opioid-exposed patients and acute opioid toxic, quickly recognized the implications of the law on the clinical practice model. The following article describes the organizational methodology used to quickly adapt to this changing landscape.

Methods and Materials
In January 2018, the Pain and Opioid Stewardship Committee (POST) at UF Health Jacksonville was created to help craft a strategic plan to address analgesic improvement within this healthcare system. As part of its strategic plan, the Committee aimed to 1) acquire relevant data that would allow elucidation of opioid use patterns, incidence of opioid-related adverse events, and identify risk factors for such events, 2) identify aspects of clinical practice that have room for improvement, and 3) directly implement these clinical changes or otherwise make recommendations for said changes. Because of the evident overlap between the controlled substances bill and the mission of the Committee, POST was tasked with overseeing implementation and compliance with HB21 when the law was announced. These responsibilities included developing, implementing, and/or monitoring:

- Relevant provider education
- Information regarding new CME requirements
- Changes in prescribing mechanisms and decision-making systems in the electronic medical record
- Expansion of prescription drug monitoring (PDMP) access and associated workflow
- Consistent use of non-opioid analgesics and appropriate use of opioid analgesics
- Guidelines for non-opioid and opioid analgesic use
- Guidelines for hospital discharge and post-surgical controlled substance prescribing
- Pharmacy reporting of required prescribing information
- Patient education

Thus, the need for compliance with HB21 and the organizational goal of opioid stewardship combined to create a unique and timely opportunity for multifaceted quality improvement within UF Health Jacksonville. Following meetings with hospital leadership, legal counsel, clinical department chairs, clinical informatics, and communication with the Florida Board of Medicine, the Committee developed a strategic plan that made recommendations across three major themes: 1) Education, 2) Clinical Guidelines, and 3) Implementation and Logistics, to be implemented in 90 days.

1) Education
1.1 CLINICAL PROVIDER EDUCATION
Recognizing that medical educational efforts are most successful when delivered in more than one format and on more than one occasion, the committee developed and implemented an educational plan with the objectives of informing clinicians about the HB21 law, providing an overall evidence-based strategy for clinical practice.
for analgesia and opioid minimization, and educating clinicians about changes in clinical informatics (e.g., EPIC prescribing and PDMP access/documentation) at UF Health Jacksonville. These objectives were aimed to be achieved via the following mechanisms:

• **Online Training**
  The Committee developed two online learning modules whose topics and objectives were to educate clinical providers regarding the basics of pain assessment, pain control, multimodal analgesia, and opioid minimization, and to provide a review of the controlled substances law and UF Health's policies and procedures for its application to clinical practice, including changes in electronic medical record (EMR) and PDMP access.

  The learning modules would be accessible securely via hospital intranet. Both modules were assigned to all clinical providers and pharmacists and made compulsory. A score of 80% on a post-test was required to complete each module.

• **Departmental HB21 Briefings**
  In order to ensure that all clinical departments had received direct communication from the Committee regarding the three objectives, a physician member of the Committee was assigned to deliver briefings to all 12 clinical departments at UF Health Jacksonville. These briefings were tailored for each department and responsive to their particular concerns.

• **Nursing Education**
  Nursing staff were educated concurrently on the key workflow items involved with implementation of HB 21. This effort incorporated both the online educational briefing modules and an in-person briefing as decided upon by nursing leadership.

  The new law also required all physicians with a Florida Medical License and DEA license to complete a two-hour mandatory Continuing Medical Education (CME) course by January 31, 2019. To guide the achievement of board-approved continuing CME on the safe and effective prescribing of controlled substances, the Committee planned to provide up-to-date information regarding organizations providing the required courses.

1.2 **PATIENT EDUCATION**

  Given the significant practice changes involved in opioid prescribing, patient education regarding these issues was deemed to be beneficial. The Committee recommended a patient education program to: 1) explain the time restrictions in acute pain opioid prescribing, 2) disclose that controlled substance prescriptions will require a review of a patient's controlled substance prescription history, 3) set expectations regarding analgesia and introduce/reinforce the mandatory multidimensional approach to pain practiced at UF Health, 4) provide information about opioid safety and proper disposal, and 5) reinforce awareness that chronic opioid therapy would be coordinated by one clinic/prescriber. Information was planned to be disbursed to patients in electronic format, via patient handouts in clinic, and through provider/patient discussions.

2) **Clinical Guidelines**

2.1 **CLINICAL/PRESCRIBING GUIDELINES FOR ACUTE PAIN**

  The use of multimodal analgesia has been shown to be effective in treating pain in the primary care setting. Particularly for acute pain, a balanced approach incorporating analgesic agents of multiple mechanisms of action is beneficial, not only for analgesic efficacy but also for opioid use reduction. The Committee thus planned and developed a primary care acute pain guideline to serve as a clear and concise reference for practitioners of all experience levels. Likewise, in conjunction with the various surgical departments, the committee planned to develop surgical-service-specific perioperative analgesic guidelines.

2.2 **PRIMARY CARE OPIOID PRESCRIBING RESPONSIBILITY**

  The Committee recommended that multiple departments establish a coordinated and consistent approach or policy identifying the party responsible for controlled substance prescription at various stages of a patient's acute, subacute and chronic pain treatment course. Coordination of variables and workflow issues such as patient volume adjustments, follow-up windows, and interdepartmental communication were identified as needing re-examination. The Committee recommended consideration of a joint agreement/policy among primary care clinics, surgical clinics, chronic pain clinics, and addiction specialists to clearly identify ownership, responsibility, and referral process for the management of pain throughout its multiple stages as applicable.

2.3 **DOSE LIMITATIONS IN PRIMARY CARE**

  Given the increased risk of opioid-related side effects such as respiratory depression, hyperalgesia, and dependence with a dose greater than 90mg of oral morphine equivalents per day as identified by the Centers for Disease Control and Prevention, the Committee recommended that community medicine departments consider a policy that would require consultation with a chronic pain expert when a threshold of 90mg of daily morphine equivalents is reached.

2.4 **RISK OF RESPIRATORY DEPRESSION /NALOXONE**

  Risk of respiratory depression and consequent need for naloxone has been shown to be increased among patients who have at least one of the following risk factors:

  - Use of more than 50mg morphine equivalents (ME) per day
  - Concurrent use of benzodiazepines
  - Concurrent use of long- and short-acting opioids

  While HB21 did not specifically mention these risk factors, the law did specify that all patients with an injury severity score (ISS) score >9 would now require a naloxone prescription. Patients who have a high injury score (or a significant level of trauma) may be more likely to require higher doses of analgesics (including opioids), opioids in a more potent form. In an effort to reduce the risk of concurrent respiratory depressant agents, the Committee and clinical leadership decided to utilize the requirement for naloxone in HB21 as a starting point for
overall respiratory depression prevention and rescue. The committee thus recommended that 1) concurrent prescription of benzodiazepines and opioids be avoided whenever possible, 2) use of long-acting opioids be reduced if possible, and 3) a naloxone prescription be given to patients who have one of the following criteria:

- Have an ISS > 9
- Use more than 50mg ME per day
- Have concurrent benzodiazepine and opioid prescriptions
- Have concurrent long- and short-acting opioid prescriptions

2.5 CLINIC VISIT REQUIREMENT FOR OPIOID PRESCRIPTION REFILL

Established practice regarding opioid prescriptions at UF Health Jacksonville required an in-person patient visit for any initial or renewal prescription. Although HB21 explicitly authorized electronic prescriptions of controlled substances, the Committee viewed a change in practice facilitating opioid prescriptions in the absence of a clinical visit as detrimental to institutional goals of opioid stewardship. Thus the Committee recommended a continued institutional standard of practice in which a direct physician/patient interaction and evaluation is required whenever any controlled substance schedule II opioid prescription is to be considered.

3) Implementation and Logistics

3.1 CLINICAL INFORMATICS (CI)

The CI team prioritized three main areas to be completed and online in the Electronic Medical Record (EMR) before July 1, 2018.

1. Implementation of a Clinical Decision Support (CDS) system to encourage practitioners to follow the necessary changes in regards to prescribing and documentation of such prescribing

2. Addition of necessary verbiage to written prescriptions

3. Easy and streamlined access to the PDMP system

Electronic prescribing.

When HB21 was signed into law, only select units at UF Health Jacksonville used a version of electronic controlled substance prescribing. Patients discharged from some units were given paper scripts. Thus, the CI team decided to pursue the standardization of electronic prescription printing in all units. Expansion to the two most populated wards was achieved by July 2018, and the effort is on-going.

Prescribing adjustments in EPIC.

Changes in the electronic medical record were instituted to provide clinical decision support (CDS) for controlled substance law changes, to advise prescribing workflow, and to facilitate documentation within these prescriptions. These included active reminders/prompts to guide clinicians during the ordering process and adding necessary verbiage on any printed prescriptions as required by law, such as “acute pain exemption,” “for non-acute pain,” etc.

3.2 ORGANIZATIONAL STRATEGY FOR PDMP ACCESS AND INFORMATION USAGE

Although access to the PDMP is open to all physicians who have a DEA number, prior to the implementation of HB21 less than 10 percent of providers at UF Health Jacksonville were registered with this resource. Given new requirements by IID 21, access to the PDMP required a strategized and individualized approach within each clinical environment with the aim of maximizing efficiency of human resources.

As part of an organizational strategy for PDMP access, the committee recommended that UF Health leadership encourage the leaders of each clinical department to motivate their providers to register for PDMP access as well as establish a process for PDMP delegate assignment and registration. Clinic-specific workflows for daily PDMP access were also encouraged. Given the sensitive nature of PDMP data, it was recommended that no PDMP data be scanned into the EMR.

3.3 PROMOTION OF KNOWLEDGE AND BEHAVIOR CHANGE

In addition to the above education interventions, the Committee recommended an internal social marketing campaign incorporating the use of both electronic and print-based communication aimed at increasing awareness of HB21, associated workflow changes, and global strategy for analgesia. Specifically, these communication methods would include frequent and high-priority electronic messages to clinical staff regarding the law and associated changes in practice at UF. The messages would be sent from the offices of the chief medical officer, chief technology officer, or committee chair and would be sent every two weeks over the course of 8 weeks prior to July 1.

In June, the hospital launched the internal social marketing campaign. The principal components of this campaign included an infographic-based poster (Figure 2) and a series of infographic screen savers. The poster and screen saver promoted key information in an infographic format: the law start date, new limits for 3- and 7-day prescriptions, a reminder regarding patients with acute pain requiring opioid prescriptions, and that access to the PDMP would be required.

Both of these items were displayed throughout the health system. Regular electronic messages were sent from hospital leadership to clinical staff regarding the law and associated changes in practice at UF. Clinicians were encouraged to ask questions about the endeavor and such inquiries were addressed as expeditiously as possible by members of the Committee.

Results

EDUCATION

By the July 1 target date, 92 percent of physicians, midlevel providers, and pharmacists had completed the online educational training. The remaining 8 percent of eligible learners completed the education by the end of August 2018. The mean post-test scores for modules 1 and 2 for all learners were 8.6/10 and 8.2/10, respectively.

All clinical departments had received a focused briefing discussing the specifics of HB21, the organizational response to the new law, and the basics of pain control by June 30. Likewise, nursing staff in all hospital units received planned
Patient education was primarily accomplished via handouts in clinic and through provider-patient discussions. A sample patient handout, which was adapted to different clinic settings, was developed and distributed to clinics throughout the health system.

The Committee disseminated information regarding the required CME as it became available. Initially, the CME was only provided by the Florida Medical Association and Florida Osteopathic Medical Association but several other options developed over time. As of late 2018, at least five Florida Board of Medicine-certified courses were available.

CLINICAL GUIDELINES
With institutional leadership encouragement and coordination, a primary care acute pain guideline was developed and approved (Figure 3). The guideline was adapted by various clinics within the departments of internal medicine and family & community medicine and began to be utilized in June 2018.

Surgical guidelines were also developed as planned in cooperation with surgical leadership from the departments of oral/maxillofacial surgery, general surgery, obstetrics/gynecology, and orthopedic surgery. These perioperative guidelines (Figure 4) highlighted multimodal analgesic approaches throughout the perioperative period and identified anticipated numbers of opioid analgesic pills to be utilized after certain procedures. The guidelines were adopted into clinical practice by July 2018.

Regarding risk of respiratory depression with opioid use, all of the Committee’s recommendations were placed into practice, particularly the avoidance of concurrent opioids and benzodiazepines if possible. Of note, a standing order for naloxone available in all clinic settings where opioids are prescribed for acute or chronic pain was developed and implemented, along with a visual prompt in EPIC which suggests to the provider an order for naloxone when criteria are met. Additionally, an in-person patient visit is still required for any initial or renewal schedule II controlled substance prescription.

IMPLEMENTATION AND LOGISTICS
During the months of April, May and June, a Clinical Decision Support system was developed and implemented into the

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**TWO ASPECTS OF SOCIAL MEDIA AND MEDICINE**

*Alyssa Capel, medicalbag.com*

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**Communication Breakdown: Using Social Media in Medicine**

Nearly half of all physicians surveyed had used social media in a professional capacity. Since its rise to prominence, social media has proven to be an important tool for general communication across all fields, including medicine. A recent study conducted by Kantar Media examined the trends of social media use by medical professionals.

Researchers found that nearly half of the physicians surveyed had used social media in a professional capacity to interact with colleagues in the past month. Nearly half of the physicians also indicated the use of an online patient portal to interact with their patients. Overall, 18% of the physicians surveyed said that they found professional social networks to be an important source of information, with the most social network use coming from those in the general surgery specialization. According to the study, the majority of physicians using social media are men younger than 45 years who see more than 100 patients per week. Other data showed that the highest number of physicians with daily exposure to professional social networks are those in pediatrics.1

With online communication establishing itself as such an important tool, social media education initiatives for medical professionals are an easy way for physicians to become comfortable using these online outlets. The Mayo Clinic runs a collaborative learning community for this purpose, the Mayo Clinic Social Media Network (MCSMN).2 Since 2010, the goal of the network has been to enhance the use of social networking tools throughout Mayo Clinic. According to the Mayo Clinic Social Media Network website, “At Mayo, we believe individuals have the right and responsibility to advocate for their own health, and it's our responsibility to help them use social networking tools to get the best information, and connect with providers as well as one another.” The Kantar Media study also examined the ways consumers and patients find value in using social media and other online avenues for health information. Many consumers look for health providers online and interact with other patients to share information about physicians. This gives patients the chance to make the most informed decision about who they will choose to seek medical treatment from. Patients may also turn to the internet to explore treatment options, which they will then discuss with their physician. This is a main reason why online visibility is so important for medical professionals: not only can they use social networks to interact with colleagues but also these outlets can also help them reach current and prospective patients.

**Physicians Should Be Cautious of HIPAA Violations During Online Reviews**

According to an article published in Medical Economics, physicians should be aware that responding to a negative health care review could potentially expose personal medical information, resulting in a Health Insurance Portability and Accountability Act (HIPAA) violation.

Physicians who defend themselves or their practice in response to a negative review by continuing the dialogue or replying to a comment could potentially expose personal medical information.

Even if the patient discloses their diagnosis, the physician could be in violation of HIPAA. The correct way to respond to negative reviews is to create a profile page on review sites or take control of an unclaimed page if it features a review. Physicians should interact with unhappy reviewers in the same way they would speak to an unhappy patient and should avoid identifying reviewers as patients.

Replies should be kept short and simple, thanking the reviewer for taking the time to share their concern and inviting them to discuss the matter further by phone.

Practices should have a clear policy in place for responding to patient complaints; front office staff should notify physicians so that they can respond to patients directly.

"Physicians should listen to the complaint and let the patient know how they plan to resolve it, or discuss reasons for prescribing a treatment. Patients are more likely to update negative reviews if they know they've been heard," according to the article.
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The U-Lite is widely used in Europe and most recently the country of Sweden awarded Sonoscan placement of these machines in all of its hospitals, outperforming the competitors in three different medical fields: emergency medicine, medical imaging consultations and interventional procedures. The French Army granted the military contract to Sonoscan for the U-Lite over the G.E. Vscan and Philips Lumify.

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Frost&Sullivan
It is for These Patients That the Doctors at Rural Hospitals Continue

Kevinmd.com

Rural hospitals are closing their obstetric wards and stopping all obstetric services — at least those hospitals that manage to remain open at all. The tertiary care centers don’t seem to mind. Always wary of those rural hospital disasters in the middle of the night. Accepting transfers from a place where they must not have the latest technology, clearly, your little hospital must be behind the times, only subspecialty care is worth anything anyway.

After all, those family doctors should just do outpatient medicine.

Just send those obstetric patients to us. Transfer them by air if you need to — our policies and procedures will protect you if they deliver on the plane, if they seize on our watch if something happens. We will keep them safe from your Podunk little town and your backward ways. Regional care is best for all, of course. As long as the weather is OK … that is — otherwise, we hope you’ll figure it out.

Never mind your Podunk hospital has won the Top-20 Rural Hospitals Award for two years running. Never mind you run drills routinely to brush up on OB emergency skills. None of that matters when you deliver less than 100 babies a year. You aren’t experienced enough to continue, and your volume is too low, your head of your OB/nursery “department” is a family doc, not a board-certified OB/GYN. ACOG and SMFM have deemed you level 1, all have endorsed this designation, all recommend you transfer the hard ones — except the AAFP, we forgot to include them.

Never mind that your patients know and trust you, that they want a relationship with their doctor. They will learn. That never stopped our big groups anyway. Never mind the precipitous delivery, that’s what ER doctors are for — they can deal with the increased shoulder dystocia risk that occurs when the baby comes so quickly. Never mind the eclamptic seizure that happens before any severe features of the 35-week mild preeclamptic presented themselves. She was scheduled for her induction two weeks from now. She should have waited.

Never mind the patient who lives at the end of the road, surrounded by nothing but forest for a hundred miles to the west and is 30 miles from the Podunk hospital to the east. Never mind that she is newly on Suboxone, proud to be clean and sober, unable to travel the 200-plus miles to the big center without a Medicaid transport. Never mind the Medicaid transport will involve a two-hour car ride starting at 5 a.m., then a three-hour bus ride there only to see her specialist for 20 minutes and make the return trip much later the same day, when the bus schedule allows. She’ll arrive home well after midnight if the driver Medicaid lines up remembers to show. Oh, and her last baby was born one hour after arriving at the hospital. I’m sure she can relocate to our bigger town for a month before her due date, a few miles away from her dealer. Too bad she moved so remotely to get away from him in the first place. I’m sure she can find someone to care...
for her other three children while her boyfriend works. She is considered “high risk,” after all — too much for Podunk hospital to handle. Never mind she refused all of this and stayed in her small town until delivery — and this Podunk hospital handled her case with perfection.

It is for these patients that the small doctors continue, the Podunk hospitals strive to stay open. It is for these patients we push our boundaries. We are small and fierce, dedicated, remaining on call for nine days at times, running short staffed when just one doc stops doing obstetrics — forced to stop by his malpractice carrier because his volume was too low.

The biggest problems are that we are human and that babies sometimes have bad outcomes. Looking through the lens of hindsight, you add a gray filter of the Podunk hospital label. The big center staff can’t help but tell the patient that they would have done better delivering at their hospital, and the malpractice lawyers lick their chops. Never mind that patient had an MFM consult, twice, and recommended delivering with you.

You should have started Mag sooner and not waited to try Tylenol for her headache. You should have moved to C-section faster, you should have been more worried about the strip, you should have transferred her at 5-centimeters dilated after an eclamptic seizure — even if the OB you called told you to push the pit and said nothing about transfer, and your tiny airport runway was closed due to ice anyway. You didn’t give that obstetrician every piece of information, and she didn’t think to ask. She likely has no clue where you are or what resources you have.

So, here I remain with my Podunk hospital in our Podunk town, trying to keep our obstetric floor open against all odds. Me, a miniature Wonder Woman, armed with my sword, my patients and OB staff cowering behind me, trusting me to protect them. Our hospital opening our doors to shield them, despite the financial hardship obstetrics adds to our bottom line.

Alas, but I am less than perfect, my nurses are less than perfect, all of us are. I could really use another superhero on my side. The giants I am facing down are intimidating, to put it mildly. Malpractice lawyers loom large, waiting for the unexpected to happen, for preeclampsia, cord accidents and drugs to do their worst. Death and disability are always lurking and are only kept at bay by a united front. So, big center, will you support me? Will you provide a lifeline of advice and support in our time of need? I am on call alone, after all.

Or will you shrug when we close our doors, saying regional care is the way medicine is practiced now — that’s just how it is. It’s better medicine anyway, or so you think. Tell that to those who live four hours away.
Real estate has a reputation for being a profitable albeit complex investment if done correctly. Investing in real estate has historically been an attractive asset class for those willing to take on more risk within this market segment. According to Standard and Poors, the S&P Global REIT index had 15-year annualized returns of 11.22% as of 9/30/2014. There are various methods available for investing in real estate and each has their own unique benefits and drawbacks.

Real Estate Mutual Funds and ETFs
There are hundreds of mutual funds and ETFs whose underlying holdings are real estate based. These funds may directly own Real Estate Investment Trusts (REITs) or companies that deal solely in real estate. They can provide a level of diversification and liquidity which supplies an investor with exposure to the real estate market without putting too much exposure in any one property or property manager.

This method of investing does not present the owner with any control over the actual property and offers no direct tax benefits associated with property depreciation. Risks are inherent in all investments and real estate mutual funds are no exception. Typical risks include market risk, interest rate risk, default risk of debt-related investments and a drop in real estate values.

REITs
Publicly-traded REITs are another option for those who prefer not to be as actively involved in the purchase and upkeep of properties. The majority of REITs are Equity REITs where they own and operate income-producing real estate. Additionally, some REITs may offer higher dividend yields than some other investments. While they can present a diversification opportunity for a portfolio, they tend to be more narrow in their focus than an index-based mutual fund.

As with mutual funds, there are no direct tax benefits from property depreciation. The restrictions regarding liquidity can also be more expensive from a fee-perspective to the owner than divesting a mutual fund. Another risk associated with REITs is that they are largely interest-rate sensitive, which can result in higher volatility when interest rates change. Publicly-traded REIT share prices can also fluctuate wildly based on regional, national and stock market influences and trends. REITs are a complex product and investors should research the appropriateness based on their individual circumstances prior to investing.

Private Equity
In addition to REIT’s, it’s possible to further diversify a real estate portfolio by investing in a private-equity real estate fund. There are multiple private-equity funds to choose from with varying philosophies and degrees of risk. A conservative fund would typically involve lower risk equity investments in stable U.S. properties using relatively little leverage. A more aggressive fund would typically involve high risk equity investments in U.S. or international properties while using higher leverage.

Private-equity funds are traditionally only open to accredited investors and are not offered to the general public. They do not offer the liquidity and transparency of publicly-traded REITs. The fees and expenses incurred from private-equity real estate funds can be higher than one would normally expect with conventional investments such as mutual funds. One challenge of the private equity real estate fund model is that investing strategy could be in response to capital flows rather than market conditions, with liquidating assets at predetermined fund termination dates for closed-end funds being a primary example. There are also scenarios where an asset could be sold to meet redemption demands in open-ended funds, which may result in less strategic decision making on acquisitions and divestitures. Be prepared to invest for at least 10 years before being able to realistically evaluate the success of the investment.
Direct Ownership
An investor also has the option to independently secure a property in their own name by paying in cash or obtaining a loan to purchase the asset. Buying real estate within an LLC may also offer increased asset protection. This could be a rental home or a building occupied by the LLC.

Investors who prefer to have direct ownership and control of their assets might find this strategy advantageous. However, the increased autonomy comes with a cost. A large repair or vacancy could potentially erode monthly or even annual profits. The task of researching properties and the maintenance and upkeep once purchased can easily take up a greater amount of time than anticipated. Many physicians who go that route may erode their investment returns by outsourcing these responsibilities to a property manager.

To match the diversification offered by many REITs, an individual would need to own multiple properties. A drawback of this strategy is that a lot of cash will be tied up in assets that are illiquid. Another risk is loss of money on the sale of the property or assuming full liability for any incident that occurs on the property past the limits of insurance coverage. Risk is inherent with real estate, as with any investment. It may offer an opportunity to supplement and/or diversify income. Leveraging tax deductions and other asset protection strategies can increase the likelihood of having a consistent income stream from real estate investments. As with any investment, carefully consider the associated risks and your own financial situation before investing.
Many physicians will tell you their path to medicine began in their youth. But for others, a career as a doctor was a later-in-life decision, a change of plans, a new challenge — for whatever reason, career number two.

Indeed, recent years have seen an increase in first-year medical residents over the age of 29 in the U.S. and Canada, according to data from the Association of American Medical Colleges. As the number of first-year medical residents has increased overall, the percentage of first-year residents over age 29 also increased — from 35 percent of the total to 35.2 percent from 2012 to 2016. That amounts to about 360 more medical trainees who made the later-in-life switch.

“These are people who may have been interested in medicine, but for whatever reason chose not to pursue it, and later decided that now is the time,” said Geoffrey Young, who oversees student affairs for AAMC. For some, the years in between were “gap years,” or working just to rebuild savings. But in other cases, people have built a robust career before even applying to medical school.

Dr. Deirdre Mattina took that route. She pursued a degree in dance while taking premed classes at Cornell. “I’ve always really liked science,” she explained. “So I was switching between dance and premed.”

She graduated in 1999. But instead of going to medical school, she ended up joining the Radio City Music Hall Rockettes. Despite the physical demands, Mattina loved performing and traveling.

“Then 9/11 happened,” she said. “And a lot of things just became a lot less important.” Mattina began to focus less on a dance career and more on contributing to society as a physician. She got a taste of it when she volunteered at a clinic in Ghana. She spent two more years with the Rockettes while applying to medical schools, graduating from the University of Michigan in 2007. Now a cardiologist, she directs the Women’s Heart Center at Henry Ford Heart and Vascular Institute in Detroit.

Deirdre Mattina (right) and fellow Radio City Rockette Jennifer Newman outside the Fox Theatre in Detroit in 2001. COURTESY DEIRDRE MATTINA

Dr. Elizabeth Swenor had longed to be a physician since childhood. But in the 1980s, she was instead teaching fifth- and sixth-graders in a rural Michigan school district.

“I come from a family of educators,” she said. “So going into teaching was just what you did.”

And she was good at it, even getting statewide recognition as teacher of the year. But her dream job nagged at her, even as she had earned a master’s degree and planned to become a school principal, as her father had done. “But then I thought, ‘No. I absolutely know what it is I’m supposed to do, and it isn’t this,’” she said.

It was still an emotionally wrenching decision, but she credits her parents’ supporting her career change at age 32.

“My mom wrote my resignation letter, I signed it, and my dad mailed it,” Swenor recalled. “Then I sold my house and moved in with my parents while I went to medical school.”

For emergency-room physician Dr. Dafydd “Dave” Williams, medicine was more like a first and third career — a steady job he returned to after his dream career. Williams trained as an emergency physician and practiced for a few years before joining the Canadian Space Agency in 1992. “I had wanted to be an astronaut since I was a little boy,” he said.

Williams was an astronaut for over 25 years. He went on two space flights, including traveling to the International Space Station in 2007, as a mission specialist on the space shuttle Endeavor.

After retiring from the space agency in 2008, Williams returned to medicine — “once a physician, always a physician,” he said.

Unique perspective

Many second-career physicians say their prior career continues to inform how they practice medicine.
For instance, after Dr. Clayton Cowl graduated premed with a minor in journalism, he worked as a reporter while studying for his graduate degree. “I covered science, but I also covered horse-show jumping,” he said. “And I would be studying between stories.”

He later went to medical school at Northwestern University. Now a pulmonologist at the Mayo Clinic, Cowl said that his background as a reporter helps his medical career.

“Interviewing skills are extremely important medical skills, and not really emphasized enough in medicine,” he said. “I think that as a reporter, you really have to listen to get the story. Doctors don’t do that as much or as well.”

Mattina, the former dancer, said her earlier career taught her the discipline needed as a doctor.

“Today I work 10 hours a day, and when I go home there are more journals to read. [With the Rockettes] we were rehearsing eight hours a day, six days a week. And it’s synchronized dancing, so you’re working as a team, which you have to do with your medical colleagues,” she said.

For her part, Swenor — who’s now practicing osteopathic medicine in Michigan — said she is still very much a teacher.

“When you’re developing lesson plans, you take into account the fact that everyone learns differently,” she said. “I try to address that with my patients. And I give them homework. Things like food journals and sleep journals, but I also give them things to read. And they have to be ready to have a discussion about it when they come back.”

A career gap
Some doctors are especially aware of differences between their old and current jobs that go beyond the obvious.

For Williams, the former astronaut, it’s the counterintuitively lower stakes of space flight. “Fallibility is the scary part of being a physician,” Williams said. “In space, it’s a ‘zero fault tolerance’ situation — we have to make sure that there are no errors, or that errors that do occur don’t have mission impact.

“And patients would like us to have zero fault tolerance in their treatment. … [But] with a shuttle mission, if something goes wrong, you can try again tomorrow. You can’t always do that with a patient.”

For others, there are simple regrets. “I really love to dance, and I miss it,” said Mattina. “But there’s not a lot of dancing in cardiology.”
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www.jamieseim.com