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Stark County Medical Society News

Fall 2017

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INSIDE THIS ISSUE:

Dr. Carl Foster

President's Message

Dr. Carl Foster

Summertime is coming to an end. It seems as if its passing has been all too rapid. This notion appears to be a function of advancing age. During the summer between my first and second years of medical school I did a clerkship at a rehabilitation hospital. An attending physician there advanced the theory that as we age each individual measure of time (hour, day, week, month, or year) becomes an ever smaller fraction of the total amount of time that we have spent on earth. So as we get older time seems to "fly".

30 years ago this past May, I graduated from Medical School and that event too seems not nearly that long ago however the morning reflection in my bathroom mirror argues against that impression. Needless to say there have been many adjustments that have been made in the practice of medicine during these many years but I have always felt privileged to be a physician. As an anesthesiologist I provide episodic care. Most often I meet my patients for the first time on the day of their surgery. So I value the immediate respect and deference that is almost invariably afforded me by the patients and their families. It is an honor and appreciation that I endeavor to deserve. I am certain that most if not all our colleagues have had similar experiences.

Noblesse oblige is a French phrase literally meaning "nobility obligates". It denotes the concept that nobility extends beyond mere entitlements and requires the person who holds such status to fulfill social responsibilities, act with generosity towards others not of family as a primary obligation. At the time of this writing this concept came to mind. The new Ohio opioid prescribing guidelines for the treatment of acute pain will have taken effect. While at first glance these parameters might seem to be still another intrusion in our practice of medicine, the role that prescribed pain medication has played in the opioid epidemic is well known. In view of the magnitude of the problem there has been enormous pressure on government to limit access to opioids. So despite the fact that fewer overdose deaths are a result of prescription narcotics, the state expects Ohio physicians to fulfill their social responsibility to limit the amount of opioids that they prescribe.

The OSMA worked closely with an ad hoc multispecialty physician task force over a 5 month period. Through testimonies, meetings, and correspondence with the Governor's office, the Pharmacy Board, and the Medical Board the final rules were drafted for prescribing opioids in acute settings reflecting the best interests of both patients and physicians. For the treatment of acute pain the Governor originally proposed a 5-day opioid limit for minors and a 7-day opioid limit for adults. There was to be no greater than 30MED (morphine equivalent doses) average dose over 5-7 days. In addition the full ICD-10 diagnosis code was to be included on every prescription for a controlled substance, regardless of length of that prescription. The final guidelines allow the prescriber to exceed the 5-7 day limit as well as the

continued on page 12

We have access to the politicians and the state medical association. Together, we have a voice that will be heard!

Contact us at starkmedical@ameritech.net or call 330-492-3333. We look forward to hearing from you!

Opinions expressed by the authors are their own, and not necessarily those of the Stark County Medical Society, Trustees or individual members. SCMS News reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted.

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SUPREME COURT UPHOLDS "APOLOGY" STATUTE PROTECTION

Scott P. Sandrock
Brennan, Manna & Diamond, LLC

As part of the tort reform initiatives some years ago, Ohio adopted what is frequently called the "Apology Statute" that is applicable in medical liability cases. The Ohio Supreme Court has upheld the protections outlined in the statute in the first case to reach the high court.

To help set the stage for the issue, physicians are unfortunately required from time to time to have discussions with patients or their families where a family member has died or serious complications have arisen, even though those consequences were a potential risk from the condition suffered by the patient or procedures associated with efforts to help the patient. In some limited circumstances, there is some question whether the negative outcome was just the normal progression of the disease or condition, or if the negative outcome may have been caused or prevented by action or omission by the physician or other health care provider.

As part of the physician's empathy towards the patient and family, physicians frequently would express feelings of sympathy, condolences or other actions to be consoling to patients or families at a time of loss. Lawsuits, however, were filed and worked their way through the courts on the premise that if a physician said to a family, "I am sorry" or similar words, could that statement be interpreted as an admission by the physician that somehow the physician was responsible for the negative outcome. Legally, the term is called "party opponent's admission" or "an admission against interest." These events commonly occur, for example, when a party involved in a traffic accident admits to an officer taking the statement that they hit the other car. That person then would have that statement used against them in a subsequent trial involving claims for damages from the auto accident.

Unlike a traffic case or a business case, physicians trained to help relieve pain and suffering, frequently are genuinely sorry for loss to a patient, although their statement of sorrow should not lead to an inference that the physician could have done anything differently that would have resulted in a potential different outcome. As you can imagine, an admission of wrongdoing has a powerful affect against a physician at trial.

In 2004, Ohio adopted the "Apology Statute," which provides:

> *In any civil action brought by an alleged victim of an unanticipated outcome of medical care***any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that are made by a health care provider *** to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim, and that related to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or as evidence of an addition against interest.*

Since the statute was adopted, a series of cases have been decided by trial courts and court of appeal interpreting the statute, but the statute had yet to be reviewed by the Ohio Supreme Court.

In Ohio, the state is divided into 12 districts for which there is a separate court of appeals hearing cases on appeal from trial courts in those various districts. A decision by one of the court of appeals is binding case authority only within that district, but may be considered in another district. Occasionally, a district will interpret a statute or rule in a manner different than a decision by another appeals court. When this occurs, it creates a conflict between the districts and if it is a matter of importance, the conflict is ultimately resolved by the Ohio Supreme Court. It is under this conflict resolution that the court interpreted the provisions of the Apology Statute.

In the case in front of the court, a patient had been admitted to the hospital after attempting suicide. The attending physician had put the patient on a 15 minute observation schedule. The next day, the patient's husband visited at the hospital, unfortunately discovering his spouse to be in the process of attempting to hang herself, and the patient ultimately died.

While the testimony was conflicting, the family claimed that the treating physician had told the family after the death that the patient had told him that she would keep trying to kill herself. The family claimed that the physician's statement should be interpreted as an admission of fault. The physician argued the Apology Statute should exclude the statement and the court ruled that statement was excluded from consideration at trial. On appeal, the court in the Stewart case interpreted the Apology Statute to mean that not only can the physician express sympathy to the patient or representatives of the patient regarding the outcome, but also any admissions of fault would be excluded from trial within the protection of the statute. The court upheld the decision of the trial court to exclude the statement.

By contrast, a decision in another court of appeals concluded that expressions of apology or sympathy were within the statute, but an "admission of fault" was beyond merely saying "I am sorry." In the other case, the court found statements beyond "I am sorry" were a non-protected admission against interest that the physician may have been at fault, and the statements could be used at trial.

As the Supreme Court reviewed these two different interpretations, the Supreme Court concluded initially that the statute itself is unambiguous and the words actually mean what the words say. The Court then goes on to conclude, using standard definitions of apology, the statutory language is susceptible of only one reasonable interpretation.

> *Under this plain and statutory language is susceptible of only one reasonable interpretation. Under this plain and ordinary meaning of*

continued on page 14

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SCMSA NEWS

Attention all SCMS members: If your spouse or domestic partner is not already a member of the SCMSA, please sign them up! The group was established as an extension to the SCMS . Our main function is to create fellowship amongst physician's families. We also raise money for our charitable fund, which gives scholarships and also does outreach in the Stark community. The dues are only $25.00 per year and $20.00 for the spouse or domestic partner of a resident.

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Medical Board Regulations Update

Scott P. Sandrock • Brennan, Manna & Diamond, LLC

The State Medical Board continues to modify its regulations regarding prescriptive authority of physicians, particularly in the area of pain management, treatment of chronic pain, and prescription of opiates.

"Chronic Pain" Rules Effective August 31, 2017

The first in a series of proposed regulations have been approved and go into effect on August 31, 2017. The first rules changes replace the term "intractable pain" and substitutes in its place a new defined term "chronic pain." Chronic pain is defined as:

> *"Pain that has persisted after reasonable medical efforts have been made to relieve the pain or cure its cause, and that it is continued, either continuously or episodically, for longer than three continuous months. 'Chronic pain' does not include pain associated with a terminal condition or with a progressive disease that, in the normal course of progression, may reasonably be expected to result in a terminal condition."*

While substantially similar to the former definition of intractable pain, it is more focused on pain that is longer than 90 days, but is not part of a terminal condition.

Should a patient present with "chronic pain" prior to prescribing any drug, the physician is required to do a standard evaluation and diagnosis. The rule, however, requires the physicians document in the treatment plan for the patient "the treatment proposed, the patient's response to treatment, any modification to the treatment plan." In addition, the physician must document the medical justification for and the intended use of any prescription drug therapy.

While some language regarding documentation had previously appeared in the regulations, the revisions further emphasize that the physician is required to document in the patient's record that the patient has given consent to a particular treatment, and prior to that consent, the patient had been informed of the benefits and risks of receiving prescription drug therapy for the chronic pain, and had been informed of available treatment alternatives.

Given the heightened public scrutiny of physicians issuing prescriptions for pain management, we would recommend practitioners consider developing a form for use in their practice that outlines benefits and risks, available treatment alternatives, and obtain the patient's written consent prior to issuing the prescription in non-emergency settings. Physicians should be aware that the burden is on the physician to prove that the physician had the conversation with the patient, that the physician had described the risks and alternatives, and that the patient acknowledged their informed consent.

The rule changes further clarify that prior to issuing a prescription for chronic pain, the physician is required to obtain an OARRS report and document they obtain the report prior to issuing the prescription.

"Opiate Analgesics" Rules Effective August 31, 2017

The State Medical Board has also approved rules which deal with prescribing opioids. These rules are focused on the treatment of "acute pain," which applies in all settings, not just for the "chronic pain" setting addressed in the other new rules. Under the acute pain rules, prior to issuing a prescription for an opioid analgesic, the physician has to document that they considered a non-opioid treatment option, conducted a history and physical examination, and after that documentation, "shall prescribe for the minimum quantity and potency needed…with a presumption that a three-day supply or less is frequently sufficient." The rule goes on to provide that except for a terminal patient, opioid analgesics should not be prescribed for more than a seven-day supply with no refills for adults, and a five-day limit for minors. Any prescription for a minor for any duration requires the physician to obtain written consent from the parent, guardian or other authorized adult to consent to the prescription for the minor.

If a physician believes that a longer prescription is needed, the burden is on the physician to document the reasons for any longer duration, and the medical reasons that there are no non-opioid medication options. The documentation will further need to describe why the physician believes that the pain will exceed the 7/5 days, specifically describing the pathology causing the pain, and to document what the physician believes to be the anticipated duration of the pain.

The rule specifically provides that a physician may not prescribe extended release or long acting opioid analgesics as a treatment for acute pain.

The rule goes on to specify that if a prescription is issued, the total MED of a prescription for treatment of acute pain "shall not exceed an average of 30 MED per day," except in limited circumstances such as amputation, major orthopedic surgery, severe burns, or extensive trauma. Any deviations from the 30 MED rule requires the physicians to document in the record the clinical judgment of the physician, the patient's needs, why the dosage has to be above

the threshold, and "the prescribing physician shall be held singularly accountable for prescriptions that exceed the 30 MED average." The rules are not clear what the Board means by "singularly accountable," but we believe that the Board will presume any deviation will be outside the standard of care should anything go wrong. The rule does go on to provide that a physician who does prescribe beyond the 5 or 7 day level is subject to a review by the State Medical Board as to dosage days supplied and conditions. We suspect the Board will monitor OARRS reports and deviations will trigger an onsite chart review.

In addition, similar to the consent rule adopted in the chronic pain setting, the physician is required to document that the patient (or a parent/guardian for a minor) had been advised of the benefits and risks of the opioid, including the potential for addiction, alternatives to the patient, and that the patient was advised of those issues prior to any prescription. If this rule is implemented, we would recommend practices having a standardized office procedure form requiring the patient's acknowledgement and consent.

The proposed rules have some exceptions for terminal condition patients, patients in an inpatient setting, or patients being treated in a licensed detoxification program. These rules are also applicable to all providers with prescriptive authority and not just physicians.

The Pharmacy Board is also working on new rules that would require a physician to include the diagnosis of the patient for any prescription for controlled substances. You should continue to monitor this situation for any additional changes.

The state of Ohio and a number of other states have filed lawsuits against pharmaceutical companies claiming that the pharmaceutical company inappropriately promoted the effectiveness of pain medication, which, according to the cases, led to a significant amount of addiction and other drug abuse problems. With the changes in both the Medical Board rules as well as the Pharmacy Board rules, we are concerned that the next round of claims may be focused on physicians and certainly anticipate that deviations from the rules may result in disciplinary proceedings or even criminal charges against providers. We encourage providers to carefully review and update their office procedures to be fully compliant with the new rules.

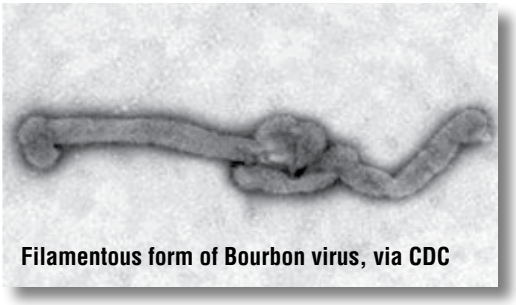
If you would like copies of these rules or have any questions concerning these matters, please contact Scott Sandrock at 330-253-4367, spsandrock@bmdllc.com.

Stark County's Reportable and Emerging Diseases Network Committee

Bourbon Virus: An Emerging, Deadly, Tick-Borne Infection

Public Health
Prevent. Promote. Protect.

In June of 2014, an otherwise healthy man in Bourbon County, Kansas died shortly after exposure to a tick bite, displaying symptoms of fever, malaise, rash, and immune system suppression. The patient did not respond to doxycycline, which is often prescribed after exposure to tick bites, and eventually died due to multiple organ failure. After an autopsy, the specimen in his blood was found to be a novel viral species within the Thogotovirus genus. Since this initial virus was identified there have been five confirmed cases of Bourbon virus throughout the South and Midwest. Some, though not all, of these cases have resulted in the death of the patient.



Filamentous form of Bourbon virus, via CDC

While there are no known treatments available for Bourbon virus, preventive measures can be taken to prevent its spread. The main method of prevention is avoiding tick and insect bites. Since it is still unclear as to what vectors can transmit this disease, the best way to prevent infection is to avoid getting bitten by any ticks or insects. Methods of protection include repellent, long sleeves, tick checks, and avoiding heavily wooded areas.

More research into this mysterious tick-borne infection is necessary to fully understand its pathogenicity and to eventually develop a vaccine or a cure. While there have not been any cases of Bourbon virus in Ohio, it is important that anyone in the area who may be exposed to tick bites be kept informed of the potential for infection and take preventive measures whenever possible.

A B.Y.O.B- Social Gathering with the SCMS and SCMSA

PLEASE JOIN US FOR AN EVENING OF WINE SHARING

Friday, November 3, 2017 • 6:30 - 9:00 PM

Home of Bill and Lorraine Murphy
2615 Brentwood Rd. NW, Hills & Dales Village

Each couple is asked to bring a bottle of wine from one of our categories. We will open and taste these wines as we also enjoy heavy hors d'oeuvres and desserts.

Please select your wine from one of these categories:
Big, Sexy Reds • Beyond the Border • Unexpected Whites

This is an evening for SCMS or SCMSA members and their spouse or significant others only. No guests please. Also, we are limiting the event to the first 60 people who return their RSVP's.

All proceeds from this event will be used to fund the SCMSA-CF Scholarship Fund.

Our evening will also include a small raffle of 4 special wines.
Tickets can be purchased now or on the evening of the wine gathering. Winners need not be present.

R.S.V.P.

Yes, I would like to attend: _____ persons x $50.00 per person = _____

No, I am not able to attend but would like to support the SCMSACF Scholarship Fund _____

I would like to pre-order raffle tickets for the wine raffle. Individual tickets at $20.00 x ____ = _____

I would like to pre-order a raffle ticket package for the wine raffle. Pkg at $100 for 8 tickets = _____

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President's Message continued from front cover

30MED limit with appropriate documentation in the medical record. Prescribers are only required to include the first four digits of the ICD-10 code and originally only on narcotic prescriptions (effective 12-29-2017). Any implementation related to other controlled substances will be delayed by the Pharmacy Board for at least 9 months.

The Medical Board has adopted the following listed rules, which are effective August 31, 2017. The rules are applicable to all physician assistants who have a valid prescriber number and to all physicians. The rules regulate the prescribing of opioid analgesics for acute pain.

RULE TITLE
4731-11-01: Definitions
(for rules in Chapter 4731-11, Ohio Administrative Code)

4731-11-02: General provisions
(applicable to prescribing controlled substances)

4731-11-13: Prescribing of opiate analgesics for acute pain

The rules are available on the Medical Boards website at the following link: http://med.ohio.gov/LawsRules/Newly-AdoptedandProposedRules.aspx. Also, a summary of the rules can be found at the following link: http://med.ohio.gov/Publications/RecentNews/TabId/246/ArticleId/50/new-limits-on-prescription-opioids-for-acute-pain.aspx. Guidance documents are being prepared, and interested parties will be notified when they are posted on the Medical Boards website.

Recently amended rules applicable to physician and physician assistant prescribing of a drug for the treatment of chronic pain can be found at the following link: http://med.ohio.gov/LawsRules/NewlyAdoptedandProposedRules/DrugTreatmentofChronicPain.aspx. In addition, guidelines for prescribing for chronic pain can be found at the following link: http://mha.ohio.gov/Portals/0/assets/Initiatives/GCOAT/Guidelines-Chronic-Pain.pdf.

Please direct any questions to Sallie.Debolt@med.ohio.gov.

On a related topic, the OSMA undertook a major revision of the Smart Rx content and interface, launching Smart Rx 2.0 during the 1st quarter of 2017. The new version condenses the modules from four to three but does not significantly alter the running time, which remains about 1 hour, 5 minutes. In addition to content updates, technical changes have made the program more user-friendly and easier to access. The upgrades will continue to reflect pending changes to Ohio's opioid prescribing guidelines. To date, nearly 2,000 physicians and healthcare professionals have completed Smart Rx and it has been well-received. I encourage all readers to take advantage of this most useful resource.

Finally the OSMA is hosting the first-ever 6th district networking event at Burntwood Tavern, 2291 Riverfront Parkway, Cuyahoga Falls, OH 44221. It will be an opportunity for both members and non-members to interact with colleagues over light appetizers and drinks. I look forward to seeing you there!

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SUPREME COURT UPHOLDS "APOLOGY" STATUTE PROTECTION . . . *continued*

> *"apology," for purposes of R.C. 2317.43(A), a "statement***expressing apology" is a statement that expresses a feeling of regret for an unanticipated outcome of the patient's medical care and may include an acknowledgment that the patient's medical care fell below the standard of care.*

The Supreme Court decided that in Ohio, the statute would be interpreted in future cases to mean that any statement by a physician expressing condolences while at the same time also even inferring that the health provider may have been partially responsible, would be excluded from consideration at any subsequent trials if a claim was later asserted for malpractice.

We understand that in the moment, a physician supporting a grieving family member may not be analyzing each word or the phrasing of their sentence for future legal interpretations of the statements. We also understand that the literature supports findings that physicians who express sympathy or even an acknowledgement they could have done better, provides some relief and comfort to families, and frequently results in claims not being filed or resolution of claims if asserted at lower costs. There are numerous publications and studies dealing with that issue.

The takeaway, however, is that as physicians are careful in clearly describing circumstances to patients, such as risks, potential side effects, and the like so that the patient has clear information, physicians should likewise be cautious in how they express their condolences or commiseration with a patient or family. Except in the most extreme cases, such as wrong site surgery, a physician who feels comfortable in having a conversation with patients should focus on the empathy for the loss and an expression that while not common, the outcome was a potential risk factor (if applicable). While I still would not recommend it, even if the physician were to add comments that could be interpreted as an admission of wrongdoing such as "I could have done better," the physician should have some comfort that the statute would exclude those statements from being used against the physician at trial.

If you would like copies of the statute or cases or have any questions concerning these important issues, please contact Scott P. Sandrock at 330-253-4367, spsandrock@bmdllc.com.

PRESIDENT'S MESSAGE SUMMER 2017 RE-PRINT

Dr. Carl Foster

Spring has sprung! The morning air is filled with the rich vocal ensemble of singing birds. The bare trees of winter are once again adorned with leaves. Flowering plants and the constituents of many vegetable gardens are virtually flying off the shelves of nurseries. Such is part of this annual rite of seasonal reawakening. But despite the annual rebirth of the out-of-doors that shifts our focus and preoccupation our indoor struggles remain. The imperative of those struggles persist and the necessity of our participation in them is inescapable. These indoor struggles are embodied in what has been referred to as the "evolving healthcare environment".

Many forces are conspiring to affect the ecosystem in which we work. These forces do not merely include new found evidence upon which we would construct the care that we provide our patients. But they also include governmental, regulatory, and economic forces as well. The GOP led House of Representatives passed the American Health Care Act (AHCA) which has been criticized and literally rejected out of hand by the GOP led Senate, which is laboring on its own proposal. It remains an enigma when the two Houses will deliver on their campaign promise to "Repeal and Replace Obamacare". And even more enigmatic is how that outcome will impact our patients' access to health insurance. In Ohio, in response to the ongoing opioid abuse crisis, the Governor and the Legislature have both introduced separate plans that would limit the amount of prescription opioids that clinicians can write for patients at any one time. In addition the Ohio Pharmacy Board has announced a proposal that would require the ICD-10 code identifying the diagnosis for which an opioid prescription is written be included on that prescription. Doctors are also bothered by flat or decreased reimbursement, rising expenses, and increased administrative and data-entry requisites which have made the practice of medicine more stressful and less rewarding.

The state of affairs in which we find ourselves leads to varying degrees of burnout. Broken down by specialty, anywhere from 40 to 60% of our colleagues are afflicted with this malady1. They experience emotional exhaustion from which they don't recover after time off. They are often cynical and negative about their patients. They can also exhibit "compassion fatigue" and treat their patients with insensitivity and a lack of sympathy2. They may experience a sense of ineffectuality and a reduced feeling of achievement. As with any disorder the best treatment is prevention. Dike Drummond MD has published 3 prevention steps that I have found to be rejuvenating in my practice. They are the "Squeegee Breath", "It's been too long", and the "Treasure Hunt"[2].

The "Squeegee Breath" is a simple purgative exercise that, "like a window washer's squeegee, in a single stroke it can wipe you clean of stress, allowing you to see clearly and be present with your patients". "Take a big breath – up to the top of your head – and hold it for a 3 count => Then exhale all the way to your toes inviting any stress, tension or worry out with your out breath => Hold the full exhale for a 3 count => Then allow your breath to breathe normally". Dr. Drummond recommends that physicians "take this "Squeegee Breath" each time they touch a doorknob to go in the room with a patient … and see what difference they notice in the quality of their day"[2].

"It's been too long" involves reestablishing old relationships. It involves identifying someone with whom it seems like "too long" since one has connected. It could be anyone, friend or relative. The physician then reconnects with that person, arranges a meeting either "by phone or in person…for a minimum of 15 minutes". If this is a good experience Dr. Drummond advises that the physician and his counterpart arrange another meeting and keep in touch which will add more life balance for both[2].

"The Treasure Hunt" is an approach for finding more joyfulness in one's work. Dr. Drummond recommends that one recalls "… what is one interaction you remember that made you smile and reconnected you with what you love about your career again?" He further recommends that "… on your next work day and before you start to see patients that you set an intention to experience this again in the day ahead" and then"… to seek it out and savor it" at least once a day[2].

To survive and flourish in this changing milieu adaptation is imperative. Although these strategies are simply employed they are deceptively effective. One enables the physician to reduce the level of stress in their workday. The second allows the physician to tap into the resources of their relationships and the sense of well-being that can be derived from renewing them. And the third step encourages an examination of the physician's practice experience which involves a change in focus that magnifies that which is good. These techniques are simplistic but valuable. They are self-implemented and relatively time efficient. They provide an easy method to help regain one's footing in this ever-changing healthcare environment.

1. **https://wire.ama-assn.org/life-career/report-reveals-severity-burnout-specialty**
2. **https://www.thehappymd.com/blog/bid/290398/Physician-Burnout-3-Signs-and-3-Simple-Prevention-Steps**

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2017 Annual Meeting

Thursday, October 19, 2017

Honoring the 2017 Lifetime Achievement Award Recipient,

Bernard R. Bonnot, M.D. (Posthumously),

our 50-Year Members, and the 2017 Retirees for their Years of Service to the Medical Profession, the SCMS, and the Community.

THURSDAY, OCTOBER 19, 2017

The Barrel Room
7901 Cleveland Avenue, NW • North Canton, OH 44720

Fellowship: 6:00 PM • Buffet Dinner: 6:30 PM
Recognition of Honorees: 7:15 PM

This is a Complimentary Dinner Meeting for SCMS Active, Retired, & Resident Members with Advance Reservations Only.
Guests are $20.00 per person.

Reservations are due by October 10th. RSVP by Calling 330.492.3333.
Cancellations will be accepted until noon on October 7th to avoid a no-show charge.