



DOH: Prevalent disciplinary actions for allopathic and osteopathic physicians.

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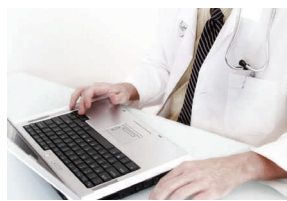
It is always interesting to consider trends in medicine, not only as they relate to the advancements made in medical technology, but also as they also pertain to the unfortunate continuing struggles faced by medical professionals. As health care attorneys, we feel it is certainly well advised to have practitioners consider the nature of the actions giving rise to Florida Department of Health (“DOH”) investigations. It is our hope that through this article, a practitioner may glean a better understanding of the more frequently observed DOH investigations and use this information to evaluate one’s own practice and perhaps avoid such an investigation or disciplinary action.

The Division of Medical Quality Assurance of the DOH (the “MQA”) indicated in its 2009-2010 fiscal year report that the number of licensees regulated by MQA was 1,002,920, an 8% and 13% increase over the two prior years, respectively. To address frequently seen issues of risk among the masses of licensees in varied professions, new laws have progressively been implemented. Compounding this effort in the medical field is the increased vigilance of hospitals, ambulatory surgery centers and practitioners who routinely implement enhanced policies and procedures to decrease risk. As the disciplinary actions we observe in our practice are varied from physicians to dentists to physician assistants and nurses, we feel it necessary to provide this information in article installments.* Thus, we first consider the disciplinary actions

affecting allopathic and osteopathic physicians. The categories below are the types of disciplinary actions we represent providers in most often, in no particular order of frequency.

Standard of Care

One of the most frequently observed violation in our practice is that of Section 458.331(1)(t), Fla. Stat. (allopathic)/Section 459.015(1)(x), Fla. Stat. (osteopathic), which concerns the commission of medical malpractice through the provision of substandard care. A multitude of offenses can fall under these statutes, which is why it is so commonly seen. Additionally, under Florida law, all closed medical malpractice claims where a settlement was paid must be reported to the Florida Department of Financial Services Office of Insurance Regulation. These cases are then referred to the DOH, at which time an investigation will be initiated and often an allegation of substandard care or medical malpractice will be cited. Furthermore, all civil complaints for medical malpractice must be filed with the DOH, at which time an investigation can be initiated. Examples of complaints falling under substandard care include anything from allegations of misdiagnosis, improper treatment and poor outcomes to personal disagreements with a practitioner or his or her staff.



Many times, the defense of an alleged standard of care violation requires a very fact-specific examination of patient care. For this reason, appropriate and detailed documentation is critical. Whether the matter investigated involves medical care or a mere discussion with a patient concerning payment of a bill, a prescription refill or the like, we implore each practitioner to ensure that they and their staff maintain timely and detailed documentation.

Recordkeeping

We routinely remind our clients that for all practical purposes under this law, "if it is not in the record, it did not happen." Failure to maintain appropriate documentation that justifies the course of treatment of a patient is a commonly seen basis for a DOH investigation. Such documentation issues can stem from failing to properly document patient histories, examination results, test results, records of drugs prescribed, dispensed or administered and reports of consultations and hospitalizations. See Section 458.331(1)(m), Fla. Stat. (allopathic)/Section 459.015(1)(o), Fla. Stat. (osteopathic) for the disciplinary violations for failure to keep appropriate medical records. We would also suggest a review of Section 456.057, Fla. Stat., and the respective rules by the Board of Medicine and the Board of Osteopathic Medicine that set out the requirements for maintaining patient records that justify the course of treatment of patients.

It is important to note that a recordkeeping violation not only pertains to the absence of information in a patient record but also if such information is illegible or insufficient to support actions taken by the provider. We commonly see violations where a patient claims he or she was not informed of a test result, was not given appropriate informed consent relative to a surgical procedure or was not informed of a medication side-effect, as well as cases where a test or procedure was delayed or never ordered. When effective recordkeeping is employed, the defense of such allegations is much less challenging as the record will support a given event occurred.

We urge practitioners to take the time to create a more detailed medical record, as it not only enhances the continuity of patient care, but also better serves physicians in the event that their care or billing practices are called into question. To

facilitate this effort, many practitioners employ Electronic Medical Recordkeeping ("EMR") systems. When used appropriately, these systems can be quite beneficial. However, where such systems are used lazily or casually, it is not uncommon to see how EMRs may actually decrease the use of beneficial and specific recordkeeping practices and present a significant setback. An overreliance on "check boxes" and "radio buttons" can certainly be detrimental, particularly concerning matters where a narrative detail is more appropriate. Practitioners must use their best efforts to ensure appropriate documentation of the informed consent process for any procedure, detailed documentation of test orders, prescription orders and refills and thorough communicative logs concerning any interactions between any member of the office staff and the patient concerning any subject.

Inappropriate Prescribing

A more recent trend of investigations have concerned issues involving the inappropriate prescribing of medications. The MQA and the Florida Legislature continue to very clearly indicate that addressing this crisis is one of its highest priorities. For fiscal year 2009-2010, 281 pain management-related complaints were filed, 8 were emergency actions concerning clinics and 16 were emergency actions relating to pain management-related practitioners.

Under Section 458.331(1)(q), Fla. Stat. (allopathic)/459.015(1)(t), Fla. Stat. (osteopathic), inappropriate prescribing relates to the dispensing, administering, mixing or otherwise preparing of drugs, legend or controlled substances, inappropriately or in excessive or inappropriate quantities. We frequently see allegations of improper prescribing of an incorrect medication to a patient as well as the prescribing of perhaps an appropriate and necessary medication in an excessive quantity or dosage. Importantly, the number of pills or dosage prescribed are not the only criteria considered in

reviewing these matters. Special attention is also given to the patient's history, including any history of substance abuse, dependency, diversion or doctor shopping. Also considered is whether any objective medical findings exist to support the patient's complaints and thus, the necessity for the medication prescribed. Both Boards have promulgated rules for the setting forth the standards for the use of controlled substances for treatment of pain. Any practitioner that prescribes narcotics should review the rules.

Due to the mounting issues in the State of Florida concerning pill mills, diversion and drug abuse, we strongly encourage each practitioner to be well informed of the newly implemented and forthcoming laws regarding the prescribing of pain medications. It is further important to be vigilant in recordkeeping as it relates to the refill of such medications, as well as in the use of a pain management agreement with each relevant patient. While a pain management agreement is not legally required, it is critical that where utilized, a practitioner must enforce each provision of the agreement or appropriately document any circumstances which may mitigate such enforcement in the event of a breach by the patient. We have seen many cases where a physician appropriately had a patient enter into a pain management agreement, yet failed to abide by the agreement through non-performance of random urine testing, the provision of early refills or replacement of medications "lost" by a patient, the allowance of obvious violations of the agreement by the patient and so forth. Weak enforcement of the provisions of such an agreement can only have disastrous consequences for the physician.

As some readers may be aware, the Governor recently signed into law HB 7095 which addresses several issues in the monitoring and regulating of pain clinics and the treatment of patients with chronic pain and goes into effect on July 1,

2011. It is important to note that the law includes a mandatory suspension of not less than six (6) months upon a finding that a provider has prescribed or dispensed controlled substances, or has caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s. 466.028(1)(p) or (x), and fined not less than \$10,000 per count. This refers to allopathic, osteopathic, podiatric and dentists respectively. Lastly, please be aware that physicians will no longer be permitted to dispense Schedule II or III narcotics from their office under this new law.

Wrong Site Surgery and the Pause Rule

For years, the State of Florida has expressed its concern over the frequency of wrong-site, wrong-procedure and wrong patient procedures. Wrong site surgery is very broadly defined and section 456.072(1)(bb), Fla. Stat., provides that a provider can be disciplined by the applicable Board for:

Performing or attempting to perform health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing or attempting to perform health care services includes the preparation of the patient.

In hopes of decreasing the number of these cases, the respective Boards have promulgated what is known as the "Pause Rule". The Pause Rule requires that except in life threatening emergencies requiring immediate resuscitative measures, that once the patient has been prepared for elective

surgery/procedure and the team has gathered and immediately prior to the initiation of any procedure, the team will pause and the physician(s) performing the procedure will verbally verify confirm the patient's identification, the intended procedure, and the correct surgical procedure site. Surprisingly, we find that the Pause Rule is not performed often and certainly not immediately before a procedure is initiated. When there is a "wrong site surgery", Florida law requires the filing of a "Code 15" Report or an office adverse incident report with the Agency for Health Care Administration ("AHCA"), which frequently identifies there was no "time out" performed as part of the analysis of the event.

We have seen countless investigations concerning a violation of the "Pause Rule," such as the implantation of an incorrect diopter lens in a patient's eye, the performance of a nerve block in the incorrect arm or the performance of a colonoscopy on Patient A instead of Patient B. It is also not unusual to see concurrent allegations regarding inappropriate consent and documentation with pause rule violations. Many times a patient and physician may have a conversation prior to a procedure where a patient may, for example, inform his or her physician that instead of having an epidural steroid injection at the planned location, that another location is desired. The physician will then proceed with performing the ESI at the desired location, rather than the planned location which was specified in a consent document previously executed by the patient. Unfortunately, when a member of the ASC or hospital notes this discrepancy, a Code 15 report will be filed with AHCA. This is a particularly difficult circumstance as there often will be no documentation of the physician's conversation with the patient in the patient's record, nor will there be a revised, preoperative consent document. Frequently, since the physician had just spoken with the patient, there is no time out performed as required by the Pause Rule. Thus, a DOH investigation will be initiated with

allegations of performance of a wrong-site procedure, inappropriate recordkeeping, and violation of the Pause Rule. Remember, Florida law requires that a patient be provided informed consent. While it does not require that such consent be documented in writing, one would be foolhardy not to have consent for a procedure properly documented.

We would be remiss not to mention that the Pause Rule was "attempted" in the majority of cases we have observed over the past few years. In fact, we frequently see cases where the Pause Rule was employed, but was not performed to completion. This includes situations where the operative team pauses, while the operating surgeon is washing his or her hands or is otherwise unavailable or not present. Additionally, when verifying information such as operative site location, surgical procedure or patient identity, we urge practitioners to be careful of the source of verification. The following are varied examples of errors we have seen where an attempt to follow the Pause Rule has failed:

- Rather than review the patient's medical record, the OR staff had a mentally incompetent patient verify surgical procedure and/or operative site and patient was incorrect.
- Staff verified surgical procedure and/or operative site by looking to the-executed consent document, which stated the incorrect surgical procedure and/or operative site.
- Staff performed a full Pause Rule, yet failed to recognize that the patient record used for verification belonged to a different patient.
- Staff observed the presence of an orthopedic brace on one extremity and assumed that it was the correct operative site, when in fact, the patient had

unilaterally decided to move the brace to the opposite extremity from the surgical site.

It is recommended that practitioners take the Pause Rule requirement seriously and avoid being mechanical in its application. It is imperative that the source of verification be accurate. Thus, verify the procedure and operative site through a review of the patient's medical record, including the consent document, as well as in a discussion with the patient or the patient's guardian. Also, perform a "time out" as required under the Pause Rule immediately before the intended surgery or procedure. This will not only benefit a practitioner in avoiding a wrong-site, wrong-procedure or wrong patient procedure, but will also facilitate the prevention of incidents where a patient claims that he or she did not provide informed consent to undergo the procedure. Following a thorough Pause Rule process will ensure that staff verify the completeness and accuracy of a consent document, which can also potentially avoid a recordkeeping violation. While this process is perceived by many practitioners as a burdensome delay, it is certainly not a waste of time and unfortunately, is a necessity that can only serve to benefit the practitioner and patient.

Retained Foreign Body

Another somewhat common violation that we see is when a foreign body is left in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or other diagnostic procedures. See Section 456.072(1)(cc), Fla. Stat., for the violation. Regrettably, this violation is still frequently observed. While many errors occur due to an unfortunate miscalculation of sponges or instruments by a circulating or operating staff member, it has been our experience that the operating surgeon may also be held responsible. The risks for such errors are of

course enhanced in cases with a high volume of blood loss, in cases where circulating and operative staff members have changed shifts intraoperatively and where more than one physician is providing care to a patient at the same time. It is highly recommended that where such actions occur, or when miscalculation is suspected, that intraoperative fluoroscopy or x-ray be employed to look for the presence of a foreign body prior to closure.

Conclusion

Much can be gleaned from reviewing the nature of the actions giving rise to DOH investigations. While it is well appreciated that a practitioner's time with a patient is limited, the absence of appropriate and timely recordkeeping is certainly deleterious across the board. Consider each of the above disciplinary actions and recognize that to vigorously defend each, appropriate and detailed documentation is imperative. Given the crisis involving the abuse of pain medications, it is critical that practitioners be vigilant in obtaining a thorough patient history to justify the use of such medications, appropriately apply and enforce pain management agreements, utilize drug screenings when such is warranted and documenting the timely provision of medication refills. Moreover, the incomplete performance of the Pause Rule is a strict violation of Florida law and thus, disciplinary action can certainly be anticipated. Again, documentation of a complete performance of the Pause Rule is critical in this regard, and certainly can serve as a mitigating factor in the event of error. Finally, solid detailed documentation is beneficial, both to the patient to facilitate continuity of care, and to the practitioner in the event that such care is called into question.

**The next article installment will cover the practice of Dentistry.*

Risk Rx



Formula for Improved Patient Care: Teamwork + Communication

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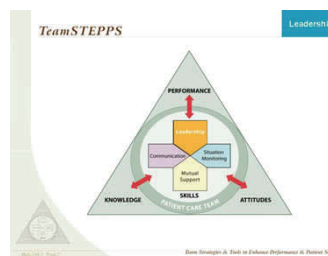
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Providing patients with the highest quality of care in a safe and effective manner is not a new concept in medicine. Nonmaleficence, which derives from the maxim, "*Primum non nocere*" or "First, do no harm" is one of the principal precepts of medical ethics. Technological advances have allowed for remarkable improvements in the ability to diagnose, treat and cure disease but at the same time have made the care of patients exponentially more complex. The ultimate ability to synthesize and coordinate our systems to care for patients relies on human effort. Despite clinical knowledge and expertise, technical know-how and individual skill, it is this complexity of care and systems-based issues that have increased the risk of quality failure and adverse patient outcomes. For example, we know from our experience of reviewing Root Cause Analyses (RCAs), that a failure in communication most often lies at the heart of an adverse patient event.

In the Department of Obstetrics and Gynecology, we recognize that one of the keys to success in improving patient care and outcomes is to improve our system of teamwork and communication both within our own department and across departments. We cannot solely rely on the wealth of indi-

vidual knowledge, expertise and skill to achieve superior results. To that end, we have implemented several programs to improve patient quality and safety.

The first initiative was to create an OBGYN Quality and Safety Committee. This committee was formed in 2008 under the leadership of our Department Chairman, R. Stanford Williams, MD and is comprised of the Physician Director of Quality (PDQ), Associate Vice President of Nursing Services, Nurse Manager of Labor and Delivery, Nurse Manager of the Mother Baby Units, Labor and Delivery Clinical Nurse Leader, Division Directors of MFM and Gynecology, Nurse Manager of outpatient OBGYN Clinics, a Shands Quality Representative, and a PGY3 OBGYN resident. The committee meets on a monthly basis to review our performance on national quality measures such as venous thromboembolic events, compliance with Surgical Care Improvement Process (SCIP) measures, patient satisfaction, and 30-day readmissions. Patient safety indicator events such as maternal 3rd and 4th degree lacerations, neonatal birth trauma, and surgical complications are reviewed on a case-by-case basis. Events which require an RCA, are also routinely referred to the Department Peer Review Committee (Chair, Division Chiefs of MFM and Gynecology) for appropriate action.



TeamSTEPPS (Strategies and Tools to Enhance Performance and Patient Safety) is a national quality initiative sponsored by the Agency for Healthcare Research in Quality

(AHRQ) and the Department of Defense to improve teamwork in healthcare. This program by and large has to do with effective communication and empowering all involved in patient care to

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speak up about safety concerns. Faculty and nurses within our department participated in formal training to implement TeamSTEPPS into everyday clinical care. Implementation continues to be a work in progress.



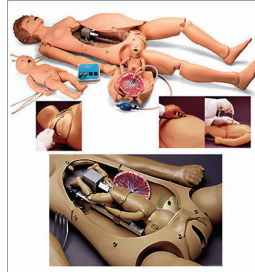
In February 2011, we had a site visit by ACOG's Voluntary Review of Quality Committee (VRQC). This review consisted of a three-day onsite survey by a team of seven experienced OBGYN quality reviewers. The reviewers toured our facilities, conducted 30-minute individual interviews with hospital and departmental leadership, faculty, nurses, and a resident representative. They also performed a chart audit. As a result of this site visit, several positive changes were implemented in areas of resident supervision, professionalism, and re-dedicating to the TeamSTEPPS approach to patient care.

It is well known that medical malpractice lawsuits in Obstetrics and Gynecology are a source of frequent litigation. Shands UF has been identified by our Self Insurance Program underwriter as one of their lowest claims clients in OB/GYN. Lloyd and Partners is our excess liability insurance broker as well as for ten other academic institutions. In a 2009 study, they found that Shands UF performed considerably better than the other participating institutions in the areas of: 1.) cost of medical malpractice indemnity plus expense per delivery, 2.) the likelihood of developing an obstetrical claim or suit, and 3.) the average OB claim cost. We are currently working on a project with our Self-Insurance Program to identify key factors that explain why Shands UF OBGYN is considered "best practice."

The Comprehensive Unit-based Safety Program (CUSP) is a hospital-wide initiative that all Shands inpatient units have been asked to implement by the Shands Quality Board. After a department-wide presentation which included soliciting input

from faculty, residents and nursing staff, the patient safety issues receiving the highest number of responses pertained to: 1. Global communication issues and 2. Care of obstetrics patients in collaboration with our Emergency Department. Although communication is a broad topic for which outcomes are difficult to measure, it was decided that we would, in fact, focus on communication and our Quality and Safety Committee is leading the efforts to carry through the next steps of implementation. Furthermore, we have dedicated a separate interdepartmental meeting to address improvement processes for collaboration with our Emergency Department.

Lastly, we are making great strides to focus on OB emergency simulation. More and more, simulation is being implemented to improve resident and medical student education, teamwork and most importantly, patient outcomes. There are a variety of reasons for implementing simulation which



include the ethics of patient care, i.e. moving away from the see one, do one, teach one mentality of medical training, as well as reduced resident work hours which limit case numbers and exposure to rare emergency situations to name a few. We recently had a grand rounds presentation given by Dr. Brent Seibel from Shands Jacksonville regarding simulation in OBGYN. Dr. Seibel is the Vice Chair of the ACOG Simulation Consortium and Centers for Excellence and has a wealth of experience and knowledge in this area.

Our goal is to establish simulation drills for the following scenarios: 1.) obstetric hemorrhage, 2.) shoulder dystocia, 3.) emergent cesarean delivery, 4.) eclampsia, 5.) uterine rupture, and 6.) maternal code.

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For gynecologic surgical training, we already have a curriculum geared toward simulation training in hysteroscopy and laparoscopy.



One area of simulation training that has required significant multidisciplinary effort is in the area of obstetric hemorrhage requiring massive transfusion. Anec-

dotally, these rare but life-threatening cases do not typically run smoothly, invoking such descriptions as “cluster” and “chaos.” However, the barriers do not necessarily seem to come from a lack of knowledge and skill of the nurses or physicians, but rather challenges with systems-based processes. One example is that our blood bank is housed across the street from our Labor and Delivery unit. Adding to the challenge is the high turnover rate of unit secretaries who are the first line to order blood products in an emergency creating a constant need for training to achieve process consistency.

We have taken a systematic approach toward improving our processes which have included meeting with OB and anesthesia physicians, nursing and the Shands blood bank manager; performing a mock hemorrhage drill to identify systems issues and conducting a multidisciplinary workshop to solve identified issues. The goals of the workshop were to accomplish the following: create a massive transfusion protocol (MTP) blood bank workflow specific for L&D, develop a quick reference laminated card for our unit secretaries and nurses to order blood products and lab tests, develop a Powerpoint education program for new staff orientation and continuing education, create emergency IV access kits and a hemorrhage evaluation cart, and create formal simulation drills. These goals are still a work in progress, but the hope is that once we have all of the necessary

pieces put together, we can then conduct drills on an on-going basis.

In summary, our department is committed to improving the quality of care that we provide to our patients. We are doing this by: conducting monthly Quality and Safety meetings, recommitting to the TeamSTEPPs approach to patient care, addressing recommendations from the ACOG VRQC site visit, partnering with the Self-Insurance Program to better understand the results of the Lloyd and Partners data, moving forward with CUSP, and implementing OB emergency simulation. Ultimately, the change in culture to one of teamwork, communication, and collaboration will be the foundation on which we build our future efforts toward safe patient care.



University of Florida Proton Therapy Institute: a unique cancer

treatment and research center

Gary Barlow, BSRT, Director for Technical Services
Theresa Edwards Makrush

The largest medical device in use today deploys one of the smallest particles known to man to effectively treat cancer patients. The device is a particle accelerator. The particle is the positively charged part of an atom called a proton. The cancer treatment is proton therapy.

There are fewer than 30 of these devices worldwide, nine in the U.S., one in the Southeast. It

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is at the University of Florida Proton Therapy Institute in Jacksonville, Fla. The 98,000-square-foot facility houses both conventional radiation therapy and proton therapy. There are four rooms for proton therapy, three that are equipped with treatment gantries that are each 30 feet in diameter and rotate 360 degrees in either direction to position the treatment nozzle. The cyclotron that generates the protons weighs 440,000 pounds and uses electromagnets to accelerate the particles to two-thirds the speed of light. Each patient is treated with a customized beam of protons, produced in the cyclotron, injected into the beamline, transported to the gantry and through the treatment nozzle. Less than a microsecond is all it takes the proton beam to travel from start to finish, to its targeted cancer.



Proton therapy is a type of external radiotherapy. The most common form of external radiotherapy uses X-rays. X-rays are waves of energy. Upon entering a patient, X-rays may interact with tissues in their path, some are absorbed in these interactions, but most pass through the patient. When X-rays are absorbed, they release radiation energy that can destroy both cancer cells and normal, healthy cells along their path. Like a bullet, an X-ray beam leaves a path of damage as it passes through the patient. Protons are particles with mass. Unlike X-rays, protons travel only a finite distance and release the majority of their radiation energy just before stopping. How far they travel is related to their acceleration—the greater the acceleration, the deeper they penetrate into the body. In contrast to X-rays, protons lose only a little energy, or radiation dose, in normal tissues on the way to the target and they release most of their energy, or radiation dose just before stopping. The protons can be accelerated to stop in the cancer. Because the protons stop in the targeted cancer, no radiation en-

ergy is released beyond the cancer, as with X-rays. In this way, protons deliver relatively more of their radiation energy to the cancer than X-rays and much less radiation to normal tissues, thereby causing less damage to normal, healthy cells. In the sense that protons deposit relatively more of their radiation energy in the target than X-rays, protons are more accurate and more efficient than X-rays.

Proton therapy enables the radiation oncologists to deliver high doses of radiation to the targeted cancer without exposing as much normal tissue to radiation as necessary with X-rays. Protons are therefore ideal for treating cancers located in or near critical organs like the brain, head and neck, eye, lung, pancreas and prostate.

The UF Proton Therapy Institute is affiliated with the UF College of Medicine's Department of Radiation Oncology and the UF Shands Cancer Center. It is a not-for-profit, 501(c)3, cancer treatment and research facility. The project was initiated in 1998 when then department chair Dr. Nancy P. Mendenhall identified proton therapy as the future of radiation oncology. Following a five-year feasibility study, facility construction began in 2003 and was completed in 2006 with the first proton therapy patient treated on August 14, 2006. With Dr. Mendenhall now serving as medical director of UF Proton Therapy Institute, the facility is fulfilling its mission: to bring cancer patients the best chance for cure with the least risk of complications and to generate scientific evidence for the optimal uses of proton therapy in cancer treatment.

Because there are currently only nine proton therapy facilities in the country, protons are a rare medical resource and the UF Proton Therapy Institute is committed to making this promising technology available to as many patients as possible. With a focus on accuracy and efficiency, approximately 94,000 treatments have been delivered to more than 2,700 patients since August 2006. The

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types of cancers treated include head and neck, brain, lung, central nervous system, soft tissue (sarcoma), lymphoma, pancreas and prostate as well as cancers in children. Proton therapy is particularly beneficial for treating cancer in children whose rapidly growing bodies are more susceptible to the harmful effects of radiation. Recent studies from St. Jude Children's Research Hospital show that even small amounts of radiation exposure in children cause permanent damage to IQ, hinder the body's normal growth and development and increase risk for secondary cancers later in life. The pediatric program at UF Proton Therapy Institute has become one of the busiest in the country, treating 15 to 20 pediatric patients each day. Thus far, more than 200 children have received proton therapy at the facility.

Patients come from near and far to have proton therapy. About 70 percent of patients come from beyond a 60 mile radius and include people from 49 states and more than a dozen countries such as Great Britain, Norway, Saudi Arabia, Pakistan, Peru, Nicaragua and Hong Kong. On average, 110 patients are treated each day Monday through Friday from 6:30 a.m. until 10 p.m. Each patient receives daily proton therapy for six to eight weeks. An active patient services program provides patients with opportunities to get to know each other, share their common treatment experiences and socialize. This social network creates a community for patients, many of whom are far from their traditional support system of family and friends.

As an academic medical treatment and research facility, the radiation oncologists and physicists at UF Proton Therapy Institute are UF faculty. The facility is one of the first clinically dedicated proton therapy centers in the world. Nearly 98 percent of all patients at the institute are on one or more protocols and clinical trials. Important areas of study include prostate cancer and pe-

diatric cancers, Hodgkin's lymphoma, lung and pancreas cancer, bone and soft tissue tumors in critical sites, brain tumors and cancer of the head and neck area. Early findings in prostate cancer, lung and pancreatic cancer, Hodgkin's lymphoma, and head and neck cancers have been presented at national and international meetings. The University of Florida Proton Therapy Institute is also collaborating with St. Jude Children's Research Hospital in children's' brain tumor trials.

UF Proton Therapy Institute is a regional, national and international resource for patients without access to proton therapy centers. Approximately 80% of patients treated are from outside the Jacksonville area, including approximately 25% who travel more than 300 miles and over 5% from overseas.

Though focused on accuracy and efficiency, the medical professionals and staff at UF Proton Therapy Institute are also dedicated to compassionate patient care. 98 percent of patients surveyed report their quality of care as excellent and would recommend it to others.

In the coming months, the UF Proton Therapy Institute will begin treatment in a new room designed especially for patients with eye tumors and other eye disorders. In addition, a new protocol will open for patients with advanced left-sided breast cancer. Treatment planning studies indicate that proton therapy in left sided breast cancer can reduce the amount of radiation received in the heart and lung while delivering the highest possible dose of radiation to the cancer.

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