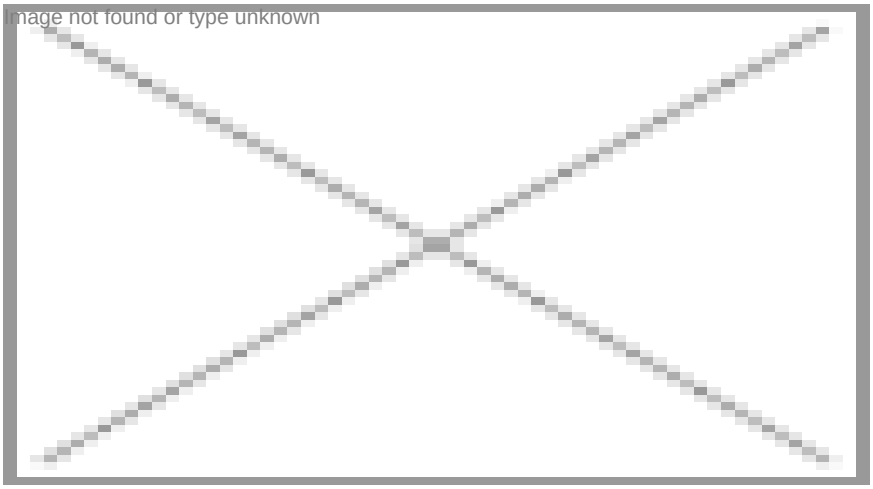
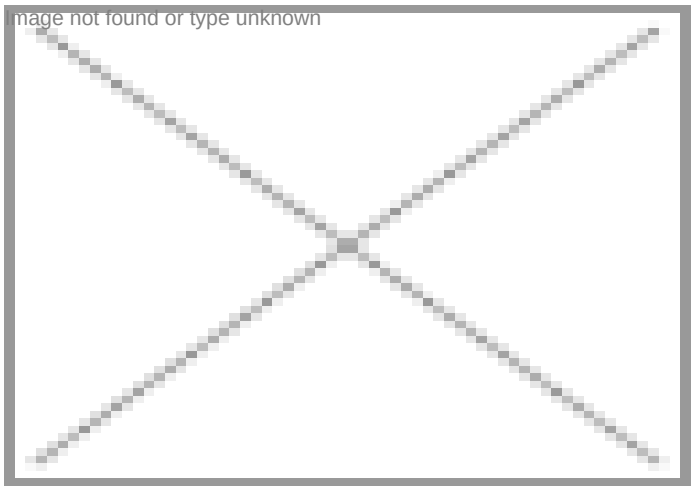
Falling Into Risk Reduction Opportunities

By Kathy Cartwright, BSN, RN, CPHQ, LNCC

Falls represent a large percentage of office and surgical accidents reported to SVMIC. Falls have also generated considerable attention from patient safety organizations. The Centers for Disease Control and Prevention have developed an initiative specifically addressing patient falls in their “STEADI” (Stopping Elderly Accidents, Deaths and Injuries”) program. [1] Additionally, the Journal of the American Medical Association noted that falls among US adults, aged 65 and older, is a leading cause of fatal and non-fatal injuries.[2] Although these injuries may seem relatively minor for most patients, it would be impossible to predict which patients will have a fatal vs. a non-fatal injury if a fall occurs. With that in mind, it is in everyone’s best interest to eliminate the possibility of any fall whenever possible. Graph 1 identifies overall the types of accidents reported.



Of all office accidents reported to SVMIC, falls occur in the largest percentage of these events. In addition, the majority of falls result in injuries that are temporary in nature, indicating that after a period of recovery, the patient is able to resume their previous level of independence. Some falls did not result in any physical injury at all and only a small percentage of the falls resulted in a permanent injury. None of the falls occurring in an ambulatory setting resulted in a death.



These graphs illustrate that the majority of office accidents in an ambulatory setting involve a fall, but the majority of the falls result in temporary or non-physical injuries. However, falls create interruptions and take you and your staff away from other patients in the office. You spend additional time examining the patient and evaluating possible injuries, which frequently requires ordering diagnostic tests and arranging transportation to an emergent care setting. The cost to you in time and resources creates motivation for the prevention of these office accidents.

Consider the possibility of this scenario occurring in your office:

An elderly patient was brought to your office for routine follow-up care, triaged by the nurse, and left sitting in her wheelchair in the exam room, unattended. Before the nurse returned to the exam room with the physician, they heard a “thud” coming from the room and rushed in to find the patient had fallen from her wheelchair, hitting her face on the nearby counter. The office staff quickly arranged immediate transportation of the patient to the local ER via ambulance, where it was determined that she sustained a nasal fracture, as well as a cervical fracture. The patient required additional medical care for her injuries. Later, the office staff determined that the nurse left the room without locking the wheels of the wheelchair.

This type of accident is preventable but requires implementing modest patient safety changes in office procedures. Patients in wheelchairs should always have the wheelchair locked when they are not moving from one location to another. It would also be advisable to avoid leaving wheelchair patients unattended, and especially if they cannot stand on their own. This may require that they remain in the lobby with their caregiver until both the physician and the nurse are able to examine the patient, reducing the possibility that the patient will have to wait for the physician after the nurse completes the intake information. If the patient gives a family member or caregiver permission to accompany them to the exam room, they are also a good option to stay with the patient if the nurse or physician cannot. SVMIC recommends documenting the patient’s mentation and mobility status, as

well as the precautions that the staff took to protect the patient's safety.

In another case, a 59-year-old female underwent lumbar steroid injections in the office without any complications. A few minutes after the procedure, the nurse evaluated the patient and confirmed that she was able to stand and bear weight. The patient indicated that she was able to change her clothes by herself, and told the nurse it would be fine for her to leave the patient while she changed. However, while the patient was changing, she lost her balance and fell on her shoulder. An x-ray revealed a shoulder fracture and required surgical repair.

This patient seemed to be able to stand on her own after her procedure, which resulted in the nurse allowing her to dress without assistance.

Many times patients don't realize how weak or unsteady they are until they make an effort to engage in activity, such as getting dressed, which may induce the dizziness and unsteadiness that led to this patient's fall. In the absence of having a family member or caregiver that can assist the patient, providing him/her with the assistance of a nurse may be the best way to ensure that the patient does not have an accident that will result in this type of harm.

Although it is rare to see a fall in the ambulatory setting with a devastating outcome, there have been cases where those occurred. In one case, a 43-year-old male seen in an office for an upper respiratory infection received intramuscular antibiotics during the office visit. The nurse asked the patient to lean over the exam table while standing so that she could administer the medications into his gluteal muscle. When the nurse administered the medication, the patient fainted and, as he fell, his head hit the wall next to exam table. The physician immediately assessed the patient and the office arranged for transport via EMS to the closest emergency room. Imaging studies identified a skull fracture with subarachnoid bleeding. The patient sustained permanent injuries and now requires assistance with activities of daily living. This case resulted in litigation in which the failure to develop policies for giving injections safely and the failure to train the staff on these policies were the primary allegations. If the staff member who administered the medications had implemented safe injection precautions to reduce the possibility of a fall, the result of receiving these injections may have been very different.

Frequently, a patient falls after receiving an injection or having a venipuncture performed. Sometimes a fall occurs after a patient takes medication, i.e., a sedative, for a test or procedure and attempts to walk or stand before it wears off. Almost half of all falls occurred in an exam room, but other locations included the hallway, lobby or the phlebotomy chair.

Many of the situations that result in a patient fall are preventable. The CDC has several resources available for healthcare providers designed to assist in screening and reducing fall risk. You can find this information here.

SVMIC also has an online educational program titled "Patient Safety in the Physician

Office Setting" which is available here. The Course Catalog contains the information for registering and taking this course. This course provides additional suggestions for improving the safety of the physician office setting.

By taking steps to eliminate the potential for a patient fall, you will be able to improve patient safety and also reduce liability risk in your office. With that in mind, use these suggestions to create or enhance your patient safety policies:

- Identify patients who may be at risk for a fall
    - Patients who have medical procedures, such as venipunctures or injections, which may create anxiety or pain
    - Patients who are elderly or adolescent

- Implement measures to reduce the risk of a fall
    - Offer a beverage and/or reassurance about the procedure to reduce anxiety
    - Have patients sit or lie down during the procedure and then assist them to a safe location after the procedure is finished for them to wait until they have been observed
    - Observe all patients for a period of time after an injection or venipuncture to ensure they are not dizzy, weak or unable to ambulate to their car
    - Assist all patients with mobility limitations or visual impairment with moving off exam tables, out of the office and into their car
    - Do not leave patients alone in an exam room after a procedure – if a family member or friend did not accompany them to the office, designate someone in the office to stay until the required waiting period is complete
    - Be sure that wheels on equipment, stools or other furniture are locked when not in use. If there is not a wheel lock available, consider marking the equipment "Staff Use Only" to discourage patients or their family from using it
    - Determine if the patient is oriented and able to follow instructions before leaving them alone after a venipuncture or procedure. If the patient does not understand that he/she should not attempt to walk alone, a friend or family member may need to stay with him/her if your staff is not available
    - Document the patient's condition on presentation to the office
        - The assessment of the patient's mentation
        - Instructions given regarding activity limitations
        - Safety measures employed and assistance offered
        - Refusal to accept assistance/follow the directions

Although falls may not be common in your office, the adage that “an ounce of prevention is worth a pound of cure” could not be more appropriate when applied to this topic. As we have learned from this study, most falls do not result in large lawsuits with paid losses. However, the injury sustained by the patient, as well as the staff time associated with addressing the patient’s care needs, creates a complication in your day. By improving your patient’s experience with a few basic safety measures, you will find yourself falling into risk reduction opportunities and saving time and resources for your practice.

[1] https://www.cdc.gov/steadi/

[2] Older Adults’ Falls Take High Toll. *JAMA.* 2016;316(18):1860. doi:10.1001/jama.2016.15623

A Time-out that Did Not Save the Day

By Dan Himmelberg, JD

Jim Logan,[1] a 54-year-old attorney and outdoorsman, had seen various providers over several years with occasional complaints of pain in one or both knees. In 2011, he injured his left knee while fishing. An MRI showed degenerative changes. Mr. Logan was initially treated with NSAIDS and pain medication. Six months later, he received a Cortisone injection in the left knee due to continued pain complaints. In early 2012, physical therapy was ordered due to bilateral knee pain. As 2012 progressed, Mr. Logan was diagnosed with bilateral osteoarthritis. His treatment, including injections in the right knee, continued. By the end of the year his right knee arthritis was assessed as mild to moderate and he started using a brace at times. This general pattern of knee pain complaints, sometimes in the left and sometimes in the right, continued through 2013 with physical therapy and other conservative care.

In November of 2013, Mr. Logan sought a second opinion and presented to orthopedic surgeon Dr. Fisher with a complaint of right knee pain. There was no mention of left knee pain. An MRI of the right knee showed moderate thinning of the articular cartilage and some bone infarctions. Dr. Fisher prescribed a Medrol Dosepak and Norco®. He recommended therapy with a different physical therapist. Mr. Logan did not return to Dr. Fisher for further care until July of 2016. He again complained of right knee pain. Plain x-rays from his PCP showed moderate osteoarthritis of that knee. Mr. Logan declined a Cortisone injection. Another MRI was ordered. This was positive for a medial meniscus tear as well as grade III arthritis. In August, Mr. Logan was seen again by Dr. Fisher. He was wearing a brace on the right knee, had an antalgic gait and the knee was tender upon palpation. In November, Mr. Logan complained that his right knee pain was interfering with his sleep and daily activities. Dr. Fisher then scheduled an arthroscopic surgery of the right knee.

When Mr. Logan presented to the hospital's surgery center, he was scheduled to be Dr. Fisher's ninth case of the day. Dr. Fisher saw him in the holding area when he was second or third in line for the OR. Dr. Fisher briefly discussed the planned surgery with Mr. Logan and marked and initialed the right leg. He wrote "Yes" and his initials on the front of the mid-leg. Dr. Fisher then continued with his other surgeries. When Dr. Fisher next saw the patient, he was prepped and draped in the OR. A time-out was called by Nurse Webber and the surgery proceeded. A partial medial meniscectomy was performed.

In the recovery room, the patient discovered that the surgery had been performed on his left knee instead of his right knee. He alerted the staff. Dr. Fisher and the staff spoke with the patient about the surgical error, although there was no clear explanation for how it

occurred. Mr. Logan expressed understanding and commented that his left knee had been bothering him also. He was sent home with the plan to return in one week to evaluate the left knee and discuss surgery on the right knee. The patient was not charged by the hospital or Dr. Fisher for the wrong site surgery. When Mr. Logan returned, the left knee was healing well. He was scheduled to return in two weeks. Mr. Logan did not return to Dr. Fisher but transferred his care to another orthopedist. The new orthopedist performed a right knee replacement six weeks later.

Mr. Logan later filed suit against Dr. Fisher, Nurse Webber and the hospital due to the wrong site surgery. He asked for an award for his medical expenses related to the later surgery performed on the right knee, pain and suffering, lost earnings due to the wrong surgery and delay in recovering from the more extensive second surgery, and punitive damages. The hospital was responsible for the actions of Ms. Webber and the rest of its staff.

The co-defendants agreed it was best to try to settle this claim as quickly as reasonably possible. However, there was significant disagreement about who was responsible for the majority of any payment. While there was a clear error in performing the surgery on the wrong knee, the genesis of that error was unclear. The surgery requisition form and preoperative orders correctly stated the right knee and Dr. Fisher marked that leg. However, the wrong knee had been prepped and draped. Nurse Webber had called the pre-surgical time-out and the error was not caught. No one could recall for certain whether Ms. Webber had called out that the surgery was to be on the left or right knee, but indications were that she likely said the left knee.

Dr. Fisher's position was that he was the only one who was known for certain to have correctly identified the right side on the day of surgery – the scheduling paperwork was correct and he marked the correct leg. Mr. Logan had taken photographs of both legs after the surgery. These showed Dr. Fisher's markings on the right leg and the surgical bandages on the left knee. The hospital argued that the marking was "pretty useless" because it was not visible after the leg was prepped and draped. Dr. Fisher's attorney noted that the hospital's surgical protocols and policies did not specify how the marking was to be done and what Dr. Fisher did was the typical routine by him and others. Additionally, other surgeons continued with the same marking technique after this surgery and the hospital did not question it or change its policies. After this surgical misadventure Dr. Fisher started marking surgery sites where his markings could be seen after draping. He also started marking a large "NO" on the incorrect side as another precaution. The hospital pressed that Dr. Fisher, as the surgeon, had the most responsibility to ensure the surgery was on the correct site. Dr. Fisher had to concede that he had not looked at his surgical paperwork in the OR, including during the time-out, and did not have a copy of his imaging of the right knee in the OR.

All of the parties proceeded to a mediation. It was quickly clear that a settlement could be reached with Mr. Logan for a reasonable global amount. However, this was as much a mediation between Dr. Fisher and the hospital as between the defendants and Mr. Logan.

After approximately ten hours of negotiation, SVMIC and Dr. Fisher agreed with the hospital to an apportionment of the settlement amount (with the hospital having the greater portion). While neither side was completely happy with the final outcome, the value of resolving the claim was recognized and accepted.

[1] All names have been changed for confidentiality.

What You Don't Know...Can Hurt You

The following article is based upon an actual claim situation experienced by an SVMIC policyholder. The details have been altered to protect our policyholder's privacy.

David[1], an employee of Dr. Jerome's medical practice, was in college studying to become an IT Specialist. David was hired to manage the practice's social media presence while he was still in high school. He posted updates to the practice's Facebook account as well as helped to respond to any negative comments that were posted, and otherwise monitored the practice's internet presence. With David's advancing education, his duties expanded to include helping with cybersecurity and any other computer related issues, including setting up new equipment.

Sandra, the practice manager and David's aunt, asked David if he thought he would be able to create a new website for the practice. Although David was not studying graphic design in school, he was aware of programs that assist in the creation of a website, and he jumped at the opportunity to help update the image of the practice and exercise some of his creativity.

David created an attractive, modernized and easy-to-use website that included an online appointment scheduler as well as links to the practice's Facebook page. The website was launched and the practice received many compliments from current patients, as well as a few new patients that came to the practice after finding them online via their website.

About three months after the website was launched, the practice received a letter that alleged that one of the images on the website was used without an active license and therefore the use of the image was considered copyright infringement. Sandra asked David if he had checked for copyright on the images that he used on the website, and he said that he thought they were all royalty free but he could not say for certain. Sandra called SVMIC because she always called any time she had a question or problem.

Fortunately, for all involved, Dr. Jerome's practice was insured with SVMIC and his policy included $50,000 of cybersecurity coverage through NAS. The cybersecurity coverage not only provides assistance for a cyber-breach or cyberattack, but also includes multimedia liability coverage*. Sandra sent a copy of the letter to an SVMIC claims attorney and when NAS was subsequently notified, they were able to assist Sandra in responding to it.

Multimedia liability provides coverage for third party claims alleging copyright/trademark infringement, libel/slander, advertising, plagiarism and personal injury for both online and offline media. The multimedia peril for which coverage is provided is defined as "the release of or display of any electronic media on your internet site or print media for which you are solely responsible and which directly results in …infringement of copyright, trademark, trade name, trade dress, title, slogan, service mark or service name…" (Cyber

Security Endorsement (01.2015) (RL 2016) P22, Section II, Number 4).

It may not occur to policyholders in this situation to report a copyright infringement claim to their cybersecurity insurance carrier. The embedded coverage included in the professional liability policy through SVMIC is specifically designed for healthcare providers and each policyholder should consider whether the limits are sufficient for their situation. Along with multimedia liability and privacy breach response coverage, the endorsement includes coverage to recover and/or replace lost data, loss of income, cyber extortion and cyber terrorism expenses, and more.

In addition to the cybersecurity coverage through NAS provided in SVMIC's medical professional liability policy, there are other tools available to our policyholders. SVMIC has partnered with NAS to bring our policyholders access to NAS cyberNET. This site features monthly cybersecurity updates, webinars and online training and support. Access this site at https://www.svmic.com/resources/cyber-security. In addition, SVMIC's Medical Practice Services offers consulting and training related to cybersecurity and HIPAA.

**Cybersecurity coverage is subject to terms, conditions and exclusions not described in this article. The information contained in this article concerning cybersecurity insurance is intended to give you an overview of the coverage available. None of the information—including any policy or product description—constitutes an insurance policy or guarantees coverage. The policy contains the specific details of the coverages, terms, conditions and exclusions and coverage determination is made by the company at the time of a claim.*

[1] All names have been changed for confidentiality

Making the Most of Team Meetings

By Julie Loomis, RN, JD

Like most busy physicians, you probably dread the monthly team meeting to take a closer look at office processes and systems. In a day filled with playing phone tag, wading through e-mails, dealing with unexpected patient situations, following up on tasks and documenting, where's the time to squeeze in another meeting? You may already meet daily for the patient-care focused "huddle", so why is another meeting important? About a third of malpractice claims list hidden flaws in processes and systems as contributing factors. Correcting flaws and filling in the gaps is not only protective, it's crucial to patient safety. Even when things seem to be going well, the "silo effect" can erode the health and function of the team. By focusing primarily on individual tasks (reception, registration, billing, triage, rooming patients, treatment, etc.), it's easy to lose perspective on the common goal and communication suffers. Although a team meeting will take time, if it is well planned, organized and adheres to an agenda, the return should be more streamlined processes, increased efficiency and optimized work flow. Gathering together regularly (typically monthly), the team is challenged to look for inefficiencies and barriers to optimal service and are empowered to offer solutions. Additionally, there could be important updates to your EHR, practice management, email and other systems that require attention and discussion. Your EHR vendor and other commercial software providers are frequently adding time-saving features to their products that can be demonstrated at the meeting.

There are some basic tips for a successful meeting. The key is fast feedback in a structured yet open atmosphere. Start with a prioritized agenda that is relevant and on task to keep your team members from becoming frustrated by a myriad of topics. Physician facilitation is essential but don't make attendance mandatory for the entire team. Instead, ask for everyone's *participation* by sending out the agenda early, offering the opportunity to attend if s/he has identified a problem or may be involved in the solution. Take meeting minutes to summarize the discussion and concisely describe the action item(s) taken and who is responsible. Begin and end on time, even if that means giving some participants follow up assignments for the next meeting.

Rather than trying to cover too much ground, give the meeting a specific focus. Invite experts from within the practice to evaluate and make recommendations for time-saving tips. Just like using "macros" for efficiency in medical documentation, giving your IT specialist 5-10 minutes to teach the latest email shortcuts or EHR enhancements can save you significant time over the course of a day. Consider creating a task force to explore a new option, such as utilizing a scribe, to determine potential benefits and cost savings. Periodically address procedures for responding to unexpected events such as a provider

or staff member who calls in sick, an office emergency, a fire drill, etc. so the event doesn't disrupt patient care.

Some practices implement a patient feedback tool, specifically to identify patient flow issues. Often, feedback can pinpoint a bottleneck in the system, preventing patients from receiving the highest level of service. For example, your practice may have a process or protocol intended for patient convenience (and practice efficiency) that ends up defeating that purpose. Do you allow patients to report to the lab for pre-physical or serial testing? If so, do you create an order for those tests on a specific date? Does your protocol cover the possibility that the patient needs to reschedule without the lab requesting new orders? Keeping track of patient callbacks related to processes is another opportunity to identify inefficiency. Do patients call back frequently for medication refills? For test results? These questions could point to the need for education on general practice policies that may be discussed at the team meeting.

Remember that regular meetings to review processes and work flow are well worth the time and effort as they can prevent a leading factor in medical malpractice claims: systems failure. Face-to-face meetings raise awareness of potential flaws and allow for centralized communication without relying on fragmented bits of information through emails or memos that can go unnoticed. For resources and more information on this topic, please see the resources section of our website.

Self-scheduling: Attracting the Coming Wave of Patients

By Elizabeth Woodcock, MBA, FACMPE, CPC

The generations known as “Baby Boomers” and “Gen Xers” constitute the majority of your patients today; however, it’s necessary for you to be thinking about the coming wave of Millennials and Gen Zers.

While addressing the needs of the new generations may concern you, the automation these patients demand not only benefits them, but can also prove advantageous to your practice. The next wave of patients craves consistent, effortless and efficient interactions.

While there are many ways to make headway towards this goal, one of the simplest is self-scheduling. Self-scheduling is available through many practice management systems but can also be accomplished by contracting with a third-party vendor.

Self-scheduling benefits patients by providing easy access, around the clock. In addition to a patient satisfier, however, the activity also provides several advantages for your practice. First, self-scheduling requires no one to pay to answer the phone, identify the patient and/or schedule the appointment. While there may be some manual intervention required on the back-end, particularly surrounding the registration process, the time expended is less than handling a patient calling to schedule an appointment over the telephone. While the solution may not require as much staffing, it typically won’t result in cutting several (or even one) employees.

The hidden – but more powerful – benefit is the drop in the no-show rate. In working with many practices that have adopted self-scheduling, my experience demonstrates a remarkable 50% drop in no-shows for patients who self-schedule.

If you’d like to attempt self-scheduling, but are worried about opening a flood gate, engage with a solution that keeps you in control. For example, release slots only for established patients; restrict the number available per day; and/or control the timeframe for advanced notification. Most importantly, do not install a system that fails to integrate slot releases. That is, if the appointments that you have made available via self-scheduling do not fill, then they need to convert to a slot available for any patient.

Ease the throttle forward after you gain comfort with the solution; most practices find that their biggest hurdle to self-scheduling is getting out of their own way.

Treating Pain Amidst Multiple Guidelines

By Rett Blake, MD

The Challenges Physicians Face

Taking care of patients in chronic pain has always been a challenge for physicians. We face many different challenges trying to help people who suffer with pain, the first hurdle figuring out the cause. There's a long list of things that can cause something as common as chronic low back pain. We have to perform the appropriate history and physical exam, order the right diagnostic studies and refer to specialists when necessary. Once we have established why the patient is in pain, we have to develop an appropriate treatment plan. This can, and usually should, involve multiple different treatment options, especially for chronic pain patients. In developing this plan, we also have to consider other medical comorbidities that a patient may have. With pain that has been present for any significant length of time, we also have to consider multiple psychological factors that can affect the patient's experience with pain and treatment outcomes. As complicated as this is, chronic pain is anything but uncommon. With chronic daily pain affecting one third of all Americans, we all see chronic pain patients regardless of specialty or area of practice. On top of all of these issues, we now have the added challenge of dealing with multiple different guidelines surrounding opioids.

Opiods Aren't the Only Option

Opioids are only one of many different treatment options for chronic pain patients. Unfortunately, they have moved too high on the treatment algorithm for most doctors over the last 20 years. As I'm sure anyone reading this article already knows, the rates of opioid prescribing have skyrocketed over the last 20 years both nationally as well as in Tennessee. Tennessee has always been near the top of the list for every negative statistic related to prescription opioids. This increase in prescription opioid utilization, along with the dramatic rise in illicit opioid availability, has created the opioid epidemic that our nation faces today. Many different factors have contributed to the increase in prescription opioid utilization by physicians. The pharmaceutical industry launched an aggressive marketing campaign that encouraged increased utilization by physicians based on weak data. Insurance companies have a long history of denying coverage for things like physical therapy, injections, and psychologically based treatments. We also have an aging and more obese population who often demand opioids as a quick and easy fix for their ailments.

Guidelines Introduced

In response to the abuse, addiction, and overdoses that followed these trends, multiple agencies and organizations introduced guidelines to limit opioid prescribing in order to curb this epidemic. These efforts started as early as 2002 when Tennessee started developing its Controlled Substance Monitoring Database (CSMD). The Prescription Safety Act of 2012 required all prescribers to register in the CSMD and to query it every time they wrote a prescription over 7 days. It also required the Department of Health to create guidelines on proper opioid prescribing which they released in 2014. The CDC also created guidelines for primary care physicians that were released in early 2016. Laws have been passed related to the regulation and oversight of pain clinics. These efforts were created with good intentions to improve medical care and save lives, and the guidelines were very effective at reducing the dose and number of opioid prescriptions nationally and statewide. We have seen a decrease in the number of prescriptions as well as the total dose of opioids across the country, but the declines have been especially noticeable in Tennessee. However, despite this drop, our numbers are still near the top of the list when compared to other states.

Most recently, we have seen the passage of Public Chapter 1039, effective July 1, 2018, which imposes very strict and absolute limits on opioids prescribed for acute and post-operative pain. Opioid prescriptions of three days or less and 180 total morphine milligram equivalent (MME) dosage or less do not require additional criteria to be met. All other opioids require certain criteria to be met by the prescriber and also must be dispensed from the pharmacy as a partial fill. This means that for a 10-day prescription, the pharmacist can only dispense 5 days' worth at the initial visit, and the patient must return for the second half of the prescription if he/she still needs it. This effort was based on data that shows opioid exposure for longer than a 10-day duration dramatically increases the chance that a person will still be on opioids one year later. This measure will hopefully decrease addiction through prevention of initial exposure. While there are some notable exceptions to this law, for chronic pain, palliative care, and cancer pain, it represents a dramatic departure from traditional guidelines because it is a law that imposes strict limits on dose and duration of a medical treatment.

Other Entities Enact New Requirements

Commercial insurance companies, state and federal payors and pharmacy benefit managers have also enacted new requirements. Many of these policies require time-consuming prior authorization steps that overwhelm both small and large practices. Unfortunately, the policies are not uniform and this creates a difficult and confusing burden for physicians. These requirements have caused some physicians to stop treating pain with opioids completely. There may also be an adverse effect on chronic pain patients who will have to deal with debilitating pain without the one measure that has proven effective for them. One study [1]of 3108 pain patients indicates that 84 percent report more pain and a decreased quality of life as a result of the CDC guidelines, and 42 percent have considered suicide. We also have to take into account the unintended consequence of

increased mortality from illicit opioids such as heroin and illicit fentanyl analogues. While we have seen dramatic decreases in opioid prescribing patterns, we have seen an increase in overdose deaths as people turn to street drugs.

As we navigate these difficult times, it is important that we always keep our patients' best interest at the forefront of our decisions. While it is imperative that we change our mindset on when and how we prescribe opioids, we must also remember that there are patients out there that do suffer from chronic pain and deserve to be treated with the same compassion as anyone else.

[1] https://www.painnewsnetwork.org/stories/2017/3/13/survey-finds-cdc-opioid-guidelines-harming-patients

How Being a Father Has Made Me a Better Doctor

By Michael McAdoo, MD

Along this pathway called life, I've had 2 distinct blessings which overlapped and played an integral role in my career. First, the opportunity to practice medicine as a calling serving my fellow man. Secondly is the God-given blessing of being a father and allowing me to pass on a father's love and blessing to my children. At times, admittedly, it was a struggle to keep the precious family time worked into an initial solo family medicine practice. My yet unmentioned blessing of a wife did a great job to cover my hours away and always elevate my standing with our 3 children.

My 3 children were always there bringing me down to earth with a reality check and keeping me focused on what really matters at the end of the day. They educated me about simple life and allowed me to share a learned compassion and thankfulness with my patients. Children truly are the joy of the Lord.

My children were also my direct connect to all public health issues and diseases working through our community, which helped improve my diagnostic acumen. Having 3 children and grandchildren involved in many extracurricular activities has also allowed me to donate my time and provide sports and camp physicals for 37 years. This has kept me involved in the community.

Initially, on opening my practice in my wife's hometown, I was known as James Criswell's son-in-law. Shortly afterwards I became known as Dixie's husband and then, for a brief moment in time, I was known as Dr. McAdoo. Soon I arrived to the elevated title of Kristi, Lori, and Matt's dad - atitle I still wear proudly today. Now I have an additional attribute as Kate, Will, Ingram, Nants, Mac, and Jackson's granddad. Found on my office wall was a framed poem with unknown author that I proudly share in summarizing today.

"My Daddy"

When Daddy signs his name
He always writes M.D.
That's so all the people know
That he belongs to me

For M.D. means "My Daddy"
Or something just the same,

And that is why he always puts
Those letters by his name

Some letters in his name are small
But these are not you see,
He always makes them big like that
Because he's proud of me.

A proud dad and doc,
Michael A. McAdoo, M.D.

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