

HealthCHAT™

DocCHAT™ ~Majed Hassan M.D., MEDICAL DIRECTOR (continued on page 2)



Mandarin
904-292-0322
Open Saturdays



Beach Blvd.
904-645-3775



Westside
904-389-2525



North side
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Well here we go again. I finally have something that bothered me so much that I have to talk to you about it.

We waited for 20 years to get healthcare reform oh I mean “reform”, sorry that must have been a Freudian slip! My understanding of reform is that you take something that is not working well and you improve it. Or maybe expecting our politicians to speak plain English is expecting too much. It doesn't matter whether you were on the left, right, or independent. You were violated (to be nice) with this monstrosity that passed with big fanfare.

Yes, I do support healthcare change. We still need to dump what we have and start all over. No, I don't support either side of the aisle or the ones in the middle but support you, our patients. I am tired of seeing all of us worked over year after year by corrupt politicians. Unfortunately, they have sold their souls to the lobbyist. Without meaningful election reforms, we cannot expect to reform anything else. When it costs so much to win an election, then the people with the money call the shots and we, the “share croppers”, are left with the crumbs.

My heart breaks when a patient tells me that he had to divorce his incapacitated wife so she can get Medicaid benefits. Their assets consisted of the roof over their heads and his salary which put them over the line. Yes, they still live together as a divorced couple. Or the patient who lost her job and insurance, so she had to wait 2 years to get follow up medical care. By that time an advanced breast cancer was discovered. What message are we sending to our children and grand children?

Well doesn't this health care bill take care of these problems? No, it doesn't! Health insurance costs are not significantly addressed with this bill. We as individuals or small companies cannot afford to buy what our “public servants” have. What I want for you and me is what our federal, state, and city governments provide to their employees, and what Congress provides to its members. Believe me, you and I are willing to pay for it too.

In the year 2000, we paid \$65 per employee for decent coverage. Now we pay \$385 per employee with a \$2000 deductible.

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Alert

The new changes to the DOT drug screen panel has been pushed back from May 1st to October 1st. The new panel will add two additional drugs and will reduce the cutoff values for some drugs.

MIDMA (Ecstasy) and 6-acetyl morphine (Heroin-specific metabolite) are added to the panel.

The cutoffs and confirmations for amphetamine and cocaine has been lowered.

The ruling on observed specimen collection is very stringent now. An observer of the same gender will be in the bathroom with the donor and will observe the urine leaving the body and entering the container. Also, we'll ask the donor to raise the shirt or the blouse etc up to the navel and to drop the undergarment to the knee level in order to look for plastic containers attached to the body . If the donor refuses to allow the observation , this will be considered a refusal to test.

According to some studies 10-15% of the work force has a substance abuse problem. That is calculated to cost the employer an average of \$7,000. per abuser in terms of lost productivity, mistakes, absenteeism etc. Alcohol abuse-habitation is not included in this.

WE CARE ABOUT YOUR HEALTH

So we have had a 500% INCREASE since 2000. What is more disturbing is that while the insurance premiums have sky rocketed, the insurance reimbursements to physicians have remained the same or decreased for many procedures.

Follow the money trail. Since the bill passed, the stock of all of the healthcare companies have gone up. Over the next few issues I'll be sharing my ideas and providing you with information about what needs to be done and how it can be accomplished. Also, we want to hear from you.

Outside of the white washing agreement of allowing the kids to stay on our insurance until their mid twenties, we will get nothing. Now outside of the sad cases of young people with congenital diseases or traumatic injuries, the numbers that require expensive health care is very minimal. So, by agreeing to it, without much fussing, the insurance companies scored huge gains by escaping from passing a bill with meaningful competition to their monopoly on health insurance fees.

As a business man responsible for insuring our physicians and staff, I can tell you that when one of the insurance companies rate goes up, they all follow within one to five percent difference. The increase can be up to 30%.

The preexisting condition waiver is great, if you can afford the premiums. Major employers already have that, the government already has that for its employees. You and I as individuals don't. Many of our patients and friends, who need to retire due to health reasons cannot do it due to the exorbitant cost of coverage as individuals. The new "reforms" didn't change any of that. The millions that will be insured and paid for by the tax payers will break the country due to the lack of price competition to insure them.

The cost of medications is ridicules. I can get the same medication in Europe, South America, or here at the armed forces dispensaries at significant savings; yet we the poor citizens who pay for everything with our taxes cannot afford some of our medications.

I have patients who skip doses in order to afford their medications. "But Doc something is better than nothing" is the answer that I get, when I ask why. Last week one patient answered by saying "I only have \$5 co-pay," when asked if he could afford the name brand that I prescribed, since a generic didn't exist. He had governmental insurance. Another patient's answer to a similar question was: "Please find me a similar generic drug or I cannot afford to fill the prescription." The patient had insurance through the employer with a \$1500 deductible. Her tax dollars are working for someone else but not for her. Something is gravely wrong with this picture.

I am sharing these stories with you because an election is coming up and things need to be changed. The bill that was passed is the beginning and not the end, as I see it. The million dollar question is do I have a better plan to offer? Or I am just blowing hot steam! I do have a better plan and will share with you next month.

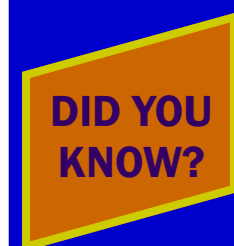
I want to let you know that the Private Care Physicians are getting the short end of the stick just like you. We are in it together and will need to work together to CHANGE it and not reform it. I am not advocating the cause of one political part or another but the cause of our citizen. We are spending 17% of our gross domestic product on health care. It is reported that up to 40% is wasted on needless bureaucracy and testing.

The latest news about the need for mammography for those who are younger than 50 has raised serious questions among females younger than 50. What is the harm produced by screening everyone in that age group or younger? Here are the concerns and some of our opinions:



Dr. ANA M. ROMERO

Dr. Ana M. Romero is Board Certified in Family Medicine with a Fellowship in Obstetrics and Gynecology from Spartanburg, South Carolina. She joined The Doctors Center in August of 2006. She is fluent in Spanish and interested in Preventative Medicine and Women's Health.



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1. **False-positive tests:** means that the mammogram was read as suspicious of cancerous tumor but the biopsy proved that it was not. A false-positive reading is considered to be a mammogram that prompted additional workup (such as further imaging or biopsy) in a woman who had no finding of breast cancer within one year. The clinical consequence of this error is recommendation for additional tests and procedures in a woman who does not have cancer, but if you have a suspicious lump don't you want to know for 100 percent whether it was cancerous or not? Are you willing to undergo the additional testing and EXPENSE (we aren't being more cynical than usual to say that the key word that prompted all of this is EXPENSE to the insurance companies, we still remember the time when they didn't pay for screening mammography for any age group)? False-positive readings are more common in younger women, because the tests are less specific and breast cancer is less common. Different studies have shown that the sensitivity of mammography and clinical breast examination is higher in older, compared to younger women. Mammography detects about 75 percent of breast cancers in women in their 40s and 90 percent of breast cancers in women in their 50s and 60s. Dose a 75 percent detection rate, constitute a sufficient reason for us to keep on ordering it for the group between 40-50? You tell us, we'll do what you want. Lifetime breast cancer risk is below 15 percent. The decision to perform mammography should be determined by individual patient risk and values through shared decision making.

2. **Over diagnosis:** we think that over diagnosis is better than under diagnosis, even with concern for the unnecessary stress that it may causes the patient. IN Europe they have a lower % of over diagnosis and the quality of care and life expectancy, in regards to breast cancer, is the same as in the USAA.

3. **Ductal carcinoma in situ** remains in place for years without causing metastasis, In the USA it will be diagnosed earlier at greater cost than other countries . But studies report the same outcome.

4. **Invasive cancer outcome** is not changed by the mammogram; this is irrelevant. If one is unfortunate, to have this diagnosed. A mammogram is not needed but other diagnostic modalities.

5. **Discomfort:** we don't believe that this was even a serious concern. We don't think that this is more uncomfortable than having a pelvic examination, so let us do away with that!!

6. **Radiation amount:** Are they kidding? There is more harm produced by inhaling car exhaust than that amount of radiation.

Below we will summarize for you the recommendations of most Medical groups regarding the age group between 40 and 49:

For women who do not wish to participate in shared decision-making, the ACP suggests mammograms every 1 to 2 years for women age 40 to 49 years. In December 2009, after professional and public reaction, the USPSTF revised their November 2009 recommendation, dropping the comment not to routinely screen women aged 40 to 49 with mammography, but continuing to recommend individualized decisions based on each patients history and discussing benefits and harms. (Continued on page 4)

WOMEN'S HEALTH ~Breast Cancer (continued from page 3)

All major North American groups making recommendations about breast cancer screening recommend routine screening with mammography with or without clinical breast examination for women aged 50 and older. For women in their 40s, or younger some groups recommend shared decision making because of trade-offs of benefits and harms:

An approach to breast cancer screening should incorporate an individual's level of breast cancer risk, established by history and by use of a risk prediction model. The model most commonly used is the Breast Cancer Risk Assessment Tool (Gail model), available online at:

www.cancer.gov/bcrisktool/

Every woman above age 50 should get a yearly mammogram. It is adequate to keep up with screening recommendations and close follow up. In making this decision it is also advised to consider the increase in health care cost as a society, and don't forget some of the recommendations by physicians are made more out of concern because of liability and legal issues not just what is medically needed.

We at The Doctors Center always welcome your feed back.

ON THE JOB INJURIES - Getting back to work

"But Doc I still have pain which I didn't have before the injury at work." This is a common protestation we sometimes hear, as physicians, when we return patients back to work. Then comes the ever present TV ad "if you were hurt at work....call me."

The physicians that treat injured employees must treat them with professionalism and objectivity while adhering to the Law. The law states, in so many words, that pain in the absence of work related injury with objective findings is not compensable.

First of all, the mechanism of injury has to be taken into account to determine work relatedness. Secondly, the presence of preexisting conditions and their contributions to the current problem has to be addressed.

Let me illustrate how this works: Patient one came to see me stating that he was pulling down a truck door to lock it when he felt pain in the shoulder going to the arm with tingling. The past medical history revealed multiple herniated cervical disc surgeries.

So the mechanism of injury will produce pain and maybe temporary tingling in the arm from stretching the nerves in the extremity. When the pain stopped and numbness didn't go away, so an MRI of the neck was obtained.

The MRI showed a preexisting condition responsible for the persistent tingling in the extremity. Thus, I decided that the continuation of the problem is due to the preexisting condition. I discussed the findings and my reasoning with the patient. He agreed to seek help from his previous surgeon and to utilize his private health insurance. In this case the strain from pulling the door was responsible for the initial treatment but the continuous tingling is due to the preexisting problem in the neck.

Patient two came to the office complaining of lower back pain. The pain started after the employee bent over a belt to pick up a small item. The patient was morbidly obese, and remember, unless there are objective findings, pain is not compensable. Also the findings have to be related to the mechanism of injury.

The mechanism of injury in this case was insignificant in comparison to the preexisting condition of obesity. So, this case wasn't recorded as work related. We are not saying that the employee didn't have pain. What is being said is that the employer is not responsible for treatment of the pain. The employer or the insurance carrier is still responsible for the initial evaluation of the employee.



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