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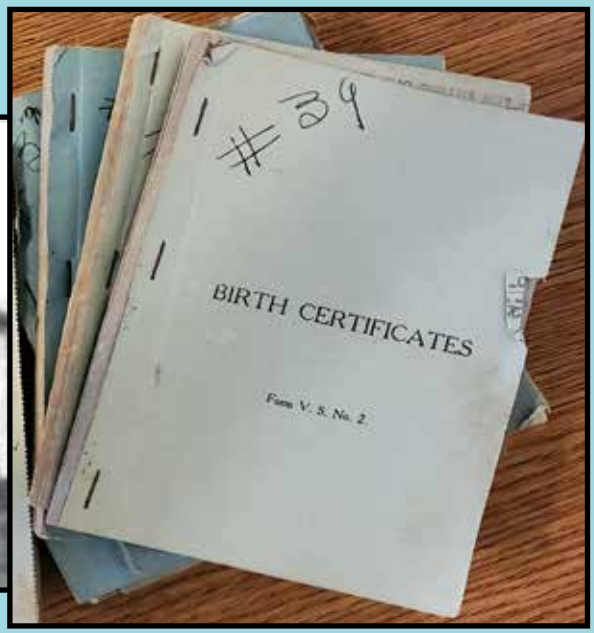
ALACHUA COUNTY MEDICAL SOCIETY

House Calls

FALL 2023



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In this Issue:
Docs Born at AGH

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Women's Group of North Florida

Raised in Jacksonville, Florida, Karen Harris received her medical degree from the University of Florida, followed by a Residency at Johns Hopkins Hospital, and is board certified in Obstetrics/ Gynecology. She returned to Gainesville to begin practice at North Florida Women's Physicians, where she practiced for 34 years. In 2018 she started the OB/GYN Residency program at North Florida Regional Medical Center as well as starting a new practice for Resident education. She is currently the Managing Partner for Women's Group of North Florida.

Christopher Balamucki, MD

North Florida Radiation Oncology

Originally from Connecticut, Dr. Balamucki received his Medical Degree from Wake Forest University, followed by an Internship in Internal Medicine at Wake Forest Baptist Medical Center, and his Residency at the University of Florida in Radiation Oncology. Upon graduation, he joined North Florida Radiation Oncology at HCA North Florida Hospital, and has practiced there for the last 12 years. Dr. Balamucki is board certified in Radiation Oncology.

Meredith Mowitz, MD

HCA North Florida NICU

Dr. Mowitz earned her Medical Degree from the University of Vermont before completing her Residency and Fellowship at the University of Florida. She remained at UF as faculty, and eventually the NICU Medical Director and Physician Director of Quality and Safety for Pediatrics. She is an experienced health services researcher with expertise in health economics, having published several papers on NICU costs and resource utilization. In 2022 she joined the HCA Florida, North Florida team serving as the medical director of the level III NICU.

Carolyn Carter, MD

UF Health Pediatrics

Carolyn G. Carter is a Pediatrician at the University of Florida. She received her Medical Degree from the UF, followed by a Residency in Pediatrics. Dr. Carter has been in practice for over 25 years and has a special interest in nutrition and preventative medicine. She has worked with medical students on medical mission trips to the Dominican Republic and Haiti and actively participates in community programs such as the Alachua County Sheriff's Office annual Safety Patrol trip to Washington, DC.

Scott Medley, MD

Retired Family Physician

Dr. Medley received his Medical Degree from the University of Kentucky, then served in the U.S. Army, where he completed his Residency in Family Medicine. He founded Gainesville Family Physicians, enjoying 20 years in Private Practice. He later served as a Hospitalist and Chief Medical Officer at NFRMC. He is a Past President of the ACMS and of the Florida Academy of Family Physicians. Currently retired and volunteering at Haven Hospice, he has served as Executive Editor of *House Calls* for the past 25 years, for which he has authored over 105 editorials and articles.

Michelle Larzelere, MD

Women's Health Specialist UF Health

Dr. Larzelere is an Assistant Professor of Obstetrics and Gynecology at the University of Florida. She received her Medical Degree from the University of Virginia, followed by a Residency in OB/GYN at UF. As a physician, her goal is to provide compassionate and evidence-based care to all patients. Clinical interests include Robotic and Laparoscopic Surgery, Contraception Management, Low-risk Obstetrics and Adolescent gynecology.

Kelly Mamelson, MD

Resident - UF Health OB/GYN

Raised in Pansacola, Florida, Dr. Mamelson recieved her Medical Degree from Florida State University and is currently pursuing an OB/GYN Residency at UF Health. She is passionate about reproductive rights and is actively working with Florida Planned Parenthood to increase access to emergency contraception for survivors of sexual assault.

ALACHUA COUNTY MEDICAL SOCIETY

Special Thanks to

Carl Dragstedt, DO

For his outstanding leadership as ACMS President, 2021-2023

ACMS is pleased to announce Officers for 2023-25

President
Christopher Balamucki, MD

Dr. Christopher Balamucki is a Radiation Oncologist at the NFRMC Cancer Center. He received an undergaduate degree in Chemical Engineering, with a double minor in Chemistry and Biology from Virginia Tech. He received his Medical Degree from the Wake Forest University School of Medicine, completing an internship with Wake Forest's Baptist Medical Center, followed by his Residency in Radiation Oncology at the University of Florida. Dr. Balamucki is experienced in treating a wide range of cancers and has published his work related to head & neck, skin and GI cancers in addition to trigeminal neuralgia treated with Gamma Knife Stereotactic Radiosurgery. He is a member of the American Society for Therapeutic Radiology and Oncology (ASTRO).

Vice President
Brittany Bruggeman, MD

Dr. Bruggeman is an Assistant Professor of Pediatric Endocrinology at the University of Florida. She joined the faculty after completing her fellowship, residency, medical school, and undergraduate training at the University of Florida, graduating summa cum laude from the Medical Honors Program- go Gators! She is board certified in Pediatrics and is a leader in patient advocacy and policy within the American Academy of Pediatrics and American Diabetes Association. Her current pursuits include the clinical care of pediatric diabetes and endocrine patients and research exploring the natural history and pathophysiology of exocrine dysfunction within type 1 diabetes.

Secretary/Treasurer
Althea Tyndall-Smith, MD

Althea Tyndall-Smith, MD moved to Gainesville in 2013 from York, Pennsylvania. She started her career in medicine in 2005, at York Hospital, after graduating from Drexel University College of Medicine in Philadelphia. She then relocated to Gainesville to be closer to family and joined the University of Florida as a Clinical Assistant Professor in the Community Health and Family Medicine Department. In 2018, Dr. Tyndall-Smith co-founded Gainesville Direct Primary Care (DPC) Physicians to allow her to "get to know her patients and to develop strong and lasting relationships, which are the foundation of exceptional health care." She enjoys her Caribbean culture through travel, cuisine, and music. In her spare time, she participates in the praise and worship team at church, playing the piano, riding her bike, and sharing her life and dreams with her husband, two sons, and a puppy named Buster.

Meet the ACMS President

Christopher Balamucki, MD

By: Jackie Owens, ACMS EVP and Christopher J. Balamucki, M.D.

JO: Where were you born and what brought you to Gainesville?

CB: I was born and raised in Connecticut, but my educational journey eventually brought me to Gainesville, Florida. Specifically, after high school, I earned my undergraduate degree in Chemical Engineering with a double minor in Chemistry and Biology from Virginia Tech. I then went on to earn my Medical Degree from Wake Forest University School of Medicine. While there, I completed my preliminary internship year in Internal Medicine at Wake Forest Baptist Medical Center. Shortly after, I arrived in Gainesville to complete my 4-year residency in Radiation Oncology at the University of Florida. After graduating residency, I joined the North Florida Radiation Oncology practice at HCA Florida North Florida Hospital, where I have been practicing over the past 12 years and feel very fortunate to be working with such a great team of physicians (Drs. Cherylle Hayes, Allison Grow, and Trey Perkins).

L to R: Dr. Chris Balamucki with his family - sons Lucas and Zachary and wife Jeanne.

JO: What prompted you to pursue medicine and specialize in Radiation Oncology?

CB: I decided to pursue medicine very late in my time at Virginia Tech, where my career path was dedicated to chemical engineering. I ultimately worked as a chemical engineer at Pratt & Whitney after graduation for approximately 1 year prior to enrolling in medical school. While pursing medical student research opportunities early on during my time at Wake Forest University School of Medicine, I was introduced to Radiation Oncology. After integrating myself into the department while doing my research, I quickly fell in love with the specialty.

JO: What do you like best about being a physician?

CB: For me, the answer is rather simple --- the sacred doctor-patient relationship! As a physician, the best part of my day is always focused around patient care. I love helping my patients who are looking for hope as they navigate through the powerful emotions associated with their diagnosis of cancer. Moreover, I really enjoy the complexity of the clinical decision-making process in addition to the utilization of cutting-edge technology in patient care.

JO: What are your goals for the ACMS in 2023-2025?

CB: First and foremost, it is an honor and privilege to serve as the president of the Alachua County

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Family night out in Palm Coast, Florida.

Medical Society (ACMS). In this role, I plan to connect with both my academic and private practice physician colleagues in our medical community, which will allow me to appropriately support and advocate on their behalf. In the end, I see the ACMS president's role as a platform to be the voice of our medical society. With that said, I always want to lead with a message best supporting the collective opinion of the amazing physicians in our community.

JO: What do you feel are the challenges facing medicine?

CB: Where do I start? Multiple factors negatively pressuring the overall quality of the doctor-patient relationship, access to care, physician / staffing shortage, healthcare insurance (including lack of coverage, prior authorization, etc...), costs of care, healthcare policy reform, effective payment models, tort reform, and the ongoing transition to corporate medicine. Next question please...

JO: Why do you believe in supporting organized medicine, especially through your county medical society?

CB: In my opinion, the collective voice of our amazing medical community through the ACMS is much more powerful than any individual voice in effecting any meaningful change in our healthcare system.

JO: Please tell our readers about your family.

CB: I am married to my beautiful wife, Jeanne, and we have two wonderful children, Lucas (16 years old, junior at Buchholz High School) and Zachary (10 years old, 5th grader at Talbot Elementary School). Both Lucas and Zachary are competitive soccer athletes and love skiing. We also have two amazing cats, Stella and Mickey.

JO: How do you spend your free time?

CB: My free time is typically dedicated to my family and on the weekends, my wife and I love embracing our role as soccer parents (lots of traveling)! Personally, I have played many sports throughout my life. I am a very passionate skier and skied for approximately 33 years. I learned how to ski during my youth growing up in New England, skiing mostly in Vermont and occasionally in Maine. As an adult, I always attempt to go out West for a few weeks of expert skiing, preferably in epic powder but that is up to Mother Nature! I enjoy playing in our local competitive USTA tennis leagues over the past 14 years and our team regularly competes in the yearly state tournament at the USTA National Campus in Lake Nona. I also love playing golf.

Dr. Chris Balamucki skiing at Big Sky; Photographer: James Robertson

Recognizing W. C. Thomas, Sr, MD: A Founding Father of AGH and UF COM

Jackie Owens, ACMS Executive Vice President

William Clark (W. C.) Thomas, Sr., MD was finishing his Residency around the time Sarah Robb retired from Obstetrics in Gainesville, Florida (1917). He moved to Gainesville in 1924 and took the reins from there, becoming a prominent Obstetrician in Alachua County and the Gainesville area. We recently received a portrait of Dr. Thomas (on loan from Mrs. Brenda Thomas and the Thomas family - inset below) and are honoring his work and life as a dedicated physician.

Dr. W. C. Thomas, Sr. was born in 1891 in Wrens, Georgia. He received his Medical Degree from Johns Hopkins University, graduating in 1915, interning at Union Memorial Hospital (formerly Union Protestant Infirmary). As World War I was under way, Dr. Thomas joined the US Army after completing his internship, and was soon promoted to the rank of Major. During his tenure in the army, he married Margaret Smith in 1918, following a seven-year engagement. Dr. Thomas was transferred as needed in the army, going from San Francisco; Manilla, Philippines; Tientsin, China; and finally to West Point Military Academy as Post Surgeon.

William Clark (W. C.) Thomas, Sr., M.D.;
Portrait by Everett Raymond Kinstler.

At that time, Dr. Thomas decided he wanted to go into private practice in Florida. Driving through Gainesville, he stopped to talk to a gentleman on the courthouse square, who turned out to be Dr. John Bishop. Dr. Bishop needed a partner in his medical practice and asked Dr. Thomas to join him. Dr. Thomas agreed and moved his family to Gainesville, Florida, in April of 1924. He and Margaret now had a family of five, with three children, W. C., Jr.; Betty, and Virginia Thomas.

Dr. Bishop died a year after their partnership began. However, Dr. Thomas honored their partnership agreement after his death (and the prior partner's agreement with Dr. King, who was previously deceased), continuing to give their widows the fees the doctors would have received.

Dr. Thomas was a founding physician of Alachua General Hospital (formerly known as Alachua County Hospital at the time and renamed AGH in 1949). He was on staff with the hospital in 1928, the year it was founded. He was Chief of Staff from 1930 – 1935; and from 1943 – 1945 (during World War II).

Dr. Thomas remained in Gainesville during WW II to care for the community. There were only three to seven physicians in the area at the time, serving a population of 38,245 in the county. After the war, he decided to specialize in OB/GYN. Dr. Thomas worked long hours, always putting the patient first. In his tenure at AGH, he delivered nearly 8,000 babies, covering three generations.

In 1947, Dr. Thomas served as the President of the Florida Medical Association. In 1948, he was instrumental in establishing the local Blood Bank. He served as President of the Florida Obstetrics and Gynecology Society in 1951. In 1965, Dr. Thomas was awarded the Arts in Medicine Award by the Florida Academy of Family Physicians. He worked closely with Senator Shands to locate the medical college in Gainesville. As a member and Chair of the Faculty Advisory Committee, he paved the way for the Florida College of Medicine.

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Dr. Thomas was a mentor to young physicians starting out in the area, helping them to complete medical school and get their practices well-established. UF Health currently has a Chair established in his name in the OB/GYN department to assist physicians and provide scholarships where needed to further the purpose of medical education. He looked after the families of fellow physicians while they were away (particularly during WW II) or had passed on.

Dr. Thomas served many roles for his patients: doctor, psychologist, advisor and friend - making all patients feel like they were of utmost importance. As Dr. Charles Gilliland describes him: "His manners were invariably courtly and his speech pure. It was indeed rare that he spoke disparagingly of anyone." Many of his patients could not pay in terms of cash, but would offer tangible gifts such as a turkey. Dr. Thomas did not discuss payment with his patients, allowing them to pay as they could.

He was known for taking catnaps for 20 minutes at a time, waking up afterwards and picking up the conversation exactly where he left off – a skill that puzzled many acquaintances. Dr. Thomas enjoyed golf on Wednesday afternoons with a foursome saying that "even an elephant should have one day a week to lie in the woods on his back." He would often be interrupted by a call for a delivery during the golf game, where he'd leave the game, deliver the baby, and rejoin the group about 3 or 4 holes later. He vacationed every August in Maggie Valley, North Carolina, with his family. At Christmas time, he delivered Chinese Honey Oranges to friends and family.

Dr. Thomas was well-known for his driving habits. He worked such long hours, making house calls at all hours of the night, that he often fell asleep at the wheel. Townspeople would quickly recognize that it was Dr. Thomas and either drive around him or wake him up if the situation warranted it. At one point, he fell asleep on the railroad track and woke to see a train coming at him. He escaped danger just in the nick of time, crediting a greater power saying: "His hand was on my shoulder." He was a devoted Methodist, and his wife was a Baptist. They maintained memberships at both churches over the years. He was known as Clark to his wife and friends, and as Dr. Thomas to countless patients over the years.

Dr. Thomas always had eight tickets on the 50-yard line to the Florida Football Games. If he couldn't use them all he would call a few friends and invite them to join him. He was always awake during Gator games.

In 1972, Dr. Thomas entered the hospital for an aneurysm repair, wanting to do whatever it took to help him live long enough to take care of Margaret. Unfortunately, Dr. Thomas died that day. The 200-bed tower addition to AGH was named after W. C. Thomas, Sr., MD, in 1975 in honor of his work.

As Dr. Maxey Dell described him: "Dr. Thomas came to Gainesville in 1924 and practiced medicine until his death in 1972. Forty-eight years filled with service, devotion and love to many people of this and the surrounding communities. He was a man of many talents, an excellent surgeon, meticulous and careful, and a gifted obstetrician."

Reference: His Hand was on My Shoulder: Portrait of a Physician - Dr. W. C. Thomas, Sr., 1991.

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A Paradigm Shift: Group Prenatal Care

By: Karen Harris, MD, MPH, Managing Partner,
Women's Group of North Florida

Delivery of high-quality prenatal care improves outcomes for mothers and babies and reduces maternal morbidity and mortality. Antenatal care has been provided as individual one-on-one visits with a physician or midwife for nearly all of my 34-year career. As I start my 35th year in practice, I would like to introduce you to a new concept in prenatal care that dramatically improves patient satisfaction and reduces perinatal morbidity.

Group Prenatal Care models originated over 30 years ago. Today there are two major organizations that sponsor it: Centering Pregnancy Institute and Supportive Pregnancy Care through the March of Dimes.

Group Prenatal care comprises 10 sessions that are made of up to 8 to 10 pregnant individuals with their support person, with a CNM or MD plus another trained facilitator. The antenatal care sessions are 2 hours long and have 3 broad components: an individual medical assessment with the CNM or MD, educational time, and social support. Pregnant women are organized into groups due the same month, or with similar high-risk health problems. Women actively participate in their own health assessments such as obtaining and recording their blood pressure, weights, and urinalysis. The health assessments are followed by an interactive session with the expectant mother, their supportive person, and their healthcare team members in which various topics are discussed. Topics are scheduled during the 10 visits to include such things as nutrition, breastfeeding, family planning, newborn care, birth, and pain management options for labor.

Patients receive high quality expanded time with their providers, over 10 times the usual amount compared to the one-on-one visit model. In addition, most groups meet at the same day and time so that patients can plan their appointments. The interactive group discussions are a highlight of the sessions as patients teach one another and strengthen the social bonds among the group and the provider. Overall, there is a 97% satisfaction rate with group care. The goal is to promote healthier communities with better outcomes through holistic evidence-based care. Families feel more prepared for labor, birth, and parenthood. Physicians providing one-on-one care may not have time in their compressed schedules to address health education and awareness on an individual basis. The individual provider also might not have adequate time to address doubts or concerns of the pregnant woman that would be covered in Group Care.

Studies have shown that individuals who participate in Group Prenatal Care have a lower risk of having a preterm birth and a baby with low birthweight. Their babies appear to spend fewer days in the NICU. Mothers have higher rates of breastfeeding initiation and duration. A key advantage is that women show improved perinatal knowledge, greater readiness for birth and labor, as well as higher satisfaction with prenatal care. They are also more likely to have appropriate birth spacing. The nurses on L&D can tell who has been in Group Prenatal Care as the patients advocate for themselves and their babies. They are knowledgeable about birth and empowered to take an active part in their healthcare decisions. These improved outcomes have the potential to save millions in health care dollars by reduced rates of preterm birth and NICU admissions.

Women's Group of North Florida started in 2018 to support the new OB GYN Residency Program at North Florida Hospital. The practice started Centering Pregnancy two years ago during the COVID19 Pandemic. As expected, there were barriers to getting the new program started and there was limited familiarity of the patient population with this innovative model of prenatal care. UF Health had a Centering Pregnancy Program, but it was no longer active. The trained facilitators of WGNF's Program are our midwives, Christina Bennett Wiley and Jane Houston.

As we sought to transform prenatal care through Centering, we faced barriers of productivity, reimbursement, and space requirements. Good news is that all insurers pay the same for Group care as one-on-one visits. However, it has taken about two years to reach group sizes that are sustainable.

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Our initial groups were 2 to 3 individuals, but now have increased to 6 to 8. Our goal is groups of 8 to 10 women due the same month.

The physical space requirements for a group session are important and may not be easy to solve for many practices. We have opened a new Suite dedicated to Centering Pregnancy, and midwifery care. The room needs to have space for individual health assessments behind a screen, while having space for a circle of chairs for around 20 people. Bathrooms, check-in capability, and an exam room facilitate the experience time.

Encouraging our low-risk pregnant women to join Centering takes education at every encounter with our system. Our receptionist who specializes in scheduling the initial prenatal appointments mentions Group prenatal care. When our patients have the initial new obstetric appointment with a nurse, she presents detailed information about Centering, and offers it to the patient. If they are interested, their first provider appointment is scheduled with one of our midwives who will be facilitating their group. Our new system has resulted in increased numbers of patients joining this innovative and transformative method of prenatal care.

Next on our wish list is to expand the model to groups with specific high-risk conditions: Hypertension, diabetes, substance use disorder, and others.

We are delighted to have a Group Prenatal Care Program to provide innovative care that has the potential to address the health inequities and disparities in maternal morbidity and mortality.

From Centering Healthcare Institute:

"Centering Healthcare Institute imagines a U.S. healthcare system that offers not just medical interventions, but combats isolation and builds communities, empowers, and educates patients, and serves as a partner to connect the most vulnerable with resources that contribute to overall health. We are driven to create a future where the risk of preterm birth, the inequities of Black women dying from pregnancy-related causes and the disparities in early childhood are greatly reduced - so that every child has the potential to enjoy future life chances, social and economic opportunities, and overall well-being.

When we expand the healthcare visit to include parental learning and connection, we can have a profound impact on health outcomes and increase the chances each family has to thrive. "

"Centering empowers patients, strengthens patient-provider relationships, and builds communities through these three main components"

Both provider and patient are involved in the health assessment. Patients receive one-on-one time with their provider and learn to take some of their own assessments. This engages them in their own self-care or care of their child.

Engaging activities and facilitated discussions help patients to be more informed, confident and empowered to make healthier choices for themselves, their children and their families.

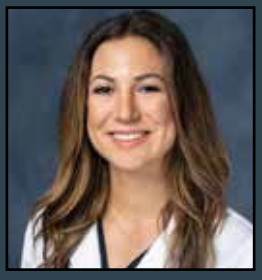
One person's question is another one's question. Patients quickly find comfort in knowing they are not alone. Participation in group care lessens the feelings of isolation and stress while building friendships, community and support systems.

Source: Centering Healthcare Institute: https://centeringhealthcare.org/ Dated: 8-11-2023.

Safely Decreasing the Rate of Cesarean Delivery

By: MIchelle Larzelere, MD - OB/GYN Specialist, UF Women's Health: and Kelly Mamelson, MD - Resident OB/GYN, UF Women's Health

Dr. Michelle Larzelere



Dr. Kelly Mamelson

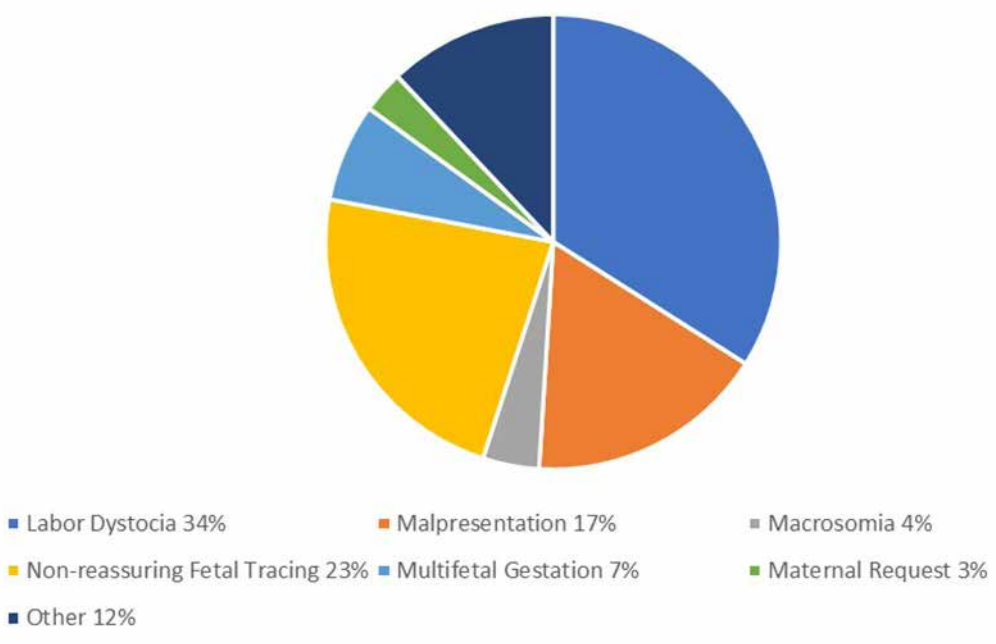
Indications for Cesarean Delivery

Cesarean deliveries have dated back to the 16th century, still being one of the most common procedures performed worldwide. This procedure ranges from a controlled, planned delivery to an emergent and life-saving surgery. The incidence of this procedure has continued to increase over the past decade, while the rate of maternal and fetal morbidity and mortality paradoxically continues to increase as well. It is important to recognize when a cesarean delivery is indicated for maternal or fetal reasons. On the same accord, it is just as essential to know when to defer this type of delivery for the sake of the fetus and the mother. The most common indications for primary cesarean delivery include, in order of frequency, labor dystocia, abnormal fetal heart rate tracing, fetal malpresentation, multiple gestation, and suspected fetal macrosomia (Fig 1).

Labor dystocia criteria includes active phase arrest in the first stage of labor and should be reserved for women who have had an adequate trial of labor. This includes having ruptured membranes and oxytocin administration. Additionally, adequate time for pushing during the second stage depends on parity and use of epidural analgesia.

Fetal heart tracing interpretation is imperative throughout a patient's labor or induction course. A category III fetal heart tracing, while rare, warrants emergent cesarean delivery. This includes absent variability with recurrent variable decelerations, recurrent late decelerations, or bradycardia. A sinusoidal pattern is also classified as category III. This classification indicates suspected abnormal fetal umbilical artery pH and/or neurological injury including cerebral palsy and encephalopathy. Notably, most tracings that are considered abnormal are classified as Category II. It is always important to consider etiologies of abnormal tracings, including umbilical cord prolapse or placenta abruption. Elements of category II tracings, including minimal variability and presence of decelerations, can indicate fetal acidemia.

Figure 1: Indications for Primary Cesarean Delivery



Fetal malpresentation includes breech, transverse, omentum posterior, or brow presentation. Per ACOG recommendations, fetal lie should be assessed at 36 weeks gestation. Multiple gestation is not an automatic indication for cesarean. For example, for a twin gestation when the presenting twin is cephalic, it is reasonable to proceed with a vaginal delivery. Patients with triplet gestation or higher should be counseled on cesarean delivery. Fetal macrosomia and excessive maternal weight gain are two additional indications for careful counseling on delivery

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methods. For diabetic patients, a fetus suspected to weigh >4500g warrants a discussion with the patient regarding the high risk of shoulder dystocia. The same holds true for non-diabetic patients with a suspected fetal weight >5000g.

Risks of Cesarean Delivery

Regardless of route of delivery, there are inherent risks to every delivery (Table 1). Specific indications, including placenta previa, placenta accreta spectrum, umbilical cord prolapse and uterine rupture, undoubtedly warrant a cesarean delivery to avoid significant maternal and fetal morbidity and mortality. Apart from specific scenarios, the cesarean delivery increases risks of severe maternal mortality, including death, hemorrhage, wound or systemic infection, PE/DVT, anesthetic complications, and uterine rupture. The incidence of placenta abnormalities, such as placenta previa or accreta, increases with each subsequent cesarean delivery. Cesarean deliveries pose an increased risk to the fetus, including admission to the neonatal intensive care unit, respiratory morbidity, and death. On the contrary, the cesarean is the appropriate delivery when there is suspected fetal macrosomia (fetal weight >5000g non-diabetics, >4500g as outlined above). The prevention of shoulder dystocia can subsequently prevent fetal death, severe neurological and orthopedic insult to the fetus, as well as preventing deep genitourinary lacerations, future incontinence, and emotional traumatic deliveries to the mother. It is essential to counsel the patients on potential risks of either mode of delivery before their expected date of induction, labor, or planned cesarean.

Decreasing the rate of Cesarean Delivery

Given the inherent risks of cesarean delivery, both the World Health Organization (WHO) and the American College of Obstetricians and Gynecologists (ACOG) have advocated for a lower rate of primary cesarean delivery. The main indications for cesarean delivery include labor dystocia, non-reassuring fetal heart rate tracings and fetal malpresentation, all of which can be addressed to lower primary cesarean rates.

Recently, the Consortium on Safe Labor has updated their definitions of normal labor progression. Historically, the active phase of labor began at 4cm dilation. Latent phase arrest was defined as longer than 20 hours in a nulliparous woman and 14 hours in a multiparous woman. Once the active phase was reached, the expected progress was 1.2 cm/h for nulliparous women and 1.5 cm/hr for multiparous women. Arrest was defined as an unchanged cervix for greater than 2 hours despite adequate contractions. The updated recommendations recognize the onset of the active phase of labor at 6 cm dilation. Latent phase arrest is rare, and most women will progress with either oxytocin administration and/or amniotomy. As long as there is maternal and fetal stability, patients should be given 24+ hours and oxytocin for at least 12-18 hours after rupture of membranes prior to diagnosis of latent stage arrest. For active phase arrest, the patient should be at least 6 cm dilated with ruptured membranes for 4 hours with adequate contractions or 6 hours of inadequate contractions and no cervical change.

Second stage arrest is defined as 3 hours of pushing in nulliparous women and 2 hours in multiparous

Table 1:	Vaginal Delivery	Cesarean Delivery
Maternal Mortality	3.6/100,000	13.3/100,000
Amniotic Fluid Embolism	3.3-7.7/100,000	15.8/100,000
Third or Fourth Degree Laceration	1.0-3.0%	N/A
Neonatal Laceration	NA	1.0-2.0%
Neonatal Respiratory Morbidity	<1.0%	1.0-4.0% (Without labor)
Shoulder Dystocia	1.0-2.0%	0%

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Cesarean Delivery

Continued from Page 15

women. However, longer durations can be tolerated based on individual factors. For example, women with an epidural may require longer labor and can be given additional time, as long as progress is being documented. Other suggestions to decrease the rate of cesarean include operative vaginal deliveries and rotation of a fetal occiput if malpositioned. Rates of operative delivery have decreased as rates of cesarean delivery have increased. The differences in adverse neonatal outcomes between these two groups are not significant. Low and outlet operative deliveries in patients without suspicion for macrosomia can safely reduce the patient's risk of cesarean delivery. Less than 3% of women will require cesarean delivery if an operative delivery is attempted.

When a cesarean delivery is necessary for a non-reassuring fetal heart rate tracing, the majority of the time it is a category II tracing. These tracings include a wide range of patterns, requiring evaluation, surveillance and possibly interventions. For evaluation, scalp stimulation of the fetal head can be performed. If an acceleration of the heart rate is noted, this provides reassurance that fetal acidemia is not present. If repetitive variable decelerations are seen, due to umbilical cord compression, position changes and/or amnioinfusion with normal saline may improve the tracing. If there is tachysystole (five or more contractions in 10 minutes over a 30 minute period) leading to concerns, decreasing or stopping uterotonic agents can help. Additionally, a uterine relaxant may be given. Supplemental oxygen, IV fluid boluses and tocolytic agents are typically used for resuscitative efforts to improve tracings, but have limited data on efficacy and safety. Interventions should be performed for category II heart rate tracings prior to intervention with cesarean delivery.

Induction of labor has been previously thought to lead to an increased risk of cesarean delivery. However, studies have shown that induction of labor does not increase the risk. Additionally, induction should be performed by 41 weeks, 0 days gestation to decrease both cesarean delivery as well as perinatal morbidity and mortality.

If fetal malpresentation is noted, attempts at external cephalic version (ECV) can be performed to decrease the rate of cesarean delivery. Currently, 85% of patients with a persistently breech fetus undergo cesarean delivery. Rates of ECV success approach 50% and is likely an underutilized technique. Performance under regional anesthesia does increase the success rate. The majority of women who have a successful ECV will have a vaginal delivery.

Sources available upon request.

North Florida NICU Welcomes New Neonatologists

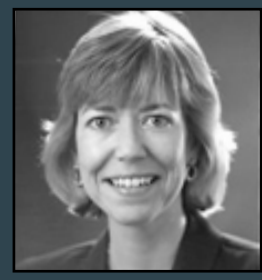
By: Meredith Mowitz, MD, HCA North Florida NICU;
Photos by: HCA North Florida

The Neonatal Intensive Care Unit (NICU) at HCA Florida North Florida Hospital is growing, along with our patients! In Fall 2022, Neonatologists Meredith Mowitz, M.D., and Sandra Sullivan, M.D., joined the NICU team, providing care to sick and pre-term infants in the NICU and to well babies in the post-partum unit. Along with experienced Neonatal Nurse Practitioners, this group is working hard to expand the services the NICU provides to our community.

Dr. Mowitz, HCA Florida North Florida Hospital's new NICU Medical Director, earned her medical degree from the University of Vermont before completing residency and fellowship at the University of Florida. She oversaw the NICU at UF Health as the Medical Director and the Physician Directory of Quality & Safety prior to joining the HCA Florida North Florida Hospital team. She brings a wealth of experience in the care of extremely low birth weight (ELBW) infants. Dr. Sullivan completed her medical degree, residency and fellowship at the University of Florida. She is highly regarded in the field of breastfeeding medicine and was previously the director and founder of the Center for Breastfeeding at UF Health. Both physicians bring extensive knowledge in research and quality improvement-driven culture change.

In recent months, the 25-bed Level III NICU has cared for increasingly complex infants, with the ability to care for a wide range of infants including those with extreme prematurity and respiratory failure. Although most infants are able to go home within a few days of birth, one in ten infants require a NICU admission, and most are not known prior to birth. Having an in-house, 24/7 neonatal nurse practitioner ensures all infants have the benefit of an advanced provider immediately available, giving them the very best care from the start. Once in the NICU, infants are cared for by a multi-disciplinary team including a dedicated pharmacist, lactation consultant, dietician, respiratory therapy and speech, language pathologist. NICU stays can last weeks or sometimes months, and involve complex and changing care for these fragile patients. Using evidence-based medicine and quality improvement science, the NICU at HCA Florida North Florida Hospital is able to provide this care, giving these infants the best start in life.

Immunizations: A Pediatrician's Perspective



By: Carolyn Carter, MD, Professor of Pediatrics, UF Health

Although I have been a pediatrician for more than 25 years, I have known the importance of immunizations or vaccines since I was a young child. I grew up hearing stories about family members I had never known who had succumbed to various infections that were now preventable. My grandmother, born in 1900, told me about her younger four-year old brother who died from the whooping cough (pertussis) and her brother-in-law who had returned from World War I only to step on a rusty piece of metal while hunting and later die from lockjaw (tetanus). My parents had friends who had contracted polio and subsequently suffered life-long physical impairments. These diseases became preventable with the development of vaccines. There was never any question my siblings and I would be vaccinated. Those pathogens, their diseases, and the pain they inflicted were real to me.

There are considerably more vaccines now than when I was a child in the '60s and '70s. In fact, the Center for Disease Control (CDC) currently recommends vaccinations to protect against 15 infectious diseases before the age of two years. See Table 1, the Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023. I have been in practice long

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Table 1 **COVID-19 vaccination recommendations have changed. Find the latest recommendations at www.cdc.gov/covidschedule**

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1st dose	◄---- 2nd dose ----►			◄---------- 3rd dose ----------►												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			◄---- 4th dose ----►				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		◄3rd or 4th dose, See Notes►										
Pneumococcal conjugate (PCV13, PCV15)			1st dose	2nd dose	3rd dose		◄---- 4th dose ----►										
Inactivated poliovirus (IPV <18 yrs)			1st dose	2nd dose	◄---------- 3rd dose ----------►							4th dose					See Notes
COVID-19 (1vCOV-mRNA, 2vCOV-mRNA, 1vCOV-aPS)					2- or 3- dose primary series and booster (See Notes)												
Influenza (IIV4)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only				
or																	
Influenza (LAIV4)											Annual vaccination 1 or 2 doses		Annual vaccination 1 dose only				
Measles, mumps, rubella (MMR)					See Notes		◄---- 1st dose ----►					2nd dose					
Varicella (VAR)							◄---- 1st dose ----►					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series, See Notes										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														1 dose			
Human papillomavirus (HPV)														See Notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes											1st dose		2nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)													See Notes				
Pneumococcal polysaccharide (PPSV23)											See Notes						
Dengue (DEN4CYD; 9-16 yrs)													Seropositive in endemic dengue areas (See Notes)				

Range of recommended ages for all children
Range of recommended ages for catch-up vaccination
Range of recommended ages for certain high-risk groups
Recommended vaccination can begin in this age group
Recommended vaccination based on shared clinical decision-making
No recommendation/ not applicable

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enough to see the before and after effects of several of these vaccines including the pneumococcal conjugate and Haemophilus influenzae type b vaccines which protect against bacteria that can cause diseases such as pneumonia, sepsis and meningitis. As an intern, resident, and junior faculty member, I regularly saw young infants with fever requiring evaluation of urine, blood, and cerebrospinal fluid. The need for such work-ups has dramatically decreased since the introduction of these two vaccines.

The most recent vaccines to become available for infants and children protect against COVID-19 infection. The latest recommendations for their use came out in April of this year. The CDC, with input from the Advisory Committee on Immunization Practices, now recommends a single bivalent COVID-19 mRNA vaccine dose for most people aged 6 years and older and bivalent vaccines for children aged 6 months to 5 years with the number of doses dependent on vaccination status and brand of mRNA vaccine. Optional additional bivalent vaccines are recommended for moderately or severely immunocompromised people aged 6 months and older and all adults aged 65 years and older. This transition to a single bivalent COVID-19 vaccine dose for most people, with additional doses for those at increased risk for severe disease is a "simpler, more flexible recommendation." The

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Table 1a:
COVID-19 Vaccine - Interim COVID-19 Immunization Schedule for Persons 6 Months of Age and Older - Moderna (Source CDC - 5/31/2023)

The following tables provide COVID-19 vaccination schedules based on age, health status, and product. For detailed guidance see Interim Clinical Considerations for Use of COVID-19 Vaccines | CDC.

Table 1a. **For Most People (those who are NOT moderately to severely immunocompromised)**

Bivalent Moderna COVID-19 Vaccine:* Monovalent Moderna vaccine is no longer recommended and should not be used.
Vaccine type: mRNA

Age	Vaccination History	Bivalent Vaccine Schedule†	Administer
6 months through 5 years‡§	Unvaccinated: 0 doses	2 doses. Administer: • Dose 1 now • Dose 2 at least 4–8 weeks¶ after Dose 1	0.25 mL/25 *µg* from the vial with a blue cap and gray label border
	1 dose of bivalent vaccine	1 dose. Administer: • Dose 2 at least 4–8 weeks¶ after Dose 1	
	At least 2 doses of bivalent vaccine	No dose	No dose
	Previously vaccinated with monovalent mRNA COVID-19 vaccine		
	1 dose of monovalent vaccine	1 dose. Administer: • Dose 2 at least 4–8 weeks¶ after Dose 1	0.25 mL/25 *µg* from the vial with a blue cap and gray label border.
	2 doses of monovalent vaccine	1 dose. Administer: • Dose 3 at least 8 weeks (2 months) after Dose 2	0.2 mL/10 *µg* from the vial with a **dark pink cap and yellow label border**
	At least 1 dose of monovalent vaccine and 1 dose of bivalent vaccine	No dose	No dose
6 years and older	Unvaccinated: 0 doses	1 dose now**	**6 through 11 years:** 0.25 mL/25 *µg* from the vial with a blue cap and gray label border **12 years and older:** 0.50 mL/50 *µg* from the vial with a blue cap and gray label border
	1 or more doses of monovalent vaccine	1 dose. Administer: • Vaccine at least 8 weeks (2 months) after the previous dose**	
	At least 1 dose of bivalent vaccine	No dose**	No dose**

* Refer to CDC's Interim Clinical Considerations for specific guidance on children who turn from 5 to 6 years of age before completing the vaccination series with Moderna COVID-19 Vaccine and interchangeability of vaccine products for all ages.

† Persons with a recent SARS-CoV-2 infection may consider delaying vaccination by 3 months from symptom onset or positive test (if infection was asymptomatic).

‡ CDC recommends bivalent vaccine doses from the same manufacturer for children 6 months through 5 years of age who are unvaccinated (no previous doses of COVID-19 vaccine) if more than 1 dose is recommended. In the following exceptional situations, a different age-appropriate COVID-19 vaccine may be administered when FDA authorization requires that a vaccine from the same manufacturer be used and a VAERS report is not required:
- Same vaccine not available
- Previous dose unknown
- Person would otherwise not complete the vaccination series
- Person starts but unable to complete a vaccination series with the same COVID-19 vaccine due to a contraindication

§ Children ages 6 months through 4 years who received bivalent vaccines from different manufacturers for the first 2 doses of an mRNA COVID-19 vaccine series should follow a 3-dose schedule. A third dose of either mRNA vaccine (Moderna or Pfizer-BioNTech) should be administered at least 8 weeks after the second dose.

¶ An 8-week interval between the first and second doses of COVID-19 vaccines might be optimal for some people ages 6 months–64 years, especially for males ages 12–39 years, as it may reduce the small risk of myocarditis and pericarditis associated with these vaccines.

** Adults 65 years of age and older: May receive 1 additional bivalent mRNA vaccine dose at least 4 months after the first dose of a bivalent mRNA vaccine.

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COVID-19 bivalent vaccine has had a lower frequency of postvaccination local and systemic reactions than previously observed with monovalent doses. No new or concerning safety findings have been identified. A rare risk for myocarditis and pericarditis was identified after receipt of monovalent mRNA COVID-19 vaccines, primarily in adolescent and young adult males. At this time, however, the data are too limited to determine the risk for myocarditis or pericarditis after a bivalent dose although preliminary estimates suggest that the risk is lower than observed after a second primary series monovalent dose. See the current recommendations for COVID-19 vaccines in the CDC COVID-19 Vaccine Charts below (Tables 1a, 1b and 1c)..

Immunizations are one of the major advances in modern medicine. They are a crucial component of pediatric healthcare as they are designed to protect children from various infectious diseases by stimulating their immune system to produce a response against specific pathogens. Here are some key points:

1. **Disease Prevention:** Different immunizations work in

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Table 1b:
COVID-19 Vaccine - Interim COVID-19 Immunization Schedule for Persons 6 Months of Age and Older - Pfizer (Source CDC - 5/31/2023)

Table 1b. **For Most People (those who are NOT moderately to severely immunocompromised)**

Bivalent Pfizer-BioNTech COVID-19 Vaccine:* Monovalent Pfizer-BioNTech vaccine is no longer recommended and should not be used.
Vaccine type: mRNA

Age	Vaccination History	Bivalent Vaccine Schedule†	Administer
6 months through 4 years‡§	Unvaccinated: 0 doses	3 doses. Administer: • Dose 1 now • Dose 2 at least 3–8 weeks¶ after Dose 1 • Dose 3 at least 8 weeks (2 months) after Dose 2	0.2 mL/3 *µg* from the vial with a maroon cap
	1 dose of bivalent vaccine	2 doses. Administer: • Dose 2 at least 3–8 weeks¶ after Dose 1 • Dose 3 at least 8 weeks (2 months) after Dose 2	
	2 doses of bivalent vaccine	1 dose. Administer: • Dose 3 at least 8 weeks (2 months) after Dose 2	
	At least 3 doses of bivalent vaccine	No dose	No dose
	Previously vaccinated with monovalent mRNA COVID-19 vaccine		
	1 dose of monovalent vaccine	2 doses. Administer: • Dose 2 at least 3–8 weeks¶ after Dose 1 • Dose 3 at least 8 weeks (2 months) after Dose 2	0.2 mL/3 *µg* from the vial with a maroon cap
	2 doses of monovalent vaccine	1 dose. Administer: • Dose 3 at least 8 weeks (2 months) after Dose 2	
	3 doses of monovalent vaccine	1 dose. Administer: • Dose 4 at least 8 weeks (2 months) after Dose 3.	
	At least 2 doses of monovalent vaccine and 1 dose of bivalent vaccine	No dose	No dose.
5 years and older‡	Unvaccinated: 0 doses	1 dose now**	**5 through 11 years:** 0.2 mL/10 *µg* from the vial with an orange cap **12 years and older:** 0.3 mL/30 *µg* from the vial with a gray cap
	1 dose or more doses of monovalent vaccine§	1 dose. Administer: • Vaccine at least 8 weeks (2 months) after the previous dose**	
	At least 1 dose of bivalent vaccine	No dose**	No dose**

* Refer to CDC's Interim Clinical Considerations for specific guidance on children who turn from 4 to 5 years of age before completing the vaccination series with Pfizer-BioNTech COVID-19 Vaccine and interchangeability of vaccine products for all ages.
† Persons with a recent SARS-CoV-2 infection may consider delaying vaccination by 3 months from symptom onset or positive test (if infection was asymptomatic).
‡ CDC recommends bivalent vaccine doses from the same manufacturer for children 6 months through 5 years of age who are unvaccinated (no previous doses of COVID-19 vaccine) if more than 1 dose is recommended. In the following exceptional situations, a different age-appropriate COVID-19 vaccine may be administered when FDA authorization requires that a vaccine from the same manufacturer be used and a VAERS report is not required: Same vaccine not available; or previous dose unknown; or person would otherwise not complete the vaccination series; or person starts but unable to complete a vaccination series with the same COVID-19 vaccine due to a contraindication
§ Children ages 6 months through 4 years who received bivalent vaccines from different manufacturers for the first 2 doses of an mRNA COVID-19 vaccine series should follow a 3-dose schedule. A third dose of either mRNA vaccine (Moderna or Pfizer-BioNTech) should be administered at least 8 weeks after the second dose.
¶ An 8-week interval between the first and second doses of COVID-19 vaccines might be optimal for some people ages 6 months–64 years, especially for males ages 12–39 years, as it may reduce the small risk of myocarditis and pericarditis associated with these vaccines.
** Adults 65 years of age and older: May receive 1 additional bivalent mRNA vaccine dose at least 4 months after the first dose of a bivalent mRNA vaccine.

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different ways, but all help the body's immune system fight pathogens. Immunizations play a vital role in preventing the occurrence and spread of serious and potentially life-threatening diseases. Immunizations have been responsible for significantly reducing the incidence of diseases such as measles, polio, diphtheria, pertussis (whooping cough), and many others.

2. Safety and Efficacy: Vaccines undergo rigorous testing and evaluation to ensure their safety and effectiveness before they are approved for use, and they continue to be monitored after the public begins using them. Regulatory agencies, such as the U.S. Food and Drug Administration (FDA), closely monitor the development and manufacturing of vaccines to ensure they meet stringent standards.

3. Herd Immunity: Vaccinations not only protect vaccinated individuals but also contribute to community immunity, also known as herd immunity. When a large portion of the population is immunized, a barrier is created that prevents the spread of diseases, safeguarding vulnerable individuals who cannot receive vaccines due to medical reasons (e.g., infants, individuals with certain medical conditions).

4. Disease eradication: Immunization has played a critical role in the eradication of diseases like smallpox and near-elimination of others, such as polio. By vaccinating children, we can work towards eliminating or controlling diseases that have caused significant morbidity and mortality in the past.

5. Vaccine Schedule: Pediatricians follow a recommended immunization schedule, such as the one provided by the CDC in the United States. - Table 1. The schedule is regularly updated and outlines the recommended vaccines and the age at which they should be administered. Following the schedule is crucial to ensure optimal protection for children.

6. Side Effects: Like any medical intervention, vaccines can have side effects, but the vast majority are mild and temporary. Soreness at the injection site or low-grade fever are the most common. Serious side effects are rare, and the benefits of vaccination generally far outweigh the risks. Pediatric providers are trained to identify and manage potential adverse events associated with immunizations. It is also worth noting here that numerous scientific studies have shown that immunizations do not cause autism.

7. Vaccine Hesitancy: Some parents may have concerns or questions about vaccines, leading to vaccine hesitancy. It's important for pediatric providers to address these concerns and provide accurate information to help parents make informed decisions. Open and respectful communication is essential to build trust and ensure the best possible care for children.

8. Ongoing Research: The field of vaccinology is continually evolving, with ongoing research to develop new vaccines, improve existing ones, and enhance vaccine safety. Pediatricians stay updated with the latest scientific evidence and recommendations to provide the best care and guidance to their patients.

Table 1c:
COVID-19 Vaccine - Interim COVID-19 Immunization Schedule for Persons 6 Months of Age and Older - Novavax (Source CDC - 5/31/2023)

Table 1c. **For Most People (those who are NOT moderately to severely immunocompromised)**

Novavax* (Monovalent vaccine)
Type: Protein Sub-Unit

Age	Vaccination History	Vaccine Schedule†	Administer
12 years and older	1 or more doses of monovalent Novavax vaccine	1 dose bivalent mRNA vaccine at least 8 weeks (2 months) after Dose 2‡	**Moderna:** 0.50 mL/50 *ug* from the vial with a blue cap and gray label border. **OR** **Pfizer-BioNTech:** 0.3 mL/30 *ug* from the vial with a gray cap
	At least 1 dose of bivalent vaccine	No dose‡	No dose‡

* Novavax COVID-19 Vaccine remains authorized to provide a 2-dose primary series (separated by at least 3–8 weeks) to people ages 12 years and older. Administer 0.5 mL/5 µg rS and 50 µg of Matrix-M™ adjuvant vaccine from a vial with a royal blue cap. A booster dose is authorized in limited situations to people ages 18 years and older who completed the primary series using any COVID-19 vaccine, have not received any previous booster dose(s), and are unable (i.e., vaccine contraindicated or not available) or unwilling to receive an mRNA vaccine and would otherwise not receive a dose. This dose is administered at least 6 months after completion of any primary series.

† Persons with a recent SARS-CoV-2 infection may consider delaying vaccination by 3 months from symptom onset or positive test (if infection was asymptomatic).

‡ Adults 65 years of age and older: May receive 1 additional bivalent mRNA vaccine dose at least 4 months after the first dose of a bivalent mRNA vaccine.

HAPPENINGS

ACMS Mystery Clue Game
Celebration Pointe - April 19, 2023

ACMS Board Members: Charles Riggs, MD; Brittany Bruggeman, MD, ACMS Secretary/Treasurer; and Norman Levy, MD, PhD.

The Trentham Santiago Group represented by Joseph Segreto, APMA; and Andrea Rodriguez; with Roslyn Levy.

Community Hospice and Palliative Care represented by Stephanie Lord, MD, Medical Director; and Charlene Stefanelli, Professional Liaison.

L to R: Julia Tung; Justine Vaughen, MD; and Roslyn Levy.

Music was provided by "Chasing Rabbits." L to R: Jeff Sims, Steve Kattell, Ellen Donovan and Robert Nobles.

PNC Bank represented by Wendy Robertson (right) talking with Althea Tyndall-Smith, MD.

HAPPENINGS

ACMS Mystery Clue Game
Celebration Pointe - April 19, 2023

L to R: Evelyn Jones, MD; Ronald Jones, MD; and Mack Tyner, MD.

UF Health represented by Erika Griffith; and Tammy Lindsay; talking with Brittany Bruggeman, MD, ACMS Secretary/Treasurer.

L to R: Ruchira Khosavanna, MD; Elizabeth Parimanath, MD; with UF Resident Board Member Varsha Kurup, MD.

Haven Hospice represented by A. J. Carter, Clinical Liaison; and Kyle Johnstone, Professional Liaison; talking with Caroline Rains, MD.

L to R: Blanca Millsaps; Rhonda Gillion Means; and Katie Comfort with the ACMS.

Coy Heldermon, MD; talking with Erika Griffith of UF Health.

HAPPENINGS

Residency Relief

Cypress & Grove Brewery - July 22, 2023

Thanks to St. Johns Asset Management for Sponsoring this Event!

UF GME Residents enjoying Mojo's BBQ.

Chris Balamucki, MD, ACMS President; and Jeanne Balamucki.

GME Residents enjoying Everything Bundt Cake.

UF GME Resident with his son.

Future GME Resident and her Mother.

Residents and Friends enjoying the event.

HAPPENINGS

ACMS

ACMS Annual Meeting & Installation of Officers

Mark's Prime Steakhouse
May 16, 2023

L to R: Charles Riggs, MD; Brittany Bruggeman, MD, ACMS Vice President; Speaker Joshua Lenchus, DO, FMA President; Carl Dragstedt, DO, ACMS Immediate Past President; Althea Tyndall-Smith, MD, ACMS Secretary/Treasurer; and Christopher Balamucki, MD, ACMS President.

Scott Medley, MD, House Calls Editor (standing); and Mark Barrow, MD.

L to R: Steve Reid, MD; Thomas Benton, MD; Elizabeth Sanders, DO; and George Thomas, MD.

Eric Rosenberg, MD, ACMS Board Member with Carl Dragstedt, DO, ACMS Past President.

L to R: Jackie Owens, ACMS EVP; Sponsor Jim Neshewat, JD, of St. Johns Asset Management; Carl Dragstedt, DO, ACMS Immediate Past President; and Speaker Joshua Lenchus, DO, FMA President.

Kristy Rowland; Aileen Colucci; and Parker Eiland; all representing our Sponsor MCMS Trust.

HAPPENINGS

2023 FMA Meeting
Hyatt Regency Orlando - July 27-30, 2023

ACMS Delegates: Front Row: Althea Tyndall-Smith, MD, ACMS Secretary/Treasurer; Brittany Bruggeman, MD, ACMS Vice President; Back Row: Steven Reid, MD; Thomas Benton, MD; Adam Means, MD; and Angeli Akey, MD.

ACMS Delegates - Front Row: Charles Riggs, MD; Chris Balamucki, MD, ACMS President; Back Row: Eric Rosenberg, MD; and Gary Gillette, MD. Thank you all for representing Alachua County!

Voting device for voting on Resolutions and Elections in the House of Delegates Legislative sessions.

House of Delegates Legislative Session at the Annual Florida Medical Association Meeting.

The Gator Caucus Group consisting of Delegates from Alachua, Brevard, Marion, Indian River, St. Lucie-Okeechobee and Volusia Counties.

In Memoriam

George Buchanan, Jr., MD - (1954 - 2023)

Dr. George Buchanan, Jr., was born in Anniston, Alabama, in 1954. He received his Medical Degree at Meharry Medical College, followed by his Residency in OB/GYN at Hurley Medical Center in Detroit, MI. Dr. Buchanan moved to Gainesville in the mid-1980s where he established a partnership with Bradford Williams, MD, in a private practice of Obstetrics and Gynecology. He was affiliated with the Gainesville Women's Health Center and the Birth Center of Gainesville. He was a compassionate physician and a respected skilled surgeon, turning no one away who could not pay. He excelled at large format flower photography participating regularly in local art shows. Dr. Buchanan is survived by his wife, Felor, and their two children, Jewell and Iraj, a well as his step-children Mojdeh and Lily.

Joseph Kovacs, Jr., MD - (1930 - 2023)

Dr. Joseph D. Kovacs, Jr. passed away on Tues May 9, 2023 at E T York Hospice Care Center surrounded by family. He was 93. He was born in Trenton, NJ, and served in the USAF during the Korean conflict. Dr Kovacs received his undergraduate degree from Cornell University, and his Medical Degree from the University of Alabama. He was a 'Bama fan, as well as a Gator fan. He was a radiologist at Alachua General Hospital for many years. He loved his family, doing crossword puzzles and reading, and he also loved to bowl. He is survived by his children Kyle Kovacs (Kathy) of Gainesville, Fl, Lori of Gainesville, Fl, Karen O'Byrne (Danny) of Apex, NC, and Gary Kovacs (Allison) of Orlando, Fl; 10 grandchildren; and 11 great-grandchildren.

Billy Brashear, MD - (1924 - 2023)

Billy Brashear passed peacefully on June 9, 2023, at the age of 98 in Gainesville, FL. He was born in Cumberland, Kentucky, and for 75 years was a devoted husband to his cherished wife Glenna. He served in World War II as an Army Liaison Pilot. Billy was a graduate of Eastern Kentucky University and the University of Louisville Medical School. He moved to Gainesville in 1954, starting his Family Medical Practice, and providing care to generations of Gainesville families. He served as Chief of Staff at Alachua General Hospital and received the Art of Medicine award by the Florida Academy of Family Physicians in 1988. Billy enjoyed spending time with his family taking vacations throughout the U.S., Canada, and Mexico and spending time at the lake house on Long Pond. He is survived by his wife Glenna; his son Bruce Brashear (Connie); daughters Daphne Brashear Herron (Jim) and Annette Brashear Ball; 4 grandchildren; and numerous great-grandchildren.

Gary Gossinger, MD - (1945 - 2023)

Dr. Gary Gossinger passed away on Monday, June 19, 2023. Born in Detroit, Michigan, he received his Medical Degree from the University of Michigan, followed by an internship at Pacific Medical Center in San Francisco, then returning to the University of Michigan to complete his Residency, where he specialized in Psychiatry. Dr. Gossinger moved to Gainesville, Florida in 1975. He was a Psychiatrist and maintained an office in Gainesville for many years, and served as the Medical Director of Vista Pavilion. He loved all water sports including fishing and diving. Gary is survived by his wife of 48 years, Ava, his daughters, Michelle Brown (Paul), and Lauren Henehan (Wade Splonskowski), six grandchildren and many nieces and nephews.

ACMS Board Highlights

Alachua County Medical Society - Board of Directors Meeting Minutes, February 13, 2023

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Monday, February 13, 2023, virtually on Zoom.com.

Treasurer's Report: Alachua County Medical Society, Inc. – a 501(c)6: Private Practice Dues for 2023 are in line with the previous year, while UF Physician Dues have declined. As UF did not grant the 50% Dues Reimbursement for 2023, some of the decline is expected. Collection of UF Physician Dues will be the priority in the months going forward. Total Membership Dues Income totals $47.6K. Net Income for the 1st month of 2023 of $40K.

Alachua County Medical Society Foundation, Inc. - a 501(c)3: The ACMS Foundation disbursed Grants totaling $17.5K, with no Grant Income reported for January. Net Loss for the month is $17.5K, with Assets totaling $111K, and zero Liabilities.

President's Report:
The Board discussed the FBOM and FBOOM Meeting in February and the letter of opposition submitted by the ACMS concerning the rule approved prohibiting certain procedures performed for the treatment of gender dysphoria in minors, and prohibiting further research on the subject. By establishing compulsory state-based practice standards that directly contradict national and international practice standards, the Florida Board of Medicine, and the Florida Board of Osteopathic Medicine, as politically appointed bodies, are setting a dangerous precedent that calls into question the Board's motives, autonomy, impartiality, and judgement. The Board stated that evidence-based medicine should continue be the standard of practice in medicine and asked the EVP to poll other medical societies in Florida concerning their position on the subject.

EVP Report: Ms. Owens reported on the Florida Department of Health Florida Reimbursement Assistance For Medical Education (FRAME) program for Physicians, PAs, LPNs and APRNs in certain areas of practice.

Alachua County Medical Society - Board of Directors Meeting Minutes, March 7, 2023

Pursuant to notice, the Board of Directors of the Alachua County Medical Society met on Tuesday, March 7, 2023, virtually on Zoom.com.

Treasurer's Report: Alachua County Medical Society: Private Practice Dues continue to increase, as well as UF Physician Dues. UF Dues, however, remain lower than the previous year and will require continuing collection efforts. Publication and Activities Incomes are lower than the previous year but, are expected to increase with the April Social & Vendor Show and the launch of the 2023-24 Physician Directory Sales effort. Total Income for the 2 months under review was $68.7K. Expenses are in line with previous years, resulting in Net Income of $52.1K.

Alachua County Medical Society Foundation:
The ACMS Foundation received Grant Income totaling $22.9K, with Grant Disbursements totaling $31.8K. Net Loss was reported of $8.9K, with Assets totaling $167K, and zero Liabilities.

President's Report: The Board discussed options available to reach out to new members which will be pursued in further detail by the EVP. The Board asked that We Care attend the next meeting to discuss the status of their programs and how much they are currently begin used by the public.
The EVP reported that she was not able to gather additional support from other medical societies in Florida concerning their position on the FBOM and FBOOM state-based practice standards. Of the medical societies Ms. Owens spoke with, they either had a mixed reaction from Board members (vote to approve a letter did not pass) or they were focusing on other medical issues in the current legislative session. The Board recommended additional organizations and medical societies to contact which the EVP agreed to pursue. The Board also discussed supporting Resolutions regarding this rule to be presented at the FMA Annual Meeting in July.

EVP Report: Ms. Owens reported on upcoming FMA Meeting deadlines and the open seat for District H Representative on the Board of Governors.

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HOSPICE HONORS

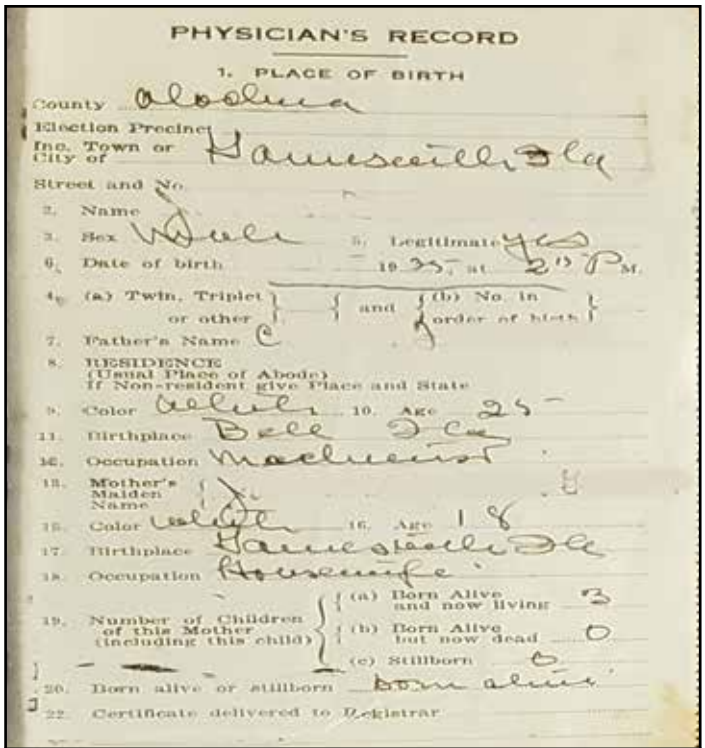
2023 Award Recipient

Born in the USA - At AGH and Elsewhere

By: Scott Medley, MD

Paul Clayton, Rudy Gertner, and I concocted this plan to review the Alachua General Hospital (AGH) Birth Records at the ACMS Robb House where they are stored in the Medical Museum, saved from the destruction of AGH by the late, great Florence Van Arnam (1929—2023). Our search was limited to births before 1950. Also, as we perused many obituaries as part of this project, it became obvious that in this Editorial we needed to include several more physicians who were not born at AGH, but who had a great impact on the practice of medicine in Gainesville.

Alachua County Hospital was opened in 1928 and renamed Alachua General Hospital in 1949, as 60 new patient beds were added.. We were able to secure our first Physician's Birth Record (Dr. Billie Evans) from 1929. All of these reports come from AGH Birth Records, from public obituaries, from other public sources, or with the permission of all the living physicians who are profiled here. Of course, this was a mammoth undertaking, and as always, due to space constraints, we've had to limit the number of docs listed here. We hope we have not left out too many physicians.



PHYSICIAN'S RECORD

1. PLACE OF BIRTH

County Alachua

Election Precinct

Ins. Town or City of Gainesville

Street and No.

2. Name

3. Sex White 5. Legitimate Yes

6. Date of birth 1935 at 2:15 P.M.

4. (a) Twin, Triplet or other } and (b) No. in order of birth }

7. Father's Name C

8. RESIDENCE (Usual Place of Abode) If Non-resident give Place and State

9. Color White 10. Age 25

11. Birthplace Dale Co Ala

12. Occupation Machinist

13. Mother's Maiden Name

14. Color White 16. Age 18

17. Birthplace Gainesville Fla

18. Occupation Housewife

19. Number of Children of this Mother (including this child) (a) Born Alive and now living 3 (b) Born Alive but now dead 0 (c) Stillborn 0

20. Born alive or stillborn born alive

22. Certificate delivered to Registrar

Redacted Record of a birth in 1935 at AGH.

Born at AGH before 1950

We were able to locate the Birth Records for most of these:

William Canfield "Billie" Evans, Jr. (1929—2011)

Born at AGH. Attended P. K. Yonge kindergarten through High School, graduating at age 16. Admitted to Duke University where he completed his undergraduate studies in only 3 years. Always "the life of the party", Billie served as the Duke Blue Devil Mascot in full costume at Duke athletic events. Graduated from Duke Medical School with honors. Served in the U. S. Army as a Captain in the Medical Corps. Practiced Family Medicine in Gainesville for 34 years, much of this time in partnership with Drs. Billy Brashear and Bob Casey.

Richard Anderson (1930—2018)

Born at AGH. Played football and basketball at GHS. Graduated from UF. Served in the U.S. Air Force in Korea. President of his class at Emory Medical School. Fellowship in Endocrinology at UF. Chairman of Santa Fe Healthcare. Ruling Elder at First Presbyterian Church. Practiced Internal Medicine near AGH in Gainesville for 40 years.

Perry Foote (1936—)

Dr. Foote, now still thriving, prefers to regale us with stories about AGH instead of about himself. Perry states that he and his brother and sister were all delivered at AGH by Dr. W.C. Thomas, Sr., MD, who performed the vast majority of deliveries at that time. Perry grew up 1 ½ blocks from AGH and played with Rudy Gertner, on the grounds of AGH.

He recalls that Gainesville was a small town then and "no one locked their doors". As for AGH, it was not air-conditioned at that time and so among the duties of the OR nurses was mopping the perspiration-soaked brows of the masked and gown-clad surgeons. There was a 50- pound block of ice in the OR with a fan blowing across it. There was no ambulance service, so Williams-Thomas funeral home loaned one of their hearses when an "ambulance" was required. Of course, Perry Foote went on to establish a solo practice near AGH as one of Gainesville's premier ENT physicians.

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Drs. Harold "Rudy" Gertner (1939—) and **Paul Clayton** (1941 —) were both born at AGH and both went on to have sterling medical careers in Gainesville. Rudy shared with us his mother's Alachua County Hospital Bill from 1939—a 9-day hospitalization for mother and baby for $68.10! Paul remembers growing up on "Franklin Street", which is now 6th avenue. He remembers that many of his neighbors owned chickens and WWII was in progress. Rudy grew up on "Margaret St", which is now 5th avenue. He remembers the signs around AGH stating "Quiet – Hospital Zone". He also remembers that a childhood friend underwent a routine appendectomy and had to remain at AGH for 2 weeks post-op, where Rudy would speak with him as the young patient stood on the AGH balcony and Rudy stood on the ground outside.

They both attended P.K. Yonge school where they played "mumbly peg" (with real pocket knives) and Little League Baseball. For high school, Paul went from P.K. Yonge to Gainesville High School (GHS), where he says he "knew about three people." They remember playing football in high school, where the average lineman "weighed about 170 pounds and got knocked around pretty good." Rudy, an Eagle Scout, went on to the University of Florida, whereas Paul attended Stanford University, (prompting me to say, "Dern, I didn't know you were that smart"). They both went on to Medical School whereupon at graduation from UF Med School, Rudy received "The John B. Gorrie Award" for being "the graduating medical student having the most promise for becoming a physician of the highest type". They both went on to impressive Residencies and Fellowships—Paul at Parkland Southwestern University Hospital and Rudy at Johns Hopkins and the NIH. Paul served as a U.S. Air Force Flight Surgeon in Okinawa for 3 years. Both of these physicians had long successful practices in Gainesville, Paul in Anesthesiology and Rudy in Vascular Surgery—two AGH Babies made good!

BORN ELSEWHERE

Actually, some of these next physicians were born before AGH was opened as Alachua County Hospital in 1928, but they all practiced at AGH for many years, and all had significant impacts on Medicine in Gainesville. Some of their stories are quite poignant, so they needed to be included.

Henry Babers, Jr. (1912—2006)
Born in Gainesville in 1912. Graduate of UF, Cornell Medical School, and University of Pennsylvania. Commanded a Mobile Army Surgical Hospital "MASH Unit" in France in WW II. Established the first Surgical Group Practice

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L to R: Paul Clayton, MD; Scott Medley, MD; and Rudy Gertner, MD; reviewing the medical birth records at the Robb House Medical Museum.

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Stacks of Birth Records from AGH, collected by Florence Van Arnam upon the demolition of the hospital.

in Gainesville in 1946. Retired after 45 years of General Surgical practice.

John Crago (1919—2011) Born in Nebraska. Moved to Gainesville at age ten. Member of the first graduating class at P. K. Yonge school at age 15, later attending Medical School at Cornell University in New York City. Served as a U. S. Army Officer in the artillery. Participated in the D-Day invasion of Normandy in 1944. One of the first Internists in Gainesville, practiced Internal Medicine for 47 years.

Charles Pinkoson (1921—2018) College at UF, Baylor University, Tulane University Medical School. Flight Surgeon in the U.S. Air Force. One of first eye and ENT surgeons in Gainesville. Later specialized in Ophthalmology only. Served as Chief of Staff at AGH on many occasions.

Alachua County Hospital (AGH) circa 1935.

Leonard Emmel (1922—) **
Moved to Gainesville from Wilson, Arkansas in about 1934. Attended Kirby Smith School and GHS with Principal Fritz Buchholz. Served in the Army in the Korean War. Practiced Internal Medicine in Gainesville for 36 years. Made frequent house calls in the early years. One-hundred and one years old this year, and still thriving. (** Derived from the Matheson Historical Museum Oral History Program, April 24, 2002)

Bruce Stechmiller (1946--)
Born in Chicago, moved to Gainesville at age 6 months. Since then, he has lived his entire life in Gainesville. Attended P. K. Yonge kindergarten, then Sidney Lanier School, Buchholz Jr. High, then GHS. (He states, "I'm a Public School kind of guy.") Internship, Residency, and Fellowship at Johns Hopkins and the NIH. Established the first Oncology Group Practice at AGH-Gainesville Hematology/Oncology Associates (later Florida Cancer Specialists). To me, Bruce is the quintessential Gainesvillian.

I hope you have enjoyed this stroll down memory lane in AGH and Gainesville . I had the good fortune to practice Medicine at AGH for 30 years, from 1979 until it closed in 2009. For many of those years I was privileged to practice alongside most of the physicians profiled here. It was quite an experience.

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- Self-care strategies
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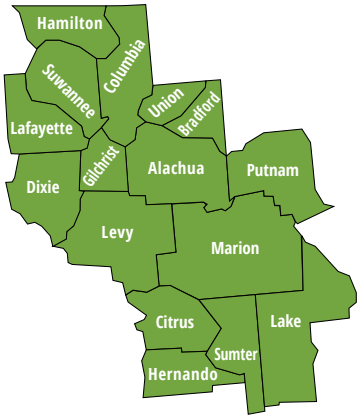

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- Effective and Free
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Connecting families to community programs

FOCUS: A one-stop entry point to home visiting programs and resources for pregnant women, infants, young children, fathers and families. Call Connect at 877-678-WELL to refer your patients to the following programs.

HEALTHY START

FOCUS: Pregnant women, infants and families with children up to age 3. A Home Visitor provides education and support in prenatal care, newborn care, breastfeeding, infant safety, child development and more.

FLORIDA MIECHV
Maternal, Infant, & Early Childhood HOME VISITING INITIATIVE

parents as teachers
BLUE RIBBON AFFILIATE

FOCUS: Parent Educators provide parents and caregivers with child developmental information and activities, free screenings and connections to community resources. Eligibility is based on specific family stressors, including developmental delay or disability.

Nurse-Family Partnership

FOCUS: Pregnant women affected by substance use are partnered with a specially trained registered nurse throughout pregnancy until the child's second birthday. The nurse conducts screenings and infant safety planning and assessments, provides family-focused case management, and supports the mother's health and wellness goals.

T.E.A.M DAD
Fatherhood Initiative of Florida
Healthy Start
North Central Florida

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