Opioid Use on the Rise: Is the Pen Mightier Than the Alternatives When It Comes to Chronic Pain Management?

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It’s no great revelation that the health care system is at a crossroads with regard to pain management. Moral, ethical, regulatory, and legal issues all play major roles in this complex, yet common, part of medical practice. This article provides an overview of pain management options, with a particular focus on the increasing use of opioids to treat chronic pain in the US and in Michigan, and how physicians – and patients – can use available resources to become more informed about treating chronic pain.

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Use MAPS to Prevent Prescription Drug Abuse in Your Practice

By Daniel J. Schulte, JD

QUESTION:
I was contacted by an investigator for the Department of Licensing and Regulatory Affairs. Apparently, a new patient of mine has gotten controlled substance prescriptions from several doctors over the last year or so. I too prescribed a controlled substance for pain as part of my treatment plan for this patient. How can this happen? What could I or should I have done not to have become a part of this?

ANSWER:
This is an all too common scenario, one that has occurred often for a very long time. Patients (as a result of necessary medical treatment or otherwise) become addicted to one or more controlled substances. Instead of buying the drugs on the street, they sometimes “doctor shop” to obtain as many new prescriptions/refills as they can. Alternatively, the patient may not be an addict and instead be posing as a patient telling you a fake story to get a prescription to sell the drugs on the street.

You can protect yourself and help prevent this from happening by using Michigan’s Automated Prescription System (MAPS). MAPS is Michigan’s prescription monitoring service, which is made available to physicians and other licensed health care professionals, law enforcement, and certain other state agencies. On the first and fifteenth of each month (this is the minimum required reporting; reporting could be made on a weekly, daily, etc. basis), pharmacies and others legally able to dispense Schedule 2-5 controlled substances are required to report information to MAPS. The information reported includes the patient’s name, the name of the drug, dosage, etc. of the drug dispensed, the prescriber, the date the drugs were dispensed, and other information that would easily enable someone to determine if doctor shopping or another illegal procurement of controlled substances was occurring.

Any Michigan licensed physician may use MAPS. In order to do so, physicians must first register online by going to www.sso.state.mi.us. Once registered, you will be able to obtain patient-specific reports. The law requires that you only request MAPS reports on your current bona fide patients. You will be asked to certify that this is the case each time you request a MAPS report. You should not use MAPS to request information on anyone who is not a bona fide current patient. All of the data maintained by MAPS is securely stored by the State of Michigan in a way that (according to the State) complies with HIPAA’s security requirements. Since the data is only being released to those who certify they are the patient’s current physician, the disclosure does not violate HIPAA.

In addition to using MAPS to prevent patients from illegally obtaining prescriptions for controlled substances, you can use MAPS to determine whether prescriptions are being illegally written or renewed in your office.

In addition to using MAPS to prevent patients from illegally obtaining prescriptions for controlled substances, you can use MAPS to determine whether prescriptions are being illegally written or renewed in your office. MM

Daniel J. Schulte, JD, MSMS Legal Counsel, is a member of Kerr, Russell and Weber, PLC.

EDITOR’S NOTE:
If you have legal questions you would like answered by MSMS legal counsel in this column, send them to: Jessy Sielski, Michigan Medicine, MSMS, 120 West Saginaw Street, East Lansing, MI 48823, or at jsielski@msms.org.
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Prescription opioid use in the US is at an all-time high – roughly quadrupling between 1998 and 2008, according to the Centers for Disease Control & Prevention (CDC).

Michigan has experienced its own prescription boom in recent years, as well.

According to a 2012 report conducted by the Michigan Department of Community Health, almost every category of controlled drug has increased in the number of prescriptions since 2003. From 2003 to 2010, the biggest increase noted was with opioid antagonists (Suboxone/Subutex, Schedule III); the number of prescriptions increased rapidly (327 prescriptions in 2003, and 285,059 in 2010). Increases shown in Schedule II (stimulants and pain relievers) drug prescriptions from 2003 to 2010 include oxycodone (113 percent), methadone (146 percent), and hydromorphone (275 percent).¹

So what is driving this alarming increase, and what do physicians need to consider down the road?

Patients in pain
Michael D. Chafty, MD, JD, a former MSMS Board of Directors member and a Kalamazoo County anesthesiologist who runs a pain management clinic, explains that of the four main types of pain – acute non-malignant, chronic non-malignant, acute malignant, and chronic malignant – the growing problem of opioid misuse and abuse really pertains to the treatment of chronic non-malignant pain.

“We used to always be able to treat acute pain, but we never really addressed the issue of chronic pain,” he said. “What we are talking about is a problem of treating chronic pain with short-acting narcotics for a long period of time. These are highly addictive substances.”

The Most Commonly Prescribed Pain Relievers in Michigan in 2010:

- **Hydrocodone**
  (Vicodin, etc., Schedule III)
  at 5.8 million prescriptions

- **Codeine**
  (Tylenol #3 and #4, Schedule III)
  at 0.72 million

- **Oxycodone**
  (OxyContin, etc., Schedule II)
  at 0.69 million

[Source: “Michigan Epidemiological Profile – Focusing on Abuse of Alcohol, Prescription Drugs, Tobacco & Mental Health Indicators – March 2012 Update,” Michigan Department of Community Health, Bureau of Substance Abuse & Addiction Services, State Epidemiological Outcomes Workgroup]
In a 2011 telephone survey conducted by the Michigan Department of Licensing & Regulatory Affairs (LARA), 27.2 percent of Michigan residents sought treatment from a health care professional for a chronic pain condition in the past year. The survey results also showed that 29 percent of Michigan residents have sought treatment from a health care professional for an acute pain condition in the past year.

The Institute of Medicine’s 2011 report on pain estimated that 116 million Americans live with chronic pain.

“JCAHO [The Joint Commission] even called pain ‘the fifth vital sign,’” says Doctor Chafty.

Working against the odds
Despite their dedication to caring for their patients, however, many issues are conspiring against physicians doing the right thing when it comes to treating chronic pain – lack of adequate time with patients, cost of doing thorough testing, societal pressure and demand, “doctor shoppers,” etc.

“On the ethical side, you have to ask yourself, ‘Do I withhold medications from a patient who is suffering with pain?’ No one wants patients to suffer,” says Fred Van Alstine, MD, a Shiawassee County family physician, who serves on the MSMS Mental Health & Substance Abuse Committee, and as a medical examiner for many years. Doctor Van Alstine saw the tragic side of prescription drug misuse and abuse. “On the other hand, most of these [opioids] do more harm than good in the end.”

And thanks to the barrage of pharmaceutical advertising, Internet resources, mobile device applications, etc. – not to mention the fact that prescription drugs are deemed socially acceptable – patients today are increasingly savvy about prescription pain relievers and aren’t afraid to request them in the doctor’s office.

“I am very conservative when it comes to prescribing pain medications,” continued Doctor Van Alstine. “We actually have a policy posted on a sign in my urgent care clinic explaining that we do not renew prescriptions for narcotics or psychotropics because we can’t track the use in this setting,” said Doctor Van Alstine.

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but I believe you need a definitive physician-patient relationship that is well documented in order to safely prescribe narcotics.”

Almost a reverse take on the old “don’t take candy from strangers” adage, Doctor Alstine simply states, “I don’t prescribe narcotics to strangers. Period.”

Doctor Chafty also advises his colleagues to be cautious and do as thorough of a work-up as they can. “Patients are part of this, too. You can’t always rely just on what they are telling you. There are other signs like their behavior, appointment attendance history, overly-interested family members,” he advises. "We should be testing patients more often, using [Michigan Automated Prescription System] for tracking purposes, taking samples. In my clinic, we make patients sign an agreement before prescribing narcotics to them. It isn’t a legal document, but it outlines what is expected of them.

“All of this takes more time and sometimes costs more money,” he continues, “but it’s worth it to provide better patient care and, let’s face it, to protect your practice.”

(See the “Ask Our Lawyer” column on p. 4 of this issue to learn more about the Michigan Automated Prescription System, or MAPS.)

‘Right-sizing’ the Treatment
Both Doctor Chafty and Doctor Van Alstine cite a multidisciplinary approach as the best way to treat and manage chronic pain. This could involve a combination of therapy, conditioning, medications, injections, and/or surgery, and a variety of allied health professionals working as a team.

LARA concurs. As the agency responsible for regulating the medical profession with regard to safe prescribing practices, LARA advocated a multidisciplinary approach, and has created its own Pain & Symptom Management web page with a multitude of resources to educate physicians and other health professionals, as well as patients.

LARA also has collaborated with all of the medical schools in Michigan to provide them with a pain curriculum that previously was lacking in the programs. The curriculum is available on the LARA website. There are also further training opportunities for physicians, including a September 27 scope of pain training course.

One of the resources LARA touts the most for physicians is a book called Responsible Opioid Prescribing: A Clinician’s Guide by Scott Fishman, MD, Professor and Chief, Pain Medicine Division, University of California, Davis. Since 2009, LARA has received funding to distribute it to all newly-licensed physicians in Michigan.

In 2011, the MSMS House of Delegates adopted Res. 19-11: That MSMS actively educate physicians about the process and extent of prescribed opiate medication diversion in the community and urge the health care providers prescribing daily opiates in chronic pain patients to monitor those patients at a minimum with yearly quantitative urine drug screens. That same year, MSMS has offered members clinical education on pain management at the Annual Scientific Education.

MSMS has also created a resources page as a “one-stop-shop” for pain management resources: www.msms.org/pain.

The author is senior manager of communications at MSMS.

[Source: “Michigan Epidemiological Profile – Focusing on Abuse of Alcohol, Prescription Drugs, Tobacco & Mental Health Indicators – March 2012 Update,” Michigan Department of Community Health, Bureau of Substance Abuse & Addiction Services, State Epidemiological Outcomes Workgroup]
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The solution to the physician shortage in Michigan may be as much about the quality of the training experience as the number of students graduating from the state’s medical schools. Who does the training and how the training is designed has as much to do with a physician’s selection of practice locale as anything, notes Robert Santonik, MD, assistant dean for Graduate Medical Education at the Central Michigan University College of Medicine (CMU).

“To some extent, it is a behavioral imprint,” he says. “If you expose a student to a set of experiences that provide outstanding mentors and role models, you are more likely to communicate to that student the value of that career choice.”

A recent study conducted by the American Association of Medical Colleges (AAMC) found that debt pressure is less of a factor in specialty choice than is commonly believed, he adds.

The aging population, anticipated expansion of Medicaid-eligible people, popularity of non-primary care specialties, the “brain-drain” of medical residents to practice locations in other states, and the loss of physicians through retirement are factors contributing to projections of an acute shortage of physicians in Michigan during the next 20 years. Reduced funding for graduate medical education programs is further compounding the problem, resulting in hundreds of medical students graduating without residency opportunities.

One of the best ways to recruit medical school graduates to community-based residencies and the generalist specialties is to pre-screen students, says Doctor Santonik. “There is some data that suggests if you recruit students into medical school from a targeted geographic region and if they complete residency training in that target region, then they are more likely to enter practice in the region.” CMU is focusing its residency on “generalist” specialties, which include primary care and first-encounter specialties such as general surgery, and is securing training sites throughout upper Lower Michigan and the Upper Peninsula. The school has more than 22 practice site affiliations.

In the CMU admissions process, a major factor in the admissions process is whether or not the student has an interest in practicing in underserved areas of Michigan. “We have a good understanding of the profiles of people who choose to practice in rural and remote areas,” says Sean Kesterson, MD, CMU associate dean. Predictors include whether the physician graduated from a public medical school, comes from a family whose household income is less than $100,000, and whether they or their spouse come from a small hometown.

CMU orients medical students to community-centered care through a two-year required course in “Society and Community Medicine,” says Doctor Kesterson. “Population health is a big part of the education model... We look at developing federally qualified health centers, the [Robert Wood Johnson Foundation] county rankings, raising awareness among students regarding the determinants of health.”

Students are required to complete a population-based research project as part of that course.

Another way CMU makes an impression on students is through a 32-week community clerkship in which small groups of medical students are assigned primary care practices in smaller communities. “If you look at the traditional model of clinical medical education, it reveals to students what it’s like to be a resident in an academic physician in a teaching hospital. It doesn’t give them great insight into the practice life of a family physician in Alpena.” In the community clerkship, “you’re talking about a significant chunk of time at a very formative stage.”

Teaching Health Centers

Most acute shortages are found in the primary care or “first-encounter” specialties, which traditionally have offered lower income potential, and practice settings that are less desirable – remote rural areas and complex urban environments. The Patient Protection and Affordable Care Act (ACA) includes funding for “teaching health centers,” designed to train primary care residents in the community setting. Unlike other
residencies funded through the Medicare program, teaching health centers are funded through the Health Resources Services Administration.

The state’s first teaching health center, based in Southeast Michigan, is a partnership between the Michigan State University College of Osteopathic Medicine and the Detroit Wayne County Health Authority, a public organization serving the health care safety net. The program, known as Authority Health, will begin training 27 residents in six primary care specialties this summer, with an anticipated 85 over three years. While the residents will fulfill their hospital-based requirements, they will spend considerably more time in community health centers and other “street-level” community health access points to get a better feeling for the medical needs of vulnerable communities – and understand the environments impacting their health and health behavior.

**Community-based Training**

Authority Health identified primary care specialties in high demand in Detroit and Wayne County: internal medicine, family medicine, pediatrics, obstetrics and gynecology, psychiatry, and geriatrics. A key difference in this model of training is not only the funding source, but also who controls the funds. The teaching health center model assumes a greater focus on community-focused practice. This model is a radical departure from the traditional hospital-based approach,” explains Michael Opipari, DO, an oncologist who has been actively involved in medical education for much of his career. He is credited with having developed the current criteria used for accrediting osteopathic residencies throughout the country.

“Graduate medical education is changing significantly and will continue to change,” he says. Community-based residency programs, creatively designed to meet the needs of residents and society, is the future of medical education, he says. Residents will still spend much of their time in the hospital setting to fulfill the requirements of accrediting bodies, but “the training environment needs to shift to a greater degree outside the hospital into the community – which this program represents.” For example, the didactic portion of the training will include lectures focused on various aspects of population health, adds Doctor Opipari.

John Sealey, DO, director of Medical Education for Authority Health, was raised in rural North Carolina, “where health care was given out sparsely. It was a cash process. I didn’t have a relationship with a physician. When I went to medical school, I promised myself that I would work in a medically-underserved area.”

A graduate of the Michigan State University College of Osteopathic Medicine, Doctor Sealey has been a cardiovascular surgeon and medical educator in the Detroit area for 35 years. He has been active in the school’s Detroit pipeline program, speaking to students at various ages about pursuing a medical career. The Authority Health teaching program is an opportunity

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“Graduate medical education is changing significantly and will continue to change. Community-based residency programs, creatively designed to meet the needs of residents and society is the future of medical education.”

— Michael Opipari, DO
to introduce the next generation of primary care specialists to opportunities in medically-underserved urban areas, he says.

If medical residents are given a good, community-based training experience, Doctor Sealey is confident that they will remain in the community. In addition, should they continue working in a medically-underserved community following their residency training, they could qualify for a loan forgiveness program, which will significantly lessen their debt load.

“The model, as we’ve designed it, will have the resident spending a lot of time in the community,” he says. Much of the residency training occurs in community health centers and other community health access points, as well as traditional hospital setting. “They will connect to the kind of patient who lives in the area on a primary care basis. It will alleviate some of the fear associated with urban living.” Likewise, Authority Health is promoting the positive opportunities of the lifestyle in metropolitan Detroit, encouraging residents to live in and experience what the city and region has to offer.

“Many people – especially those coming here from other states – have a misunderstanding as to how safe it is [in Detroit]. Once you start working here, you will feel more comfortable.” In a sense, residents attracted to the program will have a degree of urban awareness and even desire to train in the environment – just as someone will anticipate aspects of country living in a rural residency.

Community-based training allows residents to develop long-term relationships with their patients, Doctor Sealey says. “Many times, when you have a hospital-based training, you see people in a near-terminal or episodic state. When you work in the community on a regular basis, you’ll see the patient at an earlier state and become more effective with prevention.”

Doctor Sealey says the family medicine and primary care specialists currently aren’t considering establishing their practices in urban Detroit. However, he anticipates several of the projected 85 residents in the Authority Health program will choose to remain in medically underserved areas of Wayne County.

Case studies of community health center-based resident training programs show that “large proportions of graduates chose to practice either at their particular training sites or other community health centers, strengthening the primary care physician workforce. Patient satisfaction with community health center-based residency training programs is reportedly very high, with patients appreciating the service provided as well as the opportunity to contribute to resident education and experience,” according to a 2010 report published by the National Association of Community Health Centers. The report noted that individual programs will retain from 30 to 80 percent of the residency graduates in the region.

**New Reality**

For primary care, a community-based approach is the best way to train residents, Doctor Opipari says. However, accrediting agencies have been slow to accept that fact. As a result, the number of unmatched applicants for allopathic and osteopathic residencies has doubled in the past year. Five hundred applicants did not match available residencies in the 2013 residency matches, he says. “We anticipate that this will increase.”

“Even though the needs have changed in the last 15 years, GME funding hasn’t growing accordingly. In fact, it has been reduced. We already know that in many urban areas people are unable to access health care. When we add to that the anticipated physician shortage in the future it compounds the problem.

“Programs like Authority Health will prove that there are other ways of training for primary care, this is the best way, but it’s not proven yet. We will prove through our experience that this is the most viable way.... This is truly not a traditional program.”

Congress does not seem inclined to increase funding for GME slots in the future, adds Doctor Satonik. “We’re going to have to develop novel approaches to training in order to meet the looming shortage. The historical model has been hospital-based for most specialties. Yet the practice for many specialties is dividing itself out into hospital and non-hospital based. At some point our training is going to have to reflect this new reality, which will open a lot of opportunities to develop new training sites that are non-hospital based.”

It will take many untraditional programs and collaboration to meet the demand from medical school graduates and the community for first-encounter and general practice physicians, as well as “a lot of cooperation between different parties; cooperation among parties that have not historically been that cooperative with each other,” says Doctor Satonik. “In order to solve this, no one agency, no one medical school is going to do it. It’s going to take everyone coming together to solve some very complicated problems.”

*The author is a Southeast Michigan health care writer.*
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A Window of Opportunity

How Organized Medicine Led an Anesthesiologist to the State Senate

By Nick DeLeeuw

If a window of opportunity appears, don’t pull down the shade.
—Thomas J. Peters, business management author

He never intended to get into politics – let alone run for office.

Tom George entered the University of Michigan’s Medical School after completing the junior year of his undergraduate program, a year ahead of his peers. The Flint native met his future wife while completing medical school, and after graduation they settled in Kalamazoo where he began practicing anesthesiology.

But 20 years later, there he was, on the floor of the House of Representatives leading the charge to address an onerous and overbearing state bureaucracy that had been standing between physicians and their patients for years.

The state of Michigan stood out from its neighbors for a generation, requiring any physician who wished to prescribe opioids – Schedule II drugs – to first obtain a special permission slip from bureaucrats in Lansing.

Opioids like codeine and oxycodone are effective against severe pain but are also highly addictive, creating a fear of chronic, habitual abuse and leading lawmakers to substitute their own medical judgment for that of Michigan physicians.

Applications submitted by physicians were then stored and monitored, leading many to avoid treating their patients as effectively and efficiently as possible out of a fear the state might ask unfair questions or draw unflattering assumptions about their practices.

It took a Michigan physician to end the paranoia, the stigma and the inefficiency that was standing between local patients and the treatment they needed.

Tom George was elected to the Michigan House of Representatives in 2000 and almost immediately got the job done, moving the state into the twenty-first century, and establishing electronic tracking procedures that both monitored opioid prescriptions and freed physicians from the stigma of state-mandated permission slips.

Sometimes even legislation needs a doctor’s visit.

Even so, George was an unlikely candidate. Instead of politics, he'd spent decades focused on treating patients and raising a family.

An avid student of Abraham Lincoln and a self-described historical “hobbyist,” he even served as the president of the Historical Society of Michigan, the state’s oldest cultural institution.

It was that passion for history that eventually helped him close the loop around his medical education. By conducting research and completing a paper about President Abraham Lincoln's lone visit to the state of Michigan, Doctor George completed his undergraduate degree in 2009, nearly three decades after he entered medical school, graduating from UM the same spring his daughter Maria, the second of the Georges' three children, earned her degree up the road at Michigan State University.

Despite the rivalry between the state’s largest universities and his personal Lincoln scholarship, George rejects any comparison to the Civil War when it comes to the Wolverines and Spartans, at least when it comes to he and his daughter.

“Somehow we manage,” he deadpans.

Despite studying presidents and politics, it was his commitment to his patients in Kalamazoo that eventually opened George’s eyes to public service in Lansing.

“It was through the Michigan State Medical Society in the late 1980s that I got to meet my legislators,” George says. “MSMS was the window that got me interested in politics.”

INSPIRING FUTURE LEADERS, SEN. GEORGE SPEAKS TO STUDENTS AT WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE.

MSMS was the window that got me interested in politics.”
—Tom George, MD
After years working, and chairing, the Kalamazoo Academy of Medicine, George accepted the invitation of Michigan State Medical Society staff to visit Lansing and meet the lawmakers on the front lines deciding health care policy for the entire state.

He was hooked.

Tom George was elected to the state House of Representatives in 2000 and served one term before making the jump to the state Senate where he served the next eight years.

His continuing effectiveness in Lansing over the last decade, both inside the legislature and from his practice in Southwest Michigan, is a testament to the influence and importance of physicians at the state Capitol. And given the sheer amount of tax dollars being spent on health care and the amount of public health policy being discussed daily, George has helped blaze a trail he hopes more physicians will follow.

“Legislators are going to get solicited by all sorts of different groups,” said George. “One day it’s the homebuilders and the next it’s the architects, and they all have legitimate issues.” Though none, he argues, are as important to Michigan residents or as large in scale as the health care issues being tackled in Lansing every day.

The biggest expense lawmakers consider each year is health care. The 2013-2014 budget signed by Governor Snyder earlier this year earmarked more than $21.5 billion – fully 45 percent of the state’s total spending for the year – for health and human services. That outpaced state spending on education, public safety, government services and environmental protection combined.

Toss in more than a half-dozen high profile health care bills currently on the docket covering everything from Medicaid expansion to efforts to end physician supervision of anesthesia care and the potential for widespread prescribing authority for non-physicians of Schedule II narcotics, and there’s little wonder physicians’ voices and opinions are so valued and important at the state capitol.

Surprisingly, given the size and scope of the health care issues being discussed each year, George is one of only six physicians to have served in the state House or Senate in the last 20 years. Only one – Saginaw County’s state senator Roger Kahn, MD – serves in the legislature today.

According to George, that only heightens the importance of organizations like the Michigan State Medical Society and local county-based medical societies that work day in and day out to bring the concerns of physicians directly to lawmakers.

“Organized medicine is often the best way to have a say,” George believes. “Physicians shouldn’t be afraid to give law-
makers input as issues arise. There is room and a need for physicians and physician candidates, given that medicine is government’s biggest expense.”

Having a say couldn’t be more important than it is today. Although it is taking place on a different front, the battle George fought over opioid prescribing authority over a decade ago is being waged again in Lansing.

Dangerous legislation – Senate Bill 2 and Senate Bill 180 – is being considered by lawmakers in the state Senate even today that would both end physician supervision of anesthesia care across the state and give inadequately trained nurses complete, autonomous and unsupervised prescribing authority over the same dangerous, highly-addictive Schedule II drugs lawmakers once feared even letting doctors prescribe.

Both moves are transparent attempts to put the financial needs of a few health care professionals ahead of the needs of Michigan patients and both, George says, underscore the importance of physician participation in the law-making process.

“Physicians still have three fronts to cover – scope of practice issues, payment systems, and the legal malpractice environment. All three need constant attention from physicians, but, as busy doctors, we often can’t [spread ourselves that thin]. The best tools are organizations like the Michigan State Medical Society or county medical societies.”

Another lawmaker or two like Tom George couldn’t hurt, either.

The author is a strategist with Resch Strategies in Lansing, Michigan.
**QUESTION:** When attesting to Stage 1 Meaningful Use, do physicians and other eligible providers (EPs) have to report on a public health measure from the menu set?

**ANSWER:** Yes. For physicians and other eligible providers (EPs), one of the criteria for successfully demonstrating Stage 1 meaningful use (MU) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs is the inclusion of one of two public health measures in the EP’s MU attestation. EPs who do not qualify for exclusion must attest that they have the capability to submit either electronic data to an immunization registry or electronic syndromic surveillance data to public health agencies.

Unfortunately, there is much confusion over how to report these measures, which measure to report, who meets the exclusion, and whether Michigan’s immunization registry and syndromic surveillance system can receive the information. As a result, there is some concern that EPs may be erroneously claiming exclusions. EPs qualify for exclusion if the action required by the measures is not something the EP performs or the immunization registry or syndromic surveillance system cannot receive the information electronically. For example, many specialists do not provide immunizations. When EPs attest to MU, they must select and attest to the public health measure that is relevant to their scope of practice.

If neither measure is relevant, EPs must pick only one measure for which they will attest to meeting the exclusion criteria. CMS offers the following guidance in FAQ #10162:

“EPs participating in Stage 1 of the EHR Incentive Programs are required to report on a total of 5 meaningful use objectives from the menu set of 10. When selecting five objectives from the menu set, EPs must choose at least one option from the public health menu set. If an EP is able to meet the measure of one of the public health menu objectives but can be excluded from the other, the EP should select and report on the public health menu objective they are able to meet. If an EP can be excluded from both public health menu objectives, the EP should claim an exclusion from only one public health objective and report on four additional menu objectives from outside the public health menu set.”

In Michigan, immunization data can be reported to the Michigan Care Improvement Registry (MCIR). Therefore, Michigan EPs who administer immunizations will need to test with the Michigan Department of Community Health (MDCH) to show that their EHR technology can electronically submit immunization data. Upon successful completion of the test, EPs will receive a confirmation letter from MDCH. EPs need to retain this letter, with other applicable MU documentation, for a minimum of six years in case they are subject to an MU audit. The steps for

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**DocBookMD**

Physicians who are members of the Michigan State Medical Society (MSMS) have free access to the HIPAA-compliant smartphone app DocBookMD. DocBookMD is designed by and for physicians and provides secure networks for physicians to communicate, collaborate, and coordinate with their medical society colleagues. In addition to text messages and photos, DocBookMD allows physicians to:

- Assign an urgency setting to outgoing text messages and confirm receipt
- Search a local pharmacy directory
- Search a local medical society directory to locate other doctors by name or by specialty

DocBookMD is available for iPhone, iPad, iPod touch and Android phones. To get started, download the application for FREE from the iTunes App Store or Android Market. Open up the application to begin the registration process. Enter email address, state, and Medical Society. Enter MSMS member number (call 517-336-5762 if you don’t know your member number). Create password. Complete HIPAA compliance agreement.

For more details, visit DocBookMD.com.
testing with MCIR are found at www.michiganhealthit.org/public-health/steps-for-meaningful-use.

Michigan EPs who would otherwise qualify to report syndromic surveillance data to the Michigan Syndromic Surveillance System (MSSS) currently meet the exclusion to this meaningful measure due to the State’s inability to receive syndromic data electronically from EPs. At this time, the MSSS has the capacity to receive such data from eligible hospital emergency departments only (though they are working to expand that capacity yet this summer). However, if EPs who qualify for this exclusion administer immunizations, they cannot claim the exclusion for the immunization measure and must test with MCIR (as noted in the previous paragraph).

**QUESTION:** Can EPs submit data directly to MCIR from their EHR technology?

**ANSWER:** Beyond testing with MCIR, some EPs are currently using a temporary URL to electronically submit HL7 messages directly to MCIR. However, this method will be discontinued on December 31, 2013 (see the MDCH memorandum at http://mcir.org/forms/MCIR_Temp_URL_Notification_Memo.pdf). After this date, EPs will need to transmit MCIR messages via a Qualified Organization (QO). Currently in the State of Michigan there are seven QOs as follows:

- Great Lakes Health Information Exchange (GLHIE)
- Ingenium (Formerly MyHIE)
- Jackson Community Medical Records (JCMR)
- Michigan Health Connect (MHC)
- Southeast Michigan Beacon Community (SEMBC)
- Southeast Michigan Health Information Exchange (SEMHE)
- Upper Peninsula Health Information Exchange (UPHIE)

At this time, MHC and UPHIE are both “MCIR approved” QOs, which means that they are capable of transmitting HL7 messages to MCIR. The following QOs are in the process of testing immunization transmissions and should be in production very soon: SEMBC, JCMR and GLHIE. For more information on each of Michigan’s QOs, visit http://mihin.org/exchanges/.

**No-Show New Patients May Leave Physicians at Risk**

Contributed by The Doctors Company

Physicians face certain risks and responsibilities when collecting patient information prior to the patient arriving for his or her appointment.

A new patient may complete an online intake form, but not show up for the appointment. Or a new patient may complete a paper record with an intake history, but then leave before being seen. The data that is collected, either electronically or on paper, is in the hands of your office practice.

As a physician, you now face a dilemma. What is your responsibility for the information provided by a patient whom you have not seen? Whether or not you review this information, you face a risk if the patient believes that a physician-patient relationship has been established. And if the patient has indicated a serious medical condition and you don’t take action consistent with the community standard of care, then you are potentially liable.

To avoid this risk, place a disclaimer on any data-collecting instrument. The following are recommendations for disclaimers for both electronic and paper forms:

**Electronic Form Disclaimer**

Please be advised that by using this form to contact our office(s), we are not confirming an appointment nor establishing a physician-patient relationship. As a user of this mode of communication and of our website, you assume all risks with placing confidential information into this portal. Our office will follow up with you within 24 to 48 business hours. This form of communication is not intended for acute, emergency, or life-threatening health conditions. If you believe you are having a health emergency, contact 911 or go to your nearest emergency department.

**Paper Form Disclaimer**

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. <X> will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient. Protecting the confidentiality of all patients – whether they are established clients or no-shows – is important to minimize the risk of a malpractice suit. Another way to minimize your practice liability is to do a loss prevention checkup. The Doctors Company offers a “Patient Safety Interactive Guide for Office Practices,” which includes a checklist to ensure you and your office staff are protecting the confidentiality of all patients under the Health Insurance Portability and Accountability Act (HIPAA).

The Doctors Company is the exclusively endorsed medical liability carrier of the Michigan State Medical Society (MSMS). We share a joint mission of supporting doctors and advancing the practice of good medicine.

For More Information

For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.
Skin in the Game: How Kay Watnick, MD, Used MSMS to Turn Her Passion Into Law

By Stacy Sellek

Doctor Kay Watnick has her patients’ backs. Their whole bodies, in fact.

The Oakland County dermatologist has made it a mission not only to put her own patients’ health first, but also to protect people around the state, and children, in particular.

Having had one too many young patients affected by skin cancer and seeing the cases of melanoma – the deadliest type of skin cancer – among teenagers and young adults on the rise, Doctor Watnick could not sit idly on the sidelines.

“If you feel strongly and passionately about something, you need to act,” said Doctor Watnick, a physician in the Henry Ford system.

And act she did. Starting in January 2007, Doctor Watnick reached out to the Michigan Dermatological Society, which is staffed by MSMS, and MSMS, who were instrumental in introducing House Bill 4146. The bill aimed to establish parental consent requirements by minors in tanning facilities, among other things.

She explained, “I had gotten to know key staff at MDS and MSMS, and expressed my interest in legislative advocacy. Then I was invited to participate in the Doctor of the Day program in Lansing.

“That is when I realized the connection that we have to legislators,” she continued. “I realized that’s what we’re paying for at MSMS.”

A Different Kind of Access

Doctor Watnick, a Michigan native who graduated from University of Michigan Medical School, joined MSMS in 1985 as a resident at the suggestion of staff leaders at Henry Ford.

Throughout the two-year process of trying to pass HB 4146, she credits MSMS Government Relations staff for making it possible.

“Absolutely, the staff at MSMS made the difference,” she enthuses. “It was Josh lining up people for me to talk to – I couldn’t have done it without Josh Richmond.

“When you are an outsider and don’t know the system, you can’t do much good without access,” she adds.

Not that it was all smooth sailing.

She explained that it took a lot of free time, as well as time away from her practice and her family, including her husband Richard, an ophthalmologist at Henry Ford whom she met at U of M; her daughter, who is now a second-year pediatric resident at Northwestern University Hospital in Chicago; and her son, who studies law at Stanford University.

Despite the sacrifices, Doctor Watnick replies – almost without hesitation – that the biggest challenge in this process was the “politics in Lansing.”

“It took a lot of convincing, and it was tough to sell the idea of regulation to certain legislators and the business community, in general,” she recalls.

So how did she do it?

WHY MEDICINE?

Medicine wasn’t Doctor Watnick’s first profession. She began her career as a pharmacist. In her words:

“I didn’t have any female physician role models, but I always loved sciences, so I went to pharmacy school. As I began to see patients in the hospital setting, I realized how much I enjoyed that contact with people. That led me to medicine. I had planned to specialize in internal medicine, but then I had a dermatology rotation. What I liked about it was that I could do surgeries, combined with internal medicine and a variety of other things.”
“You have to address various sides of the issue,” she explains. “I tried to convince legislators that businesses wouldn’t have to pay as much for health care costs if this bill passed. Melanoma is a very expensive disease to treat. Preventing an expensive disease from spreading throughout our state would, in effect, decrease health care costs in our state.”

Obviously, that argument worked in the end, and after some compromise, HB 4146 was eventually signed into law by Gov. Jennifer Granholm in 2009.

“Despite the fact that I didn’t get everything I wanted in the bill, it felt hugely rewarding to pass it,” she says. “It was worth it.”

Doctor Watnick is once again representing dermatologists by working with MDS, as well as MSMS, in an attempt to put more teeth into the law she helped pass four years ago. House Bills 4404 and 4405 collectively would go even further than HB 4146 by not only banning all minors (under age 18) from indoor tanning facilities, but also by imposing a $150 fine on tanning facilities for violations and by requiring the facilities to register with the state and pay a $75 annual fee.

Doctor Watnick, who is MDS Immediate Past President, helmed a news conference in March at MSMS headquarters about the new tanning legislation.

Now a veteran of the legislative advocacy process, she knows how to make connections in Lansing and still lets her passion guide her. Before taking her place near the podium to get the news conference rolling, Doctor Watnick introduced herself to bill sponsor Rep. Jim Townsend (D-Royal Oak) as he walked in. Her concern was that some of his colleagues were interested in changing the bill language to lower the minimum age from 18 to 17.

“I want to make sure that age minimum remains in the bill. Otherwise, we aren’t protecting as many kids,” she said.

As for physician peers who have issues they are passionate about, Doctor Watnick definitely encourages them to get involved in advocating for those issues.

“At [MDS] meetings, I try to instill a little fire in them and inspire them,” she says. “I’ve been known to call the White House, and I show up for things in Washington and Lansing.

“The people who represent us need to hear when something needs to be changed,” she adds.

Holding tanning facilities accountable, banning minors outright, and being able to enforce the law are things that Doctor Watnick hopes they can change this time around.

The author is Senior Manager, MSMS Communications & Public Relations.
OBITUARIES

The members of the Michigan State Medical Society remember with respect their colleagues who have died.

Brian R. Copeland, MD
Midland, died June 8, 2013, at the age of 64.

Joe H. Gardner, MD
Saginaw, died June 24, 2013, at the age of 101.

Donald W. HesselSchwerdt, MD
Grand Rapids, died June 15, 2013, at the age of 91.

Carl E. Kuntzman, MD
Torch Lake and Naples, FL, died July 20, 2013, at the age of 81.

Dinesh O. Shah, MD
Lansing, died May 12, 2013, at the age of 64.

Rodman E. Taber, MD
Grand Rapids, died June 11, 2013, at the age of 93.

IN MEMORY

If you would like to recognize a colleague by making a gift or bequest in their memory to the MSMS Foundation, please contact Rebecca Blake, Director, MSMS Foundation, 120 W. Saginaw, East Lansing, MI 48823, call 517-336-5729 or send e-mail to rblake@msms.org.

Welcome to These New MSMS Members

Matthew Allen Bowen, MD, Norton Shores
Shireen A. Brohi, MD, West Bloomfield
Emily Ann Brunner, MD, Ann Arbor
Robert John Carroll, MD, Grosse Pointe Park
Nandak Sushenbhai Choksi, MD, Canton
Maureen L. Dailey, DO, Bloomfield Hills
Sarika Shrikant Deshmukh, MD, Canton
David Curtis Dewar, MD, Birmingham
Bruno Di Giovine, MD, Ann Arbor
Gregory Gafni-Pappas, DO, Ann Arbor
S. Elena Gimenez, MD, Ypsilanti
Timothy S. Hall, MD, Saginaw
Philip Alan Harris, MD, Midland

Mustafa Abdul Wareth Hashem, MD, Southgate
Micheleen Shizuka Hashikawa, MD, Ann Arbor Charter Twp
Sara Husain, MD, Ann Arbor
Effie Kaltsas, DO, Troy
Pranay Ramakaut Kanake, MD, Grosse Pointe
Harmohan S. Kochar, MD, Saginaw
Mhd Nawras Fathi Kordi, MD, Dearborn
Jon Michael Kramer, MD, Grand Rapids
Madhu Parameswar Menon, MD, Novi

Christopher Edward Morgan, MD, Grand Rapids
Masakatsu Nanamori, MD, Novi
Joanna Maria Olewicz, MD, Ann Arbor
Vivian N. Onyewuche, MD, Ypsilanti
Jessica M. Paquette, DO, Traverse City

Raisa Oleksandra Platte, MD, PhD, Grand Rapids
Paul Polyak, MD, Grand Blanc
Christina A. Richardson, DO, Lansing
Aicha Rifai, MD, Franklin
Naheed Rizvi, MD, Midland

Christopher R. Russo, MD, Grand Rapids
Dana L. Sachs, MD, Ann Arbor
Philip W. Siemer, MD, Suttons Bay
Robert T. Simkins, DO, Farmington Hills
Julie Ann Soriano, MD, Jackson
Ebru Sulanc, MD, Troy

Mary Sullivan Rockers, MD, Grosse Pointe Park
Tasleem Harris Syed, MD, Auburn Hills
Kishore S. Tonsekar, MD, Bad Axe
Sean Robert Williamson, MD, West Bloomfield
Does Your Team of Professionals Lack Coordination?

Often, physicians will seek to hire the best person in a professional field, but fail to have adequate coordination among the team members. This lack of coordination can lead to costly errors and omissions that may have otherwise been avoided if a central organizer had been leading the team.

By Nathan Mersereau, CFP, AAMS

“Of all the things I’ve done, the most vital is coordinating those who work with me and aiming their efforts at a certain goal.”

– Walt Disney

“A point person” on your team will direct the most effective wealth management process – actively coordinating your attorney, CPA, broker, and insurance agent to ensure you have a comprehensive and integrated plan. Chances are, you function as the point person if you do not have a trusted advisor to serve in this role. So the real question is, do you have enough time and/or interest to effectively coordinate your team’s efforts? If you think opportunities are being lost or you have suffered from problems you feel could have been avoided, then you are in need of a professional coordinator. Use the following checklist to determine if you would benefit from professional coordination:

- Do the individuals on my professional team (attorney, CPA, broker, insurance agent) effectively communicate with each other on my behalf?
- Do I have different investment advisors handling different portions of my portfolio?
- Are investment advisors working together to make sure there is no overlap in my investment strategy?
- Do I receive a consolidated report from my team that allows me to look at the activity of my entire portfolio?
- How often (if ever) does my entire team meet with each other?
- How much do I pay my existing team each year? Do they volunteer to discuss their fees with me?
- Who is the “quarterback” person responsible for protecting and advancing my best interests?

A lack of coordination among your professional team may lead to some or all of the following mistakes:

- Improper titling of assets that increases exposure to taxes and liability
- Inefficient beneficiary designations on IRAs that will reduce the amount that is ultimately passed on to recipients at death
- Over-insured or under-insured in the event of death or disability
- Unmanaged and costly insurance policies
- Overlapping investment portfolios which create unnecessary costs and risks
- Investments generating unnecessary taxes
- Unprotected assets left outright to children
- Inefficiently taking withdrawals from your investment portfolio

While your CPA or attorney may be equipped to function in the role of coordinator, they will often recognize their limitations. To find a true coordinator, you may need to go outside of your existing team and find a fiduciary wealth manager. A fiduciary is legally obligated to act in the best interest of their client. A fiduciary wealth manager can review your objectives and identify possible improvements in how your team can better serve you.

Want to avoid common investing mistakes? Request a copy of our newly released whitepaper "Eight Mistakes Physicians Make with Their Money and How to Avoid Them" by contacting co-author Joe Olekszyk at 888-958-1990 or download a copy from our website www.wealthcareadvisors.com.
Hepatitis B (hepB) vaccination is the most effective measure to prevent hepatitis B virus (HBV) infection and its consequences, including cirrhosis of the liver, liver cancer, liver failure, and death. In adults, ongoing HBV transmission occurs primarily among unvaccinated persons with behavioral risks [e.g., homosexuals with multiple sex partners, injection-drug users (IDUs), men who have sex with men (MSM)] and among household contacts and sex partners of persons with chronic HBV infection.1

In settings in which a high proportion of adults have risks for HBV infection (e.g., sexually transmitted disease/human immunodeficiency virus testing and treatment facilities, drug-abuse treatment and prevention settings, health-care settings targeting services to IDUs, health care settings targeting services to MSM, and correctional facilities), the Advisory Committee on Immunization Practices (ACIP) recommends universal hepB vaccination for all unvaccinated adults. In other primary care and specialty medical settings in which adults at risk for HBV infection receive care, health care providers should inform all patients about the health benefits of vaccination, risks for infection, for whom vaccination is recommended, and provide the vaccine for these at-risk adults and any adults requesting protection from HBV infection. To promote vaccination in all settings, health care providers should implement standing orders to identify adults recommended for hepB vaccination and administer vaccination as part of routine clinical services, not require acknowledgment of an HBV infection risk factor for adults to receive vaccine, and use available reimbursement mechanisms to remove financial barriers to hepB vaccination.1

In an effort to remove some of these financial barriers, the Michigan Department of Community Health (MDCH) submitted a grant application to the US Centers for Disease Control and Prevention (CDC) in 2012. After the grant was awarded, MDCH received 21,200 doses of adult hepB vaccines under this pilot program. The program aims to reduce the incidence of acute HBV infection among adults through a targeted hepB vaccination project in Southeast Michigan and Genesee County for those who present for medical care in high risk settings or who have behaviors that increase their risk of HBV infection. Southeast Michigan counties Macomb, Oakland, Washtenaw, Wayne (including the City of Detroit), and Genesee County were selected for this initiative because they have significantly higher acute HBV incidence rates as compared to the number of acute and chronic HBV cases reported throughout the state.2

Through this funding opportunity, specific settings will be able to provide hepB vaccinations to high-risk adults who either were not previously vaccinated or did not complete their hepB vaccination series. These settings include local health departments, STD and HIV facilities, facilities providing drug abuse treatment and prevention services, health care settings targeting IDUs or MSM, correctional facilities or jails, substance abuse disorder treatment centers (methadone treatment centers) and facilities that serve susceptible, foreign-born individuals from high endemic areas. The project also will seek to improve the efficiency, effectiveness and quality of immunization practices through the use of the Michigan Care Improvement Registry (MCIR) and by expanding immunization delivery partnerships so more at-risk adults are protected against HBV. This pilot program will support efforts to identify adult hepB immunization barriers and build stronger relationships with vital stakeholders.

Through this project, MDCH will be able to increase the number of high-risk adults assessed for HBV infection; immunize all assessed and susceptible clients with hepB vaccine; improve the documentation of adult hepB vaccine administration in MCIR; and reduce the overall incidence of HBV infection in Michigan. Providers in the Southeast Michigan or Genesee county

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**Changes to the Adolescent Immunization**

### Meningococcal Conjugate (MCV4) Vaccine

**Routine Recommendations:**
- First dose at 11-12 years of age with a booster dose at 16 years of age

**Catch-up:**
- If first dose is given at 13-15 years of age, give a booster dose at 16-18 years of age
- If first dose is given at 16 years of age or older, a booster dose is not recommended

### Human Papillomavirus (HPV) Vaccine

**Routine Recommendations:**
- Administer three doses of HPV4 to males and three doses of HPV4 or HPV2 to females 11-12 years of age

**Catch-up:**
- Administer three doses to females 13-26 years of age and males 13-21 years of age
- Males 22-26 years of age within a high risk group (immunocompromised due to disease, including HIV – or medication, and men having sex with men)
- Consider vaccination for all other males 22-26 years of age

### Tetanus/Diphtheria/Pertussis (Tdap) Vaccine

- No minimum interval between the last dose of a tetanus or diphtheria-containing vaccine (DTaP, Td) and a dose of Tdap when pertussis protection is needed.
- Adolescents who are pregnant should receive Tdap, irrespective of past history of Tdap receipt. Optimal timing is between 27 and 36 weeks gestation to maximize the maternal antibody response and passive antibody transfer to the infant.
- Children 7-10 years of age without a complete DTaP/Td series should receive 1 dose of Tdap in place of a dose of Td.
areas with populations as described above who wish to participate in this project should contact Kenneth Onye, MDCH Project Coordinator, at onye@michigan.gov or at 313-456-0334.

Are All Your Adolescent Patients Fully Vaccinated?

With the summer months in full swing, your office is likely very busy gearing up for the back-to-school hustle and bustle of annual sports physicals and immunizations. Use these office visits as a chance to get every adolescent patient up-to-date on all recommended vaccines. Sometimes parents of adolescents may come into your office and only want the vaccines required for school entry. Please take time to talk to these parents about the importance of immunizing their adolescent child according to the recommended schedule, including flu and HPV vaccines. The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the Society for Adolescent Medicine (SAM), and other professional medical organizations recommend that providers vaccinate based on current Advisory Committee on Immunization Practices (ACIP) recommendations. In doing so, Michigan’s school immunization requirements will be met.

All older children and adolescents need meningococcal conjugate (MCV4), tetanus/diphtheria/pertussis (Tdap), and human papillomavirus (HPV) vaccines. Those who haven’t had chickenpox disease need two doses of varicella vaccine to be fully protected. In addition, everyone (including healthy children, teens, and adults) should receive seasonal flu vaccine every year. Start vaccinating as soon as you receive flu vaccine and continue to vaccinate throughout the entire flu season (into the winter and spring months).

In recent years, several changes have been made to the adolescent immunization schedule. Adolescents now need a booster dose of MCV4 vaccine and HPV vaccine is routinely recommended for boys and girls. Recent key changes are highlighted in the sidebar.

An exciting pilot project is taking place in southeast Michigan that will utilize the Michigan Care Improvement Registry (MCIR) to send reminder and recall notices to parents of adolescents who are coming due or are overdue for vaccines. Physicians enrolled in the project will explore the use of newer technologies, including automated phone calls and e-mails, and will receive in-office feedback and training in an effort to improve the immunization coverage levels of their adolescent population. The Michigan Department of Community Health hopes to eventually expand and apply elements of this grant to the rest of the state.

Every time an adolescent patient arrives at the office – whether for a preventive or sick visit – it’s an opportunity to immunize that patient with all recommended vaccines. Back-to-school check-ups and sports physicals are an ideal time to make sure adolescent patients are fully vaccinated. Be sure to check out the educational materials for pre-teens, teens, and their parents (including a new HPV fact sheet targeting parents of 11-12 year olds) at www.michigan.gov/teenvaccines.

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Community Health Bureau of Health Professions.

**Report Dated: 5-6-2013 through 5-10-2013**

Brian W. Cook, MD
Clearwater, FL
43-01-051801
05/17/2013
Summary Suspension
Sister State Disciplinary Action
Drug Diversion
Failure to Report/Comply
Lack of Good Moral Character
Criminal Conviction – Drug Related

**Report Dated: 5-13-2013 through 5-17-2013**

Abdullahi Abudukkan Mohamed, MD
Monroe, MI
43-01-084848
05/17/2013
Summary Suspension
Lack of Good Moral Character
Criminal Sexual Conduct
Failure to Report/Comply

**Report Dated: 5-20-2013 through 5-24-2013**

Nan Beth Alt, MD
Grandville, MI
43-01-089224
32-03-003990
05/22/2013
Suspended

**Notice of Intent to Deny** – formal document that indicates the Department intends to deny the issuance of a license because of violations of the Public Health Code, past or current.

**Probation** – a disciplinary action in which the licensee’s practice is conditioned for a given period of time or until specific requirements are met. Probation can include conditions such as:
- participation in the Health Professional Recovery Program
- submission of regular reports from employer or other specified individual
- completion of specific continuing education requirement
- no violations of the Public Health Code
- other conditions deemed appropriate.

**Reprimand** – the written statement of rebuke from the Board that a specific activity of the licensee was a violation of the accepted standards of practice.

**Revocation** – a licensee can not practice for a specified period of time.

**Suspension** – a licensee can not practice for a minimum period of three years; if the violation involved controlled substances, the licensee can not practice for a minimum period of five years.

**Summary Suspension** – if the actions a licensee are considered a threat to the public’s health and safety, the right to practice can be withdrawn immediately. The Summary Suspension orders the licensee to stop practicing immediately upon receipt of the summary. The summary is hand-delivered to the licensee.

**Summary Suspension Dissolved** – the summary suspension has been removed after an administrative review and the licensee is either allowed to practice or is subject to other disciplinary actions imposed by the Board.

**Explanation of Disciplinary Terms**

**Board Order** – the legal document that is issued by the Department, on behalf of the Board, which describes the sections of the Public Health Code that have been violated and the discipline that has been imposed for the violation(s).

**Limitation** – a restriction or condition imposed on a licensee by the Board for a specified period of time such as:
- confinement of practice to a location
- supervision of practice – either on-site or periodic review by Board or other Board approved licensee
- restriction of practice to specific activities
- no access to controlled substances
- no ownership or financial interest other restrictions or conditions deemed appropriate.
It has been said that the Alliance are “the people, who take care of the people, who take care of… people.”

In June, 10 MSMS Alliance members joined national members at the AMA Alliance’s Annual Meeting and Leadership Development Conference. The two day event was held at the beautiful Sofitel Hotel in Chicago. We were treated to many fabulous speakers and educational opportunities. One speaker touched on a subject that distressed us as physician spouses – physician depression.

The subject brought me back to my husband’s very first day of residency. That morning, he walked into the operating room to find the resident call room flanked with orange tape. The third-year resident had fatally overdosed on a common anesthetic. He left behind his wife, young children and his very promising medical future. It was never determined if the overdose was accidental or intentional. The fact that it ever happened is haunting.

Twenty years later, Dr. Robert Ursano, Chairman of the Department of Psychiatry at the Uniformed Services University of Health Sciences in Bethesda, Maryland, told a conference room filled with physician spouses and partners that studies continue to show that physicians have higher rates of depression and suicide than the general population – an alarming 40 percent higher for male doctors and 130 percent higher for their female counterparts!

One can easily imagine what might cause high rates of depression in physicians. However, contributing factors are not easily identifiable. Studies show students entering medical school have similar mental health profiles as their peers. Yet, it is believed that doctors have the highest suicide rate of any profession. To make matters worse, physicians and quite often their families and friends, fail to recognize the signs of depression. Even if depression is suspected, most physicians are reluctant to seek help because of professional and personal barriers.

In the United States, nearly one in 10 people experience depression each year. The good news is that it is highly treatable. According to the University of Michigan, the two main symptoms of depression are:

- Feelings of sadness, irritability or anxiety that won’t go away.
- Loss of interest or pleasure in activities and hobbies once enjoyed, which lasts for more than two weeks.

As Alliance members we urge you to take care of yourself or let your spouse/partner take care of you. If you suspect that you might be depressed, speak up and seek help. It could save your life.

The author is President of the MSMS Alliance, comprised of physicians’ spouses.
Transitioning to Accountable Care Organizations  
**Date:** Wednesday, September 18, 2013  
**Time:** 8:45 a.m. to 4:00 p.m.  
**Location:** The Inn at St. Johns, Plymouth  
**Contact:** Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org  
**Note:** Continental breakfast and lunch will be provided.  
**Intended for:** Physicians, executives, office administrators, and all other health care professionals.

**17th Annual Conference of Bioethics – Putting the Me in Medicine: The Ethics of Personalized Medical Care**  
**Date:** September 27-28, 2013  
**Time:** Friday, September 27, 5:30-8:00 p.m.  
Saturday, September 28, 8:00 a.m. to 5:00 p.m.  
**Location:** The Campus Inn, Ann Arbor  
**Contact:** Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org  
**Note:** Dinner on Friday, continental breakfast and lunch on Saturday will be provided.  
**Intended for:** Physicians, bioethicists, residents, students, other health care professionals and all individuals interested in bioethical issues.

**The Patient Centered Medical Home: Coordinated Care, Optimal Outcomes**  
**Date:** Tuesday, October 22, 2013  
**Time:** 9:00 a.m. to 4:15 p.m.  
**Location:** Somerset Inn, Troy  
**Contact:** Caryl Markzon (517) 336-7575 or cmarkzon@msms.org  
**Note:** Continental breakfast and lunch will be provided.  
**Intended for:** Physicians, practice managers/administrators, executives, and all other health care professionals.

**MSMS Physician Executive Development Program – Fall Series**  
**Date:** Wednesday, October 9, 2013  
**Time:** 9:00 a.m. to 4:15 p.m.  
**Location:** Management Education Center, Troy  
**Webinar Date:** Wednesday, October 30, 2013  
**Time:** 7:00 to 8:00 p.m.  
**Date:** Wednesday, November 6, 2013  
**Time:** 9:00 a.m. to 3:45 p.m.  
**Location:** Management Education Center, Troy  
**Contact:** Caryl Markzon (517) 336-7575 or cmarkzon@msms.org  
**Note:** Continental breakfast and lunch will be provided.  
**Intended for:** Physicians.

**148th Annual Scientific Meeting**  
**Date:** Wednesday through Saturday, October 23 – 26, 2013  
**Time:** 1:00 p.m. to 4:15 p.m.  
**Location:** Somerset Inn, Troy  
**Contact:** Marianne Ben Hamza, (517) 336-7581 or mbenhamza@msms.org  
**Note:** Continental breakfast and lunch will be provided.  
**Intended for:** Physicians and all other health care professionals.

**Symposium on Retirement Planning**  
**Date:** Wednesday, October 23, 2013  
**Time:** 5:45 p.m. to 8:15 p.m.  
**Location:** Somerset Inn, Troy  
**Contact:** Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org  
**Note:** Dinner will be provided  
**Intended for:** Retired physicians, physicians planning for retirement, spouses, and office managers.

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Interested individuals should submit a statement of interest and curriculum vitae via mail or email by August 30, 2013 to:

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Mark R. Paschall, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

Cosmetic Office Procedures in Primary Care
Jeffrey L. Williams, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

GYN Office Procedures
Ann M. Schneider, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

Ultrasound Guided Office Procedures GYN Office Procedures
Leonard V. Bunting, MD
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Ankle-Brachial Index
Randall Colvin, MD
Staff Physician, St. John Hospital and Medical Center, Detroit, MI

The New “Accountable Care Organizations” and How They May Affect Primary Care
Kenneth Bollin, MD
Chief, Family Medicine Department, St. John Hospital and Medical Center, Detroit, MI

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For more information contact: 313-343-3877 as these may be subject to change.

ST. JOHN HOSPITAL & MEDICAL CENTER
During our medical careers, all of us have seen the miracles that advancements in pharmacology have brought to the practice of medicine. But this perspective also makes us aware of a problem that we face first-hand, and are in a front-line position to help change: prescription drug misuse/abuse.

The misuse/abuse of prescription painkillers has become a massive public health issue, although it still receives too little media coverage. The numbers, however, are frightening. Federal statistics show that, in 2006, 39 percent of US drug overdose deaths were caused by “street drugs” like heroin and methamphetamines, but 45 percent were caused by prescription medications, primarily depressants, opioids and antidepressants. That’s 16,600 people each year, says the Centers for Disease Control. Naloxone and similar counters to narcotic overdose has become a necessary tool for emergency first responders around the country.

Our patients have gotten the idea that prescription medications are safer to misuse/abuse than overtly “illegal” drugs. That means they consider using them incorrectly (to the point of dependency), sharing or selling them to others, or simply stealing them from someone’s medicine cabinet is somehow less deadly.

The toll of such misuse/abuse hits hardest at two groups. One is the young. A survey cited by Drugfreeworld.org found that 50 percent of teens believe prescription drugs must be safer than those they can obtain illegally, and almost 70 percent cited the family medicine cabinet as their source. Women also are disproportionately misusing/abusing prescription medications. In the last decade, female deaths from overdosing on prescription opioids has soared 400 percent, according to the CDC. Women in America are more likely to die from misuse/abuse of prescription pain medication than in an auto accident.

Though we hate to admit it, most of these paths to prescription medication misuse/abuse pass through the physician’s office. Very rarely is criminal abuse of the physician’s prescribing powers involved. More often, we just respond too readily in prescribing for chronic pain; it’s easy to write a prescription to make a problem go away. We may do too little to check the other medications a patient is taking, or whether the patient has been “doctor shopping” for prescriptions. The time rush we all face now makes it difficult to properly counsel patients on the risks and correct usage of powerful prescriptions. And when a patient says chronic pain is continuing, it’s so much easier and quicker to just call in a prescription renewal than to schedule another exam.

One priority during my term as president will be building awareness on this deadly problem, and encouraging more responsibility. Unless we as physicians lead the way in cutting the misuse/abuse of prescription drugs, we’ll surely see more legislation, most of which will make the practice of medicine more difficult, without really solving the problem. Take time to ask questions. Take time to make sure your patients know the dangers of addiction, overdose, and drug interactions. Educate yourself on both the benefits and the risks of the medications you prescribe.

As physicians, we would not be responding fully to this problem if we didn’t include the pending issue of expanded scope of practice. As I’ve noted, we, as trained medical professionals, still have some issues with overprescribing and misprescribing powerful medications. What if others in the healing professions, such as nurse practitioners, who lack our training and experience, should gain prescribing privileges? Would the problem grow better or worse? Any expansion in medical scope of practice will have unintended consequences. No one wants one of these consequences to be even more “raiding the medicine cabinet.”

Doctor ELM MASSIAN, a Lansing anesthesiologist, is President of the Michigan State Medical Society.
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