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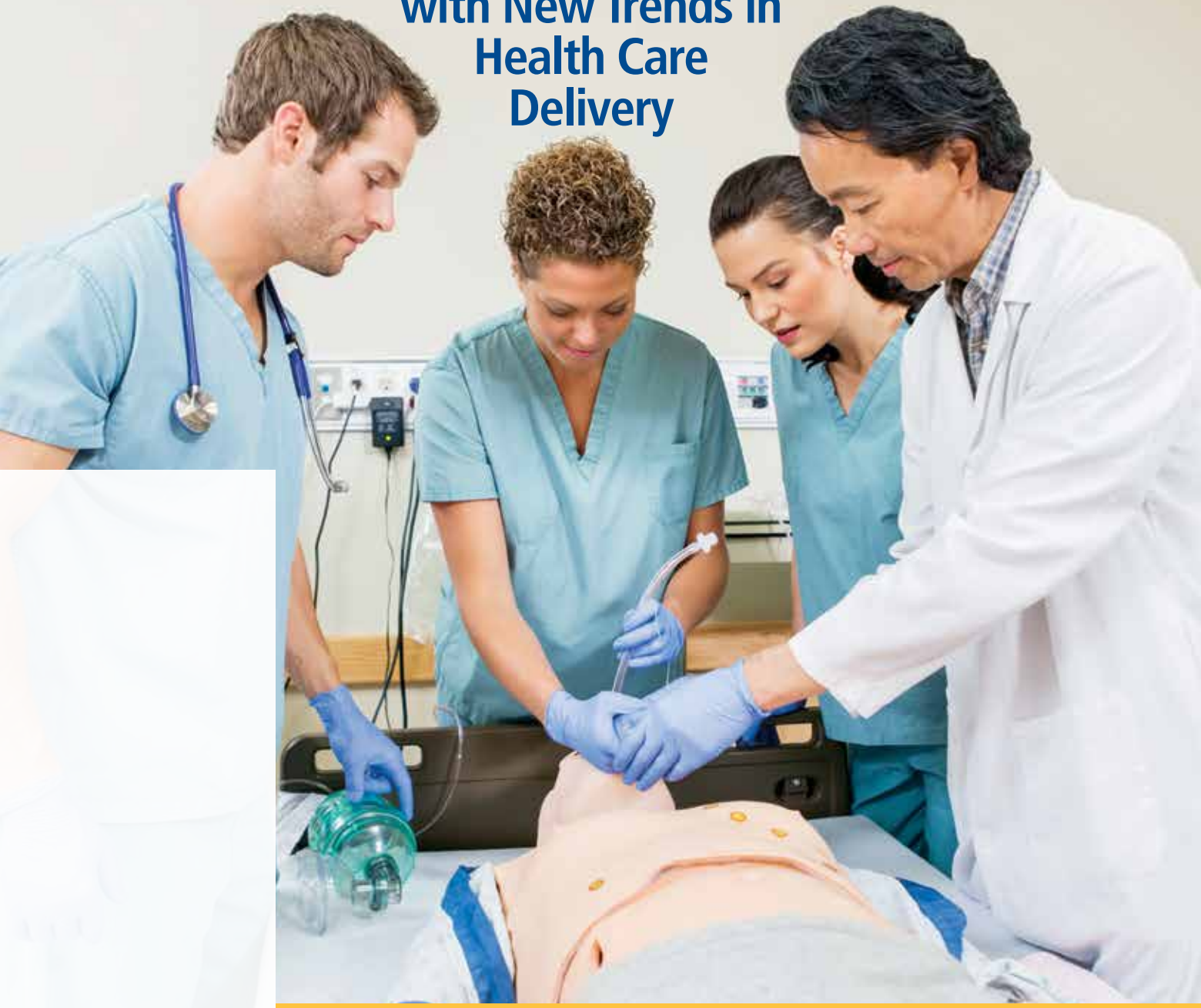
Medical School Curricula Changing to Align with New Trends in Health Care Delivery



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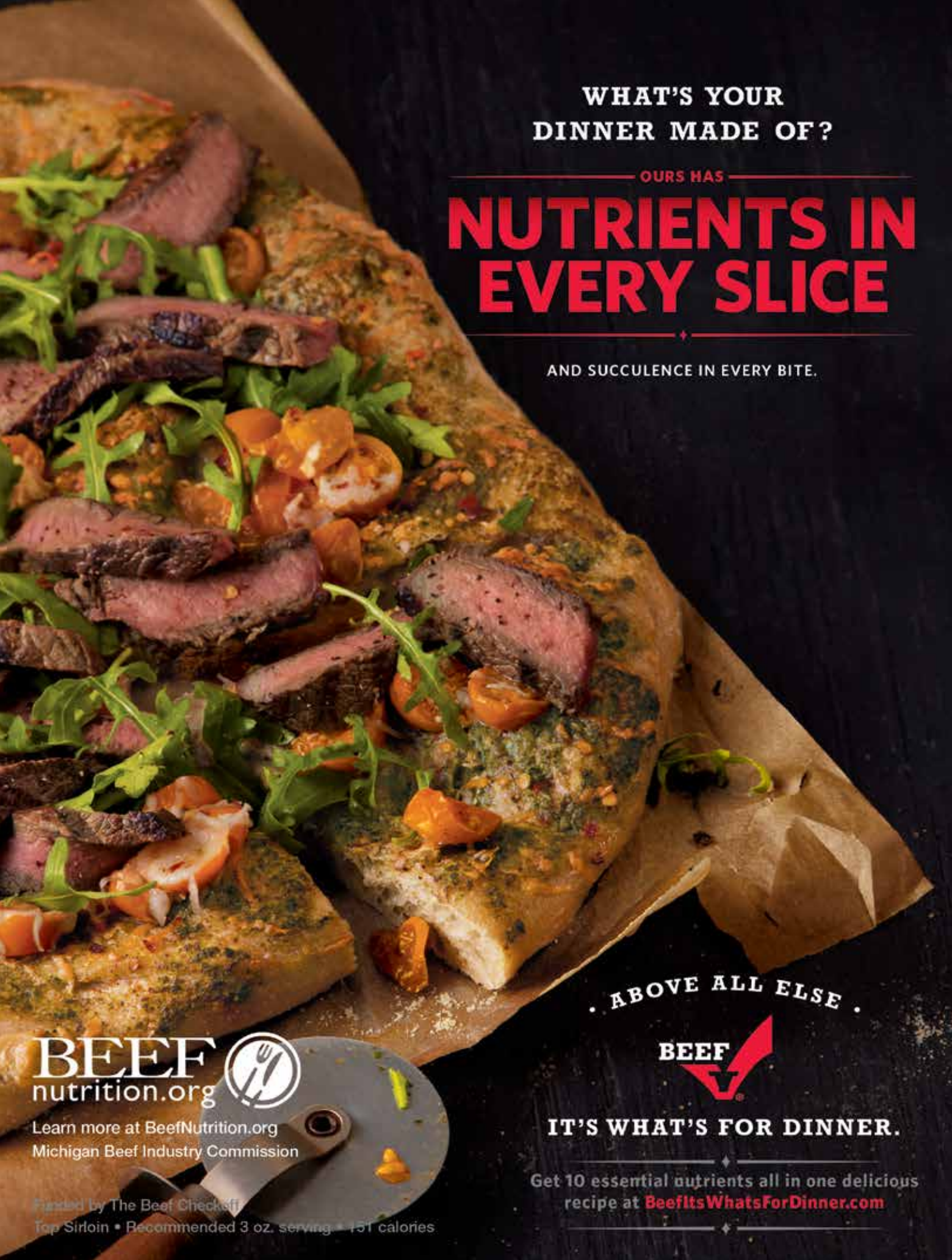
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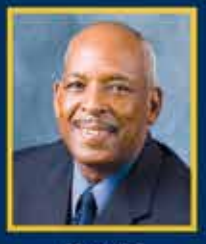
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Publication Office
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PO Box 950, East Lansing, MI 48826-0950
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COVER STORY

FEATURES

COLUMNS

DEPARTMENTS

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FTC Obtains a Court Order Requiring the Unwinding of a Hospital System Physician Practice Acquisition

By Daniel J. Schulte, JD

QUESTION:

I have seen a number of articles recently regarding a court in Idaho ordering that a hospital system's acquisition of a physician practice be unwound. The articles suggest that this court action is very unusual. Can you explain exactly what happened in this case and what significance, if any, there could be for hospital system acquisitions of physician practices here in Michigan?

ANSWER:

The case you are referring to is *Federal Trade Commission v. St. Luke's Health System, Ltd. & Saltzer Medical Group, P.A.* decided by the US District Court for the District of Idaho. The Court issued a permanent injunction against St. Luke's completed acquisition of Saltzer Medical Group and ordered that it be unwound.

St. Luke's is a not-for-profit health system consisting of six hospitals, physician clinics and other non-hospital facilities. Saltzer Medical Group is a 44-member multispecialty physician group. On December 31, 2012, St. Luke's acquired the assets of the Saltzer Medical Group, approximately $16,000,000. St. Luke's also acquired the right to negotiate payor contracts on behalf of Saltzer, establish fees for the services of Saltzer Medical Group physicians and the ability to manage the Saltzer Medical Group's day-to-day business. St. Luke's also obtained an agreement from the Saltzer Medical Group requiring that all its physicians exclusively provide their services on behalf of St. Luke's for five years.

Two separate lawsuits were filed seeking to enjoin St. Luke's acquisition of Saltzer Medical Group. The first was filed on November 12, 2012, by two competing health systems. These two competing health systems alleged that they relied heavily on Saltzer Medical Group physicians for inpatient admissions. The second lawsuit was filed on March 26, 2013, by the FTC and the State of Idaho. These two cases were consolidated. Ultimately the court found that it was "highly likely healthcare costs will rise" following the combination of St. Luke's and Saltzer Medical Group due to the dominant market position of the combined entity (80 percent of the relevant market's primary care physicians) that would enable it to negotiate higher reimbursement rates and raise fees for ancillary services (e.g., x-rays, physical therapy, etc.) to the higher hospital rates. As a result, the court ordered the unwinding of the transaction.

In addition to obtaining a high percentage of primary care physicians in the relevant market, the dominance of St. Luke's post acquisition market position was demonstrated by use of the Herfindahl-Hirschman Index (HHI). HHI is a measure of market concentration commonly used in antitrust evaluations. An HHI over 2,500 indicates a highly concentrated market and a post-acquisition increase of over 200 points raises a presumption of enhanced market power. The Court found the market in which St. Luke's operates to have an HHI of 6,219 and the post-acquisition increase to be 1,607.

This case is unusual and noteworthy because the:

1. Federal Trade Commission's seemingly newfound concern with physician groups obtaining increased bargaining power toward payors resulting from transactions with hospital systems.
2. Concerns of payors were given such significant consideration that the court extensively described the acquisition's effect on payors.
3. Enhancements to be made in patient care and other benefits to be realized by patients as a result the integrated care model this acquisition would have created did not seem to be given much, if any, weight by the Court.
4. Federal Trade Commission chose to intervene in this transaction despite its relatively small size and the remoteness of the geographic area involved.

The likely effect of this case on Michigan physicians and hospital systems remains to be seen. It certainly should cause those contemplating a transaction to pause and have an expert advise them on the competitive effects of the transaction prior to closing. It also casts some doubt on whether demonstrated increases in efficiencies in the delivery of patient care and other patient benefits will trump the potential for the post transaction entity to raise prices and other anticompetitive effects of the transaction. 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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Building Relationships With the Media

How Helping Them Helps You and the Profession?

By Kenneth Elmassian, DO

No matter your opinion of news and the media, the world watches it, reads it and now even Tweets it. For centuries, the media has played an important role in society, reporting on all topics of interest, personalities and governments. Cast as "The Fourth Estate" in 1787 by Edmund Burke, a British politician who noted the first three estates of British Parliament and then said, "but in the reporter's gallery yonder, there sits a fourth estate more important far than them all." This is the first known published reference to the media and the powerful role it plays in shaping public opinion. So why is the media important to the profession of medicine?

The media is an effective way to get news, information and messages about important issues to the specialty and your practice out to the public, policymakers, hospital administrators and your patients. You may be cautious of some media, but the fact remains that you need it and can use it to your advantage. On the other hand, journalists also need you – good stories and good, reliable sources of information to help them engage their readers or viewers.

Primary to MSMS's work with the media is the goal of enhancing the public's knowledge and understanding of the important role physicians play in patient safety and patient centered physician-led care. To help spread these messages, here are a few steps you can take to build relationships with the media:

Do your homework:
Read and watch local and national newspapers and news stations, along with keeping up with their websites. Learn who the health reporters are and read their stories.

Introduce yourself:
If you enjoyed a reporter's article, call or email him or her, introduce yourself and compliment him or her on the story. On the other hand, if you read an article and disagreed with it, you can call or email the reporter and suggest a follow-up story from a different angle. If the story's facts were incorrect, offer the correct facts in a polite and respectful way. This will help get you on the reporter's radar as an authoritative source for the next story.

Establish yourself as an expert:
Another option for getting the attention of reporters or a news outlet is to write a letter to the editor or an op-ed (opinion editorial). A letter to the editor is a short message that either supports or opposes a position taken by the outlet in its editorial pages, comments on a current issue being debated publicly or comments positively or negatively on an article or story that appeared previously. Op-eds are published "opposite the editorial pages." The editorial page editor decides which op-eds get published. Competition for this space is intense. Generally, pieces are printed based on how interesting, timely, important or offbeat the topic is. Op-eds are more difficult to get published than letters to the editor.

Develop three key messages:
These key messages are the ones you always try to weave into your interview when speaking with reporters. They should stress the importance of patient-centered, physician-led care. Visit *www.msms.org* to stay current on news and messaging.

Give reporters what they need:
The goal of a good reporter is to give readers or viewers both sides of an issue. You need to give reporters the answer to their question, but be sure to bridge and drop in your patient safety messages about physicians. Be concise – the reporter doesn't need to know everything you know about the subject, just the top-line, and don't use medical jargon. Bring your language down to a level the general public will understand.

Tell your story:
As a physician, you have rescued numerous patients from medical emergencies. For some, these rescues are routine,

"another day at the office," but for the general public those rescues are exactly why the majority of Americans prefer to have physicians taking care of them. Journalism is all about stories. You have many of them. You just need to take time, think of a few and jot them down alongside your three key messages. Be timely: News moves quickly. You may be the expert on a topic, but if you are not accessible to reporters on deadline, you won't be the one quoted. When a reporter contacts you with a media inquiry, get back to him or her as quickly as possible.

If you don't know it, say so:
Reporters will appreciate your honesty. If you don't know an answer, just tell them and offer to look into their question, research it and get back to them. Resist the temptation to speculate or comment on rumor.

Be credible:
Don't ever lie to a reporter or even stretch the truth. That will be the death of your relationship because you will have jeopardized the reporter's credibility.

Health care is a major focus of the media right now with the Affordable Care Act, scope-of-practice issues and ongoing innovations in medicine happening every day. As a physician, you are highly trained in all aspects of human physiology. You have comprehensive medical training in protecting and regulating critical life functions as well as a wide range of knowledge about medications and how they interact with the body. With a bit of preparation and research, you can share this knowledge, become a reliable source to the media, communicate your messages and let people know the important role physicians play in physician-led, patient centered care. MM

The author is Clinical Professor, Michigan State University, East Lansing. He is Immediate Past President of the Michigan State Medical Society.

Adapted with permission from American Society of Anesthesiologists Newsletter, *Communications* April 2014, Volume 78, Number 4.

Ready... Or Not? Stage 2 EHR Vendor Issues Hardship Exemption

The Meaningful Use EHR incentive program is moving forward this year into Stage 2. There are some physicians across the state, however, who will hit a road block when their EHR vendor isn't ready for the Stage 2/2014 edition requirements. While there have always been some hardship exemptions in place to help those physicians who lack direct patient interaction or infrastructure issues, the US Centers for Medicare & Medicaid Services (CMS) have added to that list to include some vendor issues.

The exemption for 2014 EHR Vendor Issues is available for the eligible professional (EP) if their EHR vendor was unable to obtain 2014 certification or the eligible professional was unable to implement meaningful use due to 2014 EHR certification delays. This exemption will protect an EP from the payment adjustment in 2015 if they are unable to attest for meaningful use in 2014 due to their vendor's ability to meet Stage 2 requirements.

Hardship exemptions will be granted only under specific circumstances and only if CMS determines that an EP has demonstrated that those circumstances will impede their ability to achieve meaningful use.

To be considered for an exemption, an eligible professional must complete a Hardship Exception application along with proof of the hardship. If approved, the hardship exception is valid for one payment year only. The applications for hardship exemptions will be taken on a case by case basis. Eligible professionals who wish to apply for this hardship exemption must do so no later than July 1.

This exemption is open to all providers for the 2014 reporting year, due to the fact that all EPs must upgrade or adopt newly certified EHRs in 2014. Because of this necessary change, all providers regardless of their stage of meaningful use are only required to demonstrate meaningful use for a three-month (or 90-day) EHR reporting period in 2014.

Eligible professionals who are demonstrating meaningful use in 2014 for the first time, must meet meaningful use for a 90-day reporting period in 2014 to avoid payment adjustments in 2015. This reporting period must occur in the first nine months of calendar year 2014, and attestation must be completed no later than October 1, in order to avoid the payment adjustments. Eligible professionals must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

It is vital that physicians and their staff do not wait until the last minute to question their vendor's status for the Stage 2/2014 edition. Implementation timelines and resources needed may affect how a practice will effectively transition to the new version of their EHR, and meet the new requirements for Stage 2.

If you haven't already, you will need to contact your vendor to discuss their timeline and what that will mean to your practice. More information about hardship exemptions and how to apply for one can be found on the CMS EHR Incentive Programs website (*https://ehrincentives.cms.gov*).

OBITUARIES

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

Richard Charles Dayton, MD
Dryden
Died June 7, 2013 at the age of 82.

James R. Glessner, Jr., MD
Grand Rapids
Died May 1, 2014 at the age of 89.

Richard M. Lundeen, MD
Platte Lake
Died May 2, 2014, at the age of 87.

Richard C. Merriman, MD
Portage
Died May 2, 2014, at the age of 87.

Douglas F. Wacker, MD
Laingsburg
Died April 8, 2014 at the age of 81.

William Bachrach Weil, Jr., MD
Okemos
Died December 21, 2013 at the age of 89.

John L. Wiese, MD
Grand Rapids
Died May 8, 2014, at the age of 91.

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 St., East Lansing, MI 48823, call 517-336-5729 or e-mail *rblake@msms.org.*

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The mission of the Michigan State Medical Society is to promote a health care environment which supports physicians in caring for and enhancing the health of Michigan citizens through science, quality, and ethics in the practice of medicine.

Sports Physical Goal: Reduce Liability Risks While Assessing Student Fitness

Contributed by The Doctors Company

Summer is the time for sports physicals. Physicians should be aware, however, of the potential malpractice risks of these examinations, especially in cases where no physician-patient relationship exists.

Depending on the legal venue, courts may hold that merely conducting a sports physical serves to create a physician-patient relationship with the same legal duties as that of an established, private practice patient. In these cases, physicians should explain the precise nature and scope of the physician-patient relationship, emphasizing that it is related solely to the examination and does not replace an annual well child exam performed by the student's primary care physician. In all cases, physicians should ensure that the parents or legal guardians provide consent for the student to be evaluated.

Cardiovascular screening, including failure to discover a latent asymptomatic cardiovascular condition, is a major area of liability risk when performing a sports physical. However, for the physician to be found at fault, it must be shown that the physician deviated from the standard of care. Generally, most courts have found that physicians who provide medical clearance for participating in competitive sports are not legally liable for injury or death caused by an undisclosed, asymptomatic cardiovascular abnormality, as long as the physician followed current consensus guidelines for conducting sports physical evaluations.

When conducting a sports physical, it is essential to take a complete medical history. This can help reduce the risk of claims for missed or delayed diagnosis of cardiovascular conditions. Patients with a personal or family history of the following may be at increased risk for cardiovascular conditions:

- Exertional chest pain/discomfort
- Syncope/near-syncopal episodes
- Excessive, unexpected shortness of breath
- Excessive, unexplained fatigue with exercise
- Heart murmur
- Elevated systemic blood pressure
- Cardiovascular disease

These exams also give physicians the opportunity to establish a cognitive function baseline that can be used to improve outcomes in the event of future head injury. It is important to establish this baseline because head injuries are becoming more common in young athletes. In the event of a head injury, the record of baseline cognitive function not only can help improve a student's outcome, but it also can serve as a factor in determining whether the student is ready to return to play after injury. These are important steps to reduce the liability risks associated with treating concussions. MM

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.***

Medical School Curricula Changing to Align with New Trends in Health Care Delivery

By Pamela Lewis Dolan

As the health care system undergoes a transformation unlike anything this country has seen in decades, a growing gap has begun to form between the skills students are acquiring in medical school and the skills and experience needed to thrive in this newly emerging health care landscape.

In an attempt to narrow this gap, medical education is in the throes of a massive facelift.

At the core of all these changes is the concept that each physician has a role to play in improving the health of a nation, not just the patient in front of them. And students should come out of medical school prepared to meet that challenge.

The American Medical Association recognized the need for changes to medical education in 2007 when it started publishing the "Initiative to Transform Medical Education" series of reports on trends in medical education and recommendations for the future. In 2013, it launched an $11 million grant program aimed at transforming medical education by awarding competitive grants to 11 medical schools that presented innovative ideas for overhauling their curricula to embody the ideas promoted in the AMA's series of reports.

To be eligible for the grant, the proposed curriculum had to accomplish four goals: develop competency-based programs that foster individualized learning concepts; include partnerships with health care organizations that could help students gain a better understanding of the health care system and health care financing; optimize the learning environment; and promote concepts such as patient-centered and team-based care, patient safety and quality.

There were 119 schools, representing more than 80 percent of medical schools across the country that applied for the grants.

The University of Michigan Medical School was the only school in Michigan to receive the award.

Like the majority of medical schools in the state of Michigan, the University of Michigan Medical School was on a multi-year journey to transform its curriculum when the grant program was announced. It was looking at both the external and internal factors that made the curriculum changes necessary. Externally, school leaders recognized that the health of those in the community was not where it should be. And internally, they recognized a crowded, silo-based curriculum, according to Rajesh Mangrulkar, MD, associate dean for medical student education. Doctor Mangrulkar played an instrumental role in the grant application process.

The school laid out a plan to create a curriculum that would, from the first year, integrate science-based learning to the clinical environment. The goal was to prepare students to leave medical school ready to lead the needed changes in health care delivery. The school is now in the beginning stages of implementing the new curriculum.

Although the University of Michigan was the only school in the state to receive a grant, Michigan has emerged as a leader in medical education transformation and innovation. Three new medical schools have opened in Michigan since 2011, each with a unique structure. And the curricula at existing schools are being transformed to better align with the future needs of the overall health care system. The state also served as the host of the first consortium of all the AMA grant recipients, held in April at the University of Michigan.

Susan Skochelak, MD, MPH, group vice president of medical education in the AMA Section on Medical Schools, said the organization was very encouraged with what it saw during the grant review process. She said all the applicants were in the process of innovative changes, and there were several exciting projects happening in Michigan.

The AMA's medical education transformation initiative had some influence over the curriculum design at the Oakland University William Beaumont School of Medicine, which sat its first class in August 2011.

Robert Folberg, MD, founding dean of the school, said the AMA observed in one of its documents that "patients were neither problems to be solved nor databases to be mined. They were people in need." Doctor Folberg said this led to a discussion among founding faculty members of, "I know you can train a student to be technically proficient and brilliant academically. I want to know how we are going to train physicians to be kind." The result was a focus on students who were not just academically gifted, but culturally sensitive and able to communicate effectively.

In its short existence, the school, which has been described as a liberal arts medical school, has already been nationally recognized for its unique approach to medical education from organizations including the Carnegie Foundation, Kaplan Publishing and *U.S. News and World Report*.

Competency-Based and Individualized Learning

Just as trained physicians are adapting to an outcomes-based model of care, students also are now expected to show outcomes by demonstrating a mastery of core competencies.

"It's not about what they know, but about practicing what they know and can they integrate it into their day-to-day," said

Tsveti Markova, MD, FAAFP, associate dean of graduate medical education at Wayne State University School of Medicine, which is in the process of redesigning its curriculum as part of its reaccreditation process.

According to a survey published in March by Academic Medicine, internal medicine residency program directors reported concerns about the skill sets new interns were bringing to their programs. Commonly lacking, they said, were self-reflection and improvement skills, organizational skills and professionalism.

Doctor Markova acknowledged that instead of passing tests and spending the required amount of time in rotations, residency directors are now looking for students who have mastered not just the science behind medicine but also the human part of being a physician.

The Michigan State University College of Osteopathic Medicine started a curriculum redesign four years ago with a goal of focusing more on the context of what a physician needs to learn as opposed to just the content, according to Donald Sefcik, DO, MBA, the school's senior associate dean.

"With the way information changes, we're spending a lot more time helping our students understand evidence-based practice and the doctor-patient relationship and how to work within a clinic setting, and all the competencies that go along with systems-based practice and problem-based learning and all those process-based contextual things that a physician will need throughout an entire practice," Doctor Sefcik said.

> "I know you can train a student to be technically proficient and brilliant academically. I want to know how we are going to train physicians to be kind."
>
> — Oakland/Beaumont's Doctor Folberg

There is also a growing recognition that each student comes to medical school with different experiences and prior knowledge. Therefore, each will grasp the needed competencies at different speeds.

"Do we know that every student is at the competent and outstanding level when they graduate or are we saying that because you fulfilled requirements by the time you're done in four years that you are done and you get the MD degree," said University of Michigan's Doctor Mangrulkar. "The focus has really been on the latter, as opposed to a competency-based approach."

One of the aspects of the University of Michigan's plan for transformation that got the AMA's attention was its plan to move toward a competency-based evaluation that will allow some students to advance more quickly and others to take more than four years, if needed, to gain the needed skills.

The Michigan State University College of Human Medicine is also working toward this approach.

"It doesn't make educational sense to divide knowledge-based competencies from experience-based competencies. It's probably not a good education," said Aron Sousa, MD, senior associate dean for academic affairs at Michigan State University College of Human Medicine.

Maryjean Schenk, MD, MPH, MS, vice dean of medical education at Wayne State University School of Medicine, said she hopes Wayne State will also create a system in which students can advance at their own pace. It would not only allow those students who arrive with an advanced knowledge base the opportunity to advance more quickly, but it would also help bring down the cost of a medical education for some students.

Understanding the Health Care System

John Billi, MD, associate dean for clinical affairs at the University of Michigan Medical School, said one of the school's goals is to empower students to be "problem solvers as opposed to victims." He said there are many problems and challenges that physicians will have to face beyond diagnosing and treating individual patients.

Doctor Billi said this goal has led to a curriculum focused on the idea that scientific problem solving can be applied to more things than just direct patient care.

"They can use critical thinking and direct evidence for all the problems they face, not just the patients in front of them," said Doctor Billi. During clinical rotations, University of Michigan students are asked to identify areas of needed improvements from a triple aim focus (improving quality and outcomes, improving the health of populations, and reducing health care costs) and work as a team to come up with solutions.

There are so many problems with the current health care environment that need fixed, he said, and every physician should be working on the solutions.

Brandon Busuito, MD, who graduated from Wayne State in May, said one of the things Wayne State did that was very beneficial was to bring in guest lecturers who helped students gain an understanding of the overall health care system and the changes taking place. He said visitors such as private practice owners, financial consultants and analysts would talk to students about the business aspects of health care they weren't learning in the classroom. Doctor Busuito is starting his residency at Henry Ford Health System this summer.

"In traditional curricula, we leave them with no understanding of the relevancy of content," said Ernest Yoder, MD, PhD, FACP, founding dean of the Central Michigan University College of Medicine, which welcomed its first class in August 2013.

One way the school plans to give students the needed context is by allowing them to view the health care system through the experience of patients. The first six months of their clerkships will be spent in a family medicine practice as "quasi medical students/junior doctors," said Doctor Yoder. The experience will allow them to follow patients through entire episodes of care or experiences, such as following a pregnant woman through her pregnancy to labor and delivery.

Optimizing the Learning Environment

A major impetus for changes in medical education in recent years has been the advancements in technology. The changes have not only applied to *what* students are taught, such as use of electronic health record systems or computerized order entry, but also *how* students are taught.

Technology such as automated simulation has allowed students the opportunity to receive hands-on experience long before they are expected to provide direct patient care. Doctor Busuito said the simulation experience he gained at Wayne State's Kado Clinical Skills Center made him feel more prepared to start dealing with patients face-to-face.

"When you are put on the spot, it's hard to simulate book-learning experiences," he said. But lifelike simulation mannequins allowed him to learn what it feels like to work with patients who, for example, crash

on the table, or whose pupils are dilated. In the lab, he was able to experience almost any scenario he could encounter with a real patient.

Doctor Markova said this type of learning, which has become a common aspect of the medical school experience over the past few years, is not only good from a medical education standpoint, but also from a patient safety standpoint.

"We know when they are comfortable with the simulation, they provide better, safer care," she said.

The simulators can also help students experience what it is like to work in a team environment. Some simulated problems require the help of a nurse or a physical therapist, giving students an opportunity to learn the communication skills necessary to thrive in a team-based environment.

Team-based approaches to learning have also changed the way medical school facilities are designed. Central Michigan, for example, created grouped seating arrangements in its classroom facilities that encourage students to work in teams.

The University of Michigan is using some of its grant money from the AMA to renovate the school library to accommodate small group spaces, according to Tony Tsai, MBA, an organizational development consultant who is serving as the project manager.

And because much of a medical student's education occurs outside the lecture halls and labs, schools are also rethinking the clinical components of their curricula to include more settings than just a hospital.

The AMA's Doctor Skochelak said one of the AMA's observations was that the majority of clinical learning was taking place in hospitals, despite the fact 95 percent of patients are taken care of in outpatient settings.

Schools are not only recreating the clinical rotations to include more outpatient care, but a growing trend is to maintain more consistency throughout medical school careers.

Oakland/Beaumont is taking the unique approach of using only one clinical teaching site for all of its students. It's one of only a handful of schools in the country with this type of structure.

"What it allows us to do is to control the entire continuum of medical education from medical student through residency through continuing medical education," said Doctor Folberg.

The University of Michigan is creating what is called M-Home learning environments. Each student will be assigned an M-Home for their entire medical school careers that will connect them to faculty, mentors, advisors and clinical care settings based on their own passions, interests and career goals.

Promoting New Concepts of Care

What is happening in medical education mirrors what is going on in the health care field overall, said Wayne State's Doctor Markova.

She said students must come out of school grounded in what the patients needs are and what the societal needs are: "Providing effective, efficient patient care; high quality, more focused on evidence-based versus expert opinion; using information technology to provide that high quality care; and also the professionalism aspect. We expect physicians to be caring, compassionate, patient-centered and, of course, competent. These are all elements of the whole medical education environment that must be aligned with the whole health care environment," Doctor Markova said.

One place health care and medical education have fallen short in the past has been patient-centeredness, she said.

Most physicians will say their focus has always been on the patient. But the way health care has traditionally been delivered suggested that the focus was really on what the physician or health system wanted, said Doctor Markova.

Appointment schedules were made according to what was convenient for the doctor regardless of how inconvenienced the patient was. There was very little attention paid to prevention as a measurement of success. And there was no such thing as medical homes. Patients were left to coordinate their own care, she said.

Joe Gorz, MD, is a 2013 graduate of the Michigan State University College of Osteopathic Medicine. One of the highlights of his medical education was the doctor-patient relationship training he received. Through simulation training exercises, Doctor Gorz said he was able to learn how to communicate effectively with patients before starting his family medicine residency at McLaren Oakland in Pontiac.

"You may come in and say, 'your blood sugar is out of control' and tell them all the things they need to do. But if you don't stop and ask the patient, 'why are you here and what can I do to help you,' and if you don't listen to them, you're not going to get anywhere."

Doctor Gorz said this aspect of his education was important because of the changes in the health care landscape toward a model of treating patients as partners. "That's kind of what they were teaching us, to look at these changes with open eyes," he said.

The health care industry is not only treating patients as partners, but also other members of the health care team. This is playing out in emerging care models such as patient centered medical homes and accountable care organizations, models in which a patient's care team is composed of professionals from multiple disciplines with whom the primary care physicians must collaborate.

"We know that in order to work in teams you have to know what the other team members are capable of doing," said Wayne State's Doctor Schenk.

Doctor Schenk said Wayne State reviews its curriculum every year, looking for needed updates. Some years the changes are little, some years they are big. In recent years, one of the big changes was a focus on interprofessional education. As part of that change, the school started a site visit program where medical students are paired with pharmacy, nursing and social work students to visit seniors in their homes to assess all aspects of their well being from their physical status to their medication compliance to their mental health.

"When we hear the words 'team-based approach,' I think I know what that means, what my role is on the team based on my professional background. But do I really know what to expect of others with other training and backgrounds in terms of their engagement on the team," said Doctor Schenk of the interprofessional approach.

Another concept that is gaining momentum in the overall health care continuum, and subsequently making its way into medical school curricula, is population health.

"Population health has always been a commitment of some specialties in health care. But over the last decade, population health has taken on a lot more importance, a lot more specificity," said University of Michigan's Doctor Billi.

He said that with a better understanding of the "triple aim" and better ways to measure outcomes, population health has become important in practice models.

"What else should we be training students on except what's important in practice. It's not enough to teach them how to take care of the diabetic in front of them, we also have to train them to think about the entire diabetic population and how are they going to make improvement across that population," said Doctor Billi.

> "If you don't stop and ask the patient, 'why are you here and what can I do to help you,' and if you don't listen to them, you're not going to get anywhere."
>
> — 2013 MSUCOM grad Doctor Gorz

Identifying Gaps

Overhauling a curriculum can be an expensive and lengthy process. But one thing Aliye Runyan, MD, has learned from the past two years serving as the education and research fellow at the American Medical Student Association, is that some issues can be addressed without a complete overhaul of the curriculum.

Physician wellness, for example, is an issue that is dangerously overlooked, but can take very little effort to address. It can be as simple as getting everyone to stand up and stretch and do a yoga pose in the middle of a long lecture, she said. "But we don't do that because it's not in our culture to take care of ourselves."

One of the goals of the AMSA is to identify unmet needs in medical education and provide programming to help fulfill them. Some of those gaps include access, social justice and LGBT issues.

The AMSA offers an online scholars program for which big-name faculty leaders from across the country teach webinars. The organization also offers more intensive training that ranges from a three-day workshop to a month-long integrative medicine rotation. The interest in some of AMSA's programming has been so strong, it has been incorporated into the curricula at various schools across the country, including some in Michigan, according to Doctor Runyan, a 2012 University of Miami Medical School graduate who will be starting a residency program in July at Wayne State.

She said implementation of the Affordable Care Act will definitely drive a lot of changes in the future. Many of the changes remain to be seen, but there will continue to be a focus on primary care and preventive health.

Doctor Skochelak said most schools are focused on addressing the same problems, but how they approach them will differ from school to school. There is no one-size-fits-all approach to medical education, which the AMA hopes to highlight with its grant program.

"When we put all of these elements together, we have a vision of the medical school of the future. There's no one school in particular that I would point to and say, 'Oh, this is it, they have the solution.' The purpose of this grant is to really push the solutions out there in ways that wouldn't have happened had they not had this grant and worked together." MM

The author is a Oak Lawn, Illinois-based freelance writer.

Physicians Need to Be Aware of Haptenation & Hypersensitivity Disorders

By Stacy Sellek

Would you know exactly how to treat a patient with chemical and/or metal sensitivity? A measure approved by the MSMS House of Delegates (Res. 7-13) is helping to raise awareness in the medical community of this condition, which some characterize as insufficiently understood and under-recognized.

The Resolution Goals

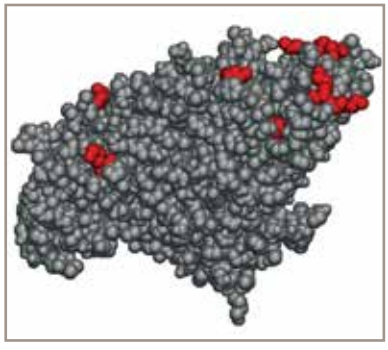
- To make physicians aware of the process of haptenation and sensitization and their multiple ramifications;
- To help physicians recognize that one can teach patients methods to avoid exposure to the haptens; and
- To help physicians include chemical sensitivity in the differential diagnosis, take a history focused on exposures to toxins and symptoms related to known toxins and testing.

The Americans with Disabilities Act accepts chemical and/or metal sensitization (e.g., due to cosmetics, medications, and fumes) as a federal disability, and according to the American Public Health Association, chemical sensitivity is estimated to be found in 12-16 percent of the US population (approximately 37-50 million people).

Sensitization can create symptoms or disease in any/or multiple organ systems and is preceded by toxic chemical or metal exposure, and it is often characterized by individuals who have developed intolerance to pharmaceutical products in their recommendeddoses. Haptenation is a known and well documented physiologic process occurring in humans, creating symptoms and disease.

Here's How the National Institute for Occupational Safety & Health at the CDC Defines Haptenation

"Low molecular weight chemical (LMW) allergens are commonly referred to as haptens. Haptens must complex with proteins to be recognized by the immune system. The majority of occupationally related haptens are reactive, electrophilic chemicals, or are metabolized to reactive metabolites that form covalent bonds with nucleophilic centers on proteins. Nonelectrophilic protein binding may occur through disulfide exchange, coordinate covalent binding onto metal ions on metalloproteins or of metal allergens, themselves, to the major histocompatibility complex. Recent chemical reactivity kinetic studies suggest that the rate of protein binding is a major determinant of allergenic potency; however, electrophilic strength does not seem to predict the ability of a hapten to skew the response between Th1 and Th2. Modern proteomic mass spectrometry methods that allow detailed delineation of potential differences in protein binding sites may be valuable in predicting if a chemical will stimulate an immediate or delayed hypersensitivity. Chemical aspects related to both reactivity and protein-specific binding are discussed." MM



Haptenation: Chemical Reactivity and Protein Binding. *CDC Photo*

The author is senior manager of communications at MSMS.

Answering the Call to Serve Physicians and Country:

Doctor Schroeder Demonstrates What It Means to Be a Leader

By Nick DeLeeuw

A veteran of the United States Air Force Reserve who saw deployment in 2003 during the height of the war on terror, Brian Schroeder, MD, thought his military days were behind him. Then his son was accepted to the United States Air Force Academy.

"I had been inactive for a few years, and my oldest son was looking to attend the Air Force Academy," said Doctor Schroeder, the Chief Medical Officer and Vice President of Medical Affairs at Sparrow Hospital in Lansing. "As a parent, you want to do everything you possibly can to protect your kids. I knew there was going to be somebody there to take care of my son, if he ever needed it.

"The very next thought that popped into my head was – boy, if somebody is going to be looking after my kid, maybe I need to continue serving so I can take care of someone else's."

He returned to the service in 2010 as his son began his first year at the Academy, joining the Air National Guard where he now serves as the flight surgeon for Michigan's 107th Fighter Squadron, based out of Selfridge Air Force Base.

"The real pleasure in doing this is serving some of the very finest people in America."

Doctor Schroeder is meeting a need both because he could and because it was the right thing to do. That kind of move is emblematic of his personality and his leadership style. While the world has no shortage of those who can spot a problem, he is a physician leader who does more than simply identify challenges – he addresses them.

Physicians like Doctor Schroeder have been leaders in patient care since before the time of Hippocrates, but medicine has changed a lot in the last 2,500 years.

It's changed a lot in the last decade.

Technology. Hospital systems. The sheer economics of the discipline. The means and methods by which physicians are trained and the way they collaborate with other providers, payers and policymakers.

Doctor Schroeder believes physician leadership – and developing physician leaders – has never been more important, with an unending assortment of outside forces doing their best to shift the focus away from medicine's foundation – putting patients first.

As the VPMA of a major independent hospital in Michigan's Capital City, he's taken a number of exciting steps the last few years to meet those challenges – but Doctor Schroeder's calling for patient-focused leadership started a good ways further west.

Born and raised in South Dakota, it was there that he first went to work as a nursing assistant, helping treat United States military veterans at the local VA hospital, while taking music classes and studying to become an EMT.

Ironically, it was a music teacher who led him to make a career out of medicine.

"One of my music professors in South Dakota pulled me aside and told me I didn't have the talent to make a living as a musician and that I should go out and study something else, to find gainful employment," he recalls with a laugh. "But I still play the guitar. I enjoy music."

He took the advice and earned an associate degree in nursing, heading to Texas after graduation where he worked as a critical care nurse and Director of Nursing at a small hospital, before making the jump to medical school.

It was also in Texas where he met his wife.

Doctor Schroeder describes his wife, Nancy, as "absolutely the best part of me," so returning to her home state for his residency at the Kalamazoo Center for Medical Studies at Western Michigan University only made sense.

When he started medical school, they had one child, but by the time he finished his residency, they had four. Michigan wasn't just Nancy's home anymore – it was their entire family's.

He's worked at a number of hospitals across the state, from Kalamazoo to Saginaw, and taken a leadership role wherever he's worked, to keep local health care systems focused on what they're there for – putting patients first.

Doctor Schroeder now spends one weekend a month and two weeks a year looking after A-10 Warthog pilots, and the balance of his days as a physician leader in Lansing looking for both efficiencies in the health care system and for ways to maximize his hospital's role in delivering patients the highest quality care.

As the Chief Medical Officer and VPMA at one of mid-Michigan's largest hospitals, he oversees medical education and research. He also oversees the medical staff office that ensures physicians who want to practice at Sparrow are who they say they are and are able to do what they say they can do.

It's a complicated job with one simple, overarching goal: preventing patients from being re-admitted to his hospital, for all the right reasons.

"I'm focused on ensuring patients get the care they need the first time through our doors."

Lt. Col. (Doctor) Schroeder examines Staff Sgt. Ernest Martinez at Selfridge Air National Guard Base. Schroeder is a physician with the 127th Medical Group, which is tasked with ensuring the medical readiness of the Airmen assigned to the 127th Wing, Michigan Air National Guard, at Selfridge.

(U.S. Air National Guard photo by Technical Sgt. Dan Heaton/Released)

It's Doctor Schroeder's belief that the best way to do that is to empower and equip physicians to deliver the highest quality care in the middle of a rapidly changing health care environment.

It is a belief he holds so strongly, it has led him to craft his own personal mission statement – "To help physicians do what they do – better."

And that's a mission he enjoys.

"Maybe the most fun thing that I get to do is to serve as a coach in the development of the medical staff," he says.

"The thing that jumps out at me the most is that going forward, we are in a period of seismic change in health care economics. In order for hospitals and systems to be successful, we need more physicians who are engaged in the process and equipped with the skills to help lead their organizations."

Doctor Schroeder listens to concerns of the medical staff at Sparrow.

Recognizing that hospital systems and independent hospitals alike still have work to do on that end, and when it comes to providing the best outcomes for patients, Doctor Schroeder recently helped launch a new physician leadership academy to provide training for the Capital region's next generation of physician leaders.

A two-year program of graduate level classes, participating physicians study everything from change management to ways to best "lead through vision"; from conflict resolution, to hospital and health care finance – topics that aren't necessarily covered in medical school.

The program is equipping new leaders not just to identify problems, but to step up and address them the way Doctor Schroeder has.

This May, Doctor Schroeder's eldest son graduated from the Air Force Academy, formally joining his father as an officer in the United States Air Force. There's a selfless, unassuming leadership that runs in the family's blood and that manifests itself in the kind of service that puts others first – good news for the Air Force and the nation it protects.

Thanks to Doctor Schroeder's work at Sparrow, focusing on patients, expanding education opportunities and equipping today's physicians for tomorrow's health care challenges, there's a growing team of new leaders offering the same kind of service to residents in Lansing. And that's great news for patients in the Capital City. MM

The author is a media and public relations consultant with Resch Strategies.

Doctor Schroeder's personal mission: "To help physicians do what they do – better."

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MICHIGAN STATE MEDICAL SOCIETY

LEGAL ALERT

Electronic Prescribing for Controlled Substances

By Patrick J. Haddad, JD
Kerr, Russell and Weber, PLC, MSMS Legal Counsel

The Drug Enforcement Administration's rule (the "Rule") allowing physicians to electronically prescribe for controlled substances was issued on March 31, 2010 and became effective June 1, 2010. Although effective on June 1, 2010, the Rule has not been declared final and remains subject to change by Congress and/or the DEA. Changes are unlikely but if they occur MSMS will update this Legal Alert.

The Rule allows physicians (and other DEA registrants) to transmit electronic prescriptions to pharmacies for Schedule II – V controlled substances if the physician uses a compliant electronic prescribing application[1]. Electronic prescribing applications that do not comply with the Rule may be used to prescribe for drugs other than Schedule II – V controlled substances. You may also print the form from a non-compliant application and manually sign/deliver the form to prescribe for drugs that are not controlled substances. Physicians are not required to use electronic prescribing for controlled substances. Instead, the Rule gives physicians this option. Prior to June 1, 2010 this option was not available to physicians, the only way to legally prescribe controlled substances was with the use of a written prescription.

Once you have obtained an electronic prescribing application that complies with the Rule, physicians must accomplish the following steps prior to using it to electronically prescribe for controlled substances.

First, identity proofing must occur (in person or remotely) so an authorization and authentication credential can be obtained. The Rule requires that the authorization and authentication credential be obtained from federally approved credential service provider ("CSP") or certification authority ("CA").

Second, at each location where an electronic prescribing for controlled substance application will be used for controlled substances, at least two individuals must be designated to manage access to the application. At least one must be a DEA registrant (a DEA authorized prescriber). These two individuals will identify for the electronic prescribing application who may access and use the application's prescribing functions.

Third, each prescriber who has been given access must set a two factor authentication prior to issuing electronic prescriptions for controlled substances. The authentication is how the application will verify that the person using the application is someone who

[1] *Such an electronic prescribing application may be stand-alone software or a part of electronic health record software. In order to electronically prescribe for controlled substances the software used must comply with the requirements of the Rule. This includes having the software audited by someone you engage to certify compliance or obtaining this certifi cation from the provider of the software.*

has been given access. The Rule requires physicians to use two of the following three authentication factors:

1. Something only the physician knows (e.g. a password or a response to a challenge question);
2. Something the physician is (e.g. biometric data such as a fingerprint or iris scan);
3. Something the physician has (e.g. a PDA, cell phone, smartcard, USB drive or other "hard token" or device separate from the computer to which the physician is gaining access).

The Rule imposes additional technical requirements if either a hard token or biometric factor is selected.

Fourth, each electronic prescription for a controlled substance must be electronically signed by the physician. The electronic signing of the prescription by the physician and its transmission are not required to occur at the same time. Physicians may fill in drug and dosage information, electronically sign the prescription and then leave it to office staff to transmit after completing pharmacy, insurance and other necessary information.

The Rule Contains the Following Additional Requirements and Restrictions:

Printed Copies of Prescriptions Following Transmission. Once an electronic prescription for a controlled substance has been transmitted, the application can print the prescription only if "copy only-not valid for dispensing" is printed on the form. In addition, the form must state the pharmacy that the electronic prescription was sent to and the date and time it was transmitted. Physicians are prohibited by the Rule from signing printed copies of electronically transmitted prescriptions. When sure the electronic transmission to the pharmacy has failed, the Rule allows you to print a prescription for signing and dispensing if the manual prescription includes a statement that an electronic prescription was transmitted and to which pharmacy it was attempted to be transmitted.

Notification. In order to avoid liability, the Rule requires physicians to notify the two individuals designated to grant access to the electronic prescribing application any time a "hard token" has been lost, stolen or compromised or that the authorization or authentication credential protocol has been compromised. The same is true upon a physician's discovery that a prescription has been electronically signed and/or transmitted by someone other than the physician who has properly been granted access.

Recordkeeping. The Rule requires physicians to maintain records related to electronic prescriptions for controlled substances for two years from the date of their creation. This provision of the Rule does not preempt any Michigan law requiring that medical records be retained for a longer period (the required period in Michigan is seven years if the prescription is a part of a patient's medical record).

www.msms.org
517-337-1351

Are Your Adolescent Patients Up to Date on All Recommended Vaccines?

An Update from the Michigan Department of Community Health

Summer is almost here and before you know it, your adolescent patients will be coming into the office for their annual sports physicals. This year, beat the back-to-school rush and immunize your adolescent patients throughout the summer. Now is an optimal time to use sick and well child visits to bring adolescents up-to-date on all recommended vaccines.

Some important changes have taken place regarding school communicable disease rules in Michigan. Beginning January 2014, schools in Michigan are now required to assess and report the immunization status of all seventh grade students, in addition to new school entrants. This will begin in the 2014-15 school year. The reporting of students in seventh grade, instead of sixth, fits better with the nationally recommended immunization schedule.

Providers are urged by major medical groups, such as the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), American College of Physicians (ACP), as well as the Centers for Disease Control and Prevention (CDC), to vaccinate according to the recommended immunization schedule put forth by the Advisory Committee on Immunization Practices (ACIP). In doing so, Michigan's school immunization requirements will be met.

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. As their child's health care provider, you remain parents' most trusted source of information about vaccines. In fact, studies consistently show that a strong recommendation from a provider is the single best predictor of vaccination and an important factor in a parent's decision to vaccinate.

Despite more than seven years of vaccine monitoring showing overwhelming evidence of HPV vaccine safety and effectiveness, HPV vaccination rates are not improving while rates for other adolescent vaccines are. Health care provider recommendations are the key to increasing HPV vaccination rates. By improving the strength and consistency of HPV vaccination recommendations, more patients will be protected from HPV-associated cancers and disease.

The National Cancer Institute's President's Cancer Panel released a report entitled Accelerating HPV Vaccine Uptake: Urgency for Action to Prevent Cancer. This report provides a plan to improve HPV vaccine uptake through five parts:

- Reduce missed clinical opportunities to recommend and administer HPV vaccines;
- Increase parents', caregivers', and adolescents' acceptance of HPV vaccines;
- Maximize access to HPV vaccination services;
- Increase global HPV vaccination in low-and middle-income countries; and
- Conduct high-priority research to advance prevention of HPV-associated cancers.

Every time an adolescent patient arrives at the office – whether for a preventive or sick visit – is an opportunity to immunize that patient with needed vaccines. Back-to-school check-ups and sports physicals are an ideal time to make sure adolescent patients are fully vaccinated. MM

These Flyers Are Available For Download From MDCH

- *HPV Vaccine: A Little Pain is Worth the Gain* – discusses why adolescents may experience more pain with HPV vaccine and how this is not indicative of vaccine safety issues
- *Vaccinate before You Graduate* – targets older high school aged adolescents, giving the reasons why it is so important to get caught up with vaccines before graduating from high school
- *Teen Vaccines: Information for Parents* – targets parents of pre-teens and teens, discussing the vaccines needed to keep them safe and healthy
- *Parent's Guide to Preteen and Teen HPV Vaccination* – answers common questions related to HPV vaccination

These materials (and more) are posted at *www.michigan.gov/teenvaccines* (click on "poster gallery").

88 Years and Counting…

By Nancy Fody

The Michigan State Medical Society Alliance began its 88th year of serving the community and supporting the family of medicine in 2014. A new year; a new challenge. Things have changed since 1926; generally Alliance members don't wear white gloves and hats anymore. But one thing hasn't changed. Alliance members are still supporting the family of medicine.

Chili cook-offs, charity balls, holiday children's parties, holiday teas, SAVE Day, welcome bags for the shelter, international luncheons, 100th birthday party, barn party, skating, hosting medical students for interviews, "Hands Are Not for Hitting" – all say the Michigan State Medical Society Alliance is at work or play for the benefit of Michigan physicians.

Today, Michigan's County Medical Society Alliances are engaged in the "Project-in-a-Day" for Immunization Education. Each County Alliance is encouraged to do one project to educate the public about the importance of vaccinations for children and adults. Alliance members are particularly concerned about the high rate of parents "opting-out" of immunizing their children for philosophical reasons. This had led to an increase in cases of measles and pertussis in Michigan.

Community shelters benefit from the Doctors and their Families Make a Difference Day deliveries of pink bags. This past year well more than 635 bags were delivered and $4200 contributed.

The Alliance supports medical education through fundraising, including a basket auction at the MSMS Alliance Annual Session held this year in Muskegon on May 2nd and 3rd, and Sharing Cards during the holidays.

The MSMS Alliance advocates for medicine. Many members called or emailed their representatives to vote for the repeal of the flawed SGR. The SGR Repeal and Medicare Provider Payment Modernization Act of 2014 may have failed again, but not from lack of trying from Alliance members.

We also support the family of medicine on a personal level. Gifts for sick children, meals for the homebound, and lots of understanding for medical families going through difficult times.

In addition helping others, we also look out for ourselves. Each Alliance member is encouraged to think about his or her own health. This year at the MSMSA Annual Session in Muskegon, Alliance members and their families were issued a challenge to take care of their own health.

So let's kick off the next 88 years by staying active, healthy, and engaged! MM

The author is President of the MSMS Alliance, comprised of physicians' spouses.

DISCIPLINARY ACTIONS

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.

12/09/2013 – 12/13/2013

Mark Paul Kallaway, MD
Alpena, MI
43-01-070855
12/09/2013
Summary Suspension Dissolved

12/23/2013 – 12/27/2013

Fitzgerald Anthony Hudson, MD
Dearborn, MI
43-01-091092
01/06/2014
Summary Suspension
Criminal Conviction

12/30/2013 – 1/03/2014

Horace J Davis, DO
Albion, MI
51-01-007157
12/27/2013
Reconsideration Granted – Final Order dated 10-14-13 – Vacated & Remanded for further Proceedings

Kathleen Marie Kleinert, DO
Detroit, MI
51-01-013318
01/26/2014
Suspended – Probation Violation

David Alan Lavine, DO
Clinton Township, MI
51-01-010468
01/26/2014
Suspended – Failure to Meet Cont. Ed. Requirements

Jeffrey Scott Russell, DO
Coldwater, MI
51-01-011799
01/26/2014
Suspended – Probation Violation

1/06/2014 – 1/10/2014

Thomas Michael Bellinger, MD
Freeland, MI
43-01-406493
01/13/2014
Summary Suspension
Unprofessional Conduct
Negligence – Incompetence
Drug Diversion, Lack of Good Moral Character, Technical Violation of the Michigan PHC

Donald Kaplan, DO, RPh
Boynton Beach, FL
51-01-005636, 53-02-018954
01/09/2014
Summary Suspension
Criminal Conviction – Drug Related

1/13/2014 – 1/17/2014

Ewa Marie Hansen, MD
Lambertville, MI
43-01-061029
02/14/2014
Fine Imposed, Reprimanded
Sister State Disciplinary Action

Edward Allan Hatt, MD
Muskegon, MI
43-01-406759
01/15/2014
Fine Imposed, Reprimanded
Violation of General Duty/Negligence

George Frederick Knight, MD
Saint Petersburg, FL
43-01-089140
01/15/2014
Fine Imposed
Sister State Disciplinary Action
Failure to Report/Comply

Arun Kumar Sherma, MD
New Orleans, LA
43-01-091222
02/14/2014
Fine Imposed, Reprimanded
Failure to Report/Comply
Sister State Disciplinary Action

Mikhayl Samy Soliman, MD
Wayne, MI
43-01-086758
02/14/2014
Suspended
Lack of Good Moral Character
Drug Diversion
Negligence – Incompetence

1/27/2014 – 1/31/2014

Farid Tanios Fata, MD
Rochester Hills, MI
43-01-072629
01/27/2014
Summary Suspension Dissolved
Revoked
Unethical Business Practice
Negligence – Incompetence
Lack of Good Moral Character
Unprofessional Conduct
Drug Diversion

Keith Jeffrey Pierce, MD
Livonia, MI
43-01-050099
02/01/2014
Summary Suspension
Criminal Conviction

2/17/2014 – 2/21/2014

Keith Jeffrey Pierce, MD
Livonia, MI
43-01-050099
02/18/2014
Summary Suspension Dissolved

02/24/2014 – 02/28/2014

Ira Stephen Lieberman, DO
Grand Blanc, MI
51-01-010758
02/24/2014
Reinstated Upon Conditions

3/03/14 – 3/07/2014

Mark Greenbain, MD
Farmington, MI
43-01-030022
03/10/2014
Summary Suspension
Criminal Conviction

Michael John Mills, MD, Educ, Ltd
Kalamazoo, MI
43-01-094779
03/09/2014
Summary Suspension
Mental/Physical Inability to Practice, Substance Abuse
Violation of General Duty/Impairment

Robert H Chatfield, DO
Swartz Creek, MI
51-01-007173
03/07/2014
Summary Suspension
Mental/Physical Inability to Practice, Substance Abuse,
Violation of General Duty/Impairment

3/17/2014 – 3/21/2014

William Jacob Alt, MD
Holland, MI
43-01-020997
03/19/2014
Voluntarily Surrendered
Criminal Conviction
Permitting Unlicensed Practice
Lack of Good Moral Character
Unethical Business Practice
Violation of General Duty/Negligence

Vincent R Elie, MD, PT
Chelsea, MI
43-01-057786
55-01-002315
04/18/2014
Reprimanded, Fine Imposed
Violation of General Duty/Negligence

John James Ghesquiere, MD
Jackson, MI
43-01-086860
04/18/2014
Suspended
Negligence – Incompetence
Lack of Good Moral Character

Rob Joseph Kamermans, MD
Albuquerque, NM
43-01-068933
04/18/2014
Fine Imposed, Limited/Restricted
Sister State Disciplinary Action

Steve Ralph Lasater, MD
Ada, MI
43-01-051317
04/18/2014
Restitution, Probation
Fine Imposed
Negligence - Incompetence

Kenneth S Merriman, II, MD
Hastings, MI
43-01-035154
03/19/2014
Community Service, Probation
Criminal Conviction – Drug Related, Violation of General Duty/Impairment

Barbara Garrett Nelson, MD
Clinton Township, MI
43-01-041753
04/18/2014
Reprimanded, Fine Imposed
Failure to Report/Comply
Sister State Disciplinary Action

Gholamreza Shareghi, MD
Marshall, MI
43-01-055253
04/18/2014
Fine Imposed, Reprimanded
Failure to Report/Comply
Probation Violation

Richard Norman Tooley, MD
Traverse City, MI
43-01-052793
04/18/2014
Fine Imposed, Reprimanded
Lack of Good Moral Character
Negligence – Incompetence

Michele Marie Zormeier, MD, RPh
Warren, MI
43-01-063539, 53-02-026798
04/18/2014
Fine Imposed
Failure to Report/Comply
Sister State Disciplinary Action

3/24/2014 – 3/28/2014

Colleen Dawn Landino, DO
Portland, MI
51-01-013079
03/27/2014
Summary Suspension
Criminal Conviction
Lack of Good Moral Character
Drug Diversion
Negligence – Incompetence
Failure to Report/Comply

Daniel Ray Smalley, DO
Ludington, MI
51-01-009049
03/30/2014
Summary Suspension
Criminal Conviction

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.

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.

Reinstate – the granting of a license with or without restrictions or conditions to an individual whose license was suspended or revoked.

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

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

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.

MSMS Foundation
Educational Conferences

New MSMS On-Demand Webinars: Education When You Want It!

- Physician Executive Development Program, featuring The Doctors Company CEO Richard E. Anderson, MD
- CDL-Medical Examiner Course
- Summary of the Affordable Care Act
- HIPAA Security Rule

Please visit website *www.msms.org/eo* for a complete listing.

ICD-10-CM Boot Camp: The Clock is Ticking

Date: Thursday, August 21, and Friday, August 22, 2014
Time: 9:00 a.m. to 4:00 p.m.
Location: Great Wolf Lodge, Traverse City
Contact: Marcie Barnum, (517) 336-5724 or mbarnum@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians, billers, and coders

The PCMH: Supporting Patients and Population Health

Date: Tuesday, October 21, 2014
Time: 9 a.m. to 3:30 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, administrators, office managers and other health care professionals

149th Annual Scientific Meeting

Date: Wednesday, October 22 through Saturday, October 25, 2014
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 22, 2014
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

The Masters Series: Medicaid Expansion Under the Affordable Care Act – Michigan's Response

Date: Thursday, October 24, 2014
Time: 8:30 a.m. to Noon
Location: Somerset Inn, Troy
Contact: Caryl Markzon, (517) 336-7575 or cmarkzon@msms.org
Intended for: Physicians, administrators, and health care executives

18th Annual Conference on Bioethics: End of Life Decision Making – Ethical Issues in Palliative Care

Date: Friday, November 7, 2014
Time: 5:30 p.m. to 8:00 p.m.
Date: Saturday, November 8, 2014
Time: 8:00 a.m. to 4:15 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

MSMS FOUNDATION

To Register Online: *www.msms.org/eo*
Mail Registration Form to: MSMS Foundation
PO Box 950, East Lansing, MI 48826-0950
Fax Registration Form to: 517-336-5797
Phone MSMS Registrar at: 517-336-7581

Welcome to These New MSMS Members

Jeffrey Barnes, MD, Isabella
Shelley Binkley, MD, Genesee
Kelly Burke, MD, Oakland
Robert Carmody, MD, Grand Traverse
Roy Elrod, MD, Wayne
Timothy Esser, MD, Grand Traverse
Amy Heeringa, MD, Oakland
Sheryl Hirsch, MD, Washtenaw
Shalini Johnson, MD, Isabella
Herman-Simon Kado, MD, Oakland
Charles Kerndt, MD, Grand Traverse
Aaron Kurjan, DO, Grand Traverse
Jeffrey Kyff, DO, Grand Traverse
Laurene Mann, MD, Kalamazoo
Matthew Martin, MD, Grand Traverse
Carissa Orizondo, MD, Washtenaw
Jennifer Schaffler, MD, Grand Traverse
John Stratton, DO, Grand Traverse
Kathryn Volz, MD, Washtenaw

Would You Like To Place A Classified Ad?

The rate for classified advertising in *Michigan Medicine*, including both print and online versions, is $1.60 per word, with a minimum of $65.00. All ads must be prepaid. Text for classified advertisements and advertising fee should be received no later than the first of the month proceeding the month of publication. All submitted ads must be typed. No handwritten or dictated ads will be accepted.

To place an ad call 888-822-3102 or email *gretchen@villagepress.com.*

Miscellaneous

In association with the Department of Surgery, Wayne State University School of Medicine Affiliated Hospitals, I am asking for those who were active in health care in Detroit during July, 1967 to contact me. The intent is to examine the impact on the care givers during the disturbances. Please notify me if you know of accounts from those who were there but have moved or passed away. **Please respond to *tj.mullin@att.net* with contact information. TJ Mullin MD.**

Employment Opportunities

Looking for physician to join and eventually assume Eastside, MI Primary Care practice. Full or part-time hospital support with income guarantee. **E-mail *GBGPYC@aol.com* for further details and discussion.**

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PHYSICIAN – DETROIT AREA

We are looking for a physician to join our group performing Independent Medical Exams (IMEs) and/or Consultative Exams for Social Security in the Detroit area. We have opportunities in the Detroit area and adjacent areas for part time work and possibly full time in the future. Our group provides all administrative needs including scheduling, transcription, assisting, and billing. Pay for the day's work is guaranteed regardless of turnout and is paid promptly regardless of time of collection. There is no call and no weekend work. Most full time physicians see patients 3 or 4 days a week. Physicians working for us have various background and training including General Practice, IM, FP, pain mgt., surgery, orthopedics, neurosurgery, and cardiology.

Contact Susan Gladys
@ 1-866-929-8766 or email susang@tsom.com

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The entire 14,551 SF space consists of 25-27 exam rooms, 2-4 procedure rooms, two reception areas, kitchenette/breakroom, lab, x-ray room, multiple conference rooms, etc. Space can be split into 3,700 and 10,851 SF suites with relative ease. Convenient location off of East Beltline between Rockford and Grand Rapids. Includes fitness center and outside golf cage. Ideal facility for Sports Medicine.

Dr. Maurice B. Goudzwaard, Principal

Practice For Sale

WELL ESTABLISHED GYNECOLOGY PRACTICE for sale in Michigan. Lakeside community with excellent private and public schools, close to major universities and metros. Excellent referral base with potential for growth. Option to do OB if desired. Will assist buyer with transition if needed. For details please email *gynecology3@gmail.com*.

Real Estate For Sale

OFFICE AVAILABLE FOR SALE in Jackson, MI. Office designed by a physician and is ready, clean, approx. 2000 sq. ft., 3 restrooms, built-in cabinets. Ganson St. w/ample parking. 2 upstairs apartments with one connecting to office. $178,000; $35,000 down or lease negotiable. **Call 989-631-5640 or 989-280-5225.**

Equestrian Estate – Fenton MI, Tyrone Township

Frank Lloyd Wright inspired 4 bedrooms, 3 bath contemporary home. Main floor includes kitchen, formal living room, dining room, sunroom, 3 bedrooms and 2 full baths. Main floor master suite with walk-in closet, dressing room and huge master bath. Walk out of the lower level family room to an in ground, negative edge pool including water falls. Lower level includes large family room, fireplace, hot tub room, full bath, bedroom, a full kitchen and multiple storage areas. Equestrian Estate includes a 56x72 horse/pole barn with 9 matted stalls, tack room and a heated wash rack. Individual lighting over stalls. 150 x 80 Outdoor arena with sand footing, clay foundation and a French draining system.

Grounds include 17 acres of pastures, 5 acres of lawn and 15 acres treed. A BIG PLUS is Sam Hill Residents and Consumers Energy have an agreement to bring natural gas to residents in fall of 2015.

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- **Family Practice – outpatient**
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The Voice of Michigan Physicians

The mission of the Michigan State Medical Society is to promote a health care environment which supports physicians in caring for and enhancing the health of Michigan citizens through science, quality, and ethics in the practice of medicine.

CONTINUING MEDICAL EDUCATION SEMINAR

Update in Radiology 2014

Wednesday, August 27, 2014 • 7:15 a.m. – 12:15 p.m.

COURSE DIRECTORS

Rojan Samudrala, MD, FACR
Director of Radiology Education, St. John Hospital and Medical Center;
Clinical Associate Professor of Radiology Wayne State University School of Medicine, Detroit, MI

Anthony Alcantara, MD
Chairman of Radiology, St. John Hospital and Medical Center;
Clinical Associate Professor of Radiology, Wayne State University School of Medicine, Detroit, MI

SYMPOSIUM

How to Image Stroke
Ellen G. Hoeffner, MD
Associate Professor of Neuroradiology, Fellowship Program Director, Department of Radiology, Neuroradiology/MRI Division, University of Michigan Health System, Ann Arbor, MI

MR Spectroscopy
Ellen G. Hoeffner, MD

Pre-operative Staging of Breast Cancer with Axillary US: When & How Can We Help?
Alexis V. Nees, MD
Associate Professor, Department of Radiology and Division of Breast Imaging, University of Michigan Health System, Ann Arbor, MI

Low Dose CT Screening for Lung Cancer
Danny Ma, MD
Director of Oncological Imaging, Department of Radiology, St.John Hospital and Medical Center, Clinical Assistant Professor of Radiology, Wayne State University School of Medicine, Detroit, MI

What Not to Miss in Head Trauma
Ellen G. Hoeffner, MD

What Not to Miss in Neck Trauma
Ellen G. Hoeffner, MD

Multidisciplinary Management of a Pulmonary Nodule Clinic: The St. John Experience
Zyad Kafri, MD
Medical Oncologist, Department of Hematology/Oncology, Lymphoma Clinic of Michigan, St. John Hospital and Medical Center;
Assistant Professor of Medicine, Wayne State University School of Medicine, Detroit, MI

Pediatric CT Dose Reductions
Laura Smith, MS DABR
Radiation Safety Officer/Senior Health Physicist, Department of Radiology, St. John Hospital and Medical Center, Detroit, MI

ACCREDITATION

St. John Hospital and Medical Center is accredited by the Michigan State Medical Society to provide continuing medical education for physicians.
St. John Hospital designates this live activity for a maximum of *4.0 AMA PRA Category 1 Credit(s) ™.*
Physicians should only claim credit commensurate with the extent of their participation in the activity.

This symposium will be held at St. John Hospital and Medical Center
Peter A. Whyte Auditorium Center for Medical Education, 22101 Moross, Detroit, MI 48236

Continuing Medical Education: St. John Hospital & Medical Center Upcoming Programs 2014-15

Sept. 10, 2014 – OB/Gyn Seminar • Oct. 22, 2014 – Family Medicine Seminar • Dec. 3, 2014 – Cardiology Seminar • Mar. 5, 2015 – Surgery Seminar

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

St John Providence Health System

ST. JOHN HOSPITAL & MEDICAL CENTER

The Time for Physician Leadership & Vision Is Now

By James D. Grant, MD

Our world is becoming increasingly complex, but with these changes, it gives us the opportunity to mold our future. The challenges we face are increased bureaucratic hurdles, more regulation, pressure to reduce costs, and increased demands by sophisticated patients.

With challenge come opportunity and instead of sitting back we must take this as our cue to forge ahead and lead us into a bright future.

Health care is changing, but we should build the future and not be afraid of it. We need to be the ones that create the agenda, not the ones reacting to it.

We Really Have Three Options:

1. We can resist change and yearn for the way things were;
2. We can submit to change and just let someone else make all of the decisions; or
3. We can drive change and shape and take the lead of the practice of medicine and the delivery of health care.

Eighty-four years ago, Sidney Garfield founded the Permanente Medical Group and at that time developed the concept of prepayment and what is known today as an accountable care organization. Things didn't come easily for him. People didn't like the idea of change. When he initially encountered resistance, this is what he said: "Institutions tend to become static; they build walls around themselves to protect themselves from change, and eventually die. You should fight that by opening up your thinking and your ideas, and work for change."

But from where will we lead this change? We will lead change in the exam room. We will lead change from the operating room and yes, we will lead change the corner office. This means leading – not managing – but leading.

As leadership expert John Kotter said, management is about planning, controlling, and putting appropriate structures and systems in place. Leadership is anticipating change, coping with change, and adopting a visionary stance.

> "Leadership is anticipating change, coping with change, and adopting a visionary stance."

We Will Not Manage, But Lead. What is the Difference?

A manager will "tell" people what to do. As leaders, we will sell our vision. A manager will minimize risk, while a leader will take risks. A manager will make rules, while a visionary leader will break rules. A leader will challenge the past, think "out of the box," and plow through whatever it takes to affect change.

Health system reform needs to be driven by us. This doesn't necessarily mean controlled by physicians, but led by physicians. Leadership is about building bridges toward common goals. We need to be sure that we are leading the teams that are driving the changes forward.

Your patients see you as a leader, but that also means leading by example. You don't realize what an impact you can make, by doing what is best for your patients, for your staff, and for our system. It's not about any one of us, but about all of us.

Leaders create change. Leaders set examples. Leadership is proactive. Leadership takes courage and leadership accepts criticism, and most importantly of all, leaders communicate clearly.

In 2009, of the 6,500 hospitals in America, only 235 were led by physicians. That translates to 3.6 percent of America's hospitals, and that number seems to have plateaued. But let me go over some of the hospitals that are led by physicians: The Mayo Clinic, UCLA, Houston Methodist, The Cleveland Clinic, Nationwide Children's. These are some of the greatest organizations in health care. Each with different health care delivery models, but all led by physicians.

Just a few years ago, a study that reviewed physician leadership in health care found that overall hospital quality scores were about 25 percent higher when doctors ran the hospitals.

Let's look locally. In February of this year, the University of Michigan and Ohio State University could agree on something within a matter of a few days: they both named physicians as their next presidents. Physicians are driving the agenda.

You have a strong voice. Physicians are heard. Legislators, policymakers, and the media want to hear from physicians.

By belonging to MSMS, you are a leader. We are a great organization and an organization for the future, but we cannot – nor will we – rest on our laurels. You will see an even better MSMS. An MSMS that leads. An MSMS that drives change. An MSMS that is here for your patients, for you, and for all Michiganders.

Thank you for your leadership and building a future that we are all proud of. MM

Doctor Grant, a Royal Oak anesthesiologist, is President of the Michigan State Medical Society.

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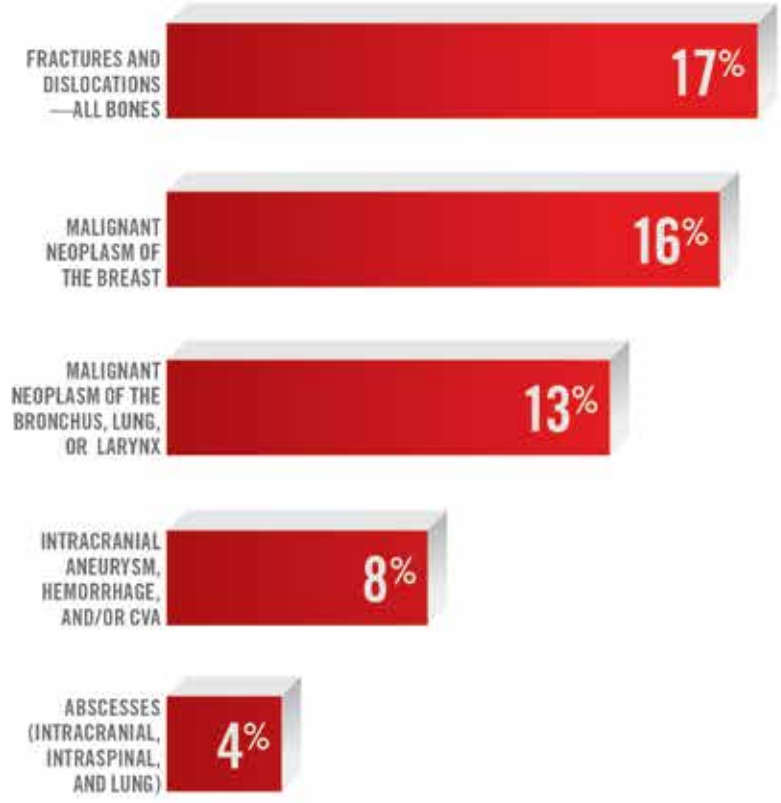

RADIOLOGY CLAIMS MOST FREQUENTLY LINKED TO FAILURE OR DELAY IN DIAGNOSIS
Source: The Doctors Company

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