Is the Sun Setting on Tort Reform Laws? Not if Michigan Physicians…

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• Why the Supreme Court Race is Important
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Come Election Day, Don’t Forget the Supreme Court

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.
Why the Supreme Court Race is Important

By Daniel J. Schulte, JD

**QUESTION:**
We were told at our recent county society meeting that the courts do not always enforce tort reforms. How can this be? Shouldn’t courts always follow the law exactly as written?

**ANSWER:**
It is true that judges do not always strictly apply the law as worded in a statute. We have seen several examples of this over the years in medical malpractice cases. Many times, the case involves a failure to comply with the notice of intent, affidavit of merit, expert witness qualification or other requirement and dismissal of the case or some other consequence adverse to the plaintiff is warranted. In these situations we have seen judges be reluctant or even refuse to enforce the statutory requirement. This may be due to the judge’s feeling that the plaintiff’s lawyer alone is responsible for the failure and is therefore unwilling for the plaintiff to suffer the consequence. A judge’s sympathy for the plaintiff may also be a factor causing him or her to look the other way or misconstrue a requirement. The exact reasons for noncompliance are known only to the judges.

A recent example is Hannah v Merlos. This case involved a dentist defendant, but the issue involved would have applied equally to an MD, DO, or other health care professional to which the medical malpractice tort reforms apply.

We all know that a plaintiff is required to file an Affidavit of Merit along with the Complaint (the defendant physician has a similar obligation to file an Affidavit of Meritorious Defense with the Answer to the Complaint). The affidavit must contain detailed information listed in the statute and be signed by someone meeting the expert witness qualification requirements. Whether the detailed information required by the statute has been sufficiently included in an Affidavit of Merit and whether the expert who signed an Affidavit of Merit meets the statutory qualification requirements can be (and frequently are) the subject of litigation. It should, however, be beyond question that an Affidavit of Merit must be filed with the complaint.

In Hannah v Merlos it was undisputed that no Affidavit was filed with the Complaint. This was brought to the attention of the plaintiff prior to the expiration of the statute of limitations applicable to the plaintiff’s claim. Instead of filing an amended complaint with an affidavit of merit attached, the plaintiff insisted that the affidavit of merit was filed with the court along with the complaint and that the court misplaced it (which the court clerk denied). The defendant filed a motion to dismiss the case. The trial court denied the motion. When the defendant filed a motion for reconsideration, the plaintiff, for the first time, produced an affidavit of merit as an exhibit to his response to the motion for reconsideration. The trial court allowed the case to go forward despite the fact that no affidavit of merit was filed with the complaint.

The Court of Appeals affirmed the trial court’s decision to ignore the affidavit of merit requirement, finding that the plaintiff had “serendipitously” filed the affidavit of merit by attaching it as an exhibit to his response to the motion for reconsideration. Despite the fact that it is undisputed that the affidavit of merit requirement had not been complied with, the trial court judge and three judges on the Court of Appeals were willing to allow the case to proceed. This is what would have happened were it not for the Supreme Court.

By Order dated April 13, 2012, the Supreme Court reversed the judgment of the Court of Appeals and sent the case back to the trial court directing it to dismiss the case. Incredibly, even in a case like this, where the failure to comply with the law is so obvious and undisputed, three Justices of the Supreme Court (Michael Cavanagh, Marilyn Kelly and Diane Hathaway) would have denied the defendant’s appeal and allowed the case to go forward. Fortunately, there are four Justices on the Supreme Court who disagreed and routinely strictly apply statutes as written (Robert Young, Stephen Markman, Mary Beth Kelly and Brian Zahra). These four Justices form a majority that is the last line of defense for those who favor strict construction and enforcement of our medical malpractice tort reforms. Of the four, two (Stephen Markman and Brian Zahra) are up for reelection in November of this year. The Hannah v Merlos case is the best and most recent example of why the Supreme Court race is so important.

Every Michigan physician should support the reelection of Justices Markman and Zahra.

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.
The future of Michigan is looking healthier than ever.

Blue Cross Blue Shield of Michigan and Blue Care Network congratulate the 3,000 Michigan Primary Care Physicians whose practices were designated as 2012 Patient-Centered Medical Homes. Every day, PCMH-designated practice teams make a difference in millions of Michigan residents’ lives.

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Leading Michigan to a healthier future.”
With an estimated 50 million Americans uninsured and hoping to benefit from the current reform laws, there are many looming questions in health care: who will be their doctor, how will we train these physicians, and who will pay for it?

The majority of graduate medical education (GME) is supported by Medicare payments to training hospitals, but the number of residency slots was capped in 1997. Since then, hospitals have added positions “over cap” without federal funds to cover them, and states—including Michigan—have decreased GME funding. Physician shortages are expected to spike medical school enrollment by 2016. As Michigan keeps adding medical schools, what remains is the bottleneck of residency programs that are not expanding. Without increasing support, this will lead to a shortage of positions as soon as 2015, and without a residency, you cannot practice medicine.

Complicating the picture, Congress is considering removing one-third of GME funding because they claim residents are not being trained in essential aspects of health care: teamwork, systems of care, or quality and safety. For its part, the ACGME has beefed up review for resident performance in these areas. As long as the payment and delivery systems reward procedures and testing, however, no amount of resident education will bend the precious cost curve the Washington bureaucrats are chasing. Discussion of increasing primary care slots will not change specialty choice until reward matches sacrifice. Tuition and debt have increased every year, and physician salary has fallen or stayed flat. This does not bode well for our future colleagues.

MSMS continues to pursue innovative solutions through its state GME coalition, advocating for state funding, and assuring support of students and residents who stay in Michigan (66 percent). Our AMA continues to prioritize medical education. Bills have been proposed to increase residency spots. Meanwhile, the future of GME is uncertain and those looming questions remain....

The author is the Resident Representative on the MSMS Board of Directors.
Are Your Prescribing Practices Secure?

Contributed by The Doctors Company

Prescription theft and abuse is a real and growing problem, making it imperative for physicians to protect themselves and their practices. In addition, a recent court ruling spotlights potential obligations to third parties when prescribing medications to patients. Together, these developments signal the need for vigilance and security in your prescribing practices.

The Prescription Regulatory Environment

The Drug Enforcement Administration (DEA) has developed federal and state regulations to safeguard prescribing practices. The Centers for Medicare and Medicaid Services (CMS) also requires that prescription pads have security features to prevent copying, modifying, and counterfeiting. Currently, 49 states have passed legislation to implement operational Prescription Monitoring Programs (PMPs), which seek to curtail prescription drug abuse and diversion through highly effective tools and strategies developed for use by government officials.

Tips to Avoid Prescription Fraud and Abuse

Physicians can incorporate electronic prescribing, or e-prescriptions, into their practice to protect themselves against diversion. Electronic prescribing promotes efficiency and reduces medical liability – two objectives of the HITECH Act. It eliminates the time-intensive process involved with tracking paper prescriptions, voids opportunity for alterations, and provides a direct connection to pharmacists to ensure accurate prescriptions.

Physicians who continue to use paper prescriptions should implement protocols with local pharmacies to manage prescription theft, forgery, and alteration. Consider these risk management tips:

- Request notifications from local pharmacies before prescriptions for controlled substances are dispensed.
- Use the control batch number on each script to track the order of prescriptions.
- Require patients to visit the office to obtain prescriptions for controlled medications.
- Note actual amounts prescribed, and give matching numerals to discourage prescription alterations (e.g., thirty/#30).

If prescription fraud occurs, physicians should investigate and notify local law enforcement, the local DEA office, and the necessary state licensing and medical boards, as well as their malpractice insurer.

Physicians may also consider terminating the physician/patient relationship with a patient who is involved in prescription abuse, theft, or diversion. If prescription fraud occurs, physicians should investigate and notify local law enforcement, the local DEA office, and the necessary state licensing and medical boards. Physicians should also contact their malpractice insurer to discuss other reporting requirements and further safeguards for preventing diversion.

Court Rules Physicians Liable for Patient’s Actions

In February, the Utah Supreme Court ruled that third parties may sue doctors for injuries caused by a patient whose actions are associated with alleged medication mismanagement. The ruling allowed relatives to sue a physician and his staff after a patient killed his wife. According to the American Medical Association, “The court ruled that when potential risks might outweigh potential benefits for a given activity, doctors must consider the potential effects their actions could have on third parties.”

While state laws differ, courts in several other states have issued similar rulings. As a result, health professionals in Utah and other jurisdictions may be found to have a legal responsibility to third parties when prescribing medicine to patients – which will likely impact the way medicine is practiced.

For more safety articles, practice tips, and interactive guides/site surveys, visit www.thedoctors.com/patientsafety.

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During this election cycle, it’s crucial for physicians to become as informed and engaged as possible in the Michigan Supreme Court race. MDPAC-endorsed candidates Justice Stephen Markman, Justice Brian Zahra, and Judge Colleen O’Brien tell MSMS’s Stacy Sellek why.

Let’s be clear: judges and justices are not your “friends.” They cannot put your issues ahead of others when writing their opinions or push your agenda during a public hearing. You cannot claim to support a “pro-medicine” court majority or judicial candidates who are “on your side.”

“It’s not ‘pro’ or ‘anti’ any organization because that’s not what the court is about,” explains Michigan Supreme Court Justice Stephen Markman, who was first appointed by Gov. John Engler in 1999, and is running for re-election to the bench this fall.

But for the sake of preserving tort reform laws, physicians can – and MUST – support the “rule of law” candidates for the Michigan Supreme Court who avoid “putting their fingers on the scales of justice,” in Justice Markman’s words. In addition to incumbent Justice Markman, those candidates include incumbent Justice Brian Zahra and Oakland County Circuit Court Judge Colleen O’Brien, who seeks to fill the seat vacated by retiring Justice Marilyn Kelly.

“It’s important that the people of Michigan, including the medical community, look very closely at this race and the [Supreme Court] records of Justice Zahra and myself,” said Justice Markman.

Why?

“Judicial philosophy matters. It all comes down to the proper role of the court,” says Justice Zahra, who was appointed by
Gov. Rick Snyder to replace retiring Justice Maura Corrigan in 2011.

All three rule of law candidates, who are endorsed by the Michigan Doctors’ Political Action Committee (MDPAC), believe their role is to interpret the existing laws on the books, not rewrite them.

“We believe the intent of the law is best derived by studying the words legislators gave us,” says Justice Zahra. “The consistent application of our laws affects the stability of our state’s economy and ensures fairness to all who enter the courtroom,” adds Judge O’Brien. “This can be especially important for physicians in ‘bad outcome’ cases where the emotional response might be to hold someone accountable regardless of the law.”

On the other side of the coin, they explain that “activist” jurists typically look at the spirit of the law, making decisions based on their empathies, as opposed to what the law says. Therefore, activist jurists tend to fill in the gaps to reach a predetermined outcome.

Meet the ‘Rule of Law 3’

If Justice Markman were to have followed his early dream of playing right field for the Detroit Tigers, who knows what the fate of tort reforms would be today. As it turned out, his passion for the law led him down a different path.

After receiving his law degree from the University of Cincinnati in 1974, Justice Markman worked in Washington, DC, for many years, serving as Chief Counsel of the United States Senate Subcommittee on the Constitution, and as Deputy Chief Counsel of the US Senate Judiciary Committee. He then was appointed by Pres. Ronald Reagan to the post of Assistant Attorney General of the US, and served as a US Attorney in Michigan after being appointed by Pres. George H.W. Bush.

He has taught constitutional law at Hillsdale College since 1993, and has spoken at every law school in the state, as well as other college and universities.

An avid sports fan, Justice Markman says he finds time to play basketball on occasion, and smiles as he notes the irony of engaging on a different kind of court. He also has enjoyed coaching his two sons’ Little League and basketball teams over the years in the Mason area, where he and his family live.

Justice Markman’s eldest son may look back someday with particular interest on his father’s opinions regarding tort reforms: his experience serving in Iraq as an Army medic influenced his decision to attend medical school.

Justice Zahra became interested in the law during high school, but recalls a guidance counselor steering him in a different direction. “I’m sure she didn’t say it the way I heard it, but I came out of that meeting concluding that I’m particularly strong at math, and I should probably pursue computer sciences or the math field. And I’m probably not cut out to be a lawyer because ‘it’s not about going to court; it’s really about a lot of reading and writing, and that doesn’t seem to be my particular strength.’”

Even at the University of Detroit Law School, where he graduated with honors, Justice Zahra remembers having the intent of earning a law degree to possibly run for congress someday, but not necessarily to become a lawyer. “But after the first semester, I just loved it, and I knew that I would be in the legal profession for the rest of my life,” he said.

Prior to his Supreme Court appointment, Justice Zahra served on the Michigan Court of Appeals for 12 years and the Wayne County Circuit Court. (Interesting fact: he is the only Supreme Court candidate this year who has Circuit, Appeals, and Supreme Court experience.)

Justice Zahra, who received his undergraduate degree from Wayne State University, is also something of an entrepreneur. He operated a small health and personal care retail store (and later a grocery store) in Detroit to finance his education.

A longtime hockey player who lives with his family in Northville Township, Justice Zahra takes to the ice in his spare time, lacing up for a local hockey league in Farmington. He jokes, “I’m so old that I say I’m proud to be in the over-40 league.”

Judge O’Brien, a 1981 graduate of the Detroit College of Medicine,}

“Those who sue you for a living already understand the stakes [of this race] very well.”

Supreme Court Justice Stephen Markman, speaking to Ingham County Medical Society members in September

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“When the Supreme Court does not speak with clarity, frivolous lawsuits increase, and justice under the law is not served.”

Oakland County Judge Colleen O’Brien, candidate for Supreme Court
“This election is extremely pivotal. For 26 years, the court didn’t have an incumbent lose until 2008. This has happened two election cycles in a row. There needs to be education of physicians about the importance of this race and of their participation.”

Supreme Court Justice Brian Zahra, addressing MSMS Board members in March

Law, knew she wanted to pursue law since her early teens. However, “it was only after appearing in courtrooms across our state that I thought of becoming a judge.”

“During this time, I often appeared before judges who applied their ‘personal’ views of the law rather than the plain meaning of laws before them,” she explained. “This was not only frustrating, but was often unfair to my clients, and led to confusion among attorneys and litigants, alike. I pledged that should I have the honor of serving as a Michigan judge, I would not allow my personal beliefs and views to interfere with an evenhanded application of the law.”

In addition to 17 years as a practicing attorney handling both civil and criminal matters, Judge O’Brien has spent nearly 14 years on the Oakland County Circuit Court. And she understands exactly how she stacks up against her opponents this fall.

“I have disposed thousands of cases, and have presided over hundreds of criminal and civil trials,” she noted. “This breadth of experience is unmatched by those against whom I am running. It has allowed me to see firsthand the importance of consistency in the law, and how it affects our citizens and our state.”

An occasional golfer, Judge O’Brien lives in Rochester Hills with her husband, who also is an attorney, and their three children. She also has a passion for teaching law, and currently serves as an adjunct professor at Cooley Law School in Lansing.

“I have had the good fortune of teaching a number of law-related classes, and have found it invigorating,” said Judge O’Brien.

Stakes Have Increased

The make-up of the high court can, has, and will continue to greatly impact Michigan’s tort reform laws.

Since our model tort reform laws passed in 1993, almost
every aspect of the laws has been challenged – Notice of Intent, Affidavit of Merit, Loss of Opportunity Doctrine and Expert Witness Qualification, to name a few. And almost all of the Supreme Court challenges have come down to a 4-3 rule of law majority vote in favor of upholding them. As a result of this climate, medical malpractice lawsuits in the state have been reduced substantially.

Contrast this with 2010, when Michigan got a taste of what happens when the court’s majority shifts. Justice Betty Weaver retired and Gov. Jennifer Granholm appointed an activist judge, Alton Thomas Davis, to replace her. Shortly thereafter, the activist majority loosened its interpretation of the Loss of Opportunity Doctrine.

“One perspective I have is having been in the minority on the Supreme Court. I guess it builds character,” Justice Markman dryly quipped.

Justice Zahra interjected, “Or some would say perhaps it reveals character.”

“During that time, the kinds of cases in which we had been upholding medical malpractice reform and had been respecting the role of the doctor in the practice of medicine, I think, were largely reflected in dissents,” Justice Markman continued. “Many precedents of the court that had been established were reversed in that period, and the court was going in a very different direction. Given a little more time, tort reforms enacted by the legislature would have largely been nullified. So it did offer, I think, a study in contrast, a case study of what’s at issue today.”

It took a rule of law majority in the Supreme Court to overturn Court of Appeals decisions that blocked doctors from objecting to plaintiffs’ faulty Notices of Intent (Roberts v. Mecosta County Hospital) and attempted to overturn Expert Witness requirements (McDougall v. Elick).

In 2009, MSMS fought legislative attempts to gut key provisions of the 1994 reforms, including Expert Witness Qualifications, Notices of Intent, Affidavits of Merit, and statutes of limitations. In 2010, additional legislation sought to make it easier for trial lawyers to win huge settlements from physicians who made legal medical record alterations, something rarely covered by liability insurance policies, leaving defendants on the hook to satisfy legal judgments.

If these measures demonstrate nothing else, they show that tort reform laws are vulnerable to continuous attacks on several fronts. Despite the fact that physicians, through MDPAC, succeeded two years ago in shifting the majority back to rule of law, the medical community can’t afford to rest on its laurels and roll back the clock on tort reform. After all, if the medical community sits idly on the sidelines and lets the court majority shift back, we only have ourselves to blame when tort reform court challenges start going the other way….

The author is MSMS Senior Manager, Communications & Public Relations.
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Whether the Patient Protection and Affordable Care Act (typically referred to as ACA) goes into effect with all of its provisions intact, is scrapped and reworked by Congress, or altered by future court challenges, one thing is clear: it has confirmed that ongoing and future efforts to evolve the structural landscape for practice and payment of medicine cannot be ignored. There is no turning back, and those who fail to engage will find it difficult to survive.

Our current health care system consumes $2.6 trillion per year and 18 percent of the gross domestic product, but still leaves almost 50 million people uninsured nationally and almost 2 million people in Michigan dependent upon Medicaid. It misses the mark on quality, as well, with the US achieving an overall score of 65 out of a possible 100 across 37 performance indicators. The status quo has become unacceptable to all stakeholders.

Concerns about the sustainability of a fragmented health care system that is wrought with escalating costs, uneven access, and variable quality has triggered a chain reaction in which major payers – public and private – have already begun to change the way they pay physicians. The changes are likely to be permanent.

Soon to be gone are payments based on the volume of services provided – patient visits, procedures and tests. In their place will be value- and outcome-based reimbursements that are conditional upon population health status and outcomes. In other words, the reimbursement system of the near future will reward physicians for statistically improving patient health and providing more bang for the buck.

As Harold D. Miller, president and CEO of the Network for Regional Healthcare Improvement and executive director of the Center for Healthcare Quality & Payment Reform, told the MSMS Board of Directors in July, “The problem is that nobody gets paid when the patient stays well.”

As payers respond to purchaser demands for more flexible and affordable health care benefits, across-the-board fee updates and fee-for-service payments are being replaced by pay-for-performance incentives and shared savings opportunities. New delivery and payment models will require physicians to practice in a way that provides for an increasing amount of clinical integration and care coordination. Physicians will be incentivized to better manage population health, as they will be measured.
on their population-level performance. Physicians will need to hit quality targets as compensation increasingly becomes tied to outcomes rather than quantity of services performed.

In an October 2011 survey of 182 health care organizations, 66 percent indicated that they incorporated quality measures into incentive programs for physicians (Hay Group Survey- Oct. 17, 2011). Another study released in January 2012, found that 72 percent of 424 health care organizations surveyed linked a portion of pay to quality (Sullivan, Cotter and Associates-Jan. 10, 2012). Various Medicare incentive programs are structured to provide “carrots and sticks,” with participation being voluntary, but negative payment adjustments imposed for non-participation after a set date. Additionally, beginning in 2013, the ACA calls for the public reporting of physician performance information.

Value-Based Payment Models
Several programs resulting from provisions in the ACA are designed to test and evaluate new payment models, such as the National Bundling Pilot Program and the Medicare Shared Savings Program. Under the ACA, the Centers for Medicare and Medicaid Services’ (CMS) Center for Medicare and Medicaid Innovation (CMI) is charged with developing innovative health care and delivery models that slow cost growth and improve quality. Additionally, CMS will be launching a new Value-Based Purchasing initiative in 2015 that will impact physicians. However, the evolution to practice and payment models based on outcomes and value rather than volume or procedures had a foothold well before the passage of the ACA.

In Michigan, several payers continue to embark on value-based incentive programs they designed years ago. One of the largest is Blue Cross Blue Shield of Michigan’s Physician Group Incentive Program (PGIP), which began in 2005 and utilizes a wide variety of initiatives designed to incentivize practice improvement through rewards to physician organizations/physician-hospital organizations (POs) and physicians for the value of health care delivered. Priority Health’s practice transformation initiatives have been evolving over the past several years. Their Partners in Performance (PIP) Program was recently expanded and currently focuses on four key elements: attributed relationships; measured outcomes for usage, quality, costs, and member satisfaction; collaboration; and rewards for prevention, improved clinical outcomes and cost-effective care. These payers are not alone in offering performance and quality incentives. While program specifics may vary, some of the common measures look at preventive screenings; medication management; technology capabilities including registry use and electronic prescribing; disease management; care coordination; and patient-centered medical home capabilities.

These new models of care and reimbursement, as well as increased regulatory demands, are forcing physicians to consider new practice strategies. Partnership and collaboration with other colleagues, whether through employment arrangements, affiliation with POs or other organized systems or care, or other alignment opportunities are fast becoming the norm. Hospitals, too, are more likely to seek hospital-physician alignment opportunities as they recognize the need to partner with physicians in order to meet quality expectations and avoid payment reductions for poor outcomes (i.e., avoidable hospital readmissions).

“The growing emphasis on population health management will drive the need for closer collaboration among physicians,”

Be in the Know about Legal Aspects of ACOs
Physicians need to become familiar with a variety of issues relative to accountable care organizations (ACOs) under the Medicare Shared Savings Program so they can make informed decisions about whether to participate, or wait and see if these organizations take root. MSMS has created a new Legal Alert exclusively for members called “What Physicians Need to Know about Accountable Care Organizations under the Medicare Shared Savings Program.” Download at www.msms.org/hcd.
says F. Remington Sprague, MD, Vice President & Chief Medical Officer of Mercy Health Partners. “Connectivity with enhanced information technology can support this, but fundamentally the culture of medical care must evolve. Broader application of algorithms based on accepted evidence of best care, mutual accountability among primary care and specialty physicians, appropriate delegation of responsibilities to other care givers, and shared decision-making models with patients will all be necessary. This is not to diminish the critical role of physicians, but we will need to learn new skills and approaches to achieve the aims of enhanced quality, greater patient engagement and lower cost.”

Trends to Employment
The administrative burden of running a practice has always been fairly high, but as payers demand more accountability for their health care dollar, physicians are under more pressure than normal. As a result, many physicians are choosing to become employed by hospitals or health systems to reduce their level of involvement in the “business end” of running a practice. According to the New England Journal of Medicine (N Engl J Med 2011; 364:1790-1793; May 12, 2011), nearly half of all primary care physicians in the United States are now employed. In our state, the Michigan Department of Community Health 2011 Physician Survey reports only 36 percent of physicians are not a salaried employee of any organization. These trends reflect a stark departure from a decade ago when the vast majority of physicians were independent. The shift is a direct result of the greater demands on physicians to focus on cost containment through improvements in population health.

Employment by a hospital or health system can provide increased stability for physicians by offering better financial security and a lower burden of day-to-day practice management than physicians have in independent practice. Under most employment agreements, a physician’s salary is at least partially guaranteed and less dependent on the finances of their practice. Data show over the last decade that practice overhead continues to rise while reimbursements have remained relatively flat. The recent economic downturn has only exacerbated the problem as many patients have lost their coverage or rely on lower paying programs like Medicaid. The failure of physician payment rates to keep pace with practice costs coupled with the need to invest in necessary and required infrastructure, such as electronic medical records (EMR) or other health information technology (HIT) have made employment an attractive option for many physicians. The cost burdens of technology requirements alone have proven to be out of reach for many independent practices.

How to Survive While Remaining Independent
While the advantages of employment by a hospital or health system may be attractive to some, many physicians are resistant to the trend because they must surrender some of the control they previously enjoyed running their own practices. For instance, under an employment arrangement, physicians have less say about their work schedule, call coverage, record keeping requirements and other general business or administrative operations, as these are typically dictated by the physician’s employer. For those physicians who enjoy their current autonomy and independence, hospital or health system employment is
not an attractive arrangement. However, physicians who desire continued independence must also understand that some level of clinical integration will be required to survive in the future practice of medicine.

Physician Organizations, especially in Michigan, will be critical to the way health care is delivered in the future. Physician Organizations (POs), Physician Hospital Organizations (PHOs), and Independent Physician Associations (IPAs) can provide doctors with the ability to link their practices into a health care delivery network without the rigidity or potential loss of independence presented by an employment arrangement. Affiliation with a PO can provide physicians with the administrative support offered by employment, such as assistance with HIT infrastructure and billing or reporting functions, without strict control over the physician’s behavior. In Michigan, affiliation with a PO is important as it is required to participate in BCBSM’s PGIP. Additionally, it can be helpful coordinating the requirements of multiple private insurance incentive programs and capturing the respective enhanced payments for quality outcomes.

So, Where Do Things Stand?

Regardless of the level of physician affiliation, one thing is certain about the future of health care in America, “the practice of medicine as a cottage industry is over,” as stated by Doctor Mark Kelley in an April presentation to physicians on the impact of health care reform. Doctor Kelley is Executive Vice President and Chief Medical Officer at Henry Ford Health System, Detroit. He is also Chief Executive Officer of the Henry Ford Medical Group,
a large, multi-specialty group practicing in metropolitan Detroit. The demands of private and public payers to contain costs by improving the health of the population will require greater clinical integration, collaboration, and system sophistication through the adoption of new practice technologies. It will also require tremendous physician leadership to guide the American health care system as it transitions into a new era.

Will physicians embrace, accept and try to influence new practice and payment models, hold out until forced to participate, or wait it out? How will physicians survive under these new delivery and payment models? Doing business the old way will be harder and likely not feasible. The system will no longer support or pay for physicians who operate in silos, unconnected to other physicians and integrated patient care plans. However, this doesn’t mean physicians can’t seek solutions and partnerships that enable independent practice working toward improved population health within a clinically integrated system. There are a variety of alignment opportunities to explore such as networking, partnering and working collaboratively.

As Doctor Jackson points out, “If our health care system is going to thrive, physicians must take the lead.”

In the next issue of Michigan Medicine, we will take a closer look at the incentive programs available to Michigan physicians, and the infrastructure they’ll need to take advantage of them.

Stacey Hettiger is Manager of Health Care Delivery at MSMS.
Paul Natinsky is Managing Partner of Creatavision Partners, LLC, a Royal Oak, MI-based marketing, communications and digital media firm.
Joe Neller is Manager, Physician Organization Liaison at MSMS.

Don’t Get Too Comfortable, Stage 2 Meaningful Use Requirements Have Arrived

J ust when everyone was starting to grasp the Stage 1 Meaningful Use (MU) requirements under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, the final Stage 2 requirements are released. As you might recall, when the EHR Incentive Programs were being developed, it was determined that in order for them to be successful, an incremental approach was needed. This was due to the varying readiness among eligible professionals, eligible facilities, and EHR vendors to meet the proposed criteria. Therefore, it was decided that the MU criteria would be rolled out in three stages.

As expected, the Stage 2 requirements build upon the Stage 1 criteria. Many of the Stage 1 menu set objectives (optional) are now core measures (required) and many of the thresholds in the Stage 1 objectives have been increased. There have also been some “groupings” of various objectives where it made sense and some modifications to Stage 1 requirements. Just like in Stage 1, eligible professionals (EPs) will have to demonstrate 20 meaningful use objectives. However, 17 of these will now be core and three of six will be from the menu set.

In regard to the reporting of clinical quality measures (CQMs), there will be more than 100 CQMs to select from under Stage 2 as compared to the current 44 CQMs. To view the complete list, visit http://go.cms.gov/IrCcod. Under Stage 1, EPs must report a total of six CQMs while Stage 2 requires EPs to report on a total of nine CQMs. The Centers for Medicare and Medicaid Services is also looking at electronic reporting options at the aggregate-level from groups and through the Physician Quality Reporting System.

As Doctor Jackson points out, “If our health care system is going to thrive, physicians must take the lead.”

In the next issue of Michigan Medicine, we will take a closer look at the incentive programs available to Michigan physicians, and the infrastructure they’ll need to take advantage of them. MM
It’s safe to say that patient engagement and the electronic exchange of information are key focuses of Stage 2. The MU criteria include measures that require sending secure messages between patients and EPs, patient online access to their health information, and electronic transmission of summary of care documents.

The table below provides a summary of the MU requirements for EPs in Stage 2:

<table>
<thead>
<tr>
<th>CORE OBJECTIVE</th>
<th>STAGE 2 MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CPOE</td>
<td>Use CPOE for more than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology</td>
</tr>
<tr>
<td>2. eRx</td>
<td>eRx for more than 50 percent</td>
</tr>
<tr>
<td>3. Demographics</td>
<td>Record demographics for more than 80 percent</td>
</tr>
<tr>
<td>4. Vital Signs</td>
<td>Record vital signs for more than 80 percent</td>
</tr>
<tr>
<td>5. Smoking Status</td>
<td>Record smoking status for more than 80 percent</td>
</tr>
<tr>
<td>6. Interventions</td>
<td>Implement 5 clinical decision support interventions + drug/drug and drug/allergy</td>
</tr>
<tr>
<td>7. Labs</td>
<td>Incorporate lab results for more than 55 percent</td>
</tr>
<tr>
<td>8. Patient List</td>
<td>Generate at least one patient list by specific condition</td>
</tr>
<tr>
<td>9. Preventive Reminders</td>
<td>Use EHR to identify and provide reminders for preventive/follow-up care for more than 10 percent of patients with two or more office visits in the last 2 years</td>
</tr>
<tr>
<td>10. Online Patient Access</td>
<td>Provide online access to health information for more than 50 percent with more than 5 percent actually accessing</td>
</tr>
<tr>
<td>11. Clinical Summaries</td>
<td>Provide clinical summaries within one business day for more than 50 percent of office visits</td>
</tr>
<tr>
<td>12. Education Resources</td>
<td>Use EHR to identify and provide education resources more than 10 percent</td>
</tr>
<tr>
<td>13. Secure Messages</td>
<td>More than 5 percent of patients send secure messages to their EP</td>
</tr>
<tr>
<td>14. Rx Reconciliation</td>
<td>Medication reconciliation at more than 50 percent of transitions of care</td>
</tr>
<tr>
<td>15. Summary of Care</td>
<td>Provide summary of care document for more than 50 percent of transitions of care and referrals with 10 percent sent electronically and at least one sent to a recipient with a different EHR vendor or successfully testing with CMS test EHR</td>
</tr>
<tr>
<td>16. Immunizations</td>
<td>Successful ongoing transmission of immunization data</td>
</tr>
<tr>
<td>17. Security Analysis</td>
<td>Conduct or review security analysis and incorporate in risk management process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MENU OBJECTIVE</th>
<th>STAGE 2 MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Syndromic Surveillance</td>
<td>Successful ongoing transmission of syndromic surveillance data</td>
</tr>
<tr>
<td>2. Imaging Results</td>
<td>More than 10 percent of imaging results are accessible through Certified EHR Technology</td>
</tr>
<tr>
<td>3. Family Health History</td>
<td>Record family health history for more than 20 percent</td>
</tr>
<tr>
<td>4. Cancer Registry</td>
<td>Successful ongoing transmission of cancer case information</td>
</tr>
<tr>
<td>5. Specialized Registry</td>
<td>Successful ongoing transmission of data to a specialized registry</td>
</tr>
<tr>
<td>6. Progress Notes</td>
<td>Enter an electronic progress note for more than 30 percent of unique patients</td>
</tr>
</tbody>
</table>

Stage 2 requirements will take effect in 2014. Most EPs will progress to Stage 2 MU criteria after two program years under the Stage 1 criteria. However, those EPs who first met MU in 2011 will operate under Stage 1 for three years. The Stage 2 final rule finalized the process in which Medicare payment adjustments beginning in 2015 will be determined for those EPs who are not meaningful users under the EHR incentive programs. The final rule also identified four categories of exceptions for EPs based on barriers including infrastructure, newly practicing, unforeseen circumstances, and specialist/provider type.

To read the rule in its entirety, visit [http://1.usa.gov/OXEzYI](http://1.usa.gov/OXEzYI).

MSMS offers a variety of tools to assist physicians in understanding and successfully participating in the Medicare and Medicaid EHR Incentive Programs. See the MSMS Health Information Technology (HIT) Webpage at [www.msms.org/HIT](http://www.msms.org/HIT) for HIT Alerts and Checklists, as well as links to helpful sites. MSMS also launched its own Meaningful Use Consultation Service that is available to physicians and their office staff at a very competitive rate. For details, contact Dara Barrera at MSMS at dbarrera@msms.org or (517) 336-5770.
On July 6, 2012, the Centers for Disease Control and Prevention (CDC) published a report to update the 1991 recommendations for the management of hepatitis B virus (HBV)-infected health care providers and students to reduce risk for transmitting HBV to patients during the conduct of exposure-prone invasive procedures. The full report is published online at www.cdc.gov/mmwr/pdf/rr/rr6103.pdf.

The primary goal of this report is to promote patient safety while providing risk management and practice guidance to HBV-infected health care providers and students, particularly those performing exposure-prone procedures such as certain types of surgery. These updated recommendations reaffirm the 1991 CDC recommendation that HBV infection alone should not disqualify infected persons from the practice or study of surgery, dentistry, medicine, or allied health fields. (See the CDC Classification of Exposure-Prone Patient Care Procedures, which accompanies this article.)

The previous recommendations have been updated to include the following changes:

- No pre-notification of patients of a health care provider’s or student’s HBV status
- Use of HBV DNA serum levels rather than hepatitis B e-antigen status to monitor infectivity
- For those health-care professionals requiring oversight, specific suggestions for composition of expert review panels and threshold value of serum HBV DNA considered “safe” for practice (less than 1,000 IU/ml)

These recommendations also explicitly address the issue of medical and dental students who are discovered to have chronic HBV infection. For most chronically HBV-infected providers and students who conform to current standards for infection control, HBV infection status alone does not require any curtailing of their practices or supervised learning experiences. These updated recommendations outline the criteria for safe clinical practice of HBV-infected providers and students that can be used by the appropriate occupational or student health authorities to develop their own institutional policies. The recommendations can be used by an institutional expert panel that monitors providers who perform exposure-prone procedures.

In addition to these recommendations, please refer to Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), posted at www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm.

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CDC Classification of Exposure-Prone Patient Care Procedures

**CATEGORY I**
Procedures known or likely to pose an increased risk of percutaneous injury to a health care provider that have resulted in provider-to-patient transmission of HBV

These procedures are limited to major abdominal, cardiothoracic, and orthopedic surgery, repair of major traumatic injuries, abdominal and vaginal hysterectomy, caesarean section, vaginal deliveries, and major oral or maxillofacial surgery (e.g., fracture reductions). Techniques that have been demonstrated to increase the risk for health care provider percutaneous injury and provider-to-patient blood exposure include:

- Digital palpation of a needle tip in a body cavity, and/or
- Simultaneous presence of a health care provider’s fingers and a needle or other sharp instrument or object (e.g., bone spicule) in a poorly visualized or highly confined anatomic site.

Category I procedures, especially those that have been implicated in HBV transmission, are not ordinarily performed by students fulfilling the essential functions of a medical or dental school education.

**CATEGORY II**
All other invasive and noninvasive procedures

These and similar procedures are not included in Category I as they pose low or no risk for percutaneous injury to a health care provider or, if a percutaneous injury occurs, it usually happens outside a patient’s body and generally does not pose a risk for provider-to-patient blood exposure. These include:

- Surgical and obstetrical/gynecologic procedures that do not involve the techniques listed for Category I
- Use of needles or other sharp devices when health care provider’s hands are outside a body cavity (e.g., phlebotomy, placing and maintaining peripheral and central intravascular lines, administering medication by injection, performing needle biopsies, or lumbar puncture)
- Dental procedures other than major oral or maxillofacial surgery
- Insertion of tubes (e.g., nasogastric, endotracheal, rectal, or urinary catheters)
- Endoscopic or bronchoscopic procedures
- Internal examination with a gloved hand that does not involve the use of sharp devices (e.g., vaginal, oral, and rectal examination)
- Procedures that involve external physical touch (e.g., general physical or eye examinations or blood pressure checks).

Welcome to These New MSMS Members

Eric Daniel Achtyes, MD, Grand Rapids
Bishr A. Al-Ujayli, MD, Rochester Hills
Shannon D. Armstrong, MD, Grand Rapids
Yasir O. Babiker, MD, Flint
James D. Balger, DO, Charlotte
Christopher R. Barnes, DO, Grand Rapids
Karen K. Berris, MD, West Bloomfield
Diane C. Bigham, DO, Grand Rapids
David D. Bonnema, MD, Muskegon
James R. Bullen, MD, Alpena
Quinter M. Burnett, II, MD, Kalamazoo
Ann Y. Burton, MD, Grand Blanc
Christopher M. Chambers, MD, Grand Rapids
Shivani Choudhary, MD, Flint
Su-Jin Chung, MD, Westland
Joseph V. Cotronoe, MD, Lansing
Casey J. Cress, MD, Spring Lake
Robert Francis Cuff, MD, FACS, Grand Rapids
Hanady A. Daas, MD, Troy
Ryan Chandler Daily, MD, Saint Joseph
Carly H. Davis, MD, Kalamazoo
Kathryn Grossman, MD, Vicksburg
J. David Maskill, MD, Grand Rapids
Bruce W. Martin, MD, Grand Haven
J. David Maskill, MD, Grand Rapids
M. Ashraf Mansour, MD, Grand Rapids
Fengxia Qiao, MD, Flint
Jeanette M. Meyer, MD, Kalamazoo
Christopher W. Uggen, MD, Kalamazoo
Keith R. Feggans, DO, Marlette
Louis E. Jacobs, DO, Garden City
Yogesh Jagirdar, MD, Flint
Leena Jindal, DO, Flint
Leroy Johnson, MD, Flint
Madhuri V. Kakarala, MD, Grand Rapids
Manish Khare, MD, Rochester Hills
Linda Lu Reese Kosal, DO, Clinton Township
Alfonso G. Llanto, MD, Watervliet
Ryan Dean Madder, MD, Grand Rapids
Miriva Magar, MD, Flint
M. Ashraf Mansour, MD, Grand Rapids
Bruce W. Martin, MD, Grand Haven
J. David Maskill, MD, Grand Rapids
Terry Merrill Matthews, DO, Lansing
Faisal M. Mawri, MD, Howell
Michael McCann, DO, Swartz Creek
Kelly Mclean, MD, Dexter
Mark E. Meenings, MD, Kalamazoo
Jeanette M. Meyer, MD, Kalamazoo
John R. Mogor, MD, Lowell
Osama Nicola Nunu, MD, Troy
Shawn Harry Obi, DO, Jackson
Duane A. Oetman, MD, Byron Center
Bryan J. Pack, MD, Grand Rapids
Taralata P. Patel, MD, Grand Rapids
Bojan Pavlovic, MD, Portage
Veera Pavuluri, MD, Alma
Sara Margaret W. Pendleton, MD, Grand Blanc
Edward Patrick Juras, MD, Traverse City, formerly of Kewadin and Bloomfield Hills, died June 29, 2012, at the age of 72.
James B. Kilway, MD, Portage, died July 22, 2012, at the age of 78.
Joseph Kopchick, MD, Savannah, GA, formerly of Muir died June 3, 2012, at the age of 91.
George H. Lewis, MD, Allegan, died July 26, 2012, at the age of 90.
Scott K. Huffaker, DO, Marlette
Louis E. Jacobs, DO, Garden City
Yogesh Jagirdar, MD, Flint
Leena Jindal, DO, Flint
Leroy Johnson, MD, Flint
Madhuri V. Kakarala, MD, Grand Rapids
Manish Khare, MD, Rochester Hills
Linda Lu Reese Kosal, DO, Clinton Township
Alfonso G. Llanto, MD, Watervliet
Ryan Dean Madder, MD, Grand Rapids
Miriva Magar, MD, Flint
M. Ashraf Mansour, MD, Grand Rapids
Bruce W. Martin, MD, Grand Haven
J. David Maskill, MD, Grand Rapids
Terry Merrill Matthews, DO, Lansing
Faisal M. Mawri, MD, Howell
Michael McCann, DO, Swartz Creek
Kelly Mclean, MD, Dexter
Mark E. Meenings, MD, Kalamazoo
Jeanette M. Meyer, MD, Kalamazoo
John R. Mogor, MD, Lowell
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Obituaries

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

Norman Carter, MD, Grand Blanc Township, died July 12, 2012, at the age of 78.
John E. Finger, MD, Saginaw, died June 27, 2012, at the age of 83.
W. Richard Harris, MD, Muskegon, died August 27, 2012, at the age of 76.
Edward Patrick Juras, MD, Traverse City, formerly of Kewadin and Bloomfield Hills, died June 29, 2012, at the age of 72.
James B. Kilway, MD, Portage, died July 22, 2012, at the age of 78.
Joseph Kopchick, MD, Savannah, GA, formerly of Muir died June 3, 2012, at the age of 91.
George H. Lewis, MD, Allegan, died July 26, 2012, at the age of 90.

Earle James McGarvah, MD, Grand Blanc, died August 18, 2012, at the age of 75.
Ramesh Naram, MD, Saginaw, died July 30, 2012, at the age of 62.
Paul T. Niland, MD, Gainesville, FL, formerly of East Lansing, died June 1, 2012, at the age of 86.
Richard John O’Malley, MD, Ionia, died July 5, 2012, at the age of 81.
Jacques M. Rosenfeld, MD, Bloomfield Hills, died June 25, 2012, at the age of 84.
William D. Walters, MD, Battle Creek, died September 2, 2012, at the age of 92.

IN MEMORY

If you would like to recognize a colleague by making a gift or bequest in their memory to the MSMS Foundation, the physicians’ own charity, 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.
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.

John Frederick Hildebrandt, MD
Ionia, MI
43-01-407296
06/13/2012
Reclassified w/Full and Unlimited License

Robert G. Kurtz, MD
Traverse City, MI
43-01-038245
06/13/2012
Suspended, Lack of Good Moral Character
Negligence – Incompetence

Brian Francis Lane, MD
Bowing Green, OH
43-01-076999
07/13/2012
Probation, Fine Imposed
Failure to Report/Comply

Sister State Disciplinary Action

Osage Augustine Linares, DO
Plymouth, MI
43-01-045607
06/11/2012
Summary Suspension Dissolved

Michele Renee Ritter, MD
Pontiac, MI
43-01-070661
07/13/2012
Fine Imposed, Suspended
Negligence – Incompetence

Veronica Lynn Vas, MD
Niles, MI
43-01-074720
06/13/2012
Reinstated – w/Limited License
Probation

Edwin Yen Wang, MD
Wilsonville, OR
43-01-071830
07/13/2012
Fine Imposed, Reprimanded
Sister State Disciplinary Action
Failure to Report/Comply

Jo Ann Johnson, DO
Linden, MI
Drug Control License
51-01-001026
06/13/2012
Voluntarily Surrendered
Technical Violation of the Michigan, PHC

Louis Ward Brittingham, Jr., DO
Lakebay, WA
51-01-006462
07/19/2012
Suspended
Sister State Disciplinary Action
Failure to Report/Comply

Steven B. DeWilde, DO
Marine City, MI
51-01-009698
06/19/2012
Reinstatement Denied

Alisa Esther Goldstein, DO
Birmingham, MI
51-01-013607
07/19/2012
Probation, Reprimanded
Failure to Report/Comply

Drug Control License

Richard S. Neely, DO
Davison, MI
51-01-004783
06/12/2012
Reinstated with Probation

Katherine Lily Richmond, DO
Garfield Heights, OH
51-01-007162
07/19/2012
Suspended

Sister State Disciplinary Action

Report Dated: 6-25-2012 through 6-29-2012
Robert Love Baker, II, DO
Lima, OH
51-01-007874
06/21/2012
Reprimanded, Probation, Fine Imposed
Failure to Meet Cont. Ed. Requirements

Paul Andrew Brown, DO
Grand Rapids, MI
51-01-015652
06/26/2012
Probation, Fine Imposed, Reprimanded
Failure to Meet Cont. Ed. Requirements

Jeffrey Scott Morrill, DO
Fort Dodge, IA
51-01-014880
06/21/2012
Probation, Fine Imposed, Reprimanded
Failure to Meet Cont. Ed. Requirements

Alan Percy Peter, DO
Macomb, MI
51-01-014745
06/26/2012
Summary Suspension Dissolved

Report Dated: 7-2-2012 through 7-6-2012
Stanley Halprin, DO
Clinton Township, MI
51-01-005465
06/29/2012
Probation, Reprimanded, Fine Imposed
Failure to Meet Cont. Ed. Requirements

Report Dated: 7-9-2012 through 7-13-2012
John Richard Wagner, Jr., MD
Warren, MI
43-01-061192
07/13/2012
Summary Suspension

Violation of General Duty/Negligence
Substance Abuse

Mental/Physical Inability to Practice

Reprimand – the written statement of reprimand 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.

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
- other conditions deemed appropriate.

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

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 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.
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Alliance Members Rally for Tort Reform

By Kathy Adams

Convening in Lansing early on July 18, members of the MSMS Alliance arrived at Boji Tower to attend the Senate Insurance Committee tort reform hearing. We were surprised to find every seat and aisle filled with people wearing white t-shirts reading, “Accountability, Not Immunity.” Since Cooley Law School is within one-half block, it appeared to be easy for lawyers and law students to show up en masse. Doctors, Alliance members, and other like-minded supporters were not as obvious, wearing our green “Put Patients First!” buttons.

During testimony, those who opposed the bills outnumbered those in support. It appeared that there was no difficulty in finding people with stories of bad medical outcomes and purported poor doctor care, but it was apparently impossible to find people to relate stories of good, thoughtful, successful medical care. I was amazed by this.

The testimony in opposition to tort reform was sad because those people’s lives were adversely affected by doctors and their care. However, that does not mean that all doctors should be tossed into the same basket. Having “one size fits all” legal consequences is expensive and unfair.

I left thinking, “What just happened here?” The testimony by the doctors in support of the tort reform bill was appropriate; however, it came across to my ears – and possibly to others – like whining. It sounded as if doctors were saying, “I want what the lawyers have.”

At the end of the day, it left us feeling frustrated and wondering what will happen to these important bills.

MSMS Alliance members believed the issue was important enough to stand for three hours in support. But this lopsided hearing showed that we desperately need to energize our community to show a larger force than we did on July 18. Ultimately, this is a crucial opportunity for all Michigan physicians to advance their profession and to improve patients’ lives.

The author is President of the MSMS Alliance, comprised of physicians’ spouses.
The Masters Series
Date: Thursday, October 25, 2012
Time: Noon to 4:30 p.m.
Location: Somerset Inn, Troy
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org
Note: Lunch will be provided.
Intended for: Physicians, executives, office administrators/managers, and all other health care professionals.

Lean Physician Practice Innovation: Finding the Time to Deliver Great Health Care

INTRODUCTION WEBINAR
Date: Thursday, September 27, 2012
Time: 7:00 to 8:00 p.m.

SESSION I
Date: Friday, October 26, 2012
Time: 8:30 a.m. to 12:00 p.m.
Location: Somerset Inn, Troy

SESSION II
Date: Wednesday, November 14, 2012
Time: 9:00 a.m. to 4:30 p.m.
Location: Eagle Crest Resort, Ypsilanti

FOLLOW-UP WEBINAR
Date: Thursday, December 6, 2012
Time: 7:00 to 8:00 p.m.

SESSION III
Date: Wednesday, January 23, 2013
Time: 9:00 a.m. to 4:30 p.m.
Eagle Crest Resort, Ypsilanti

SESSION IV
Date: Wednesday, February 20, 2013
Time: 9:00 a.m. to 4:30 p.m.
Eagle Crest Resort, Ypsilanti
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org

Note: Continental breakfast and lunch will be provided.
Intended for: Physicians, and office administrators/managers.

MSMS Physician Executive Development Program
Date: Thursday, November 8, 2012
Time: 9:00 a.m. to 4:00 p.m. (Conference)
Date: Monday, November 19, 2012
Time: 7:00 to 8:00 p.m. (Webinar)
Date: Monday, December 3, 2012
Time: 7:00 to 8:00 p.m. (Webinar)
Date: Thursday, December 13, 2012
Time: 9:00 a.m. to 4:00 p.m. (Conference)
Location: The Henry Center for Executive Development, Lansing, Michigan
Contact: Caryl Markzon (517) 336-7575 or cmarkzon@msms.org
Note: Continental breakfast and lunch will be provided.
Intended for: Physicians.

147th Annual Scientific Meeting
Date: Wednesday, October 24 through Saturday, October 27, 2012
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 24, 2012
Time: 5:45 p.m. to 8:15 p.m.
Location: Somerset Inn, Troy
Contact: Marianne Ben-Hamza 517-336-7581 or mbenhamza@msms.org
Note: Dinner will be provided.
Intended for: Retired physicians, those planning for retirement, office managers, and spouses.

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SYMPOSium

Use of Anti-psychotics in Primary Care
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Chief, Psychiatry, St. John Hospital & Medical Center, Detroit, MI

The Addicted Patient and Use of Suboxone
Bela Shah, MD
Medical Director, Eastwood Clinics, Royal Oak, MI

Behavioral Medicine Services in SJPHS:
The Services Available to PCP Patients
Debra Hollander, MD
Medical Director, SJPHS Behavioral Medicine Services,
St. John Providence Health System, Warren, MI

Adult ADHD in Primary Care
Steven Warnick, MD
Family Physician, Advantage Health Centers, Detroit, MI

Update on Alcohol Dependence and Treatments
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Come Election Day, Don’t Forget the Supreme Court
by John G. Bizon, MD

Residential election campaigns tend to draw all public attention toward the race for the White House, like a political black hole. Yet voting issues that may have the greatest impact on our lives, our professions, and our futures are often buried deeper in the ballot. Here in Michigan, a matter of great concern to the practice of medicine may not even be on the first page of your typical ballot this November – you’ll have to flip to the back to find the nonpartisan state Supreme Court voting options. But it would be a serious mistake to overlook this duty, both as a citizen, and as a physician practicing in our state.

The Michigan Supreme Court races in 2008 radically reshaped both the Court and its judicial philosophy. We saw a new, activist majority who believed that laws were passed to be rewritten – and a prime target was the body of tort reforms we’ve worked so hard to protect since they were enacted in the 1990s. As a result, Michigan physicians have been on the losing end of some important decisions that weakened liability protections.

This election year, MSMS and our Michigan Doctors’ Political Action Committee (MDPAC) are working hard to turn the judicial tide. We’re supporting the reelection of Supreme Court justices who have proven records of respecting and upholding the rule of law. Justices Stephen Markman and Brian Zahra have reputations as solid jurists who resist the temptation to legislate from the bench. MDPAC has formally endorsed them for reelection in November (as well as new Supreme Court nominee Colleen O’Brien). I urge MSMS members not only to “flip their ballots” and make sure to vote for the Supreme Court elections, but also to be activists in their communities, and contributors to MDPAC.

Perhaps you’re thinking that state Supreme Court races are a bit “down-ballot” in a year of sharply-defined presidential battles and contentious state proposals, but look at how pivotal courts have become as “gatekeepers” of government. In August, Michigan held its collective breath as the state Supreme Court decided which of the statewide proposals would make it onto the ballot this November. While executive and legislative races grab the headlines, decisions by both these branches of government must still pass muster with the third branch – the judiciary.

The forces who oppose tort reform surely recognize the value of who stays and goes on our Supreme Court. Michigan’s trial lawyer groups have been strongly funding activist opponents to Markman and Zahra, and, after their success in turning out incumbent judges in 2008, are a powerful threat. This can’t be overstated: the stakes in this year’s Michigan Supreme Court race are higher than ever for physicians. If we lose the current rule of law majority, it could be another 20 years before we get it back. And these lawyer groups have also made clear their bitter opposition to the “Patients First” package of reform laws currently in the state Senate. These bills, especially SB 1116, would help undo some of the tort reform damage done by the courts, and level the liability playing field between physicians and lawyers. If the “Patients First” package becomes law, and if the trial bar succeeds in adding activist judges to the Supreme Court, guess what will happen to these reforms?

Funding for health care already faces looming dangers. Sustainable growth rate formulas and the Accountable Care Act could combine with 2013’s “fiscal cliff” tax changes to bring devastating cuts to health care. Does Michigan really want our shrinking health care dollars to be wasted on meritless lawsuits? Contribute, call, and speak out in the run-up to Election Day – and come November, be sure to flip your ballot and vote.

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Doctor Bizon, a Calhoun County otolaryngologist, is President of the Michigan State Medical Society.
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