Doctor Kahn Goes to Lansing:

How Heart, Hard Work and a Tough Hide Catapulted Him from One-time Long Shot to One of the Most Influential Leaders in the State

ALSO IN THIS ISSUE

• An Explanation of the PPACA Ruling
• Effective Informed Consent – Fostering a Dialogue
• Leading by Example: Henry Ford Health System’s Mark A. Kelley, MD
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An Explanation of the PPACA Ruling

by Daniel J. Schulte, JD

**QUESTION:**
Can you please explain the Supreme Court’s ruling on the Patient Protection and Affordable Care Act (“PPACA”)? All the talk leading up to this decision was about whether this law was legal under the Commerce Clause. If the Court said that it was not, how did the law survive?

**ANSWER:**
The PPACA case is significant because of the nature and scope of PPACA and the novel legal issue raised – can Congress require participation in interstate commerce (i.e., require us to purchase goods or services)? The way the case was decided was as surprising as the case was significant.

First, a majority of the Justices held that the Commerce Clause does not permit Congress to mandate the purchase of insurance (or anything else) or to otherwise mandate engaging in interstate commerce by those who choose not to. Instead, Congress may only regulate interstate commerce that is already occurring and only those who are engaging in it in some way. This is a significant ruling on a novel issue. Prior to the PPACA case, the Supreme Court had never ruled on whether an individual’s refusal to participate in interstate commerce could be regulated even if the refusal, arguably, had an effect on interstate commerce. All the Supreme Court’s previous Commerce Clause decisions dealt with statutes regulating those engaging in interstate commerce. We now know that Congress cannot force participation in interstate commerce (i.e., we cannot be forced to purchase goods or services). The morning the PPACA decision was announced, several news outlets stopped reading the opinion at this point concluding and rushing to announce that PPACA was unconstitutional and struck down. They were wrong because the remainder of the opinion contained a ruling no one expected.

Second, despite the Obama administration’s repeated statements that PPACA’s “shared responsibility payment” (the amount required to be paid by those who do not purchase health insurance or are not otherwise covered) was not a tax, Chief Justice Roberts joined Justices Ginsburg, Breyer, Sotomayor and Kagan (previously thought to be an unlikely combination) to form a majority concluding that it was a tax. The conclusion that the shared responsibility payment was a tax enabled these five Justices to examine the individual mandate under Congress’s taxing authority. They then concluded that this was within Congress’s constitutional power to tax.

These two rulings must be thought of together: (1) the individual mandate and other mandates to engage in commerce are unconstitutional standing alone; but (2) PPACA survives (and presumably so would similar taxes for not engaging in required commerce) because there were five Justices willing to recharacterize the individual mandate as a constitutional tax on those who are not covered by health insurance.

The case also dealt with PPACA’s expansion of Medicaid coverage (to include all those below 133 percent of the poverty level). PPACA’s penalty for not implementing the expansion was a loss of all federal Medicaid funding (both the existing funding and the funding PPACA would provide for implementing the expansion). This penalty, a majority found, was unconstitutional. If a state refuses to implement PPACA’s expansion of Medicaid coverage, Congress can only withhold the increased PPACA funding and not withhold existing Medicaid funding as a penalty. The effect this ruling will have on the number of states implementing PPACA’s Medicaid expansion remains to be seen.

In the end, it is very surprising how small a role the Commerce Clause played in the outcome of the case compared to the role played by Congress’s taxing authority – which ended up being determinative. The long-term effect of the PPACA case will likely not be about health care but how Congress uses and what limits, if any, are placed on its newfound power to regulate interstate commerce by imposing taxes.

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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Selecting an Electronic Health Record – One Coalition’s Journey

With more than 2,300 comprehensive and modular ambulatory electronic health records (EHR) products certified for meaningful use, selection of the system that’s right for your practice might seem like a daunting task. MSMS has developed some tools to try to assist physicians and their staff with this process, including such documents as Selecting an HIT/EHR Vendor and HIT/EHR Vendor Contracting Checklist. However, sometimes the most valuable resource is lessons learned from your colleagues.

This HIT Corner focuses on the efforts of a coalition of Physician Organizations (POs) in Southeast Michigan to help physicians select an electronic medical record. This coalition, which includes physician and executive leadership representation from Huron Valley Physicians Association, Greater Macomb PHO, Olympia, Oakland Southfield Physicians, United Physicians, Oakland Physician Network Services, United Outstanding Physicians, and St. John Providence, created an evaluation process in an effort to help narrow the field from the hundreds of products on the market.

Before the EHR selection process could even begin, the coalition recognized that they needed to first establish and prioritize a set of criteria to identify vendors to contact for on-site demonstrations. For this group, the highest priority was “ease of use” and the initial selection criteria focused on improved quality over paper charts, intuitiveness to use, and increased physician efficiency. Other criteria for “ease of use” focused on prompt technical support with after-hours availability and the existing connectivity or interfaces with ancillary service providers such as labs, imaging centers and hospitals.

The array of vendors was further narrowed by the establishment of a second tier of criteria that emphasized compatibility with primary care friendly quality initiatives and a practice size of 10 physicians or fewer. From this list, EHR products with integrated practice management systems, electronic prescribing, and registry functions were given priority. Finally, this coalition of POs utilized existing market surveys such as KLAS scores and a 2011 satisfaction survey from the American Academy of Family Physicians to identify seven vendors for further consideration.

These seven vendors were invited to provide a three-hour demonstration of their product and were graded on a scorecard designed to evaluate the processes generally involved in an office visit. Physician evaluators used the custom scorecard to rank each EMR on its functionality across all elements of appointment scheduling, patient check-in, clinical triage, point-of-contact care, interoffice messaging and referrals, lab or test orders and results, prescriptions and renewals, immunizations, and patient checkout. The scorecard also included elements of importance to the POs such as population management and other reporting requirements for existing quality initiatives such as the Patient Centered Medical Home and Accountable Care Organizations. If the EMR product offered a patient portal, it was evaluated among the other elements on the scorecard criteria.

When the demonstrations were completed and the evaluation scorecards were tallied, four vendors remained as viable contenders. References from and potential on-site visits to physicians that are either past or current users of the four remaining EHR vendors, price, technical structure and security, and future viability of the vendor are some of the remaining criteria that will be used to make their final selection.

As demonstrated by this coalition of POs, planning at the front end will provide for a more efficient and informative selection process. Identify selection process participants. Select specific criteria and functionality that you want from EHR technology to enhance your practice, care delivery process (operational and clinical), and satisfaction. Prioritize criteria in order to “weed out” vendors that aren’t a good fit.

Further narrow the list of candidates by comparing the vendors’ ability to cater to your unique needs (i.e., practice size, participation in various quality programs, use of registries, compatibility with lab interfaces, etc.). Determine performance capability by inviting a select number of vendors to demonstrate their products. Create a “scorecard” to help evaluate EHR products based on your criteria, not just what the vendor wants you to see in their “packaged” demonstration. For example, if there are certain functions you need the EHR to perform, ask the vendors to show you those functions. Get recommendations from national sources and colleagues in your specialty with similar practice workflows.

Once you have narrowed down your selection to a few EHR products that have survived your rigorous review and have the functionality you desire, use your final criteria to give the “edge” to the product you ultimately select (i.e., price, technical support, training, etc.).

Regardless of the process or technology that works best for others, it’s important to conduct a thorough vetting process to select a system that works well for you (and your specialty), your practice, and/or your group. By using MSMS resources and following procedures like the one described above, the daunting task of choosing an EHR can become much more manageable.
Hippocrates once promoted the beneficence model of medicine, which encouraged minimal communication with patients about their condition. Like Hippocrates, those days are long gone, and guidance now supports the idea that patients need to understand planned medical procedures adequately so they can make informed decisions about their treatment. Effective informed consent requires a dialogue with the patient wherein they feel comfortable fully participating by asking clarifying questions and offering personal concerns.

Requirements for informed consent have not changed in modern health care, but the delivery has seen strong consumer momentum to encourage a better exchange of information. Traditionally, informed consent was limited to operative procedures, but in recognition of the high-tech nature of medicine and the potent medications that have been developed, it must now encompass a broader range of medical care, including surgical procedures, significant medical treatments, and prescriptions with side effects.

Physicians are bound, in advance of this medical care, to provide the patient with detailed information on the risks, benefits, and alternatives, including the option to not perform the procedure or treatment regimen and the effect that doing nothing would have on that patient's health status. They are also required to inform the patient about any potential clinically significant adverse drug reactions or other concerns when a new medication is ordered.

Patients can be overwhelmed by medical jargon and may be medically naïve, so it is imperative for the physician to foster an open dialogue with the patient and allow adequate time for discussion, translating key terms to common language and providing commonly asked questions that may put the patient at ease and stimulate further questions.

An area often minimized prior to medical care is the recovery period. Prior to treatment, the physician should discuss any limitations or unwelcome surprises that may arise. Often the focus is on early medical issues (e.g., pain, possible infection, drainage), but it is valuable for the patient to also understand what life will be like for a longer period of time. Perhaps they will require readily accessible restrooms or will be not be able to perform household activities. Finally, physicians will strengthen understanding and reduce potential complaints by including family members or friends in the discussions.

For more patient safety articles and practice tips, visit www.thedoctors.com.
As a cardiologist, Roger Kahn is dedicated to serving his patients and improving their health and well being. MSMS’s Stacy Sellek sat down with him recently to find out how – and why – he transitioned into being a representative of the people of Michigan.

There is one topic you won’t hear Roger Kahn bring up in his cardiology practice: politics. Although his medical experience and health care expertise have served him well in his legislative work, he will not let the door swing both ways by bringing up legislative or political topics with patients.

“I don’t think it’s appropriate,” explains the second-term senator from Saginaw. “Doctoring isn’t about doctors; it’s about delivering care to patients.”

He smiles through his silver beard and admits that if patients ask him questions about legislative issues in his practice, however, he will answer them. After all, they’re also his constituents.

Sitting in the reception area of Sen. Kahn’s legislative office, it’s easy to be overwhelmed by the grand surroundings: high ceilings; ornate moldings and fixtures; and a stately balcony overlooking the manicured Capitol lawn. These are the trappings of success in Lansing that his prestigious and well-earned post as Chair of the Senate Appropriations Committee have brought.

But as Sen. Kahn welcomes me into his office, he begins tidying up from a Mexican luncheon spread previously brought in by a constituent group. When the person responsible for guiding billions of dollars through the state budget process offers you a taco, it’s pretty hard to be intimidated.

The senator also is quick to point out that this is not his office. “It belongs to the people; it’s your office. I’m just borrowing it,” he says.

What you see is what you get with Roger Kahn. A glance around his office will tell you a lot, from the large walking stick standing in the corner (as in, “Walk softly…”) to the Latin quote hanging on the wall that serves as an important reminder of humility (“Sic transit gloria mundi,” or “The glories of the world will pass”). The gallery of photos from key bill signings he was involved with speak to his own effectiveness as legislator, and he is obviously proud and enthusiastic as he discusses bills that have made a difference for the people of the 32nd District, and across the state. And then there is the autographed Wayne State University football helmet right on his desk – a memento from his alma mater.

The House Calls…

Something that struck him as a physician and led him to eventually run for the House was seeing firsthand the inherent problems within our health care system. Senator Kahn cites examples of patients who couldn’t afford to fill the prescriptions he wrote for them, or didn’t have any insurance, felt they couldn’t afford to see him and, therefore, ended up sicker and often in the emergency room.

“It was clear to me back in 1998 that we had major problems in being able to deliver care to our people. Also, I was in a period of
great personal transition at the time and I was rethinking what I wanted to do with the rest of my life,” he explained. “Physicians are people who believe in service, by and large, so I thought I could do some kind of public service.”

As a long shot in his first House race in 2004, Doctor Kahn was determined to demonstrate a strong work ethic out in the district. He walked the 94th District two and a half times while going door-to-door and wore out two pairs of tennis shoes doing it. It paid off. Not one to rest on his laurels, he knocked on 60,000 doors in 2006 during his first Senate race. Along the way, he even developed his own signature campaign look: an American flag golf shirt.

Once he headed to Lansing, Doctor Kahn brought with him a passion for helping patients and commitment to improving health care for all Michiganders. This dedication is symbolized by a handsome brown leather doctor’s bag he keeps on a shelf behind his desk in the Capitol. Like many of the items displayed in his office, it has a story.

The bag had once belonged to a patient of Doctor Kahn’s who was also a pharmaceutical rep. This patient had gone into cardiac arrest and was resuscitated and intubated by first responders before he was brought to the hospital. Caregivers didn’t realize until it was too late that he had an advanced directive stating he didn’t want to be resuscitated. Thirty days of life support – not to mention physical anguish and enormous financial cost – later, he passed away. His wife had given Doctor Kahn the bag to remember her late husband.

Senator Kahn keeps the bag in his office to remind him of several things. “First, what a wonderful guy he was,” he says.

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5 Things You Don’t Know About Roger Kahn:

1. Proposed to his wife with a sonnet he’d written for her.
2. Once donated a pair of worn-out campaign shoes to an auction benefitting Habitat for Humanity.
3. Is the uncle of Senate Majority Leader Randy Richardville.
4. Achieved the status of “Life Master” as a bridge player.
5. Historical figure he most identifies with: Teddy Roosevelt.

“Also, it reminds me that there are other things we need to do to help people at the end of their lives to keep situations like this from happening again. And there’s a nice additional benefit as a legislator: it will save money.”

’Sitzfleisch’ & Linkage

During his nearly eight years in Lansing, Sen. Kahn has earned a reputation as someone who isn’t afraid to take up difficult issues and get things done. A prime example is the health care claims tax he helped pass last year. The law is an assessment on certain health insurance claims that draws federal dollars to Michigan.
The republican lawmaker said it took about six months to pass, in part because it had “all the warts of being a tax.”

He’s also extremely proud that he helped deliver a completed budget on time two years in a row, far from a small feat considering the colossal uphill battle involved. This stands in striking contrast to previous years of repeated legislative deadlocks, brief government shut-downs, and retroactive quick fixes.

“People like when it’s on track,” he explained. “It gives them hope, faith, and confidence in their government.”

So how has he been able to his colleagues on board to pass tough measures?

The senator, an avid chess player, throws out this term: “sitzfleisch.” It’s a German word that refers to the ability to endure, or to patiently remain in one’s seat hour after hour, making hope moves until one’s opponent gives up or blunders. It’s also described as a way of commenting on one’s staying power. This strategy apparently has paid off for the senator, who has served one term in the House and is serving his second and final term in the Senate, which ends in 2014. He’s still eligible to serve two more House terms, if he decides to run again.

In addition to the ability to stay the course, Sen. Kahn believes it helps to put out a reasonable argument, write tough bills in the most user-friendly way to get them passed, and be flexible and willing to negotiate. He is keenly aware of the fact that his legislative colleagues, patients, and constituents won’t always agree with every decision or position he’s taken. But he sees his ultimate duty as a legislator as helping to improve the state of Michigan for everyone. Period.

“You still owe representation to the people who didn’t vote for you, as well as the ones who did,” he says. “I’ve found that if you can explain to people why you did what you did, they are reasonable. They might not agree with you, but they can respect a different point of view.”

One thing that surprised him when he first took office as a representative for the 94th District was the issue of what he calls “linkage.” No, this isn’t another term for sausage-making, but rather, a reference to the political trade-offs that mark how things get done in the legislature.

So, Doctor, You Want to Run for Office…?

Senator Kahn Breaks Down What It Takes:

- Humility
- Physicality and hard work
- Sense of service
- Sense of who you are and what you want to do
- Family buy-in (“can’t do it alone”)
- Money (“it will cost you a lot to do this”)

“It is a tremendous honor, responsibility, and opportunity to serve the people of Michigan for the good of the medical profession and the state. I believe it’s worth it.”

—Sen. Kahn

“Outside the Dome

Senator Kahn stays in an apartment in Lansing during the legislative session each week, and travels home to Saginaw to see patients on Fridays when he can. “For me, it’s a great mental health break.”

In addition to continuing to practice, Sen. Kahn keeps balance in his life by writing poetry, playing bridge or chess, and spending time with his wife, Nyla, and their blended family of eight children and 17 grandchildren.

He also is dedicated to giving back to his community. One standout example is the effort he helped a local church organize during his first Senate term. They put out a call in the community to collect sports equipment to send to troops serving in Iraq, and got an overwhelming response. “We got an incredible amount of stuff – baseballs, basketballs, hula hoops, you name it,” he said. “We eventually had to send a second shipment because people continued to make so many donations.”

When asked what his plans are beyond the legislature, he’s open about the fact that he isn’t sure, but he needs to decide in the next seven months if he will seek further office.

Before he does that, though, there is still much Sen. Kahn wants to accomplish in the legislature. Topping the list is passing tort reforms. As a sponsor of SB 1115, part of the “Patients First Reform Package,” Sen. Kahn is a champion of preserving tort reforms to protect access to care, save money for all Michiganders, and ensure that physicians have a stable environment within which to practice.

Ultimately, this is an example of why he believes it has become more important than ever for physicians to become effective leaders within the profession and beyond. “Physicians need become involved. If they aren’t involved, [health care] decisions will be made by others.”

The author is MSMS Senior Manager, Communications & Public Relations.
Leading by Example

Henry Ford Health System’s Mark A. Kelley, MD

By Nick W. DeLeeuw

There was a time when he seriously considered going into journalism.

Before he ever stepped foot onto the campus of Harvard University, Mark A. Kelley, MD, felt driven toward public service. Connecting people with the world around them seemed an interesting way to serve. He did a stint at the campus radio station and, during vacations, worked as a news reporter for the The Boston Globe. Eventually, his love of science and desire to help others led Kelley to choose a medical career instead.

Kelley still gets his fix for the news when he joins WJR’s Paul W. Smith show weekly. He reaches tens-of-thousands of listeners with advice on everything from when to apply sunscreen to the benefits of adult vaccinations.

“More people probably know me from the Paul W. show than from my day job,” Kelley laughed, as he moved busily between meetings at the campus of the Henry Ford Medical Center. “People come up to me all the time with medical questions and it is great to help. I still see patients in the office and continue to find patient care incredibly rewarding.”

A quick scan of the physician’s resume and one quickly understands how it might generate invitations to appear regularly on Michigan’s most influential radio program.

A practicing pulmonary physician listed in “Best Doctors in America,” Mark A. Kelley, MD, is a Master of the American College of Physicians who maintains active teaching roles at Wayne State University School of Medicine and the Ross School of Business at the University of Michigan.

He worked for years as a professor of medicine at the University of Pennsylvania School of Medicine, where he served in a variety of leadership roles. Kelley was vice chair of the department of medicine, and chief of medicine and associate chief of staff at the Philadelphia Veterans Affairs Medical Center. He also served as vice dean for clinical af-

“We cannot burn peoples’ money, whether that’s the federal government, businesses or patients. At the end of the day, society decides what it wants to pay for health care. Our job is to advocate for our patients and provide them great value.”

Mark A. Kelley, MD
fairs at Penn and was responsible for the physician and hospital network development and for the coordination of clinical practice integration across the University of Pennsylvania Health System.

But it is his dynamic leadership at one of the nation's largest group practices that has set Kelley apart. As the chief executive officer of the Henry Ford Medical Group in metro Detroit, he oversees more than 1,200 physicians and researchers in more than 40 specialties. Kelley also serves as executive vice president and chief medical officer for the 24,000 employee Henry Ford Health System and is the man tasked with facilitating relationships between the System and the more than 1,800 private practice physicians throughout metro Detroit who provide care at Henry Ford facilities.

“There is an old joke in health care that the only time a CEO isn't thinking about his or her organization is when under general anesthesia,” says Kelley. “In these jobs, one never can fall asleep at the wheel. With so many great people counting on me, my obligation is to give them 110 percent all of the time.”

No one is napping at the Henry Ford Medical Group. Under Doctor Kelley’s leadership, the Group and Health System have been consistently recognized as among the best in the country.
Kelley practices a four-pronged approach to leadership in health care:

- Put patients and their care first
- Recruit and retain the best people
- Support the academic mission of organizations like the Henry Ford Medical Group
- Use society’s resources wisely

“We cannot burn peoples’ money, whether that’s the federal government, businesses or patients. At the end of the day, society decides what it wants to pay for health care. Our job is to advocate for our patients and provide them great value.”

This approach to leadership has proven effective. In 2011, Henry Ford Health System became the largest health care organization ever awarded the Malcolm Baldrige National Quality Award, an honor presented by the Office of the President of the United States in recognition of innovation and performance excellence.

This April, the System also received the prestigious John M. Eisenberg Patient Safety and Quality Award for its successful “No Harm Campaign,” which aims to decrease harm events through enhancing the system’s culture and standards of safety.

From 2008 to 2011, Henry Ford’s “No Harm Campaign” resulted in a 26 percent reduction in harm events and a 12 percent reduction in mortality system-wide. By comparison, the average reduction in harm events is roughly one to two percent per year in most US hospitals.

“The key to improving health care is looking at the whole spectrum of disease and figuring out where we can make the most impact,” explains Kelley. “We have to continually intercept problems up the stream, before they become more serious.”

According to Kelley, integration in health care is critical, but it means more than simply facilitating better and more comprehensive on-site patient care. Working with broader physician groups like the Wayne County Medical Society of Southeast Michigan and the Michigan State Medical Society (MSMS) provides a platform for physicians to advocate on behalf of their patients.

Groups like MSMS have made the practice of medicine better, Kelley argues, by providing a unified voice for patients in Lansing. Kelley is a respected voice at MSMS and has witnessed first-hand the benefits of collaboration with other physicians, practices and medical groups.

“Practicing medicine is difficult and physicians do not want to be isolated,” says Kelley. “MSMS is able to provide lawmakers a very reasoned, professional view from the perspective of physicians while also empowering us to learn from and support our colleagues across the state.”
Kelley points to recent proposed state cuts to graduate medical education (GME) funding as an example of the type of advocacy that is only possible when physicians work together. “Once lawmakers understood that training house staff in Michigan is essential to its supply of doctors, they backed away from many of the cuts,” said Doctor Kelley, who recently served on the Council on Graduate Medical Education, which advises Congress on issues related to the national physician workforce. “That victory would not have happened without a strong physician voice in Lansing.”

Fostering and promoting research and education are a key part of the mission of the Medical Group and an area of intense focus for Kelley, making the victory on GME particularly important. The Medical Group trains more than 700 students and residents each year and conducts more than $55 million in biomedical research annually.

“Thanks in large part to our research and graduate medical education, Henry Ford is at the cutting edge of patient care,” Kelley said. “We want to know what really works, what restores patients to better health and what is cost effective.”

As physicians in the Henry Ford Medical Group provide world-class, innovative care for their patients and train tomorrow’s doctors, Kelley is keeping his eyes fixed on the future. The mark of any successful leader is, after all, figuring out where his organization and industry are going, not where they’ve been.

But even as technology evolves, new treatments are developed and delivery methods improve, there is one bedrock principle Kelley lives by that is as old as medicine itself. “My dictum to everyone at Henry Ford is that ’Job One’ is to take great care of our patients. At the end of the day, it’s the only thing that matters.”

And if you tune in to the Paul W. Smith show during your morning commute, you’ll find out what Doctor Kelley’s patients and regular listeners already know — he is a man who practices what he preaches. MM

The author is Director of Communications at Resch Strategies in Lansing.
Turn Your Premium Into an Investment in Medicine
A Message from MSMS Treasurer Venkat Rao, MD

As your MSMS Treasurer, current member of the MSMS Physicians Services, Inc. board of directors, and former Chair of the MSMS Finance Committee, I have examined the business potential of our subsidiary, MSMS Physicians Insurance Agency. The Agency can, and should be, an even larger part of the financial infrastructure that supports the advocacy and services provided by your medical society—and helps to keep your MSMS dues costs down.

There is a simple step you can take to help strengthen and secure MSMS’s financial base: Switch your professional and personal insurance coverage to MSMS Physicians Insurance Agency.

Consider This:
No other insurance agency invests its margin back into advocating for Michigan doctors. No other agency services ONLY physicians, or understands their unique needs for their practices, families and employees. And no other agency will strive harder to provide the quality and level of attention you deserve as a physician member of MSMS.

All doctors have insurance for professional liability, health, dental, life, home, auto and more. MSMS Physicians Insurance Agency offers high quality coverage at very competitive rates. So, I urge you to lead by example and make the switch to MSMS Physicians Insurance Agency to strengthen your medical society.

Please contact Beth Elliott soon for a quote at bellott@msms.org or 517-336-5789—or request a quote online at www.mymsmsinsurance.org.

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AMA Alliance Celebrates 90 Years!

By Kathy Adams

Since 1922, the American Medical Association Alliance (AMAA) has been advocating and educating on behalf of medicine, physicians, and medical families. Convening in Chicago for its annual meeting June 17-19, the AMAA celebrated its 90th birthday in style. Cowboy boots and yellow roses set the theme, as AMAA members recognized its new president Pat Hyer of Fort Worth, Texas. The AMAA’s first president, Mrs. Samuel Red, was from Houston, Texas. A visual history of the AMAA’s 90 years was shown during the reception to honor Ms. Hyer, as well as all the past presidents.

Announced at the annual meeting was the news that the AMAA has hired NewWave Group (NWG), a management company based in Maryland, to manage the Alliance following the departure of the Alliance Executive Director in 2012. NWG President Pat Troy was a visible presence throughout the meeting. She spoke briefly to the crowd, stating that NWG believes in the Alliance and understands the culture of giving back to the community. Ms. Troy believes the AMAA has visionary leadership, an amazing board, and energetic, enthusiastic members. She also admitted that she is a person who loves change, and the AMAA is poised to make and undergo changes.

Outgoing AMAA president Emma Borders stated, “With change are new opportunities.” The AMAA continues to change to attract younger members and reflect changes in medicine – as well as changes in how the Alliance views its role. The AMAA is undergoing changes in strategy and structure, changes in technology services, and changes to build a more accurate and enhanced database through its association with NWG, which will aid in building membership and positioning the AMAA better in the future.

Leadership development training sessions were an important part of this annual meeting. Dynamic Alliance members and guest speakers presented topics about how to be a leader, how to prepare and speak to a group, and how to plan your year as an Alliance leader. Harry M. Jansen Kraemer, Jr., professor of Northwestern University’s Kellogg School of Management and former chairman and CEO of Baxter International, was the keynote speaker. He spoke about the four principles of values-based leadership and presented each attendee with a copy of his book, From Values To Action.

Awards presented to state and county Alliances for outstanding projects in Health Promotion Awareness, Legislation Education and Awareness, and Medical Association Partners illustrated how physician spouses and partners continue to be involved, advocate, and educate to remain a productive and viable force in organized medicine.

The author is President of the MSMS Alliance, comprised of physicians’ spouses.
MICHIGAN STROKE NETWORK
presents
Innovations and Trends in Stroke Care

DATE: September 28, 2012  TIME: 8 a.m. – 2:00 p.m.
LOCATION: Soaring Eagle Casino and Resort
Mt. Pleasant, MI 48358

For more information or to register, contact Karen Parrott,
St. Joseph Mercy Oakland Continuing Medical Education Coordinator at
(248) 858-6225 or parrottk@trinity-health.org.

St. Joseph Mercy Oakland, an organization Accredited with Commendation by the Michigan State Medical Society (MSMS)
accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education
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Summer is here and soon adolescent patients will come flocking into the office for their annual sports physical. This year, beat the back-to-school rush and immunize all adolescent patients throughout the summer. Utilize sports physicals to catch-up adolescents with missing doses. Every time an adolescent patient arrives at the office – whether for a preventive or sick visit – it is an opportunity to immunize that patient with needed vaccines.

A key change was made to the 2012 adolescent immunization schedule for human papillomavirus (HPV) vaccine. Providers should now routinely administer HPV4 to males and HPV4 or HPV2 to females 11-12 years of age and catch up females 13-26 years of age and males 13-21 years of age. Males 22-26 years of age within a high risk group may be vaccinated, too. High risk groups include those who are immunocompromised due to infection (including HIV), disease or medication and men having sex with men. Consider vaccination for all other males 22-26 years of age.

It’s important to remember these additional recent changes to the adolescent immunization schedule. Meningococcal conjugate vaccine (MCV4) should be routinely administered at 11-12 years of age with a booster dose at 16 years of age. For those adolescents who need to be caught up on doses, if the first dose is given at 13-15 years of age, give a booster dose at 16-18 years of age; if the first dose is given at 16 years of age or older, a booster dose is not recommended. Other individuals may need MCV4 vaccine based on age or risk factors. The rate of invasive

**Vaccines Recommended During Adolescence**
- Meningococcal
- Tetanus-diphtheria-pertussis
- Human papillomavirus
- Varicella (chickenpox)
- Influenza
- Hepatitis A
- Hepatitis B
- Measles/mumps/rubella
- Polio
meningococcal disease among individuals 17–20 years of age is about twice that of the general US population; therefore, it’s critical to protect adolescents by ensuring they receive both doses of MCV4 vaccine according to the recommended schedule.

Another important vaccine for adolescents to receive is tetanus-diphtheria-pertussis (Tdap) vaccine. When pertussis protection is needed, there is no minimum interval between the last dose of a tetanus or diphtheria-containing vaccine (DTaP, Td) and a dose of Tdap. Pregnant adolescents who have not previously received Tdap should receive a dose during their third trimester or late second trimester (after 20 weeks gestation). Children aged 7-10 years of age without a complete DTaP/Td series should receive 1 dose of Tdap in place of a dose of Td. Tdap is routinely given at 11-12 years of age.

Sometimes parents of adolescents may come into your office and only want the vaccines required for school entry. Please take time to talk to these parents about the importance of immunizing their adolescent child according to the recommended schedule, including flu and HPV vaccines.

The Adolescent Immunization Toolkit is available at www.michigan.gov/teenvaccines to address all of your adolescent immunization needs in Michigan. Here you will find helpful tools, such as:
- Quick Looks (one page summaries of key points an immunizer must know before giving a particular vaccine)
- Standing Orders
- Storage and Handling Resources
- Vaccine Administration Resources
- Vaccine Safety and Patient Education Resources (posters, flyers, brochures for your office)
- Adolescent Immunization Coverage Levels
- And Much More!

The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the Society for Adolescent Medicine (SAM), and other professional medical organizations recommend that providers vaccinate based on current Advisory Committee on Immunization Practices (ACIP) recommendations. In doing so, Michigan’s school immunization requirements will be met.

Integrating vaccine administration with other preventative and acute health care visits, along with following the current ACIP immunization schedule, are key strategies to ensuring patients have received all needed immunizations.

The April 20, 2012, Morbidity and Mortality Weekly Report (MMWR) updates an earlier MMWR on measles in the US during the first five months of 2011. Importations of measles into the US continue to occur, posing risks for measles outbreaks and sustained measles transmission. During 2011, a total of 222 measles cases and 17 measles outbreaks were reported to CDC, the highest number of US measles cases in 15 years. Most patients (86 percent) were unvaccinated or had unknown vaccination status. Of the 222 cases, 112 (50 percent) were associated with 17 outbreaks, and 200 (90 percent) were associated with importations from other countries, including 52 (26 percent) cases in US residents returning from abroad and 20 (10 percent) cases in foreign visitors. Of the 222 cases, 70

Measles: A Continuing Concern

Integrating vaccine administration with other preventative and acute health care visits, along with following the current ACIP immunization schedule, are key strategies to ensuring patients have received all needed immunizations.

For More Information
- www.michigan.gov/immunize
- > Provider Information
- > Key Facts about Measles
- www.cdc.gov/measles

Imports of measles into the US continue to occur, posing risks for measles outbreaks and sustained measles transmission. During 2011, a total of 222 measles cases and 17 measles outbreaks were reported to CDC, the highest number of US measles cases in 15 years.
individuals required hospitalization. In 2011, Michigan recorded two measles cases; both cases were adults with unknown measles immunization history. In 2012 to date, there has been one measles case reported in Michigan.

The incidence of measles in Europe in recent years has been much higher than in the US. Several European countries, including the UK, have had widespread measles in recent years due to declining rates of vaccination.

Immunization Conferences Announced for Fall 2012
The MDCH Fall Regional Immunization Conferences have been approved for 2012:
• Oct. 9 – Gaylord
• Oct. 11 – Marquette
• Oct. 18 – Troy
• Oct. 30 – Dearborn
• Nov. 1 – Bay City
• Nov. 2 – East Lansing
• Nov. 14 – Grand Rapids
• Nov. 15 – Kalamazoo

Conference registration will begin in mid-August. As more details become available, they will be posted online at www.michigan.gov/immunize (under Provider Information). A Save the Date flyer is posted on the 2012 Fall Regional Immunization Conferences web page.

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France alone had over 15,000 cases and six deaths in 2011. This raises concerns about the 2012 Summer Olympics in London. The CDC is concerned that unvaccinated travelers could bring the disease back with them. The most important thing travelers can do to avoid bringing measles back is make sure they are up to date on their vaccinations. Travelers to the Olympics and other overseas venues should consult a physician to make sure that they have been vaccinated before departure.

These cases underscore the ongoing risk for measles among unvaccinated persons and the importance of vaccination against measles. As a reminder:

- MMR vaccine is recommended at ages 12–15 months and again at 4–6 years.
- Two doses of MMR vaccine are recommended for unvaccinated health care personnel, international travelers, and students at post-high-school educational institutions.
- Adults without evidence of measles immunity should receive 1 dose of MMR vaccine.
- All persons aged ≥ 6 months who will be traveling outside the Western Hemisphere and are eligible to receive MMR vaccine should be vaccinated before travel. Children ≥ 12 months should receive 2 MMR doses (separated by at least 28 days) before travel.

Sources

New MMR Vaccine Information Statement

The MMR Vaccine Information Statement (VIS) was updated in April and is posted on the Michigan Department of Community Health (MDCH) website. Health care providers should begin using the new VIS immediately. In Michigan, it is important that vaccine recipients, their parents, or their legal representatives be given the Michigan versions of VIS because they include information about the Michigan Care Improvement Registry (MCIR). By state law in Michigan, parents must be informed about MCIR. Vaccine Information Statements that are obtained from other sources (e.g., from the CDC or IAC websites) do not contain information about MCIR.

Translation of other languages will be available at a later date. Please note that when the foreign language VIS is not the most current version, parents should also be given the current English version.

The updated Important VIS Facts handout, which lists all the current VIS dates, has also been updated.

These documents are posted on the MDCH website at www.michigan.gov/immunize under “Vaccine Information Statements.”

Preferred Products and Service for MSMS Members.
Welcome to These New MSMS Members

Yaw Appiagyei-Dankah, MD, Grand Rapids
Mark W. Armstrong, DO, Sparta
Humphrey O. Atiemo, MD, Milford
Nasser Azeez, MD, Novi
Wafa S. Barkho, MD, Farmington Hills
Suzan M. Beydoun, MD, Westland
Jennifer M. Burgess, DMD, Grand Rapids
Chi Ling Braunreiter, MD, Bloomfield Township
Hebah Hefzy, MD, Bloomfield Township
Sarah J. Brown, DO, Grand Rapids
David Anthony Bruno, MD, Grosse Pointe Shores
Timothy Cameron Griffin, MD, Grand Rapids
Richard Linas Bryce, DO, Royal Oak
Jennifer M. Burgess, DO, Commerce Township
Mark D. McAllister, MD, Bloomfield
Nisha Chellam, MD, Novi
Adrienne Choksi, MD, Ann Arbor
Henry D. Cane, MD, Novi
Matthew Colligan, DO, Marquette
David C. Cortez, MD, Petoskey
Soumitra Datta, DO, West Bloomfield
David Scott Dickens, MD, Grand Rapids
Jason Coles, MD, Grand Rapids
Matthew Colligan, DO, Marquette
Ulrich Duffner, MD, Grand Rapids
Allison J. Fabian, DO, Wyoming
Marianne M. Franco, MD, Royal Oak
Karen L. Garibaldi, MD, Grand Rapids
Joshua J. Gibson, MD, Bloomfield Hills
Philip Alain Gill, MD, West Bloomfield
Timothy Cameron Griffin, MD, Grand Rapids
Rabbi Kriakoss Hanna, MD, Bloomfield Township
Jennifer Lynn Harrington-Thompson, MD, Oak Park
Hebah Hefzy, MD, Bloomfield Township
Kimberly F. Heller, MD, Farmington Hills
Luke D. Heskett, MD, West Bloomfield
David R. Heyboer, MD, Grandville
Doreen Ibrahim, MD, Farmington Hills
Rodger Dale Jackson, Jr, DO, Chesterfield
Ellen M. Jansyn, MD, Holland
Papai Kar, MD, Ypsilanti
Christian Ernst Keller, MD, Bloomfield Hills
Michael Kolinski, DO, Grand Rapids
C V Krishnamoorthy, MD, Redford
Beth A. Kurt, MD, Grand Rapids
Brian Robert Lane, MD, Grand Rapids
Zachary C. Leonard, MD, Marquette
Lisa M. Lowery, MD, MPH, Grand Rapids
Kavita Luthra, MD, Jackson
John G. Maccart, MD, Saint Joseph
Gregory J. Makris, MD, Troy
Vinayak A. Manohar, MD, Royal Oak
Paul R. Mark, MD, Grand Rapids
Ramalingam Maruthavanhan, MD, Novi
Lauren W. Mazzurco, DO, Plymouth
Mark D. McAllister, MD, Bloomfield
Ryan Molli, DO, Livonia
Cheryl J. Mordis, MD, Northville
Michael D. Nauss, MD, Canton
Fellipe Oliveira, MD, Detroit
Peter W.L. Olson, MD, Grand Rapids
Jharana Patel, MD, Novi
Willie J. Pettway, MD, Detroit
Christopher C. Pfeifer, DO, Jackson
Al L. Romero, MD, Escanaba
Alla Ark Sakhrova, MD, Berkley
Margaret M. Samaan, MD, Troy
Eric C. Santos, MD, Grand Rapids
Yashesh R. Savani, MD, Ada
Leigh M. Seamon, DO, MPH, Grand Rapids
Liat Shama, MD, Troy
Eugene M. Shatz, MD, Grand Rapids
Fang Shi, MD, Beverly Hills
Peter Sholler, MD, Grand Rapids
Akanksha Shravastava Hanna, MD, Farmington Hills
Sharon L. Siefert, MD, Sparta
Daniel Scott Siegal, MD, Ann Arbor
Maria D. Soto, DO, Jackson
Sarah E. Strong, DO, Holland
Mariya V. Suchyta, MD, Grosse Pointe Farms
Elena J. Tanner, MD, Grand Rapids
Nathan Taylor, MD, Marquette
Peter G. Tucker, MD, Grosse Pointe Park
Christopher W. Uggen, MD, Kalamazoo
Kausik Umanath, MD, West Bloomfield
Bruce A. Van Dop, DO, Whitehall
Karen S. VanderLaan, MD, Grand Rapids
Mauricio Velez, MD, Birmingham
Gargi Vidhonia, MD, Canton
Sylvana Yalda, MD, Rochester Hills
Ferras Zeni, MD, Bloomfield
Brett T. Zimmerman, DO, Holland

Obituaries

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

Richard B. Atkins, MD
West Bloomfield, died April 6, 2012, at the age of 60

Alfredo Guillermo Fleurquin, MD
Birmingham, died April 21, 2012, at the age of 80

Mary M. Krause, MD
Rochester Hills, died April 8, 2012, at the age of 56

Donald S. Schaefer, MD
Kalamazoo, died May 28, 2012, at the age of 81

David B. Sutton, MD
Muskegon, died April 21, 2012, at the age of 60

James M. Tschirhart, MD
Saginaw, died April 12, 2012, at the age of 55

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.

### Report Dated: 4-1-2012 through 4-6-2012
- **Daniel C. Voglewede, MD**
  - El Paso, TX
  - 04/05/2012
  - Fine Imposed
  - Failure to Report/Comply
  - Sister State Disciplinary Action
  - Gary Willis Bailey, DO
  - Grand Rapids, MI
  - 04/05/2012
  - Probation
  - Fine Imposed
  - Violation of General Duty/Negligence
  - Technical Violation of the Michigan PHC

### Report Dated: 4-9-2012 through 4-13-2012
- **William F. Du Bois, MD**
  - Canadian Lakes, MI
  - 04/05/2012
  - CS License
  - Reprimanded
  - Fine Imposed
  - Technical Violation of the Michigan PHC
  - Walter R. Webber, DO
  - Conway, MI
  - 04/12/2012
  - Fine Imposed
  - Probation
  - Technical Violation of the Michigan PHC

### Report Dated: 4-14-2012 through 4-18-2012
- **John Joseph Faillace, MD**
  - Waco, TX
  - 04/05/2012
  - 06/15/2012
  - Reprimanded
  - Fine Imposed
  - Sister State Disciplinary Action
  - Failure to Report/Comply
  - Mark Alan Horton, MD
  - Jacksonville, FL
  - 04/13/2012
  - 05/16/2012
  - Fine Imposed
  - Reprimanded
  - Sister State Disciplinary Action
  - Eric Keith Lizerbram, MD
  - Carlsbad, CA
  - 04/13/2012
  - 05/16/2012
  - Fine Imposed
  - Reprimanded
  - Sister State Disciplinary Action
  - Mark Fredric Rottenberg, MD
  - Farmington Hills, MI
  - 04/13/2012
  - 05/16/2012
  - Fine Imposed
  - Reprimanded
  - Sister State Disciplinary Action
  - James Lee Sams, MD
  - Sandusky, MI
  - 04/13/2012
  - 05/16/2012
  - Fine Imposed
  - Reprimanded
  - Sister State Disciplinary Action
  - Howard B. Weinblatt, MD
  - Ann Arbor, MI
  - 04/13/2012
  - 05/17/2012
  - Summary Suspension
  - Lack of Good Moral Character
  - Failure to Report/Comply
  - 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.
- **Reprimand** – the written statement of rebuke from the Board that a specific activity of the licensee was a violation of the accepted standards of practice.
- **Revocation** – a licensee can not practice for a specified period of time; 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.

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**D I S C I P L I N A R Y  A C T I O N S**

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**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.

**Reinstatement** – the granting of a license with or without restrictions or conditions to an individual whose license was suspended or revoked.
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Conference on Child Obesity  
Date: Wednesday, September 12, 2012  
Time: 8:30 a.m. to 4:30 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, nurse administrators, public health specialists and all other health care professionals.

Michigan Conference on CME Accreditation  
Date: Thursday, September 13  
Time: 8:00 a.m. to 3:00 p.m.  
Location: Birmingham Conference Center, Beverly Hills  
Contact: Kathryn Barnes, (517) 336-5716 or kbarnes@msms.org  
Note: Continental breakfast and lunch will be provided.  
Intended for: Physicians, CME directors, educators, coordinators, and CME administrative staff members.

Conference on Bioethics  
Date: Friday, September 21 through Saturday, September 22, 2012  
Location: 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, all health care professionals, government officials, and all individuals interested in bioethical issues.

Advanced Practice Strategies for the Patient Centered Medical Home  
Date: Tuesday, October 23  
Time: 9:00 a.m. to 3:45 p.m.  
Location: Somerset Inn, Troy  
Contact: Caryl Markzon (517) 336-7575 or cmarkzon@msms.org  
Note: Continental breakfast and lunch will be provided.  
Intended for: Physicians, practice managers/administrators, executives, and all other health care professionals.

Symposium on Retirement Planning  
Date: Wednesday, October 24  
Time: 5:45 p.m. to 8:15 p.m.  
Location: Somerset Inn, Troy  
Contact: Cindy Wikstrom (517) 336-5733 or cwikstrom@msms.org  
Note: Dinner will be provided.  
Intended for: Retired physicians, those planning for retirement, office managers, and spouses.

147th Annual Scientific Meeting  
Date: Wednesday, October 24 through Saturday, October 27, 2012  
Location: Campus Inn, Ann Arbor  
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.

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  
Time: 7:00 to 8:00 p.m.

Session I  
Date: Friday, October 26  
Time: 8:30 a.m. to 12:00 p.m.  
Location: Somerset Inn, Troy  
Session II  
Date: Wednesday, November 14  
Time: 9:00 a.m. to 3:45 p.m.  
Location: Eagle Crest, Ypsilanti  
Follow-up Webinar  
Date: Thursday, December 6  
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 3:45 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  
Time: 9:00 a.m. to 4:00 p.m.  
Date: Thursday, December 13  
Time: 9:00 a.m. to 4:00 p.m.  
Location: The Henry Center for Executive Development, Lansing, Michigan

Two Webinars on Management Skills  
Date: Monday, November 19, 2012  
Time: 7:00 to 8:00 p.m.  
Date: Monday, December 3, 2012  
Time: 7:00 to 8:00 p.m.  
Contact: Jody Roethele, (517) 336-5734 or jroethele@msms.org  
Note: Continental breakfast and lunch will be provided.  
Intended for: Physicians.
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**Place:** Detroit Marriott at the Renaissance Center, 400 Renaissance Drive, Detroit, MI 48234

**Lodging:** Detroit Marriott at the Renaissance Center, 400 Renaissance Drive, Detroit, MI 48234

Register at: [www.henryford.com/cmeevents](http://www.henryford.com/cmeevents)

Tonya W. Hibbett, MBA, CME Representative, THIBBET1@hfhs.org, 313-916-8208 CME Office

**Cost:** $400/three-days, * $140/individual day* • Resident Rate: $100/3 days*

*includes congress sessions and materials, breakfast, lunch, breaks (3 day registration includes memory stick of sessions)

**CME Accreditation:** Henry Ford Health System designates this educational activity for a maximum of 23.0 AMA PRA Category 1 Credits™

**Target Audience:** Electrical & Electronic Engineers, Ophthalmologists, Optometrists, Bioengineers, Neurologists, Neurosurgeons, Neuropsychiologists, Nanotechnologists, Journalists, Visual Physiologists, Biomaterial Researchers, Medical Device Representatives, Corporate Regulatory Officials, Neuroanatomists, Neurpathologists, Neuroradiologists, Venture Capitalists

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Faculty Disclosure Statement: All faculty and planning committee members participating in continuing education activities sponsored by Henry Ford Health System are required to disclose to the audience any relevant commercial relationships, and/or non-FDA approved use of a drug or a device that is included in the presentation.

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Updates in Prenatal Diagnosis
Julie S. Moldenhauer, MD
Medical Director, Special Delivery Unit, Center for Fetal Diagnosis and Treatment, Children Hospital of Philadelphia; Assistant Professor of Clinical Obstetrics and Gynecology in Surgery, The Perelman School of Medicine, University of Pennsylvania, Philadelphia, PA

Genetics for the Women’s Health Care Provider
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ACCREDITATION
St. John Hospital & 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 the Grosse Pointe War Memorial, 32 Lakeshore Dr., Grosse Pointe Farms, MI 48236

For more information contact: 313-343-3877 as these may be subject to change.
Physicians Must Be Leaders – Or They Become Followers
by John G. Bizon, MD

The old saying “nature abhors a vacuum” applies to leadership as well. Major public issues, despite appearances, never lack for leadership. If money, influence, and the public welfare are involved, leaders will step forward to define, drive and exploit the issue. However, they may not be the leaders with the best ideas, or even the best of motives – they may just be the first to rush into the leadership vacuum.

Health care reform, nationally and in our state, faces just such a leadership gap at the moment. How we fund health care, the restructuring of our health system, liability issues, setting of priorities, and who has decision-making power are all up for grabs at present.

As I write this, we’re awaiting the US Supreme Court decision on the legality of major elements of the Patient Protection and Affordable Care Act. Yet the focus on this aspect may blind us to the bigger picture – whatever the outcome, the flux and uncertainty in our health care system will continue. And if we, as physicians, fail to step up as leaders, others will.

We’ve seen encouraging steps here in Michigan, proof that our physicians can and do take the lead in shaping new health care structures. Physician-led accountable care organization (ACO) initiatives are blossoming in the state, such as the DMC group in Detroit, Beaumont in Troy, and Pathways to Health here in Battle Creek. Muskegon, Ann Arbor, and Washtenaw County are among other areas of the state where physician organization (PO) and ACO innovation shows solid physician leadership.

This momentum is crucial, because ACOs will be a keystone of future health care reform structures. Physicians are the ideal leaders of this paradigm shift on health care. While other forces may seek to lead and shape this change, only physicians have patient concerns as their primary interest. Hospitals, insurers, and bureaucrats have a duty to stockholders or their bureaucracy – we have a duty to our patients.

Yet physicians in Michigan cannot evade leadership on one of our ongoing challenges – liability and tort reform. Here, a vacuum of physician leadership will bring disastrous consequences. The cost of providing care is directly tied to the demands of “defensive medicine” – tests and procedures primarily to fend off lawsuits. Beyond this invisible tax on health care, liability continues to shadow physicians. A recent AMA survey finds 61 percent of physicians had been sued by the time they were age 55, 40 percent more than twice. Yet no physician error was found in 37 percent of liability claims in a 2006 study, and some 64 percent of claims were later dropped or withdrawn – after inflicting physician legal costs and stress.

“Physician leadership” thus requires more than just taking the helm of big new care structures. It’s also demanded for the ongoing grassroots battle we must fight against those who would weaken Michigan’s physician tort protections. Sen. Roger Kahn has introduced a “Patients First” package of bills to strengthen liability shields, and end some of the inequities in our state medical tort system. Have you taken the lead in contacting your area legislators to support this initiative? Do they know how much “defensive medicine” adds to health care spending? Have you joined in MSMS outreach on liability reform? Are you acting as a Michigan physician leader – or as a follower?

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