

Michigan Medicine

Employment vs. Private Practice

What You Need to Know
When Choosing Your
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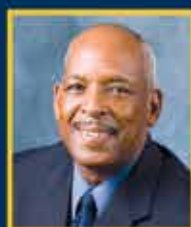
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Frequent Covenant-Not-to-Compete Issues in Employment Contracts

By Daniel J. Schulte, JD

QUESTION:

A potential employer has offered me an employment agreement containing a covenant-not-to-compete. The employer is a large group practice with two offices. Can the covenant-not-to-compete prohibit me from starting or joining a medical practice near either office? Will a 10-mile radius be enforced against me? This employment agreement states that if I breach the covenant-not-to-compete, then I will be automatically liable and must pay the employer a large penalty amount. Is such a penalty enforceable?

ANSWER:

These and other issues were addressed by the Michigan Court of Appeals in *St. Clair Medical, P.C. vs. Christopher Borgiel*. St. Clair Medical had two offices: one in Yale, Michigan, the other in Port Huron, Michigan. Doctor Borgiel worked almost exclusively at the Yale office. Doctor Borgiel had agreed in his employment agreement that he would not “embark on a medical practice within seven miles of either office for at least one year after” the termination of his employment with St. Clair Medical and that he would “reimburse the corporation \$40,000 if” he breached this covenant-not-to-compete. Doctor Borgiel then terminated this employment agreement and went to work for a medical practice located within seven miles of St. Clair Medical’s Port Huron office.

Can the covenant-not-to-compete apply to two offices when the employee works primarily at one?

Yes, if this is expressly stated in the agreement. The Court of Appeals in *St. Clair Medical, P.C.* held that the covenant-not-to-compete prohibited Doctor Borgiel from practicing at his new location, even though this location was within seven miles of the office that he provided little or no services at during his employment with St. Clair Medical.

Is a 10-mile radius from every practice location enforceable?

Probably. Doctor Borgiel, in the *St. Clair Medical, P.C.* case, argued that the seven-mile radius from the two offices was unreasonable. The Court of Appeals disagreed, relying on the Michigan Antitrust Reform

Act, MCL 445.771 et seq. and prior Court of Appeals’ decisions for the commonly understood proposition that a covenant-not-to-compete will be deemed reasonable if tailored to protect an employer’s reasonable competitive business interests and the protection provided to the employer in terms of the covenant-not-to-compete’s duration, geographic scope and the type of employment or line of business prohibited are reasonable. The Court of Appeals went on to explain that in a medical practice setting, a covenant-not-to-compete can reasonably protect against unfair competition from the departing employee resulting from the loss of patients following the departing employee to a new practice location. The Court of Appeals also recognized as reasonable the protection of the employer’s investment in the training of the employee and protecting the employer’s patient lists.

The reasonableness of a specific geographic restriction will depend on the facts and circumstances of each case. However, the Court of Appeals confirmed the reasonableness of a common approach to determining a reasonable geographic restriction to be used in medical practice covenant-not-to-compete agreements. This method involves determining where the medical practice’s patients are located and basing the geographic restriction on that particular area.

Is a covenant-not-to-compete unenforceable if it violates a professional code of ethics?

No. Doctor Borgiel, in the *St. Clair Medical, P.C.* case, also argued that the covenant-not-to-compete he had voluntarily entered into was unenforceable because the American Medical Association’s Principles of Medical

Ethics in some cases deem a covenant-not-to-compete to be unethical. The Court of Appeals disagreed, holding that the AMA’s ethical rule (when read completely) merely restated Michigan’s common law rule of reasonableness for determining whether a covenant-not-to-compete will be enforced. You should also know that the courts will enforce binding contractual obligations even if compliance with the obligation by a party would conflict with the ethical rules of an organization in which that party is a member.

Will a penalty clause be enforced?

No, but a liquidated damages clause may be. The \$40,000 liquidated damages provision contained in Doctor Borgiel’s contract was enforced by the Court of Appeals. A liquidated damages provision will be enforced if the amount is reasonable in relation to the possible injury suffered by the employer upon the employee’s breach of the covenant-not-to-compete. Liquidated damage amounts that are “unconscionable” or “excessive” and therefore are merely penalties will not be enforced. The amount of a liquidated damages provision in a medical practice covenant-not-to-compete must bear some reasonable relation to the expected loss of patient revenue arising from the employee’s breach of the covenant-not-to-compete. **MM**



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

EDITOR’S NOTE:

If you have legal questions you would like answered by MSMS legal counsel in this column, send them to: Jessy Sielski, Michigan Medicine, MSMS, 120 West Saginaw Street, East Lansing, MI 48823, or at jsielski@msms.org.



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Wind Turbines and Health

By Kenneth Rosenman, MD, FACE, FACPM

With initiatives for increasing the percentage of energy that is derived from renewable energy sources, more commercial wind turbines are being built. There are currently 14 operating commercial wind farms in Michigan with seven more being built (15 of 21 are in the Thumb). This has generated interest and some controversy about the potential safety and health concerns of these turbines. Michigan has no statewide regulations for siting wind turbines, so the regulation of siting (i.e., how close to homes, allowable levels of noise) is determined by county or local zoning boards, which typically do not have the scientific expertise to make such determinations.

The health issues related to the placement of commercial wind turbines are physical safety from structural collapse, blade failure or ice throw; shadow flicker; and noise exposure. An additional concern that is prevalent on the internet but does not have good scientific backing is Wind Turbine Syndrome, a vibroacoustic disease caused by impulsive infrasound that cannot be heard and is unrelated to the noise level.

To minimize the chance of injury from structural collapse, blade failure or ice being thrown from the blades, the minimum recommended setback from a residence for a wind turbine is the height of the tower plus the height of the blade in its vertical position. Some guidelines are more protective and recommend 1.1-1.5 times the above distance.

Shadow flicker occurs when the rotating blades of a wind turbine are positioned directly between the light and the reference point. Shadow flicker varies by

weather (sunny or overcast), time of day and season. Shadow flicker at any given location can be calculated and limitations for the number of allowable hours of shadow flicker can be specified.

Determining a safe noise level has generated the most disagreement. Noise levels from wind turbines are below levels that cause hearing loss. The concern about noise is centered on annoyance, particularly sleep disturbance. Recommendations of allowable noise levels have ranged from 40-55dBA (the noise level of a ringing telephone or whisper is 30 dBA). The more protective recommendation of a 40dBA limit to noise at night is based on selecting a level that prevents sleep disturbance and the health effects associated with sleep disturbance. The 40 dBA level is based on a consensus document from the World Health Organization (WHO), which reviewed the medical literature on environmental noise exposure and concluded that individuals who are exposed to 40 dBA measured as a yearly average of night noise outside the home are at increased risk of having increased heart rate, cardiovascular disease, hypertension, changes in sleep stages, increased awakening, an increase in body movement during sleep, self-reported sleep disturbance, increased use of sleeping pills, self-reported health problems, and insomnia-like symptoms. Constant sleep disruption can lead to increased heart rate, hypertension, an increase in body movement, and others. The studies conducted on noise have involved airport and road traffic noise.

Although there are no published, peer reviewed studies that directly link noise

from wind turbines with the adverse health effects reviewed in the World Health Organization Report, the MSMS Liaison Committee for Public Health "feels that there is no reason to suspect that turbine noise would be less harmful than noise from airport or road traffic."

In 2008, Michigan had sample guidelines, which have since been withdrawn, that recommended that the noise limits of wind turbines should be no louder than 55 dBA at the property line or lease boundary area, whichever is farther from the noise source. The MSMS Liaison Committee for Public Health "finds that this is a start but feels that the recommendations should be even more stringent and lower the decibel levels to no greater than 40 dBA at night."

The MSMS Liaison Committee with Michigan's Public Health recommended that the state develop and disseminate new advisory zoning guidelines for wind turbine usage. The committee believes these guidelines will be useful not only to local planning boards when siting wind turbines, but also to the physicians and other health care professionals who have patients that raise concern about the health effects of wind turbines. **MM**



The author is a member of the MSMS Liaison Committee with Michigan's Public Health.

RECOMMENDED READING:

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Thomas J. Petz, MD

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Sidney D. Kobernick, MD, PhD

Sarasota, FL,

Died October 6, 2013, at the age of 94.



Leo D. Parnagian, MD

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Died October 12, 2013, at the age of 82.



Earl R. Visser, MD

Grand Rapids,

formerly of Muskegon,

Died October 18, 2013, at the age of 82.



Walter J. Boerman, MD

Grand Rapids,

Died November 27, 2013, at the age of 85.

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Avoid Missed or Delayed Diagnosis by Being Aware of Risks for BRCA-Based Breast Cancer

Contributed by The Doctors Company

Recent news coverage has brought BRCA gene-based breast cancer into the spotlight. Actress Angelina Jolie's decision to get a preventive double mastectomy after testing positive for the BRCA gene may cause patients to ask physicians if they are at risk. Physicians should be aware of the risk factors for BRCA gene-based cancer in order to identify those who need testing and to avoid delayed or missed diagnosis.

A recent malpractice case highlights the failure of missing an early diagnosis. A 33-year-old woman had two female relatives, including her mother, who had breast cancer in their forties. At 31, she began getting annual screening mammograms, which showed dense breasts. She complained of a small palpable mass. However, no mass was seen on a mammogram, and the diagnosis was fibrocystic changes. No additional tests were ordered. Within six months, the mass was enlarging, and she was diagnosed with infiltrating ductal cancer that had advanced from a Stage I to a Stage III. Based on her history, she should have been tested for the BRCA mutation and given various treatment options. Additionally, no ultrasounds or MRIs were done, which possibly could have detected the cancer at an earlier treatable stage.

A woman's risk of developing breast and/or ovarian cancer greatly increases if she inherits a BRCA1 or BRCA2 gene mutation. Widespread screening is not required because together these mutations account for only 5-10 percent of breast cancers. Those with the BRCA1 mutation have a 55-65 percent chance of developing breast cancer by age 70, and those with the BRCA2 mutation have a 45 percent chance. Women have about a two-percent chance of getting ovarian cancer, but if they have a BRCA2 mutation, that risk increases to 40-60 percent.

Physicians should watch for the following BRCA mutation risk factors and discuss genetic testing with patients at risk:

- Maternal or paternal blood relatives with breast cancer diagnosed before the age of 50
- Certain cancers in a patient's family, such as pancreatic, colon, or thyroid
- Both breast and ovarian cancer in a patient's family, especially in one individual
- Women in a patient's family with cancer in both breasts
- Patient with Ashkenazi Jewish heritage
- A male in the patient's family with breast cancer
- Relative with BRCA1 or BRCA2 mutation

If the patient does test positive for the BRCA mutation, it is essential to remind her that this does not indicate she will get cancer. Patients can reduce risks of cancer with prophylactic surgery, hormonal treatment, and lifestyle changes. **MD**

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Employment vs. Private Practice: What You Need to Know When Choosing Your Practice Path

By Alicia Gallegos

After 10 years of caring for patients at his solo practice in Midland, internist David Randolph, MD, was burned out with running a business. He loved treating patients in his hometown, but the lack of pay and time-consuming work became too much to bear.

"I did a spreadsheet of my income over that 10-year period and saw it steadily declining," Doctor Randolph said. "It wasn't fun anymore. My son was born. I didn't want to spend the rest of my life practicing medicine and never seeing my family."

After much consideration, Doctor Randolph closed up shop and went to work for a larger health care group. Now a hospitalist for MidMichigan Physicians Group, which is part of the University of Michigan Health System, the doctor couldn't be happier. In his experience, the advantages of hospital employment far outweigh the benefits of solo practice, he said.

Doctor Randolph's story is not unique. He is one of a growing number of physicians in Michigan and across the country moving from private to employed

practice. In 2012, nearly 30 percent of physicians worked directly for a hospital (5.6 percent) or for a practice that was partially owned by a hospital (23.4 percent), according to an American Medical Association study released in September. Five years earlier, only 16 percent of physicians worked in one of the two settings, a 2007-2008 AMA survey found. Findings revealed also that 18 percent of physicians were in solo practice in 2012, a decrease of six percent since 2007. The number of physician practice owners in 2012 declined eight percent from 2007 to 2008.

Similar results were found in a 2013 study by Jackson Healthcare, a national health care staffing company and provider of technology solutions. In its survey of 3,456 physicians, Jackson found solo physicians decreased by six percent from 2012 to 2013, while hospital-employed physicians rose by six percent.

What is leading to this growing shift in physician employment? Perhaps more importantly, what are the advantages and



disadvantages of each practice type, and how can physicians determine the best environment for them?

Dissatisfied Physicians Leading Movement

The worsening climate of private practice is a main driver of employed-physician growth, said Peter Graham, MD, a Lansing family physician for Sparrow Health System. Reduced reimbursement, combined with new Affordable Care Act regulations and changing health care delivery models are making many doctors think twice about private practice, he said.



Peter Graham, MD

“Between electronic medical records and ICD-10, a lot of private physicians are saying, ‘We can’t keep going it alone,’” said Doctor Graham, a member of the Michigan Board of Medicine. “They’re looking at the future and saying, ‘This is terrifying.’”

In the Jackson survey, 42 percent of physicians reported being dissatisfied, with 17 percent saying they were dissatisfied in their medical practice. Dissatisfied physicians were more likely to be working 12 or more hours a day, be practice owners or work as locum tenens, the survey found. Doctors who were satisfied were more likely to be hospital employees or employees of a physician-owned practice with no ownership stake.

Electronic medical records, autonomy and practice leadership are key factors in physician satisfaction, according to an October study by RAND Corporation, a nonprofit research organization. The RAND project was sponsored by the AMA.

Doctors reported that the importance of delivering high quality care was a top contributor to overall professional satisfaction. While doctors noted some advantages of EHRs, physicians said the systems in use today are costly and cumbersome to operate, contributing to dissatisfaction. Physicians also described the cumulative burden of rules and regulations as being overwhelming and draining resources and time from patient care.

Greater physician autonomy and more control over the pace and content of clinical work also were associated to greater satisfaction, the study found. For some physicians surveyed, a leadership role within their practice was a primary way of achieving autonomy. However, some physicians reported little desire for the “business side” of medicine, deriving satisfaction from employed positions that enabled them to focus more on clinical care.

“Many things affect physician professional satisfaction, but a common theme is that physicians describe feeling stressed and unhappy when they see barriers preventing them from providing quality care,” said Mark Friedberg, MD, the study’s lead author and a RAND natural scientist.

A New Generation of Leaders

The new lens through which younger physicians view medical practice is another reason for the growing trend of employed physicians, adds AMA Board Trustee Joseph P. Annis, MD.

“A generation or more ago, physicians coming out of their training would go into small, solo practices,” he said. “Nowadays, young physicians coming out are realizing the difficulties of setting up your own practice and the [hoops] you have to jump through.”

Take Advantage of MSMS Employed Physician Services

Employed physicians are not immune to the challenges of outside forces targeting them and affecting the way they practice medicine every day. Learn about how MSMS can help you with these resources:

- **Contracting & Legal** – Employed Physician Contracting Checklist; Employed Physician Contract Review Service; Medical Staff Bylaw Review Service; Legal Alerts and Guides; MSMS Legal Counsel
- **Reimbursement & Coding** – Reimbursement Advocate Stacie Saylor, CPC; Reimbursement Advocate Alerts; Coding Alerts
- **Health Information Technology** – Alerts, patient portals, case studies, vendor tools, and a consultation service that brings HIT experts to physician offices; DocBookMD, a HIPAA-compliant mobile app
- **Education** – Clinical, leadership, retirement planning, HIT, etc. Past topics: Building an ACO with Your Physician Network; Employment Practice Models; Negotiating Arrangements; Selecting Partners in Care: Choosing an ACO; Payment Reform; Strategic Planning; Economic Trends in Health Care; Risk Contracting
- **Legislative Advocacy & Grassroots Political Action** – Recent wins: Passed Medicaid expansion; Passed Tort Reform; Passed Universal Prior Authorization; Passed Impaired Driver bills. Current Issues: Nurse Practitioner Scope Expansion; Nurse Anesthetist Scope Expansion; Auto No-Fault Reform; Patient’s Right to Know (transparency); Indoor Tanning Ban. Resources: “Doctor of the Day” in Lansing; Michigan Doctors’ Political Action Committee (MDPAC)
- **Leadership Opportunities** – MSMS Organized Medical Staff Section; MSMS committees and task forces
- **Insurance & Financial Solutions** – MSMS Physicians Insurance Agency; WealthCare Advisors financial advice and investment management

Learn more at www.msms.org/employed.

A survey released in September by Athenahealth company Epocrates found nearly 70 percent of medical students in 2013 planned to practice within a group practice or hospital, a rise of 16 percent since 2010. Seventeen percent of students anticipated going into a solo or partnership practice. Concerns about work/life balance and medical liability lawsuits are reasons medical students may avoid such practices, the survey found.

Most students do not receive much guidance about managing

MSMS Offers Resources for Physicians in Solo or Group Practices

- **Contracting & Legal** – Starting or Joining a Practice Handbook; Medical Records Guide; Legal Alerts and Guides; MSMS Legal Counsel
- **Health Information Technology** – Meaningful Use Consultation Service at your office; DocBookMD, a HIPAA-compliant mobile app; alerts; patient portals; case studies; vendor tools
- **Education** – Clinical, leadership, retirement planning, HIT, etc. Sampling of topics: Practice Transformation (Patient Centered Medical Home, Accountable Care Organizations); Physician Executive Development Program; Payment Reform
- **Reimbursement & Coding** – Reimbursement Advocate Stacie Saylor, CPC; Reimbursement Advocate Alerts; Coding Alerts
- **Legislative Advocacy & Grassroots Political Action** – Recent wins: Passed Medicaid expansion; Passed Tort Reform; Passed Universal Prior Authorization; Passed Impaired Driver bills. Current Issues: Nurse Practitioner Scope Expansion; Nurse Anesthetist Scope Expansion; Auto No-Fault Reform; Patient's Right to Know (transparency); Indoor Tanning Ban. Resources: "Doctor of the Day" in Lansing; Michigan Doctors' Political Action Committee (MDPAC)
- **Leadership Opportunities** – MSMS sections, committees and task forces; MSMS House of Delegates; MSMS Board of Directors
- **Insurance & Financial Solutions** – MSMS Physicians Insurance Agency; WealthCare Advisors financial advice and investment management

MSMS's PO Council convenes regularly to address the needs of physicians in a PO setting. MSMS also has a department specifically dedicated to helping physicians in POs and other group settings. For more information, contact Joseph M. Neller, Director of Integrated Physician Advocacy, at 517-336-5775 or jneller@msms.org.

Learn more at www.msms.org.

a solo or private practice, said Raphael L. Yechieli, MD, a radiation oncology resident at Henry Ford Health System in Detroit.

"People who came from families with dads in solo practice, they were headed straight into that," Doctor Yechieli said. "For a lot of us, it's really what you end up being exposed to. You're really exposed to one academic, hospital model" in school, he said.

In Yechieli's opinion, physicians at larger hospitals and health care systems can make a greater impact, contributing to the draw of such employment.

"The scale of what you can do is much larger," he said.

Succeeding at Private Practice

Physicians who fail to consider private practice are selling the career path short, said Riverview family physician E. Chris Bush, MD. Doctor Bush has been in solo practice for 25 years and has no intention of hanging up his shingle.



E. Chris Bush, MD

Students should "spend some time in a private practice setting and get a feel for it," said Doctor Bush, immediate past president of the Michigan Academy of Family Physicians and part of the MSMS Organized Medical Staff Section. "They should at least know there are other models that have worked for years and years and that a subset of doctors in private practice are usually very happy."

The joys of private practice include being your own boss, making independent decisions and choosing which direction to take your practice, he said.

"You control the operation, which includes the hiring and the firing and the investments you'd like to make in the practice; the different ways you'd like to move the practice forward," he said. "I don't have to get permission to take time off. I work for my patients, not any larger employer."

Doctor Bush said his practice had some lean years when the economy collapsed, but it survived and is now doing well. He supplements his income by working at a nearby hospital. His practice – a patient centered medical home – is involved in a Blue Cross Blue Shield program that awards financial benefits for quality and efficiency. He credits MSMS for helping his practice achieve PCMH designation.

"[MSMS] has been instrumental in helping our group and groups across the state," he said. "They do so much for us in the way of advocacy."

Another advantage of private practice are the close-knit bonds physicians develop with patients, said Novi family physician Kim K. Yu, MD. Doctor Yu owned her own practice until about a year ago, when she became employed at a Dearborn Heights hospital.

"I had the most amazing relationships with so many families," she said. "I absolutely miss my patients, the continuity of relationships. I miss hearing about grandkids and graduations and all of that. That's the major thing, the relationships."

Life as an Employed Physician

Leaving private practice was one of the hardest decisions Doctor Yu ever had to make, she said, but it's a choice she does not regret. The move came after 10 years of solo practice,

declining reimbursement and accumulating costs for tools such as EHRs.

"It became unsustainable to continue that practice model," she said. "I work in urgent care now. I don't have any overhead. I don't have to worry about bills, health insurance ... it's been wonderful."

Along with ditching the burden of business management, working for a larger health care system allows doctors to better manage their hours, enjoy higher income and spend more

time with family, said family practice and emergency physician Lynn S. Gray, MD, MPH. He serves on the MSMS Board of Directors. Doctor Gray has been an employed physician for 17 years, but spent 15 years as a solo practitioner. He works for Ann Arbor-based Emergency Physicians Medical Group, which provides emergency services to Lakeland HealthCare facilities.



Lynn S. Gray, MD, MPH

"When I was in solo practice, many times my day off was not my day off because a patient would go into labor,"

he said. "Now I am able to schedule time off that's not affected by a last minute emergency."

Practicing as an employed physician enables Doctor Gray to interact regularly with colleagues, discuss insights and gain fresh ideas, he said. He believes group employment has aided



David P. Wood, Jr., MD

his growth as a physician and acted as a stimulus for his continuing medical education.

An employed practice environment also allows for better care coordination and stronger medical team communication, said David P. Wood, Jr., MD, a Royal Oak urologist and chief medical officer at Beaumont Health System. He also serves on the MSMS Board of Directors.

"You have a common electronic health record," he said. "You're able to seamlessly coordinate care of your patients between hospital and the office as part of a multi-specialty group. You're able to readily refer and get immediate feedback because everyone is using the same communication."

Potential Problems Stemming from Employment

However, being an employed physician is not without its challenges.

"Hospital people don't always speak the same language that doctors do," Doctor Graham said. "That can create friction."

Doctors coming from private practice are frequently unprepared for the level of regulatory rules and training that comes with hospital employment, said Doctor Wood. For example, accreditation requirements that address storage, maintenance of drugs and safety trainings.

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“Moving from the cottage industry of solo practice to working for a large company can be frustrating,” said Susan J. Shepard, RN, MSN, CPHRM, Director of Patient Safety Education at The Doctors Company (MSMS’s exclusive liability insurer). “Hospital administrators, hospital boards and the medical staff have to work together to make changes and improvements. This can be very challenging to physicians who have not had to work in such an atmosphere and are used to making their own decisions without input from others.”

Such regulations often do not exist in private practices, but as hospital employees, physicians must abide by the rules.

“It’s all good things, but it’s things they didn’t have to do before,” Doctor Wood said.

A lack of decision-making capacity can create discord among employed physicians. Hospitals may dictate certain treatment processes that must be followed or limit the type of medical equipment doctors can use.

“Between the director of the ER group and the hospital, they choose the equipment for us,” Doctor Gray said. “We do have some say-so, but they have the final decision. When I was in solo, the final decision was up to me.”

At the same time, attempting to change a policy or obtain a new device is can be a long, arduous process filled with red tape and complex procedures.

“Moving from the cottage industry of solo practice to working for a large company can be frustrating,” said Susan J. Shepard, RN, MSN, CPHRM, Director of Patient Safety Education at The Doctors Company (MSMS’s exclusive liability insurer). “Hospital administrators, hospital boards and the medical staff have to work together to make changes and improvements. This can be very challenging to physicians who have not had to work in such an atmosphere and are used to making their own decisions without input from others.”

Personality conflicts and difficult team members are another challenge for some employed physicians, said Doctor Yu.

When solo, “you have the opportunity to employ your own staff,” she said. “Thankfully, I work with amazing people, but I know other physicians who don’t have the best staff and have to live with it.”

Contract Conflicts

One of the most common disagreements among physicians and hospitals arise from misunderstood contract terms.

Some physicians sign hospital contracts without realizing or understanding the extent of termination clauses, compensation rules or potential breaches, said Norman P. Jeddeloh, JD, a Chicago-based health law attorney and partner in the Litigation Practice Group of Arnstein & Lehr LLP. He recently spoke on the issue of physician-hospital contracts at a 2013 American Bar Association conference. Contract conflicts can lead to ugly employment battles, payment fights and even legal disputes.

“There are really a whole range of [contract] issues,” Jeddeloh

said. Doctors “should always think about not just what the employment situation looks like today, but what might happen in the future.”

Johnnye L. Dennis, senior claims consultant for Lockton Companies, says first and foremost, physicians should never sign hospital employment agreements that pertains to all employed physicians.

“The terms should be specific to that physician and the intended employment responsibilities of that physician,” she said. “That means, of course, that lawyers who understand physicians and their practice should be involved with the drafting of the contract – or at the very least, reviewing the proposed terms of the contract.... Physicians are unique employees and their employment contracts need to reflect that uniqueness.”

Physicians should make sure they understand how hospitals address termination, Jeddeloh adds. For instance, whether terminated physicians have the right to a hearing, whether the termination must be reported to a databank and if doctors will lose their hospital privileges. In some cases, contracts forbid terminated physicians from working at nearby health systems or for competitors for a period of time.

Paying close attention to the reasons in which physicians can be fired is also important, legal experts stress. Some contract language says hospitals can terminate employees “for cause,” without defining what cause is. Other language cites “breach of contract” as a reason for termination without explaining what actions constitute breaches.

In addition, contract language should have a clear job description outlining specific duties and services to be performed and ensure that the physician’s rights as a professional are clearly defined, Dennis said.

“If clearly defined in the contract, the physician will be protected should there be future conflict between the hospital and physician with respect to independent exercise of medical judgment or matters of the medical profession and care of patients,” she said.

Qualified legal counsel can help physicians negotiate the terms of their contract and advocate their best interests, Jeddeloh added.

“One of the things that a knowledgeable health care attorney can do is help the physician understand the contract and what provisions are really of concern and what provision are not really of concerns and help prioritize them,” he said. “Obviously, the physician wants to get the best deal he or she can. Deciding which issues are really important and what issues are less important can be the difficult thing.”

Clearly, there is no practice environment that is better than the other. The key is finding the practice setting that most aligns with doctors’ individual goals, lifestyles and personalities.

Taking Proactive Employment Steps

To help address concerns and questions of physicians entering into employment, the AMA in 2012 adopted guiding principles that address contractual arrangements and other challenges arising from employment. The guidance includes a model contract for physician employment.

The principles also address six potentially problematic aspects of the employer-employee relationship, including conflicts of interest, advocacy, contracting, hospital-medical staff relations, peer review and performance evaluations and payment agreement. One of the most important principles is that physicians be able to comfortably voice concerns for their patients, Doctor Annis said.

"The patient's welfare must take priority," he said. "Sometimes physicians feel under pressure for productivity, performance or referrals, [but] physicians should be able to speak up for their patients and not be penalized in any way."

Doctor Graham encourages physicians considering hospital employment to ask lots of questions of their potential employer. Inquire about such things as governance issues, EHRs, medical equipment and how decisions are made, he said.

"Be very eyes wide open and be very realistic," he said. "It's going to change your practice, just acknowledge that. It's not just going to pay the bills. Be very willing and aggressive about asking questions."

Physicians who want to stay in private practice may want to consider hiring practice extenders or finding ways to increase their patient volume, Doctor Randolph said. MSMS is a great help for doctors who need advice on staying self-employed and

for increasing revenue. The medical society can also provide assistance to doctors who need help closing down a practice correctly.

"[MSMS] is a tremendous resource that I would encourage physicians to take advantage of," he said.

Privately practicing physicians should also be honest with themselves about what they are capable of enduring and when it might be time for a practice change, Doctor Yu said.

"They really have to think about their family situation and what they're able to tolerate in terms of pay," she said. They should "decide at which point they would be willing to change their situation from private to employee. I think they need to have an end point."

Clearly, there is no practice environment that is better than the other. The key is finding the practice setting that most aligns with doctors' individual goals, lifestyles and personalities.

"It's a matter of choosing the right fit," Doctor Graham said. "It's kind of like choosing the right college. Don't choose the place with the highest ranking, find the one that's the best match for you." **MM**



The author is an Indiana-based medical writer.

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When It Comes to Preserving the Physician-Patient Relationship in a Changing Health Care Landscape,

Doctor Anderson is Walking the Walk

By Stacy Sellek

One might say that The Doctors Company is a company built for physicians, by physicians, and of physicians. And its CEO firmly believes in those tenets and demonstrates his dedication to the medical profession through his leadership.

Although he didn't set out in his career to lead one of the largest professional liability insurers in the country, Richard E. Anderson, MD, FACP, has made it his mission since he took over in 2003 as CEO and President of The Doctors Company to put the physician-patient relationship back where it belongs: at the forefront of medical practice.

But it hasn't been easy with all the changes in health care over the last several decades.

"The most significant change has been the erosion of the doctor-patient relationship," he said. "It used to be that the physician was the advocate for the patient and no one doubted that, but now, managed care, accountants and lawyers are in the exam room with the physician. The doctor-patient relationship has become secondary to the insurance-patient relationship."

Another significant change, notes Doctor Anderson, is the consolidation of medical practice, which came about even before the advent of the Affordable Care Act.

"Remaining a cottage industry is not feasible for an industry like health care," he says. "This has been a profound change."

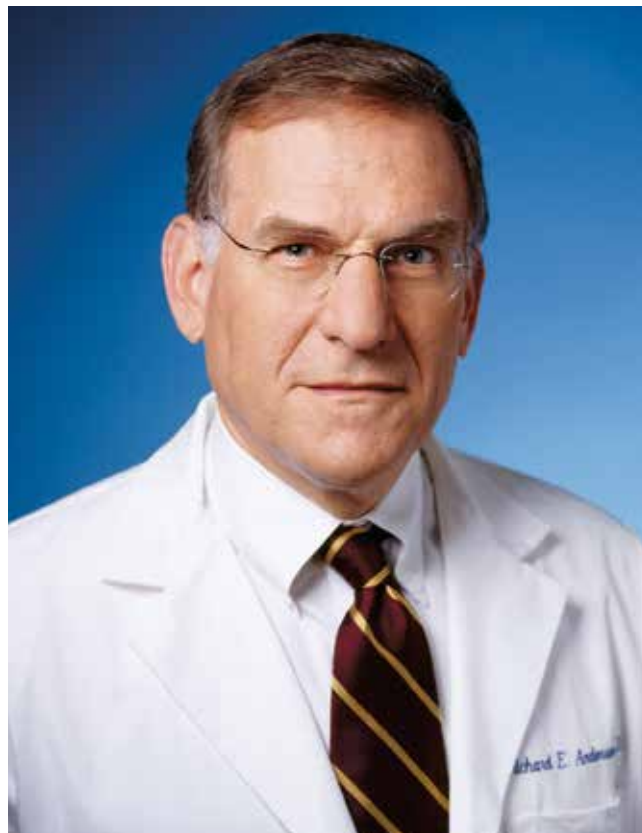
The Evolution of a Leader

"Neurosurgeons are powerful leaders," joked Doctor Anderson, himself a medical oncologist, as he explained to Michigan physicians in November the "serendipity" of how he was convinced by a colleague to become member of The Doctors Company.

In addition to serendipity, though, he attributes this transition to his "overwhelming belief that the current system of medical-legal jurisprudence does damage to medical care in US."

"As an oncologist, I was involved in the war on cancer. Medical malpractice litigation isn't the same life-death struggle, but it has exacted incredible damage on the health care system," he

"The doctor-patient relationship has become secondary to the insurance-patient relationship."



explains. "I felt a similar passion for making that system better."

After earning his medical degree from Stanford University Medical School, Doctor Anderson completed his medical residency at Harvard's Beth Israel Hospital School in Boston. He followed that with a postdoctoral fellowship in medical oncology back at Stanford Medical Center, and continued to practice as an oncologist for 25 years in California until transitioning into his executive role at The Doctors Company.

"It wasn't a planned evolution, but it was a necessary one," he says.

So what does Doctor Anderson miss most about practicing? "The art of medicine," he replies without hesitation. "And the wonders of patient care. I miss that every day. My highest professional attainment was becoming physician."

"On other hand," he continues, "I don't miss the day-to-day battles of delivering good medical care in a dysfunctional system."

"The practice of medicine is one of the glories of civilization. The art and science of healing bodies and minds is extraordinary."

Despite shifting from medical practice to executive leadership, Doctor Anderson remains involved in the issues facing physicians today through friends and colleagues who still practice, by keeping up on medical literature and conferences, and, more broadly, through the advocacy and the legal cases The Doctors Company defends every year.

"It's important to maintain an understanding of what good medicine is, what it looks like, and what is necessary to practice it today," he says.

On the Horizon

As MSMS and The Doctors Company continue working together to address the issues of patient safety, risk management and tort reform in Michigan, Doctor Anderson believes "Michigan is very strongly positioned."

"There are national medical institutions in the state, a strong voice of organized medicine through MSMS – a very forward-thinking organization, in my experience – and innovative programs coming out of the Veterans Administration for patient safety," he outlines. "There are a number of things that the country has learned from Michigan. The state sets out to practice the very best medicine."

Outside of his years "in the trenches" in medical practice, Doctor Anderson is also proud of some key professional accomplishments at The Doctors Company, and one in particular: "helping to build The Doctors Company into a significant force to advance, protect and reward the practice of good medicine."

"We've grown from a California company to the largest insurer of physicians in the US, with more than 75,000 members



Doctor Anderson emphasizes to the MSMS Board of Directors in 2010 the importance of protecting Michigan's tort reform laws by preserving a rule-of-law majority on the Michigan Supreme Court. The Michigan Doctors' Political Action Committee's grassroots action and support helped do just that with the re-election of Justice Robert Young and election of Justice Mary Beth Kelly later that year.

DOCTOR ANDERSON ON PHYSICIANS IN LEADERSHIP ROLES

When he presented to Michigan physicians in November at the MSMS Foundation Physician Executive Development Program, Doctor Anderson shared these perspectives:

- *Physicians still command respect in all areas except court and compensation.*
- *The learning curve is always there – you have to be willing to learn on the job.*
- *Look at the mission statement of your organization. If it's hackneyed and clichéd, be aware of it and rethink it.*
- *Micromanagement is a failure of leadership. Enable a culture that informs people how to make trade-offs and judgment calls without constant supervision.*
- *The way you see yourself is not at all important; it's how others see you that matters.*
- *Never lose sight of being a physician first.*



Doctor Anderson shares practical insights on leadership to physicians at the MSMS Foundation Physician Executive Development Program in November.

across the country," he notes. "We are in a unique position to be strong advocates for the profession."

When he's not working or travelling to speak and attend conferences, Doctor Anderson finds solace and balance in being a "passionate wilderness traveler" by combining hiking, backpacking, or rafting with his love of photography.

"When I'm working, I'm working, but when I get away, I get far away. I believe in working hard and playing hard," he says.

In addition, Doctor Anderson enjoys spending time with his family, which includes his wife, who works in health care, and two daughters, whom he jokes that he's both "proud and chagrined" are attorneys.

As for his future professional goals?

Doctor Anderson says, "Ultimately, I would like to play whatever part I can to get [physicians] successfully through the next 5-10 years of transition in health care." **MM**

The author is senior manager of communications at MSMS.

AMA Combats Prescription Drug Abuse Through Policy & Legislation

By Stacy Sellek

During the recent AMA Interim Meeting, physicians adopted four proposals dealing with drug availability, abuse, and pain management. The first policy gives a contemporary review of national drug control policy and calls for a variety of changes, including developing community-based prevention programs for at-risk youth and increasing the accessibility of treatment programs for substance use disorders.

A second policy aims to address opioid-associated overdoses and deaths. It directs the AMA to develop a set of best practices to inform clinical use of these drugs in managing persistent pain. It also calls for the Centers for Disease Control & Prevention to collect more robust data on unintentional opioid poisonings and deaths to develop appropriate solutions for preventing such incidences.

Another policy asks the Joint Commission to re-evaluate its accreditation standard for pain management; that standard should improve pain management practices.

The fourth policy requires the AMA Council on Science and Public Health to give a report evaluating the state of the nation's drug shortage crisis at each AMA policymaking meeting.

Getting Federal Funding

While the AMA Interim Meeting was taking place, Steven J. Stack, MD, immediate past chair of the AMA Board of Trustees, testified in Washington, DC, before the House Committee on Energy & Commerce's Subcommittee on Health to push for passage and full funding of a reauthorization bill that would help physicians combat prescription drug abuse while ensuring that patients in pain are relieved of their suffering.

Doctor Stack said that "appropriations to fully fund, mod-

ernize, and optimize prescription drug monitoring programs (PDMPs) have not kept pace with the escalation in abuse and diversion."

His testimony came as the House considers the "National All Schedules Prescription Electronic Reporting Reauthorization Act of 2013" (NASPER). PDMPs were designed to give physicians information about controlled substance prescriptions patients have obtained and filled from other prescribers.

However, Doctor Stack also told the subcommittee that "the majority of PDMPs still are not real-time, interoperable, or available at the point-of-care as a regular part of physician workflow." Reauthorization and full federal funding of NASPER would help modernize and make PDMPs fully interoperable, he added.

"To be helpful, it is essential that PDMPs are easy to use and provide reliable information to guide sound clinical decisions," Doctor Stack said. "When prescription drug monitoring programs support clinical decision-making, the efficacy is remarkable."

Doctor Stack also cited an Ohio pilot project that placed PDMPs in emergency departments and found that 41 percent of prescribers given reliable PDMP data altered their prescribing decisions. "Accurate PDMP data can directly inform sound clinical decisions, thereby reducing diversion and abuse while still ensuring that patients receive the care they need," he explained. **MM**

AMA Resources

A national sense of urgency to combat diversion and drug abuse has increased, and the AMA continues to work on a number of fronts to attack the problem while at the same time preserving access to medically necessary treatment for pain.

The AMA offers a host of resources to help physicians better understand trends in unintentional prescription opioid overdoses and the public health response, including a free webinar. Visit **www.ama-assn.org** (search "Combating Prescription Drug Abuse and Diversion").

MSMS Efforts & Resources

- MSMS received a block grant from CO*RE (Collaborative for REMS Education) to offer courses at the 2013 ASM, as well as an upcoming webinar about pain management.
- With direction from the House of Delegates this year, MSMS reintroduced the Mental Health & Substance Abuse Committee, which is working on the overuse of opioids, what physicians can do to provide alternatives and education on the use of opioids, and how to help serve those patients who are addicted to opioids.
- *Michigan Medicine* July/August 2013 issue – Opioid Use on the Rise: Is the Pen Mightier Than the Alternatives When It Comes to Chronic Pain Management? (**www.msms.org/michiganmedicine**)
- *Michigan Medicine* September/October 2013 issue – Opioid Abuse Puts Physicians Between a Rock and a Hard Place (**www.msms.org/michiganmedicine**)

Medical Clearance Does Not Clear the Patient or Physician of Risks

Contributed by The Doctors Company

Medical clearance” is when a surgeon requests clearance from an assessing physician before performing surgery on a patient. Cardiac risk is the number one reason to request medical clearance, but other risks that call for medical clearance include congestive heart failure, pulmonary embolism, anticoagulation, obesity, and high blood pressure.

Anticoagulants, for example, are often an issue in surgical claims. If the patient is taking anticoagulants, the surgeon and the physician should agree on the best approach for that specific patient. They may discuss changes in medical management that should be made to decrease risk. If they believe the patient is at risk from a respiratory perspective, the focus may be on early mobilization, incentive spirometry, and respiratory treatment.

To avoid malpractice risks, consider the following tips when dealing with medical clearance:

• Determine which patients need medical clearance.

The surgeon should assess the type of surgery and its associated risks and the health of the patient. Healthy patients with no underlying conditions who are undergoing fairly low-risk procedures don't routinely need medical clearance.

• Provide appropriate information.

Problems can arise when the surgeon does not provide enough information to the assessing physician about the surgery being proposed. The surgeon should provide information to the assessing physician about the type of surgery, how long it will take, what kind of anesthesia is anticipated, how long the patient will be immobile, what is involved in rehabilitation, and what the recovery period looks like. The assessing physician should take that information into consideration, along with exam results and knowledge of the patient, to determine if the patient is at increased risk.

• Develop a plan to mitigate risks.

The surgeon and the assessing physician should work together to determine the steps to take to mitigate risk preoperatively, intraoperatively, and postoperatively. For example, they should agree about which medications to stop preoperatively and which to continue.

There is no standard medical clearance process. Physicians should be aware of when a medical clearance would be indicated and have a good process to ensure it's done.

Medical clearance is a misnomer because it implies that the patient is cleared and there are no risks. No patient is free of risk when undergoing a procedure. The goals of the assessment are to determine the level of risk and to identify opportunities to mitigate risk – with the surgeon and the assessing physician working in concert. The decision about whether to proceed with the operation belongs to the surgeon and the patient. **MM**

For more patient safety articles and practice tips, visit www.thedoctors.com/patientsafety.



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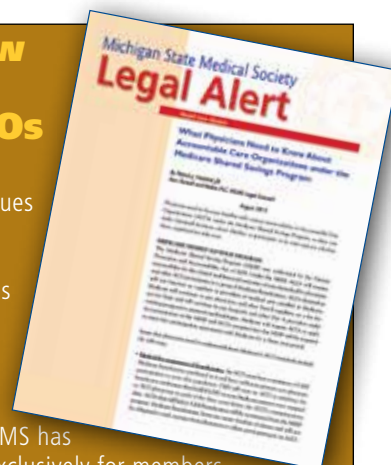
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Be in the Know about Legal Aspects of ACOs

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.**



Stepping Up to Stage 2

Congratulations to the Michigan physicians and other eligible professionals who have successfully participated in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs, otherwise known as “meaningful use.” This has not been an easy task. And, satisfaction and skepticism levels remain varied. For those physicians who began the journey in 2011 or 2012 and have been operating pursuant to Stage 1 meaningful use criteria for two to three years, 2014 presents the next hurdle with the advent of Stage 2 measures and expectations. Additionally, all meaningful use (MU) participants will need to upgrade their EHR software to be compliant with Stage 2 technical requirements. So, what steps should you take to get ready for Stage 2?

STEP 1: Upgrade Your EHR to the 2014 MU-Certified Version

If you have not done so already, check with your EHR vendor to make sure their product is certified to the meaningful use 2014 standards. If they have not yet been certified, find out their status and expected certification date.

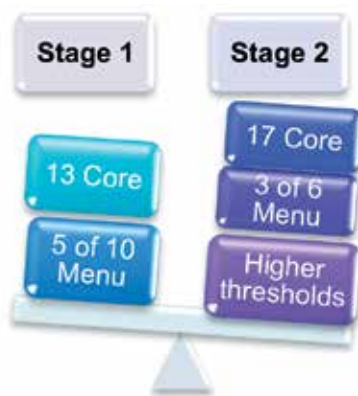
Questions for Your EHR Vendor

- When is their anticipated 2014 certification date?
- Are they able to upgrade the 2014 version to all users at the same time?
- Will they certify as complete or modular?
- Do they provide MU training and guidance? Included or for an extra cost?
- Are they able to provide interfaces, and at a negotiated price?
- Are they ICD-10 ready?
- Are they certified to submit PQRS data?

STEP 2: Prepare for Stage 2 Thresholds

Review Stage 2 requirements including new measures and enhanced metrics. As expected, Stage 2 has more core measures and higher thresholds. Many of the Stage 1 menu set measures are now required (e.g.,

patient lists by condition, structured lab values). Also, where practical, measures have been consolidated (e.g., electronic prescribing and drug formulary). There are six new measures – secure messaging (core), imaging results (menu), family history (menu), progress notes (menu), cancer registry (menu), and specialized registries (menu). Overall, there is a greater emphasis on and expectation for increased patient engagement and electronic communication and sharing of information.



Another change of which to be aware is the reporting period. Currently, the first year of meaningful use is defined by a continuous 90-day period within the calendar year. Subsequent years are reported based on a full calendar year of meaningful use. In 2014 only, all MU participants will report for a 90-day period. Participants in their first year of reporting MU under Stage 1 will choose any continuous 90-day period in 2014 (however, to avoid the 2015 MU penalty, you must start by July 1, 2014). Participants in their second year of Stage 1 MU or first year of Stage 2 MU will choose a 90-day period based on the calendar quarter – January 1, April 1, July 1, or October 1. This one-time change was made in recognition of the challenges physicians and other eligible professionals are likely to incur as they upgrade their EHRs and/or comply with the Stage 2 criteria.

STEP 3: Create a Patient Engagement Strategy

With the enhanced focus on secure messaging and online access for patients, patient portals will become the norm and

not the exception. Physicians and their staff should take this opportunity to examine portal solutions that best meet their and their patients' needs by streamlining workflows, providing access to appropriate patient data, and making available common forms.



Available Resources

MSMS offers a variety of services and resources intended to help physicians meaningfully incorporate technology tools into their every day practice. The MSMS Meaningful Use Consulting Service provides on-site assistance to physicians in any specialty or practice size to achieve Meaningful Use and receive the maximum incentive dollars available. DocBook MD offers free HIPAA-compliant messaging for MSMS members. Docright provides access to the latest information on EHR vendor products, education programming, and direct communication with other MSMS members and staff. Finally, legal alerts on patient portal usage and guidelines, selecting an EHR, contracting, and other timely issues can be found at www.msms.org/hit. **MM**

For More Information

Visit <http://www.cms.gov/EHRIncentivePrograms/> for resources and guidance provided by the Centers for Medicare and Medicaid Services. Michigan Medicaid resources can be viewed at www.michiganhit.org.

Chasing Investment Mirages

By Nathan Mersereau, CFP, AAMS

Physicians are often a target for all types of investment pitches. With an aptitude to understand complex subjects, they can presumably wade through these “opportunities” and make wise decisions. However, some of the brightest physicians hold the most unsuccessful investments. Many exotic investments promising steady returns and low risks end up with large losses – where the impact to your total portfolio can range from a minor contusion, to a near fatal accident that places it in the ICU.

Mirage investments often come in the form of private placements – some are successful, some are not. Examples include private real estate companies, budding tech companies, oil and gas-drilling programs, tax sheltered strategies and offshore investments. In recent history, the most infamous investment that caused losses for millions of investors involved collateralized debt obligations (CDO). Prior to facilitating the financial crisis in 2008, these “secure” investments were sold as a low-volatility, diversifier that consisted of “safe” residential mortgage bonds. Expansion of the CDO market was dependent on ever-rising home prices and loans to unqualified homebuyers – a bad combination. Investors were hit hard when the real estate market cooled and the financial crisis ensued.

There are some exceptions to the rule, but often trouble lies in both the type and structure of these investments. Most private placements sound exotic, certainly more so than publicly traded stocks and bonds, which may provide the illusion that they will yield better results. However, the typical outcome is greater complexity and a low or negative return on capital. If presented with any one of the following, be sure to get a second opinion before making a commitment.

- Non-Traded REITs
- Private Placements



- One-Drug Biotech Companies
- Oil and Gas Limited Partnerships
- Special-purpose Acquisition Corporations (SPACs)
- Principal Protection Funds
- Guaranteed-return Equity Index-linked Annuities
- Structured Products
- Self-clearing or Self-custody Advisors

Be extra cautious if the investment contains one or more of the following traits:

- Unable to sell the investment for a specified number of years

- Significant charges for liquidating the investment
- Lack of transparency or knowledge of the underlying holdings
- Excessive commissions paid to the selling broker (10 percent or more)
- Broker will not directly tell you how much they are paid for selling the product
- Value of tax write-off is emphasized more than the merits of the investment
- Lack of daily pricing

To avoid making an investment that you may later regret, do your homework on the product, read the fine print of the offering document, and ask the broker to clarify anything that you do not understand. If the broker cannot provide sound answers to your detailed questions, then it is likely that they do not understand all of the risks that may be involved. Even when the broker has answered your questions, it would be wise to get a second opinion from an objective third party who does not sell a similar product. Be mindful that greater complexity does not equate to a better investment opportunity.

Want to avoid making common investing mistakes? Request a copy of our newly released whitepaper *Eight Mistakes Physicians Make with Their Money and How to Avoid Them* by contacting co-author Joe Olekszyk at 888-958-1990 or download a copy from our website at www.wealthcareadvisors.com. **MM**



The author is President of WealthCare Advisors, LLC – an MSMS joint venture.

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MSMSA Legislative Day at the Capitol

By Karin Maupin

A recent study was done that examined the voting habits of 85,000 US adult citizens in congressional and presidential elections. The sample included 1,274 physicians and 1,886 lawyers. The result: doctors vote significantly less often than the general population, lawyers vote at a rate that is 22 percent above physicians and less than one third of all physicians vote! In response to these low statistics the Michigan State Medical Society Alliance (MSMSA) has decided to initiate a more active grassroots presence in the Michigan Medical Community.

On September 24, 25 members of MSMSA gathered in Lansing to prepare themselves for the first Legislative Day at the Capitol for 2013-2014. All interested county members, especially presidents and legislative chairmen were invited to attend. The day was planned by Cindy Ackerman, President of MSMSA, Karin Maupin, Legislative Chairman and Steven Japinga, Chief of Public Policy and Legislative Affairs for MSMS.

Steve Japinga worked tirelessly to set up an influential group of people

for us to visit. Amongst this austere population were Representative Matt Lori (R-Constantine) in charge of funding for Medicaid, and GME and sponsor of HB 4714 (a.k.a. the Healthy Michigan Plan or Medicaid Expansion); Senator Jim Marleau (R-Lake Orion), Chair of the Senate Health Policy Committee. Also included were Senator Tonya Schuitmaker (R-Lawton), who serves on the Senate Health Policy Committee; Senator John Moolenaar (R-Midland), Chair of the Senate Appropriations Department of Community Health Subcommittee and an important supporter of GME; and Representative George Darany (D-Dearborn), Minority Vice Chair of the House Health Policy Committee.

The MSMSA attendees were briefed on Scope of Practice Expansion (SB2) introduced by Sen. Mark Jansen (R-Grand Rapids) and the Health Care Professional Transparency Bill (HB 4524) sponsored by Rep. Gail Haines (R-Waterford Twp.). These issues the Legislative Day attendees felt very comfortable addressing, because of

their experiences as nurses, hospital and medical office staff.

As a grand finale we were invited to either go onto the House Floor or watch the Senate in action. We ended the day feeling empowered, wiser, fulfilled and ready for more. Steve Japinga, Cindy Ackerman, Karin Maupin and the rest of the staff that helped us that day Andrew Schepers, MSMS Chief Grassroots and Legislative Policy, and Matt Miner from Capital Strategies Corp. were very pleased with the response both from the legislators and attendees all of whom were looking forward to more grassroots experiences. **MM**



The author is chair of the MSMS Alliance Legislative Committee.



(l to r) Kandace Boysen, Nancy Fody, Suzanne Pederson, Lynn Moon, Kelly Narkiewicz, Rep. Matt Lori, Clara Sumeghy, Karin Maupin and Valerie Doane.

CDC and Michigan Celebrate the 20th Anniversary of the Vaccines for Children Program

An Update from
the Michigan Department of Community Health



first sent out in our newsletter Michigan Immunization Update, April 1994, alerting providers that enrollment would begin January 1, 1995.

This year is the 20th anniversary of the passage of the legislation at the federal level that established the Vaccines for Children program (VFC). This federal vaccine entitlement program is one of our nation's most successful public-private partnerships for improving public health. This national program helps provide vaccines to children whose parents or guardians may not be able to afford them. The VFC program helps more children get their vaccines according to the recommended immunization schedule – protecting babies, children and adolescents from 16 serious diseases, including measles, mumps, whooping cough, chickenpox, flu and diphtheria.

A disease history was important in the creation of the VFC program. Between 1989 and 1991, a measles epidemic in the United States resulted in tens of thousands of cases of measles and hundreds of deaths. Upon investigation, the CDC found that more than half of the children who had measles had not been vaccinated, even though many of them had seen a health care provider.

In response to the epidemic, Congress included the creation of the Vaccines for Children Program in the Omnibus Budget Reconciliation Act (OBRA) of 1993, which passed August 10, 1993. VFC became operational October 1, 1994. In Michigan, information was



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In June 1994, the Advisory Committee on Immunization Practices (ACIP) voted to expand the number of vaccines and their use in children and

adolescents eligible to receive vaccines in the VFC program. ACIP added hepatitis B and pneumococcal vaccines for those at high risk of disease; in addition, influenza and a second dose of MMR were added to the covered vaccines. ACIP continues to vote on additional vaccines that are included as covered immunizations for the VFC eligible populations.

Funding for the VFC program was approved by the Office of Management and Budget (OMB) and allocated through the Centers of Medicare and Medicaid Services (CMS) to the Centers of Disease Control and Prevention (CDC). The CDC buys vaccines at a discount and distributes them to enrolled VFC provider offices at no cost to the providers.

More than 44,000 VFC enrolled providers in the US receive vaccines.

Michigan has about 1,300 enrolled providers throughout the state.

The VFC program has contributed directly to a substantial increase in childhood immunization coverage levels and has made a significant contribution to the elimination of disparities in vaccination coverage among young children. These improvements in childhood immunization coverage have, in turn, led to the lowest vaccine-preventable disease incidence ever recorded. Today, nearly 20 years later, the VFC program continues to play a vital role in protecting our nation's health by sustaining high childhood immunization coverage levels to ensure vaccine-preventable disease incidence remains low.

Providers in Michigan who are interested in participating in the VFC program should contact their local health department regarding enrollment. Michigan needs more VFC providers, and MDCH encourages anyone who vaccinates children or adolescents to consider participating this is valuable program. **MM**



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Report Dated:

9-02-2013 through 9-06-2013

Lino Sevandal Dial, Jr., DO
Bay City, MI
51-01-014103
09/09/2013
Summary Suspension
Unethical Business Practice
Criminal Conviction
Lack of Good Moral Character
Failure to Report/Comply
Mental/Physical Inability to Practice

Report Dated:

9-09-2013 through 9-13-2013

Waddah H. Ghebe, MD
Taylor, MI
43-01-073451
09/20/2013
Summary Suspension
Technical Violation of the
Michigan Public Health Code

Carlos Max, MD
Miami, FL
43-01-029712
08/28/2013
Reprimanded
Probation
Fine Imposed
Failure to Meet Cont. Ed.
Requirements
Kenneth S. Merriman, II, MD
Hastings, MI
43-01-035154
09/20/2013
Summary Suspension
Violation of General
Duty/Impairment
Criminal Conviction – Drug Related

Report Dated:

9-16-2013 through 9-20-2013

Victor Abiragi, MD
Grosse Pointe Shores, MI
43-01-037600
10/11/2013
Probation
Fine Imposed
Reprimanded
Failure to Meet Cont. Ed. Requirements

Emanuel Joseph, Jr., MD
East Elmhurst, NY
43-01-067084
10/18/2013
Fine Imposed
Failure to Report/Comply
Sister State Disciplinary Action
Sibi Joseph Kottaram, MD
East Lansing, MI
43-01-047894
09/18/2013
Voluntarily Surrendered
Failure to Meet Cont. Ed. Requirements

Robert Charles Legg, MD
Troy, MI
43-01-053320
09/18/2013
Probation
Violation of General
Duty/Negligence
Failure to Report/Comply

R. Charles Medlar, M.D.
Jackson, MI
43-01-036871
09/18/2013
Reprimanded
Fine Imposed
Violation of General Duty/Negligence

Abdullahi Abdulkarim
Mohamed, MD
Monroe, MI
43-01-084848
09/18/2013
Summary Suspension
Dissolved
Suspended
Criminal Sexual Conduct
Lack of Good Moral Character
Failure to Report/Comply

Jonathan Robert Oppenheimer, MD
Nashville, TN
43-01-093654
09/18/2013
Reprimanded
Failure to Report/Comply
Sister State Disciplinary Action

Abdulhadi Sinan, MD
Dearborn, MI
43-01-058649
09/18/2013
Fine Imposed
Violation of General Duty/Negligence

Mervyn Winston Smith, MD
Grand Rapids, MI
43-01-053598
09/18/2013
Reprimanded
Criminal Conviction
Failure to Report/Comply

Thomas D. Spera, MD
Tucson, AZ
43-01-046233
09/18/2013
Fine Imposed
Sister State Disciplinary Action
Failure to Report/Comply

Aman Y. Upadhyay, MD
Clawson, MI
43-01-097312
09/18/2013
Administrative Complaint
dated 04/25/13 - Dismissed
Substance Abuse
Mental/Physical Inability to Practice
Impairment

Sami Salih Zamzam, MD
Grand Rapids, MI
43-01-072778
10/18/2013
Fine Imposed
Failure to Report/Comply
Sister State Disciplinary Action

Report Dated:

9-23-2013 through 9-27-2013

Brian James Gedeon, MD
Roscommon, MI
43-01-072128
09/28/2013
Summary Suspension
Mental/Physical Inability to Practice
Violation of General Duty/Impairment
Substance Abuse

Robert Martin, DO
Milford, MI
51-01-007975
09/26/2013
Summary Suspension Dissolved
Report Dated:
9-30-2013 through 10-04-2013

Milagros Tagorda Ebreo, MD
Port Sanilac, MI
43-01-032508
10/30/2013
Revoked
Lack of Good Moral Character
Criminal Conviction – Drug Related

Richard Charles Mendel, MD
Columbus, MS
43-01-097431
10/30/2013
Suspended
Sister State Disciplinary Action
Failure to Report/Comply

Kenneth S. Merriman, II, MD
Hastings, MI
43-01-035154
10/02/2013
Summary Suspension
Dissolved

Chilakamarri Ramesh, MD
West Bloomfield, MI
43-01-049350
09/30/2013
Reclassified w/Full & Unlimited License

Cande L. Sridhar, MD
Northridge, CA
43-01-040300
10/30/2013
Suspended
Failure to Report/Comply
Sister State Disciplinary Action

Ahmad S. Zia, MD
New York, NY
43-01-090919
10/30/2013
Suspended
Sister State Disciplinary Action

Explanation of Disciplinary Terms

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

Limitation – a restriction or condition imposed on a licensee by the Board for a specified period of time such as:

- confinement of practice to a location
- supervision of practice – either on-site or periodic review by Board or other Board approved licensee
- restriction of practice to specific activities
- no access to controlled substances
- no ownership or financial interest other restrictions or conditions deemed appropriate.

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

Probation – a disciplinary action in which the licensee's practice is conditioned for a given period of time or until specific requirements are met. Probation can include conditions such as:

- participation in the Health Professional Recovery Program
- submission of regular reports from employer or other specified individual
- completion of specific continuing education requirement
- no violations of the Public Health Code
- other conditions deemed appropriate.

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

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

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

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

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

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

MSMS Foundation Educational Conferences

Payment Reform: Advancing Quality and Affordability

Date: Wednesday, January 29, 2014

Time: 9:00 a.m. to 3:30 p.m.

Date: Wednesday, March 26, 2014

Time: 9:00 a.m. to 3:30 p.m.

Location: Somerset Inn, Troy

Contact: Caryl Markzon, (517) 336-7575

or cmarkzon@msms.org

Note: Continental breakfast and lunch will be provided.

Intended for: Physicians, executives, office administrators, and all other health care professionals.

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

Date: Thursday-Friday, February 27-28, 2014

Time: 9:00 a.m. to 4:00 p.m.

Location: Somerset Inn, Troy

Date: Thursday-Friday, June 5-6, 2014

Time: 9:00 a.m. to 4:00 p.m.

Location: Weber's Inn, Ann Arbor

Contact: Marcie Barnum, (517) 336-5724

or mbarnum@msms.org

Note: Continental breakfast and lunch will be provided.

Intended for: Coders and billers, billing managers, and physicians

**Additional dates/locations coming soon*

Spring Scientific Meeting

Date: Wednesday-Thursday,

May 14-15, 2014

Time: 9:00 a.m. to 8:15 p.m. (Wed.) and

9:00 a.m. to 4:15 p.m. (Thur.)

Location: The Henry in Dearborn

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

Annual Joseph S. Moore, MD, Conference on Maternal and Perinatal Health

Date: Thursday, May 15, 2014

Time: 9:00 a.m. to 4:15 p.m.

Location: The Henry in Dearborn

Contact: Marianne Ben Hamza, (517) 336-7581

or mbenhamza@msms.org

Note: Continental breakfast and lunch will be provided.

Intended for: Physicians, nurses, residents, students, and all other health care professionals working with women and their infants.



To Register Online: www.msms.org/eo

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PO Box 950, East Lansing, MI 48826-0950

Fax Registration form to: 517-336-5797

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Statin Controversies/Statin Intolerance: Real or Perceived

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Diastolic Heart Failure: Why We Remain Frustrated

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The Oral Anticoagulants: We Now have Options

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Update on ACS: 2013 Prospective

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Coronary CT: Where Are We At?

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Why Employed Physicians Need Organized Medicine

by Kenneth Elmassian, DO

Given the economic realities of health care today, such as the shift away from fee-for-service care, more Michigan physicians are weighing the pros and cons of remaining in private practice. Many are giving serious consideration to an employment model for a variety of reasons.

As physicians explore these alternative models, one fact remains: there will be no escaping the economic and political landscape of today's or tomorrow's health care challenges. Regardless of the practice model, physicians will face new hurdles in their quest to deliver patient-centered, physician-led health care.

For one thing, negotiating with a large hospital system or a large multi-specialty group single-handedly can be intimidating. Contract language is complex and multi-faceted. And after you've become employed, what happens if the relationship isn't what you'd hoped for?

Throughout your education and training, you've been taught, above all else, to put the patient first. You have to make sure your employer holds those same values. What are the alternatives if there is disagreement on what constitutes "best practice"? The AMA offers excellent guidance in its recently adopted "Principles for Physician Employment." The document's preamble states that the principles "are intended to help physicians, those who employ physicians, and their respective advisors identify and address some of the unique challenges to professionalism and the practice of medicine arising in the face of physician employment." The principles address conflicts of interest, advocacy for patients and the profession, and

contracting and payment agreements, among other issues. The bottom line is that these principles are designed to "provide broad guidance for employed physicians and their employers as they collaborate to provide safe, high-quality, and cost-effective care."

Regardless of the status of your practice model, you will never avoid today's professional reimbursement climate. Scope of practice issues, medical liability issues, and even public health issues also will affect you despite your practice setting. It's like Edgar Allan Poe's "The Masque of the Red Death." Even when the nobility locked themselves behind the castle walls, the deadly miasma still seeped in.

These are the reasons you'll need someone on your side when weighing your choices about employment. While privately practicing physicians should belong to the Michigan State Medical Society, employed physicians should belong, too, for their profession and for the well being of their patients. In negotiating with the health care systems, organized medicine offers you valuable resources for taking on employed physician issues.

For Example:

- On the legal and economic side, MSMS offers the MSMS Employed Physician Contracting Checklist that addresses key financial, legal and quality issues and the MSMS Employed Physician Contract Review Service that provides a thorough legal appraisal of your new or existing employment documents. MSMS legal staff can also help with many of your basic contracting questions at no charge, and provide more specialized advice at discounted rates. Our resources can help you find out what's "normal" for hiring terms, compensation, and benefits.

- In addition to the AMA "Principles" outlined above, the AMA offers specific information about contracting and reimbursement, as well as employment opportunities.
- MSMS offers employed physicians a virtual "safe house" through which they can discuss issues with trained staff and other employed physicians confidentially. It can be hard to stick your neck out and raise a quality, financial, or practice concern when your employer might find it disruptive. Being able to share stories, wisdom and strategies with other physicians who've "been there, done that" can strengthen your position.
- MSMS and AMA advocacy on Medicare, Medicaid, medical liability, scope of practice, public health issues affect every physician.
- Finally, MSMS can benefit the employed physician by helping you advocate for those who are really at the heart of any health care practice arrangement – your patients. Remember those Gerber Baby Food ads that said, "Babies are our business – our only business"? Well, for you and me, our patients' well-being is our only business. As a physician, you are the principal patient advocate. Your patients not only deserve it, they expect it, no matter the setting. **MM**



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

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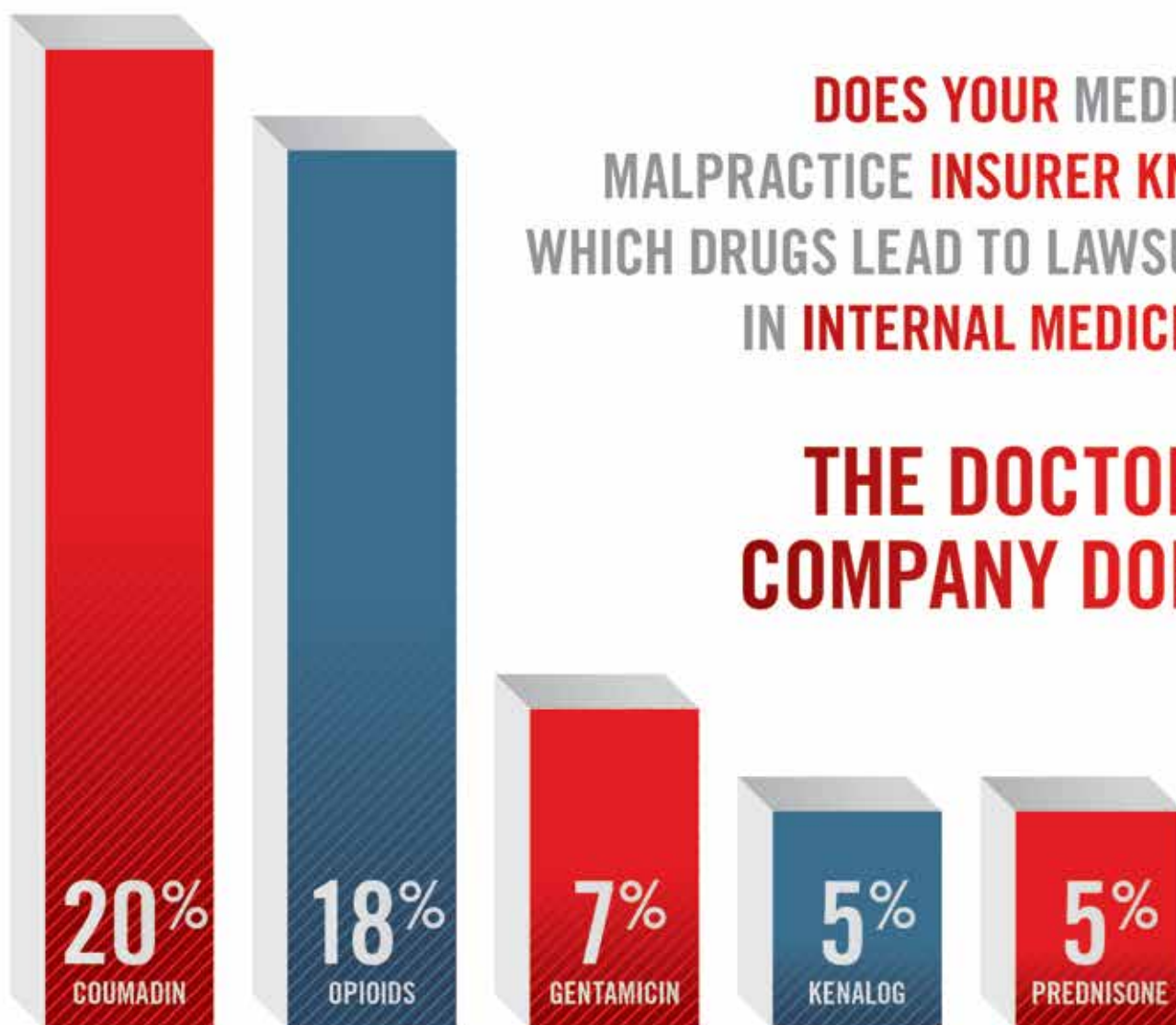


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