Increasing costs and regulatory red tape are driving solo and small practices to merge with larger entities

PAGE 13

Genomics Part 2: Action Items for Your Practice

The Sunshine Act Explained

Your Society Hard at Work for You
As a policyholder, I value ISMIE Mutual Insurance Company’s commitment to protecting Illinois physicians and our practices. ISMIE’s comprehensive risk management program is a benefit to policyholders and our patients. Founded, owned and managed by physician policyholders, ISMIE is focused on being our Physician-First Service Insurer.

ISMIE Mutual has continuously insured all specialties throughout Illinois since 1976. Policyholders know they can depend on us to remain committed to them not only as their professional liability insurance company, but also as an advocate and partner.

**Depend on ISMIE for your medical liability protection – so you can focus on the reason you became a physician: to provide the best patient care possible.**

Not an ISMIE Mutual policyholder and interested in obtaining a comparison quote for your medical liability coverage? Contact our Underwriting Division at 800-782-4767, ext. 3350, or e-mail us at underwriting@ismie.com. Visit our web site at www.ismie.com.
FEATURES

13 The New Reality: Physicians Find Safety in Numbers
Market forces, laws, and capital expenses are driving mergers and hospital employment. By Bruce Japsen

16 A Patient Advocate
An interview with Dr. Ardis Dee Hoven, the American Medical Association’s new president, reveals that she is fully committed to advocacy for physicians and their patients. By Bruce Japsen

18 The Genomics Revolution
Part two of our series focuses on how far the use of genetics in medicine has come—and how far it has yet to go. By Howard Wolinsky

PRESIDENT’S MESSAGE
2 A New Year, New Goals
By Robert W. Panton, MD

OPINION
4 Who is a “Good” Doctor?
By Joeseph Lee, Student

PRACTICE MANAGEMENT
6 Preparing for the Physician Payments Sunshine Act

LEGAL
8 Preventing Transplant-Transmitted Infections
By Sara J. Agne, JD

PUBLIC HEALTH
10 Drug-induced Movement Disorders
By Christopher G. Goetz, MD

MEMBER BENEFITS
24 Transcending State Boundaries
By Eldon A. Trame, MD, ISMS President

25 Uniting to Serve Physicians
By Elizabeth Sidney

26 Society Contributions Influence National Policies
By Elizabeth Sidney

28 Society Welcomes New Leader

30 Calendar of Events/New Members

31 Classifieds

WHO’S WHO
32 From Teacher to Dean
Dr. Russell Robertson, Dean of the Chicago Medical School at Rosalind Franklin University of Medicine and Science, is a dedicated family practitioner with a strong interest in global health.
MESSAGE FROM THE PRESIDENT

A New Year, New Goals

T IS A DISTINCT honor and privilege to serve as the 165th President of the Chicago Medical Society (CMS). The President’s Message gives me the opportunity to clarify the administrative goals of the current Board of Trustees:

1. Maintain the balanced budget.
2. Discount our membership dues.
3. Increase our membership.

These goals may seem overly ambitious and possibly contradictory, but they are achievable.

Let’s start with the budget.

Over the past several years, CMS has made significant strides toward financial stability. CMS Executive Director Theodore Kanellakes has worked tirelessly to find ways for CMS to become more cost-efficient and to deliver services to our members at lower cost. CMS has utilized new technology to lower communication costs with members, including lower-cost on-line meetings.

From 2005 through 2009, CMS had a deficit for five consecutive years, amounting to a cumulative loss of $1.49 million. In the last three years, CMS has reversed this trend and made $264,000. While the U.S. government may have $17 trillion in debt and the State of Illinois may have $100 billion in unfunded liabilities, the Chicago Medical Society owes not one dime.

Based on our new-found financial stability, the Chicago Medical Society is proposing dues discounts. CMS and the Illinois State Medical Society (ISMS) currently offer dues reductions to students, residents, members in the first four years of practice, trial members in the Partnership for Membership Growth Program, and group discounts to groups as small as three physicians. It would be much simpler to offer broad-based dues discounts to our members.

We would also like to use dues reduction to help with the vexing problem of membership. One would like to believe that the fine work of the Society would automatically translate into membership. Unfortunately, it’s not that simple.

Multi-year efforts have attempted to address declining membership. Fortunately, we have already started strong in the current membership cycle. Student and resident membership renewals occur at mid-year, and we are already seeing significantly increased resident membership. Our Treasurer, Philip Dray, MD, has previously sponsored CMS membership for more than 100 residents, and he is continuing with his generous ways.

An even more challenging problem is the regular membership renewal cycle at year’s end. We are moving toward completion of the Partnership for Membership Growth, a trial program that allowed physicians to become CMS and ISMS members for free for a year, followed by half dues for a year, before converting to full dues-paying members.

Our Immediate Past President, Howard Axe, MD, recognized the importance of integrating these trial members into CMS activities. In fact, of the 228 trial members, 88 already serve on CMS committees. The hope is that trial members who actively participate in the Society will be more likely to find value in full membership.

The three main projects for this year’s membership recruitment include: (a) the Partnership for Membership Growth Program; (b) group recruitment programs; and (c) dues discounts to stimulate demand. It is also essential for the Society to demonstrate value to all of our members, through our communications, educational activities, and advocacy efforts.

The CMS Board of Trustees is adamant that this is not the year for more membership studies. It is the year to increase membership.

Robert W. Panton, MD
President, Chicago Medical Society
Experts & Advocates in Liability Protection

For Illinois practitioners, we’re experts and advocates in medical liability insurance. Our licensed staff provides answers and support, while our agency sponsors the legislative advocacy and educational programs of the Chicago Medical Society.

We’re run by physicians for physicians, and you’ll appreciate the difference true professionalism can make.

CMS Insurance
A SUBSIDIARY OF CHICAGO MEDICAL SOCIETY

FOR MORE INFORMATION, PLEASE CALL US AT 312.670.2550 OR VISIT US ONLINE AT www.cms-ins.com
Who Is a “Good” Doctor?
Medical student learns life-changing lesson as a patient

By Joseph Lee

AD YOU ASKED me this question one year ago, my answer would have been vastly different than it is today. In the summer of 2012, after completing my first year of medical school, I embarked upon my last official summer vacation with two goals in mind: a basketball tournament in Dallas and one in Atlanta. My closest friends and I had been playing in tournaments for the past 10 summers, forging a sacred bond in the name of competition. However, two weeks before our first tournament, I was suddenly and overwhelmingly short of breath. Having been born to Korean immigrant parents, I was raised to utilize the hospital in emergent cases only, and I knew this was such a case. A few scans later, doctors discovered numerous pulmonary emboli (PE), caused by a subclavian deep vein thrombosis (DVT), and just like that, I was lying in a bed of a major hospital for a life-threatening condition.

Fast forward a few months, and I am lying in another but similar bed to treat the underlying cause of the subclavian DVT: a first rib removal.

There is little that can adequately prepare someone physically, emotionally or spiritually for undergoing surgery, and my thoughts continued to race. In addition to expecting physical pain, I felt isolated, fearful and frustrated. Fortunately, the procedure went according to plan thanks to a skilled surgeon and his team. But the attributes that made the doctor “good” went far beyond his ability to operate.

“Wow. I’m glad you are feeling better,” and, “I can’t believe you went through that,” are common reactions from people when they see the scars on my upper chest and hear about my nine months of literal blood, sweat and tears. But I remain positive and full of gratitude, knowing I gained the invaluable experience of being a patient and discovering the vulnerability and trust that patients give their doctors. Patients divulge information to doctors that they may have never told anyone else, and in doing so, they place great trust and responsibility in the hands of a doctor.

My Surgeon Understood
Many patients will not understand the mechanism...
of disease behind their condition and hope the doc-
tor will explain to them why it is they are feeling
the way they are and ultimately heal them. And
that is precisely what my surgeon understood: the
privilege of being able to care for patients and the
intimacy of the doctor-patient relationship. And
as I awoke to the care of my worried parents, they
immediately wanted to discuss the details of the
procedure that my “good” doctor had methodically
and patiently explained to them.

In study after study, patients have reported dis-
satisfaction with their medical care, not because of
lack of knowledge or health outcome, but because
their doctors did not show enough warmth in
the encounter or listen to the patient’s questions
and concerns. There are few times in life when
patients and their loved ones are more vulnerable
and in more need of compassion than when facing
hospitalization. And for some doctors, a patient
may be another item on a checklist, but that patient
is someone’s mother or father, son or daughter,
sister or brother. My “good” doctor understood
this and would often say, “If you were my son...”
when discussing treatment options. Such ideals are
rooted in love and compassion for patients, not in a
health care system that views them as clients.

Unfortunately, the ordeal of living with a
chronic illness or undergoing a major operation
extends beyond the confines of the hospital. From
creditors harassing patients for medical bills, to
prescriptions that need to be refilled or lifestyle
modifications that need to be made, the health
care experience doesn’t end when a patient walks
out the hospital door. It often takes only a minute,
as in the case of the “good” doctor, who told me
that as a student I could apply to the hospital for
financial coverage of the procedure. Anticipating
my financial concerns and directing me where to
go helped relieve my stress.

Last, the “good” doctor understands that just as
our patients are human, so are we. This means we
will make mistakes, which sometimes can result
in life-threatening consequences. With that said,
the “good” doctor practices humility and honesty,
apologizing and sharing as much information as
possible with patients. How one reacts to a mistake
is a distinguishing feature of the “good” doctor.

Of all the “good” doctor qualities I’ve described
in this piece, there was no emphasis on skill and
knowledge. Being able to fulfill the duties of mak-
ing a correct diagnosis and planning appropriate
treatment are expected. However, the intangibles
of love, compassion, foresight and honesty are what
make a doctor “good.” I learned such lessons in the
purest manner possible, by being a patient myself,
and will use them to guide me in all future patient
encounters, as I strive to be a “good” doctor too.

Joseph Lee is a third year medical student at Rush
Medical College.
Prepare for the Physician Payments Sunshine Act
Steps for making sure your information is accurate

AUGUST 1 MARKS the beginning of a sweeping transparency initiative in which pharmaceutical and medical device companies collect and report data on their financial relationships with physicians and teaching hospitals. The Physician Payments Sunshine Act, which is part of the overall health care reform law, also requires manufacturers to submit annual reports documenting transfers of value, as well as certain ownership interests held by physicians and their immediate family members. The Centers for Medicare and Medicaid Services (CMS) will post the data on a public website starting Sept. 30, 2014.

Although physicians are not responsible for reporting these financial interactions, they should take steps to protect themselves by ensuring the information is accurate before it is made public. Explaining how the program works, Shantanu Agrawal, MD, director of CMS’ data sharing and partnership group, and Anita Griner, deputy director of the CMS data sharing group, addressed doctors in Chicago for the American Medical Association’s annual meeting on June 17. The two CMS officials also sought to quell concerns about the transparency initiative, in addition to fielding questions during a special education session.

Several doctors in the audience said they were worried that once in the public domain, false or misleading information can be sensationalized, and result in professional harm even if they had done nothing wrong. However, Griner was adamant that, “Accuracy is the number one goal of the program,” and all the more reason for physicians to participate in the initiative. “We want the website data to be complete and not to be disputed,” she said.

Both officials said the Sunshine Act reflects a broader trend in the passage of transparency laws for organizations and government officials. States are increasingly enacting their own laws and within medicine, many have pushed for greater transparency.

Doctors are encouraged to begin tracking their own financial interactions right away. The consolidated individualized reports will be posted next year for physicians to review. They will have the right to challenge those reports they believe are false or misleading.

Physician-manufacturer relationships have produced many positive results, leading to discovery and innovation, Dr. Agrawal acknowledged. CMS does not want to put a chill on these relationships or impede the discovery process, he said. But the need for transparency is magnified when one considers that 94% of doctors have some form of relationship with industry, with 60% involving medical education and 40% the development of clinical practice guidelines, he said. The open payments initiative simply aims to strike a delicate balance among research, education and clinical decision-making.

The federal CMS is offering a mobile app for smartphones to help with the payment tracking process. The app features sample questions to ask manufacturers, and suggests what to say to patients on this topic.

What You Can Do Now to Prepare
The AMA offers the following guidelines for physicians:

• Update your disclosures before August 1 and regularly thereafter. Ensure that all financial disclosures and conflict of interest disclosures required by employers, advisory bodies and entities funding research, for example, are current and updated regularly.

• If you have an NPI, update the information and ensure your specialty is correctly designated. Physicians who have a National Provider Identifier (NPI) should ensure all information in the NPI enumerator database is current and regularly updated as needed. This information will be used by industry, among other unique identifiers, to ensure that they have accurately identified you.

• Inform your industry contacts that you want ongoing notice of what they report to the government.

• Ask all manufacturer and GPO representatives with whom you interact to provide you with notice and an opportunity to review and, if necessary, correct all information that they intend to report before it is submitted to the federal government.

Types of Reportable Financial Transfers
Direct. Payments or transfers of value of $10 or more. Cash or cash equivalent, in-kind items or services, stock or stock option(s), or any other ownership interest, dividend, profit, or other return on investment. Product samples and educational materials that directly benefit patients are exempt from this reporting requirement.

Indirect. Transfers not made directly to the...
physician. They are classified as either third party transfers or as other types of indirect transfers.

- **Third Party.** Transfers in which the physician does not receive payment. For example, a physician or person acting on the physician’s behalf specifies that the transfer be given to another person, such as a charity.
- **Other Types of Indirect Transfer.** Transfers of value to a physician indirectly by a third party or intermediary. For example, a manufacturer makes a payment to a physician organization and then directs the payment to be provided to a specific physician, without regard to whether the specific physician was identified in advance.
- **Ownership.** Certain ownership interests held by physicians and their immediate family members. Exceptions to the reporting rule include securities that (1) may be purchased on terms generally available to the public; (2) are listed on a stock exchange; and (3) have quotations that are published on a daily basis.

### Reporting Exemptions

- Certified and accredited CME.
- Buffet meals, snacks, soft drinks, or coffee generally available to all participants of large-scale conferences or similar large-scale events.
- Product samples that are not intended to be sold and are intended for patient use.
- Educational materials that directly benefit patients or are intended for patient use.
- The loan of a medical device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.
- Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.
- A transfer of anything of value to a physician when the physician is a patient and not acting in his or her professional capacity as a physician.
- Discounts (including rebates).
- In-kind items used for the provision of charity care.
- A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund.
- In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.
- Payment to a physician who is a licensed non-medical professional solely for non-medical professional services. For example, payment to a physician licensed to practice law and retained by a manufacturer to provide legal advice.
- Payment to a physician solely for the services of that physician with respect to civil or criminal actions or administrative proceedings.
- Transfers of less than $10 in value, unless the aggregate amount transferred, requested or designated by the manufacturer on behalf of the recipient exceeds $100 during the calendar year.

### Key Dates

**Aug. 1-Dec. 31, 2013:** Manufacturers will begin collecting and tracking payment, transfer and ownership information. Thereafter, they are required to report data for each full calendar year.

**Jan. 1, 2014:** The Centers for Medicare and Medicaid Services (CMS) will launch the portal that allows physicians to sign-up to receive notice when their individual consolidated report is available for review. This portal will also allow physicians to contact manufacturers and group purchasing organizations (GPOs) if they want to dispute a report.

**March 31, 2014:** Manufacturers and GPOs will report data for 2013 to CMS.

**April-August 2014:** CMS will provide physicians access to their individualized consolidated report for the previous calendar year. To make corrections or modifications, physicians should contact manufacturers through the online website portal. The portal is maintained by CMS.

**Sept. 30, 2014:** CMS will release most of the data on a public website.

This information is provided courtesy of the AMA. Comprehensive resources on the Sunshine Act can be found at [ama-assn.org/go/sunshine](ama-assn.org/go/sunshine). The federal CMS also helps physicians understand and prepare for public reporting. A free mobile app to help with tracking is set for release this summer. Additional registration information is forthcoming in 2013.
Preventing Transplant-Transmitted Infections

Here are the liability risks you may face and the steps you can take to reduce them

By Sara J. Agne, JD

The Centers for Disease Control and Prevention (CDC) estimates that one in 20 hospitalized patients will contract a nosocomial, or health care-associated, infection (HAI). With the risks even greater and the effects more devastating for immune-compromised organ-transplant patients, health care providers who work in or near transplant programs should take special note of the prevention and liability issues in this area.

Recognition on the Rise

Though considered rare overall, transplant-transmitted or solid organ transplant-associated infections have made the news several times in recent years. Clusters of donor-to-recipient, transplant-transmitted West Nile virus, lymphocytic choriomeningitis virus, rabies, even *Balamuthia mandrillaris* (a free-living amoeba found in soil), have all been reported in the past decade. The CDC estimates that 1% of recipients contract a transplant-transmitted infection of some type. Press coverage of these cases is fortuitous, since the U.S. lacks a uniform, national mandatory reporting or monitoring system for transplant-transmitted infections.

Transplants of all types are thought to be increasing generally. The Organ Procurement and Transplantation Network’s (OPTN) paired kidney donor pilot program is in full swing, and social media is drawing attention to recipient need and donor opportunities. Recognition of transplant-transmitted infections, including rare zoonotic infections, is also on the rise. Societal factors such as increased immigration, “transplant tourism,” travel abroad, and exotic pet ownership may increase exposure. Potential donors with evidence of unexplained encephalitis at death have received additional scrutiny in recent years.

Similar to newborn screening procedures, though, the extent and variety of pathogen screenings for donors and their organs may vary by state and by individual organ procurement organization. Sometimes the person charged with performing the transplant is the only one who can prevent a mismatch between the condition of a donor’s organ and the patient’s wishes or protect the patient from undue risk. Failure to do so may give rise to liability.

For example, a pediatric surgeon’s concerns were recently brought to the OPTN/United Network for Organ Sharing’s (UNOS) disease transmission advisory committee. In this case, transplant matches had been made before donor serologies were completed. Discussion with a transplant coordinator revealed to the surgeon instances in which his recipient patients were being offered Hepatitis C-positive organs when the patients were listed as not willing to receive such organs.

The OPTN/UNOS committee acknowledged that “[n]o transplants took place in these instances, but potential for harm was present in these near miss situations.” Its interim conclusions stated that in the event of inconsistent or pending test results, organs should be treated as positive for the tested antibody until proven otherwise, to minimize the risk of disease transmission. In other words, the most conservative approach should be used in the interest of patient safety over the desirability of a quick match and transplant.

Failure to confirm and document full informed consent for transplant procedures may give rise to litigation.”

Working With the Bar

The Chicago Medical Society and the American Bar Association have established a formal relationship to address medical-legal issues affecting CMS members and their practices. This legal section is sponsored by the Health Law Section of the American Bar Association.

For CMS members this means monthly articles from legal experts who specialize in health law. The articles will focus on topics of current interest to medical professionals as well as cover new laws and regulations as they are implemented. The authors will vary every month to ensure you receive the best information possible from the attorney who specializes in the subject matter.

If you have a particular question or would like more information on a topic, please send us your suggestions. You can send an email to Elizabeth Sidney at esidney@cmsdocs.org.
The Latest Guidance

Implementing simple best practices may help keep transplant patients infection-free and health care providers out of litigation. As with any procedure, informed consent is vital. Physicians and others should discuss the risks of transplant-transmitted infections with patients, taking special care to ensure patients comprehend the risks. The prospect of an available organ should not result in glossing over the risks. Patient directives regarding the types and conditions of organs that will or will not be offered, if available, must be clarified and honored.

A panel of CDC experts in the Draft 2011 Public Health Service Guideline for Reducing Transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) Through Solid Organ Transplantation strongly recommended that provider-patient informed consent discussions be an ongoing process from the time of listing the patient for transplant. The discussion should continue to be reopened at any time the patient remains on the waiting list. At the time of an organ offer, specifics regarding potential for HIV-, HBV-, or HCV-infection from the prospective donor should be discussed and supported by evidence of donor history and blood test results.

The draft notes that a separate informed consent discussion by the transplant center team and patient may be needed for vessel conduits, which may originate from a different donor. Conservative donor risk assessments and screenings should be conducted and verified, involving reviews of medical/behavioral history, physical examinations, and blood tests, including the most sensitive tests available for certain conditions. OPTN develops and maintains specific guidance for best practices in screening and recognizing donors with certain conditions, including tuberculosis and central nervous system infections like rabies, and for obtaining follow-up information from living donors.

Under both the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act of 2010, Congress funded the states to study and prevent nosocomial infections. Of particular note is the ongoing coalescence of reporting requirements, which can implicate federal health care incentives and state public records laws. Accurate and timely reports of transplant-transmitted and nosocomial infections improve transparency and may reduce the threat of liability.

Of additional concern are the more common nosocomial infections that immunosuppressed recipients can be especially vulnerable to during hospital stays. These include urinary tract infections, ventilator-assisted pneumonia, surgical site infections, intravascular-device-related infections, and diarrhea associated with *Clostridium difficile*. The rate of nosocomial infections in an organ transplant unit was reported in 2006 to be 62% for patients who received a kidney from a deceased donor and 40% for those who received a kidney from a living related donor. Studies have shown that adequate cleaning of equipment may prevent as many as one-third of HAIs.

And then there are cases where health care providers are the vectors—a California heart surgeon unwittingly infected five patients with staph infections during valve replacement operations last year, due to microscopic tears in his surgical gloves. Four of the patients required second operations, paid for by the hospital. Ignoring the potential for certain procedures to place additional stress on surgical gloves or other equipment, or even excessive use of hot water for provider hand hygiene, can increase the risk of infection for patients.

A Balancing Act

The risks of infection should always be weighed against the benefit of a transplant by both physicians and patients. Not all patients on the waitlist for an organ transplant are in equal need—hence the ranking of the list—and not all patients are willing to accept the same types of organs. As the CDC’s Director of the Office of Blood, Organ, and Other Tissue Safety, Matthew J. Kuehnert, MD, wrote in a blog post about the *Balamuthia* infections and deaths, “A kidney patient who is medically stable while living on dialysis may not be as accepting of elevated risk as a heart failure patient without any hope for survival.” Dr. Kuehnert’s team at the CDC investigated more than 200 reports of unexpected transplant-transmitted infections from 2007 through 2010.

In a similar vein, health care providers should assess their professional and personal comfort levels with patients who are at elevated risk. When a rabies outbreak from 2011 transplants came to light in 2013, a New York transplant surgeon, Amy L. Friedman, MD, explained to CNN that she refuses to transplant organs from a donor who died of encephalitis of unknown origin. Her comments came with the caveat that she does kidney transplants on patients who can survive on dialysis in the immediate term, so there is a slight luxury of time compared to patients who need other organs.

The emergent nature of a recipient’s need combined with the limited window of organ viability for transplant will likely mean that some conditions simply must remain unscreened for. However, health care providers engaged in the balancing act inherent to transplants may wish to take the steps outlined in this article to prioritize safety and minimize risk and potential liability.

*Sara J. Agne, JD, is an associate at Snell & Wilmer LLP in Phoenix, AZ. She may be reached at sagne@swlaw.com. She also tweets about organ and transplant law and news on Twitter as @transplantlaw.*
Drug-induced Movement Disorders

Help for physicians whose patients must take medications that have neurological side effects

By Christopher G. Goetz, MD

EVERY PHYSICIAN recognizes the adage “Do no harm,” but the complex pharmacology of prescription drugs places practitioners in the risky role of causing inadvertent side effects. Indeed, an estimated 10% of new consultations stem from movement disorders that have been induced or exacerbated by prescription drugs. Medications typically prescribed for psychiatric or internal medicine indications are often at the core of these neurological problems, according to Kathleen Shannon, MD, a professor of neurological sciences and a clinical neurologist at Rush University Medical Center. Dr. Shannon’s clinical practice focuses on Parkinson’s disease, Huntington’s disease, dystonia, and other movement disorders.

Overview of the Problem

Movement disorders are neurological diagnoses that include tremors, different forms of chorea, dystonia, myoclonus and gait disorders. Table 1 highlights different types of movement disorders and examples of frequently prescribed medications that can induce or exacerbate them. Tremors are “to-and-fro” shaking movements that can occur at rest or during movement. When rest tremor is accompanied by slow body movements, rigidity and balance difficulties, the term “Parkinsonism” embodies the syndrome. Though fully reversible with cessation of the causative agent, drug-induced Parkinsonism is clinically indistinguishable from Parkinson’s disease. When tremors occur during action, they are termed postural or kinetic, and the causative agents are usually different. The term dystonia is applied to often painful spasms and twisting movements. Chorea is a jerking movement, usually unpredictable and fleeting, involving various body parts including the face and neck, trunk and extremities. Finally, tics are often very fast movements, but differ from chorea because they are stereotypic and predictable.

Antipsychotic Agents and Related Drugs

Among the drug classes listed in Table 1, antipsychotic agents and related drugs that block central nervous system dopamine receptors provoke several different types of drug-induced movement disorders. For this reason, when dopamine receptor blocking agents are prescribed, physicians must be particularly vigilant of inducing a movement disorder in the context of treating another condition. Although antipsychotic drugs are generally prescribed by psychiatrists, these drugs are increasingly used as antidepressants and in pediatric management. As a result, physicians in many specialties must be vigilant. The widely prescribed gastrointestinal drug, metoclopramide, and several other anti-emetics used in cancer treatment, share a similar central nervous system dopamine receptor blockade. Thus, patients being treated with these agents are at risk for movement disorders. The link between the dopamine system and movement disorder is complicated because the type of movement disorder changes with the duration of drug exposure.

“Three core time-based syndromes are related to these dopamine-blocking agents: acute, subacute, and late (tardive) movement disorders,” Dr. Shannon explains. “Knowing when a drug in this class was started or increased is the starting point to understanding relationships between cause and effect in drug-induced movement disorders.” (See Table 2)

Table 1: Drug-induced Movement Disorders

<table>
<thead>
<tr>
<th>Tremor (postural/kinetic)</th>
<th>Parkinsonism</th>
<th>Dystonia</th>
<th>Chorea or dyskinesias</th>
<th>Tics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium</td>
<td>Antipsychotics</td>
<td>Antipsychotics</td>
<td>Thyroxine</td>
<td>Central stimulants</td>
</tr>
<tr>
<td>Valproate</td>
<td>Metoclopramide, and some anti-emetics</td>
<td>Carbamazepine</td>
<td>Carbamazepine</td>
<td>Methylphenidate</td>
</tr>
<tr>
<td>Thyroxine</td>
<td>Some calcium channel blockers</td>
<td>Anti-emetics</td>
<td>Levodopa</td>
<td>Lamotrigine</td>
</tr>
<tr>
<td>Cholinesterase inhibitors</td>
<td>Valproate</td>
<td></td>
<td>Antipsychotics</td>
<td>Oral contraceptives</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>5-FU and hexamethylmelamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theophylline</td>
<td>Amiodarone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicotine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Acute Movement Disorders**

Within hours of the first exposure to a dopamine blocking agent or after a dosage increase, acute dystonia is a risk, especially in younger men. This movement disorder is a sustained spasm of muscles, often involving the neck, facial, and ocular muscles (“oculogyric crisis”). Arching of the back and pain can sometimes predominate, and the sudden onset usually precipitates an emergency room visit. Rapid recognition and treatment with an anticholinergic agent usually improves this type of disorder, though a short course of oral anticholinergic treatment may be needed for several days after the emergency room visit.

**Sub-Acute Movement Disorders**

Within days or weeks of introducing or increasing the dose of a dopamine receptor blocker, three different sub-acute syndromes can develop. Neuroleptic malignant syndrome is a medical emergency characterized by diffuse muscle rigidity, hyperthermia and autonomic nervous system instability. Forty percent of cases have life-threatening medical complications and the disorder must be recognized and treated without delay. High-risk patient groups include those with bipolar illness who are already hyperactive and agitated; patients who are dehydrated or exposed to high environmental temperatures during summer months; and possibly those who received depot (long-acting intramuscular) injections of antipsychotic or anti-emetic drugs.

Akathisia is a second sub-acute movement disorder associated with dopamine receptor blockade. This distressing disorder is characterized by high levels of restlessness and physical, as well as psychic discomfort, forcing the patient to pace and move about. The movements usually involve rocking, pacing, shuffling of the legs. These movements are voluntary, and the patient moves to abate the restlessness.

Parkinsonism is the third and perhaps best recognized sub-acute syndrome associated with dopamine blocking agents. In this case, weeks after starting or increasing the dose of one of these medications, the patient develops various combinations of rest tremor, bradykinesia, cog-wheel rigidity, and balance or gait abnormalities. Typically, Parkinsonism is bilateral and symmetric, involving both sides of the body, but some patients may show tremor and slowness mostly on one side. When the tremor occurs in the lips, it has been termed “rabbit syndrome” because it resembles the munching movements of these animals. When not recognized, this syndrome can lead to falls and be misdiagnosed as Parkinson's disease. With cessation of the causative agent, signs resolve or substantially improve.

**Tardive Syndromes**

Chronic exposure to dopamine-blocking agents within the brain changes the receptor sites and can lead to longstanding and sometimes irreversible movement disorders. These late-onset syndromes occur after patients have been exposed to drug treatment for at least three months and are collectively termed as tardive syndromes. The three key movement disorders are chorea (dyskinesia), dystonia, and akathisia.

Tardive dyskinesia is the most frequent, occurring in an estimated 30% of chronically exposed subjects, followed by tardive akathisia (15-20%) and then by tardive dystonia (5-15%).

Tardive dyskinesia can occur in any age group and with any of the dopamine-receptor blockers, but elderly women on high doses of traditional antipsychotic agents are the prototypic risk population. Movements tend to involve the lips, face, and mouth (lingual-facial-buccal dyskinesia). Darting eye movements and neck jerking are very typical along with unpredictable limb or trunk movements. Tardive dyskinesia can affect dentition and be socially isolating, although many patients are less bothered by it than their families and physician are. When the dopamine blocking agent is discontinued or lowered, most patients will improve, but some are left with a permanent movement. Judicious use of these agents, keeping the dose as low as possible, and using them only for the short-term, if possible, is the best way to prevent tardive dyskinesia.

Tardive akathisia is clinically identical to the sub-acute syndrome of akathisia, but it occurs after

<table>
<thead>
<tr>
<th>Acute disorders: hours to first days of exposure</th>
<th>Sub-acute disorders: days to weeks of exposure</th>
<th>Tardive disorders: usually more than three months of exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute dystonia</td>
<td>Neuroleptic malignant syndrome</td>
<td>Tardive chorea or dyskinesia</td>
</tr>
<tr>
<td></td>
<td>Akathisia</td>
<td>Tardive akathisia</td>
</tr>
<tr>
<td></td>
<td>Parkinsonism</td>
<td>Tardive dystonia</td>
</tr>
</tbody>
</table>
chronic exposure to dopamine receptor blocking agents. Patients are uncomfortable sitting and feel better if they move about, either rocking their trunk or shifting their legs. Many will insist on walking and pacing and resist requests to sit down. Patients with akathisia may also have tardive dyskinesia, causing an array of movements, some volitional (akathisia) and some involuntary (dyskinesia).

Finally, tardive dystonia is a movement disorder involving sustained muscle contractions and postures, with frequent arching of the back and retrocolic neck movements. The spasms may be painful and distressing as well. Dystonic movements are exacerbated by movement, so patients tend to sit quietly and avoid activities. In many instances, like tardive akathisia, tardive dystonia occurs in the context of rapid movements of tardive dyskinesia, so that slow dystonic contortions distort the neck and trunk while rapid choreic jerking affects the face and mouth.

The Physician’s Role
The vigilant physician can reduce the risk of drug-induced movements by:

- Prescribing agents only when absolutely necessary and using them at the lowest possible doses for the shortest time duration necessary.
- Being aware of the risk and working with a movement disorders specialist who can detect such movements at their earliest development.

Some points for the physician to keep in mind:

- Although many newer generation dopamine-blocking agents are available, all of them, with the possible exception of clozapine, still carry some risk of inducing movement disorders.
- Among the dopamine receptor blocking drugs, the duration of exposure helps to predict the type of movement disorder that is likely to develop.
- When a drug is considered the possible source of a movement disorder, cessation and observation for six months will help to clarify the disorder’s reversibility.
- While acute and sub-acute disorders may resolve sooner, tardive syndromes may persist for months, and in some instances remain permanent.

“Movement disorders are difficult to treat when the patient must take certain drugs,” Dr. Shannon emphasizes. “Much of our educational effort involves working with our colleagues to help them with drug choices and thereby prevent neurological side effects.”

Dr. Goetz is professor of neurological sciences and professor of pharmacology at Rush University Medical Center. He is director of the Parkinson’s Disease and Movement Disorders Program at Rush. He may be reached at cgoetz@rush.edu.
Physicians Find Safety in Numbers

By Bruce Japsen

LIKE A LOT of doctors thinking of joining a larger system or selling out their practice, David Vigder, MD, worried about losing control of his practice and no longer being his own boss. Yet, at the same time, he was facing the harsh reality that insurance companies, government regulations and other influences were constantly getting in the way of his ability to control his day-to-day decisions. So, after 15 years working largely on his own with an occasional internist partner, he sold his Lake Forest practice that included a physician assistant, a medical assistant and two administrative assistants.
Coming out of Ohio State University Medical School and his internal medicine residency at Rush University Medical Center, Dr. Vigder established a practice in Chicago’s affluent northern suburbs—a dream come true for most young doctors. “There is definitely an amount of pride you take in being an owner and a boss and having the last word when working with your employees and patients,” says Dr. Vigder. “But the reality is that even though the wealthiest patients use insurance, the insurance companies set the rates and give you the same reimbursement, which is steady or falling.”

**There is, however, a transition, Dr. Golbus says, because physicians are loath to give up their autonomy, which he says is completely understandable.**

Now an employee of Evanston-based NorthShore University HealthSystem since April 2012, Dr. Vigder spends his days solely taking care of patients rather than devoting 30% or more of his time on administrative tasks. And it’s having an effect not only on his ability to do his job but also on his emotional and psychological well-being. “What I have noticed, and my patients have noticed, is that I am much more relaxed,” Dr. Vigder says. “I pretty much get to go into the office and take care of my patients and don’t have to bother with the administrative and business stuff, which I was not educated and trained to do anyway.”

Dr. Vigder is not alone.

**The Consolidation Growth**

As the Affordable Care Act and market forces place more pressure on medical care providers, physicians are finding safety in numbers by merging their practices with large medical groups, selling out to hospitals or closing their doors and taking a job as a salaried physician at a large health care system.

Physicians in group practice now make up almost half, or 49.5%, of the total number of physicians providing patient care in Illinois, according to the latest statistics from the American Medical Association. That compares to a decade ago when 33% of patient care physicians were in group practices.

In 2011, there were 32,953 patient care physicians in Illinois, the AMA data shows, and 1,412 group practices with 16,315 doctors practicing within those groups. That compares to 2003 when there were 30,264 patient care physicians in Illinois, 928 group practices and 10,056 doctors in Illinois practicing in those groups.

The consolidation wave has grown over time as managed care health plans and state Medicaid programs squeeze or cut what they pay doctors, forcing physicians into larger groups to gain leverage with insurance companies. Before John Sage, MD, and his partners sold their seven-physician Metrodocs practice in December 2011 to Advocate Health Care, he had watched operating margins fall while their overhead rose. These days, however, he and his physician colleagues no longer worry about how they may have to spend any practice profits, such as choosing between computer system upgrades or staff retirement plans. “Joining a larger system seemed to carry less risk,” Dr. Sage says. “Now, our benefits and our malpractice insurance are taken care of by Advocate.”

**Additional Pressures Emerge**

But new forces are exerting additional pressures these days.

Physicians must make huge capital expenditures in the latest health information technology and latest electronic record-keeping systems. Physicians, for example, are being forced to buy systems to prepare for the coming switch in October 2014 from ICD-9 to ICD-10 code sets that are used to report medical diagnoses and inpatient procedures.

Dr. Sage, a 67-year-old family physician who has been active in Chicago’s organized medical circles like the Illinois Academy of Family Physicians, says the increasing burdens and costs on practices will force more doctors nearing the end of their careers to retire early. The cost for a small practice to comply just with electronic health records’ standards can exceed $50,000 per physician and those are just the start-up costs, according to consultants and companies that sell information systems to doctors.

“Health care is very complex,” said Joseph Golbus, MD, president of the NorthShore Medical Group, which is a part of NorthShore University. “It requires sophisticated systems, electronic health records and hiring people to put all of this together. That is hard to do in a practice of two, three or four doctors or even 10 or 20 because of the capital required to implement these complex systems.”

In Rockford and Chicago’s northwestern suburbs, for example, even specialists are combining practices. Rockford Orthopedic Associates and Crystal Lake Orthopedics earlier this year announced merger plans that include “improving technology and enhancing customer service.”

Such market forces are part of the reason the NorthShore Medical Group has grown from about 600 employed physicians in January 2009 to 850 in January of this year. This 40% increase includes a majority of doctors considered “new recruitments,” rather than “physician practice integrations.”

**The Employment Trend**

Industry experts say employing doctors is different today than in the 1990s when large for-profit companies were buying out doctor practices. Those deals often did not work out because the physicians were not integrated into the larger system. Rather, the for-profit chains like MedPartners and PhyCor
were looking for a revenue stream and eventually were forced to consolidate themselves amid financial problems. “There is a big difference between employing physicians and integrating them into the system of care,” Dr. Golbus says.

At NorthShore, and at an increasing number of health systems, executives are preparing for seamless coordinated medical care delivery as insurance companies, employers and government health programs demand higher quality and improved outcomes. NorthShore, which operates four hospitals and affiliated practices and clinics in Chicago’s northern suburbs, has more than 800 employed physicians including about 100 who became employees through various acquisitions and practice purchases in just the last year alone, NorthShore said.

There is, however, a transition, Dr. Golbus says because physicians are loath to give up their autonomy, which he says is completely understandable. “They are masters of their own domain and worried that critical decision-making will be taken away from them.”

Dr. Sage of Advocate advises younger doctors to first take a look at the systems and hospitals where they already have staff privileges. “When my peers and I were starting out, we knew the medical staff and knew the doctors and knew the leadership,” Dr. Sage says. “I tell residents in training to check the different health care systems. They will all be consolidating and you want to talk with the physicians who are there, breathe in the air, and find out what the culture is.”

The Team Approach
Joining a larger system means physicians will have to be more accommodating of other patient care approaches, which they may or may not like.

A team approach to health care delivery is key to the new collaborative care models and the future of cost-effective patient care, according to Reid Blackwelder, MD, president-elect of the American Academy of Family Physicians, which is supporting various team approaches to primary medical such as the ACO and patient-centered medical home models. “You call people, you touch base, you work as a team,” Dr. Blackwelder says. “You work within the community.”

Groups like the American Academy of Family Physicians have watched their members increasingly join larger systems, but also form linkages with other physicians to gain support. Now, those who pay doctors are providing them incentives to deliver care in a team-based approach.

For some doctors, joining a larger practice is merely the new reality.

Recent studies show that an increasing number of young physicians prefer hospital employment over other practice options while staggering medical debt is leaving them no choice but to take employment. Banks are leery of loaning money the way they did before the financial crisis, doctors say, and physicians are not unlike other small businesses owners.

“Younger doctors are looking for a much better work-life balance and they can find that in a larger group,” Dr. Golbus says. A study published in JAMA found a strong association between wanting a “controllable lifestyle” and the choice of specialty among U.S. students in their senior year of medical school. Large groups can more easily provide that controllable lifestyle than can solo or small practices.

Young doctors are finding safety in numbers, according to a survey last year by physician staffing and recruiting firm Merritt Hawkins. Just 1% of the firm’s searches in early 2012 and late 2011 were for solo practitioners, down from 22% in 2004. “Nobody wants to be Marcus Welby anymore, practicing alone or with a partner,” Merritt Hawkins founder James Merritt says.

The movement toward group practice is also becoming a financial necessity for physicians, health system executives and doctors say. In today’s poor economy, it’s much harder for physicians to even start their own practice, according to financial consultants and industry observers.

“The financial crisis made it much more difficult for physicians to launch independent practices and, in particular, independent surgery centers and diagnostic centers,” said James Unland, president of the Health Capital Group, a Chicago-based consulting firm that works with doctors on their business and practice management strategies.

“Whereas earlier in the last decade medical people could obtain nonrecourse financing on the basis of their business plan, but that is no longer possible. The bottom line is there has been a significant lack of access to capital combined with a shortage of capital and unwillingness to commit personal resources to businesses.”

The Future
Unland worries that the inability of physicians to start their own practices or other health care ventures could stifle creativity and the entrepreneurial spirit. “My biggest concern is that we might lose a generation of physicians,” Unland said. “Doctors with even the slightest bit of entrepreneurial initiative, if they can afford to do so, are going to get the hell out of the business.”

Bruce Japsen, formerly the health care reporter at the Chicago Tribune from 1998 to 2011, is an independent Chicago health care journalist, writer and blogger for Forbes at http://blogs.forbes.com/brucejapsen and a contributor to the New York Times. He is also a regular television analyst for WTTW’s Chicago Tonight and radio analyst on health care companies and related topics for CBS’ WBBM radio 780-AM and 105.9 FM and WBEZ. He teaches writing at Loyola University Chicago School of Communication. He can be reached at brucejapsen@gmail.com.
A Patient Advocate

The AMA’s new president, Dr. Hoven, speaks out on behalf of physicians

As physicians enter uncharted territory fraught with changes to their practices, competitive threats from allied health professionals and the specter of becoming a hospital employee, the American Medical Association’s new president is leading the organization’s strategy of helping doctors surmount with the coming changes. Ardis Dee Hoven, MD, the newly inaugurated president of the AMA, told Chicago Medicine in an interview during the annual House of Delegates meeting that the national group is putting “physician satisfaction” at the top of its agenda through advocacy as well as efforts to improve physicians’ day-to-day practice. In some cases, the AMA will step up advocacy to protect doctors’ interests when it comes to scope of practice laws. The association also may offer more guidance through its staff and internally developed resources for physicians who are facing consolidation, practice buy-outs or employment. “We’re looking at ways to help navigate change,” Dr. Hoven said from the Hyatt Regency Chicago on the day she was inaugurated as the 168th president of the AMA.

Dr. Hoven, who is an internist and infectious disease specialist in Lexington, KY, is well known for her two decades of work on the AMA’s Council on Medical Service, debating ways the organization could best advise Congress on myriad issues, particularly how to save Medicare. Now she sees her primary task as preserving the long-term sustainability of physician practice at a time when more and more doctors say they are unsatisfied with their profession in the face of unprecedented change brought on by market forces and the Affordable Care Act, which will result in 30 million new insured patients come Jan. 1.

A new effort by the AMA involves looking at 30 practices across the country where both physician and patient satisfaction is high and then relaying successful lessons and strategies from these practices to physicians to learn from, Dr. Hoven said. To pull this off, the AMA has engaged the RAND Corp., a Pittsburgh-based consulting firm known for analyzing health care data, to study these 30 practices and report back to the AMA on ways the data can be useful to all doctors. The AMA then will take the information from RAND and use it to press for needed changes through advocacy in Washington. The data may also be used internally at AMA headquarters to enhance services for member-doctors. The AMA plans to create multiple models so that physician practices of all varieties and sizes can adopt the successes of the practices RAND is evaluating.

Though the AMA doesn’t expect to begin getting data to analyze until later this year, Dr. Hoven said the association plans to be aggressive and transparent in how information gathered from RAND is communicated to members. The AMA wants to disseminate practice models that will lead to more sustainable physician practices through better payment models. “We want to know what makes these practices different and why they are growing and thriving,” Dr. Hoven said. “We want to take this information, look at it and put boots on the ground to see how it works.”

There is also room for improvement when it comes to physician satisfaction. The AMA cited surveys that have measured physicians’ professional satisfaction in the range of 15-50%, but Francis “Jay” Crosson, MD, the AMA’s group vice president of physician satisfaction and care delivery, said the organization wants to improve those numbers.

Dr. Hoven said the AMA will also prepare to advocate for change if there are any hurdles to implementing new models or their related payment structures. “As we deal with insurance companies, we want these transactions to be able to occur,” Dr. Hoven said.

The AMA is already hearing from members who are upset that policymakers in Washington and state capitols are emphasizing lower-cost solutions to health care delivery that rely heavily on allied health professionals like nurse practitioners, physicians’ assistants and pharmacists. Walgreen Co. and CVS, for example, have successfully lobbied in numerous states for the right of pharmacists to administer more vaccines beyond just seasonal flu shots. What’s more, Walgreen recently stated that it wanted nurse practitioners at its 330 Take Care clinics to begin “management of chronic conditions,” moving the drugstore chain beyond simply treating routine conditions like strep throat or minor aches into what the retailer called “assessment, treatment and management of chronic conditions such as hypertension, diabetes, high cholesterol, asthma and others, as well as additional preventive health services.”

But Dr. Hoven said the AMA is pressing the idea that all care teams should be physician-led. She said both Walgreen and CVS do have partnerships with health care systems and physicians. The AMA will encourage physicians who are not already partnering or affiliating with retailers to do so, she said. Dr. Hoven said she believes Walgreen and CVS are open to that. Walgreen said it has regular discussions with physicians about partnerships and both CVS and Walgreen are partnering with doctor- and hospital-led systems to improve outcomes for their patients.

“That fact is, patients want their health care provided in systems that are physician-led,” Dr. Hoven said. “There are situations where patients may only need to see a nurse practitioner or a physician assistant,” she continued. “But as a physician, I am ultimately responsible for that patient. Communities need to start hanging together and talking.”

The AMA will be monitoring closely the role of physicians in accountable care organizations and as employees of hospital systems, Dr. Hoven said. Indeed, the AMA offers physicians’ guidance through principles adopted last year on “physician employment” and contractual arrangements. “If I am a hospital employee, my first responsibility is to the patient and not to the hospital or the hospital administration,” Dr. Hoven said.

The AMA plans to continue creating products to help physicians who become employees. For example, Dr. Hoven said doctors who are preparing to sign an employment agreement should have a provision in their contracts giving them the ability to refer patients outside the hospital’s system if necessary. “If I believe the patient would be better managed outside that system, then I should have the ability and autonomy to do that without being penalized,” Dr. Hoven said.

Bruce Japsen (brucejapsen@gmail.com) was a health care business reporter at the Chicago Tribune for 13 years.
Dr. Ardis Dee Hoven was recently sworn in as the American Medical Association’s 168th president. At the group’s annual House of Delegates meeting, Dr. Hoven told members that she was making physician satisfaction her top priority.
THE GENOMICS REVOLUTION
When he was a medical student in the early 1960s at the University of Chicago, Mark Siegler, MD, says he learned “old-fashioned classical Mendelian genetics.” This body of knowledge on inheritance is based on the work of Austrian friar Gregor Mendel with garden peas, and it dates back to the 1860s. For instance, based on this approach, physicians might track inheritance patterns of breast cancer from a grandmother to her daughters and granddaughters or prostate cancer from a grandfather to sons and grandsons. The tools were basic: just paper and pen and the patient’s memory.

“We’ve come a long way since Dr. Siegler’s student days. Ten years ago, the Human Genome Project published the first full human genome and offered the promise of a revolution in health care. Yet that revolution is only now starting to affect the everyday practice of physicians, most of whom have not learned how to use the emerging torrent of genomic data. Dr. Siegler, a general internist and head of the U of C’s medical ethics center, says, “What we’re seeing is not a renaissance of the past was imprecise. Dr. Chisholm prefers the term genomics-informed personalized medicine. “It really reflects that we’re getting useful information out of an individual’s DNA and using that information in clinical care decisions,” he says.

Like many in the field, Dr. Chisholm also says that using genomics to predict susceptibility to disease is still in its infancy. “The science isn’t strong enough to talk about clinical validity and clinical utility,” he says. “It’s not clear that we have enough solid evidence today to prove that there is much value yet. I think there may be enough solid evidence in the future.”

He says whole genome sequences can be useful if a patient has a simple rare variant of a gene that puts him at risk for disease based on Mendelian inheritance. “But,” he adds, “for complex diseases that probably result from multiple genes, we’re not there yet.” A major example he cites involves Plavix (clopidogrel), which prevents blood clots in patients who have had recent heart attacks or strokes. Most patients metabolize Plavix, but a small number only partially metabolize the drug or do not metabolize it all. (See part one of this series in the June 2013 issue, “The Path to Personalized Medicine”). Likewise, some people do not experience the desired analgesic effects from narcotics because of their genetic makeup. Likewise, based on their genetic composition, individual patients respond differently to chemotherapies: typical doses can turn out to be toxic for rapid metabolizers.

Physicians Want More Information

Peter O’Donnell, MD, associate director of clinical implementation in the center for personalized therapeutics at the University of Chicago, and an oncologist specializing in genitourinary cancers, says many physicians feel they aren’t ready for the genetics revolution. “There are studies that suggest they’re not alone in feeling a little unprepared,” says Dr. O’Donnell. For example, a survey published in a 2012 issue of Clinical Pharmacology & Therapeutics showed that 97.6% of responding physicians agreed that genetic variations may influence drug response, but only 10.3% of physicians felt adequately informed about pharmacogenomic testing.

(Pharmacogenomics is the study of probability based on a person’s genes. For instance, predicting how well or poorly the person will respond to a medication. Genomics, on the other hand, involves predicting a person’s predisposition for developing certain conditions). Dr. O’Donnell notes that only one in three U.S medical schools lists coursework in pharmacogenomics.

Rex Chisholm, PhD, a molecular geneticist and vice dean of scientific affairs at Northwestern University’s Feinberg School of Medicine, is founding director of the center for genetic medicine, a cross-campus effort involving 140 faculty members in 18 different departments in four different schools at Northwestern. He says those involved in genomic medicine don’t agree on how to refer to the emerging field, using terms such as “personalized medicine” and “precision medicine.” But, he says, the term “personalized medicine” offends some physicians because they feel they’ve always delivered personalized medicine. Likewise, the term “precision medicine” suggests that medicine practiced in the past was imprecise. Dr. Chisholm prefers the term genomics-informed personalized medicine. “It really reflects that we’re getting useful information out of an individual’s DNA and using that information in clinical care decisions,” he says.

He says whole genome sequences can be useful if a patient has a simple rare variant of a gene that
He says this approach has a clearer actionable impact on patients than does the use of genomics to predict an individual patient’s risk of developing a disease. Most genetic variants associated with a disease demonstrate “maybe an extra 10% risk of disease, he says. However, pharmacogenomics may show the patient has a manifold increased risk for side effects or for not even being able to benefit from the drug at all. “So there is a lot more opportunity to implement pharmacogenomics into patient care.”

The FDA is trying to help by including genetic findings on drug labels. More than 120 medications have known responses based on patients’ genetic variations. But Dr. Ratain says, “Most physicians never took a course in genetics plus they have forgotten all their pharmacology.”

He says the rub now is how to get physicians to implement this extra dimension of care about which they know little or nothing: “The difficulty of course is when a physician who is prescribing a drug doesn’t really want to wait for the result of a pharmacogenomics test. He’s got the patient in front of him. He wants to write a prescription and move on. He doesn’t want to say, ‘Oh, we have to send you for a test,’ which he doesn’t even know how to order and then wait for the result, etc. So there are many, many, reasons why physicians don’t want to do pharmacogenomics unless somebody tells them it is mandatory.”

Researchers at the University of Chicago and Northwestern separately have developed and are clinically testing new systems to integrate pharmacogenomics into the practices of physicians whose only previous knowledge of genetics was Mendelian inheritance. Basically, the researchers have compiled databases listing drugs with known genomic data. Patients who enroll in the research undergo genetic testing. Genetic markers are entered into the system.

In the “1200 Patients Project” at the U of C, individual patient DNA findings are compared with the drugs in the database as new prescriptions are entered into the medical record by participating physicians. The computerized system then gives the individual medication a green (go), yellow (warning) or red (stop) light depending on the patient’s markers and the data on the medications.

Researchers at the U of C have recruited general internists, cardiologists, oncologists, and a gastroenterologist, hepatologist and pulmonologist to participate as physicians receiving genetic information on their patients. The goal is to recruit 1,200 patients who agree to donate blood and have their genome scanned. So far, more than 600 patients have been enrolled. U of C physicians take care of them throughout the medical care system, from general medicine to oncology and cardiology. The goal is to explore the utility of incorporating broad pharmacogenetic testing into routine care of patients with any type of disease.

Dr. O’Donnell, who runs the program, says 14 physicians have joined the study so far. “Almost all of them have told me they have chosen to be in this study because they see that this is where medicine is heading. We’re going to have a deluge of genomic information to deal with—all physicians are—and...
they want to be prepared for that. Being in the study helps them get connected with what’s coming.” Researchers are looking at approximately 25 medications whose efficacy or toxicity is affected by a patient’s DNA.

**Practicing Personalized Medicine**

Dr. Siegler, who splits his time evenly between patient care and medical ethics, says the research is important not only for patient information, but also as a study of physician behavior in the new genomic age. He says, “I saw a lot of benefits in my own practice, and to my own patients, but I particularly liked the question they all asked about patient medications even though they had the genetic profile: ‘Will I be using it? Will I be applying it in my day-to-day interactions with patients?’ I think that’s a fascinating question, and as far as I know that question has not been looked at anywhere before.”

Dr. Siegler says the approach can help doctors practice “personalized medicine,” providing the most effective drug to the individual patient based on the person’s genetic composition. He says that theoretically pharmacogenomics offer huge benefits to patients and doctors, improving the effectiveness of medications selected for a particular patient and at the same time decreasing complications and adverse effects. He says it could enhance the FDA’s post-marketing surveillance. “If you couple the pharmacogenetic information with a newly released drug, you may have ideas about which patients you particularly want to keep an eye on in terms of developing adverse complications. If you have the right information on patients, you could even think about, let’s say, certain antibiotic choices or certainly blood pressure medicines. Perhaps medicines the doctor might have used in the past and discontinued could be reintroduced based on the studies.”

Dr. O’Donnell says the results so far look good: “Number one, physicians are looking at the information. We didn’t take that for granted. Will they have time to look at this information in a busy clinic, while they’re thinking about a lot of different things, integrating a lot of pieces of information? Will they integrate genetic information as well? But we’re finding that they are. They keep coming back to the information to look at it. And we’ve seen several instances where the genetic information actually prompted the physician to prescribe a different drug.”

He said one subject had been on a reflux medication (omeprazole) for several months. With the new data, the physician noticed that this medication was highly unlikely to work for the patient. The physician asked the patient whether the drug was helping. And the patient said he didn’t think it was. So, Dr. O’Donnell says, the patient was switched to a medicine more likely to help.

Dr. Siegler has been involved in the study since January 2013. Each day he is in clinic, he receives printouts on the patients he’ll be seeing that day who are enrolled in the 1200 Patients Project. He then goes over the pharmacogenetic information developed for each patient. “This is very specific, showing each medication patients are on, the efficacy of the medicine and the potential risks or dangers for that particular patient. And they package the information in an extremely user-friendly way. So it comes to me as either a green light, a yellow light or a red light,” he says.

He considers the option of changing medications if there is a red or yellow light, meaning the drug is either ineffective in the patient or poses serious risks based on the genome scan. So far, he has switched patients’ medicines about a half dozen times.
times in response to data from the project. He shares the information with patients to help make decisions about prescribing. “For example,” he says, “one of the standard treatments in the field is hydrochlorothiazide, a diuretic that is used as an antihypertensive. I got reports on two patients that this drug was not particularly effective in controlling blood-pressure based on their genetic information. And that led me to discontinue the drug because like any medication, it has side effects and complications, and to substitute it with a different blood pressure drug.”

**Actionable Results and Clinical Utility**

Genetic counselor Maureen Smith, MS, assistant professor at Feinberg’s center for genetic medicine, is co-principal investigator in the Northwestern eMERGE Project, which is in the second year of a four-year grant from the National Institutes of Health. She says the eMERGE PGx project at Northwestern overlaps in design to some degree with the U of C’s 1200 Patients study. “It’s no surprise that we both picked pharmacogenomics, she says. “It’s very actionable. The results have a lot of clinical utility, particularly the medications that we’ve all chosen to look at,” she says.

Northwestern is focused on providing clinical decision support tools that assist physicians with the interpretation of the test results within the electronic health record, she says. So far, 29 Northwestern internists have joined the study. Looking at three medications with boxed FDA warnings that recommend genetic testing, the study focuses on clopidogrel, the anticoagulant warfarin (see “Genetic Testing in Action” on page 23), and the cholesterol-lowering medication simvastatin. The system will be tested on 750 patients. Researchers have an algorithm that predicts which patients will be on one or more of these medications over the next few years.

Smith explains how eMERGE PGx works: “If a physician who is enrolled in the study were going to prescribe clopidogrel for a patient who is also in the study and that patient happened to be one of those who doesn’t metabolize this medication well, an alert will be triggered when the electronic prescription is written, notifying you this patient is a poor metabolizer based on genetic testing. It’s recommended that you consider an alternative medication.” The alerts are designed to fire on rare occasions such as when the prescription is being written. Other types of notices, such as best practice advisories, are also inserted into patient charts so physicians can see the genetic information without a pop-up type of notice.

Northwestern investigators worked with physicians in the general internal medicine department to understand their workflow and the best way to incorporate the genetic information into practice. According to Smith, “We have two internists on our research team and a physician advisory committee that helps design, review and evaluate the information in the EHR and its use. They will be involved throughout the four-year study.”

Within the EpicCare medical records system, Northwestern researchers have set up a portal called “My Research,” where patients will be able to review their genetic research results. Smith says her team is working with genetic counselors to develop information patients will find easy to understand. “Since patients move from doctor to doctor, it is important for them to also have access to this information to share with physicians who are not involved with the study.”

**The Benefits and Tradeoffs in Genetic Testing**

Smith envisions panels of genetic tests created to inform physicians which medications their patients may not respond to or who will need variations in the usual dosing. “There is a lot of opportunity to think about in using genetic testing to avoid side effects, and to avoid medications that aren’t useful. But I think the big issue is the tradeoff—how helpful is this information versus the cost of testing or just changing practice?” she asks. “As costs come down for these kinds of tests, and we get better at doing them and interpreting them, and physicians become more knowledgeable about how to use them, then it might start to make sense to implement a pharmacogenetic test panel in a predictive way before a prescription is written.”

By focusing on pharmacogenetics, Dr. Siegler, director of the MacLean Center for Clinical Medical Ethics at the University of Chicago, says pharmacogenomics studies like the 1200 Patients Project avoids the ethical pitfalls of diagnosing genetic diseases such as Huntington’s chorea and sickle cell anemia, which can lead to insurance and job discrimination based on genetic labeling. “You’re not labeling people if you say that a genetic profile shows that they have a certain resistance or non-responsiveness to statin drugs. If you show that beta-adrenergic agents are not effective bronchodilators with asthma, it’s good to know, but patients won’t be discriminated against.”

Still, he says, pharmacogenomics pose potential problems with confidentiality and privacy. Dr. Chisholm says these are the early days for genomic medicine. “We’re all very excited about the promise it has for improving health care, but we’re a long way from having demonstrated that. We’ve got a ton of work to do just thinking about how to effectively present complicated risk issues to patients. By and large, I think the public is not as comfortable with statistics as they are with yes and no, black and white answers.”

Howard Wolinsky is a Chicago freelancer and former medical writer at the Chicago Sun-Times. He teaches at Northwestern University’s Medill School of Journalism.
A unique program uses genetics to calculate correct doses of warfarin

By Howard Wolinsky

LIKE MANY medical scientists, Joe G. N. “Skip” Garcia, MD, vice president for health affairs at the University of Illinois at Chicago, can see the day when everyone routinely undergoes genomic testing. “Within 10 years easily, everyone will have their genome sequenced. It will be part of your medical record,” says the researcher, who is an expert on pulmonary disease and genetics.

Yet genetic testing has arrived sooner in a pioneering program at the University’s Hospital & Health Sciences System. Genomics are being used in the sometimes tricky administration of the anticoagulant warfarin (Coumadin). Warfarin is used in patients with atrial fibrillation, heart valve replacement, deep vein thrombosis, or pulmonary embolism. Larisa Cavallari, PhD, associate professor at the University of Illinois at Chicago, department of pharmacy practice, and co-director of the pharmacogenetics service, says warfarin is the leading drug-related cause of hospitalization for serious adverse events in older adults in the U.S.

“It is one of the most challenging drugs to manage partly because there is such wide variability in the dose people need, and also because it has such a narrow therapeutic index,” she says. “If the dose is a little too high, the patient is at increased risk for bleeding and if it’s a little too low, they’re at increased risk for clotting. So it’s difficult to figure out the dose someone needs to be within that narrow range.”

Dr. Garcia says he brought together UIC pharmacogeneticists from the College of Pharmacy, physicians from the College of Medicine, and team members from the Population Health Sciences Program to put in place a pharmacogenetics service that oversees the dosing of warfarin. Dr. Cavallari says, “To the best of my knowledge, we’re the first in the country, if not the world, to have made genotype-guided warfarin dosing a standard of care.”

Dr. Garcia adds, “The reason that no other hospital in America is doing this is because insurance companies will not pay for this test. But when I was the vice chancellor for research at UIC, I created an Institute of Human Genetics. We have the knowledge to do these assays in our own Institute and can do them fairly inexpensively. And the fact is that this is a smart thing to do. It reduces our liability risk, and the patient’s length of stay in the hospital because we get to the normal or therapeutic range faster. This is a good example of how we use our translational research and knowledge and apply it in the clinic.”

Dr. Cavallari explained that two genes are the focus of the program: CYP2C9, which codes for the protein that metabolizes or breaks down warfarin, and VKORC1, which codes for the protein target for warfarin. “If you have certain variants in these two genes, you need a lot of Coumadin to maintain adequate coagulation. If you have different variants, you need very low doses because you metabolize the drug very slowly or are more sensitive to it. Most people fall in the middle range,” says Dr. Garcia.

But if you’re out of the normal range, you’re at risk of either bleeding or clotting. And neither of those choices is very good, so we created a pharmacogenetics service where a patient who is ordered Coumadin also gets an immediate pharmacogenetic consult—it’s mandatory.”

Testing determines whether the patient is a slow, fast or “middle-of-the-road” metabolizer and whether the patient has increased, decreased, or intermediate sensitivity to warfarin. Dr. Cavallari says there is a 20-fold difference in the dosage amount patients require for optimal anticoagulation, preventing clotting without increasing the risk for significant bleeding. With this standard of care, the hospital’s pharmacogenetics service determines dosage based on the patient’s genotype and clinical characteristics. The standard of care includes an automatic order for genotyping. Before the second dose is delivered the patient is genotyped at the university health center’s clinical lab. Dr. Cavallari says, “We put an algorithm into the computer so that it will actually calculate an initial dose recommendation based on clinical factors such as the patient’s age, body size, race, whether or not they’re taking amiodarone,” an anti-rhythmic used to treat ventricular arrhythmias. After the initial dose, the pharmacogenetics service provides a recommendation based on both genotype and clinical factors. She estimates it costs about $250 to test for 10 genetic variants.

Dr. Cavallari says there are randomized studies nearing completion to see if genotype-guided warfarin dosing is safer and to gauge its impact on medical costs compared with standard dosing. “Some data already suggest that genotype-guided dosing improves outcomes such as decreasing the risk for bleeding and clotting,” she says. She adds that if patients are given the right dose quickly, they potentially could be released sooner from the hospital, thus reducing costs. There may be other cost savings as a result of needing fewer clinic visits after hospital discharge, she notes.

“Pending the results of these randomized control trials, the insurance companies may start reimbursing routinely,” says Dr. Cavallari. “Some already reimburse for genetic testing, but not all. But if they do start reimbursing more routinely, then I think we’ll see this on a broader scale.”
A coalition of trial lawyer groups is funding a ballot initiative to overturn MICRA in November 2014.

"A coalition of trial lawyer groups is funding a ballot initiative to overturn MICRA in November 2014."

ONE OF THE distinct pleasures of serving as president of the Illinois State Medical Society is the chance to meet and network with physicians from around the country. It’s important that we understand the challenges our colleagues in other states face, and hearing about their successes can inform and energize our own efforts.

Last month, I attended the American Medical Association’s annual meeting as well as the Organization of State Medical Association Presidents’ (OSMAP) gathering. OSMAP is a forum that allows participating states to discuss common issues and concerns. It’s a good forum for sharing ideas and discussing solutions to modern medicine’s challenges. This year’s discussion ranged from strengthening involvement at all levels of organized medicine to state progress in implementing health insurance exchanges and dealing with Affordable Care Act regulations.

One issue I heard about isn’t likely to be reported in Illinois’ media, but it impacts us all. The granddaddy of all medical liability reform laws, California’s Medical Injury Compensation Reform Act (MICRA), is once again facing a serious challenge. A coalition of trial lawyer groups is funding a ballot initiative to overturn MICRA that they hope will come before voters in the November 2014 general election. This landmark law has been controlling costs for physicians and patients in California for nearly 40 years, and if it is weakened or overturned, physicians in all 50 states will face greater liability challenges.

During our AMA meeting, our task as the Illinois delegation is to bring forward resolutions adopted by the ISMS House of Delegates. This year we presented 10. Two of our issues created quite a buzz at the meeting.

First, the AMA’s decision to classify obesity as a disease, which was widely reported in national media, stemmed in part from a resolution ISMS introduced last year. This new stance will likely have a significant impact on the way physicians address obesity with their patients, and should help make the case to health insurers to cover evaluation and treatment of obesity before any comorbidity or complications occur. Guiding national conversations on topics like this is one of our greatest responsibilities as a profession, and it is a privilege to take part.

Our second item of interest dealt with recognizing cheerleading as a sport. Our resolution on cheerleading will be studied by the AMA and considered again at a future meeting. In Illinois, the groups that regulate school sports already classify cheerleading as a sport. This designation ensures that schools enforce adequate medical safety standards to reduce potential injuries among participants and allows for better training and access to medical care. Currently only half of U.S. states recognize cheerleading as a sport, and AMA backing could give athlete protection a higher profile.

The influence of physicians in the legislative process is even more pronounced at the state level. This year in the Illinois General Assembly we contended with several scope-of-practice bills involving psychologists, advance practice nurses and dentists, to name a few. We had positive outcomes on all these bills, but Illinois came dangerously close to allowing psychologists to prescribe psychotropic drugs. A grant from the AMA Scope of Practice Partnership funded critical advocacy resources in Illinois when we were in the home stretch of this debate, and it was a significant factor in our success. The AMA meeting allowed us a forum to thank the AMA for this important support and share our story with other states on how physician organizations working together can succeed.

The partnerships that will safeguard the future of our profession are not just between organizations. They are between each one of us and our colleagues, down the street and across the country. Wherever physicians can be lulled into a false sense of security by others who do not have their best interests at heart and who urge them not to rock the boat, we will see dangerous legislation and damaging regulation adopted with greater ease. But wherever physicians know that we are the only ones who will stand up and protect ourselves and our patients, and know we must be organized and unified to be effective, we will see sensible policies and much-needed reforms winning the day. Illinois is such a place, and I hope you and your colleagues will join me in keeping it that way.

Eldon Trame, MD, is the president of the Illinois State Medical Society.

EDITOR’S NOTE: The Chicago Medical Society works through the Illinois State Medical Society to influence legislation at state and federal levels. The policymaking and legislative process begins in the CMS Governing Council, where any member can sponsor a resolution. After being debated and adopted by the CMS Council, resolutions pass directly to the State Society, with input from its influential Governmental Affairs Division. In addition to supporting pro-medicine policies and legislation, our organizations work to prevent harmful bills from becoming law.
Uniting to Serve Physicians

CMS teams with ABA, provides strategies for success By Elizabeth Sidney

Exploring Economic and legislative trends, Chicago Medical Society members learned about their practice options during the annual Physicians Legal Issues Conference. This educational program, which CMS co-hosts with the American Bar Association’s Health Law Section, took place June 13-15, in Chicago.

ACOs and Value-Based Care

Although it hasn’t kicked into high gear yet, the Affordable Care Act is already part of the national fabric, having an impact in the health care market place, said speaker Stephen L. Ondra, MD. As senior vice president and chief medical officer of Health Care Service Corp., parent of Blue Cross Blue Shield of Illinois, Dr. Ondra is on the front-lines of reshaping health care. Prior to accepting this post, he was health policy advisor to President Obama and chief medical officer of Northwestern Memorial Hospital.

Dr. Ondra compares reform to a symphony, with different instruments coming into play at different times, eventually working in unison to move the U.S. toward value-based reimbursement.

New delivery models and payment structures, chiefly the accountable care organization (ACO), will ultimately lower costs through alignment, coordination, risk sharing, and other features. Evidence-based medicine will also become the center of gravity, Dr. Ondra said. For providers who lack the resources to form an ACO, Dr. Ondra said hospitals and physicians have other options as stepping stones to an ACO. These include bundled payments, medical homes, and pay for performance programs. Overall, though, Dr. Ondra concluded that, “ACOs provide the best chance for the U.S. to achieve a healthy competitive market system.”

The Hospital Medical Staff

The medical staff, through its bylaws, is the only entity to provide independent oversight free from the economic pressures potentially placed on hospital owners. But physicians often discover the obligations of employment interfere with professionalism and other critical medical staff duties. In this session CMS Immediate Past President Howard Axe, MD, teamed with Elizabeth “Libby” Snelson, of the law firm Medical Staff PLLC, to describe conflicts that may arise and strategies to resolve them.

To start, physicians should protect their interests and those of patients by staying on top of the issues. For example, they should read emails and other documents closely. Dr. Axe told of changes in electronic voting requirements at some hospitals that now allow non-responses to be counted as “yes” votes. Another key strategy for physicians is a comprehensive set of medical staff bylaws that anticipate potential situations and employ ethical and professional principles to address them.

Medical staff should be advised the hospital attorney doesn’t always represent their best interests. Nor should medical staff necessarily accept offers of free advice from the hospital attorney or allow that individual to represent them in a hearing. In fact, the physician has the right to request a different lawyer. As a self-governing legal entity, the medical staff develops its own bylaws, criteria for membership, peer review, hearings and appeals, credentialing and privileging. For these reasons the medical staff should have its own legal counsel when their interests diverge from those of the hospital, Snelson said. Dr. Axe suggested physicians consult the Illinois State Medical Society’s model medical staff bylaws available at www.isms.org.

Race and Higher Education

Fisher vs. the University of Texas was one of the most closely watched cases of the last U.S. Supreme Court term. While awaiting the decision, speaker William A. McDade, MD, PhD, explained how this challenge to affirmative action could ultimately harm minority health research and access to care in underserved communities.

The strong relationship between diversity in medical education and health care for minorities is substantiated by numerous studies, Dr. McDade said. Legal precedent, established in Bakke (1978), and endorsed in Grutter (2003), also underscores the importance of fostering diversity in clinical care and research.

Dr. McDade, who is deputy provost for research and minority issues at the University of Chicago, said that minorities are more likely to pursue biomedical research that addresses the health needs of racial and ethnic groups. Minority doctors are more likely to practice in underserved communities. And satisfaction with one’s care and caregiver is positively associated with treatment compliance.

Dr. McDade is president-elect of ISMS and a past president of CMS. He serves on the AMA Council on Medical Education.
Society Contributions Influence National Policies

Public health and public policy dominate at the annual AMA meeting By Elizabeth Sidney

**Illinois Physicians** advanced new policies and directives at the American Medical Association's annual meeting on June 15-19. The actions below reflect the contributions of the Chicago Medical Society.

**Obesity Now Considered a Chronic Disease State**

Brought in 2012 by the Illinois Delegation, this policy paves the way for a new era in the treatment of obese and overweight patients, many observers believe. Acting upon a resolution originally from pediatrician Kamala Ghaey, MD, MPH, a member of the Chicago Medical Society and a CMS trustee, the AMA said that obesity should be reclassified as a chronic disease state. The declaration builds momentum for Medicare and other insurers to cover the cost of weight-loss counseling and treatments such as prescription drugs for chronic weight management.

The AMA action also helps to dispel notions that overeating is a behavioral choice, which fuels stigma among physicians and patients alike. Coupled with better treatment approaches, physicians and patients can now have more meaningful, open conversations about obesity and weight loss.

Although Medicare pays for obesity counseling for patients with a body mass index of 30kg/m2 or greater, most insurers do not cover primary care visits devoted to improving diet, eating behaviors and exercise. These types of discussions are often squeezed into appointments for separate health problems. The reclassification of obesity as a disease also encourages research funding into obesity prevention and treatment strategies, including the biologic, environmental and genetic factors contributing to unhealthy weight.

The Illinois resolution prompted an in-depth study by the AMA and the House's decision captured attention on Capitol Hill. Only a day after the AMA approved new policy, lawmakers introduced bipartisan legislation in the House and Senate. The Treat and Reduce Obesity Act would require Medicare to cover additional obesity treatments.

**More Policy Highlights**

The House took the following actions:

- Approved a statement clarifying the AMA's policies on the Affordable Care Act and health care reform. It includes language on repealing and replacing the Medicare SGR formula; repealing and replacing the Independent Payment Advisory Board; supporting medical savings accounts; and Medicare private contracting. The resolution also called for steps to reduce health care costs and lower insurance premiums, and provide for a sustainable expansion of health care coverage. Delegates narrowly approved language calling for “sufficient funds” to be devoted towards this campaign.
- Voted to mandate a two-year implementation period for ICD-10/11, during which time insurers would not be allowed to deny payment based on the specificity of an ICD-10/11 diagnosis. The desired outcome is for Congress and Medicare to require health insurers to give physicians flexibility following the Oct. 1, 2014, change from 16,000 to 140,000 diagnosis codes.
- Supported federal funding of organ transplants for Medicaid patients.
- Called for tougher regulations on direct-to-consumer advertising for durable medical equipment (DME) so as not to confuse patients about how to get their products. Those rules should include a disclaimer saying that eligibility for and coverage of DME is subject to specific criteria and that only a physician can determine whether a patient meets the standards.
- Adopted new policy that establishes principles for reforming the delivery of care for patients eligible for both Medicare and Medicaid, including customizing benefits for patients and ensuring that care coordination demonstration programs do not interfere with the patient-physician relationship.
- Supported a partnership between AMA and the Centers for Medicare & Medicaid Services to develop incentives for hospitals and health systems that would encourage more efficient sharing of electronic health records with independent physicians.
- Asked the AMA to work with other health professional organizations to advocate for a reduction of the fixed interest rate on the Stafford student loan program.
- Voted to continue with the Interim Meeting of the House of Delegates.
- Issued a warning against “inappropriate inquiries” from pharmacies to verify the medical rationale behind prescriptions and diagnoses, calling them an unwarranted interference with the practice of medicine.
The Illinois proposal was considered along with an obesity measure authored by seven medical specialty societies.

**Educat ing Medical Providers to Stop Human Trafficking**

The AMA will work to raise awareness about human trafficking, informing physicians of resources to aid them in identifying and serving victims. This action stems from a resolution sponsored in 2012 by William A. McDade, MD, PhD, a past president of CMS and current ISMS president-elect. With the adoption of new policy, the AMA will encourage awareness among its member groups and sections, as well as the federation of medicine, in addition to informing physicians about relevant resources, such as those listed below.

- **The Polaris Project**, which operates a 24-hour National Human Trafficking Hotline and maintains the National Human Trafficking Resource Center.
- **The Rescue and Restore Campaign**, a program of the Department of Health and Human Services that offers assistance to health care professionals, law enforcement, and social service organizations.

**Decisions Reflect CMS Actions**

The AMA acted on other proposals that the Chicago Medical Society hotly debated over the past year. While not considered by the AMA House, the CMS resolutions called for the regulation of energy drinks and ending the misuse of recertification and relicensure exams.

**Banning Marketing of Energy Drinks to Kids**

The AMA adopted policy supporting a ban on the marketing of high-stimulant caffeine drinks to adolescents under age 18. Earlier this year, the Chicago Medical Society also approved language to restrict the sale and distribution of these products to minors in Chicago and Cook County. Immediate Past President Howard Axe, MD, testified at a Chicago City Council hearing in support of a ban, in addition to spelling out the dangers of energy drinks, which are often touted as harmless athletic enhancers. When meeting with Senator Richard Durbin in February, Dr. Axe called for an FDA investigation. Super-caffeinated beverages are unregulated because their contents are classified as supplements. The FDA is now reviewing reports of illness, injury and death among young people who consumed the drinks.

**Maintenance of Certification**

The House agreed to look at this process, which many physicians say is costly, time-consuming, and unnecessary.

Earlier this year, CMS member Makis Limperis, MD, forcefully addressed the Governing Council and ISMS House of Delegates, urging organized medicine to take a stand. He said insurers and hospitals require physicians to needlessly retake the exams, using them as an excuse to deny privileges or plan participation. As a result, Dr. Limperis testified, “maintenance of certification (MOC) and maintenance of licensure (MOL) have near-monopoly control over medical practice.”

The AMA will commission an independent study to evaluate the impact of MOC and MOL on physicians’ practices, the doctor work force and patients. A progress report is forthcoming at the 2014 Annual Meeting.

The AMA will also work with the American Board of Medical Specialties and its specialty boards to determine if the mandatory exams are still needed and to explore alternatives. AMA will encourage the ABMS to ensure that member boards are transparent about the costs of preparing and administering the exams.

The AMA will hold its Interim Meeting on Nov. 16-19, 2013, at the Gaylord National Resort and Convention Center, National Harbor, MD. Please go to www.ama-assn.org for details.

William A. McDade, MD, PhD, a past president of CMS and current ISMS president-elect, says that physicians have a special responsibility to identify and assist victims of human trafficking.
Society Welcomes New Leader

Dr. Robert Panton outlines ambitious but achievable goals

THE CHICAGO Medical Society’s 165th President assumed office confronting a challenge that greets each new president: bringing more members into the ranks of organized medicine. During annual dinner ceremonies on June 11, which marked the changing of the CMS guard, Robert W. Panton, MD, an Elmwood Park ophthalmologist, said that engaging physicians is key to building a more inclusive Society. He also believes an across-the-board dues reduction is a recruitment tool whose time has come.

“One would like to believe the fine work of the Society would automatically translate into membership. Unfortunately, it’s not that simple,” Dr. Panton continued. To break through the many competing interests and demands on physicians, CMS must demonstrate value—consistently and relentlessly, he said. “In everything we provide—our communications, education, legislative advocacy, and public health leadership, physicians must recognize value,” Dr. Panton stated.

This year’s doubled attendance at the Physician Legal Issues Conference is a sign that interest in CMS is on the rise. “Through our relationship with the American Bar Association’s Health Law Section, CMS is able to guide physicians through the administrative black holes known as ACOs and health insurance exchanges,” Dr. Panton elaborated.

The annual conference, which CMS jointly sponsors with the ABA, along with smaller scale educational programs, including articles in Chicago Medicine magazine, will become even more critical in helping members navigate the evolving health care system,” Dr. Panton continued. CMS initiated the partnership with the ABA to keep members abreast of developments in the legal, regulatory, and practice climate.

The incoming president also said that CMS’ historic missions of education and public health are another compelling reason for doctors to join. “This past year, CMS testified at City Hall about the dangers of super-caffeinated energy drinks that are marketed to children and youth,” Dr. Panton said. “We came out in support of Alderman Burke’s proposed ban. And in a meeting with Senator Richard Durbin in Washington, DC, we called for an FDA investigation of health care products,” he added.

CMS also serves on a nominating committee that screens candidates for the Cook County Health and Hospitals System board. “In that capacity, we recommended several physician-members of our organization to serve on the board,” Dr. Panton noted. In still more activity, “CMS joined Chicago’s Clean Power Coalition, which pushed for a City Council ordinance that would have forced several power plants to reduce their particulate matter and CO2,” Dr. Panton elaborated. “And we strongly support member Vemuri Murthy, MD, as he actively promotes CPR awareness among physicians and patients through training workshops and publicity campaigns,” Dr. Panton said.

CMS serves on the executive leadership team

A BOARD-CERTIFIED ophthalmologist based in Elmwood Park, Dr. Panton joined his family-owned private practice, Panton Eye Center, in 1991. He is active on staff at Gottlieb Memorial Hospital, Rush Oak Park Hospital, Westlake Community Hospital, and West Suburban Hospital. A clinical assistant professor at the University of Illinois, Dr. Panton is a Fellow in both the American Academy of Ophthalmology and the American College of Surgeons.

Dr. Panton earned his undergraduate and medical degrees from Brown University, in addition to a master’s in pharmacology, also at Brown. He served his internship in internal medicine at the University of Chicago Hospitals. He completed his residency in ophthalmology at the University of Illinois at Chicago, and a fellowship in corneal and cataract surgery at the Johns Hopkins University. A CMS member since 1987, Dr. Panton currently serves on the following committees: Long-Range Planning; Continuing Medical Education; Physician Advocacy; Membership/IM; Communications/Technology; and Healthcare Economics. His previous committee appointments include: Membership (Chair); Editorial Advisory Staff (Chair); Investment (Chair); and Young Physicians Group (Chair). Dr. Panton has been a member of ISMS since 1987, serving on numerous councils and committees. He currently serves on the Committee on Finance & Medical Benevolence; Council on Economics; and CME Accreditation Appeals Panel. A delegate since 2002, he has chaired the Governmental Affairs Council.

Dr. Panton practices with his father John H. Panton, MD, his older brother Peter J. Panton, MD, and sister Elizabeth Panton Karkazis, OD. In addition to his brother and father, Dr. Panton’s wife Marika, joined the annual dinner celebration. The Pantons’ have two young children, James and Zoe, and a teenager, Jonathan.
of the Building a Healthier Chicago (BHC) coalition, organized by former U.S. Assistant Surgeon General James M. Galloway, MD, Dr. Panton continued. BHC works with local and national stakeholders, uniting and supporting organizations, businesses, and non-profits around the goals of prevention and healthy living.

“On the individual level, CMS’ work with member Neelum Aggarwal, MD, is a benefit for patients and physicians,” Dr. Panton said. Along with Dr. Aggarwal, CMS is publicizing the capabilities of Cook County’s regional Primary Stroke Centers. “This educational initiative engages local legislators and community stakeholders as we and Dr. Aggarwal host programs through our Mini-internship Program,” he explained.

“Clearly,” Dr. Panton, emphasized, “CMS has much to offer. We don’t need more membership studies this year;” he concluded. “Simply put, it’s time for action.”

Among the members and guests enjoying the festivities were the incoming president’s father, John H. Panton, MD, founder of Panton Eye Center; Dr. Panton’s older brother Peter J. Panton, MD, also an ophthalmologist, and member of the Panton eye care team. Dr. Panton’s wife Marika, a piano teacher, and two of his three children beamed as Dr. Axe passed the baton of leadership to his colleague. Many CMS past presidents were present to welcome the new leadership slate for 2013-2014.

To read more about Dr. Panton’s goals, please refer to his President’s Message on page 2.

---

**CMS OFFICERS 2013-2014**

Robert W. Panton, MD, President
Kenneth G. Busch, MD, President-elect
Clarence W. Brown, Jr., MD, Secretary
Philip B. Dray, MD, Treasurer
Kathy M. Tynus, MD, Governing Council Chair
Adrienne L. Fregia, MD, Governing Council Vice-Chair
Howard Axe, MD, Immediate Past President

**BOARD OF TRUSTEES 2013-2014**

Kenneth G. Busch, MD, Chair
Christine P. Bishof, MD
Thomas J. Chorba, MD
Philip B. Dray, MD
Mary Jo Fidler, MD
Kamala A. Ghaey, MD
John N. Kiriklakis, MD
Vemuri S. Murthy, MD
Trista M. Negele, MD
Roger L. Rodrigues, MD
Anne Szpindor, MD
Michael R. Treister, MD
Raghu R. Vollala, MD
Megan Gayeski, MD, Resident
James Wu, Student

From top: Outgoing CMS President Dr. Howard Axe (right) passes the baton to new President Dr. Robert W. Panton. Middle: Dr. John Panton (left) and son, Dr. Peter Panton (center), congratulate Dr. Vemuri S. Murthy for his CPR initiatives. Bottom: Dr. Panton’s immediate family were present; wife Marika is shown with two of the three Panton children, James and Zoe; Dr. Panton is flanked by his father and brother.
Calendar of Events

AUGUST

6 Access to Care Subcommittee General Meeting Access to Care is a subcommittee of the CMS Public Health Committee that studies recent developments and policy recommendations to increase and improve access to care for veterans, underserved populations, children, and other populations. This meeting is intended for subcommittee members, but is open to interested CMS members as well. 7:30-8:30 a.m.; conference call. To RSVP, please contact Meredith at 312-329-7326; or oney@cmsdocs.org.

14 CMS Executive Committee Meeting Meets once a month to plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-9:00 a.m.; Maggiano’s Banquets, 111 W. Grand Ave., Chicago. Please contact Ruby at 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

14 CMS Board of Trustees Meeting Meets every other month to make financial decisions on behalf of the Society. 9:00-10:00 a.m.; Maggiano’s Banquets, 111 W. Grand Ave., Chicago. Please contact Ruby at 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

15 ISMS Webinar Series HIPAA Training for Physicians & Practices: Part Two. 12:00-1:00 p.m. To register, go to the ISMS Education Catalog at www.isms.org.

15 Illinois Society of Plastic Surgeons General Meeting “Simulation Facelift and Fat Grafting-Combined Lifting and Filling for Rejuvenation of the Aging Face.” This lecture is for ISPS members and plastic surgery residents. 7:00-9:00 p.m.; Metropolitan Club, Willis Tower, 66th floor, Chicago. ISPS members may attend at no cost. To RSVP, please contact Meredith at 312-329-7326; or oney@cmsdocs.org.

SEPTEMBER

3 Access to Care Subcommittee General Meeting Access to Care is a subcommittee of the CMS Public Health Committee that studies recent developments and policy recommendations to increase and improve access to care for veterans, underserved populations, children, and other populations. This meeting is intended for subcommittee members, but is open to interested CMS members as well. 7:30-8:30 a.m.; conference call. To RSVP, please contact Meredith at 312-329-7326; or oney@cmsdocs.org.

10 CMS Governing Council Meeting The Society’s governing body meets four times a year to conduct business. The policy-making Council considers all matters brought by officers, trustees, committees, councilors, or other CMS members. Members are welcome to attend at no cost. 6:00-9:00 p.m., Maggiano’s Banquets, 111 W. Grand Ave., Chicago. To RSVP, please contact Ruby at 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

12 Illinois Society of Plastic Surgeons General Meeting “Separation, Aspiration, and Fat Equalization: Primary and Secondary Body Contouring Utilizing SAFE Lipo Concepts.” This lecture is intended for ISPS members and plastic surgery residents. 7:00-9:00 p.m.; Metropolitan Club, Willis Tower, 66th floor, Chicago. ISPS members may attend at no cost. To RSVP, please contact Meredith at 312-329-7326; or oney@cmsdocs.org.

19 Leading the Medical Community Subcommittee General Meeting Leading the Medical Community is a subcommittee of the CMS Public Health Committee whose mission is to disseminate the latest evidence-based information about early recognition and response to cardiac arrest and stroke, to encourage physician training in latest techniques of resuscitation through American Heart Association courses, and to develop educational programs for young physicians. This meeting is intended for subcommittee members, but is open to interested CMS members as well. 3:00-4:00 p.m.; conference call. To RSVP, please contact Meredith at 312-329-7326; or oney@cmsdocs.org.

CMS Career Center & Job Board

IN THIS changing practice landscape, where 49% of residents and 65% of established physicians are joining hospital-owned practices, CMS can expand your employment reach. Our online Career Center connects medical professionals with employers nationwide. Our participation in a national network allows job seekers to view hundreds of positions at leading institutions. Site services include career coaching and advice on preparing a CV and interviewing. You can store your CV and search-alerts in one place and sign up for alerts when a new job matches your search criteria. Get the most out of your membership by using the Career & Job Center at www.cmsdocs.org.
Personnel Wanted

Ophthalmology position desired: senior ophthalmology resident, graduating in 2014 from the University of Washington, Seattle, plans to relocate to the Chicagoland area and is seeking a position in the Chicagoland area starting July or August 2014. Please reply to Sheilagoyal@gmail.com.

Mobile Doctors® seeks a physician to make house calls to the elderly and disabled in Chicago. Full-time or part-time. No night/weekend work. Travel with a certified medical assistant in a company car. Malpractice insurance provided. If interested, please forward your CV to Nick at nick@mobiledoctors.com; or call 312-848-5319.

Pediatrics physician needed in our Arlington Heights (NW suburb) office. Part-time permanent position. Join our well-established, busy pediatric practice. Competitive compensation, paid malpractice insurance, vacation. Please forward CV to physician.staffing.il@gmail.com.

Practice Wanted

Ophthalmology practice wanted. Looking to buy in Chicago, northwestern suburbs or other suburban areas of Chicago. Please reply to vg1028@aol.com or fax to 874-398-4585.

Business Services


Physicians' Attorney—experienced and affordable physicians' legal services including practice purchases; sales and formations; partnership and associate contracts; collections; licensing problems; credentialing; estate planning; and real estate. Initial consultation without charge. Representing practitioners since 1980. Steven H. Jesser 847-424-0200; 800-424-0020; or 847-212-5620 (mobile); 5250 Old Orchard Rd., Suite 300, Skokie, IL 60077-4462; shj@sjesser.com; www.sjesser.com.
When Russell G. Robertson, MD, graduated from Michigan State University in 1974 with a bachelor's degree he didn't have a career path in mind. “Both my parents were teachers,” he says, “so by default I went into education.” For the next four years, Dr. Robertson taught elementary school in Utica, MI, while also earning his pre-med requirements at Oakland University in Rochester. “I didn’t think I had what it took to be a teacher,” he says.

Today, Dr. Robertson is vice president for medical affairs and dean of the Chicago Medical School at Rosalind Franklin University of Medicine and Science. “I was able to build on my experiences in elementary education and apply that to adult education,” he says. The family practitioner, who earned his MD from Wayne State University in Detroit, was recruited from Northwestern University in 2011, where he served as professor and chair of the department of family and community medicine at the Feinberg School of Medicine and also as chair of family medicine at Northwestern Memorial Hospital. Prior to then, Dr. Robertson was associate dean for faculty affairs at the Medical College of Wisconsin.

Since arriving at the Chicago Medical School, he has forged closer relationships with Advocate Lutheran General Hospital and Advocate Lutheran General Children's Hospital. He was instrumental in designating the Marianjoy Residency Program as an academic affiliate of the Chicago Medical School.

One of Dr. Robertson’s proudest achievements is his work in international health. He was the director for global education at the Northwestern Center for Global Health. And since joining the Chicago Medical School, Dr. Robertson established a strategic partnership with Chicago-based Heartland Alliance to identify and develop research, education and service projects in global health. Dr. Robertson also sat on the board of Hillside Health Care International, which operates a clinic in Punta Gorda, Belize, in collaboration with the Belizean Ministry of Health. “This was a great opportunity to provide clinical care as well as learning opportunities for students,” he says.

An interest in workforce issues was the impetus for a 2010 study led by Dr. Robertson that found almost 50% of graduating Illinois residents and fellows leave the state to practice elsewhere. While family is the primary reason, the medical liability climate is also a major consideration for those who leave Illinois to practice, he discovered.

But Dr. Robertson's calling as an educator and physician would not be complete without his connection to Chicago's medical community. “In our rapidly changing world, the Chicago Medical Society fosters important discussions around topics that are of great relevance to our profession and we need to have a voice in these conversations,” he explains.

On a personal front, Dr. Robertson met his wife Sandy during his first year teaching at Utica. “After I finished medical school, I thought ‘this wasn’t too tough, so let’s start a family,” he says. “But I owe all the credit to my wife. We have two children and now we also have three grandkids.”

As dean of the Chicago Medical School, Dr. Russell Robertson has used his experience as an elementary school teacher to advance medical education.

Dr. Robertson’s Career Highlights

A CLINICIAN, speaker, writer, teacher and program administrator, Dr. Robertson has a long list of credits and awards. He has been ranked as a “top doctor” five times by his peers and has garnered a number of grants for initiatives ranging from the clinic in Belize to elder care to family violence. In 2003, he was one of 17 physicians nationwide appointed to the Council on Graduate Medical Education by the U.S. Secretary of Health and Human Services. Never stopping, he was appointed this May to the Illinois Workforce Investment Board, Health Care Task Force.
“As physicians, we have so many unknowns coming our way…

One thing I am certain about is my malpractice protection.”

Medicine is feeling the effects of regulatory and legislative changes, increasing risk, and profitability demands—all contributing to an atmosphere of uncertainty and lack of control.

What we do control as physicians: our choice of a liability partner.

I selected ProAssurance because they stand behind my good medicine and understand my business decisions. In spite of the maelstrom of change, I am protected, respected, and heard.

I believe in fair treatment—and I get it.

To learn how we can help you lessen the uncertainties you face in medicine, scan the code with your smartphone camera.
This is how Dr. Eubanks got paid for Meaningful Use.

After practicing medicine 35 years, Dr. Reavis Eubanks knew it was time for an EHR. As a solo physician, he needed an easy transition and an effective way to begin earning up to $44,000 in Medicare incentive payments.

athenahealth helped Dr. Eubanks go from paper to payment in just six months. With guidance every step of the way and proven, cloud-based services.

- Best in KLAS EHR
- Free coaching and attestation
- Seamless clinical workflow
- Guaranteed Medicare payments**

85% of eligible athenahealth providers attested to Stage 1 Meaningful Use. And we’re ready for Stage 2.

Visit www.athenahealth.com/ChicagoMed or call 800.981.5085

---

“If it comes to Meaningful Use, athenahealth did all the legwork... and then they made it easy for me to do.”

—Dr. Reavis Eubanks

---

*ambulatory segment for practices with 11-75 physicians

** If you don’t receive the Federal Stimulus reimbursement dollars for the first year you qualify, we will credit you 100% of your EHR service fees for up to six months until you do. This offer applies to HITECH Act Medicare reimbursement payments only. Additional terms, conditions, and limitations apply.