Should early tumors be called something other than the “Big C”?

PAGE 16

The Obamacare Launch and Your Patients’ New Insurance Coverage

Healing the Healer

Making Sense of Quality Measures
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16 The Cancer Debate
Should early tumors be called something other than the “Big C?”
The debate rages on. By Howard Wolinsky

22 The Obamacare Launch: What You and Your Patients Can Expect
The health law’s essential benefits provision may clarify your patients’ coverage before they even walk in the door. By Bruce Japsen

2 Public Health Initiatives
By Robert W. Panton, MD

4 The Hidden Cloak
By Sonny Patel, Student

6 Help for Today’s Physician and Staff

10 Understanding the Illinois Parental Notice of Abortion Act
By Allie Carter

11 Hospital Consolidations
By Elizabeth “Libby” Snelson, JD

12 Sex and Gender in Atrial Fibrillation
By Annabelle S. Volgman, MD, and Neelum T. Aggarwal, MD

13 What is Gender Medicine?
By Neelum T. Aggarwal, MD

5% Discount After Five Years

Welcome New Members!

Healing the Healer
By Daniel H. Angres, MD

Rallying for Residency Spots
By Elizabeth Sidney

ISMS Spotlight: Who Writes the Rules?
By Eldon A. Trame, MD, ISMS President

Calendar of Events

Classifieds

WHO’S WHO
Toiling for Toxins
Toxicologist Jerrold Leikin, MD, channels his passion for poison to help physicians and patients. By Scott Warner
Public Health Initiatives

When the Chicago Medical Society (CMS) was founded in 1850, the organization had two chief missions: educating physicians and enhancing public health. In the very first year, CMS advocated for basic sanitation systems in the city to help control the spread of communicable diseases. By 1855, CMS empowered doctors to post quarantine signs in the homes of smallpox victims. CMS physicians worked directly with factories and slaughterhouses to minimize work-related injuries. In fact, enhancing public health continues as one of the primary missions of CMS. The Public Health Committee, chaired by Ajay Chauhan, DO, remains one of the most active CMS committees. Several public health initiatives are currently underway.

CPR/ACLS

Among our recent projects is the CPR (cardiopulmonary resuscitation) program coordinated by CMS Trustee Vemuri Murthy, MD, working with the American Heart Association. The drive to teach “hands-only” CPR to the public has been well received, with several hundred individuals being trained. Hands-only allows participants to avoid the perceived risks of mouth-to-mouth resuscitation.

CMS is also a partner in Project SMILE (Saving More Illinois Lives through Education), a coalition to raise CPR awareness and instruct individuals throughout the state.

CPR courses for physicians include Basic Life Support (BLS) and Advanced Cardiovascular Life Support (ACLS) certification, and are provided at the CMS building. Attendance continues to increase. Legislators, too, have expressed interest in learning CPR; efforts are underway to equip them with this basic life skill.

Energy Drinks

As CMS President in early 2013, Howard Axe, MD, spearheaded an awareness campaign to spotlight the dangers of energy drinks. These highly caffeinated products may increase the risk of cardiac arrhythmias. The effects are especially prevalent in children and adolescents, to whom the products are marketed. CMS passed resolutions calling for restrictions on energy drink sales to minors.

Dr. Axe testified before the City of Chicago Finance Committee on March 5, outlining the potential adverse effects and real-life case examples. Apparently, Dr. Axe was ahead of the curve. On April 11, the FDA issued a harsh warning against energy drinks containing the stimulant dimethylamylamine (DMMA).

Current Projects

• CMS has worked with Neelum Aggarwal, MD, to increase awareness of Cook County’s Primary Stroke Centers. Dr. Aggarwal coordinates the public health section in Chicago Medicine.

• The CMS Council adopted policy on Sept. 10, supporting the implementation of outdoor adult playgrounds to promote physical activity and decrease health risks. Ald. Michele Smith has introduced such legislation to the City Council, and hopes to establish the first Chicago playground in her Lincoln Park ward.

• Founded by then-U.S. Asst. Surgeon General, James Galloway, MD, Building a Healthier Chicago is a coalition of groups that promote healthier living. CMS has been a coalition member since 2008 and joined the executive team in 2012.

• The health insurance exchanges of the Affordable Care Act (ACA) opened on Oct. 1, 2013. CMS provides webinars and speakers on various aspects of the ACA roll-out. Educating physicians about the ACA will be a major educational drive for CMS in the coming year. Since its humble origins 163 years ago, CMS has been committed to the advancement of public health. The issue at hand may be smallpox quarantine or ACA roll-out, but the focus on public health remains the same.

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President, Chicago Medical Society
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The Hidden Cloak

Panelists at UIC event debate whether the ACA is a good starting point for resolving disparities in health care access By Sonny Patel

DURING MY FIRST week of surgery as a medical student, the intensive care unit nurse introduced me to Betty. “She’s our 45-year-old African-American female with a diabetic everything,” she said as a short-hand way of explaining that Betty was in the ICU for numerous complications from her morbid obesity and uncontrolled type-2 diabetes. Betty’s weight made it difficult for her to leave her bed, which led to the pressure ulcers on her hip and buttocks. Betty’s diabetes impaired her blood flow and wound healing, permitting these ulcers to rot down to the bone. When she arrived in our ICU, Betty was completely unresponsive and swollen with fluid, from a severe infection of her ulcers. Her eyes stared blankly up at the ceiling, entirely unaware of my hand on her shoulder or the family photos taped to her bedrail. Seeing such unavoidable suffering was an awful introduction the ICU.

As Betty lay in her silent state, my mind roiled with questions: Why had she not seen a doctor sooner? Why had she not followed up after the ER visits? Why were preventative measures not arranged after she was hospitalized? Why was she bounced between hospitals and nursing homes for a decade? Why do we have no choice but to discharge her to the same nursing facility that brought her to the ICU?

My questions suggested a systemic problem in the way health care is accessed. The clue to the puzzle was typed under her name on Betty’s ID sticker, “Medicaid/Self-Pay.” There is ample confusion on how disparities in access to health care should be remedied, including a number of different proposed solutions. And be it the best solution or not, starting this month, we as a country have committed to the Affordable Care Act—the most sweeping reform in U.S. health care since the creation of Medicare.

Where ACA Is Taking Us
The ACA is much more than an expansion of Medicaid and an individual mandate. It immediately affects patients, physicians, hospitals, employers, the uninsured and the underinsured. For the future, it establishes a trajectory for health care reform in America.

The ACA remains a hotly contested topic of conversation, which on Sept. 5, took the spotlight in Chicago. With the generosity of the Chicago Medical Society and support from colleagues at the University of Illinois at Chicago, I had the privilege of moderating a debate on where the ACA is taking us. The evening’s theme was “Resolved: The Affordable Care Act is a Good Starting Point for Health Care Reform.” Four supremely qualified panelists—a past CMS President and former Assistant Dean of the Chicago Medical School, William N. Werner, MD; former President of Partners for a National Health Program, Claudia Fegan, MD; President-elect of the American Medical Association, Robert Wah, MD; and State Director for Doctors for America, Ram Krishnamoorthi, MD—offered their take from various ends of the political spectrum.

Not surprisingly, there is no right answer. It’s impossible to know where Americans will find themselves a decade into Obamacare. Nonpartisan reports claim hospitals and patients will spend less money on health care and lives will ultimately be saved. But, resources are finite. Investment in one social service will require...
sacrifice from another, and at some point, we will have to contend with rationing health care to contain costs. Still, I would argue that knowing where we stand on the resolution was never the purpose—the accomplishment of the debate was in the conversation itself.

The debate gathered physicians, nurses, allied health professionals, medical students from all Chicago-area schools, activists, academics, and concerned citizens, young and old in one room. The audience provided a diverse set of perspectives. While some questions concerned how specific groups of people would be affected by the ACA, the majority of questions were about the system itself. What kind of ideal health care system is feasible? How much of our humanistic ideals or our tax dollars are we willing to sacrifice to create something sustainable? What assumptions do we hold when making demands on people who deliver care and the people who are paying for it? Ultimately, who should be responsible for making sure the patient is healthy? These are difficult questions. They come from a place of introspection, in trying to understand what health care should become. The reason that thought process is so critical is because, as Dr. Krishnamoorthi pointed out, “we haven’t seen health care reform.” We have only been placed on a trajectory, which continues to remain malleable.

Falling Through Safety Net
As I moderated the debate, my thoughts drifted back to the ICU. To policymakers, Betty may represent a cohort of people associated with a litany of labels: low-income, poor health literacy, underinsured, minority, welfare-dependent. To me, I see a person who fell through our lowest safety net, and because of that, suffered tremendously. While my questions were out of frustration, it implied that I lacked a vision of what my patient really needed outside of medicine; and that’s where the sorcery of civics comes in. Engaging young people in policy, be it through debate, town hall meetings, student government, professional guilds, or otherwise, is what bends our path. It helps us see the hidden cloak—the social context—our patients wear when they become ill. It can transform a medical student into an advocate.

Looking forward, our grossly overpriced health care system may now have to be more competitively marketed. Seeing “Self-Pay” on ID stickers will become increasingly rare. Individuals will be expected to take responsibility for their health. Hospitals will have to adjust their business model to make care delivery profitable. Primary care residencies will need to expand the number of seats. It is an exciting time to be leaving medical school. My colleagues and I sit on the precipice of something significant. It could not be a more important time to remain engaged.

Sonny Patel is a fourth-year medical student at the University of Illinois at Chicago.

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EMR Cloning: A Bad Habit

Convenient computer function may prompt patient care concerns, payment denials and legal questions By Juan P. Cueva, MD

The widespread adoption of electronic medical records (EMRs) in hospitals has resulted in a shift from the traditional clinical narrative writing style to an unintended reliance on the computer function known as copy and paste. It is also referred to as a save as macro, or carry forward, or most descriptively—EMR cloning.

Hospital attendings may have observed how medical residents and younger hospitalists, who grew up with computers, have assumed the liberty of writing and organizing their electronic hospital notes with minimal direction and no clear-cut hospital or professional standards.

The EMR function called copy and paste allows physicians to easily incorporate lab tests, round the clock vitals, and every conceivable report in a single progress note. While the feature is handy, it creates risks for the patient, hospital and physician.

However, these risks can be mitigated if physicians develop a writing style, tailored to the EMR, which makes use of the long-established hospital narrative. This narrative style is essentially storytelling that relays the particulars of the patient’s illness, with events sequenced chronologically, along with appropriately inserted clinical commentary and discussion of treatments.

In contrast, when a physician relies on copy and paste in EMR charting, vast amounts of clinical data and whole text from previous notes or the initial history and physical, regardless of author, or even the original patient, can end up being pasted into the new note. EMR cloning quickly makes yesterday’s note into today’s note but the story of the patient is muddled with a deluge of clinical information.

Worse yet, EMR cloning has resulted in Medicare and other insurance companies denying payments, thus inviting case review and new legal liabilities. Recent studies have also established EMR cloning as a potential factor in poor patient outcomes, such as when the cloning of glucose labs in hospitalized diabetics becomes harmful.

Of course, as a platform for hospital communication, EHRs have advantages, such as legibility, simultaneous access to records, and endless data storage space. Although multi-page EMR notes can be assimilated by the reader, the lack of narrative order often impedes clarity. What is now being diminished, or even eliminated, is the 100-year-old tradition of hospital narrative writing that tells the story of the patient’s condition in a manner that is easy to understand and remember. Even longtime physicians have abandoned the clinical narrative and simply click a line or two in the EMR.

While EMR cloning may appear to save time, the U.S. Office of the Inspector General (OIG) is currently reviewing duplication standards in hospital charting and has stated that the use of duplicate entries “may be associated with improper payments.” Medicare defines cloning as multiple entries in a patient chart that are identical or similar to other entries in the same chart. The independent Medicare administrative contractor (MAC) who reviews charts for appropriateness of service has been directed by the Centers for Medicare and Medicaid Services (CMS) to identify “suspected fraud, including inappropriate copying of health information” under the Benefit Integrity/Medical Review Determinations mandate.

MACs have started to deny payments on the grounds that cloning is a “misrepresentation of the medical necessity required for services rendered.” This is an absence of explicit, individual information. One MAC contractor has established policies for its reviewer to assure that medical necessity of hospital services includes documentation demonstrating that physician notes are different and not merely a copy of the initial history and physical entry. The Center for Government Services (CGS) states, “For Medicare, the medical necessity of a service is the overarching criterion for payment,” but necessity is considered fraudulent if cloning of past medical services, lab and x-ray results, and medical notes from previous days, are simply reinserted into a new day’s progress note to justify need.”

Clinical Plagiarism?

One journal article on EMR cloning went so far as to declare that physicians who copy and paste text from other physicians’ notes may be committing “clinical plagiarism” since they are documenting work that they did not perform. The article points out that, “from an auditor’s standpoint, you don’t know how much work was actually done.”

Reed Gelzer, MD, MPH, co-founder of the Advocates for Documentation Integrity and Compliance, points out that, “Overwriting (cloning) misrepresents who provided the service, which could alter the amount billed. In addition, by submitting cloned documents for billing you are committing (insurance) fraud.”

Another concern of EMR cloning in academic hospitals is that some residents’ charting may lack daily or updated physical examinations and patient assessments. The EMR’s benefit as a platform for improved communication among medical team members is diminished when cloning generates redundancy and doubts exists about the most current updates. With increased patient workloads for attending, residents, and nurses, the use of
additional health care providers such as advanced practice nurses is facilitated by succinct clinical information rather than long, cloned notes.

Undoubtedly, the characteristics of the EMR discourage reading. The electronic chart is twice as far from the reader’s eyes with much smaller type, so it appears physicians are not reading each other’s notes. This is an inherent defect of the EMR that further discourages reading all the cloned data and text.

When my hospital mandated EMR use, my first computer notes—with their tiny type, long sentences, and no paragraphs—appeared stark on the electronic page. My initial response was to bulk up my note, to give it more clinical gravitas with additional labs, vitals, and other reports. But it was easier to just add, “Discussed with resident and agree with above,” and electronically sign the resident’s note and make it my note as the physician of record.

Eventually, I stopped co-signing cloned notes and developed my own electronic charting style that briefly documented my own clinical assessment, plan of care and discussions with the family. My eureka moment came when I realized that we physicians still discuss the patient’s illness, treatments and diagnostics as a story, telling the relevant history of sickness over time. If physicians still speak to each other in the language of narrative, why not write this way as well?

The hospital EMR does enable the use of the so-called free text notes that allow the physician to write without restraint, without fill-in-the-blanks or click-the-choices. The EMR permits the use of larger, easier-to-read type. Certainly, short, multiple, double-spaced mini-paragraphs are much easier to compose and read. Other time-saving techniques include the use of the complex cumulative sentence that splices together sentences and phrases, as well as the liberal use of conjunctions and commas. This can create highly dense clauses and modifying phrases that eliminate unnecessary words and make for more concise writing.

Since EMRs are still in their infancy, physicians on relevant hospital committees should lead the development of standards for copy and paste, limiting indiscriminate cloning, and encouraging new forms of documentation within the EMR. Physicians can develop their own clinical narrative writing style based on the traditional narrative and tailor it for the computer screen. Although EMR cloning is tempting, using it wisely will improve patient safety and assist in staying compliant with insurance and government regulations.

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Dr. Cueva is a practicing pediatrician and a member of the Pediatric Performance Improvement Committee at Advocate Children’s Hospital in Oak Lawn. He can be reached at drjcueva@att.com.
In an electronic health record (EHR), you can record much more than individual patient data. With an EHR, you can retrieve reports that help you monitor the health of patients by disease, age, or other factors. As a result of EHR certification requirements for the Meaningful Use Incentive Program, most EHRs allow you to examine the quality of care you provide by tracking nationally defined and standardized measures, called Clinical Quality Measures, or CQMs. These measures use a wide variety of data found in the EHR to help review a physician’s ability to deliver high-quality care and to achieve long-term national goals of improved health care. Examining results for CQMs in your area of practice will give you a starting point for improving the care you deliver as well as understanding national health care improvement goals.

In the past, reporting CQMs was voluntary and you could get incentives for sharing data through the EHR Meaningful Use (MU) Incentive Program or through the Physician Quality Reporting System (PQRS), both of which are sponsored by the Centers for Medicare and Medicaid Services (CMS). While the MU Incentive Program provides financial incentives for adoption and effective use of an EHR, a component of which is tracking CQM data, the PQRS program uses a combination of incentive payments and payment penalties to Medicare reimbursements to promote reporting of quality information. While there are no compliance thresholds for CQMs in either system, physicians still need to report their clinical quality data to avoid penalties to their Medicare Part B payments.

Aligning MU with PQRS Programs
What are the differences between the MU Incentive and PQRS programs? To begin, CQMs are an essential component of both programs and both programs are sponsored by CMS. What changes from 2013 are the CQMs you can choose to report and the mechanism you use to report. For the MU Incentive Program, you provide CQM data using reports from your EHR when you attest to MU. PQRS, on the other hand, has a separate system that requires your biller to code Medicare claims in certain ways that ensure they are submitted for review by PQRS. This often creates challenges for physicians who want to participate in both programs but have to develop different strategies to report what is sometimes the same data to two different programs with different reporting systems. Aligning these two entities will reduce the administrative burden of delivering data to both.

Starting in 2014, the MU Incentive Program and PQRS are being aligned. In other words, CQMs reported through the EHR Incentive Program using a 2014 certified EHR will satisfy the requirement to submit PQRS measures. That means you will not need to report to both entities and there will be better centralized electronic mechanisms for reporting, including direct submission from your EHR if you are using an EHR that meets the 2014 EHR certification standards. It also means that health care providers and hospitals will be required to report using the new 2014 criteria regardless of what stage they are in of the MU Incentive Program.

### Table 1: Recommended Core CQMs for Adult and Pediatric Populations

<table>
<thead>
<tr>
<th>Adult Recommended Core Measures</th>
<th>Pediatric Recommended Core Measures</th>
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</thead>
<tbody>
<tr>
<td>Functional status assessment for complex chronic conditions</td>
<td>Weight assessment and counseling for nutrition and physical activity for children and adolescents</td>
</tr>
<tr>
<td>Use of high-risk medications in the elderly</td>
<td>Chlamydia screening for women</td>
</tr>
<tr>
<td>Documentation of current medications in the medical record</td>
<td>Childhood immunization status</td>
</tr>
<tr>
<td>Closing the referral loop: receipt of specialist report</td>
<td>Preventive care and screening: Screening for clinical depression and follow-up plan</td>
</tr>
<tr>
<td>Preventive care and screening: Tobacco use: Screening and cessation intervention</td>
<td>Appropriate treatment for children with upper respiratory infection</td>
</tr>
<tr>
<td>Preventive care and screening: Body Mass Index (BMI) screening and follow-up</td>
<td>Appropriate testing for children with pharyngitis</td>
</tr>
<tr>
<td>Preventive care and screening: Screening for clinical depression and follow-up plan</td>
<td>Use of appropriate medications for asthma</td>
</tr>
<tr>
<td>Use of imaging studies for low back pain</td>
<td>ADHD: Follow-up care for children prescribed medication</td>
</tr>
<tr>
<td>Controlling high blood pressure</td>
<td>Identification of children who have dental decay or cavities</td>
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2014 Reporting Requirements
In the new 2014 program, physicians who are participating in either or both programs will be required to report on a total of nine CQMs (Table 1). The National Quality Strategy (NQS) has recommended a set of nine CQMs for the adult population and nine for the pediatric population. However, providers will have the option of reporting on any nine CQMs relevant to their scope of practice as long as three of the six critical domains are represented. The six domains are patient and family engagement; patient safety, efficient use of health care resources; care coordination; population and public health; and clinical processes and effectiveness.

The quality measures were chosen because they are believed to have the greatest potential for improving patient care. However, there are no required CQMs and because the nine recommended CQMs are not relevant for all scopes of practice, additional measures have been added. For instance, behavioral health providers may choose the Major Depressive Disorder Suicide Risk Assessment measure, and oncologists can choose a measure related to cancer pain. One thing to consider as you select your CQMs to report on is that not all certified EHRs may be certified for all 64 CQMs. Check with your vendor to determine if the measures you intend to report on are included.

Educating Providers and Patients
As mentioned earlier, 2014 Certified EHR systems will be able to send data directly to CMS. Providers beyond the first year of Meaningful Use will be able to submit CQMs electronically through their certified EHR technology. Providers will have the option of reporting on a consecutive 90-day calendar quarter or on an entire year in 2014. As the transformation in health care progresses, EHR technology will allow you to pinpoint exactly where you can improve care and documentation. You still have an opportunity to receive financial incentives for achieving Meaningful Use in 2014 since penalties for Medicare providers do not begin until 2015.

The 2014 quality initiatives are designed to educate providers and patients in preventive care and coordination of services. Since quality improvement is a key issue in improving health care and reducing costs, enhanced coordination of EHR incentives and PQRS requirements is welcome progress. For help with developing a clinical quality program or if you have questions about quality measures, please contact us at info@chitrec.org.

Ms. Fitzgibbon is a nurse-informaticist and clinical implementation manager at the Chicago Health IT Regional Extension Center (www.chitrec.org). Dr. Kho is co-executive director of CHITREC.

Does your medical malpractice insurer know which drugs lead to lawsuits in internal medicine? The Doctors Company does.

Drugs most frequently involved in medication-related malpractice claims against internists
Source: The Doctors Company

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The law requires notice, not consent, which is an important distinction.

**ILLINOIS’ PARENTAL** Notice of Abortion Act went into effect on Aug. 15. Under the Act, health care providers are required to notify an adult family member (defined as a parent, grandparent, stepparent who lives with the minor or legal guardian) 48 hours before performing an abortion for a patient who is under age 18. The law has important implications for a health care provider’s ability to care for patients under 18 who are considering an abortion. While most young women involve a trusted adult in their decisions about unintended pregnancies, those who don’t usually have very good reasons—fear of abuse, being thrown out of their home or being forced to carry a pregnancy to term against their will. Providing care appropriately and sensitively to young women considering their options requires an understanding of this new law.

The law requires notice, not consent, which is an important distinction. An adult family member must be informed of the minor’s decision to have an abortion, but the adult cannot refuse permission or legally prevent the minor from effectuating her decision to have an abortion. Of the adult family members who qualify for notification, only the stepparent is required to actually live with the minor, and the provider is required only to notify one adult family member.

The law requires “actual notice.” The abortion provider must notify an adult family member in person or by phone of the young woman’s intention to terminate her pregnancy 48 hours before initiating the procedure. If after reasonable efforts, the provider is unable to give actual notice, the provider may send a certified letter, which is deemed delivered after 48 hours. The provider then must wait an additional 48 hours before performing the abortion.

If a physician other than the abortion provider has already given notice, the abortion provider need not do so again but must still wait 48 hours after such notice before performing the abortion. A letter for referring physicians certifying that notice has been given is available on the Illinois Judicial Bypass Coordination Project’s website.

There are a number of important exceptions to the notice requirement. First, if a minor is accompanied by a qualifying adult family member, the notice requirement (and 48-hour delay) is waived. If an adult family member waives notice in writing, the provider may proceed without notification or delay. A sample waiver letter is available on the Illinois Judicial Bypass Coordination Project’s website. It is a Class C misdemeanor for someone who is not an adult family member as defined in the Act to sign a written waiver of notice.

If the minor provides a written statement that indicates she is the victim of physical or sexual abuse or neglect by an adult family member, notice is not required. The health care provider must meet all mandated reporting requirements but may wait until after the abortion to do so. Notice and delay are also not required if the minor is married, divorced or widowed, if the minor has been legally emancipated, or if the provider determines that there is a medical emergency as defined in the Act.

Finally, notice is not required if a minor obtains a judicial waiver of the notice requirement. A judicial waiver process permits young women to go to court to demonstrate that they are mature and well enough informed to make a decision to terminate their pregnancy without forced involvement of an adult family member or that it is not in their best interest to notify an adult family member.

Physicians who in good faith give notice in accordance with the Act’s requirements, or rely on one of the Act’s exceptions to notice, are protected by a statutory immunity provision. If they fail to comply with the Act, physicians are subject to professional discipline.

The American Civil Liberties Union (ACLU) of Illinois has created a hotline to provide information about the Illinois parental notice of abortion law and to connect young women with free, trained attorneys who can help them obtain a judicial waiver if they need one. Young women may call 877-442-9727, text 312-560-6607, email judicialbypass@aclu-il.org or visit our website at www.ilbypasscoordinationproject.org.

The ACLU of Illinois has model forms and resources for health care providers, youth-focused materials for organizations serving youth, and general educational materials about the parental notice law. The ACLU has provided numerous training sessions about the law for health care providers and can arrange additional training for interested groups. Please contact Emilie Junge for more information about training and materials at ejunge@aclu-il.org or by calling 312-201-9740.

This law creates difficult barriers for young women facing unintended pregnancies and for health care providers who work with them. The ACLU will continue to work to ensure these young women are able to make and effectuate their decisions about their reproductive health care.

Allie Carter is the advocacy and outreach director for the ACLU of Illinois (www.aclu-il.org).
Hospital Consolidations
Medical staff bylaws should address complications By Elizabeth “Libby” Snelson, JD

CONSOLIDATIONS of hospitals have been going apace, and by all accounts the pace will not slow soon. Such combinations, after careful planning and due diligence, are designed to result in highly organized mega-hospitals or systems of hospitals that improve efficiency, market share and revenue stream. If you or your medical staff are part of a consolidation, the odd, new made-up name and logo will be the least of your worries. The building of hospital systems by merger or purchase affects physicians—whose patients are, after all, the reason for the hospital—in several ways. Even if the building and staff remain the same throughout the amalgamation process, physicians should be aware of possible complications.

Membership Multiplied?
Hospital consolidation can take many shapes. Under current Medicare Conditions of Participation—which all hospitals must meet or risk federal funding, which none can afford—each separate hospital must have a separate medical staff. The hospital industry tried, but failed, to change that regulation to allow a single medical staff organization across several hospitals. Separate medical staffs assure physicians more opportunity for input in the standards of care at the hospital in which they serve patients, rather than meeting general standards handed down from afar for the entire system. But preserving the standards and services that are your hospital’s hallmark, against pressure to conform to the system’s strategy, will demand the active involvement of the medical staff. Don’t take your medical staff membership for granted; know and exercise your rights and responsibilities.

Discipline Duplicated?
If the medical staff is one of several in a system of hospitals, prepare for standardization of membership and privileges. Administrators will want the consolidated board to present a single membership file, even if you are a member of a different medical staff. While efficiency is a laudable goal, a cookie-cutter approach to medical staff credentialing is simplistic. Variances in standards and rules must be respected. A disciplinary action initiated at one hospital in the system can metastasize into a suspension at every other hospital in the system, even if the rule allegedly broken does not apply to other medical staffs.

Privileges Purged?
In a big corporate integration plan, how one service functions at one hospital may, for ease of administration or cost-saving, be expanded to apply to all system hospitals as part of the “deal.” Thus, an exclusive contract at the acquiring hospital may come to encompass the acquired hospital, and thus, wipe out the privileges of all holding those same privileges in the acquired hospitals. Such exclusive contracts are not the only means by which merging hospitals can affect privileges. A religious hospital joining forces with non-religious hospitals can bring in concerns that shut down entire specialties. The classic example is a Catholic hospital that prevails upon its new partners to abide by the Ethical and Religious Directives for Catholic Health Care Services, thus prohibiting procedures that prevent or terminate pregnancy. Related privileges evaporate because the procedures can no longer be provided as a condition of the consolidation.

Representation Rejected?
Changes proposed in the 2012 Medicare Conditions of Participation would have required a hospital board to include a medical staff member, but the hospital industry succeeded in having the regulation withdrawn, even though the board may govern more than one hospital, and only one medical staff member would have been required. To date, no regulation on medical staff member representation has been adopted. A proposed replacement regulation—42 CFR 482.12 (a)(10)—would only require that a board periodically “…consult directly with the individual assigned the responsibility for the organization and conduct of the hospital’s medical staff, or his or her designee.” Even if no federal regulation establishes a minimum number of physicians to be on a hospital’s board, medical staff representation should be made a priority when a board is being designed in the course of a merger or consolidation, to assure that clinical interests are continually front and center. The Joint Commission leadership standards themselves acknowledge the logic of clinician representation in Standard LD 01.03.01, Element of Performance 10, which states, “medical staff members are eligible for full membership in the hospital’s governance, unless legally prohibited.” In a consolidated hospital board, particularly, the participation of medical staff members can promote collaboration and compliance with standards.

These and other issues that result from a consolidation should be addressed in the medical staff bylaws. Consolidations do not happen overnight; the medical staff should be involved in preparing consolidated medical staff bylaws on a parallel track with the hospitals’ consolidation planning. To assure that physicians’ rights are protected, and to facilitate an effective consolidation, the medical staff must have independent counsel.

Elizabeth “Libby” Snelson, JD, (www.snelsonlaw.com) is legal counsel for Medical Staff PLLC.
Sex and Gender in Atrial Fibrillation

Men and women react differently in the management of adverse events involving drugs used for AF By Annabelle S. Volgman, MD, and Neelum T. Aggarwal, MD

Gender differences play a major role in the manifestation and outcome of cardiovascular disease as noted by clinical and epidemiological studies. Overall, atrial fibrillation (AF) is more prevalent in men than in women, but mortality is higher in women. Concomitant valvular disease is much more common in female patients. Prevalence differences decrease with increasing age. In fact, women are generally older at presentation or time of diagnosis.

Areas of slow conduction in the atria may be associated with higher risk for AF and are more common in men. Sex hormones, especially estrogen, prolong refractory periods, whereas testosterone shortens refractory times.

Women tend to seek medical attention more frequently for symptoms of AF or its complications than men do. Age has been correlated with atrial dimensions, with men having larger, left atrial dimensions than women. Women may have a slightly higher thrombotic state that is influenced by hormones. No differences were found in fibrinogen levels but in von Willebrand factor plasma levels. Women with AF were assumed to have a greater risk for stroke than age-matched men, leading to consideration of female gender as a separate risk factor in the CHADS2 score.

Gender differences have been described in the management of adverse events involving drugs frequently used for AF. All QT prolonging drugs should be used with caution in women; amiodarone therapy may significantly increase the need for permanent pacing, especially in women. Older women are less likely to receive warfarin therapy for AF than older men, and if they do obtain warfarin, women are three times more likely to experience a major bleed.

Female patients have been reported to receive less invasive care in terms of rhythm control and electrical cardioversion. Nevertheless, female patients are generally referred later for the procedure than men and fewer women are included in studies evaluating invasive therapy.

Female patients with AF have more comorbidities, more frequent heart failure with preserved systolic function, and lower quality of life. They have an increased risk of stroke. Women appear to have a higher risk for AF related to thromboembolism off warfarin.

Patient Education
- Atrial fibrillation is a problem with the heart rhythm. When someone is in AF the atria may beat as many as 400-600 times per minute.
- Signs and symptoms of AF include the feeling of flip/flopping in the chest, unexplained shortness of breath, chest pain or dizziness or faintness.
- Risk factors for AF include high blood pressure, valvular disease, heart failure or history of heart attack, obesity, positive family history, diabetes, sleep apnea or thyroid disease.
- Treatment for AF will depend on a number of factors that include how often the symptoms occur and how bad they are, whether the patient already has heart disease and the patient's risk for stroke.
- Possible treatments include blood thinning medications to prevent clots, medication to control heart rate, electrical cardioversion to shock the heart back into a normal heart rhythm, or catheter ablation.

Clinical Trials
Patients interested in participating in AF clinical trials can check the following sites for current information: www.clinicaltrials.gov, www.nlm.nih.gov/medlineplus/clinicaltrials or www.centerwatch.com, among others. Clinical studies take place in hospitals, universities, doctors’ offices, and community clinics. The location depends on who is conducting the study.

In a clinical trial (also called an interventional study), participants receive specific interventions according to the research plan or protocol created by the investigators. These interventions may be medical products, such as drugs or devices; procedures; or changes to participants’ behavior, for example, diet. Clinical trials may compare a new medical approach to a standard one that is already available or to a placebo that contains no active ingredients or to no intervention. Some clinical trials compare interventions that are already available. When a new product or approach is being studied, it is not usually known whether it will be helpful, harmful, or no different than available alternatives. The investigators try to determine the safety and efficacy of the intervention by measuring certain outcomes in the participants. Clinical trials used in drug development are sometimes described by phases defined by the Food and Drug Administration.

Dr. Volgman is a professor of medicine at Rush Medical College and medical director of the Rush Heart Center for Women. Dr. Aggarwal is a cognitive neurologist at the Rush Alzheimer’s Disease Center.
What is Gender Medicine?

Sex- and gender-dependent differences exist on every level in human health and disease

By Neelum T. Aggarwal, MD

Prior to 2000, there was very little discussion about gender medicine. However, with the establishment of the Partnership for Gender Specific Medicine at Columbia University (1997), the Karolinska Institutet (2002), and the Charité Universitätmedizin Berlin (2003), studies began to systematically examine comparisons between women and men. In 2001 and 2010, the Institute of Medicine in the U.S. declared that being a woman or a man significantly influenced the course of disease and should be considered in diagnosis and therapy.

Biological Differences and Socio-cultural Processes

For starters, gender medicine aims to improve treatment for women as well as for men. It is different than women's health because it also focuses on men's health. Gender medicine deals with the effects of sex including biological differences between females and males. Examples of sex differences can include different concentrations of sex hormones, different expression of genes on X and Y chromosomes, or a higher percentage and deposition of body fat in women.

Gender, however, is the result of socio-cultural processes. Associated with behavior, stress, and lifestyle-related diseases, gender has been shown to determine access to health care, help-seeking behavior, and even individual use of the health care system. Recent studies have shown that gender largely determines one's compliance with preventative measures, and whether one follows up on referrals or accepts invasive strategies like a pacemaker implant, heart transplant, or other surgeries.

Relationship to Improved Care

In medicine, it isn’t easy to separate the influence of sex and gender on disease. However, we do know that considering the impact can lead to improvements in care. For example, clinical manifestations of prevalent diseases differ in women and men; it is thought that this is due partially to sex differences in disease mechanisms. Again, this is seen especially in cardiovascular disease risk factors, disease and symptoms of atrial fibrillation, myocardial infarction, and heart failure. Pre-diabetic women have shown an early decrease in glucose tolerance whereas men exhibit early elevated fasting glucose. Diabetes has a different weight as a cardiovascular risk factor in women and in men. Furthermore, it is known that the pathophysiology of coronary syndromes differs in both genders, and some stress-induced syndromes occur only in women. Exercise ECG has less sensitivity in women than in men, while ischemic sudden death occurs predominantly in men. Understanding these differences can lead to the investigation of mechanisms that may ultimately translate into new therapeutic approaches.

Another area gaining increased attention is pharmacologic and non-pharmacologic interventions. Differences in the pharmacokinetics, metabolism, and drug distribution in men and women have been identified. Many drugs require different doses in women and men for optimal effect, with one theory suggesting that at a biological level, ion-type channels in the kidney and heart may differ in men and women, therefore explaining differences in drug action and effectiveness when used to modify kidney function or heart rhythm.

“Looking forward, individualized clinical care algorithms and care plans based on individual risk profiles should be developed on top of gender-based assessments.”

Effects of non-pharmacological interventions also show differences in women and men. Coronary bypass surgery has been shown to have an earlier mortality in women and revascularization therapy may be less effective in women with unstable angina than in men. Taken together, knowledge of different therapeutic procedures with different strategies in men and women could lead to the development and incorporation of these aspects into guidelines, which can ultimately enhance the efficiency of pharmaceutical and interventional therapies.

Link to Personalized Medicine

Personalized medicine, which aims to consider all individual risk factors, including ethnicity, lifestyle, personal history, risk profiles, and genetic disposition, should also include the role of gender. Many studies have found gender to be an independent risk factor after accounting for demographics, comorbidities, and psychosocial factors. Looking forward, individualized clinical care algorithms and care plans based on individual risk profiles should be developed on top of gender-based assessments.

For more information, please check the Organization for the Study of Sex Differences (www.ossdweb.org) and the International Society for Gender Medicine (www.isogem.com).

Dr. Aggarwal is a cognitive neurologist at the Rush Alzheimer’s Disease Center and a board member of the Sex and Gender Women’s Health Collaborative (www.SGWHC.org).
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Should early tumors be called something other than the “Big C”? By Howard Wolinsky

“A rose is a rose is a rose” — Poet Gertrude Stein

SOMETIMES seem to follow that a cancer is a cancer is a cancer. But not all cancer experts think so. In fact, some leaders in the field are saying that some conditions now diagnosed as cancer, especially Gleason Score 6 adenocarcinomas of the prostate and ductal carcinoma in situ (DCIS) of the breast, ought to be called something other than the “Big C.”

Though these cells have characteristics of cancer under the microscope, they are not likely to be deadly, some experts argue. The goal, they claim, is to spare patients diagnosed with these conditions from the risks of being overtreated. The problem is sorting out which growths are likely to be deadly—and also persuading patients with the diagnosis and their doctors to monitor their conditions rather than immediately take aggressive treatment.

The National Cancer Institute (NCI) convened a panel of scientists to look at the issue. Laura Esserman, MD, director of the breast cancer care center at the University of California, San Francisco, who chaired the panel, and her colleagues called for the new definition of early cancers in the July 29 edition of JAMA. “By recognizing that cancer is not one disease, but a number of different diseases, we can individualize our treatment based on biology and avoid overtreatment,” says Dr. Esserman. “The goal is to personalize screening strategies, and focus screening policies on the conditions that are most likely to result in aggressive illness and death.”

New Research

In fact, new research suggests that early diagnosis of some major cancers, including the prime examples of prostate and breast cancer, results in “over-diagnosis” of malignancies that in most cases will not kill the patient. The result is over-treatment leading to patients being harmed without significantly reducing their risk for death. H. Gilbert Welch, MD, and William Black, MD, of the Department of Veterans Affairs Medical Center in White River Junction, Vt., and the Dartmouth-Hitchcock Medical Center, reported in the April 22 issue of the Journal of the National Cancer Institute that 60% of prostate cancers detected with prostate-specific antigen (PSA) tests and 25% of breast cancers found on mammograms could be over-diagnosed. The researchers, who reviewed data from large randomized screening trials, estimated that 50% of cancers diagnosed with chest x-rays and sputum tests are over-diagnosed. They expect the problem to increase when screening with spiral CT scanning becomes common.

The authors said cancer incidence and mortality statistics provide evidence of over-diagnosis in some cancers. For five cancers—thyroid, prostate, kidney and breast cancers, and melanoma—data from the past 30 years show an increasing number of new cases, but not an increase in deaths. The authors said cancer incidence and mortality statistics provide evidence of over-diagnosis in some cancers. In each of these cancers, an increase in screening or imaging tests has been associated with an increasing rate of new diagnoses.

“Many physicians are stuck in this mindset that everything that is called cancer is very aggressive. And everything that is called cancer is going to be harmful.”

The NCI panel called for creation of a multidisciplinary group to revise the taxonomy of cancer and to separate indolent or slow-growing cancers unlikely to cause harm from the rest. They said that screening programs inevitably identify the indolent cancers. Medical oncologist and epidemiologist, Otis Brawley, MD, chief medical and scientific officer at the American Cancer Society, said, “In those five diseases there is a dramatic increase in incidence rate without a significant change in mortality. The emphasis is on significant.”

Many, if not most, patients with indolent cancers, like those with fast-growing cancers, want the cancer treated even though they might expose themselves to side effects, such as infections, impotence and incontinence such as with prostatectomies or radiation, or even death. The NCI group
“Calling a Gleason 6 tumor not cancer could result in lawsuits against doctors if those tumors do progress—and some of them will.”

urged: “Change terminology and omit the word ‘cancer’ from premalignant or indolent conditions.” Dr. Esserman and others have suggested calling these conditions “IDLE tumors” (Indolent Lesions of Epithelial Origin) for low-risk disease. It doesn’t exactly roll off the tongue.

Former JAMA editor George Lundberg, MD, who is an anatomic and clinical pathologist and now an editor-at-large at Medscape, endorsed the idea, dubbing the growth now characterized as low-grade cancers as “indolentomas.” He says: “Ceasing to name the lesions that are most likely indolentomas with that fearsome word ‘cancer’ is the first step. Almost any patient who hears the word ‘cancer’ applied to his pathologic findings feels his hair catching on fire.” Dr. Brawley added: “In the U.S., cancer is a scary word. Everybody wants to treat cancer.”

Other than skin cancer, prostate cancer is the most common cancer in American men. The American Cancer Society estimates that in 2013 about 238,590 new cases of prostate cancer will be diagnosed in the U.S. and about 29,720 men will die of prostate cancer.

The Gleason Score

When prostate tissue is biopsied, a pathologist examines it and gives it a Gleason score based on how different the prostate cancer tissue looks from normal prostate tissue and how likely it is that the cancer will grow or spread. Most men with early-stage prostate cancer have a Gleason score of 6 or 7. Gleason 6 prostate cancers—where approximately half of all new diagnoses score—are a key example in the debate on relabeling low-grade growths.

Dr. Brawley says that few men with Gleason 6 scores—less than 10%—are willing to simply watch their cancers with digital exams and annual biopsies in active surveillance programs. Instead, he said they typically want their cancers treated aggressively—as soon as possible. He says that across the border in Canada and in many places in Europe, patients and their doctors are willing to wait.

Jonathan Epstein, MD, a urological pathologist and director of surgical pathology at Johns Hopkins Hospital in Baltimore, says: “Cancer is a word that’s associated with fear. There’s been a tremendous amount of publicity that the key to living with cancer is early detection or early treatment. That’s the dogma that’s been out there for years and years. And now all of a sudden we’re telling some patients, ‘Well, you have cancer, but it may be a good cancer, and this may be a cancer that we can watch closely—we still have to watch it—but we can avoid the side effects of the treatment just by watching it.’ It’s a big paradigm shift.”

Gleason scores run from 2-10, but nowadays 6 is typically the lowest score. But Dr. Epstein says since it is a 10-point scale, patients usually interpret a Gleason 6 as an intermediate and potentially lethal cancer that requires immediate treatment. Urologist Scott Eggener, MD, co-director of the prostate cancer program at the University of Chicago Medicine, said redefining the cancers could be a step in the right direction, leading more men to active surveillance of their prostate cancer.

Gleason scores run from 2-10, but nowadays 6 is typically the lowest score. But Dr. Epstein says since it is a 10-point scale, patients usually interpret a Gleason 6 as an intermediate and potentially lethal cancer that requires immediate treatment. He says it’s a tough call because “under the microscope they absolutely, positively should be called a cancer.”

“There’s an upside and a downside to redefining the terms used for cancers,” he adds. “I wouldn’t be opposed to redefining it as sort of a ‘cancerish’ lesion. Whether it retains the word cancer or not I think is up for debate. I favor it as long as it implies some form of disease that’s been diagnosed and that warrants attention, and doesn’t denote a benign entity for which you don’t need medical attention.”

Like many of his cohorts, Dr. Eggener says that redefining these conditions with a lowered fear factor will limit the number of people who are treated and limit the number who experience side effects from treatment. “But the problem is that people may take a laissez-faire attitude with their diagnosis,” he says. “They may say, ‘Well, I don’t
have cancer. I don't need to follow up.' As a result, there may be some patients who get lost in the shuffle and have bad things happen to them.”

**The Opposition Speaks**

Many experts also oppose changing the definition of cancer. It’s more than a semantic argument, they say, since lives may be at stake. William Catalona, MD, a urology professor at the Feinberg School of Medicine at Northwestern University, a pioneer in using PSA testing as a screening tool, says: “Gleason 6 really is cancer, and you certainly would be on very thin ice to tell anybody with a biopsy that showed Gleason 6 cancer that he did not have cancer. I think the great majority of pathologists would probably agree.”

He notes that only small slivers of prostate tissue are removed during a needle biopsy. “When the biopsy comes up Gleason 6 prostate cancer, who knows what might have been missed,” he says. “And in a series where men who would have fulfilled the most strict criteria for active surveillance—and that would be men who had only one or two of their cores showing a small amount of Gleason 3+3 prostate cancer, and had a low PSA, and a normal-feeling prostate—when these men underwent a radical prostatectomy, 30 to 40% of them were found to have other areas of cancer in their prostate that are Gleason 7 or higher. In practice you can’t do away with sampling errors, and so under-staging and under-grading of cancers is very, very common.”

Dr. Catalona also argues that telling a large number of patients who had Gleason 6 on one or two biopsies that they didn’t have cancer would be misinforming them terribly. “Not only do many men believed to have Gleason 3+3 disease actually have a higher-grade disease, there are men who truly have Gleason 3+3 disease that will *turn into* a higher-grade disease,” he says. “The danger of offering patients reassurance that their prostate cancer is a toothless lion is that they may miss their opportunity to be cured and unnecessarily be consigned to terrible suffering and death from prostate cancer.”

Gerald Chodak, MD, a former University of Chicago Medicine urologist and author of *Winning the Battle Against Prostate Cancer* says, “Calling a Gleason 6 tumor not cancer could result in lawsuits against doctors if those tumors do progress—and some of them will. It seems that a better approach is to improve education to patients—and doctors—that immediate treatment is safe in about 96% of the cases we no longer want to call cancer.”

**A Precedent for Not Panicking**

Yet Dr. Epstein notes that there are precedents for people living with a cancer diagnosis and not panicking, most notably squamous cell carcinoma of the skin. “My parents have had skin cancer. It didn’t bother them at all, and they weren’t afraid they were going to die of skin cancer,” he says. “We call them cancers, we don’t change their name.”

Dr. Epstein and his colleagues noted in the Dec. 10, 2012, *Journal of Clinical Oncology* that, “The extent to which over-treatment is caused by fear of death resulting from cancer, fear of litigation from under-treatment, and misaligned incentives that reimburse more for treating rather than monitoring when appropriate is not known. Nevertheless, fear of death resulting from cancer likely plays some role, and removing the label ‘cancer’ could reduce unnecessary treatment of low-grade disease.”

Their article was entitled “Gleason Score 6 Adenocarcinoma: Should It Be Labeled as Cancer?” The answer in short was: yes. Dr. Epstein and his colleagues have chosen not to redefine cancer and therefore not miss opportunities for cures. In their article, they described a modified Gleason system
with prognostic grading groups where, for example, Gleason score 6 adenocarcinoma is given a prognostic grade group I/V (the lowest grade) as opposed to the current Gleason system where Gleason score 6 is in the middle of the range of Gleason scores 2-10.

The Debate Rages On
The debate over dropping the word “cancer” for some growths continues with Gleason 6 being a prime example, but it also affects breast cancer and other cancers. Hematologist oncologist Steven Rosen, MD, director of the Robert H. Lurie Comprehensive Cancer Center at Northwestern University’s Feinberg School of Medicine, says there are similar discussions involving breast cancer because of the word “carcinoma” in early-stage ductal carcinoma in situ. He said DCIS is considered breast cancer and is typically treated aggressively with mastectomy, lumpectomy or radiation. But he says women don’t die from DCIS, but they can potentially die if the condition develops into full-blown invasive breast cancer that can spread in the body and become a life-threatening illness.

He says that certain cancers seem to be indolent based on genetic factors. “The question is whether there are cancers that are so indolent that over the course of many years they won’t take an individual’s life,” he says. “That’s understandable. But what is that span of time? Or do some of them spontaneously regress? My own bias is that’s going to be a minority of true cancers that truly regress because of immunologic phenomena or other biologic characteristics. My own presumption, and we see this clinically, is that certain cancers are just very indolent in nature, because of their genetic makeup—the way they respond to microenvironment signals that may keep them slowly progressing and with a lower propensity to spread. What we don’t know right now is how to distinguish those from the cancers that have the capacity to grow and spread.” But he adds that once such growths can be identified, it would make sense to define them as non-cancers.

Dr. Brawley, author of How We Do Harm: A Doctor Breaks Ranks About Being Sick in America, says: “Many physicians are stuck in this mindset that everything that is called cancer is very aggressive. And everything that is called cancer is going to be harmful. It’s hard to ask patients to accept this, when many doctors don’t accept it yet. It’s hard to understand there are some very indolent cancers out there that don’t need to be treated.”

His view on redefining cancers varies from disease to disease. “I think the most important thing we need is this discussion because doctors and patients should realize there is not just one cancer. There are very slow-growing, very indolent cancers and very fast-growing, very aggressive cancers,” he says. “Second, in certain diseases it’s a little bit easier for us now to figure out the indolent, less aggressive diseases. In prostate cancer, for example, it’s a lot easier than in breast cancer.”

Dr. Brawley notes that Gleason scores offer guidance with prostate cancer, but there is no equivalent in breast cancer. “We have grading, but it’s not to the extent that we have in prostate cancer,” he says. “DCIS in the pathologic literature has not been considered frank cancer—ever.”

Dr. Brawley adds that the pendulum has swung the other way as DCIS came to be considered a cancer. “In the 1970s and 80s, physicians were taught that DCIS was not cancer—that we should not refer to it as cancer. We were taught that we should refer to it as a growth—as a precancerous condition. In the pathologic literature, it was okay to call it in situ cancer with the understanding that true cancer is invasive. In the 1980s, a whole bunch of health care providers who treat breast cancer, breast cancer advocacy organizations, and a few others—not pathologists—started referring to DCIS as cancer. And this started snowballing. So now, 30 years later, everybody thinks of DCIS as cancer. But if you read the pathology textbooks, it still is not cancer.”

Dr. Brawley is skeptical that redefining growths will make much difference in the near term. “If low-grade prostate cancer is renamed people are going to be told, ‘We used to call this prostate cancer,’ and people are going to insist on getting it treated.”

He says he thinks that better education of patients and doctors could help as will changes in incentives to treat rather than observe, though medical practice is slow to change. “What we’re really trying to do by discussing renaming these conditions is to get doctors and patients to realize there is a huge variability in biologic behavior of these tumors,” he says. “With the Gleason score, we have some ability to predict that biologic variability. We can say, ‘This seems to be a less aggressive tumor or this seems to be a more aggressive tumor.’ We hope we can eventually go beyond the optical definitions of cancer that we developed in the 1850s and form some type of 21st century definition of cancer, which might involve genomics.”

Howard Wolinsky is a Chicago freelancer and former medical writer at the Chicago Sun-Times.
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The Obamacare Launch: What You and Your Patients Should Expect

Though allowing some physician latitude, the law’s essential health benefits provision creates a framework for how the most basic care should be delivered By Bruce Japsen

Though allowing some physician latitude, the law’s essential health benefits provision creates a framework for how the most basic care should be delivered

HE LAUNCH this fall of the Affordable Care Act may bring physicians more clarity when it comes to understanding what and how much insurance coverage their patients have, and how the Act may potentially improve patient access to health care—particularly for primary care services. For the first time, all insured health plans—which are state-regulated and generally sold to individuals and small businesses or groups—must cover ten “essential health benefits.” The health plans must provide coverage for ambulatory care; emergency services; hospitalizations, maternity and newborn care; mental health and substance abuse disorder services; prescription coverage; rehabilitative disease management; laboratory services; preventive and wellness services and chronic disease management; and pediatric services that include dental and vision care.

The idea behind requiring these essential health benefits is to bring some consistency to benefit packages and to provide basic coverage to the uninsured and to the health care marketplace in general.

Beginning Jan. 1, 2014, newly insured individuals who purchase private coverage on marketplaces known as exchanges will have access to health coverage subsidized by the government, depending on their income. Patients are choosing these plans during a six-month open enrollment period that runs through the end of March 2014.

The Certainty of Coverage

Physicians and patients can take advantage of the essential health benefits provision by forming a closer relationship when it comes to creating a primary care and wellness plan.

“The essential health benefits provision gives you a framework for how most basic care should be delivered,” says Robert Winn, MD, a pulmonary critical care specialist at the University of Illinois at Chicago Medical Center. Dr. Winn is also a member of the Essential Health Benefits Workgroup of Illinois’ Health Care Reform Implementation Council.

Because physicians will know what services are covered by insurance and what the essential benefits are, Dr. Winn says it’s an opportunity for patients to take more responsibility for their health care and wellness, partly by working within the framework. “Not only will physicians know what is covered, but patients also will know what basic benefits they have and they can use this knowledge as an opportunity to begin a conversation,” he said. “It’s a preventive model. It will improve the way doctors see patients.”

Currently, health plans in the state-regulated individual and small group market lack benefits like substance abuse services while other health plan offerings are inconsistent. The U.S. Department of Health and Human Services has said that about 60% of health plans in the individual market don’t provide maternity coverage. In addition, nearly 20% of health plans don’t cover mental health services and another 9% don’t cover prescription drugs, according to a May 2013 policy brief published in the journal Health Affairs in partnership with the Robert Wood Johnson Foundation.

While the health care law and the essential health benefits provision will certainly alleviate lack of benefits and provide general access to key services like mental health and maternity care, some medical care providers have argued that the essential health benefit provision is taking away “individuality” in the provision of medical care. These critics say the essential health benefits provision involves the government telling doctors and other medical care providers what they should be doing by setting up mandated categories of care. But Dr. Winn, while acknowledging the critics, disagrees, saying physicians will have latitude as they always have. In addition, the health plans will not be rigid in how they carry out each benefit category.

“The essential benefits provision is not saying that you have to take care of all patients the same way,” Dr. Winn said. “There can be variations and nuances in how you care for your patients. But this gives you a framework for how the most basic care should be delivered.”

More Comprehensive But More Expensive?

In general, the essential benefits provision is a boon to both physicians and patients. The health care benefits will be less expensive for people who have lost their jobs and are currently on COBRA, and will certainly help people who can’t get insurance due to pre-existing conditions. In addition, federal subsidies will help low-income Americans such as young people who may be in low-paying
Some health insurance analysts say policies for younger or single people who have historically purchased more limited benefit packages may face higher costs in 2014 when the health law and essential benefits’ provision kicks in. The new law doesn’t allow health insurance companies to carve out certain things that might previously have allowed a health plan to lower the cost of certain policies. For example, an older person may not want the added cost of maternity care or mental health coverage but could still face higher costs because of the additional required benefits.

What’s more, the essential health benefits must be offered for health plans that operate outside the exchanges as well, Illinois insurance regulators and health plans say. “The minimum benefit requirements will result in coverage being more comprehensive, but also more expensive than what many consumers choose to purchase today,” says Robert Zirkelbach, vice president of strategic communication for America’s Health Insurance Plans, a trade association and lobbying group that represents some of the biggest names in the industry, including Aetna, Humana, UnitedHealth Group and Chicago-based Health Care Service Corp., which is the parent of Blue Cross and Blue Shield of Illinois.

“These changes may also result in some policies having higher out-of-pocket costs for services, such as co-pays and deductibles, in order to minimize the impact of premiums.” Zirkelbach says.

In Illinois, the benchmark plan is Blue Cross and Blue Shield of Illinois’ “Blue Advantage Entrepreneur” plan, a preferred provider organization plan that was selected as the model other insurers will have to follow when creating basic benefit packages. A model plan was selected in each state for all health plans to use as a baseline of benefits they need to offer.

Congress decided to let each state choose a plan or set of plans to provide more local control rather than establishing a national standard for essential benefits. “The essential health benefits policy gives states flexibility to ensure that coverage offered in the marketplace will reflect what has previously only been available to healthy people who can afford it,” a spokesman for the Centers for Medicare and Medicaid Services said. “Thanks to the law, all Americans will have access to this type of coverage with comprehensive benefits.”

**Previously Unreimbursed Services**

While most physicians generally know the basics of what their patients’ health plans provide, they say the essential health benefits provision of the health law adds benefits such as behavioral health and substance abuse services that physicians don’t always deem a given. “Previously, it was not intuitive for physicians to think that prevention and wellness, dental and vision or behavioral health would be covered,” said Opella Ernest, MD, a family physician and vice president and chief medical officer at Blue Cross and Blue Shield of Illinois, the state’s largest health insurance company.

“This will be a new thing for physicians and it will give them more flexibility in providing care for their patients as well as allowing them to provide greater access to care. For physicians, it will provide a general framework for what is covered.”

Indeed, the mental health benefit is critical given the rise in mental health disorders in the U.S. and around the world. An estimated 26%—one in four—Americans age 18 and older suffers from a “diagnosable mental disorder in a given year,” according to the National Institute of Mental Health. “It’s shocking,” Dr. Ernest said. “Chronic disease increases whenever there is a mental health issue.”

“Reimbursement is a wild card….Doctors will benefit from more encounters with patients and so there are certainly financial benefits on the back end. We will just have to wait and see.”

But while physicians will have more flexibility when they know they will be reimbursed for the care they provide, payment will still vary beyond the basic benefit packages. “This will change the way physicians and health care providers get paid and how health care systems get paid,” Dr. Winn said. “You may end up having reimbursement rates that are not fully adequate.”

A study released in August 2013 by the Robert Wood Johnson Foundation and the Urban Institute said health plans would not have to make significant changes to comply with essential benefits provisions nor would they have to raise costs. Still, doctors should be leery of what the health plan will reimburse them even though their once-uninsured patients now have the ability to buy coverage.

“It’s a wild card,” Dr. Winn said of reimbursement. “Doctors will benefit from more encounters with patients and so there are certainly financial benefits on the back end. We will just have to wait and see.”

Bruce Japen is a Chicago health care journalist and writer for Forbes and 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 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 brucejapen@gmail.com.
Advocating For You
CMS leadership makes more legislative inroads

This monthly column highlights the Chicago Medical Society’s conversations with local and state legislators. Coordinated by President-elect Kenneth G. Busch, MD, the ongoing talks allow CMS to advance key health initiatives while strengthening our presence in the City Council and State Legislature. As the Affordable Care Act rolls out, CMS leaders are pressing lawmakers for answers. Not only that, we are relaying the risks and potential harm to our medical-practitioner members.

Recent advocacy on your behalf includes:

Medical Practice Act
CMS personally urged State Senator Mattie Hunter (3rd Dist.) to support a 10-year extension of the Medical Practice Act, from Dec. 31, 2013, to Dec. 31, 2023. In recent years, lawmakers have resorted to one-year extensions, much to the medical community’s alarm. The South Side legislator expressed interest in co-sponsoring legislation to restore the 10-year extension.

Telemedicine
CMS urged Senator Hunter to support telemedicine legislation in Illinois. CMS is promoting telemedicine as a means of bringing primary care to people in underserved and rural areas. Yet some insurers, citing liability concerns, refuse to reimburse telehealth services. Senator Hunter voiced interest in working with CMS and the Illinois State Medical Society (ISMS) on expanding services to patients throughout the state.

Accountable Care Organizations
Hosting State Senator Heather Steans (7th Dist.), CMS pointed out the potential adverse effects on members under the Affordable Care Act. The rise of physician super groups means that many CMS physicians will struggle for adequate reimbursement under the new payment models.

Another troubling provision of the law, CMS stated, is that primary care physicians are restricted to only one ACO.

Medicaid Reimbursement
CMS reinforced to Steans the medical community’s deep frustration with low reimbursement, and doubt over the federal expansion, which some compare to a house of cards, predicting it will fold when federal funding comes to an end.

Currently, providers contracted with the State Employee Group Health Plan wait up to 10 months for payment and non-contracted ones as long as 18 months. Designated critical care hospitals get paid on time, CMS said to Senator Steans.

The big question for many physicians: Why isn’t the Medicaid pay increase to primary care permanent? Removing the incentive to care for this patient population after two years is counterproductive, CMS explained.

5% Discount After Five Years
Loyal members get a break

While loyalty is said to be its own reward, the Chicago Medical Society (CMS) has taken that idea one step farther.

Starting Jan. 1, 2014, physicians who have been members for five years or more receive a 5% reduction on their dues.

The special discount makes CMS even more inclusive. Reductions already offered by CMS and the Illinois State Medical Society (ISMS) cover:

• Students
• Residents
• Members in first 4 years of practice

5% discount after five years

• Trial members in the Partnership for Membership Growth
• Group discounts

“The CMS Board of Trustees has approved a 5% discount for the most loyal members of CMS,” Robert W. Panton, MD, CMS president, announced in September. “Furthermore, there is strong sentiment for making future dues reductions even deeper,” he said.

Discounts are designed to encourage all physicians to join, lending an even stronger voice to organized medicine. CMS is continually evolving to represent members, their practices, and patients.

CMS/ISMS members enjoy the following benefits:

• Legislative advocacy
• Reimbursement assistance and advocacy
• Free publications
• Educational events, webinars and CME programs

Please encourage your colleagues who are not CMS members to join. Loyalty may be its own reward, but in unity there is strength. For information on membership, please call 312-670-2550 or go to www.cmsdocs.org.
Steans asked for and CMS is providing specific examples of physicians who continue to deal with excruciatingly slow payment. CMS also wants to hear from members who have trouble getting approval for patients to exceed Medicaid’s four-drug limit.

**Scope of Practice**

CMS expressed support to Senator Steans for physicians working on multidisciplinary treatment teams. Yet CMS remains steadfast that multidisciplinary care teams be physician-led to ensure continuity of care, data sharing, and common decision-making. Allowing allied health professionals to work outside their scope of education and training will further fragment care while opening up a Pandora’s box of potential liability issues.

CMS noted that state lawmakers defeated a bill to grant prescribing authority to psychologists. The medical community stood united as the Illinois State Medical Society led the charge. Lawmakers also voted down measures to expand the scope of naturopaths and midwives, another example of ISMS beating back harmful legislative proposals.

**GME Funding**

Medical schools are working hard to increase enrollment to address looming physician shortages, particularly in primary care, CMS emphasized to Steans. Four new schools produced an additional 1,000 residents for the 2013 Match pool. However, not all students were matched into residency programs, CMS told the Senator. The reason? Congress fixed the number of sponsored residency positions at 94,000 back in 1997. Lifting this cap is an urgent national priority, and CMS is advocating for increased GME funding (see page 28). CMS is providing Steans and other lawmakers with data on medical school debt, while stressing that low reimbursement and loan debt pushes students into lucrative specialties.

**CPR Training for Lawmakers**

On the educational side, CMS wants to train all state legislators in basic CPR. Senator Steans promised to spread the word, helping coordinate the program with CMS. Training would take place at the CMS building in Chicago, or in Springfield.

In recent years, CMS has instructed hundreds of individuals, including doctors, allied professionals, and members of the public in basic and advanced cardiovascular life support (ACLS). What’s more, CMS encouraged the City Council to implement a “hands-only” CPR campaign in Chicago; the governor also signed a statewide CPR proclamation.

Through CMS’ relationships with city aldermen and state legislators, your leadership continues a tradition of public health and physician advocacy. CMS is one of the oldest and most distinguished county medical societies in the U.S.

Collaborating with ISMS, we express the views of grassroots physicians on key issues in Springfield. We represent you, your practice, and your patients.

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**Welcome New Members!**

The Chicago Medical Society welcomes its newest members. We are now 101 voices stronger!

**Student District**

Elizabeth Aguila  
Evan P. Ariano  
Andre Aung  
Victoria G. Bender  
Ajay Bhandari  
Amy L. Blood  
Kamil Bober  
Noelle Boctor  
Alyssa Brennan  
Daryn K. Cass  
Connie Choi  
Michael Choi  
Michael Conrandy  
Colleen A. Considine  
Alexia Copenhaver  
Austin Culver  
Norman Decker  
John Deppe  
Laura Dickmeyer  
Patrick Donahue  
Thomas F. DuBois  
Larissa A. Epstein  
Alyssa Espinera  
Morgan Fallor  
Jarrett Gillette  
Lauren A. Gimbel  
Adam Gluskin  
Ben Goldenson  
Puja Gopal  
Nguyen Ha  
Brandon Hage  
Ajay Haryani  
Lauren M. Hughes  
Kyrie Hungerford  
Kenji Iekuresha  
Brandon Ingalls  
Preston Jacob  
Laura L. Jacobson  
Suraj Jaisinghanni  
Umang Jain  
Elizabeth Jeans  
Brian Johnson  
Amanda L. Joseph

Sara Kashani  
Brian M. Kasman  
Patrick D. Kent  
Rishi Khakhkhhar  
Nimer Khavanin  
Kevin Khoury  
Anna Kostrezwsky  
Matthew Kramer  
Andrew Kuhn  
Spencer Leblang  
Calvin Lee  
Neil Y. Li  
Sandy C. Liu  
Daniel B. Maher  
Blaine Manning  
Colin Martyn  
Sivan Mathevosarian  
Samuel McGowan  
Mary McKenna  
Luke Miller  
Sara Miller  
Matthew Mosquera  
Christopher Nas  
Lauren Nicosia  
Scolastica Nioroge  
Jessica Phelps  
Melissa Phuphanich  
Kelly Rhodes  
Andrew Rodriguez  
Giselle Rodriguez  
Katharine Rooney  
Amanda Ross  
Kathy Ruch  
Megan Sax  
Richard Seto  
Joseph Shapiro  
Ramzi Shaykh  
Christian Shoushtari  
Kacie Steinbrecher  
Amanda L. Stephenson  
Yu-Kai Su  
Shiv Sutaria  
Emily T. Tamadonfar

**Resident District**

Amy Yang, MD  

**District 5**

Susan M. Scherer, MD

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**Member Benefits**

November 2013 | www.cmsdocs.org | 25
An atmosphere of caring and support is one of the most important elements in maintaining a healthy and productive physician community.

HE CHICAGO Medical Society (CMS) is very excited about our newly formed ad hoc Physician Wellness Committee. We want to be available to our members to help guide them through any struggles they may have.

Medicine has always been a high-reward, high-stress occupation. But in the currently deteriorating health care climate, physicians are placed under even greater burden. From mounting fears of malpractice suits, decreased respect from the public, rising financial worries—including pressure to treat more patients and adapt to technological advances—physicians are under more stress than ever. This stress takes a tremendous toll on physicians’ well-being, while increasing their risk of psychiatric disorders, addiction and stress-related medical illnesses. In addition, physicians are working longer hours, a factor that only compounds these issues.

The American Medical Association (AMA) defines impairment as the inability to practice with reasonable skill and safety around patients by reason of physical or mental illness, including alcohol and drug dependence. Recognition of the impaired physician began to emerge only in the 1970s, and led to the development of physician health programs (PHPs). And for decades, these physician assistance programs, like those sponsored by state medical societies and others at the hospital level, have been critical to the identification, triage, treatment, and monitoring of physicians who may suffer from a number of maladies. Increased support and cooperation from licensing boards and hospital medical disciplinary entities has greatly assisted in this process, while a “tough love” approach that helps physicians but holds them accountable has brought these issues into the foreground where they can be openly addressed. Both physicians and patients have been helped by these efforts; physicians’ professional engagement, the quality of care they provide, and their tendency to become overwhelmed all depend on the fulfillment they find in their work. In the past, addiction was the primary issue these organizations dealt with, but over the years this effort has expanded. Comprehensive addiction programs specializing in treating physicians and other health care professionals have also contributed to excellent abstinence rates and a responsible transition to the workplace.

Physicians who struggle with conditions other than addiction, which can cause impairment, such as psychiatric disorders, chronic pain or physical conditions, and cognitive impairment, can benefit from many of the same intervention, assessment and monitoring entities mentioned. Whereas treatments here may substantially differ, such as individual therapy for a depressed physician, some of the support and monitoring strategies mentioned above may be needed if the physician’s condition has in any way shown itself in the workplace. Prevention, assessment, treatment and monitoring are critical in these instances, especially with conditions like depression, which can increase the already higher risk of suicide in physicians as a group.

The identification, support and monitoring of physicians who suffer from conditions that may potentially cause impairment has evolved substantially in the past few decades. A climate of openness, compassion and accountability has assisted both physicians and the patients they serve. It is critical that this trend continue. In recent years, political and other pressures have created a more punitive climate. If we are to continue to benefit, we must move forward, not backward, lest we recreate a dangerous and toxic environment that again drives the problem underground. If this backsliding continues, it will not reduce the problems of impairment or make the public safer. In fact, quite the opposite will result, placing all involved at greater risk.

We have set the following potential objectives for our CMS Physician Wellness Committee:

1. Provide a resource for CMS members in areas where they may have potential difficulties, including stress and burnout, but also more serious issues like depression, addiction and suicide prevention.
2. Offer the services of committee members for outreach and education to physician groups and hospital medical staffs.
3. Help facilitate events like meditation workshops and fun runs.

We are currently seeking CMS members who are interested in serving on the Physician Wellness Committee. We also plan to publish a monthly question and answer section in Chicago Medicine to address wellness-related issues. Members’ anonymity is assured. An atmosphere of caring and support is one of the most important elements in maintaining a healthy and productive physician community.

To learn more about serving on the Physician Wellness Committee or to submit a confidential question, please email Dr. Angres at dangres@presencehealth.org.
Communication **saves lives.**
Just ask Dr. Singh.

When Pamela felt a flutter in her chest and feared she might faint, she went straight to the ER. Emergency physician Dr. Singh discovered a suspicious finding on Pamela’s EKG, and sent an image of the recording to the on-call cardiologist via DocbookMD. The cardiologist quickly confirmed SVT, a condition requiring immediate medical intervention. The potentially life-threatening episode was resolved within minutes—rather than hours—and Pamela was safely discharged home. All thanks to some quick thinking and the secure mobile app, DocbookMD.

**DocbookMD is a free benefit of your CMS membership.**
Learn more about the app at [docbookmd.com](http://docbookmd.com).
Rallying for Residency Spots

CMS students join campaign to increase GME funding

By Elizabeth Sidney

“Students have a vested interest in being part of CMS’ outreach to lawmakers.”

This “Lunch and Learn” was not merely academic. Indeed, students at the University of Illinois at Chicago learned the art and science of grassroots advocacy, and how to use it to save residency training. Hosted by the Chicago Medical Society’s Student Section, “Safeguarding the Future of Graduate Medical Education” took place on the UIC campus last Oct 1. Nearly 40 heard about CMS’ campaign to lift the cap on sponsored residency positions. The advocacy campaign educates lawmakers and unifies Chicago-area medical school deans.

Luncheon speaker CMS President Robert W. Panton, MD, stressed that students have a vested interest in being part of CMS’ outreach to lawmakers. Saddled with $170,000 in debt, and no guarantee of finding a training position after graduation, students have unique perspectives to share.

Scope of Practice Concerns

Dr. Panton, who completed his ophthalmology residency at UIC, noted three bills in Congress that would boost residency positions by 15,000 over three years. CMS supports HR 1201, “Training Tomorrow’s Doctors Today Act,” by Reps. Aaron Schock (R-Ill.) of Peoria, and Allyson Schwartz (D-PA), Dr. Panton said.

He cautioned, though, that while the bills address shortage areas, they would expand the use of physician extenders, raising serious scope of practice concerns.

CMS and ISMS are adamant that multi-disciplinary care teams be physician-led to promote continuity of care, data sharing and common decision-making. Dr. Panton said. Both UIC and CMS are working to build support for HR 1201.

In addition to GME, students and residents have advocated through CMS on public health issues. The late AMA President Ronald Davis, MD, (2007-2008) launched his antismoking crusade when he was a student at CMS (see below). His resolution in the Council ultimately led to a smoking ban on commercial airline flights.

Key highlights from the Lunch and Learn:

- CMS arranged for UIC Medical College Dean Dimitri Azar, MD, to visit lawmakers in Washington, DC, in July. Making rounds on Capitol Hill, with Dr. Panton and other UIC officials, Dr. Azar told the Illinois Congressional Delegation that increased GME funding is a national priority. This was the second trip CMS made to DC in 2013 to address workforce issues.
- CMS organized a joint letter from Chicago-area medical school deans to all Illinois lawmakers, urging swift passage of legislation.
- Council meetings include keynotes by local medical school deans. Dr. Azar addressed the Council Sept. 10; Dean Russell Robertston, Chicago Medical School, speaks on Nov. 12.
- As early as 2015, American medical and osteopathic graduates will exceed the number of sponsored residency positions, the AMA says. But even in the 2013 match, 1,100 students could not land a training spot in the first round, according to the Association of American Medical Colleges (AAMC). Nearly half didn’t match during the informal period that followed.
- The U.S. faces a shortfall of 130,000 physicians by 2025, the AAMC says. Medical schools have ramped up enrollment; this year four new schools produced an additional 1,000 graduates who participated in the 2013 Match pool. Schools are on pace to increase enrollment by 30%, and estimate 21,376 first-year students in the pipeline by 2016, up from 16,488 in 2002. Training a single resident costs $101,000. The Balanced Budget Act of 1997 capped the number of residency positions at 94,000, when the U.S. population was 50 million less.
- Teaching hospitals account for 28% of all Medicaid admissions, and provide 40% of all charity care in the U.S. at a cost of $8.4 billion annually. In addition, 37,000 medical residents train at VA hospitals, providing care to active soldiers and veterans.

A Student Crusader

Back in the early 1980s, the late AMA President Ronald Davis, MD, (2007-2008) was studying medicine at the University of Chicago, where he had just earned his master’s degree in public policy. Active on the CMS Council, the young Davis used organized medicine to advance antismoking campaigns, including the smoking ban on domestic airline flights. In 1984, he became the first medical resident elected to serve on the AMA Board; he also headed the Office of Smoking and Health at the Centers for Disease Control from 1987-91. Prodded by Dr. Davis, the AMA first testified before Congress on tobacco control, joining other major health and medical groups. In 1987 Congress banned smoking on all airline flights of two hours or less, and three years later extended that prohibition to all domestic flights.
ISMS Spotlight

We know who makes the law, but who writes the rules? By Eldon A. Trame, MD

When it comes to advocating for physicians in state government, legislation is only half the battle. It’s important to be on the front lines working with legislators and encouraging physicians to speak out on important issues, but in the end, a law’s impact on your practice may be determined not by its content, but by its implementation.

ISMS Influences

When a law is enacted, the picket signs may be put away, but the real work of figuring out how to turn its requirements into reality has only begun. A complex web of federal, state and local departments and officials is always at work gathering input from stakeholders, writing rules and taking other steps to put the law into effect. The implementation of the Affordable Care Act (ACA) is a significant example of how this process can be even more difficult than the process of passing a law in the first place. What took months to draft and debate in Congress will take many years to fully roll out. For example, though efforts to fully repeal the ACA have been unsuccessful, 19 separate congressional and administrative actions have reshaped elements of the law.

Even laws that are much narrower in scope often involve a great deal of administrative wrangling. It is a difficult balancing act to understand all the interests involved and the real-world consequences of any given rule. For this reason, rules are made through a complex process that involves official notice, a public comment period, promulgation of final rules and clarification of their interpretation by the relevant agencies.

ISMS is ready at every point to make sure the voices of Illinois physicians are heard. Our influence on the “Red Flags Rules” is a perfect example. These rules originally applied to physicians, but through the rulemaking process, medical offices were exempted. This was hardly a charitable action by the rulemaking agencies, boards, workgroups, and committees.

Every year we work closely with the Centers for Medicare and Medicaid Services, the Illinois Dept. of Public Health, the Illinois Dept. of Financial and Professional Regulation, and numerous other agencies, boards, workgroups, and committees. Sometimes this means extended meetings between state officials and expert staff from ISMS. Other times, this means testifying at hearings and providing written comments on proposed rules and their interpretation. In many cases, ISMS is also able to nominate physician leaders for seats on work groups and advisory committees that are formed to help guide the rulemaking process.

There is one constant, however: as the only organization that represents all Illinois physicians, we are the first stop for any regulator in need of physician input. It is because of our relationships and expertise that we have substantive input into the rulemaking on current topics such as medical marijuana and medical certification issues for concealed carry of firearms. Even the most well-intentioned laws often have unintended consequences, which is why your support for ISMS is critical.

ISMS Educates

Once the rules are in place, ISMS is still hard at work helping you interpret them and take action to comply. ISMS offers an array of resources through our website at www.isms.org. Far from the sprawling technical documents from government agencies, our resources are practical and usable as well as thorough and detailed. For example, our library of Issue Briefs gives members guidance on a wide array of topics, including Medicare’s Physician Quality Reporting System, Physician Interaction with Recovery Audit Contractors (RACs), and more. Our HIPAA Model Privacy and Security Policies and Procedures are updated often to help you protect your patient data and prevent costly disclosures of protected information. We are continually expanding our rich set of CME offerings through our new on-demand Education Center. These are only a few examples of how a quick trip to our website can save you a major headache.

ISMS Assists

In addition to the resources on our website, our staff is available to help members personally with the unique situations they encounter in their practice environments. Whether you’re struggling with payment issues or have questions about quality reporting, ACOs or any number of topics, we are here to help. ISMS expert staff work hard to stay up-to-date with health policy issues that affect you in your daily life, and members often report that a simple phone call to ISMS has saved them time and money. Call 800-782-4767, ext. 1470, or e-mail advocacy@isms.org for assistance. So remember: our important work in the General Assembly is only the tip of the iceberg. Help your colleagues save money and protect the future of medicine in Illinois by encouraging them to join ISMS today.

Dr. Trame is the 170th president of the Illinois State Medical Society.
Calendar of Events

NOVEMBER

5 Access to Care Subcommittee General Meeting This subcommittee of the CMS Public Health Committee studies recent developments and policy recommendations to improve access for veterans, underserved populations, children, adolescents, and other populations. While intended for subcommittee members, the meeting is open to all CMS members. 8:30-9:30 a.m.; conference call. To RSVP, contact Meredith at 312-670-2550, ext. 326; or oney@cmsdocs.org.

6 ICD-10-CM: Preparing for a Successful Implementation For all physicians, practice managers, executive staff, and medical office staff. Participants will learn to: describe key elements required for successful transition to ICD-10-CM; make recommendations for each of the four phases of implementation (planning, impact analysis, implementation, and post-implementation); and discuss the code structure, format and basic conventions of ICD-10-CM diagnosis coding and understand its impact. Speaker: Nelly Leon-Chisen, RHIA, Director, Coding and Classification, American Hospital Association, Chicago. Registration/breakfast: 8:00-8:30 a.m. Presentation: 8:30-12:00 p.m.; Chicago Medical Society, 33 W. Grand Ave. Up to 3.5 CME credits; $49 per CMS member; $149 non-member or staff. Register online at: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or 312-670-2550, ext. 338.

8 Illinois Society of Plastic Surgeons General & Business Meeting—Pearlys in Body Contouring Intended for ISPS members and plastic surgery residents. 7:00-9:00 p.m.; Speaker: Tim Marten, MD; The Metropolitan Club, 66th Floor, Willis Tower. Members may attend for free. To RSVP, contact Meredith at 312-670-2550, ext. 326; or oney@cmsdocs.org.

12 CMS Board of Trustees Meeting Meets every other month to make financial decisions on behalf of the Society. 5:00-6:00 p.m. (prior to 7:00 meeting); Maggiano’s Banquets, 111 W. Grand Ave., Chicago. Questions, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

12 CMS Governing Council Meeting The grassroots governing body meets four times a year to conduct business on behalf of CMS, adopt policies, and plan the legislative agenda. All members may submit resolutions, and if adopted by the Council, are transmitted to the Illinois State Medical Society (ISMS) and American Medical Association (AMA) for implementation in either the General Assembly or U.S. Congress or both. Members are welcome to attend for free; 6:00-9:00 p.m., Maggiano’s Banquets, 111 W. Grand Ave. To RSVP, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

13 CMS Online Executive Committee Meeting Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:00-9:00 a.m.; online. Questions, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

14 End of Life Care in a Changing Healthcare Environment: The Impact of the Affordable Care Act and Accountable Care Organizations This panel of experts in end-of-life care and health policy is moderated by WGN-TV reporter and journalist Randi Belisomo. Speakers are as follows: Joshua M. Hauser, MD, Assistant Professor of Hospital Medicine, Buehler Center on Aging, Health & Society—Institute for Public Health and Medicine, and Chief of the Palliative Care Section of the Jesse Brown VA Medical Center; Bruce Japsen, former Chicago Tribune reporter and now contributor to Forbes, Chicago Medicine, and Life Matters Media; Kayhan Parsi, JD, PhD, Director of the Graduate Program in Bioethics at the Niewsanger Institute for Bioethics at Loyola University Chicago; and Lee Sacks, MD, Executive Vice President and Chief Medical Officer of Advocate Health Care. 6:00 p.m. doors open; 6:30 p.m. discussion begins and continues until 8:00 p.m.; reception immediately follows until 9:00 p.m.; Kellogg Center School of Management of Northwestern University, Wieboldt Hall, Room 540; 340 E. Superior St., Chicago. The event is free, but registration is required. Please RSVP to randi@lifemattersmedia.org.

15 OSHA Workshop Intended for physicians, physician assistants, nurses, practice managers, and dental professionals who risk potential exposure to bloodborne pathogens. Participants will learn: to implement a training program for health care employees who may be exposed to bloodborne pathogens; identify appropriate personal protective equipment; develop an emergency response plan; create a written exposure control plan for health care workers assigned as first-aid providers; and develop a strategy to prevent the spread of pandemic flu within the practice. Speaker: Sukhvir Kaar, Compliance Assistance Specialist; 2:00-4:00 p.m., Advocate Lutheran General Hospital. Up to 2.0 credits; $89 per CMS member or staff; $129 per non-member or staff. Register online at: www.cmsdocs.org or contact Elvia at emedrano@cmsdocs.org or 312-670-2550, ext. 338.

16 Indian American Medical Association (iAMA) of Illinois Annual Gala Banquet 33nd Annual Meeting and Banquet. 6:00-7:00 p.m. cocktails; 7:00-9:00 p.m. meeting and dinner; 9:00-12:00 entertainment and dancing. Rolling Meadows Country Club, 2950 W. Golf Rd., Rolling Meadows; $100 per person. For more information, call 773-275-8630 on Saturday/ Sunday; or email arora2952@att.net; or www.iamaill.org.

16-19 AMA House of Delegates Interim Meeting The legislative and policymaking body of the American Medical Association transacts business, adopts policies, and elects general officers. CMS actively participates in the AMA’s policymaking meetings, advocating for members and their patients. Resolutions adopted by the CMS Governing Council are frequently transmitted to the Illinois State Medical Society for implementation in the General Assembly before ultimately reaching the AMA, which advocates for these measures in the U.S. Congress. CMS delegates to the AMA may also submit resolutions directly to the AMA House. Physicians are encouraged to exercise this membership privilege, ensuring their voice is heard at the highest level of organized medicine. Gaylord National, National Harbor, Maryland. For information, please go to www.ama-assn.org.
Office/Building for Sale/Rent/Lease

For sale: 3,195 sq. ft. fully built-out medical condo in Doctor's Building on St. Alexius Medical Center Campus in Hoffman Estates, Ill., just off I-90. Contact Olivia Czyzynski, Sperry Van Ness: 312-676-1862.


Space for rent in downtown Winnetka Professional Center. Ideal location. Approximately 1,100 square feet. Large shared reception area, three examination rooms, private office, front reception/business office area. Call 847-446-0970.

Practice for Sale

Lucrative family practice; two offices, Homewood, Ill., and Hammond, Ind.; seven figure gross. Physician will stay two-three years and work with buyer. Contact: 312-909-9633; or email: familywellcareinc@yahoo.com.

Furniture for Sale


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Toiling for Toxins

Physician channels passion for poison to help docs, patients

By Scott Warner

ONE COULD say that Jerrold Leikin, MD, has poison in his blood. As one of only 550 board-certified medical toxicologists in the U.S., this nationally recognized poison expert works closely with patients and consults with physicians to stem the adverse effects of drugs and chemicals on the human body. He also speaks on agroterrorism, or how the human food supply has been used as a weapon to launch a multitude of toxins.

In a recent talk, Dr. Leikin relayed some horror stories from his book “Toxico-Terrorism: Emergency Response and Clinical Approach to Chemical, Biological and Radiological Agents.” He recalled the headline-grabbing event in Oregon in 1984 when the Bhagwan Shree Rajneeshee cult deliberately contaminated a salad bar with salmonella—“to influence the local elections!”

In his quest to keep the population healthy, Dr. Leikin spends his days truly steeped in all things poison. He is director of medical toxicology at NorthShore University HealthSystem-OMEGA, and is associate director of the Toxikon Consortium based at Stroger Hospital. He also serves on the staff at seven hospitals, five medical schools and three poison centers, and often assists medical examiners/coroners in diagnosing suspected deaths due to poisoning.

Avoiding Unnecessary Interventions

Most important to Dr. Leikin, however, is seeing patients, helping narrow their therapy, and finding out whether their problems are toxic. Patients come to him directly, or are referred by other physicians and poison centers. Most of the clinic visits involve environmental, occupational, or drug-related exposures. “One of the best things I can do is to tell patients that they are not being poisoned, so they don’t have to go through unnecessary interventions, such as detoxifications or antidotes,” he says.

But what motivated Dr. Leikin to embrace such a specialty? He said he first got bit by the poison bug as a child, by watching his grandfather, Michael Ucitel, a pharmacist who owned four Rexall drug stores on Chicago’s West Side up until 1966. “It was amazing how he would come up with medications that would help people, off the top of his head,” says Dr. Leikin. “He had a doctor’s mentality. He mixed his own cough syrup, and made medicines with a mortar and pestle. And, he had the world’s greatest cafeteria at his drugstore. I can still taste the cheeseburgers and milk shakes.”

Motivated by his grandfather, Dr. Leikin earned his medical degree from the Chicago Medical School in 1980, and then completed a combined residency in internal and emergency medicine at Evanston Hospital and Northwestern University. He saw that medical toxicology presented most often in the emergency department, and that interventions had to be immediate. “And the best part is that in a vast majority of cases, the patient did very well,” Dr. Leikin says. He followed his residency with a preceptorship/fellowship in medical toxicology at Cook County Hospital and the University of Illinois at Chicago.

Today, Dr. Leikin engages his family in his work. His wife Robin is a PhD and grant coordinator at Northwestern University Lurie Cancer Center in Chicago, and son Scott is studying in Tennessee to become a physician. Together, the three have written articles on emergency preparedness and poisoning. His daughter Eryn assists in data entry and research endeavors. Dr. Leikin continues building his passion for poisonings into a positive legacy.

WHO'S WHO

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Top Ten Reasons to Consult a Toxicologist

1 Any acute overdose and its follow-up. 2 Any exposure to hazardous materials. 3 Interpretation of drug or toxin in blood/urine tests. 4 The pregnant/lactating woman to evaluate any exposure to the neonate. 5 Evaluation of encephalopathy/hepatitis/neuropathy/dermatitis or cardiomyopathy of unknown cause. 6 Insect/animal bite evaluation. 7 Indoor air pollutant evaluation (i.e., sick building syndrome, mold exposure). 8 Fitness for duty evaluation. 9 Public education/poisoning prevention. 10 Drug interaction evaluation.
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