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32 A Passion for Empowering Women
As a practicing obstetrician-gynecologist, Sondra Summers, MD, feels happiest when she can empower women to make their own health care decisions. Besides being a practicing physician, Dr. Summers is also an associate professor and division director in general ob-gyn at the University of Illinois at Chicago College of Medicine among other prestigious positions.
In the final column, I invite you to look back at the year’s achievements on behalf of physicians. They came about because of your Chicago Medical Society, at work locally, statewide and nationally.

My goal, since taking office 12 months ago, has been to build on our rock-solid foundation. I thank all of you who helped with that endeavor.

Here’s a recap of what we did:

As Congress debated, CMS was polling local physicians (members and nonmembers) for their views on policies and payment models. Our survey sparked wide interest—in Forbes, Becker’s Hospital Review, and the Chicago Tribune. We brought our survey results to Congress, along with the experiences you shared with us about practicing medicine today. The frustrations you express are all part of the package we communicated to Congress.

During repeal and replace talks, we stood steadfast on our health care principles. We also maintained that any reform must include reimbursement and regulatory relief. And at this pivotal time, we made inroads with the Congressional Doctors Caucus. Our relationship with this influential group continues to grow.

We also took the lead in addressing the opioid crisis. Our work with U.S. Senator Durbin focused on legislation that is reasonable and effectively targeted, as well as education for physicians who prescribe high quantities of pain medication. These talks led to positive agreement on several issues.

As the practice environment changes, CMS met the needs of physicians with innovative education through our partnership with the American Bar Association’s Health Law Section. “Survival Guide: Emerging Issues in Health Care,” the theme of our 70th Annual Conference, delivered focused content on value-based care. Nationally recognized speakers made sense of MACRA, the alphabet soup of the QPP, MIPS and APMs. Conference goers got insider updates from U.S. Senators Richard Durbin and Bill Cassidy of Louisiana, our keynote speakers.

CMS’ biggest achievement is the passage of major legislation that protects physicians as value-based care takes hold. The Network Adequacy and Transparency Act (NAT Act) sets standards for all health plans sold in Illinois. And it got started at CMS when we first studied the problem and brought our proposed solutions to ISMS. Our recommendations were taken up by ISMS and subsequently drafted into a bill for Springfield.

I cannot downplay the importance of this CMS win. As medicine shifts from fee-for-service, we can expect many more narrow- and high-performance networks. Within these narrow plans will be tiers based on quality and performance data. Insurers will use these measures to determine how physicians are paid. And that means you.

Last of all, to address prescription drug gouging, we are working with Ald. Edward Burke to pass the Chicago Drug Pricing Transparency Ordinance. We recently gave testimony at City Hall that aligns with our new CMS policy.

Serving as your president has been a great honor. You have enlightened me personally and helped us strengthen our 167-year-old Chicago Medical Society.
Recent cases a reminder to document financial hardship and efforts to collect amounts owed

By Clay J. Countryman, Esq.

**The Waiver** of coinsurance and deductibles owed by patients treated by physicians and other health care providers has come under increased scrutiny recently. Although there are no clear legal prohibitions, commercial health insurers have aggressively pursued out-of-network providers who fail to collect or waive amounts owed by their insureds under different statutory regulations.

There have also been several recent settlements by health care providers resolving allegations of violating the False Claims Act for routinely waiving coinsurance amounts for Medicare beneficiaries.

**Fraudulent Billing Alleged**

In a recent case, Aetna sued Foundation Surgery Affiliates (FSM) and Foundation Surgery Management (FSM) for providing financial incentives, or kickbacks, to doctors to refer patients to Huntingdon Valley Surgery Center (Surgery Center) and for engaging in fraudulent billing practices.

A federal appellate court in Pennsylvania agreed with a lower court’s ruling that the defendants cannot be liable under the state’s anti-kickback law because they are not licensed health care providers; however, the court also concluded that there was a genuine dispute of material fact as to whether it was fraudulent for the defendants to bill Aetna without disclosing the fact they had waived the patient’s copay and deductible obligations.

The Surgery Center is not a contracted network provider with Aetna. By waiving the copay and deductible obligations, Aetna members can obtain services at the Surgery Center for approximately the same rate as they would pay at an in-network surgery center.

According to the court, the Surgery Center’s obligation to disclose the routine waiver of a patient’s obligations would arise from the language of the billing forms it submits to Aetna or any contractual agreements with Aetna that require such disclosure.

The court found that the billing form asks a provider to list the “total charges” and does not specify whether that term refers to the list prices or to the amounts the provider actually expects to receive.

The court also found that the Surgery Center’s rental network contracts (Beech Street and MultiPlan) through which its claims are processed did not clarify what information is required to be disclosed on the billing form. The court concluded that a lower district court erred in ruling that the Surgery Center’s billing practices (not disclosing that it had waived the patient’s obligation) are not fraudulent under Pennsylvania state law.

The issue of waiver of patient copays rarely arises with respect to the Medicare program because the Office of Inspector General has issued several guidance documents and fraud alerts warning providers against this particular practice. The OIG and other government agencies have articulated a longstanding position that copay waivers inflate the amount Medicare pays for services.

In a 1984 OIG Fraud Alert, the OIG commented “if a supplier claims that its charge for a piece of equipment is $100.00, but routinely waives the copayment, the actual charge is $80.00.” The OIG warned providers in the 1984 Fraud Alert that the routine waiver of Medicare copayments and deductibles can result in False Claims Act and Anti-Kickback Statute violations.

In another recent case, a hematology-oncology physician group practice in New York agreed to pay $5.31 million to settle allegations of routinely waiving coinsurance amounts owed by Medicare beneficiaries. According to the complaint filed by a whistleblower, “the physician group routinely waived copayments, without making an individualized determination of financial hardship or exhausting reasonable collection efforts.” Patients were given a pass because they had high balances, said they could not pay, or were frequent patients. According to the complaint, Hudson Valley often waived the associated copayment even if the patient did not request a waiver. Hudson Valley would note the automatic waiver in its billing system by indicating “9212 courtesy write-off.”

**Safeguards for Physicians**

These cases are a reminder to physicians and other providers to: 1) implement clear, realistic guidelines for evaluating financial hardship; 2) maintain documentation of financial hardship determinations; and 3) engage in reasonable, documented efforts to collect amounts owed by patients. Providers should consider implementing these safeguards for all types of third-party payers, including Medicare and commercial payers.

The information in this article is intended for informational purposes only, and should not be construed as legal advice on the topics addressed. Clay J. Countryman, Esq., (Clay.Countryman@bswllp.com) is a partner with Breazeale, Sachse & Wilson, LLP, in Baton Rouge, La.
Membership Medicine

Health care sharing offers alternative to traditional insurance

By Christina Claussner

As the uncertainty surrounding health care reform mounts, health care providers and their patients are revisiting alternatives—grassroot options outside of the traditional health insurance realm. “Concierge medicine,” a health care niche originally meant to target the wealthier constituent seeking first-class service without all the traditional health insurance red tape, has been around for quite some time. Today, its footprint is expanding and variations of “membership medicine” as it is commonly referred to, are branching out to meet the needs of many Americans concerned about the rising cost of premiums and the possibility of becoming uninsured.

Traditional concierge medicine focuses on primary care services. Members pay a monthly membership fee to have direct, unlimited access to their primary care physician without additional cost per visit. Members of concierge programs must still protect themselves from unexpected health emergencies with some sort of catastrophic high-deductible health care coverage. Alternative membership medicine models, which also have been around for decades, expand on the concierge model by providing additional coverage beyond primary care. Given the political minefield of reforms to increase access to health care, these alternative models have become more appealing.

One model is a Christian driven approach to covering health care costs without the backing of a traditional health insurance plan. Organizations such as Christian Healthcare Ministries, Medi-Share and Liberty HealthShare are ministry driven health care sharing entities that, while not insurance plans, are recognized as acceptable health coverage under the law, with religious exemption status from certain Affordable Care Act requirements. An estimated 625,000 Americans belong to health care sharing ministries, which is more than triple the number who belonged when the ACA legislation took effect in 2010. Now this cost-sharing movement has begun to explore corporate and organizational opportunities to expand their sharing reach.

How it Works

Basically, the ministries are health cost sharing entities through which Christians voluntarily share each other’s medical bills. Similar to traditional insurance plans, ministry driven programs typically require members to pay a monthly fee. The fee is generally based on the coverage type and/or a risk-adjusted methodology. Members also pay an annual deductible (known as an annual unshared amount) before their medical bills are eligible for sharing.

When members visit their primary care physician, urgent care facility or emergency room, they make a self-payment and then submit the bills to the health care ministry. The ministry then processes the bills for discounts and sharing eligibility. Bills that are eligible for sharing are published and the organization coordinates coverage of those bills among the members. A member’s monthly contributions are placed in that member’s share account until they are matched with another member’s eligible bills. Members contribute monies from their individual share account to another member’s account from which payment is made to the provider.

Administrative Ease for Providers

Health care sharing ministries encourage provider participation by reducing administrative burden with little to no referral or pre-certification requirements, often no timely filing limit and prompt payment, often within 30 days. Some ministries invite providers to join their network, but signing an agreement is typically not mandatory since members are free to see any provider they choose. If providers elect to sign a contract, they are agreeing to accept the program rates and not to balance bill the member, similar to other health plan networks. If a contract is not signed, the provider has no obligation to accept the rates as full payment for services rendered.

Will Faith Pay the Bill?

As a non-insurance alternative to health care cost savings, sharing ministries are exempt from insurance regulations, and thus these programs are built on faith and faith alone. They are not financially guaranteed programs; this can be unsettling to a provider used to working within the confines of an insurance program that is obligated to reimburse for covered services. Their viability is inherent in the moral and ethical obligations of its members and their spiritual belief in taking care of one another. Members are required to submit membership dues and contribute their monthly shared amount in order to benefit from the program’s cost-sharing approach.

From the provider’s perspective, the overall reduced administrative burden is appealing, although there may be other challenges in terms of back-office billing and collection. Nonetheless, the number of people participating in membership medicine programs continues to increase. Medi-Share and Liberty HealthShare have helped millions of people and saved billions of dollars in health care expenditures.

For this alternative to traditional health insurance, the mantra remains – “Have a little faith.”

Christina Claussner is a senior health care consultant at PBC Advisors, LLC, in Oak Brook. PBC provides business and management consulting and accounting services to physician practices and hospital systems. Visit the website at www.pbcgroup.com.
A NEW STUDY published on July 10 by JAMA Internal Medicine strongly rejects the viewpoint of some policymakers that Medicaid is a broken program that provides enrollees with inadequate access to physicians, and that they would be better off buying private insurance or going without insurance altogether. Numerous studies have shown that Medicaid increases access to care but rarely have studies focused on patient satisfaction among the enrollees. The authors of the study, “A National Survey of Medicaid Beneficiaries’ Experiences and Satisfaction with Health Care,” analyzed the results of the first-ever national Medicaid Consumer Assessment of Providers and System survey conducted by the Centers for Medicare and Medicaid Services in 46 states and Washington, DC, from December 2014 to July 2015.

The analysis showed that, overall, Medicaid enrollees across a range of demographics rated their health care 7.9 on a 0 to 10 scale, with 46% giving their coverage a score of 9 or 10. Only 7.6% gave a score under 5. “In summary, we found that Medicaid enrollees are largely satisfied with their care, and that few perceive their insurance as a major barrier to care,” write the study’s authors. “Changes to Medicaid that would result in millions of beneficiaries losing coverage could have major adverse effects.”

The analysis of the survey also showed that just 3% of Medicaid enrollees reported not being able to get care, either because of waiting times or because their Medicaid insurance was not accepted by physicians.

For the survey, the Centers for Medicare and Medicaid Services sampled four groups of adults enrolled in Medicaid as of fall 2013. The groups included people with disabilities, individuals dually enrolled in Medicaid and Medicare, nondisabled adults in managed care, and nondisabled adults in fee-for-service medical care. The response rate was 23.6%.

But while patients may be happy with Medicaid, many physicians are not. Reimbursement rates remain low and physician practices that serve Medicaid patients may find themselves squeezed for time due to the extra workload.

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Overcoming Barriers to Breastfeeding

Disparities persist when it comes to initiation and duration even as overall breastfeeding rates increase. By Anna Gonzales, MPH, Michelle D. Hoersch, MS, and Lesley J. Craig, MPH

Breastfeeding is a key strategy to improve public health across all communities because of its many health benefits for infants, children, and mothers. The American Academy of Pediatrics recommends that infants be breastfed exclusively for the first six months of life, followed by a combination of breastfeeding and the introduction of complementary foods for at least one year, and continuation of breastfeeding for as long as mutually desired by mother and baby.

Recognizing the importance of breastfeeding, the U.S. Department of Health and Human Services (HHS) sets national breastfeeding objectives every decade through Healthy People (HP), a national health promotion and disease prevention initiative. The HP2020 initiative set the following goals for breastfeeding: 81.9% of all mothers to initiate breastfeeding, with 60.6% continuing for at least six months postpartum, and 34.1% continuing to one year. As to exclusive breastfeeding, the goals are: 46.2% at three months, and 25.5% exclusively at six months.

The Centers for Disease Control and Prevention’s (CDC) “2016 Breastfeeding Report Card” shows that more than half of states have already met the HP2020 objective of 81.9% ever breastfed. The report states that four out of five (81.1%) infants born in 2013 started to breastfeed, with over half (51.8%) breastfeeding at six months, and almost one-third (30.7%) at 12 months.

Disparities and Barriers

Despite these promising figures, most states do not yet meet HP2020 breastfeeding duration and exclusivity goals. In fact, socio-demographics among children born in the five-year period of 2009 to 2013 demonstrate disparities in breastfeeding initiation, exclusivity, and duration; low-income mothers, less educated mothers, unmarried mothers, African American mothers, and young mothers (under age 20) all have lower breastfeeding rates. The Surgeon General’s Call to Action to Support Breastfeeding; released in 2011, identified numerous barriers to breastfeeding, including:

- Lack of knowledge
- Social norms
- Poor family and social support
- Embarrassment
- Lactation problems
- Employment and child care

The Call to Action also included “Barriers Related to Health Services,” which highlights challenges related to breastfeeding resulting from hospital policies and clinical practices, such as not prioritizing education and support for women to breastfeed, improper or disjointed care routines, and inadequate facilities.

Health Providers: Roles and Resources

The U.S. Preventive Services Task Force recommends interventions during pregnancy and after birth, to support breastfeeding, and it provides guidance on different approaches, categorized as professional support (individual counseling provided by a health professional), peer support (referrals to peer counselors for education and support), and formal education (usually group sessions that include general education and practical breastfeeding skills).

Additionally, the Surgeon General’s Call to Action seeks the implementation of the Baby-Friendly Hospital Initiative, a global program to ensure that maternity care practices fully support breastfeeding. Baby-Friendly recognizes hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. The 2016 Breastfeeding Report Card notes the percentage of live births at Baby-Friendly designated hospitals more than doubled from 7.8% in 2014 to 18.3% in 2016.

The CDC provides information on breastfeeding intervention strategies, with program examples and resources. Additionally, the CDC has worked with the Illinois Department of Public Health, the Cook County Department of Public Health, and the Chicago Department of Public Health to provide information, including a Hospital Breastfeeding Toolkit and the Illinois Physicians’ Statement on Breastfeeding, which provides guidance and evidence-based standards of care for physicians.

The HHS national campaign, “It’s Only Natural: Mother’s Love, Mother’s Milk,” was launched in 2013 to increase breastfeeding rates among African American mothers and families. The campaign provides educational resources and messaging that focus on breastfeeding barriers identified through formative research. Resources are available at www.womenshealth.gov/breastfeeding.

High breastfeeding initiation rates show that most U.S. mothers want to breastfeed and attempt to do so. Clinicians play a pivotal role, supporting women directly, or through referral, so that mothers can make informed choices and are successful in their decision to breastfeed.

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Breastfeeding Rates

<table>
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<th>State</th>
<th>Ever Breastfed</th>
<th>Breastfeeding at 6 months</th>
<th>Breastfeeding at 12 months</th>
<th>Exclusive breastfeeding at 3 months</th>
<th>Exclusive breastfeeding at 6 months</th>
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<td>U.S. National</td>
<td>81.1</td>
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<td>22.3</td>
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<tr>
<td>Illinois</td>
<td>81.1</td>
<td>52.5</td>
<td>29.2</td>
<td>43.2</td>
<td>25.5</td>
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Vaccines for the College Bound
A reminder on immunizations

**ILLINOIS PATIENTS** heading off to public and private colleges and universities this fall must meet several new vaccination requirements. The law went into effect Aug. 5, 2016, after the Illinois Department of Public Health changed the college immunization code (77 Ill. Adm. Code 694). Here’s what some of your college-bound patients need:

- Three vaccines that contain Tetanus/Diphtheria/Pertussis, one of which must be Tdap vaccine. The last dose of vaccine must be within 10 years. Vaccines must be at appropriate intervals (the first and second doses at least 28 days apart, the third dose no less than six months after dose number two). Tetanus Toxoid (TT, or Tetanus) is not acceptable.
- Two Measles, Mumps, Rubella (MMR) valid vaccines after the first birthday, at least 28 days apart. If students are unable to provide proof of vaccines, serologic evidence (IGG antibody titer) and a copy of lab report to prove positive immunity is acceptable.
- One Meningococcal conjugate vaccine after the age of 16 for newly admitted students starting Spring 2017 under the age of 22. Meningitis or Meningococcal vaccinations are not acceptable.

Students who enroll at a post-secondary educational institution without providing proof of immunity may not enroll in subsequent terms without acceptable proof.

**Non-Religious Exemptions**
Students may be exempted from specific immunization requirements, but only with a written statement from a physician. The physician’s statement must indicate the nature and probable duration of the medical condition or circumstance that contraindicates those immunizations, identifying the specific vaccines that could be detrimental to the student’s health.

Female students may be granted temporary exemption from immunization against measles, mumps, and rubella under subsection (a) if pregnancy or suspected pregnancy is certified by a physician’s written statement.

If a student is on an approved schedule of receipt for any required vaccine, the student will be granted temporary medical exemption for the duration of the approved schedule.

If a student’s medical condition or circumstances later permit immunization, the exemptions granted under the subsection will terminate and the student must obtain the immunizations from which the student has been exempted.

Students are exempt from the immunization requirements if they are enrolled for:

- Less than half-time during a term, semester, quarter.
- Instruction solely involving research, field work, or study outside of a classroom environment.
- Instruction that uses correspondence as its primary mode of delivery, such as remote learning via a tele-course or mail.

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New Earned Sick Leave Ordinances

In both Chicago and Cook County, physician-employers must comply unless their communities have opted out. By Kathryn L. Kaler, Esq., Kimberly T. Boike, Esq., and Ryan A. Haas, Esq.

LAST YEAR, the Chicago City Council enacted an earned sick leave ordinance (Chicago Ordinance) mandating that employers provide their employees with up to 40 hours of paid sick leave annually. Shortly thereafter, an earned sick leave ordinance was enacted by Cook County, Illinois (Cook County Ordinance), which is nearly identical in substance and form to the Chicago Ordinance, but also applies to employers located in suburban Cook County. Both the Chicago Ordinance and the Cook County Ordinance (collectively, the Ordinances) went into effect on July 1, 2017.

Affected Employers: Who Must Comply?

Nearly 100 municipalities in Cook County have exercised their home rule rights to opt out of the Ordinances. However, physician-employers located in communities that have declined to opt out are expected to comply with the Ordinances.

Both Ordinances apply to all individuals and business entities that employ at least one covered employee. However, the Cook County Ordinance applies only to employers that have a “place of business” in Cook County. On the other hand, the Chicago Ordinance applies to employers that “maintain a business facility” within the geographical boundaries of the City of Chicago, and/or those employers subject to Chicago business license requirements. Accordingly, the Chicago Ordinance may apply to an employer simply because it has a Chicago business license irrespective of whether such employer is physically located in the City of Chicago.

How Employers Acquire and Use Paid Sick Leave

A “covered employee” includes any employee who works for an employer at least 80 hours within any 120-day period, and performs at least two hours of compensable work during any two-week period in Cook County or the City of Chicago (as applicable under the respective Ordinance).

“Covered employees may use paid sick leave if they or their family members are victims of domestic violence or a sex offense. Paid sick leave may also be used in the event an employee’s child whose school or daycare facility is closed due to a public health emergency.”

Under the Ordinances, covered employees accrue one hour of paid sick leave for every 40 hours worked, up to a maximum of 40 hours of paid sick leave during any calendar year. Employers also have the option to “frontload” paid sick leave by providing employees with a lump sum of 40 hours at the beginning of each year.

Employees may carry over a maximum of 20 hours of unused paid sick leave to the following calendar year. However, employees covered by the federal Family and Medical Leave Act (FMLA) may carry over an additional 40 hours of unused paid sick leave to use exclusively for FMLA purposes, for a total of 60 carry-over hours. In the event of an employee separation, employers are not required to pay to the departing employees any of their accrued sick leave.

Paid sick leave may be used for an employee’s or an employee’s family member who is ill or injured, or receiving medical care, treatment, diagnosis or preventive medical care. In addition, covered employees may use paid sick leave if they or their family members are victims of domestic violence or a sex offense. Paid sick leave may also be used in the event an employee’s child whose school or daycare facility is closed due to a public health emergency. If an employee’s need for paid sick leave is “reasonably foreseeable” (prescheduled appointments), employers may require employees to provide seven days advance notice prior to their absence. If not, employers are required to notify employers as soon as practicable via phone, e-mail or text message.

Policies and Procedures Key to Avoiding Liability

Employers who are subject to the Ordinances and already providing paid sick leave in a fashion that satisfies the requirements of the Ordinances will not be required to provide additional paid sick leave. However, employers should carefully review their policies and procedures to ensure that existing practices meet the requirements of the Ordinances. Policies that substantially comply may need only minimal revisions. For example, a policy that requires more than seven days advance notice prior to a foreseeable absence will need to be revised. Additionally, employers may need to develop and implement appropriate mechanisms to track accrued earned sick leave and when and how it is used by employees.

The Ordinances grant employees private rights of action to pursue employers that violate the Ordinances. Successful plaintiff-employees may recover damages equal to three times the amount of unpaid sick leave denied or lost by reason of the violation, plus attorneys’ fees and costs.

If there are any doubts, employers should consult with an employment law attorney to advise on updates that should be incorporated into existing policies and procedures to mitigate or remedy potentially expensive problems in the future.

The authors practice at the Chicago office of Chuhak & Tecson, P.C. Kathryn L. Kaler, Esq., specializes in corporate transactions and estate law; Kimberly T. Boike, Esq., a principal, practices healthcare law; and Ryan A. Haas, Esq., a principal and general counsel, practices employment law affecting healthcare providers.
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.
Online Reviews Make You Want to Yelp?

Don’t be defensive, track what’s said and remember that a well-run practice will get enough good reviews to lessen the blow from bad ones.

By Benjamin Mindell


The potential for a negative online review is limited only by all the possible interactions where medicine is practiced and the capacity for outrage—justified or not—of the reviewer. For physicians, it can be a jolt to have all their expertise and commitment to patient care reduced to a one-sided narrative and a low star rating. “These attacks feel, and can be, very personal,” says Andrew Bernstein, MD, a pediatrician at a North Shore group practice. He hasn’t been the target of a negative review, but as the practice’s “tech guy” he monitors relevant sites and responds to reviews, which itself can be a minefield. The wrong reply “may fuel more arguing and can make the doctor look petty and mean.”

A study published in the February 2017 Journal of General Internal Medicine found a distinct digital divide when researchers asked 828 physicians and 494 patients in Massachusetts about their views on physician rating websites. Less than a quarter—21%—of doctors were in favor of posted “narrative comments” versus more than half—51%—of patients. More than a third—39%—of patients had made at least one visit to a physician-rating site. More than three-quarters of doctors—78%—believe comments would add to their job stress.

Yet most reviews of doctors are positive and star rating averages are closer to the five-star end of the scale than the one-star. For example, a study published in 2014 by JAMA Otolaryngology—Head & Neck Surgery found the mean score among 266 otolaryngologists on Healthgrades was 4.4 out of 5.

Unfortunately, critical reviews can carry an outsized sting. “People go out of their way to read the negative ones,” warns Derek Kosiorek, a principal consultant at the Medical Group Management Association’s Health Care Consulting Group.

A JAMA research letter published in 2014, showing responses of more than 2,000 members of the public, reported that 59% found rating sites somewhat or very important in terms of selecting a doctor. About a third—37%—who had checked a review site, reported having “avoided a physician with bad ratings.”

Responding? Try a Little Tenderness

Earlier this year, JAMA Facial Plastic Surgery published a research letter analyzing 152 five-star reviews and 112 one-star Yelp reviews of big-city dermatologists, plastic surgeons and facial plastic surgeons. One factor topped the lists at each end of the satisfaction spectrum—bedside manner, defined as “the physician's approach or attitude toward the patient.”

Similarly, patients—both reviewers and readers—are going to be watching how the practice responds to criticism. When it comes to negative reviews, “you have to look at the motivation of the people who are writing it and the people who are reading it,” says Kosiarek. As for the negative reviewers, “the best thing to do is to invite them to contact you and share their stories.”

At that point the public nature of the review site, and demonstrating openness to receiving feedback, can be an advantage. “Everyone who reads it after that is interested in that somebody is listening and responding to negative reviews,” notes Kosiorek.

Patients have the right to complain about the way they are treated. A negative online review might be more public than the doctor wants, but
it is still an expression of discontent. Responding opens the door to resolving a complaint with a patient and offsetting negative attention to the practice. It can even prompt a patient’s change of heart and result in the post being taken down, but don’t count on it.

Still, HIPAA can make that engagement tricky and even downright dangerous for the practice. The general advice from commentators is to be brief, generic, and get right to an offer to discuss the matter privately. “We recommend a public facing response where you take the conversation offline, always being mindful of protected health information,” says Andrew Rainey, executive vice president of strategy and corporate development at Binary Fountain. “For example: ‘I’m sorry to hear about the long wait time when you visited our facility. Will you please email us so we can better understand your experience?’” Always provide an email address so the patient can act on that request.

McLean, Va.-based Binary Fountain specializes in providing patient feedback management in the health care sector, and says it has tracked and analyzed more than 10 million patient reviews for clients encompassing 2,800 facilities. It is part of a greater reputation management industry that encompasses every type of consumer activity—restaurants and retail are among the most common—where a business can be profoundly affected by ratings and comments.

“For health systems, hospitals and medium/large group practices, we recommend that the marketing team respond on behalf of physicians, as opposed to a direct response from the physician themselves,” says Rainey. “Physicians often, and for good reason, take negative feedback personally. Marketing teams are responsible for the digital presence of the facilities as well as the physicians, and should take a disciplined approach to engaging patients online.” That also includes an often overlooked but valuable way to show engagement, replying to good reviews and not just to critical ones.

Be Aware of What’s Being Said

But before a practice can respond, it has to know what’s out there. “The most difficult part is monitoring,” says Kosiorek. “In order for you to respond quickly you have to know that they are there. At least weekly, you have to check in to see what is there,” continues Kosiorek. “I think a lot of practices are just blind to it. They don’t realize that the reviews are there. At a small practice, checking websites could be just part of the morning routine for a staff member.”

Primary care doctors, especially, should expect to be reviewed. In terms of reviews and any other online mentions, all doctors should be diligent. At the very least, having a Google Alert set up to track both the physician’s name and the practice’s name is a must. Also doing an occasional Google search can be useful. Not all patients go directly to specific review sites; they use the search box instead. Since searchers generally look at only the top results, it is important to experience a search the same way prospective patients do.

“Our platform helps clients identify the sources that are in most need of new patient feedback,” says Rainey. What they are looking for includes low volume of reviews, recent negative feedback, or an overall negative score.

The company’s work for clients includes facilitating the posting of data collected under the federal Agency for Healthcare Research and Quality’s CG-CAHPS program—formally, the Clinician and
Group Survey of the Consumer Assessment of Healthcare Providers and Systems—which encourages dissemination of the information. Commercial ratings sites—Yelp and Healthgrades, for example—require the reviewer to log in, individually, to each site. That’s a challenge for the smallest practice to the largest hospital system.

“We encourage our clients to run promoter campaigns, where they reach out to their patients to ask them to leave a review and rating on recommended third-party or social networking sites,” says Rainey. Methods include email, texts, word of mouth, or cards that are handed out.

Note, however, that before letting patients know that the practice is open to being reviewed, it’s important to understand the terms of service of any sites that are mentioned. Yelp is one of the most influential sites, but it has a strict policy—backed by the threat of a damaged rank—against recruiting reviewers to go to the site.

Medical ethics has traditionally asked anke at patient testimonials. Research and commentaries tend to treat online ratings as a fact of life in modern medicine. That is probably because they come with an expectation of transparency—the system should treat bad reviews the same way as good ones. The general consensus also seems to be that a few negative reviews need not be seen as disastrous if the overall trajectory is positive.

How high up a review appears is important. “More positive feedback will dilute the impact of negative reviews by pushing them lower down,” says Rainey.

But while physicians understandably don’t want outside attention focused on a negative review, practices would do well not to be defensive and should work to uncover the truth of even a hurtfully worded post. A single negative review “should be enough for you to trigger an investigation,” says Kosiorek. “Find out if that is true, and if it is true make a change. If not true, then just keep going forward.”

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PHYSICIANS might steam about unfairness upon seeing a withering review, but that is just the beginning of how online reviews favor the rights—which, after all, are deeply rooted in the tradition of free speech—of sites and reviewers. Three federal laws frame much of what doctors need to know about how they can respond. Two apply to everyone, the Communications Decency Act (CDA) and the Consumer Review Fairness Act (CRFA). The third is a law that doctors already know well—the Health Insurance Portability and Accountability Act.

In short, the CDA protects the sites that post third-party content, giving these sites protection against being sued for libel. Any recourse must be directed at the person—the third party—who wrote the review. That individual is often writing under a pseudonym, and tracking down the author can be hard. If through the website, it typically requires a court order.

The CRFA became effective in March of this year. It renders void any boilerplate contracts that block or impose penalties on an online reviewer for posting about any goods or services. Some doctors actually tried that approach, although what little momentum there was for that faded well before the CRFA took effect.

In the case of HIPAA, the patient privacy provisions directed at providers are simply no less strict when applied to an online review site. Patients can post anything about themselves, but the doctor doesn’t have the same freedom to discuss the matter. A ProPublica/Washington Post investigation’s headline neatly sums up a situation no doctor ever wants to get on the wrong side of—“Stung by Yelp Reviews, Health Providers Spill Patient Secrets.”

In terms of formal recourse, that usually leaves turning to a lawyer, and exploring the threat of filing a defamation action over a false, damaging statement about the doctor. Unlike the federal laws noted above, defamation—in the case of online reviews, libel—is typically a state civil court matter.

Many online reviews might create negative perceptions, but few rise to the level of defamation. Such cases make up only a small percentage of lawsuits overall. Of those, only a tiny number nationally are reported to have ever been brought by health care practitioners. Unlike malpractice suits and other injury cases, which are typically taken on a contingency basis, lawyers are far more likely to require an hourly rate. The deep pocket in the case—the website—is essentially invulnerable. There is a good chance the reviewer probably won’t be able to pay any sizeable judgment, if it ever comes to that. The conversation in the lawyer’s office will likely turn to a cease and desist letter, which might close the matter quietly and quickly.

When a defamation case goes public, the classic plaintiff’s position, even if an award can’t be collected, is that all the cost and effort will give them the final word—“vindicated.” But the practical outcome might very well be two words—“Streisand effect.”

It has become the shorthand term for unwanted publicity stemming from a legal action. In 2003, singer Barbra Streisand filed a privacy suit over an online image of her Malibu home, captured as part of an activist aerial photo project documenting beach erosion. As the story goes, before the action was filed, the photo was downloaded only six times. A month later, more than 400,000 visits were made to the site carrying the image. Patients hearing of a physician’s lawsuit in the media might believe that where there’s smoke there’s fire or simply be turned off by the prospect of a doctor who sues a patient.
ALL HEALTH PLANS sold in the State of Illinois will meet stringent new standards, thanks to a small but diligent group of Chicago Medical Society members. Legislation awaiting Governor Rauner’s signature, the Network Adequacy and Transparency Act (NAT Act), had its origin at the Chicago Medical Society, and shows how a few individuals, working through the Medical Society, can build a groundswell movement.

The July issue of Chicago Medicine told the history of this CMS initiative, which began under Dr. Kathy Tynus, then-president of the Chicago Medical Society. Her term leading CMS (2015-2016) coincided with the sudden narrowing of provider networks, an epidemic of surprise medical bills, and ominous reports of more plan shrinkage to come. As noted, one of Dr. Tynus' first actions as president was appointing a Network Adequacy Taskforce, to conduct weekly meetings and study the impact of narrowing on patients and their physicians.

Soon this small group of individuals was at work, fact-finding, giving and gathering testimony, listening to patients, and meeting with insurance executives. The group's final product—a set of comprehensive network adequacy proposals—was delivered to the Illinois State Medical Society Board of Trustees and to the ISMS House of Delegates in early 2016. CMS urged ISMS to act quickly, drafting a bill for introduction in Springfield.

Ultimately, with the strong CMS provisions intact, the ISMS-drafted bill passed both chambers this year; the House acted on April 24 and the Senate on May 26. This update article recognizes the other dedicated members at CMS who brought the effort forward.

Students and Physicians
Medical students were among the first to participate on the CMS Taskforce, but none more so than Christiana Shoushtari, MPH, MS. Now in her fourth year at the University of Illinois at Chicago, Shoushtari came to CMS with experience in health policy, the legislative process, and public health. Shoushtari had already earned an MPH from the University of Michigan School of Public Health in 2008, followed by an internship with U.S. Senator Debbie Stabenow, and then a job as a health legislative correspondent with former U.S. Senate Majority Leader Harry Reid.

When her father's health plan, Blue Cross and
Blue Shield, changed, Shoushtari saw the impact firsthand. The confusion and burden of having to re-establish care at another institution inspired her to act. Shoushtari quickly got to work, reviewing the network adequacy policies of other medical and specialty societies, along with health insurance trends nationally. Her research delved into New York’s Surprise Medical Bill law, and similar legislative responses to the narrowing of health plan networks and proliferation of surprise medical bills. Shoushtari also consulted the National Association of Insurance Commissioners. Staff at the American Medical Association provided a trove of network adequacy guidelines and model legislation.

Along with students, the CMS Taskforce had input from physicians at the other end of the spectrum. Longtime public health champions Drs. Peter Orris and David Ansell were active members. Known globally for his public health advocacy, Dr. Orris is professor and chief of occupational and environmental medicine at the University of Illinois at Chicago. He spent more than three decades as an attending physician at Cook County Hospital and then Stroger Hospital. He maintains an active clinical and teaching practice and holds professorships in internal and preventive medicine at Rush Medical College and Northwestern University Feinberg School of Medicine.

A fellow public health activist, Dr. Ansell is the senior vice president for community health equity at Rush University Medical Center. He trained at Cook County Hospital, going on to hold positions including chief of general medicine and primary care. He spent 10 years as chair of the department of internal medicine at Mount Sinai Hospital.

Credit goes also to Theodore Kanellakes, the Chicago Medical Society’s executive director. Mr. Kanellakes opened doors, facilitating face-to-face meetings between physicians and the top medical leadership of Health Care Service Corp., parent company of Blue Cross and Blue Shield of Illinois. Not only did Mr. Kanellakes bring participants together in one room, he was also able to guide physicians in their testimony. During these meetings, the parties were able to gain a better understanding of the policy positions and perspectives of others.

**It Takes a Team**

A victory of this magnitude is never single-handed. The network adequacy and transparency legislation demonstrates how individuals can use the structure and resources of the Chicago Medical Society to bring about reform.
A MODERN-DAY public health crisis, gun violence affects more than 100,000 Americans every year, resulting in 32,000 deaths, or 89 fatalities per day. Nearly two-thirds are suicides. In 2014, the U.S. firearm fatality rate—10.3%—matched that for sepsis and Alzheimer’s disease.

Increasingly, physicians outside of the emergency department are being urged to work “upstream” of these events, by paying attention to the risk factors that often precede a shooting. Unlike the traditional model of resuscitation and trauma care, the office visit presents opportunities for doctors to counsel and intervene, said speakers at “Preventing Gun Violence: Moving from Crisis to Action,” a program held in Chicago on March 24.

The half-day seminar looked at prevention strategies already being adopted by primary care physicians, and reported on new research and legislation that enables physicians to partner with legal and law enforcement. The event was hosted by the American Bar Association, the American Medical Association, and the Chicago Medical Society at the ABA’s downtown headquarters. Here are highlights:

Public Health Approach
Often the events that precede a shooting go ignored. But in the exam room, physicians have opportunities to counsel and intervene, said speaker Megan Ranney, MD, an associate professor of emergency medicine at Brown University’s Warren Alpert Medical School. “There’s a moment when physicians can intervene and it will thrill EM doctors,” she stated.

She advises physicians to be alert to certain risk factors, and the stages of escalation. Patients who have been assaulted or hospitalized for a firearm-related injury are at-risk since they may have PTSD or want to retaliate. Also at risk are victims of domestic violence. Alcohol abuse is strongly linked to misuse of firearms. Cognitive issues, another risk factor, affect a growing number of aging Baby Boomers.

Physicians can and must screen patients for firearm access when at least three of the high-risk conditions are present. The top three are suicide, assault and domestic violence, said Dr. Ranney.

One example she gave was of a woman who said she had been the victim of domestic violence and carried a gun in her purse for protection. For such a patient, the physician should counsel her that carrying that gun increases her risk of a gun-related incident. “In those moments of acute risk, it’s about reducing access,” Dr. Ranney said.

The federal law that prohibits the purchase and possession of firearms by certain individuals does not include everyone with these risk factors, however. Some states have filled in these gaps, preventing firearm access by people known to be dangerous.

In addition, federal law prohibits people with certain kinds of mental health histories from purchasing or possessing firearms, but this law misses many individuals who have been identified by mental health professionals as dangerous. As a result, several states such as Illinois have broadened the category of mentally ill persons who are prohibited from purchasing or possessing firearms.

Yet states with stringent rules for reporting disabilities make patients less likely to disclose gun ownership, said another speaker, Miriam Betz, MD. Contrary to popular belief, most mentally ill people are victims of gun violence rather than perpetrators, she added. Dr. Betz is an associate professor of emergency medicine at the University of Colorado School of Medicine.

Physician Gag Laws
In recent years, states have debated proposals to prohibit physicians from discussing gun ownership with their patients, notably Florida, which enacted a law in 2011. But in early 2017, the 11th U.S. Circuit Court of Appeals struck down key portions of the Florida’s “gun gag” law on grounds it infringed on the free speech rights of physicians.

The law was challenged by the Brady Center to Prevent Gun Violence, which sued the state on behalf of several doctors and more than 11,000 health care organizations.

Yet one speaker said the Florida law was never a major impediment to asking questions. The real challenge is knowing how to ask questions about gun ownership, and doing this in an effective way, argued Matthew Miller, MD, co-director of the Harvard Injury Control Research Center. Physicians, he said, need help figuring that out.

Beliefs and Opinions
Attitudes and personal beliefs about gun ownership may interfere with asking questions about firearms. Dr. Miller was coauthor of a survey in which health professionals were asked whether a gun in the home increases the risk of suicide. Just 25% said they agreed with that statement while
another 50% said they disagreed.

Another study he coauthored with Dr. Betz asked physicians and nurses at eight emergency departments how they approached suicidal patients. In an analysis, which separated patients whose suicide plans involved a firearm from those who had no specific method, 64% asked patients whose suicide plans did involve firearms about guns in the home. Only 21% discussed guns when patients said they had no specific method.

**Gun Ownership and Suicide**

In 2010, suicide was the 10th-leading cause of death in the United States, claiming 38,364 lives, with more than half of people using firearms. As the method of choice, guns surpass all other intentional means of suicide combined, which includes hanging, poisoning or overdose, jumping, or cutting.

Quite simply, states with high gun ownership rates have high firearm suicide rates, said Dr. Miller. From 2008 to 2009, states with high-gun-ownership had 7,275 suicides, compared with states with low gun ownership rates, at 1,697. Nonfirearm suicides in high-gun and low-gun states were nearly identical—4,153 and 4,341, respectively.

Looked at another way: 19,392 people committed suicide with guns in 2010, compared with 11,078 who were shot dead by someone else.

To date, there is no large study showing that safe storage training works, Dr. Miller said. In fact, he noted, those with training are more likely to store unsafely. States with storage laws and child access prevention are well-intended, but not that effective, he added.

Often the crisis underlying a suicide is temporary; the person acts on impulse and uses whatever means is readily available. But a gun is far more likely to result in death, at 90%, compared to the 10% who succeed using some other method, speaker Dr. Betz pointed out.

Among those who do survive a self-inflicted gunshot, less than 10% go on to try again. Bottom line: “If you save someone’s life today, you’ve actually saved their life in the long run, Dr. Miller said.

Dr. Betz reported one survey showing that 70% of patients said they don’t object to questions and counseling, if it is individualized. Instead of lecturing, or telling patients they must get rid of their guns, she said to ask, “what about getting the gun outside of the home?”

**Evidence-Based Research**

Keeping conversations grounded in fact, using data instead of ideology will move these conversations forward, a point that highlights the need for research, both Drs. Miller and Betz agreed. Both physicians would like to see the Centers for Disease Control and Prevention collect data and study the causes and consequences of firearm violence and unintentional injuries. This could help lead to evidence-based strategies and interventions.

Current law, however, bans CDC research into gun violence, with language that specifically forbids use of federal funding to advocate or promote gun control.

**Learning from Auto Safety**

Rather than trying to change individual behavior, a public health approach takes a broad population-based view. Here, the focus is on shared responsibility, and on prevention.

A good example can be found in motor-vehicle safety. Over the decades, fatalities have been cut by 85% per mile driven, even though drivers today aren’t thought to be any more careful or law abiding. Instead of changing behavior, vehicles and highways changed, Dr. Miller said.

Advances such as collapsible steering columns, shatter-proof glass, airbags, and seat belts have saved countless lives. These environmental changes, or systems improvements, reduce the consequences of error and dangerous behavior. Likewise, advances in design and engineering, including “smart” guns, are all vital to reducing firearm injury and death.

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**The Financial Burden of Firearms**

Firearm violence takes a tremendous toll on the nation’s health care system. Counting both medical expenditures and lost productivity, the Journal of the American College of Surgeons arrived at an annual cost of more than $70 billion. Authors of the December 2015 article estimated total costs from all firearm injuries at $123 billion, a figure that includes direct costs from injury, plus the costs of pain, suffering, and lost quality of life.

A May 2017 article in the American Journal of Public Health, reported costs for 2006-2014. During that period, costs for the initial inpatient hospitalization totaled $6.61 billion. The largest proportion was for patients with governmental insurance coverage, totaling $2.70 billion (40.8%) and was divided between Medicaid ($2.30 billion) and Medicare ($0.40 billion). Self-pay individuals accounted for $1.56 billion (23.6%) in costs. Thus, from 2006 to 2014, the cost of initial hospitalizations for firearm-related injuries averaged $734.6 million per year, with Medicaid paying one-third and self-pay patients one-quarter of the financial burden. These figures substantially underestimate true health care costs.
Gun Violence and the Second Amendment

ABA REPORT

“Athe law should encourage intelligent discussion of possible remedies for what every American can recognize as an ongoing national tragedy.”

These words, written by former Supreme Court Associate Justice John Paul Stevens shortly after the Sandy Hook killings, refer to the tragedy of gun violence.

The American Bar Association has seen some use the Second Amendment to attempt to stifle this “intelligent discussion.” While we respect reasoned views of all on the matter of gun violence, we reject the notion that the Second Amendment bars efforts to stem gun violence.

This paper describes the ABA’s policies related to gun violence and summarizes how the majority of courts, following the seminal 2008 Supreme Court case of District of Columbia v. Heller, have similarly concluded that a wide variety of laws to address gun violence are constitutionally permissible.

America’s Epidemic of Gun Violence

The United States is plagued by gun violence. Over 100,000 people are victims of a gunshot wound each year and more than 30,000 of those victims lose their lives. In 2013, the most recent year for which data is available, firearms killed 33,656 Americans—an average of more than 92 deaths each day—including 11,208 homicides, 21,175 suicides, and 905 unintentional firearm deaths.

Children and young people are particularly vulnerable to gun violence. In 2013, children and young people under the age of 25 accounted for 36% of all firearm deaths and injuries. The presence of a gun also increases the likelihood of death in incidents of domestic violence, raises the probability of fatalities among those who attempt suicide, and disproportionately harms communities of color. In 2013, African Americans suffered over 57% of all firearm homicides, even though they make up only 13% of the population. Moreover, firearm homicide is the leading cause of death for African American males ages 15-34.

In addition to the grave physical and emotional toll gun violence takes on individuals and communities nationwide, gun-related deaths and injuries burden the American public with overwhelming economic costs. Medical costs alone have been estimated at $2.3 billion annually, half of which are borne by taxpayers. When all direct and indirect medical, legal and societal costs are included, the estimated annual cost of gun violence in the United States amounts to $100 billion. Guns also play an enormous role in crime in America. In 2011, firearms were used to commit over 470,000 violent crimes, and approximately 70% of all homicides that year were committed with a gun.

The ABA’s Long History of Support for Sensible Laws to Reduce Gun Violence

For nearly 50 years, the ABA has acknowledged the devastation caused by gun violence in our society and expressed strong support for meaningful reforms to our nation’s gun laws. Since 1965, the ABA House of Delegates has considered and approved nearly 20 separate resolutions aimed at reducing firearm-related deaths and injuries. Those resolutions have included a variety of policy recommendations to fill dangerous gaps in federal and state gun regulations, including support for laws to prohibit gun possession by felons and domestic abusers, require background checks on all gun purchasers, ban assault weapons, and regulate guns as a consumer product.

Other ABA resolutions have not related to “gun laws” as such; rather, they have expressed the ABA’s support for other strategies to reduce gun violence, such as school-related programs that include peer mediation and firearm safety education. Some of these proposals have been adopted or enacted into law; others have not.

As discussed below, the courts have held that the Second Amendment to the U.S. Constitution is consistent with a wide variety of laws to reduce gun-related deaths and injuries in our nation. Nevertheless, the ABA recognizes that confusion exists among the public, even among many lawyers, regarding whether the Second Amendment provides an obstacle to sensible laws. In its role as the nation’s preeminent legal organization, the ABA seeks to educate its members, as well as the public at large, about the true meaning of the Second Amendment.

Coincidentally, as the ABA was researching this issue, so was a Task Force on Gun Violence of the New York State Bar. In its draft report of January 2015, the Task Force also concluded that “even with much unsettled about the precise contours of the Second Amendment, we expect most forms of state and federal gun regulation will be upheld under the developing post-Heller case law.”

The Second
Amendment: No Barrier to Common Sense Laws to Reduce Gun Violence
“A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms shall not be infringed.”

The Heller Decision
In 2008, in District of Columbia v. Heller, 554 U.S. 570 (2008), a divided U.S. Supreme Court held for the first time that the Second Amendment protects a responsible, law-abiding citizen’s right to possess an operable handgun in the home for self-defense. In a 5-4 ruling, the Court struck down Washington, DC, laws prohibiting handgun possession and requiring that firearms in the home be stored unloaded and disassembled or locked at all times.

The Heller decision was a dramatic departure from the Supreme Court's previous interpretation of the Second Amendment in U.S. v. Miller, 307 U.S. 174 (1939), which held that the right guaranteed by the Constitution was related to a well-regulated militia. For almost 70 years, lower federal and state courts had relied on and ruled consistently with the Miller decision to reject hundreds of challenges to our nation’s gun laws.

Although the Heller decision established a new individual right to “bear arms,” the Supreme Court made clear that the Second Amendment should not be understood as conferring a “right to keep and carry any weapon whatsoever in any manner whatsoever and for whatever purpose.” The Court concluded that the Second Amendment does not bar a broad range of limitations on who may possess firearms, what kinds of firearms they may possess, or where they may possess them.

In Heller, the Court identified a non-exhaustive list of “presumptively lawful regulatory measures,” including “longstanding prohibitions” on firearm possession by felons and the mentally ill, as well as laws forbidding firearm possession in sensitive places such as schools and government buildings, and imposing conditions on the commercial sale of firearms. The Court also noted that the Second Amendment is consistent with laws banning “dangerous and unusual weapons” not in common use, such as M-16 rifles and other firearms that are most useful in military service. In addition, the Court declared that its analysis should not be read to suggest “the invalidity of laws regulating the storage of firearms to prevent accidents.”

In 2010, in McDonald v. City of Chicago, 561 U.S. 742 (2010), the Supreme Court held in another 5-4 ruling that the Second Amendment applies to state and local governments in addition to the federal government. The Court reiterated in McDonald that a broad spectrum of laws to reduce gun violence remain constitutionally permissible.

Post-Heller Litigation
In the wake of Heller and McDonald, lower courts have been flooded with lawsuits claiming that various federal, state, and local firearms laws violate the Second Amendment. Nearly all of these claims have been rejected. Courts across the country have upheld numerous commonsense laws to reduce gun-related deaths and injuries, including those regulating:

Possession of Firearms by Criminals
- Prohibiting possession of firearms by felons.
- Prohibiting possession of firearms by domestic violence misdemeanants.
- Prohibiting possession of firearms by an individual who is under indictment for a felony.
- Prohibiting possession of firearms during the commission of a crime.

Firearm Ownership
- Requiring background checks for private firearm transfers.
- Requiring registration of all firearms.
- Requiring an individual to possess a license to own a handgun.
- Requiring handgun permit applicants to pay a fee of $340 every three years.
- Prohibiting the sale of firearms to individuals who do not reside in any U.S. state.

Firearm Safety
ABA REPORT

• Requiring the safe storage of handguns in the home.
• Prohibiting the possession of a firearm while intoxicated.

Particularly Dangerous Weapons
• Forbidding the possession, sale, and manufacture of assault weapons and large capacity ammunition magazines.
• Prohibiting the sale of “particularly dangerous ammunition” that has no sporting purpose.

Firearm Possession by Other Dangerous Individuals
• Prohibiting the possession of firearms by individuals who have been involuntarily committed to a mental institution.
• Prohibiting possession of firearms by an unlawful user of a controlled substance.
• Prohibiting possession of firearms by individuals subject to a domestic violence restraining order.
• Authorizing the seizure of firearms in cases of domestic violence.

Conditions on the Sale of Firearms
• Requiring a gun dealer to obtain a permit and operate its business greater than 500 feet from any residential area, school, or liquor store.
• Prohibiting the sale of firearms and ammunition to individuals younger than twenty-one years old.

Firearms in Sensitive Places
• Prohibiting the possession of firearms within college campus facilities and at campus events.
• Prohibiting the carrying of a loaded and accessible firearm in a motor vehicle.
• Forbidding possession of a firearm in national parks.
• Prohibiting the possession of firearms in places of worship.
• Prohibiting the possession of firearms in common areas of public housing units.
• Prohibiting the possession of guns on county-owned property.

Regulation of Firing Ranges
• Requiring firing range patrons to be at least 18 years of age.
• Requiring that ranges not be located within 500 feet of sensitive locations.
• Construction requirements, including bullet-proof windows and doors, noise limits, plumbing and electrical requirements, and separate/interlocked ventilation systems.
• Requiring that a range master be present at all times.

Although more than 900 post-Heller decisions have upheld a wide variety of regulations to reduce gun violence, there have been a few rulings striking down certain types of firearms laws. The Seventh Circuit struck down Illinois’ complete ban on the public carrying of weapons, and also enjoined enforcement of a Chicago ordinance banning firing ranges within city limits where range training was a condition of lawful handgun ownership. A district court in the Seventh Circuit struck down a Chicago law banning the transfer of firearms except through inheritance, but explicitly reiterated that cities and states have broad authority to regulate the commercial sale of firearms, including limits on the locations where dealers may operate.

In addition, a district court struck down Washington, DC,’s prohibition on all public carrying of firearms, and a divided panel of the Ninth Circuit struck down a San Diego County policy requiring an applicant for a permit to carry a concealed firearm to demonstrate “good cause” beyond a general desire for self-defense. Nonetheless, decisions striking down laws on Second Amendment grounds are quite rare.

Finally, since issuing its opinions in Heller and McDonald, the Supreme Court has repeatedly declined to hear new cases raising Second Amendment challenges. In fact, the Supreme Court has denied cert in over 60 cases, all of which involved a lower court decision rejecting a Second Amendment challenge.

Conclusion
In short, the U.S. Supreme Court and lower courts have made clear that the Second Amendment is consistent with and does not bar a broad array of sensible laws to reduce gun violence. Our nation’s courts have repeatedly found that the types of laws supported by the ABA and introduced by legislators across America do not run afoul of the Constitution.

ABA members, as well as other legal professionals and the public at large, should feel confident knowing that the Second Amendment is not an obstacle to the legal reforms our country so clearly needs to combat firearm-related deaths and injuries in America.

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WORKING WITH THE BAR

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

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

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

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Firearm-Related Injury and Death in the United States

A Call to Action From 8 Health Professional Organizations and the American Bar Association

By Steven E. Weinberger, MD; David B. Hoyt, MD; Hal C. Lawrence III, MD; Saul Levin, MD, MPA; Douglas E. Henley, MD; Errol R. Alden, MD; Dean Wilkerson, JD, MBA; Georges C. Benjamin, MD; and William C. Hubbard, JD

Abstract
Deaths and injuries related to firearms constitute a major public health problem in the United States. In response to firearm violence and other firearm-related injuries and deaths, an interdisciplinary, interprofessional group of leaders of 8 national health professional organizations and the American Bar Association, representing the official policy positions of their organizations, advocate a series of measures aimed at reducing the health and public health consequences of firearms. The specific recommendations include universal background checks of gun purchasers, elimination of physician “gag laws,” restricting the manufacture and sale of military-style assault weapons and large-capacity magazines for civilian use, and research to support strategies for reducing firearm-related injuries and deaths. The health professional organizations also advocate for improved access to mental health services and avoidance of stigmatization of persons with mental and substance use disorders through blanket reporting laws. The American Bar Association, acting through its Standing Committee on Gun Violence, confirms that none of these recommendations conflict with the Second Amendment or previous rulings of the U.S. Supreme Court.

Across the United States, physicians have firsthand experience with the effects of firearm-related injuries and deaths and the impact of such events on the lives of their patients. Many physicians and other health professionals recognize that this is not just a criminal violence issue but also a major public health problem.

Because of this, we, the executive staff leadership of 7 physician professional societies (whose members include most U.S. physicians), renew our organizations’ call for policies to reduce the rate of firearm injuries and deaths in the United States and reiterate our commitment to be a part of the solution in mitigating these events. We represent the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American Congress of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, and American Psychiatric Association. The American Public Health Association, which is committed to improving the health of the population, and the American Bar Association (ABA), which is committed to helping lawyers and the public understand that the Second Amendment does not impede reasonable measures to limit firearm violence, join the physician organizations in articulating the principles and consensus-based recommendations summarized herein.

The recommendations presented here are based substantially on the various positions approved and adopted by our organizations.

Background
In the United States, firearm-related deaths and injuries are a major public health problem that requires diligent and persistent attention. Each year, more than 32,000 persons die as a result of firearm-related violence, suicides, and accidents in the United States; this rate is by far the highest among industrialized countries. Firearms are the second-leading cause of death due to injury after motor vehicle crashes for adults and adolescents. What’s more, the number of nonfatal firearm injuries is more than double the number of deaths. Although much attention has been given to the mass shootings that have occurred in the United States in recent years, the 88 deaths per day due to firearm-related homicides, suicides, and unintentional deaths are equally concerning.

Approximately 300 million guns are owned by U.S. civilians, ranking the United States first among 178 countries in terms of the number of privately owned guns. Although some persons suggest that firearms provide protection, substantial...
evidence indicates that firearms increase the likelihood of homicide or, even more commonly, suicide. Access in the home and general access to firearms have also been shown to increase risk for suicide among adolescents and adults. This violence comes at a substantial price to our nation, with a total societal cost of $174 billion in 2010.

Our organizations support a public health approach to firearm-related violence and prevention of firearm injuries and deaths. Similar approaches have produced major achievements in the reduction of tobacco use, motor vehicle deaths (seat belts), and unintentional poisoning and can serve as models going forward. Along with our colleagues in law and public health, those of us who represent the nation’s physicians are aware of the significant political and philosophical differences about firearm ownership and regulation in the United States, but we are committed to reaching out to bridge these differences, with the goal of improving the health and safety of our patients and their families. We strongly support a multifaceted public health approach.

To reduce firearm-related injuries and deaths, it is essential to address culture, firearm safety, and regulation that maximizes safety while being consistent with the Second Amendment. In addition, improving the diagnosis and treatment of persons with mental and substance use disorders is critical, especially because of the risk for firearm-related suicides in persons with these conditions. However, we believe that efforts to address firearm-related violence should focus on reducing availability to persons who may pose a threat to themselves or others and not simply single out persons with any mental or substance use disorder.

On the basis of this background and our organizational policies, we believe that the following recommendations appropriately integrate the multidisciplinary perspectives of medical, public health, and legal professionals.

Background Checks for Firearm Purchases
Our organizations strongly support requiring criminal background checks for all firearm purchases, including sales by gun dealers, sales at gun shows, and private sales between individuals. Although current laws require background checks at gun stores, purchases at gun shows do not require such checks. This loophole must be closed. In 2010, of the 14 million persons who submitted to a background check to purchase or transfer possession of a firearm, 153,000 were prohibited purchasers and were blocked from making a purchase. Background checks clearly help to keep firearms out of the hands of persons at risk for using them to harm themselves or others. However, 40% of firearm transfers take place through means other than a licensed dealer; as a result, an estimated 6.6 million firearms are sold annually with no background checks. The only way to ensure that all prohibited purchasers are prevented from acquiring firearms is to make background checks a universal requirement for all gun purchases or transfers of ownership.

Physician “Gag Laws”
Patients trust their physicians to advise them on issues that affect their health, and physicians can answer questions and educate the public on the risks of firearm ownership and the need for firearm safety. Often, these confidential conversations occur during regular examinations and are a natural part of the patient–physician relationship. Because of this, our organizations oppose state and federal mandates that interfere with physician free speech and the patient–physician relationship, including laws that forbid physicians to discuss a patient’s gun ownership.

When appropriate, physicians can intervene with patients who are at risk for injuring themselves or others due to firearm access. To do so, physicians must be allowed to speak freely to their patients in a nonjudgmental manner about firearms, provide patients with factual information about firearms relevant to their health and the health of those around them, fully answer their patients’ questions, and advise them on the course of behaviors that promote health and safety without fear of liability or penalty. Physicians must also be able to document these conversations in the medical record as they are able and required to do with discussion of other behaviors that can affect health.

Mental Health
Although mental and substance use disorders in and of themselves are only a small factor in societal violence, they can be a significant factor in firearm-related suicide. Access to mental health care is critical for all persons who have a mental or substance use disorder. The health professional organizations represented in this article support improved access to mental health care and caution against broadly including all persons with any mental or substance use disorder in a category of persons prohibited from purchasing firearms. We also support adequate resources to facilitate coordination among physicians and state, local, and community-based behavioral health systems so they can provide care to patients, raise awareness, and reduce social stigma.

Early identification, intervention, and treatment of mental and substance use disorders would reduce the consequences of firearm-related injury and death. The overall proportion of violent acts committed by persons with mental or substance use disorders is relatively low, and those who receive adequate treatment from health professionals are less likely to commit acts of violence. Reducing firearm-related violence and suicide requires keeping firearms out of the hands of
persons who may harm themselves or others, but it is important that restrictions be applied appropriately by limiting access to such individuals rather than limiting access solely on the basis of a mental or substance use disorder.

Reporting Laws
Blanket reporting laws that compel physicians and other health professionals to report patients who are displaying signs that they might cause serious harm to themselves or others may have unintended consequences. They can stigmatize persons with mental or substance use disorders, create a disincentive for them to seek treatment, and undermine the patient–physician relationship. The health professional organizations represented in this article urge legislators considering such proposals to do so in a way that protects confidentiality and does not deter patients from seeking treatment of a mental or substance use disorder. For persons whose right to purchase or possess a firearm has been suspended on grounds relating to a mental or substance use disorder, there should be a fair, equitable, and reasonable process established for restoration that balances the individual's rights with public safety.

Assault Weapons
The need for reasonable federal laws, compliant with the Second Amendment, about “assault weapons” and large-capacity magazines has been debated recently. We believe that private ownership of military-style assault weapons and large-capacity magazines represents a grave danger to the public, as several recent mass shooting incidents in the United States have demonstrated. Although evidence to document the effectiveness of the Federal Assault Weapons Ban of 1994 on the reduction of overall firearm-related injuries and deaths is limited, our organizations believe that a common, sense approach compels restrictions for civilian use on the manufacture and sale of large-capacity magazines and firearms with features designed to increase their rapid and extended killing capacity. It seems that such restrictions could only reduce the risk for casualties associated with mass shootings.

Need for Research
As data-driven decision makers, we advocate for robust research about the causes and consequences of firearm violence and unintentional injuries and for strategies to reduce firearm-related injuries. The Centers for Disease Control and Prevention, National Institutes of Health, and National Institute of Justice should receive adequate funding to study the effect of gun violence and unintentional gun-related injury on public health and safety. Access to data should not be restricted, so researchers can do studies that enable the development of evidence-based policies to reduce the rate of firearm injuries and deaths in this nation.

Constitutionality of These Recommendations
These recommendations do not come solely from a group of health organizations without expertise in constitutional law but have been developed in collaboration with colleagues from the ABA, which has confirmed that these recommendations are constitutionally sound. For 50 years, the ABA has acknowledged the tragic consequences of firearm-related injury and death in our society and expressed strong support for meaningful reforms to the nation's gun laws, as well as for other measures designed to reduce gun violence that do not fall under Second Amendment scrutiny. Because the courts have repeatedly held that the Second Amendment is consistent with a wide variety of laws to reduce gun-related deaths and injuries in our nation (yet confusion exists among the public about whether the Second Amendment is an obstacle to sensible laws), one mission of the ABA has been to educate its members, as well as the public at large, about the true meaning and application of the Second Amendment.

The Supreme Court, in its controlling 2008 decision, District of Columbia v. Heller, concluded that Second Amendment rights are not unlimited with regard to who may possess firearms, what kinds of firearms they may possess, or where they may possess them. The Court made clear that the Second Amendment should not be understood as conferring a “right to keep and carry any weapon whatsoever in any manner whatsoever and for whatever purpose”; identified a nonexhaustive list of “presumptively lawful regulatory measures”; and noted that the Second Amendment is consistent with laws banning “dangerous and unusual weapons” not in common use, such as firearms that are most typically used by the military.

Further, after Heller, more than 900 court decisions have upheld a wide variety of regulations to reduce gun violence, and only a few rulings have struck down certain types of firearm laws. No ruling of the Supreme Court (or any other court, for that matter) calls into question any of the specific proposals that we recommend.

Conclusion
We believe that multidisciplinary, interprofessional collaboration is critical to bringing about meaningful changes to reduce the burden of firearm-related injuries and death on persons, families, communities, and society in general. We are committed to working with all stakeholders to find effective solutions through reasonable regulation to keep firearms out of the hands of persons who are at risk for using them to intentionally or unintentionally harm themselves or others, as well as prevention, early intervention, and treatment of mental and substance use disorders.
SINCE ITS founding in 1878, the Chicago Gynecological Society has worked continuously to support lifelong learning. This mission includes hosting a resident and fellow paper competition each year to encourage its youngest members to pursue research. During ceremonies on May 17 at Maggiano’s Banquets in Chicago, the CGS furthered that tradition by awarding prizes to the authors of four outstanding research papers. The evening included presentations by these contestants.

Not only does the annual competition support the organization’s educational mission, but it also reinforces the requirements of the Accreditation Council for Graduate Medical Education.

In addition to the award ceremonies, members and guests mourned the passing of Antonio Scommegna, MD, a former president of the CGS, and leader in the field. Dr. Scommegna died on March 26 of this year. The eulogy, given by Edward Linn, MD, chairman of obstetrics and gynecology at Stroger Hospital, noted Dr. Scommegna’s many contributions. In addition to mentoring leaders in the specialty of gynecology, Dr. Scommegna did much to advance the knowledge and practice of reproductive endocrinology and infertility. Among those contributions was the development of the first hormone-containing intrauterine contraceptive device.

Due to the length of the four top research papers, Chicago Medicine is reprinting the abstracts and posting the full papers on the CMS website for interested readers. A list of all the competition contestants and their paper titles appear at the end of this section.

AWARD WINNING FELLOW

PAPER TITLE: Inter-delivery Weight Gain and
Risk of Cesarean Delivery Following a Prior Vaginal Delivery

**AUTHORS:** Annie M. Dude, MD, PhD, Division of Maternal – Fetal Medicine, Department of Obstetrics & Gynecology, Feinberg School of Medicine, Northwestern University; Abbi D. Lanced-cordova, PhD, Department of Preventive Medicine, Feinberg School of Medicine, Northwestern University; William A. Grobman, MD, MBA, Division of Maternal – Fetal Medicine, Department of Obstetrics & Gynecology, Feinberg School of Medicine, Northwestern University.

**CONFLICT OF INTEREST:** No conflicts of interest.

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**PRESENTATIONS:** A version of this paper was presented at the 37th Annual Meeting of the Society for Maternal-Fetal Medicine, Las Vegas, NV, Jan. 23-28, 2017.

**ABSTRACT**

**BACKGROUND:** Approximately one-third of all deliveries in the United States are via cesarean. Previous research indicates weight gain during pregnancy is associated with an increased risk of cesarean delivery. It remains unclear, however, whether and to what degree weight gain between deliveries is associated with cesarean delivery in a subsequent pregnancy following a vaginal delivery.

**OBJECTIVES:** To determine whether inter-delivery weight gain is associated with an increased risk of intrapartum cesarean delivery following a vaginal delivery.

**STUDY DESIGN:** This is a case-control study of women who had two consecutive singleton births of at least 36 weeks' gestation between 2005 and 2016, with a vaginal delivery in the index pregnancy. Women were excluded if they had a contraindication to a trial of labor (e.g., fetal malpresentation or placenta previa) in the subsequent pregnancy. Maternal characteristics and delivery outcomes for both pregnancies were abstracted from the medical record. Maternal weight gain between deliveries was measured as the change in body mass index (BMI) at delivery. Women who underwent a subsequent cesarean delivery were compared to those who had a repeat vaginal delivery using chi square statistics for categorical variables and t tests or ANOVA for continuous variables. Multivariable logistic regression was used to determine whether inter-delivery weight gain remained independently associated with intrapartum cesarean delivery after adjusting for potential confounders.

**RESULTS:** Of 10,396 women who met eligibility criteria and had complete data, 218 (2.1%) had a cesarean delivery in the subsequent pregnancy. Inter-delivery weight gain was significantly associated with cesarean delivery, and no conflict of interest.

**CONCLUSION:** Among women with a prior vaginal delivery, inter-delivery weight gain was independently associated with an increased risk of intrapartum cesarean delivery in a subsequent pregnancy.
adverse obstetrical outcomes associated with morbidly adherent placentas with pathologic diagnosis of focal accreta.

**METHODS:** In this retrospective case control study of all morbidly adherent placentas requiring manual extraction from January 2009 to December 2014, 100 women with pathologic diagnosis of focal accreta were compared to 391 cases without focal accreta. All women with an antepartum diagnosis of placenta accreta were excluded. Bivariable and multivariable analyses were performed to identify risk factors for and adverse obstetric outcomes associated with focal accreta. Subsequent pregnancies were then evaluated to determine if a history of focal accreta was associated with adverse outcomes in future pregnancies.

**RESULTS:** In bivariable analysis, risk factors associated with focal accreta compared to no focal accreta included history of previous cesarean (19.0% vs. 10.7%, p=0.03), uterine surgery (35.0% vs. 19.7%, p=0.001), D&C (37.0% vs. 22.5%, p=0.003) and in vitro fertilization (35.0% vs. 19.7%, p=0.001). Adverse obstetrical outcomes more common in those women with a focal accreta included higher frequency of postpartum hemorrhage (59.0% vs. 31.7%, p=0.001), transfusion (30.0% vs. 5.12%, p<0.001), maternal ICU admission (10.0% vs. 0.5%, p<0.001), and peripartum hysterectomy (21.0% vs. 0.3%, p<0.001). There were no differences in adverse neonatal outcomes between the two groups. In multivariable analysis, focal accreta remained associated with history of prior cesarean as well as postpartum hemorrhage, transfusion, ICU admission and hysterectomy. In the 130 observed subsequent pregnancies, there was an increased risk of morbidly adherent placenta (42.9% vs. 19.0%, p=0.04) and recurrence of focal accreta (29.6% vs. 6.8%, p=0.05) in those women who had a focal accreta in the index pregnancy.

**CONCLUSION:** Focal accreta is associated with an increased risk of hemorrhagic morbidity and may also be associated with morbidly adherent placenta in subsequent pregnancies.

**SECOND PLACE RESIDENT**

**PAPER TITLE:** Race Impacts Success in Recipients of Donor Oocytes but Not Oocyte Donors

**AUTHORS:** Xiaojie Zhou, MD, Department of Obstetrics and Gynecology, The University of Chicago; Dana B. McQueen, MD, MAS, Department of Obstetrics and Gynecology, University of California at San Diego; Ann Schufreider, MD, Department of Obstetrics and Gynecology, The University of Chicago; Meike L. Uhler, MD, Fertility Centers of Illinois at Chicago; and Eve C. Feinberg, MD, Department of Obstetrics and Gynecology, Northwestern University, Chicago.

**PRESENTATION:** This work was presented at the American Society for Reproductive Medicine Meeting, Salt Lake City, Utah, 2016.

**CAPSULE:** Black oocyte donor recipients had a lower likelihood of achieving pregnancy and live birth.

**ABSTRACT**

**OBJECTIVE:** To evaluate the impact of race on oocyte donation.

**DESIGN:** Retrospective analysis.

**SETTING:** Private Practice.

**PATIENTS:** All oocyte donors and recipients who underwent a fresh donor oocyte cycle with fresh embryo transfer at Fertility Centers of Illinois from January 2009 to June 2015.

**INTERVENTION(S):** Collection and analysis of baseline characteristics, cycle parameters and outcomes. Race was self-reported.

**MAIN OUTCOME MEASURE(S):** Clinical intrauterine pregnancy rate and live birth rate.

**RESULTS:** 950 oocyte donors were included: 772 White (81.3%), 37 Black (3.9%), 80 Asian (8.4%) and 61 Hispanic (6.4%). There were no significant differences in the mean number of oocytes retrieved: 18.6 (SD 9.6) in White donors, 21.7 (SD 10.3) in Black donors, 17.9 (SD 7.9) in Asian donors and 17.6 (SD 7.9) in Hispanic donors. 946 donor oocyte recipients: 769 White (81.3%), 44 Black (4.7%), 72 Asian (7.6%) and 61 Hispanic (6.4%). Compared with White recipients, the adjusted odds ratio for clinical pregnancy was 0.40 in Black recipients (95% CI 0.21-0.76), 0.93 in Asian recipients (95% CI 0.571.54) and 0.70 in Hispanic recipients (95% CI 0.41-1.19). The adjusted odds ratio for live birth was significantly lower among Black recipients compared to White, 0.50 (95% CI 0.25-0.95), while the live birth rate for Asian and Hispanic recipients was not significantly different, OR 0.66 (95% CI 0.40-1.08) and 0.76 (95% CI 0.44-1.29), respectively.

**CONCLUSIONS:** There were no racial disparities observed in oocyte donors. Black recipients had worse pregnancy outcomes with reductions in clinical pregnancy rate and live birth rate. Further studies are needed to better understand the perversiveness of racial disparity in IVF outcomes.

**THIRD PLACE RESIDENT**

**PAPER TITLE:** CINE MRI During Spontaneous Cramps in Women with Menstrual Pain

**AUTHORS:** Caroline S. Kuhn, MD, Dept. of Ob-Gyn, NorthShore University HealthSystem, Evanston, and Dept. of Ob-Gyn, Pritzker School of Medicine, University of Chicago; Kevin M. Hellman, PhD, Dept. of Ob-Gyn, NorthShore University HealthSystem, Evanston, and Dept. of Ob-Gyn, Pritzker School of Medicine, University of Chicago; Frank F. Tu, MD, MPH, Dept. of Ob-Gyn, NorthShore University HealthSystem, Evanston, and Dept. of Ob-Gyn, Pritzker School of Medicine, University of Chicago; Katlyn E.
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ABSTRACT

STUDY QUESTION: Are changes in myometrial activity detectable with MRI during simultaneous episodes of cramping pain in women with dysmenorrhea?

SUMMARY ANSWER: Episodes of cramping occurred either immediately before or 32-70 seconds after a decrease in T2-weighted myometrial signal, suggesting that cramping pain may be caused by a combination of myometrial activity and hemodynamic dysfunction.

WHAT IS KNOWN ALREADY: Prior research has suggested that changes in the MR signal occur in the myometrial layer in women with dysmenorrhea. Since the mechanisms of dysmenorrhea are poorly understood, detailed characterization of the relationship between MR signal changes and spontaneous pain report would be useful for developing a diagnostic tool.

STUDY DESIGN, SIZE, DURATION: Prospective pilot study on 15 women with severe dysmenorrhea and 9 healthy controls both on and off their menses while not taking any analgesic medication.

PARTICIPANTS/MATERIALS, SETTING, METHODS: We acquired continuous 3T MRI using a single shot HASTE sequence while measuring menstrual cramp intensity self-report with a hand squeeze pressure bulb.

MAIN RESULTS AND THE ROLE OF CHANCE: Spontaneous progressive decreases in myometrial signal intensity were more frequently observed in women with menstrual pain on their menses than in the absence of pain in the same women off their menses or participants without dysmenorrhea (p's < 0.01). Consistent observations of signal changes were obtained between two raters blinded to menstrual pain or cycle day status (r=0.97, p<0.001). Episodes of cramping occurred either immediately before or 32-70s after myometrial signal change onset (p's <0.05).

LIMITATIONS, REASONS FOR CAUTION: Larger studies should be performed to validate findings across a spectrum of conditions associated with menstrual pain.

WIDER IMPLICATIONS OF THE FINDINGS: The combination of early and delayed subjective pain report—relative to a decrease in T2 weighted signal intensity—provides new evidence supportive of a contribution of myometrial activity and impaired hemodynamics to menstrual pain. MRI methodology with simultaneous squeeze-bulb pain monitoring provides a means to understand the spatial-temporal relationship between physiological changes and the perception of pain. The proposed approach will allow future studies to evaluate effects of interventions for uterine pain disorders and test mechanistic hypotheses about the etiology of visceral pain.

STUDY FUNDING/COMPETING INTEREST(S): This study was funded by NICHD and NorthShore University HealthSystem. The authors have no conflicts of interest.

OTHER PAPER COMPETITION CONTESTANTS

Aside from the winning participants, there were six other paper entries, which are listed below. The Chicago Medical Society congratulates all contestants on their excellent research.

- Treatment of Acute Hypertension in Pregnancy at Mount Sinai Hospital, by Robert Para, MD, Department of Obstetrics and Gynecology, Mount Sinai Hospital.
- Pathology of Power Morcellation: A 12-year Review, by Melinda G. Abernethy, MD, MPH; Jessica Shim, MD; and Kimberly Kenton, MD, Female Pelvic Medicine and Reconstructive Surgery, Northwestern Feinberg School of Medicine and Obstetrics and Gynecology, Northwestern Feinberg School of Medicine.
- Can Venous Cord Gas Values Predict Fetal Acidemia? By Kate Swanson, MD (first author), Chicago, Department of Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine.
- Searching for Relief: A Qualitative Assessment of the Role of Alternative Medicine and Religion in Fibroid Treatment, by Marissa Steinberg Weiss, MD.
- Management of Postoperative Pain with Preemptive Analgesia in Cesarean section: A Randomized Controlled Trial, by Mark Kosanovich, MD, and Kathy Tom, DO.
- Improved Postoperative Pain after Laparotomy for Gynecologic Indication Using Enhanced Recovery after Surgery Protocol, by Michelle Beck, MD, Rush University Medical Center; Yasmín Abedín, MPH; Louis Fogg, PhD; Amina Ahmed, MD; Edgardo Yordan, MD; Summer Dewdney, MD.
MEMBER BENEFITS

Raising Awareness for CPR

Freshman Congressman Raja Krishnamoorthi and his office-staff get hands-only CPR training

By Cheryl England

As part of an effort to broaden support for hands-only CPR, the Chicago Medical Society conducted hands-only cardiopulmonary resuscitation training for Congressman Raja Krishnamoorthi, the U.S. representative for Illinois’ 8th congressional district, and his office staff at his Schaumburg office on July 6. The one-hour session was conducted by Vemuri S. Murthy, MD, president-elect of CMS and founder of Project SMILE, a CMS program designed to raise awareness of sudden cardiac arrest and encourage bystander CPR in Cook County. “The average response time of paramedics in Chicago may be four to six minutes,” says Dr. Murthy. “Without CPR help from a bystander, that is a lot of time during which nothing is being done to help the patient.”

Congressman Raja Krishnamoorthi thanked CMS for organizing this educational program to save precious lives as well as expressed his support for hosting hands-only CPR sessions in local communities. “Congressman Krishnamoorthi’s support is crucial in helping us expand our ability to train more people in hands-only CPR,” says Dr. Murthy. “We can always use more volunteers and our local legislators are key to spreading the word.”

Dr. Murthy, a longtime volunteer of the American Heart Association (AHA), a current regional AHA faculty member, explained that educating members of the public about immediate recognition of sudden cardiac arrest and offering them basic training of immediate hands-only CPR may literally save thousands of lives each year. He also noted the importance of following the Illinois Good Samaritan Act. According to the AHA, about 350,000 cardiac arrests occur outside a hospital setting every year in the United States. Only 32% of cardiac arrest victims get CPR from a bystander. Less than 8% of people who suffer cardiac arrest outside the hospital survive.

Project SMILE (Saving More Illinois Lives through Education) was initiated by CMS in 2011 as an ongoing community project in Cook County. The SMILE training programs are being given to the general public at numerous locations such as public libraries, sporting events, places of religious worship, health fairs and more. Program participants and supporters have included legislators, aldermen and members of the Chicago Consular Corps. CMS recently began an affiliation with the Indian American Medical Association of Illinois to expand Project SMILE and is looking forward to similar affiliations with other organizations as well. “To the best of my knowledge, we are the only medical society in the country to start this type of program,” says Dr. Murthy.

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MEMBER BENEFITS

Calendar of Events

SEPTEMBER

12 CMS Council/Annual Dinner The Society’s governing body meets four times a year to conduct business on behalf of the Society. Following the Council meeting, CMS will install the 2017-2018 leadership team and present awards to outstanding physician members. 6:00-9:00 p.m., Maggiano’s Banquets Chicago, 111 W. Grand Ave. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

16 The Polish-American Medical Society Annual Physician Ball Since 1957, annual Physician Balls have been main fundraising events, providing the income necessary to support PAMS’ educational missions and many other worthy causes. Over the years, numerous Polish non-profit organizations in Chicago have received support. Time TBD; Location: Ritz-Carlton Chicago, 160 E. Pearson St. For information, please go to: www.zlpchicago.org/2017-physicians-ball.

20 CMS 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. Location: CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

22-23 Illinois Medical Directors Association 7th Annual Meeting on PALTC Join your colleagues and fellow PALTC professionals at the annual conference. Oak Brook Double Tree Hilton Hotel. Register at www.ilmda.org.

OCTOBER

21 CMS Executive Committee Meeting Meets once a month to plan Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. 8:30-9:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

21 CMS Board of Trustees Meeting Meets every other month to make financial decisions on behalf of the Society. 9:00 – 11:00 a.m. CMS Building, 33 W. Grand Ave., Chicago. For information, contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

Welcome, New Members!
The Chicago Medical Society greets its newest members. We are now 75 voices stronger!

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Dr. Sondra Summers, a practicing ob-gyn, wears a number of different hats including being an associate professor and division director in general ob-gyn at the University of Illinois Hospital and Health Sciences System. As a passionate advocate for empowering women, she finds great joy in educating her patients on their health care options.

OBSTETRICIAN-gynecologist Sondra Summers, MD, has a passion for empowering women. “I’m not the type to go out and picket,” she says. “But I feel that I can make small changes in my everyday activities.”

As an example, Dr. Summers says she feels happiest when she is able to counsel women on their options for delivery. “I like for my patients to know that they are empowered to make their own decisions,” she says. “If it is a breech delivery, she needs to know that she can choose to have a procedure to turn the baby around or have a C-section. In Chicago, a woman may not have enough social support to get the help she needs to recuperate after a C-section. She needs to understand that in order to make the best decision.”

Besides being a practicing clinician, Dr. Summers wears numerous other hats including being an associate professor and division director in general ob-gyn at the University of Illinois at Chicago College of Medicine and at the University of Illinois Hospital and Health Sciences System, the program director of the ob-gyn department, co-director of the Women’s Pelvic Health Center, a departmental facilitator for the faculty mentoring program and the division director of academic generalists in the ob-gyn department. When asked where she spends most of her time, Dr. Summers jokes, “Ask me again in October when we are fully staffed! But seriously,” she adds, “our department is in transition so right now I am mostly concerned with quality and safety issues as well as mentoring new faculty. It’s something different every day!”

Teaching comes naturally to Dr. Summers and it is also something she finds tremendous satisfaction in doing. “I come from a family of educators,” she says. “In fact, if I had not gotten accepted to medical school my next career choice was to become an educator. As a physician, I not only get to help women with their health care but I also have the chance to be constantly teaching, whether it is patients or co-workers.”

Likewise, her desire to empower women comes naturally. “My mom was a nurse,” she says. “She wanted to be a doctor but she was told she couldn’t because her hands were too small!”

Even when Dr. Summers received her medical degree in 1983 from Rush Medical College there were few women physicians even in the specialty of ob-gyn. “I really felt that I wanted to make a difference in health care for women,” she says. “Back then, most insurance plans did not cover contraceptives for women. Now I find it very distressing to see history repeating itself as we fight the same battles again for coverage.”

Still, Dr. Summers wouldn’t trade her career in medicine for any other lifestyle. “Even on rough days,” she says, “I am always sustained by the mere fact that going into work and taking care of my patients is a small way for me to give back to the community.” With countless women educated and given quality care, that might not be such a small repayment.

Dr. Summers’ Career Highlights

Dr. Summers graduated from Rush Medical College in 1983 and completed her residency at Rush Presbyterian-St. Luke’s Medical Center. She has held numerous leadership positions at the U of I Hospital and Health Sciences System, including directing a task force to create guidelines for evaluation and treatment of a pregnant patient with a possible Ebola infection. She has also held numerous administrative and education positions such as medical director for ambulatory women’s health at Loyola-Stritch University Medical Center and associate program director for residents in ob-gyn at Loyola. Among her numerous awards are Stritch Medical School Teacher of the Year and “Top 10” faculty voted for by students at Stritch.
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