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CHICAGO MEDICAL SOCIETY
THE MEDICAL SOCIETY
OF COOK COUNTY



Newsletter, December 2007, Vol. 110, No. 16

MESSAGE FROM YOUR PRESIDENT

Despite liability setback, we remain hopeful

Illinois doctors and patients made great progress two years ago when the legislature passed comprehensive medical liability reform legislation. The future was then beginning to look brighter for the younger generation of physicians.

But as you know now, the challenge to Illinois' hard-won reform has begun in earnest (see letter on page 2 from Drs. Harold L. Jensen and William E. Kobler).

The Illinois Supreme Court will be deciding a number of issues: limits on non-economic damages; the periodic payment provision; standards for expert witnesses; the "affidavit of merit," acknowledgement of mistakes and expression of grief and apologies.

Caps have been overturned before in Illinois. The cap overturned in 1976 imposed a \$500,000 limit on all economic and non-economic damages in medical malpractice cases. The state Supreme Court ruled that the General Assembly could not limit *all* damages (our neighbor, Indiana, has imposed such a limit for decades). The Court did not ban limits on damage awards, but instead required the limits to be rationally related to Illinois' interests.

The non-economic damages cap overturned in 1997 applied to all tort cases, not just medical mal-

practice. Essentially the Court did not find an adequate connection between limiting non-economic damages in all tort cases and controlling the cost of healthcare.

Despite those setbacks, we remain very hopeful. The 2005 reform law was crafted with explicit attention paid to previous rulings of the state's high court. Legal experts are confident of its constitutionality, and ISMS/ISMIE remains confident that the Supreme Court will overturn the ruling.



To learn more about the challenge to medical liability reform and how ISMS/ISMIE is acting on your behalf, go to www.RealityMedicine.com or to www.cmsdocs.org. You can also download posters for your office and copies of the Reality Medicine booklet. Or call the ISMS department of governmental affairs at (800) 782-4767.

*Thank you,
Saroja Bharati, MD
President, CMS*



November 2007

Dear Colleague:

Last week, the challenge to Illinois' 2005 medical litigation reform law began in earnest. On November 13th, Cook County Circuit Court Judge Diane Larsen ruled the reforms unconstitutional. Her decision explicitly cited the non-economic damages cap as breaching the Illinois Constitution's separation of powers clause, thus invalidating the entire reform law.

While disappointing, this trial court judgment does not represent Illinois' final word on the constitutional standing of our reforms. The entire matter now advances directly to the Illinois Supreme Court. We are confident that the justices will grasp the importance of this law to preserve patient access to care. We remain optimistic that the Supreme Court will overturn this ruling and validate the law.

At this point in the challenge, Illinois Attorney General Lisa Madigan steps in to lead the defense. ISMS and ISMIE Mutual will collaborate actively with her litigation team. Our legal interests are ably represented by former U.S. Solicitor General Theodore Olson, a highly respected appellate litigator and constitutional scholar. The law itself is expertly crafted, with strong attention to constitutional detail and prior court rulings – all aimed at preventing its overturn. We have marshaled superb legal minds and legal arguments, which will serve us well during Supreme Court consideration of this crucial issue.

Together, let's continue our battle to preserve patient access to medical care and *Keep Doctors in Illinois!*

Sincerely,

Harold L. Jensen, M.D.
Chairman, Board of Directors
ISMIE Mutual Insurance Company

William E. Kobler, M.D.
Chair, Board of Trustees
Illinois State Medical Society

*Medical liability reform remains a top advocacy priority for the American Medical Association (AMA).
Financial support being provided by the AMA to ISMS for its Reality Medicine campaign
is part of the AMA's ongoing advocacy effort. Together we are stronger.*

Highlights of the 2005 Medical Litigation Reforms

JUDICIAL REFORMS

- \$500,000 cap on non-economic damage awards for physicians and \$1 million cap for hospitals. Firm cap, not indexed for inflation and no exceptions.
- Improvements to the affidavit of merit, requiring disclosure of consulting physician's name, and that the physician be an expert in the area of medicine that is the subject of the lawsuit.
- Stronger standards for expert witnesses. Witnesses must be board-certified or board-eligible in the same specialty as the defendant. The expert must also devote a majority of time to the practice of medicine, teaching or research. Retired experts must be current with continuing medical education.
- Allow the use of annuities for the payment of portions of the award for medical costs.
- Good Samaritan immunity extended to retired physicians providing free care and for free care provided in the home.
- Allow physicians to say "I'm sorry" or other expressions of grief and apology without the statement being used against them.

MEDICAL DISCIPLINE

- Medical Disciplinary Board expanded from nine to 11 members. Four members must be members of the public.
- Doubles the number of IDFPR investigators.
- Extends the statute of limitations from five to ten years for IDFPR to investigate allegations of a pattern of practice.
- IDFPR disciplinary fine increased to \$10,000 maximum.
- Good faith immunity for persons reporting to

peer review committees alleged violations of Medical Practice Act.

- Internet profiling of physicians' professional credentials, and disciplinary and medical litigation histories.

INSURANCE REGULATION REFORM

- More power for the Division of Insurance to call hearings to determine whether rates are excessive or inadequate. Hearings are to be held at the request of one percent of insureds within a specialty, or at the request of 25 insureds (whichever is greater). Department will call for a hearing when an increase is over six percent.
- Encourages insurers to offer policies with deductibles and premium discounts for risk management programs.
- Requires submission of claims statistics and other data to the DOI. All information will be made available to the public.

THE PRECEDENT

According to *Reality Medicine*, when the state legislature responds to the will of the people and exercises the legislative powers delegated to it, as it did in enacting medical liability reform, the legislation is typically "accorded great deference by the Judiciary" (*Best v. Taylor Machine Works*). Illinois courts employ a "strong presumption that legislative enactments are constitutional" and insist that the "party challenging constitutionality of a statute has the burden of establishing its invalidity" (*McAlister v. Shick*). Essentially, "courts have a duty to sustain legislation whenever possible and resolve all doubts in favor of constitutional validity" *McAlister v. Shick*.

NEWS FOR CHICAGO PHYSICIANS

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Newsletter, December 2007, Vol. 110, No. 16

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Chicago Medicine (ISSN 0009-3637) is published monthly with one additional issue published each winter, spring, summer and fall for \$20 per year for members; \$30 per year for nonmembers, by the Chicago Medical Society, 515 N. Dearborn St. Chicago, Ill. 60610. Periodicals postage paid at Chicago, Ill. and additional mailing offices. Postmaster: Send address changes to *Chicago Medicine*, 515 N. Dearborn St., Chicago, IL 60610. Telephone: (312) 670-2550. Copyright 2007, *Chicago Medicine*. All rights reserved.

Council hears recommendations for easing crisis at CCBHS



At the request of CMS President Saroja Bharati, MD, Larry J. Goodman, MD, president and CEO of Rush University Medical Center signs his CMS/ISMS membership application and check during the Nov. 6 Council meeting, where he was keynote speaker. The Council unanimously approved Dr. Goodman's membership to the Society and warmly welcomed him.

TWO MONTHS AFTER A VISIT FROM COOK County Board President Todd Stroger, the CMS Council heard another view—this from the chairman of the blue ribbon committee charged with reviewing the embattled Cook County Bureau of Health Services (CCBHS).

Guest speaker Larry J. Goodman, MD, president and CEO of Rush University Medical Center, addressed CMS leadership on Nov. 6, relaying the committee's findings and its recommendations for rescuing the County healthcare system.

Under Dr. Goodman, the committee evaluated critical issues, such as the mission and proposed scope of service; strategies to insure financial stability; organizational and governance structures; and the need for an appointment time that would allow for the review of these issues and transition to an appropriate oversight structure.

Noting that the financial problems started evolving four to five years ago, Dr. Goodman laid out the various components of the crisis:

- The mission of the County healthcare system is at risk.
- Physician morale is low within the CCBHS, with a number of doctors leaving or preparing to leave.
- There are no long-term strategic or financial planning processes involving management and the County leadership.

- The current governance and oversight process is not adequate to address this crisis.
- CCBHS will have a significant shortfall in spite of serious expense reductions.
- Loss of credibility, inside and outside the County system.

Dr. Goodman called County the largest component of the area's safety net. Historically, CCBHS has delivered on its mission, generally providing high-quality care. While the past ten to 15 years have brought significant investment in new building, the current system is now at risk and the crisis must be addressed urgently.

Amid a lengthy list of recommendations, the committee called for the creation of an independent board of trustees to run CCBHS, noting that the nation's other public hospitals have moved in this direction. The inherent conflicts of interest slow down or delay the identification of solutions, the report states. Ideally, the board would work hand-in-hand with the governmental body, added Dr. Goodman.

The committee further recommended empowering the bureau chief to manage a diverse and complex health system with hiring and firing responsibilities, as a CEO of any large organization would have.

Advising against further budget cuts, the report calls for development of management reporting capabilities as well as the adoption of business practices typical of other hospitals and health systems. Without basic management reports and analysis capabilities, financial restructuring and assessment of that restructuring is seriously flawed and fraught with risk, says the report.

Among other items, the committee calls for improvement in revenue cycle and procurement processes, additional revenue sources for future capital needs, and for careful, cooperative long-term financial and strategic planning by the Board of Commissioners, the president, and the CCBHS.

The Cook County Board is required to respond to the blue ribbon panel's recommendations by January 2008.

Formed at the request of U.S. Senator Durbin, the review committee met over 20 times, forming into smaller groups with wide access to documents and financial reports as well as interviews with officials.

(continued on page 6)

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More information is to follow! www.cmsdocs.org or call 312-670-2550

CMS COUNCIL HIGHLIGHTS *(continued from page 4)*

NOMINATIONS FOR CMS OFFICES

The following slate of names was presented for the 2008-2009 year.

President-elect: William N. Werner, MD

Secretary: Robert W. Panton, MD

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Vice-Chairman of the Council: Howard Axe, MD

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Kamala Ghaey, MD, Nunilo Rubio, MD
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Michael Wasserman, MD

Alternate Councilors-at-Large:

Rafael Campanini, MD, Adrienne L. Fregia, MD,
Zahurul Huq, MD, Terrence Lerner, MD, William J.

Marshall, Jr., MD, Aldo F. Pedroso, MD,
Arthur R. Peterson, MD, William G. Troyer, Jr., MD

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Charles Drueck III, MD, Joan E. Cummings, MD

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William A. McDade, MD, Robert W. Panton, MD

AMERICAN MEDICAL ASSOCIATION

Delegates: Dennis M. Brown, MD,
Charles Drueck III, MD, Richard A. Geline, MD,
John F. Schneider, MD

Alternate Delegates:

Raj B. Lal, MD, Shastri Swaminathan, MD

COUNCIL ENDORSES STUDY OF SINGLE-PAYER SYSTEMS IN UNIVERSAL HEALTH CARE

The Council adopted language supporting further investigation of universal health care systems in other countries. The language also encourages the introduction of resolutions that make healthcare funding a priority and physician input indispensable.

- Healthcare must continue as a priority item of funding at the national, state, and local level.
- More detailed study is necessary of aspects of national universal healthcare coverage systems including but not limited to funding sources, payment models, overhead levels and physician education in Canada, the United Kingdom, Germany, and other appropriate industrialized nations.
- As our healthcare delivery system evolves, direct, meaningful and obligatory physician input is essential and must be present at every level of debate.
- The private practice of medicine must be permitted as the U.S. healthcare delivery system evolves.
- Appropriate resolutions reflecting these recommendations should be introduced into the House

of Delegates of the Illinois State Medical Society and the American Medical Association.

SURGE IN NEW MEMBERS

The Council elected 401 individuals for membership: 333 students, 49 residents, one second-year, one third-year, and 16 regular members. The Council further recommended one retired status change.

Since June 2007, membership has increased by 576 new members.

OUTREACH PROGRAM TO SERVE HOSPITAL MEDICAL STAFF

CMS is forming a new Hospital Medical Staff Council that will serve area hospital medical staff leaders and others with influence over colleagues, students and young physicians. Functions will include hosting quarterly meetings, providing content for newsletters, and conducting research. The first meeting in January will focus on legal/financial issues.

For more information, contact Megan Whaten, (312) 670-2550, ext. 332.

(continued on page 8)



ILLINOIS MEDICAL LAWSUIT REFORM

AFTER TWO YEARS OF HEALING

TRIAL LAWYERS WANT TO REOPEN THE WOUNDS.

Imagine being seriously injured in an accident. You receive prompt, professional medical treatment that saves your life. Then, just as you're on the brink of recovery, that treatment is taken away.

Prior to 2005, when medical lawsuit reforms became Illinois law, out-of-control liability premiums and jury awards had seriously injured our state's health care system. This forced many doctors to cut back services, leave Illinois, or retire early. The result? Many patients could not access the care they desperately needed.

Since the reforms were enacted, we've begun a near-miraculous recovery. We've stemmed the flow of doctors leaving the state, assuring greater access to care for patients. We've reduced skyrocketing medical liability premiums that are ultimately passed on to employers, workers and their families in higher health insurance costs. In short, we've started to mend a medical liability system that was on the brink of collapse.

Now, trial lawyers want to overturn this fair, sensible—and *necessary*—reform and take us back to the dark days of excessive jury awards, higher medical liability premiums, escalating health care costs, and reduced access to care for patients.

Don't let trial lawyers destroy the progress we've made on medical lawsuit reform. Let's continue working to close the wounds, provide patients with the care they deserve, and keep physicians in Illinois.

FOR MORE INFO, VISIT WWW.REALITYMEDICINE.COM.



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CMS COUNCIL HIGHLIGHTS *(continued)*

YOUR ISMS IN ACTION

Your Council heard the following update from ISMS.

- **Medicaid Billing.** ISMS has mailed brochures that assist doctors and their billing staffs in submitting “clean claims” and help reduce the turnaround time for reimbursement. The brochures are part of a series of information ISMS is providing on changes occurring within the Illinois Medicaid program.
- **Women Physicians’ Forum.** On Oct. 24, ISMS hosted 70 women physicians from the Chicago region for the First Illinois Women Physicians Forum event. Similar events will be held in 2008 and all women members of the CMS are encouraged to participate.
- **The 20/220 rule.** As part of the College Cost Reduction and Access Act (H.R. 2669), which was signed into law Sept. 27 and took effect Oct. 1, the 20/220 rule no longer exists. Under a new program, loan repayments would be capped at 15 percent of the borrower’s income that is above 150 percent of the federal poverty level. But the new program does not begin until July 1, 2009. The 20/220 regulation had enabled many resident physicians to qualify for economic hardship deferment, and defer payment for three years without accruing interest on subsidized loans. The ISMS and AMA urge all medical students and early-career physicians to call on members of Congress to fix this problem.
- **Medicare reform.** Reversal of the 2008 Medicare funding cuts is not expected to arise for debate until year’s end. The U.S. House of Representatives agreed to Senate demands to separate Medicare issues from the SCHIP (state children’s health insurance program) funding renewal. It is highly unlikely Congress will deal with the Medicare cuts until an agreement on SCHIP has been inked. The ISMS and AMA are urging doctors to continue to contact Congress (and especially our U.S. senators), urging support for a two-year positive Medicare fix. Please urge your colleagues and patients to make these calls to Washington through the AMA patient hotline, (888) 434-6200.

Your Council adopted the following two resolutions:

TO RESTORE CHECKS AND BALANCES IN FEDERAL AND STATE GOVERNMENTS

- Calls on CMS to study and research mechanisms to achieve a balance of professions in the legislature; and forward the resolution to ISMS and AMA for research and action.

RESOLUTION SUBMISSION TO ISMS

- Directs CMS to submit resolutions to the ISMS with the name of the CMS president and the original author of the resolution.



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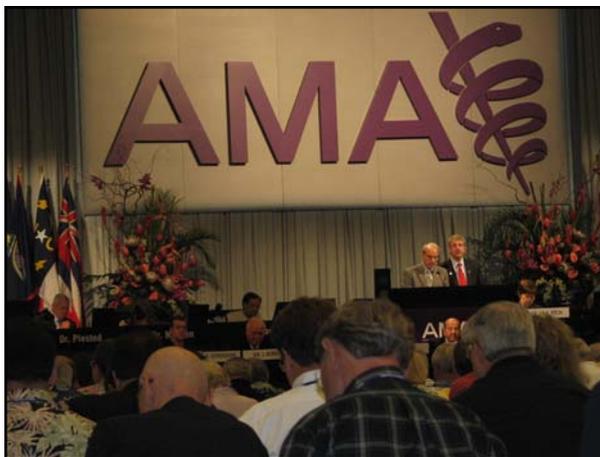
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AMA meeting focuses on advocacy, healthcare reform



The AMA Interim Meeting drew leaders of organized medicine from across the nation, including CMS officers.

TRAVELING AS PART OF THE ILLINOIS delegation, CMS leaders attended the 61st Interim Meeting of the AMA in Honolulu, Hawaii, Nov. 10-13. There they participated in dozens of programs, choosing from sessions like "Doctors Back-to-School," "Improving Patient Safety through Medication Reconciliation," "Contract Negotiation," "Economic Credentialing," and "Automation of the Physician Practice."

Delegates heard updates on AMA advocacy, state healthcare reform, medical staff bylaws, and research in medical education. But it was the annual battle to stave off further cuts in Medicare payments that generated the most impassioned discussion.

MEDICARE PHYSICIAN PAYMENTS

The AMA continues to pressure lawmakers to pass legislation that would prevent steep cuts in Medicare physician payments for 2008. But crunch time is approaching fast; under current law, Medicare physician payments for 2008 are scheduled to be slashed 10 percent on Jan. 1.

This summer, the U.S. House of Representatives passed legislation—the Children's Health and Medicare Protection (CHAMP) Act—that includes two years of positive updates. Now the AMA is working closely with county, state and national medical specialty societies, along with other stakeholders, such as AARP, in pressing the Senate to

take immediate action to avert the cuts by adopting two years of positive updates, and to establish a pathway for passage of a long-term solution in 2009.

It's important for updates to be funded in a way that does not make the overall cost of replacing the Medicare physician payment formula more expensive. Under current law, however, new spending increases must be offset by corresponding spending decreases or increases in revenue, and members of the Senate Finance Committee have yet to agree upon offsets. One option, which the AMA is strongly advocating, is reducing overpayments to private Medicare Advantage plans. By eliminating \$54 billion in excess payments to insurance companies, Congress can effectively fund payment increases for physicians and limit patient premium increases.

The Medicare Payment Advisory Committee (MedPAC) has recommended that Congress increase payment rates by 1.7 percent in 2008, which would be in line with the estimated practice cost increase. Congress needs to listen to MedPAC and tie physician payment to the Medicare Economic Index (MEI), the government's own index for the costs of running a physician practice.

Contact your members of Congress, particularly your senators, and urge them to stop the Medicare physician payment cuts. Please ask them to adopt two years of positive updates and to establish a pathway for passage of a long-term solution in 2009.

KNOW YOUR OPTIONS FOR PARTICIPATING IN MEDICARE IN 2008

With a steep 10 percent cut in Medicare physician payments scheduled to take effect Jan. 1, 2008, physicians may want to review their Medicare participation options.

Notice: The AMA Medicare Participation Options document offers members a brief overview of the current situation with respect to the Medicare payment update for 2008 and the various participation options that are available to physicians. Physicians may sign a PAR agreement and accept Medicare's allowed charge as payment in full for all of their Medicare patients. They may elect to be a

(continued on page 12)

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INTERIM MEETING *(continued from page 10)*

non-PAR physician, which permits them to make assignment decisions on a case-by-case basis and to bill patients up to 9.25 percent more than the Medicare payment for unassigned claims. Lastly, they may become a private contracting physician, agreeing to bill all Medicare-eligible patients directly and forego any payments from Medicare for two years. *The deadline to make changes in participation status is Dec. 31, 2007.* This decision will be binding for the entire year. Those considering a status change should first make sure they are not bound by any contractual arrangements with hospitals, health plans or other entities that require them to be PAR physicians. Laws in some states prohibit physicians from balance billing their patients.

ACTIONS TAKEN BY THE AMA HOUSE

- Adopted a new principle for health system reform that supports risk-based subsidies for high-risk patients. Risk-based subsidies compensate health insurers according to an estimation of the patient's future healthcare costs.
- Voted to establish principles to guide in the evaluation of state proposals for healthcare reform. The principles define coverage options, benefit packages, the delivery system, financing and administration and governance.
- Voted to adopt new ethical guidelines for physicians when discussing fetal umbilical cord blood banking with their patients. According to the new guidelines, physicians should: encourage donation to the public cord blood banks when a patient wishes to donate; obtain consent before labor begins, if possible; disclose any ties they might have to a cord blood bank; and accept no fees or incentives for referral to a cord blood bank.
- Updated its policy on HIV testing to include guidelines in support of routine HIV testing, while continuing to advocate for protection of patient autonomy and privacy.
- Passed new policy supporting Medicaid reforms that would provide disabled patients with equal access to home and community-based services so that they can live as independently as possible. The AMA supports passage of congressional legislation, the Community Choice Act of 2007, that would achieve these goals.
- Passed new policy supporting reinstatement of the economic hardship loan deferment option that many residents rely upon. The loan deferment program, known as the "20/220 pathway," allows



Chicago members of the Illinois Delegation participated in numerous sessions during the AMA meeting.

medical residents to defer payment on their loans for up to three years during their residency training based on economic hardship. Congress must act to permanently restore loan deferment for medical residents. The AMA also supports alternate mechanisms that better address the financial needs of medical residents.

- Passed new policy aimed at helping physicians who accept or donate health information technology (HIT) from or to hospitals or health systems. As part of its new policy, the AMA will: develop contracting guidelines for physicians considering accepting or donating electronic medical record and electronic health records systems from or to hospitals and health systems; educate physicians on the potential consequences associated with these partnerships; and encourage ease of use and interoperability of information systems used by hospitals and healthcare facilities.

Source: American Medical Association

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Family of CMS member appeals for help

Health insurance will pay only a portion of son's transplant-related costs

The family **Walter J. Miller III, DO**, is seeking donations to help pay for Dr. Miller's liver transplant and related costs. **Dr. Miller is the son of CMS member Walter J. Miller, Jr., MD, a retired surgeon from Oak Brook.** Donations should be made to the National Transplant Assistance Fund in Dr. Miller's name. NTAF is a non-profit organization that has been assisting the transplant community for the past 24 years.

In early 2007, Dr. Miller, who had been living in western Canada pursuing a surgical oncology fellowship, returned to the U.S., where he was diagnosed with a severe form of an autoimmune disease of the liver known as primary sclerosing cholangitis. The only life-saving procedure is a liver transplant.

While his Canadian health insurance would not cover him in the U.S., he chose to remain here because he had previously (in 2003) undergone successful removal of the right side of his liver for bile duct for cancer/cholangiocarcinoma (the same disease that Chicago Bears running back Walter Payton died of in 1999) in the U.S.

After securing U.S. health insurance at twice the normal premium and battling with the insurer to overlook preexisting conditions, Dr. Miller learned the insurer will pay only a portion of the transplant costs and post-transplant medications.

No longer working, Dr. Miller is living near the UCLA Medical Center, awaiting a liver transplant. He wife and young daughters are living in Chicago near extended family.

How to make a tax-deductible contribution

By credit card:

Please note that credit card contributions have an additional 3% deducted from them for the processing costs associated with the transaction. There is a \$25 credit card minimum. There are three ways to contribute with a credit card:

Online: www.transplantfund.org/Restricted/patient-detail.cfm?pat_id=2202. The above link should take you directly to Walter J. Miller's Web page. If it doesn't, go to www.transplantfund.org/contributions and search by last name. You may need to scroll down.

Monthly recurring contributions: go to www.transplantfund.org/contributions to download the consent form, which you should print, complete and return to NTAF via fax or email.

By phone: Call NTAF at (800) 642-8399.

By check through the mail:

Send your check to NTAF, 150 N. Radnor Chester Rd., Suite #F-120, Radnor, PA 19087. Be sure to write "in honor of Walter J. Miller" on the memo line.

CLASSIFIED ADS

Office/building for sale/rent

SPACE AVAILABLE FOR RENT IN PILSEN; 1950 W. Cermak Rd., Chicago. For family physician or pediatrician. Please call Dr. Subbaraju at (773) 376-2777.

OFFICE/DENTAL OFFICE SPACE AVAILABLE for lease in Arlington Heights (1640 N. Arlington Heights Rd.) and Lisle (1650 Maple Ave.) Great location, close to major roadways; 2000 to 3850 sq. ft. available. Contact Mark Singer at (312) 203-0011; or email Mr-MarkSinger@hotmail.com.

PILSEN OFFICE SPACE FOR LEASE ON 2130 and 2132 W. 21st St., Chicago; 7,000 sq. ft. on three separate floors in newly remodeled offices with new central heat and air. Parking is available for 10 cars in a fenced in lot. This dual building is ideal for either a legal or medical clinic. Property is fully cabled for Internet computer networks. Offices are all carpeted and have double insulated windows. Central alarm system is included. Very reasonable monthly rent \$3,000/ month. Call Juan Giron (312) 498-1630.

INTERNAL MEDICINE POSITION AVAILABLE now and July 2008. Near Chicago and western suburbs. H-1B, JI or other, all applicants invited. Good private practice benefits, salary. Fax resume to (630) 789-3420; will call to schedule an interview.

Personnel wanted

PHYSICIANS, STOP WORKING 55-80 hours a week! Mobile Doctors seeks physicians to make house calls to the elderly and disabled. Seeking one part-time and one full-time physician. Practice primary care with patients who really appreciate you. No night or weekend work. A company car and certified medical assistant are provided. Take your time practicing medicine without a waiting room full of patients. Fax CV to Michele at (312) 640-4496; or call (312) 617-2096; or mail CV to Mobile Doctors, 1229 N. North Branch #210, Chicago, IL 60622. **2322**

FAMILY PRACTITIONER OR GENERAL practitioner wanted. Full-time or part-time, Spanish-speaking neighborhood, outpatient only—40 hour week. Cermak Rd. and Ashland Ave. Call (630) 452-8445.

BUSY FAMILY PRACTICE CLINIC IN Chicago looking for general practice/family practice physician and nurse practitioner to work part-time or full-time. Send resume to: Dr. Montenegro, 4039 W. Armitage Ave., Chicago, IL 60639. Call (773) 227-2040.

FULL-TIME OR PART-TIME PHYSICIAN assistant, internist, or family practitioner for busy internal medicine office in Chicago. Fax CV to (708) 474-4574.

OUTGOING, ENERGETIC, BILINGUAL (Spanish) board-certified family practice MD

and pediatrician to join our dynamic team serving the Hispanic community. Will outbeat any employer package! Contact Kim: (708) 656-5230, email: kamelyrivera@msn.com.

FAMILY PRACTICE PHYSICIAN NEEDED! Call (773) 622-6095.

ANESTHESIOLOGIST WANTED FOR gynecology family planning surgical outpatient facilities in the Chicagoland area. Full- and part-time positions, four or six hour shifts and Saturdays-only shifts available. Residents welcome. Malpractice insurance available. No night call. Please send resume to: Attn: Administrator, 1640 N. Arlington Heights Rd., Suite 110, Arlington Heights, IL 60004; or fax to (847) 398-4585.

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LOW-COST BLOOD TEST. CHOLESTEROL only \$5. Other tests at discount prices. Send your patients. We draw blood, do tests, fax results. UNILAB, Oak Park. Phone: (708) 848-1556. Web: www.LowCostBloodTest.org.

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Anyone who thinks a physician's work is nine-to-five has no idea what it means to be responsible to patients 24 hours a day. Physicians' Benefits Trust understands how demanding your life is — that's why we offer health plans designed by physicians for physicians —and we craft every health plan we offer to your real-world needs. Our comprehensive coverage offers freedom in your choice of providers ... competitive group rates ... tax-favored Health Savings Accounts ... and no managed care requirements*. So it's hard to imagine why you'd look anywhere else. What's more, there are no cumbersome participation requirements for your group practice to satisfy. All we ask is that one group health plan participant is a member of ISMS or CMS.



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For more information (including costs, exclusions, limitations and terms of coverage) on any of the insurance programs mentioned above, call PBT at **1-800-621-0748** or visit www.pbt-ins.com.