chicago medicine
CHICAGO MEDICAL SOCIETY
THE MEDICAL SOCIETY OF COOK COUNTY

Newsletter, 2011, Vol. 114, No. 8

PRESIDENT'S MESSAGE

New CMS website, magazine for members

CMS President Dr. Thomas M. Anderson (*right*) raises a question about medical education funding during the ISMS/CMS annual Residency Program Directors Meeting on Dec. 10. ***Story begins on page 4.***

Happy new year to all CMS members and physicians concerned about the events that affect your practice of medicine. We hope the latter group will join us in 2012 as we confront a variety of state and federal challenges that require an answer from the doctors who care for patients. We must avoid the destructive effects of large government bureaucracies that are broke, that know nothing about caring for sick people, and imagine that budgets can be balanced by redirecting money paid to doctors, in the hope of improving the bottom line.

Your Chicago Medical Society is pleased to offer two new initiatives that we hope you will find valuable and informative:

- The new CMS website is now functional at *www.cmsdocs.org*. We now have the capacity for online committee meetings as well as password-protected blogs that allow the exchange of ideas and information among members. Log on and give your feedback!
- In February 2012, we will launch the inaugural revised edition of *Chicago Medicine*,

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Inside

which, going forward, will replace what is in your hands now. Beyond the four-color presentation you will find new editorial content. We will feature regular contributions from professionals who cover issues of economics, regulation, and medical-legal affairs. There will be advance notices of the many CMS programs that have proved popular and informative to doctors and medical office managers in the past.

Our hope is that you, the members, will find stimulating articles that encourage interest in change, as well as avenues for confronting the restrictions that clearly hamper and ultimately threaten to destroy our ability to care for patients. *Chicago Medicine* will be mailed to your home. Keep an eye out for it. Page through it. Let us know how we can make it better!

Thomas M. Anderson, MD
President,
Chicago Medical Society

CHICAGO MEDICAL SOCIETY

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2012 First Quarterly Midwest Clinical Conference

Date: Saturday, March 24, 2012

Location: DoubleTree Hotel by Hilton, Oak Brook, IL

Conference Hours: 8:30 a.m. – 4:30 p.m.

Exhibit Show Hours: 7:30 a.m. – 1:30 p.m.

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More details to follow!

The Chicago Medical Society is a quality continuing medical education provider.

What's in store for residency programs?

More than 80 physicians attended the ISMS/CMS annual Residency Program Directors Meeting on Dec. 10. Participants gained insight and direction on the training of residents, and also reviewed the trends and steep funding challenges ahead in GME.

Will physician supply meet the demand?

With a physician shortage looming, the funding and training of new physicians should be a high national priority, according to Paul H. Rockey, MD, MPH, Director of the AMA's Graduate Medical Education Division, and program presenter.

Citing a 2008 report in *JAMA*, Dr. Rockey predicted the U.S. will require an additional 21,000 residency slots in the next decade alone, and that the demand will continue to rise, particularly for primary care doctors.

Physician demand and supply is a complex issue but Dr. Rockey highlighted several key trends: the demands of a growing U.S. population; doubling of the nation's elderly; expanding Medicaid population in the face of near stagnant growth in primary care; one in three physicians nearing retirement; and the threat of decreases in GME funding.

Despite the opening of new medical schools and explosive growth in DO programs, the percentage of residents who completed any core program (leading to initial board certification) grew only by 4.8% between 2001-2010, Dr. Rockey stated.

In the same period, hospital-based core specialties expanded dramatically; 24% for anesthesiology, 28.3% for emergency medicine, and 33.1% for diagnostic radiology. Subspecialty graduates increased by 53.7%, with those completing a non-internal medicine subspecialty at 77%, compared to those with an internal medicine subspecialty at 32.6%. The number of new core training programs remained at zero.

Despite the lure of the subspecialties, "it is the generalist who exemplifies the core mission of a "doctor," Dr. Rockey told his audience.

Paul H. Rockey, MD, MPH, *(left)* Director of the AMA's Graduate Medical Education Division, and Thomas J. Nasca, MD, Chief Executive Officer, ACGME, address the audience.

Nicole K. Roberts, PhD, Director of the Academy for Scholarship in Education at Southern Illinois University, says that early intervention is critical to correct performance problems.

The challenging role of the generalist—managing multiple problems, advising patients on competing interventions, and accepting responsibility for their overall care—demands leadership skills and the ability to oversee team members.

In the military, for example, the general has the stars, not the technical specialist, Dr. Rockey wryly noted.

More information is needed on why residents drop out of core programs, and the impact of gender and age on the work-life balance. Other factors, such as medical school debt and projected future earnings require exploration also, Dr. Rockey said.

Funding is critical not only for more residency slots, but also for new training models, such as medical homes and ACOs; new technology, simulation training, and faculty development.

Working with other groups, the AMA has stepped up efforts to educate legislators and the public about the urgent need for new funding.

The AMA supports incentives for going into primary care. Private payers such as insurance companies should also be asked to contribute in "all-payer systems," Dr. Rockey said.

The future of accreditation

In response to the workforce challenge, the ACGME has set new "milestone goals" for institutions to meet, according to Thomas J. Nasca, MD, chief executive officer and program presenter.

Designed to make institutions more accountable—for quality, safety and oversight—the goals set the stage for "accreditation based outcomes," for both the program and the individual residents who master the core competencies, Dr. Nasca said.

This outcomes-based model tracks what is important, while also fostering improvement across the continuum of medical education.

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Michelle S. Gittler, MD, Residency Program Director, Schwab Rehabilitation Hospital: "You can't teach professionalism, but you can require it."

Key features include the rapid introduction of new competencies and standardization of basic core competencies and methods of evaluation. In the future, physicians in one state will learn the same material as their peers in the same specialty in another part of the country, Dr. Nasca explained. Educators within each specialty will work together to establish core competency elements and performance levels.

Rather than lagging behind the curve, Dr. Nasca says: "The new structure and content of residency programs guarantees that education has the opportunity to anticipate change in the delivery system,"

Ensuring performance, professionalism

Participants also enjoyed interactive discussion and case examples. Presenter Nicole K. Roberts, PhD, led the audience through a process for identifying and addressing performance problems.

Dr. Roberts, who is Director of the Academy for Scholarship in Education at Southern Illinois University, says that early intervention is critical.

Generally, problems become visible within the first six months, giving educators ample time to evaluate and regularly monitor those individuals with performance weaknesses, while also providing feedback and resources to correct the problem. Developing a plan and formally assessing the resident's progress is also recommended.

Program speakers, Drs. Paul H. Rockey and Baretta R. Casey, listen as Dr. Shastri Swaminathan asks a question.

The "whole meal deal" analogy is useful, she said, because it emphasizes strength in every area, from teamwork, to professionalism, to knowledge.

Dr. Roberts and her colleagues at SIU created a tool based on the Beaufort Wind Scale for evaluating individuals. Assessments along The Person Impact Factor Scale can range from a gentle breeze to hurricane strength.

Final decisions, Dr. Roberts stressed, should be clear and straightforward.

In the end, audience members agreed that educators should keep an open mind but maintain a high degree of vigilance.

Tomorrow's NRMP

Changes are coming in National Resident Matching Program (NRMP) policy, according to presenter Baretta R. Casey, MD, MPH, and treasurer of NRMP.

Beginning with the 2013 Main Residency Match, programs that participate in the Match must register and attempt to fill all their positions through the Match. In other words, programs must place all positions in the Match or no positions in the Match, Dr. Casey explained.

Recent studies show that the number of unmatched applicants in the Main Residency Match declined during the last decade, while the number of unfilled positions remained constant, Dr. Casey said.

Medical schools produced more U.S. graduates than ever, and increasing numbers chose to specialize in radiology and plastic surgery. One of every seven residents found positions outside the Match, she said.

In Illinois, for example, 38.6% of the state's programs, offered positions to 11.1% of residents outside the Match.

The total number of residency slots is declining due to decreased funding. And with drastic Medicare cuts on the horizon, the U.S. will have nowhere near the number of training positions needed to meet future demand, Dr. Casey cautioned.

Funding cuts impact

A 2011 survey of designated institutional officers indicates the potential impact of GME funding cuts, reported presenter Thomas J. Nasca, MD, chief executive officer of ACGME. Of the 306 respondents (total 680), 94.8% said they would reduce programs and positions under a 50% reduction scenario, and 87.7% would reduce programs and positions under the 33% reduction scenario. Fewer than 10% say they would reduce only subspecialty programs. Under the first scenario, Illinois would lose 25 to 35% of its resident and fellow positions.

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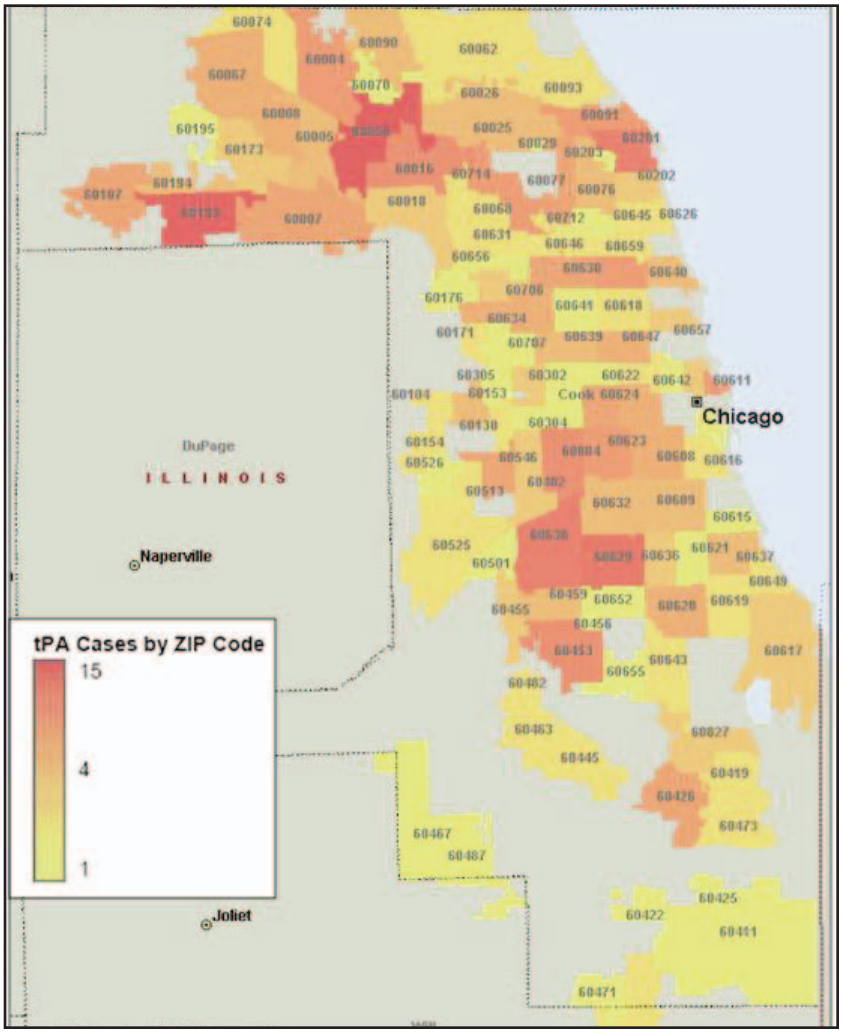
Primary Stroke Centers in the Chicago area
What are they? Where are they? And why do they matter?

By Neelum T. Aggarwal, MD, and Shyam Prabhakaran, MD

On average, every 40 seconds someone in the United States has a stroke, the nation's leading cause of disability and the third leading cause of death. Approximately 795,000 first or recurrent strokes are estimated to occur in the United States each year. The frequency of stroke type varies depending on the patient population. Those people thought to be at highest risk include the elderly and minorities. However, recent studies have shown that women aged 45 to 55 also have higher odds of stroke compared to men in the same age range. Thus, it has been recommended that organized stroke systems of care should focus on education (patients, staff and community), stroke prevention, and access to effective stroke treatments.

Despite stroke education and stroke awareness programming, less than half of stroke patients admit that they would call 911 if a stroke was occurring. This percentage is troubling to stroke specialists and other hospital personnel, as it suggests the public does not fully understand the need for access to specialized medical care in a timely manner if good functional recovery is to occur.



Cook County map shows cases by zip code where tissue plasminogen activator (tPA) was given. If received promptly, within the first 4.5 hours, to eligible stroke patients, tPA can reduce the effects of stroke and reduce per-

Tissue plasminogen activator, or tPA, is a intravenous clot-buster that has been shown to improve outcomes after stroke. If given promptly, within the first 4.5 hours, to eligible stroke patients, tPA can reduce the effects of stroke and reduce permanent disability. Since its first approval by the FDA in 1996, its efficacy and safety have been confirmed in many large studies worldwide. However, its use in clinical practice remains low (<5% of all ischemic stroke patients receive the drug).

In the Chicago area, tPA is provided to approximately 2.3% of stroke victims, with great disparities by neighborhood suggesting that educational or system gaps may prevent access to this time-sensitive therapy (see map). The data reiterate the need for programs to educate high-risk communities on the use of 911 and to implement strategies to improve rapid triage and evaluation of suspected stroke patients.

The last four years have seen a concerted effort to develop primary stroke centers (PSCs) in the Chicago-area community. These stroke centers pro-

vide state-of-the-art clinical care 24/7 to prevent stroke, minimize disability in stroke survivors, and ensure the best possible outcomes for patients following a stroke.

The medical teams that make up the stroke centers include neurologists, neurosurgeons, neuroradiologists and neurological rehabilitation specialists. Stroke care services include:

- Providing expert diagnosis and medical, endovascular, and surgical management of all cerebrovascular conditions.
- Educating patients and their families, the public, and medical professionals about stroke prevention and treatment.
- Advancing scientific research to develop new treatments and approaches to care.

Dr. Aggarwal is a cognitive neurologist at Rush University Medical Center, specializing in neurodegenerative disorders including dementia and Alzheimer's disease. She is Clinical Core Co-leader of the federally funded Rush Alzheimer's Disease Center.

Dr. Prabhakaran is a stroke neurologist and head of the section of cerebrovascular diseases and neurocritical care. Actively involved in the Chicago Area Stroke Task Force, Dr. Prabhakaran's published work addresses cerebrovascular disease, and his research focuses on acute ischemic stroke, transient ischemic attack, and intracranial stenosis.

What is a Primary Stroke Center?

Recent research has shown that some stroke patients have a better chance of survival if they are admitted to a designated primary stroke center.

Primary stroke centers offer care that begins in the emergency department and continues throughout the entire hospital stay, offering vast resources and expertise across several departments.

The Chicago area is home to 21 primary stroke centers. Emergency medical service (EMS) providers are trained to identify stroke in the field and transport patients to the nearest stroke center.

Your CMS is helping to publicize the designation in 2007 of Rush University Medical Center's advanced primary stroke center, making it one of Illinois' 50 advanced primary stroke centers.

What is a stroke?

A stroke occurs when the blood flow to the brain is decreased or stopped. The blood flow can be blocked from a blood clot, plaque, or a leak in a blood vessel.

What is TIA?

If blood flow to the brain is blocked for a brief time, there can be signs of a stroke, but the signs can go away in minutes to hours. Physicians call this a TIA (transient ischemic attack or "mini stroke"). This is a strong warning that there is a problem and a stroke could occur in the future.

What are warning signs of a stroke?

- Weakness of an arm and leg
- Numbness, tingling, or weakness in the face, arm, or leg
- Confusion or trouble understanding language
- Problems speaking

NEWS FOR CHICAGO PHYSICIANS

chicago medicine

CHICAGO MEDICAL SOCIETY
THE MEDICAL SOCIETY OF COOK COUNTY

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COUNCIL HIGHLIGHTS

Selective tax hikes, coding blog, and CPR grace agenda

The CMS Council held its quarterly policy making meeting on Nov. 22, 2011. Major actions announced at the meeting include:

CMS supports tax hikes on alcohol, tobacco

At a recent media event, CMS voiced approval for Cook County Board President Toni Preckwinkle's plan to raise taxes on alcohol and extend the current tobacco tax. The proposed tax hikes were approved by a majority of commissioners last November and incorporated into the 2012 budget. Of note: Consumers who purchase alcohol and tobacco products will see their overall taxes decrease once the infamous County sales tax is completely repealed.

CMS endorses public health leader for AMA award

The Council backed a resolution that strongly endorsed the nomination of member James M. Galloway, MD, for the AMA's Nathan Davis Award for Career Public Service in the Federal Government. Dr. Galloway is currently Assistant U.S. Surgeon General and Rear Admiral in the U.S. Public Health Service and Regional Health Administrator for Region V. He leads the Building a Healthier Chicago initiative, which aims to increase physical activity, improve nutrition, and prevent, detect, and control high blood pressure.

CMS approves coding exchange for members

The Council also endorsed a resolution calling upon CMS to implement a coding blog that will update members on new codes within their specialty areas. This service will be complemented by an in-depth online section devoted to helping medical practices avoid potentially costly and

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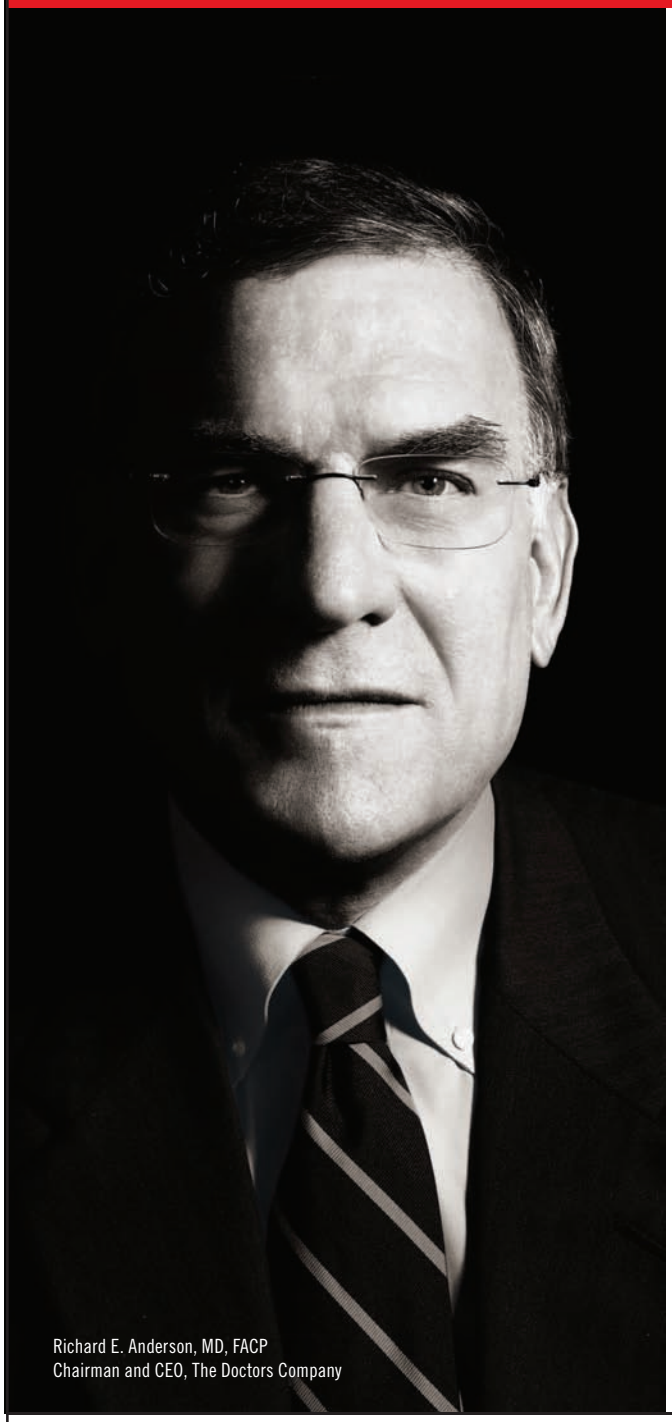
Why choose between national resources and local clout?



Richard E. Anderson, MD, FACP
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time-consuming coding errors and other pitfalls. Members will have access to CMS' preferred medical billing experts who will partner with CMS to offer this timely member benefit. In proposing the blog and website section, sponsors said they hoped members would share their coding experiences and bring their questions directly to the participating medical billing companies. The goal, said the sponsors, is to foster meaningful interaction between physicians and billing pros, thus reducing the need for costly outside consultants.

Cheers for reversal of withholding tax

The Council welcomed an act by Congress that reversed the burdensome 3% withholding provision originally created under the Tax Increase Prevention and Reconciliation Act of 2005.

Physicians lag in promoting CPR

Making his second Council address, member Vemuri S. Murthy, MD, urged his CMS colleagues to do more to reduce the shockingly high death rate from sudden cardiac arrest.

Physicians can help by giving only a few hours each year, training health care providers and the public on life-saving "hands-only" CPR.

The technique is as effective as mouth-to-mouth resuscitation, and a life skill almost anyone can learn to perform. It's as easy as calling 911, or applying the Heimlich maneuver, Dr. Murthy stressed.

He noted that physicians have long resisted promoting this simple life-saving measure, and cited an article from the 1980s calling upon the profession to promulgate CPR.

CMS is part of a growing coalition to educate the public and health profession. Known as Project SMILE (Saving More Illinois Lives through Education), the coalition includes many medical and health organizations, including ISMS and the American Heart Association. With CMS support, the coalition successfully pushed for changes to the Good Samaritan Act and a statewide proclamation declaring June 1-7 as CPR and AED Awareness Week. Coalition representatives also trained the City Council Health Committee on hands-only and AEDs.

Physicians, residents, and medical students—anyone trained in basic life support by the American Heart Association or Red Cross—can apply to become an instructor. CMS recognizes all volunteers for their contributions.

Volunteers will learn the Project SMILE format, either privately or in classes taught by coalition instructors. They will be asked to sign an agreement and assume responsibility for choosing the communities and locations for their presentations.

Project SMILE was founded by Dr. Murthy, and he continues to oversee all training and volunteer activities.

To sign up, please fill out the form below, scan, and and email it to rrubio@cmsdocs.org or mail to the Chicago Medical Society, 515 N. Dearborn St., Chicago, IL 60654, or fax to (312) 670-3646. For more information, call (312) 670-2550.

Sign up for Project Smile

Name: (please print) _____

Contact Info: _____

Related experience or certification: _____

_____

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Nominations for CMS, ISMS, AMA Offices in 2012-2013

The following physicians were nominated for leadership positions.

PRESIDENT-ELECT Robert W. Panton, MD
SECRETARY Kenneth G. Busch, MD
CHAIRMAN OF THE COUNCIL Kathy M. Tynus, MD
VICE CHAIRMAN OF THE COUNCIL Adrienne L. Fregia, MD

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Brian P. Farrell, MD
Cheryl D. Wolfe, MD
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Kuhn Hong, MD
Gerald E. Silverstein, MD
Michael J. Wasserman, MD
Ann Marie Dunlap, MD

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Hugo A. Alvarez, MD
Neelum T. Aggarwal, MD
Rafael Z. Campanini, MD
Zahurul Huq, MD
Rajeev Kumar, MD
William G. Troyer, Jr., MD

JUDICIAL PANEL
William N. Werner, MD, MPH

ILLINOIS STATE MEDICAL SOCIETY:
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Vice President: William A. McDade, MD, PhD
Vice Speaker of the House: Howard Axe, MD

TRUSTEES:
Edgar A. Borda, MD
Steven M. Malkin, MD
Kenneth G. Busch, MD

AMERICAN MEDICAL ASSOCIATION: SERVING FROM APRIL 2012 TO APRIL 2014

DELEGATES:
Charles Drueck III, MD
Richard A. Geline, MD
John F. Schneider, MD, PhD

ALTERNATE DELEGATES:
Raj B. Lal, MD
Shastri Swaminathan, MD

A full plate of policy on agenda in New Orleans

YOUR CHICAGO PHYSICIANS AND COLLEAGUES contributed to the AMA's semi-annual policy-making meeting last Nov. 12-15, 2011, in New Orleans. Major actions by the 500-plus member House of Delegates include:

Halt ICD-10 implementation

Voted to actively oppose the implementation of the ICD-10 set that would be used in place of the current ICD-9 standard for billing medical services. With approximately 69,000 codes, the expanded code set will add a significant financial burden on medical practices. ICD-9 has about 14,000 codes. The Medical Group Management Association estimates that implementing ICD-10 would cost a three-physician practice $85,000. The mandated change comes at a bad time for practices. Physicians are transitioning to EMR technology and attempting to meet quality reporting requirements.

Private contracting with Medicare patients

Restated AMA support for policy and proposed legislation (HR 1700) to ease restrictions on private contracting with Medicare patients. AMA announced a comprehensive grassroots campaign to encourage public support for HR 1700.

Keep individual Medicare payments private

Delegates heard about prolonged legal efforts by the AMA and Florida Medical Association to fight the public release of Medicare payments to individual physicians. Four related court cases were highlighted during an open forum.

New scope-of-practice policies

Adopted scope-of-practice policies that would protect patients at medical spas and during invasive procedures and anesthesia services. Delegates heard how the AMA Litigation Center can assist state medical societies in scope-of-practice lawsuits. A recent example involves AMA's support for the Texas Medical Association's efforts to keep chiropractors from performing needle EMG tests and manipulation under anesthesia and from providing medical diagnoses.

Prescription drug abuse

Encouraged the use of standardized tools to screen for substance misuse and urged physicians to query their state's controlled substance database to help ensure proper prescribing of drugs for their patients.

Health insurance exchanges

Pledged AMA support for the "open marketplace model" to encourage competition and give patients expanded choices. Encouraging state medical associations to get involved in legislative and regulatory processes, the AMA will also push for giving actively practicing physicians and their patients a role in health insurance exchange governing structures and in developing systems that allow for real-time patient eligibility information.

National drug shortages

Voiced support for HR 2245 and S. 296, which would require manufacturers to notify the FDA of any discontinuance, interruption or adjustment in the manufacture of a drug that may result in a shortage. New policy also calls on the AMA to advocate that the FDA and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible.

The house also asked the AMA Council on Science and Public Health to report back at the June 2012 Annual Meeting on progress in preventing drug shortages, especially in oncology.

Biosimilar biologics

Adopted policy to advocate for an abbreviated approval pathway for biosimilar biologics while protecting patient safety and ensuring that physicians understand which biosimilars are merely comparable to the original drug formulations, versus those that are clinically interchangeable.

Air quality standards for ozone

Approved action to request President Obama to direct the EPA to revise the ozone standard to 0.060 parts per million, noting that delaying action until 2013 will produce more cases of asthma, exacerbate chronic obstructive pulmonary disease, and lead to more ER visits, hospitalizations, and deaths in the U.S. population. (Adverse health effects have been documented at levels below the current National Ambient Air Quality Standards for ozone of 0.075 parts per million.)

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Caffeinated energy drinks

Approved action to seek regulatory action such as FDA warning labels on highly caffeinated energy drinks such as Red Bull and Rockstar. Susceptible people and those who combine the drinks with alcohol risk life-threatening effects such as tachyarrhythmias and highly elevated blood pressure.

Alternative health delivery models

Approved policy giving state governments the freedom and flexibility to test and implement new health coverage models as long as the alternatives meet or exceed the level of coverage required by the health system reform law. The new policy also calls for the alternative models to ensure that patients get their choice of physician and private health plan, and to prohibit denials based on preexisting conditions. The language expands AMA policy to include innovative pay models for all uninsured people, not only low-income patients.

Proposed legislation would allow states to apply for such innovation waivers starting in 2014, rather than 2017.

Medicaid block grants

The House voted for the Council on Medical Service to solicit further comments on Medicaid financing from AMA members. While supporting reform and innovation, physicians from some specialty societies cautioned against block grants because states would stop providing care once they exhausted the block grants. Other states have large numbers of Medicaid beneficiaries and uninsured residents.

Disaster medicine training

Adopted action to encourage all medical specialties to develop interdisciplinary and interprofessional training venues and curricula for medical students and residents. The policy encourages medical schools and residency programs to use community-based disaster training and drills, educate students and residents about legal and other contexts of disaster response, and work with medical boards to let students do supervised disaster medical work.

Medical student access to EMRs

Adopted action to encourage schools, teaching hospitals, and practices participating in clinical education to use health IT systems that allow students to read and enter data. The policy supports research on how to overcome barriers to appropriate medical student access to EMRs.

MATCH program violations

Approved action to ask the NRMP to publish "deidentified" data regarding agreement violations and the disciplinary consequences for residency programs and applicants.

Radiation hazards

Adopted new policies aimed at preventing deadly radiation overdoses and curbing the cumulative lifetime impact of radiation from diagnostic tests. New policy supports education and standards for medical personnel who use ionizing and non-ionizing radiation. The AMA also voted to raise awareness among patients about medical radiation exposure. New policy will encourage the development and use of EMRs that track the number of imaging procedures a patient has received in inpatient and outpatient settings.

Delegates directed the AMA to support campaigns initiated by the American College of Radiology and others.

HIV infected organ donation

Adopted action to support amending federal law to allow for research on both the risks and benefits of HIV-infected organ donation to HIV-positive patients who knowingly accept the organs.

Pregnancy counseling centers

Adopted action to support that any pregnancy center disclose on-site and in its advertising whether it provides or refers for birth control or abortion, and also disclose which services it does provide. Advocate that any pregnancy center follow health information privacy laws and be staffed by qualified, licensed personnel.

Health care spending

Referred proposed policy emphasizing physicians' duty to act as responsible stewards in health care spending, basing their decisions on evidence and choosing less costly options when they are of similar benefit to more expensive choices.

AMA Code of Medical Ethics

CEJA members and delegates also discussed efforts to update the AMA's Code of Medical Ethics and how physicians can interpret and apply opinions in the *Code* to their daily practice.

(continues on page 18)

stability matters.

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AMA IHIGHLIGHTS *(continued)*

Accolades for CMS' first woman leader

Dr. Olson

The AMA honored Chicago neurologist, Sandra F. Olson, MD, with its 2011 Distinguished Service Award recognizing service in the science and art of medicine.

As the first women president of both CMS and ISMS, Dr. Olson went on to lead the American Academy of Neurology. She was also the first female chief-of-staff at Northwestern Memorial Hospital.

AMA President Peter W. Carmel, MD, commended Dr. Olson's work on behalf of the medical profession, as a physician, leader, teacher, and administrator. Her service includes chairing the AMA Council on Graduate Medical Education, and membership in the Accreditation Council for Graduate Medical Education.

Dr. Olson is a graduate of the Feinberg School of Medicine at Northwestern University. In addition to seeing patients at Northwestern Memorial Hospital, Dr. Olson joined the medical school in 1969 as an instructor in neurology and continued teaching until 2005, when she retired as a professor of clinical neurology.

Strategies to eliminate pay disparities

Transparency in promotion criteria, and mentorship and training in employment contract negotiation are strategies that can reduce the salary gap between male and female physicians, according Chicago physician Susan E. Gerber, MD.

Dr. Gerber made these recommendations during an AMA session that explored ways to eliminate pay disparities for women physicians. As the coauthor of a recent article in *Health Affairs*, which studied compensation differences for new physicians, Dr. Gerber reported that female physicians of all races are paid on average only 77.4% of the salary of their white male counterparts. Said Dr. Gerber: "Disparity [in salary] persists even when adjusting for education, experience, occupation [and] union membership. By 2008 there was an unexplained gap of $16,819."

Dr. Gerber is assistant professor of ob-gyn at Northwestern University's Feinberg School of Medicine. The *Health Affairs* article is titled ""The $16,819 Pay Gap for Newly Trained Physicians: The Unexplained Trend of Men Earning More Than Women."

Source: American Medical Association. Reprinted with Permission.

(continues on page 20)

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ISMS/CMS bring together residency program directors, GME thought leaders

MORE THAN 80 LEADERS FROM RESIDENCY programs and other institutions around the state came together for an annual meeting that has grown steadily since its inception. Sponsored by ISMS/CMS, the session represents a singular opportunity for these program directors, designated institutional officials (DIOs) and others to learn about and discuss the latest ideas and developments in graduate medical education.

This year's event featured presentations from leading experts, including a nationally recognized authority on dealing with residents who suffer from performance or professionalism problems; the current CEO of the Accreditation Council for Graduate Medical Education (ACGME); and past and present Board members of the ACGME and the National Residency Match Program. Lively discussion and Q&A continue to be a hallmark of the program directors' meeting, and all those present left with new ideas and new approaches to the work they do in residency and fellowship programs around the state.

ISMS/CMS members who missed out on this year's meeting can visit *www.isms.org* to view a selection of videos from the event and download each presenter's materials. (Also, see *page 4.*)

The event took place Saturday, Dec. 10, at the University Club in Chicago.

ISMS Builds on Success with Workers' Compensation Seminar Series – Coming Soon!

In the wake of our highly successful 2011 events, including the Residency Program Directors' Meeting and our acclaimed *Health Reform University* series, in 2012 ISMS will partner with SafeWorks Illinois to host a series of practical training seminars on the *Essentials of Workers' Compensation Impairment Evaluation in Illinois*. These half-day seminars will help physicians understand recent changes to Illinois workers' compensation law and how AMA impairment guidelines may factor into future work comp cases.

Mark your calendar for March 1, when the first seminar will be held in Chicago!

Watch future ISMS publications for more details and registration information.

Coming up: 2012 ISMS House of Delegates

MAKE YOUR VOICE HEARD AT THE ISMS policy-making House of Delegates meeting next Friday-Sunday, April 20-22, 2012. As you advocate on behalf of your peers and your profession, plan also on attending the free educational sessions and listening to inspiring and informative guest speakers. For more information, go to *www.isms.org*

Resolution Submission Deadline: March 6, 2012
The deadline to submit resolutions is *45 days* before the first day of the annual HOD meeting.

The ISMS House of Delegates meeting is fast approaching, and submitting a resolution is the best way for members to impact ISMS policies and actions! The resolution submission deadline will be the close of business, **4:45 p.m., March 6, 2012**. Resolutions must be received at ISMS headquarters on or before that date; a postmark of March 6 is not sufficient.

Resolutions received after March 6 will be considered late resolutions and must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the HOD before they will be considered as business of the House.

No late resolutions will be accepted after the close of business (4:45 p.m.) on the Wednesday prior to the opening session.

Strengthen your voice with a resolution

CMS physicians regularly contribute resolutions to the ISMS policy-making table.

In fact, many resolutions sponsored at the county level propel action at the state and national level. ISMS and AMA policies on health system reform, reimbursement, medical education, and many public health issues germinated in county medical societies across Illinois and the U.S.

If you feel passionately about changing the status quo, or want your medical societies to take action, consider sponsoring a resolution.

CMS (like ISMS and AMA) has guidelines members are encouraged to follow. Attention to these matters will streamline the process and make your message more effective.

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For Additional Information and an Initial Consultation
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TIPS TO CONSIDER

Succession planning for your practice

By Rod Loewenthal, CFM, CRPC®

Many private practice physicians are so focused on developing their practices and caring for patients that they neglect a critical component of small business management: succession planning. Below are tips to consider as you begin succession planning for your private practice.

Although it can be difficult to envision a future without your practice, you must think ahead and set priorities for what you will do once you've left your practice.

• **Start early:** Creating a succession plan sooner rather than later will provide greater flexibility and more options for your practice in the long-term. Physicians should consider preparing for the transition – either selling or closing the practice – at *least* two to three years before they plan to leave. This allows time to have conversations with younger practitioners who may be interested in taking it over, and to groom the successor(s).

To begin, identify what you want to happen to the practice. As the number of people and type of practice vary for each physician, consider what your role is in your current practice and what you anticipatewill happen. Are you the sole practitioner or in a group of practitioners? Are you looking for a hospital group to purchase the practice or someone in your group to buy out your share? These details can make a big difference in how each physician monetizes his or her practice. During this time, you should also determine how involved you want to be in the practice in the years leading up to the succession, keeping in mind that your transition does not have to happen suddenly.

• **Seek professional guidance:** With the goals of your plan in place, consider securing legal counsel from someone experienced in that area, such as a practice consultant or an attorney who specializes in medical practice transitions. They can outline the legal details and help you write a plan to facilitate the process. Along with a legal expert, you should also consider consulting your financial advisor. Your financial advisor will help you identify your short- and long-term financial needs, and will help make sure your assets and investments are structured accordingly. This is important because once you retire or sell your practice, it is no longer your asset. Your focus prior to retirement may have been on capital appreciation, whereas now the focus may become income generation. Thus, a new portfolio designed with these new goals in mind may be appropriate.

Also, physicians may have large insurance policies they no longer need. A financial advisor can help you reevaluate these policies and align them to your life after practice. You may want to consider changing your life insurance type or perhaps take advantage of survivorship insurance.

You might also consider structuring ownership of the policies using a trust. This can help you plan the transfer of family wealth to the next generation, and also decrease the size of your taxable estate. When conducting an insurance policy review and considering options that include replacing an existing insurance contract, it is important to carefully consider the risks and benefits of replacement before taking action.

You should take into account your current need for coverage, your current health status and insurability, any fees and charges associated with terminating an existing contract, and your future liquidity needs.

Other alternatives include moving from a profit-sharing plan to an IRA account. A trusteed-IRA allows anyone to put different types of restrictions on their IRA, similar to what they would do with a trust. While IRA accounts can offer tax advantages, they can also have penalties when with-

(continues on page 24)

TIPS FOR SUCCESS *(continued)*

drawn from too early. Of course investments and insurance products are **not FDIC insured, not bank guaranteed, and may lose value. Since they are not deposits, they are not insured by any federal government agency, and are not a condition for any banking service or activity.**

• **Think about your life after succession**: Although it can be difficult to envision a future without your practice, you must think ahead and set priorities for what you will do once you've left your practice. For many physicians, the practice is both a defining factor in their identities and a major source of value. Compile a folder of information that covers all aspects of a practice's succession plan—from compensation and incentives to the shareholder physician's agreement—and make it available to all new recruits. This provides peace of mind to the successor and to you, the seller, by defining how the practice is governed and how members make decisions. And while you no longer have control of your practice after transition, you can remain available for questions.

Each practice differs. But success following transition almost always depends on maximizing benefits and opportunities, while minimizing risk

Compile a folder of information that covers all aspects of a practice's succession plan—from compensation and incentives to the shareholder physician's agreement—and make it available to all new recruits.

to the practice and all those involved. Begin the process ahead of time with input from various experienced professionals to help make sure that the transfer occurs successfully and gradually. A smooth transition can benefit your patients, their future physician, your family, and yourself.

Rod Loewenthal, CFM, CRPC® is a Senior Vice President—Investments and Wealth Management Advisor with Merrill Lynch, Pierce, Fenner & Smith, Inc., a registered broker-dealer, and Member SIPC. (847) 564-7170; rod_loewenthal@ml. com.

CALENDAR OF EVENTS

February 13-15

AMA National Advocacy Conference
Washington, DC

February 21

CMS Council Meeting
6:00 p.m.
Maggiano's Banquets, Chicago

February 22

CMS Executive Committee Meeting
8:00 a.m.
CMS Building

February 22

CMS Board of Trustees Meeting
9:00 a.m.
CMS Building

March 14

CMS Executive Committee Meeting
8:00 a.m.
CMS Building

March 24

Midwest Clinical Conference
Doubletree Hotel by Hilton
Oak Brook (*See ad on page 3.*)

April 18

CMS Executive Committee Meeting
8:00 a.m.
CMS Building

April 18

CMS Board of Trustees Meeting
9:00 a.m.
CMS Building

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SEEKING BC/BE INTERNIST OR FAMILY practitioner to work with a group in Chicagoland. Please call (773) 884-2782 for information.

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