MCMS Physician

Winter 2015

Official Publication of the Montgomery County Medical Society of Pennsylvania

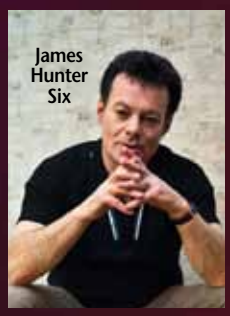
MOC:

Is it worth the time away from patient care?

The Controlled Substance Database

The Patient Should be the Center of Care

Boscov's BERKS Jazz Fest!
BERKS ARTS COUNCIL
25
2015 • 25 YEARS



April 10-19, 2015
Reading, PA

Spend 10 jazz- and blues-filled days and nights in the Greater Reading area! Over 120 scheduled events, plus great shopping and dining in one area, make the 25th annual Boscov's Berks Jazz Fest your perfect spring getaway. For tickets, call Ticketmaster toll free at **1-800-745-3000** or visit **www.ticketmaster.com** to order online.

JAZZ AT LINCOLN CENTER ORCHESTRA WITH **WYNTON MARSALIS** • **DAVE KOZ** • **INCOGNITO** • **BRIAN CULBERTSON** • **DIANNE REEVES** • **BONEY JAMES** • **PIECES OF A DREAM** **MINDI ABAIR & THE BONESHAKERS** WITH **SWEETPEA ATKINSON** • **THE SOUL OF JAZZ** FEATURING **JEFFREY OSBORNE, NAJEE, MAYSA, NICK COLIONNE, GERALD VEASLEY, BRIAN SIMPSON** **NEW YORK VOICES** AND THE **READING POPS ORCHESTRA** • **BILLY COBHAM 'SPECTRUM 40' BAND** FEATURING **DEAN BROWN, GARY HUSBAND, RIC FIERABRACCI** • **GERALD ALBRIGHT** **GOSPEL ACCORDING TO JAZZ CELEBRATION: KIRK WHALUM, YOLANDA ADAMS, KEVIN WHALUM, JOHN STODDART** AND THE **DOXA GOSPEL ENSEMBLE** • **MARC ANTOINE** • **ALEX BUGNON** **STRINGS ATTACHED** FEATURING **LARRY CORYELL, JIMMY BRUNO, VIC JURIS, JACK WILKINS, JOE COHN** • **PHILADELPHIA JAZZ ORCHESTRA** DIRECTED BY **TERELL STAFFORD** **REMEMBERING JOE SAMPLE: BOBBY LYLE, WILTON FELDER, RAY PARKER JR., JEFF BRADSHAW, NICHOLAS SAMPLE, LIONEL CORDEW, LIZ HOGUE** • **BRIAN BROMBERG** **NICK COLIONNE** • **JAZZ ATTACK: RICK BRAUN, PETER WHITE, EUGE GROOVE, ELLIOTT YAMIN** • **MARION MEADOWS** • **PAUL TAYLOR** • **JAZZ FUNK SOUL: CHUCK LOEB, JEFF LORBER,** **EVERETTE HARP** • **FOURPLAY: BOB JAMES, NATHAN EAST, HARVEY MASON, CHUCK LOEB** • **KIND OF NEW: JASON MILES, INGRID JENSEN, RAY RODRIGUEZ, MIKE CLARK, JERRY** **BROOKS** PLUS SPECIAL GUESTS **LIONEL LOUEKE, GARY BARTZ** • **PAT MARTINO TRIO** WITH **PAT BIANCHI, CARMEN INTORRE** • **LIVE AT THE FILLMORE: TRIBUTE TO THE ORIGINAL ALLMAN** **BROTHERS** • **URBAN JAZZ COALITION** • **TOMMY KATONA & TEXAS FLOOD** • **FRANK VIGNOLA & VINNY RANIOLO** • **THE JOST PROJECT: TONY MICELI, PAUL JOST, KEVIN MACCONNELL,** **ANWAR MARSHALL** • **ROYAL SOUTHERN BROTHERHOOD** FEATURING **DEVON ALLMAN, CYRILL NEVILLE, CHARLIE WOOTEN, YONRICO SCOTT, BART WALKER** • **JAMES HUNTER SIX** • **MIKEY** **JUNIOR BAND** • **ANDREW NEU** WITH **CAROL RIDDICK, DAVID P STEVENS** • **DANCE HALL DOCS** FEATURING **BRENT CARTER** • **THE UPTOWN BAND** FEATURING **ERICH CAWALLA & JENIFER KINDER** **GREG HATZA & TIM PRICE ORGAN QUARTET** • **PAT TRAVERS BAND** • **CRAIG THATCHER BAND** • **THE ORIGINAL GROOVEMASTERS** • **REGGIE BROWN** AND **BUNCH A FUNK** **THE ROYAL SCAM** • **DJANGOHOLICS ANONYMOUS: JOSH TAYLOR,CHRIS HESLOP, BILL NIXON, MICHAEL NIKOLIDAKIS, TREY LARUE** • **SAX SUMMIT: NATHAN BELLOTT, SETH EBERSOLE,** **ANDY MOHLER, GREG WILSON** • **RANDY HANSEN** • **CELEBRATE SINATRA: LOU DOTTOLI** AND THE **SOUNDS OF SUNNYBROOK DANCE BAND** • **U.S. ARMY JAZZ AMBASSADORS** AND MORE!*

Berks Arts Council

berksjazzfest.com

Boscov's

* LINEUP AS OF 11/26/14.
SUBJECT TO CHANGE

Hoffmann Publishing Group
PROUD SPONSOR OF THE BOSCOV'S BERKS JAZZ FEST

Follow us on Twitter
@berksjazzfest

MCMS Physician is a publication of the Montgomery County Medical Society of Pennsylvania (MCMS). The Montgomery County Medical Society's mission has evolved to represent and serve all physicians of Montgomery County and their patients in order to preserve the doctor-patient relationship, maintain safe and quality care, advance the practice of medicine and enhance the role of medicine and health care within the community, Montgomery County and Pennsylvania.

10% Post Consumer Waste

Contents

WINTER 2015

Features

In Every Issue

MCMS Physician is published by **Hoffmann Publishing Group, Inc.** | Reading, PA
HoffmannPublishing.com | 610.685.0914 | for advertising information: andrea@hoffpubs.com or karen@hoffpubs.com

Political Advocacy on behalf of our Patients:

Organized Medicine Facilitates Physician Participation

James W. Thomas MD, MBA
MCMS President

Most of us became physicians with noble intentions of finding elegant and timely solutions to our patients' medical illnesses, guide our patients toward healthy habits, and help them live a better life. We chose our career without regard to the growing number of external factors that more than ever are now impacting our ability to provide high quality healthcare for our patients. One such external factor is the ever changing and seemingly growing political influence with regard to the practice of patient care.

It's easy to overlook the fact that we can also make a difference outside the exam room by advocating for our patients and our profession as an integral part of the healthcare team. Balancing growing work responsibilities including documentation along with demanding personal and family life can be arduous, but you don't need hours of free time to be a successful patient advocate with the help of MCMS, PAMED and the AMA.

The Montgomery County Medical Society and Pennsylvania Medical Society strive to provide physicians with the tools and information needed to be effective patient advocates … and still have time for your family and friends.

Here are some ways MCMS, PAMED and the AMA can help you make an impact with limited time:

Keeping Physicians Informed:

The County Level

MCMS has an active Political Committee that works diligently on strengthening relationships with county legislators and providing them with resources for research. The committee works closely with the Physician Advocacy and Political Affairs staff of PAMED to coordinate informal meetings with Montgomery County legislators. The small informal meetings, usually breakfast meetings with three or four physicians and one legislator, are held periodically throughout the year to discuss policies that address the challenges physicians face in assuring quality care for their patients. It is an opportunity to collaborate on key medical issues that affect physicians, legislators and most importantly the citizens both professions serve. If you are interested in participating (especially if you are in contact with legislators already and can provide political contacts) or just want to get involved, please let us know.

On a larger scale, MCMS hosts an annual dinner in Harrisburg with Montgomery County legislators. The next dinner will be held Monday, April 20. Board members, along with interested physician colleagues, travel to Harrisburg for a collegial dinner with legislators – one that focuses on the commonalities instead of the differences. It is an opportunity to get to know our representatives away from the politics – a chance to discuss family, friends and communities. Please let us know if you are interested in attending.

The State Level

The PAMED legislative affairs staff spends the time to track hundreds of healthcare-related bills, establishes relationships with legislators, and keeps us (as physicians) up to date on important healthcare conversations at the Capitol. *Capitol Update* blogs of PAMED's Scot Chadwick and Angela Boateng are helpful at the PAMED board meetings, as are the insights provided by Marty Trichtinger, MD, and others at the MCMS board meeting. You are a few clicks away from staying informed, and are always welcome at the board meetings. Just go to www.pamedsoc.org under the Advocacy tab on the PAMED homepage, you will find the weekly blog. PAMED also sends daily short, bite-sized nuggets of this information in its daily e-newsletter, the *Daily Dose.* If you don't receive it, please consider signing up for the email at www.pamedsoc.org/recap or call PAMED headquarters to be added to the list.

Note that state legislators were busy circulating draft legislation of several healthcare bills in mid-December – a full month before Gov. Tom Wolf is to be sworn in as Pennsylvania Governor. Politics involves lots of behind-the-scenes discussions. Your county and state medical societies assist in facilitating your inclusion in some of those discussions.

The National Level

The American Medical Association has some helpful tools on its web site. The online resource can be found under the Advocacy tab on the AMA's homepage, www.ama-assn.org.

Every year in mid February, the AMA sponsors a legislative dinner in Washington, D.C. PAMPAC members and AMA members are encouraged to attend and support their state

senators and become a resource for our national legislators as well. At that time meetings with state senators and representatives are organized on key issues. Connecting with staffers and office personnel can be just as important as meeting the legislators themselves. If you are interested in attending, please let us know how you wish to contribute.

Become a Member of PAMPAC

Like it or not, money talks. Supporting pro-medicine, pro-physician candidates for elected office remains an important part of advocacy. The Pennsylvania Medical Political Action Committee (PAMPAC) uses member contributions to support the election and retention of pro-medicine candidates. You can learn more by going to www.pamedsoc.org/pampac. Several members on your county medical society board are involved on the state board and if you are interested in selecting where the money goes please contact PAMED's Larry Light to become involved with the PAMPAC board.

Making it "Easy as a Click" to Contact Your Legislator with Voter Voice

Voter Voice, PAMED's online advocacy tool, is an easy way for physicians to email to their legislators in support or opposition of bills likely to impact physicians and/or their patients.

PAMED provides sample text for each issue on Voter Voice and allows you to send it directly to your legislator in just a few clicks. While we provide sample text, we also give you the option to customize your email and include your own personal stories and experiences. You can access Voter Voice today, www.pamedsoc.org/votervoice.

Your voice is necessary in advocacy. When we all speak together, we can be a powerful force, advancing the needs of the profession in order to best serve the needs of our patients. Let MCMS and PAMED know how they can help you add your voice and how you can contribute as a resource for our state and federal legislators. ■

James W. Thomas, MD, MBA
President, Montgomery County Medical Society

montmedsoc.com

I would love to hear from you. If you have suggestions, general comments or ideas for future issues, please email James W. Thomas, MD, or the MCMS Executive Director Toyca Williams, montmedsoc@verizon.net.

A New Year Can Offer A Fresh Perspective

Jay Rothkopf, MD
Editor

Uncertainty

It's a word that summons up disparaging emotions: that flutter in the belly when you see a police car pull up behind you, or the waiting on the edge of your seat in the final few seconds of the home team's big game. For those of us in the healthcare field, uncertainty has been the rule, rather than the exception, and as a new year begins, there is no relief in sight. With control of Congress about to shift, many are undoubtedly wondering what Republican rule on Capitol Hill means for the Affordable Care Act, and healthcare reform in general. While it's impossible to predict what is going to happen, most agree that change is coming...and needed.

With that in mind, we start off by exploring something that has united physicians in the call for change: MOC. Short for "Maintenance of Certification," the ABIM's onerous requirements for doctors to remain board certified have resulted in a national outcry. PAMED's Leslie Howell gives an overview of the MOC process and physicians' concern that the process, although well-intentioned, has become onerous, cumbersome and costly. Howell is the Director of PAMED's CME, Training and Physician Leadership.

In "A Patient Wake Up Call," Dr. Alan Woronoff, a radiologist at Abington Health, details his recent experience in the healthcare system, along with suggestions on how to improve the human aspect of patient care. It's a provocative read, and one many will identify with.

Following, we take a look at a grassroots-advocacy success story: the Controlled Substance Database. Originally brought to the state medical society by Montgomery County Medical Society more than five years ago, PAMED has worked tirelessly on new legislation which is now a reality. In our "Practice of Medicine" column, we'll provide a summary of the law and what will be required of physicians in the next reporting cycle.

A quick reminder: February is American Heart month. The American Heart Association shares Derek Fitzgerald's amazing journey. After a series of health challenges, Fitzgerald got a new lease on life when he received a new heart. This avid triathlete said that getting his "new heart was like putting a fresh set of batteries in an old remote." By 2020, the American Heart Association hopes to improve the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular diseases and stroke by 20 percent.

Next, we profile Dr. James Goodyear, a past Chairman of the MCMS Board of Directors. A general surgeon in Lansdale, Dr. Goodyear is not only a pillar of his community, but has been a tireless advocate for the medical profession as well. A past president of the Pennsylvania Medical Society, he currently chairs the state's delegation to the AMA, and also has an avid interest in Civil War medicine.

Other items in this issue include a look at Computerized Provider Order Entry and its relation to Meaningful Use Stage 2, an article on the county health department's perspective on emergency preparedness, an overview of the services offered to healthcare professionals by the Foundations' Physicians' Health Programs, a political update and tips from PMSCO on making the best first impressions in your practices.

The holidays are now behind us, and as we look ahead to the coming year, both challenges and opportunity abound. I hope you will continue to join us on what has been a worthwhile journey, and let us know what you want to see moving forward. Yes, the landscape is changing, but with your dedication, commitment, and support, we will find the way forward, together. ■

Warm regards,

Jay Rothkopf, MD
Editor

PHP Evaluates, Treats and Monitors Healthcare Professionals

BY JON SHAPIRO, MD, MEDICAL DIRECTOR, PHYSICIANS' HEALTH PROGRAMS

The Pennsylvania Physicians' Health Programs (PHP), part of the Foundation of the Pennsylvania Medical Society, helps individuals suffering from addiction or work-related stress. PHP monitors a variety of healthcare professionals (HCPs)—physicians, physician assistants, dentists, dental hygienists, expanded function dental assistants and medical students, when necessary. The process of assisting HCPs might be broken down to evaluation, treatment, monitoring and advocacy. The process of referral to PHP and evaluation is a step to ensuring better health for HCPs.

Professionals are referred to PHP through many sources. We receive referrals from spouses, friends, co-workers, and employers as well as self-referrals. There has been a recent increase in the number of referrals from the Board of Medicine caused by a history of driving under the influence (DUI). These referrals occur when the applicant checks a box on the application/renewal form indicating a history of a DUI. Alternatively, the HCP may be reported to the Board of Medicine by JNET. JNET is a web-based information sharing portal for agencies in the Commonwealth of Pennsylvania. This sharing of information regarding DUI arrests has led to an increase in referrals from the state to PHP.

When the PHP receives a referral for a HCP with a possible problem, they are referred to an independent evaluator. The PHP staff obtains the appropriate releases so that we may report back to the referral source. Our case managers always strive to give the HCP a choice of evaluators that are suited to his/her individual circumstances. The evaluator will interview the HCP, perform drug tests and obtain information from collateral sources. If no impairment is diagnosed, the PHP will notify the referral source and the individual referred of the outcome. When the referral comes from the State Board, the HCP's license will be issued and no PHP monitoring will be required. If a substance abuse or psychiatric problem is defined, then the physician or HCP is given a choice of treatment centers suited to his or her problem.

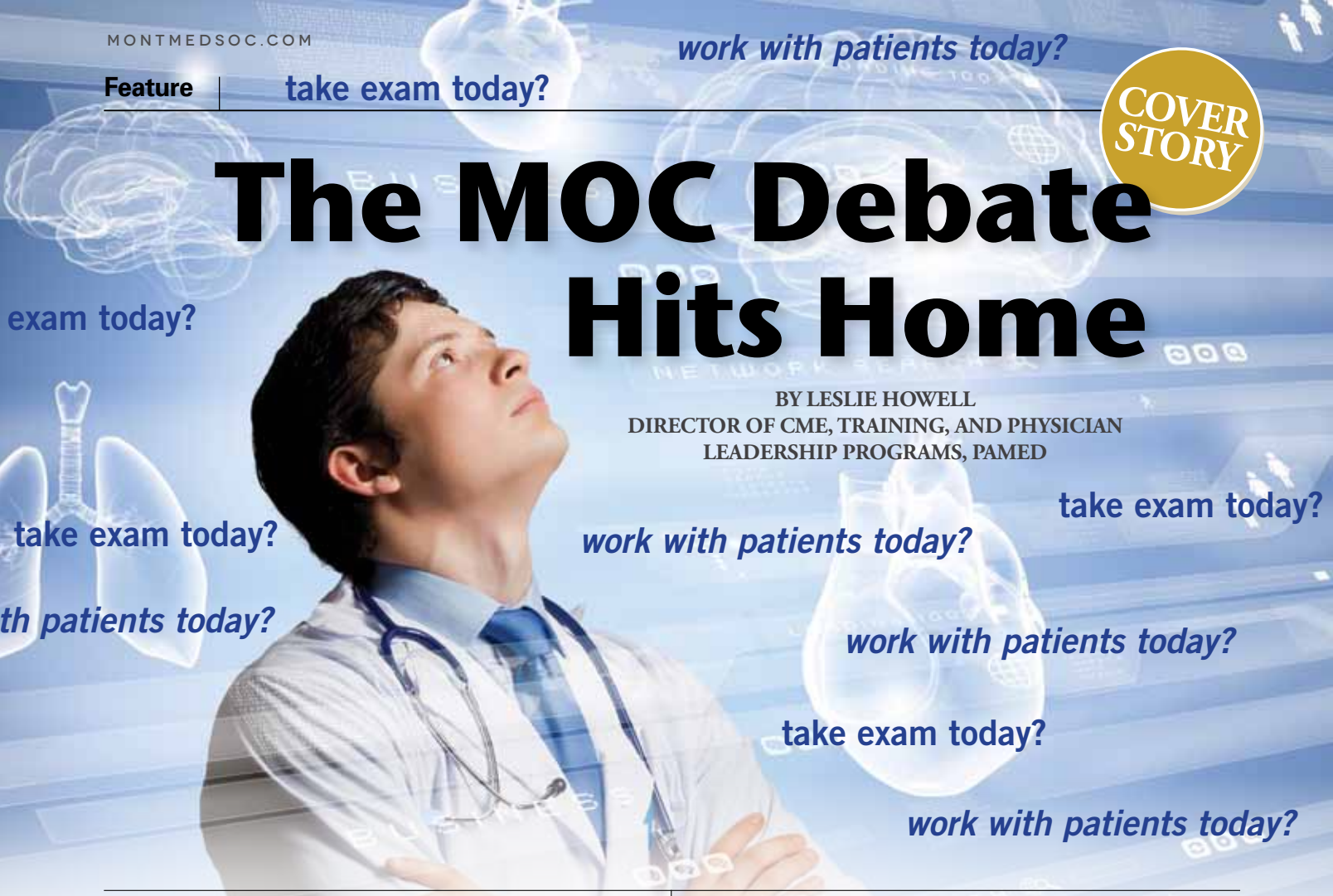
Depending on the complexity of the case, an evaluation may take between one to five days to complete. Evaluations can be an expensive and time-consuming endeavor, but they are an essential step in assisting HCPs in need. The PHP prefers to work with evaluators and treatment centers with experience in dealing with HCPs. We have no affiliation with particular centers or financial conflicts of interest. Whenever possible, the PHP offers a choice of clinicians to support the HCP's autonomy. ■

For more information regarding the treatment process for HCPs with substance abuse and psychiatric diagnoses, email us at php-foundation@pamedsoc.org. For counseling or referral service, call the Physicians' Health Programs at (800) 228-7823. PHP is a program of the Foundation of the Pennsylvania Medical Society that provides programs and services for individual physicians and others that improve the well-being of Pennsylvanians and sustain the future of medicine. Visit us at www.foundationpamedsoc.org.

COVER STORY

The MOC Debate Hits Home

BY LESLIE HOWELL
DIRECTOR OF CME, TRAINING, AND PHYSICIAN LEADERSHIP PROGRAMS, PAMED



Rarely does an issue simultaneously instill great passion and considerable angst for physicians at the level that we are seeing for the American Board of Medical Specialties' (ABMS') Maintenance of Certification™ (MOC).

Most physicians will concede that the expressed intent of MOC is appropriate: to ensure the patient community that physicians are continuing to assess and improve their knowledge and capabilities after graduate medical education (GME) training. It goes without saying that physicians are committed to lifelong learning and continuous improvement. However, this same group also contends that the current processes and practices in place across the various specialty boards are cumbersome, costly, and significantly cutting into their time with patients.

Of the four components of MOC — (I) licensure and professional standing, (II) lifelong learning and assessment, (III) cognitive exam, and (IV) practice performance assessment — the exam and the practice performance assessment appear to be the areas of greatest concern. The exam component, in particular, has been under a great deal of scrutiny. Input we've received from Pennsylvania Medical Society (PAMED) members thus far indicates that it is viewed as an uncertain measure of a physician's actual skill in his or her specialty and is punitive. Consequently, many fear that failing the exam will result in a loss of privileges at hospitals, insurance reimbursements, network participation, and possibly even employment.

PAMED has formed a Task Force on Continuous Professional Education to examine MOC in its current form and the concerns circulating throughout the state and to seek input from Pennsylvania's physicians. The goal: reshape MOC, in whatever future form it might take, into a process of continuous learning and improvement based on evidence-based guidelines, national standards, and best practices that is relevant to what a physician actually does within his or her practice of medicine and one that enhances, rather than impedes, the care of patients.

Delegates at the 2014 House of Delegates meeting, held October 17-19 in Hershey, debated the merits of the task force's initial recommendations, as well as other resolutions and reports related to MOC. One of the documents developed by the task force and adopted by the PAMED Board is a Maintenance of Certification Statement of Principles which outlines PAMED's position on what MOC should be:

- PAMED is committed to lifelong learning, cognitive expertise, practice quality improvement, and adherence to the highest standards of medical practice.

- PAMED supports a process of continuous learning and improvement based on evidence-based guidelines, national standards, and best practices, in combination with customized continuing education.
- The MOC process should be designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
- The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, and intent to maintain or change practice.
- Board certificates should have lifetime status, with MOC used as a tool for continuous improvement.
- The MOC program should not be associated with hospital privileges, insurance reimbursements, or network participation.
- The MOC program should not be required for Maintenance of Licensure (MOL).
- Specialty boards, which develop MOC standards, may approve curriculum, but should be independent from entities designing and delivering that curriculum, and should have no financial interest in the process.
- A majority of specialty board members who are involved with the MOC program should be actively practicing physicians directly engaged in patient care.
- MOC activities and measurement should be relevant to real world clinical practice.
- MOC process should not be cost prohibitive or present barriers to patient care.

The delegates also asked that several items be referred to the AMA:

- Work with the ABMS to eliminate practice performance assessment modules as currently written from the requirements of MOC.
- Develop and disseminate a public statement, with simultaneous direct notification to the American Board of Internal Medicine (ABIM) and other ABMS-sponsoring boards, that their current MOC program appears to be focused too heavily on enhancing ABIM revenues and fails to provide a meaningful, evidence-based, and accurate assessment of clinical skills.
- Investigate and/or establish alternative pathways for MOC.
- Report back to the House of Delegates at the Annual AMA Meeting in June 2015.

The delegates also recommended that PAMED ask the AMA to revoke its support for MOC if no action is taken by the ABMS in working with the AMA to make MOC requirements less onerous.

PAMED will continue to support efforts to create a reasonable and economical assessment process that provides physicians with the information necessary to improve the quality and efficiency of their practices. In recent months, PAMED surveyed Pennsylvania physicians to identify concerns and gather suggestions for improving board recertification programs. PAMED received more than 850 survey responses, approximately half coming from physicians practicing in primary care specialties. You can find a summary of the results by visiting the PAMED web site, www.pamedsoc.org/moc.

For more information on PAMED's Task Force on Continuous Professional Education or next steps on MOC, please email Scot Chadwick at schadwick@pamedsoc.org or call (717) 909-7814. ■

Frontline Groups 100% Committed to MCMS

Is your practice among an elite group that is 100 percent committed to the Montgomery County Medical Society? You can be. . .

Frontline practices – three or more physicians in a group – stand on the front line of the medical profession by making a commitment to 100 percent membership in the Montgomery County Medical Society and the Pennsylvania Medical Society (PAMED). MCMS continues to provide a forum for physicians to work collectively for the profession, patients and practice.

The Montgomery County Medical Society says thank you.

MCMS Frontline Groups as of December 2014:

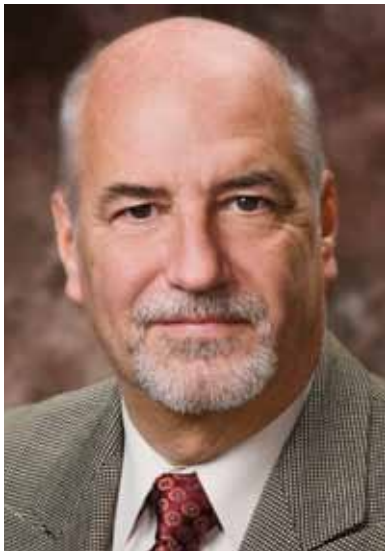
- Abington Medical Specialists
- Abington Memorial Hosp-Div of Cardiothoracic Surgery
- Abington Neurological Assoc. Ltd
- Abington Perinatal Associates PC
- Abington Reproductive Medicine
- Academic Urology-Pottstown
- Advocare Main Line Pediatrics
- Annesley Flanagan Stefanyszyn & Penne
- Armstrong Colt George Ophthalmology
- Berger/Henry ENT Specialty Group
- Cardiology Consultants of Philadelphia-Blue Bell
- Cardiology Consultants of Philadelphia-Lansdale
- Cardiology Consultants of Philadelphia-Norristown
- East Norriton Women's Health Care PC
- Endocrine Metabolic Associates PC
- Endocrine Specialists PC
- ENT & Facial Plastic Assoc. of Montgomery County
- Family Practice Associates of King of Prussia
- Gastrointestinal Specialists Inc.
- Green & Seidner Family Practice
- Hatboro Medical Associates
- Healthcare for Women Only Division
- King of Prussia Medicine
- LMG Family Practice PC
- Lower Merion Rehab
- Main Line Gastroenterology Associates-Lankenau
- Marlowe Zwillenberg & Ghaderi LLC
- Marvin H Greenbaum MD PC
- Neurological Group of Bucks/Montgomery County
- North Penn Surgical Associates
- North Willow Grove Family Medicine
- Northern Ophthalmic Associates Inc.
- Otolaryngology Associates
- Patient First - Montgomeryville
- Pediatric Associates of Plymouth Inc.
- Pediatric Medical Associates
- Performance Spine and Sports Physicians PC
- Respiratory Associates Ltd
- Rheumatic Disease Associates Ltd
- Rheumatology Associates Ltd
- Rittenhouse Hematology
- Suburban Geriatrics
- Surgical Care Specialists Inc.
- The Philadelphia Hand Center PC
- Thorp Bailey Weber Eye Associates Inc.
- Tri County Pediatrics Inc.
- TriValley Primary Care/Lower Salford Office
- TriValley Primary Care/Upper Perkiomen
- William J. Lewis MD PC

Through your membership, MCMS Frontline members and practices receive special recognition and benefits:

- A 5 percent discount on your county and state dues.
- A certificate of recognition to hang in your office.
- Regional meetings covering topics such as risk management, employment law and payer and regulatory matters. These meetings are designed exclusively for member practice managers and office staff, free of charge.
- Additional discounts and services from county and state endorsed vendors.

For more information on how your practice can become a Frontline practice, e-mail montmedsoc@verizon.net or call (610) 878-9530 or PAMED group relations at (800) 228-7823 or (717) 558-7750, ext. 1337.

Meet Your County Medical Society Leaders



James A. Goodyear, MD, continues to advocate for quality patient care in his role as chair of the Pennsylvania Medical Society's (PAMED's) delegation to the American Medical Association House of Delegates. Dr. Goodyear has possessed a national or state platform for his advocacy efforts for more than a decade, including service as president of PAMED in 2009-2010. He is a long-time member of the 21-member MCMS Board of Directors, including a term as president in 2003 and chairman from 2008-2011.

Name: James A. Goodyear, MD

Specialty: General Surgery

Currently Practices: North Penn Surgical Associates, Lansdale

Medical School: Temple University School of Medicine

Residency: Abington Memorial Hospital

Hometown: Warminister, Bucks County

Residence: North Wales, Montgomery County

PROFESSIONAL BACKGROUND

Why I chose a career in medicine: I chose medicine both as an intellectual and academic challenge as well as for its profound opportunity to provide an ongoing contribution to society. Combining the above stimuli with my interest in using my hands as well as my head directed me towards a career in surgery.

Most rewarding elements of my career: Quality patient outcomes and the physician-patient relationship.

Achievements most proud of: Staying happily married to my best friend for 45 years, being the father of five wonderful daughters, being a grandfather, helping society as a physician, serving as the 160th president of the Pennsylvania Medical Society, and continuing to serve our patients and our honorable profession in organized medicine.

OUTSIDE OF THE OFFICE

Interesting childhood fact: At age 15, I was deeply and emotionally affected by the assassination of John F. Kennedy. From that moment on, I became profoundly interested in history and the critical importance of major historic events (of which there had been so many others during the course of my life). I then traveled to Washington, DC by bus, by myself but with my parents' blessing (things were far different then), and stayed there for three days during the funeral of John F. Kennedy, an event that has had a profound and enduring effect on me. The details remain quite vivid in my memory.

How did I end up practicing in Montgomery County? I moved to Montgomery County after I was married to be closer to school (Temple University and Temple University Medical School). I stayed in Montgomery County for my training at Abington Hospital and continue to live and practice here.

What interests me outside medicine: American history, especially the American Civil War. I am currently reading biographies of each of the American presidents, from George Washington to the present.

My family: I have been married for 45 years to Cathy, my high school sweetheart and best friend and truly the world's most loving, giving and caring person. We have five wonderful daughters, all of whom are college graduates, and 11 fabulous grandchildren, all of whom give me great pleasure.

If I could be anything other than a physician: A classical musician or vocalist, or professor of American history. Perhaps a chef.

I greatly admire: Abraham Lincoln for his vision for our country; understanding of the American and human condition; commitment, compassion and fairness; and humor. *"With malice toward none, with charity for all, with firmness in the right, as God gives us to see the right, let us strive to finish the work we are in, and bind up the Nation's wounds."* A. Lincoln, Second Inaugural Address, 1865

WORTH NOTING

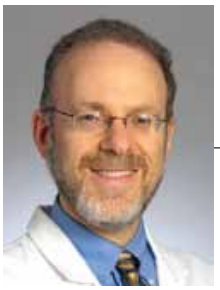
Most interesting moment in medicine: My first day at medical school. The overwhelming social responsibility of the career I was entering struck me at that moment and has remained with me, in the forefront of my consciousness, on a daily basis.

You may not know: I was a registered pharmacist prior to entering medical school, and worked my way through medical school, supporting my wife and me as a pharmacist. I am a certified professional alpine ski instructor (although currently not teaching). I plan to write a book after my retirement from medicine and surgery (historic fiction), based on the life of my grandfather, who fought in the American Civil War.

Why I stay involved in organized medicine: Organized medicine provides me with an opportunity to continue to make a meaningful difference, have my voice be heard, and be involved in the decisions that affect the course of our profession, and thereby affect the ability to provide quality care for our patients. ■

In My Opinion

The Patient Should be the Center of Care



BY ALAN WORONOFF, MD

Patient safety has been a "hot button" issue over the last 10 to 15 years in medicine. Many questions are still being debated and fine-tuned. How is patient safety defined? Is it "correct side surgery"? No falls? No infections? How do you make an environment in which patients feel safe? As a radiologist, I, too, struggle with these definitions.

Even more so as a recent patient.

I think physicians in general have a poor understanding of what "patient safety" is until they become the patient. Let me explain.

As a Patient – Fear Sets In

I recently underwent "minor" outpatient surgery. "Minor" can probably be defined as a procedure happening to someone else. But on me? Receiving anesthesia and a knife does not feel minor.

This process began months earlier with an office visit when surgery was deemed necessary to correct a non-life-threatening condition. On the day of the surgery, I entered a world of increasing vulnerability and some fear, not fully remembering everything from months before. Even though I am a physician and familiar with the environment, an unexpected sense of insecurity snuck up on me. The steps of disrobing into a thin paper gown with nothing else on, getting shaved, becoming one of many who the nurses attend to, being told to remove my eyeglasses, being transported to the surgical suite—all of these made me feel like I was descending into Dante's Inferno, though this procedure was elective and benign overall.

Everybody I met asked me my name and birthdate, as trained by the safety protocols. Although this is protocol, I kept wondering if this really helped to provide a safe environment. It sure didn't make me feel safer. Meanwhile, I had yet to see a member of the surgical team or sign consent.

Following Protocols I Can't See

I personally cannot see beyond my nose without my glasses. So, it is a very disorienting feeling, and on top of the other fraying nerves, did not give me a "safe" feeling. When I asked if that was necessary, the staff indicated that nobody proceeds to the surgical floor with glasses, lest they get lost. There was no understanding of the fear, isolation and disorientation that occurs without vision.

I finally met the surgical fellow, though I could not see him through my visual blur, nor did I get his name. When it was discovered that no consent had been signed, he handed me the form and expected me to sign it, without my ability to actually see or read the form and without actually re-explaining the surgery including risks and benefits. This may seem routine and minor to those performing the procedure, but this is a key step for building trust. This step was a big fail in my case.

I signed the consent form, but it did nothing to ensure a safe environment. It was a formality, which the fellow, the institution, and the nursing staff did not use to build trust or safety. Even though I am a medical professional, I felt powerless, intimidated, and unable to speak up. I can only imagine how non-physicians must feel.

Adding to the surreal internal angst, I also was anxious about anesthesia. The thought of being unconscious unnerves me. As a trained professional in the medical field, I know why it was necessary. But, there was a cold methodicalness which did nothing to make me feel a part of it. I do not know what could have been done differently, but it was additive—I was blind, near naked, cold, and uninformed.

Treating the Patient or the Procedure?

I never saw the fellow again, before or after the surgery, not that I would recognize him. After the surgery, I never saw the surgeon despite asking if he was coming around. I never heard from the office in the days after the surgery until I called to schedule follow-up. I asked if it were routine to not call, and later that day, I did get an apology phone call. I am not sure if that was because of my profession.

My point in all of this is to explain what it feels like to be on the other side. If we are teaching our residents and fellows that it is okay to ignore the patients in lieu of the "procedure," we have failed. If the institutions have tightened the screws so much that surgeons and physicians have no time to actually perform patient care, we have lost our way.

How did we get to a point where physicians who open a patient do not feel a personal need to follow up and see them in the post-op area? How have hospitals worried about patient safety allowed this? Are doctors so focused on the procedure that they lose sight of the patient? Am I expecting too much?

A Safe Patient Equals An Empowered Patient

I hope to remind physicians and surgeons that the patient is the center of the care. Though the surgery is the procedure, your job is not to simply cut and sew. My experience showed me that the system forgot that. My procedure became the endpoint, not me. It will make me think twice as I move forward in practice, and I hope the training institutions take note and make corrections.

Patient safety is not defined by knowing a name and birth date. It should be a safe environment in total, to provide an environment where patients feel empowered and feel safe. We will all be on the other end at some point. We need to remember that there is a patient attached to that leg or appendix. ■

Alan Woronoff, MD, is a MCMS member and practicing radiologist with Radiology Group of Abington PC.

Have you *renewed* your County Medical Society and PAMED *Membership?*

If not, it will expire on Feb. 27,

and your membership benefits—including the *Daily Dose*, PAMED's daily email newsletter—will be discontinued.

What news are you missing when you don't receive your Daily Dose?

- **Money Back**— PAMED spearheaded efforts which secured a settlement that will bring $200 million in Mcare funds back to eligible Pennsylvania physicians, hospitals, and health care providers. **www.pamedsoc.org/mcare**
- **Meet your patient safety CME needs in one place**—Members can access most PAMED CME activities (valued at $30 per credit) for free. **www.pamedsoc.org/cme**
- **Stay in compliance with new regulations, including Pennsylvania's new child abuse laws**—Get help at **www.pamedsoc.org/quickconsult** or call **717-DOC-HELP**.
- **Save at least 40 hours of staff time spent sifting through Medicare's 2015 physician fee schedule** by accessing resources that address changes that could affect your reimbursement. **www.pamedsoc.org/2015Medicarefees**
- **Make a difference in your local community.** Opportunities include grassroots physician advocacy, leadership development, and PAMED's new mentoring program. **www.pamedsoc.org/mentoring**

MONTGOMERY COUNTY MEDICAL SOCIETY 1847

Your membership ensures that you have a voice and access to the resources you need. Let us take the uncertainty about tomorrow out of your day. Renew your state and county membership today.

www.pamedsoc.org/dues
855-PAMED4U (855-726-3348)

Feature

2014 PAMED Annual Business Meeting
Oct. 17-19, Hershey
A Visual Recap



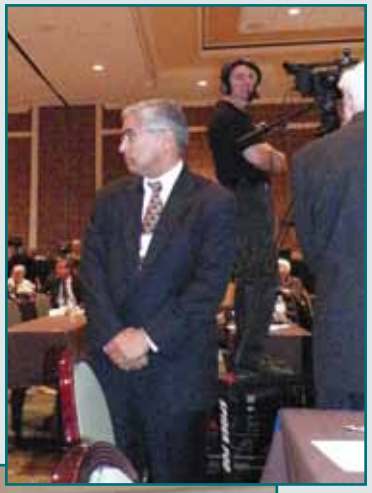









MCMS Enjoys the Spirit of Giving



MCMS Physicians enjoy good food and fellowship during their December holiday dinner at The Morton's Steakhouse in King of Prussia. Each attendee shared the holiday spirit by donating unwrapped toys to Toys for Tots.

Staff at Sen. Daylin Leach's office are all smiles after MCMS filled the office Toys for Tots collection box in December.

Triathlete Defines Meaning of 'Quality of Life'

Heart Association volunteer continues to give back

American Heart Association

Derek Fitzgerald participating in one of many marathons.

Derek Fitzgerald never met a triathlon he didn't like. But actually before 2012, Fitzgerald would describe himself as your garden variety couch potato — understanding the importance of fitness but never making it a priority.

He was a reasonably fit man, never having any health issues other than for kidney stones. But in 2003, Fitzgerald's routine bathroom break was anything but. A basin full of blood was more than a wake-up sign. He was a healthy 30-year-old who just hoped it would go away. But every two weeks, a normal bodily function would result in something out of a slasher film.

He went to see a gastroenterologist and discovered that he was nothing more than anemic. The doctor's scans never showed a trace of anything alarming. But his symptoms were recurring so the doctor did CAT Scans and PET Scans and still nothing. "Finally he decided to do an exploratory laparotomy to take a peek inside. During that surgery he discovered a grapefruit-sized tumor in my intestine. I was asymptomatic and my belly was not distended, but the tumor was malignant," remembers Fitzgerald. "So with my family around my bedside, I was told I had non-Hodgkin's Lymphoma."

A few months after the end of his six-month chemotherapy session, he developed pneumonia. But that same nagging breathing issue persisted after the medication. A second trip to the ER led to yet another dire issue: dilated cardiomyopathy with an ejection fraction (the rate at which your heart pumps blood) of 18 percent. Normal EF

American Heart Association

Fitzgerald trying to keep a positive spirit as he deals with another health challenge.

is between 55 and 70 percent.

He received a pacemaker in 2004, but his health continued to deteriorate and his EF slipped to 5 percent by January 2011. Suddenly a donor was found. Seven days later, he emerged a new man. "Getting my new heart was like putting fresh batteries in an old remote — everything just started clicking," he recalls.

Seven months after his transplant, he entered his first 5K. Two months later, he did a half marathon. Fitzgerald explains, "I did my first triathlon on April 29, 2012, then two weeks later I did a half Iron Man. In total, I've done 65 of these types of competitions/events, including Philadelphia Heart Walk 2014. I walked because I owe a debt that can never be repaid to someone that I'll never know. I walked to say thank you to all the people that supported me, and in turn, help the people that now need my support. I walked and will continue to walk because everyone deserves a fighting chance — not just to survive, but to live."

Derek's most cherished accomplishment to date is his miracle child, Emma, who was born in January 2014 after being told that fertilization would be close to impossible after chemotherapy. He remembers, "My wife, LeeAnn, and I had been trying to conceive for years, but after I was put on the transplant list, we gave up trying. Emma is a gift of life that would not be here without the gift of life I had been given."

The 2020 Impact Goal of the American Heart Association is by 2020, to improve the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular diseases and stroke by 20 percent. You can find out more about how to live a heart healthy lifestyle, local events and initiatives and about volunteering by visiting heart.org/Philadelphia or calling (215) 575-5200. ■

American Heart Association

Renowned cardiologist and immediate past AHA President Dr. Mariell Jessup from Penn Medicine stands with Fitzgerald, his wife LeeAnn, and baby Emma.

Feature

Controlled Substance Database Legislation Enacted

BY SCOT CHADWICK, LEGISLATIVE COUNSEL, PAMED

On Oct. 27, Gov. Corbett signed Senate Bill 1180 into law, authorizing the creation of a statewide controlled substance database.

The database will be housed at the Department of Health, where it will be run by a board consisting of the Secretaries of Health, Human Services, Drug and Alcohol Programs, State, Aging, the Insurance Commissioner, the State Police Commissioner, the Attorney General, and the Physician General (if the Secretary of Health is not a physician).

The board will aid prescribers in identifying at-risk individuals and referring them to drug addiction treatment programs, and will also refer information to the appropriate licensing board when the system produces an alert that there is a pattern of irregular prescribing or dispensing data.

It will also create a written notice that prescribers and dispensers will use to let patients know that information regarding their prescriptions for controlled substances is being collected by the program.

Prescribers will not be required to submit prescribing information to the program, but dispensers must electronically submit information to the program regarding each controlled substance dispensed, no later than 72 hours after dispensing a controlled substance. However, prescribers at a licensed health care facility who dispense controlled substances limited to an amount adequate to treat a patient for a maximum of five days, with no refills, are exempted from the requirement to submit that information to the program.

While the language is a bit awkward, the intent is that prescribers are not absolutely required to query the database in all circumstances prior to prescribing a controlled substance, though the bill provides strong guidance for when that should take place. Specifically, a prescriber "must query the program for each patient the first time the patient is prescribed a controlled substance by the prescriber for purposes of establishing a base line and a thorough medical record, or if a prescriber believes or has reason to believe, using sound clinical judgment, that a patient may be abusing or diverting drugs."

Prescribers will be able to designate employees for purposes of accessing the program on their behalf, and prescribers will be permitted to query the program both for an existing patient and for prescriptions written using their own DEA number. Dispensers may query the program for a current patient to whom the dispenser is dispensing or considering dispensing any controlled substance.

All law enforcement and grand jury queries of the program must be funneled through the Attorney General's office. Those queries may take place without restriction for Schedule II controlled substances, but for all other schedules, a court order based on an active investigation will be required. Access to the database is also granted to various other state officials for specifically enumerated purposes.

A prescriber or dispenser who has submitted or received information from the program and has held the information in confidence cannot be held civilly liable or disciplined in a licensing board action for submitting the information or not seeking or obtaining information from the program prior to prescribing or dispensing a controlled substance.

There are significant civil and criminal penalties for improperly accessing the database or misusing information obtained from it.

The system is supposed to be up and running by June 30. ■

The Controlled Substance Database *Now a Reality After MCMS Physician Started the Dialogue*

BY ROBERT MCNAMARA, MD, MCMS BOARD MEMBER

Your voice can make a difference. As physicians, we all know there are plenty of things to complain about with the state of medicine. On the other hand many of us incorrectly think nothing can be done about our problems. Six years ago, I brought a major practice issue for emergency medicine physicians to the Pennsylvania Medical Society House of Delegates to seek a solution. I am happy to say that after six years of steady, persistent leadership from the Montgomery County Medical Society (MCMS) and PAMED, a simple proposal will now impact the care of patients and enhance the practice of our colleagues.

In short order, Pennsylvania physicians will have access to a prescription drug database so they can better assess whether a patient is "pill shopping" and in need of evaluation for the serious medical issue of addiction. This will also help us as physicians further our role in stemming the epidemic of prescription drug abuse afflicting the younger generation.

In October 2008, with the full support of MCMS, I submitted a resolution to PAMED House of Delegates, calling for the society to seek legislation opening this database to duly licensed physicians. When the resolution was debated, it quickly became apparent that this was not just an emergency medicine issue as there was powerful testimony from other specialists including family medicine, internists and orthopedic surgeons. The resolution passed and then the hard work began to create a bill and wind its way through the labyrinth of our state legislative process. That important work was conducted by the staff and physician leaders including numerous MCMS physicians who serve at the highest levels of the medical society. Once the resolution passed, there wasn't much that I had to do other than briefly speak to staff and respond to the occasional e-mail. The statewide database is expected to be up and running by June 30.

At the end of the day, I have one less thing to complain about and I will be better able to care for my patients in the Temple ED. Thank you for your membership in MCMS and please consider getting involved or letting us know your ideas for improving the practice of medicine. It may take a while to see the change; but, it will be worth it to you, your colleagues and your patients. Your county and state medical societies are continually working for your patients, your practice and your profession. ■

Dr. Robert McNamara is a longtime member of the Montgomery County Medical Society, a past president of the society and a current member of its board of directors. He is a professor and chairman in the Department of Emergency Medicine, Temple University School of Medicine in Philadelphia.

Pennsylvania Medical Society
Doctors and Patients. Preserve the Relationship.

Pennsylvania Medical Society
Quarterly Legislative Update
December 2014

The 2015-2016 session of the Pennsylvania General Assembly began Jan. 6. On Jan. 20, House and Senate members are sworn in, as well as Governor-elect Tom Wolf. Wolf, a Democrat, will face an overwhelmingly Republican legislature, with the GOP controlling the House 119-84, and the Senate 30-20. It should make for an interesting two years.

State legislators ended the 2013-2014 legislative term with a flurry of activity, enacting several health care-related measures. Several significant initiatives were enacted this year.

Regulation of Tanning Salons

Culminating years of hard work by PAMED and its allies, on May 6, former Gov. Tom Corbett signed a new law banning use of tanning facilities by minors under the age of 17 and requiring parental consent for 17-year-olds. The new law (formerly HB 1259, now Act 41) also requires:

- Tanning facilities to post warning signs on the premises, and keep records for three years
- Customers to sign a written warning statement prior to tanning
- Tanning devices to meet federal and state standards
- Employees of tanning facilities to have training in both the use of the devices and recognition of customer skin types.

There have been several versions of tanning bills over the years supported by PAMED, the Pennsylvania Academy of Dermatology and Dermatologic Surgery, and the Pennsylvania Chapter of the American Academy of Pediatrics. In past sessions, tanning legislation would pass the Senate but stall in the House. Persistence has finally paid off, and the new law went into effect on July 5.

Lyme Disease Bill Signed Into Law

Lyme disease is the most commonly reported vector-borne illness in the United States. According to the Centers for Disease Control and Prevention (CDC), in 2012, it was also the country's seventh most common nationally notifiable disease, despite the fact that 95 percent of the cases are reported from just 13 states. Pennsylvania sits at the top of that unfortunate baker's dozen, joined only by Massachusetts as states with more than 5,000 confirmed or likely cases in 2012.

Senate Bill 177, signed into law by former Gov. Corbett on June 29, will establish a task force in the Department of Health to make recommendations to the Department regarding a wide range of surveillance, prevention, information collecting, and education measures. The Department will be charged with the task of developing a program of general public and health care professional information and education regarding Lyme disease, along with an active tick collection, testing, surveillance and communication program.

The Department will also be directed to cooperate with the Pennsylvania Game Commission, the Department of Conservation and Natural Resources, and the Department of Education to ensure that the information is widely disseminated to the general public, as well as to school administrators, school nurses, faculty and staff, parents, guardians and students.

The Pennsylvania Medical Society has long supported legislation calling for the state to take a more active role in information gathering and public education regarding Lyme disease. Unfortunately, earlier versions of the legislation also contained problematic language statutorily endorsing long-term antibiotic therapy, a controversial treatment protocol rejected by the CDC, which ultimately doomed those bills to failure.

The new law does not contain that highly contentious provision, and the Society is pleased with the bill's enactment.

Naloxone/Good Samaritan Bill Also Enacted

On Sept. 30, former Gov. Corbett signed another piece of opioid legislation into law—Senate Bill 1164, which cleared both the Senate and House unanimously.

As originally introduced and passed by the Senate, it provided Good Samaritan immunity to individuals who seek to obtain aid for someone experiencing a drug overdose. The reason this matters is that individuals with someone experiencing an overdose may have been engaged in illegal

activity at the time (i.e. selling drugs), and may be reluctant to seek help for fear of getting themselves in trouble with the law. The bill removes that obstacle, prohibiting law enforcement personnel from prosecuting an individual if he/she only became aware of the criminal activity because the individual was aiding a person experiencing a drug overdose.

The House of Representatives added an equally significant amendment to the bill, allowing naloxone, a lifesaving opioid antagonist, to be prescribed to first responders like firemen and police officers, as well as to friends and family members of persons identified as being at risk of experiencing a drug overdose. The House amendment also provides liability protection to prescribers and the aforementioned individuals if they administer naloxone in good faith to someone who they believe is experiencing a drug overdose.

The new law became effective on November 29.

Down Syndrome Bill Signed into Law

Signed into law by former Gov. Corbett on July 18, House Bill 2111 (now Act 130) will require a health care practitioner that administers, or causes to be administered, a test for Down syndrome to an expectant or new parent to, upon receiving a positive test result, provide the expectant or new parent with educational information made available by the Department of Health. Though well-intentioned, the new law will force a physician to use one-size-fits-all, state-issued material that may not be appropriate for every patient. The requirement became effective in September 2014.

Physician Dispensing in Workers' Compensation

A legislative initiative to place limits on physician reimbursements for dispensing drugs in workers' compensation cases has borne fruit, as the state House and Senate approved a bill and former Gov. Corbett signed it into law on Oct. 27. The law became effective Dec. 26.

House Bill 1846 will cap the reimbursement rate for drugs and pharmaceutical services in the workers' compensation system at 110 percent of the original manufacturer's average wholesale price (AWP), calculated as of the date of dispensing.

A physician seeking reimbursement for drugs dispensed by a physician will be required to include the original manufacturer's national drug code (NDC) number, as assigned by the Food and Drug Administration, on bills and reports. A repackaged NDC number would be prohibited and would not be considered the original manufacturer's NDC number.

Additionally, under the bill no outpatient provider, other than a licensed pharmacy, will be permitted to seek reimbursement for drugs dispensed in excess of the following, commencing on the employee's initial treatment following injury:

- For Schedule II drugs, one initial seven-day supply, and one additional 15-day supply if the employee needs a medical procedure, including surgery;
- For Schedule III drugs which contain hydrocodone, one initial seven-day supply, and one additional 15-day supply if the employee needs a medical procedure, including surgery;
- For all other prescription drugs, one initial 30-day supply.

No outpatient provider, other than a licensed pharmacy, will be allowed to seek reimbursement for an over-the-counter drug. Proponents of the legislation asserted that there has been a rapid increase in physician dispensing of repackaged drugs in Pennsylvania, specifically within the workers' compensation system. Allegedly, this practice dramatically inflates costs borne by insurance companies, employers, and ultimately, by taxpayers.

According to published reports, physician dispensing typically begins when drug distributing firms purchase large quantities of drugs (e.g. 1,000 to 10,000 tablets) and repackage the drugs into single prescription sizes (e.g.14, 21, 28 tablets) appropriate for dispensing directly to patients. It is asserted that as part of the

Continued on page 22

Continued from page 21

repackaging process, drugs are assigned a new national drug code (NDC) number and inherit a new average wholesale price (AWP), one that is typically far greater than the AWP established by the original manufacturer.

Pennsylvania's existing pharmacy fee schedule sets the maximum reimbursement rate at 110 percent of the AWP for workers' compensation pharmaceuticals, but the claim is that the higher AWP of repackaged drugs allows physicians, middlemen, and drug distributing firms to earn millions of dollars in profits.

Indeed, some dispensing firms advertise on their websites that physicians can earn hundreds of thousands of dollars in profits by dispensing drugs in their offices. The new law is intended to address that practice.

Epinephrine Auto-injector (EpiPen) Bill Signed Into Law

PAMED scored another end-of-session legislative victory this year, as the state House and Senate approved a bill that will provide help for school children with severe allergies. Former Gov. Corbett signed the measure into law on Nov. 3.

The bill was driven by the knowledge that in an anaphylactic emergency, prompt action is essential, and in theory the school nurse would be able to administer the auto-injector almost immediately. However, in practice complicating factors may delay the quick administration of epinephrine to a child who is having an anaphylactic episode. The school nurse could be indisposed for any number of reasons, with catastrophic consequences.

For that reason, in 2012 the PAMED House of Delegates endorsed legislation that would allow epinephrine auto-injectors to be stored in a secure location in a classroom, and to permit a school to designate one or more non-nurse staff members to receive training so they could administer the medication in an emergency.

PAMED steered the bill through the House and Senate without a single negative vote (a real rarity).

The bill permits a public or private school to authorize a trained school employee to:

1. provide an epinephrine auto-injector that meets the prescription on file for either the individual student or the school to a student who is authorized to self-administer an epinephrine auto-injector; and

2. administer an epinephrine auto-injector that meets the prescription on file for the school to a student that the employee in good faith believes to be having an anaphylactic reaction.

Physicians and CRNPs will be able to prescribe epinephrine auto-injectors directly to the school for that purpose.

Appropriately, the bill also contains a number of safeguards to ensure patient safety. Parents who wish their child to be exempt from the provisions of the new law can simply sign a form and opt out. And school employees who administer an auto-injector pursuant to the law will have emergency response provider and bystander Good Samaritan civil immunity.

The new law took effect Dec. 30, though the Department of Health has another 90 days after that to get the mandated training program up and running.

New Child Abuse Reporting Laws go into Effect

In the wake of the Jerry Sandusky child abuse situation at Penn State, significant changes have been made to Pennsylvania's Child Protective Services Law, and many of the most important amendments went into effect on Dec. 31.

Physicians who don't see children in their practice still need to pay close attention to these changes, because *they will now need to report suspected child abuse identified in certain circumstances outside their professional capacity.*

Additional changes include, but are not limited to:

- The new definition of child abuse is more specific and has been expanded.
- Physicians will no longer be able to fulfill their reporting obligation simply by making a report to their supervisor or other designated person in their workplace.
- The penalties for failing to make a mandatory report are increased.
- Physicians have new mandatory child abuse recognition and reporting training requirements as a condition of licensure. PAMED has developed a package of materials to help physicians understand and comply with the new requirements. The materials can be accessed on the PAMED website, www.pamedsoc.org. ■

Embracing Black Swans: A Primer on Public Health Emergency Preparedness

BY BRIAN P. PASQUALE, PHD(C), MPH, NRP
SENIOR PUBLIC HEALTH EMERGENCY PLANNER, MONTGOMERY COUNTY HEALTH DEPARTMENT

People of the world are sharing common feelings of fear, frustration, sadness and concern in the wake of the arrival of uncontained Ebola in the United States.The Ebola outbreak has sickened more than 14,000 people world-wide, killing more than 5,000, classifying it as the worst outbreak in history[1].

World-wide, thousands of lives have been lost with countless more sickened, and hundreds of children orphaned as a result of the outbreak. As a result, millions are emotionally shaken by the results of the outbreak, and here in the U.S., fears began to run high as our cultural feeling of invulnerability eroded away in September 2014, upon the discovery of the first imported case of Ebola in Texas.

"Black swans" are highly consequential but unlikely events that are easily explained in retrospect, and after these events happen, people often assimilate them into their conception of the world[2]. These events have forever redefined our lives as individuals, healthcare professionals and as a nation overall. Ebola, along with other recent focusing events, has afforded public health emergency preparedness (PHEP) a heightened awareness in our consciousness and daily priorities.

Blindness and dismissal

The arrival of Ebola in the U.S. bears many of the same surprise characteristics as the discovery of the black swan in the 1700s. For centuries, Europeans believed that all swans were white. The visible, empirical evidence was irrefutable therefore people had no reason to think otherwise, it just doesn't happen here. Similarly, Ebola first discovered in Zaire in 1976[3] was considered to be a problem of poor third-world nations by many in first-world countries, including the U.S. Again, the visible evidence spoke for itself…it just doesn't happen here.

Needless to say, when the Dutch explorer Willem de Vlamingh discovered a dark-feathered bird[4] in Australia, the discovery of the black swan dispelled centuries of beliefs and teachings of the academic world. What the world has painfully discovered about Ebola is that as our world gets more connected through travel, emerging infectious threats such as Ebola are becoming more possible almost anywhere across the globe. Just as black swans have been accepted by the European culture as ordinary over time, Ebola will have to be accepted as an ever-present threat to all people world-wide, forever shaping and changing our healthcare preparedness planning paradigms.

Bringing order to chaos

As healthcare providers, we are glued to our opinions; our expertise is rooted in our knowledge and presentation of evidence-based information. Our constituencies depend on our vast library of tacit knowledge from which we draw and form advice. They depend on physicians to be the teachers and counselors, providing wellness information especially in times of uncertainty and informational chaos. Once we have theories on a particular topic we begin to seek confirming evidence from other "experts"; this is called "confirmation bias." Luckily, we can retrain ourselves to overcome cognitive biases and to appreciate anomalous events such as Ebola. By remaining confident in what we know and conversely admitting what we still need to learn helps us depart from our epistemic arrogance and embrace the "what if" scenarios, ultimately enabling us to be effective and credible teachers to our constituency.

C 4

Continued from page 23

Public information and health promotion, the tip of the public health spear

Considering the unpredictability of public health emergency events such as Ebola, it is incumbent upon communities to quickly develop a sense of resiliency in order to absorb and ultimately recover from the effects of the incident. Community resiliency is often based in modifying people's behavior to a better outcome. Considering this, developing a robust and clear Ebola public message campaign is likely to be the most valuable tool in the long-term response to this threat. Local, culturally-competent informational campaigns have had demonstrated success[5,6] in the H1N1 pandemic response of 2009 and have yielded valuable strategic lessons for future events.

Be aware and consider the possibility of black swan events

Public health events typically take on two presentations of onset: 1) sudden impact; or 2) subtle, slow onset with ongoing and persistent effects[6]. Public health events typically differ from conventional emergencies in the nature of onset, visible damage, environmental persistence and the geographic spread. Additionally, a public health event may peak in intensity several times over months-to-years after its emergence, whereas conventional emergencies such as tornados or earthquakes peak in intensity within a very limited time period.

During the past 20 years, the U.S. has experienced numerous public health emergency events. These events were characterized by consequences that were explainable in retrospect; however, at the time of their occurrence these "black swan" events challenged the local and regional resources beyond their normal capacities. In 2003, the world watched as Toronto combatted a SARS outbreak. Again in 2009, the U.S. braced for the near-miss H1N1 pandemic, and in 2013 unusually high seasonal influenza rates pressured already stressed healthcare resources. In 2014, multiple waves of response are still underway as an unusually brutal winter season hammered the east coast early on while Enterovirus D68 moved across the country and Ebola took its place on news headlines. Consider these experiences and focus on embracing the "black swan event" concept for healthcare incident management and assist in developing a local capacity for "surprise management."[7]

Get involved

Current public health emergency preparedness (PHEP) and healthcare preparedness (HPP) programs are based on the 15 CDC-mandated core capabilities. PHEP capabilities were first established in 2002 under the technical guidance of the CDC, post-9/11. The original capabilities were strongly focused on an act of terrorism. Since that time, the core capabilities list has expanded to the current 15 that stand today. Although strongly influenced by the original terrorist planning paradigm, the current capabilities list has shifted to an "all-hazards" approach. The overarching theme behind the PHEP/HPP programs are the development of a public health / hospital preparedness network within communities that include stakeholders from all levels to address the 15 core capabilities.

The Montgomery County Health Department (MCHD) has undergone a series of successful planning, exercise and evaluation events related to its PHEP programs. The MCHD PHEP programs are based on a decentralized model of key partnerships with healthcare providers, healthcare facilities, and community stakeholders as well as academic institutions.

Several public health emergency response tools have been developed and are based on these partnerships. Recently tested in a regional full-scale exercise, community stakeholders coordinated and operated public points of dispensing sites (PODS) for mass medication dispensing. Some of the exercise participants included local health professionals who volunteer their professional skills and credentials as an active part of the Medical Reserve Corps (MRC). Demonstrated during exercise play, the resounding theme is that managing "Black Swan" events will require the whole-community planning effort, both in the immediate response phase, and for

the long-term recovery often necessary for public health emergencies.

Conclusion

While the future remains uncertain with regard to emerging infectious disease threats, we should embrace randomness and acknowledge the improbable events as being possibilities. Subtle anomalies to expected events such as local springtime flooding may lead to an unprecedented boil-water-advisory, affecting thousands of residents as well as hundreds of businesses and healthcare entities. We should continue to seek expert guidance and advice, but beware that we do not blindly follow this guidance without questioning its applicability and offering alternatives. Public health emergency planning is simply a paradigm associated with health initiatives planning that ultimately embraces "Black Swan" events.

To learn more about public health emergency preparedness (PHEP) programs in Montgomery County, contact Brian Pasqual, BPasqual@Montcopa.org, senior public health emergency planner for the Montgomery County Health Department. He can also be reached at (610) 278-5117, ext. 6722. MCHD is located at 1430 Dekalb St., Norristown, PA 19401. ■

References

1. World Health Organization. Media Centre. Ebola Virus Disease. November 24, 2014.

2. Taleb NN. *The Black Swan.* New York: Random House; 2007.

3. CDC. Imported Lassa Fever. *Morbidity and Mortality Weekly Report.* October 2004;53(38):894-897.

4. Farber M, Rogol M. The Black Swan: The Impact of the highly improbable. *PHOTON International.* 2008:72-78.

5. Kapur GB, Smith JP. *Emergency Public Health.* Sudbury: Jones and Bartlett; 2011.

6. Landesman LY, Weisfuse IB. *Case Studies in Public Health Preparedness and Response to Disasters.* Sudbury: Jones and Bartlett; 2014.

7. National Center for Biological Research and Training. *Community Healthcare Planning and Response to Disasters.* Vol 1.3. 1 ed. Baton Rouge: Louisiana State University; 2013.

Feature

PMSCO HEALTHCARE CONSULTING

First Impressions for the Front Desk

BY LYNNE GROTE BREIL, CSP

I know a little about first impressions. It's a foundation for our consulting practice where we specialize in "people skills." My recent visit to the doctor's office went like this:

Me: *[With an authoritative voice, ready to let them know this appointment is costing me money and time]* "I'm Lynne Breil, here for my 10:45 appointment."

Front Office Attendant: "Hi. Which doctor?"

Me: "Dr. Spock." [*Names changed to protect the accused.]*

Front Office Attendant: [*Eyes fixed on computed monitor]* "Your appointment was for 10 a.m." [Scanning computer screen] He's with other patients now, so he can't take you right away." *[Pausing…waiting for me to admit my mistake]* "We have to take care of other patients who were here earlier. You can wait in the reception area and I'll let you know when you can see the doctor."

Me: *[Exhaling audibly and rolling my eyes]* "But I got a call from you yesterday and they said 10:45 was my appointment time."

Front Office Attendant: *[She's clearly had this issue before…]* "If it was an automated call, those calls don't come out of this office so I don't know who it was that called you."

Me: *[Checking my phone frenetically to find the voice mail so I can prove my point.]* "Well, whoever it was said 10:45. I can't find the message now but I ***know*** that's what they said. Do you have any idea how long I might have to wait?"

Front Office Attendant: "I don't. I have to check with the doctor, and he is with other patients right now."

Let's talk first impressions. Did the front office attendant make a positive connection with me? (Regardless of whether I was right or wrong…) The short answer: No. Connecting positively (first impressions = lasting impressions) is the responsibility of whomever sees the patient first.

Here are three important steps for gatekeepers and front line staff to create a positive first impression whenever patients enter your office:

1. Use a service statement when you greet the patient. Start with a "Good morning" or "Good afternoon," followed by a service statement, like: "How can we help you?" (Use the collective pronoun "we" because it gives the impression that all professionals in your office work together to help patients.) We train front line staff to always use service statements on the phone and face-to-face.

2. Make a visual connection with them. Use eye contact, smile, and keep an open body language. Nothing communicates importance more than when you look at someone. A smile is the universal facial expression of 'acceptance.' Open body language dictates that you turn your body toward the person you're talking to, rather than keep it in the direction of a computer screen or a coworker on the other side of the glass window.

3. Take responsibility and show empathy. Take ownership of the issue your patient is presenting. Apologize for the mishap even if it wasn't your mistake. If the thought of taking responsibility for problems you didn't cause bothers you, remember that this is key to great service. And it's the gospel of legendary service institutions like Nordstrom's and Ritz Carlton Hotels. Showing empathy or understanding by saying, "I understand how frustrating that can be… why you're confused... etc.," goes a long way to calming an upset patient.

Let's re-play that part of the scenario with a diagnosis for a more satisfying patient encounter:

Me: *[Exhaling audibly and rolling eyes]* "But I got a call from you yesterday and they said 10:45 was my appointment time."

Front Office Attendant: "10:45?"

Me: "Yes, I'm positive."

Front Office Attendant: "We're sorry about that. We have 10 a.m. in our schedule here, but let me see what I can do to help you now." *[Apologizing to set the tone, and then taking ownership]*

Me: "Thanks, but you guys should get your schedules straight with the person who calls patients." *[This doesn't always work the first time…]*

Front Office Attendant: "You're right. I understand why you're upset when you were given one time and we had another. Now that you're here, let me see what I can do while you wait in our reception area. Is that all right with you?" *[Showing empathy/understanding; taking ownership, seeking approval from the patient]*

Instead of standing your ground or telling a patient what you can't do because of whomever's mistake it was, tell them (in a kind voice) how you're going to help or how you can help them.

What mattered to me in this instance – and what matters to most patients at the time of a problem – was what you will do to solve the problem right then and there. When it comes to handling a problem with an upset customer, a training colleague of mine uses the phrase, "If you explain [how and why the problem happened], it will be in vain." She's so right.

My wait for the doctor that day, after all the fuss, was only 10 minutes. It turned out fine. What happened when I first arrived, however, has stayed with me. First impressions are like that, and bad first impressions take a lifetime to undo. Patient service statistics show that more patients tell others about bad experiences than good ones.

You can't overdose on good patient service. Remember these three important steps to make first impressions with your patients positive. If these three do not work the first time, repeat the process again, and call me in the morning. ■

Lynne Grote Breil is the owner of a local communication skills firm. If you'd like to get in touch with Lynne, contact PMSCO Healthcare Consulting (PMSCO) via electronic mail at experts@consultPMSCO.com. Located in Harrisburg, PA, PMSCO is a subsidiary of the Pennsylvania Medical Society and provides a variety of consulting services for physicians and medical practices. For more information about PMSCO, visit www.consultPMSCO.com.

CPOE and 'Any Licensed Health Care Provider': Who Might That Be?

BY CAROL BISHOP, ASSOCIATE DIRECTOR, MEDICAL PRACTICE SUPPORT DIVISION, PENNSYLVANIA MEDICAL SOCIETY

With Stage 2 meaningful use (MU) reporting period around the corner, the Computerized Provider Order Entry (CPOE) has put a lot of practices in a quandary—especially about medical assistants' certification.

The final rule, dated Sept 4, 2012, from CMS clarifies that: "Any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines, can enter the order into CEHRT (certified electronic health record technology). We finalize the more limited description of including credentialed medical assistants. The credentialing would have to be obtained from an organization other than the employing organization."

There was some question as to whether scribes would fall under the category of "any licensed health care professional." However, CMS also clarified this by stating, "We do not believe that a layperson is qualified to do this, as there is no licensing or credentialing of scribes, there is no guarantee of their qualifications."

What about CPOE for laboratory and radiology orders?

The Stage 2 requirements for CPOE in 2014 have now added laboratory and radiology orders.

Computerized entry is required for 60 percent of medication orders, 30 percent of laboratory orders and 30 percent of radiology orders—excluding eligible providers who write fewer than 100 medication, radiology, or laboratory orders during the EHR reporting period.

To ensure that you comply, you must evaluate your ordering workflow, including the use of CPOE.

What happens with my MU attestation that I've already submitted?

Many practices are concerned that they're behind the eight ball already because they did not find out about the final rule (dated Sept. 4, 2012) until the beginning of 2014, as it went into effect Jan. 1, 2013.

One of their most pressing questions is, what happens with the MU attestation that I've already submitted? The answer: Relax.

For Stage 1 2013 CPOE criteria, the measure requires at least one medication order entered using CPOE for more than 30 percent of all unique patients with at least one medication in their medication list seen by the eligible provider. Eligible providers have more than likely met this measure on their own by using electronic prescribing.

Practices have a lot of decisions to make in a short period of time.

The final rule has left many practices scrambling. Are all our medical assistants credentialed? How do we get them recredentialed? Are our front office staff and referral scheduling staff eligible for any type of credential? Our medical assistant did not graduate from an accredited program—what option is available for him or her?

What about credentialing for MAs, front office staff, and others?

Physicians depend on their clinical staff and certain front office staff to assist with laboratory and radiology orders under their delegation so that they, in turn, can see more patients in the course of a day.

*For staff who **did not** graduate from an accredited MA program:*

Let's start with your practice's front office staff, referral scheduling personnel, and medical assistants who did not graduate from an accredited medical assisting program. They can meet the CMS criteria to enter CPOE under the MU incentive program through the Assessment Based Recognition in Order Entry Program (ABR).

The ABR is granted by the continuing education board of the American Association of Medical Assistants (AAMA) to applicants who meet eligibility criteria and submit required documentation and a completed application. Those interested in pursuing the ABR will need to have knowledge in skill sets such as anatomy and physiology, basic laboratory values, critical thinking, electronic health records, HIPAA, medical terminology and pharmacology. They must be employed for a minimum of 2-3 years in a health care facility and successfully complete five, one-hour CEU courses which consist of:

- Clinical laboratory testing
- Disease screening
- Legal aspects of patient care documentation
- Lost in translation: Eliminate medical errors
- Medical records: A vital wave

Successful completion of this course does not provide the applicant with any type of certification and may not be used as a credential; no fancy suffixes can be appended behind the applicant's name. It is simply an official recognition of the holder's qualifications to enter CPOE into the EHR under CMS's rules and is good for 24 months. For more information go to http://www.aama-ntl.org/continuing-education/abr-faqs.

*For medical assistants who **are** graduates of an accredited school:*

The medical assistants in your practice who have graduated from an accredited school and have never taken their test to become certified will need to furnish their original transcripts. The certifying board reserves the right to request a copy of the diploma, degree or certificate at any time. Find information about how to take the certification exam at http://www.aama-ntl.org/cma-aama-exam/faqs-certification.

The medical assistants in your practice who were previously certified but have let their certification lapse for more than 60 months must retake the certification test. Find more information at http://www.aama-ntl.org/continuing-education/faqs-recertification.

Hopefully, we've answered some of the top questions so that practices can meet CMS's requirements to move forward in compliance with CPOE for Meaningful Use reporting. ■

For more information, contact the PAMED Medical Practice Support Division at (800) DOCHELP.

$200 Million Returned to Physicians, Hospitals and Health care Providers

Pennsylvania Medical Society President Karen Rizzo, MD, points to the recent Mcare settlement as just one of the reasons why all physicians should join the state and county medical societies. "Without PAMED and our partners on their side, impacted physicians may not have found justice," she said of the settlement. "This is a valuable benefit to membership," she said. "Without a strong membership, physicians do not have a strong voice in Harrisburg."

Dr. Rizzo urges PAMED leaders and members to use the following talking points as a guide when speaking to colleagues and others about the settlement:

- On Oct. 16, PAMED, in coordination with the Hospital and HealthSystem Association of Pennsylvania (HAP) and the Pennsylvania Podiatric Medical Association (PPMA), announced the settlement of our litigation regarding the Mcare Fund.
- This litigation included our appeals of the 2009-2014 assessments and the challenge to the transfer of $100 million to the general fund from Mcare in 2009.
- This historic agreement means that $200 million will be returned to physicians, hospitals, and other health care providers who paid assessments into the fund.
- Of the $200 million:
  - $139 million will be returned in refunds for prior assessment overpayments
  - $61 million will be returned via a reduction to the 2015 Mcare assessment
- As part of the settlement agreement, PAMED and HAP will withdraw our challenge to the 2009 diversion. However, the settlement includes key protections against any future diversion. Moving forward, the commonwealth has agreed that Mcare funds will be held in trust and will not be considered the general revenue of the commonwealth.
- The commonwealth also has agreed to operate the fund on a pay-as-you-go basis going forward. This means that health care providers will not be required to put money into the fund until it is needed and the fund will not be able to build up substantial reserves such as those diverted in 2009.
- Here are answers to the most frequently asked questions so far:

• Who is eligible for the refunds?

Physicians will be eligible for a refund if they paid an Mcare assessment (or an assessment was paid for them) for any time during 2009, 2010, 2011, 2012, or 2014 (excluding 2013). Some physicians have multiple primary policies and pay multiple assessments, so they would get a refund for each policy in each year that is covered.

• Why is 2013 excluded?

Refunds are for overpayments. Looking at assessment calculations over the years, it was determined that there weren't overpayments in 2013, which is why there are no refunds for assessments paid in 2013.

• We employ midwives. Will they be eligible?

Yes, any health care provider who paid an Mcare assessment for the covered years will be eligible.

• When will I get my refund?

The refunds may not be made until 2016 due to the extensive calculations required to determine the amount payable to each eligible health care provider and the large number of providers that will be eligible for a refund. However, the 2015 assessment will be reduced by about $61 million (about one-third).

- **Will I be required to remit my refund to an employer who wrote the check for my assessments?**

This will vary depending upon your circumstances. For example, even though an employer wrote the check, you may have ultimately borne the cost due to an overhead reduction from your compensation pool. The settlement does not impact any contractual or other obligation that a health care provider may have to remit a refund.

- **How much will the refunds be?**

This will vary depending upon the years in which you paid an assessment and the amount of the assessments that you paid. A percentage reduction will be calculated for each year and you will receive a refund for each year in direct proportion to the assessment that you paid. For example, for 2011, the reduction is expected to be in the vicinity of 25 percent. So if you paid a $1,000 assessment, your refund for 2011 would be $250, but if you paid a $10,000 assessment, your refund for 2011 would be $2,500.

- **I'm going to be retired at the end of this year. As a retiree, will I be part of this?**

If you were practicing at any time from 2009-2014, you will be eligible for a refund for those years, excluding 2013. Since you will not be practicing and paying an assessment next year, you will not share in the 2015 prospective assessment relief.

- **I was talking to my state representative, and he doesn't know where the money will come from.**

Right now, the money is in the Mcare Fund. This is not money the state is repaying back to the Mcare Fund. It's money that has accumulated in the Fund as a result of over charges. The commonwealth has agreed that there is $200 million in the Fund for this settlement (above what is needed for 2014 claim payments and expenses).

Get the latest at www.pamedsoc.org/mcare. ■

Information provided through PAMED's Business of Medicine Series

Feature

MCMS Happenings

Share Your Passion Outside Medicine – A year ago, MCMS launched this new quarterly publication, *MCMS Physician.* A hearty thanks to all who have contributed articles to the publication. In addition to providing education about issues important to the profession, one main goal is to give a voice to the physicians of our community. This is your magazine. Your input is needed to provide a top-notch publication that addresses the concerns of your profession, your practice and your community. Editor Jay Rothkopf, MD, encourages physicians to submit articles for the publication. If there's an issue you feel passionate about, or love to write, but have never been published, please feel free to send an article. For more information or to send articles or ideas, please contact our Executive Director, Toyca Williams, at montmedsoc@verizon.net.

MCMS Hosts Financial Seminar – On Nov. 18, MCMS hosted a free dinner, wine tasting and financial seminar on retirement planning for physicians and their staffs. Attendees had an opportunity to hear sound advice from top wealth management experts, financial advisors and fund managers. Joe Allen of the Allen Investment Group of Raymond James provided the speakers and sponsored the dinner and wine tasting. MCMS is planning to host a seminar on asset protection in the spring. For more information, contact Toyca Williams, MCMS Executive Director, montmedsoc@verizon.net.

Join the Delegation for Annual Legislative Dinner – The MCMS Political Committee is planning its annual dinner with Montgomery County legislators. The evening dinner will be in Harrisburg, April 20. If you are interested in connecting with your legislators and would like to join the delegation, contact Toyca Williams, MCMS executive director, at montmedsoc@verizon.net or by phone at (610) 878-9530.

MCMS Awards Scholarships to Three Medical Students – MCMS selected three first-year medical students to each receive $2,500 scholarships. The three students, longtime Montgomery residents and now members of the county medical society, are John D. Arena, University of Pennsylvania Perelman School of Medicine; Alexis J. Lukach, University of Pittsburgh School of Medicine; and Diana Z. Li, Temple University School of Medicine. The students will be recognized for their achievements at the 2015 Annual Membership Dinner, June 3.

Looking for an Adventure Story, Good Food and Fellowship – Save the date for the MCMS Annual Membership Dinner, Wednesday, June 3, William Penn Inn in Gwynedd. Erin Lally, MD, who scaled Mt. Everest during her senior year of medical school, will share her story. Dr. Lally was featured in the Fall issue of *MCMS Physician*. "I felt like I could touch heaven. I was standing in a cloudless sky of brilliant blue, yet my feet were on solid ground. Looking down on the rest of the world, I felt invincible yet was reminded of my mortality by my heavy, labored breathing and numb fingertips and toes," she said. Read more, www.montmedsoc@verizon.net.

MCMS Will Honor Twelve 50-Year Members – Another highlight of the upcoming annual membership dinner is recognizing 12 members who have served as physicians for 50 years. The honorees are Hack R. Chung MD; Walter I. Hofman MD; Bruce D. Hopper MD; Marvin H. Kromash MD; Thomas D. Mull MD; Bruce E. Northrup MD, FACS; Thomas C. Sansone MD, FACS; Phlip S. Schein MD; Robert C. Schmutzler III MD; Joel L. Schwartz MD; Carol P. Webber MD; and Richard D. Weiss MD. Mark your calendar, June 3, William Penn Inn, Gwynedd.

Members Represent MCMS Well at PAMED House of Delegates – Thank you to the delegates who represented MCMS at the Oct. 18-19 PAMED House of Delegates meeting in Hershey: Frederic S. Becker MD; William N. Bothwell MD, FACS; Charles Cutler MD, MACP; Madeline A. Danny DO; James Goodyear MD, FACS; George R. Green MD; Walter I. Hofman MD; Brad C. Klein MD, MBA; Mark A. Lopatin MD; Barry Snyder MD; and James W. Thomas MD, MBA. A special thank you to members of MCMS who served in other capacities: Speaker of the House – Martin D. Trichtinger MD; Reference Committee D – James W. Thomas MD; Reference Committee E – Jay E. Rothkopf MD; Teller – Mark A. Lopatin MD and Committee on Rules and Credentials, George R. Green MD.

Congratulations to MCMS Leadership – Scott E. Shapiro MD as the president-elect of PAMED, Charles Cutler MD elected as vice president of PAMED, Martin Trichtinger MD re-elected as speaker of the House, James A. Goodyear MD re-elected to AMA delegation and William Lander MD re-elected to the Judicial Council.

MCMS Members Welcomed To Attend Board of Directors Meeting – The next board of directors meeting is Tuesday, Jan. 6, 6 p.m., MCMS office, 491 Allendale Road, Ste. 323, King of Prussia. If you are interested in attending a board meeting, contact Toyca Williams, MCMS executive director, montmedsoc@verizon.net or call (610) 878-9530. The MCMS Board represents you. For a listing of board members, visit the MCMS web site, www.montmedsoc.com.

MCMS Physicians Participate in Docs on Call Program – Seven MCMS physicians, along with their colleagues from the Philadelphia County Medical Society, fielded approximately 350 calls from CBS-3 viewers during the Oct. 28 broadcast of "Docs on Call." For 11 years, the Pennsylvania Medical Society has coordinated this valuable public service program for viewers in Southeastern Pennsylvania. Those who called during CBS-3's evening news broadcast represented a broad range of ages, and asked about a variety of health-related topics, with Ebola questions being the most prevalent. Thank you to the following MCMS members for volunteering for "Docs on Call": Madeline Danny DO, Internal Medicine; Steven Domsky MD, Cardio/Pulmonary; Michael Feinberg MD, Psychiatry; George Green MD, Internal Medicine; Mark Lopatin MD, Rheumatology; Angela Nicholas MD, Family Medicine; and Geeta Sathe MD, Physical Medicine. ■

Welcome New Members…

MCMS is pleased to welcome the following individuals who joined the Society in 2014:

To publish photos of new MCMS member physicians, please submit digital copies to montmedsoc@verizon.net

January 2014
Stuart Z. Dershaw, MD
Sandeep Dhand, MD
Kyle Solomon, MD

February 2014
Allen Chiang, MD
LaMar Christian, Medical Student
Luciano Lorenzana, MD
Sonia Mehta, MD

March 2014
Jerilyn Custer, Practice Administrator
Annie Wang, DO

April 2014
Lee P. Adler, MD
Mark Anderson, MD
Marcus E. Carr, MD
Steven M. Domsky, MD
Rotem Friede, MD
Hasan S. Khawaja, MD
Annie N. Kotto, MD
Ravi J. Kumar, MD
Mark L. Sobczak, MD

May 2014
Joan M. Addley, DO
Tulin Budak-Alpdogan, MD
Amy J. Aronsky, DO
Antonio D. Marrero, Medical Student
Michael Rachshtut, MD
Gerald F. Tremblay, MD

June 2014
Regina H. Kurrasch, MD
Ramona F. Swaby, MD

July 2014
Michael D. Esrick, MD
Benjamin Noh, MD
Nancy D. Sarvet-Haber, MD
Karen P. Zimmer, MD

August 2014
David H. Duong, MD
Alexis J. Lukach. Medical Student

September 2014
Susan B. Giesecke, MD
Pravin A. Taneja, MD

October 2014
Christina M. Abraham, MD
Jeffrey M. Blatt, MD
Anthony J. Cannon, MD
Thomas R. Comerci, MD
Deepakraj Gajanana, MD
Andrew E. Graf, DO
Lauren W. Milman, MD
Parminder S. Minhas, Med Student
Joseph L. Neri, DO
Paul M. Neumann, MD
Charles L. Nguyen, DO
Pragna P. Patel, MD
Amy Sheng, Administrator
Christopher P. Tarassoff, MD
Kristin Varacalli, DO
Seema B. Vasu, DO

November 2014
Jack E. Gitterman, MD
Kandan Kulandaivel, MD
Parminder S. Minhas, Med Student
Philip E. Silkoff, MD

Allen Chiang MD

Annie N. Kotto MD

Mark L. Sobczak MD

Alexis Lukach, Medical Student

Necrology Report

MCMS regrets the loss of these society members since June 2014.

A. Anthony Arce, MD
B. David Grant, MD, FACS
William W. Wilson, MD

Proud to be endorsed by the Montgomery County Medical Society

NORCAL MUTUAL®

SAY HELLO TO NORCAL

EXPERIENCE THE MUTUAL BENEFIT

NORCAL Mutual Insurance Company is now in Delaware! Same exceptional service and enhanced products previously offered by our subsidiary, **PMSLIC Insurance Company**, plus the added benefit of being part of a national mutual. As a policyholder-owned and directed mutual, you can practice with confidence knowing that we put you first. **Contact an agent/broker today.**

HELLO.NORCALMUTUAL.COM | 844.4NORCAL

PMSLIC®

MEDICAL PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS BY PHYSICIANS