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MEDICINE
VOLUME 43, NUMBER 4 AUGUST / SEPTEMBER 2021

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St. Louis Metropolitan Medicine (ISSN 0892-1334, USPS 006-522) is published bi-monthly by the St. Louis Metropolitan Medical Society, 1023 Executive Parkway, Suite 16, St. Louis, MO 63141; (314) 786-5473, FAX (314) 786-5547. Annual Subscription Rates: Members, $10 (included in dues); nonmembers, $45. Single copies: $10. Periodicals postage paid at St. Louis, MO. POSTMASTER: Send address changes to: St. Louis Metropolitan Medicine; 1023 Executive Parkway, Suite 16, St. Louis, MO 63141.

Advertising Information: www.slmms.org/magazine, or editor@slmms.org or (314) 786-5473. Online copies of this and past issues are available at www.slmms.org/magazine.

Printed by Messenger Print Group, Saint Louis, MO 63122.

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Today's Medical Office Staffing

Features

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News

Responding to Vaccine Hesitancy

Spike in Missouri COVID-19 cases is cause for concern; how physicians can help

Jennifer L. Page, MD, President, St. Louis Metropolitan Medical Society 2021

Jennifer L. Page, MD

The greatest investment now for our community is to support the COVID-19 vaccination effort. Unfortunately, there have been efforts to keep vaccines out of arms by reinforcing misinformation about the safety and effectiveness of the vaccines and spreading disinformation.

My parents both lost their hearing in early childhood with profound bilateral sensorineural hearing loss following a viral illness. They were unsure if it was mumps or measles, but we knew it was a childhood illness that could now be prevented—all thanks to science and vaccines. Since we used sign language, even with a communication barrier, my parents knew the value of vaccines from our pediatrician, and my brothers and I did not miss our shots.

We now have vaccines to prevent more than 20 life-threatening diseases, helping people of all ages live longer, healthier lives. Immunization currently prevents two to three million deaths every year from diseases like diphtheria, tetanus, pertussis, influenza and measles.[1] Immunization is a key component of primary health care and an indisputable human right. It is one of the best health investments for our community.

The greatest investment now for our community is to support the COVID-19 vaccination effort. Unfortunately, there have been efforts to keep vaccines out of arms by reinforcing misinformation about the safety and effectiveness of the vaccines and spreading disinformation.

As I write this article, there has been a spike in COVID numbers in Missouri because of the delta variant. Missouri has recently been the number-one state in the nation for the rate of new COVID-19 cases. That is in a large part due to low vaccination rates in rural areas. Greene County, which includes Springfield, has a vaccination rate of only 38%. On the other hand, St. Louis and St. Charles counties have among the highest percentages of those completing vaccination across the state at 49% and 47%, with the City of St. Louis at 45%.[2]

However, as we know, like any variant of this virus, it spreads quickly and pays no mind to state, county or city borders. Cox Health System in Springfield is now on "COVID diversion," transferring patients from their overwhelmed hospital to Kansas City and St. Louis, as the delta variant gains momentum in the southwest part of the state. This coincides with where there are large swaths of residents who are not vaccinated.[3]

As of this writing, all four of the St. Louis-area's major hospital systems, including BJC, SSM Health, Mercy and St. Luke's, will require employees to be vaccinated against COVID-19. Both Saint Louis University and Washington University will require students and staff to be fully vaccinated in the fall.

Ethical Guidance for Physicians on Vaccines

The AMA addressed vaccine hesitancy in the AMA Council on Ethical and Judicial Affairs report adopted at the November 2020 AMA Special Meeting of the House of Delegates. The new ethical guidance for physicians on vaccines include:

- Physicians who are not immunized from a vaccine-preventable disease have an ethical responsibility to take appropriate actions to protect patients and colleagues.
- Physicians and other health care workers who decline to be immunized with a safe and effective vaccine, without a compelling medical reason, can pose an unnecessary medical risk to vulnerable patients or colleagues. Physicians must strike an ethical balance between their personal commitments as moral individuals and their obligations as medical professionals.

- The AMA Code of Medical Ethics has long maintained that physicians have a strong ethical duty to accept immunizations when a safe, effective vaccine is available. This is especially true when a highly transmissible disease poses significant risks to patients and colleagues.
- However, it is not ethically problematic to exempt individuals when a specific vaccine poses a risk due to underlying medical conditions.
- The ethical opinion adopted by the AMA House of Delegates says that doctors "have an ethical responsibility to encourage patients to accept immunization when the patient can do so safely, and to take appropriate measures in their own practice to prevent the spread of infectious disease in health care settings.[4]

The Rockefeller Foundation commissioned research to explore how to motivate high-priority audiences to get a COVID-19 vaccine. Concerns about the vaccine stemmed from three main factors: fear of side effects, reluctance to abandon or replace self-protection measures that work, and skepticism that the vaccines will be enough to end the pandemic.

Physicians know their patients' co-morbidities and their risk if they contract the COVID-19 virus. They have an established relationship and can have an open, frank discussion regarding the patient's risk of reaction, and discuss possible medical and religious exemptions.

Social proof of others getting vaccinated—and seeing tangible benefits that come with it—may play the most significant role in motivating people to put their fears aside. In focus groups with Black and Latina frontline workers, participants pointed to very practical barriers to vaccination. They highlighted barriers to medical care generally, as well as their desire to hear from messengers they trust—and who look like them—so they can feel more confident in the vaccine discussion.[5]

To adequately address vaccine hesitancy, widespread vaccine acceptance among all demographic groups will be imperative. Physicians must continue working to build trust in vaccine safety and efficacy, especially in marginalized and minority communities with historically well-founded mistrust in medical institutions.

Physicians Are Most Trusted Messengers

We know that the best messengers for vaccine safety and acceptance are close to home—patients' personal physicians. Various studies have shown people regard their individual physicians as their most trusted source of information on COVID-19 vaccination.[6,7]

Transparency is key to trust building—greater information about how vaccines work and how they were developed. Messaging should be open, honest and comprehensive. Physicians should advise their patients about possible side effects including lethargy, mild fever, body aches and pains. They should know that these side effects often mean the vaccine is working to establish immunity.

I inform my disabled patients of the importance of vaccination for COVID-19 and present an honest discussion of their risk of sequela if they become infected. Physicians know their patients' co-morbidities and their risk if they contract the COVID-19 virus. They have an established relationship and can have an open, frank discussion regarding the patient's risk of reaction, and discuss possible medical and religious exemptions.

To promote factual information around COVID-19 online, the AMA's COVID-19 vaccines guide for physicians contains background and actions, evidence-based messaging, guidance and best practices for consideration in external communications on COVID-19 vaccine topics.[8]

Missouri is the Show Me State. We need to show our patients how vaccines are safe and effective, and are the best way to protect our community. Patients trust us to treat them when they are sick, and they should come to us for vaccine advice.

Jennifer L. Page, MD, is medical director of the Acute Rehab Program at Mercy Hospital South.

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Medical Society Statement Urges COVID-19 Vaccination

On July 7, SLMMS released a statement to the media urging all eligible persons to obtain the COVID-19 vaccine if they haven't done so already. Following is the text of the statement:

As the rate of COVID-19 infections escalates in southwest Missouri including the delta variant, threatening the St. Louis region, the physicians of the St. Louis Metropolitan Medical Society (SLMMS) encourage all who are eligible to obtain a COVID-19 vaccine.

To address vaccine hesitancy, and ultimately achieve herd immunity, widespread vaccine acceptance across all demographic groups will be imperative. Physicians are working to build trust and acceptance of the vaccine, especially among groups who are the most vulnerable. The Medical Society supports outreach efforts to deliver vaccinations to these vulnerable populations.

Studies show that patients regard their individual physicians as their most trusted source of information on COVID-19 vaccination. Physicians have the appropriate information to help others feel more confident about the vaccine and show that they are safe, effective and the best way to protect our community.

Getting the vaccine is a powerful step in taking charge of your health. Getting vaccinated also enables you to protect those around you, especially older people and those living with chronic health conditions, who are more likely to experience severe cases of COVID-19 if infected.

The Medical Society especially urges younger adults and teens to get the COVID-19 vaccination, since recent new cases, hospitalizations and deaths have been much higher among younger people.

The benefits of the COVID-19 vaccine far outweigh the risks for most everyone – ask your doctor if the vaccine is right for you. Without safe and available vaccines, we will never defeat the virus, and getting vaccinated enables you to protect yourself and those you love. We are all in this together.

MSMA, State Medical Groups Issue Vaccine Statement

The Missouri State Medical Association and other medical groups across the state issued the following statement on July 16 urging COVID-19 vaccination.

Due to the increasing prevalence of the delta variant in Missouri, the state's physicians strongly encourage its citizens to receive the COVID-19 vaccination. For the great majority of patients, the vaccine is safe and effective, and the easiest way to slow the spread of the delta variant. Your physician can answer questions about the vaccine.

As the disease continues to spread and tax the state's health systems, we encourage simple acts that can help stop the virus: practice social distancing when possible, voluntarily wear a mask in public places, and get tested if you feel sick. Doing these things will lessen the burden on our hospitals and help ensure our communities and neighbors are healthy and safe.

You can find more information on COVID-19 and the vaccine at www.MOstopsCOVID.com.

- Missouri State Medical Association
- Missouri Association of Osteopathic Physicians & Surgeons
- Missouri Academy of Family Physicians
- Missouri College of Emergency Physicians
- Missouri Chapter, American College of Physicians
- Missouri Chapter, American College of Obstetricians & Gynecologists
- Missouri Dermatological Society
- Missouri Psychiatric Physicians Association
- Missouri Society of Anesthesiologists
- Missouri Society of Eye Physicians & Surgeons
- Greene County Medical Society
- Kansas City Medical Society
- St. Louis Metropolitan Medical Society

COVID-19 Vaccine: Now Is the Time

Resources for Physician-Patient Education

Attention physicians: Please encourage your patients to get the COVID-19 vaccine. During the coming weeks, it will be critical to vaccinate as many people as possible—so we can reach that much-desired goal of herd immunity (75-80%) as quickly as we can.

Why get the vaccine?

It's safe.

Over 130 million vaccine doses have been administered in the U.S. to date.

Protect your family.

Avoid infecting family members, especially those with health risks.

Protect yourself.

Don't risk serious illness.

Protect the community.

The sooner most of us get immunized, the sooner that life can return to normal.

Where can I get the vaccine?

Hospital Systems

- BJC HealthCare – https://www.bjc.org/Coronavirus/Covid-19-Vaccines
- Mercy – https://www.mercy.net/forms/vaccinations/
- SSM Health – https://webforms.ssmhealth.com/covidvaccine
- St. Luke's Hospital – https://lukesvaccine.com/

Health Departments

- St. Louis County – https://stlcorona.com/covid19-vaccines/ or 314-615-2660
- City of St. Louis – http://bit.ly/stl-vacc or 314-612-5100
- St. Charles County – http://bit.ly/scc-vacc or 636-949-1899
- Jefferson County – https://www.jeffcohealth.org/covid19-vaccine or 636-797-3737

Pharmacies and Retail

- CVS – https://www.cvs.com/immunizations/covid-19-vaccine
- Walmart – http://bit.ly/wm-vacc
- Missouri Pharmacy Program (independent pharmacies) – http://bit.ly/mopharm
- Walgreens – https://www.walgreens.com/findcare/vaccination/covid-19

State of Missouri Vaccination Events

- https://covidvaccine.mo.gov/navigator/ or 877-435-8411

ST. LOUIS METROPOLITAN MEDICAL SOCIETY

MSMA Legislative Update

What happened in the 2021 Legislative Session that will affect Missouri physicians?

Tuesday, September 21 | 6:00 p.m. via Zoom

This year's Missouri legislative session was driven by COVID-19—from the legislation that was filed to the antics that were used to try to push legislation through. You couldn't take two steps in the Capitol without someone using the pandemic as a tool. Although this resulted in multiple curve balls being thrown, the MSMA lobbyists worked hard to push through legislation that supports the physicians of Missouri as well as block hostile laws from passing.

SLMMS invites you to join the MSMA lobbying team on Tuesday, September 21 at 6:00 p.m. via a Zoom webinar to receive a recap of the 2021 legislative session and what new laws are impacting the practice of medicine in Missouri.

To register, visit www.slmms.org and under Latest News, follow the links to register online. You will receive a link to join the webinar via Zoom in advance of the event. This event is free and open to all physicians, residents, medical students and others. You need not be a member of SLMMS or MSMA to participate.

Letter to the Editor

Another Perspective on the Equality Act

I find both the "Parting Shots" article by Dr. Gimpelson and Dr. Cornella's response interesting and feel both have valid and reasonable perspectives. I would like to add another perspective that I feel is neither critical nor supportive of either, but simply another opinion.

Like most things in the world, our usage of the English language has evolved over the years. The original and valid intents of many words have changed their meaning to coincide with changes in our culture. As examples, "rock" now is applied to a musical form as well as a behavioral norm, not simply a natural stone formation. "Cool" no longer is only a thermal paradigm, but now refers to personality, conduct, clothing, etc. So too, the "man" or "woman" usage was originally intended (IMHO) to be "XY" or "XX" but has evolved with changing social norms to be modified by "gender identity/orientation."

As an evolving culture/society, these changes should be accepted and respected, and be accorded all the legal rights and privileges associated with them. Unlike words, however, "XY" and "XX" imply a genotype, which (to my knowledge) cannot be changed despite acceptance of phenotype. Whether those phenotypes are for "XY" or "XX" (or some other alternative phenotypic assignment), the genotype (sometimes referred to as sexual assignment at birth) cannot be changed by social norms.

It seems to me, the problems occur because of semantics. Rather than assigning "men's" or "women's" restrooms, it could be simplified by assigning restrooms on genotype, not phenotype. Substitution of "XY" or "XX" vs. "man/men" or "woman/women" would resolve much of the problem. This would apply to the military or any other myriad of occupational or societal situations. With regard to athletic activities, the desire of "XYs" to compete against other "XYs," resulted in forming leagues based upon those genotypical criteria. When "XXs" decided to athletically compete against other "XXs," it resulted in forming leagues based upon those genotypical criteria. It seems to me, that if persons do not identify as "XY" or "XX," and wish to compete against like phenotypes, they might form leagues that would incorporate such phenotypes. "A league of their own," so to speak. Any such league should of course, be accorded all social, academic, financial, etc. benefits as any other leagues.

I have no problem with "XY" or "XX" leagues incorporating gender identities based upon other than phenotype, should they voluntarily decide to do so. I do have a problem with governmental policy imposing it upon them. I have no problem accepting people's differences, but strongly object to foisting such acceptance upon me. The difference between the two is basic to our constitutional "pursuit of happiness."

Gordon M. Goldman, MD, FACOG

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GENERAL SOCIETY MEETING INCLUDES COVID-19 VACCINATION UPDATE

Dr. Faisal Kahn, director of the St. Louis County Department of Public Health, will provide an update on COVID-19 vaccination efforts during the annual SLMMS General Society Meeting on Wednesday, September 1 at 6 p.m., via Zoom. All SLMMS members are invited to attend.

The General Society Meeting is an annual event where the slate of nominees for SLMMS offices proposed by the Nominating Committee is presented.

Pre-registration is required to receive the meeting link and information. If you are interested in participating, please register using the link at slmms.org, or email Dave Nowak, executive vice president, at dnowak@slmms.org and the registration link will be sent to you.

Agenda

- Call to Order
  President Jennifer L. Page, MD
- Nominating Committee Report
  Ravi S. Johar, MD, committee chair
- The committee will be recommending members for nomination to the following offices:
  - President-Elect
  - Vice President
  - Secretary-Treasurer
  - Councilors (4)
- Educational Presentation by Dr. Faisal Khan, Director, St. Louis County Department of Public Health discussing the county's vaccination efforts, followed by Q&A

General Society Meeting

Wednesday, September 1, 2021
6:00 p.m. via Zoom
Registration: slmms.org

Changes in 2022 MSMA and SLMMS Dues Billing

Due to rising administrative costs, MSMA and SLMMS will not be jointly invoicing members this year for their annual membership dues. For the past several years, many physicians who are members of both organizations have enjoyed the benefit and convenience of paying both dues from one invoice.

Physicians in District 3 will likely receive separate dues statements from SLMMS and MSMA this fall for payment of their 2022 dues. Although we realize this may be a slight inconvenience to some members, the steadily increasing financial burden on the organizations and reduced staffing requires this change. In addition, both organizations will be converting to new association management software systems that will make the individual billing more productive.

SLMMS members who previously paid only their local dues to SLMMS will not be impacted by this change.

Please know that your dues payments for both organizations ($395 for annual MSMA membership; $350 plus an optional $20 contribution to our charitable foundation for SLMMS dues) will not be changing this year. Both MSMA and SLMMS offer convenient options to pay your dues online via secure easy transactions. Contact the SLMMS office if you have questions.

We appreciate your understanding, and please know that this change will not impact the MSMA and SLMMS partnership. We look forward to representing your interests in Jefferson City during the 2022 legislative session.

Washington University Names Vice Chancellors

Dr. Eva M. Aagaard

Dr. Paul J Scheel Jr.

Three top administrators at Washington University School of Medicine in St. Louis have been named vice chancellors. **Eva M. Aagaard, MD**, has been appointed vice chancellor for medical education; **Paul J. Scheel Jr., MD**, has been named vice chancellor for clinical affairs; and **Richard J. Stanton** has been appointed vice chancellor for medical finance and administration. Dr. Aagaard, previously senior associate dean for education, joined the university in 2017 from the University of Colorado School of Medicine. Dr. Scheel, chief executive officer of Washington University Physicians, joined the university in 2017 from Johns Hopkins Health System.

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** "Typical rate charged by financial advisors" claim is based on a 2016 *InvestmentNews* study (http://blog.runnymede.com/how-much-to-pay-a-fee-only-advisor-a-look-at-average-annual-fees) showing an average advisor fee of 1.01% for an account valued at between $1 million and $5 million. Rates charged by financial advisors vary. Other fees and transaction costs apply. Similar services may be available from other investment advisers at a lower cost.

All indices are unmanaged and investors cannot actually invest directly into an index. Unlike investments, indices do not incur management fees, charges, or expenses.

This is a hypothetical example and is for illustrative purposes only. No specific investments were used in this example. Actual results will vary.

Effective Employee Onboarding: The Key to Higher Rates of Retention

Is your office's idea of onboarding a one-time event or an ongoing process that truly integrates new employees?

By Jeff Welch, Favorite Healthcare Staffing

One of the most stressful things in the lifecycle of an employee is the first day on the job. We've all been there. The first day on a new job evokes a range of emotions from excitement to nervousness. To help calm the nerves and acclimate new employees, high-performing practices and companies make it a priority to offer a robust onboarding experience.

Effective onboarding not only welcomes new employees into the organization but can also lead to higher rates of employee retention. Research conducted by the job search and review company Glassdoor found that organizations with strong onboarding processes improved new hire retention by 82%.[1]

Ideally, the onboarding experience should begin the moment the new employee walks through the door. They should receive tools, resources and networking opportunities that help them navigate their new role.

However, if that onboarding experience is not provided, "it's like blindfolding someone, throwing them into the middle of the ocean, then telling them to swim back to shore," says Kristel Haynes, director of human resources at Favorite Healthcare Staffing.

Effective onboarding ensures the new employee will be set up for success. Ineffective onboarding, however, leaves them feeling alone and vulnerable. And if these negative feelings occur early in the employee experience, the new employee will likely become disengaged. Disengagement can then lead to an employee who seriously considers leaving the job.

Jeff Welch

Jeff Welch serves as director of learning and development as well as director of diversity and inclusion for Favorite Healthcare Staffing. He holds a Bachelor of Arts degree in broadcast journalism and speech communications from Western Kentucky University. Welch currently resides in Atlanta, Ga. He can be reached at jwelch5@favoritestaffing.com.

So, what does an effective onboarding experience look like?

According to Dr. Talya Bauer from the Society of Human Resources Management (SHRM), successful onboarding addresses the four C's: compliance, clarification, culture and connection.[2]

Compliance

The aspect of **compliance** is addressed when the new employee attends the new hire orientation. Here, the employee has an opportunity to learn about the basic rules and policies of the organization. Time is also set aside for the employee to complete any necessary paperwork related to taxes and employee benefits like health insurance and retirement savings.

Typically, the organization's human resources team is tasked with addressing those compliance issues. According to Haynes, a 20-year HR veteran, the new hire orientation event "gives the employee an opportunity to review policies in a conversational manner versus simply giving them an employee handbook."

Clarification

New employees must fully understand their new role and responsibilities. This understanding typically takes place during the **clarification** phase of onboarding. Unlike the compliance-based new-hire orientation, the clarification phase is ***not*** a one-time event.

For an employee to get clarity on their new role, they might job shadow a colleague for several days to a week. They'll likely have multiple "check-in" conversations with their immediate manager or supervisor. And they might even attend various job-related training courses offered by the organization's learning and development department.

Culture

For new employees to feel the most engaged within an organization, "they need to understand the dynamics of the organization and the cultural expectations," says Haynes. An effective onboarding process gives the new employee insight into the shared values, practices and norms of the organization.

An effective onboarding process gives the new employee insight into the shared values, practices and norms of the organization.

For a greater understanding of company culture, new employees should be given opportunities to watch and listen. This could range from being given a tour of the building or campus to observing meetings and project groups without the responsibility of assignments.

New employees should be made aware of employee resource groups, e.g. women, veterans or LGBTQ networking cohorts. Lastly, they should also be allowed to freely ask questions in an effort to understand the organizational culture.

Connection

The **connection** phase of onboarding allows the new employee to develop relationships with other members of the organization. Since this phase is where the employee begins to feel included and part of the team, some argue that the connection phase is the most important part of the onboarding process.

In this phase, the new employee should be introduced to as many people as possible from their immediate co-workers to leadership. When it comes to interacting with members of leadership, "it's important the new employee gets to know the person, not just their title. This gives them an opportunity to understand the leader and their vision for the organization," says Haynes.

Events related to the connection phase are usually formal and take place within the workplace. However, don't underestimate the power of informal meetings that occur outside the workplace. New employees should be encouraged to go to lunch, attend team outings and join in social mixers with their new colleagues and associates.

Some organizations even have mentoring programs that are part of their onboarding process. To round out the connection phase, new employees are often assigned a mentor or buddy to answer questions and serve as a networking resource.

The four C's allow an organization to address onboarding from a holistic approach. And the concept is most impactful when the new employee reports to a traditional office environment. But what about remote employees?

The coronavirus pandemic has led to an increase in teleworking opportunities in many companies and organizations across the globe. Therefore, special considerations must be made when onboarding remote employees.

While the four C's are still applicable, according to Haynes, building and establishing personal relationships are even more critical in the case of remote workers. "You never want those employees to feel like they're on an island. Extra effort must be made when onboarding a remote employee, so they're made to

Continued on page 17

This article is provided through the Medical Society's partnership with Greater St. Louis Medical Group Management Association, www.mgmastl.org

Improving Diversity and Inclusion in the Workplace

How to overcome unconscious biases and aggressions that can make minority group members feel unwelcome

By Barbara Faupel, MA, FACMPE

Of the many tasks a physician's practice manager accomplishes on a daily basis, human resources can be the most time-consuming and tricky of them all. Challenges can include making sure you never say anything to an employee or patient that can be misconstrued in any way, taking the time to really listen to all points of view, and keeping the practice's stellar reputation intact at all times.

> Unconscious biases are stereotypes or beliefs that affect our actions in a discriminatory manner.

It is important to ensure your staff are well aware from day one of the practice's expectations concerning their conduct with patients and coworkers. Periodic staff meetings provide an opportunity to remind them of any new important changes. No matter how many staff are employed by your office, they all need to conduct themselves in a professional and respectful manner.

In the past year, the pandemic has shined a bright light on systemic issues that have been pushed forward with movements such as Black Lives Matter and #MeToo. We have seen working women having to stay home to take care of children who cannot go physically to school or day care, minorities being disproportionately affected by COVID-19 due to working in the more frontline jobs, and millions who are unemployed and without health insurance. Behind these injustices are systemic issues that run deep in America—including unconscious bias, microaggressions and intersectionality. More than just buzz words, these are important topics that all physicians and their practice managers need to understand and know how to deal with.

Unconscious Bias & Its Cost

Unconscious biases are stereotypes or beliefs that affect our actions in a discriminatory manner. Here are some examples:

- **Affinity bias** is showing preference for those who are similar to us.
- **Confirmation bias** is gathering information that supports our beliefs and biases while ignoring or undervaluing evidence that would disprove those beliefs.
- The **halo effect** is an initial positive impression that influences the overall perception of that individual.
- Lastly, **perception bias** is stereotyping individuals with whom we might not be as familiar and allowing those biases to affect our perceptions.[1]

Barbara Faupel

Barbara Faupel, MA, FACMPE, is the practice manager for Allergy Consultants in St. Louis. She is the 2020 MGMA Missouri Practice Manager of the Year and a past president of Greater St. Louis MGMA. This article was adapted from a webinar she gave to Greater St. Louis MGMA in spring 2021. She can be reached at barbara.faupel@stlallergy.com.

A sense of belonging increases the likelihood of a staff member being satisfied in their position at your practice.

Workplace prejudice often shows up in subtle ways, through microaggressions.[2] Microaggressions are brief everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group. These include: microinsults (being excluded from relevant meetings, being excluded or passed over for growth opportunities, etc.), microinvalidations (colleagues asserting that they are "color blind" or "don't see race," being mistaken for someone else of the same racial background, etc.), and microassaults (colleagues using racially insensitive language around them).

Intersectional differences are incredibly important to see when talking about diversity and inclusion. Intersectionality is the interconnected nature of social categorizations such as race, class and gender as they apply to a given individual or group. These create overlapping and interdependent systems of discrimination or disadvantage. Because people are unique, many identities are possible. As one example of a group with intersectional identity, black lesbian women experience discrimination as a response to their race, gender and/or sexual orientation. Therefore, their experience is unique from black straight and gay men and white straight and lesbian women.[2]

Microaggressions are brief everyday exchanges that send denigrating messages to people of color because they belong to a racial minority group.

The costs of bias include employees who burn out, bust out and/or blow up. Employees experiencing burnout can regularly feel alienated at work. They withhold ideas/solutions, are not proud to work for their companies, and do not refer people in their network to work at their companies. Employees looking to bust out plan to leave their employer within a year and actively look for another job while on the job. Employees who are at the blowing up stage discuss their companies in a negative light on social media and intentionally fail to follow through on important assignments.[3]

How to Disrupt Bias

Disrupting bias is best implemented by having diverse leadership, advancing inclusive leadership, and connecting diverse talent to sponsors.[4] Inclusion in the workplace refers to a cultural and environmental feeling of belonging. Leaders—both physicians and practice managers—who drive inclusion ensure team members speak up and are heard, make it safe to propose novel ideas, empower team members to make decisions, take advice and implement feedback, give actionable feedback, and share credit for team success. Diverse talent needs sponsors, or senior-level advocates, to boost them into leadership, effectively bypassing or negating the effects of managerial bias. The sponsor elevates their protégé's visibility within the corridors of power, advocates for key assignments and promotions for them, and puts their reputation on the line for the protégé's advancement. For those who feel marginalized by their gender, ethnicity, age, sexual identity or educational and economic background, sponsorship is particularly crucial in invigorating ambition and driving engagement.

A sense of belonging increases the likelihood of a staff member being satisfied in their position at your practice. When they are seen at work, they are recognized, rewarded and respected by their colleagues. When they are connected at work, they have authentic social interactions with their peers, managers and senior leaders. Then they are supported at work by peers to senior leaders, they are given what they need to get their work done and live a full life. And finally, when they are proud of their work and your organization, they feel aligned with its purpose, vison and values.[5]

Continued on next page

Improving Diversity … *continued*

Reminders for Your Staff

Determining what is inappropriate or offensive behavior is in the eye of the beholder; it is subjective. The intent of the person engaging in the bad behavior is irrelevant; the legal standard is that the behavior need only have the effect of creating a hostile environment.

The behavior does not have to be directed at the person who is offended. The victim does not have to be the person harassed, but can be anyone affected by the offensive conduct. The person does not need to complain to the person engaging in the behavior or tell them to stop.

There is a difference between tolerating behavior (what is voluntary) versus participating in the behavior (when it is welcome). For example, two staff members may be discussing anti-LGBTQIA+ views and be overheard by a third employee. That employee, while not the direct focus of the conversation, may have family or friends who are LGBTQIA+ or be in the closet themselves. A hostile environment has been created.

All staff—physicians and practice managers included—need to be mindful of unconscious bias that may influence how they react to and treat other people. One should never assume that someone feels or believes the same way you do about politics, religion, etc. Always be respectful of your coworkers and patients.

The Golden Rule has always been important: treat others how you want to be treated. More important is the Platinum Rule: do unto others as ***they would have you do unto them***, not as you would have them do unto you. The distinction is the Golden Rule uses only your standard for both individuals, while the Platinum Rule takes into account the other's standards and expectations.

For example, an employee should never express personal thoughts and feelings via words and deeds in the office toward someone who is transitioning. The patient or coworker should be treated with respect using the Platinum Rule: their chosen name and pronouns should be used at all times.

2020 & 2021 Legal Updates

In *Bostock v. Clayton County*, Georgia, No, 17-1618 (S. Ct. June 15, 2020), the Supreme Court held that firing individuals because of their sexual orientation or transgender status violates Title VII's prohibition on discrimination because of sex.[6] As the court explained, "discrimination based on homosexuality or transgender status necessarily entails discrimination based on sex; the first cannot happen without the second." For example, if an employer fires an employee because she is a woman who is married to a woman, but would not do the same to a man married to a woman, the employer is taking an action because of the employee's sex because the action would not have taken place but for the employee being a woman. However, keep in mind that the decision did not address related issues under Title VII such as dress codes, bathroom access, or locker room access. It also did not address various religious liberty issues, such as the First Amendment, the Religious Freedom Restoration Act and exemptions Title VII provides for religious employers.

The Equality Act: H.R.5 passed the House on February 25, 2021.[7] H.R.5 would prohibit discrimination on the basis of sex, gender identity and sexual orientation, and for other purposes. As of the writing of this article, H.R.5 is one of the bills currently in the Senate Judiciary Committee. Updates can be found on Congress's official website, it is always kept current.

How to Get Started

In the Recommended Reading section at the end of this article is a link to Harvard University's Implicit Association Test.[8] This is an online self-assessment to determine your level of unconscious bias. In addition, The Association of American Medical Colleges has an unconscious bias resources page for health professions.[9] Also included is the Fenway Institute's National LGBT Health Education Center.[10] They have assembled a resource to assist frontline health care staff in developing an affirming environment for transgender and gender non-conforming patients. When implementing best practices, they even have a script for your employees to follow.

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Practice Managers Share Views on Employee Retention

In today's tight employment marketplace, it is more important than ever for a practice to work to engage and retain employees. Here, two local practice managers share their thoughts on employee development and retention. Responding to our questions are Julie Guethler, practice administrator for Associates in Dermatology and Cutaneous Surgery, and Betty Via, executive director for Plastic Surgery Consultants and Cabbabe Plastic Surgery. Both Julie and Betty are members of Greater St. Louis MGMA, and the physicians in their practices are SLMMS members.

Julie Guethler

Betty Via

What strategies do you use to retain staff?

Guethler: The struggle is real to retain employees. We cannot keep up with the larger employers as far as benefits, but we do keep our salaries on the higher side and we offer a lot of flexibility. We find that is very effective.

Via: Our practice has an excellent benefit package, which includes some special perks that a cosmetic practice can provide in products and services. We also try to work with staff to accommodate time off needs when possible. This pertains to how we address holidays as well, because we believe that staff will work hard when we recognize the needs they have to balance family life and have time off for recreation.

Do you have a development plan for each employee in terms of training and career growth?

Guethler: We do have annual evaluations and self-evaluations. The employees meet with me and one of the owner physicians as well as their department lead. We also encourage the staff to be part of developing our policies and procedures. I am big on ownership of whatever the project is as well as accountability.

Via: We do not have a formal development plan for each employee, but we do work with those who want to advance. If they show us that they excel in their current position—which makes them someone whom we would want to train or mentor for another position—we are always willing to do that.

How much do you individualize retention efforts by the employee's age, race, gender and level of responsibility?

Guethler: It is not so much about any of those factors as knowing what makes each employee "tick." They are more than a sum of their parts and attributes. Additionally, many times an employee will hire in one position, and you can tell that it just isn't for them. In those cases, I will look for other opportunities within the practice. That is another strategy for retention.

What makes your office a great place to work?

Guethler: You can't fake caring about your employees and understanding their behaviors. Ultimately, that is what makes an office a great place to work—trust.

Via: The physicians and staff create a collaborative environment and work together well. Everyone tries to do their job, but also to inject humor and conversation into the workday when time permits. Our doctors and staff have mutual respect for each other. The staff knows the doctors have excellent surgical skills, and the doctors know the staff members provide great support services.

Preventing Discrimination and Harassment

Efforts to address racial justice both inside and outside of medical workplaces continue to be a focus

By Julie Z. Devine, JD

Many in the St. Louis medical community were active participants in last year's demonstrations after the murder of George Floyd. On June 5, 2020, as part of the "White Coats for Black Lives" protest, hundreds of medical providers, including doctors, medical students, nurses and pharmacists, protested outside of St. Louis-area hospitals.

As we reflect a year after these protests, it is clear that efforts to address racial justice both inside and outside of medical workplaces continue to be a focus. Furthermore, as workplaces in the medical field have been transformed by COVID-19, many employers are looking anew at how their workplaces function and the type of culture and atmosphere they want.

For many, addressing discrimination and harassment in the workplace is not only a moral or ethical imperative, but also a practical necessity to ensure that their workplaces can attract and retain the strongest talent. Below are some concrete steps that individual physicians can take to address discrimination and harassment in their workplaces.

- **Create a solid structure to investigate and address complaints and concerns.** Having a written policy in place is a key first step in addressing discrimination, harassment and retaliation—and one of the first questions the EEOC or Missouri Commission on Human Rights will ask about when investigating a complaint. For those physicians who are part of organizations that already have such policies, asking that those policies be reviewed and updated regularly is also important.

Julie Z. Devine

Julie Z. Devine, a shareholder with Lashly & Baer, P.C. in St. Louis, has successfully defended employers and heath care entities in state and federal court and government investigations involving claims for discrimination, harassment and retaliation, as well as wage/hour issues and FMLA claims. Julie also regularly provides advice and counseling to employers about an array of compliance issues and conducts trainings for employees and management. She can be reached at JDevine@lashlybaer.com.

Many employers are revising their anti-discrimination and harassment policies to make them more robust in terms of investigations. These changes can help ensure that complaints are thoroughly examined and that those accused of misconduct are given a fair opportunity to explain their side of the story.

As workplaces in the medical field have been transformed by COVID-19, many employers are looking anew at how their workplaces function and the type of culture and atmosphere they want.

Employers are also re-thinking the individual or entity who is best able to serve as the investigator when complaints arise. For complaints that involve senior-level executives or physicians, it sometimes makes sense to hire a third-party investigator or lawyer who does not have a prior relationship with the organization or individuals involved. This not only allows a more impartial examination of the key issues, but also provides comfort to all involved that there is not a conflict of interest or pressure to find a certain result.

- **Collect/review data about complaints and investigations.** Organizations big and small often do not have a good handle on discrimination and harassment in their workplaces. Collecting data can mean conducting a climate survey, reviewing exit interviews, or scanning social media and blogs. It also means looking for red flags, such as high turnover or low morale in certain departments.

  In addition, it is helpful if complaints about discrimination and harassment are reported to leadership of the practice or organization to ensure a full understanding of the data about complaints, and so that responses are handled in a consistent way through the organization.

Having a written policy in place is a key first step in addressing discrimination, harassment and retaliation.

- **Advocate for yearly training in anti-harassment and anti-discrimination.** There is skepticism among many that sitting for an anti-discrimination or anti-harassment training can lead to any real change. There is also increased scrutiny of the content of anti-bias trainings and seminars. However, trainings on anti-harassment and anti-discrimination can be effective if they are tailored to your organization's policies, procedures and priorities; if there is true leadership buy-in; and if it can lead to frank discussions about improving the climate. To do so, live trainings (as opposed to a generic video) are often the most effective.
- **Train supervisors about how to respond to complaints of discrimination and harassment.** In addition to trainings for all employees about the organization's anti-discrimination/harassment policies, trainings for all managers and supervisors about the company's expectations and policies are strongly recommended.

  A common mistake related to employment law is that managers and supervisors believe that an employee's complaint about discrimination or harassment must be written or made in a formal manner. Many complaints about discrimination and harassment, however, are made as part of a more casual conversation. Supervisors and managers must be able to recognize the need to report these issues to a human resources department or senior leadership. This type of training can also provide reminders about company policies around other key issues such as hiring and recruiting, to ensure fair and consistent implementation of company expectations.
- **Emphasize respect in the workplace.** It is often difficult to tell the difference between rude or disrespectful behavior and discrimination and harassment. Insisting on a climate that is respectful to all employees, and having sometimes-difficult conversations about those expectations, is one of the best ways to improve the workplace climate. Conversations should also include how supervisors and managers provide feedback when employees need to improve performance.

At this time with the confluence of COVID-19, the movement for racial justice and the #MeToo movement, we are in a period of extraordinary change for our workplaces. It is an occasion to "think outside the box" about how our workplaces operate and an opportunity to take affirmatives steps to directly address combating discrimination and harassment in medical workplaces.

Effective Employee Onboarding … *continued from page 11*

feel like a real person—not just someone on a computer screen," says Haynes.

Lastly, if budgetary resources allow remote employees to travel, it's recommended they make periodic visits to the main office. These visits allow them to establish those ever-important face-to-face connections.

Many HR and organizational development experts recommend that companies assess their current onboarding efforts. The results might surprise you. Is your organization's idea of onboarding a one-time event where new employees simply complete necessary paperwork? Or is it a holistic experience that addresses compliance, clarification, culture and connection?

If it's the latter, congratulations! Your organization has a process in place to help successfully retain new employees by making them feel like a member of the team.

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Can Employees Be Required to Get a COVID-19 Vaccine?

Yes, but employees may seek individual exceptions

By Candace E. Johnson, JD

With the COVID-19 vaccine more widely available now, many employers are asking if they can require employees to receive the vaccine and what the risks are in doing so.

Legally, employers may require employees to get a COVID-19 vaccine as a condition of employment, subject to the following limited exemptions:

- **Religious Beliefs.** Employees may request an exemption from a mandatory vaccination requirement based on their religious beliefs. Title VII of the Civil Rights Act covers protected groups, including those with religious beliefs. Employers must provide accommodations for employees with "sincerely held" religious beliefs.
- **Disability.** Employees may also request an exemption from a mandatory vaccination requirement based on a disability. If employees have a qualifying medical reason to not get a vaccine, employers must accommodate such requests under the Americans with Disabilities Act (ADA).

In these situations, employers and employees should work together and sufficiently communicate to determine whether a reasonable accommodation can be made. When considering an accommodation, employers should evaluate:

- The employee's job functions
- How important it is to the employer's operations that the employee be vaccinated
- Whether there is an alternative job the employee could do that would make vaccination less critical

Because exceptions must be made in certain circumstances, if an employee refuses to be vaccinated, employers should endeavor to find out why.

Candace E. Johnson

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If employers are hesitant to implement mandatory vaccines, they can alternatively strongly suggest the vaccine and focus on steps they can take to encourage and incentivize employees to get vaccinated. Such incentives could include:

- Make obtaining the vaccine as easy as possible for employees
- Cover any costs that might be associated with getting the vaccine
- Provide paid time off for employees to get the vaccine and to recover from any potential side effects

It is important to note that so far, the COVID-19 vaccines by Pfizer, Moderna and Johnson & Johnson are available through the Food and Drug Administration's "Emergency Use Authorization" process, which is a streamlined way to provide vaccines during a public health crisis, such as the COVID-19 pandemic. None of the COVID-19 vaccines have yet received full approval from the FDA, although manufacturers have started the formal process to gain full FDA approval for use.

The emergency use status of the vaccines has caused hesitancy for many employers as they determine whether or not to mandate employee vaccinations. The hesitancy is due, in part, to the Food, Drug and Cosmetic Act that allows individuals to refuse vaccines. There have been several federal lawsuits filed against employers who mandated COVID-19 vaccines for their workers. The lawsuits assert that plaintiffs have the federal right to refuse an emergency use vaccine.

Therefore, as the vaccines receive full FDA approval, it is likely there will be an uptick in the number of employers who will mandate employees to receive the vaccine.

In the end, navigating the COVID-19 pandemic will continue to be challenging for both employers and employees. Therefore, ongoing communication is critical to keeping employees safe, healthy and happy.

 This article was originally published by Saint Louis Construction News and Review *on March 29, 2021.*

New Law Offers Protections from COVID-19 Liability

Impacts health care providers, businesses and producers/sellers of COVID-19 supplies

By Kevin K. Peek, JD, and Killian R. Walsh, JD

On July 7, Missouri Gov. Mike Parson signed into law SB 51, passed by lawmakers earlier this year intended to solidify the protections afforded to individuals, businesses and organizations from liability to COVID-19 exposure actions. The law will take effect on August 28, adding six sections to Chapter 537 of the Missouri Revised Statutes. The additional language, which largely mirrors similar federal protections already in place, will impact individuals who own a business, practice health care, or manufacture, distribute, or sell health care products.

Anyone who wishes to bring a COVID-19 claim against health care providers will be required to prove recklessness or willful misconduct on the part of the health care provider. This is a higher standard than ordinary medical malpractice.

Simply put, the law can be used to block most COVID-19 exposure actions. Only those actions alleging exposure to the virus by **reckless or willful misconduct** will be able to proceed. The law will shield health care providers from COVID-related lawsuits unless that high standard of proof is met. In instances of medical malpractice, patients will have up to one year after discovery of the exposure to pursue legal action. Actions involving product liability can be filed up to two years after an alleged exposure, such as a claim that the virus was contracted on the premises of the business. The law also permits limited punitive damages in COVID-19 related actions. All sections of the law will expire four years after the legislation is passed unless extended.

Missouri Gov. Mike Parson signs the COVID-19 liability law as legislators and business leaders look on. (Missouri Gov. Parson Facebook page)

New section 537.1005 addresses premises liability and declares businesses cannot be held liable to a plaintiff for COVID-19 exposure unless the plaintiff can prove by clear and convincing evidence that: (1) The business engaged in recklessness or willful misconduct that caused an actual exposure; and (2) The actual exposure caused personal injury. Section 537.1005 further protects employers and business owners by creating a rebuttable presumption that the plaintiff assumed the risk of a COVID-19 exposure by entering an employer or business owner's premises where the employer or business owner had provided a substantially similar warning notice as the warning notice provided in the statute. The notice must be "clearly visible" upon entering the location or must be provided in written form to those coming to the location. Any change to a policy or practice internally to address or mitigate the spread of COVID-19 after an exposure is not considered evidence of liability.

Pursuant to Section 537.1010, anyone who wishes to bring a COVID-19 claim against health care providers will be required to prove recklessness or willful misconduct on the part of the health care provider. This is a higher standard than ordinary medical malpractice, which typically requires only negligence. It will substantially limit the number of lawsuits brought against health care providers.

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Kevin K. Peek

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Killian R. Walsh

Killian R. Walsh, JD, is a litigator with Knight Nicastro MacKay and handles pre-suit matters and active litigation in Missouri and Illinois. She has extensive experience in negotiating and working up products liability, transportation, medical malpractice, personal injury and other general liability matters. She can be reached at walsh@knightnicastro.com.

The Future of Public Health in Missouri – Where Do We Start?

The following originally appeared as a blog on Missouri Foundation for Health's website, mffh.org. This is reprinted with permission.

By Clay Goddard, MPA

As a former public health department director, I like to think I know a thing or two about public health infrastructure and preparedness. I have spent the better part of the last 25 years working with an inspired group of public health professionals to create one of the best local public health departments in the Midwest.

Even though my department was well funded and very involved in the community, we always struggled with relevancy. That is not an unusual position for a public health department to be in. Prior to the pandemic, most citizens might not have had many interactions with their local or state public health departments. That is likely a direct reflection of the ethos of the profession. The adage states that "a good day in public health is when nothing happens."

I have always viewed the field as a stealth profession. If we are doing things the right way, we are working silently behind the scenes and an invisible blanket of public health protection covers us all. If the health director is on the front page of the newspaper, things are not going that well.

But perhaps this is flawed logic. Maybe public health professionals have some culpability for what happened to our vocation. Perhaps working behind the scenes has not served us well. Just look at what has happened during the last decade. Funding for public health has eroded at both the state and national levels.[1] The field has struggled to adopt new technologies and harness the power of sophisticated analytics. We have been unable to invest heavily in leadership development. We have not done a great job of recruiting the next generation of public health leaders. We continue to struggle to get out of our silos, work across sectors, and make the important work we do relevant in our communities.

As a result, we have been left with a patchwork of haves and have-nots, with the differentiating factor being local funding. In short, health equity issues abound in our local public health system. Where you live does matter. These failings have manifested themselves at an abysmal time. A global pandemic that has taken the lives of more than a half a million Americans is probably the worst way to discover fundamental problems within your critical public health infrastructure.

Public Health
Prevent. Promote. Protect.

It is my personal belief that the public health accreditation process is the most transformative tool available to help public health departments evolve.

While it is easy to get fixated on the response to a 100-year global pandemic—especially one that entertained heated partisan political debate—the focus now needs to be placed on how we transform the existing public health infrastructure into a highly functioning public health system.

The pandemic response in Missouri has not been all bad news. I have personally witnessed some of the worst of human behavior during the last year, but I've also been lifted up by some of the best. I have watched as public health professionals remained unbowed in their battle against a silent killer, even while taking withering criticism from the very citizens they are working to protect. I have watched as under-resourced local public health departments found a way to make contact tracing, quarantine and vaccination efforts work with little


Clay Goddard

Clay Goddard, MPA, is senior director of public health transformation for Missouri Foundation for Health. He joined MFH this year after serving for 25 years with the Springfield-Greene County Health Department, most recently as department director. His accomplishments include leading the department to earn national accreditation, achieving passage of a Tobacco21 ordinance, and successfully completing regional health and community mental health assessments. He can be reached at cgoddard@mffh.org.

or no additional resources from CARES Act dollars. In short, we have good people who are battle tested that can serve as a foundation for transformation.

Obviously, transformation is a complicated process with numerous moving parts, so where do we start? Let us begin with some higher-level concepts:

Workforce: The last decade has seen sharp declines in staffing levels, and the workers that are in place do not always look like the communities that they serve. Investing in the development of the current workforce and developing a pipeline that will bring new, diverse and talented workers to the profession is critical.

Data and analytics: Many state and local public health data systems are built on antiquated platforms that perpetuate siloed approaches to data analysis. The profession has also struggled to integrate other data sets from the communities they serve. These data sets can help to flesh out the broader causal relationships driving poor public health outcomes. The inability to readily access sub-county level data that is timely, accurate and accessible is inexcusable in the digital age and needs to be remedied.

Foundational capabilities and accreditation: Moving forward, we will need to find ways to measure the effectiveness of the current public health system, agree on a minimum set of standards that we can live with as a state, and focus on pathways to performance and quality improvement. Fortunately, there are models that exist that can help facilitate this process. The Foundational Public Health Services[2] is a framework that defines a minimum set of fundamental capabilities and areas of public health expertise that should be available in every community. Research recently completed by #HealthierMO tells us that currently, less than half of our local public health departments can meet this minimum set of capabilities. This knowledge provides us with immediate pathways to begin rebuilding our public health infrastructure.

Additionally, some states have embraced public health accreditation to improve public health department performance. Currently, 21 of 114 local public health agencies in Missouri have been conferred accreditation by either the Missouri Institute for Community Health or the Public Health Accreditation Board. It is my personal belief that the public health accreditation process is the most transformative tool available to help public health departments evolve.

It is time to roll up our sleeves and begin the hard work necessary to bring much needed transformation to Missouri's public health system. We know it will be challenging and that it will create discomfort for some. Even so, this is our moment, and we can use the pandemic to inform and drive this much-needed change. There is a Japanese proverb that states, "the frog in the well knows nothing of the sea." Let's be aspirational. We have an opportunity to get out of our wells and explore the possible if we choose to.

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New Law Offers Protections …

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Pursuant to Section 537.1015, product manufacturers, sellers, distributors and the like will not be liable in a COVID-19 products liability action if the entity either:

1. Does not make the covered product in the ordinary course of business;
2. Does make the covered product in the ordinary course of business but the COVID-19 emergency requires modification of the manufacturing process; or
3. Does make the covered product in the ordinary course of business, and the use of the covered product is different than its recommended purpose and used in response to the COVID-19 emergency.

While providers and insureds are afforded significant protections under the new law, they must be mindful that reckless or willful conduct will strip them of such defenses. That said, many insurance policies exclude intentional conduct, and courts are split on whether willful and reckless conduct is the same as intentional conduct. In the years ahead, the new law and its application to insurance policies will be heavily scrutinized and dissected in the Missouri courts.

The full text of the new law can be found at: https://www.senate.mo.gov/21info/pdf-bill/tat/SB51.pdf

Engaging Members in a New Way: Sue Ann Greco Leads AMA Alliance Through the Challenges of COVID-19

Sue Ann Greco, past president of the SLMMS and MSMA Alliances, completed her term as 2020-21 president of the AMA Alliance in June. With in-person events shut down due to COVID-19, she led the Alliance in adapting its programs to a virtual Zoom format. The result was continued strong participation and continuing to achieve the core of the national Alliance mission—connecting and supporting physician families and providing health education.

Sue Ann Greco

The AMA Alliance carries out health awareness programs such as Stop America's Violence Everywhere (SAVE) and Hands Are Not for Hitting, and conducts education for the physician community on burnout and opioid abuse. It supports physician spouses families through regional meetings and the annual Physician Family Day, and by publishing the *Physician Family* magazine that covers topics of concern promoting wellness among physician families.

Icons promoting AMA Alliance events during the year.

Besides her involvement in the Alliance, Sue Ann for the past 10 years has served as practice manager for her husband, Thomas Greco, MD. She holds BSN and MSN nursing degrees and completed post-graduate courses in health care administration and legal studies. She has worked as an instructor of nursing and a legal nurse consultant. They have four grown daughters, Marissa, Tori, Ali and Lizzie.

A virtual celebration in honor of Sue Ann's presidential year was held on Saturday, June 12. More than 70 friends and family members attended, with tributes presented by many MSMA, SLMMS and Alliance leaders. Special guest was past AMA President and current World Medical Association President David Barbe, MD, of Mountain Grove, Mo.

Sue Ann Greco, back row second from right, with fellow AMA Alliance board members as they drop their masks for the photo.

Q&A with Sue Ann Greco

In the following Q&A, Sue Ann shares her thoughts on the Alliance and the year just completed.

What adjustments did you and the AMA Alliance have to make to carry on during COVID-19?

It was clear to us in May 2020 (before my term began) that our members needed to be together on Zoom calls. We were all feeling stressed because of COVID and the impact it was having on our spouses' professions. We decided early in June to present bi-monthly Zoom calls. The first Thursday of the month Zoom calls were designed to keep Alliance state and county leaders abreast of what was going on in the organization and offer guidance as to how they could keep their affiliate members active and engaged. The Zoom calls on the third Thursday of the month were hosted by the Membership Council and topics for presentations and discussion were suggested by members. The topics they chose often reflected their needs at the time, such as how to deal with homeschooling children; how to promote diversity, equity and inclusion in health care; how the AMA was assisting physicians during COVID; and how to deal with the emotional aftermath of COVID.

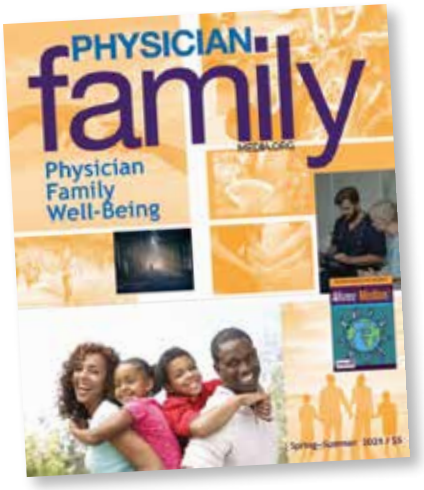
We encouraged state and regional groups to continue to meet via Zoom. Most of the state annual meetings and installations were via Zoom. As president, I missed the opportunity to visit states and reach out to potential members. We held two meet-and-greets to introduce our board to members via Zoom. One of our meet-and-greets was specifically for the young career spouses, including those married to medical students, residents, or early career physicians. This group continued to meet via

Zoom and hosted speakers on topics of particular interest to them, such as financial security during the early career years.

We decided back in October that our June 2021 Annual Meeting would have to be virtual. This gave us time to prepare a comprehensive meeting with guest speakers. All in all it went very well, but we are hoping to be together in person in 2022 when the AMA Alliance celebrates its 100th Anniversary.

What do you see as your greatest accomplishment(s) of the year?

Our greatest accomplishment this year was engaging our members across the country in a new way. We saw each other via Zoom more frequently than we would have during a normal year. We kept ourselves educated about current topics. We also partnered with the AMA by supporting their MaskUp program on social media and hosting several of their members and staff on our Zoom calls. We felt a stronger connection as an organization and even gained some new members in the process.



The AMA Alliance's publication Physician Family *provides valuable insights on issues of concern to family members of physicians.*

In a changing world, with both spouses employed and many two-physician couples, how is the role of the Alliance evolving? What contributions can the Alliance make in today's medical world?

Our society has been undergoing these changes for the last several decades. Alliance membership has continued to decrease since about 1973. The Alliance continues to try to find ways to adapt. One way we have adapted is to become more of a virtual organization. We have a much stronger presence on social media than we used to. Our *Physician Family* magazine, which is available online and on social media, is designed for young working couples. Virtual gatherings have given us a new way to connect physician spouses and physician families across the country. Young physician spouses still have a strong need to connect with others going through the same experience of moving for residency and training. We are seeing more male spouses of physicians who want to connect and want to become engaged as leaders in the organization. The AMA Alliance has a dual role in that we support physician families through connection, but we continue to encourage state and county affiliate groups to engage in health promotion projects and advocacy. That is still part of our legacy.

Sue Ann and her husband, Thomas Greco, MD, appeared in a video promoting the annual Physician Family Day in August.

What did you learn during the year?

One thing I think we all learned is that physician families are very resilient. Physician spouses have always had to adapt to their spouses' long hours and career paths, but during COVID, we had to adapt to the fact that our spouses were putting themselves in harms way on a daily basis. While our adult children were working from home, our spouses never missed a day of going into their office or the hospital. That is why keeping our connection to our members this past year was so important. We all supported each other and helped keep each other informed on all the latest news about the virus and the vaccinations. We became role models for our communities in terms of following the science and staying strong. I hope that the AMA Alliance can always be seen as positive influencers when it comes to public health. This past year called us to be at our best, and I truly believe that AMA Alliance stepped up to the challenge. It was my pleasure to serve as their president this past year.

2021 PHYSICIAN FAMILY DAY | SATURDAY, AUGUST 28

Learn more about the AMA Alliance
https://amaalliance.org/

BE AN ALLIANCE MEMBER

Join with the SLMMS Alliance in community health promotion projects and in supporting physician families. For membership information, contact Sandra Murdock, sesandram@aol.com or 314-872-8429.

PARTING SHOTS

Goodbye, Old Maintenance of Certification (MOC)

By Richard J. Gimpelson, MD

Do not be fooled by the headline of this column. The American Board of Medical Specialties (ABMS) has proposed revising the old Maintenance of Certification (MOC) with Draft Standards for Continuing Certification (DSfCC). It is not clear if the name MOC will change, but the purpose will not change. It may be difficult, but I recommend that you try to obtain a copy of the DSfCC before it is finalized. Some of the standards are excellent, but others are confusing.

Physicians who are grandfathered will be referred to as "non-time-limited certificate holders" (NTLCH). Physicians who must participate in MOC will be referred to as "time-limited certificate holders" (TLCH). NTLCH are not at risk of losing certification even if they participate in continuing certification testing and fail to meet continuing certificate requirements. However, TLCH must participate and pass certification testing to maintain continuing certification. Most physicians are motivated to keep their education and skills up to date, and do not need additional prodding to adhere to the highest standards. Something just does not seem fair.

Please note that both NTLCH and TLCH still must adhere to ABMS Professional Standards that are described as "a demonstration of commitment to carrying out professional responsibilities, adhering to ethical principles, applying the skills and values to deliver compassionate patient-centered care, demonstrating humanism, being sensitive to diverse patient populations and workforce, and practicing wellness and self-care." These are obvious self-guided rules and how does the ABMS evaluate the physician?

For those of you who are TLCH, you definitely need to review the ABMS DSfCC. You are responsible for following the standards or be at risk of losing your certification.

Dr. Richard J. Gimpelson

Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. The opinions expressed in this article do not necessarily represent the opinion of the Medical Society. Send comments on this column to editor@slmms.org.

My concern, about which I have written previously in *St. Louis Metropolitan Medicine*, is that many physicians over time reduce their practice to a specific niche in their field. They often demonstrate extreme skill, involving knowledge, research, publications and teaching. Do these experts need to be tested on all aspects of the specialty in which they were initially certified? Do physicians need to spend time away from their practice taking exams when they frequently attend local meetings covering their specialty? In addition, most physicians also attend national meetings to be educated about new medications, procedures, instruments, complications, etc. Most physicians read their key peer-reviewed specialty journals which also present new medications, procedures, instruments, complications, etc.

Has it been shown in peer-reviewed journals that NTLCH do not perform as well as TLCH? Do NTLCH get sued more than TLCH? Could TLCH spend their time better treating their patients rather than reading and taking tests on material that they never treat? Eventually, old NTLCH like me will all be gone and there will only be TLCH, who will be spending some of their time and money on tests and topics that have no contribution to their practice of medicine and surgery. If the ABMS and specialty boards need the money to survive, then raise dues a little. I would rather pay more dues and earn it back in the practice than take time and spend money on topics that are not relevant to my extremely skilled niche practice.

As a Parting Shot, get a copy of the ABMS DSfCC and decide what is best for you and your patients.

Editor's Note: If you would like to see a copy of the Draft Standards for Continuing Certification, contact the ABMS at 312-436-2600 or via the contact form on their website, www.abms.org. A public comment period on the draft standards ended July 9. The draft standards are scheduled to be considered by the ABMS board of directors in October.

WELCOME NEW MEMBERS

Thank you for your investment in advocacy, education, networking and community service for medicine.

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OBITUARY

Wilbur H. Gearhart, MD

Wilbur H. Gearhart, MD, a psychiatrist, died July 9, 2021, at the age of 95.

Born in Central City, Pa., Dr. Gearhart earned his undergraduate degree from Butler University in Indianapolis, and his medical degree from Hahnemann Medical College in Philadelphia. He interned and completed a surgical residency at Polyclinic Hospital in Harrisburg, Pa., followed by a three-year residency in psychiatry at Washington University School of Medicine. Dr. Gearhart founded the Psychiatric Associates Group in St. Louis and practiced psychiatry for 25 years. He served on the clinical faculty of Washington University School of Medicine, and was a former chief of staff at Missouri Baptist Medical Center. He joined the St. Louis Metropolitan Medical Society in 1959.

SLMMS extends its condolences to his wife Jane Gearhart; his children Linda Doak and William Gearhart; his four grandchildren; and his two great-grandchildren. ◄

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