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Health Literacy

Patients and Providers Share Responsibility

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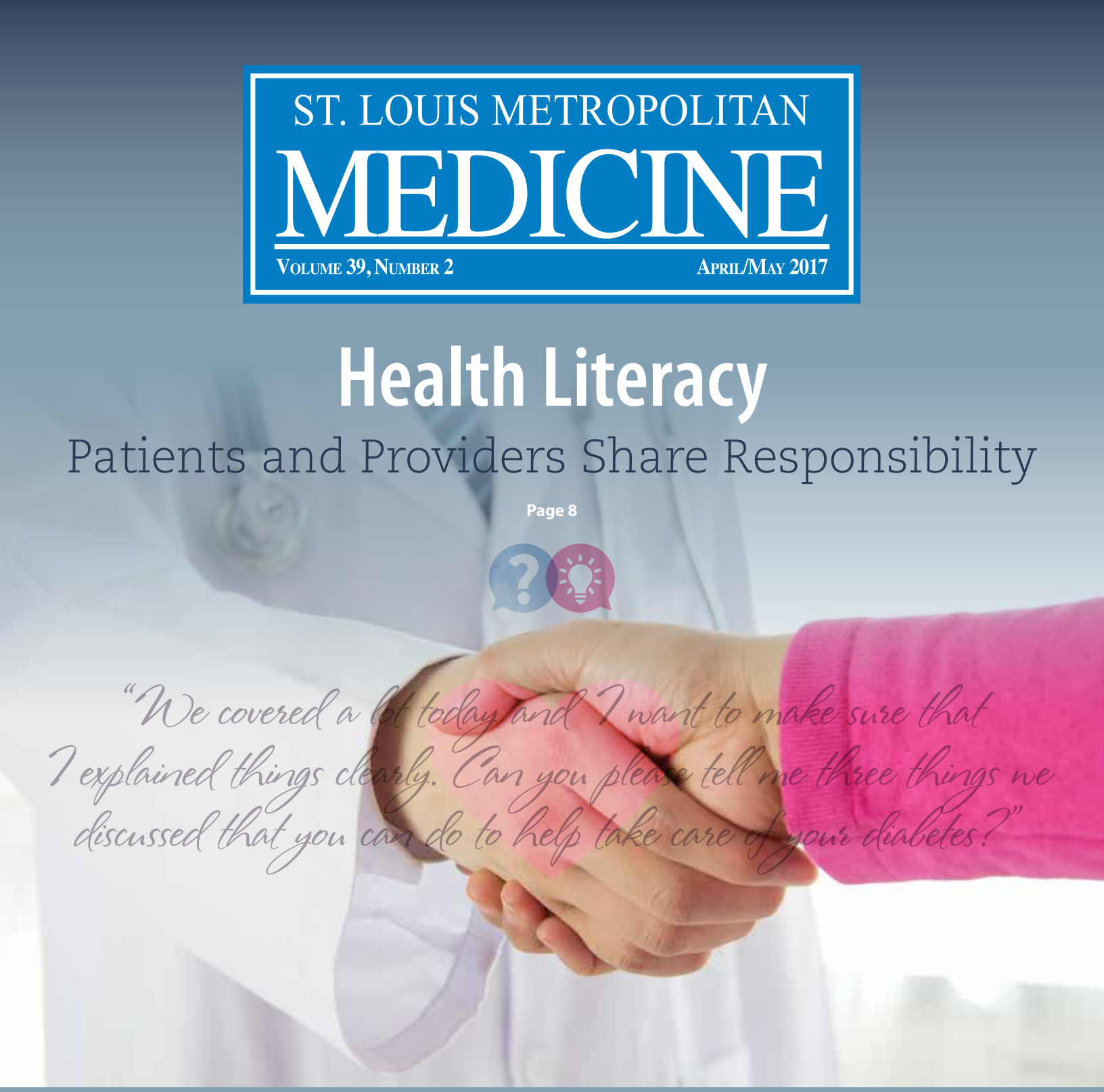

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Editor's Note: The former SCAM-Q column by Richard Gimpelson, MD, can now be found on the inside back cover spread, page 24. Harry's Homilies is on page 6 and the new member listing is on page 20.

Your Wealth Is Your Health. Or Is Your Health Your Wealth?

Obesity is "weighing down America"

By J. Collins Corder, MD, FACP, Medical Society President

Medical Society President
J. Collins Corder, MD, FACP

The total cost to treat health conditions related to obesity—ranging from diabetes to Alzheimer's—plus obesity's drag on attendance and productivity at work exceeds $1.4 trillion annually.

Health and wealth are related in many different ways. First, there is the sheer cost of unhealthy habits. For example, giving up a $10 per day of smoking or junk food habit can save $3,650 annually, plus interest, and that's just the immediate savings as there are savings over the long-term of someone's life. The CDC estimates that a 10% weight loss could reduce a person's lifetime medical costs by $2,200 to $5,300. Delaying the onset of diabetes can save thousands of dollars annually and significantly decrease medical costs.

Secondly, financial problems can affect the person's health status and vice versa. For example, overdue medical bills can result in physical symptoms of stress (migraines, insomnia and anxiety) and/or delayed or inadequate treatment. Financial stress also makes it difficult to afford recommended health maintenance practices such as routine checkups and eating the recommended 5-9 servings of fruit and vegetables per day. High health care costs can lead to a poor credit history and/or bankruptcy and reduced income available to save for retirement and other financial goals. Medical problems have been found to be associated with about half the cases of bankruptcy.

A third health and wealth relationship is that people in poor health often die at a relatively young age and spend thousands of dollars—money that could otherwise have been invested—on prescription drugs and health care costs. Many don't live long enough to collect the pension and Social Security benefits that they spent a lifetime working for. On the other hand, those who practice recommended health behaviors would be more likely to exceed average life expectancy and need a larger retirement nest egg to ensure that they don't outlive their assets. Most financial planners routinely plan for life expectancy in the mid-90s to be sure that their clients don't run out of money.

A Drain on the U.S. Economy

Obesity and excess weight is an "expanding" health problem for more than 60% of Americans, and a new study from the Milken Institute finds that it's a tremendous drain on the U.S. economy as well. The total cost to treat health conditions related to obesity—ranging from diabetes to Alzheimer's—plus obesity's drag on attendance and productivity at work exceeds $1.4 trillion annually. The total from 2014 data was equivalent to 8.2% of the U.S. GDP, which is more than twice what the U.S. spends on national defense; this exceeds the economy in all but three U.S. states and all but 10 countries.

The Milken Institute's new report, *Weighing Down America: The Health and Economic Impact of Obesity*, is the first to look at America's weight problem across all of its dimensions: direct medical treatment for 23 health conditions causally related to obesity and indirect cost including the combination of lost workdays and lower productivity due to disease. In addition, they found that more than 320,000 deaths were attributed to obesity being overweight in 2014, when the report's data was collected.

An overweight country is a serious problem not only for the patient's physical health but its enormous impact for the health of our economy. **Obesity is "weighing down America!"** In 2014, 60.7% of the population, or 188.6 million people, were either obese or overweight.

Fortunately, obesity's negative impacts on health care can be reversed, as can the economic losses associated with excess weight. It has been concluded that for an individual with a BMI of 40 or greater, a weight reduction of just 5%, would equal to savings of $2,137 in medical cost annually; for all adults with extreme obesity the savings would be $34.9 million. (A 5% reduction of weight loss would amount to 14 pounds for an American man of average height and BMI of 40, or 12 pounds for a woman.)

All geographic regions of the United States are affected by this epidemic. Human suffering, medical cost and economic impacts caused by obesity occur across all 50 states. At least 20% of the population now is obese.

Key findings from obesity data of the National Health and Nutrition Examination Survey are as follows:

- For 2011–2014, obesity is prevalent in 36% of adults and 17% of youth.
- The incidence of obesity is higher among women at 38.3% versus 34% in men. Among youth, there is no difference by sex.
- Middle-aged adults have the highest incidence of obesity at 40.2%, compared to 37% of older adults and 32.3% of younger adults.
- Obesity is higher among non-Hispanic White, non-Hispanic Black, and Hispanic adults and youth than among non-Hispanic Asian adults and youth.
- From 1999 through 2014, obesity prevalence increased among adults and youth; however, among youth, obesity did not change from 2003–2004 through 2013–2014.

Weighing Down America calculates that the cost of "direct" medical treatment for medically related obesity conditions was $427.8 million in the U.S. in 2014, representing 14.3% of total health care spending. In addition, "indirect costs" which include absenteeism from work or lost workdays and presenteeism (productivity loss or under performance at work), amounted to $988.8 million, leading to a total of $1.42 trillion!

Per-Person Cost Similar to Smoking

One widely quoted estimate from Finkelstein and colleagues, based on data from the U.S. Medical Expenditure Panel Survey, found that in 2006, per capita medical spending for obese individuals was an additional $1,429 (42% higher) compared to that of individuals of normal weight. Others found that per capita medical spending was $2,741 higher for obese individuals than for individuals who are not obese—a 150% increase. Thompson and colleagues concluded that over the course of a lifetime, the per-person costs for obesity were similar to those for smoking. Several investigators have evaluated obesity-related spending as it accounted for 8.5% of Medicare spending, 11.8% of Medicaid spending, and 12.9% of private payer spending.

Even this is an underestimate of health care cost, since it does not include people who are living in institutions who may be in poorer health than the general population.

Looking ahead, researchers have estimated by the year 2030, if obesity trends continue unchecked, obesity-related medical costs alone could rise by $48-66 billion dollars a year in the U.S.

Challenge for Physicians

As physicians we are faced with more challenges in health care delivery and in insurance requirements to reduce the cost of medical care, placing more burden on the physician in the new value-based medicine systems. We have to assume the responsibility of patients who make poor health decisions and do not change lifestyle behaviors. The federal deficit related to health care is significantly affected by poor patient choices as the burden of obesity continues to accelerate in our society. Obesity not only affects one's health but wealth, as the enormity of the economic burden continues to rise both for the patient and our society.

The enormity of this economic burden and the huge toll that excess weight takes on health and well-being are beginning to raise global political awareness that individuals, communities, states, nations and international organizations must do more to stem the rising tide of obesity.

It is possible that a clearer understanding of the obesity cost will be able to spur larger and more urgent programs to prevent and treat it. While the U.S. has made some investments in prevention—such as former first lady Michelle Obama's recent "Let's Move" initiative to reduce childhood obesity—these efforts represent relatively small steps forward. In addition, future public health prevention funding remains under threat.

To make true advances, these initiatives should be part of concerted efforts by local and national governmental, health and nonprofit organizations, food companies, advertisers and individuals (including physicians) to make healthy weights the norm rather than the exception. Area health care literacy ties in so closely with this directive and must be targeted to achieve significant changes in our patients' and community's health and behavior.

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Big Wins for Physicians and Their Patients

David M. Nowak

Executive Vice President David M. Nowak

These two victories are important illustrations of what can be achieved when organized medicine brings physicians together and the best outcomes for doctors and their patients are realized; and ultimately, the physician-patient relationship is preserved.

We're only one quarter into the year 2017, and already organized medicine has witnessed two major victories, both coming as a result of actions in the federal courts. These are both big triumphs for physicians, but even more importantly, these actions also protect free market competition to reduce health care costs for consumers.

On Jan. 23, the U.S. District Court issued a ruling that effectively blocked the proposed merger of two insurance giants, Aetna and Humana, on the grounds that the deal would hurt competition and raise consumer prices in hundreds of Medicare Advantage markets, including 54 counties in Missouri.

Approximately two weeks later, on Feb. 8, the court ruled against another proposed insurance merger, this time that of Anthem and Cigna, citing the "unhealthy concentration of market power" the newly-combined organization would possess. The Department of Justice brought the case against the merger, arguing it would create a company so large that it would eliminate competition in the health insurance marketplace.

Organized medicine, at the local, state and national levels, loudly opposed both merger efforts, warning that as the insurance marketplace experienced reduced competition, consumers would be faced with higher premiums, narrower provider networks, greater out-of-pocket costs, and reduced access to care.

Our own Missouri State Medical Association (MSMA), of which SLMMS is a component society, played a vital role in effectively "shutting down" the mergers. In the Aetna-Humana case, U.S. District Judge John Bates cited the efforts of the Missouri Department of Insurance and MSMA in his ruling.

Early on, the American Medical Association formed a coalition of state and national specialty societies to propose a comprehensive advocacy strategy. The coalition urged the National Association of Attorneys General (NAAG) and its work group to block the mergers, and identified states in which to operationalize grassroots strategies. The AMA's release of its latest edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* last fall provided a clear snapshot of competition and helped identify the markets where the proposed mergers would have the most negative impact.

Locally, these victories come right on the heels of SLMMS standing up to the insurance companies on behalf of both our members and their patients. In December, as reported in the February issue of *St. Louis Metropolitan Medicine*, we made public the results of our physician-driven insurance company survey, shedding light on the frustrations and difficulties doctors and their staffs experience working through the pre-certification process.

Why are these rulings important wins for medicine? Obviously, they preserve and protect free-market competition, but at the same time they also help protect the physician-patient relationship. In the Anthem-Cigna case, the judge's order recognized that the merger would ultimately drive health care costs up and reduce choice for patients as the in-network provider lists become more restrictive, resulting in negative consequences for physicians.

With these two mergers now "off the table," insurer competition for patients is preserved. It also gives physicians more opportunity to negotiate or demand higher quality services for their patients.

These two victories are important illustrations of what can be achieved when organized medicine brings physicians together and the best outcomes for doctors and their patients are realized; and ultimately, the physician-patient relationship is preserved.

Have You Renewed Your Membership for 2017?

Allow me to use this opportunity to make the pitch for membership and continued support of your local and state medical societies, as well as the national organization. Continued membership truly is the lifeblood of our society. We exist to serve you, and we exist because of you. If you have not renewed your membership, please do so today. If you have already renewed, thank you and please consider recruiting a colleague or nominating a fellow physician for membership.

Per the SLMMS bylaws, dues are considered delinquent each year if not paid by March 1. As I write this column in early March, we still have over 200 members with unpaid 2017 dues. Over the next few weeks, we will contact these members and urge them to renew their commitment to organized medicine.

Our staff resources are limited; you could help us immensely by contacting us to renew your membership as soon as possible.

The fight to preserve autonomy and keep the physician in charge of the health care delivery team continues. And remember, together we are stronger.

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CALENDAR

APRIL

14 Good Friday, SLMMS office closed

MAY

9 SLMMS Council, 7 p.m.
29 Memorial Day, SLMMS office closed

JUNE

11-14 AMA Annual Meeting, Chicago
13 SLMMS Executive Committee, 6 p.m.

JULY

3-4 Independence Day, SLMMS office closed

SLMMS Members Enjoy Discounted Muny Season Tickets

Summer is right around corner, as is another great season of musical theater under the stars at the Muny. Don't forget to use your SLMMS discount when purchasing new season ticket subscriptions through the Muny Corporate Advantage Program.

With a deep discount on season ticket prices, combined with the savings compared to purchasing single tickets, SLMMS members can receive the equivalent of three shows for free. It's the lowest price you'll find on Muny season tickets to seven great musicals. The 2017 schedule includes "The Little Mermaid," "A Chorus Line," "A Funny Thing Happened on the Way to the Forum," as well as the Muny premieres of "Newsies" and "All Shook Up."

The program offers guaranteed same seats for all seven shows in Terrace A or Terrace B only. Subscribers have ticket exchange privileges, and the first option to renew the same seats for future seasons. To obtain your savings, use the special promo code **(SLMMS17CA)** when ordering your tickets by phone, online or in person at the Muny box office. The code is good on **new season ticket subscriptions only when purchased between March 27 and April 30, 2017**. It is not retroactive to prior season ticket purchases or renewals, and may not be used for individual ticket purchases.

Visit www.muny.org to see the complete 2017 lineup of shows, dates and ticket prices. If you have questions about the discount program, contact Jane Schell at the Muny at 314-595-5708 or jschell@muny.org.

New Book Explores Near-Death Experiences

John C. Hagan, III, MD, editor of *Missouri Medicine*, the Missouri State Medical Association journal, has published a new book, *The Science of Near-Death Experiences*. It is a compilation of articles on the subject that appeared in *Missouri Medicine* from September 2013 through July 2015.

A Kansas City ophthalmologist, Dr. Hagan notes that this is the first scientific study of near-death experiences (NDEs) in peer-reviewed literature.

"As many as 9 million to 20 million Americans are estimated to have NDEs; perhaps 10% of successful cardiac arrest patients have a NDE. Physicians and health care professionals need to know how to recognize NDEs and how patients, especially children, should be treated after this frequently life-altering event occurs," he said.

The foreword and chapter one are by Raymond Moody, MD, PhD, who coined the name NDE and has sold over 20 million books on the subject.

The Science of Near-Death Experiences book is available on Amazon.com; the publisher is the University of Missouri Press. All profits from the book are being returned to the Missouri State Medical Association.

HARRY'S HOMILIES©

Harry L.S. Knopf, MD

ON HEALTH LITERACY

Patiens, cura te ipsum.
(Patient, cure yourself.)

We physicians are familiar with the phrase: "Physician, cure thyself." (This phrase comes from the New Testament and has been used for some occasions to advise physicians to improve their actions.) I have taken the liberty of turning it back on the public: These days, with arguments about who should care for whom, and who should pay, it seems only fitting to ask our patients to lend a hand. If patients become more aware of standards for healthy living, how to use health resources efficiently, and what their symptoms may mean, they can help lower the cost of care and decrease the burden on the system. They may literally "heal themselves."

Dr. Knopf is editor of Harry's Homilies.© He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

Health Literacy: Patients and Providers Share Responsibility

How providers can help ensure their information is heard and understood by the patient

By Jim Braibish, St. Louis Metropolitan Medicine

One of the most frustrating experiences for a physician is seeing a patient return three months later without following the treatment plan. Where did the disconnect occur? Often it is because the patient left without clearly understanding the treatment plan or was unable to follow it … examples of low health literacy.

Health literacy currently is defined by the Institute of Medicine as "The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."

However, experts say that providers have an equally important role in health literacy. Physicians and organizations should ensure that their information is tailored to the patient's education, cultural background, etc., and indeed is reaching the patient.

Over a third of U.S adults—77 million people—are rated at basic or below basic health literacy.

"The health system needs to do a better job of working with people where they are," said Catina O'Leary, PhD, LMSW, president and CEO of Health Literacy Media, a St. Louis-based nonprofit organization that assists providers and businesses in making their written and face-to-face communication more understandable. She also serves on an Institute of Medicine task force that is working to rewrite the definition of health literacy.

"The problem with the current definition is that it only focuses on the individual," O'Leary commented. "Health literacy is not just about the individual, but about the system. If you encounter a system that is not understanding of the patient, it is a significant problem."

As more patients become covered by value-based reimbursement, there will be more incentive for physicians to achieve successful patient outcomes. Promoting health literacy will be an important part of the equation. In addition, physicians say that insurance companies can support literacy efforts by covering case management services which follow the patient after they leave the office.

Few Patients Are Proficient in Health Literacy

Low health literacy is widespread. A 2003 federal study found that only 12 percent of U.S. adults are proficient in health literacy. Over a third of U.S. adults—77 million people—are rated at basic or below basic health literacy. This means they would have difficulty with common health tasks such as following directions on a prescription drug label or adhering to a childhood immunization schedule using a standard chart. The health literacy study was conducted by the U.S. Department of Education as part of its assessment of general literacy among the population.

Health literacy is lower among ethnic populations, with 54 percent of African-Americans rated basic or below basic and only 2 percent proficient. Among the Hispanic population, 65 percent rate basic or below basic and only 4 percent proficient. At basic level, a person is able to read a set of short instructions and identify what to drink before a medical test, but is unable to read instructions on a prescription bottle and determine what time a medication should be taken.

The level of health literacy decreases with age. Health literacy is basic or below basic for 70 percent of adults over age 75, compared to less than 35 percent for those under age 64. As expected, health literacy increases with education: 76 percent of those with less than a high school education have basic or below basic health literacy, while only 12 percent of those with a college education rate basic or below basic.

O'Leary believes even these figures are overestimated. "The tests for health literacy lack validity. They are not taken when the patient is feeling ill or under stress, the time when they are likely to be consulting a doctor. It's hard and scary when it's you," she said.

The economic cost of low health literacy is estimated at $106

billion to $238 billion annually, according to a study by a team for the National Bureau of Economic Research. This represents 7 to 17 percent of all U.S. personal health care expenditures. For Missouri, the study pinpoints the cost of low health literacy at $3.3 billion to $7.5 billion annually.

Barriers to Health Literacy

Where are the disconnects occurring?

Nancy Kelley, who works on health literacy issues as a program director for the Missouri Foundation for Health, said, "You cannot tell health literacy by looking at someone. You need to allow for cultural and socioeconomic factors. Even if someone has a college degree, they may not be knowledgeable about medical conditions or the health system."

Medical terminology may not be understandable to the patient, she noted. Also, when English is a second language for the patient, an interpreter should be available.

Another barrier can be patient anxiety about seeing the doctor. "Going to the doctor can be intimidating. There is a power differential. The patient may be feeling sick and scared, and afraid to ask questions. That is why it is helpful for the patient to bring a support person to the appointment," Kelley said.

Providers should carefully select the written materials they distribute and ensure they are written at an understandable level.

She pointed to use of the Internet as an emerging literacy issue. "Patients need to be able to discern what websites are legitimate sources of information. If the site is 'dot.com,' it may be a commercial site pushing its own products. Patients should rely only on trusted sites such as mayoclinic.com or webmd.com."

Providers should carefully select the written materials they distribute and ensure they are written at an understandable level. O'Leary said, "If the physician gives the patient a lot of papers and brochures, it can be hard to digest. We encourage providers to select only the materials that are most relevant."

An additional barrier she highlighted is when patients are unable to carry out treatment plans. "If the patient is told to eat healthy but lives in a 'food desert' where fresh, healthy food is difficult to obtain, it will be difficult to carry out that goal. The message has to be matched with what a person can do," she said.

Ways to Improve Health Literacy

Commonly endorsed in the health literacy field is the "universal precautions" approach. Just as the provider cannot tell by outer appearance if a patient is carrying a blood-borne disease, outer appearance does not indicate one's level of health literacy. The universal precautions approach assumes that most patients will have difficulty understanding health information.

The HHS Agency for Healthcare Research and Quality has developed a *Health Literacy Universal Precautions Toolkit*. It offers 21 tools that cover how to improve spoken communication and written communication, promote patient self-management and provide resource referrals for patients.

Communications techniques the toolkit suggests include greeting patients warmly and making eye contact; using plain, non-medical language; and using illustrations and 3-D models.

To improve communication with patients from multi-cultural backgrounds, the report suggests physicians ask such questions as, ***"Is there anything I should know about your culture, beliefs or religious practices, confidentially, that would help me take better care of you?"***

continued on page 10

TOP-RATED HEALTH LITERACY PRACTICES

Following are the health literacy practices rated by a panel of national experts as "having the potential to have the greatest impact on the greatest number of patients."

- Use a "teach-back" or "show me" technique to check for understanding and to correct misunderstandings in a variety of health care settings.
- Avoid using medical "jargon" in oral and written communication with patients, and define unavoidable jargon in lay terms.
- Elicit questions from patients through a "patient-centered" approach (e.g., "What questions do you have?" rather than, "Do you have any questions?").
- Use a "universal precaution" approach to oral and written communication with patients.
- Emphasize one to three "need to know" concepts during a patient encounter.
- Negotiate a mutual agenda with patients at the onset of encounters.
- Use professional medical interpreter services for patients whose preferred language is other than English.
- Elicit the full list of patient concerns at the outset of the encounter.

Source

"Prioritization of Health Literacy Best Practices for Health Professionals: A Consensus Study," University of Missouri-Columbia Center for Health Policy and Oregon Health and Science University Department of Family Medicine.

Health Literacy *continued from page 9*

A technique universally endorsed is the "teach-back" method. The provider asks the patient to repeat back instructions to ensure they are understood. The toolkit offers language the provider might use: ***"We covered a lot today and I want to make sure that I explained things clearly. Can you please tell me three things we discussed that you can do to help take care of your diabetes?"***

The teach-back method scored as the highest-priority health literacy practice in a survey of 25 nationally leading health literacy experts by the University of Missouri-Columbia Center for Health Policy and Oregon Health and Science University. Other top-rated priorities include avoiding medical jargon, consistently eliciting questions from the patient, using the universal precautions approach, and routinely emphasizing one to three main concepts.

Stan Hudson, associate director of the Center for Health Policy, said a core issue in improving health literacy is involving patients. "If we can get patients on the design team, we will be much better off. Health care has not been as consumer oriented as other industries. There has not been the level of end-user testing you see in consumer products," he said.

A patient-focused best practice called the "sacred moment" was developed at Twin Rivers Regional Medical Center in Kennett, Mo. When a patient arrives on an inpatient floor or for a procedure, the first provider who sees the patient—typically a nurse—will talk with the patient about their individual needs before collecting medical information.

"The provider will spend 10-15 minutes with the patient around the question, 'what is your greatest concern about being here?'" said hospital medical director and surgeon Steve Pu, DO, who also is the board chair of Health Literacy Media. "We found that patients like the interaction. Our staff feels it brings them closer to why they work in health care—to care for patients. Our rating scores went up 30 percent in every metric the first year after we implemented this," he said.

Local Programs

The MU Center for Health Policy was established in 2002 to foster dialogue about health policy issues in Missouri. It presents professional development programs on health literacy and the teach-back method. It has served MU's schools of medicine and nursing and the university hospital, as well as state and national audiences. It also provides plain language services and usability testing.

Health Literacy Media was founded in 2009 as Health Literacy Missouri, with core funding from the Missouri Foundation for Health. Based in downtown St. Louis, Health Literacy Media has 20 employees and works with hospitals, universities, pharmaceutical companies, health insurers and others to build health literacy into their operations.

Health Literacy Media has developed a proprietary guide for writing consumer-friendly materials that it uses in its service to businesses and the community, O'Leary said. It also has a contract with the Missouri Foundation for Health to provide education in communities across most of the state to help individuals learn how to obtain and use health insurance.

Advice

To summarize her recommendations to providers, O'Leary suggests, "Put yourself in the place of the people who need care. Help them be informed so they can walk out clear and confident."

For individuals, she advises, "Engage with your care providers and ask questions. Write down your questions before you go in. If the provider doesn't use the teach-back method, ask them if you can repeat what you understand as the treatment."

Hudson offers these words to providers: "Understand what evidence-based health literacy practices are available. Follow the universal precautions for health literacy. Realize that anytime you communicate with the patient, there is the risk of misunderstanding."

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Bedside Manner: An Ounce of Prevention Is Better Than a Pound of Tactics in Defending a Malpractice Case

By J. Thaddeus Eckenrode, Eckenrode-Maupin, Attorneys at Law

I'm often struck by how much easier it is to defend physicians in medical malpractice cases who are "nice doctors" than those who come in with a chip on their shoulder, appear arrogant or combative, or simply act like their mere appearance in court is a waste of their precious time. Needless to say, we spend many hours over several pre-trial preparation sessions making sure that our clients put on the best face possible for trial.

It is an unfortunate fact of life, however, that we even have to do so for many a defendant physician. Jurors are human, of course, and like all humans, they make value judgments about who they like and don't like within seconds of first encountering them. As the saying goes, "you never get a second chance to make a first impression." What is more surprising is how many intelligent, well-educated individuals simply don't get this basic fact of life.

When we have an opportunity to talk to jurors post-trial, they often aren't shy about telling us what they thought of one doctor or another, including those who appeared as experts, fact witnesses, and especially the defendant. In one recent trial, a juror told me after trial that "we all agreed that if we ever needed a doctor of that specialty, he'd [the defendant] be the one we'd go to." Needless to say, they loved that doctor, found him credible and personable, and we prevailed in that trial. The simple fact is, if the jury likes you, then your chances of winning at trial are much higher. The corollary to that truism is that if your patients like you, the chance of ever even being sued are greatly reduced.

This does not mean to suggest that you'll never get sued if you are a nice doctor or well-liked by your patients. Even the nicest doctor can have a terribly bad and unexpected outcome with a patient, or even commit an act of negligence. Some patients, of course, are simply hard to please or are difficult to deal with. Likewise, of course, even the most arrogant doctor will not be sued by every patient who has a bad outcome. Many prospective jurors tell us in voir dire about a bad medical outcome their family member has had, but that they simply never considered filing suit. The real issue here, and the point of this article, is how to avoid getting sued by those who might otherwise be quick on the litigation trigger.

J. Thaddeus Eckenrode

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Taking Time With the Patient Builds Goodwill

Bedside manner is critical. Over one hundred years ago an article in *JAMA* stated "The true basis of good bedside manner is a big heart."[1] A physician who speaks in a friendly manner, explains things calmly and sympathetically, sits with the patient, takes time to listen to their concerns and questions—perhaps even reading between the lines—is going to be seen as a "Marcus Welby" type to their patients, and even if the outcome is bad, the patients may not consider litigation. On the other hand, a physician who runs in and out of the room quickly, doesn't really make eye contact with the patient, speaks in a condescending tone or with a flippant or sarcastic demeanor, is going to be viewed more like Dr. House of the "House" TV series—perhaps a genius, but a rude one for whom no patient will have any sympathy if things go wrong.

The simple fact is, if the jury likes you, then your chances of winning at trial are much higher. The corollary to that truism is that if your patients like you, the chance of ever even being sued are greatly reduced.

This isn't news. Various studies have been done over the years in an attempt to correlate why certain patients sue. Ultimately, communication and bedside manner have been found to have a role. In one study, funded by the Agency for Health Care Policy and Research (AHCPR), the researchers recorded interactions between a number of physicians and their patients, and found distinct differences in the communication styles between those physicians who had claims brought against them and those who did not.[2]

No matter how many times I encourage physicians to take more time with their patients, the standard response I hear from nearly all of them is that they are simply too busy, often with a schedule that runs an hour or more behind (which certainly doesn't endear them to their patients). They also say insurance and Medicare reimbursements have been cut back substantially over the past several years to the point where it is hard to break even unless they squeeze in as many patients as possible. But statistics and studies support the notion that a cold demeanor or giving patients "short shrift" continues to lead some patients to consider litigation when they might not have otherwise.

Avoiding Litigation

So what can the harried, overworked physician do to avoid litigation? Some things that may help don't really take any extra time:

1. Simply smiling and looking the patient in the eye when you walk into the exam room or see them in their hospital bed is a big help. Sit down next to them; don't stand over them, or sit behind a desk, in other words, be at their level.
2. Know a little bit about them—most EHR systems now have a place where you can make some general notes. Know things like whether they go by a nickname or a name other than their first name (call him "Bob" instead of "Robert").
3. Let them call **you** by your first name. Instead of introducing yourself to new patients as "Dr. Jones," say "Hi, Mrs. Smith, I'm Tom," and let them call you that. I know some physicians feel that they've earned their title of "doctor," and others feel it is important to keep that professional stature in dealings with patients, but I recommend physicians get over that ego issue. Do you know how much harder it will be for a patient to consider suing their friend "Tom" than it will be to sue that somewhat distant "Dr. Jones?"
4. Have your staff update your office personal "notes" about patients when they are in the news, when they lose a loved one, or when they've received an accolade. Look at those notes for a moment before you walk into the room, so that you can say "Hi, Bob. I hear your son just got accepted to the Naval Academy," or so you don't ask "How's your family?" only to be told that the patient's wife was just killed in an accident. Needless to say, you'll never be able to keep up completely, but knowing something about your patients' lives is better than knowing nothing.

Be Considerate During the Exam

A common complaint we hear in depositions of plaintiffs in malpractice suits is that the doctor "only spent a minute or two with me." Granted, that is likely a gross exaggeration in most cases, but the **patient's** perception is that it was a nominal amount of time. To the extent you can, sit with them and listen to their complaints, issues and stories. Many patients will vaguely touch on something they want to discuss when they are seeing you for something else. Listen to those subtle cues and ask about them. Engage them in enough "non-clinical" conversation to demonstrate that you care about them personally, but don't miss the details of why they are there.

Likewise, many plaintiffs will say that the doctor's exam was cursory, when the doctor knows it was very thorough. Proving that at trial isn't difficult, assuming your records are complete, but why ever put yourself in that position? As you examine the patient, take a moment occasionally to tell them what you are doing. They'll remember a lot more about what your exam entailed if you talk to them as you do it.

But don't turn your back on them to make your notes. To the extent possible, face them (and talk to them) as you enter information or data in your EHR or paper chart. There are pros and cons to having a nurse or scribe in the room with you. Needless to say, record keeping is better.

> Taking extra time with your patients, changing your communication style when necessary, and finding a way to be friendly no matter how hectic a day you are having personally, are bound to save you from at least one lawsuit at some point in your career.

Likewise, speaking out loud about the various physical exam findings to your assistant helps show the patient how much you are doing, but keep in mind that some patients don't like you talking about them in the third person to someone else (you can almost hear them thinking "you do know I'm right here, don't you?"). Some just feel that their issues are personal between you and the patient. Ask them if they mind someone taking notes for you as you do your exam. Again, this is what a "nice doctor" would do, and they'll likely remember you considering their point of view. Needless to say, if they don't want anyone else in the room, agree to that, but then it falls to you to make a good record of the visit. However, as noted above, don't turn your back on the patient just because you have had to assume the "charting" responsibility.

A friendly demeanor with patients can be most easily achieved by finding things to laugh about. However, use humor carefully. For every patient who likes your jokes and your sarcasm there may be another who is offended. Admittedly, it can be difficult to figure that out, but you have to do so. When you first encounter a patient, let them talk about their problems. Those who joke with you are probably the ones with whom you can joke and develop a good rapport. Those who are very serious probably won't like your sense of humor and will take your jokes as insulting. To them, speak politely, calmly and reassuringly, but avoid the stand-up comedy, or at least keep your jokes self-deprecating, and to a minimum.

continued on page 14

Nothing beats a follow-up call from you (not your nurse) later in the day after you've performed a procedure of some sort on a patient, especially if that call comes at night when they don't expect to hear from you. If the patient isn't home, leave a HIPAA-compliant message and encourage them to call if there are any problems. Document that you made the call (if you are sued later, it is great evidence to show the jury that you took the time to follow up, even if the patient doesn't recall it). That should be your routine, not something you do just occasionally for the more "serious" cases.

Engage them in enough "non-clinical" conversation to demonstrate that you care about them personally, but don't miss the details of why they are there.

It also goes without saying that you should try to encourage your office staff to take the same friendly, interested approach to your patients. It is not unusual to hear patients complain about a physician's staff members, but I surmise that it is less likely that any doctor is going to be sued because his/her nurse shows a poor attitude than they ever would be if the doctor is rude, disinterested or communicates poorly. Nevertheless, the more any patient feels comfortable in your office—from their initial encounter at the desk until you release them from your exam—the less likely you will be sued.

You don't want to think of them this way, but realistically, every patient you see is a potential future malpractice plaintiff. There is no way that simply being a "nice doctor" is going to prevent you from ever being sued. However, taking extra time with your patients, changing your communication style when necessary, and finding a way to be friendly no matter how hectic a day you are having personally, are bound to save you from at least one lawsuit at some point in your career. The truth is, you'll never really know—if you **aren't** sued you won't know that a patient considered it. But I can guarantee that the investment of time in changing up your practice procedures a little bit will be a far better use of your time—and far less stressful—than spending a week or two in trial some day in the future. ◄

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Free Educational Programs Offered by League of Healthcare Experts

SLMMS physicians and their practice administrators are invited to participate in an ongoing series of free health care education programs provided by the League of Healthcare Experts. The programs are scheduled throughout the year and will be promoted in the monthly SLMMS electronic member updates and at slmms.org.

The League of Healthcare Experts began eight years ago with a single seminar on the health care stimulus bill. It was so successful that it grew into more events with various sponsors on a variety of health care topics.

"Our programs are strictly educational in nature, with no marketing of services, just an introduction to those experts who can help physician practices with a myriad of services," explains Ann Grana, program coordinator. "We focus on current topics and have recently presented programs on Meaningful Use, electronic health records, malpractice and risk management, banking updates, new payment models, HIPAA compliance, and more recently MACRA and MIPS. Participants are surveyed and we create programs from what our attendees request."

Participating organizations in the League of Healthcare Experts include Keystone Technologies, Keane Insurance Group, HealthCore Value Advisors, GBS Information Systems, Enterprise Bank & Trust, Datafile Technologies, and Anders CPA + Advisors.

On Friday, April 21, LHE will present a daylong workshop, "Updates from Washington," discussing legislative updates and how the new administration may affect health care. The program will be presented in partnership with the Healthcare Financial Management Association of St. Louis at the Lodge Des Peres from 9:00 a.m. to 2:00 p.m.

The next lunch and learn workshop, "Fog Computing," is scheduled for Thursday, May 18 from 11:30 a.m. to 1:00 p.m. at Keane Insurance Group, 135 West Adams in Kirkwood. The featured speaker will be Aaron Jackson, vice president of solutions architecture with Keystone Technologies. Lunch is provided by the sponsors.

All League of Healthcare Experts programming is free of charge, but advance registration is required. View the schedule of programs and register by visiting www.leagueofhealthcareexperts.com. You may also subscribe to their online newsletter. ◄

INNOVATION CORNER

Spotlighting the work of the SLMMS Innovation Committee with the growing biotechnology startup community in St. Louis

Immunophotonics

Immunophotonics is a biotech company developing a proprietary drug for use in a minimally invasive therapeutic cancer vaccine (inCVAX) for the treatment of metastatic tumors. While additional clinical trials are needed to further assess safety and efficacy, initial first-in-human clinical trial results are encouraging. The company, founded in 2009, is located in the Cortex biotechnology hub in St. Louis, near Washington University.

Tomas Hode, PhD, chief executive officer and co-founder, explains that St. Louis has been an ideal home for them. The company relocated to Missouri several years ago due to the availability of "angel" funding, and the great infrastructure available for biotech start-ups, including outstanding lab facilities, physician involvement, and community support, as well as the continued ability to raise funds, has contributed to their initial success.

Radiologist Christopher Swingle, DO, SLMMS president-elect and a SLMMS Innovation Committee member, has been a physician advisor for Immunophotonics for the past year. "I assist with quality assurance of the images that they are acquiring from their offshore clinical trials, as well as provide over-reads on studies and assistance with protocol design," he explained.

Hode shared that the company has a network of at least 20 physicians working as both collaborators and advisors, and that "their importance cannot be overestimated." The physicians can, for example, help assess outcomes, safety, and the desired impact of the therapies. "Ultimately, they will be the end users of the product," he continued. "They help us decide which paths to take, and they provide incredible feedback. It is vital to the success of the product that physicians are familiar and comfortable with it."

Dr. Swingle agrees that physician involvement is key. "There are some great science, medical device and pharma people working in the St. Louis start-up community. But what they need to complete the picture is the perspective of a practicing clinician," he explained. "In the case of medical imaging, a radiologist's insight into imaging protocols, radiation safety and image quality can mean the difference between success or failure of a clinical trial of a new therapeutic. Similarly, a surgeon who knows the reality of the operating room or an internist who manages a diverse patient population frequently possesses insight that our scientist colleagues at a start-up might not have."

Working with a start-up can be invigorating, says Dr. Swingle. "It's a great opportunity to re-ignite the fire of curiosity that we had in training," he added. "It's a chance to leverage your medical knowledge that serves dozens of patients a day in clinical practice to potentially hundreds or thousands of patients across the world."

Want to get more involved in the St. Louis biotech innovation community? Take the Innovation Committee's survey. To learn more about the SLMMS Innovation Committee and available opportunities, contact the SLMMS office.

Staying Ahead of Provider Enrollment

Maintaining current provider enrollment (credentialing) ensures you remain in networks and helps patients find you

By Chastity D. Werner, CMPE, RHIT, NCP, CRCR, Anders CPAs + Advisors

Provider enrollment has become one of the more multifaceted business processes faced by our health care providers today. With processes changing at such a rapid rate, it can be very challenging for even the most advanced clinics and facilities. For providers to not only keep up with which payer is changing what process, but to then implement these changes and communicate with all involved stakeholders, makes "Mission Impossible" appear elementary.

One of the most common misconceptions is that the credentialing process is a menial task that can be completed in one's spare time. This process often falls under the practice or clinic manager that will do it when they get a moment, but that moment never comes. They realize it's too late after receiving a call from a regular, long term patient asking why their doctor is now out-of-network, or they receive a denial that cannot be appealed or collected resulting in revenue lost.

If payer processes are not completed properly and timely, it can severely impact your organization from a financial and patient satisfaction standpoint. Whether it is the inability to obtain proper authorizations or pre-certs, claims being denied or claims being processed out-of-network (causing higher patient responsibility), the end result impacts your bottom line and ability to properly treat your patients.

There are several ways you can prevent this from occurring. Below are a few pointers that will help put you ahead of the game.

CAQH is no longer an option, it is a requirement. The CAQH (Council on Affordable Healthcare Quality) system once was optional, but today it is a requirement for most major payers. Payers use CAQH to update their records and stay current on changes for providers in their networks. If you do not maintain

Chastity D. Werner

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The CAQH system has become a standard requirement for most major payers.

and attest your file quarterly, you are at risk of being terminated by payers. The platform has advanced in many ways and will identify on the initial screen whether items or documents are outdated/expired or if there are conflicts with the stored information. When information for you or your practice changes, make sure to update CAQH accordingly.

Once information is proofed for accuracy and current supporting documents are uploaded, do not forget to attest! CAQH will allow providers to authorize other persons to update and attest their information. Providers can do this by signing an authorization form obtained from CAQH, which is valid for up to three years, or calling and providing verbal consent to CAQH. Be mindful if multiple individuals have access to a provider's CAQH profile, they can change information that may cause complications, especially if the provider works for multiple organizations with different billing identifiers and addresses. It is better to have one gatekeeper that communicates with all organizations and makes needed changes. If you or your staff are unfamiliar with CAQH and its functions, they have great on-demand webinars and training manuals on their website.

Perform a provider to payer reconciliation annually. Performing an annual reconciliation with payers allows providers to immediately identify if the payer has invalid information, whether that was caused by needed revisions not being made, enrollment not being completed, or a revalidation request was missed and the provider in turn has been terminated. If any discrepancies are identified, you need to act immediately to have the information updated and corrected. This not only can cause financial hardship if the provider is no longer in network, but many times the database is utilized for multiple areas including provider directories. If not updated, it could cause patients to retrieve invalid information when

searching on the Internet for the specific provider or specialty. This is another reason you will want to complete all information related to your practice such as specialty, hours and services offered. It can become a free marketing tool you can track by patient referral types.

Review provider directories. A majority of payers offer provider directories online. Keep in mind when patients are looking for your new address, a provider of your specialty or a clinic near their location, this is what they will utilize. If you identify incorrect or outdated information you can contact the payer and have the information changed. After requesting the change, remember to follow up 30-45 days later to verify the changes were updated.

Know whether your contracts are individual or organization. Similar to billing, all payers perform their contracting processes differently. While some payers require providers to be under a group contract, others require the provider to be individually contracted and the group be linked to the provider. By knowing your contracts you will know which steps to take to update and correct information. If the contracts are individual, you can complete or send a link letter to the payer to have the provider added to your group. This can reduce processing time and allow the provider to be enrolled quicker.

Know the payer's process. Although it is impossible to know all processes and keep up with changes for all of the payers in your patient base, it is imperative you keep up with your major payers. Knowing the shortcuts and online steps can save time and frustration in the end. Most of the major payers today have great website tools that explain their processes.

It is never a one and done. One of the most common errors clinic and providers make is to not put forth the energy and time needed to stay current, communicate, and maintain current information with payers. Although in most cases the information is simple to complete, the process can be very time consuming when following up with the payers and ensuring the application or changes were processed and completed. Depending on the size and need of your organization, this may be tracked on a spreadsheet or one of the many software platforms available.

Outsourcing the process. If your organization does not have the skillset, staff or time to perform the enrollment and maintenance tasks, consider outsourcing the entire process. This can be a cost-effective approach that will pay for itself in the long run if performed properly.

Organizations that master the provider enrollment processes can achieve many positive results including increased patient volume and revenue. If set up and maintained properly, you can turn the above process into a marketing tool that will help spread the word about new services and locations for your organization.

What the "Soft Market" Means for Physicians

By Monte Shields, The Keane Insurance Group

Every industry has its own jargon. The medical malpractice insurance business is as bad as any for spewing out vocabulary that only the experts can follow. Tails, Nose Coverage, Retroactive Dates, Reinsurance, and these days, the hottest topic: the **"Soft Market."** You may have had your medical malpractice broker mention this term to you in a renewal meeting in the last couple of years. But what does it mean? And how does it affect physicians?

How Can a Market be Hard or Soft?

All insurance markets go through hard and soft cycles. Whether its auto and homeowners insurance, life insurance, commercial insurance, or professional liability insurance, they all have their ups and downs. The economy has a great deal to do with the changes in rates and in profitability. Severity and frequency of insurance claims also can affect and influence changes. For example, when a bunch of claims or settlements cause insurance companies to pay out large sums of money for many years in a row, those companies will begin to raise rates to make up for those losses.

> Indicators suggest that this soft market is different than the cycles in the past because the insurance carriers continue to make profits with the lower rates.

When several of those companies decide the line of insurance is not profitable for them, they pull out of the market, or even worse, shut down the business completely. A sudden reduction in availability of insurance along with an increase in rates creates a "hard market." It's a situation where the consumer has very few options for buying insurance, and the rates are unaffordable. The few insurance companies that hang in there and still offer coverage continue to raise premiums to make sure they remain profitable. In many cases, underwriting guidelines are narrowed making it difficult for the consumer to qualify or meet the guidelines. In medical professional liability insurance, this means some very good doctors have to seek coverage in the "non-standard" market, which charges even higher premiums.

Monte Shields

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The Current Trend

The medical malpractice insurance market has experienced the same cycles as other insurance lines. In the early part of the 2000s we were in a hard market where physicians were paying some of the highest rates in U.S. history. Many doctors were closing their doors and moving across state lines to find more favorable malpractice insurance rates and guidelines. A high number of doctors shut down their private practices or retired early because they couldn't afford the premiums. There were so few insurance carriers willing to compete in the medical malpractice insurance market, physicians with even just one claim were forced to go to the non-standard market for coverage.

All that changed between 2003 and 2005, depending on the state. By the mid 2000s most states saw a gradual shift toward a soft market for medical malpractice insurance. The shift occurred for several reasons: Medical malpractice claims leveled off or decreased, a few states enacted tort reform bills that helped limit the damages insurers would have to pay out, and insurance companies seeing an opportunity began offering coverage where they weren't previously. This increased the number of carriers available to physicians, creating competition. Rates started leveling off in 2008 and 2009 in most areas of the country. By 2010 we were experiencing lower premiums. Rather than lose a customer to a competitor, insurance companies started matching or beating competitors' quotes received by physicians. **That trend is continuing today and is predicted to stay on course for at least another couple of years.**

Statistics show that premiums for medical professional liability insurance went down dramatically from 2010 to 2015. The industry rate surveys of the large medical malpractice companies show a continuous drop annually. Recent reports suggest that rates may have leveled off in most states. Indicators suggest that this soft market is different than the cycles in the past because the insurance carriers continue to make profits with the lower rates. This is probably due to the lower number of claims against the companies. However, this profitability will likely come under some pressure for some insurance companies as past reserves eventually need to be increased.

What Does this Mean for You?

For a physician in private practice who must purchase medical liability insurance every year, the soft market is great news! This situation has created an opportunity for you to find the broadest coverage at the lowest rates available in recent history. In most states and specialties doctors have multiple options for coverage. **But you have to do your homework.** Most physicians are only looking at price when making a decision to renew their current coverage or to move to a new company. **Looking at price only is a mistake.** There are other important factors as well. Look into the financial strength of the company, find out if they provide aggressive defense of policyholders, or if they include additional coverage for things like cyber liability at no extra charge.

Also consider the structure of the company. Do you know the difference between a stock insurance company, a mutual insurance company, or a risk retention group? If not, you should seek advice from an independent professional liability insurance broker. Once you've narrowed your search to a few good options, look for policy features that need to be there: consent to settle clause, free tail for retirement, zero deductible, liability limits that meet the hospital and state requirements, etc.

No one can accurately predict a change in the medical malpractice insurance market, but for now physicians are enjoying some of the best options and rates available.

Study Finds Colorectal Cancer Rates Have Risen Dramatically in Gen X and Millennials

A new study finds that compared to people born around 1950, when colorectal cancer risk was lowest, those born in 1990 have double the risk of colon cancer and quadruple the risk of rectal cancer.

The study is led by American Cancer Society scientists and appears in the *Journal of the National Cancer Institute*. It finds colorectal cancer (CRC) incidence rates are rising in young and middle-aged adults, including people in their early 50s, with rectal cancer rates increasing particularly fast. As a result, three in ten rectal cancer diagnoses are now in patients younger than age 55.

To get a better understanding, investigators led by Rebecca Siegel, MPH, of the American Cancer Society used "age-period-cohort modeling," a quantitative tool designed to disentangle factors that influence all ages, such as changes in medical practice, from factors that vary by generation, typically due to changes in behavior. They conducted a retrospective study of all patients 20 years and older diagnosed with invasive CRC from 1974 through 2013 in the nine oldest Surveillance, Epidemiology and End Results (SEER) program registries. There were 490,305 cases included in the analysis.

The study found that after decreasing since 1974, colon cancer incidence rates increased by 1% to 2% per year from the mid-1980s through 2013 in adults ages 20 to 39. In adults 40 to 54, rates increased by 0.5% to 1% per year from the mid-1990s through 2013.

Three in ten rectal cancer diagnoses are now in patients younger than age 55.

"Trends in young people are a bellwether for the future disease burden," said Siegel. "Our finding that colorectal cancer risk for millennials has escalated back to the level of those born in the late 1800s is very sobering. Educational campaigns are needed to alert clinicians and the general public about this increase to help reduce delays in diagnosis, which are so prevalent in young people, but also to encourage healthier eating and more active lifestyles to try to reverse this trend."

The St. Louis Metropolitan Medical Society supports the 80% by 2018 colorectal screening campaign of the American Cancer Society and other partners. For more information, contact Katie Wrenn of the Cancer Society at katie.wrenn@cancer.org.

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Physician News


Paul J. Scheel, Jr. MD

Paul J. Scheel, Jr., MD, has been named associate vice chancellor for clinical affairs at Washington University School of Medicine and chief executive officer of Washington University Physicians. His appointment is effective July 1. Dr. Scheel currently serves as vice president of the Office of Johns Hopkins Physicians in the Johns Hopkins Health System and medical director of Integrated Renal Solutions of Johns Hopkins Healthcare in Baltimore. He succeeds James P. Crane, MD, (SLMMS), who has led Washington University Physicians for more than 25 years.


Rajesh Swaminathan, MD

St. Anthony's Medical Center has named **Rajesh Swaminathan, MD**, as chief medical officer. Bringing more than 16 years of experience as an intensivist and medical director in the St. Louis area, he most recently was medical director of the intensive care unit at Anderson Hospital in Maryville, Ill.


J. William Campbell, MD

J. William Campbell, MD, has been named medical director of St. Luke's Medical Group. He has been with St. Luke's since 2004 and is well-known for his clinical expertise in infectious disease.

Hospitals

- **Mercy** and **St. Anthony's Medical Center** in St. Louis announced an agreement in which St. Anthony's will affiliate with Mercy's four acute care hospitals and 730 physicians across the greater St. Louis region. The St. Anthony's brand will be retained.
- **SSM Health Saint Louis University Hospital** shared renderings of the new $550 million hospital and ambulatory care center to be built just north of the current hospital building. The new hospital will feature 316 private patient rooms, an expanded Level 1 trauma center and emergency department, larger intensive care units, expanded patient parking, green space, and areas for any future campus expansion. Groundbreaking is scheduled for Aug. 31.

- **Barnes-Jewish West County Hospital** will break ground this spring on a new hospital and adjoining medical building to replace the current facility. The new hospital will have 64 private patient rooms and 14 operating rooms, with room for expansion to 100 inpatient rooms and 16 operating rooms.

- **Siteman Cancer Center** at **Barnes-Jewish Hospital** and **Washington University School of Medicine** has opened a clinic for adult survivors of childhood cancer at the center's south St. Louis County location. The Lifelong Outcomes Clinic provides long-term care aimed at preventing, detecting and treating delayed complications of childhood cancer and addressing the mental health concerns of adult survivors of childhood cancer.

WELCOME NEW MEMBERS

Kevin E. Behrns, MD

1402 S. Grand Blvd., M268, 63104
MD, Mayo Clinic School of Med., 1988
Born 1958, Licensed 2016 ► **Active**
Cert: Surgery

Melinda B. Chu, MD

222 S. Woods Mill Rd., 63017
MD, Saint Louis Univ., 2009
Born 1981, Licensed 2015 ► **Active**
Dermatology

Marlon C. Torrento, MD

212 Hospital Ln., #200, Perryville, 63775
MD, Univ. of the Philippines, 2003
Born 1972, Licensed 2009 ► **Active**
Cert: Internal Medicine/Infectious Disease

Daniel J. Young, MD

510 S. Kingshighway Blvd., 63110
MD, Eastern Virginia Med. School, 2015
Born 1987 Licensed 2016 ► **Resident**
Diagnostic Radiology

WELCOME STUDENT MEMBER

Saint Louis University School of Medicine

Ashley E. McGuinness

Gilbert E. Corrigan, Sr., MD, PhD

Gilbert E. Corrigan, Sr., MD, PhD, a board-certified anatomical and forensic pathologist, died May 17, 2016, at the age of 87.

Born in Detroit, Mich., Dr. Corrigan received his undergraduate degree from Case Western Reserve University, his MS in genetics from University of Notre Dame; his PhD in anatomy from Ohio State University and medical degree from Wayne State University. He completed his residency at Ohio State University and Harvard/Boston Children's Hospital; and internship at Harper Hospital in Detroit. He completed a fellowship in forensic pathology at the University of Maryland-Baltimore Medical Examiner's office.

Dr. Corrigan served in the U.S. Army Reserves at the 21st General Hospital, and was ultimately promoted to lieutenant colonel.

He served as chief medical examiner in Detroit, and opened the Bexar County medical examiner's office in San Antonio, Texas. He was a professor of pathology at Saint Louis University School of Medicine, and the chief of laboratories at the VA Hospital in St. Louis.

Dr. Corrigan joined the St. Louis Metropolitan Medical Society in 1975.

Dr. Corrigan was preceded in death by his wife, Esther Cabrera Corrigan and his son, Gilbert Corrigan, Jr. SLMMS extends its condolences to his children, Esther M. Corrigan MD, Joseph Corrigan, Daniel Corrigan, Rachel Pickering, Matthew Corrigan, Rebecca Corrigan, Samuel Corrigan, Phillip Corrigan and Sarah Serou; and his nine grandchildren.

Theodore M. Meiners, MD

Theodore M. Meiners, MD, an obstetrician-gynecologist, died March 1, 2017, at the age of 93.

Born in St. Louis, Dr. Meiners received his undergraduate degree from the University of Central Missouri, and his medical degree from Washington University, and then completed his internship at St. Luke's Hospital.

He was in private practice, and served on staff at St. Luke's Hospital, Christian Hospital, SSM Health DePaul Hospital and Missouri Baptist Medical Center. He also served on the faculty at Washington University School of Medicine.

Dr. Meiners joined the St. Louis Metropolitan Medical Society in 1949, and became a Life Member in 1999.

SLMMS extends its condolences to his wife, Emilie Elfrig Meiners; his children, Linda Aldridge, Lucy Morrow, Barbara Stegmann, David Meiners, Susan Meiners, Nancy Canavera, Cynthia Meiners, Bill Schroer MD, Tim Schroer and Liesl Schroer; his grandchildren and great-grandchildren. He was preceded in death by his first wife, Mary Jean Davis Meiners.

Frederick D. Peterson, MD

Frederick D. Peterson, MD, a board-certified pediatrician, died March 2, 2017, at the age of 85.

Born in St. Louis, Dr. Peterson received his undergraduate degree from Knox College and his medical degree from Washington University. He completed his internship and residency at St. Louis Children's Hospital where he also served as co-chief resident; he then served as associate professor of clinical pediatrics at Washington University School of Medicine.

At St. Louis Children's Hospital, he was instrumental in helping to establish a new program, Community Office Practice Experience (COPE), which revolutionized the manner in which ambulatory pediatrics is taught to residents, providing them training one day a week in the office of a practicing pediatrician. He received the Washington University School of Medicine Faculty Achievement Award in 1992.

Dr. Peterson served as president of the St. Louis County Medical Society in 1974. He joined the St. Louis Metropolitan Medical Society in 1960, and was made a Life Member in 2005.

SLMMS extends its condolences to his brother, William Peterson.

David L. Simon, MD

David L. Simon, MD, a board-certified pediatrician, died March 5, 2017, at the age of 89.

Born in St. Louis, Dr. Simon received his undergraduate and medical degrees from Saint Louis University. He completed his internship at Mercy Hospital St. Louis.

He was in private practice, and served as an associate professor of clinical pediatrics at Saint Louis University School of Medicine. He was on staff at SSM Health Cardinal Glennon Children's Hospital, SSM Health DePaul Hospital, Mercy Hospital, the former Jewish Hospital and the former St. Joseph Hospital-Kirkwood.

Dr. Simon joined the St. Louis Metropolitan Medical Society in 1951, and became a Life Member in 1994.

SLMMS extends its condolences to his wife, Barbara Simon; his son, Alan Simon; his five grandchildren and two great-grandchildren.

Nathaniel Murdock, MD: Alliance 2017 Doctor of the Year

By Gill Waltman, SLMMS Alliance

"Wherever the art of medicine is loved, there is also a love of humanity."

– Hippocrates

This was the quote used by Sue Ann Greco to sum up the lifelong service of Nathaniel Murdock, MD, this year's recipient of the Alliance Doctor of the Year Award.

"For over 50 years, Dr. Murdock has been a tireless servant to the art of medicine and to humanity through his practice, his community service, and his commitment to organized medicine," said Sue Ann in presenting the award.

The Doctor of the Year Award recognizes a Medical Society member who has been an advocate for the profession of medicine, an advocate for quality health care, a role model for future physicians, and a supporter of the Alliance. Dr. Murdock's wife, Sandra, is a longtime Alliance member and currently co-president.

Dr. Murdock is a board-certified obstetrician-gynecologist who graduated from Howard University in Washington, D.C., and received his medical degree from Meharry Medical College in Nashville, Tenn., in 1963. He completed his internship and residency at the former Homer G. Phillips Hospital in St. Louis and served two years in the U.S. Air Force, achieving the rank of captain. He was inducted into the American College of Obstetricians-Gynecologists in 1972, and for more than 45 years has served on the faculty in the department of obstetrics and gynecology at Washington University School of Medicine and has had affiliations with all the major hospitals in the St. Louis area.

Dr. Murdock joined SLMMS in 1969 and served as president in 2001. He has served as an alternate delegate to the American Medical Association since 2002. He is a longtime member and former vice-councilor of the Missouri State Medical Association. Since the 1970s, Dr. Murdock has been active in the Mound City Medical Forum, including serving as president from 1986-1988. He served as president of the National Medical Association from 1997-1998, and as president of the St. Louis Gynecological Society from 1997-1998.

Continuing to be active in many civic, religious and philanthropic activities, Dr. Murdock is an active member of All Saints Episcopal Church. He is a life member of the Urban League and the National Association for the Advancement of Colored People.

Presenting the 2017 Alliance Doctor of the Year Award to Nathaniel Murdock, MD, are, from left: Claire Applewhite, Sandra Murdock, Sue Ann Greco, Dr. Murdock, Angela Zylka, Gill Waltman, Jean Raybuck and Jo-Ellyn Ryall, MD.

He is the recipient of many awards and honors, including the Medical Society's 2015 Robert E. Schlueter Leadership Award. He also is a past recipient of the Mound City Medical Forum Distinguished Leadership Award and the *St. Louis American* Lifetime Achievement Award in Medicine.

The Alliance thanked Dr. Murdock for his substantial support and spiritual advice to the Alliance for many years. For the young doctors-to-be in the audience, it was an opportunity to present a shining example of what a life dedicated to the profession of medicine can be.

Alliance Coming Events

Fashion Show Fundraiser

Saturday, April 29
11:30 a.m. Luncheon and Fashion Show
Neiman Marcus, Zodiac Room

Installation of Alliance Officers

Thursday, May 11
6:30 p.m. Dinner and Program
Venue TBA

Doctor of the Year, SLU Free Clinic Honored

Alliance members and guests gathered for the annual Doctor of the Year dinner on Feb. 10 at the Hilton St. Louis Frontenac Hotel. The Doctor of the Year Award was presented to Nathaniel Murdock, MD (see accompanying article).

Also honored at this event was Saint Louis University School of Medicine's Health Resource Center (HRC). First opened in 1994 in the basement of St. Augustine's Catholic Church, its mission is to provide free medical services to the communities of St. Louis with particular focus on the needs of the underserved and underinsured populations.

Michael Railey, MD, of Saint Louis University School of Medicine and Eva Frazer, MD, were honored for their support of the SLU Health Resource Center free clinic in north St. Louis. From left, SLU medical students Katie Bates, Jessica McGee and Brittany Barley; SLU psychology doctoral candidate Tamisha Thelemaque; Dr. Railey; Dr. Frazer; and Alliance members Sandra Murdock, Sue Ann Greco, Angela Zylka and Gill Waltman.

In August 2013 with the help of former SLU trustee Eva Frazer Roberts, MD, the clinic moved to the spacious Victor Roberts Building on North Kingshighway. It is staffed by medical students and volunteer attending physicians, providing an educational component along with quality patient care. Approximately 90 percent of SLU medical students rotate through the clinic during their education and help raise funds to purchase supplies for the clinic.

The Alliance honored Dr. Roberts and Medical Director Michael Railey, MD, for their contributions to making the HRC an integral part of providing health care for the St. Louis community. Dr. Railey also is associate dean of diversity and student affairs for the School of Medicine. Utilizing proceeds from the dinner and donations from Southside Comprehensive Medical Group and Senectus II, the Alliance presented a check to the HRC.

See the SLMMS Facebook page for more photos from the Doctor of the Year: www.facebook.com/saint.louis.metropolitan.medical.society.

Named to 2017 Women of Achievement

Claire Applewhite

Claire Applewhite, Alliance member and wife of 2011 SLMMS President Thomas A. Applewhite, MD, has been named one of 10 recipients of the 2017 Women of Achievement Award. She is being recognized in the category of educational achievement for her work on the Alliance Voices of Excellence program and other community service. The award will be presented at the annual Women of Achievement Luncheon on May 16. Founded in 1955, the program honors St. Louis-area women for outstanding volunteer service.

Alliance Advocates

Several Alliance Members traveled to Jefferson City Feb. 21-22 to attend the MSMA Alliance winter board meeting and Day at the Legislature. This is an opportunity taken by many Alliance members from across the state to meet and participate in visits to legislators on behalf of organized medicine. They were briefed by the MSMA lobbyists on bills that support the viewpoint of physicians and those that MSMA opposes. These included support of the prescription drug monitoring program (HB 90, SB 314) and medical student suicide awareness (HB 569, SB 52), and opposition of the helmet repeal bill (HB 235, SB 323). The Alliance advocates for the profession of medicine and patients as well as the promotion of responsible legislation through awareness, education and involvement.

Classic Movie Fundraiser

A favorite Alliance program is the annual classic movie fundraiser. This year's movie was *Singin' in the Rain*, featuring Gene Kelly, Donald O'Connor and a young Debbie Reynolds. This movie masterpiece was shown on Saturday morning, Feb. 25, at the Hi-Pointe Theatre. Angela Zylka was the driving force behind this Alliance event which raises funds to distribute small scholarships and gifts of luggage to graduating medical students on Match Day. Those entering primary care or family medicine are favored. Funds help with student expenses as they make plans to begin their residency programs, often in another state. Angela made the presentations at the Saint Louis University Match Day event on March 17.

Articles by Gill Waltman, SLMMS Alliance

PARTING SHOTS

Maintenance of Certification: How to Make an Idea Difficult, Expensive and of Minimal Value

By Richard J. Gimpelson, MD

Many physicians who are now in practice, and those who are soon to come, are required to pursue a Maintenance of Certification (MOC) program of required reading and periodic open- and closed-book exams to stay board certified in their specialty. However, older physicians like me are "grandfathered or grandmothered in" and do not have to pursue MOC.

I am writing this column based on my personal bias as well as the responses of many colleagues that I have queried. Most physicians that I have talked with see no value in MOC, since they are constantly educating themselves because of pride, compulsiveness and, most importantly, to make sure they can deliver the best care possible to their patients. These physicians have stated that the MOC is a waste of their time, a waste of their money, and does not have strong evidence-based proof that it makes them better physicians.

To illustrate the value—or lack thereof—of MOC, I want to use my practice, Mercy Clinic Minimally Invasive Gynecology, as an examle. One of my partners and I are old enough to be grandfathered in board certification. Our youngest partner is required to take part in MOC to stay board certified.

We are a niche practice that covers all aspects of minimally invasive gynecological surgery (MIGS). This surgery is done through small or no incisions. Most patients are treated either as outpatients or with an overnight stay. Recovery is usually less than 24 hours to less than 3-4 weeks. We have chosen to narrow our practice to maintain our high level of delivering MIGS. We are not alone, as many physicians, over time, decide to narrow their practice to what they enjoy, and to what they do well. They are eager to keep up on this area of their practice and do less or none of the practice activities that they were trained in and for what they received their initial board certification.

Two of us are recognized internationally as experts in our field, and our youngest partner is already nationally recognized and on his way to international recognition. We constantly pursue education to stay on the cutting edge of MIGS. We are involved in publishing, teaching and research that is not even covered in our specialty's MOC-required reading and exams. We have invented or worked on inventions to make our specialty safer and better.

Depending on membership or non-membership in specialty organizations, the cost for participating in MOC can be many thousands of dollars as well as take time away from family and patients. This poses another concern. Why should specialty organizations charge non-members more than members for the MOC program participation? The specialty organizations are not the boards.

My solution is to have the boards require a specific level of CME credit hours in the specialty to maintain certification. The educational content and location of CME credit hours should be left up to the physician. I suspect it will be more appreciated by and less intrusive or costly for the physician. These requirements can also be applied to grandfathered and grandmothered physicians (heaven forbid!). This would require all physicians in a specialty to "Maintain a Level of Education" (MLE). In other words, MLE rather than MOC.

I hope that I still maintain my specialty organization membership after penning this most enlightening column. My goal is to make the physician's job happier and healthier as well as keep the patient happier and healthier. My solution is so simple, that I cannot understand why the ivory tower pundits, medical specialty board committee members, and members of specialty organization boards did not think of it first. I do not mind if they take credit for my plan as long as they adopt it.

Power to the docs!

Dr. Richard J. Gimpelson

Dr. Gimpelson, a past SLMMS president, is co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

Finding "True Medicine" in Annual Honduras Mission

Editor's Note: This is the first in a semi-regular series of features on community service work by area physicians. If you have a suggestion for this feature, please email it to editor@slmms.org.

By Jim Braibish, St. Louis Metropolitan Medicine

Last November, Saint Louis University otolaryngologist and SLMMS Councilor Alan Wild, MD, completed his 15th weeklong medical mission trip to Honduras to provide care to poor residents in the remote community of Catacamas.

For Dr. Wild, the mission is not just an opportunity to help others, but also "allows me to do what I went into medicine to do, to take care of patients."

He leads the November ENT Brigade, one of four missions that St. Louis-area physicians make to Catacamas each year. Fellow SLU otolaryngologist John Eisenbeis, MD, has led a spring ENT Brigade for 16 years, and there is an ob-gyn mission led by Richard Brennan, MD, (SLMMS). The Pulmonary Brigade is led by Washington University asthma specialist Mario Castro, MD, who originated the Honduras missions some 22 years ago. The four missions are supported through the International Medical Assistance Foundation, based in Clayton.

Without these and other missions, specialty care is not available in this central Honduran community. The dry climate and unpaved roads combine to create very dusty conditions, impacting residents' health.

"We see a lot of sinus problems, asthma and chronic cough," Dr. Wild said.

Joining Dr. Wild on November's ENT brigade were his associate physician, Adrienne Childers, MD, and two other ENT physicians plus an ENT chief resident. Making up the balance of the 20-member team were two anesthetists, an anesthesia resident, three medical students, three nurses, a physician assistant, two surgical technicians and an audiologist. They also were joined by two soccer coaches who conducted a camp for area youth. In 2015, Dr. Wild's wife, Sue, an RN, served.

Working 12-15 hours a day for five days, the brigade performed 52 surgeries including tonsillectomies, adenoidectomies, cleft palate repair, advanced ear surgery, sinus surgery and more. They also evaluated 210 patients in clinic.

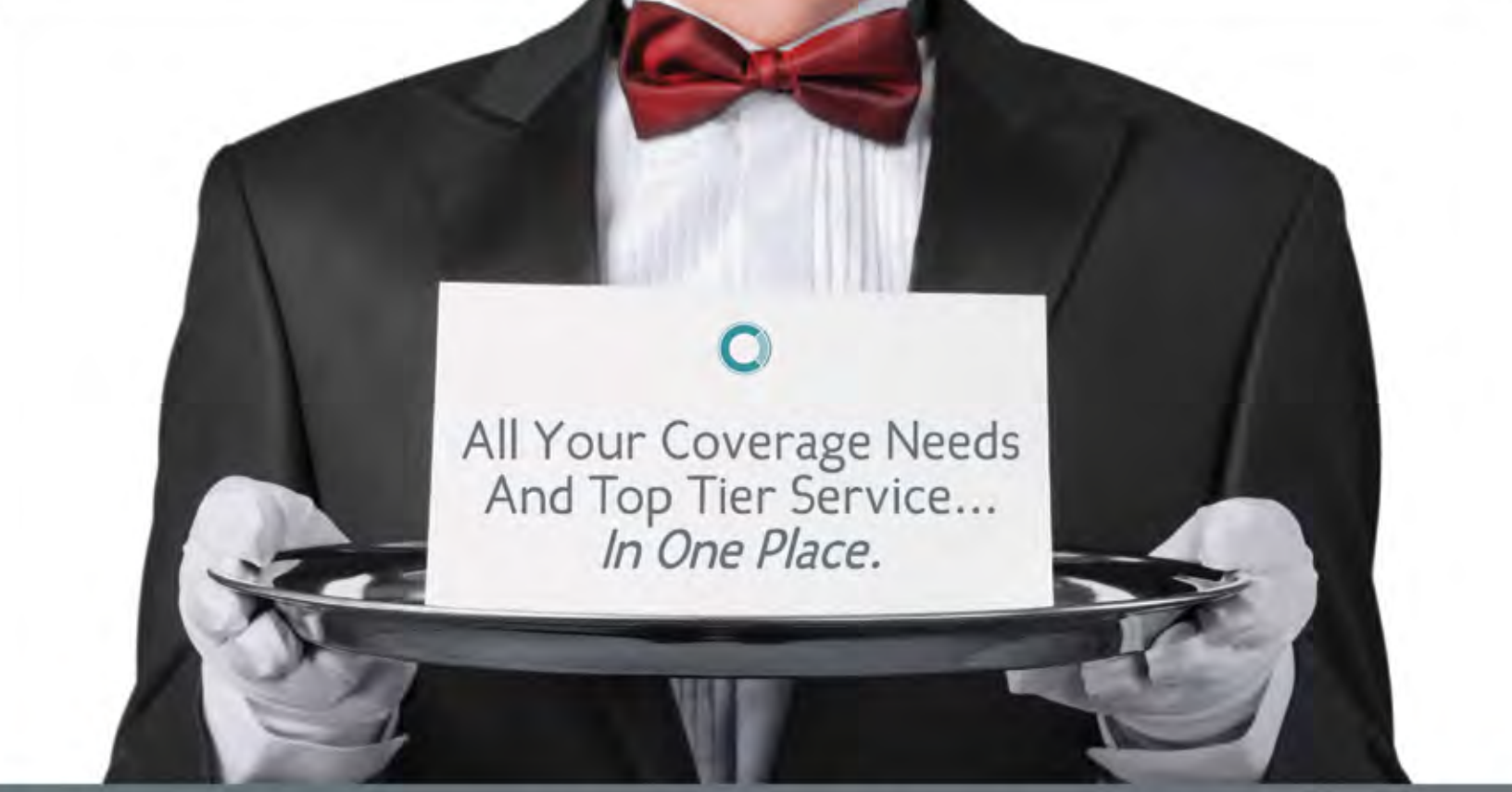
As chief of the November brigade, Dr. Wild coordinated all the logistics including assembling the equipment and supplies, recruiting volunteers, and making the travel arrangements.

Among the most memorable patients for Dr. Wild over the years has been a young man who had injured his face in a fall from his bicycle. He had disfiguring scarring and couldn't breathe through his nose. "He had become a social outcast. The surgery changed his life. The next year, he and his mother came back to us with tears of gratitude," Dr. Wild recalled.

The week in Honduras recharges Dr. Wild's love of medicine. "This is an opportunity to do true medicine. You are not encumbered by the EHR and all of the extra hindrances. You meet the patient, identify the problem and help with the problem. We focus on the actual delivery of health care."

For more information on the Honduras missions, visit www.imedaf.org.

❶ Members of the 2016 ENT Brigade. Dr. Wild is in the middle row at left in the white shirt.
❷ In 2015, the brigade fitted hearing aids for a 10-year-old boy who had been nearly deaf since birth. Dr. Wild's wife, Sue, an RN, is at left.
❸ Dr. Wild in surgery.



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