

# ST. LOUIS METROPOLITAN MEDICINE

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## Young Physicians: Their Challenges, Commitment to Medicine



### Young Physicians

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# Today's Cost of Becoming a Physician Is Costing Us Future Physicians

## Medical student debt and the growing shortage of primary care physicians

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



Medical Society President  
J. Collins Corder, MD, FACP

Efforts aimed at increasing diversity, reducing relative debt, and helping students cope with or feel confident in their ability to manage debt may have a substantial influence on those students wavering between primary care and subspecialties.

We are hearing more and more about the challenges that young physicians face as they go through medical school training, choose a field in residency, and then decide to practice as an employed or an independent physician, or leave the field of medicine altogether.

These challenges also involve important decisions of what specialty/subspecialty they enter, so they can establish a lifestyle they wish to experience and the work-life balance that is so important to many who enter medicine. Central to all of these is the enormous debt that most medical students carry at the end of their medical school training.

After graduating from a private medical school in 1978, my debt was over \$25,000. After completing my residency in internal medicine, I had thoughts of completing a fellowship in dermatology but due to this “enormous debt” facing me, I elected to start my practice of internal medicine along with working emergency rooms to quickly repay my debt so that we could begin a normal life. My wife was in medical school at the time and subsequently would be entering residency in radiology. It was my feeling that with these hurdles facing us, it would be best not to go into dermatology. Needless to say, my lifestyle would be much different if I would have gone into dermatology; but let it be said that I have been very happy in this field that enables me to do what I love for over 36 years in treating patients in primary care.

### Student Debt Rises and Fewer Choose Primary Care

A 2014 article in *Medical Education Online* described the problem:

“In 1992, the median indebtedness at graduation for medical students was \$50,000. Twenty years later in 2012, this figure was \$170,000. Even when inflation is accounted for, this represents a dramatic increase in the cost of medical education to the student. The rise in cost and debt has coincided with an ever-growing shortage of primary care physicians and a decline in the monetary return on investment for a career in primary care. This has prompted leaders in medical education to propose new models of education that reduce time in training and rely on competency-based approaches rather than a time-in-training model.

“However, the high and rising median debt does not tell the whole story. From 2002 to 2012, the number of students graduating with no debt decreased from 17% to 15%, while the number of students graduating with over \$200,000 in student loan debt increased from 5% to 29%. At the same time, the proportion of students matriculating from families with incomes in the bottom quintile has decreased; underrepresented minorities rank cost as the number one deterrent to pursuing a medical education. These facts suggest that the high cost of attendance may be negatively influencing diversity in medical schools and that the distribution of medical education debt is becoming ever more skewed.”<sup>1</sup>

The overemphasis on GPAs and test scores favors students who are more focused on individual achievement than community service, according to G. Richard Olds, MD, founding dean of the University of California-Riverside School of Medicine and the current president at St. George's University School of Medicine in Grenada.



“The other somewhat undiscussed but I think very concerning trend, is today 80% of the medical students come from the top two-fifths of the economic stature,” Dr. Olds said, “meaning we’re largely training the sons and daughters of wealthy Americans today. And then we’re somehow surprised that they don’t go into underserved areas.”<sup>2</sup>

In fact, at his prior position at Case Western University, Dr. Olds found that the strongest predictor of going into primary care wasn’t GPA, or research—it was having worked in the Peace Corps.

The *Medical Education Online* report continued, “Students with higher debt relative to their peers at their home institution reported higher frequencies of feeling callous towards others, were more likely to choose a specialty with a higher average annual income, were less likely to plan to practice in underserved locations, and were less likely to choose primary care specialties. Students with higher aggregate amounts of medical student loan debt were more likely to report high levels of stress from their educational debt, to delay getting married and to report disagreement that they would choose to become a physician again, if given the opportunity to revisit that choice. Increases in both aggregate and relative debt were associated

## How Does This Affect the Future of Medicine in Our Country?

Colin West, MD, a primary care doctor and professor of medicine at the Mayo Clinic in Rochester, Minn., and also a prominent researcher on the economics of primary care states, “There’s data to suggest in the mid to late 1990s, about 50% of all U.S. medical school graduates were choosing primary care careers and current estimates are below 20% now.”<sup>2</sup>

He goes on to say that the pipeline of future primary care physicians has slowed down resulting in roughly only 30% of physicians currently practicing primary care, compared to 70% 50 years ago. Adding on to this is the problem of the age distribution of the older primary care doctor who will be retiring and having much less in the pipeline to replace them. Although it’s hard to say, most researchers believe that with our expanding and aging population, we’re going to have a shortage of primary doctors on the order of 52,000 within a decade. If you consider that an average primary doctor cares for about 2,000 patients, that adds up to a large number of people who will not be able to have a primary care physician. So you’d think desperate debt-ridden med students would be lining up to fill the demand, right?



**The rise in cost and debt has coincided with an ever-growing shortage of primary care physicians. . . . This has prompted leaders in medical education to propose new models of education that reduce time in training and rely on competency-based approaches rather than a time-in-training model.**

with delaying having children, delaying buying a house, concerns about managing and paying back educational debt, and worrying that educational debt will influence one’s specialty choice.”<sup>1</sup>

The study found that students with more relative and absolute debt are more likely to choose a higher paying specialty or explicitly desire a higher income, respectively. “The implication here is that debt influenced students towards their respective outcomes. However, the alternative explanation is that students who desire a higher paying specialty or higher explicit income are more likely to tolerate higher debt levels to do so. The truth is likely a combination of these two hypotheses, where some students feel the pressure of their debt, while others feel the security of their future incomes.”<sup>1</sup>

Experts say there are several reasons hampering the government’s efforts to increase the ranks of new physicians entering primary care and family practice. The financial burden of carrying staggering student debt pushes many new doctors toward higher-paid specialties. That’s reinforced by a culture in medical schools that still encourages specialization, which often takes longer training, attracts the most ambitious students and holds greater societal prestige.

Dr. West further clarifies the root of the problem stating, “In the last few years only about 6% of graduating medical students plan a career in family medicine, and only 2% plan a career in general or primary care internal medicine.” But why not just visit specialists as needed? According to Dr. West, “Primary care is the front line of medicine . . . it is taking care of the entire patient. It is like trying to have a great team without a quarterback.” He adds that subspecialty-driven care without primary care coordination is much more expensive.<sup>2</sup>

As I look back at when I graduated from medical school, it was much simpler. I had fewer options in my career, and the expense of medical school was worrisome but less expensive. Physician burnout was not recognized as it is today. There were much fewer opportunities outside of medicine after medical school, which makes it more of a challenge for the medical graduate today. The medical graduate/resident is faced with business, technology, and entrepreneurial sectors all at once without what one described as a “clear road map.” As one medical student/resident stated, “Due to the lack of experience we have in actually living the day-to-day life of residents and different specialties, we are often unprepared to make a lifelong decision in September of our fourth year. This has resulted

*Continued on page 4*

## Today's Cost of Becoming a Physician... ▶ *continued from page 3*

in a 4% average annual attrition rate among residents, most transitioning to another specialty, but some leaving medicine altogether.”<sup>3</sup> More options are available for pay with a reasonable salary out of medical school without a residency; this makes it even harder when you consider the 3-10 years of training and accompanying small salary the resident still has ahead.

### How Can This Major Problem Be Corrected ... Or Can It?

Although absolute recommendations are difficult to make, the data suggest that relative debt influences the decisions of future physicians and makes a case for all medical schools to reduce or control debt, particularly among those students who borrow the most. Efforts aimed at increasing diversity, reducing relative debt, and helping students cope with or feel confident in their ability to manage debt may have a substantial influence on those students wavering between primary care and subspecialties.

However, programs to help students cope with the current system may not go far enough. Reforms that create shorter paths to specific career options, such as those that rely on assessments of competency rather than time in training, are an excellent first step, but bolder innovations are needed. These may include programs that financially benefit medical students for their valuable contributions, such as teaching assistant roles and patient education activities, which can begin to both lower the cost of education and reduce overall health care spending.

But those formative educational experiences of being exposed to primary care settings while in medical school aren't the biggest influence on the ultimate choices of medical students. A survey by the Association of American Medical Colleges (AAMC) showed individual personality and role models were far more significant factors when it comes to the eventual specialty choice.

“The most successful primary-care training programs,” according to Atul Grover, MD, AAMC executive vice president, “identify students who already know they want to be primary-care physicians when they start medical school.” Those showing the most interest often come from rural communities.<sup>4</sup>

Boosters of the programs to train more primary-care physicians argue that other specialties need to care about the looming shortage. “You can't do all the other (specialties) unless you have primary care,” said Dr. Grover.

Major university medical centers have established programs such as University of Maryland's Primary Care Track, Duke University's Primary Care Leadership Program, and Texas Tech University's Family Medicine Accelerated Track.

Texas Tech's admissions officers look for students for the Family Medicine Accelerated Track (FMAT) who eventually want to practice in small towns, which face a shortage of qualified doctors willing to locate in their communities. The FMAT program has graduated 31 students and counting since its inception in 2011. The Texas Tech FMAT program was funded by a five-year, \$1.5 million grant from the Health Resources and Services Administration. Since 1999, the HRSA has provided more than \$9.4 billion in grants to medical schools and other organizations that aim to increase the ranks of primary-care providers and other health care professionals in underserved communities.<sup>4</sup>

Not long after Keeley Hobart started medical school at Texas Tech University in 2011, she joined a federally funded program that allowed her to finish school one year early and receive a scholarship equal to a full year of tuition. The caveat: the program's curriculum focused exclusively on preparing medical students to become family physicians, one of the lowest-paid specialties in medicine.<sup>4</sup>

Steven Berk, MD, dean of the Texas Tech School of Medicine, said the culture at Texas Tech has shifted since the FMAT program began. The students in the program are well-respected by classmates and staff because of its “rigorous” three-year curriculum, he said.<sup>4</sup>

The persistent effort led about 72% of medical schools to create programs encouraging students to enter primary care by 2014, up from 49% in 2009, according to a 2015 survey from AAMC.<sup>4</sup>

Dr. Richard Olds of St. George's University said in addition to looking at applicants differently, he's creating different incentives such as if the student agrees to practice in a medical shortage area of need for five years, their medical school is free.<sup>2</sup>

More than 85% of medical school graduates have some kind of educational debt, according to the American Medical Student Association (AMSA).<sup>5</sup> The group says medical school debt can be a burden for years. It can make the medical student feel they



**The financial** burden of carrying staggering student debt pushes many new doctors toward higher-paid specialties. That's reinforced by a culture in medical schools that still encourages specialization, which often takes longer training, attracts the most ambitious students and holds greater societal prestige.

can never get on top of it ... except that the medical student can; it just takes a little discipline.

“If people just live like a resident for a few years after residency, they can rapidly pay off these loans no matter what specialty they have chosen, what medical school they attended, or how they paid for it,” says James Dahle, MD, founder and editor of “The White Coat Investor.” He is a full-time practicing physician who blogs about financial literacy for physicians and further states, “I’ve seen docs many times pay off their loans in one or two years.”<sup>5</sup>

It is recommended for those with student loan payments to make payments during their residency even in small amounts as this will pay off over time. There are income driven repayment plans based on discretionary income such as the Revised Pay As You Earn (REPAYE), Income-Based Repayment (IBR) and Pay As You Earn (PAYE) which define discretionary income as the difference between your income and 150% of the poverty guideline for your family size and state of residence. For the Income-Contingent Repayment (ICR) plan, discretionary income is the difference between your income and 100% of the poverty guideline for your family size and state of residence. If you have Parent Plus loans, the only income-driven repayment plan you can use is the ICR plan.<sup>5</sup>

than the previous generation of doctors. They also are more attracted to collaborative work. Are these truly attainable in the field of greatest need, primary care?

Medical schools should require more rural medicine clerkships and residency programs which can help expose learners to all areas of community/family medicine. Exposure to rural medicine can also highlight the benefits of work-life integration, short commutes, and being able to see your family and friends over lunch, for example. Having this opportunity can help young doctors practice using their knowledge base, as well as researching or consulting with others, to treat patients with symptoms or diagnosis that they might not have seen in urban settings. There are not many of these kinds of programs around but this could help establish a young doctor in a community willing to help in medical school debt payback for that student.

Will the changing system in reimbursement to value-based medicine be a positive influence in changing the decisions that young medical students/residents make? Is the young debt-ridden doctor willing to take on risk in MACRA or an ACO when they already are faced with enormous debt? Studies on the young physicians’ willingness to do so do not look favorable.

There are those who feel that a greater “chunk of money” from insurance groups or employers to keep people healthy will do



“Today 80% of the medical students come from the top two-fifths of the economic stature, meaning we’re largely training the sons and daughters of wealthy Americans. And then we’re somehow surprised that they don’t go into underserved areas.” – G. Richard Olds, MD

If the medical student has federal student loans and works in public service, the Public Service Loan Forgiveness program may help pay them off. If one is working at an eligible nonprofit organization or if one provides a public service at a for-profit organization, these direct government loans may be forgiven after 120 total payments under the program.<sup>5</sup>

No matter what the resident situation is, they should not feel like they are stuck with medical student debt forever. “It is recommended that one has to take advantage of their high salary rather than spend it,” Dr. Dahle states.<sup>5</sup>

### What Direction Will the Millennial Generation of Doctors Take?

As more and more baby boomer doctors reach retirement, the first of the millennial generation of doctors are starting to practice or look for work. But this new generation has different expectations for their careers than the doctors who are currently retiring. Is it up to the clinics, training institutions and government to adapt—and quickly—to their changing needs?

The young doctors have also been encouraged to think more about work-life balance, mentorship and additional training

more to prevent disease and keep patients out of hospitals. This quest in the rewarding of quality over quantity could hopefully inspire the medical students and residents in seeing this “sea change in medicine” as the tipping point. Otherwise, we will not have the quarterback in our health care system that is necessary to go forward and will thus be susceptible to total collapse. ➔

#### References

1. Rohlfing J, Navarro R, Maniya O, et al. Medical student debt and major life choices other than specialty.” *Medical Education Online*. November 2014. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4229497/>
2. Why don't young doctors want to work in primary care? *The Pulse*. June 23, 2016. <http://www.newsworks.org/index.php/local/the-pulse/94723-why-dont-young-doctors-want-to-work-in-primary-care>
3. Medicine for Millennials—What Has Changed. Interview with Niko Kurtzman, fourth-year medical student at Thomas Jefferson University. *NEJM Catalyst*. Jan. 5, 2017. <http://catalyst.nejm.org/millennial-medical-student-change/>
4. Castellucci M. Medical schools tackle primary care shortages. *Modern Healthcare*. Nov. 5, 2016. <http://www.modernhealthcare.com/article/20161105/MAGAZINE/311059982>
5. Anderson T. 3 Tips to Wipe Out Medical School Debt. *Forbes*. April 8, 2016. <https://www.forbes.com/sites/tomanderson/2016/04/08/3-tips-to-wipe-out-medical-school-debt/#7ff16e7e53f3>

# Staying “Relevantly” Young

## How do SLMMS and organized medicine make ourselves relevant to the younger physician?

By David M. Nowak



Executive Vice President  
David M. Nowak

Nearly two-thirds or 65.1% of physicians under age 40 were employees in 2016, compared to just 51.3% four years ago.

If age is relative, why do so many strive to be relatively young? Perhaps to look better, feel better, or simply replace the yearnings of one's lost youth. In today's association management world, we embrace a somewhat different challenge—staying “relevantly” young.

In this issue of *St. Louis Metropolitan Medicine*, we explore the issues of young physicians—the challenges they encounter and the rewards they reap in the practice of medicine. I'm thrilled that we have for our readers three very well-conceived articles by members of our leadership team: President Collins Corder, MD, Vice President Ramona Behshad, MD, and Immediate Past President Samer Cabbabe, MD. Their observations prompt me to reflect on the challenge our organization faces to attract younger physicians to society membership, engage them in our initiatives, and remain relevant to their medical careers.

On May 31, the American Medical Association announced the results of a new study that found, for the first time since the group began documenting trends in medical practice arrangements, less than half of patient-care physicians had an ownership stake in their practice. And the drop was significant—from 53.2% in 2012 to 47.1% in 2016.

Younger physicians lean more strongly toward employment, according to the study. Nearly two-thirds or 65.1% of physicians under age 40 were employees in 2016, compared to just 51.3% four years ago. While the percentage of employed physicians among those over age 40 also increased, it did so at a much more modest rate.

At the same time, association membership continues to decline, especially among post-baby boom or Gen X and Gen Y physicians.

As more young physicians choose the employment route, fewer are supporting or choosing organized medicine. SLMMS is not immune to this trend. While we attract medical students with free student memberships, our number of young actively practicing members is on the decline.

Younger physicians are more technologically-savvy, and much more likely to embrace evidence-based medicine as opposed to expert opinion and experience; younger physicians are much more inclined to make work-life balance a priority; and finances play a much larger factor in their career choices, particularly the decision to go employed versus pursuing private practice.

Another recent AMA study indicates that while there are plenty of similarities in younger and older physicians' views of medical practice, there are also many generational differences. Younger physicians are more technologically-savvy, and much more likely to embrace evidence-based medicine as opposed to expert opinion and experience; younger physicians are much more inclined to make work-life balance a priority; and finances play a much larger factor in their career choices, particularly the decision to go employed versus pursuing private practice.



Interestingly, nearly 80% of younger physicians also say they hope to seek out related fields beyond patient care, such as entrepreneurial endeavors, consulting opportunities, hospital/health system executive roles, and academic research.

The challenge is, how do SLMMS and organized medicine adapt to these changing trends and remain relevant to the younger physician? A young doctor herself, Dr. Behshad explores this in her article on page 12. She concludes that younger physicians must “take back medicine,” and if they choose not to take a stand, provisions and mandates will be imposed upon doctors “without any voice.”

I wholeheartedly agree. Our members tell us that advocacy is the greatest benefit of organized medicine. But there are also opportunities for mentoring, networking, leadership development and social engagement. In recent years, SLMMS has developed student chapters at both local medical schools to introduce the benefit of organized medicine at the outset of the study of medicine.

Involving younger physicians is essential to the future viability of organized medicine. And, more than ever, strong organized medicine is vital to today's younger physicians' practice success and career satisfaction. We must remain “relevantly young.” ➔

Sources:

AMA News Release, “New AMA Study Reveals Practice Owners Are No Longer the Physician Majority,” May 31, 2017.

AMA Wire, “Millennial Physicians Sound Off on State of Medicine Today,” March 27, 2017.

## NOTICE

St. Louis Metropolitan Medical Society General Society Meeting

**Tuesday, September 19, 2017**  
**7:00 p.m.**

St. Louis Metropolitan Medical Society Office  
680 Craig Road, First Floor Conference Room  
Creve Coeur, Mo.

**Nomination of 2018 Officers, Councilors and  
MSMA Delegates**

*All members are invited to attend.*

### Agenda

**Call to Order ➔ President J. Collins Corder, MD**  
**Nominating Committee Report ➔ Ravi S. Johar, MD, Chair**

**The committee will be recommending members  
for nomination to the following offices:**

**President-Elect ➔ Vice President**  
**Secretary-Treasurer ➔ Councilors (4)**



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# Register Now for the 2017 Physician Leadership Institute

It's back and it's bigger than ever. The 2017 Physician Leadership Institute (PLI) begins on Saturday, Sept. 16, and this year expands from five sessions to six. The highly interactive, high-intensity course is designed for physicians only, and focuses on the development of leadership skills and a better understanding of the business side of practicing medicine. The PLI is developed and presented by Anders Health Care Services and SLMMS, who are joined this year by a third educational partner, Maryville University.

Responding to input from physician graduates, the PLI curriculum has been redesigned to add an additional session that focuses on building leadership skills. The course will meet over six Saturday mornings from September through November, however the sessions have been shortened to conclude by 12:15 p.m. Classes will be held at Anders' educational facilities in their offices at 800 Market Street, Suite 500, in downtown St. Louis. Up to 21 CME hours will be awarded for completion of the entire curriculum. Tuition is \$900, discounted to \$600 for SLMMS members or Anders clients. Group discounts are also available.

The individual sessions cover current relevant topics such as population health management, technology in health care, recent developments in employment law, and a better understanding of revenue cycles, documentation and coding, and reimbursement. Experts also provide updates on legal issues in medicine, a practical risk management discussion, and a highly popular seminar on medical ethics led by SLMMS member and renowned expert Ira Kodner, MD.

A combined total of 38 physicians from St. Louis and throughout

the state have graduated from the first two Physician Leadership Institutes. They will be invited to join this year's participants for the final session to share how they are incorporating what they learned in the program in their medical careers.

You may register as well as view the full six-session curriculum and speaker line-up at [www.anderscpa.com/physician-leadership-institute](http://www.anderscpa.com/physician-leadership-institute) or use the link found on [www.slmms.org](http://www.slmms.org)

For more information, contact Dave Nowak, SLMMS executive vice president, at 314-989-1014, ext. 105, or [dnowak@slmms.org](mailto:dnowak@slmms.org). —

## THE 2017 PHYSICIAN LEADERSHIP INSTITUTE

Sept. 16 and 23  
Oct. 7 and 21  
Nov. 4 and 11

8:30 a.m. – 12:15 p.m.

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Up to 21 CME hours will be awarded

Tuition: \$900 for six sessions (\$600 for SLMMS members)

Information/Registration: [www.anderscpa.com/physician-leadership-institute](http://www.anderscpa.com/physician-leadership-institute)

## New MPHP Medical Director



Dr. Lisa Thomas

Lisa Thomas, MD, MA, began her duties as the new medical director for the Missouri Physicians Health Program on July 1. Dr. Thomas is a 1994 graduate of the University of Missouri School of Medicine, where she completed a residency in psychiatry followed by fellowships in child/adolescent and forensic psychiatry. She also earned a master's in clinical psychology from Washington University.

Dr. Thomas has worked in both the private and governmental sectors, and has experience in inpatient, outpatient and

residential treatment settings. Most recently, she spent nine years as a staff psychiatrist at the Veterans Hospital in Columbia, Mo. She is also a 2016 graduate of the SLMMS Physician Leadership Institute.

The MPHP also recognizes Charles Sincox, MD, FAAFP, who recently retired as medical director and thanks him for his many years of dedicated service to the program. Dr. Sincox will continue to serve as a medical director emeritus and as a member of the Physicians Health Committee. —

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# AMA President David O. Barbe, MD, MHA, to Speak Oct. 4 to SLMMS

Newly inaugurated American Medical Association President David O. Barbe, MD, MHA, of Mountain Grove, Mo., will present the SLMMS Hippocrates Lecture on Wednesday, Oct. 4, at Spazio Westport.

The first Missourian to serve as AMA president in 90 years, Dr. Barbe is a board-certified family physician with Mercy Clinic Family Medicine. He also is vice president of regional operations for Mercy Springfield Communities, with oversight of five hospitals, dozens of clinics and nearly 200 physicians and advanced practitioners. He is a past president of MSMA.

His topic will be, "How the AMA Affects Everyday Practice – What Have You Done for Me Lately?" Dr. Barbe will discuss how physicians face many challenges as they practice medicine in today's world: record-keeping and regulatory burdens imposed by government and other payers; technology that does not always function properly; and a patient population increasingly struggling with chronic conditions.

Dr. Barbe will describe how the AMA is playing a lead role in developing solutions to these and other practice challenges, and how AMA advocacy is making a positive difference in physicians' and patients' lives. He will also explain ways participation in organized medicine can benefit individual physicians in their daily lives. The lecture will be followed by Q&A with Dr. Barbe.

Invitations to the Hippocrates Lecture will be mailed to SLMMS members in late summer. Reservations are required by Wednesday, September 27, and can be made by contacting Liz Webb at 314-989-1014, ext. 100, or [lizw@slmms.org](mailto:lizw@slmms.org). ➔



*David Barbe, MD, MHA, gives his inaugural address to the AMA Annual Meeting in June. In his speech, Dr. Barbe said physicians are obliged to show true leadership by modeling the right behavior, working together, and developing consensus-based solutions. He noted that these obligations are especially heightened during a time when many patients' access to health care is threatened by the uncertainties of health-system reform.*

## 2017 SLMMS HIPPOCRATES LECTURE

**Wednesday, Oct. 4, 2017**

Spazio Westport

12031 Lackland Road, Maryland Heights

6:00 p.m. – Cocktail reception

7:00 p.m. – Dinner immediately followed by lecture

Free for SLMMS members; \$40 for non-members and guests

Speaker: Newly inaugurated AMA President  
David O. Barbe, MD, MHA

RSVP: Liz Webb, 314-989-1014, ext. 100, or [lizw@slmms.org](mailto:lizw@slmms.org)

## SLMMS Launches Practice Video Benefit

SLMMS has partnered with Make Believe TV, a local video production company, to offer physician practice videos at a reduced price. Placed on the physician's website, the video provides a general introduction to prospective patients, describing the physician's services before the patient decides to make an appointment.



Mary Scott of Make Believe TV is an Emmy-nominated video producer with a master's degree in health services administration. Her dual background makes her uniquely qualified to both understand the benefits of a medical practice, and convey those benefits to the public in a personal and understandable manner. Her short introductory videos have helped physicians grow their practices significantly.

The regular price for an introductory video shot on location at the physician's office is \$795. Make Believe TV will offer a 25% discount on the package price—only \$595 for SLMMS members, and the Medical Society receives \$100 of that fee.

Contact the SLMMS office or Make Believe TV at 917-628-6322 for more information, or visit [makebelieveTV.com](http://makebelieveTV.com). ➔





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# Young Physicians: Take Back Medicine

## Organized medicine can help shape the future in this time of great opportunity and challenge

By Ramona Behshad, MD

Both the science as well as the practice of medicine is constantly evolving. In days gone by, the aims of our profession seemed straightforward. Our objective was to heal the sick. Doctors were highly respected and considered to be knowledgeable members of society. They worked longer hours and were challenged with fewer resources. What will young physicians face today?

Young physicians are facing one of the greatest opportunities in history. Advances in science and technology are happening at a remarkable pace, giving doctors tools and treatments unimaginable to the previous generations of physicians.

While exciting, today's world poses unique challenges that anyone entering the profession needs to understand. These problems are not insurmountable and thankfully, the profession is known for attracting smart, caring people who love challenges. These young doctors need to be mentored, whether it's answering questions on how to balance work and personal life, avoid burnout, interact with legislators, or how to preserve the doctor-patient relationship.

I have worked in private practice and academic medicine. I am a mother and a wife. I come from a family of physicians. Having many mentors, and taking the best from each person, gives me a richness and diversity of learning that I can share with my colleagues of any age.



Dr. Ramona Behshad

*Ramona Behshad, MD, is an assistant professor of dermatology at Saint Louis University School of Medicine, specializing in cutaneous oncology and reconstructive surgery. She is SLMMS vice president for 2017 and president of the MSMA Young Physicians Section. She received her medical degree from Case Western Reserve University, where she also completed her dermatology residency. She completed her Mohs micrographic surgery and dermatologic oncology training in St. Louis, and is a fellow of the American College of Mohs Surgery.*

### Women in Medicine

When I decided to be a doctor as a young girl, there was no Doc McStuffins in my toy collection. Accessorized with a white coat and stethoscope, she is an image of women in medicine that my generation lacked growing up. As more women enter medical school, her character reflects the changing face of medicine. Despite the rapid growth of women in medicine—now accounting for half of all U.S. medical graduates—hurdles such as lack of representation in leadership, disparities in salary and gaps in academic positioning persist.

He encouraged me to complete the task at hand and to overcome the fear that the final product will not be perfect. Perfectionism is exhausting, and his advice served me well in balancing work and family.



In response to these issues, female trailblazers are needed. For young women in medical school and residency wondering if they have to choose a career or a family, I hope they consider that there are strong arguments for doing both. When it comes to work-life balance, home responsibilities don't solely fall on women anymore. Sheryl Sandberg, the chief operating officer of Facebook, stated that the most important career choice you will make is whom you marry, suggesting that success in your personal life is linked with success in your career. I am most fortunate to have met and married my husband who is my biggest supporter and advocate. His intellect and humor have influenced the way I handle difficult situations.

Being a mother has taught me to deal critically and logically with complex information and also to be compassionate and warm with my patients. Before I became a mother I had no idea how this would impact my work; but in many ways, being a mother has made me a better physician and a better leader.

In balancing the two, I learned to be comfortable with some degree of imperfection thanks in part to my mentor and department chair, Kevin Cooper, MD. When working on

my first journal article submission, he said that 90% done was better than 0% done. He encouraged me to complete the task at hand and to overcome the fear that the final product will not be perfect. Perfectionism is exhausting, and his advice served me well in balancing work and family. A man of his repute did not expect perfect, but he did expect me to complete a task.

### Managing Time

Perfectionism is common among physicians, and due to an overwhelming workload and increasing responsibilities, younger and older physicians are plagued by burnout. We are being buried under paperwork and demands that have nothing to do with patient care. According to a study in the *Annals of Internal Medicine*, for every one hour of patient contact, a physician spends two hours doing administrative work.<sup>1</sup> Computers and automation create distance between the doctor and patient that can compromise their relationship.

On this point, I was able to learn a great deal from Keramat Behshad, my father and also a physician. I consider myself his youngest apprentice, starting from a very early age and getting to see how much he loved his work and his patients. He taught me that science has some of the answers but that you have to understand the patient and his family in order to really make a difference. Because of him, I sit down during every patient visit and finish my notes outside the room. He also taught me to get an early start on the day. Our team arrives at the office before 7 a.m. This is certainly early, but it also allows us to finish our workday to leave time to commit to the family for the remainder of the day.

Reducing burnout will only be feasible when we have more independence over the particulars of our occupation and when society knows our value.



While young physicians are broadly labeled with “quality of life syndrome,” there are plenty of hard-working physicians that are being minted in medical schools across the country. Starting on time also allows me to stay on time and prevents me from rushing through visits and procedures in an attempt to catch up. This advice, and this schedule, has done so much to allow me to balance professional time and personal time and to remain present during patient encounters instead of focusing on a “to do” list.

### Value of Organized Medicine

Reducing burnout will only be feasible when we have more independence over the particulars of our occupation and when society knows our value. We are judged by regulators for outcomes that seem irrelevant to us as we focus on disease states and providing cures. Unless measures are taken, however, burnout is likely to increase. According to the Association of

American Medical Colleges report, the projected physician shortage will reach 85,000 physicians by 2020, which will further stress an overburdened system.<sup>2</sup> Early in my career, I learned the value and the power of organized medicine. During my fellowship and my first few years in practice, George Hruza, MD, encouraged me to participate in organized medicine by starting locally. My involvement keeps me connected to broader issues in medicine. If we choose not to take an active role, we will have provisions and mandates given to us, without any voice. Now is the time to take charge locally, statewide, and nationally. We face many challenges in medicine, but we owe it to our patients, colleagues, and society as a whole to do all we can to ensure that our profession thrives for years to come. Young physicians will be impacted the most, and every physician reading this article should maintain their membership in their local and state medical associations. They are here to help us, and funding them properly gives us power. In the United States, as we go through health care reform that may reshape how and which care is delivered, physicians must be at the table as decisions are made. The lack of involvement in organized medicine results in a weakened ability to protect the high standards of care we have developed for patients.

If we choose not to take an active role, we will have provisions and mandates given to us, without any voice.



*Continued on page 14*



I encourage you to take back medicine for yourself and your patients. It is an exciting time to be a physician.



## Young Physicians: Take Back Medicine ➤ *continued from page 13*

### Take Back Medicine

As president of the Young Physician Section of the MSMA, I encourage you to take back medicine for yourself and your patients. It is an exciting time to be a physician. Every day presents the opportunity of being educated by the challenging conditions with which patients present, by the ever-evolving therapeutic approaches that can be undertaken, and even by technologically savvy residents, medical students and colleagues. I have long been drawn to organized medicine and I urge you to join me in supporting these organizations.

Every day presents the opportunity of being educated by the challenging conditions with which patients present, by the ever-evolving therapeutic approaches that can be undertaken, and even by technologically savvy residents, medical students and colleagues.



Over the last few decades, many organizations have become irrelevant or extinct, but the MSMA continues to seek ways to help young physicians. The benefits of membership within MSMA are many, ranging from educational resources in print and online, free CME at the MSMA annual convention, and

access to great networking opportunities. There is detailed guidance and information about concerns and challenges new physicians will encounter when moving into any type of practice arrangement including licensure, contracting, and insurance, among many others. The MSMA is attuned and sensitized to the concern about the whole continuum of distress of physicians from burnout to depression, to addiction, to other forms of mental health conditions, and has a series of webinars, presentations, and workshops to educate members on recognizing and dealing with these issues.

Both SLMMS and MSMA represent our megaphone to regulators on a myriad of topics, from pay-for-performance to malpractice reforms to health care reform to Medicare reimbursement, among others. Tell your state lawmakers what you think. Become active in SLMMS and MSMA. Your interest may be far-reaching, such as medical liability reform, or it may be local, such as restrictive insurance networks. Choose to be involved in making the rules instead of being subject to them without any input. Trial lawyers and health plans will continue lobbying. Will physicians, young and more experienced alike, get lost in the shuffle because of their busy schedules? ➤

#### References

1. Sinsky C, Colligan L, Li L, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Ann Intern Med.* 2016;165:753-760. <http://annals.org/aim/article/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties>
2. Recent Studies and Reports on Physician Shortages in the US. American Association of Medical Colleges. Oct. 2012. <https://www.aamc.org/download/100598/data/>

## HARRY'S HOMILIES®

Harry L.S. Knopf, MD

### ON STARTING OUT (IN MEDICINE)

The beginning is the most important part of the work.

—Plato

It was often told to me by my teachers that medicine is a demanding mistress. And how right they were. After 50 years of practice and teaching, I can attest to the aphorism. But this homily is aimed at those of you who are beginning the task. If you begin well, you must surely end well, and vice versa. Don't take shortcuts, be thorough and honest with each of your patients. Do your homework; never stop learning. But just as important: **Get a life!** Start at the beginning to plan for "down time." Don't skip vacations, try to maintain family face time. Yes, there will be times, especially at the start where that other life will be harder than being a physician. A good spouse will help immensely, but don't ask me how to pick one. I was just lucky—and I still am (after more than 50 years.) There are some things that are even a mystery to Harry's Homilies.... ➤

*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.*



A healthcare professional in teal scrubs is attending to a patient in a hospital bed. The patient is wearing a white hospital gown and looking up at the professional. The background is a clinical setting with medical equipment.

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# Perspective: Young Physicians

## Younger SLMMS members share their views on the challenges they face and the rewards of medicine

By Jim Braibish, St. Louis Metropolitan Medicine

**H**ow do younger SLMMS members view the challenges their generation of physicians face? How do they manage time for their families? Is medicine rewarding for them? Do they plan to continue medical practice, or consider other career options?

Two younger Medical Society members shared their thoughts with *St. Louis Metropolitan Medicine*.

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### Bryan Burns, DO

- Internal Medicine, St. Anthony's Primary Care Consultants
  - Age: 38
  - Married, five children ages 7-19
  - D.O., Oklahoma State University
  - Son of SLMMS member Ed Burns, MD
- 

**Unique challenges for younger physicians:** Most importantly, our generation faces the rising costs of health care and the explosion of information that has flooded our medical system. We as a society do not have a way to continue to cover the increasing cost of health care. Our patients are often forced to make decisions on their care based in part on finances. In terms of technology, information has exploded. Patients are becoming more aware of diagnosis, treatments and alternatives like never before. Rather than the paternalistic care we provided decades ago, we must work with patients collaboratively. They

have access to apps, trackers and wireless devices that, if used correctly, can help improve care.

**Rewards of medicine:** Medicine has been more rewarding than I could have envisioned the day I graduated. The rewards come internally in the form of knowing that our practice is saving lives by diligently treating diabetes. It comes externally, when a patient takes time to thank you. Just last week, a patient thanked me for coming to his wife's wake.

**Work-life balance:** Medicine can be all consuming, especially primary care. I know that my family sacrifices their time with me for the profession I have chosen. We travel often so I can give them undivided time. I also schedule my patients in such a way that I can have mornings with the kids and take them to school daily, and have one early afternoon a week to allow me to coach their grade school sports teams. I adamantly want my staff to have the same work-life balance.

**Leadership roles:** Within St. Anthony's, I currently serve as the chair of our Population Health Committee, leading our organization's efforts to improve value-based care. Others: medical director for Essence Healthcare; member, United Healthcare Physician Advisory Board; member, Midwest Health Initiative Physician Leadership Council. Through that, I have had the opportunity to travel to Stanford to share ideas with other like-minded physicians and speak on the total cost of care at a summit in Washington, D.C.



Medicine has been more rewarding than I could have envisioned the day I graduated.

— Bryan Burns, DO



I am learning more and more how important it is to stay connected to organized medicine and learn from my peers.

— Whitney Brothers, MD



**Other volunteer service:** I am active in my children's schools. I currently volunteer with the St. Catherine Laboure men's club to coach grade school athletics, fundraise, and provide help for any needs that spring up around the school and parish. Additionally, my youngest has become a figure skater for the Metro Edge Figure Skating Club and I spend much of my winter in ice rinks helping whenever I can.

**Career thoughts:** I love having a medical practice and I do want to continue that into the future. That being said, I enjoy improving clinical practice and the health care system. To balance these two, I began a health care consulting company, Effectus Healthcare, to work with physicians to improve their daily practice and to work with larger groups, health systems and insurers to design systems that encourage and assist providers in moving toward value-based care.

**Advice to other young physicians:** What matters to patients is that they feel cared for and have a doctor who will be available in their time of need. Practicing medicine with compassion and dedication will lead to success, no matter the specialty.

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#### Whitney Brothers, MD

- Ophthalmologist, West County Ophthalmology
  - Age: 40
  - Married, two boys ages 6 and 8
  - M.D., University of Missouri-Kansas City
  - Surgical training at Saint Louis University Eye Institute
- 

**Unique challenges for younger physicians:** There is so much paperwork that it can distract from the patient care. It is challenging to give every patient the amount of time they deserve. I am more aware of the business side of medicine than in my earlier years. There are limitations on what we can do in a short office visit. It is important to listen to the patient and tackle each problem as it arises. Sometimes that requires more follow-up and phone calls to make sure the treatment and plan are working. Challenges within the business can

include increased debt/overhead and decreased insurance reimbursements.

**Rewards of medicine:** As an eye surgeon, it is very rewarding to be able to restore sight to a patient. Even when we can't fix everything, we can help by addressing their fears and helping them through any medical concerns they have. Sometimes the patient just wants to be understood or heard. I never want the "extras" to keep me from being focused on what matters most—care for the patient.

**Work-life balance:** A happy doctor makes for happy patients. When I am able to make time for my family, I feel I can listen better and have more patience for the "red tape" of paperwork and insurance claims, etc.

**Service in organized medicine:** I am learning more and more how important it is to stay connected to organized medicine and learn from my peers. There is so much more to being a doctor than just taking care of patients. Unfortunately, prior authorizations with medications, and insurance companies blocking needed labs or testing, take up so much time. Organized medicine can advocate for us, so we can give patients the care they need. I have personally had help from SLMMS. An insurance company had delayed payment on most of my patients for over 16 months. I had spent countless hours on paperwork and phone calls to get it straightened out. I finally contacted SLMMS and filed a formal grievance. It was resolved swiftly. They were able to get through in ways my billing department and I were unable to.

**Other volunteer service:** I volunteer with organizations at my children's school.

**Career thoughts:** I will continue as a partner in my current group (private practice). I look forward to addressing the unique challenges that medicine presents and gaining insight on how to best help patients as medicine evolves.

**Advice to other young physicians:** Learn as much as you can about all that is involved in medicine and know when you need to reach out for help and guidance. ➤

# The Exploitation and Abuse of Medical Students and Residents

**Maltreatment includes physical and mental abuse, long hours, low wages, shortage of residency positions; what are some solutions?**

By Samer W. Cabbabe, MD, FACS

Approximately 300-400 physicians commit suicide annually. Male physicians are 1.4 times more likely to kill themselves than men in the general population, and female physicians are 2.3 times more likely.<sup>1</sup> Given that a typical doctor has about 2,300 patients under his or her care, that means more than a million Americans will lose a physician to suicide this year.<sup>2</sup> Depression and physician burnout are contributing factors in physician suicide that begin during medical school and residency and continue into practice.

In a study of six medical schools, nearly one in four students reported clinically significant symptoms of depression. Almost 7% said they had thought of ending their lives in the last two weeks. In another recent study, 29% of residents suffered from significant symptoms of depression. And those symptoms escalated within a year of starting training—a sign that residency programs themselves were contributing to the problem.<sup>1</sup> What is happening in medical school and residency programs that is causing so many physicians and medical students to burn out?

Medical students and physicians are raised in a culture where they are not allowed to show weakness or ask for help. In addition, to visit a psychiatrist can be professional suicide, meaning that they risk loss of license and hospital privileges and professional stature among peers and patients. This could easily be considered borderline abuse, and it begins in medical school and continues through residency.

## Studies Report Extent of Abuse

A 1990 *JAMA* article reported on a survey of the incidence, severity and significance of medical student abuse as perceived by the student population of one major medical school.



Dr. Samer W. Cabbabe

*Samer W. Cabbabe, MD, FACS, is a plastic surgeon in private practice. He was 2016 SLMMS president.*

Approximately 46.4% of all respondents stated that they had been abused at some time while enrolled in medical school, with 80.6% of seniors reporting being abused by the senior year. More than two-thirds (69.1%) of those abused reported that at least one of the episodes they experienced was of “major importance and very upsetting.” Half (49.6%) of the students indicated that the most serious episode of abuse affected them adversely for a month or more; 16.2% said that it would “always affect them.”<sup>3</sup>

As a result of these studies, multiple medical schools in the 1990s instituted reforms such as policies to reduce abuse and promote prevention. To gauge the effectiveness of the reforms, surveys of medical students were done at the end of their third year. After more than 10 years of reform, there appears to have been a slight drop in the numbers of students who report experiencing mistreatment. Unfortunately, according to the 2012 study, more than half of all medical students still said that they had been intimidated or physically or verbally harassed.<sup>4</sup>

There are numerous reasons why medical students may be abused. According to a 2014 study from the *Journal of Academic Medicine*, the nature of mistreatment differed between students interested in primary care and those interested in a subspecialty. It appears that faculty and residents are biased against certain specialties that differ from their own and may embarrass or criticize students who express interest in those specialty areas.<sup>5</sup>

This type of abuse of medical students continues well after medical school and into residency. Other types of abuse also present themselves in this dual employee-trainee role where residents are led to believe that they contribute minimally to patient care based on their salaries and the way they are treated. How else could a resident believe that their work is worth less than that of a nurse practitioner or physician assistant earning double their salary while working half the hours?

## Rising Tuition, Low Salaries, Difficult Working Conditions

In 1996, the median cost for tuition and fees at a private medical school was \$24,963. In 2017, the median tuition, fees and health insurance for a medical student had increased to \$57,472,

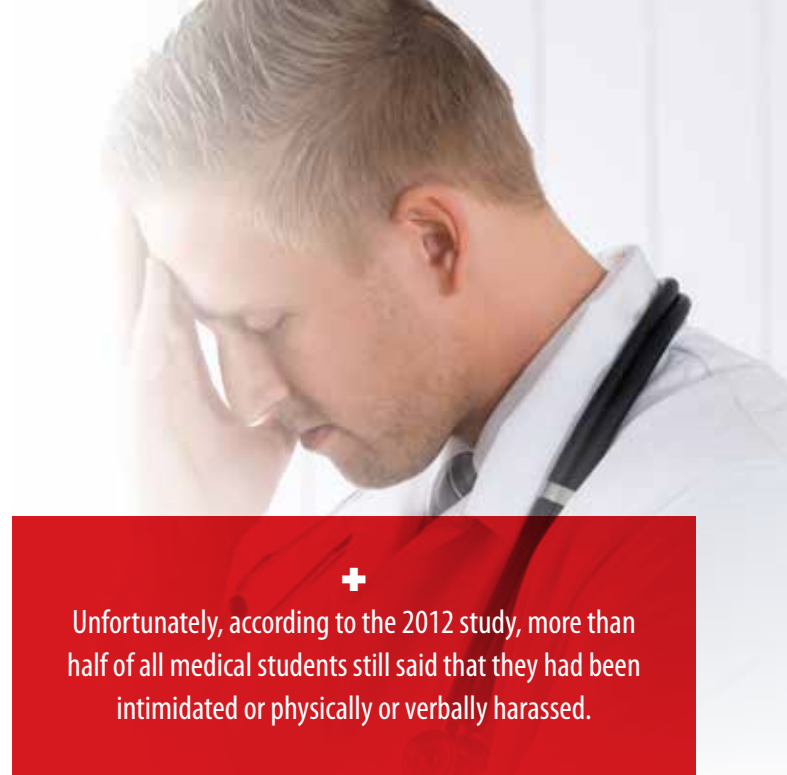


representing an increase of 130%.<sup>6</sup> However, the median salary for a first-year resident increased from \$32,789 in 1996 to \$54,107 in 2017 over the same time period, representing an increase of only 65%.<sup>7</sup> Resident salaries simply have not kept pace with the cost of medical school. This has led to increasing debt for young physicians. Students who graduated from MD-granting schools in 2014 and had debt owed nearly \$180,000 on average, according to a report from the Association of American Medical Colleges.

CMS subsidizes residencies in two parts. The first is the Direct Graduate Medical Education (DGME) payment, costs of training new doctors (salaries, benefits and teaching costs). The second, larger part is the Indirect Medical Education (IME) adjustment, costs that hospitals and health care centers incur because trainees are expected to be slow and inefficient, and otherwise generally increase the cost of care. Medicare subsidies for graduate medical education total over \$10 billion annually—an average of \$112,642 per resident as of 2014. It can be questioned whether hospitals need these subsidies, since at some point in the training process residents are most likely bringing in money for the hospitals. In fact, the Medicare Payment Advisory Commission has found that the indirect payment rate is almost twice as high as can be justified by empirical data once you look at the costs of care at teaching hospitals versus non-teaching hospitals.<sup>8</sup> As a matter of fact, Washington University reported \$9 million in net assets at the end of 2016 and an endowment of \$6 billion. Barnes-Jewish Hospital posted a net profit of \$84 million in 2014, while BJC HealthCare posted a network profit of \$112 million.<sup>9</sup> Saint Louis University Hospital, on the other hand, posted a \$30 million loss in 2016 which likely led to its recent sale to SSM Health. The question must be asked if all of these training hospitals should be receiving federal subsidization, or merely the ones operating at a loss.

In 2002, Paul Jung, MD, and two other physicians filed a class action antitrust lawsuit against the National Resident Matching Program (NRMP) or the “The Match.” They alleged that the NRMP is “a computerized processing system that assigns graduating medical students a single, non-negotiable employment opportunity. Resident physicians are forced to take the position and accept all conditions of employment. The Match reduces competitive pressure on hospitals that employ residents and enables them to pay reduced salaries while demanding long and unsafe work hours from residents.”<sup>10</sup>

They also challenged as illegal the exchange of detailed wage information among these hospitals. “The routine exchange of this information facilitates price-fixing by providing a baseline to which employers add or subtract a small amount for regional cost-of-living differences. Hospitals also use other price-fixing tools that are even more direct. For example, employers have been provided with worksheets to help them calculate the ‘average’ wage paid by an employer in their region. On another occasion, hundreds of employers were asked whether they



Unfortunately, according to the 2012 study, more than half of all medical students still said that they had been intimidated or physically or verbally harassed.

avored establishing rigidly fixed prices in the form of a ‘national uniform salary schedule.’ Nearly 70% said yes.”

The lawsuit also challenged regulations that make it effectively impossible for resident physicians to change hospitals that employ residents.<sup>10</sup>

The lawsuit originally named a host of medical organizations and teaching hospitals as defendants. In 2004, U.S. District Judge Paul L. Friedman dismissed six of the defendants but ruled that the lawsuit could proceed against the remaining organizations, including the National Resident Matching Program.<sup>10</sup>

### Federal Legislation Reduces Protections

Meanwhile, the medical establishment, growing increasingly concerned about the legal fees and the potential liability for hundreds of millions of dollars in damages, turned to Congress for help. They hired lobbyists to request legislation that would exempt the residency program from the accusations. A rider, sponsored by Senators Edward M. Kennedy (D-Mass.) and Judd Gregg (R-N.H.), was attached to the Pension Funding Equity Act, which President George W. Bush signed into law in April 2004.<sup>10</sup>

That provision states that the maintenance of or participation in the residency match does not constitute an antitrust violation, as long as there is no outright price fixing. It also says that the Match cannot be used as evidence in an antitrust case, the issue that Judge Friedman cited as the primary factor in his decision.<sup>11</sup>

Compounding this issue is the fact that 1,059, or 5.7% of allopathic U.S. seniors did not match. If you include

*Continued on page 20*

## The Exploitation and Abuse... ➤ *continued from page 19*

international graduates, osteopathic graduates, and recent U.S. graduates, that number approaches 8,281 representing 23% of total applicants.<sup>12</sup> In 1997, the Balanced Budget Act effectively cut the number of residency slots available by reducing the reimbursement allocated to hospitals involved with resident education for patient care.

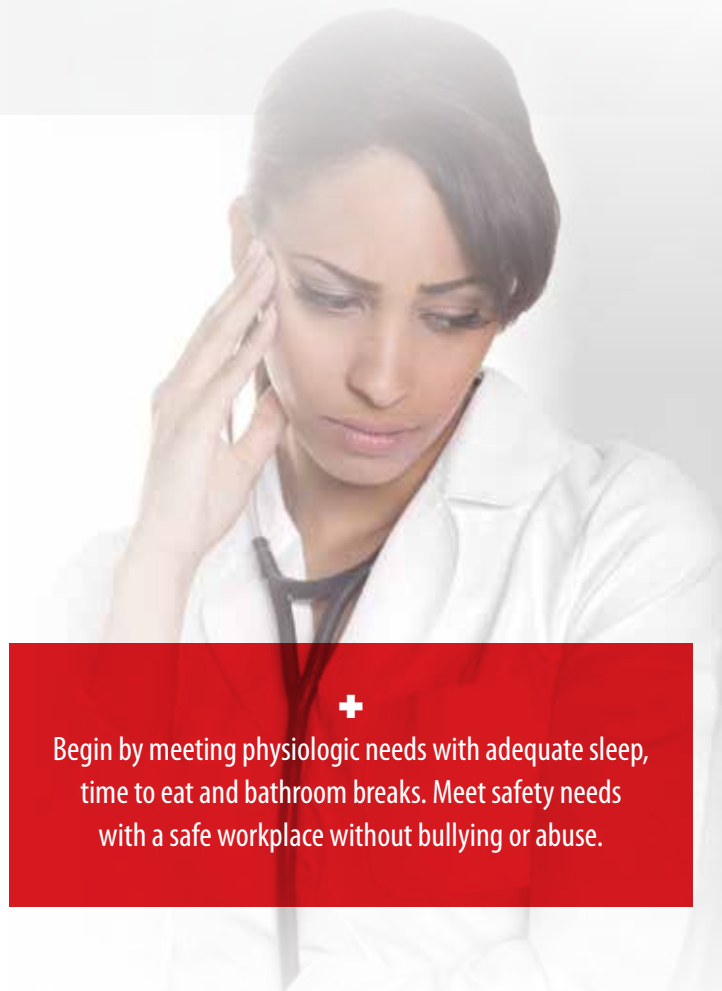
With a nationwide shortage of 90,000 physicians projected by 2020, U.S. medical schools are on track to increase their enrollment by 30%. However, without more residency slots available, it will be difficult to increase the number of practicing physicians despite increased medical school enrollment. In 2013, two bills were introduced into the U.S. House, the Resident Physician Shortage Reduction Act and the Training Tomorrow's Doctors Today Act. Neither bill passed.<sup>13</sup> As a result of the current physician shortage, nurse practitioners and physician assistants are filling the void and now seeking independent practice. Organized medicine continues to seek legislation to oppose independent practice of mid-level providers and to expand the number of residency positions available to medical students.

One anonymous physician has stated: "Medical residents have fewer labor protections than Chinese factory workers." They go on to explain that in 2003, the first regulations (for most states) went into effect, stating that residents could not work more than 80 hours per week. This was obviously not enforced and many residents continued to work up to 120 hours a week while only "reporting" 80 hours out of fear of retaliation.<sup>14</sup>

Meanwhile, in 2012, the Fair Labor Association published their recommendations for Foxconn, Apple's major supplier in China, to address their current production practices. Included in this list was excessive overtime, which had been peaking at 60-70 hours per week, and is now capped at 49 hours per week total including overtime. Another problem cited was the 1.2 million Chinese workers who were not given all of their overtime pay.<sup>10</sup> Residents, however, work well over 50 hours a week and furthermore, receive no overtime benefit, meals or gas mileage reimbursement for call duties.

### Bullying by Physicians, Nurses

The usual bullying culprits of residents are the attending physicians. In a 2016 meta-analysis article by BioMed Central, the most frequently noted form of mistreatment was verbal abuse, with the most common perpetrators being fellow physicians of higher hierarchical power. Their conclusion was that mistreatment exists due to its cyclical nature and the existing culture of medical training and that these disruptive behaviors affect the well-being of both medical residents and patients.<sup>15</sup>



+

Begin by meeting physiologic needs with adequate sleep, time to eat and bathroom breaks. Meet safety needs with a safe workplace without bullying or abuse.

Nurses are known to be involved in the act of bullying resident physicians. According to a 2014 study in the *Journal of Surgical Education*, surgical residents had experienced each of 22 negative acts (11.5%-82.5%) surveyed. Work-related bullying occurred more than person-related bullying and physical intimidation. Ignoring of recommendations or orders by nurses occurred on a daily, weekly or monthly basis for 30.2% of residents (work-related bullying). The most frequent person-related bullying act was ignoring the resident when they approach or react in a hostile manner (18.0%), followed by ignoring or excluding the resident (17.1%).<sup>16</sup>

### Seeking Solutions

What are the solutions to these troubling issues affecting medical students, residents and physicians? According to Pamela Wible, MD, an authority on this subject, "The goal would be to help medical students be the self-actualized doctors described in their personal statements for which they were accepted into medical school in the first place. Begin by meeting physiologic needs with adequate sleep, time to eat and bathroom breaks. Meet safety needs with a safe workplace without bullying or abuse. Social needs can be met by allowing students to feel part of a community with time for intimate friendships. And finally, self-esteem needs. Medical students should feel honored and respected for their contributions and level of mastery in medicine. Not belittled. Not shamed. Not pimped. Not hazed."<sup>17</sup>

She goes on to recommend: “Meet social needs with Matched Mentorship Programs. Use match.com technology to match first-year medical students with second years—and physicians within their specialty of interest. Meet safety and self-esteem needs using non-violent communication which is based on the premise that every behavior is an attempt to meet a need.”<sup>17</sup>

Finally: “Every medical school needs a 24/7 helpline staffed by medical students. Build in support for transitions from second to third year, traumatic cases and medical errors. Again, medical students and physicians should not be left to cry themselves to sleep in their pillows alone at night with no support. That’s inhumane.”<sup>17</sup>

Kenneth Ludmerer, MD, Distinguished Professor of Medicine at Washington University, suggests: “The single biggest problem in residency training today is that the patient workload is too great. Residents today see three to four times the number of patients they did in the recent past. This is the modern form of economic exploitation of residents. Residents need a manageable patient census so they can be thorough, reflect and pay attention to detail—all of which are necessary for learning and for good patient care.”

He goes on to say: “Two economists calculated how much a more manageable patient load would cost: \$1.6 to \$1.7 billion nationwide. In late July 2014, another Institute of Medicine

committee recommended that we do away with indirect medical education payments to hospitals and use the money to create a fund for education innovation. I recommend that we use 25% of this fund to improve the learning environment by hiring additional personnel to take the pressure off residents.”<sup>18</sup>

Other suggestions are to always be aware of physicians’ needs and never ignore their cries for help. Never assume a physician will be able to deal with every problem on their own. Physician wellness programs with 24/7 access to psychologists skilled in physician mental health are available in some areas. There is the Missouri Physicians Health Program sponsored by MSMA and supported by SLMMS. Moreover, just as our health care system is being overhauled, so too should medical training and labor laws protecting health care providers.

Furthermore, the Indirect Medical Education funds from CMS should be used to increase residency positions, and organized medicine needs to continue to advocate for this. Finally, we need to realize as physicians that many students will choose their desired specialty based on whom they consider to be a role model to them. If we want the best and brightest to follow in our footsteps, then we should set a positive example for them to follow and give them the positive attention and respect they deserve. ◀

*References on page 26*



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## Calendar for Continuing Medical Education

Aug. 10-12	Washington University/St. Louis Children’s Comprehensive SEEG Course
Aug. 11-12	Clinical Allergy for the Practicing Physician
Sept. 8-9	Advances in Oncology and Hematology
Sept. 9	18th Annual St. Louis Critical Care Update
Sept. 15-16	Comprehensive Spine Care Conference
Sept. 16	Determination of Death by Neurologic Criteria
Sept. 23	Fetal Cardiac Screening: A Practical Approach
Sept. 29	Evaluation & Management of the Pulmonary Nodule
Oct. 5-6	Annual Symposium in OBGYN
Oct. 27-28	15th Galaxy of Gastroenterology
Nov. 3-4	44th Washington University Kilo Diabetes Symposium
Dec. 2	Congestive Heart Failure



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# Filling the Gap – How Physicians and Aspiring Medical Students Learn from Each Other



By Julie Guethler, MGMA of Greater St. Louis

**R**ecent trends show that aspiring medical students often take a year off between earning their bachelor's degrees and entering medical school. One local practice is tapping into this resource to enhance their workforce and provide beneficial education to students.

Richard C. Bell, MD, with his medical practice, Associates in Dermatology and Cutaneous Surgery in Chesterfield, hires students in this "gap year." The practice primarily utilizes the students as scribes, and they perform some of the tasks typically handled by medical assistants such as rooming patients, answering calls, and setting up procedures for the physicians. This allows the physicians to spend more time with their patients instead of entering data into the EMR. The program is in its third year.

Dr. Bell said, "The gap year student-employees have provided an enthusiastic, hardworking, highly capable workforce. They come to the practice with a background in technology unmatched by most of the physicians. They have been very helpful in our transition to EMR and have solved many of our technological issues."

The gap year student-employees have provided an enthusiastic, hardworking, highly capable workforce.



He continued, "I believe that this program has met the needs of the students also. Our bi-weekly teaching sessions have allowed for didactic teaching and an opportunity to gain experience in presenting in front of a group, a skill required in medical school and residency. The students have also had the experience of

working with patients of diverse cultural, socioeconomic and educational backgrounds, an opportunity often not encountered until well into medical school. Furthermore, they have learned to work with the team of employees in the office, something that many physicians never experience—coming into an office setting after residency as a physician employee or even as a practice owner."

Michael M. Penkoske, MD, career consultant at Washington University, notes that prospective medical students seek opportunities like this as they use the gap year to enhance their qualifications for medical school. Reasons may include:

1. To fill in a "gap" or deficiency in one's candidacy. Applicants for medical school engage in a variety of extracurricular activities to show they understand what medicine entails and service projects that demonstrate their care and concern in the service others.
2. To develop relationships with professors, mentors, etc., from whom they can receive meaningful letters of recommendation.
3. A need to raise one's GPA by doing additional coursework. This can also be true of re-taking the MCAT to achieve a better score.
4. Time to give the proper attention to medical school applications.

Others may choose a gap year for personal reasons, such as taking a break before medical school perhaps to travel or save money; gaining more time to work on a project before starting medical school, e.g., continue their work on a project in the lab perhaps to get their name on a publication; or affirming that medicine is really the right career choice for them.

The result I have observed of Dr. Bell's use of gap year students is a win-win. Watching these students over the course of the year, their growth is palpable. From a manager's perspective, they are bright, respectful, and caring toward the patients and can often help with projects that other staff don't have time to complete. Watching these wonderful young people launch into the next phase of their careers has been a privilege. —



Julie Guethler

Julie Guethler is practice management consultant at Transform Healthcare Strategies, providing support to physician practices in the areas of revenue cycle management, workflows, space design and interim management services. She is a past president of MGMA of Greater St. Louis. Julie can be reached at [guethler@sbcglobal.net](mailto:guethler@sbcglobal.net) or 314-420-1067.



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

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# Ob-Gyn Society Recognizes Resident/Fellow Research Papers

**R**esidents and fellows from the area's three ob-gyn training programs showcased their research papers at the St. Louis Obstetrical & Gynecological Society's annual scientific meeting on May 2. Programs represented were Mercy, Saint Louis University and Washington University.

From the peer-reviewed papers submitted, seven were chosen for presentation and the top three papers received awards. Following are excerpts from the abstracts of the awarded papers. For more information, contact Ob-Gyn Society member and Saint Louis University professor Dorothea Mostello, MD, [mostello@slu.edu](mailto:mostello@slu.edu).

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## First Place – President's Award

### Use of Hormone Replacement Therapy After Risk Reducing Salpingo-oophorectomy and Risk of Malignancy in Genetic Mutation Carriers: A Pilot Study

*K.A. Mills, MD; M.F. Meyer, MD; J.C. Cripe, MD; K.C. Fuh, MD, PhD; and P.H. Thaker, MD; from Division of Gynecologic Oncology, Washington University*

#### Objectives

Assess the effect of hormone replacement therapy (HRT) on the incidence of subsequent malignancies in all high-risk genetic mutation carriers who underwent a risk-reducing salpingo-oophorectomy (RRSO), as well as determine any associations between use of HRT and other health outcomes at a single institution.

#### Study Design

Women age 18-51 years with confirmed high-risk genetic mutations who underwent RRSO between 1995 and 2016 were included in this IRB-approved retrospective cohort study. Categorical and continuous variables were analyzed using chi-square or Fisher's exact test and student t-test or Mann-Whitney U test as appropriate.

#### Results

Seventy patients met inclusion criteria. Thirty-eight (54%) received HRT, of which 21 (55%) received oral estrogen and progesterone formulations. The median duration of follow-up after RRSO was 6 years. Identified mutations included BRCA1 (n=42) and BRCA2 (n=25), Lynch family (n=2), and RAD51 (n=1) and were not significantly different between groups. There was no difference in race, BMI, mutation type, history of hysterectomy or years since RRSO between groups. There was no significant difference in incidence of malignancy

between groups (10.8% vs. 6.2%,  $p=0.68$ ). All subsequent malignancies identified were breast carcinomas. Outcomes including osteoporosis, stroke, myocardial infarction, venous thromboembolism and death were rare and not different between the cohorts.

#### Conclusions

In this single institution retrospective chart review, there was no statistically significant difference in incidence of malignancy after RRSO in patients with high-risk genetic mutations treated with HRT. Further large scale studies confirming long-term safety and clarifying provider and patient motivation for use of HRT in all types of high-risk mutation carriers are warranted. —

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## Second Place – Editor's Award

### Impact of Obesity on Outcomes of Pregnancies Complicated by Twin-Twin Transfusion Syndrome Requiring Fetoscopic Laser Photocoagulation

*Christopher Buchanan, MD; Kristin Bianchi, MD; Colin Miller, MSW; Laura Vricella, MD; Emanuel Vlastos, MD; from Obstetrics, Gynecology, and Women's Health, Saint Louis University*

#### Objective

To determine if maternal obesity, defined as BMI  $\geq 30$ , has an impact on surgical and obstetric outcomes for pregnancies affected by twin-twin transfusion syndrome requiring fetoscopic laser photocoagulation of placental anastomoses.

#### Methods

This is a retrospective cohort of pregnancies complicated by twin-twin transfusion syndrome and requiring fetoscopic laser photocoagulation at a single center between July 2009 and March 2017. Outcomes were stratified based on maternal BMI  $\geq 30$  or  $< 30$ , based on weight at the time of procedure. Obesity was further stratified by class: class I (BMI 30-34.9), class II BMI (35-39.9) and class III (BMI 40 and greater). Data obtained include gestational age at time of intervention, placental location, Quintero stage, anesthesia and operative times, interval from laser to delivery, gestational age at birth, survival to birth and survival to discharge. Operative and anesthesia times were also analyzed based on placental location.

#### Results

A total of 108 patients underwent laser surgery for twin-twin transfusion syndrome and met criteria for inclusion in our analysis during the study period. Sixty-one (56%) of the patients

had a BMI  $\geq 30$ : 32 (30% of all patients) with Class I Obesity, 19 (18%) with Class II Obesity, and 10 (9%) with Class III Obesity. There were no differences in location of placenta, Quintero stage, gestational age at intervention, operative time, anesthesia time, or interval from procedure to delivery. For fetal and neonatal outcomes, there was no difference in survival to birth or survival to discharge from the NICU. There was a significant difference in survival to birth between the two groups (P 0.04) but there was no difference in any survivor to birth. The median operative and anesthesia times were less with posterior placentation for all BMI groups (P <.05).

## Conclusion

Obstetric and surgical outcomes were similar between non-obese and obese women undergoing laser treatment for twin-twin transfusion syndrome, even in a population with a high obesity rate. Anterior placentation resulted in longer operative and anesthesia times regardless of BMI. ➡

## Third Place – Community Award

### Impaired Autophagy Contributes to Obese Patients Decreased Ability to Undergo In Vitro Decidualization

*Maureen Schulte, MD; Andrew Cusumano; Wendy Zhang, PhD; Arin Kettle-Oestreich, PhD; Kelle H. Moley, MD; from Washington University*

## Objectives

Evaluate autophagic flux in obese and lean women. Defective Endometrial Stromal Cell (ESC) decidualization can lead to infertility and poor pregnancy outcomes. Autophagy is the catabolic process of intracellular recycling and has been shown to be defective in obese tissue. We hypothesized that obese women would have impaired autophagic flux as assessed by Western blot analysis.

## Methods

Women with regular menses, proven fertility and exclusion criteria of endometriosis were enrolled at the time of elective tubal ligation. Members of the decidualized group were exposed to 1 mM medroxyprogesterone acetate and 0.5 mM cAMP for nine days. The mRNA expression levels of prolactin and Insulin Like Growth Factor Binding Protein 1 (IGFBP1) were measured by quantitative RT-PCR. The fold change in gene expression between control and decidualized samples was calculated. ATP assays were performed to assess the ATP activity in control and decidualized cells. Western blot analysis was performed measuring accumulation of cytoplasmic LC3- II and p62 which determines autophagic flux.

## Results

Thirty-seven patients were enrolled with 23 obese patients and 14 lean patients. The fold change in gene expression of both markers of endometrial decidualization prolactin and IGFBP1 exhibit a statistically significant (p<0.05) decrease in obese

patients compared to lean. ATP assays demonstrate inability of obese patient to sustain a decrease in ATP levels in decidualized cells. Western blot analysis revealed impaired autophagic flux in obese patients compared to lean.

## Conclusions

By controlling the in vitro hormonal environment and measuring markers of endometrial decidualization, we established that obese women have ESCs that have reduced ability to undergo normal decidualization. ... Impaired autophagy is one mechanism responsible for the decrease in decidualization in obese patients and novel therapies targeting this mechanism could alleviate poor decidualization and ultimately poor pregnancy outcomes in this population. ➡

## Additional Presented Papers

### ➡ Uterocervical Angle as a Predictor of Latency in Preterm Premature Rupture of Membranes

*William M. Perez, MD; Laura K. Vricella, MD; Collin Miller, MSW; Saint Louis University*

### ➡ Obesity and Cell-Free DNA “No Calls:” Is There an Optimal Gestational Age at Time of Sampling?

*Mary C. Livergood, MD; Kay A. Lechien, MS, CGC; Amanda S. Trudell, DO, MSc; Mercy Hospital St. Louis and Obstetrix Medical Group*

### ➡ Rate and Factors Predictive of Ureterolysis During Laparoscopic Surgery Involving Endometriosis

*L. Liu; S.W. Biest; B.A. Winner; Washington University*

### ➡ Text for Diabetes - Do Text Interventions Improve the Percentage of In-Range Glucose Checks?

*Sarah Hostetter, MD; Christopher Buchanan, MD; Jeffrey Gavard, PhD; Angela Gupta, BS; Shannon Grabosch, MD; Dorothea Mostello, MD; Saint Louis University*

## MSMA Honors 50-Year Physicians

Congratulations to the following SLMMS members who were honored for 50 years of medical practice at the 2017 MSMA annual convention:

- ➡ Wallace Berkowitz, MD
- ➡ Judith Ho, MD
- ➡ Yasuo Ishida, MD
- ➡ Harry L.S. Knopf, MD
- ➡ William Lampros, MD
- ➡ Edward O'Brien, Jr., MD
- ➡ Gary Ratkin, MD
- ➡ Stanley Thawley, MD

# Year-End Awards



During Loyola Academy's June 7 year-end assembly of students and parents, Alliance members presented awards for top honors in their "Drugs Are Not for Me" program. ➔

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## CAbi Fashion Show

Thursday, Sept. 7,  
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Information:  
Kelly O'Leary,  
kellyoleary20  
@gmail.com

## The Exploitation and Abuse... ➔ *continued from page 21*

### References

- Graham J. Why are doctors plagued by depression and suicide? A crisis comes into focus. *Stat News*. July 21, 2016. <https://www.statnews.com/2016/07/21/depression-suicide-physicians/>
- Wible P. When doctors commit suicide, it's often hushed up. *Washington Post*. July 14, 2014. [https://www.washingtonpost.com/national/health-science/when-doctors-commit-suicide-its-often-hushed-up/2014/07/14/d8f6eda8-e0fb-11e3-9743-bb9b59cde7b9\\_story.html?tid=pm\\_national\\_pop&utm\\_term=.f6e7c039bf90](https://www.washingtonpost.com/national/health-science/when-doctors-commit-suicide-its-often-hushed-up/2014/07/14/d8f6eda8-e0fb-11e3-9743-bb9b59cde7b9_story.html?tid=pm_national_pop&utm_term=.f6e7c039bf90)
- Silver HK, Glick AD. Medical Student Abuse Incidence, Severity, and Significance. *JAMA*. Jan. 26, 1990; 263(4):527-532. <http://jamanetwork.com/journals/jama/article-abstract/380396>
- Fried JM, Vermillion M, Parker NH, Uijtdehaage S. Eradicating medical student mistreatment: a longitudinal study of one institution's efforts. *Academic Medicine*. 2012 Sep;87(9):1191-8. <https://www.ncbi.nlm.nih.gov/pubmed/22836847>
- Oser T, Haidet P, Lewis P, et al. Frequency and Negative Impact of Medical Student Mistreatment Based on Specialty Choice: A Longitudinal Study. *Academic Medicine*. [http://journals.lww.com/academicmedicine/Abstract/2014/05000/Frequency\\_and\\_Negative\\_Impact\\_of\\_Medical\\_Student.23.aspx](http://journals.lww.com/academicmedicine/Abstract/2014/05000/Frequency_and_Negative_Impact_of_Medical_Student.23.aspx)
- Tuition and Student Fees workbook. Association of American Medical Colleges website. <https://www.aamc.org/data/tuitionandstudentfees/>
- Survey of Resident/Fellow Stipends and Benefits Report 2016-2017, November 2016. Association of American Medical Colleges website. <https://www.aamc.org/download/471828/data/2016stipendsurveyreportfinal.pdf>
- Rampell C. How Medicare Subsidizes Doctor Training. *New York Times*. Dec. 17, 2013 <https://economix.blogs.nytimes.com/2013/12/17/how-medicare-subsidizes-doctor-training/>
- St. Louis Health Care Industry Overview 2016, Vol. 3: Hospital Quality and Financial Overview. St. Louis Business Health Coalition. [https://c.ymcdn.com/sites/stlbhc.site-ym.com/resource/resmgr/Health\\_Care\\_Industry\\_Overview/stlbhc\\_hospital\\_quality\\_and\\_.pdf](https://c.ymcdn.com/sites/stlbhc.site-ym.com/resource/resmgr/Health_Care_Industry_Overview/stlbhc_hospital_quality_and_.pdf)
- Jung P. Protect medical residents from hospitals' abuse. *Baltimore Sun*. May 21, 2002. [http://articles.baltimoresun.com/2002-05-21/news/0205210333\\_1\\_resident-physicians-patient-care-employers](http://articles.baltimoresun.com/2002-05-21/news/0205210333_1_resident-physicians-patient-care-employers)
- Robinsonaug S. Antitrust Lawsuit Over Medical Residency System Is Dismissed. *New York Times*. Aug. 14, 2004. <http://www.nytimes.com/2004/08/14/us/antitrust-lawsuit-over-medical-residency-system-is-dismissed.html>
- Results of 2016 NRMP Main Residency Match Largest on Record as Match Continues to Grow. National Resident Matching Program News Release. March 18, 2016. <http://www.nrmp.org/press-release-results-of-2016-nrmp-main-residency-match-largest-on-record-as-match-continues-to-grow/>
- Sholtis B. Some med school grads fail to get residency. *Pittsburgh Post-Gazette*. May 25, 2014. <http://www.post-gazette.com/news/health/2014/05/26/Some-med-school-grads-fail-to-get-residency/stories/201405260083>
- Medical residents are abused more than Chinese factory workers. KevinMD. April 23, 2012. <http://www.kevinmd.com/blog/2012/04/medical-residents-abused-chinese-factory-workers.html>
- Leisy H, Ahmad M. Altering workplace attitudes for resident education (A.W.A.R.E.): Discovering solutions for medical resident bullying through literature review. *BMC Medical Education*. April 27, 2016. <https://bmcmmeduc.biomedcentral.com/articles/10.1186/s12909-016-0639-8>
- Schlitzkus LL, Vogt KN, Sullivan ME, Schenarts KD. Workplace bullying of general surgery residents by nurses. *J Surg Educ*. 2014 Nov-Dec;71(6):e149-54. <https://www.ncbi.nlm.nih.gov/pubmed/25433963>
- Wible P. Physician Suicide 101: Secrets, Lies & Solutions. Oct. 26, 2014. <http://www.idealmedicalcare.org/blog/physician-suicide-101-secrets-lies-solutions/>
- The Long View on Residency Training: Interview with Kenneth Ludmerer, MD, professor of medicine at Washington University. Johns Hopkins Medicine website. [http://www.hopkinsmedicine.org/news/publications/hopkins\\_medicine\\_magazine/extras/springsummer-2015/the-long-view-on-residency-training](http://www.hopkinsmedicine.org/news/publications/hopkins_medicine_magazine/extras/springsummer-2015/the-long-view-on-residency-training)



## Donald O. Burst, MD



Donald O. Burst, MD, a board-certified orthopedic surgeon, died June 3, 2017, at the age of 96.

Born in St. Louis, Dr. Burst received his undergraduate degree from Northwestern University and his medical degree from Saint Louis University. He completed his internship at the former St. Louis County Hospital and his residency at the Veterans Administration Hospital at Jefferson Barracks.

Following his military service in the Army Air Corps, he went into private practice. He was on the faculty of Saint Louis University School of Medicine, and on staff at St. Anthony's Medical Center and the former Deaconess Hospital, serving as chief of staff at both hospitals.

Dr. Burst joined the St. Louis Metropolitan Medical Society in 1945, and became a Life Member in 1985. Dr. Burst served as president of the St. Louis Orthopedic Society.

Dr. Burst is predeceased by his wife, Alice Burst. SLMMS extends its condolences to his children Bonnie Freeland, Jacqueline Golemon and Donna Burst; his seven grandchildren and 17 great-grandchildren. —

## Galileu "Lee" Cabral, MD



Galileu "Lee" Cabral, MD, a board-certified internist, died June 24, 2017, at the age of 76.

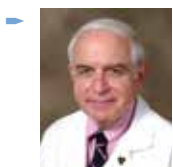
Born in Minas, Brazil, Dr. Cabral received his undergraduate degree from the Colegio Cristo Redentor and his medical degree from University of Juiz de Fora School of Medicine in Brazil. He completed his internship at Missouri Baptist Medical Center, where he was the chief medical resident.

Before coming to the United States, he served as a lieutenant in the medical corps of the Brazilian Navy from 1965 to 1968. He was in private practice, and served on the staffs of Missouri Baptist Medical Center, Christian Hospital and St. Luke's Hospital.

Dr. Cabral joined the St. Louis Metropolitan Medical Society in 1972.

Dr. Cabral was predeceased by his wife, Kathleen Cabral. SLMMS extends its condolences to his sons, Anthony Cabral and William Cabral. —

## — NEWSMAKERS —



Dr. Nicholas T. Kouchoukos

**Nicholas T. Kouchoukos, MD**, (SLMMS), was awarded the 2017 A.N. Bakoulev prize from the Russian Association of Cardiovascular Surgeons for outstanding contributions to the development of cardiovascular surgery. He delivered the Alexander Bakoulev Memorial Lecture entitled, "Progress in the Management of Chronic Aortic Dissection," at the Annual Session of the Scientific Council of the A.N. Bakoulev National Center for Cardiovascular Surgery in

Moscow on May 22. He is an attending cardiovascular surgeon at Missouri Baptist Medical Center.



Dr. Inderjit Singh

**Inderjit Singh, MD**, (SLMMS), has been named a fellow of the National Kidney Foundation in recognition of his promoting awareness of kidney disease. A nephrologist in private practice, Dr. Singh is a member of the foundation's scientific advisory board. He also is a member of the SLMMS Council.

## Thank You to Give STL Day Donors



For the first time, the St. Louis Society for Medical and Scientific Education (SLSMSE) participated in Give STL Day, the St. Louis area's annual day of online giving sponsored by the St. Louis Community Foundation, on May 11. Thank you to the generous individuals who made gifts to SLSMSE, supporting physician education and community service programs:

- Jim Braibish
- Edmond Cabbabe, MD
- Dave Nowak
- Jason Skyles, MD
- Liz Webb

# Some Friendly Advice

By Richard J. Gimpelson, MD

We all know that when someone gives us “friendly advice,” it occasionally has no value.

Well, I am giving friendly advice to our legislators and government leaders because I know much more about the practice of medicine than nearly all of them put together.

I am aware that many of you, my colleagues, know even more than I, so if you want to add to my friendly advice or correct me, please feel free to do so. Our patients deserve the best medical care possible, and it will not come from politicians who cannot agree with each other on the best method to deliver medical care. I will follow with some of my recommendations for improving medical care in the United States.

Since the Republicans and Democrats do not work together, I can help them get along. The Affordable Care Act is failing, and the Democrats must preserve the legacy of former President Obama. The Republicans have had eight years to come up with a plan, but cannot agree with one another to repeal and replace the Affordable Care Act. Now, let me be clear: I do not believe that politicians should be designing medical care, but we know they feel they must have control over any medical plan for us, even though they do not talk to each other.

Recommendations:

- 1) Call the new medical care bill Trump and Obama Presidential Superior Comprehensive American Medicine Quality Care; in other words, TOP SCAM-Q Care. The Republicans and Democrats will now supposedly work together and come up with a great plan.



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 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](mailto:editor@slmms.org).*

- 2) Replace all the bureaucrats and ivory tower physicians with physician clinicians and businessmen who know what excellent care is and who are financially knowledgeable and responsible.

These are two recommendations that should help to come up with an efficient, sensible and cost-effective medical care plan.

The key to success is to let those in recommendation #2 do all the planning and details of TOP SCAM-Q Care, and let those in recommendation #1 take all the credit.

I am sure my colleagues can come up with many more recommendations. In eight years I graduated from medical school, finished my ob-gyn residency program, and began taking care of patients by delivering the highest quality care in the world.

To put time in perspective, I have listed the three most important documents in United States History:

- 1) The Constitution – just over three years to write and ratify
- 2) The Declaration of Independence – just over three weeks to write and approve
- 3) The Gettysburg Address – written in less than one day

Another way to look at the past eight wasted years is to see our greatest accomplishments: We were born, learned to talk, walk, eat, and go to the bathroom by ourselves, and finished third grade.

Other great achievements in less than eight years are:

- 1) Gateway Arch – Although designed in 1947-48, it was built in two years and eight months.
- 2) It took eight years and two months from the time President John F. Kennedy gave his famous speech until Neil Armstrong walked on the moon. —

# Young Scientists, Future Physicians Display Projects

Each year, middle and high school students from throughout the area get a taste of scientific research in the Greater St. Louis Science Fair. The Medical Society annually sponsors the awards in the Health and Medicine category.

A team of SLMMS members and Saint Louis University medical students judged the Health and Medicine entries and chose seven winning projects. Creators of the winning entries received awards in the form of college savings account contributions and gift cards. The awards are funded by the Medical Society's charitable foundation, the St. Louis Society for Medical and Scientific Education (SLSMSE).

Ashley Newport, STEM special projects senior coordinator for the Academy of Science St. Louis, said, "The students are always so proud when the St. Louis Metropolitan Medical Society recognizes the hard work they put into their projects. We believe our most valuable resource for the future of innovation in our

country is the next generation of STEM leaders. This encourages them to pursue their dreams, and helps to ensure a brighter future for us all!" —



SLMMS members and SLU medical students volunteered as judges.

## SCIENCE FAIR ENTRANTS CREATE EXPERIMENTS USING THE SCIENTIFIC METHOD TO PROVE OR DISPROVE A HYPOTHESIS. WINNERS FOR 2017 ARE:

### GRADE 12

#### Katie Kersting

St. Joseph's Academy

*Neurobehavioral Outcomes of Preterm Infants*

### GRADE 11

#### Ashleigh Weismiller and Emily Meara

St. Joseph's Academy

*The Effect of Technology Use and Other Stimulations Before Going to Bed on Sleeping Patterns*

### GRADE 10

#### Abbigail Nagl

Gateway Science Academy

Middle and High School

*Battle of Hand Cleaners*

### GRADE 9

#### Anna Jeschke

Dayspring Academy

*The Effects of Hard and Healthy*

### GRADE 8

#### Vishnu Kumar

Crestview Middle School

*How Do Brain Waves Affect Test Grades?*

### GRADE 7

#### Debrah Popham

Parkway Northeast Middle School

*The Effect of Position on Memory*

### GRADE 6

#### Lucas Gerken

Green Park Lutheran School

*Vitamin C Levels*

Left to right: Katie Kersting, 12th Grade; Ashleigh Weismiller and Emily Meara, 11th Grade; and Debrah Popham, 7th Grade. Honoree photos courtesy of Academy of Science St. Louis.





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