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CHICAGO MEDICINE

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Chicago Medicine (ISSN 0009-3637) is published monthly for $20 per year for members; $30 per year for nonmembers, by the Chicago Medical Society, 515 N. Dearborn St. Chicago, Ill. 60654. Periodicals postage paid at Chicago, Ill. and additional mailing offices. Postmaster: Send address changes to Chicago Medicine, 515 N. Dearborn St., Chicago, IL 60654. Telephone: 312-670-2550.

Volume 115 Issue 6 June 2012

FEATURES

Your Society, Our Future

Howard Axe, MD, was installed as the 164th President of the Chicago Medical Society in ceremonies on June 12. Watch for coverage in the July issue of *Chicago Medicine*.

AS I WRITE my first message, I am reminded of those physicians who held this office before me, and feel honored to represent you. No matter what your career stage or practice structure, be it solo or group, employed or academic, the Chicago Medical Society unifies the profession and is there to help you. As my predecessors have said, despite our differences, we have more in common—caring for our patients and establishing a suitable work-life balance—than we have differences. Sure, we may have differing opinions, but sharing and appreciating these differences helps to develop meaningful solutions to the issues we all face regularly.

CMS is a membership organization. It is only through your involvement that we can create policy and advocate for fellow physicians and our patients. It is the grassroots membership that can communicate to patients and families about the current healthcare system, both locally and nationally. By crafting and introducing resolutions for our Council to debate, each of you has the ability to shape the policies of organized medicine.

Many have noted how we have actively engaged physicians the past few years, while evolving to better meet the needs of our members. You may have seen the renewed *Chicago Medicine* magazine, which you received last month, with timely articles by established healthcare journalists. We also developed a robust website, which I encourage all of you to explore. You will find it easy to navigate and full of additional content in a user-friendly format.

Prior to our legislative advocacy trip to Washington, DC, last February, Dr. Anderson and I asked you to tell us your most urgent concerns so we could relay them to our senators and congressmen. Rest assured I will continue seeking your comments.

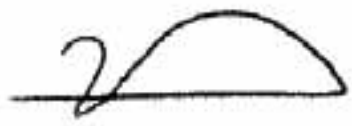
We are working more closely with the Illinois State Medical Society to improve our organizations' education and advocacy. We continue to reach out to specialty societies and academic institutions to make sure they feel represented by our organizations.

I invite those of you who want to help change the profession to step forward and volunteer locally, instead of simply complaining to each other in the doctors' lounges of our institutions. Please let your leadership know how we can better meet your needs.

You can even let us know when we have done something meaningful that affects your daily practice. And share your involvement with the Society with those you know who might not be members and not know what we are doing on their behalf, and encourage them to join.

We need to speak with a unified voice on behalf of all physicians to advance our agenda, locally, and at the state and national levels.

I look forward to a year of continued change and challenge as we toil on behalf of our patients and the Medical Society.



Howard Axe, MD
President, Chicago Medical Society

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Dollars Within Reach

The Medicaid EHR Incentive Program begins **by Abel Kho MD, MS**

"If you are considering the transition to an EHR, now is your best chance to offset upfront costs."

CONGRATULATIONS are in order. Tens of millions of dollars are going out the door to hospitals and physicians who have selected or made improvements to an electronic health record (EHR) system. And here's the news that might surprise you: getting those dollars was easy.

Starting this spring, the state of Illinois began distributing incentives to doctors who have successfully completed the first step toward achieving Meaningful Use under the Medicaid EHR Incentive Program. Here at the Chicago Health Information Technology Regional Extension Center (CHITREC), we have assisted 447 physicians in Chicago claim $9.6 million and counting in incentives.

For the first year of the program, all physicians must do is provide proof they have adopted, implemented or upgraded (AIU) a certified EHR. The AIU bonus is intended to offset a portion of your costs to go digital. The year-one payment of $21,250 per provider is more than the amount received in the first year of the Medicare Incentive Program ($18,000), and does not require demonstrating Meaningful Use. Physicians on the Medicaid track reach Meaningful Use during the second year of the program.

If this sounds like easy money, that's because it mostly is. If you are considering the transition to an EHR, now is your best chance to offset upfront costs. Use this as your guide to getting started toward AIU.

Qualify

To qualify for the Medicaid Incentive Program, you must be a licensed physician with at least 30% Medicaid patient encounters by volume (20% if you are a pediatrician). An online tool (*cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html*) can help determine eligibility for this program. The Medicaid Meaningful Use program pays a maximum of $63,500 over six years. For more information on qualifying for federal incentive programs, visit *www.chitrec.org*.

Qualifying doctors can complete the first year in the Illinois Medicaid EHR Incentive Program (AIU) in two steps: register as a participating provider with the federal government, and attest to your qualification status with Illinois Department of Healthcare and Family Services (HFS).

Register

The registration system at *ehrincentives.cms.gov* allows you to indicate that you wish to participate in the Medicaid program for Illinois. You will be required to confirm your National Provider Identifier (NPI) number and contact information and identify a payee, which is the legal name and tax ID number for the business entity that will receive the incentive payments.

Attest

Demonstrating AIU requires providing your certified EHR's product number and two pieces of billing data from any consecutive 90-day period from the previous calendar year. The billing pieces must show the number of patient encounters paid for by Medicaid during the 90-day period and the number of patient encounters paid for by any insurance during the same period. Please reference *www2.illinois.gov/HFS/MEDICALPROVIDER/EHR/Pages/EP.aspx* for more information on collecting this billing data. In addition, you will be asked a short series of questions to further confirm your eligibility for the program before submitting attestation at *myhfs.illinois.gov*.

Gathering information required for registration and attestation takes time. The biggest problem we encountered during the 2011 attestation came when physicians waited too long to prepare before the deadline.

To help you along, CHITREC has posted free webinars and online guides to walk you through the process on our website (*www.chitrec.org/announcements/chitrec-ehr-incentive-program-registration-attestation-webinar-series*). If you and your practice need help with the attestation process, contact us for more information at *info@chitrec.org*, or by phone at 312-503-2986.

Dr. Kho is an internist, and the Co-executive Director of the Chicago Health IT Regional Extension Center.

Before You Register

THE REGISTRATION process has its challenges, but a little preparation can make it easier. So before you begin, make sure you have the following in hand:

- NPI.
- A valid Illinois state ID. If you're not from Illinois, there is another option available.
- Your NPPES Web User Account. If you don't have one, contact the EHR Incentive Help Desk at 888-734-6433.
- Your HFS Identification information. For help, contact the Provider Participation Unit at 217-782-0538 to request your Provider/Payee combination.
- Two pieces of billing data that help determine that you meet the minimum Medicaid Volume. You will want these documents to show:
  1. Number of office visits billed to Medicaid over any consecutive 90-day period from the previous calendar year.
  2. Number of office visits billed to any insurance type over the same 90-day period.
- The certification number for your EHR.

Feds Announce Record "Takedown"

Medicare Fraud Strike Force brings new charges against providers

STEPPING UP enforcement, Medicare Fraud Strike Force operations in seven cities recently resulted in charges against 107 providers, including doctors, nurses, and other medical professionals, according to an announcement on May 2 by Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius.

The defendants charged are accused of healthcare fraud, conspiracy to commit healthcare fraud, violations of the anti-kickback statutes, and money laundering. The charges involve medical treatments and services such as home healthcare, mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME), and ambulance services.

One defendant in Chicago was charged for his alleged role in a scheme to submit approximately $1 million in false billing to Medicare for psychotherapy services.

HHS also suspended or took other administrative action against 52 providers following a data-driven analysis and credible allegations of fraud. The Affordable Care Act significantly increased HHS' ability to suspend payments until an investigation is complete. In addition to making arrests, agents also executed 20 search warrants in connection with ongoing strike force investigations.

According to court documents, the defendants allegedly participated in schemes to submit claims for treatments that were medically unnecessary and oftentimes never provided. In many cases, patient recruiters, Medicare beneficiaries and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, who would then submit fraudulent billing to Medicare. Collectively, the doctors, nurses, social workers, healthcare company owners and others charged are accused of conspiring to submit a total of $452 million in fraudulent billing, the highest amount of alleged false Medicare billings in a single takedown.

"As charged in the indictments, these fraud schemes were committed by people up and down the chain of healthcare providers," said Assistant Attorney General Lanny A. Breuer. "These indictments remind us that Medicare is an attractive target for criminals. But it should also remind those criminals that they risk prosecution and prison time every time they submit a false claim."

The joint Department of Justice and HHS Medicare Fraud Strike Force is a multi-agency team of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques.

Since their inception in March 2007, Medicare Fraud Strike Force operations in nine locations have charged more than 1,300 defendants who collectively have falsely billed the Medicare program for more than $4 billion.

"These indictments should also remind those criminals that they risk prosecution and prison time every time they submit a false claim."

Problematic Billing Errors

THE CENTERS for Medicare and Medicaid Services recently released comprehensive error rate testing (CERT) results, in addition to recovery audit findings on problematic billing errors.

The April 2012 issue of the quarterly Medicare provider compliance newsletter also contains detailed guidance on preventing improper claims submissions and billing issues, along with links to other information sources.

The six problematic billing errors identified by contractors all involve inpatient hospital care.

Section 6401 of the Affordable Care Act requires healthcare providers to have compliance programs in place as a condition of enrollment in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The U.S. Department of Health and Human Services (HHS) is developing the "core elements" of such programs in consultation with the Office of the Inspector General.

The CMS report identifies the findings below:

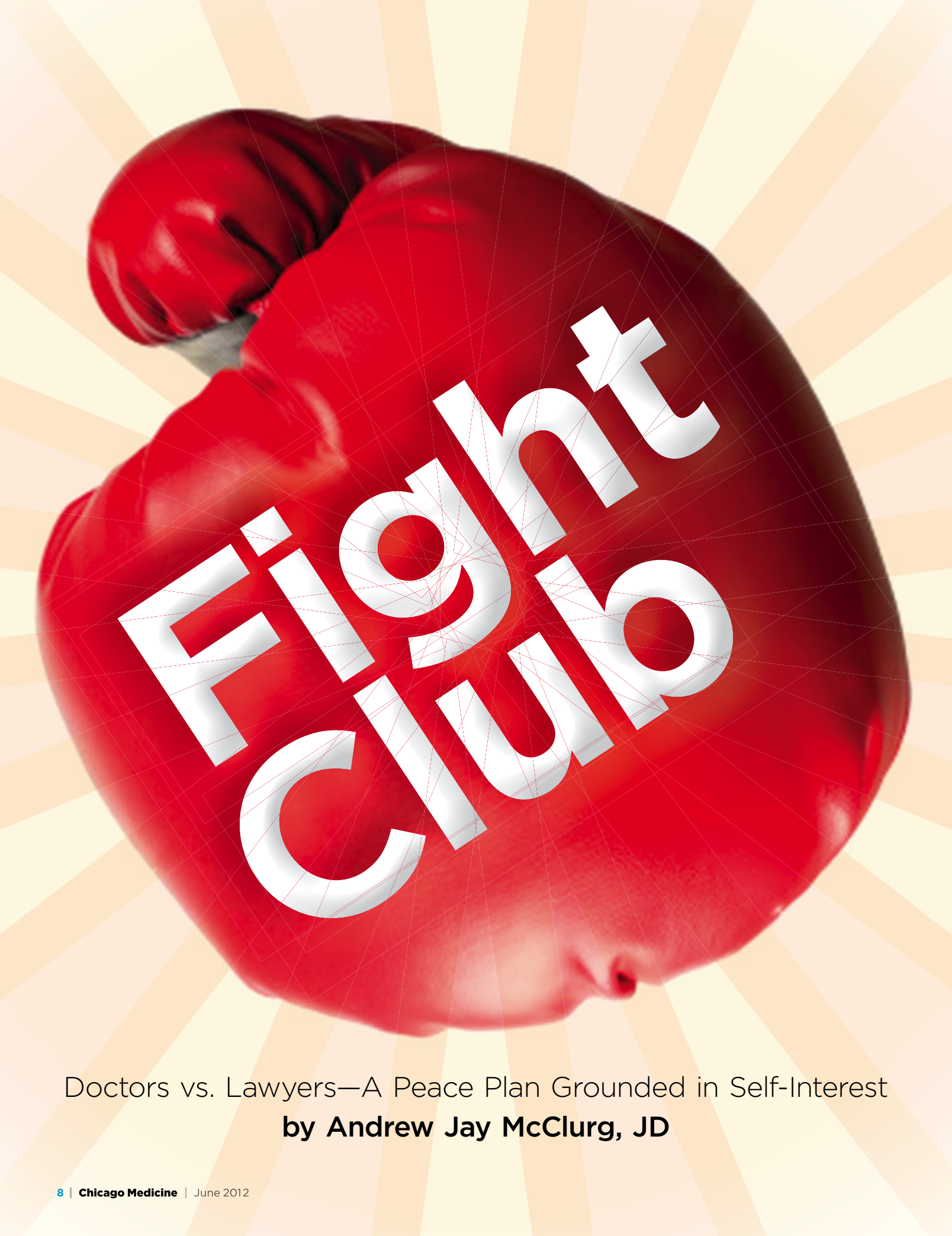
CERT Findings

- Medically unnecessary three- to five-day qualifying hospital stays for skilled nursing facilities.
- Improper payments for the three E/M codes that replaced codes for inpatient hospital consultations.

Recovery Audit Findings

- Cholecystectomy—incorrect secondary diagnosis.
- Kidney and urinary tract disorder—incorrect principal diagnosis.
- Transient ischemic attack—services rendered in a medically unnecessary setting.
- Craniotomy and endovascular intracranial procedures.
  Small and large bowel procedures.
  Spinal fusion.

To review the report, please check the April 2012 issue of the Medicare Quarterly Compliance Newsletter at *www.cmsgov.com*.



Doctors vs. Lawyers—A Peace Plan Grounded in Self-Interest

by Andrew Jay McClurg, JD

"Congratulations on your article about improving relations between attorneys and physicians. It is a wonderful job. I can just predict your next article: Improving Relations between Rapists and their Victims."

A physician sent the message above to Peter Jacobson, a health law professor, in response to an article in which Jacobson suggested that doctors and lawyers should work to repair their antagonistic relationships. The reply, one of several less-than-effusive responses Jacobson received from doctors, reflects the malignant antipathy between doctors and lawyers. The doctor-lawyer fight plays out publicly in a variety of forums, principally the national tort reform movement. Like professional wrestlers, the fighters sometimes resort to dirty tactics. This offensive quotation reflects an unseemly, embarrassing spectacle for two distinguished professions.

In his article, Jacobson argued that doctors and lawyers share core social and ethical values that provide a basis for reducing the conflict between the two groups. My article takes a different approach: appealing to the baser motivation of self-interest. Moral philosophers and psychologists alike have long asserted that self-interest is one of the strongest of all human motivations. As I explain, doctors and lawyers have substantial shared professional and personal interests in de-escalating their attacks on one another.

My article also proposes several concrete steps to improve communication and understanding. I have no illusion that the utopian day will arrive when doctors and lawyers dance, sing, and bathe together in the Woodstock tradition. So long as lawyers continue to sue doctors, complete reconciliation will not occur. But enhanced civility and communication would be important steps toward achieving toleration. Legitimate policy disagreements important to all Americans exist between the medical and legal professions. Resolving them will require more dialogue and less squabbling.

The Doctor-Lawyer Fight

Despite many commonalities that social psychology "liking research" would suggest should lead to harmonious relationships, the nation's one million+ lawyers and nearly one million doctors seem forever destined to be at odds. While doctors and lawyers usually function well together in their individual relationships as patients or clients of the other, the professions do not hold each other in high regard.

While limited, research on this topic proves an antipathy. A study by Paul Fitzgerald found that most lawyers have a high degree of trust in their personal physicians, but the trust level declines dramatically in their professional relationships. Only 41% of lawyers gave high trust ratings to the doctors with whom they deal professionally. Doctors similarly place high trust in their personal lawyers, but only 29% gave high trust ratings to the lawyers they deal with on a professional basis.

Relations between doctors and lawyers got off to a rocky start in the first reported U.S. medical malpractice case, Cross v. Guthery, decided by a Connecticut court in 1794. The defendant operated on the plaintiff's wife to remove a breast. She died three hours after the surgery because, according to the court, the defendant "performed said operation in the most unskillful, ignorant and cruel manner."

The jury awarded the plaintiff £40. One can imagine relations got frosty when the defendant doctor asserted that the plaintiff wasn't entitled to damages because he allegedly had agreed to settle the case for £15—which the doctor claimed the plaintiff owed him "for doctoring his wife." The court rejected the defense and ruled for the plaintiff.

Medical malpractice lawsuits were rare when Cross was decided. Early on, some physicians actually embraced malpractice litigation as a way to cleanse their ranks of quacks and charlatans. At the time of the American Revolution, only 5% of the nation's 3,500 medical practitioners had any type of medical degree. Relations soured, however, with a surge of lawsuits filed between 1840-50, a period denoted by James Mohr as the nation's first "medical malpractice crisis."

By 1860, a book review of an early treatise about medico-legal jurisprudence opined that "law and medicine had evolved into mutually incompatible professions." Less restrained assessments of the relationship were abundant. As Mohr noted, "[i]t would be easy to fill several hundred pages full of vituperative, anti-legal rhetoric from medical journals after mid-century."

The first unflattering comparison by doctors of lawyers to a certain ocean predator was reported around this time. In 1878, physician Eugene Sanger wrote that medical malpractice lawyers "follow us as the shark does the emigrant ship." The epithet has enjoyed impressive staying power. A hundred years later, the president of the Association of American Medical Colleges told a graduating medical school class, "We're swimming in shark-infested waters where the sharks are lawyers."

Commentators have offered a variety of reasons why doctors and lawyers don't see eye to eye, including: different approaches to determining "truth" (objective scientific truth for doctors versus adversarial truth for lawyers); conflict between the right of self-determination (highly valued by Anglo-American law) and the primacy given by doctors to the patient's best physical health interests, which does not always coincide with self-determination; and language barriers attributable to the specialized vocabularies of each profession, including different meanings ascribed to crucial terms such as "causation" and "injury."

But, of course, the primary bone of contention between doctors and lawyers is that some lawyers sue doctors. Medical malpractice suits matter deeply to doctors. Being sued for medical malpractice can damage a doctor's reputation, threaten personal assets, and drive up insurance premiums. Doctors see lawsuits as an attack on their integrity. While malpractice lawsuits may be business as usual for plaintiffs' lawyers, they are intensely personal to physician-defendants.

Thus, it is not surprising that doctors harbor anger and resentment toward a profession holding such power to disrupt and harm their lives and livelihoods.

Tort Reform Gladiators

For most of history, the doctor-lawyer fracas was largely a backroom brawl of interest only to the combatants, but the tort reform movement took the fight public. The public never hears about architects and engineers or dentists and accountants duking it out, but doctors and lawyers regularly grapple in highly publicized ways in the war over who is most responsible for malpractice lawsuits and high healthcare and

malpractice insurance costs.

Fallacious, inflammatory attacks are regularly employed in the tort reform debate to poison public opinion toward lawyers, and to a lesser extent doctors. Pro-tort reform rhetoric continually tells citizens that lawyers are greedy and responsible for higher healthcare costs, and for forcing doctors to flee their states or quit practicing altogether. Many of the broadsides are blatant ad hominem attacks and fallacious appeals to emotions such as hatred and fear.

Lawyers generally have been more restrained than doctors in their public assaults on doctors. Most public lawyer rhetoric about the malpractice debate focuses on debunking doctors' claims about why tort reform is needed, what it will accomplish, and who it will affect. But lawyers do frequently attack doctors on a couple of fronts: the frequency and deadly results of medical errors and the failure of the medical profession to effectively police doctors who regularly act carelessly or incompetently.

Although it comes down harder on lawyers than doctors, the tort reform movement regularly hammers home to the American public that neither group can be trusted.

Pummeled Professions

Doctors and lawyers can only dream of the good old days when they were looked up to with awe as people "of mystery and magic, members of a sacerdotal class in close communion with the gods." The images of both professions have taken severe public relations hits in recent decades. While doctors regularly fare better than lawyers in "most respected profession"-type surveys (with doctors generally ranking in the top quartile and lawyers in the middle of the pack or lower), both professions are in dire need of public relations makeovers. Googling the terms "I hate doctors" and "I hate lawyers" brings up hundreds of thousands of hits.

Increasingly, contrary to the ethos of their professions, both doctors and lawyers are seen as driven more by self-interest than by a desire to serve their patients and clients. An ABA study of lawyer perceptions found that "lawyers have a reputation for winning at all costs, and for being driven by profit and self-interest, rather than client interest." Doctors see themselves as being portrayed as "greedy and motivated by a desire to maintain their incomes and stave off malpractice suits."

Both professions are the target of demeaning jokes. Lawyer jokes are so plentiful that there are lawyer jokes about lawyer jokes: "How many lawyer jokes are there? Only three. The rest are documented case histories." While not as prevalent as lawyer jokes, doctors also serve as the butt of jokes, taking it on the chin for their perceived super-sized egos.

Of course, a number of factors contribute to the bruised public images of the medical and legal professions. But while it cannot be empirically shown, a contributing factor is the continuous tearing down of one another's profession. People believe what they hear. A substantial body of research, for example, shows that information disseminated in the media about the civil litigation system, including advertising by pro-tort reform groups, has a powerful influence on public perceptions.

"Lack of trust may cause the public to be more willing to support government regulation that hurts both professions."

Tattered Trust

A byproduct of lower public perceptions of our medical and legal systems is diminished trust, the cornerstone of attorney-client and doctor-patient relationships. Nobel-prize winning economist Kenneth Arrow identified two pillars of trust: competence and conscience. As reflected in the tort reform debate, the doctor-lawyer battle focuses heavily on chipping away at the doctors' competence trust-pillar and the lawyers' conscience trust-pillar, as in "doctors are going to kill you" and "lawyers are going to cheat you."

When patients and clients lose trust in their doctors and lawyers, all parties suffer. Declining trust of doctors and lawyers may cause people who have a choice to avoid seeking their services and take matters into their own hands. Clients and patients may withhold embarrassing information, the disclosure of which would make them more vulnerable. They may question advice they receive or decline to follow it at all.

The more often the public hears doctors insisting they have to practice defensive medicine because of lawyers, the more people will distrust not only lawyers for causing the problem, but doctors when they order tests. Patients may begin reacting to every test with the internal question: "Do I really need this [fill in the blank: expensive/time-consuming/painful/invasive/side effect-fraught] test or is my doctor just doing this to me cover his ***?" Lack of trust also may make patients and clients more likely to resort to legal action when results come out differently from what they had expected or hoped for.

On a broader policy level, lack of trust may cause the public to be more willing to support government regulation that hurts both professions (e.g., contingency fee limits for lawyers, payment cuts to doctors). Already, the public is quick to lay blame on both professions for the high cost of medical care. If the public can't trust the medical and legal professions to do the right thing on their own, they may endorse substituting regulation in what Professor Mark Hall called a "functional alternative" to trust, further eroding professional autonomy.

In light of mounting evidence that public confidence is declining for all professions, doctors and lawyers have a joint stake in working together to build and sustain trust and respect in the professions as a whole. When broad-based assaults are made on the professions generally, there is no reason to believe any particular profession will be spared.

Trust is also lacking, of course, between doctors and lawyers themselves. Both groups must wake up to the reality that massive shifts occurring in our heavily regulated healthcare system will necessitate more doctor-lawyer alliances. Doctors will have no choice but to rely on—and trust—lawyers to steer the course and fight to protect their rights. This, of course, is already happening. One early series of lawsuits by doctors against managed care organizations led to a quotation that surely must contend for the "Things I Never Thought I Would Hear" Hall of Fame: "We doctors suddenly found ourselves in trouble, and the only place we could turn was to the trial lawyers for help."

Prescriptions for Improving Relations

The medical and legal professions are never going to be free from confrontation, but progress is possible. Below are some

suggestions, most of which focus on increasing interaction and communication between the two groups.

Doctors and lawyers do not understand each other. That much is clear. While a variety of academically oriented explanations, such as different training and approaches to problem-solving, have been offered, the primary explanation might be much simpler: they just don't know each other. Doctors and lawyers rarely interact except in professional contexts, some of which are contentious. Given the opportunity to get to know each other in non-confrontational settings, doctors and lawyers would realize they have much in common.

Medico-Legal Courses for Medical and Law Students

The best stage of their careers for doctors and lawyers to begin understanding each other would be at the beginning: while they are in school. Professional schools are where students become socialized in the values, relationships, and overall cultures of their new professions. Students are more open-minded than fully formed professionals. They have not yet had a chance to become as jaded and cynical.

An interesting 1998 study compared the views of medical, law, and business students on a variety of issues in the healthcare system. The major finding was that their views were remarkably similar. All three groups, for example, agreed at similarly high levels about fundamental healthcare principles, including every citizen's right to healthcare and access to a doctor when they need it.

The only areas of notable difference in opinion involved, not surprisingly, cost containment issues that might affect the respondent's respective profession. But even here the differences were not nearly as dramatic as one might expect. On the key issue in the doctor-lawyer fight—reforming the medical liability system—85% of law students, compared to 98% of medical students, agreed that liability reform would be effective at reducing healthcare costs.

Law and medical school Professor Sheldon Kurtz, University of Iowa, has long taught a law and medicine seminar in which law students shadow doctors and residents on the job. He said the course helps "de-demonize" law students and lawyers to medical professionals, while teaching law students to appreciate the complexity of medicine, including its inherent outcome-uncertainty.

Joint Continuing Education Programs

Most states impose continuing education requirements for both doctors and lawyers. State physician and attorney licensing bodies should work together to encourage and develop joint doctor-lawyer programs approved to satisfy their respective required annual CLE and CME hours. For example, several legal CLE programs on tort reform exist. Imagine how much richer the experiences would be if those programs included both legal and medical professionals as presenters and audience members.

"Public confidence is declining for all professions; doctors and lawyers have a joint stake in working together to build and sustain trust."

Joint Social Events

Bar and medical associations organize many social programs, as well as sporting events for members. Each group should make an effort to reach out to the other and bring the two groups together. Make the sporting events charitable affairs and donate the proceeds to charities that both groups can get behind, such as organizations providing free legal and medical services to low-income people. Such events would carry the added benefit of bolstering the public images of both professions within their communities.

An AMA-ABA Committee to Improve Doctor-Lawyer Communication

The American Medical Association and American Bar Association are the largest organizations representing, doctors and lawyers, respectively. With their resources and stature, the two organizations could, working together and leading by example, do much to encourage and facilitate improved doctor-lawyer relationships. Regrettably, the two organizations join forces all too infrequently. Their most noteworthy collaboration, a study of narcotics addiction, occurred half a century ago.

A joint AMA-ABA committee or task force devoted to studying and improving doctor-lawyer relations would open a portal of communication between the professions, and, importantly, provide avenues for funding proposals of the type described in this article.

A Balanced Jointly Moderated Medico-Legal Blog

Doctors and lawyers operate hundreds of blogs. Most of them are marketing tools for law firms or medical clinics or forums for hyperbolic one-sided advocacy for or against tort reform, but many medical and legal blogs offer substantive, high-quality content. What is missing is a blog, moderated jointly by scholastically credible doctors and lawyers, aimed at balanced presentation and commentary on medical and legal news and issues of interest to both professions. Providing a trusted, respected forum where lawyers and doctors would feel comfortable expressing their opinions on important medico-legal issues could collect a treasure trove of useful information and points of view.

Conclusion

The author experienced an epiphany of sorts when he told two treating physicians he was doing research about doctor-lawyer relationships. Both doctors are busy specialists who had provided good care, but not a lot of quality bonding time. The mere mention of the research, however, caused an almost startling transformation in their demeanors. One doctor pulled up a chair and began talking animatedly about the high suicide rates among physicians. The other doctor, a surgeon, said, "the public doesn't understand us." "Us," as in doctors and lawyers together. He added, with resignation, "We need each other."

He was correct. Like it or not, we do need each other. Not only for the benefit of our patients and clients and the advancement of public policy, but also for our own sakes.

Professor Andrew Jay McClurg is the Herbert Herff Chair of Excellence in Law at the University of Memphis, Cecil C. Humphreys School of Law. He can be reached at: One Front Street, Memphis, TN 38103; Office: 901-678-1624; Cell 901-270-8393; or email: amcclurg@memphis.edu.

Retail Medicine

Clinics team up with traditional medicine, physician groups **by Bruce Japsen**

IT WASN'T LONG ago that giant retailers and pharmacy chains were fending off criticism from doctors and other traditional providers of medical care over the concept of retail medicine.

Organized medical groups, including the American Medical Association and others, worried about the quality of care and the lack of physician involvement or supervision when retailers like Wal-Mart, Walgreens and CVS were making efforts to lure patients into the backs of their stores for primary medical care.

Generally staffed by nurse practitioners and sometimes physician assistants, retail health clinics have blossomed across the country as a primary care option for routine maladies like ear infections, strep throat, or a child's head lice. More than 1,300 retail clinics now exist, and the clinics are projected to grow by at least 100 a year for the next several years as more retailers enter the business, as well as grocers like Jewel, Safeway, and Kroger, invest heavily in the concept.

Criticism Softening?

The retailers started nearly a decade ago, offering evening and weekend hours when doctors' offices are generally not open. And that drew an outcry from doctors who worried about the lack of physician supervision and quality of care if patients substituted a nurse practitioner or physician assistant who they did not see regularly for a primary care doctor and a medical home.

But the volume of criticism from providers of medical care appears to be softening as more doctors, clinics, and some of the nation's best known healthcare provider systems form partnerships with retail giants.

In some cases, the doctors or clinics became the medical directors at individual clinics. In newer models, retailers are partnering with doctors to more effectively coordinate medical care.

Take CVS/Caremark, which first began to open retail clinics nearly a decade ago under its MinuteClinic subsidiary, but increasingly is seeking partnerships with medical care providers as its model.

MinuteClinic formed its first provider partnership in 2009 with Allina Hospitals in the Minneapolis area. Today, it has 14 partnerships that include relationships with the likes of the Cleveland Clinic, Henry Ford Health System, and Advocate Health Care in Chicago.

"Our partnerships include some of the largest and most prominent systems in the country," said Dr. Andrew Sussman, president of MinuteClinic and associate chief medical officer of CVS/Caremark. "Taken together, they represent 125 hospitals and 35,000 physicians. Most are led by physicians and physician groups."

Despite the early criticisms by physicians, Dr. Sussman said it's not the intention of the retailer to take business away from physicians. Rather, it is designed to assist doctors in managing patients' medical care and pharmacy needs.

"The physicians collaborate with our clinicians and provide quality oversight, teaching, and back up," Dr. Sussman says.

CVS' MinuteClinic, the largest of the retail clinic operators in the U.S., with more than 550 locations, plans to open 100 new clinics a year through 2016, doubling its presence across the country.

"The notion that these health systems need an efficient and convenient place for disease management could be one reason for the expansion," wrote Thomas Charland, chief executive of Minneapolis-based Merchant Medicine, which follows the growth of the retail clinic industry, in a December 2011 report on the increasing partnerships between retailers and providers.

"These MinuteClinic partners, like the Cleveland Clinic, hope that close coordination with primary care physicians will make a big difference in managing chronic disease."

In Chicago, CVS last year signed an agreement with Advocate's doctor group, Advocate Physician Partners, which has physician-medical directors at about two dozen MinuteClinics in the Chicago and Bloomington areas where Advocate also operates hospitals. Advocate has a network of more than a dozen hospitals and more than 250 sites of urgent and outpatient medical care throughout the state.

"Advocate executives believe it could end up winning more referrals of patients who access care at retailers and don't have a regular physician."

Advocate executives believe it could end up winning more referrals of patients who access care at retailers and don't have a regular physician.

"This partnership allows Advocate physicians to provide a medical home for many patients who seek care at MinuteClinic and do not have a relationship with a physician," said Dr. Lee Sacks, president of Advocate Physician Partners, at the time the MinuteClinic partnership was announced last year.

Consistent with AMA Protocols

The moves by Walgreens and CVS are consistent with protocols written in recent years by groups like the American Medical Association, which pushed for closer ties between physicians and retailers as the in-store clinics began to proliferate.

The AMA policy encouraged retail clinics to use "standardized medical protocols derived from evidence-based practice guidelines to ensure patient safety and quality of care." Further, the AMA wanted a referral system in place with community-based physicians.

Following much debate and several meetings, the AMA developed policy on retail health clinics that was approved by its policy-making House of Delegates in 2006 and amended in 2007. (*See box on facing page.*)

There is still resistance to the retail clinic idea, but Merchant Medicine's Charland says that applies "more specifically to nurse practitioners and physician assistants practicing solo."

But market forces that are causing more consolidation by physicians make a nurse-practitioner or physician assistant a less

competitive threat.

"Primary care physicians are working for large health systems under a salary arrangement as opposed to private practice," Charland said in interview. "This insulates them from the competitive threat. As we move closer to 'population management' under the accountable care organization model, physicians have no choice but to encourage patients to go to the most appropriate venue for care based on the seriousness of their injury or illness. This is taking the emotion out of the argument."

Under the Affordable Care Act that President Obama signed into law two years ago, there is a financial reason for this more coordinated model between doctors and retailers. The Medicare program is working on financial incentives through so-called ACOs that provide better care that leads to lower costs.

And in the private insurance market, health plans are increasingly writing financial rewards into their contracts with providers if doctors and hospitals can improve the quality of care they provide while at the same time save money.

Seeking Patient Compliance

Walgreens and Northwestern Memorial Hospital in Chicago, for example, developed a "coordinated healthcare program" last year that is first being used as a pilot with Walgreens and hospital employees who have Northwestern Memorial Physicians Group as their primary care provider. If successful, it could be expanded to a broader population.

Dr. Daniel Derman, president of Northwestern Memorial Physicians Group, said the program provides a "richer conversation" for patients with their primary doctor that is supported by the pharmacy documentation.

He said it is necessary when studies show that just two-thirds of patients are taking their medications as prescribed, and so doctors and pharmacists have to be more aggressive about patient compliance.

Developed by Northwestern doctors and Walgreens pharmacists, the coordinated care program involves an intervention plan at the pharmacy counter. When patients with certain chronic diseases, such as hypertension, diabetes, and asthma pick up their medications, they can receive "point of care" counseling from a pharmacist.

"Many of our chronic disease patients tell us they see their pharmacist more often than they do their doctor," said Kermit Crawford, Walgreens president of health, wellness and pharmacy.

The Northwestern doctors and Walgreens pharmacists developed a plan for each disease state. The counseling session includes a series of questions developed by the doctors and pharmacists to make sure patients adhere to their medications and understand their diseases.

In the past, Dr. Derman said, it would be common for physicians to write a prescription and take it for granted that patients would take their medications. A physician would rarely talk with a pharmacist about the patient's care plan.

"Those two entities never dealt with each other," Dr. Derman said of pharmacists and doctors. "We're working on perfecting that relationship. What can we do to influence the patient's compliance? We can do a lot."

Bruce Japsen is an independent Chicago healthcare journalist and a contributor to the New York Times and writer for the Times' Prescriptions healthcare business and policy news blog. He was healthcare business reporter at the Chicago Tribune for 13 years and is a regular television analyst for WTTW's Chicago Tonight, CBS' WBBM radio 780-AM and 105.9 FM and WLS-News and Talk, 890-AM. He teaches healthcare writing at Loyola University Chicago and has taught in the University of Chicago's Graham School of General Studies medical editing and publishing certificate program. He can be reached at brucejapsen@gmail.com.

AMA Policy on Store-Based Health Clinics (H-160.921)

1. It is AMA policy that any individual, company, or other entity that establishes and/or operates store-based health clinics should adhere to the following principles:
   - **a.** Store-based health clinics must have a well-defined and limited scope of clinical services, consistent with state scope-of-practice laws.
   - **b.** Store-based health clinics must use standardized medical protocols derived from evidence-based practice guidelines to insure patient safety and quality of care.
   - **c.** Store-based health clinics must establish arrangements by which their healthcare practitioners have direct access to and supervision by MD/DOs, as consistent with state laws.
   - **d.** Store-based health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community.
   - **e.** Store-based health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.
   - **f.** Store-based health clinics must clearly inform patients in advance of the qualifications of the healthcare practitioners who are providing care, as well as limitations in the types of illnesses that can be diagnosed and treated.
   - **g.** Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to ensure the safety of patients.
   - **h.** Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care.
   - **i.** Store-based health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care.
2. AMA will continue to monitor the effects of store-based health clinics on the healthcare marketplace, and report back to the House of Delegates.
3. Health insurers and other third-party payers should be prohibited from waiving and/or lowering co-payments only for patients who receive services at store-based health clinics (CMS Rep. 7, A-06; CMS Rep. 5, A-07).

Chicago Collaborative Targets Obesity Epidemic

"Obesity-related diseases are among the top ten causes of death in Chicagoans aged 15 to 64."

A **NEW CITYWIDE** campaign looks at the policies, systems, and environments that shape individual health, with the goal of implementing sustainable changes and improvements to encourage healthy behavior.

The Consortium to Lower Obesity in Chicago Children (CLOCC) at Children's Memorial Hospital leads Healthy Places, in partnership with the Chicago Department of Public Health (CDPH). The initiative, which began in September 2010, runs through September 2012.

The collaboration underscores the complex nature of obesity by addressing four areas that significantly affect obesity rates: food access, breastfeeding education and support, healthy school environments, and safe walking and biking. The campaign advocates for healthy food options, breastfeeding support at local hospitals, physical activity throughout the school day and after school, and safe places for active living. A call-to-action encourages Chicagoans to help with these built-environmental changes being made by the City and various community stakeholders as part of the Healthy Places project.

"The campaign shows we're thinking about how we can make changes to our environment that improve Chicagoans' health," said Bechara Choucair, MD, who is CDPH Commissioner. "Healthy environments are crucial to combat obesity and we all have a role to play in making change happen in this area."

Healthy Places has partnered with City and community-based organizations on a host of obesity prevention initiatives. They include improving fresh food access at neighborhood corner stores and collaborating with city stakeholders to develop a Food Plan to guide food-related policies and land use decisions in Chicago.

Obesity-related diseases are among the top ten causes of death in Chicagoans aged 15 to 64: cancer, heart disease, stroke, and diabetes. Nearly one-third of adults in Chicago are obese and 22% of children ages 3 to 7 are obese—more than twice the national average. According to America's Health Rankings, obesity cost Illinois $3.6 billion in 2008 alone.

Healthy Places is also working to make active living easier in Chicago. Neighborhood "walkability" assessments in assorted Chicago communities examined barriers to safely accessing city streets and parks. The data are helping community organizations to advocate for neighborhood improvements. The campaign is also defining transportation-related policies to make Chicago's parks easier to access by foot or bicycle.

The citywide education campaign relies on various formats to reach the public: print, radio, television, online, and neighborhood centers.

Healthy Places is a $5.8 million project funded by the Centers for Disease Control and Prevention (CDC) through the U.S. Department of Health and Human Services' Communities Putting Prevention to Work initiative. The Affordable Care Act's Prevention and Public Health Fund allocated funds for the project.

For information about Chicago's obesity prevention efforts, please visit www.healthyplaceschicago.org.

Here's one of several ads Healthy Places is sending through the media to encourage individuals to improve their health.

Metastatic Renal Cell Carcinoma

State of the art treatment **by Joseph I. Clark, MD**

NEARLY 61,000 new cases of kidney cancer were expected to be diagnosed in the United States in 2011, and more than 13,000 Americans were expected to die of the disease in 2010. Renal cell carcinoma (RCC) represents roughly 2-3% of all malignancies, and disproportionately affects older people, with a median age at diagnosis of 65 years. Approximately 90% of kidney cancers are RCC, and 85% of cases are clear cell tumors. About one-third of patients have metastatic disease, and up to 40% of patients who present with localized disease will develop recurrences. The five-year survival rate for metastatic RCC (mRCC) is less than 25%.

Patients with RCC may present with a suspicious renal mass and complaints of hematuria, flank mass, or flank pain. For those with mRCC, signs and symptoms may include adenopathy, bone pain, and pulmonary symptoms due to lung parenchyma or mediastinal metastases. The array of signs and symptoms, coupled with the discouraging outlook for patients with mRCC, has spurred the development of various prognostic criteria to guide risk stratification and clinical decision-making (Table 1). The most widely used set of criteria is that developed by the Memorial Sloan-Kettering Cancer Clinic (MSKCC). The original version (1999) defined five clinical features as predictive of shorter survival in mRCC: low hemoglobin (i.e., below the lower limit of normal [ULN]); high serum lactate dehydrogenase (>1.5 ULN); high corrected serum calcium (>10 mg/dL); absence of prior nephrectomy; and low Karnofsky performance status (<80%). The updated MSKCC criteria (2002) replaced prior nephrectomy with time to treatment with interferon (IFN)-α of less than one year, based on results from two Phase III trials showing a survival benefit associated with cytoreductive nephrectomy prior to IFN-α therapy.

The MSKCC and other mRCC prognostic criteria can be used to guide treatment selection in clinical practice. Several current treatment options are summarized below.

Current Approaches to Management of mRCC

Surgery

Treatment guidelines for mRCC generally recommend cytoreductive nephrectomy before systemic therapy in patients with an excellent performance status, potentially resectable primary RCC, and multiple non-resectable metastases. Reports from the Southwest Oncology Group (SWOG) and the European Organisation for Research and Treatment of Cancer (EORTC) Genitourinary Group suggest that nephrectomy followed by IFN-α therapy can potentially delay time to progression and improve survival in patients with mRCC. Additionally, an MSKCC study demonstrated that metastasectomy can prolong survival in selected patients with recurrent RCC, particularly those with a single site of recurrence and/or a long disease-free interval.

Systemic Therapy

Cytokine therapy

High-dose bolus interleukin-2 (HD IL-2) was approved by the Food and Drug Administration (FDA) in 1992 for patients with mRCC based on data from seven Phase II trials involving 255 patients. In these trials, objective responses were reported in 15% of patients, including complete responses (CR) in 7% and partial responses (PR) in 8%. A striking feature of the Phase II trials was the durability of responses: the median duration of response was 54 months for all responders and 20 months for those with a PR; the median duration of response among complete responders had not been reached at the time these data were reported. Additionally, median survival in these seven trials was 16 months. More recent reports reveal higher overall response rates (ORR) of 28-29% with HD IL-2; these results are likely due to better and more stringent selection of appropriate candidates for HD IL-2 therapy.

Despite the advent of targeted therapy and continued use of IFN-α cytokine therapy in combination with bevacizumab (a monoclonal antibody that inhibits vascular endothelial growth factor [VEGF] receptors), HD IL-2 retains an important role in the treatment of mRCC. The IL-2 SELECT Cytokine Working Group (CWG) trial, initial results of which were presented at the 2010 ASCO annual meeting (and for which a manuscript is in preparation), represents an attempt to identify molecular and immunologic predictors of response to HD IL-2. Additionally, the ongoing PROCLAIM Registry trial, which is being conducted at Loyola University Medical Center (LUMC) and several other institutions around the country, aims to establish a high-quality observational database of real-world clinical data on HD IL-2 when used to treat patients with mRCC and metastatic melanoma, and to identify predictors of response.

In the past, IFN-α had also been commonly used to treat mRCC, although Phase III trials in this setting show it provides only a modest clinical benefit in terms of ORR, progression-free survival (PFS), and duration of response.

Notably, adjuvant use (i.e., following nephrectomy) of IFN-α or HD IL-2 is not considered standard of care for non-metastatic RCC.

Targeted Therapy

Targeted therapy is the most commonly used treatment modality for mRCC, and is typically administered in the outpatient setting. Six targeted agents have been approved by the FDA for treatment of mRCC. One of them, sunitinib, inhibits multiple tyrosine kinases including platelet-derived growth factor receptors (PDGFR)-α and –β, VEGFR-1, -2, and -3, stem cell factor receptor (c-KIT), FMS-like tyrosine kinase (FLT)-3, colony stimulating factor (CSF)-1R, and the neurotrophic factor receptor (RET). In a Phase III trial in 750 patients with previously untreated mRCC, sunitinib was superior to IFN-α with regard to ORR (47% vs. 12%), overall survival OS (median 26.4 vs. 21.8 months), and PFS (median 11 vs. 5 months), with an acceptable safety profile.

Sorafenib is a small molecule that is similar to sunitinib in that it targets multiple tyrosine kinases including VEGFR-1, -2, and -3, PDGFR- β, FLT-3, c-KIT, and RET, as well as multiple isoforms of the intracellular serine-threonine kinase RAF.*2* In the Phase III TARGET trial, which involved 903 patients with advanced RCC, sorafenib was superior to placebo as second-line therapy after prior cytokine treatment, particularly in terms of PFS (median 5.5 vs. 2.8 months). Another Phase III adjuvant

Table 1: Clinical Prognostic Criteria for mRCC

Set of Criteria	Lead Author and Year	Prognostic Factors
MSKCC, version 1	Motzer 1999	Corrected serum calcium • Hemoglobin • Karnofsky performance status • Lactate dehydrogenase (LDH) • Prior nephrectomy
MSKCC, version 2	Motzer 2002	Corrected serum calcium • Hemoglobin • Karnofsky performance status • LDH • Time from initial diagnosis to treatment with IFN-α
Cleveland Clinic	Mekhail 2005	Corrected serum calcium • Hemoglobin • LDH • Presence of liver, lung, or retroperitoneal nodal metastasis • Prior radiotherapy • Time from initial diagnosis to treatment with IFN-α
French Prognostic Criteria	Escudier 2002	Alkaline phosphatase • Corrected serum calcium • LDH • Number of metastatic sites • Time from nephrectomy to metastatic disease

Table 2: Ongoing Trials of Targeted Therapy-based Combinations and Sequential Therapy in mRCC

SOURCE: www.ClinicalTrials.gov

Study	ClinicalTrials.gov Identifier	Sponsor	Phase	Status
Study of E7080 alone and in combination with everolimus in subjects with unresectable advanced or metastatic RCC following one prior VEGF-targeted treatment	NCT01136733	Eisai Inc.	Ib/II	Recruiting
Comparison of sequential therapies with sunitinib and sorafenib in advanced RCC (CROSS-J-RCC)	NCT01481870	Yamagata University	III	Recruiting
BeST trial: bevacizumab, sorafenib, and temsirolimus in advanced RCC	NCT00378703	National Cancer Institute (NCI)	II	Ongoing but not recruiting
OSI-774 and bevacizumab in the treatment of patients with mRCC	NCT00193154	Sarah Cannon Research Institute	II	Ongoing but not recruiting
Phase 1b study of LY573636-sodium in combination with sunitinib malate in patients with mRCC	NCT01258348	Eli Lilly and Company	Ib	Recruiting
Study of Avastin (bevacizumab) in combination with low-dose interferon in patients with metastatic clear cell renal carcinoma	NCT00796757	Hoffmann-La Roche	II	Ongoing but not recruiting
Avastin and temsirolimus following tyrosine kinase inhibitor failure in patients with advanced RCC	NCT00782275	Beth Israel Deaconess Medical Center	II	Recruiting
Everolimus and bevacizumab in advanced non-clear cell RCC	NCT01399918	Memorial Sloan-Kettering Cancer Center	II	Recruiting
Phase I study of Doxil and temsirolimus in resistant solid malignancies	NCT00703170	Washington University School of Medicine	I	Ongoing but not recruiting
Phase I study of docetaxel and temsirolimus in resistant solid malignancies	NCT00703625	Washington University School of Medicine	I	Ongoing but not recruiting

trial, E2805 (conducted by the Eastern Cooperative Oncology Group [ECOG]), is a three-way comparison of sunitinib, sorafenib, and placebo in patients with resected RCC; the trial was recently closed to accrual, and results are pending.

Temsirolimus is an inhibitor of the mammalian Target of Rapamycin (mTOR) protein. It regulates cell growth, apoptosis, angiogenesis, and micronutrients via downstream effects on various proteins. In the Phase III Global Advanced Renal Cell Carcinoma (ARCC) trial, comprising 626 patients with previously untreated, poor-prognosis mRCC, temsirolimus monotherapy was superior to IFN-α monotherapy in terms of OS (median 10.9 vs. 7.3 months) and PFS (median 5.5 vs. 3.1 months). However, the combination of temsirolimus and IFN-α did not improve OS or PFS, and was associated with an increased incidence of multiple adverse events (AEs), including grade 3 or 4 anemia, anorexia, infection, diarrhea, stomatitis, weight loss, thrombocytopenia, neutropenia, and leukopenia.

Everolimus is an oral mTOR inhibitor approved for use in patients with advanced RCC after failure of sorafenib or sunitinib. Its approval was based on results from the Phase III RECORD 1 (renal cell cancer treatment with Oral RAD001 given daily) trial, which involved 416 patients with mRCC. The trial met its primary endpoint of superiority to placebo in terms of PFS (4.0 vs. 1.9 months); AEs were mostly mild to moderate in severity. Updated results from RECORD 1 showed a median PFS of 4.9 months for everolimus, compared to 1.9 months for placebo. The Southwest Oncology Group (SWOG) is comparing everolimus to placebo in the adjuvant setting in the ongoing Phase III EVEREST trial (also known as S0931), which is being conducted at 434 sites, including Loyola University Medical Center.

As noted above, bevacizumab is a recombinant humanized monoclonal antibody (mAb) that binds and neutralizes circulating VEGF-A. It is approved in combination with IFN-α for treatment of advanced RCC. In the Phase III AVOREN trial, which involved 649 treatment-naïve patients with mRCC, both PFS (10.2 vs. 5.4 months) and ORR (30.6% vs. 12.4%) were greater with this combination than with IFN-α monotherapy. The combination was not associated with a significant increase in AEs, compared to IFN-α alone. A trend toward improved OS (23.3 vs. 21.3 months) with bevacizumab plus IFN-α was not significant. Similar results were reported in the CALGB 90206 trial, in which the bevacizumab + IFN-α combination was superior to IFN-α alone with regard to PFS (median 8.5 vs. 5.2 months) and ORR (25.5% vs. 13.1%) in 732 patients with previously untreated clear-cell mRCC. Updated survival data from CALGB 90206 showed no significant difference between the combination and IFN-α alone in terms of OS (median 18.3 vs. 17.4 months).

The roster of currently available targeted therapies also includes pazopanib, an oral angiogenesis inhibitor targeting VEGFR-1, -2, and -3; PDGFR-α and –β; and c-KIT. In an open-label Phase III trial involving 435 treatment-naïve patients with clear-cell advanced RCC and measurable disease with no prior therapy or one previous cytokine-based treatment, pazopanib significantly prolonged PFS in the overall study population (median 9.2 months vs. 4.2 months for placebo). In a treatment-naïve subpopulation of 233 patients, median PFS was 11.1 months for pazopanib, compared to 2.8 months for placebo. The ORR in the overall population was 30% among pazopanib-treated patients vs. 3% for those receiving placebo. The incidence of grade 3 hepatotoxicity in Phase III trial, as indicated by elevated alanine (30%) and aspartate (21%) transaminase levels, necessitates monitoring of liver function before and during treatment. Additionally, heart rhythm irregularities have been observed in pazopanib clinical trials. An ongoing international Phase III adjuvant trial, sponsored by GlaxoSmithKline (manufacturer of pazopanib), is comparing pazopanib to placebo in patients with resected RCC.

Potential Future Treatment Approaches

Two mAbs in development show particular promise as potential new immunotherapeutic agents for the treatment of mRCC. One agent, MDX-1106, provides checkpoint blockade by inhibiting the programmed death (PD)-1 protein, which itself may suppress antitumor immunity. MDX-1106 was well tolerated in a Phase I study in 39 patients with refractory solid tumors; two patients with RCC attained a PR, including one patient with mRCC whose response lasted 16+ months. Ongoing trials using this agent in patients with advanced RCC aim to better define the optimal dose and schedule of this agent. The other agent, MDX-1105, targets the PD-1 ligand 1 (PD-L1), and may enhance the T-cell-mediated immune response to neoplasms. A Phase I multi-dose study of MDX-1105 is currently recruiting patients with advanced or recurrent solid tumors.

In the area of IL-2 based combination therapy, the CWG has characterized the combination of HD IL-2 and bevacizumab as safe and active in mRCC, noting that the addition of bevacizumab to IL-2 therapy appears to prolong PFS. In a Phase II study of this combination in 49 patients with mRCC, the CWG reported a median PFS of 9.0 months, two-year PFS of 15%, an ORR of 28% (CR = 8%; PR = 20%), and stable disease (SD) in 42% of patients. Toxicities associated with the combination were no different from those associated with either agent used alone. A manuscript for this study was recently submitted for publication. The CWG (of which LUMC is an active member) also plans to combine HD IL-2 with hydroxychloroquine as an autophagy agent in a Phase I/II trial in patients with advanced RCC.

Another focus of ongoing research in mRCC is the use of targeted agents, either as the basis of combination therapy or sequentially with other agents (see Table 2 for a listing of ongoing trials in this area). Axitinib, an inhibitor of VEGF-1, -2, and -3, has been studied in the second-line setting following first-line systemic therapy with a sunitinib-, bevacizumab-, temsirolimus-, or cytokine-based regimen. In the Phase III, open-label, 723-patient AXIS trial, axitinib-treated patients achieved significantly longer PFS (median 6.7 vs. 4.7 months) and a higher ORR (19.4% vs. 9.4%) compared to those receiving sorafenib. Subgroup analysis revealed a PFS advantage for axitinib in both the prior cytokine subgroup (12.1 vs 6.5 months) and the prior sunitinib subgroup (4.8 vs 3.4 months).

For Further Information

Patients with advanced mRCC and their family members and caregivers are encouraged to contact the Kidney Cancer Association (*www.kidneycancer.org*) for information about managing the disease. The Association is a particularly good resource for referrals to kidney cancer specialists.

Joseph Clark, MD, is Professor of Medicine, Hematology/Oncology, Fellowship Program Director, Hematology/Oncology, Cardinal Bernardin Cancer Center, Loyola University Medical Center.

Dr. Clark has served on speakers' bureaus for Novartis, Pfizer, and GlaxoSmithKline, and served on advisory boards for Prometheus and Genentech.

For the list of references, please contact Elizabeth Sidney at *esidney@cmsdocs.org;* or 312-670-2550, ext. 335.

At Work for You

CMS benefits enhance your practice and protect your autonomy

THERE HAS NEVER been a more important time to be a member of the Chicago Medical Society and Illinois State Medical Society. When you join our two organizations, you become part of a dedicated network of 12,000 Illinois physicians who are working together to achieve a unified healthcare front and fight against unfair insurer reimbursement practices, restrictions on physician autonomy and the erosion of valuable legislation that protects physicians' practices. CMS and ISMS can help enhance your practice, improve your bottom line, and protect your autonomy as a physician. Read on to discover the many benefits of membership.

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Since 1850, the Chicago Medical Society has been at the forefront of medicine in Cook County, ensuring that our members are represented in the areas of public policy, governmental relations, and community relations. Through our advocacy efforts in both Cook County and the Illinois State Medical Society, our physician leaders and staff strive toward a common vision—that you might spend more time treating your patients and less time navigating the obstacles that threaten your autonomy and undermine your practice of medicine.

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- Reimbursement advocacy and assistance
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- Practice management techniques.
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Events are held throughout the county and state. Please view the calendar at *www.cmsdocs.org* or check the Calendar of Events section of *Chicago Medicine* magazine.

Reimbursement and Advocacy

The ISMS Division of Member Advocacy supports physicians—especially those in solo practice, partnership, or small group settings—who face increasing financial pressure due to ongoing changes in the healthcare delivery system. We recognize that physicians like you are under constant pressure to streamline your business operations while continuing to provide access and quality care to patients. It is often a struggle to implement stringent federal and state regulations and grapple with health plans that employ confusing, inconsistent, and unfair payment practices.

We offer hands-on support to physician-members in a variety of areas to ensure a healthy bottom line for their practices:

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For more information, please contact the ISMS Division of Member Advocacy at *www.isms.org.*

Practice Management Made Perfect

Join us **by Alina Baban, Chair, CMS Practice Manager Section**

GREETINGS to all practice managers in Cook County. I encourage you to join the Chicago Medical Society's new Practice Manager Section. Our goal is to foster a strong working environment through education and teamwork. Membership allows you to shape CMS programs and services based on your professional needs and interests, while advancing your practice's financial health.

The Society provides access to the latest information on practice development and expansion, cost containment, research, and patient education. The Section facilitates conversation on medical management issues. Through our forums, blogs, and networking events, you have greater access to your colleagues and expert opinions. In addition, CMS offers Section members an online career center and job board.

As the section's first Chair, I ask you for your input. Please contact me at cmspresident@cmsdocs.org.

Practice managers who work in the offices of CMS physician-members qualify for a discounted dues rate of only $99 per year. The nonmember rate is $395.

To download an application, please go to *www.cmsdocs.org.*

Ms. Alina Baban is co-founder and COO of Medical Device Provider, Inc., Executive Office Manager for Medical Arts Unlimited, Corp., a comprehensive medical practice, and President of Precision Provider Services, Inc., a management consulting company. She cares directly for patients as an allergy/immunotherapy and surgical technician, and is certified in medical coding and billing. Ms. Baban holds an undergraduate degree in biology and chemistry from the University of Illinois at Chicago, and is pursuing a master's degree in healthcare administration. She is a member of the American Health Information Management Association (AHIMA), and Health Billing and Management Association (HBMA).

"CMS recognizes the essential role of practice managers on the healthcare team," says Alina Baban, Chair, CMS Practice Manager Section.

Legislative Advocacy

Medicaid reform and what it means for you

"Legislation that passed in both houses contains significant Medicaid reform, but no rate reductions for physicians, thanks in part to ISMS advocacy."

THE CHICAGO Medical Society is working through the Illinois State Medical Society to introduce and influence legislation at the state and federal levels. The process begins in the CMS Governing Council, where physician members sponsor resolutions. Once adopted, resolutions are debated by the State Society, with input from its influential Governmental Affairs Division. In addition to supporting pro-medicine policies and legislation, our organizations work to prevent harmful bills from becoming law. Our scope is ambitious and comprehensive. And members enjoy tangible results and savings as a result of our advocacy.

Physicians Step into Fray

Few issues were more contentious in Springfield in recent weeks than the fight over Medicaid "reform"—a fight precipitated by massive funding shortfalls and increased burdens on the Medicaid system, both present and future.

ISMS Fought Back

Legislation that passed in both houses of the General Assembly on May 24 contains significant Medicaid reform, but no rate reductions for physicians, thanks in part to ISMS advocacy.

SB 2840 will significantly cut Medicaid spending by almost $2 billion, while adding $375 million to the Medicaid coffers by way of a cigarette tax increase that would be matched by the federal government. The legislative package is now on its way to Governor Pat Quinn, who is expected to sign the bills.

The new legislation includes Medicaid eligibility changes, benefit reductions, utilization controls and rate reductions for some hospitals, nursing homes and healthcare professionals. It will also impact recipients who need prescription drugs, as they will be limited to four prescriptions per month unless they obtain prior approval for additional prescriptions. The senior prescription drug assistance program, Illinois Cares Rx, is eliminated.

In addition to the Medicaid reform package, the House and Senate passed related legislation that includes definitions of hospital charity care and the hospital assessment program.

Low Rates a Barrier to Care

While the legislation does not cut physician payment rates, other providers will be affected, such as hospitals, with the exclusion of critical access hospitals, safety net hospitals, public hospitals, and Federally Qualified Health Centers. Dentists are exempt from a rate reduction. Hospitals will receive a cut of 3.5%, and nursing facilities will have various payment reductions to their nursing and capital rates, and institutions for mental disease will have a 2.7% cut.

ISMS has long advocated against reductions in physician payment rates, pointing out that further cuts in reimbursement are inconsistent with the Affordable Care Act, which includes a provision that Medicaid rates for primary care services should be increased to Medicare rates for two years starting in 2013. The provision in the ACA clearly recognizes the inadequacy of Medicaid's low rates, and how they act as a barrier to care. Since rates in Illinois are among the lowest in the country, it should be clear that for access to care to improve, rates should be increased, not decreased.

ISMS Informs Lawmakers

In the weeks leading up to the Medicaid reform debate in Springfield, ISMS sent a position paper to every member of the Illinois General Assembly, detailing the insufficiency of current reimbursement to cover physicians' costs, and emphasizing the dire threat further cuts would pose to patient access to care. The paper outlines many of the principles for Medicaid reform that were formulated and voted upon by ISMS' own members. It proposes to lawmakers innovative approaches for addressing the challenges faced by our Medicaid system and provides policy guidance that could improve patient care while also realizing significant savings. The white paper can be found on the ISMS Legislative Action Hub.

ISMS will continue to work behind-the-scenes with state agencies responsible for implementing these major reforms to ensure that regulations are not onerous to physicians.

Reform Highlights

Among other changes, the legislation:

- Reduces Family Care for adults from 185% of the federal poverty level (FPL) to 133% FPL.
- Eliminates medical general assistance program for adults.
- Creates integrated care programs for individuals with chronic mental health conditions, with capitated payment based on health outcomes.
- Reimburses medically unnecessary C-sections at the vaginal delivery rate.
- Eliminates group psychotherapy for nursing home residents.

The material above is excerpted from the ISMS website. To learn more, please go to www.isms.org.

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ISMS House of Delegates

Advocating for you and your practice

"CMS physician-delegates brought 15 resolutions, or roughly one-third of proposals addressed at the April 20-22 House meeting."

YOUR CHICAGO Medical Society actively shapes legislation in Illinois through its annual participation in the Illinois State Medical Society's House of Delegates.

This year's meeting was no exception. CMS physician-delegates brought 15 resolutions, or roughly one-third of proposals addressed at the April 20-22 House meeting. Some resolutions reflected discontentment with the current health-care system, while others proposed new public health protections. Nearly all CMS resolutions drew strong support from delegates who packed the overflow meeting rooms. Many will be taken up in June by the American Medical Association's House of Delegates convention in Chicago.

The CMS resolutions were first introduced in the Society's grassroots Governing Council. This incubator of ideas and initiatives produces many resolutions for consideration at the ISMS House. Once adopted, they form the basis of legislation in the Illinois General Assembly. Some resolutions go to the AMA, the highest level of organized medicine, for policy and action.

Both the ISMS and AMA Houses allow members from all backgrounds and practice modes to cross paths and share ideas. As our organizations' policy-making bodies, they are a source of strength when speaking out to the U.S. Congress or Illinois General Assembly.

As one of the nation's largest county medical societies, CMS represents a highly diverse physician community, with the nation's largest academic "medical district," and second largest public health system, seven teaching institutions, and 60-plus hospitals. CMS is the only local organization to unify and represent physicians' common goals.

Here are adapted highlights from the ISMS House meeting.

1 Educating Medical Providers as First-Line Responders to Stop Human Trafficking

Adopted an amended resolution directing the ISMS to: (1) adopt policy that encourages physicians to act as first responders in addressing human trafficking; and request the AMA to: (2) adopt similar policy to encourage physicians to act as first responders in addressing human trafficking; and (3) encourage the creation of a curriculum to screen for and identify victims of human trafficking and increase awareness of the resources available to help restore basic human rights and dignity to victims in captivity; and (4) call for the development of guidelines on how to intervene, with the purpose of educating and empowering medical students, physicians, and all healthcare professionals to act as first-line responders against human trafficking.

Dr. Howard Axe (standing at dais), Vice Speaker of the ISMS HOD and incoming President of CMS, listens as Dr. Richard A. Geline, AMA Delegation Chair, addresses the delegates.

2 Smoking Bans in Cars with Children

Adopted an amended resolution directing the ISMS to: (1) adopt policy in support of a smoking ban in cars and passenger vehicles when children under the age of 18 are present; and (2) form partnerships with other stakeholders to seek the introduction of legislation in Illinois that would ban smoking in cars when children under the age of 18 are present.

3 Dementia Care Unit Certification

Adopted an amended resolution directing the ISMS to: (1) support the concept of

certification of nursing homes and assisted living facilities that promote special "dementia" units, to ensure that these units can truly meet the needs of this population, and that the staff in these units are specially trained to meet the requirements of such certification; and (2) support or cause to be introduced legislation in Illinois in support of certification of nursing home and assisted living facility "dementia" units; and (3) join other interested stakeholders in promoting such "dementia" unit certification procedures in nursing homes and assisted living facilities, to ensure the safety and well-being of this vulnerable population.

4 Stimulate Antibiotic Research and Development (R&D)

Adopted an amended resolution directing ISMS to: (1) support legislation requiring the re-evaluation of FDA guidelines for clinical trials of antibiotics, including an increase in the period of patent protection, and giving antibiotics priority review; and request the AMA to (2) support legislation requiring the re-evaluation of FDA guidelines for clinical trials of antibiotics, including an increase in the period of patent protection, and giving antibiotics priority review.

5 Work Place Survey Regarding Charitable Care by Illinois Physicians

Referred for study a resolution directing the ISMS to (1) poll its membership on the provision of charity care by individual members and assemble a total tally that includes the number of patients, estimated hours of service, and value of uncompensated care delivered annually, beginning with the 2011 calendar year; and (2) allow individuals responding to such a poll to remain anonymous and confidential; and (3) allow individuals who wish to make public their contributions to do so and be recognized individually in ISMS publications; and (4) create an award for the individual who has provided the greatest and most significant amount of charitable healthcare in Illinois and award this honor at the annual meeting starting in 2013; and (5) promote to the press, local and state government, the findings and facts along with the cumulative data proving the massive contribution of free and at "cost" medical and surgical care by Illinois physicians.

Ougoing CMS President Dr. Thomas M. Anderson, reviews agenda items with Dr. Kathy M. Tynus, Vice Chairman of the CMS Council.

6 Obesity Should Be Considered a Chronic Medical Disease State

Adopted a resolution directing ISMS to: (1) recommend that obesity and overweight be recognized as a chronic medical condition (de facto disease state) and urgent public health problem; and (2) recommend that providers receive appropriate financial support and payment from third-party payers, thus ensuring providers have an incentive to manage the complex diseases associated with obesity; and request the AMA to (3) recommend that obesity and overweight be recognized as a chronic medical condition (de facto disease state) and urgent public health problem; and (4) urge that providers receive appropriate financial support and payment from third-party payers, thus ensuring providers have an incentive to manage the complex diseases associated with obesity; and (5) work with third-party payers and governmental agencies to recognize intervention

Press-Ganey Hospital Consumer Assessment

CMS physicians weighed in on resolutions from other county medical societies, which called for a re-examination of resident work hours, purchase of non-prescription over-the-counter drugs using a health savings account, and comprehensive sex education in Illinois. Delegates approved language to remove the Press-Ganey Hospital Consumer Assessment of Healthcare Providers and Systems, and other post-hospital survey questions that use subjective patient measurements for evaluation of pain management while in the hospital or emergency room. Physicians voiced support for a "rigorous and continuous evaluation" of current ACGME resident duty hour policy and its effect on patient care and training. The resolution also directed AMA to encourage adoption of practical standards that meet both patient and provider needs.

CMS Treasurer Dr. Philip B. Dray leads discussion on resolutions.

as an essential medical service; and (6) establish a comprehensive ICD-9 code for medical services to manage and treat obese and overweight patients.

7 Medicare Records Retention and Overpayment Recoupment

Adopted a resolution directing the ISMS to: (1) communicate to the Department of Health and Human Services its strong objection to the proposed plan to collect overpayment of Medicare services within 60 days of discovery, regardless of how this might affect the cash flow and solvency of a medical practice; and (2) express to the HHS its strong objection to the proposed rule that would require practices or auditors to report any overpayments that were discovered within 10 years of the date the funds were received instead of the current six-year requirement, due to the burden this would place on physicians' practices, which in essence is another unfunded mandate; and (3) introduce similar resolutions to the AMA annual meeting in June 2012.

8 Lien Act Amendment

Adopted a substitute resolution directing the ISMS to: (1) support or cause to be introduced legislation to amend the Health Care Services Lien Act to provide written notice to lien-holders when a lawsuit is not pursued.

9 Repeal or Revise the Patient Protection and Affordable Care Act (PPACA)

Adopted an amended resolution directing the ISMS to (1) work for the repeal or revision of the flawed PPACA to correct deficiencies and replace it with a financially sustainable system that incorporates provisions that require a fair contribution by all stakeholders; and (2) introduce a similar resolution to the AMA House of Delegates for consideration and adoption.

(The provisions of the Patient Protection and Affordable Care Act (PPACA) that increase the number of Medicaid beneficiaries by 25%, decrease funding for Medicare, including a lack of a fix to the sustainable growth rate formula and lack of tort reform for medical liability cases, are not only financially unsustainable, representing unfunded mandates, but also unfairly place the burden on physicians, leading to the bankruptcy or dissolution of physician practices.)

10 Inadequacy of Illinois Department of Healthcare and Family Services to Manage Medicaid Expansion

Referred for decision a resolution directing the ISMS to: (1) call upon the governor and the Illinois state legislature to fully fund the legislated Illinois Health Policy Center, or contract for services from a center in another state, to ensure fiscally tight administrative control of the federally mandated expansion of Medicaid, resolve the state's indebtedness to Medicaid providers, and coordinate patient care supported by Medicaid; and (2) request the ISMS Board of Trustees to review other states' contracts for outside state Medicaid management and assistance in the establishment of state health policy centers, and report back to the ISMS House of Delegates with their findings.

11 Problem of Medical Liability Insurance for Physicians in Practice

In lieu of existing policy reaffirmed a resolution directing the ISMS to: (1) make every effort to

Spreading the Word on Charity Care

As part of their core values, physicians routinely provide uncompensated care to patients. Yet their good work often goes unrecognized, said one resolution that generated lively debate. Many delegates wanted ISMS to draw attention to the issue at a time when the state of Illinois is looking closely at the amount of charity care delivered by not-for-profit hospitals. No one knows the amount and dollar value of care freely given without the expectation of payment, many argued. Delegates agreed that ISMS should define the scope of "charity care" in addition to studying this complex issue. The information gleaned would indeed be valuable, delegates concluded.

scuss with Illinois insurance companies a reduction in malpractice premiums to improve the financial situation of physicians in Illinois.

12 Re-evaluation of Illinois Center for Health Policy
In lieu of existing policy reaffirmed a resolution directing the ISMS to: (1) join the Chicago Medical Society in a meeting with representative members of the state legislature, governor's office, pertinent state agencies, and with leadership of the University of Illinois at Chicago Medical Center and the University of Illinois Institute for Government and Political Affairs, to discuss the current status of the Illinois Center for Health Policy; and (2) request adequate funding support for the establishment of the Illinois Center for Health Policy; and (3) encourage or introduce state legislation that would allow other interested academic institutions to establish the Illinois Center for Health Policy.

13 Medicaid Reimbursement with JCAHO Accreditation for Correctional Health Care
Adopted a resolution directing ISMS to: (1) support the study of the issue of Medicaid reimbursement for all correctional healthcare in Illinois; and (2) after such study, consider re-submission of a resolution to the AMA House of Delegates asking that body to reconsider study of the issue of Medicaid reimbursement for all correctional healthcare.

14 Synthetic Gasification
Adopted a substitute resolution directing the ISMS to: (1) request the AMA to study the health effects of clean coal technologies, including synthetic gasification plants, for report back to the AMA House of Delegates at its 2013 annual meeting; and (2) direct the ISMS to collaborate with medical and public health partners in Illinois, including the Illinois Environmental Protection Agency, to work toward monitoring the environmental and health effects of synthetic gasification plants, inform the public of their findings, and report back to the ISMS House of Delegates at the 2013 annual meeting.

15 e-Cigarette Ban
Adopted a substitute resolution to direct the ISMS to (1) adopt as policy that electronic cigarettes should be classified as drug delivery devices and that the sale of e-cigarettes should be prohibited if they are not FDA-approved.

The Annual ISMS House of Delegates Meeting took place at the Oak Brook Hills Marriott Resort.

The CMS Insurance Agency

Led by doctors for doctors

"The agency offers continuous support and experience to help you navigate the medical liability marketplace."

NOT SO MANY years ago, a number of professional liability insurance companies in Illinois stopped writing policies due to frivolous lawsuits and jackpot justice, leaving physicians scrambling to obtain affordable insurance.

The Chicago Medical Society responded by forming the CMS Insurance Agency to assist physicians in meeting their insurance needs.

As a wholly owned subsidiary of the Medical Society, the Agency operates under the supervision of a physician board that understands what's important to physicians: delivering high-quality patient care while protecting doctors and their practices at an affordable rate. Integrity and outstanding service form the basis of all we do.

The Agency offers continuous support and experience to help you navigate the medical liability marketplace. We offer coverage review and comparisons; in-person consultations to ensure every physician or group is maximizing premium reductions; risk management resources to improve the delivery of patient care; and educational programs on medical and insurance issues.

The Agency has established relationships with reliable insurance companies with proven records in unstable times.

Indirect Benefits and Services

Profits not reinvested in the Agency are available to support the mission and objectives of the Society, a not-for-profit association representing more than 17,000 physicians in the Chicago area.

When you choose the CMS Insurance Agency as your broker, you are supporting the activities of the Chicago Medical Society.

Past and ongoing educational programs of the Society include seminars on cardiovascular disease and telemedicine; continuing medical education conferences; OSHA training workshops for the medical team; and parliamentary procedures workshops.

The Medical Society advocates on your behalf for comprehensive tort reform, Medicare reimbursement reform, and pro-medicine and patient care health policy development.

We also host legislative breakfast meetings that introduce lawmakers to their physician constituents, and mini-internships in which legislators shadow a physician for a day at the hospital or clinic to learn the realities of medical practice.

Appointing our Agency as your broker of record will not change your professional liability insurance policy and will not increase your premium.

For more information and a quote, please call 312-670-2550.

Support Chicago Medical Society Advocacy

Member Education Fund

THE CHICAGO Medical Society Foundation Education Fund was created to ensure the mission and future of the Chicago Medical Society. We ask that you take the time to support those who support you, keeping in mind all the ways CMS has helped you in your professional career.

The Fund accepts gifts of cash, stock, life insurance, and other financial instruments. All contributions are 100% tax deductible. Contributions are invested in a portfolio with long-term growth objectives. Up to 4% of the average market value of the Education Fund can be disbursed annually.

The CMS Foundation Board evaluates and determines the disbursements from the Advocacy Fund.

- Friend: $500 or less
- Patron: $500-$1,000
- Benefactor: $1,000-$5,000
- Corporate: $5,000

Also, please consider including CMS in your will with a bequest or other accommodation. To make a contribution, go to *www.cmsdocs.org* or call 312-670-2550. You may also contribute on your dues invoice when you renew your membership. Or, you may write a check to: The Chicago Medical Society Foundation Education Fund, 515 N. Dearborn St., Chicago, IL 60654.

CHICAGO MEDICAL SOCIETY

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communicate collaborate coordinate

Welcome New Members!

THE CHICAGO Medical Society welcomes its newest members elected in May 2012. We are now 40 voices stronger!

District 1
Mahesh C. Patel, MD

District 5
Sandeep Chunduri, MD
Robert G. Fitzgerald, MD
Eric R. Kallwitz, MD
Claudia M. Lora, MD

District 6
Sanjeev K. Akkina, MD
Tamika A. Alexander, MD
Ahmad A. Aref, MD
Aamir Badruddin, MD
Jamie L. Berkes, MD
George T. Chiampas, MD
Marina Del Rios, MD
Henry W. Dove, MD
Amir S. El Shami, MD
Rajyasree Emmadi, MD
Afshin Farzaneh-Far, MD
Lawrence E. Feldman, MD
Anthony G. Finder, MD
Michael Fischer, MD
Victor R. Gordeuk, MD
Iris S. Kassem, MD
Subhash C. Kukreja, MD
Anand N. Kumar, MD
Alberto M. Locante, MD
Sherry K. Nordstrom, MD
Bernard H. Pygon, MD
Miriam I. Redleaf, MD
Ari B. Rubenfeld, MD
Anna C. Porter, MD
Jessica A. Shepherd, MD
Krzysztof B. Siemionow, MD
Terry L. Vanden Hoek, MD
Peter J. Weiden, MD

District 7
Sadia Haider, MD
Ana C. Ricardo, MD
Ignatius Y. Tang, MD

District 8
Carletha C. Hughes, MD

Student District
Saima T. Chaudhry

Resident District
Bridget Nord, MD
Jordan L. Sheran, MD

Calendar of Events

JUNE

27 CMS Executive Committee Meeting Meets once a month to: plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. *8:00–9:00 a.m.; CMS Building, 33 W. Grand Ave., Chicago. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.*

27 CMS Board of Trustees Meeting Meets every other month to make financial decisions on behalf of the Society. *9:00–10:00 a.m.; CMS Bldg., Chicago. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.*

JULY

18 CMS Executive Committee Meeting Meets once a month to: plan Chicago Medical Society Council meeting agendas; conduct business between quarterly Council meetings; and coordinate Council and Board functions. *8:00–9:00 a.m.; CMS Building, 33 W. Grand Ave., Chicago. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.*

18 2012 OSHA Workshop Training for Potential Exposure to Bloodborne Pathogens Workshop is intended for physicians, physician assistants, nurses, practice managers, and dental professionals, who will learn to:

- Implement a training program for healthcare employees who may be exposed to bloodborne pathogens.
- Identify appropriate personal protective equipment (PPE).
- Develop an emergency response plan.
- Create a written exposure control plan for healthcare workers assigned as first-aid providers.
- Develop a strategy to prevent the spread of pandemic flu within the practice.

10:00 a.m.–12:00 noon; Speaker: Sukhvir Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; CMS Building, 33 W. Grand Ave., Third Floor, Chicago. Participants may earn up to 2.0 Credits. CMS member or staff $89 per person, non-member or staff $129 per person. To register or learn more, please contact Elvia 312-670-2550, ext. 338; or email emedrano@cmsdocs.org.

AUGUST

8 2012 OSHA Workshop Training for Potential Exposure to Bloodborne Pathogens Workshop is intended for physicians, physician assistants, nurses, practice managers, and dental professionals, who will learn to:

- Implement a training program for healthcare employees who may be exposed to bloodborne pathogens.
- Identify appropriate personal protective equipment (PPE).
- Develop an emergency response plan.
- Create a written exposure control plan for healthcare workers assigned as first-aid providers.
- Develop a strategy to prevent the spread of pandemic flu within the practice.

10:00 a.m.–12:00 noon; Speaker: Sukhvir Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; Webinar (login access information will be provided with confirmation). Participants may earn up to 2.0 Credits. CMS member or staff $89 per person, non-member or staff $129 per person. To register or to learn more about the program, please contact Elvia 312-670-2550, ext. 338; or email emedrano@cmsdocs.org.

22 Annual Golf Outing & Parliamentary Procedures Workshop An interactive and engaging session covering basic principles and rules of parliamentary law, with the latest update on the newly revised Robert's Rules of Order, 11th Edition, which supersedes all previous editions, and is intended to automatically become the parliamentary authority in organizations whose bylaws prescribe any other version of Robert's Rules of Order. *Workshop 8:00 a.m.–12:15 p.m.; Lunch 12:15–1:00 p.m.; Tee Time 1:00 p.m.; Speaker: Joan M. Bundley, MPH, RN, Professional Registered Parliamentarian & Mediator; Oak Brook Hills Marriott Resort & Willow Crest Golf Club, 3500 Midwest Rd., Oak Brook. Activity is non-CME. Cost: $125 per person. To RSVP, please contact Elvia 312-670-2550, ext. 338; or emedrano@cmsdocs.org.*

SEPTEMBER

7 2012 OSHA Workshop Training for Potential Exposure to Bloodborne Pathogens Workshop is intended for physicians, physician assistants, nurses, practice managers, and dental professionals. (See Aug. 8 listing for program details.) *9:30 a.m.–11:30 a.m. Speaker: Sukhvir Kaur, Compliance Assistance Specialist, OSHA-Chicago North Office; DoubleTree by Hilton Hotel, 1909 Spring Rd., Oak Brook. Participants may earn up to 2.0 Credits. CMS member or staff $89 per person, non-member or staff $129 per person. To register or learn more, please contact Elvia 312-670-2550, ext. 338; or email emedrano@cmsdocs.org. For online registration, please visit www.cmsdocs.org.*

Member Publications

INFORMATION IS POWER, and CMS and ISMS produce several publications full of valuable information. Here is a list as well as descriptions of each publication. We hope you enjoy reading each of them!

Chicago Medicine, a publication covering news and issues of relevance to physicians, including policy updates, practice management, key news from the Chicago Medical Society and more.

ISMS Weekly Rounds, a weekly e-newsletter that is filled with updates on ISMS' most recent activities, benefits, upcoming events and more.

CMS CONNECT, a professional networking site that allows you to communicate and collaborate. Available through the Chicago Medical Society's new members-only section of the website, CMS Connect is designed for the exclusive use of CMS members. Members are guaranteed a highly interactive experience and unique means to connect virtually with CMS' 6,000+plus members.

CMS and ISMS members are informed physicians!

CHICAGO MEDICAL SOCIETY

Presents the 2012 Annual Golf Outing & Parliamentary Procedures Workshop

Wednesday, August 22, 2012
Chicago Marriott Oak Brook Hills Resort & Willow Crest Golf Club,
3500 Midwest Road, Oak Brook, IL
Registration Fee: $125 (Member Rate)
Questions? 312-670-2550 / emedrano@cmsdocs.org/
www.cmsdocs.org

This workshop provides an interactive and engaging session that covers the basics on the principles and rules of parliamentary law with the latest update on the newly revised Roberts Rules of Order, 11th Edition, which supersedes all previous editions and is intended to automatically become the parliamentary authority in organizations whose bylaws prescribe any other version of "Robert's Rules of Order."

SPEAKER BIOGRAPHY
Joan M. Bundley, MPH, RN, PRP, *Professional Registered Parliamentarian & Mediator*

PROFESSIONAL QUALIFICATIONS: Registered Parliamentarian since 1991. Professional Registered Parliamentarian since 1995. Earned certificate in mediation, March 2002. Experienced in areas of conducting effective meetings, mediating disputes, drafting, amending and revising bylaws, special and standing rules, and training organizational officers, board and committee members to their roles and responsibilities. Experienced in preparing delegates and presiding officers for their specific duties during conventions and membership meetings of various sizes. Holds current membership in the National Association of Parliamentarians and the American Institute of Parliamentarians

Co-authored a course on basic parliamentary law and practice. Serves as instructor in basic and advanced parliamentary study to prepare individuals to take the National Association of Parliamentarians' qualifying examinations. Conducts seminars and workshops on parliamentary procedure and law. Organizations served include the American Public Health Association, Washington, DC, National Black Nurses Association, Washington, DC Illinois Society for Advanced Practice Nursing, Springfield, IL, the Illinois Nurses Association, Chicago, IL, the National Council of State Boards of Nursing and the Law Student Division of the American Bar Association, both headquartered Chicago, Illinois. Professional offices past and present include: President, Chicago Association of Parliamentarians, 2000-2004 and Vice President, Registered Parliamentarians of Illinois, 2002-2003. Membership Chair, Illinois Association of Parliamentarians, 2009-2011, President, Registered Parliamentarians of Illinois, 2011-2013.

Schedule:

8:00-8:15 a.m.	Registration Check-in & Continental Breakfast
8:15-12:15 p.m.	Parliamentary Procedures Workshop
12:15-1 p.m.	Luncheon
1 p.m.	Tee Time!

Please RSVP to insure an accurate food count and space. Seating is limited to the first 40 participants!
Phone: 312-670-2550 or Fax 312-670-3646

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classifieds

Personnel Wanted

Physician Care Services is seeking full-time and part-time physicians for home visits to the elderly in the Chicagoland area. Scheduling, malpractice insurance, MA, company car provided. Quarterly bonus program. Please email CV to *skookich@mplhealth.com* or fax: 708-336-7420.

Full-time or part-time position for internist or family practitioner in busy Chicago area. Good pay and benefits. Will sponsor H1Visa. Fax CV to 708-474-4574 or email: *sarojverma@comcast.net*.

Mobile Doctors seeks a full-time physician for its Chicago office to make house calls to the elderly and disabled. No night/weekend work. We perform the scheduling, allowing you to focus on seeing patients. Malpractice insurance is provided and all our physicians travel with a certified medical assistant. To be considered, please forward your CV to Nick at *nick@mobiledoctors.com;* or call 312-848-5319.

Physician Care Services is seeking full-time and part-time psychiatrists for individual and group therapy counseling in our Oak Forest Rehabilitation Center. Please email CV to skookich@mplhealth.com or fax: 708-336-7420.

Seeking BC/BE internist or family practitioner to work with a group in Chicagoland. Please call 773-884-2782 for information.

Primary Care--MD at Home is looking to hire BE/BC primary care physicians to make house calls on the elderly homebound. Contact Matt Turman at 312-243-2223 or email: *mturman@md-athome.com*.

Infertility specialist gynecologist needed in the suburban Chicagoland area. Please send CV to *administrator@networkgci.net* or fax 847-398-4585.

Urologist or urogynecologist specializing in urinary incontinence needed in the suburban Chicagoland area. Please send CV to *administrator@networkgci.net* or fax 847-398-4585.

Part-time physicians needed. Surgical family planning center in the Chicagoland area needs various specialties including anesthesiologist, gynecologist, urologist, internist, and other specialties. Please send CV to *administrator@networkgci.net* or fax 847-398-4585.

Position Wanted

Board-certified diagnostic radiologist with more than 30 years of clinical experience seeks part-time position in the Chicago area. For more information, call 312-590-5167; or email *mahinz@hotmail.com;* or go to *www.michaelahinzlimited.com*.

Office/Building for Sale/Rent/Lease

Medical business/office for sale. Call 773-478-9445; fax 773-478-9424.

Busy medical and dental center for rent at 63rd and Ashland. Ideal for home health/physician. Call 773-412-8452.

Medical suite in Mount Prospect Professional Building with 1,546 square feet, accessible to Northwest Community Hospital, Lutheran General Hospital, and Alexian Brothers Hospital. The suite has four exam rooms, reception area, storage, lavatory, and more. Please call Joe at Cione Properties 847-754-6521.

Space for rent. Winnetka Professional Center. Great downtown location. Two available suites can be rented separately or together for up to six operatories. Call 847-446-0970 for details.

Business Services

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"I am optimistic that the County health system can become fiscally sustainable and less dependent upon taxpayers for a subsidy that is now about $250 million," says Dr. Ramanathan Raju. "But most important, healthcare is not an industry; patients are not commodities; our future will be judged on how we help our patients."

County Outreach

Two CMS members have big plans **by Scott Warner**

Ramanathan Raju, MD

CEO, Cook County Health & Hospitals Systems

First he helped reduce a $1 billion budget gap in the nation's largest municipal healthcare organization, the New York City Health and Hospital Corporation. Then he headed to Chicago to work on whittling away the nearly $100 million deficit facing the Cook County Health and Hospitals System. And he relishes the opportunity. "This is an iconic public hospital system; there are not many public hospital systems like Cook County's in this country," Ramanathan Raju, MD, told the *Chicago Tribune* last fall on his appointment as the system's new CEO.

Dr. Raju left his number two spot as executive vice president of the New York system eager for a new challenge. Board-certified in surgery and a fellow of the American College of Surgery, Dr. Raju also has an MBA, and has taught residents and medical students for many years. "I started at the bottom rung in medicine, and gained enormous insight" he says.

Praised for his extensive operational knowledge, business strategy acumen, collaborative management style and deep commitment to the public hospital mission, Dr. Raju is working on patient safety, access to care and delivery of cost-effective care.

To accomplish these goals, Dr. Raju has been holding conversations with Cook County Board President Toni Preckwinkle, the Illinois Hospital Association, Metropolitan Chicago Healthcare Council, as well as leaders of the largest medical centers in the County. Together they are working to develop an effective strategy to improve access for all patients in Cook County, both insured and uninsured.

Joseph Pulvirenti, MD

Chairman, Infectious Diseases, Provident Hospital

One could say that his message is infectious. As president of the Chicago-area Infectious Disease Society (CAIDS), Joseph Pulvirenti, MD, is working to educate local physicians on infectious disease. And to help spread the word, he has enlisted the Chicago Medical Society, teaming his organization with CMS as an affiliated society.

This new relationship gives CAIDS the opportunity to gain advocacy for its specialty group. And, as a member of the CMS Governing Council, CAIDS can help craft policies and legislation reflecting their members' needs.

Dr. Pulvirenti, who has served as Director of Inpatient HIV Services at Cook County Hospital, is using his expertise to make the CAIDS website "a hub of infectious disease programs" in the city.

"We want physicians to come to our website and ask questions—about a patient with a particular problem, or to seek information about outbreaks in the city," Dr. Pulvirenti said. In addition, the website will present papers, and provide a speakers' forum. And down the line, he plans for the website to be a patient resource as well.

For more information, please contact Dr. Pulvirenti at *Joseph.Pulvirenti@Hektoen.org,* or go to *www.caidsociety.org.*

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