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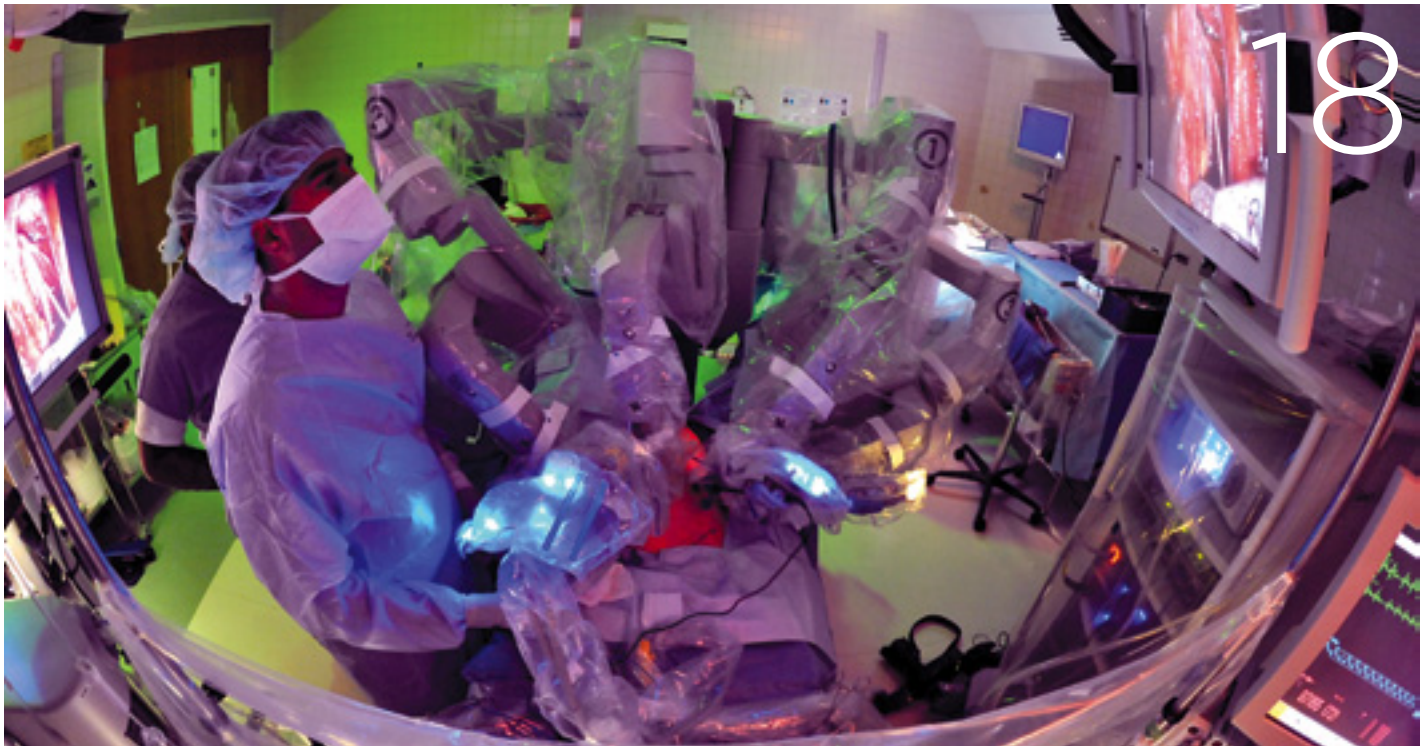
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A New Year, the Same Game

AS WE BEGIN a new year, President Obama and the new Congress will be sworn into office. The decisions they make will be influenced by the lobbying efforts of numerous organizations. The same scenario will take place in Springfield and Chicago. We are working to improve our ties to local government, and need your help. We have created a “Key Contacts” program, and ask that you inform us of any professional or personal relationships you have with politicians. Your Chicago Medical Society leadership will represent your interests with political leaders in Washington, DC, in February in conjunction with the AMA National Advocacy Conference. Many of you, however, may be unfamiliar with the political process. So here is a primer on how the game works.



First, money talks. Many sources will confirm the idea that you get what you give. Physicians are outspent by the insurance industry, big tobacco, pharma and attorneys. In the health care arena, the AMA has competition from the American Academy of Orthopedic Surgeons, American College of Radiology, American Society of Anesthesiologists, and American College of Emergency Physicians, to name many of the bigger players. Instead of speaking with a unified voice, each of these organizations moves their own political agenda, often without regard to the other medical specialty societies. This could potentially weaken our own collective voice and limit our ability to reshape the health care landscape.

Second, have patience. It can take three to five years for legislation to move through the political process to become law. Just because a topic doesn't seem to gain the ear of a politician the first time it is introduced doesn't mean that it isn't worth pursuing. It will often gain momentum the more it is discussed. We must be persistent in our efforts.

Third, size matters. As leaders of our organization, we are often asked by politicians how many physicians we represent. When we answer, “25 percent,” it begs the question, “who is representing the other 75 percent?” The real answer is likely no-one, since those physicians are removed from the process because they are either too busy to be involved or do not understand that their non-participation in organized medicine greatly weakens the efforts of those who are trying to defend our profession and our patients. This is why every physician needs to join organized medicine as their professional obligation. CMS speaks for all physicians on topics relevant to our profession.

Fourth, consider the wild card. Our wild card is our relationship with our patients. Most physicians seem unaware of the influence we have on our patients, even in matters not related to their health care. When we engage our patients in the process, they will become more informed of the issues and how they impact the care delivery system. For example, if patients understood the discrepancy between malpractice insurance costs in Illinois and neighboring states, they would better understand our issues. Or if they understood why physicians are selling their practices to the local hospital or retiring early, the stereotype of the “rich doctor” might be altered. Informing our patients of the issues doesn't have to involve promoting one political party over another, but explain how the issue affects our ability to practice medicine and deliver high quality care.

So, write a resolution for the Governing Council to debate. Help us increase our membership and our voice as we advocate for physicians and patients. Encourage colleagues to join. If employed, ask your employer to include your dues in your benefits package. Help us be an even greater voice as we compete with other groups to shape the future of health care locally and at the state and federal levels. Together we are stronger.

Howard Axe, MD
President, Chicago Medical Society

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Breaking the Code

The importance of addressing end-of-life issues **By Aneet Ahluwalia, MD**

ONE OF OUR jobs in the hospital is to address code status. From a patient's perspective, being in the hospital is scary, and asking about what would happen if their heart stopped is sure to make it even more so. Opening the discussion can be uncomfortable for health care providers, too. But it does get easier with repetition.

Ideally, this situation should be addressed in an office with a primary care physician, allowing more time for reflection and discussion with family in a non-pressured environment. However, this is often not the case. Plus, there's no formal way to transmit the information from outpatient to inpatient settings. Living wills and other directives as well as speaking with family members are ways to bridge the gap, but at times the question of emergent resuscitation is not addressed in these documents or discussions.

Wording is crucial in discussions—it is important to reduce the fear that arises from addressing possible death. Normalizing the situation can help, for example, by saying, "I don't foresee this happening, but this is a question I have to ask everyone who comes into the hospital." In addition, people may not know the difference between emergent resuscitation and prolonged life support. It often helps to ask two separate questions such as, "In an emergency, what would your wishes be..." and "If you were on a ventilator with limited chance of functional recovery..." Perhaps we should amend the way we document, discuss, and teach code discussions to include separate categories for


emergent resuscitation and prolonged life support, which may make the distinction more understandable. Additional interventions that should be addressed are a feeding tube and pressors.

We should also guide our patients in these discussions since the general public has little understanding about end-of-life care and emergent resuscitation. Often, a young relatively healthy patient changes his or her status to Full Code when given a full explanation of the difference between emergent resuscitation and prolonged intubation. Obviously, we want to avoid ageism and discrimination, but we must educate our patients that being elderly with multiple medical problems, including terminal illness, entails a lower percentage chance for meaningful recovery from emergent resuscitation. We must find out patients' priorities, their opinions on balancing quality and quantity of life, their feelings about meaningful recovery and function, what they define as suffering and what they are willing to endure, and if they have something they are looking forward to. Often, people with an increased morbidity change their decision to DNR once they are given information regarding possible recovery and the actions that can occur during a code such as intubation and CPR, which can break ribs.

These discussions can help avoid care that the family and patient may end up viewing as unhelpful and improve the quality of the end of life. In 2008, the national Coping with Cancer project published a study showing that terminally ill cancer patients who were put on a mechanical ventilator, given electrical defibrillation or chest compressions, or admitted, near death, to intensive care had a substantially worse quality of life in their last week than those who received no such interventions. Their caregivers were three times as likely to suffer major depression.

As always, cost come into play. Cost is difficult to discuss when it comes to mortality, but it must be considered—25 percent of all Medicare spending is for the five percent of patients in their final year of life, and most of that money goes for care in their last couple of months. In Lacrosse, Wisconsin, there was a systematic campaign to get physicians and patients to discuss end-of-life wishes; the results were low end-of-life health care costs without sacrificing life expectancy.

Ultimately, we must arm patients with accurate, easy-to-understand information presented in a nonthreatening manner in order for them to make the best decisions for themselves. The discussion can ideally begin outside the hospital.

Dr. Aneet Ahluwalia is a third-year internal medicine resident at Northshore Evanston. 

Dr. Ahluwalia advocates compassion and early discussions with patients about end-of-life wishes.



Work Smarter, Not Harder

Memorization techniques can open up whole new worlds **By Paras Patel**

JUST THINK about it: a submarine filled with endothelial cells just lands on the beach and crushes an Audi TL,” I told my friend. “Then just use the major system and you’ve got the numbers and interleukins memorized, and you’re set.”

This statement might sound somewhat delusional and nonsensical, but it demonstrates a technique that I have been using for the better part of a year to memorize massive amounts of information as a second-year medical student. Back in college, memorizing information was easy to do because the bar wasn’t very high, but the challenge of learning clinical medicine has been an entirely different story. It’s a challenge that has tested my wits and resilience, but, most profoundly, it has tested my ability to change, learn, and grow. And part of this process has been learning new ways to learn rather than cramming tons of information into my head without rhyme or reason.


I first heard about mental images as a memorization method when I stumbled upon a book called *Moonwalking with Einstein*. The author, Joshua Foer, describes his journey as a reporter covering the 2005 U.S. Memory Championship where contestants memorized massive amounts of information in record time and with a level of recall that would astound even the highest performing student. Foer takes a look at how these individuals were able to memorize long, sprawling poems and entire books with relative ease. At first he assumes that such people were either geniuses or had conditions that enabled them to remember things that regular folks could not, but ultimately realizes that their skills derived from their techniques. And by learning these techniques and attempting to memorize massive amounts of information himself, he ultimately goes on to win the U.S. Memory Championship the following year. Truly a remarkable story, and one that has direct implications for your average medical student struggling to stay afloat in a sea of proteins, signaling chemicals, and metabolic pathways.

So what are these magical methods of memorization? There are several, but one in particular—the Memory Palace—involves placing objects in a scene in order to remember basic lists of information. The process boils down to assigning objects to things you want to memorize, and then placing them throughout a familiar location in your mind, like your home or workplace. The technique works best when you engage the senses by mentally feeling, smelling, hearing, and tasting the objects you place in your scenes, thereby engaging multiple parts of the brain and strengthening the encoding of memories. I can’t do the technique justice in



words; it really must be experienced for one to truly understand the power of the mind and just how much we are capable of remembering and understanding.

These memorization techniques have improved my exam performance and reduced my stress when it comes to studying, but the overall lesson is much larger. It was only after discovering these methods that I was truly able to appreciate the power of our human mind. We possess incredible abilities when it comes to retaining large amounts of material, but part of harnessing that talent is knowing how to unlock it in the right way. I no longer see the path ahead in school as an endless deluge of information. It is now much more beautiful, serene, and in tune with what I have always known at my core: every last one of us is capable of great things, but harnessing the ability to pursue our dreams is more than just working hard. It’s knowing how to work, and doing it in a way that is in tune with who you are as a person. For some, that will mean flash cards, books, and outlines. But for me it’s crazy mental images, and I’m okay with that.

Paras Patel is a second-year medical student at the University of Chicago Pritzker School of Medicine and a student councilor for the Chicago Medical Society’s Medical Student District. 

Medical student Paras Patel uses a variety of memorization techniques to help him absorb the flood of information presented to him.

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The Last Mile of Meaningful Use

Don't overlook it **By Tom Lee, PhD, MBA, and Abel Kho, MD**

AS THE FEB. 28 deadline fast approaches for eligible providers in the Medicare incentive program to attest to Meaningful Use, the term “fire drill” may come to mind. Medicare incentive program participants attesting to MU Payment Year 1 will lose \$5,000 per provider from their available incentive payments if they miss the February deadline. If you're in this category, it means you must meet MU for 90 days in 2012 and attest by Feb. 28 to receive the maximum \$44,000 reimbursement over five years.

Providers in the Medicaid program don't have the February 2013 attestation deadline for receiving maximum incentive payments. However, to avoid risking penalties on Medicare claims, if they have any, Medicaid incentive program participants should meet MU for 90 days in 2013 and attest by March 30, 2014. Because 2014 is the first year penalties can be given, the Centers for Medicare and Medicaid Services is offering a special extension. Medicaid providers who attest to Adoption, Upgrading and Implementation in 2013 have the option to complete their 90 days of Meaningful Use in 2014 and attest by Oct. 1, 2014, to avoid penalties.

“Luckily, if you make a plan for walking that last mile, you can be rewarded with your incentive dollars and smoother attestation process.”

Increasingly, practices are finding that, even after the MU measures are met, organizing MU data, archiving it to prepare for CMS audits, and submitting it to Medicare or Medicaid is not as easy nor as quick as anticipated. These final activities standing in the way of providers and their incentive dollars can be called the “last mile of Meaningful Use” and are often overlooked in planning and staffing.

Luckily, if you make a plan for walking that last mile, you can be rewarded with your incentive dollars and a smoother attestation process. Paying attention to reporting and maintaining accurate records can make all the difference in how prepared you will be.


After MU measures are met, organizing MU data involves compiling a list of activities not generally automated by EHR vendor reporting tools. For example, practice leadership often wants to see easy-to-read summaries of MU performance and projections of future performance. Creating these views usually requires copying and pasting data from vendor reports into custom-built spreadsheets to generate charts. For multi-provider practices,

it has become increasingly difficult to track each provider's MU program (Medicare or Medicaid), payment year, 90-day MU reporting window, and, soon, the current stage of MU (Stage 1 or Stage 2). If a provider joined the practice in the middle of the year, it may be necessary to access and import MU data from the previous practice to derive a complete set of attestable measures.

CMS and state Medicaid agencies are starting to audit a random selection of practices for MU compliance and asking to see supporting information for the measure values that were attested. It is important that there be no discrepancies between the attested values and those found within the source EHR. However, in practice, it is common for EHR historical data to be modified, even for legitimate reasons such as open visits in the reporting period being signed off slightly after the 90-day MU reporting window. Therefore, it is critical to capture a static snapshot of the MU measure values calculated by the EHR and used for attestation. However, this can be a manual, error-prone process that should be carried out with care. For example, it is important to store the snapshots in a secure location that can be accessed even if there is staff turnover.

Once these activities are completed, there is the final step of submitting the MU functional and quality measures to the CMS or state Medicaid websites. Practice staff must manually enter each provider's measure values into the websites and verify them against input errors before completing the process. The CMS website may be slow during peak periods—anticipate heavy usage on the few days leading up to the Feb. 28 deadline. If a practice decides to carry out the submission process manually, staff should plan to set aside adequate time to learn how the attestation websites work and iron out any issues well ahead of the deadline.

Chicago practices interested in getting assistance for this or any of the aforementioned last-mile MU activities are welcome to contact the Chicago Health IT Regional Extension Center for assistance. In addition to providing tools and educational materials to help practices prepare for the MU attestation process, CHITREC has recently entered into a contract with SA Ignite, Inc., which provides a software platform for automating MU monitoring and submission as a one-click process. To find out more, call us at 312-503-2986 or visit www.chitrec.org

About the authors: Dr. Kho is an internist and co-executive director of the Chicago Health IT Regional Extension Center (www.chitrec.org). Dr. Tom Lee, PhD, MBA, is the founder and CEO of SA Ignite, Inc. Visit www.saignite.com. 

Five Key Elements to Marketing

Use these preliminary steps to build a base for your marketing strategy **By Alina Baban**

IN THE PAST, physicians looked at marketing as something unthinkable. Yet, physicians who do not market themselves and their practices are less likely to succeed in the ever-changing health care landscape. It is essential to develop and maintain an effective marketing strategy to ensure the health of the practice. Marketing can be exciting and can set your practice apart from competitors, but you will need to invest time and energy into a preliminary plan before placing valuable resources into your strategy. Here are five key preliminary elements to focus on:

1 Know your practice. Before you place marketing at the top of your to-do list, you must have a clear picture of your practice's core beliefs. What your practice believes in should be determined, developed, and elaborated through your marketing strategy. Your practice can be the one that provides patients with the most education, the best patient service, the shortest wait times, or simply the practice with the friendliest staff. Having clear and consistent practice beliefs will help shape your brand identity.

2 Build your brand identity. Brand identity sets your practice apart from the practice down the street. Your brand identity should incorporate the name of your practice, your trademark or phrase, and have a visual appearance such as a logo or constant color. Your brand identity should always be included on letterhead, envelopes, and business cards. Consistency in your logo, color, and name will make your marketing strategy more effective once it is in place.

3 Determine your referral sources. You must find out where your referrals are coming from in order to strengthen and protect those relationships. Are your patients being referred to you by other patients, physicians, hospitals, or the Internet? By knowing the answer to this simple

question, your marketing strategy can generate a steady stream of patients. If you are unsure where your referrals are coming from, find out! Change your intake form to ask your patients directly by asking, "Who may we thank for referring you?" It is not enough to just *know* the answer—you must *use* the answer to thank your referral sources. If patients referred another patient to your practice, sending a simple thank you note for their trust takes a couple of minutes and makes a lasting impression.

4 Set a frequency and budget. Budgeting is the most difficult preliminary element of marketing since it is usually placed at the bottom of the necessity bucket. Keep in mind that marketing does not always come with a large price tag. There are many free or inexpensive steps you can take to market your practice. One example is to ensure the accuracy of your physician's online profile with various databases such as Healthgrades, Vitals, Yellow Pages Online, and hospital physician profiles. The frequency of your marketing strategy should also be planned and should be executed at least bi-annually to be effective.

5 Determine your target market. Are your patients senior citizens who are more likely to turn to the yellow pages to find you or are they of a younger generation that would want to schedule appointments on their mobile phones? Based on your patient population, you should decide how to best market your practice in the yellow pages, or newspapers, or newsletters, on the Internet, or in email.

Following these five preliminary elements will help build a strong base for a successful marketing strategy.

Alina Baban is chair of the CMS' Practice Manager Section. 

“Marketing can be exciting and it can set your practice apart from competitors, but you will need to invest time and energy into a preliminary plan.”

Your Practice Management Colleagues

MEMBERSHIP in the Chicago Medical Society's Practice Manager Section is an excellent way to expand your professional networking horizons. Practice managers employed in the offices of CMS physician members enjoy a discounted dues rate of only \$99 per year. The nonmember rate is \$395. To download a membership application, please go to www.cmsdocs.org or call 312-670-2550.

7 Easy Steps to Capture Email Addresses

Email is a surprisingly neglected marketing strategy that never gets off the ground because of the lack of addresses **By Lonnie Hirsch and Stewart Gandolf, MBA**

ONE OF OUR BIGGEST moments of frustration in working with health care providers around the nation is when we discover that they don't have an email marketing strategy. The reason? Many offices have a record of only 100 email addresses, and some offices have even fewer.

Email is a popular and effective marketing communications tool. It's accepted, even preferred, by a large segment of the public. More than 90 percent of U.S. Internet users use email, and most use it on a daily basis.

An email strategy is completely appropriate for many, although not all, providers. It is nearly immediate, easy to use and low cost. It's an effective way to increase patient satisfaction, retention, referrals and revenue.

“Email works, but the first step is to have a system to regularly collect email addresses. In all cases, we're talking about asking for the patient's permission and that they opt-in with an understanding of what will be sent.”

To be clear, we are not talking about physician-patient email involving medical matters where there are legitimate concerns about privacy, liability, reimbursement, workload, etc. This is a permission-based email strategy, and for many medical and dental practices, hospitals, orthodontists, cosmetic surgeons and other health care providers—principally in elective care—the health care marketing opportunities are strong and varied.

The bottom line is that email works, but the first step is to have a system to regularly collect email addresses. In all cases, we're talking about asking for the patient's permission (opt-in, decline or opt-out), and that they opt-in with an understanding of what will be sent and that it will be pertinent and valuable to them. These are individuals who want to hear from you; often they prefer email over phone calls or regular mail, and they are happy to provide their email information with an understanding of the type of information you will be sending and that it is something they will value.

Here are seven easy ways to build your contact list quickly:

1 Initial intake forms: Include a permission request and multiple spaces for email addresses as part of your standard office form. Some people have more than one email address in the household.

2 Use update moments: Ask for email addresses when you confirm or routinely update records on file. Add this to the standard clerical steps.

3 Ask on your website: Invite people to subscribe to your eNewsletter, or timely updates, via a simple form on your website. Sites can be programmed to capture the data submitted and automatically update your master list.

4 Use your social media: If you have a Facebook page or Twitter account you can invite people to register, or subscribe by email. Not using social media yet? This may be a good opportunity to begin.

5 Offer a prize: There are a dozen ways to structure a contest with products or services in your office as an incentive for submitting an email address. Be clear that you are asking permission to use their email address subsequent to the contest.

6 Provide an instructional series: Invite people to receive a multi-part string of educational email advisories or lessons on a subject, or subjects, of interest. Free, of course.

7 Reward allegiance: Create a loyalty program that includes special offers or early promotional announcements that are available via email. The idea of exclusivity has a built-in appeal factor.

In fact, it's easy to build an email contact list. Many physicians can use email successfully in their marketing mix, but they are shy about the idea, unaware of its value, or are too busy to introduce a new office routine.

Lonnie Hirsch and Stewart Gandolf, MBA, are Founding Partners for Healthcare Success Strategies, a full-service healthcare marketing company. You can find them at www.healthcaresuccess.com.

Avoiding Costly Telephone Mistakes

Fortunately, these mistakes are easily fixed **By Joseph Capko**

ALL OF US by now have had the feeling of being held captive by a merciless phone tree or being asked, “Can you please hold?” before being left in limbo for five, ten or even 15 minutes or more. Like you, patients don’t like having their time wasted when calling your practice. Nonetheless, many practices have taken high demand and technological developments as an excuse for failing to review and refine the systems they have in place for serving their patients over the phone. If you’ve recently reviewed your online presence and encountered a negative review, you can appreciate how important it is to establish with your patients a sense that you are dedicated to taking good care of them regardless of whether they are in or out of the exam room.

Improving patient phone service needn’t be an overwhelming chore for your already busy office. In fact, this process is ideally suited for working on around your schedule as there are many components that can be improved in blocks of 15 minutes.

Most modern telephone systems have


impressive reporting capabilities, despite the fact that most practice staff usually know nothing about them. Make it a priority to generate reports that can serve as benchmarks for your practice’s performance in this area. How long do callers wait on hold? How many calls come in relative to your patient visits? When do calls come in?

One very common problem is the rush of calls that often occurs as the practice opens up after the lunch hour. Since the lunch hour is one of the most convenient times for many of your patients to call, the simple fact is that you should have telephone coverage over lunch. Rotating this assignment through your staff is easy to implement—you’ll get more new patient bookings and smooth the flow of calls, meaning happier patients and staff.

You should have a current diagram of your phone tree that illustrates that patients can find their way through the tree in a timely manner. Consulting with your systems reports, eliminate branches of the tree that are infrequently accessed. You’ve probably been the victim of a phone tree that didn’t offer you any appropriate choices from which to choose—the choices

should be mutually exclusive (non-overlapping) and all-inclusive (giving an option for all callers, for example, “For all other callers, please stay on the line.”)

It is hugely important that whoever handles the calls appreciate how patients experience the totality of customer care. Naturally, many patients calling into a physician are tired, sick and in pain. Considerate and compassionate care should be delivered at every single point of contact. Accordingly, time is of the essence and you’ll want to have good, solid data on what patients are calling about and when in order to serve them in a timely manner. A quick and easy way to collect this data is for those covering the phone to keep a log of the types of incoming calls—sometimes for just a single day is sufficient—and use this data to assess the quality of your existing systems. Heading this process can be a great opportunity for receptionists to shine when they present their findings at your next staff meeting.

Joseph Capko is a senior marketing and market research consultant with Capko & Company. You can find him at www.capko.com. 

How to Make Waiting Time More Enjoyable

WAITING takes time. Time is money. While everyone can get more money, no one gets more time. Therefore, when your patients have to wait, make the experience as pleasant as possible:

- Provide reception activities such as a minimum of eight different magazines that reflect the interests of your patients, crossword puzzle pads, Etch-a-Sketches, stationery and stamps for writing letters, and a telephone for local calls.
- Offer a library of consumer health books, with reviewer notes—the reviewers being folks from your department or practice. A local bookstore may provide the library for you in exchange for displaying the store’s business cards and a sign saying that any of the books can be ordered by phone.
- Provide reception distractions, such as art exhibits by children, “Words of Wisdom” from older Americans, a bird feeder outside a window, headphones and relaxation tapes, or an aquarium. Offer individual, comfortable seating, possibly including rocking chairs.
- Create a gallery of positive patient comments. Have glass cut to fit over your tables and insert the comments between the table and the glass. Be sure to obtain patient permission first!
- Create a “wall of honor” of staff members with their comments about what they like to do in their spare time, why they came to work at this organization, what their family is like, etc.
- Frustration can increase if patients see staff members taking care of “non-patient” tasks rather than taking care of them. If possible, indirect care responsibilities, such as charting and telephone calls, should be done out of the view of waiting patients.
- Even if patients have waited during prior visits, a sincere apology for a wait is helpful when employees are perceived to be doing everything they can to be responsive to the patient quickly. On the other hand, an insincere apology, or one that is routinely given as if giving it will excuse the wait, can increase a patient’s anger about waiting.

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Building a Healthier Hospital

Hospitals can be a key player in the fight against obesity **By James M. Galloway, MD, MPH**

THE UNITED STATES is experiencing unparalleled levels of obesity. Currently, nearly 36 percent of adults and 17 percent of children ages two through 19 years are obese. What is more concerning is that since 1980, obesity prevalence among children and adolescents has almost tripled. A recent report from Trust for America's Health estimates that all 50 states are on track to have obesity rates greater than 44 percent by 2030. In Illinois, the report shows the rate of obesity may double, reaching almost 54 percent in 2020. Obesity has become one of the main contributors to medical problems such as heart disease, stroke, type 2 diabetes and certain types of cancer in the U.S. When quantified for Illinois, the numbers equal more than 1.5 million new cases of type 2 diabetes; more than three million new cases of coronary heart disease and stroke; more than three million new cases of hypertension; and nearly 500,000 new cases of obesity-related cancer.

Beyond the medical impact of obesity, there are considerable economic effects. The rising rates of obesity were associated with nearly \$40 billion in increased medical spending through 2006, which includes \$7 billion in Medicare prescription drug costs. These costs translate to an additional \$1,152 per year in medical spending for obese men, which is largely attributable to hospitalizations and prescription drugs, and an extra \$3,613 each year for obese women. When considered on a nationwide level, these expenditures total \$190 billion per year in additional medical spending, which is more than 20 percent of all U.S. health care spending. If Illinois can decrease its obesity rates by just five percent, it has the potential to save more than \$9 billion in 10 years and \$28 billion in 20 years.


Many initiatives are currently underway to tackle rising obesity rates. They range from national policy, such as *The Healthy Hunger Free Kids Act*, to city-specific measures, such as those being undertaken by our own mayor in Chicago, to smaller scale programs such as workplace wellness initiatives. More recently, hospitals have been identified as a potential source of obesity prevention and health promotion for the role they play in nutrition for patients, visitors, and staff. As of 2010, there were 5,754 registered hospitals in the U.S. with a total of 36,915,331 admissions. Considering that an individual hospital serves anywhere between several hundred thousand to one million meals per year to employees, patients and visitors, most of whom are a captive audience dependent on the food options provided by the hospital, these institutions provide a significant vehicle by which to encourage healthy eating.

The CDC has also recognized the need to increase access to healthy food and beverages in hospitals through its Healthy Hospital Practice to Practice Series, which presents case studies of hospitals seeking to better support the health of employees. They have sought to increase healthy food and beverage options in hospitals by encouraging food procurement policies that are environmentally sound and socially responsible. The importance of using hospital food as a method of health promotion and obesity prevention is currently receiving a great deal of attention.

In synergy with these national efforts, Building a Healthier Chicago—a collaborative of more than 150 local and national stakeholders and steered by an executive committee consisting of Chicago Medical Society leadership, Institute of Medicine of Chicago, Chicago Department of Public Health, and U.S. Department of Health and Human Services-Region V—is developing a workgroup to coordinate efforts on the Building a Healthier Hospital initiative in Chicago, which is focused initially on healthy hospital cafeterias.

Since its creation in 2008, the goal of BHC has been to improve the health of Chicago's residents and employees through the integration of new and existing public health, business, medical, and community efforts. Partnering with the Metropolitan Chicago Healthcare Council, BHC will develop and promote hospital food that is balanced, nutritious and tasty, providing a critical component of the healthy living model. The initiative will challenge Chicago-area hospitals to improve the health of patients, visitors, and staff with healthy meals emphasizing local produce, when possible. BHC will also examine broader processes such as cooking with healthier oils and eliminating trans fats, as well as promoting access to healthier beverages.

One Chicago-area provider, Vanguard Health Systems, which operates MacNeal Hospital in Berwyn and three other Chicago-area hospitals, has undertaken its own initiative to ban all sodas and sugary drinks at their sites. BHC's goal is to encourage other Chicago-area hospitals to follow Vanguard's lead and take their efforts even farther in promoting a hospital nutrition system that focuses on healthy foods as well. Considering the significant reach of a hospital system, an enormous potential exists for nutritious food promotion and distribution, which will ultimately help curb rising rates of obesity.

Dr. Galloway is Assistant U.S. Surgeon General and Acting Regional Director, Regional Health Administrator, Region V. For a list of references please contact esidney@cmsdocs.org. 

“Recently, hospitals have been identified as a potential source of obesity prevention and health promotion for the role they play in nutrition for patients, visitors, and staff.”

Healthy Change

A call to action for a better Chicago **By Bechara Choucair, MD**

A **S THE SAYING** goes, “Change is the only constant in life.” Change can make us uncertain, confident and, at times, optimistic. When it comes to policies that shape the health and wellness of Chicago, change has been a good thing. In 2011, when Mayor Emanuel released his transition plan, he called on the Chicago Department of Public Health to help and CDPH responded with Healthy Chicago, the City’s first comprehensive public health priorities agenda. Healthy Chicago is a call to action for all Chicagoans to engage in changing the standard of health in the City. It focuses not just on how individuals behave, but also on how the City as a whole behaves.

A healthy city is one that offers healthy food options, provides places for physical activity, prepares for health emergencies, creates safe environments, ensures access to care, and works to eliminate health disparities. Since the implementation of Healthy Chicago in 2011, we have seen improvements in these areas, but it is only the beginning. Recently, we’ve seen three major health policy changes introduced in our City, including two great initiatives that directly impact the health and wellness of our youth.

The Chicago Public Schools set new guidelines and requirements for students in nutrition, nutrition education and physical activity with updates to the District’s Local School Wellness Policy. The new policy’s nutrition requirements will further ensure that all CPS schools align with the U.S. Department of Agriculture’s Healthier U.S. Schools Challenge, a key component of First Lady Michelle Obama’s Let’s Move initiative. The HUSSC requires schools to demonstrate efforts around healthy food, nutrition education, and physical activity.

Along with providing healthy school food that meets or exceeds USDA standards, the new policy directly affects the school environment by introducing or raising the bar in the following areas:

- Convening school Wellness Teams and regular reporting of school wellness activities.
- Implementing minimum grade level requirements for nutrition education.
- Requiring recess for elementary school students.
- Prohibiting the use of food or physical activity as a reward or punishment.
- Ensuring that students regularly participate in physical activity.

With the change, CPS joins other large urban school districts in cities such as New York, Houston and Los Angeles in passing and implementing policies that promote healthy school environments.

CPS also introduced a new Healthy Snack and



Beverage Policy that sets new standards for all food and drink made available in schools, outside of the federal school meals programs. Requirements and improved standards address the snacks and drinks offered in vending machines, food sold for fundraising purposes, and food sold by vendors on school property. The policy also encourages schools to promote healthy options during in-school celebrations.

These two policies are part of our Healthy CPS initiative, a comprehensive effort to improve the health and well-being of Chicago’s students. The initiative is supported by a \$4.4 million grant from the U.S. Department of Health and Human Services. In addition, Mayor Emanuel introduced in November an ordinance supporting the conversion of vending machines in all City departments to healthy vending machines. These new machines will ensure that City employees and the visiting public are provided with healthy snack and beverage vending options.

To assure affordability of the new options, the price of healthier snacks and beverages cannot exceed the price charged for the less-healthy options. Also, the vending machines will display calorie information so consumers can make more informed choices. The healthier snack and beverage items will be placed prominently within the vending machines.

Policy change is an unparalleled tool that helps shape the health of our City. To learn more about the Chicago Department of Public Health, visit our website at www.CityOfChicago.org/Health or follow us on Twitter @ChiPublicHealth and Facebook at www.Facebook.com/ChicagoPublicHealth.

Dr. Choucair is commissioner of the Chicago Department of Public Health. 

The Chicago Public Schools introduced a new Healthy Snack and Beverage Policy that sets new standards for all food and drink made available in schools, outside of the federal school meals programs.

Fundamentals of the Physician-Medical Spa Relationship

Associating yourself with a medical spa is perfectly legitimate—as long as you do it correctly **By Carolyn V. Metnick, JD, LLM, and Julie A. Veldman, JD**

MEDICAL SPAS are on medical boards' radars nationwide. Medical spas bring in significant sums, primarily in private pay cash, and create contention and competition among licensed health care providers and unlicensed medical spa staff. In recent years, these relaxing oases have been popping up everywhere while drawing the scrutiny of state regulators. The Illinois Department of Financial and Professional Regulation has medical spas on its radar. Proper entity formation and ownership, as well as appropriate medical director participation can help insulate medical spas and physicians and other health care providers who work in them from liability.

Understanding the Corporate Practice of Medicine Doctrine

Like most states, Illinois prohibits the corporate practice of medicine. The corporate practice of medicine doctrine generally prohibits unlicensed individuals and entities owned by laypersons from providing medical services. The rationale for this prohibition is largely based on public policy considerations. Namely, if an unlicensed person or entity owned by an unlicensed person were to employ a licensed physician to provide medicine, then the unlicensed person or entity could interfere with the physician's exercise of independent medical judgment. The fear is that by controlling physicians and their compensation, the employer could undermine the physician-patient relationship. While unlicensed individuals obviously cannot provide medical services, the corporate practice of medicine prohibition is not this simple. Many states, including Illinois, have carved out exceptions to the prohibition.

One improper trend that runs afoul of the corporate practice of medicine prohibition is the control of a licensed professional who is providing the medical spa services by a business entity or layperson. For example, medical spas owned and operated by unlicensed individuals are employing and contracting physicians to provide medical director services and to supervise other individuals providing services. This structure poses significant risks in Illinois and would in many other states.

Formation and Organization of a Legally Accepted Medical Practice

Physicians in Illinois who are not employed by a hospital or other licensed institution are

generally limited to practicing medicine in a business form of a professional corporation, a medical corporation or a limited liability company. The Illinois Professional Corporation Act and the Illinois Medical Corporation Act adopt rules from the Illinois Business Corporation Act, which governs business corporations, with some important differences. In a medical corporation or professional corporation that provides medical services, only licensed physicians may be shareholders, directors and officers. In Illinois, physicians may also practice medicine through a limited liability company as long as the managers are permitted to practice medicine under the Illinois Medical Practice Act and each member is licensed under the Act or is a registered Illinois professional corporation, medical corporation or appropriately structured and licensed limited liability company. The bottom line is this: general business corporations formed under the Illinois Business Corporation Act should not provide medical services, including those medical spa services designated as such by the IDFPR.

Medical practices (and medical spa practices) must be organized appropriately in terms of corporate structure. Additionally, they must obtain a certificate of registration from the IDFPR. In Illinois, medical corporations, professional corporations and limited liability companies providing medical services must be registered with the IDFPR. Physician practices often overlook this administrative filing requirement that involves an initial registration and annual renewal, each with fees. The filing results in the issuance of a certificate of registration by the IDFPR.

Physicians who affiliate with medical spas as a medical director, employee, contractor or otherwise should be aware of these corporate requirements and make a reasonable effort to confirm that the practice or business they are doing business with is appropriately organized. Basic information on corporate structure and IDFPR registration can be found on the Illinois Secretary of State website and the IDFPR website, respectively. Illinois limited liability companies, medical corporations and professional corporations must file articles with the Secretary of State upon formation. Additionally, all Illinois entities or foreign entity such as those from other states doing business in Illinois, are required to file annual reports. Basic information from the articles and annual reports is available online. Additionally, the public can see whether an

“General business corporations formed under the Illinois Business Corporation Act should not provide medical services, including medical spa services.”

entity has an active registration with the IDFPR through a search on the IDFPR website.

Practice of Medicine/Unlicensed Practice

Unlicensed practice is a hotly debated political issue, especially in the medical spa world. Licensed providers are forcing the hand of state regulators to protect their turf from invasion by unlicensed individuals who perform the licensed provider's professional services for less. State legislatures typically define the "practice of medicine" and make it a felony for any non-physician to engage in the professional services reserved for physicians. A state's case law and medical board interpretation of the statutory definition of the "practice of medicine" drastically affect the state's understanding of unlicensed practice by non-physicians. Unlike most states, however, Illinois does not provide a statutory definition—or therefore case law or board interpretation of—the "practice of medicine." Illinois' nebulous regulation of unlicensed practice makes case-by-case consideration of scope of practice parameters very important.

Supervision/Delegation and Unlicensed Medical Spa Staff

Closely tied to unlicensed practice is the issue of physician delegation and supervision of unlicensed individuals. The provision of medical services by those who are not appropriately supervised by physicians is common in the industry. Frequently, individuals who are licensed to provide cosmetology and esthetician services do not understand where the line is drawn between their scope of practice and the practice of medicine. The Illinois Barber, Cosmetology, Esthetics and Nail Technology Act specifically states that cosmetologists and estheticians are prohibited from using any technique, product, or practice intended to affect the living layers of the skin. Illinois licensed electrologists are licensed only to provide permanent hair removal, utilizing only solid probe electrode type epilation. Services involving laser technology (for example, laser hair removal) may only be performed if delegated by a licensed physician pursuant to the requirements for physician delegation to unlicensed persons.

The IDFPR has offered additional clarity through a Warning Report that provides that Botox, chemical peels, collagen injections, colonics, liposuction and microdermabrasion (except for that which is superficial or light and intended only to remove dead skin cells, oil and other debris from the skin) constitute "medical procedures" (for example, the practice of medicine) and are not within the scope of practice of a cosmetologist or an esthetician. Therefore, only licensed physicians or others appropriately supervised by a licensed physician may provide these services.

While physicians may delegate the performance

to a person functioning as their assistant, physicians must examine the patient and determine the appropriate course of treatment before these procedures are performed. Moreover, individuals who are performing acts delegated by a physician may not hold themselves out as a cosmetologist or esthetician because these acts are not part of the practice of cosmetology or esthetics. Other medical spa services subject to delegation limitations include: laser hair removal, tattoo removal, varicose vein treatments, laser skin tightening, and any treatments that affect tissues below the surface of the skin, or which inject into (for example, Botox) or remove from (for example, liposuction) the body.

Accordingly, when an esthetician, cosmetologist or electrologist provides any medical spa procedures that are outside the scope of their licensure, the individual is considered an "unlicensed person" and rules relating to physician delegation to unlicensed persons apply. Proper physician delegation to unlicensed persons must be in line with certain requirements. First, the unlicensed delegatee must practice in the delegating physician's office or practice setting. Accordingly, and as confirmed by the IDFPR, a physician may not delegate to an unlicensed person unless the unlicensed person is practicing at an office or practice *owned and operated* by the physician. A non-physician owned medical spa may not, therefore, allow an unlicensed person provide any medical services pursuant to physician delegation. This requirement does not, however, mean that the physician owner or medical director is required to maintain the medical spa (or the location where delegated procedures are performed) as his or her principal practice setting.

Second, the physician delegation to unlicensed persons must occur in relation to an established physician-patient relationship. Third, the physician must ensure that each unlicensed delegatee is appropriately trained and experienced. Liability is with the delegating medical director if the delegatee's competency is not established and a patient is harmed as a result. Last, the physician, or other licensed health care provider designated by the physician who is acting within his or her scope of practice, must provide direct on-site supervision when the unlicensed delegatee is providing delegated medical procedures.

Laws Surrounding the Issues of Fraud and Abuse

Since most medical spa procedures are not covered by Medicare or Medicaid, the federal Anti-Kickback Statute and Stark Law are generally not applicable. However, many states, including Illinois, have adopted their own versions of the Stark Law and Anti-Kickback Statute. The federal Stark Law applies to referrals made by a physician for designated health services to an entity in which the physician or (an immediate family member) has

“A non-physician owned medical spa may not allow an unlicensed person to provide any medical services pursuant to physician delegation.”

“Unlike the federal law, the Illinois Stark Law only applies to investments and not to compensation arrangements. It is also not limited to Medicare or Medicaid.”

a financial relationship and where payments are made under Medicare or Medicaid.

The Illinois version of the Stark Law, known as the Health Care Worker Self-Referral Act, applies to a broader range of health care professionals (not just physicians) for the referral of a patient for any services to an entity outside the health care worker's office or group practice in which the worker is an investor. Such a referral is prohibited unless the worker directly provides the services in the entity and personally performs them. Other statutory requirements must also be met. Unlike the federal law, the Illinois law only applies to investments and not to compensation arrangements. Additionally, it is not limited to Medicare or Medicaid and therefore applies to patients who are paying out-of-pocket or through private insurance. If you are a physician with an ownership interest in a medical spa or other entity to which you refer patients, self-referral laws such as the Illinois Health Care Worker Self-Referral Act should be considered.

Illinois' version of the Anti-Kickback Statute is known as the Insurance Claims Fraud Prevention Act and prohibits the payment or offer to pay, directly or indirectly, in cash or in kind for patient referrals or for any payment under an insurance program. This Act is broader than the federal Anti-Kickback Statute because it applies to payments made by any insurance program, not just federal ones such as Medicare or Medicaid. Any financial arrangements between a physician and a medical spa owner should be carefully analyzed to ensure that there is no illegal remuneration for the referral of patients.

Fee Splitting Prohibitions Specific to Illinois


Illinois, along with a few other states such as

California and Florida, takes one of the strictest positions against physician fee splitting. Specifically, Illinois law prohibits a physician from dividing with anyone other than physicians with whom the physician practices any fee, commission, rebate or form of compensation for professional services not actually and personally rendered, with certain exceptions. The fee-splitting prohibition applies to a broad range of arrangements where a non-physician is paid under a formula based on physician revenues and collections.

It is important to note that many other licensed professionals have similar fee-splitting prohibitions. Fee-splitting violations may result in disciplinary action, including loss of licensure, and fines up to \$10,000 per violation. Financial arrangements between licensed professionals and unlicensed professionals should be analyzed to ensure against prohibited fee-splitting.

The Importance of Using the Appropriate Corporate Model

Physicians should consider the significant legal issues that can occur when affiliating with a medical spa. The financial success and longevity of a medical spa and protection of a professional license rely on employing the appropriate corporate model, ensuring proper medical director involvement, and determining proper delegation and supervision methods for the various health care providers and medical staff members within the practice. Associating with a medical spa is not something that should be done lightly.

Carolyn V. Metnick and Julie A. Veldman are attorneys with the Chicago office of Barnes & Thornburg LLP. Both are members of the firm's health care department where they represent a wide range of health care providers, including physicians and physician organizations. They advise clients on transactional and regulatory health law matters. They may be contacted at cmetnick@btlaw.com and jveldman@btlaw.com, respectively. 

Working With the Bar

THE CHICAGO Medical Society and the American Bar Association have established a formal relationship to address medical-legal issues affecting CMS members and their practices. This legal section is sponsored by the Health Law Section of the American Bar Association.

For CMS members this means that you get monthly articles from legal experts that specialize in health law. The articles will focus on subjects of current interest to the medical profession as well as cover new laws and regulations as they are implemented. The authors will vary every month in order for you to

get the best information possible from the attorney that most specializes in the subject matter.

If you have a particular question or would like more information on a subject, please send us your suggestions. You can send an email to Elizabeth Sidney at esidney@cmsdocs.org.



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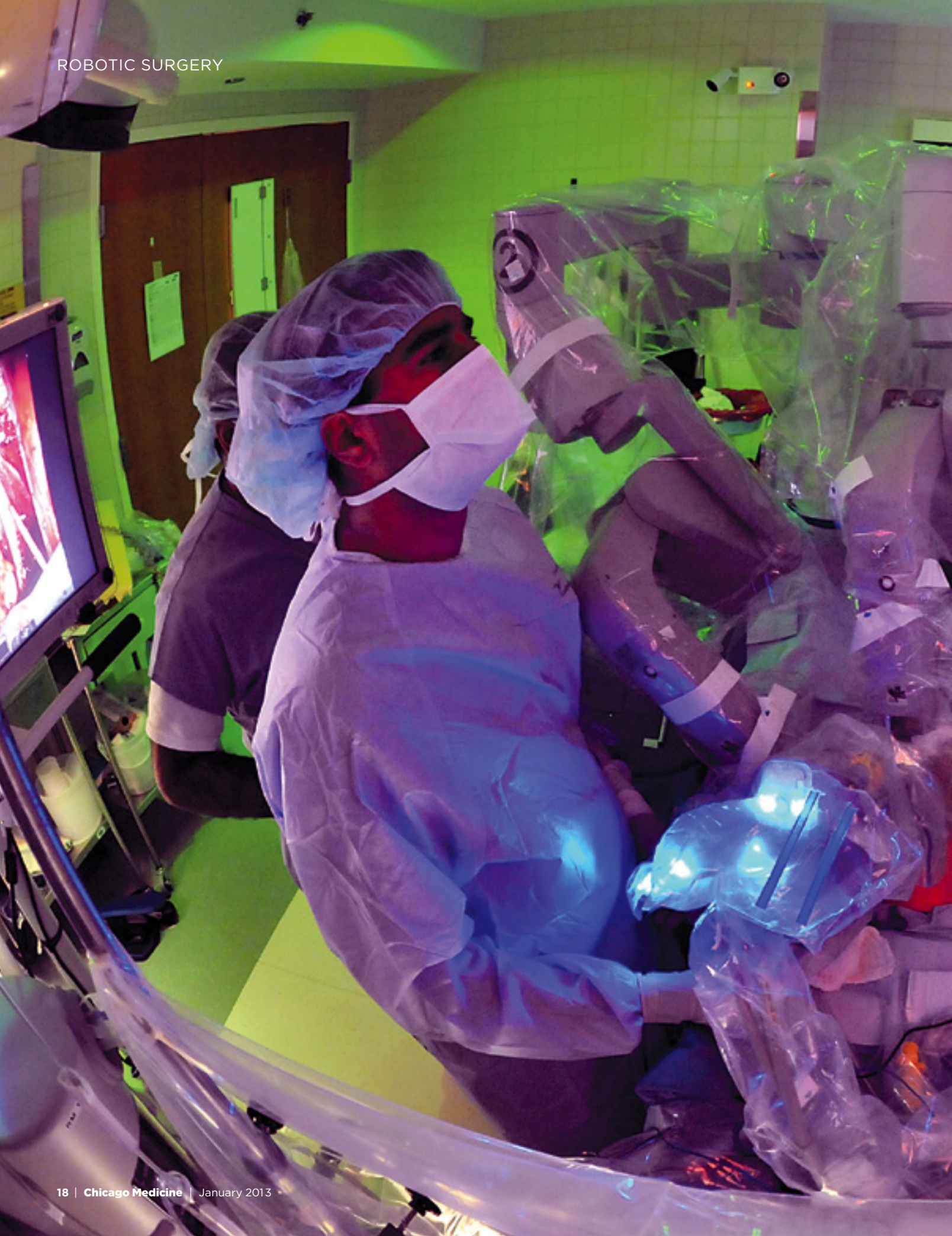
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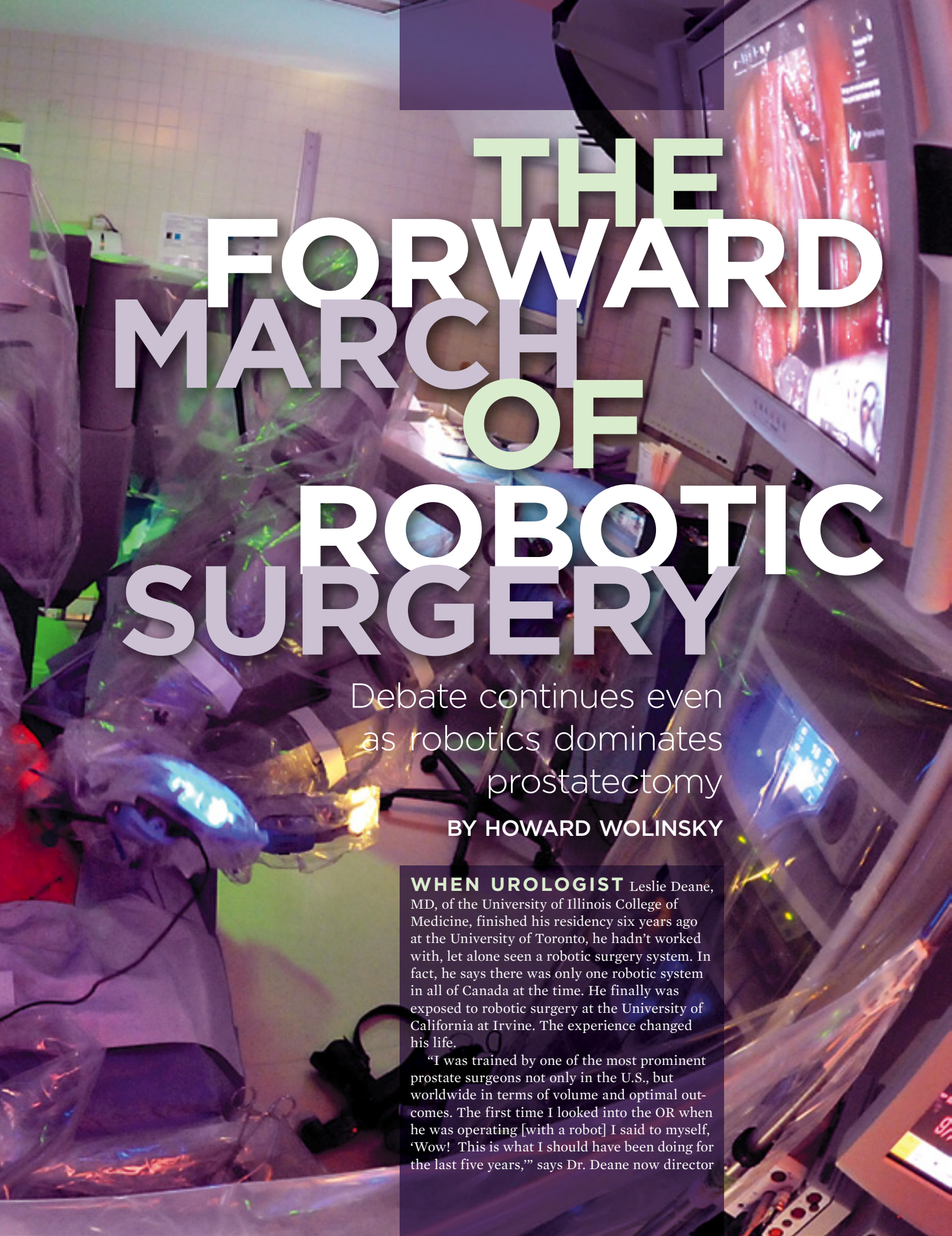
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THE FORWARD MARCH OF ROBOTIC SURGERY

Debate continues even
as robotics dominates
prostatectomy

BY HOWARD WOLINSKY

WHEN UROLOGIST Leslie Deane, MD, of the University of Illinois College of Medicine, finished his residency six years ago at the University of Toronto, he hadn't worked with, let alone seen a robotic surgery system. In fact, he says there was only one robotic system in all of Canada at the time. He finally was exposed to robotic surgery at the University of California at Irvine. The experience changed his life.

"I was trained by one of the most prominent prostate surgeons not only in the U.S., but worldwide in terms of volume and optimal outcomes. The first time I looked into the OR when he was operating [with a robot] I said to myself, 'Wow! This is what I should have been doing for the last five years,'" says Dr. Deane now director



Dr. Gregory Zagaja has been using the robotic technique for nearly 10 years and says, as with other surgery, the more surgeons use robotics the better they are at it.

of laparoscopy, endourology and robotic urologic surgery at UIC.

These days, robotics has come to dominate prostate surgery. According to Sunnyvale, Calif.-based Intuitive Surgical, Inc., which makes the da Vinci Surgery System, 80 to 85 percent of surgical prostatectomies are now performed robotically. Globally, there are more than 2,300 da Vinci systems, including more than 1,700 in the U.S. There are more than 70

systems in Illinois alone.

Still, experts and physicians alike continue to debate the value of robotic surgery vs. traditional methods. Gerald Chodak, MD, former urology professor at the Pritzker School of Medicine at the University of Chicago says that the robotic juggernaut was partly responsible for his decision to quit performing prostatectomies in 2007 and to close his private practice, Midwest Prostate and Urology Health Center, the next year. “I stopped doing prostate cancer removals because I didn’t want to

have to make a sales pitch for doing it my way. People want new in the U.S. They think new is always better. And the hype for robotic prostatectomy was that way,” he says.

A Quick History of Robotic Surgery

But robotic surgery isn’t new. The first robot-assisted surgical procedure occurred in 1985 when the PUMA 560 robotic surgical arm was used in a neurosurgical biopsy. This led in 1987 to use of the system in a cholecystectomy. The U.S. Food & Drug Administration in

1990 approved the first robot for use in endoscopic surgeries.

In 2000, the FDA approved the da Vinci Surgery System. It is the first comprehensive robotic system with surgical instruments and camera utensils. The da Vinci system provides the surgeon with a 3-D view of the surgical field. The surgeon sits at a console about 10 feet away from the patient so he or she doesn’t need to wear a sterile gown. Using both hands and feet, the surgeon manipulates the surgical arms that are attached to the surgical instruments. The operating table-side team inserts the instruments through the patient’s skin, making an incision anywhere from about 0.5 to 2 centimeters in diameter.

Originally, da Vinci was intended for heart surgery. But robotic technology has caught on

with prostatectomy, opening a pathway for other innovative surgery, especially in gynecology. Robotic surgery over the past decade has become the most commonly performed method for removing the prostate in the U.S.—though surgeons are still vigorously debating its merits.

The Effectiveness Debate

Probably the biggest bone of contention between proponents and opponents of robotic prostatectomy is that of effectiveness. Myriam Curet, MD, medical director of Intuitive Surgical and a consulting professor at Stanford University School of Medicine, who did her residency at the University of Chicago, contends that recent literature with the large databases, involving tens of thousands of patients, consistently has shown robotic prostatectomy has a lower mortality rate, a lower morbidity rate, better potency, and better continence rates than laparoscopic or open surgery.

William Catalona, MD, professor of urology at Northwestern University Feinberg School of Medicine and a pioneer in nerve-sparing radical prostatectomy, disagrees. He has performed at least 6,000 cases, more he says than any other surgeon. He considers the open technique superior.

He says the goal for prostatectomy patients is a “trifecta”: cure the cancer, prevent incontinence and retain the ability for erections. “My own view of robotic prostatectomy is that patients have less chance to achieve the trifecta. If surgeons are totally focused on getting all of the cancer out and go widely around the prostate to get clear margins, with a robot they have to burn the prostate out and there’s a greater chance that the heat and the electricity will permanently damage the nerves. The patient might be cured, but he is less likely to be potent.

“Or,” continues Dr. Catalona, “if the surgeon is overly focused on preserving potency and trying to keep the heat and the electricity away from the nerves and sort of comes too close to the prostate, then there’s the possibility that he or she will leave a little bit of the prostate and not get all of the cancer out so that (patients) would be potent but less likely to be cured.”

He says that when he performs open surgery, he doesn’t use thermal energy or electricity, but instead relies on a traditional scalpel and scissors. “I think you have a better opportunity to get all of the cancer out and preserve potency. I think they have a better chance for the trifecta. Their recovery time from the operation has been shown to be the same.”

But Gregory Zagaja, MD, director of the prostate cancer program at the University of Chicago and a proponent of robotic surgery, says most high-volume surgeons do not use electrical energy. “If indeed there was significant nerve damage, [the surgeons] wouldn’t be reporting the outcomes that they’re having.”

Dr. Curet concurs with Dr. Zagaja. “The



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mortality rate is three times higher in an open prostatectomy than a robotic prostatectomy,” she says. “And now with the data showing better potency and continence, I think that data really are in conflict with what [Dr. Catalona] is saying about nerve damage.”

The Data Debate

Even the studies and data surrounding the efficacy of robotic prostatectomies vs. open surgery are contentious. “The cancer outcomes appear to be the same, so when you look at short-term surrogates, the margins, they’re the same,” says Dr. Curet. “And the data that we have long-term—and obviously there needs to be more data regarding this—shows that survival rates are the same. So, patients are getting the same cancer outcomes, with fewer complications and better functional outcomes. There have been a half a dozen publications, all of them really good quality publications. They’re not 20 or 50 case studies. They’re not just one single institution. They’re reflective of real-world data with tens of thousands of patients being done at multiple institutions, and I don’t think you can get stronger data than that.”

However, Dr. Chodak says in his view a well-done study has not been conducted that proves an advantage for robotic surgery. “Without a randomized study comparing results of different surgeons on a variable group of patients, valid comparisons are impossible. Studies have shown that complication rates are higher among lower-volume surgeons and the average number done in the U.S. is fewer than 20 (per surgeon).”

Dr. Catalona is skeptical about long-term survival data on robotic prostatectomy. “It has only been approved by the FDA for 12 years and has only been widely used for 10 years. This amount of time is insufficient to evaluate mortality from prostate cancer,” he says.

Dr. Chodak, who has stayed active in the field by doing patient education on prostate cancer through a website, www.prostatevideos.com and authoring the 2011 book, *Winning the Battle Against Prostate Cancer: Get the Treatment That is Right for You* says the popularity of robotic surgery comes from marketing not science. “Thus far, no good study has proven that robotic surgery has better cure rates or lower complication rates. Nevertheless, billboards and hospital websites frequently make such claims. In fact, the learning curve with robotic surgery is steep and many doctors using the da Vinci system, have not done enough of them to achieve the same low complication rates achieved by more experienced surgeons.”

Dr. Catalona says: “There are some patients who basically want to have robotic surgery because they’ve been told it’s state-of-the-art, so they would not come to me because they know I don’t do it and go to someone who does robotic surgery. But my honest, personal view is that most of the surgeons

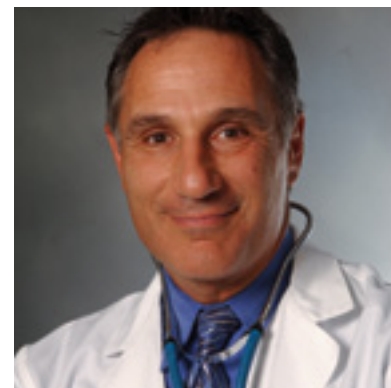
who specialized almost exclusively in prostate cancer surgery before the robot came out have not switched to the robot because they realized that initially several hundred patients would be sacrificed, with poorer outcomes. Nobody wants to give a patient an operation that is not going to give them the very best chance.”

A Question of Speedy Recovery

Dr. Chodak says the robot initially was promoted as a means for a one-day hospital stay. Along these lines, Dr. Deane says some centers now operate on patients early in the morning and send them home that night—so it’s “less than a 23-hour stay.” “We’ve had patients say, ‘Doc, can I go home this evening, the day of the operation.’ They kind of look good enough to go home, but you just did a major prostate operation. It would be pushing the hospital a lot to send that person home the same day,” he says.

But Dr. Chodak says that a quicker release is not necessarily robotic magic. In 1993 he was able to reduce hospital stays for patients undergoing prostatectomies to 1.1 days from 5.5 days by changing anesthesia techniques. “Eighty percent of my patients went home the next day, and 10 percent could have gone home the next day but refused to. When robotic surgery came along with a two-day hospitalization, I did not see a reason to switch methods.”

Dr. Deane says: “Robotic surgery has made the radical prostatectomy an easier operation to learn, an easier operation to teach, and an easier operation to perform. We operate in an essentially bloodless field. The carbon dioxide that we use to fill the abdomen is pressurized. It’s at 15 mm of mercury pressure, which will slow down if not stop most venous bleeding. Venous bleeding is troublesome in open prostate surgery when you don’t have that compressive effect of the gas. Robotic surgery allows us to see things much better because we’re looking at a clear operative field with no blood in the way. We can see the sphincter, the apex of the prostate, the margins of the prostate, and where the nerve bundles are. This allows us to meticulously preserve these structures. Robotics has changed the game in terms of prostate cancer surgery tremendously.”



Dr. Gerald Chodak believes that the popularity of robotic surgery is due more to marketing than to any thorough scientific study.



Dr. Leslie Deane says that robotic surgery has made the radical prostatectomy an easier operation to learn, teach and perform.

On this point, Dr. Catalona says the robots enable “less experienced surgeons to perform the operation without the fear of life-threatening bleeding. For the patients, this should not be totally reassuring, since they might be able to have an open operation with better outcomes by a more experienced, more skillful surgeon.”

But Dr. Deane is quick to point out that the magnification on a robotic system—12 to 15 times larger than life—is superior to any other visualiza-

“These days, robotics has come to dominate prostate surgery. According to Calif.-based Intuitive Surgical, which makes the da Vinci Surgery System, 80 to 85 percent of surgical prostatectomies are now performed robotically.”

tion method for a surgeon. “It doesn’t get better than that,” he says. “The way to learn anatomy is via a scope where it’s really magnified. It’s better than any cadaver dissection. It’s better than any anatomy textbook for seeing the visceral organs in the abdomen, pelvis and chest.” He notes that most surgeons use special glasses that magnify images by three- to five-fold.

The Problem With Calculating the True Costs

Medicine is facing increasing pressures in these cost-conscious times. And debate continues over the cost for robotic surgery. Intuitive Surgical says the average sale price for a robotic system in the U.S. is \$1.4 million, including the first year of service. Service agreements average \$100,000 to \$170,000 a year. The cost of instruments and accessories is \$1,300 to \$2,200 per procedure.

Dr. Curet concedes that when looking only at the cost of buying a system, robotic surgery costs more than traditional surgery on a per-case basis. However, she adds: “If you look at the overall cost of care for patients—factoring in the recovery period, how soon they go home, what their complication rates are, possible complications and readmissions, and the cost of somebody taking time off work to take care for patients during their recovery period—the overall cost is less for the robot than it is for open surgery.”

Dr. Zagaja says the price debate over open vs. robotic surgery is still brewing: “There hasn’t been a good analysis. If you just look at numbers based on the actual surgical procedure, it is more expensive to utilize the robot. On the other hand, there’s a shorter hospital stay, so that also decreases the total hospital cost.” Dr. Chodak says absent from this comparison is the perineal prostatectomy, which is less expensive than either method and has comparable results.

Dr. Zagaja says Swedish researchers took a broader look at the return to work following surgery. [Hohwu, Lena et al, “Open retropubic prostatectomy versus robot-assisted laparoscopic prostatectomy: A comparison of length of sick leave,” *Scandinavian Journal of Urology and Nephrology* Jan 2009, Vol. 43, No. 4, Pages 259-264.] “If employers and insurance companies are not paying disability for patients to be off work for six to eight weeks for an open procedure and instead they’re back to work within two weeks, well, then that’s a big economic savings to society in general and so, it’s probably going to help in the long run,” he says.

He says the research is “a mixed bag. There’s a little bit of debate as to whether robotics, with regard to prostatectomy, is cost-effective. Most people would say it’s a wash.”

Dr. Catalona says the European national health plans generally have rejected paying full freight on robotic prostatectomies. He says patients who want robotic surgery there have to pay the difference out-of-pocket. “It’s very, very hard to break even unless you really have a very high volume. So if you were a hospital and bought a robot and didn’t do a lot of cases, you would lose a lot of money.”

Getting Past the Learning Curve


Another issue surrounds the surgeon’s learning curve. Dr. Zagaja, who has been performing the robotic technique for nearly 10 years, says research shows, as with other surgery, the more surgeons use robotics the better they are at it. “To get beyond the learning curve it’s probably 50 cases. To have a high degree of proficiency, it’s in the range of 250 to 300 cases, and to maintain that proficiency you should probably be doing 50 cases per year.”

But Dr. Chodak is concerned that individual surgeons don’t have enough experience to develop or maintain proficiency. He notes that the typical urologist performs fewer than 10 prostatectomies per year.

The Debate Continues

As the debate continues, what should patients with prostate cancer do?

Dr. Chodak says these patients should choose the surgeon, not the method: “Ask very specific questions when selecting a surgeon such as, ‘Doctor, how many of these procedures have you done in the last four to five years? What percentage of your patients are cured and what percentage have any urinary leakage or erection problems after a full recovery?’”

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Cracking the da Vinci Code

Robotic surgery operates beyond the prostate, going into areas such as hysterectomy and mitral valve repair

Robots aren't just for prostates.

Though the role of da Vinci robotic systems in prostatectomies is well known, the robot now plays an even bigger role in gynecology, especially hysterectomies to remove the uterus as well as myomectomies to remove fibroids and sacrocolpopexies to repair pelvic prolapse. Myriam Curet, MD, medical director of Intuitive Surgical Inc, the manufacturer of the da Vinci robotic system, says, "About a year ago [robotic prostatectomies and hysterectomies] were 50/50, but now hysterectomies are a little bit higher."

Intuitive's system originally was intended for cardiac surgery. But Dr. Curet says a U.S. surgeon who trained in Europe recognized that performing laparoscopic prostatectomies came with a steep learning curve and that robotic surgery might be an easier route to perform minimally invasive prostatectomies. "Laparoscopic prostatectomy is very difficult for surgeons to do," says Dr. Curet. "It presents significant limitations due to the 2-D visualization, counterintuitive movement of the instruments and ergonomics. Laparoscopic penetration of the prostate has always been low, at less than 15 percent, and the procedure is limited to only a few surgeons, primarily in Europe. The da Vinci surgery has offset those limitations by restoring 3-D visualization, providing intuitive movement of the instruments with normal pitch and yaw of the wrist as well as significant improvement in ergonomics."

Dr. Curet says the market drove the move to prostatectomies and later gynecologic operations rather than Intuitive Surgical's internal decisions. The da Vinci system was approved for prostatectomies in 2003. Two years later, it got the green light for hysterectomies.

Sandra Valaitis, MD, chief of the section of gynecology and reconstructive pelvic surgery at the University of Chicago Medicine, says that unlike laparoscopic instruments, which are long and rigid and have a limited range of motion, the robotic instruments enhance flexibility and range of motion. "When you're using the robotic instruments, you can use them the way in which your hand works," she says. In fact, Dr. Valaitis, who specializes in pelvic floor repairs, says the robot provides surgeons with a greater range of motion than is possible otherwise. She notes that laparoscopic surgery can be assisted with the robot.

She says that one downside with robotic instruments in robotic surgery is the loss of physical feedback, "the touch, that tactile sensation," while operating. However, the robot removes fine tremors.

The robot has been especially useful in performing sacrocolpopexies, sparing patients from large abdominal procedures. Dr. Valaitis adds: "Patients who you thought would need an open abdominal hysterectomy are able to have robotic surgery. Our oncologists and gynecologists are using robotic surgery now for their patients. They're able to do lymph-node dissections and more radical procedures that in the past have always been done with open surgery and now can be done with the robot. It has opened the doors for a lot of patients who otherwise would have needed an open surgery procedure but can now have minimally invasive surgery instead."

Intuitive lists the following operations for which its robot has been used:

- Radical prostatectomy, pyeloplasty, cystectomy, nephrectomy, ureteral reimplantation
- Cholecystectomy, Nissen fundoplication, Heller myotomy, gastric bypass, donor nephrectomy, adrenalectomy, splenectomy, bowel resection and other colorectal procedures
- Oropharyngeal, laryngeal and hypopharyngeal resections; floor of mouth and oral cavity resections
- Hysterectomy, myomectomy and sacrocolpopexy
- Internal mammary artery mobilization and cardiac tissue ablation
- Mitral valve repair, endoscopic atrial septal defect closure
- Mammary to left anterior descending coronary artery anastomosis for cardiac revascularization with adjunctive mediastinotomy

Dr. Curet says: "Our mission is to extend the benefits of minimally invasive procedures to the broadest patient population possible while maintaining value for the surgeons and medical centers we serve. We work closely with surgeons to address patient needs and research procedures and product improvements that help overcome the limitations of traditional open and laparoscopic surgical procedures."

Ready or Not, Here Comes Obamacare

Five key things physicians should consider doing in the next 12 months **By Bruce Japsen**

WITH THE RE-ELECTION of President Barack Obama, the Affordable Care Act is no longer in jeopardy of being repealed, setting the stage for the largest expansion of health care coverage since the inception of the Medicare health insurance program for the elderly in 1965.

Though some benefits have already kicked in since President Obama signed the legislation into law in April 2010, such as health coverage for children 26 years old and younger, and certain preventive care for the elderly, the biggest expansion of coverage to potentially 30 million uninsured Americans will happen Jan. 1, 2014. Less than one year from now, about half of the uninsured targeted for benefits under the law and who are not eligible for expanded Medicaid coverage will be able to purchase private insurance on state or federally regulated exchanges.

For those who will care for these newly insured Americans, it means there will be pent up demand for medical care for previously uninsured patients. But new rules and cost-containment strategies will also be invoked by the private health plans operating on the exchanges because these insurers will be required to spend at least 80 percent of the premium dollar on medical care. That is good news for doctors who have long worried insurers spend too much on administration but it also means health plans will be watching what they spend on medical care more closely than ever to meet the new regulations they face. And that could create challenges for physicians.

Here are five key things health policy experts and those who work with insurance companies and employer health plans say doctors should be prepared for.

1 Prepare for employment changes or opportunities. More and more hospital systems, looking to control costs are buying out physician practices and making the physicians salaried employees. In some cases, physicians welcome this trend, giving up autonomy so they don't have to deal with the headaches of running their own practice or having to spend potentially hundreds of thousands of dollars on new information systems, billing software and the like. NorthShore University HealthSystem, which operates four hospitals and affiliated practices and clinics in Chicago's northern suburbs, has more than 800 employed physicians including about 100 who became employees through various acquisitions and practice purchases in just the last year alone, NorthShore said.

Meanwhile, Advocate Health Care, the Chicago

area's largest provider of medical care with more than one dozen hospitals throughout Illinois, has seen its number of employed physicians in the Advocate Medical Group more than double in the last five years to more than 1,000 physicians. It now includes 1,000 physicians and another 100 advanced practice nurses and physician assistants. "The economies of private practice are increasingly difficult and it is also becoming more difficult for physicians to face regulatory burdens alone," said Dr. Jim Dan, president of Advocate Medical Group. "To me, patients have better outcomes in an organized group environment," Dr. Dan added. "That is not to say an individual physician is better or worse but with the infrastructure and management, there is more information and less fragmentation. That creates more safety and better outcomes."

2 Prepare to practice medicine differently. If the way physicians and hospitals are paid truly moves away from fee-for-service to a model where providers are encouraged and rewarded financially for keeping patients healthy, doctors will "need to learn how to practice medicine more efficiently with less office-based care," said Dr. Michael Cryer, national medical director for the employee benefits consultancy Aon Hewitt.

Aon Hewitt works with most major self-insured employers who are willing to reward physicians by paying for phone-based medical care and various efforts to monitor patients via telephone, e-mail and text messaging. More insurers and self-insured employers are also willing to incorporate into reimbursement the payments for nurse-practitioners and home health care workers who will be needed to work with a physician's practice to manage the population of patients they serve. "With 30 million people coming into the system, there are not enough doctors to see all of these patients," Dr. Cryer said.

So, what if insurers don't pay doctors for these new efforts to keep patients well and at home? "Physicians should demand it," said Dr. Cryer. They have leverage when there is a shortage and should be reimbursed for any interaction they perform to keep people well and away from the doctor's office or hospital. "Those are all things that physicians provide themselves and which they ought to be paid for," Dr. Cryer said.

3 Be prepared to be measured. Dr. Howard Bauchner, the editor of the *Journal of the American Medical Association*, tells a story about being a few years past his 50th birthday when his primary care doctor told him it was time for a colonoscopy. Not only was Dr. Bauchner being urged to get the diagnostic test as a necessary preventive

health screening, but his physician was also being compared to others and he needed to hit the necessary quality indicators health plans use to reward doctors and provide patients and consumers with adequate measures and ratings. “I was screwing up his metric,” Dr. Bauchner said.

Increasingly, doctors are being measured not only by large health insurance companies but also by the Medicare health insurance program. And measures such as the Healthcare Effectiveness Data and Information Set are on the verge of being used toward a next step that ties the outcome of the patient’s care to that measure, analysts say. “Eventually, the measure will not just be the measure but the outcome that the measure produces,” said Aon Hewitt’s Dr. Cryer. “That is the next step. It’s not just to measure an action but to measure a result.”

Physicians need to make sure they are aware of these measures and rules that health plans will use. Aon Hewitt said all major insurance carriers from Aetna and Cigna to Humana and UnitedHealth Group and Blue Cross and Blue Shield plan to use them. Dr. Cryer advises doctors to become involved in the creation and use of these measures. “Physicians need to be involved in how that measure is going to be used,” Dr. Cryer said. “Measures will drive those results only if those measures are correctly designed. Physicians need to be part of that. They are tired of being ignored. Now is their chance to be heard.”

4 Be prepared to take on risk. Whether it is through an accountable care organization or a bundled payment, insurance companies pay a group of medical-care providers to deliver all the services a patient needs. This future health care system places more risk on physicians, and is a radical departure from fee-for-service medicine because medical-care providers are banding together through their practice, clinic or a business umbrella like an ACO, to manage populations of patients. The insurance companies pay for care but often allow the providers to keep a portion of money they save by keeping their patients healthy. *JAMA*’s Dr. Bauchner describes this population-based medical care as moving from an “individual mandate” to a “population mandate.” Dr. Bauchner says, “This is probably the most fundamental change within the Affordable Care Act.”

An ACO works like this: a health insurance company or Medicare contracts with doctors and hospitals through an ACO, which pushes high quality, less expensive care rather than today’s fee-for-service reimbursement system that often leads to excessive care by paying for each treatment or procedure that isn’t always better. The providers in an ACO are responsible for managing the care of the health plan enrollees and are financially rewarded if the enrollees, or patients, stay out of the more expensive hospital. “You are


responsible for the patient population,” Advocate Medical Group’s Dr. Dan said. “You need to reach out to the patient.”

5 Be prepared to be profiled. One way health plans are trying to reduce costs is through physician “profiles,” which can be used as a basis for lowering a doctor’s reimbursement or ranking them generally through a star system that could market them more favorably or less so to patients through their employers or insurance companies. These profiles are gaining momentum as something physicians need to closely monitor in both the private health insurance market and Medicare program, which is facing potentially dramatic cuts as Congress and the White House look to reduce the deficit. Health policy observers only expect profiling to be expanded as the Medicare program looks to reduce costs.

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A study by researchers led by the RAND Corp., and published in the November issue of the *Health Affairs* journal, said recent findings show that less experienced doctors are 13 percent more costly in the way they practice medicine than their veteran colleagues, which could result in less-experienced physicians being excluded from health plan networks. The RAND researchers say these profiles, which are generally viewed by health plan enrollees on an insurance company website, use a star-rating system that can possibly lead to a patient’s choosing one doctor over another. The consumer can typically see the “profile” in the form of a star-rating next to a doctor’s name that is related to cost, efficiency or the provider’s use of resources, RAND researcher Dr. Ateev Mehrotra said.

In the future, though, profiles will be used to narrow networks of doctors because insurance companies are under pressure from the Affordable Care Act to control costs. “This kind of cost profiling is going to be widely used,” said Dr. Mehrotra. “We found that physicians with fewer than 10 years of experience had 13.2 percent higher overall costs than physicians with 40 or more years of experience. It is possible that one driver of health care costs is that newly trained physicians practice a more costly style of medicine.”

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CMS Legislative Breakfasts bring you face-to-face with your elected representatives and civic leaders, in hospitals or other locations of your choice. One example is a breakfast with State Senator Heather Steans (7th Dist.) at Swedish Covenant Hospital. Members gave the North Side Chicago Democrat their perspectives on defensive medicine, insurance reform, Medicaid reimbursement, medical education, and loan forgiveness. They used this time to discuss a study by CMS member Russell Robertson, MD, which found more than half of Illinois medical residents leave the state due to medical liability costs and loan repayment issues.

The Legislative Breakfast program complements the Mini-Internship program. At your request, CMS staff works with District leaders and hospital medical staff to arrange these breakfasts—all you do is choose the representative. For details or to schedule a breakfast in 2012-2013, please contact Christine Fouts 312-670-2550, ext. 326 or cfouts@cmsdocs.org.

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This new CMS website function informs members of new and pending legislation, encouraging them to engage with their congressional representatives. The site provides contact information, links, sample letters, and guidance on communicating effectively with legislators.

Governing Council

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CMS also will collaborate on issues important to our affiliated constituents and CMS members. We offer valuable resources and services, such as studying specific issues they bring to us.

Authoring Resolutions

As the legislative body for both our organizations, the ISMS House meets once a year to set objectives on key issues, ranging from scope-of-practice and reimbursement reform, to public health and graduate medical education. The resolutions members submit to the CMS Governing Council directly shape these objectives. ISMS also works directly with the Illinois General Assembly to introduce and influence legislation promoting and protecting medical practices and individual physicians.

Member Discounts

CMS and ISMS membership offers you exclusive, time- and money-saving benefits. By taking advantage of these discounts and services, you can earn back more than the investment of your dues dollars. Our members have access to billing and collection services, medical products and supplies, health, life, disability insurance, group practice insurance, banking and investment services, and more. The money you save through your societies will help keep your practice more profitable.

Access to Events and Educational Programs

CMS and ISMS regularly host seminars, CME programs, webinars, conferences, meetings, and educational workshops on a variety of topics essential to running the business side of your practice. You'll find programs on topics such as:

- Implementing electronic medical records
- Proper coding, billing and collection
- Managing Medicare
- Practice management techniques
- Understanding and implementing legislative and policy regulations
- And much, much more

Events are held throughout the county and state. Please view the calendar at www.cmsdocs.org or check the Calendar of Events section of this magazine for details.

Reimbursement Assistance

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 changes in stringent federal and state regulations and grapple with health plans that use confusing, inconsistent, and unfair payment practices. ISMS offers hands-on support to members in a variety of areas to ensure a healthy bottom line for their practices.

- Reimbursement assistance, which can help you recoup thousands of dollars by showing you how to appropriately respond to health plans through efficient appeals processes and claims reconsideration.
- Direct assistance with resolving reimbursement issues.
- Numerous workshops and seminars that teach physicians and their staff how to maximize reimbursements.
- Various toolkits to help you better manage your finances.
- Assistance with federal and state pre- and post-payment audits and compliance.
- Information on healthcare issues, mandates, and new policies to keep members informed about day-to-day reimbursement issues.
- Pro-active work with public and private payers to prevent onerous provisions from getting into contracts in the first place.

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

New Initiatives


As always, CMS strives to create new programs of value to its members as the landscape changes. Some of our latest initiatives include:

- **Women Physicians Forum**—The forum looks at the unique needs and interests of women physicians in Cook County. As the local counterpart of the Illinois ISMS Women Physicians Forum, the group is structured to focus on three key areas: (1) representing and

advocating on behalf of women physicians; (2) networking; and (3) offering services specific to women physicians. The Women Physicians Forums provide the means for a strong representative voice on behalf of the growing number of women in medicine.

- **Committee for Academic Physicians**—Formed to improve CMS' representation of physicians involved in academic medicine, this committee addresses the unique regulatory and financial issues that affect academic physicians, and provides a forum to discuss them. The committee is responsible for researching the feasibility of policies, activities and services that ultimately enable CMS to better serve the needs of academic physicians.
- **Young Physicians Group**—This group focuses on the concerns of physicians under 40 years of age or within the first eight years of professional practice. The YPG major goal is to strengthen the value of CMS young physician membership by (1) enhancing young physician practice of medicine, including the transition into practice; (2) facilitating the participation of young physicians in policy development and other activities of the CMS; and (3) promoting young physician leadership throughout organized medicine.
- **Council on Hospital Medical Staff Leadership**—In response to the growing demands on medical staff leadership, CMS formed a Council on Medical Staff Leadership, which is designed to be a valuable resource to you and your hospital. The Council is composed of medical staff presidents, presidents-elect, secretaries, and representatives of the AMA's Organized Medical Staff Section and focuses on issues affecting hospital medical staffs.

Contact Us

Through our advocacy efforts, our physician leaders and staff strive toward a common goal—that you spend more time treating patients and less time navigating the obstacles that threaten your autonomy and undermine your practice of medicine. Recognizing the diverse needs of our prospective members, we offer specialized memberships for physicians, practicing residents, medical students, and practice managers. For additional information on the benefits of membership or to apply, visit www.cmsdocs.org or call us 312-670-2550. 

Governing Council Highlights

A quarterly meeting jam-packed with presentations, resolutions and elections

By Elizabeth Sidney

THE CHICAGO Medical Society hosted its quarterly Governing Council Meeting on Nov. 27, following a lively CME workshop on professionalism (see “Patient Care is Paramount” on page 30). The quarterly Governing Council meeting is an advocacy platform for Chicago-area physicians, where they can create policies and propose legislation for debate by the Illinois State Medical Society House of Delegates, the legislative body for both CMS and ISMS. County medical societies, like CMS, act as a springboard for physician-friendly laws that ISMS will implement in the General Assembly. Every quarterly meeting offers an excellent opportunity for member physicians to engage with CMS leaders and observe their Society at work.

Health Reform Survived

Before the Council began scrutinizing resolutions, the group heard an informative presentation on health care reform from Mr. Michael Gelder, senior health care policy advisor to Governor Pat Quinn. Illinois is preparing for the Affordable Care Act’s implementation in 2014, and Mr. Gelder made these key points about the preparation in his presentation:

- As a bridge to a state-based exchange, Illinois will participate in a federal partnership the first year. This will allow the state to take the lead on plan management and in-person consumer assistance. The exchange and navigator functions will be run by the federal exchange, which is funded through an assessment on insurers selling on the exchange.
- Online reports detail how federal funding is used to assess the marketplace, estimate costs, and engage health providers, insurers, consumer advocates and the business community to understand exchange-related issues. The state awarded a contract to design and implement an integrated eligibility system, and a request for proposals to solicit a vendor to build the technical infrastructure.
- Health plans in the individual and small group markets, both inside and



The room was packed for the CMS quarterly Governing Council Meeting.

outside the exchange, must offer a core package of items and services. The essential health benefits benchmark plan represents a “typical employer plan” already sold in the state. The governor’s council approved the BlueCross BlueShield of Illinois BlueAdvantage small group plan augmented with the federal BlueVision package and the AllKids dental package.

- The Exchange will permit apples-to-apples comparison of plans and a simplified process for enrolling and managing insurance. Small business owners can offer insurance to their employees through a streamlined, easy-to-use web portal.
- The ACA will offer premium subsidies for individuals eligible for the exchange. Anticipating about 350,000 newly eligible for Medicaid by 2017, the state is seeking input on a benchmark package of benefits that will be available for the expanded population.

Illinois isn’t taking on additional financial obligations at a time when the state is broke, Mr. Gelder told skeptical Council members who asked about a 10-year plan for providing care. He predicted that, “An influx of federal dollars will help

support physicians and nurses, while the increased economic activity should generate income.” He is confident that preventing ER overuse and “getting out fee-for-service” will yield huge savings.

Citing conflicting projections, audience members wanted to know how many new beneficiaries to expect in Illinois. They asked how so many patients will be absorbed into the delivery system; Mr. Gelder replied the state doesn’t anticipate all eligible Medicaid patients enrolling.

Responding to questions about the physician-nurse relationship, Mr. Gelder stated he wanted to hear from the medical community. Legislators will likely revisit the Medical Practice and Nurse Practice Acts. ACA implementation relies heavily on health care extenders to meet the needs of an expanded insured population.

Mr. Gelder also wants members’ ideas on stemming the exodus of doctors to states with lower medical liability insurance premiums. Acknowledging the problem of dismal reimbursement, he said, “Low and slow pay” is a travesty, making it hard to bring more physicians into the delivery system.”

Just how all the moving pieces of health care reform will fall into place—and how the components will

work together remains unknown. Many physicians say they wonder who will be coordinating care and ensuring access, and who will assume liability. Members can email comments to Mr. Gelder at Michael.gelder@illinois.gov.

Resolution Results

After the presentation and ensuing discussion, the Council moved on to the work at hand—reviewing the resolutions previously presented and making decisions about whether to move them along to the Illinois State Medical Society or whether to refer them for study. Here are the resultant decisions for each resolution.

Basic Life Support Knowledge and Skills for Physicians

The Council approved a measure to encourage all physicians to train themselves with basic life support courses. CMS will pass the resolution on to the ISMS and AMA for adoption. Vemuri S. Murthy, MD, District 5 Trustee, is the sponsor.

Methods for Enforcing Rules of the Road on Bicyclists in Order to Decrease Bicycle-Motor Vehicle Accidents and Injuries and Bicycle-Pedestrian Accidents and Injuries

The Council voted to refer this resolution to the Public Health Committee for study. The sponsor, Michael R. Treister, District

Trustee, called for city stickers and state licenses for bicyclists.

DNR vs. Do Not Treat

The Council voted down a resolution that said attending or treating physicians should have the power to override a DNR if they believe a patient can be restored to a reasonably full and active lifestyle. The sponsor is Sheldon D. Schwartz, MD, District 2.

Patient Transitions and Continuity of Care

The Council reaffirmed CMS/ISMS/AMA policies that support seamless care for patients following transfer from the hospital to a nursing home, particularly the timely administration of medications. The sponsor is Sanford Franzblau, MD, District 4.

Adequate Payment for Primary Care

As a reaffirmation of CMS/ISMS policies that advocate for higher pay for primary care doctors, the Council restated its endorsement of this resolution. The sponsor is Anthony C. Delach, MD, District 8.

Creation of a Chicago Chapter of the Society of Physician Entrepreneurs

Acknowledging interest in this resolution, the Council voted to refer it for legal review before further discussion. The sponsor is John E. Vazquez, MD, District 6

Medication Management in Assisted Living Facilities


This resolution, sponsored by Rajeev Kumar, MD, District 5, was referred to the Public Health Committee for study.

Protect Physician Certification

The Council agreed to refer this resolution, authored by Makis Limperis, MD, District 5, to the Physicians Advocacy Committee for additional review.

New Resolutions on Tap

- Electronic Prescription of Schedule II Controlled Substances, by Rajeev Kumar, MD, District 5
- Prescribing Controlled Substances in Long-term Care, by Rajeev Kumar, MD, District 5
- Residents' Rights to Make Potentially Unsafe Choices in Long-term Care, by Rajeev Kumar, MD, District 5
- Interference in Medical Practice, by the Chicago Medical Society Executive Committee
- Protect Physician Certification, by Wei T. Wu, MD, District 7, and Chung J. Wey, MD, District 5

Members are invited to submit resolutions and testify before the CMS Reference Committee in person or via phone on Feb. 4 at 7:00 p.m. Call 312-670-2550 for details. Submit your resolutions via email to esidney@cmsdocs.org; or fax 312-670-3646. 

Leadership Nominations

YOUR CMS colleagues nominated the following slate of physicians for leadership positions in 2013-2014:

President-elect: Kenneth G. Busch, MD

Secretary: Clarence W. Brown, Jr., MD

Council Chair: Kathy M. Tynus, MD

Council Vice Chair:
Adrienne L. Fregia, MD

Councilors-at-Large

Neelum T. Aggarwal, MD
E. Boone Brackett, MD
Ann Marie Dunlap, MD
Brian P. Farrell, MD
Earl E. Fredrick, Jr., MD
Kuhn Hong, MD
Gerald E. Silverstein, MD
Michael J. Wasserman, MD

Alternate Councilors-at-Large

Zahurul Huq, MD
Nivia Lubin-Johnson, MD
Makis G. Limperis, MD
Vemuri S. Murthy, MD

Judicial Panel

William N. Werner, MD, MPH

ILLINOIS STATE MEDICAL SOCIETY

President-elect

William A. McDade, MD, PhD

Vice Speaker of the House:

Howard Axe, MD

Trustees

Thomas M. Anderson, MD
Kathy M. Tynus, MD

Shastri Swaminathan, MD
Kenneth G. Busch, MD

AMERICAN MEDICAL ASSOCIATION

Delegates

Peter E. Eupierre, MD
Sandra F. Olson, MD
M. LeRoy Sprang, MD

Alternate Delegates

Thomas M. Anderson, MD
Steven M. Malkin, MD
William N. Werner, MD, MPH

The next Governing Council meeting is scheduled for Tuesday Feb. 26, 2013, at 7:00 p.m., at Maggiano's Banquets, Chicago.

Patient Care is Paramount

Video scenarios generate lively discussions during this CME workshop on professionalism
By Elizabeth Sidney

THE CHICAGO Medical Society hosted an engaging, interactive workshop for both medical trainees and longtime physicians focusing on behaviors that may support or undermine a culture of professionalism in health care settings. The Nov. 27 CME workshop is designed for use in teaching institutions and by professional societies to underscore the values of professionalism and help members build their competencies in this area.

Here are workshop highlights:

Focus on Professionalism

“We assume all medical school graduates are smart,” said Aashish K. Didwania, MD, residency program director at Northwestern University’s Feinberg School of Medicine. Dr. Didwania, along with Vineet M. Arora, MD, an associate professor specializing in internal medicine at the University of Chicago, spoke as representatives from The Chicago Professional Practice Project, a partnership involving Northwestern University, U of C, and NorthShore University HealthSystem.

The two doctors showed CMS members how they use video scenarios in their workshops to improve medical training and professional conduct in the hospital. After viewing each video, participants fill out debriefing worksheets, noting both positive and negative behaviors. The presenters then guide discussion around behaviors depicted in the videos. Each video features a medical student, resident, intern, and attending physician.

Dr. Didwania explained that programs now want to know if residents are “nice,” possessing humanistic qualities, and not simply intelligent. Expanding on this theme, Dr. Arora said the U of C looked to students for answers on how to teach professionalism. When asked who they learn from, students noted the powerful influence of residents and attending physicians on their own behavior.

The workshop program generated animated conversation, with CMS members analyzing the scenarios with the two doctors. As a group they examined how certain behaviors could harm patient care or the learning environment. The direct and indirect consequences of behaviors, both in the short- and long-term, as well as a review of prevention strategies rounded out the discussion.

The Chicago Professional Practice Project is funded by the American Board of Internal Medicine Foundation to advance medical

professionalism into clinical policy and practice. The ABIM Foundation encourages a shared understanding of professionalism by physicians and physician leaders, medical trainees, consumer organizations and patients, delivery system leaders, payers and policymakers.

Hospitalists’ Influence


Medical trainees learn through informal interactions and incidents throughout the educational process, according to a study published in the September 2012 issue of the *Journal of Hospital Medicine*. The authors, who include both Drs. Arora and Didwania, argue that behavior in the hospital contributes to the hidden curriculum that shapes young doctors’ views on professionalism. Because of their frequent contact with medical trainees, hospitalists could have a major influence on residents’ behaviors and views of professionalism. To gain more insight into this possibility, a multicenter study of internal medicine hospitalists employed at the U of C, Northwestern, and NorthShore measured hospitalists’ perceptions and participation in unprofessional behaviors.

While the team found that hospitalists seldom participate in unprofessional behavior, job characteristics (clinical, administrative, night shifts), age, and site were associated with different types of unprofessional behaviors that may affect the learning environment and patient care.

Younger hospitalists, and those with any administrative time were more likely to participate in behaviors like “celebrating” a blocked admission. Hospitalists with less clinical time were more likely to make fun of others.

In their previous work, the authors of the study demonstrated that internal medicine interns reported increased participation in unprofessional behaviors such as on-call etiquette during internship. They cited examples like refusing an admission (“blocking”) and misrepresenting a test as urgent.

In 2011, the ACGME expanded its standards by making certain that the program directors and institutions ensure “a culture of professionalism that supports patient safety and personal responsibility.”

The authors suggest the use of novel curricular tools to teach residents the interpersonal and communication skills called for in the 2011 ACGME Common Program Requirements. Role modeling by attending physicians and residents is crucial, they said, along with positive contact with residents and students. 

“Role modeling by attending physicians and residents is crucial.”

“As physicians, we have so many unknowns coming our way...

One thing I am certain about is my malpractice protection.”

Medicine is feeling the effects of regulatory and legislative changes, increasing risk, and profitability demands—all contributing to an atmosphere of uncertainty and lack of control.

What we do control as physicians:
our choice of a liability partner.

I selected ProAssurance because they stand behind my good medicine and understand my business decisions. In spite of the maelstrom of change, I am protected, respected, and heard.

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The Medical Practice Act Extension

The act has a one-year reprieve but what comes next? **By William N. Werner, MD**

“The Medical Practice Act not only codifies our scope of practice as physicians in Illinois, it also set the fee we must pay to maintain active medical licenses.”

IN EARLY DECEMBER, Illinois’ Senate and House of Representatives passed a one-year extension of the Medical Practice Act with no increase in the physician licensure fees. The Act was due to sunset on Dec. 31, but will now be in effect through the end of 2013. At first blush, this may seem like a routine “rubber stamp” to extend expiring legislation, but in this case there is much more to the story.

IDFPR’s Fiscal Gap

The Medical Practice Act not only codifies our scope of practice as physicians in Illinois, it also sets the fee we must pay to maintain active medical licenses. Those fees are paid into the Medical Disciplinary Fund, which is used by the Illinois Department of Financial and Professional Regulation to pay for investigation and discipline of physicians.

The Medical Disciplinary Fund currently has only \$2.4 million and will not see a significant influx of funds until medical license renewal in 2014. Therefore, the IDFPR is seeking a supplemental appropriation of nearly \$10 million to tide the department over until the next cycle of licensure renewal. IDFPR has threatened layoffs within its medical division unless the supplemental appropriation is passed by Illinois lawmakers to keep the fund solvent. If layoffs come to fruition, they could result in lengthy delays in administrative and disciplinary functions as soon as this year.

Origin of the Shortfall

It is hardly a coincidence, however, that IDFPR is seeking \$10 million to keep the lights on until 2014. That \$10 million is just about the same amount of money that legislators have swept from the Medical Disciplinary Fund over the last 10 years—for purposes *other than the regulation of physicians*.

In light of this, ISMS is deeply concerned about the possibility of a licensure fee increase, which has been proposed by IDFPR in recent negotiations. Such an increase could have a harmful effect on medical care in Illinois. Our state is not known for being friendly to physicians, and this step would only further tarnish our reputation—a serious blow, given that already more than half of the new physicians we train in this state choose to practice elsewhere.


Illinois physicians do not want to see the state’s disciplinary apparatus fall apart, but neither do we believe it is fair to sweep our duly-paid licensure fees out of the Medical Disciplinary Fund, then ask us to pay more in the future to cover the shortfall. As of this writing, the General Assembly was expected to consider a supplemental



Dr. William Werner questions the reprieve of the Medical Practice Act.

appropriation when it returns in January.

ISMS is ready for another year of advocating for the best possible outcomes on all issues pertaining to medicine. We will keep you informed of all legislative news of importance to physicians in the upcoming session and beyond. For all the latest, be sure to watch for upcoming issues of *Weekly Rounds* and log on to ISMS’ Legislative Action Hub at www.isms.org.

William N. Werner, MD, is the president of the Illinois State Medical Society. 

EDITOR’S NOTE

The Chicago Medical Society works through the Illinois State Medical Society to influence legislation at the state and federal levels. The policymaking and legislative process begins in the CMS Governing Council, where any physician member can sponsor a resolution. After being debated and adopted by the CMS Council, resolutions pass directly to 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.

Nominate a Colleague for a CMS Award!

EVERY YEAR, at the Chicago Medical Society's Annual Dinner and Meeting in June, four member physicians receive prestigious awards from their peers. Below are descriptions of the award categories. Nominees must be members of CMS and nominations must be received by May 1.

Henrietta Herbolzheimer, MD, Annual Public Service Award

This award recognizes physicians for outstanding contributions in the local community or government. (Contributions need not be health-related.) The award communicates to the City of Chicago and Cook County the important work of physicians, while encouraging CMS members to participate in community or civic affairs. Honorees are selected on the basis of their community service. Past presidents of CMS are not eligible until five years after their term of office has ended.

Physician of the Year Award

This award recognizes local physicians for recent contributions or achievements in the field of medicine, as clinicians, researchers, educators, or leaders. Recipients are honored for improving the lives of patients locally, nationally, or throughout the world, as well as service on behalf of the medical profession.

Outstanding Student/Resident/Fellow of the Year Award

This award recognizes medical students who are most likely to become well-rounded outstanding physicians or clinicians. Recipients are honored for compassion toward patients, professional behavior, clinical and academic excellence, and service to their medical organizations and or community.

Recognizes medical residents and fellows who go above and beyond their duties, serving as role models to those they lead and educate, while exhibiting overall achievement in their field, clinical promise, innovation skills, and commitment to the medical profession and or community.

Lifetime Achievement Award

This award recognizes distinguished careers in medicine. The award honors recipients for their sustained commitment and contributions to patient care, i.e., as clinicians, educators, researchers, humanitarians, thought leaders. Also recognizes physicians' contributions to their profession.

Nomination Instructions

To nominate a physician, please provide the following information in its entirety:


- **Biographical Data.** Provide an updated curriculum vitae, or a sheet giving in 300 words or less the date and place of

birth, education, pertinent professional information, and, if desired, family information.

- **Photograph.** All nominations should be accompanied by a black and white, glossy, head-and-shoulders photo of the nominee.
- **Nomination Rationale.** List the reasons why you are nominating this physician for an award. Please list specific dates, offices held, projects, accomplishments, and so forth.

Everyone is encouraged to submit nominations. In the past, a number of nominations have come from the general public. Other nominations have been made by civic groups, hospitals, public officials, friends, medical colleagues, CMS Districts, and medical specialty groups.

There are many good physicians. Please keep in mind that these awards are not only for excellence as a physician, but also for the many things a physician has accomplished in addition to his or her professional medical work. Nominations may be made by letter, fax, or email.

To check on a physician's membership status, please call Elvia Medrano at 312-670-2550, ext. 338; or email emedrano@cmsdocs.org. Nominations may also be mailed to the Chicago Medical Society, 515 N. Dearborn St., Chicago IL 60654, Attn: Elvia Medrano or faxed to 312-670-3646, Attn: Elvia. 

Two Days in DC

YOUR CHICAGO Medical Society leaders are actively seeking your input prior to their annual visit with members of the Illinois Congressional Delegation in Washington, DC, this Feb. 11-13. As participants in the the American Medical Association's National Advocacy Conference, CMS uses this prime opportunity to relay our members' opinions and concerns about many pressing issues. When not on Capitol Hill, the CMS team participates in AMA forums and educational programs on physician advocacy.

We also encourage all CMS mem-

bers to attend this event. Participating in the National Advocacy Conference will help empower you to be an advocate for patients, the medical profession and an improved health care delivery system.

At the conference you will hear from political insiders, industry experts and members of Congress on current efforts underway to reform, refine and implement health system reform. You can take part in the discussions that will help shape the future of AMA advocacy.

This year's featured conference

speaker is Chuck Todd, political director and chief White House correspondent for NBC News and host of the *Daily Rundown* on MSNBC. The master of ceremonies for the Dr. Nathan Davis Awards will be Terry Moran, co-anchor of ABC News' *Nightline*.

CMS will make all travel arrangements for members, including hotel booking and flights. For this assistance, please call Ruby at 312-670-2550, ext. 344; or email her at rbahena@cmsdocs.org. A detailed conference agenda can be found on the AMA website at www.ama-assn.org.

Calendar of Events

JANUARY

16 CMS Insurance Agency Board Meeting The Insurance Agency Board meets quarterly to discuss insurance agency business and programs. All members are welcome to join in. 8:00-8:30 a.m.; *online*. For more information, please contact Megan at 312-670-2550, ext. 332; or mwhalen@cmsdocs.org.

16 Chicago Gynecological Society OB/GYN Jeopardy Residents from Chicago-area institutions will compete against each other as well as program directors and CGS members to test their medical knowledge. 6:00-9:00 p.m.; *Maggiano's Banquets, 111 W. Grand Ave., Chicago*. For more information or to RSVP, please contact Amanda at 312-670-2550, ext. 325 or aworley@cmsdocs.org.

18 Winter Networking Event Please join the CMS's Medical Student District, Resident District, and Young Physicians Group at this annual gathering. Heavy appetizers and open bar included. Registration is ongoing. 8:00-10:00 p.m.; *Rock*

Bottom Brewery, One W. Grand Ave., Chicago. For information, please contact Christine at 312-670-2550, ext. 326 or cfouts@cmsdocs.org.

23 CMS Executive Committee Meeting The Executive Committee 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.; *Chicago Medical Society, 33 W. Grand Ave., Chicago*. For more information, please contact Ruby at 312-670-2550, ext. 344 or rbahena@cmsdocs.org.

FEBRUARY

2 Polish American Medical Society 63rd Annual Physicians' Ball TBA; Ritz-Carlton, Chicago. For information contact Dr. Kornelia Król at 773-799-0544 or go to www.zlpchicago.org.

11-13 AMA National Advocacy Conference At this annual event, the American Medical Association holds forums and educational

programs on physician advocacy, while allotting plenty of time for members to visit legislators on Capitol Hill to voice their opinions on health care issues and concerns. For more information on the event—and how CMS is supporting its members—see “Benefit of the Month” below. *Registration is on-going*. For more information, please contact Laura Villagomez at 312-464-5606 or laura.villagomez@ama-assn.org.

20 CMS Executive Committee Meeting The Executive Committee 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.; *Maggiano's Banquets, 111 W. Grand Ave., Chicago*. For more information, please contact Ruby at 312-670-2550, ext. 344 or rbahena@cmsdocs.org.

20 CMS Board of Trustees Meeting The Board of Trustees meets every other month to make financial decisions on behalf of the Society. 9:00-10:00 a.m.; *Maggiano's Banquets, 111 W. Grand Ave.,*

Chicago. For more information, please contact Ruby at 312-670-2550, ext. 344 or rbahena@cmsdocs.org.

26 CMS Governing Council Meeting The Society's governing body meets four times a year to conduct business on behalf of the Society. The policy-making Council considers all matters brought by officers, trustees, committees, councilors, or other CMS members. 6:00-9:00 p.m.; *Maggiano's Banquets, 111 W. Grand Ave., Chicago*; no cost to members. To RSVP, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org.

MARCH

20 CMS Executive Committee Meeting The Executive Committee 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.; *Chicago Medical Society, 33 W. Grand Ave., Chicago*. For more information, please contact Ruby 312-670-2550, ext. 344; or rbahena@cmsdocs.org. 

Benefit of the Month

SAVE THE DATE! On June 13-14, the Chicago Medical Society is partnering up with the American Bar Association's Health Law Section to offer you the Physician Legal Issues Conference 2013. You'll hear presentations from experienced health care lawyers as well as from your physician colleagues about the changing practice landscape. Topics for this two-day, jam-packed conference include:

- Physician contracting
- Fraud and abuse
- Medical malpractice
- Physician wellness
- Privacy and HIPAA issues with social media
- Medical staff
- Electronic health records and HIPAA concerns
- Payment delivery models for ACOs

The conference will be held June 13-14, 2013 at the Radisson Blu Aqua in Chicago. Please contact Amy Alder, senior meetings planner, at amy.alder@americanbar.org for more information about the program and to reserve your spot. Or go to www.americanbar.org/groups/health_law. This is one conference that you won't want to miss!

classifieds

Personnel Wanted

Ob-gyn physician needed (part-time or full-time) for family planning clinic in the Chicagoland area. Please fax resumes to 847-398-4585 or email to administration@officegci.com.

Physicians needed in all specialties, including but not limited to anesthesia, urology, ob-gyn, gastroenterology, family medicine, and dermatology, for a family practice in the Chicagoland area. Part-time or full-time schedules available. Please fax resumes to 847-398-4585 or email administration@officegci.com.

Physician Care Services is seeking physicians for home visits to the elderly in the Chicagoland area. Scheduling, malpractice insurance, MA, company car provided. Please email CV to skookich@mpihealth.com or fax 708-336-7420.

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.

Office/Building for Sale/Rent/Lease

Medical office building for rent; 1006 N. Western Ave., Chicago 60622; elevator to second floor. Contact: Chris Davis 312-286-9186; or Dr. Helio Zapata 956-566-2383.

For sale: Successful, longstanding family planning clinic in the Chicagoland area. Asking price \$3.2 million. Please fax inquiries to 847-398-4585 or email administration@officegci.com. Serious inquiries only.

Downtown Elmhurst medical suites for rent, from 781-2,400 sq. ft. in the established busy Elmhurst Professional Center, with excellent parking, x-ray and lab facilities on site. Call Mickey at Prudential Realty 630-279-9500.

New medical office sublease in the Glen in Glenview. Available any day except Friday. Two exam rooms, conference room, and lab. Newly furnished, with HS Internet. One to three-year sublease. Call Cindy 847-404-3153.

Space for rent in Downtown Winnetka Professional Center. Two available suites can be rented separately or together for up to six operatories. Approximately 1,000 square feet each. Private office, reception desk, and large shared reception room. Ideal satellite location. Call 847-446-0970 or email ssdental@sbcglobal.net for details.

Welcome New Members!

The Chicago Medical Society welcomes its newest members elected in December 2012. We are now four voices stronger!

Student District

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The Secret: Loving What You Do

The hours fly by when you are passionate about your work **By Cheryl England**

WHEN LARRY Goodman, MD, graduated from the University of Michigan Medical School in 1976, little did he envision that he would end up as chief executive officer for Rush University Medical Center, an academic medical center which garnered national rankings in 11 of 16 specialty areas in *U.S. News & World Report's* 2012-13 America's Best Hospitals issue. Along with being CEO, Dr. Goodman also holds positions as president of Rush University, president of Rush System for Health, and as professor of medicine at Rush Medical College. An internal medicine and infectious disease specialist, Dr. Goodman got his first taste of administrative work when he became the assistant dean at Rush Medical College shortly after finishing his infectious disease fellowship at Rush. "After that," he says, "I had a succession of positions each with larger and larger budgets to manage. I also maintained my clinical work until becoming CEO."

In 1995, Dr. Goodman became the medical director of Cook County Hospital (now Stroger Hospital). He was at County during the planning for the new Stroger Hospital and for the creation of the Ruth M. Rothstein Core Center, one of the nation's largest outpatient centers for the prevention, care and research of HIV/AIDS and other infectious diseases and a great example of the public-private partnership between County and Rush. "County was a great place to work," says Dr. Goodman, "and I learned an incredible amount about working

in public health systems and providing care for the underserved."

In 1998, he was appointed as Rush's senior vice president of Medical Affairs and dean of Rush Medical College. In 2002 he was named CEO of Rush and president of Rush University.

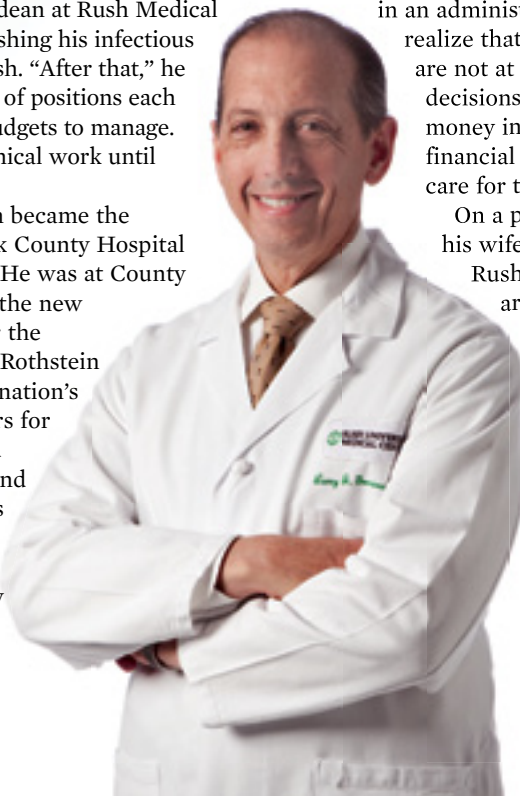
To this day, Dr. Goodman credits both his experience with the Cook County Health Services and the fact that he maintained his clinical and teaching duties as factors that have helped him to make big picture decisions that assist Rush in maintaining its reputation for quality health care and furthering its education, research and community service missions. "There is definitely an advantage to staying

tied to the clinical side of medicine while being in an administrative position," he says. "You realize that the critical business decisions are not at all separate from the clinical decisions. There is often need to put money into things that are not necessarily financial winners but are critical to health care for the community."

On a personal front, Dr. Goodman met his wife Michelle, a cancer nurse, at Rush. His two sons, Max and Samuel, are currently in law and medical school respectively. "We also have three large dogs," says Dr. Goodman. "So it's a pretty busy house!"

Despite all of his accomplishments, Dr. Goodman remains modest—especially about the hours he puts in for work. "All jobs in medicine take time," he says, "whether they are clinical or administrative. If you are fortunate enough to love what you do, no matter the job, then you'll be glad to spend the hours necessary to do it well." **C**

Rush University Medical Center CEO Dr. Larry Goodman has never met a job he didn't like—and he has put in the hours over the years to prove it.



Dr. Goodman's Career Highlights

NARROWING DOWN Dr. Goodman's accomplishments is tricky. His list of honors ranges from two awards as outstanding medical resident to awards from Rush for his long and valued service. His interest in academics began in 1980 as an academic advisor at Rush Medical College and culminated in his current position as president of Rush University. He is a three-time winner of the Phoenix Award given by the senior class of Rush Medical College to a faculty member who excels in medical education and exhibits exceptional professional and personal qualities. An accomplished author, Dr. Goodman has also won a variety of grants, including a \$1 million consortium grant from the Robert Wood Johnson Foundation for a minority medical education program. Under his leadership, Rush completed a financial turnaround before initiating a ten-year, \$1 billion campus redevelopment plan, including a new 806,000-square-foot hospital building. And, of course, Dr. Goodman has long been active in organized medicine, belonging to the Chicago Medical Society among others.

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