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Cover Art:
Pennsylvania Station, Pittsburgh
by Robert Trivus, M.D.
Dr. Trivus is a psychiatrist.
Keep talking to your patients about colon cancer screening.
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If everyone who’s 50 and older would get screened for colorectal cancer, the death rate could be cut in half*. You play a critical role in your patients’ decisions to get tested. So make it a priority to talk to your patients about getting screened. For some helpful tools, call us at 1-800-ACS-2345 or visit www.cancer.org/colonmd. This is how we can work together to prevent colorectal cancer. This is the American Cancer Society.

*Source: http://prg.nci.nih.gov/colorectal/
The energy emitted by ACM S President Terence W. Starz, M.D., is just amazing and enormous. He is connecting the dots and moving to build bridges, calling diversity strength, as he goes from meeting to meeting just like a butterfly. Soft and gentle, having a smile and a purpose, consistent and persistent. Encouraging and validating, providing guidance and energy, so readily emitted by his persona. It is beautiful to see Terry become the lightening rod of excitement, making the best out of any situation. “Listen, I am not going to spend my time fighting. I want to work with all willing to make a difference in the way we think and enrich our region,” he says, his smile sparking such discussions.

His visionary goals for prompting diversity in the professions are remarkable and very timely. Having had the opportunity to listen to his vision and then observing him tirelessly seeking input from all has been a great morale booster for many. Bringing together a very strong leadership commitment to this focus is indeed commendable. Business, architecture and legal professionals came together to discuss this very theme over the past several months. As this leadership addresses the challenges and offers solutions for promoting diversity and hence strengths, we all need to foster the ideas generated and make this theme a success for our entire region. We can, in turn, set an example for the rest of the nation in being diverse and enriched by our cultural and educational heritage. In the mechanical modes of our lives, Terry brings a breath of fresh air.

Dr. Starz has that warm personality of genuine willingness to bring togetherness among fragments. I want to take this moment to salute him and his team for creating harmony among many and therefore having the vision of a future for all of us.

With a wild and infectious smile, Terry brings among us both wisdom and strength. He challenges all of us to come together for a better tomorrow. He has selected the topic of his tenure: The subject tonight is love.

The work starts
As soon as you open your eyes
in the Morning.

Hope fully you got
Some good rest last night.

W hy go into the city or the fields
W ithout first kissing
 The Friend
W ho always stands at your door?
It takes only a second.

H abits are human nature—
W hy not create some that will mint Gold?
Your arms are violin bows
Always moving.
I have become very conscious upon
W hom we all play.

T hus my eyes have filled with warm
Soft oceans of divine music
Where jeweled dolphins dance
Then leap into this World.

—Hafiz, Shams ud din Muhammad

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.
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Trans-crypt-shun
(a case for voice recognition technology)

■ Pain unrelieved by anal cheese sticks (analgesics)
■ Bologna amputation (below knee amputation)
■ Biesenbois (B - as in boy)
■ Small open area on the left residual limb (left residual limb)
■ Thymes amputation
■ Signs amputation (for Syme’s amputation)
■ Moderate disc protrusion at the tip of T-11 level which is significantly impacting upon the thoracic heart (thecal sac).
■ Actual order on a chart: D/C cervical spine (D/C cervical spine collar)
■ All patients admitted with diagnosis of suicide must be seen by psychiatry (before or after the pathologist?!)  
■ There has been a change in his cyclotropic medications. (for psychotropic)
■ The patient required repeated Q’s in questioning to provide a history. (cues and questioning)
■ Prognosis is darted. (guarded)
■ Prosthetic cancer resection (prostatic)
■ Lower parochial plexitis (brachial)
■ His injury occurred when he was lifting heavy five-gallon buckets of pain. (paint)
■ Dx: Aggression in sleep disturbance (depression and)
■ Patient had coddle epidural steroid injection (caudal)
■ She complains of peer seizes in her hands and legs (paresthesias)

■ Surgical findings: right knee minuscule tear (meniscal)
■ The patient is tolerating his Cinnamate without difficulty. (Sinemet)
■ I consoled the patient regarding smoking cessation. (counseled)
■ He also developed a foot drop from a cranial nerve contusion. (peroneal)
■ Status post 6th rib resection (resection)
■ He exhibited no cognitive transitional movements. (no difficulty with)
■ Past medical history is significant for laparoscopic left knee surgery (arthroscopic)

Thanks to Barbara E. Swan, M.D., a physiatrist at Allegheny General Hospital, for these humorous samples taken from actual transcription records. Dr. Swan can be reached at (412) 359-4356.
An Urgent Public Health Concern

Melinda M. Campopiano, MD

In Allegheny County the leading drug of abuse is not marijuana like in the rest of the country, but opiates. Opiates are the class of drug most commonly associated with serious morbidity and mortality in people with addiction. While we have increasing rates of opiate use among young people, a shameful overdose death rate, and climbing numbers of people with Hepatitis C, new regulations have been proposed which will make the work of Prevention Point Pittsburgh (PPP) to stop this tide of death and disability largely ineffective.

PPP has been in existence in some form since the early 90s. Its mission is to provide sterile injection equipment to injection drug users in order to prevent the transmission of HIV and Hepatitis B and C. A sterile syringe for every injection also means fewer local and systemic infections. This has been proven in communities all over the country. Prevention Point Pittsburgh also provides overdose prevention and case management services including referrals to drug-treatment, medical care and shelter.

In 1995 and again in 1998 the Pennsylvania Medical Society adopted a resolution supporting the provision of sterile injecting equipment to injection drug users as an effective means of preventing the spread of HIV and Hepatitis. In 2002 the Board of Health (BOH) recognized the merits of syringe exchange as a public health intervention and suspended the state requirement for a prescription to legally possess syringes for those people who participate in PPP’s program.

Recently the County Council challenged the need for this program in our community. I believe the questions arose because of the use of emergency powers by the BOH to make syringe exchange possible. Initially the County Council demanded the suspension of syringe exchange until effectiveness studies could be conducted. It is impossible to perform an outcomes analysis for PPP because reporting Hepatitis C and HIV infections was not mandatory before PPP began operating. It is also akin to studying whether hand washing is effective at preventing the spread of infection in Pittsburgh like it is elsewhere.

In response to the pressure, the BOH has proposed restrictions for syringe exchange. At first read the restrictions may seem innocuous (see: http://www.achd.net/infectd/pubs/pdf/needlereg.pdf), but asking members of a marginalized population to provide multiple personal identifiers and coercing them to be tested for disease will only serve as a deterrent. The model currently used by PPP is known to be the most effective in reaching all members of the drug using community and should not be tampered with.

PPP provides a timely and life-saving intervention. I urge you to submit comments regarding the proposed restrictions to the BOH during the period of public comment which ends June 25th.

I urge you to submit comments regarding the proposed restrictions to the BOH during the period of public comment which ends June 25th.
Dr. Campopiano is a family practitioner and associate editor of the ACM S Bulletin. She also serves on the ACM S Board of Directors. She can be reached at campopianomm@gmail.com.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.

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Results of Bulletin Reader Survey

The Bulletin Editorial Board recently considered a change in format from black and white with a color cover, to a full-color magazine, inside and out. After considerable research and deliberation, the Editorial Board has decided to continue at this time with the magazine’s current format.

The majority of readers who responded to last month’s Readers’ Survey indicated they wanted the Bulletin to basically remain as it is now. Their responses also favored the current length of the magazine and said they preferred to continue receiving it through the mail as opposed to online. Two thirds of the respondents are active members in the medical society.

If you have any comments on the Bulletin that you would like to share with our readers, please e-mail Medical Editor Safdar I. Chaudhary, MD, at safdar3@gmail.com.

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Allegheny County Medical Society is offering free posters explaining body mass index (BMI) and showing a colorful, easy-to-read BMI chart. The posters can be used in your office to help you talk about weight loss and management with your patients.

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June is a time of transition. Medical students like me become interns, interns become residents, residents become fellows and fellows become attendings. Summer is also a time for perspective, which it seems I may have lost over my four years of medical school.

Do you remember the first time that you approached a hospital as a professional? I do. I can clearly recall arriving in Pittsburgh on my interview day for med school. As I stood on Fifth Avenue looking up at the huge medical complex that stretched on for blocks and rose into the air, I was simply awestruck. I never thought that I would be able to attend such an institution. I wrongly assumed that I could never enter its doors without feeling a sense of awe.

Do you remember your first time at the bedside? I do. Wearing my clean white coat as a second-year medical student, I wondered why this nice woman had consented to talk with me while she was in the hospital. The instrumentation surrounding her looked as foreign as a space ship, and I constantly worried that something would go wrong and I’d be to blame. She looked so fragile that I was afraid to touch her. When my time with her was up, I was ready to leave for sure.

Do you remember your first patient who died? I do. He was an 82-year-old trauma victim who had suffered massive hip injuries. While being transferred from the ER to the angiography suite, he coded; he passed away while I was doing chest compressions. When the attending ended the code and pronounced him dead, no one said a word. We just walked back to the ER and went on with our night.

That brings me to the present. Recently my uncle was admitted to a hospital that was hundreds of miles from me. On hearing the news of his illness, I transformed from an objective medical student into a worrying family member. Even though I received multiple daily updates from my parents, I was still unable to get a clear picture of what was happening from their descriptions. For weeks, I listened over the phone as he went from pre-op to post-op to ICU to palliative care. Exhausted, he finally died. On Match Day, when I found out where I would be going for residency, instead of sharing that day with my classmates, I went to his funeral and cried as I had cried for no patient in four years of medical school. Standing in the cemetery among thousands of graves, I remembered what I had forgotten. I remembered how big the hospital seemed, how patients revere their caretakers and will do everything not to offend them, how much families cherish when they are treated with honesty, and how painful the death of a loved one really is.

How do you retain your perspective when you are transitioning? How do you care completely for others when you yourself are presented with challenges that are totally overwhelming? In the face of these obstacles, how will I be the doctor that I want to be? I don’t know. The best I can offer is this: I hope that the act of recalling my experiences as a person and confronting my fears as a doctor will enable me to connect with perspectives I have lost. I hope that by remembering my first times in the hospital, I will remember that my office is often a patient’s sanctuary. I hope that when I talk with a patient or family member, I will remember that I am not only speaking to those in the room, but to all the relatives with whom they will share my words. I may not always succeed at these things, but you’ll have to forgive me—I’m in transition.

Dr. Altman is a recent graduate of the University of Pittsburgh School of Medicine who begins his Internal Medicine internship in July at Mount Sinai Hospital in NYC. He can be reached at ria1@pitt.edu.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the Bulletin, or the Allegheny County Medical Society.

The Bulletin ◆ 271
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As this is an election year, the Allegheny County Medical Society has received several inquiries concerning use of the meeting room in the ACM S building for political events. The medical society has had a policy governing this type of usage for several years, and its Board of Directors recently reaffirmed that policy. It is as follows:

The ACM S meeting facility can be rented for events or political events when sponsored by a member or members.

The event must be for a registered candidate of a recognized political party.

Such events must pay the rental fee and any ancillary charges incurred as posted at the current rate by the society. Rental information is available on the society’s website or directly from the society office. The same rates are charged to all groups including specialty societies and other related medical groups that conduct meetings at the society building.

The society will provide notice of political events to the membership when a request signed by 20 members is received. Notification is done by use of the membership e-mail addresses. E-mails shall note that the event is not an official function of the society, but a private event sponsored by physician members.

I want to stress that the medical society is a non-partisan organization whose facility is available for rental by physicians supporting any legitimate candidate for elected office. We encourage physicians to be active in political campaigns with the candidates of their choice. In the society’s work advocating for physicians on issues important to the practice of medicine, we work with all legislators on the local, state and federal level. It is unlikely that we will agree with all of the positions of any candidate or legislator all of the time, but we must work with those who are elected.

I again note that these political events are not sponsored by the society, but the board believes it important that members are notified so that they have current information and can act, whether or not they support that particular candidate.

While physicians do not always agree on issues, it is critical that they be politically active, both as physicians and citizens. The ACM S Board of Directors encourages members to study the issues, meet the candidates, evaluate their positions, work with them and, most importantly, vote for the candidate of their choice. It is our fundamental right and obligation as American citizens to do so. We believe political action by physicians is important and we try to provide them information through election issues of the Bulletin in which political candidates are invited to respond to medical issues (next scheduled for October 2006).

I hope that this addresses and clarifies our existing policy. As always, the Board of Directors welcomes any comments or suggestions for alteration.

Dr. Goodman is an oncologic orthopedist, currently serving as Board of Directors chair; he can be reached at (412) 682-8144.

June 2006
Urological association meets
The Pittsburgh Urological Association hosted a meeting on May 8 at Morton’s Restaurant. The evening program featured James B. Mondzelewski, MD, who presented Flomax: Why Urologists Love It, Why Ophthalmologists Hate It. Dr. Mondzelewski provided in-depth information on the effect of Floppy Iris Syndrome in cataract patients using Flomax.

During the business meeting, Jay Herman, MD, program director, announced the Urological Association of Pennsylvania will hold its annual meeting in Pittsburgh, July 29-30, at the Sheraton at Station Square. Guest speakers will include: Andrew Bloschichak, MD; Jeffrey K. Cohen, MD; Eric Klein, MD; C. Alan Hughes, MBA; Michael Ferragamo Jr., MD; and Sandip Vasavada, MD. The program will also include a Malpractice/Legislative Update featuring Roger Mecum, executive vice president of the Pennsylvania Medical Society. PU A members are encouraged to attend.

Dr. Herman also announced meeting dates for the remainder of 2006, including September 11 and November 6, and, in 2007, January 8 and March 12. Meeting notices will be sent one month prior to the scheduled date and will include location, topic and speaker information. For information on becoming a member of the PUA, contact Nadine Popovich at (412) 321-5030 or e-mail npopovich@acms.org.

PM S launches wellness program
The Pennsylvania Medical Society (PM S) has launched its Family Health and Wellness program, including a patient-friendly website (www.myfamilywellness.org). The program, designed to be a starting point for people looking for medical help, provides guidance on medical...
issues for Pennsylvania residents, such as aging, asthma, obesity and mental health. Contact Chuck Moran at the PMS at (717) 558-7820.

Award nominations being accepted
Nominations are now accepted year-round for the Frederick M. Jacob, Nathaniel Bedford, Ralph C. Wilde and Physician Volunteer awards. These prestigious awards recognize member physicians who have made extraordinary contributions to medicine and humanity, as well as to the medical society.

ACMS also is accepting nominations for the Benjamin Rush award that recognizes lay individuals and organizations for outstanding contributions to the health and welfare of citizens of Allegheny County on behalf of the medical profession.

Two new awards, the ACMS Community and Physician Workplace Diversity awards, have been established to recognize workplace fairness, equality and opportunity.

For more information and nomination forms for any of these awards, log on to www.acms.org or call Elizabeth Fulton at (412) 321-5030. Nominations are due at the society office by October 6.

ACMS calls for nominations
The medical society’s Nominating Committee is seeking candidates for the ACMS Board of Directors and other elected offices, including delegates to the Pennsylvania Medical Society. The committee is also looking for individuals interested in serving on the following ACMS committees: Communications, Legislative, Membership and Occupational Medicine, as well as the Bulletin Editorial and Peer Review boards.

The need for physician leadership is critical during this time of change in the medical profession. Please respond by June 30. Nominations forms are available for download at www.acms.org. For more information, call John Krah at (412) 321-5030.

Once you’ve read your Bulletin, please pass it on to a physician friend and invite him or her to join the Allegheny County Medical Society. A membership application appears on page 289 or can be downloaded at www.acms.org.
On May 12 ACMS President Terence Starz, MD, participated in a panel discussion on health care reform sponsored by the Allegheny County Bar Association's Health Law Section. Also participating on the panel moderated by John Gismondi, Esq., were State Senator Jay Costa, State Representative Mike Turzai and Beverly Holland, Esq., Governor's Office of Health Care Reform. Pictured above are (l to r): M. Theresa Creagh, Esq., chair of the ACBA Health Law Section; Senator Costa; Mr. Gismondi, Dr. Starz; Ms. Holland and Congressman Turzai.

Dr. Levine

The American Society for Aesthetic Plastic Surgery recently named Leo R. McCafferty, MD, plastic surgery, chair of its Bylaws Committee. He also was placed on the society's Legislative, New Members and 2006-2007 Program committees.

Dr. Narduzzi

The Pittsburgh Tribune-Review featured JoAnn V. Narduzzi, MD, internal medicine, as a Newsmaker in May. The YWCA of Greater Pittsburgh honored Dr. Narduzzi with a Tribute to Women Leadership Award.

Dr. Reshmi

Representing the ACM Speaker’s Bureau, Chandrappa S. Reshmi, MD, ophthalmology, spoke on common eye diseases and disorders to the North Hills AARP in May.

Dr. Upperman

Also representing the ACM Speaker’s bureau, Edward Snell, MD, family medicine, spoke on the topic of sports injury prevention at a lunchtime session in April for Nova Chemical employees.

The Western Pennsylvania Hospital appointed Christopher A. Troianos, MD, anesthesiology, chairman of the Department of Anesthesiology. He will also serve as the director of the anesthesiology residency program at the hospital.

The Association for Academic Surgery appointed former ACM member Jeffrey Upperman, MD, its information and technology committee chair. Dr. Upperman is a pediatric surgeon at the Children’s Hospital of Los Angeles, California.

Dr. Waltrip

The American Academy of Orthopedic Surgeons recently inducted Robert L. Waltrip, MD, orthopedic surgery, as a fellow during the academy’s 73rd annual meeting in Chicago. The Pittsburgh Tribune Review featured Dr. Waltrip as a Newsmaker in April for this accomplishment.

(Editor’s Note: This news item ran in the May Bulletin with the wrong photo, which also appeared with a May “Dear Doctor” column. Our apologies to Dr. Waltrip for this error.)

Send your Activities & Accolades items to the attention of Elizabeth Fulton at ACM S, 713 Ridge Ave., Pittsburgh, PA 15212 or e-mail efulton@acms.org. We also encourage you to send a recent photograph indicating whether or not it needs to be returned.

June 2006
Guidelines
The Allegheny County Medical Society invites you to enter its 2006 ACMS Writing Contest. You must be an ACMS member in good standing; editorial board members and ACMS staff employees are not eligible. Entries should be humorous in nature in one of three categories:

- Poetry (limited to 40 lines),
- Anecdote (between 500 and 750 words total),
- Short Story (1,000 to 2,000 words total)

Judging and Winning
One winner will be selected in each of the three categories outlined above; entries exceeding the limits noted above will be disqualified. Members of the ACMS Editorial Board will review all contest entries and a five-member panel will select the winners. Winning entries will be published in a fall issue of the ACMS Bulletin and the winning authors will receive a choice of a $50 cash prize or Pittsburgh Symphony tickets.

Preparing Your Entry
Please double-space your entry and print single-sided, numbering pages in the upper right corner, and include a footnote on each page with the entry category and title (i.e. “Anecdote: Cats in the O.R.”). Attach a cover containing the author’s name, phone, e-mail, category (poetry, anecdote, short story), entry title and an accurate word count. Note: The author’s name should appear ONLY on the cover page.

Entry by e-mail is preferred (attach word file) to lsmith@acms.org; or you may FAX your entry to (412) 321-5323. E-mail and faxed entries must arrive no later than Friday, August 11. You may also mail your entry on a disk (include a printed copy), or mail a hard copy to ACMS Writing Contest, 713 Ridge Avenue, Pittsburgh, PA 15212. Mailed entries must be postmarked by Thursday, August 10.

Additional Information
Entry in this contest certifies that your poem, anecdote or short story has not appeared elsewhere in either online or print form, and that the material is submitted solely for purpose of judging in the 2006 ACMS Writing Contest. The Allegheny County Medical Society assumes that you have not plagiarized or infringed on any copyrighted material and cannot be held accountable for copyright violations.

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JUNE/JULY CALENDAR


June 20, 3:30-5 pm .......... Obesity Task Force Meeting
June 20, 6 pm .................. ACMS Board of Directors
June 26, 6 pm .................. Pittsburgh Obstetrical/Gynecological Society
July 4 .............................. ACMS office closed for Independence Day
July 6, 2-5 pm ............... PMS Videoconference

Cultural Competency and Medical Diversity

Make our readers LOL (laugh out loud)
Enter the 2006 ACMS Bulletin Writing Contest
See page 277!

The John J. Kane Regional Centers honor those who promote and restore health through encouragement and activity during National Therapeutic Recreation Week from July 9th – July 15th.

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Immigration is constantly in the news today and it’s about time. If it’s true that there are 11 million illegal aliens in the United States, we have a problem. The president is sending the National Guard to the border. “Round them all up and ship ‘em out,” some people say. Others want all illegal workers who pay their taxes and a financial penalty to be put on a track to U.S. citizenship. Some argue that the illegal workers are needed and, if they were not here working, many of our businesses and services would be shut down. On the other hand, the illegal workers compete with U.S. workers for low-skilled jobs and depress the need for innovation.

This is the same discussion America had 20 years ago when approximately 4 million illegal aliens, then called “undocumented,” were legalized in an amnesty program. The amnesty brought undocumented aliens out of hiding so that they would no longer be an underclass in our society. The idea was that the humane thing was to allow those living and working and contributing to our country to get a one-time break if their only offense was violation of the immigration law. At the same time, the “magnet” of employment was going to be removed, once and for all, by the imposition of employer sanctions. The law shifted the responsibility of verifying the employment documents of new workers to the employer and imposed penalties on the employer, up to criminal penalties, for violation.

For 20 years, there have been employer sanctions for failure to properly fill out the I-9 Form and for engaging the services of aliens unauthorized to work in the U.S. My guess is that, to some readers, I-9s are unfamiliar and the existence of employer sanctions is news. The government simply did not and maybe could not enforce the employer sanctions law. So the magnet (President Reagan’s term) of employment continues to bring millions of workers to the U.S. Many employers take the limited risk of engaging their services. Recently, the stakes have been raised. There have been some high profile government raids on offending employers and some creative lawsuits. The lawsuits are private suits.
claiming RICO/treble damages against firms that gain unfair competitive advantage over their competition by employing illegal workers at reduced wages.

What does any of this have to do with the medical profession? In the first instance, according to the American Medical Association, international medical graduates from 127 countries made up 23.3 percent of all U.S. physicians in 2005. While some areas remain underserved by physicians, there are physicians who can’t get visas to come to the U.S. and others who have to wait and wait before being able to become permanent residents of the U.S. There is a disconnect between illegal and legal immigration issues.

There also is a shortage of nurses that illegal workers cannot fill. The availability of foreign nurses has slightly eased the nursing shortage, but immigration is not a panacea. Employers are often disappointed that the reality of the process is much different from their expectation. One of the problems is the difficulty in securing a non-immigrant temporary worker visa for nurses to allow foreign-trained nurses to come to the U.S. and work sooner rather than later. The U.S. Citizenship and Immigration Services has taken the position that it is the extraordinary nursing position that requires a Baccalaureate degree, therefore closing the door for nurses to come to the U.S. “quickly” in temporary worker, H-1B status. In addition, all nurses seeking an immigrant or non-immigrant visa, even those who have a U.S.-granted Master’s degree in nursing, must pass the CGFNS “Visa Screen” exam, and that is time consuming. On the other hand, Congress has recently made available enough immigrant visas that there is no delay in filing for a qualified nurse’s permanent residency.

Immigrants in other occupations are not so lucky. There are not enough employment-based immigrant visas for professionals who were born in either China or India.
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Let's take an Indian-born physician who was trained in the U.S. on a J-1, exchange visitor visa. That physician is subject to the two-year home residence requirement. To secure a waiver, a clinician will need an offer of employment to practice at least 40 hours a week in a medically underserved area or in a location that serves a medically underserved area. The process of securing a waiver, especially in Pennsylvania, is cumbersome and complex. It does however result in up to 30 J-1 physicians being recommended for waivers under the Conrad 30 program and more through the Appalachian Regional Commission.

Once the waiver has made its way from an interested government agency recommendation to the Department of State, and then to immigration for approval, the physician has 90 days to begin his or her work at the petitioning site in H-1B, temporary worker, status. The waiver is conditional on practicing three years in a medically underserved area. The H visa is conditioned on the physician being paid the prevailing wage and being credentialed with USMLE 1, 2 & 3, as well as a Pennsylvania medical license.

Usually, while the physician is working off his or her three-year obligation, the employer begins the permanent residency process. The date of filing the alien labor certification or the immigrant visa petition sets the alien's place in the long line of people waiting for a visa to be immediately available for our Indian physician. It could take years for the physician’s priority date to become current so that he or she may seek a green card or permanent resident status. There simply are not enough visas.

All one has to do is look around to see that many workers are foreign born. They are making a contribution to their employer's business and, in the case of health care professionals, making a contribution to the health of the population and to the profession they serve.

Mr. Whitehill chairs the Immigration Group of Fox Rothschild, LLP, a law firm with offices in five states and which serves as counsel to the ACM S. He is based in Pittsburgh and can be reached at rwhitehill@foxrothschild.com.
Why the above title for an editorial on disparity in health care? The reason is that unequal access to health care may be the source of most of our nation’s disparity in health care outcome. This title has also been used in the Healthy People 2010 Report coordinated by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.¹

Disparity is defined as “the condition or fact of being unequal, as in age, rank, or degree.”² The National Healthcare Disparities Report (developed by the Agency for Healthcare Research and Quality (AHRQ) presents a number of differences related to access, use and patient experience of care by racial, ethnic, socioeconomic and geographic groups based on valid measures.²

Basic Factors—The poverty cycle

Although most would attribute disparities to racial or ethnic differences, these are not the only factors. Decreasing levels of income and education have both been shown to have negative effects on health. Socioeconomic Status (SES) is the term used to represent these factors.

Low levels of income have a very significant impact on health. Poor nutrition, deficient educational systems, increased toxic environmental exposures in the home and neighborhood, stress related to violence, higher homicide rates, overcrowding, lack of access to safe play and exercise areas can contribute to poor health. Lower income levels are greater in women and people with disabilities.³,⁴,⁵,⁶ Low income is often related to lack of health insurance.

Low income rural and urban areas often are physician shortage areas. Living in physician shortage areas can result in poor access to preventative care, higher use of emergency rooms for acute care, delay in early diagnosis and more effective treatment of diseases such as asthma and cancer. Low income can affect access because a choice has to be made between paying for basic food needs or traveling to seek medical care.

Level of education is also important to health status. Higher levels of education correlate with greater likelihood of using preventive medicine and having a primary care physician. Greater education can relate to greater income, having health insurance and less delay in receiving needed treatment. Lower levels of education may be
reflected in less healthy lifestyles. Illiteracy may inhibit access to medical care, even if it is offered without cost.

Race and ethnicity are factors in evaluation of access and quality in health care. African-Americans, Asians, Hispanics, Americans Indians/Alaskan Native and Native Hawaiian and other Pacific Islanders have:
- lower rates of being insured,
- fewer sources of ongoing care,
- less likelihood of having a usual primary care provider, and
- more difficulties and delays in obtaining needed health care.

As physicians, we evaluate and treat the individual patient. If questioned, physicians would largely reply that they do not discriminate in their care. Yet, at the population level of evaluation, “minorities are more likely to be diagnosed with late-stage breast cancer and colorectal cancer compared with whites. Patients of low SES are less likely to receive recommended diabetic services and more likely to be hospitalized for diabetes and its complications...African-Americans and poorer patients have higher rates of avoidable hospital admissions (i.e., hospitalizations for health conditions that, in the presence of comprehensive primary care, rarely require hospitalization).” These reports suggest that larger issues than the individual office evaluation may come into play. Some of these may be cultural and linguistic barriers on both sides. Evidence of stereotyping of patients in expected responses to treatment has been documented. On the patient side, a culture of disadvantage, poor health, physical limitations, lack of knowledge of disease, attitudes, preferences and beliefs may coalesce to influence health-seeking behavior in a negative way.

In summation, health care disparity needs to be addressed. Obviously, attacking the poverty cycle with better education, job opportunities and safer neighborhoods is one approach. In the health care realm, improving access and quality are the key issues. Improving health care will require a three-tiered approach.

At the federal level, continuing the definition of geographic physician shortage areas (both rural and urban) will be needed. National programs are already at work setting goals to define and decrease disparities (Healthy People 2010). The AHRQ is also working to better define the mechanisms of disparity and offer suggestions.
Allegheny County Opens Allegheny Link to Aging and Disability Resources

If you have patients who are over age 60 or disabled and who need long-term services, including housing needs, they can be referred to a new resource center in Allegheny County. Allegheny County is one of two demonstration sites in the Commonwealth to operate the pilot project Aging and Disability Resource Center (ADRC). Cumberland County is the other site. ADRCs are one-stop centers for information on resources and services for people age 60 and older and for individuals with disabilities, regardless of their age, income, type of disability or ability to pay for services. By contacting the Allegheny Link to Aging and Disability Resources, callers can receive information about long-term living services and supports; referral to programs and services; benefits and options counseling; help in filling out applications for services; and follow up.

The Allegheny Link accepts walk-in referrals at the office located on the first floor of the Human Services Building, One Smithfield Street, Downtown. Telephone inquiries are taken at (866) 730-2368 (Voice) or (412) 350-5205 (TTY) from 8:30 a.m. to 4:30 p.m., Monday-Friday. ADRC is administered by the Governor’s Office of Health Care Reform (OHC) in collaboration with the PA Department of Aging and The PA Department of Public Welfare. For more information, please visit the DHS website at www.county.allegheny.pa.us/dhs/link/directmail.pdf

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FEATURE continued from page 285

for improvement. National monies for health care should support the creation of local culturally sensitive health care facilities.

At the state level, insurers have created CHIPs (child health insurance programs) to increase access to health coverage for all children. Outreach programs to increase the utilization of these programs are needed. Levels of disparity vary state-by-state. Individual states need to assess and critique the reasons for their disparity differences. States with high immigrant populations will have to address their special cultural and health concerns.

This is not just a monetary issue. Budgeting Medicaid, Medicare or CHIP dollars will not solve this problem alone. Access is more than just an economic problem. Access is a local cultural problem. Studies in Baltimore, Maryland, have shown that if local health care centers are provided in underserved areas, many health care disparities disappear. The reasons for this success are:

• Traveling is minimized (neighborhood health facility);
• having free access to a regular primary care physician increases the use of preventive medical practices like immunizations and early pre-natal care;
• regular visits are times for teaching the value of preventative medicine; and
• these local health care centers were partially staffed with persons of similar ethnic and racial composition which made for higher utilization rates of the facility (greater community acceptance).10

At the community level, support for creation and utilization of these local health care facilities in physician shortage areas needs to be generated. Financial and political support should be encouraged from the local communities and employers. These groups should work to encourage community use of the medical services. This should be applied to both urban and rural underserved communities. The goal of this program should not be just minorities but also the poor and under-educated. Local schools can also help by educating the children and their parents in the basics of good nutrition, exercise and preventive medicine.

Physicians should also support steps to decrease health care disparity. Physician political support should encourage development of local health facilities in physician shortage areas. Cultural awareness and sensitivity training should be given in medical school curricula and as CME classes for practicing physicians. Increasing the numbers of minority physicians should help as well.

Our hope for a good outcome in care should extend from our office (the micro level) to our nation (the macro level).  

Dr. Teeple is an anesthesiologist, a member of the ACMS Board of Directors and past-president of the ACMS. He is currently finishing work on his Masters in Public Health. Dr. Teeple can be reached at teeple@acms.org.

References
1Healthy People 2010 Report coordinated by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services.
2The National Healthcare Disparities Report (developed by the Agency for Healthcare Research and Quality (AHRQ).
The State of Medicine in Pennsylvania—2005

The Pennsylvania Medical Society (PMS) initiated *The State of Medicine in Pennsylvania—2005* to bring to light a number of key factors influencing health care delivery in the commonwealth. Its purpose is to provide concrete data to initiate discussion with stakeholders on policy decisions to preserve patient’s access to quality health care in the commonwealth. At the May 23 meeting of the ACMS Board of Directors, PMS President Mark A. Plasio outlined some of those key points:

✓ Medical care is the second-leading employer in the U.S. and the leading employer in Pennsylvania.

✓ Commercial insurance enrollment (excluding Medicare and Medicaid HMO) has declined from a total of 7.1 million lives in 2000 to 5.4 million lives in 2004.

✓ Pennsylvania health insurance premiums are higher than the rest of the U.S. and are increasing at greater rates.

✓ Pennsylvania hospital total net patient revenue has increased from $16.4 billion in 1998 to $23.8 billion in 2004.

✓ Pennsylvania’s physician supply suggests there could be serious challenges meeting the increase in demand for health care services. Physician payment levels in the commonwealth place recruitment activities at a competitive disadvantage compared to other states.

✓ In 2004, only 7.8 percent (down from 50.5 percent in 1994) of residents remained in the commonwealth to practice permanently.

✓ Pennsylvania has some of the highest medical liability insurance rates in the country. In 2004, the National Practitioner Data Bank documented physician liability insurance payouts of $450 million, up from $180 million in 1991.

**Conclusion**

Policymakers’ attention to important trends affecting health care will help Pennsylvania retain quality providers, maintain access to quality care for its citizens and address critical funding issues. Maintaining a robust health care economy will also retain Pennsylvania jobs and potentially attract new health care industry. Ignoring the data could lead to the exportation of Pennsylvania’s health care and medical providers to other states.

A complete copy of the report is posted at www.acms.org or can be obtained by calling (412) 321-5030.
APPLICATION FOR MEMBERSHIP

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(412)321-5030 FAX (412)321-5323
acms@acms.org www.acms.org

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M.E. #: __________________________
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Last  First  Middle

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Sex: __________________________
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Present Type of Practice:
□ Solo  □ Two Physician  □ Hospital (Non-Government)
□ Industry  □ Medical School  □ Government/Military
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Dates: __________________________

Within the last 5 years, have you been convicted of a felony crime?  □ Yes  □ No. If yes, please provide full information.
Within the last 5 years, has your license to practice medicine in any jurisdiction been limited, suspended or revoked?  □ Yes  □ No. If yes, please provide full information.
Within the last 5 years, have you been the subject of any disciplinary action by any medical society or hospital staff?  □ Yes  □ No. If yes, please provide full information.

If elected to membership, I agree to conduct myself professionally and personally according to the principles of medical ethics and to be governed by the Constitution and Bylaws of the Allegheny County Medical Society and the Pennsylvania Medical Society.

I hereby release, and hold harmless from any liability or loss, the Allegheny County Medical Society, the Pennsylvania Medical Society, their officers, agents, employees, and members, for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character and other qualifications for membership.

I also authorize the above named organizations, in the consideration of my application, to make inquiry of any of my references and institutions by which I have been employed or extended privileges, as to my qualifications. I further authorize any of the above persons or institutions to forward any and all information their records may contain and agree to hold them harmless for any actions by me for their acts.

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05/31/06 jdi

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Special Report

Eliminating Health Care Barriers for Women with Disabilities

An estimated 27 million American women are living with disabilities that frequently result in under-utilization of the most routine preventive and primary health care services. A RAND Health study conducted with support from the FISA Foundation in Pittsburgh identifies a range of financial and other barriers that impede provision of and access to appropriate health care, even for women with disabilities who have insurance coverage.1

Like all women, women with disabilities require preventive care, including regular medical and gynecological checkups, mammograms and reproductive care. However, the standard equipment made available for many routine exams is often not accessible for women with disabilities who may need specially designed chairs or tables in order to be examined. In addition, women with disabilities often have complex health needs that require them to receive care from at least one clinical specialist, and many may require care from multiple specialists and social service providers. Although effective models for providing coordinated and continuous care do exist, their application to this population has been limited. Many of the women who were interviewed for the RAND study stated that they had difficulty in accessing adequate transportation and support services, and in finding appropriately trained health care practitioners who understand the full scope of their health care needs.2

At a conference held in Pittsburgh last month, Dee Delaney, executive director of the FISA Foundation, classified five categories of barriers for this population:3

1 Physical barriers, such as mammogram machines and scales that require a patient to stand, or exam tables that can’t be lowered for wheelchair transfers. Women with mobility limitations may find it painful or physically impossible to position appropriately on basic medical equipment.4

2 Communication barriers for women with hearing or visual impairments. Essential health information may not be available in a form they can access, including Braille, large print, audio recording or simplified language.4

3 Attitudinal barriers. Disability training for providers and medical students is needed to reassess negative attitudes and faulty assumptions. Medical professionals often assume that women with significant disabilities are asexual and may fail to provide essential preventive care such as breast exams, mammograms, pap smears and screening for intimate partner violence.5

4 Economic barriers that play a significant role in preventing women with disabilities from accessing health care. Additionally, medical exams and routine procedures may take significantly more time for people with disabilities, but reimbursement does not compensate for the additional time, providing a financial disincentive to health providers.6

5 Other barriers, such as the need for medical research related to this population and lack of transportation or childcare, among others. Transportation can be a major barrier in making and keeping appointments. According to the 2000 Census, approximately 560,000 people with disabilities indicated they never leave home because of transportation difficulties.7

FISA Foundation, a local grantmaking foundation, has the mission of “building a culture of respect and improving the quality of life for three populations in southwestern Pennsylvania: women, girls and people with disabilities. During the past five years, the foundation has invested more than one million dollars in grants initiatives designed to strengthen access to and quality of health care for women with disabilities.8

If you are interested in learning more about the FISA Foundation, including a comprehensive list of commu-
nity organizations participating in the effort to improve access to health care for this population and additional resources for physicians who wish to learn more about the topic, log on to the foundation’s website: www.fisafoundation.org.

Information for this report was provided by the FISA Foundation. For more information, contact FISA Executive Director Dee Delaney at (412) 456-5550 or dee@fisafoundation.org.

References

2 ibid


5 ibid

6 ibid

7 ibid


The public may seem Far Away
Reach them through this ACMS member benefit

Dear Doctor...
Share your knowledge and expertise with the public through the Dear Doctor column, published in the Pittsburgh Post-Gazette health section on Wednesdays.

Contact Elizabeth Fulton at 412.321.5030 or log on to www.acms.org for more details.
Tobacco has been cited as the single most preventable cause of illness and death in the United States today. The most recent estimates show that approximately 22 percent of adults in the U.S. smoke. And these figures do not include those individuals using smokeless tobacco or those who have frequent exposure to secondhand smoke either at home or at work. According to the Centers for Disease Control, smoking-related illnesses in 2004 cost Pennsylvania $4.78 billion, and 20,000 lives were lost due to tobacco-related diseases.

Lack of time in a busy office practice is probably the most frequently cited reason for physicians not asking about smoking status and/or offering smoking cessation counseling. Lack of familiarity with available resources, including individual and group counseling, cessation programs, telephone Quitlines and access to pharmacotherapy—irrespective of insurance coverage—only further deter provider efforts to intervene. Other considerations include frustration with low success rate, lack of adequate reimbursement and the need to prioritize medical and psychosocial issues, including co-morbid medical problems, substance abuse and domestic violence.

Patients themselves often have little confidence that they can quit smoking, having already made multiple unsuccessful attempts to quit. The Gallup Organization showed that 60 percent of smokers have thought about quitting and 35 percent have attempted to quit. Many report not being asked about smoking habits or exposure to secondhand smoke by health care providers and are unaware of insurance coverage for counseling and/or NRT and of community resources that are available at little or no charge.

Brief interventions as short as three minutes increase cessation rates dramatically and work better than simple advice to quit. A single 5-15 minutes counseling session by a trained provider, coupled with specific self-help materials, can improve cessation rates by 30 to 70 percent. The guidelines emphasize how important it is to identify every smoker and that tobacco use be addressed at every office encounter: every visit—every time—smoking status as a fifth vital sign. Chart reminders to inquire about smoking status, documentation of smoking status and referral information for treatment options must be available at every encounter. When a “system change” is created, whereby office personnel are also engaged in this effort, there is an even greater potential for success.

Tobacco Free Allegheny (TFA) is a nonprofit organization funded by the Allegheny County Health Department and is part of the statewide tobacco control program supported by the Pennsylvania Department of Health. TFA’s mission aims at changing the community norms surrounding tobacco use, making it uncommon to use, see or be negatively impacted by tobacco use or exposure to secondhand smoke. Its comprehensive approach toward achievement of that mission is to support cessation, prevention and education activities throughout the county. Just one example of programs supported by Tobacco Free Allegheny was the development and dissemination of the tool kits for physicians over the past year; these tool kits are available at no cost to medical professionals by contacting Allegheny County Medical Society at (412) 321-5030.
Materials to assist providers in engaging patients who smoke in quit attempts include (see insert in centerfold):

**Fast Fax**
Proactive phone counseling has been shown to increase quit rates by as much as 40 percent. Providers, nurses or office support staff can use the Fast Fax form. With the agreement and signature of the patient, the patient’s name and phone number is faxed to the Quitline. The Pennsylvania Free Quitline (877-724-1090), provided by the Department of Health in partnership with the American Cancer Society, is a free telephonic smoking cessation counseling service and referral source available 24 hours/day, 7 days a week. Quitline counselors will contact the patient directly, offer resource information, set a “quit date” if requested and continue with telephonic counseling support. Pregnancy-specific counseling is available.

**Tobacco Cessation Resource List**
The resource list, by location and zip code throughout Allegheny County, was created for providers to be knowledgeable about referral sites that were conveniently located for patient access. Several programs are available in multiple locations around Allegheny County and, in some instances, the counselors will meet clients at their location of choice. Many programs offer free nicotine replacement, provided by Tobacco Free Allegheny through the Pennsylvania Department of Health.

**Clean Air for Healthy Children and Families Training Program**
This smoking cessation training program ensures that effective advice is being delivered by every health care professional to every patient who smokes or is exposed to secondhand smoke. It is appropriate for all health care providers, nurses, office staff, outreach workers, community workers and behavioral health providers. Both individual practice and group practice trainings can be arranged through the local representative of the Clean Air Program at (724) 327-2756. Trainers for the Clean Air Program will meet with office managers to help implement the program and offer on-going office support.

**Target Stores incentive program for pregnant women**
Target Stores in Allegheny County have joined with Smoke Free Mothers/Smoke Free Families Coalition and Tobacco Free Allegheny to promote efforts of pregnant women to stop smoking. Any pregnant woman in Allegheny County who enrolls and completes an approved smoking cessation program will receive a $50 gift card to Target Stores. If she remains smoke-free, as confirmed by a carbon monoxide monitor two months later, she will receive another $25 gift voucher.

Information for this report was provided by Dr. Janet Fromkin, coordinator of the Smoke Free Mothers/Smoke Free Families Coalition at the University of Pittsburgh, a project supported by Tobacco Free Allegheny. For additional information, call Dr. Fromkin at (412) 445-4017 or call Tobacco Free Allegheny at (412) 322-8321.
A disability insurance policy is usually a vital component of financial planning for physicians. Although disability insurance is essential to protect you and your family’s welfare, too many physicians either purchase too little protection or none at all. The majority of financial planning remains focused on making sure you have enough life insurance and the proper investment strategy; yet disability is four times more likely to occur than death, and years of savings can be wiped out in one year if there is no income.

Buying disability income insurance is important and choosing the right disability plan is paramount.

In the mid-1980s, professionals were usually advised to consider only non-cancelable policies with an own occupation definition of disability. Since then, good disability contracts are more difficult to find, more expensive and the underwriting process is more difficult to complete. Buying disability income insurance is important and choosing the right disability plan is paramount.

Non-cancelable disability insurance refers to a policy with provisions and cost structure that can never be changed. The own occupation definition of disability provides the insured with claims benefits if they are unable to perform their specialty as a result of a disability. For example, a surgeon who loses a finger would be considered disabled and entitled to collect full benefits, even if it might be possible to practice in a different field of medicine. So, no matter how much or how little he or she can earn in another specialty, the insurer will pay provided the insured can’t work in the original pre-disability occupation.

These liberal benefits associated with “non-can,” “your occ” policies required higher premiums from the outset. Worse than anticipated claims experience has seen the costs of these policies approach unaffordable levels. Non-cancelable policies are available from fewer carriers and only at much higher costs. Physicians who want non-cancelable coverage can find it from some carriers, but they must be prepared to face restricted benefits, increasingly stringent underwriting qualifications and higher premiums. Physicians and their insurance agents are forced to re-evaluate the appropriate features in order to achieve the needed benefits-to-value ratio. Coverage of the highest quality has little meaning if the physician is forced to buy too little protection due to its cost.

More affordable, guaranteed renewable disability plans are an attractive alternative, especially for physicians just starting their practice. A guaranteed renewable policy permits the insurance company to increase future premiums, but only with Insurance Department approval and only for an entire class of insureds. Guaranteed renewable policies cannot “single out” insureds because of consider-
The own occupation definition of total disability is another coverage feature that is increasingly difficult to afford. Since the reason a person purchases the coverage in the first place is to replace income lost in the event of an injury or disability, it may make more sense to consider an income replacement policy instead. Income replacement policies cost much less, but they only pay benefits when you lose income as the result of disability. But, in most cases, this was the physician's initial coverage goal.

Physicians who prefer an “own occ” definition of disability may want to consider a plan that switches to income replacement after several years of benefit payments. The definition of income replacement is also an important factor. You and your agent must make sure it is reasonable and that the insurer will not expect you to take any kind of work, just work in keeping with your qualifications and education.

The amount of coverage you can obtain is based on your earned income (net of business expenses). Each new policy takes into consideration other disability coverage you already have in place. Most carriers provide coverage for up to 70 percent of your income, but riders are available that could cover 100 percent of your income if you are catastrophically disabled. When reviewing your disability insurance options, make sure that you understand how the benefits “integrate” with other disability coverage, Social Security or Workers’ Compensation. Some policies (typically employer group disability plans) will reduce their payments if you are receiving benefits from elsewhere.

If you have disability insurance as part of an employee benefits package, you may think you’re protected; chances are, the benefits fall short of your real needs, paying you for a limited time, and only a limited portion of your salary. After taxes, group disability benefits typically are reduced to about 40 percent of your salary. If you pay the premiums yourself, the benefits are generally tax free.

Remember that it is important that you have some type of coverage. A physician with no disability protection accepts the full risk of a disability (100 percent of income lost), when disability strikes. So whether you choose non-cancelable or guaranteed renewable, your occupation or income replacement, you are transferring most of the risk to the insurance company.

The Allegheny County Medical Society sponsors disability coverage through USI Colburn Insurance Service. USI Colburn representatives offer both non-cancelable and guaranteed renewable plans, as well as own occ and income replacement choices. The ACM S has worked with USI Colburn to assure that they understand physicians’ needs. A qualified and experienced USI Colburn Insurance representative can help you sift through the many options available and help you decide which are most important for your situation.

Information for this report was provided by USI Colburn, the endorsed disability administrator for the Allegheny County Medical Society. For more information on disability income insurance, contact USI Colburn Insurance Service at (724) 873-8150 or (800) 327-1550, or visit www.colburn.com.
To maximize revenues to the medical practice they support, billing departments in Southwestern Pennsylvania historically have focused upon the reimbursement guidelines for Medicare, Highmark, Medical Assistance and a few commercial insurers. The three to eight percent of total annual revenue that a practice collects from patient co-payments, patient deductibles or from patients without insurance is often ignored by many practices as chump change. Those days are over...

With costs for health insurance premiums rising every year, many employers are selecting health insurance policies that carry significant co-payment/coinsurance amounts. Or, they are choosing health savings accounts, which often have lower-cost premiums but carry patient deductibles in the ballpark of $2,000 for an individual and $5,000 for a family. The cost of health care is shifting from employer to employee, and physicians will bear the brunt of this shift. No longer will the majority of patient-due invoices have a $20 balance!

This trend in the type of insurance policies purchased in the market necessitates a dramatic change in thinking for the billing department and for the practice at large. For instance, does your practice...

- instruct all patients when they schedule an appointment to bring their checkbook, credit card or debit card so they can remit their co-payment at the time to service?
- teach check-out staff how to diplomatically collect money?
- have a written policy to address a patient’s financial hardship?
- send no more than one patient statement for a $20 balance?
- inform patients who habitually ignore their past-due balances about potential consequences of their lack of payment?
- have a relationship with outside collection agencies to assist with collection duties that cannot be handled by in-house staff?

If the answer is “no” to any of the above questions, your practice is losing patient revenue, slowing down cash flow and incurring extra overhead expense. And until a documented financial policy is implemented with daily tactics in place, the practice will continue to needlessly lose money. The loss may seem to be minimal now, but it will increase in conjunction with patient out-of-pocket responsibilities.

Collecting money from patients can be an onerous task for most of us who work in billing departments. Here’s the billing department’s fantasy work process: We spend a lot of up-front time making sure that we create well-designed encounter forms, develop a reasonable fee schedule, enroll our providers in all the insurance plans with which they participate, and appropriately
The cost of health care is shifting from employer to employee, and physicians will bear the brunt of this shift.

set-up and maintain the practice management information system.

Every location that sees patients is trained to obtain accurate patient demographic and insurance information. Services are reported to the billing office the same day that they are provided, with all associated diagnosis codes, authorizations and progress notes. We submit a clean claim (electronically), receive the payment in 14-21 days and post it (electronically), and never have to get our hands too dirty. Every once in a while, a claim may be denied on a technicality (due to the insurer’s poorly programmed computer, of course), so we send an appeal letter; maybe make a call or two to our buddy in the adjudication department. The additional payment shows up three weeks later. We mail patient statements daily (electronically), but never for the visit co-payment, since that is always collected at the time of checkout. Any patient due balance is always simply for the deductible or co-insurance amount, which the patient pays within 30 days because they had already reviewed the explanation of benefits (EOB) from their insurer and had budgeted the money in advance.

This scenario is definitely a dream for some of us! But it can be real for many well-managed practices. And one trend that will put a wrench into the well-oiled, revenue-generation machine is that of the patient owing a larger portion of the fee. No longer will the patient A/R comprise less than 10 percent of the total A/R.

A medical practice that prepares for this change by creating financial policies that honor the philosophy of the physician owners while respecting the law and integrating patient collection-oriented procedures into every task that affects the revenue stream, will mitigate potential negative effects of a larger, future self-pay receivable.

Ms. Kell is CEO of the Kell Group, LLC, in Pittsburgh. She can be reached at (412) 381-5160 or dkell@kellgroup.com. Visit www.kellgroup.com.

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Several months ago, the ACMS Communications Committee received a complaint regarding a print and billboard advertising campaign promoting certain physicians’ services. In the course of discussing the content of the ads, the committee raised broader questions concerning physician advertising guidelines, ethics and the need for a policy to effectively scrutinize such complaints. “The committee quickly realized that before we could make a recommendation regarding the ad in question, we first needed to devise a fair review policy,” says Leo McCafferty, MD, chair of the ACMS Communications Committee.

AMA Code of Ethics

In 1975 the Federal Trade Commission launched an antitrust suit against the American Medical Association, asserting that the organization’s prohibition of physician advertising restricted competition and caused substantial injury to the consumer. The initial court ruling required the AMA to repeal restrictions on physician advertising. After several years of legal wrangling, the FTC won its suit and, in 1982, the AMA lifted the ban on physician advertising. Consequently, the AMA code of ethics imposes no restrictions on publicity other than providing guidelines to protect the public from false or deceptive advertising practices.

Further defining the criteria, the code states that advertisements cannot be materially misleading or mislead due to omission of information. The AMA identifies advertising vehicles that carry significant potential for deception such as patient testimonials, which might not reflect the results that patients with comparable conditions generally receive. The AMA also discourages aggressive advertising if it creates unjustified medical expectations. Likewise, physicians who profess great success in treating a large number of ailment-specific cases may be creating the misleading expectation of favorable results in every case treated. The AMA code notes that physicians who bill themselves as uniquely skilled or offering an exclusive remedy may be misleading the public because the ethical obligation to share medical advances equalizes ability and care. However, if the claim of exclusivity is true to a distinct geographical location, it is more likely to hold true.

In light of these explanatory parameters, the overriding principle in the AMA code of ethics is that advertising cannot be restricted, regardless of format or content, as long as the information provided is true and not misleading.

ACMS Action

As a result of the initial complaint and subsequent research and discussion, the ACMS Communications Committee agreed to form an official position on the issue of physician advertising and to publish information in The Bulletin regarding publicity protocol. In addition, the committee discussed with the Board of Directors the potential need of an ethics ad hoc committee to review concerns received about specific physician advertisements. The committee also wrote a resolution on physician advertising to be presented to the House of Delegates of the Pennsylvania Medical Society in October. The resolution recognizes the commitment of ACMS and PMS to truth in advertising as
outlined in the American Medical Association’s code of ethics and encourages that PMS adopt a position on ethics in advertising and develop a review mechanism to address advertising complaints.

“We do not discourage physician advertising. However, we urge physicians who advertise their services or who participate in hospital advertisements to use common sense and carefully consider the content of the piece to avoid potentially misleading the public regarding outcomes,” Dr. McCafferty says. 

Dr. Goetz is director of communications for the Allegheny County Medical Society. She can be reached at lgoetz@acms.org.

REFERENCES


ACMS Communications Committee Resolution on Physician Advertising
(To be presented to the House of Delegates of the Pennsylvania Medical Society in October)

√ Whereas, County medical societies and the Pennsylvania Medical Society are committed to truth in advertising as outlined in American Medical Association guidelines; and

√ Whereas, A renewed increase in advertisements featuring physicians recently has appeared that potentially could not be in compliance with AMA guidelines; and

√ Whereas, addressing the gray areas of advertising that could be interpreted as crossing an ethical threshold can be difficult, such a review is important; therefore be it

√ Resolved, That the PMS adopt a position on ethics in advertising; and be it further

√ Resolved, That the PMS develop a review mechanism to address advertising complaints.

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