WESTCHESTER PHYSICIAN

December 2009 Vol. 20 No. 4

From the President . . .

WCMS Official Statement Regarding Health Care Reform

John J. Stangel, MD, WCMS President
Supported by WCMS Board of Directors

(The following position statement was adopted by the WCMS Board on 11/30/09 and sent to all members via blast email and blast fax. It has also been sent to all county medical societies in New York, MSSNY and the media.)

We, as practicing physicians in Westchester County, New York, opposed the official AMA support of HR 3962, commonly known as the "Affordable Health Care for America Act", and currently strongly oppose the Senate Bill 3590.

We applaud the efforts to expand health insurance coverage for Americans, as well as reforming the insurance market to eliminate pre-existing condition exclusions and arbitrary coverage caps. We strongly support the repeal of the Medicare SGR-based physician payment formula, investment in quality improvement initiatives, and the assurance that health care decisions remain with patients and their physicians. We further praise the proposed streamlining of the insurance claim process.

AMA's support of HR 3962, without specifically enumerating the other onerous elements contained within the bill, significantly compromises our organized profession's future response to these unreasonable and potentially devastating provisions.

Further government intrusion into our healthcare system interferes with our ability to provide the best possible care for our patients. The massive legislations in both Houses of Congress threaten the very existence of many solo and small group practices in this county. With diminishing reimbursement and no recourse in the burdensome medical liability system, many of us can no longer afford to care for our patients. The consequent loss of medical office and medical facility jobs will likely drag the economy deeper into recession. It also dilutes the quality of medical care given to the public. Our profession should be allowed to practice in a free market environment, similar to our professional colleagues in dentistry, law, accounting, and business. We, as physicians, provide a critical function for society.

The House has also passed the "Medicare Physician Payment Act of 2009" (HR 3961), and the debate on all health care legislation has now moved to the Senate. This does not change our position on the current health care reform proposals. We are moving toward the endgame and the need to take a clear, strong stand is even greater. We oppose any legislation which negatively impacts patient care, unfairly and adversely affects our profession, or compromises the physician-patient relationship. Furthermore, we oppose any proposal that includes a public option for we believe it is a "Trojan Horse" for a single payer system, a model we (as well as the AMA) also do not support. *(continued on page 8)*

A Look Inside . . .

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Mark Your Calendar

January 7, 2010
WCMS Board Meeting—6:30 pm
WCMS Offices

January 11, 2010
CME Committee Meeting—5:00 pm
WCMS Offices

January 20, 2010
Ophthalmology Section Meeting—6:00 pm
David Chen Chinese Restaurant, Armonk

March 9, 2010
MSSNY State Legislative Day
Albany, NY

Newsletter Submissions Welcome

If you would like to submit an article, letter to the editor, announcement, classified ad, member in the news, etc. for publication in the ***Westchester Physician,*** the deadline for the January issue is December 31st.

Please email these to Peter Acker, MD, Editor at **Peterrba@aol.com** and Lori Van Slyke, Newsletter Coordinator at **lvanslyke@gmail.com.**

From The Editor . . . Politics and Policy

By Peter Acker, MD

The H1N1 epidemic has abated a bit giving us primary care docs a chance to catch our breaths, though as is oft said "the only thing predictable about influenza is its unpredictability" so we're not relaxing quite yet. Also, at least in my office, we are doing a brisk flu vaccine administration business which keeps our front office and nursing staff on their feet bustling around with charts and needles. As for pediatricians, we are less burdened with schedules packed with sick visits, and therefore have more free time to answer questions and disseminate information about the "swine flu" vaccine, for which the populace apparently has an inexhaustible appetite for. Those discussions coupled with the odd free moment that heretofore has not been afforded to me, have allowed me to reflect recently upon the hoary nexus between politics and policy.

Though some of our patients roll up their sleeves and with a "you're the doctor and you know best" shrug of their shoulders submit to having a long sharp needle jabbed deep into their flesh, the majority want to discuss the issue first. Some of the questioning is informed and utterly reasonable considering that the overriding issue is their own child's health and well being. With others, an insistent tone of skepticism, even suspicion creeps in; that there are various hidden agendas at work, from the government, the scientific and medical establishment, and from the pharmaceuticals. While skepticism in general is a deeply ingrained and functional human trait, it has flourished particularly in this country, with its founding history so rooted in the democratic principles of accountability and the constant questioning of authority. Our founding fathers from the very beginning, legislated in a sea of raucous debate and this tradition has remained in force to this day as witnessed by the bipartisan rancor in our congress. This is, in general, a good thing, and indeed I enjoy discussing, explaining, and persuading. But, at the end of the day, if too many people decide to leave their sleeves unrolled, I know deep in my heart that public health will suffer.

So back to the question of politics vs. policy. Several recent events have highlighted the tension between them. To wit: the two recent reports from USPSTF (United States Preventive Services Task Force) and ACOG (American College of Obstetricians and Gynecologists) that changed the recommendations for mammography and pap smear screening which were released (coincidently!) while healthcare reform was being debated. Also, the "climategate" scandal, in which hacked emails have purported to show fudging of the climate data, has provided the global warming skeptics with a huge and early Christmas gift and just before the Copenhagen conference. Unfortunately, many are instantly politicizing and producing inflammatory sound bites, rather than reflecting. Take global warming for example. I've been hearing a lot of chortling from right wing pundits and even from some of my colleagues who seem to take deep pleasure in the embarrassment that the scientific climate "establishment" is undergoing. I don't pretend to be terribly knowledgeable about the arcane data upon which predictions of global warming are based, but I can't help but be concerned. As Spencer Weart, a physicist and historian says (quoted in the NY Times) "The physics of the greenhouse effect is so basic that instead of asking whether it would happen, it makes more sense to ask what on earth could make it *not* (italics mine) happen. So far, nobody has been able to come up with anything plausible in that line." To me, it seems hubristic to assume that we can add tons and tons of carbon dioxide to our atmosphere and conclude that it must be inconsequential.

Our debate, whether about the safety of vaccines, our climate or on healthcare reform, should be comprehensive, rational, civil and with recognition of complexity. Dismissing healthcare reform as "death panels" or joking about Al Gore do very little to advance mankind's wrestling with consequential issues of the day. ✦

Commissioner's Corner . . .
Breast Cancer Screening

Maureen Bradley, RN, MS, FNP-C, Clinical Coordinator, Cancer Screening Program
Mary M. Landrigan, MPA, Administrator for Strategic Outreach
Cheryl Archbald, MD, MPH, Deputy Commissioner, Community Health

Breast cancer is the second leading cause of cancer deaths among women in Westchester County. From 2002 through 2006, an average of 153 Westchester women lost their lives to breast cancer each year.

Screening Methodologies

Routine mammography every one to two years in women 40 years of age and older is an evidence-based intervention that has received a Category B rating from the United States Preventive Services Task Force (USPSTF).

While mammography continues to be the primary screening methodology for the early detection of breast cancer, other technologies are being used in addition to mammography. Although full-field digital mammography is not significantly different from film mammography in the early detection of cancer, computer-aided detection (CAD) may enhance the sensitivity of this type of mammography. Breast ultrasound can also be utilized to detect cancer when used in conjunction with mammography for women with radiologically dense breasts.

Clinical breast exams (CBEs) and breast self-examinations are common components of preventive breast health exams, although the USPSTF considers the evidence to be insufficient to recommend their use.

Women who are considered at higher risk for breast cancer should receive breast cancer screening at early ages and may also be considered for additional screening methods. Healthcare professionals can determine a woman's risk of developing breast cancer by using one of several risk assessment tools, such as the Breast Cancer Risk Assessment Tool (**www.cancer.gov/bcrisktool**), which include family history and other potential risk factors (such as current age, personal history of breast abnormalities, age at menarche, age at the first live birth, and race) in determining breast cancer risks.

Women who have the BRCA-1 or BRCA-2 mutation also have a lifetime increased risk for breast (36 to 85 percent) and ovarian (16 to 60 percent) cancer. According to the National Cancer Institute, there are currently no standard criteria for recommending or referring someone for BRCA1 or BRCA2 mutation testing.

Promoting Timely Breast Cancer Screening

The Westchester County Department of Health encourages healthcare professionals to develop strategies to ensure their patients receive timely breast cancer screening. Chart reminders and patient recall systems are examples of techniques that have been found to increase cancer screening rates. For practices using electronic medical records, electronic reminder notifications can be developed to alert physicians when necessary preventive screenings are due. As lack of health insurance can be a significant barrier to recommended breast cancer screening, the Westchester County Health Department facilitates free or low cost breast, cervical, and colorectal cancer screening for

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Commissioner's Corner—Breast Cancer Screening

(continued from page 4)

uninsured and underinsured patients through the Cancer Screening Program of Westchester County (CSP). The CSP is a New York State Department of Health grant-funded program that works through a network of committed primary care providers, neighborhood health centers, hospitals, radiology sites, gastroenterologists, breast surgeons, and community partners to assure affordable routine cancer screening for uninsured and underinsured patients 40 years old and older.

If an eligible CSP patient is found to have an abnormal breast screening, the patient is referred to a partnering radiologist and/or breast surgeon at no-cost for a consultation and diagnostic evaluation. Uninsured patients diagnosed with breast cancer through the CSP are also assessed for eligibility in the Medicaid Cancer Treatment Program, which provides health insurance coverage and medications throughout the course of cancer treatment.

Health care professionals are encouraged to refer uninsured and underinsured patients to the CSP for facilitated access to cancer screening services through the partnership network. Uninsured women who are diagnosed with breast cancer through a private provider are also eligible to be screened for the Medicaid Cancer Treatment Program.

To promote timely follow-up of patients identified with abnormal breast cancer screening, the CSP has also received a grant from The Greater New York City Affiliate of Susan G. Komen for the Cure for the fourth year in a row. The grant allows for a clinical nurse coordinator to provide assistance in addressing financial, transportation and language barriers that may affect patients' ability to obtain the recommended diagnostic work-up.

By facilitating patients' access to recommended cancer screening, Westchester physicians can make a significant impact in diagnosing and treating cancer in its earliest stages.

For more information on breast cancer screening or the Cancer Services Program, please contact the Health Department at (914) 813-5000 or access the Department's website at www.westchestergov.com/health. ✦

Enrollment for the 2010 Medicare Participation Extended to January 31, 2010

Due to recent revisions that were made to the 2010 Medicare Physician Fee Schedule (MPFS), the Centers for Medicare & Medicaid Services (CMS) has extended the 2010 Annual Participation Enrollment Program end date from December 31, 2009, to January 31, 2010 - therefore, the enrollment period now runs from November 13, 2009, through January 31, 2010.

The effective date for any Participation status change during the extension, however, remains January 1, 2010; and will be in force for the entire year. Contractors will accept and process any Participation elections or withdrawals, made during the extended enrollment period that are received or postmarked on or before January 31, 2010.

Note: This is an extension of the annual participation enrollment period dates in CR 6637 *(Transmittal 1832 -- Calendar Year (CY) 2010 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures), dated October 16, 2009.)*

The Participation Agreement (CMS-Form 460) is available on the CD-ROM that is sent out annually by your Medicare contractor during the Annual Participation Enrollment period. Your contractor will also make the Participation Agreement available to you by placing it on their Websites with Participation enrollment (and termination) instructions. ✦

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Westchester County Medical Society's Official Statement Regarding Health Care Reform

(continued from page 1)

HR 3962 was passed without any language specifically addressing reform of the medical liability system. Instead, it inappropriately outlaws caps on attorney contingency fees and punitive damages. Any meaningful health care proposal must include tort reform to eliminate the waste inherent in our current "defensive medicine climate" as well as make the practice of medicine affordable for many of our specialists here in New York and in other liability "crisis" states.

The cost of the suggested health care proposals appears monumental. In spite of reassurances from our legislators in Congress, we believe that these proposals will enormously add to the cost of health care and will, in effect, destroy our health care system. The practice of medicine must always remain a sacred "contract" between patient and physician, and the only meaningful role for our government is to facilitate this relationship.

If this letter expresses your views, I invite you to email me at Docs4healthreform@yahoo.com and we will compile all the names of supporters and forward them to our representatives in Washington and Albany*. Please include your city or town of residence so that we can notify the appropriate legislators. Please also forward this letter to others and encourage them to contact me and support our cause.

This is the time to act. We must be heard! ✦

**We are compiling a list of all those who have responded and will be forwarding the names, along with the position statement to appropriate state and congressional legislators.*

WCMS' statement against the Health Care Reform Bill was mentioned in an article posted December 3, 2009 on the *New York Times* website. This article can be found on page 14 of this newsletter.

We Need Your E-mail Address!

The WCMS has set up a blast e-mail service so that important and timely information can be distributed to members as soon as it is received. If you would like to receive these communications, we will need your e-mail address.

If you have not done so already, please send this to us via email to **doneill@wcms.org** or you can fill out and detach this form and either fax it to **(914) 967-9232** or mail it to our office at ***333 Westchester Avenue, Suite LN01, White Plains, NY 10604:***

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News from *The Physician Consortium*

Kira Geraci Ciardullo, MD

It has been my honor and pleasure to represent the Medical Society of the State of New York at the AMA derived ***Physician Consortium for Performance Improvement* (PCPI).** This organization was brought about by the need to establish quality standards and measures by physicians for physicians. The majority of the participants are researchers, academicians and practicing clinicians in every medical specialty and subspecialty as well as primary care physician organizations.

For the most part, professional specialty societies populate this consortium and develop very fundamental measures that relate to each field of medicine. Once these measures are developed, sent out for public comment and discussion and then redesigned by the work group staffed by medical professionals, they are sent to the National Quality Forum and NCQA for review. The majority of the measures developed by physicians have been accepted and incorporated into Centers for Medicare and Medicaid as quality measures.

There is a detailed, elaborate and scientific approach to the development of the measures and yes, the statisticians are with us at all times. In very simple terms, it is first determined through a variety of sources including medical journals that there is a "gap" in care or that a specific set of guidelines are not routinely being followed. The work group does an extensive review of the literature based on agreed upon criteria to review best practices and outcomes. This information is evaluated and recommendations for measures are developed. Just recently, new asthma care measures were developed. They have been out for public comment for over a month. I hope to provide for our readership both here in Westchester and throughout the State the Internet links to all those measures that will be sent out for public comment. It is the intention to include as many physician voices as possible.

Although there has been much criticism of the use of measures to reimburse physicians and there remains much dissent about guideline use, I would suggest that physician organizations and your fellow colleagues developing these measures is far better than insurance companies or the government. Although not perfect, the consortium has impressed me with being very ethical, careful and scientific in its deliberations. Those of us who represent "the common man" in the trenches every day from the 50 state medical societies also help keep the measures relevant and appropriate to every day patient care. I have often offered the arguments that no matter how statistcially relevant a measure may be, if it cannot be implemented easily in a busy practice it is valueless. The early phases of PQRI (Physician Quality Reporting Initiative) clearly showed the frustration many physicians had with implementing the measures and also with proper reimbursement and credit for using the measures.

Yet, make no mistake about it, quality measures are here to stay. The ones I have seen and reviewed are very straightforward and would most likely be very much part of what a physician would do every day. It simply needs to be recorded as done. Those physicians who have had to work with hospital quality measure requirements are already well aware of this phenomenon.

The most recent conference I attended in October devoted an entire day to "meaningful use" of electronic medical records. Dr. Blumenthal of the Office of Health Care technology addressed us regarding HIT implementation and he was well aware of the hurdles physicians face. Apparently, the definition of meaningful use has not been "codified" and will hopefully be coming out sometime in January There is a great deal of activity now being devoted to incorporate these measures within EMR programs so that each patient visit will have a "built-in" set of critical measures that should be recorded for the visit based on the diagnosis or medical problem.

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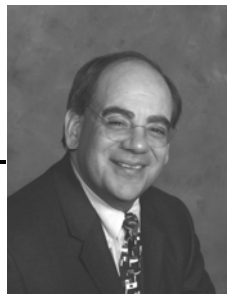
A Member's Opinion . . .

About Healthcare Reform— *Don't Sacrifice Cancer Care*



By Gino Clement Bottino, MD
Westchester Hematology Oncology Associates, Mt. Kisco

While the war on health care reform continues, there is another battle raging now: the Center for Medicare and Medicaid Services (CMS) will cut payments <u>further</u> starting in 2010 for each of the major components of cancer diagnosis and care - chemotherapy, consultations, diagnostic imaging and therapeutic radiation. Starting in January, payment for the administration of life-saving cancer drugs will be cut by 5%, with further cuts increasing to almost 20% by 2013. A disaster in cancer care delivery is imminent. Why? Because cuts already in place from the start of 2009 have reduced reimbursement levels to a level that most local Oncologists cannot already live with.

These drastic reductions in reimbursement from Medicare will undermine the quality and the availability of medical care for cancer patients in this country. Many oncologists will have to under-treat or outright refer patients away, while many will leave oncology practice. More cuts to Medicare, the federal health program for the elderly that provides care for 45% of cancer patients, will jeopardize access to cancer care only rivaled by the crisis of the underinsured.

Cuts in Medicare reimbursement to oncologists for cancer drug administration have occurred every year since 2004, totaling more than a 25% decrease in reimbursement from 2004 to 2009. Estimates are that about half of the essential services provided by community cancer facilities are currently not even reimbursed at all. Making this bad situation worse, CMS is also scheduled to cut physician-related Medicare payments for <u>all</u> physicians by an additional 21.2% effective January 1, 2010.

While many suspect this is merely a case of already overpaid doctors wanting a bigger slice of the pie, I can only share the disastrous situation of my own practice. My brother and I have run a small community oncology practice serving the Bronx, Manhattan and Westchester County for the past 30 years, and it is now on the verge of bankruptcy due to Medicare reimbursement cuts. We recently laid off staff again (from 28 staff in 2000 to 7 now), and further layoffs are imminent.

Medicare allows us a margin of 2% on the chemotherapy drugs we administer, yet it costs us 4-8% to buy and store the drugs, causing a net loss of 5-8%. In 2006 we had grown our practice to twice as many patients as in 1996 but we made only half the income. This decline has continued and we are making only 15% of what we were making ten years ago in spite of working longer hours and seeing 35-40 patients per day. (This is no joke or overestimation, it is based on my practice statistics from 1996 to now).

What this means for patients is that after manipulating and adapting to absorb decreases in reimbursements, we have no room left. Our only choice now is to make cuts that will affect patient care, or go out of practice completely. We are currently the only practice in our immediate area taking indigent and Medicaid patients, and we will likely need to stop taking any indigent and Medicaid patients going forward. We are already sending some chemotherapy patients to the county and local hospitals, which are pushing back to avoid increasing their own loss. I am seeing for the first time in 30 years, patients refusing cancer treatment, choosing less-effective but cheaper drugs and discontinuing treatment after their financial resources are exhausted.

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A Member's Opinion . . .
About Healthcare Reform—*Don't Sacrifice Cancer Care*

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Because the solution to the cancer care crisis is caught up in the health care reform debate, we have no idea how to budget and plan for what may be a drastic shortfall in cash flow in less than 30 business days. We may face combined Medicare payment cuts in excess of 25%, which is substantial considering that Medicare accounts for roughly half of all our cancer care. Yet we are still expected to support the current staff and infrastructure required to provide quality cancer care.

Ultimately, the current Medicare reimbursement cuts and the threat of future cuts will result in a shortage of providers of cancer care and will prevent cancer patients from having access to the latest advances in cancer therapy. Cancer imaging and cancer chemotherapy infusion are suffering these cuts, access to life prolonging drugs is being denied, and the reimbursement for chemotherapy is so low that many oncologists – myself included -- may have to shut down their practices. I have personally polled over 90% of the oncologists in Westchester County, and we are all on the brink of practice failure without making drastic changes in the way we practice.

As physicians, we know that our fate is inextricably tied to the fate of the U.S. healthcare system and that cost-cutting is inevitable. But Congress is trying to balance the budget by reducing access to cancer care services through drastic cuts in Medicare reimbursement, making the crisis far worse rather than resolving it.

As oncologists, we know that the rhetoric about doctors spending too much money at the end of life refers directly to us and our patients. Yes, we spend significant money on keeping our patients alive an extra 2 years, similar to the same costs and survival statistics as patients on dialysis; but of what value is another 2 years of your life worth? In 30 years of practice and thousands of patients, only 5 people over the years said "thanks, but no thanks, doc."

As professionals, how much more of this can we endure? Many of us will just opt out and retire early, or leave the area. Who will speak up for us if we do not speak up for ourselves? In particular, in Westchester County, where our overheads run very high, the cuts by CMS are a disaster! Will our own Medical Society address this or just accept Obamacare like the AMA?

We are fortunate to have the best cancer survival statistics and the best access to cancer care in the world. But Congress must fix the flaws in the Medicare system that will devastate community care of cancer patients, so the sick do not pay the price in the name of "cost savings."

I invite any and all politicians and news media to come to my office in the Northern Westchester Hospital Cancer Center to see for themselves, and verify, the current crisis in Cancer Care.✦

NEWSLETTER SUBMISSIONS

Letters, articles, comments and opinions for publication in the *Westchester Physician* are welcome.

Please email these to Peter Acker, MD, Editor at ***Peterrba@aol.com*** and Lori Van Slyke, Newsletter Coordinator at ***lvanslyke@gmail.com***.

The article below was posted on the New York Times website on December 3, 2009 and mentions WCMS' official statement against the Health Care Reform Bill.

Many Doctors' Groups Oppose Senate Bill

by Kevin Sack

Even though the American Medical Association offered some qualified support to the Senate health care bill this week, many other medical groups were unqualified in their opposition. A coalition representing 240,000 physician specialists, like the American College of Surgeons and the American Society of Cataract and Refractive Surgery, said that it "must oppose the bill as currently written."

That position, conveyed in a letter this week to the majority leader, Senator Harry Reid of Nevada, stood in sharp contrast to the one taken by American Medical Association, which also wrote to Mr. Reid. While stopping short of endorsing the bill, the A.M.A. letter expressed support for its central elements and then listed a variety of "serious concerns" for consideration during the ongoing floor debate. The group had previously endorsed the health care legislation that passed the House last month.

But outright opponents include the California Medical Association, which represents 35,000 physicians. It declared this week that it would oppose the current Senate legislation, joining counterparts in Texas and Florida that took stands in late November.

In the New York region, the Westchester County Medical Society announced its opposition, and directly confronted the AMA.

In a statement released on Wednesday, the Westchester society's president, Dr. John J. Stangel, criticized the Senate bill's inclusion of a new government insurance option and the absence of measures to make it harder to sue doctors. The A.M.A.'s support, he wrote, "significantly compromises our organized profession's future response to these unreasonable and potentially devastating provisions."

The letter that the surgeons and other specialists sent to Mr. Reid took issue with a laundry list of provisions in the Senate bill, including the establishment of a Medicare advisory board with the authority to set reimbursement policy, increased reporting on physician errors and outcomes, an excise tax on elective cosmetic surgery, and measures that might boost payments to primary care doctors at the expense of specialists. Each of those were also among the concerns cited by the AMA.

Also like the A.M.A., the specialists said they supported many underlying changes in the bill, like prohibiting health insurers from denying coverage because of pre-existing health conditions.

The California doctors emphasized the Senate bill's failure to make adjustments in a Medicare payment formula that would otherwise result in deep cuts in physician payments in coming years. The House passed a measure last month to avoid the cuts. "There is no way health care reform can work if patients can't get access to a doctor," said Dr. Brennan Cassidy, the California group's president. "The Senate bill fails to fix major problems in Medicare and Medicaid, which currently suffer from chronic underfunding that undermines access. ✦

News from *The Physician Consortium*

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I must say as I struggle with adapting to an electronic record in my office, I miss those moments in the patient visit where intuition and simply talking could reveal more about a diagnosis than doing the arithmetic and checking off those objective parameters. And as much as I truly understand the need to do the right thing at the right time for the right patient, maybe there can yet be a measure design that would account for that "quality time" I give my patients.

I hope to keep you updated on my activities at the Consortium and help you understand the truly outstanding work that is being done by your colleagues. ✦

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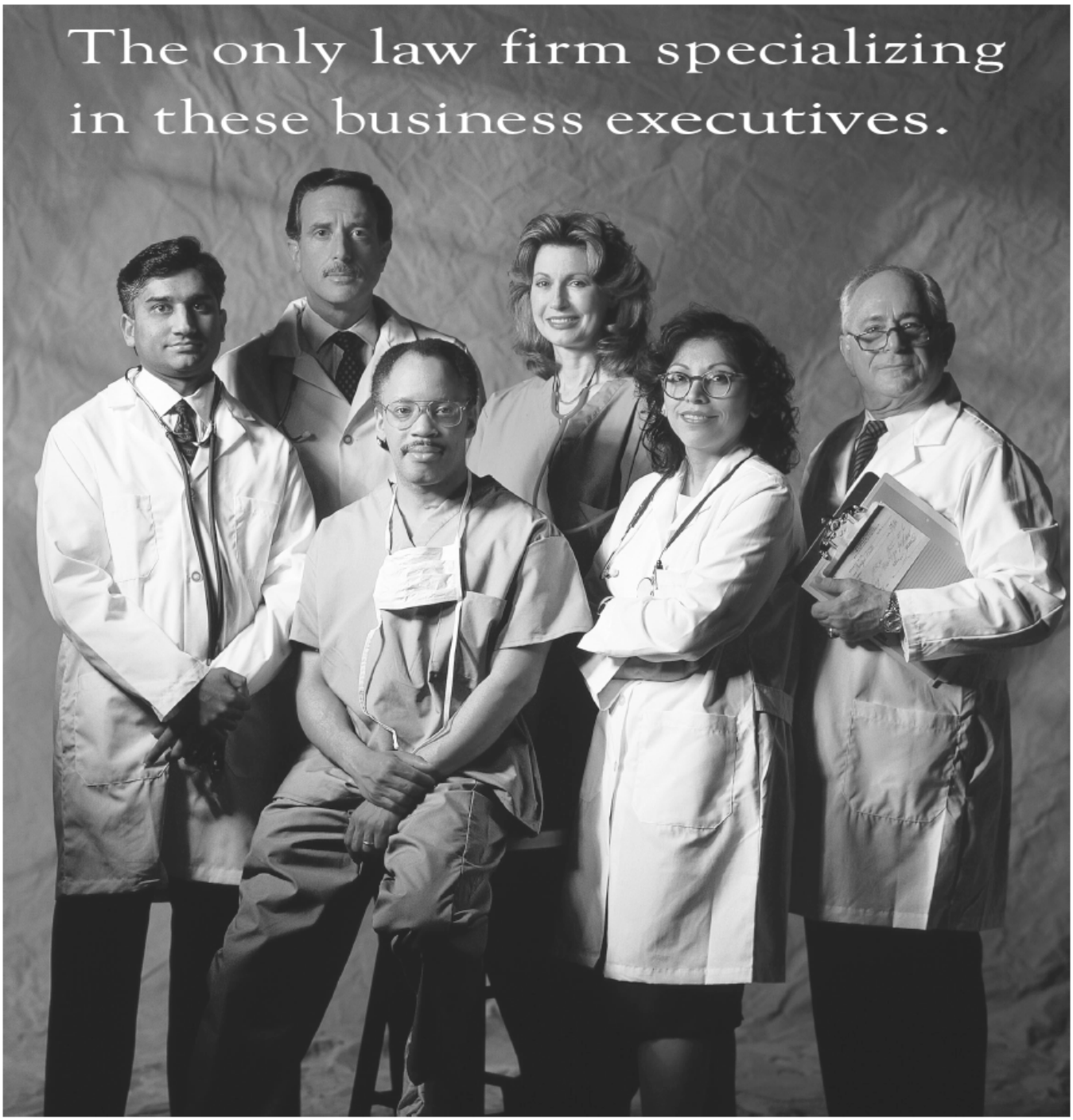
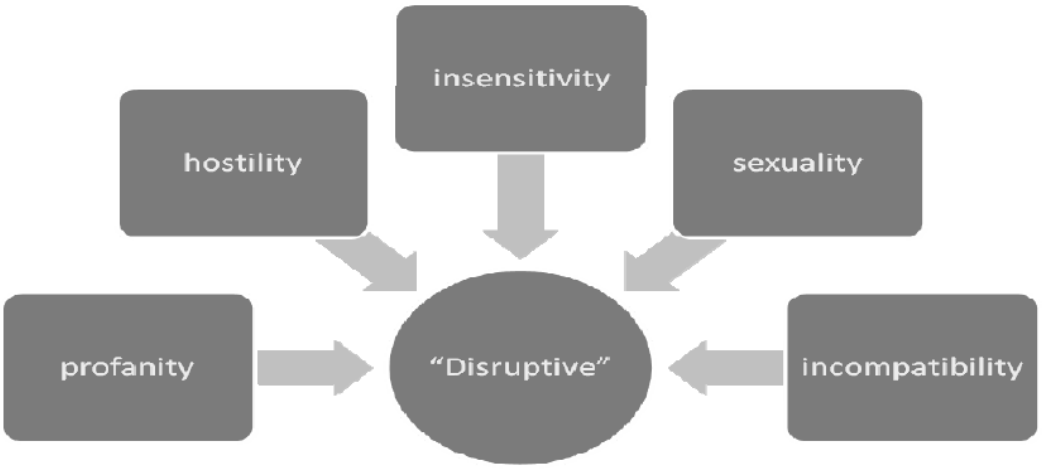


Abusing the False Label of "Disruptive" in Today's Medicine

By Michael J. Schoppmann, Esq.
Kern Augustine Conroy & Schoppmann, PC

The impact of being branded by a "Scarlet Letter" in Nathaniel Hawthorne's time pales in comparison to what is wrought upon unsuspecting practitioners labeled as "disruptive" in today's medicine. Virtually irremovable once affixed, the brand of "disruptive" can summarily ruin an otherwise brilliant medical career and should prompt every practitioner to immediately, and aggressively, risk manage their practice to avoid even the inference of any such status.

"Disruptive" - defined in countless fashions throughout medical staff bylaws, employee manuals/handbooks and other governing rules and/or regulations - is basically any style of interaction with practitioners, hospital personnel, patients, family members, or others that is deemed to interfere with patient care. While no one questions the need for the orderly administration of patient care, the abuse of that worthwhile goal is revealed when one considers the stunning breadth of "any style of interaction" – interpreted by some to include even facial expressions, tone of voice and/or body language.



Equally disturbing is the question of who will hold the power to "deem" such interactions to be disruptive? Does that person hold inappropriate (*i.e.*, economic, personal, etc.) or appropriate motivations? Further, and in essence, is there anything that cannot be "deemed" to "interfere with patient care"?

The overly broad and unduly vague nature of such a label as "disruptive" can only lead to further misuse and greater abuse against practitioners. In order to begin to risk manage such a threat, every practitioner should immediately obtain, review and challenge, if necessary, the following from their employer and/or their medical staff:

- Any all Code(s) of Conduct
- Any Employee Handbooks/Manuals
- Any Medical Staff By-Laws
- Any Departmental Procedures and Protocols

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Abusing the False Label of "Disruptive" in Today's Medicine

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If any standard therein is poorly defined, unworkable in its vagueness or subject to self-serving interpretation, it should be challenged immediately through any means or mechanisms available (*i.e.*, the offices of the medical staff, human resources, union representatives, contract revisions and/or seeking new employment/affiliation). If accepting of the "behavioral standards" in either an employment setting or as a member of a medical staff (or both), every practitioner must orchestrate and maintain unwavering compliance with those standards or run the risk of being adversely and permanently labeled as "disruptive".

In the event of an investigation of his or her conduct, every practitioner must be made aware of the fact that **no** investigation (even those couched as "informal" or "internal") is brought that does not carry the potential for serious and irreparable professional damage. Therefore, **no** practitioner should (1) allow a complaint to go unaddressed and/or unresolved or (2) attend a meeting concerning their status (either as an employee and/or medical staff member) without first knowing (a) who will be attending; and (b) the topics to be discussed.

Every practitioner who attends such an investigative meeting should (a) take careful and copious notes of what is said and by whom (b) demand an opportunity to weigh what has been presented and respond at a later point – possibly in writing and (c) never be coerced into signing any document or documents at such a meeting.

Moreover, if an investigation is concluded in the practitioner's favor, that disposition should be committed to writing, provided to the practitioner and secured in the practitioner's relevant file (*i.e.*, employee, medical staff, etc.) in order to accurately, and permanently, reflect the practitioner's tenure and standing.

In conclusion, every practitioner's ability to avoid the label of "disruptive" rests with whether he or she is willing to proactively secure a firm grasp of the standards by which such an adverse judgment may be placed and either abide by those standards, initiate the effort to change the standards or remove themselves from a climate in which the standards only serve to enable adverse action against the practitioner. To remain silent, unaware or uninvolved will only serve to empower the structures which seek to abuse the intentions, process and goals of those who honorably seek to address the truly "disruptive" practitioner. ✦

References: ***American Medical Association (AMA) Policy:*** *H-140.918 Disruptive Physician. www.ama-assn.org.* ***Joint Commission on Accreditation of Healthcare Organizations (JCAHO):*** *Behaviors that Undermine a Culture of Safety: Standard LD.03.01.01. www.jcaho.org.*

Kern Augustine Conroy & Schoppmann, PC, Attorneys to Health Professionals, www.drlaw.com, has offices in New York, New Jersey, Florida and Illinois. The firm's practice is solely devoted to the representation of health care professionals. Mr. Schoppmann may be contacted at 1-800-445-0954 or via email - schoppmann@drlaw.com.

REMINDER: In celebration of the holidays, the the WCMS/WAM offices will be CLOSED from ***Friday, December 25, 2009 to Monday, January 4, 2010.***

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