Westchester Physician

June 2013 Vol. 28, Issue #6

President's Message

"Reflecting on a Great Year"

By Thomas T Lee, MD, FACS, WCMS President

The following remarks were presented by outgoing president, Thomas T. Lee, MD, at the WCMS Annual Meeting, June 7, 2013.

It has been a great year for the Westchester County Medical Society. We have 170 attendees for this wonderful gathering. This event would not have been possible without the support of our business partners, sponsors, members, and friends. I would especially like to acknowledge my wife Margaret and my three children for their understanding and support over the past year. It has been my honor and privilege to work with the Officers and Directors of the WCMS and staff, whom I will individually acknowledge. I would like to thank President-elect Dr. Robert Lerner, Immediate Past President Dr. Abe Levy, Vice President Dr. Louis McIntyre, Treasurer Dr. Robert Ciardullo, Secretary Dr. Howard Yudin, and Westchester Academy of Medicine President, Dr. Joseph Tartaglia for their support and input on the Executive Committee and the Board. This year would not have been possible without the capable administrative team of our Executive Director Mr. Brian Foy, Membership & CME Director Karen Foy, Bookkeeper Rhonda Nathan, and our Counsel, Mr. Don Moy from Kern Augustine Conroy & Schoppmann. Amongst us are MSSNY officers and trustees who have served as past WCMS presidents: MSSNY Trustee and MSSNY Past President Dr. Michael Rosenberg, MSSNY Trustee and past Speaker Dr. Mark Fox, President-elect Dr. Andy Kleinman, House of Delegates Vice-Speaker Dr. Kira Geraci-Ciardullo, and Ninth District Councilor Dr. Bonnie Litvack. We also have the pleasure of having among us past WCMS presidents Drs. Robert Soley, William Walsh, Peter Liebert, and Al Tinger.

Last year, I set out to focus on stabilization and diversification of our membership base, improvement of revenue through academy and membership functions, and sharpening our legislative focus through collaborative efforts with our partners in health care. I believe we were able to achieve many of our goals in twelve short months.

WCMS remains at the fore-front of state healthcare legislative efforts as demonstrated by our ongoing legislative achievement. This past year, the WCMS Legislative Committee worked with MSSNY, other county medical societies, specialty societies, and state legislators from both sides of the aisle to move legislation to protect out of network benefits. The issue was highlighted by the Senate passage of the bill in 2012 and re-introduction in 2013, as well as its inclusion in the Senate budget early this year. I visited Albany on many occasions this past year for legislative meetings with various Senate and Assembly leaders, as well as Department of Health (DOH) and Department of Financial Services (DFS) leaders to help advance the Society's legislative agenda including: defeat of adverse

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A Look Inside . . .

The Westchester Physician

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(914) 967-9100 / FAX (914) 967-9232

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Upcoming Events
Mark Your Calendar

Monday, June 24th - 6:00 pm
Advanced Certificate in Medical Practice Management Information Meeting

Tuesday, June 25th - 6:30 pm
Affinity Group Seminar

Wednesday, June 26th - 6:30 pm
Affinity Group Seminar

Thursday, September 5th - 6:30 pm
WCMS Board of Directors

Monday, September 9th - 5:00 pm
CME Committee Meeting

Thursday, September 26th
(see page 12)
Academy Golf Outing, Dinner and Fundraiser at Westchester Country Club

Newsletter Submissions

Members are encouraged to submit articles, letters to the editor, classified ads, members in the news, etc. for publication in the Westchester Physician.

The deadline for the July/August 2013 issue is July 12th.

Please email your submissions for review to Karen Foy, Managing Editor @ *kfoy@wcms.org*

WCMS Blast FAX & Email Service

If you have not been receiving WCMS blast FAXES and emails, we may not have your correct fax number or email on file. This is how we communicate with our members on important and timely issues, including legislative alerts and upcoming events. Please update this information by sending it to Karen Foy at *kfoy@wcms.org*. Your information will be used for WCMS communications only and will not be shared with third parties.

From The Editor
"Reaction to Gunplay"

By Peter Acker, MD

My column entitled "Gunplay" garnered some reactions which were published in last months "Westchester Physician." One (Dr. Martin Lederman) raised the legitimate question as to whether my piece was too overtly political. I gave the matter a lot of thought and responded to him in a letter which I have reproduced below. Dr. Lederman, by the way, just returned from a medical mission to Nepal and he was kind enough to write an account of his mission work which you will find in these pages.

"I always appreciate feedback and your recent letter with its point eloquently and gently stated, certainly stimulated me to think! Your point in some ways is well taken. My column traditionally has been about the day to day experiences and impressions of a physician – a perspectival look at the world through the lens of one physician. It usually, but not always had some sort of direct connection to medicine. For example, several years ago I wrote a column entitled "Letter from Holland" which commented on how bicycle friendly the country was and proffered that there was a connection between the lack of obvious obesity among the populace and the extensive use of bicycles. Arguably this could be construed as a political observation, i.e. changing infrastructure to accommodate more bikes would be a political process with opinions on both sides. There is no question that the point was more implicit than what I delivered in "Gunplay" and I concede that I did let my passion run away a bit. But embedded in the column is the simple point that guns constitute a public health issue which directly affects the health of those in my purview, the children who have no power and are in every sense of the word, innocent. So, for example, if a Florida pediatrician is enjoined from making an inquiry about guns in the household for the express purpose of assuring safe storage and thus lessening the chances of a firearm injury to a child, is this simply politics?

I will make another point about politics before dealing with your essential objection which was about the appropriateness of my column's venue. There is, I think, an arc of history which I believe in the long run is progressive. For example, in the 1840's, slavery was a "political" issue that "reasonable" men could disagree about. In 1900, women's suffrage – ditto. Today, gay marriage is a highly charged political issue. I would predict in another generation it will go the way of slavery and woman's suffrage. All of these share the aspect of subjugation of certain portions of society. It may be hubristic, but I think that common sense gun regulation will one day be just a part of the normal fabric of our society, just as seatbelts are and the result will be fewer pediatric deaths.

Now to the main point of your letter! I will concede that a regular reader of my column may have found "Gunplay" jarring. I considered this, but decided in the end that putting something out with a very strong point of view was within the parameters of a publication that states in it's letterhead that the articles represent the opinion of the author and not that of the medical society. However, I will assure you that it is not in my nature to harangue very often!"

♦

One World One Vision
By Martin E. Lederman, MD

A seven year old Muslim girl is in my examining room in an Eye Clinic in Mombasa, Kenya. I am part of a teaching mission sent by "One World One Vision" to the "Lighthouse for Christ" in Mombasa. The Chief of Ophthalmology of the facility is at my side. The girl has severe strabismus which, in her culture, makes it difficult, if not impossible, for her to marry. Kenya, a country of over forty five million, has a population of individuals with strabismus of over nine hundred thousand. One World One Vision is a non-profit organization of committed individuals dedicated to reducing vision loss resulting from ocular misalignment (strabismus) and pediatric cataracts. Its outreach is global with emphasis on developing countries whose affected citizens, many of whom are children, have little or no access to effective care. Strabismus in children causes severe visual disability including loss of vision in one or both eyes, lack of binocular vision, lack of depth perception and abnormal visual field. The social aspect of strabismus, particularly in developing countries, is much more severe. Social ostracism, reduced marriage prospects and reduced employment are just a few of the social disabilities faced by persons with strabismus. As one individual said to me years ago (the Vice President of a regional bank) "my job is to discuss loan applications with good customers. If I cannot look that individual in the eye, they will not trust me and will go elsewhere."

Having been part of missions to developing countries for over twenty years, I have heard that social concern voiced many times. Interestingly, the prejudice that exists in certain areas against individuals with strabismus is societally based. For example, Ulysses S. Grant, the General and President of the United States, was married to a woman with severe esotropia. She refused surgery and he loved her despite her visual disability which others had said was quite disfiguring and painful to look at. Mesoamericans in the pre-Columbian age were said to encourage esotropia in children which was thought to be especially attractive. Unfortunately, many individuals in our world do not enjoy that special status. On a mission to Panama several years ago, several children brought for surgery could not be safely operated upon as they were so malnourished because their parents were not feeding them properly.

"One World One Vision" was formed in order to teach evaluation and treatment techniques in order to multiply, many fold, treatment opportunities for afflicted individuals. Missions have been completed in Belize, Kenya and, most recently, Nepal with planning for other missions to other parts of Africa, South East Asia and Central America.

The seven year old Muslim girl had surgery in Mombasa to correct her strabismus. The surgery was successful and her father said to me "you doubled her dowry." The smile on his face was all the payment that I needed!

♦

(continued from page 1) President's Message
medical liability bills; funding restoration of Excess malpractice premium; defeat of retail clinic authorization; as well as advancement of the out of network transparency and adequacy legislation. Such efforts were made possible by the continued viability of MSSNY-PAC, and I urge you to contribute to this very important cause.

Our Society has a strong tradition of diversity and inclusion and this past year highlighted the above tradition. Putnam County Medical Society (PCMS) finalized its administrative service agreement with our Society and their Board and PCMS members have been involved in our Society functions since September. With the efforts of many, we consummated the first institutional membership in this county. Our Society serves physicians of all stripes and has grown its membership by 400 members this past year.

With the membership drive, increased CME activities and revenue, streamlined operation, and expense reduction, the Society was able to balance its books in a very difficult economic environment. At the same time we preserved and even enhanced our many membership activities including last year's annual meeting, summer membership pool party, fall legislative brunch, Holiday party, March Lobby Day, and now this annual meeting. We must continue to grow in order to serve our membership and profession. Our persistent efforts this past year assured the future financial viability and success of the society.

In closing, I greatly appreciate the ongoing support of our sponsors and friends. Much remains to be done by this great Society for its physicians and the patients they care for. I ask for all physicians' continued participation and involvement in this great Society to preserve our honorable profession. Thank you.

♦

In Memoriam

Guus L.N.D. de Laive, MD passed away on April 1, 2013.

Renew Your Membership Now!

If you haven't already done so, please renew your membership now! Your continued support enables the WCMS to continue their advocacy and programs on your behalf.

To pay your dues on-line go to www.mssny.org or you may call Karen Foy, Director of Membership, at 914-967-9100.

Legal News

Hospital Self-Insurance Fund Lacking

The Medical Society of the State of New York (MSSNY) has requested that the Governor look into the issue of hospitals self-insuring against medical malpractice claims and whether the hospital self-insurance fund is adequately funded. MSSNY's request was made as the result of joint legal filings made on behalf of a group of approximately 50 hospital-employed attending physicians and the Committee on Interns and Residents, on behalf of hospital Residents (collectively, the "Doctors") in connection with the Chapter 11 bankruptcy petition filed by Interfaith Medical Center (IMC) in December, 2012, in the U.S. Bankruptcy Court in Brooklyn. IMC had promised it would continue to provide medical malpractice claim coverage for services provided by the Doctors to IMC patients through IMC's self-insurance plan, allegedly to induce the Doctors to remain at IMC during the post-bankruptcy filing reorganization. The Doctors assert that IMC now acknowledges that its self-insurance fund is not sufficiently funded to pay anticipated claims. The Doctors have asked the Court for allowance of Administrative Expenses (claims that are provided a first priority in distribution) seeking to compel IMC to provide for medical malpractice coverage for the Doctors for post-petition claims. A hearing on the Doctors' motion was set for May 20, 2013.

CMS Proposes Changes to Incentive Reward Program & Enrollment

CMS has issued a rule proposal increasing the CMS Incentive Reward Program potential reward amount, for information on individuals and entities who engage in acts or omissions resulting in sanctions, from 10% of the overpayments recovered in the case or $1,000, whichever is less, to 15% of the final amount collected applied to the first $66,000,000 for the sanctionable conduct. The proposal also revises the Medicare enrollment process to further protect against program fraud by: 1) expanding the instances in which a felony conviction can serve as a basis for denial or revocation of enrollment; 2) enabling CMS to deny enrollment if the enrolling physician, provider or owner had an ownership relationship with a previously enrolled provider or supplier that had a Medicare debt; 3) allowing revocation of Medicare billing privileges if the physician or provider has a pattern or practice of submitting claims for services that fail to meet Medicare requirements; 4) providing a 60 day limitation on the period in which a revoked physician can submit claims for services furnished prior to the revocation letter's date; 5) make re-enrollment bars effective beginning 30 days after notice of revocation; 6) allowing physicians only one chance to correct all deficiencies that serve as the basis for revocation through a Corrective Action Plan; and 7) clarifying that physicians enrolling as ordering/referring providers do not have Medicare billing privileges and cannot bill Medicare.

Sepsis Protocols Required

The New York State Department of Health has adopted regulations, effective May 1, 2013, that require the medical staff of each general hospital to adopt, implement, periodically update and submit to the Department of Health evidence-based protocols for the early recognition and treatment of patients with severe sepsis and septic shock ("sepsis protocols") including components specific to the identification, care and treatment of adults and of children. According to the DOH, the mortality rate from sepsis (between 20 and 50%) depends largely on how quickly patients are diagnosed and treated. DOH will publish guidance to assist facilities in developing protocols that include an appropriate process for screening all patients to ensure early recognition of sepsis and establishing clear timeframes for administration of antibiotics and full protocol implementation. ♦

AMA NEWS

Deadline for Avoiding 2014 E-Prescribing Penalty is June 30

In 2014, a Medicare payment penalty of 2 percent will be applied to individual eligible professionals or group practices participating in the Electronic Prescribing Group Practice Reporting Option (GPRO) if they are not successful electronic prescribers. CMS will automatically exclude from the penalty those professionals and group practices who meet the criteria listed in the Electronic Prescribing (eRx) Incentive Program: 2014 Payment Adjustment Fact Sheet. Individual eligible professionals and groups participating in eRx GPRO who were not successful electronic prescribers in 2012 can avoid the 2014 payment adjustment by meeting the specified reporting requirements between January 1 and June 30, 2013.

Clinicians also can apply for hardship exemptions, which include: (1) practicing in a rural area without sufficient high-speed Internet access; and (2) being barred by local, state, or federal law from e-prescribing. The deadline for hardship exemption applications, accomplished by including a G-code on a Medicare claim, is also June 30. Significant hardships associated with a G-code may be submitted via the Communication Support Page or on at least one claim during the 6-month 2014 eRx reporting period (January 1 – June 30, 2013). If submitting a significant hardship G-code via claims, it is not necessary to request the same hardship through the Communication Support Page. Please note that the hardship exemptions for achieving Meaningful Use or demonstrating intent to participate by registering in the Medicare or Medicaid Electronic Health Record (EHR) Program by June 30, 2013, will be automatically processed by CMS. Therefore, entering a hardship exemption request through the Communication Support Page will not be necessary. More information about avoiding the Medicare e-prescribing penalty is available on the CMS Website.

Sequester Guidelines Issued for Medicare Advantage Plans

Recently, CMS sent a memorandum to Medicare Advantage and stand-alone Part D prescription drug plans to advise them that their per member per month payments are being reduced by 2 percent due to the budget sequester. The memo states that, to offset the sequester cuts, plans "are not permitted to modify the currently-approved benefit or cost sharing structure in any way. This includes increases in premiums or cost sharing, or reductions in benefits in an attempt to offset the lower payments due to sequestration." It also states that whether and how the sequestration affects Medicare Advantage plan payments made to contracted providers is governed by the terms of the specific contract between the plan and the provider; further, plans must continue to follow the prompt pay provisions established in their contracts. Go to www.ama-assn.org/go/regrelief and click on Medicare Advantage to view the memo. ♦

WCMS Board Highlights - May 2013

At its meeting on May 2, 2013, the WCMS Board...

- Welcomed **Susan Northover, Regional Account Director, and Ravi Patel, Account Manager, Visiting Nurse Service of New York (VNSNY),** who presented to the Board regarding the many services available to physicians through VNSNY. The Board was very appreciative of the presentation, asked many questions, and thanked VNSNY for sponsoring the meeting and agreeing to support the June Annual Meeting.

- ***Approved a recommendation from Louis McIntyre, MD, Vice President that the WCMS partner with the Hagan School of Business, Iona College, in offering physicians an opportunity to earn credits toward an "Advanced Certificate in Medical Practice Management."*** A series of masters-level courses will be offered in the business of medicine. The first course will start in late August. WCMS member physicians will obtain a discount on tuition and books. More information, including registration, forthcoming in June.

- Received the report of the President of the Academy, Joseph Tartaglia, MD, which included confirmation that **the 2013 Academy Golf Outing and Fundraiser will be held on Thursday, September 26th at Westchester Country Club.** Further information will be sent to the membership starting in June. ***Save the Date!***

- Received the Report of the Audit Committee as presented by Peter Liebert, MD, Chair. Dr. Liebert reported that the Committee met with the Auditors to debrief this year's audit and that the Committee, satisfied with the clean audit report, is recommending approval. ***The Board approved the 2012 Audit report as presented and thanked Dr. Liebert, his Committee and Brian Foy, Executive Director, for their prudent stewardship of the WCMS and Academy resources.***

- ***Approved the Report of the Membership Committee,*** **welcoming four (4) new regular members and five (5) Resident members.** *The Board also observed a moment of silence to note the passing of Abraham Halpern, MD, age 88, long-time member and former Chair of the WCMS Ethics Committee.*

- Reviewed a list of unpaid WCMS members for 2013 and agreed to make phone calls encouraging renewal and support of WCMS/MSSNY. Board members were encouraged to stop by the WCMS and make calls the week of May 13-17.

- ***Congratulated the following WCMS Board Members who were elected to MSSNY Office at the April MSSNY Annual Meeting: Andrew Kleinman, MD, President-elect; Kira Geraci-Ciardullo, MD, Vice Speaker; Mark Fox, MD, Trustee; Bonnie Litvack, MD, 9th District Councilor.***

- Heard an update from Brian Foy, Executive Director, regarding the upcoming Annual Meeting, June 7, 2013, at Westchester Country Club. *RSVP required!* He also reported on the summer office renovations, including new paint and carpeting, all included with the new lease. ♦

Westchester County Medical Society

&

Iona College - Hagan School of Business

Present

An Advanced Certificate in Medical Practice Management

A five-course program designed for medical professionals seeking advanced education in the business of healthcare

The first course, "Health Care Industry Analysis" begins Wednesday, August 28, 2013.

Classes taught on Wednesday evenings, 6-9 PM, at the Westchester County Medical Society, 333 Westchester Avenue, Suite LN01, White Plains, NY 10604.

A minimum of 10 physicians required to begin course.

Register by contacting Iona College vjarekprinz@iona.edu or (914) 633-2420

Westchester County Medical Society members receive a 10% discount on tuition, and reduced student services fees.
Registration required by August 15, 2013.

An open meeting will be held on June 24th beginning at 6 PM to answer any questions. Please plan to attend to learn more about this exciting new member benefit.

Medical Practice Management

The goal of the Medical Practice Management Advanced Certificate is to provide the sole or small group practitioner (MD, OD, DMD, DDS, PA) or the health care professional who wants to be an executive in a large medical or dental group with a business background with which to perform in a non-patient care role. The Certificate is comprised of 5 courses (15 credits) which may be applied towards the MBA degree.

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Course Descriptions

FIN 671 Health Care Finance

Basic principles of accounting, budgeting, financial analysis and reimbursement are reviewed for application at the service level of health care organizations. Course methods include computer-based instruction and exercise.

HCM 621 Population Health

The emphasis of the course will be on the expanded responsibility of physicians and institutions, in cooperation and or joint ventures, adopting a risk relationship with payors and the broader community including public health issues. Achieving substantive improvement in the wellness of a population in anticipation of performance based reimbursement models in an ethical environment is at the core of this course.

HCM 651 Health Industry Analysis

The focus of this course is on identifying and understanding factors that affect the health care industry as a whole and its component parts. Specifically, the course examines how trends in health technology, personnel, health status, disease and government affect health care. These and other factors affecting public health, hospitals, medicine, and long-term care are analyzed from a variety of perspectives with tools such as epidemiology and cross-national analysis.

HCM 653 Health Care Management

This course first examines the relevant aspects of socio-behavioral disciplines for studying and understanding health services administration. Management and organization research is presented, analyzed and examined for effective practical skills.

IS 628 Total Quality Management

The purpose of this course is to understand the philosophy, concepts, principles and meaning of Total Quality Management (TQM) and to relate these to the implementation of quality management systems in goods and services industries, education, government and not-for-profit organizations. The course will focus on the development of a quality vision, quality mission, quality ethics, quality code, quality training program and the use of a five-year strategic quality plan with annual quality programs as a way to implement TQM.

IS 629 Health Care Information Systems

This course examines basic concepts and terminology of computer-based healthcare information systems and health information management (HIM). Systems design, development, systems selection and vendor management, implementation and operation are reviewed for application at the department and enterprise level of healthcare organizations. Security and control of healthcare data are emphasized. An introduction to telemedicine, tele-health and e-health is also included.

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Westchester Academy of Medicine
2013 Golf Outing & Fundraiser

Thursday, September 26, 2013
Westchester Country Club
99 Biltmore Avenue
Rye, NY 10580

Registration, Driving Range & Box Lunch—11:30 AM
Shotgun Start at 12:30 PM
Golf Format: Scramble
6:00 PM—Cocktails
6:45 PM—Buffet Dinner/Awards/Raffle*
***Please consider making a donation—For more information contact Karen Foy at kfoy@wcms.org**

Individual—$400 ◊ Individual plus Hole Sponsorship—$550
Foursome—$1,400 ◊ Foursome plus Hole Sponsorship—$1,500
Hole Sponsor $250

Additional Sponsorship Opportunities Available
Cocktails/Dinner Only—$150 per person/$250 per couple

All proceeds will benefit the Westchester Academy of Medicine
For more information and other sponsorship opportunities, contact Brian Foy at 914-967-9100 or bfoy@wcms.org

Have You Established a Health Commerce Account? The New I-STOP Law Requires it Set it Up TODAY!

"Duty to Consult" the PMP Effective August 27, 2013

The duty to consult the NYS Department of Health's (DOH) Prescription Monitoring Program (PMP) becomes effective August 27, 2013. The PMP will need to be checked for every patient that is prescribed a Schedule II, III or IV controlled substance. The "duty to consult" does not apply for inpatients at hospitals or clinics.

To access the PMP, physicians will need to obtain a Health Commerce System (HCS) account. To establish a HCS account go to: https://hcsteamwork1.health.state.ny.us/pup/top.html and follow the instructions.

New accounts are usually established within two weeks and once the application is processed, the physician will receive an email from the DOH with documents. The documents **must be printed, notarized and received back** by the DOH for your user ID to be issued.

Physicians will also need to complete the official New York State Prescription Form, DOH-4329 (7/12), have it notarized and forward it to the NYS DOH Bureau of Narcotics Enforcement.

Designated office staff should also sign up for a HCS account. This will enable them to check the PMP database for the physician beginning on August 27, 2013.

More information may be obtained by going to the following website: www.health.ny.gov/professionals/narcotic/practitioners

E-prescribing Requirement Effective March 27, 2015

E-prescribing will be required for all New York State prescriptions effective March 27, 2015, pursuant to regulations adopted by New York State. While the e-prescribing mandate goes into effect on March 27, 2015, physicians who comply with these regulations may now begin to electronically prescribe controlled substances (EPCS), as long as their EPCS systems are DEA certified. You must call BNE so that they can verify that the software you use has been DEA certified. Transmission of a prescription of a controlled substance using software that is not DEA certified will fail. The prescription will not be filled. You should know that very few e-prescribing vendors have been certified by the DEA. Included on the list of certified EPCS systems are the following: Allscripts, Cerner Corporation, DrFirst, Epic, Glennwood Systems, MD Toolbox, NewCrop, NextGen, and RxNT Stratus EMR.

A waiver process has been established under regulations from the e-presciping mandate. A copy of the adopted regulations, including the limited exceptions and the waiver process to the e-prescribing requirement, can be found by going to the following website and clicking on the e-prescribing regulations: http://www.health.ny.gov/regulations/recently_adopted/. ♦

Sixty Plus Years of Reflections on the Medical Profession By An "Old Timer"

Marvin Moser, M.D. - Clinical Professor of Medicine - Yale University School of Medicine
Emeritus Chief of Cardiology - White Plains Hospital

When I graduated from medical school in February 1947, I looked forward to a profession in which physicians were admired and respected in the community. I, like most of my classmates, expected to earn a good living, but few of us aspired to wealth. I entered medicine not as an idealist determined to save humanity, but because of a keen interest in pursuing a profession that dealt with people. I had an aversion to entering the world of business; I wanted to do something that required me to remain intellectually curious.

It was an exciting time. Medical school was completed in three years because we were in the midst of World War II; I then entered into five years more of rigorous training that often involved 20-hour shifts and working at least six days a week. The practice of medicine was vastly different in those days. In the '40 and early '50s, advertising by physicians was considered unethical. Hospitals were places where people went when they were truly sick; hospitals were prohibited from advertising. They were not profit centers to make money. Doctors worked in clinics for many hours a week, without pay, but as a condition of remaining on the staff. Advertisements urging patients to "ask your doctor" about X or Y drug were not FDA approved. Medical education was pursued for the joy of teaching and passing on knowledge. Scientific papers were written by the researchers who actually did the research. Stockholders and executives of health care companies were not siphoning off 20-30 percent of health care dollars.

The tools we had to work with then would be viewed as primitive today, but we listened to patients, did some of the laboratory work ourselves, and learned how to put two and two together as any good clinician or diagnostician should. Technology was in its infancy; few people had even heard about CAT and PET scans or MRIs. We relied on stethoscopes and a few other simple tools, our training and judgment, and our hands, eyes and ears to make a diagnosis and institute treatment. We were looked up to as role models and considered pillars of the community. We didn't watch the clock and, as noted, we didn't expect to become millionaires.

The Influence of Technology – Good and Bad

Fast forward to the 1990s and 2000s. Many doctors are now technocrats. We no longer have to listen to a heart murmur or to a patient describing a headache. We can order an echocardiogram to tell us all about the interior of the heart and the state of the heart valves. We can get an MRI to rule out a brain tumor, even though taking a few minutes to question the patient might have diagnosed a tension headache.

Many medical students pick their specialties with an eye to anticipated income. While some physicians today complain about the fee structure, the fact is that a large number earn substantial incomes. There are, of course, exceptions: family physicians and pediatricians, for example are at the low end of the income scale, largely because they perform few high-cost procedures. In just a few decades, we have progressed or more correctly in many cases regressed---from a profession to a profit-oriented business.

Exciting advances in technology have dramatically improved diagnostic and treatment capabilities, but many of these procedures are overused and abused---in many cases for economic, not medical, reasons. A great many people in the medical profession have been co-opted by industry, by pharmaceutical companies attempting to prove that their product is better than one that just became generic, by instrument companies trying to prove that patients need costly procedures, by hospitals that, in years gone by, were mostly for people who were sick, but now advertise to lure patients for high-tech procedures while cutting back on basic, less-profitable care.

(Continued on page 16)

(Continued from page 15) *Sixty Plus Years*

We should not, however, completely blame industry for the current state of affairs; their job is to sell a drug or a procedure. Nor can we overlook the enormous beneficial contributions of pharmaceutical companies, which have developed new therapies that have made such a great difference in the treatment of numerous diseases, including diabetes, hypertension, and cancer. These efforts must continue, but changes must be made in the way new drugs and procedures are marketed. We can certainly place some of the blame for current abuses on the greed of some physicians and their desire to become celebrities. Many have let their scientific judgment lapse by doing protocol research for drug and instrument companies and participating almost as sales persons at national meetings to advocate particular products. Negative studies are often not published and bias has clearly influenced scientific inquiry.

Medical Education

Medical education has also been transformed. At one time, physicians took pride in educating others; they took the time to learn and transmit knowledge. Today, aside from some academic institutions, much of the 'hands on" medical education and training is done by physicians who, in many cases, are directly or indirectly coached by industry. Grand Rounds, once an exciting place to learn about the latest medical treatment from unbiased speakers, have been co-opted in many institutions by pharmaceutical and procedure companies. They oftentimes pay for and provide the speakers with lecture materials. Significant attendance at conferences in many hospitals only occurs when the topic relates to the business of medicine.

Articles in scientific journals often are not written by those who sign off as senior authors; instead, more and more frequently they are written by science writers employed by an agency that, in turn, is paid by a company.

Even so, American medicine is still the best in the world. But sadly, we have allowed a complex system of for-profit care to emerge, both in hospitals and through health care companies and other plans, such as Medicare Advantage, that view medical care as profit centers.

Many of us who were practicing in the 1950s – 1970s have an increasing sense of frustration over what has happened to our profession and by the dehumanization of medical care in some doctors' offices and in contemporary "up-to-date" hospitals. Unanswered telephone calls and delays in reporting results of x-rays and blood tests are common examples of the lack of empathy and caring that should be part of the medical profession.

There is also universal frustration over the spiraling cost of medical care, much of it driven by the overuse and abuse of technology as well as the privatization of for-profit hospitals and publicly owned health care companies. As the nation's annual medical bill spirals past the two trillion dollar mark, no one can deny that medicine is now big business. Few people fully realize how profitable the health-care business has become. Nor are they fully aware of the exorbitant salaries paid to health-care company executives or of the huge profits stockholders reap from the health-care industry. Where is all of this money coming from? Simply put, from the dollars that should be going to pay for medical care. Instinctively, patients do not want to turn their health care over to a Federal bureaucracy, but few realize that Medicare, perhaps our most successful and satisfactory health-care delivery system, operates with an overhead of about three percent, compared to 20-30 percent for-profit plans.

It is also an ongoing concern about the extent to which postgraduate and continuing medical education is being distorted by promotional activities. Many scientific reports so glowingly described by the media are, in reality, often based on studies designed to "prove" a specific premise favorable to a drug company or instrument manufacturer.

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(Continued from page 16) *Sixty Plus Years*

What can be done? Somehow we must gradually move toward a single-payer program, curb some of the major abuses in the profit-driven overuse of technology. We must also modify the thrust of hospitals away from major profit centers, such as cardiovascular or orthopedic surgery, and divert some of these efforts and dollars to preventive practices. We all know that, in the long run, preventive medicine pays high dividends both in real savings and the quality of life, but at the moment, it simply does not pay many doctors or institutions to offer it.

No one wants to vilify industry or hospitals; we all have benefited greatly from their activities. But the advances have come at a cost we should attempt to moderate. I am convinced that many doctors and hospitals are resorting to unnecessary (and expensive) tests, not just to limit their liability to malpractice litigation, as is often claimed, but to increase their income. The fact is, doctors can still earn a good living without overusing tests. Similarly, they still should be providing simple services, such as answering telephone calls or refilling prescriptions, without charging an annual fee or becoming boutique or concierge doctors. Too often people with simple ailments like sore throats, a stomach ache, etc. are unable to reach their doctor or are referred to an emergency room by an answering service only to incur almost fictitiously high charges. Somehow, this sequence of events must be changed.

It is of interest to review the changes in the delivery of medical care over the last 60 years- the transition of medicine from a profession to a profit-oriented trade. Now is the time to rethink some of these changes that may not have resulted in better medical care.

Editor's Note: Dr. Moser has been a member of the WCMS since October, 1953, and has obtained the status of Life Member. ♦

Westchester County Medical Society

The WCMS & The Affinity Group will be presenting two seminars on:

Making Your Retirement Program Work Harder for YOU!

Fact: Most medical practices sponsor a retirement program. But not all retirement programs are created equal. Learn how your peers are taking full advantage of creative 401(k) / Profit Sharing / Cash Balance programs to:

- **save more annually for retirement (as much as $200K+)**
- **save more in taxes now**
- **reward key employees**
- **minimize overall staff contributions**
- **build in flexibility of contributions**
- **diversify investments outside of traditional mutual funds**

Peter M. Coleman, ASA, EA, FCA a leading retirement consultant/actuary will lead an interactive discussion on how medical practices specifically are using these "tools" to effectively meet their objectives without breaking the bank. Attendees will learn what designs might be suitable for their own practice and how they can be implemented—even for calendar year 2013.

Seminar 1: Date - June 25th; Time - 6:30pm

Location - WCMS Offices

This program is geared to those physicians looking to contribute between $40K - $200K annually toward their own benefit.

Seminar 2: Date - June 26th; Time - 6:30pm

Location - WCMS Offices

This program is geared to those physicians looking to contribute between $10K - $100K annually toward their own benefit.

This presentation is designed to be "audience" interactive and therefore seating is strictly limited to the first 12 to respond, so reserve your spot today.

To RSVP, contact Karen Foy by email: kfoy@wcms.org, or by phone: 914-967-9100.

Westchester County Medical Society
333 Westchester Ave., Suite LN01
White Plains, NY 10604
Phone: 914-967-9100
Fax: 914-967-9232

Affinity
THE AFFINITY GROUP, LLC

A Preferred Business Partner of the WCMS

Saving for Retirement – Not all Plans are Created Equal

Nick Preddice and The Affinity Group would like to introduce Peter M. Coleman, Managing Partner of Benefit Practice, an independent retirement. Mr. Coleman will be speaking at the Medical Society on the evenings of June 25th and 26th and will be discussing how a strategically designed retirement plan can help you keep more of your hard-earned money out of the hands of the IRS. Please take a few minutes to read Mr. Coleman's article below.

Most professionals we speak with are very concerned about finding ways to lower their tax bill and ensuring there is a cushion to draw upon when they decide to retire. There are very few programs available today where the government actually "pays" you (through a tax deduction) to save.

One of the most powerful ways to accomplish this is through qualified retirement plans. Typically business owners start off by sponsoring a 401(k) Plan so that they can defer up to $17.5K ($23K if age 50+). When they want larger contributions they add on a "profit sharing" component to bring their total benefit up to $51K ($56.5K if age 50+). **Rule of thumb** - in order for an owner to maximize his benefit under this type of plan, the "cost" for the firm is typically 4.5% - 6% of staff's compensation.
But when the business owner wants even greater benefits (*i.e.*, $50K - $150K +) they look to a relatively "new" program – a Variable Cash Balance Plan (VCBP).

What is a VCBP? It is a defined benefit plan that has the look and feel of a profit sharing plan. Unlike traditional pension plans of the past the VCBP is designed to have the value of the benefits rise and fall based on the actual return of the investments. The uncertainty of the annual contribution requirements that plagued the old plan designs (especially when there was a loss in investments) is all but eliminated.

So how does this concept work? In "simple" terms you marry your 401(k)/Profit Sharing Plan with the VCBP for nondiscrimination testing purposes. And based upon IRS regulations you are able to leverage the benefit provided to staff in the 401(k)/Profit Sharing Plan to significantly reduce their required contribution in the VCBP while greatly increasing the owner's benefit.
How much could this VCBP be worth at retirement? A 52 year old physician earning $450K+ could contribute sufficient amounts each year to reach a maximum lump sum value (at age 62) of approximately $2.55M. This will be in addition to the physician's account value in his 401(k)/Profit Sharing Plan.

What we typically hear next is "What's the catch?" or "Sounds too good to be true." Let's be honest, with ANY retirement program there is never a free lunch – there is always a cost to provide benefits to staff in order for an owner to receive a benefit – you have it now in your current program. But with the right design and demographics the additional cost to significantly increase your tax deductions could be relatively minimal (especially after reflecting the tax savings).
Below is an example of an actual client:

	Comp.	Age	(A) 401(k) Deferrals	(B) Profit Sharing	(C) Variable Cash Balance	(B) + (C) Total Employer Contrib.	(A) + (B) + (C) Total Owner Benefit	Allocation of Employer Dollars
Owner Physician	$600k	50	$23.0K	$17.0K	$165.9K	$182.9K	$205.9K	92.2%
Office Manager	120K	46	6.0K	3.6K	0.0K	3.6K		1.8%
Staff A	36K	25	2.0K	2.7K	0.7K	3.4K		1.7%
Staff B	50K	35	3.0K	3.8K	1.0K	4.8K		2.4%
Staff C	39K	27	0.0K	2.9K	0.8K	3.7K		1.9%
Totals				**$30.0K**	**$168.4K**	**$198.4K**		**100.0%**
Tax Savings [(1)]				**$12.0K**	**$67.4K**	**$79.4K**		

(1) Assumes a 40% combined tax bracket for the Practice

To learn more about this or other designs that could help you achieve your financial goals please contact Peter M. Coleman, ASA, EA, FCA – Managing Partner, The Benefit Practice – Pcoleman@BenefitPractice.com or (203) 517-3502.

Please note the views and opinions expressed by Mr. Coleman are his and do not reflect the views and opinions of Nick Preddice, The Affinity Group, LLC, or Massachusetts Mutual Life Insurance Company.