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IN THIS ISSUE

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Spirituality in Medicine

Editor's Note: This article was originally printed in the September/October 2009 issue of the Medicus.

By: Pyara Chauhan, MD

ANY PHYSICIAN WHO IS GENTLE, EMPATHETIC, AND CARING IS SPIRITUAL IN A GENERAL SENSE. Whenever you can project genuine understanding of the needs of your patients beyond the technical aspects of medicine, you are spiritual. Most Americans are religious but you can be spiritual without professing any religion.

All of us enjoy thousands of bounties of nature unconditionally and freely bestowed on us. The rain from heaven, sunshine, the shade of a tree, are all there for the taking for man and beast alike. All of us in the health care field are lucky to be able to return some of these favors of nature.

The society at large bestows its trust and respect on us. The least we can do is to be compassionate and respectful in return.

Those of us who have faith in God or a Higher Power are fortunate in their ability to draw from the tremendous resources within the well organized institutions of faith. True believers are blessed with that inner voice, the guiding light, which steers them along. Being empathetic and caring comes naturally to them. In Christian Medical College in India where I was lucky enough to learn the practice of medicine, the professor of surgery and the entire surgical team routinely invoked blessings prior to all surgical procedures. In that institution, spiritual as well as physical healing melded together almost imperceptibly to make patients whole.

"In their interactions with doctors, patients do not cease to be human beings who have deep and wide ranging needs. Indeed, in times of illness, questions of life and death may loom all the more strongly in a patient's consciousness," writes Athar Yawar in the Journal of the Royal Society of Medicine. In the same publication, William Osler is quoted as saying, "Nothing in life is more wonderful than faith .... the one great moving force which we can neither weigh in the balance nor test in the crucible.... Faith has always been an essential factor in the practice of medicine."

In times of illness, questions of life and death may loom all the more strongly in a patient's consciousness.

Kathleen Krebs, RN, writing in the Nursing Administration Quarterly, 2001, states "Prayer and spirituality are now recognized complementary therapies and receiving funding through the National Institutes of Health." Studies have shown that patients who seek refuge in faith and spirituality are better able to cope with the devastating effects of illness and tend to live longer than patients without such supports to lean on. Even though Mother Theresa was neither a nurse nor a physician, she is a prime example of the healing powers of spirituality. Everyone, of course, remembers and marvels at the dedication and service rendered to the patients under her care by Florence Nightingale. If all of us physicians and nurses and other hospital staff follow these examples, healthcare in this country will improve by leaps and bounds especially in terms of patient satisfaction.

By the way, in my younger days as a physician "Spirituality in Medicine" went by the name of "Bedside Manner". The more things change, the more they remain the same!

IT'S RENEWAL TIME: MSMS DUES ARE 88% TAX DEDUCTIBLE

By: Adrian J. Christie, MD; Kimberly Lovett Rockwell, MD, JD; Donald R. Peven, MD;

Contributions or gifts to the Michigan State Medical Society (MSMS) and any County Medical Society (CMS) are not tax deductible as charitable contributions for Federal income tax purposes. However, a portion of your dues may be tax deductible as ordinary and necessary business expenses. MSMS estimates that 12% of your 2018 dues will be nondeductible as this portion is allocable to lobbying as defined by law.

If you pay for your 2018 MSMS dues prior to December 31, 2017, you may deduct up to 88% of that as a business expense.

STAYING ON TRACK FOR 2017 MIPS REPORTING: PICK YOUR PACE

At this point in the year, physicians should verify that they that they are on the right path for their goals for the Medicare Merit-based Incentive Payment System (MIPS). If not, they should take advantage of the "one patient, one measure" reporting option to avoid a 4 percent payment penalty in 2019.

In deciding which pick-your-pace participation track to choose, physicians should consider whether their focus will be earning a bonus or avoiding a penalty. They also need to determine which measures are the most feasible to report, and evaluate their capacity for submitting 90 or more days of data.

For physicians who have not collected quality or Advancing Care Information measures or completed improvement activities, or are confused by the MIPS process, the minimum reporting option may be the best course of action to take. The AMA "One Patient, One Measure, No Penalty" (https://www.ama-assn.org/qpp-reporting) tutorial offers a step-by-step guide to complete the minimum-reporting process and help physicians avoid a 4 percent Medicare payment penalty for 2019.

Read more at AMA Wire (https://wire.ama-assn.org)

MICHIGAN DELEGATION RALLIES SUPPORT FOR MSMS RESOLUTIONS AT AMA

The Aloha Spirit was ever present at the 2017 American Medical Association (AMA) Interim Meeting held November 11-14, 2017. Your Michigan Delegation, led by Chair James D. Grant, MD, MBA, successfully advocated for consideration of nine resolutions that were initially directives from the 2017 MSMS House of Delegates (HOD). All nine resolutions received favorable consideration with seven being adopted as introduced or as amended and two being referred with report back at an upcoming AMA meeting.

Similar to the MSMS HOD process, Michigan's Delegation to the AMA must submit and testify on Michigan's resolutions before respective committees in order to garner support and address any opposition.

"I commend the members of the Michigan Delegation for their preparation and advocacy in support of these resolutions" Doctor Grant said. "I am proud of their efforts and resulting outcomes."

Michigan's resolutions dealt with a variety of topics impacting care delivery, education and training. Highlights include:

- Removing financial barriers for living organ donation by encouraging paid leave for organ donation;
- Encouraging strategic collaboration with the US Department of Health and Human Services to advocate and advance policies of importance to physicians and patients and to promote physician leadership and input;
- Ensuring that any future regulations pertaining to the repair or refurbishment of medical tools, devices, and instruments are based on objective scientific data;
- Revising the Preadmission Screening and Resident Review requirement for nursing facility placement to provide more consistent enactment among states and to allow more reasonable and cost-effective approaches to this mandatory screening process; and
- Expanding awareness about the influence of sex and gender on clinical medicine and the work being done in this area.

To view the top stories from the AMA's Interim Meeting including action on policies related to Medicaid, prescription drug costs, and electronic prescribing barriers, visit https://wire.ama-assn.org/ama-news/house-delegates.

BLOOD PRESSURE CONTROL, DIABETES PREVENTION BEST WORK WITH PROPER IMPLEMENTATION OF PREVENTION TOOLS

Nearly 85 million people in the U.S. have high blood pressure and 84 million have prediabetes. Prevalence of type 2 diabetes in Michigan has exceeded the national average for 30 years. Approximately 500,000 Michigan residents are aware that they have prediabetes. What's even more striking is that hypertension and diabetes often go hand in hand, which can create a lethal combination -- one that significantly raises patients' risk for heart attack or stroke. These staggering statistics and life-threatening consequences prove that prevention of both conditions is critical.

Prevention of both high blood pressure and diabetes is also very feasible. Ensuring that patients get screened for prediabetes and have accurate blood pressure measurement done during routine clinical visits becomes a one-two punch for stemming the tide of these conditions.

Prevention is only possible, however, when it's done properly. A recent survey found that many primary care physicians could not identify all 11 risk factors that indicate a patient qualifies for a prediabetes screening. And additional research also found that although trained in the technique, medical students could not perform all 11 steps required to achieve accurate blood pressure measurement.

Why accurate measurement is critical

Achieving improved blood pressure control is key to managing hypertension -- and saving lives -- and physicians play an important role. In order to do this successfully, accurate blood pressure measurement is essential.

According to a paper published in The Journal of Clinical Hypertension, 159 medical students were tested on their knowledge of the 11 elements of BP measurement during a simulated patient encounter as part of the Blood Pressure Check Challenge. Results from the simulation revealed that the mean number of elements students performed properly was 4.1, with the average student failing to perform more than one-half of the skills properly. Only one student scored 100 percent.

Although blood pressure measurement is quite common in clinical practice, formal training in the procedure is limited to medical school for most medical students, and no retraining is offered during residency, fellowship or clinical practice for physicians to test their skill.

"Until we have a system in place where physicians are retrained at regular intervals, we have to make sure that medical students master measuring blood pressure while in school," says Michael Rakotz, MD, Vice President, Chronic Disease Prevention and Management at the American Medical Association.

"While it is true that other members of the clinical team take the vitals at most office visits, many physicians will confirm elevated blood pressures themselves before making a diagnosis or initiating treatment."

Without accurate BP measurement, improving BP control does not seem likely because physicians can't reliably identify which patients

Thanks to Your Generosity the 2017 Holiday Sharing Card Project Raised $4,455

We would like to thank the MCMS members who participated in the 2017 MCMS Foundation Holiday Sharing Card Project. Due to your generous donations we were able to raise $2,140 for the Macomb County Food Program and $2,315 for Turning Point Shelter for women.

need more aggressive treatment vs. those who do not.

Physician tools for BP control

This highlights the need for accurate BP measurement to be taught and reinforced throughout the entire career of clinicians from medical school onward.

Fortunately, tools are available for practicing physicians, such as the Target: BP (https://targetbp.org) improvement program, a joint national initiative between the American Medical Association and the American Heart Association, to encourage health care practices and clinicians to prioritize blood pressure control.

The initiative supports health care organizations and teams who participate by providing them tools, resources and the latest research on sustaining BP goal rates of less than 130/80 mm Hg within their patient populations.

When medical practices and health care organizations commit to improving blood pressure control through the program and achieve high blood pressure control rates of 70 percent or higher, they become eligible to be a part of the Target: BP Recognition Program and get publicly recognized for their efforts.

Physician tools for diabetes prevention

In addition to tools that help improve blood pressure control, physicians also have access to diabetes prevention resources. Some useful tools include:

- Online prediabetes risk test (https://doihaveprediabetes.org), a 1-minute quiz to determine if patients have prediabetes and lifestyle tips to help lower their risk for the condition
- Prevent Diabetes STAT (https://preventdiabetesstat.org), a toolkit that encourages physicians to screen, test and get patients to act to lower their risk and provides resources such as patient handouts, sample scripts for patient follow-ups and sample referral forms
- National Diabetes Prevention Program (https://www.cdc.gov/diabetes/prevention/index.html), a Centers for Disease Control and Prevention-recognized nationwide list of in-person and online programs for patient referrals

With consistent, effective use of tools that improve blood pressure control and screen for diabetes prevention, physicians can partner with patients to reduce chronic, life-shortening health conditions and better the nation's health.

LEGAL ALERT: RECOGNITION OF ADVANCED PRACTICE REGISTERED NURSES BY MICHIGAN STATUTE


LEGAL Alert
MSMS
Recognition of Advance Practice Registered Nurses by Michigan Statute

Public Act 499 of 2016, effective April 9, 2017, defines an "advanced practice registered nurse" ("APRN") as a registered professional nurse who has been granted a specialty certification by the Michigan Board of Nursing in one of the following health professions specialty fields: nurse midwifery, nurse practitioner, or clinical nurse specialist. By this definition, nurse anesthetists do not qualify as APRNs. However, this does not alter the Board of Nursing's specialty certification for nurse anesthetists.

Read the full legal alert at https://www.msms.org/Resources/Health-Law-Library/APRN-Legal-Alert

LEGAL ALERT: WHAT PHYSICIANS NEED TO KNOW WHEN PATIENTS FILE FOR BANKRUPTCY


LEGAL Alert
MSMS
What Physicians Need to Know When Patients File *for* Bankruptcy
Background

Medical debt continues to be a significant cause of consumer bankruptcy filings. A patient's bankruptcy will typically affect a physician when the patient owes a balance for deductibles, co-payments or non-covered services when bankruptcy is filed. Physicians should be aware of their rights and of their responsibilities to their patients.

Read the full legal alert at https://www.msms.org/Resources/Guides-Checklists-Alerts/What-Physicians-Need-to-Know-When-Patients-File-for-Bankruptcy

Henry Ford Macomb Hospital

HENRY FORD MACOMB PHYSICAL THERAPISTS TRAIN ON NEW EKSO GT

Henry Ford Macomb physical therapists were recently trained on how to use a newly donated exoskeleton, the EKSO GT, manufactured by Ekso Bionics. The state-of-the-art equipment is designed to speed up the recovery process by getting patients back on their feet sooner.

The device assists patients who have leg weakness and fills in the gap between where the patient is currently functioning at and the strength normally needed to ambulate. It also significantly reduces the physical demand usually placed on the therapist when working with this population of patients, making it much safer for the patient and therapist.

Henry Ford Macomb is one of only a few places in Michigan to offer this new technology.

Physical therapists Angeline Ellena, Alex Bahoura and Ron Angeles test out the new exoskeleton equipment at Henry Ford Macomb's inpatient rehab gym.

HENRY FORD MACOMB HOSPITAL HIRES NEW DIRECTOR OF SURGICAL SERVICES

John Pittoors has joined Henry Ford Macomb Hospital as the Director of Surgical Services.

In this role, he will oversee all operations and growth related to the Surgical Services department.

He was previously with St. John Providence Health System as Vice President of Clinical Services and has more than 30 years of experience in the industry.

Pittoors, of Macomb Township, earned an MSN from Walsh College and a BSN from Wayne State University. He is a member of the American College of Health Care Executives.

St. John Macomb Oakland Hospital

ST. JOHN HOSPITAL ACHIEVES COMPREHENSIVE STROKE CENTER CERTIFICATION

St. John Hospital & Medical Center (SJH&MC) achieved Comprehensive Stroke Center certification, after successfully completing The Joint Commission Stroke Center survey in late September. The designation is for two years.

As a Comprehensive Stroke Center, St. John Hospital & Medical Center is now recognized for having the specific abilities (resources, staff and training) to receive and treat the most complex stroke cases, and can lead to better outcomes. As the only eastside Detroit hospital with this designation, SJH&MC is a regional leader in treatment of stroke patients.

Congratulations to the SJH&MC Stroke Team and leaders: Dr. Paul Cullis, chief of Neurology; Dr. Richard Fessler, chairman of Surgery; Dr. Robert Dunne, vice chief of Emergency Medicine; and Makenzie Thimm, nurse practitioner and stroke coordinator.

MIHU OFFERS INNOVATIVE APPROACH TO PATIENT CARE AT SJMOH

St. John Macomb Hospital (SJMOH) welcomed the mobile integrated health unit (MIHU) to the hospital campus in late November. This mobile unit will provide additional patient care space needed to manage patient flow as existing inpatient beds go "offline" to accommodate the upcoming tower expansion construction project. The MIHU is located on the south side of the hospital between the Webber Cancer Center and the Emergency Department, in the former location of the mobile PET/CT. The MIHU will be the temporary home for the fast track area of the ER, which serves patients in need of low acuity emergent care. Construction begins on the Tower Expansion in January 2018. The MIHU was "made to order" for SJMOH; below is a rendering of the exterior of the unit.

SJMOH TEAMS WORKING FOR THOSE WHO ARE HUNGRY

In December, the St. John Macomb-Oakland Emergency Medicine Residency Program staff donated their time to the local food bank to give back to the community . During their visit, they moved 18,064 pounds of food which equates to 14,451 meals! In addition, the group donated funds to purchase 396 gallons of milk for families in need.

SJMOH ER residents who rolled up their sleeves at Gleaners Food Bank

Hospital-wide food drives at both the Warren and Madison Heights campuses were also held, netting 842 pounds of associated food and $600 in donations. This kind of support makes it possible for Gleaners to reach its goal of distributing more than 40 million pounds of food to hungry neighbors in SE Michigan every year.

SHARE YOUR NEWSWORTHY ITEMS

Have you or a MCMS colleague been elected to a position (specialty society, hospital, community based program, etc.) or honored for your volunteer service within the community or abroad? Let us know.

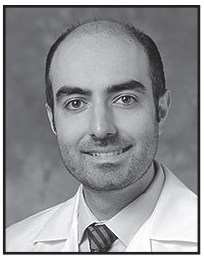
We would like to recognize MCMS members in the "Member News" section of the Medicus. Contact Heidi Leach at mcms@msms.org or macombcms@gmail.com with newsworthy information.

Publication is subject to availability of space and the discretion of the Editor.

Medical Records of Retired Physicians

Patients looking for their medical records from retired physicians frequently contact the MCMS. If you are retired or will be retiring shortly, please contact the MCMS at 810-387-0364 or email mcms@msms.org and let us know how patients can retrieve their records. If the records have been destroyed, please inform us of that also so we can note our database accordingly. Thank you!

New Members



PAUL D. BACIU, MD
Ophthalmology – Board Certified

Medical School: University of MI, 2012. Post Graduate Education: Wayne State University, completed 2013; Henry Ford Hospital, completed 2016; Bascom Palmer Eye Institute (FL), completed 2017. Hospital Affiliation: Henry Ford Hospital. Currently practicing at Henry Ford OptimEyes Super Vision Center, 33100 Gratiot Ave., Clinton Twp., MI 48035, ph. 800-436-7936.

NEELIMA KUNAM, MD
Psychiatry – Board Certified

Medical School: SRI Ramachandra Medical College, 2012. Post Graduate Education: Henry Ford Health System, completed, 2017. Hospital Affiliation: Henry Ford Macomb. Currently practicing at Henry Ford Behavioral Health, 15420 19 Mile Rd., Clinton Twp., MI 48038, ph. 248-398-3200.

MOHAMMED H. MAHMOUD, MD
Pulmonary Disease – Board Certified, Critical Care – Board Certified, Internal Medicine – Board Certified

Medical School: Ain Shams Univ. Faculty of Medicine, 2006. Post Graduate Education: St. Joseph Mercy Hospital (Ann Arbor), completed 2014. Hospital Affiliation: Henry Ford Macomb. Currently practicing at Henry Ford Medical Center – Sterling Heights, 3500 15 Mile Rd., Sterling Hts., MI 48310, ph. 800-4367936.

SUMUL Y. MODI, MD
Neurology – Board Certified, Vascular Neurology

Medical School: B.J. Medical College and Civil, 2010. Post Graduate Education: Henry Ford Hospital, completed 2017. Hospital Affiliation: Henry Ford Macomb. Currently practicing at Henry Ford Medical Center – Lakeside, 14500 Hall Rd., Sterling Hts., MI 48313, ph. 800-436-7936.

MOHAMED A. MOHAMED, MD
Rheumatology – Board Certified, Internal Medicine – Board Certified

Medical School: The University of Khartoum, 2006. Post Graduate Education: Interfaith Medical Center (NY), completed 2014; Wayne State University School Medicine, completed 2017. Hospital Affiliation: Henry Ford Hospital. Currently practicing at Henry Ford Medical Center – Lakeside, 14500 Hall Rd., Sterling Hts., MI 48313, ph. 800-436-7936.

CHRISTIE MORGAN, MD
Otolaryngology – Board Certified

Medical School: Boston University School of Medicine (MA), 2009. Post Graduate Education: Boston University Hospital (MA), completed 2014. Hospital Affiliation: Henry Ford Hospital. Currently practicing at Henry Ford Medical Center – Lakeside, 14500 Hall Rd., Sterling Hts., MI 48313, ph. 800-436-7936.

ACTIONS TAKEN TO QUANTIFY, CUT THE BURDENS OF PRIOR AUTHORIZATION

By: Andis Robeznieks, Senior Staff Writer, AMA Wire

Physicians always knew completing prior authorization (PA) requests were a drain on their time and energy. But this year, new survey data helped quantify just how much of a drain they actually were, and a plan of action was developed to tackle the issue.

Survey says: "Burden is high." A survey conducted in December 2016 helped arm physicians with the data they needed in 2017 to define just how much of a burden PA requests were to their staff and to themselves. Typically, physicians completed an average of 37 PA requests a week, which took 16.4 hours to process, for an annual burden of 853 hours, according to a Web-based survey of 1,000 practicing physicians.

Most PA requests could not be handled electronically and needed to be processed via telephone or fax, which added to the demand on physician and staff time. And too often PA requests are not a one-and-done affair, as 80 percent of physicians participating in the survey reported that they sometimes, often or always are required to repeat the process for stabilized patients being treated for a chronic condition.

Rule No. 1: Allow patients to access proper treatment. In an effort to slash administrative burdens, protect patient access to necessary treatments and encourage appropriate management of resources, a set of 21 principles to guide PA and utilization-management (UM) requirements was developed by the AMA and 16 organizations representing physicians, medical groups, hospitals, pharmacists and patients.

"Strict or bureaucratic oversight programs for drug or medical treatments have delayed access to necessary care, wasted limited health care resources and antagonized patients and physicians alike," former AMA President Andrew W. Gurman, MD, said in a statement.

The 21 principles were divided among five broad categories:

- Clinical validity. UM criteria need to be based on up-to-date clinical criteria and never cost alone.
- Continuity of care. PA requirements must not disrupt patients' care.
- Transparency and fairness. All coverage restrictions need to be fully disclosed to the public in a searchable, electronic format, and denials must include detailed explanations.
- Timely access and administrative efficiency. There must be a maximum response-time limit for UM decisions, and health plans must accept standardized electronic processing of PA requests.
- Alternatives and exemptions. Health plans should offer alternative, less burdensome approaches to resource management than PA.

Payers, IT vendors recognize need for reform. During the annual Healthcare Information and Management Systems Society's conference, a multistakeholder discussion on PA revealed agreement across the industry on the need for reform of current processes. A representative of Blue Cross Blue Shield Louisiana described how her organization was working on moving toward electronic, automatic processing and away from needing to make telephone calls and sending faxes.

The Workgroup for Electronic Data Interchange, an organization designed to bring together key stakeholders to improve health care information exchange, noted that it had established a PA workgroup.

The group's goals are "to identify the challenges that electronic prior authorization submitters experience that keep or deter them from submitting the prior-authorization requests electronically" and to "streamline the process to get the decision for prior authorization request to the submitter in as close to real-time as possible."

PHYSICIANS TOOK MULTIFACETED APPROACH TO OPIOID EPIDEMIC IN 2017

By: Andis Robeznieks, Senior Staff Writer, AMA Wire

An AMA Opioid Task Force report issued this spring showed that physicians are working to help end the nation's opioid epidemic. This includes reducing opioid prescriptions, getting educated on pain-management issues, becoming certified to provide office-based medication-assisted treatment (MAT), and making more use of prescription drug-monitoring programs (PDMPs). Here are some of other news developments AMA WireÆ has reported on this year.

Physicians and students being educated on safe opioid prescribing. The AMA Opioid Task Force report noted that 118,550 physicians completed courses offered by state and specialty societies on opioid prescribing, pain management, addiction and other related topics in 2015 and 2016. These efforts continued in 2017 with the Maryland State Medical Society (MedChi) facilitating free training programs on the how to use the Screening, Brief Intervention and Referral to Treatment strategy and how to make better use of the state's PDMP. "One of our roles is education outreach," MedChi CEO Gene Ransom said.

Modules on safe opioid prescribing for chronic pain and "what every prescriber should know" about opioid morbidity and mortality were made available on the AMA

Educational Center website.

Amid an epidemic, these physicians are taking action. Physicians such as Dr. Wakeman and David Dickerson, MD, are taking immediate action to help patients. As director of the University of Chicago Medicine's acute pain service and chair of its Pain Stewardship Program, Dr. Dickerson advocates for a holistic approach that includes customizing care for individual patients, reducing the supply of opioids vulnerable to diversion and increasing access to MAT.

New role and practice model for pediatric primary care. There are too few pediatric physicians specializing in addiction medicine and too few inpatient treatment beds, according to Sharon Levy, MD, director of the Adolescent Substance Abuse Program at Boston Children's Hospital and the American Academy of Pediatrics representative on the AMA Opioid Task Force. The solution advocated by Dr. Levy includes integrating opioid use disorder treatment into pediatric primary care.

Payers and policymakers need to follow evidence. Strong evidence exists on how to treat opioid-use disorder. The challenge is getting payers and policymakers to understand it so that physicians and other health professionals are better able to follow it, according to Sarah E. Wakeman, MD, medical director of the Substance Use Disorders Initiative at Massachusetts General Hospital. "We spent many decades trying to punish people into getting well," Dr. Wakeman said, and this approach has not worked.

President directs declaration of opioid public health emergency. In his October announcement, President Donald Trump encouraged states to seek a waiver from a 1970s Institute for Mental Disease exclusion rule restricting Medicaid funding for inpatient treatment to facilities with no more than 16 beds. A report from the president's Commission on Combating Drug Addiction and the Opioid Crisis had recommended this move as "the single fastest way to increase treatment availability across the nation."

The president's announcement was welcomed by the AMA, and Patrice A. Harris, MD, chair of the AMA Opioid Task Force, stressed that

"Ending the epidemic will require physicians, insurers, drug manufacturers, and the government to follow through with resources, evidence-based treatment plans and smart public policies at the national and state levels," Dr. Harris said.

Requirements of the Mental Health Parity and Addiction Equity Act not being met. That was the conclusion of a study looking at seven major health plans in New York and Maryland. The study cited other research that found only 10 percent of the 20.8 million of people who met addiction criteria received any treatment, in part because barriers to insurance coverage remain hard to identify. Also, enforcement of the Parity Act is driven by consumer complaints, but families and patients often don't know what their coverage is supposed include, or how or where to complain.

AMA urges attorneys general to follow Schneiderman's lead. Last year, New York Attorney General Eric Schneiderman reached an agreement with Cigna to end prior authorization for MAT. He followed it up in January with an agreement with Anthem to do the same. The AMA followed up that news with a letter to the National Association of Attorneys General urging them to work with insurers in their states to take action against MAT prior authorization requirements.

GLOBAL PHYSICIAN ETHICS PLEDGE GETS BIGGEST MAKEOVER IN DECADES

By: Tanya Albert Henry, Contributing Writer, AMA Wire

Physician leaders have given the international modern-day Hippocratic Oath the most substantial update that it has seen in nearly 70 years, with revisions reflecting changes in the relationship between patients and physicians, and changes in interactions between physicians and their colleagues.

The World Medical Association (WMA) first adopted the Declaration of Geneva in 1948 as the contemporary successor to the 2,500-year-old Hippocratic Oath. Since then, just minimal amendments were made. But in October - after two years of gathering feedback from WMA member national medical associations, external experts and the public - the WMA adopted the revised Declaration of Geneva at its General Assembly meeting in Chicago.

In addition to the declaration's being called "The Physician's Pledge" for the first time, the policy:

- References respecting the autonomy and dignity of the patient, which was not previously recognized in the declaration.
- Adds that the "well-being" of a patient will be a physician's first consideration, amending a clause to state that the "health and well-being of my patient will be my first consideration."
- Creates an obligation for respect between teachers, colleagues and students. Previously, it called for students to respect their teachers, but included no reciprocity.
- Establishes an obligation for physicians to share medical knowledge for the benefit of their patients and the advancement of health care.
- Requires physicians to attend to their own health, well-being and ability so they can provide the highest standard

of care. This comes at a time when physicians have seen an increase in workload and a rise in occupational stress.

- Augments an existing clause that calls for a physician to practice with conscience and dignity by having physicians pledge to practice with conscience and dignity "in accordance with good medical practice." This was done to more explicitly invoke the standards of ethical and professional conduct that patients and physicians' peers expect.

These changes "have enabled this pivotal document to more accurately reflect the challenges and needs of the modern medical profession," German physician Ramin Walter Parsa-Parsi, MD, MPH, wrote in a JAMA Viewpoint essay about the revised policy. Dr. Parsa-Parsi is chair of the WMA's Declaration of Geneva workgroup and a member of the WMA Medical Ethics Committee and WMA Council.

WMA President Yoshitake Yokokura, MD, of Japan, noted that physicians' lives today are completely different than they were in 1948.

The hope is that the revised Declaration of Geneva "will be used by all physicians around the world to strengthen the profession's determination to maintain the highest standard of health care for patients," he said.

The newly revised declaration is far from the only ethical guidance for physicians. The AMA has offered ethical guidance since the organization's founding meeting in 1847, when the Association adopted the principles of the AMA Code of Medical Ethics. That living document guides physicians on meeting the ethical challenges of practicing medicine. The Code, among other things, says that physicians "shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights" and "shall support access to medical care for all people."

The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.

Health Department

Macomb County Health Department

Reportable Diseases Summary

Diseases Reported in Macomb County Residents*

Cumulative total for previous years; year-to-date total for November, 2017

	2017	2016	2015	2014	2013
AMEBIASIS	0	1	0	1	1
BLASTOMYCOSIS	0	1	0	1	0
BOTULISM (FOODBORNE)	0	0	0	0	0
BOTULISM (INFANT)	0	0	0	0	0
BRUCELLOSIS	0	0	0	0	0
CAMPYLOBACTER	108	96	79	86	68
CHICKENPOX	29	33	32	88	40
CHLAMYDIA	3,094	3,185	2,736	2,474	2,523
COCCIDIOIDOMYCOSIS	2	2	2	7	2
CREUTZFELDT JAKOB	2	2	2	2	1
CRYPTOCOCCOSIS	1	1	1	2	1
CRYPTOSPORIDIOSIS	6	10	1	9	7
CYCLOSPORIASIS	12	2	0	1	0
DENGUE FEVER	0	1	1	0	0
DIPHTHERIA	0	0	0	0	0
EHRLICHIOSIS	1	3	0	1	0
ENCEPHALITIS PRIMARY	2	1	2	3	0
ENC POST OTHER	1	1	1	2	2
FLU-LIKE DISEASE	24,825	21,747	27,943	28,824	42,842
GIARDIASIS	18	23	17	21	20
GONORRHEA	806	801	522	477	600
GRANULOMA INGUINALE	0	0	0	0	0
GUILLAIN-BARRE SYN.	8	10	4	6	8
HEMOLYTIC UREMIC SYN.	0	0	0	0	0
HEPATITIS A	174	9	5	4	5
HEPATITIS B (ACUTE)	4	9	6	7	8
HEP B (CHRONIC)	99	110	125	136	118
HEPATITIS C (ACUTE)	37	31	16	15	7
HEP C (CHRONIC)	842	931	673	693	480
HEPATITIS D	0	0	0	0	0
HEPATITIS E	0	0	0	0	0
H. FLU INVASIVE DISEASE	17	14	11	9	11
HISTOPLASMOSIS	0	5	5	2	3
HIV^	58	57	64	55	54
INFLUENZA	3,541	2,164	1,143	831	147
KAWASAKI SYNDROME	4	5	10	5	9

	2017	2016	2015	2014	2013
LEGIONELLOSIS	54	34	25	24	31
LISTERIOSIS	2	1	1	1	0
LYME DISEASE	6	3	5	1	0
MALARIA	2	2	2	1	0
MEASLES	1	0	0	0	0
MENINGITIS VIRAL	40	43	60	44	75
MENINGITIS BACTERIAL/BACTEREMIA *(EXCLUDING N. MENINGITIDIS)*	11	9	10	8	4
MENINGOCOCCAL DISEASE	0	1	1	1	0
MUMPS	3	2	0	2	0
PERTUSSIS	68	37	35	83	108
POLIO	0	0	0	0	0
PSITTACOSIS	0	0	0	0	0
Q FEVER	0	0	0	0	1
RABIES ANIMAL	2	1	1	3	2
RABIES HUMAN	0	0	0	0	0
REYE SYNDROME	0	0	0	0	0
ROCKY MNTN SPOTTED FVR	0	1	0	0	0
RUBELLA	0	0	0	0	0
SALMONELLOSIS	66	78	82	75	76
SHIGELLOSIS	44	50	22	9	4
STEC**	9	7	9	11	6
STREP DIS, INV, GRP A	29	31	27	26	18
STREP PNEUMO, INV + DR	41	55	52	45	58
SYPHILIS	58	79	108	77	78
SYPHILIS CONGENITAL	0	0	2	0	1
TETANUS	0	0	0	0	0
TOXIC SHOCK SYNDROME	0	0	1	1	1
TUBERCULOSIS	10	11	6	11	11
TULAREMIA	0	0	0	0	0
TYPHOID FEVER	0	0	1	1	0
VIBRIOSIS	0	1	0	0	0
VISA	1	0	0	1	2
WEST NILE VIRUS	7	2	4	0	3
YELLOW FEVER	0	0	0	0	0
ZIKA	0	4	0	0	0

*Includes both Probable and Confirmed case reports

**Shiga-toxin producing Escherichia coli per MDHHS; combo of E. coli & Shiga Toxin 1 or 2

Audit Dec 8, 2017

^ Previously reported as "AIDS"

UTILIZE MSMS' WEBSITE ENGAGE (WWW.MSMS.ORG/ENGAGE)

Connecting constituents and Lawmakers is a critical and central function of grassroots advocacy. Engage gives users access to an editable, prefilled web-form letter sending system, which has become the easiest and most effective way for constituents to contact their Lawmakers. With Engage, YOU become a "virtual lobbyist," so please familiarize yourself with Engage and Take Action Now!

TAKE ACTION

Interstate Medical Licensure Compact (MSMS opposes)

House Bill 4066 would set up an "interstate medical licensure compact," creating one more onerous and unnecessary bureaucratic barrier between Michigan physicians and their patients.

The legislation would create a new licensure process for physicians, and drive up costs on patients. The bill would create an entirely new bureaucracy between states for physicians that may at some time wish to leave Michigan and practice elsewhere.

The bill would consume physicians' time and money, taking them away from the exam room and the operating suite, and raise costs while providing absolutely no benefit for patients.

The new system would also require for the first time that Michigan physicians participate in costly, unnecessary Maintenance of Certification procedures just to be eligible for licensure.

It is a bad solution in search of a nonexistent problem, and one that would have a serious negative impact on Michigan patients and their pocketbooks.

Please urge your lawmaker to vote NO on HBs 4066.

7-DAY LIMIT ON THE PRESCRIPTION OF OPIOIDS (MSMS OPPOSES AS WRITTEN)

Michigan is in the midst of an opioid abuse crisis, and the Michigan State Medical Society is leading the fight to find solutions that work for physicians and their patients. Thoughtful action on this front will save lives and a lot of needless heartache.

However, Senate Bill 274 should not be part of the solution

The legislation, sponsored by state Senator Marty Knollenberg, implements a 7-day limit on the prescription of opioids. In many cases, such a requirement is reasonable and even advisable, but physicians need to have the flexibility to extend the length of a prescription when appropriate for patient care. Most state models have that kind of flexibility, and Michigan should be no different.

Decisions on how to practice medicine should be left to the physicians, not lawmakers in Lansing.

Please urge your lawmaker to vote NO on SB 274.

MI'S IMMUNIZATION WAIVER WORKS! ASK YOUR LAWMAKER TO VOTE 'NO' TO HBS 4425 & 4426, AND SENATE BILL 300

Childhood immunizations protect our kids from dangerous infectious diseases like measles, mumps, rubella and more, but they can't help if parents don't get their kids vaccinated.

Michigan recently approved a change to Michigan's childhood immunization standards requiring parents of school-aged children who seek a "non-medical exemption" to immunization requirements to have their waiver certified by their local health department.

While individuals may still choose and obtain a waiver for any reason, the new rule has led to better education about the safety and effectiveness of immunizations, encouraging informed decisions.

It's a common sense reform that's protecting kids and making Michigan a healthier state, and immunization waiver rates have plummeted as a result. That means our children are safer and healthier.

Unfortunately, lawmakers in the House and Senate have introduced House Bills 4425 and 4426, and Senate Bill 300, misguided legislation that would roll back these effective, lifesaving initiatives and undo the progress Michigan has made protecting children from vaccine-preventable diseases.

According to testimony by state officials, Michigan's improved opt-out policies are working and they're making kids healthier. Now's not the time to turn back the clock on this critical reform.

Please urge your lawmaker to support Michigan kids first by voting NO on House Bills 4425 and 4426, and Senate Bill 300.

MICHIGAN STATE MEDICAL SOCIETY
120 W. Saginaw, Lansing, MI 48823
msms@msms.org • www.msms.org
517-336-5762

State and County Medical Society Membership Application

MACOMB COUNTY MEDICAL SOCIETY
P.O. Box 62 • Yale, MI 48097
810-387-0364 • 810-387-0372 (fax)
mcms@msms.org

Do you work 20 hours or less per week? ☐ **YES** ☐ **NO**
Is your spouse a member of MSMS? ☐ **YES** ☐ **NO**
Is this the first year you have practiced in Michigan? ☐ **YES** ☐ **NO**

Please PRINT or TYPE

FULL NAME _____ (Last) _____ (First) _____ (Middle Initial) MD or DO (Circle One)

HOME ADDRESS, CITY & ZIP _____ _____ (Area Code & Telephone Number)

OFFICE ADDRESS, CITY & ZIP _____ _____ (Area Code & Telephone Number)

PRACTICE NAME _____ _____ (Office Fax Number)

EMAIL ADDRESS _____ For mailing, please use (check one): ☐ **Office** address ☐ **Home** address

BIOGRAPHICAL DATA Sex: ☐ Male ☐ Female Birth Place _____ Date of Birth _____ (Month Day Year)

Maiden Name _____ Spouse's Name _____

Government Service (check one): ☐ Military ☐ National Health Service Beginning Date _____ Completion Date _____

EDUCATION (please complete or attach CV)

	INSTITUTION	LOCATION	DEGREE	YEAR GRADUATED Beginning	Ending
College/University					
Medical School					

INTERNSHIP, RESIDENCY, AND FELLOWSHIPS	SPECIALTY	COMPLETION DATE

License: MI # _____ Date Issued _____ ECFMG # _____
License held in other states/countries (list states or countries) _____

PROFESSIONAL DATA Present Type of Practice (check appropriately):
OFFICE BASED: ☐ Solo ☐ Hospital Based ☐ Teaching ☐ Research ☐ Government
☐ Group Practice Name _____ ☐ Other (specify) _____

Specialty _____ Subspecialty _____
Board Certifications (list specialties & dates) _____

Present Hospital Appointments (list dates) _____
Teaching Appointments (list dates) _____
Previous Medical Society Membership (list dates) _____
Specialty Society Memberships _____

Within the last five years, have you been convicted of a felony crime? ☐ Yes ☐ No If YES, please provide full information.
Within the last five 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 five 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.

I agree to support the MACOMB COUNTY MEDICAL SOCIETY Constitution and Bylaws, the MICHIGAN STATE MEDICAL SOCIETY Constitution and Bylaws, and the Principles of Ethics of the American Medical Association as applied by the AMA and the MSMS Judicial Commission.

Signature _____ Date _____

AMA AMERICAN MEDICAL ASSOCIATION

WHEN COMPLETED, please mail to MSMS or FAX to 517-336-5797. THANK YOU!