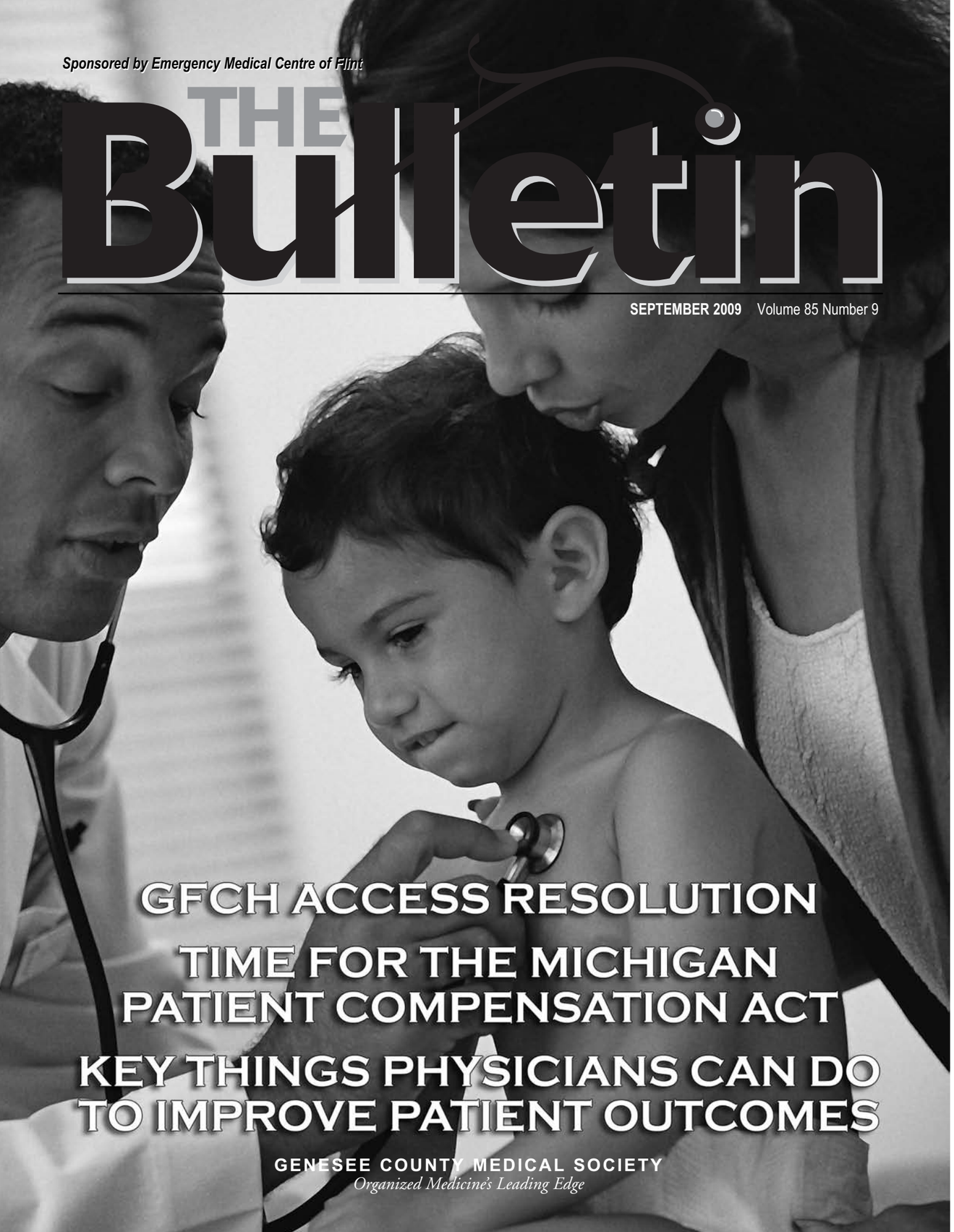

Sponsored by Emergency Medical Centre of Flint

THE Bulletin

SEPTEMBER 2009 Volume 85 Number 9

GFCH ACCESS RESOLUTION

TIME FOR THE MICHIGAN PATIENT COMPENSATION ACT

KEY THINGS PHYSICIANS CAN DO TO IMPROVE PATIENT OUTCOMES

GENESEE COUNTY MEDICAL SOCIETY
Organized Medicine's Leading Edge

THE BULLETIN is published monthly by The Genesee County Medical Society.

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SEPTEMBER 2009 Volume 85 Number 9

THE Bulletin

Read by 96% of GCMS members.

FEATURE ARTICLES

REGULAR FEATURES

Our Vision

That the Genesee County Medical Society maintain its position as the premier medical society by advocating on behalf of its physician members and patients.

Our Mission

The mission of the Genesee County Medical Society is leadership, advocacy, education, and service on behalf of its members and their patients.

PLEASE NOTE

The GCMS Nominating Committee seeks input from members for nominations for the GCMS Presidential Citation for Lifetime Community Service. The Committee would like to be made aware of candidates for consideration.

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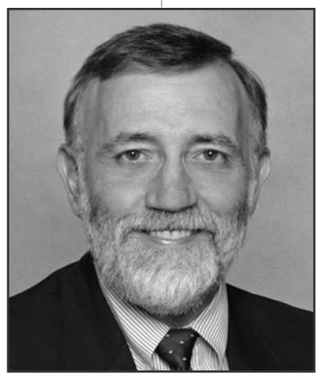
A CALL TO SERVICE



John A. Waters, M.D.

As physicians we are all called to service, service to our fellow man, service to our community and service to our profession. I believe overall, we do a wonderful job of providing those services. Now is certainly a time of great stress to our community. Our help will be needed more than usual. We are seeing more patients without insurance, jobs or money. We are helping via the Free Medical Clinic, the Genesee Health Plan, the hospitals and our own medical practices.

At the GCMS we are working hard to help you, your practice and your patients.

Here are some examples of what we are working on:

1. Monthly office managers meetings to help them run a better office for you
2. Legislative advocacy in Lansing
3. Helping you safely deal with the insurance bureaucracy
4. Leadership and advocacy at the Greater Flint Health Coalition
5. Peer review
6. Malpractice defense advocacy and support for malpractice reform
7. Help with insurance and professional contracts
8. Action Alert Center for Easy contact Legislators
9. Local face of organized medicine
10. Patient referrals
11. Liaison between physician members and press

While being your active advocates, we are also seeing a decline in income related to the economy in general and Flint's in particular. We have had aggressive cost cutting over the years and must now look to enhance our income. We have not had a dues increase for 18 years and choose not to do one now. However, we do need your service to continue our efforts on your behalf. Here is how:

1. You can refer and recruit new members,
2. You can seek sponsors for our dinner business meetings
3. You can seek sponsors for the Ball
4. You can refer patients to the Emergency Medical Center on Ballenger which we endorse
5. You can use PPI, the answering service which we endorse
6. You can donate to the Medical Society
7. You can seek new advertisers for our Bulletin and even advertise yourself
8. If you are an Alliance member you can help too by referring potential sponsors or advertisers
9. You can help the Society pay its building costs
10. You can encourage your friends and colleagues to do the same

As you can see we all have the opportunity to make a difference and improve health care and our Society which is working so very hard to help you and your practice. So lend a hand wherever you can and together we will make a real difference in health and health care.

ANY RELIEF FROM MEDICATION COSTS IS WELCOME

Daniel Ryan, MD

Any physician who has direct contact with patients on a daily basis is keenly aware of the financial burden many patients endure due to the costs of their medications. A recent story in the *Detroit Free Press* focused on the significant savings enjoyed by those who purchase medications from Canadian pharmacies. Discounts on many commonly prescribed drugs can be substantial, such as Lipitor (72%), Actos (74%), and Plavix (56%).

Currently, a person traveling to Canada is allowed to bring back a 90-day personal supply of a particular medication purchased from a Canadian pharmacy. Buses from the states make organized outings to Windsor pharmacies for just such purposes, with a side trip to a casino thrown in so that day trippers have the opportunity to parlay their prescription savings into gambling winnings. Makes perfect sense!

Drugs ordered via the Internet from Canada are not allowed to be mailed to the United States. The FDA holds the position that Canadian pharmacies are subject to a tightly regulated system while outfits that sell over the internet are not controlled. A company manufacturing drugs for export can exempt itself from Canada's Food and Drug Act, however nonsensical that may seem.

The Pharmaceutical Research and Manufacturers of America (PhRMA) reports that many drugs sold from Canadian internet operations may actually be made in China, Sri Lanka, and India. These countries tend to have lax inspection and oversight of drug manufacturers and would not be compliant with FDA regulations. Critics of PhRMA charge that U.S. drug companies are more interested in large profits and wage a misleading campaign to convince Americans that Canadian source drugs are unsafe. There have been very few instances of patients becoming ill or dying from use of adulterated, counterfeit, or mislabeled medications purchased over the internet.

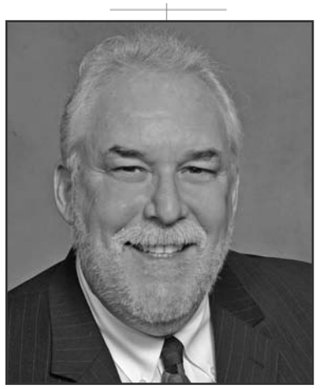
Critics of re-importation of U.S. made drugs from Canada point out that drug companies have enormous fixed costs to create the latest and greatest miracle compounds. They are charging a relatively high price in the free and largely competitive United States. in order to recoup the cost of extensive research and development and be profitable. Canada's socialist health care system has strict price controls on drugs. The U.S. system allows the creativity to develop new drugs and effectively subsidizes our neighbors to the north. Unfortunately, we cannot subsidize ourselves.

A new provision attached to the Homeland Security budget bill would prevent the Customs and Border Protection agencies from interfering with mailed, re-imported drugs from Canada, as long as it is a 90-day supply, or less, and only for personal use. Fewer Americans are venturing across the border to purchase their medications compared to just a few years ago. Reasons include drug coverage available through Medicare, more stringent border patrols, and domestic retail programs offering cheaper medications, usually generics.

As long as prudent safeguards are in place to assure that re-imported drugs are not a hazard, patients may as well have the convenient option of ordering from Canadian internet companies and possibly save money that can be better spent at a casino in the United States.

EXECUTIVE DIRECTOR'S MESSAGE

HEALTH COALITION ACCESS DOCUMENT SPONSORS AND ADVERTISERS NEEDED GCMS AMA LEADERS



Peter Levine, MPH

Please take time to review this reprint of a Greater Flint Health Coalition document which is of significance to this community. The Greater Flint Health Coalition developed a resolution on Access to Care which was completely redrafted by the GCMS Board of Directors, specifically by a subcommittee of three appointed Board members, Drs. Lawrence Reynolds, Robert Soderstrom, and John Waters. Their draft was approved, and forwarded to the Greater Flint Health Coalition for its Board of Directors approval. The Board, following significant discussion, did approve this document after only two minor wording changes. It is a remarkable document, which reflects a consensus between all of the players, including insurance companies, the Medical, and Osteopathic societies, the hospitals, the GISD, UAW, General Motors, and all the players who served on the Coalition. It has been forwarded to the White House and shared with all of the legislators of this area, both federal and state. I commend it to you for reading. Your GCMS leadership spent a considerable amount of time on this document. It has also been forwarded to MSMS and other interested organizations.

As I am writing this Directors Memo, the most recent Med-A-Gram hit my desk. It is a dramatic document, because on its front page it notes that three GCMS members where elected to leadership positions at the most recent AMA annual meeting, including Dr. Bobby Mukkamala who was elected to the AMA Council on Science and Public Health, Dr. Cathy Blight who was reappointed Chair of the Council on Long Range Planning and Development, and Dr. AppaRao Mukkamala who continues to serve on the Council on Legislation.

The Medical Society is seeking sponsors for its Ball, and general membership meetings, as well as advertisers for the *Bulletin* and the Roster. If you know of any vendors, services, or individual physicians or groups of physicians who would like to participate in this process, please do not hesitate to let me know. Sponsorship and advertising has become a very important part of keeping GCMS dues stable as they have been for over 18 years. In addition, while we have a very high penetration of membership, we can always use more members. Numbers are critical to working on your behalf. Please do not hesitate to let us know of any non-members who might be willing to join and please do not hesitate to ask non-members to join. I thank you in advance for your help on these important matters.

Please be reminded that PPI Communications is the endorsed answering service of the Genesee County Medical Society. The Emergency Medical Centre of Flint is the endorsed urgent care of the Genesee County Medical Society. You can help the Society and keep your dues low by utilizing these services managed by myself on behalf of our members.

GCMS HAS TWO ENDORSED SERVICES:

THE EMERGENCY MEDICAL Centre of Flint. Please contact Joanne Pratt at 810-232-6101.

PPI COMMUNICATIONS PHYSICIANS ANSWERING SERVICE Please contact Debbie Green at 810-733-9921.

SAVE THE DATE:
GCMSA/ GCMS Presidents' Ball
Warwick Hills Country Club
November 7, 2009

MSMS BOARD LISTENS TO MEMBERS WHEN SETTING STRATEGIC PLANNING PRIORITIES

Venkat Rao, MD
District VI Director

With the input of 547 MSMS members who took its online strategic planning survey, the MSMS Board of Directors agreed at its planning session on July 17 to focus MSMS efforts during the next year on four themes: quality and safety; prevention, wellness and personal responsibility for health; health care resource stewardship; and ensuring the viability of primary care. (Congratulations to the five MSMS members who won $100 gift cards for completing the survey!)

These categories were selected from the 13 themes that MSMS members were asked to prioritize in the electronic survey. The MSMS Board's final selection of priority areas closely mirrored input from membership. The themes originate from the MSMS Future of Medicine initiative (www.msms.org/future). While these four areas will be MSMS priorities, other themes including universal coverage through a reformed insurance market, electronic health information, and partnering with patients, among others, will remain on the MSMS agenda as part of the Future of Medicine initiative.

The MSMS Board started the process of outlining next actions for each of the four priority areas. This starts a continuous process that will be further refined at the Board's meeting on October 21 in conjunction with the MSMS Annual Scientific Meeting at the Somerset Inn in Troy.

Be sure to watch your e-mail for additional Board meeting coverage!

GCMS HAS TWO ENDORSED SERVICES:

THE EMERGENCY MEDICAL Centre of Flint. Please contact Joanne Pratt at 810-232-6101.

PPI COMMUNICATIONS PHYSICIANS ANSWERING SERVICE Please contact Debbie Green at 810-733-9921.

Meeting Held on Blue Cross Issues and Hurley Millage

Practice Managers Met in June to Discuss Blue Cross Issues and Hear about Hurley's Millage.

Polly Sheppard and Laura Stoyanoff gave the group on overview of the upcoming Hurley millage issue and handed out information to bring back to their offices for distribution.

Blue Cross Blue Shield representatives, Pam Yanis, Tina Gach, and Kate Simon gave a very informative session to the assembled managers regarding various Blue Cross Blue Shield issues that the Practice Managers needed help resolving or understanding, they included:

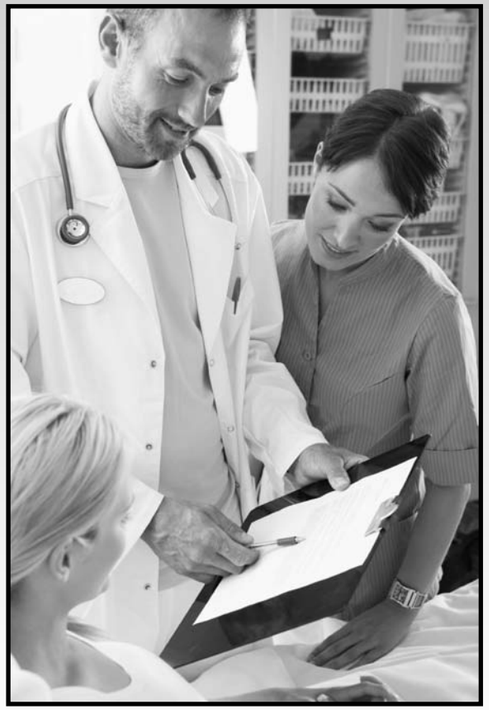
- MedAssurant
- Super Bill
- MOSS
- Web-DENIS
- BlueCard (for out of state patients)
- Mapping problems
- Linking to EOB
- Real time information
- EFT
- MPI

After the meeting was concluded, Tina Gach gave a private session for some of the Practice Managers on different issues specific to their practices.

ATTENTION!

If you know of potential sponsors or advertisers to support the Genesee County Medical Society please contact Marcia at 810-733-9923.

Key Things Physicians Can Do To Improve Patient Outcomes



Prepared for members by the GCMS Community & Environmental Health Committee

1. When physicians are ill, they should refrain from close patient contact unless necessary precautions are taken. The same is true for office staff.

2. Physicians should cultivate healthy habits when examining patients, i.e. washing hands, wearing gloves, wearing a mask if indicated, using sterilized equipment. etc. Office staff should adhere to the same habits as well.

3. Physicians can promote healthy behavior by becoming a role model for patients by not using tobacco, maintaining proper body weight, avoiding alcohol and/or drugs, and exercising to maintain good health.

4. Physicians should not overbook appointments so that quality of care does not suffer.

5. Physicians should develop a system to promptly review diagnostic tests, and consultations.

6. For quality purposes physicians should adopt various means of communication to remind patients of issues relating to their health.

7. Physicians should bring community health awareness to public gatherings.

8. Physicians should display compassion to both the patient and his or her loved ones when indicated.

9. Physicians should report spousal, elderly, or child abuse.

10. Physicians should educate themselves, their staff, and patients about available health related resources in the community.

11. Physicians should provide well-ventilated, clean waiting rooms for patients, and ask patients not to wear fragrances.

12. Physicians should exercise strong work ethics, including attention to punctuality.

13. To reduce community wide morbidity and mortality, physicians should consider volunteering in Free Medical Clinic settings.

14. Physicians should maintain control of their profession through involvement in their professional societies.

15. Physicians should make physical and visual contact with every patient to enhance bonding, attention and compliance.

16. Physicians should be honest with their patients.

NEW DAY
"WEDNESDAY"
September 23rd, 2009
Annual International Luncheon
at the home of
DR. DANISH ALAMY
8345 Warwick Grove Ct.
Grand Blanc, MI 48439
Social Time 11:00 a.m.
Meeting 11:30 a.m.
Lunch served at noon
RSVP to Mary Ryan 810-235-3415, or Anita Mannam: amannam@sbcglobal.net
A dish to pass to feed 10, or members $15
Prospective members free

Physician Dinner Meeting
To Learn More About
Diabetes Group Visits

The Greater Flint Health Coalition & Genesee County Medical Society invite you to join us to learn how Diabetes Group Visits can be conducted in your practice, leading to improved patient outcomes, improved practice efficiency, and better reimbursements!

GENESEE COUNTY MEDICAL SOCIETY

Join us for dinner on:
September 16, 2009
6:00 p.m. – 8:00 p.m.
Fandangles'
6429 West Pierson Rd # 3
Flushing, Michigan 48433
(Dinner will be served)

GREATER Flint HEALTH COALITION

This event is dedicated to providing the tools needed to implement diabetes group visits in your practice!

SPACE IS LIMITED – RSVP TODAY!

I will be attending the September 16th Diabetes Group Visit Physician Dinner Meeting at Fandangles'.

NAME:_____

ORGANIZATION:_____

PHONE/EMAIL:_____

RSVP with the Greater Flint Health Coalition via fax at (810)232-3332, telephone at (810)232-2228 or email at gfhc@flint.org

GREATER FLINT HEALTH COALITION
BOARD OF DIRECTORS

Resolution on Universal Access to Health Care

During the past several months the Greater Flint Health Coalition invited Genesee County to participate in a community-wide dialogue regarding health reform by widely circulating a draft resolution on universal access to health care through local media, newsletters, and presentations. This activity culminated in the *Greater Flint Health Coalition Resolution on Universal Access to Health Care*. This document reflects the input and deliberations of community members and organizations representing physicians, hospitals, business, organized labor, government, grassroots community organizations, healthcare consumers, educators, insurers, and most importantly – the residents of Genesee County. The Resolution was adopted by the Board of Directors of the GFHC on June 15, 2009.

WHEREAS the Greater Flint Health Coalition (GFHC) is a broad-based, community healthcare coalition based in Flint, Michigan and comprised of hospitals, physicians, labor, insurers, business, purchasers, consumers, educational institutions, and faith-based organizations whose mission[1] is to:
- Improve the health status of its citizens, and
- Improve the quality and cost effectiveness of the health care system in its community.

WHEREAS the GFHC Board of Directors committed in its 2007-2012 strategic plan[1] to:
- Advocate for universal access to health care as an overriding goal of the Coalition
- Advocate four key principles for health care coverage:
  - Universal
  - Continuous
  - Affordable/Sustainable
  - High quality – effective, efficient, safe, timely, patient centered, and equitable.

WHEREAS the Greater Flint Health Coalition's Board of Directors issued a consensus statement on August 18th, 2008 to support the principles of Ascension Health's "100% Campaign" which promotes universal access to health care based on social justice.

WHEREAS the GFHC has a rich history of improving access to health care in Genesee County by formerly serving as the official outreach agent for Michigan's State Children's Health Insurance Program (SCHIP) named MIChild from 1998 to 2003, and by its creation of the Genesee Health Plan in 2001, a federal and county funded program for the uninsured in Genesee County, all of which are based on the commitment of the physicians and hospitals of this county.

WHEREAS in order to meet the GFHC's goals relative to access to health care, the GFHC has concluded that the United States must move beyond continued "band-aid" approaches to solving our health care system's structural flaws by considering true systemic reform.

WHEREAS, to embark upon this goal of healthcare reform in order to realize universal access to care, the GFHC recognizes the following fundamental structural flaws in the nation's healthcare system. The United States spends more money per capita on health care by 53% than any other nation in the world[2]; at the same time, 47 million Americans lack health insurance and another 6-10% of the population has inadequate coverage[4]. Also the United States ranks 37th among industrialized nations in certain specific population-based health outcomes[3].

WHEREAS, the current economic crisis of 2008–2009 may give pause to some regarding the nation's ability to achieve universal access to health care, the GFHC contends that the absence of universal access to health care is a contributing factor to the woes of the nation's economy, thus making healthcare reform essential to reducing the suffering due to the economic crisis. The current healthcare system, which is both employer-based and non-universal, has the following impact on the economy:

According to the Bureau of Labor and Statistics Career Guide to Industries, health care is the largest industry in the United States for the year 2006, providing 14 million jobs, 13.6 million jobs for wage and salary workers and about 438,000 jobs for the self-employed.

- Seven of the top twenty-five in growing occupations is health care related.
- Health care is anticipated to generate three million new hourly wage and salary jobs between 2006 and 2016, more than any other industry.
- Most health care workers have jobs requiring less than four years of college education, but diagnosing and treating practitioners are among the most educated workers.
- About 580,000 establishments make up the health care industry, varying greatly in terms of size, staffing patterns, and organizational structures.
- Health care is the biggest employer in the State of Michigan.
- Health care is the largest employer in Genesee County.
- In 2007, 16% of the country's gross domestic product (GDP) was attributed to the cost of health care. It is predicted that by 2016 healthcare spending will reach $4.2 trillion, equal to 20% of GDP[5].
- However, the U.S. economy lost more than $207 billion because of poor health and the shorter lifespan of the uninsured[6] in 2007.
- Healthcare benefits make up 30.2% of employers' compensation costs. Since healthcare premiums increased 78% between 2002 and 2007 and continue to grow[7], potential for economic growth is severely weakened by current shortcomings of the system.

GFHC BOARD OF DIRECTORS INCLUDES THE FOLLOWING:

AFL-CIO
Baker College of Flint
Blue Cross Blue Shield of Michigan
Citizens Banking Corporation
City of Flint
General Motors Corporation
Genesee County Board of Commissioners
Genesee County Department of Human Services
Genesee County Health Department
Genesee Intermediate School District
Genesee County Medical Society
Genesee County Osteopathic Association
Genesee Regional Chamber of Commerce
Genesys Health System
Hamilton Community Health Network
HealthPlus of Michigan
Hispanic/Latino Community
Hurley Medical Center
McLaren Regional Medical Center
Michigan State Senate
Mott Children's Health Center
Mott Community College
United Auto Workers
United Teachers of Flint/MEA
University of Michigan-Flint

WHEREAS, it is the GFHC's belief that enough money exists in the current system to pay for universal access to care by addressing reform to the above noted structural flaws. Some of the current displaced funding includes:
- 25-30% of the health care dollar is spent on administration as driven by the demands of the current system's structure[8]: Administrative expenditures which lead to measurable improvements in medical quality and efficiency are appropriate.
- The exorbitant costs of means testing, underwriting and delays for Medicaid, State Children's Health Insurance Program, and private health insurance plans.

WHEREAS, it is the GFHC's position that access to health care is a right for all citizens and not simply a privilege for those who can financially afford it as dictated by the structure of the current system.

THEREFORE BE IT RESOLVED, THE GFHC ADVOCATES TO PRESIDENT BARACK OBAMA'S ADMINISTRATION THAT UNIVERSAL HEALTH CARE ACCESS BE MADE AVAILABLE TO ALL CITIZENS OF THE UNITED STATES WITH ALL DELIBERATE SPEED.

BE IT FURTHER RESOLVED, the GFHC recommends that the universal healthcare coverage program be:
- A plan which is as comprehensive in benefits as Congressional health plans, and
- Allows for a private, regulated, insurance system.

BE IT FURTHER RESOLVED, it is the GFHC's belief that enough money exists in the current system to pay for universal access to care by addressing reform to the above noted structural flaws. Some of the current displaced funding includes:
- 25–30% of the health care dollar is spent on administration as driven by the demands of the current system's structure[8]: Administrative expenditures which lead to measurable improvements in medical care quality and efficiency are appropriate.
- The exorbitant costs of means testing, underwriting and delays for Medicaid, State Children's Health Insurance Program, and private health insurance plans.

BE IT FURTHER RESOLVED, covering the 47 million uninsured individuals under the current health system would cost an additional $103 billion[9] annually. This is noteworthy as in addition to the above cited areas of savings due to current structural flaws, there are numerous areas that can possibly be corrected in the current system to supplement the cost of providing universal coverage to all citizens, including but not limited to:
- Negotiation of pharmaceutical and durable medical equipment prices (like the United States Department of Veterans Affairs) for Medicare Part D
  - Projected savings approximating $184 billion[7]
- Limitation of direct-to-consumer pharmaceutical advertising.
  - Projected savings approximating $3 billion[10]
- Eventually eliminate the need for Medicare Advantage
  - Projected savings approximating $65 billion[11]
- Replace the current tort based malpractice system with a patient focused compensation system based on the workers compensation model to save on the expenses of defensive medicine and improve relationships between patients and their physicians.
- Standardize all billing systems to the Medicare system to reduce administrative overhead variations occurring in insurance companies, hospitals, physician's offices, and all other facilities which must bill for reimbursement from any insurance company.
- Align electronic medical records to a single standard.

BE IT FURTHER RESOLVED, that access be maintained by assuring adequate congressional funding of Graduate Medical Education, and education of allied health professionals.

BE IT FURTHER RESOLVED, it is the GFHC's belief that this new universal health care system be financed through general taxation (this does not infer a tax increase) and not be employer–based in order to end the "Gordian Knot" of employment and health care benefits in the United States.

BE IT FURTHER RESOLVED, this demand for healthcare reform is not only the will of the GFHC, it is also the will of the American people as 62% of registered voters agree that reform is needed more than ever before[12].

BE IT FURTHER RESOLVED, the GFHC Board of Directors requests congressional support for immediate reform to the United States health care system. This reform should include a rigorous review of the highlighted issues to ensure the new system is one that is universal, sustainable, affordable to all Americans, continuous, and of high quality.

SOURCES: *AVAILABLE UPON REQUEST*

Greater Flint Health Coalition
519 S. Saginaw Street, Suite 306
Flint, MI 48502
PHONE: (810) 232-2228
FAX: (810) 232-3332
EMAIL: gfhc@flint.org
www.gfhc.org

Protection From Liability for Volunteer Physicians

By Jonathan M. Hartman, Esq., Cline, Cline & Griffin, P.C

"Free" or donated medical care is increasingly becoming a necessity, often the sole option even, for those less fortunate in many communities including ours. This is true especially in light of our nation's delicate economic situation, characterized by mass layoffs and the decline of employer-paid health insurance. Sad but true; but no relief is yet in sight. Two primary categories of physician volunteerism are protected under Michigan law. The distinction drawn between the two categories is based primarily on whether the circumstances under which the care is provided constitutes an emergency. Both are addressed herein below.

You may be aware that Michigan law affords protection from civil liability, often referred to as immunity, to volunteer physicians providing care in a variety of circumstances. Notably, however, immunity in certain contexts is not an absolute protection against being sued. Rather, the statutory immunity provides an absolute defense to a claim of professional negligence. This distinction is often confused. In other words, the volunteer physician can still get sued for negligence. Specifically, Michigan law allows informed practitioners who render "free" care to do so in a relatively worry-free manner. Specifically, the law, in pertinent part, reads:

A licensee who provides to a patient nonemergency health care that the licensee is licensed to provide, and who receives no compensation for providing, is not liable in a civil action for damages for acts or omissions, unless the acts or omissions were the result of gross negligence or reckless behavior including that intended to harm the patient.

However, potential pitfalls to the unwary or misinformed are out there. In particular, the limitation on liability only applies if (1) the care is provided at a "free clinic" or as a result of a specialty referral from a "free clinic" or volunteer physician, and (2) only if the patient (before care is rendered) is provided with and signs a disclosure form that both describes the immunity afforded the provider and the fact that the care is free and that no compensation will be sought. Significantly, however, "free" surgical procedures that customarily require more than a local anesthetic are not protected. MCL 333.16277.

Moreover, exceptions to these statutory protections also exist. For example, Michigan's Public Health Code carves out an exception to immunity for a volunteer physician found to have committed "gross negligence," a term defined as "conduct so reckless as to demonstrate a substantial lack of concern for whether an injury results." MCL 333.16185. Other exceptions to statutory immunity in a volunteer physician context include "willful and wanton misconduct," and/or "acts or omissions intended to injure the patient." MCL 333.16277.

Similar protections are afforded to retired physicians, previously licensed, out of practice for three or more years, but who remain current with CME requirements. Retired physicians able to donate their expertise to the indigent population can apply for and receive a special volunteer license to render "free" non-emergency care in the community, and upon so doing receive the described cloak of immunity from civil liability. MCL 333.16184 and 333.16185.

Likewise, in an emergency, Michigan's laws extend a partial protection to a physician who either (1) responds to and provides care in an emergency without compensation, and (2) responds to a life-threatening emergency within the hospital, when the provider had no duty or obligation to respond. MCL 691.1501 and 691.1502. These are commonly referred to as the Good Samaritan statutes. The exceptions to the immunity are, again, in cases of "gross negligence" or "willful and wanton misconduct." The best examples of (1) include the "team doctor" who screens would-be team members for requisite fitness levels and/or responds to the injury on the field. Also covered under this law is the physician who is summoned outside to the street adjacent to his professional office to assist a motorcycle accident victim prior to paramedics arriving (this actually happened to me, I waited in my physician's examination room until he returned). The best example of (2) is the physician, who is not on-call and has no direct responsibility to respond to requests for assistance, but who comes in to the hospital (or perhaps is already there) in response to an emergent situation. Gordon v. William Beaumont Hospital, 180 Mich App 488 (1989) is illustrative of (2) and therein the Court of Appeals upheld the physician's Good Samaritan immunity in dismissing the claim.

In sum, the common denominator with these protections is the care must be rendered without the expectation of compensation. In the cases of non-emergent "free" care, the patient must sign an informed disclosure document before the care is received. Please do not hesitate to contact this writer with questions about these immunity issues, the preparation of the requisite patient forms, and the set up of non-profit corporations for "free" clinics. Cline, Cline & Griffin, P.C. has expertise in these fields of practice, and would be pleased to assist in safeguarding your statutory protections.

Genesee County Medical Society Board of Directors Meeting – May 26, 2009

MINUTES

Motion:
That the report on the Budget Report ending April 30, 2009 be approved as presented. The Motion Carried.

Motion:
That the GCMS Board of Directors approve this revised Greater Flint Health Coalitions Access resolution as presented, and that Levine and Dr. Boucree support the revisions as presented to the GCMS Board at the next Greater Flint Health Coalition Board meeting. The Motion Carried.

Motion:
That the following requests for membership be approved.
Edmund Louvar, MD

Requesting Reinstatement:
Shagufta Naz Ali, MD

The Motion Carried.

Motion:
That the Genesee County Medical Society communicate to its members and to Hurley Medical Center that it supports the passage of the Hurley Millage, and that a letter be send to the Hurley Medical Center to that effect. The Motion Carried.

YOUR $$$ AT WORK

- GCMS interfaced with legislators on multiple occasions to oppose a Michigan tax on physician gross receipts
- GCMS interfaced with the legislature on multiple occasions to oppose an 8% cut in physician Medicaid payments
- GCMS communicated with federal elected officials to support elimination of the SGR to avoid a 21% cut in physician reimbursement by the Medicare program
- GCMS met with several non-members in an effort to secure their membership
- GCMS sent solicitations to potential sponsors for the GCMS/GCMSA Ball
- GCMS solicited advertising for the 2010 GCMS Roster
- Five GCMS members serving on the MSMS Board attended the mid-summer Board meeting and strategic planning session
- GCMS arranged help for several physicians having problems with third-party payors
- GCMS provided a meeting venue for two physician meetings
- GCMS put finishing touches on Town Hall meeting on the Future of the Automobile Industry
- GCMS sent membership information to every non-member in the phone book

ATTENTION!

If you know of potential sponsors or advertisers to support the Genesee County Medical Society please contact Marcia at 810-733-9923.

Genesee County Medical Society Dinner Business Meeting

September 9, 2009

A Town Hall Meeting
on
THE FUTURE OF THE AMERICAN AUTOMOBILE INDUSTRY, WHAT EVERY GENESEE COUNTY PHYSICIAN NEEDS TO KNOW!

With the bankruptcy of General Motors, this region is entering what might be called a "post industrial era". David Cole, PhD, Chairman, of the Center for Automotive Research will be our keynote speaker. Dr. Cole often serves as keynote speaker at major international meetings on the future of the automobile industry, and is often heard on national media.

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COME READY FOR A DISCUSSION!

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$30 GCMS Members & Spouses per person - $20 Hospital Residents and Students
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6 p.m. - Registration and Social Hour
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7 p.m. - Meeting
7:15 p.m. - Presentations

Please mail check with reservations to:
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4438 Oak Bridge Dr., Ste. B
Flint, MI 48532

Call Marcia at 810-733-9923 for more information.

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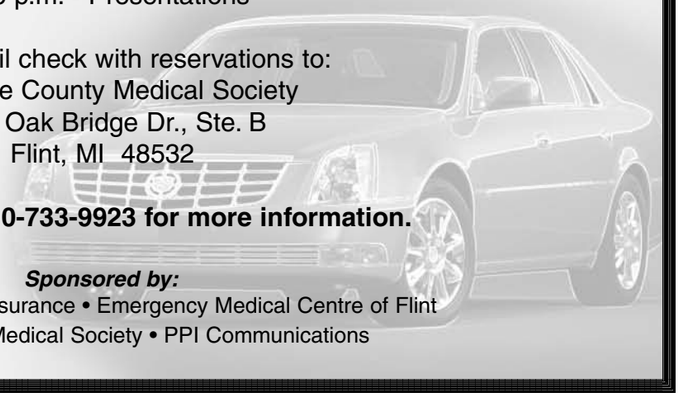

GCMS/MSMS NEW MEMBER APPLICATIONS

Jamal Hammoud, MD
Internal Medicine/Endocrinology
5040 Villa Linde Pkwy, Ste. C
Flint, MI 48532
Ph: (810) 230-0788
Fax: (810) 230-8650
Dr. Hammoud received his medical degree from the University of Damascus, FAC of Medicine, Damascus, Syria in 1980. He completed his residency at Wayne State University Affiliated Hospital and the University of Michigan Hospital. Dr. Hammoud is Board Certified in Internal Medicine and Endocrinology. He is sponsored by Amitabha Banerjee, MD and S. Bobby Mukkamala, MD.

Eric Zimmerman, DO
Neurology
Flint Neuroscience Center
G3239 Beecher Rd., Ste. C
Flint, MI 48532
Ph: (810) 732-9222
Fax: (810) 732-4344
Dr. Zimmerman received his medical degree from Michigan State University College of Osteopathic Medicine, East Lansing, MI in 1999. He completed his residency at Pontiac Osteopathic Hospital, Pontiac, MI and St. John Oakland Hospital, Madison Heights, MI. Dr. Zimmerman is Board Certified in Neurology. He is sponsored by Amitabha Banerjee, MD and S. Bobby Mukkamala, MD.

Yahya Osman-Malik, MD
Nephrology
G3283 Beecher Rd.
Flint, MI 48532
Ph: (810) 230-9901
Fax: (810) 230-9916
Dr. Osman-Malik received his medical degree from the University of Khartoum FAC of Medicine, Khartoum, Sudan in 1982. He completed his residency at Henry Ford Hospital in Detroit, MI. Dr. Osman-Malik is sponsored by Amitabha Banerjee, MD and S. Bobby Mukkamala, MD.

Margaret Beran, MD
OBGYN
One Hurley Plaza
Flint, MI 48503
Ph: (810) 762-6426
Dr. Beran received her medical degree from the University of Nebraska, Omaha, NE in 2005. She completed her residency at Hurley Medical Center in Flint, MI. Dr. Beran is sponsored by Amitabha Banerjee, MD and S. Bobby Mukkamala, MD.

Josephine Bello, MD
Family Medicine
G3317 Beecher Rd
Flint, MI 48532
Ph: (810) 720-0800
Fax: (810) 720-2800
Dr. Bellow received her medical degree from Philippine Muslim-Christian College of Medicine FNDN, Antipolo, Rizal in 1988. She completed her residency at McLaren Regional Medical Center, Flint, MI. Dr. Bello is sponsored by Amitabha Banerjee, MD and S. Bobby Mukkamala, MD.

Allecia Wilson, MD
Forensic Pathology
630 S. Saginaw St.
Flint, MI 48502
Ph: (810) 762-7777
Fax: (810) 762-7786
Dr. Wilson received her medical degree from the University of Michigan in Ann Arbor, MI in 2004. She completed her residency at the University of Michigan and a Fellowship at Miami Dade Medical Examiners Office in Miami, FL. She is Board Certified in Anatomic Pathology and Forensic Pathology. Dr. Wilson is sponsored by Amitabha Banerjee, MD and S. Bobby Mukkamala, MD.

HURLEY RESIDENTS:
Thalia R. Pachiyannakij, MD
Farrah F. Ahmad, MD
Sherif Gobrial, MD
Sunil Meruga, MD
Srinivasa Reddy Sanikommu, MD
Aisha Rush, MD
Arveity Setty, MD
Kenni Allen El-Amin, MD
Sushma Bangaldre Raju, MD
Lakshmi Gowda Hanumaiah, MD
Ruchira Singh, MD
Nisha Kalia, MD
Hareesha Chakunta, MD
Narendra Veerapaneni, MD
Smaik Mohammed Tabrez, MD
Olga Zand, MD
Irmgard Philipowitz, MD
Ghidah Caettoche, MD

GENESYS RESIDENTS
Mufaddal Abdulai, MD
Michelle J. Auerbach, DO
Jerel Brandt, DO
Megan Bridges, DO
Tammy Chen, MD
James Cusser, MD
Nicholas Draeger, DO
Lawrence Gooss, DO
Derrick Hoover, MD
Kendra Johnson, DO
Gurinderpal Khaira, MD
Heather LaClair, DO
Paul McGowan, DO
Jered Mancell, DO
Therese Mead, DO
Darshan Patel, MD
James Shurlow, DO
Joshua Walker, MD
Zachary Allred, DO
Michelle Balmaceda, MD
Matthew Brewster, DO
Benjamin Brown, DO
Daquesha Chever, DO
Merlyn Devaseelan, MD
Paul Fagan, DO
Maurilio Hernandez, MD
Max Izbicki, DO
Simran Kaur, MD
Uzma Khan, MD
Stacey McEwen, DO
Jozia McGowan, DO
Silvana Matte, MD
Robert Milanes, MD
Lakshmi Polavarapu, MD
Vijay Tirumalasetty, MD

MCLAREN RESIDENTS
Christopher Verioti, DO
Shahin Sheibani-Rad, MD

It's Time to Update Our Records!

Please take a moment to complete this form. It can be faxed or mailed. *Please print or type*

Name _____

Practice Name _____

Office Address _____

Office Telephone (Listed) _____ (Unlisted-for-GCMS use only) _____

Office Fax _____ Office Email Address _____

Update of Board Certified (Specialty) _____

Year Board Certified _____ Board Eligible In _____

Home Address _____

Home Telephone (Listed) _____ (Unlisted-for-GCMS use only) _____

Home Fax _____ Home Email Address _____

If you are retired, where are your previous patient's medical records located? _____

Please notify GCMS when a change in this information occurs.

Genesee County Medical Society
4438 Oak Bridge Dr., Suite B, Flint, MI 48532
(810) 733-6260 Fax (810) 230-3737

GCMS MEETINGS - SEPTEMBER 2009

Recessed for September - Legislative Liaison @ GCMS
9/2, 7:30 a.m. - Bulletin Committee @ GCMS
9/21, 12 Noon - Membership Committee @ Grill of India
9/22, 5:15 p.m. - Finance Committee @ GCMS
9/22, 6 p.m. GCMS Board of Directors @ GCMS
9/23, 12:30 p.m. - Community & Environmental Health Committee @ Sagano Japanese Restaurant
9/24, 8 a.m. Practice Managers @ GCMS

THE MICHIGAN PATIENT COMPENSATION ACT

A Much Overdue Alternative to the Tort System for Resolving Physician/Patient Conflict

Robert M. Soderstrom, M.D.
Chairman, Task Force on a Patient Focused Compensation System
Michigan State Medical Society

Health care reform is at the top of America's political agenda and rightfully so. There is much that needs correcting, but it will be difficult to achieve fundamental and effective reform without a primary re-evaluation of the way the system resolves conflict between doctor and patient. The fault-based tort system with its focus on drawn out litigation and punishment for the "negligent" physician has thorny tentacles which pervade all aspects of medical care. While arguments fly back and forth about the actual dollars involved, there can be no question but that the tort system drives unnecessary costs in both hospital and outpatient care. It effects peer review in a deleterious way and it significantly impairs the patient safety effort by discouraging the voluntary reporting of errors by medical care personnel. No sincere effort at health care reform in the United States can appropriately progress without addressing this fundamentally flawed process for resolving doctor/patient conflict.

The state of Michigan achieved the much desired medical "tort reform" in 1993 with financial caps on noneconomic damages and certain restrictions that make it more difficult to launch a lawsuit. It has led to fewer lawsuits and a lowering of malpractice insurance rates in the last few years, but the adversarial process remains in place and is deeply flawed. Most of the money in the system is taken by the legal process, not by patients who have suffered an injury. It still takes years for conflict resolution which does not help injured patients who need compensation at the time of the injury. A patient must initiate the process by filing a lawsuit. Those injured patients who elect not to file a lawsuit have no chance, of course, of receiving compensation. These criticisms alone emphasize the need for an alternative process.

There is much known about the current malpractice system that doesn't make physicians happy. Perhaps at the top of the list are the studies that show that most people who sue have not suffered a medical injury. This kind of information is not too surprising to physicians familiar with available malpractice data. In Michigan it is borne out by the fact that even 13 years after perhaps the best tort reform legislation in the country, 75% of the cases filed have no payout, 20% are settled out of court, and about 5% go to trial and, when they do, doctors win a majority of the cases.

Part of the reason for this is that physicians are not initially involved in the process. Who is in the best position to identify a medical error? Physicians, of course, but physicians rarely voluntarily report errors under the tort system. So patients who suspect that an error adversely affected their care have no idea whether or not it is true. They have no alternative but to consult an attorney who also has no idea. The attorney hires a doctor at $500 an hour to review the chart and make a determination. Such a process is very costly and without merit.

However, the same studies that reveal that most people who sue have not suffered a medical injury also reveal that most patients who suffer a medical injury do not sue. Why don't more patients sue? It is hard to know for sure. Some don't sue because they don't realize they have suffered a medical injury. Some don't sue because there isn't enough potential money in the case for an attorney to get involved. Some don't sue because they like their doctor and they know that if they sue they will lose their doctor. Some don't sue because they despise the tort system as much as physicians do. But none of these reasons provide an adequate rational for not compensating a patient who has, in fact, suffered a genuine medical injury that caused loss of income and personal suffering.

But since these people do not sue then, of course, nothing is known about their injuries. And if nothing is known about their injuries, then, of course, nothing is known about how to prevent them. Since most people who do sue have not suffered an avoidable medical injury, one can very effectively argue that the current system provides all the wrong information if the goal is medical error prevention and appropriate patient compensation. Those who are in the best position to identify actual errors in care are physicians, but under the tort system physicians are not likely to report them.

So what would an alternative system look like if these two goals were paramount: #1: the identification and prevention of medical errors and, #2, the appropriate compensation of those patients who have, in fact, been injured in the medical care system?

Unlike the current system, a new program for patient compensation would need to be open and transparent. Every hospital would have a patient safety office that would focus on error prevention. Every patient would be asked upon discharge if they felt their care was impaired in any way by a medical error. Every complaint would be investigated. According to proposed legislation, prepared by the Michigan State Medical Society, a hospital would have 21 days to respond to a patient complaint about error. The primary obligation of all medical care personnel would be error reporting - and near misses would be included, too. The ultimate goal would be for the great majority of medical errors to be reported by the care-givers themselves. This information would be collated, disseminated to all hospitals, and acted upon quickly so that processes that lead to error could be corrected before further patient harm occurs. If there is an agreement at the hospital level that a medical error led to an avoidable patient injury, then the patient could be quickly compensated at the time of the injury which is when financial support is most needed. Also, the events that led to the error could be examined and corrected in a timely fashion so that future patient injury could be prevented.

Appeals would be made to a state commission consisting of two citizens, two physicians, two hospital representatives, an insurance representative, and an attorney. The commission would employ an ombudsperson whose job it would be to investigate cases appealed from local hospitals. This commission would also have a defined period to respond as to whether an avoidable medical injury occurred. The commission could refer the case for review by a committee of three physicians who would make a recommendation to the state commission as to whether or not an error occurred. Compensation would be awarded to injured patients based upon a pre-determined compensation schedule, much like that used for workers compensation or the auto no-fault process.

The state commission would also have the job of collating medical errors from all the hospitals in the state and promptly informing hospitals of necessary changes to prevent future errors and subsequent patient injuries.

If denied at these two levels, patients would have a final route of appeal to a medical court. At this point, attorneys would represent the parties for a defined fee as is the case in workers compensation court. A medical court judge with appropriate experience in medical compensation law would make a final decision. This judge would have the right to level very significant fines if physicians and/or hospitals were found to have hidden information or changed charts, etc.

In this approach, patient compensation is not linked to proving negligence. Rather, it is linked to the occurrence of an avoidable medical error that led to medical injury. A question of physician misbehavior or incompetence would be referred to the state Medical Licensing Board and pursued thru a separate process. A physician could be required to review certain educational requirements, sanctioned in multiple ways, or have his/her license revoked, but this process would occur independently of whether or not a patient was compensated for an injury.

This proposed legislation is the result of six years of meticulous work by the Michigan State Medical Society's Task Force on a Patient Focused Compensation System stemming from a resolution from the Genesee County Medical Society of Flint, Michigan. If adopted, this approach would encourage doctors to report errors, provide a more appropriate universe of actual medical errors and therefore assist error prevention efforts, return most of the money in the malpractice system to patients who have suffered injuries, and allow doctors to work with their patients to achieve appropriate compensation when injury occurs. It would dissolve all the barriers to conflict resolution and medical error prevention that are so ingrained in the tort system.

The primary premise of medicine is well known: first, do no harm. But physicians are human and mistakes will be made. Mistakes should never be tolerated and everything must be done to prevent them, but mistakes will nonetheless occur. So if harm occurs, what is the responsibility of the medical profession? As a profession, physicians have neglected to build an appropriate structure for recognizing error and properly compensating those who suffer injury as a result of error. It is part of the reason the tort system exists. It is time to offer an alternative that will help, rather than hinder, the ultimate goals of health care reform.

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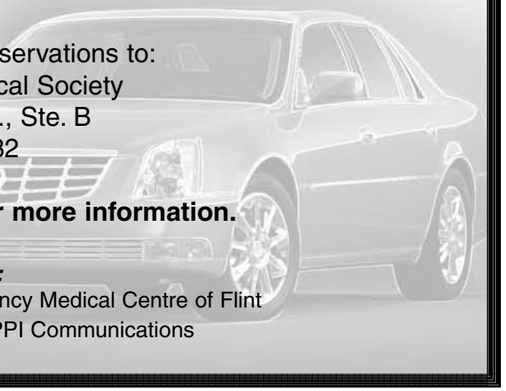

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SAVE THE DATE:
GCMSA/ GCMS Presidents' Ball
Warwick Hills Country Club
November 7, 2009

Happy Birthday Doctor
SEPTEMBER

Aruna Anne	1	Pradyumna Kuver	16
Pratap Aravapalli	1	David Diskin	18
John Chahbazi	1	Michael Beer	18
Vani Manyam	1	Albert Macksood	18
Brian Shapiro	1	Theodore Fellenbaum	18
Eugene Becker	3	M. Monir Khoulani	19
Douglas Congdon	4	Pongchayut Surapipith	20
Ramotsumi Makhene	4	Peter Farrehi	21
Bonita Wang	4	Donald Robinson	22
Damayanthi Pandrangi	5	Joon Park	23
Jimmy Wayne Brandon	6	James Walker, II	23
AlexanderChan	6	George West	23
Joyce Fahrner	7	John Carr	24
Linda Lawrence	7	Michael Gedwill	25
Joseph Kingsbury	8	Terry Krznarich	25
Richard McMurray	9	Benjamin Ramirez	25
Robert Soderstrom	9	Mahesh Sharman	25
Richard Kovan	10	Hung Ming Chu	26
Marjorie Otero	10	Burt Parliament	26
Scott Garner	11	Keith Heslinger	27
Gary Weber	11	Paul Dake	27
Ishwar Dass	13	Eugene Chardoul	28
Neelam Dutt	13	Sergio Ponze	28
John Love	13	Rosario Villareal	28
Kelvin Callaway	13	Manoharan Eustace	29
Norman Walter	13	Barry Miller	29
Rommel Aquino	13	Peter Moody	29
Roger Black	15	Nkechi Onwuzurike	29
John Doyle	16	Stephen Kalstein	30
Harold Dumas	16	Robert Molnar	30
James Kure	16	Ahmad Abdel-Halim	30
		Kenneth Steibel	30

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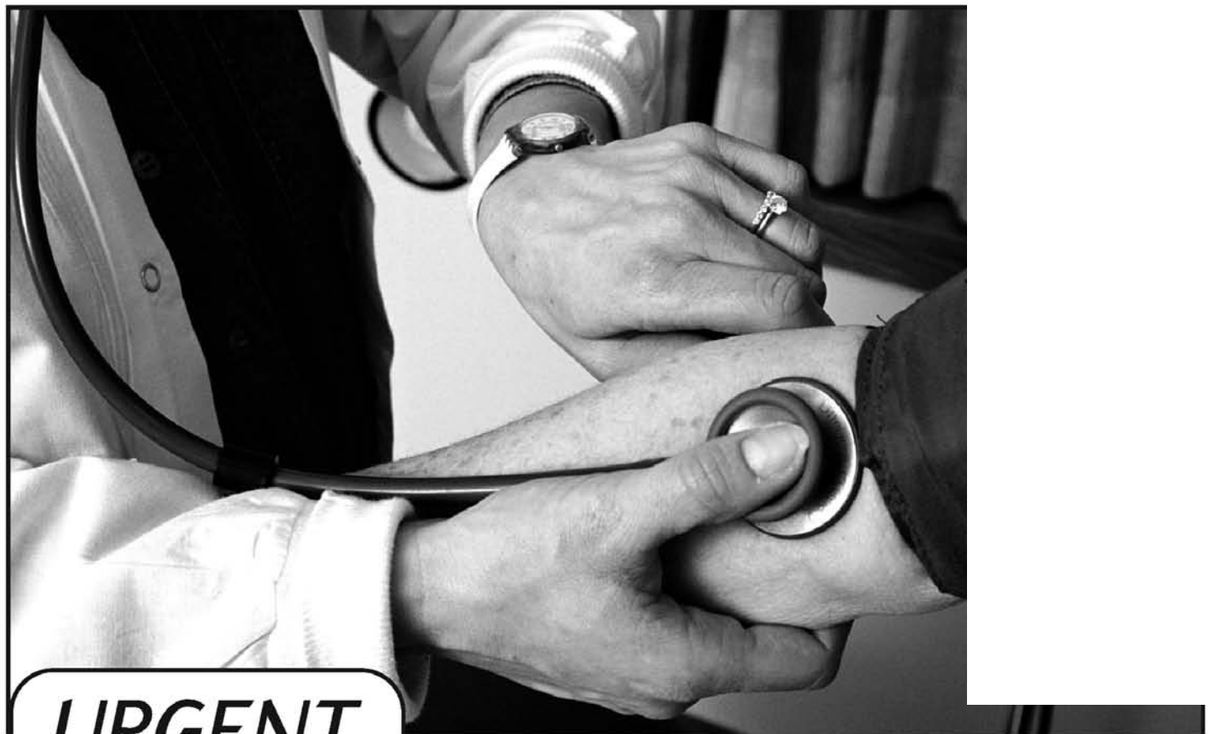

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