THE Bulletin

APRIL 2012 Volume 88, Number 4

SAIL THE CAPE!

TOWN HALL MEETING – MSU PLANS

LEGAL ALERT – POWER ATTORNEY

GENESEE COUNTY MEDICAL SOCIETY

Organized Medicine's Leading Edge

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APRIL 2012 Volume 88, Number 4

THE Bulletin

Read by 96% of GCMS members.

FEATURE ARTICLES

REGULARS

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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ADVANCED CARE PLANNING

Laura A. Carravallah, MD

Initiated by a very generous grant from the family of Dr, and Mrs. Joseph Batdorf, the Greater Flint Health Coalition convened a pan-community group to coordinate Advanced Care Planning in our county. Our own Dr. Bobby Mukkamala and Pete Levine played a significant role on behalf of GCMS in bringing this set of sessions to fruition.

As we are well aware, while there is widespread agreement on the need to have discussions with our sickest patients around advanced directives, this has not been as widely implemented as we all would wish.

There are many significant barriers to realizing the ideal of discussing patients' wishes around these issues before they reach a state in which they can't communicate. Sometimes patients or their families are uncomfortable discussing these issues, and physicians may also be uncomfortable talking about these issues for a variety of reasons. Another problem is that it is sometimes difficult to complete a Durable Power of Attorney for Health Care (DPoAHC), which is the legal document used in Michigan. It requires multiple discussions and signatures. Additionally, it can be intimidating to be asked to fill out a "legal document" – both because of literacy deficits and also because of a mistrust of the establishment.

The Batdorf family bequest enabled the Greater Flint Health Coalition to bring in the Gundersen Health System's "Respecting Choices" program from LaCrosse, Wisconsin. This program is very exciting in that they have found a way to have more than a 90% advance directive completion rate for the 400 patients who died in their county over two years, and more than 99% of the patients were found to have treatment decisions consistent with the instructions in those documents (JAGS. 2010:58:1249-1255). This is an astounding achievement, and similar results have been replicated in Minneapolis/St. Paul, and also Australia.

Gundersen is able to achieve this substantively through two interventions. The first is to divide the process of discussions with patients into three levels, and to attempt these at different stages of life and illness. The first level is initiated around 55 years of age when a person may not have any significant health concerns. At this point, the patient is approached by a trained lay health educator around a need to support their autonomy and to understand their health values and priorities. They are asked to help delineate the level of cognitive functioning at which they may decide that they would no longer want life-prolonging treatments. This removes the complicated, technical and often misleading discussion of which interventions they would or would not like, and instead focuses on the level of functioning and quality of life which would no longer be acceptable to them. The second level might occur when a patient has a significant chronic disease, such as diabetes or heart failure. At that point, the discussion surrounds the type of complications that might ensue, and what level of intervention that the patient may want in various contingencies. The third level is centered on patients with serious or life-threatening conditions. These patients then have a discussion around which interventions they would or would not want, and a portable set of Physician Orders for Life Sustaining Treatment (POLST) is developed.

In addition to discussing and obtaining the documentation of patient wishes, it is also important to ensure that this documentation is immediately available to all appropriate health providers. While some systems can be designed using designated repositories and protocols to exchange this information across likely venues, this is an area in which more policy and protocol will need to be developed in our community.

We will need to have many more discussions before we will be able to implement an Advanced Care Planning system that brings us closer to this level of success, but this has been a very encouraging start. All three medical centers have pledged support to this goal and the Greater Flint Health Coalition has committed staff and resources to supporting this project over time. I am very excited and encouraged by these steps, and I hope that I will have the opportunity to report further progress toward the goal of a system that optimally honors our patients' autonomy and their values regarding the health care that they receive.

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THE PROTONS ARE COMING, THE PROTONS ARE COMING!!

Machinery is the new messiah.
– Henry Ford (1863 - 1947)

Daniel Ryan, MD

Expected to be open for business in December 2012, the McLaren Proton Therapy Center (MPTC) on Beecher Road in Flint adds a new dimension to cancer treatment for patients in mid-Michigan and points well beyond. Construction of the facility began in October 2010 and will be fully integrated with the Great Lakes Cancer Institute at the same site.

So what is Proton Therapy and how does it differ from other types of radiation treatment for cancer, you may ask? Proton Beam Therapy (PBT), as the name implies, is a type of ionizing radiation that uses protons focused in a beam to irradiate cancerous tissues. The advantage of PBT is that it can be more precisely targeted to the diseased tissue than other formats of external beam radiation. Ionizing radiation damages the DNA of rapidly dividing cells, such as cancer cells, thus killing them or severely inhibiting their ability to reproduce themselves. Protons have greater mass as compared to electrons and have reduced scatter into adjacent healthy tissues. The beam does not broaden as it progresses on its course. Theoretically, this property lessens collateral damage associated with other radiation therapies. Also, the radiation dose is at its maximum just over the last few millimeters of the particles range and there is no exit beam damage.

Two broad categories of cancers tend to be more effectively treated with PBT compared to conventional radiotherapy. Those that require higher doses of radiation such as skull base, para-spinal tumors, and resectable sarcomas; and those types where it is desirable to limit the radiation dose to surrounding normal tissues such as pediatric cancers and prostate cancer. Children are at high risk for secondary tumors and deformities associated with radiation therapy because of the abundance of rapidly dividing normal cells. Many PBT centers devote the majority of treatment time to prostate cancer because it is more common than most of the other above mentioned cancers, and it is more profitable to treat.

PBT was first used in the 1950s and the first hospital-based Proton Therapy Center was built at Loma Linda University Medical Center in California in 1990. As of June 2011, there were about 37 PTC's in the world. The number is low because of the tremendously high costs usually associated with bringing a center on line. The MPTC is the first PBT center in Michigan. The MPTC is touted as representing "a new era for lower cost breakthrough technology" because of much lower construction costs and more efficient use of space with the latest PBT innovations and instrumentation.

As with any new and expensive medical technology, there is controversy surrounding the expected proliferation of PBT's throughout the country. Opponents object to the high cost of the centers and question the motives for building them as many are financed by private investors and venture capitalists seeking profit. The fear is that PBT will foment another "medical arms race" with taxpayers and insurance premium payers footing the bill. They argue that cancers that may be effectively treated with conventional radiation will be steered to PBT because of higher reimbursement. Time will tell if the objections are warranted.

Treatment of Inflammatory Bowel Disease with Whip Worm

By Qazi Azher, MD, FCAP, FASCP
on behalf of the GCMS Community
& Environmental Health Committee

When the human body comes under attack by foreign antigens, it responds by using T-helper (Th) cells to produce cytokines (hormonal messengers). Two counter-regulatory immune responses are seen called Th1 and Th2. The Th1 response typically occurring in viral and bacterial infections, which is characterized by an increase in interleukins IL-12 and Y-interferon, Th2 respond by IL-4, IL-5, and IL-13. Th1 produces pro-inflammatory activity and the Th2 cytokines produce anti-inflammatory response, but also promotes allergic response. In normal human beings there is a good balance between Th1 and Th2 response. Overtly active Th1 response impedes Th2 and vice versa. Th1 response is seen in cell-mediated immunity (M. tuberculosis), but is also involved in organ specific autoimmune diseases (Crohn's disease). Th2 counteracts the effects of Th1 cytokines. They have, as mentioned, anti-inflammatory activity. Th2 cell predominance is seen in diseases such as systemic lupus erythematosis and progressive systemic sclerosis and allergic diseases.

Intestinal helminthes induce Th2 cytokine release and non-specifically down regulate Th1 responsiveness (1,2,3). Epidemiological studies show that IBD (inflammatory bowel disease) is most common in Western industrialized countries with a good sanitized environment. Alternatively, developing countries with all their environmental problems show markedly significant cases of IBDs. Statistically, prevalence of IBD is inversely proportional to the prevalence of helminthic parasites in that population.

Under experimental conditions, a number of helminthic infestations have been shown to induce Th2-type inflammation and also down regulate the Th1 response. Th1 immune responds to unrelated bacterial and viral infections (4, 5,6). Therefore colonization with intestinal helminthes might be beneficial in reducing inflammation in patients with IBD. Recently, lots of studies have used Trichuris suis (porcine whipworm) eggs from pigs for treatment (7). They make sure these eggs are pathogen free before using them for trial. About 2,500 eggs were ingested orally with 30 ml of Gatorade. Patients were followed every two weeks without additional helminth ova therapy. The baseline and follow-up efficacy responses were monitored every two weeks using standard clinical indices. The treatment observation period was at least 12 weeks. During the treatment in one study all patients improved clinically without any adverse clinical events or laboratory abnormalities. Three of the four patients with Crohn's Disease (CD) entered remission; the fourth patient experienced clinical response but did not achieve clinical remission. Patients with ulcerative colitis (UC) experienced a reduction of the clinical colitis activity index to 57% of baseline. Benefit was temporary in some patients with a single dose, but it could be safely prolonged with maintenance therapy every three weeks.

ADVANCED DIRECTIVES

Peter Levine, MPH

One of the most interesting aspects of my job is that I get talk with people about a wide variety of issues, virtually all of which dramatically impact the general population in very significant ways. Medical care is provided in a highly complex environment with macro and micro components. One of the most fascinating issues is end-of-life care. End of life care and patient self determination has been a hot button topic in health care policy discussion for decades.

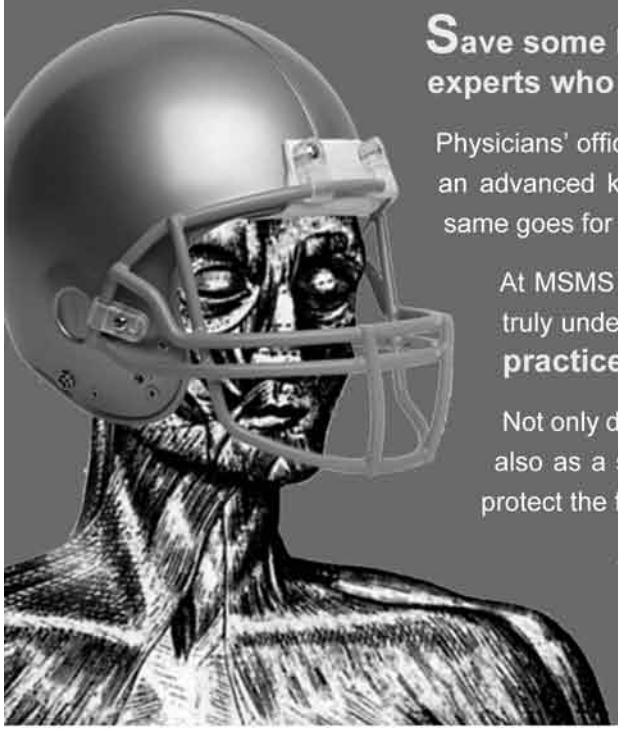
The Genesee County Medical Society's position throughout my tenure has been that the doctor patient relationship is sacrosanct. We have recently embarked, in conjunction with the Greater Flint Health Coalition, and all its members, on what will hopefully be a major project to significantly increase the number of individuals in this community who have advanced directives and who understand what an advanced directive is and what it means to their family, to them, and to the physician or physicians who must react to that advanced directive. Changes to the system will be required to move forward with this concept, but all the key parties appear to be in accord to do so. This is an issue revolving around quality, patient preference, and patient self determination. There is no reflection, when it comes to advanced directives about what the content of those directives should be. Some patients want everything done. Some patients want little done. Some patients are concerned about maintaining quality of life, and some patients are concerned about other factors. The bottom line is that patients do need to be informed when making these decisions, and their families also need the same information.

I have been surprised at how many people told me they hadn't done an advanced directive yet. These things are not simple to do, partly because the more information you have the more complicated the process might seem. The only thing that I can say is having done mine not that long ago, getting it done is a big relief. It puts things in perspective and provides a sense of personal accomplishment, but also gives one the knowledge that they have given a gift to their family and to ones own physician by having made wishes clear.

I encourage everyone who hasn't done an advanced directive to do so. Someday we are all going to need one.

Figure 6 *Anatomy of MSMS Physicians Insurance Agency*

A CEREBRUM IS A TERRIBLE THING TO WASTE



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MSMS BOARD STRATEGIC PRIORITIES HELP DRIVE THE FUTURE OF MEDICINE

Venkat Rao, MD
District VI Director

Your MSMS Board of Directors hit the ground running this year as it drives the MSMS Future of Medicine (FOM) (www.msms.org/future) strategic objectives forward. The Board and leaders from each of the FOM committees will further these strategic objectives:

Viability of Primary Care - In addition to creating a special Task Force on Primary Care and incorporating the issue into such ongoing efforts as the Physician Organization Council and the Committee on Health Care Quality & Economics, MSMS leadership is scheduling meetings with Michigan's major payers to advocate for primary care incentives, as well as advocating at the capitol on issues that directly affect primary care (Medicaid funding levels, tax policy, scope of practice, GME funding).

Quality & Safety - Among the ongoing efforts in quality and safety, MSMS is working with Medical Advantage Group and its LEAN contractor to identify best practices throughout the state. MSMS leaders also are supporting the efforts of the Michigan Health & Safety Coalition, as well as educating members on several different quality initiatives, such as MPRO, MQIC, Keystone, and Patient Safety Culture.

Medicaid - The Board of Directors sees the viability of Medicaid as absolutely essential to the health of Michigan's patients. Medicaid has been a long-standing priority of MSMS, as demonstrated in its continual efforts to protect funding, coverage and reimbursement, as well as its frequent meetings with Michigan Medicaid and advocacy at the capitol. MSMS has been working diligently to preserve access to patients even as the program remains sorely underfunded. Also, the Medicaid program will see an influx of new patients as health care reform rolls out, and this safety net program must be fixed because what exists is not sustainable, and cannot be expanded in its present state. Making Medicaid a strategic priority will allow the Board to direct additional resources to this key issue.

Health Care Resources Stewardship - Health care stewardship was identified by MSMS leadership as a key component to improving health care outcomes across the widest spectrum of patients. MSMS will build off of work from the past year and identify the most effective organizations and initiatives and build off of them to help Michigan's patients make informed health care decisions and improve health care delivery, in an effort to reduce overall health care costs, but not at the expense of quality and safety.

Child Obesity - Strengthening coalitions, supporting the governor's 4x4 recommendations for public health, and working to ensure that children had access to healthy foods in child care and school settings were

among some of the actions taken by the MSMS Board and its FOM leaders.

Michigan physicians certainly recognize that health care is at a point of departure. The status quo threatens everyone: Patients. Payers. Physicians. Other providers. We all know things need to change. We seek a more cohesive system down the road. The MSMS Board of Directors' Strategic Objectives to define the Future of Medicine key off of the comprehensive report (www.msms.org/future) MSMS commissioned that queried stakeholders—some of the best minds in business, labor, government, consumer groups, hospitals, nursing, insurers, health plans, long-term care and law. The consensus was clear: we need to change direction now and physicians must help lead the way.

View a short video message from MSMS Board Chair James D. Grant, MD, about our strategic priorities at www.msms.org/future.

For more information about MSMS Future of Medicine strategic objectives, contact MSMS Executive Director Julie Novak at 517-336-5735 or jnovak@msms.org. For information on the work of the committees contact Director, Health Care Delivery Rebecca Blake at 517-336-5729 or rblake@msms.org.

GCMS MEMBERS

If you are interested in having access to the "Members Only" section on the GCMS.org website please call or email your password to Sheree at sayres@gcms.org or call 733-9923.

Thank you.

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Sailing the Cape!

By Dr. Peter & Cheryl Thoms

Having never traveled south of the Equator and having been fascinated with the tales of sailing around Cape Horn, when the opportunity to do both on Princess Cruise Lines came up, we booked our departure from Valparaiso, Chile.

Getting to Valparaiso is a story all by itself. The 43-hour interval from a Flint departure to landing in Santiago, Chile at midnight was tiring, and we had yet to gather our bags, clear customs and meet our driver for the two-hour ride to our Valparaiso hotel. Fortunately, we left Flint three days before embarkation. The day of relaxation was welcome and provided the needed interlude before departure.

Each stop of the cruise was its own unique experience.

Punta Arenas, Chile on the straits of Magellan introduced us to a colony of the diminutive Magellan penguins. A one-hour tour bus ride took us through the small settlement into the desolate landscape of the colony's domain, a protected sea shore where these, the smallest of the penguin family, mate and raise their chicks.

Standing perhaps 16 inches tall they dig nests in the sand, often at the base of small bushes that effectively protect them from the cold blistering winds coming out of the southwest. The chicks, about 6 weeks old, stayed close to mom and dad as they waddled down to the sea shore following well worn paths. We watched with fascination from the cordoned walkway that carefully avoided their pathways. Once at the beach, these flightless birds frolicked in the icy water of their subarctic domain.

En route to our destination we watched cormorants with their long wings soaring high over head. Emu were pecking the ground as they strutted along looking for a dinner of insects.

Sailing out of Punta Arenas we turned down the Beagle Channel headed for Ushuaia, Argentina. To see the spectacular glaciers we were on deck at 6 a.m. Right on time, the series of glaciers came into sight. Tumbling down from the higher peaks inland each one had its own characteristic. French Glacier, was the most beautiful. Starting from peaks several thousand feet high, it wound its way toward the channel ending in a river cascade waterfall that tumbled over a cliff before flowing into the salty water. An overcast sky broke open just as the show began casting the morning rays of sun onto the pristine snow rivers and snow crusted peaks making for breathtaking vistas.

Ushuaia offers very little to see. The town of 2,500 can be toured in less than half an hour. Its fascination lies more in its history as it calls itself the world's southern most settlement.

(Part 1)


WELCOME
BIENVENIDO
Punta Arenas
E ANTARCTIC GATE
ntrada a la Antártica / Antarc

Our bus tour took us west to the border with Chile where several National Parks preserve the past for the future. Though we did not see them, this coastal area is home to the few remaining aboriginal people whose presence goes back 3,000 years. They dwell in secluded regions living as they always have. Their lifestyle, which involves nakedness, is surprising, given the fact that frigid weather dominates this area nine months of the year and even in the middle of their summer - December through February - nocturnal temperatures hover in the 40s. We were told that they smear their bodies with oil garnered from whales.

The focal points of these parks are the glacial lakes. Their beauty was being enjoyed by numerous campers who had pitched their tents along the shore in designated areas.

As we maneuvered out of the harbor the captain announced that weather conditions coming from the west were too treacherous to risk our planned route around Cape Horn. Winds over 70 knots and waves of 12 - 14 meters were being reported in the South Pacific just west of the Cape. He decided to increase our speed and cruise through a channel east of the rocky island. At about 5 a.m. we were passing the cluster of uninhabited islands that precariously protruded above the crashing waves. Now headed east we were ahead of the storm in a relatively calm sea.

Two days at sea preceded our next stop at Stanley in the Falkland Islands. The temperatures in the 70s and a light breeze made for a delightful ride. Less than 24 hours before we were to anchor, the captain announced that we were denied entry because an outbreak of enteritis was reported by the ships medical department. Actually, the number of cases had been diminishing. Much speculation flashed about the boat as to the real reason. But for whatever the reason denial was the prerogative of the island's authorities and we altered course toward our next destination.

Buenos Aires, Argentina is a beautiful city where 14 million people, one-third of all Argentineans, live. We took a City Tour.

Our first stop was the must-see tomb of Evita Peron. Born into a relatively poor Italian family from Milan, as a teenager she caught the eye of General Peron who married her. Living in Buenos Aires as the First Lady she filled the role well. She died from cancer in 1952 and first was buried in her home town. Moved several times, her body rests now in a simple black marble crypt.

The cemetery is a must see. Extraordinary mausoleum-like structures have been erected, row upon row, separated by narrow passageways six- to eight-feet-wide. Many of these measure 30 feet high and are adorned with Madonna figures among others. We were fortunate to be there shortly after 9 a.m. Long lines quickly form just to pass by the Evita tomb.

One characteristic of Buenos Aires is its vast park system. Some of the parks consist of only a few acres. Other parks stretch over a mile. We were there in their summertime. The parks were populated with children playing, young adults courting and the elderly enjoying the sunshine's warmth.

Two of the stops were at small parks where a cluster of statues commemorated various aspects of Venezuela's history. These were just a sampling of the 100 or so plots set aside for the pleasure of the populace.

Another stop was at a square (actually more like a triangle) made famous sometime ago by a man who introduced the idea of colorful variety. Buildings adjacent to one another were painted in bright red, blue, pink, yellow etc. On a balcony over a prominent souvenir store were three animated full figures depicting Evita, flanked by a famous soccer player and a prominent politician.

The Tango originated in this city, but was made popular when the European aristocracy took it up. Transported back to Argentina, it has become synonymous with Buenos Aires. It was, therefore, fitting that our lunch stop was at a large restaurant that could seat over 200 on each of three levels. On each level was a dance floor. After a steak dinner we were entertained by a troupe of dancers in beautiful attire. Sometimes it was one couple. At other times up to four couples took the floor.

Soccer, or "futbal" as it is known in Argentina, is a national passion. In 1930, to commemorate their 100th year of independence, a state-of-the-art soccer stadium was built, seating 30,000.

The inaugural event was The World Cup, which they proudly point out was the first time they won it. A small but interesting museum, incorporated into the arena, houses the vast history of Argentina's prowess in the event including several World Cup championships.

In next month's *Bulletin* we will move on to Uruguay and Brazil!

Physicians Implement Group Visits and Reap the Rewards!

Like many communities, Genesee County is experiencing the growing burden of chronic disease. Rushed practitioners are looking for new ways to deliver health care that improves the health of the population, enhances the patient experience of care and reduces, or at least controls, the cost of care. Group visits are one response to the limitations of traditional medical office visits. The Greater Flint Health Coalition's Diabetes Group Visit Project is available to assist physicians wishing to implement this model of care.

What are Group Visits?

Group visits are shared medical appointments that offer a one-on-one medical evaluation with a group educational session that emphasizes self-management behaviors. Group visits are commonly used in the treatment of diabetes, asthma, heart failure, chronic pain, and obesity/overweight. Typically a group visit involves 7-10 patients with a common chronic disease diagnosis meeting for a 1 ½ to 2 hour medical appointment with a physician and medical staff. Guest experts may be scheduled to present on topics such as nutrition, diet, exercise, and specialty services. Family members of patients are often invited to attend.

Benefits of Group Visits

Research has shown group visits improve the quality of care and patient outcomes, increase patient satisfaction, enhance the engagement of patients as partners in the management of their health conditions, increase physician productivity and practice efficiency, increase provider satisfaction, and reduce emergency department visits and hospitalization rates.

Group visits support the PCMH model:

- Patient-centered
- Team approach
- Eliminate access barriers
- Focus on quality & safety
- Utilize HIT
- Whole person oriented
- Coordinate & integrate care
- Payment reflects added value

Group visits are reimbursed utilizing the same E & M codes as traditional office visits. They may provide increased reimbursement through quality incentive programs, pay for performance programs and PCMH payment for added value.

Putting to Rest the Perceived Barriers to Group Visits

Quick simple answers exist to the most frequent reasons providers give for not implementing group visits:

- Group visits are recognized as a legitimate treatment method and insurers approve reimbursement for group visits with the proper documentation.
- Patient privacy is addressed by having all patients sign a consent form and confidentiality agreement prior to participation in the group visit.
- Practices implementing group visits have found both patient and providers like them. Patients appreciate the opportunity to meet and learn from others with the same health condition. Physicians find group visits allow them to provide more effective education and to better understand the barriers their patients' experience.

Resources are Available for Implementing Group Visits

The Greater Flint Health Coalition's Diabetes Group Visit Project has a number of resources to assist any physician interested in implementing group visits:

- The Group Visit Replication Manual is a comprehensive document containing all the background information and tools needed to offer group visits including the documentation and coding necessary for receiving reimbursement of group visits. Supporting materials have been developed specifically for utilizing group visits to treat diabetes, asthma, heart failure and chronic pain. The Group Visit Replication Manual is available online at www.gfhc.org.
- Local expert Paul Dake, M.D., Chair of the Diabetes Group Visit Project is available to assist physicians and their staffs with the design, implementation and initial facilitation of group visits within their own practices. Physicians are invited to attend and observe one of Dr. Dake's diabetes group visits which he conducts bi-monthly at the McLaren Family Medicine Clinic.
- The Diabetes Group Visit Project Workgroup meets regularly to support and engage physicians in the diabetes group visit concept. Membership includes representation from the hospitals, physician practices, and health insurance organizations. The Workgroup periodically hosts Physician Champion Educational Events, dinner meetings with presentations and roundtable discussion on group visit implementation. The Workgroup is available to problem solve the challenges or barriers physicians may encounter with group visit implementation.
- Limited financial support is available for physician practices implementing group visits to secure meeting space rental and guest presenters to provide patient education.

Those physicians interested in learning more about the benefits of group visits and the resources available to assist with implementing group visits may contact the Greater Flint Health Coalition by phone at (810)232-2228 or email at gfhc@flint.org.

GCMSA UPCOMING EVENTS

4/20, 7 p.m. - Wine Tasting: Dr. Dan & Mary Ryan's Lake Fenton Home
5/4-5/6 - Annual Session, Ann Arbor
5/19, 9 a.m. - Healing Hands 5K Run/Walk
5/22, 11:30 a.m. - Geranium Luncheon, Warwick Hills

GCMS MEETINGS

– APRIL 2012 –

4/2, 8 a.m. - Legislative Liaison Committee Meeting
4/4, 7:30 a.m. - Bulletin Meeting
4/16, 12 Noon - Membership Committee @ GCMS
4/24, 6 p.m. - GCMS Board of Directors @ GCMS
4/25, 12:30 p.m. - Community & Env. Health Committee Meeting
4/26, 8 a.m. - Practice Managers @ GCMS
4/27-4/29 - MSMS House of Delegates, The Henry, Dearborn
5/3 - Town Hall on the Future of MSU College of Human Medicine's Plans for Flint

Legislative Liaison

On February 6, the Legislative Liaison Committee met with Senator John Gleason. The committee reviewed issues relating to the auto no-fault legislation which is still being pushed. The governor is seeking an auto no-fault fee schedule, and some Republicans are opposing it at this point. MSMS is opposing the auto no-fault changes as well as the helmet repeal legislation which is tied to the auto no-fault bill. Senator Gleason supports continuation of the current auto no-fault laws.

The committee also heard an update on medical marihuana hearings. House Bill 4851 would define the doctor patient relationship. MSMS supports House Bill 4851, as does Senator Gleason.

The state budget was discussed at length. Senator Gleason expressed support for language which would add $31 million to the Medicaid budget to cover the cost of early diagnosis of autism. MSMS is supporting that language because it is perceived as a vehicle which would move the state closer to mental health parity. The state budget contains a 17% reduction in graduate medical education funding.

Members wishing to attend Legislative Liaison Committee meetings are welcome to do so. Please contact Pete Levine.

Check Out Our Website: www.gcms.org
Call Sheree Ayres to give her your password (810) 733-9923.

What does child abuse look like?

From a lecture given at Weiss Advocacy Center – March 26, 2012

By E. Gullekson, MD, Medical Director – Case Management, Blood Management and Child Evaluation Clinic, McLaren – Flint

First to know what child abuse looks like, we need to know what abuse doesn't look like!

As John F. Kennedy said fifty years ago: "the great enemy of truth is very often not the lie- deliberate, contrived, and dishonest- but the myth- persistent, persuasive and unrealistic."

Many of us believe myths because they are comforting. Here are several of them.

- Myth – Only pretty little girls are sexually abused
- Myth – Most child abusers are strangers
- Myth – Only men rape children
- Myth – My child would tell me if anything like this happened to them
- Myth – This could never happen to my child
- Myth – Teaching about child sexual abuse will scare the child
- Myth – If my child was abused I would know
- Myth – It can't happen in my family
- Myth – Sexual abuse is a family matter and should be dealt with as such

Thus we can feel secure and smug if our family is tidy, clean, educated, well fed, has good friends, wears designer clothes, takes exotic trips, is religious, and attends private schools. Or is that a myth?

All of the above are myths. Not true. They are lies! Even if we would like to believe otherwise.

Take a "time out." Do you believe any of the myths we have just discussed. "Time outs" are taken in surgery before the surgery begins. We identify the patient, the part to be operated on, the procedure, the informed consent of the patient and any worry on the part of any member of the team. Let's have that attitude now, as we explore how we recognize sexual abuse. Sexual abuse is when a child or young person is pressured, forced, or tricked into taking part in any kind of sexual activity with an adult or young person.

"It's not denial, I'm just selective about the reality I accept."

HERE ARE A FEW FACTS –

- 1 in 4 girls and 1 in 6 boys are sexually abused before the age of 18
- 85% of sexual abuse occurs within the child's social sphere by a friend, relative, teacher, religious leader, or neighbor
- A majority of abused children are silent (at times "scared silent")
- You can teach a child of three how to lower their risk of abuse

WHAT CAN YOU DO?

- **Teach your child proper names for parts of the body. We tell a child to point their eyes, nose, ear, foot, but invent names for the genitalia such as "private parts."**
- **Teach your child that they have the right to decide who touches their body.**
  - o Teach them "good touch"
  - o Teach them "bad touch"
  - o Teach them "unwanted touch"
  - o Teach them "sexual abuse touch" – "where your bathing suit covers"
- **Saying NO**
  - o Children have a right to say no, although our culture says "do as you are told":
  - o Is it ok to say no if your dad asks you to brush your teeth?
  - o Is it ok to say no if a teacher touches your penis?
  - o Is it ok to say no if an adult asks you to wear a seatbelt?
  - o Is it ok to say no if someone says don't tell your parents?
- **Teach your children about "bad" secrets**
  - o If a secret makes a child uneasy it is a bad secret and should be told. Remember: "No one keeps a secret so well as a child" – Victor Hugo

- **How do you check?**
  - o Ask organizations about criminal checks
  - o Ask about staff training
  - o Ask the child why they feel uncomfortable in a situation
  - o Get specific about outings (school, camp)
  - o Is it a group or one-to-one encounter?
- **Tell your child**
  - o Don't talk to strangers unless they are with an adult they trust
  - o If a stranger asks the child to go with them – teach them to YELL-RUN-YELL!!
  - o Use a "safe word" that child has with you
  - o Meet at a safe place - predetermined
  - o Work in pairs or groups – not alone
- **Internet Activity**
  - o 1 in 5 children are sexually solicited on the internet
  - o The Internet is a dangerous hunting ground for pedophiles
  - o Parents should block inappropriate Internet activity
  - o The computer should be in shared family space
  - o Teach them – don't meet anyone from a chat room
  - o Teach them – don't give out personal information
  - o If a child becomes secretive – find out why

If your child or patient has been the object of child sexual abuse you may see:

- Changes in behavior
  - o Doesn't want to be left alone
  - o Reverts to immature behaviors, example – sucking thumb
  - o Changes at school
- **Radical mood swings**
  - o Being evasive
  - o Health Issues
  - o Increased eating or decreased eating
  - o Self destructive behavior
  - o Genital discomfort
  - o Headaches, stomach aches
  - o Depression, suicidal
- **Inappropriate Sexual Behavior**
  - o Excessive masturbation
  - o Graphic language
  - o Sexual aggression
  - o Tries to be unattractive
  - o Refusal to undress in gym

"The only thing necessary for the triumph of evil is for good men to do nothing."
– Edmund Burke

If you suspect abuse:

- Don't freak out
- Stay calm
- Get help
- Report it
- Listen to the child – don't probe
- Reassure the child – this was not their fault – they are still loved
- Don't confront perpetrator
- Get help for yourself

What does the physical look like in an abused child?

- 95% of the time the physical is negative. No one can see a "touch" unless the touch causes damage, (example rip, tear, or abrasion).
- A negative exam does not mean abuse has not occurred
- A perpetrators goal is not to injure a child
- The damage is in the child's brain

Practice Managers

Tony Cuttita of the Greater Flint Health Coalition provided an overview of the Commit to Fit program which is designed to improve health in the greater Flint area. The purpose of doing this is for all the right reasons related to public health and outcomes, and also to make Flint a more attractive place for businesses, and to raise children. There was extended discussion following his presentation about the importance of medical students and residents being involved in Commit to Fit and creating competitions between practices, hospitals, and programs.

Check Out Our Website
www.gcms.org

YOUR $$$ AT WORK

- GCMS began revising its strategic plan
- GCMS held meetings for practice managers covering descriptions of new health systems, quality initiatives, and other abbreviated terms which can make a practice managers life very confusing
- GCMS submitted two resolutions to the MSMS House of Delegates
- GCMS co-hosted with the Greater Flint Health Coalition, a 2-day symposium on Advanced Care Planning
- GCMS continued to provide input to the Genesee Health Plan on its efforts to achieve a millage renewal in November
- GCMS members held fundraisers for several candidates for upcoming State elections
- GCMS hosted several meetings of non-profit groups whose goals coincide with those of GCMS

THE PHYSICIAN'S ROLE WHEN A GUARDIAN IS NEEDED

By: Tim Knecht

The population of Genesee County is aging. Fortunately, none of us are. Modern medicine has made it possible for all of us to live longer lives. With longer life expectancies, diminished mental capacity becomes more common.

Some people have made plans for this contingency by executing Durable Powers of Attorney for finances, for health care or for both. The term "Durable" when used in context with Power of Attorney means the Power of Attorney is effective even after a person's disability. Many Durable Powers of Attorney for finances require a person to be disabled, as determined by two physicians, before the person appointed in the Power of Attorney can act on behalf of the disabled person.

For people who have not planned ahead by obtaining a Durable Power of Attorney for finances or for health care, the court system remains as the only option for the appointment of a Guardian and/or a Conservator. When a family finds itself in a situation where a loved one is unable to make decisions for himself or herself, if there is no Durable Power of Attorney in place, the family must petition the Court for Appointment of a Guardian and/or a Conservator for that person. A Guardian is able to make personal and health care decisions for an individual. A Conservator takes care of a person's money. The Court will only appoint a Guardian or Conservator for someone if a physician provides a written opinion that this person is unable to take care of his/her own personal and/or financial affairs.

When appointment of a Guardian or Conservator is necessary, a family member will often accompany an elderly individual to the doctors office and will ask for a short note or statement that this person is unable to take care of his/her own personal or financial affairs. If, in your medical judgment, you believe that is the case, please provide this individual with a short written statement this person is unable to take care of his/her own personal and/or financial affairs. This simple statement makes it possible for someone else, usually another family member, to assist in managing the day to day affairs of this person, your patient.

A word of caution. There is no shortage of people in this world willing to take advantage of a vulnerable elder adult. Most of these people are driven by greed. Some believe they are entitled to whatever the elderly person may have because they have been a caregiver. There is no specific profile for this person. If you sense, however, that a person is bringing a vulnerable adult into your office with improper motives, be cautious and ask a lot of questions.

If you have further questions, please feel free to contact the author at (810) 232-3141 or tknecht@ccglawyers.com.

GENESEE COUNTY MEDICAL SOCIETY
DINNER BUSINESS MEETING

Thursday, May 3, 2012

A Town Hall Meeting on

The Future of Michigan State University College of Human Medicine

Flint, Michigan - Campus

Michigan State University will be expanding its medical school in Flint in dramatic ways. In addition, it will be housing the public health component of its medical school here. The University is committed to this community and is actively seeking input from the physician community. Come to hear their plans and ideas regarding Public Health Research, the MPH program (including practicum students and outreach), the medical school expansion, and the big picture for the University in Flint. Come also to provide feedback to them. Speakers for this meeting will include Leslie Johnson, Program Coordinator for the Program in Public Health, Jerry Kooiman, Assistant Dean for External Relations, MSU College of Human Medicine, Jeffrey Dwyer, MD, PhD, Associate Dean for Research and Community Engagement, MSU College of Human Medicine, and Dean Sienko, MD, MPH, Associate Dean for Public Health and Preventive Medicine, MSU College of Human Medicine.

Please also come to hear an update on the GCMS strategic plan, which is designed to maintain this organization as Michigan's most productive county society. Please invite your colleagues and spouses.

All physicians, spouses, and family members of GCMS and GCMSA and interested other professionals are invited.

$30 - GCMS Members, Spouses & Their Practice Managers
$20 - Residents & Students
$50 - Non-Members & Non-member Practice Managers

Reservations required by April 27, 2012

FLINT GOLF CLUB
3100 Lakewood Dr., Flint, MI 48507

6 p.m. - Registration &Social Hour
6:30 p.m. - Dinner
7 p.m. - Meeting
7:15 p.m. - Presentations

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

Call Sheree at 810-733-9923 or email at sayres@gcms.org for more information.

Genesee County Medical Society Board Meeting

February 28, 2012 - MINUTES

In Attendance

*Shafi Ahmed, MD
Abd Alghanem, MD
*Suresh Anné, MD
*Qazi Azher, MD
*Amitabha Banerjee, MD
Jagdish Bhagat, MD
Cathy Blight, MD
*Laura Carravallah, MD
Edward Christy, MD
Pino Colone, MD
*Niketa Dani, MD
Deborah Duncan, MD
Hesham Gayar, MD
*Mona Hardas, MD
*John Hebert, III, MD
Michael Jaggi, DO
*Rima Jibaly, MD
*Gary Johnson, MD
Jitendra Katneni, MD
Farhan Khan, MD
Samasandrapalya Kiran, MD
*Nita Kulkarni, MD
*Paul Lazar, MD
Sreen Mannam, MD
AppaRao Mukkamala, MD
*Bobby Mukkamala, MD
*Gerald Natzke, Jr., DO
Venkat Rao, MD
Lawrence Reynolds, MD
*Brenda Rogers-Grays, MD
*Raymond Rudoni, MD
Dan Ryan, MD
*Jagdish Shah, MD
Jawad Shah, MD
Robert Soderstrom, MD
Kenneth Steibel, MD
*Peter Thoms, MD
*Tarik Wasfie, MD
*John Waters, MD

Staff:
*Rosa Wang
*Peter Levine, Staff
*Venu Vadlamudi, MD

Guests:
*Justin Lockwood – MSU Student
*Erin Lorencz – MSU Student
*Angela Marchin – MSU Student
*Amanda Winston – MSU Student
*Rachel Paneth-Pollack – MSU Student
*Nabil Abou-Baker – MSU Medical Student
*Jonathan Hartman – CC&G

CALL TO ORDER:
The meeting was called to order at 6:00 p.m. by Laura Carravallah, MD, President in the Rapport Conference Room.

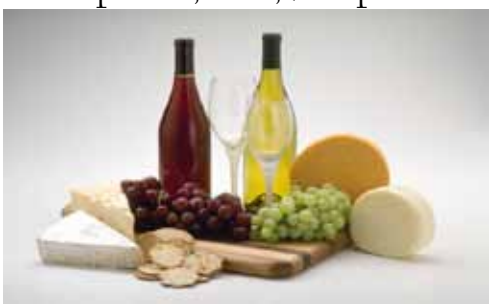
Review of Minutes:
Motion: That the minutes of January 24, 2012 Board of Directors meeting be approved as presented. The Motion Carried.

Motion: That the Budget to Actual Report for the period ending January 31, 2012 be approved as presented. The Motion Carried.

Strategic Plan:
Dr. Carravallah introduced David Fox facilitator for the GCMS Board strategic planning process. The strategic plan was revisited as the sole business of the meeting. The draft plan was referred to the Executive Committee for revision, resubmission to the Board in March, and presentation to the membership at the May Dinner Business Meeting.

Adjournment:
No further business appearing. The meeting was adjourned at 7:50 p.m.

GCMS Alliance
Wine Tasting Event
April 20, 2012, 7:00 p.m.



Location:
Dr. Daniel & Mary Ryan's Lake Fenton Home
Catered by Chef Luis Fernandez
Wine provided by a Sommelier from
The Great Lake Wine Co.

RSVP:
Mary Ryan: (810) 235-3415
Cheryl Thoms: (810) 732-7719
pscIthoms@earthlink.net

$50/person, seating is limited to 40 people

HAPPY BIRTHDAY DOCTOR

APRIL

Devinder Bhrany	1	Syed Sattar	10	Gerald Cole	22
Muhammad Jabbar	1	Edwin Smith	10	Alan Weamer	22
Gail Dawson	2	David Seubert	11	Thomas Bossi	23
Vemblaserry Jayabalan	3	Elisea Singson	12	Donald Bryant	24
Kenneth Jordan	3	Jeffery Diskin	13	Ziyadeh Khoury	25
Wilbur Boike	5	Huda Elhwairis	13	Nita Kulkarni	26
Imad Issawi	5	W Archibald Piper	13	James Martin	26
Carlo Dall'Olmo	6	Fook Cheung Kuet	15	Rima Jibaly	26
Qazi Azher	6	Don Rubino	15	Hesham Gayar	28
Kurt Mikat	7	M Varkey Thomas	15	Ok Kyun Kang	28
John Bauer	9	Peter Thoms	15	Richard Prior	28
Gregorio Lecea	9	Abdullah Raffee	19	Sunita Tummala	29
Susan Smith	9	Gregory Forstall	21	Mark Camens	29
Byung Ho Chang	10	Louis Coriasso	22	Seif Saeed-Elasad	30

CLASSIFIEDS

OFFICE SPACE AVAILABLE
Small office located by front door of Genesee County Medical Society suite. Great exposure for businesses seeking visibility with physicians. Conference room availability possible. Office size 100 sq. ft. at $12 per sq. ft. triple-net. Additional office space available. Contact Pete Levine at (810) 733-9925 for details.

FULL-TIME PHYSICIAN NEEDED
at the Emergency Medical Center of Flint Various shifts available for part-time, as well. Must be willing to do minor stitches, infants & children, splinting, and minor eye & ear procedures. This is a classic urgent care much like family practice. Hours of operation 9:30am – 9pm, 7 days a week, closed on major holidays Located at 2284 S. Ballenger Hwy., Suite 2, Flint, 48503. Contact Pete Levine at 810-733-9925.

If you or someone you know would like to advertise in *The Bulletin* please contact Sheree at sayres@gcms.org or (810) 733-9923.

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

GENESEE COUNTY MEDICAL SOCIETY
4438 Oak Bridge Dr., Suite B
Flint, MI 48532
810-733-9923

Please PRINT or TYPE

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

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 _____

Languages Spoken _____

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(ies) _____

Board Certifications (list specialties & dates) _____

Present Hospital Appointments (list dates) _____

Practice History _____

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 GENESEE 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 Genesee County Medical Society, or FAX to 517-336-5797. THANK YOU!