PENNSYLVANIA MEDICAL SOCIETY — THE POWERFUL VOICE FOR PHYSICIANS

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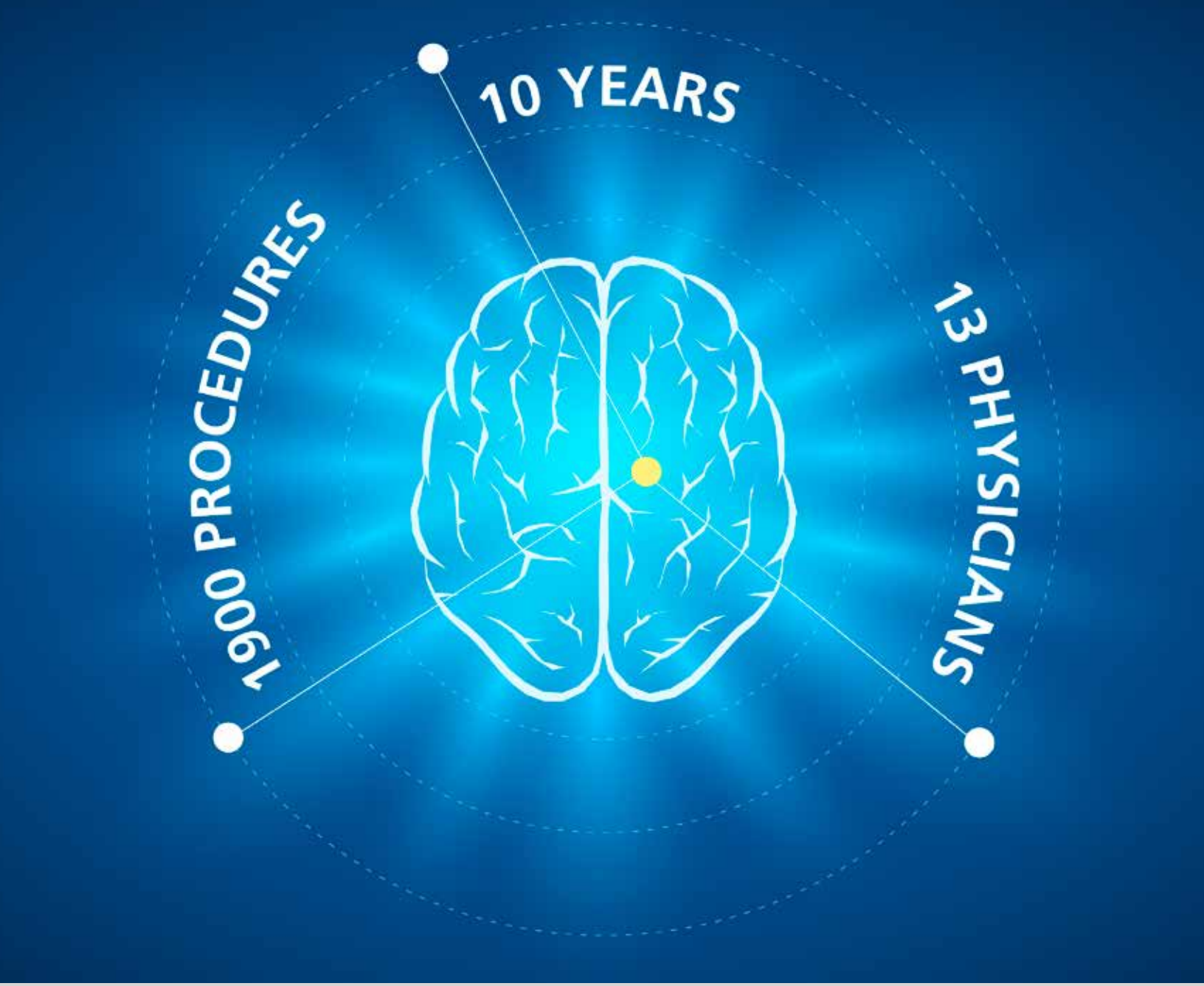
PHYSICIAN

THE ART OF MEDICINE

Advocating for the Doctor-Patient Relationship

Spring / Summer 2018 | Volume 5 | Number 2



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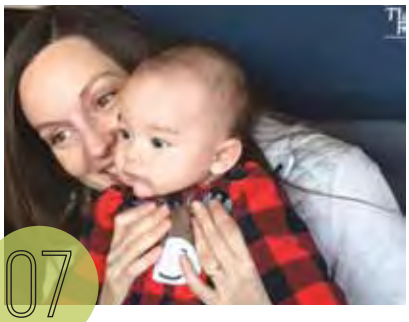

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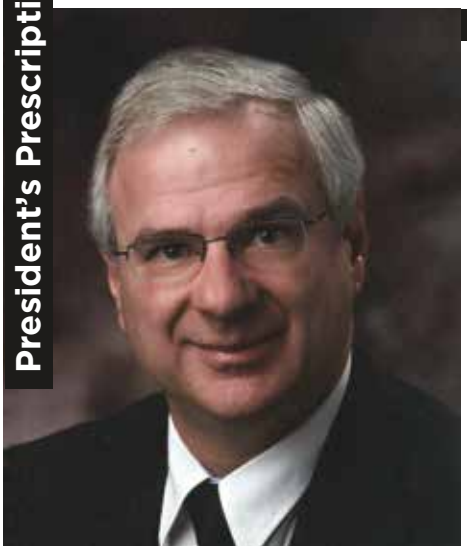

Theodore Christopher, MD, FACEP
President, PAMED

GETTING PHYSICIANS BACK TO THE ART OF MEDICINE

When you see a piece of art or hear a piece of music, it evokes empathy and emotions. It stimulates a different part of the brain. But, what does this have to do with medicine?

The Art of Medicine is really gaining traction in medical schools today. At Jefferson, we have a College within the College (CwiC) humanities track, where students are exposed to professional artists and a core curriculum of arts workshops, including theater, visual art, music, writing, and critical inquiry. These sessions will develop skills in young physicians related to observation, interpretation, reflection, critical thinking, effective communication, and empathy.

WE NEED TO GET BACK TO PRACTICING OUR ART — SEEING AND CARING FOR OUR PATIENTS, NOT OUR PAPERWORK!

Building technical and conceptual skills in the arts and humanities allows for practicing habits of mind that are as essential to the successful practice of medicine as mastery of basic science and other clinical skills. Many of these workshops take place at art museums or local theater companies and are now coordinated with liberal arts universities.

In this issue of *Pennsylvania Physician*, check out how the Penn State College of Medicine infuses humanities and the Art of Medicine into its education on page 30. You'll also read several other fascinating articles about the Art of Medicine, such as the art of advocacy (page 48), the art of residency and motherhood (page 7), and the art of palliative care (page 22).

You'll also learn more about the Pennsylvania Medical Society's (PAMED) new brand, The Art of Medicine, which focuses on not only educating, but also advocating and navigating a path for physicians to return to the Art of Medicine — so that we may get back to why we went to medical school in the first place: to keep patients healthy.

Physicians struggle for medical autonomy, and it feels like there's a never-ending sea of roadblocks — new legislation/regulations and insurance policies just to name a few. We should be able to treat patients how we see fit, not how we are mandated by the government or insurance companies. We need to get back to practicing our art — seeing and caring for our patients, not our paperwork!

Let's rise and stand together so we can paint a better landscape for Pennsylvania physicians.

If you are a member, thank you for your continued support in membership. If you're not yet a member, join us at *JoinNow.pamedsoc.org* and let us help return you to the Art of Medicine.

Theodore Christopher, MD, FACEP
President, PAMED

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SPRING | SUMMER 2018
VOLUME 5 | NUMBER 2

EDITORIAL
Executive Vice President:
Martin P. Raniowski, MA, FCPP
Deputy Executive Vice President:
Heather A. Wilson, MSW, CFRE, FCPP
Editor-in-Chief: *Kerry Royer*
Deputy Editor: *Rachel Damrauer, MPA*

CREATIVE
Design:
graphcom
Stacy Bolden

SALES
Sales Representatives:
Kylee Myers, (717) 420-2243

Published in partnership with:
graphcom
1219 Chambersburg Road
Gettysburg, PA 17325
Phone: (800) 669-1664

Pennsylvania Physician is published by the Pennsylvania Medical Society (PAMED), 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17150-8820.

Mission: The Pennsylvania Medical Society is the voice of Pennsylvania's physicians, advancing quality patient care, the ethical practice of medicine, and advocating for the patients they serve. We promote physician leadership, education, professional satisfaction, practice sustainability, and the public's health.

Subscriptions: For subscription information, call (800) 228-7823, Ext. 2653, or email *PennsylvaniaPhysician@pamedsoc.org.*

Postmaster: Send address changes to *Pennsylvania Physician*, PAMED, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA 17105-8820.

SUMMONING THE HEART OF MEDICAL PRACTICE

On Sept. 12, 1962, President John F. Kennedy addressed a large crowd at Rice Stadium in Houston to advocate for the American people to endorse the Apollo program, a national effort to land a man on the moon. I often consider the strength it took him to lead our country there.

The resounding chorus beckoned the American people when he said, "We choose to go to the moon. We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win, and the others, too."

The part of the address that speaks most powerfully to me is when President Kennedy said, "So it is not surprising that some would have us stay where we are a little longer to rest, to wait. But this city of Houston, this State of Texas, this country of the United States was not built by those who waited and rested and wished to look behind them. This country was conquered by those who moved forward — and so will space."

What if in 1848, those who founded PAMED would have decided to rest, to wait? I'm so grateful to those who took action and spurred our establishment. It takes strong leadership to ignite new beginnings.

PAMED is launching an exciting new campaign to focus on the Art of Medicine. We are summoning what is at the heart of the medical practice. We honor our roots of preserving the doctor-patient relationship. Our new way of communicating does not diminish the past, but rather helps us evolve to a new stage. I take inspiration from those before us who decided not to be afraid of where we are going — and took a leadership role to grow and change.

Martin P. Raniowski, MA, FCPP
Executive Vice President, PAMED

As we stay true to the values that kindled our beginnings, PAMED is changing to become more responsive and timely, and allow for a better outreach to *every* member. That outreach includes the opportunity for interactive ways to communicate between you and PAMED.

You chose to become a physician not because it was easy but because it was a calling. It was a hard choice but one you accomplished. We have more hard choices ahead; however, PAMED is here for you, will listen to you, and will continue to work on your behalf.

If you are a member, thank you and we look forward to engaging with you more and more. If you are not a member, you can find out more of what PAMED does for physicians by joining at *JoinNow.pamedsoc.org.*

Martin P. Raniowski, MA, FCPP
Executive Vice President, PAMED

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Pre-course Enduring Materials: The Pennsylvania Medical Society designates these enduring materials for a maximum of *9.0 AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activities.

Designation & Accreditation Statement:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Pennsylvania Medical Society and The Foundation. The Pennsylvania Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

The planning committee members and faculty do not have any relevant financial relationships to disclose.

Coming Soon
Best Practices and Communications Course

This course is a two-day educational program aimed at enhancing medication prescribing behaviors and will examine this important topic from legal, regulatory, biomedical, clinical, patient, and patient safety perspectives.

This course is designed to address provider-patient as well as provider-provider communications. Attendees will learn to enhance their patient-centered interviewing skills and will also review best practices in healthcare team communication.

Learning Objectives:

- Improve their communication with patients and healthcare peers
- Identify strategies to improve overall healthcare team communication
- Apply patient-centered communication techniques in patient encounters
- Understand factors contributing to practitioner burnout

The Foundation of the Pennsylvania Medical Society

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Congratulations PAMED Staff inducted into Fellows of the College of Physicians of Philadelphia

Martin A. Raniowski, MA, FCPP

Heather A. Wilson, MSW, CFRE, FCPP (second from right)

Photos above by Todd Photography

The nation's oldest medical society, ***The College of Physicians of Philadelphia,*** welcomed 30 new members to its prestigious Fellowship of leading experts in the medical and public health fields including Foundation of the Pennsylvania Medical Society Executive Director and Deputy Executive Vice President of the Pennsylvania Medical Society Heather A. Wilson, MSW, CFRE, FCPP, and Executive Vice President of the Pennsylvania Medical Society Martin A. Raniowski, MA, FCPP. ⬣

CALENDAR OF EVENTS

LEARN ABOUT UPCOMING EVENTS

Foundation of the Pennsylvania Medical Society Lifeguard CMEs

Controlled Substance and Opioid Prescribing Educational Course

- **Nov. 8 - 9** Philadelphia

Learn more and register at *www.lifeguardprogram.com*

2018 PAMED Board of Trustees Meetings

- **Aug. 14 - 15** PAMED Headquarters, Harrisburg
- **Oct. 26 & 28** Hershey Lodge, in conjunction with PAMED's 2018 House of Delegates

Practice Administrator Leadership Development Training

PAMED Headquarters, Harrisburg

- **July 19** (Topics include communication strategies, strategic thinking and decision making, and employee engagement/ performance management)

www.pamedsoc.org/ PracticeAdminLeadership

Fall Practice Administrator Meetings

- **Sept. 18** Hilton Garden Inn, Cranberry Township
- **Oct. 2** PAMED Headquarters, Harrisburg

www.pamedsoc.org/ManagerMeeting

2018 - 2019 Year-Round Leadership Academy

Combination of live and online courses; live courses will be held at PAMED Headquarters in Harrisburg.

- **Sept. 14, 2018** New Model of Physician Leadership: Leading from the Front (Live)
- **Oct. 2018** Resolving Conflict (Online)
- **Nov. 2018** Ethical Challenges of Physician Leaders (Online)
- **Jan. 2019** Fundamentals of Physician Leadership: Quality (Online)
- **Feb. 2019** Principles of Financial Decision Making (Online)
- **March 2019** Strategic Thinking (Online)
- **April 12, 2019** Fundamentals of Physician Leadership: Negotiation (Live)
- **May 2019** Fundamentals of Physician Leadership: Influence (Online)
- **June 21, 2019** Physician Performance Management (Live)

www.pamedsoc.org/YRA

2018 House of Delegates

- **Oct. 26 - 28** Hershey Lodge, Hershey

www.pamedsoc.org/calendar

THE ART OF MOTHERHOOD AND RESIDENCY

BY SOPHIE OH, MD

My first day on inpatient service back from maternity leave, our team sets out for rounds with our census lists, pens, and stethoscopes. First up, a 77-year-old gentleman with a COPD exacerbation. We arrange ourselves standing in a half-circle around the patient's bed. He's thin and frail-appearing. My sign-out sheet says that his contact person is his neighbor; he has friends but no family. He isn't sure which medications he's supposed to be taking.

The medical student starts her presentation. I stand with my hands clasped in front, clutching my sign-out list with its numbers, checkboxes, and medication dosages. I'm half-listening and my mind wanders. Suddenly, it occurs to me that this man lying on the bed was once my son's age. He was once three months old, with smooth skin and chubby cheeks and an adorable toothless grin. Then I think — he once had a mother who watched his face for hours while he slept, who marveled at his tiny fingernails, who had hopes for him — what did she hope for? What did she imagine life would have in store for him?

The next day, I'm seeing my patients before the sun comes up to prepare for rounds. My 99-year-old patient with pneumonia in the progressive care unit is deaf, bedbound, has poor eyesight, and has dementia. She also has a dry sense of humor and amazingly loves her thickened apple juice and thickened water that the nurses spoon feed to her because of her dysphagia.

"How are you feeling today? Still having that cough?" I ask her as I walk into her room.

No answer.

"HOW ARE YOU FEELING TODAY?" I scream into her ear.

"Yes please," she says, gesturing toward the thickened juice on her bedside table.

I have six more patients to see. My main goal in this room is to obtain the information I need to write the subjective and exam portions of my progress note. But her nurse is in another room, so I open the juice container and feed her a spoonful.

"HOW IS YOUR COUGH?"

"Yum. More please."

Another spoonful. I'm getting antsy because I don't have time for this. **"HOW DO YOU FEEL COMPARED TO YESTERDAY?"**

"Yum. More please."

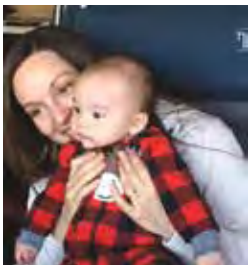
Another spoonful. **"HOW IS YOUR COUGH?"**

"Yum. More please."

We all need care when we are very young and when we are very old. While my son is young, while I'm still around, I can take care of him myself, or I can choose caregivers I trust to make sure his needs are met with patience and kindness. Here in this elderly patient's hospital room, I am confronted with the inescapable fact that when my son grows old, I won't be there to care for him.

I hope that he is lucky in love and friendships, so that when he is in the hospital, he has phone calls and visits from his children, grandchildren, friends, or neighbors. And I hope that when he asks for his thickened juice from a busy resident, she will take the time to sit with him, chat briefly, or rearrange his pillows to make him more comfortable.

So I pull up a chair and help my patient finish her juice. In that moment, I wasn't just a busy resident preparing for rounds. I was a mother, taking the time to feed another mother's child.



Sophie Oh, MD, is a family physician in Abington.

IN THAT MOMENT, I WASN'T JUST A BUSY RESIDENT PREPARING FOR ROUNDS. I WAS A MOTHER, TAKING THE TIME TO FEED ANOTHER MOTHER'S CHILD.

HOW DO YOU CULTIVATE THE ART OF THE DOCTOR/PATIENT RELATIONSHIP?

We asked members of PAMED's sections about the doctor/patient dynamic. Here's what they told us.

Sonia Bhandari, MD

RESIDENTS AND FELLOWS SECTION PERSPECTIVE

SONIA BHANDARI, MD

RESIDENT
GENERAL SURGERY, PHILADELPHIA

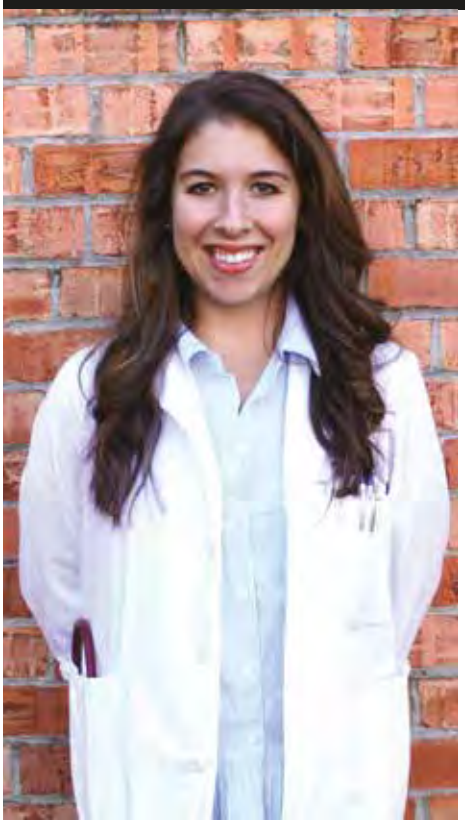
"Preconceived notions about race, religion, gender identity, and social norms often serve as the first hindrance to forming an immediate connection in the patient-physician relationship. As physicians, we are taught to always look beyond that. But for patients, trust is not always given away easily. After all, these individuals trust us with their health and treatment. They should, of course, be able to form that relationship on their own accord.

As a Southeast Asian female, many times patients judge my care before uttering a word due to these very same preconceived notions.

Through medical school and now residency, I've come to understand and experience that the physician can often make the first step of building trust. Being knowledgeable, polite, and confident — but not arrogant — seems to help patients bring their wall down just enough to come to understand details of their lives that may help us treat their current conditions. In return, we must also see all of our patients as individuals as opposed to sects of individuals, from which may stem misunderstandings and unnecessary assertions.

Past experiences often cause individuals to pass judgment subconsciously and behave differently with them, which may then shadow the ultimate treatment for which the patient is seeing you. In our time and age, I strongly feel that cultivating a healthy and productive patient-physician relationship can only be done if we set aside our differences and truly treat one another as individual human beings."

CULTIVATING A HEALTHY AND PRODUCTIVE PATIENT-PHYSICIAN RELATIONSHIP CAN ONLY BE DONE IF WE SET ASIDE OUR DIFFERENCES AND TRULY TREAT ONE ANOTHER AS INDIVIDUAL HUMAN BEINGS.



Gillian Naro

MEDICAL STUDENT PERSPECTIVE

GILLIAN NARO

PENN STATE COLLEGE OF MEDICINE, MS2

VICE CHAIR OF COMMITTEE ON BIOETHICS AND HUMANITIES, AND MEMBERSHIP CHAIR FOR REGION 6
AMA

AMA CHAPTER PRESIDENT AND PAMED SCHOOL DELEGATE
PENN STATE COLLEGE OF MEDICINE, HERSHEY

"In medical students' pursuit of clinical and scientific knowledge, we also must quickly learn detachment. In this profession, detachment does not mean we are cold and uncaring; rather, it is a unique way to facilitate stronger connections.

We are mindful of emotions in the moment when visiting a patient, and we indulge in sharing in their hopes and fears and pain. Empathizing with these feelings is what ultimately guides us to make the right decisions to help these patients. Healthy 'detachment' is leaving those feelings in the exam room so we do not carry them with us to the next patient, thereby allowing us able to properly devote ourselves to each individual. This process helps us as medical students and physicians to make unbiased decisions and remain professional.

While we don't bear the full weight of every tragedy, we maintain a vulnerability that allows us to relate to and empathize with those we treat. This is the art and practice of medicine. A physician with 26 years of experience shared this advice: 'To commit yourself long-term to the relationship, put everything into it. Ask the hard questions. Be part of the family, but be detached enough to do the work.'

This art, this balance, is what makes this profession not merely a career, but a calling."

What Are PAMED's Sections?

Rapid, radical change faces the medical profession, but the younger generation — early career physicians, medical students, residents, and fellows — have the opportunity to shape their own futures. Similarly, the International Medical Graduates section brings together physicians with diverse backgrounds to share their concerns and experiences.

PAMED's sections for these diverse groups serve as their voices across the state. Members of the sections are engaged and involved in PAMED initiatives and policymaking.

PAMED's Sections:

Early Career Physicians Section (ECPS)

Residents and Fellows Section (RFS)

Medical Students Section (MSS)

International Medical Graduates Section (IMG)

To get involved in one of the sections, contact our Knowledge Center at 855-PAMED4U (855-726-3348). Or, email us at KnowledgeCenter@pamedsoc.org.

ENGAGING IN MIPS: THE QUALITY PAYMENT PROGRAM IN 2018

BY TARA GENSEMER

As we look at 2018 reporting, the Centers for Medicare and Medicaid Services (CMS) continues to build the Quality Payment Program (QPP) infrastructure assisting clinicians to make the transition from volume to value. Year 2 changes include further burden reduction and bonus opportunities for participants as part of CMS' Patients over Paperwork Initiative.

Clinicians who choose to participate in the Merit-based Incentive Payment System (MIPS) — one of two tracks within the QPP — will be scored based on their level of participation in four performance categories:

1. **Quality —** Replaces Physician Quality Reporting System (PQRS)
2. **Cost —** Replaces the Value-based Payment Modifier
3. **Promoting Interoperability —** Formerly known as Meaningful Use, and more recently known as Advancing Care Information
4. **Improvement Activities —** Introduced as a new QPP category in 2017

These categories will be scored individually and added together for a MIPS final score. Quality weight will be reduced from 60 to 50 percent, and Cost will be factored into Year 2 at 10 percent. Promoting Interoperability will remain at 25 percent and Improvement Activities at 15 percent.

The MIPS final score will determine a clinician's payment adjustment: positive, negative, or neutral. One major change for QPP clinician engagement has been the increase of the MIPS performance threshold, which outlines the points necessary to achieve a neutral or positive payment adjustment. The performance threshold has increased from 3 to 15 points for the 2018 performance period, requiring more participation efforts from clinicians in 2018 to earn payment adjustments between +/- 5 percent.

To successfully report quality measures for 2018, clinicians and groups will be reporting quality data for the entire year. Reporting options for the Quality performance category remain the same in Year 2, although the threshold for complete data submission has increased from 50 to 60 percent of all patient data, regardless of payer.

While CMS moves toward full implementation of the program, QPP Year 2 introduces scoring of the MIPS Cost performance category. The Cost component of MIPS replaces the Value-based Payment Modifier program, and is referred to as "Resource Use" in the MACRA legislation. The Cost category evaluates clinicians on the costs associated with their Medicare patient population, and is a measure of the cost of Medicare spending. No reporting is required of clinicians; all scoring is based on Medicare claims data.

Scoring improvement for the Quality performance category is new for 2018. Quality improvement can earn reporters up to 10 percentage points and will be based on scoring improvement from the previous year. It is not necessary to select the same quality measures to achieve improvement scoring. Your improvement score will be based on the rate of improvement at the performance category level, not the measures selected.

In an effort to help reduce small practice burden, CMS is awarding a small practice bonus of 5 points, which will be applied to the final score for MIPS eligible clinicians in groups, virtual groups, or Alternative Payment Model (APM) entities that have fewer than 15 clinicians.

MIPS will be scored based on clinicians' level of participation in four performance categories:

1. **Quality**
2. **Cost**
3. **Promoting Interoperability**
4. **Improvement Activities**

As an added benefit, participants who treat complex patient populations based on medical complexity can earn up to 5 bonus points. This complex-patient bonus will be measured using the average Hierarchal Condition Category (HCC) risk score plus a score based on the percentage of dual-eligible beneficiaries.

To earn small practice or complex patient bonus points, data must be submitted for at least one performance category for the 2018 performance period.

Policies related to the creation of virtual groups were finalized for participation in Year 2. A virtual group is a combination of two or more taxpayer identification numbers (TINs) consisting of 10 or fewer eligible clinicians. This group of multiple TINs elects to participate in MIPS as a virtual group. The formation of virtual groups provides for shared resources and responsibility for measurement of MIPS performance. Virtual groups will aggregate their data across all TINs within the virtual group for all four MIPS performance categories. Then, each member will have their performance assessed and scored at the virtual group level.

Several provisions of the 21st Century Cures Act will be implemented, including special status reweighting of the Promoting Interoperability performance category. In 2018, MIPS eligible clinicians will see that off-campus outpatient hospital was added as a place of service, prompting automatic reweighting of the Promoting Interoperability category to the Quality category. Retroactive to 2017, clinicians who are based in an Ambulatory Surgical Center will also receive this automatic reweighting.

Eligible clinicians using a decertified EHR, those experiencing significant hardship exceptions under MIPS, and small practices able to demonstrate overwhelming barriers that prevent participation can submit a hardship exception application by Dec. 31, 2018, to reweight the Promoting Interoperability performance category to zero of the MIPS final score.

An additional bonus opportunity available to clinicians in Year 2 includes a 10 percent bonus for using 2015 Certified EHR Technology (CEHRT). Bonus opportunities carried over from Year 1 include a bonus for additional high-priority measures and end-to-end electronic reporting of the Quality performance category.

For more information on MIPS, APMs, and the QPP Year 2, PAMED offers a comprehensive guide to members for successful participation. To access *MACRA Made Simple — A Guide to the Quality Payment Program Year 2,* visit *www.pamedsoc.org/MACRA.*

Find out how PAMED's Care Centered Collaborative can help you with MIPS reporting and more at *www.patientccc.com.*

Tara Gensemer is a practice support specialist with PAMED's Practice Support Team. Email her at *tgensemer@pamedsoc.org.*

MALPRACTICE

TAKES THE STAGE IN ERIE

When the rigors of practicing medicine start to pile up, there's one way to find a healthy diversion for a few physicians and others involved in health care in Erie — they take it to the stage. Malpractice, a rock band boasting "Healthcare with Attitude," has been playing live events for more than five years.

By day, Paul Mirone, MD, is a family practice physician, but also performs as rhythm guitarist and back-up vocals for Malpractice. He was playing bass at church when he was asked to join the band that consists of a trauma surgeon who is lead singer, two family physicians, a nurse practitioner, and the husband of a nurse practitioner.

Malpractice Bandmates (left to right) Paul Mirone, MD; Jeff Larson, CRNP; Mike Marino, David Dexter, MD; and Rob Chandler, DO.

HEALTHCARE WITH ATTITUDE

Anyone involved in health care wonders how they find the time to rehearse. "We all come from a musical background so we are lucky in that the songs come easily to us and we often play what we know," says Dr. Mirone. They play rock, pop, new wave, country, and the occasional request — they once had to learn "Hang on Sloopy" for a party consisting of Ohio State University fans.

Malpractice has its own fan following affectionately known as the "Band Aids." They come to see the band perform at outdoor venues such as Erie street fairs, bars, restaurants, and vineyards. The band's first gig was a birthday party, and they have been receiving requests to play via word of mouth ever since.

"We sometimes have to turn down invitations because of our hectic schedules." says Dr. Mirone who was once on set while he was on call. "Of course, my pager went off the moment before we were about to start," he says. But who could better understand this dilemma than his fellow physician bandmates?

Dr. Mirone says the best part of being in the band is the euphoria of watching the crowd's curious reaction to a rock band whom they know from the exam room. "But when the crowd starts to sing along, play air guitar, and dance, that is absolutely the part I enjoy most."

Medicine Is Under Attack!

"Get ready! The next wave of legislation is rolling in."

Support pro-physician, pro-patient legislators
Join PAMPAC—the muscle of PAMED!

Make an impact on PAMED's legislative priorities:

- Informed Consent
- Prior Authorization
- Opioid Abuse
- Telemedicine
- Team-Based Care/Scope of Practice
- Maintenance of Certification (MOC)
- Drug Formularies

PAMPAC
Pennsylvania Medical Political Action Committee

PAMPAC is the political arm of the Pennsylvania Medical Society. Membership in PAMPAC is voluntary and serves as the united voice of physicians in the political arena. PAMPAC contributes to candidates for state office who support the priorities of the Pennsylvania Medical Society membership.

Learn more about these and other issues at **www.pamedsoc.org/Advocacy.**

17/593

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> Thank you for providing outstanding educational programs. PAMED's CME courses on both *Recognition and Reporting of Child Abuse and Addressing PA's Opioid Crisis: What Health Care Teams Need to Know* were very useful indeed, to the extent that I have already shared much of what I learned with several other physicians. The courses increase a physician's understanding of these important issues and introduce and provide resources that will support further learning and commitment to utilize aspects of the courses in our daily practice of medicine.

Phyllis Dioguardi, MD, PAMED Member
Philadelphia

MEDICINE'S GREATEST MASTERPIECE: HEALTHY PATIENTS

HOW PAMED IS HELPING PHYSICIANS RETURN TO THE ART OF MEDICINE

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7 years (or more) of medical school and residency

12,000 – 16,000 hours of clinical training and supervised patient care

Wow … These numbers say it all. Becoming a physician takes an extraordinary amount of dedication and commitment. And, that commitment to provide the best possible care for patients doesn't end after residency: It lasts a lifetime.

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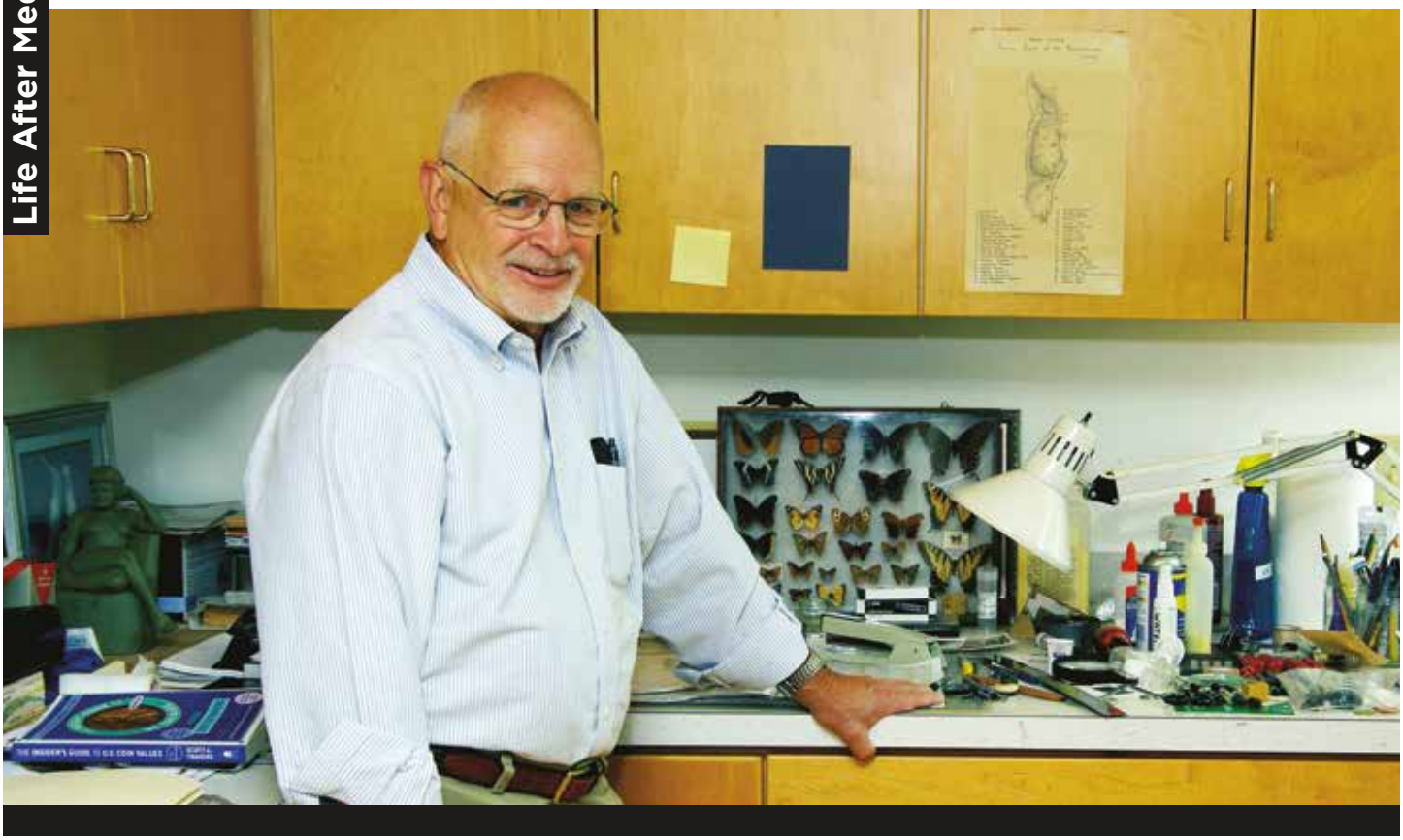
These interactions — helping people, making a difference — are exactly why physicians want to pursue medicine in the first place. **Medicine is an art.**

PAMED is here to ensure that Pennsylvania physicians can keep their focus on patients, on the Art of Medicine, instead of on confusing regulations and non-clinical responsibilities. We assist physicians by **advocating** for care-centered bills, **educating** members on policy changes, and **navigating** administrative tasks.

We've been working with our members to find out how we can help you keep bureaucrats out of your exam room and steer clear of roadblocks that can get in the way of patient care. With the help of ideas and input from physicians, PAMED has launched our Art of Medicine awareness initiative. Check out a quick video that shares the essence of this movement at *www.pamedsoc.org/ArtofMedicine.*

"Change happens so quickly in medicine that we often don't have the time or energy to celebrate our profession," says PAMED Board member Candace Good, MD, a psychiatrist from State College. "The video reminds us that what we do is special and inspires us to protect the physician-patient relationship. PAMED can help us do that."

Let's courageously stand together so fellow physicians in Pennsylvania can confidently stand alone. If you're not yet a PAMED member, join us today at *JoinNow.pamedsoc.org*. If you are a member, thank you for your support.



David Leber, MD

PRACTICING ART WITH THE EYE OF A SURGEON

A favorite sculpture of David Leber, MD, graces a table in his living room. Hands gently clasped in prayer resemble those of his minister father. Dr. Leber created this piece from wood. His inspiration was his father. The hands themselves now resemble those of his own, strong from a long career as a surgeon and tough from decades of use as an artist.

Dr. Leber retired last winter from plastic surgery at his practice on Front and Division Streets in Harrisburg. He now focuses on his lifelong avocation of art by joining the Seven Lively Artists group and uses mediums such as clay, woodcarving, photography, pencil sketches, and pastels. He has recently taken up plein air painting.

An interest in the aesthetic elevated everything he accomplished professionally. Aural surgery became this sculptor's master work. He specialized in cleft palate and ear reconstruction surgery. "The study of sculpture teaches the third dimension, which is imperative when examining the head or face. The angles are important when putting the bones back together and relies on an artistic realism sense. I can better visualize a profile and a front view and then balance the cleft palate in the jaw," says Dr. Leber.

"In turn, medical knowledge informed my sculpture as I specialized in how to portray the anatomy. I'm able to define how the muscles attach to the bones," he says.

He first recognized his talent when he was in high school. "I earned first place in the science fair sculpting from 'Grey's Anatomy.' I was awarded the prize in the biological descriptive division. That always gave me comfort in my expertise," he says.

Dr. Leber has always had an artistic side, which led him to illustrate reference books as a medical student. In college he traveled to the West Indies and Cuba to illustrate more than 250 watercolor pieces of lizards and butterflies for textbooks. He has also completed pen and ink versions of ear reconstruction manuals. "I'm a detail person and that has helped me in all mediums whether it is on paper or with patients," he says. He taught ear reconstruction and his

> I'm a detail person and that has helped me in all mediums whether it is on paper or with patients.
> — David Leber, MD

intricate method of repair to medical students. These complicated procedures require meticulous attention and the eye of an artist.

Travel has fueled Dr. Leber's career. In fact, he has participated in more than 35 mission trips to the Philippines, Thailand, India, Honduras, and Ecuador, where he has been known to donate his time to perform 50 cleft palate surgeries in five-day stints. Spanning the world with his mission trips proved rewarding. The globetrotting also allows him to hone his birdwatching hobby. He has been to every continent including Antarctica to see penguins.

"Retirement? It doesn't feel like retirement," he says. He is busy visiting with his grandson and holding art exhibitions in galleries, including the Pennsylvania State Museum and the Art Center School and Galleries. He also enjoys tennis, golf, and stamp and coin collecting. By the way, if you happen to come across any 1954 or 2009 Jefferson nickels, send them his way. They would complete his collection!

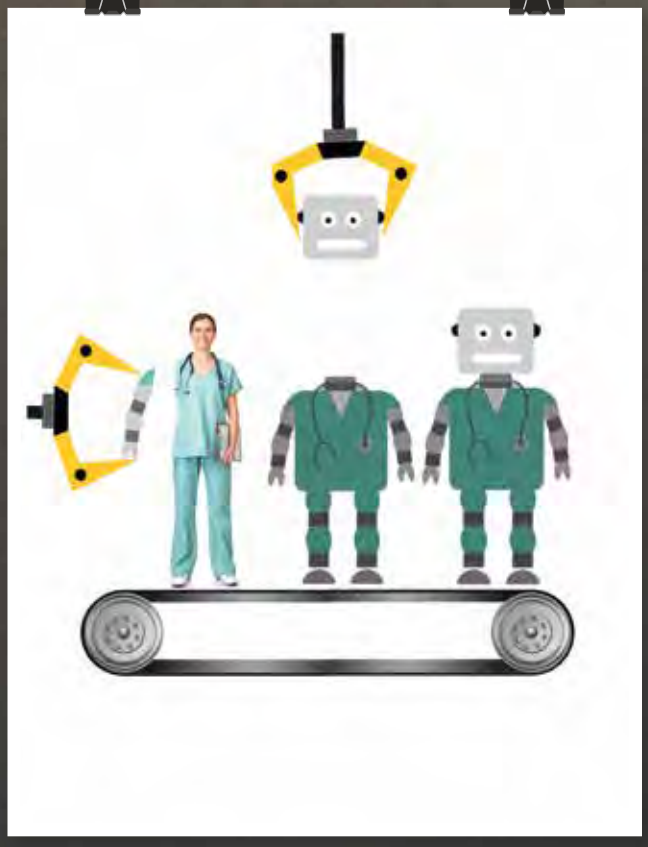
Dr. Leber created this sculpture, "Flames," from walnut and bass (Linden) wood.

Art Student

PAMED EVP Martin A. Raniowski, PAMED President Theodore A. Christopher, MD, and PAMED Board Chair John Gallagher, MD, meet with Art Students Walker Banninger, Rachel Keel, and Ellie Cochran.

This year, PAMED partnered with Pennsylvania College of Art and Design, Lancaster, to support *Art for Social Good*, a class led by Bill Dussinger. Students produced work to be used in PAMED's new marketing messages focusing on the Art of Medicine.

PAMED recognized the artists' work at a quarterly board meeting.



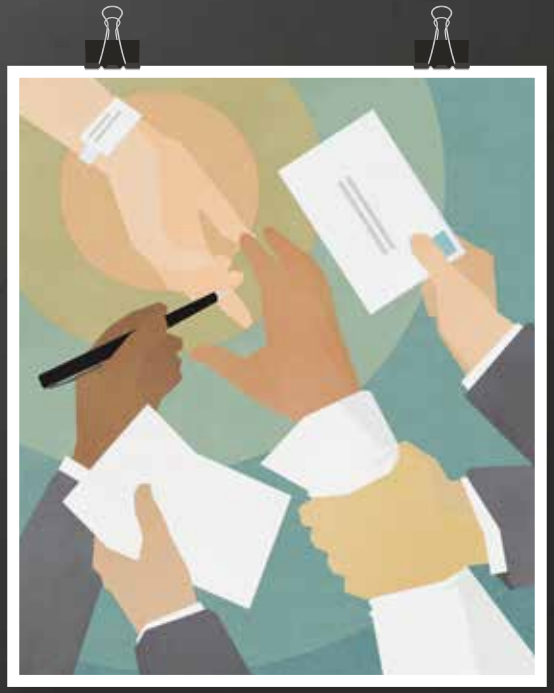
Rachel Keel
"Robots and The Assembly Line"

Logan Myers
"Paperwork"

Awards

Brieanne Trevorrow
"Roadblock"

Walker Banninger
"Puppet"



Ellie Cochran
"Hands"


THE
ART
OF
PALLIATIVE
CARE
By Ric Baxter, MD

COMPASSIONATE CARE AT END OF LIFE IS MORE THAN JUST MEDICINE

People come to the end of their lives in ways that reflect who they are and how they have lived — following the story of themselves. Death is frequently sad, occasionally angry, sometimes chaotic, sometimes joyful, but always personal and unique. In many ways, palliative care and hospice are the most intimate of the caring professions. We are invited to be with people at their most vulnerable moments — to bear witness to unique individuals and their life stories and to walk a journey between life and death. We are called to bring our whole selves into another's suffering and not turn away.

Hospice, as mandated by Medicare's Conditions of Participation, is about the ***anticipation, prevention,*** and ***treatment*** of suffering. All care provided to hospice patients and their families is palliative care — patient/family-centered, holistic, and interdisciplinary care aimed at achieving the goals of dignity, comfort, and life closure. The effective practice of palliative care requires a broad base of medical knowledge if we are to effectively anticipate the needs of that patient-family unit of care.

We must know about their disease, their treatments, their performance status, their social and financial status, and their prognosis, in the short- and long-term. We must be fluent in the language of medicine. Then, we must listen to who they are as individual human beings — what gives their lives meaning, what sustains them, what they are losing. We must learn the language of them.

Finally, we must fully understand our colleagues and what their goals and expectations are for this person and for our involvement with them. We must be able to have a non-judgmental understanding of all of these factors and, at best, put all of these pieces together into a completed picture — sometimes the Mona Lisa, sometimes Jackson Pollock.

The art of palliative care is the thoughtful and judicious application of all that we can bring to support an individual in whatever way is most helpful to them. It may be the expert relief of pain and management of pain and pain medications in an increasingly conflicted society, ensuring comfort and non-judgmental support while establishing safe practices.

Morphine is a useful tool that can be very effective; it is only dangerous when misused. Acupuncture, massage, and Reiki, etc. may also be important options to consider for the person who does not want medicine. Ketamine is proving to be useful in off-label and unexpected situations.

Understanding the multiple causes of nausea and the full spectrum of options that can be brought to bear for the aid of someone suffering is more than the use of Zofran. We must be particularly open and sensitive to the added complexities associated with severe illness combined with significant behavioral health issues, requiring open communication across health care silos and a broad understanding of treatment options. The potential utility of Ketamine for depression arose out of work with severely depressed hospice patients. Working with gynecologic colleagues to consider the palliative placement of a G-Tube in the presence of carcinomatosis and intermittent partial bowel obstruction that may allow a patient to continue to pursue cancer directed treatment.

The art of palliative care requires self-exploration regarding the nature of suffering, excellent and effective communication skills, and the largest "toolbox" possible. As a palliative care physician, I do not ever know what the patient/family ***needs.*** If I can hear what they ***want*** (what is most important), I can open that "toolbox" and always have options for them.

Those options may be grounded in solid medical evidence or they may be appropriate off-label application of existing treatments. They often incorporate non-medicinal approaches to care, and they are ***always*** part of that person's unique plan of care. We must always be mindful that our mere presence may be therapeutic: "... suffering is a mystery that demands a presence." *Anonymous*

Ric A. Baxter, MD, is the network chair, Department of Palliative Medicine; the medical director, St. Luke's Hospice, and program director for St. Luke's University Health Network's Hospice/ Palliative Medicine Fellowship. He is a past president of Pennsylvania Hospice and Palliative Care Network (PHPCN) and currently sits on its Board of Directors. In 2017, Dr. Baxter was honored with The Nancy Bohnet Award for Excellence from the PHPCN. The lifetime achievement award honors an individual who exhibits honesty and integrity in their everyday work and throughout their career.

Editor's Note: The opinions expressed in all guest editorials are those of the author and do not necessarily reflect the views of PAMED.

Pennsylvania Supreme Court to Hear Two Medical Liability Cases

By Andrew Harvan, Esq.

Upcoming court rulings could significantly impact medical liability defense in Pennsylvania. PAMED, with support from the American Medical Association (AMA), has filed amicus briefs in both of the following cases.

Mitchell v. Shikora

In *Mitchell v. Shikora*, the Pennsylvania Supreme Court will decide whether evidence concerning the known risks and complications of a surgical procedure may be presented in a medical liability trial.

This case stems from a bowel injury that the plaintiff, Lanette Mitchell, suffered while undergoing a hysterectomy. Alleging physician negligence, Ms. Mitchell filed a professional liability suit against the medical providers who performed the procedure. Despite Ms. Mitchell's objections, evidence of the general risks and complications associated with hysterectomies was presented at trial. Ms. Mitchell claimed this evidence was irrelevant to her suit's claim of physician negligence and unfairly prejudicial as it misled the jury to infer that her injuries were the result of surgical complication.

Following a jury verdict in favor of the defendants, Ms. Mitchell filed a motion seeking a new trial excluding the risk/complications evidence. The trial court denied Ms. Mitchell's motion. Ms. Mitchell subsequently appealed to the Pennsylvania Superior Court.

The Superior Court reversed the trial court's decision and remanded the case for a new trial without the risk/complications evidence. To reach this conclusion, the Superior Court relied heavily on the recent Pennsylvania Supreme Court case, *Brady v. Urbas*.

In *Brady*, the Supreme Court held that the admissibility of risk and complication evidence is to be conducted on a case-by-case basis. However, unless introduced to establish the relevant standard-of-care, such evidence is generally irrelevant where physician negligence and not lack of informed consent is claimed.

Applying this reasoning to Ms. Mitchell's case, the Superior Court held that Ms. Mitchell's consent to undergo a hysterectomy, despite the risks, was irrelevant to the issue of whether the procedure was or was not performed negligently.

Following the Superior Court's decision in favor of Ms. Mitchell, the defendants appealed to the Pennsylvania Supreme Court. It is expected that the Supreme Court's decision in *Mitchell* will further clarify when risk/complication evidence is admissible under the *Brady* holding.

PAMED has filed an amicus brief in support of allowing general risks and complications evidence in medical liability cases.

Nicolaou v. Martin

In *Nicolaou v. Martin*, a patient asserts that she could not have known her Lyme Disease had been misdiagnosed as Multiple Sclerosis (MS) until she received the results of a later diagnostic test. However, the patient's social media posts indicate otherwise.

Under Pennsylvania law, a plaintiff has two years from the date of alleged malpractice to file a medical liability claim. However, the commencement of this 2-year period can be put on hold if a plaintiff, despite reasonable diligence, could not discover their injury. This exception is known as the "Discovery Rule."

In 2001, Nancy Nicolaou sought medical treatment following a tick bite. After four separate tests for Lyme Disease yielded negative results, Mrs. Nicolaou was diagnosed with MS in 2006. In July of 2009, Mrs. Nicolaou sought help from Nurse Practitioner Rita Rhoads, a specialist in Lyme Disease. Nurse Rhoads began treating Mrs. Nicolaou for Lyme, but a diagnostic test was needed to confirm Nurse Rhoads' clinical diagnosis. Due to financial difficulties, Mrs. Nicolaou was unable to pay for the test until February 2010. On Feb. 13, 2010, Mrs. Nicolaou's diagnosis of Lyme Disease was confirmed.

Also, on Feb. 13, 2010, Mrs. Nicolaou posted on Facebook: "I had been telling everyone for years I thought it was Lyme and the doctors ignore(d) me," to which a Facebook friend of Mrs. Nicolaou's responded: "[Y]ou DID say you had Lyme so many times."

On Feb. 10, 2012, Mrs. Nicolaou filed a medical liability suit against the medical providers who had treated her between 2001 and 2008. Claiming that Mrs. Nicolaou's suit was not timely filed within the 2-year statutory period, the defendants sought dismissal of the case. Mrs. Nicolaou countered that her 2-year period to bring suit began on Feb. 13, 2010. Until her final medical tests confirmed her Lyme Disease, Mrs. Nicolaou argued, she could not have reasonably discovered her previous medical providers' misdiagnosis and thus had no basis for her suit.

The trial court dismissed Mrs. Nicolaou's case. Mrs. Nicolaou then appealed to the Superior Court where a three-judge panel ruled in her favor. The defendants subsequently appealed for reconsideration by the entire Superior Court. Upon this reconsideration, the Superior Court held that sometime before Feb. 10, 2010, Mrs. Nicolaou knew, or reasonably should have known, that her previous medical providers had misdiagnosed her Lyme Disease as MS. To support this conclusion, the Superior Court opined that Mrs. Nicolaou's Facebook posts and her treatment with Nurse Rhoads undermined her argument that she did not believe she had Lyme Disease before February of 2010.

Mrs. Nicolaou subsequently appealed to the Pennsylvania Supreme Court. The Supreme Court must now decide the Discovery Rule's applicability to Mrs. Nicolaou and whether there is a genuine issue of material fact, which should be presented to a jury, as to whether the Discovery Rule should be applied.

PAMED has filed an amicus brief in support of maintaining the integrity of the 2-year statute of limitations and the Discovery Rule. ⬣

Andrew Harvan, Esq.,
serves as PAMED's legal and regulatory analyst.

The ABCs of the NPDB: Disputing a Report

By Andrew Harvan, Esq.

The Winter 2018 edition of *Pennsylvania Physician* outlined the general reporting requirements of the National Practitioner Data Bank (NPDB). Specifically, the article discussed who can and what must be reported to the NPDB. View this article at *www.pamedsoc.org*.

Once processed, a NPDB report is virtually permanent. NPDB information, however, can be voided if successfully appealed. Federal regulations, found at 45 CFR §60.21, contain a specific process by which the subject of a report can dispute NPDB information.

How Will I Know If I Am the Subject of a NPDB Report?

Once a report is processed, the NPDB will send a notification of the report, either through the mail or electronically, to the report's subject physician.[1] Physicians may also perform a self-query at any time and request all reports of which they are the subject of.[2] There are, however, monetary fees for self-queries.[3]

How Can I Dispute a NPDB Report?

If a subject physician disagrees with the accuracy of a NPDB report or questions whether the report was submitted in accordance with NPDB reporting requirements, the physician or their personal representative can enter the report into "disputed status."[4]

As long as a report remains in disputed status, a notation identifying that the report is under dispute will exist on the report in the NPDB. This notation will be visible to all queriers of the report. The reporting entity and all identifiable past queriers of the report will also receive notification that the report has been placed in disputed status.[5]

Entering a report into disputed status does not trigger an automatic review of the report by the NPDB. After placing a report in disputed status, the subject of the report must first attempt to resolve the dispute with the reporting entity.[6] Reporting entities are solely responsible for the accuracy of information contained in NPDB reports. Only a reporting entity can revise, correct, or modify a report.[7] The NPDB has no power to edit submitted reports.

Confronted by a disputed report, the reporting entity can choose to void, revise, correct, or leave the report as is. If after 60 days, the subject physician has not received a response from the reporting entity or is unhappy with the response received, the physician may request secretarial review of the report.[8] Requesting secretarial review of a disputed NPDB report is known as elevating a report to "dispute resolution."

Federal regulations give the secretary of the Department of Health and Human Services (HHS) the authority to review, at the request of subject physicians, the accuracy of NPDB reports.[9] This authority, however, has been delegated from the secretary of HHS to the Division of Practitioner Data Banks within the Health Resources and Services Administration's (HRSA) Bureau of Health Workforce.

The NPDB will only review disputes pertaining to the factual accuracy of a report or whether a report was submitted in accordance with NPDB reporting

[1] 45 CFR §60.21(a)

[2] 45 CFR § 60.18(a)(2)(ix)

[3] 45 CFR § 60.19

[4] 45 CFR §60.21(b)(1)

[5] 45 CFR §60.21(b)(2)

[6] 45 CFR §60.21(b)(3)

[7] 45 CFR §60.6

[8] 45 CFR §60.21(b)(3)

[9] Id.

[10] 45 CFR §60.21(c)(1)

requirements.[10] The NPDB will not consider the merits or appropriateness of a reported action or the due process that the subject received.[11] Dispute resolution, the NPDB cautions, is not a venue to challenge malpractice payments or professional review investigations.

Through dispute resolution, the NPDB will render one of the following decisions:

1. Conclude the report's information is accurate and reportable to NPDB, disputed status notation will be removed, and report will remain as is.

2. Conclude report's information is inaccurate and direct reporting entity to revise the report accordingly.

3. Conclude that the adverse action was not reportable, the NPDB will void the report and distribute notice of voiding to all identifiable past queriers.

4. Conclude that the disputed issue is outside the scope of NPDB review, report will be removed from disputed status.[12]

Once a decision is reached by the NPDB, the NPDB will send the subject and reporting entity notification of the decision and a statement explaining the rationale used to reach this decision.

Reconsideration & Further Appeals

Reconsideration of a dispute resolution decision may be requested.[13] The subject must submit a written request for reconsideration. This request must succinctly explain what issues the subject believes were inappropriately reviewed by the NPDB during its first consideration of the dispute and also include any information that was previously unavailable during the first review.[14] Either the previous decision will be affirmed, or a new final decision will be issued.[15]

To varying degrees of success, physicians have also challenged dispute resolution decisions in federal court under the Administrative Procedure Act (APA). The APA provides that individuals who have suffered a legal wrong because of a government agency decision are entitled to judicial review of that decision.[16] To succeed in such a case, the wronged party must demonstrate that the agency action was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.[17]

Adding a Subject Statement

The subject of a NPDB report can add a statement to the report at any time.[18] The report need not be in disputed status for the subject to add a statement.

Subject statements do not revise, void, or otherwise alter NPDB reports. However, subject statements provide an opportunity for the subject to clarify their involvement, give perspective on the reported event, explain their conduct, or provide additional information that can mitigate the negative impact of a report.

Subject statements are left to the discretion of the authoring physician. The NPDB reserves only the right to redact confidential information and offensive language. Unless edited or removed by the author, subject statements become a permanent part of the report.

Additional Information

Steps can be taken to prevent the dissemination of information to the NPDB. These steps include ensuring that due process rights are respected during professional review proceedings and understanding what actions require a report to the NPDB.

If you wish to dispute a NPDB report, it is recommended that you seek experienced legal counsel immediately. The NPDB Dispute Process is a highly technical procedure governed by specific regulatory provisions.

Pursuant to policy passed at PAMED's October 2017 House of Delegates, PAMED opposes any use of the NPDB to manipulate or dissuade physicians from application and participation on medical staffs.

PAMED is developing additional educational resources on the NPDB for member physicians. These resources will further explain the intricate details of the NPDB, how NPDB reports can be disputed, and steps that can mitigate the damage of a NPDB report. ⬣

Andrew Harvan, Esq., serves as PAMED's legal and regulatory analyst.

[11] Id.

[12] 45 CFR §60.21(c)(2)

[13] NPDB Guidebook: Chapter F-Dispute Process: https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp?page=FDisputeProcess.jsp

[14] Id.

[15] Id.

[16] U.S.C. § 702

[17] 5 U.S.C. § 706(2)(A)

[18] 45 CFR §60.21(b)(3)

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THE GOLDEN AGE OF HEALTH CARE

Penn State Health Milton S. Hershey Medical Center Celebrates 50th Anniversary and the "Art of Caring"

Dennis Gingrich, MD, at a graffiti art-inspired mural in the Penn State Health Milton S. Hershey Medical Center Children's Hospital by muralist Betsy Blyler, coordinator for artistic improvement (at right).

Photos by Shannon Fretz Photography

Knock. Knock. "Hi, I'm Betsy from Center Stage, the art department. Okay if I come in?"

The patient, newly admitted and just settled into her room, agrees, and Betsy enters the room, toting an iPad loaded with art images and a portfolio bag of high-quality art prints. She explains highlights of the *Pick a Pic* program, where patients have the opportunity to choose artwork that hangs in their room during their hospital stay at Penn State Health Milton S. Hershey Medical Center. The Association for Faculty and Friends at the Medical Center funds the program that had a research grant from National Endowment for the Arts.

The typical hospital bed view is a sea of white boards, filled with medical messages written in dry erase marker. Instead, at Hershey, the hospital installed frames in the line of vision, white boards relegated to the side, making way for patients' choice of nearly 100 prints of original paintings by established local artists.

Pick a Pic — a program that also graces other hospitals throughout the country — is just one Medical Center initiative that uses the power of art to create experiences accessible to patients, family, and staff to foster a calm, positive environment of care. Other efforts include creative arts and performances by professional-caliber musicians in the main lobbies and surgical waiting areas.

Like many health care institutions across the country, the Medical Center has embraced the growing arts in medicine movement. Though more recent, arts in medicine also reflects the humanistic approach to medicine envisioned when the Penn State Health Milton S. Hershey Medical Center was founded 50 years ago. When the Penn State College of Medicine opened its doors, the Department of Humanities was one of its initial academic units. Also, it was the first department of its kind to be included in a U.S. medical school.

Betsy Blyler, Penn State Center Stage artist, hangs "Strite's Orchard" by Beth Bathe in a patient room for the *Pick a Pic* program.

PICTURED ABOVE, A CENTER STAGE ARTIST CHANGES ARTWORK IN A PATIENT ROOM.

In a 2017 *Journal of American Medical Association (JAMA)* article from Penn State's Department of Humanities, researchers found that having the choice of artwork in their room gave patients a sense of control. "But beyond the aesthetic and symbolic value of the artwork, patients ... expressed a simple appreciation for being empowered to maintain control of one aspect of their environment during an otherwise miserable, incapacitating stretch of their lives."

"Other patients talked about their paintings not merely as pleasant distractions, but rather as objects that transported them. For instance, landscapes of Pennsylvania Dutch farmhouses, log cabins in the Poconos, backyard gardens, and sunsets along the Susquehanna River evoked thoughts of returning home to loved ones; wooded Appalachian hillsides and realist portraits of native freshwater fish from local streams invited reverie of recent vacations and symbolized the promise of returning to the outdoors after treatment."

—*JAMA*

Photo by Deb Tomazin

COMICS MIGHT NOT SEEM

like required reading for medical students, but that's what's on the syllabus for a unique course taught at Penn State College of Medicine. The month-long class, called *Graphic Storytelling and Medical Narratives*, has medical students read a variety of book-length medically themed comics and also tell their own stories using the medium of comics. By creating comics, the medical students reveal some of the challenges of transitioning from laypersons to physicians, and give voice to the many experiences they have amassed while learning to care for patients with serious illness. According to Michael Green, MD, MS, (pictured above) the creator of this first-of-its-kind course, students thirst for the opportunity to reflect on the challenges they face and to express these challenges creatively.

Michael Green, MD, MS, interim chair of the Humanities Department, describes the humanities as "an integral part" of medical students' education at Penn State Hershey. "Our faculty members have diverse backgrounds, including literature and writing, anthropology, psychology, drama, nursing, bioethics, and end-of-life care," he explains. "In the first and second years of medical school, we seek to foster development of humanistic, curious health care professionals who practice collaborative inquiry and self-reflection."

While the Medical Center has grown by leaps and bounds, the essence of the organization hasn't changed. "Medicine is not only science, it's an art. And that art is caring for people," says professor emeritus, Graham Jeffries, MD, the founding chair of medicine at the Medical Center. "That relationship between a physician and a patient, I think that is still the critical piece," he says. "I think there is a lot of emphasis here on the factors that go into the quality of life and what we can do to improve that."

During their pre-clinical years, students are required to take courses in humanities, science of mind-body, critical thinking, medical ethics and professionalism, and communication. Later, during their final year of medical school, students return to the humanities, selecting from a long list of "selective" courses that range from jazz and the Art of Medicine, to photography, end-of-life care, comics, and medicine. "The fact that humanities has been integrated into the fabric of the institution from the onset has allowed our department to engage in some really innovative teaching that, I think, is hard to do at more traditional institutions," Dr. Green says.

Contributing to the Medical Center's unique approach to the art of healing is its long and proud history in family and community medicine. Like Humanities, the Department of Family and Community Medicine was part of the Medical Center since its founding and was the country's first department of its kind in an academic health center.

PAMED Board Trustee and Penn State Professor of Family and Community Medicine and Humanities Dennis Gingrich, MD, grew up "in the little town of Hershey" where his lifelong family doctor, who even delivered him, was Thomas Leaman, MD. Dr. Leaman became the first chair of an academic family medicine department in the country when he moved his practice from a few blocks away to the hospital as it was still under construction. Dr. Gingrich followed Dr. Leaman to the Medical Center as his patient and later accepted both educational and career advice. He came back to Penn State Hershey as a medical student and, later on, faculty in Dr. Leaman's department. Dr. Gingrich says, "He was thoughtful, friendly, open, wise, and a good listener, and I could talk to him about anything."

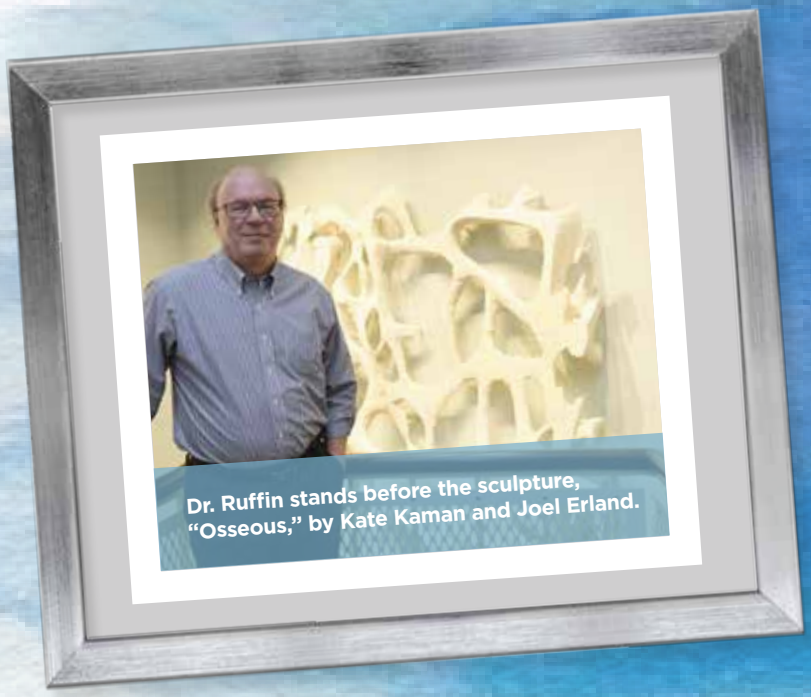
As Dr. Gingrich's career continued at Penn State, Dr. Leaman asked him to be his personal family doctor, in a true circle of life. When Dr. Gingrich agreed, he said he only needed to know what his mentor taught him throughout this unique lifelong relationship: to try to be thoughtful, friendly, open, wise, and a good listener.

Last year, the Department of Family and Community Medicine welcomed new Department Chair Mack Ruffin IV, MD, MPH, from the University of Michigan Medical School in Ann Arbor, Mich. He was drawn to the opportunity to lead the department after examining the foundation of Penn State College of Medicine and the origins of the Department of Family and Community Medicine.

"The Medical Center and the discipline of family medicine were created in 1960s during a time of social unrest: Americans were facing race riots, Vietnam War protests, the draft, and Republican and Democratic National

"Medicine is not only science, it's an art. And that art is caring for people."

—Graham Jeffries, MD



Dr. Ruffin stands before the sculpture, "Osseous," by Kate Kaman and Joel Erland.

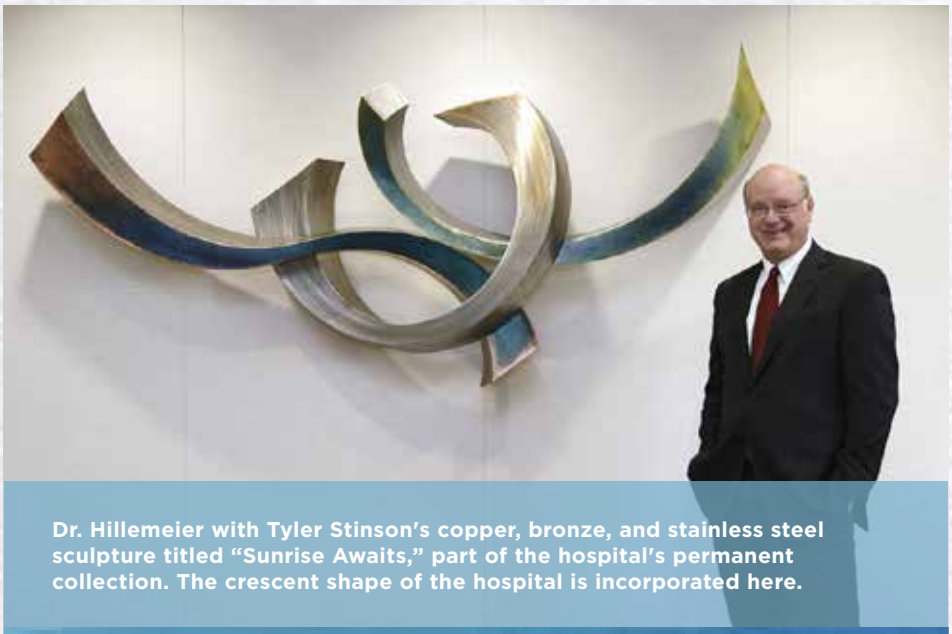
MACK RUFFIN IV, MD, MPH, (pictured at left) says he finds joy in caring for patients over many years. He enjoys family medicine and helping his patients stay healthy. "I had been with them from birth, the 'terrible twos,' adolescence, teens, college, and starting all over again. I delivered children of patients who I delivered. I have been there with families for losses of children, parents, spouses, and grandparents. I have helped families deal with bad news of cancer, dementia, stroke, diabetes, and symptoms that defy diagnosis," he says. Recently, he received a lifetime achievement award from the Society of Teachers in Family Medicine — the Curtis G. Hames Research Award. It honors those whose careers over the years exemplify dedication to research in family medicine.

Convention clashes. Medicaid was barely born. Globally, individuals were threatened by the Cold War, the Space Race, and events like the Six-Day War. The discipline of family medicine was a response to the depersonalization of medicine at the time.

"We can hold a mirror up to today's social and political climate to see the need for an academic center that values family. This focus will lead us to great education and great patient outcomes. A need for a discipline that embraces the many facets of health is as much in need today as it was five decades ago," says Dr. Ruffin.

Students in the very first medical school class at Penn State College of Medicine were assigned a family whom they would follow and help to navigate through health care. This practice continues to this day as the "Patient as Teacher Project" — an initiative embedded in the Humanities curriculum. In this program, students visit a patient in their home and learn about the lived experience of illness. Some students even make documentary films about their patients, and screen them in a project called "Short-Film Storytelling."

This pentatych work, titled "Wednesday" by Ellen Slupe, is part of the hospital's permanent collection.



Dr. Hillemeier with Tyler Stinson's copper, bronze, and stainless steel sculpture titled "Sunrise Awaits," part of the hospital's permanent collection. The crescent shape of the hospital is incorporated here.

THE ARCHITECTURAL DESIGN OF THE FIRST PHASE OF

the Medical Center was built in the iconic shape of a crescent. "In the most basic terms, the building was situated to show an embrace of the community," says A. Craig Hillemeier, MD, (pictured above) dean of Penn State College of Medicine, chief executive officer of the Penn State Health Milton S. Hershey Medical Center, and Penn State's senior vice president for health affairs. A watercolor painting, "Sunlit Crescent" (in frame, next page), commissioned by regional artist Brienne Brown was recently added to the Medical Center's permanent collection. It is placed in Dr. Hillemeier's office. "The artist's family member was a patient here, and I am reminded every time I see the shape of the artwork that we are rooted in this community to embrace it as part of our family — it is the guiding principle in how we practice."

Dr. George T. Harrell Jr., founding dean of the Penn State Milton S. Hershey Medical Center and College of Medicine, had the wisdom to develop a Department of Humanities in the College of Medicine with an eye toward producing what one article from that time described as 'doctors with handbags and hearts.' He called for the library as the central focal point in the crescent. The location symbolizes that its physical space brings together knowledge, research, education, and patient care.

"Our aim is to teach medical students to treat the whole person and expand on what directly affects health on a mental, environmental, and social level."

—Mack Ruffin IV, MD, MPH

"Our aim is to teach medical students to treat the whole person and expand on what directly affects health on a mental, environmental, and social level," explains Dr. Ruffin. "Patients are sent to specialists by disease, but people are individuals, not diseases. We employ a fundamental aspect of all health care: We can never replace human interaction. Research shows that when doctors don't touch a patient, there is not a bridge to building trust. The healing touch of the Art of Medicine is lost."

The "art of caring" so aptly put by founding chair Dr. Jeffries is deeply woven into the educational experience at the College of Medicine. "From the moment our students start in the profession of medicine course through to the last day of the fourth year, our goal is to produce compassionate, inquisitive, and broad-thinking physicians," says Dr. Green. These approaches have been bedrocks of the Hershey medical student experience for its first 50 years, and their continued emphasis bodes well for the next 50 and beyond.

MEDICAL CENTER CELEBRATES 50 YEARS

A humanistic approach to medicine was envisioned when the Penn State Health Milton S. Hershey Medical Center was founded 50 years ago. The Milton S. Hershey Trust, charged with distributing funds in the philanthropic mission of its founder, made the initial $50 million donation to Penn State University to establish a medical school and teaching hospital in Hershey. Samuel Hinkle, then-president of Hershey Chocolate Corp. and serving on both the board of the Hershey Trust and as a trustee of Penn State, first made the proposal for a medical school between Philadelphia and Pittsburgh.

In a later interview, he recalled: "My own conclusion was that he [Milton Hershey] was so interested in relieving human suffering, that he would certainly approve an idea where we could have a fine medical school and teaching hospital here." The groundbreaking was a short three years later on Feb. 26, 1966. The College of Medicine opened its doors to the first class of students in 1967, and the Medical Center accepted its first patients in 1970.

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Kathleen Costanzo, DO

"THE ABSOLUTE BEST DAY"

FOR ERIE FAMILY PHYSICIAN AND PAMED EVERYDAY HERO AWARD WINNER

Kathleen Costanzo, DO, is a family medicine and sports medicine physician at Saint Vincent Family Medicine Center in Erie. Dr. Costanzo is also a faculty physician at Saint Vincent's Family Practice Residency Program. In July 2018, she will assume the role of director of the Osteopathic Focus Track at the Saint Vincent Residency Program.

Recently, Kathleen Costanzo, DO — a family and sports medicine physician in Erie and winner of PAMED's Everyday Hero Award for April 2018 — had what she called "the absolute best day."

She began her workday by treating a newborn baby and ended the day caring for a 98-year-old patient. For a family physician who loves treating a full spectrum of patients and conditions, it doesn't get any better than that.

Dr. Costanzo's path to becoming a physician was more unconventional than most. She was an athlete in high school, and that experience led her to choose a career as a physical therapist.

At age 30, after realizing she was looking for a more extensive role in patient care, she began medical school at the Lake Erie College of Osteopathic Medicine (LECOM). With its whole person philosophy, it offered the perfect blend of medicine for her.

"Family medicine chose me," Dr. Costanzo says when talking about how she decided to specialize in primary care. She was diagnosed with lymphoma during medical school and had to undergo six rounds of chemotherapy while still in school.

Her diagnosis didn't stop her from achieving her goal of becoming a physician. To continue her treatment, though, Dr. Costanzo needed to remain in Erie while completing her medical school rotations. She was able to see patients in sub-acute hospital settings where there were fewer health risks for her. That experience, along with her interest in treating a breadth of conditions, led her to family medicine.

Now, she brings her unique perspective to her work with medical residents at Saint Vincent's Family Practice Residency Program. Timothy Pelkowski, MD, who nominated Dr. Costanzo for the award, says, "She is dedicated to patient care and will routinely go above and beyond the call of duty to help the patients she is treating and the family medicine residents she is educating."

Dr. Costanzo wants her residents to get the most out of their residency. She keeps an eye out for physicians who may be struggling with personal challenges and tries to make sure they have the help and resources they need. "They all know they can come to me about anything," she says. If someone in the program is having a bad day, she's there to talk or text and offer support.

A natural curiosity about the world has made Dr. Costanzo a compassionate doctor as well as a mentor to her younger colleagues. It has also led her to new opportunities to use her skills as a physician. While she was practicing for a time in York, Dr. Costanzo got the opportunity of a lifetime. With the encouragement of a colleague, she became a team physician for USA Weightlifting.

"It is a natural fit for me," she says of her role with USA Weightlifting. Due to the repetitive nature of the sport, the athletes benefit from having access to an osteopathic physician.

She's had the chance to work with and travel with the team to far-flung places like Poland and the former Soviet Republic of Georgia. This summer, Dr. Costanzo will serve as the medical director for USA Weightlifting's National Championships and, in the fall, will be a Team USA physician for the Youth Olympic Games.

No matter what her endeavor, Dr. Costanzo is willing to give everything she has. That quality hasn't gone unnoticed by her colleagues. "Kathleen is lighthearted, fun to work with, engaging, and quick to smile," says Dr. Pelkowski.

It seems likely there will be plenty more "absolute best days" on the horizon for Dr. Costanzo.

"I WILL NEVER BETRAY MY HIPPOCRATIC OATH,"

SAYS SCRANTON CARDIOLOGIST AND PAMED EVERYDAY HERO

Dr. Olsen (left) accepts the Everyday Hero award with Sen. John Blake (D-Lackawanna/Luzerne/Monroe) (right) and Charlene Kircher (middle), the patient who nominated him for the award.

Kevin Olsen, MD, is a cardiologist from Scranton, who has been serving his community for 30 years. He received PAMED's March Everyday Hero Award, after being nominated for the honor by one of his patients.

"I believe in empathy and compassion for patients," says Kevin Olsen, MD, a cardiologist in Scranton and winner of PAMED's March Everyday Hero Award.

Dr. Olsen understands the value of getting to know his patients and doing a proper history. "You can find a lot of answers in a patient history," he says.

He stresses the humanitarian side of medicine. He says practicing medicine without the component of a strong physician-patient relationship is like being a cook rather than a chef.

Given Dr. Olsen's dedication to patient care, it comes as no surprise that Dr. Olsen was nominated for PAMED's Everyday Hero Award by one of his own patients, Charlene Kircher. She describes Dr. Olsen as family, saying, "We are not related, but that is how I feel because that is the way I am treated in the office by him and his staff."

"He makes you feel very easy to talk to and not uneasy to ask questions, and does not rush you in and out," says Kircher. She credits Dr. Olsen for saving the lives of several family members.

Dr. Olsen, a native New Yorker and a father of three sons and two stepdaughters, has served patients in Scranton for 30 years and is part of the fabric of the community. His path to becoming a physician, however, started when he completed his undergraduate degree at Columbia University. He then attended medical school, graduating from the University of Connecticut School of Medicine.

Initially, Dr. Olsen had thoughts of becoming a pediatrician but, ultimately, he was drawn to the field of cardiology. He says he liked the medicine side of cardiology and the opportunity to do interventions and help people with blockages.

Following a fellowship at Hartford Hospital in Connecticut and some time spent in a university setting, he looked for a chance to set up his own practice. He eventually settled on Scranton as his new home.

While much of Dr. Olsen's time is committed to patient care, he does take the opportunity to enjoy several pastimes, including music. He has a 1941 Steinway piano, and you can often find him playing classical music on the weekends.

Dr. Olsen and his loving companion, Suzi, are also the proud owners of two dogs — both Cavapoos, a breed of dog that is the offspring of a poodle and a Cavalier King Charles Spaniel. They also recently adopted a rescue cat and enjoyed the experience so much that they ended up sponsoring several cat adoptions at a local shelter.

His pets are always there to greet him at the door when he returns after each busy workday spent making sure that patients like Kircher get the best care possible. It's a commitment he takes very seriously — he has devoted his life to helping his patients.

"I will never betray my Hippocratic oath," says Dr. Olsen.

PHILADELPHIA EMERGENCY PHYSICIAN SAYS TAKING CHANCES LEADS TO OPPORTUNITIES

Wayne Bond Lau, MD, is an emergency physician at Thomas Jefferson University Hospital in Philadelphia. At Jefferson, he serves as associate professor of emergency medicine, director of the Clinical Translational Research Track of the Scholarly Inquiry program at Sidney Kimmel Medical College, director of the Jefferson China Center, and associate director of the Jefferson Japan Center. He was honored with PAMED's Everyday Hero Award for February 2018.

"Saying yes is important," says Wayne Bond Lau, MD, an emergency physician at Thomas Jefferson University Hospital in Philadelphia. He knows doctors often face many demands, and, understandably, they may be tempted to guard their time with care.

Dr. Lau warns against being too cautious, though, saying it can lead you to miss the most meaningful opportunities. His advice? "Take chances."

It was the act of taking a chance that led Dr. Lau to Philadelphia's Chinatown Clinic at the Holy Redeemer Church. A decade ago, his younger sister — also an emergency physician — was a medical student at Drexel University and a volunteer at the Chinatown Clinic. She encouraged him to participate as well.

Dr. Lau was impressed with the clinic and its mission, but he waited until he had completed his residency to become more involved. He wanted to be sure he had the time to fully commit to the clinic and the patients who would come to rely on him.

"We take care of people who can't take care of themselves," says Dr. Lau. He's been volunteering at the clinic for more than a decade and now serves as director of the program.

Every Wednesday, for more than 15 years, the Chinatown Clinic has provided free health care services to patients who do not have health insurance. There are about 30 patients who come through the doors on an average night, and they're treated for everything from sniffles to serious medical conditions. Volunteers are often available to assist with interpreting languages such as Indonesian and Chinese.

Wayne Bond Lau, MD

Dr. Lau has found a way to share his vocation for serving others with the medical students he teaches at Jefferson University's Sidney Kimmel Medical College. Each year, he selects several of his students to volunteer at the Chinatown Clinic.

He interviews each applicant carefully, making sure the young men and women he accepts are available every week and can take a sense of ownership of the program. The clinic's patients count on seeing familiar faces, he says.

Not surprisingly, Dr. Lau brings the same passion that he has for patient care to his work teaching medical students and residents. His focus is on making real connections with his students. He knows firsthand that medical school can be a struggle, and he tries to ensure that the material he teaches is broken down into easy-to-understand pieces.

Dr. Lau's dedication has not gone unnoticed by his colleagues. "His lifelong compassionate and altruistic care to patients and his longstanding commitment to helping vulnerable populations and healing all those who pass through our doors is unparalleled," says PAMED President Theodore Christopher, MD, who nominated Dr. Lau for the award.

Helping people is second nature for Dr. Lau. He thinks that's also the reason why he chose emergency medicine as his specialty. His field has a strong element of social justice, he says. You need to be able to make a connection to someone in less than a minute and establish a sense of trust.

Dr. Lau is quick to credit his parents for instilling his sense of social responsibility and for offering him steadfast support. Family is important to him, so much so that he and his wife recently decided to move to a five-and-a-half acre property five minutes down the road from where his parents live.

"People are surprised that I live out in the country," he says with a laugh, "because they see me as such a city person." But, for him, there's nothing better than mowing the lawn with his dad, side-by-side on their John Deere lawnmowers. He's grateful for the simple joys of seeing those long, green rows of freshly mown grass and of spending time with loved ones.

‘WE ARE STRONGER TOGETHER’

KELLEY CROZIER, MD, AND HER TEAM GO THE EXTRA MILE FOR PATIENTS

Kelley Crozier, MD, MBA, chair of the Department of Physical Medicine and Rehabilitation and medical director at Reading Hospital Rehabilitation at Wyomissing, Tower Health, was honored with PAMED’s Everyday Hero Award for January 2018.

The bride, a patient at Reading Hospital Rehabilitation, was unable to leave the facility. Despite the challenges, the team of Kelley Crozier, MD, MBA, was determined to make their patient’s wedding day special.

When a patient care aide saw the bride was teary-eyed at the thought of wearing sneakers for the ceremony, the aide skipped lunch to buy her a pair of ballet slippers. An occupational therapist made a veil to attach to the bride’s cranial helmet, and the chaplain made sure the chapel was filled with fresh flowers. There was music during the ceremony, thanks to the VP of nursing who played the violin.

Weddings and events like these are all part of a day’s work for Dr. Crozier. She is quick to give credit to her team, saying they are the real heroes.

Every Christmas, staff members donate to share a meal with several former patients in need. They also hold a carnival each September during rehab week, an event that Dr. Crozier thinks may be just as much fun for the staff as it is for their patients.

“The thing about giving to others is it also gives to yourself,” says Dr. Crozier. “These projects are an amazing team bonding and morale boosting experience.”

In the field of rehabilitation medicine, teamwork is essential. That’s what drew Dr. Crozier to the specialty. In fact, she was all set to accept a residency match to become an ENT surgeon when her trajectory changed suddenly.

One of Dr. Crozier’s high school friends became quadriplegic following an accident, and she had the opportunity to observe her friend’s care at the rehab facility. She was bowled over by the tireless work the team did to integrate patients back into society.

Kelley Crozier, MD, MBA

A final medical school rotation at Magee Rehab Hospital in Philadelphia convinced Dr. Crozier that physical medicine and rehabilitation was the right choice for her. “I love the breadth of the field, the holistic involvement with patients, the continuity of long-term care with my patients, and I love working with the interdisciplinary team.”

Many of Dr. Crozier’s colleagues view her as a role model and mentor. Vinti Shah, DO, a palliative care physician, nominated Dr. Crozier for the Everyday Hero Award. “You symbolize what it means to be a mentor when you rearrange your jam-packed schedule because a new physician on staff asks if you will please have lunch with her,” said Dr. Shah, during the award presentation.

In 1985, when Dr. Crozier graduated from medical school, there were a lot of female residents looking for a female mentor and not enough mentors to go around. The culture was different back then, she says, and often she heard the message that you can’t be a woman and a doctor. Of course, she knew it was possible, and it was then that she decided she would try to be a role model for women physicians and give them a place to vent and be supported.

Her advice for women physicians is the same advice she would give to any young woman just starting out in her career: pick a life partner that cherishes you, rethink stereotypes of what you believe a traditional mother/wife looks like, and delegate tasks that don’t bring you joy.

“We are stronger together, and we cannot do it all alone,” says Dr. Crozier. For her, teamwork will always be the foundation of everything she does.

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I Believe

in the Art of Medicine

I believe that human beings are more complex than the sum of our parts and that true healing requires more than prescriptions. There is power in a health care provider taking the time to listen and laying hands on a patient, an experience that cannot be replaced by a computer algorithm. I believe that something is lost when our profession is forced to run like a business and we refer to patients as clients or consumers. We get so caught up in the science of evidence-based medicine that there is little time to explore the literature, philosophy, and history of medicine.

I am proud to have attended a medical school that continues to incorporate the humanities into its curriculum. I learned ethics by reading books on the Tuskegee Syphilis Study; the writings of Oliver Sacks made neurology come alive. The Art of Medicine included not only drawings in "Netter's Atlas of Human Anatomy" but also slides of oil paintings from the late 1800s.

In Thomas Eakins' "The Agnew Clinic," a surgeon performs a mastectomy in a medical amphitheater at the University of Pennsylvania. When you ask a roomful of people how the painting differs from a picture of a modern operating room, most readily identify that the doctor would be wearing a mask and gloves. It's the women in the room who point out that the only females in the painting are the helpless patient and the nurse awaiting orders. Women are no longer just in the periphery, and 51 percent of the students in the background of the painting would also be women.

Modern images of doctors are more like caricatures, burned out and buried in paperwork. Except we don't even have paper charts anymore — we spend our day clicking away in electronic health records trying to master the art of being a doctor and a data entry clerk at the same time.

I chose psychiatry because it was a specialty that valued the human experience. I love psychiatry, but there are days when the art feels lost: patients in the hospital are sicker than they were 10 years ago, we have fewer days to treat them, and there are more restrictions on our prescribing. I am glad that I trained at a time when residents still learned the art of therapy and localizing brain lesions without relying on a head scan. I marvel at the complexities of the human brain as I ask a stroke patient, who can't speak a single word, to sing, and hear him belting out "Happy Birthday" in a clear baritone.

> There is power in a health care provider taking the time to listen and laying hands on a patient.

I can't predict the future of medicine, but I do believe that integrating traditional medicine with mindfulness practices is key. Taking time for yoga and meditation allows me to be more present for my patients. The gift of regular practice is also the awakening of prana, the creative energy with which I share this narrative. I believe in the breath. **I believe in the Art of Medicine.**

By Candace Good, MD

PAMED Board Member Candace Good, MD, is a psychiatrist in State College, affiliated with Mount Nittany Medical Center. She is a Penn State Hershey College of Medicine alumna.

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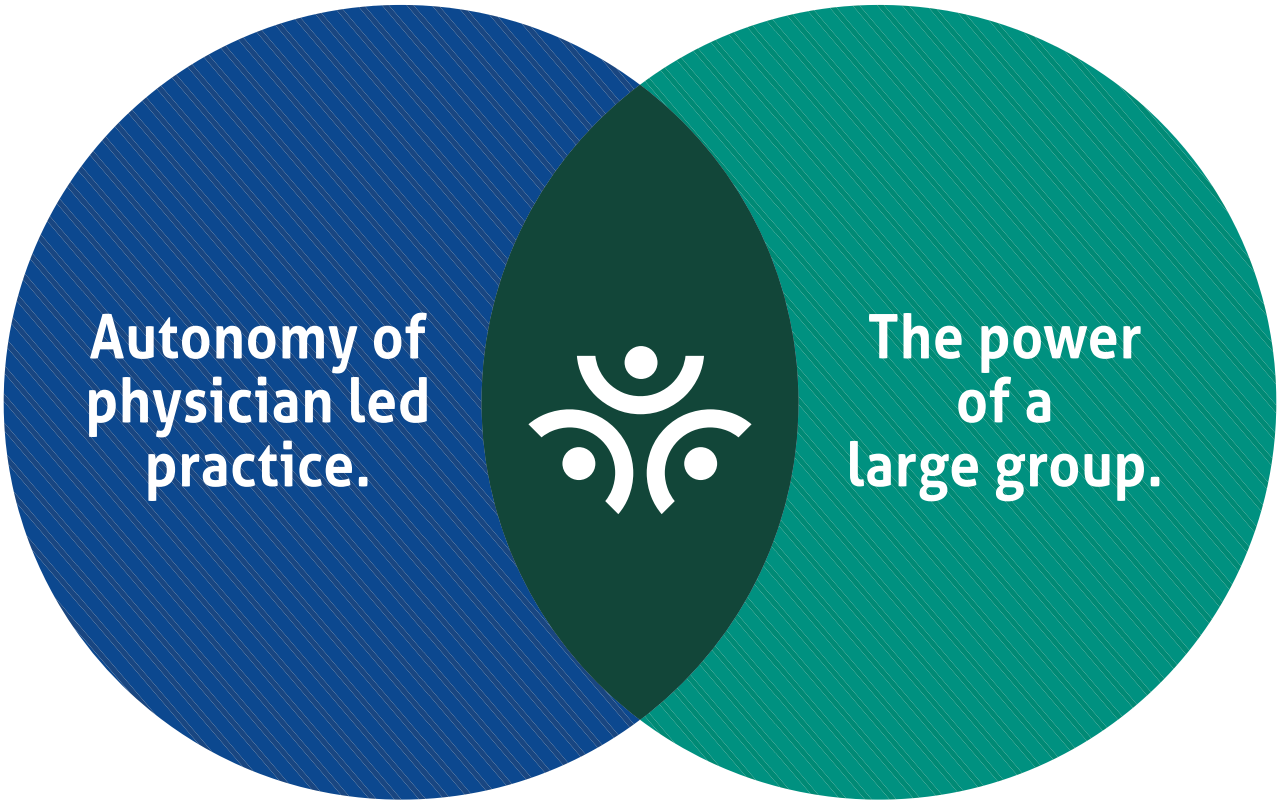

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THE ART OF ADVOCACY — WHAT IT TAKES TO BE THE VOICE OF PENNSYLVANIA PHYSICIANS

Attention to Detail and a Methodical Approach

When you think of art in terms of an occupation, the first trades that come to mind may be painting, pottery, or woodworking. A career in the arts requires meticulous attention to detail and a methodical approach, which takes time — even years or a lifetime — to perfect.

The same can be said about the Art of Advocacy. It too requires meticulous attention to detail and a methodical approach. Advocacy involves patience, resilience, determination, and finesse. Advocacy entails being apprised of the legislative pulse and acting accordingly.

Self-improvement blogger James Clear ponders how long it takes for one to be great and the amount of time that it takes to be world-class. He cites John Hayes, a cognitive psychology professor at Carnegie Mellon University who examined successful composers, painters, and poets. The general formula Hayes references is 10,000 hours, which equates to 10 years of practice. Clear says, "Even a genius like Mozart had to work for at least 10 years before he produced something that became popular." But it's not just putting in the time. Clear says, "It's not the same thing as practicing deliberately."

For 170 years, PAMED has had a long-standing history of deliberately practicing advocacy. PAMED leads with purpose by meeting with legislative stakeholders and policymakers, by positioning physicians as the ultimate champions of safety, and by advocating for policies and programs that promote patient-centered, physician-led team-based care.

Advocacy requires knowing the right people, getting beyond gatekeepers, and having a compelling story to tell. PAMED employs five dedicated people within the Government Relations department who constantly knock on doors, raise funds for PAMED's Pennsylvania Medical Political Action Committee (PAMPAC), and generate awareness among legislators regarding the effect specific legislation may have on Pennsylvania's physicians and patients.

Fostering Meaningful Relationships

A relationship is defined by "Merriam Webster" as "connecting or binding participants: such as a kinship." Relationships are not built by people who talk *at* one another. Relationships of any substance are built on a foundation of trust. That means that both participants need to be truthful, dependable, and knowledgeable. The PAMED Government Relations team works deliberately to personify these adjectives when representing Pennsylvania physicians in the field.

Relationships are at the heart of advocacy. Thoughtful conversations need to take place surrounding a subject matter. Pre-existing relationships with legislators are invaluable, especially when dichotomous perspectives converge. As a result of the relationships that our team has developed, PAMED Government Relations team members are "at the table" and are heard.

PAMED's seven legislative priorities are informed consent, physician-led, team-based care, prior authorization reform, addressing the opioid abuse crisis, maintenance of certification, telemedicine, and drug formularies. Membership with PAMED allows the Government Relations team to make certain that these priorities remain at the legislative forefront. To go a step further, contribute to PAMPAC — the muscle of PAMED — by going to *www.pampac.org*. Member contributions are used to support the election and retention of pro-medicine candidates. PAMPAC also campaigns against vulnerable incumbent legislators who consistently vote against the interests of patients and physicians.

Practicing the Art of Advocacy requires attention to detail, a methodical approach, fostering meaningful relationships, time, and support. Simply put, Government Relations is the voice of Pennsylvania physicians.

Become an Effective Physician Advocate

Here are just a few tips to be an effective physician advocate:

1. **Build relationships and get to know your state and federal legislators.** Whether it's scheduling a meeting in their office, talking to them in the community, or inviting them to your practice, physicians are in the best position to help educate lawmakers about the issues affecting physician practice and patient care.

2. **Get engaged in advocacy efforts.** When PAMED sends out a call to action, take a minute to email or call your legislator(s) and provide personal stories related to the issue that illustrate why the legislation is needed or why it should be opposed. PAMED lobbyists advocate for Pennsylvania physicians and patients every day, but legislators have told us it's a lot more impactful when they hear directly from physicians and patients.

3. **Contribute to PAMPAC.** PAMPAC — the muscle of PAMED — supports physician-friendly, pro-medicine, and pro-patient candidates running for state office.

Learn more in our Physician Advocacy Basics CME course at *www.pamedsoc.org/AdvocacyBasics.*

Gerald Tracy, MD

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What would you do with seven moving boxes full of 150 years' worth of old medical journals?

"WELL, I READ THEM ALL," SAYS GERALD TRACY, MD.

Dr. Tracy, a founder of what is now the Geisinger Commonwealth School of Medicine, in Scranton, sifted through the historical documents and artifacts chronicling the history of Luzerne and Lackawanna counties' medical societies.

He has procured space at the medical school to share pieces of Northeast Pennsylvania's medical history with the public. Dr. Tracy has amassed and displayed a collection that has attracted historians.

Visitors can read a medical textbook from 1859 and view items that had been donated to the county medical societies such as a late 1800s leather medicine pouch complete with corked glass vials held by leather loops. Displayed are antique stethoscopes, a tracheotomy kit, and an early blood pressure cuff. A Civil War-era dissection kit in wooden case holds blades, tourniquets, and a saw that today's physicians can only imagine how they were used.

With the help of Iris Johnston who is Geisinger Commonwealth's library specialist, Dr. Tracy came upon a fascinating discovery: "Iris very astutely picked up a letter and could not make out the signature." After reviewing it more closely, he realized it was sent in March 1917 by the renowned Dr. William Osler to Luzerne County Medical Society member Dr. Lewis Taylor.

According to the *Scranton Times*, "Doctors today call Osler the 'father of modern medicine.' He was known to love medical libraries, and in his letter he applauds Taylor for his efforts to promote medical education in the northeast."

Dr. Tracy is following in Dr. Taylor's footsteps to offer a medical library. He engenders to impress upon his medical students that they should take a certain pride in their chosen profession because they can visit the library and museum to contemplate how far back the healing arts go.

Tonyehn Verkitus, executive director for both medical societies in Luzerne and Lackawanna counties, says that having this curated collection is important to members because it helps physicians realize that they are part of a long history of health care in Northeast Pennsylvania. "It's also important to students as it helps them seem how far the profession has come and will continue to evolve."

Editor's note: In our previous County Spotlight, *Pennsylvania Physician* identified J. Fred Stoner, MD, as "the initial planner" of the Lawrence County Medical Society pain, addiction, and law symposium. Dr. Stoner wishes to recognize that other individuals contributed to the launch of the symposium. *Pennsylvania Physician* regrets the error and thanks Dr. Stoner for the correction.

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>
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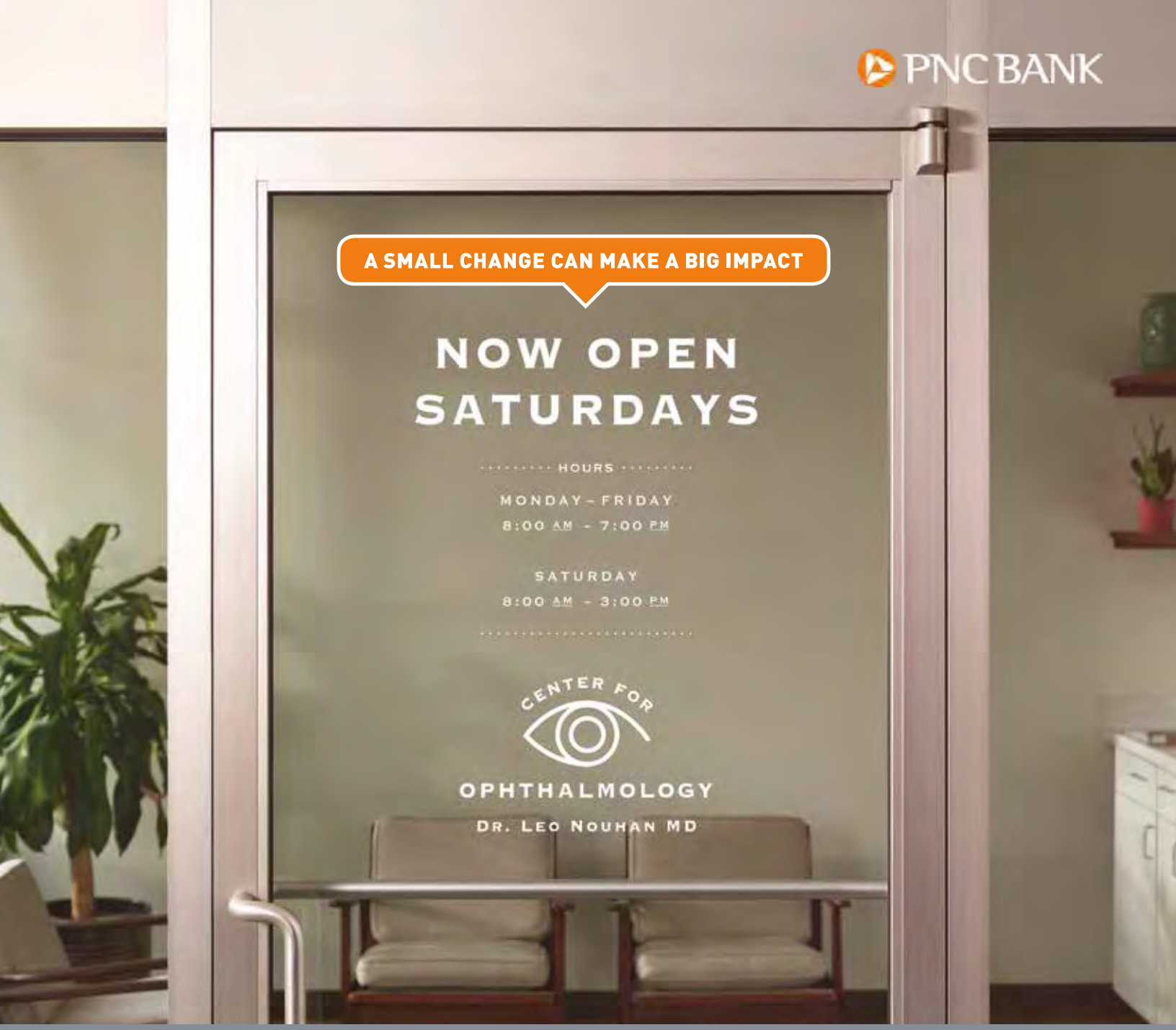

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