PENNSYLVANIA MEDICAL SOCIETY — THE POWERFUL VOICE FOR PHYSICIANS

pennsylvania PHYSICIAN

WOMEN IN MEDICINE

The Changing Landscape of Women In Medicine

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Get Engaged in PAMED's

Women Physicians Section

The Pennsylvania Medical Society (PAMED) invites all active and associate PAMED members to get involved in our new Women Physicians Section (WPS).

- ✓ Learn about effective networking
- ✓ Voice concerns and share common experiences
- ✓ Educate and encourage paths to leadership roles in organized and academic medicine
- ✓ Establish a network of women physician leaders
- ✓ Advocate to advance PAMED policy on issues affecting women and advise the PAMED Board

Learn more at **www.pamedsoc.org/WPS**.

Not yet a PAMED member? Join PAMED and your county medical society at www.pamedsoc.org/join or by calling PAMED's Knowledge Center at 855-PAMED4U (855-726-3348).

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Danae Powers, MD
2018-19 President, PAMED

WOMEN PHYSICIANS PLAY A CRITICAL ROLE IN MEDICINE

Mentors can play a critical role for many physicians.

The wisdom they pass along can fill in the gaps of medical education and help to meet unforeseen challenges. As *Pennsylvania Physician* magazine celebrates women in medicine, one of the most notable signs of progress is the number of women available to guide the next generation.

To be clear, there are gender gaps that still need to be addressed — gaps in pay and leadership roles serve as just two examples. But, it is also an optimistic time.

PAMED OFFERS A MEANINGFUL VENUE FOR WOMEN PHYSICIANS TO LEARN FROM SHARED EXPERIENCES, TAKE ON LEADERSHIP ROLES, AND ADVANCE POLICY THAT IMPROVES THE WAY WE DELIVER CARE TO PATIENTS.

Nationally, 2017-18 marked the first medical school class with more women than men. Women make up nearly one-third of the physician population here in Pennsylvania — a number that is expected to rise steadily over the coming decades.

In October 2018, the Pennsylvania Medical Society (PAMED) changed its bylaws to include a Women Physicians Section. This means that PAMED offers a meaningful venue for women physicians to learn from shared experiences, take on leadership roles, and advance policy that improves the way we deliver care to patients.

As your president, my job is to make it easier for you to engage with advocacy priorities. PAMED members brought forward many well-articulated issues at the 2018 House of Delegates, which we are now dedicated to addressing on your behalf.

You can follow the progress of these issues on PAMED's website. I encourage you to find out more at *www.pamedsoc.org/HOD* to stay informed and get involved.

Learn more about how to get engaged in PAMED leadership or tell us what topics you are passionate about at *www.pamedsoc.org/GetEngaged.*

If you are a member, thank you for your support and involvement. If you are not a member, please join at *JoinNow.pamedsoc.org* and add your voice to our efforts.

Danae Powers, MD
2018-19 President, PAMED

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THE POWERFUL VOICE FOR PHYSICIANS

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Learn more about Dr. Johanna Kelly and some of our other Everyday Hero Award winners starting on page 44.

INSPIRED BY MY DAUGHTER

My wife and I recently heard from our 9-year-old daughter's teacher. She told us that the class activity was to take turns going around the room and each child would choose adjectives to describe themselves. My daughter's words were "strong" and "independent." And then she followed that by, "Just ask my dad." I could not be prouder.

This is what I want for her: a work environment where my daughter truly can pursue any career that she wants. Her words inspire me and remind me to be even more driven to make decisions today that make room for opportunities tomorrow.

Our Women in Medicine focus in this issue explores the changing landscape of medicine. Currently, there are more women in medical schools than ever before so it's vital that there should be equal representation of women in leadership in organized medicine.

My daughter's words call for parity … no … they demand it. It pleases me to inform her that the senior team at PAMED is comprised equally of men and women. Our deputy executive vice president and our senior general counsel are influential women in leadership. PAMED's president and the chair of PAMED's Foundation are women leading us to make a conscious effort to listen to the voices of women, ask questions, and hear the honest answers that will propel us in the right direction.

I don't want my daughter to work hard toward a goal only to find that she is told that she can't achieve it because of her gender. We have to continue to work toward a fair work environment, which is why PAMED will support women in medicine to find fulfilling careers and to live a balanced life.

If you are a current member, thank you for your membership. If you are not yet a member, you can join us at *JoinNow.pamedsoc.org* to be a strong and independent catalyst for the evolving, inclusive field of medicine.

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

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

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What's Your Art of Medicine?

The Pennsylvania Medical Society (PAMED) is on a mission to advocate, educate, and navigate on behalf of physicians throughout Pennsylvania, guiding them back to the Art of Medicine.

We've been asking physicians, "What's Your Art of Medicine?" and here's what some of them told us:

Candace Good, MD
Member Since 2015

"I believe that something is lost when our profession is forced to run like a business."

"I believe that doctors don't only motivate their patients to get better, but they encourage their patients to help themselves."

Linda Famiglio, MD
Member Since 2001

What's your Art of Medicine? See what your colleagues are saying and share your story at **www.pamedsoc.org/ArtofMedicine**.

19/767

Not a current member? Learn more and join today at **www.pamedsoc.org/ArtofMedicine**. You may be eligible for a $95 introductory dues offer.

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On Call Calendar

CALENDAR OF EVENTS

LEARN ABOUT UPCOMING EVENTS

PAMED Board of Trustees Meetings

- **April 30 – May 1** PAMED, Harrisburg
- **Aug. 13 – 14** PAMED, Harrisburg

www.pamedsoc.org/Board

The Board of Trustees also will meet on Oct. 25 and 27 during PAMED's annual House of Delegates Meeting, which will be held Oct. 25 - 27 at the Hershey Lodge in Hershey.

www.pamedsoc.org/HOD

Legal Conference for Physicians

- **Sept. 13 – 14** PAMED, Carlisle

www.pamedsoc.org/LegalConference

Fall 2019 Practice Administrator Meetings

- **Sept. 12** Doylestown Health & Wellness Center, Warrington
- **Sept. 25** PAMED, Harrisburg (plus live webcast)

www.pamedsoc.org/ManagerMeeting

Foundation Resiliency Retreat

- Physician Resiliency Summit
  June 5-6, 2019
  Eden Resort
  222 Eden Road
  Lancaster, PA 17601

www.foundationpamedsoc.org/summit

www.pamedsoc.org/calendar

INSIGHTS ON INTEROPERABILITY

BY TARA GENSEMER

I remember the day in 2011 when the practice where I worked began our electronic health record (EHR) training. There was a buzz of excitement and apprehension in the air. Our practice invested in certified EHR technology (CEHRT) in preparation to participate in the Medicare EHR Incentive Program, Meaningful Use (MU).

As many of you may recall, the Health Information Technology for Economic and Clinical Health Act (HITECH) proposed a concept of the meaningful use of interoperable EHRs throughout the nation.

Over the first two years, I worked to refine workflow, increase staff buy-in, review monthly dashboards to make sure we were hitting our MU measures, perform the security risk analysis, set up the patient portal, integrate the immunization registry, and — the *piece de resistance* — integrate a health information exchange.

Our system was ready for interoperability, but we quickly learned that others were not. Much was needed to address direct secure messaging, lab orders, electronic prescribing, care coordination, and sending clinical documentation to other providers. The data in and out of the office was difficult to get flowing in either direction.

Fast forward eight years and more than 80 percent of office-based physicians have shifted from paper to EHRs.[1] More data is flowing into the patient EHR, and at times even consumed directly into the patient record. I can't tell you how excited I was the first time vaccination data was consumed directly into a chart from a local pharmacy.

Although there has been much progress across the health IT landscape, there has also been much frustration. We observe physicians stating the EHR is a tool for the administrative process and quality programs rather than an instrument to improve patient outcomes. Some state they feel more like "data entry clerks" than physicians, while others are feeling the financial burden of maintenance and upgrade fees.

The practice management function built into an EHR has been a huge boost to administrative productivity. The HIPAA Administrative Standards and Operations have streamlined eligibility status, claims reporting, and remittance; reduced accounts receivable days; and allowed time for monitoring claim errors, front-end edits, and the rework of a claim to ensure timely filing.

On the other hand, those who have invested in the software continue to face interoperability challenges: administrative, clinical, and financial.

Interoperability is key in offering patient-centered health care, improving efficiency, reducing redundant work, and providing a longitudinal — or

[1]"Electronic Medical Records/Electronic Health Records (EMRs/EHRs)." Centers for Disease Control and Prevention, National Center for Health Statistics, *www.cdc.gov/nchs/fastats/electronic-medical-records.htm*.

comprehensive — patient record. How do we accomplish this while reducing physician burden and improving patient outcomes and satisfaction?

The collaboration of EHR vendors and application programming interface (API) developers presents one interoperability solution. An API interface with an EHR can result in successful health information exchange and achieve interoperability while streamlining a current process that may result in more administrative work.

In an attempt to alleviate the challenges of interoperability, the 21st Century Cures Act (Cures Act) was signed into law on Dec. 13, 2016. Title IV addresses the delivery of health care and interoperability.

The Cures Act helps set the foundation to achieving a health information technology (HIT) infrastructure throughout the nation. It promotes electronic exchange and use of patient health information using technology, enabling physicians to access patient information regardless of where care was given.

Last year, speakers at the Office of National Coordinator's Interoperability Forum challenged software developers with a goal of eliminating the fax machine in medical practices by 2020, and challenged stakeholders to attempt "No Fax Friday" on Friday, Oct. 12, 2018. Why is this important to you? Practices will not be prepared to eliminate the fax machine by 2020. Other priorities for the advancement of interoperability, such as lab orders, prior authorization, care coordination, and referral management, need to be addressed before considering the removal of a fax machine.

In December, PAMED presented testimony to the National Committee on Vital and Health Statistics (NCVHS) to ensure that at the core of regulation and administrative standards for health IT, patient-centered principles of increased access to health care, improved quality, enhanced efficiency and value in the delivery of health care to patients will remain at the epicenter when finding solutions to interoperability amidst stakeholder collaboration.

As I reflect on how workflows and the use of EHRs have changed over the last eight years, from MU to Advancing Care Information to Promoting Interoperability, No Fax Friday, and the Cures Act, there has been a shift in requirements that have taken minimal burden off physicians. To achieve better outcomes, reduce physician burden, expand administrative simplification, and advance interoperability, the time is now for physicians to take an active voice in policymaking and standards to ensure HIT moves in a direction that works for all stakeholders.

Tara Gensemer, CAHIMS, is a practice support specialist with PAMED. Email her at *tgensemer@pamedsoc.org*.

PEDIATRIC CLINICALLY INTEGRATED NETWORK POWERED BY PEERS & PROFESSIONAL PASSION

CARE CENTERED COLLABORATIVE HOSTS Q&A WITH DR. MUNDELL

Marylee Mundell, DO, is essentially a health care "action figure." Highly skilled and with extraordinary energy, she manages a private practice, a busy staff, and a full patient panel at Pediatric Care Group, P.C., in Jenkintown. It is the very group she founded with two partners 15 years ago. The practice now has four pediatricians and three nurse practitioners. It cares for more than 6,000 patients and their families.

Dr. Mundell also leads the Quality Committee for Women & Children's Health Alliance (WCHHA), a Clinically Integrated Network (CIN) of more than 110 independent general and specialty pediatricians in southeastern Pennsylvania. In our interview with her, we explore her commitments to medicine, her view of leadership, and the passions of a growing number of physicians who, like herself, have joined together to practice independently in a CIN. They work together at the front lines of care in the communities they serve.

Q: *DR. MUNDELL, TELL US ABOUT YOUR PRACTICE AND WHY YOU CHOSE A CAREER IN MEDICINE AT A TIME WHEN THERE WERE NOT AS MANY WOMEN IN THE PROFESSION AS THERE ARE NOW.*

Dr. Mundell: I have been a practicing pediatrician for 23 years. I was initially drawn into this specialty when my sister was struck by a car in front of our house and sustained a serious head injury. I was 10 years old; it changed our family forever, and it brought us into the world of health care in a dramatic way. I spent more than a year with my sister and our family in pediatric hospital wards and later at home as we all tried to help her return to health. She required an additional year of therapy to learn how to walk again.

All the good and bad I saw at that young age galvanized in me a desire to help others through the art and practice of medicine. Over the years, I have worked in many practice environments, including caring for the underserved and AIDS patients in the National Health Corps. I am driven to bring all that I can — my clinical skills, my compassion, and my energy — to help others achieve and maintain the best health possible for them. I have a special interest in children with learning disabilities and developmental challenges.

Q: *ACROSS YOUR CAREER SO FAR, WHAT HAS BEEN MOST SATISFYING?*

Dr. Mundell: So far, I have had a wonderful career and have been honored to care for thousands of children. Satisfaction for me comes from making a difference in a child's life. Being a general pediatrician has many roles: I am the child's physician, the parent's teacher, the child's teacher, and a resource and advocate for the community where I live. As a small business owner and a leader in my practice, I also have had to develop business skills to complement my clinical know-how.

I am proud of the practice I helped start, and I also am proud of our current team — each person in the practice. The most satisfying aspect of being a pediatrician is knowing that parents and their children trust me, trust my medical opinion. Caring for a child and knowing that my interventions and my care make a difference to them — it is truly satisfying. It is a relationship everyone involved values deeply.

A: *IF YOU WERE MENTORING YOUR YOUNGER SELF, WHAT WOULD YOU WANT HER TO KNOW NOW?*

Dr. Mundell: When I was finishing my residency, I had no idea what area of pediatrics I wanted to pursue. I also was fearful of pursuing positions that came with authority and responsibility. Women typically put a lot on their plates. Female physicians often are equally interested in having a career and family, but sometimes there is a fear of giving too much time to their career. Looking back, I would tell my younger self not to worry my way into that problem.

All female physicians need to know that a successful career that includes community and social involvement does not rule out a family. It also does not mean that your family will suffer. On the contrary, I have found that the more engaged I am with my profession, patients, practice, and community, the happier I am. I am married and have a 10-year-old stepson and a wonderful husband. I have never been happier, and I am more involved than ever in my practice and profession.

Q: WHAT'S YOUR DEFINITION OF LEADERSHIP IN MEDICINE?

Dr. Mundell: A leader in medicine is a professional who stands up for the patient. It really is that simple and that complicated. Medicine might have gotten complicated, but people have not. A leader is honest — steadfast even when all the others have left the room.

A leader puts the patient first. It is very easy to get caught up with ego. Remember, as physicians, we have taken an oath to do no harm. In order to do no harm, we must do many other things. Going the extra mile is an everyday jog for leaders.

Physicians like Dr. Mundell (center), when supported by strong practice managers and with targeted case management support, can both deliver outstanding care to patients and be accountable for health care costs that are in their control. Dr. Mundell is pictured here with Gary Evans, administrator, and Diane Littlewood, RN, MSN, CCM, from The Collaborative.

Q: *TELL US ABOUT THE WCHHA CIN? WHY DID YOU JOIN?*

Dr. Mundell: Our CIN took shape about two years ago. It was the brainchild of Gerry Cleary, DO, a colleague I admire greatly. I joined because of him. Quality improvement was always important to me, even when it was not as well defined as it is today. Being a part of the National Health Corps gave me a good foundation; it had clinical protocols in place for quality assurance and improvement decades ago.

Our CIN was created to help sustain and support pediatricians in their endeavor to provide quality medical care, and, equally important, to help those doctors and staff survive in this complicated medical world.

I was honored to be asked to be the director of quality improvement for our CIN. This clinical and business model allows physicians to lead their own network. Doctors know what is best for their patients. A good physician is practicing the standard of care and listening to the patient.

Our pediatric CIN further enables physicians and allows them to attain and maintain the highest quality and standards of care. It will also work with the insurance companies to illuminate the best practices and the quality measures that should be tracked. We are creating a world where physicians interconnect to form a living, breathing network that strives to deliver the best quality of care to children in Pennsylvania in a personal way. It is truly, literally physician-led.

> Caring for a child and knowing that my interventions and my care make a difference to them — it is truly satisfying.

Dr. Mundell also served on Pennsylvania's Joint State Commission for Child Safety. Pictured here with her practice co-owner Marie Carrier-Kinsley, MD.

Q: *WHAT HAS* THE CARE CENTERED COLLABORATIVE *ADDED TO YOUR NETWORK?*

Dr. Mundell: PAMED's involvement is instrumental. Through its subsidiary, *The Care Centered Collaborative*, we have accessed much needed and additive business, clinical, and analytical support. The population health/data analytics capabilities it has invested in and made accessible to us will allow us to better understand, interpret, and act on opportunities to improve care.

The Collaborative also offers care management expertise. We have worked closely with Diane Littlewood, RN, MSN, CCM, from that team to create a strategy to onboard practices to the population health platform and develop protocols for the member practices. Without The Collaborative, our network would not have been able to make the smooth transition from its inception to current to growth.

Our CIN is growing! New physicians are seeking us out each week — and we intend to bring the best of what medicine can offer to pediatricians, our teams, and most importantly, our dear patients and their families. We will demonstrate our success here in southeastern Pennsylvania first — and then expand across the state. That's our goal.

WOMEN & CHILDREN'S HEALTH ALLIANCE

If you would like to know more about our CIN for general and specialty pediatrics, you can explore our website and click on the Contact tab to reach WCHHA at *wchha.org*.

Find out more about The Collaborative at *www.patientccc.com*.

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- Appellate court case review

Pennsylvania Physicians Legal Issues Conference

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www.pamedsoc.org/LegalConference

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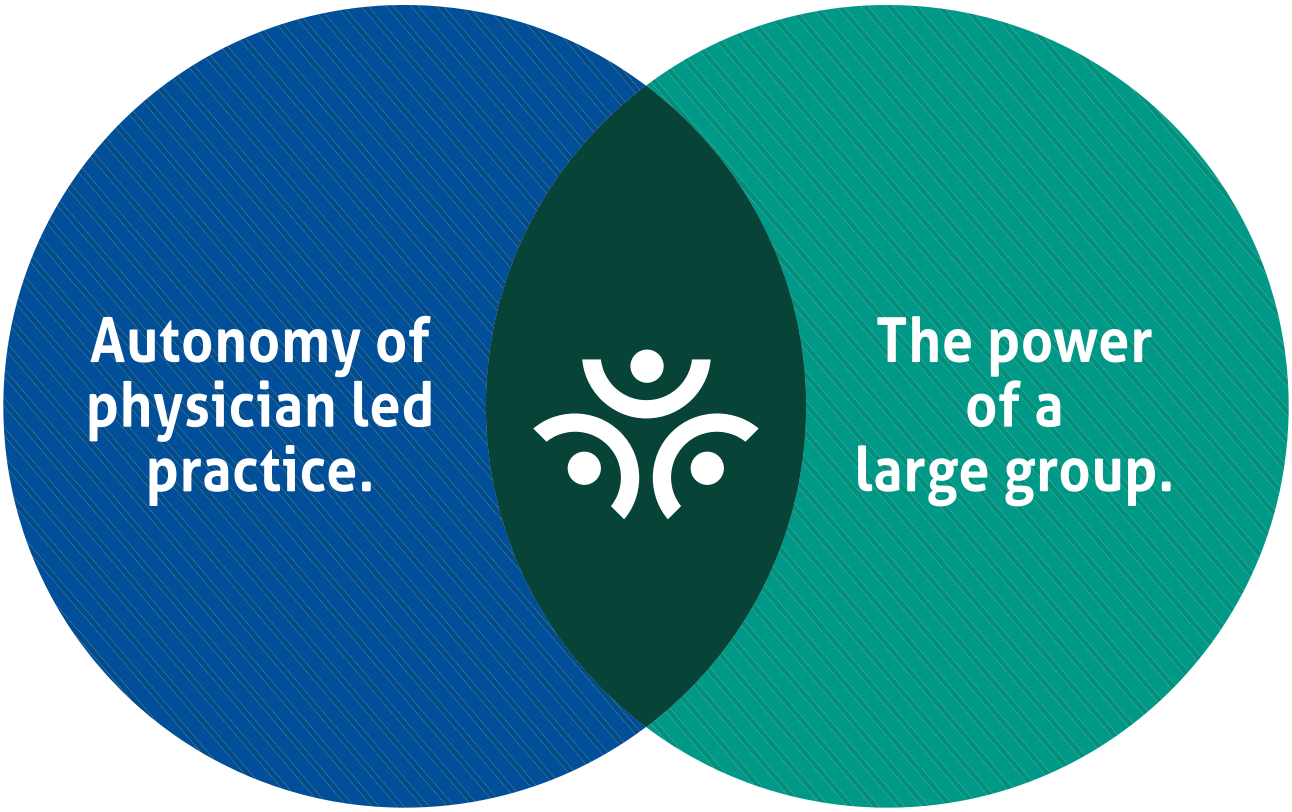
PAMED members can access information about laws, regulations, and other issues that impact the practice of medicine. Visit our Legal Resources Center at **www.pamedsoc.org/LegalResources**. Not yet a member? Join today at **www.pamedsoc.org/Join**.

Yes, you can have the best of both worlds.



Introducing our Clinically Integrated Network.

Led by your fellow Pennsylvania physicians, the Pennsylvania Medical Society's clinically integrated network (CIN) enables practices like yours to prosper in the evolving healthcare world.

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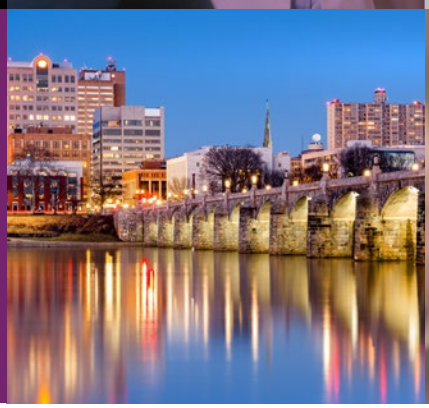

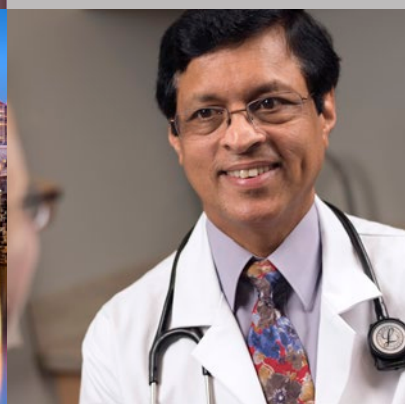

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"SEE ONE, DO ONE, TEACH ONE"

BY KARA GARCIA, MD

We've all heard this phrase in medical school and residency, especially regarding procedures. It could also be applied to the idea of mentorship and leadership in our profession. For a lot of physicians in their early career, though, they rarely have the opportunity to "see one" who is much like themselves. Having a diverse group of physicians, including women, in leadership positions provides young physicians with a tangible career path to follow. And, what is leadership if not showing someone the way?

I graduated from medical school in 2004 and joined the workforce as a general pediatrician after my chief residency in 2008. I had wonderful bosses before I joined private practice and have always felt supported in my career decisions throughout medical school, residency, and post-residency. One thing missing from my experience, though, is a female mentor — and I'm in pediatrics! I have yet to meet a mentor whose life resembles my own, or whose path I may follow. That is not to say these people don't exist, but as I reflect on my own experience, I recognize a need for female physician leaders.

Trends show that women are outpacing men in medical school enrollment. But at the same time, women hold only 20 percent of the titles of division chief, medical school dean, department chair, or hospital CEO, according to Medscape. If we look forward to a field of leaders that appropriately reflects the demographics of our profession, we will see women and men of a variety of different backgrounds holding leadership positions. The path to leadership can be harder for women, but as more women join our profession, more female leaders can demonstrate what can be achieved.

I was discussing writing this article with a fellow alumnus of the PAMED Leadership Academy, knowing that I would be writing about the importance of having female physician leaders. I pondered my own leadership positions, and he kindly reminded me that leaders play many different roles. We lead by setting an example, by educating ourselves, having solid knowledge and passing it on, and by advocating for those with quiet or unheard voices.

I am a woman. I am a mother and wife. I am a pediatrician and practice owner. I am the daughter of an American educator and a Mexican physician. In my practice, I hope to show young girls that they, too, can become a doctor. I hope to show mothers that they, too, can have a job and raise their children and feel good about it. I hope to show everyone I interact with — my coworkers, my staff, my patients — a thoughtful, deep respect that can be passed on to others.

Kara Garcia, MD, is an outpatient pediatrician at Tan and Garcia Pediatrics in Harrisburg.

Check out PAMED's wealth of leadership resources at *www.pamedsoc.org/LeadershipAcademy*.

"I am a woman. I am a mother and wife. I am a pediatrician and practice owner. I am the daughter of an American educator and a Mexican physician. In my practice, I hope to show young girls that they, too, can become a doctor.

FINDING CREATIVE SOLUTIONS IN PRIMARY CARE

BY MELISSA GREER, DO

Recently I attended a mental health and addiction recovery summit where health care professionals came together to discuss how to serve mental health better locally. Some of the biggest obstacles discussed were burnout/staff turnover affecting continuity of care and required reimbursement documentation burdens. Questions arose as to how we can improve this unsustainable situation of reimbursement requirements, which so negatively impact the mental health of the mental health caregivers.

If we are giving so much attention to reimbursement requirements, how can we have time to see the human beings in front of us and find creative solutions to problems such as the crisis of drug addiction?

Already in my family medicine training, I began to see the challenges leading to burnout. Efficiency based on Kaizen manufacturing principles have been superimposed onto doctors and medical organizations without regard to the nature of human health care. These efficiencies without insight are creating wounds in health care practitioners who are still trying to meet the needs of wounded patients.

While still a resident, I had an eye-opening experience during a job interview at a hospital in Wisconsin. When inquiring about the role of physicians in the local community, I was told, "We don't say 'physician' or 'doctor' here. We call all the MDs and NPs 'value producers' because you produce what is valuable to the hospital."

I soon learned that this kind of thinking permeates the entire system, even if it is not spoken as openly. As long as we see the time a doctor spends with a patient as a commodity that is purchased or see the patient as a pure consumer, it's difficult to develop a healing relationship between them. More wounds are created if doctors feel coerced to practice a certain way based on financial motivations. Satisfaction surveys are great when you are buying a sofa, but they do little to help a doctor to care for or better understand a patient. Quality control and evidence-based decision-making, which are necessarily a part of person-based individual care, become misleading when they alone guide practice and, worse, are directly related to reimbursement. Necessary freedom in scientific medical thinking becomes restricted. Medicine then becomes mediocre at best and pathological at worst.

All physicians know how much space we need for creative contemplation. What we learn in our training does not give us all we need for this rich and complicated vocation of caring for human illness and health. Making time to continually learn and allow for deeper questions as well as practice self-care is essential in this vocation. If we are honestly in the business of health, it is time to find other solutions ensuring that burnout has no home in medicine.

I began to feel that I was adding to a social pathology through the approaches expected of me while in contract with insurance companies. This brought more serious contemplation on what kind of practices would actually bring health to all involved. I found that it really does take a community thinking creatively to make the kind of change we'd like to see in the world.

In the fall of 2017, I was part of a group that co-founded a nonprofit, community-supported medical clinic based on a Direct Primary Care practice model outside of the insurance system. I now practice family medicine in a beautiful clinic which values long-term doctor-patient relationships. Patients choose the length of their own appointments, with a new patient appointment ranging from 55 to 85 minutes. Both the doctor and the patient have time to discuss questions of health and illnesses. Our membership-based, community-supported model is economically inclusive: a percentage of all membership fees goes toward a solidarity fund to help those who cannot afford the standard fees. We strive to be patient-centered and economically transparent. We continually offer classes on a variety of health topics such as one's relationship to self-care, lifestyle, community, and nature.

Our future vision is to grow, work with more doctors, nurses, and therapists, and build a space inspired by healing architecture. We hope to provide a model for other communities to serve future generations and continue to find creative solutions in their own communities.

Melissa Greer, DO, is a family medicine physician practicing at Carah Medical Arts in Phoenixville.

WOMEN ROLES IN MEDICINE: A PAMED MEMBER'S PERSPECTIVE

BY KRISTIN VAN ZANT, MD

Progress Has Been Made

Women physicians are demonstrating amazing professional growth as a community. Considering the social, professional, and personal hurdles that women have fought to overcome, there is now a more inclusive range of talent, diversity, leadership, and expertise in our growing numbers. The percentage of women enrolled in medical school is now greater than 50 percent. Pennsylvania's numbers are heartening, too — there has been an increase (43 percent) in the number of female physicians.

Women physicians continue to do great things. I'm proud that I'm part of addressing the opioid crisis by providing mental health/addiction clinical services for three dual-diagnosis behavioral health and addiction programs in Philadelphia as part of Public Health Management Corporation's behavioral health services. The programs include:

- **Pathways to Recovery** — A program in the heart of the opioid epidemic in the Kensington/Port Richmond area that takes people from the streets/community, jails, hospitals, and detox/rehab facilities and provides them with 45 days of a partial hospitalization program dedicated to providing evidence-based treatments, including medication-assisted treatment
- **Chances** — An all-women intensive drug and alcohol outpatient program
- **Interim House** — An all-women residential drug and alcohol treatment program with a daycare onsite

There's Still Work to Be Done

However, there is a harsher underside to the female physician perspective. Certain issues such as systemic sexism, sexual harassment, a large gender pay inequality, glass ceiling in academic departments, poor pregnancy and maternity leave support, and ageism place women once again at an unfair disadvantage.

Grappling with these pressures can be contributing factors to burnout, depression, and higher suicide rates than the general population. The rates of depression in female physicians are higher than male physicians. Female physicians have higher rates of completed suicide — 2.5 to 4 times greater than the general population. These are disturbing statistics with underlying complex determinants, yet we must continue to work toward much better outcomes for the rising generation of female physicians.

There are reasons to be hopeful and encouraged by the latest trends in the broader social landscape. The courageous #MeToo and #TimesUp movements have exposed traumatic experiences that can now be subjected to corrective legal actions. In addition, the recent successes in women elected to public office have been overwhelmingly positive. Within the medical community, there are growing numbers of women in leadership positions at the American Medical Association, American Psychological Association, as well as other specialties. As the next waves of younger female physicians enter the workplace, we will need to continue to work toward broad gender parity.

THERE ARE REASONS TO BE HOPEFUL AND ENCOURAGED BY THE LATEST TRENDS IN THE BROADER SOCIAL LANDSCAPE.

Kristin Van Zant, MD, is a psychiatrist in Philadelphia.

2018 HOUSE OF DELEGATES

More than 300 physicians, residents, and medical students gathered to set PAMED policy, and network with peers. Learn more, including an update on resolutions and how to get involved, at *www.pamedsoc.org/HOD*.

Danae Powers, MD, was inaugurated as PAMED's 169th president on Oct. 27, 2018.

Top Physicians Under 40 Award winners gather at a networking event.

Delegates listen to debate on the House floor.

Medical students participate in Medical Student Health Care Debates.

Medical students gather at the Medical Students Section annual meeting to talk about the future of medicine.

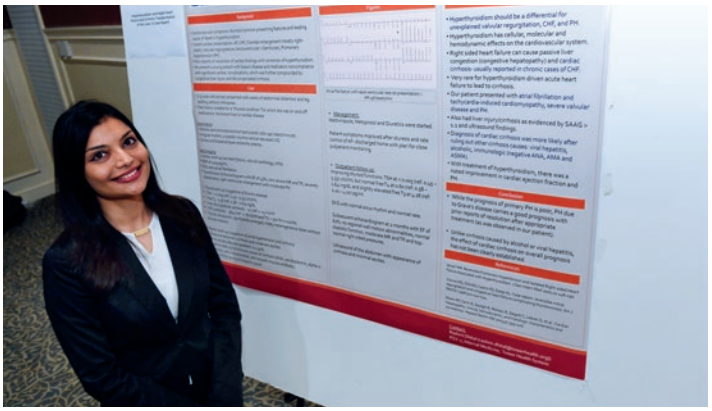
Women Physicians Caucus Meet and Greet on Oct. 26. They became an official PAMED section — The Women Physicians Section — on Oct. 28.

RESIDENTS & FELLOWS POSTER CONTEST

The annual Residents & Fellows Poster Competition was held on Saturday, Oct. 27, during PAMED's 2018 House of Delegates. Congratulations to the winners.

1st Place Winner — Nihit Shah, Easton Hospital, "Transoral Incisionless Fundoplication: Effectiveness in Improving Typical and Atypical Symptoms of Gastroesophageal Reflux Disease Incompletely Controlled with Medical Therapy"

2nd Place Winner — Jennifer Colella, WellSpan York Hospital, "A Case of Neuroborreliosis Causing SIADH"



3rd Place Winner — Rashmi Dhital, Reading Hospital, "Hyperthyroidism with Right Heart Failure and Cirrhotic Transformation of the Liver: A Case Report"

Crowd Favorite — Bindiya Shah, Easton Hospital, "Dysphagia Lusoria: An Uncommon Cause of Dysphagia Caused By a Common Vascular Anomaly"

THE CHANGING LANDSCAPE OF WOMEN IN MEDICINE

by Susan Lindt

In the last decade, the number of female physicians grew in the U.S. by more than 43 percent —

a dramatic jump suggesting women have arrived in a field historically dominated by men. Despite that phenomenal growth, statistics show the pay gap continues unabated, men still dominate leadership positions, and female physicians routinely handle more childrearing duties than male counterparts.

Some of Pennsylvania's most accomplished female physicians weighed in on the changing landscape for women in medicine. While they hail from different specialties, backgrounds, and generations, they say nuances suggest parity is still a long way off, but without exception, they're optimistic.

"It's getting better, but right now, in many ways, women in medicine are still treated differently than men," says Amelia Paré, MD, FACS, a Pittsburgh surgeon in private practice. "I look forward to the future when women will be accepted as equals."

WOMEN IN MEDICINE

BY THE NUMBERS

While female physicians have gained a foothold in the profession, statistics throughout history show men still dominate leadership roles.

1860

200

Female physicians worked in the United States

1900

7,000+

By the beginning of the 20th century, that number jumped

TODAY

376,500+

Physicians and residents are women

Source: American Medical Colleges

The Wage Gap

In 2017, Doximity, a social network for medical professionals, surveyed 65,000 physicians across 40 medical specialties. Results show female physicians were paid 27.7 percent less than male counterparts — that's an average of $105,000 less per year.

"We know the gender pay gap exists — it's not something that was 'back in the day,'" says Vinti Shah, DO, who has been practicing for seven years and is currently section chief of palliative medicine at Reading Hospital-Tower Health.

Salary negotiations can be especially complex for women. Studies show employers may view a quality displayed by a man negotiating a raise as an asset, but the same quality in a woman may be viewed negatively.

"Men generally ask for what they think they deserve. They don't wait for someone to tell them what they're worth," Dr. Shah says. "But women are notorious for not asking."

More recent studies, including one published last year in the *Harvard Business Review*, show women now ask for raises as often as male counterparts — but they're receiving them 25 percent less often.

Researchers haven't accounted for this disparity yet. But, it compounds professional and financial ground women lose when they choose motherhood.

"Young female physicians who want to have children then have to contend with the challenge for career advancement," says Andrea Feinberg, MD, chief health officer at Geisinger Innovation, and a member of the Pennsylvania Commission for Women. The commission tackles challenges all women face, including maternity leave's impact on the wage gap and career advancement.

"If we want to close the wage gap, we have to make maternity leave available to all women in a way so they won't be penalized," Dr. Feinberg says. "This is something we have to decide to support as a society."

Sherry Blumenthal, MD, an OB-GYN and past chair of the Pennsylvania Section of the American Congress of Obstetricians and Gynecologists, says women are hit twice by pay inequality: first by lower pay, and then by salaries calculated on productivity, which aren't adjusted for maternity leave. The American culture of salary secrecy means women often learn

7 VOICES TRACK THE PACE OF PROGRESS IN PENNSYLVANIA

BY JEFF WIRICK

Start here to read more about seven perspectives on the pace of progress.

Nearly 1 out of 3 Pennsylvania physicians are women. As those numbers continue to rise, so does the ability to address the sizable gender gap that remains in medicine.

Between 2008-2018, Pennsylvania has seen a 43-percent increase in the number of women physicians, according to figures compiled by PAMED. This compares to an increase of 17.8 percent in the overall number of licensed Pennsylvania physicians.

"I think it takes a certain amount of courage to be able to speak up [about gender gaps]," says Aleesha Shaik, MPH, a fourth-year medical student at Drexel University College of Medicine. "But the fact that there are so many more females in the field today allows us to rely on each other."

only by chance that they're underpaid compared to the salaries their male colleagues earn.

Dr. Blumenthal aims to level the playing field.

In 2017, she established the PAMED Women Physicians Caucus (WPC) so women could exchange ideas and take action on issues affecting them.

Dr. Blumenthal set to work composing two resolutions that both passed at October's House of Delegates (HOD): one elevated the caucus to the Women Physicians Section (WPS), so it may self-govern and propose resolutions to the HOD; the other supports eliminating punitive salary policies for physician mothers who take maternity leave and directs the WPS to develop best practice maternity leave guidelines that PAMED can promote to physician employers.

Both resolutions are vehicles to affect greater change, and that's what Dr. Blumenthal has her eye on.

"I'm very pleased," she says. "We have a lot of work to do."

JOANNIE YEH, MD,
MEDIA

The rise of the #MeToo movement and social media have helped women physicians better share their experiences and struggles, says Joannie Yeh, MD, a pediatrician from Media.

Dr. Yeh began networking with other women physicians a few years ago on Twitter, where she learned about many of her colleagues' challenges. Using the hashtag #GirlMedTwitter, Dr. Yeh and several other physicians and medical trainees built an online network that has since turned into Girl Med Media, a nonprofit focusing on leadership opportunities within hospital and academic medicine.

"My husband always asks me, 'Why can't you just be a pediatrician?'" Dr. Yeh says with a laugh. "I think I would have been just as happy because I've always had support. I want other women to have the type of support that I have.

"I am hopeful for the future. Hopefully with increased awareness of the gender gaps, and increased cohesive efforts to close the gender gaps, things will be better."

Increasing the number of women physicians in leadership positions can lead to a more equal playing field, says Dr. Yeh.

"There are studies showing that when women go through leadership workshops, they are retained at a higher rate for leadership roles," Dr. Yeh says. "So, one of the ways to change is for women to invest in themselves and go to training. Generally speaking, men are more willing to take a risk and invest. Women are not. But when women do invest, their investments do well."

WOMEN IN MEDICINE

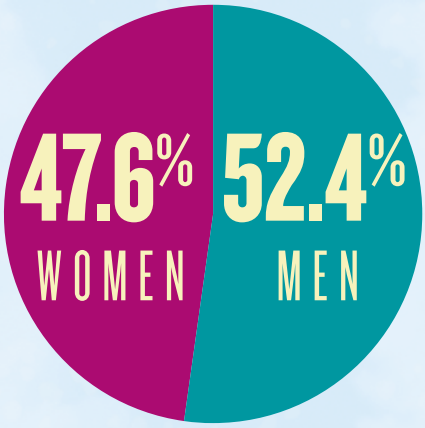
BY THE NUMBERS

According to the Association of American Medical Colleges,

42,000

WOMEN

were enrolled in American medical schools from 2013-2017, with a near-even split of men and women.



Maternity Leave and After

Lynn Michele Lucas-Fehm, MD, JD, Abington-Jefferson Health clinical director of breast imaging, had three children during her 25 years as a radiologist. When pregnant with her first, there was no such thing as "maternity leave," so she took sick time. By her second pregnancy, she could take unpaid leave. For her third pregnancy, a "cursory" maternity leave policy was in place, but not an especially generous one.

Dr. Lucas-Fehm says not much has changed in this regard.

"Back then, you were in a male-dominated profession, and men don't have babies, so why would they have maternity leave?" Dr. Lucas-Fehm says. "Now, corporate America has policies in place. Some companies even allow men to take time off. But in medicine, we haven't gotten there yet."

Returning to work after having a baby has its own challenges, with new mothers pumping breast milk in bathroom stalls and nowhere to store it. There's also a stigma some physicians sensed among male doctors after they became mothers.

"I was driven to prove I worked hard or harder than anybody else because I didn't want to be viewed as a 'mommy tracker,'" says Candace Good, MD, a State College psychiatrist and owner of Sig: Wellness Studio who had her daughter during residency in the early '00s. "I felt like I had to work harder than the males because if I wasn't as good, they'd attribute it to my kid being sick."

Women use different means of dealing with the challenges of maternity and childrearing as physicians — Dr. Paré says many adopt because their childbearing years are spent working.

"No women took time off to have kids when I was in school," Dr. Paré says. "If you left, you didn't know if there would be a job for you when you got back. Women felt like they couldn't even be late because they didn't want to give anyone an excuse to get rid of them. There was always someone looking to take your spot. That's why I'm a 52-year-old with a 12-year-old son. He's the best thing in our lives, but we're always the oldest parents at everything."

Other female physicians got around these challenges by creating all-female practices where schedules are flexible because family life is prioritized.

"We envisioned a practice of women," says OB-GYN Jessica Krebs, MD, a founder of LG Health Physicians Lancaster Physicians for Women. "We all have the same struggles with childcare, family obligations. We're flexible and open to helping each other so everyone can get to school functions. It was a big advantage that we didn't have anyone in our practice for whom that wasn't a priority."

There's change on the horizon here, too. Dr. Good senses today's residents generally put more weight on quality of life outside medicine, and the culture seems to bear it.

And 2017 marked another telling milestone: it was the first time the number of women enrolled in U.S. medical schools (50.7 percent) outnumbered men, according to the Association of American Medical Colleges.

"It doesn't even occur to women that they're going into a male-dominated field anymore," says Dr. Good, who maintains a clinical teaching appointment with the Penn State College of Medicine and is chair of psychiatry at Mt. Nittany Medical Center. "But the attitude and shift I see in people changing their time commitment isn't just a female movement — they're all putting more emphasis on quality of life."

THEN AND NOW

With more women entering medicine, practical and larger challenges women once faced are becoming issues of the past.

At Reading Hospital-Tower Health, in-house daycare put an end to the "daycare dash" female physicians used to make, and dedicated space is available for lactating mothers.

A lack of salary transparency still feeds the wage gap. But, the internet has shed light on that gap and put some information, such as self-reported salary surveys, in the hands of women negotiating equitable contracts.

> **ONE OF THE GOALS OF PAMED'S WOMEN PHYSICIANS SECTION IS TO EMPOWER WOMEN. "FIRST, WE NEED TO DELIVER THE INFORMATION THAT THERE IS A WAGE GAP, THERE'S A LEADERSHIP GAP, THERE'S STILL SEXUAL HARASSMENT. THERE IS STILL AN ISSUE WITH HAVING MEDICALLY SOUND MATERNITY LEAVE. THEN, WE NEED TO EMPOWER WOMEN TO FIGHT FOR IT."**
>
> – SHERRY BLUMENTHAL, MD

SHERRY BLUMENTHAL, MD
ERDENHEIM

She founded and served as the first chair of PAMED's Women Physicians Caucus, which started in 2017. She also served as co-chair with Lynn Michele Lucas-Fehm, MD, JD, until the Caucus became an official Section.

"There have been many changes but not nearly what should have occurred," Dr. Blumenthal says. "That is extremely unfortunate, and that's something that I believe needs to change radically."

Dr. Blumenthal says two of the most significant disparities are a 30-plus-percent salary gap and lack of support for women after childbirth. Like Dr. Yeh, Dr. Blumenthal believes it's important to educate women about these disparities and fight for change.

"First, we need to deliver the information that there is a wage gap, there's a leadership gap, there's still sexual harassment. There is still an issue with having medically sound maternity leave," Dr. Blumenthal says. "Then, we need to empower women to fight for it.

"Women are programmed to have everyone like them. You are perceived as aggressive rather than being appropriately assertive as a physician needs to be. It's not accepted well by society. So, when negotiating salary, women are much more likely to just say okay. Men are much more likely to start asking for more or to negotiate. Women need to find out what their male counterparts in the same position are earning. And then they need to advocate for themselves."

Home/Work Balance

More than other disparities, women physicians cited bearing the bulk of home responsibilities as their greatest challenge.

"It's a silent discrimination," Dr. Paré says. "It's still not socially acceptable for men to stay home with kids, so women are usually relied on to get the kids to the bus. When a kid has a nosebleed at school, she's the parent who's called."

A 2014 study published in the *Annals of Internal Medicine* showed female physician researchers spent nine more hours on domestic duties and were more likely to take time off work when children are sick than their male counterparts.

A 2017 study published in *JAMA Internal Medicine* indicated women in two-physician partnerships worked 11 fewer hours per week outside the home than female physicians without children.

Like many women in two-physician partnerships, Adele Towers, MD, tried to find a professional situation allowing time for her to parent three children. As a part-time physician, she saw no growth potential and felt discounted by colleagues. When she returned to full-time medicine, her home life suffered.

"My work led to the collapse of my marriage," says Dr. Towers, a University of Pittsburgh associate professor of psychiatry and medicine, and UPMC Enterprises director of risk adjustment. "I was working 60 to 80 hours a week. That wasn't easy with three kids, but back then men didn't take care of kids. If your spouse doesn't support your career, it is not conducive to a good marriage."

Dr. Towers joined a cohort studied in *BMJ* in 2015: female physicians are more likely to divorce than male physicians, and the more hours female physicians work, the higher their rate of divorce.

The next generation of women physicians may have an easier time thanks to a cultural shift in parenthood.

"IT DOESN'T EVEN OCCUR TO WOMEN THAT THEY'RE GOING INTO A MALE-DOMINATED FIELD ANYMORE."

–CANDACE GOOD, MD

DENISE JOHNSON, MD
MEADVILLE

Denise Johnson, MD, has seen a large shift during her career in medicine. She was part of the first all-female residency OB/GYN class at Vanderbilt University Medical Center in Nashville.

That was when there were still more men in the OB/GYN specialty than women. Today, OB/GYN is one of the few female-majority specialties.

In recent years, Dr. Johnson has served on Gov. Tom Wolf's Pennsylvania Commission on Women and become chief medical officer at Meadville Medical Center in Meadville.

She says an increasing number of practice options have helped women establish medical careers while balancing family responsibilities.

"There's job sharing. There's outpatient only; there's inpatient only. In time's past, there weren't those options," says Dr. Johnson. "The newer generation has different work styles, different priorities.

"Physician organizations are having to make that adjustment, especially if you want to keep good people. Large organizations have been slow to make that change, but there are more and more people requiring or demanding different types of practice, so we've really had to adjust to accommodate that."

As the number of women physicians continues to grow, it's easier for them to amplify their voice, says Dr. Johnson.

"Maybe they didn't feel like they could speak out (in the past), but they also didn't see other people speaking out," she says. "I think there are vocal people that help bring about change, but there are also a lot more people.

"I think medicine has become more attractive to women because the flexibility has allowed them to practice during peak childbearing years."

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WOMEN IN MEDICINE

BY THE NUMBERS

Of women who identified as holding leadership positions in medicine, less than 15 percent held top spots as department chairs, CEOs, and CMOs.

>3% are CMOs

4% are CEOs

6% are department chairs

9% are division chairs

15% are practice partners

16% are committee leaders

29% are practice owners

40% are medical directors

44% are assistant professors

Source: Association of American Medical Colleges

"THE REAL STORY ABOUT ACADEMIC MEDICINE IS THE SMALL NUMBER OF WOMEN IN HIGHER RANKS — THAT'S WHERE THE DISPARITY LIES."

–EILEEN MOSER, MD

"Parenting isn't just a mom thing — it's a mom and dad thing," Dr. Shah says. "My husband is a hands-on dad. He knows it's important for me to be successful as a physician and a mom, and if I'm not successful in one realm, it will hinder the other."

Dr. Paré views the challenge of doing it all at home and at work as a strength women physicians take into their professional lives that actually makes them better doctors.

"The reality is, women's days are a lot different than men's days, even if they're both doctors," Dr. Paré says. "My husband's a heart surgeon. He doesn't think about groceries or laundry, but I do. But that's what makes women really good doctors — we get it done. The same mentality that makes you figure out your kid's Halloween costume an hour before the party is what makes you a better doctor. It's an important characteristic that shouldn't be underestimated."

Mentoring/Leadership

One of the first caucus initiatives tackled in 2017 was developing a female mentorship program. It promises to tackle a "chicken and egg" effect: there are few women physicians in top leadership ranks, so young women aiming high don't have many role models to help them reach their goals.

"The real story about academic medicine is the small number of women in higher ranks — that's where the disparity lies," says Eileen Moser, MD, an internist, associate dean for medical education, and a professor of medicine at Penn State College of Medicine-Penn State Health.

Dr. Moser cites a 2014 AAMC study showing women comprised only 21 percent of full professors, 34 percent of associate professors, and 16 percent of medical school deans in 2014.

Dr. Moser says new options make it easier for women to take time off and then resume their professional tracks, including flexible scheduling and research and publication extensions. But like maternity leave, these options still set back women professionally.

LYNN MICHELE LUCAS-FEHM, MD, JD
PHILADELPHIA

Data from the American Medical Association (AMA) and Kaiser Foundation reveals that 34.5 percent of physicians delivering care in the U.S. are women. An even more significant statistic: 2017 was the first time more women enrolled in medical school than men.

Yet, studies also reveal that women hold significantly lower leadership positions. According to the AMA, of the women who identify themselves as leaders, very few reported being department chair, chief executive officer, or chief medical officer.

Lynn Michele Lucas-Fehm, MD, JD, a diagnostic radiologist from Philadelphia, says one of the goals of PAMED's Women Physicians Section is to encourage paths to leadership roles.

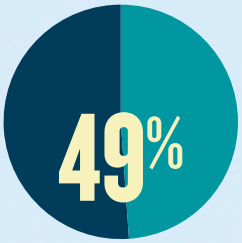
"The reasons why women have not achieved widespread leadership positions are complicated, but one factor is certainly the criteria that have been traditionally utilized to determine who will be promoted," says Dr. Lucas-Fehm. "As more and more women enter the workforce, the metrics determining promotion will change.

"The more women there are in the profession, the more equal the playing field will become. The current point of view as to what makes someone a better physician leader will evolve as the number of women in medicine increases."

BY THE NUMBERS

More nuanced, a 2017 study in the *Journal of Women's Health* examined how physician speakers were introduced at Internal Medicine Grand Rounds.

of the time women introduced male speakers using their professional titles



of the time men introduced female speakers using their professional titles

Researchers concluded this difference in professional title use may heighten the sense of isolation, marginalization, and professional unease expressed by women in academic medicine.

"It's wonderful to go part time, but if you're trying to climb the ranks, it sets the clock back. If you have an extension because you can't make the track for publication, that also sets the clock back," she says.

The result: fewer women reach top academic ranks.

"And that has ramifications on younger women and what they see as possibilities for their future," Dr. Moser says. "If they don't see people in higher ranks that look like them, they can't envision themselves in those roles. And it's really important because having a mentor can double their chances of being promoted in the workplace."

Sometimes mentorships develop organically. Dr. Shah was so impressed with a colleague's aplomb in a tense situation, she invited her to lunch, and a relationship developed.

"A few months later, I realized she had become my mentor," says Dr. Shah, who still gets advice on balancing home life with her duties at Reading Hospital, where a formal women's mentoring program has been developed.

Dr. Shah especially needed help navigating the female/male dynamic in tough administrative situations.

"If a man raises his voice, he's perceived as being passionate. If a woman does that, she's perceived as being emotional," Dr. Shah says. "If I have a difficult administrative situation, my mentor may give me tips; we may role play the entire meeting. I also ask for mentoring on leadership in general. Physicians are in uncharted territory when it comes to leadership because we aren't trained for it."

Dr. Good says she learned valuable leadership skills and gained "emotional energy" to put her ideas out in group settings at PAMED's Year-Round Leadership Academy.

"It was the best thing I ever did for myself because it's still challenging to find female mentors for administrative issues, contract negotiations, leadership skills, and encouragement to seek administrative roles," says Dr. Good, who is helping to organize the mentorship program. "Women have a lot of ideas about how to shape policy and make things run better, but they need to become active participants in the discussion."

AS THE NUMBER OF WOMEN PHYSICIANS CONTINUES TO GROW, IT'S EASIER FOR THEM TO AMPLIFY THEIR VOICE, SAYS DR. JOHNSON.

PAMED has many opportunities for members to enhance their leadership skills. Learn more at *www.pamedsoc.org/LeadershipAcademy.*

If the WPS is an indicator, women physicians are eager to make changes. While Dr. Blumenthal wishes the WPS had formed sooner, she's encouraged by interest from women and support expressed by men for their initiatives.

"Women are very enthusiastic — we already have about 90 women on our Facebook page," Dr. Blumenthal says. "And many men supported the caucus because they have daughters in medicine."

With three daughters pursuing medical careers, PAMED past president Theodore Christopher, MD, FACEP, gained an insider's view of what women experience in medicine via his daughters' anecdotes — some of which he finds "kind of amazing" for 2019.

In his 2017 inaugural address to PAMED, Dr. Christopher, a professor and chairman of the Department of Emergency Medicine at the Sidney Kimmel Medical College of Thomas Jefferson University, forecasted a women's wave in the profession that would reshape medicine for everyone. "I said to all the men in the room, 'Look to your left, look to your right, because in the coming years, those chairs will be filled by women.'"

Dr. Christopher recognizes a wide pay gap, conscious and unconscious biases, and sexual harassment still plague women in medicine. But, he says the next decade will bring dramatic changes.

"In the medical field, it's hard for women to speak up — these guys are their professors, they grade them, they hire them, and a lot of what men do is clandestine," Dr. Christopher says. "But ask me how things are 10 years from now. We've already made progress just because there are more women in medicine."

Dr. Lucas-Fehm says a trend for young physicians to choose jobs with large systems rather than private practice means more physicians will work under system-wide policies governing promotions, maternity leave, and harassment. And that will also bring rapid change.

"'LOOK TO YOUR LEFT, LOOK TO YOUR RIGHT, BECAUSE IN THE COMING YEARS, THOSE CHAIRS WILL BE FILLED BY WOMEN.'"

–THEODORE CHRISTOPHER, MD, FACEP (LEFT)

Pictured with former PAMED President Karen Rizzo, MD, FACS

DANAE POWERS, MD
STATE COLLEGE

During her anesthesiology residency, PAMED President Danae Powers, MD, noticed a strange phenomenon: she seemed to get more personal information from patients than her male counterparts.

She often wondered why. *Did they think I was the nurse? Did they feel more comfortable because I was a woman?*

Years later, as more women enter medicine, Dr. Powers says those types of experiences have become less common.

"I think the allowable range of expression in women has become broader," explains Dr. Powers. "Men could be calm, quiet, aggressive, assertive, and loud. [In the past,] women could only be quiet, not assertive or loud. That is changing, and it is a good thing.

"I think it's a result of more and more women coming into this profession. People's experience becomes much more a result of the individual instead of, 'Oh, that's the girl.'"

"Hospital systems will have policies in place, so I'm very optimistic a lot of these issues will be solved," Dr. Lucas-Fehm says. "Change is inevitable just because of sheer numbers — in 20 years, all the women in medical school now will be the decision-makers. Men are our best allies in making these changes. They have wives and daughters, so these changes are good for all of us."

Dr. Moser agrees. She's undaunted by the relatively slow pace of change when she considers progress women have already made in medicine.

"There's a lot of frustration out there – I get that," Dr. Moser says. "But social change takes a long time, and the next generation of women is even more empowered, so absolutely, things will change."

For Dr. Paré, the great number of women entering a traditionally-male field will be an equalizing force for the practical challenges: X-ray gear and surgical instruments sized only for men, hospitals providing locker rooms only for male surgeons, and maternity leave policies. For larger, cultural shifts, such as balancing home and work responsibilities, and receiving recognition for what women bring to medicine, Dr. Paré says women have new allies they didn't have before.

"Men are more receptive than ever at looking for creative ways to help solve these problems. We still have a long way to go, but there's been a huge change in the way men look at these issues," Dr. Paré says. "It's exciting to see women get the recognition they deserve. I'm excited about the future."

Susan Lindt is a freelance medical writer from central Pennsylvania.

"SOCIAL CHANGE TAKES A LONG TIME, AND THE NEXT GENERATION OF WOMEN IS EVEN MORE EMPOWERED, SO ABSOLUTELY, THINGS WILL CHANGE."

– EILEEN MOSER, MD

"CHANGE IS INEVITABLE JUST BECAUSE OF SHEER NUMBERS — IN 20 YEARS, ALL THE WOMEN IN MEDICAL SCHOOL NOW WILL BE THE DECISION-MAKERS. MEN ARE OUR BEST ALLIES IN MAKING THESE CHANGES. THEY HAVE WIVES AND DAUGHTERS, SO THESE CHANGES ARE GOOD FOR ALL OF US."

– LYNN MICHELE LUCAS-FEHM, MD, JD

Many of the women physicians in this article hold leadership positions, such as on the PAMED Board of Trustees. To learn more about how you can get involved in PAMED, contact PAMED's Knowledge Center at 855-PAMED4U (855-726-3348) or *KnowledgeCenter@pamedsoc.org* or go to *www.pamedsoc.org/GetEngaged*.

AMELIA PARÉ, MD, FACS
PITTSBURGH

Plastic surgery remains a male-dominated specialty (about 12-13 percent of plastic surgeons are women, according to the American Society of Plastic Surgeons). While training for surgical specialties can be time-consuming and demanding, Amelia Paré, MD, a plastic surgeon from Pittsburgh, says it is possible to juggle a demanding career while raising a family.

"It is a commitment being a physician no matter how you do it," she says. "There are a certain number of birthdays and holidays and anniversaries that you're going to miss. I don't think anyone does it without a very supportive partner."

While there remains room for improvement, Dr. Paré says there is more "empathy for childbirth and childcare" in medicine today.

"Working as an employed physician or working in a larger group practice, it's almost like a beehive mentality today," she says. "You all want a common goal — and that's very uplifting."

Another sign of progress: the blatant discrimination that Dr. Paré experienced in her residency is less common. When she interviewed for plastic surgery fellowships in the '80s, more than one program told her they don't accept women.

"They said the last female they took went on maternity leave, and they couldn't afford to have a resident be out that long," remembers Dr. Paré. "That would not fly today."

ALEESHA SHAIK, MPH, MEDICAL STUDENT
PHILADELPHIA

The women who enter medicine today have one advantage that previous generations of women physicians lacked: greater access to experienced female mentors.

Aleesha Shaik, a fourth-year medical student at Drexel University College of Medicine, says one of her mentors, Marilyn Heine, MD, has been critical in helping her expand upon her interest in public health and treating the homeless. Dr. Heine wrote a recommendation letter for Shaik for Harvard University's master's in public health (MPH) program and often sends her articles on homelessness.

"When I told her that I was applying for an MPH, she connected me to public health experts that she had worked with," Shaik says. "I had many conversations with people based on her initial contact who provided me with more guidance. She has really gone above and beyond.

"Having that kind of mentorship myself makes me so much more likely to provide it to other people in the future."

While Shaik still sees gender bias in medicine, she's hopeful for the future.

"I am really excited at the prospect of having more females in the field to normalize our presence," she says, "and show that we are perfectly capable of taking care of patients. Having (advocacy) groups dedicated to these issues will allow women to have a forum to share their experiences, organize, and create change."

ON THE COVER
DR.HEINE AND HER CONTRIBUTION TO PAMED

Marilyn J. Heine, MD, FACEP, FACP, FCPP,
is an emergency physician and hematologist oncologist in active clinical practice in southeast Pennsylvania.

She has held prominent roles in PAMED including 162nd president, and is in leadership positions in state and national medical specialty societies and the American Medical Association (AMA).

A past president of the Bucks County Medical Society, she serves on its Executive Committee, and as a Delegate in the PAMED House. She is past president of the Pennsylvania College of Emergency Physicians and served on the board for the Pennsylvania Society of Oncology and Hematology.

A member of the AMA Council on Legislation Executive Committee, she is also on the AMA Ambassador Steering Committee, Delegate in the AMA House, and has served on the AMPAC Board of Directors.

A tenacious advocate for physicians and patients, Dr. Heine is chair of the Physicians Advisory Board for her congressman. She advised President George W. Bush on physician issues and testified before the Pennsylvania General Assembly and Congress.

She received gubernatorial appointments to the Commonwealth Health Care Reform Implementation Advisory Committee, eHealth Committee, and State Board of Medicine where she was chair.

She is a media spokesperson on health care and is Clinical Assistant Professor of Medicine at the Drexel University College of Medicine.

Dr. Heine has received many awards including the inaugural PAMPAC R. William Alexander, MD, Award "for contributions to the medical profession through grassroots political involvement and advocacy" and the American College of Emergency Physicians Colin C. Rorrie, Jr., PhD, Award for Excellence in Health Policy.

"WOMEN LEADERS CAN POSITIVELY INFLUENCE MEDICINE AND PROVIDE UNIQUE PERSPECTIVES AS WE IMPACT POLICY. WE DEMONSTRATE THAT THERE IS OPPORTUNITY FOR OTHER WOMEN PHYSICIANS WHO ARE INTERESTED IN LEADERSHIP. WE CAN SERVE AS ROLE MODELS AND HELP MENTOR AND SPONSOR YOUNGER WOMEN PHYSICIANS. DIVERSITY AT THE TOP ENCOURAGES BROADER MEMBERSHIP AND MAKES AN ORGANIZATION STRONGER, FLEXIBLE, AND MORE RESILIENT."

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NOW OFFERING

ACCESS TO AHPs FOR PENNSYLVANIA SMALL BUSINESSES

Federal Rules for Association Health Plans Relaxed

PAMED Legal Team Outlines Next Steps for Pennsylvania Implementation

BY ANGELA BOATENG, ESQ.

On June 21, 2018, the Employee Benefits Security Administration of the U.S. Department of Labor published its final rule on Association Health Plans (AHPs), relaxing the federal requirements for small businesses and self-employed individuals to establish and maintain an AHP.

PAMED's legal team prepared a primer for physicians who are unfamiliar with the Department of Labor's final rule. Read further for a description of AHPs, a summary of the final rule, a brief overview of Pennsylvania's plans regarding implementation of the final rule, and next steps for PAMED.

MEWAs and AHPs

AHPs are a specific type of Multiple Employer Welfare Arrangement (MEWA). AHPs are intended to allow two or more employers to offer or provide health insurance benefits to their employees and their employees' beneficiaries.[i]

AHPs have been described as an option for small business employers to expand access to employer-sponsored health insurance coverage for their employees with the following benefits: broader access to more affordable health coverage; increased bargaining power for hospitals, doctors, and pharmacy benefit providers; and greater administrative efficiency by transferring the day-to-day administrative responsibilities from an individual employer to the AHP sponsor.

AHPs still must comply with the Employee Retirement Income Security Act (ERISA) and are subject to state regulations governing MEWAs.[ii] AHPs are also subject to several other federal laws: the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accessibility Act (HIPAA), the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act, and other group health plan laws.

Summary of Final Rule

Definition of a "Bona Fide Group or Association of Employers"

Under ERISA, for multiple employers to be treated as a single "employer," they must be members of a "bona fide group or association of employers." To be considered a bona fide group or association, the participating employers are required to have "control" and "commonality of interest."

Historically, the "control" has meant that employer members were required to have influence over the design and operation of the group health plan. The definition of "commonality of interest" was less concrete; prior to the passage of the final rule, the Department of Labor applied a facts-and-circumstances method to determine whether this standard was satisfied.

The final rule has relaxed and reaffirmed several requirements for the definition of a "bona fide group or association of employers."

Control — Under the final rule, employer members must control the group health plan and the functions and activities of the group or association. Although the employer members are not required to manage the day-to-day affairs of the group or association, the control exercised must be present in form and substance.

Commonality of Interest — The final rule makes it easier for a group or association to meet the "commonality of interest" by allowing the standard to be met in two ways.

Employers in the same trade, industry, line of business, or profession may establish commonality. This standard may also be satisfied by geography — when the *principal place of business* of the participating employers within a region does not exceed the boundaries of the same state or the same metropolitan area.[iv] A metropolitan area may include more than one state. This is permissible even if the group's or association's membership includes unrelated employers in multiple unrelated trades, industries, lines of business, or professions.

A group, association, or their AHP is not required to cover the entire state or an entire metro area for the group or association to qualify as bona fide. Groups and associations may cover segments of geographic areas that otherwise meet the commonality of interest definition, provided that segmentation is not engineered to discriminate based on a health factor.

Must Have at Least One Substantial Business Purpose[v] — The final rule explains that a group or an association must have at least one ***"Substantial Business Purpose" (SBP)*** unrelated to offering and providing a health plan to its employer members and their employees, even if the primary purpose of the group or association is to offer such coverage to its members. The substantial business purpose is not required to be a for-profit purpose.

The rule does not define substantial business purpose; however, a safe harbor under the rule states that a substantial business purpose may exist where the group or association would be a viable entity even in the absence of sponsoring an employee benefit plan.

Must Have an Organizational Structure[vi] — A group or association must have a formal organizational structure with a governing body as well as bylaws or other similar indications of formality appropriate for the legal form in which the group or association operates.

Participating Employers Must Have Control Over the Group or Association and the AHP — The employer members must control the functions and activities of the group or association. Additionally, the employer members must control the group health plan; they must have a say in the plan design and operation. Although the employer members are

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[i] 29 U.S.C. 1002(40).

[ii] U.S Department of Labor. Association Health Plans: ERISA Compliance Assistance, https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-publication-ahp.pdf. Accessed Nov. 30, 2018.

[iii] U.S Department of Labor, Employee Benefits Security Administration; Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28919, (June 21, 2018) (codified at 29 CFR Part 2510).

[iv] The principal place of business is that of the employers participating in the group or association, not the principal place of business of the group or association or AHP.

[v] U.S Department of Labor, Employee Benefits Security Administration; Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28917, (June 21, 2018) (codified at 29 CFR Part 2510).

[vi] *Id*. at 28918.

not required to manage the day-to-day affairs of the group or association, the control exercised must be present in form and substance.

Eligible AHP Participants[vii] — The following individuals are able to participate in a group health plan sponsored by the group or association: (1) Employees of a current employer member of the group or association; (2) former employees of a current employer member of the group or association who became entitled to coverage under the group's or association's group health plan when the former employee was an employee of the employer; and (3) the beneficiaries of such individuals.

An AHP must continue to provide COBRA and other post-employment coverage to persons who became eligible for coverage by virtue of an employee-employer relationship with an employer that is connected to the bona fide group or association and the AHP.

Health Insurance Issuer Cannot Sponsor an AHP[viii] — Health insurance issuers are prohibited from constituting or controlling a bona fide group or association. However, health insurance issuers may provide administrative services to AHPs (e.g., third-party claims administration, medical provider network design, pharmacy network design, recordkeeping services, and assistance in setting up an AHP, etc.)

Health insurance issuers may also participate as an employer member of a bona fide association of insurers that sponsors an AHP. Thus, a group or association of health insurers acting as employers may sponsor an AHP for the benefit of their employees. Health insurers and their subsidiaries may be involved in the control of a bona fide group of association or AHP in such entity's capacity as a participating employer.

Nondiscrimination[ix] — The final rule notes that, like any other group health plan, AHPs cannot discriminate in eligibility, benefits, or premiums against an individual within a group of similarly situated individuals based on a health factor. AHPs may, however, distinguish between groups of individuals based on bona fide employment-based classifications consistent with the employer's usual business practice. AHPs' ability to discriminate based on non-health factors is subject to state regulation.

AHPs will be permitted to charge different premiums to different member employers in much the same way that a single large employer could charge different premiums to employees in different operating divisions, locations, or occupations within a company.

Working Owners

Under the final rule, working owners (e.g., sole proprietors) without common law employees may qualify as both an employer and employee for the purpose of participating in an AHP.[x]

To be eligible, working owners must earn wages or self-employment income from the trade or business for providing personal services to the trade or business and either (1) work at least 20 hours per week or at least 80 hours per month providing personal services to the trade or business, or (2) earn income from the trade or business that equals at least the working owner's cost of coverage for the working owner and any covered beneficiaries in the group health plan sponsored by the group or association in which the individual is participating.[xi]

Essential Health Benefits and Comprehensive Coverage Requirements

The Affordable Care Act requires health plans in the individual and small group markets to cover essential health benefits (EHBs), which include items and services in the following 10 benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.[xii]

Because AHPs are not subject to the rules of the individual and small group markets, AHPs are not required to provide EHBs.[xiii] If an AHP were to cover EHBs, however, the maximum out-of-pocket limit and annual and lifetime dollar limit provisions would apply.

AHPs must comply with federal laws that require the provision of certain benefits. For example, under federal law, AHPs must provide coverage for certain recommended preventive services without additional cost sharing. And, pregnancy-related expense for employees and their spouses must be reimbursed in the same manner as those incurred for other medical conditions.

Also, AHPs must comply with state rules regarding the mandatory provision of certain benefits. The final rule uses Pennsylvania's requirements as an example. Since AHPs would be grouped in the large market, in Pennsylvania AHPs would be required to cover in-patient and outpatient services for severe mental illness, substance use disorders, autism services, childhood immunizations, mammography, annual gynecological and routine pap smear, colorectal cancer screening, diabetic supplies and education mandate, chemotherapy, mastectomy and reconstructive surgery, children and developmentally disabled patient access to quality dental care.[xiv]

[vii] *Id.* at 28920.

[viii] *Id.* at 28921

[ix] *Id.* at 28926.

[x] *Id.* at 28929.

[xi] *Id.* at 28947.

[xii] Center for Consumer Information and Insurance Oversight. Information on Essential Health Benefits. www.cms.gov/cciio/resources/data-resources/ehb.html. Accessed Nov. 29, 2018.

[xiii] U.S Department of Labor, Employee Benefits Security Administration; Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28933, (June 21, 2018) (codified at 29 CFR Part 2510).

ERISA Preemption and State Regulation of AHPs

The ERISA gives states significant latitude in regulating AHPs under state laws and regulation. The final rule does not change existing state authority as established under section 514 of ERISA.

ERISA does not give the Department of Labor the authority to exempt any fully insured AHP from any state insurance laws that can apply to a fully insured MEWA plan under ERISA.

The final rule also explains that fully insured AHPs may be subject to state laws that regulate the maintenance of specified contributions and reserve levels. The final rule also notes that federal law does not supersede state insurance laws when applied to health insurance issuers that sell policies to AHPs and when applied to insurance policies that AHPs purchase to provide benefits.

Additionally, ERISA enables states to subject AHPs to licensing, registration, certification, financial reporting, examination, audit, and any other requirements of state insurance law necessary to ensure compliance with the state insurance reserves, contributions, and funding obligation.

ERISA Fiduciary Status and Responsibility of AHP Sponsors

Under the final rule, AHPs are subject to all of the ERISA provisions applicable to group health plans including the fiduciary responsibility and prohibited transactions provisions in Title I of ERISA. Furthermore, AHPs are subject to the same disclosure requirements mandated by ERISA and all existing federal regulatory standards governing MEWAs, including those established under the Affordable Care Act: Summary Plan Descriptions (SPDs), Summary of Material Modifications (SMMs), Summaries of Material Reduction in Covered Services or Benefits (SMR), and Summary of Benefits and Coverage (SBC).

The Final Rule and Implementation of AHPs in Pennsylvania

Prior to the passage of the final rule, the Pennsylvania Department of Insurance expressed concern that the new rule could impact consumer access to quality, affordable coverage, the state's regulatory authority, and market stability.[xv] In March 2018, the state Department of Insurance also submitted comments in response to the Department of Labor's proposed rule expressing similar concerns.

After the passage of the final rule, Pennsylvania joined 10 states and the District of Columbia in a lawsuit against the Trump administration. The lawsuit makes several allegations, questioning the legality of the final rule. As of the writing of this article (December 2018), the outcome of the litigation is still pending.

In August 2018, Pennsylvania Secretary of Insurance Jessica Altman outlined the Department's plans for regulating in Pennsylvania AHPs pursuant to the final rule:[xvii]

- **The AHP must be formed under state law and have been in active existence for at least two years.** To provide coverage for its members, AHPs in the state must be formed as specified by state law, including that it is maintained in good faith for purposes other than that of obtaining insurance, and has been in active existence for at least two years.
- **The AHP must be fully insured.** The health care coverage AHPs issue to its members in Pennsylvania must be fully insured by an entity licensed and with a certificate of authority to do the business of health insurance in the Commonwealth.[xviii]
- **The AHP must have a certificate of authority.** Since AHPs are a type of MEWA, the AHP must be licensed and have a certificate of authority to conduct health insurance business in the state. If the AHP does not satisfy this requirement, it is illegal.

[xiv] downloads.cms.gov/cciio/State%20Required%20Benefits_PA.PDF

[xv] Department of Insurance. Acting Insurance Commission comments on Proposed Rule on Association Health Plans. www.media.pa.gov/Pages/Insurance-Details.aspx?newsid=331. Accessed Dec. 4, 2018.

[xvi] Pennsylvania Insurance Department. March 6 Letter to the U.S. Department of Labor commenting on the Trump Administration's proposed rule on Association Health Plans. www.insurance.pa.gov/Pages/Homepage/Testimony_Speeches.aspx. Accessed Dec. 4, 2018.

[xvii] Pennsylvania Insurance Department. Letter to the U.S. Department of Labor Seeking Clarity on the Association Health Plan Final Rule. www.insurance.pa.gov/Documents/Press%20and%20Communications/Testimonies,%20Remarks,%20Speeches/2018/DOL%20HHS%20Letter%208.2.18.pdf. Accessed Nov. 26, 2018.

- **AHP health plans will be subject to state health insurance laws.** The health care coverage an association issues to its members in Pennsylvania will be subject to all Pennsylvania legal requirements for health insurance (e.g., licensure, solvency, form and rating standards, examination provisions, and enforcement).
- **Sole proprietors are not "employers."** Although working owners (e.g., sole proprietors) without common law employees may qualify as both an employer and employee for the purpose of participating in an AHP under the final rule, this will not be the case in Pennsylvania. According to the Secretary, a sole proprietor continues to be a part of the individual market and is not an "employer" for the purposes of health insurance coverage.

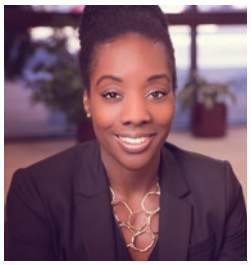
In the August 2018 letter, Secretary Altman explains that, as required by state law and the Affordable Care Act, health plans for employer members of an association will be required to provide policy forms and rates consistent with the market in which each employer member is a part: sole proprietors will have individual policies; employer groups of 2-50 will have small group policies; and, employer groups with more than 50 will have large group policies. Secretary Altman also stipulates that to do business in Pennsylvania, an AHP organized in another jurisdiction must comply with all applicable state laws and regulations.

There are, however, several organizations in support of AHPs. The Coalition to Protect and Promote Association Health Plans, a coalition of 16 organizations, has joined together with the stated purpose of assisting "federal and state policymakers…strike the right balance between regulating [AHPs] and providing the appropriate level of flexibility to allow organizations to provide comprehensive AHP health coverage to their small employer and self-employed individual members." In a letter dated, August 29, 2018, the organization reached out to the Pennsylvania Department of Insurance expressing their interest in implementing AHPs in the state, while noting their shared interest to protect against AHP fraud and promote consumer protection.

PAMED, AHPs, and Next Steps

In October 2018, the House of Delegates (HOD) considered Resolution 18-508—PAMED Association Health Plan. In light of the publication of the final rule, the resolution directed PAMED to "study the Department of Labor Final Rule, to explore the possibility and financial risk for PAMED to facilitate the development of an Association Health Plan for its members" and "assess the anticipated potential impact of an Association Health Plan on retention and recruitment of members."

The HOD voted to refer the resolution to the PAMED Board of Trustees for study. Accordingly, the board will study the issue and report back to the HOD with a recommendation in 2019.



Angela Boateng, Esq., serves as PAMED's General Counsel.

[xviii] Under fully insured plans, the AHP would pay premiums to an insurance carrier and the carrier is responsible for paying health care claims based on the benefits outlined in the policy. In contrast, with fully-insured plans, the employer assumes the financial risk, paying for the health care claim costs for its employees as they are submitted.

NEW STATE LAWS ON PATIENT TEST RESULTS AND ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

In October 2018, Gov. Tom Wolf signed two health care laws on patient test results and electronic prescribing of controlled substances.

The Patient Test Result Information Act took effect on Dec. 23, 2018. This law requires entities performing a diagnostic imaging service to directly notify the patient or patient's designee when, in the judgment of the entity performing the test, a significant abnormality may exist.

Physicians and facilities can submit questions regarding the application of Act 112 to the Department of Health to *ra-dhsecofhealth@pa.gov.* Please make sure to include "Act 112" in the subject line.

The new electronic prescribing law mandates that all Schedule II through V controlled substances, except when dispensed or administered directly to a patient by a practitioner or authorized agent, other than a pharmacist, to an ultimate user, shall be prescribed electronically. This law, which will take effect on Oct. 24, 2019, replaces the traditional method of prescribing controlled substances to a patient (i.e., paper prescription pads).

In response to member questions about the new laws, PAMED created these member-exclusive *Quick Consult* fact sheets that answer physicians' frequently asked questions:

Physician FAQs on Pennsylvania Law Concerning Electronic Prescribing of Controlled Substances – Offers details on topics such as what is required for inclusion in the patient notice, exceptions under the law, and acceptable methods of communication to the patient.

Physician FAQs on the Patient Test Result Information Act – Provides answers to common questions, including exceptions under the law, how to apply for an exception, and penalties for violating the law's requirements.

The fact sheets are available online at *www.pamedsoc.org/QuickConsult*. There, you'll find PAMED's complete library of resources to help physicians and practices navigate current health care laws and regulations.

IN MEMORIAM Raymond Grandon, MD

Deepest condolences to the family of Raymond Grandon, MD, of Harrisburg. Dr. Grandon died Dec. 9, 2018. His dedication to patients and the profession of medicine serve as an example that all physicians can emulate.

PAMED remains grateful for his leadership. For 11 years, Dr. Grandon chaired PAMED's Council on Scientific Advancement, which was responsible for our continuing medical education activities. He was also a fixture on PAMED's Board of Trustees, serving as PAMED president in 1982.

Other notable accomplishments included organizing the first televised heart surgery in the 1950s and an appointment by Gov. Milton Shapp to the State Board of Medical Education and Licensure in the 1970s.

Dr. Grandon made a lasting mark on generations of patients in the Harrisburg area as an internal medicine physician and pioneer in the field of cardiac rehab. When he retired in 2015, at age 96, he was considered one of the world's oldest practicing physicians.

FIERCE SUPPORT FOR PATIENTS IS ALL IN A DAY'S WORK FOR THIS READING PEDIATRICIAN AND PAMED EVERYDAY HERO

Johanna Kelly, MD

Pediatrician Johanna Kelly, MD, is a physician partner at Reading Pediatrics in Reading. She also serves as Reading Pediatrics' director of personnel and is a member of the practice's mental health committee. Dr. Kelly is the recipient of PAMED's Everyday Hero Award for October 2018.

Becoming a physician wasn't a foregone conclusion for Johanna Kelly, MD. She confesses to being fearful of her own pediatrician when she was a child. But, she turned that early trepidation into a strength and is now a steadfast, passionate advocate for her pediatric patients.

"I love helping families take care of their kids," Dr. Kelly says. "I feel incredibly privileged and honored to work with all the families I have known over the years and to be the recipient of their trust."

> "I feel incredibly privileged and honored to work with all the families I have known over the years and to be the recipient of their trust."

Dr. Kelly's affinity for public service was evident early on. During her time as a college undergraduate, she volunteered in her community and worked one summer at a workshop for mentally disabled adults. Those experiences helped her realize that a career in medicine fit her interests.

She deferred her acceptance to medical school for a year to participate in the Jesuit Volunteer Corps, working at a bilingual inner-city health center in Washington, D.C.

"I saw how the doctors working there did not just see patients, they became involved in their community exploring the systems and structures that can keep people unhealthy," she says.

She feels fortunate that her practice, Reading Pediatrics, has found ways to integrate itself into the fabric of the community. As a physician partner, she's justifiably proud of the breadth of services Reading Pediatrics provides to patients 365 days a year.

When the practice found that it was often challenging to connect patients with mental health services, they worked to find a way to offer that care in house. "Mental health issues overlap with physical health issues," Dr. Kelly explains.

She's seen how much these services can ease the burden on families, helping them avoid ER visits in times of crisis and offering them a support network.

When Dr. Kelly reflects on what the future holds for the next generation of physicians, her thoughts turn to her daughter, Shea, who is applying to medical school now. Her daughter is heading into a life in medicine with her eyes wide open, having seen both the successes and the struggles her mother has experienced over her career.

During a family dinner several years ago, her daughter asked Dr. Kelly about her day. What followed was the story of how her mom had spent hours on hold with an insurance company, working to gain authorization for a vital drug that had the potential to stabilize a vulnerable infant patient. Dr. Kelly didn't give up until her message was received loud and clear – her patient's life was in jeopardy without the medication. It took all day, but Dr. Kelly got the approval her patient needed.

Dr. Kelly credits her husband Dan, daughter Shea, and son Danny for being her personal everyday heroes. For a decade, her husband, now an elementary school teacher, made sacrifices in his career to stay home and care for their children. And, over the years, her family opted to delay things like evening meals when she was at the office so they could spend time together as a family.

When you talk to Dr. Kelly, her passion for what she does shines through. She applies a focus and energy to everything in her life – work with patients, family time, community service, and the interests that sustain her.

In Dr. Kelly, her patients have a staunch supporter who will never be afraid to speak out on their behalf.

TREATING MILITARY VETS EXPANDED HORIZONS FOR THIS PENNSYLVANIA PSYCHIATRIST AND PAMED EVERYDAY HERO

Eduardo Rueda Vasquez, MD

Eduardo Rueda Vasquez, MD, provides outpatient telepsychiatry services to children and adults in the Community Services Group clinics in both Williamsport and Lancaster. He also serves as a volunteer assistant professor in the Division of Psychiatry of the Department of Clinical Sciences of the Geisinger Commonwealth School of Medicine. Dr. Rueda Vasquez is the recipient of PAMED's Everyday Hero Award for September 2018.

Early in his career, during a rotating internship in Norfolk, Va., psychiatrist Eduardo Rueda Vasquez, MD, began meeting patients who would influence the course of his career and his approach as a physician.

Norfolk is home to Naval Station Norfolk, the world's largest naval station and the hub for the U.S. Atlantic Fleet. "During my internship, I treated many veterans of several wars, among them a few World War I veterans suffering from the effects of war, and I learned from them, their experiences, and the historic moments they lived," says Dr. Rueda Vasquez.

One such patient was an elderly man who had served on the British battleship HMS Irresistible, a ship that was involved with naval operations during WWI and that ultimately sank after striking an enemy mine. Dr. Rueda Vasquez was able to work with him to help manage symptoms of trauma triggered by the 60-year anniversary of that naval disaster.

A decade and a half later, in 1990, Dr. Rueda Vasquez began serving as a U.S. Army staff psychiatrist during Operation Desert Shield and Desert Storm.

"As a reservist, I was given 24 hours to mobilize to active duty," he recounts. "I served during the concentration period, when about 1 million troops from the U.S. and around the world gathered in Fort Benning, Ga., for infantry and combat training, during the six months prior to the start of the war."

He was put in charge of the outpatient services, serving all the units assembled for infantry and airborne training and the regular active duty units that function in Fort Benning.

His time in the military also led him to realize that telemedicine could serve as an important tool to help address the medical needs of service members.

In 1995, Dr. Rueda Vasquez submitted a proposal to the then-commander of the U.S. Army Medical Research and Materiel Command to apply telepsychiatry to the prevention and treatment of combat stress and other mental disorders, whenever it became technologically possible.

Now, technology has advanced to the point where telemedicine and telepsychiatry have become a reality. In his current role, Dr. Rueda Vasquez provides outpatient telepsychiatry services to children and adults in the Community Services Group clinics in both Williamsport and Lancaster.

"It is possible now with the right technological tools, such as computers and robotics, to practice several specialties in medicine, especially psychiatry, just about anywhere on earth," says Dr. Rueda Vasquez. He is also quick to point out, though, that technology could never replace the administrative, nursing, counseling, and support staff of his organization.

Dr. Rueda Vasquez reflects that his experience in the military was such a valuable one that he would not hesitate to recommend it to a physician just starting out. He says it offers physicians the opportunity to experience an enhanced practice in addition to the one the civilian world offers, including treating patients in underserved populations.

His path in medicine, which began while he was in medical school in Colombia at the Universidad Nacional de Colombia, has been sparked by his openness to new experiences. "Psychiatry helps people to deal with their life problems," Dr. Rueda Vasquez says. Through his military service and his willingness to embrace new technologies like telepsychiatry, he's found a multitude of ways to shepherd his patients through difficult experiences.

Linda Turzai, Sam Osten, Kathleen Osten, MD, and Rep. Mike Turzai

FOR THIS CRANBERRY FAMILY PHYSICIAN, THERE'S NOTHING BETTER THAN SEEING PATIENTS MAKE PROGRESS

Kathleen Osten, MD, is a family medicine physician practicing in Cranberry. She also serves as medical director of Heritage Valley Health Network's Clinical Integration Network and Accountable Care Organization. Dr. Osten is the recipient of PAMED's Everyday Hero Award for November 2018.

"I love the continuity of family medicine," says Kathleen Osten, MD. For her, spending time with patients isn't solely about providing medical care. It means the opportunity to interact with patients over time – observing family dynamics and getting a chance to understand each person's specific challenges.

Dr. Osten earned a scholarship to attend Jefferson Medical College through the U.S. Armed Forces Health Professions Scholarship Program. She was gravitating toward a primary care specialty, and Jefferson offered a strong family medicine program.

Following medical school, she completed a civilian residency and then served in the Air Force as a physician at Sheppard Air Force Base in Wichita Falls, Texas. Her work there included sick calls for the newly enlisted, the treatment of active duty service members and their families, and care for retired military members.

A few years after her military service concluded, she and her husband chose the Pittsburgh area, where she grew up, as their new home. She's been taking care of patients in the region ever since.

Dr. Osten has the privilege of sharing in her patients' milestones. She enjoys hearing their latest news or seeing photos of their children and grandchildren. It's all part of developing a strong relationship and ensuring patients begin to feel comfortable discussing health issues that are not always easy to talk about.

When she was first starting out in medicine, one of her mentors told her, "Talk to your patients and listen." It was a simple piece of advice that is the foundation of her approach to every patient encounter.

The art of listening is critical in Dr. Osten's work with patients managing chronic conditions like diabetes.

"More and more people are getting diabetes and getting it at a younger age," Dr. Osten says. Her role, as she sees it, is to help patients manage this lifelong disease so it doesn't control their lives.

Dr. Osten recalls one male patient who was reluctant to seek treatment for his diabetes – he made his appointment only at the urging of his wife. Dr. Osten has learned from experience that you have to meet patients where they are, so she was careful to bring him along slowly. "You can't fix everything at once," she says. It took several years and some trial and error, but he was successful in getting his symptoms under control.

Dr. Osten's experience with chronic care management has given her a unique perspective that she brings to her other role as medical director of HVHN's Clinical Integration Network and Accountable Care Organization.

"As I get older, I work more hours," she laughs. When her children were younger, she practiced part time. Now that two of her children, Natalie and Jeremy, are both college students studying engineering and Matthew, her youngest, is a high school senior, Dr. Osten has chosen to take on additional leadership responsibilities with HVHN. She credits her husband, Sam, for his support and encouragement as she pursued these new roles.

She typically spends two days each workweek assisting her organization with meeting its quality goals.

Seeing a patient make progress is one of Dr. Osten's favorite things about family medicine. Dr. Osten says she doesn't really believe that there are "difficult" patients. She understands that her patients are individuals with unique experiences that shape their perception of health care.

Through her interactions with patients and her work to improve the community's overall health through quality initiatives, she has dedicated her career to helping patients achieve their goals.

"DECISION TRUMPS INCISION" FOR THIS PHILADELPHIA SURGEON AND PAMED EVERYDAY HERO

Alexander Kutikov, MD, FACS, is chief of the Division of Urology and Urologic Oncology at Fox Chase Cancer Center in Philadelphia. He also serves as a professor in the Department of Surgical Oncology at Temple University's Lewis Katz School of Medicine. Dr. Kutikov received PAMED's Everyday Hero Award for August 2018.

"Modern medicine is complex, but, in the end, it's still very human," says Alexander Kutikov, MD, a surgical oncologist who specializes in the treatment of prostate, bladder, and kidney cancers at Fox Chase Cancer Center in Philadelphia.

Dr. Kutikov is an expert in his chosen field of urologic oncology, including procedures like robotic surgery. He takes even more pride, though, in the human side of medicine and helping his patients through the difficult decision-making process that comes with a cancer diagnosis.

Compassionate care is at the heart of everything Dr. Kutikov and his team do at Fox Chase Cancer Center. "We try to stay true to the human aspect of it and communicate that we're there for [our patients]," he says. "That resonates with [them]."

One of Dr. Kutikov's patients, pediatrician Gerard Margiotti, MD, nominated him for the award and describes him as a healer. "He is undeniably among the best, technically proficient surgeons in his field: an excellent diagnostician, warm, caring, and compassionate," says Dr. Margiotti. "Dr. Kutikov called personally several days in a row to check on my progress."

"Decision trumps incision" is one of Dr. Kutikov's mantras. He emphasizes that the most important thing you can do as a surgeon is to make sure you're making the right call. And, Dr. Kutikov explains, the right call often doesn't include surgery at all. There are times when doing nothing is the best option.

Gerard Margiotti, MD; winner Alexander Kutikov, MD, FACS; PAMED Trustee Mark Lopatin, MD; and PAMED staff Katie Jordan

For certain cancers, the best approach is simply to monitor patients, says Dr. Kutikov. "In my clinic, some of the most satisfying encounters we have involve convincing patients not to have surgery."

While watching and waiting is often the best choice for patients, that strategy can be a stressful one. At Fox Chase Cancer Center, which is part of Temple Health, patients have access to innovative programs – including mindfulness courses and support groups – that help them manage the stress and emotional toll that a cancer diagnosis can take.

Dr. Kutikov's path toward medicine began in St. Petersburg, Russia, where he was born and lived during his early childhood years. At age 11, he moved to the U.S. with his family and continued his education.

When he began his time as a student at Harvard Medical School, Dr. Kutikov hadn't yet decided upon a specialty. Sage advice from his now-wife Jessica Kutikov, MD, a pediatrician, as well as encouragement from physician mentors ultimately convinced him that a surgical specialty was the right fit for him.

"Surgeons hate to retire," says Dr. Kutikov with a laugh. He explains that his field offers so much to those who practice it: the ability to establish long-term relationships with patients, multi-faceted experiences and opportunities, and a meaningful vocation.

A typical week for Dr. Kutikov is busy and full of variety. Each week includes two to three days of surgeries, at least one day for biopsies and scopes, and time spent on administrative tasks connected to his role as chief of Fox Chase Cancer Center's Division of Urology and Urologic Oncology.

He also helps to train urologic fellows. "It always keeps you fresh," he says, noting that the residents and fellows he works with offer as much to him as he offers them.

Staying on the cutting edge of his field is important to Dr. Kutikov. He has published some 200 publications and is active on the national academic scene. That involvement started in medical school when he and a fellow student started a website for urologic surgery.

When asked how he manages the challenges of a rewarding but also demanding profession, Dr. Kutikov is quick to mention how fortunate he is to have an incredibly supportive family. "I owe a lot to my wife," he says. And, he's deeply grateful for his children – Bennett, Jonah, and Lilah. Without his wife and children in his life, he says, he couldn't be the physician and the person he is today.

"IT'S IMPORTANT TO SUPPORT FAMILIES IN THE GOOD TIMES AND THE BAD,"

SAYS STATE COLLEGE PHYSICIAN AND PAMED EVERYDAY HERO

Rep. Kerry Benninghoff and James Powell, MD

James Powell, MD, is a pediatric hematologist/oncologist and pediatric hospitalist with Mount Nittany Physician Group and CANCER CARE PARTNERSHIP, a partnership between Mount Nittany Medical Center and Penn State Cancer Institute, in State College. He also serves as a Clinical Assistant Professor of Pediatrics for the Penn State College of Medicine. Dr. Powell is the recipient of PAMED's Everyday Hero Award for December 2018.

"I'm a small-town guy," says James Powell, MD. He's known in his tight-knit community – which is home to Penn State's University Park campus – as a compassionate physician who takes care to include his young patients' families in the treatment process.

Pennsylvania State Representative Kerry Benninghoff nominated Dr. Powell for the Everyday Hero award. "He is an extremely kind and empathetic person, and in return a tremendous physician," Rep. Benninghoff said. "Our family is forever grateful for the loving care he gave our daughter."

During Dr. Powell's fellowship at Duke University Medical Center, his physician mentors drove home how vital it was to provide empathy and comfort to patients and families dealing with a cancer diagnosis. It is a lesson that has always stayed with him.

His support extends to families who have lost a child to cancer. "It's important to support families in the good times and the bad," Dr. Powell says. He makes a point of calling to check in with families in the months following their child's passing. "They appreciate knowing that you're thinking of their child, that they are not forgotten."

Dr. Powell grew up in Hazleton and had a strong support system behind him. He was the first in his family to go to college, and he credits his parents and his teachers in Hazleton for laying the groundwork for his decision to pursue a career in medicine. "They always stressed the importance of working hard and getting a good education," he says of his parents.

His ties to Penn State University began early, when he was an undergraduate studying molecular and cellular biology.

Dr. Powell went on to choose Penn State College of Medicine for his medical education. His experience with leukemia patients during a clinical rotation, as well as his work with patients during his first year of residency at St. Christopher's Hospital for Children in Philadelphia, solidified his decision to specialize in pediatric hematology/oncology.

One of Dr. Powell's stops in his journey as a physician was at Penn State Health's Milton S. Hershey Medical Center, where he worked from 2003 until 2008. While there, he helped to establish a pediatric sickle cell anemia program which is still going strong to this day. "Sickle cell disease is a devastating illness," Dr. Powell says, and he's proud of his work to help patients gain more access to treatment.

In 2008, Dr. Powell made the decision to move to State College and join Centre Medical & Surgical Associates, which became part of Mount Nittany Physician Group in 2011.

His current role with Mount Nittany Health is a varied one. He typically spends at least one or two days a week in his hematology/oncology clinic. For the past year, Dr. Powell has also worked as a pediatric hospitalist for his organization. As a hospitalist, he provides care to a variety of pediatric patients – from newborns in the nursery to children admitted to the hospital.

In addition to his clinical duties, Dr. Powell is the Pediatrics Clerkship Director for the University Park Regional Medical Campus of the Penn State College of Medicine. He also serves as Clinical Associate Professor of Pediatrics.

State College has been proven to be a good fit for Dr. Powell and his wife, Miriam, to raise a family. He says he is indebted to his wife and to his two sons – Michael, age 11, and J.J., age 9. They've been understanding and supportive of the difficult hours that a physician is sometimes required to keep.

"We're a sports and athletics-driven family," he says. His wife currently works with the Penn State Lady Lions basketball team. And, Dr. Powell often helps with coaching for his sons' teams.

This self-described "small-town guy" has found his niche in State College, a place that's enabled him to raise his family as well as offer his pediatric patients – including children with cancer and blood diseases – and their families the care and compassion they need.

FROM STUDYING MEDICINE BY CANDLELIGHT TO BECOMING A PHYSICIAN LEADER

A CHAMBERSBURG PSYCHIATRIST'S JOURNEY

Irakli Mania, MD

Irakli Mania, MD, is the medical director for Keystone Behavioral Health. He also serves as vice chairman of the Mental Health Board for Franklin and Fulton Counties and is secretary-treasurer of the Central Pennsylvania Psychiatric Society. Dr. Mania is the recipient of PAMED's Everyday Hero Award for January 2019.

A unique "Georgia to Georgia" partnership – a collaboration and health care exchange between the cities of Atlanta and Tbilisi – brought psychiatrist Irakli Mania, MD, from the country of Georgia, a former Soviet republic, to Emory University in Atlanta, Ga.

Dr. Mania first came to the U.S. in 2000 through a program led by the late Ken Walker, MD, professor of medicine at Emory. But, Dr. Mania's journey to becoming a physician began much earlier.

HIs experiences growing up in post-Soviet, postwar Georgia were a major force behind his decision to become a psychiatrist and an addiction specialist. War, he says, had destroyed the country's infrastructure and fostered an environment in which illegal drug use could thrive.

"I saw, as a teenager, my first drug epidemic," he says. "I felt helpless at the time and could not do anything for my peers who were dying by overdose or from crime-related events."

Dr. Mania remembers his time at medical school in Tbilisi as one of the happiest times of his life, despite difficult conditions. "Acquiring all this knowledge was thrilling," he says. "I remember studying under candlelight, in cold, and with copied material as opposed to original books."

He thrived as a student and earned a research associate position at Emory University. The transition to a new country and culture was relatively seamless, Dr. Mania says, thanks to a close network of friends and physicians from his homeland.

Dr. Mania continued his medical training during a psychiatric residency at Drexel University's College of Medicine. While there, he served as a chief resident and completed a year-long residency elective focused on addictive disorders.

Early in his tenure as a physician with Keystone Health, Dr. Mania obtained the required buprenorphine waiver he needed to treat opioid addiction. "I think once people start to come for treatment, we are able to do a lot for them," he says.

What is immediately evident about Dr. Mania is his boundless energy and enthusiasm for helping his patients. "I like movement, there are always wheels turning in my mind, coming up with new ideas, things to develop," he says.

In August 2016, Dr. Mania became the medical director for Keystone Behavioral Health. "One thing that I take pride in is that I am trying to get to know my co-workers," he says of his leadership style.

Dr. Mania has seen Keystone Behavioral Health grow in the ten years since he joined the organization. They continue to add clinicians to Keystone's ranks.

"As a medical director, I constantly seek new ideas and try to develop new things," he says.

He has helped to bring a new depression treatment called transcranial magnetic stimulation (TMS) to Keystone Behavioral Health patients. Designed for patients with treatment-resistant depression, TMS is an office-based procedure which safely delivers magnetic pulses to the brain.

When possible, Dr. Mania also offers free consultations to family and friends in his native country. "Unfortunately, the state of mental health treatment and the system in general in Georgia is not very good still," he says.

Dr. Mania and his wife, a neurologist who is also from Georgia, have two young daughters, and they have been able to keep their family connections strong. "We have grandparents on both sides who live in Georgia but come on a regular basis to help with children," he says. His family keeps him energized – he couldn't do what he does without them.

"Love what you do" is Dr. Mania's advice to physicians just starting out in their careers. His own passion for his work shines through. The chance to make a difference is what made Dr. Mania choose medicine in the first place. "Seeing somebody getting better, putting a smile on somebody's face, makes my day."

WILKES-BARRE CANCER PHYSICIAN STANDS BY HIS PATIENTS THROUGH EVERY STEP OF TREATMENT

Raghava Reddy Levaka Veera, MD and Carol Ferrell.

Raghava Reddy Levaka Veera, MD, is a hematologist/oncologist with Geisinger. He is the recipient of PAMED's Everyday Hero Award for February 2019.

"You have to be an optimistic person to get into this field, but at the same time realistic," says hematologist/oncologist Raghava Reddy Levaka Veera, MD. In his role with Geisinger, where he's been practicing since 2016, Dr. Levaka treats a variety of cancers ranging from head and neck to gastrointestinal.

He understands that a cancer diagnosis can be scary for any patient. When he discusses treatment options with patients, he works hard to give them a sense of control and ownership. "I talk about the bigger picture," he says. Innovations in cancer treatment continue to advance, and, in some cases, cancer can be managed as a long-term, chronic condition that can be controlled with treatment.

Dr. Levaka was nominated for the Everyday Hero award by one of his patients, Carol Ferrell, who feels that the kindness and care he shows is exceptional. "He is by my side each and every step of the way," she says, noting that he uses his knowledge of new and innovative technological advancements to help patients like her choose the right care plan.

His entire team deserves credit for the award, Dr. Levaka is quick to point out. "I accept this award on behalf of the whole team at Henry Cancer Center at Geisinger Wyoming Valley Medical Center," he says.

When it comes to treating cancer, it's important to take a multidisciplinary approach. "It's not a one-man army," Dr. Levaka says. Cancer can't be treated successfully by a single physician – It involves an entire health care team working together with a patient.

Dr. Levaka regularly attends multidisciplinary conferences and clinics where many specialists – including medical oncologists, surgeons, radiation oncologists, pathologists, radiologists, and others – work together to help create care plans for their patients. Another crucial part of his work is keeping up with the latest research and new treatment options. In the last few years alone, significant innovations such as immunotherapy have changed the way certain cancers are treated.

His commitment to his field began early. "I was destined to become a doctor," Dr. Levaka says, reflecting on his childhood in India. His mother had dreamed of becoming a physician herself, but financial and social issues at that time made it difficult for her to pursue that path.

While he was growing up, Dr. Levaka's parents encouraged him to pursue a career in medicine. When it came time for him to apply to medical school, his father and mother were by his side to support him and help ensure he was prepared to succeed.

Dr. Levaka graduated from Kurnool Medical College in Andhra Pradesh, India. He then took the next step in his career as an internal medicine resident at Abington Memorial Hospital. At Abington, his first rotation as an elective was in oncology/hematology. He knew right away that a sub-specialty in hematology/oncology was the right choice for him.

Following his residency, he completed a fellowship with Fox Chase Cancer Center, in Philadelphia. Dr. Levaka considers himself fortunate to have had an opportunity to train with the cancer specialists there and emphasizes how instrumental they were in providing a strong foundation for him.

Family continues to play a significant role in Dr. Levaka's life. He and his wife, a software engineer, have a two-year old son. As a physician, husband, and father, he takes pride in knowing that he has been able to achieve his parents' dream for him.

THE CHANCE TO HAVE AN IMPACT ON PEOPLE'S LIVES INSPIRES THIS PITTSBURGH EMERGENCY MEDICINE PHYSICIAN


Keith Murray, MD

Keith Murray, MD, FAWM, FACEP, is an emergency medicine physician with UPMC Mercy in Pittsburgh. He serves as medical director for two Pittsburgh SWAT teams. Dr. Murray also serves as Clinical Assistant Professor of Emergency Medicine at the University of Pittsburgh. He is the recipient of PAMED's Everyday Hero award for March 2019.

Emergency physician Keith Murray, MD, doesn't hesitate when asked why he chose his specialty. "You can directly impact someone's life in a short period of time," he says.

The fast pace of emergency medicine also drew Dr. Murray to the field. He's a high-energy person who is eager to challenge himself through new experiences.

While training at the University of Chicago, Dr. Murray made a connection – with the help of his wife, surgeon Jennifer Holder-Murray, MD – that would shape the direction of his career.

His wife was completing a trauma rotation in Chicago, and she saw how important a role the police played in stabilizing patients before they could be treated at the hospital. She realized her husband would enjoy working with law enforcement and introduced him to Dr. Andrew Dennis, a trauma surgeon at Chicago's Cook County hospital as well as a police officer. That's how Dr. Murray's work with police SWAT teams – units specially trained to handle critical threats to public safety – began.

After Dr. Murray and his wife moved to the Pittsburgh area, he found new opportunities to work with law enforcement. He now serves as medical director for two SWAT teams in Pittsburgh. The teams typically train 16-24 hours per month. "We try to make it as realistic and tough as possible," Dr. Murray says.

Dr. Murray's team had to rely on that rigorous training on the morning of Oct. 27, 2018, when they were called to respond to an active shooter incident at the Tree of Life synagogue in Pittsburgh's Squirrel Hill neighborhood. A shooter had opened fire on worshipers at the synagogue, and 11 people lost their lives that day.

It was the kind of call that emergency responders hope they never have to receive. What happened that day, though, showed Dr. Murray that the training works. "Being as close to the point of injury as possible saved lives," he says.

Dr. Murray stresses that lives were saved due to the efforts of many people working together – police, emergency medical services, the trauma team at UPMC Presbyterian and UPMC Mercy where the injured were transported, and countless others.

Training and preparation play a major part in another one of Dr. Murray's professional roles – as a physician in the emergency department at UPMC Mercy. He typically works three to four shifts a week there. "We're a super busy Level 1 Trauma Center," he says. Level 1 trauma centers are equipped to provide the highest levels of care to patients.

Each week, Dr. Murray's team at the hospital conducts a tabletop exercise which allows them to talk through what they would do during a specific emergency scenario. And, around twice a year, they conduct mass casualty drills to measure their preparedness.

"At UPMC, there's a really good collaboration between emergency medicine physicians and trauma surgeons," Dr. Murray says. He's also proud of the quality and breadth of training they offer to trainees – including pre-hospital emergency medicine in which a physician works in the field with ambulance personnel.

For the past several years, Dr. Murray has been involved with UPMC's "Stop the Bleed" initiative. "Stop the Bleed" is a national campaign to educate the public on bleeding control techniques that have been shown to save lives.

He is more committed than ever before to providing "Stop the Bleed" education to police and other members of his community. "We go out to every single law enforcement agency that we can find," he says.

Dr. Murray's life as an emergency physician keeps him busy and focused. Another aspect of his specialty that he appreciates, though, is that it allows for good work-life balance. He enjoys a variety of hobbies including jujitsu but, most of all, he loves spending time with family and his two young children.

Family is the top priority for Dr. Murray and his wife. "At the end of the day, we always sit down together at the dinner table," he says. ⬣

DR. HEATHER FARLEY

BREAKING GROUND ON PHYSICIAN WELL-BEING

Heather Farley, MD, MHCDS, FACEP, was a successful physician running the emergency department for Christiana Care Health System in Middletown, Del. She was being groomed for additional leadership positions within the organization when her whole world changed.

One winter day, Dr. Farley had cared for a patient and, following the standard of care, discharged the patient from the emergency department. The patient died on the way home from the hospital.

Heather Farley, MD, MHCDS, FACEP

"That case really rocked my world professionally and personally," Dr. Farley says. "That experience as a physician — thinking, 'Did I make a mistake? Did I miss something? Is it my fault this person is no longer there for their family?' That's pretty difficult to navigate as a physician and one of the unique and particularly challenging circumstances we have to deal with."

Dr. Farley went to a dark place. Without a support system established, she kept her feelings to herself.

"There is a culture of silence and shame in medicine, and you don't talk about things like this. So, I didn't," she says.

Inside, she didn't want to be a physician anymore.

"I was going to find anything else besides medicine to do and actually got to the point of writing my letter of resignation and gave it to my boss," she says. "To his credit, he didn't accept it."

Instead, Dr. Farley's supervisor worked with her with the help of an executive coach.

"I was able to rediscover why I went into medicine in the first place," she says. "I recognized that I still had value as a physician, and there were still things I enjoyed about medicine."

Caring for the Caregiver

Dr. Farley's story is one that many physicians can relate to, but few discuss.

"I did some research, and there is a whole body of literature around this — being the [second] victim and all the emotional trauma that health care providers go through after experiencing adverse events," she says. "It was actually the fork in the road for me in my career. I realized that I didn't want anyone to ever go through what I went through."

With this insight, Dr. Farley embarked on a culture change in her own organization and developed the Care for the Caregiver peer support program. She trained 45 peer supporters who now provide emotional first aid to medical professionals across Christiana Care Health System.

"THERE IS A CULTURE OF SILENCE AND SHAME IN MEDICINE, AND YOU DON'T TALK ABOUT THINGS LIKE THIS. SO, I DIDN'T."

"They serve as a friendly, confidential ear from someone who has been there to help you process those difficult emotions that are part of an adverse event," Dr. Farley says.

Creating this program spurred her interest in overall physician well-being. There was no blueprint for doing this type of work, even though it was desperately needed.

Dr. Farley proposed a comprehensive program around physician and health care provider well-being. And with support from the very top leaders at Christiana Care, the Center for Provider Wellbeing opened in 2016.

"The Center for Provider Wellbeing aims to foster joy and meaning in work for providers and their teams," Dr. Farley says. "I think we are a model for the rest of the nation and internationally on how to do this well."

With the leadership of Dr. Farley and her team, Christiana Care has expanded its focus beyond individual support to interventions that increase the resilience and well-being of teams, as well as programming that reaches across departments and service lines.

The Center has representation on the National Academy of Medicine Action Collaborative on Clinician Well-Being and Resilience, and Dr. Farley sits on the steering committee for the national Physician Wellness Academic Consortium led by Stanford University.

Prioritizing a Culture of Wellness

Many consequences arise when physicians burn out. Dr. Farley puts them into three categories: patient care, financial, and personal.

"There are links between burnout and increased medical errors, decreased patient experience scores, and adherence to medical treatment recommendations," she says. "Being well ourselves really impacts the quality of care we are able to provide our patients."

Dr. Farley also believes investing in care provider well-being is a smart choice for health systems, given the financial cost of burnout.

"Burned out physicians are less productive but also more likely to leave an organization," she says. "The cost of physician turnover is anywhere from $250,000 to $1.1 million per physician."

Physicians' Health Program Supports in Time of Need

For doctors experiencing extreme stress from adverse events at work, or for those battling mental illness or burnout, it can be difficult to know where to turn. **The Physicians' Health Program** (PHP), a program of The Foundation of the Pennsylvania Medical Society, is here to provide support in times of need.

"The staff at the PHP serve as staunch advocates for all of the participants in their programs," says Virginia E. Hall, MD, FACOG, FACP, board chair of The Foundation of the Pennsylvania Medical Society. "Through referrals for assessment and treatment, along with providing monitoring services, the staff at the PHP is dedicated to guiding physicians and other eligible health care professionals to a journey of healing and wellness. The ultimate goal is for participants to return to their chosen profession safely and to find joy in their work again."

For more information about the PHP, visit *paphp.org* or call (866) 747-2255.

Programs like the PHP — as well as Student Financial Services and LifeGuard — are only made possible through gifts from generous donors to The Foundation of the Pennsylvania Medical Society. To make an impact, visit *www.foundationpamedsoc.org/donate*. Every gift, no matter how big or small, truly changes lives.

But the consequences Dr. Farley focuses on most are personal.

"Burned out physicians have higher rates of depression, divorce, and death by suicide," she says. "The suicide rates for physicians are astronomical with more than 400 physicians per year dying by suicide."

Female physicians, in particular, have a higher rate of burnout and suicide.

"Women often have the dual role burden of being a caregiver at work and a caregiver at home, and in general they feel more pressure and tend to take on more of that care in the home and care of the children than their significant others," she says.

Ultimately, Dr. Farley hopes her work makes a positive impact far and wide.

"A lot of my work has been focused on changing the environment in which our physicians work," she says. "I like to use the canary in the coal mine analogy — you can't just take the canary and teach it to be more resilient and stick it back in the same coal mine and expect it to survive. You actually have to change the coal mine."

"Women often have the dual role burden of being a caregiver at work and a caregiver at home, and in general they feel more pressure and tend to take on more of that care in the home and care of the children than their significant others.

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PHYSICIANS WITH LONG-TERM DISABILITY

COMMON ISSUES THAT CAN JEOPARDIZE YOUR FINANCIAL SECURITY

BY ETHAN F. ABRAMOWITZ, ESQ.

As an attorney dedicated to representing disabled professionals with Individual Disability Insurance (IDI) and Long-Term Disability (LTD) insurance matters, I am often in the unenviable position of informing clients of the deficiencies in their coverage. Such was the case during a recent consultation with a physician, who was forced to cease practicing due to a rheumatological disorder affecting her physical and cognitive function.

Prior to becoming disabled, she was employed by a prominent teaching hospital and had both clinical and academic responsibilities. Her compensation structure reflected this and was itemized as Clinical Compensation, Academic Compensation, and Bonus Compensation.

Like many physicians, the client purchased an IDI policy with "True Own Occupation" coverage and a "Future Increase Option" rider from a financial advisor during residence. She paid for the same with post-tax dollars. When she left her prior employer and began working at the teaching hospital, she was provided with an employee benefits package that included an employer-sponsored LTD plan.

Without consulting a qualified financial consultant, she allowed her IDI coverage to lapse. She explained that she did so because her employer paid 100 percent of the LTD premium, so she did not see a need in having two disability insurance products, and she preferred to save the $3,600 ($300 a month) IDI premium payment.

This decision significantly compromised her financial security when she became disabled and ceased working.

Why Is Disability Insurance Important?

Statistics show that 25 percent of physicians will cease practicing prematurely due to a disabling medical condition.[1] The financial consequences of becoming disabled can be devastating if physicians lack proper financial planning. Specifically, studies indicate that 38 percent of disabled physicians will struggle to pay their normal living expenses within three months of losing their regular income.[2] These studies also indicate that approximately 65 percent of disabled physicians will be unable to pay their normal living expenses within one year of becoming disabled[3].

[1] U.S. Social Security Administration, *The Facts about Social Security's Disability Program*. SSA Publication No. 05-10570, January 2015

[2] Id.

[3] Council for Disability Awareness, Disability Divide Consumer Disability Awareness Study, 2010

To avoid significant financial hardship, it is recommended that physicians obtain disability insurance that provides a net benefit equal to 60 to 70 percent of their gross earnings. This general rule accounts for the applicability of tax consequences. However, as will be outlined below, there are a number of factors that can affect a physician's perceived disability coverage.

Three issues that affect perceived LTD benefits:

1. How the monthly LTD benefit is calculated

Unlike IDI products, which contain a set numerical monthly benefit, LTD plans traditionally utilize a formula to determine a physician's monthly benefit. The LTD benefit is typically based on a percentage of the physician's "*Covered Monthly Earnings*." Generally, the LTD plan will state the physician's monthly benefit is the lesser of 60 percent of their "*Covered Monthly Earnings*" or the Maximum Disability Benefit (the number agreed upon when the employer negotiated the coverage and specified in the LTD plan).

For this client, her original IDI policy, which lapsed, contained a set "*Maximum Monthly benefit of $10,000*, whereas her LTD plan defined her monthly benefit as "*60% of monthly earnings to a maximum benefit of $15,000 per month*." As outlined below, failing to understand the definition of "*Monthly Earnings*"/"*Covered Monthly Earnings*" can significantly impact a physician's perceived coverage.

To properly understand one's coverage, physicians should review the definition of their *"Monthly Earnings"/"Covered Monthly Earnings."* Most LTD plans seek to limit the company's financial exposure by excluding other forms of compensation such as bonus and only cover the physician's base monthly salary from clinical practice.

2. The effect of "*Other Income Benefits*"

Camouflaged within most LTD plans is a provision regarding "*Other Income Benefits*." This provision entitles the LTD plan administrator to reduce a physician's monthly benefit dollar for dollar, if they are receiving income from any of the listed sources.

While the LTD plan will provide a detailed list, the most common "*Other Income Benefits*" that could affect a physician's LTD benefit are: State Disability Benefits, Social Security Benefits, Workmen's Compensation, Salary Continuation, Voluntary Retirement Payments Attributed to an Employer Funded Plan, and Benefits Received from Other Group Disability Plans. In practice, the most common "*Other Income Benefit*" that affects clients' LTD benefits is Social Security Disability.

To assess your exposure to reductions based on "*Other Income Benefits*," you should thoroughly review the definition section of your LTD plan. If your LTD plan contains a list of "*Other Income Benefits*," understand that your LTD plan administrator will seek to apply a dollar-for-dollar reduction to your monthly benefit.

3. Tax consequences

Similarly, unlike most IDI products which are paid for with after-tax-dollars and provide a tax-free benefit, most LTD plans are paid for with pre-tax-dollars. This results in the disability benefit being subject to both federal and state income tax liability. As such, if a physician is relying on an LTD plan that was paid for with pre-tax-dollars, and depending on where they live, the LTD benefit could be subject to federal, state, and city/local income tax obligations. These tax consequences can significantly reduce a physician's perceived coverage, jeopardizing their financial security.

To assess your tax liability, simply review how your premiums are paid with your employer and/or a certified public accountant.

The Consultation

When meeting my client for the first time, she explained that she let her IDI policy lapse because it was capped at $10,000 a month/$120,000 a year, and her LTD plan provided her with a $15,000 a month/$180,000 a year benefit. She advised that her gross income was $300,000 a year, and she believed she was over insured and did not see the need for both policies.

We discussed her earnings, and she advised that while her annual gross income was $300,000, her clinical salary was set at $150,000 and her academic salary and bonus compensation were both $75,000 a year.

My client believed she was entitled to the maximum monthly benefit of $15,000. The LTD plan defined her monthly benefit as "*60% of monthly earnings to a maximum benefit of $15,000 per month*." By applying simple math, her calculation might appear reasonable:

- $300,000 divided by 12 months provides an average monthly income of $25,000.
- 60 percent of $25,000 provides a monthly benefit of $15,000.
- As such, she believed she was entitled to the maximum monthly benefit of $15,000.

However, by not accounting for 1) the definition of "*Monthly Earnings*," 2) the applicability of "*Other Income Benefits*," and 3) tax consequences, she significantly miscalculated her monthly benefit and surrendered an IDI policy that provided significantly better protection.

1) Covered Monthly Earnings

The definition of "*Monthly Earnings*" was not located on the specification page in the front of the LTD plan. Rather, it was buried on page 20 of the LTD plan. The definition of "*Monthly Earnings*" **excluded** all compensation other than her "current monthly rate of pay from **Clinical Practice**."

This definition specifically excluded her $75,000 academic salary and $75,000 bonus compensation. By excluding 50 percent of her gross income ($150,000), her monthly LTD benefit was reduced from the anticipated $15,000 a month maximum benefit to $7,500 a month. By not fully understanding the definition of her "*Monthly Earnings*," the client overestimated her monthly LTD benefit by 50 percent and surrendered an IDI policy that would have provided her with a $10,000 a month benefit. This miscalculation resulted in her overestimating her LTD coverage by $7,500 a month/$90,000 a year.

This issue is not unique to this client's LTD plan. Similar issues have occurred in private practices where the shareholders set a monthly draw and rely on distributions. Depending on the wording of the LTD plan, and how the income is identified on pay statements, LTD providers will seek to exclude the same from a physician's "*Monthly Earnings*."

To confirm your monthly benefit, review the definitions contained within your LTD plan. If you still have questions, discuss these with human resources and/or someone with knowledge and experience dealing with these products.

2) Other Income Benefit Offsets

Based on this client's medical condition, she was eligible for Social Security Disability. This provides her with a monthly benefit of $2,500/$30,000 a year. Under her LTD plan, her $7,500 a month/$90,000 a year benefit is reduced to $5,000 a month/$60,000 a year. By not fully understanding the definition of her "*Other Income Benefits*" and "*Monthly Earnings*," the client overestimated her monthly LTD benefit by 66 percent or $10,000 a month/$120,000 a year.

To understand the effect of *Other Income Benefits* on your LTD plan, review the itemized list and assess your potential eligibility for each noted benefit. Add these numbers together and reduce them from your noted monthly benefit. This will provide you with a general estimate of potential reductions in your LTD benefit.

3) Tax Liability

This client also did not account for the tax liability on her LTD benefit. Since 100 percent of the premiums for her LTD plan were paid for by her employer with pre-tax-dollars, 100 percent of the benefit was classified as taxable income. Based on where this client lives, her benefit is subject to federal, state, and city income tax liability.

Accordingly, her $5,000 a month/$60,000 a year benefit was subject to a combined tax liability of approximately 35 percent. Her tax liability reduced her benefit from $5,000 a month/$60,000 a year to $3,250 a month/$39,000 a year.

To assess your tax liability, simply review how your premiums are paid with your employer and certified public accountant. If the premiums are paid for with pre-tax dollars, then the benefit is most likely subject to tax liability.

The Financial Fallout

Had the client consulted with a financial planner and/or another qualified consultant prior to letting her IDI policy lapse, she could have kept both policies in place. She would have received her tax-free, $10,000 a month IDI benefit, the benefits provided under her LTD plan, and Social Security Disability.

Unfortunately, this client misunderstood her LTD coverage and significantly compromised her financial security. When this client entered my office, she believed her LTD plan covered 60 percent of her gross earnings and provided a $15,000 a month/$180,000 a year benefit. After going through our analysis, she was devastated to learn that she overestimated her coverage by 78 percent, leaving her with an LTD benefit of $3,250 a month/$39,000 a year to support her family.

My client's story is becoming all too common and can be easily avoided by consulting with a qualified professional to review and assess your coverage. Your financial security, and your family's well-being, may one day depend on it.

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Make 2019 a Year of Learning

The Pennsylvania Medical Society (PAMED) is on a mission to advocate, educate, and navigate on behalf of physicians throughout Pennsylvania, guiding them back to the **Art of Medicine**.

Here are some of the ways we're educating physicians and their staff in 2019. Don't miss these opportunities.

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WHAT DOES THE NEXT GENERATION OF WOMEN NEED TO KNOW ABOUT THE PRACTICE OF MEDICINE?

We asked members of PAMED's sections about the future for women in medicine. Here's what they told us.

Lauren Kramer, DO

RESIDENT PHYSICIAN PERSPECTIVE

LAUREN KRAMER, DO

VICE CHAIR
PAMED'S RESIDENTS AND FELLOWS SECTION

EMERGENCY MEDICINE/INTERNAL MEDICINE PGY-3
ARIA HEALTH SYSTEM, PHILADELPHIA

The practice of medicine is perpetually evolving. With each generation of practitioners, there are advancements in medical technologies and treatments, as well as the discovery of new diseases. In every passing generation, women's roles in the profession of medicine have significantly changed from allied health professionals to physicians. I firmly believe that the proverbial "glass ceiling" no longer exists for most women in medicine. If one walks through the halls of the hospital, one may realize there are more women physicians than men. I believe that my graduating medical school class was more than 50 percent female.

Women in medicine pursue aspirations that some may feel are out of reach, but if one perseveres these goals can be accomplished. My mother dreamed of becoming a veterinarian while in college, but her college advisor told her that it was a male-dominated field and discouraged her from applying to veterinarian school. While I was growing up, my parents made sure I understood I could achieve anything to which I set my mind. They instilled in me the confidence to chase my dreams.

Although throughout the world there is still a discrepancy in the equality of women regarding employment, I believe that in the U.S., women in medicine are treated equally. My most valuable advice for the next generation of women in medicine is to strive for excellence, pursue one's goals even in the face of adversity, and become a practitioner that sets the tone for future generations.

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.

The new Women Physicians Section empowers women to share their voice in organized medicine.

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)

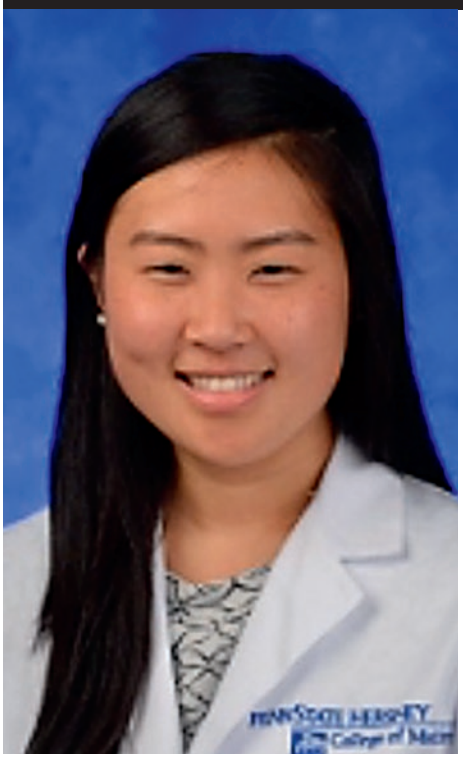
International Medical Graduates Section (IMG)

Medical Students Section (MSS)

Residents and Fellows Section (RFS)

Women Physicians Section (WPS)

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.



Gloria Hwang

MEDICAL STUDENT PERSPECTIVE

GLORIA HWANG

PENN STATE COLLEGE OF MEDICINE

In 1849, Dr. Elizabeth Blackwell was the first female to receive her medical degree in the U.S., and in 1874, she founded the London School of Medicine for Women. Today, females make up more than one-third of all licensed physicians.

Throughout my third year at Penn State College of Medicine, I have discovered that the field of otolaryngology head and neck surgery (OTO-HNS) encourages building a work-life-family balance, achieving excellence in surgical techniques and technology use, engaging in research, and inspiring the next generation of physicians. During this year's American Academy of OTO-HNS, the Women in Otolaryngology committee hosted lectures about cultivating women as leaders and mentors.

During my otolaryngology clerkship, I had the opportunity to learn from leading female head and neck surgeons Jessyka Lighthall, MD, Meghan Wilson, MD, and Karen Choi, MD, all of whom continue to encourage students to pursue otolaryngology. Dr. Lighthall, who leads the field of facial plastic and reconstruction surgery, inspires students through her wide range of aesthetic facial surgical procedures, international surgical mission trips, and incredible family life. I had the privilege of caring for pediatric patients and learning the importance of training residents and building trust with children from Dr. Wilson, who is trained in pediatric otolaryngology and skull base surgery. Dr. Choi specializes in head and neck oncological surgery and continues to motivate students and residents to build strong surgical skills for many of the complex and advanced surgeries for head and neck cancer patients.

The next generation of women should look to their mentors who show us the positive impact of female physicians.

Carrie Delone, MD

WOMEN PHYSICIAN PERSPECTIVE

CARRIE DELONE, MD

FORMER PENNSYLVANIA PHYSICIAN GENERAL
INTERNAL MEDICINE
HOLY SPIRIT HOSPITAL, HARRISBURG

U.S. women physicians earned 27.7 percent less in 2017 than male doctors across all specialties, according to a Doximity survey of 65,000 physicians. Despite scrutiny of the issue, the gender gap in pay is widening. As a medical director responsible for hiring physicians across numerous specialties, I have not witnessed purposeful discrimination against women. However, the reasons for gender disparity in pay are evident.

Women typically fail to advocate for their expertise and experience as confidently as their male counterparts. Females are more tentative about making demands. Contract negotiating skills are not taught or stressed during our long years of education and training. Female mentors are unable to coach skills they do not possess. Additionally, women are less likely to move their family for better pay. Health care organizations know this and reward their workforce accordingly. This unconscious bias puts women at a disadvantage.

Women must understand the dynamics and causes of the compensation gap. With acknowledgment of the role they must play to change the current reality, women can and will alter this reality. Blaming the current situation on others and factors beyond individual control will not achieve improvement.

More female mentors are needed, and those mentors must be knowledgeable about contract negotiations. Women must be willing to advocate for themselves strongly and walk away from positions with noncompetitive salaries. Those in control of physician salaries are motivated by cost containment. They are not sympathetic to narrowing the gender pay gap. Women can and must take the lead to affect the change they deserve.

Kalyani Meduri, MD, MS

INTERNATIONAL MEDICAL GRADUATE PERSPECTIVE

KALYANI MEDURI, MD, MS

GASTROENTEROLOGY
COMMONWEALTH HEALTH, KINGSTON

Women are the backbone of society. This is the most promising time for women in medicine with the news that more than 50 percent of new enrollees in U.S. medical schools are female. It has been a long road for women since Elizabeth Blackwell, the first woman physician of modern times, gained admittance and later received a medical degree from Geneva Medical College.

Still, women are struggling to gain the same recognition and status as their male colleagues. There is increasing data regarding gender discrimination for women at every stage of their careers in health care. Either the widening salary gap or the high rate of burnout or the discrimination by both patients and evaluators, there are still lots of issues that need to be addressed. There is clear evidence to suggest that female physicians provide higher quality of care despite career interruptions for childbearing, part-time employment, and higher home and work responsibilities. The results of a study published in the *Journal of the American Medical Association (JAMA)* in 2017 showing that hospital mortality and readmission rates are lower for hospitalized patients treated by female internists is a great positive reinforcement for their efforts.

It is the first time ever that women have immense support from different committees and programs to advocate for and encourage leadership. There are significant numbers of special interest groups across the different specialties both in professional groups and social media networks. It is especially a very exciting phase in gastroenterology where all four major GI societies made history in 2017 when, for the first time, all presidents were women. This shows that there is slowly but surely hope for a future for all the women in medicine.

Let's stand together, work together, and rise together.

Vinti Shah, DO

EARLY CAREER PHYSICIAN PERSPECTIVE

VINTI SHAH, DO

PALLIATIVE MEDICINE, SECTION CHIEF
TOWER HEALTH, READING

From my student clerkships to present day, I've had the opportunity to walk the hallways of many different hospitals. Most hospitals take care to honor physicians who have contributed meaningfully to patient care and leadership. Hospitals usually have a hallway that is lined with names or pictures of physicians honored in previous years. What never ceases to amaze me though is that most of the physicians who are honored and recognized are men.

More women are going into medicine now than in preceding generations, and yet these names and pictures do not really seem to reflect that.

It is imperative that the next generation of women knows that merely practicing medicine is not enough. If we wish to advance ourselves and to have more credibility, we need to be more engaged. We need to seek out leadership opportunities or lift women physicians who have that interest. We need a seat at the table and when in that seat, we need not to shy away from voicing our brilliance. We need to stop waiting to be asked.

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