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Volume 120 | Number 3 | May/June 2023 **www.msma.org/missouri–medicine**

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Editor: John C. Hagan, III, MD / drjhagan3@gmail.com / 816–478–1230
Managing Editor: Lizabeth R.S. Fleenor / lfleenor@msma.org / 573–636–5151
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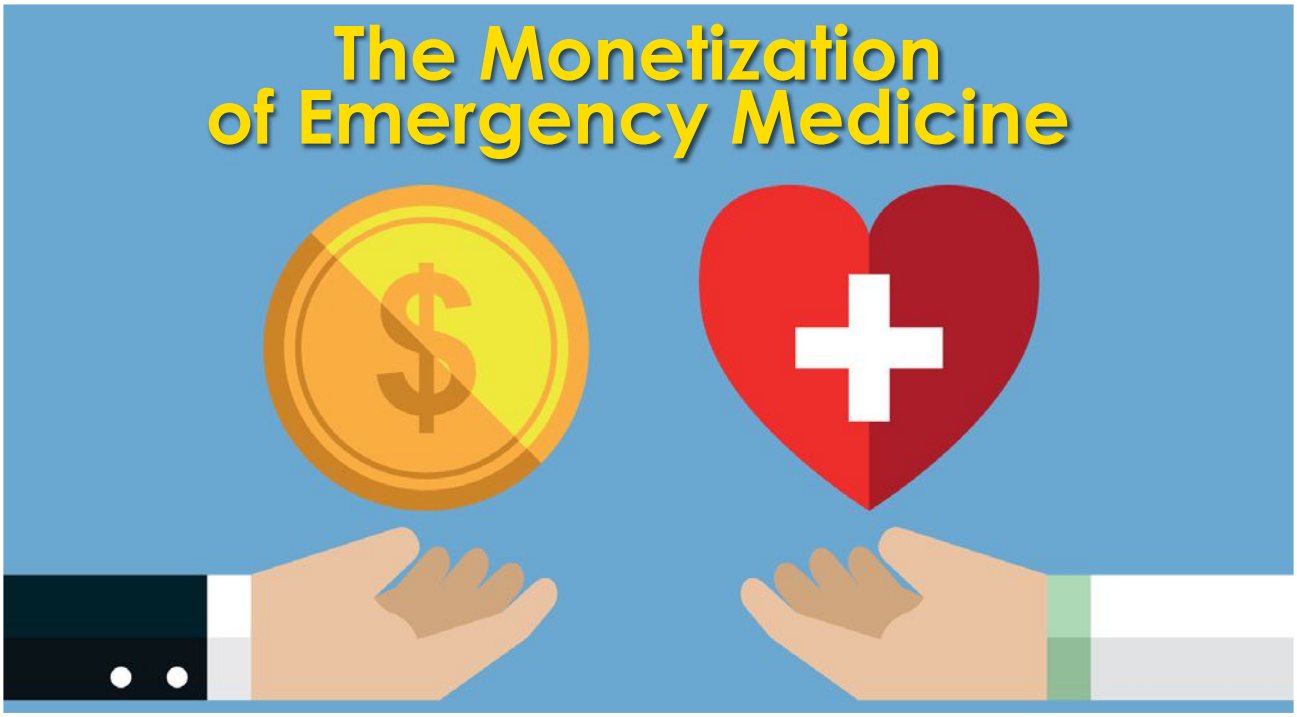
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The Monetization of Emergency Medicine



by Louis Jamtgaard, MD & Lawrence M. Lewis, MD

A recent op-ed piece in the *Journal of the American Medical Association* is a grim reminder of the threat of greed in our healthcare system.[1] The monetization of medicine is not a new phenomenon. Pharmaceutical and medical device companies have been profit-driven for many decades. Hospitals, however, up until the 1980s were mostly single, small institutions, whether community, doctor-owned, or charity non-profit hospitals.

In the late 1980s, 12% of acute care hospitals were owned by nationwide hospital chains.[2] Today, roughly two-thirds of the nation's 5,000 hospitals are parts of chains, up from about half of hospitals 15 years ago.[3] A full 20% are investor-owned.[4] These mergers started with large investor-owned healthcare companies like HCA and Tenet, but then spread to many academic medical centers that began their own acquisitions and mergers in the following decade.

A generous interpretation of the reason for the mergers and acquisitions was to decrease healthcare costs through "economy of scale," but of course healthcare costs kept rising. Although the consolidation of single hospitals into multi-hospital systems and chains has led to distinct changes in the management and practice of urban and suburban hospitals, the rural areas have been the most affected. There have been 380 mergers among rural hospitals between 2005 and 2016 and nearly 100 rural hospital closures between 2010 and 2018.[5] To be fair, hospitals face a diversity of financial pressures, but investor-owned companies interested in higher profits for shareholders have little incentive to keep a struggling hospital open.

Not spared from the risks of mergers and acquisitions, pharmaceutical corporations and investor-owned hospitals increasingly have focused on profits, with serious consequences at both the micro and macro-economic level. At the micro or individual patient level, Americans are charged much more for their medications than people in other countries and often cannot afford them, as was recently illustrated



Louis Jamtgaard, MD, (left), is an Emergency Physician at Mosaic Life Care, St. Joseph, Missouri. Lawrence M. Lewis, MD, is Professor, Emergency Medicine, at Washington University School of Medicine, St. Louis, Missouri.

with both insulin and the epinephrine auto-injector pens, with public uproar over price gouging.

At the same time millions of Americans have large medical debts due to hospital bills, which are often sold off and serviced at high interest by the $9 billion medical patient financing industry. One published study showed that 42% of patients over 50 years of age with a new cancer diagnosis made between 2000 and 2012 had depleted their entire savings over a two-year period.[6] Besides the financial impact on patients, maximizing profits might cause actual harm. The Institute of Medicine found that unnecessary healthcare services total $210 billion annually.[7] Although fee-for-service and the drive to increase profits might not be the dominant factor for unnecessary testing, both serve as disincentives to clinical initiatives to reduce wasteful practices, some of which result in harm to patients.[8]

On the macro-economic level, the growth of our healthcare sector to 20% of our GDP basically starves out the ability to fund many potential goods and services. The federal deficit and national debt are heavily influenced by this enormous industry.

On a more personal level, the monetization of medicine affects those providing healthcare. Burnout is an increasing problem in healthcare, even before COVID-19, affecting nearly half the physician workforce in a 2017 survey.[9] Most recently, burnout is affecting over half of physicians surveyed, and almost two-thirds of emergency physicians.[10] The bureaucratic tasks associated with the ever-increasing pressure to increase throughput and documentation, whether medically necessary or not, along with the lack of support to provide the necessary resources to ease these pressures has been identified as the dominant factor in physician burnout.[10] Now, besides these pressures, which often directly conflict with providing thoughtful and careful patient care, the increasing threat of job insecurity looms due to financial demands on hospital systems and private equity firms to replace physicians with less expensive and less trained personnel.

This is not an attack on the use of Advanced Practice Providers (APPs) within the umbrella of emergency care. In fact, we want to acknowledge the important contributions of APPs, including nurse practitioners and physician assistants, to the delivery of emergency care.[11] We believe that APPs are best utilized as members of a physician-led team and should not be utilized as replacements for emergency physicians. As endorsed by ACEP, we believe that board certified emergency physicians are "the gold standard for emergency department care" and should lead the clinical mission of emergency departments through direct patient care, medical directorship, and supervision of APPs.[12]

We are opposed to the practice of replacing physicians with NPs for profit-driven measures, as the data suggest that overall healthcare expenditure in fact goes up, and certain patient outcomes are worse.

The use of APPs in the emergency department (ED) precedes the ascent of private equity in emergency medicine (EM). However, the drive to maximize profits inherent to the private equity business model, has exacerbated this trend into potentially problematic models of care. Originally envisioned as providers who could improve access to primary care, the growth of APPs in non-primary care settings has been exponential. The expected growth rate of NPs in non-primary care settings is expected to reach 141% by 2025, whereas the corresponding growth rate of physicians is expected only to rise by 21%.[13]

As physicians, we recognize the impact of Centers for Medicaid and Medicare (CMS) limits on graduate medical education training of resident physicians. A 2018 snapshot of the EM workforce for hospitals across the United States indicated that 61% are physicians and 24.5% are APPs.[14] While use of APPs in the ED has traditionally focused on "low acuity" or "fast track" patient encounters, recent data indicate APPs have shifted toward treating more "high acuity," complex patients. A 2023 observational study analyzing CMS provider utilization and payment data for emergency services showed APPs have nearly doubled their proportion of high acuity encounters, from 5.1% in 2013 to 9.7% in 2019.[15] This increase was even more pronounced in the rural setting which increased high acuity billing from 7.3% to 16.4%.[15] Authors noted the relative increase in high acuity billing was not the same across providers, with NPs showing a significant increase relative to physicians over the same time. The authors interpret this as NPs in fact encountering

more high acuity patients and not just billing more aggressively.

It's logical to see why private equity firms with large holdings in healthcare delivery benefit from this trend and have financial motivation to further expand APP utilization in the ED. APPs simply cost less. They can bill up to 85% the rate of a physician yet cost roughly 40% of a physician's salary.[16] To private equity, NPs might be seen as a profitable replacement for emergency physicians. Recent studies have shown that ED care provided by APPs may be associated with increased overall healthcare costs. However, recent studies have shown that ED care provided by APPs may be associated with an overall increase in healthcare costs. The Kaiser Health Network highlighted a working study by Chan et. al which showed that: "NPs increased the cost of ED care by 7%…and total health care spending by 15%."[17] Findings among other studies differ, with some demonstrating care provided by APPs was associated with increased testing and costs, while others did not.[18,19]

It is not just the potential for increased costs however. Chan et. al also found certain patient outcomes were notably worse in patients managed by NPs. The authors noted that patients managed by NPs in the ED had increased 30-day preventable hospitalization, despite more resources being used in their evaluation and treatment.[17] While overall 30-day mortality was not statistically different between NPs and physicians, there were important subsets of patients who had increased mortality when care was provided by an NP, notably patients with a sepsis diagnosis.

One potential contributing factor to poorer patient outcomes is the lack of standardization in certifications and qualifications of NPs working in the ED. Currently, the majority of NPs in the ED have either received certification as a Family Nurse Practitioner (FNP), Adult Acute Care Nurse Practitioner (ACNPs), or Primary Care Practitioners (PNP). Although a certification pathway as an Emergency Nurse Practitioner (ENP) exists, as of a 2018 survey, only 10% of practicing NPs in the ED had achieved ENP certification.[12,20] Combined with the varied scope of practice laws throughout the United States, the practice of emergency care in the U.S. is inconsistent and confusing. Currently a patient presenting to an ED has reasonable probability of encountering an NP with no specific certification or training in emergency care, and with little to no direct supervision by an EM physician. Further, the lack of physician input or supervision may not be communicated to the patient.

For all the above reasons, we support ACEPs guidelines that APPs "should not perform indirect unsupervised care in the ED…regardless of state law or hospital regulation." We favor working together as a team with NPs or PAs. We believe in a collaborative framework, where ideally all APPs and NPs achieve emergency certification, and experience real-time collaboration and supervision by a board-certified EM physician. We are opposed to the practice of replacing physicians with NPs for profit-driven measures, as the data suggest that overall healthcare expenditure in fact goes up, and certain patient outcomes are worse. We encourage members of the Missouri State Medical Association and the Missouri College of Emergency Physicians to analyze their own hospital and departmental policies regarding use of APPs in the ER and encourage administration to support national guidelines to protect patients and provide the highest quality of emergency care possible.

It should not be misconstrued that we object to cost containment in Medicine or serving within a broadly trained clinical team. The U.S. spends more on healthcare than any other nation on earth and our health outcomes are often poorer than in many other countries.[21] There are ongoing efforts by ethical and knowledgeable multidisciplinary organizations to reduce healthcare expenditures while maintaining or improving outcomes. The areas being targeted are well known drivers of healthcare costs, including unnecessary healthcare testing and diagnostic procedures, inability to negotiate over pharmaceutical costs, high administrative costs, and fraud and abuse.[22,23] We should recognize that reducing the cost of healthcare by reducing wasteful services or excessive pharmaceutical charges is not a shared goal with those who would monetize medicine to squeeze any profit that can be made for their shareholders and CEOs. A complicated discussion is required to address the financial issues of healthcare delivery in this country in a patient-centered and care-driven way, one that merits direct physician participation.

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A Physician's Journey Through the Discovery of AIDS: The Memories Never Fade

by John Yeast, MD

Rene Leriche, a physician and author, once wrote: "Every surgeon carries within himself a small cemetery, where from time to time he goes to pray—a place of bitterness and regret, where he must look for an explanation of his failures."[1]

In many instances, however, prevention of those failures may have just been timing in the evolution of medical advancements.

Throughout the history of medicine, discoveries in diagnosis and treatment have led to major changes in patient outcome. During the 19th century, introduction of anesthesia for surgery, and development of aseptic techniques to reduce infection, had tremendous impact on the practice of medicine, the patient experience, and patient outcome.

The 20th century contained many discoveries and innovations that saved countless lives. Accurate methods to crossmatch and transfuse blood, development of antibiotics, advanced imaging techniques, safer surgical anesthetics, development of myriad laboratory procedures to aid in diagnoses have all become standards of care throughout the world. During a physician's professional career, it is common to witness such developments/advancements that have improved outcomes and saved lives during their practices. That is an inevitable result of progress.

Over forty years ago, in early 1981, I served as a Navy Ob-Gyn physician, stationed at a West Coast hospital. In May of that year, I saw a new patient who



John Yeast, MD, MSPH, is an Emeritus Professor of Obstetrics and Gynecology, University of Missouri-Kansas City School of Medicine, and former Vice President of Medical Education and Research, Saint Luke's Hospital of Kansas City. He practiced maternal-fetal medicine for 30 years in Kansas City.

had recently arrived in the United States. Her husband had been stationed in the Far East, where they met and were married. When he was transferred back to the east coast of the US, he chose to have his wife stay on the west coast to be closer to his family. His wife spoke limited English, and though pregnant brought no medical records. None of this was terribly unusual in a military facility, especially at coastal bases.

At her initial visit, she was already in her third trimester with their first child. Her pregnancy proceeded uneventfully, without any complications, except we were never able to obtain earlier prenatal records. Her pregnancy did proceed beyond what she thought as her due date. Fetal surveillance was normal.

Early on a Sunday morning, she presented to the hospital with a fever, abdominal pain, and findings consistent with an intrauterine infection. Her unborn baby had died likely due to the infection. My associate, who was on call, began antibiotics and attempted to induce labor all day. As the hours passed, she became sicker, requiring us to perform a cesarean section to empty her uterus in hopes of resolving her infection. The seriousness of her condition required additional antibiotics, blood transfusions, and a nine-day hospital stay. Cultures of both the uterine cavity and the stillborn were consistent with *Bacteroides* sp. Devastated, the patient and her husband struggled to understand how this happened.

In 1988, seven years later, I had left the Navy, completed a fellowship in maternal-fetal medicine, and located to a midwestern city to direct a high-risk pregnancy program. In June 1988, on a Friday evening, I recall receiving two telephone calls. The first: a reporter for a California newspaper, asking me if I recalled the patient—asking if I remembered her name. Initially I didn't, but upon describing the case to me I immediately remembered her and the lost pregnancy. A second phone call followed, essentially the same topic, but this time from a local news reporter. Each of the callers shared that a major story was about to be widely reported, regarding the family.[2]

Following the initial stillbirth, the couple had relocated to another base, having two children, a daughter, and then a son, two years apart. Both were described as uneventful pregnancies. Shortly after the birth of their son, however, the baby suffered numerous infections and failure to thrive. After referral to a specialty center, he was found to be HIV positive. Subsequent testing revealed that both mother and father were HIV positive. The infant son died shortly after his first birthday. Their daughter tested negative for HIV and remained so with serial testing.

The son had been born in 1983, then died in 1985. Infectious disease experts were only beginning to understand the complexities of this disease, now called Acquired Immune Deficiency Syndrome (AIDS).[3] Along with their extended family in New England, the couple consulted numerous experts. They also sought legal counsel as someone suggested to them the source of the infection could have been the transfusions required at the time of her stillborn. In 1981, at the time of the initial pregnancy loss, it was not known that HIV could be acquired from a transfusion. That was subsequently proven in 1985. Testing became available to screen blood shortly thereafter. "Look backs" at cases prior to 1985 estimated a 90% risk of transmission when transfused with an HIV positive unit of whole or packed cells.

The series of events for this family was tragic, and almost unimaginable. As the reporting of AIDS cases increased across the country, thousands of young people faced dying with marginal treatment available. This family had already suffered the loss of a child due to AIDS, and now faced the possible loss of their own lives and leaving an orphaned daughter. No effective treatment was yet available, and the lifesaving treatments they sought from experts did not yet exist.

In 1986, the Navy conducted a review of the case following a series of concerns raised by the family and their Senator. They concluded that the stillbirth could have been avoided by earlier delivery of the infant, but found no real fault in the management of the pregnancy. The possibility of HIV transmission from the two-unit transfusion was not "causally relevant" in the report, as it was unknown at the time of transfusion that transmission could occur that way. Federal authorities did confidentially identify the two donors whose blood was used for her transfusion. One agreed to be tested in 1986. That individual tested HIV negative. The second donor refused to be tested, denying any health issues, and reported being well.

In the summer of 1988, the family embarked on a major public relations effort to garner support for their claims that the care provided by the Navy, namely the transfusions administered in 1981, resulted in infection of all of the family, except one daughter. By this time, the mother had died, and the father was showing early symptoms of disease. Over the next several months, a number of articles were published throughout the US

and in the Far East about this family.[4,5] At least 200 newspapers, major news magazines, and all three major television networks carried the story. At the same time, the family filed a lawsuit seeking over 50 million dollars in damages. The trial attorneys for the family expanded the public exposure of the details of the case, while the US attorneys, serving as defense, asked all potential defense witnesses to refuse comment. During the next 12-18 months, I had numerous patients leave my practice after learning about this case from news media. I also had several physicians who regularly referred to me, call and say they felt uncomfortable sending patients to me or my practice due to this case.

In a 1989 bench trial held before a federal district judge, numerous experts testified for both the plaintiffs and the defense. About eight months after the trial, the judge ruled the government negligent for not delivering the first baby earlier, and concluded that the transmission of the HIV infection mostly likely occurred from the transfusion. While it was not known at the time of the delivery that HIV could be transmitted from blood transfusions, it was known that other diseases could be. Thus, had the baby been delivered earlier, she would not have been exposed to those two units of blood, presuming that was the source of her infection.

Following a series of appeals later that year (1990), an award was agreed to by the parties and presented to the father shortly before his death. The sole family survivor, the then eight-year-old girl, was entrusted to the care of her father's brother and sister-in-law.

Many tragic stories arose during the early years of the AIDS epidemic. Many questions raised about this case were never fully answered. Were the transfusions the "source" of the HIV infection? Since the second child was not infected, could either the father or mother have been infected after the stillborn delivery, and even after the birth of the surviving child, subsequently exposing the other spouse? Alternatively, could either have been infected before the stillbirth, and the source of the infection not be attributable to contaminated blood?

Forty years ago, had we the knowledge, the tools, and the therapies available today, the parents would likely be retired, and in their early 70s. Presumably the stillbirth would not have occurred, as better dating criteria for pregnancies, and more aggressive management of post-date pregnancies would likely have resulted in more accurate date of confinement and avoidance of going over due.[6] The couple would have two sons, ages 40 and 36, and a daughter 38-years old. We can easily imagine they would have grandchildren as well.

With advances in blood safety technology, even if the mom had required blood transfusions, testing of banked blood (which began in 1985) leaves the risk of HIV infection with a unit of blood testing negative to be estimated as only 1:3,000,000 units given.[7] Further, if either parent had been infected by any route, effective multi-drug regimens now allow a normal lifespan, undetectable viral loads, and no risk of transmission to HIV-negative contacts.[8] Life could have been nearly normal for all of them.

Forty years is a long time, but this case is as fresh in my mind today as when I received that phone call on that Friday night in June 1988. The tragedy for this family, magnified by the national attention surrounding this case, still leads to thoughtful reflection. I find troubling the ethical argument of holding an individual, or institution liable for failing to prevent harms caused by infectious disease prior to knowledge informing an established standard of care that could have prevented that harm to occur.

Now, looking back over my career, the identification, management, and treatment of HIV infected patients is likely the most significant medical development during my professional life. But the presumed events that led to such a tragedy for this family preceded our understanding of how AIDS might be acquired.

And that leads me to my small cemetery, where I go, from time to time—a place where I wrestle with reflections and regrets. A place that may indeed be bittersweet, but where I find solace, in how discovery and science, over time, give me pause, and yet provides me hope as a physician and lover of the mysteries of medicine.

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Physician Liability for Failure to Stock Naloxone

by Andrew Katon, JD

***As of yet,* there are no cases on point as to whether a physician's office should have naloxone readily available in the event of a sudden emergency from a member of the general public needing immediate access to naloxone.**

Introduction

Imagine, a man bursts through the door of your medical office, begging you to call 9-1-1, his friend has overdosed on an illicit drug cocktail containing fentanyl. Your medical staff rushes to assist the overdose victim. But the one critical thing your office lacks in this situation is a ready supply of naloxone. Are you or your other medical providers at risk for not having naloxone on hand, whether it is professional discipline[1], or civil, or criminal liability?

The opioid epidemic in the United States (US) is a well-known problem, with thousands dying every month from overdoses on heroin, other drugs that also contain lethal levels of fentanyl, and even prescribed opioid-based pain medications. The US Centers for Disease Control (CDC) reports that more than 100,000 Americans died from a drug overdose in 2022.[2] This figure has more than doubled since 2015.

In 2020, approximately 75% of all drug overdose deaths involved an opioid.[3] Missouri accounted for more than 2,100 of the overdose deaths, while Illinois accounted for more than 3,800 of them.[4] Sadly, and tragically, many of these deaths could have been prevented if the user or someone near them had the opioid antagonist naloxone (commonly known by the brand name Narcan). Naloxone is a nasal spray (sometimes used in auto-injection as well) that is administered to the patient and is effective even if the patient is unconscious at the time of administration. Narcane is responsible for saving the lives of tens of thousands of overdose patients since it was first approved for use by the US Food and Drug Administration (FDA) in 2015.[5]

This article will address the potential for liability for physicians who choose not to stock naloxone at their practice office. After a push from the American Medical Association (AMA) and other supporters for the wide-spread availability of naloxone, the FDA approved Narcan to be sold over the counter (OTC), without a prescription, on March 29, 2023.[6] Further, all 50 states in the US have some form of immunity that allows anyone, including laypersons (Good Samaritans), to administer naloxone to a suspected overdose victim.[7] Note, that under Missouri law, a person who administers naloxone to another person in a good faith belief of an opioid overdose must immediately contact emergency personnel.[8]



Andrew Katon, JD, is a Senior Associate in the Dallas office of Husch Blackwell. Husch Blackwell represents physicians and physician groups as well as a full spectrum of healthcare providers and other businesses. The information contained in this article should not be construed as legal advice or a legal opinion on any specific facts or circumstances. The contents are intended for general information purposes only, and readers are encouraged to consult their attorney concerning specific situations and specific legal questions.

These laws are designed to shield those who prescribe, dispense, and administer naloxone to a suspected overdose victim from criminal, civil, and/or professional liability. Given the efforts by authorities to make naloxone widely available to the public, and the immunities that are offered for potential liability, physicians who practice in a medical office setting (i.e., not in a hospital setting) would be wise to maintain at least some small stock of naloxone in the off chance that someone enters their office in need of naloxone, either for themselves or someone else nearby.

Efforts Made to Make Naloxone Widely Available to the Public

Before getting to the issue of physician liability, it makes sense to understand the state of the law as it applies to naloxone availability in general. Since the onset of the opioid epidemic in the early 2000s, efforts have been made by authorities to make naloxone widely available, despite the requirement for a prescription. Even before March 29, 2023, naloxone was a regular part of a first responder's medical kit.[9] If police or emergency medical services find an overdose victim, they can provide naloxone to the victim to facilitate recovery.

In 2019, the US territory of Puerto Rico allowed the sale of naloxone without a prescription, with administration allowed via nasal spray or else auto-injection.[10] On February 15, 2022, the Honorable Rahul Gupta, MD, of the AMA, sent a letter to the White House urging it to increase the availability of naloxone to the nation's pharmacies and the community at-large. The Honorable Dr. Gupta urged the FDA to remove the prescription requirement for naloxone and all other barriers to the access of naloxone.[11] He further stated: "There is no moral, medical, or safety-related reason for the lifesaving 'overdose reversal agents' to remain locked under prescription regulation." Finally, on March 29, 2023, the FDA authorized the sale of the nasal spray version of naloxone without a prescription throughout the US.

In a public release statement, FDA Commissioner Robert M. Califf, MD, stated: "The FDA remains committed to addressing the evolving complexities of the overdose crisis. As part of this work, the agency has used its regulatory authority to facilitate greater access to naloxone by encouraging the development of and approving an over-the-counter naloxone product to address the dire public health need. Today's approval of OTC naloxone nasal spray will help improve access to naloxone, increase the number of locations where it's available and help reduce opioid deaths throughout the country. We encourage the manufacturer to make accessibility to the product a priority by making it available as soon as possible and at an affordable price."[12]

State Laws Regarding Immunity from Civil, Criminal, and Professional Liability

In addition to the advocacy of the AMA, many states throughout the US have enacted so-called "next generation" naloxone access laws, including Missouri, Illinois, and Kansas.[13] Between 2018 and 2020, 35 states legislated some variation of a "next generation" naloxone access law.[14] These laws provide various levels of immunity to those who prescribe, those who dispense, and those who administer naloxone. Twenty-eight states (including Missouri and Kansas), offer civil, criminal, and professional immunity to those who prescribe naloxone.[15] Illinois has laws that offer criminal and professional immunity, but not civil immunity.[16]

Similarly, 29 states (including Missouri, Illinois, and Kansas) provide those who dispense naloxone with immunity from civil, criminal, and professional liability.[17] And 35 states provide civil and criminal immunity to those laypersons for "good faith" administration of naloxone to a suspected opioid overdose victim. Finally, 17 states have state law provisions regarding the co-prescription of naloxone along with an opioid. In some states, the physician is required by law to co-prescribe naloxone along with any prescription for an opioid.[18] In other states the physician is only required to inform the patient who is getting an opioid prescription about the availability of naloxone.[19]

A Physician's Duty

Given the immense problem that the opioid epidemic has caused in the US, it is not unreasonable to expect that a member of the general public (and who is not otherwise a patient of a particular physician), who is experiencing an opioid overdose (or someone acting for them while the victim is unconscious) might simply enter the nearest physician's office they can find and ask for help. In this circumstance the following questions are raised in Missouri:

1. Does the physician have a legal duty to provide naloxone to an overdose victim?
2. What if the physician's office does not have any naloxone to provide?
3. Can physicians incur legal liability if they do not either provide the naloxone or else failed to keep some naloxone on hand in the event of this sort of emergency?

For most jurisdictions in the US, a physician's principal legal duty is to their patient. And while the medical profession is widely regarded as having moral or ethical duty to the work for the welfare of the general public,[20] they are not generally regarded as having a legal requirement to treat just anyone that they see having a medical emergency that does not already have a patient relationship with the physician.[21] At most, a physician might have a legal duty to a close relative of a patient in some circumstances such as where they are accompanying a patient for an office visit, or a separate legal duty to someone to whom the patient poses a threat, such as the relative of a psychiatric patient.[22]

In some states, including Missouri and Illinois, a physician's duty to protect members of the public often relate to whether a physician should have warned a patient about the side-effects of a particular medication or medical condition.[23] This is mostly used in the context of where a patient on prescribed medication or with a known medical condition causes an accident where a member of the public was injured.[24] As of yet there are no cases on point as to whether a physician's office should have naloxone readily available in the event of a sudden emergency from a member of the general public needing immediate access to naloxone.

When it comes to liability, whether it is professional, civil, or criminal, an important consideration is the pertinent "standard of care." An important criterion on this issue is what other similarly positioned physician offices are doing in this regard? As more and more physician offices stock this readily available and incredibly beneficial medication, the expected standard of care will increase, and potential liability for failing to stock it grows.

Circumstance can readily be foreseen where a member of the public comes into the physician's office with an emergency, wherein either that person or a companion has overdosed on an opioid. In such a situation, it is reasonable to conclude that the medical staff would rush to attend to the victim and begin rendering aid. At this point, in some jurisdictions, the victim may now become the physician's patient, for liability purposes, once aid is rendered, even if voluntarily and gratuitously.[25] Now, the physician's legal duty to the victim becomes much more tangible, and liability becomes more likely, when the physician-patient relationship is not dependent on compensation or contractual obligation.[26]

In this scenario, if the physician's office has naloxone, it could be administered immediately. While first responders who would eventually show up would likely have naloxone, it may not be in time to prevent the victim's death or other serious injury. Given the immunity laws in place that protect such prescription writers, dispensers, and persons administering naloxone from various forms of liability, the case for physician offices containing some inventory of naloxone is very strong.

Conclusion

Given the widespread problem of opioid overdose deaths in the US, public health officials and the AMA has worked in concert to effect change in public policy to make naloxone widely available to the public. In March 2023, the FDA permitted the sale of naloxone nationally as an

over-the-counter product, no longer requiring a physician's prescription. Further, the worsening of the opioid epidemic makes it likely that a physician's office may have an encounter with someone in the general public in an emergency involving an opioid overdose.

Although many physicians practicing medicine in this way would not have a legal duty to render aid to the victim of an opioid overdose because they have not established a physician-patient relationship, such an emergency could rapidly turn into one if the physician or other practitioners in the office start to render aid to the overdose victim.[27] Consequently, it would be advisable for those physicians whose offices are in areas where these kinds of emergencies are likely to arise to maintain perhaps a small, manageable stock of naloxone to avoid the potential for liability. With the prescriber, dispenser, and administrator immunities from various liabilities, it only makes sense in the long run to keep some on hand at all times, if feasible.



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Editor: John C. Hagan, III, MD, FACS | drjhagan3@gmail.com
Managing Editor: Lizabeth R. S. Fleenor, BJ, MA | lfleenor@msma.org

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25. *see Mackey v. Sarroca, supra* at 21; Illinois law does not require that a physician receive compensation for establishment of the physician-patient relationship for purposes of liability. Missouri common law generally indicates that the physician should expect compensation or has some contractual obligation to treat the patient or provide medical advice before the physician-patient relationship and attendant duties arise. *Corbet v. McKinney*, 980 S.W.2d 166, 169 (Mo.App.E.D. 1998); *see also Lowe*, 592 S.W.3d 10, 19. However, the Corbet court stated that it will look for "indicia of consent" and other evidence of a consensual relationship to determine if there is a physician-patient relationship. *Id.*
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Correspondence

The Deadly Missouri Fentanyl Epidemic: 2023 Update and Why We Carry Naloxone

On March 29, 2023, the FDA approved Narcan 4 mg naloxone nasal spray for OTC use, which "clears the way for Narcan to be made available in places without pharmacies—convenience stores, supermarkets and online retailers."[1] This increased access should significantly benefit Missouri's rural counties, particularly in northwest Missouri, which experienced an increase in fatal opioid overdoses in the first half of 2022.[2]



This same period last year recorded, for the first time in years, a decrease in the overall rate of fatal opioid overdoses in Missouri.[2] This followed the decrease in opioid death rates in 2021 for St. Louis City.[3] We attribute the St. Louis City decline to the efforts of the Addiction Science team at the University of Missouri-St. Louis, led by Associate Professor Rachel Winograd, in partnership with the Missouri Department of Mental Health. The partnership, in addition to efforts in community education, distributed over 120,000 doses of naloxone in 2022.[4]

One other update about fentanyl regards supposed "Narcan-resistant fentanyl." We heard that such cases have occurred within the areas with high opioid fatality rates along the I-44 corridor. This rumor has surfaced in other places. In Minnesota, a police chief supposedly identified "Narcan-resistant" fentanyl.[5] However, The National Heroin Coordination Group stated in response to claims that some fentanyl analogs can render naloxone ineffective: "If administered quickly and at a sufficient dose, naloxone and other opioid antagonists are effective against all opioids regardless of their potency."[6] Even poisonings with carfentanil, a highly potent fentanyl analog used as an animal tranquilizer, can be reversed, as in the case of a Missouri teenager from Grain Valley, Missouri, who survived his carfentanil overdose after treatment at Kansas City Children's Mercy Hospital.[7]

Narcan resuscitation failure in a case of fentanyl poisoning does not imply naloxone-resistant fentanyl. A recent wave of poisonings with fentanyl contaminated with xylazine is noteworthy for a poor response to Narcan.[8] Xylazine, approved for veterinary use, causes profound sedative, hypotensive, and analgesic effects. Often referred to as "tranq," xylazine has only recently begun to appear in significant numbers in illicit drugs. Xylazine slows respiration and heart rate, sometimes to lethal levels, and is noteworthy for skin ulcers and abscesses that may require surgical intervention.

Doctors, nurses, counselors, first responders, and everyone who wants to be a Good Samaritan: consider carrying two or more doses of Narcan as we do. You will be prepared when the occasion arises. These lifesaving sprays, weighing less than one-half ounce, can reverse opioid toxicity and restore breathing. The new OTC status may lead to availability of Narcan in retail outlets everywhere. Nevertheless, prompt Narcan administration is critical. We will keep Narcan in our backpacks.

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William V. Stoecker, MD, MS
Dermatology, Adjunct Assistant Professor
University of Missouri - Columbia
Rolla, Missouri

Jonathan Kopel, MD, PhD
Texas Tech University Medical School
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In the News

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Missouri Medicine Announces New Editorial Board Member

Missouri Medicine announces a new Editorial Board member. Board members are selected on the basis of exceptional professional accomplishment and expertise in their specialty.

Amanda M. Kingston, MD, is the new Editorial Board member for Psychiatry. Dr. Kingston is an Assistant Professor of Clincal Psychiatry and Forensic Psychiatry Training Director at the University of Missouri - Columbia. She received her Fellowship in Forensic Psychiatry at Yale University and served as the Medical Director at Fulton State Hospital.



Dr. Kingston replaces **Laine M. Young–Walker, MD,** who is stepping down from this position. *Missouri Medicine* wishes the best for **Dr. Young-Walker.**



MSMA Members in the News

Greene County Medical Society installed the following MSMA members as new Executive Council officers for 2023: **Sanjay Havaldar, MD**, (left), will serve as GCMS President; **James Rogers, MD**, was named President Elect; **Vu Le, MD**, will serve as Secretary; and **Jim Blaine, MD**, will serve as Treasurer. **Minh-Thu Le, MD,** accedes to the position of Immediate Past President. **Jennifer Lynch, MD**, and **Kayce Morton, DO**, will serve as GCMS Counselors. Also honored at the gathering was Cathy Leiboult, who retired after serving as GCMS Managing Director for more than 20 years.

MSMA member **Indumathi Baskar, MD**, has won first place in the Family Doctor category of the *Jefferson City News Tribune* Readers' Choice 2023. Dr. Baskar is an Internal Medicine physician at Jefferson City Medical Group.

Errata

There is a correction in the formula in the statistical analysis and explanation to the measurements from the September/October 2020 Volume 117:5 *Missouri Medicine* in the article entitled Anatomical and Radiographic Characterization of the Lateral Patellofemoral Ligament of the Knee by Kevin Marberry, MD, Karl Boehm, DO, Fredrick Korpi, DO, Jane C. Johnson, MA, and Peter Kondrashov, PhD.

The correction can be found at https://drive.google.com/file/d/161zfFKleORlIZi1blU_xqEhI5WQszon4/view. **MM**



The Leaky Pipeline in Academia

by Mary Anne Jackson, MD

As we navigate the complexities of our healthcare system in academic medicine, recruitment of the best and brightest medical students and recruitment and retention of talented faculty is central to ensuring top quality patient care. It is critical in our goal to diversify our workforce to eliminate health disparities.

The term "leaky pipeline" has been used as a metaphor to identify the loss of women in science and medicine who opt out of an academic career even as they are starting to expand their footprint.



Mary Anne Jackson, MD, FAAP, FPIDS, FIDSA, a Pediatrician in Infectious Disease, is Dean and Professor at the University of Missouri - Kansas City School of Medicine and Children's Mercy Hospital, Kansas City, Missouri.

The challenge is formidable as the pipeline is rich, but women leaders are less commonly competing for or selected for significant roles as CMOs, chief physician officers, deans, department chairs, journal editors, and medical society leaders. We continue to see a promotion gap where fewer women are moving to full professor rank. A recent study that covered a timeframe of 35 years looking at medical graduates between 1979 and 2013 found fewer women than men who made it to the upper faculty ranks, with no significant narrowing of this gap during the timeframe.[1] While some note these equity gaps are beginning to narrow, the pace is glacially slow, and certain groups, like women of color, have even smaller representation in leadership positions.

Add to this, the alarming numbers of women exiting the practice of medicine, that has clearly been amplified by the COVID pandemic challenges and its aftermath. There is no doubt that mentors, sponsors,

and allies are vital to the success of women in medicine who are considering career options and aspire to academic specialties and leadership roles where women are underrepresented, but this is not enough. The competing priorities of personal homelife and professional responsibilities in the workplace must be met with more options for flexibility, autonomy of schedule, and even more resources to tackle the "work outside of clinical work," such as the disproportionate time women spend on clinical note writing and increased patient portal requests compared to men.[2]

I've been struck that the challenges in closing the gender gap start early with more biases targeting women as they start in their journey in medical school. This is where the role of mentorship and allyship becomes critical. For many the challenges are alleviated somewhat once they enter residency and fellowship training. Some have suggested this relates to the robust infrastructure and leadership in residency programs especially those that have discrete pathways for aspiring leaders. The barriers become more active once the clash of personal and professional life changes emerge in mid-career. Gender gaps that materialized early in women physician's careers become most tangible as they approach the conflict of navigating the responsibilities of being a parent with competing opportunities for leadership roles, particularly as they contemplate roles that are at the top of the academic hierarchy.

The gender bias that continues within healthcare organizations is a key obstacle and spotlights the role of organizational leaders to raise women up. Words and actions must align with the recognition that stereotypes that persist, and directly undermine the environment needed for women leaders to succeed. The insidious impact of marginalization and subtle forms of differential treatment from the student to faculty level is clearly associated with higher rates of burnout and the "leaky pipeline" in academia continues.

As leaders, it is critical that we listen to those who navigating challenges in their career and who are asking for support, and encourage them to be thoughtful, honest, and strategic in their requests, and to insist that organizational leadership acknowledge them and work as our partners to respond. The benefits of assuring gender equity including pay equity are well established. Including more women at the top levels of leadership in medicine is associated with more innovative teaching, expanded research with a health equity focus, improved access to care in underserved communities, improved financial performance within organizations and better patient outcomes.[3,4]

Building the path toward more women physician leaders requires intentionality in action and must include the engagement of our male colleagues as our allies. It also requires women leaders to be unwavering in setting the cultural change that starts at the top, as we develop organizational goals with metrics that really move the needle toward gender equity.

Building leadership opportunities for women and people of color needs to identify that these individuals encounter more levels of "invisible" work that can end up discouraging them from seeking roles where real decision making occurs. Invisible work includes work that is uncompensated and/or unrecognized but that is deemed necessary to promote an organization. This includes such tasks as representing the organization in advancing diversity efforts, chairing committees, and leading mission critical work in the well being space. Important work, yes, but work that can be more equitably shared.

Future trends in healthcare promise to include multiple challenges. Our patients will include an increase in those with multiple chronic diseases, a substantial increase in those over the age of 80 years, and an increase in underinsured. The innovative work we do in medical education and in training the workforce of tomorrow is exciting, and integrating new smarter EMR technology and incorporating new discoveries in artificial intelligence and genetics will be transformational. As we navigate the complexities of our healthcare system in

academic medicine, recruitment of the best and brightest medical students and recruitment and retention of talented faculty is central to ensuring top quality patient care. It is critical in our goal to diversify our workforce to eliminate health disparities.

If we work together to bridge the gender gap, our profession ultimately benefits at all levels. Preserving our lifeblood—that is our faculty—is key. Tangible interventions that we know have good return on investment include provision of faculty development resources, including those that demystify the academic promotion process. Those who participate in faculty development programs increase their understanding of the promotions process, develop an increased comfort with navigating negotiations, and improve their time management. Those who complete programs are more likely to move forward on promotion and have better retention rates.5

At the University of Missouri - Kansas City School of Medicine through our Faculty Scholars one-year professional development program, faculty identify their strengths and gaps, find mentorship, sponsorship, and allies as they develop a clear understanding of the promotion process. Overall, the first cohort of scholars had success moving forward with promotion and some have taken on other leadership roles within the school of medicine; this year, we welcomed 10 new scholars to the program.

Beyond the Scholars program, there is a robust menu of other faculty development opportunities that focus on professionalism, responding to microaggressions, optimizing self-care, and a faculty mentorship program that allows us to connect junior faculty with appropriate mentors. One-on-one career counseling is available through our Associate Dean in the Office of Professional Development. This pass year, Christine Sullivan, MD, Professor and Associate Dean, introduced a Leadership Book Club that is well attended and brings differing perspectives from a wide range of faculty (clinicians, teaching faculty, researchers) who are or aspire to be leaders. Each book focuses on topics such as improving communication skills, building trust, emotional intelligence, and building teams. And we've begun work to launch a "Mindfulness in Medicine" curriculum for medical students, understanding the importance of such work in reducing burnout and promoting professionalism and more effective patient centered care.

For those like myself in leadership roles where we have influence, we need to advocate fiercely for all of those entering a career in medicine—and to counteract the insidious impact of naysayers. For aspiring students, matriculating students, residency trainees, and faculty colleagues, we need to be ever more active in sending positive feedback and validation, ensuring access to leadership development, role modeling work life balance, even providing resources in the work-life space and ensuring access to reliable and credible physician mentors, sponsors, and allies. Importantly in this post pandemic timeframe, we need to be straight about the barriers we all continue to see and navigate and work actively to make positive changes that will stem the toll from the leaky pipeline.

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MM

Lessons Learned from COVID Pandemic: Are We Prepared for the Next One?

by Kamani M. Lankachandra, MD

The novel coronavirus pandemic (COVID-19) upended most of our lives. University Health/ Truman Medical Centers Laboratory in Kansas City was not immune to the wrath of this devastating disease. The testing demand for COVID for both hospital workers and the community became an unprecedented challenge for laboratory personnel and available technology. This article reviews how our hospital laboratory coped with it.

Background

At the beginning of the COVID outbreak in the United States (US), we, like other hospitals across the nation, did not understand the impact the illness would have on our communities. "Just wait until Easter, it will go away" was our wishful thinking. Since there were relatively few samples, UMKC/UH Department of Pathology first sent nasopharyngeal swabs to the state laboratory. By the end of May 2020, we realized the magnitude of the pandemic. Like most of the US, Kansas City's lockdown was in full swing. The Laboratory System Director and I had to develop a plan for implementing timely and accurate testing platforms and managing our laboratory workforce.



Kamani M. Lankachandra, MD, is Professor, and Chair, the Department of Pathology, University of Missouri Kansas City School of Medicine, and University Health/ Truman Medical Center, Kansas City, Missouri.

Limited Resources

At the beginning of the pandemic in 2020, we had only two instruments with testing capability for COVID. Given the scarcity of resources, we had to come up with a plan: who do we prioritize? Choices included symptomatic patients, patients with severe respiratory illness, all hospital admissions, or admissions via community screening. We ended up creating algorithms with the help of emergency room physicians, infectious disease specialists, and administrative personnel who were involved in COVID acute care and management.

Next to emerge was a significant testing supply issue. Our lab had been put on a limited resource list where we were allocated a restricted amount of supplies for testing. We needed to expand our testing capacity. University Health's leadership was more than helpful in this regard. Having heard our concerns, they allocated resources to purchase additional instruments. By mid-2020 we had secured multiple testing platforms with expanded capacity for molecular as well as antigen testing.

Lessons Learned

Multiple platforms with wider testing capabilities are essential to deal with potential technical issues within the testing instruments and limitations of available test kits and other supplies.

Staffing Issues

As in other hospital departments, we had to address staffing shortages, and those who were COVID positive, whether or not they had symptoms, had to isolate themselves for extended periods. Staff members with young children often had to take additional time off as schools closed for in-person learning. Some members of the workforce had to face the unthinkable reality of loved ones becoming severely ill and some succumbing to the disease.

We worried that the laboratory would be unable to provide essential services due to staffing shortage. Surprisingly, they all showed up to work every day in spite of many personal challenges including their own exposure to COVID, child care, and losing loved ones to COVID.

Lesson Learned

Your staff are more resilient and loyal than you may think. As you set examples and show up for work, they will follow. That said, staff also need access to paid sick time to deal with their own sickness or that of their loved ones, so that they do not spread illness or burn themselves out.

Mental Health

Laboratory staff was under enormous pressure due to effects of pandemic. Ultimately, it was surprising to learn that most of our staff did not know the resources available to us to address personal wellbeing and mental health issues.

When we were first faced with COVID, there were times we had to come up with innovative and time-intensive strategies to better understand the new pandemic. One example, during the height of the pandemic we were short on COVID kits but the demand for them was high. We had already agreed to engage in community testing in certain areas of the city, so we had to find a way to do so. We did reach out to our neighborhood labs to see if they had capacity for extra testing, but they all were overwhelmed with the demand. Instead, we decided to utilize a sample pooling method. This technique requires precision, sample selection, and unbelievable dedication from technical staff. After many hurdles, we perfected it, using sample pooling until we received sufficient supplies from vendors. During this process, some of our staff members were visibly overwhelmed and needed support.

Are We Prepared for the Next Pandemic?

With all the knowledge we have about COVID-19, one of the lingering questions is: are we prepared for the next one? We can start planning now. This is how I envision future preparedness for a possible pandemic.

- Invest in technology and educate the workforce.
- Create more robust global information sharing platforms to identify and study potential pathogens.
- Make reasonable government and private funding available for pandemic preparedness activities throughout the globe.
- Minimize healthcare disparities among minority groups and create universal health care.
- Educate communities regarding efficacy of vaccines and ways to control infections such as wearing a mask in public spaces when one has a respiratory illness.

With all of these measures future outbreaks may not be preventable, however we may be able to minimize their impact on global health and economics.

Lessons Learned

New processes and testing methods will have their own impacts on the staff that bear them out. It is important to have mental health resources available to the staff, particularly in stressful times. This kind of support should not be limited to taking surveys and holding seminars, but should act upon concerns of our staff members. It is important to educate our staff members as to how and when to ask for help.

Equity in Health Care and Looking Forward

A huge elephant in the room that few are willing to talk about is the issue of equity in health care, or for the purposes of this article, equity in COVID responses. University Health has witnessed the well-documented fact that African American and Hispanic communities suffered the most severe complications of COVID disproportionately.

This pandemic has shown us that laboratorians can do so much to aid our community. We were excited when University Health/Truman Medical Centers began to reach out to the community and start mobile COVID testing, since, as we have long believed, we are here to serve the community.

When this pandemic is in the past, I hope that every one of us can look back and be proud of what we have achieved as a community. While we all have lost loved ones so near and dear to our hearts to this virus, we should be able to tell the next generation how we overcame so many obstacles and heartbreaks during this time, but were able to serve our fellow humans.

Lessons Learned

We have a duty to provide affordable health care for everyone. Although this seems like an unattainable dream, we should still strive for it.

Dr. Martin Luther King, Jr., reminded us:"The arc of the moral universe is long, but it bends toward justice." We all can play a part in helping this arc to bend so swiftly! **MM**

Physician Moms: Too Many Hats to Wear

by Evanthia Omoscharka, MD & Hana Hamdan, MD

COVID-19 pandemic had its life changing effect on women in general and women in the health care system in particular. A lot of pandemic-related measures such as prolonged periods of social isolation, unexpected employment disruptions, school closures, financial distress, and changes to routine, are having an unprecedented negative impact on women's mental well-being[1] including women physicians and women in the healthcare field.

Studies show that women physicians are more likely than male physicians to experience depression, burnout, and suicidal ideation.[1] One group of physicians has been affected by this pandemic more profoundly, specifically, physician moms. This group of physicians has always been torn between their careers and their home lives, let alone juggling these two responsibilities during a global pandemic.

At the beginning of the pandemic one of us (EO) was a single physician mother of two boys, with no close family for help. The other (HH) was a physician mother of three, coming from a dual physician household with also no close family to reach out for help. We both had our fair share of teary moments behind our closed office doors. The situation felt scary, overwhelming, and quite frankly oftentimes surreal. Between work duties, managing online learning, dealing with last minute disease exposure announcements from schools, and countless COVID tests, we both would not even imagine what each day will bring forth.

Physician moms have unique personal characteristics. They can be married or single. Some have newborns, others have older children. Some have multiple children. Some have children with special needs. Very often they come from dual physician households. Sometimes these physician moms care for elderly and sick parents or other family members.

Physician moms also have a wide range of professional responsibilities. They are health care executives, private practice owners, academic physicians, employees of hospitals, or group practices. They are professors, medical directors, researchers, or business owners. No matter what the setting or parameters, there is one common denominator. They are all mothers; and balancing a carrier in medicine while raising children is an ongoing challenge, with or without a pandemic.

The COVID pandemic disrupted everything about our lives, family, social activities, sports, exercise, spiritual practices, shopping, vacation time, leisure activities, and sleep. Physician moms often bear a disproportionate burden of childcare and domestic responsibilities. In majority of cases they comprise the backbone of the household. School and day care closings during the pandemic were the biggest sources of stress on our daily lives. There was a need for alternative ways to educate children whether that meant finding online instructors or completely transition to homeschooling. Finding childcare when schools were closed was sometimes impossible and definitely very expensive.



Evanthia Omoscharka, MD, (left), is Associate Professor, Residency Program Director and Director - Cytopatholgy and Hana Hamdan, MD, is Associate Professor, Assistant Program Director, Director - Transfusion Services; both are in the Department of Pathology, University of Missouri Kansas City School of Medicine, and University Health/Truman Medical Center, Kansas City, Missouri.

We conducted a short survey on an online/social media group of physician mothers. We asked them to name the greatest challenge they had to face during the COVID pandemic. Not surprisingly, most responses were related to childcare instability and health and safety of their families. Some of the responses included the following: taking care of sick children when there is no available daycare while needing to be at work at the same time; dealing with last minute cancellations and closures of schools and daycares; finding child care for after school and on days of illness; balancing the guilt of childcare and work; being scared of dying and leaving the kids behind; bringing COVID home to children that are too young to be vaccinated; having unrealistic expectations for last minute coverage; having unrealistic expectations for academic productivity and low priority administrative tasks; the cognitive overload of having to be constantly making risk-benefit decisions about what one feels comfortable doing; dealing with frequently changing CDC recommendations not based on science; having a profoundly different experience than non-physicians; lack of insight from the rest of the professional world about what we are experiencing; and getting significant pay cuts as compared to our male colleagues.

Due to lack of social support, the COVID pandemic had multiple unintended consequences on this group of professionals. Such consequences included loss of a job and income, increased furlough rates compared to male physicians, and loss of academic productivity. Many physician mothers had to consider non-clinical carriers that would allow them to work from home, and others had to take family medical leave. On the far end of the spectrum, some physician mothers decided to leave medicine altogether. Ehrenstein et al. found that during the 2006 influenza pandemic, 24% of physicians felt it was acceptable to abandon their workplaces to protect themselves and their families and 25% felt they should be allowed to decide if they should report to work.[2]

On the other hand, the pandemic exacerbated gender inequalities. Another pandemic study data[3] showed distinct disparity between women and men physicians with physician mothers being much more likely than physician fathers to lose childcare or in-person school for their children (84% vs 66%); far more likely to have primary responsibility for childcare or schooling (25% vs 1%); and more likely to perform the majority of daily household tasks (31% vs 7%). They were nearly twice as likely to maintain work from home during the pandemic's early months (41% vs 22%). Women physicians were more than twice as likely to have voluntarily reduced their work hours during the pandemic (19% vs 9%), even though physician mothers were already less likely to work full-time than physician fathers before the pandemic (73% vs 91%). In couples where both were physicians working full-time before the pandemic, 26% women reduced their hours vs 3% of men.[3]

The COVID pandemic has definitely increased awareness of health system strengths and weaknesses and the central role of physicians. This short survey illustrated that physician mothers are primarily concerned with childcare and health and safety of their families. These concerns should be prioritized in future disaster planning to ensure this specific workforce can continue to perform their jobs and workplaces need to be cognizant of the needs of women physicians with children at home. Pandemic planning by academic institutions and hospitals should incorporate childcare options for employees and provide ample time for parents to find childcare options when scheduling shifts.[4]

We need to find ways for greater support for family care needs, such as childcare and paid family leave, along with wellness programs tailored for physician mothers. A shift in the culture around work-family balance issues is also needed, such as normalizing the use of sick days and parental leave among male physicians in order to weaken gender biases in work and family expectation.[5] Physician mothers need access to the resources and support necessary to navigate similar unprecedented and uncertain situations in the future.

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Adaptations of Pathology Residencies During COVID-19

by Zubaidah Khalaf, MD & Soheila Hamidpour, MD

Pathology is the medical discipline that provides essential diagnostic information to patients and clinicians. In United States (US), to become a pathologist, a candidate must satisfactorily complete education in an accredited medical school and a minimum of three years in an approved pathology residency. Most pathology residents choose to study both clinical and anatomical pathology (CP and AP) which adds an additional training year.

The University of Missouri-Kansas City School of Medicine (UMKC) combined anatomic and clinical pathology program is a four-year program having a total of eight residents. Unless specified differently, references are to this program. The anatomic division includes tissue evaluation via daily in-person slide reviews on a double-headed microscope, in-house autopsy service, pediatric pathology at nearby Children's Mercy Hospital, outside forensic autopsies at the Jackson County medical examiner's office. Cytology is taught by participating in ultrasound-guided fine needle procedures. In the clinical division residents engage in group resident-attending discussions, laboratory rounds, and off-site rotation at the Community Blood Center. Residents rotate in cytogenetics and pediatric pathology at Children's Mercy Hospital and hematopathology and microbiology at St. Luke's hospital, both in Kansas City.

On March 11, 2020, the World Health Organization declared COVID-19 a pandemic, and hospitals started postponing elective surgeries and implemented social distancing. Pathology departments around the country adopted innovative methods to provide a high level of service to their physicians and patients while still delivering quality medical education. Alternatives were sought to adapt hands-on, collaborative learning during the pandemic. Training programs faced common and disparate challenges. Collectively these adaptations worked well during the pandemic and some will be incorporated into post-pandemic education.

Many pathology programs implemented distant slide review via whole scan imaging scanner,[1, 2] or via telephone/email,[3] while other programs used plexiform barriers on multiheaded microscopes.[4] Virtual teaching was used in some pathology residency programs.[1-3, 5-9] Others used a hybrid model, alternating between on-site and remote anatomic training.[10] Large surveys of teaching institutions were conducted; the majority of the responders agreed on the negative impact of COVID on the teaching/learning process.[3, 4] The full impact of the pandemic on some programs is indeterminate.[1, 5] There were some positive aspects of the pandemic, including higher resident involvement in research, increased interaction with laboratory managers and CP teaching faculty,[8] and improvement of skills in using digital pathology.[10] Our pathology program adopted distant learning modalities through various formats and platforms to avoid pandemic-related educational deficiencies.



Zubaidah Khalaf, MD, is a Pathology Resident, and Soheila Hamidpour, MD, (left), is Associate Professor, Director - Clinical, Anatomic, and Pathology Course; both are in the Department of Pathology, University of Missouri Kansas City School of Medicine, and University Health/ Truman Medical Center, Kansas City, Missouri.

Survey of Pathology Residency COVID Adaptations

This study reports the adaptations of pathology teaching programs during the COVID pandemic and the strategies used to overcome them. We surveyed our current pathology residents and reviewed the literature on strategies other programs used and assessed effectiveness.

Methods

We have summarized measures taken to minimize virus transmission by the UMKC hospitals and pathology department. We reviewed the literature using PubMed and Google Scholar. We conducted a survey among our pathology residents to assess the impact of the COVID pandemic on their training, social lives, and mental health. We used a questionnaire with open-ended questions, all residents completed the survey within two weeks (Figure 1).

Figure 1. UMKC Pathology Intradepartmental Questionnaire

1. How do you think COVID affected your training regarding signing out, autopsies, electives, and outside rotations?
2. Please share your comment about the new learning environment (morning conferences) since COVID started.
3. How was your social life affected by the pandemic?
4. Did the pandemic impact your physical or mental well-being?
5. How did COVID affect your household income?
6. Please share any personal or family experiences with COVID infection.
7. Is there anything else about your experience during this pandemic that you would like to mention?

Findings

COVID globally overwhelmed healthcare systems including pathology teaching programs and clinical services.[11] We present the results of our research in these categories: A) measures taken by hospitals and pathology department; B) an intradepartmental survey; and C) a review of literature.

COVID Adaptations

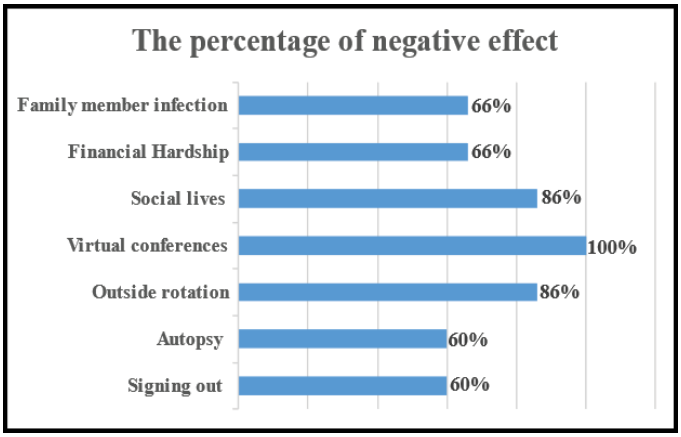
New measures implemented at UMKC hospitals included mandatory use of personal protective equipment (PPE), cancellation of elective surgical procedures, restriction of patient visitors, mandatory COVID tests on all patients, screening of employees for COVID symptoms or exposure, and mandatory leave for ill employees.

In the UMKC pathology department, outside rotations e.g., blood bank and forensic pathology, were cancelled and residency interviews were conducted virtually.

We temporarily switched to on-the-phone slide reviews instead of traditional one-on-one sessions. All in-person activities like daily didactics and tumor conferences were conducted via online Zoom meetings. Organizations such as the College of American Pathologists and the United States and Canadian Academy of Pathology offered resident lectures for home use.[12, 13] Our program provided learning materials to residents such as downloadable lectures and question banks.

Due to lack of full room ventilation, our institution quickly began a policy of hospital autopsies only on patients with a known negative COVID status.

Figure 2. Results of UMKC Pathology Intradepartmental Survey



Intradepartmental Survey Results

We conducted the intradepartmental survey via questionnaire in summer 2022. Most of our residents reported negative impacts on their personal and professional lives (Figure 2).

Review of Literature

Other pathology residency programs took different measures to manage education and patient care during the pandemic. These measures included

Figure 3. Pros and Cons of Modifications in Residency Training Education during the COVID Pandemic Regarding Online Video/Virtual Microscopy Conferences

Pros
- The flexibility of the time and place
- The ability to record the lectures
- Getting more familiar with the technology
- Avoiding learning interruption due to the pandemic
- The ability of the residents to revisit the cases after being signed out (in places with available digital slides archive)
- Improvement in the level of skills in using digital pathology

Cons
- Less interactive
- Limited viewing due to small screen size
- Loss of the visual input
- Higher level of distraction
- Negative impact of technical issues
- Reduced nonverbal communication
- Dependence on the quality of available tools and internet connectivity
- Dependence on the person's familiarity with the technology

Figure 4. Pros and Cons of the Social, Financial, and Pandemic-Related Changes

Pros
- More time spent with the family
- More time for self-study
- Increase the level of familiarity with the new technology
- More time for research activities
- Higher exposure to clinical pathology

Cons
- Social isolation
- Financial hardships
- Decrease in the number of educational cases
- Difficulty in enrolling in electives and outside rotation

whole slide imaging (WSI) via scanners for personal learning, slide conferences, and didactic learning sessions,[1] Others used a combination of in-person teaching with plexiglass barriers at a multiheaded scope and remote teaching using a camera attachment, enabling remote learning and real time feedback to the lecturers.[5]

A majority of 261 pathology trainees, program directors, and faculty reported that an increase use of digital pathology had adversely affected the quality and effectiveness of their teaching.[3]

At the Ohio State University Wexner Medical Center (OSUWMC) in Columbus, Ohio, the digital slide workflow was already in place when the pandemic happened, and their transition to pure digital sign-out was easy and smooth. The residents were exposed to the same number of cases as pre-pandemic.[2] A national survey on Spanish pathology residents reported a reduction in workload and learning activities as a negative impact on their training.[4] The University of Toronto pathology program adopted similar methods and started a citywide weekly "Virtual Gross Round," "Virtual Autopsy Round," and an online resident in-house exam. Their survey with 20 participants reported a negative impact on their education. They concluded that virtual learning is as effective as in-person learning, but skill and attitude are best acquired through in-person teaching.[6]

Another study in a dermatopathology training program found some benefits to virtual teaching such as quantitative increase in online lectures, flexibility in time and place, and a larger pool of presenters. Other benefits were spending more time with family, more self-study time, and being away stressors in the conventional resident's life. Negatives responses toward virtual education included reduced visual prompts, fewer audience responses, reduced non-verbal communication, social isolation, and limitations in elective rotations.[7]

The Department of Pathology at Houston Methodist Hospital redeployed the trainees from the AP service into various laboratories and CP services allowing them to work with the managers and CP faculty. They also provided trainees with some unique opportunities such as participation in the development and continuous quality improvement of COVID testing. They reported that virtual meeting tools have become crucial for communication, educational activities, and potentially improved research.[8]

In a study at Aga Khan University Hospital in Pakistan, all academic sessions like slide seminars and journal clubs were conducted virtually via Microsoft Teams during the pandemic. They held monthly resident exams

through Google Docs. They reported an overall positive experience, and concluded the pandemic was an opportunity for new paths for residency education and discarding some traditional old methods.[9]

At the University of Texas MD Anderson Cancer Center, Houston, they transitioned to a hybrid on-site and remote anatomic training, in which fellows alternated weekly between working remotely and working on-site. A survey conducted among the fellows concluded the hybrid method was effective in maximizing learning opportunities while maintaining the safety of staff and community.[10]

Brown University found that the involvement and responsiveness of the audience were affected by the transition to remote teaching due to imperfect internet connectivity, audio problems, interruptions due to unintended activation of computer "sleep mode," poor sound quality, and limited viewing due to small screen size, and a plethora of incidental distractions.[14]

The overall pros and cons of the different measures taken for pandemic-related education are summarized in (Figure 3) and other effects on life aspects in (Figure 4).

Conclusion

Most UMKC pathology residents reported a negative impact of the COVID on residency training and their personal life. The new virtual learning modalities were partially effective and reduced the pandemic impact. COVID adaptations allowed residents to find personal and professional growth and new ways of self-education. Our clinical and learning environment adapted to the new modalities which are efficient and effective. Virtual activities will remain. COVID adaptations and experiences were similar among a survey of other medical teaching institutions. The full impact of the COVID-19 pandemic on residency training and patient care will not be fully understood for many years.

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MM

Novel Hematological Biomarker Adopted for Early Sepsis Detection Emerges as Predictor of Severity for COVID Infection

Valerica Mateescu, MD & Kamani Lankachandra, MD

This study demonstrates a unique pattern of the hematological biomarkers that could predict severity and outcome in COVID patients at their initial presentation in the ER



Valerica Mateescu, MD, (above), is Associate Professor, Director of Hematopathology; Kamani M. Lankachandra, MD, is Professor, Chair, and Associate Program Director; both are in the Department of Pathology, University of Missouri Kansas City School of Medicine, and University Health/ Truman Medical Center, Kansas City, Missouri.

Abstract

Sepsis is a major health care burden with significant contribution to morbidity, mortality, and hospital resource utilization. Monocyte Distribution Width (MDW), the novel hematological biomarker, was clinically implemented in our laboratory for early detection of sepsis (ESId) in 2019. When COVID-19 pandemic hit in 2020, we noticed some similarities of the laboratory data of the COVID patients with patients previously diagnosed with sepsis. The aim of this study was to evaluate the value of the hematological data including MDW in predicting COVID disease severity and outcome. A retrospective study was conducted on 130 COVID-infected patients who presented at our hospital during March and April 2020. Collected data included clinical, laboratory, and radiological findings. This study demonstrates a unique pattern of three hematological biomarkers that predicted severity and outcome in COVID patients at their initial presentation in the Emergency Room (ER): higher absolute neutrophil count (ANC), lower absolute lymphocyte count (ALC), and higher MDW.

Introduction

Sepsis is a major global health care burden and despite progress in diagnosis and treatment options, sepsis-related morbidity and mortality remain unacceptable elevated.[1] According to the most recent Centers for Disease Control data, about 1.7 million adults in America develop sepsis and at least 350,000 adults who develop sepsis die during their hospitalization or are discharged to hospice. One in three patients that die in a hospital had sepsis during that hospitalization. Sepsis, or the infection causing sepsis, starts before a patient goes to the hospital in approximately 87% of cases.

University Health/Truman Medical Center (UH/TMC) is an academic medical center, the only safety net hospital in the region, that combines a teaching function at the University of Missouri-Kansas City School of Medicine (UMKC SOM) with a mission to serve vulnerable and diverse populations in the neighboring states Missouri and Kansas, while implementing cutting edge technology.

Soon after the US Food and Drug Administration had given 510(k) clearance to

Beckman Coulter's Early Sepsis Indicator Monocyte Distribution Width (ESId-MDW) on April 22, 2019, the UH/TMC Hematology Laboratory (HL) became the first clinical laboratory in the US to implement MDW as an early sepsis indicator at the initial ER encounter.

The clinical laboratory validation of the MDW was conducted on 357 consecutive patients that fulfilled sepsis criteria[2, 3, 4] within 12 hours of ER admission, starting on July 2019. To coincide with Sepsis Awareness Month, effective September 16, 2019, the UH/TMC HL launched the ESId application on the Unicel DxH 900 Coulter Cellular Analysis System to help identify sepsis in ER adult patients. ESId application, a quantitate measurement of MDW added to routine complete blood count (CBC) in the ER, is intended for use in adult patients (18-89 years of age). ESId, as any clinical laboratory tool, should not be used as the sole basis to determine the absence of sepsis. ESId, reported as MDW on a CBC-differential (CBC-Diff), should be used as part of a sepsis identification protocol. ESId informs early clinical decision making, similar to an additional systemic inflammatory response syndrome (SIRS) criterion.[1, 4]

When SARS-CoV-2 (COVID-19) infection hit the US in early 2020, posing new challenges of an emerging pandemic, and the first COVID-infected patients started to be diagnosed at our hospital in early March 2020, it became critical for us to understand the pathological aspects of the new viral disease. During the first months of the COVID pandemic, a mainstream pathogenic hypothesis emerged suggesting that COVID infection may represent a hyperimmune disorder secondary to a macrophage activation syndrome, and manifested by a complex immune response associated with a systemic inflammatory response syndrome (SIRS).[8, 10]

As our COVID cases started to build up and the number of the Intensive Care Unit (ICU) cases was on the rise, we looked at the available COVID studies[7, 8, 10, 11] and at our laboratory data including the MDW, the novel hematologic biomarker already implemented in our laboratory for early detection of sepsis in patients presenting to the UH/TMC ER. The CBC-Diff is routinely performed in the ER and the MDW is automatically reported with CBC, becoming quickly available for physicians without additional request.

We noticed some similarities of the COVID critically-ill patients with our patients previously diagnosed with sepsis, and we were interested to further study the potential value of the MDW, the novel sepsis indicator (ESId) in predicting COVID disease severity and outcome. A formal clinical study was begun.

Study Design

The objective of this study was to better understand the clinical and laboratory changes in COVID patients in order to predict the outcome at their initial presentation in the ER and eventually help clinicians to prioritize health care resources accordingly.

Design

A retrospective chart review was conducted on COVID patients who presented at our hospital during March and April 2020. Based on clinical severity, patients were divided in three groups: Severe (Inpatient), Moderate Emergency room (ER), and Mild (Outpatient). Collected data included clinical, laboratory, and radiological findings.

Materials and Methods

The study was approved by the institutional review board (IRB) in accordance with the ethical standards established by UMKC and UH/TMC. From March 1, 2020 to April 30, 2020, all patients who presented to the UH/TMC ER and tested positive for the coronavirus infection COVID were retrospectively enrolled in this study. The test results were extracted from the patients' electronic medical records in our hospital information system. The patients were divided based on their clinical severity into three groups as follows: Inpatient group (patients with severe symptoms who required hospital admission to the medical ward and/or the ICU for at least one day); ER group (patients with moderate symptoms who required admission to the ER for a few hours only, being discharged on the same day); and the Outpatient group.

MDW is tested from a K2EDTA whole-blood venous sample within two hours of collection. MDW

values greater than 20.0 U together with other laboratory findings and clinical information aid in identifying patients with sepsis or at an increased risk of developing sepsis within the first 12 hours of hospital admission. MDW results >20.0 U are interpreted in association with other clinical information. MDW values less or equal to 20.0 U cannot exclude sepsis or the development of sepsis within 12 hours of hospital admission.

Hematology Laboratory Data

White blood cell count (WBC), absolute neutrophil count (ANC), absolute lymphocyte count (ALC), absolute monocyte count (AMC), absolute eosinophil count (AEC), platelet count (PLT), and MDW levels were collected.

Coagulation Laboratory Data

D-Dimer, Prothrombin Time (PT), Partial Thromboplastin Time (PTT), and Fibrinogen levels were collected when available.

Statistical Methods

Descriptive statistics were used to measure continuous variables mean ±SD, minimum, maximum and range for each group. Chi-square test and two tailed T test were used to show statistical difference between the Inpatient group and ER group regarding laboratory data and radiological findings. Logistic regression analyses were conducted to estimate and test the effect of potential predictor with death as outcome variable. P values less than 0.05 were considered to indicate statistically significant differences. SPSS version 24.0 (SPSS, Inc., Chicago, IL, USA) was used for data analysis.

Results

One hundred thirty patients were enrolled: 42.3% Outpatient, 30% Inpatient, and 27.7% ER.

Hematology and coagulation laboratory data at presentation was available for the Inpatient group and ER group only, therefore correlation could not be achieved in the Outpatient group.

Hematology Laboratory Data

The mean WBC count for Inpatient group was (7.65±4.53 x 10^9/L) compared to the ER group (6.36±2.01 x 10^9/L), (p value 0.920), with the majority of patients presenting with normal counts (Table 1). The majority of Inpatient group 28/39 (71.79%) presented with statistically significant lower absolute lymphocyte count with a mean (0.95± 0.45 x 10^9/L) compared to 22/36 (61.11%) of the ER group mean (1.44± 0.70 x 10^9/L), (p value 0.001) (Table 1).

The Inpatient group 31/39 (79.49%) had a statistically significant higher absolute neutrophil count at admission (p value 0.044), with a mean value (5.426± 3.468 x 10^9/L), compared with the ER group mean (4.174± 1.447 x 10^9/L), with 37/39 (94.87%) of patients having normal counts (Table 1).

Increased absolute monocyte count was noted in the majority of the Inpatient group 22/39 (53.85%) and the ER group 18/36 (50%), with mean (0.62±0.23 x 10^9/L) and (0.62±0.29 x 10^9/L), respectively, with no significant difference (p value 0.943) (Table 1). The MDW value was high in 19/21 (90.48%) of the Inpatient group compared to 22/30 (73.33%) of the ER patients, and was statistically significant higher in the Inpatient group (p value< 0.000), with a mean value (25.595± 3.881 U), compared with the ER group (21.65±3.27 U) (Table 1). The absolute eosinophil count of the majority of the Inpatient group 38/39 (97.44%) with mean (0.04±00.09 x 10^9/L) and the ER group 24/36 (66.67%) with mean (0.07±0.12 x 10^9/L) was decreased, without a significant difference (p value 0.258) (Table 1). There was no statistical significance between these two groups regarding PLT count with mean Inpatient PLT count (216.59±116.58 x 10^9/L) compared to ER group (213.92± 65.63 x 10^9/L) (p value 0.215). The Inpatient group 29/39 (74.36%) and the ER group 30/36 (83.33%) had normal counts (Table 1).

Coagulation Laboratory Data

D-Dimer, Prothrombin Time (PT), Partial Thromboplastin Time (PTT), and Fibrinogen levels were collected when available. The D-Dimer was noted to be elevated in the majority of patients of both groups: 26/39 (66.67%) of the Inpatient and 5/6 (83.33%) of the ER group, with no statistically

Table 1. Descriptive Hematology and Coagulation Laboratory Data in the Inpatient and the ER groups

Variable Groups	N	Range	Minimum	Maximum	Mean	Std. Deviation	P value
WBC x 10^9/L Inpatient ER	 39 36	 16.2 8.5	 2.7 2.3	 18.9 10.8	 7.65 6.36	 4.53 2.01	0.920
Neutrophils x 10^9/L) Inpatient ER	 39 35	 14.8 5.7	 1.4 1.6	 16.2 7.3	 5.43 4.17	 3.47 1.45	0.044
Lymphocytes x 10^9/L Inpatient ER	 39 36	 1.6 2.6	 0.3 0.3	 1.9 2.9	 0.95 1.44	 0.45 0.70	0.001
Eosinophils x 10^9/L Inpatient ER	 39 35	 0.40 0	 0 0	 0.40 0.40	 0.04 0.07	 0.091 0.12	0.258
Monocytes x 10^9/L Inpatient ER	 39 36	 1.0 1.3	 0.2 0.3	 1.2 1.6	 0.62 0.62	 0.23 0.29	0.943
MDW (Unit) Inpatient ER	 21 30	 15.7 11.6	 17.3 15.2	 33 26.8	 25.60 21.65	 3.88 3.27	<0.000
PLT x 10^9/L Inpatient ER	 39 36	 678 265	 79 49	 757 314	 216.59 213.92	 116.5842 65.63	0.215
D-DIMER ng/ml Inpatient ER	 32 5	 13367 1499	 214 200	 13581 1699	 1735.73 680.4	 2742.91 598.82	0.402
Fibrinogen mg/dl Inpatient	18	788	239	1027	595.72	205.92	NA

significant difference (p value 0.402). A higher mean value (1735.73±2742 ng/ml) was noted in the Inpatient group compared to the ER group (680.40±598.82 ng/ml) (Table 1). The PT was noted to be high in 14/23 (60.9%) of the Inpatient group and 2/4 (50%) of the ER group, with no statistically significant difference (p value 0.683). The PTT remained normal in the majority of the Inpatient group 15/23 (65.2%) compared to the ER 2/4 (50%), with no statistically significant difference (p value 0.561) as well (Table 1). Fibrinogen level was elevated in 15/18 (83.33%) of the Inpatient group with a very high mean (595.72 ±205.92 mg/dl) compared to the normal reported range 200-400 mg/dl. No fibrinogen level data was available for the ER group, therefore statistical difference could not be achieved (Table 1).

Discussion

The Inpatient group had a statistically significant higher absolute neutrophilia (increased ANC) compared to the ER group (P = 0.044). Absolute lymphopenia (decreased ALC) was found in 71.79% of Inpatient group compared to the ER group (P = 0.001). Absolute monocytosis, eosinopenia, and normal platelet count were noted in most of the Inpatient and the ER patients. A statistically significant finding was a higher monocyte distribution width (MDW) in the Inpatient group (90.48%) compared to the ER group (P < 0. 000). High mean D-Dimer, PT time and Fibrinogen levels were noted in both the Inpatient and the ER groups. All patients were negative for influenza A, B, and respiratory syncytial virus. Statistically significant radiological findings were noted in 92.31% of the Inpatient group compared to the ER group (P = 0.005). The case fatality rate (CFR) was 12.82% in the Inpatient group compared to 3.85% in all groups. Older age, higher WBC, ANC, and MDW were associated with longer hospital stay and increased mortality (P < 0.05).

Conclusion

This study demonstrates a unique pattern of the hematological biomarkers that could predict severity and outcome in COVID patients at their initial presentation in the ER: higher ANC, lower ALC, and higher MDW, similar to other studies.[5, 6, 7, 9, 11, 12] Hospitalized patients in the ICU showed a significantly higher MDW compared with the ER cohort group, suggesting that this novel sepsis indicator should be considered as a prognostic marker, together with other laboratory data. COVID sepsis resulted in increased morbidity and mortality, and contributed to increased hospital resource utilization. The reported deaths in the present study had significantly higher levels of MDW, and all cases had sepsis as the terminal event. This might indicate that MDW could be utilized for early sepsis occurrence in COVID infection and serial measurements throughout hospital stay might be a great tool for clinicians to monitor patients' response to therapy and predict their outcome. Additional studies involving large cohorts are warranted to shed more light on the prognostic role of the MDW in infections associated with sepsis and potentially guide resource utilization and therapeutic decision-making.

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Disclosure

None reported.

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"Low 5": A Five-Step Electronic Medical Record Prescribing Checklist to Lower Opioid Prescribing in Primary Care

by Ray Segebrecht, MD, Sarah Young, PharmD, Laraib Sani, MD, Suveen Angraal, MD, Jeffrey Hackman, MD & Kavita Jadhav, MD

Our results from this pilot study show promising signs of a reduction effect from our "Low 5" opioid prescribing checklist in the electronic medical record on opioid prescribing.



Ray Segebrecht, MD, (above), is in Internal Medicine; Sarah Young, PharmD, is a Pain Management Pharmacist; Jeffrey Hackman, MD, is the Chief Medical Information Officer; and Kavita Jadhav, MD, is in Internal Medicine. All are at University Health, Kansas City, Missouri. Laraib Sani, MD, is an Internal Medicine Resident at the University of Missouri - Kansas City, Kansas City, Missouri. Suveen Angraal, MD, is a cardiovascular medicine clinical fellow at the Yale School of Medicine, New Haven, Connecticut.

Abstract

Since the start of the 21st Century, the use of opioids for pain management in primary care has increased along with a concomitant rise in opioid associated deaths. The use of opioids is associated with risks of addiction, respiratory depression, sedation, and death. There is no checklist available in electronic medical records to guide safe prescribing of non-opioid pain management options prior to opioids in primary care. Our quality improvement project pilot study aimed to reduce unnecessary opioid prescribing in an urban academic internal medicine clinic by incorporating a checklist of five first-line non-opioid therapy suggestions into electronic medical records. Following its implementation, opioid prescribing dropped by an average of 38.4 percent per month.

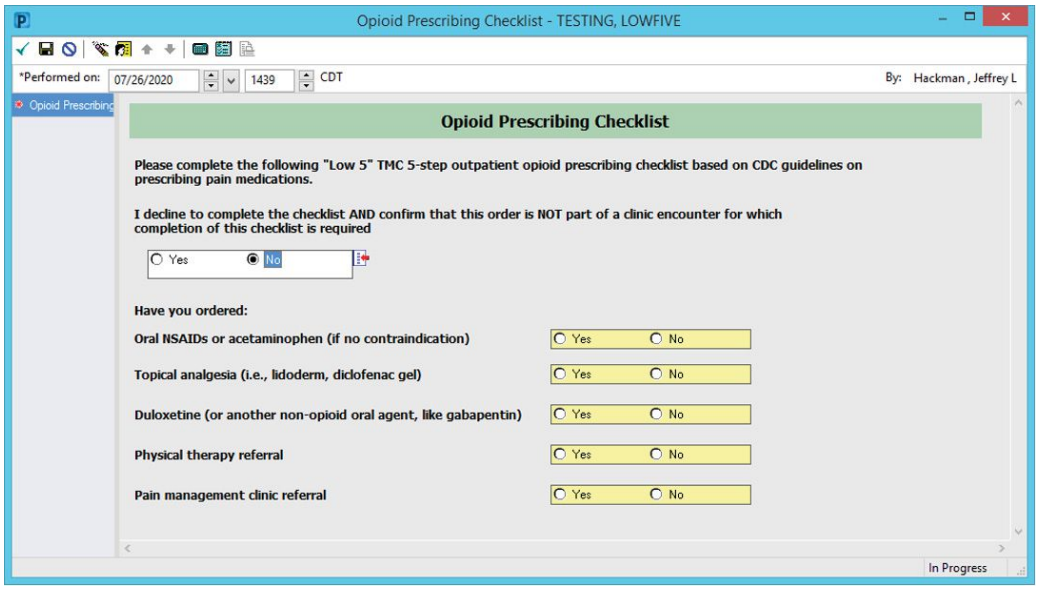
Introduction

United States opioid deaths soared four times higher with the rise in opioid prescriptions since 1999, and primary care is responsible for half of these prescriptions. [1,2] Adopting dispensing policies and incorporating information technology have been shown to reduce inappropriate opioid prescribing.[1,3] However, no searchable studies have integrated a checklist of first-line pain control modalities into electronic medical record prescription orders. We aimed to reduce inappropriate opioid prescribing in the University Health (UH) primary care internal medicine clinics in the Health Sciences District by building a checklist of first-line non-opioid therapy options into electronic opioid order placement.

Methods

Our intervention was a five-step opioid prescribing checklist built using ideas from Centers for Disease Control and Prevention (CDC) guidelines and incorporated into the electronic medical record as a "hard stop" requiring completion prior to outpatient opioid prescribing in UH Health Sciences District primary care internal medicine clinics (Figure 1).[4] The checklist asked prescribers if they had ordered: 1. Oral NSAIDs or acetaminophen (if no contraindication); 2. Topical analgesia (i.e. lidoderm, diclofenac gel); 3. Duloxetine (or another non-opioid oral agent, like gabapentin);

Figure 1. "Low 5" checklist for first line non-opioid therapies for management of outpatient opioid prescribing



4. Physical therapy referral; and 5. Pain management clinic referral.

Prescribers were not required to answer "yes" to all of the five checklist questions, and prescriptions that were part of inbox cross coverage were excluded. The actual clicking through the five "yes"/"no" boxes can be completed in less than one minute, although for unfamiliar patients, finding the necessary history to answer the questions correctly could take longer.

We launched the intervention on August 1, 2020, and we continued data collection through July 1, 2021. We then compared the number of prescriptions each month to the number of prescriptions in the same month one year prior over a 12-month intervention period. The percent reduction in opioid prescriptions was calculated using the following formula: X-Y/X (key: Y = number of prescriptions in each month during 12-months of intervention and X = number of prescriptions in each month 12-months prior to the corresponding intervention month).

Evidence

We saw an overall reduction in the number of opioid prescriptions in the University Health primary care internal medicine clinics after launching our intervention. The number of opioid prescriptions dropped from each month leading up to the intervention to each month of the intervention with exception of the month of May (Figure 2). We saw the largest reduction from November 2019 (133 prescriptions) compared to November 2020 (61 prescriptions), which was a 54.1 percent decrease (Figure 3). The second largest reduction was a 49.9 percent decrease from August 2019 (169 prescriptions) compared to August 2020 (88 prescriptions). The average reduction per month was 30.6 percent over the entire year (or 33.4 percent over the 11 months that saw a reduction).

Limitations

Although this pilot study shows promise for the "Low 5" electronic medical record checklist being an effective tool for reducing unnecessary opioid prescribing, it does not show which alternate interventions were most utilized or most effective for avoiding the need to prescribe opioids. A follow-up study could help reveal this by providing an opportunity to track and analyze data on how many "yes" answers are entered as a percentage of the total number of answers to each question. We would recommend that follow-up studies be conducted for longer than one year and attempt to control for other variables to confirm that the correlation we observed in reduced opioid prescriptions was in fact an effect caused by the checklist. Additionally, a longer follow-up study could determine whether, as we suspect, the one month without a reduction was an outlier due to unique circumstances specific to that month.

Figure 2. Graph indicating opioid prescriptions per month

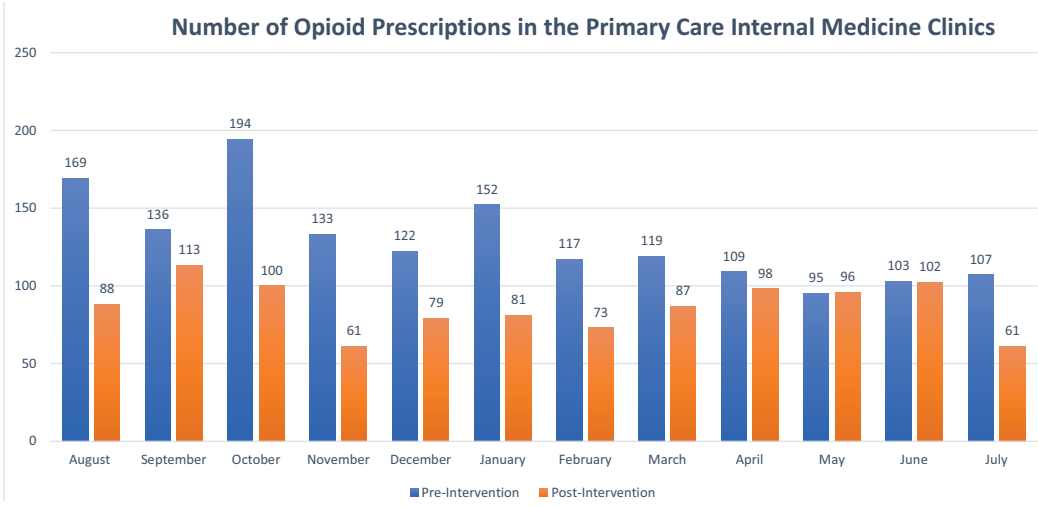


Figure 3. Percent reduction in opioid prescriptions pre-intervention and post-intervention

Month	Pre-Intervention 2019-2020	Post-Intervention 2020-2021	Percent Reduction
August	169	88	-47.9%
September	136	113	-16.9%
October	194	100	-48.5%
November	133	61	-54.1%
December	122	79	-35.2%
January	152	81	-46.7%
February	117	73	-37.6%
March	119	87	-26.9%
April	109	98	-10.1%
May	95	96	+1.1%
June	103	102	-1.0%
July	107	61	-43.0%

Conclusion

This quality improvement pilot study aimed to reduce unnecessary opioid prescribing in an academic internal medicine clinic by reminding prescribers in the electronic medical record to consider optimizing five other non-opioid modalities for pain management prior to signing their opioid prescriptions. Our results from this pilot study show promising signs of a reduction effect from our "Low 5" opioid prescribing checklist in the electronic medical record on opioid prescribing. Longitudinal data over a more extended period and more patient level data is needed to further help confirm this causative relationship. A longer-term study with more data including data adjusted for race, sex, ethnicity, visit type, comorbidities and COVID-19 effects on clinic volume would help determine if there is any variation or confounding effect from fluctuation in these additional variables.

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Disclosure

None reported.

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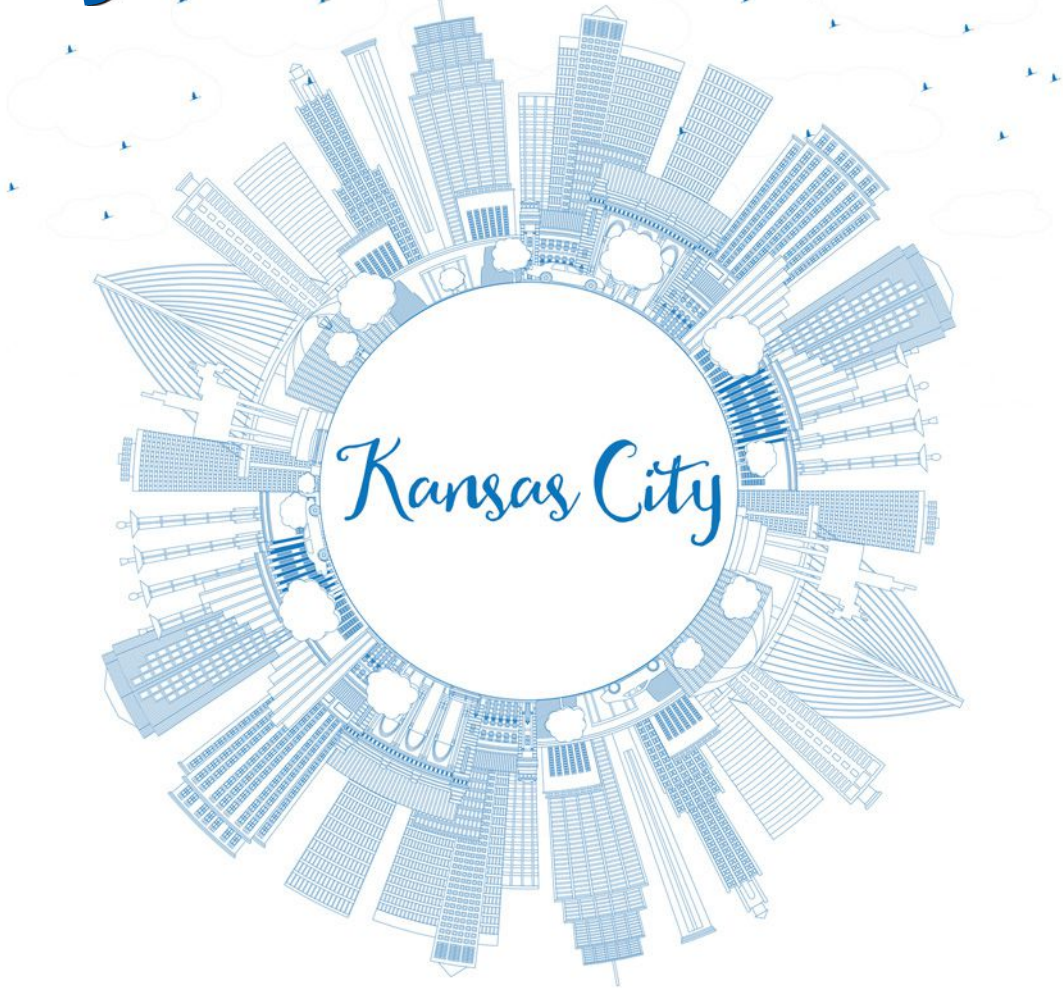
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Lancer G. Gates, DO, FACOI

Kansas City, Missouri

Lancer G. Gates, DO, FACOI, Fellow of the American College of Osteopathic Internists, will serve as President of the Missouri State Medical Association in 2023-2024. He was formally installed in Kansas City, Missouri, April 1, 2023, during MSMA's 165th Annual Convention.

Dr. Gates was born and raised in Columbia Cross Roads, Pennsylvania, the son of public school educators Wayne and Juanita Gates. He earned a Bachelor's degree in pre-medicine from Pennsylvania State University. He matriculated medical school at the Andrew Taylor Still University in Kirksville, Missouri, obtaining a Doctor of Osteopathy degree in 1996. Dr. Gates then completed his internal medicine residency training at Wilson Memorial Hospital in Johnson City, New York. He is board certified in internal medicine by both the allopathic and osteopathic accrediting bodies.

Dr. Gates began general medicine practice in 1999 as an employed physician of Lourdes Hospital at Vestal Medical Associates in Vestal, New York, providing both outpatient and inpatient patient care. In 2001, Dr. Gates moved back to Missouri to provide inpatient and outpatient patient care at the Boulware Medical Clinic in Liberty, Missouri. His wife, Stacey, helped him incorporate Gates Hospitalists, and in December of 2002 this private hospitalist group began providing hospitalist care for patients at Liberty Hospital and North Kansas City Hospital. For the first year, he practiced alone 24/7 caring for patients while Stacey served as the practice manager. About a year later, his friend and medical school classmate, Rusty Bergman, DO, joined him, and together they continued to build the group. Nearly 21 years later the practice has grown to 11 board certified physicians, all MSMA members.

Dr. Gates has been a proponent of independent physician practice and was a founding member of the Kansas City Metropolitan Physicians Association (KCMPA). He served on the charter committee of CENTRUS, a quality initiative including KCMPA, North Kansas City Hospital, AdventHealth, and the University of Kansas Hospital. Today, he serves on the CENTRUS Health Payment Transformation Committee and is the co-chair of the CENTRUS Health Performance Improvement Sub-committee.

As an educator, Dr. Gates each year serves as a preceptor to nearly 20 third and fourth year medical students from the Kansas City University for their rotation in internal medicine. He has also served as a hospitalist consultant for Berkshire Hathaway's Medical Protective medical malpractice insurance company.

A long time public servant, he served on Missouri Governor Matt Blunt's Health Care Stabilization Fund Feasibility Board from 2007-2010. He served on the Clay County Judicial Selection Committee from 2008-2013. Since 2021 he has served as an elected member of the Clay County Public Health Department Board of Trustees.

Dr. Gates is a champion of organized medicine. Shortly after arriving back in Missouri in 2001, he became active in the Kansas City Medical Society. He was awarded the KCMS Doctor of Distinction 2007, and served as the KCMS President in 2014. He has been an active member of MSMA, serving as Councilor, Vice-Speaker, and Speaker of the House.



Alliance Installs 2023-2024 President

Sana Saleh
Kansas City, Missouri

Sana Saleh, MSMA Alliance President for 2022-2023, was re-elected for the 2023-2024 year.

Sana has been an active county, state and national Alliance member since 1996. Sana brings an array of skills and experiences from the work that she had done both overseas and as a volunteer in her community.

She was born in Amman, Jordan. She traveled to the United States (US) and earned a bachelor's degree in Biology at Mills College, in Oakland, California 1983.

Back in Jordan, in the years that followed, she worked for the City of Amman's Urban Development Department (UDD) assessing the health status of the population following the provision of clean water supply.

This kindled her interest in public health, so she returned to the US, where she earned her Master's degree in Public Health/International Health at Johns Hopkins University in 1987 and she began working for the United Nations Children's Fund (UNICEF) Regional Office in monitoring and evaluation.

During her UNICEF years, she travelled to Algeria, Djibouti, Egypt, Iran, Iraq, Jordan, Morocco, Sudan, Syria, Tunisia, and Yemen. Sana co-authored scientific papers with UNICEF and the London School of Tropical Medicine on methods of measuring childhood and maternal mortality in the field.

She planned to pursue a PhD in Public/International Health on a full scholarship at Johns Hopkins when she met George Saleh, DO, an OB-GYN, which changed her plans. They married in Amman in 1992 and moved to Kansas City, which they have called home ever since.

Sana has been active in her children's schools throughout their upbringing, and has been involved with her church and served on the Vestry. She currently is a member of the Kansas City Ballet Guild and the International Relations Council of Kansas City. She is also a part-time substitute teacher.

Her goals this year are to focus on expanding "Stop the Bleed" program around the state, and promote and encourage Alliances throughout Missouri in forming new partnerships and strengthening the existing ones.

George and Sana have three children and two grandchildren. **MM**

Dr. Gates, continued

He sits on the MSMA Legislative Affairs Committee and also is chair of the MSMA Insurance Agency Board of Directors. Sitting on the on the Editorial Board of MSMA's journal Missouri Medicine, he represents hospitalist medicine. He is active in the Kansas City Regional Osteopathic Medical Association, serving as President in 2018-2019 and an active member of the Missouri Association of Physicians and Surgeons (MAOPS). He was awarded the MAOPS Physician of the Year in 2008.

He has been married for 25 years to Stacey, a Cornell Law School graduate and the business manager of Gates Hospitalists, and they have three daughters and three sons. In his free time he enjoys ballroom dancing, and playing tennis with his daughters and sons. In 2022, he self-published *The Parent's Guide to Youth Tennis, Volumes I & II*.

His goal for his year as President of the MSMA is to grow and engage its membership, while preserving the sanctity of the patient-physician relationship. **MM**

State of the Association: Presidential Address

by George Hubbell, MD, 2022-2023 MSMA President

Good morning. As I have traveled around the state in the past year to county and component medical societies, I can't help but having observations, most importantly the conclusion that there is still a relevant need for the Missouri State Medical Association, even after 173 years.

Our discipline is in crisis not just because of the recent pandemic which has added new complexities for us in our day-to-day functioning as physicians. Our efforts during the pandemic were Herculean and efforts well recognized by the communities in which we work but return has certainly been to a new normal. I'm happy to report membership in our organization is remains strong and is growing, but we need to grow larger and more resonant. In my short delivery today I'm going to make several pleas, if you don't listen to anything else, please listen to my pleas.

Burnout in our profession pre-pandemic was approaching a problematic level of 30%. Post-pandemic that burnout level has now soared to 60%. The cause for burnout is prolonged stress that can include lack of satisfaction from work, cynicism, and emotional exhaustion. Alarming surveys reveal about one in five physicians are preparing to leave their practice in the next two years.

Currently, 74% of physicians are employed and so retorts by our hospital CEOs like: "We need to meet and have lunch" simply aren't enough. You can't take the canary from the coal mine, teach it to recover, and then stick it back in the same coal mine and expect it to survive. One needs to place attention on the coal mine.

MSMA will be offering a weekend retreat for wellness and stress reduction October 20-22 at Margaritaville on the beautiful Lake of the Ozarks. Please hold those dates on your calendar. Additionally, the Missouri Physicians Health Program, which is owned by MSMA, helps struggling physicians return to healthy lives, whether that be from substance abuse mental health to burnout.

Plea #1

If you or colleagues are exhibiting signs of burnout, please give them the Missouri Physicians Health Program number and tell them about the weekend retreat for their entire family.

As we all assume the greatest duty of MSMA is to provide advocacy for our profession and patients, ancillary things such as five forms of regular communication, including the much-awarded *Missouri Medicin*e, and the MSMA Insurance Agency, independent and working just for you, are all part of your membership. These both remain stable, most solvent and entirely relevant, thanks to Ronnie Staggs, Liz Fleenor, and Jeff Howell daily efforts.

I must also mention the $300,000 in medical school scholarships this year to all six medical schools by our Foundation that now has given $12M in scholarships throughout the years.

Each workday, statewide advocacy is preserving and protecting our practices and that which our MSMA organization is most identified. Jeff Howell, as well as our lobbying team, offer input and direction to our legislative body. Many times it has been said: "If you're not at the table, you'll be on the menu." So many pieces of legislation touch our discipline in some way and our vigilance to scope of practice: COVID, malpractice, the insurance and pharmaceutical industry issues, public health, the opioid epidemic, the *Dobbs* decision, MOC, and licensing, to name a few.

Part of your membership is having an avenue to be involved with one or many of these subjects, whether it be in person for legislative committee testimony or written online comments on

individual bills that can be easily made from your keyboard and have gravity you can palpate. And remember, the cost for not acting in some way is most high.

Plea #2

Please offer testimony for legislative bills that are near and dear to you and respond to calls for action. Collective voices make the strongest echoes in Jefferson City.

No segment of the healthcare industry is currently immune from the pursuit of profit with global medical incorporatization. Pharmaceutical company costs are rising even for simple and long-term medications through monopolization and flaws in patent laws despite much research coming from government funded studies, profiteering by the medical insurance industry for even Medicare supplements designed to hold down costs but in the end adding billions to the bottom line.

I shouldn't leave out hospital pricing games and coding schemes with consolidation that has left hospital systems with sometimes large balances that are invested and exist despite large-on-paper operating losses. Additionally, I can't help but mention the windfall of salary increases for administrators at every level. And all mentioned are mostly legal but wrong. Unchecked greed is has prospered under the current laxity, these are behaviors that pose an existential threat to sustainable and compassionate care as we now know it.

Finally, this morning, I'd like to call for you to engage in an adventure, something for which I've had the opportunity to serve for the last few decades. While all of us on the stage today are in leadership and get our recognition, it is recognition due you, for you're in the trenches furthering health for your patients and community. I thank my forefathers for the tutelage and direction I took and want to encourage you to pursue leadership.

It is said that small words given sometimes in passing mean the most, especially the small



Incoming President Lancer Gates, DO, presents George Hubbell, MD, with his outgoing President's plaque.

prompts on lifestyle and recommendations we give our patients, sometimes that they long remember with everlasting significance.

So, in that vein, I want you to pursue leadership and make it a great journey. Forty-seven percent of physicians are now over 55 and we already have a shortage in all counties in our state save one. It will be essential and is inevitable we all become leaders at some level on a healthcare team for the deficits that exist. Leadership development involves experiencing new responsibilities and roles not familiar to have accomplishment and success. MSMA was a great way to shepherd such skills and for me was a true awakening. Physician leaders must be servant leaders there to selflessly steward and guide a disordered, highly consolidated, and profitable health system.

The values essential are those of ethics, to exude respect, be authentic, and reliable, all in the context of our Hippocratic Oath. So, of all the institutions for which we can call, who can you champion and fully trust? MSMA!

Plea #3

Get involved in leadership at any level you are comfortable. Make it a life goal.

Thank you. **MM**

Alliance at a Hundred and One and Having Fun!

by Sana Saleh, MSMA Alliance President - From her speech to the MSMA House of Delegates

One Hundred and One! is the age of our national Alliance that was born here in the heartland in St. Louis, Missouri, in 1922. We celebrated its centennial last June in Chicago with a grand gala recalling the history of various decades.

Two counties from Missouri received national awards last year: Greene County Alliance for its successful Physicians' Family Day at the Dickerson Zoo in Springfield, attracting more than 300 participants including physician families. The second award was granted to the St. Louis Alliance for their Hungry Heroes project, where they distributed 250 bags filled with nutritious treats to frontline workers – ED, ICU, EMS staff, and Security. The St. Louis project continues to expand and has served more than four hospitals since its inception with a total of 1,000 bags, most recently at Mercy South. St. Anthony's Hospital honored our very own Edmond Cabbabe, MD, and his wife Rima, in celebration of Doctors' Day this year.



Alliance members take a spin around the 360° photo booth at the Presidential Reception. Right to left: Sana Saleh, Jacqueline Nguyen, and Donna Corrado.

Since June of last year, your Missouri Alliance has provided a $500 grant to North Kansas City Hospital to promote the Stop the Bleed program. Buchanan County continues to distribute its SAVE (Stop America's Violence Everywhere) handbooks to its school districts to educate and teach non-violence to school age children.

In addition to its Family Zoo event in August, Greene County Alliance holds another family event in February at the Discovery Center Museum to bring medical families together with a successful attendance in place.

The Kansas City Alliance continues with its pillowcase dress health project that has shipped more than 50 dresses a year since 2014 to port cities overseas to help support preventive measures to keep young girls safe from human trafficking. The Alliance also grants $3,000 in scholarships annually to allied health professionals, mostly nursing students who exhibit academic excellence and financial need. The boutique that takes place during the holiday luncheon raises money to support our local charities.

On the state level, the MSMA Alliance supports the six medical schools across Missouri during their Match Day or graduation ceremonies providing pizza and gifts for soon-to-be-residents. Our Holiday Sharing Card raised more than $6,400 this year and we hope to add more from this weekend to the MSM Foundation, providing scholarships to medical students.

Liz Fleenor, MSMA office, generously assisted us in improving our website at www.msma.org/alliance making it more user-friendly, accessible, and resourceful for members. We also rebranded our *Show Me Alliance* newsletter to a monthly digital version, with two printed annually, and renamed it MSMA *Alliance Connect.*

We raised awareness on drug and human trafficking through educational presentations at our annual Fall Conference with special attention to



George Hubbell, MD, presents Jon Patterson, MD, with MSMA's Legislative Award.



MSMA's Resident and Fellow Section.

Alliance address, continued

fentanyl poisoning that is killing almost 200 people a day. We invited Auxiliary members from MAOPS to attend our conference on the campus of the Kansas City University.

In addition, we supported the House of Medicine during Physician Advocacy Day in February at Missouri's Capitol, and we will continue to support and promote physician families and the health issues that affect them.

In conclusion, as some of you know, national Doctors' Day was on Thursday, March 30th. On behalf of the MSMA Alliance, we would like to thank each of you for your hard work and dedication to the medical profession. As you exit the room, Alliance members will hand out lapel pins of carnations that represent Doctors' Day as a token of appreciation. If you want to know more about Doctors' Day, you can scan the QR code and read how it was established. It was our very own Janet Campbell from Sedalia, whose husband was A.J. Campbell and an MSMA Past President, who helped establish a national Doctors' Day.

Thank you for your time and your support. **MM**



Kirby Turner, MD, takes a survey on Medicare and Medicaid Expansion.



MSMA's Reference Committee.

165th House of Delegates Resolution Actions & Decisions

Resolution #1 – Access to Gender-Affirming Surgery and Hormone Replacement Therapy for Transgender and Gender-Diverse Individuals

Action: Substitute Resolution #1 Adopted

RESOLVED, that our MSMA supports legislation to protect access to gender-affirming care for adults over 18 years of age.

Resolution #2 – Access to Puberty-Suppressing Hormone Blockers for Transgender and Gender-Diverse Youth

Action: Referred to MSMA Council

RESOLVED, that MSMA supports access to medically-indicated puberty-suppressing hormone blockers for transgender and gender-diverse youth.

Resolution #3 – Allowing Transgender and Gender-Diverse Individuals to Change Their Gender Marker on Birth Certificates

Action: Resolution Not Adopted

RESOLVED, that our MSMA opposes any efforts to deny an individual's right to determine their stated gender marker or gender identity on identification documents, including birth certificates.

Resolution #4 – Dobbs – EMTALA Emergency

Action: Substitute Resolution Adopted

RESOLVED, that our Missouri State Medical Association will advocate for policies to ensure that all patients in Missouri receive prompt, complete and unbiased emergency health care that is medical sound and evidence-based, in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Resolution #5 – Dobbs – Liability Insurance Exceptions for Certain Criminal Conduct

Action: Substitute Resolution Adopted

RESOLVED, that the Missouri State Medical Association work with medical liability insurers and medical care facilities to discourage the termination of liability coverage or clinical privileges of any physician who has been charged with a crime arising from the provision of evidence-based healthcare; and be it further

RESOLVED, that this resolution be submitted to the American Medical Association House of Delegates.

MSMA Votes to Redraw Statewide Member Districts

MSMA's original 10-district apportionment in Missouri was transformed at the recent House of Delegates to incorporate and support more rural districts and their physicians for a more nimble approach to representing its members.

Moving forward, each Councilor District will be entitled to one Councilor for each 250 active, retired, and resident members, or a fraction thereof, and shall be entitled to one Vice Councilor.

Current MSMA Districts 6 and 8 are combined into District 8 and comprises the counties of of Barry, Barton, Bates, Benton, Cedar, Christian, Dade, Dallas, Greene, Henry, Hickory, Jasper, Johnson, Laclede, Lafayette, Lawrence, McDonald, Newton, Pettis, Polk, Ray, Saline, St. Clair, Stone, Taney, Vernon, and Webster.

Current MSMA Districts 9 and 10 are combined into District 6 and comprises the counties of Bollinger, Butler, Cape Girardeau, Carter, Crawford, Dent, Douglas, Dunklin, Howell, Iron, Jefferson, Madison, Maries, Mississippi, New Madrid, Pemiscot, Perry, Phelps, Pulaski, Oregon, Ozark, Reynolds, Ripley, Scott, Shannon, St. Francois, Ste. Genevieve, Stoddard, Texas, Washington, Wayne, and Wright.

Find your District Councilor at msma.org/governance. Contact Jeff Howell at jhowell@msma.org.

Resolution #6 – Dobbs – Medical Staff Privileges Protections for Certain Criminal Conduct

Action: Combined with Resolution #5 to create Substitute Resolution #5

Resolution #7 – Supporting Access to Evidence-Based Reproductive Healthcare

Action: Substitute Resolution Adopted

RESOLVED, that MSMA supports legislation that protects physician-patient autonomy, and opposes the criminalization of medically-necessary healthcare and policies

that restrict Missourians' ability to access healthcare in Missouri and other state.

Resolution #8 – Firearms Safety and Violence Prevention

Action: Referred to MSMA Council

RESOLVED, that our MSMA support legislation that supports red flag laws that allow the court to remove weapons from those at high risk of violence (mental illness, escalating threats, substance abuse and domestic violence) and support legislation for a universal background check requirement to purchase firearms.

Resolution #9 – Opposing Bans on Medical School DEI Requirements

Action: Amended Resolution Adopted

RESOLVED, that our MSMA oppose legislation that prohibits medical schools from requiring education on social determinants of health.

Resolution #10 – MSMA Human Rights/ Discrimination Policy

Action: Resolution Not Adopted

RESOLVED, that MSMA human rights/discrimination policy be amended to read "All human beings are equal in dignity and rights and are therefore entitled to the same freedoms, without discrimination based on sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities."

Resolution #11 – Waiver of Network Considerations in Emergencies

Action: Referred to MSMA Council

RESOLVED, that our Missouri State Medical Association will forward to the House of Delegates (HOD) of the American Medical Association (AMA), for its consideration at the AMA HOD Annual Meeting in Chicago in June of 2023, a proposal that our AMA will advocate and

MSMA House of Delegates Vote on New Policies

The policies below were developed out of resolutions submitted by MSMA members to the House of Delegates. For the complete list of policies and the year adopted, please visit the MSMA member-only area at msma.org/governance. Log-in is required.

Education Requirements – Medical Schools

The MSMA opposes legislation that prohibits medical schools from requiring education on social determinants of health. (2023)

EMTALA Medical Emergency

The MSMA will advocate for policies to ensure that all patients in Missouri receive prompt, complete, and unbiased emergency health care that is medically sound and evidence-based, in compliance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA). (2023)

Graduate Medical Education Funding

The MSMA supports state legislation to implement state funding of GME positions in Missouri. (2023)

Loss of Liability Coverage/Clinical Privileges – Criminal Conduct

The MSMA discourages the termination of liability coverage or clinical privileges of any physician who has been charged with a crime arising from the provision of evidence-based healthcare. (2023)

Reproductive Healthcare – Access to

The MSMA supports legislation that protects physician-patient autonomy and opposes the criminalization of medically-necessary healthcare and policies that restrict Missourians' ability to access healthcare in Missouri and other states. (2023)

Texting-and-Driving

The MSMA supports legislation that would prohibit texting and driving. (2023)

Transgender Healthcare

The MSMA supports legislation to protect access to gender-affirming care for adults over 18 years of age. (2023)

MM



MSMA's Medical Student Section.



Left, Sana Saleh, MSMA Alliance President, and right, Jacqueline Nguyen, AMA Alliance President.

Resolution Actions & Decisions, continued

lobby for new laws and/or regulations that would compel health care insurers to waive their "network" considerations for their covered patients, and to reimburse hospitals and doctors at their typical "in-network" rates that existed at the time of onset of an emergency, in instances when care is provided to patients who have agreed to be transferred to a site that is typically considered by that insurer to be "out of network", during times at which a Declaration of Emergency has been declared and placed in force by a State Governor or by the President of the United States, whether that state of emergency is the result of a natural disaster, an act of war, or a pandemic.

Resolution #12 – Pelvic Exams for Anesthetized Patients

Action: Referred to MSMA Council

RESOLVED, that our MSMA oppose non-consensual pelvic exams of anesthetized patients solely for learning purposes in the state of Missouri.

Resolution #13 – Price Caps for Drugs Developed Utilizing State Grants

Action: Resolution Not Adopted

RESOLVED, that our MSMA recognizes that policies and legislation that limit generic drug development, and therefore patients' ability to afford and access medications, have negative repercussions for Missouri residents' health and wellbeing; and be it further,

RESOLVED, that our MSMA supports legislation to implement price caps and ceilings for pharmaceutical drug prices which were developed through grants funded in part or in whole from the State of Missouri, and therefore Missouri taxpayers; and be it further,

RESOLVED, that our MSMA supports legislation requiring all pharmaceutical drug companies to sign a legally binding agreement to not exceed a predetermined out-of-pocket price for medications developed through grants that were partially or fully funded from the State of Missouri, and therefore Missouri taxpayers henceforth.

Resolution #14 – Support for the Interstate Medical Licensure Compact

Action: Referred to MSMA Council

RESOLVED, that the Missouri State Medical Association support legislation that enrolls the Missouri Board of Healing Arts as a member of the Interstate Medical Licensure Compact.

Resolution #15 – Elected Officials on MSMA Executive Committee

Action: Resolution Not Adopted

RESOLVED, that the MSMA Constitution & Bylaws Committee review Chapter VII of the MSMA Bylaws to include a potential prohibition that MSMA members may not serve on the MSMA Executive Committee while serving as a publicly elected official at the state level of government; and be it further,

RESOLVED, that this resolution be referred to the MSMA Constitution & Bylaws Committee.

Resolution #16 – Council Parliamentarian

Action: Resolution Not Adopted

RESOLVED, that the MSMA Constitution & Bylaws Committee review and Chapter VI of the MSMA Bylaws to include the appointment of a Council Parliamentarian; and be it further,

RESOLVED, that this resolution be referred to the MSMA Constitution & Bylaws Committee.

Resolution #17 – Support for State GME Funding

Action: Resolution Adopted

RESOLVED, that our Missouri State Medical Association



Leaders of MSMA's Women Physicians Section.



Left, MSMA Alliance President Elect Donna Corrado, and right, Kay Johar.

(MSMA) support state legislation to implement state funding of GME positions in Missouri.

Resolution #18 – Texting-and-Driving

Action: Substitute Resolution Adopted

RESOLVED, that the Missouri State Medical Association support legislation that would prohibit texting and driving.

Resolution #19 – Resolutions

Action: Resolution Adopted

RESOLVED, that the MSMA Bylaws Chapter III, Section 1, be amended as follows:

Chapter III. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Convention. All resolutions must be received at the Association office no later than 21 days prior to the opening session of the Annual Convention to be accepted as business of the House of Delegates and will be included in the Delegate's Handbook. At the discretion of the Speaker, these conditions would not apply for resolutions of good wishes, condolences, congratulations and others of a personal nature.

Resolution #20 – Council Representation

Action: Resolution Adopted

RESOLVED, that the MSMA Bylaws Chapter IV, Section 5, be amended as follows:

Chapter IV. Election of Officers

Section 5. Each Councilor District shall be entitled to one Councilor for each 250 active, retired and resident members, or a fraction thereof, in that Councilor District as of August 31 of the preceding year. Each District shall be entitled to one Vice Councilor; and be it further

RESOLVED, that current MSMA districts six and eight be combined into district eight, so that the new district eight will be comprised of the following counties: Barry, Barton, Bates, Benton, Cedar, Christian, Dade, Dallas, Greene, Henry, Hickory, Jasper, Johnson, Laclede, Lafayette, Lawrence, McDonald, Newton, Pettis, Polk, Ray, Saline, St. Clair, Stone, Taney, Vernon, and Webster; and be it further

RESOLVED, that current MSMA districts nine and ten be combined into district six, so that the new district six will be comprised of the following counties: Bollinger, Butler, Cape Girardeau, Carter, Crawford, Dent, Douglas, Dunklin, Howell, Iron, Jefferson, Madison, Maries, Mississippi, New Madrid, Pemiscot, Perry, Phelps, Pulaski, Oregon, Ozark, Reynolds, Ripley, Scott, Shannon, St. Francois, Ste. Genevieve, Stoddard, Texas, Washington, Wayne, and Wright.

Resolution #21 – Commendation for Rep. Jon Patterson, MD

Action: Resolution Adopted

RESOLVED, that the Missouri State Medical Association commends Dr. Patterson for his excellent prior service to the state and its citizens as a member of the House of Representatives.

Resolution #22 – Resolutions by Medical Students

Action: Resolution Not Adopted

RESOLVED, that the MSMA Constitution and Bylaws Committee review Article IV of the MSMA Constitution and Chapter III, Section 3 of the MSMA Bylaws to consider prohibiting medical students from:

(1) Serving as delegates at the MSMA House of Delegates, and

(2) Submitting resolutions to the MSMA House of Delegates; and be it further,

RESOLVED, that this resolution be referred to the MSMA Constitution and Bylaws Committee. **MM**

Presidential Inauguration Address

by Lancer Gates, MD, 2023-2024 MSMA President

Good evening! I thank all of you for attending this 165th MSMA Annual Convention. I extend a special thanks to Benita Stennis, Liz Fleenor, and the rest of the MSMA staff for organizing this great event. I thank my spiritual advisor, and the musicians this evening. For those of you wondering, the musical prelude was the Glasgow Love Theme. Who knew that Glasgow had both a coma scale and a love theme?

I thank all of my allopathic and osteopathic brothers and sisters here this evening. I want to thank everyone that I work alongside each day. Dr. Ragu Adiga, CEO Liberty Hospital, and Dr. Stephen Reintjes, CEO NKC Hospital, my medical staff colleagues, and all healthcare workers at these hospitals.

I want to recognize and extend a special thank you to the physicians with whom I practice, some of whom are here tonight (Dr. Corey Lewis, Dr. Rahul Kapur and Dr. Alex Pankratov) and the others that are covering the practice this evening (Dr. Rusty Bergman, Dr. Bobby Evangelidis, Dr. Ashley Hole, Dr. Abdu Bouzid, Dr. Anthony Carandang, Dr. Ross Elliott, and Dr. Chris Chapman. I thank my friends here this evening.

Finally, I thank my family members present here tonight, my wife Stacey and daughters Ava, Ella, and Scarlett, and my sons Ethan and Mason. I also thank my sister Laura and brother in-law Rich Schneck, and my parents in-law Linda and Greg Snodgrass; and I also want to thank my family that is unable to attend in person: my son Carson, my parents Wayne and Juanita, my sister Melissa and her family, my brother Zachary and his family, and my parents in-law Ruth and Terrence Griffin.

At the reception following this Presidential inauguration we will celebrate with food, drink, fellowship, and dance. Ballroom dancing is similar to participating in organized medicine. This evening we will explore these similarities.

Chapter 1
DANCE PARTNERS

We all need dancing partners, after all it does take two to tango. MSMA deals with many different issues and has many different partners. This year MSMA partnered with MAOPS for the Missouri Physician Advocacy Day, and for CME opportunities through the Virtual Osteopathic Conference, and for the upcoming Physician Wellness Seminar. The MSMA Alliance and the MAOPS Alliance are also working together in what I have coined the Alliance of the Alliances.

MSMA also partners with the AMA, and annually submits resolutions to the AMA for consideration, and the delegation from MSMA considers resolutions submitted by other physician organizations. Several of our MSMA members serve on leadership roles of the AMA.

MSMA works with Missouri legislators and the Governor. Speaking of elected officials, the MSMA has proven to be a fertile advocacy training ground, yielding many physician legislators each Missouri legislative season, like Dr. Lisa Thomas who is present here this evening. I echo what Dr. Hubbell asked of you this morning. Please consider serving as a partner in Jefferson City as an elected official.

Chapter 2
LEADING & FOLLOWING

In dance there is a leader and there is a follower. The leader has to lead, and the follower has to allow the leader to lead. This only works if the leaders give 50% of their weight to their followers, and the followers give 50% of their weight to their leaders. MSMA is effective because the leadership leans on the membership, and the membership leans on the leadership.

Chapter 3
DANCING TO THE TUNES OF TODAY

Just when you think you have dancing figured out, along comes either a new song, or a variation of an old song. In organized medicine our "songs" are the issues that involve the practice of medicine. Sometimes MSMA leads the way on new issues and sometimes we borrow great ideas from other states and put a Missouri spin on them. At the conclusion of this program you will be entertained by the music of pianist Scott Joplin who was adopted from Texas by way of Sedalia, Missouri …the ultimate Texas two-step.

MSMA leads on issues including addressing narcotic poisonings, preserving the collaborative practice



On behalf of Marc B. Hahn DO, the President and CEO of Kansas City University, Ed O'Connor, DO, the Vice Provost of KCU, presented MSMA President Lancer Gates, DO, with a proclamation stating: "Therefore, on this date, the First of April in the year Two Thousand and Twenty-Three, Kansas City University extends its heartfelt congratulations and best wishes for success."

agreement, preserving autonomy of the patient-physician relationship, and preserving the fundamental ideals of our Hippocratic Oath.

Without MSMA we would all be like Billy Idol "Dancing With Myself"…left to face the music alone. With MSMA we can get into the swing of things on the advocacy dance floor of the Jefferson City capitol rotunda.

Chapter 4
TAKING SMALL STEPS

Dancers plan at least two steps ahead but take only one small step at a time. If we want to grow MSMA, we need to plan and perform just like a dancer.

What do you call a person that does the same thing 15 times and expects a different result? Speaker of the House.

We cannot expect our House of Medicine to flourish unless we do something different. Today more physicians are employed by hospitals than are in the private practice of medicine. Many private medical practices and not-for-profit hospitals utilize non-compete clauses. The MSMA does not support the use of non-compete clauses by not-for-profit hospitals. The FTC is currently holding an open comment period regarding their plan to ban the use of non-compete clauses. MSMA needs to make every effort to recruit and engage both hospital employed physicians and privately practicing physicians. We need to grow and engage our membership by "giving our message" to all Missouri physicians, and by "getting the message" from all Missouri physicians.

Chapter 5
GETTING BACK ON BEAT

Dancers learn how to dance on beat. They also can recognize if they are off beat, and then quickly get back on beat. The music doesn't stop. Organized medicine can and does occasionally get off beat.

Both the MSMA leaders and the MSMA followers need to recognize if we don't have the pulse of the membership, and we must quickly find the pulse again …hopefully within just a couple of heartbeats. Over the next year I plan to keep my finger on the pulse of the practice of medicine in Missouri by holding "Fireside Chats" with all Missouri physicians (MSMA members and non-members) every third Wednesday of the month at 7:00 p.m. via Zoom. At these "Fireside Chats" the MSMA staff and I will listen to Missouri physicians who are facing the issues of the day.

Chapter 6
EMERGENCY TURNS

Dancers occasionally need to make an emergency turn when they find themselves moving against the counterclockwise current of the other dance couples. Medicine has its own emergencies and we must act swiftly. MSMA has the leaders, the active members, and the highly trained staff to respond quickly to emergencies, whether it is by teaching "Stop the Bleed" classes, or by responding to Supreme Court verdicts that involve the practice of medicine.

Chapter 7
GETTING NEW DANCERS ON THE DANCE FLOOR

It is easier to teach a young dancer new steps. You know what they say in medicine, you can't teach an old "dog….tor" new tricks.

Newly trained doctors are the lifeblood of MSMA.

Recipients of the 50-Year Physician Pin

Twenty-five physicians were recognized with their 50- Year Physician pin award during MSMA's Presidential Inauguration. Congratulations to all our 50-Year Pin recipients!

- John T. Anstey, MD – St. Louis
- Octavio R. Chirino, MD – Manchester
- Robert L. Corder, MD – St. Joseph
- V. Rao Devineni, MD – Bridgeton
- Richard J. Gimpelson, MD – Ballwin
- Samuel D. Hoeper, MD – Kansas City
- Roger P. Jackson, MD – North Kansas City
- Gary M. Johnston, DO – Kansas City
- Jerry D. Kennett, MD – Columbia
- Ronald D. Leidenfrost, MD – Chesterfield
- Michael L. Loren, MD – Lee's Summit
- Michele C. McIntosh, MD – Independence
- Douglas M. McNeal. MD – Springfield
- Peter H. Mestad, MD – Overland Park
- Larry D. Paskar, MD – Chesterfield
- Frank O. Petkovich, MD – St. Louis
- Granville J. Phillips, MD – Perryville
- James A. Roller, MD – Columbia
- John L. Rollo, MD – Des Peres



Jerry Kennett, MD, (center) accepts the 50-Year Physician Pin from Drs. Gates (left) and Hubbell (right).

- Gregory C. Starks, MD - Kansas City
- John A. Stith, MD – St. Louis
- Leslie E. Tucker, MD – Washington
- Robert P. Wankum, MD – Jefferson City
- Robert W. Wilmott, MD – St. Louis
- Michael J. Wurm, MD – Maryville

Presidential Inauguration Address, continued

If we want to attract and engage these new members then we need to address their educational costs and residency availability.

The cost of medical education continues to rise and students are drowning in debt. Today, we deposit our money in the banks, and the bankers then extend student loans for medical education. It only makes sense to eliminate the middleman. Unfortunately it is hard to make change without coins. If our MSMA membership grows exponentially, and our reserves grow likewise, then we might find ourselves in a position to directly invest in the medical students coming behind us by utilizing income sharing agreements. We could literally invest in the future of medicine.

Each year medical schools are increasing both in number and in class size. This is creating a larger pool of applicants for residency positions. The federal government has not been expanding residency positions at a corresponding pace. Each year on match day, more United States medical school graduates overflow from the pool. MSMA led the effort to temporarily shore up the pool with sandbags by creating a class of assistant physicians. This is not a long term solution to this problem. We need to work with the AMA to engage our federal and state legislators to increase the number of residency positions.

Chapter 8 & The Final Verse
A TIME TO DANCE

None of the attendees of the first MSMA Convention are here with us tonight, but their wisdom has transcended time through this organization that we call the MSMA. An organization that has been held sovereign by generations of Missouri physicians.

Today, our generation's wealth of knowledge in the art and science of medicine fills our own Ark of the Covenant. Tonight let us carry this Ark of the Covenant next door to the inaugural reception, and let us be like David and dance with all our might! **MM**

Credentials and Appointments

The 165th Annual Convention of the Missouri State Medical Association was held March 31-April 2, 2023, at the Westin Crown Center Hotel, Kansas City, Missouri. Timothy Swearengin, MD, Springfield, presided as Speaker of the House of Delegates. Parliamentarian was Jo-Ellyn Ryall, MD, St. Louis.

The Committee on Credentials announced that there were 7 Officers, 16 Councilors, and 58 Delegates in attendance for the Opening Session of the House of Delegates.

This report and the minutes of the 164th Annual Convention as published in the May/June 2022 issue of *Missouri Medicine* were approved.

At the Second Session of the MSMA House of Delegates, the Committee on Credentials reported that there were 7 Officers, 19 Councilors, and 72 Delegates in attendance.

Reference Committee members were: Carlin Ridpath, MD, 8th District – Chair; Chakshu Gupta, MD, 1st District; George Hruza, MD, 3rd District; Charles Van Way III, MD, 7th District; Rachel Kyllo, MD, 10th District.

The MSMA Nominating Committee members were: Sarah Florio, MD, 7th District – Chair; Chakshu Gupta, MD, 1st District; Barbara White, DO, 2nd District; Gary Gaddis, MD, 3rd District; Martin Willman, MD, 4th District; Albert Hsu, MD, 5th District; Warren Lovinger, Jr., MD, 6th District; James Blaine, MD, 8th District; David Barbe, MD, 9th District; Kirby Turner, MD, 10th District; Marc Mendelsohn, MD, Young Physician Section; Raghuveer Kura, MD, International Medical Graduate Section; Carlin Ridpath, MD, Women Physicians Section; Kelly Schmidt, MD, Resident and Fellow Section; Lacey Raper, Medical Student Section. **MM**



MSMA thanks the members of the Reference Committee who served and provided the final report to the House of Delegates. Front row, from left: Charles Van Way III, MD - District 7; Carlin Ridpath, MD - District 8, Chair; Chakshu Gupta, MD - District 1; standing, from left: Rachel Kyllo, MD - District 10; and George Hruza, MD - District 3.



MSMA House of Delegates leadership, from left: Laurin Council, MD, Vice Speaker; Tim Swearengin, DO, Speaker; and Jo-Ellyn Ryall, MD, Parliamentarian.

MSMA Elects Leadership: 2023-2024

OFFICERS

President
Lancer Gates, DO, Kansas City

President Elect
David Pohl, MD, St. Louis

Secretary
Ellen Nichols, MD, Joplin

Treasurer
Elie Azrak, MD, St. Louis

Immediate Past President
George Hubbell, MD, Lake Ozark

1st Vice President
James DiRenna, Jr., DO, Kansas City

Honorary Vice President
Jeff Copeland, MD, St. Peters

Honorary Vice President
Alexander Hover, MD, Ozark

Speaker
Tim Swearengin, DO, Springfield

Vice Speaker
M. Laurin Council, MD, St. Louis

COUNCILORS

Council Chair (8th District)
Brian Biggers, MD, Springfield

Council Vice Chair, (4th District)
Kevin Weikart, MD, Lake St. Louis

1st District
Chakshu Gupta, MD, St. Joseph

2nd District
Hossein Behniaye, MD, Hannibal

3rd District
Erin Gardner, MD, St. Louis
Jenny Page, MD, St. Louis
Inderjit Singh, MD, St. Louis
Christopher Swingle, DO, St. Louis

5th District
Lisa Thomas, MD, Lake Ozark
Amy Zguta, MD, Columbia

6th District
Lirong Zhu, MD, Clayton
Dorothy Munch, DO, Poplar Bluff

7th District
Betty Drees, MD, Kansas City
Joanne Loethen, MD, Kansas City
Fariha Shafi, MD, Overland Park, KS

8th District
David Kuhlmann, MD, Sedalia

Organized Medical Staff Section
Amy Patel, MD, Kansas City

International Medical Graduate Section
Louis DelCampo, MD, Springfield

Young Physician Section
Rachel Kyllo, MD, Arnold

Women Physicians Section
Kelly Schmidt, MD, Columbia

Resident & Fellow Section
Rachana Raghupathy, MD, St. Louis

Medical Student Section
Jay Devineni
University of Missouri - Columbia

VICE COUNCILORS

2nd District
Barbara White, DO, Hannibal

3rd District
Ramona Behshad, MD, St. Louis

4th District
Keith Ratcliff, MD, Washington

5th District
Jennifer Powell, MD, Osage Beach

6th District
Nathaniel Barbe, DO, Mountain Grove

7th District
Sarah Florio, MD, Lee's Summit

8th District
TimSwearengin, DO, Springfield

Organized Medical Staff Section
Albert Hsu, MD, Columbia

International Medical Graduate Section
Raghuveer Kura, MD, Poplar Bluff

Young Physician Section
Sara Hawatmeh, MD, Ballwin

Women Physicians Section
Adriana Canas-Polesel, MD, St. Louis

Resident & Fellow Section
Julia Dmowska, MD, Columbia

Medical Student Section
Lacey Raper
University of Missouri-Columbia

AMA DELEGATES & *ALTERNATE DELEGATES

Elie Azrak, MD, St. Louis
Peggy Barjenbruch, MD, Mexico
Edmond Cabbabe, MD, St. Louis
Joseph Corrado, MD, Mexico
Betty Drees, MD, Kansas City
Charles Van Way, III, MD, Kansas City

*George Hruza, MD, Chesterfield
*Ravi Johar, MD, Chesterfield
*Joanne Loethen, MD, Kansas City
*Kayce Morton, DO, Springfield
*Charlie Adams, Kansas City University

AMA & WMA PAST PRESIDENT

David Barbe, MD, Mountain Grove

ALLIANCE

President
Sana Saleh, Kansas City

President Elect
Donna Corrado, Mexico

MM

2023 Convention General Sessions & Speakers



Health Equity Opportunities for Doctors and State Medical Associations by William Jordan, MD, MPH, (right), and moderated by Lancer Gates, DO (left).



The Opioid Epidemic: Striving to Provide Holistic Care to Patients Who Use Drugs by Nathan Nolan, MD, MPH, MHPE, (right), and moderated by David Barbe, MD. Photo with George Hubbell, MD, MSMA President.



Environmental Health: An Overview for Missouri Physicians by Elizabeth Friedman, MD, MPH, (left), and moderated by George Hubbell, MD, (right).



Marijuana/Cannabis Guidance for Medical Providers: Follow the Science by Roneet Lev, MD, FACEP, (left), and moderated by Brian Biggers, MD, (right).

Summary of Council Actions: 2022-2023

Meeting of April 2, 2022 – Renaissance St. Louis Airport Hotel

David Pohl, MD, St. Louis, was elected Chair of Council; Brian Biggers, MD, Springfield, was elected Vice Chair of Council; M. Ellen Nichols, MD, was elected Secretary; Elie Azrak, MD, St. Louis, was elected Treasurer.

Meeting of July 17, 2022 – Courtyard by Marriott, Jefferson City, Missouri

More than 60 new members have joined MSMA this summer and our advocacy efforts are ramping up for the fall election cycle and the 2023 legislative session. Here are the highlights from the July 2022 Council Meeting held in Jefferson City.

President George Hubbell, MD, noted that physician-to-physician recruitment is the best method to gain members. He encouraged members to share the recently published Legislative Review with prospective colleagues, emphasizing what MSMA does for them, then encouraging them to join using MSMA's "Summer Special" dues rate that is currently being offered. MSMA leadership and lobbying team are also interested in talking to your local society, medical staff meetings, and to medical students as we have several visits to medical schools lined up in the coming months. Contact MSMA to set up the meetings at cmartin@msma.org.

Advocacy

After a well-attended virtual townhall meeting regarding the overturning of Roe v. Wade, which garnered good discussion, the MSMA Council endorsed sending out a statewide press statement. The statement can be found at www.msma.org/press-statements.

MMPAC will host fundraiser events for medicine-friendly candidates throughout the state in conjunction with the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS). Fundraisers for two candidates are upcoming for George Hruza, MD, on August 10, and for Tony Luetkemeyer on August 4.

David Barbe, MD, Past MSMA, AMA, and WMA President, presented an update on federal affairs, with the MSMA lobbyists giving a state update.

MSMA will offer an Advocacy Workshop on Saturday, October 15, which is open to all members. It will be held in conjunction with the quarterly Council Meeting in Jefferson City. Attendees will hear from MSMA's advocacy team, state capitol legislative staff, and Senator Caleb Rowden about how to advance legislative priorities and engage with legislators.

Physician Advocacy Day will be February 7, 2023, in Jefferson City, and will be hosted with MAOPS.

Legislative resolutions included Resolution #9 – Insurance Coverage for Colonoscopies After Positive Test, which will be reconsidered at the October Council meeting. The Council also approved the following resolutions:

Resolution #8 – Patient Safety Reporting

The Committee recommended that the following substitute resolution be adopted:

RESOLVED, that the MSMA support legislation to prohibit retaliatory actions against physicians for reporting safety concerns to regulatory authorities or accrediting bodies.

Resolution #12 – Access to Out-of-State Health Care

The Committee recommended that the following substitute resolution be adopted:

RESOLVED, that our MSMA oppose policies that restrict Missourians' ability to access health care in other states.

The MSMA Insurance Agency reported that it can help identify needs and serve clients with insurance products, especially with the challenging market for professional liability. Contact them at www.msma.biz.

Membership

MSMA is introducing a new category for physicians who will be receiving or have received their Missouri license within six months of the date of application for membership called "New Licensee." Dues are $225.

A webinar series for Students, Residents, and Young Physicians will be offered this fall in collaboration with the Arizona Medical Association and the Wisconsin Medical Society. Registration information at www.msma.org/events.

MAOPS has asked MSMA to join them and the Missouri Academy of Family Physicians in hosting a physician wellness retreat in the fall of 2023. Mr. Howell appealed for volunteers to assist in organizing the event.

The MSMA Council has approved the dues categories for the 2023 dues year. They will remain the same as last year.

- Active Member $395
- New Licensee $225
- Retired Member $75
- 1st Year Practice $50
- 2nd Year Practice $100
- 3rd Year Practice $150
- 4th Year Practice $200
- Residents/Fellows Free
- Medical Students Free

Medical Economics

The House of Delegates referred two resolutions to the Commission on Medical Economics, Third Party Medicine, and Government Relations. The following substitute resolutions were adopted:

Resolution #2 – International Medical Graduate Employment

RESOLVED, that MSMA acknowledge the administrative burden that accompanies the hiring of International Medical Graduates, especially in underserved and rural areas, and support federal efforts to lessen that burden; and be it further,

RESOLVED, that this resolution be submitted to the American Medical Association House of Delegates at their next appropriate meeting.

Resolution #10 – Improving Prior Authorization Process

RESOLVED, that the MSMA support legislation to improve transparency and reduce the administrative burden of the prior authorization process to benefit patients and physicians.

Public Health

MSMA's Commission on Public Health discussed Resolution #4 - Climate Change Recognition. The Council referred this back to the Commission for further review and change.

Education

MSMA's Annual Convention will feature four CME general sessions and topics are being finalized. Esse Health was reaccredited for four years; Mosaic Life Care's progress report was approved; and Greene and Cape Girardeau counties have relinquished their accreditation status.

Alliance

Sana Saleh, MSMA Alliance President, and Donna Corrado, President Elect, presented a check to the MSM Foundation for $8,070, representing funds raised by the Alliance in the past year. KCMS Alliance has received a grant from the national Alliance and has been approved to begin a Stop the Bleed education program through North Kansas City Hospital, with classes starting in the fall. The grant money will be applied toward making Stop the Bleed kits, which will be given to those who participate in the training. Mrs. Saleh reminded everyone that all physician spouses are welcome to join the Alliance.

Reports

The Council heard additional reports from the Missouri Delegation to the AMA, Missouri Physicians Health Program, and Actions and Recommendations from the MSMA Annual Convention.

Appointments & Announcements

The Commission Councilor Advisor

appointments are: Medical Economics – David Kuhlmann, MD; Continuing Education – Louis DelCampo, MD; Public Health – Lirong Zhu, MD; and Physicians Health Committee – Lisa Thomas, MD

The MSMA Annual Convention will take place March 31 – April 2, 2023, at the Westin Crown Center in Kansas City, where Lancer Gates, DO, will be installed as the next MSMA President.

Meeting of October 16, 2022 – Courtyard by Marriott, Jefferson City, Missouri

MSMA ramped up its advocacy efforts for 2023 and demonstrated the value of membership as it announced its top priorities for medicine during the October Council Meeting in Jefferson City.

After an advocacy survey was sent to the Association membership, results showed MSMA should continue to protect the physician-patient relationship, physician autonomy, and scope-of-practice expansions by mid-level providers. MSMA will work with allies to correct certain aspects of the post-Dobbs trigger law. The Council also received an update on the Assistant Physician program, the results of which will be used to guide the upcoming legislative session.

MSMA is one of 124 national and state medical and specialty organizations who co-signed a letter asking Congress for actions against the mounting instability of the Medicare physician payment system. The letter asked for an end to the destructive cycle of annual Medicare cuts and to establish a permanent Medicare payment system that improves and preserves patient access to physician care.

Your Association is encouraging the Missouri Department of Social Services to add nuance to the administrative action process for improper payments and fraudulent claims for MO HealthNet services and has offered recommendations regarding exclusion, failure to meet standards for participation, refusing to execute a new provider agreement, failure to provide and maintain quality and services; and reprimands/censors.

MSMA President George Hubbell, MD, reported that he had contacted the U.S. General Accounting Office in Washington, DC, and provided feedback regarding the challenges presented by the electronic health record (EHR). He also addressed the "hold harmless" clause, which exempts vendors of EHR software from liability.

Legislator Lunches are being planned for the upcoming year, as well as in-district legislator meet-and-greets.

MSMA will be collaborating with the Missouri Association of Osteopathic Physicians and Surgeons (MAOPS) on the 2023 Physician Advocacy Day at the Capitol in February, as well as a physician wellness retreat at the Lake of the Ozarks in fall 2023. MSMA will participate in MAOPS' virtual osteopathic conference, which is a three-day live CME event in February 2023.

The Council approved the recommendation to not adopt amended Resolution #9 – Insurance Coverage for Colonoscopies After Positive Test.

Membership

Alexander Hover, MD, reported nearly a hundred new members had joined during the 2022 Summer Special and a near-record number of medical students have signed up this year. The auto-renewal feature offered by Wild Apricot has helped with dues renewals.

The Association is also sponsoring a Women Physicians Section webinar series, and weekly webinars aimed toward Residents/Fellows, Medical Students, and Young Physicians. The Residents are planning a mixer in November.

Brian Biggers, MD, reported that the first students that graduated from the MU School of Medicine Springfield satellite campus are returning to practice in the area, after seven years since the campus became operative.

Amy Patel, MD, Council representative to the Organized Medical Staff Section, stated that she is the Chair of the American College of Radiology's Radiology Advocacy Network (RAN), and that they are creating a pre-Radiology RAN comprising medical students, particularly those who have not matched.

Public Health

Albert Hsu, MD, reported that the Commission on Public Health discussed Amended Resolution #4 – Climate Change Recognition. The Council approved the amended resolution:

RESOLVED, that the MSMA recognize and agree with the scientific consensus on climate change, that the Earth is warming, and that human actions are a cause, and be it further,

RESOLVED, that the MSMA Commission on Public Health monitor ongoing AMA activities relating to climate change and make suggestions to the MSMA Council accordingly.

Education

MSMA's Commission on Continuing Education is planning four General Sessions during the 2023 Annual Convention in Kansas City, March 31- April 2. They include Diversity in Medicine, Environmental Health, Opioid Epidemic – Striving to Provide Holistic Care to Patients Who Use Drugs, and Medical Marijuana.

AMA Delegation

Edmond Cabbabe, MD, reported on AMA activities whereby MSMA will bring two resolutions to the AMA Interim Meeting this month. He attended the AMA Board retreat in Laguna Beach, California, where they identified areas of focus for the upcoming year. Dr. Cabbabe reported that the Heart of America Caucus is well-represented at the AMA level: Dr. Cabbabe serves as Chair of the Council on Long-Range Planning and Development; Charles Van Way, MD, is a rising star in OMSS; Elie Azrak, MD, serves on the AMPAC Board; Jerry Kennett, MD, serves on the AMA Foundation Board; and David Barbe, MD, has risen through many roles, ultimately serving as President of the World Medical Association. Dr. Cabbabe thanked all for their service.

Missouri Physicians Health Program

As a result of William Woods, MD, stepping down as Chair of the MPHP Board, John Cascone, MD, reported that has taken on those duties. MPHP is also seeking to fill two Board vacancies. Dr. Cascone reported that there are currently 74 physicians or medical students participating in the program and provided further details on program participation.

MSMA Insurance Agency

Your MSMA Insurance Agency encourages members to inquire about any upcoming insurance renewal needs. Reviews are free and may save money. The Agency also announced a new medical malpractice program through MedPro Group for Board Certified Plastic Surgeons. Contact Mary Hogan at 636-922-9201 for more information.

Alliance

Sana Saleh reported that the MSMA Alliance had a successful Fall Conference on the campus of Kansas City University. MSMA Alliance and the Auxiliary of MAOPS are encouraging a collaboration with areas of activity including the opioid crisis, education, and prevention. She encouraged everyone to participate in the Alliance's Holiday Sharing Card program, the funds from which help the Missouri State Medical Foundation to provide medical student scholarships.

Around the State

MSMA's President, George Hubbell, MD, visited the Greene County Medical Society's Physician Family Day at the Zoo in August, and attended the Tri-County Medical Society's meeting at the home of David Chalk, MD, in Washington in September. He attended Kansas City Medical Society's Annual Meeting in October. He also reported the Lake Ozark Medical Society is hosting in-person meetings, attended by physicians, nurse practitioners, and pharmacists.

Chakshu Gupta, MD, St. Joseph, reported that the Buchanan County Medical Society is meeting monthly, and most recently had a presentation by the local Drug Task Force. They are also implementing a scholarship program for medical laboratory scientists to incentivize students to pursue that career field.

Hossein Behniaye, MD, Hannibal, suggested that the issue of the EHR is a galvanizing point when talking to potential new members.

Inderjit Singh, MD, reported that the St. Louis Metropolitan Medical Society heard a recent presentation on value-based care by Rishi Sud, MD, MBA, the Chief Medical Officer of Esse Health.

In District 5, Amy Zguta, MD, reported that the Boone County Medical Society plans to host a family event in 2023. They continue to offer webinars focusing on wastewater monitoring, monkeypox, and other topics.

Betty Drees, MD, reported that the Kansas City Medical Society installed new officers for 2023. Lancer Gates, DO, and Fariha Shafi, MD, serve on the KCMS committee to find speakers for priorities of the upcoming year which are the opioid crisis and physician wellness/burnout.

The Quad Counties Medical Society met in late summer, many attendees of whom were residents and medical students, reported Dorothy Munch, DO. She spoke about the effectiveness of Narcan, and stated that they have two Narcan vending machines in Poplar Bluff.

Within the Women Physicians Section, Joanne Loethen, MD, reported that the WPS is continuing its virtual webinar series, with the next session in December titled "#HeForShe," which focuses on gender equity and inclusion in medicine.

Alex Shimony in the Medical Student Section stated the MSS will conduct a resolution-writing workshop.

Meeting January 21, 2023 – Via Videoconference

Advocacy

A number of scope-of-practice bills that have been introduced were discussed, as well as a rule proposed by the Federal Trade Commission relating to non-compete agreements.

MSMA thanked the many physicians who have been offering testimony on bills this session, including the extension of post-partum benefits through MOHealthnet.

MSMA member and Representative Lisa Thomas, MD, noted that physicians need not appear in person to testify, but can offer testimony on-line. She offered advice on how to use the House and Senate websites to track bills and hearings. Dr. Thomas reported that she has been named Vice Chair of the Health and Mental Health Policy Committee. A new committee on Health Care Reform has been formed and she will be involved with that committee as well.

To keep members informed and active, MSMA is publishing links at msma.org on how to look up legislators, schedules of committee hearings, including their members, and emailing calls-to-action communication when matters of interest arise.

MSMA member and Representative Jon Patterson, MD, will receive the MSMA Legislator of the Year award.

On the national level, MSMA signed on with 83 other national and state medical societies and organizations to register strong opposition to the "Improving Care and Access to Nurses Act" which would endanger the quality of care that Medicare and Medicaid patients receive by expanding the scope of practice for non-physician practitioners.

President George Hubbell, MD, has represented the MSMA at the annual meetings and installation of officers of the Kansas City Medical Society, St. Louis Metropolitan Medical Society, and Greene County Medical Society. He attended the Missouri Hospital Association's annual meeting and participated in the AMA's Interim Meeting in November. He also spoke on advocacy and MSMA efforts at the Bothwell Medical Staff meeting in Sedalia.

Membership

Alexander Hover, MD, reported an increase of nearly 3% in active membership over last year, and 13.6% increase for overall membership. Resident members have nearly doubled.

Committee on Council Representation

Council Chair David Pohl, MD, presented a proposed resolution to reconfigure and re-design new councilor districts with proportionate numbers in each. The proposed districts seek to combine members while maintaining the current council size. The resolution was approved and will be proposed at the MSMA Annual Convention in April.

Thank You to Our 2023 Sponsors!













Council Actions, continued

Constitution and Bylaws

Dorothy Munch, DO, reported that the Committee discussed Chapter 3, Section 1, of the MSMA Bylaws, which addresses the deadline for submitting resolutions for consideration by the HOD, as well as the introduction of late resolutions from the floor. Since resolutions are now submitted online rather than via U.S. mail, this section is antiquated. The section also needs to be amended because resolutions are now posted online for member comments, and late resolutions do not receive sufficient online scrutiny.

The Committee's recommended resolution requires future resolutions to be submitted to the MSMA office 21 days before the HOD meeting and eliminates the late resolution process currently outlined in the Bylaws. In accordance with current Bylaws, only resolutions of good wishes, condolences, congratulations, etc., will be considered after the 21-day deadline.

Education & Annual Convention

The 2023 Annual Convention will open on Friday, March 31, with a General Session starting at 4:15 pm.

All attendees at the General Session will receive two drink tickets to the complimentary Convention Opening Reception at 5:30 p.m. Everyone is welcome! Members are encouraged to bring a non-member colleague!

Physicians Health Program

John Cascone, MD, reported that MPHP has videos posted on its website, which will also be shared via mass emails, that outline what MPHP provides in terms of treatment and support of alcohol, substance abuse and mental health disorders.

Alliance

Sana Saleh, Alliance President, reported that the Holiday Sharing Card program raised more than $6,200 for the MSMF scholarship fund. She thanked all who contributed.

Reports

Other reports that were approved included those of the MSMA Insurance Agency, the Committee on Publication and Editorial Board, and the MSMA Delegation to the AMA.

MSMA and MAOPS are hosting a physician wellness seminar at Lake of the Ozarks, October 20-22. Topics and speakers are being finalized. There will be activities for families and support for those who bring children. **MM**

Reports of the Delegate Handbook: 2022-2023

Report of the Secretary

The Missouri State Medical Association had 4,099 members at the end of the 2022 dues year (August 31, 2021). This was a net gain of 84 members from our membership of 4,015 as of August 31, 2021. Following is a breakdown according to classification.

Year	Students	Residents	Active	Honor	Total
2021	1,457	382	1,882	294	4,015
2022	1,578	387	1,859	275	4,099

The number of member deaths reported during 2022 totaled 10.

The Committee on Nominations, which is appointed by the President, from the House of Delegates, must submit nominations for the following offices:

Three Vice Presidents to fill the expired terms of Keith Frederick, DO, Rolla; Karen Edison, MD, Columbia; and Stuart Braverman, MD, Sedalia.

Speaker and Vice Speaker to fill the expired terms of Tim Swearengin, DO, Springfield, and Laurin Council, MD, St. Louis.

Three Delegates and One Alternate Delegate to the AMA to fill the vacancies created by the expiration at the conclusion of the 2023 Annual Convention of the terms of Delegates: Elie Azrak, MD, St. Louis; Betty Drees, MD, Kansas City; Charles Van Way III, MD, Kansas City; and Alternate Delegate: Nikita Sood, Washington University (one-year term). The new two-year terms will begin at the conclusion of the 2023 MSMA Annual Convention and end at the conclusion of the 2025 MSMA Annual Convention.

The terms of the following Councilors will expire in 2023: 1st District – Robert Corder, MD, St. Joseph; 2nd District – Hossein Behniaye, MD, Hannibal; 3rd District – David Pohl, MD, Town and Country; Robert Brennan, Jr., MD, St. Louis; 4th District – Kevin Weikart, MD, Lake St. Louis; 6th District – David Kuhlmann, MD, Sedalia; 7th District – Betty Drees, MD, Kansas City; 8th District – Brian Biggers, MD, Springfield; 10th District – Dorothy Munch, DO, Poplar Bluff; Organized Medical Staff Section – Amy Patel, MD, Kansas City; Women Physicians Section – Tammara Goldschmidt, MD, Ballwin; Young Physician Section – Sara Hawatmeh, MD, Ballwin; Resident and Fellow Section – Christina Kratschmer, MD, St. Louis; Medical Student Section – Alex Shimony, Washington University.

The terms of the following Vice Councilors will expire in 2023: 1st District – Chakshu Gupta, MD, St. Joseph; 2nd District – Barbara White, DO, Hannibal; 4th District – Keith Ratcliff, MD, Washington; 6th District – Jennifer Conley, MD, Nevada; 8th District – Timothy Swearengin, DO, Springfield; 10th District –Rachel Kyllo, MD, St. Louis; Organized Medical Staff Section – Albert Hsu, MD, Columbia; Women Physicians Section – Carlin Ridpath, MD; Young Physician Section – Marc Mendelsohn, MD, St. Louis; Resident and Fellow Section – Anup Bhattacharya, MD, St. Louis; Medical Student Section – Maddie Sauer, University of Missouri-Columbia.

Members shall meet virtually or by email prior to the Annual Convention to elect the Councilors and Vice-Councilors for their respective districts and sections. The election shall be certified to the House of Delegates on the prescribed form which will be furnished.

The House of Delegates will hold its first session on Saturday, April 1, at 8:30 a.m., and its second session on Sunday, April 2, at 8:15 a.m.

Registration will take place online at https://www.msma.org/event-4941485/Registration, and in-person at the Annual Convention from 3:00-6:00 p.m. on Friday, March 31, and 6:30 a.m.-5:00 p.m. on Saturday, April 1.

Report of the Treasurer

The report of the Treasurer which includes the Financial Statements will be published in future edition of *Missouri Medicine*.

Report of the Executive Vice President

You should be proud that your Missouri State Medical Association is widely recognized as the voice of medicine in Missouri. Be it the Missouri General Assembly, the countless governmental bureaus and

agencies, the business community, the insurance industry, hospitals, advocacy groups, or the media, MSMA is considered the leading advocate for your profession and your patients. Following is just a sample of the many things your MSMA did for you in 2022.

State Legislative Activities

Your MSMA lobbyist team enjoyed a very good year in the state Capitol in 2022. They are quick to credit you and your MSMA colleagues with much of that success, not only for your active involvement in the political process, but also for the respect you command in your community. MSMA is involved in more legislative healthcare issues than any other organization in the state; everything from scope of practice to tobacco, and tort reform to Medicaid expansion. Your lobbyists are among the first to arrive at the Capitol every morning, and among the last to leave at night. Their diligence and effectiveness is unsurpassed. Rather than overwhelm you with details on the myriad bills and issues they work on, I'll refer you to our weekly Legislative Report and 5 Things MSMA Members Need to Know About the State Legislature, which members receive during the legislative session. If you are not reading these e-publications, you're missing out.

Other Notable Activities

Despite only having the resources and numbers of a smaller-sized state medical association, your MSMA is one of the most diverse and active state organizations in the nation. Here are just a few of the activities undertaken on your behalf over the last year.

Your President and MSMA staff were able to attend a number of local society meetings across the state. From Nevada to Washington, and from St. Joseph to Joplin, your leadership and staff continue to make themselves available to every local society, no matter how large or small.

MSMA boasts an outstanding group of member physicians who give the better part of a week twice a year to represent you and your patients in the AMA House of Delegates. It is thankless work at times, but there is not a better AMA delegation than yours. Please thank them. In 2022, both national AMA meetings were in-person, after a long hiatus due to the pandemic.

MSMA was vocal in its support for local public health authorities during the pandemic in 2022. Staff also worked tirelessly participating in COVID data, testing, and vaccine distribution meetings.

In addition to its regular duties, your MSMA staff also provides top-rate administrative services for other medical societies, and serves on or maintains liaison with a large number of external governmental and private-sector committees, task forces, boards and commissions.

Membership Services and Benefits

Your MSMA staff and leadership are constantly striving to bring even more value to your membership. One constant priority is to improve communications with our members and respond more quickly to answer questions and resolve issues. We encourage you to visit the MSMA website often. More content is constantly being added, with more timely information to help you and your office staff. Two years ago, MSMA migrated to a new and improved website, and a new user-friendly membership database. Also, you can now pay membership dues online and access our membership database to search for your physician colleagues.

Missouri Medicine, MSMA's outstanding award-winning scientific journal, is free to you with your membership. It now is published in digital format as well as the traditional paper copy. One of the most important reasons for Missouri Medicine's national reputation and ability to attract quality manuscripts and have academic departments eagerly commit to producing our signature theme issues is our global footprint via MEDLINE, PubMed, PubMed Central, Scopus Elsevier, EBSCO, and now ProQuest databanks. You can find current and archived electronic editions on our website.

Progress Notes, our monthly newsletter (free to members), is chock-full of timely news items, tips, and information. An electronic version, e-Progress Notes, is also distributed monthly by email.

MSMA also offers you free CME credits at the Annual Convention every year, and numerous other opportunities to earn CME through our statewide CME recognition program. MSMA accredits 20 entities to offer CME, many of which participate in joint providership across the state. Yet another membership benefit.

I would ask you to also be mindful of the more direct benefits your MSMA membership offers. For example, we are partners with Moneta, an outstanding financial services firm that provides MSMA members

with expert financial planning and investment services. SHINE is a health information exchange (HIE) which facilitates electronic medical records software sharing clinical information with other EMRs in addition to providing assistance with MIPS compliance. We also have a relationship with the Resolve Physician Agency, which offers a wide range of career services, including job placement, contract review and negotiation, practice evaluation, benefits analysis, debt management, and a lot more, all at a discount to MSMA members.

MSMA's Affiliate Organizations

Your Missouri State Medical Foundation has loaned more than $11.8 million to Missouri medical students since its inception more than fifty years ago. The Foundation board made the decision in 2017 to cease its loan program due to the number of private lenders in the market. The focus is now on scholarships for Missouri medical students. In 2022, MSMF awarded $300,000 in scholarships to 60 medical students at all six of the allopathic and osteopathic medical schools in the state. And the Foundation offers $5,000 matching funds to local medical societies to create scholarships for medical students. Physicians are now able to donate to the Foundation on the MSMA website.

Your Missouri Physicians Health Program is widely considered one of the most successful of its kind in the nation. Last year the program served 74 physicians who are dealing with chemical, emotional, or behavioral issues. You can assist your colleagues by asking your hospital medical staff and administration to contribute funds to this exceptional and vitally important program.

Your Missouri Medical Political Action Committee is one of the most respected and effective association PACs in the state. In the last election cycle MMPAC contributed close to $130,000 to support physician-friendly candidates across the state. Membership begins at the $100 Sustaining Member level, but you can demonstrate your political savvy by upgrading to one of the Super levels: Silver ($250), Gold ($500), or Diamond ($1,000). Of course, any amount is appreciated. You can now donate to MMPAC through PayPal or the MSMA website. Your participation is essential to our political effectiveness.

Your MSMA Insurance Agency was formed by MSMA and is directed by physicians to serve you and your practice. This independent insurance agency is a trusted source for all lines of insurance, and provides some financial support for MSMA. Please visit the Agency's website for more information.

The MSMA Alliance has dedicated and enthusiastic physician spouses who work tirelessly to promote health education and support health-related charitable activities, all aimed toward improving the health and welfare of all Missourians. And they are a force to be reckoned with when they march on the Capitol every year to advance medicine's legislative causes. They are also a great group of fundraisers for the MSMF.

Your Organization

It is nearly impossible to list all of the duties and services MSMA provides for the physicians of Missouri. The advocacy and representation, the publications, the CME, the Foundation, the Physicians Health Program, the Alliance, and your AMA Delegation all cumulate in an organization deeply rooted in service to its members and the patients they serve. The MSMA is YOUR organization, and your officers and staff welcome your thoughts on how best to serve you and your fellow members. Feel free to seek them out – at this convention or at any time – and share your ideas.

Heartfelt Thanks

On behalf of the staff and the entire MSMA membership, I want to express undying gratitude for your officers, councilors, committee members, and other leaders who give so much of their time and resources for the betterment of the Association and patient care in Missouri. They are nothing short of extraordinary.

I also want to express my appreciation for allowing me to work with talented and dedicated MSMA employees whose creativity and diligence are unmatched anywhere. Lizabeth Fleenor, the Director of Communications, is the managing editor of your award-winning *Missouri Medicine* and *Progress Notes*, designs all the MSMA pamphlets and logos you see, and oversees MSMA's website. Benita Stennis, the Director of Operations and Education, does all of our meeting planning – including the Herculean task of organizing the Annual Convention – and also directs all of the impressive CME programming. Our Executive Services Specialist, Cheri Martin, keeps the office running like a well-oiled machine, day in and day out. She also manages MMPAC's day-to-day activities,

as well as MSMF and MSOA, and she serves as liaison to the WPS, IMG and YPS sections. Cassie Williams, the Membership Data & IT Specialist, tends to our complicated member database and coordinates all the membership billing and mailing for MSMA. She's the one you want if you need to know if someone has paid their dues. Carol Meyer, the Administrative Assistant, is that invaluable team member who can play any position. She spends a lot of time helping with the meeting planning and CME activities, but she's the go-to person when anybody on staff needs a little extra help.

And finally, please allow me to thank you, the physicians of Missouri, for the opportunity to serve you in this outstanding organization.

Report of the Alliance

One Hundred and One! is the age of our national Alliance that was born here in the heartland in St. Louis, Missouri, in 1922. We celebrated its centennial last June in Chicago with a grand gala recalling the history of various decades.

Two counties from Missouri received national awards last year: Greene County for its successful "Physicians' Family Day" at the Dickerson Zoo in Springfield, MO, attracting more than 300 participants including physician families. The second award was granted to the St. Louis Medical Society Alliance for their Hungry Heroes project, where they distributed 250 bags filled with nutritious treats to frontline workers – ED, ICU, Security and EMS staff. The St. Louis project continues to expand and has served more than four hospitals since its inception with a total of 1,000 bags, most recently at Mercy South. St. Anthony's Hospital honored our very own Edmond Cabbabe, MD, and his wife Rima, in celebration of Doctors' Day this year.

Since June of last year, your Missouri Alliance has provided a $500 grant to North Kansas City Hospital to promote the Stop the Bleed program. Buchanan County continues to distribute its SAVE (Stop America's Violence Everywhere) handbooks to its school districts to educate and teach non-violence to school age children.

In addition to its Family Zoo event in August, Greene County holds another family event in February at the Discovery Center to bring medical families together with a successful attendance in place.

The Kansas City Metro Alliance continues with its pillowcase dress health project that has shipped more than 50 dresses a year since 2014 to port cities overseas to help support preventive measures to keep young girls safe from human trafficking. The Alliance also grants $3,000 in scholarships annually to allied health professionals, mostly nursing students who exhibit academic excellence and financial need. The boutique that takes place during the holiday luncheon raises money to support our local charities.

On the state level, the MSMA Alliance supports the six medical schools across Missouri during their Match Day or graduation ceremonies providing pizza and gifts for soon-to-be-residents. Our Holiday Sharing Card raised more than $6400 this year and we hope to add more from this weekend to the MSM Foundation, providing scholarships to medical students.

Lizabeth Fleenor from MSMA office generously assisted us in improving our website that is under MSMA/alliance, making it more user-friendly, accessible, and resourceful for members. We also rebranded our "Show Me Alliance" Newsletter to a monthly digital version, with two printed annually.

We raised awareness on drug and human trafficking through educational presentations at our annual Fall Conference with special attention to Fentanyl poisoning that is killing 197 per day. We invited Auxiliary members from MAOPS to attend our conference on the campus of the Kansas City University.

In addition, we supported the House of Medicine during Physician Advocacy Day in February at Missouri's Capitol, and we will continue to support and promote physician families and the health issues that affect them.

In conclusion, as some of you know, national Doctors' Day was on Thursday, March 30th. On behalf of the MSMA Alliance, we would like to thank each of you for your hard work and dedication to the medical profession. As you exit the room, Alliance members will hand out lapel pins of carnations that represent Doctors' Day as a token of appreciation. If you want to know more about Doctors' Day, you can scan the QR code and

read how it was established. It was our very own Janet Campbell from Sedalia, whose husband was A.J. Campbell and an MSMA Past President, who helped establish a national Doctors' Day.

Thank you for your time and your support.

Commission on Continuing Education

The Commission reviewed and approved MSMA Provider Reaccreditation for Esse Health-St. Louis, MO and also approved the 2022 Annual Convention for 4.0 AMA PRA Category 1 Credits™.

Providers withdrawn from accreditation include North Kansas City Hospital-North Kansas City, MO, Greene County Medical Society-Springfield, MO, and Cape Girardeau Area Medical Society-Cape Girardeau, MO

MSMA staff applied for reaccreditation with the ACCME in July of 2021. In March of 2022, the ACCME rendered an accreditation decision. The MSMA received full accreditation for four years.

The Missouri State Medical Association currently accredits 19 entities statewide.

MSMA staff conducted new provider training at MSMA headquarters on Wednesday, February 16, 2022. Staff from six accredited entities attended the training.

MSMA staff attended the ACCME's Virtual Spring Meeting April 25-28, 2022.

The ACCME State Medical Society Meeting was held December 1-2, 2022, in Chicago, IL. MSMA staff and Hamsa Subramanian, MD, attended. The Standards for Independence and Integrity were reviewed in depth, and there was discussion regarding states establishing regional recognition bodies as recommended by the ACCME.

Additionally, staff and Commission members completed education sessions at their leisure via the online courses hosted on the ACCME Academy.

Commission on Medical Economics, Third Party Medicine and Governmental Relations

The Medical Economics Commission met via conference call on June 28, 2022, to discuss the 2022 MSMA Resolutions referred to the Commission. The Commission made the following recommendations to the MSMA Council, which were approved:

Resolution 2 – International Medical Graduate Employment

Mr. Chairman, although the original resolution contained only one resolved statement, we believe adding an additional resolved gives better direction to staff. The first resolved statement gives direction to MSMA and the second calls for submission to the AMA House of Delegates. Therefore, we recommend Council adopt the following substitute resolution:

RESOLVED, that MSMA acknowledge the administrative burden that accompanies the hiring of International Medical Graduates, especially in underserved and rural areas, and support federal efforts to lessen that burden; and be it further,

RESOLVED, that this resolution be submitted to the American Medical Association House of Delegates at their next appropriate meeting.

Resolution 10 – Improving Prior Authorization Process

Mr. Chairman, we believe this resolution establishes much-needed policy regarding prior authorization (PA). Although MSMA has historically been deeply involved in prior authorization issues at the capitol, MSMA has no written policy regarding this issue. We feel our substitute resolution is broad enough to give MSMA advocacy staff wide discretion, yet not so narrow as to exclude future PA issues. Therefore, we recommend Council adopt the following substitute resolution:

RESOLVED, that the MSMA support legislation to improve transparency and reduce the administrative burden of the prior authorization process to benefit patients and physicians.

Committee on Membership

The 2022 MSMA membership year closed with 1,859 active members (a 1.2% decrease from 2021), 387 residents, 1578 students, and 275 retired members. Membership has decreased 42% since the end of the 2014 dues year (August 2014).

Approximately 207 physicians have joined as new members so far in the 2023 dues year. In addition to traditional recruiting methods, there was a positive response to MSMA Councilors sending hand-signed letters to non-members. Peer-to-peer outreach is the most beneficial way to maintain and grow membership.

MSMA offered a "Summer Special" discounted membership rate in 2022 that attracted 88 new members.

MSMA recently adopted a new membership database system which includes a new website. It also allows for recurring credit card payments, a paywall for members-only content, and other membership-friendly characteristics.

With the pandemic travel restrictions being lifted, MSMA staff was able to participate in a number of events across the state in 2022, including medical school recruitment events.

In addition to our social media presence, MSMA hopes to attract more members through additional advocacy publications and events. We encourage all members to follow us on social media and share our posts.

Missouri Physicians Health Program

This has been a busy year as indicated by the number of referrals and the numerous Missouri physicians that were assisted. The MPHP provides a variety of services. This includes consultation, intervention, referral for treatment, monitoring and advocacy. The consultive service is especially active. Hospital administrators, physicians, colleagues and family members call the Program Coordinator or Clinical Coordinator to make a referral, discuss a potential referral or brainstorm about the necessity of making a referral. Information is often requested about how to identify problems, what services are available and how to handle issues of impairment should they occur. Many hours are required to meet their needs.

In this cycle, MPHP saw a total of 74 clients, covering 74 medical specialties, released 25 participants with the main contracts being recovery and mental health. The MPHP provides a safe and knowledgeable venue for any question or concern about physician health.

MSMA Insurance Agency

Your MSMA Insurance Agency is an independent insurance agency owned and directed by MSMA. The Agency offers policies for professional liability, individual and group health, workers compensation, business office coverage and individual disability and life.

The Agency has been in operation for over 20 years. In that time the Agency has been able to contribute back to the MSMA to help offset cost to the members, while also finding the best coverage and cost for our policyholders.

The board is supportive of the Agency and encourages all MSMA members to contact the Agency for a no obligation quote for any of their insurance needs.

Missouri State Medical Foundation

The Foundation has made more than 3,000 medical school student loans over the past 52 years, totaling nearly $12 million. The loan program has been closed and the Foundation funds the MSMA scholarships that have been awarded over the past 17 years.

In 2022, the Foundation awarded $5,000 MSMA scholarships to ten Missouri medical students at each of the six medical schools.

Last year, 60 Missouri medical school students received $300,000 in MSMA scholarships. This gives the Foundation a cumulative scholarship total of $1.87 million awarded to Missouri natives who are attending a medical school in Missouri.

The Foundation has also matched funding up to $5,000 for local medical society scholarships. The MSMA Alliance has been an important partner to the Foundation through generous fund-raising activities, contributing nearly $8,000 in 2022.

Committee on Publication

Volume 119 of *Missouri Medicin*e published original research, up to date scholarly reviews, and analysis of important individual and public health matters. This volume published five issues featuring "theme" articles and one issue presenting an interesting variety of scientific topics and micro-series. It contained 564 pages and a record number of 59 scientific articles.

In Volume 119, the Journal published two First Literature Reports, two Feature Reviews, and continued to focus on the COVID-19 Pandemic. David S. McKinsey, MD, and Joel P. McKinsey, MD, MSMA members, along with others, authored the definitive two-part history of COVID-19 in Missouri.

*Missouri Medicin*e in multiple articles focused on the poison pill public health crisis suggesting methods to reduce the 100,000+ deaths/year from fentanyl, meth, and other deadly, addicting drugs.

We are what we eat. Popular diets were scrutinized in a series of articles from UMKC and Children's Mercy Hospital. Several of the Journal's articles were reprinted by other state medical associations and newspapers.

Continuing an encouraging trend, the Journal received its highest number of unsolicited articles. The acceptance rate for unsolicited manuscripts is about 30%. We have the longest publication queue of high-quality papers in our 118-year history. The Journal has an international footprint and manuscripts were submitted from several foreign countries. Our theme issues are fully subscribed through July/August 2024. Theme issues have regular contributions from faculty at the four allopathic and two osteopathic medical schools in Missouri.

In 2022, the Journal was invited to be indexed by ProQuest Health & Medical Collections/EBSCO Information Services. ProQuest is a comprehensive medical information resource for researchers, students, faculty, and healthcare professionals. In addition to biomedical content from MEDLINE, the collection aggregates content in all forms of media to support the learning, teaching, and research needs of institutions. This includes medical reference eBooks, instructional videos, dissertations, and working papers. Missouri Medicine is indexed by all the world's leading data banks and archived at PubMed Central.

Our thanks to the Contributing Editors and Publications Committee for their outstanding work: Justin M. Albani, MD, Betty M. Drees, MD, David A. Fleming, MD, Arthur H. Gale, MD, Emily A. Hillman, MD, William R. Reynolds, DDS, MD, and Charles W. Van Way, III, MD.

We welcomed Amy Cabbabe, MD MMSc, FASA as a new Contributing Editor, replacing Jeffrey Copeland, MD. We thank Dr. Copeland for his work on the Journal and as a former MSMA President.

Missouri Medicine announced the retirement, resignation, or relocation out of state of the following esteemed Editorial Board Members: David H. Cort, MD, Gastroenterology; Jonathan M.T. Bath, MD, Vascular Surgery, Christopher R. Carpenter, MD, MSc, Statistics and Methodology, Howard M. Rosen, MD, FACE, ECNU, Endocrinology, Jose M. Dominguez, MD, Colon and Rectal Surgery; and Evan S. Schwarz, MD, Toxicology and Addiction Medicine.

*Missouri Medicin*e welcomed the following eminent physicians to the Editorial Board:

Sanjay K. Havaldar, MD, Gastroenterology, Scott Kujath, MD, FACS, FSVS, Vascular Surgery,

Jeffrey F. Scherer, MA, PhD, Statistics and Methodology, Sherry X. Zhou, MD, PhD, Endocrinology, Erik M. Grossmann, MD, Colon and Rectal Surgery; and Douglas M. Burgess, MD, Toxicology and Addiction Medicine.

Missouri Medicine would like to publicly thank the following invited non–Editorial Board experts who did peer-review of submitted manuscripts in 2022: Phillip Boysen, MD, An–Lin Cheng, PhD, John Daniels, MD, James J. DiNicolantonio, PharmD, Sean Gratton, MD, Charles M. Lederer, MD, Louis S. Martone, MD, David McKinsey, MD, Lenard Politte, MD, Rithwick Rajagopal, MD, Gloria Seo, MD, Eric A. Voth, MD, and Melissa Toyos, MD.

The Publication Committee and its Editor/Chair commends Lizabeth R. S. Fleenor, BJ, MA, for over two stellar decades as Managing Editor. Her commitment and expertise have been a major factor in the ascension of *Missouri Medicine* to national prominence.

The Publication Committee Chair and Editor, John C. Hagan, III, MD, and Managing Editor, Lizabeth Fleenor, BJ, MA, appreciate the many contributions of the MSMA, its leadership, Alliance and active members and others. The Publication Committee appreciates the Association's continued support of the Journal. By any objective criteria *Missouri Medicine* is among the top three state medical society journals in the United States. **MM**

2023 Annual Convention Attendance

Delegates	*73*
Members	*68*
Staff	*10*
Guests	*54*
Officers	*7*
Councilors/Vice	*30*
Alliance	*18*
Total	*223*

(Actual numbers will not balance due to overlaps in positions served.)

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Elie Azrak, MD
Martha Council, MD
Keith Frederick, DO
Lancer Gates, DO
George Hubbell, MD
Margaret Ellen Nichols, MD
Tim Swearengin, DO

COUNCILORS
Hossein Behniaye, MD
Brian Biggers, MD
Robert Brennan, Jr., MD
Louis DelCampo, MD
Betty Drees, MD
Tammara Goldschmidt, MD
Christina Kratschmer, MD
David Kuhlmann, MD
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Tom Weigand, MD

District 2
Barbara White, DO

District 3
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Edmond Cabbabe, MD
Martha Council, MD
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George Hruza, MD
Ravi Johar, MD
Jennifer Page, MD
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Jeffrey Thomasson, MD

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Navin Choudhary, MD
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Matthew Meier, DO
David Poggemeier, MD
Keith Ratcliff, MD
William Sill, DO
Ngozi Wilkins, MD

District 5
Peggy Barjenbruch, MD
Joseph Corrado, MD
Milamari Cunningham, MD
Albert Hsu, MD
George Hubbell, MD
Jerry Kennett, MD
Jennifer Powell, MD

District 6
Warren Lovinger, Jr., MD

District 7
Justin Albani, MD
Thomas Allen, MD
Richard Butin, MD
Samuel Caughron, MD
Blake Cooper, MD
Doug Dehning, MD
James DiRenna, Jr., DO
Sarah Florio, MD
Lancer Gates, DO
Nicholas Golda, MD
John Hagan, MD
Randolph Jackson, MD
James Overlease, MD
Kevin Skelsey, MD
John Stanley, MD
Jonathan Tovey, MD
Charles Van Way, II , MD

District 8
James Blaine, MD
John Cascone, MD
Norman Knowlton, III, MD
Margaret Ellen Nichols, MD
William Reynolds, MD
James Rogers, MD
Tim Swearengin, DO
James Wolfe, MD

District 9
David Barbe, MD

District 10
Kirby Turner, MD

Kansas City University
Charlie Adams
Bethany Baumgartner

University of Missouri-Columbia
Mikala Cessac
Lacey Raper

University of Missouri-Kansas City
Dharti Patel
Satyanarayanan Sivasankar

Washington University
Hannah Lynn

International Medical Graduate Section
Raghuveer Kura, MD

Resident & Fellow Section
Julia Dmowska, MD
Salil Kulkarni, MD
Rachana Raghupathy, MD
Kaitlyn Reichl, MD
Kelly Schmidt, MD

Women Physicians Section
Carlin Ridpath, MD

Young Physician Section
Rachel Kyllo, MD
Marc Mendelsohn, MD

DELEGATES AT LARGE
Past Presidents
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Edmond Cabbabe, MD
Jeffrey Copeland, MD
Joseph Corrado, MD
James DiRenna, Jr., DO
George Hruza, MD
George Hubbell, MD
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Norman Knowlton, III, MD
Warren Lovinger, Jr., MD
John Stanley, MD
Jeffrey Thomasson, MD
Charles Van Way, III, MD
James Wolfe, MD

Speaker
Tim Swearengin, DO

Vice Speaker
Martha Council, MD

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Sequential pulses to a polyp ignited a

surgical fire

in the patient's airway.

Surgical fires were among the 10 most common sentinel events reported by hospitals to the Joint Commission in 2021.*

If a sentinel event happens and a ProAssurance insured is involved, they have direct access to medical liability claims specialists and risk management consultants with experience navigating these types of malpractice claims.

We've seen the worst you can imagine and have the expertise to help reduce risk and ensure a vigorous defense from day one. The principle of fair treatment guides every action we take in defense of our physicians and healthcare providers.

PROASSURANCE®
Treated Fairly

Healthcare Professional Liability Insurance & Risk Management Services

* The Joint Commission, *Sentinel Event data released for first 6 months of 2022*. Visit: **bit.ly/3zzsloj**

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Introducing
A Malpractice Program

FOR BOARD CERTIFIED PLASTIC SURGEONS IN MISSOURI

MSMA – together with MedPro Group – has worked diligently to provide an industry-leading healthcare liability solution for Board Certified Plastic Surgeons.

Carrier Highlights:

- MedPro Group has an A++ (A.M. Best) financial strength rating
- Local defense provided by Missouri legal experts and claims managers
- A Berkshire Hathaway company that has defended physicians since 1899

Highly competitive rates matched with industry-leading coverage

- Prior acts coverage available: no tail purchase required to participate in program
- Free retirement tail after one year of coverage, regardless of age
- $50K cyber liability coverage at no additional charge
- Available policy types: Claims-made, Occurrence, and Convert to Occurrence®
- Comprehensive risk management solutions including on-site risk consultations, online courses, and free assessment tools

Reach out to Mary Hogan to find out why MedPro is the best fit for you.

Mary Hogan
MSMA Insurance Agency
636.922.9201 | 866.676.2467

A.M. Best rating as of 7/14/2022. Standard & Poor's rating as of 9/29/2021. All data is derived from MedPro Group records and calculations; claims data range is 2012-2021 unless otherwise indicated. In order to qualify for a free tail, you must have a retroactive date at least 48 months prior to the date of retirement and be insured by the company for 12 months on a mature Claims-made policy. MedPro Group is the marketing name used to refer to the insurance operations of The Medical Protective Company, Princeton Insurance Company, PLICO, Inc. and MedPro RRG Risk Retention Group. All insurance products are administered by MedPro Group and underwritten by these and other Berkshire Hathaway affiliates, including National Fire & Marine Insurance Company. Product availability is based upon business and/or regulatory approval and may differ among companies. © 2022 MedPro Group Inc. All Rights Reserved. MW-220858