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Submissions to the November/December 2019 Newsletter should be received by the Chapter office no later than November 20, 2019.
FROM THE PRESIDENT

I want to address firearm violence and how it affects us not only as citizens—but also as emergency physicians in the state of Michigan. I know well how controversial this issue is to discuss; I’m sure some of you are on edge already waiting to see if I’m advocating for changes you support or oppose. Which camp is Lanphear in?

First of all, I will make the disclaimer that this column reflects my views and is not a position paper for the Michigan College of Emergency Physicians. I do want to make the case for taking action as physicians to help prevent this disease. I hope most of you are as tired as I am of our societal polarity that makes us proud to be oppositional. I think we can swallow some pride and work together to find solutions that are successful.

When I look for common ground on preventing gun-related mass casualty incidents, I see well-meaning people caught in a no man’s land. There seems to be great political and personal risk out there in the middle.

Do we need more weapons in the right places? Can we get rid of the wrong weapons and identify the wrong people to have weapons? The Second Amendment to our Constitution is not the problem, but neither is it the solution. We are cautioned by many not to make an emotional or political response to mass casualty events. But we know these debates fade away as the tragedies become history.

What should we do as organized emergency physicians in the state of Michigan? Do we just decry the violence and wait for solutions to be found outside organized medicine? I don’t believe that is the right approach. Gun violence is a disease because it is trauma. We must advocate for prevention. What can we do to help prevent this disease?

ACEP has a Firearm Safety and Injury Prevention policy statement revised and approved by the Council in 2013. It isn’t about taking the gun out of your hands and it’s not about arming more people. The policy advocates for further research, improved access to mental health services, firearm safety discussions with patients, improved technology to make firearms safer, universal background checks, and restricting access to military weapons. Furthermore, ACEP supports studying Gun Violence Restraining Orders and Extreme Risk Protection Orders. There are two resolutions to be debated at the 2019 ACEP Council meeting: one regarding further support of a public health approach to firearm violence, and the other involves gun violence and intimate partner violence. This should remind us that firearm violence is not just a mass casualty problem, but its prevention involves saving lives at the individual level, as well.

We must find common ground to prevent this disease. Our country has become polarized on so many issues. We must not let firearm violence divide us so that this disease continues unchecked. If research reveals measures that are effective to reduce gun violence, then we must be strong and support them. It’s no different than advocating for seat belts, airbags, and motorcyclist helmets. I am concerned with you that it is just a matter of time before one of our Michigan cities has its name attached to a firearm tragedy. We will be ready to treat the casualties, but we should be working to prevent them. The lives we save may be among our families, our friends, and our coworkers. §

Warren Lanphear, MD, FACEP

MCEP Calendar of Events

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November 19, 2019

TRAIGHT TALK

The Johnson Center
Howell, MI

This course presents valuable information and updates for emergency physicians, billing and coding professionals, and group managers. Two tracks are offered: Advanced Professional Coding Track and Physician/Administrative. Lunch offers unstructured time to interact with peers and to share information about the dynamic reimbursement environment.
IN DEFENSE OF NALOXONE

As I continue to learn about the values of the Michigan College of Emergency Physicians, I am struck by the participation in social justice and advocacy activities on behalf of our specialty and our patients. It is with this aim in mind that I reflect on the care that I delivered to a drug addict.

He was a 25-year-old male who presented to the emergency department with a GCS of 3. His pupils were pin-point, his lips blue, and his respiratory rate was 9 breaths per minute. As we looked for an IV site, we noticed a tattoo of a child’s face on his forearm and track-marks in his antecubital fossae. Within seconds of placing a line and administering naloxone, he was revived.

Staff members of an emergency department are accustomed to the Lazarus-like effect that naloxone has—the drug can convert a patient who is agonally breathing and quickly return him to consciousness by competitively antagonizing the mu opiate receptors in the central nervous system. The drug is indispensable, especially in light of the continuing Opioid Crisis.

He told us that he wasn’t trying to kill himself; that he was trying to get high. After completing his third stint in rehab, and after 90-days sober, he had relapsed and he was not interested in medication-assisted treatments like buprenorphine - he just wanted to go home. Yes, he understood that he came in to the emergency department near-death. And yes, he understood that next time it might be too late.

I prepared his discharge paperwork, provided him with a shamefully outdated list of substance abuse and rehab centers, and discharged him. Documenting later that night, I felt a pit in my stomach as I realized that I had forgotten to prescribe him naloxone—addiction is a chronic disease and relapses are common. When this happens again, I had left him without a life-line.

While naloxone is available at 1500+ pharmacies in Michigan as a standing order (House Bill 5326 passed in 2017), I wish I had discussed this medication at length: how it can be prescribed by the pharmacist and that the patient does not need to be known by the prescriber; that it can be administered by non-medical personnel intranasally (IN) or intramuscularly (IM); how the cost ranges from $7 (IN) to $60 (IM) and that it’s covered by many insurers.

I could not cure his addiction, so at the very least, I should make it less deadly for him to keep using.

Or would prescribing naloxone make him sicker? Some argue that this harm reduction method has had an adverse effect. Doleac and Mukherjee published, “The Moral Hazard of Lifesaving Innovations: Naloxone Access, Opioid Abuse, and Crime,” in March 2019. Their study attempts to draw a causal relationship between the availability of naloxone and an increase in opioid-related emergency department visits, theft, and mortality. In other words, as naloxone becomes ubiquitous, people with opioid addictions will engage in riskier behaviors. Their study has been widely criticized based on methodology and has been sited as an example of the cautionary mantra: “correlation does not equal causation.”

While the study was flawed, I wanted a vocabulary and evidence to refute the skeptics of out-of-hospital naloxone administration. “Preventing Opiate Overdose Deaths: Examining Objections to Take-Home Naloxone,”

1 Walley AY, Xuan Z, Hackman HH, et al. Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis. BMJ. 2013;346:f174
2 Community-Based Opioid Overdose Prevention Programs Providing Naloxone—United States, 2010. JAMA. 2012;307(13):1358-1364. doi:
BUDGET BATTLES DOMINATE THE CAPITOL

Governor Gretchen Whitmer proposed her budget in early March of this year, and legislative Republicans sent her their version in late September. The last week of September started with a fervor of activity as Governor Whitmer leveled an unprecedented volume of vetoes throughout the 2019-20 Fiscal Year budget, and then moved more than $620 million in inter-department transfers via approval of the State Administrative Board. The State Administrative Board is typically used for approving contracts and hasn’t been used since the early 1990s as a budgeting tool, but it was Governor Whitmer’s last use of leverage to reboot the budget discussions.

Most of the vetoes and transfers were on one-time road spending items. However, health care did get caught up in the budget mess as funding for rural hospitals was slashed and Autism funding eliminated. The Governor’s motive with the cuts was to force Republicans to the bargaining table again. Republican leadership has yet to take that bait and instead insisted that the budget was done, and the Governor can “own” the programs she’s vetoed, mainly the Autism funding and Pure Michigan vetoes.

The process of restoring the vetoes has already begun, albeit slower than most would like. Governor Whitmer called a “quadrant” meeting where the leaders of the four legislative caucuses gather to discuss items of significance to the state. There was not a lot of talk about fixing the budget holes created by the vetoes, but there was some agreement to work together on items of common interest, such as criminal record expungement, raising the age for trying youths as adults, and some gaming issues. Discussion of a supplemental budget to restore the vetoed items has not begun publicly, but many legislators are anxious to close out the budget cycle that began October 1st.

While these budget issues may seem like inside baseball to many, they are of interest to MCEP members as the vetoes have impacts on health care in the state, particularly in rural areas. The ongoing budget saga also distracts the legislature from dealing with other issues of importance to our members.

“SURPRISE BILLING”

Lots of attention has been given to this issue at the federal level, but given the gridlock in D.C., commercial insurers have taken this fight to the state houses as well. Michigan has had multiple bills in play since late spring. MCEP is working with other healthcare providers to help educate legislators on the topic, and fight back against the insurance companies trying to regulate contract terms between providers and insurers. We expect a committee hearing to take place this fall, so please stay tuned to MCEP for updates and calls to action.

VIOLENCE IN THE EMERGENCY DEPARTMENT

As the frequency of violence in the healthcare workplace continues to grow, MCEP still discusses this topic with lawmakers in the Michigan House and Senate. We are arranging for tours of hospital emergency departments throughout the fall, so if you have any interest in hosting your local state representative or senator, please reach out to the MCEP offices.

LEADERSHIP DEVELOPMENT PROGRAM

We are looking for individuals who have demonstrated a commitment to emergency medicine and who have great potential for growth.

The Leadership Development Program, developed by the Michigan College of Emergency Physicians, will combine elements of mentoring, organizational education, skills training, and guided experiences to selected participants.

Between 6-10 participants will be selected for the 2020 program year. This is a competitive process and the Leadership Task Force will carefully review each application that is received by the December 31, 2019 deadline.

Please visit our website, https://www.mcep.org/about-.../leadership-development-program/, for the Nomination Form/Application.

LEADERSHIP DEVELOPMENT PROGRAM

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There are two types of coding audits: internal and external. An internal audit is performed by an employee of the organization, whereas an external audit is performed by individuals outside of the organization. Both types of audits are necessary to ensure compliance with the ever-changing mandated medical coding guidelines that are in alignment with other groups of the same specialty. Internal audits are valuable to confirm that staff is following the current coding guideline practices established by the provider group. External audits tend to be more objective and can provide recommendations about broader industry standards. It is the responsibility of each entity to determine the frequency of both types of these audits. The frequency should be consistent and closely adhered to.

The focus of the audits should be on provider documentation and how that translates to proper E&M code designation. They should provide feedback on the completeness of the documentation and any concerning inconsistencies between providers and national best practice guidelines. Improper E&M code assignment or incomplete documentation can not only be a target of a potential payer audit, but it can also be a potential problem from a medicolegal standpoint.

The external audit can identify potential problems in documentation, as well as highlight areas that need improvement and provider education. Likewise, they can also identify proper documentation and compliance and alignment with similar practices. The external audit also specifically evaluates those ICD-10 codes, CPT E&M, procedural codes, and modifiers assigned after documentation. These audits also serve to safeguard the organizations compliance with local, state, national, and governmental payer regulations. Medical coding falls under the jurisdiction of CMS and the Office of the Inspector General (OIG). An external audit can alert an organization to potential “red flags” before a payer identifies a concern. A discovery of abuse or alleged fraud can carry risk of loss of reputation, financial penalties, and can result in significant legal ramifications including incarceration. In the event a payer identifies a particular issue with an organization, the organization can then use audit results to show due diligence in compliance and standard coding guideline practices.

Once the results of these audits are apparent to the provider group, it’s imperative that the group designate individuals to review the specifics. The first step is to determine if the group is in agreement with the results of the audit. If the audit and the coding team are in agreement, then it’s considered an internal error. If the audit and the coding team are in disagreement, or show a deviation from the current coding guidelines, then certain steps need to be initiated. A multidisciplinary group (clinicians, coders, administration) should review the variances and the auditor’s justifications for the claim. This group should then approach the auditor recommendations openly and determine if the provider organization wants to adopt the new recommendations. A follow-up discussion with the auditor will give the provider group and coding team an opportunity to discuss the variances and add further comfort/clarity before enacting change. If it is decided that the recommendations are to be adopted, then the coding team needs to be re-educated and re-audited. The providers will also require feedback and reeducation.

This is a lengthy process but could potentially be very beneficial from a financial, compliance, and medicolegal standpoint.

Don H. Powell, DO, FACEP
President- Medical Management Specialists
Michelle M Renis, CPC, CEDC, ICD-10
Director of Coding & Reimbursement- Medical Management Specialists

The Michigan College of Emergency Physicians offers this course to members and non-members as a one day option at the MCEP office for you to prepare and take the LLSA exams. The course allows for group participation while taking the on-line test. It is a great way to have fun and get it done!
ABSTRACT:
A pericardial effusion secondary to hypothyroidism is a rare phenomenon. A female patient presented to our Emergency Department (ED) with left flank pain and abdominopelvic CT demonstrated an incidental pericardial effusion. Bedside echocardiogram suggested mild RV diastolic collapse without cardiac tamponade. Subsequent laboratory analysis was significant for marked hypothyroidism. The patient remained hemodynamically stable so emergent pericardiocentesis was not indicated. She was initiated on high dose levothyroxine and her condition significantly improved without the need for surgical intervention.

CASE PRESENTATION:
A 37-year-old Caucasian female presented to our ED secondary to left lower flank pain. She characterized it as an achy pain of two weeks duration. She was evaluated in our emergency department one-week prior with similar symptoms, and at that time, a CT renal stone protocol was negative. On the day of return to the ED, her left flank pain became worse. Upon arrival to the ED, the patient had stable vital signs. Her medical and surgical histories were noncontributory. Physical examination was only remarkable for facial swelling, hair loss in the anterior scalp, and non-pitting edema in the bilateral upper and lower extremities.
Laboratories including CBC, BMP, liver, gallbladder, and pancreatic enzymes were within normal limits. Troponin was negative. Pregnancy and urinalysis were also negative. The 12-lead ECG demonstrated sinus bradycardia with a low QRS voltage. A CT abdomen and pelvis with IV contrast demonstrated a large pericardial effusion. The follow-up bedside echocardiogram was significant for circumferential pericardial fluid (Figure 2). The patient remained hemodynamically stable so a pericardiocentesis was not indicated.

Thyroid studies demonstrated TSH 145.1, FT4 0.14, Total T3 <10.0 ng/dL, Anti-thyroglobulin antibody was 272.8 U/mL, anti-thyroid peroxidase was >19000 U/mL. The patient was given a 100 mcg bolus of IV Levothyroxine in the ICU and remained hemodynamically stable. Cardiovascular surgery recommended medical management with thyroid replacement and consideration of pericardial window only if the effusion persisted.

**DISCUSSION:**

The normal pericardium is a fibroelastic pouch surrounding the heart. Between the myocardium and pericardium is approximately 50 mL of fluid that lubricates the beating heart and also acts as a barrier to prevent infection. Compared to serum, pericardial fluid has high LDH and protein content. The pericardial sac can hold 80 to 200 mL of fluid that accumulates acutely, and up to 2 L if the fluid accumulates gradually. Compared to serum, pericardial fluid has high LDH and protein content. The pericardial sac can hold 80 to 200 mL of fluid that accumulates acutely, and up to 2 L if the fluid accumulates gradually. A pericardial effusion develops when the fluid within the pericardial sac exceeds the amount that mesothelial cells can resorb.

Hypothyroidism is a rare cause of pericardial effusion. In a study by Sagrista-Sauleda et al, 322 patients with a mean age of 56 years were identified with a pericardial effusion. The most frequent etiologic diagnoses were acute/chronic idiopathic pericarditis (29%), iatrogenic effusion (16%), and cancer (13%). Hypothyroidism consisted of only 2% of the total (n=6). In a study by Strohbe et al with 269 patients, the most frequent etiologies were idiopathic (26%), malignancy (25%), and iatrogenic (20%). No subjects in that study had a pericardial effusion attributed to hypothyroidism. Hypothyroidism is a disorder of the endocrine system in which the thyroid gland does not produce sufficient thyroid hormone. Worldwide, a lack of iodine in the diet is the most common cause of hypothyroidism. However, in western countries, Hashimoto’s thyroiditis is most common. The main serological feature of Hashimoto’s is the presence of a high concentrations of anti-thyroid peroxidase (TPO) and anti-thyroglobulin (ATG) antibodies. Studies show that hypothyroidism is associated with detrimental effects on the cardiovascular system, including bradycardia, decreased cardiac output, and pericardial effusion. The incidence of pericardial effusion is 3-6% in mild cases of hypothyroidism, and increases to 30%-80% with severe hypothyroidism. This severe hypothyroidism causes increased capillary permeability, which allows more pericardial fluid to drain into the pericardial space, subsequent disturbances in electrolyte metabolism, and a disruption in fluid resorption by the mesothelial cells.

In the absence of hemodynamic compromise, the treatment of the underlying medical cause of pericardial effusion is indicated. Hashimoto’s thyroiditis is typically treated with T4 monotherapy (levothyroxine). Rasmussen et al and Ivy and Smolar et al documented several cases in which pericardial effusion from hypothyroidism recurred after pericardiocentesis and regretted only after thyroxine treatment was initiated. Pericardiocentesis is indicated emergently only if cardiac tamponade develops or hemodynamic instability ensues.

**REFERENCES:**

**CHOOSE A BUSINESS STRUCTURE**

Typically, there are two types of business entities that independent contractor physicians will choose from.

**Sole Proprietor:** The simplest choice for most single member emergency medicine practices. Set up federal tax ID, also known as an EIN, for business bookkeeping. (No additional set up is needed.)

**Limited Liability Corporation (LLC):** The LLC may also be considered. This structure provides flexibility with tax filing options. LLC’s can file taxes using different models: S-Corp, LLC or C-Corp. How do you decide? Review your options with a trusted CPA. Requirements and legislation vary from state to state. Ask your CPA also to calculate possible tax benefits for each option.

**SET UP A BUSINESS CHECKING ACCOUNT**

As an independent contractor, you are a business owner. Keep your business accounting separate from personal & household funds. Use your business checking account to deposit all paychecks and pay all business related expenses. When tax time arrives it will be much easier (and accurate) to tally up year end income and expenses.

**CALCULATE ESTIMATED TAXES**

**Year 1:** You are not required by the IRS to send in estimated tax payments your first year of business. However, it is in your best interest to save ahead for taxes. The entire tax bill will be due April 15th for the prior year.

**Years 2 +:** Your business now has an income track record. You are now responsible for sending estimated tax payments to the IRS each quarter. The first payment is due April 15th. (You owe BOTH prior year taxes and Q1 estimated taxes on April 15th.) Subsequent payments are due on June 15th, September 15th and January 15th. Make sure to include Social Security and Medicare taxes with your payments (often referred to as self employment taxes).

**SECURE HEALTH INSURANCE**

As soon as you leave your residency or fellowship, your health insurance terminates. You will need to secure your own health insurance. (If you are married, examine joining your spouse’s coverage.) You may use COBRA if you have a gap before your new coverage begins. Insurance options vary state to state. Consider joining a local small business association as they may offer health insurance packages to their members. This may provide a “group” option even when you are self employed. If you purchase your insurance privately, work with a local broker who can quote multiple carriers. Make sure your personal physicians are “in network”, compare deductibles, maximum out of pocket expenses, co-insurance percentages and availability of an H S A plan.

**EXAMINE H S A PLAN OPTIONS**

This is a tax free savings account option that is associated with high deductible health care plans. Please note: You must have a high deductible health care plan in the same year you fund the H S A. Typically, this a cost saving option for the self employed. Contributions are fully tax deductible, growth within the plan is tax deferred, and withdrawals for eligible medical expenses are tax free. The funds may remain in the account for an unlimited amount of time, until medical expenses are paid from the H S A account. In 2019, families can deduct up to $7,000 (individuals up to $3,500).
PROTECT YOUR INCOME WITH DISABILITY INSURANCE

Employer disability coverage ends with residency and fellowship. Purchase an “own-occupation” specialty specific disability insurance policy. These policies will replace a portion of your income if you become ill or injured and cannot work in your specialty. Disability insurance policies provide income to pay your mortgage, car payments, medical bills and daily expenses. Work with an independent agent that compares policies from multiple companies.

ESTABLISH A RETIREMENT PLAN

As a self-employed physician, you can set up your own tax deductible retirement plan. These plans can provide significant tax savings during your working years. Your income, future savings goals, and Roth IRA funding goals (via conversion) are factors that can help “tilt” the decision between the retirement plan options.

SEP-IRA: Self-employed physicians can contribute approximately 18.6% of “net income” to a maximum of $56,000 (2019 limit). The deadline to fund a SEP IRA is your tax filing deadline (4/15 of the following year). If needed, filing an extension will allow you to delay your tax return and extend your SEP IRA funding period until 10/15. Funds owed to the IRS are still due by 4/15.

Solo 401 (k): Self-employed physicians can contribute up to 100% of income capped at $56,000 (2019 limit). The deadline for plan opening and employee “election of funding” is 12/31. Funding may follow up to the tax filing deadline (4/15 of the following year). Filing an extension will allow you to delay your tax return and extend your 401(k) funding period until 10/15.

Defined Benefit Plan: An option to “super-charge” retirement savings for tomorrow and tax savings today. Self-employed physicians can potentially contribute more than $100,000 per year. Funding limits are determined through actuarial factors such as age. Defined benefit plans are recommended after all other retirement savings options have been maximized, excess cash flow is significant, and a history of income stability has been established. Defined benefit plans require a “commitment” to the IRS to fund for at least 5 years.

SECURE MEDICAL MALPRACTICE INSURANCE

Medical malpractice insurance is a specialized type of professional liability insurance that covers physician liability arising from disputed services that result in a patient’s injury or death. In many states and medical systems malpractice insurance is a requirement to practice. Make sure to understand the difference between “Claims-Made” and “Occurrence-Based” policies. If you are practicing in multiple states, make sure your policy provides coverage in all states that you practice medicine.

ASSESS LIFE INSURANCE NEEDS

Along with your income rising, so may your new expenses. Are you moving or buying a new home? Family growing? Life changes are an appropriate time to assess your life insurance coverage. If you died, how would your family be financially impacted? Purchasing 20 & 30 year term insurance can help protect those who financially depend upon you as your wealth builds.
The Michigan College of Emergency Physicians just celebrated its 50th year as a chapter on Mackinac Island. This is a great accomplishment for one of the largest and most influential chapters in ACEP. For the last several years, the meeting has been held at the storied Grand Hotel on Mackinac Island. This island is also the setting of a famous event that had important ramifications in medicine.

In the early 19th Century, an obscure U.S. Army physician named Dr. William Beaumont (1785-1853), used a unique opportunity to explore an area of medicine that until that time was a completely unknown aspect of animal physiology: digestion of food (please note that my admiration for this great physician is not because he is the namesake of my hospital). Beaumont’s study of digestion is well known to most physicians. His professional career began after completing his medical training at St. Alban’s Hospital in Vermont. He then secured an appointment as an assistant surgeon in the U.S. Army during the War of 1812 from 1812-1815. After a short stint in private practice, he re-joined the Army in 1820 and was assigned to Fort Mackinaw. At that time in U.S. history, northern Michigan was the newest frontier.

It is important to note that working for the Federal Government was a viable practice option for physicians of that day. In the early 1800’s, physicians were not held in particularly high esteem. This was likely well deserved as medicine had not advanced much past the dictums of physicians of the past including those of ancient Greece and Rome. Innovation and cutting-edge advances in practice were antithetical to the concepts of treatment that remained tied historical teachings. Physicians typically earned a very modest salary. As such, working for the Army as Dr. Beaumont did, at least guaranteed a steady income.

On June 6, 1822, Alexis St. Martin (1794-1880) finally insulted someone at a saloon in Mackinaw City one time too many. He worked in the fur trade and was someone who was noted to be rather unpleasant. He became much more unpleasant when drunk. On that fateful day, he suffered a shotgun wound to the right side of the anterior abdomen. He was cared for by Dr. Beaumont and went on to develop a gastric fistula that was open to the skin. Beaumont realized he had an unprecedented opportunity to study digestion, a process that in those early days of the 18th Century was an utter mystery. Theories of the time relied more on magic that actual physiology. Given Mr. St. Martin’s proclivity towards excessive drink, Dr. Beaumont hired him as a handyman in order to keep him available for continued observation of the mysteries of digestion. Essentially, Beaumont tossed food tied on a string through the fistula and pulled it out after a period of time looking at the degradation process. It was the first time the process of digestion was observed firsthand.

Beaumont published his results in 1838. His monograph slowly made its way across the U.S. and eventually to Europe. The impact of that paper needs to be considered in the light of the medicine of that day. The “New World” was considered a backwater of uneducated, uncouth, ignorant, violent, gun toting savages who had little to offer the more cultured and superior societies of Europe, which was particularly true in science and medicine. This was not a completely inaccurate impression. If a physician wanted advanced medical training, one went to Europe - to London, Paris, or Vienna where the “modern” science of medicine was being taught. No medical advance had ever come out of the New World up to that point in time.

This seminal study on digestion rocked the medical establishment because of its authorship, quality, and innovation. Had aliens come down from Mars with a medical study it would not have been more surprising. Not only was the paper innovative, but it also opened up opportunities in medical
research: research that could occur on the frontier away from the major medical centers back East.

Beaumont’s seminal study set the stage for the next major advance to come out of America – general anesthesia. On October 16, 1846, Dr. William T. G. Morton (1819-1868) performed the first operation under general anesthesia at Massachusetts General Hospital. This advancement would have had a far more difficult time working its way into medical literature and practice had it not been for Beaumont’s study that put U.S. medicine on the map. His study ushered in a growth in medical research; in a mere 100 years, U.S. medical centers were as highly regarded as those in Europe for advanced training.

Just to complete the story, Dr. Beaumont had great difficulty keeping Alexis St. Martin around as one can imagine with a confirmed alcoholic. He eventually ran away from his position as Beaumont’s handyman and went back home to Canada where he died 27 years after Beaumont, on June 24, 1880. Beaumont stayed in contact with him but could not convince him to return for further study. The fistula never healed and was essentially unchanged when St. Martin died. Dr. Beaumont relocated to St. Louis where he established a successful private practice. On a cold spring day Beaumont slipped on an icy step, he hit his head, and died in on April 25, 1853 (of a presumed ICB). Innovation is one of the bedrock skills of an emergency physician, I like to think that one of the great innovators in medicine, Dr. William Beaumont, would be rather proud of us.
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