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The United States vs. the World

By Richard J. Gimpelson, MD

By the time you read this column, I will have had my left knee replacement surgery. Making an appointment with my orthopedic surgeon, Dan Martin, MD, took less than a week. I could have scheduled surgery within two to three weeks; however, I requested the surgery be done at the end of August, and it was scheduled.

I know all of you are wondering why I did not have the surgery in a country with socialized medicine. Well, I preferred to have the procedure done without delay, so I stayed in the United States; besides, my insurance would not cover the out-of-network procedure in another country.

Let's look at the facts:

The average time from office visit to surgery is three weeks in the U.S., eight weeks in Canada, and 12.6 weeks in Great Britain.

If we look at the percentage of patients waiting over 12 weeks in several European countries:

- Netherlands 15.2%
- Switzerland 16.1%
- Spain 18.5%
- Germany 19.4%
- Norway 28.0%
- Italy 36.3%
- United Kingdom 41.7%
- Portugal 58.1%

If you want to go to an English-speaking country, the percentage of patients who wait over four months include:

- United Kingdom 38%
- Canada 27%
- New Zealand 26%
- Australia 23%
- United States 5%

Now all is not so swift in the U.S. when one looks at the Veterans Administration system. The Baltimore VA has an average wait for a knee replacement of four and one-half months. In fairness to the VA, I must report on the Michael DeBakey VA Medical Center in Houston. This medical center did a miraculous turnaround and reduced the waiting time from 18 months to four to six months.

So, at the present time, you are best having your knee replacement in the U.S. If you are a veteran, you better move to Houston to get your care.

I am not sure what the future brings as the Affordable Care Act gets overwhelmed, over-utilized, and underfunded. So, go out and get that knee replaced now before our medical care system approaches that of Europe or the above-mentioned English-speaking countries.

Dr. Gimpelson, a past SLMMS president, is co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

Dr. Richard J. Gimpelson

HARRY’S HOMILIES ©

Harry L.S. Knopf, MD

ON TRAVELING IN SUMMER

Don’t do in summer what you can put off until fall.
Cover Feature: Online Reviews and the Yelping of Medicine

Your Online Reputation CAN Work for You!
Simple tips for monitoring and making online reviews enhance, not hurt, your Internet presence
   ➞ By Jamie Verkamp-Taylor, (e)merge Medical Marketing Consultants

Legal Considerations in Responding to Online Patient Reviews
What, if any, action should you take?
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Local Physicians Watch Online Reviews
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As you read this column, we have just dived head-first into a muddy pond. Will we find the water warm and deep with no consequences? Or will we not realize that the water is only four feet deep and suffer a cervical spine fracture? I know that there are probably many oddsmakers in Las Vegas as well as many of my physician friends betting on the latter. Of course I am talking about the implementation of ICD-10.

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the United States health-care industry’s adaptation of the international ICD-9 list of alphanumeric codes to describe diagnoses. The current codes are six characters long and the use of them theoretically improves consistency among physicians in recording symptoms and diagnoses mainly for the purpose of reimbursement. The use of the codes is also beneficial to the research industry.

Most other countries have already moved to the more complex ICD-10 released in the 1990s. In 2008, the Centers for Medicare and Medicaid Services announced the adoption of ICD-10-CM, which will be the U.S. version of ICD-10. The implementation has been delayed due to both political issues as well as technical matters. Upgrading from the current version to ICD-10 is going to require significant workflow changes among physicians and support staff. Due to the delay in implementation, other countries are leaving the U.S. behind as far as research is concerned.

ICD-10-CM was to go into effect on Oct. 1, 2015, after a series of delays. The new coding system is able to account for modern advances in treatment and medical devices. Many more classification codes are found in ICD-10 than in the current version. While ICD-9 has 13,000 codes, ICD-10 expands the number to 68,000 codes. The terminology has been modernized and some of the codes have a combination of diagnoses and symptoms so that fewer codes need to be reported. Specificity is increased in the new code set allowing more information to be reported in each code. For example, the new coding allows designation in laterality (left vs. right).

The reason behind the change is that the practice of medicine has changed over the last 25 years in a very dramatic way. Many new technologies, conditions, treatments and devices are available. Many different payment plans are also available and these codes are mandatory in determining coverage.

Perusing the Internet, as well as the actual ICD-10 online codes, can cause random bursts of laughter. Some of these categories are found within the ICD-10:

- Problems in relationship with in-laws (Z63.1)
- Art gallery as the place of occurrence of the external cause (Y92.250)
- Opera house as the place of occurrence of the external cause (Y92.253)
- Pecked by chicken, initial encounter (W61.33XA)
- Burn due to water-skis on fire, initial encounter (V91.07XA)
- Swimming pool of prison as the place of occurrence of external cause (Y92.146)
- Spacecraft collision injuring occupant (V956.43XS)
- Fecal Urgency (R15.2)
- Knitting and Crocheting (Y93.D1)
- Struck by Turtle (W59.22XA)
- Sucked into Jet Engine (V97.33XD)
I have come up with a few of my own codes. I doubt these exist, but I have not been through all 68,000 codes.

- Carpal tunnel syndrome caused by using an EMR system
- Severe aversion to NFL mascots
- Abdominal pain of absolutely no significance
- Breath sounds diminished by obesity
- Failure to thrive in adulthood
- Gravity assisted concrete poisoning
- Acute exacerbation of chronic nonsense

I hope some of these brought a smile to your face. Good luck to all of my fellow physicians with your transition into ICD-10.

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**CLARITY FINANCIAL PLANNERS OFFERS SLMMS MEMBER BENEFIT**

For many years, Mason Road Wealth Advisors (MRWA), has offered investment and financial services to SLMMS members. In early September, Bill Bender, principal with MRWA, announced the formation of a new wealth advisory partnership called Clarity Financial Planners, LLC.

Bender has added a new partner, Shannon Moenkhaus, a certified financial planner with nearly 20 years of experience in income and estate tax planning. All other team members from MRWA are making the transition to the new firm.

SLMMS members can save significantly on advisor fees through the member benefit with Clarity. In addition, minimum investment levels are lowered for the highly regarded Dimensional Funds normally accessible only to institutional investors.

To contact Clarity Financial Planners, call 314-548-3500 or visit www.clarityfinancialplanners.com.
It’s quite remarkable to think how much the Internet has influenced our lives. Just a few short years ago, the term “yelp” referred to the sharp cry of an animal. Now, in our 21st century vocabulary, it’s taken on an entirely different meaning related to sharing one’s opinion of a restaurant, business, experience or service.

The digital age has given rise to online bloggers, commentators and critics. Everyone always had an opinion; now, thanks to the online community and social media, everyone now also has an outlet for their voice to be heard. Which inspired me to begin thinking, in this new era of comments, likes and shares, what is our membership community thinking, sharing, liking or commenting about our Medical Society?

It’s no secret that our organization has been struggling with declining membership in recent years. In fact, over the last 15 years, SLMMS has witnessed only one year when membership numbers increased over the previous year. As more physicians move into employment contracts, and less remain in private practice, they do not see the need for society services or find the benefits of membership as relevant. This is a phenomenon that medical societies (in fact, many membership organizations) are experiencing across the country.

But actually, at a time when frustrations with government interference, regulatory requirements and reimbursement challenges are at an all-time high, organized medicine is needed more than ever. The SLMMS vision—physicians leading health care and building strong physician-patient relationships—and our mission—supporting and inspiring members to achieve quality medicine through advocacy, communication and education—couldn’t be more relevant.

So, when a colleague asks you about SLMMS and “what has your membership done for you lately,” how do you respond? Do you remind them that:

- SLMMS is the largest physician organization in the St. Louis area that brings together doctors of all specialties;
- SLMMS leaders are working with other committed doctors across the state and throughout the country to pass legislation and favorably impact policy for physicians;
- SLMMS introduces resolutions designed to improve the practice of medicine in our community;
- SLMMS presents or sponsors educational programs specifically for doctors, including our successful Physician Leadership Institute;
- SLMMS supports important community health efforts and scientific education;
- SLMMS supports and represents YOU, the physician?

If you are not having these conversations with your colleagues, I encourage you to initiate them. Only approximately 20 percent of the licensed physicians in the St. Louis area are members of SLMMS, yet all doctors benefit from the good work of our organization. Please positively “yelp” about SLMMS membership.

Pass along your copy of *St. Louis Metropolitan Medicine*. Share your SLMMS email updates with your fellow physicians who are not members. These communication tools share the latest updates and information about Medical Society activities. (If you are not receiving our regular e-updates or we do not have your current email address in our database, please contact the SLMMS office or send an email to me at dnowak@slmms.org.)
Invite a prospective member to a SLMMS program or event. On page 5 of this issue, you will read details about our upcoming holiday party. Watch your email for details about other SLMMS social events we are planning. And, remind colleagues the second installment of our Physician Leadership Institute begins in February.

Encourage your fellow physicians to get involved in organized medicine. We’re beginning the process of authoring resolutions to bring forward at the Missouri State Medical Association meeting next spring in St. Louis. We welcome additional voices and opinions; let the SLMMS office know if you would like to serve as a delegate.

Now, more than ever, physicians need organized medicine. And organized medicine needs you. I always say, and I firmly believe, together we are stronger. Spread the word.

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SLMMS 2016 Installation Banquet and Annual Meeting

**Saturday, January 9, 2016**

*Note early reservation deadline – December 18, 2015*

Join in celebrating the installation of Samer Cabbabe, MD, as 2016 SLMMS President and the 2016 SLMMS Council, and the presentation of SLMMS Awards.

6 p.m. Reception; 7 p.m. Dinner

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Nominees Announced for SLMMS 2016 Officers and Councilors

Election takes place online November 1-25

Your Medical Society is pleased to announce the slate of officer and councilor candidates who will lead the Society in 2016. The election will take place online at www.slmms.org from Nov. 1 to 25.

Samer W. Cabbabe, MD, FACS will succeed automatically to the position of 2016 SLMMS president from his current status as president-elect. Dr. Cabbabe is a plastic surgeon with Advanced Plastic Surgery, Ltd. He is certified by the American Board of Surgery and the American Board of Plastic Surgery. He is chief of plastic surgery, St. Anthony’s Medical Center. Dr. Cabbabe holds his undergraduate and medical degrees from Saint Louis University. He served as an SLMMS councilor from 2011 to 2013, was vice president in 2014 and president-elect in 2015. Dr. Cabbabe and his wife, Amy Alvarez Cabbabe, MD, have two children.

Up for election will be candidates for president-elect, vice president and secretary-treasurer along with four councilors. Councilors are elected to three-year terms; an additional six councilors will continue their unexpired terms.

Learn more about our candidates by reviewing their biographies that follow. To help give insight on their thoughts about the Medical Society, we have asked them to respond to the question, “How can SLMMS make the most impact to support physicians in the St. Louis region?”

**J. Collins Corder, MD, FACP | President-Elect**

**Practice:** Internal medicine, private practice with BJC Medical Group. Board certification, internal medicine and geriatrics. NCQA certified, stroke/cardiovascular. American Diabetes Association certified, diabetes care. Hospitals: Missouri Baptist Medical Center, SSM Health St. Mary’s Hospital - St. Louis.

**Education:** B.S., Oklahoma State University. M.D., Saint Louis University. Internship and residency, SSM Health St. Mary’s Hospital - St. Louis.

**Birthplace:** McAlester, Okla.


Other Professional/Community Activities: Fellow, American College of Physicians. Member, American Geriatrics Society. Midwest Health Coalition Physician Leadership Council member representative for SLMMS. Past president, Midwest Medical Associates; past president, St. Louis Society of Internal Medicine. Past active teaching staff for St. Mary’s Internal Medicine Residency Program; former Chamberlain School of Nursing board advisor. Missouri Baptist Palliative Care Committee, 2008-present. McKnight Crossing Church of Christ and coordinator for Room at the Inn.

**Personal:** Wife, Patricia Corder, MD, radiologist; one son, one daughter. Hobbies: gardening, tennis, church, pets.

**Other:** I love to teach providers in training and enjoy learning from my patients, and peers.

**How can SLMMS make the greatest impact?** Each year we are seeing the loss of independence and decision making along with reduction in just compensation for our services. Our time for patient care is being diverted to the EHR and dealing with insurance carriers in non-patient care struggles. We are scrutinized more than any profession and this will increase in the future. We must have a strong voice and, historically, we are lacking unity and communication in advocating for ourselves and our patients. Through SLMMS, we can represent our profession in an organized manner.

**Christopher A. Swingle, DO | Vice President**

**Practice:** Nuclear medicine. Attending physician, West County Radiology at Mercy Hospital St. Louis. Certified: American Board of Nuclear Medicine, Certification Board of Cardiac Computed Tomography, Certification Board of Nuclear Cardiology. Hospitals: Mercy Hospital St. Louis, Mercy Hospital Washington, Mercy Hospital Springfield (Missouri).

**Education:** B.A., University of Kansas. D.O., Kansas City University of Medicine and Biosciences. Internship and residency, Emory University.

**Birthplace:** St. Louis.

Other Professional/Community Activities: Greater St. Louis Society of Radiologists (past president), Missouri Radiological Society, Society of Nuclear Medicine, Radiological Society of North America. Stewardship committee, Mary Queen of Peace Catholic Church.

Personal: Wife, Katherine; children, one son and one daughter. Hobbies: endurance running, cycling, classic car enthusiast, outdoor grilling. Celebrated graduating medical school by going skydiving for the first (and only) time.

How can SLMMS make the greatest impact? Clearly, medicine is evolving at an extraordinarily rapid pace to an uncertain future. We are quite fortunate to have SLMMS as a resource for education and political representation during these times. As the voice of medicine for St. Louis, we have a unique avenue to engage community leaders that would be impossible otherwise. An additional strength is the diversity of talent of our members. By leveraging this rich network, we can foster non-clinical proficiencies such as negotiation skills, practice management and political advocacy that will be necessary for us to shape medicine’s future.

Jason K. Skyles, MD | Secretary-Treasurer

Practice: Diagnostic radiology. Hospitals: Mercy Hospital St. Louis and Mercy Hospital Washington.

Education: B.S. and B.A., Saint Louis University. M.D., Saint Louis University School of Medicine. Internship, Forest Park Hospital; residency and fellowship, Wake Forest University.

Birthplace: St. Peters, Mo.


Honors and Awards: Phi Beta Kappa and Alpha Omega Alpha.

Personal: Wife, Kristin; two sons and one daughter.

How can SLMMS make the greatest impact? I believe SLMMS can make the biggest impact by assuring accurate and timely distribution of information regarding health-care policy to all physicians in the St. Louis region. We provide a forum for physicians of all specialties to discuss the important issues regarding us and our patients. During these discussions, position statements and talking points can be developed and disseminated to give the providers in our region a unified voice.

continued on page 10
**Michael G. Beat, MD, MPH, MBA | Councilor**

**Practice:** Radiation oncology; medical director, Arch Cancer Care. Certified, American Board of Radiology. Hospitals: Missouri Baptist Medical Center, Des Peres Hospital, SSM Health Saint Louis University Hospital.

**Education:** B.A., Kansas State University. M.D. and Master’s of Public Health and Tropical Medicine, Tulane University. Internship, Walter Reed Army Medical Center; residency, Barnes Hospital and Washington University.

**Birthplace:** Nashville, Kan.

**SLMMS/MSMA/AMA Service:** Joined SLMMS 2003.

**Other Professional/Community Activities:** American Society of Radiation Oncology, Association of Military Surgeons of the U.S. Member, Prostate Cancer Treatment Pathways for the U.S. Oncology Value Pathways Powered by the National Comprehensive Cancer Network. Member, Radiation, Diagnostic & Treatment Technology committee and Managed Care committee, The US Oncology Network. Supports ZERO—The End of Prostate Cancer Run/Walk.

**Personal:** Wife, Kelly; two sons and one daughter. Hobbies: attending children's sporting events, watching Cardinals baseball, reading, running. Served in the U.S. Army Medical Corps; transitioned out from Brooke Army Medical Center in San Antonio as a Lieutenant Colonel.

**How can SLMMS make the greatest impact?** As a recent graduate of the inaugural class of the SLMMS Physician Leadership Institute, I have experienced first-hand the positive impact that SLMMS offers to directly support physicians. This unique program recognizes the rapidly changing health-care environment in which we work and has taken action to better educate and equip our colleagues to proactively participate in and lead this evolution. The course stimulates thoughtful interaction among physicians from a variety of health-care settings in an executive classroom encounter. The resulting conversations promote innovative ideas and creative solutions by facilitating shared insight and experiences. These continued SLMMS-sponsored educational opportunities provide an important resource for physicians that can influence our practices and the hospital relationships that we share.

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**C.B. Boswell, MD, FACS | Councilor**

**Practice:** Plastic surgeon, Bodyaesthetic Plastic Surgery and Skincare Center. Certified, American Board of Plastic Surgery. Hospitals: Barnes-Jewish West County Hospital, Des Peres Hospital.

**Education:** B.S., Southern Methodist University; M.D., University of Wisconsin. Internship, general surgery, Barnes-Jewish Hospital; residency, plastic surgery, Barnes-Jewish Hospital. Jack Owsley Fellowship, San Francisco, 2001; PACES Plastic Surgery Fellowship, Atlanta, 2002.

**Birthplace:** Ames, Ia.

**SLMMS/MSMA/AMA Service:** Joined SLMMS 2014.

**Other Professional/Community Activities:** Fellow, American College of Surgeons. Member, American Society of Plastic Surgery, American Society for Aesthetic Plastic Surgery. Past president, vice president and secretary, Missouri Association of Plastic and Reconstructive Surgeons. Past president, St. Louis Area Plastic Surgery Society. Member, Aesthetic Surgery Education and Research Foundation, Plastic Surgery Educational Foundation. Chief of staff-elect, Barnes-Jewish West County Hospital.

**Personal:** Wife, Jill Yamauchi; one daughter. Hobbies: fly fishing, gardening, reading, playing tennis with my 11-year-old daughter.

**Other:** The surgical procedures that I most enjoy performing are body contouring after massive weight loss as these patients still see themselves as obese, even though they have already lost their weight. Once the excess skin is removed, patients can appreciate the results of their hard work.

**How can SLMMS make the greatest impact?** One of the major issues that all physician practices face is the continued increase in practice operating costs. The Medical Society can use its power as a group of physicians to leverage better purchasing opportunities for its member physicians. SLMMS has already helped reduce malpractice costs by partnering with Keystone Mutual Insurance. Other opportunities for SLMMS would be to negotiate group insurance rates, and use group purchasing power to improve the costs of medical supplies, office supplies and physician disability coverage.
SLMMS Dues Adjustments for 2016; Online Payment Available

In an effort to help offset rising costs, the St. Louis Metropolitan Medical Society Council has voted to slightly increase dues in 2016 for active members by $10. Dues will increase to $350 annually, plus the optional $20 contribution to the Medical Society’s charitable arm, the St. Louis Society for Medical and Scientific Education (SLSMSE), for a billed total of $370.

Contributions to SLSMSE are crucial to continuing its charitable work. SLSMSE supports a variety of programs and services each year, including the Greater St. Louis Science Fair, the annual Hippocrates Lecture, the Missouri Physicians Health Program, and various projects of the SLMMS Alliance. However, the additional $20 is optional and members may decline to make the contribution. As a 501(c)(3) nonprofit foundation, contributions to SLSMSE are tax-deductible to the full extent allowed by law.

Dues for active members in the first year of practice following the completion of their training program are discounted 50% and will now be $175. Dues for all other membership categories, including retired ($100 annually), resident/fellow ($25 annually), and student (no dues) will remain unchanged for the coming year.

Online payment of dues is now available and is a simple and easy click away. You may pay your dues through our secure site by visiting www.slmms.org and selecting the “pay dues online” box on the home page. You will receive your 2016 dues statement by early October; it must be paid in full by Jan. 1, 2016. You may set up an installment plan with scheduled payments through March 2016 by calling Chris Saller-Sorth, SLMMS business manager, at the SLMMS office. If you are a member of MSMA, your state and local dues will be billed jointly and only one payment is necessary for both. If you have any questions, contact the SLMMS office.

Continuing on the Council (Terms began in 2014 or 2015)
- David K. Bean, DO
- Ramona Behshad, MD
- Robert A. Brennan, Jr., MD
- James W. Forsen, MD
- JoAnne L. Lacey, MD
- Andrea R. Sample, MD
Your Online Reputation CAN Work for You!

Simple tips for monitoring and making online reviews enhance, not hurt, your Internet presence

By Jamie Verkamp-Taylor, (e)merge Medical Marketing Consultants

What did we do before we had smartphones? How did we find our way before Siri? What did we do before “Google” was officially deemed a verb and we could turn to it to answer our every question or help to meet many of our needs? Our methods of communication and knowledge-share have rapidly changed with the onset of the Internet, social media and other technologies like smartphones. I’ve heard it said, “If it’s not on Facebook, it’s as if it didn’t really happen.” Our lives offline are now increasingly more intertwined with our online lives, and that has had a dramatic effect on personal relationships, along with engagement with brands and businesses.

The Internet has changed the way all industries do business and most importantly, interact with their customer base. With 84% of Americans now having access to the Internet—that’s up 52% from a similar study conducted in 2013—more people have access to more information. They can pay bills online, manage their money, stay connected with family and friends, and research any and all topics they deem important, including their health—all while streaming the latest episode of their favorite TV series. In looking further into the behaviors of Americans, an April 2015 study conducted by Pew Research Center reports that 64% of Americans own a smartphone and 62% of those smartphone users have accessed their device to look up information regarding a health condition; that’s a higher percentage than those who access mobile banking from their device.

These smartphone users are turning to their mobile devices for real-time information to help them make decisions, and many of these decisions are influenced by the multiple review platforms and other consumer information-share that takes place online or through social media channels (think referrals from your closest friends on Facebook … because “crowdsourcing” is now also an official word in the dictionary). In this same study, 79% of smartphone users reported using a social media platform daily; this list includes Facebook, Instagram, Twitter and also peer-review sites like Yelp and Trip Advisor.

What does all of this Internet usage and interweaving of online and offline worlds mean in the health-care industry? It means a lot; it has changed and continues to change the way we communicate with our consumers—the patients. Let’s break this impact down further and more specifically to what it means for the reputation of our health-care providers and our organizations. Reputation management has become a big business in all industries—and also a very big concern for physicians and the organizations that serve patients. Nearly 78% of all patients now turn to Google before visiting their doctors’ offices, according to a 2013 Pew Research Center study. They are looking for information about their conditions and concerns, but they are also looking for the best provider. They are visiting review sites like Yelp, but they are also visiting the plethora of physician-specific review sites like Healthgrades, Vitals and RateMyMD.

With so many patients viewing these review sites each day, it has never been more crucial for physicians to monitor their online reputation than it is today. These online reviews have the potential to more dramatically affect the reputation of a physician than traditional word-of-mouth; these reviews live online “forever” and they can spread quickly.

While these review sites and patient Internet access may have left many physicians and health-care organizations feeling vulnerable to reputation attacks or other negative side effects, it doesn’t always have a negative effect. When you are aware and monitoring your online reputation, along with engaging patients through other online tools like social media or your patient portal, you stand to benefit significantly from the power of the Internet and virtual word-of-mouth. Here are a few tips

Jamie Verkamp-Taylor is a speaker, trainer and consultant in health-care marketing and operates (e)merge Medical Marketing Consultants. She speaks on topics related to patient experience excellence, new marketing initiatives and health-care social media. She has written for Medical Group Management Association and American Medical Association publications, and received the Edward B. Stevens Article of the Year Award from MGMA and the American College of Medical Practice Executives for an article on social media in health care. She can be reached at 816-565-1657, jamie@emergewithus.com.

12 October/November 2015
for getting your reputation in check and staying on top of any issues that may arise:

1. **Awareness is key!** You can’t manage what you don’t measure and the same is true with your online reputation. Be sure you are tuned into the conversation online and who is talking about you. If you identify a negative review quickly, many times, a service recovery for that disgruntled patient can take place or at minimum you can work to minimize the residual damage from the posting. Here are a few ways to monitor your reputation (P.S. these are FREE!)

   a. Set up a Google Alert for each physician’s name in your organization and also the name of your practice or business. These alerts will be emailed to you and can catch any content containing these keywords; for example, if someone blogs about an experience with you on their mommy blog site, a Google Alert can send you an email to let you know of the posting.

   b. Claim your review site profiles. Some of the most popular physician review sites are Healthgrades, Vitals and RateMyMD. Google your name, see which sites populate on that site and then click the “claim your profile” or “is this you?” link! Most of these sites will allow you to add an email address for notifications of any reviews, update basic contact information and add a picture—all for free. This is a VERY helpful in monitoring online reviews!

2. **The best defense is a better offense!** Negative comments and lackluster reviews will happen from time to time. It’s inherent when dealing with many different people on issues so personal such as their health. However, you don’t have to be vulnerable online. Consumer studies report that for every negative review a consumer reads about a product or service, it takes three positive comments to neutralize that one negative review. Consumer studies report that for every personal such as their health. However, you don’t have to be vulnerable online. Consumer studies report that for every negative review a consumer reads about a product or service, it takes three positive comments to neutralize that one negative comment in the buying decision process. Let’s apply that same thinking to your reputation management strategy.

   a. Drive satisfied patients to your review sites; ask for the review! More physicians are being proactive and prompting patients to share their experiences before they leave the office. Upon closing the patient visit, direct patients to review sites or other social media channels to share their comments. Print these links on business cards, and even deploy tablets in the office to make it easy and convenient to leave a review or a star rating. Send a follow-up email thanking the patient for their trust and include a link to your review site(s) to make it very easy to complete. Think about your patient flow and where it may make sense to encourage staff to engage in these conversations—and don’t shy away from encouraging patients yourself! Patients are always more compliant when the physician gives them instruction or a request.

b. Are you social with your patients? Social media platforms can be a great way to spread your positive word-of-mouth with potential patients and Internet researchers. Patients can now leave reviews on Facebook and you can directly monitor/control those! The more information you post and share with your patients, the more opportunity you give potential patients to get to know you, your practice culture and approach. Informational videos, blogs and the curation of valuable health information can all be very beneficial and key in your offensive strategy to owning your online reputation.

3. **Where’s Goose?** I need my wingman! When a negative comment strikes, don’t fret. You do have options to minimize the collateral damage and stay on track with your goals. Again, being proactive is key. If you are monitoring online, you should be notified in a timely manner either from Google or one of the review sites hosting that comment. Most social media platforms notify the administrators of any activity in real-time as well. While the tendency may be to hop online and defend yourself, fight the urge to further engage the commenter online. Sites such as Yelp are now offering guidelines to businesses on how to respond properly to negativity and I have found those tips to be very helpful. Keep in mind, you want to show the commenter and also others that you are aware and watching your Internet presence, and that you care. The best approach is to acknowledge that review and suggest that the commenter call the office should they want to discuss this further and provide a contact number. It is always best to have any exchanges with a disgruntled patient offline, rather than online. Rarely do those turn out well!

If there was a problem and you have since fixed a process or issues, you may also consider reporting back on how things have changed or improved since that person’s experience. Not all negative comments may be from highly disgruntled, unreasonable patients; we stand to learn from all comments, both positive and negative, so don’t forget to read these with an open mind or have someone who isn’t as close to your business review the comment to see if it warrants a closer look for improvements.

There are many benefits to online engagement with patients and having a strong Internet presence. Online reputation management should not be feared when approached proactively; in many instances I’ve seen it become a very powerful tool for marketing and also building loyal relationships with patients in a time where physician loyalty (and brand loyalty in general!) are lower than ever. For additional recommendations and practical strategies to take control of your online reputation I suggest picking up a copy of Dr. Kevin Pho’s book, *Establishing, Managing and Protecting Your Online Reputation; A Social Media Guide for Physicians and Medical Practices.*

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St. Louis Metropolitan Medicine 13
Legal Considerations in Responding to Online Patient Reviews

What, if any, action should you take?

By Hannah M. Nelson and Stuart J. Vogelsmeier, Lashly & Baer, P.C.

More and more, people are turning to online review sites, social media and blogs for more than just happy-hour recommendations. Given that many patients have already reviewed and diagnosed themselves with information found on the Internet before they even walk through a physician’s door, it is not surprising that patients are just as likely to consult online reviews in selecting a physician. Likewise, an increasing number of patients are sharing their experiences, opinions and complaints about physicians on the Internet on blogs, social media and online review sites. A physician’s online presence is no longer limited to the information the physician releases on the Internet. Content on these sites is incredibly easy to access and can almost immediately have a positive or negative impact on a physician’s business. As such, there is a sincere and legitimate concern that negative reviews posted online can jeopardize a physician’s reputation and business.

It makes a lot of sense for a physician to ask, “What type of recourse do I have? Can I sue my patient? Can I respond to these reviews online? Should I do anything at all?” There is no real easy answer to what a physician should do; however, there are practical legal implications to consider when deciding what to do.

Recourse through the Online Review Site

The physician may wish to contact the online review site to request that a negative or false review be taken down from the site. However, the physician may not be successful in convincing the online review site to remove the review, unless a physician can demonstrate that the review violates the site’s content guidelines.

Yelp, for example, directs business owners to contact the reviewer or post a public response in the event of an issue. Angie’s List’s website indicates it will never remove a review unless the reviewer who posted the review contacts Angie’s List directly.

A physician would also likely be unsuccessful in suing the review site as the suit would likely be preempted by federal law. An online review site cannot be held responsible for content provided by third parties under the federal Communications Decency Act of 1996. An online review site would argue that it merely posts comments, and thus, the site is protected under the Act. Such was the case when a New York dentist sued Yelp for defamation and deceptive business practices. Yelp successfully defended the case under the Communications Decency Act of 1996 and avoided liability.

Should I Sue the Patient?

Filing a defamation suit against a patient who posts a negative online review could be more detrimental to the physician than the negative review itself. A negative Yelp review is rarely going to be the first thing that pops up on Google when a potential

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patient searches a physician’s name; however, an article with a colorful title about the physician suing a patient could very well be the first thing that pops up on Google for a while.

That being said, doctors have sued patients for online reviews. For example, in 2012, a disgruntled patient was ordered to pay two Arizona plastic surgeons $12 million for defaming two surgeons in public meetings, online forums, and on her own website. However, the court of appeals since overturned the verdict and ordered a new trial. Likewise, in 2010 a Minnesota neurologist sued a patient’s son for defamation over several negative comments the patient’s son had posted online. Four years (and presumably a few legal bills later), the case was dismissed.

A defamation suit is not easy to win. Defamation includes spoken defamatory words (slander) and written defamatory words (libel).

Establishing a case of defamation is difficult, as the plaintiff has to prove that multiple elements are present. To win a defamation case, the plaintiff has the burden of establishing the following:

1) Publication. This is met when the patient makes the statement to another person; this likely would be met easily when a patient posts a review online.

2) A defamatory statement that identifies the plaintiff. The statement must actually be about the physician bringing the case.

3) The statement is false.

4) The statement is published with the requisite degree of fault.

5) The plaintiff suffered provable damages.

Prior to speaking with an attorney, a physician should ask, “Is the statement I’m upset about true?” If the physician can prove that the patient fabricated the story, the physician might be able to prevail on a defamation claim.

There are also other practical legal considerations to consider in suing a patient. First of all, doctors generally are not sympathetic parties, which can hinder their ability to succeed in any suit. Filing a defamation suit could also potentially be very costly. An attorney may not agree to take a physician’s case on a contingent-fee basis. Additionally, even if the physician does prevail, a patient-reviewer may be judgment-proof. Finally, a negative online review might already be a warning shot that the patient is considering filing a malpractice suit, and filing a defamation lawsuit against a patient may encourage the patient to file a malpractice suit.

Suing the patient might indeed be the best course of action in cases where a review indeed falsely alleges serious misconduct. However, more importantly and in most cases, should the physician sue the patient? The answer typically is not as clear.

Responding to the Patient

Physicians may consider responding publicly or privately to a patient’s online review. Many physicians may choose to respond publicly to exercise what little control they have over this particular dimension of their online presence.

In responding publicly, it is important to tread lightly and make certain that the physician does not disclose confidential information or violate the Health Insurance Portability and Accountability Act (HIPAA).

Although a restaurant owner can freely refute negative reviews by responding directly online with information about a restaurant patron, a direct rebuttal from a physician may be illegal. HIPAA prevents a “covered entity” (i.e., a physician) from disclosing protected health information without the patient’s consent. Covered entities are not free to disclose protected health information just because a patient chooses to publicly disclose protected health information. This simply does not amount to consent. As such, as frustrating as it might be for physicians to bite their tongues, they simply cannot disclose any protected health information because they do not have the patient’s consent to disclose the protected health information.

Can a physician ever appropriately respond to an online review? Sure. However, once again, the physician must tread carefully because the consequences of violating state privacy laws along with the penalties for violating HIPAA can be steep. A physician should take into account their own business goals and consult with an attorney well-versed in HIPAA prior to responding to a patient’s online review. Below is an example review followed by possible responses.

“My visit to Dr. X’s office was an absolute nightmare from start to finish. I ended up waiting in a crowded waiting room for over an hour. By the time I finally saw Dr. X, she failed to even address my concerns about my upcoming sinus surgery. I’m pretty sure she just wanted to bill me for the office visit.”

Patients have written worse things about their physicians on the Internet and likely will continue doing so. Nevertheless, physicians worry that negative reviews, like this one, can jeopardize their reputations. As such, the physician may choose to respond, and it is crucial that the physician tread carefully when responding.
SAMPLE RESPONSES:

A) We understand that a wait in any waiting room can be difficult for anyone. We want our waiting room to be an extension of our great patient care. We provide an assortment of free coffee and tea for all of our patients and family members to enjoy to make the wait a little easier.

Response A is also appropriate because a physician can freely disclose general information about their practice in a public response. Parking, waiting room, wait times, office décor, and check-in policies are all appropriate to address as long as the physician does not bring in protected health information.

B) I specifically addressed your concerns about your upcoming sinus surgery. I wasn’t trying to just bill for an office visit. Not that it really matters because you don’t pay your bills anyway!

Response B is obviously inappropriate; however, it is easy to see how quickly an angry physician could fire back this response especially when the physician has done their best to provide high-quality care. Even though the patient brought up the sinus surgery in the review, this simply does not amount to consent and the physician cannot directly address the health care of an individual patient. Likewise, publicly addressing an individual’s payment and billing information will also land a physician in HIPAA hot water and must be avoided.

C) My policy is to always schedule an office visit in advance of surgery to make sure that my patients are receiving the best and safest care possible. This allows me to check on the patient one more time before surgery to address any questions or concerns they have leading up to the surgery.

This is also an acceptable response as the response generally addresses the physician’s policies and procedures without disclosing any protected health information. This response also does not confirm that the reviewer was in fact a patient, which is important to avoid in responding to online reviews.

D) We are committed to high-quality patient care and want to respond to all concerns so that we can effectively address our patient’s concerns and improve the patient experience going forward. We would really appreciate the opportunity to discuss your concerns. Please feel free to call us to address your concerns at your earliest convenience.

Response D allows the physician to publicly respond in a manner that shows the patient and other potential patients that the physician takes concerns seriously; however, the response does not disclose any protected health information or even confirm that the reviewer is a patient.

If the patient provides their name with the review, the physician may consider responding directly to the patient to avoid the HIPAA and state privacy minefield a physician encounters in responding publicly. The physician should first review the patient’s file to see if the patient has any legitimate concerns to assess the potential exposure.

If the physician does choose to directly reach out to the patient, it may be that the patient just wants to be heard. Initially, the physician should avoid the urge to admit fault or promise a specific resolution. That being said, the physician should make it clear that the physician takes the patient’s concerns seriously and that the physician really wants to understand the nature of the patient’s concerns.

Online reviews are not going anywhere. If anything, they will continue to increase and further impact the delivery of health care. As such, however, if a physician elects to deal with online reviews, the physician should consult with an experienced health law attorney to make sure the physician is proceeding in a legally prudent manner.

This article is for informational and educational purposes only. Physicians and others should contact their advisors for assistance.

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Local Physicians Watch Online Reviews

By Jim Braibish, St. Louis Metropolitan Medicine

As more patients seek out physician review websites, SLMMS member physicians are monitoring what is being said online. Depending on the size of the practice and area of specialty, some have employees whose principal responsibilities include keeping up with the review sites and other social media.

At St. Louis Cosmetic Surgery, Patient Relations Director Rhonda Shrum monitors sites including Realself.com, Vitals.com, Healthgrades.com, Google, Yelp and the practice Facebook page. She added, “Multiple times per week I simply google my doctors’ names and see what’s appearing. Is there a new site popping up that I’ve never heard of?”

She updates review sites that provide the most traffic for the practice. “On RealSelf, for example, each of my doctors has a profile picture, a cover photo, detailed descriptions of procedures performed in the office, before and after photos, and links to questions they have answered for Realself users. I also make sure Google+, Vitals, and Healthgrades profiles are up to date. If the site allows, I link to our social media pages. We maintain a popular blog, Facebook page, Twitter feed, YouTube channel, and Instagram account.”

Signature Medical Group has a full-time Digital Marketing Strategist, Melissa Gall. She said there are hundreds of review sites now to track, and attempts to keep them up to date for the 130 Signature physicians covering a variety of specialties. Particularly important is to make sure the physician’s address, phone and specialty are correct.

Plastic surgeon Samer Cabbabe, MD, in a two-physician practice, is training the new patient coordinator to monitor the review sites. He is signed up for Google Alerts to be notified by email of updates, and regularly conducts web searches, “googling” to see what appears. “I update my physician profile on certain sites, and place photos, statements and procedure information. These include Realself, Angie’s List, Healthgrades, Vitals, Facebook, Yellow Pages and Yelp,” he said.

SURVEYS SHOW REVIEW ACTIVITY

From a University of Michigan study reported in JAMA, Feb. 19, 2014:

- 59% consider physician rating sites to be “somewhat important” or “very important” when choosing a physician; however this portion remains well below the percentages identifying as important other factors: 95% for accepting one’s health insurance, 95% for convenient office location and 85% for word of mouth from family and friends.
- Of the 65% of consumers who are aware of physician rating sites, 36% went online in the past year to seek physician ratings or reviews.
- Of those who sought out physician ratings, 35% reported selecting a physician based on good ratings and 37% avoided physicians with bad ratings.
- Among those who did not seek physician ratings, 43% cited a lack of trust in the information on the sites.
- Only 5% have given ratings or left comments on physician review sites.

From a 2014 Software Advice survey:

- 24% of patients use online reviews and 11% use them often.
- The most trusted rating sites are Yelp (26%), Healthgrades (26%), Rate MDs (24%), Vitals (10%) and ZocDoc (8%).

SURVEY LINKS

http://www.softwareadvice.com/medical/industryview/online-reviews-report-2014/
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Local Physicians …  continued from page 18

Dermatologist George Hruza, MD, in a two-physician practice, and ophthalmologist Ranjan Malhotra, MD, in a two-physician and two-optometrist practice, said they monitor the major review sites but do not have staff with committed responsibility for them. “My staff and patients also will tell me what they have read or seen,” said Dr. Malhotra, adding that he is considering assigning a staff person.

Dr. Hruza said he has placed profiles and photos on some of the more popular sites, but is not paying for any premium services.

While all monitor the review sites, they also are cautious in responding to negative comments. All cited HIPAA concerns in posting anything about a patient’s case online.

When St. Louis Cosmetic Surgery receives a negative review, Shrum will follow up. “I will often contact the patient offline to see if we can resolve the situation. Sometimes, the patient will remove the review after they feel they’ve been heard.”

Signature follows up privately with both positive and negative reviews. Gall said, “We appreciate positive reviews and know that our patients are generally happy; but, if there is a negative review, we will put them in touch with the practice office manager to find out how we can make their experience better. We tend not to post any responses online.”

Said Dr. Hruza, “The best way to minimize the effect of the occasional negative review is to encourage your patients to post positive reviews when they are happy with your practice. We have found that lots of positive reviews averaging out the negative ones is the most effective strategy.”

Online review sites are indeed becoming more important, Gall said, “The younger generations are growing up commenting and reviewing online. This is something we have to pay attention to moving forward.”

According to Shrum, “I rarely see a patient walk through the door anymore who hasn’t done research online, and reviews are the first thing they read, often before they read the surgeon’s biography. On a site like Realself, for example, not only can patients leave reviews, but they can upload their own photos and blog about their entire experience. Our patients converse with other patients and potential patients online.”

I have very exciting news! I am starting a new wealth advisory partnership called Clarity Financial Planners. My new partner is Shannon Moenkhaus who is a Certified Financial Planner. Shannon has been a wealth advisor for nearly two decades – specializing in income and estate tax planning. I look forward to her being my partner in the wealth management business. My entire team is moving over to Clarity. I appreciate your trust and confidence in me and my team over the years and look forward to working with you in our new partnership.

-Bill Bender

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Chesterfield, MO 63017

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Patient Satisfaction: The Never-Ending Challenge

Creating a positive experience is important as more patients comment online

By Christine M. Keefe, CPA, CMPE, MGMA of Greater St. Louis

The increase in online patient reviews is making patient satisfaction more important than ever. What defines patient satisfaction in a medical practice? While quality is of paramount importance, it may be hard for patients to truly evaluate quality of care. What else do patients base their satisfaction on? Often it is the patient experience, which has many facets.

- **First impressions count:** Scheduling the appointment begins the process, which includes the efficiency of the appointment process, friendliness of the staff, clarity of instructions and setting expectations. But … know your audience. We are dealing with multi-generational customers. Younger patients tend to prefer to handle everything online and not talk to a human. Other patients prefer to call and schedule their appointment with a live person. We have to adjust to accommodate all styles and preferences.

- **Registration process:** Every patient hates filling out forms, but it is expected, especially if realistic expectations were set during the appointment process. Here again, the friendliness and efficiency of your personnel is key. Your front desk staff can quickly drive patients away from your practice if they are unfriendly or inept. Many patients expect high standards of service, and we must strive to meet these standards.

- **Wait times:** Patients never like to wait, but setting realistic expectations can minimize dissatisfaction. We must streamline our workflows to be as efficient as possible. Giving patients something to focus on, makes the time go by faster, whether it is TVs in the waiting room, WIFI availability, educational programming or information about their procedure.

- **Face time with the provider:** Bedside manner is as important as ever. The quality of the provider’s interaction with the patient can “erase” poor impressions made by the rest of the encounter … and vice versa.

The overall patient experience, not just the interaction with the provider, is important to patient satisfaction. Your staff is key to satisfied patients. They must come to work every day ready to be friendly, compassionate, attentive, efficient team players and be good communicators. How in the world do we make this happen? As health-care managers, a big part of our job is making this happen by hiring the right people, training, scheduling, workflow efficiency, building a solid team, and aligning incentives.

At Metro Imaging, we have incentivized our employees to make patient satisfaction a priority. When a patient includes one of our employee’s names in our satisfaction survey, it impacts that employee’s quarterly bonus. This has engaged our employees in the process and increased our survey response. Patients provide valuable feedback, both positive and negative, which we share with the employee, allowing them to learn how they are perceived by patients.

Patients are becoming more engaged in their health-care decisions as their out-of-pocket expense increases. Monitoring online reviews is critical, but the process starts in our offices by promoting and internally monitoring patient satisfaction.

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Christine M. Keefe, CPA, CMPE is the CFO & Director of Strategic Initiatives for Metro Imaging, LLC, an independent group of outpatient imaging centers serving the greater St. Louis area. Chris can be reached at cfo@metroimaging.org or at 314-333-6725.

SLMMS has established a partnership with the Medical Group Management Association of Greater St. Louis (MGMA), including sharing information across publications, across websites, through organizational committees, and via joint educational programs. For more information on MGMA, visit www.mgmastl.org.
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- Chesterfield, MO 63017
- 314-469-6622
- www.chesterfielddayschool.org
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  - Saturday, Oct. 17, 9 a.m.-noon

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continued on page 24

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–Alan Greenspan
Efforts Focus on Reducing Prescription Drug Abuse

Deaths from pharmaceutical opioid overdoses quadruple since 1999; measures advocated include state prescription drug monitoring

By Jim Braibish, St. Louis Metropolitan Medicine

The problem of prescription drug abuse and redirected use has exploded over the past decade. Public health officials, medical leaders and others are calling for greater prevention and treatment measures to stem the growth. And Missouri is garnering national attention as the only state not to have a prescription drug monitoring program. Physicians are advised to exercise caution in prescribing painkillers.

Every day in the United States, 44 people die as a result of prescription opioid overdose, according to the Centers for Disease Control. All forms of drug overdose, including prescription and illicit drugs, became the leading cause of injury death in the U.S. in 2012, exceeding motor vehicle traffic crashes for people ages 25-64. Of the 43,982 drug-overdose deaths in the U.S. in 2013, 22,767 (51.8%) were related to prescription drugs. Of those, 16,235 involved opioid painkillers and 6,973 involved benzodiazepines. Poisoning deaths from opioids have quadrupled since 1999.

In 2012, health-care providers wrote 259 million prescriptions for painkillers, enough to medicate every American adult around the clock for a month, the CDC reports. At the same time, the CDC says about 12 million Americans age 12 and older—1 in 20—reported using prescription painkillers for nonmedical reasons in the past year.

While prescription drug abuse crosses all ages and socioeconomic groups, some are more likely to abuse or overdose, according to the CDC. Many more men than women are likely to die of overdoses. Middle-age adults have the highest prescription painkiller overdose rates. People in rural counties are twice as likely to overdose on prescription painkillers than people in big cities. And, whites and American Indians are more likely to overdose than blacks.

“The misuse and abuse of prescription drugs is a very serious problem in the Midwest and in the U.S. as a whole. It affects the young as well as the middle-aged and seniors,” said Anthony Scalzo, MD, director of the Division of Toxicology at Saint Louis University School of Medicine and SLUCare emergency physician at SSM Cardinal Glennon Children’s Medical Center.

Besides opioids, he notes that prescription drug abuse also involves the use of stimulants such as medications used for ADHD, along with relaxants such as benzodiazepines. “It is often combined with alcohol and/or other drugs of abuse,” he said, citing a recent study of high school seniors that found that an estimated 64.4% co-ingested prescription stimulants with other substances such as alcohol and marijuana.

He also emphasized the related problem of heroin abuse. “It is so cheap out on the streets that it has been the preferred drug since it is less expensive than prescription narcotics such as oxycodone.”

Members of the Greene County Medical Society Alliance in Springfield, Mo., have created a video and educational module addressing the issue of prescription and over-the-counter medication abuse by young people. “Pills are NOT a Party!” targets children ages 10-12, a prime age identified by the CDC when drug abuse can begin. Since its release in 2012, the 15-minute animated video has been seen by thousands of children in Springfield schools, and was rolled out nationally with the help of a grant from the American Medical Association Foundation. For more information, contact Barbara Hover of the Greene County Alliance at arhover2@aol.com.
From Prescription Opioids to Heroin

“We are losing a lot of people, and a lot of lives are being ruined from prescription drug abuse,” said anesthesiologist Joseph Forand, MD, (SLMMS), president of the medical staff at St. Anthony’s Medical Center. Since the mid-2000s, Dr. Forand has been on the forefront of advocacy for a prescription drug monitoring program and other prevention and treatment measures, in his capacity with the Missouri Society of Anesthesiologists where he was 2007-08 president. He also served on the Missouri State Board of Health from 2005 to 2013.

Dr. Forand noted how opioids act on a primitive part of the brain, called the pleasure center or “I want more” center, first identified through research with rats by James Olds and Peter Milner in 1954. It is easy to become addicted to opioids because they leave the user craving for more of the substance. This craving consumes users and they will do almost anything to get more, he said.

The danger of opioids is that they are respiratory depressants. When anesthesiologists instill them in a patient during medical procedures, the effect is carefully monitored. However, an individual overdosing the drugs could cause their breathing to stop.

He also points to the problem of prescription drug abuse being a gateway to heroin addiction, particularly among youth. “Seventy-two percent of heroin addicts began with prescription pain medicine abuse. This is all too common,” he said, adding that today’s street heroin frequently is cut with fentanyl which has 50 times the potency.

These concerns motivated him to lead the production of a 20-minute video, “Anatomy of an Overdose,” released in 2014 on the dangers of heroin and prescription drug abuse.

Theodore Cicero, Ph.D., professor of neuropharmacology in psychiatry at Washington University, has studied trends in drug abuse. His study of 9,000 treatment center patients, released in May 2014, found that abusers were switching from prescription opioids to heroin because of the cost—$80 for an 80-milligram tablet of OxyContin, compared to $10 for a similar amount of heroin. A 2010 reformulation of OxyContin is another cause.

His research shows today’s average heroin user started the drug at age 23, and got high with prescription drugs prior to moving to heroin. They also tend to live in suburban or rural areas and more than 90 percent are white. This is in contrast to the 1960s and 1970s, when more than 80 percent of heroin users were young male minorities who lived in inner cities.

Public Health Approach

Nationally, officials are increasing emphasis on a public health approach to the problem. Current areas targeted by the CDC Center for Injury Prevention and Control include enhancing state prescription drug monitoring programs, evaluating policies to prevent “doctor shopping” and “pill mills,” ensuring health-care providers follow safe and effective prescribing of painkillers, and conducting public education.

Missouri is the only state without a prescription drug monitoring program. Legislation has been introduced and supported by a wide coalition ranging from MSMA and the Missouri Society of Anesthesiologists, to the Missouri Pharmacy Association and the Missouri Chamber of Commerce. The legislation has stalled in the Missouri Senate, where the opposition has been led by State Sen. Rob Schaaf, MD, (R-St Joseph), who cites privacy concerns. Missouri’s opposition to prescription drug monitoring was the subject of a July 2014 article in The New York Times.

In 2013 testimony to the Missouri Legislature and a letter to the editor in the St. Louis Post-Dispatch, Dr. Forand wrote, “‘Doctor shoppers’—those who claim to have a condition amenable to treatment by prescription painkillers and who go from one doctor’s office to the next seeking these drugs—are numerous in Missouri. … At present, there is no way for a physician to know if his or her patient already has painkiller prescriptions. … Like it or not, the lack of any monitoring program has helped Missouri gain a national reputation as a place that makes painkiller prescriptions readily available to abusers.”

He also cited state data showing nearly 900 deaths in Missouri annually from prescription-drug overdose. “From a public health standpoint, a 50 percent reduction in these deaths would save 450 lives, nearly six times more than are estimated to be saved by primary enforcement of seat belt laws,” he wrote.

Lawrence Kuhn, MD, medical director of SSM Behavioral Health, concurred. “In Missouri, it’s easy to game the system. Physicians I talk to in other states are comfortable with a prescription drug monitoring program. It allows them to identify patients receiving medication from several prescribers.”

The problem of prescription drug abuse, and all drug abuse, is complex with no simple answers, Dr. Kuhn added. “People have been abusing opioids for centuries. You are not going to legislate it away. Restricting access to prescription opioids could also just direct more people toward heroin. It’s going to take a number of different approaches.”

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One measure he suggests is greater prescribing of buprenorphine, a drug used to treat opioid addiction. While it can be prescribed by any physician, including primary-care physicians, current rules make it burdensome for the physician, he said. Drug courts are another effective measure.

Dr. Scalzo added, “More support for education about the dangers of prescription drug abuse would be welcomed as well as limitations on prescription volumes. It is not uncommon and supposedly more convenient for certain prescription warehouses to supply a patient with 90 days’ worth of medication. While this may be convenient for some, it increases the risk of misuse, abuse and diversion.”

Even if a prescription drug monitoring program is implemented in Missouri, it could be a while before such a system is widely used as providers learn the system, devote time to use it, and any system functionality issues are overcome, according to a recent study in Oregon.

Advice to Physicians and the Public

For the physician, Dr. Forand said, some warning signs that a patient might be a potential abuser include asking for a drug by name, or giving an excuse such as they lost their prescription.

Symptoms evidenced by an abuser noted by Dr. Scalzo can include pressure of speech, agitation, withdrawal signs such as unexplained tachycardia (fast heart beat), as well as sweating, nausea, vomiting, and shakes. Also noticed can be change in personality or loss of attention to hygiene.

The CDC offers the following suggestions to health-care providers:

- Talk with your patients about the risks of taking prescription opioids, including addiction, overdose and death, and about other pain treatment options that may be appropriate for their condition.
- Prescribe the lowest effective dose and only the quantity needed for the expected duration of pain.
- Plan with your patients on how to stop opioids when their treatment is done.
- Provide your patients with information on how to use, store, and dispose of opioids.
- Avoid combinations of prescription opioids and sedatives unless there is a specific medical indication.

Dr. Kuhn added, “We need to de-stigmatize those with drug problems and view it as a medical problem, not a lack of moral control or self-discipline. If we can see it that way, it is easier for the physician to address with the patient.”

Resources for Physicians

AMA Opioid Task Force to Reduce Prescription Opioid Abuse

- Includes continuing medical education to promote appropriate prescribing, along with federal and state legislative advocacy information.

MSMA Resource Guide to Prescribing, Administering and Dispensing Controlled Substances
http://www.msma.org/mx/hm.asp?id=GuidetoPrescribing#.VGfLzPnF8c0

Missouri Prescription Drug Monitoring Program
NOW Coalition
www.mopdmpnow.org

Centers for Disease Control, Prescription Drug Overdose Website
www.cdc.gov/drugoverdose/

U.S. Substance Abuse and Mental Health Services Administration
http://www.dpt.samhsa.gov/providers/prescribingcourses.aspx
- CME course on prescribing opioids for chronic pain.

“Anatomy of an Overdose” Video
www.stlheroinfilms.org

References

Centers for Disease Control, Prescription Drug Abuse Website
CDC National Center for Injury Prevention, “Preventing Prescription Painkiller Overdoses.”


“Nation reaches ’turning point’ in addressing Rx abuse crisis,” AMA Wire, April 28, 2014.

“Missouri needs a robust program to monitor prescription drugs,” letter to the editor, Joseph Forand, MD, St. Louis Post-Dispatch, January 12, 2013.

SSM Health to Construct New Hospital and Outpatient Care Center to Replace Saint Louis University Hospital

SSM Health is committing $500 million to build a new replacement hospital and outpatient care center within the next five years. The new facilities will be located in the immediate vicinity of the current hospital—now known as SSM Health Saint Louis University Hospital.

The announcement was made as SSM Health and Saint Louis University mark the official start of their expanded partnership, which includes Saint Louis University Hospital joining SSM Health St. Louis. In June, SLU announced it would reacquire the hospital from Tenet Healthcare Corporation and would contribute the facility to SSM Health in exchange for a minority financial interest and governance rights in SSM Health St. Louis. The deal became official September 1.

For the past several decades, Saint Louis University’s physician practice, SLUCare Physician Group, and SSM Health have partnered to provide pediatric and maternal-fetal medicine services to patients at SSM Health Cardinal Glennon Children’s Hospital and SSM Health St. Mary’s Hospital.

The relationship between SSM Health and the university extends back more than a century. In 1903, SSM Health’s founding congregation, the Sisters of St. Mary (now known as the Franciscan Sisters of Mary) welcomed SLU School of Medicine students into their hospitals for education and training. In 1928, the university and the sisters worked together to establish SLU’s School of Nursing. In 1933, the sisters and SLU opened the hospital on South Grand Boulevard today known as SSM Health Saint Louis University Hospital. The hospital continued to be owned and operated jointly until 1959, when the Sisters donated their share to the University. SLU sold the hospital to Tenet Healthcare Corporation in 1998.

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MD News

- Mercy Clinic, the multi-specialty physician group affiliated with Mercy Hospital and Mercy Children’s Hospital, recently added the following new doctors and new satellite offices:
  - Yuval Asner, MD, pediatric psychiatrist, at Mercy Clinic Child and Adolescent Psychiatry
  - Kaitlin Poeth Beckman, MD, infectious disease physician, at Mercy Clinic Infectious Disease
  - Jennifer M. Chung, MD, internist, at Mercy Clinic Internal Medicine–Old Tesson
  - Elliott Farberman, MD, and Lynn Nelms, MD, pediatricians, at Mercy Clinic Pediatrics–Hazelwood and Mercy Clinic Pediatrics–O’Fallon
  - Jennifer M. Heeley, MD, pediatric geneticist, at Mercy Kids Genetics

- Venkata Kenguva, MD, internist, and Ryan L. Kroeger, DO, with Mercy Clinic Adult Hospitalists–St. Louis, serving at Mercy Hospital St. Louis
- Daniel M. Maxfield, MD, general surgeon, at Mercy Clinic Surgical Specialists
- John Moore, MD, anesthesiologist and pain management physician, at Mercy Clinic Pain Management; also as director of Pain Management at Mercy Hospital St. Louis
- Robert H. Neumayr, MD, cardiologist, and Mark W. Vogel, MD, cardiologist, at Mercy Clinic Heart and Vascular
- Aaron Pickrell, MD, at Mercy Clinic Adult Hospitalists–St. Louis
- Christie Pickrell, MD, emergency medicine physician, at Mercy Hospital St. Louis
- Sreelatha Varma, MD, family medicine physician, at Mercy Urgent Care Center–North County

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Medical therapies have come a long way in a short time. One hundred years ago, Bayer & Co. had just introduced aspirin for pain control. Barbiturates were new, and just starting to replace bromides for headaches and stress. Alexander Fleming had not yet discovered penicillin.

Since then, we have witnessed a medication revolution. Now we have meds for ailments of persons of all ages. Some are prescribed, some generic, some just deemed “supplements.” They come in all shapes and sizes. They are swallowed, inhaled, absorbed, injected and infused.

Americans have an ever-growing reliance on all types of medications. Neutraceuticals like amino acids, vitamins and probiotics enjoy a market expected to reach $75 billion annually in the U.S. by 2017. The vitamin category alone has grown at 7.4% per year from 2009 to 2014. The domestic over-the-counter (OTC) drug market continues to expand as well, from $1.9 billion in 1964 to $17.1 billion in 2011.

Prescription medication use has also surged in recent years. Patients expect prescriptions when they visit the doctor, and physicians are justified to write them. Why? Prescription meds can help people. Many of the successes of the last century of medical practice involve prescribed drugs. Antibiotics, vaccines, anti-hypertensives and chemotherapy can improve mortality and quality of life. As such, medical science publications and clinical guidelines emphasize prescribing one’s way to “best practice.” Indeed, to satisfy quality-reporting benchmarks, physicians now must prescribe certain meds for certain conditions pro forma, or they must justify why not.

In its 2013 annual update of health-related trends in the United States, the Centers for Disease Control (CDC) reports:

1. Prescription drug spending in 2011 was $263 billion in the U.S., representing 9.7% of all health-care expenditures—an increase from 5.6% in 1990.
2. Opioid analgesic consumption alone increased 300% between 1999 and 2010. Correspondingly, death rates for poisoning involving opioid analgesics more than tripled between 2000 and 2010.
3. According to the National Health and Nutrition Examination Survey (NHANES), the percentage of U.S. citizens reporting they take five or more drugs in the past month increased from 4.0% in 1988–1994 to 10.1% in 2007–2010 (age-adjusted). Forty percent of those 65 and older reported taking five-plus prescription medications in the last month.

Evaluating Polypharmacy

So how much better off are we living through pharmacy? No doubt, doctors add medications with honorable intentions, backed by strong science. But are we good enough at subtracting them also?

The word “polypharmacy” has no single universal meaning. Some experts simply use it to imply a specific number of concomitant drugs—five or more is a common range. The geriatric curriculum web page at the Landon Center on Aging at the Kansas University Medical Center defines it as “the use of several drugs or medicines together in the treatment of disease, suggesting indiscriminate, unscientific, or excessive prescription.” It may not be unjustified to suggest that multiple concurrent medications heighten patient risk.

In the elderly population, the number of medications directly correlates with fall risk, as well as emergency room visits and hospitalizations for adverse medication events. Nursing home residents have a higher risk of hospitalization and death, if they take certain medications at higher doses or with greater risk of interaction.

Paula Span, long-time Washington Post correspondent and now educator at the Columbia University Graduate School of Journalism, writes “The New Old Age—Caring and Coping” series for the New York Times online. In recent posts, she laments the high incidence of nursing home patients taking dementia medications with questionable indications, and the prevalence of anxiolytic prescriptions for insomnia in the elderly. She cites the American Geriatrics Society guidelines, which explicitly caution doctors to minimize these practices. Although a non-clinician, she pens compelling prose, and her critiques remind us that sometimes less is more.

Burgeoning prescription med use among children reflects medical progress, yet has also triggered alarms. The NHANES study suggests 23% of children under the age of 18 reported taking 1-4 prescription drugs in the last month. Compared to similar survey tools from 1988-1994, antibiotics have declined for kids with cold-like symptoms. However, asthma medication use has doubled, and central nervous system
stimulant use (for conditions like attention-deficit disorder) has risen sharply. Pediatric patients with autism spectrum disorder often take multiple different psychotropic drugs.15 Long medications lists are common among hospitalized children,16 raising concerns about unintended risks.17

In a way, prescription drug benefit and risk sit on either end of a seesaw, while the individual patient adjusts the fulcrum. Most efficacy data on medical therapies are derived from trials with large treatment and control groups. We look for statistical significance among groups, and apply group results to our individual patient. In this imperfect system, physicians often must accept a “number needed to treat” (to achieve the desired outcome) in the high teens or 20s. We can only hope our patient is fortunate enough to avoid side effects and benefit well from the medication.

Greater Use of Personalized Data

Many health-care visionaries race to develop more “personalized medicine.” They aspire to employ an individual’s gene and protein data to tailor therapies. They strive to use cell- or receptor-specific imaging tools to guide highly focused treatment. Maybe then we could decrease medication numbers and potential side effects, while boosting therapeutic benefit. While some examples exist today, particularly in the hematology and oncology realm, these hopes remain a frontier in medicine.

Whole genome sequencing has helped physicians individually pinpoint leukemia therapy at the DNA and RNA level, and extend the life of Dr. Lukas Wartman, physician scientist at Washington University.18

Famed cardiologist and researcher Dr. Eric Topol has spent 40 years promoting applied genetic and technology solutions Famed cardiologist and researcher Dr. Eric Topol has spent 40 years promoting applied genetic and technology solutions to improve the care of individual patients. He tweets daily about the promise of genomics and nanoparticles.19 His forthcoming book, The Patient Will See You Now,20 is expected to laud the digital revolution in medicine, predicting it will empower patients to guide doctors in personalizing their care.

Deborah Estrin is a professor of computer science at Cornell Tech in New York City and a professor of public health at Weill Cornell Medical College. In her 2013 TEDMED talk,21 she paints a future landscape of patient-centered health. She anticipates doctors will adjust and tweak care based on “small data” derived from patients’ personal and daily interactions with technology. Using the “digital bread crumbs” left behind from patients’ smart phones, web searches and Fitbit-like biofeedback tools, doctors will customize medication doses.

At St. Louis Children’s Hospital, when prescribing antiepileptics, residents and fellows-in-training demonstrate novel and time-honored approaches to personalized medical therapy. Trainees review seizure medication therapeutic benefits and side effects with attending physicians, pediatric pharmacists and patient families, according to F. Sessions Cole, MD, (SLMMS), chief medical officer and vice chairman of pediatrics. Children’s Hospital promotes a culture of “antibiotic stewardship,” in which trainees learn from infectious disease experts about antibiotic spectrum, drug metabolism in individual patients, and anticipated side effects.

Soon myriad technologies may enhance our prescribing successes and minimize our losses. So, should we hold our breath awaiting a better tomorrow? Clearly not. Every day doctors personalize patient care. In a world of guideline-directed medical therapy and large randomized controlled trials, one might easily forget the foundation of medicine is personal. The history of present illness and the social history seem less glamorous these days, but they are keys to a vast treasure chest of patient-specific data. We must remember to apply new data to our patient, not the other way around. The doctor-patient relationship remains the cornerstone of customized patient care.

Prescription medications help many patients, but may cause problems. Optimizing drug benefit and mitigating risks are complicated, dynamic tasks for physicians. To effectively add and subtract medications, we wield new and old tools. Scientific data and technology continually hone our prescribing skills. Our relationship with our patients lends perspective and truly personalizes all health decisions.

Medical advancement is a meandering journey. Doctors and patients walk the road together. We endure many turns and switchbacks. Eventually the path straightens, and we progress.

References

## CALENDAR

### OCTOBER

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<tr>
<td>13</td>
<td>SLMMS Council, 7 p.m.</td>
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<tr>
<td>16</td>
<td>World Food Day, 6 p.m., John Burroughs School</td>
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<tr>
<td>17-18</td>
<td>MSMA Quarterly Meeting, Jefferson City</td>
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<td>21</td>
<td>MGMA Practice Advocacy Conference, 7:30 a.m. - 4:00 p.m., St. Charles Convention Center</td>
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### NOVEMBER

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<tr>
<td>10</td>
<td>SLMMS Council, 7 p.m.</td>
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<tr>
<td>14-17</td>
<td>AMA House of Delegates Interim Meeting, Atlanta</td>
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<tr>
<td>25-27</td>
<td>Thanksgiving Holiday, SLMMS office closed</td>
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### DECEMBER

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<tr>
<td>3</td>
<td>SLMMS Holiday Party, 5:30-7:30 p.m., MAC West</td>
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<tr>
<td>8</td>
<td>SLMMS Council, 7 p.m.</td>
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<tr>
<td>24-25</td>
<td>Christmas Holiday, SLMMS office closed</td>
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<tr>
<td>31-1</td>
<td>New Year’s Holiday, SLMMS office closed</td>
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### COMMUNITY EVENT

The St. Louis Area Business Health Coalition will hold its annual meeting on Tuesday, Nov. 17, from 7:30 a.m. to 12:00 noon at the Ritz-Carlton Hotel. Featured speakers will be Stuart Altman, Ph.D., professor of national health policy at Brandeis University, and Shawn Leavitt, senior vice president of global benefits at Comcast, NBC Universal & Comcast Spectator. Information: Melissa Hogan, 314-721-7800, mhogan@stlbhc.org.

### Newsmakers — continued from page 29

- Robb Hicks, MD, (SLMMS), internist, physician development coach and recovery/sobriety coach, presented a lecture and experiential workshop on Relapse Prevention at the Missouri Department of Mental Health’s Spring Training Institute on May 29.

- Claire Applewhite, wife of SLMMS Past President Thomas Applewhite, MD, has published her latest novel, *The Doctor’s Tale*. The mystery story takes place at St. Louis City Hospital in 1975. For information or to order: www.claireapplewhite.com.

### Hospitals

- Mercy broke ground on a new location at I-55 and Butler Hill Road. The 11,000-square-foot outpatient facility will offer Mercy Clinic primary care and OB/GYN practices, and laboratory and imaging services will be available.

- Mercy Kids is partnering with the Archdiocese of St. Louis Catholic Education Center on a new pilot program, Mercy Kids in Schools, to address and respond to trauma and stress for both students, their families and school staff. The program launched in January at three Catholic elementary schools: Most Holy Trinity, St. Louis Catholic Academy and St. Louis the King. Developed as a result of research that showed the harmful effects of childhood trauma on future physical and mental health, it aims to reduce trauma incidents and the negative impact of childhood trauma by providing prevention and intervention techniques to the children and their families.

### Research

- The Boeing Company has selected Mercy to offer a new Preferred Partnership health-care plan option to certain employees in the St. Louis area beginning in January 2016. Employees who choose the Preferred Partnership option will experience cost savings in several ways: lower paycheck contributions for some options and lower costs for primary care office visits and generic drugs.

- Washington University researchers have identified a pathway that leads to the formation of atypical blood vessels that can cause blindness in people with age-related macular degeneration. The research increases understanding of how specific immune cells can contribute to vision loss in macular degeneration, and it also may help identify treatments by providing a molecular pathway to target. The study is published online Aug. 11 in the journal *Nature Communications*. Principal investigator is Rajendra S. Apte, MD, PhD (SLMMS), the Paul Cibis Distinguished Professor of Ophthalmology and Visual Sciences at the School of Medicine.

- Saint Louis University has been awarded a three-year, $2.5 million grant from the U.S. Department of Health and Human Services, to improve the health of older Missourians by training primary care health providers in geriatrics. The project will address the significant shortage in underserved urban and rural areas of health care professionals who know **continued on page 33**
Jack L. Croughan, MD

Jack L. Croughan, MD, a board-certified psychiatrist with a subspecialty in alcoholism and chemical dependency, died Aug. 10, 2015, at the age of 72. He was the medical director of the Missouri Physicians Health Program for more than 20 years.

Born in Santa Cruz, Calif., Dr. Croughan received both his undergraduate and medical degrees from the University of Kansas. He completed his internship at the University of Southern California Medical Center and his residency at Washington University.

In addition to his private practice and work with MPHP, he also served as medical director of Chestnut Health System and was a board member of the National Council on Alcoholism and Drug Abuse-St. Louis Area. He was also on the faculty at Washington University, and on staff at Barnes-Jewish Hospital, St. Anthony's Medical Center and the former Incarnate Word Hospital.

Dr. Croughan joined St. Louis Metropolitan Medical Society in 1982.

SLMMS extends its condolences to his wife Patricia Croughan; his children, Sarah Thompson, Anthony Pepe, Rebecca Pedone, Rachel Pepe, and Leah Croughan; as well as his eight grandchildren.

Bruce I. White, MD

Bruce I. White, MD, a board-certified plastic surgeon, died Sept. 2, 2015, at the age of 75.

Born in Kansas City, Mo., Dr. White received his undergraduate degree from Beloit College and medical degree from the Washington University School of Medicine. He completed his general surgery training at Jewish Hospital, and his plastic surgery training at Ohio State University. Dr. White served in the Air Force in the medical health assistance program from 1967-1968 in Sa Dec, Vietnam.

In private practice, Dr. White founded St. Louis Cosmetic Surgery, Inc. He was on staff at Barnes-Jewish Hospital, Missouri Baptist Medical Center, St. Luke's Hospital and Mercy Hospital St. Louis. He was an instructor in surgery at Washington University School of Medicine.

Dr. White joined St. Louis Metropolitan Medical Society as a resident in 1973.

SLMMS extends its condolences to his wife Ellen White, and his children, Daniel White and Laura White, MD.

Robert H. Friedman, MD

Robert H. Friedman, MD, a pediatrician board-certified in allergy and immunology, died Sept. 4, 2015, at the age of 91.

Dr. Friedman received his medical degree from Washington University School of Medicine. He served his residency at St. Louis Children’s Hospital. He served stateside as a first lieutenant in the U.S. Army during World War II and the Korean War.

Besides his private practice, he was an associate professor of Pediatrics at Washington University School of Medicine. He was on staff at St. Louis Children’s Hospital, Barnes-Jewish Hospital, Missouri Baptist Medical Center, St. Luke’s Hospital Mercy Hospital St. Louis and SSM Health DePaul Hospital. He also served as a medical consultant for the primates at the St. Louis Zoo.

Dr. Friedman joined St. Louis Metropolitan Medical Society in 1961 and became a Life Member in 1998.

SLMMS extends its condolences to his wife Lois Heifetz Friedman; his children, Andrew Friedman, Tom Friedman and Emily Friedman; and his four grandchildren.

Washington University received a $7.3 million grant from the National Institutes of Health to investigate the immunological basis of lung transplant rejection, with the aim of improving the long-term outlook for patients. The new funding will support three projects over a five-year span that investigate different immunological aspects of lung transplant tolerance, or the ability of the immune system to recognize a transplanted lung as the body’s own. One will study the link between tolerance and the development of new lymphoid tissue within newly transplanted lungs; another will examine how newly transplanted lungs are more likely to be rejected if key immune cells are missing; the third will look at the role of infection-fighting immune cells called neutrophils in building tolerance.

Newsmakers continued from page 32

how to care for older adults. It will involve professionals and students in geriatric medicine, geriatric psychiatry, nursing, social work, physical therapy, occupational therapy and interprofessional education. Collaborative partners include A. T. Still University Osteopathic Medical School/Missouri Area Health Education Center in Kirksville and Perry County Memorial Hospital. University and community partners are Washington University, SSM Health, Myrtle Hilliard Davis and John C. Murphy Health Centers, Northside Youth and Senior Service Center and the St. Louis Alzheimer’s Association.

SLMMS extends its condolences to his wife Lois Heifetz Friedman; his children, Andrew Friedman, Tom Friedman and Emily Friedman; and his four grandchildren.
Alliance Combines Fashion with Fundraising

Two fundraising fashion events were held in August at the home of CAbi associate Carrie Kreutz. CAbi (Carol Anderson by design) is a fashion line of versatile and moderately-priced clothing made available by a direct sales route, or what is often called “social selling.” The company has two seasons, fall/winter and spring/summer.

Alliance member Angela Zylka organized the Thursday, Aug. 27, evening and Saturday, Aug. 29, afternoon fundraisers. At both events, Carrie described and modeled the latest offerings from the new fall/winter line and then members and their guests tried on various outfits before ordering their favorites. A percentage of the sales generated go directly to support local Alliance community health projects.

Become an Alliance Member!
For membership information, contact Membership VP Angela Zylka, angelazylka@gmail.com.

Holiday Sharing Card Supports Medical Foundations

This holiday season, please join the Alliance in supporting the AMA Foundation and Missouri State Medical Foundation with its annual Holiday Sharing Card project. Donors to the annual appeal are listed in the electronic holiday sharing cards and in the December issue of St. Louis Metropolitan Medicine. Help support the Foundations that work to strengthen the patient-physician relationship and improve the health of our communities.

Please make check payable to the AMA Foundation or the MSM Foundation. Please complete this form and return it with your check by November 10 to:

Gill Waltman
35 Frontenac Estates Dr.
St. Louis, MO 63131

For further information, grh@slu.edu.

COMING EVENTS

OCTOBER 9-11
Alliance North Central States Regional Leadership Development Conference, co-hosted by the MSMA Alliance with programming by the Kansas State Medical Society Alliance. Sheraton Clayton Plaza Hotel.
- Information: Sue Ann Greco, suanngreco@sbcglobal.net.

OCTOBER 20-21
MSMA Alliance Fall Conference, Old Hawthorne Country Club, Columbia.
- Information: Sue Ann Greco, suanngreco@sbcglobal.net.

DECEMBER 4
Annual Holiday Charity Giving Party at the home of Kelly O’Leary, 11:30 a.m. Gift presentation to Alliance-supported charities.
- Information: kellyoleary20@gmail.com.
Students Build Speaking Skills

The annual *Voices of Excellence™* project kicked off in September at Loyola Academy of St. Louis. *Voices of Excellence™* is an educational program developed by the Alliance and spearheaded by member Claire Applewhite. Students write a five-paragraph essay on an assigned topic, then present their essays orally before a panel of judges. The topic this year addressed how to curb violence. Sixth graders were asked how they would end violence in their community; seventh graders, how they would end violence in their city; and eighth graders, in their state. Twice-weekly sessions, with Alliance members assisting in the coaching, were held at the school between Sept. 10 and 24.

The top three winners in each grade were invited to a Sept. 29 luncheon at the Missouri Athletic Club downtown where they gave their prize-winning presentations before an audience made up of family, teachers, Alliance members and MAC members.

The first-prize winners from each grade are being invited to give their presentations once more at a Saturday, Oct. 10, dinner during the Alliance North Central States Regional Meeting, in recognition of SAVE Day (Stop America’s Violence Everywhere).

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   Publisher: St. Louis Metropolitan Medical Society, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120. Editor, David M. Nowak, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120; Managing Editor, James Braibish, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120.
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13. Publication title: St. Louis Metropolitan Medicine
14. Issue date for circulation data: August/September 2015
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<table>
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<th>Average No. Copies Each Issue During Preceding 12 Months</th>
<th>No. Copies of Single Issue Published Nearest Filing Date</th>
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<tr>
<td>a. Total no. copies (net press run)</td>
<td>1,878</td>
</tr>
<tr>
<td>b. Paid circulation</td>
<td></td>
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<td>(1) Mailed outside-county paid subscriptions</td>
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<tr>
<td>(2) Mailed in-county paid subscriptions</td>
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<td>(3) Paid distribution outside the mails including sales through dealers and carriers, street vendors, counter sales, other</td>
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<td>(4) Paid distribution by other classes of mail through USPS</td>
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<td>d. Free or nominal rate distribution</td>
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<td>(2) In-county</td>
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<td>e. Total free or nominal rate distribution</td>
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<td>f. Total distribution (sum of 15c and 15e)</td>
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<td>g. Copies not distributed</td>
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<td>h. Total (sum of 15f and 15g)</td>
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<td>i. Percent Paid (15c divided by 15f times 100)</td>
<td>89%</td>
</tr>
</tbody>
</table>
16. Paid electronic copies: 0
17. This information is printed in the October/November issue.
18. I certify that all information furnished on this form is true and complete. David M. Nowak, Editor.
Advice on Issues You May Encounter in Your Practice

By Jessica Flora, PHR, Research and Solutions Analyst, AAIM Employers’ Association

Q Are employers required to provide Personal Protective Equipment (PPE) to their employees?

Answer

Effective May 15, 2008, OSHA issued a rule regarding employer payment for PPE. With few exceptions, OSHA now requires employers to pay for personal protective equipment used to comply with OSHA standards. The rule makes clear that employers cannot require workers to provide their own PPE. Furthermore, the worker’s use of PPE they already own must be completely voluntary. A few examples of PPE that employers must pay for include rubber boots with steel toes, goggles and face shields, welding PPE, and hearing protection. To learn more information regarding this OSHA rule, visit www.osha.gov.

Q Are you required to keep a hard copy of Form I-9?

Answer

No. The U.S. Citizenship and Immigration Services (USCIS) does not require you to keep hard copies of I-9s if you store them electronically. They state that you may use a paper system, an electronic system, or a combination of paper and electronic systems to store I-9 forms. The USCIS website includes a list of controls that must be in place for the electronic storage of I-9. For more information, visit http://www.uscis.gov/i-9-central/retain-store-form-i-9/storing-form-i-9.

Q Can we provide an unpaid internship, or do we have to pay our interns?

Answer

Internships are normally considered employment relationships under the Department of Labor. This means they are subject to FLSA and are eligible for overtime and minimum wage.

According to the DOL, if all of the following six factors are met, an employment relationship does not exist between an intern and the company that sponsors the participant.

- The internship, even though it includes actual operation of the facilities of the employer, is similar to training that would be given in an educational environment;
- The internship experience is for the benefit of the intern;
- The intern does not displace regular employees, but works under close supervision of existing staff;
- The employer that provides the training derives no immediate advantage from the activities of the intern, and on occasion its operations may actually be impeded;
- The intern is not necessarily entitled to a job at the conclusion of the internship; and
- The employer and the intern understand that the intern is not entitled to wages for the time spent in the internship.

Q When randomly drug testing employees, can we take the employee off of the random list after they have been selected to be tested?

Answer

No. For the drug test to be truly random, the employees who are chosen to be tested must be added back to the pool from which they were drawn. On the next random selection, there should be a chance the same employee may be chosen again. This procedure ensures the drug test is truly random and that any employee has a chance of being chosen.

AAIM Employers’ Association is an association of over 1,600 member organizations in the St. Louis region and throughout Illinois. AAIM provides tools for its members to foster organizational growth and develop the potential of individual employees. For more information about AAIM, call 314-968-3600 or visit www.aaimea.org.
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