WESTCHESTER PHYSICIAN

October 2016 **Volume 32, Issue 9**

PRESIDENT'S MESSAGE

For the last 2 months I have explored what is wrong with the Medical system. Looking at it shows the problems are all related to management and changing laws. So fixing the system is about change in management and laws.

What I did not say is what is right with the system. What is right is us, all the caregivers. Doctors, nurses, physical therapists, social workers, dieticians; you name them, any of the caregivers, and that is what is right. We all strive to do the best we can for our patients. We all fight the system to do this.

We have spent our lives in the service of the people, for their good over our own. We all continue to do this. We may be pushed to hurry up and take less time, but somehow we still manage to give our patients what they need. We stay extra hours, we spend time at home to learn more, we spend our own money to get supplies and the education we need, we even volunteer on off days to care for the people.

This is why the "system" has not failed. If it was just a factory job, we would have all quit by now. But the caregivers still care.

Some of you know that I teach at NY Medical College and have for over 20 years. I am also amazed that with each and every new "crop" of students, they just seem to get better. Smarter, with higher grades, and more dedicated than ever. They know they are looking at worse working conditions, and a decrease in the amount of "reimbursement" for what they do. But they still come.

To fix what is wrong we need 2 things: First we need a voice, a seat at the table of decision making. Second we need to set our goals, both for our patients and for our profession.

Since Hillary Clinton's time, and currently under President Obama, no doctor, or group representing doctors, has been involved in making the decisions and developing the government's health plan and strategy. The AMA was involved in the ACA. They signed on for the promise that the SGR would be fixed in the law. It wasn't and that was another nail in the coffin of the AMA as a group that represents doctors. This has to change. This has to be a primary goal. Also, what is good for hospitals' is not always what is good for caregivers. Large corporate medical systems and hospital systems are becoming more common and prominent because that is the only way to fight back and have a voice.

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GINO C. BOTTINO, MD
President, WCMS

INSIDE THIS ISSUE

UPCOMING EVENTS

Student Wine Tasting
Thursday, November 17, 2016
New York Medical College
Alumni House
20 Sunshine Cottage Road
Valhalla, NY
7:00pm

WESTCHESTER PHYSICIAN

Published by the
Westchester County Medical Society
333 Westchester Ave., Suite LN01
White Plains, NY 10604
914.967.9100 / FAX 914.967.9232

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FROM THE EDITOR…
PETER J. ACKER, MD
COLUMBUS DAY

As alluded to in my last column, the days continue to get shorter and Fall is here in earnest with cooling temperatures. My tomatoes had a banner year this summer, producing huge quantities of red and golden juicy globes. Apparently, the hot dry summer which required that I water frequently acted like anabolic steroids upon their growth, producing gaudy red demonstrations of their vitality and virility. Early on I flattered myself that it was my horticultural genius that produced such abundance, but that notion was effectively silenced by the number of surplus tomatoes that were proffered to me by friends, neighbors and patients. I now have a freezer packed with frozen tomato sauce which I will user all winter in remembrance of summer. Interestingly enough, that usual producer of summer overabundance, the zucchini decidedly underperformed this season.

The tomato, of course, is a New World plant, originally native to Central and South America. Columbus, I dare say, never had the opportunity to taste a tomato. Surprisingly, based on the wide extreme popularity of the fruit and its central place in Italian cuisine, it took a very long time for Old World acceptance of this New World plant. It was feared to be poisonous (as the leaves are – indeed it is botanically in the same family as the deadly nightshade). Columbus, as we all learned as schoolchildren, landed in the new world more than 500 years ago, but this seminal events celebration of a holiday is of much more recent vintage. While it is celebrated in various ways throughout the Americas, it's origins in this country were the result of lobbying of Angelo Noce, a first generation Italian living in Denver, Colorado. In 1905, then Governor Jesse MacDonald of Colorado proclaimed October 12 to be a state holiday. So Colorado is not only a pioneer in legalized marijuana! Finally, in 1934, once again in response to Italian-American lobbying, President Franklin Roosevelt declared Columbus Day a federal holiday.

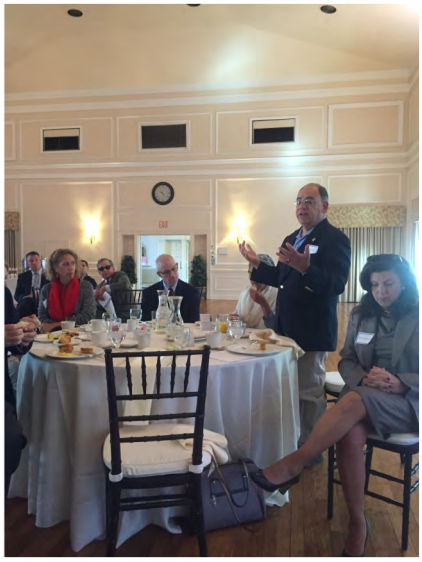
Of course, this day is not universally celebrated. The City of Berkeley, beginning in 1992 has renamed the holiday "Indigenous Peoples Day" (in contrast to San Francisco, just across the bay, which has had the longest continuous history of annual Columbus Day parades –since 1868). Other states have also dissented. Hawaii celebrates it as "Discover's Day" in recognition of the original Polynesians who settled the Islands. South Dakota has designated it as "Native American Day". Oregon simply demurs from celebrating any holiday on that day.

It is not difficult to understand and sympathize with the dissenters. Clearly, providing Europe with the tomato and potato were not the only seismic changes created by Columbus's landing. The wholesale subjugation of indigenous populations was the most cataclysmic. I found in researching this piece the following quote from Columbus's original diary: "They do not bear arms, and do not know them, for I showed them a sword, they took it by the edge and cut themselves out of ignorance.... They would make fine servants.... With 50 men we could subjugate them all and make them do whatever we want". History does tend to generally honor the winners.

♦

Legislative Breakfast Recap

Louis McIntyre, MD, Chair Legislative Committee



WCMS & OCMS Members engaging candidates

The Westchester County Medical Society Held a Candidates Forum at the White Plains Woman's Club on Sunday, September 25th. The brunch meeting allowed candidates for the state Assembly and Senate to present their views and policy prescriptions for issues related to the health and medical care of their constituents. The WCMS Legislative Committee picked four areas of interest to focus on during the Forum; medical malpractice insurance and tort reform, the accelerated pace and implementation of onerous regulations and mandates on physicians; the transparency, fragility and stability of insurance networks and exchange insurance plans and the ever decreasing spiral of physician payment and new, untested payment methodologies. The committee crafted several questions related to these issues and the candidates addressed each during the Forum. It was enlightening and led to some spirited debate.

Unfortunately, the value of the debate was restricted to only a handful of Society members as attendance was sparse despite the convenient venue and robust panel of incumbents and challengers.

The Committee would like to thank all who attended, especially the candidates who took time out of their busy schedules to present their ideas and positions to the Society. In attendance were (in order of appearance): Assemblywomen Amy Paulin and Shelly Mayer, Senate candidate Julia Killian, Assemblywoman Sandy Galef, Assemblyman Steven Otis, Assemblyman David Buchwald, Assemblyman J. Gary Pretlow, Assembly candidate Gregory Purdy, Senate candidate Aleksander Mici, Senator Terrance Murphy and Assemblyman Thomas Abinanti. Thanks also to WCMS staff and Executive Director Janine Miller for organizing the event, and to MSSNY President, Dr. Malcom Reid for attending.

Most importantly, please remember to vote in November!

Letter to the Editor:

Peter Acker, MD

I have been reading Peter Acker's columns in Westchester Physician for a number of years. I have always admired his thoughtfulness and erudition, usually tinged with more than a touch of humor. His variety of subject matter and his wealth of knowledge are often breathtaking. I was thus particularly pleased to read in the September issue that two of his daughters have decided to follow him into pediatrics. It must be very gratifying for him to know what an excellent role model he has been. Congratulations to all of them.

Sincerely,
Preston L. Winters, MD, FACP

Mark Your Calendars!

Upcoming WCMS Board Meetings:

All Board meetings are held on Thursdays beginning at 6:00pm in the WCMS Headquarters located at 333 Westchester Avenue, Suite LN01 in White Plains, NY. If you are interested in attending a meeting, please call or email our office.

November 10
December 8
January 12
February 9
March 9
April 13
May 11

(914) 967-9100—jmiller@wcms.org

PRESIDENT'S MESSAGE

(Continued from page 1)

But that is not enough. We need our medical societies to fight for our profession, and us as professionals. Organized medicine as currently structured cannot effectively advocate for docs.

This won't happen until more of us join our medical societies. The government and industries know that our societies, at best, represent only 25% of us. And even though we try and speak for all, we are few. There are 36 thousand Primary care doctors and 43 thousand practicing specialty doctors in NY State. Out of 79 thousand practicing (and about 30 thousand more that do not actively practice) only a little less than 20 thousand belong to the state medical society and only 18% belong to the AMA.

I know I am talking to the faithful in the society, but our main job has to be membership recruitment, for the benefit of us all! Without good numbers of members, we will not get a seat at any table!

I and the other board members also feel strongly that practicing doctors need representation and support to challenge the institutions they work for. We are no longer independent practitioners, but he hired help; that is just the reality of the situation. I have started to hear numerous stories and complaints about unfair treatment of individual physicians by the corporations they work for. This will become more and more of an issue in the future. So who will represent our interests and be our "union rep?" It should be our medical societies.

Let's now talk about our goals, first the patient-centric goals. I believe there are likely a lot of ways to implement change to the system that can work. And there is probably no specific right way. But to make it work, whatever it is that is done, it must follow the goals we set out for it. Currently, the main goal the government had in enacting the Affordable Health Care act was to control the money spent by government, while increasing the cost to those that could "afford to pay it." The goal was to reduce government health care spending by the billions, even within the first years. This of course has not happened. It was to cover the 50 million uninsured working people of the country. It has been claimed as a success while covering at best 15 of the 50 million. All I hear about it from my patients are complaints!

The biggest complaint I hear from patients is their lack of time with their doctors. We are not just technicians tuning an engine. As caregivers we need to interact on a human level to be effective and really make a difference. We are not widgets in a machine and we need time. Time has been taken away from our care and needs to be returned. To get time back we need more independence and better pay. No amount of management will change this and no false attempts at "insuring quality" will change this either.

Patient-centric Goal #1) More time with our patients.

Often patients are changing the doctors they see, and going to specialists due to insurance coverage and not because that is who they want to see. Patient choice and ability to choose their doctors is often talked about and they are told they can keep their doctors; but we all know it is not true. Patients should have the right to see who they want. Most doctors would see a patient out-of-network for the same price or an added copay as the insurance would pay for an in-network doctor, but they are excluded from doing this. Out-of-network billing should be available to all patients.

Patient-centric Goal #2) Bring back the patients' ability to see the doctors they want to see.

Patients then complain of their doctors' hands being tied down, not able to do the tests we want to do and give the medications we want to. They are concerned they are getting short changed, and they are. When caregivers conform to outside requirements and judgments for companies that know not the patients, and have no real interaction with the patient, they are dehumanized and treated as a commodity. This is goes against the patient-doctor bond.

Patient-centric Goal #3) Doctors should have more autonomy in ordering tests and choosing medications for their patients.

We are all concerned about the cost of medical care. All my patients complain of the high cost of insurance and medications. Medical care is labor intensive, and that is especially true of caregivers. Doctors account for 12% of the Medicare dollar, but we are all aware of the raising costs of medications, durable goods and services. Especially as the population ages, and we become more technologically advanced, the cost keeps going up. This has been the main driver for change in government policy and what has led to the "Affordable" Health care act. Reducing the overall cost of medical care is a daunting problem. We cannot hold back technology and advances in medical care. And reducing the time people have with the caregivers is not the right thing to do for the society.

Without reducing care for people in general, it may not be possible to reduce the cost of care. Part of the issue is what we, society, want for ourselves. We seem to want health care coverage at a very high level for everyone. Many of us feel it is a right as a human being.

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KERN AUGUSTINE, P.C.
Attorneys to Health Professionals

Final Section 1557 Rule

Nondiscrimination in Health Care Programs and Activities

By: Donald Moy, Esq.
DMoy@drlaw.com

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). This law prohibits discrimination on the basis of race, color, national origin, sex, age or disability in health programs or activities.

Section 1557 builds on long established Federal civil rights laws and extends these nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which receives federal financial asstance from the U.S. Department of Health and Human Services (HHS);
- Any health program or activity that HHS has involvement in administering;
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces.

For example, hospitals that accept Medicare or doctors who receive Medicaid payments or who receive other federal financial assistance are included as "covered entities" under the Final Rule.

Section 1557 has been in effect since its enactment in 2010 and the HHS Office of Civil Rights has issued a final rule to implement section 1557, which was published in the Federal Register on May 18, 2016. The Final Rule became effective on July 18, 2016.

Among the requirements of the Final Rule, covered entities must post notices of nondiscrimination and taglines that alert individuals with limited English proficiency to the availability of language assistance services. The Office of Civil Rights has translated a sample notice and taglines for use by covered entities into 64 languages. For translated materials, visit DrLaw.com. The notice requirement becomes effective within 90 days of July 18, 2016, on October 16, 2016.

The Final Rule also requires covered entities with 15 or more employees to have a grievance procedure and a compliance coordinator. The Final Rule includes a model grievance procedure.

Is your medical practice a Covered Entity under the Final Rule? Does participation in Medicare part B or receipt of payments under Medicaid make a doctor's office a covered entity? Although HHS in the Final Rule takes the position that a doctor's participation in Medicare Part B alone does not constitute federal financial assistance, HHS takes the position that receipt of payment under Medicaid constitutes federal financial assistance, and HHS estimates that the vast majority of doctors are covered entities because they receive payments from Medicaid or receive federal financial assistance through other means. For more information, read the full article on this section of the rule.

To view the full article, visit DrLaw.com.

YOU CAN PLAN ON IT

Webster's definition of "planning" is simple: *the act or process of making a plan to achieve or do something."* However, when it comes to financial planning for doctors, things can quickly evolve from simple to more complex. You can plan on it: from medical school through residency to single or group practice, physicians' lives, finances, and goals are continually evolving. As complexity builds, working with a knowledgeable and experienced financial planner can both help you realize your life goals and also avoid missteps that can easily derail the best-laid plans.

"Do I really need a financial planner?" is a logical question that in our experience many medical professionals have asked themselves. Some things to keep in mind as you answer the question:

- *As my practice, professional obligations and family all grow, do I have the time to devote to keeping a financial plan on track and making adjustments when appropriate?*
- *Do I have the time and energy to keep pace with financial market and other developments that can have a critical impact on my personal and family finances?*
- *Can I properly assess all the risks that can arise as my career progresses – business and legal risk, estate planning, and adequate protection of my earning power?*

Of course, physicians have the ability to make important financial decisions. We provide guidance and input on key areas such as retirement planning, investments, family needs, income protection, and philanthropic goals. The client uses our process to validate their decision making and to realize their overall vision. He or she makes the final determinations on the broad direction and content of the plan.

Below are a few points a good financial planner might raise with you in an introductory conversation:

- ***How did you get started in your current practice or position?*** *This is more than a polite conversation starter. Your answer provides insight into what is important to you, your aspirations, and other priorities and interests.*
- ***What is the legal structure of your practice?*** *Whether you practice as part of a team or as an individual, the specific legal structure impacts the risk profile of the practice.*
- ***Do you have a specific retirement plan in place?*** *Many medical practitioners are so deeply engaged with the practice or other responsibilities that they do not take time to craft a specific retirement plan with appropriate funding, asset allocation, etc. A good retirement plan is a reflection of your post-retirement goals and desired life style.*
- ***Do you have appropriate asset protection?*** *Creating a solid asset protection plan is critical in an environment where malpractice suits are common, and tax planning is imperative.*

As a financial planning team, we recognize the importance of utilizing other professional resources, too, such as attorneys and CPAs who can function like a board of directors to assure that a plan is comprehensive and that all bases are covered.

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Student Wine Tasting
New York Medical College
Thursday, November 17

Alumni House
20 Sunshine Cottage Road
Valhalla, NY 10595
7:00pm

All WCMS Members are welcome!

RSVP: jmiller@wcms.org

PRESIDENT'S MESSAGE

(Continued from page 4)

It is not the amount of money that is the problem, just how we want to spend it!

In other industrialized countries the cost of medical care is significantly less than in the US. There are 3 main reason for this. Maybe the most significant one is that there is no medical malpractice for government based medical care. This not only reduces the cost for insurance, but reduces the cost of goods, supplies and services too. We have been fighting to curb the cost of malpractice in Albany through the medical society for years. Just in the last year we defeated a bill that would have allowed the lawyers an extended "look back" time that would have increased the cost of care for everyone up to 25%. In states that have put a cap on the amount able to be recovered for just "pain and suffering" the cost of insurance has dropped significantly. NY state remains the state with the highest medical insurance costs, by a huge number! Clearly medical-legal reform is a key to reduction of the cost of medical care to our society!

In industrialized nations the administrative cost of medical care is much less as they have the hospital systems administer and make decisions about rationing of the healthcare dollars. This has multiple levels of duplication of administration work and bureaucracy. With a "fractured" care system this is unavoidable.

Finally, Europeans accept rationed health care and expect less. They also except a system that allows one to get better health care, if you pay more for it. This was always thought to be a "show stopper" in the USA where everyone expects great health care no matter who is paying for it. Interestingly the Affordable Health Care Act (Obamacare) has introduced a 4-tiered system ranging from Bronze to Platinum, with Platinum recipients having to not just pay more, but incur more of a tax burden to pay for others. The per capita cost of Medicare is about 550 dollars a month, which is about the average of health plans in the US too. People on Obamacare plans now pay about 100 dollars less, but this is going up at least by 20% or more this year. A more clearly defined separation of the 4-tiered system might be able to reduce this significantly.

Medicaid, on the other hand, has no tiered delivery of health care. In fact, Medicaid patients often get more services than people with private insurances. The cost of Medicaid to the state is about half the budget, and growing. State government keeps trying to change and revamp the Medicaid system almost every year to lessen the financial burden, with virtually no success. In my opinion, for both Medicaid and Medicare, the more the government does to try and "fix" the system and make it less expensive, the more expensive it has become! Why can't they get it right? Because they are not doctors and they really cannot control what they do not understand at a basic level, and as they don't even have us be part of the decision makers revamping the system, it will never work.

The insurance industry and medical industries in general have exhibited unprecedented greed when dealing with the public. Unlike government that is trying to stop expenditures; industry continues to increase its profits. They are making obscene amounts of money with what seems to be a complete lack of countermeasure controls by government. The reason for this is obvious: as the largest insurance company in the world, the US government has a conflict of interest. It is also true that the amount of money given to our representatives from medical industry helps keep their interests more important than that of the people. The reason President Obama got the ACA passed was by having the insurance industry leading the decision making process and being "cut into the deal!"

Patient-centric Goal #4) reduce the cost of medical care to our patients.

Measures to accomplish this by are: medical-legal reform, reducing the bureaucratic administrative cost of delivery of the medical care system, having an independent Insurance Regulatory Agency, and include practicing doctors as part of the decision making process for health care law. Or at least keep it from raising more than inflation yearly. (Note the insistence of having Practicing Doctors involved). The likelihood of an independent insurance regulatory agency is small, yet having an independent public oversight review board is not. We have this for looking at what the police do. Why not for this?

Sometimes what our patients need is not enough for providing quality medical care. Our profession and its practice should be defined and defended by our practicing physicians; just like with the nurses and other medical professionals.

The nurses, if anything, have done a better job of this than physicians. They unionized, and all nurses must belong to, and be represented by, their state society. They still have all the same issues we all do, but at least their practice is more protected than ours.

We need goals that are doctor-practice centric.

One of the main reasons that our medical society was formed, was to develop a set of medical ethics for physicians to adhere by. This is still one of the key elements of the medical society's function and continues with little interference from government or industry. Just last year the state societies with in conjunction with the AMA, revamped the Code of Medical Ethics. As a member of the state Ethics Committee I helped with this process and I am very proud of this work; so it is no surprise that my first goal is:

(Continued on page 14)

Westchester Academy of Medicine
7th Annual Golf Outing & Fundraiser
Thursday, October 6, 2016—Westchester Country Club—Rye, NY

On Thursday, October 6th, forty golfers took advantage of the beautiful fall weather and enjoyed playing in the *7th Annual Westchester Academy of Medicine Golf Outing & Fundraiser*. The Outing was held at Westchester Country Club in Rye. Following the golf, an additional group of members and guests joined the golfers for dinner, fellowship, and prizes. Joseph Tartaglia, MD, President of the Academy, welcomed everyone, thanked the Golf Committee, recognized and thanked all sponsors, and presented Mary Ellen Pilkington with the 4th Annual "Friend of the Academy" award. All proceeds directly benefit the Academy's very busy CME activities and its scholarship fund, which annually contributes toward events which foster student interest in careers in medicine.

The Academy would like to thank the following sponsors and participants for their generous support of this year's outing:

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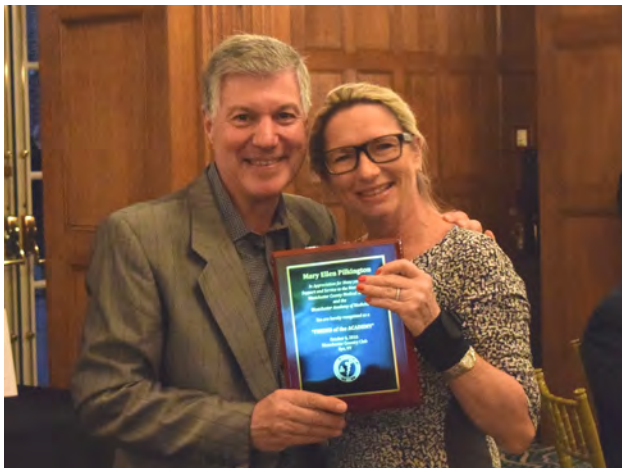
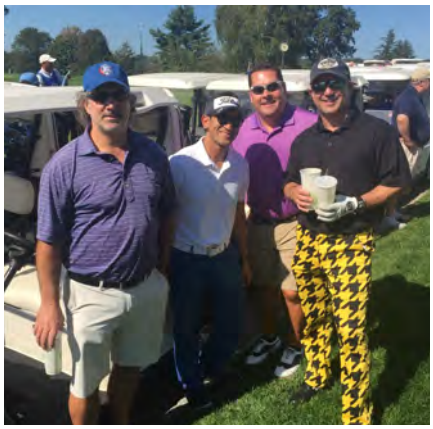
2016Golf Committee:

Joseph Tartaglia, MD, Chair, President Westchester Academy of Medicine • Louis F. McIntyre, MD • Robert Ciardullo, MD • Ameet Goyal, MD • John SanFilippo • Steve Malfitano • Mary Ellen Pilkington • Janine Miller, Executive Director

"Friend of the Academy" Award
Presented to
Mary Ellen Pilkington



Dr. Joseph Tartaglia, President of the Westchester Academy of Medicine, presented Mary Ellen Pilkington with the 4th Annual "Friend of the Academy" award at the Golf Outing Dinner on Thursday, October 6, 2016. Ms. Pilkington was honored with this award for her many years of support and service to the Westchester Academy of Medicine. Mary Ellen has been an integral part of the planning and execution of the Golf Outing, and our raffle in particular, since it began seven years ago. The Westchester Academy of Medicine would like to thank Mary Ellen Pilkington for all of her hard work and dedication.



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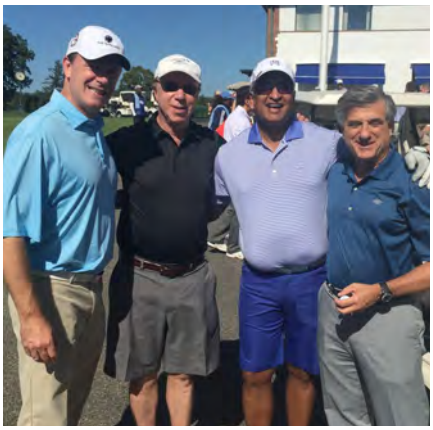

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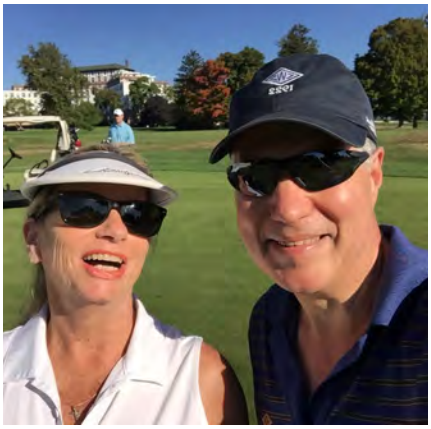
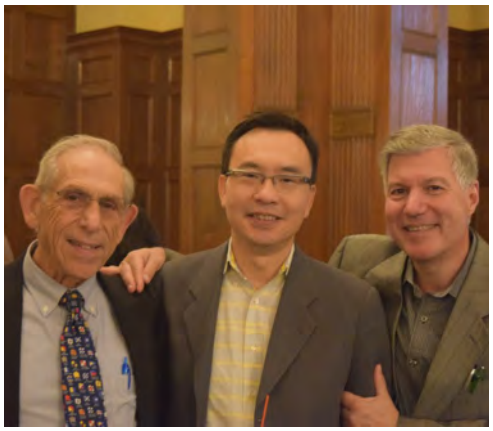
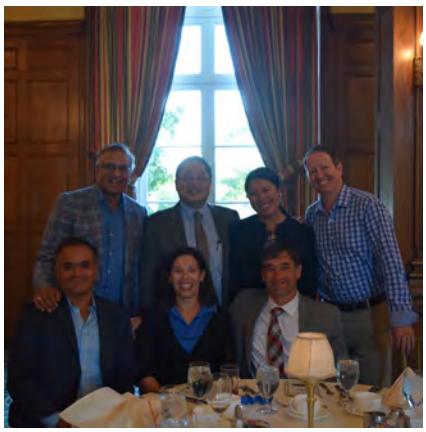


Mary Ellen Pilkington & Joseph Tartaglia, MD

Joseph Tartaglia, MD; Chris Fugazy; John Bryan, Barry Mitchell & Gary Raniolo



Robert Lerner, MD; Thomas Lee, MD; & Joseph Tartaglia, MD



Ameet Goyal, MD; Richard Yung, MD; Ying Yung;

PRESIDENT'S MESSAGE

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Practice-centric goal #1) Medical Ethics must be maintained by physicians; and should be the bases of the practice of medicine.

The doctor-patient bond is at the very heart and center of our practice, and all our ethical issues revolve around this. However, this special bond is being challenged and eroded by outside forces including government and industry manipulation, and the economic pressure of the high cost of medicine on society. With doctors becoming the hired help, they must listen to their bosses, or lose their livelihood. This puts us in an untenable position. Only a strong Medical Society has the chance of defending doctors as I discussed before.

One solution to this is, that the business practice of medicine should only be owned by practicing doctors. Industry, and hospital systems should contract with doctor practices to provide services. This works in California where the Kaiser-Permanente system has functioned for decades. What many people do not understand that this is 2 separate groups, with the doctors being in the doctor owned Permanente company, contracted to the Kaiser Health network. As of now there are 2 different and competing developing large corporate groups in NYS. One is that of large doctor owned medical groups like the Mont Kisco Medical Group and WestMed. The other current group-large corporations, are health network corporations that hire and "own" doctors. I am sure that the corporate heads of the health networks would say the doctors have kept their medical ethical standards, but we all know (and so do the patients) that it is just not true. There is just too much of a conflict of interest and power over practitioners on the corporate side. Furthermore, the competition between networks and these large corporations does not provide for good healthcare or even reduced pricing. In no other country in the world are medical services competed for with media advertising and messages telling patients one place is better than another. How does that provide for comfort and feeling confident that you are being well cared for?

The only way to accomplish what we seek is to bring back transparent cost and price to the system. Get rid of fee schedules, and allow doctors and hospitals to price their services. Make insurance what it is supposed to be; a hedge against catastrophic loss as opposed to a first dollar coverage vehicle. Have high deductibles with tax free health savings accounts. Currently this cannot happen because the government actually wants to control health care. Plus, the changes that have already occurred with consolidation and oligopoly in delivery systems will cement the current paradigm and prevent meaningful reform. I think the only way for physicians to collectively advocate in this environment is some type of union structure, even though I oppose such entities in general. They have forced us into this situation. I think we can do this through our medical societies.

Practice-centric goal #2) The patient-doctor bond must be preserved and free from attack by non-medical influences.

This doesn't mean that doctors should not take into account societal and economic needs and influences on the practice of medicine. All medical practitioners are well aware of the social and economic pressures on our medical system. All too often we find ourselves being told what to do *Medically* for our patients by government and industry based not on science and patients' needs, but on what powerful interest groups can force on the system through laws or media influence.

Practice-centric goal #3) Only medical professionals should practice their profession; and our professional societies determine what the practice should be.

Stop legislating medicine and treatments or allowing insurance companies to regulate the practice of medicine; this has only led to high cost and overutilization. Stop legislating how doctors and other medical professionals should be trained, we have institutions that do this well and are run by physicians and medical professionals teaching the practice of medicine. These laws and industry policies have only added cost to the system and have taken away patient's rights to be treated by their health professionals. Stop allowing companies to advertise goods and services that must be ordered by medical professionals. This too causes not only overutilization of these products, but generates mistrust in medical care.

I believe we have been devalued by government and Industry on purpose, as a way to control us and our patients. Paranoid? Maybe. But as we become more the hired help, part of the "medical team" (that includes navigators from government and industry), called "providers" of services, and not called what we are; we have lost respect in society. Mostly by the people that deal with us on a business level, not by the patients. But it is not the patients making the decisions any longer.

Practice-centric goal #4) The office we hold, obtained through long hours of education and hard work, should be given the respect it deserves.

I am not a provider of medical services; that is a corporation or an institution. What I am is a doctor and I deserve to be treated and respected accordingly, by everyone! This is not hubris, but affirmation of the station achieved. It is no different than the respect we give our presidents after they achieve office, no matter what you thought of them beforehand.

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President's Message

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As for reimbursement of services. As most of us now work for corporations; let's call it what it really is-payment. In no other profession is the payment for work so restricted as it is in medical care. Since it is no longer possible for the average person to pay the bill when presented, we must all have insurance. Because of this physicians are told what we can make from government and industry. Can you imagine lawyers being told what they can charge by the people who pay them? How about accountants, architects, engineers? The wolves guarding the hens are telling the hens what they will pay them to eat their eggs and them.

Practice-centric goal #5) Medical professionals should be compensated according to their: underlying talent, hours of education, level of achievement, and level of liability.

I used underlying talent so that a normally thinking person will understand this aspect. Just like not everybody can become a professional ball player, so too, not everyone can do what we do. First you have to have the talent and drive to become a medical professional, and we represent only the few. And within this, some of us achieve more than others, study longer and obtain a higher level of achievement. This should be rewarded. Currently it is not at all, at least for doctors. If we are treated poorly we become burned out no matter how much we want to serve the public good. Most of us go into medicine not really caring that much about the money. Some of that is because we assume that we will be treated as well as those before us, but this is no longer true. Eventually it will destroy the practice of medicine. Unfortunately, that may be just what industry and government wants. So my final words are: If we do not stand up for ourselves and our profession, who will? If we do not join our medical societies and be counted, who will we count on? Show this to those who are not members, or at least talk to them about these issues. Get them to join.

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