

Nebraska Medicine

Spring 2016 | Volume 15, Number 1

Leadership

The value and importance
of physicians doing their part



Nebraska
Medical
Association

Advocating for Physicians and the Health of all Nebraskans

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President's Message *Leadership*

by Harris Frankel, MD
NMA President

In the 2003 movie *Old School*, three friends open a fraternity near their alma mater. In one of the scenes, Frank (played by Will Ferrell) is seen streaking through the center of campus. In an effort to measure his success, he looks back and realizes that no one has followed him. Funny as this may be, it certainly raises the “following” question: are you truly leading if nobody is following?

In his book, *The 5 Levels of Leadership*, John Maxwell provides a clear view of what leadership is and what it is not. For some, he says, leadership may be a mystery; like walking down a dark corridor. These people have a sense of where they want to go, but can't see the light ahead to get there. For others, he says, it may be a theoretical exercise based in an equation and variables worthy of study, research and debate. Maxwell defines leadership as a verb, not a noun, and so clearly articulated anyone can learn the five levels he outlines. He goes on to say good leadership is not about advancing

yourself, but rather your team. For us, our team is the organization, the Nebraska Medical Association.

Daniel Goleman suggests IQ and technical skills are important, but emotional intelligence is the “sine qua non” of leadership. While it is important to identify individuals with the “right stuff,” such things as enthusiasm, vision, honesty, transparency, intellectual talent, and a willingness to make tough decisions with high stakes for which one is willing to be accountable, are most important. Goleman sees emotional intelligence as a predictor of effective performance, rooted in the traits of self-awareness, self-regulation, motivation, empathy, and social skill.

Jim Collins wrote the ever so popular book *From Good to Great*, in which he talks about two other traits he sees in effective leaders; resolve and humility. He cites the importance of leadership in setting a vision and being able to move an organization to its goals. He also points out how an ineffective leader can drive an organization straight into the ground.

That is why leadership matters.

Many have studied what it takes to be an effective leader. At the end of the day, an invitation to lead is an invitation to make a difference. While some great leaders are born with many key attributes of leadership, there clearly are certain traits leaders share and which can be acquired and practiced to be more effective leaders. Good leadership builds teams and elevates organizations. Effective leadership can change communities and more.

The strength of our organization is dependent upon the effectiveness of our leadership...yours and mine. As members of the NMA, as advocates for our colleagues, patients, and public health alike, we have the responsibility to lead, shape and influence health policy and not let it define us. We must *educate and advocate*. Nothing, however, is more critical to the future success of health care than for physicians to *lead*.

Harris □



Executive Vice President's Message

by Dale Mahlman
NMA Executive Vice President

Y(our) time is now! Make 2016 the year you get more involved in organized medicine and the legislative process!



This is my (our) annual call to action. Don't allow the profession of medicine to become an occupation, leaving others to make decisions on your behalf without the benefit of your educated well informed assistance. It's as easy as an email, written note, or phone call, but lack of action will guarantee a future decided for you, not with you.

New for 2016 the Nebraska Medical Association will be represented in our lobbying efforts by Mueller Robak, Nebraska's premier lobbying and governmental relations firm. The NMA has been fortunate over the years to have outstanding lobbyists like David Buntain (28 years) and Ann Frohman (3 years), and we look forward to a long and successful relationship with Bill Mueller, Kim Robak, Matt Schaefer, J. Bub Windle, Mary Johnson and the staff of Mueller Robak. They have and continue to represent various medical specialty societies, but look forward to being the "face" of the NMA and organized medicine as a whole in the rotunda and beyond. We are in very good

hands moving forward!

This issue of Nebraska Medicine focuses on leadership by physician members at various levels and in various places. We are fortunate to have among us many outstanding representatives of medicine that have given their time and expertise to represent your profession. Leadership is often defined as establishing a clear vision, sharing that vision with others so they will follow willingly, providing the tools necessary to realize the vision, and then managing the interests of all involved in the pursuit of the vision. It's as easy as that, if that is easy.

In addition to the leadership recognized in this edition, we have many more examples of members providing their expertise in their local communities serving their school boards, county boards, church councils and in other volunteer roles. As has been mentioned previously, we have two Lincoln physicians, Drs. Dale Michels and Les Spry, campaigning to represent the 25th District in the Legislature. Both are fine candidates and great examples of our membership, and one will hopefully be elected to display their leadership in the 2017 Nebraska Legislature. You can read more about both of them in this issue.

I'd also like to mention that in 2016 the Nebraska Medical Association is making a concerted effort to recruit

and engage the osteopathic physicians in Nebraska. Membership in the NMA has been available to every doctor of medicine and osteopath licensed in good standing in the state of Nebraska. The leadership of the Nebraska Osteopathic Medical Association (NOMA) has recently been re-energized and reached out to the NMA about opportunities to partner. Nothing makes more sense to the leadership of the NMA than to welcome all osteopathic physicians to join the NMA and assist in "Advocating for Physicians and the Health of all Nebraskans."

The NMA will continue to be the pre-eminent unifying physician medical organization in the state of Nebraska, and with the addition of all interested osteopaths in the state, an even stronger organization for the patients of Nebraska. Medicine remains a highly respected profession, and the leadership provided by the representatives of organized medicine is becoming more and more important in these ever changing times.

I'm a fan of the former UCLA Basketball Coach John Wooden, who was not only famous for his many victories but also his leadership development. His quote: "things turn out best for the people who make the best of the way things turn out" can be applied as we work together to provide the leadership to make things turn out the best! □

My thoughts on physician leadership

by Peter J. Whitted, MD, JD

Disclaimer: Nothing I say is particularly profound, unfortunately, but hopefully worth reiterating.

To practice medicine is a true privilege and with it comes an enormous responsibility to our patients and the profession. Physician involvement and eventual leadership is simply the natural result of a desire to influence the future direction of medicine. Each of us, because of our very backgrounds, brings to the profession a unique set of beliefs and, at least at some level, the desire to influence others and evoke change.

One of my earliest memories was accompanying my father while he tacked up a Roman Hruska senate campaign sign at 114th & Pacific (brick east and west, dirt north and south) in 1956. This type of parental example and sibling rivalry demanded that if we were to be heard, we needed to get involved...so we did...certainly not always successfully.

A circuitous educational path through law school created an (generally undeserved) impression in the medical arena that I knew something about the law. I always remember what our professor said at the beginning of Torts, "you intuitively know more about Torts now than you will at the end of this course"...that is true, as is the disuse atrophy associated with lack of practice. Law, however, at least partially, resulted in my being elected UNMC Student Regent...not because I was so special, but because I

was interested.

The most fascinating thing about medical leadership is that there is truly a dearth individual willing to "wade into the water." This is sort of surprising since all of you have been involved in leadership positions from student councils on. The fact that you are reading several scenarios from those who have gotten involved tells you that many more are sought and needed to advocate for our patients and our profession.

The one common theme I suspect of those who have been involved in organized medicine (hate that term since it implies some sort of union-like apparatus and coercion) is the presence of a mentor(s) who significantly influences their path. This is certainly personally true. We and others lead by example. Dr. John Ramsell encouraged me to take up scope of practice issues; Dr. Richard Meissner introduced me to MOMS and NMA; Dr. Jack Filkins medical staff issues; and Dr. Stanley Truhlsen the American Academy of Ophthalmology. This resulted in leadership positions in a number of organizations from hospital medical staff to the Nebraska Lions Eye Bank, to MOMS and the NMA, the Nebraska Academy of Eye Physicians and Surgeons and the American Academy of Ophthalmology, as well as a number of community non-profits along the way including the University of Nebraska Foundation. These all have been enormously rewarding.

Perhaps the most surprising thing is that it takes very little to get involved... basically show up with a desire and a willingness to participate. None of us are all that special or irreplaceable, but we all wish to be engaged in shaping our future. Remember, "if you are not at the table, you are on the menu."

Lastly, I want to mention I've had the opportunity to be involved in the professional liability arena since the mid 1970s (law school thesis outlined a solution to the medical malpractice crisis of that era). As chairman of the NMA Professional Liability Committee when St. Paul exited the malpractice market in the early 2000s, I participated in the interview process for those worthy carriers seeking an NMA endorsement. COPIC (Colorado Physicians Insurance Company) stood out as a different kind of company...a patient safety company with the desire to change the system such that ultimately these types of companies are no longer needed. As the sole Nebraska board member, I have had the opportunity to witness progress toward that goal, which has been an extraordinary privilege. This may be my greatest contribution to the profession.

In short, show up, get involved in what you are passionate about, and influence the future. This applies not only to medical organizations, but to the community at large. You will be richly rewarded. □



Leading a voluntary health organization

by Alan Thorson, MD
Past President, American Cancer Society

I was honored to receive the invitation to contribute one small part to this important issue of Nebraska Medicine dealing with leadership and the important role of physicians in advocating for our patients and our profession. The significance of the latter is sometimes overshadowed as we focus on our patients and overlook the critical need for a strong and respected profession to make it possible to deliver all that we want for our patients. The role of physician leadership in either role (patient or professional advocacy) is paramount to our success in providing the quality of health care we all aspire to.

My specific assignment was to share with you some thoughts about my recent presidency of the American Cancer Society: what it meant to me, what I learned and the value received; all in hopes of encouraging others to become involved in leadership positions. The American Cancer Society (ACS) is the largest voluntary health organization in the United States. The success of the ACS relies on the support of 2.5 million enthusiastic volunteers supported by a talented and dedicated professional staff raising nearly \$900 million dollars annually for patient support, research, prevention and detection/treatment of cancer. As to what it meant to me, personally, it was an incredible honor to be asked to serve as president. Beyond that, it was just plain awesome.

Of course, as a volunteer position

taking up 50 percent or even more of my time, it would not have been possible without the support and encouragement of my partners. I was fortunate in that it was not just I participating in that volunteer leadership position, but all of my partners also. Together we found a way to make it happen. That is how it should be. The point here is that you can be a leader without necessarily stepping out in front of the crowd. You can be a leader by accepting some self-sacrifice (which my partners did) in supporting someone who is willing to take that step. Leadership can be exercised by quietly taking the steps necessary to help others dream more, do more and become more.

Whether a leader is quietly sitting on the sidelines or carrying the torch, their work is about helping others reach their full potential as individuals or groups. As president of the ACS, I learned that one of the great benefits of being a volunteer leader is that you can't go about helping someone else achieve their goals and potential without secondarily and unknowingly reaping some benefits yourself. In the words of Ralph Waldo Emerson, "It is one of the most beautiful compensations of life that no man can sincerely try to help another without helping himself." Leading is a way to grow yourself, to improve yourself . . . and your community . . . and your nation, for you . . . and for your children . . . and your children's children. How beautiful is that? There is no sweeter value earned, no sweeter compensation than that.

And I learned there are downsides too. When you choose to be a leader, you will find that often you are asked to be a bridge between opposing ideas or

variances of opinion. Sometimes one of those ideas may be yours. It doesn't take you long to realize that, in the words of Roy West, "If you're going to be a bridge, you've got to be prepared to be walked upon." Sometimes that hurts, but you understand the importance of that bridge. Without that bridge, probably nothing is going to happen. The best chance of success is if you can get each side to feel like they were the ones that came up with the solution that "bridged" the gap.

It is important to have physicians in visible leadership positions, so we can all reach our full potential as providers of quality health care to our patients and to maintain the integrity of, and respect for, our profession. Such leadership positions can serve as bridges between our members and our patients and between our profession and other interested parties. Just as important, however, is to recognize that such positions are not the only path to leadership. We can all serve as leaders through our everyday words and actions in our institutions, in our offices and in our homes.

I have had the privilege and honor of learning, serving and benefiting from my experiences in leading the ACS. I now have the equal privilege and honor of learning, serving and benefiting from my experiences every day, leading in my home and my office, supporting those who now serve in those publicly visible leadership positions. We all have that privilege. To paraphrase Martin Luther King, Jr., "If you can't fly, then run; if you can't run, then walk; if you can't walk, then crawl; but whatever you do, . . . lead." □



Musings of a past president

by *Sushil Lacy, MD, FACS*
Past President,
American Urological Association

“Leadership and learning are indispensable to each other”

—John Fitzgerald Kennedy

I found this to be true during my several leadership positions and it started initially when I became president of the Nebraska Urological Association (NUA). It continued while I was president of the South Central Section of AUA (Kansas, Missouri, Nebraska, Colorado, Texas, Arkansas, Oklahoma, New Mexico and the country of Mexico), president of the American Association of Clinical Urologists (the national organization of urologists with the sole purpose of promoting and preserving members professional autonomy and financial viability) and during my tenure as president of the American Urological Association (AUA). With more than 21,000 members the AUA is the largest and most prestigious urological organization in the world. With an 88,000 sq. ft. office headquarters in Baltimore and more than 154 employees I had the daunting task of heading up a large multimillion dollar organization. Previous leadership roles certainly helped me make a smooth transition. AUA had a challenging and constructive year dealing with fiscal, scientific, health policy, patient advocacy and complex international issues. However, working with a wonderful Board of Directors made my job easy. Always keeping in mind, that “Leaders become great, not because of their power, but be-

cause of their ability to empower others” (John Maxwell) and “A genuine leader is not a searcher for consensus but a molder of consensus” (Martin Luther King, Jr.), was my mantra for success.

My experience was enormously educational, extremely humbling and occasionally challenging when dealing with the Centers for Medicare and Medicaid Services (CMS) in regards to urological issues. I have had the privilege and opportunity of representing urology on the Hill for the past 15 years. I found our congressional representatives and senators very cordial and agreeing with all our talking points, but offering no real action or solutions. I think the only success organized medicine can claim over the years is the repeal of the Medicare Sustainable Growth Rate (SGR). Though frustrating, I came to have a very good understanding of how Washington works. I doubt if anyone can fully experience this without being closely involved.

I traveled the world representing the AUA at national meetings in European, Asian, Middle Eastern and South American countries and in many U.S. cities. Visiting 12 countries and 18 cities provided an amazing experience for which I will always remain thankful. Exchanging urological information with colleagues in various parts of the world was extremely useful. I believe the world of urology has grown significantly through these interactions and information exchanges. AUA has become a global community with the latest cutting edge scientific information being presented at our annual meetings where the total registration averages 16,000-17,000 and usually 52 percent

of registrants are from foreign countries. This event in itself was awesome for me when addressing an audience of more than 5,000 attendees at some of the sessions.

I was lucky to have the honor, privilege and humbling opportunity that few individuals will have and for that I am grateful. The opportunities to participate in organized medicine in various ways is available to all physicians, and it is up to them to get involved if they want to see the changes that they constantly complain about in casual venues like the doctor’s lounge. Unfortunately, very few of us take the first step of getting involved at the local level to work towards achieving our goals. I would like to encourage my fellow physician members of the Nebraska Medical Association to get involved and stay involved in organized medicine. I can assure you that once engaged, the experience will be rewarding and you will make a difference in shaping the future of health care and preserving the best care for our patients. We all can be leaders in some form if we only take that first step to get involved and be advocates for our profession and our patients. Our health care system is in a flux and according to Yogi Berra “the future ain’t what it used to be.” Remember that unless we are at the table, we will end up being on the menu. Seems that this has been happening during the past few years and we must rally to take control. After all, as Peter Drucker said: “The best way to predict your future is to create it.” □



How organized medicine fosters excellence

My years as President of the College of American Pathologists

by Gene N. Herbek, MD, FCAP
Immediate Past President,
College of American Pathologists

“The truth is that our finest moments are most likely to occur when we are feeling deeply uncomfortable, unhappy, or unfulfilled. For it is only in such moments, propelled by our discomfort, that we are likely to step out of our ruts and start searching for different ways or truer answers.” M. Scott Peck



I first stepped out of my comfort zone during my last two years as a resident in pathology and laboratory medicine at the Nebraska Medical Center. I became active in the House Officers Association and served as president during my last year of residency. Pathology residents were not traditionally recognized as participants or leaders in medical organizations involving the entire general medical residency staff. This opportunity was not one I sought, but one that fellow residents and pathology faculty role models and mentors encouraged me to take. The reality then, as today, is that many physicians do not realize the value organized medicine brings to their patients or their practices.

Many excellent medical associations rely on volunteers to advance medical care. In my specialty, I chose to volunteer the majority of my time for the Col-

lege of American Pathologists (CAP). The CAP mission is to serve patients, pathologists and the public by fostering and advocating excellence in pathology and laboratory medicine. Patients are healthier thanks to that excellence, and the CAP relies on the expertise of volunteer pathologists and clinical laboratory specialists to serve that mission.

The words of the mission statement were not as meaningful to me before my involvement with the CAP as a member of the Board and as an officer of the Board. There were many challenging situations in the years leading up to my term as President, but I learned different ways of working with professionals and experts in other medical associations. I found new perspective and a deep appreciation for all of them and the CAP.

As CAP President, I had the opportunity to travel and meet pathologists from around the world inspecting laboratories and sharing educational opportunities. The challenges that pathology and medicine in general are facing in the United States are not unique to us. Issues that revolve around an aging population, fiscal restraints and an expanding body of medical knowledge led by molecular medicine and pathology are universal. It reassured me to see quality laboratory medicine and pathology practiced in every country I visited, whether in China, India,

South Korea, Australia or Ireland.

And, our Canadian colleagues are close working partners with the College of American Pathologists.

Collaboration is critical to the success of many professional medical organizations and is a key recommendation of the most recent Institute of Medicine report, “Improving Diagnosis in Health Care.” The recommendation states, “Health care organizations should develop and implement processes to ensure effective and timely communication between diagnostic testing health care professionals (pathologists and radiologists) and treating health care professionals across all health care delivery settings.” The CAP leadership recognized the importance of working together at the organizational level several years ago when the CAP partnered with the American Society of Clinical Oncology and the American College of Surgeons.

In response to the 1999 IOM report entitled “To Err is Human,” the American College of Surgeons (ACS) developed a program to accredit cancer programs to ensure quality cancer care. The CAP developed cancer protocols for pathologists to use in order to standardize cancer reporting and provide all the important data elements needed to care for patients with cancer. Pathologists and other physician experts continue to develop and revise the CAP Cancer Protocols as new information comes to light. Today,

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How organized medicine fosters excellence

My years as President of the College of American Pathologists

(continued)

all ACS-accredited cancer centers require use of these protocols. This partnership continues to grow and validates for me the choice I made years ago to volunteer for the CAP.

The partnership with the American Society of Clinical Oncology (ASCO) and the CAP began with guideline recommendations issued in 2007 to improve interpretation of HER2 testing for breast cancer. This was followed in 2010 with an ASCO-CAP joint guideline to improve hormone (estrogen and progesterone) receptor testing for patients with breast cancer. Both guidelines lead to improved patient care. Oncology and pathology experts working together for the benefit of patients by ensuring quality cancer care gives everyone a sense of accomplishment. We have learned much about one another's specialties. This understanding has led to greater cooperation

and appreciation for our respective roles in patient care.

An ASCO-CAP meeting at ASCO headquarters in Washington, D.C., was held earlier this year to determine how CAP members could work with ASCO oncologists and surgeons on the international stage. The meeting agenda was centered on improving cancer treatment worldwide. Oncologists and pathologists in the U.S. shared their successful implementation of onsite pathology services in Rwanda and sub-Saharan Africa. Oncologists who volunteered their time to care for patients with cancer overseas saw firsthand that appropriate cancer treatment cannot occur without an accurate diagnosis.

Pathologists are in short supply in many areas around the world. I experienced an epiphany that day, when pathologists, surgeons and

oncologists from Vietnam, Honduras, Haiti and Uganda spoke with passion about their need for quality pathology services. Healing begins with an accurate cancer diagnosis. The physicians treating cancer in the U.S. had come to understand and appreciate this truism by working with physicians in countries where qualified pathologists are unavailable. It was one of the best days of my professional career—an experience I would not have had if I had not volunteered for the CAP.

By stepping outside of my comfort zone during my pathology residency, I found ways to enrich my professional career as a diagnostic pathologist. As CAP President, I found truer answers and was inspired by altruistic members of the medical profession. I hope every physician will take the opportunity to do the same. □

Leadership, how does it happen?

by Robert Wergin, MD, FAAFP
Immediate Past President
American Academy of Family Physicians

Wow! What a past three years it has been for me personally as an officer for the American Academy of Family Physicians (AAFP). The AAFP represents more than 120,000 family physicians, students and residents nationwide. I was honored to be asked to write a few comments about leadership and what it means. This began a process of self-reflection of how I arrived in my current position as board chair of the AAFP.

I started my journey as a resident in family medicine when I became a member of both the Colorado Academy of Family Physicians and the national AAFP in 1979. I served in several leadership positions in the Colorado Academy of Family Physicians and the AAFP back then. How did it happen? First and most important are two things, be there and be yourself. Showing up and being authentic is an important trait that likeminded individuals can see and appreciate. Your fellow members can see your vision and identify with you. Steven Covey wrote, "Leadership is communicating to people their worth and potential so clearly that they come to see it in themselves." The individual members you serve with be-

come energized and ready to take on whatever challenge they and your organization may face.

At our board level we have a rule to always assume good intent. When you develop a culture of creativity and trust almost anything is possible. There will be obstacles in your path, but that brings up another point of "cheerful persistence." I witnessed this in action for the first time when meeting with a congressional leader about the Sustainable Growth Rate (SGR) formula. The congressman's health aid immediately upon sitting down began to aggressively challenge and voice frustration about our organization's approach to the Affordable Care Act. One of my fellow officers who was leading the meeting acknowledged the congressman's concerns and offered help, but then asked "What about this Sustainable Growth Rate formula for Medicare, and how could we help to resolve this flawed formula?" The aide immediately launched back into his tirade which again brought about our acknowledgment and offer for support, but again "What about this SGR?" question. By the end of our conversation it went very well and was quite collegial. As we were leaving I commented to my fellow officers how brutal and difficult the conversation was and they commented "Oh no, that went a lot better than last year." Cheerful persistence paid off by consistently returning

to our vision in a respectful and pleasant manner when on April 16, 2015, the SGR was laid to rest. Cheerful persistence is a good quality in leadership and in life.

Transparency and being respectful of others is critical to success. Bad news never gets better, and it is almost always better to get it out and begin working on solutions. Solutions come in many forms and working together utilizing everyone's input is critical in collaborating to come up with the best solution. Collaboration to arrive at the best answer is always preferable to compromise. Compromise results in both parties being dissatisfied with some part of the answer where collaboration arrives at the best answer.

Finally, and maybe most importantly, just listening to others' concerns is the most important trait of a leader. Listen, acknowledge, challenge, repeat. Understanding others' concerns sheds new light on an issue and again brings about the best solution. Diverse members with diverse opinions allow an organization to see an issue from all sides to arrive at the best solution.

For myself, serving others and making lives better for my patients and my fellow family physicians has brought a great joy and meaning to my life. It has been challenging to lead a national organization and still maintain my practice in a rural community, but I wouldn't want it any other way. Like I began, "Wow!" □



Experiences in medical student leadership

by Alicia Smith

MD Candidate

University of Nebraska College of Medicine

This past June, after one year of medical school, I packed everything I could into my car and moved to Washington, D.C. From my apartment I can see the Capitol. Everyone I meet seems to work in politics. When I first started as the Government Relationship Advocacy Fellow (GRAF), I thought I knew a lot about health care; I was mistaken. My first few weeks working with the American Medical Association were a whirlwind. I received more information in those weeks than I had in medical school, and I didn't think that was even possible. It has been more than six months since I moved to Washington, and I have a much more thorough understanding of the health care system and the numerous complexities that impact how physicians care for patients. Now, when people ask what I do, and it's usually their first question in Washington, I feel pretty confident when I say "I work in health care policy."

As a brand new medical student I hesitated to apply for this position. I had just made new friends, finally had my bearings in the classroom, and wasn't really sure how this would affect my career path. I was interested in politics and knew the importance of organized medicine, but I wasn't sure where I fit into that picture. Regardless, I went for it and today I have no regrets. I have had the opportunity to live and work in our nation's capital and more importantly have a small degree of influence on the

national discourse in health care policy. I now have an understanding of the health care system that I would have never gained through medical school alone. Even greater, I have witnessed firsthand the important work of organizations like our AMA around critical issues affecting practicing physicians such as the Meaningful Use requirements. When I started in June, this program was terrifying for physicians because of the impact it would have on their daily practice and accordingly, it was at the top of the AMA advocacy agenda. Over the next six months physicians, state societies, specialty societies, legislators, and the AMA worked together to affect positive change to the program. In January 2016, the Acting Administrator of the Centers for Medicare and Medicaid Services announced that Meaningful Use will no longer exist in its current state. I believe that this frame shift would not have occurred without the work of physicians in organized medicine.

I have the privilege of witnessing the successes of organized medicine every day. I watch comment letters go out the door on every issue that affects patients or physicians. I observe the formation of political alliances and the strength that comes from developing physician coalitions around issues of common interest. Most impressively, though, I receive communication from medical students who recognize that they are the future of medicine and are dedicated to carrying the banner of our profession like so many who came before us. The medical students of the AMA are some of the

brightest, most passionate in the country. They truly understand that they are the voice for the future of the profession. For a portion of my fellowship, I traveled the country talking to students about this very topic. My very first presentation was to more than 170 students, and I was a nervous wreck. The next day I had two emails from first year medical students asking about leadership positions in the AMA. I was so impressed; they had only been in medical school for one week!

I realize that not every student is going to take a year off and move to Washington, and that not every physician wants a career in politics. When I spoke to students about organized medicine, my goal was to help them see that medicine needs student and physician leaders at every level. I've learned that medicine can be dictated by many outside forces. These influences are felt by physicians for certain, but us students are impacted as well, even as we learn how to do H&Ps and physical exams. If medicine were as simple as the doctor-patient relationship, we could all ignore the rest, but an understanding of the system and being an advocate is nearly a requirement for success. One of my peers once told me "welcome to medical school, you are now a part of the system, and that means that you must be part of the solutions." Over the past year I have learned just how true that statement is, and I hope to continue to be a leader in seeking those solutions. □



Why in the world?

by Dale Michels, MD
Candidate for Legislative District 25

Regularly, I am asked why in the world would you run for the Legislature? Why? Because I feel I have the ability to represent Legislative District 25 (Kathy Campbell's current district) well and to serve the citizens of Nebraska. During the almost 42 years I have served my patients and the medical community of Nebraska, I have learned a lot. My desire is to bring that experience to the Legislature.

From the outside: I see the Legislature missing some practical medical advice because there is no physician in the Legislature. I will be able to use my cradle to grave patient experiences to help serve. I recognize that government doesn't have to do all things for all people and know that most of my patients have some responsibility for their health.

From the medical side: I see the need

for conscience protection of all health care professionals so they can care for patients using their own ethical and moral standards as their guide. I will remain firmly pro-life in caring for and serving patients. Although we always can do more, sometimes the best thing to do is to do no harm by not trying to do more and more. My past service has prepared me to take on this new role with enthusiasm and the same dedication I have given my patients.

From the finance side: I recognize that expansion of government into health care doesn't mean better care or wiser use of funds. I see that putting more money into something does not mean better outcomes. I understand that Nebraskans see working together, helping each other and looking for the greater good is important. I see many of our patients feel entitled to programs that will be paid for by my kids and grandkids resulting in medical over spending and poor use of resources. We have to find better ways to control spending as we can't control taxes without

spending limits or we must be willing to give up services. We know that if we are given a raise (i.e. more tax revenue) and say we won't spend more, that our goal of saving usually gives way to just spending the raise. We have to limit expenses in some way if we are going to really cut taxes. There are a lot of inefficiencies in government, but even fixing these may not effectively control spending although that would be a start.

Finally, I have been asked about the death penalty and the possible inconsistency with my pro-life view. My response is simple. The death penalty is reserved for those convicted of heinous crimes. What crime did the baby commit?

I want to thank the NMA and other medical and community organizations for the opportunity to serve with them. I look forward to continuing to serve you in the Unicameral.

For more information or to assist with my campaign go to www.dalemichels.com. □



Musings by a candidate for Legislative District #25 of the Nebraska Unicameral

by *Leslie Spry, MD*
Candidate for Legislative District 25

Running for Legislature is hard work! I knew I was interested in policy and debate. New skills and much effort are required to be successful candidate. These skills include connecting with voters. As I started walking my district, I found it enjoyable. I really did learn a great deal and was able to develop an “elevator speech” that allowed me to quickly express reasons for running and connect with voters. People actually answered the door bell and talked to me!

Fundraising is a skill that does not come naturally, but is critical to any campaign. As the saying goes, no money, no mission. I needed to identify someone who could teach me how to do this. My campaign manager, Mary Johnson, has been instrumental in teaching me how to succeed and be a better candidate. She has tutored me on how to be successful at fundraising. She has introduced me to individuals who have made me a better candidate.

I believe that government must be smarter and more efficient. Citizens of

my District believe taxes, and especially property taxes, are too high. I have offered proposals that will reduce property taxes, improve our system of child welfare, and improve public health. I have proposed that we change the classification of soda pop, sport drink and candy to “not food” and hence subject them to sales taxes. Money raised could offset property taxes. We need to provide transitional health insurance coverage for working families whose incomes place them between the poverty level (where they would be eligible for Medicaid) and employer offered health insurance. As working individuals advance into the traditional workforce, we should provide preventative health care so that healthy individuals can enter that workforce. As uninsured individuals enter the workforce only to discover preventable health problems, this becomes a burden for employers and results in families facing bankruptcy and keeping them in poverty. Supervisors of case workers need advanced education to deal with foster children and wards of the state. This would help to cut down on the high turnover seen in case workers. We need

better systems in place for the Department of Health and Human Services to be successful in administering programs in our state. My experience as a member of the State Board of Health gives me insight needed to make good policy decisions for legislation.

My conversations with leaders, including Governor Ricketts, convince me that striving to make government smarter and more efficient will lead to lower taxes and better services for the citizens of Nebraska. Meeting current senators, talking with lobbyists and policy makers in the state helps me to understand the important role that state senators have in establishing good policy and passing laws that reflect that policy. I am proud to be endorsed by the Nebraska State Education Association. I continue to seek other endorsements.

I believe all this work will make me a better state senator.

Learn more about my campaign at www.spryforlegislature.com. ☐



Necrology

Stanley T. Mountford, MD
Omaha

10/13/2015

Edward A. Holyoke, Jr., MD
Omaha

10/25/2015

Erin C. Bundren, MD
Omaha

11/1/2015

Sebastian A. Zarbano, MD
Omaha

11/1/2015

Richard C. Toren, MD
Lincoln

12/18/2015

Donald Dynek, MD
Lincoln

12/30/2015

Adam E. Zoucha, MD
Omaha

1/21/2016

Nebraska Osteopathic Medical Association (NOMA) to be recognized as NMA specialty

In the state of Nebraska there are over 200 actively practicing osteopathic physicians. Many belong to the NMA and county medical societies, and serve as faculty at our medical schools. Osteopathic physicians have practiced in Nebraska for well over 100 years.

Until recently an osteopathic medical society had served in the state for the purpose of providing a required osteopathic physician to the State Boards of Health and Medicine.

In 2015, the Nebraska Osteopathic Medical Association (NOMA) was formally organized and has gained state and Internal Revenue Service recognition. In 2016, NOMA anticipates gaining full American Osteopathic Association (AOA) accreditation.

Realizing the importance of a broad base of educational, advocacy and collegial interaction among all state physicians, NOMA has affiliated itself

with the Nebraska Medical Association (NMA) and the Omaha and Lincoln medical societies and will be recognized as a specialty society within NMA.

NOMA will offer membership to osteopathic physicians as an add-on to NMA dues or for NOMA only. Membership services will be provided by NMA; membership in both associations is encouraged.

NOMA will have educational time within the annual NMA annual membership meeting, provide recommendations for State of Nebraska boards, and in the future send a voting delegate to the AOA. In addition, an osteopathic physician will attend the NMA specialty society's quarterly meeting.

If you would like additional information about NOMA, please call NMA Specialty Societies Director Sarah Dunbar at (402) 474-4472 or email sarahd@nebmed.org. □

Save
the Date
9/16/16

2016 NEBRASKA MEDICAL ASSOCIATION

ANNUAL MEMBERSHIP MEETING

FRIDAY, SEPTEMBER 16
HOLIDAY INN DOWNTOWN
LINCOLN, NE

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steer the future of medicine in Nebraska.

Watch our events page
for more information coming soon!

www.nmaevents.org



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Ask a Lawyer

Patients recording encounters with their physician

One of our physicians brought me an article about how patients are recording physician visits – both knowingly and unknowingly to the physician. There are several states that have enacted two-party consent laws to protect physicians from being sued when they did not know they were being recorded. What does Nebraska law say about patient's recording their physician visit without the physician knowing about it?



Like most states, Nebraska is a one-party consent state, meaning that one party to a conversation can record a conversation without getting the other party's consent. Neb.Rev.Stat. § 86-290(2)(c). Federal law also allows for this as well. The recording of patient-physician encounters will likely occur more and more because it is easy to do and because it is easy to conceal.

Some reasons for making the recording may be legitimate and should not be a cause for concern on the part of a physician. For example, if a patient has memory issues or hearing issues, he or she may want to record the encounter so it can be reviewed after they get home. The patient may also want to share the information with his or her spouse or family member. Perhaps the complexity of the patient's health issues and unfamiliar terms may motivate recording to allow review of the discussion afterwards.

Of course, a patient or family member may record an encounter to use against the physician. That is certainly a possibility and an unfortunate fact of life.

If a physician is aware of and concerned about the motivations behind an individual recording the encounter, terminating the professional relationship might be in order provided the process used to terminate the patient allows appropriate advance written notice to avoid potential claims of patient abandonment.

On the other side of the equation, there are apps being created to allow physicians to video record encounters with patients with the data being stored as part of the patient's medical record or online. Patients can access those recordings to help them remember their physician's orders and advice. Medical Memory, LLC, is a Phoenix-based start-up company created by a neurosurgeon to help patients remember what he told them at their office visit through the app.

Even if a patient records a conversation with the patient's physician, not everything a physician says to a patient, a patient's family member or a patient's representative is necessarily admissible in court or in an arbitration. For example, a physician's or physician's employee's conversations with a patient or a patient's family member about an unanticipated outcome of medical care or treatment is not admissible where the "statements, affirmations, gestures, or conduct" are expressions of "apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence" and "which relate to the discomfort, pain, suffering, injury, or death of the alleged victim because of the unanticipated outcome of medical care." Such statements cannot be used as evidence in court or an arbitration as an admission of liability on

the part of the physician. However, if a physician commiserating with a patient also says she "really screwed-up," that statement of fault, which may be part of a statement of sympathy or compassion, can be admitted into evidence. Neb.Rev.Stat. §27-1201(1).

Since some patients will desire to record their conversations with their doctors, planning ahead to address that possibility is advisable. Some possible strategies include the following:

- Have a policy that cell phones may not be used or be "on" when in the physician's office. Many offices do this already, although it is unclear how that rule is enforced. This is an indirect way to deal with recordings by cell phone.
- Directly prohibit recordings by patients and post signs to that effect – This could be counterproductive and needlessly defensive, however.
- Have a policy that permits recordings to be made with the physician's permission and post a sign to that effect. This may prompt those who would otherwise record secretly to ask for permission to do so. The policy and notice could include a warning that the physician and office are not responsible for the loss, theft, or inappropriate disclosure of such recordings that could occur from a source outside of the physician's office. That type of warning could deter some recording.
- The physician could record all patient encounters using an app that will include the recording in the patient record. A policy and notice to that effect should be provided to patients and

(continued on Page 18)

Case Study – Lessons in liability: *working with PAs*

By COPIC's Patient Safety and Risk Management Department

Dr. Hancock, an orthopaedic surgeon, performs a three-hour surgery at noon on a complicated tibia fibula fracture. The surgery goes well, but later that night the patient's pain increases markedly. George, a physician assistant (PA) in Dr. Hancock's office, is on call. George increases the pain medicine significantly after he has a phone call with the patient. George does not see the patient or communicate with any physician about the call. The next day the patient calls the office in the morning and schedules an afternoon appointment with George. Dr. Hancock is out of the office and repeated attempts to contact him are unsuccessful.

George is worried about the amount of pain the patient is having (it is more than he is used to seeing). The pain is associated with swelling and numbness of the foot. Because Dr. Hancock is not available, George discusses the case with an orthopaedic surgeon named Dr. Monroe, who is not in the office and does not see the patient. They decide on conservative treatment, which involves elevation and rest. The pain escalates and the next morning, the patient returns to the office. Dr. Hancock is back, sees the patient, and diagnoses compartment syndrome. The patient is brought back to surgery, but the release is unsuccessful and the patient is left with significant weakness and neuropathy in the leg.

PA's AND LIABILITY ISSUES

George is an experienced PA (more than two years of experience) and does

not need the physical presence of his supervising physician per Nebraska Department of Health and Human Services (NDHHS) guidelines. He took the phone call and did not consult with a physician or document the call. Therefore, the liability for his actions falls on his supervising physician. The supervising physician is identified on an agreement form required by NDHHS.

Because the supervising relationship does not change until actively rescinded by either the PA or the physician, it can often be outdated. PAs and their supervising physicians move into different practice arrangements over time and may not update agreement as this happens.

George's supervising physician is Dr. Hancock, who was at an out-of-state conference. George met with the patient during the office visit, consulted with Dr. Monroe, and then documented that discussion. If Dr. Hancock had been consulted on the post-op care of his patient prior to being off duty, he would likely have been able to alert the subsequent providers to the patient's high risk of compartment syndrome following the complicated tibia fibula procedure.

Liability claims arise more frequently out of the failure to recognize the complication and timely rescue rather than criticisms of the technical performance of the actual procedure. The scope of practice for PAs can sometimes not match an understanding of the risks. Acute complaints in the early postoperative period are often fielded by the PA. In this case, George was not aware of the details of the operation and its high risk for compartment syndrome.

CASE OUTCOME

The critical issues were:

- The patient made contact with the office on three occasions before the complication was recognized.
- When Dr. Hancock, the physician who operated on the patient, finally saw the patient, he quickly made the diagnosis of compartment syndrome and his note said "obvious signs of compartment syndrome" necessitating emergency fasciotomy.
- The required supervising agreement per the NDHHS for the PA was not done and there was a claim of improper supervision against the clinic.
- There was no documentation of any phone calls. This brings into question whether critical information was exchanged and acted on.

PRACTICAL SUGGESTIONS

- Be sure that you have accurate, up-to-date agreements. Per the NDHHS, the supervising physician must:
 - Keep the agreement on file at his/her primary practice site;
 - Keep a copy of the agreement on file at each practice site where the physician assistant provides medical services; and
 - Make the agreement available to the Board of Medicine and Surgery and NDHHS upon request.
- Sample agreement forms are available at <https://www.nebraskapa.org/>
- Each physician assistant and his/her su-

(continued on Page 18)



Ask a Lawyer *(continued)*

could be incorporated into the general consent completed upon check-in.

- If the patient asks to record the encounter or it is evident he or she is doing so, tell the patient that the physician will also record the conversation as well. Retain the physician's copy in the medical record.

Other strategies to address the issue of patients recording office visits probably exist as well.

In some occupations such as law enforcement, body cams are becoming more desirable. We are not “there” yet in the medical profession, but in this era of instant world-wide information,

cameras on every building and street corner, drone surveillance, and cheap, readily available technology, one should assume that most everything outside of one's home is subject to being recorded by someone at some time.

If a patient or patient's family member wants to record a conversation with you, legally, there is not much that can be done to prevent it. Similar to avoiding headlines in the local newspaper, the best advice is to not say anything that you wouldn't want to hear played back in court. As lawyers say, “Govern yourself accordingly.” □

Ask a Lawyer is a feature of the Nebraska Medical Association newsletter. If you have a legal question of general interest, please write the Nebraska Medical Association. Answers to your questions will be provided by the Nebraska Medical Association's legal counsel, Cline Williams Wright Johnson & Oldfather, L.L.P., 1900 U.S. Bank, 233 South 13th Street, Lincoln, Nebraska 68508-2095. The answer in this issue was provided by Jill Jensen. Questions relating to specific situations should continue to be referred to your own counsel.

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Case Study – Lessons in liability: *working with PAs* *(continued)*

supervising physician shall be responsible to ensure that:

- The scope of practice of the physician assistant is identified;
- The delegation of medical tasks is appropriate to the level of competence of the physician assistant;

- The relationship of and access to the supervising physician is defined; and
- A process for evaluation of the performance of the physician assistant is established.
- Understand which physician is responsible and liable for any given encounter with a PA. Experienced PAs can practice without physical supervision, but both physicians and PAs should understand the high-risk scenarios that should trigger a discussion and documentation of that discussion. □

ter with a PA. Experienced PAs can practice without physical supervision, but both physicians and PAs should understand the high-risk scenarios that should trigger a discussion and documentation of that discussion. □

To predict or to prepare?

That is the question for 2016 & beyond.

by Kent Kramer
Provided by the Foster Group

For global stock market investors, the news from 2015 and the early part of 2016 has been marked by periods of unsettling volatility and decline. In December, global stock markets virtually all weakened to make 2015 a negative year for the majority of stock investors, capping off another year of historically low interest rates and sluggish economic numbers globally.

As even the most successful investors realize, negative stock market returns are to be expected from time to time, as often as three years out of every 10. For the U.S. stock market, as measured by the S&P 500 Index (without dividends), 2015 was the first negative year since 2008. These market pullbacks are an ordinary part of investing in riskier assets (stocks) associated with the higher expected returns that investors need to build wealth over their lifetimes.

However, as negative as the economic news has been (e.g., China, oil prices, global growth) along with the rippling effects on world markets in early 2016, investors need to remind themselves that these kind of events are nothing new; they have happened with regularity throughout market history, and they are inherently unpredictable.

To illustrate how “normal” these kinds of declines are, the following table reveals the U.S. stock market alone has had 262 declines of 5 percent or more since 1926, an average of about three per year. Note, too, that the average number of trading days to create the decline was

less than five (under one week).

Knowing these facts wise investors *prepare* for the future, rather than trying to *predict* it, by holding well-diversified portfolios appropriate to their current and future growth and liquidity requirements. An investor’s growth and liquidity requirements, along with an understanding of their general tolerance for risk, is best discovered through a comprehensive planning process. This is true for individuals and institutions.

An important example of comprehensive planning involves the careful projection of an investors future cash flow requirements. The portfolio is then constructed to provide adequate liquidity, covering seven to 10 years, or more, of projected cash flow needs. This part of the portfolio allocation can be referred to

as the “lifeboat,” a shelter from storms.

The purpose of the lifeboat is to create a degree of protection in the form of capital preservation, so the growth assets in the portfolio (e.g. global stocks) are not needed on a regular basis for cash flow. When stock markets are providing solidly positive returns, these holdings become excellent sources for meeting cash flow requirements. When those same stock markets are negative, even plunging for a period, the lifeboat containing short-term, high quality fixed income, provides a stable source of liquidity to meet current and future spending and lifestyle requirements until equity markets recover.



(continued on Page 20)

Exhibit 1: Returns after Corrections

US LARGE CAP: JANUARY 1926–JUNE 2015				Annualized Compound Return		
Cutoff for Decline	Frequency of Such Declines	Avg. Horizon for Decline (Trading Days)	Avg. Magnitude of Decline	for Next 1 Year	for Next 3 Years	for Next 5 Years
5%	262	4.1	–7.55%	13.24%	9.43%	10.02%
10%	28	4.6	–14.25%	23.56%	8.89%	13.33%
Unconditional annualized compound return for full sample is 9.32%.						
INTERNATIONAL LARGE CAP: JANUARY 2001–JUNE 2015				Annualized Compound Return		
Cutoff for Decline	Frequency of Such Declines	Avg. Horizon for Decline (Trading Days)	Avg. Magnitude of Decline	for Next 1 Year	for Next 3 Years	for Next 5 Years
5%	58	4.8	–7.71%	17.30%	9.03%	9.38%
10%	9	5.6	–13.33%	24.73%	12.69%	12.89%
Unconditional annualized compound return for full sample is 4.05%.						
EMERGING MARKETS: JANUARY 1999–JUNE 2015				Annualized Compound Return		
Cutoff for Decline	Frequency of Such Declines	Avg. Horizon for Decline (Trading Days)	Avg. Magnitude of Decline	for Next 1 Year	for Next 3 Years	for Next 5 Years
5%	74	4.8	–8.12%	24.82%	11.84%	10.33%
10%	15	5.5	–14.04%	42.23%	13.36%	11.20%
Unconditional annualized compound return for full sample is 9.49%.						

Declines are defined as periods with consecutive days of negative index returns with cumulative losses at or above the cutoff. Annualized compound returns are averages across all declines. US Large Cap is the S&P 500 Index, provided by Standard & Poor’s Index Services Group. International Large Cap is the MSCI World ex USA Index. Emerging Markets is the MSCI Emerging Markets Index. MSCI data © MSCI 2014, all rights reserved. Past performance is not a guarantee of future results. Indices are not available for direct investment; therefore, their performance does not reflect the expenses associated with the management of an actual portfolio.

To predict or to prepare? That is the question for 2016 & beyond. *(continued)*

As a reminder, as bad as global stock market returns were in 2007 and 2008, a portfolio comprised of 50 percent S&P 500 Index and 50 percent Barclays U.S. Aggregate Bond Index fully recovered in less than two years from what seemed like total catastrophe at the market bottom in March 2009.*

It's never easy to go through turbulent markets, even though they are to be expected. Remember that the important work of preparation must be done prior to the next extra-ordinary period through planning, preparation and

engaging in a portfolio strategy based on robust academic research, as well as real world experience.

** Source: S&P 500 Index and Barclays U.S. Aggregate Bond Index (rebalanced monthly).* ☐

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The information and material provided in this article is for informational purposes and is intended to be educational in nature. We recommend that individuals consult with a professional advisor familiar with their particular situation for advice concerning specific investment, accounting, tax, and legal matters before taking any action.



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2016 NMA Edition

VECTOR: SMALL CHANGES MAKE A BIG DIFFERENCE

**Mark Stadtlander**

CFP®, Chief Executive Officer

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