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contents
May/June 2010, Volume 106, No. 3

features
4 President’s Message
8 Our Editor Speaks
9 Guest Editorial
36 General News
37 Photo montage—Haiti
38 SPECIALNews—Med Mal Challenge
39 Health System Reform—Its Impact on WV
42 WESPAC Contributors
43 WESPAC 2010 Primary Endorsements
44 2010 Legislative Wrap-Up
48 Robert C. Byrd Health Sciences Center of West Virginia University News
49 Marshall University Joan C. Edwards School of Medicine News
50 West Virginia School of Osteopathic Medicine News
51 Bureau for Public Health News
52 Physician Practice Advocate News
53 New Members
54 Obituaries
56 West Virginia Medical Insurance Agency News
59 Classified Ads
60 Manuscript Guidelines/Advertisers

In this issue…

Scientific Articles
12 A Review of the American Heart Association Revised Guidelines for the Prevention of Infective Endocarditis
16 A Young Male with Sudden Onset Left-Sided Weakness
19 Free Muscle Flap Reconstructions Using Interpositional Vein Grafts vs. Local Anastomosis: A 5-Year Experience
24 Successful Pregnancy Following Conservative Surgical Therapy of an Invasive Molar Gestation
26 Geographic and Temporal Comparisons of ATV Deaths in West Virginia, 2000-2008

Special Article
Finding a Faster Route to Practice: From Medical Student to Board Certified Physician

Cover photo courtesy of Angela S. Johnson

The [West Virginia Medical Journal] is published bimonthly by the West Virginia State Medical Association, 4307 MacCorkle Ave., SE, Charleston, WV 25304, under the direction of the Publication Committee. The views expressed in the Journal are those of the individual authors and do not necessarily reflect the policies or opinions of the Journal’s editor, associate editors, the WVSMA and affiliate organizations and their staff.

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A sleepless night or early morning awakening is gifted by nature with an encounter of a new dawn. John O’Donohue’s beginning paragraph in his book “Anam Cara” – describes it so well and is worth repeating here to share – Thus – LIGHT IS GENEROUS

“If you have ever had occasion to be out early in the morning before day breaks, you will have noticed that the darkest time of night is immediately before dawn. The darkness deepens and becomes more anonymous.

If you had never been to the world and never known what a day was, you couldn’t possibly imagine how the darkness breaks, how the mystery and color of a new day arrive. Light is incredibly generous, but also gentle. When you attend to the way the dawn comes, you learn how light can coax the dark. The first fingers of light appear on the horizon, and ever so deftly and gradually, they pull the mantle of darkness away from the world.”

Quietly before you is the mystery of a new dawn, the new day.

A new day — in my experience brings an epiphany — In a perfect world — life is smooth and delightful, money grows on trees and no one we love ever dies.

In a real world, socks don’t match, we don’t agree, we never have enough money, often we are caught off guard and when we least expect it — things change.

NB — For more emphasis read this article with background music — If you feel the Health System Reform is apocalyptic — play Giuseppe Verdi’s — La Forza Del Destino.

If you feel Health System Reform is utopian — use as background music the duet of Tabisha and Ko-Ko from the Mikado, “There is beauty in the bellow of the blast”.

After 14 months of being marinated with debates, twists and turns, on health system reform, President Obama on March 23, 2010 signed into law “The Patient Protection and Affordable Care Act (H.R. 3590).

This health system reform legislation gives new direction and will dramatically change the nation’s health care system — extending coverage to an estimated 32 million Americans while raising costs and reduction in services for millions of others. The individuals who will gain the most are low-income people who do not receive health insurance from an employer.... just about everyone else loses, says Dr. John Goodman, President and CEO of the self-described National Center on Policy Analysis.

Advocates of the new law, naturally have a different view. They argue that winners include anyone with a pre-existing condition, recent college graduates who cannot get coverage through their

What Do Doctors Stand to Gain Or Lose In All Of This

Although the currently uninsured population clearly benefits, the new legislation brings both positives and negatives to doctors.

The key areas are new Medicaid patients at Medicare reimbursement rates, potential new business opportunities for primary care, funding issues and controlling expenses, negative issues over lack of tort reform, continued chaos with Medicare reimbursement rates and absence of incentive for prevention efforts.

About 16 million Americans will be added to the Medicaid program. In West Virginia one in three residents are without insurance and this equates to 300,000 West Virginians.

Some physicians view this as a boon to their practice as they anticipate new patients at a fairly attractive reimbursement rate. Still many physicians have no interest in this part of new Medicaid patients.
Pundits talk of upward to 60% of physicians will refuse to care for these new patients. Throughout the country some doctors are limiting their percentage of Medicare patients or even eliminating them entirely. Some doctors will avoid the new Medicaid patients as they claim dealing with government insurance programs is a snarled tangle of onerous and frustrating paperwork.

New Business Opportunities for Primary Care?

The roster of newly insured patients could turn into a flood or it could turn out to be less than anticipated. But in many cases, it could present practice opportunities for doctors. • New business models may attract primary care physicians willing to hire more PAs and NPs in order to see patients. Doctors who expand in this way could increase their volume of patients while containing costs by using healthcare providers with salaries less than that of physicians. • Inner-city practices may spring up. Some doctors may be interested in setting up practices in inner cities or areas where patients are now served by clinics or training hospitals. There might be more demand in inner-city areas or indigent areas where the Medicaid population is greater. Many of those distressed areas probably have a paucity of physicians to begin with. • Payment instead of unpaid charity care. Hospitals currently lose millions of dollars annually on charity care for patients who show up in the emergency room without insurance and who do not pay their bills. Physicians also do not get paid—or receive a pittance—for unpaid charity care. If patients going to hospital emergency rooms have insurance—even at Medicare rates—hospitals and doctors will receive at least some degree of payment. • More primary care doctors will be trained. There are provisions for increasing the number of primary care doctors to be available in the future to care for the additional patients. However, it’s not a given that all newly insured patients will opt to see primary care doctors in office practices. Most uninsured people are being seen now, whether it’s in clinics or hospital emergency rooms. There are also people who have the opportunity to see physicians but don’t access them. And some patients may not be diligent at managing their healthcare or getting screening tests every year or three years.”

Funding the Plan and Controlling Expenses

A new tax being levied to fund health system reform may hit doctors (and other high earners) harder than the rest of the population. The legislation calls for a 3.8% Medicare Part A (hospital insurance) tax on unearned income for individuals making more than $200,000 and for married couples $250,000. Many doctors are in that tax bracket. You’ll pay a tax on your investment capital gains, and if you sell your house, you’ll pay a tax on the capital gains. Paying hefty taxes may lead doctors to question working nights and extra hours. When such a large chunk of income goes to taxes, it becomes less attractive to take personal time to bring in more income. Most Americans do not have the stomach for the raise in taxes needed to make healthcare a right and not a privilege. Ultimately, this will be untenable. The cost of these entitlement programs will be astronomical. It sounds good that insurers have to accept everyone with preexisting conditions, but where does the money come from?

Tort Reform Is Overlooked

The inattention to malpractice reform has two effects:
• It fails to lessen the number of lawsuits brought against doctors by plaintiffs looking for a quick jackpot. It also neglects to address the very real issue of defensive medicine, which doctors say jacks up the costs of healthcare.

Jackson Health Care and the Center for Health Transformation recently reported that of physicians surveyed nationally 73% said they practice some form of defensive medicine. Physicians order hundreds of exams every year to document conditions that don’t exist. Even if they know that the chance of something being there might be 1 in 10,000, they will still order. In this legislation, there was little bone to discuss tort reform.

Gallup conducted the six-week, nationwide survey across all specialties. These physicians reported that 26% of overall healthcare costs can be attributed to the practice of defensive medicine.

Continued Chaos With Payment Rates

Notably absent was any mention of fixes to the Sustainable Growth Rate (SGR), which determines physician reimbursement. Medicare Reimbursement cuts—whether or not made at the full 21.2% When the SGR was enacted into law in 1997, the plan was that Medicare payments for physician services under Part B would be adjusted annually according to the SGR to keep spending for these services in line with growth in the national economy. Every year, the SGR calculates a physician payment update based on a formula that compares target expenditures to actual expenditures for previous years. Since 2001, actual expenditures for physicians services have exceeded target expenditures and thus led to a calculated decrease in the physician payment update in each subsequent year. Every year since 2003, Congress has been called upon to provide temporary legislation to reverse the projected cuts in physician reimbursement. Unless Congress acts to change the SGR
acknowledges the vast void while as yet another angle appears, it new information, and humbly adapt is. Healthy perspective welcomes the ability to see the world as it is. The patient has little financial incentive to be a collaborator. The legislation contains no financial incentives directed at patients to encourage them to lower their cholesterol, quit smoking, lose weight, or in other ways to take responsibility for their health. At the moment, responsibility rests with public education programs and with physicians who are supposed to motivate patients. The patient has little financial incentive to be a collaborator.

Viewing the rest of the world from the hill we call home (Conchita’s Peak), I accept the challenge and ask our members not to lose perspective of the significance of health system reform. Perspective is the ability to see the world as it is. Healthy perspective welcomes new information, and humbly adapt as yet another angle appears, it acknowledges the vast void while appreciating our fast paced private life; it can see the forest and the trees, the sun and the stars. Unfortunately as physicians we have relinquished our own thinking and instead look to classifications, schemes, and algorithms to think for us. We need to pause to digest the true significance of HR 3590 and put it in its proper place. Change is coming and we need to dress up for its presence.

The 2010 West Virginia Legislative Session has finally ended. I came early on dressed up as a Gladiator rendering my salutations to our honorable legislators. The Medical Professional Liabilities Act of 2003 was left unscathed, although this is still a very attractive target. Be prepared to have this revisited soon from several fronts—challenges to our allies in the legislatures including Senator Jenkins and Senator Stollings, changing the makeup of the Supreme Court Justices and challenges to the unconstitutionality of MPLA.

June 30th will usher out the demise of the unpopular healthcare provider tax. Let’s not be lulled that we will not hear of this ever when things become difficult for the State to provide the added expense of increased burden of new (300,000) insured, do not be surprised if this will be resurrected under a new guise.

The legislature also addressed the problem of substance abuse and drug diversion and addiction.

**SB 365** – Requiring pharmacies provide personnel online access to controlled substances database.

**SB 81** – Creating WV Official Prescription Program Act

**SB 362** – Prohibiting providing false information to obtain controlled substances prescription.

Scope of practice issues dominated the legislative session. The fight between the optometrist and the medical community on SB 230 garnered the most attention both locally and at the national level. We should compliment the campaign and the tenacity of our West Virginia Ophthalmology Association under the aegis of their Legislative Chairman Stephen Powell.

Although a watered down version was finally approved after much discussion and e-mails (300 plus) sans laser surgery and the use of the term “Optometric Physician” The bill presented to the Governor was described as flawed and had language inconsistencies.

Letters we have sent to the Governor underscoring the technical deficiencies to veto the bill, had been delivered not once, but twice. Quietly and without fanfare he signed it to law on the eleventh hour. I can tell you that our legislative leadership and its members, most especially our own Legislative Committee Chairman, Austin Wallace and Lobbyist, Amy Tolliver have diligently gathered and disseminated information. Thank you to the 300 plus e-mails sent to the legislators in opposition of SB 230 supporting our Ophthalmology associates. It is WVSMA at its best.

As the full mantle of Health System Reform envelopes the state, there will be more challenges by non-physicians on medical scope of practice. Invading barbarians are at the gates – be prepared!

From Conchita’s house on top of the hill, the light at dawn is magical. I now leave you with the Spirit of Zen.

“Freedom comes through complete acceptance of reality. Those who wish to keep their illusions do not move at all. Those who fear them run backwards into greater illusion, while those who conquer them walk on.”

Let’s change. Git!

Carlos C. Jimenez, MD
WVSMA President

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I Couldn’t Have Said It Better Myself!

On Monday of last week, a tremendous explosion tore through the Upper Big Branch Mine in Raleigh County. Two men were hospitalized, and 29 miners could not be accounted for.

The news was very bad. Emergency services, mine rescue specialists and mine rescue teams streamed to the site from all over the state. Not long after, reporters and cameramen from all over the nation converged near the mine. The intense media scrutiny added to the terrible pressures the miners’ families faced as they waited for information. The presence of so many news teams also tested members of the community, who graciously rallied not only to support the miners’ families but also to help those in the media do their jobs.

A very bad time brought out very fine behavior.

Then came the lawyers. This past Tuesday, some of the miners’ obituaries began appearing in the paper. A full-page expression of sympathy from the National Mining Association also appeared. So did an ad from the Underwood Law Offices, headquartered in Huntington.

“As the families of the victims of the Massey mine disaster cope with the loss of their loved ones, they are also coming to grips with the fact that their tragic loss didn’t have to happen,” it began.

“You Need Real Experts On Your Side,” it said. “One of the keys is to start right now.”

“Call the Underwood Law Offices Now to Find Out More.”

The ad concluded: “Call us now.”

Mark Underwood, the firm’s principal shareholder, explained to Daily Mail Business Editor George Hohmann:

“Our thought process was, our thoughts and prayers are going out to the miners’ families. We felt we had to do something. We were so touched by what is going on down there.”

Like troll for business? As Hohmann explained, law firms typically receive a third of the amount awarded by courts in such cases.

Charleston lawyer Harry Bell took a different tack. He told Hohmann he couldn’t bring himself “to run TV or newspaper ads before all of the funerals,” and went on to offer some free advice to the families:

There’s a two-year statute of limitations for filing a suit alleging wrongful death. There is no need for families to rush to make decisions.

Good to know.
By STEPHEN R. POWELL, M.D.

Some of you may have seen the recent newspaper, radio and TV coverage of the “dispute” between optometrists and medical organizations at the Capitol. The question for you is simple as well: Do you want someone who is not a licensed medical doctor and surgeon performing surgery on your eyes? That’s the issue. That’s what this disagreement is all about. That’s what’s being considered in legislation (SB230).

Ophthalmologists across the state receive referrals from optometrists every day. The two professions work well together to provide a comprehensive range of care. Optometrists earn a bachelor’s degree and then a doctorate in optometry. They examine eyes, prescribe glasses and have good general training. Optometrists refer patients to ophthalmologists for complicated medical procedures, surgeries and treatments.

Medical doctors trained in the practice of medicine and surgery earn a bachelor’s degree and a doctorate, too. But then these physicians go on to internship and residency for another four years or 12,000 hours of supervised medical and surgical training. This includes the study of the human body and surgery, and how the body reacts to different medications and diseases, many of which affect the eyes. Then, and only then, have ophthalmologists earned the privilege of performing medical procedures on your eyes.

The bill now moving through the Legislature has certainly taken a twisted route. It started out dealing with rules for the Board of Optometry and - at least as of this writing - will permit optometrists to perform some eyelid surgeries, laser surgery in the eye, do injections around the eye, and order laboratory tests. These are not permitted in West Virginia now, and laser surgeries by optometrists are not permitted in 49 states. So, what if something goes wrong? Are optometrists trained to prescribe medications that may affect blood pressure, or interfere with diabetes treatment?

Are optometrists trained to know how and when to adjust medications for patients with impaired kidney function? Have optometrists performed hundreds of surgeries under the watchful eye of experienced surgeons before being granted the privilege to cut on patients without supervision?

If laser surgery by optometrists is such a good idea, why did the Veterans Administration, after a five-year study, adopt a policy that only physicians trained in the practice of medicine and surgery of the eye can perform laser surgery on our nation’s veterans and prohibit optometrists from doing so? If this is such a good idea, why does the state chapter of AARP oppose it? And why do 20 medical organizations - including the West Virginia Board of Medicine, the Hospital Association and the Medical Association - oppose it? Many senators and delegates are well-intentioned and approachable and have looked at these issues. They hear talk from all sides and are subjected to lots of political pressure. What we need now is for the public to tell them patient safety should come first.

It is the opinion of your medical doctors and surgeons that it’s important for your own patient safety that you contact your legislators immediately and ask them to vote against SB230, the “optometry surgery bill.” Simply put, it is bad medicine.

Powell is a Morgantown ophthalmologist and past president of the West Virginia Academy of Ophthalmology.
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Scientific & Special Articles

A Review of the American Heart Association Revised Guidelines for the Prevention of Infective Endocarditis 12

A Young Male with Sudden Onset Left-Sided Weakness 16

Free Muscle Flap Reconstructions Using Interpositional Vein Grafts vs. Local Anastomosis: A 5-Year Experience at a Rural Tertiary Care Center 19

Successful Pregnancy Following Conservative Surgical Therapy of an Invasive Molar Gestation 24

Geographic and Temporal Comparisons of ATV Deaths in West Virginia, 2000-2008 26

Finding a Faster Route to Practice: From Medical Student to Board Certified Physician 30
A Review of the American Heart Association Revised Guidelines for the Prevention of Infective Endocarditis

Nasira Roidad, MD
Internal Medicine/Pediatrics Resident
Larry Rhodes, MD
Chief, Section of Pediatric Cardiology
Brad Warden, MD
Assistant Professor Department of Cardiology
All of WVU Morgantown

Introduction
In our careers as physicians, it is not often that we experience a significant change in the therapies or preventive measures for diseases we learned in medical school and residency training. Several examples of these include the routine use of screening colonoscopy for colon cancer, the use of ICDs for patients with low ejection fractions, and the development of a vaccine for certain types of human papillomavirus for cervical cancer prevention.

In April 2007, the American Heart Association published revised recommendations for the guidelines for infective endocarditis (IE) prophylaxis. One may think that this revision does not impact clinical practice to the same effect as the examples listed above. However, for over 50 years, physicians and patients have closely abided by the prophylactic measures previously recommended for a frightening condition, and now those recommendations have been modified. Although physicians may find this transition to a more simplified approach to prophylactic measures appealing, patients may be more reluctant to accept this perspective. This difficulty in acceptance is partly the consequence of our impact as physicians. For the last half-century, we have emphasized to our patients the importance of antibiotic prophylaxis prior to dental procedures in order to prevent the rare, but life-threatening infective endocarditis. We gave them cards to put in their wallets indicating their need for antibiotics prior to procedures. After these interventions, it is understandable that a patient may find it difficult to do away with this ritual and accept the risk we present to them. In order to understand the progression of this change in preventive medicine, we need to review the background and development of guidelines through the years.

Background
The earliest report of endocarditis was in 1554 in the book Medicini by Jean François Fernel. After several hundred years of theory development and research by scientists around the world, the American Heart Association (AHA) published the first document recommending prophylaxis against bacterial endocarditis. This historic year was 1955. What was the rationale for prophylaxis? Endocarditis generally follows bacteremia. If bacteremia is caused by certain procedures, then antibiotics should be given to those patients with predisposing heart conditions prior to procedures. After these interventions, it is understandable that a patient may find it difficult to do away with this ritual and accept the risk we present to them. In order to understand the progression of this change in preventive medicine, we need to review the background and development of guidelines through the years.

The first recommendations for prophylaxis in patients with rheumatic or congenital heart disease were for patients with rheumatic or congenital heart disease undergoing dental procedures or oral manipulation. The drug of choice was penicillin given prior to the procedure and for the following five days. This was also suggested for patients having GI or GU surgery.

Over the last 50 years, changes have been made to these recommendations most often involving the duration of prophylactic therapy. Penicillin/amoxicillin remains the ideal antibiotic for those without sensitivity. In 1997, the AHA provided a more detailed set of recommendations dividing the types of underlying heart diseases into high risk, moderate risk and negligible risk categories as well as specifying which procedures were high, intermediate, or low risk. They used these divisions and the planned procedure (dental, respiratory, GI or GU) to determine the specific prophylactic recommendations. Included in this recommendation was also limiting the administration of antibiotics to simply prior to the procedure.

Present Day
In May of 2007, the AHA reviewed the principles behind the recommendation for IE prophylaxis and the literature to support them. According to their official report, there were five basic principles for formulation of their guidelines. They included: 1) IE is uncommon, but life threatening and prevention is preferable to treatment. 2) There are certain underlying cardiac diseases that predispose to IE. 3) The bacteria known to cause IE occurs commonly in association with invasive dental, GI, or GU procedures. 4) Antibiotic prophylaxis was proven to be effective for prevention of experimental IE in animals. 5) Antibiotic prophylaxis was thought to be effective in humans for prevention of IE associated with dental, GI, or GU procedures. They felt that the first four of these principles held true today;
however, there was no clear scientific evidence to support the fifth.

**Discussion**

When trying to understand the risk of bacteremia that may lead to IE, they found that the transient bacteremia exposure during a brief dental procedure was a much lower risk to patients than the more frequent bacteria exposure we experience on a daily basis from routine activities. A study from Roberts, estimates that brushing teeth two times per day for one year had a 154,000 times greater risk of exposure to bacteremia than that resulting from tooth extraction. Güntherloth quantifies the time of exposure risk by pointing out that there is a cumulative exposure of 5370 minutes of bacteremia over a one month period in dentulous patients, resulting from random bacteremia from daily measures (such as chewing, tooth brushing, flossing) compared with a 6-20 minute duration associated with tooth extraction. Durack points out that the bacteremia related to procedures is short-lived. The detection of positive blood cultures is highest 30 seconds after a tooth extraction. Güntherloth compares with a 6-20 minute duration associated with tooth extraction. Durack points out that the bacteremia related to procedures is short-lived. The detection of positive blood cultures is highest 30 seconds after a tooth extraction. A study from Roberts, estimates that brushing teeth two times per day for one year had a 154,000 times greater risk of exposure to bacteremia than that resulting from tooth extraction.

If patients develop symptoms of endocarditis following a procedure, the interval of symptom onset should be short, within 2 weeks. Those patients who have a longer incubation period probably did not develop endocarditis as a direct result of the procedure. Nonetheless, the true upper limit of incubation period is not known for certain. The AHA presented this research in its guidelines to support the fifth. They shifted from focusing on prophylactic therapy for those patients with the highest predisposition to the acquisition of endocarditis to those with the highest risk of adverse outcome from IE.

**Table 1. Cardiac Conditions Associated With the Highest Risk of Adverse Outcome From Endocarditis for Which Prophylaxis With Dental Procedures Is Reasonable**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prophylaxis Reasonable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Prosthetic cardiac valve</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Previous IE</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Congenital heart disease (CHD)*</td>
<td>Yes</td>
</tr>
<tr>
<td>- Unrepaired cyanotic CHD, including palliative shunts and conduits</td>
<td>Yes</td>
</tr>
<tr>
<td>- Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first 6 months after the procedure†</td>
<td>Yes</td>
</tr>
<tr>
<td>- Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Cardiac transplantation recipients who develop cardiac valvulopathy</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Except for the conditions listed, antibiotic prophylaxis is no longer recommended for any other form of CHD.
†Prophylaxis is recommended because endothelialization of prosthetic material occurs within 6 months after the procedure.
There has been limited research in the association of GI and GU tract procedures and IE. There are few cases reported of IE temporally associated with a GI or GU tract procedure, and there are no studies to show a clear link between the two. There has also been an increase in antimicrobial-resistant strains of enterococci. Therefore, antibiotic prophylaxis solely to prevent IE is no longer recommended by the AHA for GI or GU tract procedures.¹

### Conclusion

So, what is the take home message from the AHA’s latest revision? For those patients who previously required prophylaxis as well as those who continue to need it based on the new guidelines, the emphasis of prevention should be on good daily oral hygiene. The important preventive measures include brushing teeth, flossing and seeing a dentist for regular check-ups.¹³ These are the points that should be discussed with patients. For primary care providers, these are already part of routine health maintenance concerns. One should continue to offer prophylaxis to those patients at highest risk of adverse outcome (see Table 1). As discussed above, one may find that both adult patients and the parents of pediatric patients have difficulty in discontinuing the prophylactic antibiotic if they no longer fit the criteria. In this case, one has to consider the risk versus benefit of taking an antibiotic prior to procedures. Most often, this decision will be made on an individual basis. One may consider reviewing the article’s main points with the patient and use a shared decision making process to determine what is best for that patient. In looking to the future, the importance of prophylaxis for IE remains, as does the need for further research and prospective trials. There shall continue to be ongoing evolution of this issue as is the case in many aspects of medicine; however, the unchanging and common thread among all practitioners continues to be doing what is best for patients and society as a whole, especially in matters of the heart.

### References


---

### Table 2. Dental Procedures for Which Endocarditis Prophylaxis Is Reasonable for Patients in Table 1¹

| All dental procedures that involve manipulation of gingival tissue or the periapical region of teeth or perforation of the oral mucosa |

*The following procedures and events do not need prophylaxis: routine anesthetic injections through noninfected tissue, taking dental radiographs, placement of removable prosthodontic or orthodontic appliances, adjustment of orthodontic appliances, placement of orthodontic brackets, shedding of deciduous teeth, and bleeding from trauma to the lips or oral mucosa.*

---

### Table 3. Regimens for a Dental Procedure.†

<table>
<thead>
<tr>
<th>Situation</th>
<th>Agent</th>
<th>Adults</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td>Amoxicillin</td>
<td>2 g</td>
<td>50 mg/kg</td>
</tr>
<tr>
<td>Unable to take oral</td>
<td>Ampicillin OR Cefazolin or Ceftriaxone</td>
<td>2 g IM or IV 1 g IM or IV</td>
<td>50 mg/kg IM or IV 50 mg/kg IM or IV</td>
</tr>
<tr>
<td>Allergic to penicillin</td>
<td>Cephalaxin† OR Clindamycin OR Azithromycin OR clarithromycin</td>
<td>2g 600 mg 500 mg</td>
<td>50 mg/kg 20 mg/kg 15 mg/kg</td>
</tr>
<tr>
<td>Allergic to penicillins or ampicillin and unable to take oral medication</td>
<td>Cefazolin or ceftriaxone † Clindamycin</td>
<td>1g IM or IV 600 mg IM OR IV</td>
<td>50 mg/kg IM or IV 20mg/kg IM or IV</td>
</tr>
</tbody>
</table>

*Or other first or second generation oral cephalosporin in equivalent adult or pediatric dosage
† Cephalosporins should not be used in an individual with a history of anaphylaxis, angioedema, or urticaria with penicillins or ampicillin.*


A Young Male with Sudden Onset Left-Sided Weakness

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Introduction
Neurosyphilis is the infection of the central nervous system by Treponema pallidum subspecies pallidum, which can occur any time after the initial infection. We present a case of neurosyphilis as a pontine stroke in an otherwise asymptomatic immunocompetent male.

Case Report
A 38-year-old Caucasian, previously healthy male developed sudden onset left-sided numbness, weakness, slurred speech and left facial droop, with worsening difficulty walking over 24 hours. The patient did not smoke or use cocaine. He sought care at the local emergency room. Initial work-up with CT and MRI did not reveal any acute intracranial process. He was subsequently transferred to a tertiary care hospital for further evaluation and management.

On initial evaluation, patient was in no apparent distress. Blood pressure (BP) was 144/72, Pulse 76 and respiratory rate 16. Physical examination was significant for left eyelid and facial droop with decreased sensation on the left side of the face. Power and reflexes were decreased in the left proximal and distal upper and lower extremities. The remainder of the physical exam was within normal limits.

The patient was living with his current male partner for the last six months and both of them denied history of body rash, injection drug use, genital ulcers or sexually transmitted infections.

An HIV antibody test was negative. MRI brain showed small right-sided pontine infarct and white matter abnormalities in right frontal lobe (Figures 1 and 2). A lumbar puncture was performed. It showed CSF glucose of 37 mg/dL, protein of 77 mg/dL, RBC 0/µL, WBC 7/µL with a negative HSV-1,2 DNA PCR, Gram and India ink stain. Cultures of the CSF fluid did not show growth of any organism.

A hyper-coaguable state work-up was negative. Intracranial MRA showed apparent narrowing of the A1 segment of the right anterior cerebral artery (Figure 3), while extracranial MRA showed slight narrowing of the left vertebral artery terminus at the confluence of the vertebral arteries (Figure 4).

Patient’s CSF VDRL was positive, with a positive serum Treponema pallidum particle agglutination assay (TPPA). Given the signs and symptoms, radiological and laboratory findings, he was treated as a case of neurosyphilis.

Discussion
Meningovascular syphilis occurs due to involvement of blood vessels in the subarachnoid space resulting in arteritis, leading to thrombosis, infarction and ischemia. The middle cerebral artery is the most commonly affected part of the circulation, although involvement of other blood vessels such as cerebellar arteries is possible.

In recent years, men who have sex with men (MSM) have accounted for an increasing number of estimated syphilis cases in the United States. In the current era, it is estimated that 64% of syphilis cases in the United States occur in the MSM population. These infections are characterized by high rates of HIV co-infection and high risk sexual behavior.

Figure 1.
MRI Brain, Axial: Diffuse weighted imaging of pons 1.7 x 0.8 cm area of high signal (white arrow head) on diffusion-weighted imaging compatible with a small area of infarct.

Figure 2.
MRI Brain, Axial: FLAIR imaging of cerebral hemispheres. A punctate focus of increased signal within the subcortical white matter of the left frontal lobe, which is non-specific in nature (white arrow head).
highlights syphilis as an important cause of stroke in otherwise healthy asymptomatic MSM patients.

Clinical suspicion and spinal fluid examination are keys to the diagnosis of neurosyphilis. Confirmation of initial infection can be done by use of serum non-treponemal (VDRL and RPR) and treponemal (FTA-ABS, TPPA) tests. The non-treponemal tests may be nonreactive in late neurosyphilis, hence serum treponemal testing should be performed if there is a clinical suspicion for late neurosyphilis. The CSF-VDRL, considered as the gold standard for diagnosis of neurosyphilis, can be falsely negative in 22-69% of these patients. CSF FTA-ABS is sensitive but not specific and is recommended by some for use in clinically suspicious patients with lymphocytic CSF pleocytosis and a nonreactive CSF-VDRL.

For neurosyphilis, CDC STD treatment guidelines recommend a 10-14 day course of aqueous crystalline penicillin G 18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion.

Some specialists recommend benzathine penicillin 2.4 million units IM once per week for three weeks after completion of the two weeks treatment. This is to be followed by serial CSF examination every 6 months to monitor white cell count and VDRL titers after therapy. Retreatment with a full course may be required based on monitoring of these values.

Our patient was treated with intravenous Penicillin G 4 million units every 4 hours, followed by three doses of benzathine penicillin 2.4 million units IM once per week. He was discharged to a rehabilitation facility in his hometown, with follow-up arranged for serial lumbar puncture every 4-6 months to monitor CSF white blood cell count, VDRL titers. The patient made a partial recovery and was able to walk using a cane 1 year after completion of treatment.

References
6. Centers for Disease Control and Prevention. Primary and secondary syphilis among men who have sex with

Figures 3 and 4.
MRA image of brain vasculature: Narrowing of the A1 segment of the right anterior cerebral artery (white arrow head) and of the left vertebral artery at the confluence of vertebral arteries (black arrow heads).

Drug or Alcohol Problem? Mental Illness?
If you have a drug or alcohol problem, or are suffering from a mental illness you can get help by contacting the West Virginia Medical Professionals Health Program. Information about a practitioner’s participation in the program is confidential. Practitioners entering the program as self-referrals without a complaint filed against them are not reported to their licensing board.

ALL CALLS ARE CONFIDENTIAL
West Virginia Medical Professionals Health Program
PO Box 40027
Charleston, WV 25364
(304) 414-0400 | www.wvmphp.org
Free Muscle Flap Reconstructions Using Interpositional Vein Grafts vs. Local Anastomosis: A 5-Year Experience at a Rural Tertiary Care Center

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W. Thomas McClellan, MD  
Plastic Surgeon  
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Abstract

Background: The use of free muscle or myocutaneous flaps is well established as a means for reconstructing tissue defects over nearly any part of the body. This free tissue transfer is based on the availability of a robust blood supply in the recipient wound. The reliability of native blood supplies within the zone of injury is suspect even in the best of conditions. There are several causes of flap failure however; one of the most common is vascular compromise. Though refinements in the technique of vascular anastomosis have lessened the risk, it is still significant, especially when dealing with an area of injury at the recipient site. The mechanisms of scar formation and healing that occur within the zone of injury are still significant, even in the best of conditions. There are several causes of flap failure however; one of the most common is vascular compromise. Though refinements in the technique of vascular anastomosis have lessened the risk, it is still significant, especially when dealing with an area of injury at the recipient site. The mechanisms of scar formation and healing that occur within the zone of injury are still significant, even in the best of conditions.

Methods: We will examine interpositional vein grafts versus local anastomoses in the context of free tissue transfer for wound coverage in the traumatized and reconstructed patient. We will retrospectively review the case histories of free tissue transfers preformed at West Virginia University Hospital over a 5-year period (2001-2006). We will examine data including the demographics of our patient population, type and locations of the free flaps, length of stay in the hospital, time interval between injury and repair, and the success and failure rate.

Results: The overall success rate was 38 out of 45 or 84%. Success was defined as a healthy flap and preservation of the limb and/or successful wound coverage at time of discharge. Flap success was present in 16 of 23 (78%) of the vein interposition grafts, and flap failure occurred in 5 (22%). In patients with local anastomoses, 20 out of 22 flaps survived (91%) with 2 failures (9%).

Goals: We will demonstrate that the use of interpositional vein grafts for free tissue transfer is a viable option in the wound coverage. We will demonstrate that this is especially true in the patient population that exists in rural America.

Introduction

The primary goal in any patient is to return him or her to as normal a life as possible after repair of injury. The ability to cover tissue defects has greatly helped to fulfill this goal. The use of muscle, myocutaneous, fasciocutaneous, or bowel free flaps is well established as a means for reconstructing tissue defects over nearly any part of the body. These free tissue transfers are based on the availability of a robust blood supply in the recipient wound. The reliability of native blood supply within the zone of injury is suspect even in this era of improved diagnosis and increased experience with free tissue transfers. Despite this, free flaps remain one of the most delicate surgeries performed.

The causes of flap failure are varied; however, one of the most common is vascular compromise. Refinements in the technique of vascular anastomosis have lessened but not abolished the risk. The processes of scar formation and healing that occur within the zone of injury often limit the potential for viable anastomotic targets, leading to delay in wound coverage and exposure of the patient to potential complications of an open wound. Free flap failure can be devastating, even leading to the loss of limb. Therefore, all measures possible to ensure the survival of the transferred tissue must be employed. Numerous authors have sought to elucidate factors responsible for success or failure. Our study seeks to add to this discussion by evaluating the experience in a tertiary care center serving a predominantly rural population.

Patients and Methods

All consecutive free tissue transfers were examined for a 5-year period (July 2001 to April 2006) at West Virginia University Hospital. They represent the work of the two plastic and reconstructive surgeons at this rural tertiary care institution. For this discussion, the definition of traumatized tissue has been extended to include tissue that has been exposed to radiation therapy and chronic infection, as these are common in our population. Clinical parameters were retrospectively reviewed from patient’s charts, including demographics, use of interpositional vein grafts or local anastomoses, timing, complications, length of stay, and perioperative nutritional status. The rates of success of vein grafts and local anastomoses were compared.

Results

During the 5-year period, 42 patients required free tissue transfer. There were 31 males and 11 females and their mean age was 43 (range...
The length of stay averaged 18.7 days (range 6 to 80 days). Those with vein interposition grafts averaged 18.3 days while those with local anastomoses averaged 15.6 days. Among all of the patients requiring free flaps, the average albumin in the perioperative period ranged from 2.06 to 3.11 g per dL and average prealbumin ranged from 8.8 to 18.2 mg per dL. (Table 1)

Most cases were the result of trauma (motor vehicle accidents, falls, crush injuries, etc.). Cancer, and chronic wound infections also were present. We only had one penetrating injury, a self-inflicted gunshot wound to the face, during this time. (Table 2) Most tissue defects were found on the lower extremities (25 out of 42 or 59%). Upper extremity defects 5% (2 of 42), breast defects 12% (5 of 42), and head and neck 24% (10 of 42) complete the distribution of defects. Loop grafts were used 23 times in 22 patients, (19 males and 3 females). One male, a hemophiliac who had shot himself in the face, required two loop grafts to the face. The native vessels were used 22 times in 22 patients. Two patients required both an interpositional vein graft and native anastomosis to salvage their limbs and both were finally successful. (Table 3)
Those patients requiring a vein interposition graft for their free flap underwent a three-team approach. First, one of two vascular surgeons harvested and inset the autologous vein as an arteriovenous loop fistula. Next, two plastic surgery teams would work to harvest the donor flap and prepare the recipient wound. The arteriovenous loop fistula would be divided after the donor flap was explanted and passed to the receiving team. While the flap was being reimplanted, the harvest team would close the donor defect. The arterial anastomosis was created first in typical end-to-end fashion. The flap was allowed to perfuse for a brief period of time, usually 20 minutes, before the venous anastomosis was completed, again in end-to-end fashion. An implantable Doppler was placed on the venous limb of the vascular pedicle in nearly all cases. The body of the flap was then inset and any skin grafting that was necessary was completed.

Those patients receiving local anastomoses underwent surgery utilizing a two-team approach with just the plastic surgeons. Donor flaps were dissected out in standard fashion and the local vessels prepared for an end-to-side anastomosis. These patients too, had a Doppler implanted on the venous limb of the vascular pedicle. The flap was then inset and finished with any skin-grafting that was necessary.

All patients were monitored in the intensive care unit postoperatively and all were started on a Dextran-40 infusion (35ml/hour) for a period of 5 days. Regular post-operative flap checks were performed on an hourly basis by the house staff for the first 3 days.

All the arteriovenous loop fistulas were created using autologous reversed saphenous veins. The most common donor tissue used was the rectus abdominus myocutaneous flap. Latissimus, free radial forearm, jejunal, and scapula flaps were also employed however. (Table 4)

The overall success rate was 38 out of 45 or 84%. Success was defined as a healthy flap and preservation of the limb and/or successful wound coverage at time of discharge. Flap success was present in 18 of 23 flaps, or 78% of the vein interposition grafts, and failed in only 5 (22%) patients. In patients with local anastomoses, 20 out of 22 flaps survived (91%) with 2 failures (9%). Complications in these patients overall included venous congestion, thrombosis, infection, bleeding, and in some, eventual flap failure. In the patients with interpositional vein grafts, infection and thrombus were most common. In those with the local anastomoses, venous congestion and thrombus were seen most often. (Table 5)
Table 5.

<table>
<thead>
<tr>
<th></th>
<th>Interpositional Vein Graft (%)</th>
<th>Local Anastomosis (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous Congestion</td>
<td>1 (4%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Thrombus</td>
<td>4 (17%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>Hemorrhage</td>
<td>3 (13%)</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td>Infection</td>
<td>5 (22%)</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td>Flap Failure</td>
<td>5 (22%)</td>
<td>2 (9%)</td>
</tr>
</tbody>
</table>

Discussion

The decision to anastomose a free flap locally or with the aid of a vein interposition graft relies heavily on the type of injury and the timing.3,4,5,6 Much recent work has been aimed at further defining when it is appropriate to anastomose free flaps within the zone of injury.1,4,6,7,11,16 A decision must be made between the inherent difficulties of interpositional vein grafts, with their multiple anastomoses and length, and the reliability of the vasculature within the zone of injury.14 Local anastomosis has often been preferred due to the relative ease and speed of the reconstruction.4 However, the local changes within the zone of injury, especially with delay in presentation, often complicates the native vasculature so that local anastomoses are more difficult.4,8,10 In fact, our average length of time from initial injury to the first plastic surgery consult is 637 days overall and 116.4 days when oncologic cases are not considered. (Table 6)

The reason for the delay in presentation for definitive tissue coverage in our population is unclear. Perhaps most of the delay is due to the rural nature of our state and its medically underserved population. On average, patients who received a local anastomosis (usually after an acute trauma) did so within about 14-19 days after initial plastic surgery consultation. Certainly, it is well known that time is of the essence in the reconstruction of traumatic injury in the acute setting. However, it has been our experience that delays in presentation or the other internal or external injuries suffered in this traumatic setting have required a delay in wound closure. Kolker et al. has described successful anastomosis (94%) within the zone of injury, regardless of the time frame.4 Stompro and Stevenson agreed, listing a 91% success rate.9 In fact, Isenberg and Sherman have discussed their ability to proceed with free tissue transfer within a matter of days after an injury.10 They talk of subjectively rating the local vasculature for “friability, perivascular scarring, transmural thickening, and the presence of perivascular hemorrhage…” and with these observed criteria, they could rely on the local vessels they encountered.10 They have even reported success rates as high as 100% with such local anastomoses.10 However, these results are exceptional and the more widely quoted success rates have been around 90%. This study certainly supports this latter figure.

Alternatively, those requiring a vein interposition averaged 754 days from insult to plastic surgery consultation and an additional 17-19 days for definitive tissue coverage. Again the delay likely represents the wide dispersal of patients and medical facilities within our population base. The relatively lower success rate (78%) in the interpositional vein grafts seen in this study, may well attest to this delay in presentation. Nearly all of the patients in this category would fall into Kolker’s “chronic” subgroup. Although he remarks that their experience did not show any difference between the acute and chronic patients, he does go on to state that any person with evidence of compromised blood flow within the zone of injury should receive a proximal graft.4 The patient cohorts within this study reveal their preference for proximal vascular anastomosis despite their conclusions, as only 35 flaps were placed distally compared to the 416 placed proximally. In fact, Kolker is correct when he states, “the decision to perform free flap microanastomosis to clearly uninjured vessels proximal to the zone of injury [sic] must be weighed against the anatomic and technical difficulties of performing such an anastomosis.”4 However, in our population, the numbers of “selected” patients are relatively small and the amount of fibrosis and vascular damage is significant by the time the patient presents to the operating room for tissue coverage.

In addition, this study reports those receiving a free tissue transfer for oncologic repair were successful at a rate of 93% (14 of 15).12,13 A local anastomosis was employed a majority of the time accounting for 73% of the vascular supply to the free flaps. The local anastomosis was preferred in this population especially in all of the breast cases as they were all immediate reconstructions. (Table 7) The interpositional vein graft was employed in about half of the head and neck cases because of either poor quality of the native vessels due to prior exposure to radiation, or the distance from the vascular supply to the defect was too great. All of the interpositional vein grafts survived without complication.

It was interesting to note also that the general nutritional status and length of stay in the hospital...
was consistent in both populations. This is somewhat counterintuitive as common experience in the literature has stated that the complication rate for interpositioned vein grafts is more significant. It should also be noted, in addition, that the patient’s nutritional status did not seem to be a factor in the success or failure of the flaps they received. Certainly, it is well known that nutrition plays a vital role in wound healing and this study does not argue to the contrary especially in the survival of free tissue transfers, but that it was interesting that it did not seem to play a more prominent role.

The zone of injury remains the mysterious gate-keeper surrounding any traumatic wound, either from blunt or penetrating injury, chronic inflammation of infection, or the degeneration of tissues after radiation therapy. Experience with free tissue transfers with anastomoses at the local level has advanced to the point of creating reliable and reproducible wound coverage. The experience at this tertiary care center has led to the conclusion that the use of a vein interposition graft should still be employed especially in cases where wounds do not have defined zone of injury, or when the field has been irradiated, or finally, when the defect to be covered is too distant from a reliable vascular supply. The interpositional vein graft allows a consistent, reliable, vascular pedicle with the flexibility to access wounds throughout the body and should be maintained in the armamentarium of flap surgery.

References

Table 6.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Interpositional Vein Grafts</th>
<th>Local Anastomosis</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Insult to Consult (mean)</td>
<td>754 days</td>
<td>461.5 days</td>
<td>637 days</td>
</tr>
<tr>
<td>Without Oncologic Cases (mean)</td>
<td>142.4 days</td>
<td>78 days</td>
<td>116.4 days</td>
</tr>
<tr>
<td>Consult to OR (mean)</td>
<td>17 days</td>
<td>18.8 days</td>
<td>19.1 days</td>
</tr>
</tbody>
</table>

Table 7.

<table>
<thead>
<tr>
<th></th>
<th>Interpositional Vein Grafts</th>
<th>Local Anastomosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td>0</td>
<td>5 (45%)</td>
</tr>
<tr>
<td>Head and Neck Cancer</td>
<td>4 (100%)</td>
<td>5 (45%)</td>
</tr>
<tr>
<td>Osteogenic Sarcoma</td>
<td>0</td>
<td>1 (10%)</td>
</tr>
</tbody>
</table>
Successful Pregnancy Following Conservative Surgical Therapy of an Invasive Molar Gestation

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Michael L. Stitely, MD
Roger C. Toffle, MD
WVU School of Medicine
Department of Obstetrics and Gynecology

Abstract

Background: An invasive mole is a form of persistent trophoblastic disease. The traditional surgical treatment is hysterectomy.

Case: A young nullipara presented with a positive pregnancy test 6 months following a suction curettage for an incomplete abortion. Radiologic imaging was suspicious for intramural ectopic gestation. She was treated with methotrexate but became thrombocytopenic with failure to resolve the abnormal gestation. Surgical excision of the mass was performed. Pathologic evaluation revealed the diagnosis of invasive molar pregnancy. The β-hCG levels remained negative for greater than a year. The patient subsequently conceived and underwent a cesarean delivery of a viable infant at 36 weeks gestation.

Conclusion: Conservative surgical excision can successfully treat invasive molar gestation. This should be considered for patients who desire future fertility and have contraindications to medical therapy.

Introduction

Gestational trophoblastic disease is an abnormal pregnancy occurring from an aberrant fertilization event. This maternal tumor is unique because it arises from fetal tissue. An invasive molar gestation is a variation of a hydatiform mole where the hydropic villi invade the uterine wall or blood vessels and develops only after uterine evacuation of a molar pregnancy. Excessive trophoblastic overgrowth and penetration of trophoblastic elements into the myometrium are distinguishing features of an invasive molar gestation which tends to be locally invasive and usually does not result in widespread metastatic disease.

Persistent gestational trophoblastic disease is normally treated with single agent chemotherapy with methotrexate. Medical treatment failures are usually treated by hysterectomy. Treatment of invasive molar gestation by conservative surgical excision has been described in the literature. However, 7 of 22 patients in one trial required additional chemotherapy following the surgical excision for persistent β-hCG elevations.

Case

A 24-year-old woman presented to our facility with the presumed diagnosis of an intramural ectopic pregnancy. Six months prior to admission, she underwent a suction curettage for a presumed incomplete abortion with pathology showing some hydropic changes of the villi. She was placed on oral contraceptives and had regular monthly menses until 2 months prior to admission. A pregnancy test was obtained and was positive but serial levels of beta-hCG plateaued.

The patient was hemodynamically stable with no discomfort. Her quantitative β-hCG on admission was 6283 IU. Transvaginal ultrasound (See Figure 1) revealed a cystic structure within the uterine wall with a marked increase in vascularity, suspicious for intramural ectopic pregnancy. Because of the lack of symptoms, a normal CBC, renal, and liver function tests and the fact that her HCG levels were already plateauing, it was decided to attempt to treat her with single dose methotrexate. She was given one dose of 50 mg/m² of intramuscular methotrexate, and her beta-hCG levels decreased to 5777 IU on the second day after methotrexate injection.

Follow-up quantitative β-hCG values initially fell to 5081 IU but then plateaued at 5011 IU. Repeat ultrasound showed increased size and vascularity of the cystic mass along with a small amount of cul-de-sac fluid. At this point,
She underwent a chest x-ray, which was normal. Her follow-up platelet count had fallen to 71,000 but there was no other evidence of bone marrow suppression. She underwent leucovorin rescue as the thrombocytopenia was felt to be due to the methotrexate. Her platelet count improved to 121,000 after one dose of leucovorin. Further methotrexate therapy, even in the context of a multi-dose regimen, was felt to be contraindicated. Interventional radiology was consulted and performed a uterine artery embolization in an attempt to decrease blood flow to the area in case surgical intervention was necessary. Her quantitative β-hCG initially dropped following the uterine artery embolization but then began to rise once again to a level of 3342 IU. Laparotomy was performed and the round ligaments were ligated and divided in order to reduce the time needed for hysterectomy in case of excessive bleeding. A bladder flap was developed, the anterior sheath of the broad ligaments opened, and the ligaments were penetrated lateral to the ascending branches of the uterine artery. A Penrose drain was passed through these defects to provide a tourniquet effect to the ascending branches of the uterine arteries. A rubber-shod clamp was placed over the proximal left tube and dilated vessels in an attempt to interrupt collateral blood flow. The serosa overlying the mass was injected with dilute vasopressin and the serosa was opened using a monopolar electro surgical device. The mass had a capsule that was immediately beneath the serosa and extended into the myometrium and contained villous-like material and dense tissue. The capsule and its contents were removed using the monopolar electro surgical device. Flowseal and Gelfoam were placed in the base of the myometrial incision, and the defect was then closed using 2-0 chromic. The serosa was closed using 3-0 vicryl in a baseball suture fashion, and the Penrose drain was removed. The total estimated blood loss for the procedure was 300 mL. The pathologic evaluation of the tissue revealed an invasive molar gestation.

Her quantitative β-hCG levels remained negative for over 1 year. She then became pregnant and underwent a Cesarean delivery at 36 weeks gestation due to concern for uterine rupture if labor were to occur. Small bowel was noted to be adherent to the uterine fundus. The uterine wall was intact.

**Conclusion**

The initial treatment for persistent trophoblastic disease in the form of invasive molar gestation is single agent chemotherapy with methotrexate. If chemotherapy fails or is contraindicated and future fertility is desired, conservative surgical excision may be appropriate for treatment and definitive diagnosis. In our case, this approach led to negative β-hCG levels for greater than 1-year post therapy and the subsequent delivery of a viable infant.

**References**

Scientific Article | West Virginia Medical Journal

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Abstract
During the 9-year period from 2000-2008, West Virginia experienced 301 deaths related to All-terrain Vehicles (ATVs). The distribution of ATV deaths across the top 20 counties in West Virginia accounted for nearly seventy percent of the ATV-related deaths during the 9-year study period. Time-of-day was a significant predictor of population-based rates, and a 34% decrease in the fatality rate from 2.94 in 2006 to 1.93 in 2008 occurred. We opine that the decline in ATV mortality is possibly due to better enforcement of the (WV Code Chapter 17F), mandatory ATV regulations passed by the West Virginia State Legislature in 2004. Improved safety vigilance and ATV operator adherence to manufacturers’ safety guidelines may have also contributed to the decreasing incidence of ATV deaths. While the current downward trend is most welcome, more attention should be directed towards high-risk behaviors including alcohol and drug abuse and driving on paved surfaces.

Introduction
Previous research has described the epidemiology and characteristics of ATV-related mortality in West Virginia.1-4 During the decade of the 1990s, West Virginia had the second highest number of ATV deaths (124) compared to all other states, and a fatality rate of 0.7 deaths per 100,000 population; a rate significantly higher than any other state.2 Adolescents and the elderly were identified as high-risk subgroups.4,5 Based on death certificate information, West Virginia has experienced at least 301 ATV-related deaths from 2000 through 2008.

About one-fourth of these deaths have occurred in children less than 18 years of age; 95% of the victims were not wearing helmets and 15% were passengers. About one-third of ATV crashes have occurred on surfaces not intended for safe ATV use including public roads, streets and highways. States, such as West Virginia with no ATV safety requirements (prior to 2004), experienced an ATV-related fatality rate double that of states with some level of ATV safety regulation.2

Table 1. Distribution and rate of ATV-related deaths by County, 2000-2008.

<table>
<thead>
<tr>
<th>County</th>
<th>Deaths</th>
<th>Proportion of Deaths</th>
<th>2004 Population</th>
<th>Fatality Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kanawha*</td>
<td>20</td>
<td>6.64%</td>
<td>195,218</td>
<td>1.14</td>
</tr>
<tr>
<td>McDowell*</td>
<td>17</td>
<td>5.65%</td>
<td>24,726</td>
<td>7.64</td>
</tr>
<tr>
<td>Mingo*</td>
<td>15</td>
<td>4.98%</td>
<td>27,389</td>
<td>6.09</td>
</tr>
<tr>
<td>Monongalia</td>
<td>14</td>
<td>4.65%</td>
<td>83,918</td>
<td>1.85</td>
</tr>
<tr>
<td>Fayette*</td>
<td>12</td>
<td>3.99%</td>
<td>47,049</td>
<td>2.83</td>
</tr>
<tr>
<td>Lincoln*</td>
<td>12</td>
<td>3.99%</td>
<td>22,564</td>
<td>5.91</td>
</tr>
<tr>
<td>Raleigh*</td>
<td>12</td>
<td>3.99%</td>
<td>79,175</td>
<td>1.68</td>
</tr>
<tr>
<td>Cabell*</td>
<td>11</td>
<td>3.65%</td>
<td>94,801</td>
<td>1.29</td>
</tr>
<tr>
<td>Jackson</td>
<td>11</td>
<td>3.65%</td>
<td>28,477</td>
<td>4.29</td>
</tr>
<tr>
<td>Wyoming*</td>
<td>11</td>
<td>3.65%</td>
<td>24,698</td>
<td>4.95</td>
</tr>
<tr>
<td>Logan*</td>
<td>9</td>
<td>2.99%</td>
<td>36,502</td>
<td>2.74</td>
</tr>
<tr>
<td>Roane</td>
<td>8</td>
<td>2.66%</td>
<td>15,359</td>
<td>5.79</td>
</tr>
<tr>
<td>Boone*</td>
<td>8</td>
<td>2.66%</td>
<td>25,721</td>
<td>3.46</td>
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<tr>
<td>Hampshire</td>
<td>7</td>
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<td>21,542</td>
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</tr>
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<td>Marion</td>
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<tr>
<td>Mason*</td>
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<td>2.33%</td>
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<tr>
<td>Putnam</td>
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<td>2.33%</td>
<td>53,836</td>
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<tr>
<td>Braxton</td>
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<td>1.99%</td>
<td>14,950</td>
<td>4.46</td>
</tr>
<tr>
<td>Calhoun</td>
<td>6</td>
<td>1.99%</td>
<td>7,415</td>
<td>8.99</td>
</tr>
<tr>
<td>Mercer*</td>
<td>6</td>
<td>1.99%</td>
<td>62,070</td>
<td>1.07</td>
</tr>
<tr>
<td>Other 35 Counties</td>
<td>95</td>
<td>31.56%</td>
<td>860,540</td>
<td>1.23</td>
</tr>
<tr>
<td>State</td>
<td>301</td>
<td>100.00%</td>
<td>1,808,344</td>
<td>1.85</td>
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A March 2008 Morbidity and Mortality Weekly Report article reported that lower socioeconomic status, lower level of education attained, and single or divorced marital status were associated with higher rates of ATV-related deaths in West Virginia from 1999-2006.7 To date, little has been done to describe geographic and temporal patterns of ATV deaths across West Virginia, particularly in those counties which account for most of the state’s ATV deaths.
deaths. Therefore, the purpose of this report was to identify the top 20 counties in West Virginia for ATV mortality, and determine if temporal features such as month, day-of-week, or time-of-day may influence mortality patterns from 2000-2008.

**Methods**

Death certificates, obtained from the West Virginia State Registrar, for the 301 ATV-related deaths that occurred in West Virginia from 2000-2008 were reviewed. Information related to the county where the fatal crash occurred, year, month, day-of-week and time-of-day were recorded and entered into an Excel spreadsheet. Time-of-day was grouped as early morning (Midnight - 5:59 am), morning (6:00 am-11:59 am), afternoon (Noon - 5:59 pm) and evening/night (6:00 pm-11:59 pm). Months were grouped in seasons: Spring (March, April, May), Summer (June, July, August), Fall (September, October, November), and Winter (December, January, February). Days-of-week were grouped as weekday (Monday-Thursday) or weekend (Friday-Sunday).

R statistical software was used to fit the count data into a Poisson regression model using population-based ATV mortality rates as the response variable and the seasons, times of day and weekend versus weekday as predictor variables. Separate models were fitted for seasons, time-of-day and weekend versus weekday. Rates were calculated using U.S. Census Bureau data, the WV and county populations for 2004. The midpoint in the 9-year study period was used as denominator values.

**Results**

The distribution of ATV deaths across the top 20 counties in West Virginia is shown in Table 1. These counties, out of the state’s 55 counties, accounted for nearly...
Table 3. Time of ATV crash as a predictor of fatality rates

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Estimate ± Std Error</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midnight – 5:59 am</td>
<td>-0.02 ± 0.40</td>
<td>NS</td>
</tr>
<tr>
<td>6:00 am – 11:59 am</td>
<td>0.12 ± 0.10</td>
<td>NS</td>
</tr>
<tr>
<td>Noon – 5:59 pm</td>
<td>0.16 ± 0.07</td>
<td>0.02</td>
</tr>
<tr>
<td>6:00 pm – 11:59 pm</td>
<td>-0.12 ± 0.07</td>
<td>NS</td>
</tr>
</tbody>
</table>

seventy percent (205 of 301) of the ATV-related deaths during the 9-year study period. Further, twelve of the 20 counties, which are located in the southern part of the state, accounted for over 46% of all the deaths (140 of 301). These twelve counties also accounted for about 38% of the state’s population and 26% of the land area. Calhoun County, whose population ranks 50th in the state, experienced the highest population-based rate of 8.99 per 100,000 population. At the other end of the spectrum, Kanawha County ranked 1st in population with a fatality rate of 1.14, second lowest among the 20 top counties. The rate for the remaining 35 counties was 1.23 and for the entire state, 1.85.

During the first six years of the study period, deaths increased consistently from 15 in 2000 to a record high of 52 in 2006 (see Table 2). Fatality rates also increased proportionally.

Sixty-four percent of the deaths occurred on the weekend with Saturday alone accounting for about 38% of the state’s population and the highest number of ATV-related deaths, it should follow that Kanawha would have the highest fatality rate, as well. Results presented above show that this is definitely not the case. In fact, Calhoun County, with a 2004 population less than 4% of Kanawha’s and 14 fewer ATV deaths, had a fatality rate nearly eight times higher, 8.99 and 1.14, respectively.

Discussion

After the initial geographical analyses, one might conclude that because Kanawha County had the greatest population and the highest number of ATV-related deaths, it should follow that Kanawha would have the highest fatality rate, as well. Results presented above show that this is definitely not the case. In fact, Calhoun County, with a 2004 population less than 4% of Kanawha’s and 14 fewer ATV deaths, had a fatality rate nearly eight times higher, 8.99 and 1.14, respectively. This finding supports the observation by Rodgers in his study of national ATV fatality rates from 1990-1999, where he reported that the rural nature of a state contributed to rate differences. While relatively higher rates have been observed in many of West Virginia’s counties, the overall rate for the state from 2000-2008 is consistent with rates reported in earlier studies.

Even though ATV fatalities in West Virginia continue to be a local as well as a national public health concern, Table 2 shows a decline in ATV population-based fatality rates after 2006. The 34% decrease in the fatality rate from 2.94 in 2006 to 1.93 in 2008 is significant and should give us pause. We opine that the data fit the model extremely well. During the afternoon period (i.e., noon to 5:59 pm) there was a significant proportional increase in the number of ATV deaths (p = .02).

While the current downward trend is most welcome, more attention should be directed towards two continuing high-risk behaviors. Review of medical examiner records and toxicology data of 112 fatal ATV crashes from 2004-2006 revealed that alcohol was detected in the blood of 50% of the decedents and of those, 88% had blood alcohol concentrations at or over the legal limit of 0.08%.

Drugs of abuse, including marijuana, opioid analgesics, and diazepam were identified in 21% of the deaths. The location of the crashes is also of major concern. Recent data, from a report prepared for Governor Manchin, showed that at least 53% of the fatal crashes occurred on paved surfaces including streets and highways – many of which are in the counties described in this study. While some of these locations were legal for riding in accordance with the 2004 law, many were not. Manufacturers have continuously recommended that ATVs not be operated on paved surfaces such as asphalt and concrete. ATV tires are bulbous, with low air pressure and wide treads that do not grip well on hard surfaces like roads. Stricter enforcement of this part of the law is strongly warranted. In addition, the required ATV Awareness Course should be strengthened by more aggressively addressing these high-risk behaviors. If ATV operators are made more aware of these risks, then ATV mortality should continue its recent downward trend.
Acknowledgement

This research was supported by grant # 5R49CE001170 from the National Center for Injury Prevention and Control, CDC, to the West Virginia University Injury Control Research Center. Contents are sole the responsibility of the authors and do not represent official views of the CDC.

References
Finding a Faster Route to Practice: From Medical Student to Board Certified Physician

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West Virginia School of Osteopathic Medicine

Abstract:
An examination of two types of educational tracks used by medical students seeking a faster route to practice: 1) “3+3” programs that combined the final year of medical school with the first year of a primary care residency, and 2) graduating from medical school after only three years. The “3+3” programs were discontinued despite reports indicating their success. Three year medical school options are still available at a handful of medical schools. Finally, the paper will explore why and how medical schools might wish to enact a three year curricular option.

Introduction
Are we forcing new physicians to endure too much clinical training before receiving a full license to practice medicine? In the 1970s, it was not uncommon for physicians to open up a practice after only three years of clinical time. Today’s medical students average over five years of clinical education. If a 22 year old entering medical student decides to pursue a primary care field, the earliest age this student can expect to be fully licensed to practice medicine is 29. If the student decides to pursue a more specialized field, such as combining undergraduate college education with medical school, are inherently limited in scale, and will not be discussed. We can either develop accelerated residency tracks that permit students to enter the profession more rapidly, or develop curricular tracks that allow students to graduate medical school after three years. Unfortunately, the accelerated residency choice is no longer an option for American Osteopathic Association (AOA) or Accreditation Council for Graduate Medical Education (ACGME) approved programs, especially for ACGME residencies, where pilot programs were attempted with great success only to be discontinued anyway. Three year medical curricular options show promise, and the adoption of a three year curricular option is a realistic possibility for both osteopathic and allopathic medical schools.

I. Graduate Medical Education Considerations
Many primary care residencies developed highly regarded “3+3” programs where the final year of medical school was combined with the first year of the student’s residency. If many students, professors, schools, and hospitals favored these programs, why did the ACGME approved “3+3” programs disappear? It was not a funding issue. In the combined year, the rookie physicians paid fourth-year tuition to their medical school, and the hospital received first year Medicare resident funding for the same student. It was not a quality issue. Hospitals eagerly embraced accelerated students, and multiple studies have demonstrated the high quality of the accelerated graduates. The ACGME has not explicitly stated why the programs were discontinued, leaving one to speculate about many possible reasons. Did the ACGME feel that it was stepping on the toes of the Liaison Committee on Medical Education (LCME) by working with medical students that had not yet received their degree? Was it a political problem - did residency directors from excluded programs complain that they were unable to compete for the best residents interested in primary care?

“3+3” Programs Were Successful
Accelerated family medicine residency programs at Marshall University and the University of Tennessee attracted motivated students, often those in the top of their class. These schools were two of twelve to receive approval in 1989. In addition to the saved time, students were attracted to
the prestige associated with an accelerated program. Hospitals were pleased with the quality of the students. Authors of the Marshall study stated “"[t]here has been a consistent impression of the faculty that most first-year accelerated residents have generally become indistinguishable in performance from the traditional PGY-I residents at six to nine months following orientation.“ The program successfully encouraged its trainees to practice in West Virginia—81% of residents remained in West Virginia.

The Tennessee case demonstrates the financial contentment of all parties involved. Students benefited—they received residency pay a year earlier, and were able to practice one year sooner. The medical school was content—it still received fourth year tuition dollars from the now “resident” students. Hospitals were content—they were pleased with the quality of the students, and they continued to receive Medicare GME funding for the residency positions. The Tennessee authors also noted that “beneficial outcomes of accelerated residencies include a savings to society and taxpayers since there is a decrease in the time and educational financing for the production of a well-trained physician.”

The following observations from the University of Tennessee were promising.

“The key finding of this study is that, when compared to the traditional curriculum of 4 years of medical school and 3 years of residency (4+3), residents in the accelerated curriculum (3+3) demonstrated performance scores equal to or better than their non-accelerated counterparts. Using annual In-training Examination scores beneath the 20th percentile as one indicator, accelerated residents scored better than their peers. Further, these accelerated residents frequently distinguished themselves as chief residents and with other honors. These Tennessee students were, on average, in the middle of their classes academically, and [the] data suggest[s] that students need not be at the very top of their class academically to succeed in an accelerated program. All students achieved the objective milestones of licensure and passage of the ABFM certification examination, despite the shorter and less-costly training.”

Will Residency Programs Generate Independent Accelerated Options?

If residencies decide to increase their focus on established competencies rather than lockstep “meaningful contact hours,” residency programs could offer residents the opportunity to complete the residency at an accelerated pace. These new accelerated tracks would need to overcome two main hurdles. First, the AOA and ACCME would need to rewrite program certification language establishing an exact number of required residency years before a student may become board certified. When a student has met these competencies and passed the licensing examination, the student could be fully certified without regard to how quickly these tasks may have been accomplished.

The second barrier is imposed by hospitals, which have numerous financial incentives to prevent rookie physicians from finishing residency earlier. Convincing hospitals to allow residents to leave “early” will be difficult because residents provide a cheap source of labor, and hospitals average almost $100,000 of Medicare funding per resident. Hospitals do not want to give up this direct source of income, especially during the resident’s last year, when the resident is providing very efficient and effective care. Outdated payment incentives established by the Centers for Medicare and Medicaid Services (CMS) increase hospital efforts to defend an old and inefficient training system. Actions by Congress to correct misguided financial incentives may be required before accelerated residencies are possible.

A Creative Family Medicine Program

Today, family medicine and other primary care residencies struggle to retain talented students, and it is not uncommon for allopathic family medicine residencies to be filled entirely by international medical graduates. The West Virginia Family Medicine Rural Scholars Program (WVFMRSP) attempts to entice students into family medicine with a similar prestige factor, but without the ACCME prohibited reduced year of training. The student’s fourth year of medical school is treated like the first of residency, but the student still must complete three years of residency after graduating from medical school. Program participants receive a $10,000 stipend during their fourth year of medical school, avoid the match process, and will have considerable unscheduled time to conduct research during their final residency year.

The WVFMRSP is a creative idea given West Virginia University’s inability to enact a “3+3” program. In the meantime, other schools might increase their competitiveness for residents by adopting similar programs. The WVFMRSP treats a first year medical student just like a first year resident with relatively few benefits to the student. The student receives the $10,000 stipend, but does not receive residency pay, and the student will still spend three more years as a resident. While the research year might be very valuable and important to some students, one might speculate that the final year is dedicated to research because the young physician has completed family medicine training, but the residency director is simply not permitted to “graduate” students due to the requirements of the ACCME and/or AOA. The WVFMRSP’s existence provides evidence that students are capable of beginning residencies after their third year of medical school, and
that preventing students from obtaining residency credit during their fourth year cheats the students out of a year of full-time practice.

**Combined Medical School and Residency Years (“3+3” Programs) Are Not Permitted**

Despite “3+3” program success, these programs stopped enrolling new students in 2001. Fourth year medical students are currently barred from participating in any residency program accredited by the AOA or the ACGME. The “Accreditation Document for OPTI [Osteopathic Postdoctoral Training Institution] and the Basic Document for Postdoctoral Training Programs” published by the AOA states in section L subsection 2.1 that “the program shall enroll only graduates of COCA [Commission on Osteopathic College Accreditation] accredited COMs [Colleges of Medicine].” The ACGME Institutional Requirements in section II. A. 1. similarly states that residency applicants must be “graduates” of a medical school. Without a change to the “graduate” requirement in these documents, “3+3” programs will never again be permitted.

If one were to convince the ACGME or AOA to allow non-graduates (i.e. fourth-year medical students) to enter residency programs, many state laws use similar language requiring “graduate” status to achieve the temporary practice rights afforded to medical residents. The West Virginia Secretary of State Code of State Rules contains a regulation that “[a]n application for an educational training permit shall include proof that the applicant is a graduate of a medical school approved by the AOA.” In many states, regulations may need to be amended to provide exceptions for “3+3” program participants.

Drs. Steven Berk, Michael Ragain, and Troy Fiesinger attempted to start a “3+3” family medicine residency program at Texas Tech by submitting a proposal to the ACGME in early 2009. They hoped to establish a “3+3” example that could be followed by multiple family practice residencies across the nation. According to Drs. Berk and Ragain, favorable responses to the proposed accelerated “3+3” program were received from the American Board of Family Medicine, the Association of Departments of Family Medicine, and the Association of Family Medicine Residency Directors. In spite of this support, the proposal was declined by the ACGME. The group redirected its efforts toward designing a three year medical degree, and in March of 2010 it announced LCME approval for a three year medical school option open to a limited number of medical students committed to family practice.

**II. Analysis of the Three Year Medical School Curricular Option**

Reducing the length of medical school to three years leads to considerable financial savings for future physicians and the reduced amount of time in school may make the medical field more attractive to potential applicants. A March 2006 University of Pennsylvania study determined that “even if total medical school tuition remained constant, a one year reduction in the duration of medical school still yields a financial benefit of $100,000 or more to future physicians.”

Papers by Dr. Whitcomb and Dr. Irby developed at the Josiah Macy Foundation’s Conference on “Revisiting the Medical School Educational Mission at a Time of Expansion” make salient arguments. Dr. Whitcomb’s article “Shortcomings in the Pursuit of Medical School Education Mission” states as follows:

“At present, no medical school requires all students to experience the same specific coursework during the four years of the education program. Indeed, until relatively recently, the entire fourth year of the program was elective in many schools, and it continues to be largely elective in most even today…. Given the costs involved, it makes no sense to require students to spend a fourth year taking a variety of electives that are not deemed to be core elements of the program.”

Dr. Irby’s article titled “New Models of Medical Education” states as follows:

“There should be three primary options for the fourth year: 1) direct entry into residency if all competencies are met; 2) remediation of deficiencies if competencies are not met; and/or 3) pursuit of scholarship and electives. This structure will allow a reduction in the time to practice, reduce student debt, and still allow some students to pursue elective options and scholarship. If the student enters directly into residency or pursues the option of scholarship, the academic credit for the fourth year should be double counted for graduation from medical school and residency training in order to reduce the total amount of time before entry into practice.”

Some medical schools have already embraced these words of advice. As discussed above, readers should realize that Dr. Irby’s recommendation that the old “3+3” programs that combined the last year of medical school with the first year of residency are no longer an option. As indicated by the recent Texas Tech experiment, interest in “3+3” programs may be fading, while interest in the three year medical school curricula may be increasing.

**Accelerated Medical School Curricula Examples**

We might begin by looking at the guidance provided by the medical school accrediting bodies. The undergraduate requirements specified by the COCA and LCME offer some general guidance on specific course subject areas. COCA specifies several subject areas that should receive attention, including internal medicine, family medicine, pediatrics, geriatrics,
obstetrics & gynecology, preventive medicine & public health, psychiatry, surgery, and radiology. In standard ED-15 the LCME recommends that rotations in family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery be completed, and in standard ED-17 that rotations in other multidisciplinary areas, such as pathology, be made available to students. The most important piece of guidance is found in standard 6.1.1 of the COCA documentation, closely mirrored in standard ED-4 of the LCME documentation, and it states that “[t]he minimum length of the osteopathic medical curricula must be at least four academic years or its equivalent as demonstrated to the COCA. Guideline: The curriculum should provide at least 130 weeks of instruction.” This 130 week requirement appears to be the only explicit timing requirement for medical schools seeking to develop an accelerated curriculum. Both the COCA and the LCME have approved three year medical school programs that are currently in place. In the discussion that follows, we will consider five medical schools (four LCME and one COCA) that offer innovative curricular options, each with its own flaws and advantages.

Duke University School of Medicine – A Research/Dual Degree Oriented Curriculum

The traditional two years of basic science courses are completed during year one, required rotations are completed in year two, year three is spent conducting research or work toward a dual degree, and year four is dedicated to elective rotations. If the Duke student opts to pursue a dual degree not directly related to medicine during the student’s third year, this student will only be receiving three years of medical education prior to receiving an MD. This curricular model may not be suitable to the majority of medical schools. Due to the large numbers of dual degrees and an increased research focus, Duke medical graduates may be more likely to have careers outside the standard practice of medicine – either in a research or administrative capacity – and Duke’s innovative curriculum prepares its students accordingly. With regard to dual degree programs, Duke is not unique. Many medical schools across the country offer dual degree programs, and graduates often find ways to graduate from both programs in only four years.

University of Minnesota Medical School – A Potential 3.5 Year Curriculum?

The Minnesota curriculum allows students to complete medical school in 3.5 years via the “Flexible MD” program. According to the admissions department, most (if not all) students use the program to extend their education, and those that have been eligible to graduate early opted to take more electives instead. (Paul T. White, Associate Dean of Admissions, Minnesota Medical School, Personal Communication on June 24, 2009.) While some medical schools could look to this type of curriculum as one more possibility to attract students with diverse needs, it is not the ideal model for schools looking to offer an accelerated option.

University of Calgary Faculty of Medicine & McMaster University Faculty of Health Sciences

Calgary students complete a fairly standard series of first and second year basic science courses oriented around a “clinical presentation” curriculum. The third (final) year, students can choose the amount of time they wish to allocate a clinical subject area, 4 to 12 weeks, and they have 10 weeks of pure electives. McMaster students attend school 11 months out of the year and use a problem-based block learning approach to qualify for their MD degree at the end of their third academic year. McMaster students complete basic science courses in 1.5 years, and spend 1.5 years in clinical rotations.

A study comparing the three year Calgary curriculum to other four year LCME approved Canadian curriculums stated that “the three-year curriculum developed at the U of C produces an equivalent graduate—and one who might possibly be slightly better in communications and professionalism skills—than those who graduate from four-year medical schools in Canada.” A Canadian Medical Association Journal article argues that the fourth year is not necessary, and points out that there is no hard evidence that the fourth year is vital, or prepares students to be more competent physicians. “Without systematic evaluations, deans of medicine will be left with only tradition as a defense when education ministers demand better evidence, given the high professional and social costs. As for medical students, they should ask whether a fourth year will make them better and wiser physicians rather than simply older and poorer ones.”

Lake Erie College of Osteopathic Medicine

The Lake Erie College of Osteopathic Medicine (LECOM) is currently the only osteopathic school offering a three year curriculum leading to a doctoral medical degree. LECOM’s three year program, known as the Primary Care Scholars Pathway (PCSP), is open to anywhere from six to twelve students in each entering class. The chief mechanism used by LECOM for saving educational time is the elimination of “audition” clinical rotation electives. April of their second year students begin to complete sixteen four-week clinical rotations. For COMLEX II & PE eligibility purposes, the traditional ‘third year’ of medical school is considered complete after the eighth clinical rotation, and comprehensive review time for both...
Advantages and Barriers Medical Schools Might Encounter When Enacting a Three-Year Option

**Advantages:**
1. Increased Premedical Student Interest and Awareness of the medical school
   a. Many students may prefer the opportunity to finish their degree one year earlier
   b. Desired class size increases may be easier with higher application volumes
2. Ease of implementation - No need to make changes to basic science curricula
3. Less stress on already established clinical rotation sites
   a. Fewer preceptors will be needed (since there are fewer fourth year students)
   b. Decrease in administrative expenses associated with fourth year students
   c. Desired class size increases will not be inhibited by a lack of preceptors

**Barriers:**
1. Total tuition revenues may decrease - Students electing to pursue the accelerated track might pay higher tuition rates for the extended curriculum during their third year, but these students would not be expected to pay the standard fourth year of tuition
2. Some clinical rotation sites might resist adjustments to their rotation schedules
3. Ensuring students obtain desired residencies by appropriately handling the temporary surge in graduating student volume as the first class of three year graduates matriculate
4. Logistical difficulty scheduling COMLEX or USMLE exams for accelerated students

The amount of knowledge that medical students must master has grown substantially since the 1970’s. Few continue to argue that all of the basic science courses can be taught in one year, even though Duke medical students somehow manage this challenge. In the early 1970s, it was possible to practice general medicine after a single post graduate internship year. This was why it was important that future physicians receive two years of clinical education while in medical school. Today, even if medical students spend only one clinical year in medical school, they will still have a minimum of four years of clinical education prior to practice. Two years of basic sciences are needed, but two years of clinical rotations are often unnecessary, and students should be afforded the opportunity to enter residency programs after a single year of clinical training. The table on the opposite page may help to clarify this difference.

Medical schools that are preparing students to be practicing physicians, especially in primary care specialties, could create a three year curricular option by removing a year of clinical “audition” rotations while leaving the two years of basic sciences largely untouched. Schools might expect students participating in accelerated medical school curricula to achieve similar levels of success compared to students enrolled in “3+3” programs. A three year medical school option can be expected to have a larger impact than the “3+3” programs, which were limited to a small number of primary care residencies.

It is important that accelerated programs be set up as “options”
available to students rather than a new requirement of all students. This will allow schools to gauge student interest in the accelerated program, while accommodating students that wish to stay for a fourth year. Accelerated medical school options can be clinically structured to encourage students to enter needed primary care fields. Students opting to remain for a fourth year could be permitted to pursue a variety of clinical electives, research interests, or dual degree work. We have found a faster route to practice, now it is up to medical schools to embrace it.

References


May/June 2010 | Vol. 106 | 35
Wheeling Jesuit University Health Center Adopts Electronic Medical Records

BY TRICIA LOLLINI

The Wheeling Jesuit University (WJU) Health Center has launched HEALTHeWV (HeWV), a paperless records system that gives health care professionals quick access to patient information, clinical practice guidelines and patient education materials. “Implementing HEALTHeWV into our university health center provides a great opportunity for our collaboration with Sponsored Programs. This partnership in turn, will help us to work better together across the University - including with faculty in our health-science programs. It’s a “win-win” in a lot of ways,” states Christine Ohl-Gigliotti, Dean of Student Development.

HeWV, a congressionally sponsored program brought to the state through the efforts of Senator Robert C. Byrd (D-WV) and managed by the National Technology Transfer Center (NTTC) at Wheeling Jesuit University offers health care providers quick access to the latest in evidence-based medicine guidelines and improving patient-provider communication with use of electronic health surveys and electronic charting. HeWV goes beyond a typical electronic medical record (EMR) system to focus on patient care and improving patients’ health outcomes. HeWV went “live” for the first time in 2006 at Wheeling Health Right. Since then it has been adopted by 29 additional clinics. The WJU health center is the first college campus health center in the state to adopt the system.

The WJU Health Center is committed to the mission of Wheeling Jesuit University to educate young men and women. It seeks to remove and reduce health-related barriers to learning and to encourage each student to become knowledgeable in both prevention of illness and in responsible self-care. The Health Center functions as a resource to provide direct health care through high quality, comprehensive, cost-effective, accessible service to meet the needs of the individual student.

“We have been working hard in training for the HEALTHeWV program and appreciate the time the HEALTHeWV staff took to help us prepare for the initiation of the program. We look forward to the positive changes and anticipate the program will provide us with a better ability to track student health needs” says Amy Cronin, RN and Nurse Coordinator at the health center.

The Health Center, in line with its holistic approach, offers student counseling services, commits itself to the principles of health and well-being and aspires to provide services which will enhance emotional health, personal growth, and interpersonal development.

WJU Vice President for Sponsored Programs, J. Davitt McAteer, says the University’s role in the HEALTHeWV project is an extension of its overall mission to make a positive difference in the lives of fellow West Virginians.

“We are proud that Wheeling Jesuit University is West Virginia’s first student health center to use HEALTHeWV. We believe it will only improve the already efficient and effective work of the health center staff as well as further the already positive experience our students have at the center.”

With the success of HEALTHeWV, Senator Byrd says West Virginia can serve as a model to other states considering EMR systems.

Clinics interested in more information about the HeWV program can contact Melissa Mealy at (304) 243-4375, mmealy@nttc.edu or visit www.healthewv.net.

The youngest of 28 Jesuit colleges and universities in the United States, Wheeling Jesuit University offers students a high-quality private education. Since 1995 U.S. News & World Report has ranked Wheeling Jesuit University among the top institutions in its “Best Master’s Universities in the South” category. The campus is home to the Robert C. Byrd National Technology Transfer Center, the Erma Ora Byrd Center for Educational Technologies and the Clifford M. Lewis Appalachian Institute.
Haiti Relief Efforts

Photo montage by Donna Tassos

Inset: photographer Donna Tassos, RN

MEDICAL AND MINISTRY STAFF INCLUDE: Large photo above, Becky Barido, RN. Top, left to right: Sonal Shah, MD, Rick Hayes, MD, Rafael Gomez, MD, Ayssha Rahman, MD (holding the baby). Bottom and center, left to right: Pastor Andre Jean, Lora Hayes, RN, two group photos, Paul Nanda, MD, and Lindsey Clark, RN.
THE FIGHT IS ON!
Med-Mal Caps Challenge Heads to WV Supreme Court

We’ve been expecting this for several years now since the passage of our comprehensive medical liability reform legislation (HB 2122) in 2003. A case challenging the non-economic damages cap was accepted to be heard by the WV Supreme Court of Appeals. Justice Ketchum was the one dissenting vote. Justice McHugh recused himself because he is on the Board of Trustees of Thomas Hospital, and Chief Justice Davis replaced him with Circuit Judge Ronald Wilson. The briefing and oral argument schedule is yet to be set.

On April 15, the WV Supreme Court voted 4-1 to accept the petition for appeal in McDonald v. City Hospital, Inc. The case involves a Medical Professional Liability Act (MPLA) jury verdict for the plaintiffs, awarding $1,129,000 to the plaintiff and $500,000 to his wife for loss of consortium, splitting liability between the doctor (70%) and the hospital (30%). The award to the plaintiff included $1M in noneconomic damages for past and future pain and suffering. On post trial motion, Circuit Judge Silver reduced the award to $500,000, applying the MPLA cap per WV Code § 55-7B-8b which caps noneconomic damages at $250,000 or $500,000 if there is death or substantial permanent injury. Judge Silver’s ruling meant the wife’s award was reduced to “0” and the plaintiff’s to $500,000. The plaintiffs challenged the constitutionality at the circuit court level and pursued the issue on appeal.

The WVSMA is taking this challenge very seriously and we will be gearing up to engage in this battle to support the position that the noneconomic damages caps are constitutional and an appropriate exercise of legislative power. The noneconomic damages “caps” are a critical piece of the 2003 legislation, and maintaining them is essential to the state’s ability to attract and maintain new doctors.

Now is the time for physicians to stand together.

21% Medicare physician payment cuts stopped until June 1, 2010

On April 15, the Senate and House of Representatives passed, and the President signed into law, H.R. 4851 the “Continuing Extension Act of 2010.” This legislation reinstated Medicare physician payments to the March 31 levels, again postponing the 21.3 percent cut that was supposed to take effect January 2010. This most recent extension of 2009 payment rates will continue through May 31, and be applied retroactively to all physician services provided to Medicare patients in April.

The legislation also includes a clarification to the definition of electronic health records (EHRs), amending language in the “American Recovery and Reinvestment Act of 2009” (the Stimulus Bill) to allow clinic-based physicians who bill through hospitals to receive bonus payments for the adoption of EHRs.
Health System Reform and its Impact on West Virginia

President Barack Obama signed the Patient Protection and Affordable Care Act (H.R. 3590) into law on March 23, 2010. This law is being proclaimed by many to be the most significant health reform legislation passed by congress in generations. The monumental bill is expected to bring down health care costs for American families and small businesses, expand coverage to millions of Americans and end bad practices of insurance companies. So how does this legislation impact West Virginians and more specifically West Virginia’s practicing physicians?

The information below is a compilation of information obtained from a variety of sources including the American Medical Association (www.AMA-Assn.org) and the Department of Health and Human Services (www.HealthReform.gov).

Under the reform legislation, the Obama administration at the Department of Health and Human Services is projecting the following:

- 256,000 West Virginia residents who do not currently have insurance and 41,000 residents who have non-group insurance could get affordable coverage through the health insurance exchange.
- 204,000 West Virginia residents could qualify for premium tax credits to help them purchase health coverage.
- 372,000 West Virginia seniors would receive free preventive services.
- 66,000 West Virginia seniors would have their brand-name drug costs in the Medicare Part D “doughnut hole” halved.
- 20,000 small West Virginia businesses could be helped by a small business tax credit to make premiums more affordable.

There has been a great deal of talk about what this 2,400+ page bill covers and doesn’t. The following is a basic summary of the core components of the legislation and the impact on patients, physicians, businesses and insurers.

Medical Liability Reform

Many have asked the question “what is included in the bill relating to medical liability reform?” The short answer is “not much”. There is no liability reform component of this legislation but the following points are included:

- Does establish a competitive grant program for states to develop, implement and evaluate innovative medical malpractice reforms.
- Does extend medical liability protections under the Federal Tort Claims Act to officers, governing board members, employees and contractors of free clinics.
- Does authorize a Government Accountability Office (GAO) study and report on whether the development or implementation of guidelines, standards, or payment adjustments (e.g., health care acquired conditions) specified in multiple sections of the bill would result in new causes of action or claims against health care providers.

How the Bill Expands Health Insurance Coverage

The legislation is projected to expand insurance coverage to an additional 32 million persons by 2019, equating to coverage of 59 percent of the uninsured. The following is a synopsis of the mechanisms through which this will be accomplished:

1. Expanding Medicaid eligibility to all individuals under age 65 (including childless adults) up to 133 percent of the federal poverty level (FPL).
   - Federal government will cover 100 percent funding for the expansion of Medicaid coverage to all individuals from 2014 to 2016, diminishing to 90 percent in 2020 and thereafter.
   - Projected 16 million uninsured Americans will become covered under Medicaid and the Children’s Health Insurance Program by 2019.
   - The legislation requires Medicaid payment rates to primary care physicians providing primary care services be no less than 100% of Medicare payment rates for 2013 and 2014, and provides 100 percent federal funding for the incremental costs to states of meeting this requirement.
2. Provides “premium” credits to individuals and families up to 400 percent of FPL ($88,200 per year for a family of four) for the purchase of private health insurance.

3. Provides dependent coverage for children up to age 26 under all individual and group policies.

4. Requires coverage of children with pre-existing conditions in 2010 & insurers can’t drop insureds if they get sick.

5. Establishes a temporary “High Risk Pool” for adults with pre-existing conditions – until 2014 when all insurers are required to cover pre-existing conditions for adults.

6. Disallows lifetime financial limits on benefits.

7. Preventive services (mammograms, immunizations) covered by insurers with no co-payments or deductibles.

8. Medicare patients who hit “doughnut hole” will receive $250 rebate from Medicare and after 2011 will receive 50% discount on prescription drugs.

9. State based health insurance exchanges will begin in 2010 for persons without access to employer-based insurance coverage.

10. In 2011 states can require insurers to justify premium increases and impose penalties for excess increases.

**Requirement for Insurance Coverage**

A core component of the success of the reforms is that most Americans will have some sort of health care coverage. If coverage isn’t available either through a person’s employer or by qualifying for government run programs (Medicaid, CHIP, Medicare) individuals will be required to purchase coverage. There are various exemptions for different income levels but basically, by 2014 individuals will be required to obtain health insurance coverage or pay a penalty to the government which incrementally rises over time. That penalty is: $95 in 2014, $325 in 2015, $695 in 2016 or as a % of income in the amount of 1% in 2014, 2% in 2015, and 2.5% in 2016. After 2016, the penalty will increase annually by the cost-of-living adjustment.

**Impact on Insurance Company Practices**

Insurance companies are prohibited from denying coverage based on pre-existing conditions. Premiums may not be based on gender and health status. Insurers may not drop coverage if policyholders get sick, and once insured, individuals and families will be guaranteed renewal of their health insurance policies.

**Impact on Insurance Premiums for Insured**

- Health insurance premiums will not rise for most people.
- The Congressional Budget Office (CBO) predicts that premiums in the large group market (nearly 70 percent of the non-elderly covered population) would drop 0 to 3% in 2019.

- Premiums in the small group market (13 percent of those with insurance coverage) may fall – CBO predicts a change from -2% to +1% compared to current law.

- Premiums in the non-group market (17 percent of those with insurance coverage) are expected to rise by an estimated 10 to 13%. While premiums will likely rise in this market, such policies will contain richer benefits. Additionally 57% of the non-group enrollees will likely receive a subsidy making their actual contribution 56 to 59% lower.

**Impact on Physician Practices: the Positive**

- Physicians will continue to exercise considerable control over the practice of medicine and the care that they provide to their patients.
- By covering the uninsured it cuts into the $24 billion plus annually in charity care provided by physicians.
- The financial impact is particularly acute when private and public payments are declining or flat, and physicians are less able to cover the cost of treating uninsured patients with revenue from insured patients.
- The time and cost burden of physicians’ practices interactions with health plans is large. Administrative simplification provisions will reduce these costs. Physicians spend on average about 140 hours and $68,000 a year just dealing with health insurance bureaucracy. The Obama Administration estimates this adds up to 754,200 hours and $366 million in costs to West Virginia physicians. By simplifying and standardizing paperwork and computerizing medical records, doctors will be able to focus on caring for their patients instead of dealing with bureaucracy.
- Many payment improvements are included in the legislation that when combined will result in immediate and significant Medicare payment increases for many physicians.
  - 10% incentive payments for primary care physicians.
  - 10% incentive payments for general surgeons performing major surgery in health professional shortage areas.
  - 5% incentive payment for mental health services.
  - Medicare quality reporting incentive payments extended. Incentive payments of 1 percent in 2011 and 0.5 percent from 2012–2014 will continue for voluntary participation in Medicare’s Physician Quality Reporting Initiative (PQRI).
  - Administrative simplification - national rules are to be implemented between 2013-2016 to standardize and streamline claims processing.

**Impact on Physician Practices: the Negative**

- Value index adjustments to individual physician payments based on cost and quality outcomes by 2015.
• Potential penalties on physicians who do not successfully participate in the Physician Quality Reporting Initiative (PQRI) by 2015.
• Public reporting of physician claims data to develop performance reports.
• Independent Payment Advisory Board (IPAB) to develop proposals to cut Medicare spending if the target rate of growth is exceeded. The Secretary of HHS required to implement the proposals unless a statutory override (Projected cuts would total $13 billion over 10 years.)
• Utilization assumption for high-cost imaging equipment will be increased to 75 percent effective Jan. 1, 2011 (Net cuts $2.3 billion over 10 years).
• New physician-owned hospitals will be banned from participating in Medicare and limits are placed on growth of existing physician-owned facilities (net cuts $500 million over 10 years).

Impact on the States

State budgets are expected to be relieved from rising health care costs as reform:

Reduces state employer premiums: Coverage would immediately be expanded to the uninsured, decreasing the amount of uncompensated care costs that gets shifted to the premiums of state employees. For states that provide early retiree health benefits to their state employees, a reinsurance program would provide premium relief of up to $1,200 per family policy per year for all employees.

Reduces uncompensated care: The Obama Administration estimates that West Virginia providers lose $482 million in uncompensated care each year, which states subsidize at least in part. Under the reform, uncompensated care would begin to be reduced immediately as more uninsured people gain coverage.

Invests in the health care workforce: The Obama Administration estimates approximately 169,000 people, or 9 percent of West Virginia’s population, cannot access a primary care provider due to shortages in their communities. Health insurance reform will expand and improve programs to increase the number of health care providers, including doctors, nurses, and dentists, especially in rural and other underserved areas.

Impact on Employers

Small Business Tax Credit: Businesses with 50 or less employees which contribute at least 50 percent of the total premium cost of their employees, who have average annual wages below $50,000 will be eligible for the tax credits of up to 35 percent (for tax years 2010-2013) of the premium paid for their employees. The credit phases out as firm size and average wage increase. In tax years 2014 and later, for eligible small businesses purchasing coverage through the state exchanges, the tax credit increases to 50 percent of the employer’s contribution toward the premium.

According to the IRS, the wages and hours of physician business owners and partners will not be counted in calculating either the number of full-time employees or the average annual wages.

Large Businesses would have no “employer mandate” but “employer responsibility”: Businesses with more than 50 employees which do not offer health insurance to their employees must reimburse the government for subsidies provided to their employees who use the exchange to purchase health insurance. The penalty amounts to $2,000 multiplied by the number of full-time employees in excess of 30.

40 percent excise tax (“Cadillac” tax) on high-cost health plans: Beginning in 2018, an excise tax will be imposed on the coverage provider (i.e., insurer, plan administrator or employer depending on the type of coverage) of high-cost employer-sponsored health plans with aggregate values exceeding $10,200 for individual coverage and $27,500 for family coverage. The tax is equal to 40 percent of the value of the plan that exceeds these threshold amounts.

Expenses allocable to Medicare Part D subsidy: Effective 2013, employers that currently sponsor retiree prescription drug plans will no longer be able to deduct amounts contributed to them. However, future Medicare Part D subsidies will continue to be tax-free to the employer.

Limitation on excessive health insurance company compensation: Effective 2013, the deduction for executive and employee compensation for health insurance providers is limited to $500,000 per applicable individual. The limit applies to all officers, employees, directors and other workers.

Taxes and Credits

Annual fee on health insurance providers: Beginning in 2014, a fee will be applied on net premiums of all health insurers based on their market share. For non-profit insurers, only 50 percent of net premiums will be taken into account in calculating the fee. Exemptions are granted.

Annual fee on pharmaceutical companies and medical device manufacturers: New annual fees on certain manufacturers and importers of branded prescription drugs (including biological products, but excluding orphan drugs) would be imposed beginning in 2011 based on annual sales and set to reach a certain revenue target each year. Beginning in 2013, an annual excise tax of 2.3 percent will also be imposed on the sale of Class I medical devices by manufacturers, producers or importers. Class I includes the vast majority of orthotics and prosthetics, as well as durable medical equipment. Exemptions are provided for eyeglasses, contact lenses, hearing aids and any device that is generally purchased at retail for individual use.

Excise tax on indoor tanning services: Effective July 1, 2010, an excise tax of 10 percent will be imposed on the amount paid for indoor tanning services.
WESPAC is the West Virginia State Medical Association's bipartisan political action committee. We work throughout the year with elected officials to make sure they understand the many facets of our healthcare system.

WESPAC's goal is to organize the physician community into a powerful voice for quality healthcare in the West Virginia Legislature. We seek to preserve the vital relationship between you and your patients by educating our legislators about issues important to our physicians.

WESPAC contributions provide critical support for our endorsed candidates. Your contribution can make the difference between a pro-physician/patient candidate winning or losing.

To make a contribution to WESPAC, please call Amy Tolliver at (304) 925-0342, ext. 25

2010 WESPAC Contributors

The WVMSA would like to thank the following physicians, residents, medical students and Alliance members for their 2010 contributions to WESPAC. These contributions were received as of April 19:

**Chairman's Club ($1000)**
- Patrick P. Dugan, MD
- Dana Olson, MD

**Extra Miler ($500)**
- David A. Bowman, MD
- James L. Comerci, MD
- Generoso D. Duremides, MD
- Michael A. Kelly, MD
- Michael A. Stewart, MD

**Dollar-A-Day ($365)**
- Greenbrier D. Almond, MD
- Edward F. Arnett, MD
- D'Ann E. Duesterhoeft, MD
- Michael O. Fidler, MD
- William L. Harris, MD
- Sushil K. Mehrotra, MD
- Stephen R. Powell, MD
- L. Blair Thrush, MD
- John A. Wade, Jr., MD
- Mark D. White, MD

**Campaigner ($100)**
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- Ophas Vongxaiburana, MD
- Syed A. Zahir, MD

**Campaigner Plus (> $100)**
- Kenneth J. Allen, MD
- Kamalesh Patel, MD
- Finbar G. Powderly, MD
- Richard A. Rashid, MD
- Syed M. Siddiqi, MD
- Diane E. Shafer, MD

**Donor**
- Luis A. Almase, MD
- Lynn Comerci,
- Kathleen Mimnagh, MD

**Important READ!**

The WESPAC Board currently has vacancies for which we are soliciting nominations. If you know someone who would be a great addition to the Board please contact our Director Amy N. Tolliver, MS at amy@wvsma.com or (304) 925-0342. Self nominations are encouraged.

WESPAC Board Members 2010-2011

**STATE AT-LARGE - 2 SEATS**
- Phillip R. Stevens, MD, Chairman
- M. Tony Kelly, MD

**WVMSA COUNCIL REPRESENTATIVE - 1 SEAT**
- F. Tom Sporck, MD, Secretary

**FIRST CONGRESSIONAL DISTRICT - 2 SEATS**
- Ken Nanners, MD
- David W. Avery, MD

**SECOND CONGRESSIONAL DISTRICT - 2 SEATS**
- John Wade, MD
- Other seat vacant

**THIRD CONGRESSIONAL DISTRICT - 2 SEATS**
- Ahmed D. Faheem, MD
- Other seat vacant

**ALLIANCE REPRESENTATIVE - 1 SEAT**
- Terry Waxman
- Amy N. Tolliver, MS, Treasurer
## WESPAC 2010 Primary Election Endorsements

The following are the WESPAC endorsements for the 2010 Primary Election. Please tear out this page and take it to the polls on Election Day, Tuesday, May 11th.

WESPAC endorses healthcare friendly candidates who will promote initiatives supported by the WVSSMA and the physician community.

WESPAC is a voluntary, bipartisan, unincorporated organization composed of physicians, residents medical students and their spouses and is a separate segregated fund established by the West Virginia State Medical Association (WVSSMA).

### Federal and Statewide Offices

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2010 Legislative Session Wrap Up

At midnight on Saturday March 13 the WV Legislature adjourned calling an end to the 2010 Legislative Session. As usual they continued meeting on a limited scale the following week to focus on the final passage of the State budget bill.

For physicians this was a pivotal legislative year. The focus on scope of practice and the legislatures’ certain interest in passing legislation for the optometrists against the objections of the physicians, hospitals, others in the medical community and even the AARP, sent a direct message that we should be concerned about the success of such attempts by other special interests next year.

There was a plethora of other bills introduced this Session which aimed to grant scope of practice expansions to the nurses, pharmacists and the radiologist assistants. Most of the bills didn’t gain much support and none passed. However, it very well may be a different story in the coming years. It is evident nationally that nearly all allied health professional groups are vying for scope expansions. This will continue to be a top priority of the WVSMA.

The following is a summary of key issues addressed during the 2010 legislative Session.

For a quick look at all bills, you can visit the legislative website at www.legis.state.wv.us

Medical Liability Law Safe for Another Year

The WVSMA is always looking out for bills that might take a bite out of our hard fought medical liability reforms. This Session was a good one on this front where no bills were addressed which would have weakened our reforms. The pharmacists did try to get a bill passed (SB 8) which would have clarified they are considered a healthcare provider under the medical professional liability act and thus protected by the caps and other measures. This legislation did pass the Senate but did not make it onto the agenda of the House Judiciary Committee.

Provider Tax Phase out on Home Stretch

After a long ten-year phase out of the health care provider tax, on July 1, 2010 physicians, chiropractors, dentists, nurses (RN’s & LPN’s), opticians, optometrists, podiatrists, psychologists and therapists (PT’s & Massage) will no longer pay the provider tax in West Virginia! This is a monumental success which all physicians should celebrate. Over the past few years while the West Virginia tax has been phasing out, other states have actually been looking to implement new provider taxes in order to shore up the state budgets. Sound familiar?

Optometrists Expand Scope of Practice: Lose battle on Laser Surgery and “Physician” Designation

The Legislature adjourned at midnight on Saturday and about an hour before passed SB 230 the optometry scope expansion bill.

A big THANK YOU to all who engaged on the effort to weaken the bill. Over 350 emails were sent to members of the Legislature through the use of our advocacy system and numerous phone calls were made. The engagement of physicians, both ophthalmologists and all other specialties was critical to this effort and really made a positive impact.

The two biggest concerns with the bill were absent from the final draft - laser surgery and the use of the term “optometric physician”. On the laser issue medicine succeeded in getting language in the bill that specifically states an optometric licensee “may not use a therapeutic laser”. On the optometric physician issue their statute is still silent - the bill did not address the issue. So these were two huge wins!

That’s not to say that they didn’t get a lot - which they did. The final bill is bad but is truly as good as we could get it this year. The following is a summary of the bill:

- Allows use of epi-pens, additional injections must be defined by Board of Optometry and approved through the Legislative Rule-making process. There is a prohibition from injecting into the globe of the eye;
- Allows prescribing and dispensing of contact lenses that contain and deliver pharmaceutical agents that have been approved by the Food and Drug Administration as a drug. (this was actually pushed by Johnson & Johnson, these contacts are not on the market yet);
- Allows the Board of Optometry to add new drugs and new drug indications to their drug formulary without going through the Legislative Rule-making process;
- Allows optometrists to order laboratory tests rational to the examination, diagnosis, and treatment of a disease or condition of the eye;
- Allows optometrists to perform the following surgical procedures and allows the board to determine through Legislative rule additional procedures:
  - Remove a foreign body from the ocular surface and adnexa utilizing a non-intrusive method;
  - Remove a foreign body, external eye, conjunctival, superficial, using topical anesthesia;
  - Remove embedded foreign bodies or concretions from conjunctiva, using topical anesthesia, not involving sclera;

West Virginia Medical Journal
• Dilation of the lacrimal puncta
• Closure of punctum by plug;
• Epilation of lashes by forceps;
• Remove corneal foreign body not through to the second layer of the cornea using topical anesthesia;

The legislative rule-making process requires a board to file their rule with the Secretary of State (SOS) and allow a 30 day public comment period (which happens mid-summer). Then the board must respond to each comment/recommendation made and re-file the rule (either modified or not) with the SOS. Then the rule goes through a first layer of legislative scrutiny through the Legislative Rule-making Review Committee. That committee may modify the rule, then the rule is finally introduced into the legislative system as a bill (in January) that must go through the entire legislative process like any other bill and may be amended in any committee.

**Credentialing Process to Become Streamlined**

After two years of review by stakeholder groups and the Insurance Commissioner’s Office, the Legislature has passed legislation aimed at simplifying the credentialing process for physicians and other healthcare providers. **HB 4176** directs the Insurance Commissioner’s Office, through the Credentialing Committee to begin work on developing legislative rules for contracting with a single Credentials Verification Organization (CVO). This CVO would be responsible for verifying the credentials for providers then disseminating that information to the entities (insurers, hospitals) which credential those providers. It is expected that through this process and timelines for credentialing which are also included in the bill will simplify the credentialing process for physicians and will shorten the duration of time.

The Credentialing Committee has until June of 2011 to finalize the rules for the CVO and then the Legislature must approve those rules before the Insurance Commissioner’s Office may move forward on contracting with an entity. This is the beginning of a long process that should prove to be very beneficial. The following are the basic components of this legislation:

- The bill allows the Insurance Commission to enter into contract with a company to perform credentials verification for all practitioners who require credentialing;
- This company will be established as the one credentialing verification organization (CVO) in the state which all insurers and hospitals (any entity which credentials practitioners) must use for credentials verification;
- It will streamline the credentialing process and enable credentialing of physicians in a more timely manner;
- The bill establishes timelines that the CVO, Insurers, and practitioners must meet to perform their credentialing functions and decisions;
- Payment to the physician is retroactive to the date verified credentials are given to the insurer.

**Bills Address “Doctor Shopping”, Substance Abuse**

With the increasing concern with controlled substance abuse issues in West Virginia the legislature has been looking at finding ways to focus their attention on addressing the problem. However, finding the silver bullet solution to this problem has evaded most. Senators Evan Jenkins and Ron Stollings took a stab at the problem and proposed a list of about eight bills addressing various components of the issue. The following is a summary of the bills that passed:

**SB 365 - Requiring pharmacies provide personnel online access to controlled substances database.**

It was discovered that some of the largest and busiest pharmacies in the state (including WalMart) had policies which hampered the pharmacists’ ability to utilize the best tool in fighting doctor shopping. Pharmacists did not have access to the Controlled Substances Monitoring Database. This bill requires all prescribers and dispensers of controlled substances (it does apply to physicians) to have “electronic” access to the database. The Board of Pharmacy is responsible for developing rules to implement the law. The WVSSMA will keep our members apprised of the developing rules.

Additionally included in this bill is a provision that clarifies the State Medical Examiner’s Office may have access to the database for use in post-mortem examinations.

**SB 81 - Creating WV Official Prescription Program Act**

This bill requires the Board of Pharmacy to establish a rule implementing a statewide tamper-resistant prescription paper program. The paper will be required to be used for all prescriptions (currently just Medicaid requires tamer resistant paper) and the board is responsible for approving the safety features that must be included in the paper and establishing the approved vendors. Additionally they will develop a tracking method (i.e. numbering of prescriptions) to ensure prescriptions are valid.
SB 362 – Prohibiting providing false information to obtain controlled substances prescription
The bill clarifies the current law regarding doctor shopping. It modifies the language to clarify that “it is unlawful for a patient, in an attempt to obtain a prescription for a controlled substance, to knowingly withhold information from a practitioner that the patient has obtained a prescription for a controlled substance of the same or similar therapeutic use in a concurrent time period from another practitioner.” It is currently a misdemeanor to violate this law. The bill raises the penalty from six to nine months in jail and raises the fine from $1,000 to $2,500.

SB 514 – Clarifying language in Controlled Substances Monitoring Act
This bill clarifies all dispensers of schedule II-IV (including physicians) must report to the Controlled Substances Monitoring Database. There was an error in the current statute that failed to include the requirement for reporting the dispensing of schedule III and IV drugs. This law does apply to physicians who dispense such medication in office.

Women’s Right to Know Act Modified: Physician Penalties Removed
The WV Right to Life group pushed hard this Session for legislation (SB 597) to require women seeking an abortion to view an ultrasound prior to the procedure. Many obstetric physicians raised concerns about the bill and the ambiguity about when the ultrasound would have to be provided and by which providers. The legislation was ultimately totally re-written to simply require information be provided to the patient which informed her of her option to view an ultrasound image if she so wishes.
As this legislation was being debated in both the Senate and House, the issue of the penalties to physicians in current law kept resurfacing. Ultimately all physician penalties (which included loss of license for failure to provide written information to the patient) were removed from the law.

Other Bills of Interest Which Passed
All bills may be accessed by visiting the legislative website at www.legis.state.wv.us.

SB 122 Increasing mental health treatment refusal age of consent
This bill raised the age of refusal from twelve to eighteen. The bill was vetoed by the governor due to constitutional conflicts.

SB 213 Budget Bill
This bill contains the provisions of state budget for fiscal year 2011

SB 422 Limiting liability for non-health care provider defibrillator users
This bill limits liability for good Samaritans who help out in an emergency.

SB 449 Relating to PEIA preexisting conditions limitations

SB 483 Authorizing HMOs offer point of service option
The bill allows HMOs to offer point of service options to enrollees so they may access physicians out of network in certain instances.

SB 665 Transferring certain Health Care Authority’s duties to Insurance Commissioner

HB 2485 Allowing pharmacy interns to vend pseudoephedrine and other chemical precursors of methamphetamine
The bill clarifies those pharmacy employees who may sell pseudoephedrine. It simply addresses an oversight in the current statute that didn’t list all the pharmacy employees who might be involved in the sale.
HB 2503 Requiring licensed tattoo artist to inform patrons, prior to performing the tattoo procedure, of the potential problems that a tattoo may cause in relation to the reading of magnetic resonance imaging
   The DHHR is responsible for developing the information to be shared by the tattoo artists.

HB 2773 Increasing the monetary penalties for selling tobacco products to minors
   The bill increases the fines to persons who sell tobacco products to minors and clarifies that an employee may be discharged for violating the act.

HB 4273 Relating to professional employer organizations
   The purpose of this bill is to authorize the Insurance Commissioner to apply the same enforcement provisions to unlicensed professional employer organizations (PEOs) as are applicable to unauthorized insurers and to allow the fraud unit to investigate PEOs.

HB 4373 Eliminating the twelve-month look-back period for certain children who have had employer sponsored insurance
   The bill gives the WV CHIP board the authority to determine eligibility of children who have had insurance coverage previously by removing the requirement that children may not be covered if they have had insurance in the prior twelve months.

HB 4425 Developing a pilot program for unlicensed personnel to administer medication in a nursing home
   The bill authorizes the RN Board and Health Care Association (nursing homes) to develop education and training standards for the Med Aide program. The standards would be reviewed by the Legislature when completed, then a pilot bill would authorize implementation of the program in early 2011.

HB 4531 Mandating that shackling of pregnant women who are incarcerated is not allowed except in extraordinary circumstances
   The bill clarifies that incarcerated pregnant women may not be shackled unless they pose a risk to themselves, someone else or their baby. The physician must authorize. Division of Corrections officials say this is no longer done but the code needed to clarify the practice is banned.

OFFICE MANAGERS ASSOCIATION
OF HEALTHCARE PROVIDERS, INC.
www.officemanagersassociation.com

We invite you to join our organization which consists of members who manage the daily business of healthcare providers. Our objectives are to promote educational opportunities, professional knowledge and to provide channels of communication to office managers in all areas of healthcare.

We currently have eleven chapters in West Virginia.

Visit us on our website for more information or contact: Toni Charlton – President at 304-670-7197 or Donna Lee - State VP Membership at 276-322-5732.
More than Half WVU Med School Grads Match to Primary Care Residencies

More than half of the WVU School of Medicine Class of 2010 will train in primary health care fields and about 39 percent of all graduates will stay in the state for their residencies.

The class learned where they will continue training at Match Day luncheons at all three medical school locations in Morgantown, Charleston and Martinsburg in March.

Students will work in 23 different fields of study. More than half chose internal medicine, pediatrics, family medicine, or obstetrics/gynecology.

Other popular fields this year were anesthesia, psychiatry, orthopaedics, emergency medicine and surgery.

Two thirds will stay either in West Virginia or go to a border state for their training.

The upcoming academic year marks the 50th anniversary of WVU’s Graduate Medical Education (GME) program. WVU has the largest number of GME offerings in the state, with more than 50 specialty training programs, all of which are fully accredited. One-half of these are the only such specialty programs offered in the state.

(Akkary Uses SILS at Ruby Memorial Hospital)

Ehab Akkary, M.D., director of bariatrics and advanced laparoscopic surgery at West Virginia University, is providing what he calls the “most minimally invasive of minimally invasive surgeries” – single-incision laparoscopic surgery (SILS).

Traditional laparoscopic procedures require a minimum of three small incisions. With the SILS procedure, a single incision is made inside the belly button and is used as the access point for all needed equipment. Because of the location of the incision, any scar that occurs as a result of the procedure is completely hidden.

Dr. Akkary began performing SILS procedures in the summer of 2009. WVU was one of the few institutions across the nation that adopted this unique approach early on.

Most of the SILS surgeries Akkary performs are gall bladder and appendix procedures. To date, he has done about 50 of those cases using SILS. “This approach can be implemented selectively in various abdominal operations, including weight loss surgeries,” he said.

Akkary advises that the SILS procedure does take slightly longer than traditional laparoscopic surgery. There is also no significant decrease in post-surgical pain or recovery time. However, for those who are concerned about multiple incisions and scars, this procedure may be the answer.

“This is the natural evolution in advanced laparoscopic surgery,” Akkary said.

For more information on minimally invasive surgery at WVU see http://www.hsc.wvu.edu/som/Surgery/MinimallyInvasive.

WVU School of Medicine in Top 10 for Rural Medicine

The West Virginia University School of Medicine has been named one of the top ten schools of medicine in the country for rural medicine. WVU made the top ten list for the second time in U.S. News & World Report’s 2011 edition of “America’s Best Graduate Schools.”

The rankings are based on ratings by medical school deans and senior faculty in the nation’s 125 accredited medical schools and 20 accredited schools of osteopathic medicine.

The School of Medicine also was listed in the top 50 for primary care.

School of Medicine students at WVU learn and care for patients in rural areas of West Virginia as part of the requirements for graduation. They work in partnership with rural communities and with other health care providers in rural clinics across the state.

About half of WVU School of Medicine graduates choose to practice in primary care areas, such as family medicine, internal medicine, emergency medicine, and pediatrics.

The number of physicians who practice in rural, underserved communities has increased by 200 percent in recent years.
MU’s Chapmanville Center to Provide Care, Teaching

Marshall University and the Chapmanville community broke ground April 2 on a new Rural Health & Clinical Education Center that will expand both health care services and career training opportunities in the region.

The new facility, which will be the permanent home of Chapmanville’s Coalfield Health Center, was made possible by $2.73 million secured by United States Sen. Robert C. Byrd and a strong collaboration among community leaders, the Logan Healthcare Foundation and Marshall’s Robert C. Byrd Center for Rural Health.

“When Marshall University officials approached me about funding this project several years ago, it was an easy decision,” Byrd said in a letter read during the groundbreaking. “For years I have worked diligently to improve health care infrastructure throughout West Virginia, and it was clear to me that this health care project had the potential to make a lasting difference in improving the wellbeing of the residents of this region.”

Senate President-Lieutenant Governor Earl Ray Tomblin was the keynote speaker. The program also included Roger McGrew, chairman of the Logan Healthcare Foundation; Dr. Charles McKown, vice president and dean of the medical school, and MU President Stephen J. Kopp, Ph.D. Congressman Nick J. Rahall and state senator Ron Stollings, M.D., spoke briefly as well.

In addition to the expanded health care it provides, the new center will offer educational opportunities that will yield long-term benefits for the region, said Jennifer Plymale, an assistant dean at Marshall’s medical school and the director of its Center for Rural Health.

“Creating this hub for a rural teaching center will draw students from many health disciplines to the heart of the coalfields for education, and that significantly increases the possibility of recruiting healthcare providers to this area and retaining them,” Plymale said.

Tomblin, who worked to develop the infrastructure essential for the center’s success, said before the event the facility will benefit the area economically as well.

“What only will the center provide much-needed primary care services for the area, but it will also serve as an economic development engine for the area with jobs, a new high-tech facility, and cooperative partnerships with businesses, higher education and other providers in the area,” he said.

On the first floor, the new center will have a family medicine and pediatrics clinic, complete with satellite X-ray and blood-draw/laboratory facilities. Later, specialty clinics will occupy the second floor, providing permanent or rotating services. The center will incorporate support spaces needed for training medical students and resident physicians, as well as students training in other health professions.

Electronic linkages will give the Chapmanville center’s staff and students access to the extensive education, research and public service programs of Marshall’s Center for Rural Health and medical school. The new facility also will be a satellite location for the Center for Rural Health’s mobile medical unit, which provides health screening, education and direct service programs throughout southern West Virginia.

The Logan Healthcare Foundation provided the site at no cost and has made a direct grant of $180,000 for operating and start-up assistance, and Marshall’s Center for Rural Health has committed $150,000 in start-up support. 

As Sen. Ron Stollings looks on, Dr. Charles McKown, Robert McGrew, Jennifer Plymale, Sen. Earl Ray Tomblin and Dr. Stephen Kopp break ground for new center.
Dr. Robert Holstein to Lead WVSOM Alumni Association

Dr. Robert Holstein, a 1979 graduate of the West Virginia School of Osteopathic Medicine (WVSOM), was elected president of the WVSOM Alumni Association at the Association’s annual winter meeting in Charleston, WV, last month. The Charleston native will serve a two-year term.

“I will serve honorably and diligently alongside a most dedicated Board of Directors,” Holstein said. “Together, we plan to continue to advance the mission of the Alumni Association in supporting WVSOM and its students, faculty, administrative staff and graduates.”

“We are proud of our WVSOM family and desire to keep alive the distinctiveness of our school and profession by adhering to the foundational principles of those who preceded us and who have sacrificed so much to assure our success,” he said.

A board certified family medicine physician in Inverness, Fla., Holstein received a Bachelor of Arts degree from Anderson University, Anderson, Ind. in 1974. He is a 1970 graduate of Dunbar High School in Charleston.

He and his wife, Jean Casey Holstein, have two children, Stacy and Scott.

WVSOM Alumni Association Grant to Fund Anatomy Video

Three third-year medical students plan to use a grant from the West Virginia School of Osteopathic Medicine (WVSOM) Alumni Association to enhance the teaching of Anatomy at the Lewisburg school. Students Matt Cauchi, Nathan Mullins and Sarah Shaw – Graduate Teaching Assistants (GTA) for the Anatomy Department – will use the $3,500 grant to produce a Gross Anatomy dissection video series.

The students hope to have the first set of videos available by the beginning of the 2010-2011 academic school year.

“The grant will allow us to purchase additional computer equipment and software needed to complete the project,” said Cauchi. “We have produced approximately six hours worth of dissection videos so far, and hope to tape another 10 hours or more this semester.”

In addition to assisting first-year students with the Anatomy course, Cauchi said he expects the videos to be used by second-year students in reviewing material for the COMLEX I Board Examination.

Cauchi, Mullins and Shaw wrote and submitted the grant with the help of Anatomy professors Dr. Jandy Hanna and Dr. Christine Eckel. The WVSOM Alumni Association reviewed and awarded the grant.

WVSOM Talent Show Proceeds Given to Community Groups

West Virginia School of Osteopathic Medicine students raised approximately $3,000 for community organizations during the 14th annual Follies Talent Show at Carnegie Hall March 6.

Organizers said $2,000 will be donated to the performing arts in Lewisburg (Trillium, Greenbrier Valley Theater and Carnegie Hall) while $1,000 will go to Communities in Schools of Greenbrier County.

“The Follies is another example of our students’ commitment to supporting the community while showcasing their talents in music, dance, comedy and other gifts,” Dr. Meg McKeon, assistant vice president for Student Development, said.

McKeon said WVSOM students provide thousands of hours of direct volunteer service to the citizens of Greenbrier County every year, and stage fundraisers that result in significant donations to local organizations.

“The amount of support our students provide to the Greenbrier Valley – while maintaining a very demanding academic schedule – makes WVSOM unique in academic circles,” she said. “I am very proud of all the hard work and service our students provide to others.”

The Follies is sponsored by the Undergraduate American Academy of Osteopathy. Last year, the event raised nearly $2,000 for community organizations.
West Virginia Health Statistics Center Child Asthma Survey Enables Development of State Asthma Plan

Good data can lead to meaningful plans for action. Physicians are critical partners when it comes to actions that will make a difference in addressing the burden of asthma on our citizens. Asthma is a serious, sometimes life-threatening respiratory disease that affects the quality of life for millions of Americans. According to the 2008 Behavioral Risk Factor Surveillance System (BRFSS), an estimated 9.6% (138,000) of adults and 11.5% (43,000) of children in West Virginia currently have asthma.

The West Virginia Health Statistics Center (HSC), in collaboration with the CDC, maintains the Behavioral Risk Factor Surveillance System (BRFSS), a state-based system of health surveys that collects information on health risk behaviors and health conditions. In the past, only limited data on asthma in adults aged 18 years and older have been available through BRFSS. In order to increase the data available on asthma, the Centers for Disease Control and Prevention (CDC) converted the National Asthma Survey to a call-back survey administered nationally as part of BRFSS in 2005. HSC began conducting the BRFSS Adult and Child Asthma Follow-up Surveys annually in 2007. These surveys better define the burden of asthma in West Virginia by providing new information on asthma, such as demographics, recent asthma history, symptoms and episodes, health care utilization, knowledge of asthma management, modification to environment, medications, costs of care, work/school related asthma, and alternative therapies.

Prior to 2007, the only data available for children with asthma in West Virginia was the BRFSS Child Prevalence Module. This module only provided prevalence numbers for children with asthma in West Virginia. Using the data available in this new survey, the West Virginia Asthma Education and Prevention Program (WVAEPP) has developed “A Strategic Plan for Addressing Asthma in West Virginia, 2010-2014” available online at: http://www.wvasthma.org/AboutTheAEPP/AsthmaStrategicPlan/tabid/1227/Default.aspx.

This plan not only targets reducing the burden of asthma in adults, but also in children. A major goal in this plan is to teach West Virginians with asthma to self-manage symptoms effectively. Data from the 2007 and 2008 BRFSS Child Asthma Call-back Surveys were used for planning interventions that would increase self-management in West Virginians with asthma. Regular visits to a health care professional are essential in asthma control, however only 64% of children with asthma reported visiting their healthcare provider at least twice in the past 12 months. The National Heart, Lung, and Blood Institute (NHLBI) recommends the use of a spacer/holding chamber when taking inhaler medication, but in West Virginia only 45% of children reported using a spacer with their inhaler medication. Another recommendation of the NHLBI is annual flu vaccine regardless of asthma severity, however less than half of West Virginia children reported receiving their annual flu vaccine in the past 12 months. This and other data available in the BRFSS Asthma Call-back Surveys can be used to help WVAEPP, physicians, and others determine what is needed to help children with asthma breathe easier in West Virginia.

Additional information on BRFSS and other HSC products and services is available at: www.wvdhhr.org/bph/hsc/statserv/BRFSS.asp. For more information on asthma in West Virginia you can visit WVAEPP’s website at: http://www.wvasthma.org.

Sharon Hill
Asthma Epidemiologist
Health Statistics Center
Customer Service in the Medical Office

The importance of customer service has recently become more of a focus and priority for medical practices. Numerous articles have been written on the topic, including one that appeared in the *New England Journal of Medicine*. At our recent Physician Practice Conferences, the session led by Certified Etiquette and Protocol Consultant, Pam Harvit, “Office Protocol and Etiquette,” has become one of the highest rated sessions.

Why all this emphasis on medical etiquette and good customer service? Why should practices be concerned about the etiquette involved in treating patients? Better yet, how does your practice measure up customer service wise?

It’s just plain common business sense that any medical practice can ill afford to do without.

One reason for stressing the importance of good customer service in the medical office is based on a very simple economic principle. With changes in insurance plans and the consumer-driven healthcare plans, more patients are paying customers; therefore, they are becoming more knowledgeable about costs. As informed consumers, they are more likely to choose where they want to receive their medical care.

More importantly, lack of etiquette (otherwise known as rudeness!) may actually increase the risk of liability for a physician office. According to a Harris study, a patient’s choice to change physicians was often not attributed to the medical care received, but because of rude treatment in the office. Research also shows that happy patients generally are less likely to sue. According to a University of Texas study, there is a clear association between communication/respect of patients and the incidents of lawsuits.

Finally and most importantly, your customers are people first and patients second and they deserve to be treated as such. Good manners and good customer service in the medical office can help to emphasize the importance of patient satisfaction and professionalism among all staff in the medical profession.

Most practices would like to believe that their patients experience the best care in their offices; not only the clinical care, but the care encountered during every step of the patient’s medical office visit. Here are some questions that all practices should ask themselves if they want to improve their clinical customer service skills.

1. Is the staff acknowledging and greeting each patient as he/she enters the practice? This is very important as first impressions are lasting impressions!
2. Are patients being advised if the physician is running behind? Often, a very simple explanation and apology upfront will alleviate the developing anger that a patient may experience as he or she waits to see the physician.
3. Does everyone on the staff wear a nametag? Do those who have direct patient contact introduce themselves and explain their role in the treatment process? This is important to the patient so that he/she is aware of the function of each staff member.
4. Does the staff really listen to the patients (even a complaining one)? This indicates to the patient that he/she is important and that the practice cares for him/her.
5. Finally, does anyone on the staff tell the patient “thank you” as he/she leaves? This simple phrase can make a huge difference in how the patient perceives his/her treatment. Remember—a happy patient is generally a more satisfied and compliant patient.

While this list of suggestions is by no means a complete list, perhaps it can serve as a starting point for offices to look at ways to improve their patient relationships. It also gives you the opportunity to see how your practice measures up in customer service.

It is important to remember that quality customer service is becoming increasingly more important in today’s society and that patients are your customers. With all the emphasis on state of the art medical equipment, electronic health records, the latest technology and the most highly skilled staff, we should not lose sight of the fact that in the medical office, patients should be the number one priority. Utilizing good manners and good customer service skills can ensure that your staff presents themselves as compassionate and caring professionals who represent quality medical care to your patients.

On a personal note, I recently visited a large teaching hospital where I observed the attitude of the medical staff toward their patients and family members. One of the most noticeable observations was the caring and friendly greetings that were given, from the volunteer at the information desk, patient reception clerks, medical assistants,
nurses and physicians. Every patient was treated as a person first and a patient secondly. I listened as patients and families in the waiting area discussed the friendliness of the staff. The positive comments provided a refreshing reassurance to newer patients and their families.

When a physician was running behind, a staff member (always with a name tag) came into the waiting room to give a brief explanation, and advised the patients as to the delay. She assured each patient that the physician would give him/her the same time consideration when he or she went back to the examining room. She offered a restaurant style pager to patients who wished to visit the cafeteria or just wait in another area of the clinic. Finally, as patients were leaving the clinic after their appointments, they were given a friendly “good bye” and “thank you for being so patient with us today.”

Not surprisingly, most patients were smiling as they left the facility.

As I thought about the overall experience, it occurred to me that much of the patients’ experience depends on the courtesy shown to them by the medical practice staff. It would seem that the care and concern shown for the overall patient experience may have a direct relationship on the patient’s attitude toward the visit; therefore increasing compliance and the possible outcome of treatment.

It might be as simple as just remembering that good customer service is just remembering the Golden Rule—“Do unto others as you would have them do unto you.”

Barbara Good
WVSMA Physician Practice Advocate

We would like to welcome the following physicians and medical students to the WVSMA:

**Cabell County Medical Society**
Ann Conjura, MD

**Central West Virginia Medical Society**
Kimberly Farry, MD

**Eastern Panhandle Medical Society**
Shannon Bentley, MD
Romulo Estigoy, MD

**Kanawha County Medical Society**
Kathleen Bors, MD
Chitta Sarker, MD

**Monongalia County Medical Society**
John Lubicky, MD
Olusola Oduntan, MD
Rohma Shamsi, MD

**Parkersburg Academy of Medicine**
Darcy Conner, DO

Please direct all membership inquiries to: Mona Thevenin, **WVSMA Membership Director**

Just a friendly reminder...

**Have you renewed your 2010 WVSMA Membership?**
Obituaries

The WVSMA remembers our esteemed colleagues...

Alfred John Magee, MD
Dr. Alfred John Magee, 90, of Charleston passed away March 31, 2010.
Alfred was the son of Hugh and Mary J Magee. He was born in Jersey City, NJ, and was preceded in death by his brothers, Edward, Hugh, Joseph and George, and their wives, as well as his sister, Mary.
He is survived by his wife of 56 years, Joyce, and leaves behind his daughters and their husbands, Louise and Jeff McClung and Susan and John O’Brian; sons and their wives, Harry and Elizabeth Magee, Edward and Janet Magee, John and Julie Magee and Richard and Junko Magee; 11 grandchildren; and many nieces and nephews.
He was an active member of St. Agnes Catholic Church and served in the U.S. Army. He practiced ophthalmology for 32 years in Charleston and eight years in Summersville and was a clinical professor of ophthalmology at West Virginia University.
Memorial contributions may be made to St. Agnes Catholic Church, 4801 Staunton Ave. SE, Charleston, WV 25304, or a charity of your choice.

Lee H. Pratt, MD
Dr. Lee H. Pratt, formerly of Charleston, died Nov. 15, 2009, in Okatie, S.C., at the age of 64.
Dr. Pratt and his wife, Bonnie, had lived in the Hilton Head area of South Carolina, since his retirement from the practice of neurology in 2002.
He was a graduate of the West Virginia University School of Medicine and practiced in Charleston since 1975. He was a longtime boating enthusiast and an officer of the Hilton Head Island Power Squadron. He was also a member of several motorcycling groups, including HOG and the Motorcycling Doctors Association.
At the time of his death, he was a volunteer at the Hilton Head Island “Volunteers in Medicine” Clinic.
He is survived by his wife, Bonnie; three children, Travis, Tierney and Trevor; and five grandchildren.

Carl J. Roncaglione, MD
Carl J. Roncaglione, MD, 87, of Charleston died March 17, 2010.
Many knew him as “Doctor Ron” or “Doctor Carl.” He was born February 25, 1923, in the town of Oak Hill, the second of six children of the late Louis and Hazel Roncaglione.
He grew up in the mining towns of Pocahontas, Virginia, and Amonate, Virginia. He graduated from Big Creek High School, War, WV, class of 1939. At Emory and Henry College, Emory, Virginia, he graduated in the class of 1943, with a B.A. degree in chemistry and biology. At Notre Dame University Midshipman School he was commissioned an ensign DVG USNR, and after Underwater Demolition School, Fort Pierce, Florida, and Amphibious School in Patuxtent, Maryland, in 1944 he became skipper of USS L6T 879 (Landing Craft Tank) which made multiple amphibious landings in the battles of New Guinea, the Leyte Gulf, Subic Bay, Lingayen Gulf, Corregidor and Manila in the Philippines in WWII.
After WWII he received his medical degree followed by five years residency in orthopedic surgery at the Medical College of Virginia, Richmond. His debut in orthopedic surgery in Charleston was July 1, 1956. He retired March 31, 2001. Orthopedic organizations in which he participated and into which he was inducted included the American Board of Orthopedic Surgery, the American Academy
of Orthopedic Surgeons and the American College of Surgeons.

He was a past president of the Kanawha Medical Society, the West Virginia State Medical Association, the Tri-State Orthopedic Society, and the West Virginia Board of Education. He was a life member of the Southern Medical Society, the Republican National Committee, BASS (Bass Anglers Sportsman Society), a member of Masonic Lodge No. 20 AF&AM for over 50 years, a 32nd degree Scottish Rights Mason, and a member of the Beni Kedem Shrine. He belonged to American Legion Post 20. He was deeply appreciative of the designation by his colleagues as the West Virginia Orthopedic Surgeon of the year in 1955. His passions were small mouth bass fishing, tennis and golf.

On June 25, 1949, he married Tommie Ballard McCoy Roncaglione. Her death on January 2, 2007, was a devastating event from which he never fully recovered. Doctor Carl was preceded in death by his parents and an older brother, Howard Marshall Roncaglione; and a younger brother, John Elwood Roncaglione.

Surviving are three sisters, Virginia Roncaglione Courtney, Shrewsbury, MA, Lillian Roncaglione Bazzle, Williamsburg, VA, and Betty Roncaglione Ball, Titusville, FL. Surviving children include Tommie Sue and Chet Roberts of Charleston and their children, Cheston and Eva; Katie and Robert McKean of Lakeland, FL, and their sons, Brock and Reed; and Susan and Jim Roncaglione of Charleston and their children, Carl III, Louis, Sam, Willie, and Felix.

Memorial contributions may be directed to Emory and Henry College Development Office, Emory, VA 24327-0905, Charleston Baptist Temple, 209 Morris St., Charleston, WV 25301, or the Medical College of Virginia, P.O. Box 0156, Richmond, VA 23298-0156.

Carl and his family express their deepest and most sincere thanks to his physicians, medical caregivers and providers at CAMC Charleston Memorial Hospital, Drs. Hamrick, Alasadi, Nellhaus, Thalheimer, Lily, and Ridenour, Dr. Pfister, the CAMC staff on the Surgical Intensive Care Unit, and the CAMC Staff on Four North.

Charles Winkler Jr., MD

Charles Pinckney Winkler Jr., MD, 53, of Richmond, died April 7, 2010. He is survived by his two children, Jennifer W. Winkler and Charles P. Winkler III; his parents, Dr. and Mrs. Charles P. Winkler; his sisters, Kathryn W. Nicholas and Carol W. Lormand and her husband, Michael; two nephews, Jamie Nicholas and Dylan Lormand; his uncle and aunt, Dr. and Mrs. Moseley Winkler, and cousins, Kristy Zak, Adele Holmes, Ann Holbrook and Betsy Willis; his aunt, Betty Roberts, and cousins, Holly Morgan, Scott Roberts, Nancy Talaba and James Winkler. Born October 11, 1956 in Richmond, Va., Chuck graduated from St. Christopher’s School and the University of Virginia, with distinction from both. He received his M.D. from the Medical College of Virginia, completed a residency in obstetrics and gynecology in 1990, and practiced in Charleston, West Virginia, for the next 20 years. He was a Fellow of the American College of OBGYN. Chuck was loved by his patients and respected by his peers. He was a beloved son, brother and father and will be sorely missed by his family.

The family requests that, in lieu of flowers, donations be made to the St. Christopher’s School Foundation, 711 St. Christopher’s Rd., Richmond, VA 23226.

The West Virginia Medical Journal is honored to publish the obituaries of West Virginia physicians. Please send copy to:

Angie Lanham
Managing Editor, WV Medical Journal
PO Box 4106
Charleston, WV 25364 or
E-mail to: angie@wvsma.com
Introducing: Dave J. Mueller, Physician Services Specialist

In the summer of 2009, the West Virginia Medical Insurance Agency made a pledge to its clients in the form of an emphasis on its services by introducing the tag line of “Valued Assistance.” We explained that “Valued Assistance” reflected our promise to our clients to improve their overall insurance position when utilizing our services.

A major step in reinforcing this promise has recently occurred at the WVMIA with the hiring of Dave Mueller, as Physician Services Specialist, effective April 1, 2010.

Dave Mueller is a native West Virginian, returning home (his hometown is Huntington) to accept a position with the West Virginia Medical Insurance Agency that will allow him to bring his out-of-state medical professional liability experiences to provide “Valued Assistance” to West Virginia physicians.

Most recently Dave has been a senior account executive with MAG Mutual Insurance Company, the largest physician owned insurer in the Southeast and the director of medical relations and marketing for The MD Company of Alpharetta, Georgia. The MD Company’s services included the provision of physician practices with education and strategies to improve patient care and reduce practice costs.

During his nine years with MAG Mutual, Dave was responsible for client relationship management servicing physicians, surgeons, and health care administrators. Dave achieved a 90%+ customer retention rate for 8+ years by fostering and solidifying relationships with physicians and administrators. While at MAG Mutual, Dave actively participated in the Georgia physicians’ 2005 tort reform “White Coat Day” and other efforts to bring tort reform to the State of Georgia.

“Dave will add knowledge and depth to our physicians’ insurance team with the West Virginia Medical Insurance Agency. He is an excellent choice to assist the Agency further in its commitment of “Valued Assistance” to our clients throughout West Virginia. With Dave’s unique set of skills and knowledge of medical professional liability insurance, we expect him to work well with the physicians of West Virginia” said Steve Brown, WVMIA, Agency Manager.

Dave also has experience working with physicians on a more direct basis as he worked with IntraOptics and with O cudyne in regional and national management positions establishing a series of physician education courses that focused on...
the then latest surgical developments and techniques in eye surgery.

Dave’s role with the West Virginia Medical Insurance Agency will be to provide “Valued Assistance” in the form of medical professional liability, workers’ compensation, business owners, employment practices and directors’ and officers’ insurance products as well as other insurance products offered to physician clients. The West Virginia Medical Insurance Agency is a wholly owned subsidiary of The West Virginia State Medical Association; its only clients are physicians; therefore, its “Valued Assistance” is specifically directed to its client base of physicians only. West Virginia Medical Insurance Agency was established in 2004 and currently is one of West Virginia Mutual Insurance Company’s largest producers, representing more than 300 doctors in the State of West Virginia.

Please welcome Dave Mueller back to his home state as he works with us to achieve our goal of “Valued Assistance” to the physicians of the state of West Virginia.

Dave Mueller may be contacted at the Agency by calling 1-800-257-4747 ext 29 (locally at 304-925-0342 ext 29) or by e-mail at dave@wvsma.com.

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**Good to be home...**

“It’s very special and exciting to now be apart of the West Virginia Medical Insurance Agency’s professional team. The Agency does an excellent job serving the physicians of West Virginia, and I’m very fortunate to be apart of their commitment to professionally serving the doctors of our great state. Steve Brown and his staff have made me feel so welcome to be back home, and I’m looking forward to working with doctors and fulfilling the Agency’s pledge of providing “Valued Assistance” while helping physicians with their medical practice needs. It’s great working with doctors and helping them secure the right level of coverage at the best possible price.”

“Coming home to West Virginia and working with the Agency and its parent organization, the West Virginia State Medical Association, is super. The Association helps doctors in so many ways, and I hope to do my part to be involved in as many medical conferences and educational programs as possible. In my new position with the Agency, I know I can help doctors improve their position in the market. I have worked with doctors and their office administrators for over 20 years in various capacities, but my new role as Physician Services Specialist is a unique, once-in-a-lifetime opportunity that will be both challenging and rewarding.”

“I plan to hit the ground running and help surgeons and physicians with their practice and personal insurance needs. In the past, the professional liability market has been volatile. Doctors were leaving the state and patients were finding it more difficult to find access to complete health care. But since the passage of tort reform in WV in 2003, and the formation of the West Virginia Mutual Insurance Company, rates have steadily decreased. Doctors have now returned to WV, and patients have better access to all health care specialties. Through the Agency, we can help doctors with their insurance risk and the business-side of medicine so that they can focus on quality patient care. It is truly a win-win situation for our doctors and their patients.”

Dave Mueller
Physician Services Specialist

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**Welcome**  
Dave Mueller, Physician Services Specialist

Dave Mueller joins the staff of the West Virginia Medical Insurance Agency, returning home to West Virginia after serving physicians in the Southeastern United States for the past 11 years.

**To Contact Dave Mueller**

**Call:** 1-800-257-4747 ext. 29  
**Fax:** 1-304-925-3166

**Email:** dave@wvsma.com
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Authors: A cover letter from the corresponding author should be submitted with the manuscript. All persons listed as authors should have participated sufficiently in the work to take public responsibility for the concept.

Format: All articles may be submitted by email or on CD. Microsoft Word is preferred, but other programs are acceptable. All tables or figures should be created separately from the body of the manuscript as .tif, .jpg or .pdf files in a high resolution format with corresponding file names such as, Table 1, Figure 1, etc. Legends should be included for all tables and figures.

References: References should be prepared in accordance to the “American Medical Association Manual of Style.” These instructions for authors are available online at www.jama.com.

Photographs: Please submit high resolution digital files with an image size of 300 dpi at 100% of size. This high resolution size must be equal to 2.5” by 2.5” minimum size. Low resolution photos may be rejected or print with poor quality.

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Subscription Rates:

$60 a year in the United States
$100 a year in foreign countries
$10 per single copy

POSTMASTER: Send address changes to the West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364. Periodical postage paid at Charleston, WV.

USPS 676 740 ISSN 0043 - 3284

Claims for back issues should be made within six months after publication. Microfilm editions beginning with the 1972 volume are available from University Microfilms International, 300 N. Zeeb Rd., Ann Arbor, MI 48106.

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