maofp connections

A PUBLICATION FROM THE MICHIGAN ASSOCIATION OF OSTEOPATHIC FAMILY PHYSICIANS

OCTOBER
2021

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TABLE OF CONTENTS

PRESIDENT'S REPORT

As I begin my new role as President, I am both honored and humbled. I have been a part of this board for nearly a decade and have had the opportunity to meet so many individuals whom I admire and respect. As I reflect back, I think of Joanne Grzeszak, DO who initially nominated me for a position on the board. More recently, I have enjoyed my role working with former presidents Tina Metropoulos, DO and Kristen Sumners, DO who I was also able to work with during their residency training. Finally, I cannot talk about my time on the board without mentioning Larry Abramson, DO whom I had great admiration for. These physicians are only the start of a long list of amazing individuals who are part of the MAOFP family.

Over the past couple of years, MAOFP has gone through many changes and challenges. This started in 2019 with the signing of a new management company (Ngage Management). Ngage has led us through a transition of uncertainty and financial stresses brought about by unforeseen circumstances. This included the COVID-19 pandemic and ultimately the cancellation of our 2020 Summer Conference. 2021 has been a year of renewal. Our Education Committee was able to put together our first ever "virtual" conference and, more recently, we held our Summer Conference in Muskegon, Michigan. This conference was our first in-person conference in more than a year but also included a virtual, on-demand option for individuals who prefer a web-based format. Our Education Committee is now hard at work planning the 2022 Winter Conference. I truly hope all of you can join us.

Moving forward, I hope to continue with the strong traditions that have been set up by our previous leaders. I hope to expand our collaborative relationships with other health care organizations that support our goals. I also believe we need to continue to be a strong advocate for osteopathic medicine and the benefits of OMM. This needs to be done not only through legislation, but through the commitments of our medical schools to train qualified students and our residencies to provide opportunities for continued OMM training. This has become more important than ever as we have seen the loss of several of our ONMM plus one residency programs over the past several years (two in the state of Michigan).

Under the guidance of Ngage and the wisdom of a hard-working board, I believe the MAOFP has come through the past few years more nimble and stronger than ever. I look forward to the rest of 2021 and to an amazing 2022!

Best Wishes,

Joel Bates, DO
MAOFP President 2020-2021

MARK YOUR CALENDARS!

Winter Family Medicine Update

January 20-23, 2022
Boyne Mountain Resort and Virtually On-Demand

Make plans now to participate in MAOFP's Winter Family Medicine Update. This is a great opportunity earn up to 22 CME credits and network with other physicians, residents, and medical students.

The educational content will include presentations on implicit bias, cardiology, hot topics in GI and infectious disease, OCC recertification, rheumatologic diseases, new asthma guidelines, and more. The agenda will also include a poster presentation competition and opportunities to network and visit with exhibitors.

Registration to open in November 2021.

Michigan Family Medicine Advocacy Day

March 23, 2022
Anderson House Office Building, Mackinac Room | 124 N. Capitol Ave., Lansing, MI

Michigan Academy of Family Physicians (MAFP) and Michigan Association of Osteopathic Family Physicians (MAOFP) invite family physicians, family medicine residents, and medical students to save Wednesday, March 23, 2022, on their calendar to advocate for family medicine in Downtown Lansing.

MICHIGAN FAMILY MEDICINE
ADVOCACY DAY
2022

Michigan Family Medicine Advocacy Day includes breakfast, lunch, and a morning advocacy seminar, followed by meetings with state legislators and their staff to discuss and share personal experiences regarding legislative and policy issues impacting access to primary care, the family medicine practice environment, and the patient-physician relationship.
Collectively, MAFP and MAOFP represent more than 4,500 family physicians and family physicians-in-training across the state.

Watch your email for additional details and registration.

CONNECTIONS AND REFLECTIONS AT 2021 MAOFP SUMMER FAMILY MEDICINE UPDATE

Members of the Michigan Association of Osteopathic Family Physicians in attendance at the recent Summer Family Medicine Update made long-awaited connections with colleagues and came away with valuable information about the Association and current issues facing DOs across Michigan. The in-person event was held July 29 – August 1, 2021, at the Van Dyke Convention Center in downtown Muskegon, with an online and on-demand virtual option available August 16 through the 31st.

Sessions kicked off Thursday afternoon after a warm welcome back to in-person events by MAOFP president, Dr. Tina Metropoulos. Attendance reflected a relatively even split as 64 members attended the conference in-person with 51 joining virtually. Eleven organizations exhibited at the conference.

Friday morning saw the first full day of conference activity, beginning with an opening breakfast sponsored by AbbVie. A full slate of informative and educational sessions made way for the evenings big event, the MAOFP Summer Fest. After a long break from in-person networking due to the pandemic, members were elated to be back together and grateful for a fun and casual atmosphere in a safe and hygienic environment thanks to the MAOFP planning committee and valued event partners.

Attendees were met with a full agenda Saturday morning, starting with the All-Membership Meeting and Breakfast sponsored by Allstate Medical. Once called to order by MAOFP President Dr. Tina Metropoulos, Dr. Saroj Misra, Governor of the American College of Osteopathic Family Physicians (ACOFP) provided a brief update, followed by an update from event sponsor MSU College of Osteopathic Medicine's Director of Development, Chris Surian on happenings and plans within MSUCOM. In her outgoing President's report, Metropoulos shared an overview of MAOFP's 2021 strategic plan which illustrated that the overarching strategic imperative is to transform MAOFP to a sustainable model to better serve and engage Michigan osteopathic family physicians. Goals were established related to organizational viability, education and strategic partnerships. She also shared key accomplishments achieved over the past year, including virtual education, MAOFP's mentor program, virtual physician lounges, Family Medicine Advocacy Day, ACOFP Congress of Delegates and increased membership.

In the annual financial update, Dr. Robert Camara presented a report on MAOFP's current financial status. Camara reported that COVID impacted MAOFP similarly to many other associations and the organization ended 2020 with a net loss. The loss was mainly due to reduced conference and membership revenue because of the cancellation of the 2020 summer conference. He was pleased to share that due to increased membership and profitable conferences, MAOFP increased its total assets to $264,790, approximately $56,000 more than the previous year.

Dr. Metropoulos presented the board slate for voting. A motion was made, seconded and passed to approve the slate as proposed and as follows:

President - Joel Bates, DO
President-Elect - Lina Rayes Yousif, DO
Secretary/Treasurer - Robert Camara, DO
Past President - Tina Metropoulos, DO
Directors:

- Term expiring 2022 – Kelly Arenz, DO, FASAM; Lee Begrow, DO, FAAFP; Patrick Botz, DO; Jodi Flanders, DO, FACOFP
- Term expiring 2023 – Ryan Smith, DO
- Term expiring 2024 –William Barker, DO; Nathan Fitton, DO; Gretchen Goltz, DO; Victoria Torgler, DO

Resident Director - Jacquelyn Small, DO
Resident Alternate - Faith Palmer, DO
Student Director - Olivia Welch

As the final step of his transition to MAOFP leadership, Dr. Saroj Misra led Dr. Joel Bates through the oath of office and installed him as the 2021-2022 MAOFP President. Dr. Bates expressed his honor for being elected to the position and encouraged all members to consider serving in a volunteer leadership role to connect with other members and make a positive impact on osteopathic family medicine. Before adjournment, Dr. Bates led the 2021-2022 Board of Directors through the oath of office.

At the end of the day's sessions, and the Product Theater Lunch sponsored by Horizon, attendees gathered again for an evening event, this time the much-anticipated President's Reception, sponsored by the MSU College of Osteopathic Medicine. Along with networking and relaxation, attendees recognized MAOFP past presidents, outgoing President Tina Metropoulos, DO and outgoing Board members Kristen Sumners, DO; Jennifer Hanna, DO; Libby Pionk, DO; Brianna Eisaman, DO and Sarah Baribeau. Because of the canceled Summer Event last year, award recipients from 2020 and 2021 were honored at the reception. Ryan Smith, DO was recognized as Family Medicine Resident of the Year for 2020, with Kyle Casadei, DO receiving the honor for 2021. Kathleen Rollinger, DO was awarded Family Physician of the Year for 2020 with Richard Bryce, DO claiming the esteemed honor for 2021. The last award of the evening was the Lawrence Abramson Distinguished Service Award which was most appropriately bestowed upon Andrew Adair, DO, FAAFP for 2020 and Jodi Flanders, DO, FACOFP for 2021. With another day of learning and the evening celebration behind them, attendees and exhibitors alike had two main takeaways – the MAOFP Education Committee knocked it out of the park with the conference's educational agenda and it felt wonderful to be together again.

With only a few sessions and final matters to settle on Sunday, the successful event wrapped up leaving attendees feeling educated, motivated and looking forward to the next scheduled MAOFP event, the Winter Family Medicine Update, scheduled for January 20-23, 2022, at Boyne Mountain Resort. Thank you to all those who attended, in person or virtually! Find registration for our next event at information at www.maofp.org.

Thanks to the Education Committee for developing an excellent educational agenda!
Jodi Flanders, DO, FACOFP | Sarah Baribeau | Lee Begrow, DO | Patrick Botz, DO
Brianna Eisaman, DO | Tina Metropoulos, DO | Saroj Misra, DO, FACOFP | Victoria Torgler, DO
Marissa Rogers, DO | Jaclyn Small, DO | Ryan Smith, DO | Kristen Sumners, DO
Stephan Swetech, DO, FACOFP, Distinguished

Thank you Sponsors!

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ALLSTATE MEDICAL "The path to health" A higher quality of life

HORIZON

College of Osteopathic Medicine

PREPARING FOR THE "EPIDEMIC" BEYOND THE PANDEMIC: WHY YOU NEED A PLAN FOR ADDRESSING COVID-19'S ACCOMPANYING OPIOID RISKS

Article provided by Michigan Professional Insurance Exchange (www.mpie.org)

Protecting Your Practice in a Post-COVID Landscape

- A look at what providers are facing with the COVID-exacerbated opioid crisis
- Here's where the opioid epidemic stands today
- CDC tips for mitigating opioid risks at your practice
- Steps to protect your practice from opioid liability
- A glance at new possibilities for telehealth and opioid management
- Using proper referrals as buffers against opioid liability

Physicians Are Facing an Ongoing Crisis in the Spring of 2021

Every physician needs to know that we are coming off the deadliest year on record for opioid overdoses. During the past 12 months, we've seen the highest number of opioid-related deaths ever recorded in the United States. Unfortunately, it's happened a bit "quietly" because the COVID-19 pandemic has raged on for months to siphon resources, brainpower, and budgets from hospital systems and private clinics.

Fast Fact: More than 2.5 million Americans suffer from opioid-use disorder.

Yes, the Opioid Crisis Is Already at Your Practice's Door

Many people are calling the impending opioid fallout resulting from COVID-19 the epidemic after the pandemic. While it's uncertain if there will ever indeed be a post-COVID world for physicians, we already see signs of how the landscape will shape up once we've moved away from the eye of the storm.

One of the emerging post-COVID worries is that a deluge of opioid usage generates devastating consequences that will continue for decades. While the opioid crisis is something that medical professionals have been aware of for years, more vigilance is required as pressures related to COVID-19's societal impact widen the scope of at-risk groups.

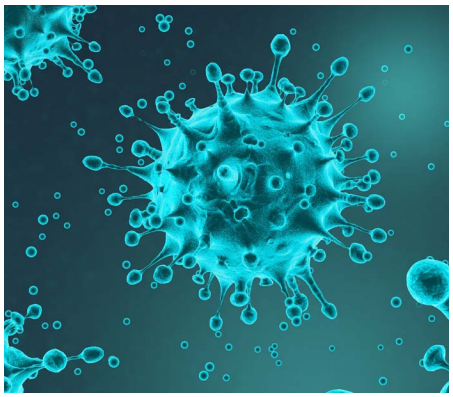
Here's a look at some statistics from the past 12 months physicians need to face as they help patients manage pain during a precarious time for socio-economic stability and mental health:

- Synthetic opioids appear to be the primary driver of the increase in overdose deaths in the United States.
- According to the ***Overdose Mapping and Application Program (ODMAP)***, national overdose submissions have increased **20 percent** since the first reported case of COVID-19.
- Based on the American Medical Association's ***most recent briefing***, more than 40 states have reported increases in opioid-related mortality. Concerns have also increased for people with mental illness and substance use disorders.
- According to the Centers for Disease Control (CDC), **over 81,000 drug overdose deaths occurred in the United States in the 12 months ending in May 2020. This represents the highest number of overdose deaths ever recorded during a 12-month period.**
- During the pandemic, 37 of the 38 U.S. jurisdictions with available synthetic opioid data reported increases in synthetic opioid-involved overdose deaths. A total of 18 jurisdictions saw increases more significant than 50 percent. A total of 10 states reported increases of 98 percent or more.

Data can also tell us which synthetic opioids people are turning to during the pandemic. During the summer of 2020, a national laboratory service named Millennium Health analyzed urine drug tests to create a snapshot of usage. Based on their findings, there was an ***increase of 32 percent for non-prescribed fentanyl***. Methamphetamine use increased by 20 percent. This is significant for physicians because ***research*** has indicated the co-use of methamphetamine and opioids as a possible outcome of ineffective opioid substitution therapy (OST) treatment. Co-use often enters the picture when a patient perceives a lack of pleasures following stabilization while on OST treatment.

Fast Fact: 73 percent ***of preventable opioid deaths occur among those ages 25 to 54***. However, the number of deaths among people aged 55 and older is rapidly growing.

Understanding Why the Post-COVID Opioid Crisis Is Here to Stay



Over the course of a year, the global pandemic has upended day-to-day life for many people. It has taken away loved ones, ended livelihoods, and changed the way we socialize. All of this has created significant stress that will continue to affect people for years to come. Take a look at some of the consequences of COVID-19.

Social Isolation:

- Being separated from others has caused many people to experience loneliness, stress, anxiety, and depression.
- Many of their "positive" coping tactics have been taken from them during the pandemic for people in recovery.
- According to the National Institute of Environmental Health Sciences, ***50 percent of Americans report that COVID-19 negatively impacts their health.***
- The pandemic has triggered an increase of 1000 percent in emotional distress reported to national hotlines.

Health Fears:

- The pandemic has brought on nearly constant fear of getting infected, infecting family members, or losing vulnerable loved ones to COVID-19.
- The loss of health care coverage has exacerbated fears related to costs for seeking healthcare.

Home Confinement:

- Many people now have an excess of unstructured time that used to be filled by obligations and activities.
- For people in recovery, the cancellation of in-person recovery meetings has removed support and accountability.
- Many people are self-medicating because they have been unable to visit doctors in person.
- Loss of contact with peers and advocates can make it difficult for some people to find meaning that sustains them in their recovery.
- Worries about the future can fuel opioid use.
- The pressures of trying to work from home while children are attending school virtually can be detrimental to sober living.

Economic Stress:

- For people across many industries, the pandemic has brought job losses or reduced hours. This creates stress over how to cover bills.
- Some people are working in workplaces with inadequate safety measures that are creating stress and worry.
- Many people are performing in workplaces with constantly changing safety and health guidelines. This fact is creating stress, pressure, and confusion for workers.

The above factors have taken a toll on people's mental health and contributed to increased stress and anxiety for many people. Stress is a significant trigger for substance abuse, which explains the rise in opioid-use disorders this past year.

Since the pandemic's after-effects aren't likely to go away anytime soon, we can expect to see an increase in substance abuse as people continue to cope with job loss, worry about illness, and more.

Buffering Your Practice from the Looming Post-COVID Opioid Crisis
The biggest challenge that many providers face when it comes to opioid liability is a lack of clarity. In December, the CDC released a health advisory for medical and public health professionals. Here are the highlights ***directly from the CDC*** that you need to know about:

- Talk to patients about the changing illicit drug supply, risk factors, and risks for overdose.
- Prescribe naloxone to individuals at risk for opioid overdose stemming from opioid-use disorders and prior history of overdose.
- Co-prescribe naloxone to patients with high morphine milligram equivalents. This also applies to patients receiving opioids and benzodiazepines.
- Expand locations for overdose prevention and education.
- Counsel patients that multiple doses of naloxone may be needed for a single overdose event due to the potency of illicitly manufactured fentanyl and fentanyl analogs.
- Expand access to treatment for substance use disorders.
- Provide FDA-approved medications for opioid-use disorder (MOUD) that include methadone, buprenorphine, and naltrexone. Take advantage of the fact that the government has loosened restrictions to make it easier to obtain MOUD treatment via telehealth.
- Ensure treatment access for people who are transitioning from institutional settings, such as hospitals, residential treatment centers, or the criminal justice system.

To enact these tips, consult with CDC guidelines, state regulations, and federal regulations.

Fast Fact: According to researchers at the University of Michigan Health Lab, ***one in 20 young adults uses opioids for too long after common surgeries***. Nearly 5 percent of young adults are continuing to receive opioid refills long after surgery.

The Importance of Referrals for Reducing Opioid Liability

One potential avenue for liability is the failure to refer a patient to pain-management specialists. For example, a doctor may work with a patient suffering from chronic pain for years following back surgery. In this case, the doctor may have an obligation to refer the patient to a pain-management specialist who can help the patient pursue a pain-free life without the use of pain medications to manage pain. The patient may bring up a medical malpractice case if they become addicted to opioids due to being prescribed medications for pain for several years.

There is a real threat of a doctor being found negligent if a medical professional equates this lack of referral to medical malpractice when testifying on behalf of the patient. To avoid this, make referrals part of the plan for long-term, medication-free wellness for patients struggling to find relief within the expected timeline.

Protecting Your Practice During the Post-COVID Opioid Wave
As we navigate this tumultuous time for mental health and addiction recovery, doctors should be conservative when prescribing opioids. Physicians who prescribe large volumes of opioids can be flagged by the Drug Enforcement Administration (DEA) for dispensing more than is medically necessary.

To protect yourself against liability, we offer the following best practices:

- Practice 1. Limit dosage and quantity to the lowest possible amount to address a patient's pain-needs effectively.
- Practice 2. Carefully document all treatments.
- Practice 3. When prescribing opioids to patients, provide detailed reasons for why an opioid is being prescribed.
- Practice 4. Make sure that you're following the requirements for physical/telehealth examinations with all patients before opioids can are prescribed.
- Practice 5. Care providers can also ***reduce liability by using medication agreements or contracts with patients.***
- Practice 6. It's also essential to set appropriate goals with clients regarding both the timelines for using medication and the appropriate amounts of medication.

- Practice 7. Check ***prescription drug monitoring programs (PDMPs)*** when screening patients.

According to the DEA, failure to properly check prescription databases can be a basis for illegal prescription distribution. You can look at the DEA's website to see an example of a case where a doctor was sentenced to 70 months in prison for conspiring to distribute controlled substances ***here***.

Fast Fact: The National Institute on Drug Abuse Medications ***formally recommends a whole-patient approach that integrates behavioral counseling as part of something called Medication-Assisted Treatment (MAT).*** MAT increases social functioning, boosts treatment-retention rates, decreases opioid use, reduces opioid-related overdose deaths, and lowers criminal activity.

Telehealth: An Outlet for Patients During a Time of Crisis
Increasingly, patients are turning to telehealth resources for treatment for both medical and mental-health issues. In response to COVID-19, restrictions on medications for opioid-use disorder (MOUD) and telehealthcare have been eased. This trend has helped to alleviate some of the traditional barriers to care. However, other obstacles have emerged. For this reason, a hybrid telehealth-office model is suggested by many researchers. The most significant barrier is that many MOUD patients don't have consistent access to Internet-connected devices. There is also the barrier that some patients may not have access to quiet, private spaces to engage with care providers.

Fast Fact: In 2020, the Drug Enforcement Agency (DEA) officially confirmed that care providers can ***now prescribe a controlled substance to a patient using telehealth technology***. Here are the conditions that must be met:

- The prescription must be issued for a legitimate medical purpose by a practitioner acting in the usual course of their professional practice.
- Telemedicine communication is conducted in real-time using a two-way audio-visual communication system that is interactive.
- The practitioner is acting in full accordance with applicable federal and state laws.

Previously, providers could prescribe controlled substances using telehealth platforms as long as they had already conducted in-person evaluations with patients who would be receiving prescriptions. With this new update, the requirement to perform an in-person assessment is entirely waived. Ultimately, offering telehealth services is a way for care providers to reduce risks for transmission of COVID-19. However, each practitioner must keep up with the latest developments regarding what is required to dispense telehealth prescriptions.

Fast Fact: A doctor can be found liable for pain medication addiction if negligence can be proven.

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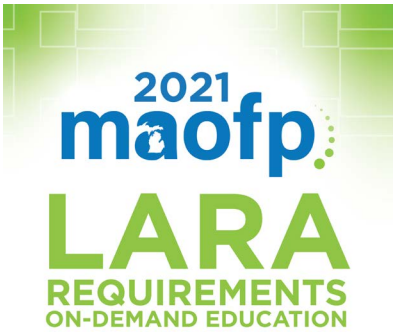
LEARNING OPPORTUNITIES

ON-DEMAND COURSES

MAOFP is excited to launch it's newest on-demand learning opportunities! These events include LARA Requirements On-Demand Education, The Business of Medicine On-Demand Program and 2021 Highlights: Clinical On-Demand Education. Those who attend will have access to sessions, event evaluations and CE credits. We invite you to register for all of the learning opportunities offered!

Registration deadline is December 10, 2021.
The deadline to complete education is December 17, 2021.



LARA Requirements On-Demand Education

This on-demand education bundle allows you to earn 6.25 AOA Category 1-A credits and fulfill the following LARA education requirements for licensure renewal:

- Pain and symptom management (3.25 hours)
- Medical ethics (1 hour)
- Human trafficking (1 hour - one-time requirement)
- Opioid and controlled substance awareness (1 hour - one time requirement for prescribers with a controlled substance license)

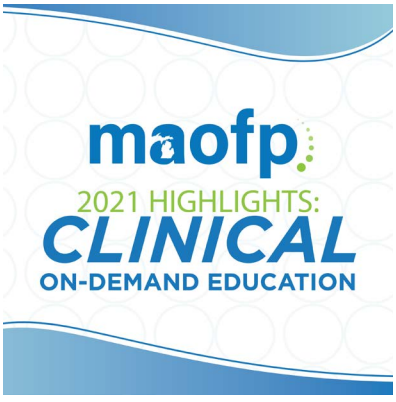
Learn More

Business of Medicine On-Demand Program

The MAOFP Business Of Medicine On-Demand Program includes important education related to the business side of medicine such as telemedicine, billing and coding, social media, direct primary care, the patient experience, and more.

This on-demand education bundle offers the opportunity to earn 7.0 AOA Category 1-A credits.

Learn More



2021 Highlights: On-Demand Education

Were you unable to participate in MAOFP's 2021 conferences? This on-demand education package contains select presentations from our 2021 winter and summer conferences. This education bundle offers the opportunity to earn 14.75 AOA Category 1-A credits. This sessions include high-quality education on clinical topics including infectious disease, women's health, addiction medicine, dermatology, ENT, geriatrics, and more.

Learn More

DETROIT STREET CARE SERVES AND ADVOCATES FOR THOSE EXPERIENCING HOMELESSNESS

By Ivan Ayer, OMS-II
MSUCOM and President of Detroit Street Care

For the last seven years, Detroit Street Care (DSC) has continuously strived to be the voice for our brothers and sisters experiencing homelessness. Our goals span from providing necessities such as food, water, supplies, and medical care to advocating for the rights of our patients and everything in between. Even throughout the global pandemic, we worked to continue to provide for the community in every way we could. This would not have been accomplished without our incredible team here at MSUCOM.

As businesses began to close and shelters began limiting their capacity, we saw an increased need to provide these necessities to our friends on the street and we started a weekly supply packing initiative. At weekly events, we pack supplies such as full meals, hygiene kits, COVID-19 sanitation kits, and even foot care kits. We began distributing our COVID kits at the beginning of the pandemic as we recognized our patients had limited access to supplies necessary to protect themselves and help prevent further spread throughout the community. These kits include face masks, hand sanitizer and a pamphlet on COVID safety education.

Our current activities include weekly street outreach and student run clinics. Every Wednesday, we send an outreach team to distribute food, water, and any of the aforementioned kits as needed. We work closely with several of Detroit's homelessness outreach teams to coordinate and provide basic needs, case management, and medical care to all our patients. We hope to provide resources and be the bridge to different programs that our patients may need from rehabilitation, mental health services, and even transition to housing. In addition to our care on the streets, we are also running weekly student run clinics through our partnership with two local shelters: The Pope Francis Center and The Open Door Ministry at Fort Street Presbyterian Church. At these clinics, students and physician preceptors provide medical care to our friends experiencing homelessness and provide services ranging from chronic disease maintenance to wound care and foot care.

A significant part of Detroit Street Care includes standing alongside our brothers and sisters experiencing homelessness, amplifying their voices, and being an advocate for their rights. This past year, we worked together with our physician preceptors, city outreach teams, The National Law Center for Homelessness and Poverty, ACLU Michigan, and Street Democracy to draft policy to end unlawful encampment removal in the City of Detroit.

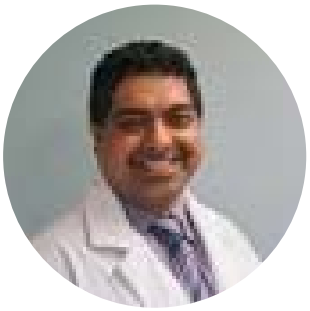
Ultimately, Detroit Street Care hopes to lessen the negative mental, physical, and emotional burden that our brothers and sisters endure. They are voices that need to be heard and Detroit Street Care will always be listening.

Support us and our friends experiencing homelessness through our Amazon Wishlist: ***https://www.amazon.com/hz/wishlist/ls/11L50E3KU331T/ref=cm_go_nav_hz***

THE PLATINUM RULE: UPGRADING THE GOLDEN RULE FOR TODAY'S SOCIETY

By Saroj Misra, DO, FACOFP

MAOFP Past President; member, ACOFP Diversity, Equity and Inclusion Task Force; governor, ACOFP Board of Governors



This article was originally produced for the ***ACOFP blog***. It was included with ACOFP's permission.

Most of us at one time or another have heard of "The Golden Rule," the concept of treating others as you wish to be treated (or a similarly-phrased statement). This concept dates back to the earliest civilizations and religions of the world and has been identified as a basic ethical or moral tenet of most major faiths that exist today. So pervasive and essential is this idea that it was endorsed by 143 leaders of world faiths in 1993's Declaration Toward a Global Ethic. Many of you reading this article probably learned this rule during your formative years—if not from your parents, then most likely from your teachers.

There is probably a good reason that most of us learn the Golden Rule when we are children—it serves as a simple way for us to think about respecting others using the only frame of reference we are capable of as youngsters: ourselves. As we grow and mature, however, we gain the capacity to ask questions, explore ideas and actively learn about other people in terms of their history, their experiences, their challenges and their triumphs. Importantly, we can develop the capacity to recognize that others' values may be different from ours because of the way life has shaped them. Considering this growth pattern, it becomes far clearer that the Golden Rule's biggest challenge is the assumption that others around us are just like us—that the people we interact with (be they patients, peers or society in general) have had similar upbringing, life experiences and challenges to us. The Golden Rule implies that what we value will be what others value as well. As has become increasingly evident and publicized over the last two decades, the experiences of people in this country have been and continue to be incredibly diverse, resulting in a diverse population where people may value different things and hold different ideas about what it means to be treated with respect or valued within society.

We need a better approach—one that recognizes that people's experiences, beliefs and values are not only potentially different but are worthy of respect. In his book, The Art of People, Dale Kerpen suggests that following the Golden Rule is ok, but following the "Platinum Rule" is much better. The Platinum Rule says, "Treat others as they want to be treated." In this way, we focus on the needs of the individual and we do so through their lens, rather than through ours. The Platinum Rule can be applied in many ways in our personal and professional lives.

As physicians, we often use our own lens of experience to approach how we make treatment decisions; we don't always take into account how the patient's background and values might impact the choices we offer and make in delivering care. When we apply the Platinum Rule, we start to be more focused on what the patient needs in the way they need it. Sometimes, we apply the rule without even thinking about it. For example, I became much more savvy about anticipating reactions to my parenting suggestions after I had children of my own—and more empathetic too! Always pay attention to your patients' experiences and use them to inform how you counsel others; recognize that if you apply the Platinum Rule, you can learn from patients as well as teach them.

Most physicians are leaders in some fashion in their careers—within offices, health care systems, professional societies and community organizations. Applying the Platinum Rule in how we lead others is effective in ensuring that people feel engaged and valued. In addition, using the Platinum Rule helps leaders to identify and address micro-aggressions—"The everyday slights, indignities, put downs and insults that people of color, women, LGBT populations or those who are marginalized experiences in their day-to-day interactions with people," as defined by psychologist Derald Sue—that may be occurring but are not recognized. If we apply the Platinum Rule, instead of saying "I wouldn't care if they said or asked that" or "What's the big deal? It doesn't bother me," we end up saying "This hurts these individuals, so I'll be more respectful of that fact."

Many traditionalists might see the Platinum Rule as just being "politically correct." As physicians, I would suggest that applying the Platinum Rule has nothing to do with politics or correctness. It is all about recognizing the need to value people the way they wish to be valued. In this way, it is not unlike Sir William Osler's famous quote: "The good physician treats the disease; the great physician treats the patient." Our profession is all about treating the patient—and the Platinum Rule reminds us to do so in a way he or she will value.

A DAY IN THE LIFE OF A DO

By Rachel A. Young, DO
MAOFP Past President; 2021 ACOFP New Osteopathic Family Physician of the Year Award

This article was originally produced for the ***ACOFP blog***. It was included with ACOFP's permission.

On an ideal day, I begin with a workout or meditation, a smoothie and—my favorite—a homemade Nespresso latte for my commute. During my 45-minute drive to work, I enjoy catching up with medical podcasts, audiobooks, NPR or "music Fridays." I arrive at work at McLaren Greater Lansing Family Medicine Residency Program around 7:45 am where I serve many roles: core faculty, clinic director (CD), associate program director (APD), attending physician, resident advisor and colleague.

When I took on my position as a core faculty member in a residency clinic, it was important to me to keep learning the practice of medicine. So, I see my own private panel of patients on Monday and Wednesday afternoons, as well as Tuesday and Thursday mornings. I have administrative time during the other parts of the day. Admin time is when I serve in my other roles as CD and APD. Fridays are my teaching day.

On Mondays and Wednesdays, I have morning admin time for my role as our CD. This is filled with operational or leadership meetings, prepping for those meetings, catching up on emails and the impromptu needs of the day. I may meet with the program director or our office manager to work on ongoing projects. For example, we write office policies or proposals to order new equipment for the office. Recently, we have been designing our new clinic. This has been a tremendous undertaking but is also an opportunity to innovate and expand our clinic in new directions for patient care and resident wellness.

On Tuesday and Thursday afternoons, I balance my roles as a faculty member and attending. This is when I prep for patient care and huddle with my medical assistant, respond to patient messages, sign off on documents and labs, and cosign resident notes for my responsibility as a preceptor. Often, I will have meetings with the residents or students I mentor and even fill in for precepting needs. There is time to meet with other faculty members to collaborate on quality improvement projects or have our team meetings.

Fridays are residency focused. I am the preceptor for "Senior Fridays," where I enjoy educating our soon-to-be graduates about practice management and billing. I worked in private practice for five years before joining the residency, and I'm known for bringing a knowledge of quality measures, accountable care organizations and insurance incentives to my style of teaching. In the afternoon, we have our family medicine didactics, where I might give a lecture or critique one provided by a resident. I enjoy hearing from our specialists who often present lectures that help me stay up-to-date. As the APD and CD, I provide the weekly administrative updates about clinic operations, policy changes, billing updates and quality initiatives.

I commute home sometime after 5 pm most days, enjoying catching up with friends or family or listening to an audiobook for my book club. Once I'm home, my husband and I enjoy cooking

together, watching a comedy or cooking show, and spending time with our miniature schnauzer, Winston. We've been doing Home Chef since 2015 and have enjoyed expanding our recipe repertoire. Over the past several months, we've been preparing for the addition of our first child due in October. This means balancing doctor appointments and experiencing life as a patient myself. On weekends, we care for our home on four acres in the woods, walk in the many parks around our home with our dog, and catch up on the usual "adulting." We appreciate spending time with our families and friends every chance we get, especially at the lake.

Another role I serve is acting as an advocate for the profession. Several evenings per month, I'll sign onto a virtual conference call for one of our Michigan organizations (the Michigan Association of Osteopathic Family Physicians [MAOFP] or the Michigan Osteopathic Association [MOA]) or ACOFP, where I am a leader, volunteer, innovator and problem solver. One of my favorite functions right now is chairing the Women of Excellence Committee for MOA, where we are designing the curriculum for a new Women's Leadership Institute.

A passion of mine is medical advocacy. I've been chairing the MAOFP Advocacy Committee for several years. We write ACOFP resolutions, respond to new bills proposed by Michigan legislature and keep our membership up-to-date about changes in health policy that impact their practices. A new and exciting position is serving as a vaccine champion for the "I Vaccinate" campaign. In the past month, I've done TV, Facebook Live and radio interviews educating the public about COVID-19 vaccines and the importance of vaccine catch up for all other childhood vaccinations. Our residency program also has a monthly spot on the local TV station where we address a medical topic that is important to the public. It's a fun way to connect with our community and engage them in their health.

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As you can see, being a family physician can look very different for each person. A few years ago, my days were very similar, filled with patient care and then organizational involvement on weeknights. Now, I have the opportunity to incorporate the leadership skills I acquired through those organizations into my day-to-day job as a director. I love that each day is different. It keeps me learning and growing, but also keeps me inspired and excited about the future of medicine. I'm never bored! More administrative time allows me to expand my interest in advocacy. Being a leader in the office allows me to more quickly impact the improvement of the healthcare system, even if it is just through the wellness of our staff and resident physicians. I'm grateful to still balance all this with what brought me to the profession in the first place, practicing family medicine and making a difference in the lives of patients. But now I can take that to the next level by also modeling this for our learners and preparing them for their future careers. I hope that I inspire them to be a positive part of the changes in health care.

CAREER ADVANCEMENT THROUGH THE MAOFP MENTOR PROGRAM

MAOFP launched the Mentor Program earlier this year. This program facilitates meaningful one-on-one relationships that enable participants to meet professional development goals, bolster their career, and make lasting connections with fellow MAOFP members and peers.

There are 24 participants in the inaugural offering of this program including practicing and retired physicians as well as resident doctors and medical students. The mentorship pairings and interactions are driven by the goals and interests of the mentee. Therefore, physicians and future physicians at any point in their career can benefit from giving or receiving mentorship. The Mentor Program will be offered on an annual basis with the next enrollment opportunity in Spring of 2022.

Perspectives from participants:

“I am incredibly grateful for MAOFP’s Mentor Program. Through meeting Dr. Begrow, I have not only had the opportunity to learn more about Family Medicine firsthand, but also been given the privilege of being a part of a warm and welcoming organization. Dr. Begrow has been a fountain of wisdom and insight and has provided encouragement and support since our pairing. Furthermore, because of him I was able to attend my first Family Medicine conference through MAOFP, which reaffirmed my love for the specialty. I hope that as a physician, I will have the chance to give back to medical students as much as I have received thus far.” - Jourdon Robinson, MS, OMS-II

“It has been a pleasure to be involved the MAOFP Mentor Program as it has kept me in touch with the current challenges facing our students. The perspective I have gained through interactions with Jourdon, has benefited me personally and as a late career physician. When you give back, the gift comes back to you.” - Lee Begrow, DO

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LIVING IN A STATE OF TRANSITIONS

By Trevor R. Evans, DO
Family Medicine PGY-1, Beaumont Grosse Pointe

I recently started my residency in Family Medicine and it has been one of the biggest challenges of my life. I always thought of myself as someone that struggles with transitions, but in reality, anyone that makes it all the way to residency has thrived in transitional states in one way or another. Every doctor had to transition from undergrad to medical school and transition from classroom study to clinical study. Some people also transition from entirely different careers as well. Making the change from medical student to resident physician is just another transition in the long road to accomplishing our goal of becoming a full-fledged doctor.

I was incredibly excited to start residency. I had studied, planned, networked, and knew I had made the right choice with Family Medicine. The program I matched had everything that was important for my future training; a diverse patient population, faculty support for the use of OMT, and special training in integrative medicine and LGBTQ+ health.

Right before starting in July, I was nervous about quite a few things. Was I going to like my co-interns? My intern class was going to be six interns from five different medical schools. Did I learn enough in medical school to actually feel comfortable being someone else's doctor? I had always heard so much about imposter syndrome. Were the rigors of residency training going to be too much? Only time would tell.

By the end of my first floor month, a lot of these questions had been answered. I was incredibly fortunate to find great support and friendship in my coresidents. Even on rotations where I'm on my own with just attendings, I know I have my friends to back me up, even if it's just to listen to me vent at the end of a long shift. The resident lounge at the hospital has become a second home to me, a place of comfort even if it is a place of business.

As for my medical knowledge, I've found it interesting how much knowledge I use daily that I didn't get from a textbook. I realized this one day while helping one of my coresidents on the inpatient floor. She needed to do a thorough skin check on a larger patient, and I came along to help her. My coresident was impressed by my "incredible skills" of moving the patient with ease, without harming the patient or my own back. I had learned how to do this while working as a nurse assistant prior to medical school. I did not think learning to turn patients as a nurse assistant would have come in handy all these years later.

It made me think of other important skills residents need that aren't directly taught in medical school. Sure, most of the medical knowledge came from books; but a decent number of OMT techniques I use I picked up from other students and residents at AAO conferences. Feeling comfortable working and mentoring medical students stemmed from all the leadership activities I did in undergrad and medical school. The ability to confidently hold a conversation about patient care with specialists probably came from all the time I spent chatting and networking with attendings at conferences sponsored by MAOFP and others. Being able to walk into a patient's room and make a fast connection with a new stranger took a lot of practice, learned from all my community service experiences.

In the moment, we don't often realize what skills and strengths we're building just by doing activities we enjoy or doing jobs we think are just steppingstones. I'm grateful for the experiences I had, and I will never take them for granted now that I know how much they're aiding me in my medical training.

There are still things I am learning to deal with as a resident. In the last few months, I've had

to have difficult conversations with patients and families, been a part of code teams, and seen patients die. Working in a nursing home prior to medical school, I thought I would have had some immunity to being strongly affected by these types of events. I was wrong. Being a doctor does not automatically give you the coping skills necessary to deal with death and mortality.

As much as I can thank previous experiences for helping me cope with residency training, there are still many things that can only be learned by time and experience. I've had long conversations with my attendings and senior residents about this and they agree. The important thing is making sure to have the necessary support system to have the experiences, learn, and grow without getting burned out. To me, that means healthy boundaries with patients, caring and understanding from my residency program, and always having my friends, family, and partner just a phone call away.

Being someone's doctor is a privilege and I am excited to have chosen this career. Although it can have its challenges, it has its rewards too. In just a few short months I've already delivered a baby, helped patients start on new healthy lifestyles, used OMT to treat chronic pain, and had quite a few laughs with my coworkers in the back room. I'm living in yet another state of transition on my path to being a physician and doing my best to make the most of each moment.

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William Cunningham, DO, MHA, Associate Dean for Global Health, MSUCOM

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