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Winter 1993
Planning for the 21st Century: Primary Medicine Initiative

primary care; the national average among medical schools is 30%. Wood’s ambition, through a comprehensive Primary Medicine Initiative (PMI) beginning in the college, is to raise that figure to 75% in eight years.

The reformist answer to the problems of health care is not simply to stem the tide of specialization. "First and foremost," says Dean Wood, "we are committed to the development of a physician with the combination of breadth and scope of knowledge to suffice for the practice of the future. That means they would handle the vast majority of health concerns for people of every age group in their communities, including many procedures which are only done by specialists today. When referral to a specialist is necessary, these doctors would continue to coordinate the care for their patients."

Where will these physicians come from? A new curricular concept being developed at MSUCOM proposes to forge the "primary medicine" physician of the 21st Century.

New Curriculum

Osteopathic medical education today involves four years of college, four years of medical school, one year of a rotating internship, and one to four years of residency. Often, it all might occur in four or more schools or hospitals, all with different ways of teaching. To support the development of the new generalist, MSUCOM is developing a new curriculum for primary medicine, one that continues seamlessly through the completion of a primary care residency.

It starts with a prematriculation program that would identify and nurture students with an interest in primary medicine, and concludes with continuing medical education that would enhance the primary medicine skills of practicing physicians.

Community Involvement

MSUCOM can model the development of the primary medicine physician, but it cannot single-handedly change American medicine. Partnerships with individuals and communities that can affect the practice environment — state and federal legislators, health agencies, health institutions, physicians’ associations, community organizations, patient advocacy groups, etc. — will be necessary.

"A medical school can no longer take the paternalistic approach that says ‘we have all the answers’," Wood stressed. "It is our hope to develop and model a system of collaboration with those of similar commitment. In parallel, we are working to educate physicians who will take the same collaborative approach in meeting the health needs of their communities — physicians who do not limit their practice to clinic or hospital, but who see themselves as positive agents of change to work with others to enhance health for all."

Current Status of Planning

While the vision and the general directions — developing a physician for the future, new curricular continuum, and building community partnerships — are clear, and the decision to make the PMI "an integral part of the College mission" is taken, Wood emphasizes that "nothing is set in concrete." Within the College, staff and faculty have been designated to work on planning through an initial committee structure, and how the planning process proceeds is now up to them.

The various Task Forces are just now beginning to meet, and the planning process is expected to take 18 months. The results of Task Force deliberations are discussed at a monthly meeting of the coordinators. Within the College, this is a unique, systems-based way of approaching a massive undertaking: one that will depend heavily on broad-based support within and without the College. The beginning contributions of the many College personnel forming the initial Task Forces, and letters of support received from the Michigan Departments of Public and Mental Health, the Governor, state and federal agencies, and others attest to the existence of such support and to widespread recognition throughout the community that more primary medicine generalists are needed.

— by David Ellis

The MSU College of Osteopathic Medicine:

- Has graduated 1,722 alumni, 62% of whom are practicing primary medicine, and two-thirds of whom remain in Michigan. One-fourth of Michiganans’ D.O.’s are MSUCOM graduates.
- Is the first state-supported and university-based osteopathic college.
- Enrolls more than 1,000 students; 58% are female; 17% are minority; 14% are economically disadvantaged.
- Was the first to offer joint D.O./Ph.D. degrees in a Medical Scientist Training Program.
- Provides more than 30% of the continuing medical education credits required for relicensure of Michigan D.O.’s.
- Provides graduate medical education for nearly 360 interns and 60 residents, and takes a leadership role in a nationally-recognized consortium for graduate medical education.
- Includes more than 800 Michigan D.O.’s who volunteer their time to teach MSUCOM students. Their contribution of time is valued at more than $7.5 million annually.
- Emphasizes care for medically underserved citizens, and sustains a high proportion of service to Medicaid, Medicare, and uninsured patients.
GME Financing

As an article on "The Potential of Graduate Medical Education" was published in the Spring 1992 issue of *Communiqué*. The article included an unsourced table demonstrating "Hospital Costs vs. Reimbursement for Residency Training." While not taking issue with the article's main thrust, we believe the table does not accurately reflect the current state of graduate medical education (GME) financing. Below we present an overview of the recent history and current status of GME funding, and predict that one substantial portion of such funding—indirect medical education (IME) cost reimbursement—will continue to be reduced and may ultimately be eliminated.

**The Nature of GME Financing**

Hospital interns and residents are salaried staff, and as such they represent part of the cost of doing business for a hospital, as do any other employees. Funding or revenues to cover the cost of GME are received from health care payers via patient care revenue. The methodology of payment varies with insurance carrier, with Medicare being the main source of specifically identified reimbursement for medical education.

Prior to 1983, hospitals were reimbursed their historical costs plus approximately 2 percent for patient care. This reimbursement system tended to encourage over-provision of services. In 1983, alarmed at the rapid escalation in Medicare costs, government introduced the "prospective payment system" (PPS), in which hospitals were NOT reimbursed based on their actual costs, but instead received fixed payments per discharged patient regardless of actual cost. After PPS was adopted by Medicare initially, other insurers initiated similar programs.

The fixed payments are worked out on the basis of "diagnosis-related groups" (DRGs). Simply put, a DRG is computed based on the average length of hospital stay for a given type of diagnosis, and that is all the hospital may claim, regardless of the actual length of stay.

However, certain "cost pass-through" exceptions were allowed, one of those being the cost of GME. Under PPS, Medicare support for GME continued but under two different methods. Direct medical education (DME) expenses were paid as they were before—that is, as a "pass-through" cost paid on a "reasonable cost" basis. Additional costs that hospitals incurred as a result of GME (such as additional tests ordered by residents as a part of their educational activities) were accounted for by an indirect medical education (IME) reimbursement.

**DME Reimbursement**

DME payments are intended to reimburse providers for:

- Salary and fringe benefits paid to residents and interns
- The portion of teaching physician salaries and fringe benefits associated with teaching and supervision of residents
- Other costs directly attributable to medical education, such as clerical salaries, telephone, office supplies, etc., and
- Indirect costs (depreciation, administration) allocated to DME through the Medicare cost report "stepdowns."

**IME Reimbursement**

IME was intended as an approximated "adjustment" which would reimburse providers for the additional operating costs incurred by a provider because it has a resident training program. Such costs include those that:

- Are not easily identifiable as being related to medical education (e.g., extra lab tests ordered by residents, added complexity to medical records departments)
- Are unquantifiable, and
- Are an "add-on" to the federal portion of PPS payments, and are calculated based on a formula, developed by the Health Care Financing Administration (HCFA), that measures teaching intensity.

**The Problem with DME/IME...**

In practice, the IME payments often exceed the DME payments. This has led to a perception that, overall, GME is a profit center for the hospitals, since total payments for GME exceed total direct costs. However, we have tried to point out above, the financing of GME is complex and it is virtually impossible today to determine if GME is making money or losing money for a hospital.

It is clear that during the 1980s, two major modifications to the methodology of GME financing occurred. These changes, made at the level of the federal government, have substantially reduced payments for GME. We believe that the payment for IME will continue to be reduced and probably eliminated during this decade.

Additionally, there have been marked effects on some community hospitals. Community hospitals that engaged in vigorous program development during the early 1980s were adversely affected by the 1989 regulations. These retroactive regulations severely impacted such institutions by preventing them from recovering the actual costs of program development.

From the healthcare payer's perspective, it is clear that healthcare costs have escalated dramatically, and these payers are determined to slow the growth. We believe that GME financing will continue to be a major target for cost reduction.

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by Oliver Hayes and David Ellis

Readers seeking more information on this topic are referred to O'Hare, Patrick K., "Medicare GME regulations: A challenge for teaching hospitals." In *Healthcare Financial Management*, February 1990.

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excess of $40,000 per resident for 1984 were subject to intense audit of their records for 1984. This has meant, in practice, that some costs have been disallowed, and that therefore hospitals might actually return funding to HCFA.

Regarding the second element: The inflation factor update has been tied to the urban consumer price index (CPI-U) for most of the years retroactive to 1985. Yet the medical price index was considerably higher than CPI-U in those years, and this effectively reduces the payment to the hospital for each year.

Regarding the third element of the equation: While the weighting for residents in initial residency period is 1.0, the weighting for those NOT in initial residency (fellows, greater than five years, transfers, etc.) is only 0.5. Again, the net result is to increase the provider's financial burden.

Additionally, if a resident in Hospital A is rotated to Hospital B for, say, one quarter, then even if Hospital A pays the resident's full salary, Hospital A may claim only 75 of that resident's FTE and Hospital B may claim the remaining 25 FTE.
OGMET, the Consortium for Osteopathic Graduate Medical Education and Training, was founded in 1989 with a goal to promote excellence in osteopathic graduate medical education. To be brief — we want residency training that's comparable to that provided by the allopathic profession. To do it, we've pooled the resources of Michigan State University and its College of Osteopathic Medicine with 14 teaching hospitals and more than 3,200 osteopathic physicians. We offer residencies in general practice, internal medicine, and obstetrics and gynecology. The consortium is an exciting concept. And, it's working. More than 250 osteopathic graduates are now serving their residency in OGMET member hospitals.

Currently, OGMET is the only consortium of its kind in the country. It seems fitting that Michigan should be the first to implement such an idea. Our state is home to more osteopathic physicians than any other, and Michigan D.O.s have always taken a lead in influencing health care issues. Many of our residents tell us the camaraderie and professional networking opportunities provided through Michigan's "family of D.O.s" was a factor in their decision to come here. Aside from the support of a larger community of D.O. colleagues, OGMET offers these advantages not always found in residency programs:

- A university-based experience and Michigan State University certification
- A tradition of osteopathic strength in college, hospitals, and facility
- Monthly educational days (230 formal curriculum hours for internal medicine and general practice, 370 hours for obstetrics and gynecology)
- Basic science courses
- Board review courses
- And faculty development programs for all instructors.

The OGMET education day format, through the pooling and sharing of resources, has permitted us to attract nationally recognized speakers and provide workshops which utilize the faculty and facilities of the College of Osteopathic Medicine. An open invitation is extended to all osteopathic physicians to attend one of the education days. OGMET is also actively recruiting medical students to join its residency programs. We invite students to attend the educational days; we speak at medical schools; and we distribute a newsletter, OGMET Rounds, three times a year to all medical students. Our numbers grew from 227 residents and track interns last year to 252 this year — an 11% increase in our first full year of programs.

We encourage the involvement of the entire osteopathic medical community in OGMET's efforts to improve residency training programs. For further information about OGMET, please call 1-800-685-5769.

—Christopher T. Meyer, D.O.
OGMET Executive Director

MSUCOM Dean to Lead Certificate of Need Commission

Dean Douglas Wood is the new chairperson of the Michigan Certificate of Need Commission, a state panel that provides standards to review medical care facilities' requests to expand services.

The five-member commission, appointed by Gov. John Engler, develops standards for the Michigan Department of Public Health to evaluate certificate of need applications. These applications are submitted to the state by health care facilities seeking approval to purchase new medical equipment, provide specific health care services or increase the number of beds available. The commission is charged to create standards that ensure that medical technology and services are distributed proportionately and fairly to populations around the state.

Wood is the first physician appointed to the commission.

"The commission's regulatory role is based on a legislative directive to ensure that services are available and that health care costs are contained," said Wood. "A physician's perspective is both essential and appropriate in the efforts to achieve these objectives.

"I will strive to bring to the commission my perspectives as an osteopathic physician and as a medical educator."

The commission's first hearing under Wood's leadership was held on Oct. 19. Members of the public commented on the commission's report to the Michigan legislature and on its review standards for open heart surgery services.

Douglas Wood, D.O., Dean of MSUCOM
ILLUSTRIOUS CAREERS COME TO AN END

We are sad to announce the death, on September 15 in England, of John McMillan Mennell, M.D. Dr. Mennell was clinical professor in the Department of Physical Medicine and Rehabilitation from 1985 until his death.

An internationally recognized teacher and lecturer, Dr. Mennell made outstanding public and professional contributions to the field of manual medicine. Though retired from public practice in 1976, Dr. Mennell remained active on the national and international graduate medical education circuit, and contributed four textbooks and three book chapters on the musculoskeletal system. These contributions, and his commitment to creating understanding and overcoming prejudice, earned him the Walter F. Patenge Medal of Public Service in 1988.

He was educated at Cambridge University and the St. Thomas Hospital Medical School in England. He was certified by the American Board of Physical Medicine and received the Diploma of Medical Radiology and Electrolym from Cambridge. He was a consultant to the United States armed forces, the Tennessee Valley Authority, and the United States Congress.

Through his writings and teachings, Dr. Mennell will continue to inspire and guide present and future generations of osteopathic physicians and the medical community as a whole.

—Manoj Thatte

Dr. John F. Bourdillon, F.R.C.S., passed away on October 6, 1992, while visiting the Michigan State University campus. He was a member of the MSUCOM manual medicine course faculty as clinical professor of physical medicine and rehabilitation.

Born February 14, 1914 in Oxford, England, Dr. Bourdillon was educated at that famous university town's Balliol College and later at St. Thomas' Hospital, London.

Graduating at the outset of World War II, he spent the war years serving in the Royal Air Force Orthopaedic Service, returning briefly to St. Thomas' Hospital and then on to Addenbrooke's Hospital, Cambridge, as senior orthopaedic registrar after the ending of hostilities.

From 1950 to 1967, Dr. Bourdillon was a consultant orthopaedic surgeon in Gloucester, England. Subsequently, he emigrated to Canada, becoming established in private manipulative practice in Vancouver, B.C.

He authored numerous journal articles and his book *Spinal Manipulation* is in its 4th edition (1982). He was a Fellow of the Royal College of Surgeons both in his native Britain and also in Canada.

Dr. Bourdillon will be missed by the many students who attended his lectures on manipulation and allied subjects in Britain, Canada, the United States, New Zealand, and Australia, and by all his friends and colleagues at MSUCOM.

—David Ellis

COMMUNIQUÉ WELCOMES NEW EDITOR

Publication of the next (Winter) issue of *Communiqué* will be in the capable hands of a new editor, Manoj Thatte. Manoj brings a wealth of communications experience to the job. Before leaving his native India in pursuit of a master’s in advertising and public relations at Michigan State, he worked on a wide variety of advertising, promotional, marketing, and public relations campaigns, and holds an undergraduate degree in marketing management.

He plans to bring his advertising and public relations background to bear in making *Communiqué* an effective means of communicating the initiatives taken by the College of Osteopathic Medicine, and in that we can all join in wishing him every success.

Manoj Thatte
Today, some 40 million Americans lack access to health care. Within that substantial minority are communities and sub-groups with needs both acute and chronic. They include the indigent—people totally lacking in resources, as well as those who find it difficult to obtain access to some aspects of medical and health care for a variety of reasons—teenage mothers, substance abusers, and AIDS sufferers.

You may have read a lot about how the MSU College of Osteopathic Medicine intends to help ameliorate this situation. In the last issue of Communiqué, for example, we published excerpts from the College mission statement:

The College intends to educate a unique type of osteopathic primary medicine physician... to practice efficient, effective, cost-conscious, community-integrated medicine.

The goal... is to develop a system of osteopathic education and service which works with community groups to address the health care needs of the people of Michigan.

The College will strive to educate osteopathic physicians to be committed to the practice of community-integrated health care.

These are fine words, but are there deeds to back them up? Indeed there are, and you do not have to look very far to find them.

Look, for example, in Dr. Richard E. Griffin's office, in the Department of Community Health Science. Sitting next to a besmocked human skeleton you may find a physician coordinating the geriatrics program at MSUCOM, contributing his knowledge and experience to the state's osteopathic licensing board, or fulfilling some other of his numerous duties. But delve a little deeper, and you'll also find a "jailed" physician from way back, still spending two days a week in a cell at Ingham County Jail, ministering to the medical and health needs of the inmates.

Or stop by the office of the associate dean for health policy. Ordinarily, you'll find Dr. Barbara Ross-Lee surrounded by paper. But at other times, you'll find another MSUCOM physician spending a her time meeting the needs of medically underserved people, at a clinic of the Black Child and Family Institute in downtown Lansing.

These are just two among many MSUCOM physicians serving just two among many branches of the medically underserved population. And the College's deeds include future as well as present service, since clinical care offered by the College supports the clinical education of medical students interns, and residents.

**OLD WINE, NEW BOTTLE**

For many years, the College has been heavily involved in serving the underserved. "We have been acting out the vision for some time," insists Dr. Bernard Kay, chairperson of the MSUCOM Department of Pediatrics. "We have just not expressed it before."

Dr. Ross-Lee agrees. She would like the College to "get the word out" about its vision, and sees the College's community care initiatives as "appropriate involvement" by a university, since the private sector has "ah... different motivations." She notes also that while Michigan State University is "a very real and visible entity" in the eyes of the underserved population in the Lansing area, the same cannot be said of the College itself.

"We have been acting out the vision for some time... We have just not expressed it before."
"When you provide the nuts and bolts, as opposed to the glitz, you tend to get overlooked," she said.

Perhaps the real value and significance of the College's new mission statement, therefore, is that it gives formal expression to COM's long-standing de facto commitment to community service, and the purpose of this article is to illustrate the fine deeds that substantiate the fine words. It looks first at initiatives taken at the College and departmental levels, with sidebars illustrating specific activities of MSUCOM physicians. Second, it focuses on issues surrounding the question of how to persuade more young D.O.s to accept the community care challenge.

### MSUCOM Activities at the Ingham County Health Dept., 1991

<table>
<thead>
<tr>
<th>Child Health Clinic Activity</th>
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<tr>
<td>Child Health Clinic Visits, Total</td>
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<tr>
<td>Child Health Users</td>
</tr>
<tr>
<td>Juvenile Home Visits, Total</td>
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<td>Juvenile Home Users</td>
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*Source: Ingham County Health Department Annual Report, 1991*

### Initiatives

MSUCOM's involvement in community health initiatives can be broken down into three levels: College, departmental, and individual. In sidebars, we look at the activities of selected individuals. Below, we examine College-wide and selected departmental initiatives.

**"Goals of the project include not only to provide access and needs related to primary care, but also to introduce students to settings in which they might practice and to socialize them to community-level work."**

1. The education of students on campus will integrate clinical science with community health sciences.

2. The education of students in the community will include community-oriented care, not just individual care. Students need to understand the community system and what other facilities exist within it. And they need to be able to identify what is missing, as well as what is there.

3. The University will become an integral part of a community's planning and decision-making processes, with the primary function not of taking leadership but instead of facilitating self-generated community initiatives. In Dr. Papsidero's words, it will be "a resource of knowledge, technical assistance, and consultation" to community planners and decision makers.

Echoing Drs. Kay and Ross-Lee's earlier comments, Dr. Papsidero feels that in many respects this model has been working for years, but in a fragmented, uncoordinated way. The aim now, he says, is to take the vision implicit within the model and make it more focused. On the pragmatic level, that means involving more faculty, especially physicians, who are not already involved in community health work.
More support persons will also be needed, and one idea is to recruit Ph.D.s to spend time in the communities as part of the program and also to involve people who are already part of the communities with master's and bachelor's degrees, to help maintain continuity in the program.

Phase I of the Kellogg project, which incorporates this community health model, has focused on rural areas, and clinics in Houghton Lake/Roscommon and Hillman/Atlanta are the test-bed. Through a link-up to a video-conferencing system in Roscommon's Kirtland College, students in Lansing "can see what a tractor accident looks like, or see what happens when someone mistakes a Coke™ bottle filled with old oil for 'the real thing,'" says Dr. Kay.

Phase II, focusing on urban primary care and centered on Ingham County, is just getting underway. Ingham County is in many ways a model for the provision of primary care to the indigent and underserved. "Its immunization rate among those populations is one of the highest in the country," Dr. Kay points out, with justifiable satisfaction.

(2) Departmental

MSUCOM departments are involved not only at Ingham County Jail and the Black Child and Family Institute, but also at the St. Lawrence Hospital Substance Abuse Treatment Unit, the Ingham County Health Department Adult Health and Youth Clinics, the Cristo Rey Clinic serving many Poor Hispanics, the Ingham Medical Center Family Medicine Clinic, and the Friendship Clinic for the homeless.

The box (see page 7) showing the statistics of MSUCOM involvement at Ingham County Health Department facilities is testament to the sheer volume of indigent care delivered by the MSUCOM Department of Pediatrics and others. However, there is not space in this article to describe all departmental initiatives, therefore we focus on two: the Departments of Family Medicine and Community Health Science (CHS).

Department of Family Medicine

Dr. Ross-Lee's involvement at the Black Child and Family Institute (BCFI) clinic began when she was a member (later chairperson) of the Department of Family Medicine.

BCFI itself is a community effort. It has many volunteers providing a variety of needed services, including others from MSUCOM.

Medical situations of particular concern in this population are substance abuse, teenage pregnancy, and AIDS.

Eighty percent of the BCFI patients have no insurance. Twenty percent have Medicaid.

Reflecting both the College-wide goal and the actual practice of programs such as BCFI, Dr. Ross-Lee sees the department as having two major missions in community health:

- To provide care
- To expose students not only to the medical needs of the underserved, but also to the sociocultural dynamics and diversities of the population.

To these ends, the department has developed strong linkages with practicing family medicine D.O.s in Michigan. These linkages not only facilitate educational programs to expose students to primary care early in their careers, but also continuing medical educational programs for physicians.

According to Dr. Martin Hogan, now interim chairperson, the department is involved in work at the Ingham County Health Department Adult Health Clinic (staffing the Family Planning Clinic), the Friendship Clinic, and the Ingham Medical Center Family Medicine Clinic (serving the indigent and underserved).

Another aspect of the department's - and indeed the College's - community involvement is to extend ambulatory clerkships (currently operating only in Lansing) to the Flint area, which has a significant number of underserved. These clerkships involve taking students out of some hospital rotations and putting them instead into community clinics. The program will be extended further, to underserved populations in other areas of Michigan.
The department is also working with the Ojibwe American Indian community in the Sault Ste. Marie area of northern Michigan, which is building a new clinic. The clinic and an educational program being developed will provide elective opportunities for students to practice community-oriented medicine.

![Image: MSUCOM Activities at the Ingham County Health Dept., 1991](source: Ingham County Health Department Annual Report, 1991)

Back on campus, the Department of Family Medicine offers an elective course (FM 515) in health care in underserved areas. It covers such topics as:

- What physicians practicing in medically underserved areas say they wish they had learned in medical school
- Experiences of faculty physicians in practice in underserved areas and in urban and rural shortage areas
- Community-oriented primary care in a community health center
- Health care in prisons, and
- Practice economics in fee-for-service and prepaid settings.

"Medicaid only supports detoxification, not rehabilitation."

Department of Community Science

Besides providing 24-hour coverage at Ingham County Jail, through Dr. Griffin and Dr. George Gross, the Department of Community Health Science is also involved 16 hours a day at the Ingham County Health Department Adult Health Clinic (oriented to preventive medicine), and Youth Clinic (serves Medicaid/underserved), and on a 24-hour, seven-days-a-week basis at the St. Lawrence Hospital Addictions Clinic, which includes a 12-bed inpatient unit.

Dr. Gross sees his department's efforts as being to "take care of the populations no one else wants to." He means the substance abusers, adult and juvenile offenders, and the working poor. For substance abusers, he notes, "Medicaid only supports detoxification, not rehabilitation." Alcoholics form fully 60 to 65 percent of his substance-abuse patients, and most of the rest are cocaine and crack addicts. Of the juveniles he sees in detention centers, acne and VD are prevalent problems. Most of the AIDS/HIV work is undertaken by Dr. Howard Teitelbaum, also of CHS.

While treatment is the most salient aspect of these efforts, prevention is also a major part of the job. "We do this so routinely," says Dr. Gross, "that I do not think about it being anything out of the ordinary. Our patient population is transient and for the most part poor, without access to the health care system. We think that if they can stay healthy they will certainly save money on health care, and being healthy they are presumably better able to work and earn money." To that end, the doctors "stuff" the patient with prevention information, and hope that some of it sticks.

Like the Department of Family Medicine, CHS also strives in campus classrooms to inculcate community service knowledge and ideas among students. Dr. Don Coleman is developing a minority health studies program and is currently offering a course on Minority Health Issues, an interdisciplin ary, inter-collegiate course involving faculty who deal with minority issues from various perspectives.

These, then are only the more visible elements of COM's efforts to serve the underserved. There are other unsung heroes in this battle, individual physicians and students who give of their time in other settings (a rather striking example is that of Dr. John Downs, D.D.S., D.O., who was...

(Continued from page 8)
**COMMUNITY-ORIENTED CARE AND THE NEW D.O.**

Issues involved in getting the young D.O. to practice community-oriented care might be categorized, very roughly, into "personal" and "professional/educational" issues, though there is considerable overlap among them. Examples of "personal" issues include human values, feelings of acceptance, glamour, income, and status. Examples of "professional/educational" issues include the growing ambulatory base, increased teaching personnel requirements, access to sub-specialties, student selection, and malpractice concerns.

**Personal and Professional issues**

**Human values**

What Dr. Howard Teitelbaum likes about working among the disadvantaged is that "it consistently calls into question one's values. It requires you to take care of people because they're people—perhaps abused as children or as adults, suffering hardships, having difficulty getting money to eat, and facing the injustices of the health care system."

**Staleness; income; acceptance**

Dr. Kay recalled that as a young graduate, he faced three concerns about moving to a distant rural practice:

1. Would I get stale?
2. Would I make a liveable income?
3. Would my family be accepted into a community with a different culture, and even religion, from our own?

Besides family acceptance, Dr. Kay adds, it is equally important for communities to be alerted to the need to make the new osteopathic physician feel accepted into the community. "When they have a mind to, some rural communities make the physician feel like royalty," he said.

**Glamor and glitz**

MSUCOM's community involvement programs for students enable them to see pathologies and diseases of poverty they might not see in other settings. Putting students "where the real world is," asserts Dr. Kay, de-emphasizes the dwindling inpatient base and emphasizes the growing ambulatory base.

**MSUCOM Activities at the Ingham County Health Dept., 1991**

<table>
<thead>
<tr>
<th>Friendship Clinic</th>
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<tbody>
<tr>
<td>(For the Homeless)</td>
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<tr>
<td>Total Visits: 2,895</td>
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<tr>
<td>Total Users: 1,124</td>
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</table>

Source: Ingham County Health Department Annual Report, 1991

Dr. Hogan would agree. Medical students want to get into hospital, rather than community, settings, he says perhaps because they are charmed by the popular portrayal of hospital work as being "the glitzy part of medicine," and because they perceive that "that's where it's all at." In fact, says Dr. Hogan, by the time the students find out that the action is outside the hospital, it is too late. Students need to understand that the experience they receive in hospitals may not be fully adequate for what they probably will face later. After graduating, they will tend to serve not in hospitals, but in community clinics, he said.

"When they have a mind to, some rural communities make the physician feel like royalty."

**Lower student/teacher ratio**

According to Dr. Kay, one of the costs associated with ambulatory care as opposed to inpatient settings is that it
requires a much lower student/teacher ratio — 2:1. While a dozen students might crowd around a single physician in a hospital ward, the exigencies of ambulatory settings, where the students might be dealing separately with patients in different consultation rooms at the same time, the physician cannot afford to be stretched any thinner.

"By the time the students find out that the action is outside the hospital, it is too late."

Access to sub-specialties

Another area of concern within the broad sphere of access to primary care is specific access to certain sub-specialties. Orthopedics and ophthalmology are two such areas, where care for the indigent and underserved is hard to obtain. Specialists in such areas tend to be either financially unable or unwilling to become involved, or simply too busy, according to Dr. Kay.

Other issues

Dr. Ross-Lee sees the limited number of available physicians as not the only barrier to care for the underserved. The whole environment for the practice of primary care in general has an adverse effect, she feels. In her estimation, the main factors are:

- Lower reimbursement rates for primary care physicians that make repayment of often staggering student loans impossible
- The cost of continuing one’s medical education
- Malpractice questions
- Lack of resource supports within communities
- Unrealistic community expectations
- The perceived credibility of primary care physicians vs. specialists

Sense of ownership and belonging

Care for people with no health insurance is often provided through impersonal hospital emergency rooms. But arguing from her own experience in serving the underserved, Dr. Ross-Lee feels people want their "own" clinic — something they feel is "theirs." For this reason, Hispanics in need of primary care who are shunted routinely to the Cristo Rey clinic, and not to any other clinic, do not mind the stereotyping, she said. "The stereotyping is bad, but it works — they receive care in 'their own' clinic."

Student selection

Dr. Hogan echoed the feelings of several faculty interviewed for this article, in stating that student selection criteria need review, if we are seriously to tackle the issue of physician distribution in underserved areas. Young science majors from urban areas may be favored by the existing selection process, yet these may be the ones least likely to want to serve in resource-poor areas.

As part of the College's new Primary Medicine Initiative, research will be conducted on the College's admissions profile, as a result of this concern.

Reflecting these sentiments, Dr. Griffin opined that one or some combination of three things will have to happen before more new doctors are attracted to his branch (corrections medicine) of community health medicine: (1) some form of national health service needs to be introduced; (2) the remuneration rates for specialists need to be reduced; and (3) young faculty need to be attracted to teaching at the osteopathic colleges and practicing primary care.

To some extent, the market may make some of the necessary adjustments without intervention. For instance, as ever-more M.D.s eschew primary care, the primary care job market for D.O.s is increasing. This is true nationwide, but is especially so in the southern United States which is "crying out" for primary-care D.O.s, said Dr. Kay.

By deed as well as by word, MSUCOM has long served the community. Its ability to identify, and readiness to address, the difficult issues discussed above are strong evidence of its continued commitment to the community as we prepare for the 21st Century. — by David Ellis
COM students celebrate 100 years of osteopathic education

MSUCOM faculty, staff, and students observed 100 years of osteopathic education with a birthday party on this fall.

An appropriately decorated cake and an informal address by Philip E. Greenman, professor of biomechanics, marked the centennial of the Kirksville College of Osteopathic Medicine, established in 1892 as the American School of Osteopathy in Kirksville, Missouri.

Greenman, a 1952 graduate of the Philadelphia College of Osteopathic Medicine, compared the professional limitations imposed on osteopathic physicians when he entered practice to the virtually unlimited possibilities facing today's osteopathic physicians. While changes in the profession have often resulted from actions of the allopathic community, he believes that future change will come from within the osteopathic community. Greenman also described medical practice of the late nineteenth century. Today's routine use of technology makes it difficult to believe that the sphygmomanometer did not appear until 1896.

Students invited Greenman to speak because of his reputation in osteopathic manipulative medicine. The celebration also provided a "housewarming" opportunity for the new COM Student Lounge, which students helped design, decorate and furnish.

Kobiljak scholarship

Mike Oneka, COM '94, is this year's recipient of the Stefan Kobiljak Jr., D.O., Scholarship. The renewable $5,000 award, named for a 1985 MSUCOM alumnus, was established by the Kobiljak family to recognize highly motivated students for their compassionate and caring nature.

"We are very thankful for and flattered by the award. It means more to me to be selected than just to get the money. It is a great honor," he said.

Oneka received his bachelor's degree in history in 1980 and was the first person in his family to attend college. Although he had considered going to medical school when he was younger, he was not confident of his ability. He worked for the Detroit Fire Department as an emergency mobile medical technician thinking it might reinforce his interest in medicine as a career.

"Oneka is not sure what he would have to do after medical school, but he believes that citizenship is just as important as professionalism.

"Being a physician is more than being a good clinician. You should care about people and about issues."

He has worked as a youth counselor, establishing a job program for teens and young adults, and as a counselor at a camp for hemophiliacs. He believes in being an advocate for people in need and treating everyone with respect.

"People make a difference once person at a time" is his philosophy.

CIBA-GEIGY Award

Ilana Kutinsky, COM '94, has received the CIBA-GEIGY Award for Outstanding Community Service. The award recognizes sophomore medical students for outstanding contributions to their communities. Recipients are nominated and selected by fellow medical students.

Kutinsky served as class vice president last year and is currently on the Legislative Awareness Committee, which organizes letter-writing campaigns to Congress on issues of concern to medical students. She was appointed to the Judicial Ethics Committee, which reviews non-academic student disciplinary matters, and is active with Sigma Sigma Phi, an honorary service fraternity.

Training as an AIDS educator by the Students Teaching AIDS to Students (STATS) project led to Kutinsky’s recent appointment as director of a health and human sexuality program at a youth center in Detroit. She has assisted in providing physical examinations for Special Olympics and has combined recreation with service as a volunteer for wheelchair tennis organizations. Kutinsky was awarded a complete set of Nettel Atlases, a collection of ten books which describe and illustrate the anatomy, physiology, embryology and pathology of the human body by system.

-- Katie Donnelly, Public Relations
1976

Kevin B. Karikomi, of Westerville, Ohio, is in solo dermatology and dermatologic surgery practice. He teaches undergraduate medical students and is involved in GME. Kevin is father to four children—Matthew (10), Michael (9), David (3), and Daniel (15 months).

G. Leponde, of Farmington Hills, is in group practice, specializing in ENT and facial plastics, and teaches undergraduate medical students and GME.

1977

John Rowda specializes in ophthalmology in a group practice at the Citrus Memorial Hospital near his home in Lecanto, Florida.

John G. Steigerwald lives in Traverse City, where he practices and teaches pathology at the Grand Traverse Community Hospital. He served as hospital chief of staff during 1989-91.

Kenneth Wuluk's home is in Sterling Heights, where he serves in a group medical practice and teaches undergraduate medical students as a preceptor.

1978

Ronald Marino lives in Babylon, New York, and specializes in pediatrics in group and hospital practice. Besides being involved in GME and in teaching general and behavioral pediatrics to undergraduate medical students, Ronald conducts research on general pediatrics topics, such as physicians’ attire, bedwetting, and umbilical separation.

William McDevitt, of Waterford, is a urology specialist in group and hospital practice at Pontiac Osteopathic, Botsford, and Huron Valley hospitals. He teaches hospital and office urology to undergraduate medical students and is involved in GME.

Fred Walkerly specializes in anesthesiology at Hackley and Mercy hospitals in Muskegon. His home is in Spring Lake.

1979

Anne Pawlak-Simpson is chief of staff for 1992-93 at Garden City Hospital, where she specializes and teaches undergraduate medical students in neurology. She is also a member of the Board of Governors of the American College of Neuropsychiatry. Her husband has completed residency and is now also in group practice. Their home is in Livonia.

Robert L. Snyder is a clinical associate professor and an anesthesiology specialist at the Mid-Michigan Regional Medical Center in Midland, where he also lives. He teaches undergraduate medical students and is involved in GME.

David G. Tatian lives in Jamestown, and is medical director and health officer of the Allegan County Health Department, besides being in general group practice.

1980

Douglas L. Marsh is in solo general practice and lives in Melvindale.

Pierce M. Sherrill, of Forestville, Wisconsin, practices emergency medicine at the Door County Memorial Hospital.

Robert J. Stotel is Chief of Cardiology at Botsford General Hospital and is in group and hospital practice at several other Michigan hospitals, specializing in internal medicine and cardiology, which he also teaches to undergraduate medical students. His home is in Farmington Hills.

1981

Steve Morgan lives and works in Traverse City. He practices and teaches his specialty, emergency medicine, at the Grand Traverse Community Hospital.

Peter Rodin is a family practitioner in group and hospital practice. He has been director of family practice residency at Bon Secour Hospital and medical director at the Bon Secour Family Practice Center since 1990. He lives in Grose Pointe Park.


1982

Daniel P. Eardley lives in Newport, Rhode Island, and practices general surgery at the Charlton Memorial Hospital in St. Anne’s. He is also associated with the Tri-Estates Clinic—the oldest private clinic in New England.

Thomas J. Stout, of DeWitt, is in group and hospital general practice at Clinton Memorial Hospital.

1983

Linda L. Kurtz’s home is in Berwyn, Pennsylvania. She specializes in radiology at the Sacred Heart Medical Center.

Joyce Michael is looking for an associate for her solo general practice in Colorado Springs, Colorado. Joyce’s twin daughters became four years old in February this year.

1984

Ronald A. Bradley, an assistant professor of psychiatry at MSUCOM, has been named chairperson of the Department of Psychiatry at Lansing General Hospital, and serves as psychiatric director at Horizon Center. He was recently interviewed on “Women and Addiction” by WABC.

Jay A. Klein is medical director at the Birchwood Nursing Center and in solo and hospital (Grand Traverse Community Hospital) general practice in Traverse City, where he lives.

W. John Mallgren, of Tulsa, Oklahoma, is in the third year of psychiatry residency at the University of Oklahoma, where he teaches psychiatry to undergraduate medical students. John’s wife is in the R.N. program at Tulsa Junior College.

James Ranta specializes in family medicine at St. Mary’s Hospital, where he also teaches undergraduate medical students and is involved in GME. His home is in Grandville.

Theresa Rosse is in group general practice in Saranac, where she lives.

Mary C. Whitmer recently had an addition of twins to her family, making a total of six children. Caleb Paul weighed 6 lbs. 5 oz., and Emily Grace weighed 7 lbs. 4 1/2 oz. ("A lotta baby!"). Her husband Gary continues to be "Super Mr. Mom" after 12 years of being at home "until the youngest goes to school."

1985

L.R. Searls lives in DeWitt, and specializes in emergency medicine at Lansing General Hospital, where he is director of emergency services. Dr. Searls also teaches undergraduate medical students, and is married with four children.

Jeffrey Sonenshein is in solo general practice in Huntington Woods.

Keith Stevens, of Rochester Hills, specializes in pulmonary/critical care in group practice at Beaumont, St. John’s, and M. Clemens General Hospitals.

John Tower lives in the Detroit area and is in group practice at the William Beaumont Hospital. His specialty is internal medicine.

Barbara Walters-Scherrer lives in Chapel Hill, North Carolina, and practices psychiatry at the Holly Hill, Rex, and North Carolina Memorial hospitals, where she is also involved in GME.

Martin K. Weitzel, of Auburn, New York, is in solo general practice at the Auburn Memorial Hospital.

1986

David J. Mccario lives in Stow, Ohio, and practices at the children’s Hospital Medical Center, where his specialty is pediatric emergency medicine. Besides practice, David is also involved in teaching and research.

David P. Nebeling, of Davenport, Iowa, teaches OMT to undergraduate medical students at Davenport Medical Center and is in solo general practice.
Debra L. Peren became one of Henry Ford Hospital's two neuromuscular specialists in 1991 after completing a fellowship in neuromuscular disorders and EMG. The hospital is in Detroit, and Dr. Peren's home is in nearby Livonia.

Kathy Rosema lives and is in group general practice in Muskegon, working at Muskegon General and Hackley hospitals. She and husband Mack presented their five-year-old son, Mack James, with a baby sister—Meghan Katherine—on August 11, 1991.

Stephen M. Swetech's family—including four-year-old son Jonathan Alexander, 21-month-old daughter Maria Stephanie, and wife Grozda—are "ecstatic" at the publication of his article on spinal-anesthesia-induced hypotension in the December 1991 issue of the JACEP. He is currently in general practice with the Macomb County Hospital and the First Care Medical Center, both in Warren.

Pamela Thompson, is in group general practice in Lansing, and is marrying Scott Roberts on October 17.

1987

Timothy A. Plontrowski is in group general practice in Lapeer.

David P. Walters specializes in emergency medicine, which he practices, teaches, and researches at Botsford General Hospital. His home is in Brighton.

1988

Robert O. Smith is in general practice in Wichita, Kansas.

M. Ann Spillan's home is in Grosse Pointe Woods, and she specializes in adult and child psychiatry at Lafayette Clinic, Receiving Hospital, Children's Hospital, and the Detroit Medical Center. Her son, Steven, who married in 1990, graduated from the University of Michigan Law School last year and has taken an interest in medical law.

Maureen E. Van Duerbeker is in residency at Mount Clemens General Hospital, specializing in urology. She recently married Dr. Bruce Hall, radiologist at the hospital. Their home is in Shelby Township.

Sanford Vieder recently became attending staff member of the Department of Emergency Medicine at Botsford General Hospital. Sanford's home is in Southfield.

Michael C. Viedenburg, of Harper Woods, is a resident in internal medicine at Detroit's Henry Ford Hospital, where he also teaches and is involved in research on preventing cardiovascular disease, smoking cessation, and clotting mechanism and cardiovascular disease. He and his wife Rebecca, who teaches childbirth classes, have two children—Jeffrey (4) and Kari (1). He plans to do a fellowship in cardiology and specialize in preventive cardiology.

1989

David Wang lives in Detroit, and is a neurology resident at the Henry Ford Hospital. He teaches neurology to undergraduate medical students and is involved in GME.

1990

Stephen C. Bloom is currently in his third year of residency in physical medicine and rehabilitation at the Rehabilitation Institute of Chicago—Northwestern University Hospitals. His current research projects include post-poliomyelitis syndrome, joint replacement, and pregnancy with spinal cord injury. He and his wife Betsy had a daughter, Alison Clare, on April 4 this year, and are enjoying the Chicago area.

1991

Nancy Meachum Provan lives in Indianapolis, Indiana, and is an intern at Westview Osteopathic Hospital. She married Christopher Provan in June 1991.

Audrey Trainer lives in East Lansing, and is an intern at Lansing's Sparrow Hospital.

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**MSU College Of Osteopathic Medicine**
**MSUCOM-ALUMNI**

To keep MSUCOM aware of your achievements, we would appreciate if you could spend a few minutes of your time and complete this questionnaire.

1. Your Name and Date of Graduation: _______________________
2. Address (if different than on label): _______________________
3. Home and Daytime Phone #: ___________________________  
4. Are you involved in generalist medicine? ________________
5. If not, what is your area of specialization? ______________
6. Please provide an update on recent accomplishments you would like to share with your D.O. colleagues. ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
7. Would you be interested in making contributions in the form of features, columns, stories or articles to Communiqué? If yes, please indicate specific interests. ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

Thank you for your cooperation.

Return to Manoj Tbatte, Communiqué editor, Office of Public Relations, A310 E. Fee Hall, MSUCOM, East Lansing, MI 48824-1316
### December

- Dec. 3: COGMET DAVGP Surgical Clerk
- Dec. 4: Infectious Disease Conference, 6.5 cr.
- Dec. 7: COGMET Bedside Teaching, Flint Osteopathic
- Dec. 18: COBO

### January

- Jan. 6: COGMET General Practice Education Day
- Jan. 13-17: Osteopathic Social Science: Part II, Tucson, AZ, 40 hrs.
- Jan. 15: COBO
- Jan. 21: COGMET OR/GYN Education Day
- Jan. 28: COGMET Internal Medicine Education Day

### February

- Feb. 3: COGMET GP Education Day
- Feb. 4: COGMET Basic Science
- Feb. 10-14: Gastrointestinal Conference—Part III (WMLT)
- Feb. 11: COGMET Basic Science
- Feb. 12: COGMET Board of Directors
- Feb. 17: COGMET Executive Committee
- Feb. 18: COGMET OR/GYN Education Day
- Feb. 25: COGMET IM Education Day
  
For information on any COGMET event, please contact Luanna Tomlin at 555-6562.
MSUCOM Entering Class 1992

Daniel J. Abraham
Robert Fraser Allum
Bret Andrews
Kevin Batterbee
Michelle M. Bauer
Martin Belkin
Amy Blasing
Christine Tratton
Racquel Brockington
Julie Burgos
Michael Burr
Peter Cabala
Ramon Cantu
Kelly Chara
Katarina Cisaruk
Amy Clark
Jonathan S. Cooper
Gail Coulter
Maureen Dailey
Christopher Daisy
David Donaldson
Lon Dowie
Gary L. Dubisky Jr.
Timothy J. Dykstra
Katherine Elkins
Andrew H. Erlich
Chad A. Faber
Barbara Falkell
Jonathan Fellows
Gilbert A. Field
Michelle Gauthier
Michael J. Gilmore
Stacey Goldfine
Eric D. Good
Jodi Greenfield
Mary Greiner
Shawnna Gugel
Susan M. Hague
Debora Hahn
Brian Hays
Daniel Heardl
Janet Heasley
Jack Heethouse Jr.
Timothy Heilman
Karla Hemphill-Harris
Kenneth Hentschel
Deborah Hervey
Kevin Howard
Kwashuia Ikram
Jeanette Jackson
Kathy M. Jackson
Heidi Johnson
John Randall Johnson
Anthony J. Kawa
Lynn Kelley
Brian M. Kelly
David J. Kersbergen
Linda Klaviter
Kristine Knop
Shawn Kosnik
Karen R. Kohl
Laure Kovalsk
Timothy Kval
Mindy Lane
Eric Leep
Raquel LePera
Ronald Lippmann
Richard Lloyd
Catherine Loniewski
Vinh Duc Luu
Kim Mahler
Jayne H. W. Martin
Flavia Mattias
Brian McComb
Louise McFarland
Nicolle McIntyre
Mizzie McKay
Scott McPhilimy
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Todd Prochnow
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Elizabeth Schneideman
Carlos Sotelo
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Paul Stoll
Bridget Y. Tah
Uyen Thai
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