

Nebraska Medical Association

**CELEBRATING**

**150 YEARS**

**OF ADVOCATING  
FOR PHYSICIANS  
AND THE HEALTH OF  
ALL NEBRASKANS**

Plus a review of  
the 2018 Annual  
Membership Meeting

Nebraska Medical Association

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# President's Message

By Britt Thedinger, MD  
NMA President

On Friday September 14, 2018, your Nebraska Medical Association held its 150th annual meeting. In the summer of 1990, my wife and I moved to Omaha to start my medical and surgical practice - Ear Specialists of Omaha - not expecting on becoming president of the NMA 28 years later, let alone its 150th president!

One of the highlights from the evening's inaugural dinner was a last minute Resolution related to our retiring Executive Vice President Dale Mahlman which stated:

Be It Resolved:

- That the 2018 NMA Annual Meeting be dedicated to Dale Mahlman in honor of his dedication, time, efforts, sacrifice, and leadership on behalf of our profession and association, physicians, our patients, and the health of all Nebraskans;
- That Dale Mahlman receive our unending thanks for elevating the involvement, effectiveness, and awareness of our NMA across the state and country, with the Legislature and Governor's office, and with various business and public health entities; and
- That Dale Mahlman receives a lifetime honorary membership in the Nebraska Medical Association.

I would also like to share with you some comments from my inaugural address.

With respect to our history and heritage and giving tribute to our 150th year of existence I would like to refer to the President's Address of the annual meeting of 1918 from 100 years ago. Dr. C.L Mullins from Broken Bow began his address "Members and friends of the Nebraska State Medical Association... In conformity with the custom of our society it is one of the duties of the president to call to the attention of the association, such matters, as in his judgment, should receive its practical consideration. The needs of the war in its successful prosecution are paramount! The needs here are vital, urgent, and immediate. I feel that we should engage in no activities, no matter how important locally, that can in any way interfere or hinder the giving of our full strength to our government

in prosecuting to a successful conclusion the war in which we are engaged. But first, I wish to express to the members of our association my sincere appreciation for the high honor conferred upon me. It is a great honor and carries with it responsibilities I feel ill prepared to meet."

Like Dr. Mullins I'm honored to be your designated caretaker for the coming year following in the footsteps of the previous 149 physicians who assumed this same position.

One of the happiest days of my life was receiving that letter of acceptance to medical school. I was and am still honored to be a member of what I believe is the greatest profession. With that membership in the medical profession comes certain responsibilities. Protecting and enhancing our profession should be **every** physician's concern. The best way to do that is through our local and state medical societies.

We should all be proud of the efforts of the NMA over the past 150 years. Historically, looking back at our association journals and records, it was an honor and a distinct privilege to be a member of the NMA, and you were expected to be a member. Today, I strongly believe that all physicians should be members of the NMA!

Physicians are professionals - we're physicians - not providers!

Professionals are agents of their patients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government guidelines which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Every day your Nebraska Medical Association staff, board, and various members work to protect our profession. As your president, it will be my main effort this coming year to continue what is the first part of our motto - Advocating for Physicians.

Your NMA's main role is to listen. I declare this the year of the ear! We want to hear and to learn how to help better assist our fellow physicians take care of our patients and



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## President's Message (continued)

how to enhance the patient-physician relationship. We want to hear from our colleagues about barriers and difficulties you encounter causing hardships in practicing medicine.

In addition, your NMA needs to continue to push for access to health insurance. We need our state senators to allow individuals, ranchers, farmers, and small business owners to join associations or organizations to allow group purchasing of health insurance to make it affordable.

We need to find enhanced funding sources for our Nebraska Coalition for Patient Safety. We need to continue the efforts of people like Evelyn McKnight, PhD, and Tom McKnight, MD, in education of issues like safe injection practices.

We need to help our fellow physicians better understand the new rules about opioid prescribing in light of new state legislation.

We need to focus on trying to eliminate pre certification requirements for imaging studies or medications which take up so much time.

We need to help eliminate this relatively new term of physician burnout by advocating for better EMRs, abandon burdensome requirements for EMRs, and enhance interoperability of health information technology.

We need to enhance our Licensure Assistance Program regarding physician health and mental health.

We need to advocate for lower drug pricing, more generic competition, and more price transparency to encourage competition by the various pharmacies.

We as an organization should continue to help our fellow physicians by supporting reducing paperwork and needless regulations and to increase physician Medicare pay - adjust Medicare fees with medical inflation!

We need to improve and simplify the Medicare Quality Payment Program. Eliminate payment penalties and budget neutralities. We should work to repeal MIPS, the merit-based incentive payment system and use quality and cost metrics that capture only what is under physician control and not penalize us for improper patient compliance and choices.

We as an organization should continue to emphasize the doctor and the patient as the ones who should make medical decisions, not insurance companies or hospital bureaucrats. We as an organization should continue to emphasize that physicians and medical staffs are responsible for medical decisions and care within a hospital, not the administration. We need to advocate and protect our employed physicians in this role. We need to continue to monitor hospital by-laws.

Finally, we need to continue to acknowledge that third party payment introduces conflict of interest and government regulations reduce access to care. Honest, publicly accessible pricing and accounting "transparency" is essential to controlling costs and optimizing access. Confidentiality is essential to good medical care. Physicians should be treated fairly in licensure, MOC, peer review, and other proceedings. And, of course, the NMA is responsible for preserving our malpractice cap!

Thank you again for this honor. Happy 150th to all of you, and I look forward to working with and hearing from all of you!

GO Big MED!

Britt

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# Executive Vice President's Message

By Dale Mahlman  
NMA Executive Vice President

As I move closer to my last day (January 4, 2019) with the Nebraska Medical Association I stop periodically to wonder if I really ever did it “my way?”

If I would have done it my way, I would have never had to write one of these columns, let alone 40 or more. I would have never sat through hearings on the motorcycle helmet bill or any scope of practice bill. There were lots of times when I thought that we were fighting an uphill battle, but in the end I always felt that the NMA had the best interest of the patient in mind so I continued on remembering the mission of the NMA.

I have had the privilege to work with and for some of the best people. Your NMA staff has always had the best interest of NMA membership in mind and my management style was simple: put the best people in the right places and then get out of their way. Our physician leadership has been a pleasure to work for. I have the utmost respect for each and every one of them.

Because there are too many people to name individually, I also have had the privilege to represent the best and the brightest physicians in the state, or at least those that pay their annual \$390 dues. I can say our leadership and members are second to none. Your focus on the patient and the profession is always clearly communicated. Those that are not involved or engaged in the efforts of organized medicine are missing out on great opportunities to advocate for their profession and patient care!

One of my primary responsibilities in the “old days” was to be the Budweiser mule for a long standing “poor old county doc.” The same person who chewed my backside

in my previous career with a regional preferred provider organization became the stuff of legend early in my NMA career. Whether this physician was advocating at the local, state or national level, I was always in that zone of fear/amazement at his passion and commitment. Since I spent time with him in Chicago, New Orleans, Dallas, San Diego, Honolulu, etc., attending meetings, subsequent meetings since his departure have not been the same and I am forever grateful to have finally been considered to be on his good side. He was a physician who did it his way, but with great passion.

Growing up, when other kids said they wanted to be a police officer or a firefighter, I always said I wanted to work for the Nebraska Medical Association. Fortunately, after many failed attempts to be successful in the insurance and managed health care worlds, I was given the opportunity to join the NMA in October of 2002. Other than my first marriage (fortunately, I have only been married once), the births of my two daughters, my three holes in one, the NMA has been the best thing that has happened to me.

While I’m not really retiring January 4, just changing directions again, I hope I have left the NMA a better place than I found it. As the caretaker for this 150-year-old gem, I have also wondered “what if” this closes on my watch. Since it appears I will be passing along a viable and thriving professional association, please continue to support both financially and with your time and effort, your Nebraska Medical Association.

To close, I love this old quote, “It’s what you learn when you know it all that really counts.” What I know is that I have enjoyed every day working for the physician members of the Nebraska Medical Association. □





# Congratulations NMA...

*"Membership in NMA means that I can be a voice for not just myself and my patients, but physicians and patients around the state to make health care better for all Nebraskans. No one else has our perspective on the way that legislative and regulatory decisions affect the day to day work of caring for people at every stage of life. If we don't take our seat at the table through membership in NMA or other physician organizations, no one else will be there to ensure that unique perspective is represented."*

– Jordan Warchol, MD

*"No other organization better represents the interests of medicine to all Nebraskans. The ethics of solid practice, the support of disease prevention, and the effective delivery of health care have strong advocates from this organization."*

– David Filipi, MD

*"Fifty years ago I was the first student to join the Nebraska Medical Association. It's hard to believe that I have been a member for a third of the NMA's existence. Organized medicine in Nebraska has been and continues to be critically important to our profession and our patients. Serving our patients and protecting them from the self-interest of others has been our job one. I continue to believe that if we put the interests of our patients first, we will be well taken care of. I am grateful for the opportunity to have served on multiple committees, as president and on the Foundation board. Even as I have retired from active clinical practice, I look forward to the NMA continuing to benefit our patients and our profession."*

– Dale Michels, MD

*"As a busy physician, I can't drop what I'm doing and run down to the Legislature to advocate for my position. The NMA and our lobbyists allow me to know what is going on in the Legislature. I can then plan my days that I can be available to let the Legislature know what is important to me and my patients."*

– Les Spry, MD

*"Being a part of the NMA has given me the opportunity to connect with physician mentors and role models who exemplify effective medical advocacy and dedication toward bettering the medical profession, both in Nebraska and nationally."*

– Michael Visenio, MPH, Medical Student

*"For 150 years, the Nebraska Medical Association, an organization representing all state physicians, has improved the health of Nebraska by enhancing the quality and safety of patient care through physician and patient education, support of and improvements in state health policy, better rural and urban healthcare delivery, and education in common disease prevention."*

– Rowen Zetterman, MD

*"Being president of the Nebraska Medical Association during my time in 1983-84 was a great honor. It allowed me to travel the state on behalf of the NMA speaking to medical staffs and physicians about the issues of the day."*

– Duane Peetz, MD

# The NMA's Legacy of Advocacy

By David Buntain

Cline Williams Law Firm

Throughout its 150-year history, the Nebraska Medical Association has played an important role advocating for Nebraska's physicians and the patients they serve. Though the practice of medicine has changed dramatically since 1868, many of the issues confronting the medical community today are merely the latest iteration of controversies that the NMA has faced during its entire existence.

For example, the NMA's most significant legislative achievement in the last 50 years was the passage of the Hospital Medical Liability Act (HMLA) in 1975. This landmark law placed a cap on recoverable damages in medical liability cases and created the Excess Liability Fund to assure patient recoveries. Physicians may be surprised to learn that 50 years before the HMLA, the NMA was already at work protecting physicians involved in malpractice suits.

In 1919, the NMA adopted by-laws that created a Medico-Legal Defense Committee. This Committee oversaw a Defense Fund "for defending members for alleged malpractice" if the member "placed his case in the hands of the Association" in accordance with its rules. Every NMA member was entitled, "to receive, without expense, the services of an attorney and counselor at law in any action for malpractice brought against such member" in any Nebraska court. While the NMA paid for the physician's attorney, any settlement or verdict was the responsibility of the physician.

And here is the most surprising fact: to pay for this malpractice defense fund, the NMA set aside one dollar per member each year out of the physician's annual four-dollar dues assessment.

By the time that the HMLA was introduced in 1975, the frequency and cost of medical malpractice claims had outpaced the Medico-Legal Defense Fund and the liability insurance industry which replaced it. Confronted with an exodus of medical liability carriers from the market, the NMA's leadership launched a massive political effort that was funded in part by a special assessment on members.

Since passage of the HMLA, the Association continues to monitor the operation of the law, respond vigorously to court challenges, and update the law as needed. The premium surcharges paid by participating physicians and hospitals has built the Excess Liability Fund to its current level of over \$90 million.

Nebraska's medical liability law has thus achieved the goals which led to its enactment: improving the affordability and availability of malpractice insurance, encouraging physicians to locate and practice in Nebraska, and improving the availability and affordability of medical services in the State.

Such public advocacy has been a hallmark of the NMA since its inception. Indeed, the formation of the NMA can be traced to efforts by organized medicine to protect the public from untrained physicians and promote medical education. In 1867, the year Nebraska became a state, a resolution of the American Medical Association encouraged U.S. physicians to use "all of their influence" to secure legislation requiring that all persons seeking to practice medicine must be examined by a state board of medical examiners before being licensed.

One year later, Nebraska physicians formed the NMA and began working for legislation to regulate the practice of medicine in Nebraska. In 1881, Nebraska enacted a "registration" act, requiring practitioners to register with the county clerk, presenting evidence of having obtained a diploma from a legally-chartered medical college, or evidence of 10 years of practice. This law proved to be unenforceable, since it was impractical to prove the validity of diplomas purportedly issued by schools in other states.

In 1891, Nebraska finally enacted its first physician licensure law, empowering the State Board of Health to certify physicians on the basis of a diploma from a medical school in good standing. To qualify, the medical school had to give a preliminary admission examination, require attendance of at least three courses of lectures of six months each over a three-year period, and have a full faculty of professors in all of the branches of medical education.

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# 4/89-4/90; A Year of Change



By Richard Raymond, MD

Dale Mahlman has asked me, as the youngest NMA president ever, to provide an article with some insights as to why I ran for that office when I did.

Three simple reasons.

1. When Duane (DJ) Peetz was the NMA president, he was also the guy who came over to O'Neill from Neligh to do surgery on my patients on a regular basis and never with any questions or complications. He was a huge influence on my political involvement and got me really going with some presidential appointments to certain committees.  
We spent a lot of Nebraska evenings in his Aztec flying back to Neligh from NMA committee meetings talking medical politics. I am guessing he is the oldest surviving NMA president at this time.
2. My father was in failing health, and he had always been active in the community: school board, Chamber of Commerce, volunteer fire department, etc. And he always made certain our U.S. House of Representative elected officials from our rural district knew him on a first-name basis. I wanted to let him know I also believed in serving, and I wanted to make him proud.
3. Younger readers (heck, most are younger than my 71 years) will not remember or even know that in 1988 when I ran for election as president-elect Nebraska had a three tiered Medicaid and Medicare reimbursement system that complicated recruiting physicians to rural Nebraska.

Omaha and Lincoln docs got top dollars for what they did. Physicians in counties with a population of over 25,000 received silver medal rates, and those of us family physicians really in rural practices got maybe half of the fees going to Omaha family physicians. And the Omaha family physicians had immediate backups for OB emergencies, reading X-ray films, ER docs to cover their practices at night and on weekends, etc. Looking at that fiscal disparity, why would any young doc want to join us in O'Neill?

(And yes, I was the youngest physician, at age 38, in that town of 4,500.)

So I felt that if I wanted to remain in rural Nebraska with an adequate number of partners to enjoy a lifestyle of not being constantly on-call, I needed to do something and that involved leading the NMA to a solution.

During my year as president-elect I met with almost every rural county medical society, begging them to get more NMA members so they would have more delegates to vote at the upcoming annual NMA meeting. It was probably the biggest increase in NMA membership in history; certainly for rural Nebraska at least.

I was advised by some Omaha MDs active in the NMA that I would divide the NMA in two, and it would no longer be a political force. I took that chance and we passed a resolution to take to our elected D.C. officials to make rates equal across the board in a budget neutral manner, and they got it done.

The irony of all this is that my term ended in April 1990 and in July 1990, I moved to Omaha to establish a family practice residency at Clarkson Hospital. But at least my graduates knew they could charge and get just as much if they went where they were needed most, to rural Nebraska, as if they stayed in Omaha.

One next to last thought; I may also have been the longest serving NMA president. At the annual NMA meeting in 1988 C. A. McWhorter was sworn in as the next president. He died suddenly in July and by default I, as president-elect, became president. I needed the year to get those increased delegate votes so I talked Omaha board representative Don Pavelka, MD, into assuming the role of president at our annual board retreat in September of that year.

Don said he would handle the media, committees, etc., if I would do the travel required. Tough decision. At that time the president served as an alternate delegate to the AMA meetings and that winter it would be held in Hawaii.

OK, Don, you got a deal.

Organized medicine, like the NMA and the AMA, are the only ways for physicians to have advocacy for themselves and their patients. The local county medical societies are

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# Reflections From the First Female NMA President

By Michelle Petersen, MD

When asked to reflect on being the first woman president of the NMA, I considered my presidency. I was elected in 2002 at the age of 44 years, one of the younger physicians elected as president and the second pediatrician. The presidency went smoothly, all things considered. The malpractice cap had been challenged and upheld. The organization, its executives, and members worked through the year with other organizations and the Legislature without upheaval. Nothing exploded, the organization continued, and Al Thorson, MD, received his gavel and the pumpkin on schedule, as it should be.

Accepting and voting for a woman as the president of the Nebraska Medical Association did not occur spontaneously. That has been a process of growth and change over many generations not only in Nebraska but across the United States.

Prior to the middle ages, women were regularly involved in medicine with major surgical and obstetric papers written by women. However, during the middle ages, King Henry VIII decided “No carpenter, smith, weaver, or women shall practise surgery.” In 1540, he granted the charter for the Company of Barber Surgeons in which women were barred. It’s been an uphill battle since then.

Centuries later, Dr. Elizabeth Blackwell was recognized as the first woman physician in the United States, graduating from Geneva Medical School in New York in 1849. Unfortunately, though she finished medical school, she was not offered a job; she could work as a midwife, not a physician. By the 1850s, there were women’s medical colleges being started across the United States with approximately 200 women physicians by 1860. The majority of the new women physicians were trained by former women students within these colleges.

Omaha Medical College accepted Dr. Georgia Arbuckle Fix in their second class; she graduated in 1883. She practiced in the Omaha area for three years prior to homesteading in western Nebraska and continuing to practice medicine there. Notably, she served as vice president of the Douglas County Medical Society during her time in Omaha.

In 1889, Nebraskan Dr. Susan LaFlesche Picotte graduated from the Woman’s Medical College of Pennsylvania. As the first Native American woman physician, she returned to practice around the Bancroft area. It was an interesting note in one biography that “she would even take her children on house calls with her sometimes.” Our children could certainly empathize with that.

There were around 7,000 women physicians by the early 1900s. The AMA published a directory of physicians in the U.S. in 1906 with 128,000 names. If the women were included, they would have comprised almost 6 percent of physicians at that time.

In 1980, all medical schools were open to women with most having a 10-30 percent admission rate. The 1984 graduating class of UN College of Medicine had 31 percent women. Thirty-five years later, the class is now 50 percent women.

In the 1990s, women’s involvement in organized medicine, private practice, and medical education expanded rapidly. By 1998, Dr. Nancy Dickey was elected as the first woman AMA president. The NMA had a similar increase in involvement with Dr. Susanne Eilts elected as vice speaker in 1999 and then speaker from 2001-2004. Dr. Linda Ford was AMA delegate 1998-2008. Dr. Tamara Johnson was the young physician delegate 1991-1994, Dr. Michelle Petersen in 1995, Dr. Mary Drey in 1999 and Dr. Joann Schaefer in 2004. I was the first female president in 2002 with the second, Dr. Kryn Buckley, serving as president 2005-2006.

There are currently over 376,000 women physicians in the U.S. This represents about 35 percent of practicing physicians. There are approximately 42,000 women in medical school representing about 50 percent of those students. The majority of practicing female physicians are in internal medicine, pediatrics, family practice, and OB/Gyn comprising upwards of 60 percent of physicians each area. About 40 percent of general surgeons are women with anesthesiology, emergency medicine, psychiatry, diagnostic radiology, and dermatology rounding out the top 10



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# Observations of 38 Years, 1962-2000 – Not a History of the Nebraska Medical Association... but Some Thoughts



By Bill Schellpeper

When I became an employee of the Nebraska Medical Association in 1962, the organization was called the Nebraska State Medical Association. Eventually the word “state” was taken out of the name. The senior executive was called the executive secretary, and the number two person the executive assistant.

Subsequent to that, the senior executive was named the executive vice president, and the number two person was named the associate executive director.

In 1962 the staff totaled four people, annual dues were \$35, and the NMA had 1,288 paid members. The annual budget was \$53,160; investments/reserves totaled \$77,711.81 at year end.

At that time, the NMA was housed in the Sharp Building in downtown Lincoln, and there was insufficient room for committee meetings. Meetings were nearly always held in Room 901 or 921 of the original Cornhusker Hotel, located one block from the Sharp Building. Lincoln did not have liquor by the drink, except in private clubs, so NMA staff would carry liquor to each meeting and tend bar. In fact, when I was interviewed for the job I was asked, among other things, if I could mix drinks. The meetings would begin at 5:00 p.m. and the administrative assistant, later named the executive assistant, and subsequently named the assistant executive director, wrote and then typed the minutes before mailing them out. The minutes were copied on Thermofax paper, which were yellow sheets of chemically treated paper that became brittle, faded, and eventually fell apart.

In 1970 the NMA office moved to the brand new First National Bank Building (now U.S. Bank) located at 13th and M streets, where we subleased approximately a fourth of the 19th floor from Cline Williams, the law firm we utilized. In 1979 the office moved to the northwest corner of the 15th floor of the building as both the NMA and Cline Williams

needed more space. In 1997 NMA moved to the 15th floor, and now resides on the 12th floor of the U.S. Bank Building.

Early on in my employment, like the first day, I was cautioned to always refer to physicians as “Doctor,” and not call them by first name even when one might suggest that I do so. Very important, in my opinion, and I always insisted that NMA staff do so. It just seemed that is how it should be. I was always comfortable showing this respect for the members as they spent a tremendous amount of time, effort, and work achieving the status of their profession. This was even the case regarding an individual with whom I was a good friend during college days.

The NMA newsletter at the time was pink and had been since before 1960. The color may have been selected originally because it was the least expensive paper available for an in-house mimeograph printing process. The executive secretary at the time, Merrill Smith, was a former small-town newspaper editor/publisher who had been an employee of the NMA since 1935. At one point we attempted to modernize the newsletter by having an artist create a new look and change the color. The problem was that members of the NMA didn’t recognize the thing and readership disappeared. We changed back to pink and the response was gratifying. The Association also published the Nebraska Medical Journal for 80 plus years and won a few national awards along the way.

Kenneth Neff followed as the next executive secretary and as my boss, mentor, and friend. He gave advice, instructions and counsel to the small-town kid who knew nothing about association work in 1962. I enjoyed working for Ken and will always remember the great time we had traveling with our wives, Ida and Betty. Ken went to be with the Lord on August 28, 2018, at age 94.

A great deal of planning went toward the Annual Session. There were dual scientific programs that ran two full days. The 1962 Annual Session featured 27 guest speakers followed by one day devoted to sporting events.

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## Observations of 38 Years, 1962-2000 – Not a History of the Nebraska Medical Association... but Some Thoughts (continued)

At the time the NMA did not have a Board of Directors, but a five-member Board of Trustees that addressed finances only. Policy decisions were made by a Policy Committee comprised of the president, president-elect, and the three immediate past-presidents.

A highlight of responsibility as an NMA employee was working with and for the Auxiliary, eventually known as the Alliance (spouses' group). Their many projects including physician recognition activities, addressing domestic violence, the health gallery, and fundraising efforts were worthwhile and commendable. Their involvement in legislative issues, their Annual Legislative Day and NMPAC participation were of great assistance and importance.

In the early 1970s, professional liability insurance companies were, for the most part, leaving those states in which they were not the endorsed carrier. In Nebraska, this included such companies as Aetna and Hartford. Medical Protective was remaining in Nebraska but would only insure new physicians who joined a group currently insured by the company. A crisis situation was quickly developing. St. Paul insured a sizeable percentage of Nebraska physicians, so an NMA committee traveled to St. Paul, Minn., to request the company accept an endorsement by the NMA. An arrangement was agreed to. The increasing cost of professional liability coverage being experienced in the early 1970s prompted the NMA to seek remedial/stabilizing legislation in Nebraska. A committee of five physicians worked with legal counsel for approximately one year to draft the legislation, meeting nearly every two weeks. The legislation was passed by the Nebraska Legislature in 1976, and through a mechanism structured by the Department of Insurance, the Attorney General's office, and the NMA, it was submitted to the Supreme Court and declared constitutional soon after. The NMA funded this activity with a \$100 member assessment in 1976 and a \$150 assessment in 1984. Major effort preceded and subsequently included the passage of LB 434, the Hospital/Medical Liability Act.

The Association staff began providing administrative

services to Nebraska specialty societies/organizations in 1979 and due to the success and benefits to all involved in this activity it eventually provided services, to various degrees, for 10 organizations in addition to the NMA, the Nebraska Medical Foundation (NMF), and the Nebraska Medical Services Corporation.

The NMF was incorporated in 1948 as a nonprofit charitable organization. In the early years, the Foundation provided direct loans to medical students. In order to expand its volume of loans, an agreement was struck with the First National Bank and Trust Company of Lincoln under which the bank loaned \$12.50 for each dollar of guarantee provided by the NMF. This service grew to the point where approximately one million dollars was outstanding in student loans. The loan rate was 1 percent over prime, and the recipients were expected to begin some limited repayment when they started their residencies.

In my time at the NMA, I traveled a total of 119,920 ground and air miles within the state to commission and committee meetings outside Lincoln, country medical societies meetings, and travel to other NMA-reflected business. Outside the boundaries of Nebraska, I travelled a total of 369,868 miles.

The federation concept of organized medicine, has, in my mind, always been and continues to be crucial to the success of the mission to represent physician members to the extent desirable and necessary. The NMA had unified county, state, and AMA membership until 1973 when the NMA House decided to de-unify with the AMA. The NMA Board recommended in 1985 that Nebraska return to unified status, however the House of Delegates rejected the recommendation.

The dedication of members and elected officers to the NMA was highly commendable... as was the dedication of the staff I worked with over the years. Tremendous people dedicated to the mission of the NMA.

I am proud to have been given the opportunity and privilege to serve the members of the Nebraska Medical Association. □



# Reflections



By Sandy Johnson

When I received the call asking me if I would write about my time at the NMA, one thing will always stand out in my mind. As I arrived at the NMA, the cap on malpractice verdicts was being challenged in the Supreme Court, and I had the opportunity to accompany Chuck Pallesen and David Buntain and hear Mr.

Pallesen argue for the constitutionality of the cap. It was an experience I have always remembered. We waited 15 months before we received the court decision finding the cap constitutional. At that time only one other case had taken that long for a decision to be rendered. It was also at that time that our legislative team worked with the state Legislature to raise the cap from \$1.25 to \$1.75 million. We worked closely with Tim Wagner who was the director of the Department of Insurance as we worked on the stability of the Excess Liability Fund. The number of cases were rising, the amounts awarded were increased, and the funds were decreasing. We did work with the Legislature on the attachment point of liability cases which has proven successful in making the Fund stable to this day.

Another huge issue at the time was that St. Paul Insurance announced that they were going to pull out of the medical malpractice market. This was a very big deal for Nebraska as the NMA had endorsed them since the 1970s and they insured 60 percent of our market. Peter Whitted, MD, JD, chaired our Professional Liability Committee at the time. This committee spent many hours interviewing the four companies still in the Nebraska market. Ironically, at the June AMA meeting that year, Jerry Buckley, MD, at the head of COPIC, had approached me about having an interest in coming into the Nebraska market. Shortly after, Dr. Buckley and Gerry Lewis Jenkins were invited to meet with our committee. It was apparent from the beginning that they were a different company as they talked about risk management and patient safety. It did not take long for the committee to vote on endorsing

COPIC, and the NMA continues to do so to this day. When I retired from the NMA, COPIC asked if I would consider working on some special projects for them. I agreed to do so for a couple of years; it has now been 10 years! Dale Mahlman will now be taking my place there as I ride off in to the sunset once again.

Public health had a big emphasis during that time. In 2007, NMA Communications Director Carole Bates, on behalf of the NMA, accepted the Public Health Association Service Award for strong efforts to promote public health in Nebraska. We worked on passage of Nebraska's smoke-free law and fought diligently to keep the motorcycle helmet law. We created task forces on men's health, women's health, health care reform, and alcohol use by minors plus many others that addressed important issues where physicians can make a difference.

There were so many issues we worked on that it is impossible to begin to list them all. Standouts include a \$500,000 grant we received from the Physicians Foundation to assist members with EHRs, workers' compensation, mental health, and so many more. A real highlight for me was traveling the state with many of our presidents to share our work, but also to listen to member issues and concerns.

I was blessed with a great staff that worked very hard for the NMA. I had the privilege of working with some wonderful physicians who served as president while I was at the NMA – these included Drs. Patrick Brookhouser, Michael Horn, Michelle Petersen, Alan Thorson, Roger Meyer, Kryn Buckley, Rowen Zetterman, and Ron Asher. I feel like I left the NMA in good hands with Dale Mahlman. A big highlight for me personally was receiving the NMA Friend of Medicine Award. Having good presidents at the NMA makes such a difference for the organization, and the NMA has been blessed over the years with physicians who are willing to give so much of their time to make the profession better.

I look forward to many more years of success for the Nebraska Medical Association. □

## The NMA's Legacy of Advocacy (continued)

The NMA's interest in licensure laws continues to this day, as changes in medical practice such as telemedicine challenge existing regulatory needs. In addition, the NMA has devoted considerable resources to responding to proposals by a myriad of other health professions which encroach upon or otherwise affect the practice of medicine.

Since the State initially licensed physicians 125 years ago, more than 30 other types of providers have sought the protection and imprimatur of state credentialing. To help the Legislature sort through such proposals, the NMA in 1985 led the way in enacting a system to review proposed new professions and practice-scope changes. Since then, NMA physicians have been valuable participants in many of the statutory reviews that have been conducted.

In addition to medical liability and licensure issues, the NMA has always had a strong focus on public health. Over the decades, Nebraska physicians have advocated for many policies and programs to prevent disease, prolong

life, and promote health. NMA's founding physicians could not have foreseen the extent to which Nebraskans have benefited from their organizational efforts.

Such initiatives have included creation of the state board of health, the statewide collection of vital statistics, universal newborn screening, and the establishment of a cancer registry. More recently, Nebraska physicians have spearheaded efforts to pass the Clean Indoor Air Act, implement federal and state patient safety laws, regulate the use of tanning beds, and retain the requirement that all motorcycle riders wear helmets.

And so, as the NMA marks its 150th anniversary, Nebraska physicians can truly say, "What's past is prologue." As medicine continues to evolve and as health care policies remain an enduring topic of political debate, the need for effective advocacy is as strong as ever and should continue to be a central mission of the NMA. ☐

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## 4/89-4/90; A Year of Change (continued)

also important for local issues, but Nebraska remains the best place to practice medicine because of the Nebraska Hospital Medical Liability Act that was passed by the Unicameral in the early 1970s and has served to limit malpractice awards and keep insurance rates among the lowest in the nation. That one issue alone should make every physician willing to ante up the annual NMA dues, even if not an active part of the process.

(I will add that the years serving on the board, going

through the chairs of the presidency, and the opportunity to be involved at the AMA level were some of the most rewarding years of my professional life. Probably mainly because it got me out of the doctor's lounge where most were complaining about insurance, fees, patient issues, and workloads and got me in an environment where everyone, including our great NMA execs, wanted to make life better for physicians and their patients.) ☐

## Reflections From the First Female NMA President (continued)

specialties for women. Medical and surgical subspecialties continue to be under-represented. In academics, about 35 percent of associate professors are women physicians, but only 25 percent are full professors and less than 10 percent of women in leadership positions are department chairs.

One hundred and seventy years ago, women were refused admission to medical school: *"It was commonly assumed women were morally unfit to practice medicine, that they were ignorant, inexact, untrustworthy, un-businesslike, lacking in sense and mental perception, and contemptuous of logic. **Not to mention immodest.**"* In 1980, 130 years later, when a respected male OB/Gyn was asked if a woman would do well in OB, he said he didn't think that would work: "what husband would let his wife leave the vacuuming and the children to deliver a baby?" Thirty-five years later, a current medical student heard an attending joke that it should be allowed to make IUDs a requirement for female residents, that way the call schedule wouldn't be as difficult to accommodate pregnancy.

Understanding these things, the most important thing about being the first woman president is that it happened. Not because it was an eventful presidency, but that it was the presidency and because it went smoothly.

There have to be the firsts so there can be the seconds and the thirds and the 376,000 and counting. The **practice** of medicine is also changing rapidly with more emphasis being placed on balance between career and family for both men and women. Health care and electronic medical records are creating increased stress in an already stressful field. Physicians are being challenged from all sides and we have to support one another and encourage one another in the days ahead. Regardless of our age, our gender, or our ethnic background, and because of our experiences, it is most important to be involved. We cannot expect to move forward when we sit on the sidelines. Though the environment may not always be friendly or respectful, it is well worth your time and your effort to be there for **all** of our futures. □



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# 2019 NMA Advocacy Breakfast

February  
12  
2019  
7:30-9:00 a.m.

\* Please note new location

due to construction at the Capitol:

**Hruska Building,**

**Nebraska State Bar Association**

**Conference Room**

635 S. 14th Street, Suite 130

(West side of the Capitol)

For more information  
contact the NMA  
at (402) 474-4472,  
visit our website, or  
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# 2018 Annual Meeting Recap



## Britt Thedinger Installed as 2018-19 President of the Nebraska Medical Association

**B**ritt Thedinger, MD, of Omaha, was installed as 2018-19 president of the Nebraska Medical Association (NMA) on Friday, September 14 at the association's Annual Membership Meeting & House of Delegates. The event took place at the Regency Marriott in Omaha.

Dr. Thedinger was born and raised in Kansas City. He is a graduate of Vanderbilt University with a Bachelor's of Science in Molecular Biology. His medical degree is from the University of Kansas Medical School. Dr. Thedinger completed his residency in Otolaryngology – Head and Neck Surgery at Harvard University. He went on to complete an Otolaryngology – Neurotology fellowship with The Otolaryngology Group/Ear Foundation in Nashville. In 1992, Dr. Thedinger established Ear Specialists of Omaha, a private practice dedicated to the medical and surgical treatment of ear, hearing, and balance disorders in both children and adults.

Dr. Thedinger is a Past President of the Metro Omaha Medical Society and has served on the boards of Catholic Charities, Jesuit Partnership, Omaha Hearing School, and Duchesne Academy. He currently serves on The College of St. Mary Board of Directors and has been involved in the Omaha Chamber of Commerce. Dr. Thedinger has served six years each as vice speaker, then speaker of the NMA House of Delegates.

Dr. Thedinger is an active member of the NMA's Commission on Legislation & Governmental Affairs and the Commission on Professional Liability and is a longtime donor to NMPAC. □

## Welcome New Board Members



Todd Hlavaty, MD  
(President-elect)  
North Platte



George Hansen, MD  
Lincoln



Bob Wergin, MD  
Milford

*We'd like to offer a sincere thank you to our outgoing board members for their service to the NMA and the patients of Nebraska.*



Todd Pankratz, MD  
(2016-17 President)  
Hastings



Gerald Luckey, MD  
David City



Michelle Walsh, MD  
Lincoln



Jordan Warchol, MD  
Omaha

(continued on Page 17)

## 2018 Annual Meeting Recap (continued)

### 2018 Award Winners



#### **Distinguished Service to Medicine**

Alan Thorson, MD  
*Omaha*



#### **Physician of the Year**

John Massey, MD  
*Lincoln*



#### **Young Physician of the Year**

Michael Israel, MD  
*Lincoln*



#### **Friend of Medicine**

Evelyn McKnight, PhD  
*Fremont*

### 2018 50 Year Practitioners

Anil K. Agarwal, MD	Melvin Hoffman, MD
John F. Aita, MD	Ansar U. Khan, MD
Joseph C. Anderson, MD	Fred Kiechel, III, MD
Jehangir B. Bastani, MD	Terrence J. Kolbeck, MD
Larry C. Bausch, MD	Harvey A. Konigsberg, MD
David A. Baxter, III, MD	Charles A. Longo, Jr., MD
Subhash C. Bhatia, MD	Larry J. Marshall, MD
J. Kemper Campbell, MD	Fred A. Mausolf, MD
Peter F. Coccia, MD	Lonnie R. Mercier, MD
Richard E. Collins, II, MD	Eugene R. Schwenke, MD
Wallace E. Duff, MD	Carol L. Scott, MD
Donald E. Fischer, Jr., MD	William J. Smith, MD
John M. Ford, MD	Richard C. Sposato, MD
Richard O. Forsman, MD	Dennis F. Strauss, MD
Donald M. Gentry, MD	Dean F. Tamisiea, MD
Fredric B. Gnau, MD	Kay E. Ticen, MD
Michael L. Grush, MD	Robert T. Urban, MD
Robert D. Harry, MD	Donald M. Uzendoski, MD
George P. Hemstreet, III, MD	Fred E. Youngblood, MD
Jon J. Hinrichs, MD	

### 2018 Scholarship Winners

John Bader	Luke Kiefer
Andrea Bollom	Harrison Lang
Ben Branigan	Devor O'Connor
Noel Bruner	John Riley, III
David Bunker	Jeremy Reitingier
Margaret Butler	Alexandra Schelble
Christopher DeAngelo	Alicia Smith
Kaitlin Hehnke	Meghan Thacker
Sarah Hotovy	Eric Villanueva
Juliana Kennedy	Michael Visenio
Rohan Khazanchi	Zachary Wordekemper

View photos from our event on the NMA Facebook page! Make sure to Like our page when you are there. We are also on LinkedIn, Twitter, and Instagram.

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# 2018 Annual Session Resolutions

The following resolutions were presented and acted upon at the 2018 Annual Membership Meeting. *As a reminder, resolutions can be submitted to the NMA Board of Directors by any member at any time throughout the year.*

## RESOLUTION #1 – DESTIGMATIZING ADDICTION AND SUBSTANCE USE DISORDERS

WHEREAS, addiction is a chronic brain disease<sup>1</sup> and is the most severe form of substance use disorder, a chronic medical illness with potential for both relapse and recovery<sup>2</sup>, and

WHEREAS, 20.1 million Americans have a substance use disorder and only 6.9% receive treatment<sup>3</sup> and 1 in 7 people in the United States will develop a substance use disorder over the course of their lifetime<sup>2</sup>, and

WHEREAS, substance use disorder has historically been viewed as a moral failing and social problem rather than a chronic medical illness, and treatment of substance use disorders has been siloed from mainstream health care and patients with substance use disorders have been subjected to discrimination and stigma by the health care system and health care providers, and

WHEREAS, language related to substance use disorders shapes attitudes among health care professionals towards patients with addiction and commonly used terms like substance abuse and drug abuser explicitly and implicitly convey that patients are at fault for their disease<sup>4</sup> and influence perceptions and judgments even among highly trained, experienced health care professionals<sup>5</sup>, and

WHEREAS, negative attitudes among health care professionals regarding patients with substance use disorders are linked with reduced empathy and engagement with patients, reduced delivery of evidence-based treatment services and poorer patient outcomes<sup>6</sup>, and

WHEREAS, according to the U.S. Surgeon General<sup>2</sup>, clinically accurate, preferred terms include “substance use,” “substance misuse,” “substance use disorder,” “recovery,”<sup>3</sup> while non-preferred, stigmatizing terms include “substance abuse,” “drug abuse,” “addict,” “alcoholic,” and “clean” or “dirty,” therefore be it

RESOLVED, that the Nebraska Medical Association use

clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all discussions, resolutions, reports, and educational materials regarding substance use and addiction, and be it further

RESOLVED, that the Nebraska Medical Association encourage the use of patient-first language (patient with a substance use disorder, patient in recovery) in all internal and external communications regarding patients affected by substance use, and discourage the use of stigmatizing terms including substance abuse, drug abuser, addict, alcoholic, clean and dirty, and be it further

RESOLVED, that the Nebraska Medical Association educate the physicians of Nebraska on the appropriate use of clinically accurate terminology in treating patients with substance use disorders and encourage the adoption of non-stigmatizing and patient-first language throughout the state agencies of Nebraska.

Following introduction by Kelly Caverzagie, MD, and discussion of the resolution, a motion was made, seconded, and approved to accept by the HOD.

## RESOLUTION #2 – INTEGRATE OPIOID PRESCRIPTION MONITORING INTO ELECTRONIC HEALTH RECORDS

WHEREAS, Nebraska has an opioid prescription monitoring system, and

WHEREAS, this system is not generally integrated into electronic health records systems, and

WHEREAS, the lack of integration places administrative burdens on physicians and staff who must query the monitoring system in addition to using their electronic health records systems, and

WHEREAS, integration of data from a state monitoring system into electronic health records has been achieved in North Carolina, therefore be it

RESOLVED, that the Nebraska Medical Association will advocate for integration of the prescription drug monitoring system into electronic health records systems.

(continued on Page 19)

## 2018 Annual Session Resolutions (continued)

Following introduction by Marvin Bittner, MD, and discussion of the resolution, a motion was made, seconded, and approved to accept by the HOD.

### **RESOLUTION #3 – TWO YEARS VS THREE YEARS PHYSICIAN CREDENTIALING**

WHEREAS, the Joint Commission requires recredentialing of physicians in organizations such as hospitals every two years, and

WHEREAS, recredentialing is an administrative burden for physicians, and

WHEREAS, there is a lack of generally accepted evidence that recredentialing every two years promotes a safer clinical environment than re-credentialing every three years, and

WHEREAS, medical staff leadership continuously monitors medical staff employing such measures as Ongoing Professional Practice Evaluations and reports from the National Practitioner Data Bank, therefore be it

RESOLVED that the Nebraska Medical Association request our American Medical Association to study replacing The Joint Commission's 2-year recredentialing standard with a 3-year recredentialing standard.

Following introduction by Marvin Bittner, MD, and discussion of the resolution, a motion was made, seconded, and approved to accept by the HOD.

### **RESOLUTION #4 – AMEND THE RIGHTS OF THE TERMINALLY ILL ACT TO RECOGNIZE 'NEBRASKA EMERGENCY TREATMENT ORDERS' AS A STANDARDIZED HEALTH CARE DECLARATION**

WHEREAS the population living with serious, life-threatening illness, who often receive health care at multiple facilities and institutions is increasing, and

WHEREAS these people are often transported locally and regionally by Emergency Medical Services, and

WHEREAS Emergency Medical Services are required to initiate aggressive life sustaining treatment, despite the presence of a Declaration, unless they have a physician's order to the contrary, and

WHEREAS the Rights of the Terminally Ill Act of 1992 establishes the right of all citizens to make a declaration regarding their directives for medical treatment at a time of life-threatening illness or injury that leaves them unable to make medical decisions, and

WHEREAS these declarations, also known commonly as living wills, have been limited in their effectiveness due to vague and non-specific wording that is difficult to interpret at the time of medical emergency, and

WHEREAS the Nebraska Emergency Treatment Orders form has been developed and piloted by Nebraskan physicians and lawyers, therefore be it

RESOLVED that the Nebraska Medical Association support an amendment to the Rights of the Terminally Ill Act to

- a. Update the definition of "life sustaining treatment" and "terminal condition" to reflect modern medical practice;
- b. Offer a standardized declaration, the Nebraska Emergency Treatment Orders (NETO) form that includes: scope of treatment, indications for withdrawing treatment, desire for CPR, and long-term artificial nutrition and hydration;
- c. Allow this form to include medical orders written for Emergency Medical Services by the patient's doctor based on the patient's declaration;
- d. Include all declarations in the state health information exchange;
- e. Establish a periodical review of the standard form to adjust to changes in medical practice.

Following introduction by Lindsay Northam, MD, and discussion of the resolution, a motion was made for an amendment to the resolution as follows:

SUBJECT: RESOLUTION TO AMEND THE RIGHTS OF THE TERMINALLY ILL ACT AS A STANDARDIZED HEALTH CARE DECLARATION

- b. Offer a standardized health care declaration that includes: scope of treatment, indications for withdrawing treatment, desire for CPR, and long-term artificial nutrition and hydration.

*(continued on Page 20)*

## 2018 Annual Session Resolutions (continued)

Discussion followed. After discussion of the amendment, a motion was made, seconded, and approved to accept the amended resolution by the HOD.

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### **RESOLUTION #5 – NEUTRAL PAY FOR OUTPATIENT FACILITIES**

WHEREAS, The American Academy of Family Physicians (AAFP) has officially supported “Neutral Pay” for outpatient facilities, and

WHEREAS, passage of such a proposal will have diverse effects on Nebraska physicians and hospitals, and

WHEREAS, ample discussion of the risks and benefits is essential information for Nebraska physicians, and

WHEREAS, delegates to the AMA and other medical and political organizations need to know the will of Nebraska physicians, therefore be it

RESOLVED that this topic should be discussed at the NMA annual session and that the information should be disseminated to all Nebraska physicians both for educational purposes as well as to foster feedback.

Following introduction by Ron Asher, MD, and discussion of the resolution, a motion was made and seconded to postpone until 2019 House of Delegates. Discussion ensued. Motion failed.

A motion was made, seconded, and approved to refer this resolution to the NMA Board of Directors for review and action.

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### **RESOLUTION #6 – RECOMMENDING MEDICAL BOARD APPLICATION AND RENEWAL BE BROUGHT INTO COMPLIANCE WITH AMERICAN WITH DISABILITIES ACT (ADA)**

WHEREAS, physician suicide has reached alarming rates, and

WHEREAS, treatment of depression can reduce suicide rates, and

WHEREAS, physicians hesitate to seek treatment for mental health concerns due to fears about future employability, and

WHEREAS, AMA and Federation of State Medical Boards have advised states to revise the language of their Medical

Board applications and renewals to reflect current standards as outlined by the ADA specifically regarding the questions about health and mental health history (Section I - Conviction and Licensure Information, Section 2, Health, Mental Health, Substance Use questions), and

WHEREAS, Nebraska Medical Board application and renewal is currently not in compliance with ADA standards, therefore be it

RESOLVED, that the Nebraska Medical Association advocate to appropriate entities that the State of Nebraska Medical Board Application and renewal forms be amended to reflect ADA-appropriate language such that questions on the application be focused on current impairment or ability to perform job duties and not distant past history of illness or treatment.

Following introduction by Jamie Snyder, MD, and discussion of the resolution, a motion was made, seconded, and approved to accept by the HOD.

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### **RESOLUTION #7 – IMMIGRATION PROPOSAL TO DECREASE TRAUMA TO CHILDREN**

WHEREAS, immigration raids cause significant stress and trauma to the children of detained workers, and

WHEREAS, fear of immigration authorities can cause immigrant parents to avoid taking their child for medical care, and

WHEREAS, children of detained workers may suffer from depression, anxiety, and behavioral problems, and

WHEREAS, separation from parents can result in long-term alterations in brain development, and

WHEREAS, 6 million U.S. citizen children under the age of 18 live with a parent or family member who is undocumented, and

WHEREAS, immigration raids can leave children unattended/without a caregiver, and

WHEREAS, some children left unattended have no option except CPS custody and foster care, and

WHEREAS, it is often difficult for children in CPS custody and foster care to be reunited with their parents which adds to ongoing trauma to the children, and

*(continued on Page 21)*

## 2018 Annual Session Resolutions (continued)

WHEREAS, nursing infants are separated from their detained mothers, and

WHEREAS, prenatal care for pregnant women is disrupted during detention with potentially catastrophic consequences, and

WHEREAS, babies born to pregnant women who are apprehended are born prematurely, or are small for gestational age at birth, therefore be it

RESOLVED, that the Nebraska Medical Association supports changes to immigration policy that requires U.S. Immigration and Customs Enforcement (ICE) to contact local community support agencies to assist with coordinating childcare when workers are apprehended and to allow nonviolent immigrant detainees to be quickly reunited with their families while waiting their court date, and

BE IT FURTHER RESOLVED, that the Nebraska Medical Association encourage U.S. representatives and senators from Nebraska to submit federal legislation to ensure these actions.

Following introduction by Donna Faber, MD, and discussion of the resolution, a motion was made for an amendment to the resolution as follows:

THEREFORE BE IT RESOLVED, that the Nebraska Medical Association supports changes to immigration policy that urges U.S. Immigration and Customs Enforcement (ICE) to contact local community support agencies to assist with coordinating childcare when workers are apprehended and to allow nonviolent immigrant detainees to be quickly reunited with their families while waiting their court date, and

Discussion followed. After discussion of the amendment, a motion was made, seconded, and approved to accept the amended resolution by the HOD.

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### **RESOLUTION #8 – REVISE NEBRASKA STATUE 23-3211 TO ALLOW HEALTH CARE PROFESSIONALS TO WITHHOLD A RESIDENTIAL ADDRESS FROM THE PUBLIC RECORD**

WHEREAS, health care professionals are significantly exposed to violence or threats of violence relative to the general population with the health care field statistically one of the most violent non-law enforcement industries in the United States;<sup>1</sup> and

WHEREAS, in 2006, the State of Nebraska passed Statute 28-931 to help address this issue, making assault on an officer, emergency responder, certain employees, or a health care professional a Class IIIA felony; and

WHEREAS, from 2002 to 2013, health care workers were four times more likely than private industry workers, on average, to have incidents of serious workplace violence;<sup>2</sup> and

WHEREAS, 70% of actual violence is under-reported<sup>1</sup> and health care workers can be victims of violence in or near their home of residence; and

WHEREAS, law enforcement professionals can utilize Revised Statute 23-3211 which states “*Unless requested in writing, the county assessor and register of deeds shall withhold from the public the residential address of a law enforcement officer who applies to the county assessor in the county of his or her residence.*”<sup>3</sup> to limit access to their home address, and therefore be it

RESOLVED, that the Nebraska Medical Association advocate that the Nebraska Legislature Revise Statute 23-3211 to include health care professionals so these individuals have the choice to withhold a residential address at the county assessor and register of deeds from general public access in accordance with the same obligations that are currently contained within the existing statute.

Following introduction by Samuel Hutchinson, DO, and discussion of the resolution, a motion was made, seconded, and approved to accept by the HOD.

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### **RESOLUTION #9 – APPROPRIATE INTERVENTION AND PROTOCOL TO PROTECT INFANTS WITH POSITIVE DRUG SCREENS**

WHEREAS, there has been an increased awareness of drug exposed infants being born in communities across Nebraska, and

WHEREAS, these infants are being returned to the environment of exposure with limited support, often with the mother, and

WHEREAS, there are concerns of continued infant drug exposure through breastmilk and the environment, and

(continued on Page 22)



## 2018 Annual Session Resolutions (continued)

WHEREAS, there are increasing instances of high-risk infant situations including drug arrests of a birth parent within days of infant discharge, failure to follow up for infant exams and illnesses, and infants being released to parents with all previous siblings placed out of the home, therefore be it

RESOLVED, that the NMA work with the Nebraska Department of Health and Human Services and Child Protective Services, and other appropriate agencies, to determine an appropriate intervention and protocol to protect infants with positive drug screens and who are at risk for further drug exposure or injury if returned to the home.

Following introduction by Michelle Walsh, MD, and discussion of the resolution, a motion was made, seconded, and approved to accept by the HOD.

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### RESOLUTION #13 – DALE MAHLMAN

WHEREAS, Dale Mahlman joined the Nebraska Medical Association in 2003 as the front office receptionist and had the good fortune to follow in the footsteps of Sandy Johnson becoming the Executive Vice President of the NMA in 2007, has decided to retire on January 4, 2019, and

WHEREAS, Dale has a wife, Jackie, two daughters, two grandchildren, and two dogs who are the reasons for his NMA success, and

WHEREAS, Dale upon his retirement once again has the good fortune of following in Sandy Johnson's footsteps, will assume a position with COPIC, and

WHEREAS, when not at the COPIC office, which will be often, Dale will be found at Jet Splash in which he values his membership there just as much if not more than his membership at Hillcrest Country Club, and

WHEREAS, when Dale would tell people he was "going to get my nails done" this meant he was on his way to Hillcrest Country Club or some other golf venue to conduct "official" business, and

WHEREAS, like Sandy, Dale never missed a meeting and has committed to memory, the name, office location, home address, home and business phone numbers, likes and

dislikes, political nuances, and dietary restrictions of all 49 state senators, and

WHEREAS, if you see Dale walking the streets of Lincoln, the hallways of the Capitol, DHHS, or attending any meeting, he will be accompanied by a Styrofoam cup, and

WHEREAS, if you ever call Dale after hours no matter what time of day or night, he's always out walking the dogs, and

WHEREAS, Dale's comments about "Attitude and Effort" – "He/She is a Dandy" – "See you in the morn – be safe out there," his personal hygiene, beloved OCD habits and supreme "handyman" skills will be forever missed in the NMA office, and

WHEREAS, Dale has continued the NMA tradition of keeping the motorcycle helmet bill intact, therefore be it

RESOLVED, that the 2018 NMA Annual Meeting be dedicated to Dale Mahlman in honor of his dedication, time, efforts, sacrifice, leadership on behalf of our profession and association, physicians, our patients and the health of all Nebraskans, and be it further

RESOLVED, that Dale Mahlman receive our unending thanks for elevating the involvement, effectiveness, and awareness of our NMA across the state and country, with the Legislature and Governor's office, and with various business and public health entities, and be it further

RESOLVED, that Dale Mahlman receives a lifetime honorary membership in the Nebraska Medical Association and is permitted to miss one meeting of his choice prior to his official retirement day. And be it further

RESOLVED, congratulations, he will be missed.

Following introduction and discussion of the resolution, a motion was made, seconded, and approved with a round of applause. Mr. Mahlman was presented with a variety of gifts for his never-ending service to the NMA.

Questions about this year's resolutions can be directed to NMA Executive Vice President Dale Mahlman (dalem@nebmed.org) or NMA Executive Vice President Designee Amy Reynoldson (amyr@nebmed.org) or (402) 474-4472. ☐

## New Members

### Kearney

Anuradha Tunuguntla,  
MBBS, FACC  
Jason Shuda, MD  
Syed Mehdi, MD

### Lincoln

Hemantha Koduri, MD,  
FACP  
James Roat, MD  
Rick Fermelia, MD, FACS  
Suzette Clarke, MD  
Adam Pleas, MD

### Omaha

Syed Alam, MD  
Geoffrey Allison, MD  
Lekha Anantuni  
Daniel Crespo  
Artunduaga, MD  
Micah Beachy, DO  
Allison Bell, MD  
Scott Benson  
Jennifer Bourne, MD  
Rachel Bowers, MD  
Kristin Bremer, MD

Kevin Brittan  
Brenton Bussinger  
Alex Cantral  
Christina Case  
Kelly Cawcutt, MD  
Lillia Cherkassiy, MD  
Robin Chirackal, MBBS  
Dallin Christensen, MD  
Samantha Cox  
Lauren Crowther  
Steven Curry, MD  
Arianna Dalamaggas  
Amanda Dave, MD  
Navdeep Dehal, MD  
Adriano DellaPolla  
Luke Desilet, DO  
Paul DiGiovanni  
Kyle Drehmel  
Jalal Dufani, MD  
Julie Eclov, MD, PhD  
Alisandrea Elson, MD  
Amanda Emmert, DO  
David Fu  
Kali Gagnon, DO  
Alheli Arce Gastelum, MD  
Caitlin Gillespie, DO

Grant Goertzen  
Connor Griggs  
Nicole Gruner, MD  
Sai Giridhar Gundepalli, MD  
Mounika Guduru, MD  
Navnika Gupta, MBBS  
Nicole Heafner  
Dalton Hegeholz  
Frances Hindt, MD  
Kyle Hinz  
Ryan Hunter, MD  
Samuel Hutchinson, DO  
Archana Kanteti, MD  
Umair Khan, MD  
Darby Luckey, DO  
Dhilhan Marasinghe, MD  
Rachel Marlow, MD  
Peter Martin, DO  
Philip McCarthy, DO, MPH  
Amber McMahon  
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# Medical Student Update

## Strategies to Enhance Intellectual Development and Interpersonal Skills in Medical Education in the Era of Electronic Medical Record



By Haley D. Heibel  
Creighton University School of Medicine

The physician made eye contact with me as I spoke, "The patient was afebrile overnight and this morning." "What were his labs this morning?" she asked. She took notes as I recited his laboratory values. When we moved on to discuss the physical examination findings from

the morning, I was enthusiastic to share with the attending physician the changes I had noted from my previous examination because I recognized she was paying attention to what I had to say. The residents and other medical students similarly made eye contact and waited eagerly to hear what the physical examination findings were. When the team rounded, we discussed treatment plans together with the patient and took notes on a notepad. I sincerely felt that we were functioning as a team. The attending physician provided an environment that encouraged active listening and team participation through her example.

The increasing use of electronic devices for patient care creates new obstacles for delivery of patient care and medical education. It can additionally be a distraction for the novice medical student. Although learning how to become competent in the use of electronic medical records (EMR) is one necessary skill the student must learn, there are several other aspects in clinical education that take precedence. These include understanding the diagnosis and management of medical conditions, completing a thorough yet focused physical examination, and learning to connect with patients. It is important that medical students learn discipline with the use of electronics, and it can begin through observation of attending physicians.

Physicians, residents, and medical students who have adjusted to the use of EMR face new challenges in their interactions with patients. Active listening becomes more

difficult when the focus becomes ensuring that the correct checkboxes have been filled on a template. Additionally, it is important to develop awareness of how the use of EMR may alter physicians' interactions with residents and medical students.

However, it is not just interpersonal interactions that may be altered with the use of EMR, but the mental processes involved in medical decision-making. Reich<sup>1</sup> describes how the thought processes of a hospitalist were transformed when adopting EMR. She initially had used a critical analysis of the patient's signs and symptoms to determine which diagnostic tests to order to arrive at a diagnosis, but when introduced to the order sets of EMR, she felt an urgency to arrive at a diagnosis early in the process of clinical evaluation. Embi et al<sup>2</sup> suggest that the use of EMR may inhibit intellectual development by physicians' recognition that there was a diminished expression of thought processes in residents' electronic medical documentation, and an inclination for residents to report medical data without thoughtful interpretation.

There are reasons to be optimistic about the use of EMR in medical education and training, as it offers innovative opportunities for physicians to create a stimulating educational environment and to discuss patient cases. Through increased documentation availability educators may emphasize providing feedback specific to diagnostic reasoning. Encouraging the use of dictated notes in medical student education requires students to actively think about their documentation and may enhance oral presentation skills. □

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# Medical Student Update

## AMA Calls for Action to Combat Gun Violence

By Laura Newton  
UNMC

At the AMA's Annual Meeting this past June, physician delegates overwhelmingly voted in favor of adopting a stronger stance on gun violence. This action speaks to the societal relevance of the AMA as our country continues to battle mass shootings, street violence, and rising suicide rates.

This is not the first time the AMA has taken steps to address gun violence; over the past few decades it has put forth policies supporting efforts to ban assault weapons, declaring gun violence a public health crisis, pressing for more research on prevention, and calling for stronger background checks and better funding for mental health services. However, amidst mounting frustration about the continued inaction from both state and federal lawmakers and the inability to find common ground to address this public health crisis, the AMA chose to adopt policies that reaffirm and further strengthen its stance on this urgent issue.

The policies AMA delegates voted to adopt in June include:

- Support for increasing the legal age for purchase or possession of guns and ammunition from 18 to 21
- Advocacy for schools as gun-free zones
- Support for a ban on assault-type weapons and high-capacity magazines
- Support for legislation that requires registration of all firearms as well as licensing and safety courses for gun owners

- Opposition to federal legislation permitting "concealed carry reciprocity" across state lines
- Support for legislation permitting relatives of suicidal individuals or those who have threatened imminent violence to seek court-ordered removal of guns from the home
- Encouragement and resources for better physician training in how to recognize patients at risk for suicide
- Elimination of legislative loopholes to prevent purchase or possession of guns by individuals found guilty of domestic violence or convicted for stalking

Physicians across the nation bear witness to the devastating impact of gun violence on individuals, families, and communities nationwide. With firearms ranking as the twelfth most common cause of death in the United States and the third most common in children, we as advocates for the health of our communities have a duty to call for recognition of gun violence as a public health crisis and for legislative action to address it as such. For me personally, witnessing the AMA speak out about gun violence has demonstrated the powerful ways we can advocate for our patients outside the clinic or hospital by calling for policies that promote healthy communities. The AMA provides an excellent platform for this kind of advocacy, and I look forward to seeing how our UNMC chapter will continue to engage with AMA colleagues both locally and nationally in these efforts. □





# Nebraska Medical Association Insurance Group, Medical Professional Liability Insurance



*By Tim McMahon CIC, AIC*

*Tim McMahon is a Sales Executive with Nebraska Medical Association Insurance Group.*

## Career Milestones for Physicians

Occasionally, I attempt to surprise my wife with home improvement projects to show initiative and skill in hopes of receiving praise and permission for my hobbies. The pantry was in need of reorganization, so I made my first (and likely last) trek to Bed Bath & Beyond for some ideas. Two hanging spice racks were just the ticket!

My ability to correctly space and level the racks was superior even to the multitude of professionals featured on HGTV. My wife would be so impressed! Yet when she came home, a look of horror (somehow combined with shades of complete pity and shame) came over her face. While perfectly level, the screws on the right side had come through the beautiful new cabinetry exposed on the other side of the wall...

Enter Billy the Painter. Billy saved my bacon! While he was able to repair and repaint the damaged cabinetry perfectly, he also did his best to help minimize the damage to my ego. With masterfully placed examples and pregnant pauses, he convinced my wife that I'm not the only moron in town. He receives calls daily from homeowners with similar "challenges."

I'm old enough to know better. I should have consulted a professional, took time to evaluate the consequences, or simply asked my wife. As a physician travels through the various milestones in a career, many varied opportunities and circumstances will be presented. While it's impossible to plan out the future perfectly, there is great value in seeking a professional opinion when contemplating the next step in a career or business venture. In this article, we will discuss the significant milestones as it concerns medical professional liability insurance.

During medical school and residency, you are concentrating on academics, patient interaction, and applying both to be the best physician you can be. When

the time comes to decide where you will begin your career, how much time do you devote to reviewing contract terms about professional liability insurance? Is there language on your obligation to pay for a "tail" should you leave before X number of years? Do you know how much that "tail" could cost? Do you know what a "tail" is? If you are planning to practice in Nebraska, make certain that you become familiar with the Nebraska Hospital-Medical Liability Act and the Excess Liability Fund. In particular here, be aware of the need to "tail" out your Fund coverage in parallel with your underlying insurance policy.

Understanding the end game will benefit you should another career opportunity arise sooner than you planned, or if a change in your personal life dictates a move. Understanding the concept of claims-made professional liability policies in general, coupled with knowledge of the Nebraska Excess Liability Fund requirements, will help guide you the rest of your career. Contact a professional at this stage for a Med Mal Insurance 101 review. Or...you can call "Billy" years later.

Throughout your career in medicine, you will visit with attorneys, accountants, and financial planners. You'll receive advice on when, if, and why to form a PC, LLC, etc. for your practice. The advice will likely be with purpose, but don't forget to contact your insurance agent before the formation of such entities. Will the entity employ more than just yourself? Will the entity hold assets? These are only a few of the questions your agent will present to you. The entity will most likely need to be added to one or more of your insurance policies, and in some cases, there may be additional premium due should the exposure to the insurance carrier increase.

You may be in a leadership and/or ownership position within a physician group, and with that comes the responsibility of ensuring that the practice is properly covered. The practice of medicine has evolved, and so has medical professional liability insurance. For example, it's widely understood now that the healthcare industry is one of the top two targets of cybercriminals. Have you reviewed the cyber liability endorsement that is likely attached to

*(continued on Page 27)*

## Nebraska Medical Association Insurance Group, Medical Professional Liability Insurance (continued)

your policy? Do you have limits sufficient enough to finance a full-scale breach? What if your staff comes to work in the morning to find that your system is being held hostage, and the hacker is asking for a ransom? Do they know who to call?

The medical professional liability insurance environment is as competitive as it has been in the past 15 years in both pricing and coverage. When was the last time you reviewed all aspects of your insurance policy? Special consideration should be given to understanding the exclusions (what is NOT covered), the consent to settle provisions, retirement tail provisions, billing fraud and abuse defense limits, licensure defense limits, and early claim resolution services.

Furthermore, there is an abundance of risk management information and resources available to physicians and staff via the insurance companies. Does your company have risk management professionals ready and available to walk you and your team through the online resources as well as visit your clinic for assessments and in-services? Already practicing telemedicine or considering it? Most companies have best-practices material online and risk managers to help guide you in this ever-emerging segment of practice. And, don't forget to consult with your agent to ensure compliance with the Nebraska Excess Liability Fund requirements. Make it a point to have staff leadership log in and review your carrier's online resources.

Finally, you are ready to retire. Or are you? In my 17 years in this industry, this has been one of the most challenging decisions physicians face. Before you make your final decision, discuss your plan with your insurance agent. If you decide to work part-time and phase into retirement, you may qualify for a part-time discount.

When you fully retire, you may be entitled to a free or reduced cost tail. What if you reverse course and come out of retirement?

The considerations to be given to your professional liability coverage are extensive but can be placed into proper context by a thorough review and discussion with your agent. This is especially important in Nebraska for reasons already noted. That's what we do at Nebraska Medical Association Insurance Group. Give us a call now, or you can call "Billy" later.

*Tim McMahon is available at (402) 861-7011 or [timmm@nebmed.org](mailto:timmm@nebmed.org).*



### **About NMAIG (Nebraska Medical Association Insurance Group)**

*NMAIG, a partnership between NMA and The Harry A. Koch Co., provides services statewide to NMA physicians, their families, and employees. The Koch Co. has been insuring the health care industry for over 50 years. We currently work with 40 acute care and critical access hospitals, as well as 1,500 physicians in Nebraska and the surrounding area. They range in size from solo practitioners to fully integrated health care systems. The dedicated team of insurance professionals is ready to develop programs that fit your needs from commercial insurance and employee benefits to personal insurance.*

## Ask a Lawyer

### Mandatory Reporting to the National Practitioner Data Bank: When does a resignation of privileges with a hospital trigger a mandatory duty to report a physician to the National Practitioner Data Bank?

If a physician is under investigation for issues of professional conduct or competence, resigning one's clinical privileges risks triggering a health care facility's mandatory duty to report the matter to the National Practitioner Data Bank ("NPDB").

If a mandatory duty to report exists, a facility must submit a report to the NPDB with a copy to the Nebraska Department of Health & Human Services Licensure Unit within 30 days.

Hospitals and other health care entities that follow a formal peer review process are required to file reports with the NPDB whenever they take an "adverse clinical privileging action" against a physician under certain circumstances. If the adverse action involves a professional review action that adversely affects a physician or a dentist's clinical privileges for more than 30 days, or if it involves accepting the surrender of "clinical privileges or any restriction of such privileges by a physician or dentist" while the physician or dentist is "under investigation" by the entity relating to "possible incompetence" or "improper professional conduct," or "in return for not conducting such an investigation or proceeding," a mandatory duty to report the action to the NPDB arises. 45 C.F.R. § 60.12(a)(1)(i) & (ii).

Generally, the withdrawal of an initial application for medical staff appointment or clinical privileges before a professional review action occurs, should not be reportable to the NPDB. However, the question becomes more complicated if the physician is "under investigation" by the facility for possible incompetence or improper professional conduct or if the withdrawal is in return for not having such an investigation or professional review action. Note that, a "professional review action" is an action or recommendation of a health care entity that (1) occurs during a professional review activity, (2) is based upon the professional competence or professional conduct of an individual practitioner that adversely affects or could adversely affect the health or welfare of a patient or patients, (3) "which affects or could affect adverse a physician's privileges . . ." "Professional review activity" means a health care entity's activities to determine whether an

individual physician may have clinical privileges, to determine their scope or any conditions upon them, or to change such privileges. 45 C.F.R. § 60.3.

According to the *NPDB Guidebook*, a physician's voluntary withdrawal of an application for privileges or nonrenewal of medical staff membership or privileges while under investigation by a health care facility for possible incompetence or improper professional conduct or to avoid such an investigation, must be reported by the facility to the NPDB. See U.S. Dep't of Health & Human Services, Health Resources and Services Admin., Bureau of Health Workforce, *NPDB Guidebook*, at 110 (April 2015). In either circumstance, a physician's knowledge of an investigation being conducted is not required. *Id.*

Although the NPDB defines "investigation" very broadly, the term is not synonymous with ordinary, routine, quality improvement or peer review activities as to all practitioners or even as to a particular practitioner. Routine or general reviews of cases or practitioners are not considered "investigations" for purposes of NPDB reporting. However, if issues related to a particular physician's professional competence or conduct are identified, the process involved in such review is likely to be considered an "investigation." The term is not controlled by how it is defined in a facility's medical staff bylaws, policies, or procedures. *Id.* at 111. An investigation is likely to exist for purposes of the NPDB reporting duty if the activity would be a "precursor" to a professional review action. *Id.*

*Ask a Lawyer* is a feature of the NMA Advocate. If you have a legal question of general interest, please write the Nebraska Medical Association. Answers to submitted questions are provided by the Nebraska Medical Association's legal counsel, Cline Williams Wright Johnson & Oldfather, L.L.P., 1900 U.S. Bank Building, 233 S. 13th St., Suite 1900, Lincoln, NE 68508–2095. The answer in this issue was provided by Jill Jensen of the Cline Williams Law Firm. Questions relating to specific, detailed, and factual situations should continue to be referred to your own counsel.

# Navigating the Risks of Curbside Consults

## Key Considerations for Those Being Asked for (or Seeking) Advice

By Dennis Boyle M.D.

COPIC Department of Patient Safety and Risk Management

*SCENARIO 1: A PCP sees a patient who has just returned from Southeast Asia and is suffering from severe diarrhea. Later that day in the hospital cafeteria, the PCP bumps into a colleague who is an infectious disease specialist. The PCP asks his colleague “what is best to treat traveler’s diarrhea from Southeast Asia for a patient with a sulfa allergy?”*

*SCENARIO 2: A midwife calls an obstetrician (who she doesn’t know) and asks her to look at a patient’s fetal monitoring strip. It’s later in the evening and the midwife doesn’t want the obstetrician to see the patient and insists on just getting her advice.*

Which of the above scenarios may increase liability risk for the physician who is being asked for his or her advice? Both of these situations are examples of informal consults, also referred to as “curbside consults.” But, there is a key distinction: one of the scenarios represents asking a colleague for more general information, while the other is asking for very specific advice on a patient.

In simple terms, a curbside consult is an informal solicitation of another physician’s advice or opinion. It is generally characterized by the following:

- Typically limited in scope.
- The physician being consulted doesn’t review the patient’s chart, talk to the patient, or examine the patient.
- Often times, it involves physician colleagues who know each other.
- The physician being consulted does not charge for his or her service or have a financial relationship for the consultation.
- The consults can occur on the phone, in person, or via email.

### IS THERE A PHYSICIAN-PATIENT RELATIONSHIP?

This is the core question in terms of liability with curbside consults. Here are some factors that are examined in order to answer this:

- Does the consultant physician have a formal contract or agreement with the treating physician or the hospital/facility where the treating physician works?

- Is there a financial relationship (i.e., is your group paid to be on call or do you bill to answer the question)? Any financial remuneration is a key factor in establishing a physician-patient relationship, and if a court finds a monetary relationship with the consultant, there will likely be liability.
- How complex is the advice being sought? Low-risk consults would include general informational requests, no request for a diagnosis or testing, and non-specific advice. A question such as “how long should you be off of an anti-platelet drug pre-scope?” would be considered a simple, informational question. Whereas “when would you do surgery on this patient?” would require more details than a simple phone discussion.
- How much is the asking physician relying on the advice of the physician who is consulted? An “implied” physician-patient relationship may be established when a physician provides advice that changes a patient’s treatment plan, even if it is via another medical provider.
- An implied physician-patient relationship does exist if you are covering a patient for a colleague. This also applies for physicians who are supervising allied health professionals when the physician is responsible for making a patient care decision.

The more a physician being consulted provides advice specific to a patient, like ordering tests or adjusting medication, the more likely the physician may be exposed to liability or may be viewed as part of the care team.

### CLARITY IN COMMUNICATION IS IMPORTANT

The requesting provider should be very clear and keep questions concise and general. They should also ask themselves if an official consult is warranted. Make sure you provide adequate information that is not colored by the answer you want. If you are asking for specific advice, offer the consultant a chance to officially see the patient.

On the part of the informal consultant, clarify whether your discussion is going to be documented in the medical record. If you believe the case warrants you officially seeing the patient, then say so. If the requestor is going to document your discussion, review the wording that they will be using. □





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## Should I Invest the Money I Am Saving for a Future Purchase?

MATT MOKLESTAD, CFP®, MBA, AIF®, *Advisor*

I am a self-proclaimed member of what I like to call the “Van Clan”. No, I’m not part of the adventurous group of people that travel around the world in campervans. My wife and I just have a plain old minivan that we carry our three kids around in. Although not the coolest of vehicles, I’ll admit that it’s extremely practical, and the sliding doors are nice. However, our van keeps having issues, and we are probably going to have to replace it within the next few years.

Consequently, we have begun to set aside dollars for this future purchase, which brings up the question: “Should we invest this money?” We often get this question from clients, and our answer is usually the same; it depends.

When it comes to saving and investing, a lot depends on your time frame. A general rule of thumb is that you shouldn’t invest in stocks if you need the money in five years or less. Five years is still a relatively short time period for something as unpredictable as the stock market, so you may want to be even more conservative. The last thing you want is for there to be a market downturn without enough time for your investments to recover before you need the money.

Question: “What about investing in fixed income for shorter-term needs?”

Again, it depends. I recently wrote a blog about the two primary characteristics we focus on when choosing the bond funds in our portfolios; maturity and credit. Both are important to consider because the longer the maturity and the lower the credit quality, the more volatile the holding will be.

Here are a few thoughts on investing in fixed income for short-term cash needs:

- Overall, stick with high quality bonds. Lower quality bonds, which some advisors refer to as high yield or “junk” bonds, tend to be riskier and more correlated with equity markets, meaning they will likely go down as stocks fall.
- Short-term (1-2 years) cash needs are best met with short-term bonds, because of their lower volatility.
- Intermediate-term needs (3 years and beyond) may be better met with longer, intermediate-term bonds.

Some investors like to match their time frame with the maturity of an individual bond. For example, if you know that you have a liability coming due in three years, you could buy a bond that matures in three years to match the liability. However, there are other considerations involved in buying individual bonds, like liquidity, lack of diversification, and potentially higher transaction costs to name a few. For short-term cash needs we prefer to use either money market funds (cash) or bond funds with a duration closely matched to the investment time frame. This provides diversification and daily liquidity, often at a very low cost.

So how do you think my wife and I should invest the money we are saving for a new vehicle? Because our time frame is short (the van may stop running in three years or less!), we have opted to save this money in short-term high-quality bond funds.

Everyone’s situation is different, and there often are many things to consider before making an investment decision. It’s always a good idea to review your financial plan with your financial advisor before making an investment decision.

**For a complimentary, no-obligation financial Second Opinion, please call 1-844-437-1102**

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