Recommended Reading: The New Medicine and the Old Ethics by Albert R. Jonsen
"...federal payment for Medical Services has changed medical practice in major ways."
The same could be said for payment by other third party payors.

LEE COUNTY MEDICAL SOCIETY

# Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 22, NO. 2

Fort Myers, Florida
Mary C. Blue, M.D.

April, 1998

## NO APRIL MEETING

NEXT GENERAL MEETING

**May 18, 1998**

*"Medical Families' Involvement In Politics"*

**Speaker:** Rep. Burt Saunders

## STATUS QUO HAS GOT TO GO

*Bruce J. Lipschutz, D.O.*
*Secretary, Lee County Medical Society*

I waved good-bye to my wife and daughter and was off to D.C. for my first AMA Leadership Conference. The program listed some real heavyweights in the speaking industry - Bill, Ted, Newt, and Colin. Was this meeting going to be some political circus, or would it have some real meaning? Sunday, March 8th highlighted a day of break-out and general sessions. My curiosity about the AMA organization turned to one of amazement to see hundreds of doctors coming together from all over the States to represent their Medical Societies.

The common theme of the day and the Conference turned to patients - their rights, their health and their well being. Speaker after speaker considered that the patient was the central character.

President Clinton urged for tougher legislation/regulation of tobacco, especially to minors. Ted Kennedy fostered more health care for all. Newt Gingrich echoed Bill Thompson (Congressman from California) who spoke of letting the free market bring down costs and improve quality via medical savings accounts and the like.

But most of all, Colin Powell stirred us to realize that his Program for Youth was targeted to prevent the drugs, violence, tobacco and poor life styles that all lead to later health issues. His words about his own past were inspiring.

*It then became clear that this organization of administrators, leaders, doctors and meetings really is something much more than that.* The AMA continues to represent all of us, especially the patient to the Congress and HCFA on issues such as:

- Evaluation and management coding
- Frivolous fraud and abuse
- Gag clauses for doctors and managed care
- Tobacco regulation
- Private contracting of physicians with insurance companies

The AMA continues to fight for your patients - little did I understand this while isolated evaluating my office patients, prior to my trip to Washington. Leaders of the country are getting the message because of the AMA and so should we all.

Responsiveness to change, relevance to the needs and concerns of physicians, and the reality of AMA policies is how the AMA will move forward, keeping our vision, member service and unity.

Like AMA President Percy Wootton said *"Status Quo Has Got to Go"* if we are to move forward for the benefit of all of our patients.

## 3rd ANNUAL GOLF TOURNAMENT "LEGAL-MEDICAL CHALLENGE CUP"

**SUNDAY, MAY 17, 1998**

1:00 pm ~ Shotgun/2 person teams
Lexington Country Club
Contact:
Dr. John Petersen or
Dr. Scott Harris 939-9939
Sign-up form in Society Office

## PRESIDENT'S MESSAGE

*David M. Reardon, M.D.*

### "SEASON OF CHANGE"

Spring is upon us. It is the season of change. The boys of summer are in town. Men play a boy's game on fresh green fields with crisply chalked lines. The past is history and the future of the long season ahead is perfect.

Bruce Lipschutz and I just came back from the AMA National Leadership Conference (NLC) in Washington, DC and I am as optimistic as a rookie in spring training. The meeting was an impressive display of the effect that the AMA has had on your behalf in Washington. One powerful leader after another addressed the enthusiastic conferees with a message of change signaling to me, at least, that they have gotten "the message" from the physicians through the efforts of the AMA and from our patients. The list of speakers was awe-inspiring: President Bill Clinton, General Colin Powell, Speaker of the House Newt Gingrich, Supreme Court Justice Antonin Scalia, Senator Edward Kennedy, Senator Phil Graham, Senator Spencer Abraham, Administrative Chair of the National Bipartisan Commission, Representative Bill Thomas, and Head of HCFA Nancy Ann Min-DeParle.

It may be the springtime of a new era in Washington. Almost every speaker spoke of change. Change in health care, the insurance industry, the tobacco industry, in social security, and in Medicare. Many of the goals of change espoused from both sides of the political aisle are the same. Our leaders discussed a Patients' Bill of Rights, which would include removing ERISAs so that health plans would be liable for medical decision making, ban on gag clauses, broader freedom for physicians to negotiate terms of patient treatment, appropriate safeguards to insure the confidentiality of patient medical records. All speakers felt doctors should make medical decisions, not accountants for HMOs.

There were some differences, however. The two most obvious were the Democrats wish to expand Medicare to those who have lost their private insurance through job loss, change, or retirement and Democratic opposition to medical malpractice reform and general tort reform. The Republicans clearly disagreed, questioning why a system that is broken, on the verge of bankruptcy and recently patched together until 2010 by the slick accounting maneuver of shifting the fastest growing segment of Medicare, home health, from a Part A program to a Part B program, would be expanded!

The point is, the time is right for change. Though the espoused goals appear to be the same, the crisp chalked lines of the playing field will be drawn over how the measures will be achieved. In the most simplistic terms, those in the Camp of President Clinton and Senator Kennedy will continue to "allow" the market forces implemented by privately run HMOs to shape the new landscape of medicine, but any imperfections will be addressed with ever increasing bureaucratic rules and regulations. I believe this will continue to choke our practices with burdensome and superfluous paperwork and hassles, detracting from time spent engaged in patient care and therefore compromising quality.

Those ascribing to a smaller government solution were Rep. Newt Gingrich, Sen. Phil Graham, Rep. Bill Thomas, and Sen. Spencer Abraham. They believe that by putting health care dollars, health care decision making and appropriate tax incentives in the hands of the patients a true free market in health care would result, creating controlled market cost reductions and a demand for continued, and most likely, increasing quality. This is certainly the case in every other industry where real market forces are allowed to work.

I could bog you down with a wealth of information I learned at the NLC. Giving you details of how the health care industry as we know it, with 95 cents of every health care dollar coming from a third party payer and tax incentives for the industry, not individuals, is an illogical aberration that arose as a way to bypass wage and price controls implemented during WWII. This disconnection of the patient from the payment for services has driven up demand, consumption, and the price of health care. Or the fact that government "fixes" of Medicare over the years have resulted in over 45,000 pages of HCFA regulations (this is in contrast to the IRS having only 12,000 pages of regulations). But I won't burden you.

We stand on the verge of this change but our jobs are not complete. Market forces have begun to act but the evolution is not yet finished. If we implement bureaucratic stopgap measures to "fix" the imperfections of managed care, we could wind up with a system having the worst features of both worlds. We must work with our legislators directly and through the AMA to allow the evolution toward a competitive, free market system to reach maturity. We must not act in haste as we sense this opportunity. We must be thoughtful and persistent in our actions.

You may ask yourself, "How, in the midst of this chaos we know as medicine, did we arrive at a place where the leaders of the country dare to make changes in health care which are potentially more positive than any we have seen in our lifetime?" The answer is simple - the AMA. In the words of Speaker Gingrich, "You can't appreciate what your Society has done for you in Washington." For those physicians who tell others and me, the AMA is "not relevant and does nothing for me"...think again. If the AMA were irrelevant, why would the most powerful and influential leaders in our society today take time from their busy schedules to address us with their concerns regarding the health of our patients and the status of our profession? So, if you are not a member of the AMA, join today! If you are a member, when a colleague next admonishes you telling you how "the AMA does nothing for me" let them know that it is the most respected and effective voice we have as physicians and they should join.

*We still have a long season ahead but the future is ours to shape.*

## AS I RECALL...

*Roger D. Scott, M.D.*

### "A LONG WAY BABY"

In 1958 when one saw a woman in the hospital with a highly starched white uniform, white cap and a pin, one knew that this was an RN. The cap was designed specifically for her School of Nursing and was very distinctive. In fact when I first came to Fort Myers I was able to identify a graduate from the Maryland School of Nursing by her cap. Incidentally, she is no longer nursing but is still around Fort Myers. In those days male nurses were as scarce as hen's teeth. When a Doctor arrived on the floor, nurses immediately jumped up to a standing position and offered any assistance possible in the care of the patients. This was always a bit embarrassing as I had always stood for a woman. There were some LPN's around but not many and most of the RN's did much of the menial labors. In fact, in the operating room on weekends when it was not active, the nurses always shined our white operating shoes for us. I haven't had a nurse offer to shine my shoes in a long time. Private Duty Nurses often attended the most severely ill patients as there were no ICU's. It was not customary for nurses to advance beyond nursing supervisor or as Head of Nursing. The one subspecialty or special field was Nurse Anesthesia but basically the nurses today have far expanded fields available. Even though "we have come along way baby", I still like the old nurse uniform; they were certainly distinctive and a badge of honor but I'm sure that the current nurses are happier not to have to wash and starch the uniforms but to appear in scrubs and other less complicated outfits. You know, we really owe a great deal to our nursing associates as they have provided so much in medicine for the care of patients and their families, as well as, support to the physicians.

The term "Doc" was pretty much considered a slang expression and most people did not refer to physicians as "Doc". Docks were considered to be for attaching a boat rather than a professional.

Most doctors' offices, as well as businesses, used fountain pens rather than the relatively new ball point pen. In fact, some documents were not considered legal when signed by a ball point pen! I wonder how many of you today have ever used a fountain pen and blotter as these are pretty well fallen by the wayside. Ball point pens were first produced in the latter stages of WWII when they were exclusively used by the military and were then released for civilian use after the war was over.

Appreciate Wally Dawson's comments and I concur. Joe Selden was like a big brother to me. Wally had a great singing voice and often sang "Primrose Lane" while assisting me in the O.R. It was the custom for Family Doctors to assist with their patients.

## In This Issue...

**LEE COUNTY MEDICAL SOCIETY BULLETIN**
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The Editors welcome contributions from the members. Opinions expressed in the BULLETIN are those of the individual authors and do not necessarily reflect policies of the Society.

## MEMBERSHIP ACTIVITY

### APPROVED FOR ACTIVE STATUS

Charles Brown, M.D. Pamela Hackl, D.O.
Alexandra Konowal, D.O. Brian Schwartz, M.D.
Michael Weiss, M.D.

### TRANSFER TO COLLIER CMS

David Axline, M.D. Edward Toggart, M.D.

### WELCOME NEW MEMBERS

Bruce Berget, M.D. Frank Campanile, M.D.
Jeffrey Colon, M.D. John L. Cossu, D.O.
Clarisa Cuevas, M.D. James Dougherty, M.D.
Alan Goldstein, M.D. Mario Mangieri, M.D.
Steven Sager, D.O. Douglas M. Stevens, M.D.
Richard J. Weiss, M.D. William Wood, Jr., M.D.

### REACTIVATION

Bipin Shah, M.D.

### LIFE MEMBERS

(LCMS/FMA members for 35 years)
Peter Bercaw, M.D. Robert Rex Tate, M.D.

## PARTNERSHIPS: MAKING A DIFFERENCE

### DO NOT DRIVE WHILE USING ALCOHOL OR DRUGS

*Catherine Larned, M.D., speaking to the Drivers Education and Physical Ed class at Mariner High School, March 24th at 7:30 am.*

*Angelo Vaughn, Sheriff's Department, Hal Eskin, Esq., Andy Sweet, Esq., and Victoria Sweet, R.N., spoke to the students on the potential medical/ legal outcomes of driving under the influence of alcohol or drugs.*

If you would like to participate in this community program, on behalf of the medical community, contact Victoria at 433-2988 or the Society office.

## MINI-INTERNSHIP PROGRAM

*On March 16 & 17, 1998, the LCMS provided a two-day mini-internship program in which the following physicians and business professionals participated:*

**First Row:** *Mini-Interns Richard Jenkins Safety Administrator for American Power Conversion; Kenneth Iglesias, Senior Vice President of Colonial Bank; Michael Guifoyle, Data Manager for the Health Planning Council of SWFL; and Jill Lampley, Financial Director for Hope Hospice.*

**Second Row:** *The physicians who participated were Alan Siegel, M.D. Coordinator of the Mini-Internship Program; Michael Weiss, M.D., Gastroenterology; Julio Rodriguez, M.D., Family Practice; and David M. Reardon, M.D., President LCMS. Not pictured: Gordon Burtch, M.D., General/Vascular Surgeon; Brian Hoffmann, M.D., General/Vascular Surgeon; Michael Sweeney, M.D., General/Vascular Surgeon.*

All the interns were invited guests at the General Membership Dinner Meeting on Monday, March 16, 1998 and for a debriefing breakfast on Wednesday, March 18, 1998 hosted by Mr. Bill Johnson, CEO of Lee Memorial Health Systems. The debriefing provided an opportunity for the interns and faculty to share their thoughts and feelings about their experiences. Some experiences shared were:

"Excellent program! I benefited tremendously from attending this program. Thanks to everyone for their time and participation." ~ *Kenneth Iglesias, Senior VP, Colonial Bank*

"...Somehow these doctors, despite high patient loads and long stressful hours are able to provide the human elements of compassion and good communication with their patients and their families." ~ *Richard Jenkins, Safety Administrator, American Power Conversion*

"Medicine has become a business, full of government regulations that impedes the relationship a physician and patient can develop. Medicine is an extremely demanding career both physically and emotionally..." ~ *Jill Lampley, Financial Director, Hope Hospice*

We would like to extend our thanks to Alan Siegel, M.D. the Mini-internship Program Coordinator and to the participating physician faculty.

## LEE COUNTY MEDICAL SOCIETY ALLIANCE/FOUNDATION NEWS

*Respectfully submitted by Kathy Marchildon, Corresponding Secretary, LCMSA*

### BUCKLE BEAR PROGRAM

Buckle Bear and LCMSA volunteers are driving home the message of car safety. Through the Buckle Bear Program over 1800 children in 38 area schools have learned how to be good passengers and to "buckle up", since last September. Concepts are taught through a lap puppet presentation, a video and a specially designed book. Teachers receive a packet that includes parental information and classroom activities that reinforce the concepts presented. Enthusiasm has been high. The children have been delighted in giving Buckle Bear a "high five" and receiving a hug and safety sticker in return. Future additions to the program include bicycle and pedestrian safety as well as a car seat distribution program for the less fortunate.

### 1998 CHARITY BALL NEWS

The countdown has begun and the 15th Annual Charity Ball "Moon Over Havana" will rise brightly at The Sanibel Harbor Resort and Spa on May 23rd, 1998. The major recipient this year, The Lee County Breast Screening Program, saves many lives and your support of this worthwhile organization will aid their efforts. Please send in sponsorship donations, from your office, as soon as possible! If you would like more information please contact Charity Ball Chairman Barbara Rodriguez at 433-9654.

The Charity Ball Golf Tournament will be held the morning of the Ball, Saturday, May 23rd at Gulf Harbour Yacht and Country Club. Breakfast along the yacht basin will be at 7:30 with a shotgun start at 8:30. Also included, in the $75 entry price, are lunch, green and cart fees and a complimentary photo. Undoubtedly, a great value for such a beautiful course; sign up brochure to follow or check the box on the Charity Ball Response Card!

Tickets to the Ball are a value at $295 per couple. Cost includes the following: cocktails from 7 to 8 pm, you and your date photographed by Nocera Studio, dinner, dancing the night away, and live entertainment. At midnight an elegant coffee station and scrumptious delicacies will tempt your taste buds. On Sunday morning there will also be a generous Brunch for 2 adults and 2 children from 9:30 till noon. After purchasing your Ball tickets, if you are going to make this a special getaway weekend, rooms are available at a reduced rate to Charity Ball Attendees. Please mention you will be participating when making your reservations. The Sanibel Harbour Resort and Spa has an *excellent kid's club* and for a nominal fee your kids can have a great time as well. Also of note, registered guests may dock their boat *free of charge*.

Last, but certainly not least, Raffle Tickets, for over 40 fabulous prizes will be pre-sold again this year. You can purchase them at the Charity Ball Preview Party at Devonwood Estates on March 21st or any day thereafter by calling Rachelle Isaacson at 561-6764 or Michele Sager at 768-3730 or pre-purchase, for the first time this year, when sending in your Charity Ball Response Card.

## AMA NATIONAL LEADERSHIP CONFERENCE

Washington, DC ~ March 7-10, 1998

*Drs. David Reardon & Bruce Lipschutz with Dr. Glenn E. Bryan, President-Elect of FMA at the AMA Leadership Conference.*

*U.S. President, Bill Clinton*

*Photos provided by Dr. Lipschutz*

## THE QUESTION MAN

OPINIONS - EDITORIALS
LETTERS TO THE EDITOR
John W. Snead, M.D.

### APRIL'S QUESTION: "SHOULD THE EXECUTION OF CONDEMNED CRIMINALS BE SUPERVISED BY A PHYSICIAN?"

*Roger D. Scott, M.D. Surgeon*

"I was in the Maryland State Pen. (as a surgeon) for the last hanging and the first gassing in the State of Maryland. I was requested to be present for the "event", but I declined to be present as it was my feeling that my life is devoted to saving rather than the taking of lives. I still feel strongly about this, but I also feel that capital punishment is needed. If some other physician feels that he wishes to be present or to participate, I would not have any disrespect for him."

*Carol J. Huser, M.D. Forensic Pathology District Med. Examiner*

"The interest of both the condemned and the public are served by supervision of executions by an unbiased medical professional whose presence could help insure the procedure is properly performed as specified by law and that no procedural or equipment problems contribute to a prolonged or unnecessarily painful death. Participation should be voluntary and not required of any physician morally opposed to capital punishment. Both supporters and opponents hold passionate beliefs, and the question of whether executions should be conducted and if so by what means is hotly debated. It is in everyone's best interest that the public and Legislative bodies have the benefit of valid, scientifically sound, and unbiased observations as only an informed society can be expected to make rational decisions."

*Stephen F. Scholle, M.D. Anesthesiology*

"The goal of a physician is to preserve life and health and to relieve suffering. Physicians are an advocate for the individual patient and should do what is best for that individual (notwithstanding the desire of some managed care plans). Clearly, a physician involved in an execution is not acting for the "patients" benefit but rather is acting as an agent of the State. While as physicians we are members of the community and have responsibilities to the community and to the government, I do not believe it is in the best interest of society or the profession to have physicians acting as executioners."

*Joseph O'Bryan, M.D. Internal Medicine*

"To the question of physician supervision of executions, the answer should be a resounding No. The AMA Council on Ethical and Judicial Affairs first addressed this issue in 1980 and revisited the problem in 1993. Their recommendation stated: "An individual's opinion on capital punishment is the personal and moral decision of that individual. However, a physician as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution." The Florida Senate has a bill pending, CS-S13 360 Execution by Lethal Injection which provides for execution by lethal injection if electrocution is held to be unconstitutional. Amendment attempts by physician Senators Myers and Sullivan, which would bar doctors from participating in lethal injections, were defeated. A bill co-sponsor, Senator Burke commented it was important a physician be present to determine the amount of drug needed for lethal injection. (Obviously Dr. Burke had not read the AMA guidelines from the Ethical and Judicial Affairs Council). The solution to this legislative rigmarole is to abolish the death penalty in any form and to utilize life imprisonment WITHOUT parole as punishment for capitol crimes. –Not that I expect to see that happen in my lifetime."

***May's Question:***

### "SHOULD ANYONE OTHER THAN A MEDICAL DOCTOR BE ALLOWED TO USE LASERS ON A HUMAN BEING?"

Send your comments to the Medical Society. BULLETIN deadline is the 15th of each month...we want to see you in the print media!

## "I LOVE MY LAWYER: HE TAUGHT ME HOW TO CHARGE"...OR "I LOVE MY MANAGED CARE COMPANY: THEY TAUGHT ME HOW TO CHARGE."

*By High F. Hill III, M.D.*

My attorney rushed into my office, waving a piece of paper. "What is this thing?" he cried.

"Counselor," I said, leaning back in my chair, "always good to see you. How's my favorite legal eagle? Sit down. Can I have the receptionist bring you coffee?"

"Look at this," he insisted, thrusting the offending document across my desk. "It came in today's mail."

"I recognize it," I said smiling. "Isn't it great? I knew you'd be excited when you got it. This will revolutionize medical billing - and I got the idea from you!"

"But it doesn't look anything like a doctor's bill," he protested.

"Of course not," I replied. "Remember that little legal matter you handled for me recently?" A hint of suspicion crossed his features. "After examining your statement for service rendered," I continued, "I went out and bought some legal billing software and adapted it into my practice."

He slowly sank into the chair opposite my desk. "But I've been your patient for years, and I've never gotten anything like this before."

"That's the beauty of it!" I exclaimed. "I'm not practicing any differently, I'm just billing for it properly now."

As my enthusiasm waxed, his waned. "But $1,249.17 for a proctoscopy?" he asked incredulously.

"Yes, isn't that terrific," I marveled along with him. "And the software lays out everything in such detail! I never realized how hard I was working until I started billing this way."

He reached across my desk and reclaimed the statement. "I guess this is the breakdown of the time I spend in your office."

"Couldn't be clearer could it?" I acknowledged. "There's the entire visit-divided according to the time it took to do the initial examination. Explain the proctoscopy, perform the procedure, and discuss it with you afterward - with each segment rounded to the nearest tenth of an hour. Also, now that I'm billing for *it as a distinct service, I don't feel so bad about having to spend 20 minutes recording my observations on* your chart."

"What's this item labeled 'Research'?" he asked peevishly, jabbing his finger at the statement.

"Another excellent idea I got from you," I chuckled. "I used to spend hours every week reading journals. Now I do it like you lawyers do: I research each patient's problem as it comes up. That way I can bill for the research time."

"All itemized," he murmured, gazing at the statement. "Travel time to the library, mileage expense, research time, call to university colleague, review of literature suggested by colleague..." his voice faded.

"The next item is my favorite," I said. "Remember that little problem you recently worked on for me? There was an item for conference time on your bill. When I asked about it, you said you'd discussed my case with two lawyers in your firm. Well, until I started keeping track with this billing program, I had no idea how often I was conferring with my own associate. As a convenience to you, I've listed his time on my statement, too."

He looked stunned for a moment then managed another question: "This out-of-state meeting - what does that have to do with my proctoscopy?"

"I can't tell you how grateful I am to you for getting me started on this," I said. "Since Uncle Sam won't let me deduct the entire cost of these expensive seminars anymore, it's especially nice to be able to bill for them. You want me to be up on the very latest aspects of your problem, don't you?"

"Well, of course," he mumbled, "but..."

"You're wondering how I arrived at those figures, aren't you? Well you see there are 50 patients in my practice who have your particular condition. So I just took all my expenses from the three-day meeting and allocated them equally among the 50 of you. With the software, it's really a piece of cake."

"Great," he sighed. "I suppose this section here was suggested by my calling a tax specialist about your trouble with the Internal Revenue Service?"

"Exactly!" I grinned. "After my research, and after attending that meeting, I decided to get you a second opinion on that lesion I thought was benign. And with this new billing system I can afford to call around until I find the subspecialist who's absolutely the best qualified to consult on each patient's problem."

Still staring at the bill, he seemed to stiffen a bit. "Here's something I hadn't noticed before. What's this 'phone call from spouse'?"

"I had to spend a long time reassuring your wife on the phone," I said.

"Okay," he said grudgingly, "but how did you get this total? You multiplied the time by $200 an hour?"

*"Right," I answered, gesturing at the framed degrees on my wall. "You and I are about the same age. You* went to a law school for three years and bill $150 an hour. I went to medical school for four years, so I bill at $200 an hour. Come to think of it," I mused, "maybe I should factor in the years I spent in residency."

"Oh no, no," he babbled, pushing himself up from the chair. "That's fine. Thanks for taking the time to explain."

"Not at all," I said. "Whenever you need me, just call. Always glad to talk with my lawyer, my patient, and the man responsible for this wonderful new billing strategy. You've shown me how to make conversations such as this quite profitable, actually."

His face fell. "You don't mean..."

"Of course!" I answered, giving him a firm clasp on the shoulder. I glanced at my new desktop timer. "We've enjoyed 17.35 minutes together. That's 0.3 hour. Would you like to be billed today or wait until the end of the month?"

"The end of the month is fine," he said weakly. As I guided him to the door, I noticed how his breathing was shallow and labored, his skin pale, his forehead sweating."

"Listen," I said pausing in the doorway. "I've got some new thoughts about marketing this new billing system, and I am going to need legal advice."

His respiration steadied. He eyed me evenly.

"Maybe I can stop by your office sometime and we can talk," I suggested.

The light began to return to his eyes. His shoulders straightened. "Yes. Marketing. Maybe a syndicate. Closely held corporations. Contracts." He quickened. "Deals."

The color was returning to his cheeks.

By the time he stepped into the waiting room, he looked almost normal again. As he left I turned to the receptionist.

"Send in the next client...er, patient."

*A personal note from the author. "The article was originally titled 'How I Learned to Stop Worrying and Love My Lawyer's Bill, ala Dr. Strangelove.' I have a book on Florida Malpractice Law published by C.V. Mosely. As a result, I know how the membership must feel about my legal colleagues in the Sunshine State. Just keep your heads low and your powder dry. Don't shoot 'til you see the dollar signs in their eyes and aim right for their little black hearts. Best Wishes."*

*This article was printed by Medical Economics Company in 1988. Reprinted by permission.*

## FMA WORKING ON YOUR BEHALF

*Linda E. Barr, Our Field Representative*

The Florida Legislature convened its 1998 session March 3rd after several months of interim committee meetings, where a number of the Florida Medical Association's issues had already been discussed. We typically track 200-300 bills, while focusing on between 10 and 20 priority issues, some of which I will discuss here.

### SUPPORT ISSUES

### MANAGED CARE

The first support issue, which is a carry-over item from past sessions, is Due Process for physicians treating HMO patients. In some areas of the state HMOs are so prevalent physicians feel pressured to join managed care panels in order to maintain a viable practice, but they can be removed from these panels during the term of their contract without being informed of the reason for termination and without any avenue for a hearing or appeal. House Bill 1087 would require managed care companies to provide physicians a forum for presenting their cases for continual panel membership before termination or non-renewal of a contract.

Because of practices such as termination without cause from managed care panels, physicians and legislators have been looking for alternatives to traditional HMOs, such as Provider Sponsored Organizations (PSOs). This is a relatively new concept that has already received attention from Congress, where PSOs have been authorized to provide health care coverage for Medicare patients. Parameters are currently being established by HCFA, and state legislation will likely mirror those regulations when they are published in March or April. The FMA is seeking relaxed solvency requirements for start-up Provider Sponsored Organizations to reflect unique characteristics of these arrangements. Physicians support regulation that does not favor one PSO model or provider group over another in the ownership and management structure of a PSO, but we believe that PSOs must be majority owned and controlled by licensed health care providers.

In addition to legislation requiring Reimbursement of Non-Contracted Hospital Based Physicians for providing covered services to an HMO's subscribers and Prohibition of Hold Harmless Clauses, the FMA is supporting House Bill 1547, the HMO Bad Faith bill. This bill provides protection for HMO subscribers by giving them legal rights similar to those enjoyed by traditional health insurance policy holders. Specifically, this proposal would: 1) make it illegal for HMOs to discriminate in coverage based on race, color, creed, marital status, sex or national origin; 2) make it illegal for HMOs to engage in certain unfair dealings in premiums; 3) give HMO patients the ability to enforce their rights to be free from discrimination, illegal dealings in premiums, unfair claim settlement practices, and bad faith denial of medically necessary covered services; and 4) give HMO consumers substantially the same rights and remedies that consumers of traditional health insurance have enjoyed since 1982.

### TORT REFORM

For the last year a group of concerned businesses, including the FMA, have been meeting to develop meaningful tort reform legislation. The medical community has two issues that are included in the coalition's proposal: refining the Definition of Expert Witness and allowing a defendant physician's attorney to informally talk with the plaintiff's Subsequent Treating Physicians.

The current criteria for serving as an expert witness requires only that the provider establish to the court's satisfaction that he or she possesses sufficient training, experience, and knowledge as the result of practice or teaching in the specialty of the defendant or in a related field of medicine sufficient to testify to the prevailing standard of care. The FMA supports a new definition requiring the expert witness to be licensed by an appropriate regulatory agency, be trained and experienced in the same discipline or school or practice, and be board certified and actively practicing in the same specialty if the defendant physician is a specialist.

Under current law, while a plaintiff's attorney has unlimited access to subsequent treating physicians, the defense attorney must go through the formal discovery process (subpoena and deposition) in order to talk to them. Revising this law allows the defense attorney to speak informally with subsequent physicians and recognizes that when a patient sues a physician or other health care provider, the patient is placing his or her own physical condition and treatment in controversy, including the records pertaining to that condition and treatment. In addition to leveling the playing field between plaintiff and defendant, allowing defense attorneys to confer informally with subsequent treating physicians promotes speedy and less expensive resolutions of malpractice claims.

The other tort reform issue organized medicine is pursuing is in response to a Florida Supreme Court decision ruling that a plaintiff can plead out of the NICA and pursue a civil malpractice suit alleging that the injury was not birth-related. This ruling appears to be contrary to the intent of the NICA law, which was designed as an "exclusive remedy" for birth-related neurological injuries. The proposed legislation would clarify that an administrative law judge should determine the applicability of NICA, not a jury at the end of a long, costly civil case. The proposal will also explore the viability of lowering the infant weight from the current 2,500 grams, provided an actuarial study ensures that such a change would not result in additional assessments.

Finally, committees have already heard testimony from FMA members in regard to the First District Court of Appeal's Wingo Decision, which declared that the Patient Self-Referral Act of 1992 prohibits a physician or group from providing designated health care services to their own patients if they accept referrals from outside physicians with no financial interest in the group practice. Proposed legislation would clarify that a solo or group practice may provide designated health services to its own patients and to patients from outside referrals, as long as outside physicians receive no compensation for such referrals.

### OPPOSE ISSUES

Once again, we will be fighting efforts to expand Wrongful Death Statute to allow adult children of a deceased parent and parents of an adult child to recover non-economic damages for loss of companionship or pain and suffering in medical malpractice cases. The House Bill (HB 25) is a carry over from the 1997 session, and is currently in the House Health Care Services Committee and the Senate Bill (SB 144) was temporarily tabled by the Judiciary Committee in February. Your legislators need to hear from you on this one!

Another bill we've seen before, but which never went anywhere, is a proposal by the Agency for Health Care Administration to disclose that a complaint has been filed or an investigation begun against all practitioners regulated by chapter 455, Florida Statues, prior to finding of Probable Cause. Current law requires that this information be kept private until ten days after there is a determination that probable cause exists.

Bills have also been filed (HB 3049/SB 248) to allow disciplinary boards or the Department of Health if there is no disciplinary board, to permanently revoke the license, certificate or registration of any health care practitioner or other licensee under the Division of Medical Quality Assurance who has been found by the board to have committed Sexual Misconduct in the person's professional practice. The FMA agrees that certain offenses should trigger action against a professional's license, but this bill goes too far and we are attempting to negotiate a compromise.

Finally, as in past years, several ancillary providers and non-physicians would like to expand their Scope of Practice. During the 1997 legislative session legislation was passed creating a task force to study the prescribing of controlled substances by ARNPs. The task force has recommended that ARNPs be authorized to provide medical care without the general supervision of a physician, including assessing, diagnosing, identifying outcomes, prescribing and preforming minor surgical procedures. A patient's medical care would not be reviewed or supervised by a physician, compromising a patient's safety and quality of care. Psychologists are also hoping to get approval to prescribe psychotropic drugs.

Your FMA lobbying team will closely monitor these and other issues affecting the practice of medicine, but we need your help back home. Your phone calls and letters to local legislators have a much more significant impact than all the professional lobbying in the world, so when you receive a Legislative Alert, take a minute or two to call your senator and representative to relay your personal feelings on the issue. If you can't speak directly to the legislator, it's just as effective to leave a message with his or her legislative assistant.

For updates on legislation or to get more information on these issues during session, call me or the FMA Office of Government Relations at 1-800-762-0233.

## NEW MEMBER APPLICANTS

### Application for Membership

*Active members are requested to express to the Committee on Ethical & Judicial Affairs or Board of Governors any information or opinions they may have concerning the eligibility of the applicants.*

### ANTHONY D'ANGELO, MD ~ General/Vascular Surgery

**Medical School:** New York University School of Medicine, New York, NY (1986-90)
**Internship:** Long Island Jewish Medical Center, New Hyde Park, NY (1990-91)
**Residency:** Long Island Jewish Medical Center, New Hyde Park, NY (1991-95)
**Fellowship:** Long Island Jewish Medical Center, New Hyde Park, NY (1995-97)
**Board Certification:** American Board of Surgery. Dr. D'Angelo is an associate with the Surgical Associates of SW Florida at 2675 Winkler Avenue, Suite 490, Fort Myers.

### NUEL CELEBRADO, MD ~ Pediatrics

**Medical School:** University of the Philippines, Manila, Philippines (1983-87)
**Internship:** Philippines General Hospital, Manila, Philippines (1987-88)
**Residency:** Philippines General Hospital, Manila, Philippines (1989-91)
SUNY at Stony Brook, Stony Brook, NY (1991-94)
**Fellowship:** SUNY at Stony Brook, Stony Brook, NY (1994-95)
**Board Certification:** American Board of Pediatrics. Dr. Celebrado is an associate with the Southwest Florida Pediatric Network at 13685 Doctor's Way, Suite 140, Fort Myers.

*A mistake was made in the February Bulletin regarding Chris Marino, MD. The correct information follows:*

### CHRIS J. MARINO, MD ~ Neurology

**Medical School:** Uniformed Services University School of Medicine, Bethesda, MD (1982-86)
**Internship:** Walter Reed Army Medical Center, Washington, DC (1986-87)
**Residency:** Walter Reed Army Medical Center, Washington, DC (1987-90)
**Fellowship:** Walter Reed Army Medical Center, Washington, DC (1995-96)
**Board Certification:** American Board of Psychiatry and Neurology. Dr. Marino is an associate of the Neurology Specialists of Southwest Florida at 4048 Evans Avenue #201, Fort Myers.

## TAKING BACK THE PRACTICE OF MEDICINE

*Write Your Congressional Members*

### FRAUD AND ABUSE

**Environment**

Fraud and abuse has no place in the practice of medicine and the AMA is dedicated to setting the highest ethical standards for the profession. The AMA is committed to working with the Administration and Congress to pursue solutions that will target those few physicians intent on defrauding the government.

In recent years, however, it is has become politically popular for the Administration and Republicans and Democrats in Congress to seize the fraud and abuse issue. In the process, the definition of fraud and abuse has expanded beyond the traditional definition of intentionally defrauding the government. Little or no distinction is made today between inadvertent errors, legitimate issues of medical judgement, and true fraud. A good example of this phenomenon is the report the Inspector General (IG) released last year regarding the Health Care Financing Administration's (HCFA) 1997 financial statement that was widely trumpeted as uncovering $23 billion in fraud. The report reads: "These improper payments could range from inadvertent mistakes to outright fraud and abuse. We can not qualify what portion of the error rate is attributable to fraud." A close examination of the report reveals that the IG included Medicare claims that were not finally adjudicated. An analysis of HCFA's first quarter 1997 records indicates that physicians and other professionals reimbursed under Part B won 70% of the appeals when carriers had initially denied their claims.

The broadening of the fraud definition has implications for payment policy issues. The Administration has recently categorized several payment policy issues as fraud initiatives. For example, President Clinton announced in the FY 1999 budget that he will urge Congress to expand HCFA's current "Centers of Excellence" demonstration project enabling Medicare to receive volume discounts on certain surgical procedures. The Administration introduced a similar payment proposal last year and Congress rejected it. The Centers of Excellence proposal is a policy to reduce Medicare payments and it should not be labeled as addressing waste, fraud, or abuse.

In order to comply with federal government requirements, physicians are obligated to be familiar with thousands and thousands of pages of rules and regulations. These regulations are complex and cumbersome. While there are many volumes of information, some of the more prevalent include: carrier instructions which now consist of more than three four-inch volumes; CPT procedure codes; IDC diagnosis codes; carrier processing requirements; OSHA standards; and CLIA regulations, if the office does lab work. Complying with these regulations is overwhelming for physicians.

### FRAUD AND ABUSE TALKING POINTS

**Inadvert Billing or Coding Errors**

We would like Members of Congress to write to the Secretary of Health and Human Services and the Attorney General to urge them to instruct the Inspector General and the Department of Justice that physicians should not be penalized for inadvertent errors.

**Knowing and Willful**

The criminal penalties of the Health Insurance Portability and Accountability Act (HIPAA) do not apply unless a provider has a specific intent to violate the Act. Under this "knowing and willful" standard, prosecutors must prove that the physician has voluntarily and deliberately committed a fraudulent act. Last year, the Administration sought to repeal this intent standard. While there is no legislation moving at this time, we anticipate that the Administration may try to weaken this standard. Urge your Members of Congress to oppose any attempt to repeal the "knowing and willful" intent standard.

**False Claims Act**

The Department of Justice (DOJ) is currently utilizing the False Claims Act (FCA) to pursue a number of high-profile investigations to address Medicare billing errors. Many of these investigations target institutions for "billing mistakes". While hospitals have been the focus of the DOJ's investigations, we are concerned that physicians will be next. Urge your Members of Congress to support efforts to establish reasonable thresholds for triggering the application of the False Claims Act.

*Prepared by the American Medical Association ~ Private Sector Advocacy Group ~ March 4, 1998*

## DECIDING ABORTION, SUICIDE ISSUES IS DUTY OF CONGRESS, SCALIA SAYS

*Glen Johnson ~ Associated Press*

Congress, not the Supreme Court, should decide such vexing questions as abortion rights, the death penalty and physician-assisted suicide, Justice Antonin Scalia said yesterday.

Scalia, a conservative, said the proper way to cope with 20th century issues is to write laws addressing them, not expect the Supreme Court to revise the intent of an 18th century document.

"It is not supposed to be our judgement as to what is the socially desirable answer to all of these questions. That's supposed to be the judgement of Congress, and we do our job correctly when we apply what Congress has written as basically and honestly as possible," Scalia told a leadership meeting of the American Medical Association, a rare speaking engagement open to reporters.

The justice also scolded the news media and members of the public who criticize court decisions without a full understanding of the issues or statutes involved.

"Indeed, often I and my colleagues do not like in particular the results we produce," Scalia said, but such decisions are a sign of a court adhering to the law and not extrapolating its meaning.

"The system is really garbage in, garbage out," Scalia added, drawing laughter.

"If you have a very bad statute, not only should you expect a result to be a very bad result, I would argue that you should criticize the judges as being in violation of their oath if they do not produce a bad result, because it's not supposed to be our call," the justice said.

Scalia was appointed to the high court in 1986 by President Ronald Reagan. Since then, he has established himself as one of the court's most conservative members.

The justice has said several times publicly–and repeated yesterday–that he views himself as an "originalist." He defines that as someone who is faithful to the Constitution's text.

"In my Constitution, if you want the death penalty, pass a statute. If you don't want the death penalty, pass a statute the other way. You want a right to abortion, create it the way most rights are created in a democracy: Pass a law. If you don't want it, pass a law the other way. And if you want a right to (physician-assisted) suicide, the same," Scalia told the doctors' group.

"Having the Constitution mean whatever five out of nine justices think it ought to mean these days is not flexibility but rigidity."

*(Washington Post, March 1998)*

## ODDS & ENDS

- Kaiser Permanente, one of the country's largest not-for-profit HMOs posted a record $270 million loss for 1997, even though its membership grew 19% to almost 9 million. Some observers note that the financial difficulties being experienced by Kaiser, as well as by large for-profit systems like Oxford Health and PacifiCare, are directly related to a financial strategy of trying to increase market share. While they are succeeding in part, most employees choose more flexible plans that result in higher medical costs on the part of HMOs. In addition, many HMOs are under investing in management systems, and this creates problems when enrollment exceeds computer capacity.
*(Wall Street Journal, February 17, 1998) MARKET TRENDS*

- The prompt payment issue is heating up in Texas, where the Texas Department of Insurance (TDI) has weighed in on behalf of physicians and other providers, issuing a warning that if health plans do not provide prompt payment as required by law they will be subject to disciplinary action. Under Texas law, plans must pay providers for covered services within 45 days and must pay physicians their capitated payment fees within 60 days after the enrollee has selected a primary care physician. A TDI investigation found significant violation of the provisions, and indicated that penalties for non-compliance can range from a small fine to losing the insurance license.
*(Houston Business Journal, February 2, 1998) MARKET TRENDS*

- A Securities and Exchange Commission (SEC) task force has issued rules to standardize accounting by physician practice management companies (PPMCs) that may have a significant impact on future PPMC deals. Among other things, PPMCs will be limited to their ability to consolidate the revenues of affiliated physician practices into their corporate revenues. To do so, they must enter contractual agreements of at least 10 years with the practices, and must have exclusive control over key operating issues and matters such as total physician compensation. The rules also disallow pooling-of-interest mergers, which means companies must actually purchase practices. Observers note that the rules could make it somewhat more difficult for PPMCs to tap the public market and may also lower the prices for physician practice acquisitions.
*(Modern Healthcare, January 19, 1998) MARKET TRENDS*

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For More Information Contact FMA Headquarters, 800-762-0233
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8. Service to Your Profession

## I'M A DOCTOR, NOT A PAPER PUSHER!

*Dr. Jody Robinson*

Starting this July, under the federal government's new Medicare Correct Coding Policy, doctor will be spending alot more time on paperwork rather than patient care. In fact, documentation requirements are on the verge of subsuming medical care itself. These regulations started as a legitimate effort to determine that services government pays for have actually been delivered. But they've developed into a Rube Goldberg system in which auditors with little or no medical training will determine if doctors are actually doing their jobs instead of committing fraud all day long.

Under little-publicized provisions of the 1996 Health Insurance Portability and Accountability Act (the Kennedy-Kassebaum law), enforcement responsibility will rest with 450 FBI agents hired specifically for this purpose. This also means that if you are a Medicare patient, the FBI will have unfettered access to your medical records.

The new regulations, issued by the Health Care Financing Administration, are so heavy-handed that it is clear they have little or nothing to do with the care of the patient. For example, to justify a 25-minute visit with a Medicare patient, a physician will have to generate a written record including-just try to follow this-the chief complaint, an extended history of the present illness (four or more elements, or the status of at least three chronic or inactive conditions); a review of systems (an inventory of two to nine bodily systems); pertinent past medical, family and social history; plus either a detailed examination (including at least six organ systems or body areas with at least two elements each or at least 12 elements in two or more organ systems or body areas), as well as two out of three of either multiple diagnosis or management options, a moderate amount or complexity of data to be reviewed, along with the risk of complications or morbidity or mortality.

There's more. Somewhere along the line, a numbingly complex matrix of required elements must be consulted for each medical interaction to determine which level of office-visit service should be coded for billing to Medicare. Failure to do so with consistent accuracy can subject the miscreant physician to fines of *up to $10,000 an incident. So the physician must turn to elaborate tables of symptoms and body parts to be* sure that the reported number of findings are distributed among the right number of body systems and duly recorded.

The effective date of these new regulations was delayed to July from January after a howl of protest from physicians. But there is little indication that they will be substantially modified. They should be dumped altogether.

The concept of standardizing the work to be expected with various levels of care seems reasonable at first glance. Medical records, after all, once consisted of little more than scanty scribbled observations. But the days of undocumented medical treatment have long since passed. Physicians, who have labored for at least 30 years under the threat of malpractice litigation, long ago became conscientious at recording the details of significant findings and treatments.

A look at the new regulations leads to the unavoidable conclusion that a disproportionate amount of time will be consumed by pedantic record keeping, at the expense of the patient. The information mandated is so voluminous-lots of chaff for little or no wheat-that it's of no use to the next person to use the medical record either.

Such a single-minded focus on documentation may satisfy the bureaucrat and account, but it can be hazardous to the patient. After all, a doctor can only do so much in 15 to 30 minutes. Every unnecessary or arbitrary documentation mandate takes away from the time available to evaluate symptoms, formulate a diagnosis or a treatment plan, explain the problem, write prescriptions...and, oh yes, comfort and console the patient. These requirements are demeaning to physicians, surely among the most skilled, educated and ethical professionals in our society.

The real purpose of these regulations is to find ways to reduce the payment for services provided to patients by applying the rule: *If it isn't documented, it didn't happen.*

How can a doctor keep the patient's needs foremost in mind when every interaction is laden with administrative burden and fraught with legal peril? "The secret of caring for the patient is to care for the patient," said the great early-20th-century physician William Osler. To put it in contemporary lingo, it's the patient, not the chart. Documentation should not become the tail that wags the dog.

On the other hand, if this is good medicine for doctors, perhaps every government official and employee should be subject to similar work-substantiation requirements. It might be instructive to have each of our public servants report minute-to-minute activities and accomplishments in comparable detail, so we could all see just where our tax dollars are going.

Dr. Robinson practices Internal Medicine in Washington, DC.

*(THE WALL STREET JOURNAL ~ Wednesday, April 1, 1998)*

## REPORT ON AMPAC CAMPAIGN SCHOOL

*Steven R. West, M.D.*

Eliot Hoffman, Valarie Hoffman, my wife, Jane, and I were able to attend the AMPAC Campaign School that was held outside of Washington, DC in Alexandria, Virginia. This school has a fantastic reputation, and I am here to attest to the fact that I was quite impressed with not only the content material covered in the school, but also by the teachers who presented the material. The people that were responsible for educating us about campaigns and the political process were all well respected experts in their field. They were all active in political campaigns serving as consultants and campaign managers. They brought with them a variety of experiences in all kinds of campaigns throughout the country. Not only were they experienced, but they were fantastic speakers and teachers, making the material exciting and entertaining.

The entire process of running a political campaign was discussed from deciding to run, to the importance of financing, how to deal with a hostile press, developing a message and delivering the message to the voter, targeting precincts, and finally, getting the vote out.

The most important aspect for members of FLAMPAC was what things to look for in a successful campaign. A campaign that is well run increases the chance for success and hence is worthy of FLAMPAC support. Many campaigns should win and don't because they are simply mismanaged. Campaigns are lost, not won. There are approximately seven items that should be systematically analyzed before we commit FLAMPAC resources into a campaign.

1. **Vision** ~ We need to look at the vision of the candidate to determine what the candidate believes in, what his/her political philosophies are. Can the candidate communicate the message? Can the candidate talk the vision? Can the candidate explain why he or she is running?
2. **Research** ~ The second thing that needs to be looked at critically is research. Did the campaign research its own candidate's life to determine if there is any potential weakness or skeletons in the closet that will be a problem? Also, did the campaign do opposition research, researching the positions, voting record, life experiences and character of the opponent?
3. **Targeting** ~ Has the campaign determined how many votes it will take to win? How do they arrive at that figure? What races did they look at historically to make this determination? What are they going to do to get the votes to win? In other words, what precincts are going to be targeted in a systematic manner to make sure that they have on election day enough votes to win. How are they going to get out the vote?
4. **Message** ~ How was their message developed? Is their message clear and concise? Is it contextual? Is it emotional? Is it contrasting from the opponent's message? Do they stay on the message or does the campaign and candidate have a tendency to wander from the message and focus? Does the candidate know the message cold?
5. **Budget** ~ Has the campaign budgeted adequate funds to run an office? Is the campaign run like a business? Are the appropriate withholding taxes and business policies and procedures in place that any business has that hires employees? Have they gotten appropriate legal advice and accounting advice? Have they adequately budgeted for TV, radio, direct mailing, travel and routine business overhead? Because of lack of funds, will they go "dark" before the election? Do they have something as simple as liability insurance? Have they hired too many employees? Too many consultants? Do they have a campaign plan? Do they follow the campaign plan?
6. **Fund Raising** ~ The most important item in any campaign is their fund raising plan. Do they have donor lists? Have all the potential donors been contacted? Once these potential donors are contacted, have they followed up? Do they have a plan in place to make certain that they will have enough money to meet their budget? Can the candidate raise money?
7. **Consultants** ~ Finally, have they hired consultants which provide them with the technical expertise to target their voters, to develop their message, to help them deal with the potentially hostile press, to help them "earn media", and to help them with not only fund raising, but running a well thought out and well orchestrated media campaign?

I simple cannot convey to you all the amazing and interesting items that were covered in campaign school. They provided us with more than two notebooks full of material and I took two legal pads full of notes. I would urge anyone that is interested in learning more about the political process to take advantage of this wonderful campaign school that the American Medical Association has developed. Currently, if you are a member of AMPAC, they will pay for your flight to Washington, DC, some of your meals are covered, and they waive the registration fee ($1,000 for non-members). *It is quite a deal.*

**1998 MEMBERSHIP DUES ~ NOW DUE!**

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## UNIONS: WHITE COLLAR OR BLUE COLLAR: SHOULD PHYSICIANS JOIN?

*THIS ARTICLE CONTAINS GENERAL EDUCATION INFORMATION WHICH IS NOT INTENDED FOR LEGAL ADVICE NOR SHOULD YOU CONSIDER IT AS SUCH. ALTHOUGH WE WELCOME YOUR CALLS, LETTERS AND E-MAIL, PLEASE UNDERSTAND THAT MERELY CONTACTING HOLLAND & KNIGHT WILL NOT ESTABLISH AN ATTORNEY-CLIENT RELATIONSHIP BETWEEN US. CONSEQUENTLY, YOU SHOULD NOT CONVEY ANY CONFIDENTIAL INFORMATION TO US UNTIL A FORMAL ATTORNEY-CLIENT RELATIONSHIP HAS BEEN ESTABLISHED.*

If you are fed up with-one-sided managed care contracts, low reimbursements rates and bureaucratic red tape, tired of taking orders from non-physicians concerning the treatment of your patients, you may have considered joining a Union. Would such an alliance permit you to regain some of the bargaining power you have lost in the past five years?

Before you trade your lab coat in for a blue satin windbreaker embroidered on the back with "Physicians and Surgeons Local 101," consider asking your attorney for some advice and discuss the alternatives. A union card may not be your ticket to freedom.

Over the past few years, many physicians have felt the financial and professional effects of managed care penetration. Most physicians felt that they had no recourse but to sign whatever the HMO sent them, because they had no leverage. Those who tried to fight or negotiate often found themselves passed over. This growing sense of powerlessness has prodded many doctors to look for ways to increase their bargaining power with managed care plans. As a result doctors in many markets have explored joining unions to provide a vehicle for collective bargaining. According to union sources, about a third of the doctors in Brevard County, Florida are unionized and the Federation of Physicians and Dentists Organization, which is headquartered in Tallahassee, Florida, has over 2500 members in Florida and Connecticut. But what can a union really do for you to help you negotiate with managed care plans? The short answer is, right now under the current state of the law, not much. While membership in a union may carry with it benefits in terms of lobby clout to help change the laws and influence public opinion, because of prohibitions under the state and federal antitrust laws, a union cannot lawfully negotiate fees or reimbursements rates for physicians who are independent practitioners as opposed to employees.

So, why not at least try negotiating through a union? Well, for one thing the risks are high; violators of the antitrust laws may face felony fines of bankruptcy proportions, prison sentences, and payment of treble damages to persons (like HMOs) who suffer economic damages. An ironic thought: to pay damages to the HMO you had wanted to organize against? There are alternatives.

### THE LABOR EXEMPTION UNDER THE FEDERAL ANTITRUST LAWS

The biggest obstacle to collective bargaining by physicians is the Sherman Antitrust Act. The purpose of this law, passed in 1890, is to promote competition among providers of all goods and services in order to lower prices and improve quality. The Act broadly prohibits "any contract, combination, or conspiracy in restraint of trade," and has been held to cover the services of all workers, including doctors, lawyers and engineers.

To permit labor unions to bargain collectively, Congress has amended the antitrust laws and the labor laws to exempt certain labor relations activities from the antitrust laws. However, to qualify for this exemption, the labor activities must "involve or grow out of a labor dispute" which is defined as a "controversy concerning the terms and conditions of employment."[1] Thus, the key to the collective bargaining exemption is status as an employee.

While a growing number of physicians are employed by hospitals, clinics or managed care entities, most physicians today are self-employed independent contractors and are not able to collectively bargain unless they integrate themselves into a network of other physicians and share risk, further discussed below.

### OTHER LIMITS ON COLLECTIVE BARGAINING BY PHYSICIANS

Worse yet, even if you are an employed physician, you may not be eligible to join a union and collectively bargain if you are a supervisory employee, who does not enjoy the same protection under the National Labor Relations Act as do non-supervisory employees. Compounding this problem is the fact that the definition of "supervision" has been broadly interpreted to mean the ability to hire, discipline or otherwise control other employees for the benefit of the employer. In one case, participation in internal peer review or patient services committees within a managed care organization has been held to be a position of supervision.

The counter argument is that such activities are policy making activities and are a part of the independent legal obligation of the professional health care provider to the patient, and not part of the responsibility to the employer. Nonetheless, it is clear that many employed providers, particularly if they are salaried, will not be eligible for collective bargaining because they are part of management.

Furthermore, by statute in many states there are other restrictions; physicians and other providers have a limited ability to strike. Therefore, their ability to bargain collectively is limited. Since withholding of care is unpopular and dangerous, the most effective "strike" tactic might be a "paper strike" in which physicians refuse to sign medical records so that the employing organization cannot collect payment from third party payers. However, such an activity would probably be a contractual violation and might also initiate disciplinary action by the respective licensing board.

### ALTERNATIVES TO UNIONS

The "Messenger Model" form of arranging contracts between physicians and MCOs is generally approved, provided certain restrictions are observed. Generally, this means that the "messenger" must act as a mere conveyor of information and not as a negotiator; however, there are other more subtle restrictions not discussed here. In the Messenger Model type of contracting, the union could fulfill the messenger role as well as render other services, such as providing the physician with objective analysis of offers and historical rate and cost data where individual providers are not identified with the data.

If several physicians integrate their practices to form a single entity which can market itself to third party payers as an IPA or Physician Joint Venture, some aspects of the antitrust prohibition on negotiation of fees can be avoided. There are intricate federal safety zones that guide physicians in this area, and competent consultation is essential to effect proper structuring.

A Multi-provider network, more commonly known as a Physician-Hospital Organization (PHO), is more sophisticated than the physician joint venture, and can market jointly to third party payers. The rules for PHOs are still evolving, and there are no firm antitrust guidelines yet established, as there are for joint ventures. Association with a PHO should be proceeded by in-depth consultation with a knowledgeable health law attorney.

### CONCLUSION

The negotiating table is slowly leveling between physicians and managed care entities as the market responds to the growth of managed care. Some economists and regulators worry that physician networks are gaining too much bargaining power; therefore, it will not be surprising if we see more, rather than less, regulation in this area.

As more physicians become salaried employees, unions will undoubtedly seek to play an increasing role in the health care industry, but this is expected to occur without federal legislative support. Clearly, much of what unions can do for self-employed physicians can be accomplished through other vehicles with which more physicians have greater experience. Examples include a local medical association. Caution should be exercised here, however, because a local medical association may jeopardize its tax exempt status by engaging in certain activities on behalf of its members.

FINALLY, the draft of the proposed new STARK II REGULATIONS have just been published, as noticed in another part of this issue. NEW AND OLD PRACTICE ARRANGEMENTS MUST BE MODIFIED TO CONFORM TO THESE REGULATIONS, which are now "technically" in effect.

Jerome Hoffman, Esq. and A.S. Weekley, Jr., M.D., Esq. ~ The Health Law Group, Holland & Knight LLP

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[1] *29 U.S.C. ss. 104, 113.*

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