"Obstacles are those frightful things you see when you take your eyes off your goal" Henry Ford

LEE COUNTY MEDICAL SOCIETY

Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 27, NO. 05

FORT MYERS, FLORIDA
Daniel Schwartz, M.D.

SEPTEMBER 2003

GENERAL MEMBERSHIP MEETING

September Meeting

THURSDAY, SEPTEMBER 18, 2003
PREVENTION OF MEDICAL ERRORS
2 HOURS CME CREDITS
Royal Palm Yacht Club
2360 West First Street
Downtown Fort Myers
6:00 p.m. – Dinner/7:00 p.m. – Program
Speaker: Cliff Rapp, Vice President
Risk Management, FPIC

November Meeting

THURSDAY, NOVEMBER 20, 2003
HIV/AIDS AND DOMESTIC VIOLENCE
2 HOURS MANDATORY CME CREDITS
Royal Palm Yacht Club
2360 West First Street
Downtown Fort Myers
6:00 p.m. – Dinner/7:00 p.m. – Program
Speakers: James E. Harrell, MD, Domestic Violence
Robert Schwartz, MD, Infectious Disease

These activities have been planned and Implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Florida Medical Association and First Professionals Insurance Company. The Florida Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The Florida Medical Association designates activities for a maximum of 2 hours in Category 1 credit towards the AMA Physician's Recognition Award. Each Physician should claim only those hours of credit that he/she actually spent in the educational activity.

LCMS Members Dinner NC, CME $50—Total $50
Retired, Applicants, Spouses, Physician member PAs Dinner $25, CME $50—Total $75
Non-Members Dinner $25, CME $100—Total $125

Please RSVP:
LCMS, PO Box 60041, Ft Myers, FL 33906
Tel: 239-936-1645 Fax: 239-936-0533

Inserts

1. SEPTEMBER MEETING NOTICE
2. LCMSA/F MEMBERSHIP FORM
3. FLORIDA DEPARTMENT OF HEALTH RELEASE
4. AAPS REPORT
5. COMMITTEE SIGN UP

In This Issue. . .

President's Message

"WE'RE NOT THERE YET."

Ralph Gregg, M.D.

What a difference a day makes. Just two days ago, I finished writing my piece for this space, which was basically a recap of the progress of Tort Reform in Washington and Florida over the summer. In our nation's capital, Tort Reform continues to be blocked by the U.S. Senate Democrats, but we are slowly picking up votes. Fortunately, we still enjoy the support of Senate Majority Leader Bill Frist, who promises to reintroduce favorable legislation this fall. In Florida, I was about to report that progress had been even slower, but the debate more mean spirited. Until yesterday, Friday, August 8th, the Florida Senate leadership continued to deny that a problem even existed. In June, the Senate held a sham hearing and issued a wildly biased report showing that there is no malpractice crisis in Florida! Radio and television ads have been produced by the trial bar and Republican Senate Majority Leader King denouncing Governor Bush and the House for their position on Tort Reform. Then yesterday, at least as far as Florida is concerned, everything changed.

It was announced that the Florida House and Senate had reached an agreement on key elements regarding medical malpractice, Tort, and insurance reform. As of this writing, no official language is available, so it is hard to come to solid conclusions about the compromise. Despite this, many in the media and legislature are claiming victory and announcing the end of the crisis. But a first review of the major points of this compromise reveals problems, which must be resolved for reform to be effective. What follows is an abbreviated list of the compromise "highlights:"

- provides a physician cap on non-economic damages of $150,000 for the emergency room setting with an aggregate cap of $300,000,
- provides a cap on non-economic damages of $500,000 for each physician with an aggregate cap of $1,000,000 per claim,
- allows caps to be pierced to the aggregate amount in the event of death, permanent vegetative state, or other extraordinary circumstances, and
- provides for a "rates freeze" for the rest of the year.

There is much more to the compromise, including physician discipline and the regulation of insurance companies; but these points are enough to expose the problems.

First and foremost, the "cap" is no cap at all. The aggregate figures will only encourage suing multiple physicians to reach the aggregate cap. If the cap can be pierced in the event of "extraordinary circumstances", then we have no meaningful cap. A rate freeze is of little help when we already have the highest insurance rates in the country. The cap of $150,000 for emergency services is great, but to whom will the cap be provided? Will the obstetrician who is on call and emergently delivers a baby be included in this category? There needs to be a clarification on these issues. And then there is the biggest problem of all, at least as I see it. What good is it to have a soft, $500,000 cap when virtually no one in this county can afford malpractice insurance coverage greater than $250,000? What are these guys thinking?

Obviously, the compromise needs work. For these and other reasons, the FMA does not support it in its current form. However, we must also recognize the progress that this compromise represents and work to improve it before a vote in the next special session. We will not give up.

2003 FMA ANNUAL MEETING

The 2003 Florida Medical Association Annual Meeting was held August 28 – August 31, 2003 at the Westin Diplomat Resort and Spa in Hollywood, FL. The following physicians attended in your behalf as delegates from the Lee County Medical Society.

Howard Barrow, M.D.
Michael Fletcher, M.D.
James R. Fuller, M.D.
Ralph Gregg, M.D.
Eliot Hoffman, M.D.
Richard Murray, M.D.
Julio L. Rodriguez, M.D.
James H. Rubenstein, M.D.
Alan D. Siegel, M.D.
Douglas Stevens, M.D.
Dean Traiger, M.D.
Steven R. West, M.D. (Attended as FMA Board Member)

The Lee County Medical Society along with the medical societies from Charlotte, Collier, Manatee, and Sarasota make up the Lower West Coast Caucus. Marguerite P. Barnett, M.D. (Sarasota), George Thomas, M.D. (Manatee), Steven R. West, M.D. (Lee), and Corey Howard, M.D. (Collier) all ran for a seat on the Florida Delegation to the American Medical Association. (At the time of press we do not know the out come) Dr. West ran UNOPPOSED for FMA Secretary.

As I Recall...

Roger D. Scott, M.D.

SEPTEMBER SONG

September always seemed to be a good month throughout my life except for *September 11th* when this country was so dastardly attacked by terrorists and will never be erased from my memory.

Even as a child *September* seemed to herald the lessening of the terribly hot Florida season and the beginning of slightly cooler weather. For some reason I didn't seem to mind going to school, but I am a night person (most of these articles have been written after midnight), and it was awful to have to get up in the mornings. As each year passed it seemed that school became more and more interesting. I left the University of Florida in June 1945 to attend the University of Virginia in Charlottesville and there *Septembers* really showed season change and cooler weather.

It was on *September 21st 1946* that Dotte Roberts and I were married at the University chapel in Charlottesville; a lovely spot for a small wedding. The date was chosen because it was between semesters, and we could have a week's honeymoon in the Blue Ridge Mountains of Virginia (so beautiful at that season). As this was the end of World War II, many married veterans were using the GI Bill to attend college in contrast to pre-war students who were usually single; therefore housing was sparse in Charlottesville. For us to obtain an apartment (extremely small & in basement), in addition to paying rent, I had to stoke the basement furnace with coal several times a day to supply the old building with heat. The ceiling in the apartment was extremely low and had a large pipe (carrying hot water) running through the entire length of the apartment that was a frequent head bumper! Despite these drawbacks, we did feel extremely fortunate to have our place instead of a single room. This was the first time Dotte (Florida born) had ever been exposed to snow and ice-skating and in November 1946 she developed a middle ear infection that failed to respond to sulfanilamide. The ENT doctor advised that this was progressing into mastoiditis, and she was scheduled to undergo a mastoidectomy; a formidable procedure at that time. As she was preparing to go to the hospital, her doctor said that he was able to get an extremely scarce new miracle drug called penicillin that was just then beginning to appear for civilian use. He gave her (I'm not sure how much) only one injection of penicillin in beeswax, and low and behold she miraculously recovered without surgery!

The next *September (1947)* we matriculated to the University of Maryland Medical School in Baltimore where we had a very nice basement apartment downtown at 101 East Chase Street. I don't know how I would have made it through medical school without Dotte's help for she supplied me with stability, encouragement, assisted with my studies and quizzes, and would go to the anatomical lab on Saturday afternoons and read out loud the instructions for dissecting a cadaver while I dissected & smoked a cigarette or two!

On *September 1st 1949* (Labor Day!), Dotte presented me with a 9 lb 7 oz baby boy born in Miami, Florida just two weeks before I had to go back to school. She stayed with me through all of the hard years of medical school, internship, two years of military service (a great time) and four years of surgical residency. We came to Fort Myers in July 1958 (three children at that time), and she was so helpful in establishing my first practice. *September 10, 1960* we experienced Hurricane Donna in our brand new house and were blessed with no major damage. Sadly, Dotte died on April 6th 1967 on Jewett I at Lee Memorial Hospital — far too young for such a wonderful person to leave this world. Just as life must go on after *September11th*, our lives had to continue after such a personal tragedy.

Shane (my youngest daughter by my second marriage) married Tony Oliver, a very fine young Canadian, in Toronto on *September 21, 2002* (she was not aware of the coincidence of this date to my first wedding). I had always wanted to visit Quebec City and stay at the Chateau Frontenac so wonderful Vonnie Jones and I went there and were secretly married at the Chateau on *September 14, 2002*. We only "went public" with our announcement after Shane and Tony's wedding.

Now you've experienced my "September Song". The old musical version of "September Song" as sung by Walter Houston was a great song.

This has been a very personal article dedicated to the memory of Dorothy Roberts Scott (November 16, 1923 – April 6, 1967)

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

PRINTERS
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MEMBERSHIP ACTIVITY

New Practice Locations

Michael Fletcher, M.D.
Pain Management Center at Bonita Springs
26800 Tamiami Trail South, Ste 150
Bonita Springs, FL 34134
(239) 947-7246 (O)
(239) 949-7258 (F)

Stephen Prendiville, M.D.
SWFL Facial Plastic Surgery Associates, Inc.
4120 Del Prado Blvd.
Cape Coral, FL 33904
(239) 541-0199 (O)
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1415 Homestead Road North
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Alexandra Konowal, D.O.
Konowal Vision Center
9450 Corkscrew Road Bldg 2
Estero, FL 33928
(239) 948-7555 (O)

LCMS STATS

June 16, 2003 - August 15, 2003

	Current	YTD
PHONE CALLS RECEIVED	**655**	**3774**
From Physicians and Office Staff	80	767
For Referrals	178	1279
For Background Checks	38	184
Filing Complaints	5	27
Regarding Non-Members	23	137
Regarding Alliance	10	62
Regarding CMS, FMA, and AMA	47	168
Miscellaneous Calls	274	1150
APPLICATIONS SENT TO PHYSICIANS	**10**	**40**
MEETINGS	**9**	**42**
Attended on behalf of LCMS	4	14
Society Meetings	5	28
DIRECTORIES DISTRIBUTED	**18**	**88**

Highlighting a Social Service Agency

RONALD MCDONALD HOUSE OF SOUTHWEST FLORIDA

Karen Parsly, Executive Director

When an unlikely partnership was formed in Philadelphia in 1974 between an NFL team, a children's hospital and a restaurant chain, none of its members could have imagined that their dream of a "home-away-from-home" for families of seriously ill children would grow to become an international phenomenon.

The Ronald McDonald House, located on the campus of The Children's Hospital at Health Park took ten years in the planning, and was opened in 1996. It has 6 bedroom suites that will sleep families of 4; a kitchen and laundry room; play room; library and lanai.

The Ronald McDonald House of Southwest Florida is supported solely by the community, including local McDonalds' restaurants, local civic groups and businesses, individuals, organizations, direct donations – including endowments, memorials and bequests. It also hosts major fundraising events including an annual Storybook Ball and Fall Classic Golf Tournament.

Around the world there are more than 200 Ronald McDonald Houses in 18 countries, on five continents, providing 3,000 guest rooms every night. More than 20,0000 volunteers donate more than 1,000,000 hours of service each year, and as new houses open, those numbers will increase. Locally we serve approximately 175-200 families each year. While the majority of our families come from Florida counties, we have also provided lodging for families from Germany, Haiti, Belize, Costa Rica Columbia, Panama, and Guatemala.

For further information or a personal tour you may telephone 437-0202 or E-Mail: kparsley2@earthlink.net. Visit us online at www.ronaldmchouse.com.

ATTENTION PRESCRIBING PHYSICIANS – CHANGE IN LAW

Message Posted by Florida Department of Health – Division of Medical Quality Assurance Board of Medicine. Effective July 1, 2003, SB 2084 provides the following:

Section 1. Section 456.42, Florida Statutes, is created to read:
456.42 – Written prescriptions for medicinal drugs.

A written prescription for a medicinal drug issued by a health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in both textual and numerical formats, and the directions for use of the drug; must be dated with the month written out in textual letters; and must be signed by the prescribing practitioner on the day when issued.

OCTOBER 16 HIPAA DEADLINE

All HIPAA covered entities should have started testing software and systems on April 16, 2003, and must be HIPAA compliant by Oct. 16, 2003. If you are a covered entity and have not started testing, you are behind and need to start immediately. For information on code set requirements, go to www.cms.gov/hipaa.

LEE POPULATION INCREASE

	2003	2002	Increase	Percentage Increase
Florida	**17,057,795**	**16,674,608**	**383,187**	**2.3%**
Lee County	**497,022**	**475,073**	**21,949**	**4.6%**
Collier County	**291,902**	**277,457**	**14,445**	**5.2%**
Charlotte County	**151,994**	**148,521**	**3,473**	**2.3%**
Bonita Springs	**39,906**	**39,154**	**752**	**1.9%**
Cape Coral	**122,373**	**113,253**	**9,120**	**8.1%**
Fort Myers	**52,527**	**51,323**	**1,204**	**2.4%**
Fort Myers Beach	**6,792**	**6,741**	**51**	**.8%**
Sanibel	**6,224**	**6,135**	**89**	**1.5%**
Naples	**22,343**	**22,057**	**286**	**1.3%**

Note: Figures are preliminary.
Source: University of Florida Bureau of Economic and Business Research The News-Press

ODDS AND ENDS

2004 MEDICARE PAYMENT SCHEDULE PROPOSED RULE

The 2004 Medicare Physician Payment Schedule proposed rule was published in the August 15, Federal Register and will be open for comment through October 7. The AMA has arranged for Medicare officials to brief specialty staff on the rule next week and will be soliciting specialty input as we prepare comments on the rule. A draft of those comments will then be shared with state and specialty societies for possible use as a starting point for your own individualized comments. Key provisions of the rule follow.

Payment Update: In March, CMS projected a –4.2% update for 2004. Although steeper cuts are possible, the proposed rule did not provide any new projection but noted only that the estimated update is "highly likely" to change before it is finalized later this year. CMS is not required to publish an update projection in the proposed rule but it made an exception last year.

Medicare Economic Index (MEI): CMS is proposing to re-weigh the cost components of the MEI based on more current data. The revision only increases the projected 2004 MEI from 2.4% to 2.5%, however, and CMS's calculation of the projected 2004 MEI includes only a 6.6% increase in professional liability insurance (PLI) costs compared to an 11.3% increase last year. The final rule will incorporate more current data, which could further change the MEI.

Geographic Adjustments: The geographic practice cost indexes (GPCIs) which measure regional variations in work (physician earnings), PLI and practice expense all were scheduled for revision in 2004. In order to incorporate new data from the 2000 census, however, CMS has decided to wait until 2005 to update the work and practice expense GPCIs. This is in marked contrast to the PLI GPCI where CMS not only will make revisions in 2004 but is making a significant effort to include the most recent information possible. Data collection has delayed completion of the revisions, however, and the PLI GPCIs will not be published until the final rule.

Relative Value Unit Adjustments: Changes in the MEI weights are also reflected in the calculation of work, practice expense and PLI relative values. As a result, the share of total RVUS allocated to PLI will increase by 21.7% but this increase will be offset by reductions in the RVUs going to work and practice expense. CMS also lauds the work of the RUC's Practice Expense Advisory Committee (PEAC) and updates the prices for medical supplies. Practice expense changes for oncology will be discussed in a separate rule on Medicare payment for drugs that has not yet been released.

Other: The proposed rule also would modify the monthly physician payments for end stage renal disease treatment and would reduce the administrative burden associated with the diabetes education benefit.

FLORIDA'S HEALTHCARE: ON THE ROAD TO RECOVERY

John O. Agwunobi, M.D., M.B.A.
Secretary, Florida Department of Health

As I watched Governor Bush sign the historical medical malpractice liability reform bill into a law, I recognized the enormous public health significance of the event. The Florida Department of Health is charged with responsibility for promoting and protecting the public's health. As its Secretary, I have spent much of the last few years fighting to maintain and improve access to quality healthcare in Florida, even as that very access was threatened by the medical malpractice insurance rate crisis. I believe that in signing the bill into law the Governor set our healthcare system on the road to recovery.

The law addresses healthcare quality, physician discipline, tort reform, alternative dispute resolution and insurance code reform. Importantly, it also provides us the tools to accurately measure the "vital signs" of our system in the future. It provides for the collection and monitoring of critical insurance, malpractice and access to care measurements. Going forward, we will be able to monitor the effect of the legislated prescription on the crisis. We will be able to confirm that all is going as planned. We will be able to accurately identify the cause and need for further intervention in the future. This law provides us the tools to support our citizens and the access to quality care they deserve. Once the key provisions of the law begin to impact the system it will provide our physicians and hospitals with relief from the rapidly increasing medical malpractice insurance rates through an immediate freeze in rate increases with rate reductions.

The law doesn't do everything that everyone called for, but given the diversity of opinion on this issue, no law could ever have satisfied every position. Making the right diagnosis was just as difficult as finding the right prescription. But now that all is said and done, I believe the democratic process came through for us all. The process resulted in a law that, in the final analysis, puts us on the right road to recovery.

I commend Governor Bush, President King and Speaker Byrd's diligent commitment to finding a comprehensive solution for the crisis that threatened healthcare access in Florida. This was no easy task for those whose responsibility it was to craft a solution. The debate was both passionate and, on occasion, confrontational. We should respect the commitment and effort that went into the law by taking the time to read and understand its broad ranging impact. This is a comprehensive law that, as a result of collaboration, compromise and consensus, will ultimately protect access to healthcare for all Floridians by encouraging quality care, enhancing physician discipline, immediately halting increasing insurance premiums, maintaining remedies for future victims of medical malpractice and physicians' access to affordable insurance coverage.

Other provisions include improving patient safety and quality of care. The law requires hospitals to establish patient safety plans and committees; requires hospitals and physicians to personally notify patients when they have been harmed; requires college and university healthcare training programs to provide instruction in patient safety. It also requires doctors to have training in the most common misdiagnosed conditions.

The law requires the development of a statewide infrastructure to improve patient safety, through coordinated efforts to identify and correct the sources of medical errors and use of new technologies. A public information system will be developed to provide consumers with better information to help choose the safest hospitals with the best quality of care.

This law recognizes the importance of disciplining that small percentage of physicians who harm patients. It puts the power of disciplining physicians back into the hands of the Board of Medicine, who are the most appropriate and experienced to discipline physicians. Additionally, in formal hearings, physicians will now go before a specialized Administrative Law Judge with experience in healthcare.

The Department of Health is impacted by this law in several additional ways. It improves the department's access to patient records to investigate discipline cases; allows the department to subpoena the physician's patient records in disciplinary proceedings; and mandates the expedited evaluation and investigation of a physician who has committed repeated and gross negligence. The department will also convene a workgroup to determine ways to improve discipline and report back to the Legislature.

This law is a culmination of hard work and long hours in addressing an extremely complex issue. I commend and appreciate the leadership and diligence of both Governor Bush and the Legislature in finding a comprehensive solution for Florida's healthcare access crisis. I firmly believe Florida's healthcare is on the road to recovery. The prognosis is good!

NEW GUIDELINES HELP PHYSICIANS ENSURE SAFE AND SECURE INTERNET PRESCRIBING

In an effort to help physicians safely and securely prescribe medications to patients via the Internet, the AMA House of Delegates (HOD) recently adopted new guidelines stating that physicians should obtain medical history information and perform a physical examination before prescribing medications online. "The AMA supports the use of this new technology to help physicians care for their patients." Said AMA President-elect John C. Nelson, M.D. "Physicians can refer to these new guidelines as they integrate online prescriptions into their practices while continuing to provide high quality care."

Based on recommendations prepared by the AMA's Council on Medical Service, the new guidelines suggest physicians transmit prescriptions over a secure network that includes features such as password requirements and prescription encryption. In addition, the guidelines stress that physicians who prescribe medication using the Internet should either be licensed in the states where their patients live or meet the regulatory requirements of individual state medical boards. Prior to this action, AMA policy supported Internet prescribing, but stressed the need for appropriate safeguards to ensure that online communications did not replace the interpersonal aspects of physician/patient relationships. To showcase the preservation of this important medical relationship, the AMA and other societies in 1999 founded Medem, an online physician/patient communications network. Visit http://www.ama-assn.org/ama/pub/article/1616-7802.html to learn more about the AMA's new Internet prescribing guidelines.

NEW MEMBER APPLICANTS

Application for Membership

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

BRIAN FABIAN, M.D. – DERMATOLOGY
Medical School: Louisiana State University, Shreveport, LA (1987-91)
Internship: Wilford Hall USAF Medical Center, San Antonio, TX (1991-92)
Residency: Henry Ford Hospital, Detroit, MI (1995-98)
Board Certification: American Board of Dermatology
Dr. Fabian is in solo practice at 26800 South Tamiami Trail, Suite 310, Bonita Springs, FL34134.

DANIEL MCKENNA, M.D. – OTOLARYNGOLOGY
Medical School: Albany Medical College, Albany, NY (1994-98)
Internship: Thomas Jefferson University Hospital, Philadelphia, PA (1998-99)
Residency: Thomas Jefferson University, Philadelphia, PA (1999-03)
Dr. McKenna is in group practice with ENT Specialists of Florida at 39 Barkley Circle, Fort Myers, FL 33907.

GREG MICHAELS, M.D. – RADIOLOGY
Medical School: University of Southern California, Los Angeles, CA (1982-86)
Internship: White Memorial Center, Los Angeles, CA (1986-87)
Residency: University of California, Orange, CA (1987-91)
Board Certification: American Board of Radiology
Dr. Michaels is in group practice with Florida Radiology Consultants at 6311 South Pointe Blvd, Fort Myers, FL 33919.

UNDERSTANDING BINDING ARBITRATION

What are the benefits of binding arbitration?
Medical malpractice lawsuits are often very lengthy and expensive for all parties. This cost contributes to the rising costs of healthcare. Arbitration is a relatively informal process of resolving dispute that is an alternative to the traditional court system. Through arbitration, patients and physicians both benefit because they are able to more promptly resolve malpractice claims and for less cost to each party. Arbitration should avoid unreasonable jury awards, thereby lowering costs, which would positively impact rates and the cost and the availability of healthcare.

How does arbitration work?
The process starts with a notice from one party demanding arbitration. The physician and the patient each name an arbitrator to serve on their behalf. An arbitrator is like a judge, in that he or she listens to the evidence presented by both sides and decides whether malpractice occurred. These two arbitrators then pick a third member of the panel. At the arbitration hearing each party will be represented by their own attorney. Each party will have the opportunity to present evidence and cross-examine witnesses. All three arbitrators listen to the evidence and participate in the decision by applying the same law as a court. The arbitrators can award any amount or kind of damages.

What does binding arbitration mean?
The decision of the arbitration panel is final. Neither party can go to court to appeal the decision, except on very limited grounds. Both sides are bound by the arbitrator's decisions.

How do I participate in arbitration?
FPIC has developed an arbitration program that is complimentary to all insured physicians in Florida. The program provides an arbitration agreement, a short video for patients to view, answers to common questions, and instructions for implementation. For additional information, or to reserve your copy, contact Amy Waller, Director of Communications, 800-741-3742, ext. 3057 or waller@fpic.com, or online at www.medmal.com.

CAPTIVE INSURERS: THE RIGHT MEDICINE FOR PHYSICIANS IN CRISIS

By Mark B. Koogler, Esq.

Today's medical malpractice liability insurance world for physicians is in critical condition. Premium rates for liability insurance, where such insurance is affordable or even accessible, are skyrocketing. Insurers writing this insurance are failing or withdrawing from states, as losses mount and investment income shrinks. The success of recent initiatives by state legislatures to enact tort reform is uncertain but will certainly not be immediate. A crisis of affordability and accessibility now exists in at least 18 states, and the crisis is looming in another 20 states. As a result, many physicians are on life support, closing their doors in Florida either by retirement from the practice of medicine or relocating to other states with lower premium rates, greater availability of insurance or caps on awards.

A Captivating Option

Physicians have historically relied on commercial insurers for their liability coverage. As the market has hardened and certain specialties have been hit by cyclical premium increases, physicians have begun to explore alternatives to traditional insurance. Options include risk retention groups, self-insurance and captive insurance companies. Captives in particular have become a viable option for physicians interested in managing their own risks and controlling their own future. A captive is an owner-controlled insurance company that insures the owner's liability risks.

Most insurance-owned captives have arisen from physician groups willing to share risk and retain earnings and groups that have an infrastructure to establish and maintain the insurance program. The keys to a successful physician-owned captive include a long-term financial and administrative commitment, prudent funding, effective loss controls for underwriting and claims management and fairness among participants. Failures in this area have generally arisen from the lack of capital, unpredictability of losses or reluctance to share or bear the risk of liability or a long-term commitment to the program. A captive insurance company is not a silver bullet to resolving all of a physician's insurance issues but it should be viewed as a long-term solution that mitigates the cyclical nature of insurance premiums and puts risk management in the hands of those who know their business best — the physicians.

Is a Captive Feasible?

Physicians must determine whether an alternative option, such as a captive, provides a better solution than the current commercial insurance market. First, physicians should have an actuarial firm undertake a feasibility study to evaluate which option, if any, is most suitable and compare the costs of commercial insurance with the costs of appropriate alternatives. The feasibility study helps identify which of the alternatives is most efficient, least complicated, least expensive, legally sound, responsive to current needs and flexible to adapt to future circumstances. The study will also help quantify the needed premium and capital levels and reserves.

Offshore Is the Place to Be

Physicians also need to determine the domicile of the captive. A captive, although an insurance company, is not designed to be an insurance company for purposes of doing business in a particular state. A captive allows the owner to avoid the more onerous financial and other legal requirements applicable to commercial insurers, provided the captive does not violate various state laws dealing with the conduct of insurance business in a particular jurisdiction. As a result, captives have greater flexibility than commercial insurers in investment policies, capitalization and regulation; however, a captive should never neglect its responsibilities to act in a prudent fashion to assure it can pay claims and operate its business.

Any domicile for establishing a captive should be evaluated in terms of sophisticated regulation, stability and infrastructure. In addition, ease of doing business, capital/surplus requirements, perception and accessibility are key factors. Bermuda has historically been a favorite of captive owners; however, the Cayman Islands are becoming a preferred domicile for physician-owned captives. Both domiciles have long-standing and respected regulators and an infrastructure comprised of insurance managers, accountants and actuaries that support the captive industry. Within the United States, Vermont has been the leading home for captive insurers, but as alternative risk mechanisms have grown in popularity in recent years, other states, such as South Carolina, Montana and Hawaii have enacted laws to attract captive owners.

Capitalization, premium deductibility, access to reinsurance, claims management and favorable tax treatment all make captives an increasingly attractive alternative to commercial writers of medical malpractice liability insurance. As physicians continue to feel the pain of high premium rates, severe jury awards and lack of access to insurance, the feasibility of establishing a captive is just what the doctor ordered.

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2004 Dues Notices Are In The Mail
We Have Changed Our Billing Schedule
For Offices With Year Endings Of September and October

GENERAL MEMBERSHIP MEETING THURSDAY SEPT. 18, 2003
2 HOURS CME PREVENTION OF MEDICAL ERRORS

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