April 2008
Volume 32, Issue 1

LEE COUNTY MEDICAL SOCIETY

Bulletin

Editor: John W. Snead, M.D.

2008 LCMS General Membership Meetings

May General Meeting
Thursday, May 15, 2008
6:30 PM

Topic: "Emergency Preparedness and Disaster Management: Medical, Ethical and Legal Challenges."

Special Speaker:
Anna Maria Pou, M.D.
Rick Simmons, Esq

Royal Palm Yacht Club
2360 West First Street
Downtown Fort Myers, FL

Limited Seating

Make reservations to:
Lee County Medical Society
239-936-1645

Pictorial Directories Available

2007-2008 LCMS Pictorial Directories are available for your office and patients at no charge. They can be picked up at our office at:
3805 Fowler Street, Ste 2
Fort Myers, FL 33901

Insert

- **May 2008 Meeting Notice**
- **Interact Technology Solutions Ad**
- **Pause/Time-Out Form & Surgical Log**
- **Medicare Appeals Process**
- **HMA Annual Meeting**
- **FMA Resolutions Form**

Inside this issue:

President's Message

Of Candidates, Quality and Rhetoric

Dean Traiger, M.D.

With the 2008 Presidential contest in full swing, healthcare is one of the main issues that all the candidates are addressing to try to convince voters they are the best person to lead the country for the next 4 years.

Senator Hillary Clinton's health plan is based on 5 main themes:

1-Offer new coverage choices for the insured and uninsured
2-Lower premiums and increase security
3-Promote shared responsibility
4-Ensure affordable health coverage for all
5-A fiscally responsible plan that honor our priorities

Senator Clinton's focus is on "quality care". In fact, she mentions quality 58 times in her 16 page booklet outlining her health plan. Her other area of focus is in providing "affordable health coverage for all". She promises lower premiums, increased security against loss of coverage and exorbitant costs by ending unfair health insurance discrimination. Also, each and every American will be *required* by law to have health insurance. There will be no more uninsured period. Patients will have a choice of sticking with their current insurer's health plan (assuming they decide to stay in the health care market), or may choose to join the government's plan that is offered to members of congress (spin for any government employee), or a "quality" public plan similar to Medicare. When did Medicare become synonymous with quality care?

According to Senator Clinton's plan, relying on the consumers or government alone to fix the system is inadequate. She proposes that insurance companies should end discrimination in choosing their clients and that pharmaceutical companies should offer fair prices. Providers will work with patients and businesses to provide high-quality care. Employers will help finance the system.

Senator Clinton proposes to pay for this system by lowering spending by "increasing quality and modernization". She estimates that 56 billion dollars is wasted each year due to inefficiency, overpayments and unnecessary spending. Another proposal to finance her plan is to issue a tax cut. Tens of millions of Americans will receive a tax credit to help pay for their premiums while employers will see limitations in their tax exclusions for health care and by discontinuing the tax cuts instituted by President Bush for those making over $250,000.

One must assume that we must be providing inadequate care now without quality or using modern technology in the delivery of said healthcare. Many hospital systems and practitioners will be required to update their technology, at a huge expense, while at the same time dealing with reduced payments from Medicare and 3rd party insurers that will total up to 40% cut in the next few years.

Senator Barack Obama's health initiative has the following features:

1-Guaranteed eligibility. No American will be turned away. In contrast to Sen. Clinton's plan health insurance is not required but is available to all.
2-Comprehensive benefits. Again, similar to the plan offered to the members of Congress.
3-Affordable premiums, deductibles and co-pays.
4-Subsidies. Patients that do not qualify for Medicaid or SCHIP will receive an income-related federal subsidy to buy into a private or public plan.
5-Easy enrollment.
6-Portability and choice. The ability to move from job to job without changing or jeopardizing their health care coverage.
7-Quality and efficiency. Participants will be required to report data to ensure standards of quality, health information technology and administration are being met.

President's Message continued on page 5

LEE COUNTY MEDICAL SOCIETY BULLETIN
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Lee County Medical Society Mission Statement & Disclosure Policy

The purpose of the LCMS is to unite the medical profession of Lee County, FL, into one compact organization; extend medical knowledge and advance medical science; elevate the standards of medical education; strive for the enactment, preservation and enforcement of just medical and public health laws; promote friendly relations among doctors of medicine and guard and foster their legitimate interests; enlighten and alert the public, and merit its respect and confidence.

All LCMS Board of Governors and Committee meeting minutes are available for all members to review.

Membership Activity

Members in the News

Trevor Elmquist, D.O. recently earned the certified ophthalmic executive designation. The certification is awarded by the American Society of Ophthalmic Administrators and is given to candidates who meet nationally recognized standards in ophthalmic administration, including finance, accounting, marketing, operations and management. Dr. Elmquist has practiced ophthalmology for more than 15 years and specializes in medical and surgical eye care.

Alexander Eaton, M.D. was recently selected as one of the best doctors in America 2007-8 by Best Doctors, Inc. Best Doctor's Inc. is comprised of 50,000 top medical specialists in more than 400 subspecialties. Each selection is based on anonymous peer-review polling.

Steven R. West M.D. will be honored as the first recipient of the American Heart Association's "Dr. Pascotto Golden Heart Award" at the 2008 Lee Heart Ball on May 10. The award is given to a physician who has made a life-long contribution to improving heart health within the community.

Address Change

Physicians Primary Care-Pediatrics
1261 Viscaya Parkway, Suite 101
Cape Coral, FL 33990
Phone: 573-7337

HealthPark Pulmonary Specialists
9981 HealthPark Drive, Suite 454
Fort Myers, FL 33908
Phone: 343-6800

New Location

Michael Gross, M.D.
260 Beth Stacey Blvd., Ste 240
Lehigh Acres, FL 33936
Phone: 369-0700

Moved from Area

Michele Blair, D.O.

New Location

W. Dan Wood, M.D.
Lee Physician Group-Pediatrics
260 Beth Stacey Blvd., Ste C
Lehigh Acres, FL 33936-6013
Phone: 343-9888

New Members

Reggie Augusthy, D.O.—Physical Med & Rehab
Pierre Hyppolite, M.D.—Physical Med & Rehab
Dean D. Lin, M.D.—Neurosurgery
Jose Pacheco, M.D.—Radiology
Kultar Singh, M.D.—Neonatology
Matthew Ward, M.D.—Diagnostic Radiology

New Member Applicant

Douglas Brust, M.D.—Dr. Brust attended Columbia University in NY, NY where he obtained his MD in 1993. He completed his internship/residency at Brigham and Women's Hospital in Boston, MA (1996-98). He completed a fellowship at National Inst. of Health Clinical Ctr in Bethesda, MD (1998-2003). Dr. Brust is an infectious disease specialist with Internal Medicine Assoc at 1528 Del Prado Blvd, Cape Coral, FL 33990.

FMA Annual Meeting

The FMA Annual Meeting will be held at the Rosen Shingle Creek in Orlando, FL, July 31-August 3, 2008. *The date has been moved up a month.* We are requesting that you send us your resolutions; please use the enclosed Resolution Form and fax back to our office at 936-0533.

As I Recall...

Roger D. Scott, M.D.

April News

What a surprise it was to read some of the articles that appeared in "The Daily Florida Union" newspaper that I am reproducing here.

"To the Editor of the Union. Why cannot the people of this city be made to understand that the gasses arising from water closets and privies, are moat deleterious to health and probably cause more disease than any other nuisance; and why do they not make daily use of dry earth or ashes, which absorb and prevent the escape of these gases, and does prevent sickness in their own houses as well as those of their neighbors? A walk about the city at night will make it evident to the most careless and obtunded nostril that no attention is given by the majority of the people to this matter. An Anxious Inquirer*" Oh! I forgot to tell you that this newspaper was printed* "Jacksonville, Sunday Morning, October 1, 1882*" so* ***April News*** *fool on you! The U.S. census of 1880 revealed Jacksonville's population to be 7,650 and Duval County's population was 19,430.*

"The City Physician's Report for September. Dengue has been epidemic during the month in this city, and earlier epidemic in several other cities of Florida. No specific cause has as yet been given for the prevalence of this disease. Notwithstanding hundreds of cases have been treated during the month of this, broken-bone fever, there has not been a single death attributed to this disease. In fact the mortality for the month has been exceedingly low -- during the whole month there have been only 10 deaths from all causes. One died from old age, one from organic disease of the heart, one from consumption, one from convulsions, one from paralysis, one from meningitis, one from inanition, one from congestion of the brain, one from typhoid fever, and one from remittent fever. Total deaths for September 1881 were eighteen; September 1880 were twenty-four; September 1879 were eleven. The population has been increasing rapidly since 1879 and the mortality decreasing. No better proof is needed that the strenuous efforts made to put our city in a good sanitary condition have not been in vain."

"Pensacola's September 30 report: 783 cases of yellow fever to date, and seventy eight deaths. The disease has been spreading rapidly for a week, and it has unfortunately been chiefly confined to very poor people. Southern people, especially those of Mobile and Memphis, have sent most liberal contributions and our local board has been enabled promptly to relieve all distressed up to this time."

Large ads appear for panaceas "Dabys Prophylactic Fluid eradicates malaria, scarlet fever, bedsores, sore throats, frosted feet, chilbains, piles chafing, rheumatism, ship fever, catarrh, erysipelas (*Not syphilis you folks.*), burns, scars, dysentery, scurvy, prevents smallpox and diphtheria. Prevents cholera and purifies and heals ulcers. In case of death it should be used about the corpse -- it will prevent any unpleasant smell. The eminent Physician, J. Marion Simms, M.D., New York, says I am convinced Prof. Darby's Prophylactic Fluid is a valuable disinfectant Vanderbilt University Professor of Chemistry N.T. Lupton states that it is theoretically and practically superior to any preparation with which I am acquainted. Indispensable to every home. Perfectly harmless used internally or externally for man or beast. The fluid has been thoroughly tested, and we have abundant evidence that it has done everything here claimed. " (*Does that last statement sound familiar today? Wish we had some of this today!)*

"As prepared by Dr. H. Mosley, his Lemon Elixir is a pleasant lemon drink, a substitute for all Cathartic and Liver Pills, that positively cures all Biliousness, Constipation, Indigestion or Dyspepsia, Headaches, Colds, Loss of appetite, Impurities of the Blood, Pain in the Chest or Back, and all other diseases caused by a disordered liver and kidneys the first great cause of all fatal illnesses. For sale by H.C. Tison, 11 E. Bay Street."

"DISINFECT with STOWE'S OYSTER-SHELL LIME 90 CENTS A BARREL A.B. Hussy's Store 14 West Bay Street"

"DISSTON PURCHASE -- 4,000,000 ACRES! All their lands for sale at $1.25 per acre in blocks of not less than 80 nor more than 640 acres" *in several counties including some in Monroe. (All of the land comprising the current Lee, Hendry, and Collier counties were part of Monroe until 1887 when all of them became Lee County, but in 1924 Hendry and Collier were carved from the large Lee County.) Just think how much property you could've owned for $100 except the offer expired May 1, 1883!*

All of this information, excepting my *comments*, comes from the gift of this antique newspaper to me about eight or ten or maybe fifteen years ago (*How time flies. I just looked up the date on the envelope and it was January 2, 1989!*) from the distinguished Charles ("Chuck") W. Ruffner of Miami, Florida. Little is known today of a deed done by Chuck, an attorney, who did all of us (medical and otherwise professionals) a great service in 1961. The state of Florida had passed a law allowing individuals and groups of professionals to incorporate (become Professional Associations /P.A.) but the U.S Internal Revenue Service refused to accept the ruling, which would allow professionals to have pension plans and many other tax benefits. The Florida Bar (legal) appointed Chuck as Amicus Curiae (or something like that -- a representative for all of us professionals) to fight the IRS, and so he did and won a victory for the professionals to incorporate and have many tax advantages that we enjoy today. Now LLC's appear to be replacing PAs as they are not as complicated and have less tax problems, but still allow retirement funds etc. So thank you again Chuck for your service to all of us in medicine.

We regret the passing of Frank DiPlacido a fine oral surgeon and gentleman.

Lee County Medical Society Alliance News

Mary Macchiaroli and Jennifer Kim, Co-Presidents

We want to thank everyone for their insightful and valuable input on the matters put forth in last month's newsletter. As co-presidents, we believe it is not our job to make decisions that affect the operations and the future of the Alliance, but to facilitate discussion among the members and provide opportunities for the membership to make those decisions. With that in mind, we held a meeting on February 27th to discuss the opportunity recently provided to us to host the Southwest Florida Wine Fest. Thank you to Nancy Barrow, Juli Bobman, Tracy Cullimore, John Miksa, Betty Rubenstein, Tami Traiger and Sherri Zucker for attending the meeting and participating in the discussion. As a result of the discussion at the meeting and communications we have received via e-mail, the Alliance declined the opportunity to become the primary sponsor of the Wine Fest. We have now been offered the opportunity to become a secondary charity for the Wine Fest. Look for more information and details regarding this opportunity over the next few weeks via e-mail.

Another opportunity that we were presented with was to have a sponsor underwrite all or a portion of the cost of each Monthly Supper Club. Thank you to everyone who responded via e-mail. As a result of everyone's input, we have decided to decline the opportunity. The most compelling and most cited reason for declining was the fact that those attending enjoy the intimate atmosphere offered at the monthly dinners and many thought that intimacy might be compromised by inviting an "outsider" in to "work the room". We certainly appreciate offers to financially support the Alliance, but at the same time, we too enjoy the intimacy and the opportunity to socialize in a casual setting while enjoying the many wonderful restaurants around Lee County.

What the past month has shown us quite clearly is that we have a committed and connected membership within Lee County. We are grateful for the support and involvement we receive from our new and long-standing members. In case you did not notice, the above highlighted list of those in attendance at the Wine Fest meeting includes four past presidents of the Alliance! Through our travels and involvement in the Florida Medical Association Alliance and the American Medical Association Alliance, we realize how lucky we are to have our past leaders actively involved in our current meetings and events. Many other alliances are not so lucky. In addition, we rely on the leaders and staff of our Lee County Medical Society on a regular basis (probably far too much!). Dr. Dean Traiger and Ann Wilke provide unparalleled support and advice when it comes to making decisions for the Alliance. Thank you both and thank you everyone for helping to make this year a good one for the Alliance. Please feel free to call on us if you have any questions or wish to discuss current or future projects.

Florida's Workers Compensation Update

Liza Battaglia, General Lines Agent, Professional Benefits

In light of the bad economic news of the day, the bright spot on the horizon is that workers compensation rates for doctors offices have gone down for the third year in a row! Three years ago, doctors were paying $1.05 per thousand of payroll for their coverage. Today that rate is .57 cents per thousand – almost half.

How did that happen? You may be aware that the rates for workers compensation coverage are set by the State of Florida legislative branch for every employer. That is why the cost is the same for each type of employer across the board. Since claim severity and costs have fallen recently, so has the price of the coverage. Several changes to the law took place a few years ago that limited the amount of compensation an attorney could make on a workers comp case (and you thought the medical profession was the only one regulated). In addition, more proof was required to accept a claim for an injury that could not be proven, i.e. back injury with no correlating medical evidence, headaches, etc. The resulting fall of contested claims and awards had a direct impact on your costs.

In addition to the falling rates, the dividend program endorsed by your local county medical society has continued to pay top dividends to members of the Society (some counties in SW Florida have been paid the maximum of 24.8% back to doctors of their premium for five years in a row), further cutting your costs.

The 2008 maximums of corporate officer compensation are $119,600 and $48,600 minimums on included partnerships. That means a doctor who owns his own corporation could be included on his own policy for any work related injury for $682 per policy year. That coverage pays all medical and a small wage benefit for a claim. Whether you carry sufficient benefits on all of the doctors/officers in your group or not, you should be carrying workers comp on them as a cost effective benefit.

Please call Professional Benefits at 1.800.741.5170 or 941.957.1310 and ask for Liza Battaglia or Taylor Tollerton to learn more about this coverage and the County Medical Society Membership Dividend Programs.

President's Message continued

The plan to financing this initiative is by reducing inefficiency and poor quality care. The Obama plan will improve efficiency and lower costs in the health care system by:
(1) Reducing costs of catastrophic illnesses for employers and their employees. The Obama plan would reimburse employer health plans for a portion of the catastrophic costs they incur above a threshold if they guarantee such savings are used to reduce the cost of workers' premiums.
(2) Lowering costs by ensuring patients receive and providers deliver quality care. This will be done by promoting disease management programs, coordinate and integrate care, require full transparency about quality and costs, promoting patient safety and aligning incentives for excellence.
(3) Lowering costs through investment in electronic health information technology systems. Sen. Obama will invest $10 billion a year over the next five years to move the U.S. health care system to broad adoption of standards-based electronic health information systems, including electronic health records.
(4) Lowering costs by increasing competition in the insurance and drug markets.

Senator Obama also addresses medical malpractice and tort reform: "Increasing medical malpractice insurance rates are making it harder for doctors to practice medicine and raising the costs of health care for everyone. Barack Obama will strengthen antitrust laws to prevent insurers from overcharging physicians for their malpractice insurance. Obama will also promote new models for addressing physician errors that improve patient safety, strengthen the doctor-patient relationship, and reduce the need for malpractice suits."

Senator John McCain has a more limited initiative for health care. While Senators Clinton and Obama have detailed 15-16 page booklets on their plan, **Sen. McCain has (at best) a 2 page bullet point document called "Straight Talk on Health Reform".**

The theme expressed by all three candidates centers on enhancing quality while reducing costs. **Sen. McCain proposes that patients have more personal responsibility in their care. He states that controlling health care costs will require fundamental change – nothing short of complete reform of the culture of our health system and the way we pay for it. Also, to facilitate development of national standards for measuring and recording treatments and outcomes.**

He recommends "building genuine national markets by permitting providers to practice nationwide". I can only wonder what exactly this means.

Senator McCain does support "rapid deployment of 21st century information technology systems". He also mentions passing tort reform to eliminate frivolous lawsuits and excessive damages awards.

Sen. McCain did not provide any information as to how his plan would be financed.

As we draw closer to November and we must all choose who shall be the leader of the free world for the next four years – the choice, at least when it comes to healthcare is no further clarified. Certainly, we will see major shifts and fundamental changes if the next President is a Democrat. Neither of the Democrat health plans appear really viable nor would the proposed changes be likely to take place during their 4 year term. If Sen. McCain is elected, then it seems things will remain mostly status quo for the foreseeable future.

One can only hope that as the race is reduced to 2 candidates that these plans further evolve into meaningful healthcare reform for insured and uninsured while providing fair compensation to those providing the care. Additionally, I pray that we all be blessed with that magical but elusive substance called "quality".

Rabies Vaccine Shortage

Michael Barnaby, Lee County Health Department Public Information Officer

As most of you are aware, the rabies vaccine supply has been limited since last fall due to manufacturing problems. The state pharmacy has notified health departments that additional limitations have been put in place. The county health departments are now limited to twenty (20) doses of rabies vaccine per month. That amount limits us to treating only four (4) cases per month.

Because of this limitation, the health department will only be able to treat high risk cases. Cases that will not be included for post exposure prophylaxis are bites from small rodents such as squirrels, and bites from animals that are available for quarantine and/or testing.

There may be the necessity of referring individuals who have started rabies vaccine back to the emergency room or their private physician if their bite history does not fall into the high risk category, or if the health department has used it's allotted vaccine.

Physicians may order *Imovax Rabies Vaccine* from Sanofi Pasteur at (800) 822-2463 if you need to start or complete a vaccine series on your patient.

This shortage is expected to last for the next 6 months.

Book Report

"Lives at Risk: Single-Payer National Health Insurance Around the World"

John C. Goodman

Editors Note (David McKalip, M.D., Chair, CMA Council on Medical Economics):

Mike Weston, M.D., member of the FMA Council on Medical Economics has taken the time to summarize the key findings of a book written by John C. Goodman **"Lives at Risk: Single-Payer National Health Insurance Around the World".** His co-authors are Gerald Musgrave and Devon Herrick. John Goodman had offered a synopsis of his book as a policy analysis for the Cato Institute which can be found at http://www.cato.org/pub_display.php?pub_id=3627 or "Policy analysis #532" at www.cato.org.

Dr. Goodman systematically evaluated numerous commonly held beliefs about a government run or nationalized health system and exposes many of the well-hidden flaws in such systems. In general, patients are subject to rationing, waiting lines, less innovation and older technology and medications. Those with cancer are far more likely to die of their disease compared to in America and health care resources are inequitably distributed between urban and rural settings. In addition, Dr. Goodman's paper shows how the numbers of infant mortality and life expectancy are not accurate variables on which to base the success of a health care financing system since there are many social factors that influence those outcomes. Dr. Goodman concludes that these are the consequences of a healthcare system run by politicians and bureaucrats.

Thanks to Dr. Weston for sharing his valuable committee work product with us. Also included are his personal observations to the FMA Council on Medical Economics as they work on analyzing health system financing in Florida.

"Healthcare in a Free Society: Rebutting the Myths of National Health Insurance"

A summary by Dr. Michael Weston.

John Goodman in his paper attempts to debunk the Myths associated with National Health Insurance (NHI) systems in several major countries. He seeks to show that the claims by certain persons or seen in some reports, that indicate that the Healthcare System in the United States spends more money and achieves worse results are misguided.

He goes through twelve myths and then explains why each in turn is false. In some cases, it may be due to flaws in the way information is collected, measured or interpreted. In others he reveals facts that are not widely known or are either hidden, distorted or ignored by those who wish to promote the National Health Insurance System.

The Myths are:

1. **In countries with NHI systems, people have a right to healthcare.**
   - Actually none of these countries has a "right to healthcare" clause in their system.
   - Spending is limited by limiting the supply of resources or rationing.
   - A study in New Zealand showed that of the patients waiting for surgery or other treatment; a large percentage had been waiting for over two years.

2. **Countries with NHI systems, deliver high quality healthcare.**
   - US doctors see on average 2,222 patients per year.
   - In Canada, doctors see about 900 more patients per year.
   - In the US; patients get more procedures done; like Cardiac Caths. and Angioplasty.
   - There have been questions about whether we do too many tests and procedures in this country. So it could be that we do too many and they don't do enough. (Author MW: Not Goodman's point).
   - One area where the stats don't seem to bear out the myth of high quality care in NHI countries is in the area of Cancer mortality. In the UK; the Cancer mortality rate is about 70% higher than it is here. At the time of the study; the rate in the UK was 275/100,000 population and in the US it was 194/100,000 population.
   - 40% of British cancer patients never see an Oncologist.
   - It was found that patients in countries with NHI had less access to critical medical procedures, new technology and the latest and most effective medications.

3. **Countries with NHI make healthcare available on the basis of need rather than the ability to pay.**
   - What was found is that access is not equitable between residents and usually goes according to income and influence.
   - Rich and influential persons are often able to jump the queue and get treatment, only waiting a fraction of the time that other residents do.
   - The elderly, ethnic minorities and patients in rural areas are often discriminated against with regard to expensive treatments.
   - In the UK the number of persons paying out of pocket for healthcare has recently increased by 40%.

4. **Although the US spends more than other countries with NHI, Americans don't get better healthcare.**
   - Two of the metrics often used for these comparisons

are Life Expectancy (LE) and the Infant Mortality Rate (IMR).
- Goodman states that neither is a good indicator of the quality of a country's healthcare system.
- He states there is little correlation between healthcare spending and LE. The HC system may affect a small part of the population, he argues, but the average person's LE has much more to do with genetics and lifestyle. (Author MW: This could be an area of some controversy).
- He shows charts breaking down male LE as of 1999; ranging from 68.4 to 80.9; and IMR broken down by Ethnicity, Geography, Income and Education.
- Goodman states that these stats; LE and IMR, have nothing to do with the quality of and the access to healthcare. (Author MW: This conclusion bears close scrutiny and is the subject of investigation in our FMA Council on Medical Economics).
- Goodman states that a better measure is a comparison based on those diseases that modern medicine can treat effectively.
- He looks at overall cancer mortality where it was 46% in New Zealand and the UK and 25% in the US, with several other developed countries somewhere in between. For prostate cancer the mortality rate ranged from 57% in the UK; down to 19% in the US.

5. Countries with NHI systems create equal access to healthcare.
- We covered most of the relevant points above such as disparate treatment of residents with differing incomes, etc.

6. Countries with NHI hold down costs by operating more efficient HC systems.
- Goodman uses a number of examples to show that this is not a valid claim.
- The average LOS in a US hospital is 5.4 days vs. 6.2 in Australia and 9.6 in Germany.
- He also points out that sometimes, what appears to be cost efficient operation is actually under-investment. Such as not replacing older equipment with newer more accurate or effective machines. This of course can make a major difference in areas such as Radiation therapy; both in terms of effectively treating the cancer as well as limiting injury to surrounding healthy tissue.
- It was found that in many cases hospitals tended to get filled with chronic patients, while acute patients waited for care. It seemed to take much longer to get these patients out of the acute beds and into NHs, ALFs, etc.
- In a direct comparison of the British NHS with Kaiser Permanente; it was shown that Kaiser's costs were roughly the same; but with many more doctors and much shorter waits.

7. NHI would benefit the elderly and minorities.
- Goodman states that in those countries where there is NHI and ethnic minorities the minorities are marginalized and most of the resources are directed to the more affluent, white, urban majority.
- He states the elderly do even worse since they are essentially pushed to the back of the queue and may be denied services altogether.
- Although a large percentage of cancers are diagnosed in patients over 70 years old, patients in that age range are routinely denied screening tests that would likely pick up cancer at an earlier stage.

8. Countries with NHI have been better than the US in controlling costs.
- A study done by Johns Hopkins showed that those countries were not better than the US in controlling costs.
- Also in recent years; many of these countries have been experimenting with US style managed care to try to reduce costs.
- Canada has arranged for a large number of its cancer patients to come to the US for treatment.

9. NHI would reduce the cost of Prescription Drugs for Americans.
- Actually, access to new drugs is often restricted in NHI countries.
- Drug companies are not well reimbursed, so they tend to focus elsewhere geographically.
- In the UK many medications are available to private pay patients, but not to NHS patients.
- In a process called mandated switching, doctors are forced to switch patients from their preferred meds to others that have the same indication regardless of other factors, such as effectiveness, if the other medication is cheaper.

10. Under NHI, funds are allocated so they have the greatest impact on health.
- The reality is that in many cases critical services such as dialysis may not be covered for some patients while others have much less critical services such as daycare paid for.

11. NHI would lower HC costs because of Preventive Health services.
- It has been found that in many cases, preventive care may be discouraged in order to save on costs.
- Obviously this reflects a short term view of holding down current costs while ignoring the fact that much higher treatment costs may be saved in the future.
- It may also lead to a worse outcome for the patient.

12. The problems of NHI systems in other countries could be remedied by a few reforms.
- It had been found that politically it makes more sense to give less critical services to many people (voters) who are only mildly ill that to give major and expensive services to a much smaller number of patients (voters) who are very ill.
- Since NHI systems are essentially run by politicians; they will tend to make decisions from the stand point of

Information Empowers Medical Staffs In Call Crisis

Jeffrey Cohen, Esq.

Some doctors on hospital medical staffs are being squeezed in the call coverage crisis and they don't know their rights. They don't know what the law requires and they are afraid of being disciplined by the Department of Health or Board of Medicine or Osteopathic Medicine if they refuse to do exactly what hospital administration requires of them on the call issue. Medical staffs need information and leadership in order to survive a serious weakness in today's healthcare delivery system: the delivery of emergency care.

Hospitals are just as concerned about the problems they face in providing emergency care. Hospitals are regulated by EMTALA, COBRA and many other onerous state (the Florida Access to Emergency Services and Care Law) and federal laws that pertain to delivering emergency care. Many of these laws assume an ideal delivery environment which simply doesn't exist. Hospitals may be afraid they will be reported, fined and maybe even decertified by Medicare, the death knell for a hospital. The key in terms of how a hospital system survives is how it acts in the face of these threats, this fear. It isn't the stresses that define the hospitals and their ability to work well with their medical staff. It's how they react to those stresses. If they view the issue of handling emergency care as one they share with the doctors, they will find ways to survive it and prosper. If, however, their approach is to offload the problem onto the backs of their medical staffs, they will struggle and may fail. There is nothing more threatening to a fear -based hospital than an informed medical staff. But for a hospital that approaches challenges like the call crisis as one shared by them and the doctors, an intelligent and informed medical staff is a great ally.

This article is intended to be a shot in the arm of medical staffs, a call to action, in the call crisis. It is not intended to polarize hospitals and medical staffs. But the current reality is that some hospitals and medical staffs have not found ways to approach problems like the call crisis together. Instead, some staffs experience hospitals' approach to working through such crises as being pushed around and misled about what will happen if the physicians don't do exactly what the hospital wants them to do. This article is for those medical staffs.

Myth #1. If the medical staff doesn't take call in the amounts and at the times required by the hospital, the medical staff will be subject to Agency for Health Care Administration ("AHCA") or Board of Medicine (or Osteopathic Medicine) action.

This is simply misleading. Though if a physician is scheduled for call, he or she must respond to the call schedule or risk fines and penalties, COBRA, EMTALA and related state laws all impose the regulatory obligation for providing emergency services on the licensed hospital, not the medical staff. And in fact, EMTALA has what can be described as a "do the best you can" standard. The hospital isn't going to be disciplined or lose its Medicare participation if it can't provide hand call coverage, for instance, 24/7.

The state law that pertains to a hospital's call obligations is not as flexible as the federal law. Florida law generally requires that a hospital ensure provision of emergency services within its service capability, either directly or indirectly, on a 24/7 basis. BUT ... what if a hospital does not have the ability to provide 24/7 care? There is a way out. Florida law specifically provides a process through which a hospital may apply for an exemption. In considering the exemption requests, AHCA looks at a number of factors that are provided in the law. Exemptions have been granted to hospitals throughout the state that have applied.

A wise hospital and medical staff will have a system through which physician and hospital leadership will sit together and design the best call coverage they can. Hospitals might consider paying medical staffs when compensation is an issue. They will explore indemnification and sovereign immunity when that is an issue. And if, after having done all that, there are still gaps in coverage, hospitals and physicians might jointly approach the state for an exemption. A healthy hospital/physician healthcare system will work together on this complex societal issue, with community needs and their own realistic capabilities in mind.

Myth #2. The state will require each physician to give a certain amount of call days to the hospital system. There is some magic number and a physician's failure to deliver will be met with penalties.

Wrong. Again, if a physician is listed on the call roster, he or she must respond to call. However, with regard to the "big picture" and the determination of emergency call policy and practice, each hospital's and medical staff's situation is unique. Each community's medical needs is also unique. And each physician's circumstances are unique. There is no magic number or magic solution. The state is not coming into any hospital with riot gear to remove or discipline a physician who has decided, pursuant to hospital policy, he/she will take just one day of call or no call at all. For example, if a hospital's policy or medical staff bylaws provide that physicians having a certain "senior status" need not be included in the call roster, state regulators will not overturn that. The laws do not impose on physicians themselves the overall obligation to provide emergency services. The laws impose the obligation onto hospitals.

That said, medical staffs have to pay particular attention to their medical staff bylaws, since they routinely address the situation and may even empower the hospital Board to shove a solution down the medical staff's throats. What do the medical staff bylaws say? They are a contract between a medical staff and hospital. Do they need to be rewritten? Does the medical staff have independent legal counsel? In this day and age, that has become standard.

Continued on next page

Information Empowers Medical Staff Cont'd

Not because hospitals can't be trusted, but simply because of the complexity of today's world and the fact that lawyers are trained to (1) have one client, and (2) approach things in a way that benefits that client.

So what solutions are there for medical staff members facing the call crisis? First, there has to be negotiation/discussion with hospital administration. Hospital and physician leadership must jointly find solutions that work for both parties. Second, some medical staff members are changing their delineation of privileges ("DOP"), which is interesting because a medical staff members call obligation must be supported by their DOP. If a physician on staff has privileges for spine, but not brain, then they should not be on the call roster for brain. However, if a physician is credentialed by the hospital in a manner that could be interpreted to be for both spine and brain, regardless of whether the physician actually practices on spine or brain, that physician might be expected to provide call in accordance with his/her credentials. Emergency call should be based on the actual credentials of each physician and each physician ought to ensure that his or her credentials actually reflect his or her practice. Third, many physicians are resigning when things cannot be worked out with hospital administration. And this does present real legal risk for a medical staff member.

The short story is that a medical staff member may decide to drop off a medical staff, but may not have an agreement with any other physician to do it. The law allows for the decision to drop off a medical staff to be made one physician at a time, but not jointly. As such, the worn instruction for antitrust compliance that anything after the word "let's" will get you in trouble applies here. If you ultimately decide it's time to drop off a medical staff, make that decision privately, without agreeing with any other physician to do so (even one in your practice).

Medical staffs must become empowered by knowledge and communication. They have to step up to the plate via their medical staff organizations as the footing of the healthcare delivery system continues to transform.

This article presented for educational purposes only and should not be taken as a substitute for legal advice which should be obtained from personal legal counsel.

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What the FMA Does For You

The FMA monitors the activities of the 33 regulatory board or councils of the Department of Health, paying especially close attention to the Boards of Nursing, Chiropractic Medicine, Dentistry, Medicine, Optometry, Osteopathic Medicine, Pharmacy, Podiatric Medicine, and Psychology. When necessary, the FMA vocally supports or opposes certain issues that come before these boards.

In December 2007 the FMA covered the Board of Dentistry when they proposed a rule that would allow dentists to perform cosmetic Botox injections, the FMA spoke against the rule.

At the Board of Nursing the FMA opposed action of nurses opening independent nursing practices and performing many duties outside the scope of practice for nursing. Also the FMA is monitoring a proposed rule regarding the administration of conscious sedation by nurses.

The FMA asked the Board of Medicine to increase the fees physicians are permitted to charge for copying a patient's medical records. The current permissible charges have been in place since 1988 and should be increased to compensate for inflation.

The Regulatory Affairs Counsel for the FMA is Jennifer Forshey, Esq. and she can be reached at FMA headquarters at 1-800 -762-0233. Ms. Forshey is currently monitoring the Department of Health Boards and the Division of Worker's Compensation at the Department of Financial Services.

The FMA monitors theses issues and ensures that our members' interests are considered in the rule making process and in agency policy decisions.

Support the FMA, Join Today

PO Box 10269, Tallahassee, FL 32302 Tel: 800-762-0233

Case Study: Inadequate Communication Leads to Stroke

First Professionals Insurance Company

This case study analysis reflects on actual First Professionals' case.

Case Analysis

The patient, a 65 year-old male, underwent prosthetic cardiac valve placement and was placed on Coumadin under management by his internist. The patient returned monthly to the internist's office and/or clinic lab for coagulation panels and dose regulation. Several years later, the patient missed several lab visits, which went unnoticed by the internist until 6 months later when the patient was treated for urinary tract infection and his chart was reviewed. A coagulation panel was then done and a dosage adjustment was necessary. The internist instructed the nurse to reduce Coumadin *by* one milligram daily and call patient with the new regimen. The nurse phoned the patient's home and relayed the instructions to patient's wife. Two weeks later the patient was admitted via ER with a diagnosis of ischemic stroke, sustained significant neurological and cognitive deficits. Wife wrote "reduce Coumadin *to* one milligram daily." The nurse did not document the phone conversation wherein the patient was instructed to reduce the dose by one milligram daily.

Risk Management Discussion

Stroke remains a leading cause of death and malpractice claims against physicians. Few medical specialties are immune. Often, these malpractice claims have little to do with competency of the physician but rather faulty monitoring and system failures. Frequently, the physicians indefensibility is attributed directly to inadequate management of anticoagulation therapy. Loss prevention measures shown to reduce errors, deter lawsuits before they are pursued, and preserve defenses necessary to defeat the unavoidable claim include:

- Identify patients at risk for stroke according to established clinical standards.
- Identify all patients for whom anticoagulation (Warfarin) is indicated.
- Document a specific reason or contraindication whenever a high-risk patient is not on Warfarin.
- Educate patients about the implications of anticoagulation therapy Document these efforts
- Create written policies and guidelines pertaining to patient identification and documentation.
- Establish written procedures for monitoring patients or anticoagulation therapy and follow them.
- Discuss potential risks and benefits of therapy with the patient and/or caregiver.
- Obtain informed consent.
- Document patient refusal or noncompliance.
- Keep AF patients consistently in INR 2.0—3.0 range.
- Commit to appropriate monitoring system.
- Utilize a Warfarin monitoring regiment system.
- Seek legal or risk management advice when uncertainty arises.

Information in this article does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. First Professionals recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only. First Professionals Insurance Company is Florida's Physicians Insurance Company and the endorsed carrier for professional liability insurance.

Florida Supreme Court Ruling on Amendment 7

Karl Altenburger, M.D., FMA President

March 6, 2008, the Florida Supreme Court in a 4-3 decision issued an opinion on two cases involving the effect of Amendment 7 on the confidentiality of peer review and medical incident reports. Amendment 7, cleverly labeled as the "Patient's Right to Know About Adverse Medical Incidents," was the trial bar's way to obtain state-sanctioned confidential peer review information for use in medical malpractice lawsuits. To lessen the effect of this amendment, legislation was enacted providing that the Amendment was not applicable to documents created prior to the Amendment's passage. This legislation also placed restrictions on the documents that could be obtained under this Amendment and who could obtain them. Finally, the legislation made it clear that the Amendment had no effect on existing privilege statutes.

In a decision that Justice Wells in dissent described as "contrary to the law and fundamental fairness," a sharply divided Supreme Court ruled that Amendment 7 is self-executing and retroactive, and its provisions apply to records existing prior to its passage. In addition, the Supreme Court ruled that several of the key provisions of the implementing legislation are unconstitutional.

The Court's ruling effectively ignores over twenty years of statutory protection for peer review records and opens these documents up to access by the public, clearly in contravention of the expectations of the physicians who participated in the peer review process. While hospitals will have to continue to provide peer review as mandated by law and report adverse incidents, this opinion will likely have disastrous consequences on the effectiveness of such review.

The FMA has studied the Court's opinion in depth and is in consultation with the Florida Hospital Association to determine what avenues, if any, are open to address this unfortunate ruling. The FMA encourages each physician who participates in hospital peer review to consult with their medical staff attorney as well as the hospital administration to determine how best to proceed with peer review given the new legal landscape produced by the Supreme Court's decision.

AMA Principles of Medical Ethics

Preamble:
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
IX. A physician shall support access to medical care for all people.

The Principles of Medical Ethics constitute the Preamble to the much longer *Code of Medical Ethics*. The Code of Medical Ethics and opinions of the Council on Ethical and Judicial Affairs (CEJA) may be found on the Code of Medical Ethics and CEJA Reports page.

Adopted June 1957; revised June 1980; revised June 2001

Odds and Ends

Fingerprinting Cards for Medical License

If you are a new physician and are applying for your Florida Medical License you will need a fingerprinting card. Visit the Department of Health's website for more information: www.fldoh.sofn.net

2008 HMA Annual Conference

The Health Management Association Annual Conference this year will be held on Friday May 9 from 8:00-5:00, at Diamond Head Resort, Fort Myers Beach. Mark your calendars now, this will be one of the best conferences that we have had, we will have great speakers, Vendors, Sponsors and lots of Door Prizes. If you have any questions please contact our Conference Chairperson-Debbie Gnegy @ 239-432-4387 or e-mail her at Debbie.Gnegy@leememorial.org

Prescribing Rules for Physician Assistants

Dispensing PA's may only dispense for their supervising physician in compliance with the following requirements:

1. The supervising physician is registered as a dispensing practitioner with the Board of Medicine
2. PA must be registered as a prescribing PA with the Board of Medicine
3. PA may only dispense within the scope of practice of the supervising physician
4. PA may not dispense controlled substances

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