LEE COUNTY MEDICAL SOCIETY

Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 19, NO. 2 | Fort Myers, Florida | Mary C. Blue, M.D., Editor | April, 1995

APRIL MEDICAL SOCIETY MEETING

"AS I RECALL... LCMS, MEDICINE... FACTS, TRIVIA & HUMOR"
Spouses are invited to attend

CAN YOU IDENTIFY THIS?
CIRCA 1958

SPEAKER:
ROGER D. SCOTT, M.D. - GENERAL SURGEON

Dr. Scott is a native of Florida, born in Lake Wales. He obtained his medical degree at the University of Maryland School of Medicine in 1951. He came to Fort Myers in 1958 to start his private practice in surgery in the Crescent Building in downtown Fort Myers. When he joined the Medical Society it was called "Lee, Charlotte and Hendry County Medical Society." There were 38 members.

In January, 1994, Dr. Scott was given the "Life Member Certificate" by the Florida Medical Association to honor 35 years of membership in his State Association and the LCMS.

Come walk with Dr. Scott down memory lane to what seems like a simpler time, or was it? ◆

APRIL MEDICAL SOCIETY MEETING

Royal Palm Yacht Club • April 17, 1995

Social Time: 6:30 p.m. • Dinner Time: 7:00 p.m.

SPEAKER:
ROGER D. SCOTT, M.D.

TOPIC:
"As I Recall LCMS, Medicine...Facts, Trivia & Humor"

ALSO...
SPECIAL PRESENTATION BY KATHY KLEIST,
Director, Health Education Center of S.W. Florida
"What the Health Education Center Is"
(See Enclosed Brochure)

DINNER BY RESERVATION ONLY

CANCELLATIONS: By Noon, Friday before meeting.

Spouse or Guest - Dinner $20.00

MAKE CHECKS PAYABLE TO: LEE COUNTY MEDICAL SOCIETY

"A GENTLER, KINDER PRO"

By Steven R. West, M.D. - FMA PRO Committee

The Florida Medical Quality Assurance, Inc. (FMQAI) is now the PRO for the State of Florida. The Fourth Scope of Work conducts what are called cooperative projects, or a cooperative effort between the PRO and collaborating partners - physicians, practitioners, organized medicine and hospitals. This cooperative effort results in the partners' action to measurably improve processes and outcomes related to specific clinical issues. To be a cooperative project, a project must meet the following two requirements: 1) a project must identify quality indicators related to a care issue based upon research or practice guidelines, and 2) the quality improvement plan (QIP) must address measurable improvement during the period of collaboration.

These cooperative projects have replaced the previous pleasant experiences which we have had with the PRO in the past. The PRO no longer attempts to single out individual physicians; it no longer attempts to sanction hospitals, individual physicians, or practitioners who did not meet its somewhat arbitrary guidelines. These new cooperative projects are educational in nature. During the course of a project, data collection will occur; the

Continued on Page 3

PRESIDENT'S MESSAGE

RONALD J. DELANS, M.D.
(Looking to the Future)

WHO DOES THE MEDICAL SOCIETY REPRESENT?

The Lee County Medical Society is the local branch of the American Medical Association. But who does the Medical Society represent? This is a question so basic that I never thought it would require an explanation. I felt we all knew the commission and charge of our organization. However, events and discussions over the past few months have left me wondering; do we really know what our organization is about, and who it represents?

There is a passage in the bible that addresses the concerns which I am about to detail. Irrespective of your spiritual beliefs, there is a fundamental truth spoken when Matthew quotes Christ as saying, "No one can serve two masters. Either he will hate one and love the other or he will be devoted to one and despise the other." Our Medical Society can only serve the interests of one entity, and that is the physicians of Lee County. We are an organization of physicians, for physicians, and by physicians. We organize to serve our common interests.

Some of you may be saying to yourself, "What about our patients?" "Doesn't the Medical Society represent the patients of Lee County?" The answer to this question is yes. We, as physicians, have always been and should always be patient advocates. We must stand up for what is in the best interest of our patients. The Medical Society when it represents physicians defacto represents patients because of the intertwined interests of both physicians and patients.

However, this commonality of interests between doctors and patients is being stressed by the current trends in Managed Care. The insurance industry is subtly directing us to focus our goals on cost containment rather than patient care. When cost becomes the compelling factor in health care decision-making then we will have abdicated, at least in part, our role as patient advocates. The single biggest issue as Managed Care bores down on an area such as

Continued on Page 2

NATIONAL LEGISLATION

MEDICARE, THE NEXT TARGET

Liz Kagan, Chairman
American Medical Association Alliance
Legislative Affairs Committee

On January 1, 1995, the first baby boomer became eligible for membership in the AARP - the American Association of Retired Persons. Soon, baby boomers will reach the age of 65 and be eligible to join the ranks of the almost 36 million elderly and disabled people on Medicare. Medicare is the nation's second biggest entitlement program only exceeded in size by Social Security. Currently, Medicare eats up 12% of all federal spending and will increase to 18% within 10 years. In 1967, Medicare cost $5 Billion. This year it will cost $176 Billion and the number is expected to double by the Year 2000.

The addition of services and the increase in the number of people who qualify for them as well as the cost of modern technology are some reasons for the explosive growth. With government's promise of more and more coupled without a reliable way to pay for Medicare, the entire system is in crisis. Payroll taxes on workers today pay for the care of the retired. Right now it requires 4 workers to pay for each Medicare beneficiary. In a few years, as our population ages, there will be only 2 workers to pay for each Medicare beneficiary. By the time that most of the baby boomers reach age 65, there will be nothing there to fulfill the promises.

Reductions in fees paid to physicians and hospitals will not solve the problem. A true transformation of the Medicare system is required to turn the system around. The

Continued on Page 2

COMING EVENTS:

Mark YOUR CALENDAR for the MAY MEETING!

"SURFING THE INTERNET"
or
"THE INTERNET AND THE HEALTH CARE PROFESSIONAL"

Mr. Marcus P. Zillman, National Internet Consultant will bring us on screen surfing of the internet and how you can be a part of this fast growing communication database. ◆

FMA ANNUAL MEETING
MAY 31 - JUNE 4, 1995

Sheraton, Bal Harbour, Miami Beach. CME Credits offered for Risk Management, HIV/AIDS, Workers Comp and various scientific seminars. ◆

FLORIDA LEGISLATIVE SESSION
MARCH 17 - MAY 5, 1995

LEE COUNTY MEDICAL SOCIETY BULLETIN
P.O. BOX 60041
Fort Myers, Florida 33906-0041
Phone (813) 936-1645
FAX (813) 936-0533

The Lee County Medical Society Bulletin is published monthly with the June and August Editions omitted.

CO-EDITORS
Mary C. Blue, M.D.
John W. Snead, M.D.
Daniel R. Schwartz, M.D.

EDITORIAL BOARD

PRESIDENT
Ronald J. Delans, M.D.

PRESIDENT-ELECT
Alan D. Siegel, M.D.

SECRETARY
Thomas E. Teufel, M.D.

TREASURER
George C. Kalemeris, M.D.

PAST PRESIDENT
Steven R. West, M.D.

MEMBERS-AT-LARGE
William R. Keith, Jr., M.D.
Thomas E. Kowalsky, M.D.
Bruce J. Lipschutz, D.O.
David M. Reardon, M.D.
David M. Shapiro, M.D.

MANAGING EDITOR
Ann Wilke, 936-1645

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.

MEDICAL BOOKMARK

Narges Ahmadi, Medical Librarian

The recently revised library policy allows patients, their families and the community at large to check out from the library books and video programs identified as "consumer health" materials. These popular works written in easy to understand language cover the broad spectrum of health-related topics suitable for patient education. The ever growing number of patients and their families referred to the library by the physicians find them very informative and helpful. The staff of the library would appreciate any donation of patient education material to this collection.

This month's additions to the professional collection:

Advanced Therapeutic Endoscopy
AIDS Knowledge Base
Atlas of Surgical Operations
Christian Faith, Health and Medical Practice
Classic Cases in Medical Ethics
Code of Medical Ethics
Hypertension
Kaplan and Sadock's Synopsis of Psychiatry
Low Back Pain
Orthopaedic Sports Medicine
Primary Care Medicine
Textbook of Respiratory Medicine
Understanding the Patient's Perspective
Unresolved Grief: a Practical, Multicultural Approach for Health Professionals.

Among new NCME video programs:

Pediatric Anesthesia
The Physician's Role in Identifying and Managing Domestic Violence
Managing Otitis Media with Effusion in Young Children: AHCR Clinical Practice Guideline
HIV and Herpes
Sweet's Syndrome
Challenges in Surgical Oncology: Case Study in the Management of Extensive Pelvis and Upper Thigh Sarcoma.

Almost 50% of requests for Library services come from physicians. The majority of literature searches and inter-library loan deliveries are performed for the doctors and their staff. ◆

PRESIDENT'S MESSAGE...*Continued from Page 1*

Lee County is whether there is literally enough money to provide adequate health care to our patients. We must ask if insurance companies' profits are too high. We must also ask, do employers see that enough money is left on the table for health care when they contract with the insurance industry? The answer to these questions is probably no. If there isn't enough money left on the table, can we as physicians still be the patient advocates that we desire and need to be? There is clearly pressure on us as physicians to serve two masters; the patient with quality health care and the insurance industry with cost containment. This position is ultimately not tenable. Managed care is here to stay and we must work with them, but when they cross the line and ask us to compromise or deny care, we must remember who we serve. As long as we remember this, our Medical Society will continue to serve both physicians and the best interests of our patients. If we decide that we serve the insurance industry, then our interests and our patients' interests will be divergent. Suddenly, organized medicine will no longer defacto represent patients' interests and our organization will lose the broad respect it has enjoyed in our community.

In a parallel line of reasoning, the Lee County Medical Society should not represent any particular hospital or faction of physicians. We have been accused of being aligned either with this hospital or that hospital, or with one faction of physicians or another. This is simply not true. When the interests of our physician members coincide with the interests of a local hospital, we will work with that hospital for a common goal. Likewise, when the interests of the Medical Society are aligned with a particular faction of physicians be they primary care, specialty care, independent physicians, or employed physicians, we again will work with that faction for the common goal of the Medical Society. We are very mindful that there are increasing divisions and alignments in the medical community, not only between hospitals but between physicians. We must strive to find common ground and support the common good.

Our Medical Society will only survive if we serve all of our physician members. This concept will not be lost on my watch. ◆

MEDICARE, THE NEXT TARGET...*Continued from Page 1*

AMA is proposing a plan to transform Medicare that centers around six principles.

1. Give the people who use Medicare a financial stake in their own health care decisions through the use of Medical Savings Accounts. There is currently no sense of individual responsibility - no connection between the care and the cost of that care.
2. Make the financing of Medicare more equitable. Right now, the young people at the bottom of the income ladder are footing the bill for the older people. We must restore balance and fairness.
3. Open up Medicare to price competition by relaxing nonsensical price controls and allowing consumers of health care to be sophisticated, smart shoppers.
4. Tear down the regulatory maze that makes Medicare a bureaucratic nightmare. Medicare is run by dozens of private contractors, each with its own set of rules and standards. For example, an older woman is 180 times more likely to be turned down for a mammogram in southern California than in northern California. We need to simplify the system, end the inequities and enact one set of rules.
5. Call on America's physicians to join in a major campaign to reduce the level of care that is just not necessary, in conjunction with the revision of professional liability laws. We need to end defensive medical practices.
6. Reduce fraud and abuse by the handful of unscrupulous practitioners inside and outside of medicine who steal millions if not billions from Medicare each year.

These principles for the transformation of Medicare need to be discussed at a table which includes physician leaders as well as our leaders in Washington. Without physician involvement, it won't work. But to begin the process, the AMA has proposed a change in the very premise of Medicare itself so people who can afford to pay their fair share do so, while those who can't still get publicly-financed care. In other words, provide all of the Medicare benefits for some of the people, and some of the Medicare benefits for all of the people. Let's hope our elected officials don't go for a quick fix but instead get to the root of the problem and overhaul the basic structure of the Medicare system itself. ◆

FEE CAPS FOUND UNCONSTITUTIONAL - AGAIN!

As the Legislature once again debates whether to repeal Section 16 of Chapter 92-178, Laws of Florida, which placed a fee cap on certain providers of diagnostic services, the litigation over the constitutionality of the law continues. Having obtained a judgment declaring the law was unconstitutional this past July, opponents of the law suffered a setback this fall when an appellate court stated that the lower court did not have the jurisdiction to make that decision. On February 13, 1995, however, the lower court had the opportunity in another case to render a ruling identical to its July 1994 decision declaring the fee caps unconstitutional. As a result, fee caps currently are unconstitutional and may not be enforced by the Agency for Health Care Administration. Any further questions regarding this issue may be directed to the FMA Headquarters Division of Legal Affairs. ◆

PHYSICIANS IN THE NEWS

Richard A. Chazal, M.D., a member of Quality of Care Committee of the Florida Chapter of the American College of Cardiology, helped write the White Paper to deliberate the issues and potential solutions on coronary artery disease. He chaired Group I, Patient Identification and Bystander-Initiated Actions. This White Paper is printed in the February issue of the *Journal of the Florida Medical Association.* ◆

A letter to President Clinton from **Dr. John T. Donaldson** was extensively quoted in an editorial in the *St. Petersburg Times*, February 19, 1995 edition written by Martin Dyckmann. The editorial makes several valid points about the excessive costs that are generated when government bureaucracy becomes involved in health care. ◆

THE QUESTION MAN

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

"WHAT IS YOUR OPINION OF THE FEDERAL GOVERNMENT'S ATTEMPT TO DESIGNATE CERTAIN INSTITUTIONS AS "CENTERS OF EXCELLENCE?"

Richard A. Chazal, M.D. (Cardiologist)

"The concept of Centers of Excellence theoretically promises increased quality and efficiency. The principal concern with the concept is that the definitions of quality and measurements may be very difficult and thus there is a risk of promoting unfair competition and potentially closing down other high quality centers."

NEXT MONTH'S QUESTION

"HOW SHOULD NON-BOARD CERTIFIED PHYSICIANS PREPARE FOR THE FUTURE?"

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

LEE COUNTY MEDICAL SOCIETY ALLIANCE NEWS

SUPPER CLUB PLANS A TRAIN RIDE

The Lee County Medical Society Alliance Supper Club has something special planned for the month of May. We will be taking the Seminole Gulf Murder Mystery Dinner Train for a ride filled with mystery and intrigue. The train departs out of Metro Mall at 6:15 p.m. on May 13 and we should arrive back by 10:00 p.m. This is a popular event so R.S.V.P.'s are required and a 24 hour cancellation policy exists. Please call Maruchi at 482-2636 for questions or to reply. For general supper club information, call Victoria at 481-5797. The supper club is a relaxed way to get to know other members and provides fellowship after a hard week! Watch the newsletter for upcoming events. ◆

SPEAKERS BUREAU UPDATE

We would like to take this opportunity to give our "Special Thanks" to the following physicians who answered our call to go out into the community and represent LCMS in 1994:

Dr. John B. Fenning, Dr. Mark Gorovoy, Dr. Jerry Kantor, Dr. Salvatore Lacagnina, Dr. Steve Levine, Dr. Mark Mangano, Dr. Joseph Mazza, Dr. Lawrence Schoenfeld, Dr. Peter Sidell, Dr. John Snead, Dr. Harvey Tritel, Dr. Steven R. West, and Dr. Mary Yankaskas.

There is interest in the community for speakers from Internal Medicine and Family Practice. At present we lack volunteers for speakers in both these areas. If participation in the Speakers Bureau is of interest to you, we would greatly appreciate your contacting the LCMS office. ◆

DISNEY DISCOUNT CARD

The Disney World and Disneyland Discount Card is now available through the Walt Disney Magic Kingdom Club, offered by the Lee County Medical Society. If you would like to receive the discount card, you may do so by contacting our office, 936-1645. ◆

"A GENTLER, KINDER PRO"...*Continued from Page 1*

data will be analyzed by the FMQAI and provided to the hospital facility through the FMQAI feedback meetings. During these meetings guidelines and goal standards, or benchmarks, will be shared. The hospital facility will then be asked to assess the data in an effort to establish opportunities for improvement in the process of care. The facility will be responsible for initiating any quality improvement plans. The FMQAI will support and assist as necessary with the conception of the quality improvement plan.

These projects are designed to improve care and are not designed to find bad hospitals or bad doctors.

Some of the projects that the PRO is presently undertaking includes a national study entitled "The Cooperative Cardiovascular Project (CCP)." The CCP involves sampling 100% of acute myocardial infarctions for an 8-month period. They will determine the quality indicators that are present: 1) they will see if the diagnosis of an acute myocardial infarction was confirmed by physical exam, EKG's and enzymes; 2) they will find out, where appropriate, if thrombolytic therapy was administered; 3) they will determine if the patient was given aspirin, if heparin was administered, if IV nitroglycerine was administered. They are also going to look at the door-to-needle time to see how long it took for the thrombolytic therapy to be administered. Finally, they will also look at the timing of aspirin administration. These are the quality indicators they are going to be looking for at the time of presentation to the hospital with an acute myocardial infarction.

At the time of discharge, they are going to see if the patient was receiving aspirin or a beta blocker if indicated; they will also look to see if the patient was receiving an angiotensin enzyme inhibitor if there was evidence of a reduced left ventricular ejection fraction. They are also going to determine if the patient was receiving a calcium channel blocker with a decreased ejection fraction. This is a negative indicator - as you know, there is clear evidence that patients with reduced ejection fraction should not be on a calcium channel blocker. They will also look to see if the patient was counseled, if appropriate, for smoking cessation. Following the collection of baseline data, this will be reviewed with the hospitals. The hospitals will be compared statewide and nationwide to determine how well care is being provided. The hospitals will be asked to come up with a quality improvement plan; once that quality improvement plan is instituted this will likely just consist of improving care in the emergency room, as well as educating the medical staff and nursing staff regarding the proper care of patients being treated for acute myocardial infarction. The data will then be re-analyzed to determine if there was an improvement in care.

Other projects the PRO is working on include medication usage - making certain that aminoglycoside levels are being checked, as well as dilantin and theophyllin levels. They are also looking at the use of aspirin in patients with angina pectoris. Other projects will include hysterectomy utilization in various areas, as well as hysterectomy quality care, ptosis repair, and prevention of falls in hospitals. They are also looking at atrial fibrillation, anticoagulant prophylaxis for stroke, and HMO immunization for influenza. There is a project involving nursing homes and critical lab values; there is a project involving advanced directives; and one on the use of pneumovacs in the end-stage renal disease population.

Over the years, physicians, organized medicine and hospital organizations have been very critical of the PRO. Our efforts to improve the PRO have been heard by the powers in Washington. The PRO's mission and the manner in which it does business has been changed. I would strongly urge all of you to participate in these projects, and encourage this educational and cooperative approach which the PRO is undertaking. ◆

PRIMARY CARE CLINIC/HOMELESS SALVATION ARMY INTERIM CARE CENTER

1994 STATISTICS

In January an appeal went out to our members to volunteer their time to the Homeless Clinic on Tuesday nights and to make a financial contribution. As of this issue of the **Bulletin** the response from 411 members has been: **Volunteered:** Seven (7) physicians signed up to help with the Clinics. **Donations:** Nineteen (19) members - $1,695.00.

1994 INFORMATION ABOUT THE CLINICS

Clinic Patients Seen - 627	**Cost:**
Physicians - Clinic Time (24 physicians and 2 PA's/40 Clinics)	$26,400
Hospital & Outpatient Procedures - 3	$63,300
Medical Supplies	$20,000
Pharmaceutical	$80,000
Physicians (Sub-Specialty)	$12,500
Total In-Kind Services	**$202,200**
Emergency Room Deferred Services	**$103,455**

The Interim Care Center and the Primary Care Clinic have two dedicated employees, Dale Milhauser and Sharon Harding. Each of these individuals give more than they receive. But we do have a payroll to meet and supplies to buy, to continue the Clinic.

WE NEED NOT ONLY YOUR FINANCIAL SUPPORT BUT FOR YOU TO VOLUNTEER YOUR TIME IN THE CLINIC. Contact Dale or Sharon afternoons at 332-0140 to make a difference. ◆

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.

DAVID B. SUDDERTH, M.D. - Neurology

Dr. Sudderth was born in Clovis, New Mexico. **Medical School:** University of Copenhagen; Copenhagen, Denmark (1974-77). **Internship:** Medical College of Wisconsin; Madison, Wisconsin (1985). **Residency:** Medical College of Wisconsin; Madison, Wisconsin (1985-87). **Fellowship:** Mini-Fellowship in Epilepsy at Bowman Gray School of Medicine (1988); Fellowship in Electrophysiology at Emory University (1988-89). **Certification:** American Board of Neurology. ◆

MANAGED CARE INFORMATION

If you have information you would like to share with your colleagues on managed care, use this Bulletin space.

TRY THIS METHOD TO SET A CAP RATE THAT MATCHES YOUR CURRENT INCOME

Here's a technique, developed by a practicing radiologist, Thomas Dehn, Milwaukee, that answers your two most vexing questions about capitation: volume and pricing. Remember, the basic capitation PMPM formula is volume/1,000 x price divided by 12 months (PNI, 9/19/94, p. 3).

Make the pricing part reflect your current income, Dehn suggests. But we don't want to move too fast. Let's start with the volume.

VOLUME. Know the ratio of your procedures. "The concept is amazing in its simplicity," says Dr. Dehn. Take all the procedures with codes impacting your specialty for a given year and a set population. Assign ratios, but be sure the total reaches 100%. **Beware:** A practice does not a population make, unless you're the only provider of your kind in an area (single-source provider). Since this is rare, you may need to ask your HMO for this data.

For radiology, Dehn surveyed PPOs and single-source providers and was astonished at the similarities in the ratio of procedures: General radiology, 59%; Mammography, 15%; Ultrasound, 11%; CTMR, 7%; Fluoroscopy, 4%; nuclear, 3%; and angio-interventional, 1%. These numbers stand up across the country.

PRICE. Doesn't it sound reassuring to be able to maintain your income? To do this, Dehn says figure out your average receipt for each procedure. **Let's do an example.** Assume the average receipt for general radiology was $30. Remember, the utilization ratio is 59%. **Formula:** $30 x .59 - $17.70 PMPY. Do this process for each procedure. After doing this, assume our radiology practice arrives at $40 PMPY.

Next, adjust this overall number for anticipated utilization. Dehn has uncovered these national numbers (which jump if you take out California): 0-20 year olds use 0.4 radiology services/year, or 400/1,000; 20-40 year olds, 0.6 services/year; 40-65 year olds, 1 service/year; Over 65, 2.8 services/year.

You can run the numbers on your practice to get a feel for utilization by age. For example, if you provide 750 exams/1,000 members, your utilization would be 0.75. Apply this figure to the $40 PMPY. **Formula:** 0.75 x $40 - $30 PMPY. Then divide $30 by 12 (months) and get your PMPM of $2.50. And this would be a rate that keeps your income at current levels. ◆

Reprinted by Permission of Physician Network Insider

DID YOU JOIN YOUR NATIONAL (AMA) & STATE (FMA) POLITICAL ACTION COMMITTEE (FLAMPAC) ORGANIZATIONS?

If not, someone else is carrying your load! Each of you cannot take time to go to Washington all year long or Tallahassee for three months to lobby on your behalf - AMA is there to interact on your behalf to the several thousand bills filed in the U.S. Congress. Many erroneous bills are defeated each year.

FMA is moving its headquarters as mandated by the House of Delegates to Tallahassee to act on your behalf.

These two organizations are there to serve the will of their membership - that's you, the physician. ◆

U.S. HOUSE OF REPRESENTATIVES ADOPTS TORT REFORM MEASURES

By a vote of 265 to 161, the U.S. House of Representatives last week overwhelmingly approved H.R. 956, the Common Sense Product Liability and Legal Reform Act. The bill includes the bipartisan Cox-Geren amendment, proposed by Christopher Cox of California (R) and Pete Geren of Texas (D) which would impose a $250,000 cap on noneconomic damages for all health care liability awards. The amendment was approved 247-171.

Other measures included in the bill would limit the liability of product sellers, institute a 15-year statute of repose for all products, eliminate joint liability for noneconomic damages in all civic actions and limit punitive damage awards in all civic actions, including medical liability greater than $250,000 or three times the amount of economic damages.

The victory was achieved through cooperative efforts between the AMA, state medical societies, county medical societies and Alliance members throughout the country. We were successful in obtaining support of the majority of Florida's U.S. Congressional Delegation. Of particular note is the tremendous cooperation and support we received from Reps. Charles Canady and Bill McCollum, who serve on the House Judiciary Committee. Congressmen Canady and McCollum convinced House Judiciary Chairman Henry Hyde to allow medical liability to be considered as part of the House Republican contract on liability reform. In addition, we received strong support from Rep. Porter Goss, a member of the Rules Committee who contributed to the introduction of the Cox-Geren amendment from the floor of the House. FMA President Dick L. Van Eldik, M.D., FMA Council on Legislation Chairman Frank E. Kucera, M.D., FLAMPAC Director Michael Harrell and FMA EVP Donald C. Jones met with numerous members of Florida's Congressional Delegation in Washington last week, prior to the House vote. With the AMA's assistance, they secured much needed support from our Delegation. They were assisted by a tremendous Florida grassroots key contact campaign for which they are sincerely grateful.

Members of the Florida delegation voting for the Amendment were:

Representative Michael Bilirakis
Representative Charles Canady
Representative Mark Foley
Representative Tillie Fowler
Representative Porter Goss
Representative Bill McCullum
Representative John Mica
Representative Dan Miller
Representative Pete Peterson
Representative Ileana Ros-Lehtinen
Representative Joe Scarborough
Representative Clay Shaw
Representative Cliff Stearns
Representative Dave Weldon, M.D.
Representative Bill Young

Please contact these members and thank them for their support. ◆

AMA'S ETHICS COUNCIL IS SEEKING PHYSICIAN COMMENTS

The Council on Ethical and Judicial Affairs is seeking comments from physicians for use in developing or revising five ethical reports on several topics. The reports will go before the **AMA House of Delegates at its meeting in June. Comments should be directed to attorney David Orentlicher, M.D., Ethics and Health Policy Counsel, Health Law Division, AMA, 515 N. State St., Chicago, IL 60610.**

Patenting of medical processes

There has been a substantial increase in the number of patents taken out on new medical procedures. Concern has been expressed that patenting of procedures will lead to withholding important medical innovations from physicians and their patients and drive up the cost of medical care. In this report, council will consider the ethics of patenting medical procedures.

Genetic testing of children

As a result of the Human Genome Project, physicians will be able to test for an increasing number of genetic traits. In many cases, a genetic diagnosis can lead to therapeutic intervention. In others, such as Huntington's disease, that is not the case.

In this report, the council will address the question of genetic testing of children at the request of their parents.

Managed care and prescription drug use

Managed care plans use a variety of techniques to limit the cost of prescription drugs. While many of these techniques help to ensure that patients receive the most cost-effective care, they also may unduly restrict the ability of physicians to prescribe the most appropriate drugs. In this report, the council will recommend guidelines for balancing the need to contain costs and the need to protect patient welfare.

Informed consent to treatment by medical trainees

Patients cared for in medical training institutions receive more care, treatment and diagnostic attention because there are more physicians and students available to spend time with them. At the same time, principles of informed consent and veracity require that patients understand that their care involves students and physicians who need additional training. In this report, the council will develop guidelines to ensure that patients have adequate information about their medical team.

Issues related to physician participation in capital punishment

The council continues to review a draft report, "Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed; Retrieval of Organs Following Execution."

The council previously reserved judgment in these issues when it issued its report on "Physician Participation in Capital Punishment" in December, 1992, pending consultation with relevant professional associations. ◆

APRIL MEDICAL SOCIETY MEETING
Royal Palm Yacht Club
April 17, 1995
Social Time: 6:30 p.m.
Dinner Time: 7:00 p.m.
SPEAKER:
ROGER D. SCOTT, M.D.
TOPIC:
"As I Recall..."
ALSO:
KATHY KLEIST,
Director, Health Education
Center of S.W. Florida
DINNER BY RESERVATION ONLY
CANCELLATIONS:
By Noon Friday before meeting
Spouse or Guest - Dinner $20.00

LEE COUNTY MEDICAL SOCIETY
P.O. Box 60041
Fort Myers, Florida 33906-0041

Bulk Rate
U.S. Postage
PAID
Ft. Myers, FL
Permit No. 534