LEE COUNTY MEDICAL SOCIETY

Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 21, NO. 4

Fort Myers, Florida
John W. Snead, M.D.

July, 1997

COST VS HEALTH - WHO WINS?

Bruce J. Lipschutz, D.O. - *Secretary LCMS*

Last week before morning office hours, I settled down in the doctor's lounge for just one peaceful moment. The oatmeal was superb as usual. My colleagues were preparing for yet another day of successes and frustrations. On the table was the day's WALL STREET *JOURNAL. Was I going to learn of INTEL's split or* tips on a new investment or the next medical miracle? NO...all I found was a glaring headline that said, "SOME HMO's NOW PUT DOCTORS on a BUDGET FOR PRESCRIPTION DRUGS." The front page story went on to remind me of how HMO's are preparing to put the burden of drug cost back on the physicians.

The article quotes a patient "If costs are going to be motivating the doctors, patients' health won't be their primary concern".

In essence this is how it works. Mrs. Smith comes to your office feeling sad and blue that 1990's medicine is just not what she was used to in the great 70's and 80's. She can't stop being upset about how impersonal things have gotten. No one listens like they used to and the bill is prepared by some corporate entity. I tell her I understand and could fix all her troubles with a new wonder antidepressant but unfortunately, due to her HMO's restrictions, we can only put her on a 30 year old drug with huge potential side effects. The conflict is if I place her on a "higher priced" and possibly better drug, the extra cost could come out of her own pocket.

So many health related issues need to be considered.

- niacin vs "satins"
- broad spectrum penicillins vs cephlosporins or quinalones
- tricyclic antidepressants vs sertonin reuptake inhibitors
- otc antihistamines vs nonsedating antihistames
- diurectics vs ace inhibitors
- antacids vs proton pump inhibitors

the list goes on and on.....

The question is who should make the decisions regarding drug therapy? Of course, the physicians should *determine the course of action but not if it is to be based on* cost or conflicted by "the cheaper I prescribe the more I pocket at years end" philosophy.

According to the article one contract with HealthNet to a physician group of Napa Valley, California was established at $12.50 per pt., per month for drugs. The actual prescribing costs per patient for this team of doctors of their 3,200 pts. was $17 per month.

It has always been the philosophy of the LEE COUNTY MEDICAL SOCIETY (and I hope most doctors) that patients health comes first and cost far second. Let us not let yet another corporate structure put us at odds or conflict with the very reason we went into medicine - THE PATIENTS HEALTH AND BEST INTEREST. ◆

George C. Kalemeris, M.D.

PRESIDENT'S MESSAGE

George C. Kalemeris, M.D.

"MOVING AND SHAKING"

The Florida Medical Association is a moving and a shaking!

I have been attending the FMA delegates meeting for the last 8 years and have often been impressed with the slow changes in organized medicine despite the fast paced change in the world around us. This is the nature of a representative democracy on the one hand but does not seem to be the nature of the type of organization needed to respond to the antagonists constantly attacking the House of Medicine and its provision of high quality health-care.

That now has changed. The House of Delegates spoke loudly at the annual meeting with an overwhelming voice. It is now time for a change. Two dark horses have been elected to the FMA top brass to change the nature of how we operate.

The first dark horse, Glenn Bryan, an orthopaedic surgeon from Melbourne, Florida and past FLAMPAC President, was elected President-Elect by focusing on a grass roots campaign and writing individually to each of the FMA delegates. He wrote asking for ideas concerning the development of the "New FMA", handwriting each letter. He incorporated these ideas into "Glenn's Plan".

The heart of "Glenn's Plan" is leadership, membership and political action.

His concept of "leadership for change" focuses on development of leaders with fresh faces that accept and embrace change with new ideas. Contested races should be the norm, forcing candidates to actively debate their ideas before membership, bringing forth the issues and providing the forum for discussion that will keep the organization young and in step with its membership. New leaders will be prepared through a variety of leadership development activities sponsored by the FMA. Are there any of you out there who are interested? Here's your opportunity!!!

Glenn's membership plan incorporates a multi-prong approach by:

1. actively recruiting all new Florida medical licensees.
2. development of dual membership incentive programs between Florida specialty societies and the FMA.
3. institution of a dual membership incentive between the Alliance and the FMA.
4. enhancement of communication with hospital medical staffs.

Political activism is a core service of the state and county medical societies. Glenn feels that focusing on our number one resource, our patients, we can capitalize on our role as the protector of the doctor/patient relationship. Legislation, regulation, and political activism both at grass roots level and through FLAMPAC will be his number one priority.

The second dark horse is our own Barbara Harty-Golder from Sarasota, a member of the Southwest Florida Caucus who was elected as treasurer on the "No more fiscal irresponsibility" ticket. Barbara is a practicing pathologist in Sarasota who is a graduate from Stetson Law School and brings a wealth of expertise to this office.

Why has there been such monumental change in contested races within the FMA? While the campaigns of the two dark horses were run effectively and in a deep grass-roots fashion, the demographics of the board of delegates has changed dramatically over the last several years. Women, blacks, hispanics and the youth are now recognized as delegates in the house and actively participating in the submission of resolutions, participating the debates and voting their conscience. The participation of these groups has changed the political base of the state organized medicine.

I see these changes as very positive. An organization can survive only through being relevant to its membership. Relevance can only be sustained through effective representation of its membership proportionately and evolving to confront and accept the change necessary for the organization to support its membership through the provision of appropriate leadership, active maintenance of current membership, recruitment of additional membership and political activism. This "New FMA" is moving to confront and accept change and shaking up its leadership! Are we, as members willing to support these changes? I believe we will! ◆

AS I RECALL...

Roger D. Scott, M.D.

WITCH DOCTOR?

As "country boys," we used to catch and play with frogs. Now you city slickers probably never saw a frog until you took biology, but we all knew that frogs caused warts when they peed on you. Most of my childhood I got by without getting any warts but ultimately I did get a wart that was resistant to the usual country forms of treatment such as rub it with a raw potato and bury the potato under the back steps; rub it with a rabbit's foot 3 times on the full moon; rub peanut butter on it in a graveyard; and similar remedies. My brother, a junior in medical school home for the Summer, was extremely well medically educated and knew exactly what to do. He poured fuming nitric acid on the wart and finger, and it really did a great job of destroying the wart and almost my entire finger. There was a hole present that you wouldn't believe but in about six months this healed. For these reasons, I was extremely happy to read an article in either the JAMA or New England Journal in 1961 or '62 about treatment for juvenile warts that was 80% effective with no trauma to the child. This was a rather unorthodox article and yet with it appearing in one of the prestigious journals, I felt that it was worth a try. Well, believe it or not, the treatment was tried on several juvenile kids with multiple juvenile warts and these gradually disappeared over a 6 week period.

Tom Wiley (Peds.), had referred a child with extensive juvenile warts for fulguration. When I called him on the phone and told him of my planned unorthodox treatment, he thought this was hilarious and called me a Witch Doctor. After convincing him that this was written up in the prestigious journal, and that I had had successes with it, he agreed to participate and allow me to use the treatment. After seeing the efficacy and the ease with which these warts were cured, he sent me two or three other patients for the Witching Rx, and then there was a spell (no pun intended) when I didn't receive anymore patients. Finally a patient came from him with juvenile warts, and when I explained to the parent my "Witch Doctor Treatment" and the need for cooperation, she said "Dr. Wiley tried that and it failed!". So after much talk the patient was treated and the warts did disappear when treated by the Witch Doctor. One evening my oldest daughter had her friend, one of John Gadd's daughters (John was administrator of

(continued on page six)

In Memoriam - Marcus M. "Duffy" Moore, M.D. - *November 26, 1933 - June 4, 1997*

Dr. Moore, a seventh-generation Floridian, was born in Pensacola and grew up in Orlando, where he graduated from Orlando High School. Despite being a professional "Devil's Advocate", he successfully negotiated The Citadel, and then made the unusual transition to Duke University School of Medicine, graduating in 1959. He served in the Army for two years following internship. His Pediatric residency was done at the University of Florida, and in 1964 he began practice at the Children's Clinic, with Tom Wiley and Charles Donegan.

He believed there was value in organized medicine, and was Past-President of the Lee County Medical Society ('74-'75) as well as the Florida Pediatric Society. Those are just the milestones that go, in frames, on the wall.

The other things are harder to categorize. He was always a hard worker, which, as he said, allowed him to provide his children with "all of their needs, and some of their wants." Duffy was an insulin-dependent diabetic who made few concessions to his disease, and it made few concessions to him. Despite this affront to his health, he was a tireless advocate for his patients, whom he loved dearly. Parents he considered more of an acquired taste. His other love, outside his family, was the outdoors, the woods and the waters of Florida, complete with whatever flora and fauna were in season, and his vehicle mired up to the hubcaps.

When he couldn't get away, he could always locate someone to argue with. About anything. Multiple small strokes led to his retirement, and he finally had one stroke too many and too severe. His immediate survivors are his wife, Jennifer, and his sons, Marcus and Robert.

Duffy swam upstream as far as he could go. He was an intelligent and well-trained physician who did his best for his patients. He was an original. And he will be missed. **John R. Agnew**

A friend, a parent, a colleague.

Managing Editors Note: Dr. Marcus Moore was the first president that I served under when I came on board. I was concerned about my abilities and knowledge to do the job, he put me at ease and guided the Medical Society through a change in staff. He was always working over the years to make organized medicine work for the betterment of its members. He never stopped being a working member even with his retirement. We all benefit from his involvement and his dedication to his profession which served him well. - Ann ◆

In This Issue...

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

MEMBERSHIP ACTIVITY

New Members

Kip C. Cullimore, M.D.
Howard Eisenberg, M.D.
Teresa Kelly, M.D.
Paul D. Mantell, M.D.
Joseph P. O'Bryan, M.D.
James O'Mailia, M.D.
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Dropped

Randolph S. Geslani, M.D.
Anamika Jain, M.D.
Vikas Jain, M.D.

Resigned

Nils Diaz, M.D.
Jeffrey W. Lewis, M.D.

CLASSIFIED ADS

ARE YOU A PART OF THE PROCESS?

Steve West, M.D., LCMS Legislative Chairman

The 1997 Florida Legislative Session is over. Overall, the 1997 session was a successful one for the Florida Medical Association with several issues passing that were good for physicians and their patients and several bad ideas were defeated.

Left to right: George C. Kalemeris, LCMS President; Jill Edison, FMAA President; Linda Barr, FMA Field Rep.; Steve West, M.D., LCMS Legislative Chairman, as they prepare to do cholestrol screening in The Rotunda of the Capital building during "The Days In The Capital" sponsored by the FMA Alliance.

The success that the Florida Medical Association had this year in the legislature and for that matter, any failures, is all about political muscle. Political muscle is about power and money. It's something the trial lawyers, the tobacco industry and HMO's learned some time ago. We physicians can no longer afford to ignore this fact, even if some of us find it distasteful.

In order to further the political goals of medicine and our patients, the Florida Medical Association established a legally separate branch called FLAMPAC. Its role is to fund raise and help to elect candidates friendly to medicine and educate legislators about medical issues. While successful, financial influence is limited by $500 per election year, per candidate. Not much effect can be had for $500 when House races can cost $150,000 and Senate races, $300,000.

To impact an election, it was necessary to find a legal way to invest large amounts in campaigns of medicine's friends. The 1000 CLUB thus was born. This allows multiple physicians and groups to contribute the maximum donation to a single candidate up to a $1000 per physician. The last election cycle year in 1994 we gave as much as $25,000 to a single race in order to elect friends of medicine. Guess what, those friends who were elected with the 1000 CLUB funds filed our bills and got them shepherd through the legislative process. They also helped kill the ones that would be bad for medicine and our patients.

Why is this necessary? Four to six years ago we were getting hammered in Tallahassee with the Governor's health plan, lay midwives, and mandatory CME increases. Physicians went to Tallahassee hat in hand for help. If legislators helped us, there was no reward; if they opposed us, no penalty. We were essentially irrelevant.

A group of physicians decided to change this. As good clinicians, they diagnosed the problem and then wrote prescriptions for the cure. Money. Political power is all about fear. Can you produce it in your enemies? Can you prevent it in your friends?

Below you will find a list of bills that passed the Florida Legislature that were supported by organized medicine: It is now illegal for managed care organizations to place gag clauses in their managed care contracts. The duplicates registration fees have been eliminated for physician's office labs. The authority for medical complaint investigations have been transferred out of the Agency for Health Care Administration which has been a political pawn of the Governor to the Department of Health which is run by a physician. The trial bar was unsuccessful in its attempt to expand wrongful death and allow non-dependent relatives to sue for non-economic damages in medical professional liability suits. This would have increased the number of malpractice suits.

If you can please become a 1000 CLUB member ($1,000 every two years). I also encourage your spouse to become a member of FLAMPAC as well. This money will be used to help us legislatively so we can practice medicine and care for our patients. ◆

POLITICAL $ CENTS $

All Politics is local • All Politics is Personal • All Politics is Competitive

Elections

1998 will be a busy election year in Florida and "your" future!

Become Involved!

- Register to vote this year.
- Be willing to do "something" for a candidate and yourself.
- Join FLAMPAC, LeePAC and the 1000 Club. (If you don't financially help, the lawyers and others will...not may!)
- Write letters/visit and educate Legislators about your issues before they go to Tallahassee. THEY LIKE LETTERS - How to start your letter....I have never written a letter before, but this issue is so important to me....
- Check out the AMA - Grassroots Hotline for great information - 1-800-833-6354, you will need your Medical Education Number found on the address label of JAMA/AMA News.

What We Hear About 1998 Elections in Florida/Lee:

1) Governors Race Possibilities:
Buddy Mackay — Sandra Mortham
Keith Arnold — Toni Jennings
Bob Butterworth — Rick Dantzler
Jeb Bush

2) Senator Fred Dudley is thinking about announcing for Attorney General of Florida.

3) Rep. Ralph Livingston and Rep. Burt Saunders are considering running for our Senate seat.

4) Two seats will be open in Lee County - Do we have any takers to run from our members???

We can help you win...AMA Campaign School - November 14-16, 1997.

Democracy

"Government by the people; rule of the majority; the supreme power is vested in the people, and exercised by them directly or indirectly through a system of representation involving periodically held free elections." ◆

VENEZUELAN MEDICAL RELIEF WE NEED YOUR OLD EQUIPMENT/SUPPLIES

The non-profit organization of Christian volunteers was founded in 1995 in Lee County to provide health care to those who cannot help themselves in Santa Cruz, Venezuela (the Guajito Indians).
They have built a hospital and are collecting your extra or old medical equipment, outdated or expired supplies of all kinds.
Please contact:

Jerry Brow, President
3446 Marinatown Lane
North Fort Myers, Florida 33903
(941) 656-6539

COVER YOUR ASSETS

If the "Big One" does not strike this year, it may happen next year....or the next...NATURAL DISASTERS...floods, tornadoes and hurricanes are a few found in Florida. Does your office have a disaster plan? Are your patient's records protected? How about your computer? Three or four backup tapes for a different staff member to take home. Do you have enough insurance to cover your office and will it cover every asset if you have to start over again? Prepare now - not after the disaster. Have a plan at the office and the home. Make sure everyone understands their role before and after.
Patients are part of your planning - make sure your medically dependent patients and their caregiver are signed up at a Special Needs Shelter. Necessary prescriptions need to be filled ahead of time and for several weeks after the disaster. Enclosed is a Hurricane Tracker Safety Guide compliments of Printer's Ink. ◆

THE QUESTION MAN

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

"WHAT CAN BE DONE TO COMBAT UNDERUTILIZATION OF CARE UNDER CAPITATED CARE PLANS"

"...my response is a system or check should be built-in to capitated care plans, whereas, if a patient is recognized to have not been managed in an expeditious fashion, or appropriate consultations sought for complex problems, then penalties, either financial or administrative, would be levied against the plan managers or gatekeepers so that some level of responsibility is felt and shared by those in control."

Brian W. Hummel, M.D. Thoracic Surgery

"Unfortunatly, under capitated plans, physicians will deliver the minimal amount of care necessary to keep state regulators and malpractice attorneys away from their doors and to keep patients ignorantly smiling. Most care will probably be delivered by assistants. Elective surgery will virtually disappear and semi-elective surgery (i.e. joint replacements, glaucoma surgery, and all but the densest cataract operations) will be avoided by physicians. I can see it now, instead of telling patients how improved their quality of life will be after a successful operation, ophthalmologists will be out there telling patients "you could go blind if you have this operation!"

Scott L. Geller, M.D. Ophthalmologist

"The answer lies in looking at the West Coast and utilizing common sense. Both of these suggest that a fee-for-service system for primary care and a fully capitated risk sharing arrangement for specialist should help balance utilization. This system would be integrated under a single organization such as a PHO or, preferably, an independent physicians' organization with an active QA/UM program and full computerization. These computer programs can be used to monitor both over and under utilization using peer comparison."

Alan I. Richman, M.D. Internal Medicine Rheumatology

September's Question:

"DO HMO's HAVE A FIDUCIARY DUTY TO DISCLOSE PHYSICIAN INCENTIVES TO PATIENTS"

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

LCMS ALLIANCE/FOUNDATION NEWS

Respectfully submitted by Kathy Marchildon, Corresponding Secretary

Charity Ball

This year the Alliance celebrated its Fifty-first year of working side by side with the Medical Society, and continuing the tradition of supporting health related charitable endeavors. The Fourteenth Annual Lee County Medical Society Alliance Foundation's 1997 Charity Ball, "A Night on the River Nile", was held on May 24th at the Ritz-Carlton in Naples. The guest enjoyed a night of fine dining, dancing, great entertainment and Egyptian decor - a party at the pyramid with panache!

Through the generous support of our underwriters, sponsors, program patrons and grand raffle supporters, over $80,000 was raised. Seventy percent of the proceeds will go to this year's major charity ball recipient, Abuse Counseling and Treatment, Inc. (ACT), with the other thirty percent allocated for our mini-grant program.

The golf and tennis tournaments were once again a big part of the weekend. Participants had fun playing their favorite sport with their friends and colleagues. Brunch on Sunday morning was a restful respite following the gala where revellers partied until the early morning hours.

Hats off to the hard working chairs, Nancy Barrow, Franky Margolin and Maruchi Muniz

(continued on page four)

FLORIDA MEDICAL ASSOCIATIONS HOUSE OF DELEGATES REPORTS

(your voice in medicine)

Lee County Delegates Attending on Your Behalf.

George C. Kalemeris, M.D.
Valerie C. Crandall, M.D.
Alan D. Siegel, M.D.
James Rubenstein, M.D.
Steven R. West, M.D.
Francis L. Howington, M.D., Chairman
David M. Reardon, M.D.
Ralph Gregg, M.D.
David M. Shapiro, M.D.

Please take time to thank each of them for taking time out of their busy practices at their own expense to represent you and the issues of medicine.

REFERENCE COMMITTEE I - HEALTH EDUCATION AND PUBLIC POLICY

David M. Reardon, M.D., Delegate

To participate yields relevance. The Lee County Medical Society Delegation has just returned from the Annual FMA Meeting, held in Bal Harbour, Florida this year, where we participated in a productive and informative process. I am amazed and awestruck by the talent, dedication and hard work that everyone there displayed from our leadership to the lowliest young delegate like myself.

For many years I didn't understand the relevance of organized medicine as it relates to my practice and more significantly as it represents all of us as unified to the public, to the legislature and to ourselves. But a funny thing happened a few years ago. I was encouraged, no berated, to participate after unjustly accusing the LCMS President at the time of "doing nothing for me." What a revelation to find out that this is "our" organization that it does have a relevance to me as an individual practitioner and allows us to preserve, better than anything else around, the profession of medicine, which is under full scale attack from all sides. I hardly need to point this last fact out to any of you. It is in participating that the Medical Society has become an organization that does something *for me. It is in participating that I, a single physician,* have direct impact into the process that makes organized medicine more responsive to all our needs.

The FMA Annual Meeting is the consummation of many individuals giving freely of their time to participate in the process, to guide our future and to protect the interest of our patients and our ability to care for our patients in an ever changing world. Resolutions from county societies, specialty groups and individuals went their way from the grassroots level, through regional caucuses, into reference committees at the FMA and finally to the Floor of the House of Delegates for discussion and either adoption or defeat. The true character of our organization is witnessed on the floor of the house-we the members of our society determine for ourselves what our direction will be; what our legislative agenda will be. It's awesome to watch and even more satisfying to participate.

Many important items were discussed. A few major discussions the Reference Committee I centered around:

Res 97-1 Adopted - FMA supports legislation which permits physicians to test for any infectious disease, including HIV, without precounseling requirement; Hospital medical records include notation of infectious disease in a confidential manner for appropriate treatment and protection of the health care provider; all patients entering a hospital for invasive procedure receive confidential HIV testing.

Res 97-19 Adopted - FMA supports Florida Board of Medicine's effort to create usable guidelines for weight loss therapies in a medical context: prescribing of weight loss therapies remains professional, selective, and prudent.

Res 97-21 Adopted - Encourage physicians to participate in the Board of Medicine's Expert Witness Program.

Res 97-27 Not Adopted - Legislation to make the act of Domestic Violence a felony when committed in the presence of a minor.

Res 97-28 Adopted as Amended - Calls for national regulation of cruise ship medical facilities and develop a scorecard for consumers to make informed choices.

Res 97-31 Adopted as Amended - The FMA recognize the health hazards of second hand smoke.

Res 97-33 Adopted as Amended - FMA/AMA supports CDC guidelines on screening patients for Iron overload and hemochromatosis.

Res 97-35 Amended - 1) FMA to seek audit of NICA reserve funds; utilization of the fund for past five years; administrative costs; overhead and other expenses; number of physicians enrolled; future plans for NICA. 2) FMA seek legislation if discontinued in future, all monies to be returned to physicians.

Res 97-43 Adopted - ER physicians can discharge Baker Act 1 pt if they pose no harm.

Res 97-46 Adopted - Restriction of use of Three-Digit N-H telephone's number's.

Res 97-51 - Support legislation regarding Pt with intractable pain to obtain a license to receive controlled medicine re: DEA classes I-IV - Referred to Board of Governors for study.

Res 97-77 - Referred for study - Surgical first assistants - 1) Govern by standards established by American College of Surgeons. 2) Licensed physicians in Florida.

This year, "stand-in-line leadership," was challenged and defeated as two relative outsiders were elected: Glen Bryan as President-Elect and Barbara Harty-Golder as Treasurer. Both were elected on the theme of our organization becoming more responsive and relevant to its members, which should attract badly needed new members and to make our organization more fiscally streamlined and responsible. I believe this is an exciting time for the LCMS and the FMA. We are on the way to becoming the organization you want us to be, the one you need us to be - but the best thing you can do is participate. Get involved today - you will be amazed at the difference you make. ◆

REFERENCE COMMITTEE II - FINANCE AND ADMINISTRATION

Francis L. Howington, M.D.
Delegate and Chairman

Reference Committee II dealt with several resolutions on membership and by-law changes:

1) a. Membership recruitment and retention were made the top priority of county medical societies.
   b. Provisional membership was eliminated from the State but remains optional at local level.
   c. County societies have uniformed/requirements for recruitment.
2) Established a special section for international medical graduate members.
3) Adopted a strong commitment to the Principles of Medical Ethics.
4) Approved preparing a statewide list of Board Eligible/Certified physicians in goodstanding to be expert reviewers as the situation may warrant and made available to the defense attorneys.
5) This Reference Committee reviewed the pass actions this year of the FMA Board of Governors, Councils and Committees.
6) A full report of the FMA's financial situation was presented by the FMA Treasurer and Staff for Delegates to review. The move from Jacksonville has been very costly, not only monetary but in staffing. We will be working to make us more fiscally sound in 1997-98. ◆

REFERENCE COMMITTEE III - LEGISLATION

Steven R. West, M.D., Delegate

At the recent Florida Medical Association House of Delegates meeting, Reference Committee III, which is a committee on legislation, received a report from the Board of Governors regarding physician profiling. This year's legislature passed a law which would require physicians to provide the state with information regarding their practice. The Florida Medical Association supports the patient's freedom of choice in regards to his/her health care including the choice of a physician. The Board of Governors, the Florida Medical Association and the House of Delegates made recommendations regarding the content of the information that would be provided by the state to individuals seeking to choose a physician. This information would include information such as training, medical school, hospitals with staff privileges, faculty appointment, and professional community service activities.

Disciplinary action taken by the Florida Board of Medicine or the Florida Board of Osteopathic Medicine and/or professional Boards from other states within a specific time period should also be included in the information. Criminal convictions, felonies and serious misdemeanors as well as professional liability judgements and settlements which led to disciplinary actions by the Florida Board of Medicine or the Florida Board of Osteopathic Medicine including comparative data regarding other physicians in comparable specialties in practice settings over the previous five years would be included. In this report, there should also be a published disclaimer indicating that this information does not reflect the quality of medical care rendered by that physician. It was felt that it is important that the individual physician be allowed to make a statement containing explanations regarding any positive or negative data presented by the state agency. It was also recommended that any information of public registry should be updated within 90 days and notification of it changed by the subject physician.

The committee also recommended and the House of Delegates passed a recommendation that would increase the staffing of the Board of Medicine so that the timeliness of the investigative process could be improved. Complaints could be investigated quickly as well as directing the Board of Medicine to establish mechanisms for reviewing judgements and settlements. This would detect patterns of behavior suggesting the need for Board investigation of poor medical care. It was felt that these recommendations would insure that the physicians are protected as well as the patients of the State of Florida.

LCMS's resolution 97-3 - Managed Licensure - was adopted as amended. Seek all avenues to provide that all managed care/insurance representatives (i.e. clerks, nurses, physicians) involved in clinical patient care decisions in Florida be licensed under the appropriate licensing Florida Statues; and that all commercial and Medicare triage servers be filed with the Department of Health. Resolution filed by F.L. Howington, M.D. ◆

(House of Delegates Reports continue on page four)

123RD PRESIDENT OF FMA - CECIL B. WILSON, M.D.

Optimism, Enthusiasm, Perserverance

Cecil B. Wilson, M.D., was installed as 123rd President of the Florida Medical Association at the Annual Meeting Change of Leadership ceremony, Saturday, May 31. At the Sheraton Bal Harbour. In taking office, Dr. Wilson eloquently presented his theme for the year: **optimism, enthusiasm and perserverence.**

Dr. Wilson's goal for the Florida Medical Association is that the organization "continue to be a strong advocate for the right of physicians to enjoy the practice of their profession unfettered by unreasonable constraints, in an environment that allows them to provide medical care for their patients, the citizens of Florida." Dr. Wilson enters his term for office optimistic about the future of health care and determined to meet the challenges facing physicians today.

To meet these challenges will require a continuing strong emphasis on pushing for needed legislative and regulatory reform at the state and federal level; a strengthened grassroots political action program; and support of legislators who understand and back FMA priorities, Dr. Wilson said. More importantly, he concluded meeting all these challenges will require intense efforts, supported by full measure of his prescription of optimism, enthusiasm and perserverance.

Dr. Wilson Welcomes Your Calls

FMA President Cecil B. Wilson, M.D., will be available each Wednesday and Thursday from 1:30 - 5:00 p.m. to take calls from FMA Board Members, county medical and specialty society officers and executives, FMA members and staff. Dr. Wilson can be reached by phone at (407) 647-2122 or by fax at (407) 647-6701. He can also be reached by e-mail at Cecil_Wilson@ibm.net.

FMA Elected Officers - 1997-98

President - Cecil B. Wilson, M.D.

President-Elect - Glenn E. Bryan Jr., M.D.

Vice President - Mathis L. Becker, M.D.

Secretary - H. Frank Farmer, Ph.D., M.D.

Treasurer - Barbara Harty-Golder, M.D., J.D.

Speaker, House of Delegates - Harold G. Norman Jr., M.D.

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REFERENCE COMMITTEE IV MEDICAL ECONOMICS

James H. Rubinstein, M.D., Delegate

Three items dominated discussion in this Reference Committee. I will present the problems raised and their potential solutions (passed resolutions)

Problem #1:

"We have you surrounded. Do not order that PSA and come out with your hands up" or Resolution 97-64 "Medicare Fraud and Abuse - Administrative Threat."

The Reference Committee heard testimony regarding the aggressiveness of the new campaign against Medicare fraud and abuse. Evidently, innocent mistakes, such as isolated instances of computer glitch induced double billing, have been triggering investigations. The same has been true of ordering of preventative and screening studies which are viewed as medically unnecessary.

Note that the Kennedy-Kasselbaum Bill and the current "Medicare Fraud, Abuse, and Waste Prevention Amendments of 1997", hope to save Medicare $480 billion over the next four years through penalties, claim denials, policy changes, recoveries, and settlements. The legislative proposal extends civil monetary penalties of $50,000 for each violation of the Federal Anti-Kickback Statute. Episodes of fraud and abuse can carry a $10,000 penalty for each violation and up to two years in prison. The bill produces $500 million in funding in order to pursue the guilty. It seems imperative that the innocent or naive do not get caught in a net cast too wide.

Potential Solution #1:

"Resolved, the FMA meet with HCFA and BC/BS of FL requesting an overview and cessation of the inappropriate interpretation of fraud and abuse."

Problem #2:

"Sure you can have a medical savings account, you just can't put money in it" or Resolutions 97-8, 97-15, and 97-16.

The House heard testimony that the now infamous Kennedy-Kasselbaum legislation has limited MSA's to companies with less than 50 employees. Also, contributions are limited to $2,250 per individual and $4,500 per family per year. The hope would be to expand this option to be adequately funded by tax free contributions.

Potential Solution #2:

"Resolved, that the FMA reaffirm current FMA policies related to Medical Savings Accounts; and be it further Resolved that the FMA encourage the AMA to have as one of its highest legislative priority changes in the Medical Savings Accounts that will allow Americans who want them to have them available and allow funding of such MSA's at the highest level allowed for medicare anywhere in the country."

Problem #3:

"AFL - CIO - M.D and D.O." or Resolution 97-69 "Collective Bargaining"

Forty-five percent of practicing physicians now draw salaries from hospitals, group practices, public health agencies, the government, or managed care companies, yet while other employees can collectively bargain physicians cannot.

Potential Solution #3:

Resolved, that the Florida Medical Association and the American Medical Association seek means to remove restrictions for physicians to form negotiating units in order to negotiate reasonable payments for medical services, and to compete in the current managed care environment; and be it further

Resolved, that the FMA look into the possibility of either itself or a subsidiary organization forming a physician negotiation unit; and be it further

Resolved, that full details should be reported by staff to the Fall Meeting of the FMA Board of Governors for action; and be it further

Resolved, that the FMA be directed to research the ability of physicians to participate in collective bargaining to ensure the quality of care rendered to patients, maintain professional standards and better manage the business of medicine. ◆

REFERENCE COMMITTEE IV MEDICAL ECONOMICS

Alan D. Siegal, M.D., Delegate

This Reference Committee discussed several issues regarding medical economics. It was attended by no *less than the President-Elect of the AMA*, Percy Wootlow, M.D., from Virginia, who was an active participant. The big issue was the creation of Doctor's unions. This movement is originating in the more advanced managed care areas like Dade and Broward County: but there was a surprising amount of state-wide support. It was pointed out that 50 percent of members of the American Academy of Family Physicians are employed; and these physicians might be best represented by a union. The AMA is looking into "negotiating units" to do the same thing without the term "union"; they have also ruled out the strike as a bargaining tool. There will be more interest in some form of collective bargaining and the FMA will look into how it should be done.

Many other interesting issues were discussed including non-compete clauses in HMO contracts; standardized credentialing forms for managed care companies; and eliminating disincentives to enroll in Medicaid. Medical Savings Accounts were widely supported. Unfortunately, we were informed that the present Kennedy-Kasselbaum bill which authorizes MSA is actually written to slow growth of those accounts. The limit on companies with less than 50 employees and the four year trial period are meant to slow these plans down for the near future.

I left this meeting with a clear recognition that we need the FMA and AMA so that we can understand the problems, decide on the best solutions, and then try to advocate our positions in Tallahassee and Washington.

Clearly we have leaders who can do this - and they need our support! ◆

LCMS/ALLIANCE NEWS *(continued from page two)*

Rodriquez and the Charity Ball Committee for a job well done at this years major charitable event.

Welcome Brunch

Every year the Lee County Medical Society Alliance and Foundation boards welcome new physician's spouses by hosting a Welcome Brunch. This year's brunch will be held Wednesday, September 3rd at the home of Jay and Franky Margolin. Plans are well underway for this event which is being chaired by Noreen Kurland, Sue Savage and Maureen Schwartz. If you know any new physicians in town, please contact Noreen at (941) 481-8820, or Sue at (941) 482-3185, or Maureen at (941) 468-1999.

Potluck in Paradise

Our 7th Annual Potluck in Paradise will be held on Saturday, September 20th at 7:00 p.m. at the home of Mike and Kathy Marchildon. All members are encouraged to come and enjoy a fun evening of informal dining. Paula Machlin and Karen Weiss, co-chairs, are already preparing for this event which always proves to be an unforgettable evening of meeting new physicians and their spouses as well as "catching up" with old friends and colleagues. The food is delicious, the dress is casual; Come and Enjoy!!

Please Note: To contain the cost of hosting this event, we will not be sending out individual invitations to all members.) Therefore make sure to mark your calendars now as follows:

7th Annual Potluck in Paradise

When: Saturday, September 20th, 1997 - 7:00 p.m.
Where: Mike and Kathy Marchildon
11511 Wellfleet Drive
Fort Myers, Florida 33908
RSVP: Paula Machlin: (941) 561-2767
Karen Weiss: (941) 768-3293

IMMUNIZATION GUIDELINES FOR FLORIDA SCHOOLS AND CHILD CARE FACILITIES 1997/98 SCHOOL YEAR

Summary of Changes for School Year 1997/98

- A second dose of measles vaccine (preferably MMR) is required for children attending grades kindergarten through fourth (K-4th).
- Children entering, attending or transferring to seventh grade will be required to have completed the hepatitis B vaccination series, a second measles vaccination (preferably MMR) and a tetanus-diphtheria booster.
- Florida Certification of Immunization, Form 680 has been revised to incorporate the new immunization requirements.
- County Health Departments who are on the Health Clinic Management System have the capability to generate a computerized Florida Certificate of Immunization.

Additional Kindergarten Requirements for School Year 1998/99

- Children entering, attending, or transferring to kindergarten in Florida schools will be required to have completed the Hepatitis B vaccination series. (10D-3.088, F.A.C.)

The Florida Certification of Immunization (Department of Health Form 680), required by the rules, must be used to document immunization requirements for admittance or attendance in a child care facility, public or non-public school, grades preschool and kindergarten through twelve. The Department of Health Form 680 has been revised to incorporate new immunization requirements: effective with the 1997/98 school year children entering, attending or transferring to seventh grade will be required to have completed the hepatitis B vaccination series, a second dose of measles (preferably MMR), and a tetanus-diphtheria booster; effective with the 1998/99 school year children entering, attending, or transferring to kindergarten will be required to have completed the hepatitis B vaccination series.

Immunization

- The global eradication of smallpox was officially declared at the World Health Organization's World Health Assembly in 1980. The last naturally acquired case of smallpox was reported in Somalia in 1977.
- About 80% of the world's children have been immunized against six diseases: diphtheria, measles, pertussis (whooping cough), poliomyelitis, tetanus and tuberculosis. But many African countries, under 50% of children have been immunized.
- *About 300 million children were immunized* against poliomyelitis in 1995. India alone immunized 82 million children in a single day.
- More than 700,000 deaths from tetanus among newborn babies were prevented in 1995 by immunization of women with tetanus toxoid vaccine.
- New or improved vaccines are being developed against diarrhoeal diseases, dengue, Japanese encephalitis, measles, bacterial meningitis, neonatal tetanus and tuberculosis.

EPIDEMIOLOGIC HIGHLIGHTS - LEE COUNTY 1991-1996

Sexually Transmitted Diseases

- Chancroid and congenital syphilis have remained pretty much under control over the last few years.
- Hepatitis B has remained low since 1994, reduced in half in 1996 compared to 1995.
- AIDS has remained stable since 1994, decreasing slightly in 1996.
- Chlamydia reporting was instituted in the latter part of 1993. Since 1994 it has been increasing, rising hand in hand with gonorrhea. In fact, chlamydia surpassed gonorrhea in the past three years. Primary and Secondary syphilis have been dramatically reduced since 1994.
- Both Early and Late Latent syphilis had reductions of fifty percent in 1996 over 1995.

But unfortunately, to date for 1997 we are seeing the following increases:

- Combined syphilis cases, on a monthly average, are running double 1995's and triple 1996's cases.
- Gonorrhea averages per month in 1995 ran 38.59, for 1996 33.8 cases, but to date for 1997 have shot up to 51.6.
- Chlamydia averages for 1995 51.4 cases and 50.75 for 1996, but for 1997 has spiked to 5489.

Gastro-Intestinal Disorders

- Salmonellosis has increased slightly over the last two years.
- Campylobacteriosis has remained quite stable.
- Hepatitis A has decreased dramatically over the last two years.
- Shingellosis was low in 1994 and 1995 but there was a community-wide outbreak in 1996.
- Ameobiosis is rarely seen these last few years.
- Giardiasis has been up for 4 years. For 1996, particularly, it nearly doubled from 1995.

Vaccine Preventable Disorders

- This group of diseases remains quite controlled. H. Influenza came down from 11 cases in 1993 to 2 in both 1995 and 1996. No specific outbreaks were noted in the last three years.

Miscellaneous Disorders

- Most diseases in this category remain in "good shape". Legionaire's Disease reported nearly doubled for 1996 compared to the previous three years.

We request that all Lee County physicians:

- Report all conditions listed as a Reportable Communicable Diseases to appropriate personnel of our Public Health Agencies, so that they can be handled in a timely manner and disease outbreaks can be prevented.
- Inform their patients regarding possible disease transmission to their contacts in the community.
- Communicate healthy life-style choices to patients and ask questions regarding sexual activities during routine history and office sessions (particularly patients above the age of 13).
- Because both gonorrhea and chlamydia occurrences are highest in the 14-19 age group, we request that physicians be more watchful for these conditions, and if detected use more aggressive treatment schedules. Clinicians involved in prenatal care should screen their patients more often for GC and chlamydia - at least once a trimester.

For more information about this document or any other disease, please contact Dr. Judith Hartner, Director, or Dr. Prakash Patel, Epidemiologist, at the Lee County Health Department, (941) 332-9510. ◆

NEW MEMBER APPLICANT

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.

STEPHEN LEIF HELEGMO JR., M.D. - ORTHOPEDIC SURGERY

Medical School: John Hopkins University, Baltimore, MD (1982-86)
Internship: John Hopkins University Department of Surgery, Baltimore, MD (1987-91)
Residency: John Hopkins University Department of Surgery, Baltimore, MD (1991-92)
Fellowship: John Hopkins University, Department of Orthopedic Surgery, Baltimore, MD (1992-96)
Board Certification: Board Eligible. Dr. Helegmo is an associate with the Sports Medicine and Orthopedic Specialist at 8350 Riverwalk Park Blvd., S-3, Fort Myers, FL.

KENNETH A. TOLEP, M.D. - INTERNAL MEDICINE, PULMONARY DISEASE, AND CRITICAL CARE

Medical School: S.U.N.Y. Health Science Center, Syracuse, N.Y. (1982-86)
Internship: Thomas Jefferson University Hospital, Philadelphia, PA (1986-87)
Residency: Thomas Jefferson University Hospital, Philadelphia, PA (1987-89)
Fellowship: Temple University - Pulmonary Disease/Critical Care, Philadelphia, PA (1989-92)
Board Certification: American Board Certified in Internal Medicine, Pulmonary Disease, and Critical Care. Dr. Tolep is an associate with Associates in Pulmonary Medicine at 3615 Central Avenue, Fort Myers, FL.

EMAD KASSIM SALMAN, M.D. - PEDIATRIC ONCOLOGY AND HEMATOLOGY

Medical School: American University of Beirut, Beirut, Lebanon (1983-87)
Internship: American University of Beirut, Lebanon (1987-88)
Residency: University of Florida, Jacksonville, FL (1988-91)
Fellowship: University of Florida, Jacksonville, FL (1995-96)
Board Certification: American Board Certified in Pediatrics and Pediatric Hematology and Oncology. Dr. Salman is an associate at Nemours Children's Clinic at 9800 HealthPark Circle #110, Fort Myers, FL..

BALACHANDRAN PRABAKARAN, M.D. - CARDIOLOGY

Medical School: Government General Medical Hospital, Madras, India (1975-78)
Internship: New York Medical College, New York, NY (1979-80)
Residency: New York Medical College, New York, NY (1980-81)
Fellowship: New York Medical College, New York, NY (1982-84)
Board Certification: American Board of Internal Medicine and American Board of Cardiovascular Diseases. Dr. PrabaKaran is an associate with Florida Heart Associates at 2675 Winkler Avenue, Suite 460, Fort Myers, FL.

SUBHASH KSHETRAPAL - CARDIOLOGY

Medical School: University of Rajasthan, Jaipar, India (1978-82)
Internship: United Kingdom (1983-87)
Residency: New York Medical College, Bronx, NY (1987-89)
Fellowship: Michael Reese Hospital, Chicago, IL (1989-92)
Board Certification: American Board of Cardiology in 1991 and American Board of Internal Medicine. Dr. Kshetrapal is an associate with Florida Heart Associates at 2765 Winkler Avenue, Suite 460, Fort Myers, FL

CYNTHIA J. MCCURDY, M.D. - OBSTETRICS AND GYNECOLOGY

Medical School: University of Rochester, Rochester, NY (1979-83)
Internship: Portsmouth Naval Hospital, Portsmouth, VA (1983-84)
Residency: Portsmouth Naval Hospital, Portsmouth, VA (1984-87)
Board Certification: American Board of Obstetrics and Gynecology. Dr. McCurdy is an associate with Associates in OB/GYN at 9981 Healthpark Circle #454, Fort Myers, FL

PHYSICIAN CLIA DENIALS ARE COMING!!!!

Effective July 1, 1997, any physician clinical laboratory service(s) filed with the Medicare Carrier will not be reimbursed without having an appropriate Clinical Laboratory Improvement Amendment (CLIA) number previously entered in the Medicare processing system. It is important to note that while your CLIA number is not currently required on the actual claim (paper or electronic), this future requirement is tentatively scheduled for October 1, 1997. Please read the Medicare Updates for the final implementation date and claim form completion requirements...

If you are a physician filing any diagnostic clinical laboratory service(s), the carrier must receive positive verification of your CLIA eligibility for either a current CLIA certificate of use, waiver, or certificate for physician performed microscopy service(s) from Florida's Agency for Health Care Administration (AHCA) and/or the Health Care Financing Administration (HCFA). Only positive CLIA verification will result in allowing claims to process through the Medicare system.

Unfortunately, should you receive any denials due to CLIA eligibility, the Florida Medicare Carrier cannot change or adjust the denied claims until you have corrected any CLIA eligibility errors with Florida's AHCA at (904) 487-3063. This agency is responsible for coordinating any CLIA issues with the HCFA and the Medicare carrier.

Note: Please remember, whenever you bill for clinical laboratory services you must indicate the UPIN of the ordering physician (this would be your UPIN number if you were the ordering physician)... ◆

AHCA TO DO OFF-SITE MICROSCOPY INSPECTIONS FOR SOME CLINICAL LABORATORIES

Effective May 24, 1997, Chapter 483, Part I.F.S., was amended by the passage of SB 270 to authorize the Agency for Health Care Administration (AHCA) to inspect laboratories on-site or off-site at least every two years. In response to this change, AHCA developed Microscopy Evaluation Survey that can be used in lieu of an on-site survey. At this time, off-site surveys will be limited to those holding CLIA Provider Preformed Microscopy (PPM) certificates which have not had a state licensure inspection within the past 24 months. All other laboratories (excluding those performing waived tests) will continue to have on-site surveys conducted by either AHCA or approved accreditation organization representatives.

Under CLIA, laboratories with a PPM certificate are exempt from federal biennial inspection. While the state licensure requirements for physician office laboratories are similar to CLIA in many respects, Chapter 483, Part I.F.S., does not make specific distinction between the CLIA category of PPM and other testing categories. Thus, CLIA PPM certificate holders are not exempt from state biennial inspection. With the introduction of the Microscopy Evaluation Survey, these providers will be offered an alternative to the on-site survey.

AHCA anticipates distributing these surveys during the next two weeks. Once the laboratory receives the survey, it must be signed and returned to AHCA within 21 days to avoid on-site inspection. Laboratories that submit an incomplete survey, fail to return the completed survey within 21 days, or indicate laboratory practices that are not in compliance with the applicable regulatory requirements will be scheduled for an on-site survey.

The State of Florida clinical laboratory licenses for these physician office laboratories cannot be renewed until a completed satisfactory survey has been returned, or an on-site survey with a recommendation for licensure has been made by AHCA. All clinical licenses expire on September 30, 1997.

If you need additional information, please call Judy Cooper, FMA staff at (904) 224-6496 or Patricia James, AHCA staff at (904) 487-3063. ◆

PLEASE TAKE NOTE THE MAXIMUM ALLOWED COST FOR REPRODUCING MEDICAL RECORDS

From the most recent issue of FLORIDA ADMINISTRATIVE CODE/AGENCY RULES: Chapter 59R-10.003 **Cost of Reproducing Medical Records**: (1) Any person licensed pursuant to Chapter 458, Florida Statute, required to release copies of patient medical records may condition such release upon payment of requesting party of the reasonable cost or reproducing records. (2) Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: (a) For the first 25 pages, the cost shall be $1.00 per page. (b) For each page in excess of 25 pages, the cost shall be .25 cents. (3) Reasonable costs of reproducing x-rays, and such other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the materials and supplies used to duplicate the record, as well as the labor cost and overhead costs associated with such duplication. ◆

NATIONAL PROVIDER IDENTIFIER PROJECT

The National Provider Identifier (NPI) project will create a uniform provider identifier for use by all federal health programs (i.e., Medicare, Medicaid, etc.).

Use of the NPI will also be an integral part of the Medicare Transaction System (MTS) initiative through its enhancement of safe guard activities and simplification of administrative activities.

The NPI will be unique to each health care provider regardless of practice location and replace both the carrier-assigned Provider Identification Number (PIN) and Unique Physician Identification Number (UPIN) for claims processing purposes.

Based on material available to us at this time, the NPI will be required on all Medicare Part B claims received after December 1, 1997.

There will be no grace period for this requirement, and all claims submitted without NPIs will be returned to sender.

Medicare carriers will be responsible for the dissemination of NPIs to existing providers. The current NPI project timeline indicates this activity will begin in August 1997. ◆

WHAT'S HAPPENED TO THE HEALING PROCESS?

By Robert M. Goldberg

A stick ripped through nine-year old Steven Olsen's cheek and lodged in the base of his brain. But Steven was not rushed to the nearest hospital.

Instead - following the instructions of his parents health plan - they called a toll-free number for permission to go to a hospital of the insurer's choice. Ten hours later, surgeons removed the stick and mended the gash. Days later Steven was still feeling ill. Was his injury the cause, asked his parents. Shouldn't we get an MRI? No, said the managed-care gatekeeper, it's the flu: Give Steven some Advil and wait.

Two more days, and Steven's head was throbbing. His parents took him to the hospital. Twice they asked the doctors if the injury had anything to do with the pain and whether he should get a brain scan. Twice they were told he had some form of meningitis. Steven was sent home after a day, still in pain.

Steven's condition kept getting worse. Finally, weeks later, he got a brain scan. It showed an abscess in his brain, caused by the stick, which was inducing seizures - hence the pain. Because he had been left *untreated, Steven went blind and developed* cerebral palsy. His intellectual development is now stunted. His parents found out that their health plan knew all about the possibility of a brain abscess, even as it was forbidding Steven to get an $800 scan or see a neurologist.

Delivering "Inputs"

Steven Olsen is a victim of the slow death of the doctor-patient relationship, at the hands of both corporate and government bureaucracies. Of course doctors still see patients, make diagnoses, write prescriptions and perform surgery. But increasingly they are losing authority over their patients' care. Instead, they are expected to deliver medical "inputs" according to organizational directives. Those who resist are treated as uncooperative employees. Is it any wonder that Texas recently passed legislation allowing patients to sue health-maintenance organizations for malpractice? Or that an increasing number of doctors are joining labor unions?

An HMO executive, quoted last September in the Business Record of Des Moines, Iowa, summed up the industry's approach chillingly: "We see people as numbers, not patients. It's easier to make a decision. Just like Ford, we're a mass-production medical assembly line, and there is no room for the human equation in our bottom line. Profits are king." That comparison insults Ford, a company that has become focused on customer satisfaction. Indeed, any company in any industry would go bankrupt if it had the take-it-or-leave-it attitude of most managed-care organizations, with their gatekeepers and indifferent "benefits managers" who often stumble over the pronunciation of medical procedures.

Health plans are not directly accountable to either doctors or patients. For them the key to profits is to get doctors to do what they are told and to keep patients in the dark. Even doctors who aren't employees of an HMO are often pressured to behave as if they were. Despite their claims to the contrary, HMOs frequently threaten to "lay-off" doctors - kicking them out of a plan - if they fail to hold down costs or hit their quota of patients.

Physicians have accepted limits on their income, with resignation if not acceptance. They are willing to learn ways to improve the quality of care. But they are frustrated, because the quality of their relationships with their patients has deteriorated under managed care. Doctors work the same number of hours - fewer, in some case - under HMO contracts. But the loss of control over resources, restrictions on referrals and the pressure to hurry through a larger number of patients per hour engender cynicism and resentment.

A survey of 200 primary-care physicians in the New York area by New York Doctors MSO, a physician practice management group, found that 45% believe that managed care has had a "negative impact" on the quality of physician-patient relationships. (Eleven percent said the relationship has improved under managed care.) Nearly half the doctors surveyed said they had recently considered leaving the profession.

Many managed care organizations maintain that limiting doctor autonomy eliminates wide differences in the amount and quality of care. They said that their systems will intregrate care, providing better treatment at lower cost than a lonely doctor in a traditional practice can. Several managed care plans, including HealthPartners in Minnesota, have lived up to these claims. But they have taken great pains to preserve physicians' autonomy and to encourage patients to become more involved in their treatment. Most plans, however, make it harder for doctors and patients to create such a partnership.

Make no mistake: A strong doctor-patient relationship is critical to successful treatment. Studies have shown that more than half of all Americans fail to understand or follow through on a doctor's advice, often ending up sicker than they were before seeking treatment. Likewise, half of all parents leave their pediatrician's office confused about his directions. Studies of doctor-patient relationships in the treatment of diabetes, mental illness and heart disease show that more time, information and patient involvement in treatment decisions contribute to better health. And surveys show that patients consistently rank good information second only to clinical skill as the most important thing a doctor has to offer.

On average, doctors spend eight minutes talking to each patient, less than half as much as a decade ago. As managed care drives up the number of patients a doctor must see, the time he can devote to each continues to dwindle. Doctors who feel they have lost the freedom to practice medicine are less likely to take a personal interest in their patients. They show up, do their job, get paid, gripe about the boss and try not to get emotionally involved.

Managed-care organization should take seriously the movement toward litigation and regulation. The 1974 Employee Retirement Income Security Act, which governs employer-provided health plans, provided managed care organizations virtual immunity from liability. But this barrier is crumbling under public pressure. Other states are likely to follow Texas's lead, spurred by a Virginia federal court ruling that Erisa does not pre-empt state claims alleging medical malpractice by physicians and vicarious liability by HMOs. In this case, a couple sued when they found out that the HMO paid their child's pediatrician bonuses for avoiding excessive treatments and testing. The court allowed the claims to go forward because they involve the quality of medical care provided by physicians.

After The Fact

The ability to sue HMOs for malpractice, however, will not improve the doctor-patient relationship, and thus will not insure that people will get better care. First, lawsuits occur after the fact. It will likely still be more cost effective to let people (or their estates) sue than it will to give doctors and patients more control over medical decisions. Second, plans are forcing doctors to pay for their patients' care out of their own pockets if they exceed a certain average rate per patient. Oxford Health Plan, for instance, allows specialist to manage the care of patients without any direct intervention. But Oxford requires such doctors to stay under budget, as defined by Oxford. If someone gets sicker or dies because a doctor tries to stay under budget, the legal liability could well fall on the physician.

There is no defensible economic or clinical reason that health care has to take these forms. Enhancing the doctor-patient relationship could generate better care at lower cost. But our lumbering and statist medical system is leaving less and less room for a doctor-patient partnership. Steven Olsten was left brain damaged and blind not because he didn't have "access" to integrated health care systems or the best medical technology in the world, but because among the too many doctors just following orders, there wasn't one he could trust to do the right thing. ◆

Mr. Goldberg is a senior research fellow at the Center for Neuroscience, Medical Progress and society, George Washington University. Reprint Wall Street Journal 6/18/97.

◆

AS I RECALL...

(continued from page one)

LHM), over for the evening, and my daughter asked me to treat her friend's warts. In those days one was not worried about malpractice suits and since John was a friend, I took the liberty of treating his daughter as no invasion was necessary. When John was called he roared with laughter and thought this was the craziest thing he had ever heard, but agreed to participate and be patient. Low and behold in three to four weeks he called and apologized advising that the treatment did work!

Well as the years rolled by and pediatrics left my practice, I haven't been treating juvenile warts, but about 8 months ago a lady came to my office with a breast lump and wanted to know if I could Witch it off! She said her daughter had been treated by me as a Witch Doctor when she had warts years ago and they disappeared so she had hoped that I could do the same with the breast lump! We did get rid of the breast lump but it was a Bard Parker blade rather than with the witching.

This probably sounds absurd too such well educated physicians but it really does work. Now, the way that is done is so simple but it does take some explanation, takes explanation to the patient's family and if it is a referred patient, it takes ALOT of explanation to the patient's doctor. Unfortunately I think that my space has run out for this article so we must conclude this without the method. If you are at all interested in the methodology of this treatment I will be most happy to explain it to you or if enough people request we will include this as a separate article. All of this is true.

Special thanks go to smiling George K. because it is always so nice to see his smiling face looking over at my articles. ◆

MEDICAL SOCIETY MEETINGS 1997

September 15, 1997
Florida Health Department
Dr. James Howell

◆

October, 1997
Planning a Fun Meeting!

◆

November 17, 1997
6:00 pm - Dinner
CME Credits
1 Credit Hour each
HIV/AIDS
Domestic Violence

LEE COUNTY MEDICAL SOCIETY
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