One little smile can fill the room with sunshine.

LEE COUNTY MEDICAL SOCIETY Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 25, NO. 03 | FORT MYERS, FLORIDA | JOHN W. SNEAD, M.D., EDITOR | MAY 2001

LEE COUNTY MEDICAL SOCIETY MEETINGS FOR 2001

GENERAL MEMBERSHIP MEETING
MONDAY, MAY 14, 2001
END-OF-LIFE ISSUES AND PALLIATIVE CARE

Royal Palm Yacht Club
Upstairs Dining Room
6:00 P.M. - Dinner
7:00 P.M. - Program

Speakers: Mary Stegman, M.D.
Diane E. Smith, M.D.

Costs: Members - No Charge
LCMS Applicants & Retired - $25.00
Non Members - $75.00

Dinner will be served promptly at 6:00 P.M. **Program starts promptly at 7:00 p.m.** You must stay the complete two (2) hours to receive the credits. This year, you may substitute 2 hours of End-of-Life CME in place of HIV/AIDS and Domestic Violence if you completed them in the previous biennium.

Mail your reservations and check to the LCMS
P.O. Box 60041
Fort Myers, FL 33906

2 HOURS OF CME

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Florida Medical Association and the Lee County Medical Society. The Florida Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

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

NO MEETINGS JUNE, JULY, AUGUST

Inserts

1. **MAY 14, 2001 MEETING NOTICE**
2. **GOLF TOURNAMENT ENTRY FORM**
3. **FLORIDA MEDICAL ASSOCIATION CME ONLINE FLYER**

In This Issue...

PRESIDENT'S MESSAGE

Low Fat Diet

Peter Blitzer, M.D.

I get frustrated when my prejudices are not supported by the facts. This happened recently when I read an article in the journal *Science* about low fat diets. I was chagrined to learn that there is no good evidence that health is improved by reducing the proportion of total calories that come from fat.

Of course I was in good company in my assumptions about evils of dietary fat. Since 1976 it has been the recommendation of the Federal Government that Americans follow what we all would consider a low fat diet: limiting fat intake to less than 30% of the total calories consumed. None other than Senator George McGovern, who was an early devotee of Nathan Pritikin, initiated this recommendation; McGovern was then Chairman of the Select Committee on Nutrition and Human Needs. A young journalist, working for the committee, wrote up the guidelines. He had no expertise in medicine, nutrition, or epidemiology.

The recommendations for a low fat diet have remained in force for twenty-five years, even though there have never been convincing data showing such a diet lengthens life. In fact there is not even proof that lowering the proportion of calories from fat aids long-term weight reduction.

The absence of studies demonstrating a benefit of a low fat diet does not stem from lack of funding. The Federal Government has spent over half a billion dollars on epidemiological and interventional trials. Among these are the Framingham Study and the MRFIT study. In none of these studies did the subjects who ate low fat diets live longer.

What researchers have demonstrated is that there are lifestyle changes that confer a modest level of protection from arteriosclerosis: exercise, avoidance of obesity, and a "Mediterranean Diet" (high in monounsaturated fats). There is no evidence that limiting total fat intake to less than 30% of the calories protects against arteriosclerosis.

Epidemiologists are finally becoming bold enough to speak out against the need to "limit total fat intake to less than 30% of the calories." The article in *Science* quotes a British epidemiologist as saying, "The anti-fat movement was founded on the Puritan notion that something bad has to have an evil cause, and you got a heart attack because you did something wrong, which is eating too much fat."

Prejudice dies hard. You will probably still see me in the doctors' lounge eating my low fat diet, but I will not be so smug about it.

1901-2001 - The 100th Anniversary of the AMA House of Delegates

By Roberta Ghidara, Archivist; Records Management and Archives

The AMA's House of Delegates is rightly considered the cornerstone of the Association. From this democratic assembly comes the policy that shapes the AMA's work "promoting the art and science of medicine and the betterment of public health," as well as the spirit and values that infuse that work. The year 1901 is a milestone in the history of that body of delegates, for it marks the reorganization of the AMA into the assembly we know today.

From the date of its founding in 1847, the AMA had annually met to discuss important matters of business, assembling its members from state and specialty societies into a General Assembly. Policy resolutions were discussed among the members as they are today, but equal representation was not present. Some states overcrowded the Assembly with delegates, while others were underrepresented.

By 1900, organizational problems, such as unequal representation in the Assembly, had reached an impasse. In the remaining months of that year, the Assembly commissioned a Committee on reorganization, chaired by Dr. J. N. McCormack, to investigate the restructuring of the AMA.

In 1901, the Committee presented its finding, proposing a set of constitutional amendments that transformed the Association. A new 'House of Delegates' would act as the AMA's governing body, designed to be, in the words of Morris-Fishbein, "A single closely knit unit based on a truly democratic system of representation." This House would consist of representatives from state medical societies, plus delegates from the military and AMA sections. State representation would be based on a ratio of one delegate per five hundred members, with a maximum of one hundred and fifty delegates in the House.

In the years following this reorganization, the newly formed House of Delegates debated issues, which dramatically impacted the history of medicine in the United States, including the transformation of medical education, public health and safety, national health insurance and patient's rights. We are proud to honor the House of Delegates in this edition of the bulletin; their dedication to America's physicians and patients embodies the heart and soul of the American Medical Association.

To learn more about AMA history and read the Proceeding of the House of Delegates, visit the website at www.ama-assn.org/history.

AMA ANNUAL MEETING WILL BE HELD
JUNE 17 - 21, 2001
CHICAGO HILTON AND TOWERS
CHICAGO, IL

AS I RECALL...

Who is C.W.?

Roger D. Scott, M.D.

For forty-three years I have been searching for C. W. Stribley and have inquired of a number of people around Ft. Myers, but none seem to know who C. W. was. The *News Press* came to my rescue on 3/3/01 with an article about the sale of Casa Rio, a riverfront house on McGregor Blvd., directly adjacent to the Ford Estate. It seems that this house was built (1920-28) by none other than C. W. Stribley who was in the paper mill business and was the inventor of wax paper (never knew who invented it) and check watermarks. Margaret and Hart McIntyre purchased the house in the early 1960s. I had been in this house on at least two or more occasions socially for parties given by them, unaware that it was the former home of the elusive C. W. The McIntyre's sold it to Bruce Scott who kept it for many years. At least twice I was in the house while the (unrelated to me) Scotts occupied it, still oblivious of C. W.'s prior ownership. So, you can see now why I am delighted to know who C. W. Stribley was, but you don't know the why of it.

Mr. Stribley donated the elevator for the "new" Lee Memorial Hospital (the brick hospital), opened on April 18, 1943. Almost each day from August 1958 until 1968 when we moved into what you now know as the Lee Memorial Hospital on Cleveland, I used to say good morning to Mr. Stribley as I gazed at the small bronze plaque on the back wall of the elevator that stated: "This elevator donated by C. W. Stribley". So now you have the why of it, and another of life's mysteries solved for me!

Also pictured in the same article is a dredge filling the land for the Stribley House. Bay Street was on the waterfront and Edwards Drive was nonexistent. All of the property now north of Bay Street represents dredged fill from the 1930s. Before that and more recently, much of the riverfront was filled including the Stribley and other properties along the river on the south bank primarily. In 1958, all of the Cape Coral shoreline was mangrove trees, and we used to fish the shoreline and sloughs ("Slews"); now it is seawalls and fillings. The dredging prior to a few years ago was allowed almost indiscriminately and one could dig a channel into his property from the channel to his dock at home if living on the riverfront.

For sometime it has been illegal to dump trash and raw sewage from the city and county into the river; however, it was not uncommon to find trash and articles or particles from toilets floating down the river. For many years boats pumped raw sewage, garbage, & trash into the river. This was true of many of our rivers, especially the St. Johns. Gradually the laws have tightened now, and I believe that everyone has either their own septic tank or county sewers. Boats are better and now we have a much cleaner river.

So many people have asked "Was the river empty of water during hurricane Donna?" Yes, all of the water was driven into the gulf by the wind on the leading part of Donna and during the "eye" (1 ½ hrs) one could see only mud (no water all the way across the river). We struggled through the mud some distance but couldn't make it to the channel where it was reported that about two feet of water was present. There was rapid refilling of the river when the backside of the storm came across.

So at last, C. W. you have been found and may you rest in peace.

Didyakno: The first brick building in Ft. Myers was built in 1897 by Harvie Heitman and still stands on the NW corner of First and Jackson Streets.

Editor's note: We received several letters to Dr. Scott and they are printed under "We Get Letters"

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

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Distinct Impressions 482-6262

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NEW PRACTICE NAME:
Colonial Family Medical
Washington Baquero, M.D.
Eduardo Gonzalez, M.D.

More Physicians Opt Out of Medicare

As of June 30, 2000, HCFA reported that 1,396 physicians and other practitioners (including 82 clinical psychologists and 42 clinical social workers) had opted out of Medicare. The best represented physician specialties, in descending order, are: psychiatry, 492; family practice, 156; general practice, 121; internal medicine, 86; Ob/Gyn, 82; plastic and reconstructive surgery, 45; dermatology, 38; osteopathic manipulation, 27; physical medicine/rehab, 23; orthopedic surgery, 21; general surgery 21; ENT, 18; anesthesiology, 18; ophthalmology, 12; allergy/immunology, 12; emergency medicine, 10.

AAPS News, March 2001

LAPTOP COMPUTER NEEDED

The medical museum of history is in need of a laptop computer for the purpose of cataloging the items donated to the museum. If you can donate a used one, please contact Ann Wilke at 936-1645 or Dr. Jacob Goldberger at 275-6659 Ext 226.

Tax DEDUCTION will be available.

LCMS Alliance Foundation News

Respectfully submitted by Monica Schneider, Corresponding Secretary

DUES ARE DUE!

After checking with your office, please renew your membership to the LCMS Alliance, for your spouse, if this has not been done. We can't do our important work without you! Your benefits of the newsletter, directory, and directory listing will not continue without paying dues.

Your dues provide our organization with funds for:
- Community service
- Legislative education
- Much more!

Your dues provide:
- Alliance newsletter
- Alliance directory
- Networking and friendship opportunities
- Much more!

Please make check payable for $90.00 to LCMSA and mail to: Donna Homolka, Treasurer, 11760 Hampton Greens Drive, Fort Myers, FL 33913. We appreciate your contribution even if you cannot be an active member! Thank you, Victoria Sweet/President & Barbara Rodriguez/ Membership.

SUPPER CLUB

We enjoy getting together with friends and meeting new people, join us in a night of fun and dining:
Saturday, May 12th 7:00 p.m.
Roy's in Bonita Springs
Mark your calendars! Please RSVP by May 8th for our next rendezvous to Maria Galang 561-3499 or Angie Ferrer 437-8897.

OIG Designates Seniors as "The Mole"

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

One of the hottest new shows of the season is the "reality" show The Mole. The premise is that, among the contestants, engaged in various physical and mental challenges, is a mole, a saboteur. The object of the game is, of course, to identify the mole and to minimize the damage he does.

No need to turn on your television. A similar reality show is playing itself out in your medical office on a daily basis. The Office of Inspector General has targeted Medicare Fraud and Abuse for increased enforcement, and has "deputized" senior citizens as civilian enforcement agents, hoping that the nation's Medicare recipients will ferret out fraud and abuse. As a result, every physician who treats Medicare patients now has to view his patient not only as a person in need of his services, but potentially the source of a complaint that might trigger a Medicare audit, a full-blown investigation or civil or criminal litigation for billing irregularities. Given that the billing rules are so Byzantine that no human being could possibly file an accurate bill for every patient, this is an unsettling prospect.

Both the Feds and the AARP (www.aarp.org) are encouraging patients to be watchdogs. The Medicare website (www.medicare.gov) lists "detection tips" for detective-patients. Medicare advises patients to be suspicious if a provider:

- Tells a patient that the test is free, in exchange for the patient's Medicare number.
- Tells a patient Medicare "Wants" him to have a particular service
- Represents that he "Knows how to get Medicare to pay" for a service
- Encourages multiple testing because "The more tests we order, the cheaper they are"
- Offers free services or equipment

In particular, Medicare advises beneficiaries to be on the lookout for

- Physicians who routinely waive co-payments without checking on the patient's ability to pay.
- "Free" consultations
- Claims that a provider "represents" Medicare
- Physicians who pressure patients into expensive treatments
- Bills that contain charges for treatments not received
- Telemarketing and door-to-door tactics

The problem with the Medicare list is that even honest and well-meaning physicians and their staff can fall afoul of these "warnings," even when acting properly and in good faith. Patients who have been told that a physician "accepts assignment," for example, have been known to become outraged when told they are responsible for 20% of the bill, assuming that accepting assignment translates into "no need to pay" for the patient. Similarly, when Medicare denies reimbursement for medically indicated services, patients may jump to the conclusion that the physician is trying to defraud the system.

There's no way to eliminate the "moles" in your practice –there are too many of them. But a little preventative care, for your staff and your patients, can help avoid trouble down the line be defusing problems before they get reported. A few suggestions:

- Instruct your staff in the risks of fraud, and the sorts of advice patients are getting about identifying potential fraud.
- Teach your staff to avoid comments that might raise questions of fraud. For example, in advising a woman over 50 that she needs a mammogram and that it is covered by Medicare, it's best to say just that – not that "Medicare will pay for this, and under Medicare guidelines, you should have a mammogram."
- Identify someone (nice) on your staff to be the resource person for billing questions. Makes sure your patients know who that person is, and encourage them to bring up problems or questions. Post a sign if you have to.
- Explain tests, and when you are aware of them, billing practices, as clearly as you can. For example, patients need to know that they may receive multiple charges for the same event, depending on who is involved: a bill from the hospital, radiologist and pathologist for a needle breast biopsy, for example.
- Be available to talk with your patients about their billing questions, especially if they aren't satisfied with the answers from your staff.

Reprinted from the March, 2001 issue of SCMS Topics

THE QUESTION MAN
OPINIONS – EDITORIALS
LETTERS TO THE EDITOR
John W. Snead, M.D.

May's Question: "Is the New Handheld Prescribing Technology Beneficial?"

(We received no responses for the question in the April Bulletin)

"I have been without my I-Scribe prescription writer for almost two weeks. For one thing I don't have terribly good handwriting and this prints out a legible copy of a prescription with my signature on it, which should be an important asset in terms of possible medication errors and even subsequent law suits. The fact is, FPIC Insurance has promised us a 5% discount for using this device.

Another asset is that I don't have all the pre written prescriptions stacked around my treatment console as I used to have, which makes for a neater office and improved situations for fire hazards because sometimes my alcohol lamp caught these things on fire.

Thirdly, I don't get calls back from the pharmacy telling me that this particular prescription is not allowed under my patient's Health Care Plan because I have the patient's formulary to select from when I write the prescription.

For all the above reasons, I have become very dependent upon it.

I have to say before I talk someone else into taking on the instrument, not all of us use it. One of my five partners does not care for it; at least never got into using it. It is a little trouble at first because you have to pick prescriptions and maybe customize what you ordinarily use but once you have done that they are in the unit to be picked from very quickly just by "point and click" and not only that, all of my patients and their prescription information is in the unit and if someone needs a refill it is easy enough to just find the patients on a scrolling list and 'point and click' again to write the prescriptions."

James H. Fuller, M.D.
Otolaryngology

July's Question: "What are the problems with the National Practitioner Data Bank?"

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

Arthritis Trends & Treatment CME

The Arthritis Foundation/ Southwest Region's second annual Continuing Medical Education (CME) conference entitled "Trends & Treatment" will be held at the Colony Beach and Tennis Club on Longboat Key, September 21-23, 2001.

The seminar has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Arthritis Foundation and the University of South Florida. This educational activity will provide a maximum of 10 hours in category 1 credit toward the AMA Physician's Recognition Award.

The conference is open to all interested physicians. For more information including agenda and fees contact the Arthritis Foundation at 1-800-741-4008 or 941-739-2729. Deadline is September 1st.

LCMS Stats

MARCH 14, 2001 - APRIL 13, 2001

	Current	YTD
Total Phone Calls Received	505	1897
From Physicians and Office Staff	88	288
For Referrals	160	639
For Background Checks	26	114
Filing Complaints	1	19
Regarding Non-Members	9	47
Regarding Alliance	15	41
Regarding CMS, FMA, and AMA	25	75
Miscellaneous Calls	181	674
Meetings	13	48
Attended on behalf of LCMS	7	28
Society Meetings	6	20
Applications Sent to Physicians	14	34
Pictorial Directories Distributed	515	534

The FMA and the Florida Medical Foundation Launch Public Relations Campaign

By: Sandra B. Mortham, EVP/CEO

The HMO industry has spent 100 million dollars to block legislation that would hold them accountable for medical decisions that they make that harm patients. The Florida Medical Association is supporting legislation that would hold managed care organizations responsible and accountable for their decisions.

The FMA together with the Florida Medical Foundation has launched a public service campaign to inform patients of their rights as members of HMOs.

This campaign, which began in Tallahassee and will later be expanded to several parts of the state, includes radio ads, television spots and billboards. The campaign message features several county medical society members who have agreed to represent the FMA as we champion patient's rights.

This is a very exciting project and I would like to thank the members of the FMA Council on Public Relations and Communications as well as the members of the Foundation Board of Directors for their input and active participation during this campaign effort.

The FMA does not have the financial resources to go head-to-head with the insurance industry. What we do have is the strength of our membership and the power that brings if all physicians stand united together to protect Florida patients.

The decisions made by members of the Florida Legislature certainly impact the rights of patients and the profession of medicine.

The FMA would like to thank the following legislators for sponsoring the Patients' Rights Act of 2001: Representatives Negron, Sobel and Weissman as well as Senators Brown-Waite, Campbell and Posey.

INTERNET MEDICAL RESOURCES

Obesity Online

by Michael Barnaby – Public Information Officer, Lee County Health Department

According to the American Obesity Association, at http://www.obesity.org, obesity affects at least 70 million Americans - more than one-third of all adults and one in five children. Each year it causes at least 300,000 excess deaths in the U.S. and costs the country more than $100 billion. This second leading cause of unnecessary deaths in America is also, unfortunately, an internet gold mine. A quick search engine query for "fast weight loss" returns an astounding 540,000 references, mostly touting diet products ranging from the dubious to the dangerous. (Remember, the amount of information online is astounding: Google.com, a popular search engine, indexes nearly a billion and a half web pages).

Patients may tend to want quick fixes when browsing the net for weight loss and diet information; well-promoted and flashier sites than the AMA or CDC abound. But for those looking for solid information, here's a small sampling of available, user-friendly obesity information:

- The American Dietetic Association, at http://www.eatright.org offers, among many things, a practical and entertaining excerpt from "Dieting For Dummies," written by a Registered Dietician. The site also has fact sheets, daily nutrition and healthy lifestyle tips, and is home to the non-profit American Dietetic Association Foundation.
- "Helping Your Overweight Child", at http://www.niddk.nih.gov/health/nutrit/pubs/helpchld.htm, is a service of the National Institute of Diabetes & Digestive & Kidney Diseases (http://www.niddk.nih.gov/index.htm). At first glance, this website seems to offer only a small amount of basic but well presented data. But click on "Publications" and a wealth of online information appears. Although not well identified, "Publications" in this case means online information, and includes titles such as Binge Eating Disorder, Choosing a Safe and Successful Weight-Loss Program, Gastric Surgery for Severe Obesity, Helping Your Overweight Child, Improving Your Health: Tips for African American Men and Women, and much, much more. A rich source of information for your patients.
- KeepKidsHealthy is online at http://www.keepkidshealthy.com. The site is the work of Vincent R. Iannelli, MD, FAAP, a board certified Pediatrician in Dallas, Texas and member of the Dallas County Medical Society, Texas Medical Association and Fellow of the American Academy of Pediatrics. Patients will find the site attractive, easily navigated and very informative. Under Nutrition, the website offers a Weight Management area specifically geared to childhood.
- For physicians: Michael D. Myers, M.D., who has been actively specializing in the treatment of obesity, weight control and eating disorders since 1980, offers a wealth of information at http://www.weight.com. The site, though appearing somewhat informal at first glance, actually contains a great deal of information. Among other features, Myers discusses various medications, at times offering practical editorial comments based on his experiences.

We Get Letters

Dear Dr. Scott:

I have enjoyed AS I RECALL for years and am led to respond to your entry of March.

Please don't miss your #50 reunion. When I attended my 50th I had a great time, far better than the 25th.

Your mention of 1947 took me back. When classes started in September we were annoyed to find that very many of the new class were married and had quite different ideas from ours. We were horrified when a ladies auxiliary was established at the Phi Chi Fraternity.

I still practice on a semi-retired basis and I strongly support the advice of Everett Koop, that one should not "Slide down the slope" but rather keep going and "Fall off the cliff at the end." It would appear that you have similar views.

Sincerely,

J. Williams Simpson, MD
Associate Medical Director SWFAS
Temple University School of Medicine 1948
AKA James W. Simpson, Bill Simpson

Mini-Internship Program

The LCMS provided a two-day mini-internship program on March 19 & 20, 2001. The following physicians and business and community leaders participated: From left to right: Alan Siegel, M.D., Coordinator of the Mini-Internship Program; Ms. Diana McGee, Medicare Consultant; Ms. Frances Ward, Student; Ms. Donna Tisch, Attorney, Fowler & White; Ms. Debbie Middleton, Director, Medical Staff Services, East Pointe Hospital. Participating but not pictured: Carmen Barres, M.D., Internal Medicine; Lorraine Golosow, M.D., Plastic/Reconstructive Surgery; Vidya Kini, M.D., Physical Medicine & Rehabilitation; Robert Martinez, M.D., Orthopedic Surgery.

The interns were invited guests at the General Membership Dinner Meeting on Tuesday, March 20, 2001, and for a debriefing breakfast on Wednesday, March 21, 2001, at East Pointe Hospital. The debriefing breakfast offers an opportunity for the interns to share their thoughts and feelings about their experience. The following is a comment from one participant:

"Changed my perception of my doctors and what they deal with. I would have enjoyed more time in the program, but at the end of each day I was worn out! So you probably are right with two days."

Diana McGee, Medicare Consultant

New Member Applicants

APPLICATION FOR MEMBERSHIP

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

ANTONIO BUNKER-SOLER, M.D. – ALLERGY AND IMMUNOLOGY/ PEDIATRICS
Medical School: University of Puerto Rico, San Juan, PR (1970-74)
Internship & Residency: Brooke Army Medical Center, San Antonio, TX (1974-75)
Residency: Brooke Army Medical Center, San Antonio, TX (1975-77)
Fellowship: Fitzsimmons, Army Medical Center, Denver, CO (1979-81)
Post-Graduate: Texas Children's Hospital, Houston, TX (1994-95)
Dr. Bunker is in practice with the Allergy & Asthma Care Centre, PA at 4017 Del Prado Blvd, Cape Coral, FL.

Practice Management Tips and Techniques

PHYSICIAN COMPENSATION ISSUES

From Econamedix, LLC

Recently our Practice Management Advisory Group has been getting more questions than ever before relating to physician compensation issues. As reimbursements levels continue to fall, physicians are taking a closer look at the remaining income and have a desire to make sure that their ultimate compensation accurately reflect their contribution to the practice.

As with any legal contract, the best solution is to create the simplest possible agreement that can gain the support of all members of the group. Sometimes this is impossible because physicians in the group may be in different stages of their careers, may have different lifestyles, etc. One thing is for sure, if there is a large disparity in the amount of production from different physicians in the practice, a more complex formula may be needed to be to ensure that all members are being treated fairly.

In years past, splitting profits equally between physicians was very common. But as computers systems have been upgraded to better track both production and expenses, many new ways to distribute profits have become available to better track individual contributions. Splitting profits equally works well when production is nearly equal. By that we mean that production as measured by charges should not vary more than 5% points between the top producer and the bottom producer. Once this is exceeded then the top producer begins to resent the subsidy of the other physician's salary. Of course, there are always exceptions such as if the top producer's income is largely the direct result of referrals from the bottom producer, if this was a quid pro quo exchange for a low buy-in to the group, or perhaps if the senior partner in the group spends much of his / her time in the governance of the practice. As such, many individual elements must be taken into consideration before finding the ideal formula for a specific practice.

Continued on page 4

We Get Letters

Dear Dr. Scott:

Thank you, thank you, thank you for speaking at the 50th Anniversary celebration of the Lee Memorial Hospital Auxiliary.

From this point on when someone recalls the Welcome Post, they will think of your daily cheeseburger and fries!

You were wonderful sir and the committee that planned the event is sincerely grateful for your participation.

Sincerely,
Karen Krieger
Lee Memorial Hospital

Let's Shut Down the FMA

Greg Arterburn, MD, FACR

Not infrequently I am asked by fellow physicians "Why do we need the FMA - or the AMA for that matter?" Dr. Mathis Becker at the recent Annual Meeting of the FMA had an intriguing response to this question. He suggests that we shut down the FMA for one year - and let everyone see what would happen.

Without the FMA and its powerful political influence in Tallahassee next year, here is what you could expect, based on bills that already are under consideration.

Advanced Registered Nurse Practitioners (ARNPS) would be allowed to prescribe controlled substances with no physician oversight. Optometrists would get hospital admitting privileges. Optometrists would gain laser surgery privileges. Psychologists (who can receive a Ph.D. by taking only ONE COURSE in the biological basis of behavior) could prescribe psychotropic drugs. FMA and the PCMS believe these things are wrong.

Pharmacists (who are trained to compound and dispense drugs and not to diagnose and treat patients) could modify drug therapies or administer immunizations without physician approval. FMA and the PCMS believe this is wrong and will oppose efforts to change current laws.

HMO's would continue to be largely unaccountable for failure to exercise ordinary care when making health care treatment decisions. The 1% tax on certain physician's office practices would continue. Insurance companies would increase their use of their "all products clause" in insurance and health maintenance organization practice contracts with physicians, requiring physicians to participate in all of the health plan's current or future health plan products if they want to do any business with the insurance company. FMA and the PCMS believe these things are wrong.

All adverse incidents occurring in physician's offices would become public record even though there may not be any probable cause to impose discipline against the physician. Medicaid reimbursement would continue at its present intolerable low rates. Optometrists would continue to manage post-operative eye care, a practice that has recently developed for economic reasons. The American Academy of Ophthalmology has stated that it is unethical and wrong for MDs to share post-operative care for economic reasons especially as an inducement for surgical referrals or the result of coercion by the referring practitioner. No other specialty allows co-management by a non- MD or DO. FMA and the PCMS fight for physicians on these issues.

The unreasonable PIP insurance deadline of 30 days for physicians to file a claim for persons injured in automobile accidents would continue. Under current law, a physician has 30 days to file a claim, which can be extended to 60 days if a notice is sent to the insurance company within 21 days of treatment. Even if the physician through no fault of his/her own (e.g. patient supplies incorrect insurance information) sends the bill past this timeframe, neither the insurance company nor the patient has to pay. FMA and the PCMS believe this is wrong. (This one interests me. Recently our hospital corporation installed a new computer system. It took over a month for the hospital to program the new computer in order to supply the hospital physicians with complete and accurate billing information. I suppose we can write off the PIP claims during that time - when it is your ox that is being gored, it gets your attention.)

Trial judges would continue to allow almost any "expert witnesses" testify against physicians in medical malpractice cases. Often these are "professional witnesses" trained to display a personality and demeanor that captures the interest of the jury. The current law has a big "loophole" that allows the trial judge to let any health care provider testify as an expert if the judge feels that the health care provider possesses sufficient training, experience, and knowledge (practicing or teaching) in the specialty of the defendant or in a related field of medicine. Liberal interpretation of this allows "experts" to testify on the basis of "knowledge" acquired only by reading texts or journals in a given specialty. FMA and the PCMS believe this is wrong.

Plaintiff's attorneys would continue to have the upper hand when speaking with treating physicians. While plaintiff attorneys are free to discuss the plaintiff's medical condition and treatment with every physician the plaintiff has ever seen, the defendant's attorney is prohibited from doing likewise. Rather, the defendant's attorney must resort to the formal discovery process (i.e. subpoena and deposition) each time they wish to speak with a treating physician, adding time and expense to the litigation process. FMA and the PCMS believe this is wrong.

Currently non-physicians cannot perform surgery, prescribe oral medications, or interpret medical tests such as blood tests and radiological exams. Without organized medicine guarding the door many non-physicians would almost certainly try to broaden their scope of practice. Insurance companies and trial lawyers always have their well-funded lobbyist in Tallahassee working their side. Without FMA opposing these groups, our life as physicians would be dramatically different. Yes, we could shut down the FMA for a year – and everyone would likely realize what a good job they have done – but we might not recover from the experiment. Ga

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Physician Compensation Issues
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The most common way to deal with this is to split some of the income based on productivity. In the extreme case all income is split based on productivity as measured by payments. Each physician's income is directly related to his or her own production. The actual net income though will also be influenced by how expenses are split. If they are split equally, it will reduce the lowest producer's income the most and if it is split in the same ratio as production, it will benefit the lowest producer the most since he or she will be producing the least.

So what is done most often? Well, there are thousands of compensation formulas and as we said earlier they are highly dependent on individual situations, but we can safely say that the groups with the highest overall productivity have a significant percentage of physician compensation based on production. That would mean that at least one-half of a physician's income is based on his or her own production. Expenses would often be split in the same ratio or split the fixed overhead (rent, utilities, receptionist, manager) equally and the variable expenses in the same ratio as production.

Do compensation agreements based solely on productivity breed competition between partners and splinter the practice? The simple answer is probably yes. Is that unhealthy? Only if the individual competition reduces the productivity of the group and affects patient care. This happens if someone decides it is better to see new consults than it is to assist in surgery for example. This could be solved by splitting the surgical fee for the primary and the assist on a 60/40 basis as an example. There is probably more danger in allowing a large difference in production and no difference in pay. This tends to drive out the top producers from the group and that is the worst possible outcome if other elements of the practice are sound.

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