There cannot be managed care without physicians

LEE COUNTY MEDICAL SOCIETY Bulletin

THE VOICE OF LEE COUNTY MEDICINE

VOLUME 27, NO. 03 | FORT MYERS, FLORIDA | Mary C. Blue, M.D., EDITOR | MAY 2003

GENERAL MEMBERSHIP MEETING
MAY 15, 2003
at
ROYAL PALM YACHT CLUB
2360 West First Street
Downtown Fort Myers
6:30 P.M. - Social Time
7:00 P.M. - Dinner Meeting

Speakers will be our very own

RAYMOND KORDONOWY, MD
"HOW I RID MYSELF OF MANAGED CARE"
&
RONALD CASTELLANOS, MD
"CENTERS FOR MEDICARE & MEDICAID SERVICES: CONCEPTS FOR REIMBURSEMENT"

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

Inserts

1. MAY GENERAL MEMBERSHIP MEETING
2. TENNIS TOURNAMENT SIGN UP
3. WHAT IS INFORMED CONSENT?

In This Issue...

8th Annual Legal/Medical Golf Tournament
May 10th
Call 936-1645

President's Message

YOU SAY YOU WANT A REVOLUTION...

Ralph Gregg, M.D.

As frustration within our medical community continues to mount, I'm asked the same question almost daily: "When are we going to strike?"

This is no simple question. As I have written in the past, organized medicine has seen several recent victories on the malpractice front. However, the roadblocks we now face in both the U.S. and Florida Senate are leading to a sense of desperation among Florida physicians. The current round of medical liability insurance rate increases is accelerating this desperation. Within our community, I have heard of rate increases ranging between 35 and 200%. Obviously, these increases threaten the very existence of our local physicians' practices.

Thus the question: "When are we going to strike?"

Unfortunately, before we can address this question, we must understand the law regarding work stoppages and physicians. This is necessary because the Federal government, through the Sherman Antitrust Act, takes a dim view of competitors (i.e. physicians) collaborating in work stoppages for economic gain. Penalties for violating the Sherman Act are punishable by fines up to $350,000.00 per individual and injured parties may collect treble damages. These penalties are meant to be a strong deterrent.

Case law states that physicians cannot jointly strike in support of lower malpractice premiums, as this represents an economic gain. However, because of the inherent conflict between the First Amendment and Antitrust Laws, the courts have created an exception to the Sherman Act. The exception allows for joint efforts from competitors to occur in order to influence government officials and the courts. These efforts must not have an economic advantage as the intended consequence of the strike.

Therefore, if physicians elect to strike as a political statement to pressure legislators to make malpractice insurance more accessible and available, not cheaper, the courts MAY view this kind of work stoppage as legal. A strike must also seek to minimize any harm to patients. If physicians are not available to provide emergency services to patients, the courts may view the anti-competitive harm as overriding any benefit to the strike and declare it illegal. This is an extreme simplification of the legal issues surrounding physician work stoppages as presented by the FMA.

In summary, it appears that physicians who jointly strike in order to obtain lower malpractice premiums are in danger of criminal and civil penalties, according to the FMA analysis.

Where does this leave us?

Holding the short end of the stick, as usual. If you or your group decides to initiate a work stoppage, you must be very careful in how you present it and be sure that patients are not placed at risk.

Any joint action with other physicians or groups of physicians may be illegal. Fortunately, there is one course of action that cannot be taken away. This is the individual's right to act in his or her own best economic interest. Reducing high-risk care and reducing care provided at a loss may be the only ethical and legal course when one's practice is in jeopardy. This, unfortunately, will result in reduced patient access to care. It is the inevitable response from physicians that legislators fear and the one that will force them to respond to this crisis.

STAYING ABREAST OF SARS

By Michael Barnaby, Public Information Officer, Lee County Health Department

The surest way to stay abreast of the rapidly evolving Severe Acute Respiratory Syndrome situation is by way of the Internet. The Florida Department of Health, Centers for Disease Control and Prevention, and World Health Organization (WHO) websites are constantly updated to reflect the most current news and conditions. As an example, available at the click of a button at CDC are:

- Case Definition
- Clinical Description
- Diagnosis/Evaluation
- Exposure Management
- Isolation & Infection Control
- Treatment
- Reporting
- References

Additionally, the WHO website provides:

- Worldwide updates on a near daily basis
- Cumulative number of cases reported
- Affected Areas
- Map of Cumulative Number of Reported Cases
- Epidemic curves
- Availability and use of laboratory testing
- Images of the new coronavirus
- A comprehensive list of worldwide resources, including links to the Departments of Health in Hong Kong, Singapore, and a host of cities and nations worldwide.

Links to the above can be found at the Florida Department of Health (DOH) Internet site, which offers:

- Guidance for Health Departments
- Advice for Travelers
- Interim Guidelines for Medical Transport of SARS Patients
- Specimen Collection - Labs
- Press Releases

CDC: http://www.cdc.gov/ncidod/sars/
WHO: http://www.who.int/csr/sars/en/
FDOH: http://www.doh.state.fl.us/

As I Recall...

Roger D. Scott, M.D.

L.C. Washburn, M.D.

Well, it seems I've had my time with the "crazies" and so; it's now about time to become more serious with these articles.

Lawrence Clementine Washburn, M.D. came to Fort Myers in 1884, as did Dr. William Hanson so I cannot distinguish which of these doctors represented the second and third doctors to appear on our Fort Myers scene. Thus far, I do know that Dr. Richard Anderson was here in 1880 so I consider him the first doctor of record.

Dr. Washburn (hereafter known as "LCW") was an extremely busy, well-established physician in Muncie, Indiana ready for retirement so he purchased a large farm and spent some time there. He was unable to fully attend to the farm work and continue with his very active practice so he turned management of the farm over to his son, William Roswell. LCW found some time to donate to the farm and did experimental work developing new methods of crossbreeding. His success came to the attention of the U.S. Government, and he accepted the appointment to take charge of the government testing station in Fort Myers in 1884. (Larry Garrett, M.D., retired Fort Myers anesthesiologist, has done much the same thing in retirement at his cattle ranch in Arcadia, FL but as yet has not been recognized by the federal government except to pay taxes.)

Dr. and Mrs. Washburn's entourage i.e. their son William, wife Laura, and baby Carrie Maude, traveled (probably by train) to New Orleans. They then found it necessary to come to Punta Rassa by boat and then on to Fort Myers on a Caloosahatchee steamer, as there were no trains or roads from New Orleans this way. The exact date of their arrival in 1884 is not recorded, but Fort Myers was described as a "frontier cow town of scant population and few buildings".

The good doctor wished to give up his medical practice and devote himself fulltime to agriculture, but there were "no other doctors here" so instead, he continued to practice medicine.

Unfortunately, very little information is obtainable regarding Dr. Washburn's activities in Fort Myers except to know that he was the first coroner in the first group of elected Lee County officials when the county was formed on May 17, 1887. He gave care to the citizens, Seminoles, and also served as a veterinarian at times! As was the case in those times, physicians had to "make" their own medicines, and one of his salves was especially effective against skin cancer. After LCW's death, (year unknown to me) attempts were made to locate the formula for this "wonderful" salve, but it departed with him.

Soon after their arrival in Ft. Myers, William bought a 160-acre citrus grove, and LCW spent much time working with William to develop a fine grade of citrus fruits that were shipped nationwide. The fruit was so wonderful that it won a "1st Prize" at the 1904 St. Louis World's Fair!

LCW along with Dr. John Hall (no information obtained on Dr. Hall) were on the first passenger train out of Fort Myers on May 10, 1904. Dr. & Mrs. Washburn donated half the funds to build a Baptist church.

William's family continued to grow and besides daughter Carrie Maude, along came Laura Edna (who had the first baby grand piano in Ft. Myers), Mary Olive (employed by Jacobs Jewelers in Jacksonville for 42 years & the first female watch maker in Florida and incidentally, repaired my family's watches!), Myrtle Lillian (the first professional vocalist on the first radio station in Jacksonville), & finally a boy, William Lawrence with one more to come, Sidney Muriel. William's grove was so successful that it was possible for him to open a sporting goods store that soon expanded to china, cut glass, jewelry, watch repair, and optometry! LCW and William bought an entire block on Lee Street for their two homes. It was reported by neighbors that these were very hospitable happy families.

Dr. & Mrs. Washburn predeceased William who died in 1930 and Laura lived until 1942.

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Nina Barry (died April 4, 2003) was a nice lady who had been very active in the Lee County Medical Society Auxiliary years ago. Her husband (Carey N., MD) is our oldest living physician (Urologist) having begun practice here in 1953 or 54.

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FMA: www.fmaonline.org
AMA: www.ama-assn.org
The Lee County Medical Society Bulletin is published monthly, with the June and August editions omitted.

MEMBERSHIP ACTIVITY

RESIGNED
Paul Lorenz, M.D. (Retired)

RELOCATED
Neurology Associates of Lee County
Harris L. Bonnette, M.D.
Edward F. Steinmetz, M.D.
8200 College Parkway
Fort Myers, FL 33919
(239) 939-2863 (O)

Steven Sager, D.O.
13685 Doctor's Way, Ste 350
Fort Myers, FL 33912
(239) 768-7071 (O)
(239) 768-7077 (F)

LCMS STATS
March 12, 2003 - April 15, 2003

	Current	YTD
PHONE CALLS RECEIVED	**594**	**2216**
From Physicians and Office Staff	147	487
For Referrals	192	827
For Background Checks	28	106
Filing Complaints	3	18
Regarding Non-Members	22	83
Regarding Alliance	13	38
Regarding CMS, FMA, and AMA	16	84
Miscellaneous Calls	173	573
APPLICATIONS SENT TO PHYSICIANS	**13**	**40**
MEETINGS	**7**	**29**
Attended on behalf of LCMS	3	7
Society Meetings	4	21
DIRECTORIES DISTRIBUTED	**144**	**199**

LEE COUNTY MEDICAL SOCIETY ALLIANCE NEWS

Ann Shah, PhD, Corresponding Secretary

The LCMSA&F Annual Meeting was held on March 20th at the Royal Palm Yacht Club near Downtown Fort Myers. Meeting highlights included the election of the 2003-2004 Executive Board. The following nominated slate of officers was unanimously approved by the general membership in attendance:

Vice President – Tami Traiger
Treasurer – Suzanne Kotula
Recording Secretary – Ann Shah
Corresponding Secretary – Leann Luerhman
Nominating Committee – Liz Kagan, Karma Marino, Cheri O'Mailia

The approved Executive Board members and next year's Co-Presidents Lynne Bacon and Linda Chazal will be installed on May 8th at Mama Pasta. Please join us in congratulating next year's leadership.

2003 Rally at the Capitol Tallahassee, Florida March 27, 2003

We would like to extend a sincere thanks to the following Lee County physicians for making the long trip to Tallahassee on behalf of the Lee County Community at the Days At The Capitol: Steve West, Gary Allen, Gerry Gamez, Eliot Hoffman, Brian Hummel, Steve Prendiville, Mike Rosenberg, Rick Torricelli and Tracy Vo. Thank you to Jonathan Daitch for providing transportation from Lee County to Charlotte County.

We would like to thank the Charlotte County Medical Society for sponsoring the bus trip and providing sustenance and signage for the Rally.

We would like to thank all the physicians and staff that supported the Rally by closing their office.

Lee County Medical Society Alliance President, Cheri O'Mailia is the photographer and our hero for banishing the lawyers' lobbyists from our midst.

ODDS AND ENDS

DEFINITION OF "PROFESSION"

An occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members profess a commitment to competence, to integrity and morality, to altruism, and to the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which grants the profession the right to autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society. (Derived from the Oxford English Dictionary and the literature on professionalism.)

2003 FMA ANNUAL MEETING – START PLANNING NOW

The 2003 FMA Annual Meeting will be held August 28 -31 over the Labor Day Weekend. This year's venue is at the Westin Diplomat Resort and Spa in Hollywood, Florida. Start planning now and bring the entire family. Our special room rate will be expanded through the holiday weekend. You and your family can enjoy sunny Hallandale Beach, golf with your colleagues or indulge in Spa activities. The FMAA will have Kids' Alliance activities for all children. To make hotel reservations, call the Westin Diplomat at 888-627-9057. Mention the FMA to receive our special group room rate of $120 (single/double).

Some of the events this year include the Florida Medical Expo, featuring 80 exhibit booths, a new seminar for Office Managers and a Family Fun Night. There will be an increased number of CME opportunities as well. Be sure to attend the opening House of Delegates on Friday afternoon when, Olympic triple gold medallist, Nancy Hogshead-Makar will be our special guest speaker.

NEW AMA ANALYSIS SHOWS 18 STATES NOW IN FULL-BLOWN MEDICAL LIABILITY CRISIS

The ill effects of a broken medical liability system have put six more states in crisis, according to a new AMA analysis released this week. Arkansas, Connecticut, Illinois, Kentucky, Missouri and North Carolina are the latest states where the current liability system is affecting patient care. "How many more patients will have to lose access to medical care before lawmakers decide to act and pass proven reforms, including a cap on non-economic damages?" asked AMA President Yank D. Coble Jr., M.D. "There is something terribly wrong when dedicated professionals, who have trained for years, want to give up the work of a lifetime and retire, move to another state or stop offering high risk procedures such as delivering babies."

"Our system has evolved into a lawsuit lottery, where select patients and their lawyers get astronomical awards, and many patients suffer access-to-care problems because of it," Dr. Coble said. "California's law works, and we have the facts that prove it." Visit http://www.ama-assn.org/ama/pub/article/9255-7341.html for a more detailed description on the new crisis states.

CPT EDITORIAL PANEL NOMINATIONS NOW ACCEPTED

The AMA Board of Trustees will consider nominations to the Current Procedural Terminology (CPT) Editorial Panel at its June meeting. The CPT Editorial Panel is responsible for maintaining CPT, and is authorized to revise, update or modify CPT. The Panel is comprised of 16 members, 11 nominated by the AMA and one each from the Blue Cross and Blue Shield Association, the Health Insurance Association of America, the American Hospital Association and the co-chair of the Health Care Professionals Advisory Committee.

Committee members are physicians primarily nominated by the national medical specialty societies represented in the AMA House of Delegates. The Committee's primary objectives are:

- To serve as a resource to the CPT Editorial Panel, by giving advice on procedure coding and appropriate nomenclature as relevant to the member's specialty;
- To provide documentation to staff and the CPT Editorial Panel regarding the medical appropriateness of various medical and surgical procedures under consideration for inclusion in the CPT code;
- To assist in the review and further development of relevant coding issues and in the preparation of technical education material and articles pertaining to CPT coding; and
- To promote and educate its membership on the use and benefits of the CPT code.

TOWARD SOCIALIZED MEDICINE: FIGHTING THE LEVIATHON

Edward R. Annis, M.D.

The Misnomer of "Insurance"

There are laws against the mislabeling of products to hide their real ingredients or to claim the presence of a component that is lacking. But which is the worse disservice to Americans? The mislabeling of products manufactured for sale, or the misrepresentation of ideas or political actions? Millions have been led to believe that programs such as Social Security and Medicare are insurance simply because they are called "social insurance."

Even though the Medicare Part A card is labeled "Health Insurance," the United States Supreme Court held long ago that Medicare is not insurance, but rather a tax on one segment of the population to pay the bills for another segment. In other words it is a tax on workers to pay the medical bills of retirees. Similarly, Social Security is a tax on today's wages to pay a pension to those retired at age 65, or even at age 62. No insurance contract exists for either of these programs, and no Social Security or Medicare funds are banked for investment and growth.

In the early 1940s until the governments intrusion into medicine by Medicare in 1965, private medical insurance was expanding rapidly. In 1965, 7.7 million of the 16 million Americans then over the age of 65 were covered by private medical insurance. That insurance, like home owners insurance, car insurance, and life insurance, enabled policyholders to share the risks of catastrophic or unexpected needs.

Insurance was not only readily available but also reasonable in cost because it was utilized only by those faced with costly services in cases of serious illness or accident. In order to be insured, the risks had to be unpredictable. Before government interfered, costly medical and surgical needs were rarely experienced by more than 5 to 6 percent of the public in any one year.

Contrast the situation today, when insurance is expected to cover all minor aches and pains and to cover federal or state mandates for coverage that is neither needed nor desired.

Accelerating Cost Increases

Today, the half-life of medical knowledge is estimated to be less than five years. There is a steadily emerging stream of new and better diagnostic and therapeutic tools, along with an expanding pharmaceutical industry. The new medications may be more expensive, but they possibly obviate the need for still more expensive and invasive treatments, hospitalization, or surgery.

As costs increase, we hear or read almost daily that some 39 to 40 million people are without insurance for medical care. While no clamor exists for investigating, which costs are excessive, or which costs are unnecessary, there are insistent demands for government to assure universal coverage of these excessive costs.

Often described as one-seventh of the nation's economy, medical services constitute the only segment denied the freedom of the marketplace, as a result of government regulations, mandates, and price controls. Rules and regulations for Medicare alone have now reached 130,000 pages, and a recent government report stated that for Medicare alone, more than 2 billion dollars every month is lost because of mismanagement, waste, and fraud.

While President Clinton in his inaugural address stated that "the era of big government is over," since that date more than 400,000 pages have been added to the Federal Register.

Why should never-elected bureaucrats, protected by tenure and assured of lifetime economic protection because of taxpayer-paid pensions, be empowered to write rules and regulations, print them in the Federal Register, and then implement them with the force of law? Congressional failure of oversight has allowed these unaccountable bureaucrats to impose ever-increasing, unintelligible paperwork on citizens with its attendant costs.

One of our Founding Fathers, James Madison, wrote: "It will be of little avail to the people that laws are made by men of their choice, if the laws be so voluminous that they cannot be read and so incoherent that they cannot be understood.... that no man who knows what the law is today can guess what it will be tomorrow!"

Contributing to the cost increases are the overhead of agencies like Blue Cross/Blue Shield that are assigned by the government to handle economic transactions. Managed care, a euphemism for the entrepreneurial interference between patients and physicians for profit-making ventures, takes another chunk out of the medical dollar, including lavish compensation of chief executive officers. In August 2002, it was reported that Anthem paid its CEO $13,000,000 in 2001.

Government regulation and managed-care overhead, both extraneous to medical care, are major contributors to costs, yet they make no direct contribution to the actual care of the sick and the injured.

The Growth of Litigation

A third contributor to cost is the predatory section of the trial bar. Plaintiffs lawyers even advertise on television to incite litigation for stress, worry, and concern over what might happen, disregarding the absence of any known impairment.

The last 20 years have seen a steady growth of class-action suits, making multi-millionaires and sometimes billionaires of lawyers, especially those milking the cash cows of asbestos and tobacco. Newly attained wealth has been used to gain political power at both state and federal levels. For example, in the year 2000, the Democratic Party committees received $11.6 million in contributions from wealthy trial lawyers and their lobbyists, even exceeding the $11.3 million that the Democrats received directly from labor unions.

Physicians, no matter how talented or experienced, are limited by price controls that deny even the very wealthy the ability to reward their doctors more generously than the government allows. Meanwhile, young attorneys start at $100 to $150 per hour. Some older attorneys receive $500 to $800 per hour, and some attorneys have even received in excess of $30,000 per hour.

California Medicine reported in August, 2002, that in recent years 25 percent of California physicians had been sued, with only 10 percent of the cases getting to court with a legitimate cause. The other 90 percent includes those that settled rather than incurring the expense of defending a non-meritorious suit.

What Can Physicians Do?

Our best weapon is truth. We must make our case to our patients. Unless our freedom and economic rights are restored, we will continue to be overwhelmed by more government intrusion. Patients need to hear that the most direct, the most economical, and the best medical care is a result of direct contract between patients and their physicians, with no middleman.

Americans need to be reminded that the Constitution grants only limited and defined powers to the federal government. The government does not have a legitimate authority to deny physicians the right to receive a market price for their services: a right enjoyed by mechanics, plumbers, carpenters, architects, engineers, athletes, film stars, government employees, and lawyers.

Shortly after his inauguration, President Ronald Reagan, speaking before a crowd of 5,000 at the Jefferson Memorial, presented his Economic Bill of Rights, based on fundamental constitutional principles: 1. Freedom to work; 2.Freedom to enjoy the fruits of that work; 3. Freedom to own and control property (that includes intellectual property); 4. Freedom to participate in a free market.

Physicians today are denied every one of these freedoms. It is time to say "Enough!" Only strong, sustained political activism will regain these rights. To win the battle, we must fight it, and as Winston Churchill told the graduating class of his old prep school, "Never, never, never give up!"

Edward R. Annis, M.D. is a Past President of the American Medical Association. This article is derived from remarks made to an annual meeting of the Florida Medical Association, Part I of this article appeared in the Winter 2002, issue of *The Medical Sentinel.*

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.

CRAIG A. MACARTHUR, MD – PEDIATRIC HEMATOLOGY/ONCOLOGY

Medical School: Washington University, St. Louis, MO (1981-87)
Internship: Children's Hospital, Los Angeles, CA (1987-88)
Residency: Children's Hospital, Los Angeles, CA (1988-89)
Fellowship: Children's Hospital, Los Angeles, CA (1989-92)
Children's Hospital, Los Angeles, CA (1992-93)
Board Certification: American Board of Pediatrics in Pediatrics and Hematology-Oncology
Dr. MacArthur is in group practice with Pediatric Hematology/Oncology Center at 9981 S. HealthPark Drive #156, Fort Myers.

JOHN RODRIGUEZ, MD – RADIOLOGY

Medical School: University of Miami, Miami, FL (1992-96)
Internship: University of Florida, Gainesville, FL (1996-97)
Residency: University of Miami, Miami, FL (1997-2001)
Fellowship: University of Miami, Miami, FL (2001-2002)
Board Certification: American Board of Radiology
Dr. Rodriguez is in group practice at Florida Radiology Consultants, 2726 Swamp Cabbage Court, Fort Myers, FL 33901.

Part IV

THE AMERICAN MEDICAL ASSOCIATIONS' CLARIFICATION OF GIFTS TO PHYSICIANS FROM INDUSTRY

GUIDELINE 6

Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional or specialty medical associations.

(a) When a company subsidizes the travel expenses of residents to an appropriately selected conference, may the residents receive the subsidy directly from the company?

Funds for scholarships or other special funds should be given to the academic departments or the accredited sponsor of the conference. The disbursement of funds can then be made by the departments or the conference sponsor.

(b) What is meant by "carefully selected educational conferences?"

The intent of Guideline 6 is to ensure that financial hardship does not prevent students, residents and fellows from attending major educational conferences. For example, we did not want to deny cardiology fellows the opportunity to attend the annual scientific meeting of the American College of Cardiology or orthopedic surgery residents the opportunity to attend the annual scientific meeting of the American Academy of Orthopedic Surgeons. However, it was not the intent of the guideline to permit reimbursement of travel expenses in other circumstances, such as when conferences or symposia are designed specifically for students, residents or fellows.

Accordingly, "carefully selected educational conferences" should be interpreted as follows: funds may be used for the reasonable travel and lodging expenses of students, residents and fellows to attend the major educational, scientific or policymaking meetings of national, regional or specialty medical associations.

The Council recognizes that there may be some exceptional conferences for all physicians or even for just students, residents, or fellows that do not fall within this definition of carefully selected educational conferences but that meet the spirit of Guideline 6. Accordingly, the Council will consider proposals for travel and lodging subsidies for such conferences on a case-by-case basis and grant approval to those that meet the spirit of the guidelines.

GUIDELINE 7

No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

(a) May companies send their top prescribers, purchasers, or referrers on cruises?

No. There can be no link between prescribing or referring patterns and gifts. In addition, travel expenses, including cruises, are not permissible.

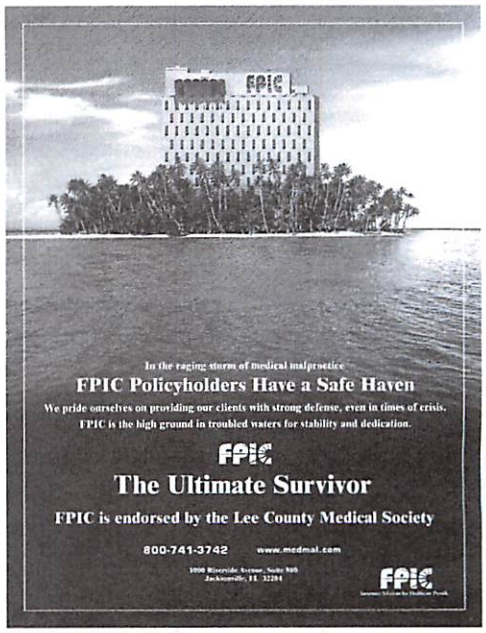
(b) May the funding company itself develop the complete educational program that is sponsored by an accredited continuing medical education sponsor?

No. The funding company may finance the development of the program through its grant to the sponsor, but the accredited sponsor must have responsibility and control over the content and faculty of conferences, meetings, or lectures. Neither the funding company nor an independent consulting firm should develop the complete educational program for approval by the accredited sponsor.

(c) How much input may a funding company have in the development of a conference, meeting, or lectures?

The guidelines of the Accreditation Council on Continuing Medical Education on commercial support of continuing medical education address this question.

This article was continued from the April 2003 issue of the Bulletin. Gifts to Physicians from Industry is an ongoing series of articles that was taken for the AMA's Council on Ethical and Judicial Affair Clarification on Gifts to Physicians from Industry (E-8.061). Issued 1992. Updated December 2000 and June 2002.



BUSINESS OWNERS - LET'S RETHINK HEALTH INSURANCE!

Raymond Kordonowy, M.D.

It is time for the insurance industry to release its monopoly on the health care dollar and get out of the way of the delivery of affordable health care. As a physician and small business owner, I feel employers need to rethink how we provide health benefits and demand better options. I believe that this nation has been sold too much health insurance.

If an employer of a small business wishes to provide insurance to his/her employees there are really very few options. It has become politically correct for insurance companies to pay doctor and hospital bills. Full coverage is the most expensive form of insurance. It provides the insurance company the most profit and control.

PPO and HMO insurance is easily sold in the market place because it encourages access to health care. It addresses society's concern that certain people avoid health care due to cost issues. The biggest problem with this approach is it actually encourages over utilization. It makes us dependant upon the insurance company for access to health care. The more dependent upon the insurance industry we become, the more control the industry has on how much they can charge us for coverage. Insurance dependence allows the industry to control the flow of health care dollars into their profit schemes and away from the actual delivery of health care. This lack of competition results in lack of creativity for other insurance models.

I believe there is a much more common sense approach to providing affordable health care to more individuals. This is the Medical Savings Account (MSA) model. It places the responsibility of health care utilization squarely in the hands of the consumer. It improves individual responsibility for health care consumption while promoting the most competitive environment for the delivery of services.

The present MSA model allows self employed individuals to deduct $4,600- $5000 pretax annually for the use of health care expenses. If not used in a given year, this money can be rolled over and an additional $5,000 dollars can be sheltered each year for medical expenses. If, at the age of 65 years, the MSA money is not used for health care, it can be used as part of a retirement fund. If used for nonmedical expenses it is then taxed.

The MSA model is a start in the right direction. It needs to be loosened significantly in order to maximize its real potential. Under the current rules, the MSA model is only provided to self-employed businesspersons. Present MSA's have to be tied to a PPO model of health insurance. I suspect the insurance lobby arranged for this restricted and noncreative model. I argue persons and small businesses should be allowed portable Medical Savings Accounts that are not tied to specific insurance plans (or any insurance plan if so chosen). Being allowed to roll over any unused moneys annually, we could quickly decrease our dependency on health insurance. If the MSA model wasn't mandated to be tied to a PPO insurance plan, we could shop for competitively priced catastrophic insurance coverage. Catastrophic insurance would provide the peace of mind we all need in the event very high, unexpected health costs occur. Americans are currently experiencing 20-40% annual insurance rate hikes. By assuming more initial out of pocket risk, each individual or family can go out to the market place and bid for less expensive insurance premiums. Let me illustrate this: Presently the average annual expense for an individual health insurance policy is roughly $5,760. The average annual family coverage is $9,600- $10,000. Typically the employer covers this annual cost with the employee pitching in for variable portions as well. Throughout the year there are now additional co-pays and out of pocket costs incurred by the employee. In the MSA model, employers and employees would fund an annual MSA of $2000- $5000 dollars. If not used, the MSA would be rolled over annually. In 2-3 years it would not be at all unreasonable for a large proportion of employees to be able to afford and request $10,000 deductible, catastrophic insurance policies. This would result in individual policies selling at $1000 annually instead of $5,000- $6,000 annually. In three to five years, the majority of employees would be accruing potential retirement money while enjoying unprecedented lower annual health insurance premiums.

Those unfortunate individuals with high medical expenses would still get their health care. Instead of paying all their hard earned money to the health insurance industry, employees would have money in their MSA to actually pay for medical expenses. Some individuals or families will end up using their saved account money due to high expenses. Their customized, catastrophic insurance can be called upon to cover expenses above the out of pocket limit.

In the aforementioned example there is more personal responsibility for expenses. When analyzed on a cost basis, we literally can't afford to ignore its liberating power. There would be far less administrative expenses/overhead because the insurance company would not need to be involved/contacted for most of the care purchased. The insurance company only need be notified if the insured individual actually had enough medical expense receipts to demonstrate his/her out of pocket limit for the year has been spent. In the vast majority of cases the insurance company would not have to be contacted.

I would ask that voters and business owners demand loosened MSA rules from our government. Insurance companies should be mandated (through legislation if necessary) to provide competitively priced, higher deductible, less intrusive insurance policies. Employers should be willing to take more responsibility for the actual expenses of health care. It is time for the insurance industry to loosen its chokehold on the throats of the average wage earner and small business owner.

FIRST QUARTER SCORECARD ON

AMA's Federal Advocacy Agenda For 2003

PROFESSIONAL LIABILITY REFORM

Objective: Secure 15 or more votes in U.S. Senate to pass federal MICRA style reforms.

Status: U.S. House of Representatives passed H.R. 5 (HEALTH Act) by vote of 229-196 on March 13. Winning margin increased by 12 votes (similar bill passed House in September 2002).

In the U.S. Senate, negotiations continue on a potential bipartisan bill to stabilize medical liability premiums.

MEDICARE PHYSICIAN PAYMENTS

Objective: Pass legislation to stop March 1 cut and implement long-term update fix.

Status: President Bush signed PL 108.7, 117 Stat 11, the Consolidated Appropriations Resolution, into law on February 20, 2003. This legislation increased Medicare physician spending by $54 billion and enabled HHS to fix past projection errors identified by the AMA. This legislation resulted in a 1.6% increase effective for services rendered on or after March 1, 2003 and blocked a projected 4.4% cut (6% swing). Legislation passed earlier this year was an important step, but problems remain with the Medicare physician payment formula. HHS projects a cut of 4.2% effective January 2004. The cuts are attributed to lower than expected growth in GDP and increases in the volume of physician services. The AMA is continuing to press Congress and the Administration to change the Medicare physician payment formula to provide annual updates that reflect increased costs in the delivery of patient care.

MEDICARE REFORM

Objective: Passage of targeted prescription drug benefit, other modernization proposals and regulatory relief initiatives.

Status: Congressional action on Medicare reform and prescription drug coverage is expected to kick into high gear this spring. The AMA is committed to working with Congress and the Administration to improve the Medicare program.

The House Ways & Means and Energy & Commerce Committees have marked up H.R. 810, the "Medicare Regulatory and Contracting Reform Act of 2003." This contains a number of regulatory relief initiatives advocated by the AMA, including due process protections for Medicare audits.

EXPANDING COVERAGE FOR THE UNINSURED/INSURANCE MARKET REFORMS

Objective: Work with other physician groups and RWJ Foundation to build public and political support for initiatives to expand health insurance coverage through tax credits, insurance market reforms and state demonstration projects.

Status: AMA President, Yank Coble, MD, represented the AMA in the national kick-off of RWJ-sponsored Covering the Uninsured Week in early March. The AMA is working with AAFP and other national specialty groups on a Sense of Congress resolution to provide coverage for all Americans by 2009. In addition, the AMA is working with the Bush Administration on regulations to implement a new tax credit option for workers displaced by trade agreements.

PATIENT SAFETY

Objective: Enact legislation to promote voluntary reporting systems for improving patient care with strong confidentiality protections.

Status: The U.S. House of Representatives passed H.R. 663, the Patient Safety & Quality Improvement Act, by a vote of 418-6 on March 12. This legislation would establish a voluntary reporting system with strong confidentiality protections.

Senators Jeffords, Breaux, Gregg and Dr. Frist have introduced S. 720, "Patient Safety and Quality Improvement Act" (similar to H.R. 663).

ANTITRUST

Objective: Pass legislation to enable physicians to negotiate with large health insurance companies and press Department of Justice and Federal Trade Commission to adopt changes in enforcement policies.

Status: Rep. Spencer Bachus (R-AL) and Rep. John Conyers (D-MI) introduced H.R. 1120, a bill that would establish demonstration projects for physicians to negotiate with large health insurers. H.R. 1120 is similar to legislation introduced in the 107th Congress by former Rep. Barr and Rep. Conyers.

Rep. Ron Paul (R-TX) has also introduced H.R. 1247, legislation modeled after the original Campbell/Conyers antitrust bill that passed the House of Representatives in the 106th Congress.

FUNDING FOR BIOMEDICAL, HEALTH SERVICES RESEARCH AND GME

Objective: Advocate increased funding for NIH, AHRQ and graduate medical education.

Status: Decisions on congressional appropriations will occur after final approval of a budget resolution that establishes a spending framework for fiscal year 2004.

The AMA has registered opposition to draft proposals by the Medicare Payment Advisory Commission (MedPAC) to drastically reduce Medicare GME payments. MedPAC subsequently dropped this recommendation.

DISEASE PREVENTION / HEALTH PROMOTION

Objective: Improve public health through initiatives to promote health and prevent premature deaths.

Status: Over two years ago, the AMA called on FDA to remove ephedra products from the marketplace. The AMA is working closely with the FDA to prevent further deaths linked to ephedra products.

As a result of AMA advocacy, Medicare payments for flu, hepatitis and pneumonia immunization were increased 94% effective March 1, 2003. This action will help efforts to achieve vaccine goals in the HHS Healthy People 2020 initiative.

If you have not joined the AMA, please consider supporting their efforts on behalf of all physicians. Carry your fair share.

MARK YOUR CALENDARS NEXT LCMS MEETING MAY 15, 2003

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