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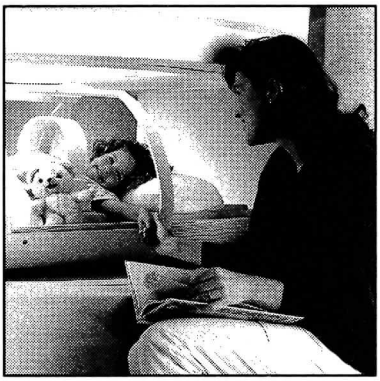

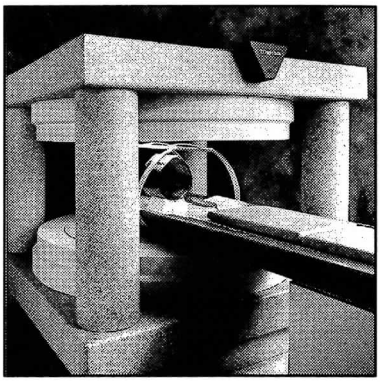

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TOUGH, SMART AND YOURS

medical economics
SEPTEMBER 6, 1993

DON'T YOU WISH THESE DEFENSE LAWYERS WERE YOURS?

This big, multistate firm rarely loses a case. But it's more than luck, or even legal skill, that's behind its enviable record.

By Howard Eisenberg

Successfully defending a brain-damaged baby case is the courtroom equivalent of pitching a no-hitter. Because the "sympathy factor" can add millions to a jury's award, many insurance carriers would rather settle than fight.

Not so the P•I•E Mutual Insurance Co. of Cleveland, Ohio, and the 4-year-old law firm—Jacobson, Maynard, Tuschman & Kalur—that does all its defense work. In 21 brain-damaged baby cases it has defended for the doctor-owned company, its record is a remarkable 19-1-1, the last a hung jury. In 1988, its overall scorecard read 35 wins, 5 losses—all malpractice cases.

There's more to those numbers than luck. "Or even legal skill," adds JMT&K founding partner Aaron Jacobson, who was one of Ohio's leading plaintiffs' lawyers before he, Larry E. Rogers, Herbert S. Bell, M.D., and 70 other Cleveland doctors formed P•I•E in 1975.

"It's the concept behind the firm that makes it work. Physician specialty panels review every lawsuit to decide whether the defendant deviated significantly from the standard of care. If he did, we pay. If he didn't, we defend. Makes no difference whether it's a $5,000 or a $5 million case. We label it 'No pay.' That policy has resulted in a lot of cases being dropped. Perhaps more important, it's discouraged the filing of many other cases. Plaintiffs' attorneys have learned that we're fair negotiators when our doctor's in the wrong, but won't back down when he's right."

That approach pays off. "According to the most recent report I've seen from the General Accounting Office," says Larry Rogers, P•I•E president and CEO, "in 1984, about 57 percent of medical-malpractice claims were closed without payment. Through 1988, we've closed an average of 78 percent of our cases without a dime changing hands. And it's my understanding that, without including defense costs, St. Paul Fire and Marine Insurance Co.'s 1988 average gross payout for cases closed in Ohio with payment was $52,500. Our comparable figure was about $10,000 below theirs. That's partly why we can sell an OBG specialist in Ohio—an industrial state that ranks among the most litigious—$1.2 million in coverage for just $26,400."

The unique marriage of P•I•E and JMT&K has been so successful that the carrier has expanded into five other states: Indiana, Kentucky, Maryland, Missouri, and West Virginia. Where P•I•E goes, there goes JMT&K, with nine branch offices to date. The firm has 65 trial attorneys, and may well be the nation's largest devoted well-nigh exclusively to medical-malpractice defense.

Could the insurer-defender symbiosis, if duplicated by other doctor companies, make a significant contribution to reducing malpractice litigation nationwide? An up-close look at how JMT&K operates may help to answer that question.

Every lawyer develops a medical specialty

"Our firm's lawyers read more medical books than law books," says P•I•E Vice President Gerard C. Oppenrorth, himself a veteran defense attorney. Robert Maynard explains: "New cases are discussed at our weekly staff meeting, so that every lawyer is familiar with every case. But we assign cases to our attorneys according to medical specialty. They're well-versed in their fields, so they don't have to reinvent the wheel with each case."

Last year, the firm's OBG specialist, attorney Jerome S. Kalur, who had won 16 consecutive brain-damaged baby cases, faced one of his toughest challenges when he defended a GP who'd attempted a midforceps delivery that ended in a Caesarean section and a severely brain-injured baby. Recalls Kalur: "I didn't think the doctor had caused the damage, but our position was weakened by the fact that he didn't have midforceps privileges. Based on that departure from the standard of care, our doctor panel voted to settle, and, since the hospital was also involved, a combined sum of $1.5 million was offered. Plaintiffs turned us down flat.

"I wanted to depose the doctors who'd been involved in the mother's care during her hospitalization, but the attorney for the plaintiff baby insisted it would violate the mother's physician-patient confidentiality. That privilege would terminate automatically when her medical records were introduced at the trial end of the plaintiff's case. Meanwhile, I was in the no-win position of having to tell the jury, 'It couldn't have been the midforceps,' without offering them another reasonable brain-damage theory."

Fortunately, the plaintiffs rested their case on a Friday afternoon, giving JMT&K time for a weekend rally. "Twenty minutes later," says Kalur, "I was in the hospital pathologist's office with an order permitting me to view the mother's placental slides." Meconium staining had been charted, and Kalur had a hunch that fetal distress had begun long before the for-

The winning firm's four founders at Cleveland's 8th District Court of Appeals (from left): Jerome S. Kalur, Aaron Jacobson, James M. Tuschman, and Robert Maynard.

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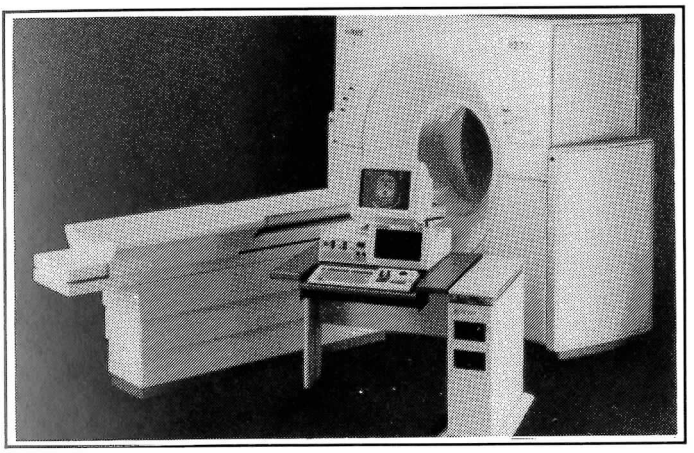

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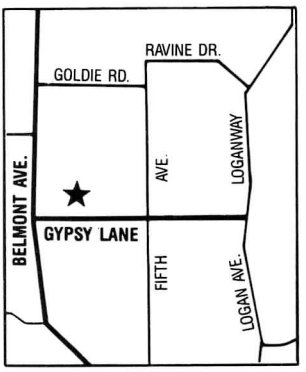

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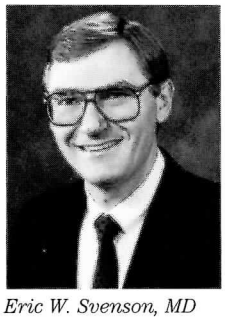
Socialized Medicine - Single Payer Style Versus Managed Competition

"...managed competition is also socialized medicine. So the choice is not between socialized medicine and a lesser evil; actually, the choice is only between a logical and an illogical method of administering socialized medicine."



Eric W. Svenson, MD

Like most of us, I have been trying to pay close attention to any news stories regarding Clinton's health-care reform plan, which was first scheduled to by finalized last month. Considering Clinton's budget bill difficulties, it now seems to be too controversial to emphasize health-care, and recent news articles suggest that the plan will probably not be announced until fall.

Depending on whether news articles are based on preferences expressed by Mrs. Clinton or by the President's economic advisors, there is a lot of conflicting information reported that makes it hard to predict if the federal plan will require comprehensive coverage or simply a basic benefits guarantee. Extensive mental-health coverage, elective abortion coverage, prescription drugs and long-term care are ideas that come from Mrs. Clinton's direction, while a leaner basic plan seems to be favored by the economic advisers. However, concepts such as a global budget, universal coverage, stress on preventative care, some lip service toward malpractice reform and funding through payroll and "sin" taxes seem to be constants.

Managed competition—rather than a single-payer (Canadian style) system—has also remained a constant of Clinton's preference. However, since Mrs. Clinton recently assured governors (probably more out of desperation for solutions than anything else) that states will be allowed much autonomy and flexibility in crafting their own plans to meet overall national guidelines, single-payer systems may still be an option for some states. Also, as Republicans may be able to add market-incentive solutions to the options, the final plan may involve a mixture of all three characteristics. Regrettably, it seems to be unrealistic to hold out much hope for the survival of private practice.

In Ohio, state health-care reform flexibility probably means some version of Representative Hagan's Health Security Act, the key features of which are printed in this issue. The standard benefits package, compared with what is available for most of us now, is very—probably unaffordably—comprehensive and even includes dental and eye care. There is a $25 co-payment due for "inappropriate" use items, which is a refreshingly practical approach to all the pipe dream rhetoric about the need for "consumer responsibility."

Although my most serious objection involves the managed-competition aspect, I have other objections to the plan that are probably either solvable, or that I can force myself to live with. One problem is that by over-relying on a primary doctor gatekeeping system, redundancies in the referral process may become overwhelmingly burdensome and bog down the entire system. I think, simple common sense would dictate that more specialists should be added to the list that patients can self-refer to; otherwise, it is going to require two office visits for what is now solved in one. There is some gatekeeping that may be economically necessary by a primary-care physician, but not to the extent required by this type of health plan. There are other, more efficient guidelines to prevent unnecessary services. I see another drawback with the choice of benefits beyond the standard package. With open enrollment, there is no reason why people would not choose a lean package while they are in good health and then switch to a better package when they have a health problem. I think the better package would soon be unaffordable for anyone—only the sickest people would be enrolled because they alone have the incentive to buy them. As a business owner who has always provided health insurance for employees, I also have a fairly bad attitude about now having to supplement other employers' business expenses. I also resent being thrown into one big risk pool with smokers. It is just outright hypocrisy for politicians to brag about equity in a health plan and about saving money by focusing on preventative care if they are not willing to tax cigarettes beyond the reach of everyone's pocketbook. Of course, there are other lifestyle-related health problems, but smoking is probably the biggest and the easiest one to solve. Even giving the tobacco industry their profit margin in taxpayer money would be cheaper than what we are paying now for the

health problems caused.

I think the most serious problem with Hagan's plan is that now, in contrast to his former "Canadian-style" single-payer plans, he is embracing the "managed-competition" concept. If the choice is between managed competition and single-payer, my choice is single-payer. I realize that the Canadian-style single-payer system is referred to most often as "socialized medicine," but the thing to remember is that managed competition is also socialized medicine. So the choice is not between socialized medicine and a lesser evil; actually, the choice is only between a logical and an illogical method of administering socialized medicine. Any market forces that benefit physicians are totally negated under either system. Both systems share every characteristic of socialized medicine: global budget (rationing), price controls (fee schedules), universal coverage, regulation and taxpayer funding. The drawbacks of the managed-competition brand of socialized medicine, however, are far worse than those of the single-payer brand.

To an impractical degree, the success of managed-competition hinges on a complex interaction of many yet to be organized parts. The Hagan plan divides the state into three regions with each region organizing a Health Care Alliance to contract with three to five "qualified plans." On the other end, businesses and individuals will be expected to organize themselves into government-sanctioned buying cooperatives to negotiate coverage with these qualified plans. As for doctors, when we have figured all this out and have contracted here and there with these various entities that are going to have more "take it or leave it" clout than even Blue Cross/Blue Shield, in the end, we are still going to end up with fee schedule price controls. There isn't a dime's worth of difference in what the major insurers allow right now for various procedures and there isn't going to be even two-cents difference under managed-competition. We aren't going to be paid any more under managed-competition than we would be paid under a single-payer system.

Promises to cut paperwork requirements for doctors can only be realized under the single-payer system. We should only have to file one type of claim with one payer system period. Under managed competition, we would still have socialized medicine PLUS the worst of competitive medicine - numerous health plans with just enough differences in processing treatment permission and payment to be illogically burdensome. If we must have socialized medicine, it is better to have one crazy bureaucracy to contend with than several different ones—with patients switching back and forth between them. Also, one

cont. on pg. 14

OHIO UNIVERSAL HEALTH SECURITY ACT PRINCIPLES

- Universal coverage - no health screening, no pre-existing conditions limits, no age or employment status exclusions - every Ohioan is covered
- Comprehensive benefits for all
- Affordable cost - for employers, individuals, state and local government budgets
- Effective costs controls - elimination of cost shifting, administrative simplification to reduce costs, global state budget, capitation of rates, end to clinical waste
- Equitable funding which creates a level playing field for employers and for individuals
- Single system - a single health care authority
- Freedom of choice - choice of between 3 to 5 plans per region, including at least 1 freedom-of-choice of provider plan in each region
- Health Security - health-care benefits separated form employment status
- Coordination with specialized systems of care for special need populations, e.g., medically fragile children, persons with severe mental illness, etc.
- Quality and appropriateness standards to insure appropriate treatments, to eliminate waste, reduce cost
- Uniform data system
- Consumer service, education, information for making best choices, health promotion
- Malpractice reform which preserves the right to sue but mandates mediation, establishes the use of practice protocol as an affirmative defense

Medical Democracy in Action

The annual convention of the Ohio State Medical Association was recently held in Cleveland on May 14-16. The setting occurs when the economic and political fortunes of medicine are at the crossroads. The President and Mrs. Clinton's health-care reform initiatives remain nebulous and closeted—away from medicine's and the public's eye. Interestingly, the powers that be seem to consist of theorists, politicos, and representatives from the insurance giants. It appears that the providers and consumers of medical care have been largely excluded from these negotiations. Subspecialists and surgeons find themselves under attack for supposedly having caused health-care costs to skyrocket. Primary-care physicians find themselves in a newly favorable light as the potential gatekeepers of a brave new system but have yet to hear much about what is to be done about the increasing burden of regulation and paper work that has fallen heavily upon primary-care physicians over the past several years. And finally, the public is finally waking up to the fact that health-care reform does not mean a new, bigger free lunch.

I attended the convention as a medico-political neophyte. Alternate delegates attend the annual convention as pinch-hitters. It is an opportunity to observe and understand how a large professional society can conduct affairs of business while maintaining an air of organization and efficiency. The House of Delegates is composed of delegations representing the various districts throughout the state. Our own district, the sixth, is composed of Mahoning, Trumbull, Columbiana, and Stark counties.

The district delegation organized itself in a series of caucuses held earlier this year. There we reviewed all the proposals that were to come before the House of Delegates at the annual meeting. I enjoyed the spirited debate that evolved on many of the issues and appreciated the skill necessary to guide the caucus meetings on the behalf of the chairperson. To each delegate's credit, there seemed to be great uniformity in adopting the delegation's view once the vote had been taken. I further noted at the convention that districts tended to be very homogenous in the way they approached a particular issue in order to increase their political effectiveness on the floor of the convention. There was considerable quid pro quo at the social events that went on between and after the House of Delegates Meetings.

For me, the most interesting part of the convention was the final meeting of the House of Delegates. It was at this meeting that all the proposals before the House were voted upon, and it was decided whether each proposal would be supported or discarded as policy for the OSMA. The debate from the floor on many issues was formidable - the give and take between districts and individuals was spirited and sometimes passionate. It was interesting how a convincing argument held by relatively few delegates on the floor could sway the opinions of the majority and, not infrequently, entirely change the status of a once popular or unpopular proposal. Another thing that interested me was how differently the House of Delegates seemed to feel about letting the State Council "take care of it." There seemed to be a palpable sense of urgency that important issues should not be taken off the floor of the House just because they were controversial or because considerable time might be required to debate the issue. True, sometimes the issues, once debated, were sent to the Council for further consideration. However, I was surprised how many of the issues that were slated for referral to Council ended up being decided on the floor of the House.

So concluded another annual meeting of the OSMA. The first meeting of the newly elected Council was to be held that very afternoon to organize itself and begin to grapple with tough issues that the House had not been able to resolve. As I looked back over the listed issues that the House had not been able to resolve and the listed issues that had been referred, I did not envy them their job, especially after the busy and sometimes hectic three day meeting that preceded it. I did come away with a sense that my interests as a physician were in the hands of good stewards. And I was proud that my professional society was organized in such a way as to be democratic and truly representative of its members. □

L. Kevin Nash, MD

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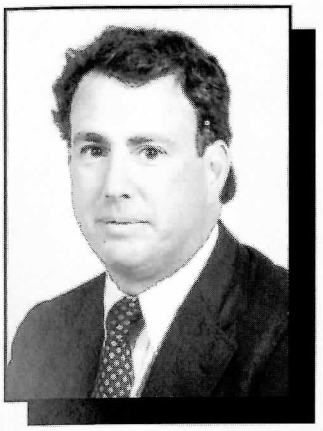

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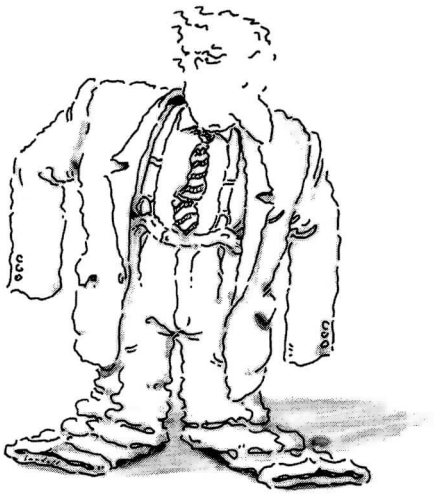

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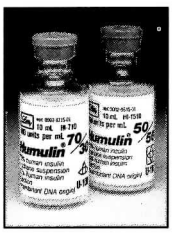

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"Healthy Outcomes" Project Combats Infant Mortality

A voluntary collaborative effort among hospitals and public health agencies is underway in Mahoning County to combat infant mortality and promote healthy outcomes of pregnancy. The centerpiece of the "Healthy Outcomes" project is a coordinated prenatal referral system that aims to promote early access to care.

Wide visibility will be given to the one phone number (747-2696) that pregnant women can call to be referred to a clinic or physician for an initial prenatal visit. The referral system will be aware of waiting periods at all prenatal clinics and will refer the woman to the facility with the shortest waiting list and/or the clinic that is most convenient to the woman.

Anonymity is offered to the callers, but for women who are willing to share their names and addresses, the Healthy Outcomes project will follow-up to determine if the woman keeps her scheduled appointment. The Avoid Infant Mortality program of the City of Youngstown Health Department will seek out participants who did not attend appointments. The Catholic Service League will provide similar follow-up for non-city residents.

Healthy Outcomes is the result of cooperation among St. Elizabeth Hospital Medical Center, Tod Children's Hospital, Youngstown Osteopathic Hospital, the Mahoning County Health Department, Youngstown City Health Department and the Mahoning County Medical Society.

Healthy Outcomes aims to reduce all the preventable causes of infant mortality: late prenatal care, smoking, teenage pregnancy, poor nutrition, drug and alcohol use. Healthy Outcomes' referral system aims to get pregnant women to doctors earlier in their pregnancy. The project also will provide education and assistance with the other identified risk factors through education and efforts by local chapters of the American Lung Association and March of Dimes, Woman-to-Woman (drug and alcohol counselling center), WIC (supplemental feeding program), and Planned Parenthood.

A project of the Mahoning County Children's Health Coalition, Healthy Outcomes welcomes the participation of private physicians as well. Doctors who would like to join the referral network should call Help Hotline at 744-5111 and ask to be included in the system. It is expected that the majority of the callers will be Healthy Start Medicaid recipients or uninsured. The Children's Health Coalition is participating in the Healthy Outcomes referral network.

Questions about Healthy Outcomes can be addressed to Matthew Stefanak, county health commissioner; Neil Altman, city health director; Kris Hoce, administrator, Tod Hospital; Sr. Jean Orsuto, St. Elizabeth Hospital; or Karen Franzone, Youngstown Osteopathic Hospital.

The Children's Health Coalition developed the Healthy Outcomes project because of concern about the persistently high infant mortality rate in Mahoning County. While the rate has dropped for black infants from 1987-1991 perhaps due in part to the Avoid Infant Mortality outreach programs, black infant mortality is still very high at 16.6 per 1,000 live births. Meanwhile, the overall infant mortality rate in the county has actually increased over the four years and stood at 11.9 per 1,000 live births in 1991, well above the statewide average.

While some of the endemic causes, such as poverty, poor maternal self-esteem, lack of health insurance, and inadequate health education, will take major developments to ameliorate, the Children's Health Coalition hopes the collaborative community effort of Healthy Outcomes will help

address the infant mortality crisis.

The coalition welcomes physician participation in this project and other coalition activities. Currently, task forces are working on infant immunization, lead poisoning, environmental tobacco smoke and medically fragile children. The coalition would like to develop a working relationship with private physicians and is beginning discussion with Dr. Charles DeMario in June about a project to encourage a pregnant woman's follow through with prenatal care. For more information about the Mahoning County Children's Health Coalition, call Elliot Legow, coordinator, at 744-3196, or come to one of the monthly meetings at First Presbyterian Church at Wood Street and Wick Avenue near downtown Youngstown. The coalition next meets July 16 at 9:30 a.m. □

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President's Page *(cont. from pg. 7)*
single bureaucracy is going to be cheaper to maintain in the long run for taxpayers.

Making a mockery of rhetoric about the "informed patient," an essential feature of managed competition requires restrictions on the patient's ability to choose doctors. Typically, Clinton describes limited choice like this: "Choice of doctors will be guaranteed, but within networks." (Joining those phrases is as contradictory as joining "managed" and "competition" to described socialized medicine.) Patients may be informed enough to realize one heart program is better that another, or one obstetrics program is better than another, but be prevented from taking advantage of the knowledge. At this point, it is probably impossible even to imagine what kind of special dispensation would enable a patient to go out of state or to a nationally known medical center. Hagan's plan requires at least one "freedom of choice" option per region, but the majority of patients will of necessity be in the cheaper, more restricted plans. For most doctors and patients, these network restrictions will be a nightmare. Community referral patterns based on the strengths of local hospitals and physician groups will be illogically carved up by these networks. Hospitals in any community have different strengths and weaknesses. One hospital may have a strong cancer or pediatric program, while another may have a strong obstetrics or heart program. In every city, major hospitals and their aligned physician groups will probably belong to opposing networks, either resulting in marginal care for some ailments or forcing a duplication of programs that would otherwise be unnecessary to serve the entire community. As some of us have already experienced, networks would also seriously interfere with the referral patterns of hospitals in smaller communities that are aligned with hospitals in nearby larger communities. For example, my group covers both Trumbull Memorial and Sharon Regional, bringing patients to Western Reserve Care System for high-end technical services which are more efficiently provided at the larger cancer center. A network including Trumbull Memorial or Sharon Regional could very well exclude Western Reserve Care System, forcing me to turn over patients to another doctor at another hospital for a portion of their treatment, inconveniencing the patient, and duplicating the consultation and planning required to continue his treatment. A lot of specialists covering smaller hospitals are aligned with opposing larger hospitals, and these artificial network divisions are going to cause illogical havoc.

As for paying for health reform, doctors are going to be soaked every which way for Sunday, either way the plan is administered. Thinking as a taxpayer, there is no reason to prefer one option over another.

There are all kinds of reasons why the cost of socialized medicine will probably bury us all—overuse, aging population, lifestyle factors, social problems and government subsidy of care based on factors other than financial need. But if we are forced into socialized medicine, we need to support the most logical system of organizing it, and the best interests of physicians and patients points to a single-payer system. The single-payer system allows freedom of choice for patients, freedom of referral patterns based on quality and effectiveness, and a fraction of the paperwork. There are no advantages for us under the managed-competition method of socialized medicine. Given global budgets with price-fixed fee schedules and the clout of Health Care Alliances, negotiating would be a waste of time with no room for gain. There would be limited patient choice, limited referral choice and more paperwork. This confusion of these entities creating, sorting out and organizing themselves would drive us all crazy. We would have to cooperate as providers and as employers or employees needing health plans. There are obvious reasons why insurance companies would back managed-competition, but no reason for physicians and patients to back it.

Logical gatekeeping economies and consumer responsibility safeguards could be built into a single-payer system of socialized medicine as effectively and easier than a managed competition system of socialized medicine. Like most of us, my first choice is private practice. But, as socialized medicine seems to be upon us, I hope Hagan returns to his first preference for a single-payer system of administration, and I hope some of you will be convinced to support it as the lesser of two evils forced upon us. □

Holly Ambrose
Terry Blessing
Marjorie Bosley
Vanessa Bowman
Stoney Bowser
Amy Brode
Nancy Brode
Hyland Burton Jr.
Cheryl Campolito
Cele Connelly
Tom Craven
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Kevin Murphy
Greg Musser
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Butch Paluga
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Michael Reardon
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Paul Rella
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"Health Matters Live Line" Airs Again

Twenty-one physicians from our Society were featured in the latest segment of "Health Matters Live Line." The live TV broadcast aired on Wednesday evening, April 21, on WYTV's channel 33. The program is a collaborative effort of our Society, the Easter Seal Society and WYTV. A panel of physicians answered 363 phone calls from viewers during the one-hour broadcast.

Dr. Denise Bobovnyik, chairperson of the Young Physicians Committee, opened the program with anchor Len Rome. Rome then introduced four physicians who discussed specific health concerns. Dr. Jay Osborne spoke on cholesterol. Dr. L. Kevin Nash discussed diabetes. Dr. Art Duran talked about hypertension, and Dr. Sandy Naples discussed back disorders.

The phone panel was staffed by the following volunteers: Drs. Thomas Albani, Dianne Bitonte Miladore, James Botsko, Nicholas Garritano, Chris Knight, Jennifer Lloyd, Anthony Mehle, Michael Miladore, Douglas Naylor, Robert Piroli, Santuccio Ricciardi, Lawrence Schmetterer, Melinda Smith, Thomas Traikoff, Luis Villaplana, and Lyn Yakubov.

The Society applauds our Young Physicians for continuing this popular program for a second year. The next broadcast is scheduled for Monday, October 18. Stay tuned. □

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The Auxiliary received the following awards
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COMMUNITY OUTREACH AWARD

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President-Elect ..... Mary Walton
Vice-President ..... Sue Berny
Treasurer ..... Jocelyn Buxman
Recording Secretary ..... Donna Broker
Corresponding/Communications ..... Linda Amsterdam
Past President/Advisor ..... Rose Mary Memo

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President-Elect ..... Donna Hayat
Vice-President ..... Mary Walton
Treasurer ..... Linda Evan
Secretary ..... Paulette Panozzo
Corresponding Secretary ..... Debbie Wilson
Past President ..... Pauline Sarantopoulos

MCMS Auxiliary News

On Sunday, May 2, the Mahoning County Medical Society Auxiliary presented "Sumptuous Settings '93" at Mr. Anthony's in Boardman.

For a second year, local merchants, artisans, and Auxiliary members created exquisitely decorated table displays. Participants used floral arrangements, crystal glassware, fine china and linens to express numerous themes. The program featured cooking demonstrations and a performance by the Westbrook String Quartet. Proceeds from the event will be used to support the Mahoning Valley Food Bank, the Potential Development Center, and the Functional Skills Training Center for multi-handicapped children. Donna Hayat chaired the successful fund-raiser.

At the state annual convention in May, Auxiliary delegates voted to support a name change for the state organization from Ohio State Medical Association Auxiliary to Ohio State Medical Association Alliance. Each local auxiliary must vote on the proposed name change. □

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The following applications for membership were approved by Council:

First Year in Practice:
Arthur W. Duran, DO
Sandy P. Naples, DO
Amy Hutchinson Proia, MD

Information pertinent to the applicants should be sent to the MCMS by July 15, 1993.

Society Dinner Meeting

The May 18 Society dinner meeting was held at the Youngstown Club. There were 116 members and guests in attendance. Dr. A. Robert Davies, vice president and chief medical director of Nationwide Insurance Company, presented a program titled "Health Care Reform Under the Clinton Administration." Dr. Davies was accompanied by Robert Clinger, director of Medical Society and Member Relations, OSMA.

The business meeting was conducted by President-Elect, Dr. Chester Amedia. He announced that the MCMS By-laws were approved by the OSMA and that copies of the by-laws would be sent to the members. The next Society meeting is scheduled for Tuesday, September 21, at the Youngstown Club. □

At A Glance...

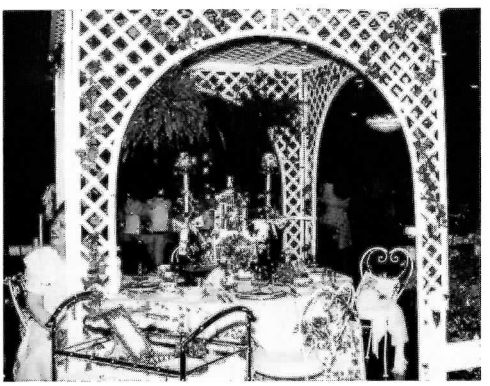
1993 - 1994 Auxiliary Officers left to right: Donna Hayat, president; Mary Walton, president-elect; Donna Brocker, secretary; Linda Amsterdam, corresponding secretary; Susan Berny, vice president; Dolly Handel, installing officer

Left to right: Robert Clinger, OSMA and Dr. A. Robert Davies, society speaker

Left to right: Gregg Clark and Laura D'Alesandro, Upjohn representatives

"Sumptuous Settings" committee left to right: seated - Donna Hayat, Pauline Sarantopoulis; standing - Norma Garritano, Rosemary Memo, Chef Bruce Calder

"Wedding Feast" - left to right: Padmaja Ginde, Mohini Khanna



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Sarita S. Nath MD
Anesthesiology
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Phone: 759-4440
MED. ED: Bhopal Medical College Bhopal, India
INTER: Western Reserve Care System, Youngstown, OH
REDCY: Western Reserve Care System, Youngstown, OH

Howard G. Slemons DO
Family Practice
Office: 250 W. Liberty Street
Phone: 534-1978
MED. ED: Ohio U. Col of Osteop. Med., Athens, OH
INTERN: Warren General Hospital, Warren, OH
REDCY: Western Reserve Care System, Youngstown, OH

Adopt-A-Resident

The Society wishes to thank all those members who participated in the Society's "Adopt-A-Resident" program. Many doctors have paid the annual dues for new resident members since the program began. Letters will soon be sent to the membership requesting their participation in a second round of sponsorships for new residents. The Society thanks the following doctors for their generous contributions:

T. Albani
C. Amedia
R. Bacani
R. Bailey
H. Bennett
A. Biscardi
J. Butterworth
Y.T. Chiu
D. Chung
F. Couch
M.S. Dasu
L. Deppisch
D. Dunch
S. El-Hayek
A. Franco
N. Gantt
A. Garg
N. Garritano
R. Gilliland
B. Gordon
N. Hazelbaker
K. Kaplan
H. Khanna
K. Knight
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M. Miladore
C. Molloy
K. Nash
R. Piroli
A. Rabinowitz
R. Roth
B. Rothschild
C. Schaub
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M. Smith
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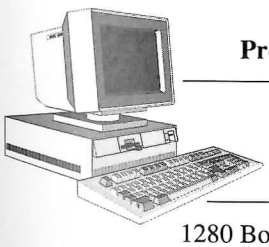

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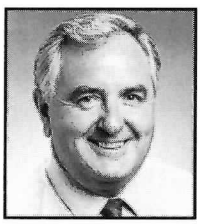

Dr. Maruschak is a retired dentist from Poland, Ohio.

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President

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The Bridal Veil

1990 - Original Oil on Board

Tazim Jaffer

To capture this month's featured artist in words is not an easy task. Presently residing in Youngstown, but born in Tanzania, East Africa, of East Indian parents, Tazim Jaffer has grown and evolved into an "Ambassador of Nations" artist. The youngest of seven children, Tazim grew up in a small crowded home where her only privacy was a mosquito net covered bed. Here Tazim retreated and lived in her own imaginary world of dreams and fantasies. Upon leaving the private world to study abroad, Tazim became like a flower bud opening for the first time to see the sun...a whole universe outside her home in Tanzania. Tazim has since traveled all over the world where she welcomes and embraces all things with an almost childlike innocence; however, she is a sophisticated, very intelligent woman who is aware of the political and religious infusions of most cultures, and yet she embraces them with so much eager curiosity, acceptance, and joy.

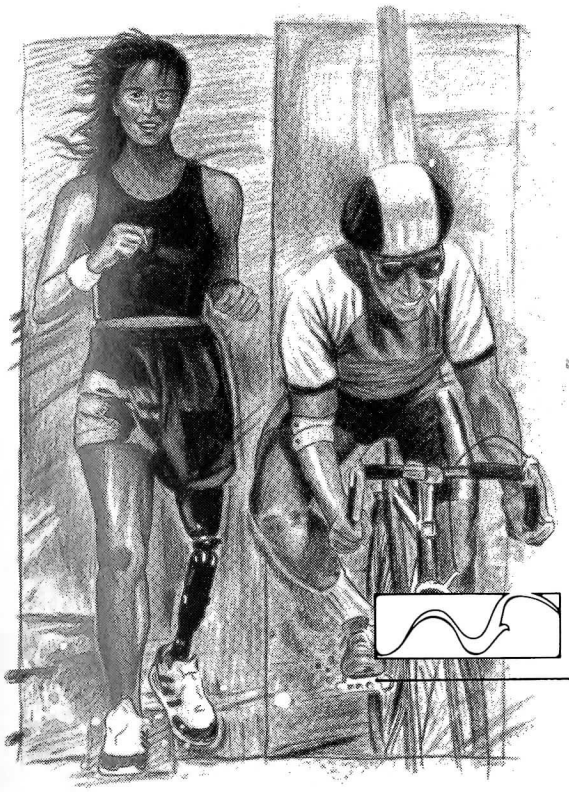
Tazim has a Business Administration degree from London, England, and a Bachelor of Fine Arts degree from YSU but is a self-taught artist. Her world of art includes paintings, installations, sculptures, photography, 3-D art, weaving and jewelry design. To view her photography is like opening up a *National Geographic Magazine*. The quality is superior. Most of her paintings reflect the brilliance of color found in her photography. Her paintings burst with emotion, rhythm, colors, and one almost has a feeling of extreme, urgent energy exploding from the canvas. Yet amid the complexity of all this, sensitivity and love of artistic expression help control her brush. Tazim brings the viewer with her to lands and peoples of different nations, eliciting an awareness and acceptance of all our differences yet all our oneness as human beings. Admittedly, a background in these cultures gives much more meaning to her work, which I suppose is an artistic statement in itself to point to the embarrassingly lack of going beyond the immediate "mosquito net covered bed" most of us reside in.

Tazim's *The Bridal Veil* was produced during field work in India for her Bangalore exhibition. She used a landscape as background because she traveled large parts of the Indian countryside looking for Indian brides. Her title integrates the bridal veil concept of nature's waterfall and human customs. Superimposed are the hands of brides. Ritually, Indian brides paint their hands and feet with intricate floral and geometrical patterns with henna. While Asian Americans are adhering to this tradition, Indians in India are using machine made stencils to apply quick fixes on their hands and feet. Here, Tazim has presented a diverse picture of Indian culture and the richness in colors and patterns associated with India. With this background knowledge, I can appreciate *The Bridal Veil* all the more, but I wonder if Tazim has not infused more into this work than the obvious. Hands are the most commonly used parts of the body used to communicate beyond language barriers. The posture of these hands are one of greeting...and one of reaching. These hands are moving separately but together towards a higher plane than that which binds men together on earth. There appears to be a spiritual message of reaching out to one another and together toward a singular oneness. This indeed is a very beautiful painting. This painting is Tazim Jaffer. As she has said of herself, "Sometimes I become so engrossed in painting that this experience becomes almost mystical, and I realize that I am expressing something from within myself in the language of art."

Tazim Jaffer has exhibited worldwide in many selected solo and group exhibitions. She has received numerous awards in juried exhibitions, with representation in several very prestigious institutions such as the National Archives of Women Artists in Wash., D.C., National Museum of Women in Arts in Wash., D.C., and National Archives of Visual Artists, North Carolina Central University, Durham, N.C. Tazim was recently awarded a research grant from the Ismalil Institute in London, England, to visually and texturally record life cycle rituals in India.

Tazim is the wife of Dr. Nazim Jaffer, a member of MCMS. □

Jeannine M. Lambert



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Health-Care Reform

The seeds of health-care reform have been planted, and the roots are beginning to take hold. What will emerge from all the nurturing by the Clinton task force and lobbying by the various interested parties remains to be seen.

The Clinton administration stated that the task force recommendations won't be announced until September of this year. Some states have taken this "window of opportunity" to investigate the feasibility of developing their own health-care reform recommendations to him by 1/1/94.

States, such as Oregon, Vermont, Minnesota, and Hawaii, have led the way in reforming health-care. Hawaii has had employer mandated provisions since 1974 and has retained its Medicaid program. By enactment of its state health insurance plan (SHIP), it has increased the level of insurance coverage to 98 percent of its citizens. In Ohio, the State Medical Society has empowered a task force of its own to deal with health-care reform. The task force headed by current President Walter Reiling, M.D., of Dayton, has already held four meetings. This task force is composed of 23 physicians with a mix of primary-care doctors and specialists. This group draws from all sectors of the state. The group has been using the "Blendon Construct" as the source of its deliberations.

The construct author, Robert Blendon, Scd of Harvard School of Public Health, identifies the seven critical issues that account for the main features of any national health plan. 1) Should everyone be guaranteed by federal law a health insurance plan? 2) How should universal coverage be provided? 3) How will guaranteed access to insurance be paid for? 4) Should Medicaid be retained? 5) What should constitute the standard benefits package? 6) How should health-care costs be controlled? 7) Who should administer the national health plan?

Thus far, the group has agreed that all Ohioans should have a health-care plan and that the basic coverage would be provided by expanding the existing employer based system. The task force reached a consensus that the current method of employer based financing should gradually be converted to an individual based system of financing.

The group thus far has worked together in a collegial fashion despite differences in opinions. There has been a good exchange of ideas. As the group works through the Blendon Construct and the issues of cost controls are discussed, a more lively atmosphere is certain to follow.

Just where and how the physicians will fit into this new era of health-care reform remains to be defined. Antitrust relief measures will be needed to allow physicians and in particular organized medicine to play on a "level field" in dealing with health-reform issues. The OSMA and AMA will need to deal with this in a timely fashion.

In serving on the OSMA's Ohio health-care reform task force, I have come away with several observations. Dr. Reiling is the right person at the right time for heading the task force. He is insightful and good at forming a consensus. He has allowed all members the opportunity to express their views and debate them. I have been impressed by the quality of the individual members of the task force. These doctors are well informed about the issues at hand. The OSMA Legislative Department has been extremely helpful and competent in preparing the task force members to do their jobs.

Finally, I believe that the members of the task force find this endeavor challenging, constructive, and eventually workable. It is my belief that the physicians of Ohio will be well served by the efforts of the OSMA health care reform task force group. Stay tuned. □

Daniel Handel, MD.
Chairperson, MCMS Committee on Legislation

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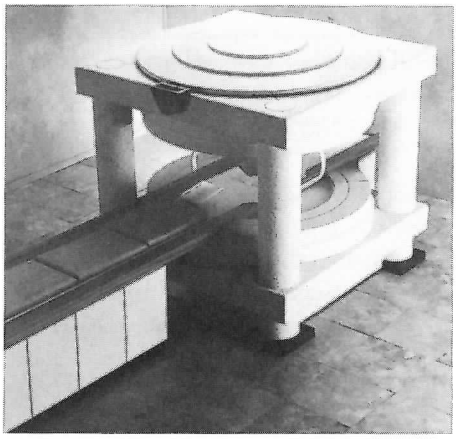

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60 Years Ago — May/June 1933

There were lots of meetings in those days, and they were well attended. On April 4, there was a special meeting on cancer with seven scientific papers presented by members. Seventy-five members attended. April 20 was the Sixth Annual Post-Graduate day which lasted all day and included dinner and an evening program. Three hundred and forty-nine physicians attended. New members were **Chester S. Lowendorf**. Smallpox and typhoid were still a problem.

50 Years Ago — May/June 1943

Letters continued to pour into the *Bulletin* from doctors all over the world who were trying to adjust to military life, while at home, the few remaining doctors were trying to keep up with the increased load, and their families were contending with food stamps, gasoline rationing, and shortages of everything. New members were **Genevive Delfs** and **Edwin R. Brody**.

40 Years Ago — May/June 1953

The only thing available for the prevention of poliomyelitis at that time was gamma globulin. It appeared to lower the incidence of infection in children who had been exposed to active cases. A committee was created to study and make recommendations on the use of gamma globulin. **Arthur Rappoport** was chairman with **Ivan Smith** as co-chairman. Committee members were **Lou Shensa, Art Shorten** and **Chuck Sterzbach**. New members that month were **Paul E. Ruth, James L. Finley** and **George L. Altman**.

Robert R. Fisher, MD

30 Years Ago — May/June 1963

Dr. Stewart Patton died at the age of ninety. His old office in North Jackson was later moved to the Canfield fairgrounds where it serves as a typical turn of the century doctor's office in the Pioneer Village. The Health Department reported 68 cases of chicken pox, 84 cases of measles and 90 cases of mumps. No polio, no typhoid, no smallpox were reported, but gonorrhea and syphilis were on the rise. **John Buckley** became a new member. **John Rogers** was president-elect of the Ohio Heart Association.

20 Years Ago — May/June 1973

President **Ed Pichette** decided it was too early to ask the members to vote on the acceptance or rejection of the PSRO concept. It appeared to be the beginning of a National Health Plan. At the May OSMA meeting, **Jack Schreiber** was re-elected to a two-year term as Alternate Delegate to the AMA. **Dr. Schreiber** also served as delegate from Mahoning County to the OSMA along with **John Melnick, F.A. Pesa** and **Ed Pichette**. Alternates were **Drs. Abdu, Anderson, Moskalik** and **Sovik**. New members were **P.K. Solemani, S.S. Husain** and **A. Hafiz**.

10 Years Ago — May/June 1983

There was no May issue of the *Bulletin* as the time demands of the OSMA meeting left little time for the executive - secretary, **Robert Blake**, to get it put together. Precious little was reported in the June issue for that matter. There were several new members to report; they were **Chester Amedia, Ernesto Antuaco, Joseph Colella, Jerome Hightower, William B. Rich** and **Adon Weinberg**. That was for May. Then, in June came another group; **James F. Ervin, Catherine Molloy** and **Jeffrey D. Resch**. □

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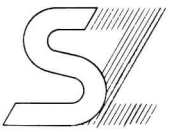

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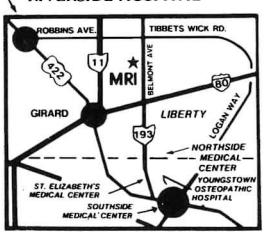

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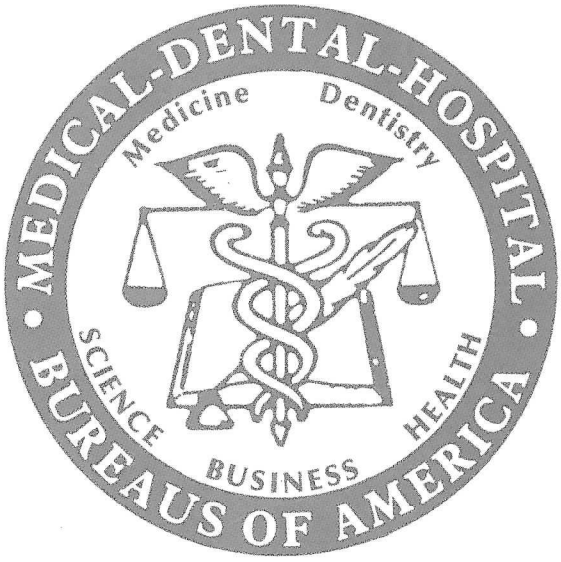

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