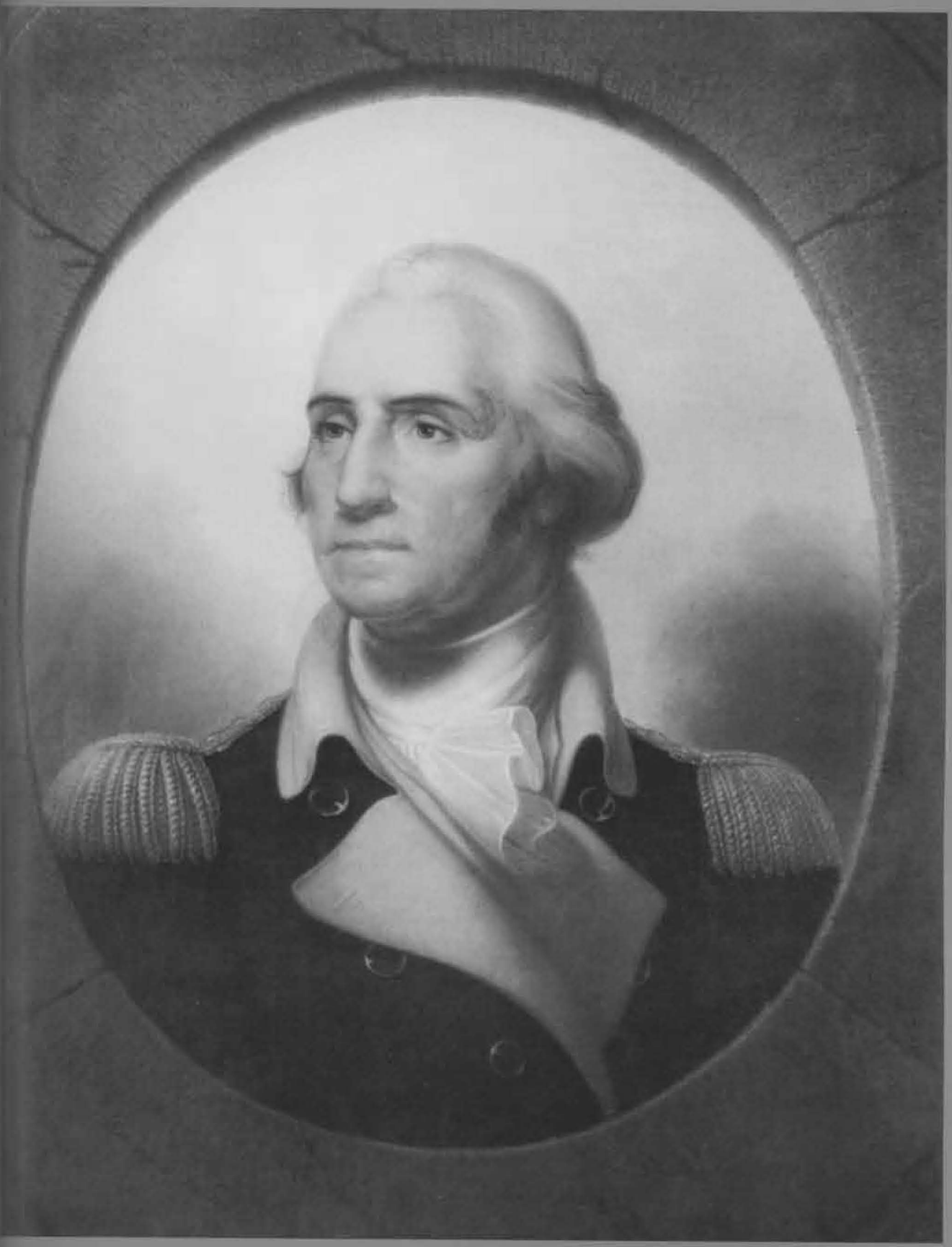
BULLETIN



TIN OF THE MAHONING COUNTY MEDICAL SOCIETY VOL. 66 NO. 5 FALL 1996

BULLETIN

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President's Page

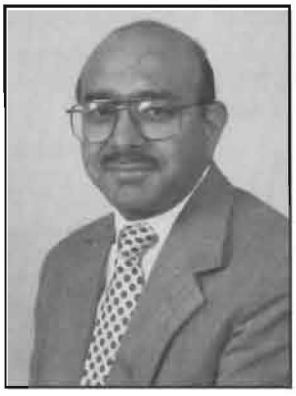
Re-engineering of the Medical Staff

RE-ENGINEERING AND DOWNSIZING ARE THE BUZZ WORDS FOR THE NINETIES. RE-ENGINEERING DEMANDS THAT ONE CONsider the assumptions, redundancies, glitches, and bureaucracies of the current system, and then invent a new process to carry out the functions of the medical staff in a more efficient fashion. Re-engineering is a shift to process-based thinking that involves understanding the old process, inventing and constructing a new process design, and implementing the new organizational structure.

Before considering the re-engineering of the medical staff organization, we must look at the core functions of the medical staff. Basically, the hospital medical staff organization was created to provide quality care for the patients and to make recommendations regarding the qualifications of those who wish to provide care.

The Medicare and Medicaid regulations require that the hospital have an organized medical staff which operates under bylaws approved by the governing body, and is responsible for the quality of medical care provided to the patients by the hospital. The medical staff has three hospital-needed functions: 1) to provide patient care; 2) to evaluate and improve the quality of care provided; 3) to assess and make recommendations regarding the qualifications of those who wish to provide care. Credentialing and quality review were the voluntary work of the medical staff, but it was always the hospital that bore the legal consequences if it failed to meet its duty.

Chander H. Kohli, MD



Too few physicians do all the work while noncontributing physicians may still vote, attend meetings and have the ability to disrupt the process. The medical staff is an organization carefully constructed not to act. Clinical departments are anachronistic - most medical staffs are still divided into traditional departments and sections of medicine, such as surgery, pathology, radiology, OB-GYN, pediatrics, and so on. Such divisions make less and less sense as specialties overlap. For example, plastic surgeons, ENT, oral, and maxillofacial surgeons all perform procedures on the face and head.

When the hospital started to hire physicians to perform various administrative duties, including the corporate practice of medicine, they began to compete against the private practitioners. This brought tension, and problems drove a wedge between hospitals and physicians. Prospective payments introduced by Medicare in 1983 altered the way the hospitals were paid, and the hospitals found themselves at financial risk for physician practice patterns, thus adding to the deteriorating relationship between the hospitals and the physicians. Lately, various organizations like PHOs, IPAs, PPOs, and HMOs have caused further confusion in the relationship between hospital and staff. This has led to loss of trust between hospitals and physicians, and has put physicians against each other.

In the traditional set-up of hospital staff organization, there are many levels of hierarchy that involve too many committees and departments which have overlapping responsibilities and functions. These problems have made this organization susceptible to confusion, and legal problems have rendered it slow-moving and ineffective for getting anything done in a timely manner. The bureaucratic set-up to which we are accustomed is expensive to maintain and control, and takes more and more time and effort to sustain. We have to compete against better-organized, well-funded entities like HMOs and insurance companies. We have to reorga-

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President's Page

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nize our staff so that it will be more productive and functional, with less bureaucratic confusion.

The medical staff should be restructured to represent functional "Services", rather than anatomical divisions, as has been done in the past. Each Service should have functional sections. The chief of each of these sections would form the "Council" of that Service. These Councils would send their representatives to the "Executive Committee". A community-based hospital with less than 500-bed capacity could be reorganized into 4-6 functional Services.

The Medical Staff Functions contain the following processes:

1. Credentialing/Recredentialing: While certain aspects of this process are well-defined and can not be side-stepped, it may be possible to construct several tracks of processing to speed up this function.

2. Peer Review and Committee Structure: The medical staff evaluates and monitors care through the process of several functions, which include surgical case reviews, blood and blood components usage review, medical records review, pharmacy and therapeutics review, utilization review, and infection control review.

Medical staff re-engineering suggests that these functions may not need a separate committee for each. JCAHO requires only one committee that is the "Medical Executive Committee". The Medical Staff Committees could include a Medical Executive Committee, Credentials Committee; Quality Assessment and Improvement Committee; and Joint Conference Committee, which is a resolution mechanism for hospital and medical staff, and a Technical Advisory Committee, composed of a panel of physicians who have special expertise and are chosen to work on specific issues. Such a method may eliminate committees which meet on a monthly basis, but actually accomplish little. Most of the issues at hand not covered by the Standing Committees will be submitted to small Ad-hoc Working Groups. The groundwork would have been completed by this Working Group prior to review by the Executive Committee.

3. Restructuring of the Medical Staff: This may be done in a number of ways, as mentioned above.

4. Corrective Action: Hearing and Appellate reviews need to be maintained as the stronghold of the medical staff, with the bylaws containing the necessary procedures and safeguards to protect due process.

Re-engineering should be viewed as a tool to reinforce bonds and core values of the medical staff, while seeking to streamline and focus on the efficient functioning of the staff. It should not be considered a quick-fix solution or undertaken with the idea of change for the sake of change. When we build, let us build with the future in mind. Let us not turn this futuristic change down for personal motives.

Medical Board Has New Rules on Virus Reporting

The State Medical Board of Ohio has released new rules that require physicians infected with the human immunodeficiency virus (HIV) or the hepatitis B virus (HBV) to report that fact to the Ohio Department of Health. The new AIDS self-reporting rules became effective in late July.

Rules also call for physicians to report other physicians who they know or suspect may have HIV or HBV.

Infected physicians are to notify prospective patients of their seropositivity only before the patient is scheduled for exposure-prone invasive procedures.

Members of the MCMS may obtain copies of the HIV-HBV rules by contacting the OSMA's Division of Legal Affairs at (800) 766-6762.

HOSPICE OF THE VALLEY

And I Thought I Knew About Hospice...

EVERYTHING I THOUGH I KNEW ABOUT HOSPICE IS WRONG.

I USED TO THINK THAT HOSPICE WAS A home nursing service for dying cancer patients. But it is far more than that. True, Hospice has a fine coterie of nurses who are experienced in palliative care; but a plethora of other services is bundled into the whole package.

For example, Hospice of the Valley offers a personal care team that goes into the patient's home to bathe him. A bath sounds like a humble luxury, but many of the hospice patients are difficult to move. Often they live with relatives who themselves are frail and unable to lift the patients. Simply bathing the patient allows him to spend his final days free from the indignity of being dirty or smelling bad.

Many patients find themselves overwhelmed by a confusing array of bills, insurance forms, and public agency paperwork. Others need an advocate and interface with a large and often indifferent bureaucracy. The hospice social worker comes to the patient's home to help him with these problems. Also, she is trained and experienced in helping to smooth out the ruffles of intrafamily relationships that often emerge as the family proceeds through the stress of the patient's death.

Eric Chevlen, MD
Medical Director, Hospice of the Valley

Eric M. Chevlen, M.D.

The spiritual aspect of the patient's dying is as important as the physical. The hospice chaplain is trained in rendering (in a non-sectarian fashion) spiritual solace that the dying need. He participates in all of the multidisciplinary team meetings, and visits the homes of patients who request his intervention.

I would be shortchanging Hospice if I neglected to mention the role of the medical director, so I shall describe that too. The attending physician is always in charge and has the final say in the management of the case. But the medical director discusses the pain or other palliative problems of the hospice patients with the nurses every week. When the Hospice nurses contact the referring physicians with recommendations for modifications in therapy, the recommendations are based on discussions with a board-certified specialist in pain medicine. The medical director is also available for phone consultation concerning difficult palliative problems.

The Hospice volunteers offer another valuable component of the Hospice service. Taking care of a dying relative can be physically and emotionally taxing. Volunteers go into the patients' homes to give the primary caregiver a respite. The caregiver can use a few hours to attend to personal needs, or just to get away for a while, knowing that the patient is not alone or uncared for.

Just as serious illness and death affect the whole family, not just the patient, so too Hospice services include concern for the entire family, even after the patient's death. After the patient dies, the Hospice team maintains contact with the survivors to help them through the difficulties of mourning. This bereavement service, which is available for a year, is particularly valuable when the survivors include young children.

Finally, and most importantly, the Hospice nurses must be considered. These extraordinary women have all chosen to become Hospice

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NEOUCOM

Students inducted into clinical training

MEMBERS OF THE CLASS OF 1999 AT THE NORTHEASTERN OHIO UNIVERSITIES COLLEGE OF MEDICINE WERE INducted into the clinical portion of their medical education in a special "White Coat Ceremony" in which each student received a white lab coat with a NEOUCOM patch.

Elisabeth Young, MD, associate professor of internal medicine at St. Elizabeth Health Center in Youngstown and graduate of the NEOUCOM class of 1985, was the featured speaker at the August program. The White Coat Ceremony is designed to signify for students the responsibilities that accompany the wearing of a white coat in a medical setting. The white coat represents to society that the person wearing it is not only competent and professional, but also compassionate in his/her care of patients. The medical students received their white coats the day before their first day of clinical studies in NEOUCOM's associated hospitals in Akron, Canton and Youngstown.

NEOUCOM students in the class of 1999 proudly wear the white lab coats they received in the White Coat Ceremony in the College's Amphitheater of Hippocrates.

Students at NEOUCOM spend the first year of medical school immersed in basic medical sciences—anatomy/embryology; behavioral sciences; biochemistry/molecular pathology; medical genetics; microbiology/immunology; microscopic anatomy; neurobiology; general pathology; and physiology.

The second year of medical school serves as the bridge from classroom and laboratory work to the clinical settings. Two days a week students attend classes on the Rootstown campus; three days a week learning occurs in a smaller group format in hospitals at the College's clinical campuses.

This introduction to clinical training, which comes earlier at NEOUCOM than at most other medical schools, helps students develop and strengthen skills in interviewing, physical diagnosis and history taking.

NEOUCOM's White Coat Ceremony is sponsored by the Office of Student professional Development and Advising, with a one-time grant from The Arnold P. Gold Foundation, a public not-for-profit organization that develops and supports programs to foster humanism in medicine. The Gold Foundation established the first White Coat Ceremony at Columbia University in 1993 and this year received a grant from The Robert Wood Johnson Foundation to help establish similar ceremonies at medical schools throughout the United States.

The Arnold P. Gold Foundation was founded in 1988 by Dr. Arnold P. Gold, his wife, Sandra O. Gold, Ed.D., and several colleagues and friends who felt that the issue of compassionate patient care was of crucial importance and should be addressed in medical education. In addition to the White Coat Ceremonies, The Gold Foundation raises funds to support a number of other innovative programs and projects designed to emphasize the importance of joining humanistic care with clinical excellence.

In Memoriam

ANGELO RIBERI, MD

February 22, 1925
September 1, 1996

In Memoriam

MORRIS S. ROSENBLUM, MD

January 25, 1905
September 15, 1996

On The Cover

Porthole Portrait of George Washington

Oil on canvas, 36 x 29" (91.44 x 73.66 cm.)
By Rembrandt Peale (1778-1860)

ALTHOUGH KNOWN AS A MEMBER OF ONE OF AMERICA'S MOST FAMOUS ARTISTIC FAMILIES, ONLY RECENTLY HAS REMbrandt Peale emerged from the group as an individual who virtually embodied the industrious, experimental, yet above all fickle age of capitalism in which he lived. Ever seeking imaginative means by which to weave the production and appreciation of art into the fabric of the American democratic enterprise—working in many of America's growing cities and founding a museum to foster national taste—Rembrandt Peale forged a career for himself characterized as much by failure as success. But, whereas such fits and starts were once considered reason to overlook him, the persistence with which he met them is now thought by one scholar to be the quality that makes him "quintessentially American."

Raised in the long shadows of his accomplished artist-father, Charles Willson Peale, and the heroes and statesmen whose portraits lined the walls of his father's gallery, Rembrandt was, in a sense, surrounded by the achievements of past masters. The challenge to distinguish himself as an artist was compounded by a lack of public interest in the arts, his poor business skills, and his desire to depart from the well-trodden path of portrait painting. However, it was as a portraitist that Peale was able to support his large family and combine his high-minded, nationalist ideals with an art that appealed to a large audience. Having first painted George Washington in 1795, and having won acclaim for his *Patriae Pater* (1824, Collection of the United States Senate, Washington, D.C.), Rembrandt stated in the 1850s that his true calling was "to multiply the Countenance of Washington." By his death in 1860 he had done so no less than seventy-nine times, systematically producing simplified versions of the *Patriae Pater* that became known as the porthole portraits, of which the Butler Institute's is one.

Possibly seeking to surpass his father in painting America's great figures, Rembrandt sought to capture the visage of the founding father both for the edification of the public and as the crowning achievement of his career. He perceived himself singularly qualified to paint what he called the "standard likeness" of Washington, writing that, "Among the few persons now living, who can speak of their own impressions...concerning the personal appearance of Washington, I may be supposed to have some claim on the confidence of the rising generation—educated to venerate the memory of *him*, who will always be 'first in the hearts of his countrymen,'" Emphasizing the fact that he had painted Washington from life, Rembrandt supported his claim by soliciting testimonials from other men who knew Washington personally and could confirm the accuracy of his portrait. He sought to distinguish himself from other artists who had painted the first president from life, and at last to match the accomplishments of his father, whom he acknowledged as having painted "the *first* portrait of Washington in 1772."

Rembrandt's insistence on the importance of his direct contact with Washington is ironic. With his subject long dead, his *Patriae Pater* and the subsequent porthole portraits were actually composites of his 1795 portrait and others he had admired, such as the famous bust by the French sculptor Jean-Antoine Houdon. Nevertheless, his enterprise was a success, coming at a time of renewed interest in Washington as a national hero. The importance of Rembrandt Peale's icon-making to the evolution of American culture has been confirmed most recently in the potency of 1960s Pop Art images, and by that movement's revelation of our society's ongoing interest in icon creation.

Daniel Strong

Excerpted from "Master Paintings from The Butler Institute of American Art," published by Larry N. Abrams, 1994

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OSMA/MCMS Major Medical Plan

Attention MCMS members who are insured through the OSMA/Mahoning County Blue Cross Blue Shield of Ohio (BCBSO) major medical plan:

We're pleased to report that your BCBSO health insurance premiums will not increase in 1997!

We've been informed by the OSMA Insurance Agency, and BCBSO, that premiums for all MCMS policyholders, as well as any new policyholders, will be guaranteed not to change for twelve months beginning with 1997 plan anniversary dates. With this 1997 rate renewal, our health insurance rates will have remained level for 3 1/2 years.

Another piece of good news related to our sponsored plan:

Effective 1-1-97 a Prescription Drug Card will automatically be added to all in-force and new policies, with no additional premium cost! This new benefit provides a $5.00 co-payment on generic drugs, or $10.00 co-payment on brand names. Additionally, the same co-payment limits will apply to 90-day maintenance supplies. (Specific plan information on this new benefit will be soon provided to each insured.)

If you have any question regarding the MCMS/OSMA sponsored health plan, or you're interested in an individual or group premium quote, please contact John Mayer at the OSMA Insurance Agency. He can be reached by calling 800-766-6762.

Hospice of the Valley

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nurses, rather than hospital or office nurses, despite the difficult traveling it requires and the emotional strain of dealing with only dying patients. They have made this choice because they are dedicated to providing the best in palliative care, which in short means relieving the suffering of the dying. Among them, these nurses have decades of experience, and have the cumulative store of knowledge and wisdom that comes from years in this kind of work.

Just as my knowledge of the services provided by Hospice was incomplete, so also was my knowledge of the types of patients helped by Hospice, and the optimal time frame for Hospice intervention.

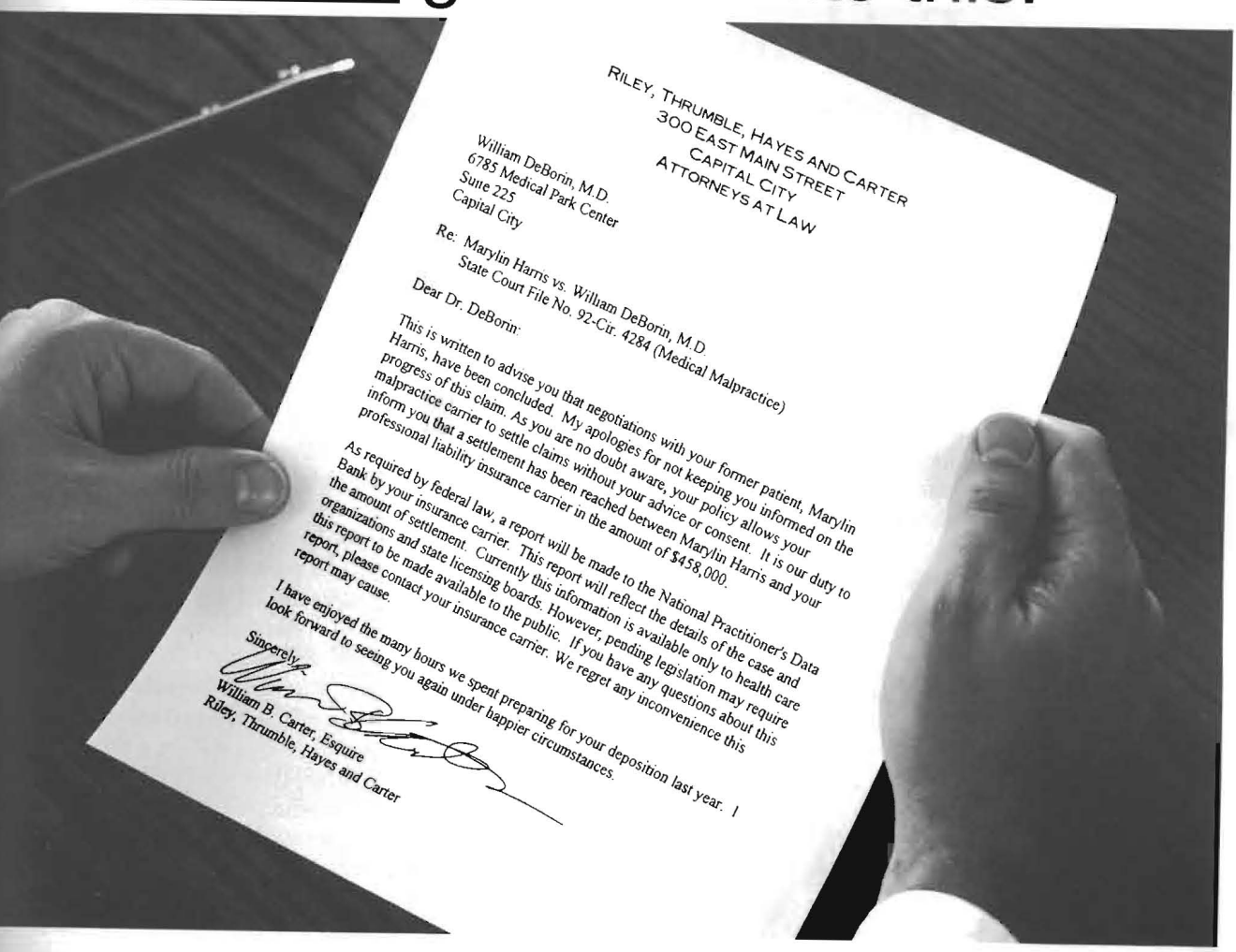
Hospice is not just for cancer patients. Any patient for whom care is to be palliative only is a potential beneficiary of Hospice care. Many of the patients who benefit from Hospice have end-stage COPD, heart failure, or cirrhosis. Others are in the final stages of Alzheimer's disease. These patients have palliative needs just like cancer patients, and they greatly appreciate the home-based gentle therapy that Hospice can provide.

As a non-profit agency, Hospice of the Valley provides these services to all who need them, regardless of their ability to pay. In addition to all of the aforementioned services, Medicare, Medicaid and private insurance beneficiaries who elect the Hospice Benefit program receive the drugs needed for palliation of their terminal illness at no cost. As if that were not enough, these patients also receive the following at no cost to them: durable medical equipment, physical therapy, speech therapy, diet counseling, occupational therapy, and outpatient diagnostic services. Even doctor bills are much less a worry for these patients, since Hospice pays directly to the physician 100% (not 80%) of the Medicare allowable portions of a consultant's bill.

In the broader sense, of course, the Medicare patient is not getting a free service. He has already paid for it in many years of Social Security and Medicare taxes. The Medicare benefit is structured for a duration of six months, although it is readily extended beyond that. But half of the patients are referred to Hospice only one month before they die. What a shame that so many Medicare patients are not "getting their money's worth". Since they are referred to Hospice when they are so close to death, they thereby fail to receive the valuable services that they have paid for throughout their working career. More significantly, late referrals to Hospice shortchange the patient by denying him the amount of time necessary for creating a therapeutic bond with the multidisciplinary team that comes to help him die at home naturally, with comfort and dignity.

Hospice is more than I thought it was; and perhaps more than you thought it was, too. National Hospice month is a good time for us to think about this wonderful agency that does so much for so many.

Medical Protective Policyowners *NEVER* get letters like this!



RILEY, THRUMBLE, HAYES AND CARTER
300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marylin Harris vs. William DeBorin, M.D.
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

Any allegation of malpractice against a doctor is serious business. If you are insured by The Medical Protective Company, be confident that in any malpractice claim you are an active partner in analyzing and preparing your case. We seek your advice and counsel in the beginning, in the middle, and at the end of your case. In fact, unless restricted by state law, every individual Medical Protective professional liability policy guarantees the doctor's right to consent to any settlement--**no strings attached!** In an era of frivolous suits, changing government attitudes about the confidentiality of the National Practitioner's Data Bank and increased scrutiny by credentialing committees, shouldn't you have The Medical Protective Company as your professional liability insurer? Call your local General Agent for more information about how you can have more control in defense of your professional reputation. Also available through select Independent Agents.

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A New Epidemic in Mahoning County:
What Can Physicians Do About Firearm Injuries?

GUNSHOT INJURIES AND DEATHS HAVE ESCALATED TO EPIDEMIC LEVELS IN MAHONING COUNTY - IN 1994, FIREARMS became the leading mechanism of injury death, accounting for nearly half of injury deaths and accounting for twice as many deaths as the next leading mechanism - motor vehicles (figure 1). With 73 firearms injury deaths in 1994, Mahoning County's death rate was almost twice the national average and almost three times the *Healthy People 2000* objective for reducing this cause of death (figure 2).

It comes as no surprise to anyone who watches local newscasts that three-quarters of these firearms deaths are homicides and, if suicides are counted, nearly all firearms injury deaths were intentional (figure 3). Many of these deaths occur among young people; of the 28 deaths among persons under 24 years of age in 1994, seven were among **children** (figure 4). These numbers reflect what is happening in many communities across the nation: 11% of American children and adolescents who die are shot. More male teens, ages 15 to 19, are killed by guns than by any natural cause. Firearms have become the leading mechanism of preventable death, and - because so many young people are victims - of potential life lost by our citizens in Mahoning County.

Matthew Stefanak
Mahoning County Health Commissioner

Are these firearms deaths truly preventable, considering the national passion for bearing arms (there are more than 200 million firearms in the United States, including handguns in one out of four homes)? The impulsive nature of many homicides and suicides suggests that a substantial portion of these deaths might be prevented if immediate access to firearms was reduced. More than half of homicide victims in the United States are killed by persons they know. In fact, there are 43 fatal shootings of family members or acquaintances for each instance in which a gun at home is used in self-defense. In many instances, these homicides are committed impulsively and the perpetrators are immediately remorseful. Similarly, a substantial proportion of the nation's 30,000 suicides each year are committed impulsively.

The controversy over gun control has obscured the fact that a range of educational and legislative strategies may be effective in reducing the immediate access of susceptible persons to loaded firearms. For example, immediate access to loaded firearms would be reduced if:

- weapons and ammunition were stored in separate locations
- parents locked up their weapons and ammunition so that children could not use them unsupervised
- trigger locks were installed on all weapons at home.

Judging by the high priority given to violent and abusive behavior as a community health problem by our Commission for Community Health and hundreds of Canfield Fair goers asked to rank health problems last summer, the public health and medical professions may soon be called upon to join community efforts to control the violent behavior that is made so lethal with firearms.

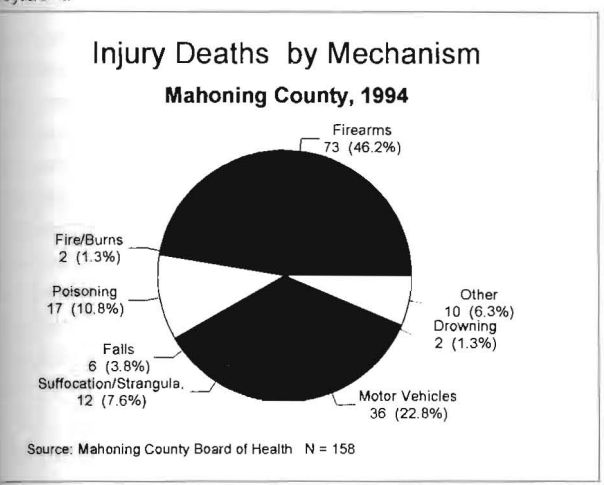
Former Surgeon General C. Everett Koop and the American Academy of Pediatrics recognized the important role physicians can play

in counseling parents and teens to reduce the risk of firearm injuries for all family members when they designed a physician educational program known as STOP (Steps to Prevent Firearm Injury). Firearm injury risk reduction is a relatively new area of counseling for most physicians. Those who wish to incorporate injury risk reduction counseling into their practice may benefit from review of the epidemiologic literature on firearm injury risk and learning about some effective patient counseling techniques. Counseling materials are available for purchase from the American Academy of Pediatrics at (708) 228-5005 or for loan from Tracy Styka of the Mahoning County Board of Health - Health Assessment Unit at 788-5011.

Secondly, Physicians can support the efforts of a local group - the Mahoning Valley Safe Kids Coalition - that is working to reduce unintentional firearm injuries in children, through parent education and support of *Healthy People 2000* objectives for the enactment of child access prevention laws. Lark Dickstein, the Safe Kids Coordinator, can provide more information about these efforts at 740-KIDS.

The first step toward control of an epidemic is to identify the preventable causes of the epidemic. By incorporating questions about firearm injury risks in preventive counseling, physicians can contribute to our community efforts to control the epidemic of firearm injuries in Mahoning County.

Figure 1



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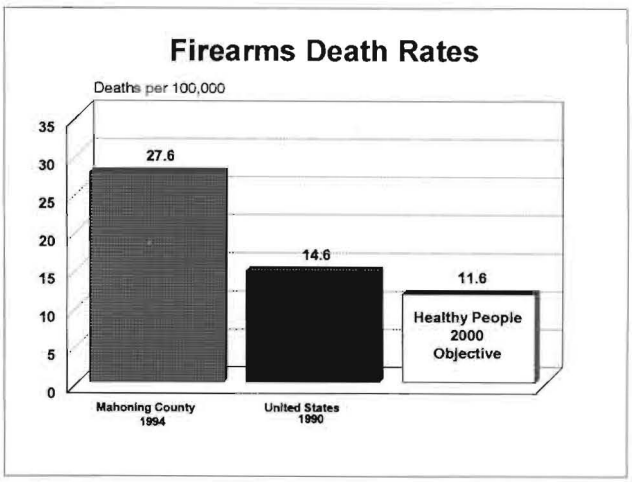

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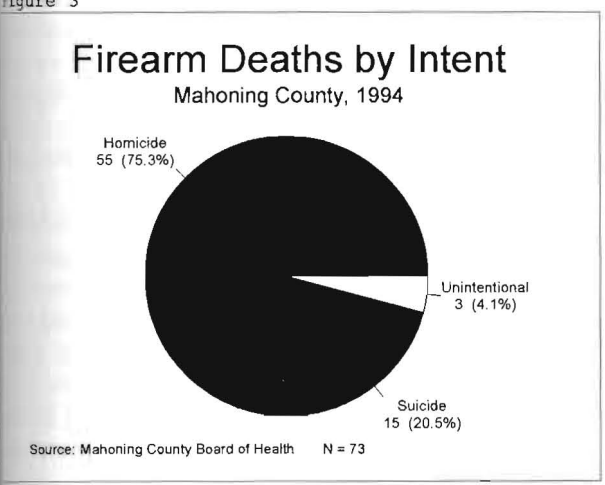
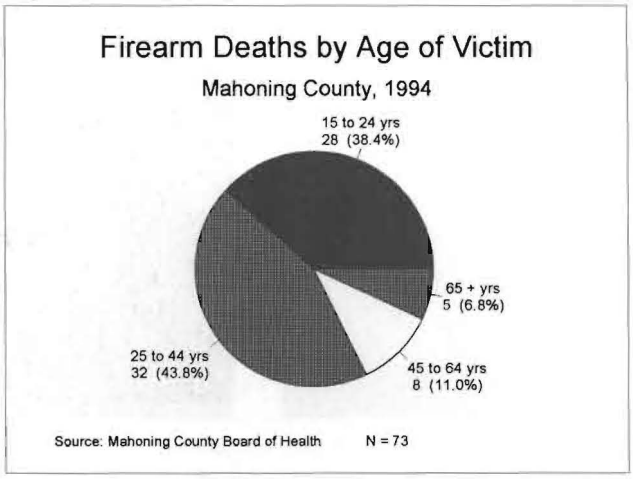


Figure 4



State Medical Board of Ohio

Medical Licensure in the 1990s—and Beyond (Part II)

THE LAST ISSUE OF THE BULLETIN INCLUDED THE TEXT OF OHIO MEDICAL BOARD EXECUTIVE DIRECTOR RAY Bumgarner's speech about centralized credentialing, delivered to the American College of International Physicians this past summer. Mr. Bumgarner's remarks were part of a "mini-seminar" he and I presented about the role of state medical licensing boards across the country, the discrepancies that still exist, and what the future holds. In this issue, we turn to the charge of state medical boards and how to protect your license.

ROADS TO LICENSURE AND CRASHING ALONG THE WAY

Anand G. Garg, M.D., Ph.D.

Before we begin our journey, let us understand the origins of medical regulation. We must realize that though it may be different in our respective countries, here in the United States it is a privilege to practice medicine, *not a guaranteed right* simply because we have earned a degree in medicine. My father used to say, "Study well. Be a doctor. What you have in your head, no one can ever take away. Wealth may vanish, but not knowledge." This seemed logical fatherly advice, except that he did not realize the different playing rules that could exist in a far distant land, this other world! As we are all aware, here in the United States, we cannot do anything without a medical license. It makes no difference how many degrees we have attained. In the absence of a license to practice medicine, all that knowledge has no value for practical reasons and/or economic needs of living and support. We have traveled so far and worked hard to obtain our medical license. *Let us help ourselves retain it and avoid losing it.*

Anand G. Garg, MD, PhD

Ray Q. Bumgarner, JD

Since the mid-1800s, state legislatures have realized that the practice of medicine by untrained, unscrupulous, and/or incompetent persons is so potentially dangerous to the public that it requires comprehensive regulation. Thus, medical boards were created throughout the United States charged with the responsibility of regulating the practice of medicine within their jurisdictions. Ethical admonitions and legal prohibitions were merged in statutory language governing the discipline of licensed physicians. Each individual state retained total responsibility for the practice of medicine within its jurisdiction.

In their infancy, medical boards focused on matters of medical education, testing for licensure and elimination of wide-spread quackery. But as these issues were resolved during this century, the focus shifted to ensure that minimal standards of medical practice were maintained. That shift necessitated even greater emphasis on medical board licensing and disciplinary actions. Medicine has made sweeping changes since the 1800s, especially since the World War II era.

Dramatic changes have particularly been realized during the last decade, in this age of high technology and computers. It has become difficult to keep pace with the ever-changing role of computers. The rapidly growing role of telemedicine is a present-day concern for the boards and the Federation of State Medical Boards in addressing the entire system of medical practice.

As we face these challenges, we must con-

tinue to remind ourselves that ***medicine is also an art.*** *We are truly privileged to be trusted with the charge of taking care of people. It is up to us to combine the science, the art and the technology into the right mix for our practice.* It is not, and was never meant to be, a business—except for the snake-oil salesmen of the past, the quacks and charlatans of yesteryear, and perhaps even today. We must continue to be vigilant and wary of such practices and avoid such company or association. The present pattern of managed health care brings to light new kinds of fraudulent practices. Even a few bring disgrace to our worthy profession and accountability for us all.

For most physicians, contact with their State Medical Board is limited to their initial application for license and subsequent license renewals. Many physicians consider that quite sufficient. This attitude stems from ignorance of the role of medical boards and their charge, as well as the belief that regulation is inherently punitive, and that much of what medical boards do bears little or no relationship to the day-to-day practice of medicine. It is fallacious, and we are sadly mistaken if we believe so. Through my experience as a member of the State Medical Board of Ohio and its past president, I might be able to strip away those misconceptions about medical boards and help you in the process.

The first point of interest to note on our journey is that medical boards across the country share a mission that focuses on public protection. This mission is accomplished by:

1) setting and defining standards to draw the line between safe and dangerous medical practice;
2) ensuring that those licensed have sufficient training and ability to enable them to practice according to acceptable standards;
3) maintaining surveillance to identify those licensees who practice below standards or without the necessary qualifications;
4) taking action to stop substandard practice, or practice by those without qualifications; and
5) letting others know about the actions taken by the Board.

Although medical discipline, as it has evolved in this country, is intimately intertwined with each of these elements, the foremost aspects of the disciplinary scheme remain as follows:

(1) to set standards,
(2) to identify violations, and
(3) to take corrective actions to stop substandard practices.

Each state has enacted a list of statutes, commonly referred to as the Medical Practices Act, which serves as the framework for the Medical Board's activities. Although unique to each state, the Act includes information such as:

- the role and structure of the Medical Board;
- the definition of the practice of medicine;
- medical license eligibility criteria;
- grounds for disciplinary action;
- authority for the Medical Board to investigate complaints, conduct administrative hearings and issue disciplinary sanctions; and
- mandatory reporting requirements

This regulatory framework is supported by administrative rules and position papers.

Rules are promulgated by medical boards to explain how the agency will carry out the statutes. They ordinarily have the force and effect of law.

Position papers, sometimes called policy statements, are written and adopted by medical boards to serve as guidelines for medical practice. They are advisory only, and usually do not have the effect of law. However, they serve as the Board's official opinion on specific issues. It would be prudent for each of us to follow these guidelines in our practice in order to stay out of trouble.

Through these statutes, rules and position papers or policy statements, medical boards accomplish the first element of their mission: to set and define standards that will draw the line between safe and dangerous medical practice. It cannot cover everything. Ultimately, when the determination as to whether or not statutory standards have been violated, it is revealed only through the weight of professional opinion

as provided by expert testimony. This is understandable, as acceptable standards of practice continue to evolve with the advent of new technologies and techniques every day. Moreover, there are differences in practice patterns, available resources, needs of the rural versus the urban community, and emergency versus routine care, just to list a few.

With standards in place, practice must be restricted to those having the requisite training and ability that should enable them to practice according to these standards. Certain types of practice or procedures may have to be restricted on an individual basis, due to lack of training, ignorance of new developments, availability of technical resources or, of course, poor outcome and results. This is the basic gatekeeper function inherent in all professional licensing. The initial licensing process assures that minimum training requirements have been met for licensure. It also assures that prior practice problems are not following an applicant from one state to another (sometimes referred to as "state-hopping"). In other words, it assures that *only qualified and safe drivers travel the highway*.

Sadly, this is where discrepancies in graduate training requirements and other discriminatory attitudes creep in. National organizations have worked hard to reduce or eliminate these unfair practices. *Fairness and uniformity of standards are goals*.

The federal government began to address some of these discriminatory practices by establishing COGME (the Commission on Medical Graduate Education) in 1994. However, a lot needs to be done and the process is slow. We all need to continue to work together to achieve the final goal of an equitable and fair product.

The examination component of licensure is aimed at evaluating whether or not an applicant has the necessary fund of knowledge to enter medical practice. Complaints of the past regarding two different standards of examinations—the FLEX and the National Boards—have been addressed by having a single licensure examination now in place: the USMLE. However, this examination pathway has raised some complaints of a different nature: unfairness.

CME Requirement

The requirement for periodic license renewal is based upon the need to identify any practice problems surfacing since initial licensure and the need for continuing medical education. This may be our *first speedbump*. Approximately 27 states have mandated a specific number of continuing medical education hours to maintain licensure. Ohio requires 100 hours of CME to be completed every two years. The goal of this requirement is to assure that licensees keep up to date with the advances in their profession.

Experience has shown that approximately 8% to 10% of the Ohio Board's licensees apply for license renewal despite their lack of CME hours. When a physician certifies that he has completed the statutorily required CME, when, in fact, he has not done so, it constitutes "fraud, misrepresentation, or deception in securing any license issued by the board." It becomes a violation of the Medical Practices Act.

Frequently, the penalty for such a violation is indefinite license suspension, for not less than 30 days, payment of all appropriate fees, documentation of CME obtained during the stated biennial period, and documentation of 100 hours of CME for additional biennial periods. It is easy to see how a physician could avoid this problem.

Minimal Standards of Care

Once a Board has determined those qualified to practice, it must continually maintain surveillance of its licensees to identify those who practice below standards or without minimum qualifications. The cynical view has long been that the profession protects its own, and patients have little or no expertise upon which to base an evaluation as to the quality of the care they have received. We all know that we have not done a good job of properly policing ourselves, and we still do not do it effectively. The public today is more informed and savvy; often they are told what they need by the media even before we learn it. It is no wonder, therefore, that this area of regulation has been subjected to intensive legislative and media scrutiny in recent years. This scrutiny has resulted in the development of new laws, rules and regulations, peer reviews, restrictions on scope of practice, and so on.

At the Board level, two basic responses have resulted from this criticism:

- Boards have been forced to make the public aware of their existence and to "open their doors" to those who may wish to register a complaint about the care they, or their loved ones, have received. In Ohio, we established a three-person public inquiries division in September 1989 to receive complaints and provide general information to the public and the profession alike. The addition of this staff dramatically changed the number of complaints received by the Board. In 1989, the Ohio Board received 1152 complaints, while in 1995 the Board received 2501 complaints — a 117% increase.

- Mandatory reporting requirements have been enacted to make more information available to regulatory bodies. In Ohio, state reporting requirements were established in 1987. (Similar reporting laws passed by the federal government became effective in September of 1990 with the opening of the National Practitioner Data Bank.)

Currently, 45 states have mandatory reporting requirements for licensees. Others frequently required to report information to the regulatory body include:

- hospital medical staffs/administrators
- other health care entities (HMOs, clinics, insurers)
- peer review organizations
- professional medical societies
- liability insurance carriers, and
- the courts

The most frequent types of information required to be reported to the medical board are privilege actions and malpractice payments.

While the complexity and diversity of the mandatory reporting provisions prevent me from providing an in-depth review at this time, it is in our best interest to familiarize ourselves with these requirements.

It is noteworthy to realize that the increased accessibility to medical boards, along with the mandatory reporting requirements, have provided additional information to boards about the type and quality of care provided by its licensees. While medical boards are *complaint-driven entities*, not all complaints or concerns received by a particular board merit disciplinary sanction. There may be considerable variability in the processing and disposition of complaints by boards. Through regionalization of boards, and the Federation of State Medical Boards, these variances are addressed on a continuing basis, as are issues related to examination, endorsement and other topics. The goal continues to be working toward consistency and uniformity.

Each board has established some type of complaint assessment and review mechanism. Complaints criticizing a physician's choice of a blue lab coat over a white lab coat, or inviting you to take a ride on a flying saucer obviously do not warrant any action and are closed upon receipt. Yet other complaints regarding a poor surgical outcome, or a doctor's prescribing practice, warrant further investigation by the board.

To answer the question as to who complains and what they complain about, let's take a short detour. The Ohio Medical Board regulates approximately 36,400 MDs, DOs and DPMs. The Board is also responsible for overseeing approximately 2500 massage and cosmetic therapists, as well as 600 physician assistants. In 1995, the Ohio Board received 2501 new complaints, involving:

quality of care issues	36%
licensure/renewal/restoration issues	15%
out-of-state disciplinary actions	13%
prescribing issues	11%

Other types of complaints received by the Ohio Board involve issues relating to:

- sexual improprieties
- violation of a license limitation
- office management/unprofessional conduct
- fraud/unnecessary services
- criminal acts or criminal charges
- impairment of ability to practice
- unlicensed/illegal practice

The source and origin of complaints are varied. The majority are received from:

- other physicians or health care providers
- patients/family members
- board staff
- other state or federal agencies
- hospitals/health care entities/insurers
- newspapers

Decisions as to which complaints merit further review and which can be closed

The grounds for disciplinary action found in every Medical Practices Act serve as a benchmark for determining which complaints require further evaluation. In reviewing the grounds for disciplinary actions carefully, you will note that these standards are not exclusively practice related. Social and moral judgments, as imposed by the lawmakers when establishing professional standards, are also an important part of this process.

The following activities are common grounds for disciplinary action that may place your license in jeopardy:

- deviation from acceptable standards of practice
- inability to practice safely due to physical or mental disability
- impairment of ability to practice in accordance with acceptable standards due to personal alcoholism or chemical dependency
- violation of state or federal controlled substance laws, and other prescribing issues
- fraudulent misrepresentation in applying for licensure or during periodic renewal of such license
- engaging in fraudulent misrepresentation in the course of practice
- engaging in false or misleading advertising practices
- commission of a criminal act (a felony, a misdemeanor in the course of practice, or a misdemeanor involving moral turpitude)
- disciplinary action taken by another state licensing body, or agency of the federal government
- violating, or attempting to violate, any rule of the licensing board
- violating, or attempting to violate, any term, condition or provision of a Board Order
- practicing beyond the scope of a license
- aiding/abetting unlicensed practice of medicine
- violating a code of professional ethics

Understanding that there are at least two sides to every story, boards often elect to further investigate complaints alleging violations of the Medical Practices Act. A sampling of the investigative techniques used by boards, includes:

- a personal interview by a Board investigator
- subpoena of complete original office medical records
- interviews with the complainant or other witnesses to the alleged activity

Through its investigative efforts, the Board can obtain enough information to determine whether or not a disciplinary sanction should be imposed.

The Board is served by a staff of experts and professionals who monitor and administer different areas, including licensure, public information, investigations, enforcement, and administrative hearings. The Ohio Board has 12 members—9 physicians (7 MDs, 1 DO and 1 DPM) and 3 consumers—who have been appointed by the Governor and approved by the Senate.

The size and makeup of each board, its staff, and the amount of its budget varies from state to state. The Ohio Board has approximately 80 employees. In addition, the office of the Attorney General serves as the Board's legal counsel. We also utilize physician experts in a variety of specialities selected from a list maintained in the Board's offices. The Ohio Board's annual operating budget is approximately $5.5 million, funded primarily from licensure and renewal fees.

The Medical Practices Act provides a wide range of disciplinary sanctions available to the Board, including, but not limited to:

- revocation of license
- suspension of license
- probation
- stipulations, limitations, restrictions and conditions relating to practice

- reprimand
- remedial education (mini-or focused residencies, for example)
- imposition of fines

In closing, if I may, I would like to offer some tips on *how to circumvent speedbumps and avoidable delays* in your medical career travels:

- Be familiar with your state's Medical Practices Act, rules and policies — we are held accountable for adhering to these mandates.
- Answer all application questions honestly and thoroughly at the time of initial license and at each renewal.
- Respond promptly to any correspondence or inquiries sent to you from your licensing board.
- Remember that you are responsible for providing quality care to your patients, despite the increasing restraints placed on medicine by guidelines that may be focused more for economic reasons rather than good patient care.
- Cooperate fully and cordially with a medical board investigator, if contacted.
- Maintain accurate records of your attendance and participation at the requisite number of CME courses during the reporting period.
- Actively participate in local peer review processes, for they are the cornerstone of the current regulatory scheme.
- Understand the concepts underlying mandatory reporting requirements — you play a critical role in maintaining the integrity of the medical profession.

Good luck!

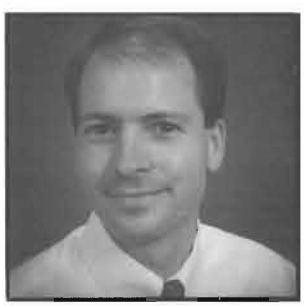
Medical Board staff members Joan K. Wehrle and Lauren Lubow contributed to this article.

MCMS *New Members*

Greg L. Bogen, MD
General Surgery/Surgical Oncology
Office: 500 Gypsy Lane Phone: 740-3489
MED. ED: NE Ohio Univ. College of Medicine, Rootstown, OH
INT: Western Reserve Care System, Youngstown, OH
REDCY: Western Reserve Care System, Youngstown, OH
FELLOW: Univ. of Mississippi Medical Ctr., Jackson, MS
SPONSORED BY: Jeffrey R. Rubin, MD; John J. Turner, MD; Karl F. Wieneke, MD

Michael W. Burley, MD
Cardiology
Office: 6505 Market Street Phone: 726-0100
MED. ED: Univ. of Massachusetts, Worchester, MA
INT: Presbyterian Univ. Hospital, Pittsburgh, PA
REDCY: Presbyterian Univ. Hospital, Pittsburgh, PA
FELLOW: Presbyterian Univ. Hospital, Pittsburgh, PA
SPONSORED BY: George J. Aromotorio, MD; Robert R. Houston, MD; J. Richard Hurt, II, MD

John E. Fassler, MD
Critical Care Nephrology
Office: 3622 Belmont Avenue, #22 Phone: 759-0059
MED. ED: Ohio State Univ. College of Med., Columbus, OH
INT: Vanderbilt University
REDCY: Ohio State Univ. College of Med., Columbus, OH
FELLOW: Ohio State Univ. College of Med., Columbus, OH
SPONSORED BY: Roberto A. Bacani, MD; Sergul Erzurum, MD; Erdal Sarac, MD



Michael P. Haggerty, MD
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Office: 1011 Boardman-Canfield Rd. Phone: 758-0975
MED. ED: NE Ohio Univ. College of Med., Rootstown, OH
INT: St. Elizabeth Medical Center, Youngstown, OH
REDCY: St. Elizabeth Medical Center, Youngstown, OH
SPONSORED BY: Ralph W. Colla, MD; Robert L. Collins, MD; Nicholas M. Garritano, DO

Raul Lopez, MD
General Surgery and Endoscopy
Office: 25 Manor Hill Drive #300 Phone: 702-0900
MED. ED: Univ. Central Del Este, San Pedro De Macoris
INT: Western Reserve Care System, Youngstown, OH
REDCY: Western Reserve Care System, Youngstown, OH
FELLOW: Ponce District Hospital, San Juan, P.R.
SPONSORED BY: Emil S. Dickstein, MD; Armand Garcia, MD; Jeffrey D. Resch, DO

Kevin A. Spear, MD
Urology/Male Infertility
Office: 1011 Boardman-Canfield Rd. Phone: 758-0975
MED. ED: Medical College of Ohio, Toledo, OH
INT: Akron General Medical Center, Akron, OH
REDCY: Akron General Medical Center, Akron, OH
FELLOW: University of Illinois, Chicago, IL
SPONSORED BY: Ralph W. Colla, MD; Robert L. Collins, MD; Nicholas M. Garritano, DO

American Medical Association

Did You Know...

The number of women in medicine has skyrocketed, increasing more than 425 percent since 1970. According to the AMA's recently-released *Physician Characteristics and Distribution in the U.S., 1995-1996 Edition*, the number of women physicians increased by 6 percent during last year, while the number of men in the profession grew only 1 percent. Female physicians number 133,263, representing almost 20 percent of the physician population. Women now comprise 42 percent of medical students.

The increase in the number of women in medicine has been reflected in the AMA's membership and leadership. The AMA is the largest member organization of women physicians in the United States. Women continue to be the fastest growing segment of AMA membership. Further, women physicians currently serve on the AMA Board of Trustees, as presidents of their state, county and specialty societies; and are setting policy for medicine in the AMA's House of Delegates. The percentage of women in the House of Delegates has more than doubled since 1990.

From the Bulletin

A Look Back...

Sixty Years Ago
Sept./Oct., 1936

A new medical building at the corner of Market and Boston was nearing completion. The occupants were to be **McClenahan, Sears, Fred Middleton, Dick Middleton, Ray Hall, Oscar Axelson and Russell Rummell. Luke Reed** opened an office at 1920 Market Street, and **Craig Wales** opened an office at Belmont and Guadalupe. **Paul Mahar, Sr.** and his bride returned from their honeymoon on the Great Lakes.

Fifty Years Ago
Sept./Oct., 1946

New members were **Nathan Belinkey, Rollis Miller, Clyde Walter, Sidney Keyes, Robert Kiskaddon and Kenneth Camp. Edwin Brody** left for New York to study dermatology. **Oscar Axelson** was awarded the bronze star for meritorious service in Europe. **Lewis Deitchman** died from a coronary thrombosis.

Forty Years Ago
Sept./Oct., 1956

James Smeltzer finished a tour of active duty with the U.S. Navy and returned to the private practice of Internal Medicine. New members were **Robert Wiltsie, Bertram Katz** and **Irving Berke.**

Thirty Years Ago
Sept./Oct., 1966

Steve Ondash was elected president of the Ohio Chapter of the American College of Physicians. **Richard Murray** had a one-man showing of his paintings in New York. **A.E. Rappoport** gave a paper on automation and computer use in laboratory pathology to the International Congress of Pathologists in Rome. **Angelo Riberi** addressed the South American Congress of Cardiovascular Surgery at Caracas, Venezuela.

Twenty Years Ago
Sept./Oct., 1976

As part of the Bicentennial Celebration, the Medical Society placed a granite marker on Dutton Drive, a new street created when Eye Care Associates built a new building just off Woodland Avenue. The street was named for **Dr. Dutton**, Youngstown's first physician. Also, a marker was planned for the grave of **Dr. Woodbridge**, the first president of the MCMS. New members were **Fred Kunkel, John R. LaManna, Jr., Herbert Parris, B.A. Slabochova, Joseph Cleary, Robert Cuttica, Prabhudas Lakhani, and Bruce Mervis.**

Ten Years Ago
Sept./Oct., 1986

President **Richard Memo** and editor **Emil Dickstein** both editorialized on the shenanigans going on in the Health Care Industry, which were designed to reduce hospital stays and increase profits. **Vernon L. Goodwin**, a prominent otolaryngologist and past president of the MCMS, passed away after a long illness, at age 75.

Robert R. Fisher, MD

Robert R. Fisher MD

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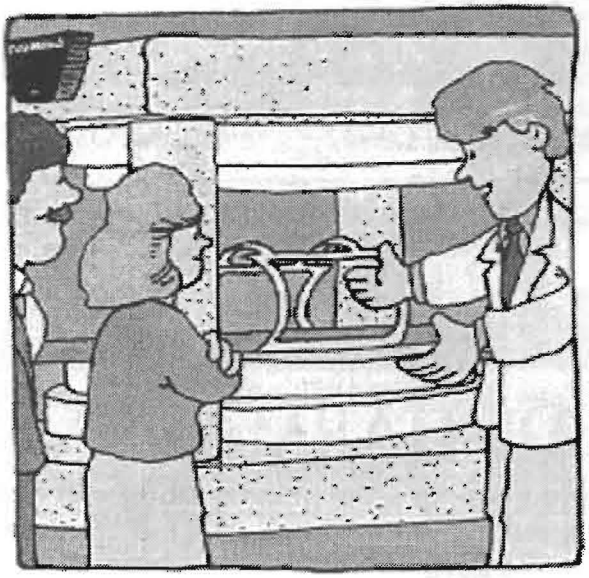

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The following applications for membership were approved by Council:

FIRST YEAR IN PRACTICE:
Anup S. Bains, MD
Mark K. Hirko, MD
Maria T. Madden, MD
Donald Um, MD

SECOND YEAR IN PRACTICE:
Adam G. Crouch, DO

ACTIVE: Joseph A. Cerimele, DO

Information pertinent to the applications should be sent to the Mahoning County Medical Society Council.

BOOKLET AVAILABLE ON CHRONIC FATIGUE SYNDROME (CFS)

The National Institute of Allergy and Infectious Diseases (NIAID) has revised its popular booklet developed to inform the medical community about chronic fatigue syndrome (CFS). *Chronic Fatigue Syndrome: Information for Physicians* can assist physicians and other health professionals in developing a supportive program of patient management that dispels myths about CFS and its treatment, offers reassurance, and helps patients and their families adjust to living with this chronic illness. Free copies can be obtained by writing to: CFS Booklet; NIAID Office of Communications (31/7A50); 31 Center Drive, MSC 2520; Bethesda, Maryland 20892-2520. To order or download the publication online, visit NIAID'S home page at http://www.niaid.nih.gov.

Meetings

Retired Physicians

Retired physicians from Western Reserve Care System meet on the third Thursday of each month at 12 noon for lunch at the Ground Round in Boardman.

If interested in more information, contact Dr. DeCicco at (330) 788-2131 or Dr. Fisher at (330) 533-8748.

CADUCEUS GROUP DISCUSSION

The Greater Youngstown Caduceus Group's CLOSED discussion meeting will be held in the Education Building, North Side Hospital on Tuesdays at 12:15 PM.

For additional information, contact Joyce Burns at the Medical Education Department, WRCS, (330) 740-3574.

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