BULLETIN

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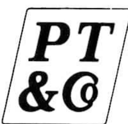

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January 16, 1990
March 20, 1990
May 15, 1990
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"He who does not learn from history is condemned to repeat it."

George Santayana

Who speaks for me? As a physician in private practice, I am under constant pressure from outside agencies that attempt to intrude into my professional relationships with my patients. The Federal government continues to use its massive bureaucratic power to tell me how, when, where and at what price I may treat my Medicare patients. This is done through HCFA, PRO's and the insurance carriers. The State government sets my fees and tells me which procedures I may perform through Medicaid and the Bureau for Children with Medical Handicaps. The insurance companies have made deals with employers for care through HMO's, PPO's, and IPA's.

"Since no one now speaks for me, I must speak out for myself until a legitimate format can be established."

Each of these agencies has its own set of unique rules that must be followed or penalties accrue, such as refusal of payments, removal from the panel of providers, or even legal action by the government agency involved.

Since I am an individual (or partner or small corporation) involved in providing medical services, my "business" relationship is with the patient who voluntarily seeks my services. We essentially come to an agreement in which I perform a service in return for a fee. In the past the service was provided and appropriate recompense was agreed upon by the two parties. The only parties involved were the physician and the patient.

Now we cannot even begin our transaction until we are sure that all the qualifiers have been met. Very few patients have direct responsibility for paying all fees involved or entering into an agreement for advanced services without the approval of the financial agent (insurer).

Some of the limitations appear to be almost arbitrary. For example, under BCMH regulations I may do an Adenoidectomy and Tympanostomy Tube insertion but may not include a Tonsillectomy even if the usual criteria exist for the Tonsillectomy as well. This certainly does not serve the best interests of the patient but the bureaucratic regulations are satisfied. Similarly, some companies will approve a tonsillectomy only if there have been at least five treated episodes of tonsillitis in the last year. Four or less episodes are not acceptable, regardless of the severity of the episodes or the clinical appearance of the tissue. Is the insurance company concerned for the well-being of the patient or for the company's profit margin? An insurance company exists primarily to make a profit for the owners. The care of the insured is of secondary importance.

However, through careful manipulation of the factors, the government and insurance companies have effectively focused attention onto the physicians and providers of health care as the villains in the scenario. HCFA has been setting our Medicare fees for years, but congressmen such as "Pete" Stark continue to blame the physicians and hospitals for the spiraling costs over which we have very little control. Patients are much more medically sophisticated and want the very best and latest in treatment and technology for their problem, regardless of the cost. Of course someone else is usually paying the tab.

The frustration over these issues has brought about sporadic calls for a "Doctor's Union". Unfortunately Fed-

James A. Lambert, MD

eral law perceives physician practitioners as competitors in the delivery of health car services. Any agreement on prices, boycotts or other refusal-to-deal issues is considered a horizontal restraint of trade under anti-trust law and subjects for prosecution. Even though our payments may be primarily through third party intermediaries, we are not viewed as employees and hence may not form any type of bargaining unit.

I belong to several professional organizations who do perform some group empowered activities. However there is no weapon available to force a response from the targeted "foe". We cannot strike or form collective bargaining units. I pay my dues to the American Medical Association, the Ohio State Medical Association, the Mahoning County Medical Society, the American College of Surgeons, and the American Academy of Otolaryngology. All these organizations assure me that they are working for my best interests. At least two of them however are going in different directions on Federal legislation. None of them are empowered by me to act for me as a bargaining agent with the government or the insurance companies.

Patrick Henry in a very different context but obviously mindful of the need to avoid a call for common action (in his case conspiracy and treason, as opposed to our restraint of trade) said, "I know not what course others may take, but as for me, give me liberty or give me death!" Are we not faced with similar choices? Are we not now on the threshold of servitude to the government agencies and insurance companies? If we do not accept this servitude, are we not faced with sanctions that amount to an economic death? If we are to leave the practice of medicine, is this not professional death? Since no one now speaks for me, I must speak out for myself until a legitimate format can be established. Are we yet, in Tennyson's words, "made weak by time and fate, but strong in will to strive, to seek, to find, and not to yield."

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Peer Review

The Fall of 1990 brings with it some drastic changes in the field of Medicine. The CLIA '88 reform is on the horizon, Medicare mandated claims filing is here and now the National Practitioner Data Bank will soon be in existance.

The National Practitioner Data Bank is a record of *1) Medical Malpractice Payments, 2) Licensure actions taken by Boards, 3) Clinical Privilege Actions, and 4) Society membership actions against a physician.*

"...it discredits the medical profession, placing us in the leagues with other national information processors such as the FBI and credit bureaus."

The data is to be used by Hospitals for physician privilege applications (a MUST), state licensing boards and certain specified health care entities, and lastly, a plaintiff's attorney ONLY if it can be shown a hospital did not request the data as mandated and the information can only be used against the hospital, not the physician.

There are elaborate methods to notify a physician of information in their "file" as well as disputing and rebuttal forms. All of this amounts to more paperwork, bureaucracy and mistrust.

The Act is to protect the public from incompetent physicians. It establishes a centralized data bank to record professional misconduct, licensure status and malpractice claims. Also it provides protection and incentive for physicians participating in effective Peer Review programs.

The impetus seems to be a lack of any clear method by which the medical profession polices itself. Reports of physicians successfully moving from state to state practicing incompetent medicine adds to this notion.

Denise L. Bobovnyik, MD

Peer Review is generally annoying and sometimes downright threatening. To new physicians it is just one more item left out in training along with office management, business practice, insurance and Medicare/Medicaid 'processes. There is a lack of urgency in this matter. Not participating in peer review hasn't to this point brought any consequences. The process is somewhat time consuming. Standards must be set and time is spent reviewing physicians as well as being reviewed.

The need for Peer Review is evident. In my mind I know why the NPDB was created. In my heart though, it discredits the medical profession, placing us in the leagues with other national information processors such as the FBI and credit bureaus. I feel this will only strengthen the idea that "something is going on among physicians." I also see the day when consumer activists are granted access to the information (although now prohibited) in the data bank to make physician choices. Remember that "guilt" is not a consideration in being reported to the Data Bank, only the fact that a settlement was paid. Those physicians who are in specialty fields with a high "nuisance suit" level are more likely to be reported as paying larger numbers of malpractice settlements. This is well known and easily explained in the medical community but may be more difficult to explain to the lay person.

The bottom line is strong and effective Peer Review - YES! A National Data Bank and $10,000.00 fine for not reporting information... I'm skeptical.

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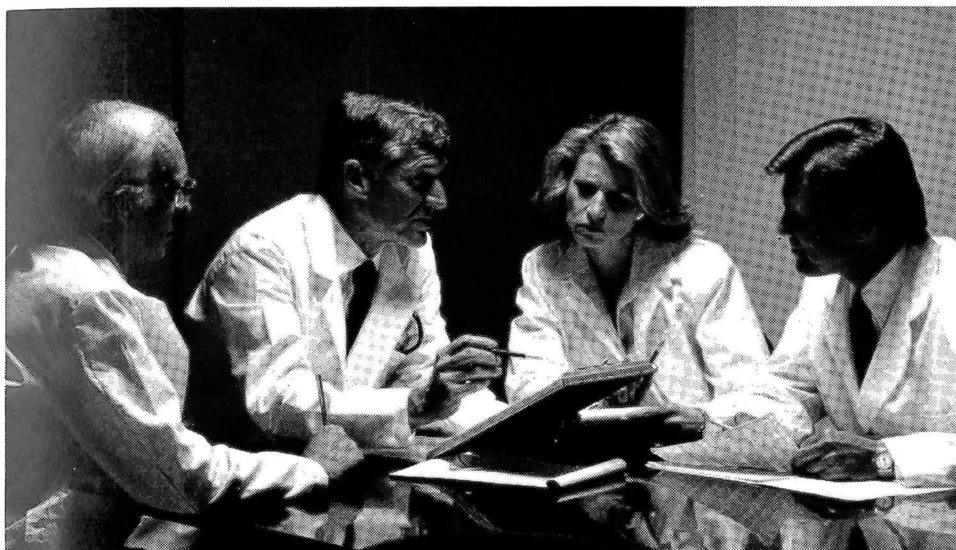

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How does "health" fit into your practice?

There's a significant difference between "health care" and medical practice. If doctors don't emphasize the broader topic with still more commitment, then their influence will continue to decline.

Medicine is called the great "healing profession," as physicians do great deeds in helping the sick get well. That's wonderful, but most people would prefer to avoid physicians by staying healthy in the first place.

Your value in society arises largely when the health system breaks down — when your patient gets sick. Billions of dollars are poured into hospitals, diagnostic services and doctor bills to reverse those illnesses and injuries, and physicians' incomes—though jeopardized by many new challenges—continue to be very high. In effect, what's spent on *medical* care dwarfs what is spent on maintaining and improving the public's *health*.

Health Is Key Word

Is that how it should be? Probably not, for the greatest gain for the greatest number of people lies in having a still healthier society. Over the years, for example, improvements in sanitation, nutrition and inoculation have had a greater effect on our dramatically increased life expectancy than have cardiac surgery, MRI machines and even the explosion of general medical knowledge.

Perhaps unfortunately, greater personal challenges—and financial rewards—still lie in practicing medicine rather than in cleaning our air. The tangible aspects of a tough diagnostic or surgical case, a good patient outcome and generous (through increasingly regulated) fees appeal to far more people than the amorphous, often bureaucratic efforts to improve general health factors. Being a physician has a lot going for it, even in this age of doctor-bashing.

I recall attending a community health seminar a few years ago in Chicago. Physicians comprised about half of the 200 attendees, but they were *not* the dominant participants. It was refreshing to experience the audience's uniform commitment to people's health, in which medical service was only one part of the picture.

What's Your Role?

My question for you, physicians and managers in all variety of medical practice, is whether you are giving enough attention to *health*. Are you so busy with each patient's medical problem that the bigger challenge in health care is being ignored? If you are like so many of the physicians and managers I talk to, you may not even think the issue is relevant.

The focus does, of course, vary among specialties and among individuals. Primary care physicians and multi-specialty clinics offer stop-smoking, weight loss and blood pressure control programs for their patients. Some cardiologists emphasize prevention, including participation in the American Heart Association's "Heart RX" program. Patient newsletters emphasize seat belt usage, breast self-examination and skin cancer prevention. And many doctors emphasize good health habits in one-on-one patient consultations.

Still, these efforts are inconsistent. Worse yet, they only hit some citizens while millions of others—particularly the so-called "underserved"—live in ignorance and disregard even of basic health concepts. So even the physicians

who take pride in emphasizing prevention in their patient encounters make only a small dent in the overall need to improve health.

Whose Job Is It?

Some doctors say "It's not my job." They were trained to handle medical conditions in patients needing their expertise, while other people are trained to cope with broader health needs. That may be true, but then don't get so upset over physicians' loss of power and prestige.

Having a decisive role in the health care system—as medical societies seek to perpetuate it—calls for being *leaders* in dealing with the system's major needs.

As an individual physician, you can be committed to counseling prevention to your patients and promoting health in your community. Larger group practices can take more aggressive roles, having the resources to develop larger, more visible health promotion programs. As health care financing pressures further squeeze medical service fees, a group presence in the larger (health care) arena is still another reason why the trend to larger group practice will continue.

My Conclusions

As I see it, hospitals and physicians are competing for part of a much larger resources "pot": the so-called "health care dollar." But doctors (and hospitals) will keep on losing the battle unless they become more instrumental in the larger picture. This means broadening your perspective beyond medical services.

If that's beyond your role as a solo or small group practitioner limiting yourself to treating patient illnesses, don't be surprised if larger group practice dominates the health scene in your town. Or, in the alternative, the health care industry becomes still more dominated by non-physicians.

Leif C. Beck
LL.B., C.P.B.C.

Editorial Note: We acknowledge the cooperation of Leif Beck, who has granted reprint rights for topics which have appeared in his regular monthly publication, The Physician's Advisory. His organization, the Health Care Group, with offices in Plymouth Meeting, PA is a group of leading national consultants and attorneys specializing in medical practice organization and management.

Reminder: CME hours due before December 31, 1990

Ohio physicians must have completed 100 hours of continuing medical education credits between January 1989 and the end of December 1990. All licensed physicians must certify that they have completed their CME when they complete their relicensure forms. The Ohio State Medical Board routinely audits physicians to verify their compliance. False certification is fraud and can result in licensure suspension or revocation. If you have questions about your CME, contact the State Medical Board at (614) 466-3934.

Emergency Medical Treatment and the Good Samaritan Law

Ever since Hypocrites created the physician's oath, doctors have found themselves in a predicament when it comes to providing unsolicited medical care in emergency situations. They have had to balance their natural desire to provide the medical care for which they are trained, against the potential civil liability that might result from their well intentioned efforts administered on the scene without the proper equipment or support.

A typical emergency situation involved the doctor happening upon a roadside car accident or, perhaps, finding himself eating in a restaurant when another patron becomes ill. More than a few doctors found themselves defendants in a lawsuit as a result of having rendered care in such emergencies outside the hospital or doctor's office. Thus, while physicians always have desired to follow Hypocrites precepts, that at least some ambivalence to offering emergency help developed over the years is understandable. Recognizing the costs to society of the dilemma, the legislature began to address the issue in the 1970's.

"...immunization from liability does not apply in situations where treatment is provided in exchange for payment or the expectation of payment."

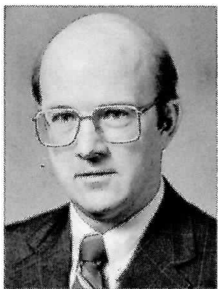
If identifying a problem existed was easy, finding a solution was not as simple. After much debate, the legislature decided that a specific statute offering protection to those offering emergency help was necessary. Commonly known as the "Good Samaritan Law", Ohio Revised Code Section 2305.23 provides that:

> "no person shall be liable in civil damages for administering emergency care or treatment at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, for acts performed at such emergency, unless such acts constitute willful or wanton misconduct. Nothing in this section applies to the administering of such care or treatment when the same is rendered for remuneration, or with expectation of remuneration, from the recipient of such care or treatment or someone on his behalf."

Certain of the language of the statute is especially noteworthy in the fact that "no person" is liable for civil damages for providing care at the scene of an emergency, as long as they did not act with willful or wanton misconduct. Thus, non-doctors, too, receive the benefits of the law. For instance, in one of the few cases that have interpreted the statute, Held v. Rocky River, the court ruled that an off-duty firefighter who pulls a firefighter from a stream of rushing water is immunized from liability for his negligent acts under the statute. The public policy rational of the statute is to induce anyone happening upon the scene of an emergency to come to the aid of the person in distress, recognizing that emergency aid will surely be beneficial to a recipient in dire straits much more often than not.

Of note to the physician, however, is the fact that immunization from liability does not apply in situations where treatment is provided in exchange for payment or the expectation of payment. The reason for this is obvious. Payment or the expectation of payment transforms an altruistic or "Good Samaritan" act into a physician/patient relationship in which doctors must contractually live up to a standard of care without immunization from liability.

In sum, when coming upon an emergency scene, physicians since 1977 can feel comfortable in rendering assistance because of the Good Samaritan law. The law protects the medical professional and the layman, thereby allowing doctors and non-doctors alike to act as Hypocrites urged 2,000 years ago.



Nils P. Johnson Jr., JD
Attorney Johnson is a partner in the Canfield law firm of Johnson and Johnson. He is a contributor to several publications, including Ohio Magazine.

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Mandatory Claims Filing Policy — Overview

Effective September 1, 1990, as a result of OBRA 1989 the following guidelines go into effect regarding mandatory claims filing (these regulations also apply to claims submitted to the Travelers). Physicians and suppliers:

- Must file claims for their medicare patients.
- May not charge the beneficiary for preparing and filing the claim.
- May continue to request payment from the patient at the time of service on non-assigned claims.
- Can expect that assigned claims which are not filed within one year of the date of service will be reduced by 10% per claim.
- Are not required to take assignment on any claim unless the physician has signed an agreement to participate in the Medicare program, or the beneficiary is also a recipient of state medical assistance program (Medicaid).
- Will be monitored by medicare for compliance, and physicians who do not submit claims for their patient/beneficiary within one year may be subject to a civil monetary penalty of up to $2,000 per violations.

Although not a part of OBRA '89, physicians may continue to attach superbills to the HCFA-1500 claim form (for the time being).

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AIDS and the Law

On August 2, 1989, Governor Richard F. Celeste signed into law Amended Substitute Senate Bill No. 2. This Bill is otherwise known as the Ohio Comprehensive AIDS Bill. As this is a very lengthy bill, the next several of my articles will attempt to deal with the highlights.

Neil Altman, MPH
Health Commissioner
City of Youngstown

A. General Provisions of Am. Sub. S.B. 2

Multifaceted legislation which enacts statutory provisions covering the following areas:

1. Authorizes the Ohio Department of Health to develop programs for AIDS education and the care and treatment of persons with AIDS.
2. Licensing of Community Alternative Homes.
3. Requirement that informed consent be obtained (with some exceptions) before HIV testing, and regulates manner in which test results may be disclosed.
4. Prohibits government agencies and private nonprofit corporations from denying services to a person who refuses to take an HIV test or reveal test results.
5. Permits a person who may have been exposed to HIV infection while providing health or emergency treatment to seek a court order compelling the person treated to undergo an HIV test.
6. Requires donated body parts and fluids to be HIV tested.
7. Grants certain immunities to employers of persons with HIV infection.
8. Prohibits insurers from taking certain actions based on HIV tests and AIDS in regard to applications for insurance.
9. Requires certain accused sex offenders and all persons sentenced to a state penal institution to be given HIV tests. Results available to victims.
10. Creates a civil cause of action for violation of these new statutory provisions.

B. Selected Provisions

1. ODH Responsibilities (Ohio Revised Code Sections 3701.24 and 3701.241)
   The Director of Health is charged with developing and administering the following:
   (a) Statewide surveillance system to monitor the number of cases of AIDS and HIV infection. Periodic reports due to the House and Senate.
   (b) Counseling and testing programs for groups at risk for HIV infection, including procedures and sites for confidential and anonymous testing.
   (c) Confidential partner notification system to alert and counsel sexual contacts of individuals with HIV infection.
   (d) Risk reduction and education programs.
   (e) Pilot programs for long term care of individuals with AIDS, including nursing homes and alternative settings.
   (f) Assist communities in establishing AIDS task forces and support groups.
   (g) Approve test or tests to be used for AIDS testing and interpretive guidelines.
2. Informed Consent for HIV Testing (O.R.C. Sec. 3701.242)
   (a) An HIV test shall only be performed if informed consent is obtained from the

individual from the person or state agency performing the test.

(b) Consent may be oral or written, but to be informed the following information must be provided to the person to be tested:

(1) Oral or written explanation of the test procedure including its purpose, limitations and meaning of results.

(2) An oral explanation that the test is voluntary and consent may be withdrawn at any time before the individual leaves the testing site and that the individual may elect to have an anonymous test. If anonymous test service not available, testing center must refer to site that has such a program.

(3) An oral or written explanation about behaviors known to pose risks for transmission of HIV infection.

NOTE: *The Director of Health is authorized to adopt rules as to what information is required to satisfy informed consent requirements.*

(c) A minor may consent but not refuse AIDS testing without parental consent.

(d) The person or agency ordering an HIV test shall provide counseling at the time test results are revealed or a diagnosis of AIDS made. If self referral, the testing site must provide counseling. A list of resources for further treatment, support and counseling must also be provided.

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Applications Rising with Increasing Interest in NEOUCOM

For most young people, summertime means vacation. It's a time away from school, studying and homework. But for 113 young men and women, this summer has been the start of a six-year path which, if all goes well, will culminate in the award of Bachelor of Science and Medical Doctor degrees in 1996.

The program takes place through the Northeastern Ohio Universities College of Medicine (NEOUCOM) and three consortium universities: Youngstown State University, Kent State University and the University of Akron. Students attend classes year-round during their first two years of undergraduate education and then spend the next four academic years in the medical curriculum.

A large portion of the medical school curriculum actually takes place in the community as well - specifically at eight major teaching hospitals including St. Elizabeth Hospital Medical Center and Western Reserve Care System in Youngstown.

This year's entering class consists of 113 students, one of the largest classes ever, reflecting an extremely high number of applicants. Total number of applicants to the six-year B.S./M.D. program for 1990 was 500, compared with 405 in 1989, a 23 percent increase. Likewise, students seeking direct entry to the four-year NEOUCOM medical program rose from 501 in 1989 to 962 in 1990. Nationally, the number of applicants to medical school is up eight percent.

We are extremely pleased with the number and quality of applicants and happy they have chosen a challenging, yet very rewarding career; medicine.

The average high school GPA for the students in the Class of 1996 is 3.86 (out of 4.0); average ACT composite of 28 (out of 36) and average SAT total of 1187 (out of 1600).

Seventy-nine high schools from 32 Ohio counties are represented including Columbiana, Mahoning, Portage, Trumbull, Stark, and Summit.

Increasing numbers of applicants to the medical school can be attributed to several factors, which can be summarized in three words: choices, resources and opportunities.

Choices include the application to the traditional four-year medical program or the alternative six-year path to a B.S./M.D. degree. The six-year program can mean a savings of at least $30,000 when compared to the eight-year sequence, as well as a savings of time which can be spent in postgraduate study, research, recreation or other valuable experiences.

Resources include more than 1,200 clinical faculty members at the eight teaching hospitals, with a combined capacity of over 6,100 beds. A total of 17 hospitals throughout northeast Ohio are associated with the medical school. Library computer access to the 17 hospitals and three state universities is also available through the Oliver Ocasek Regional Medical Information Center at the NEOUCOM Rootstown campus. In addition, the Information Center offers a media center, complete microcomputer laboratory, and over 73,000 books and bound journals and nearly 1,100 current journal subscriptions.

Finally, opportunities include the vast array of possibilities awaiting NEOUCOM graduates. The nearly 800 NEOUCOM alumni have prospered in residency programs in and out of the state of Ohio and approximately 50 percent of these graduates have been offered chief residency positions. NEOUCOM graduates can be found all across the United States as successful family practitioners, surgeons, psychiatrists, researchers and more. NEOUCOM graduates are represented in every specialty with about one-half choosing primary care. Our enrollment and application numbers reflect the growing success of NEOUCOM.

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Associate Director of Admissions
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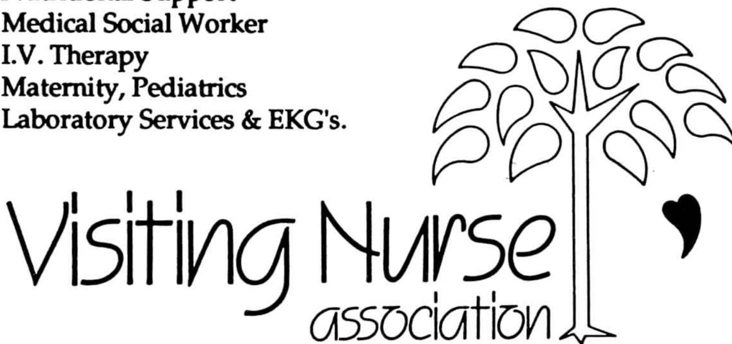

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Mahoning Board of Mental Retardation

Invites Physicians to View Life within the Sheltered Workshop

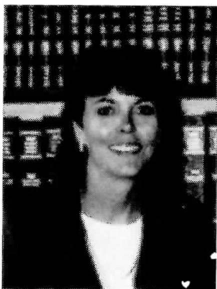
What is a sheltered workshop for the mentally retarded like? As Communications Coordinator for the Mahoning County Board of Mental Retardation and Development Disabilities, I am asked that question quite often. When I respond that the three MASCO (Mahoning Adult Services Company) facilities operated by the Board are expected to gross just under half a million dollars in sales this year, I am often met with a look of disbelief. Many people find it hard to believe that mentally retarded adults are capable of "real work".

"Many people find it hard to believe that mentally retarded adults are capable of 'real work'."

As proud as we are of our adults' accomplishments, we are also concerned — more so than a typical employer — about the health and safety of our adults. Many of our adults with mental retardation also have other severe disabilities which must be overcome on the job. A job which may be simple for a typical person to perform may push a mentally retarded person who also has cerebral palsy to their physical limit.

As physicians, you know that understanding a patient's lifestyle — particularly employment demands — is crucial when prescribing treatment. Unfortunately, many people with mental retardation have limited or no verbal communication skills. While friends or family may help you fill in some of the blanks, few can accurately describe the demands their loved one encounters on the job.

On Thursday, September 27, 1990, at 1:00 p.m., the Mahoning County Board of MRDD will open its doors to area physicians and their staff to present a "Physician Awareness Program". Area physicians and their employees interested in learning more about life within the sheltered workshop are welcome. The program will take place at Bev MASCO, 825 Bev Road, in Boardman.



Judy Shipsky
Communication Coordinator

The "Awareness" agenda will include an introduction to MCBMRDD programs, an outline of health services offered at facility clinics, a description of health concerns encountered by the R.N.s operating the clinics, and a tour of the facility to observe the adults in their work environment.

The MCBMRDD serves over 450 adults at its MASCO facilities. Since the mental and physical functioning level of each adult is unique, services are provided through an Individual Habilitation Plan (IHP). The IHP is a list of written goals appropriate to the adult. A new IHP is written annually and periodically reviewed to measure its efectiveness. Whenever possible, habilitation goals are accomplished through production activities.

Technological and medical advances in the field of mental retardation and positive attitudinal changes towards people with MRDD give even the lowest functioning adult a chance to participate in production. These same trends allow higher functioning adults a chance to gain competitive, community employment.

The sheltered workshops of the near future will serve only the lowest functioning and most medically involved MRDD adults. At the same time, the production demands of the workshops are projected to increase, placing greater physical demands on this work force. As medical and MRDD professionals, we must keep the lines of communication open and active so these adults can reach their highest possible potential.

To learn more about the changes in the mental retardation field and observe the environment of today's sheltered workshops, we urge you to attend the September 27 Physician Awareness Program. An RSVP to Judy Shipsky, Communications Coordinator, at 797-2835 is requested in order to project attendance. □

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50 Years Ago — September 1940

September always signifies the end of summer, the Canfield Fair, and the resumption of the school year. This year there was more to worry about than these mundane matters, as Hitler was on the move in Europe, with his "blitz-krieg" attack, and many small nations had fallen victim. The battle of Britain had begun, and the Surgeon General was already asking for volunteers for medical officers for the armed forces. Among those to volunteer early were O.M. Lawton, Martin Conti, and R.V. Clifford.

40 Years Ago — September 1950

Dr. Harold Teitlebaum was appointed medical director of the Mahoning County Tuberculosis Sanitorium, succeeding Dr. William Newcomer. Dr. Fred Coombs and Dr. Arnoldus Goudsmit addressed the new Mahoning County Academy of General Practice on "The Uses of ACTH and Cortisone". Dr. E.J. Reilly was president of the General Practice group. Dr. Ivan Smith addressed the Youngstown Hospital Staff on "Physical Medicine". Dr. Patrick Cestone opened an office for the practice of general surgery after returning from the Army. Dr. Kenneth Hovanic joined Dr. H. Brian Hutt in the practice of pediatrics.

30 Years Ago — September 1960

President Dr. Fred Schlecht, in his President's message for August reminded us that "The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration." He felt that the Medical Society should take a positive stand on the financial activities of its members, or the consequences would be government intervention and controls.

Along the same lines, a New Jersey Blue Cross rate study committee issued a stern warning to the medical profession that socialized medicine would be the result unless the medical profession would "devise controls on the monopoly it exercises in the areas of hospital utilization and hospital medical care". In a letter to the editor, Dr. Frank Gelbman wrote "some kind of government sponsored medical, hospital and nursing home care for the aged is a certainty".

Robert R. Fisher, MD

20 Years Ago — September 1970

Editor Dr. John Melnick was questioning the wisdom of the increasing use of para-medical personnel in the field of medicine, and the tendancy of the government to "regiment" the practice of medicine. President Dr. Robert Jenkins wrote on the pros and cons of group practice as encouraged by the Federal Government, all with the ultimate goal of lowering the cost of medical care.

Osteopathic physicians were showing up in increasing numbers on the hospital house staffs. At St. Elizabeth's they had Dr. David Dortin, Jr., Dr. Ronald Aiello, and Dr. Robert Bakondy. At YHA there was Dr. Richard D. Arnott, and Dr. James Thullen. All were Youngstown natives.

10 Years Ago — September 1980

The complaints about physicians' fees continued, with President Dr. Pat Brucoli reporting that the grievance committee had had more than the usual number of complaints about physicians charging more than the third party would pay.

Bulletin Editor and "Man of the Year", Dr. Richard Murray continued his vitriolic attack on the government, and more specifically, on the nations bankers. He predicted, however, that only about ten years of control wre left to them.

Dr. Richard Goldcamp died at the age of 65, in Rockledge, Florida. Dr. Gerald Klebanoff died at the age of 48, of a massive heart attack, in Saul Sainte Marie, Michigan. □

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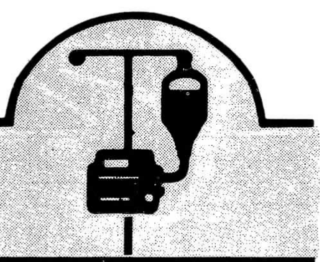

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Looking Forward — Predictions for the Nineties

Will medical societies in the nineties face stormy skies or balmy weather? A combination of both predicted guest speakers at the 9th Annual Conference of the American Association of Medical Society Executives (AAMSE), attended by Eleanor Pershing, MCMS Executive Director. Following are some medical trends and problems that were highlighted in conference sessions.

In the opening general session, expert panelists gave their predictions of trends that may impact association management and medicine in the next decade.

Harrison Coerver, a strategic planner for associations, stressed five issues: time, minorities, environment, work-force, and communications. Coerver suggested that medical societies must adapt to the time famine plaguing their members. Evolving family structure, longer physician work hours, and heated competition for volunteers will force medical society executives to re-examine their methods of service delivery and membership participation and involvement. In the nineties, medical societies will turn more to communication technology to bring continuing education and other programs to their members.

Citing projections of rapid growth in the United States' minority population, Coerver predicted that medical associations that make minority participation a priority issue now will reap dividends for decades to come. Physicians will need to become attuned to the lifestyles of more diverse ethnic groups.

Coerver suggested that medical societies respond to Americans' growing concern about their environment. Medical associations can bring much needed management skills to environmental issues while providing community service opportunities for their organizations.

Acknowledging an overloaded communications system, Coerver felt medical associations can address this problem by being discriminate as to the type and amount of information sent to its members.

Lastly, Coerver noted that although many organizations express concern about the quality of future workers, few associations have initiated programs to retain quality workers. Medical societies must plan now for anticipated difficulties in retaining quality support staffs.

Russell Coile, Jr., a futurist specializing in the health care industry, foresaw several trends influencing the next decade. He predicted that rapid growth in the country's aging population would be a major force affecting medical economics.

Physician practice revenue will rise substantially during the nineties, but practice costs will jump concurrently. Coile cited several factors that may drive up to 90 percent of young doctors into group practice; including increased labor costs, and rising malpractice insurance premiums.

Managed care will become more pervasive by the mid-nineties when HMO and PPO participants represent more than half of a physician's practice. Physicians will continue to face increased regulatory pressure from public agencies and private insurers as the public targets doctors as the key variable in slowing inflationary medical costs.

Consumerism is going to be a force in the nineties, compelling physicians to respond to rising patient expections. Doctors can expect legislative pressure for outcome disclosures and consumer guides. Quality assurance and utiliza-

tion guidelines for private practice may become a reality.

Lastly, Coile anticipated extensive debate on ethics and economics throughout the nineties over such issues as health care rationing, uncompensated care, and rivalry between the young and old for medical services.

A general session entitled "Views from Beyond" featured panelists who gave their attention to the public's perception of medical issues.

Nancy Gibbs, an associate editor at Time magazine, said recent Time cover stories on medical topics had generated intense reader response. She felt that many problems confronting medicine would benefit from improved reciprocal communications between physicians, the medical community, and the public.

Gibbs noted that doctors are often portrayed negatively in the media. Mainstream media derides doctors for being arrogant, greedy, and uncommunicative. Television sitcoms, on the other hand, protray doctors who are gifted, smart, and dedicated. Portraying doctors as miracle workers has raised public expectations to unsustainable levels. Any imperfect outcome thus becomes grounds for penalty.

Gibbs predicted consumerism would continue to grow, forcing doctors to spend more time marketing themselves and competing for patients. This trend will reinforce medicine's image as a business and will further erode public confidence in the medical profession.

The threat of lawsuits continues to impede patient-doctor communication as doctors view each patient as a potential threat. In polls, physicians overwhelming express their professional dissatisfaction. They cite fear of lawsuits, loss of control, consumerist attitudes, and medicine's changing organization.

Gibbs suggested that medical societies take a leading role in communicating physicians' concerns and their prescriptions for change to the public. Currently, the public views doctors as stonewallers trying to maintain the status quo for the sake of privilege and income.

Arnold-Relman, a physician and editor-in-chief of the New England Journal of Medicine, expressed several concerns about the future of American medicine.

According to Relman, the country needs a health care system that adequately provides for all citizens at a price our national economy can afford. The current health care system fails on several fronts limited access, runaway costs, and inadequate accountability and quality.

So far, piecemeal efforts have focused mainly on costs. According to Relman, the current system encourages competition, entrepreneurship, and revenue generation. To curb spiraling costs in the near future, Relman anticipates greater emphasis on prepayment plans, waste reduction in billing and collections, and more economical group practices.

Relman predicted that physicians will decide in the next decade whether to conduct their profession as an industry or follow a service model. He noted, doctors can be leaders in solving this country's health care crisis or pawns manipulated by other policy makers.

Calm waters or stormy seas? The views and predictions of these speakers and others at the AAMSE conference suggest that medical societies must look over the horizon to effectively navigate the complex issues facing medicine in the nineties.

DATA BANK TO OPEN SEPTEMBER 1

The National Practitioner Data Bank will begin operations September 1, 1990. The data bank was established by the U.S. Department of Health and Human Services to collect information relating to the professional competence and conduct of physicians, dentists and other health-care practitioners.

Final regulations released by HHS include mandatory reporting of all medical malpractice payments as well as licensure and adverse credentialling actions taken by hospitals and peer review organizations on physicians and dentists. Persons who receive information from the data bank must use it only for the purpose for which it was provided, or face a penalty of up to $10,000 for each violation. Physicians may dispute the accuracy of the information about themselves through written objections.

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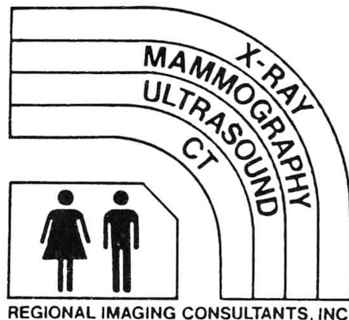

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Linda Weber Kiousis
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Watercolor

This month our cover features "Affodyl," a watercolor by local artist Linda Weber Kiousis. The title of the piece is middle English for daffodil and means "early-comer." The work portrays a scene of Youngstown's Smokey Hollow district near Youngstown State University.

This fall Linda's work will be reviewed in the fourth edition of The New York Art Review, an illustrated survey of the New York City art scene. The publication features selected artistic "giants," as well as up-and-coming artists whose works are just beginning to receive museum and gallery attention.

Publication in The New York Art Review is just the lates in a long list of honors and awards that Linda has earned in recent years. Her striking watercolors have received national recognition in shows, such as the 1989 American Realism Competition, the San Diego International Art Exhibition, and the "American Artist" National Arts Competition.

Born and raised in Cleveland, Linda graduated from the Cleveland Institute of Art and Case Western Reserve University. Her work is found in public, private, and corporate collections nationwide.

The *Bulletin's* cover piece can be seen in this month's "The Best of 1990" Show at the Apple Gallery in Boardman. □

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Medicare and the Federal Budget

The relatively moderate Medicare cuts of $2 billion that Congress agreed upon last Spring for FY-1991 have now gone by the wayside due to mounting pressure to reduce the federal deficit. Revised projections have raised the anticipated budget deficit by $20 billion, forcing the President and congress to contemplate medicare budget reductions in the range of $6 billion.

Participants in the budget summit meetings also are discussing other issues of interest to physicians such as a proposal to charge physicians $1 per claim for non-electronically submitted Medicare claims; the AMA proposal to delay 1991 balance billing limits; a proposal to require state Medicaid programs to buy drugs through a formulary at discounted prices; a proposal to establish a national living will, and a physician recertification proposal. The OSMA will keep you updated on this process.

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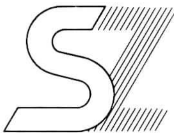

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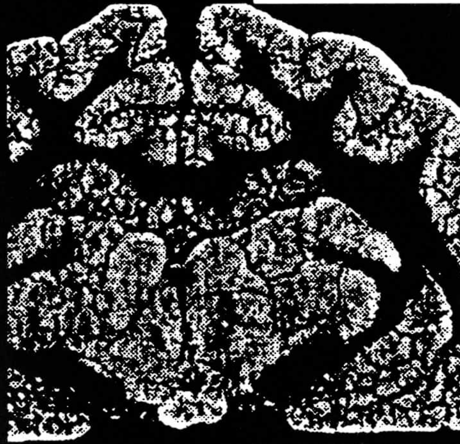

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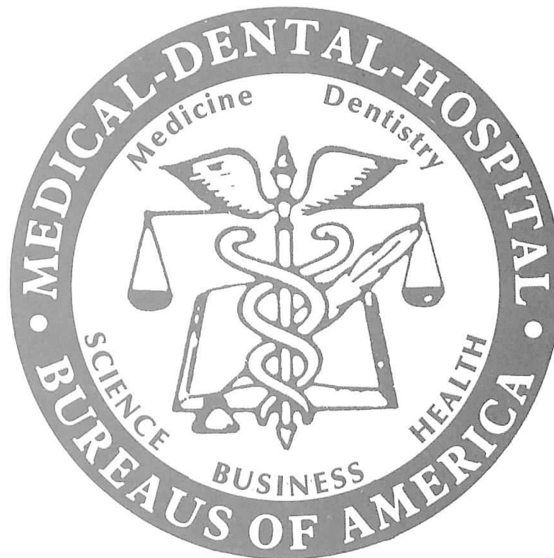

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