BULLETIN

LETIN OF THE MAHONING COUNTY MEDICAL SOCIETY VOL. 66 NO. 4 SUMMER 1996

BULLETIN

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The Bulletin is published six times a year by the
Mahoning County Medical Society, 5104 Market Street,
Youngstown, Ohio 44512. Phone (330) 788-4700. Fax (330) 788-0704.

Subscription rate of $20.00 per year is included in MCMS dues. Correspondence and changes of address should be mailed to the above address.

From the Desk of the Editor

Dear Colleagues,

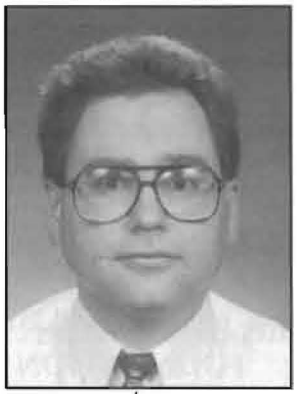
PLEASE LET ME EXPRESS MY DEEPEST SYMPATHIES TO THOSE ABOUT TO READ MY INAUGURAL EDITORIAL FOR THIS JOURNAL. Please forgive my tortuous prose, poor grammar and disorganized thoughts. Those who know me at St. Elizabeth's will not be surprised at my rambling. For those who do not know me, I will introduce myself. I have been a staff neurologist at St. Elizabeth's for thirteen years. I am a native of Youngstown and a YSU graduate.

Confessions are also in order. I accepted this job as co-editor with Dr. Erzurum with reluctance. I admit that I "volunteered" for this position only after much physical, verbal and emotional abuse from our leader, Dr. Chandler Kohli. I refused on numerous occasions, but when Chan finally pinned me to the ground and stuck bamboo shoots up my fingernails, I had no choice but to accept.

I really struggled for topics to write about in this article. First, I planned to use Dr. Dave Pichette's previous editorials, since he thought no one ever read them. I was just going to substitute my name and picture for his. But, Dave decided he would have to charge me for the articles, citing health care reform and decreasing income, so I dropped that idea.

Then, I decided to pursue a different course. I don't know about you, but I am really tired of reading articles about health care reform, politics and our deplorable status as physicians. Now these articles are necessary, but while reading them I have experienced severe, throbbing headaches, especially in both temples. As a neurologist, I know that severe, new-onset headaches can be dangerous to your health. Therefore, I refuse to write even a single word about health care reform, politics, etc.

Donald J. Tamulonis, Jr., MD



I propose a different approach...something we need more desperately than the latest news of Medicare cuts from Congress. I propose a "humor column", that is, a listing of the latest and best jokes. Many of my colleagues at St. Elizabeth's feel that I am an expert in jokes; in fact, they say I am a joke. But, I won't pat myself on the shoulder. Hopefully, with your help, I can get a list of jokes for this column. If you hear any good ones, please let me know! At the end of this article (which, thank goodness, will be soon) you will find my telephone number, fax number and mailing address. There used to be many jokes circulating at St. Elizabeth's, but unfortunately there is not a lot of humor at that institution these days. I don't know the situation at Western Reserve, but I suspect it is the same. By the way, lawyer jokes are preferred.

If I get desperate, I am also considering a gossip column. So, if you hear any juicy tidbits or slander about local hospital administrators, politicians or judges, please feel free to let me know. I promise I will not let the truth and facts interfere with my responsible reporting.

Finally, if I get really desperate, I will appreciate your sending me news about a great restaurant or a recommended movie, book or play. As a last resort, I can even resurrect Esther Hamilton's "Around Town" from *the Vindicator*.

Again, thanks for bearing with me. I will be writing to you.

Donald J. Tamulonis, Jr., M.D.
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President's Page

Patient Drain

ALL OF US HAVE EXPERIENCED THE LOSS OF A PATIENT TO ANOTHER PHYSICIAN. THIS EXPERIENCE CAN ELICIT VARIOUS EMOtions, ranging from relief to indignation, but often it leaves us wondering "What happened?". Perhaps we will never know, or care to find out, why the patient sought care out of town. Many patients nowadays are fiercely independent and well read. However, the need for educating the community with regard to the excellent health care available in the Mahoning County is paramount.

Patient drain from our community occurs for various reasons. I do not refer to the patients that we all (appropriately) refer to tertiary care centers. Ideally, these patients return to us for all other health care needs. My concern is that many patients are leaving when the care they need can easily be provided here in their own community.

In my opinion, a primary reason patients leave is lack of knowledge on the part of the patient, his significant advisors, or his primary care physician. Perhaps the PCP refers the patient out of town because he is not aware that the necessary services are available here. Perhaps the patient chooses to go out of town at the suggestion of family or friends, again without proper guidance. These scenarios for patient drain are certainly further encouraged by the ease of patient self-referral through media ads providing toll-free numbers.

Out-of-town care is not always in the patient's best interest. Over the years, many of my patients, friends and acquaintances have voiced their disappointment in seeking routine medical care outside of the community. Their complaints include long waits, lack of hands-on examinations, feelings of dissatisfaction with the physician, feeling lost in the system, and being rushed through in an impersonal way. Of course the inconvenience of travel distance is a major disadvantage to the patient and his family.

Some tertiary care centers do not accept patients who have been injured in accidents. And some patients who go out of town for routine medical or surgical care are surprised to find that they encounter physician resistance in being accepted for follow-up care after they return - especially when the physician believes he could have done as well or better for that patient. In other cases the patient or family may feel embarrassed by having to ask for help when things have not gone as expected of town. Continuity of care does suffer.

In my experience, patients are better off being cared for by physicians who know them and their families. It is helpful when their PCP and their specialists know one another and work closely together on a daily basis.

With the present conundrum in health care there are fewer choices for patients and physicians. Perhaps we should make some extra efforts, when appropriate, to protect our patient base. The least we can do is to genuinely attempt to care for the members of our community. We can do this not only by sharing our knowledge and expertise, but also by communicating with one another so that we all know what is available and can provide local options when appropriate.

Chander H. Kohli, MD

AMA ANNUAL MEETING

A Report From The AMA Annual Meeting 1996

IN JUNE I ATTENDED MY FIRST ANNUAL MEETING AS AN ALTERNATE DELEGATE TO THE AMA HOUSE OF DELEGATES HELD IN CHIcago. At the opening session of the House, there were 430 delegates seated. The Ohio Delegation has 13 delegates with a like number of alternate delegates. Our Ohio Delegation is very ably chaired by Dr. Ted Castle of Cleveland. Several weeks prior to the annual meeting, the Ohio Delegation met to review all 104 reports and 210 resolutions that were to be brought up before the AMA House of Delegates. This preconvention meeting was an absolute necessity to help prepare myself and other members of the Delegation to adequately represent our fellow physicians from the state of Ohio.

The annual AMA meeting dealt with a wide array of issues involving social economics, science, medical education, public health and the structure of organized medicine, including future representational issues in the House of Delegates.

The House also considered a subsequent report of the Federation study that offered far-reaching changes in the structure and operation of the various levels within organized medicine. As a result of this Federation report, once a year the AMA will send a specialty representation "ballot" to each AMA physician member and fourth-year medical student member. This ballot will ask each member to identify on the ballot one specialty society to represent him or her in the AMA/Federation House of Delegates for the next year.

Daniel W. Handel, MD

Daniel W Handel, M.D.

The number of delegates or alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 2,000 AMA members or portion of 2,000 AMA members who select that particular specialty society on the annual ballot. This will hold true for the first three years beginning in 1997. Starting in the fourth year specialty society delegate allocation will be on the basis of one for each 1,000 members or fraction thereof. Each specialty society seated in the House will be allocated at least one delegate. This balloting process will begin in the fall of 1996 and will serve as the basis for the 1997 delegate allocation.

Another issue discussed dealt with counseling and testing of pregnant women for HIV. The House of Delegates passed a resolution that the AMA support the position that there should be mandatory HIV testing of all pregnant women and newborns, with counseling and recommendations for appropriate treatment. The House also adopted a Board of Trustees report on mandatory testing of semen donors using established CDC, FDA and ASRM guidelines.

The House of Delegates also discussed the issue of physician-assisted suicide, and considered a Board report and four resolutions on the issue. In essence, the delegates voted to reaffirm the existing policies that are in opposition to physician-assisted suicide. The call for additional activities on the part of the AMA, such as initiating an educational campaign to make palliative treatment and care decisions on the standard of care for meeting the needs of patients at the end of life; improving the quality of care for patients at the end of life; and working with local, state and special medical socie-

continued on page 1

Construction begins on NEOUCOM's Center for Studies of Clinical Performance

"SIMULATED" PATIENTS, PHYSICIAN RATERS, STATE OFFICIALS AND COMMUNITY MEMBERS WERE ON HAND FOR the ground-breaking ceremony to start construction of the Center for Studies of Clinical Performance at the Northeastern Ohio Universities College of Medicine (NEOUCOM). The facility will house simulated physician offices, which will be used for the instruction and evaluation of clinical and diagnostic skills of medical students and residents.

The construction of the Center is a milestone for the College. Medical educators nationwide have discovered that a very efficient way to teach and evaluate clinical and diagnostic skills is by using "standardized, simulated patients"—people who are trained to act as patients with well-defined symptoms and conditions—in a simulated office setting. Physician-raters then measure the student's performance according to standardized criteria.

"Simulated" patients and physician raters took part in the ground-breaking ceremony for NEOUCOM's Center for Studies of Clinical Performance.

"Primary care physicians spend a great deal of their time with patients in the clinical setting," explains Robert S. Blacklow, M.D., NEOUCOM president and dean. "The physician's ability to accurately assess a patient's condition and needs is one of the most important aspects of diagnosis."

Because of NEOUCOM's high-quality standardized patient program, the National Board of Medical Examiners is considering using the Center for the simulated patient portion of its Step II examination, one of three steps necessary for physical licensure.

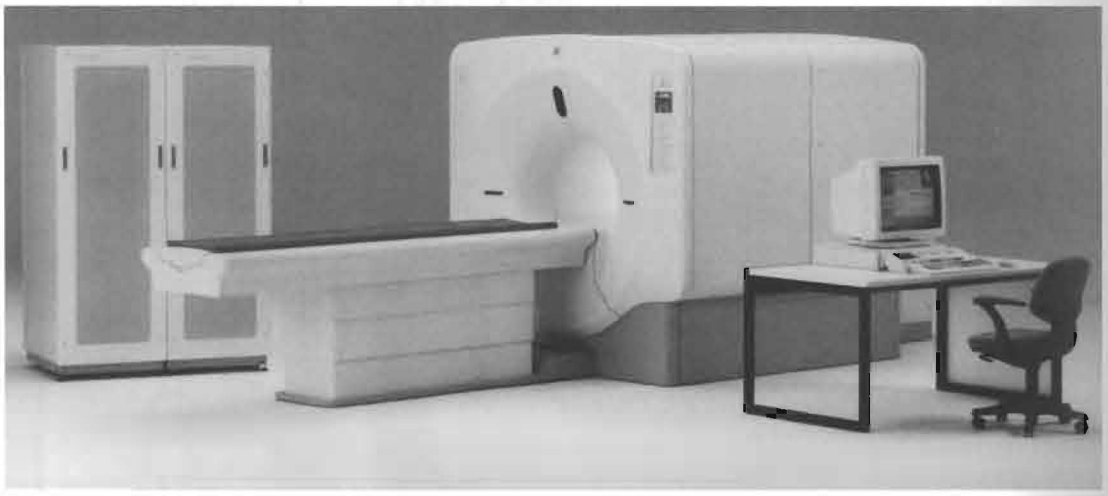
As Blacklow told those gathered for the ground breaking, "The current strategic plan of USMLE, the national licensing exam, calls for the continuing development of standardized patients with a target for implementation at the turn of the millennium. Their implementation plans envision close liaison between the NBME and assessment programs at schools like NEOUCOM to provide the backbone for test administration."

Blacklow then cited a letter NEOUCOM received from Daniel Klass, director of the Standardized Patient Project for the NBME: "As our plans mature, it is more than just encouraging to see well-planned executed programs like yours as evidence that standardized patient methods are becoming an integral part of the culture of the modern medical school. You should be pleased and proud to be in the vanguard of this activity."

The Center will include 16 patient examination rooms assembled around a central viewing area, space for adjoining offices, meeting rooms, seminar rooms and storage space. Audiovisual equipment (television cameras, microphones and speakers linked to television monitors, videotape recording and playback machines) and computers will be installed in the patient assessment rooms to facilitate evaluation of student clinical competency.

The Center will be used not only to teach and assess clinical skills of NEOUCOM medical students and affiliated residents, but it may also be used by faculty, students and residents of other medical schools in the region for student assessments, standardized patient trainer workshops, faculty development programs and technical assistance or advisory services.

NOW OPEN
PHYSICIANS MEDICAL IMAGING



We at PMI are pleased to announce the arrival of a world class G.E. SIGNA CONTOUR MRI unit. This state-of-the-art diagnostic equipment is the first fixed unit of its calibre to be installed in the United States. We are proud to be able to offer this advanced technology to the people of the Youngstown area.

With quality and professionalism, we have now served this community for over twenty years. The loyal support of all of our patients has helped us in making this dream become reality.

We believe that this new unit will be a great addition, and will compliment our existing CT, mammography*, fluoroscopy and general radiology services.

Professional Services Provided by Radiology Consultants, Inc.

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2. sending 100% of your contribution to the medical school of your choice.

Make your check payable to AMA-ERF for $25.00 (or more if you wish). Please complete the form below and send it, along with your check, to Melinda Knight, 221 Overhill Rd., Youngstown, Ohio 44512, by November 25.

Remember, this is a charitable cause to which we have a deep commitment. Please be generous and let us hear from you soon.

Mahoning County Medical Society Alliance

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____**Medical Student Assistance Fund** — provides funds for student financial aid in the form of scholarships, grants, and loans.

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(Print name as it should appear on Holiday Sharing Card.)

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YOUNGSTOWN, OH 44512
782-2821

On The Cover

My Garden, 1900-03

Oil on canvas, 41 x 40" (104.14 x 101.60 cm.)
By Gari Melchers (1860-1932)

INTERNATIONALLY CELEBRATED AS A MAJOR LATE NINETEENTH-CENTURY PAINTER, GARI MELCHERS PRODUCED HUNDREDS OF PAINTings in studios in France, Holland, Germany and America. His success began early when one of his paintings, *The Letter* (c. 1882, The Corcoran Gallery of Art, Washington, D.C.), was accepted at the Paris Salon in 1882. In 1889, Melchers was awarded a grand prize medal in the American painting section at the Universal Exposition in Paris, an honor bestowed only upon Melchers and John Singer Sargent. That Melchers was an honored painter in Europe and America is clear from his long exhibition history, the awards he won, the commissions, and the number of his works purchased by museums and collectors in this country and abroad.

The basis for Melchers's art can be found in his childhood within Detroit's German immigrant community and his early instruction, both from his German-born artist father and at the academy in Düsseldorf, where he learned sound academic principles and a commitment to solid images. After graduation Melchers entered the Académie Julian in Paris and subsequently was accepted at the Ecole des Beaux-Arts. In 1884, he joined George Hitchcock in establishing a permanent studio in the Egmonds, Holland. Monumental paintings like *The Sermon* (1886, National Museum of American Art), and *In Holland* (1887, Belmont, The Gari Melchers Estate and Memorial Gallery, Fredericksburg, Va.), which used as models the townsfolk of the Egmond area, established Melchers's reputation as a painter of Dutch scenes that celebrate the virtues of an unsophisticated life of hard work and pious reverence. However, Melchers's diversity of styles and subjects is remarkable. At the beginning of his career in the early 1880s, he painted the peasants of Brittany and Holland in realistic depiction based upon his Düsseldorf training, the Hague School artists, and the Paris Salon. In the late 1880s and the 1890s, his art was influenced by Symbolism, and at the turn of the century he turned to Impressionism for inspiration. Melchers's interest in Impressionism, as with other styles of painting, was assimilated from sources in France, Germany, and America. This combination, seen in *My Garden*, has been appropriately described as a "lightened palette of academic Impressionism, which, combined with careful drawing, constitutes an international style hailed by contemporary critics."

My Garden was painted at George Hitchcock's home, "Schuylenburg," in Egmond aan den Hoef, one of three Dutch villages clustered along the North Sea shore that share the name of Egmond. Beginning in 1884 when they shared a studio, Melchers and Hitchcock maintained an enduring friendship. By the early 1890s Egmond had become the summer home to students attracted by their success. Because of this influx, including many Americans on break from art schools in Paris, Hitchcock established a school at Schuylenburg. While Melchers chose not to teach on a formal basis, he was active in art discussions and critiques. In 1903, Melchers married Corinne Mackall, who had studied with Hitchcock. Although they established their own home and Melchers painted a number of outdoor scenes there, he continued to paint at Schuylenburg as well.

Exact dating of the landscapes and interior genre scenes from this period is not always possible. In *Gari Melchers: A Retrospective Exhibition*, the work is dated c. 1903 and described as "the first of several intimate garden scenes..." Based upon its style and title, suggesting the period before Melchers and Corinne had their own garden, the date of 1900-1903 seems likely.

The scene is from across the pond towards the impressive seventeenth-century farmhouse and large tree-shaded lawn where three servant girls, dressed in black-and-white uniforms, share a moment of conversation. A postcard from the same period, with a similar viewpoint and showing the statue of a cherub standing in the pond, may have served as Melchers's initial inspiration for the painting, or the picture may have inspired the postcard. Whatever the case, the bold, robust brushstroke and glorious palette of yellows, pinks, blues, and green infuse the setting with vitality and with the glowing warmth of an idyllic autumn day.

Diane Lesko

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

MCMS New Members

Robert A. Felter, MD
Pediatric Emergency Medicine
Office: 500 Gypsy Lane Phone: 740-3908
MED. ED: Georgetown Univ. School of Medicine, Wash., D.C.
INT: Naval Regional Medical Center, San Diego, CA
REDCY: Naval Regional Medical Center, San Diego, CA
SPONSORED BY: J. James Anderson, MD; John S. Venglarcik, MD; Kurt J. Wegner, MD

Arthur P. Wood, MD
Otolaryngology, Head & Neck Surgery
Office: 7227 Glenwood Avenue Phone: 629-2144
MED. ED: Pa. State Univ. School of Medicine, Hershey, PA
INT: Mayo Graduate School of Medicine, Rochester, MN
REDCY: Mayo Graduate School of Medicine, Rochester, MN
SPONSORED BY: John W. Babyak, MD; James A. Lambert, MD; Eugene L. Potesta, MD

The following applications for membership were approved by Council:

FIRST YEAR IN PRACTICE:
Gregg L. Bogen, MD
John E. Fassler, MD
Michael P. Haggerty, MD
Kevin A. Spear, MD

ACTIVE:
Michael W. Burley, MD
Raul Lopez, MD

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

AMA Report

continued from pg. 8

ies to develop programs that would facilitate referrals to physicians who are qualified to provide necessary palliative care, as well as the physiological and psychological needs of patients seeking help at the end of life. Also recommended was the establishment of a faculty of physicians with expertise in end-of-life care, that could provide consultations for other physicians caring for these patients.

The AMA House of Delegates discussed, in some detail, the point-of-service option. In the end, the delegates voted to reaffirm the existing AMA policy, that restrictive plans offer an optional point-of-service feature so that patients who choose such plans may elect to self-refer to physicians outside the plan at additional cost to themselves.

I found the annual meeting to be very educational, and I came away with the feeling that Ohio physicians are well represented. I have been impressed by the leadership of the Ohio Delegation and feel that our Delegation was well prepared for the annual meeting.

The AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the AMA may present testimony at the Reference Committee Hearings, and of course discussions on the issues provide ample opportunities to get your views across.

If you cannot come to the meeting, you can still be represented through your delegate or alternate. Let your Delegation know your opinions. You can even prepare a resolution and request that it be submitted to the House of Delegates. Remember that you do have an AMA presence within your community. Your delegates and alternates know how to carry forth your point of view, so make it a point to let them hear from you. Thank you for the opportunity to present this report.

Diagnosis Coding Can Affect Your CASH FLOW!!

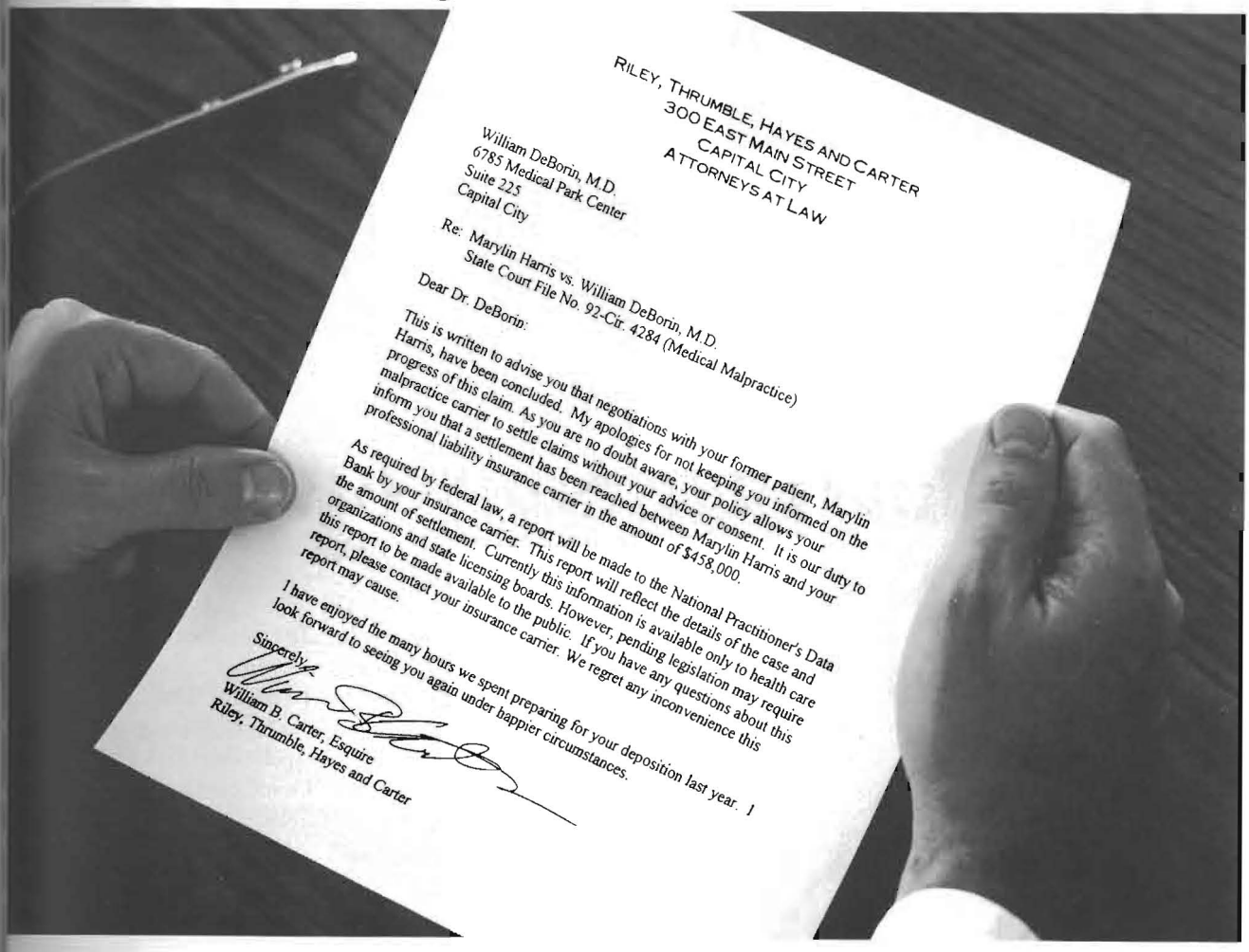
Starting in July, Nationwide Medicare began rejecting claims submitted with incomplete or invalid diagnosis codes. This was in accordance with instructions received from the Health Care Financing Administration (HCFA).

Effective for claims processed on or after October 1, 1996, physicians may use the 1997 updated ICD-9-CM codes. Claims processed on or after January 1, 1997, must contain the most recent (1997) valid diagnosis codes.

Failure to submit claims with incomplete or invalid diagnosis codes will result in a rejection of your claims. Beginning January 1, 1997, failure to submit claims with ICD-9 codes for 1997 will also result in a rejection of your claims.

It is imperative that you purchase a new ICD-9 code manual each year. You may wish to contact the publisher of your current manual to obtain a new manual for 1997. These ICD-9 code manuals are also available at medical bookstores. Providers interested in obtaining an ICD-9 code manual on CD-ROM can contact the Government Printing Office at (202)512-1800.

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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AMA

AMA Persistence Brings New Antitrust Rules

THE PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION DECLARED THE REVISIONS OF THE ANTITRUST GUIDELINES released by the Federal Trade Commission and the Department of Justice "a significant step forward in ending the discrimination of prior agency policies against physician joint ventures."

Said Daniel H. Johnson, Jr., MD, AMA president, "The revised guidelines should result in more choice for patients, more competition, and better health care. Our persistence has paid off. There is more to be done, but the agencies have done three things we asked for:

"First, they have acknowledged the fundamental changes in the health marketplace, in particular the power of insurance companies and employers, and the benefits to patients of physician designed and controlled ventures.

"Second, they have agreed not to hold physician joint ventures "per se" unlawful simply because they do not reimburse physicians under a capitation mechanism, whereby physicians were rewarded for providing fewer services. Fee for service ventures and other kinds of arrangements will now be given an opportunity to demonstrate their merits under a "rule of reason" test, if they are otherwise true joint ventures.

"Third, agencies will now permit physician joint ventures of the size necessary to be competitive. Patients want choice of physicians and plans. The agencies will not block plans with 50 percent of physicians in competitive marketplaces. Insurance companies have never had to limit the size of their plans. The narrow "safety zone" formulas are not to be taken in any way as maximum tests.

"We believe in an open marketplace and we believe in the value of the patient-physician relationship. Neither ideal was given adequate weight in prior agency interpretations of the antitrust laws."

The revised antitrust guidelines resulted from an intensive three-year campaign by the AMA aimed at removing barriers to physician joint venture networks. The campaign also resulted in the introduction of the "Hyde Bill" (H.R. 2925), sponsored by Rep. Henry Hyde, (R, Ill.), chairman of the House Judiciary Committee, with 153 bipartisan co-sponsors. The bill would require a "rule of reason" approach to physician networks.

"FTC Chairman Robert Pitofsky, Assistant Attorney General Anne Bingaman, and their respective staffs have responded with a more reasonable set of enforcement policies," Dr. Johnson said.

"While today's action represents a milepost, we still have a way to go before we reach a level playing field," he added. "The health care market is undergoing rapid changes. Antitrust and other regulatory policies will require even deeper adjustments. We will continue to work with Mr. Hyde and other Congressional supporters on reasonable antitrust policy.

"Finally, it should be noted that the new antitrust guidelines represent a defeat of an intense insurance industry campaign to block changes in policy. Physician networks now have a great chance to compete effectively with commercial companies, and expand the range of choices available to our patients."

For further information, contact James Stacey at (202) 789-7419.

Medical Licensure in the 1990s—and Beyond

ON JULY 20, 1996, AS PRESIDENT OF THE AMERICAN COLLEGE OF INTERNATIONAL PHYSICIANS (ACIP), I WAS pleased to address the organization at its annual meeting and to share the podium with Ray Bumgarner, the Executive Director of Ohio's State Medical Board, an internationally recognized expert on medical licensure and discipline. Our goal was to conduct a "mini-seminar" about the role of state medical licensing boards across the country, the discrepancies that still exist and what the future holds.

Although our presentations were directed toward an international audience, I believe that the topics addressed are of general importance for any physician who plans to be a part of the rapidly changing health care system in the United States.

In this issue of the *Bulletin*, I'd like to share some insights about the national move toward centralized credentialing. Our remarks about the emerging role of state medical boards as arbiters of the nation's medical care will be summarized in a future issue.

A RATIONAL LICENSING SYSTEM

Ray Q. Bumgarner, Executive Director,
State Medical Board of Ohio

Those who successfully navigate the backwaters of the U.S. medical licensing system and achieve licensure in at least one state deserve our congratulations, for not everyone escapes that rite of passage to physicianhood unscathed. Unfortunately, those who

- embark upon a change in career path,
- or change location,
- or, with the ascendancy of managed care, have a change forced upon them

will be required to renavigate the licensing system, often under a different set of rules, being treated all the while as if they had never previously held a license to practice.

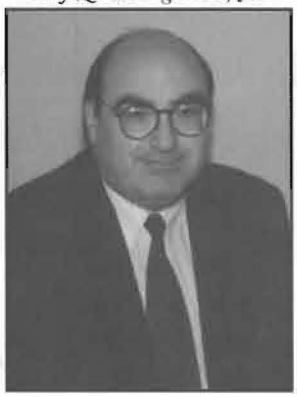
How could such a patchwork quilt of a medical licensing system evolve? The answer is largely political. After all, the American political-legal system is based upon federalism, featuring multiple states, with the U.S. Constitution reserving to each state the general police powers necessary to protect the health, safety and welfare of its citizens, and each state having authority to enact its own laws. Consequently, we have reached the current state of affairs simply because each state has been free to adopt its own, sometimes shortsighted, approach over the past 100 years or so, with each state convinced that its own way is best.

The goal here is not to tell you exactly what documents will be required by a particular state, or how long the licensing process is likely to take. Only representatives of the licensing authority from the state in question should be relied upon to provide that information. Providing some general information about the licensing requirements of the fifty states, however, cannot hurt. A short synopsis of comparative information from the 1995-1996 Federation of State Medical Boards *Exchange* booklet can be revealing.

For instance, one stepping stone to licensure in many states is graduation from an "approved" medical school, required for initial licensure in 36 states, while for endorsement licensure in 34 states. Yet the definition of "approved medical school" may not be consistent from one licensing jurisdiction to another.

Anand G. Garg, MD, PhD

Ray Q. Bumgarner, JD



Completion of graduate medical education obviously represents a second stepping stone to medical licensure in the U.S. From the Federation information we can summarize the accredited training requirements for initial licensure. Here, "accredited training" means training that has been recognized by the Accreditation Council for Graduate Medical Education (ACGME) in the U.S. or the Royal College of Physicians (RCP) in Canada.

For initial licensure:	*Foreign school*	*U.S. / Canadian school*
3 years	*24 states*	*3 states*
2 years	*10 states*	*8 states*
1 year	*12 states*	*40 states*
Unspecified	*5 states*	*0 states*

Turning to endorsement licensure, we find somewhat different requirements for graduate medical education.

For endorsement licensure:	*Foreign school*	*U.S. / Canadian school*
3 years	*20 states*	*2 states*
2 years	*9 states*	*7 states*
1 year	*12 states*	*39 states*
None	*1 state*	*0 states*
Unspecified	*9 states*	*3 states*

The problem with these statistics, however, is not just that they illustrate glaring inconsistencies in licensing requirements from state to state. In fact, the numbers themselves are not comparable. Some states, for instance, may impose different graduate medical education requirements based upon whether or not the applicant graduated from an "approved medical school". Other states may accept equivalent training or experience as a substitute for part of the graduate medical education requirement. Truly, the only certainty here is uncertainty.

Of course, a myriad of additional requirements for medical licensure exist above and beyond the educational component. Some typically faced when endorsing a medical license from one state to another include:

- ECFMG certification
  - -37 states require submission of the either one's original ECFMG certificate or a photocopy of that certificate
  - -Three states have established limits on the number of times a candidate is allowed to sit for the ECFMG certification examination before passing
  - -One state requires that the applicant must have successfully completed the ECFMG examination within the last 10 years
- Documentation of having passed an English proficiency test is required by 14 states. Interestingly, only seven states require it for initial licensure.
- Documentation of eligibility for licensure in one's country of training is required by 11 states.
- Submission of original educational credentials from one's country of training is required by 27 states.
- A certified translation of foreign language documents is required by 43 states, and one board may request a translation at its discretion.
- Personal interviews are required of endorsement licensure applicants by 18 states, while 6 states reserve the right to interview applicants at their discretion.
- Oral examinations are required of endorsement licensure applicants in five states, while one state may require such an examination at its discretion
- SPEX examination is required by nine states, while nine other states may exercise this option in their discretion.

A logical question is whether the current U.S. medical licensing system can be characterized as a rational one. In my opinion, it's doubtful at best. Can anything be done about it? My personal response, at least, is "yes". A better job can be done on behalf of the profession and

State Medical Board of Ohio

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the public alike. But will we actually do anything to improve it? Of that, unfortunately, I cannot be sure. Nevertheless, some progress has already been made, and exciting opportunities for landmark improvement lie just ahead.

Many of you are familiar, I am certain, with the 1990 General Accounting Office Report on Medical Licensing by Endorsement, which, in my opinion, concluded the obvious—that licensing requirements differ in the U.S. for graduates of foreign and American medical schools. In its body, that report categorized standards for medical licensure as falling within three interrelated areas:

1) education standards;
2) examination standards; and
3) experience standards.

By reviewing national data and visiting six states, GAO surveyors concluded that educational standards and documentation requirements for medical licensure tend to be similar throughout the U.S. Examination and experience requirements, however, often differ.

Although the GAO report failed to inspire immediate change, it did recognize the difficulty some graduates of foreign medical schools have in documenting their education and called attention to the need for a clearinghouse to maintain and verify such records. Of course, a fair question would be to ask how much progress has been made on the national front subsequent to that report. On at least one successful note, the Federation of State Medical Boards and the National Board of Medical Examiners have, since 1990, combined forces to originate a so-called "single examination pathway," the United States Medical Licensing Examination (USMLE) for all who desire to enter graduate medical education or obtain a medical license in this country. That's one mission accomplished.

The Federation of State Medical Boards, recognizing concerns about variance in the remaining licensing standards and requirements, also hosted a discussion among state medical board executives in April 1993 to address endorsement licensure issues. Some general conclusions arose from those discussions. Two, in particular, were that

- There will likely be greater impetus for physician mobility in the future, not less, and
- Licensure should not unnecessarily impede mobility.

Perhaps, in retrospect, what happened at the Federation meeting will turn out to have been of critical importance to the future of medical licensure in the U.S. For a consensus was reached, among the very individuals largely responsible for managing and maintaining the current licensing system, that improvements were needed. Moreover, there came a realization that significant change could be accomplished.

As a result, 1993 Federation President Dr. Hormoz Rassekh established a special Ad Hoc Committee on Licensure by Endorsement. That committee promptly and methodically set about the business of reviewing past and present trends, establishing goals, crafting definitions, developing guidelines for the member boards, and formulating recommendations.

Although inevitably falling short of providing answers to every challenge presented by the existing licensing system, the committee recommendations, as subsequently adopted by the Federation at its annual meeting in the spring of 1995, do lay the foundation for a new licensing architecture in the U.S. The Federation, in a valiant effort to "shake up" the existing system, has now formally suggested to all medical licensing boards that:

1) Applicants for endorsement licensure should provide evidence of identity, medical education and training, and of having passed an approved licensure examination.
2) State medical boards should recognize and accept a collection of specific core licensing documents. The required items for purposes of identification would be a recent photograph, a birth certificate or passport, and any applicable name change documents. Items for purposes of demonstrating medical education and training would be an MD diploma or its equivalent, a medical school transcript, any applicable clinical clerkship documentation, and graduate medical education documentation. Documentation of USMLE Steps 1, 2, and 3; USMLE approved exam-

nation combinations; old state licensure examinations; the FLEX; National Board examinations; and the LMCC would suffice for examination information.

3) A central credentials verification service should be established for verifying, authenticating and archiving the core licensing documents as identified above.
4) State medical boards should initiate use of, and promote use of, such a service.
5) Applicants for licensure by endorsement should provide supplemental documentation to evidence sequential and continuous post-licensure experience.
6) State medical boards should develop mechanisms to identify specific applicants who should be required to demonstrate current competence.
7) State medical boards should review their requirements for licensure by endorsement in an effort to identify any possible barriers to license portability.
8) State medical boards should adopt policies or regulations to allow licensure by endorsement for applicants meeting the requirements in effect as of the date of the applicant's initial licensure in the U.S.

An underlying premise of the Federation recommendations is that candidates for licensure in the U.S. should be able to provide their core education and training documents to a centralized repository to be maintained by the Federation of State Medical Boards only once, ordinarily at the time of their initial licensure application in the U.S. The core documents could then be authenticated by the Federation through primary source verification and permanently stored, to be accessed and relied upon in the future by all state licensing boards as the practitioner moves from state to state. The repetitive, almost pernicious, document chase as we know it today could then become a thing of the past.

Shortly following acceptance of the Ad Hoc Committee's report by the Federation's member boards, and a subsequent detailed study, the Federation's Board of Directors voted to implement the suggested credentials repository and verification service, now labeled with the acronym FCVS – for Federation Credentials Verification Service.

In December 1995 Ohio became the first state to endorse exclusive, prospective use of the FCVS, effective upon its availability to all Ohio license applicants. As it stands now, Utah and Wyoming will be the first states to use the FCVS service, beginning in August 1996. Ohio will join in September, with Georgia, Maryland and Virginia to follow in December. In addition, 14 medical boards have agreed at the time of writing to accept FCVS-verified documents. They are

Arizona	Massachusetts
California	Montana
Hawaii	New Hampshire
Idaho	New Mexico
Indiana	Oregon
Kentucky	Rhode Island
Louisiana	Texas

I think most of us would agree that the existing licensing system deserves change. Inequities and delays abound. Attempts at change, however, do not always flourish when initially proposed. When the Federation of State Medical Boards, for instance, introduced the FLEX in the 1960s as a national examination for medical licensure in the U.S., it took a number of years for universal acceptance to follow. The current effort to create a single, nationally-recognized repository and source of licensing credentials for everyone must likewise overcome significant bureaucratic inertia to succeed in the 1990s. Yet the FCVS offers a step toward significant renovation of the U.S. medical licensing system. Its adoption nationwide could herald removal of other barriers to a rational licensing system. For that reason alone, the FCVS deserves our endorsement and encouragement—as long as it meets expected standards for quality. And should idealism prove insufficient motivation for support, one can always cite the potential advantages offered by "one-stop" access to vital licensing documents and credentials.

Medical Board staff members Lauren Lubow and Joan K. Wehrle assisted with this article.

From the Bulletin

A Look Back...

Sixty Years Ago
July/Aug., 1936

As usual, July brought the arrival of new interns. At St. Elizabeth's, **Murrill Szucs** was the new medical resident, and the surgical resident was **J.K. Herald.** The new interns were **Michael Sunday, Stephen Ondash** and **Andanto D'Amore.** At YHA, **John Renner** and **John Rogers** stayed on as residents, and new interns were **Barclay Brandmiller, Gabriel DeCicco, Rollis Miller** and **Milton Yarmy.**

Fifty Years Ago
July/Aug., 1946

It was the 100th anniversary of the Canfield Fair, and **Stuart Patton** was in charge of the medical exhibit. Only six members volunteered to man the exhibit, which was the first exhibit to show 100 years of medicine with old equipment, old pictures and even an "iron lung". **J.L. Fisher** wrote a humorous article about the problems that the returning veteran physicians had with learning the names of all the new pharmaceuticals that had come out while they were in the service. **Horace K. Giffin,** chief of pathology at YHA, reported a case of leprosy, diagnosed from a skin biopsy sent in by a Dr. Hubler.

Forty Years Ago
July/Aug., 1956

President **Gabe DeCicco** pondered whether patients should be told the whole truth when they have a fatal disease. **Robert Wiltsie** opened an office for the practice of pediatrics in the new Wickliffe Medical Center. **Kurt Wegner** joined **Sidney Davidow** in the practice of pediatrics. **Milton Steinberg** was elected a Fellow in the American College of Angiology. St. Elizabeth's and Youngstown Hospital each held their ex-intern and resident day on June 21, at different locations.

Thirty Years Ago
July/Aug., 1966

President **Art Resch** wrote that the family physician was becoming extinct, and that family practice was becoming the step-child of medicine. Editor **Bob Jenkins** wrote that the County Medical Society had the "care and feeding of the physicians as its primary interest". He pointed out that the meetings were good, the food was good and the fellowship with our peers was good for all members.

Twenty Years Ago
July/Aug., 1976

Publication of the *Bulletin* was suspended during the summer months of this year. No information is available.

Ten Years Ago
July/Aug., 1986

Publication of the *Bulletin* was suspended during the summer months of this year. No information is available.

Robert R. Fisher, MD

Robert R. Fisher MD

FROM THE OSMA

Are you paid promptly?

Members who fail to receive prompt payment from insurers, as required by the 1988 prompt-pay law, have a new recourse. The Ohio Department of Insurance has dedicated one of its staff members to work with the OSMA's Ombudsman office to resolve prompt-pay problems between members and insurers. While most cases are able to be resolved between the physician and the carrier, or the OSMA and the carrier, members who aren't reimbursed promptly for services will now have an opportunity for an ultimate review outside of the carrier. For more information, contact Bill Fry, OSMA Ombudsman, at 1-800-766-6762, Ext. 213.

$825,000

Abutting Squaw Creek Country Club golf course, this fabulous home features a marble foyer with one of a kind staircase, warm living room and den with oak floors, millwork and beautiful built-ins, formal dining room and butler service pantry, gourmet kitchen, four bedrooms plus guest quarters, office, 5.5 baths on a double lot.

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Liberty/Hubbard classic Southern Georgian on about 8 acres with a nine stall horse barn and indoor riding arena, tackroom & paddock...additional income form the garage apartment and a traditional quality built main home with beautiful views and accommodations; a third floor live-in features 2 bedrooms, bath & living area trimmed beautifully in knotty pine.

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Exclusive Audubon Woods in Poland Village has a home for sale and it is priced to move...about 1 acre on the wooded cul-de-sac sits a quality built four bedroom two story featuring a fireplace in the family room & den/ study, formal dining room and country kitchen and a private setting for the screened porch.

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Seclusion, quality and dramatic rooms and views are the hallmark of this Liberty classic...about 5000 sq. ft. on 3 wooded ravine acres. Master suite with dual baths and balcony, dining room with fireplace, a cozy wood paneled den, 4 fireplaces and a protected porch to enjoy the natural surroundings.

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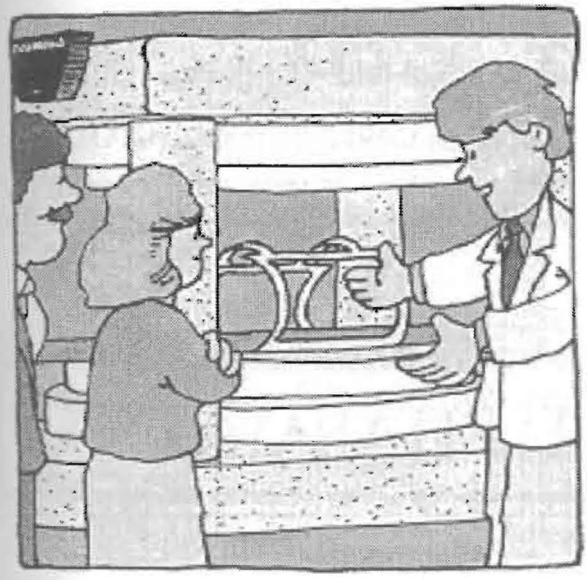

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Did You Know?

An American Medical Association study found that for the first time, physicians employed in large group practices outnumber solo practitioners. The number of solo practitioners fell to 29.3% by 1994 from 40.5% in 1983, while the number of employed physicians rose to 42.3% in 1994 from 24.2% in 1982.

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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