

INSIDE  
THIS ISSUECommunity Outreach  
Page 2, 15Physician Advocacy  
Page 3, 16, 17, 18Board Update  
Page 4, 5Legislative Advocacy  
Page 6, 7, 8, 19Practice  
Management  
Page 9Government  
Regulations  
Page 10, 11Patient Wellness  
Page 12Charitable Giving  
Page 13, 14In Brief  
Page 17Member Matters  
Page 20

## The Academy of Medicine Education Foundation (AMEF) Continues the Tradition of the Cuyahoga County Medical Foundation (CCMF)

In 1958, the Cuyahoga County Medical Foundation (CCMF) was formed by the physician leadership of the medical society then known as the Academy of Medicine of Cleveland and Cuyahoga County Medical Association. The original funding for the CCMF was from voluntary contributions as a result of successful polio vaccination programs sponsored by the Academy of Medicine of Cleveland in 1958 and 1962. The largest continuing commitment of CCMF has been student scholarship grants to worthy students in the medical field. Since 1958, CCMF has granted more than 1.3 million to such worthy, qualified students.

In 1999, the Academy of Medicine of Cleveland became known as the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA). In addition, due to the organization's name change, the AMC/NOMA physician leadership has now established a foundation known as the Academy of Medicine Education Foundation (AMEF). As of December 1, 2004, the foundation formerly known as the Cuyahoga

County Medical Foundation (CCMF) officially merged into the Academy of Medicine Education Foundation (AMEF). AMEF plans to continue the traditions and purpose of the CCMF.

The mission of AMEF is to enhance healthcare through education of the medical profession and the community. The purpose of AMEF is to add a charitable component to the AMC/NOMA and to partner with the AMC/NOMA in implementing new initiatives for both physicians and the patient population through charitable, educational and scientific efforts. AMEF enhances the philosophy of the AMC/NOMA in its focus on health-oriented education for physicians, their staff and patients by providing support for meaningful education and highlighting the value and quality of healthcare. A showcase for a philanthropic spirit is provided through the Foundation for physicians who desire to give back to the community and the profession they serve.

Over the years, in addition to providing student scholarships, the Foundation has funded the  
*(Continued on page 2)*

## President Bush's Visit to Cleveland Promotes EMR Technology to Increase Quality of Care

President George W. Bush came to Cleveland on January 27 to talk with physicians and urge their support for transforming health care from a paper-based to an electronic enterprise and AMC/NOMA physician leaders, members and staff were in attendance. Joining President Bush for the visit were Ohio Governor Bob Taft and

*(Continued on page 3)*



Secretary Michael Leavitt, the newly appointed Health and Human Services leader, introduces the President and the panel to the audience.

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**CCMF Merges with AMEF**

*(Continued from page 1)*

Sabin Oral Sunday initiative in Northern Ohio as well as a polio and tetanus immunity programs; provided funding and developed the Poison Information/Control Center in Northern Ohio; funded and administered the Tel-Med project, a program still offered to the community, by the AMC/NOMA; funded a program designed to help provide medical care to residents in the county who were unemployed; co-sponsored and funded various healthcare-related seminars and programs across the community.

The AMEF board will meet periodically to determine the appropriate usage of AMEF funds. The AMEF board may use the funds for the following charitable and educational purposes:

- (a) promoting education and research in the field of medicine by the establishment or financing of fellowships, scholarships, lectures, research projects, and awards, on such terms as the Trustees may deem best;
- (b) providing and promoting educational programs on the science of medicine, including presentations on clinical care and new procedures;
- (c) providing and promoting health education for the welfare of the community, identifying public health issues and unmet community health care needs and make proposals for dealing with such issues and filling such needs for the benefit of the public;
- (d) maintaining and providing educational materials and publications concerning health care to the members, related public service organizations and citizens of the community;
- (e) supporting medical education at local medical schools by providing lectures and counseling services;
- (f) supporting local public health programs and initiatives;
- (g) sponsoring seminars on topics of medical education and public health issues;
- (h) assisting in the production of educational radio and television programs, telephone recordings, and computer and electronic programs and materials, designed in each case to educate members of the general public on matters of health care and public health issues;

- (i) making grants, donations, or contributions of funds or other property in the trust estate to other charitable, scientific, and educational trusts, organizations or institutions, organized and operated for any of the purposes set forth in subparagraphs (a) through (h) above, or for uses that are in furtherance of any of the other purposes of this Trust, including for medical research and education, public health programs, and public and community education relating to health care and wellness programs, provided that no part of the net income of such trusts, organizations, or institutions inures to the benefit of any private shareholder or individual and that no substantial part of the activity of such trust, organization, or institution is the carrying on of propaganda, or otherwise attempting to influence legislation, or participating or intervening in any political campaign.

The first meeting of the AMEF board took place in early February and determined that AMEF will continue to provide scholarships to third and fourth year medical students who have been or are residents of the Northeastern Ohio counties, are attending Case Western Reserve University School of Medicine, Cleveland Clinic Lerner College of Medicine of Case Western Reserve University, Northeastern Ohio Universities College of Medicine, or Ohio University College of Medicine. Additional information on the criteria for these scholarships will be provided in future publications and disseminated to the referenced medical schools. Scholarships will be presented at the AMC/NOMA Annual meeting each year.

The AMEF board also approved co-sponsoring the March 2005 seminar entitled "Developing New Directives for Addressing Patient Safety and Medical Liability in Northern Ohio" — a seminar that will outline other forms of alternative dispute resolution mechanisms as well as provide information on how to bridge the gap between patient safety and medical liability.

In addition, the AMEF board-approved AMEF co-sponsorship and funding of the well-established and well-known *Healthlines* radio program — a program that provides healthcare-related information to the community. This sponsorship will provide AMEF with an opportunity to become better known to the community and the physicians who appear on the program.

Please mark your calendars for the annual AMEF fundraising event in August 2005. The event is a charitable golf outing in memory of Marissa R. Biddlestone, the daughter of the executive vice president and CEO of the AMC/NOMA who succumbed to leukemia. The event will be held August 8, 2005 at the Chagrin Valley Country Club. Last year's event raised more than \$38,000 for AMEF, and these funds will be utilized for medical student scholarships. Please plan to attend this worthwhile event — or if you do not golf, consider a donation to AMEF. Brochures will be sent out in the coming months.

Included in this issue of the *Cleveland Physician*, is an article about charitable giving. In addition, members will soon receive a mailing from AMEF asking for contributions along with a brochure relative to charitable bequests. Please plan to contribute to AMEF — your support is greatly appreciated.

**MEET THE AMEF BOARD OF TRUSTEES:**

The AMEF Board of Trustees is comprised of dedicated individuals who have the vision to see the value of a charitable component to the AMC/NOMA. The Foundation Board of Trustees is responsible for making decisions, developing policy, and providing specific direction to the Foundation. The Foundation Board of Trustees is committed to the mission and purpose of AMEF.

- Ronald A. Savrin, M.D., *President*
- John A. Bastulli, M.D.
- Richard B. Fratianne, M.D.
- Kevin T. Geraci, M.D.
- Edward Kilroy, M.D.
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- William H. Seitz, Jr., M.D.

Elayne R. Biddlestone,  
*Secretary-Treasurer*

AMC/NOMA members who wish to make a donation to AMEF or require additional information regarding the foundation, our seminar, or the upcoming fundraising event, please contact Ms. Elayne R. Biddlestone at the AMC/NOMA offices. ■

## President Bush's Visit to Cleveland Promotes EMR Technology to Increase Quality of Care

(Continued from page 1)

U.S. Reps. Ralph Regula (R-Canton) and Steven LaTourette (R-Painesville).

The event, entitled "A Conversation on the Benefits of Health Care Information Technology with President George W. Bush and The Cleveland Clinic," brought the new Health and Human Services (HHS) Secretary Michael Leavitt, to our city on his first full day on the job, to introduce the President.

Among the President's guests who discussed their experience with electronic medical records (EMR) were: Dr. C. Martin Harris, the Clinic's Chief Information Officer; Dr. Robert Juhasz, a CCF primary care physician; a CCF patient; Dr. Jorge del Castillo, associate chief of emergency medicine at Evanston Northwestern Healthcare in Illinois; Barth Doroshuk, president and CEO of a Washington ENT group; and Dr. David Brailier, the new national health information technology coordinator.

Bush discussed the need to shift away from paper-based medical records. He indicated, although the medical field has implemented advanced technology, it still has not caught up to other industries' use of information technology to make their businesses more cost-effective and efficient. He described the technology changes in medical care machinery as "fantastic" and feels its expanded application to medical records and prescription writing is the logical next step.

"We've got fantastic new pharmaceuticals that help save lives, but we've got docs still writing records by hand. And most docs can't write very well anyway...can you?" the President said, a comment that drew laughter from the audience.

Prior to introducing Dr. Brailier, the President drew applause from the audience when he stated that in addition to working toward an electronic medical record system he is working to ensure there is a fair and balanced judicial system put into place in the United States. He stated, "The members of Congress and the Senate must realize that the medical liability crisis is driving physicians out of practice and we need medical liability reform right now."

Dr. Brailier, a former Senior Fellow at The Health Technology Center in San Francisco, is providing national leadership and the coordination necessary to



President Bush moderates the panel in a discussion about electronic medical records.

achieve the President's 10-year goal. In Cleveland, he outlined four goals: to make information available across the country through the use of a "medical Internet"; ensure that physicians are able to use electronic health records; allow patients to view their own health information; and modernize the manner in which government reports public health information.

Dr. Harris stated the real value of electronic medical records is what can be done with the data. With more than 1,200 physicians from CCF using this tool, he knows there are many ways the technology helps treat patients. Among them are increased efficiency, patient safety and patient accountability. He said since physicians can readily access data, their charts are accessible when a patient comes to the main campus from a satellite office. He relayed to the audience the technology helps with patient safety issues. For example, prescriptions are now checked by computers looking for any adverse drug event. He said the technology also helps improve the overall quality of care. Patients can enroll in the CCF's MyChart program, an Internet tool allowing patients to access their personal health information. This tool also allows patients to view their lab tests, renew prescriptions and view health maintenance alerts. He explained the patients are active participants in the health care decision-making process. Dr. Harris reiterated this is all done in an environment where the information is secure.

The President commented he would like to see these types of networks grow but they have to be able to "talk" to one another on a national basis. He said, "We will need interoperability, but confidentiality must be maintained."

Dr. Juhasz presented his viewpoint on how EMR has assisted him in streamlining his practice, located about 15 miles from CCF's main campus. After using the technology, he is able to enter patient data in the records using charting tools; and the patient can participate during that time in giving an accurate history. He also has the ability to look at any test-

ing or consultations performed on the patient previously at another location. Patients can review test results as well as their doctor's notes. He noted EMR has really assisted him in efficiently and effectively running his practice. One of Dr. Juhasz's patients provided her input on how the MyChart program has helped her to understand her lab results as well as provide peace of mind during the course of her treatment. Also presenting the viewpoint of a small practitioner's office that utilizes EMR was Barth Doroshuk, from a Washington, D.C. ENT group.

Dr. Jorge del Castillo, indicated his healthcare group implemented EMR two years ago and it has completely changed the record keeping process. Dr. Castillo indicated it would be a boon to the nation if physicians could log on to a main database and get information on patients across the United States.

The President said he believes the cost benefit realized by the implementation of EMR across the nation would be tremendous — not only for large practices but for private practitioners as well. The President indicated the federal government's role is to help people get started in this process and to provide funding to make this a reality.

(Note: In December 2003, Bush signed into law the Medicare Modernization Act, which directed the NCVHS to develop recommendations for standards for electronic prescribing in the ambulatory-care setting. President Bush's budget for FY 2006 would increase to \$125 million funding for demonstration projects to test the effectiveness of health information technology, and allow for widespread adoption in the health care industry. The administration said it is also seeking an additional \$50 million for the current fiscal year; in addition to \$50 million Congress previously appropriated, to support use of such technology.)

**The AMC/NOMA salutes our members and the staff at the Cleveland Clinic Foundation for arranging this event. ■**



## Ohio State Medical Board Update

At a recent AMC/NOMA Board of Directors meeting, Mr. Tom Dilling, executive director of the Ohio State Medical Board, announced he has chosen to step down for personal reasons and the Board is currently looking for his successor. The core of the State Board remains the same and the officers will remain the same. The role of the Board is to protect and enhance the health and welfare of Ohio's citizens through effective regulation. The AMC/NOMA Board thanked Mr. Dilling for his many years of hard work on behalf of the medical profession.



Mr. Tom Dilling, executive director of the Ohio State Medical Board, addresses the AMC/NOMA Board at their January meeting.

### Allied practitioners

Mr. Dilling briefly discussed the issue regarding requests by allied practitioners to change their scope of practice through the legislature. Mr. Dilling mentioned the physician assistant legislation will be back for review again this year. He also mentioned there was a movement over the past few months by pharmacies to provide rapid strep tests to customers at their stores in Columbus and Toledo. The State Board was able to intervene and stop the practice, which the Board considered the unlicensed practice of medicine, but this issue will more than likely arise again. In a related matter, the Federation of State Medical Board is considering adopting guidelines on what states should address when dealing with scope-of-practice issues. Some points to be presented for adoption at the FSMB May meeting include: whether the scope-of-practice change is needed; and whether the need can be verified; impact on patient safety; the licensure certification and registration processes set up to handle the scope-of-practice change; if independent practice is called for or if physician collaboration or supervision is needed; and what financial implications are tied to the change in scope of practice. AMC/NOMA will keep our members informed of any legislation in Ohio related to scope of practice change requests.

### State Board Web site changes

Mr. Dilling then mentioned the State Board of Ohio was one of the states to pilot the online licensure renewal. As of November 1, 2004, licensees had the ability to renew their licenses online. Physicians eligible for renewal receive a letter from the Board explaining how to use the new service. In addition, it is easy for licensees to keep address infor-

mation up-to-date with the use of the Board's online change of address link at [www.med.ohio.gov](http://www.med.ohio.gov).

### Changes in medical education venues:

There are growing concerns on the part of State Medical Boards relative to offshore medical schools offering MD degrees to those holding other professional titles (such as chiropractors and dentists) through accelerated online coursework and minimal clinical experience. It was reported that the Federation of State Medical Boards has formed a Special Committee on the Evaluation of Undergraduate Medical Education to study such issues.

### Disciplinary activities/medical experts

The State Board of Ohio remains strong in their disciplinary activities. They are doing more with the Quality Improvement Project panels. The Board has had some concerns about the time needed for experts to review materials for the Board as well as the difficulty in locating experts in some clinical fields. A "Call for Experts" has recently been posted on the Board's Web site. This link explains the need for experts, the expectations of experts, and an informational questionnaire for completion and return to the Board's offices.

In a related matter, Mr. Dilling reported that Ohio HB 215 (Medical malpractice claim review) went into effect on September 13, 2004. Key provisions of the bill include:

- Clarifying that the Ohio State Medical Board's jurisdiction over out-of-state doctors who testify as experts in malpractice trials extends beyond the time of their actual testimony as the doctor licensed in another state is "deemed to have a temporary license" in this state solely for the purpose of providing testimony;
- Establishing qualifications for expert witnesses who provide testimony.

The Board will be reviewing these provisions in the future.

### Obtaining physician practice data

At the invitation of the State Board, the AMC/NOMA recently participated in a conference conducted by the Federation of State Medical Boards and the Association of American Medical Colleges (AAMC). The goals of the new AAMC Center for Workforce Studies are to study and document physician workforce issues related to supply, demand, use and distribution by specialty and region. In addition, the Center wants to undertake and promote more systematic physician workforce data collection and analysis with the assistance of physician associations, medical schools and others. The AAMC has been working to collect data to try to answer future supply and demand questions relative to the physician workforce.

AAMC believes medical school enrollment has not kept pace with the growing population. Looking to the future, the demand for physicians in 2020 will exceed the supply. The key factors influencing future demand for physician services are: growth of the population; aging of the population; increasing rates of utilization; advances in medicine leading to improved diagnosis and treatment, not prevention; economic growth of the nation; changes in the delivery system; insurance and financing; and cost containment efforts.

The key factors influencing the future supply of physicians include changing lifestyle choices of physicians including hours of work, along with the aging of the physician workforce and retirement patterns. This could result in the increased use in the future of nurse practitioners, physician assistants or other clinicians. AAMC has noted that on average physicians practice between 30 to 35 years before retirement and physicians

*(Continued on page 5)*

**Ohio State Medical Board Update**

*(Continued from page 4)*

may need to practice longer to meet the demand. There is also concern about physicians cutting back their practice or eliminating certain services and what impact that may have in the future. In addition, it is unclear how long doctors are working in a given week. Younger physicians value lifestyle more and not practicing as many hours during the week, which will contribute to the workforce shortage issues. It was also noted there have been some real disincentives for physicians to remain in practice due to the medical liability crisis and no one is entirely sure what the expectations are from medical students either with regard to the future of the practice of medicine.

AAMC endorses a 15 percent increase in medical school enrollment by 2015 and elimination of the Medicare GME cap. The increase in enrollment could be achieved through expanding existing schools, adding new schools, and addressing high debt and high medical education issues. AAMC believes additional data and research is needed to guide medical schools, teaching hospitals, the physician community, policymakers and the public in addressing the physician workforce issue.

Based upon the above discussion, AAMC had requested a roundtable conference call with the Federation of State Medical Boards (FSMB) because they believe the FSMB and their respective state licensing Boards could play a major role in obtaining data from physicians to use in tracking the physician workforce. Every state licensure Board has re-licensure forms or re-registration forms sent to physicians. It would be beneficial if the State Boards could include a form with these documents to collect additional data. For example, in New York when a physician re-registers there is a survey included in the registration packet. This survey provides invaluable information relative to the physicians in that state.

State policymakers across the nation are asking if the medical schools are providing enough physicians in the state and whether or not the graduates from the medical schools in the state remain in the state to practice. If this data were collected through the State Boards it would allow states to compare how many physicians they have and what the trends are occurring across the nation. There is debate as to whether or not there actually is a physician workforce

shortage on the horizon. Over the next five to 10 years, state policymakers will need to understand the dynamic that is at work. The State Boards are in a great position to participate in this type of data collection. The FSMB staff asked AAMC to prepare a core set of questions that could be used in data collection at the state levels and FSMB would distribute the questions to their member Boards to get their input.

*(Note: Following the conference call, AMC/NOMA staff obtained a copy of the physician survey that is sent out in New York State. In New York, at the time of licensure and re-licensure, physicians must fill out a survey that is meant to collect data from physicians in the state on current work status; training status, and their activities in medicine (i.e., time spent in patient care, research, teaching or administration). The survey also collects physician data relative to location of schooling (including residency training) and where the physician attended medical school with specific N.Y. information listed. This helps track whether or not physicians who went to school and trained in N.Y. remained there to practice after completing their training. Other questions include: practice location; number of hospitals where the physician has admitting privileges; practice settings; and specific questions regarding percentage of payments to the physicians from Medicare, Medicaid, self-pay or Other. Specialty data is also collected along with information on what percentage of time the physician spends on direct patient care in their principal specialty. Of significant importance to states that have been impacted by the medical liability crisis, the survey would track whether or not in the 12 months following completion of the re-registration whether or not the physician plans to retire from patient care, cut back patient hours, move to another location in the state or move out-of-state. In addition, the survey asks for patient care practice status such as whether or not the practice is full and not accepting new patients, the practice is nearly full, or if they are still accepting new patients on a regular basis.*

*AMC/NOMA members will recall that over the past year there have been numerous articles published regarding the number of licenses issued by the State Medical Board of Ohio — and these articles insinuated there was no*

*shortage of physicians in Ohio due to the medical liability crisis. However, the numbers as published in the articles were misleading because the total number of licensees in the state listed included not only M.D.'s and D.O.'s but all types of licensees in the state such as physician assistants and massotherapists. The other key factor that was not tracked or published by the OSMB in their licensure data is the number of physicians on their licensure list who have cut back their practice, are planning to retire, or have moved to another part of the state, possibly due to the medical liability crisis. If Ohio utilized a survey instrument similar to that utilized in New York, this data might have been readily available. In addition, if a physician shortage is predicted in the next two decades, collection of this type of data could be useful.)*

At the AMC/NOMA Board meeting, Mr. Dilling stated that he is aware that the AMC/NOMA is interested in the State Board tracking physician-specific data to determine which physicians are remaining in the state after training here, physician practice patterns and trends and other data. In terms of the State Board collecting this type of data, the State Board would be a logical place to collect this information, but there would probably have to be some legislation to make that happen. With the new licensure timetable in Ohio and staggered renewals every three months it would take almost two years to cycle through and get data on all physicians. Mr. Dilling indicated there would have to be continued discussions or some sort of partnership developed to explore whether or not this could be done in Ohio. He indicated the Board would probably need the expertise or assistance of another entity to assist with the data collection if this project were to move forward.

**As a result of the meeting with the State Board staff, the AMC/NOMA Board of Directors plans to pursue working with the State Board and other appropriate parties to determine if collecting additional information from physicians at the time of licensure and re-licensure would be of assistance in physician workforce and practice trends, and further work with the State Board to explore how the data would be tabulated and utilized if it were collected in Ohio. ■**



## Legislation Creating a Pilot Program Mandating Arbitration of Medical Negligence Claims Prior to the Filing of a Lawsuit

John A. Bastulli, M.D., Vice President of Legislative Affairs

Over the past few months, the new AMC/NOMA lobbyists, legal counsel, staff and legislative chairman have met to formulate legislation that would allow for a pilot project in the state of Ohio to provide for an alternative dispute resolution process. This envisioned mandatory arbitration program would be created to consider the benefits of arbitration for any dispute concerning the professional negligence of a healthcare professional, hospital, or a healthcare facility. The proposed legislation would amend certain sections of the Ohio Revised Code and enact additional sections to establish a pilot program mandating arbitration of medical negligence claims prior to filing a lawsuit. The legislation is required due to the medical malpractice crisis in Ohio, which has significantly impacted patients, providers and the state's economy.

The program would be established under the Superintendent of the Department of Insurance to determine the benefits of using arbitration in medical negligence disputes. Five years after the effective date of the legislation, the superintendent shall submit a written report on the use of arbitration panels to the governor and the legislature. The legislation includes current law that provides for a four-year statute of repose for medical negligence cases. It also requires the statute of limitations be tolled until sixty days after the arbitration panel serves all parties with the panel's decision and during the process a claim could not be filed in the courts.

Under the arbitration process outlined in the legislation, a claimant must give written notice to the alleged parties involved. The notice must contain the factual basis for the claim; the standard of practice or care alleged to be applicable; the manner in which the applicable standard of practice was breached; what action allegedly should have been done to achieve compliance with a standard of practice or care; and the manner in which it is alleged that the breach of the standard of practice or care was the proximate cause of the injury claimed in the notice.

Within 150 days of receiving the notice the physician or health care professional may respond to each allegation made by the claimant or — if applicable, they may

file a motion with the court for dismissal of the claim, accompanied by an affidavit of noninvolvement. An affidavit of noninvolvement is to set forth, with particularity, the facts that demonstrate that the defendant was misidentified or otherwise not involved individually or through the action of the defendant's agents or employees in the care and treatment of the plaintiff; was not obligated individually or through the defendant's agents or employees to provide for the care and treatment of the plaintiff; and could not have caused the alleged malpractice individually or through the defendant's agents or employees in any way. The parties are to have the right to challenge the affidavit of noninvolvement by filing a motion and submitting an affidavit with the court that contradicts the assertions of noninvolvement made in the defendant's affidavit of noninvolvement.

The current law sets forth that a physician from another state who testifies as an expert witness in Ohio in any action against a physician for injury or death, whether in contract or tort, arising out of the provision of or failure to provide health care services, is to be deemed to have a temporary license to practice medicine in Ohio solely for the purpose of providing such testimony and is subject to the authority of the State Medical Board of Ohio. The conclusion of an action against a physician is not to be construed to have any effect on the Board's authority to take action against a physician who testifies as an expert witness under this section.

Current law provides that in order for a person to be deemed competent to give expert testimony, the person is currently required to be licensed by Ohio or another state, and to devote three-fourths of the person's professional time to the active clinical practice of medicine or surgery, or to its instruction in an accredited university. This section of current law has been amended to also require that the person practice in the same or a substantially similar specialty as the defendant. The law specifically prohibits a court from allowing an expert in one medical specialty to testify against a health care provider in another medical specialty unless the expert shows both that the standards of care and practice in

the two specialties are similar and that the expert has substantial familiarity between the specialties. If the person is certified in a specialty, the person must be certified by a board recognized by the American Board of Medical Specialties or the American Board of Osteopathic Specialties in a specialty having acknowledged expertise and training directly related to the particular health care matter at issue.

Current law provides that nothing is to be construed to limit the power of the trial court to adjudge the testimony of any expert witness incompetent on any other ground. The provision providing that nothing is to be construed to limit the power of the trial court to allow the testimony of any other expert witness, has been amended to provide that nothing is to be construed to limit the power of the trial court to allow the testimony of any other witness, on a matter unrelated to the liability issues in the medical claim, when that testimony is relevant to the medical claim involved.

All claims alleging medical negligence shall be arbitrated prior to proceeding to trial. The judge to whom an action is assigned shall refer a claim to arbitration by written order within a given time frame. The panel shall consist of three members, one representing the claimant, one representing the respondent, and a third member agreed to by those members to serve as the chair of the panel. The arbitration panel shall be composed of three voting members from the American Health Lawyers Association Alternative Dispute Resolution Service. It should be noted that if, at any time, a claimant alleging medical negligence enters into a settlement agreement concerning the claim, the settlement agreement will be filed with the Superintendent of the Department of Insurance.

A party to a medical negligence claim has the right, but is not required, to attend an arbitration hearing. The Ohio Rules of Evidence shall apply to arbitration hearings. Factual information having a bearing on damages or liability shall be supported by documentary evidence when possible. The parties' presentation before the arbitration panel, the filings, briefs or summaries and the findings of

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## Legislation Creating a Pilot Program

(Continued from page 6)

the panel shall be admissible in any subsequent court proceeding. The full written opinion, however, will not be admissible. To the extent permitted by the Rules of Evidence, an admission made by a party or a party's representative to the panel, and witness testimony given at the arbitration hearing, shall be admissible in any subsequent court proceeding.

Within 14 days after the arbitration hearing, the panel shall make an evaluation and notify each party of its evaluation in writing. The evaluation shall include a specific finding on the applicable standard of practice or care. The evaluation shall set forth the panel's awards and shall indicate if any award is not unanimous. All dissenting opinions of members shall accompany the evaluation. If the panel determines that a complete action or defense is frivolous as to any party, the panel shall so state as to that party. If the action proceeds to trial, the party who has been determined to have a frivolous action or defense shall post a cash or surety bond, approved by the court in the amount of \$50,000.00 for each party against whom the action or defense was determined to be frivolous. If judgment is entered against the party who posted the bond, the bond shall be used to pay all reasonable costs incurred by the other parties and any costs allowed by law or by court rule, including reasonable attorney fees. The evaluation shall include a separate award as to each cross-claim, counterclaim, and third-party claim that has been filed. For this purpose, all such claims as noted above filed by a single party shall be treated as a single claim.

Each party shall file a written acceptance or rejection of the arbitration panel's evaluation within 28 days after service of the panel's evaluation. The failure to file a written acceptance or rejection within the 28 days constitutes acceptance. A party's acceptance or rejection of the evaluation shall not be disclosed until the expiration of the 28 day period, at which time the chairperson of the panel shall mail a notice to all parties to the action indicating each party's acceptance or rejection of the evaluation. If all parties accept the arbitration panel's evaluation, the chairperson of the panel shall mail a copy of the panel's awards to all of the parties and shall add all fees, costs, and interest to the date of judgment.

In a case involving multiple parties, all of the parties on either side of the claim have the option of jointly accepting all of the panel's awards or they can accept some awards while rejecting others. However, as to any particular opposing party, the party shall either accept or reject the awards in their entirety. A party that accepts all of the awards may indicate in their acceptance that the acceptance is contingent upon the opposing parties accepting the awards. If this limitation is not imposed, the accepting party shall be considered to have agreed to an entry of judgment. If the limitation is included and some of the opposing parties reject any of the awards, the party including the limitation is considered to have rejected the awards shall be entered as to those opposing parties who have accepted the portions of the evaluation that apply to them.

In both single claimant and multiple claims, if all or part of the evaluation of the arbitration panel is rejected by opposing parties, the action shall proceed to trial on the unresolved matters, subject to the party filing a complaint with the court within 60 days. If a complaint is filed and the action proceeds to trial, the parties involved shall not reveal the amount of the evaluation's awards until the judge has rendered judgment.

If a party has rejected an evaluation and the action proceeds to trial, that party shall pay the opposing party's actual costs unless the verdict is more favorable to the rejecting party than the evaluation. However, if the opposing party has also rejected the evaluation and award, that party is entitled to costs only if the verdict is more favorable to that party than the evaluation. Any arbitration agreement agreed to by all parties shall be binding on all parties to the agreement.

The proposed legislation was drafted in an effort to create a fair and reasonable forum for resolving medical malpractice claims, while quickly and efficiently disposing of frivolous claims. Senator Kevin Coughlin (R-27) has agreed to sponsor the legislation in the Ohio Senate. A press conference was held on March 2, 2004 in Columbus to announce the introduction of this important legislation that would greatly benefit the medical community. On hand to present at the press conference were: Senator Coughlin, **Dr. John A. Bastulli** and **Dr. John Clough**. Other organizations currently supporting the legislation are the Ohio Osteopathic Association, the Summit County Medical Society, and the Ohio Podiatric Medical Association.

For more information on this important legislation, please contact: Elayne R. Biddlestone at the AMC/NOMA offices at (216) 520-1000, ext. 321. ■

### Snapshot of Key Points in the mandatory arbitration legislation:

- The statute of limitations is tolled until sixty days after the arbitration panel serves all parties with the panel's decision;
- A four (4) year statute of repose for medical negligence cases;
- A procedure for a medical provider to file an Affidavit of Noninvolvement to extricate himself/herself from a medical negligence case;
- The requirements for expert witnesses set forth in R.C. 2743.43 apply to the arbitration;
- The Ohio Rules of Evidence apply to the arbitration, and all statements or evidence submitted at the arbitration are admissible at a subsequent trial to the fullest extent allowed under the Ohio Rules of Evidence;
- The arbitration panel's decision is admissible at the subsequent trial of the claim (however, the panel's written opinion will not be admissible);
- A provision requiring the filing of a \$50,000.00 bond by a party whose claim or defense is determined by the arbitration panel to be frivolous;
- Penalty provisions, including attorneys' fees, if a party rejects the arbitration panel's decision and a subsequent trial of the claim results in a decision that is not as favorable to that party.



## Legislation Creating a Pilot Program

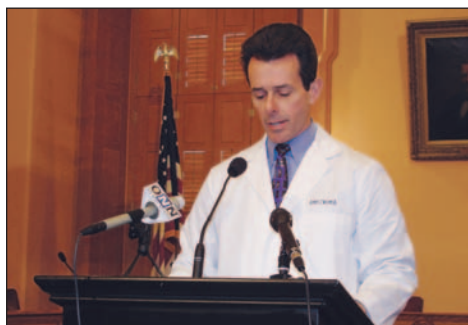
(Continued from page 7)



Senator Coughlin outlines to the media why mandatory arbitration legislation is needed in Ohio. Members of the AMC/NOMA were with the Senator to show our support of the legislation. (From left to right, Dr. John Clough, Senator Coughlin, Dr. John Bastulli)



Dr. Clough presents his comments on the mandatory arbitration legislation—noting that it is a critical step in fixing a system that has been broken for far too long.



Dr. Bastulli discusses the impact of the medical liability crisis on physicians and the community.



Dr. Bastulli responds to a question from a reporter during the press conference.

## Legislative Report

Prepared by Michael Caputo, AMC/NOMA lobbyist

### Two-Year Operating Budget Contains Several Medical Related Provisions

Governor Taft's proposed two-year operating budget has two main components: spending proposals for all state programs and agencies as well as a proposal to dramatically alter Ohio's tax code. Due to a series of accounting maneuvers and the use of one-time funds, Ohio is faced with a structural deficit for the next two years of approximately \$5 billion. For this reason, practically every program has received a recommendation to either be funded at current levels or receive a reduction in funding.

The Taft administration has proposed several methods to curb spending in Medicaid, although the program will still see an increase of approximately \$577 million over the biennium. Among the proposals being considered:

- A reduction in the reimbursement rate paid to nursing homes in FY 2006 and freezing that rate in FY 2007.
- Freezing the state share of hospital inpatient services.
- Freezing rates for Intermediate Care Facilities for the Mentally Retarded.
- Reducing Medicaid Coverage for low-income individuals. The proposal is expected to affect approximately 25,000 adults, as the eligibility would decrease from 100% of the federal poverty level to 90%.
- Eliminating Dental and Vision Services for adults. Currently, there are about 800,000 adults on Ohio Medicaid. Roughly 249,000 receive dental coverage while 147,000 receive vision services.
- Discontinuing Disability Medical Assistance. There are 15,000 adults currently enrolled in the Disability Medical Assistance Program.

Statehouse observers expect strong opposition to these proposed cuts. Because the Ohio Constitution requires a balanced budget, Ohio cannot deficit spend. What this means, essentially, is any new money spent to restore the above programs will come either through a reduction in funding for other programs or an increase in revenue collections (taxes). AMC/NOMA lobbyists will be monitoring the biennium budget process very closely and will provide updates on the deliberations as developments arise.

### Captive Insurance Legislation to be Introduced

As the medical malpractice crisis continues to drastically impact the ability of Ohio doctors to obtain insurance coverage, the Ohio Department of Insurance has been reviewing a number of possible remedies to provide relief to the medical community. One proposal, which seems to be gathering substantial momentum, is the allowance of captive insurance companies in Ohio. Currently, 22 other states allow for captives and the overwhelming data suggests that insurance coverage of this type does provide relief both in terms of cost and availability.

AMC/NOMA's lobbyists are part of a working group established by ODI Director Ann Womer Benjamin to fully explore the ramifications of creating statutory authority for captive insurance companies to operate in Ohio. The medical community can expect to see this issue brought forward with the release of a final report by the Ohio Medical Malpractice Commission this spring. AMC/NOMA is monitoring this issue very closely and will provide additional information once more details emerge.

### Small Business Health Insurance Options a Legislative Priority for the 126th General Assembly

HB 5 (Raussen, R-Cincinnati) and its companion - SB 5 (Hottinger, R-Newark) - permit small employers to offer health care plans that do not provide benefits otherwise required by law. Additionally, the bill provides for the operation of health savings accounts in a manner consistent with federal law. The final component of the bill places a limit on an insured's liability for co-payments and deductibles under a health benefit plan.

Due to the far-reaching implications of this proposal, several stakeholders are in the process of providing input on how Small Business Health Insurance Options should be expanded. Working with interested parties, Representative Raussen has indicated a substitute version of the bill will be forthcoming.

AMC/NOMA is following this bill and its related changes. A modified version of the bill is expected to pass the General Assembly sometime this spring. All AMC/NOMA members interested in learning

(Continued on page 19)





The Academy of Medicine Cleveland/Northern Ohio Medical Association  
(AMC/NOMA)



### Medical Records Fact Sheet Update Effective January 1, 2005

#### Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics. Current Opinion **7.05**. Under Ohio Law (R.C. §**4731.22 (B)(18)**), violations of the AMA ethical rules can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. Ohio Revised Code §**2913.40 (D)** mandates the retention of records associated with Medicaid for a period of at least six (6) years after reimbursement for the claim is received by the physician. It is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires five (5) years retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §**2305.113**). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18<sup>th</sup> birthday. The statute can be "tolled" or otherwise extended in other situations, and the date on which a cause of action "accrues" can vary. As a practical matter, all of this makes it difficult to define the Ohio statute of limitations with absolute certainty. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMC/NOMA recommends that physicians keep medical records indefinitely, if feasible.

#### Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §**3701.74** obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 1, 2005, the maximum fees that may be charged, are as set forth below.

- (1) The following maximum fee applies when the request comes from a patient or the patient's representative.
  - a) No records search fee is allowed;
  - b) **For data recorded on paper:** \$2.50 per page for the first ten pages; \$0.51 per page for pages 11 through 50; \$0.20 per page for pages 51 and higher  
**For data recorded other than on paper:** \$1.70 per page
  - c) Actual cost of postage may also be charged
  
- (2) The following maximum applies when the request comes from a person or entity other than a patient or patient's representative.
  - a) A \$15.35 records search fee is allowed;
  - b) **For data recorded on paper:** \$1.02 per page for the first ten pages; \$0.51 per page for pages 11 through 50; \$0.20 per page for pages 51 and higher  
**For data recorded other than on paper:** \$1.70 per page
  - c) The actual cost of postage may also be charged

Ohio Law requires the Director of Health to adjust the fee schedule annually, with the first adjustment to be not later than January 31, 2006, to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. If you have any questions regarding this fact sheet or other practice management issues, please contact the AMC/NOMA at (216) 520-1000 ext 314.

## HIPAA Security Rule: The Time for Compliance Has Arrived

John Schiller, Esq., Walter & Haverfield, LLP

Now that you have all become familiar with HIPAA's privacy rules, to the extent you have not already done so, it is a good time to gain a basic understanding of the HIPAA Security Rule. As you may know, April 2005 is when providers who submit claims electronically must be in compliance with the Security standards. Small health plans have until 2006. As a preliminary note, while the Security Rules dovetail the Privacy Rules, one important difference is that the Security Rules only apply to electronic-protected health information (e-PHI), which is patient information that is stored on computers or transmitted electronically. The HIPAA Privacy rules apply to both e-PHI and paper records.

The focus of compliance with the HIPAA Security Rules is not merely the avoidance of possible civil and criminal penalties. While that is obviously important, equally important are the other sources of potential liability that may result from breaches of the HIPAA Security Rules. Claims of a breach of duty of care to maintain the confidentiality or integrity of patient information, invasion of privacy, and the breach of a duty of care in the outsourcing of the security function are all theories that trial lawyers may assert in cases of unauthorized disclosure. The point of the Security Rules is to ensure confidentiality, integrity and availability of e-PHI. If you do not comply with these rules you are compounding the trouble you will find yourself in should there be inadequate protection disclosure of e-PHI.

There is no way to discuss all of the security issues under HIPAA here. What I will try to do is give you a sense of what the law requires and enough information to ask the right questions of whoever is in charge of making sure the practice is HIPAA compliant. As a physician or other health care provider, you should be aware that your office or practice group needs to ensure the security of the e-PHI that you maintain and transmit. What does that mean? It means that confidentiality of a patient's physical and mental health information must be maintained at all times; the integrity of the e-PHI must be maintained; and the e-PHI must be readily available. HIPAA allows a great deal of flexibility in how this is done.

HIPAA requires that covered entities

take reasonable and appropriate measures to ensure the integrity and confidentiality of e-PHI against any reasonably anticipated threats or unauthorized disclosure. This includes taking specific steps to ensure compliance by officers and employees.

HIPAA recognizes how different office settings can be and does not apply a "one size fits all approach". Covered entities are required to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to confidentiality, integrity, and availability of its e-PHI, taking into account the following:

- The size, complexity and capabilities of the Covered Entity;
- Its technical infrastructure, hardware and software capabilities;
- The cost of security measures; and
- The probability and criticality of the potential risks to e-PHI.

Here is what you must do to be in compliance. First, you must have a security officer who has final authority over security. This may be the same person who acts as the HIPAA privacy officer. Second, you must do a risk analysis. Do your practice's administrative processes, physical environment, and computer systems adequately protect the e-PHI you maintain and transmit? These are the three security standards established by HIPAA. Each addresses a distinct concern. It is up to your practice to identify areas that are vulnerable and devise methods to reduce detected areas of risk. In doing so, you should identify and consider all information systems, software programs and databases that house e-PHI, including electronic medical record systems, billing systems and registration and email systems.

Each of the standards contains two kinds of specifications. There are specifications deemed required and others that are deemed addressable. Required implementation specifications must be met. Those that are addressable may be met, satisfied with an equivalent alternative or not implemented. This is one of the ways HIPAA is flexible. Note that whatever decision is made to satisfy the HIPAA Security rules must be documented.

The administrative standard deals with the office policies and procedures for the use of computers, access, staff training, passwords, etc. In short, does your office

have procedures in place to ensure the confidentiality, integrity and availability of its e-PHI? Below are a few required implementation specifications:

**Risk Management** - you need to have sufficient security to reduce risk to a reasonable and appropriate level. This process involves undertaking a "risk assessment" and taking steps to reduce any vulnerable areas that you may have discovered.

**Sanction Policy** - you need sanctions for employees who fail to comply with security policies and procedures. These policies (and sanctions) should be included in your employee handbook. Employee training is required under the standards and it's a good idea to require employees to sign agreements stating that he or she has read, understood, and will comply with both the privacy and security policies.

**Information system activity review** - you must conduct a regular review of security incident information. What will this uncover? You might find that someone has repeatedly tried to log into the system and been denied. You might also learn who has been accessing patient information and determine whether that access was appropriate. (If there has been a breach of security you must take immediate action.) How often you review this information will depend on your practice.

Most importantly, you must have this all documented. (45 C.F.R. Section 164.316) This is critical in the event of an inadvertent disclosure because it shows you have taken reasonable and necessary steps to avoid the disclosure and will help in an effort to avoid expensive penalties and civil liability for a Security violation.

HIPAA's physical security standards relate to how you protect access to the physical areas where you have stored e-PHI. Ask yourself: where are the computers located, who has access to that area, and when? Every covered entity must have a policy for the appropriate use and configuration of workstations that store and use e-PHI. This policy needs to include how you will add, reuse, or dispose of electronic media that contain e-PHI. (45 CFR Section 164.310)

*(Continued on page 11)*



**HIPAA Security Rule***(Continued from page 10)*

The HIPAA technical security safeguards address access controls (such as passwords); monitoring controls (so you can document who has accessed a particular computer and when); integrity (making sure that e-PHI is not improperly altered or destroyed); authentication of user (changing passwords regularly); and transmission security (having measures in place that ensure the e-PHI is being transmitted properly, (e.g., encrypted in code) so as not to be vulnerable to interception.

There are many physicians who have left HIPAA compliance to an office manager who may outsource billing or other office management responsibilities to third parties known under HIPAA as "business associates." Examples of work done by business associates includes: software vendors, transcription services, consulting services, or even law firms handling litigation matters or a Medicare

audit. If the business associate creates, maintains or transmits e-PHI on your behalf, you must make certain the business associate has agreed to properly safeguard the e-PHI. It should be a specific provision in the business associate agreement, which may require the practice to amend the business association agreements it obtained last year, to comply with the HIPAA Privacy Rule.

The business associate agreement must do four things:

- (1) Ensure the business associate implements administrative, physical, and technical safeguards to protect the security of the e-PHI;
- (2) Ensure any agents or subcontractors of the business associate agree to implement appropriate safeguards to protect the e-PHI;
- (3) Agree to report to you any security incident (when it becomes aware of it); and
- (4) Allow the termination of the business associate agreement for a violation of any of the above.

Do not make the mistake of assuming your practice has properly protected itself in its business associate agreement. Review and update these agreements before April 20, 2005.

Compliance with the Security Rules is undoubtedly not your number one priority. But in the event of an unauthorized disclosure, the failure to have complied with the Security Rules will make your situation even worse.

While I have discussed some of the more important aspects of the Security Rule, the information in this article is a summary of complex statutes and rules and is not intended to cover all of the "fine points" or address all possible situations. Accordingly, it is not intended to be legal advice, which should always be obtained in consultation with an attorney.

End Note: See generally 45 C.F.R. Section 164.302 *et seq.* ■



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## Patient Awareness Under Anesthesia: A New JCAHO Sentinel Event Alert

Mark V. Boswell, MD, PhD, Associate Professor of Anesthesiology, Chief, Division of Pain Medicine, Department of Anesthesiology Case and University Hospitals of Cleveland

The idea of being awake and paralyzed during surgery is frightening to patients. It also continues to be a popular topic with the media. Last year, during the American Society of Anesthesiologists' (ASA) annual meeting, a nationally televised morning news show featured a patient who recounted a terrifying experience of awareness under anesthesia. The telecast was timed to coincide with the meeting and provided some rather awkward publicity for the Society. The charge was leveled against anesthesiologists that more should be done to prevent awareness under anesthesia.

In October 2004, The Joint Commission on Accreditation of Health Care Organizations (JCAHO) issued a Sentinel Event Alert on "Preventing, and managing the impact of, anesthesia awareness" (JCAHO, Sentinel Event Alert, Issue 32, October 6, 2004). Although the specific events that led up to the announcement were not disclosed, JCAHO clearly had the issue on its radar screen, and the alert must now be addressed by hospitals.

Although the ASA addressed the issue of awareness in an editorial in *Anesthesiology* in 2000 (*Anesthesiology* 2000;92:597-602), the Joint Commission has asked the ASA and the American Association of Nurse Anesthetists (AANA) to evaluate the adequacy of current monitoring practices, while acknowledging that awareness can't always be prevented.

Before considering the JCAHO recommendations, it is worthwhile reviewing the facts about awareness under anesthesia. A recent study published in *Anesthesia and Analgesia* in 2004 (*Anesth Analg* 2004;99:833-839) reported results from 19,575 patients who received anesthetics at seven academic medical centers in the United States. Using a structured interview technique with patients in the postoperative recovery room and again at least a week after surgery, a total of 25 awareness cases were identified, with an incidence of 0.13% (1.3 cases per 1000 anesthetics). In addition, there were 46 cases of possible awareness and 1183 cases of possible intraoperative dreaming. The data suggest that there are approximately 26,000 cases of awareness each year in the United States, assuming that about 20 million general anesthetics are administered annually. Awareness was more common in patients with underly-

ing medical problems and a higher ASA physical status, but patient age and sex did not influence the incidence of awareness. Similar data were reported in a Swedish study in the *Lancet* and an Australian report in the *British Journal of Anaesthesia*, both published in 2000.

Awareness occurs when general anesthesia is insufficient to maintain unconsciousness and prevent recall. General anesthesia, not just a deep form of sleep, depresses cerebral and subcortical function, including the reticular activating system and other brainstem functions. Inadequate anesthetic depth can allow awareness and recall. A patient may or may not experience pain because of variable suppression of pain processing pathways under light general anesthesia.

A large number of awareness cases occurred during endotracheal intubation and surgical incision, both times during surgery when stimulation is highest. Common experiences included auditory recall and sensations of not being able to breathe or move, which occurred in about 48% of cases. Pain was reported in 28% of cases and anxiety and panic in 36%. Thus, the problem is rare but real and can have significant consequences, which must be addressed.

Unfortunately, the best way to prevent awareness is not known. The usual monitors that measure blood pressure, pulse rate and end-tidal anesthetic concentrations are not specific or sensitive for detecting awareness. A monitor of cortical function, such as an EEG, is of theoretical benefit, but impractical in the operating room. However, a proprietary processed EEG device has been promoted as being useful in detecting inadequate anesthetic depth. The monitor, sold under the name of BIS® (Bispectral Index®; Aspect Medical Systems, Newton, MA) may measure the hypnotic component of anesthesia and predict the probability of consciousness. Recovery of consciousness during a general anesthetic is usually associated with BIS® values of >60 (on a scale of 0 to 100). Although the effectiveness of BIS® in preventing awareness remains unknown, it is capable of allowing a reduction in the amount of anesthetic needed to maintain anesthesia.

The editorial in *Anesthesiology* suggested ways to reduce the risk of aware-

ness and how to manage the impact of awareness, should it occur. These recommendations were reviewed in the JCAHO Alert, issued in October 2004. Recommendations to reduce the risk of awareness include: 1) premedication with amnestic drugs, such as benzodiazepines; 2) administering more than a "sleep dose" of induction agents when they will be followed immediately with intubation; 3) avoiding muscle paralysis when possible; and 4) conducting periodic maintenance of the anesthesia machine, vaporizers and ventilator.

When someone reports awareness, it is important to: 1) interview the patient and record the details of the episode in the chart; 2) apologize to the patient if awareness occurred; 3) provide reassurance and sympathy regarding the event; 4) explain what happened and why (e.g., cardiovascular problems that required a light anesthetic); and 5) offer psychological support and notify the surgeon and other key personnel involved.

The JCAHO recommends health care organizations take specific steps to help prevent and manage awareness under anesthesia. The health care organization should develop an anesthesia awareness policy that educates clinical staff about the problem and how to manage patients who experience awareness; identify patients at higher risk of awareness before surgery; ensure effective use of anesthesia monitors; provide appropriate postoperative follow-up of all patients having general anesthesia; and refer patients for treatment when indicated. The JCAHO recognized that current data do not support the use of EEG monitors, such as BIS® for routine awareness detection, although it noted that such devices may have a role in preventing awareness in patients at high risk, particularly during cardiac, obstetric and major trauma surgery.

The recommendations of the Joint Commission must now be addressed by more than 15,000 health care organizations nationwide. The recommendations appear to be reasonable and are an interim step in preventing and managing anesthesia awareness. Eventually, monitors will be able to identify inadequate levels of anesthesia, which will be a definitive step toward eliminating the problem of awareness under anesthesia. ■



## Combining Charitable Giving with Smart Tax Planning

By Philip G. Moshier, CFP®, Sagemark Consulting, a division of Lincoln Financial Advisors, a Registered Investment Advisor.

Are you hanging on to some low-basis, highly appreciated assets that you would gladly sell if you could somehow avoid losing much of the value to taxes? One solution might be an estate planning arrangement known as a Charitable Remainder Trust. This type of trust may provide you with income tax deductions and other tax breaks, while enabling you to convert an appreciated asset (such as stocks or bonds, real estate or a work of art) into an income stream for life.

With a Charitable Remainder Trust (CRT), you transfer assets into the trust and may take a charitable income tax deduction, subject to certain limitations. Since the asset will not pass to your favorite charity like the Academy of Medicine Education Foundation (AMEF) for several years, the deduction will be less than the assets' current value. The trust, in turn, may sell the assets and invest the proceeds into high income-producing investments. The trustee pays the donor a certain amount each year for a stated period, usually for the donor's lifetime, and then turns over the principal (also known as the "remainder" interest) to the charity named by the donor in the trust agreement. The charity could be your alma mater, a museum, church or any other qualified charitable institution like the AMEF.

When the CRT sells the asset, it pays no immediate tax on the gain, so all the proceeds can be re-invested to produce income. If you had sold the asset outright instead of giving it to the CRT, you would have paid the Internal Revenue Service capital gains taxes on your profit, in addition to any capital gains tax imposed by Ohio. In setting up a CRT, you may name yourself as trustee, which enables you to manage the investment of the funds in the trust. You might want to review this with a financial advisor, as there could be reasons why this is not prudent, given your particular financial situation. Alternately, by using a professional trustee such as a bank or the charity itself, you could help ensure that the arrangement complies with the complex legal rules, which must be followed to retain the tax benefits.

Suppose a 65-year-old doctor owns \$100,000 worth of ABC Company stock that he or she bought some years before for \$20,000. He or she wants to sell the low-yielding shares and invest the pro-

ceeds in U.S. Treasury bonds. But by simply selling the stock, he or she would pay capital gains tax of \$12,000 on the \$80,000 profit. So the doctor transfers the stock into a CRT instead, and elects to receive \$7,000 annual income for the rest of his life, at which time the principal will go to his or her favorite cause — the AMEF. The trust sells the shares and buys 4 percent Treasuries, paying no current capital gains tax on the \$80,000 gain. The yearly income stream the trust pays out will generally be considered distributions of ordinary income, on which the doctor will pay tax.

He or she also has available an income tax deduction in the year the transfer is made. Since the stock will not pass to the charity for several years, however, the deduction will be less than the stock's current market value. The available deduction will be equal to the present value of the remainder interest given to the AMEF at his or her death.

Calculation of the deduction is based on four main factors: the fair market value of the asset; the life expectancy of the income beneficiary (the person receiving the yearly payout); the discount rate; and the payout rate chosen by the income beneficiary. In this example, using a 4.2 percent discount rate, the doctor's available deduction would be approximately \$35,000, subject to certain limitations.

Whether you choose to make a gift of an asset directly to a charity or through a CRT, the value of the asset, together with any future appreciation, will effectively be removed from your taxable estate that may reduce your estate tax liability at your death. With a CRT, you can shrink your taxable estate by the amount ultimately retained by the AMEF. Of course, since the AMEF is the ultimate beneficiary of the trust assets, you will want to make sure you have otherwise adequately provided for your family.

One way to replace assets donated to charities is by purchasing life insurance for the benefit of your heirs. Funds to purchase the insurance policy may be available through increased income resulting from the tax deduction for the donated asset and the cash flow produced by the investment of the trust proceeds. By holding the insurance policy in an irrevocable trust and making it the owner of the policy, the death bene-

fit may be kept out of your estate, thereby reducing your ultimate estate tax bill. Of course, insurance applications are subject to underwriting approval.

There are two kinds of Charitable Remainder Trusts to choose from; both are irrevocable meaning they can't be cancelled once the trust document is executed. The "Annuity Trust" throws off a steady income flow at a fixed amount each year — \$5,000 or some higher amount annually, for instance. These types of CRTs tend to be more popular with people in their seventies or older who want the security of a guaranteed pay out in their old age and who don't want to take the risk that a market dip could erode the trust principle a few years down the road.

Unlike the Annuity Trust, the Charitable Remainder "Unitrust" pays out a fixed percentage of the net fair market value of the trust assets as it may vary from year to year. Unitrusts pay a variable return, but annual distributions fluctuate with the fortunes of the invested funds. While Annuity Trusts are appraised just once, Unitrusts must be revalued each year, which can drive up administrative expenses, especially with hard-to-value assets such as closely held business interests, real estate or artwork. Unitrusts also permit additional contributions of property under certain conditions, which can increase your income. Younger investors tend to prefer a Unitrust to an Annuity Trust because its flexibility can help provide a hedge against inflation over the long-term.

The Internal Revenue Code limits the yearly Annuity and Unitrust payments from a CRT and mandates a minimum percentage value for the charity's remainder interest. Regardless of which type of CRT is used, the annual amounts received by the donor are generally subject to income tax, either as ordinary income or as capital gain.

Donating art, antiques, collectibles or other tangible personal property is subject to a special rule, which affects the size of your up-front income tax charitable deduction. Donating such property which you have owned for more than one year usually generates a charitable deduction equal to the object's fair market value at the time of the gift, so long as the charitable institution uses the  
*(Continued on page 14)*

**Combining Charitable Giving with Smart Tax Planning**

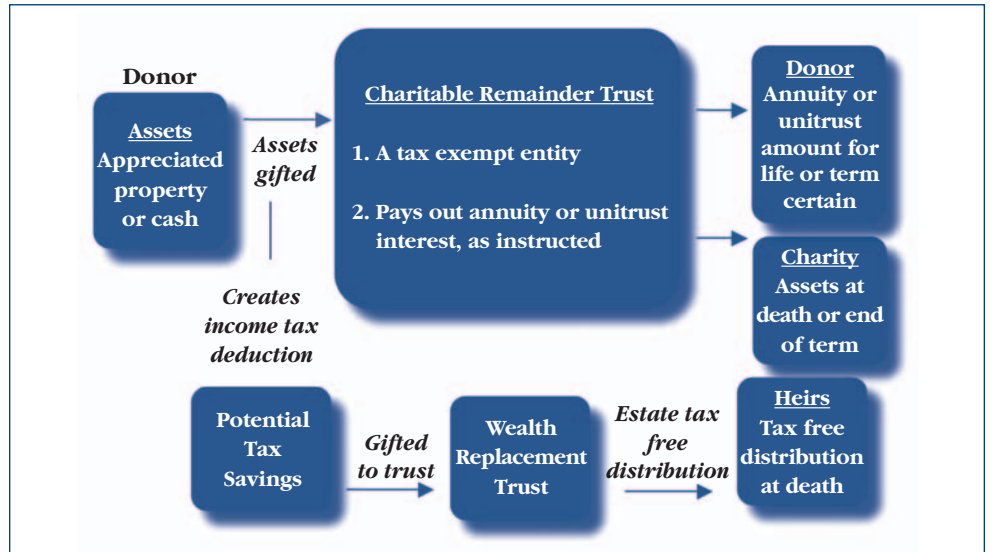
*(Continued from page 13)*

object in a manner related to its charitable purpose.

Thus, donating a Picasso to an art museum that plans to display it in its gallery would clearly meet the “related use” rule. But giving the painting to the AMEF that, in turn, sells it and uses the proceeds to support various causes would not be a related use. If the AMEF does not intend to use the art work to further its charitable mission, your income tax deduction is limited to your basis (generally, what you originally paid for the object) not its current, appreciated value.

Your deduction may be similarly limited if collecting art is your business, because the artwork would be considered part of your inventory. The amount of deductions you are allowed in any one year are further limited by your adjusted gross income and the type of charitable organization to which you are contributing. Generally, gifts to public charities generate larger tax deductions than gifts to private charities.

It may be easier to meet the “related use” rule by giving an artwork directly to



a charity, instead of through a trust, thereby increasing the amount of your deduction. Using a CRT as a receptacle for a sculpture, for instance, will probably limit the deduction to your basis. If the CRT converts the sculpture into an income-producing asset, the “related use” test will not likely be met. Nevertheless, the CRT may still be a viable method of transferring appreciated works of art with a low cost basis from a collection in

order to avoid immediate capital gains, create a revenue flow, and reduce the size of the donor’s taxable estate.

Properly drafted, a Charitable Remainder Trust may be successfully used to achieve numerous tax and financial planning objectives. Consult a professional adviser to determine whether charitable giving should be a part of your financial planning strategy. For information on AMEF see page 1. ■

# It's Time For Your Financial Check-Up

Thanks in large measure to the work of health care professionals like you, Americans are enjoying longer, healthier lives than ever before. Plan to make the most of the coming year. Retirement planning is like preventive medicine. build a nest egg now and be more comfortable later.

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## AMC/NOMA Presents at Case Health Policy Week Session

AMC/NOMA leadership recently was invited to speak during the Case Western Reserve University Health Policy Week session, hosted by the Case medical students, on the topic of "The Effect of Medical Liability on the Practice of Medicine." **John A. Bastulli, M.D.**, presented on behalf of the AMC/NOMA along with Mr. Maxwell Mehlman, Professor of Law at Case along with J.B. Silvers, Esq., Associate Dean for Resource Management & Placement at Case.

Professor Mehlman began the session by stating that in his opinion it is difficult to review the extent of the medical liability crisis because it is hard to obtain reliable data on the issue and there are studies that show physicians are not leaving the practice of medicine. Clearly, the current malpractice system is problematic in that it does not do a good job in paying out to the injured and it does not improve practitioners who may be practicing negligent medicine. Also, the manner in which the legal system assigns damages to people injured in medical malpractice cases is not coherent because there are significant differences in the amount of awards. He also commented that the medical profession has persuaded legislators to put caps on noneconomic damages, however, there is debate as to whether or not this would actually hold down medical malpractice premiums.

Dr. Bastulli indicated the medical liability system is inefficient and haphazard. There is plenty of data to prove there is a real problem and physicians are indeed leaving practice. He provided the audience with an overview of the medical student survey done by the AMC/NOMA that clearly showed Case medical students felt they were not learning enough from their professors about the medical liability crisis. Many of the students did not plan to stay in Ohio because of the medical liability climate and the majority of the students surveyed were not planning to get into a high-risk specialty due to the crisis. He stated, "These types of decisions will affect access to health care in the future."

Dr. Bastulli cited the recent \$30 million decision handed down in Cuyahoga County. He said, "There are certainly questions and issues surrounding a verdict of that magnitude. The system is not fair to small business or the general public. Everyone pays when that kind of verdict is upheld. The gold standard was the



Larry Latson, Jr., Case medical student and program planner, introduces the three presenters (left to right) **Dr. John A. Bastulli**, Mr. Maxwell Mehlman and J.B. Silvers, Esq.

MICRA legislation in California that included caps on noneconomic damages AND on attorney contingency fees." He added, "Everyone should ask how much of that \$30 million decision is slated to go to the attorneys in that case? The answer is probably more than 40 percent. Bottom line, there should be a cap on these fees."



Case medical students listen to the presentation on medical liability issues.

Dr. Bastulli then addressed Mr. Mehlman's remarks regarding not having enough good data available in order to evaluate the extent of the problem. He said, "Some have pointed to state medical board data to show there is no shortage of physicians. What is unapparent is the fact the state medical boards do not track changes in the physician work force, they do not take into account mobility or when a physician has cut back their practice or, in fact, retired. Doctors may still have an active license and be retired from practice."

He said, "The AMC/NOMA recently participated in a teleconference with the Federation of State Medical Boards that provided background showing the United States will be facing a physician shortage within the next two decades. There was discussion about the state

boards beginning to track physician data such as practice trends, whether the physicians were trained in the state, where they held their license (to show if physicians who train in the state remain) and other pertinent data. The Ohio Department of Insurance (ODI) recently completed a physician survey and we have learned it does show physicians across the state are reducing their scope of practice." He again reiterated that all of these factors coupled with the liability crisis will lead to problems with access to quality health care in the future.

Dr. Bastulli summarized that organized medicine believes in order to have effective tort reform something needs to be in place similar to MICRA, a hard cap on noneconomic damages of \$250,000 and a cap on attorney contingency fees. He also briefly mentioned legislation the AMC/NOMA is working on that would provide for alternative dispute resolution.

Mr. Silvers' presentation dealt primarily with explaining how insurance rates are calculated, how the actuaries determine what amount of money needs to be available in the future to cover claims, which can be affected by declining income.

A closing comment was made that there are cases that do not hinge on the degree of disability and, in fact, when you get to the issue of pain and suffering, the jury is primarily acting on pure emotion. That issue is certainly one that deserves additional review and debate.

AMC/NOMA staff also attended the session and provided the medical students with background materials on the medical liability crisis from the AMC/NOMA, along with information on the importance of becoming involved in the AMC/NOMA and organized medicine. ■

## AMC/NOMA Leadership Keeps Communication Lines Open with ODI

In an effort to keep the communication lines open with the Ohio Department of Insurance (ODI), the AMC/NOMA leadership recently met with Ann Womer Benjamin, Esq., director, during her visit to Cleveland. Topics on the discussion table were: ODI's survey data, the status of the Ohio Medical Malpractice Commission's final report, arbitration legislation, tail coverage and HB 215 rulemaking.

Ms. Womer Benjamin explained to the AMC/NOMA representatives that the detailed physician survey sent out last summer has now been tabulated, however, release of the data is not immediately planned. ODI believes the data provides good, reliable and accurate information that is not just anecdotal that physicians are leaving the state or cutting back on their services. The AMC/NOMA lobbyist will follow up with ODI to ascertain when and how the aggregate data may be released to interested parties.

On the concept of alternative dispute resolution, which the AMC/NOMA believes must be implemented in Ohio in order to reduce the number of medical liability claims filed in the courts, the AMC/NOMA provided the Director with an overview of the mandatory arbitration legislation that is being drafted by the Legislative Service Commission (LSC). Ms. Womer Benjamin requested a copy of the legislation as soon as it has been prepared. She also asked that copies of the proposed legislation be sent to her staff. The Director also noted that she would be presenting at the upcoming AMC/NOMA seminar and some of the topics pertained to alternative dispute resolution concepts.

The AMC/NOMA representatives asked Ms. Womer Benjamin about the status of AMC/NOMA's letters to the Department addressing the tail coverage issue and specifically our proposal of model policy language for the insurance companies. She indicated a letter was forthcoming from ODI regarding the tail coverage issues. She also stated new medical liability insurance companies are entering the market and they are experiencing a moderation of rates. In addition, there was some discussion about ODI's charge relative to SB 86 - Immunity for Health Care Providers.

Relative to SB 86 - ODI has been mandated to evaluate certain issues relative to health care provider immunity and report back their findings. Specifically, the Ohio Medical Malpractice Commis-

sion is to study: (1) the affordability and availability of medical malpractice insurance for health care professionals and health care workers who are volunteers and for nonprofit health care referral organizations; (2) the feasibility of whether the State of Ohio should provide catastrophic claims coverage, or an insurance pool of any kind, for health care professionals and health care workers to utilize as volunteers in providing medical, dental, or other health-related diagnosis, care, or treatment to indigent and uninsured persons; (3) the feasibility of whether the State of Ohio should create a fund to provide compensation to indigent and uninsured persons who receive medical, dental, or other health-related diagnosis, care, or treatment from health care professionals or health care workers who are volunteers, for any injury, death, or loss to person or property as a result of the negligence or other misconduct by those health care professionals or workers; (4) whether the Good Samaritan laws of other states offer approaches that are materially different from the Ohio Good Samaritan Law as amended by this Act. The AMC/NOMA asked to be kept apprised of this review by the commission.

With regard to HB 215 rulemaking authority for ODI relative to insurers and others, ODI will be obtaining both hospital and physician claims data but they will not be reviewing individual businesses or how they are run. ODI plans to focus on the insurance companies and obtain specific information from captives, however, they will not be obtaining data on claims that have been filed and dismissed. Only on claims where there is a payment. The AMC/NOMA leadership informed the Director we were pleased to learn of her success in working with the Ohio Supreme Court and the plaintiff bar association to place specific language in HB 425 which asks that the Ohio Supreme Court adopt rules governing data collection on contingency fees that plaintiffs' attorneys receive and adopt rules of professional conduct requiring attorneys who represent persons on medical malpractice claims to file a report with the Department of Insurance or the Department's designee. The report would describe the attorney fees and expenses received for the representation as well as any other data necessary for the Department to reconcile the attorney fee and expense data with other medical



*Ann Womer Benjamin, Director of the Ohio Department of Insurance (ODI), (center) visits the AMC/NOMA offices in January to meet the new AMC/NOMA lobbyist Mr. Michael Wise (left) and Dr. John A. Bastulli (right).*

malpractice closed claim data received by the Department. The data would be reported to the ODI in a confidential format, and in turn the ODI would then issue an aggregate report to the Ohio General Assembly.

Ms. Womer Benjamin also provided an update on the Ohio Medical Malpractice Commission's final report expected in April 2005. She indicated the group could potentially meet four more times prior to issuing their final report. Ms. Womer Benjamin indicated that there is still debate as to whether the final report will contain a recommendation to develop a Patient Compensation Fund (PCF). She asked for feedback from the AMC/NOMA relative to this concept.

After the meeting with the Director, the AMC/NOMA sent a written reply to her request from comments on the PCF concept indicating that although it would appear the implementation of a PCF in other states has helped to stabilize their medical liability market, we are of the opinion that unless the PCF included the recommendations of the Pinnacle Report (i.e., a hard cap of \$250,000 on noneconomic damages as well as a cap and/or sliding scale for attorney contingency fees) than the PCF would have little effect and we probably could not support it. In addition, the AMC/NOMA has some very real concerns about how a PCF would be financed in Ohio. We are of the opinion that other entities such as health care facilities, health insuring corporations, and possibly attorneys (i.e., a percentage of court awards) should have to pay into the PCF as well as physicians. Unless there were a funding mechanism included as part of the PCF that did not place the entire financial burden on

*(Continued on page 17)*



**AMC/NOMA Leaderships Keeps Communication Lines Open with ODI Director** *(Continued from page 16)*

physicians we probably would not support the concept. However, if legislation

were introduced in the future regarding the start-up of a PCF in Ohio, the AMC/NOMA would review it and take a position on it based upon the content of the legislation.

(The AMC/NOMA legislative committee

and our lobbyists will continue to monitor the activities of the ODI and provide periodic reports to our members. Members requiring additional information on this story, please contact Ms. E. R. Biddlestone at the AMC/NOMA offices.) ■

**In Brief**

**Medicare Physician Payment Advisory Commission Suggests a 2.7 Percent Increase to Medicare Physician Payments in 2006**

Physicians serving Medicare patients received a glimmer of hope in January 2005 when MedPAC, the Medicare Physician Payment Advisory Commission, suggested a 2.7 percent increase in reimbursements for physicians who serve Medicare's senior and disabled patients. This news conflicts with the Medicare program's trustees who predicted a 5.2 percent cut next year. If this suggestion is considered and enacted by Congress, the new MedPAC recommendation will go a long way to secure patients' access to care. Every year, Medicare physicians and their patients must rely on Congress to approve the Medicare physician payment formula projections. The underlying formula that set Medicare payments for physicians, known as the Sustainable Growth Rate (SGR), is fundamentally flawed because it is inappropriately tied to the ups and downs of the economy — not the health care needs of America's seniors. Under the current Medicare physician formula, the Medicare Trustees have predicted payment cuts totaling 31 percent over the next eight years — while at the same time the costs of running a practice and caring for patients will go up 19 percent.

**New Med Mal Company Granted Certificate of Authority by ODI**

The Ohio Department of Insurance (ODI) granted licensure for a doctor-owned medical malpractice insurance company in Ohio December 14, 2004. The company, Healthcare Underwriters Group Mutual of Ohio (HU), headquartered in Columbus, Ohio is run for and by doctors and offers protection against claims of malpractice. Although rates are not predicted to be much lower than other Ohio insurance companies, HU hopes to avoid the dramatic increases seen in recent years. The company has indicated that they already have 200

applications, with a goal of 500 in the first 12 months. The company is organized as a not-for-profit corporation. It will carry group reinsurance so physician policyholders will not be assessed for unanticipated losses. However, excess profits will be distributed either as dividend payments or as reductions in future premiums, subject to the approval of the state insurance regulator, according to the company.

**Office of the Inspector General (OIG) issues report on Medicare Reimbursement in a Nonhospital Setting**

The Office of the Inspector General (OIG) has issued its final report to the Centers for Medicare and Medicaid Services (CMS) and Congress on Medicare

reimbursement for the training of residents in nonhospital settings such as clinics, physician offices, and nursing homes. The report also analyzed current compliance with Medicare requirements and the extent to which supervisory physicians in nonhospital settings volunteer their time to train residents.

The report entitled, "Alternative Medicare Payment Methodologies for the Costs of Training Medical Residents in Nonhospital Settings," was mandated as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

For a copy of the OIG report, please go to <http://oig.hhs.gov/oas/reports/region2/20401012.pdf> ■

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\*Ms. Carulas earned the distinct honor of also being named one of the "Top 50 Women" on the Super Lawyers List.

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## Highlights from American Medical Association (AMA) Interim Meeting in Atlanta

### Solving Medical Liability Crisis is Still Top Agenda Item

The AMA House of Delegates convened in Atlanta in December to review various topics of importance to physicians and their patients. At the apex of the activity were the four reference committees, which discussed and debated more than 125 reports and resolutions, some of which resulted in new AMA policy. The AMA House voted to adopt new policies regarding the uninsured; specialty hospitals (an issue of importance to Ohio physicians); concealed health care costs, Medicare cuts; confidentiality of the peer review process; reality TV; importation of prescription drugs by wholesales and pharmacies; expert witness testimony; and the flu vaccine shortage. Also reviewed in an educational session was P4P — Pay for Performance, which explored initiatives that affect a physician's reimbursement based on performance against a set of explicit measures.

#### Policy Highlights

The AMA adopted policy that states expert witnesses in medical liability issues should at a minimum, be required to have comparable education, training and occupational experience in the same field as the defendant; have occupational experience that include active medical practice or teaching experience in the same field as the defendant; and that both practice and/or teaching experience be within five years of the date of the occurrence giving rise to the claim. The policy also calls for expert witnesses to be board certified.

The AMA adopted a report from the Council on Ethical and Judicial Affairs (CEJA) dealing with collective action by physicians. The report recommends that physician participation in advocacy should be voluntary and free from undue pressure from colleagues. It advises physicians to seek legal counsel as some legal matters may put them or their practice at risk should antitrust laws be violated. This report resulted in a new opinion from CEJA regarding collective action by physicians.

The AMA will further efforts to ensure honest testimony from expert witnesses by creating model state legislation for physicians testifying in state court on medical liability cases. The legislation would be based on existing rules that

mandate full and timely disclosure of expert witness opinions, reports, qualifications, compensation and prior testimonial experience.

Three vaccine-related items were adopted, including a report that supports the development of a strong adult and adolescent immunization program in the United States. Also adopted was an item advocating for programs that ensure the production, quality assurance and timely distribution of sufficient quantity of vaccines recommended by the Centers for Disease Control and Prevention to the U.S. population at risk.

The AMA also adopted a report on specialty hospitals and their impact on health care. This issue has come up in the Ohio legislature. The most significant recommendation in the AMA report is that the AMA will oppose efforts to temporarily or permanently extend the 18-month moratorium on physician referral to specialty hospitals in which they have an ownership interest. The AMA also adopted policy encouraging physicians who contemplate forming a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital.

The AMA adopted new policy to support the importation of prescription drugs by wholesalers and pharmacies, only if certain conditions are met to ensure patient safety. The conditions include:

- All drug products are Food and Drug Administration (FDA) approved and meet all other FDA regulatory requirements
- The drug distribution chain is "closed," and all drug products are subject to reliable, electronic track and trace technology
- Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of imported prescription drugs.

The AMA continues to have strong opposition to personal importation of prescription drugs via the Internet until patient safety can be ensured. The AMA will continue to educate its members on

the risk and benefits associated with drug importation and re-importation efforts.

The AMA will continue to pursue MICRA-based reform as its top priority, and will pursue liability reform efforts by any and all legislative options that would result in fair and equitable remuneration for injured patients and promote patient access to care.

The AMA will continue to make the prevention of further Medicare physician payment cuts a top priority. Due to the flawed Medicare physician payment formula, the AMA will seek replacement of the formula with payments that reflect actual increases in the cost of practicing medicine.

These are just a few of the highlights of the AMA Interim Meeting. The AMC/NOMA will continue to monitor AMA activities and apprise our members of any new policies or legislative initiatives at the national level.

(Note: Copies of the complete reports and proceedings of the AMA House of Delegates are available on the AMA Web site at [www.ama-assn.org](http://www.ama-assn.org)) ■

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**Legislative Report***(Continued from page 8)*

more about HB 5 should contact AMC/NOMA. The AMC/NOMA supports HB 5.

**Chiropractor Solicitation Targeted for Regulation**

Ohio State Senator Jim Jordan (R-Urbana) recently introduced legislation intended to restrict the manner in which chiropractors solicit business in Ohio. SB 40 states that a chiropractor shall not, sooner than the end of the first thirty days following the occurrence of an accident or the filing of a claim, solicit chiropractic business related to the accident or claim by contacting the residence or workplace of a victim, claimant, or relative of a victim of the accident or claimant in person, by telephone, or by facsimile transmission, or by having an agent contact the victim, claimant, or relative by any of those means. A chiropractor may, however, solicit via direct mail or electronic communication (email). The AMC/NOMA has a position of support with technical assistance on SB 40.

**Legislature Looks to Control Products Used in Manufacturing Methamphetamine**

In response to the growing crisis of methamphetamine use in Ohio, Senator John Carey (R-Wellston) has introduced a measure, which will alter the way in which medication containing certain ingredients is distributed. Specifically, SB 53 regulates the manner in which medication containing pseudoephedrine is distributed. The bill places restrictions on products with ONLY pseudoephedrine as the active ingredient. For products such as these, the proposal requires the product to be placed behind a counter, limits purchasing to two packs (or 6 grams) at a time and requires a photo ID (purchaser must be at least 18 years old). The AMC/NOMA has a neutral position on SB 53 at this time.

**Senator Coughlin Introduces Measure to Change Judicial Selection Process in Ohio**

SJR 3 proposes amending the Ohio Constitution to provide for the appointment of the Chief Justice and Justices of the Supreme Court of Ohio by the Governor for 10-year terms, subject to retention elections by the electors of the state. SJR 3 also creates a Supreme Court Nominating Commission, which shall submit to the Governor the names of

nominees to the Supreme Court. The commission shall be made up of either nine, eleven or thirteen members. No more than half plus one nor less than half minus one shall be lawyers admitted by the state bar. This measure is sure to create a great deal of dialogue on how our justices or selected. AMC/NOMA will monitor the dialogue and keep the membership informed on the status of the discussion. The AMC/NOMA has a neutral position on SJR 3 at this time.

**Universal Health Care Measure Expected to Gain Momentum**

SB 68 (D-Hagan) proposes to establish and operate the Ohio Health Care Plan to provide universal health care coverage to all Ohio residents. This legislation mirrors similar legislation introduced by Rep. Hagan in the last General Assembly. The proposed law establishes the Ohio Health Care Plan, which will provide all qualifying Ohio residents and all qualifying persons employed in Ohio with coverage for inpatient and outpatient hospital care, preventive care, mental health, vision, hearing, prescription drugs, dental, emergency services, rehabilitation services, hospice care, home care, health maintenance care, medical supplies, necessary transportation for covered health care services, and all other necessary medical services as determined by any state licensed, certified, accredited, or otherwise authorized provider. Coverage will not include procedures strictly for cosmetic purposes. Coverage will be provided regardless of income or employment status. There will be no exclusions for pre-existing conditions, and there will be no co-payments or deductibles. Patients will have freedom of choice of eligible health care providers and hospitals. Payment to health care providers for all covered benefits is to be made from a single public fund, called the Ohio Health Care Fund. Funding of the Plan shall be obtained from the receipts from taxes levied on employers' payrolls to be paid by employers; receipts from taxes levied on businesses' gross receipts; and receipts from additional income taxes. In the event that additional revenue is needed, the Ohio Health Care Board will seek a special appropriation.

Employers who on the date benefits are initially provided by the Plan are subject to collective bargaining agreements or private contracts providing health care benefits will either become a participant in the Plan or provide additional

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benefits where necessary so that until the expiration of the agreement the benefits provided will be at least the same as the benefits under the Plan. Upon the expiration of these agreements, the employers and employees will become participants in the Plan. The Plan is to be administered by the Ohio Health Care Agency under the direction of the Ohio Health Care Board. In the absence of waivers for Medicare and Medicaid, these plans will be considered primary insurers and the Plan will be the secondary insurer. The AMC/NOMA is neutral on SB 68 at this time.

For information on this report or the AMC/NOMA initiated mandatory arbitration legislation, or if you are interested in testifying on any of this legislation, please contact the AMC/NOMA executive staff at 520-1000, ext. 321. ■



## A Toast to Membership

More than 40 AMC/NOMA members, residents and medical students and their spouses attended this year's wine tasting event held on Sunday, January 30 from 5 to 7 p.m. at Club Isabella in Cleveland. The site was selected for its location near the Case medical school. Guests who included residents and medical student members, had the opportunity to sample wines from Sonoma and countries such as France, Italy and Australia. A local wine connoisseur discussed the particular flavors and ingredients of each glass of wine as well as recommended suitable food accompaniments. The venue provided the perfect atmosphere to mingle with fellow AMC/NOMA members and their guests. ■



From left to right, Mrs. Deborah Corn, Dr. Robert Corn, Dr. Raymond Scheetz, Mrs. Sherry Scheetz and Dr. Victor M. Bello enjoy a moment at the wine tasting event.



Dr. Kevin Geraci talks to Tara Sheets, a medical student, (right) and her guest (center) who attended the wine tasting event.



Dr. George Kikano, AMC/NOMA president elect, (left) chats with Dr. Donald Barich (right).

## Colleague's Corner

*Recognizing outstanding AMC/NOMA members for their honors, awards and achievements, in addition to their work to spread health and wellness messages to the community.*

### Dr. Collins Tapped for Government Appointment

Congratulations to Dr. Thomas E. Collins, Jr., M.D., who was appointed by Governor Bob Taft to be a member of the State Board of Emergency Medical Services (EMS). The Governor made the appointment based on recommendations submitted by The Ohio Chapter of The American College of Emergency Physicians, one of two organizations eligible to nominate EMS-certified physician candidates to this particular EMS board seat. In his new position, Dr. Collins and the board will be responsible for overseeing the training and certifying of all emergency medical technicians and firefighters, approving all training institutions and instructors as well as administering the State Board of EMS' grants. Dr. Collins' three-year appointment expires Nov. 12, 2007.

### Dr. Ponsky Named New Case, UH Surgery Chair

After a national search, Case Western Reserve University and University Hospitals of Cleveland found their new chairman of the Department of Surgery at the Cleveland Clinic. Dr. Jeffrey Ponsky, who was the Clinic's director of endoscopic surgery, began his new job at Case and UHC Feb. 1.

### CSU Honors Dr. Cosgrove

Dr. Toby Cosgrove, chief executive officer and chairman of the Cleveland Clinic Foundation's Board of Governors, was presented the first Cleveland State University President's Medal from CSU President Michael Schwartz. The medal, awarded in December 2004, recognizes Dr. Cosgrove for his commitment and dedication to the medical field and his influence on the university's interests and mission.

### Dr. Weiss Appointed Medical Director of the Joslin Diabetes Center Now at St. Vincent Charity Hospital

Dr. Daniel Weiss, M.D., FACP, was recently appointed medical director of the nationally renowned Joslin Diabetes Center that became affiliated with St. Vincent Charity Hospital in January. The Joslin Diabetes Center, established in 1898, is an internationally recognized treatment, research and education institution affiliated with Harvard Medical School. ■

## Welcome Our New Members

The AMC/NOMA is pleased to welcome 40 group members from the medical staff of Marymount Hospital and 10 group members from Ridgepark Medical Association, Inc. We are pleased to have the support of these two organizations. We hope Marymount and Ridgepark Medical Association, Inc.'s support inspires other regional hospitals, groups and health professionals in northern Ohio to join the AMC/NOMA and support its efforts to promote the practice of the highest quality of medicine. For more information on individual or group membership, contact Linda Hale, membership and marketing coordinator, at (216) 520-1000 ext. 309. ■

## Join Us for the Second Annual Memorial Golf Outing

The Second Annual Marissa Rose Biddlestone Memorial Golf Outing commemorating Executive Vice President/CEO Elayne Biddlestone's late daughter. On Monday, August 8, 2005 AMC/NOMA members will gather at Chagrin Valley Country Club to participate in this special fundraiser benefiting the Academy of Medicine Education Foundation (AMEF). Your contributions will assist in expanding educational programs including medical school scholarships as well as implementing new initiatives to assist both physicians and the patients they serve. For more information regarding this event contact the AMC/NOMA at (216) 520-1000 ext. 309. ■