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"Saving Northern Ohio Medicine and Protecting Patients"

More than 165 physicians, health care leaders, lobbyists, attorneys and patients attended the above referenced March 26th seminar. The seminar was open to everyone interested in health care with the main theme to concern the multi-faceted medical liability problem. The participants in the program were provided with politically practical, legal and ethical solutions to the liability crisis and received useful information on how to improve the future of the practice of medicine.

The morning began with opening remarks from the President of the AMC/NOMA, **Dr. James Lane**. Dr. Lane outlined for the audience the issues facing physicians in Northeastern Ohio and urged all physicians to join with AMC/NOMA in our legislative and advocacy efforts on behalf of all physicians. The past president of the Cleveland Academy of Osteopathic Medicine, Dr. George Thomas, provided additional opening remarks.

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Dr. Lane provides the opening comments for the March 26th seminar.



AMC/NOMA Physician Leadership Meets with State and Federal Leaders Regarding Legislative Issues

On March 23rd, AMC/NOMA physician leadership and staff attended a breakfast meeting with Governor Taft to learn more about the upcoming Ohio Supreme Court elections. Governor Taft discussed the extreme importance of the upcoming Ohio Supreme Court race. He discussed SB 281 and the fact that it is highly likely that a case testing this legislation will come before the Ohio Supreme Court in the next year or so. The Governor urged everyone present to get the word out to colleagues, physicians, and their employees about the importance of the 2004 Ohio Supreme Court race. (NOMPAC note: the AMC/NOMA political action committee NOMPAC sup-



Governor Taft spends a moment with Dr. John Clough, a member of the AMC/NOMA legislative committee at the March breakfast meeting.

ports the reelection of Justice Thomas Moyer and Justice Terrence O'Donnell to the Ohio Supreme Court as well as supporting Judge Judith Lanzinger in her candidacy for the court.)

Later in March, a meeting took place between AMC/NOMA physician leaders and Senator George V. Voinovich. There were several topics covered including medical liability legislation.

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Correction:

Dr. Thomas J. Steinemann was incorrectly identified in the March/April issue. We regret the error.

Saving Northern Ohio Medicine and Protecting Patients (Continued from page 1)

The first set of speakers was part of a panel on medical liability and physician discipline. Mr. David Martin of the Premium Group kicked off the panel discussion. Mr. Martin illustrated the key differences between medical liability insurance and other types of insurance.



Mr. David Martin, President of the Premium Group provides the audience with information on the medical liability companies in Ohio.

For example, home and auto insurers know their results for a given year; they know how many claims they have outstanding and their value. Not so in medical malpractice. The average time between incident and suit is 13 months and the average time between suit and adjudication is 35 months. A medical malpractice lawsuit becomes an insurer's liability at the time the claim is first made. This liability exists for nearly three years before its value is known. Mr. Martin showed data indicating that frequency of claims is not the driver of the medical malpractice cost crisis. He contends that severity is the irrefutable cause driving up malpractice costs. There is clearly data to show that severity, or drastically higher court awards, are the cause. Medical malpractice insurance must carry a "long tail" — and insurance companies in the 1990's did not accurately predict the award severity for future cases and collected too few premium dollars in those years to pay settlements three years hence. It is difficult to accurately predict where the courts will be in three years and all lines of insurance depend upon the ability to accurately forecast losses in future years.

Ms. Ann Womer Benjamin, director of the Ohio Department of Insurance followed Mr. Martin. The Director stated that as everyone knows, tort reform became effective in Ohio April of 2003. It is also a fact that insurance companies need to have tort reform in effect for a longer period of time in order for it to begin to impact rates. She also believes the companies have indicated that it is important to have the tort reform legislation upheld by the Ohio Supreme Court before it can be relied upon as part of their future rate making. Though nominal, tort reform has begun to make an impact in the rate making in Ohio. Companies are concerned that if they were to reduce rates due to the passage of tort reform, and three years from now the Ohio Supreme

Court declares it to be unconstitutional, this decision would be retroactive and all judgments made during that period would increase. The good news is that we have several cases already in court that will undoubtedly take some years to move up, but that coupled with experience with tort reform should assist in stabilizing the Ohio market. The Director indicated that the medical malpractice insurance industry issue has been a top priority at ODI and they are working very hard to restore stability to the medical liability insurance market. There is also an increasing awareness on the part of the administration and the legislature of how serious this is becoming. One item that has just occurred is the passage of a bill that would allow the director to set up a state medical malpractice insurance company if the market completely went south. Another recommendation is that the general assembly should pursue legislation to create a medical review screening process. Finally, she has recommended that the General Assembly give immediate consideration to establishing a patient compensation fund similar to those found in other states such as Indiana and Wisconsin. The fund would provide a secondary layer of insurance coverage reducing the cost of the primary layer that a physician would pay. For example, a physician may pay the initial amount and then the patient compensation fund, based on premiums, would provide the additional layer of coverage.

Regarding the rate increases, the Director noted that the companies are required to file their rate increases with ODI for review and the department determines if they are actuarially justifiable and legally sound. To date, the rate increases submitted by the companies have been justified. There have been discussions with the companies to see if there is any way to reduce the rates and still help maintain the financial solvency of the companies however, since the rates are justified there is no way to do that. ODI data shows that the five major companies offering medical liability coverage in Ohio have been completely without profit for the last five years. She has been asked why these insurance companies are staying in Ohio at all. Some operate in other states and they are doing a little better in other states than they are doing in Ohio. Some have other areas of business in which they are involved that may be helping them along. They are frankly trying to weather the storm. There is nothing compelling them to be here right now because, though they are not making any money in Ohio, they believe the market will improve. The insurers feel overall rates are gradually getting to the place in Ohio where future increases will be more on an annual basis, tied to inflation, rather than huge spikes we have been experiencing.

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These companies are also being scrutinized far more closely. A request was made to all the carriers in Ohio for very detailed lawsuit, settlement and claims information and we are still collecting this information. Under ODI's regulatory authority, we have gone into the five major companies to investigate their rating and underwriting procedures to be sure they are consistent, legal and being fairly applied.

While ODI is working on several initiatives to ease the crisis a rate freeze is definitely not under consideration. With only five major companies voluntarily doing business in Ohio, all operating at a loss, a rate freeze could have two disastrous results — 1. The companies would be compelled to leave the Ohio market and/or 2. They would be forced into insolvency and would be unable to pay pending claims.

Other relief measures include the possibility of introducing a Senate Bill requiring medical malpractice insurance companies to give doctors 60 days advance notice for a significant premium increase and a 60 day advance notice of cancellation. The bill would also require these companies to give the Department of Insurance significant advance notice when pulling out of a particular specialty area or geographic market.

The Director concluded, saying she is beginning to see signs of other companies returning to the Ohio market and she is using every creative and regulatory means at her disposal to ease this situation.

The next presenter was Mr. Tom Dilling of the State Medical Board of Ohio — the state licensing and regulatory authority. Mr. Dilling provided an overview of the make-up of the Board, their responsibility to protect and enhance the health and safety of the public through effective medical regulation, and the number of complaints reviewed by the Board each year. Mr. Dilling indicated that the OSMB

is well respected across the country and for the past eight years the OSMB has ranked in the top 10 in terms of serious disciplinary actions. Mr. Dilling emphasized the importance of this — since it illustrates that physicians as a profession in the state of Ohio are doing something to protect the profession and protect the public, which is an important goal.

Following Mr. Dilling was **Dr. Bill Seitz**, President-Elect of the AMC/NOMA. Dr. Seitz provided a detailed discussion regarding the effects of medical liability insurance on physician distribution and access to care. Dr. Seitz pointed out there has been a definite change in the relationship a physician has with insurance companies, malpractice companies, attor-

neys and at times, patients — rather than being a confidant, physicians are considered adversaries. Economic demands such as increased costs, reduced reimbursements, increased work volume and less time to spend with patients have resulted in reduced satisfaction for physicians. Overall the runaway malpractice costs coupled with decreased reimbursements are driving some physicians out of practice. The other effect is that new physicians are avoiding high-risk specialties, and the best and the brightest are not choosing a medical career. Medical students are exposed to disgruntled physicians and are choosing what they consider "safe" specialties in "safe" locations.

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Medical Student Survey

AMC/NOMA surveyed the medical students at Case Western Reserve University regarding the medical liability crisis to determine whether the medical liability crisis will be a factor in their choice of specialty, and whether it will factor in when they decide on which state to complete their residency training. In addition, we asked if their professors have been discussing the medical liability situation with them and if so, in what detail?

The survey results clearly show that if the medical liability crisis continues in Northern Ohio that the physicians of tomorrow may not remain in this area to practice medicine. In addition, based upon these results, the AMC/NOMA plans to work with Case in the coming months to assure that there is more information provided to medical students on the issue of medical liability.

Survey results:

Has the medical liability crisis been a factor in your choice of specialty?

Yes 52% No 39% Undecided 9%

Would the crisis be a factor in your choice of state which you complete residency training?

Yes 48% No 36% Undecided 16%

Have your professors discussed the medical liability situation?

Yes 49% No 51%

There were a great many comments included with the survey results and they cannot all be printed here. A sample of the comments received from the medical students were:

"I know I won't go into OB/GYN."

"Certain specialties are totally out of the question!"

"Not interested in specialties most affected."

"I took a U.S. Military scholarship to avoid the liability issue."

"Hearing the frustrations of practicing doctors has led me to not even consider some specialties."

"I have eliminated being a surgeon for just this reason."

"I have completely ruled out OB and surgery."

"It strikes fear into every medical student's heart!"

"I am too much in debt to risk more."

"Ohio and Florida are at the bottom of my list."

Any AMC/NOMA member interested in seeing the entire survey results may contact E. Biddlestone at the AMC/NOMA offices at (216) 520-1000, ext. 321.



Mr. Tom Dilling, Executive Director of the OSMB addresses the audience.

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Dr. Seitz outlined his own personal experiences showing that at multiple hospitals there are fewer physicians that will take emergency calls in his field of hand and upper extremity surgery, causing delays in patient follow-up and inadequate access. In addition, the AMC/NOMA conducted a statewide survey of hospitals, asking key questions about problems with call schedule, problematic specialties, and patient care issues and asked for comments. Overall, the survey showed that 136 physicians from the 38 hospitals responding to the survey have quit practicing. The hospitals indicated this has decreased specialty access, made in-patient consults difficult, and has severely limited the ability to provide some services. The hospitals also reported their patients are concerned and uncertain about their access to care. Additional concerns were having problems recruiting new physicians in certain specialties and the inability to compete with better reimbursement and lower rates elsewhere. One hospital administrator said, "Our weather has been replaced by our malpractice climate," resulting in increased waiting time and reduced patient satisfaction. It was also noted there is increased pressure on hospitals to pay for call coverage that had been provided for free as part of staff responsibility. Dr. Seitz concluded his remarks by stating that physicians are caught in a "spiraling conundrum" where an increased number of suits with exorbitant awards has caused the malpractice insurance companies to either leave the state or increase rates. This further increases the costs to physicians, decreases physician satisfaction, decreases availability of physician services and, in turn, decreases patient access to care causing patients to be less satisfied and more angered with the care they're receiving. We must find a resolution to this prob-

lem to retain our physician base and provide patients with access to care.

During the afternoon session, the seminar participants heard from national speakers on the topics of patient safety, why patients sue and a reliable justice system.

The first speaker of the afternoon was Mr. Jeff Pariser, the Executive Director of Common Good, a coalition dedicated to restoring the ability to make common sense choices and promote legal reform. The group of healthcare experts calls upon the United States Congress to immediately initiate hearings on the broad effects of litigation on healthcare (not just on the immediate litigation



Mr. Jeff Pariser, Executive Director of Common Good.

insurance crisis) and to consider recommendations on how to create new systems of medical justice that will promote better care. The AMC/NOMA has signed onto the petition developed by Common Good calling for a complete change to the medical justice system.

Mr. Pariser pointed out that the underlying problem, in the view of Common Good, is unreliable justice. When a physician enters a courtroom, that doctor has no idea whether he is going to win the case or not. Jury panels, are randomly chosen, don't have any ability to apply a standard of care with consistency because they are always different. Juries cannot set precedents and they cannot

judge on whether a physician's conduct is within the standard of care or not.

The other problem is that they can't award damages equitably across the spectrum of injuries, and do not award damages for pain and suffering the same across similar cases. Juries do not explain their decisions and a physician may not know exactly why the jury found a doctor liable. Was it because the jury did not like your expert, or because of the manner in which you kept your records? Or is it because something really was wrong? Jurors also lack the expertise to determine the standard of care. This is where the battle of the expert witnesses comes in. The fact is you can find experts, on both sides of the coin, to testify to almost anything as being within the standard of care, or not. Whether they are credible, reliable, decent human beings is another thing, but you can find people to testify. So, you end up getting jurors deciding largely based on expert credibility. This is the key fact.

Studies have shown that the primary determination of whether someone is going to recover damages, and whether you as a doctor are going to be found liable for negligence, is the extent of injury not the extent of fault. If there is a tragic outcome, you are much more likely to be found liable regardless of whether you did anything wrong. Jurors see the "tragic situation" and act accordingly. They view it as social insurance. So you end up with a social insurance system as opposed to a liability insurance system.

In the end, we want to make sure, as physicians and as a society, that the compensation is for injuries that are caused by physicians who do not meet the standard of care. None of us can control the fact that everyone dies sooner or later. There are many outcomes that are not ideal or unavoidable; nevertheless, the liability system should not award damages for such. In the end, the system is not punishing bad physicians, it is punishing bad outcomes rather than discouraging negligent practices. We ought to be encouraging meeting the standard of care while encouraging safety and quality.

A poll in the *Wall Street Journal* showed 72% of physicians view their patients as potential adversaries. That absolutely affects the way physicians practice. If a physician's fear of a lawsuit prevents open communication, it is harder to improve quality and safety. It also allows bad providers to avoid accountability, and remain in the system.

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The entire panel from the morning session answers questions from the audience (l to r) Mr. David Martin, Mr. Tom Dilling, Ms. Ann Womer Benjamin and Dr. William H. Seitz, Jr.

So what does Common Good advocate? We want to encourage safe practices. We want to improve safety and quality of care and the way to do that, we believe, is by an open sharing of information, which is not happening. The legal system discourages it. It does not reward best practice or expose unsafe practices because there is no open communication because the legal system is not trustworthy. Studies show increased communication is one of the greatest possibilities for improvement. In most cases, when a law suit is filed, institutions tend to shut down and it becomes the individual doctor who is part of the case as opposed to the many things that led up to the problem and why it occurred.

The only group of people who will tell you that the current system works are trial lawyers. One of the Common Good proposals is that if you could take juries out of the situation and use a system where the practitioners are making the decisions you would immediately speed up and streamline the process. The answer is simple — have the decision makers review the medical records and make the decisions, without outside experts. You would reduce the battle of the experts and probably the costs and time involved in reviewing a case. The main concern for physicians is that they want to be sure to provide quality care and meet the standard of care. Physicians want assurance if there is a bad outcome, that was not preventable, that there are some protections. A more efficient system of justice would ultimately mean that the victims will get more money as opposed to the lawyers. We propose that juries shouldn't make these decisions. We think you need reliable results that will encourage good practitioners and drive out bad practitioners. You also need reliable results to restore your confidence in the legal system. That would ultimately foster openness and reduce defensive medicine.

So how do we propose you do that? We think you need panels with practice experience making liability determinations. The jury should not be making liability determinations; people with medical experience should be making these determinations. Common Good advocates for medical courts. We think that you all would feel much more comfortable being judged that way and we think it would lead to much better medicine for everybody.

The second speaker of the afternoon was David Studdert, PhD, JD, Associate

Professor of Law & Public Health, Harvard School of Public Health, presenting on the topic of "Patient Safety and the Medical Liability System." He began by stating that it is clear there are new imperatives in the medical marketplace that relate to patient safety. Patient safety has emerged as a real issue and it is very hard for any physician to ignore it as we respond to the major developments in health care especially the medical malpractice environment. If one were to track the origins of the current climate surrounding patient safety it would lead to the release of the Institute of Medicine (IOM) report in December 1999. The most provocative finding from that report was the number or volume of preventable deaths in the United States each year. The implications of the report, that medical error as the 8th leading cause of death, resulted in the IOM's call for greater prevention — particularly through tracking and reporting systems.



Dr. David Studdert addresses a question from the audience.

Due to the IOM report, the number of researchers evaluating patient safety in the United States has increased substantially. They question whether or not the malpractice system has the capacity to provide insights into the causes of medical errors. One area of discussion is the issue of deterrence. Deterrence theory is tort 101 for law students — who learn that tort liability exists for two reasons. First, to compensate patients or injured parties for wrongs and second, to deter dangerous behavior. In the field of medicine, this equates to the creation of incentives to be sure physicians achieve high levels of good quality care. Put in non-lawyer terms — deterrence is really a concept of whether or not the medical liability system promotes quality. Studies on deterrence in various fields including medicine, have noted it is hard to find a behavioral response to threats of lawsuit in almost any area of so-called dangerous behavior.

One other study that looked at this in the context of health care and medicine

was the Harvard medical practice study. This study involved the review of 31,000 hospital records and the simultaneous review of malpractice claims filed in the State of New York. Investigators tried to model deterrence based on hospital adverse event rates and physician adverse event rates along with the liability exposure that they faced. This was then linked to two outcomes — the percentage of hospitalizations that had adverse events associated with them and the percentage of adverse events that were due to negligence. While there was some association between claims, volume at the hospital level and the percentage of adverse events within the hospital, it could not be linked to the presence of deterrence in the delivery of health care. The reality is there is no strong match up between instances of negligent injury and lawsuits, which is one of the reasons deterrence does not work the way it should.

What about the relationship between malpractice and efforts to improve patient safety? There is a concern among physicians that the public tends to regard the issue of medical error very simplistically, that medical error and negligence are the same thing. Even among lawyers there is a sort of dissonance. Twenty years of patient safety shows that negligence and medical error are not the same thing. Error may be the result of many factors — some of which involve individuals, some involve institutions, and some can involve relationships between individuals and institutions. Instances of error do not align all that well with instances of negligence. Instances of negligence are a subset of error but a small subset — this is a distinction that the public does not grasp well and may result in anxiety and litigation. Finally, the idea that the tort crisis has created a siege mentality is one that many feel occurred when the IOM report got a little ahead of where physicians were on this issue.

How does this manifest in terms of medical practice? One of the key areas is in the way that reporting systems operate. There are many reporting systems in the U.S. that are not doing well in terms of "catchment." Research shows that there is underreporting because of apprehension about litigation. In many of your hospitals, the risk manager or the quality officer is asking you to be forthright about reporting system errors. Legal protections that attach to those systems are often quite good, however, they have not been tested well in the courts — and so physicians
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are being asked to report on errors at a time when litigation and premiums are on the rise. There are fears about the use of the information in litigation, and for many clinicians it is a tension they feel in their daily practices. This tension can spill over to basic communication with patients and there is an inability for providers and patients to come together over the medical error issue because of the malpractice environment.

Dr. Studdert posed the question regarding whether or not the malpractice system has the ability to shed any light on the things that happen in day-to-day medicine. The tort system is likely to be a system that is with us for a long time, so we need to ask ourselves what we can get out of it that will help improve patient safety? Most bothersome is that this process is secretive for legal reasons. But to prevent future errors, we need to know why errors have occurred in the past. There is confidentiality from the moment a lawsuit is filed. In fact, often from the moment the incident occurs, instances are cloaked in confidentiality. This carries through to the litigation and even settlements are often confidential. Though there is a lot of useful data in medical malpractice claims, it is practically impossible to get any morsel of information from this system. Many investigators around the country have tried to tap into that resource, but until the medical malpractice system is capable of supporting those types of analyses to improve quality retrospectively, it is not helping with patient safety.

In conclusion, Dr. Studdert noted that there is reasonable evidence that caps stabilize the insurance market and provide short-to-medium-term relief for physicians. However, caps do absolutely nothing to improve patient safety. As physicians and legislators move through the debate on tort reform we should remind ourselves that we are living in a different time now and there are concerns that many physicians hold dear about patient safety that somehow need to find their way into the reform discussion.

Following Dr. Studdert was Dr. Gerald Hickson, Associate Dean for Clinical Affairs, Director, Vanderbilt Center for Patient and Professional Advocacy presenting on the topic of "Why Patients Sue." Dr. Hickson summarized selected malpractice research on why people sue and

who gets sued. His discussions included how to structure difficult interactions, deal with patients' reactions to bad news, present information about suspected errors, and present information when another health provider has contributed to an unexpected outcome. Finally, Dr. Hickson covered how risk management data and patient complaints can drive institutional quality improvements.

Dr. Hickson outlined a study done in Florida identifying families who filed suit against their obstetricians. The study indicated that those filing suit did not care whether they were right or wrong to do so. The study asked who sent you to the attorney in the first place? What made you make that decision?



Dr. Hickson drives home a point during his presentation.

The study found that one-third said they were advised to sue by an influential other. Of these families, 60 percent said that we never even considered the possibility until someone they trusted and whose judgment they valued suggested they should file a lawsuit. Who are these individuals and why do they do that to physicians? In 90 percent of these cases, it was a physician that told the patient to sue. Others who filed suits stated that they did it because they needed money or they believed that there was a "cover-up." Some individuals, when they come to believe you know things that you're not sharing — will assign that to a sinister motivation on your part. Some of the respondents that thought there was a "cover-up" said they felt that the only way they could find out what happened to their child was to get an attorney, put that physician on the stand to ask questions under oath. A percentage of those responding wanted the doctor to pay in the form of revenge — such as loss of the doctor's license. It is believed that this particular response is part of the grieving process; when something has happened to a loved one beyond your control, the personal loss can be accommodated by exposing the doctor for the terrible physician he or she is.

What do you do in your own practices when you have patients with adverse outcomes? Do you just let the family leave? Do you ever follow up? What kind of organized approach do you have? Dr. Hickson noted it is important to think about these questions and be proactive in terms of risk reduction. If someone needs professional assistance, or has questions and there is no link back to the team, you may wind up with a suit that's inappropriately driven. It is essential to have good communication skills and show concern for the patient and their family.

The reality is — errors occur and patients are injured — so good communication and concern are important, but when? Before, and not after the problem arises, physicians usually try to make right with the patient after an adverse event becomes apparent. Establishing good communications begins when your receptionist picks up that phone for the first time. You need to set the stage right then to begin to deal with things appropriately or you're going to pay for it. Poor communication prompts some patients to sue compounding the errors' potential impact. We know poor communication will prompt some patients to sue; 85 percent of suits are not valid, and since the system is poorly equipped to separate them out, the medical profession needs to deal with this matter constructively.

Dr. Hickson explained a model of basic intervention by which complaints are evaluated, reviewed and the content of letters are provided to the physicians. This information is confidential and peer review protected. Some patient allegations have no merit — based more in perception than fact. Some complaints may be outside of the physician's control, caused by the system or equipment and it helps to identify these issues. The model has been developed to train colleagues who are in the same discipline to present to one another. Research confirms physician behavior can be motivated to change when the message is delivered by a respected colleague, committed to confidentiality, who wants to share the data in the spirit of collegiality. We help our mentors who deliver this data, and try to anticipate the predictable responses that they may receive. A report card is produced that shows a complaint index and indicates where the physician is in relation to his colleagues. The study also provides physicians summaries of the kinds of complaints they generate, because complaints vary among physi-

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cians. Data has been collected from over 400 interventions in multiple states with individuals who stand out. Some of these interventions are challenging, but the vast majority of individuals respond in a professional way. Interestingly enough, the single most common response from physicians is that they never had any sense that this was true and they are stunned. Other reactions include denial, anger or rationalizations. But by and large, once physicians are provided with the data, they want to deal with it.

In closing, Dr. Hickson noted that insurance cycles will continue to happen and medical professionals' interest in malpractice also cycles. Cycles are highly correlated yet errors continue so physicians and the medical system need to constantly examine why and learn. Dr. Hickson emphasized that patient complaints delivered one at a time provide no comparative feedback and single complaints may be dismissed. Unsolicited patient complaints offer good information about a medical group or medical center and all complaints should be captured, stored, coded and returned back to the staff. Serious review of all complaints can help promote change in the system.

Ms. Carolyn Towner, of the Towner Policy Group and the AMC/NOMA lobbyist, provided the first presentation of the state legislative portion of the afternoon program. Ms. Towner provided detailed information on how to get a message across to legislators. It is very important to get to know your legislators, and help those that you want help from. She pointed out that due to term limits in Ohio, legislators can only serve for 8 years. So this changeover creates a need for constant lobbying of the legislators and getting to know your representatives.

It is important to develop a positive message that stresses benefits to the public that will result from the enactment of the legislation. Physicians need to work in campaigns and with the AMC/NOMA on building relationships with other groups that favor key legislation. To get a bill passed, be persistent because the process usually takes three sessions. If you do not get agreement, realize that passing legislation is a process and changes will be made. It is also critical that physicians deliver a consistent message — there is nothing worse than having a group of your peers delivering a conflicting message. AMC/NOMA does a good job of providing materials and information to members to take with them when going to see a legislator and



Ms. Carolyn Towner, the AMC/NOMA lobbyist, provides information on how to deal with legislators.

participate in the process. Ms. Towner encouraged the group to work with her and the AMC/NOMA on letter writing campaigns and developing key contacts with legislators in order to get the AMC/NOMA legislative message across at the Statehouse.

Following Ms. Towner was **Dr. John Bastulli**, the Vice President of Legislative Affairs for the AMC/NOMA. Dr. Bastulli provided an overview of Senate Bill 281. A key point that he emphasized regarding SB 281 was the binding arbitration aspect of the legislation. He reminded the participants in the audience that physicians may ask their patients to sign an arbitration form. If the form remains in force beyond 30 days, it is binding on both parties. Dr. Bastulli strongly suggested that physicians utilize the AMC/NOMA model arbitration form in their practices. *(Editors' note: to obtain a form call the AMC/NOMA at (216) 520-1000 or go to our Web site at www.amcnoma.org under the Medical Liability section.)*

Dr. Bastulli then proceeded to discuss the work of the Ohio Medical Malpractice Commission to date, as well as the ongoing AMC/NOMA legislative and advocacy agenda. The AMC/NOMA lobbyists have attended every meeting of the Ohio Medical Malpractice Commission and provided information and feedback to the AMC/NOMA legislative committee. In addition, AMC/NOMA physician leadership and staff have met individually with the Director of the Ohio Department of Insurance on a quarterly basis. In March, the Commission approved an interim report that recommended legislators in Ohio consider several measures to stabilize the medical liability climate in the state. Some of these measures include:

- Explore the need for statutory changes such as limiting attorney fees
- Explore changing the statute of limitations including the 180-day notice provision
- Require the plaintiff and defendant to file an expert's report before trial would proceed
- Explore creating separate courts to handle medical liability cases
- Recommend that the Ohio Supreme Court consider special certification of attorneys authorized to bring medical malpractice cases
- Recommend that the legislature enact a statute requiring medical liability insurance companies to report claims data to the Ohio Department of Insurance
- Pursue legislation creating a medical review screening process to pre-screen medical malpractice lawsuits
- Give immediate consideration to establishing a patient compensation fund to help reduce medical malpractice rates.

Dr. Bastulli further stated that the AMC/NOMA plans to work closely with our lobbyists and legislators to implement as many of the initiatives proposed by the Commission as possible. The AMC/NOMA will also work toward getting legislation introduced and support legislation that would further the positive steps taken by tort reform and to combat the damaging effects on physicians and their patients by the destabilization of the professional liability insurance market. These initiatives include but are not limited to:

- **Mandatory Mediation/Arbitration**
If a patient signs an arbitration form as outlined in SB 281 and it remains in force, the agreement is binding.



Dr. Bastulli responds to a question from the audience on the issue of state legislation and medical liability.

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Saving Northern Ohio Medicine and Protecting Patients

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However, if there is no arbitration agreement in place and a claim has been filed, arbitration is not mandatory under SB 281. Therefore, AMC/NOMA supports the concept to allow for mandatory mediation of claims prior to a case going to trial — and the mediation results should be admissible as evidence if the case does go to trial.

- **Establishment of a Medical Review Panel** – During the debate on SB 281, AMC/NOMA testified in support of the establishment of a Medical Review Panel to provide for pre-litigation screening to eliminate frivolous claims. This medical liability system reform from MICRA was not enacted in SB 281. The benefit of a medical review board is that it removes lawsuits from the system before they occur by identifying whether the claim is valid or not. Other states have successfully instituted this type of panel. The HB 215 — Medical review panels — has been introduced in Ohio through the efforts of meetings with legislators to establish medical review panels. AMC/NOMA strongly supports this legislation and we have testified in favor of the bill. We encourage all Northern Ohio physicians to write to their Ohio legislators in support of HB 215.
- **Creation of a Sliding Scale for Attorney Contingency Fees** – During the debate on SB 281, the AMC/NOMA provided expert testimony and data to the Ohio House and Senate during testimony on SB 281 that showed that a cap on attorney contingency fees results in a 12 percent increase in damage awards retained by the plaintiff. The AMC/NOMA continues to strongly support a sliding scale for attorney contingency fees.
- **Development of a Patient Compensation Fund (PCF)** – The PCF is meant to enhance or increase market availability and affordability of professional liability coverage. The AMC/NOMA believes that the PCF concept may have merit. A PCF would include an annual surcharge on all medical malpractice policies.
- **Explore changing the statute of limitations including the 180-day notice provision** – Consider a statu-

tory requirement that medical liability insurance companies would have to provide physicians with 60-days notice if their policy is being non-renewed, cancelled or they can expect a significant premium increase. Insurance companies would also be held accountable to the ODI if they plan to discontinue writing policies in Ohio.

- **Recommend that the legislature enact a statute requiring medical liability insurance companies to report claims data to the Ohio Department of Insurance** – This proposed statute (as recommended in the Commission report) would require medical liability insurance companies to report claims data such as parties to the claim, the cost associated with the claim, and the disposition of the case to the ODI.
- **Expert review/reports** – Require a plaintiff and defendant to file an expert's report before trial. Require that the expert must be in the same specialty as the physician involved and the report filed must provide an expert opinion as to whether or not the applicable medical standard of care had been met.
- **Special Certification of Attorneys** Ask that the Ohio Supreme Court consider special certification of attorneys who handle medical liability claims.
- **Medical Courts** – Consider establishment of special courts to handle medical liability cases, composed of judges trained in medical standards.
- **Constitutional amendment** – HJR 15 is a resolution that calls for a constitutional amendment that would permit the General Assembly to determine limitations on noneconomic damages awarded by juries in medical malpractice cases. The AMC/NOMA legislative committee will review this concept in the near future.

Dr. Bastulli informed the seminar participants that the AMC/NOMA did not advocate for a rate freeze at this time (see related story on page 10.)

With regard to the 2004 Ohio Supreme Court races, Dr. Bastulli indicated that the AMC/NOMA's Political Action Committee (NOMPAC) will be very active in this campaign. Once again, we face the challenge to ensure that the justices on our Supreme Court interpret the law rather than legislate from the bench. To meet this challenge, NOMPAC seeks to keep Chief Justice Thomas Moyer and Justice Terrence O'Donnell on the court and



It was standing room only for the presentations by Senator Voinovich and Secretary Tommy Thompson.

elect Appellate Court Judge Judith Ann Lanzinger. These individuals are dedicated to preserving the principles of judicial fairness. Dr. Bastulli urged all physicians to become involved in this campaign through contributions to NOMPAC.

Following the session on state legislation were two speakers representing government from the federal level. The AMC/NOMA was very pleased that both Senator George V. Voinovich and U.S. Department of Health and Human Services Secretary Tommy Thompson took the time out of their schedules to participate in this seminar.

Senator Voinovich stated that he is aware that lawsuit abuse is not only driving doctors out of the profession. He indicated that when he was Governor of Ohio he passed a meaningful tort reform bill only to have it overturned by the Ohio Supreme Court. He urged the physicians in the audience to work toward keeping tort reform in place in Ohio by supporting the Ohio Supreme Court candidates recommended by the AMC/NOMA. Two years ago, the American Tort Reform Association did a study in Ohio which figured that litigation costs the average Ohioan \$635 annually. The current tort reform legislation must stay in place and other legislation will need to pass to keep the practice of medicine viable.



Senator George Voinovich addresses the physicians in the audience regarding key legislation at the federal level.

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The Senator stated that he has been a supporter of the Health Act and the Patients First legislation, both of which would have provided broad based medical liability reform, but failed to achieve the number of votes necessary for passage. The Senator also wants to make sure that Ohio's Medicare beneficiaries have access to their physicians without being jeopardized by inadequate reimbursement from Medicare. He worked to assure that physicians were provided an increase this year as well as pushed for passage of the Medicare Prescription Drug and Modernization Act.

And just as medical malpractice rates are increasing and your reimbursements from Medicare are wavering, paperwork related to health care is bogging down your offices. The Senator indicated he would support changes in the HIPAA regulations to simplify the system.

Secretary Thompson followed the Senator and stated emphatically that he wanted to do something about transforming the practice of medicine. He spoke of informatics — changing to the most modern technology possible. Very soon HHS will be rolling out a new uniform lexicon costing \$14 million — that will be distributed free of charge to doctors and hospitals. It will be a uniform glossary of terms and treatments across America. The Secretary has also asked the Institute of Medicine to come up with a uniform patient record for standardized use across America.



Secretary Tommy Thompson presents information on HHS initiatives that affect physicians.

HHS also plans to establish uniform standards for computers and computer systems that will have uniform languages and standards across America. He has also asked the FDA to come up with bar coding to enable the scanning of all medicines given to patients to reduce the number of hospital errors. Secretary Thompson noted that there are probably some physicians asking what about the cost? He indicated that each year HHS takes in about 1 to 1.2 billion each year

in fines because of fraud and abuse. He believes that we should take at least 50%, about \$600 million a year, and put those funds towards setting up this new technology across the country and start transforming medicine.

On the issue of liability, Secretary Thompson stated it is sad that we allow the trial lawyers in America to prevent good legislation that would keep doctors practicing medicine, from being passed. There are too many frivolous lawsuits; too many runaway verdicts, and physicians must get motivated. The only thing that stands between you and success are the trial lawyers. He encouraged everyone to partner with him in Washington and pass a bill to cap non-economic damages and establish meaningful tort reform at the federal level.

With regard to the HIPAA regulations, Secretary Thompson stated that there have been changes in the law since it was first developed, however, at this point in time, there are not many complaints coming in about HIPAA. HHS cannot change the law, but they can change the rules and some of the definitions that are going to make it easier for you to continue to practice medicine. If physicians find HIPAA rules and regulations that are causing problems, he encouraged them to provide a copy of those rules underlining what is of concern and suggest a solution.

The Secretary closed by reiterating that he needs the help of physicians. He needs input on rules and regulations, and he will need help in order to pass a good liability bill this year. The only way it will happen is with physicians' support and willingness to unite with one another across America.

Dr. Richard Ludgin wrapped up the seminar by reiterating how important it is for physicians in the Northern Ohio area to utilize the resources of the AMC/NOMA during this debate on tort reform and other vital physician advocacy issues. He stated that the medical profession in Northern Ohio has to speak



Senator Voinovich and Secretary Thompson respond to questions from the audience.



Dr. Richard Ludgin wraps up the seminar for the day.

with a unified voice through the AMC/NOMA. He stated that the AMC/NOMA is the only organization in the community that speaks for the broad constituency of physicians. He reiterated the importance of the legislative and advocacy agenda and encouraged physicians to get involved in the legislative process. He indicated that the AMC/NOMA is truly the physician advocacy organization in Northeastern Ohio and that all physicians should participate in our efforts.

(Editor's note: This overview of the seminar is a brief synopsis of the presentations. It does not include all portions of the presentations.)

Editor's wrap-up of seminar: The effectiveness of the AMC/NOMA, like that of any professional society, is directly related to the number of members who actively participate in its programs and activities. The success of the AMC/NOMA efforts and activities is entirely dependent upon strong commitment and involvement in organized medicine. This year we are continuing our campaign to assist physicians with the medical liability crisis by providing tangible and verifiable survey information on the medical liability crisis to legislators and the media. We are continuing to keep the public informed of the crisis through the media, our Web site, physician office brochures and meetings with both federal and state legislators. This seminar "Saving Northern Ohio Medicine and Protecting Patients" was one such initiative. In addition, as a result of this seminar, the AMC/NOMA legislative chairman will represent the Academy on Senator Voinovich's Ohio Health Care Task Force. ■

AMC/NOMA Legislative Committee Provides Opinion on Medical Liability Rate Freeze Legislation

Recently, the AMC/NOMA sponsored a seminar entitled, "Saving Northern Ohio Medicine and Protecting Patients." Several of the presentations included information regarding legislation that calls for a rate freeze for medical liability premiums. The AMC/NOMA believes that while legislation establishing a rate freeze or rollback in liability premiums may appear to be a viable approach to the medical liability problem, we are concerned that those advocating for this legislation have not completely reviewed the result of such a policy.

There is nothing that requires medical liability insurers to write policies in Ohio. Of only five companies operating in this state, three are showing signs of financial stress. A rate freeze would almost certainly result in these companies leaving the Ohio market or becoming insolvent, as has happened in other

states following similar legislation. Data from the Ohio Department of Insurance shows Ohio liability insurers have experienced dramatically decreasing profits since 1998, making it clear that the Ohio market is unprofitable and undesirable for medical liability insurers. In light of this, the AMC/NOMA is unable to support any legislative proposal that could further erode this precarious market and worsen the situation for many Northern Ohio physicians. In addition, there have already been hearings before the Ohio Medical Malpractice Commission where the five remaining medical malpractice insurance carriers presented data regarding their finances (see legislative section on page 13.)

The AMC/NOMA understands that physicians are searching for solutions and ways to express their frustration due to the rising medical liability costs.

Dissatisfaction among physicians with this situation has risen to the point where some are now talking about participating in a work stoppage to exert pressure on the legislature to resolve the professional liability insurance crisis.

The AMC/NOMA legislative committee has reviewed and approved the accompanying article regarding the antitrust implications of physician work stoppages. This information is presented for educational purposes to aid physicians in their individual decision-making process in determining whether to participate in a work stoppage and should not be taken as a substitute for legal advice. We suggest that individual physicians should contact a private attorney to receive legal advice as to whether they should participate in any work stoppage.

(For more information on the work stoppage issue see next page.) ■

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Antitrust Implications of Physician Work Stoppages

The Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) realizes that frustration and anger among physicians is on the rise because of the recent professional liability insurance crisis. Physicians are finding it increasingly difficult to find and/or afford professional liability insurance. Physicians are searching for solutions and ways to express their frustration. To that end, physicians are seeking legislative changes to resolve the current professional liability insurance crisis.

During the debate on tort reform in Ohio, the AMC/NOMA provided testimony and input to assure the passage of meaningful legislation. In addition, we are working with other groups to find additional legislative solutions to the problem. The AMC/NOMA anticipates that in the coming months legislation will be filed to implement additional tort reform recommendations such as establishing medical review panels, creating a patient compensation fund, requiring certification of attorneys, requiring expert reports and review of claims, establishing a sliding fee scale for attorney contingency fees; and establishing other alternative dispute mechanisms.

Physicians are searching for solutions and ways to express their frustration. The level of frustration and anger among physicians has risen to the point where some physicians are now talking about participating in a work stoppage to exert pressure on the legislature to enact legislation to resolve the professional liability insurance crisis. Physicians in Ohio have seen physicians in other states participate in work stoppages to pressure their legislatures to enact legislation and are beginning to think about participating in similar work stoppages here in Ohio.

Before any physician participates in a work stoppage, there are two things physicians need to know. First, Ethical Opinion E-9.025, "Collective Action and Patient Advocacy" of the American Medical Association provides, in pertinent part that: Strikes reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences is contrary to the physician's ethic. Physicians should refrain from the use of the strike as a bargaining tactic.

Second, physicians need to be aware of the fact that the Sherman Antitrust Act prohibits agreements between two or

more persons that unreasonably restrain trade, including certain types of boycotts or strikes. Unilateral action by one physician, on the other hand, will not trigger the antitrust laws, even if that action results in a restraint of trade. Specifically, Section 1 of the Sherman Antitrust Act provides that: Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

The penalties for violating the Sherman Act are severe. The Sherman Act provides that any person violating the antitrust law is guilty of a felony and will be punished by a fine not exceeding \$10 million, if a corporation, or, if another person, by a fine not exceeding \$350,000. The antitrust laws also provide that any person who is injured by the antitrust conduct may bring an action in court and may recover treble damages. Similarly, any attorney general may bring an action to enforce the antitrust laws, and may also recover triple damages.

In construing the Sherman Act, the courts have held that certain types of agreements or practices between two or more persons are so plainly anticompetitive that they are conclusively presumed to be illegal. Included in this category of agreements or practices are agreements among competitors to fix prices or to restrict output. These types of agreements or practices are considered "per se" violations of Section 1 of the Sherman Act. Agreements or practices that do not fall within this category are analyzed under the "rule of reason" to determine whether, under all of the circumstances of the case, the agreement unreasonably restrains trade. Under the "rule of reason" analysis, a plaintiff must prove (1) an anticompetitive effect of the participant's conduct on the relevant market, and (2) that the conduct has no procompetitive benefit or justification. The presumption in cases brought under the Sherman Act is that the "rule of reason" applies.¹

Included under the type of agreement or practice that has been considered a "per se" violation of the Sherman Act is a boycott among competitors where the participants have agreed or conspired to participate in the boycott to raise prices or to improve their individual economic interests. A "boycott," in its simplest aspects, is defined to be an agreement among economic competitors to sever or limit economic relations with another

economic competitor or competitors. The United States Supreme Court has held that the "per se" approach is generally limited to boycotts "in which firms with market power boycott suppliers or customers in order to discourage them from doing business with a competitor."²

The federal courts have also held that boycotts designed to drive out competitors, to raise prices, or to achieve some economic benefit to those participating in the boycott are viewed as illegal "per se." At the same time, the courts have held that concerted actions on non-price restrictions, or boycotts not designed to raise prices, but to achieve some other goal are not illegal "per se," but, instead, are analyzed under the "rule of reason." Some of these cases involve application of the so-called *Noerr-Pennington* doctrine. Due to the conflict between the First Amendment and the antitrust laws, the federal courts created an exception to the Sherman Act that provides immunity from the antitrust laws for joint efforts to influence government officials, including the executive, judicial and legislative bodies of the government. This exception to the Sherman Act is referred to as the *Noerr-Pennington* doctrine. The courts, however, take a narrow view of this exception, so it is important that any joint actions by physicians conform to the requirements established by the courts for this exception. If the courts decide that the joint action by physicians is not genuinely aimed at procuring favorable governmental action, this immunity is not available.

There are several important federal cases that have interpreted the *Noerr-Pennington* doctrine that merit discussion. First, in one case, the court determined that an economic boycott by NOW that was politically motivated to achieve a legislative goal was not within the scope of the Sherman Act and, therefore, did not violate the antitrust laws.³

In that case, NOW organized an economic boycott of states that failed to ratify the Equal Rights Amendment. The court stated that it believed Congress' concern in enacting the Sherman Act was not the elimination of boycotts, but the elimination of boycotts used by a competitor against a competitor in the business of competing. In other words, the court believed that the scope of the Sherman Act was limited to commercial boycotts as opposed to social or political

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Antitrust Implications of Physician Work Stoppages

(Continued from page 11)

activities. The court concluded that NOW's boycott was not in violation of the Sherman Act. It is important to note that one of the factors used by the court in arriving at its decision was the court's finding that the NOW boycott was "non-economic," in that it was not undertaken to advance the economic self-interest of the participants.

In another case involving the *Noerr-Pennington* doctrine, the United States Supreme Court tried to distinguish between the degrees of antitrust immunity for acts of petitioning the government.⁴

It stated that the scope of the protection afforded by the *Noerr-Pennington* doctrine depended on the source, context and nature of the anticompetitive restraint at issue. Absolute immunity from the antitrust laws will result when the restraint is the result of valid governmental action as opposed to private action. In addition, where the anticompetitive restraint directly from private action, the restraint will not form the basis for antitrust liability if it is "incidental" to a valid effort to influence governmental action. The court concluded that the activity in question was not immune under the *Noerr-Pennington* doctrine because it involved a commercial activity and not a valid effort to influence governmental action.

Finally, in another case interpreting the *Noerr-Pennington* doctrine, the United States Supreme Court held that a strike by competing lawyers who performed court-appointed criminal defense work in the District of Columbia violated the Sherman Antitrust Act.⁵

In that case, the lawyers complained that their reimbursement rate for their services was too low to allow them to provide effective legal assistance to indigent criminal defendants. The court stated that the social justifications offered by the lawyers for their strike did not make their strike any less illegal, because the undenied objective of the strike was an economic advantage for those who participated in the work stoppage. The court refused to justify the work stoppage by the lawyers under the *Noerr-Pennington* doctrine because, while in *Noerr* the alleged restraint of trade was the intended consequence of the public action, in this case the boycott was the means by which the lawyers sought to obtain favorable legislation. As

a result, the court found that the work stoppage by the lawyers constituted a "per se" violation of the Sherman Act.

These cases interpreting the Sherman Antitrust Act are very important because they demonstrate that the courts take a dim view of any work stoppage where the purpose of the work stoppage is closely tied to the individual economic interests of the participants in the work stoppage. First of all, a concerted work stoppage by competing physicians that is designed to reduce output or to improve the economic well-being of the participants, will, most likely, be viewed as a "per se" violation of the antitrust laws. The courts will conclusively presume these types of work stoppages to be illegal without looking into the claimed purpose or overall competitive effect of the work stoppage. On the other hand, if the purpose of the work stoppage is not closely tied to the individual economic interests of the participants in the work stoppage, but instead is tied to pressuring the legislature to enact legislation to ensure the availability and accessibility of professional liability insurance, the courts may elect to analyze the work stoppage under the "rule of reason" test and not view the work stoppage as "per se" illegal.

These cases also demonstrate that a work stoppage by competing physicians that is not designed with the sole purpose of influencing the legislature to enact tort reform legislation will not be protected under the *Noerr-Pennington* doctrine and will not be entitled to absolute immunity from the Sherman Act. If physicians participate in a concerted action to go on strike because they cannot afford the premiums for professional liability insurance or because they seek legislation to make that insurance more affordable, it is highly likely that the courts will treat the work stoppage as a "per se" violation of the Sherman Act. Work stoppages designed to improve the economic well being of the participants will be viewed as illegal. On the other hand, a concerted activity by physicians may not violate the antitrust laws if it is "incidental" to a valid effort to influence governmental action to enact legislation that is not designed to improve the economic well being of the participants, even though the anticompetitive activity may also have a commercial impact. In other words, if the work stoppage by physicians is the primary means by which the participating physicians intend to pressure the Legislature to enact legislation, the courts will prob-

ably view the work stoppage as illegal. If the work stoppage is only incidental to valid efforts to lobby the Legislature to enact legislation to make professional liability insurance more available and accessible, the work stoppage may not be viewed as illegal, even though the work stoppage may have a commercial impact.

In summary, it is highly likely that if physicians jointly decide to participate in a work stoppage or strike and withhold their services from hospitals and patients, even in an emergency situation, and the aim of the strike is to improve the economic well-being of the physicians participating in the strike, the courts will treat the work stoppage as "per se" illegal, and the participants will be subject to the criminal and civil penalties available for violations of the Sherman Act. In addition, such a strike would also violate Ethical Opinion E-9.025, discussed above, because patients would be deprived of access to care and the strike would eliminate or delay necessary care. The cases discussed above clearly show that any strike designed to lower professional liability insurance premiums to make the insurance more affordable to the participants of the strike will most likely be illegal. A work stoppage cannot be designed with that goal, and must minimize any anticompetitive harm, including harm to patients. If physicians are not available to provide emergency services to patients when needed, the anticompetitive harm caused by the work stoppage may be viewed as overriding any benefit derived from the strike.

This article is presented for educational purposes to aid physicians in their individual decision-making process in determining whether to participate in a work stoppage and should not be taken as a substitute for legal advice. Individual physicians should contact a private attorney to receive legal advice as to whether they should participate in any work stoppage. Portions of this article were reprinted with the permission of the Florida Medical Association. ■

¹ *Levine v. Central Florida Medical Affiliates, Inc.*, 72 E3d 1538 (11th Cir. 1996).

² *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447 ((1986).

³ *State of Missouri v. National Organization for Women*, 620 F2d 1301 (8th Cir. 1980).

⁴ *Allied Tube & Conduit Corp. v. Indian Head, Inc.*, 486 U.S. 492 (1988).

⁵ *F.T.C. v. Superior Court Trial Lawyers*, 493 U.S. 411 (1990).

State House Report

by Carolyn Towner and Kristy Smith, Towner Policy Group

Senate Bill 187 – Medical Malpractice Insurance Policies

On March 30, 2004, Senate Bill 187, a bill pertaining to deferred annuities, sponsored by State Senator Scott Nein (R-Middletown), was substituted, amended, and passed by the Senate Insurance Committee. An amendment was included at the request of the Ohio Department of Insurance (ODI) that deals with the cancellation, termination and nonrenewal of medical malpractice insurance. The amendment requires medical malpractice insurers to notify the ODI 60 days in advance of cancellation of policies. It also requires 120 days advance notice for dropping specialty or regional insurance and it sets a 180-day notice if an insurer plans to leave Ohio. The cancellation policies affect new policies written after the effective date of the bill. The bill was passed by the Ohio Senate by a vote of 33-0 on March 31, 2004 and will now be referred to a Committee in the Ohio House of Representatives.

Taft Signs Medical Liability Bill and Calls for Additional Measures of Stabilization

On Monday, April 12, 2004 Governor Bob Taft signed House Bill 282 at Grant Medical Center in Columbus. House Bill 282 provides for the establishment of a Medical Liability Underwriting Association (MLUA) for medical liability insurance and a Stabilization Reserve Fund. House Bill 282, sponsored by State Representative Larry Flowers (R-Canal Winchester), authorizes the Director of the ODI to establish a new MLUA if the market worsens. The MLUA would write primary insurance coverage for doctors unable to find medical liability coverage. The bill contained an emergency clause and became effective immediately.

Taft also announced a five-point plan outlining additional measures to stabilize Ohio's medical malpractice market. Taft's five-point plan includes:

- Passage of *Senate Bill 187* that requires medical liability insurers to provide 60 days notice of cancellations or rate increases by policyholders; provide 120 days notice to the ODI if an insurer intends to stop coverage of a specialty or geographic area; and sets a 180-day notice if an insurer plans to leave Ohio.

- Legislation to allow doctors to form *self-insurance entities* in Ohio to better meet their needs.
- Legislation enacting the ODI and Medical Malpractice Commission's recommendation for a *data reporting statute*.
- Ohio Supreme Court and Ohio General Assembly action to establish a process to *screen certain medical malpractice claims*.
- Legislation that creates and funds a *patient compensation fund* at the earliest possible date.

Physician Assistants Bill Undergoing Hearings

House Bill 147, sponsored by State Senator Lynn Wachtmann (R-Napoleon), revises the physician assistants' law and allows physician assistants to prescribe drugs. The bill has been referred to the Senate Health, Human Services and Aging Committee where it has had several hearings.

In his testimony before the Senate Health, Human Services and Aging Committee on March 17, 2004, Terrence O'Donnell of the Ohio Association of Physician Assistants (OAPA) highlighted the need for updating Ohio's law regarding physician assistants, explaining that 47 other states and the District of Columbia have enacted prescriptive authority for physician assistants. The bill is set to undergo several changes related to the educational requirements of the PA as well as a change in the manner in which the drug formulary is established. AMC/NOMA's position on this legislation is neutral with technical assistance.

Medical Malpractice Commission Issues Interim Report

On March 9, 2004 the Ohio Medical Malpractice Commission released its Interim Report to the Governor and members of the General Assembly, recommending actions that could help stabilize medical malpractice rates in Ohio. To view the complete text of the Interim Report visit the Ohio Department of Insurance Web site at www.ohioinsurance.gov.

The Commission recommended the following legislative action in their report:

- House Bill 282, which authorizes the Director of Insurance to create a Medical Liability Underwriting

Association (MLUA) if the current medical malpractice market further deteriorates, should immediately be passed by the General Assembly and presented to Governor Bob Taft for signature.

- The Ohio General Assembly should enact legislation requiring the reporting of medical malpractice lawsuit data, patterned after Florida Statutes. Such legislation is necessary to evaluate fully the causes of the medical liability crisis in Ohio and to assist the Department and General Assembly in monitoring the market.
- The General Assembly and interested parties should continue to pursue expeditiously legislation creating a medical review screening process to prescreen medical malpractice lawsuits.
- The General Assembly should give immediate consideration to establishing a patient compensation fund to help reduce medical malpractice rates.

The Medical Malpractice Commission has held 10 meetings to date. At their March meeting the Commission discussed charitable immunity and legal reforms.

At their April meeting, the Commission met with the insurance executives from the five medical liability carriers still operating in the State of Ohio. These executives all testified that the companies' declining investment returns have not played any part in the increasing rates. They stated that only small portions of their investments are in equity instruments.

In addition, the executives indicated that an increase in the frequency and severity of medical malpractice claims is primarily responsible for recent increases in liability insurance rates. The executives said the companies face difficult challenges in forecasting future claims and payments, noting that rates are set over a longer-term period, rather than other insurance industry sectors, which have rates based on two- to three-year periods.

The executive from OHIC Insurance Company said his company lost about \$44 million between 1997 and 2000, when it collected \$120 million in premiums and paid out \$164 million in claims. He noted that OHIC rates for physicians
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State House Report

(Continued from page 13)

in Cuyahoga County are 40% higher than in the rest of the state. That increase, he said, is attributed to the county's higher loss costs.

The president and CEO of American Physicians Assurance Corporation said his company had a "disastrous" entry into the Ohio market. He said that the company, which did not have significant experience in Ohio — established its initial rates based on the competitive market. Those rates turned out to be too low, which produced a \$139 million loss between 1995 and 2003.

The senior counsel for The Doctors Company pointed to the MICRA law in California that has been credited with keeping that state's liability rates lower than in Ohio and elsewhere. He said that MICRA has helped stabilize the rates in California. MICRA includes among other provisions a \$250,000 cap on noneconomic damages; tiered limits on attorney fees; periodic payments for future payments and a requirement that plaintiffs provide a 90-day notice of an impending claim to allow for negotiations.

The executive from Medical Assurance stated that to his knowledge no medical malpractice insurer has made money in Ohio over the last five years. He said Medical Assurance believes that at this time its current rates are appropriate, but he noted that any action to reduce or freeze rates would impact the company's continued operations in the state. One of the executives noted that a cap on rates for a year would be "devastating" to his company.

The executives also testified that the medical liability insurance market in Ohio is beginning to stabilize, due in large part to rate increases and the state law limiting jury awards. All of the executives from the five companies told the Ohio Medical Malpractice Commission they believe they will turn profits this year after five years of losses. Rate increases should moderate over time, but they will not decline any time soon. The executives stated that doctors are likely to face double-digit increases in premiums until the Ohio Supreme Court upholds the 2003 law capping awards for noneconomic damages.

The AMC/NOMA lobbyists and physician leadership were in attendance at the commission meeting to hear the testimony of the five insurance executives. A copy of their full testimony is available at the AMC/NOMA offices.

Concealed Carry Handgun Act

House Bill 12, the concealed carry handgun law will take effect on April 7, 2004. This Act allows certain Ohioans to carry concealed handguns if they obtain a state-issued permit. A limited list of facilities was exempted from the provisions of the bill, as public buildings of the state or any political subdivision, day care centers, churches, police stations, and establishments serving alcohol. House Bill 12 does permit private entities to determine whether to allow concealed handguns in their facilities.

You can be considered a "concealed carry-free" entity by *posting notices, developing policies and procedures, and training staff* on the pertinent provisions of the new law:

1. **Post signs** in conspicuous locations, such as all entrances to buildings and parking lots, prohibiting all firearms and handguns on the property or premises. These signs should be directed at all persons who enter the property or premises, including employees, patients, guests, visitors, customers, and vendors.
2. **Have a policy or rule** prohibiting employees from bringing handguns into all areas of the workplace, including parking lot areas. Make the policy known to all new and existing employees and include it in the employee handbook. Violations of the policy should be disciplined accordingly.
3. **Have a policy or rule** prohibiting clients, guests, visitors, patients, and vendors from bringing handguns onto the employer's property or premises. Again this policy should extend to the entire premises, including parking lot areas. Include in the policy actions to be taken if a guest, patient, vendor, or visitor brings a concealed handgun onto the property, such as removal from the premises and reports to the police.

A copy of House Bill 12, as enacted, may be obtained from the State's Web site: www.legislature.state.oh.us

HB 215 bill is substituted — removing medical screening panel language

House Bill 215, sponsored by State Representative Jean Schmidt (R-Loveland), would have required medical claims against healthcare providers to be reviewed by a medical review panel prior to the claim proceeding in court. This legislation was substituted on April 20, 2004 and no longer applies to medical screening panels. As substituted, the bill provides the following:

Colorado "I am sorry law" – Prohibits the use of a defendant's statement of sympathy as evidence in a medical liability action. Expressing sympathy has been used as an admission of liability and this provision would allow a physician to express sorrow without having it used against him/her.

Expert Witnesses – The bill requires a physician from another state that testifies as an expert witness in Ohio to be deemed to have a temporary license to practice medicine in Ohio and is subject to the State Medical Board of Ohio. Discipline may result from expert testimony that is tantamount to unprofessional conduct, including the provision of expert testimony that is false or completely without medical foundation.

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.

Medical Claims Data Collection – The bill regulates the collection and disclosure of medical claims data by the ODI. Every insurer writing medical malpractice insurance in Ohio is to provide the following information to the ODI, which will collect and summarize on statewide, physician specialty, and geographic bases and the ODI is to publish and release in the form of a public report.

Medical Claims Court – The bill urges the Ohio Supreme Court to establish a medical claims court on a pilot project basis in the temporary language in the bill. The bill establishes that the Ohio General Assembly urges the Ohio Supreme Court to establish, on a pilot-project basis, a medical claims court that compels a plaintiff to exercise due diligence in examining the basis for a medical liability claim and to adopt a uniform statewide case management system for medical liability claims modeled after the Franklin County Common Pleas Court system.

Mandatory Discovery Disclosure Rules – In another section of temporary language the Ohio General Assembly urges the Ohio Supreme Court to amend the Rules of Civil Procedure to incorporate the mandatory discovery disclosure rules embodied in Rule 26 of the Federal Rules of Civil Procedure. The rule would encourage early disclosure of witnesses. ■

Changes in Medicare Reassignment Prohibitions — Impact and Potential Opportunities for Healthcare Providers

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On December 8, 2003, President Bush signed into law the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (the "MMA") considered by some to be the most wide-sweeping set of changes to the Medicare program since its inception in 1965.

Included among the many changes in the Medicare program resulting from the MMA are changes that will make it easier for medical groups to obtain reimbursement from Medicare for work performed by physicians with independent contractor arrangements with those groups. These changes also provide more flexibility for hospitals and other healthcare providers to enter into various types of arrangements with medical groups. Where there previously were strict limitations as to where work could be performed by independent contractor physicians if the contracting entity desired to bill for these services, the changes resulting from the MMA significantly relax these restrictions allowing for reimbursement regardless of where the work is performed. Prior to these changes, physicians were prohibited from reassigning benefits to entities with which they had independent contractor arrangements unless their services were provided on those entities premises.

Although MMA was signed into law effective December 8, 2003, these changes in permitted reassignments will be implemented pursuant to Transmittal 111 of the Medicare Claims Processing Manual as of March 12, 2004.

In conjunction with implementing these changes, Centers for Medicare & Medicaid Services (CMS) is seeking certain program integrity protections. To accomplish this, CMS is encouraging that the following safeguards be included in contractual arrangements between the entity parties:

- Joint and several liability is shared between the entity submitting the claim and the person actually furnishing the service, for any Medicare overpayment relating to such claim; and

- The person furnishing the service has unrestricted access to claims submitted by the entity for the services provided by that person.

Impact of Changes

Where previously prohibited, on and after March 12, 2004, physicians can reassign benefits to medical groups who can then bill for the physicians' services at any location where they are performed (e.g., a hospital or independent ambulatory surgery center) rather than being limited to billing only for services performed on the medical group's premises.

There is also increased flexibility for arrangements between hospitals or other related healthcare providers and medical groups. For example, a hospital that employs a physician can lease that physician to a medical group in need of additional staffing and the medical group can bill for that leased physician's services regardless of where they are performed.

Of course, any of the foregoing arrangements would still need to be structured to comply with applicable federal and state self-referral and anti-kickback laws.

Potential Strategic Opportunities

With the additional flexibility created by the changes in reassignment discussed above, healthcare providers may want to re-evaluate existing contractual arrangements with physicians as well as reconsider possible arrangements with physicians that were passed by because of the previous reassignment restrictions.

If you want to know more about how these changes in reassignment might impact your operations, please contact please contact Jan Van Dyne (614/365-2811) David Grauer (614/365-2786) or Julie Chicoine (614/365-2767) in the Columbus office, or any other Squire, Sanders & Dempsey L.L.P. attorney with whom you work. We have extensive experience in dealing with these issues and structuring arrangements that comply with these requirements while still achieving the desired outcome. ■

Medical Mutual Suspends Pilot Product

Early in 2004, Medical Mutual of Ohio sent out letters to physicians in 10 counties in NE Ohio stating that MMO would be introducing a new product, SuperMed High Performance, by April 2004. MMO stated that this product had been developed in response to concerns raised by area employers that rising health care costs have made it difficult for them to maintain marketplace competitiveness and to continue to offer their employees adequate health care coverage. The counties included in the initial MMO pilot were: Summit, Stark, Medina, Portage, Richland, Ashland, Holmes, Tuscarawas, Wayne, and Carroll counties — with the possibility of branching into Cuyahoga County at a later date. The intent of the SuperMed High-Performance pilot product was to "tier" or "group" network physicians based on their relative cost efficiency. While physician reimbursements would not change, and no physician would be removed from the network, patients of those physicians identified as the least cost effective would pay higher out-of-pocket expenses.

In a letter to the AMC/NOMA Executive Vice President/CEO, MMO has notified the AMC/NOMA that pilot program has been suspended for further review. Physicians will not be tiered or grouped based on their relative cost performance. All physicians who had been notified that they were designated as "Group 2" under the SuperMed High-Performance Product have received letters by mail informing them of MMO's decision to suspend the program. The chief complaint among the physicians that originally received the letter from MMO was that they had not been given a chance to improve their performance, thus denying them the opportunity to be placed in another group of physicians prior to the product launch. MMO will continue to ask physicians to make improvements and use the information to refine their networks. They have agreed to educate affected physicians on cost and quality performance as well as how to identify opportunities for improvement. ■

Medicare Prescription Drug Law: Just the Facts

The following is a basic primer for the Medicare Prescription, Improvement and Modernization Act signed into law last December that also addresses physician reimbursement and the Stark Law.

Prescription Drug Coverage

- "Medicare Part D" will be available to seniors in 2006, with initial enrollment beginning in November 2005 through May 2006. For 2004, eligible seniors will receive a discount card for 10-25% off their current drug expenses.
- Benefits to be administered by private health plans

Participating plan sponsors agree to a minimum level of benefits that include:

- \$35 monthly premium
- \$250 deductible
- coinsurance of 25% up to an initial coverage limit of \$2250
- \$2 co-pay for all generic and multiple-source drugs
- \$5 for all other drugs
- 5% of the discounted price once out-of-pocket limit of \$3600 has been reached

Beneficiaries who fall below 150% of the federal poverty line are eligible for additional benefits:

- A sliding scale premium
- \$50 deductible
- no gap in coverage
- coinsurance of 15% up to the out-of-pocket limit of \$3600
- copays of \$2 and \$5 after out-of-pocket limit is met

Beneficiaries who fall below 135% of the federal poverty line are eligible for additional benefits:

- No premium or deductible
- Co-pays of \$2 and \$5 until the out-of-pocket limit of \$3600 is met, none thereafter

Those with dual eligibility for Medicare and Medicaid with incomes below the poverty line are eligible for:

- Reduced co-pays of \$1 and \$3
- No co-pay for those living in a nursing home

Additional dollars can be saved by opting between two plans:

- Remaining in the traditional

Medicare program and enroll in a separate prescription drug plan

- Joining the new Medicare Advantage plan with an integrated benefit

Changes for physician reimbursements include:

- A minimum increase in physician reimbursement this year
- The addition of initial preventive physical examinations and cardiovascular and diabetes screening
- Screening and diagnostic mammography is no longer included in outpatient prospective payment system (PPS)

Stark Law regarding specialty hospitals

- 18-month moratorium on the application of the whole-hospital exception to the Stark Law to physician-owned specialty hospitals to study their impact on health care delivery
- Grandfather clause on those already in existence or under development at the time of this law's effective date ■

Pollen Line Gears up for 2004 Allergy Season

The AMC/NOMA will again sponsor the Pollen Line at (216) 520-1050, a free service accessible 24 hours a day, Monday through Friday, from May 1st to October 15th. **Dr. Mohan J. Durve** will help allergy sufferers through another season by forecasting conditions in the greater Cleveland area. Dr. Durve will take a pollen count each morning and record his findings on the density of the

allergens, the probable effect on those who are sensitive to those agents and what precautions to take. Local television stations and *The Plain Dealer* also use AMC/NOMA's Pollen Line allergen levels in their weather reports during the allergy season. The Pollen Line has been a service to the community for more than 40 years, originally initiated as a partnership with the Cleveland Health

Museum and Lutheran Medical Center.

Dr. Durve is currently in private practice limited to allergy-immunology of children and adults. He is an assistant clinical professor in the Departments of Pediatrics at both Case Western Reserve University School of Medicine and the Northeastern Ohio University College of Medicine. ■

Plan Now for the Next Flu Season!

To ensure the availability of the influenza vaccine for administration in the fall of 2004, physicians and providers should begin to order their vaccine supplies immediately. Last year, large numbers of cases of influenza began to appear in October, and activity was widespread. Anticipation of increased demand for vaccine this fall makes it imperative for physicians and providers of Medicare beneficiaries, and other individuals at a high risk for complications, to immediately begin preparations for the 2004-05 flu season. The newly enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 did not change the basis of payment for the influenza vaccine which remains at 95% of the average wholesale price.

West Nile Virus: Local Lessons Learned

Anna Mandalakas, MD

Medical Director, Cuyahoga County Board of Health

Assistant Professor, Pediatrics, Case Western Reserve University School of Medicine

Since its introduction into North America in 1999, West Nile virus (WNV) has rapidly spread across the continental United States and emerged as a significant cause of seasonal illness and mortality in human and animal populations. In addition to the general population, WNV human infection emerged as a specific problem in several newly identified at-risk populations — solid organ transplant recipients, transfusion recipients, neonates, pregnant and breastfeeding women, immunocompromised persons and the elderly. In 2002, Cuyahoga Co. reported 221 cases of WNV disease in humans representing nearly 50% of all cases in Ohio and ranking third highest among US counties. Among these 221 cases were 155 cases of WNV neuroinvasive disease (WNND) and 13 deaths. In 2003, Cuyahoga Co. reported 24 cases including 21 cases of WNND and 3 cases of WNV fever. The first human case of WNV in the United States in 2004 was reported from Scioto County, OH on April 9th.

Because most WNV infections in humans do not result in severe illness, the true rate of human WNV infection can only be determined by measuring the proportion of the population with evidence of recent infection based on serologic testing. In December 2002, the public health community of Cuyahoga Co. conducted a household-based seroprevalence survey to estimate neighborhood- and county-wide WNV infection rates, and to identify host and environmental factors associated with risk for human infection. This study resulted in a number of important findings that may help to prevent, control and diagnose WNV disease in Greater Cleveland and in other communities:

- Residents were well-informed of the risk of WNV exposure, but did not consistently protect themselves from exposure.
- The main source of WNV information for county residents was reported to be the TV news (95%). In comparison, 20% of county residents reported receiving information about WNV from their healthcare provider.
- Between 10,400 and 59,900 county residents aged 5 years and older were infected with WNV in 2002.

This represents roughly 2% of our population.

- Based on 155 WNND cases reported from Cuyahoga Co., approximately one WNND case occurred for every 160 persons infected with WNV in 2002.
- Younger persons had a higher infection rate than older persons, but were much less likely to develop WNND. The weighted seroprevalence was higher in the 5-17 year old persons (6.5%) compared to 18-64 year old persons (1.3%) and to persons 65 years old and older (1.4%). We estimate the ratio of WNND cases to the number of infected persons to be 1:4167 for 5-17 year old persons; 1:154 for 18-64 year old persons; and 1:38 for persons \geq 65 years of age.
- Seroprevalence rates did not vary among the areas surveyed, but rates of disease reporting varied considerably suggesting that disease reporting is not uniform.
- Nearly 2% of participants had previous infection with other members of the Flaviviridae family (ie., St. Louis Encephalitis, Yellow Fever, Dengue, Japanese Encephalitis and others) that resulted in baseline false positive results when relying on commercial laboratory ELISA testing. Accurate diagnosis in these participants required more costly confirmatory testing with the plaque reduction neutralization assay available through the CDC and other select laboratories.
- Two of the six participants with previous St. Louis Encephalitis (SLE) infection were children aged 9 and 10 years. This is of particular relevance since the last reported case of SLE in Cuyahoga Co. was in 1978 and the last reported case of SLE in the State of Ohio was in 1984.

In areas of long-established WNV transmission, IgG antibody seroprevalence may be as high as 75%. Thus, in the United States, reliance on baseline IgG antibody measures will lead to a greater number of diagnostics errors with each transmission season. These diagnostic errors may be avoided through the laboratory evaluation of convalescent specimens acquired 2 or more weeks after the acute sample is collected.

The epidemic season for mosquito-borne encephalitis traditionally begins in July and may continue into early October. During the 2004 season, The Ohio Department of Health will offer free WNV diagnostic testing for all hospitalized with symptoms consistent with a diagnosis of WNND. The ODH will require the provider to work with their local health department in order to obtain a shipping ID for each sample. Patients with mild illness (i.e., fever, headache, rash) or no symptoms (persons with recent mosquito bites but no acute symptoms) do not need to be tested for WNV, but may be directed to a private lab. If the private laboratory detects a positive for WNV, it should be reported to the local health department to facilitate confirmatory testing at the ODH laboratory.

Samples for testing include:

- 1) CSF (testing by IgM MAC ELISA)
- 2) Sera (Acute and convalescent testing by IgM MAC ELISA and indirect IgG ELISA)

It is important to note that paired acute (obtained within 8 days of illness onset) and convalescent (2 or more weeks after the acute sample is collected) serum samples are required to definitively diagnose a case of arboviral encephalitis. Even if the acute sample is negative, a convalescent sample is still needed to evaluate changes in antibody levels.

Cases of WNV throughout Cuyahoga County may be reported to the Cuyahoga County Board of Health via phone (216) 201-2080 or fax (216) 201-1315. For further information on WNV, the following Web sites may be useful:

- www.ccbh.net
- <http://www.odh.state.oh.us/ODHPrograms/ZOODIS/WNV/wnv1.htm>
- <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> ■

AMC/NOMA is Pleased to Announce a New Member Benefit

The Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) is pleased to partner with Cuyahoga Community College's (Tri-C) Center for Health Industry Solutions to offer Certification Courses and Continuing Education Unit Seminars at discount prices for AMC/NOMA members and staff.

Earn your Certification and CEUs through Cuyahoga Community College's Medical Practice Management Seminars. AMC/NOMA members and their staff are eligible for special discounts for the following courses in Cleveland. **Programs are taught by Practice Management Institute (PMI) or local Cleveland expert instructors and focus specifically on Medical Practice needs.**

Daytime courses by PMI	Duration	Start Date
• Coding by Specialty: (all 4-hour seminars)		
• Cardiology		June 21
• General Medicine		June 24
• OB/GYN		June 23
• Orthopedics		June 25
• Surgery		June 22
• Compliance Officer Training Clinic	2 day	July 20
• Front Desk Specialist	3 hour	July 22

Evening courses

• Customer Service Workshop	3 hour	August 18
• Medical Coding for the Physicians' Practice Introductory: 126 hours	42 evenings	June 14

Members and/or their staff will need an exclusive AMC/NOMA course number to register and obtain the discount. For course number and discount pricing details you may call, Linda Hale at the AMC/NOMA at (216) 520-1000, ext. 309, or email her at lhale@amcnoma.org. Or you can call Cuyahoga Community College's Center for Health Industry Solutions at (216) 987-2274 or e-mail Maryjean Cannon at maryjean.cannon@tri-c.edu.

To view the course descriptions and campus locations visit www.healthindustry.solutions.info or go to the AMC/NOMA at www.amcnoma.org and click on the Practice Management link for more information. ■

AMC/NOMA WANTS TO HEAR FROM YOU!!!

If you have any article ideas for upcoming issues of the *Cleveland Physician* we want to hear from you. Or if our members have any specific ideas or news that you would like included in our weekly email blasts to members please send these in to the AMC/NOMA. In addition, if you know of a physician who has left practice or is planning to leave practice due to the medical liability crisis that would be interested in sharing their story or issues with the AMC/NOMA (for possible publication) please contact the AMC/NOMA at (216) 520-1000 ext. 321 or email us at concerns@amcnoma.org ■

CLASSIFIEDS

PHYSICIAN OPPORTUNITIES - Full- or Part-Time in medicine, general surgery, cardiothoracic surgery, pediatrics and OB/GYN. \$110-250K, never on call, paid malpractice. Physician Staffing, Inc., 30680 Bainbridge Rd., Cleveland, OH 44139. (440) 542-5000, Fax: (440) 542-5005, E-mail: medicine@physicianstaffing.com

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Medical Office for Sublease, Chagrin Blvd., Pepper Pike location, 2 days/week, reasonable rates (216) 591-0523.

Specialists needed for new major Medical Center in Riyadh, Saudi Arabia. Time period ranges from minimum of six months to permanent status. Excellent salary, fringes, and living arrangements.

The following specialists are needed: Anesthesiologists, Dermatologists, General Internists and all Medical Subspecialties, General Surgeons and all Surgical Subspecialties, Neurologists, Ophthalmologists, Pediatric and Adult Intensivists and ER Physicians, Pathologists, Radiation Oncologists and Radiologists.

Interested physicians should e-mail: ssnm3@hotmail.com.

The Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) is pleased to welcome 1,034 new members from the professional staff of the Cleveland Clinic Foundation.

The AMC/NOMA is truly pleased to have the CCF physicians as group members of our organization. We thank CCF for making this choice and hope it will serve to encourage other regional hospitals, groups and health professionals in northern Ohio to follow suit and join the AMC/NOMA. There is strength in numbers — and physicians must stand together to speak with one voice to promote the practice of the highest quality of medicine.

AMC/NOMA physician leadership meet with State and Federal leaders regarding legislative issues
(Continued from page 1)

Key points of the meeting were as follows:

Electronic medical records (EMR) – the AMC/NOMA has asked Senator Voinovich to pay close attention as to how the government plans to fund EMR in the future. It is important to remember that physicians cannot afford another unfunded mandate.

HIPAA regulations – the Senator believes that these are cumbersome and increase the paperwork and overhead expenses for physicians. He hopes to get on the finance committee if he is reelected and he would like any assistance he could get from physicians on how to change these regulations.

Federal medical liability legislation – the AMC/NOMA leadership stressed the importance of trying to get the Senate to

pass medical liability legislation at the federal level. During this debate, AMC/NOMA leadership provided several examples about increases in medical malpractice rates and the impact on physician practices. Senator Voinovich indicated that he would like to see more organized support on the part of physicians when medical liability legislation is introduced in the Senate. The two senators from Ohio are on board with this legislation, however, there needs to be a

concerted effort to get the Senators from the other states to agree to the concept.

In addition, the AMC/NOMA has been asked to send a physician representative to Senator Voinovich's Ohio Health Care Task Force — a group that meets quarterly with the Senator to discuss issues important to medicine and physicians that are under review at the federal level. The AMC/NOMA legislative chairman, **Dr. John A. Bastulli**, will represent the AMC/NOMA at these meetings. ■



Physician leaders meet with Senator Voinovich to discuss issues of importance to physicians and their practice.

ANNUAL MEETING 2004

AMC/NOMA celebrates 180 years of organized medicine in Northeast Ohio

The Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) held its 2004 Annual Meeting Dinner and Awards Presentation at the Ritz-Carlton Cleveland Hotel on Friday, April 30.

This year's prominent list of honorees included **Nathan A. Berger, MD**, who received the John H. Budd, MD, Distinguished Membership Award for his outstanding contributions to healthcare in the greater Cleveland community. **Ronald A. Savrin, MD, MBA**, was honored with the Charles L. Hudson, MD, Distinguished Service Award for his work as an outspoken representative of the AMC/NOMA on behalf of all northeast Ohio physicians. The Clinician of the Year Award was presented to **Arthur E. Burns, MD**, for his outstanding dedication to his young patients in this community for over 30 years.

William H. Seitz, Jr., MD, was honored with the Outstanding Service Award for his long-standing loyalty to the AMC/NOMA especially for his service as the program facilitator for the highly successful Mini-Internship Program. Later that evening Dr. Seitz was inducted as the AMC/NOMA's 104th President for the coming year 2004-05.

The Special Recognition Award went to **Monica B. Robins**, health anchor for WKYC-TV3. Ms. Robins was recognized for her informative medical reporting in cooperation with the physicians at the Academy of Medicine of Cleveland/Northern Ohio Medical Association.

Elayne R. Biddlestone, Executive Vice President/CEO of the Academy of Medicine of Cleveland/Northern Ohio Medical Association, received the Honorary Membership Award for her service and dedication to numerous community, public relations and legislative initiatives that have greatly benefited the

physician members of the AMC/NOMA. A Presidential Citation was presented to **J. Richard Ludgin, MD, JD**, for his extensive dedication to alleviate the medical liability burden facing the majority of physicians in our area.

The evening's honors also included recognition of AMC/NOMA physician members celebrating the 50th anniversary of their medical school graduation. The event concluded with a farewell speech from outgoing president, **James Lane, MD**, as he passed the gavel to **William H. Seitz, Jr., MD**.

50 Year Awardees

- | | | |
|------------------------------|-------------------------------|--------------------------|
| William George Ansley, MD | Pedro M. Guinto, MD | Bosko Pop-Lazic, MD |
| Robert Ernest Botti, Sr., MD | Kemal Gursal, MD | John Lewis Porter, MD |
| Marvin J. Brown, MD | Shattuck W. Hartwell, Jr., MD | William R. Pudvan, MD |
| John Joseph Cahill, MD | Lansing C. Hoskins, MD | Irwin H. Readerman, MD |
| Cornelio B. Deogracias, MD | Nancy K. Johnson, MD | Octubre A. Reyes, MD |
| Teresita P. Deogracias, MD | Layton M. Kest, MD | Victor Scharf, MD |
| James Angus Doull, Jr., MD | Spiros G. Kyrkos, MD | Percival D. Seaward, MD |
| Josef Edelstein, MD | Ignacio G. Lahorra, MD | Willard D. Steck, MD |
| Edwin Harvey Eigner, MD | Beverly A. Likly, MD | Harold L. Unger, MD |
| Alfred Fader, MD | Hans A. Lindt, MD | Vlasta Vyroubal, MD |
| Aaron Jerome Fine, MD | Donald S. Linton, Jr., MD | Robert James Wallace, MD |
| David Foxman, MD | William H. Lippy, MD | |
| Norman Ward Goldston, MD | Demetrius Pawlyszyn, MD | |



Dr. William H. Seitz, Jr., presents Dr. James Lane with the President's medallion and thanks him for serving as the AMCINOMA's 103rd President.



Dr. George Kikano, AMC/NOMA 2005-2006 President-Elect, at the reception with his wife, Mona.



AMC/NOMA President Dr. James Lane presents Ms. Robins with the Special Recognition Award.



Dr. J. Richard Ludgin, AMC/NOMA Secretary-Treasurer and his wife, Cynthia.



Prior to the event, the Past Presidents in attendance took a moment to line up for a group photo. L to R - Drs. Ronald A. Savrin, John A. Bastulli, Richard B. Fratianne, Kevin T. Geraci, Donald W. Junglas, Theodore J. Castele, Robert J. White, and Ronald L. Price.



The physicians receiving their 50-year award pause for a group photo prior to the event. L to R - Drs. Ignacio G. Lahorra, Edwin H. Eigner, Pedro M. Guinto, Octubre A. Reyes, Teresite P. Deogracias, Norman W. Goldston, Nancy K. Johnson, Victor Scharf, Lansing C. Hoskins, and Cornelio B. Deogracias.



The honorees for the evening gather for a group photo. L to R - Drs. Nathan A. Berger, Ronald A. Savrin, William H. Seitz, Jr., Ms. Monica L. Robins, Ms. Elayne R. Biddlestone, and Drs. Arthur E. Burns and J. Richard Ludgin.



The AMC/NOMA past presidents congratulate Ms. Biddlestone upon receiving the AMCINOMA Honorary Membership Award.



AMC/NOMA Immediate Past President Dr. Kevin T. Geraci presents Dr. Arthur E. Burns with the Clinician of the Year Award



Dr. Nathan A. Berger delivers his speech thanking the AMC/NOMA for honoring him with the John H. Budd Distinguished Membership Award.