

**ATTENTION  
MEMBERS:**

Important information regarding our annual CME seminar is included as a flier insert in this issue. The 2006 seminar, entitled "Riding the Wave of Change in the Practice of Medicine," will be held on Friday, February 17, 2006 at the Embassy Suites in Independence. Please register early as space is limited.

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## AMC/NOMA Leadership Takes Action on Impending Medicare Payment Cuts

### Communications to the Public and Regulators Send Strong Message

During the last couple of months, the President of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) addressed a group of over 120 seniors at Tri-C regarding the impending Medicare payment cuts. In addition, Dr. Kikano sent comments regarding the payment cuts to the Centers for Medicare and Medicaid Services in response to their call for comments on the changes noted in a recent Federal Register. During the Tri-C presentation, Dr. Kikano stressed the importance of passage of the two bills in Congress aimed by adjusting the Medicare reimbursement formula. He explained to the group that under current law, the Centers for Medicare and Medicaid Services (CMS) is required to adjust payments to physicians based on a formula that ties reimbursement changes to the gross domestic product and that using that



President **George E. Kikano, MD**, delivers commentary and insight on the scheduled Medicare payment cuts as part of a lecture series to seniors at the Eastern campus of Tri-C.

formula — physician payments would be cut an estimated 4.3 percent in 2006.

*(Continued on page 4)*

## Liability Concerns Kept in Forefront

### Local Business Leaders Learn of AMC/NOMA Legislative Initiatives

In early September, Dr. John Bastulli, Vice President of Legislative Affairs, was invited to present to the Chagrin Falls Rotary Club by long-time AMC/NOMA member Dr. John Makley. Dr. Makley has been committed to offering health-care-related topics and presentations to the Rotary in order to educate the group on the various issues of importance to physicians and their patients. Dr. Makley asked Dr. Bastulli and the AMC/NOMA to present on the issue of medical liability and the impact this issue has had upon patient access and quality of care.

The main topic of the presentation revolved around the legislative activities of the AMC/NOMA with specific emphasis on the medical liability issue and how it has affected physicians and their practice. The presentation included background data on the federal tort reform legislation under review and an overview of the current tort

*(Continued on page 3)*



Legislative Chairman **John A. Bastulli, MD**, educates members of the Chagrin Falls Rotary Club on tort reform initiatives and their potential impact on physicians practicing in this area.

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**Liability Concerns Kept in Forefront**  
*(Continued from page 1)*

reform laws in Ohio. Dr. Bastulli emphasized to the audience that the medical liability crisis still exists and that medical liability insurance rates are still high for physicians, especially in Northeastern Ohio. He provided AMC/NOMA survey statistics from physicians showing that many physicians have reduced their scope of services, or in some cases, left the region due to the medical liability climate. He also provided the group with information from both residents and medical students who were surveyed by the AMC/NOMA that clearly showed that this talented group of new physicians are happy to study and train in Northeastern Ohio, but when it comes time to choose a location to practice many of the individuals in this group would prefer to

practice outside of Northeastern Ohio because of the legal climate in our area and the medical liability rates.

The Rotary group also learned about the bill currently under review at the Ohio Statehouse calling for mandatory arbitration — SB 88. The group learned that interested party meetings have occurred and that there are discussions underway about a substitute bill that may include other forms of alternative dispute resolution such as mediation (see SB 88 update in AMC/NOMA legislative report pg. 5.)

Some members of the audience questioned the need for additional legislation relative to other forms of dispute resolution versus adopting additional regulations for the medical liability insurance carriers. Dr. Bastulli outlined the role of the Ohio Department of Insurance (ODI). He specifically emphasized ODI's oversight role over the insurance companies in the state as well as the fact that

there are some signs of stabilization at this time but the rates remain high. The reality is that these companies must carry reserves to cover claims that could occur years from now. In addition, he cited the fact that in Wisconsin the caps on noneconomic damages were just overturned by their Supreme Court resulting in premium increases — and in Ohio the tort reform laws have yet to be tested by our Supreme Court. Dr. Bastulli noted that this is one of the reasons that the AMC/NOMA believes that some sort of alternative dispute resolution mechanism must be put into play in Ohio to offer another alternative to the courts.

*Editor's note: AMC/NOMA physician leadership is available to present to community groups, physician groups and others on AMC/NOMA activities and other related topics. For more information on the AMC/NOMA speaker's bureau opportunities, contact Sara Lieberth at (520) 1000, ext. 320. n*

CLEVELAND  
**PHYSICIAN**

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**Flu Season Underway — Supplies Steady**  
Physicians among high-priority group for vaccination

Unlike the rough waters healthcare professionals had to tread during the 2004 influenza season with too-short supplies, this year looks like smooth sailing with an estimated 90 million doses of vaccine to distribute.

The supply surplus, compared with last year, is due in large part to the green light given Chiron Corp. by the Food and Drug Administration (FDA) earlier this year having passed preliminary on-site inspections of their vaccine production facilities. As yet final approval is pending from the FDA. The company's shut down last year resulted in a halved supply to the US market.

As always, priority groups are established by the Centers for Disease Control and Prevention, which this year added those made homeless by Gulf Coast hurricanes to the top of the list. But increasing focus is also being placed on

healthcare professionals' vaccination rates, as many are advised to "lead by example" and get vaccinated against influenza. According to the CDC, only about 40% of healthcare workers receive the vaccine in a given flu season. Among the target vaccination groups, those over 65 are getting even more attention this year as CMS' Administrator Mark McClellan, MD, reminds physicians that the payments for both the influenza and pneumonia vaccines have increased this year, and the administration fee for both has more than doubled since 2004, with the national average now \$18, up from \$8.

Each year, 36,000 people die from the flu, and 200,000 are hospitalized. Of the nearly 40,000 cases and more than 4,000 deaths reported each year from invasive pneumococcal disease in the U.S., more than half occur among adults for whom the vaccine is recommended. n

**FIGHTING THE FLU**

Three antiviral drugs have been approved for preventing flu:

- Amantakine • Oseltamivir • Rimantadine

*When used for prevention in healthy adults, they are about 70% to 90% effective*

Four antiviral drugs have been approved for treating the flu:

- Amantakine • Oseltamivir • Rimantadine • Zanamavir

*If taken within 2 days of getting sick, these drugs can reduce the symptoms of the flu and shorten the illnesses' duration by 1-2 days*

**AMC/NOMA Leadership Takes Action on Impending Medicare Payment Cuts**  
*(Continued from page 1)*

Dr. Kikano further explained that all patients will be adversely affected by these proposed payment changes because Medicaid and private insurers use Medicare rates as a resource for their reimbursement rates. In addition, he informed the group that of all of the providers serving Medicare patients, only physicians are being subjected to lower payments in the CMS proposed rule. He showed data and graphs that confirmed that over the next seven years, inpatient hospital payments are projected to rise 32 percent while payments to physicians will be reduced by 31 percent. Graphs provided in the presentation included survey data collected by the AMC/NOMA from our member physicians regarding how they would respond if the Medicare payment cuts were put into effect (for the exact percentages obtained in the survey see Dr. Kikano's letter to CMS below.) Dr. Kikano explained that one of the reasons that the AMC/NOMA survey data showed that many physicians would cut back on Medicare patients or stop taking Medicare patients altogether if the cuts go into effect is due to the already skyrocketing medical liability costs physicians have to bear in Northern Ohio. He informed the audience that it is obvious that if you couple the high medical liability costs with a reduced payment for Medicare services, doctors cannot continue to see Medicare patients.

Dr. Kikano urged the members of the audience to go to either the American Medical Association (AMA) or the AMC/NOMA Web site to review important information regarding the Medicare payment cuts. Members of the audience were also encouraged to write or call their representatives to ask for their support of the bills currently in Congress



**Dr. Philip Junglas** discusses the effects payment cuts to physicians will have not only on patients but in terms of the broader issues surrounding access to care and practice viability with Healthlines host, **Dr. Ronald A. Savrin**.

that would stop the impending Medicare payment cuts.

In September, AMC/NOMA member Dr. Philip Junglas was interviewed on the *Healthlines* radio program and covered

similar topics with regard to the Medicare payment cuts. An MP3 recording of the interview may be heard at [www.amcnoma.org](http://www.amcnoma.org) under the *Healthlines* link.

**Letter sent by AMC/NOMA President Dr. George E. Kikano to CMS in response to their request for comments to rules published in the Federal Register regarding the Medicare payment issue:**



September 14, 2005

Centers for Medicare & Medicaid Services  
 Department of Health and Human Services  
 Attention: CMS-1502-P  
 Mail Stop C4-26-05  
 7500 Security Blvd.  
 Baltimore, MD 21244-1850

Re: 42 CFR Part 405

As the president of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA), an organization representing more than 4,000 physicians in Northeastern Ohio I am writing to comment on the Medicare Program; Revision to payment policies under the physician fee schedule for calendar year 2006; proposed rule.

It is my understanding that under current law, the Centers for Medicare and Medicaid Services (CMS) is required to adjust payments to physicians based on a formula that ties reimbursement changes to the gross domestic product. Under that formula — physician payment would be cut an estimated 4.3 percent in 2006. The Sustainable Growth Rate (SGR) formula that is used by CMS to determine the Medicare physician payment updates is clearly flawed. The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

Using the current formula, Medicare is projected to impose physician payment cuts of 26 percent over six years beginning in 2006, while the cost of running a practice and caring for patients increases 15 percent. From 2006-2014 - Medicare payments in Ohio would be cut by \$4.97 billion. For physicians in Ohio, the cuts over this period will average \$20,000 per year for each physician in the state. It is projected that Medicare physician payment rates in Ohio would be cut by more than \$101 million in 2006.

All patients will be adversely affected by these proposed payment changes because Medicaid and private insurers use Medicare rates as a resource for their reimbursement rates. In addition, of all of the providers serving Medicare patients, only physicians are being subjected to lower payments in the CMS proposed rule. Data from CMS confirms that over the next seven years, inpatient hospital payments are projected to rise 32 percent while payments to physicians will be reduced by 31 percent.

The AMC/NOMA realizes that ultimately the administration and Congress will have to act in order to replace the SGR, however, CMS and its' administrators have the ability to review comments from physicians, physician organizations and other healthcare providers regarding the proposed payment and policy changes and try to find ways to improve physician payment without adding to overall Medicare costs. For example, CMS includes the cost of physician-administered drugs in its calculations of Medicare spending for physician services, and drug spending consumes an ever-growing share of the SGR target and is a major factor in projected pay cuts. CMS should consider working with the administration to remove drug costs from the SGR, which would significantly reduce the costs as well as encourage Congress to eliminate the SGR and adopt the same payment updates that are used for hospitals and other Medicare providers.

The AMC/NOMA recently surveyed our members asking what they would do if the Medicare proposed payment rates were implemented in 2006. More than 38% of those responding indicated that they would close their practice to new Medicare patients, and more than 20% indicated they would stop seeing Medicare patients altogether. Couple that information with the fact that a physician shortage has been predicted in the next decade — and it is easy to see that patient care will be compromised.

For the sake of our patients and profession, the members of the AMC/NOMA ask that the proposed payment changes be carefully reviewed. If the proposed payment changes are implemented, Medicare payment rates in 2014 will be little more than half what they were in 1991, after adjusting for practice cost inflation. As it is, Medicare payments already lag behind increases in practice costs. The AMC/NOMA believes that the CMS proposed payment changes for 2006 would adversely affect how Medicare patients will be cared for in the future. If you have any questions regarding our comments please feel free to contact me through the AMC/NOMA offices at (216) 520-1000.

Sincerely,  
 George E. Kikano, MD  
 President  
 The Academy of Medicine of Cleveland/Northern Ohio Medical Association

FROM THE EXECUTIVE OFFICES

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## SB 88 – Mandatory Arbitration Legislation Update:

Senator Kevin Coughlin continues to gather information on SB 88 from the AMC/NOMA and other sources such as the Ohio Supreme Court (OSC.) Senator Coughlin has expressed doubts about the overall level of support in the legislature for mandatory arbitration inclusive of loser pay provisions. Currently, there may be bipartisan support for another statewide alternative dispute resolution approach in the form of mandatory mediation. However, mandatory arbitration has not been ruled out as a possible pilot project in Northern Ohio. There is also some discussion about requiring arbitration following a mediation process. In addition the premise is for SB 88 to continue to require some form of mandatory alternative dispute resolution that is done before the filing of a suit and includes admissibility in court of developed evidence.

One approach under review would encourage resolution of medical liability disputes without protracted litigation by requiring plaintiffs suing physicians and other healthcare professionals to file a Notice of Intent to Sue along with the expert affidavit specifying at least one act of negligence. The parties must then participate in a mediation in an attempt to resolve the dispute before the suit is filed. This provision would apply to suits against accountants, lawyers, professional engineers, and other professionals as well as medical doctors. The OSC is working with parties to consider changes to SB 88. The AMC/NOMA has asked to be a participant in the OSC discussions to discuss alternatives.

The AMC/NOMA leadership believes that our members, the physicians in Northeastern Ohio, need an alternative dispute mechanism in place to stop the flow of lawsuits and lopsided verdicts that occur in our area. The AMC/NOMA's proactive stance on this issue, primarily working with our lobbyists and the legislature to consider legislation providing for ADR, is a laudable goal and one we plan to continue to pursue in the coming months. Clearly, there will be changes to the legislation, but this is not uncommon in the legislative process. The AMC/NOMA leadership will remain diligent in our cause and work toward the adoption of some form of ADR in Ohio — in the hope that it will be an ADR process that will benefit our members and the patients they serve in Northeastern Ohio

## Constitutional Amendment on Justice Selection

S.J.R. 3, sponsored by Senator Kevin Coughlin, would amend the Ohio Constitution to provide for the appointment of the Chief Justice and Justices of the Supreme Court of Ohio by the Governor for 10 year terms, subject to retention elections by the electors of the state. S.J.R. 3 also creates a Supreme Court Nominating Commission which shall submit to the Governor the names of nominees to the Supreme Court. The commission shall be made up of either nine, eleven or thirteen members. No more than half plus one nor less than half minus one shall be lawyers admitted by the state bar.

In a recent op-ed to newspapers across the state, Ohio Supreme Court Chief Justice Thomas Moyer issued an appeal for a total rethinking of the way in which justices come to sit on the court. Billed as a 'guest opinion column,' Moyers' three-page missive was intended to both answer critics and offer some criticism of his own in ultimately calling for an amendment to the Ohio constitution and implementing an appointive-selective system to select judges. Moyer was responding to "recent news stories and commentary" he said wrongfully suggested the justices of the Supreme Court of Ohio are influenced by campaign contributions. Citing a number of cases in which he himself voted against those who had supported him during reelection campaigns, Moyer argued that the independence and impartiality of judges was paramount in preserving the integrity of the Court. Short of amending the constitution, Moyer suggested lengthening judicial terms to reduce the need for more frequent and costly campaigns.

## Update on Physician Assistants Legislation – HB 305 and SB 154

The Ohio State Senate Committee on Health, Human Services and Aging recently heard testimony on proposed bill SB 154 — Prescriptive Authority for Physician Assistants. The bill, a companion to [HB 305](#), would allow physician assistants to prescribe medication and generally have more authority to practice by requiring PAs to attain a master's degree. Representatives from the Ohio Academy of Family Physicians and the Ohio Association of Physician Assistants offered proponent testimony on the matter. The requirement to attain a master's degree was of contention, and the issue

of PA's graduating from Ohio programs migrating in large numbers to neighboring states with prescriptive authority in place. Both the Ohio Pharmacist's Association and the Ohio State Medical Board testified in opposition to the bills, claiming they would not result in a decrease in the cost of care but only a decrease in the quality of it. Many medical organizations are in favor of the legislation. The AMC/NOMA legislative committee is still reviewing the content of the physician assistant legislation and plans to take a position at their next meeting.

## HB 117 – Health Care Services – regarding provision of complementary health care services

In mid-October, HB 117, a bill that creates the Ohio Consumer Health Freedom Act, which permits individuals to provide complementary or alternative health care services without violating other specified laws if the individual does not engage in specified prohibited activities, received its sixth hearing. Nine witnesses testified in opposition to the bill with a recurring theme of concern about lack of education and training requirements contained in the bill. A representative of the Ohio State Medical Board testified that the bill "clears the way for the return of snake oil tonics and elixirs" and puts "witchcraft, voodoo and urine therapy on a par with legitimate medical practices." He was of the opinion that passage of the bill would legitimize these practices. Other witnesses testified about oversight of the practice as well as patient risks. The AMC/NOMA opposes HB 117.

## SB 186 – Nonprofit Hospitals to Provide Free Care

Senator Ray Miller (D-Columbus) has introduced legislation that would mandate nonprofit hospitals provide free care for certain citizens. The bill would ensure free care for a person whose family income is at or below 200% of the federal poverty level. The proposal includes requirements for nonprofit hospitals to do more in terms of notifying patients on what additional financial aid may be available. The bill would also force hospitals to report regularly to the Dept. of Health on the amount of charitable care they provide. The Ohio Hospital Association has concerns with the mandates. The AMC/NOMA will be reviewing this bill at the next legislative meeting.

*(Continued on page 6)*

(Continued from page 5)

**Update on SB 113 Health Insurance Covering Diabetes and SB 116 Health Insurance Coverage for Bipolar Disorder**

SB 113 would require insurance companies to provide benefits for diabetes equipment, supplies, medication, and self-management education. SB 116 would prohibit discrimination in the coverage provided for the diagnosis, care, and treatment of biologically based mental illnesses in sickness and accident insurance policies. The Senate panel reviewing both of these bills has temporarily suspended hearings as frustrated leaders work to resolve conflicting claims about needs and costs. This suspension took place after a hearing where small business opponents testified against additional government mandates. Opponents noted that state mandated benefits such as those outlined in these two bills were unfairly applied to small group and individual policyholders since employers with union workers and large self-insured companies are exempt from state imposed mandates under federal law. In the last legislative session, Governor Taft threatened to veto bills imposing additional health coverage mandates, however, he has made no similar comment in the current session. The AMC/NOMA has a position of neutral with technical assistance on both of these bills and we will continue to monitor their progress.

**November Ballot Issues to Review Carefully**

Over the last several months, a group named Reform Ohio Now — or RON — began circulating hundreds of thousands of petitions to place four proposals on this November’s ballot. All four ballot initiatives — if passed — would amend the Ohio Constitution. The four RON proposals will appear as Issue 2, Issue 3, Issue 4 and Issue 5 on the November ballot. Some organizations are of the opinion that these issues would tilt the political environment in favor of trial attorneys and labor unions and against professionals, such as physicians.

Of the four ballot issues, State Issue 3 is of greatest concern to organized medicine and the AMC/NOMA. State Issue 3, would lower the contribution limits to \$1,000 per election cycle for legislative

candidates and \$2,000 per cycle for statewide candidates. The proposed constitutional amendment would also tighten the ban on corporate contributions. Under State Issue 3, political action committees such as NOMPAC would be limited to contributing a maximum of \$500 to state candidates, whereas organizations like labor unions could contribute up to \$10,000. In addition, labor unions would be permitted to use corporate dues dollars to support state candidates while all other groups would be forced to utilize only personal contributions from their members. In effect, State Issue 3 gives labor unions and similar organizations a huge political advantage over physicians and other groups.

RON has also initiated Issues 2, 4 and 5, which address absentee voting, legislative districts and state election oversight. RON has portrayed these “reforms” as necessary to radically change the political system. Proponents plan to use recent Statehouse scandals to convince voters to support their proposals. Many organizations have expressed opposition to these initiatives.

**November Ballot Issue One Would Advance Growth in Medical Technology**

Issue 1, also known as the “Jobs for Ohio” issue, if passed, will authorize the State of Ohio to issue approximately \$2 billion dollars in bonds over the next several years. Specifically, this initiative funds three measures to stimulate economic growth in Ohio. Issue 1 is a bond package that will enable the advancement of technologies in fields that will drive growth in the global economy, including medical technology. Of the \$2 billion, \$1.35 billion over the next ten years will be dedicated to traditional infrastructure improvements and \$500 million will assist Ohio entrepreneur’s through technology infrastructure improvements. Many groups have endorsed Statewide Ballot Issue 1, and Issue 1 has received bi-partisan support from many of Ohio’s elected leaders.

The AMC/NOMA will provide a report in the next issue of the *Cleveland Physician* regarding how these ballot issues fared on the November 8, 2005 ballot. For additional information on these or any AMC/NOMA legislative initiatives, please contact Elayne Biddlestone at the AMC/NOMA offices at (216) 520-1000, ext. 321. n

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## Call for 2006 AMC/NOMA Honorees

The AMC/NOMA invites you to nominate an individual who is a member of the AMC/NOMA that you believe is deserving of special recognition by the organization. Any physician who wishes to nominate an individual for one or more of these awards should complete the form below and mail it to AMC/NOMA, 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131. You may also fax your nominations to Elayne Biddlestone at (216) 520-0999 OR you may call (216) 520-1000, ext. 321, to provide your honoree nominations over the phone. Deadline for submission: 12/05.

- **JOHN H. BUDD, M.D. DISTINGUISHED MEMBERSHIP**  
This award is bestowed upon a member of the AMC/NOMA who has brought special distinction and honor to the medical profession, to our community and to our physician association as a result of his or her outstanding accomplishments in biomedical research, clinical practice or professional leadership. Often, such an individual has already gained national and/or international recognition because of the importance of his or her contributions to medicine.
- **CHARLES L. HUDSON, M.D. DISTINGUISHED SERVICE**  
Awarded to a physician whom the AMC/NOMA deems worthy of special honor because of notable service to and long activity in the interest of organized medicine.
- **CLINICIAN OF THE YEAR**  
Awarded to a physician whose primary contribution is in clinical medicine and whose service to his/her patients over many years has reflected the highest ideals and ethics of, and personal devotion to, the medical profession.

• Your Name: \_\_\_\_\_

• Your Nomination: \_\_\_\_\_

• Nominated for the following award: \_\_\_\_\_

Please include an explanation as to why you are nominating this individual

## Are you Interested in Running for the AMC/NOMA Board of Directors in 2006?

Directors are elected to represent their district, which is determined by primary hospital affiliation or at large for a two-year term. Members of the Board are responsible for addressing issues of importance to physicians and the patients they serve, and setting policy for the AMC/NOMA. If you are interested in running for the board of directors, please return this form with your name and contact information to the AMC/NOMA, 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131. You may also fax your information to Elayne Biddlestone at (216) 520-0999 OR call her at (216) 520-1000, ext. 321. Deadline: 12/05.

Yes, I am interested in running as a candidate for the AMC/NOMA Board of Directors

Name: \_\_\_\_\_

Contact information: \_\_\_\_\_



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**Gerard A. Banez, Ph.D.**  
The Cleveland Clinic  
Division of Pediatrics

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## A Prescription for Politics

These are not unfamiliar stories: Accounts of the already too-busy clinician who makes the time to get politically involved on an issue of importance to their colleagues; tales of physicians offering testimony, lobbying for a cause, meeting with legislators, supporting campaigns and the like in the interest of their own practices and their profession as a whole. Over the course of the last decade, especially, issues have arisen in the state legislature or even on the national stage that have incited and inspired a new kind of physician activism. While the medical liability crisis has certainly been in the forefront, several matters have likewise seen increased advocacy on behalf of physicians — by physicians. The Academy of Medicine Cleveland/Northern Ohio Medical Association recognizes with gratitude the efforts of all our members who have worked through the years supporting issues significant to organized medicine. The following vignettes represent but a few of the legislative initiatives advanced by AMC/NOMA members.

John A. Bastulli, MD, seems to have politics in his blood. For him, for nearly as long as he's been a physician, he's been an informed advocate on his peers'



*"Physicians need to participate...to educate themselves and their patients."*

John Bastulli, MD  
Board Member, Past-President

behalf. It seems to come naturally to the man who for years has actively chaired the legislative committee of the AMC/NOMA and tirelessly worked on issues of importance to physicians both in this region and across Ohio. Throughout his career, he has petitioned legislators on everything from the scope of practice for CNAs and global billing fees for hospital-based physicians to alternative dispute resolution for medical liability cases. He initiated the Greater Cleveland Anesthesia Council, has presented inexhaustibly to local business and political groups and been interviewed for more television, radio and print stories than one could count. Through it all, through the fortifying of his own commitment to organized medicine, one issue remains at the top of his list to champion: Getting more physicians involved. Dr. Bastulli recently told of instances in which physicians approached him and asked why they should commit to getting involved when so much was being done on their behalf anyway? "Physicians need to participate in organized medicine and the legislative process of their medical societies," he said, "to educate themselves as well as their patients on the issues that are critical to the practice of medicine. They need to take an active role." Bastulli grants that the professional liability insurance crisis has certainly gotten more doctors to sit up and take notice, and that many are more politically "tuned in" than they were only a few years ago. But it takes action, he said, getting involved in the election of state legislators and justices to the state supreme court, supporting candidates through fundraisers, etc., that gets issues of importance to physicians in the forefront — and keeps them there.

When a 14-year-old female patient presented with corneal scarring in the emergency room at MetroHealth Medical Center in 2001, her physician Thomas Steinemann, MD, couldn't have guessed he'd be needling Congress for a regulatory change in the FDA four years later. The patient had worn decorative plano contact lenses she'd purchased at a video store. As a result, within the year of her initial emergent visit, Steinemann performed a corneal transplant on the young woman, for whom he said this was a "life altering event," considering her



Dr. Thomas Steinemann (right) with bill sponsor John Boozman (R-Ark) following a congressional briefing in October on the dangers of decorative contact lenses.

increased risk for various complications ever after. Truth be told, Dr. Steinemann's life changed as well. He felt something had to be done about the unregulated and unmonitored use of these over-the-counter novelty items. "I don't think of myself as an activist. But in this situation I thought, 'if I don't say something about it, who will?'" Once enlightened on the subject, Steinemann said a patient-by-patient basis bore his suspicions out. He published one series of case studies in October 2003 and another just this summer detailing serious eye injuries from using the decorative lenses. Initially, he said, navigating through the political channels made for a rough ride. "I didn't know where to turn." From the state medical board and optical dispensers board to the Cuyahoga County prosecutor all the way to the office of chief counsel at the FDA, Dr. Steinemann received a "lesson in government I never got in 12th grade civics at Sandusky High School." Finally, he was directed to communicate his concerns to the FDA's Center for Medical Devices, where he learned nothing less than a bill through Congress could remove the lenses from the shelves of beauty parlors and gas stations and the unwitting hands of teenagers across the country. After one unsuccessful try last year, legislation was again introduced in both the Senate and the House this year that would amend the "Federal Food, Drug and Cosmetic Act" to provide that all contact lenses shall be deemed to be medical devices. The bill passed the Senate on July 29, while a companion bill, H.R. 371, is awaiting House consideration. Dr. Steinemann said he is pleased with the progress of the proposed legislation, and that it proves physicians can make a significant difference. "We can deal on an individual

*(Continued on page 9)*

**A Prescription for Politics**

*(Continued from page 8)*

basis with our patients, or as a collective and effect a policy change," he said. "I'm happy to say the system works."



OB-GYN Laura David, MD, doesn't cloak her cynicism in veiled optimism. Because in her field, a downright exodus has taken place — her colleagues, and many AMC/NOMA members, have left Ohio as their brand of practicing medicine became prohibitive. Either they left in search of liability premium relief or they've stayed and "resigned themselves to lower incomes and mass marketing, in a way they never would have accepted several years ago." For those that have continued to practice here, Dr. David among them, becoming more politically aware and active is a must-need situation. In David's case, getting involved has been both a challenge to her precious time with patients and to a focus on the positive changes that have taken place. Over the last four years, she has worked diligently with the Ohio Advisory Section of ACOG District V, bringing information and guidance to specialists around the state. She said she believes physicians have become more tuned in to politics in the last several years, "but mostly out of fear, anxiety and desperation." She further noted that the issue of medical liability in

particular often forces doctors outside their comfort zone. "We are uncomfortable in challenging the lawyers who offend us and the insurance companies that diminish our value to society," she said. "We have always been taught to be comforting, not confrontational. We bear our burdens rather than speak boldly, and we have not made our case known well enough to our patients or other professionals. We have a general mistrust in the political system and the way it has failed us in the past."

It was the issue of Certificate of Need, the common name for a diverse group of state laws attempting to control health care costs by regulating supply, that incited the political activist in Dr. John Clough. In states where they apply, these laws require that a permit, usually called a certificate of need (CON), be issued by a state health planning agency before a health care facility may construct or expand, offer a new service, or purchase equipment exceeding a certain cost. Ohio repealed its twenty year CON law in 1995. Throughout his many years involved in organized medicine, Dr. Clough has seen his share of political issues affecting physicians. Most recently, he offered his comments at a press conference in March of this year on means of alternative dispute resolution the AMC/NOMA worked hard to get before the legislature. He, too, believes that the issue of liability tort reform, more than most others, has caused physicians to take notice of the political process. "Some of it has been productive, and some not," he said. "But it clearly got everybody's attention." He suggests working with professionals who can assist physicians in becoming more savvy politically, such as AMC/NOMA lobbyists who have helped members prepare for proponent testimony or navigating the political landscape with greater ease. "Work with someone who can help you prepare, and warn you about the pitfalls."

Daniel Cudnik, MD, has been proactively engaging the workings of government for years, including several trips to Washington D.C. last year where he met with dozens of legislators on Medicare issues. He believes for doctors, there exists a general misunderstanding of the process, and that often this breeds disen-



*Dr. John Clough delivers his comments at a press conference announcing the introduction of alternative dispute resolution legislation in March of this year.*

agement. "Government is not some special thing that is all wisdom and knowledge," he said. "Don't be afraid of politicians, they are just like you," he advised. "Praise them for the good things they've done and nicely chastise them for the things you think they've done wrong." Dr. Cudnik also said that while his lifelong love of country and its constitution have driven his political activism in the past, the malpractice crisis has provided him "new impetus to move forward." He believes doctors could be more involved politically, overall. "Physicians can and should control their own destiny, but they have to participate either financially, personally, or both at the state and federal levels." He further suggests physicians use their reception and exam rooms for placing pertinent literature/posters to educate patients on issues important to healthcare. "Get your patients involved," he said.

The AMC/NOMA ardently supports the efforts of members who show interest in pursuing legislative matters or wish to get involved in the political process on any level. At [www.amcnoma.org](http://www.amcnoma.org), sample letters to Congress are routinely posted, as timely letter writing campaigns are made easier via our "Find Your Legislator/Eye on the Statehouse" link. Physicians who engage the political process on issues important to their profession are a cornerstone of organized medicine — and a critical component of a vital physician organization advocating on their behalf. *(Editor's Note: If you are interested in running for the AMC/NOMA Board of Directors or know of a colleague you would like to nominate for one of our yearly service awards, please see page 7 in this issue.)* n

**Residents Learn  
Business of Medicine**



*Mr. John Shelley of Squire, Sanders & Dempsey outlines estate planning and tax basics for young physicians during the 2005 Resident Seminar at Healthspace Cleveland in October.*

The Academy of Medicine Cleveland/Northern Ohio Medical Association presented a well-attended seminar Oct. 5 on the business aspects of practicing medicine with content and speakers targeting the specific issue residents will face entering today's healthcare marketplace.

Residents from University Hospital, Cleveland Clinic and Fairview Hospital were on hand to learn about such issues as employment contracts, liability coverage, asset management, estate planning, starting a practice, and tax concerns from a lineup of expert guest speakers. AMC/NOMA President George Kikano, MD, delivered the welcoming remarks for the event held this year at HealthSpace Cleveland, and encouraged the young physicians to take advantage of the wealth of information being provided. The seminar was sponsored by the AMC/NOMA with presenters from Hilb, Rogan & Hobbs; McDonald Hopkins; Sagemark Consulting; Squires, Sanders & Dempsey; and Walthall, Drake and Wallace.

**Medical Scholarships of  
the Academy of Medicine  
Education Foundation**

Scholarship applications can be obtained from the registrar or financial aid offices of eligible schools. The filing deadline is January 31, 2006 for

medical students who meet AMEF scholarship eligibility criteria:

1. AMEF awards scholarships each year to third- and fourth-year medical students (M.D./D.O.) who are or were residents in Cuyahoga, Summit, Lake, Geauga, Ashtabula, Lorain or Portage counties, and who demonstrated an interest in involvement in organized medicine, leadership skills, community involvement and academic achievement.

2. AMEF scholarships will be awarded to third- and fourth-year medical students attending the following institutions: Case Western Reserve University School of Medicine, Cleveland Clinic Lerner College of Medicine of Case, North-eastern Ohio Universities College of Medicine, and Ohio University College of Medicine. n



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## AMC/NOMA Board Reviews the Conscience Clause Issue

In some areas of the United States, pharmacists who believe that they have a right to refuse to dispense medications are attempting to implement a conscience clause. Such a clause will allow them to fall under the same legal umbrella that shields physicians and nurses. Conscience-clause laws give job protection for healthcare professionals who refuse to perform procedures based on moral or religious grounds. Every state but Alabama, New Hampshire and Vermont has a conscience-clause law. Most of these were passed soon after *Roe v. Wade*. Most existing conscience clauses cover abortion and sterilization, but new proposals call for expanding coverage to include ignoring do-not-resuscitate orders, and refusing to prescribe or dispense contraceptives.

Legislators in some states are debating the conscience clause in this new context. Most of the debate revolves around a pharmacist dispensing emergency contraception. In Wisconsin, an anti-abortion group is backing a bill to protect pharmacists who refuse to dispense certain drugs against retaliation by employers or lawsuits filed by patients seeking damages. In Illinois, the governor declared a statewide "emergency rule"

requiring pharmacists to provide emergency contraception and birth control without delay after an Illinois pharmacist refused giving it to two women. In Ohio, anti-abortion pharmacists are being urged to oppose passage of a new pharmacy practice act because it does not contain a conscience clause. Currently, seven states have laws or policies on whether or not pharmacists can refuse to fill prescription orders for emergency contraception. This session, there are 19 bills across the country on both sides of the issue, but none have become law.

There is no set law or legislation under review in Ohio regarding this issue at this time, however, the board of the Academy of Medicine of Cleveland/Northern Ohio Medical Association determined that our organization should develop a policy on this issue. Therefore, at the September board meeting of the AMC/NOMA the following resolution was adopted as policy:

RESOLVED, That the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) supports responsibility to the patient as paramount in all situations and the principle of access to medical care for all people, and be it further

RESOLVED, That the AMC/NOMA support legislation that requires individual pharmacists or pharmacy chains to fill legally valid prescriptions or to provide immediate referral to an appropriate alternative dispensing pharmacy without interference, and be it further

RESOLVED, That the AMC/NOMA support legislation to protect patients' ability to have legally valid prescriptions filled, and be it further

RESOLVED, That the AMC/NOMA enter into discussions with relevant associations to guarantee that, if an individual pharmacist exercises a conscientious refusal to dispense a legal prescription, a patient's right to obtain legal prescriptions will be protected by immediate referral to an appropriate dispensing pharmacy.

*Editor's note: Following the passage of the resolution the president of the AMC/NOMA sent a letter to the Ohio Pharmacists Association to open up a dialogue on the conscience clause issue. For additional information on this matter contact E. Biddlestone at the AMC/NOMA offices at 520-1000. n*

## AMC/NOMA Takes Stance on Drug Safety/Trials Database

Lately, attention has been focused on the issue of drug safety due to recent high-profile developments in the media including the withdrawal of drugs from the market, and controversy about the benefits and risks of certain drugs. Questions have been raised about adequate access to scientifically credible data related to drug safety and efficacy, especially for drugs that are already marketed for widespread clinical use. Pharmaceutical trial data — especially adverse events not noted in original studies but that emerged after drugs were approved have become an all too frequent news item.

An intricate system of laws and regulations drives the drug approval process in the United States. Pharmaceutical manufacturers, the Food and Drug Administration, and physicians and their patients all play a role in minimizing the risks and enhancing the benefits of prescription drug products. Recently, several developments such as drug withdrawals; use of antidepressants in children; and concerns about cardiovascular toxicity from COX-2 inhibitors have focused attention on the gap between important clinical data available to the FDA and what is generally available to physicians and the public.

Reps. Henry Waxman (D-Calif.) and Edward Markey (D-Mass.) recently introduced a bill (HR 3196) that would establish

a mandatory federal clinical trials database. The Fair Access to Clinical Trials Act seeks to provide patients, clinicians and the public with access to information on the safety and efficacy of prescription drugs and medical devices. Under the legislation, sponsors of privately and publicly funded trials would register results on an online database. In addition to trial results, the online database would include preliminary information, such as hypotheses, sponsors and investigators. The bill would grant the Health and Human Services Secretary authority to penalize those who do not comply.

At the September meeting of the Academy of Medicine of Cleveland/ Northern Ohio Medical Association (AMC/NOMA), the board of directors adopted the American Medical Association directives to the FDA relative to enhanced physician access to FDA Data. The AMC/NOMA board adopted the following AMA directives:

1. Urge the Food and Drug Administration (FDA) to issue a final rule, as soon as possible, implementing modifications to the format and content of the prescription drug package insert with the goal of making the information more useful and user-friendly to physicians;
2. Urge the FDA to collaborate with physician organizations to develop better risk communication vehicles and approaches;

3. Urge the FDA to apply new tools to gather data after drugs are approved for marketing, including a broader use if targeted post-approval studies, institution of active and sentinel event surveillance, and data mining of available drug utilization databases;
4. Monitor the design and implementation of any independent drug safety board that may be instituted within the FDA, or external to the agency, and respond as appropriate;
5. Support adequate funding to implement an improved FDA postmarketing prescription drug surveillance program.

The AMC/NOMA board of directors passed these directives in response to a request from a group practice in Northeastern Ohio. This group asked for the AMC/NOMA support of these directives and requested that the AMC/NOMA work with the group to educate the public and legislators about these important issues. The AMC/NOMA board is reviewing the feasibility of establishing an ad hoc committee to evaluate this matter and provide recommendations to the board. AMC/NOMA members interested in learning more about this initiative may contact Ms. E. R. Biddlestone at the AMC/NOMA offices at 520-1000. n

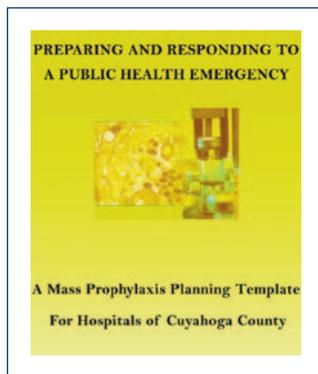
## Hospital Planning Template Created for Mass Prophylaxis

No one likes to think about the difficult decisions one might have to make in the event of a biological or chemical terrorist attack. Physicians, nurses and other medical professionals will be in the unenviable position of being both potential victims of the attack as well as front-line workers. They will be torn between the need to protect themselves and their families and their obligation to treat their patients. In order to assure that our strong regional healthcare network can remain intact during a crisis situation, a detailed and robust planning process is critical.

The federal government has a stockpile of medications that includes antidotes for chemical weapons and antibiotics and vaccines for bioterrorism attacks. There is also a national plan in place to deploy these medications to states once a large-scale attack has been confirmed. Each state is responsible for determining how these supplies will be distributed once they are delivered. Most states, including Ohio, have regional disaster planning areas. Under the Ohio plan, several planning regions have been organized throughout the state. Each regional planning committee is responsible for determining how to distribute the supplies to local agencies for administration to the public.

The federal distribution plan calls for mass prophylaxis clinics in public buildings such as schools and libraries with support provided by local health departments. However, no uniform template exists at the federal or state level to provide priority services to healthcare providers in order to make rapid response easier. The Cuyahoga County Medical Advisory Committee, comprised of infectious disease physicians in Northeast Ohio and including several AMC/NOMA board members and staff, agreed that a plan to address this need should be developed. It was recommended that this region should operate separate clinics to provide any necessary vaccines or antibiotics to healthcare providers so they may respond quickly to disaster needs. The plan also provides these medications for the families of medical professionals so that they are safe from additional exposure or the development of serious illness. This will allow these professionals to focus their attention on where they are needed most. While there is no mandate to develop these clinics, health care agencies are strongly encouraged to do so.

The City of Cleveland's Department of Safety serves as the Northeast Ohio Regional Metropolitan Medical Response System (RMRS) Coordinator, and is the lead agency responsible for coordinating planning efforts pertaining to receipt of pharmaceutical stockpile supplies for Northeast Ohio. The Cuyahoga County Board of Health serves as the Regional Public Health Coordinator for Northeast Ohio and works collaboratively with RMRS and the Regional Hospital Coordinating agency, the Center for Health Affairs. In order to comply with the federal mandate for mass prophylaxis clinics, officials from medical, public health and safety forces developed a template for activating mass prophylaxis clinics in 56 municipalities in Cuyahoga County.



This mass prophylaxis clinic template served as a guide in developing a similar template for health care facilities. Health care facilities that were already participating on a regional disaster planning committee were asked to form a taskforce to work with the local health department. Infection Control Practitioners from University Hospitals of Cleveland, St. Vincent Charity, St. John West Shore and Lake Hospital System participated in the project. Their task was to develop a template for health care facilities to follow in planning clinics that will be dedicated exclusively to the early prophylaxis of health care providers and their families. When the hospital template was completed, the Medical Advisory Committee, the local chapter of the Association for Professionals of Infection Control, and the Center for Health Affairs distributed it to a variety of health departments and healthcare facilities throughout the region.

Initially, the health care facility blueprint was to be based on the community mass prophylaxis model. However, taskforce members identified several issues

unique to health care facilities that would have to be included in the new template. These became focal points for the template and included (a) where to locate clinics so they are convenient to staff but not disruptive of other services, (b) how to designate eligible staff families during planning and how to identify them at the time of the clinic, and (c) how to prioritize staff and families to take into account both seriousness of exposure and disaster response manpower needs. The result of this task force effort was a 24-page reference document available on the Web at [www.ccbh.net/services/epidemiology/bt/hguide.html](http://www.ccbh.net/services/epidemiology/bt/hguide.html). This manual includes sample notices to employees, sample signage directing the public to community clinics, designs for clinic flow, suggested supply lists and a range of other pertinent information.

While the taskforce was working on the template, health care facilities across Ohio were asked to make a first-round "guesstimate" of the number of staff and families that would be served at their clinics. The suggestion for making estimates was to count the number of employees and multiply by a factor of approximately three. This methodology takes into account spouses and children of health care workers in need of prophylaxis. This estimate is currently the primary basis for determining the amount of supplies that will be sent to each health care facility that chooses to develop a clinic.

Both the template and the supply estimates are of vital importance to physicians. While the template assumes that physicians and their families will be included in the clinics, the initial estimates of demand in our region did not include counting independent practitioners. It is difficult to anticipate where physicians, their families, and perhaps their office staff members will turn for assistance in the event of such an attack. They may choose to go to the facility closest to home or office, where the bulk of patients are admitted or perhaps where they may be called upon to provide disaster services. All of these important questions illuminate the need to assure that public messaging during a disaster is clear in the minds of both the lay and medical community throughout the region. In the event of such an emergency, the incident command structure established at the designated emergency

*(Continued on page 13)*

## Hospital Planning Template Created for Mass Prophylaxis

(Continued from page 12)

operations center will assure that these messages are clear. As plans are enhanced and procedures are further refined, it is imperative that physicians who are not employees of health care facilities become involved in this planning process in order for them to know whether their preferred facility has developed a plan and so that they can be correctly counted at the facility they designate as their preferred primary prophylaxis site.

Physicians can become involved in this planning process in a variety of ways. First, individual physicians may call their local health department for specific information regarding planning in their area. Second, they can contact their Regional Hospital Coordinating agency to determine the scope of coverage currently planned in their service area. Third, they can contact their appropriate medical committee at one or more hospitals where they admit patients. This committee can work with the hospital disaster planning committee to assure

that physicians are included in the estimated numbers for the clinics. And finally, any physician is welcome to personally attend disaster planning committee meetings to help members plan for this and other issues that are specific to the needs of independent practitioners.

The hope, of course, is that these plans never need be implemented. Nonetheless, we are confident that the strong regional health care network in Northeast Ohio will ably serve our community if they are called upon in the event of a terrorist attack. n

The following individuals contributed to this article:

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## Report on 2005 Allergy Season: Mild to Moderate

By Arthur Varner, MD

2005 was my first year reporting the pollen count for the AMC/NOMA Pollen Line. It was quite enjoyable and I hope helpful for patients.

The 2005 pollen season was pretty kind to those with pollen allergy and hayfever. Tree pollens started out strong with hot, dry weather in April causing significant symptoms. However, the snow storm on April 24 not only damaged many trees but also seemed to prevent the oak pollination. The wet, cool May delayed the grass pollen season, but when the grass pollen did arrive we saw one of the highest grass pollen counts ever on June 6. That was short-lived and overall the grass pollen season was tame compared to previous years. As usual, Cleveland had the lowest levels of ragweed pollen of any major Midwestern city — this season was especially mild. Molds increased as the summer pro-



gressed but had not reached severe levels by October 1. Curiously, patients with dust mite allergy had severe symptoms in August and September, presumably due to the hot, humid weather that promotes mite growth. Patients with hayfever should have had a good season in 2005. If their symptoms were not well-controlled they should visit their doctor or allergist for a better regimen for next season. I don't think we can expect this mild a season next year, but like the weather in Cleveland, you never know. See you April 15, 2006 for the AMC/NOMA Pollen Line reports.

*Editor's Note: The AMC/NOMA extends its gratitude to Dr. Varner for his enthusiasm and commitment to the Pollen Line. This is the first year Dr. Varner conducted the counts and related reporting, and the 47th year for the program itself. n*

## Ohio Medical Reserve Corps Update

The need for comprehensive and up-to-date medical volunteer data was highlighted recently when disasters on the scale of Hurricanes Katrina and Rita hit the Gulf Coast area. The Ohio Emergency Management Agency dispatched 32 doctors, nurses and emergency personnel trained in search and rescue to Mississippi for an indefinite time period the weekend after Katrina hit. These individuals were already listed on volunteer databases and trained for such efforts.

Currently in Ohio, there are 15 local Medical Reserve Corps operating under the auspices of the health departments in their respective areas. These MRCs collect names of medical volunteers and provide that information to the Ohio Department of Health. In the past, the Academy of Medicine of Cleveland/Northern Ohio Medical Association, in cooperation with the local health departments, collected names of professionals to help populate an MRC database, however, to date, there is no MRC in place in Cuyahoga County instituted under our local department of health. Discussions are underway to determine how to best coordinate the efforts of an MRC in Cuyahoga County. There are still many unresolved issues relative to an MRC such as credentialing and liability matters. Updates on the MRC will be included in future issues of the *Cleveland Physician*. In the meantime, physicians may sign up to volunteer by going to [www.serveohio.com](http://www.serveohio.com). Click on "Healthcare Professionals Needed" to enter a volunteer profile on the citizen corps site. n

## The Cities Readiness Initiative Explained

By Kevin P. Wallace, Co-owner, The Brasco Group LTD.

(The Brasco Group is a private company specializing in emergency, disaster, and security planning and training)

An old adage warns that “failing to plan is planning to fail.” In today’s post 9/11 environment, the world’s major institutions as well as government, the private sector, and individuals were required to rethink their concept of an “emergency.” What previously constituted a proper response, is no longer valid, when faced with today’s diverse and diabolical types of threats. One such contemporary threat is the use of a biological agent intended to contaminate a large population. This bioterrorist scenario would precipitate a public health emergency. The federal government has attempted to counteract and mitigate this case of biological terrorism through the creation of the Cities Readiness Initiative.

The Cities Readiness Initiative, or *CRI* as it is commonly referred, is a program funded by the federal government and administered through the Center for Disease Control. *CRI* is focused on reducing the threat posed by an anthrax (bacterium *Bacillus anthracis*) release in a major metropolitan area. The *CRI* program seeks to increase the participant cities ability to receive and dispense medicine and medical supplies from the Strategic National Stockpile (SNS). The pilot year for the *CRI* program was fiscal year 2005 and included 20 cities and the National Capitol Region. The cities participating in the *CRI* program were chosen based on their population and geographic location, and not on any specific threat. Participating cities for 2005 were:

- Atlanta, GA
- Boston, MA
- Chicago, IL
- Cleveland, OH
- Dallas, TX
- Denver, CO
- Detroit, MI
- Houston, TX
- Las Vegas, NV
- Los Angeles, CA
- Miami, FL
- Minneapolis, MN
- New York, NY
- Philadelphia, PA
- Phoenix, AZ
- Pittsburgh, PA
- St. Louis, MO
- San Diego, CA
- San Francisco, CA
- Seattle, WA
- District of Columbia



At the September, 2006 AMC/NOMA board of director's meeting, Mr. Wallace responds to questions from the board regarding the *CRI* initiative.

The *CRI* program was “city” specific for 2005, but is expanding in 2006 to a “regional” concept. For example, the “region” designated for Cleveland in 2006 is the Cleveland Metropolitan Statistical Area (MSA) and includes Elyria and Mentor, Ohio in addition to the counties of: Cuyahoga, Geauga, Lake, Lorain, and Medina. The *CRI* program in 2006 expanded to include the cities of Columbus and Cincinnati, along with their associated MSAs. Several other large cities throughout the country were also funded.

The basic objective of *CRI* is, “to help cities develop a mass prophylaxis plan.” Given the nature of the bacterium *Bacillus anthracis* postexposure prophylaxis is most effective when administered within 48-hours of exposure. Therefore, given this situation and the need to potentially provide prophylaxis to the entire population of the City of Cleveland (478,000 pop est. July 2002), the project takes on the nature of a distribution/delivery operation rather than a typical flu clinic style operation where detailed medical history and triage is performed.

The City of Cleveland Department of Public Health (CDPH) has established a formal working group to guide the development of the *CRI* plan. This group includes representatives from CDPH, the Ohio Dept. of Health (ODH), the Cuyahoga County Board of Health (CCBH), Cleveland Dept. of Public Safety, and a private contractor (the Brasco Group).

A great deal of work has been done in Cleveland over the last year and some of the milestones include:

- A statistical analysis on the population and detailed analysis and selection of suitable medication dispensing

locations has been made along with a determination of the staffing requirements for those medication points of dispensing (PODs) for the City has been completed.

- Outreach efforts with the Red Cross, the Center for Health Affairs (CHA), The Hospice of the Western Reserve, Business Emergency Preparedness Association (BEPA) and The Regional Transit Authority (RTA), to gain their input and support for the overall *CRI* efforts were made. Other outreach efforts included community non-profit medical services and other community agencies. These meetings are ongoing.
- The development of an extensive public information plan that will allow the city to quickly and succinctly communicate key information to the citizen of Cleveland or adjacent affected areas.
- The creation of signage for all the POD locations and translation of fact sheets about anthrax into the main non-English languages spoken in the city.
- The creation of a basic POD operations procedure guide/plan.
- Finally, the City is in the early stages of exploring, with the partnership of the United States Postal System (USPS) to deliver an initial dosage per household (1 bottle of 20 tablets of doxycycline).

While no plan can completely account for every possible nuance of a given situation, a comprehensive, fully integrated, and efficient plan will provide both a meaningful level of deterrence *and* the protection of the intended population.

To learn more about how you can become involved with the *CRI* program call, Meagan Meyer at 664-3076 n

## The Other Oath: Preparing For Your Malpractice Deposition

By Stephen P. Griffin, Esq.

The pursuit of medical malpractice claims is big business for plaintiffs' attorneys. Due to the current liability climate, it is not unlikely you may find yourself defending your own standard of care in a deposition. These tips should better prepare you for that moment.

### Acquire the Correct Perspective

Do not be intimidated by the examining attorney, who has a tiny fraction of your medical knowledge. No matter how diligent, the attorney must mostly rely on the questions fed to him by his retained expert or cursory medical research not fully appreciated or understood.

### Know the Facts

Superior medical knowledge alone will not suffice. Master the facts. Some cautionary advice: don't think you need to play detective to prepare for your discovery deposition. Your attorney will advise exactly what material he wants you to review. This usually includes discovery depositions taken and the chart or records you used to document your care. Know your chart thoroughly. It's not necessary for you to memorize it, as you can always refer to the chart.

### Control the Tempo

It's simply a matter of momentarily pausing after the question. He may fire a series of questions, badger you with, "Isn't that correct; well isn't it?" But, he won't be able to force you to answer until you're ready. Pausing allows you to control the tempo and knocks the legs out from under the cross-examiner.

### Pausing Helps Your Attorney

The dead air allows your attorney to state an objection on the record, if necessary. Most objections refer to the form of the question, and you will proceed to answer. However, there may be an occasion where the plaintiff's attorney is seeking privileged information. If you volunteer an answer, you might waive the privilege, including attorney-client, physician-patient, or peer review. By pausing, you allow your attorney to unequivocally instruct you not to answer. Additionally, an objection may tip you off to a problem with the question.

### Think First

Contemplate your answer before saying it aloud. Anything said out loud will leave a path of reasoning on the record. It offers the examining attorney additional areas of potential inquiry. Know that the plaintiff's attorney is taking each word you utter as a thread, which will be used to weave a rope to hang around your own neck. In a deposition, less is more. Be direct and concise.

### Answer the Question

A deposition is not time for speeches, apologetics or teaching. It is the classic "Q & A" interrogation. Attorneys have the power of subpoena to conduct a deposition. This does not give them the right to badger, guilt, argue, or degrade you and wear you down. Your only obligation is to appear and answer the questions truthfully. You are not there to educate the plaintiff's attorney. They must hire medical experts and utilize their knowledge and opinions. Why testify against yourself and be a free source of testimony and information for the opposition? If a plaintiff's attorney fails to cover an important subject, so be it.

### No Assumptions

If an examining attorney asks you a question that makes no medical sense, challenge him. Tell him to rephrase the question or let him know it makes no medical sense. Advise him that his chosen words, phrases, or definitions are not utilized by medical professionals. Do not assume that you have been asked an unambiguous question. Invariably, your assumption will be used to your detriment. Most plaintiffs' attorneys start a deposition by saying, "Doctor, if you answer a question I will assume you understand it." Ask him to define terms. Usually, he will ask you to define the word or he will quickly move to another subject.

### Medical Literature

Do your best to respond to questions from medical literature in **general terms**. Do not acknowledge any medical literature, periodical or treatise as "authoritative" or as a "reasonably reliable authority." These terms have legal evidentiary consequences with which you will not want to contend. Referring to a journal or treatise as authoritative opens you



up to be cross-examined from any page of that source. Your lawyer cannot put the book or journal on the witness stand to cross-examine. Simply admit that you try to stay current with as much literature as possible and that you find it applicable in varying degrees, but that nothing is authoritative.

### Testify to the Record

Recognize that testifying to a jury and giving a deposition are completely different scenarios. In a trial you testify to the jury, while in a deposition you testify to the record. You need and want them to understand your testimony and medical care provided. Do not believe that the examining attorney is your audience in a deposition. Speak to the record. Keep in mind who reads the record: the reviewing experts from both sides. Speak to them. Convince the reviewing experts that you are qualified, well-trained, knowledgeable, concerned, and diligent. You need to come across as an experienced practitioner who is well-aware of the prevailing standard of care and in compliance with it at all times.

### Limit Your Opinions

Confine your opinions to those areas of expertise where you have directed your practice. Testify on those aspects of the case in which you were involved and have adequate knowledge. Your attorney may have the expert pediatrician waiting in the wings to give her opinion. The last thing your defense needs is for you to contradict your own expert.

### Keep Your Cool

Try to clear yourself of emotion. Think clinically when responding to questions, as if analyzing the matter with your colleagues. Be as objective as possible. The plaintiff's attorney is hoping to "reach you." Perhaps, he is holding out hope that he can find the "right button to push" in front of the jury. It would be a tragedy for

*(Continued on page 16)*

### The Other Oath: Preparing For Your Malpractice Deposition

(Continued from page 15)

the jury to return a verdict on a character flaw rather than the facts.

#### Do Not Be Naïve

Whether the plaintiff's attorney utilizes aggressive tactics or a friendly approach is irrelevant: be on your guard. One is meant to shake an answer free and the latter to disarm you. Regardless of how charming or sincere, the plaintiff's attorney is not your friend and does not have your best interest at heart.

#### Other Preparations

Other than awaiting a verdict, preparing for deposition can be the most anxious time of a lawsuit. Use your nervous energy to propel you to adequately prepare. Work closely with your counsel to spot issues. Before you proceed to your discovery deposition, it is advisable that your attorney obtain at least one expert defense review. The expert can provide a roadmap to prepare for potential lines of inquiry regarding the patient care, proximate cause and/or injuries. Accept the assistance.

Rarely is a physician surprised by subject matters covered, especially if a thorough review of the record has been accomplished and an expert review obtained.

#### The Standard of Care

To defend yourself at the deposition, your care must fall within the acceptable standard of care. Ohio courts define it as the duty to act as a physician of ordinary skill, care and diligence under similar conditions. Be alert for questions that are so obvious that they might fool you. For example, the plaintiff's attorney may try a rather odd approach by asking: "Now Doctor, it is not going to be your testimony that you met the standard of care on every aspect of your treatment of this patient, is it?" While he appears to be asking you something reasonable, it would be fatal to agree with this question. He is inviting you to admit that you breached the standard of care.

#### Stay Out of the Corner

Don't let yourself get painted into the corner with admissions. Plaintiffs' attorneys adept at malpractice depositions will quote broad, sweeping, general medical principles. The principles are usually widely accepted so it would be unreasonable to disagree. There will be a series of general questions, and ultimately a sudden switch to one fact specific to your case. Whenever you are asked general medical questions, ask the plaintiff's attorney, "Do you mean in general or do you mean in this case?" If the attorney responds that he means in general, your answer should begin by stating, "In general then..." In this fashion, your answer can never be quoted out of context at the time of trial if the attor-

ney tries to impeach you with deposition testimony. If the attorney responds that he means specific to the case, your answer should be, "The general rule doesn't apply to this case, it is an exception and here is why..."

#### Beware the Hypothetical Question

Plaintiff lawyers like to simplify matters by asking hypothetical questions. These hypotheticals often seek your medical opinions based upon very limited data. This is not how you practice medicine. You collect all data needed to reach diagnostic conclusions. Be cautious in answering a hypothetical question that you have sufficient information to form a truthful and complete answer.

#### Do Not Waive Signature

Read your deposition. There are always mistakes in transcribing medical depositions. The terminology is a huge challenge for even the best court reporter. Additionally, upon reflection, you may see a miscommunication or misunderstanding. If you have an accent, all the more reason to read. You will need to execute the errata sheet to set the record straight. You will need to timely ensure your corrections become a matter of record.

By following these simple instructions, you will do well defending yourself — should you need to.

*Stephen P. Griffin is a shareholder with Buckingham, Doolittle & Burroughs, LLP in Canton, Ohio. n*

*Wishing A Joyous and  
Happy Holiday Season*

To All Members of The Academy of Medicine of  
Cleveland/Northern Ohio Medical Association

From: Your AMC/NOMA Board of Directors and Staff

## Medicaid Managed Care Options Extended Statewide

By: Jeff Corzine, MS, Health Systems Administrator for the Ohio Department of Job and Family Services

As part of the state budget bill (Am. Sub. HB 66) passed by the Ohio Legislature, Medicaid health care providers and consumers will begin to see considerable changes to the Medicaid program in Ohio. The most significant of these will be the enrollment of more than 1.3 million Medicaid consumers in Medicaid Managed Care Plans (MCPs) by December 31, 2006.

MCPs offer Medicaid consumers additional services including: a "medical home" setting for their health care needs, toll-free access to member services representatives for help in accessing health services, a network directory of health care professionals and access to specialized services for special health care needs including care management services. For providers, MCPs offer assistance in the care management of patients with complex health care needs, assistance with patient health care issues and questions through a toll-free, 24/7 nurse hotline, prevention-focused health promotion and patient education programs and services.

Currently, more than 555,000 Ohio Medicaid consumers are enrolled in one of seven (7) MCPs, covering 17 Ohio counties. When completed in the first quarter of 2006, an additional 170,000 Medicaid consumers will be enrolled in an MCP, bringing total current enrollment to over 700,000 Medicaid consumers.

Statewide expansion of the Medicaid managed care program will be conducted in two phases. In Phase I, Medicaid consumers participating in the Covered Families and Children (CFC) program will be enrolled first. MCPs will be selected by region. The state has been divided into eight regions based upon geography, and in- and out-migration patterns of health care use in the region. A minimum of two and a maximum of three MCPs will be selected per region. Selection of the MCPs are expected to be completed by the end of the first quarter of Calendar Year (CY) 2006. Initial enrollment of CFC consumers is expected to begin during the third quarter of 2006 and continue until December 31, 2006.

MCPs participating in the Medicaid Managed Care Program will be selected competitively through a Request for Application (RFA) process which began on September 20, 2005. To date, 19

health plans have expressed interest in participating in the program. A listing of these plans is available at the Department's Web site [www.jfs.ohio.gov/ohp/bmhc/pro-man-care.stm](http://www.jfs.ohio.gov/ohp/bmhc/pro-man-care.stm).

In Phase II of the statewide expansion, 125,000 Medicaid consumers who are Aged, Blind or Disabled (ABD) will be enrolled in a Medicaid MCP. MCPs again, will be competitively selected to serve a portion of the ABD Medicaid population. It is expected that the competitive selection process for this procurement will begin in the first quarter of CY 2006.

Approximately 400,000 ABD Medicaid consumers will be exempt from enrollment in an MCP. These include, but are not limited to, ABD children, Medicaid/Medicare dual-eligibles, consumers with a spend-down, institutionalized consumers and consumers who are participating in a home and community-based waiver program. These persons will continue to receive health care services through the traditional Medicaid fee-for-service program.

ODJFS has a communications strategy with the goal of keeping all stakeholders informed about the progress of the expansion. ODJFS will be working across

the state, meeting with provider groups, associations, community groups and other government and service agencies to update them on the progress being made and to understand issues of concern and mutual interest. BMHC is keeping an active Web site where anyone interested in the statewide expansion can find up-to-date information. The Web site is located at <http://www.jfs.ohio.gov/ohp/bmhc/statemhc.stm>. Additional Web pages focusing on issues specifically relevant to consumers and providers are linked to this main page.

*(Editor's Note: The ODJFS staff has already met with the executive vice president/CEO of the AMC/NOMA to discuss the Medicaid managed care plan expansion. AMC/NOMA staff stressed the importance of open lines of communication, timely information provided to physicians as well as the importance of stringent financial oversight of the companies participating in the Medicaid MCP. In addition, the AMC/NOMA staff has requested that the ODJFS provide a presentation to the AMC/NOMA board of directors in November 2006.)* n

### AMC/NOMA Bylaws Change

In accordance with the bylaws of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) the following amendments to the AMC/NOMA bylaws are to be published to the membership prior to final approval by the board of directors: These bylaws amendments have been approved by the board of directors for publication. Any comments on these bylaws amendments may be forwarded to the executive vice president of the AMC/NOMA.

#### Article III. Duties of Officers

*Section 5. Any then-serving officer or president elect, except the Chief Executive Officer, absenting him/herself from more than two (2) Board of Directors meetings per year or 2 Executive Committee meetings per year without due cause shall automatically forfeit his/her office and the vacancy shall be filled pursuant to Article II in a meeting by the Board of Directors that is to be held as soon as practicable, but more than sixty (60) days after position became vacant by operation of this provision.*

#### Article V. Duties of Standing Committees

*b. "Meetings of the Executive Committee shall occur at least 6 times a year. Any Executive Committee member absenting him/herself from more than 2 Executive Committee meetings per year without due cause shall automatically forfeit his/her position on the committee and the vacancy shall be filled by an appointment made by the President, or if the President has been removed under this provision, then by the President elect."*

## Is Your Office In Order for the New Year?

By Lynn Ballard, CMC, CMIS, CMOM  
Practice Management Institute

In this exciting and challenging time of year most practices are on the fast track preparing for the New Year. This is the time to clean up the accounts receivable, re-evaluate current processes and systems, identify problems, and set new goals and standards for the upcoming year. Working together as a team, it is important to address the coding and reimbursement process early, preparing your office for a productive and profitable 2006.

For the coders in the practice, the ICD-9-CM diagnosis changes are out with mandatory use as of October 1. CPT changes follow quickly in November with required use January 1 of the New Year. No longer do we have a 90-day grace period that so many counted on, considering regulations stemming from HIPAA. This was the buffer time to use as the learning curve for the new codes as well as get them entered into our computer database. Unfortunately, many practices have not ordered their coding resource materials, and now find themselves on a back-order list.

Medicare changes follow-up quickly in early November. Anyone with Internet access can link to the CMS Final Rule when published in the Federal Register. Beginning November 1, 2005 check daily at [www.access.gpo.gov/su\\_docs/fedreg/frcont05](http://www.access.gpo.gov/su_docs/fedreg/frcont05). You will find the information from CMS when you scroll down to the Department of Health and Human Services you will be looking for Medicare Program Revisions to Payment Policies, Physician Fee Schedule for Calendar Year 2006; Final Rule. You will find full details with relative value units and detailed information regarding the Medicare changes from initial proposal to final rule. Here are some basic things to consider in the months of November and December:

- Do you have your new CPT and ICD-9-CM manuals for 2006?
- Will you need to change, delete or add any CPT or ICD-9-CM codes in the computer?
- Have you ordered your computer software update if applicable?
- What about the super-bill, encounter form, or walkout statement? Any changes needed to be made there?
- Don't forget about the Medicare fee schedule. The revised schedule must

be input into the computer in order to collect accurate payment at the time services are rendered.

- Have you reviewed all of your managed care contracts? You might need to put a pencil to paper and figure if the Medicare fee schedule changes are going to be a big financial loss or gain if your contracts are based on Medicare RVUs.
- Are you aware of any new Level II & current Level III HCPCS codes required by your Medicare carrier? Are you using them?
- Do you have access to Medicare's Correct Coding Initiative also commonly known as the Correct Coding Policy? It can be found online at <http://www.cms.hhs.gov/physicians/ccredits/default.asp>. Remember, use of this document is one of your main protections against inaccurate, fraud-

ulent or abusive CPT code patterns. Never "appeal" a Medicare claim without reviewing the CCI.

- Have the coders in the practice received the appropriate training and updates to act as part of the quality assurance team on correct and accurate coding? This helps ensure proper reporting of services as well as appropriate reimbursement for services rendered. Review your Medicare and managed care newsletters and annual disclosure report. Each of these areas can and do affect your practice bottom line. Be prepared for 2006.

Lynn Ballard is Vice President of Professional Services for Practice Management Institute. PMI teaches a wide range of courses pertaining to medical office coding, reimbursement, compliance and office management. n

The AMC/NOMA is pleased to provide this article courtesy of Practice Management Institute (PMI.) Practice Management Institute works with the Center for Health Industry Solutions at Tri-C to provide classes for office managers and physicians. The AMC/NOMA members and/or staff are eligible for a substantial discount to attend these classes. AMC/NOMA members and/or staff may earn Certification and CEUS through Cuyahoga Community College's Medical Practice Management Seminars. CEUs are offered from AAPC, AAMA and PMI depending on the course content. The following November/December 2006 classes are now open:

- **CERTIFIED MEDICAL CODER** by PMI (3.5 CEU)
- **CCS CODING EXAM REVIEW** (.5 CEU)
- **ADVANCED ICD-9-CM CODING CONCEPTS** (.4 CEU)
- **CCS-P CODING EXAM REVIEW** (.5 CEU)
- **RADIOLOGY: HIGH TECH/HIGH DEMAND CODING** (.3 CEU)
- **MEDICAL TERMINOLOGY/ANATOMY & PHYSIOLOGY** (3 CEU)

Members and/or their staff will need an exclusive AMC/NOMA course number to register and obtain the discount. For course numbers, call Linda Hale of AMC/NOMA at (216) 520-1000, ext. 309, or e-mail [lhale@amcnoma.org](mailto:lhale@amcnoma.org). For course information, visit [www.amcnoma.org](http://www.amcnoma.org) Practice Management or [www.advancecareer.info](http://www.advancecareer.info), or contact Tri-C's Center for Health Industry Solutions at (216) 987-3071 or e-mail [Alison.Arkin@tri-c.edu](mailto:Alison.Arkin@tri-c.edu).

### Attention Office Managers and AMC/NOMA members:

The AMC/NOMA is working on revamping our quarterly newsletter specific to practice management and insurance reimbursement issues entitled "Practice Management Matters." Watch for the winter issue of practice management newsletter in the coming months.

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