Committed to Pennsylvania Physicians

PMSLIC was established twenty-five years ago by physicians for physicians. Our concern for health-care professionals practicing in Pennsylvania extends beyond writing policies. Our defense of good medicine is vigorous.

Risk management activities are tightly integrated with underwriting standards. We lobby persistently for meaningful medical liability reform. While malpractice carriers falter and fail, PMSLIC is taking actions today to maintain a stable source of professional liability insurance for Pennsylvania physicians for the future.

- An advocate for meaningful medical liability reform
- Founding partner of Citizens Allied for Pennsylvania Patients (CAPP)
- Endorsed by the Pennsylvania Medical Society
- Owned by NORCAL Mutual Insurance Company — formed and owned by physicians
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Cover Art: Code Blue
see page 157
Dear ACMS Member:

You have probably already received information from the Pennsylvania Medical Society concerning a “Code Blue Week” to be observed April 30 through May 6 in Pennsylvania. The “Code Blue” designation is to communicate to the public and the legislature the severe circumstances that the practice of medicine and the provision of healthcare in Pennsylvania is in due to the professional liability insurance availability and affordability crisis.

During that period of time, physicians are encouraged to contact our elected officials. We must continue to petition our legislators at both the federal and state level, and Pennsylvania Governor Ed Rendell, for their leadership and action in taking immediate steps to reduce the cost and to create greater availability of liability insurance in Pennsylvania. We will assist you in contacting your elected officials; more information will be sent to you. You may also wish to invite your legislators to address the medical staff at area hospitals.

The Allegheny County Medical Society Board of Directors has agreed to support the designation of this time period as “Code Blue.” The following activities have been scheduled in Allegheny County:

Wednesday, April 30, 9 a.m.-6 p.m.
American College of Surgeons Fellows Interviews

Thursday, May 1, 9 a.m.-noon & 1-4 p.m.
Current Issues in Obstetrics and Gynecology
Moderator: William R. Crombleholme, MD

Friday, May 2, 8 a.m.-3 p.m.
ACMS Spring Clean-up at YMCA Camp Kon-O-Kwee/Spencer (Zelienople)

Monday, May 5, 8 a.m.-noon
Risk Management: Error Reduction in the Hospital
Moderator: G. Alan Yeasted, MD

Monday, May 5, 1 pm-3 pm
Medical Liability Issues in Orthopaedic Surgery
Moderators: Jeffrey Baum, MD; Mark A. Goodman, MD; Gerald W. Pifer, MD

While you may choose to close your office to engage in these activities, it is critical that arrangements be made so that no patient experiencing a medical emergency is unattended. It is also important that you communicate your plans to your hospital administration and referring physicians to ensure that care will be available.

We urge your attention to information made available by both the county and state medical societies and encourage you to take the actions that you personally feel are merited to address this situation. For additional information log on to http://www.codebluecentral.org.

Sincerely,

G. Alan Yeasted, MD
Thoughts from Our Medical Editor

Tort Reform: A Matter of Quality Health Care

Safdar I. Chaudhary, MD

We all have gotten used to receiving quality health care in this region; however, this infrastructure to deliver efficient health care is in great jeopardy. When any system loses its checks and balances, it naturally becomes ineffective and chaotic. Physicians continue to work under mounting pressures to preserve effective care for all of us. As the advances in medicine continue, so do their profound impact on the health and well-being of our communities. Mortality and morbidity continue to decline due to advances in surgical and medical interventions. As a testimony to a good healthcare system, expectancy and the quality of life have steadily improved. Living longer and having higher expectations of healthcare delivery pose interesting challenges, however. With finite healthcare resources, effective strategy and planning are needed to deliver accessible and affordable advances in medical treatments to all of us.

During these times of medical advances, it makes no sense to deplete precious healthcare resources for the deep pockets of a few trial attorneys. The American healthcare system has always spent an enormous amount for the useless practice of “defensive medicine.” In the past decade, trial attorneys have embarked upon drilling giant holes in healthcare delivery and its dwindling resources.

Under the pretense of “protecting the rights” of patients, they are chipping away the “rights” of patients to affordable health care. By dramatizing medical errors and lobbying intensely, they have spent an enormous amount of resources capitalizing on frivolous lawsuits, thereby draining an already strained healthcare system.

Under the deceitful disguise of patient advocacy, trial lawyers have escalated enormously the cost drivers of health care. This is depleting the healthcare resources needed to continue medical research, academic excellence and state-of-the-art medical care. With checks and balances, we as a nation have demonstrated the ability to be at the forefront of the healthcare arena. This pride of our nation need not be jeopardized by a few greedy souls who have no regard for patient care. After all, those who deliver patient care on a daily basis in the trenches can only witness the misery and suffering of human beings. These economically hard times are difficult for employers, employees and healthcare delivery systems alike.

With our economy in a struggling mode, people are increasingly losing their healthcare benefits. Doctors are seeing patients with only partial healthcare benefits or without any at all, trying to help them in all possible manners. It is common to see patients without coverage for care they desperately need. Lack of prescription coverage is very common. Most physician offices are spending an enormous amount of resources and energies on those who are suffering and can’t advocate for themselves. Of course, it is rewarding to see thousands of patients improve and reflect in gratitude in the usual office settings outside of the drama of a court. However, this expected courtesy and prompt health care in our neighborhood is under a threat of extinction.

Multiple medical and surgical specialties, both nationally and in the Commonwealth of Pennsylvania, have been sounding an alarm of skyrocketing malpractice premiums due to ever-escalating jury awards for medical negligence damages. Interestingly, patients get to see only a small fragment of the settlement money; the intent of trial lawyers is not the

We are dedicating this issue of the Bulletin to reflect the enormity of the malpractice crisis and its impact on this region’s healthcare needs.

April 2003
Dr. Chaudhary is a psychiatrist and medical editor of the Bulletin. He can be reached at schaud2815@cs.com or (412) 427-6828.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the BULLETIN, or the Allegheny County Medical Society.

It is prudent to visit and observe health care in any doctor's office or in a hospital setting these days. The talk at any brief moment in between patient care is, "What is next on the horizon?" Physicians pause to ask: Can I continue to practice a profession with diligence and empathy for those who are inflicted with trauma and disease? Do I quit my practice, or do I move out of state? Why can't common sense prevail? These questions echo through discussions these days as the clock continues to tick for the ever mounting malpractice crisis and the urgent need for tort reform.

The crisis continues to unfold as lawmakers at national and state levels struggle with these issues: ever increasing pharmaceutical costs, growing elderly population, an underinsured or uninsured population, an employer-based healthcare system, hospitals and physicians getting out of practices of delivering affordable care and economic hardships. These and other factors pose difficult ethical, and economical challenges requiring thoughtful discussions and consensus. Needless to say, rising malpractice costs are rendering it impossible to deliver affordable care for our patients. We need to keep our employers and employees healthy from both the economic and health standpoint. Cheaper health care across the border and in other parts of the world is tempting for many employers.

However, preserving jobs and stimulating economic growth in this country and our region is very essential to maintain a vibrant and healthy society.

We are dedicating this issue of the Bulletin to reflect the enormity of the malpractice crisis and its impact on this region's healthcare needs. We are very thankful to all partners in this struggle as we attempt to bring back some sanity to an insane out-of-control malpractice crisis.

It is our hope that effective, affordable and accessible health care can remain available to residents of our region, our neighbors, our families and all of us. We believe that resolving the malpractice crisis and instituting comprehensive tort reform are key steps towards that goal. We envision continued growth in our industry and economy, as well as medical breakthroughs— if the malpractice crisis can be averted. This, however, will require resolve and a strong partnership from all concerned citizens to make it work. After all, it is matter of the continued quality of our health.

Dr. Chaudhary is a psychiatrist and medical editor of the Bulletin. He can be reached at schaud2815@cs.com or (412) 427-6828.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the BULLETIN, or the Allegheny County Medical Society.
Mr. C. Michael Weaver, secretary of the Commonwealth of Pennsylvania, recently sent out an official letter to physicians in which he warned us that, "All physicians licensed by the Commonwealth have a lawful obligation not to abandon their patients." He went on to state that, "A stoppage of practice may be detrimental not only to your patients, but also to your practice, as well as your license."

There are a number of unspoken assumptions in this unbelievably offensive letter, but in this brief column I address just one, the inference that physicians may not have a work ethic that favors their patients' needs.

Mr. Weaver, here are some ready examples taken from the real and recent life of real university physicians I know personally. And I am proud to know them:

- Due to a landing gear malfunction, a plane-load of Pittsburghers coming home from their business trips has a near crash landing late on a Sunday evening. As tears and hugs and handshakes and addresses are exchanged, it develops that the only passenger not calling off sick the next day, is the physician.
- A surgeon with a low-grade fever runs down to the ER between the fourth and fifth operations on Monday, has a chest x-ray diagnosing pneumonia, runs back up to do the fifth operation for a patient, and works 11-hour days the rest of the week taking care of patients.
- A physician has a thyroid lobectomy and, in spite of the one to two weeks off work required by normal people after this operation, returns to work three days later, saying, "The patients were calling."
- A physician returns to work full-time at five, six and six weeks after the caesarean births of consecutive children carried at a maternal age of 35, 38 and 41 years.
- On behalf of patients already asleep and ready under their general anesthesia, surgeons continue with scheduled elective operations minutes after being informed of their own mother's death and a father's abrupt death. Subsequent time off work is zero days and two days.

Mr. Weaver, the physicians I am proud to work with get no two-hour lunch and often no lunch at all. They eat breakfast while walking to whatever they are late to next. They have no gym, no company cell phone, no billable minutes and a huge malpractice overhead. They have a huge malpractice threat under which they are expected to function impeccably, without error, without respite, every single day of their life. They literally lose sleep over it as they fulfill their commitment to patients by answering pages around the clock. How dare you warn them about patient abandonment? How many personal injury lawyers would work under these conditions? As my associate expresses it, "Well, you just feel responsible to the patients." Mr. Weaver, to whom do you feel responsible?
Dr. Marryshow is an orthopaedic surgeon. He can be reached at docshow@attbi.com.

Kimberly P. Cockerham, MD

Code Blue
Time for physicians to care
Not just complain
But take time
From their practice
From their lives
From their families

C = Contact
O=Others (ancillary staff, patients, your local and federal representatives)
D = Devote time
E = Emergently = RIGHT NOW

B = Believe in participation
L=Legislatively (contact representatives) & Legally (contact lawyers)
U = Unrelenting
E = Education for all

As I write this, we are at war in Iraq. The media and the nation are focused on this important conflict. But within the Commonwealth of Pennsylvania, we face our own conflict. Independent of what occurs internationally, medicine in America, and particularly in this state, will remain in crisis. Even with war raging, the dollars devoted to health care exceed the military and Pentagon budget combined.

The quality of health care in our state, especially in the long run, is being challenged. These issues are bigger than the regional healthcare system alliances. We need to rise above local divisions to take a united stand for the patients of Pennsylvania.

Potential proposals (beyond tort reform with mandatory limits) include:
1. Limit the fees that can be provided to physicians who

Dr. Cockerham

Dr. Marryshow is an orthopaedic surgeon. He can be reached at docshow@attbi.com.
provide expert opinions to discourage physicians from abandoning ethics for financial reimbursement.

2. Require a panel of physicians and lawyers to decide whether a case is frivolous (goes to binding arbitration) or valid (goes to trial).

3. If a case is deemed unworthy but a trial is demanded, the patients and their lawyers pay defense fees and damages (time spent out of the office preparing and participating in the trial) to the physician if the case is lost.

We are at great disadvantage:
The legislature is comprised of lawyers...
We don’t like to get involved...
We hope someone else—not so busy—will make it all go away...

CODE BLUE NEEDS YOU!

Dr. Cockerham is an ophthalmologist. She can be reached at kpcorb@aol.com.

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**Dr. Swan is a psychiatrist. She can be reached at bswan@wpahs.org.**

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**BARBARA E. SWAN, MD**

I have absolutely no argument with the fact that the current medical malpractice situation in Pennsylvania is unsustainable. I have never been able to understand the concept of damages for “pain and suffering.” Economic losses can be quantified; emotional damages cannot. Our court system should not be in the business of placing dollar amounts on “pain and suffering.” I am also disturbed by the general belief in our society that all bad outcomes are due to someone’s negligence and deserve compensation. And something is seriously wrong when the average annual malpractice premium for an OB/GYN in Pennsylvania is higher than the median income for a Pennsylvania citizen.

But I must confess to having mixed feelings about the Pennsylvania Medical Society’s call for a Code Blue emergency. Although I feel the goal of the project is a good one, I am concerned about unintended consequences. Will patients be alienated by the inconvenience of their doctors’ offices being closed, rather than becoming more aware of the larger issue? And will the resulting loss of income for hospitals operating on a razor-thin margin push some over the edge? What about the effect on other healthcare workers, such as nurses, phlebotomists, aides, therapists and technicians? What about the effect on our office staff? I can afford to forgo a week of income, but I suspect many of them cannot.

Therefore, although I support the right of physicians to protest our state’s lack of decisive action, I have not yet decided if I will participate in this particular project. I am unsure if it is worth the potential costs to my patients, my hospital and those with whom I work. In the meantime, I will continue to write to my state and federal government representatives and discuss the issues with my patients and friends.
**Jonathan Kaye**

I'll never forget Thursday, March 20, 2003: It’s the day that my classmates and I received our first job offers as doctors. Known as Match Day, we each took our turns walking up to the front of a crowded auditorium and receiving an envelope containing our “match.”

As we excitedly approach graduation, it is impossible not to also consider what yet lies ahead of us as residents: sleepless nights on call away from our friends and families, innumerable belittlements at the hands of our superiors, and years of waking to alarms hours before sunrise. Although we all anticipated these indignities when we began our arduous journeys toward medical school, we also anticipated that the intellectual, emotional and financial rewards of a medical career would eventually justify them.

But the realization of this hope is under attack by the exorbitant jury rewards in malpractice suits and the consequent skyrocketing malpractice premiums exacted upon many doctors. The necessity that every medical decision occasion the question, “Would this be defensible in a litigation?” rather than, “Is this best for the patient?” takes significant pleasure away from doctoring. More importantly, it is pernicious for patient care. This nonsense begs the question of whether our nation’s best and brightest college students will continue to aspire to careers in medicine. Given the average indebtedness of recent medical graduates and the current practice climate, how can we question college students’ decisions to endeavor toward other professions?

Two important changes would go a long way toward restoring medicine to the profession it once was. First, the medical profession must do a better job of policing itself. There are incompetent physicians and they must be forced out of practice. Second, the malpractice attorneys must be stripped of all incentives to file and pursue frivolous law suits. Either the fear of countersuits must be made real, or their fees for a successful litigation must be capped.

It will be regrettable indeed if my generation of doctors does not retire having reaped from our medical careers the rewards that I know our predecessors have reaped. But our suffering would pale in comparison to that of our patients.

Mr. Kaye is a medical student. He can be reached at jdkst40@pitt.edu.

The opinions expressed in this column are those of the writers and do not necessarily reflect the opinion of the Editorial Board, the BULLETIN, or the Allegheny County Medical Society.

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**Got something on your mind?**

As a member of the ACMS, there are many ways to express your thoughts:

- Call the 24/7 Physician Hotline at (412) 321-5035, ext. 131 and let us know what you’re happy with (or unhappy with), or tell us how we can better serve you as a member. Tell us what’s on your mind. We’ll take note and, if appropriate, publish it in an upcoming issue of the Bulletin.

- Write a Letter to the Editor of the Bulletin. Did you agree or disagree with something you read in the Bulletin? Express yourself and share your opinion with our readers. If you have even more to say than a few paragraphs, write a “Perspective” (500-900 words) and e-mail it to lsmith@acms.org or FAX it to Linda Smith at (412) 321-5323.

- Become an associate editor of the Bulletin and contribute editorials on a regular basis, as well as helping to shape the direction of the medical society’s membership magazine. Send your letter of interest in becoming an associate editor, along with one or two writing samples to Dr. Safdar Chaudhary, Medical Editor, ACMS, 713 Ridge Avenue, Pittsburgh, PA 15212.

- Log on to www.acms.org/express and submit your ideas for the Bulletin. We’d be happy to research your ideas for features and special reports, or to add your favorite website to our list to be shared with our readers.

Please let us know what your thinking!

Linda L. Smith, Bulletin Managing Editor
The number of doctors who are unhappy with the quality of their professional lives is growing alarmingly. Doctors are expressing fury and frustration over availability and affordability of professional liability insurance and their inability to obtain meaningful tort reform. Several instances of physicians closing practice, moving to other states and abandoning risk-prone procedures are being documented. Amidst this turmoil, a Code Blue status has been declared in this state. Physicians are asked to show solidarity for their cause by taking time out to seek the help of legislators on meaningful tort reform.

As physicians mull over this proposal and argue about the ethics and professionalism of their action, this should help with their decision.

When healthcare providers' salaries are being reduced, their malpractice insurance and medical licenses are placed in jeopardy, and when they must deal with Health Maintenance Organizations that act with impunity, they are virtually "locked out of practice." When this escalates to the point that care can no longer be provided, physicians must be permitted to close their doors. Some would mistakenly call that a strike.

The American Medical Association has a no-strike policy.

The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. This Oath was conceived some time in the fifth century B.C. The Oath of Hippocrates has remained in Western Civilization as an expression of ideal conduct for the physician.

At its first official meeting in 1847 at Philadelphia, the American Medical Association established its code of ethics. In general, the language and concepts of the original code adopted by the association in 1847 have remained the same throughout the years. There were revisions, of course, which reflected the temper of the times; major revisions occurred in 1903, 1912, 1947 and 1994.

Webster's Collegiate Dictionary defines professionalism as the conduct, aims or qualities that characterize or mark a profession or a professional person. Medical professionalism differs from other professions in both content and motivation. But it is not what we do as doctors, but how we do it that defines medical professionalism.

If our collective effort with actions related to Code Blue brings the necessary changes we seek, then it would be a worthy cause, for this will keep qualified physicians in practice, and our patients will have access to health care. One has to envision this action as advocacy for patients’ rights and not as self-centered action.

Codes of ethics and rules of etiquette are written to guide us and should be periodically adapted to reflect the changes in our environment.

Hippocrates could never have imagined the problems that the medical liability issue could cause, yet he would surely have wanted physicians to do everything in their power to continue treating the sick.

Some aspects of medicine are fundamental and timeless. Medical practice, however, does not stand still. Clinicians must be prepared to deal with changes and reaffirm what is fundamental.

Dr. Gopal is a colon and rectal surgeon and a member of the ACMS Board of Directors. He can be reached at (412) 466-7450 or guttocut@sgnet.com.

The Bulletin April 2003

Your Board of Directors

Professionalism and Ethics

KRISHNAN A. GOPAL, MD
Patients and physicians invited to PMS meeting
To support the many physicians who are preparing to close their offices in order to focus on patient activities and to petition their legislators for reform, the Pennsylvania Medical Society has committed to providing communication, administrative, research, legal, lobbying and leadership services. The society is supporting physicians who are closing their practices for a one-week period, while also recognizing and supporting the actions of physicians who close their offices on other dates or for a longer period of time. The state society is inviting patients and physicians to participate in events it is sponsoring on April 30 in State College and May 6 in Harrisburg. Log on to www.pamedsoc.org for more information.

Spring Cleaning set for May 2
As part of the medical society’s community outreach efforts, this year’s ACMS Spring Cleaning event will take place on May 2 at YMCA Camp Kon-O-Kwee/Spencer near Zelienople. Volunteers are needed to clear the camp’s nature trail, build an elevated walkway on part of the trail and work on landscaping and other miscellaneous jobs. Contact Elizabeth Fulton at (412) 321-5030, Ext. 100, or efulton@acms.org with questions or to volunteer. Please register by April 25.

Urologists to meet May 5
The April meeting of the Pittsburgh Urological Association (PUA) has been rescheduled for May 5 at the ACMS headquarters. Guest speaker David R. Staskin, MD, who will present Stress Incontinence Surgery—The Minimally Cutting Edge, is the director of the Section Voiding Dysfunction, New York Presbyterian Hospital and associate professor of urology and obstetrics and gynecology at Weill-Cornell Medical School. Registration and cocktails begin at 6:00 p.m., followed by dinner at 6:45 and the program at 7:15. It is offered at no charge to PUA members, and the non-member guest fee is $35. Call Nadine Popovich at (412) 321-5030 to register.

continued on page 166

Get out of the office and get a breath of fresh air!

Spring Cleaning
May 2, 2003

Volunteers are needed for the annual ACMS community outreach event to work on a variety of projects to spruce-up YMCA Camp Kon-O-Kwee/Spencer near Zelienople for the summer!

If interested in volunteering Friday, May 2, call Elizabeth Fulton at 412-321-5030.
Experience
A combined 310 years of Physician Healthcare Service and solution experience in Pittsburgh. That means we have the knowledge base to provide the best in medical solution and service!

Commitment
22,000 square foot Pittsburgh warehouse means a commitment to our community to provide the best service, solutions, quality and price to your practice.

Service Technicians
Our factory-trained, locally certified service technicians provide expert service for your equipment, translating to less down time.

Customized Savings
Consultant services to analyze your product use and provide cost containment and produce standardization. That means significant savings to reduce medical supply and utilization costs with our customized programs.

Accurate Results
Distributor of Choice (DOC) program provides continual maintenance and calibration of diagnostic equipment (scale, BP, otoscope, ophthalmoscope) and sharp surgical instruments—accurate results for your diagnostic and surgical procedures.

OUR MISSION is to serve each customer as if he or she were the only customer by providing each office with the best healthcare services and solutions for quality patient care.

We value your partnership in helping us to serve you. Thank you, physicians, administrators and office staff, for directing and advising us on medical supply products, services and costs.

Annual picnic to be held on June 15
Now is the time to mark your calendar for the ACMS annual Family Fun Picnic to be held once again on Father’s Day, June 15. Kennywood Park opens at 11 a.m., and rides begin operating at noon. All-day ride passes, including a picnic buffet, are $25/adult and $18 for children under age 12. General admission, including a picnic buffet, is $15/adult and $13 for children under age 12. Park admission only (no buffet) is $21 to ride all day and $8 for general admission. The picnic buffet will be served between 4 and 6 p.m. at Pavilion #23 beside the Log Jammer ride. Please watch for your personal announcement and call or e-mail Jim Ireland with questions at (412) 321-5030, Ext. 101 or jireland@acms.org.

Medical directors annual meeting announced
The Pennsylvania Medical Directors Association (PMDA) has announced its annual scientific meeting to be held on November 7 at the Pittsburgh Marriott City Center. For more information, call the PMDA meeting manager Diane Langner at (888) 633-5784 or (717) 558-7850, Ext. 1482.

PMS looking for nominations
The Pennsylvania Medical Society (PMS) is looking for nominees for its various councils and commissions for appointments effective October 19, 2003, including:
- Council on Policy, Advocacy & Governmental Affairs
- Commission on Public Health
- Council on Membership and Member Services
- Commission Communications and Technology
- Commission on Group Practices and Practice Managers
- Commission on Continuing Medical Education
- Council on Patient Advocacy.

Appointments are made annually by the PMS president-elect for a term of one year, with a maximum tenure of six years. Please submit your nominations no later than June 2, including a brief curriculum vitae and an appointment form. Remember that nominees must be members of the PMS. For additional information, call the Allegheny County Medical Society at (412) 321-5030.

HIPAA staff training video available
The Pennsylvania Medical Society is making available a
HIPAA staff training video, Making HIPAA Privacy Work in Your Practice, at a cost of $39 plus tax for its members. For $89 plus tax, members can purchase both the video and the manual, Making Sense of HIPAA Privacy. For more information, call the PMS Business Resource Center at (877) 272-2425 or e-mail brc@pamedsoc.org.

Annual photo contest delayed until late summer
Because of the change to a monthly format, the Bulletin has a backlog of winning photographs from the 2002 contest. For this reason, the call for entries for the annual photo contest will take place later this summer instead of the spring as in past years. In the meanwhile, put your favorite photos aside and watch for an announcement here in a few months.

Medical ‘biz in the ‘Burgh
According to a report by the University Center for Social and Urban Research at the University of Pittsburgh on behalf of the Pittsburgh Regional Alliance, hospitals and state government were the two top generators of job growth in the Western Pa. area last year. On a percentage basis, those segments were the top gainers in net employment in the six-county Pittsburgh Metropolitan Statistical Area, each showing an increase of 4.3 percent from December 2001 to December 2002. Those two segments and several others expanded, but overall local manufacturing employment declined by 2.4 percent over the last year noted. Job gains included 3,100 in the health services sector, including 2,500 at hospitals.

Anthony V. D’Amico, MD (right), was guest lecturer at the February meeting of the Pittsburgh Urological Association, speaking on Prostate cancer: combined modality staging and its utility in treatment selection. Dr. D’Amico is chief of Genitourinary Radiation Oncology and associate professor of radiation oncology, Brigham and Women’s Hospital, Dana Farber Cancer Institute, and Harvard Medical School. PUA Program Director Jay Herman, MD, appears on the left.

IS YOUR OFFICE HIPAA COMPLIANT?
We can help you develop a secure and cost effective program to destroy patient information that will protect the privacy of your patients as well as your reputation.

If you are currently handling your shredding in-house, our service may be of even greater interest and value to you.

If you are already out-sourcing your shredding, we will save you money.

♦ No preparation: no removal of staples, binder clips or paper clips. No need to separate records from their file folders.
♦ No in-office noise, paper dust, bagging or shredder maintenance.
♦ A certificate of destruction is provided for all materials.
♦ All materials are recycled.

Whether you are accumulating and discarding patient information on a daily basis or purging your records once a year, you will benefit by adopting our service!
The president of the Pennsylvania Medical Society disputes claims that Pa. has the most doctors who repeatedly are involved in malpractice. Dr. Edward H. Dench Jr. addressed a report from Washington, D.C.-based Public Citizen, which said about 11 percent of doctors in the state account for 84 percent of malpractice payments, giving Pa. the highest number of repeat offenders in the United States.

Testifying before the state Senate Banking and Insurance Committee, Dench said the medical society’s analysis of the National Practitioner Data Bank figures shows Pa. actually ranks 40th nationwide in repeat offenders. He said Public Citizen failed to understand that malpractice awards and settlement payments in Pa. are reported to the data bank by both the primary insurer and the state’s MCARE Fund—causing Public Citizen to overstate the number of malpractice awards, while understating the average size of payouts.

According to Public Citizen, 10.6 percent of Pa. doctors had multiple malpractice payouts during the past 12 years, while Dench said the true number is 7.5 percent.

[3/6/03 Patriot News]

One in eight Allegheny County residents has no health insurance. A new survey by the Allegheny County Health Department, which interviewed 5,000 residents by phone last year, estimates that about 150,000 Allegheny County residents—roughly 12.5 percent of the total—lacked health insurance last year. In 2002, the county rate was higher than the statewide number of 9.2 percent during 2001. Of county residents making between $20,000 and $30,000 per year, about 15 percent lacked health insurance, while four percent of those making more than $50,000 a year weren’t covered.

[3/11/03 Pittsburgh Post-Gazette]

Highmark Inc., which rolled out its Community Blue health plan in mid-1998, is expected to discontinue the plan by the end of next year. Health benefits analysts said the loss of the plan could mean large increases in the costs of health insurance coverage for the companies that chose the plan, in which about 216,000 individual subscribers are enrolled. Highmark’s new chief executive, Dr. Ken Melani, said that Community Blue—which offered lower premiums in exchange for restricted choice of hospitals—will be discontinued as part of a planned overhaul of Highmark’s lineup of health plans that will reduce the number of offerings in an effort to cut administrative costs.

[3/27/03 Pittsburgh Post-Gazette]

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MaryBeth Salama, MD, family practice, spoke to students at Wilkinsburg Middle School in February on what it is like to be a doctor.

Judith S. Black, MD, geriatrics, spoke to an Alzheimer’s support group at the Alzheimer’s Outreach Center at Hill House on February 25 on the topic of living wills and healthcare power of attorney.

[3/20/03 Sun Sentinel]

April 2003
Eugene N. Myers, MD, professor and Eye and Ear Foundation Chair of the Department of Otolaryngology at the University of Pittsburgh School of Medicine, spoke at the 2nd National Meeting of the Foundation of Head and Neck Oncology in Calcutta, India, in January.

Also in January, Dr. Myers spoke at the 55th Annual Conference of the Association of Otolaryngologists of India in Patna, India, and at the 10th Annual ASEAN ORL Head and Neck Congress in Brunei, Darussalam. In February, Dr. Myers spoke at the Primera Reunion de las Academias Americana y Ecuatoriana de Otorrinorinolaringologia: IV Curso Internacional de Cirugia Endoscopica Nasosinusual in Quito, Ecuador.

Dr. Myers has been appointed to the editorial board of the Turkish Journal of Ear, Nose and Throat, published monthly.

Jeffrey S. Upperman, MD, general surgery, was recently appointed chair of the ACMS Child Health Advisory Committee. Dr. Upperman served on the Child Health Advisory Committee as vice-chair in 2002. He also serves on the medical society’s Legislative and Communication Committees.

In addition, Dr. Upperman has recently been designated a Fellow of the American Academy of Pediatrics (AAP). Almost 40,000 of the academy’s 55,000 members have earned the designation of Fellow (FAAP). Fellows are recognized by their colleagues and the Board of Directors as demonstrating excellence in training, leading to board certification, as well as demonstrating high ethical and professional principles and conduct.

James Bradley, MD, orthopedic surgery, was featured in March as a Pittsburgh Tribune-Review Newsmaker as the new president of the National Football League Physicians Society. He will serve a two-year term as a representative of the NFL team doctors.

continued on page 170
The American Medical Association Foundation honored Adam Gordon, MD, MPH, at its inaugural Excellence in Medicine Awards Ceremony in March in Washington, D.C. Dr. Gordon, who was among 25 medical students, 25 residents and fellows, and 25 young physicians from around the country who received the awards for demonstrating outstanding leadership skills in non-clinical and community service activities, is an assistant professor of medicine at University of Pittsburgh Center for Health Equity Research and Promotion.

George J. Magovern, MD, thoracic surgery, was the first recipient of the American Heart Association’s (AHA) Pulse of Pittsburgh Award. Dr. Magovern was presented with the award at the AHA Allegheny County Division Heart Ball on February 15. This award recognizes an individual’s leadership in the fight against heart disease and stroke.

Gregorio Delgado, MD, chairman, Department of Obstetrics and Gynecology, Western Pennsylvania Hospital, received the 2003 Provider-Physician Health Care Hero Award from the Pittsburgh Business Times on March 6 during an evening reception and awards ceremony held at the Sheraton Station Square.

John C. Gaisford, MD, FACS, director, Burn Research, Western Pennsylvania Hospital, received the 2003 Lifetime Achievement Health Care Hero Award during the same awards ceremony.

Bennylin J. Ferguson, MD, associate professor of otolaryngology at the University of Pittsburgh School of Medicine, was a guest faculty lecturer for the Sociedad Mexicana de Alergia en Otorrinolaringologia in February. She also was an invited guest moderator at the ENT Meeting of the GCC Countries in Dubai, United Arab Emirates, in March.

KDKA-TV reporter Paul Martino interviewed ACMS President-elect G. Alan Yeasted, MD, about the professional liability insurance crisis, specifically addressing the allegations made by Ralph Nader’s Public Citizen group challenging the medical malpractice claims of physicians. The 30-minute show aired on Cornerstone Television (WPCB-TV in the Pittsburgh area) several times in March.

James Weise, MD, nephrology, was recently elected president of the Renal Physicians Association, a national organization of more than 2,200 members. The RPA advocates for excellence in nephrology practice, and in health service practice and socio-economic issues for all nephrologists.

Jonas T. Johnson, MD, professor and vice chair of otolaryngology at the University of Pittsburgh School of Medicine, gave two lectures, Current Philosophy for Management of the Neck for Head and Neck Cancer and Changing Trends on the Management of Laryngeal Cancer at Oregon Health Science University in Portland, Ore., on January 13.

Dr. Johnson

ACMS President-elect Edward Tseplee Jr., MD (left), on WPCB-TV’s Focus on the Issues, seated here with show host Jerry Bowyer.
Alzheimer’s Education
As part of its Jay L. Foster Memorial Lecture Series in Alzheimer’s Disease, the University of Pittsburgh Graduate School of Public Health (GSPH) will present a community lecture, Alzheimer’s Disease in the Community, on May 15 at 1:00 p.m. The lecture, to be held at the IBEW Conference Center on the South Side, is directed to a lay audience, including family members of Alzheimer’s disease patients, caregivers, staff of skilled nursing facilities and the general public. Refreshments will be served and parking is free.

The GSPH also will present a scientific lecture on Alzheimer’s disease later in the afternoon on campus at A115 Crabtree Hall beginning at 4:30 p.m. with a reception to follow. The public is welcome to attend this lecture, but is reminded that it is intended for a scientific audience, including physicians, researchers and academia.

For information on either lecture, contact Gloria Curtis at (412) 383-8849 or gcurtis@gsph.pitt.edu.

Heart Walk on May 24
Highmark Blue Cross Blue Shield is sponsoring Walk for a Healthy Community, a 5K walk leaving from Station Square at 9 a.m. on May 24; a one-mile fun walk steps off at 9:10 a.m. Money raised by the 5K walk, which will be fully accessible to those of all ages and abilities, will empower the Working Hearts coalition to continue raising awareness about women’s heart health. For additional information, call (412) 594-2583 or log on to www.workinghearts.org.

Free booklet on aging
The National Institute on Aging is making available Aging Under the Microscope: A Biological Quest, a free booklet that explains in easy-to-understand language what scientists are learning about aging, including the latest findings from top biology-of-aging researchers. To obtain copies of the 50-page book, which is intended as a resource for journalists, educators, students, policymakers and the general public, log on to www.nia.nih.gov or call (800) 222-2225.

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Jon B. Tucker, MD, orthopedic surgery, wrote about treatments for rotator cuff injuries. He wrote that, for less active patients, physical therapy and steroid injections may be enough to relieve their pain. Dr. Tucker discussed surgery as an option when conservative treatment fails or when a patient is more active.

Steven G. Docimo, MD, pediatric urology, answered a question about undescended testis, a common diagnosis in a newborn. If not treated, he said, the testis can lose the ability to produce sperm, resulting in a higher risk of developing testis tumors in adulthood. The condition can be treated as early as six months of age by relocating the testis to the scrotum.

The Dear Doctor column is published regularly in the Pittsburgh Post-Gazette’s Health Section. To contribute a Dear Doctor column, call Elizabeth Fulton at (412) 321-5030 or e-mail efulton@acms.org.
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Richard A. Finegold, MD, age 70, passed away March 10. Dr. Finegold, a urologist, graduated from the University of Maryland Medical School and interned at Montefiore Hospital. He served a residency at Pittsburgh Medical Center Hospital and continued to serve the Pittsburgh community for 43 years. He is survived by wife Marian, daughters Carolyn Wolff, Marcia Langhoff and Helene Blodgett, son Stephen Finegold and five grandchildren.

April 20-26 is National Organ and Tissue Donor Awareness Week and National Minority Cancer Week. April 27-May 3 is National Volunteer Week. May is the month for the following national awareness programs: Arthritis, High Blood Pressure Education, Digestive Diseases, Melanoma/Skin Cancer Detection & Prevention, Sight Saving, Stroke, Trauma, Neurofibromatosis and Osteoporosis. May 3-10 is National Safe Kids Week, May 4-10 is National Suicide Awareness Week and May 7 is national Anxiety Disorders Screening Day. (Source: U.S. Dept. of Health and Human Services).

April Calendar

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April 22, 6-9 pm .............. Allegheny Vascular Society
April 23, 5:30 pm .......... Pittsburgh Pathology Society
April 29, 9-4 pm .............. Economedix & ACS Practice Mgt.
April 30, 9 am-6 pm ........ American College of Surgeons
May 1, 9 am-4 pm .......... Current Issues in Obstetrics & Gynecology
May 2, 8 am-3 pm .......... ACMS Spring Cleaning at Camp Kon-O-Kwee/Spencer
May 5, 8 am-3 pm .......... Risk Management: Error Reduction in the Hospital
May 5, 5:30 pm .............. Pittsburgh Urological Association
May 9, noon-6 pm .......... American College of Surgeons
May 12, 5 pm .................. Pittsburgh Obstetrics/Gynecological Council
May 12, 6 pm .................. Pittsburgh Obstetrics/Gynecological Society
May 13, 9 am-1 pm .......... PMS Videoconference: Interspecialty Group
May 13, 10 am-noon ...... ACMS Alliance
May 13, 6-9 pm .............. ACMS Board of Directors
May 14, 6-9 pm .............. Medical Assistants
May 15, 10 am-1 pm ...... PMS Videoconference: Practice & Practice Managers
May 16, 8:30 am-1 pm .... Three Rivers Adoption Council

Mental Health

5th Int’l Conf. on Bipolar Disorder—June 12-14. Sheraton at Station Square, Pittsburgh. Sponsor: Western Psychiatric Institute & Clinic, et al. For information, call (412) 605-1224 or e-mail lichokja@psu.edu.


Ongoing Continuing Education Programs & Conferences. Sponsor: Western Psychiatric Institute & Clinic, et al. CME available. For information, call (412) 624-2523 or log on to www.wpic.pitt.edu/oerp.

Miscellaneous

Management of Anemia in ICU Patients—May 3. Hilton Pittsburgh & Towers. Sponsor: International Center for Postgraduate Medical Education (ICPME). 3.0 Category 1 Credits (AMA PRA). Call (888) 864-2763 or e-mail register@icpmed.com.


8th International Symposium on Recent Advances in Otitis Media—June 3-7. Marriott Harbor Beach Resort, Fort Lauderdale. Sponsor: UPMC et al. Call Tricina Cash at (412) 647-8255 or e-mail casht@msx.upmc.edu. Visit www.upmc.edu/coeohs/otitis.htm.

15th Conf. of the Society for Menstrual Cycle Research—June 4-7. Pittsburgh. Sponsor: U. of Pittsburgh School of Nursing, et al. For information, call (614) 863-0356 or e-mail pkm@psu.edu.


Misc. Interactive Physician Workshops—August & September. Sea Crest Oceanfront Resort, Cape Cod. Sponsor: SEAK Inc. Call (617) 328-1605 or visit www.seakinckb@aol.com.

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As a medical director at Highmark Blue Cross Blue Shield, I often face the challenge of balancing the expectations of employers and consumers with the pressing realities of medical practice for physicians and their office staff. This balancing act focuses on three inter-related issues in health care:

• Preserving broad access for consumers to physicians and hospitals;
• Keeping the cost of care affordable; and
• Improving the quality of care.

The medical malpractice issue in Pennsylvania has brought into sharper focus the challenge I encounter, almost daily, in balancing these three worthy, but sometimes conflicting objectives.

Accessible health care

We are deeply concerned about access to care for our members and all Pennsylvanians, especially for our region’s large elderly population. Physicians are telling me that, because of rising medical liability premiums, they are considering leaving practice, retiring, moving to another state or cutting back the services they provide.

From a patient perspective, this is an unacceptable development. Your patients—and our members—should not bear the burden of longer wait times for appointments, longer trips for a doctor visit or the loss of access to a physician altogether. Public policy on medical malpractice must reinforce the message that we all must make sure that good physicians stay in Pennsylvania and that new physicians want to practice here.

Affordable health care

Few would dispute that the rising cost of medical services is the number one issue facing our industry. The medical malpractice issue is driving up costs in a number of ways. Physicians are feeling the need to practice defensive medicine, increasing the use of services and further driving healthcare cost increases. Rising office practice expenses increase pressures on insurers for higher reimbursements.

Solutions to the malpractice issue must acknowledge and address the myriad pressures on physicians that result in higher healthcare costs.

Quality

Since my responsibilities at Highmark involve clinical quality improvement, I am deeply troubled by the impact of medical malpractice on the well-intentioned efforts of physicians to deliver high-quality care. The current malpractice climate in the state impairs cooperative efforts to identify medical errors, collect and analyze mistakes, and encourage open review of case studies and education on how to prevent errors. Full and open discussion of clinical quality issues and errors is difficult if physicians know the data discussed can be used in a malpractice lawsuit.

What should be done to make the medical malpractice system fairer? The General Assembly took some important steps in 2002 by addressing the issue of joint and several liability, shoring up weaknesses in the CAT Fund and limiting venue changes for medical malpractice litigation.

We support the medical community’s call for legislative action to cap non-economic damages and punitive damages and to limit attorney contingency fees in medical malpractice litigation. A long-term solution must be built on a platform of systematic reform, reflecting shared responsibility by all parties, aimed at maintaining access to affordable, high-quality care that has been the hallmark of our healthcare delivery system.

Dr. Vinson, a family practitioner, is medical director for quality management at Highmark Blue Cross Blue Shield. He can be reached at carey.vinsonmd@highmark.com.
As a proud, native Pittsburgher in a medical school class full of “foreigners” (anyone not from Pittsburgh), I constantly find myself defending the city and the state. For some reason, people feel duty bound to inform me about how bad the drivers are here, or the weather, or the roads, or the nightlife or any number of other things that are totally out of my control. And so I stick up for this great place that I hold near and dear to my heart, even when they’re right (but especially when they’re wrong). Yet there is one complaint that the future doctors are “right-on” about, and for which I can offer no defense: Pennsylvania is a terrible place to be a physician right now.

Most of my classmates will graduate in severe debt. They will go on to residencies that afford them less spending money than they have now. Most of us will not have salaries commensurate with our education level until some time in the next decade. To think that, after all of that work, we will end up turning over half of our income to insurance companies is not exactly enticing us to stay in the state. Why should we stay? Why should we not move to California, where they value their doctors; and, from what I’m told, the weather is better, the people are nicer, they don’t know what potholes are, and the “streets are paved with gold?”

But the money isn’t the only issue. Let’s be honest: Any one of us could have gotten a job in consulting or investment banking and retired at the age of 30 or 40. We knew getting into this that medicine was no longer the way to get rich. Every single prospective student that I interview tells me he or she wants to be a doctor in order to “help people.” Of course, they usually preface with the phrase, “I know this sounds like a cliché, but…“ Well, it might be a cliché, but it’s true. When I finally have patients, I want to be in a position to help them. I don’t want to fear them. I don’t want to practice defensive medicine. I don’t want to run and hide under the hospital attorney’s desk every time I make a mistake. I don’t want to be in an adversarial relationship with the very people that I joined this profession to help. Unfortunately, this is the situation that exists in Pennsylvania today.

The healthcare system is broken. Well, not so much broken, as completely and utterly shattered into thousands of tiny pieces. Greedy trial lawyers may be scattering the pieces around and putting the valuable ones into their pockets, but tying them up and locking them in the closet won’t fix the system. It might stop the pieces from being scattered, but it won’t put them back together. It won’t bring health care to the millions of people who don’t get it, and it won’t stop doctors from making mistakes.

We need a new system that provides care to everyone in this country. We need a system that allows for open discussion about medical errors without fear of frivolous litigation. We need a system that allows open discussion about medical errors without fear of frivolous litigation.
Mr. Tobias is a medical student at the University of Pittsburgh Medical School. He can be reached at azt3@pitt.edu.

The opinion expressed in this column is that of the writer and does not necessarily reflect the opinion of the Editorial Board, the BULLETIN, or the Allegheny County Medical Society.
We are all aware of the turmoil created by the malpractice insurance situation. Insurance costs in many states have risen dramatically. The availability of insurance in some states has declined or has become almost non-existent. Physicians who cannot obtain or afford insurance in some states are retiring early or joining in a mass exodus to more favorable locations. Tort reform legislation has been introduced on both the state and federal levels.

One short-term remedy proposed by a national hospital chain is to subsidize physicians for the increased cost of medical malpractice insurance. The Office of Inspector General of the Department of Health and Human Services (OIG) recently responded to such a proposal. In a letter dated January 15, 2003, OIG was careful to emphasize that its letter did not constitute an advisory opinion, because the hospital request was not made in accordance with the appropriate federal regulations. However, the OIG letter was helpful in defining the government’s position on this issue.

The OIG acknowledged the need for assistance to “forestall disruption in the provision of medical services” and of the “current disruption in the medical malpractice liability insurance markets in some states.” Furthermore, OIG recognized the impact on both access to healthcare and quality of care.

The hospital malpractice insurance subsidy proposal contained six main points:

1. It would be a temporary or interim program;
2. Assistance would be available only to current active or new members in the medical staff;
3. The amount of subsidy would be limited to the increase to the physicians’ current malpractice costs;
4. The amount of the subsidy would not be related to the value or volume of any physician services or referrals;
5. The subsidy would not be dependent upon any physicians’ office locations or other hospitals; and
6. The physician would be required to perform certain services and waive certain litigation rights in order to participate in the plan, and the hospital represented that this exchange constitute fair market value for the subsidy.

As previously noted, the OIG did not issue an advisory opinion. The OIG did assure
the hospital that, “We will take these considerations into account in evaluating temporary financial arrangements designed to help assure continued access to care and will exercise our enforcement discretion accordingly.”

The OIG did identify the existing safe harbor available under the existing Anti-Kickback Safe Harbor Regulations, i.e. 42 CFR 1001.952: (i) malpractice insurance costs for employees, (n) malpractice subsidy as part of the recruitment package for a new practitioner, and (o) malpractice subsidies for OB services in primary care health shortage areas. The OIG also noted that the Department of Justice has separate jurisdiction over the enforcement of the anti-kickback statute and that CMS has primary jurisdiction over the enforcement of the Stark Act and regulations.

Mr. Cassidy is a shareholder with Tucker Arensberg and co-chair of the firm’s Healthcare Practice Group. He can be reached at (412) 594-5515 or at mcassidy@tuckerlaw.com.

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I really enjoy the practice of refractive surgery: LASIK, LASEK, PRK. These are acronyms for procedures that modify the shape of the cornea to correct nearsightedness, farsightedness and astigmatism. I always got a kick from the WOW factor that patients describe when they read the eye chart without glasses on the first postoperative day—the joy they experience when they realize that they can swim, jog, golf, ski or just see the clock in the middle of the night without any visual correction. In fact, the expertise and reputation in refractive surgery was an important reason that I chose to do a fellowship in cornea and refractive surgery at the Massachusetts Eye and Ear Infirmary in Boston.

Sadly, that phase of my career is over, as I have ceased to perform these procedures. Trial lawyers are training their sights on LASIK. A recent landmark case established the “rate” for LASIK lawsuits at two million dollars per eye, far exceeding the insurance limits in the CAT Fund. In this case, the surgeon met all guidelines for patient selection and performed technically perfect surgery. Despite perfect unaided visual acuity, the plaintiff complained of “glare,” an ocular equivalent of low back pain or chronic fatigue that is immune to objective verification. This news was rapidly shared among legal firms, greatly encouraging the plaintiffs’ bar. Legal websites now solicit anyone “subjected” to LASIK. Colleagues inform me that copycat cases are multiplying. Although I no longer perform LASIK, I intend to notify patients, colleagues and representatives of the worsening situation in our state. The week identified for Code Blue is an ideal time for advocacy and education.

GLEN C. COCKERHAM, MD

I had the experience of being sued by (a patient) for making her breast implants “too natural looking.” The case was ultimately thrown out, but depositions were taken and I have a record of being sued in City Hall. The defense was going to subpoena her sexual partners who allegedly said how she bragged about her implants. This was the deterrent.

GUY M. STOFRMAN, MD, FACS

I cannot by any stretch of the imagination understand what has happened in Pennsylvania. In my own case, I fought very hard to come back from what can only be described as one of the worst events of my life. Imagine my surprise when I tried to find malpractice (coverage) as a solo practitioner and found that nobody in Pennsylvania was writing for individuals anymore. When I further found that, even though I had never had a malpractice suit, but because I had a blemish on my record, I had to go with only one state company, I was horrified. The company I now must use only covers six-month periods and costs a total of four times more than I have ever paid in my life for malpractice. My malpractice premium is now $22,000 per year, and I don’t do anything but basic medicine. This is an outrage. Something must be done immediately.

EUGENE L. YOUNGUE III
MD, MS, PHA

D r. C ockerham

D r. Stofman

Glen C. C ockerham

G u y M. Stofman
There are some basic truths that must be spoken, however, before change can be effected. The lawyers must admit that they are milking the system. I would like to see how many lawsuits would exist if they were capitated like primary care.

Tort reform is also very important. You cannot put a price on human tragedy, but you shouldn’t be able to buy a sports car with it either.

The M-CARE Fund is useless, especially the all-at-one-time method of payment. We as physicians must take control. If we let lawyers and insurance companies continue as they have, things will surely get worse.

The opinions expressed in this column are those of the writers and do not necessarily reflect the opinion of the Editorial Board, the BULLETIN, or the Allegheny County Medical Society.
Legislative Issues in the Medical Liability Crisis

The Question:
Despite the passage of significant legislation in the last session, work remains to be done in the professional liability crisis on both availability and affordability. In your view, what remains to be done in Pennsylvania to resolve this issue?

Long-term Solutions Are Needed

Dan Frankel (D)

In an ideal world, the medical community would need only to concern itself with the art of practicing medicine. Unfortunately, this is not an ideal world, and I am well aware of the acute problems that our physicians, hospitals and medical care facilities are facing today. Pennsylvania ranks high in national statistics in medical malpractice jury awards, and skyrocketing insurance premiums are encouraging our skilled doctors, especially those performing high-risk specialties, to relocate their practices to states where liability reform is already in place. Others are closing their practices and taking early, unplanned retirement because they can no longer afford their liability insurance. This alarming trend has been particularly evident in Western Pennsylvania where exorbitant malpractice costs threaten to shut down cash-strapped hospitals and trauma centers. More importantly, Pennsylvania’s medical malpractice dilemma has created an adversarial divide between our state’s medical and legal communities in epic debate over a problem without a simple solution.

Last year, members of the General Assembly took steps to remedy the problems plaguing our state’s healthcare system, and I was proud to support these legislative initiatives. In recognizing that the curtailment of frivolous medical malpractice litigation would result in much needed relief for malpractice insurance consumers, I remained a strong advocate of many early tort reform proposals introduced in the legislature. Specifically, I worked diligently to garner support for legislation to eliminate “joint and several liability” (Act 57 of 2002) and “venue shopping” (Act 127 of 2002). As you know, in many medical malpractice lawsuits, lawyers often try to move cases to a court with a judge and jury more sympathetic to their plight. As such, venue shopping has often resulted in inflated jury awards, thus leading to exorbitant increases in liability insurance. On a similar note, the “joint and several liability” legislation removed the ability of claimants to target deep-pocketed defendants sharing only a minute proportion of the wrongdoing.

While I consider the passing of Act 13 (MCARE), Act 57 and Act 127 significant first steps toward meaningful malpractice reform, I still recognize that more needs to be done to remedy Pennsylvania’s medical malpractice crisis. However, I am apprehensive that the medical community’s interminable focus on capping non-economic damages as a solution to this complex problem is merely a quick fix and an ad-hoc approach that is not likely to provide the relief we are working towards. Furthermore, I am not convinced that the basis of this argument—excerpted from MICRA, California’s medical malpractice reform, specifically the implementation of standardized caps—has resulted in overwhelming reductions in their medical liability premiums.

Although I would agree that the idea behind caps is...
valid—it would hold down the amount a claimant could make, thus lowering the costs of malpractice insurance—I feel that implementing caps on a blanket basis is inherently unfair. Moreover, I believe that using this cookie-cutter approach to rule in malpractice claims is not realistic, given the fact that seemingly similar circumstances could be quite different beneath the surface, thus leading to substantial unanticipated negative ramifications on a case-by-case basis. Furthermore, the time factor that is involved in having this legislation enacted creates another significant drawback. The constitutional amendment required to institute damage caps would have to survive the political muster of two legislative sessions. Even in the realm of the possibility that the proposal would not perish, we would be five years out with no immediate relief in sight. I believe that our efforts would be better spent in focusing on other aspects of this multi-faceted problem.

Although I understand the need to enact quick, short-term remedies to this dire situation, I also believe that we must look hard to examine long-term solutions to the medical malpractice crisis, particularly those which will provide reductions in medical errors, improve physician accountability and ensure patient safety. Should we find a way to successfully breathe a higher degree of flexibility into damage caps, I would consider all reasonable proposals of this nature. However, in light of the significant drawbacks to the caps proposal, I will continue to investigate other alternatives to solving the malpractice crisis, such as instituting a

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of the law. I am well aware of the unpredictability of the civil litigation system.

Before we can move forward with additional reforms, it is important to understand the recent tug of war with respect to medical malpractice reform in this state.

Our state House of Representatives led the charge on resolving Pennsylvania’s medical malpractice insurance woes as early as December 2001 and passed an initial version of medical malpractice tort reform in January 2002 by a vote of 164 to 32. This comprehensive legislation contained a version of caps on jury awards for non-economic damages, or “pain and suffering.” After much haggling, we passed a compromise bill in mid-March. The final version (House Bill 1802) did contain some true reforms, but not as many as contemplated:

- Affidavit of non-involvement demonstrating misidentification or non-involvement of a defendant can be filed to get that defendant removed from a case.
- Plaintiffs are precluded from recovering for past medical expenses and/or past lost earnings incurred up to the time of trial to the extent that such loss is covered by a private or public benefit or gratuity.
- A statute of repose was instituted providing that no cause of action asserting a medical professional liability claim could be commenced after seven years from the date of the alleged tort or breach of contract.
- Payment of damages for loss of earnings or earning capacity will receive a “reduction to present value” discount.
- Future medical damages can be paid in the future in periodic payments instead of at the time of the award.
- More stringent expert qualifications were imposed, requiring any expert to have an unrestricted medical license, be actively engaged in a clinical practice or have retired from a clinical practice in the last five years, and possess the same or similar board certification as the defendant physician.

In June 2002, we passed legislation that overhauled the rule of joint and several liability, a rule that encouraged plaintiffs to name as many defendants as possible in a suit. The bill, known as the Fair Share Act, was signed into law June 19, 2002. The new legislation implemented a system of comparative responsibility in which most defendants are responsible for only their share of damages.

I was privileged to be the prime sponsor of this legislation in the House and to lead the floor debates.

Mr. Frankel is State Representative in the 29th District. He can be reached at (412) 422-1774.

More Work Needed at the State Level

Mike Turzai (R)

Pennsylvania is undoubtedly plagued by a troubled civil justice system, particularly in the area of medical malpractice claims. Too many frivolous lawsuits are filed. Too often, juries award outrageous sums of money to plaintiffs. These claims result in both nuisance settlements and high malpractice insurance premiums and surcharges. Physicians are leaving Pennsylvania. We are not attracting new physicians to stay here to practice, despite numerous medical schools and residency programs within the state. Thus the availability of quality health care has been jeopardized.

Recently, Republicans in the Pennsylvania House of Representatives held a press conference in Harrisburg to call on the governor to declare the commonwealth to be in a state of emergency due to our unstable medical malpractice insurance market. While some strides have been made over the last year, clearly more needs to be done. I personally campaigned on the issue of enacting tort reform, not only because my wife is a physician, but, as a commercial and insurance defense litigator, I saw the glut of frivolous claims filed each year in a variety of areas of the law. I am well aware of the unpredictability of the civil litigation system.

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In October 2002, the General Assembly enacted a venue reform bill that requires a malpractice case to be heard in the county where the alleged incident occurred. The act will prevent attorneys from “venue shopping” in order to find trial locations where juries tend to give extremely high awards.

Why haven’t these reforms stemmed the rise in insurance premiums? As Jim Redmond of the Hospital & Healthsystem of Pennsylvania stated in testimony to the House Health and Human Services Committee, “Since these (reforms) apply only to incidents on or after the effective date of the acts and are spread over a multi-year period, it will take several years before the full financial benefits are realized.”

What effect, if any, would federal legislation have on state law governing malpractice claims? Tort law—including malpractice—has always been the province of the states, not the federal government. The vast majority of malpractice claims are brought in state courts. Even when claims are brought in federal court on diversity of citizenship grounds, state law controls the substance of the claims. The federal government may be able to establish limits on malpractice claims based on its power to regulate “interstate commerce,” thereby preempting existing state laws. It is not clear, however, that the federal government has that power. The courts have obviously not had an opportunity to address the constitutional validity of such proposed legislation.

Why haven’t more extensive reforms, including a cap on non-economic damages, been enacted yet? There are a number of reasons. As an initial matter, many special interests—particularly the trial bar and interest advocacy groups close to the trial bar—have been vehemently opposed to caps and other reforms. These groups are willing to engage significantly in the political process (grass roots activities such as letters to legislators, rallies, letters to the editor, political contributions) to stop change. Even when willing to enact reform, the state legislature has resorted to compromise positions given the competing interests.

Secondly, as a result of our system of checks and balances, it is easier to prevent legislation from passing than to have it enacted. To pass legislation, you need a bill to first run and then pass the House, then run and pass the Senate, and finally be signed by the governor. If a bill

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is not run in either chamber, it dies. If the governor vetoes it, a two-thirds override is necessary to enact the law which, given the present make-up of the chambers, is almost impossible.

Finally, as for caps, our state constitution has a provision that prohibits limits on damages. To change the constitution, both chambers have to pass an amendment by a majority twice, both in the 2003-04 session and the 2005-06 session. The amendment would only have to be passed in one session if both the House and the Senate provided two-thirds favorable votes. In either scenario, the measure would have to then proceed to a statewide referendum and pass by a majority. Once the constitution is changed, a bill enacting specific caps would still have to pass the Senate and House and be signed by the governor.

Despite these impediments, I believe we can enact caps on non-economic damages and institute other real reforms. The crisis is real and the momentum is on the side of those who support reforms. Healthcare providers must engage in the political process and must be seen as willing to engage long-term, not just short-term. Furthermore, we need to develop necessary political support in the populace beyond healthcare providers. Support from medical providers alone will not get the job done.

To establish this support, we must frame the argument in a three-fold perspective. First, laypersons (non-medical providers) have to recognize that, if changes are not made, more doctors will leave, more hospitals will close, fewer medical advances will be made and their access to quality health care will continue to diminish. Second, we must continue to explain that there are far too many lawsuits and that the litigation system is out of control. People from many walks of life are tired of having their decisions second-guessed in a court of law. Finally, we must make clear that we are not opposed to justly compensating those individuals harmed by truly negligent acts.

I am a prime sponsor of a resolution providing for an emergency constitutional amendment to cap non-economic damages in medical malpractice cases. Proposals by Rep. Flick (R-Chester County), Rep. Godshall (R-Montgomery County) and Reps. McIlhinney (R-Bucks County) and Watson (R-Bucks County) would also provide, in some fashion, caps on non-economic damages. I am also working on a proposal to provide compulsory arbitration of medical malpractice claims.

Other legislative proposals currently pending before the House of Representatives include:

• Establishing medical liability pretrial review screening panels in order to weed out frivolous lawsuits (Rep. Bard, R-Montgomery County);

• Eliminating or reducing the requirement that doctors carry medical liability insurance (Bard and Rep. Lewis, R-Monroe County);

• Implementing sliding scale caps on attorney’s fees in medical malpractice claims (Rep. Godshall, R-Montgomery County); and

• Immunity for physicians and hospital personnel providing trauma services (Godshall).

The opinions expressed in this column are those of the writers and do not necessarily reflect the opinion of the Editorial Board, the BULLETIN, or the Allegheny County Medical Society.
Going Beyond the Patient/Physician Relationship

ADAM J. GORDON, MD, MPH

"I shall...work with my profession to improve the quality of medical care and to improve the public health, but I shall not let any lesser public or professional consideration interfere with my primary commitment to provide the best and the most appropriate care available to each of my patients."

Oath declared by the graduates of the Pennsylvania State University College of Medicine

"I will maintain, by all the means in my power, the honor and the noble traditions of the medical profession."

Oath declared by the graduates of the University of Pittsburgh School of Medicine

We have all read in the media the need for physicians to continue to practice traditional medicine because, "doctors have sworn the Hippocratic Oath." It would be surprising for the public to know that many graduating medical students no longer swear the Hippocratic Oath. As the environment in which physicians practice in society has changed, the oaths that medical students declare upon graduation have evolved. While all medical school oaths relate such traditional principles of preserving patient welfare and access to health care, many oaths, such as those above, have embraced the concept that students are graduating into a profession. Professionalism within medicine defines and delineates how physicians interact with the society at large.

Physicians today will graduate into a healthcare environment where external pressures challenge the concept of the physician professional.

Being a physician in the current, sometimes chaotic, healthcare climate necessitates that the physician practices his or her profession outside the clinic, operating room or hospital room. The physician professional goes beyond the responsibilities of the patient/doctor relationship to improve the welfare of the patient and all patients. What is a physician professional? What should physicians do further to improve the health of their patients and their profession?

There have been many discourses of what it is to be a physician professional. The ABIM, ACP-ASIM Foundation, and European Federation of Internal Medicine through the Medical Professionalism Project recently published the Charter on Medical Professionalism (Annals of Internal Medicine, 2002;136:243-246). In the charter, the project sponsors developed three principles that govern the physician professional: the primacy of patient welfare, patient autonomy and social justice. These principles then form the foundation for ten commitments of physician professional. As a professional, physicians are committed to:

1. professional competence,
2. honesty with patients,
3. patient confidentiality,
4. appropriate relations with patients,
5. improving the quality of care,
6. improving access to care,
7. a just distribution of finite resources,
8. scientific knowledge,
9. maintaining trust by managing conflicts of interest, and
10. professional responsibilities.

Everyday in patient encounters, the physician professional, through dedication, commitment and hard work, exemplifies these commitments. Yet, each day, physicians are confronted with forces outside the patient/physician relationship that challenge their commitment as a physician professional. How can physicians improve the

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quality of and access to health care with medical liability cost skyrocketing, forcing them to relocate their practices to a more hospitable settings? How can physicians be committed to scientific knowledge when decisions of patient hospital admissions/discharges must be argued with health insurers or other regulators? These external forces impact the commitment of physicians to their profession.

The current healthcare environment requires physicians to exert their opinions and influence from clinic offices to offices of other health professionals, administrators and policy makers. Going beyond the patient/physician relationship advances the physician profession. Physicians can advance their profession by appreciating the broad issues that impact the provision of health care and using this knowledge to participate in addressing the issues that impact their patients’ health.

The issues that confront physicians’ ability to practice their profession in Pennsylvania are not trivial. Just mentioning some of the constraints of the climate of medical practice will irritate many physicians: increased medical liability insurance, decreased scope of practice, reduced patient reimbursement, the need for increased productivity, decreased patient contact, increased paperwork, increased fees, changing requirements to practice medicine, and increased accountability in many facets of providing care (often non-professional).

When thinking of these issues, many wonder, “Where are the concerns of the patients?” Physicians hear the concerns of patients. Patients are worried about long delays to see physicians, decreased time spent with healthcare providers, increased cost of medications, changed medications due to changing formularies, and dealing with changing insurance regulations. The physician is often the first and sometimes only provider that hears these patients’ concerns. Does the physician responsibility to better the health of the individual patient end by just listening to their patient concerns? Physician encounters with patients enable physicians to be a unique, informed advocate for them.

Physicians also are in a unique position to advocate for improving the business side of medicine. The current healthcare environment increasingly promotes account-ability, regulation and productivity. It may be surprising to some that most physicians were not taught in medical school how to be productive business persons or employees. Physicians have been taught to improve the health of their patients, but they learn the business and administrative side of medicine on the fly. It is no wonder why some physicians, when confronted with administrative problems in their practices, insulate themselves from the fray. Physicians often just want to see patients.

Yet, it is not alone sufficient to just understand and complain about the issues that may impinge upon delivery of health care to their patients. Physicians are in a unique position to advance their profession and influence the quality of health care for all patients. Some action steps that physicians can take to advance their profession are simple. Physicians can promote patient education of issues that constrain the provision of health care. They can join medical and specialty societies. They can contribute to a political action committee or a like-minded politician. They can write letters to the press.

Physicians can also exert enormous and increasing influence on political leaders to improve the delivery of health care. I recently had the opportunity to participate in the 2003 National Advocacy Conference in Washington, D.C. This three-day event, sponsored by the American Medical Association, provided opportunities for physicians to learn about the political process, how to interact with political leaders, and about advocacy initiatives of organized medicine. Topics ranged from addressing the medical liability crisis to protecting commitment to Medicare patients, to improving patient safety and increasing access to quality health care.

During the conference, we met with our congressional delegations. In such visits, it struck me that physicians are a relatively new voice in Washington. Legislatures and the administration know that physicians are able to exert enormous influence over many constituent voters. They want physicians, who tend to be very influential voters, to give their input regarding problems that face the practice of medicine. Policymakers know that, if physicians are unhappy with the medical environment, then their patients are likely unhappy with the...
Tort Reform and Physicians: The Path to Success

Bruce W. Dixon, MD

Tort reform is an issue that is affecting many lives throughout our nation. Bruce W. Dixon, MD, is no exception. As director of the Allegheny County Health Department, Dr. Dixon deals with all aspects of healthcare. From bioterrorism to hypothermia and pollution to STDs, he is responsible for the health and well-being of the constituents of Allegheny County. To him, medical malpractice reform is just the tip of the iceberg for continued success within the medical community.

“Tort reform is a necessary part of a bigger picture in healthcare financing reform,” Dr. Dixon explains. He sees the need for making a clear distinction between true medical malpractice and the other lawsuits which may be filed. This is something that he believes has not been made particularly obvious to the community at-large.

An abundance of Dr. Dixon’s duties surround safeguarding of the rights of the people in the county. He realizes that the costs of defending and settling lawsuits that are not based on true medical malpractice are passed on to the people either directly or indirectly through healthcare insurance premiums. And, according to Dr. Dixon, “Those costs impact all individuals, whether or not they are suffering from an illness and cannot afford the increase in costs.”

Not only does Dr. Dixon see tort reform as a decisive issue that needs addressed, he also views the problems surrounding it equally as crucial to review. He notes that, although there are clearly problems on all sides, there are essential issues surrounding communication between members of the medical community and their patients. “Physicians, by and large, do not talk well with patients,” Dr. Dixon contends. “The medical community’s inability and failure to talk to patients in a way that the patients can understand has led to some of the increased litigations that occur.” He hopes that, through more comprehensible communication, some of these lawsuits can be prevented.

Dr. Dixon realizes that much of what occurs in medicine is still not an exact science. “We’re dealing with something that has an awful lot of judgment associated with it,” Dr. Dixon suggests. This judgment causes many physicians to incorporate the most advanced technology in their treatment plan. “There is an issue of how much one does or doesn’t do because we’re not dealing with a pure science. Our community standards have evolved to the point where we’re doing more instead of less, which has contributed to the higher cost of care and may be contributing to some of the unhappiness with the care,” Dr. Dixon explains. The use of some of the various technological advancements without clear communication, coupled with what he considers “the medical community’s inability to view each person as an individual,” can make patients feel less satisfied with their quality of care, contends Dr. Dixon. This dissatisfaction may be causing people to turn to the legal system to try and solve their problems.

One of the most unfortunate results of the increasing insurance rates and high rate of settlements is that good physicians are abandoning their practice of medicine, feeling that this is the only answer to this problem. “It’s a shame because the people who are leaving tend to be the people who are more experienced and have more stability. Because of their experience they tend to be, to a greater degree, the ones with better judgment,” Dr. Dixon notes.

By working together with their patients to create an environment where the legal system has a place only for true medical malpractice claims, good physicians can continue to do what they do best—use their judgment and practice medicine. With physicians responding to their patients’ needs, communicating effectively and using their best judgment when practicing a sometimes inexact science, the community that Dr. Dixon represents will be able to reap the benefits of medical malpractice reform.
Good morning, I’m Dr. Alan Yeasted, a practicing internist and president of the Allegheny County Medical Society. I would like to begin by thanking Representative Turzai and his colleagues for the opportunity to attend and participate in this Policy Committee Hearing on the liability insurance crisis in Pennsylvania and for your leadership on this issue. I hope that the testimony that you hear and have already heard today reinforces the fact that the healthcare system in Pennsylvania is broken and that long-term reform is needed immediately.

For those of you who do not know me, I would like to give you a little background. I was raised in Tarentum, PA, the son of a steelworker. After doing my undergraduate work at St. Vincent College in Latrobe, I went on to medical school and graduated from the University of Pittsburgh School of Medicine in 1974. I completed my residency at Mercy Hospital and have been practicing medicine in the Pittsburgh area ever since. Two years ago, I accepted the position as vice president of medical affairs at St. Clair Hospital and have been practicing medicine in the Pittsburgh area ever since. Two years ago, I accepted the position as vice president of medical affairs at St. Clair Hospital, although that takes up a large portion of my time, I still see patients two days a week. I share this brief biography with you to illustrate that, not only are my roots here, but my patients are here, my colleagues are here and my love for medicine is based in Pittsburgh.

I can’t imagine practicing medicine anywhere else! That is why I am deeply concerned about the direction that health care is heading in Pennsylvania. The medical liability insurance crisis is a serious problem that is threatening the quality and availability of health care for patients. Physicians and nurses are patients, too. We receive care from the same doctors and nurses in the same institutions. We want everyone to receive high quality care, but this crisis is forcing physicians to make tough economic decisions by leaving the state, retiring early and giving up high-risk procedures that they have trained so long and hard to perform. And young doctors simply aren’t coming here to practice.

We must continue to work with our legislators, business community, insurers and hospital leaders to achieve long-term reform.

According to evidence from the Pennsylvania Bureau of Health Professions, since the inception of the current phase of the liability crisis in 1997, the rate of increase in the total number of physicians in the state has fallen to zero, and high-risk areas and high-risk specialties show alarming declines statewide.

Personal injury lawyers claim that Pennsylvania has one of the largest physician populations under the age of 35, with 5.5 percent of the nation’s younger doctors practicing in Pennsylvania. What the trial lawyers fail to mention is that these figures include residents—physicians in training. We have six medical schools in Pennsylvania, so those numbers are misleading. The problem is that they are not staying in Pennsylvania after they complete their residencies. Young doctors are avoiding Pennsylvania like the plague! The proportion of younger practicing physicians who are under the age of 35 has dropped from 12.4 percent in 1989 to 4.7 percent in 2000. Nationally, we have gone from 12th to 41st in the proportion of younger physicians practicing in the state.

And who can blame young physicians for not want-
We must continue to work with our legislators, business community, insurers and hospital leaders to achieve long-term reform. Unfortunately, there does not seem to be any compromise with personal injury attorneys. The present system works very well for them.

Many contributing factors must be addressed before we will have a permanent solution in Pennsylvania, though. Medical errors must be reduced and eliminated. We must continue to work with everyone involved in patient care and organizations like the Pittsburgh Regional Healthcare Initiative to identify and reduce true medical errors. We must support the development and implementation of technology such as computer order entry in a time sensitive, cost efficient way. We must work with all entities, hospitals, insurers and government, to see that this occurs as quickly as possible.

No doctor or nurse wants to injure a patient. That is why it is our duty and obligation to continuously work together to improve systems to reduce and eliminate true medical errors. As a profession, we must continue to educate the public about the difference between true medical errors and bad outcomes that go beyond our control as human beings. No attempt to improve a person’s health is totally risk free.

We believe that patients have every right to be compensated fairly and quickly if they are injured; however, it shouldn’t take three to five years in court with up to 50 percent of the compensation going to attorneys’ fees. Lawsuit abuse continues to limit patients’ access to care and increase the costs of health coverage. Seven out of 10 malpractice cases are dropped, dismissed.

Pennsylvania Physicians in Action—A Word from the Pennsylvania Medical Society

Pennsylvania physicians recognize that the time to act is now. Grassroots physician groups, medical specialty organizations, patient groups and their supporters are planning Code Blue events around the commonwealth in the last week of April and the first week of May. Physicians are preparing to close their offices to petition government, attend local public health events and help educate the public about the urgent need for medical liability reform. For more information, log on to www.pamedsoc.org/irac or call (800)-566-TORT.
withdrawn or found in the favor of the defendant. It costs doctors, hospitals and insurers a lot of money to defend themselves in cases that have no merit, and it costs taxpayers by tying up the courts.

Without liability reform, the crisis will only get worse. Substantial progress has been made in Pennsylvania, but more must be done. Physicians propose that a $250,000 cap on “pain and suffering” damages be enacted immediately. This $250,000 would be in addition to jury awards for economic damages that compensate injured persons for objectively quantifiable monetary losses (past and future). In medical liability actions, economic damages include compensation for losses such as medical and related expenses, lost earnings and the cost of domestic assistance.

Physicians have also recommended that a sliding scale be imposed on attorneys’ fees and that all pain-and-suffering awards go directly to the patients. Why should an attorney receive up to half of an injured person’s “pain and suffering” award? Attorneys oppose caps on pain-and-suffering awards because they take a significant portion of such awards as part of their fee in addition to the fee taken from economic damage awards.

In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA) to address a medical liability crisis that was crippling their medical care delivery system. MICRA includes a package of medical liability reforms, including a $250,000 cap on non-economic damages and a sliding scale on attorney contingency fees, among other things. Today, the MICRA reform package has a proven track record in achieving medical liability savings, while ensuring prompt and fair payments for those injured and in need. We can learn from this example.

The healthcare system is broken and on the brink of collapsing. This issue isn’t about physician demands; it is about access to care for individuals, and about making our Pennsylvania communities desirable for people in which to live and work. Health care and medical resources consistently rank as a prime factor in individual evaluations of locations. Dealing successfully with this issue is critical to the economic future of Pennsylvania and the health of our citizens.

Thank you.

Dr. Yeasted is an internist and the president of the ACMS. He can be reached at yeasted@acms.org.
The time to act is now. We must remain committed to obtaining meaningful and substantive reform of the professional liability system before it bankrupts the healthcare delivery system, not only in Pennsylvania, but in the United States. The causes are many, and every physician is aware of the impact on their practice and on the hospitals which serve our community. The issue has the attention of the President of the United States; the legislation which has passed the U.S. House of Representatives, was written by two Pennsylvanians, Congressman Jim Greenwood and John Murtha. Allegheny County Representatives Melissa Hart and Tim Murphy have demonstrated strong leadership and commitment to reform. At the federal level, the attention is now on the Senate, where Senator Rick Santorum is seeking to craft a bipartisan bill. Both Senators Santorum and Arlen Specter need to hear from physicians and their patients to ask them to make this happen.

Concurrently, we are working at the state level to build on the reforms that were enacted last year. We still have a crisis in Pennsylvania. There is extremely limited availability of insurance, and the rates are continuing to increase. Much depends upon new Governor Ed Rendell, who now has the report from his task force and must choose which legislative options to pursue. Half measures will not suffice; this problem must be addressed head on.

Much has been made of what appears to be a focus on “caps” on pain and suffering awards, which are in addition to “economic” damages and any punitive awards. But simply put, across the nation (if we are to retain the current legal system of hearing and trying cases), the two reforms that appear to have restrained the rate of increase of liability premiums are a sliding scale on personal injury attorneys’ contingency fees and a cap on pain and suffering awards (non-economic) damages. Other insurance reforms are needed, and physicians and hospitals display a daily commitment to the reduction and elimination of errors. But the legal system must change to reflect the original concept of compensation for negligent injury and not the expansionist concept that it has become of economic redistribution for every perceived dissatisfaction.

We can achieve the goal of creating a system that compensates injured parties expeditiously and with some rationality, but we must remain committed and dedicated to effect this change.

“No army can withstand the strength of an idea whose time has come.”

—Victor Hugo

Mr. Krah is Allegheny County Medical Society executive director. He can be reached at (412) 321-5030 or jkrah@acms.org.

To contact your senators:

Senator Rick Santorum, Phone (412) 562-0533
web: santorum.senate.gov/emailrjs.html

Senator Arlen Specter, Phone (412) 644-3400
e-mail: arlen@specter.senate.gov
The following information prepared by the Pennsylvania Medical Society (PMS) is being made available to our readers who may be approached by members of the media with questions concerning the liability insurance crisis.

Points of Emphasis and Background

The First Amendment of the U.S. Constitution: “Congress shall make no law respecting an establishment of religion or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.”

While there have been some positive steps in the past year by the state to resolve the liability insurance crisis, doctors worry that not enough has been done and patient care is being jeopardized as each day passes. Since doctors do not want to see health care deteriorate, doctors are petitioning government to protect patients.

You may hear people calling this a “work stoppage” or other similar words. But it’s not. There’s a fine line between a work stoppage and a person’s right to petition government. But, nonetheless, there is a line. Health care is not shut down. Patients continue to receive care that they need. Physicians are simply expressing their opinions through the First Amendment that more needs to be done to preserve patient care. The PMS wants our government to know that if this crisis isn’t resolved soon, patient care will be jeopardized.

As physicians attend events to raise awareness of this liability insurance crisis, they have made arrangements for patients to receive care. If an emergency happens, such as an accident in the home or maybe chest pains, patients are best served by going to emergency rooms, which are fully staffed.

Tips

- This is a patient access issue. Always put the patient first by talking about access issues.
- Do not lose sight of the prize at the end. Ultimately, the public will vote to accept placing limits on non-economic awards.
- Treat all reporters like you would your mother. Respect them. Do not get into a fight with a guy that buys ink by the barrel. Make your points clear, but do not argue, curse or show anger.
- Use real examples of access issues. Anyone can twist statistics. We’ve seen this by many so-called “consumer groups.” But you win with real stories. Show how patient care is jeopardized by lawsuit abuse through real examples.

Additional facts

- Despite having less than five percent of the national population, Pennsylvania’s total medical liability insurance payouts (awards and settlements) in 2000, according to the National Practitioner Databank, was nearly 10 percent of the national total. Pennsylvania’s total was the second highest in the country: $352,309,905.
- According to an analysis of data from the National

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The average medical malpractice payment in 1991 was $208,000. By 2001, that increased 93 percent to $402,000. That ranks Pennsylvania third in the country for highest average.

The number of $1 million-plus settlements between 1991 and 2002 increased significantly. In 1991, there were 43 payments at or above $1 million, and for the first nine months of 2002, there were 153.

The number of paid jury awards of $1 million or more also increased significantly between 1991 and 2002. In 1991, there were zero such award payments. For the first nine months of 2002, there were 15 such award payments.

According to Jury Verdict Research, the median jury verdict between January 1994 and August 2001 in Philadelphia was $972,909. For the rest of the state, excluding Philadelphia, it was $410,000.

Personal injury lawyers often pocket 40 percent of jury awards and 33 percent of settlements, in addition to costs.

When personal injury lawyers aren’t winning big, they’re losing often. In fact, personal injury lawyers have a 70 percent error rate in their pursuit of the jackpot jury award. According to the Physician Insurers Association of America, seven out of 10 medical malpractice claims between 1985 and 2000 were dropped, dismissed, withdrawn or found in favor of the defendant.

But, even when the personal injury lawyers are losing, they’re robbing patients of access to doctors, and driving up healthcare costs. According to the Physician Insurers Association of America, the median cost to defend and win a case in front of a jury in 1995 was $46,603. By 2000, that increased 43.27 percent to $66,767, money wasted that only siphons off resources from patient care.

The ultimate trickle down effect is that our out-of-control tort system deprives Pennsylvanians of health care, while driving up what consumers pay for care.

A 2002 study by the American Association of Health Plans conducted by PricewaterhouseCoopers says that litigation is responsible for seven percent, or $5 billion, of new healthcare costs—equivalent to the price of health insurance for two million Americans.

Another 2002 study by Common Good and conducted by Harris Interactive shows that defensive medicine is extremely high (91 percent of the survey participants have noticed other physicians practicing defensive medicine, and 79 percent say they themselves do so because of liability worries). No one is debating that defensive medicine drives up the costs of health care.

This all confirms a 2001 study by the PMS that discovered 89 percent of doctors are practicing defensive medicine.

The 2001 PMS study also indicated that 72 percent of doctors have deferred the purchase of new equipment or the hiring of new staff due to the skyrocketing medical liability insurance costs.

Of course, there are numerous anecdotal stories about doctors retiring early, giving up high-risk procedures or moving out of the state as a result of the liability insurance crisis.

Using state-provided data from March 2002, a survey during the summer of 2002 by the PMS of high-risk specialists found that 17 percent of ob/gyns and 18 percent of neurosurgeons have either changed to non-operative, changed to part-time surgery since 2001, decided to move the majority of practice out of state, left Pennsylvania totally or retired early. A survey by the Pennsylvania Orthopaedic Society found similar results for orthopedic surgeons.

Ultimately, Pennsylvania needs to learn what Californians learned in the 1970s: Limiting attorney contingency fees on a sliding scale and placing a reasonable limit to non-economic awards after a person has been fully compensated for financial losses is...
necessary to keep trauma centers open, hospital units functioning, ambulance crews operating and simply to preserve health care. According to Californians Allied for Patient Protection, U.S. premiums increased 420 percent between 1976 and 1999. But, in California, they increased only 168 percent, even after being held hostage by the court system for a decade. This is a direct savings from medical tort reform that preserves access to care. In addition, these reforms benefit injured patients because the time to settle in California is 23 percent shorter than states without a cap, therefore allowing the injured patient to receive appropriate compensation faster. (In addition, the cost to settle is 53 percent lower.)

The public wants lawsuit abuse reform

In a November 2002 survey of 1,237 Pennsylvanians who are members of the Patient Advisory Board at the PMS, 91.67 percent said that we need to have standards to limit awards to reasonable levels.

According to a February 2003 report from the Office of Strategic Initiatives at the White House, 83 percent of Americans see too many lawsuits in America; 80 percent say personal injury attorneys take too much of their clients’ awards; and 76 percent believe medical liability lawsuits threaten access to quality healthcare for families.

According to a February 2003 report from the American Tort Reform Association, 83 percent of Americans think too many lawsuits and greedy personal injury lawyers are to blame.

According to a February 2003 Quinnipiac University poll, 72 percent of Pennsylvanians surveyed support a limit on the amount of money awarded for pain and suffering in medical liability cases.

Solutions

Greedy personal injury lawyers in pursuit of jackpot jury awards cause lawsuit abuse and have caused Pennsylvania to have one of the highest medical liability insurance payouts in the country. As a result, personal injury lawyers are responsible for higher healthcare costs, including health insurance, thus depriving patients access to care they deserve and need and interfering with patient safety.

To end lawsuit abuse and to save access to care, Pennsylvania should designate a reasonable amount of money that can be awarded for non-economic damage after a person has received full compensation for economic loss (past, present, and future), and it should allow injured patients to receive the majority of awards by placing a sliding scale on contingency fees charged by personal injury lawyers.

Why are these solutions needed?

The actions of personal injury lawyers are the root of the current crisis. They are causing patients to lose access to care. Placing a cap on non-economic damage awards and a sliding scale on contingency fees is necessary to rein in lawsuit abuse.

These media tips are provided by The Pennsylvania Medical Society to be used by physicians petitioning government on the need to solve the liability insurance crisis. After using these talking points during an interview with the media, please send an email to stat@pamedsoc.org. Please report name of media outlet, contact person at media outlet, and phone number of media outlet contact.
Josef E. Fischer, MD, FACS

The U.S. is a wonderful country, especially to those of us whose immigrant experience is not that far in the past. The opportunities, the freedom, the ability to participate, the meritocracy, and the ability to get where one needs to go through hard work, perseverance, and a little bit of luck are beyond compare with any other nation in the world. I point out to my children, and generally anyone else who will listen, what a wonderful opportunity we have to succeed in this country if we will only try.

However, other countries have my admiration as well. Food is better in Paris and, indeed, throughout all of France. It seems very difficult to get a bad meal there. Although the culinary status of the U.S. has improved dramatically with the training of young, enthusiastic American chefs, still one must admit that France and Belgium outdo us in this area. I happen to like England and find, despite the passing of its homogeneity, that country much more civilized than here. For example, the British still queue up without line-crashing, although that is less common than it used to be.

There are some aspects of American culture that are difficult to comprehend, not the least of which is self-hate, which is evidenced periodically by the younger generation or some members of the intellectual elite and liberal left. To these individuals, it seems everything is better everywhere else, although this attitude is less stylish than it was before September 11, 2001.

In the 1980s, we were told that we were headed for economic disaster and that Japan was going to overtake us and become the dominant economic power in the world. I suppose the same group of people will shortly be telling us that China is about to overtake us as well. Periodically, a malaise sweeps through the country, fanned by the aggressive and liberal media.

One of the most flagrant signs of American self-hate is our love for other medical systems that do not perform as well as ours. The continued infatuation with the Canadian system, despite the wholesale flight of anyone who can afford to come south of the border to receive care, is utterly beyond me. Long waiting lists, inadequate opportunities to treat, continued restrictions on lifesaving technology, the gutting of premier medical programs and institutions, and a florid “brain drain” continue to be a part of the Canadian medical landscape.

Although the infatuation with the Canadian system is less prominent than it used to be, the media, and to some extent those economic gurus who think they know everything about the medical system, continue to trash what once was a pretty good construct in the U.S. My question to them is, What border would they cross to obtain their health care? At the present time, we can’t go south, although perhaps with improvement in Mexico, that may one day be possible.

In my view, the most egregious admiration for a medical system is for England’s National Health Service (NHS). It is true that the NHS has some wonderful qualities. It is totally free, not only for residents and citizens, but for visitors as well, and it is regionalized. People have their own family physician, and so they are not deprived of their support systems when they are most in need of medical care. It is civil and civilized.

Nonetheless, I have always said that if one wants to see where this country is going, then take a look at the NHS. The NHS has been suffering from chronic malnutrition. Only 6.8 to 6.9 percent of the gross domestic product of the U.K. has been allocated to the NHS. This starvation diet has finally wreaked sufficient havoc in the system that its problems—continuous undercapitalization, inability to improve physical facilities, lack of expansion of facilities, and loss of medical personnel at the same time the population is aging and presenting increased needs—have finally come home to roost. The result is not pretty.

History

First, a look back. The NHS, organized in 1948, was a bold step well ahead of its time. At the time, physicians in the U.K. occupied a position in society not quite the same as that held by physicians in the U.S., but not terribly different. They were wooed into joining the NHS with financial and other benefits. And, to an extent, despite the fact that the NHS was chronically underfunded, some investment and the enthusiasm of many of the practitioners held the NHS together reasonably well for about 30 years.

The reason it lasted that long, I believe, is because early recruits to the NHS had been trained as...
professionals and continued to practice as professionals. It is unlikely that they would change their modus operandi to that of employees. Also, up until the late 1970s, the aging system had not seen the debility of outmoded facilities, lack of investment in technology, and aging infrastructure to the extent that one sees now.

Toward the middle of the 1960s, the almost universal approval of the NHS among Britain’s patient population began to change, and signs of discontent were emerging. Accident floors began to close throughout London. In fact, a patient with a head injury at this time may have traveled for an hour before getting reasonable care at an accident floor. Physicians’ and surgeons’ salaries did not keep pace with inflation. Waiting lists began to lengthen. My guess is that the emergence of these indicators of discontent paralleled the appearance within the workforce of physicians who had never been trained as professionals, but who had been employees throughout their entire experience in the medical profession.

There is a difference between a professional and an employee. A professional gets the job done regardless of hours and circumstances. An employee does his or her job in the time allotted. Some “physician employees,” to be sure, realize they are dealing with human lives and go far beyond the expected effort, but others just do their job. Indeed, given the tax structure in the U.K., a number of the physician employees, when offered time-and-a-half or double-time to work, for example, overtime at accident floors or to keep accident floors open, simply said that as employees they had no obligation to do so, and besides, most of it would be taken by taxes. They would rather be home with their families or at the local pub with their friends.

This particular distinction between professionals and employees has been completely lost on the economists and the self-appointed gurus who control what happens to American medicine. They fail to understand that if you treat people as employees, even if they may have been trained as professionals, they will no longer act like professionals but like employees, and, indeed, if one looks around the U.S., there are signs of this shift in attitude throughout the health care system.

In the mid-1970s, when the last of those individuals who had entered the NHS as professionals retired, England
had a physician workforce consisting largely of individuals who had always been trained as employees and had always worked as employees. The cracks began to widen and the infrastructure began to come apart.

Current status
Fast-forward 25 years. By this time, the chronic underfunding has become so pervasive that the Blair government has promised £1.5 billion investment in infrastructure, technical equipment, and new facilities. There are those who think that after the five decades of chronic underfunding, this is a drop in the bucket and will never restore what was lost. Of greater concern are three themes that seem to be surfacing simultaneously and that appear to signal a real crisis. The third is a symptom of the first two.

1. Lack of physicians. Britain’s economy, after decades of stagnation, is now undergoing a rebirth with the advent of opportunities in technology, finance, and light industry. The traditional smokestack industries, such as coal, iron, and steel, have been driven into the ground by militant unionism, very much as in this country. Automobile manufacturing seems to be undergoing the same steady decline in the U.K. as in the U.S., in which the share of the U.S. market which American-made cars now comprise is less than 60 percent for the first time in history. But now the U.K. has a shortage of medical students and physicians. Where choices abound, people vote with their feet. The Blair government has now requested 10,000 foreign physicians to join the NHS. Mind you, these are not physicians at the ordinary level. These are consultants—the individuals who occupy the highest level in the NHS and who apparently cannot be drawn from endogenous British medical schools. The chronic “brain drain,” the lack of attractiveness of the NHS, and the persistent inability to pay physicians adequately has finally hit home. The parallel with what is happening in the U.S., as I will detail below, is frightening.

2. The waiting lists are now out of control. Waits of a year are common for just about everything in the U.K. Indeed, the government has finally taken steps to make certain that patients get needed operations. Where? Not within the U.K. The capacity, the skill, and the facilities simply do not exist. Forty thousand patients will probably go to the

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Where you’ve been is just as important as where
you’re going. G. Alan Yeasted, MD, a board-
certified physician in internal medicine, sums
up his journey through life in one simple sentence, “I’ve
been blessed.”

Dr. Yeasted’s roots are firmly planted in the Pitts-
burgh area as he was born and raised in Tarentum and has
lived in Mt. Lebanon with his wife and family since
1978. The son of a steelworker, Dr. Yeasted’s early years
were spent playing basketball with his friends.

Growing up in a loving household with four sisters
and one brother, Dr. Yeasted believes that two role
models, his father and a close family friend known
affectionately as “Uncle Joe,” helped shape who he is as a
person and helped him begin the path to becoming a
physician. “They were two different personalities,” Dr.
Yeasted says, adding that they both helped prepare him
for what he would encounter in his future.

His father, he explains, worked two jobs and stressed
the importance of a college education and doing what was
right, no matter what the cost. Uncle Joe was very
involved in the community and even helped build
basketball courts for the neighborhood children. “One
taught me the strength and purpose that you have to have
in medicine and the other taught me the kindness that
you need when you take care of people,” he explains.
Those two qualities—strength and kindness—make up
the cornerstone of the path of his life.

Dr. Yeasted’s strength and purpose began to take
shape as he attended St. Vincent College in Latrobe for
his undergraduate training and then chose to continue his
education at University of Pittsburgh School of Medi-
cine. Remaining close to home, he completed his intern-
ship and residency at Mercy Hospital of Pittsburgh. As a
fourth-year medical student on a community medicine
rotation, he began working with Drs. Samuel E.
Tisherman and Neal Zweig. They formed a tight bond
and close friendship. Three years later, when Dr. Yeasted
completed his training, they offered him a partnership in
their growing Mt. Lebanon practice. The group expanded
to seven physicians and began seeing patients out of St.
Clair Hospital in Pittsburgh’s South Hills.

In 2000, Dr. Yeasted’s path took a new course when
he became vice president of medical affairs at St. Clair
Hospital. Because of his administrative duties, his patient
load isn’t as large as it used to be, but Dr. Yeasted’s desire
to make a difference continues. “When you’re in private
practice, you try to improve health care on a one-on-one
basis. In this job, I try to improve health care for the
entire South Hills community. And, that’s a real nice
challenge.” Maintaining the balance between administra-
tive duties and the practice of medicine is something that
Dr. Yeasted has been able to achieve. “I wouldn’t want to
give up private practice. I wouldn’t want to lose touch
with the patients,” he explains.

His goal as an administrator is to continuously
Dr. Yeasted's kindness can be seen reflected back in the eyes of those whose lives he has touched. As president of Allegheny County Medical Society, he sees one of his goals as "guaranteeing to the patients of this community that we are going to maintain a high quality of care to the public." Throughout his journey helping his patients, he has always spent time giving back to the community around him. Dr. Yeasted has been coaching and officiating high school sports since the 1980s. He enjoys watching the children in his neighborhood begin to choose their own paths, quite simply, he says, "It's enjoyable because it makes you a part of the community."

Watching children grow has been an integral part of both his and wife Jo Ellen's journey together for the past 30 years. With five children ranging in age from 18 to 30, Dr. Yeasted and his wife have been teaching their children the same lessons of strength and kindness that have shaped their lives.

All of his children have begun their own journeys based on the values their father has instilled in them. Three of his children have chosen careers in the medical field: a son is enrolled in Mercy Hospital's School of Nursing and his two youngest children are studying pre-med at John Carroll University.

Dr. Yeasted relishes the time he spends with his children, their husbands and wives and his grandson, especially on their annual vacation to Cape May, New Jersey. "It's always a wonderful time," he smiles. "We've been going there for years and we always have a blast." They even invite close family friends, continuing Uncle Joe's sentiment that family extends into the community.

Dr. Yeasted's life can seem chaotic to an outsider, but to him, what he does is all in a day's work. Whether he is tending to his duties at St. Clair Hospital, taking time being soccer and basketball games, refereeing soccer and basketball games, attending meetings at the medical society, children or making a difference on his path to make a difference in the lives of children, or helping his patients, he always has a lot of activity and love in his life. "As doctors, we are committed to our patients and we can do something. How many people can come home from work and know that they have helped someone and we can." He says, "It's that simple thing saying, 'I feel like I did something. How is that?'

Dr. Chaudhary is a psychiatrist and medical editor of the Bulletin. He can be reached at schaud2815@cs.com. Ms. Spisak is a freelance writer in the Pittsburgh area. She can be reached at (412) 398-6439 or lspez@aol.com.
The Allegheny County Medical Society Board of Directors met on January 28, 2003. Board Chair Gerald W. Pifer, MD, called the meeting to order at 6:15 p.m.

Dr. Pifer reviewed the 2003 election results, 2003 meeting calendar, ACM Mission Statement, Physician Ethical Practice Guidelines and 2002 ACM Year in Review report. Board Secretary Terence W. Starz, MD, noted the mission statement required some changes and updates and volunteered to work on a revised version for the board’s consideration.

Special reports

Dorothy Hostovich reported for the ACM Alliance. The basket raffle held at the annual dinner raised $3,000, which was matched by the ACM Foundation and benefited CCAC Allied Health Career Scholarship Fund. The annual Doctor’s Day event is April 5 at the Nevillewood Clubhouse.

Dr. Safdar I. Chaudhary, ACM Bulletin medical editor, reported on changes in the Bulletin. The board confirmed Dr. Chaudhary’s appointment for a second year of his three-year term.

Adam Tobias, Medical Student Section representative, reported the guest speaker program is going well. The Tar Wars national campaign is underway, in which medical students visit elementary schools with anti-smoking information. Margaret Gibson announced she was elected regional delegate and will be a member at the Pennsylvania Medical Society (PMS) House of Delegates this fall. The board approved a contribution to the Medical Student Section for the Region VI Conference in February in Bethesda, Md.

ACM President G. Alan Yeasted, MD, is seeking a resident for the open resident representative position. The board approved for a one-year term Dr. Yeasted’s appointment of Donald P. Orr, MD, and Morris E. Turner, MD, as members-at-large to the board.

Alan A. Axelson, MD, reported that the Pittsburgh Regional Healthcare Initiative (PRHI) had received a two-year grant and a contract from the Center for Medicare and Medicaid for a pilot project to track patient information, improvements and outcomes.

Dr. Pifer reported on the Allegheny County Jail Health Advisory Board. The jail will be overcrowded within a year. The warden is seeking ways to address the problem, possibly by using halfway houses and early release programs.

Shirl Shaffer, PMS Foundation senior director of philanthropy, presented Carol E. Rose, MD, with a gift of appreciation for her service on the PMS Foundation board. Shaffer said the work of the foundation exceeded its goals and raised more than $500,000 for student loan funds.

Unfinished business

The board reviewed a letter from Dr. Yeasted to the ACM membership regarding the Medicare payment formula. ACM will work with PMS and the American Medical Association (AMA) to continue to press for correction.

Discussion followed on medical liability. President George W. Bush recently came to Pennsylvania to discuss malpractice and is in favor of caps for pain and suffering awards. He also indicated support for a new version of the Greenwood-Murtha Bill. In a recent meeting, Senator Arlen Specter stated he would consider caps on awards. PMS and AMA are representing physician concerns, and ACM will continue to work on state and federal levels for reform legislation. Physicians and patients should contact their local and state representatives and ask them to address this issue.

PMS is looking ahead to the 2004 Pennsylvania Supreme Court judge election. PAMPAC anticipates supporting the candidate with a track record in decisions restraining liability and plans active involvement of physicians in the campaign of a nominee whose decisions are consistent with medicine’s position.

U.S. Representatives Tim Murphy and Melissa Hart held a town meeting at Forbes Regional Hospital in Monroeville, where more than 100 physicians presented their stories and ideas on malpractice. They suggested Pennsylvania work with other states in the same state of crisis to press for federal action.

Neil Rosen, representing the Allegheny County Trial Lawyers Association, wrote a misleading article for the Pittsburgh Post-Gazette. Dr. Loren Roth prepared a written reply and asked ACM to “sign-on” with other medical societies.
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in support. The board approved support of the column and its submission to the Post-Gazette.

A suggestion was made that a “task force” of the groups that participated in the November 14 news conference come together to work on issues. A “liability coalition” meeting will be convened to review updates and provide plans for further action.

The Trial Lawyers are sponsoring a nationwide “medical rights bus tour” with survivors of medical negligence to educate the media about the harmful effects of President Bush’s proposal to federalize medical malpractice claims. ACMS will provide appropriate background material to the media on this issue.

**New business**

ACMS Executive Director John G. Krah noted that the number of membership renewals are higher than last year, and letters have been sent to physicians who have left Allegheny County asking them to identify the reasons for their relocation.

Christina Morton, communications manager, reported that Healthy 4 Life hosted open house fitness days at 10 local YMCAs in January.

In February, web chats featuring cardiovascular physicians will take place. She also outlined recent media interviews with Drs. Pifer and Yeasted.

Ms. Morton and Mr. Krah met with Dr. Maria Simbra, former medical student representative to the board, part-time neurologist and a health reporter for KDKA-TV. Dr. Simbra is seeking ideas on public health-related topics and invited board members to contact her with suggestions of issues to be covered.

Mr. Krah noted that the society is planning a Medical Student Career Night with Dr. Barbara Barnes and the University of Pittsburgh School of Medicine in March. This third biannual program gives medical students the opportunity to meet with physicians and ask specialty-specific questions.

This is a summary report. A full report is available by calling the ACMS office at (412) 321-5030. Board meetings are open to members. If you wish to attend, contact the society to request a schedule and meeting agenda. The next regular Board of Directors meeting is Tuesday, May 13 at 6 p.m.

Please let us know what you like or don’t like about the new Bulletin. Call (412) 321-5035, ext. 131, e-mail bulletin@acms.org or log on to www.acms.org.

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LOOKING BACK IN TIME:
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Bulletin, Vol. 17, No. 3, January 21, 1928

We have many times heard brother medical practitioners express in positive terms of disrespect their opinion of these doctors of medicine who constantly appear in court, on personal injury cases, associated with such lawyers as to lead one to believe that the fee to be received for medical testimony will be based upon the size of the verdict handed down to the plaintiff. Never until recently, however, have we had opportunity to learn the opinion of a prominent jurist regarding the true worth of the testimony of the professional medical expert.

In a personal injury case recently tried in Pennsylvania, a verdict was given against the defendant from which an appeal was made for a retrial on the ground that the verdict was excessive. The lower court, having refused a new trial, the action was carried to the Supreme Court of Pennsylvania. Judge Kephart of the latter court, in reversing the lower court and granting the motion for a new trial, referred as follows, in no uncertain terms, to the almost negative value of the testimony of the professional medical expert:

“The professional expert, whose testimony we relate above, frequently appeared in court as a witness in personal injury cases, and the inference from his evidence is that he made the giving of testimony in such actions a business. One of the evils in the trial of personal injury cases is padding the claim with evidence of the professional medical expert. It certainly is not proper ethical practice. There may be cases where one, because of knowledge peculiar to a given litigation, is frequently called in as an expert, whose testimony may be accepted without question, as, for instance, an expert in land and building values; but this evidence is susceptible of rebuttal, and, moreover, unlike the medical testimony, it is not buttressed by technical knowledge accompanied by scientific expressions capable of confusing a jury. When considering a motion for a new trial, based on an excessive verdict, ordinarily, but little weight should be given to such testimony.”

Now that we have the opinion of a distinguished judge as to the worthlessness of most of such testimony and the ethical standards of such practice, we would like to have the opinion of qualified neurologists regarding the actual harm to the injured plaintiff that may result from his or her listening in court to the testimony of a physician under oath to the effect that the injuring received, which are oftentimes only subjectively manifested, are permanent in character.

We believe that the professional medical expert is often ethically an morally off-color, and must be differentiated from the physician who is called upon occasionally to give in court expert testimony which is based on knowledge and experience which makes him an authoritative specialist.

—Anonymous

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continent for surgery.3 What a disgrace. A country that holds itself as a second-tier world power cannot take care of its own sick, and has to export them to the European Union. Does anyone really realize what this says about a system that has totally failed?

3. Long waits on accident floors. Long waits in waiting rooms on accident floors now lead to deaths that seem to be avoidable. The Times of London indicates a death that was an accident waiting to happen in a hospital that everyone viewed as a “hell-hole” and that was chronically accused of having—in addition to horrid physical facilities, urine-stained walls, unbelievable stench in the corridors, and filth throughout—the inability to care for its patients.4 A patient with a relatively minor arm burn lay on a gurney for nine hours and bled out from a Cushing’s ulcer. Apparently the question is whether he had been seen and monitored during the period of time on an accident floor.

The nature of having to send patients to a foreign country, and even worse, having to rely on foreign countries to furnish physicians, leads to an interesting quandary with respect to the NHS. Will interpreters be furnished?

The U.K. government now promises a massive infusion of funds in order to be able to rectify the situation. However, many, including a former health minister for a former Labor Party administration (and therefore not a member of the opposition), believe that no amount of money can rescue the system in its current form.

Parallels to U.S.

Does this all sound familiar? Perhaps. I assume that no one who is that given the way the government really monitoring the situation for the federal government, including those self-appointed gurus and economists who seem to control American medicine, is really concerned about a 21 percent drop in medical school applicants from a high of 46,968 in 1996-1997 to 37,092 in 2001,5 a year (2001) in which 68 places in general surgery programs remained unfilled, and not only in mediocre training programs, but now in good training programs as well.6

The level of indebtedness of medical students is such that many of them, in my humble opinion, will never be able to repay their debt. The criminalization of medicine and the assumption that a physician is a criminal until proven otherwise has taken its toll in the standing of the medical profession. One cannot hope for physicians who are paid less and unable to educate their children in the schools they themselves attended (which is probably the line in the sand) to urge other people, including their children, to go into medicine. No one wants to get paid less than the neighborhood plumber and at the same time be subject to the barbs and arrows of society.

There is a crisis coming in the U.S., a crisis in access. My guess is that it will be here in less than five years, particularly at a time when the number of elderly is increasing and the needs are increasing as well. The gurus do not believe me, but there are lots of other individuals who are not MDs in medical care who do. Indeed, on the coasts, there are increasing numbers of physicians who refuse to see Medicare patients. It’s a shame that this action will be necessary in order to have some redressing of the situation. My guess is responds to things, there will be more draconian laws, penalties, fines, imprisonment, and so on. These efforts will only make the matter worse.

Unless and until those societal leaders and politicians who have savaged a pretty good system come to their senses and look “across the pond,” as the English say, and see what has happened to a once fine medical system, the same will happen here. No amount of criminalization, harassment, litigation, and downright threat will rectify this situation unless physicians feel better about themselves and their profession. It will be interesting to see which way this country will turn, but I certainly would not want to bet that sensible reforms, increased payment, decreased hassle, tort reform, elimination of unfunded mandates such as the Emergency Medical Treatment and Active Labor Act, and decreased criminalization of medical practice will occur. We will then reap the whirlwind.

REFERENCES


Dr. Fischer is chairman, department of surgery, and Mallinckrodt Professor of Surgery, Beth Israel Deaconess Medical Center, Boston, MA. He is a member of the College’s Board of Regents and Chair, Health Policy Steering Committee.

ACMS Board Member Christopher Daly, MD, submitted this article for our readers. It was reprinted with permission, having first appeared in the February 2003 Bulletin of the American College of Surgeons.
**Classifieds**

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