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Fact Sheets of Georgia’s Trauma Physicians
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Thanks to Beth Frits from Doctors’ Hospital and the Joseph M. Still Burn Center and Ken Koser, Outsider Films for the cover photos.
The Average Value of Life

I don’t know how you place a value on life. I do, however, know that we can save 700 lives in Georgia each year if we elevate the state’s trauma death rate to the U.S. average. We will no doubt hear about budget constraints when the trauma system is discussed in 2009’s legislative session. In fact, we’ve already heard such rumblings. But try and talk about economic realities to a trauma surgeon when they have to face that mother or father, brother or sister, daughter or son. The bottom line is that there is no greater role for government than our safety and security.

As the House of Medicine in Georgia, MAG has taken a leadership role in cultivating an environment that will hopefully result in an adequate and sustainable funding mechanism for the state’s trauma system. Gov. Sonny Perdue and the legislature found the resources to keep the lights on in 2008, but the state faces a multiple-level crisis unless fundamental change takes place.

This is especially true in rural Georgia, where minutes carry a higher-than-usual premium in the trauma care world. I have been told that the area south of Macon on I-75 is referred to as the “Corridor of Death” in trauma care circles. As a physician and somebody who lives in Georgia, I find that repugnant and unacceptable.

A permanent funding solution for the trauma system in the state is a top-tier priority for MAG. So much so that we formed a task force under the auspices of MAG’s Council of Legislation to do just that. This group of extraordinary physicians have spent countless hours dedicated to the effort; I offer them my thanks, and I’m proud to call them MAG members.

Their leader, William Hardcastle, M.D., is quoted extensively in an article — “Permanent funding mechanism the key for trauma care system in Georgia” — that appears on page 18 of this edition of the Journal that addresses the state of the trauma network in Georgia. I sincerely hope you’ll read the article, as well as Dr. Hardcastle’s commentary on page 24. I also hope that you’ll take an active role in our grassroots advocacy efforts when we ask in the coming months. Just like our recent efforts to protect Medicare funding, I am convinced that the voice of medicine can make a difference for Georgia’s trauma system if we act in a united way.

Based on the research that I’ve seen, it’s clear that there’s widespread public support for a statewide trauma system in Georgia. The people who live in the state understand that this is a peace-of-mind issue at the highest level — and they’re prepared to pay for it. That said, one of MAG’s roles is to help convert that public will into public policy.

Trauma care is a complicated problem, and it’s going to require solutions that are comprehensive and integrated and permanent. No, it’s not going to be easy. But I’m optimistic that our leaders will make the right decision when they reach the proverbial fork in the road when it comes to trauma care in Georgia. I have never strived for average. But if average saves 700 lives, I’m going to make an exception this time.
EDITOR’S MESSAGE

Election Time – A Matter of Trust

One of the greatest strengths we have as a country is that we get to elect our leaders, especially our president. If they do a good job, they get re-elected. The job of the president is to be commander-in-chief of our armed forces and to head our executive branch of government, which enforces and implements our laws and judicial decisions. Historically, the generals who led our nation to victory in war – as did our first president, George Washington, and most recently Dwight Eisenhower – were easy choices to lead our nation in peace time. They did not need to make stirring speeches to lead us; they had fought for and earned our trust. Our enemies knew that these leaders had proven military experience, and that helped keep the peace.

A president not tested militarily can be an invitation to be tested by our enemies. I am old enough to remember Jimmy Carter being elected president on the basis that he would bring “change” to post-Watergate Washington. During the Iran hostage crisis, I recall a guest on The Tonight Show who was the oldest living veteran at that time – at over 100 years of age. He was asked what he thought of President Carter’s handling of the crisis. His response: “It takes backbone to run our country,” which was loudly applauded by the audience. It was no accident that the hostages were released when President Ronald Reagan took office. As for Jimmy Carter, I did not hear a lot of references to his “presidency of change” during the recent Democratic National Convention. I did hear a speech from and a lot about party “star” Bill Clinton – whose presidency will, unfortunately, be remembered for defining “sex” for the next generation with his embarrassing activities in the White House. I then heard another great speaker, Barack Obama, promise billions in spending while at the same time lowering our taxes. For those who have ever balanced a checkbook, we know that simply does not work – and we know unaffordable campaign promises when we hear them.

At the Republican Convention, I saw real leadership and concern for country over campaign. I heard about a true American hero tested many times in war. I heard about a man who put his country over his desire to run for the presidency, including standing up to his own party when he thought our country’s interests were at stake. An unpopular stand at the time, to say the least. When Sen. John McCain gave his acceptance speech, it was clear that he was not the gifted speaker that Clinton, Obama or even his vice presidential choice, Sarah Palin, are. But he did not need to be. Based on historical facts and my life experience, I believe he is the best choice for president and he has my vote. I trust him to keep us safe. I trust him to know war, and considering his children are presently serving in the military, I trust him to end the conflict as soon as it’s safe to do so.

Who do I trust to help heal our ailing health care system? Once again, I trust a veteran of the system, John McCain – who has personally required a lot of medical care – to preserve what is good in our system and improve what is not. Excerpts from both presidential candidates’ Web sites are included in this issue of the Journal so you can decide for yourself. I think there is some good and some bad in both plans, but Sen. McCain’s seems more affordable and contains elements that stand a reasonable chance of becoming law.

Speaking of passing legislation, be sure to read past MAG President Dr. S. William Clark’s recounting of the veto override of H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008. The time is clearly here for all physicians to be politically active and concerned. When it comes to legislation, we need to think strategically to ensure that we do not hurt ourselves in the long run.

The efforts of our excellent AMA representatives are outlined in AMA Chairman Dr. Joe Bailey’s report. This edition of the Journal also features an article on the AMA’s Voice for the Uninsured Campaign, which is designed to help solve our health care system’s deficiencies. With his column, Dr. Robert M. Clark does an excellent job of addressing the shortage of primary care physicians in the state. MAG Executive Director David Cook reviews the economic impact associated with medical practices, another reason our legislators need to take steps to help improve the environment for physicians.

An alarming deficiency in Georgia’s health care system is the lack of appropriate trauma and disaster care, a major focus of this issue of the Journal. Our trauma-related articles cover the Savannah and Augusta medical communities’ excellent response to the sugar refinery disaster in Savannah, Grady Memorial Hospital’s problems and potential solutions, and a piece on the SERVGA Medical Reserve Corps – should a disaster arise. MAG President Dr. Jack Chapman summarizes the life and death problem of trauma care in Georgia with his introductory message, and he addresses the leadership role that MAG and Past President Dr. Bill Harcastle are taking to

Continued on page 4
Water, Energy, Auto Plants…and Doctors

The two biggest problems facing physicians today are decreased payments and increased administrative burdens — the progeny of government intrusion into the practice of medicine. We look to that same government for solutions. We tell lawmakers that the state’s health care policies must change for the sake of patient care. It’s a message that we deliver with passion and consistency, and it’s a message that resonates with our elected officials. Yet today’s legislators are preoccupied with the realities associated with the economics of health care (e.g., premiums, Medicare and Medicaid budgets).

It’s no wonder, then, that it’s becoming increasingly difficult to attract the best and the brightest into medicine. Physicians aren’t encouraging their children to follow in their footsteps. And a substantial number of physicians over age 55 are seeking early retirement at a time when they could be making their greatest contribution to patient care.

As a result, it’s estimated that there will be 1,500 fewer physicians and three million more people in the state 10 to 12 years from now. A study by Tripp/Umbach predicted that the physician shortage will cost Georgia more than $5 billion each year in increased emergency room care alone by 2020.

These are important messages that we deliver with regularity. What we often fail to promote, however, is the significant economic contribution that physicians make in the state.

Physician practices are businesses that affect the economy in much the same way a manufacturing plant does. Physicians create jobs and generate revenue. They purchase goods and services. And they maintain a healthy and productive workforce.

According to a 2006 study by the University of Georgia’s Carl Vinson Institute of Government, the economic benefit associated with non-hospital based physicians in Hall County alone was placed at $1 billion per year. (Note that MAG has commissioned a study to evaluate the economic impact of physicians on a state-wide basis, an analysis that should be completed in the next several months.)

With that in mind, Georgia’s legislators should institute policies that will improve the practice environment in the state to recruit and retain physicians as a means for economic stability and growth. Specifically, they need to institute policies that will increase payments and reduce administrative burdens.

Georgia has taken some excellent first steps to create a pro-physician environment. The state passed meaningful tort reform, and it opened new markets when it reformed its CON laws. But we clearly need to do more.

In the end, the state has to compete for physicians in much the same way it does for other resources like water, energy, and automobile plants.
Can you identify with this cartoon? Unfortunately, I’m sure this is all too often the result no matter how clearly you feel you’ve explained your diagnosis and treatment plan to a patient — one who assures you that he or she understands your direction with a confident nod. Effective communications can be difficult — something your spouse or your teenager will attest to. I’m sure.

There are a number of variables that affect the way medical providers like physicians, nurses, technicians, and clerical personnel communicate with patients, including age, income, employment status, religion, race, and ethnicity. But in my opinion, the most important factor is literacy. According to The Partnership for Clear Health Communication at the National Patient Safety Foundation, effective patient communications are important for a number of reasons – foremost of which are the enormous macro economic costs associated with low health literacy. For example, the health care costs for individuals with low literacy skills are four times higher than those with high literacy skills.

Low literacy is one of the reasons that just half of all patients take medications as directed. And patients with cognitive disabilities such as diabetes, asthma, hypertension who also have low health literacy don’t fully understand their disease or how to manage their treatment regimen.

Research shows that there are 90 million people in the U.S. who have low literacy skills, 90 million people who are less capable of negotiating the health care system. One in five American adults reads at the fifth grade level or below. And the average American reads at the eighth or ninth grade level — yet most health care materials are written for audiences above the tenth grade level. Of those with inadequate literacy skills, there are 50 percent more likely to be hospitalized than those with adequate literacy skills. Research shows that there is a direct relationship between low literacy and patient compliance and medical errors.

Low literacy is one of the reasons that just half of all patients take medications as directed. And patients with cognitive disabilities such as diabetes, asthma, hypertension who also have low health literacy don’t fully understand their disease or how to manage their treatment regimen.

The issue is even one of great importance to Georgia’s leaders. Gov. Sonny Perdue signed a proclamation declaring October as National Health Literacy Month in Georgia. The proclamation was submitted by the MAG Alliance. So with all of this in mind, what is it that you can do to help alleviate the problem in your practice? Contact the MAG Alliance (Kris McCall at 678.303.9284 or kmccall@mag.org) to schedule a class for you and your staff. We can help you develop strategies to communicate with your patients in better and more effective ways.

I’ve never seen a program better aligned with the mission of the MAG Alliance. I believe it can enhance your practice in October as Health Literacy Month in Georgia. The proclamation was submitted by the MAG Alliance. So with all of this in mind, what is it that you can do to help alleviate the problem in your practice? Contact the MAG Alliance (Kris McCall at 678.303.9284 or kmccall@mag.org) to schedule a class for you and your staff. We can help you develop strategies to communicate with your patients in better and more effective ways.

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United We Stand

by S. William Clark III, M.D., MAG Immediate Past President

July’s last-minute Medicare victory carried a distinct, magnolia-laced fragrance. Much of that success can no doubt be attributed to a united, fully-energized group of physicians from southern states who told their story in a potent way.

In the first vote on the Medicare payment funding cut that took place before the July 4 break, nine Republican senators bravely broke party ranks – just one of them, North Carolina’s Elizabeth Dole, from a southern state.

But something changed. The phone lines started lighting up. Physicians who had never contacted a member of Congress picked up their phone and did just that. They made a difference...a big difference that resulted in a veto-proof, pro-medicine vote that included widespread support from congressional leaders from a number of southern states – including pivotal aye votes from Georgia’s U.S. Senators, Saxby Chambliss and Johnny Isakson. This, despite a presidential veto.

I am convinced that there is a direct link between our efforts to educate our elected officials and the decision that they ultimately made. I believe that was true in Georgia, and I believe it was true in other southern states.

MAG’s Executive Committee took the initiative to schedule a teleconference with Senators Chambliss and Isakson, which was instrumental in securing their support for H.R. 6331, the Medicare Improvements for Patients and Providers Act.

H.R. 6331 is a classically-decorated Christmas tree, with more than a few ornaments (i.e., social program expansions) that many of us might not completely support or understand. So in this bill, a dermatologist might see warts – an historian a Trojan horse, perhaps. But because we needed to be strong advocates for H.R. 6331 without amendments as a practical matter, I believe we must also stand by our congressional leaders if and when any unintended consequences unfold.

In the meantime, we should harness the momentum that has been created by the massive outcry among physicians to become an even more formidable grassroots leader in the public policy arena.

Finally, we need to prepare for the health care finance debate that we know is coming – regardless of who resides at 1600 Pennsylvania Avenue.

What the Medicare debate illustrated to me is that we can make a difference when we speak with one voice. This is a decisive and exciting time, indeed.

MAG Goes Live with Web Site Upgrades, Poll

MAG recently upgraded its www.mag.org Web site, highlighted by the introduction of an innovative poll. The upgrades were designed to make the Web site more user-friendly and to better employ space on the home page.

“We believe that these enhancements will enable MAG to deliver its messages to its members and other key stakeholders in a better, bolder and more efficient way,” says MAG President Jack M. Chapman Jr., M.D. “And we are genuinely excited about the poll, which we believe makes the site more dynamic and interactive.”

The “MAG Pulse” poll will enable MAG leadership to secure real-time feedback from its physician members and patients on important health care issues, which can help serve as the basis for the organization’s strategic direction.

Dr. Chapman is encouraging physicians to participate in the poll, pointing out that, “We need critical mass for this become a credible feedback mechanism.”

A number of pages on mag.org that were previously blocked for non-members are now available on an unrestricted basis. And MAG will be adding a physician referral resource to the Web site.

Dr. Chapman is encouraging physicians to visit www.mag.org and register or update their e-mail address using the “Sign up for e-mail updates” tab on the home page.
The American Medical Association held its annual meeting in June in Chicago. During an emotional opening session speech, AMA President Ronald M. Davis, M.D., detailed his battle with pancreatic cancer and called on the nation’s physicians to leave a legacy for the next generation. His message was one of hope for organized medicine. Dr. Davis touched upon the many issues affecting physicians today, including the political process surrounding Medicare physician payment cuts.

The House of Delegates elected J. James Rohack, M.D., as president-elect of the AMA. Dr. Rohack is a cardiologist from Temple, Texas who has served as a member of the AMA Board of Trustees for the past seven years. Delegates also re-elected Denver psychiatrist Jeremy A. Lazarus, M.D., to another term as speaker and Andrew W. Gurman, M.D., a hand surgeon from Altoona, Pennsylvania to a second term as vice speaker.

AMA launched the Heal the Claims campaign and it unveiled the National Health Insurer Report Card. The Heal the Claims campaign is designed to hold health insurers accountable for making claims processing more cost-effective and transparent and to empower physicians with a system to reduce the administrative burden associated with getting paid by the health insurers. The report card will put a spotlight on the problems (e.g., inconsistency and confusion) that emerge when health insurers use different rules for processing and paying claims. The report card will provide an in-depth look at the claims processing performance of Medicare as well as Aetna, Anthem Blue Cross Blue Shield, CIGNA, Coventry Health Care, Health Net, Humana and United Healthcare. AMA encouraged all physicians to take part in the Heal the Claims campaign.

During the Council on Ethical and Judicial Affairs Committee forum that was held in concert with the AMA meeting, Chairman Mark Levine, M.D., led a discussion on physician payment for on-call hours that included a review of the medical cases that led to the Emergency Medical Treatment and Active Labor Act. Although opinions were mixed, a number of AMA members stressed that hospitals are obligated to provide applicable equipment.

“We need to work out something for physicians so that they can be prepared, be available, and be equipped,” said Billie Luke Jackson, M.D., an alternate delegate from Georgia, who described how an ophthalmologist she knows had to use general surgery tools for performing an on-call procedure.

During reference committee hearings, Georgia’s delegates and alternates monitored discussions and gave valuable testimony. At each caucus meeting, reports and resolutions were discussed and strategic plans were made to bring Georgia’s resolutions to a favorable outcome in the house of medicine.

The following actions were rendered by the AMA on the resolutions submitted by the Medical Association of Georgia on behalf of physicians in Georgia:

**AMA Resolution 5 A-08, Employment Relations** – Reference Committee on Constitution and Bylaws, HOD Action, Adopted as amended.

RESOLVED, that our American Medical Association Council on Ethical and Judicial Affairs submit a report on the ethical implications of permitting physicians to be employees of non-physician healthcare providers whom the physician is charged with supervising.

**AMA Resolution 211 A-08, Advance Directives** – Reference Committee B, HOD Action, Adopted Board of Trustees Report 9 in lieu of Resolutions 211 and 233 and that the remainder of the report be filed. The Board of Trustees report recommended that the following recommendation be adopted in lieu of Resolution 216 (A-07), and that the remainder of the report be filed: 1) That our American Medical Association reaffirm existing Policies, D-140.976, H-85.965, H-85968, H-140.970, H-140.985, and E-8.081, E-2.22 and E-2.225.

**AMA Resolution 212 A-08, Elimination of Physician’s “Appointment for Representative” Requirement in Medicare’s Prescription Drug Program Appeals** – Reference Committee B, HOD Action, Adopted that our American Medical Association urge the Centers for Medicaid and Medicare Services to immediately simplify the current Part D Prescription Drug Program Appeal Process by allowing physicians to submit an appeal without beneficiary approval.

**AMA Resolution 213 A-08, Payment Neutrality Between Medicare Advantage and Traditional Fee-For-Service-Medicare** – Reference Committee B, HOD Action, Adopted Resolution 236 in lieu of Resolution 213, which states, RESOLVED, that our American Medical Association express our grave concerns to President Bush, the Executive Branch and Congress that a veto of legislation concerning a budget reduction in the Medicare Advantage Program with a corresponding increase in the Medicare Physician Fee Schedule would be an egregious error.
Ask Your Colleagues: Are YOU a MAG Member?

Even though barriers to practicing medicine continually arise, many physicians do not recognize the benefit of membership in the Medical Association of Georgia. Our track record is proof that there is strength in numbers: We’ve passed tort reform, successfully sued major insurance companies for improper payment practices, and blocked expansion of scope of practice attempts by allied health providers. Yet in order to continue winning the battles physicians continue to face, we need your help to ensure that your colleagues are on board.

Let your non-member colleagues know about the hard work MAG is doing on their behalf and the benefits MAG has to offer. New member dues are only $275 for the first year. Ask them to visit www.mag.org or call 800.282.0224, ext. 9268, to join the state’s largest and most successful physician advocacy organization TODAY!

The Medical Association of Georgia: Building a Better State of Health Since 1849

AMA Resolution 104 A-08, Fair Treatment of Physicians when Pre-existing Conditions are Discovered – Reference Committee A, HOD Action, Referred for decision, that our American Medical Association support HR 2833 and HR 2842 in respect to the elimination and/or streamlining of health plan pre-existing conditions.

AMA Resolution 103 A-08, AMA Progress on Removing Patient Translation Costs from Physician Responsibility – Reference Committee A, HOD Action, Adopted as amended with change in title, RESOLUTION 103 – REMOVING PATIENT TRANSLATIONS AND INTERPRETATION COSTS FROM PHYSICIAN RESPONSIBILITY.

RESOLVED, That our American Medical Association provide an update to its membership on the progress it has made on eliminating the requirement that physicians pay for translation and interpretation services for patients, an analysis of the implications of current regulatory activity on this issue, and plans for addressing the problem.

AMA Resolution 214 A-08, Doctor of Nursing Practice – Reference Committee B, HOD Action, Adopted as amended, that our American Medical Association oppose the National Board of Medical Examiners participating in any examination for Doctors of Nursing Practitioners (DrNP) and refrain from producing test questions to certify DrNP candidates. That our AMA adopt a policy that Doctors of Nursing Practice must practice as part of a medical team under the supervision of a licensed physician who has final authority and responsibility for the patient.

The Board of Trustees submitted several reports to the AMA for adoption or information. Three of these were related to resolutions submitted by Georgia’s AMA Delegation in November 2007. This included…

Board of Trustees Report 17 A-08 adopted by the AMA as amended relates to Resolution 919 I-07, Centers for Medicare and Medicaid Services Policy on Hospital Acquired Conditions – Present on Admission.

Board of Trustees Report 22 A-08 filed for information relates to Resolution 923 I-07, National Provider Identifier (NPI) Implementation.

Board of Trustees Report 32A-08 adopted by the AMA relates to Resolution 921 I-07, Support for Appropriate Billing and Payment Procedures for Physicians.

Information on items of business that were addressed at AMA meeting – including reference committee highlights – is available at www.ama-assn.org/ama/pub/category/18187 using your AMA user name and password.

Please note that MAG will lose a delegate/alternate seat unless its membership increases significantly at the AMA level. This concerns me because of what MAG’s delegation has achieved at the national, AMA level and because losing a delegate would represent a heavy burden on the remaining members. With that in mind, we’re working hard as a delegation at the local level to increase membership in AMA so that we can maintain our seven delegates and seven alternates going into AMA’s meeting in November.

In closing, I’d like to recognize Georgia’s AMA Delegation for the significant contributions that they’ve made on behalf of physicians and patients in Georgia.

Delegates
S. William Clark III, M.D., Waycross, Vice Chairman
Bob G. Lanier, M.D., Atlanta
Alva L. Mayes, M.D., Macon
Joy A. Maxey, M.D., Atlanta
Thomas E. Price, M.D., Roswell
Roy W. Vandiver, M.D., Decatur
Alternates
John S. Antalis, M.D., Dalton
E. Dan DeLoach, M.D., Savannah
Michael E. Greene, M.D., Macon
William R. Hardcastle, M.D., Atlanta
Billie Luke Jackson, M.D., Macon
Alan L. Plummer, M.D., Atlanta
Sandra B. Reed, M.D., Thomasville
Student Delegate/Alternate, AMA MSS Region 4
Matthew Singer, Mercer University School of Medicine
Paul W. Wang, Mercer University School of Medicine

We were also honored to have MAG President Jack Chapman, Jr., M.D., of Gainesville and MAG President-Elect M. Todd Williamson, M.D., of Lawrenceville attend the AMA meeting. Thank you for your ongoing support. It is an honor to serve the members of the Medical Association of Georgia.
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Barack Obama’s Plan for a Healthy America: Quality Affordable and Portable Coverage for All

Excerpts from www.barackobama.com/issue/healthcare

Covering uninsured Americans: Barack Obama will make available a new national health plan to all Americans, including the self-employed and small businesses, to buy affordable health coverage that is similar to the plan available to members of Congress. The Obama plan will have the following features:

• Guaranteed eligibility. No American will be turned away from any insurance plan because of illness or pre-existing conditions.
• Comprehensive benefits. The benefit package will be similar to that offered through Federal Employees Health Benefits Program (FEHBP), the plan members of Congress have.
• Affordable premiums, co-pays and deductibles.
• Subsidies. Individuals and families who do not qualify for Medicaid or SCHIP but still need financial assistance will receive an income-related federal subsidy to buy into the new public plan or purchase a private health care plan.
• Simplified paperwork and reined in health costs.
• Easy enrollment. The new public plan will be simple to enroll in and provide ready access to coverage.
• Portability and choice. Participants in the new public plan and the National Health Insurance Exchange will be able to move from job to job without changing or jeopardizing their health care coverage.
• Quality and efficiency. Participating insurance companies in the new public program will be required to report data to ensure that standards for quality, health information technology and administration are being met.

National Health Insurance Exchange: The Obama plan will create a National Health Insurance Exchange to help individuals who wish to purchase a private insurance plan. Insurers would have to issue every applicant a policy, and charge fair and stable premiums that will not depend upon health status. The Exchange will require that all the plans offered are at least as generous as the new public plan and have the same standards for quality and efficiency. The Exchange would evaluate plans and make the differences among the plans, including cost of services, public.
• Employer contribution. Employers that do not offer or make a meaningful contribution to the cost of quality health coverage for their employees will be required to contribute a percentage of payroll toward the costs of the national plan. Small businesses will be exempt from this requirement, and will receive a new Small Business Health Tax Credit.
• Support for small businesses: Obama will create a Small Business Health Tax Credit to provide small businesses with a refundable tax credit of up to 50 percent on premiums paid by small businesses on behalf of their employees.
• Mandatory coverage of children: Obama will require that all children have health care coverage. Obama will expand the number of options for young adults to get coverage, including allowing young people up to age 25 to continue coverage through their parents’ plans.
• Expansion of Medicaid and SCHIP: Obama will expand eligibility for the Medicaid and SCHIP programs and ensure that these programs continue to serve their critical safety net function.
• Flexibility for state plans: Due to federal inaction, some states have taken the lead in health care reform. The Obama plan builds on these efforts and does not replace what states are doing.
• Lower costs by modernizing the U.S. health care system: Reducing costs of catastrophic illnesses for employers and their employees: The Obama plan would reimburse employer health plans for a portion of the catastrophic costs they incur above a threshold if they guarantee such savings are used to reduce the cost of workers’ premiums.

Helping patients:
• Support disease management programs. Obama will require that providers that participate in the new public plan, Medicare or the Federal Employee Health Benefits Program (FEHBP) utilize proven disease management programs.
• Coordinate and integrate care. Obama will support implementation of programs and encourage team care that will improve coordination and integration of care of those with chronic conditions.
• Require full transparency about quality and costs. Obama will require hospitals and providers to collect and publicly report measures of health care costs and quality, including data on preventable medical errors, nurse staffing ratios,
John McCain believes we can and must provide access to health care for every American. He has proposed a comprehensive vision for achieving that. For too long, our nation’s leaders have talked about reforming health care. Now is the time to act.

Americans are worried about health care costs. The problems with health care are well known: it is too expensive and 47 million people living in the United States lack health insurance.

**John McCain’s vision for health care reform**

McCain believes the key to health care reform is to restore control to the patients themselves. We want a system of health care in which everyone can afford and acquire the treatment and preventative care they need. Health care should be available to all and not limited by where you work or how much you make. Families should be in charge of their health care dollars and have more control over care.

**Making health insurance innovative, portable and affordable**

McCain will reform health care making it easier for individuals and families to obtain insurance. An important part of his plan is to use competition to improve the quality of health insurance with greater variety to match people’s needs, lower prices, and portability. Families should be able to purchase health insurance nationwide, across state lines.

McCain will reform the tax code to offer more choices beyond employer-based health insurance coverage. While still having the option of employer-based coverage, every family will receive a direct refundable tax credit – effectively cash – of $2,500 for individuals and $5,000 for families to offset the cost of insurance. Families will be able to choose the insurance provider that suits them best and the money would be sent directly to the insurance provider. Those obtaining innovative insurance that costs less than the credit can deposit the remainder in expanded Health Savings Accounts.

McCain proposes making insurance more portable. Americans need insurance that follows them from job to job. They want insurance that is still there if they retire early and does not change if they take a few years off to raise the kids.

McCain will encourage and expand the benefits of health savings accounts (HSAs) for families. When families are informed about medical choices, they are more capable of making their own decisions and often decide against unnecessary options. HSAs take an important step in the direction of putting families in charge of what they pay for.

**A specific plan of action: ensuring care for higher risk patients**

McCain’s plan cares for the traditionally uninsurable. McCain understands that those without prior group coverage and those with pre-existing conditions have the most difficulty on the individual market, and we need to make sure they get the high-quality coverage they need.

McCain will work with states to establish a guaranteed access plan. As president, McCain will work with governors to develop a best practice model that states can follow – a Guaranteed Access Plan or GAP – that would reflect the best experience of the states to ensure these patients have access to health coverage. One approach would establish a nonprofit corporation that would contract with insurers to cover patients who have been denied insurance and could join with other state plans to enlarge pools and lower overhead costs. There would be reasonable limits on premiums, and assistance would be available for Americans below a certain income level.

McCain will promote proper incentives. McCain will work with Congress, the governors, and industry to make sure this approach is funded adequately and has the right incentives to reduce costs such as disease management, individual case management, and health and wellness programs.

**A specific plan of action: lowering health care costs**

McCain proposes a number of initiatives that can lower health care costs. If we act today, we can lower health care costs for families through common-sense initiatives. Within a decade, health spending will comprise 20 percent of our economy. This is taking an increasing toll on America’s families and small businesses. Even Senators Clinton and Obama recognize the pressure skyrocketing health costs place on small business when they exempt small businesses from their employer mandate plans.

Cheaper drugs: lowering drug prices. McCain will look to bring greater competition to our drug markets through safe re-importation of drugs and faster introduction of generic drugs.

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Obama’s health plan from page 10

hospital-acquired infections, and disparities in care. Health plans will also be required to disclose the percentage of premiums that go to patient care as opposed to administrative costs.

Ensuring providers deliver quality care:
• Promote patient safety. Obama will require providers to report preventable medical errors and support hospital and physician practice improvement to prevent future occurrences.
• Align incentives for excellence. Providers who see patients enrolled in the new public plan, the National Health Insurance Exchange, Medicare and FEHBP will be rewarded for achieving performance thresholds on outcome measures.
• Comparative effectiveness research. Obama will establish an independent institute to guide reviews and research on comparative effectiveness, so that Americans and their doctors will have the accurate and objective information they need to make the best decisions for their health and well-being.
• Tackle disparities in health care. Obama will tackle the root causes of health disparities by addressing differences in access to health coverage and promoting prevention and public health. He also will challenge the medical system to eliminate inequities in health care through quality measurement and reporting, implementation of effective interventions such as patient navigation programs, and diversification of the health workforce.
• Insurance reform. Obama will strengthen antitrust laws to prevent insurers from overcharging physicians for their malpractice insurance and will promote new models for addressing errors that improve patient safety, strengthen the doctor-patient relationship and reduce the need for malpractice suits.

Lowering costs through investment in electronic health information technology systems:
Obama will invest $10 billion a year over the next five years to move the U.S. health care system to broad adoption of standards-based electronic health information systems, including electronic health records, and will phase in requirements for full implementation of health IT. Obama will ensure that patients’ privacy is protected.

Lowering costs by increasing competition in the insurance and drug markets:
• Obama’s plan will force insurers to pay out a reasonable share of their premiums for patient care instead of keeping exorbitant amounts for profits and administration. His new National Health Exchange will help increase competition by insurers.
• Lower prescription drug costs. Obama will allow Americans to buy their medicines from other developed countries if the drugs are safe and prices are lower outside the U.S. Obama also will repeal the ban that prevents the government from negotiating with drug companies, which could result in savings as high as $30 billion. Finally, Obama will work to increase the use of generic drugs in Medicare, Medicaid, and FEHBP and prohibit big name drug companies from keeping generics out of markets.

Fight for new initiatives
Advance the biomedical research field. Obama has consistently supported funding for the national institutes of health and the national science foundation. Obama has been a champion of research in cancer, mental health, health disparities, global health, women and children’s health, and veterans’ health. Obama will strengthen funding for biomedical research, and better improve the efficiency of that research by improving coordination both within government and across government/private/non-profit partnerships.

Fight AIDS worldwide. As president, Obama will continue to be a global leader in the fight against AIDS. Obama believes in working across party lines to combat this epidemic and recently joined Sen. Sam Brownback to promote greater investment in the global AIDS battle.

Support Americans with disabilities: Obama is committed to strengthening and better enforcing the Americans with Disabilities Act (ADA). Obama also is committed to ensuring that disabled Americans receive Medicaid and Medicare benefits in a low-cost, effective and timely manner.

Improve mental health care. As president, Obama will support mental health parity so that coverage for serious mental illnesses is provided on the same terms and conditions as other illnesses and diseases.

Protect our children from lead poisoning. As president, Obama will require that child care facilities be lead-safe within five years.

Reduce risks of mercury pollution. Obama has a plan to significantly reduce the amount of mercury that is deposited in oceans, lakes, and rivers.

Support Americans with autism. Obama has been a strong supporter of more than $1 billion in federal funding for autism research on the root causes and treatments, and he believes that we should increase funding for the Individuals with Disabilities Education Act.
McCain's health plan from page 11

Chronic disease: providing quality, cheaper care for chronic disease. Chronic conditions account for three-quarters of the nation's annual health care bill. By emphasizing prevention, early intervention, healthy habits, new treatment models, new public health infrastructure and the use of information technology, we can reduce health care costs. We should dedicate more federal research to caring and curing chronic disease.

Coordinated care: promoting coordinated care. Coordinated care with providers collaborating to produce the best health care offers better outcomes at lower cost. We should pay a single bill for high-quality disease care which will make every single provider accountable and responsive to the patients’ needs.

Greater access and convenience: expanding access to health care. Families place a high value on quickly getting simple care. Government should promote greater access through walk-in clinics in retail outlets.

Information technology: greater use of information technology to reduce costs. We should promote the rapid deployment of 21st century information systems and technology that allows doctors to practice across state lines.

Medicaid and Medicare: reforming the payment system to cut costs. We must reform the payment systems in Medicaid and Medicare to compensate providers for diagnosis, prevention and care coordination. Medicaid and Medicare should not pay for preventable medical errors or mismanagement.

Smoking: promoting the availability of smoking cessation programs. Most smokers would love to quit but find it hard to do so. Working with business and insurance companies to promote availability, we can improve lives and reduce chronic disease through smoking cessation programs.

State flexibility: encouraging states to lower costs. States should have the flexibility to experiment with alternative forms of access, coordinated payments per episode covered under Medicaid, use of private insurance in Medicaid, alternative insurance policies and different licensing schemes for providers.

Tort reform: passing medical liability reform. We must pass medical liability reform that eliminates lawsuits directed at doctors who follow clinical guidelines and adhere to safety protocols. Every patient should have access to legal remedies in cases of bad medical practice but that should not be an invitation to endless, frivolous lawsuits.

Transparency: bringing transparency to health care costs. We must make public more information on treatment options and doctor records, and require transparency regarding medical outcomes, quality of care, costs and prices. We must also facilitate the development of national standards for measuring and recording treatments and outcomes.

Confronting the long-term challenge
McCain will develop a strategy for meeting the challenge of a population needing greater long-term care. There have been a variety of state-based experiments such as Cash and Counseling or The Program of All-Inclusive Care for the Elderly (PACE) that are pioneering approaches for delivering care to people in a home setting. Seniors are given a monthly stipend which they can use to hire workers and purchase care-related services and goods. They can get help managing their care by designating representatives, such as relatives or friends, to help make decisions. It also offers counseling and bookkeeping services to assist consumers in handling their programmatic responsibilities.

Setting the record straight: covering those with pre-existing conditions
Myth: Some claim that under McCain's plan, those with pre-existing conditions would be denied insurance.

Fact: McCain supported the Health Insurance Portability and Accountability Act in 1996 that took the important step of providing some protection against exclusion of pre-existing conditions.

Fact: Nothing in McCain's plan changes the fact that if you are employed and insured you will build protection against the cost of any pre-existing condition.

Fact: As President, McCain would work with governors to find the solutions necessary to ensure those with pre-existing conditions are able to easily access care.

Combating Autism in America
McCain is very concerned about the rising incidence of autism among America's children and has continually supported research into its causes and treatment.
Voice for the Uninsured

During its annual meeting, the American Medical Association’s reaffirmed its proposal to cover the uninsured — voting to conduct studies on free clinics and health savings accounts. “While we work to cover the uninsured, we need to find ways to care for those in need now,” said AMA Board Member Cyril Hetsko, M.D. “The AMA will be looking into ways free clinics can fill the void for uninsured patients until we can get everyone covered.”

During the meeting, the AMA posted billboards around Chicago as part of its Voice for the Uninsured campaign, its three-year, multi-million dollar effort to spur action to cover America’s uninsured. Two new campaign television ads were unveiled and will begin to air nationwide this fall.

Additional information on the uninsured and AMA’s Voice for the Uninsured campaign is available at www.VoiceForTheUninsured.org.

Overview of the AMA Reform Proposal

Problems with the U.S. health care system have become all too familiar: relentless growth in the number of the uninsured, skyrocketing costs, dwindling employee health benefits, avoidable illness, premature death, health disparities based on race, ethnicity and income. Increasingly, many insured, middle-class Americans worry that rising health care costs will jeopardize their ability to access affordable coverage in the future for themselves and their families. As advocates for patients, physicians have a particular stake in finding viable, effective approaches to ensure that everyone has health insurance coverage. The AMA has made covering the uninsured an ongoing, top priority and its proposal to expand health insurance coverage and choice addresses the needs of all patients, regardless of income or health status. Through the Voice for the Uninsured campaign, the AMA is focusing public attention on health system reform as we move through the 2008 election cycle. The campaign encourages everyone to vote with these issues in mind and help drive change in the American health care system.

Synopsis

The AMA proposal to cover the uninsured and expand choice uses an approach advocated by growing numbers of scholars and policymakers from diverse quarters. The strategy is to pinpoint and address fundamental flaws in how people currently obtain and pay for health insurance in the United States, flaws that limit the availability and affordability of coverage, especially for those with low earnings or no employee health benefits. Dramatic improvement is possible by making better use of existing government resources devoted to health care and health care coverage, including the billions of dollars spent subsidizing employment-based private insurance. These resources should be drawn upon to, in essence, give people money to pay for a health plan of their choosing. The AMA proposal would expand health insurance coverage and improve fairness by shifting government spending toward those most likely to be uninsured: people with lower incomes. It would also reduce the hidden bias favoring employment-based coverage, which provides special employee tax breaks for insurance obtained through an employer. Those without insurance through a job don’t get this tax break, and would finally get assistance under the AMA proposal. Employees who are dissatisfied with their employers’ health plan offerings could choose to buy insurance elsewhere and still be eligible for assistance. Especially in this context, health insurance market regulations should be reformed to establish fair “rules of the game” that protect vulnerable populations without unduly driving up premiums for the rest of the population. Regulations should also foster market experimentation to find the most attractive combinations of plan benefits, cost-sharing and premiums. In short, the AMA advocates a clear role for government in financing and regulating health insurance coverage, with health plans and health care services being provided through private markets, as they are currently. The AMA proposal gives patients more control over our nation’s health care dollars, while increasing affordability and choice. It reflects important social values and traditions, such as assistance based on need, freedom of choice, market innovation and fairness. Pragmatically, the AMA proposal is fiscally sound and permits flexible implementation. For example, any one of these pillars could be implemented independent of other reforms. Three specific actions are needed to achieve this vision of covering the uninsured and strengthening our nation’s health care system.

Three pillars: The Foundation of the AMA Proposal

The AMA proposal to expand health insurance coverage and choice is based on three pillars:

1) Subsidies for those who most need financial assistance obtaining health insurance. This assistance could take the form of tax credits or vouchers, should be more generous at lower income levels, and should be earmarked for health insurance coverage. It is important to note that the government already gives people financial assistance to buy private health insurance — well over $125 billion each year — with an employee income tax break on job-based insurance that is...
hidden from public view. This tax break gives more assistance to those in higher tax brackets, and gives no assistance to those without employee health benefits. Shifting some or all of this assistance to tax credits or vouchers for lower income people would reduce the number of uninsured and improve fairness in the health care system.

2) **Choice for individuals and families in what health plan to join.** Today people are effectively locked into the health plans their employers offer, often just one or two plans, which are subject to change from year to year. A change in employment typically means a change in insurance coverage. In contrast, under the AMA plan, people could use tax credits or vouchers to help pay for premiums of any available insurance, whether offered through a job, another arrangement or the open market. As with job-based insurance today, health plans would still have to meet federal guidelines for covered benefits, but people would have greater say in what types of benefits and plan features they value. Coupled with individual choice, tax credits benefit recipients directly, and everyone indirectly, by stimulating the market for health insurance. If enough people have enough purchasing power – and enough say over how that purchasing power is used – insurers will be compelled to offer better, more affordable coverage options.

3) **Fair rules of the game that include protections for high-risk patients and greater individual responsibility.** For markets to function properly, it is important to establish fair ground rules. A proliferation of state and federal health insurance market regulations has made it more difficult and expensive for insurers to do business in many markets. The AMA proposes streamlined, more uniform health insurance market regulations. Regulations should permit market experimentation to find the most attractive combinations of plan benefits, cost-sharing and premiums. It is also important that market regulations reward, not penalize, insurers for taking all types of patients. People should have a guarantee that they will not lose coverage or be singled out for premium hikes due to changes in health status. Market regulations intended to protect people who have high health risks typically have backfired, sometimes disastrously, by driving up premiums for younger, healthier people and leading them to drop coverage.

To help high-risk people obtain coverage without paying astronomical premiums, additional targeted government subsidies are needed for high-risk people that would allow insurers to keep premiums down in the regular market. Individuals also need to be encouraged to play fairly by taking responsibility for obtaining health insurance without waiting until illness strikes or medical attention is needed. People who are uninsured despite being able to afford coverage should face tax implications.

**Conclusion**

The three pillars of the AMA reform proposal, combined with careful consideration of ways to get the best value from health care spending, provide a prescription for achieving health insurance coverage for everyone. While additional details will have to be worked out, any meaningful course of action presents challenges of similar scope and magnitude. The AMA believes that unresolved questions can no longer stand in the way of action, and that covering the uninsured is both imperative and possible.

Visit www.voicefortheuninsured.org for more information on the AMA proposal.

**Health Care Costs**

No health insurance reform proposal would be complete without giving serious consideration to managing health care costs. The AMA’s work on developing solutions to address rising health care costs is ongoing, and its current focus highlights areas that physicians can influence. The AMA has identified four broad strategies to contain health care costs and achieve greater value for health care spending:

- reduce the burden of preventable disease;
- make health care delivery more efficient;
- reduce nonclinical health system costs that do not contribute to patient care;
- promote value-based decision-making at all levels.

The AMA’s approach to gaining better control of health care costs is to ensure that we get the best value for our health care dollar.
As the presidential campaign debate over health care intensifies, I am often asked by patients to comment on the ongoing health care crisis. Like many of my patients, I am also frustrated by the decrease in access to quality care in our nation.

Americans need greater access to high quality, affordable care. Yet in just the last 18 months, the Augusta area has lost at least six primary care physicians who have given up their medical practices. We simply cannot achieve needed reforms in quality, safety, and cost if patients do not have access to family doctors, internal medicine doctors, and pediatricians to provide the first level of contact in our health care system.

A good example of the potential access problems ahead is seen in Massachusetts, which recently instituted universal coverage via a new state law requiring residents to have health insurance. Officials initially estimated that this law would result in 150,000 uninsured persons seeking care; the actual demand came closer to 350,000. The New York Times now reports that the state’s primary care physicians do not have the capacity to manage the unexpectedly high demand for their services.

Such gaps in access to health care are largely due to the lack of focus on primary care in the United States health care system. According to a recent report from the American College of Physicians (ACP), which represents 120,000 internists, primary care – the backbone of the nation’s health care system – is at grave risk of collapse.

As our population grows older and lives longer, we will require the kind of care that primary care doctors do best: preventing illness and managing chronic conditions. The ACP predicts that by the year 2025, our country will need 44,000 additional primary care physicians.

Ideally, everyone should have access to a primary care physician for ongoing medical care. Extensive research by Barbara Starfield, M.D., of John Hopkins University and others has shown that good primary care improves health among our population in a variety of ways, including longer life expectancy and fewer deaths from heart disease, stroke, infant mortality and low birth weight. The stronger a nation’s primary care orientation, the fewer early deaths from asthma, bronchitis, emphysema and pneumonia. In 2005, Dr. Starfield reported that increasing the supply of primary care physicians by just one doctor per 10,000 people (a 12 percent increase) could result in as many as 127,000 fewer deaths per year.

Instead, our nation is losing primary care physicians and falling behind countries whose health care systems are based on primary care. The average life expectancy of Americans is shorter than that of Canadians, Japanese, and the populations of Western Europe. A recent analysis of 19 industrialized nations shows that despite spending the most money per person on health care, the United States has the highest death rate from treatable conditions. In terms of populations actually reaping the benefits of medical progress, countries with primary care-based systems are dramatically outpacing the United States.

Primary care providers currently comprise only 36 percent of the physician workforce in the United States, compared to other advanced countries, where 50 percent to 70 percent of all physicians are in primary care. Sadly, this trend does not appear to be improving.

According to 2005 figures, one in five doctors who entered primary care in the early 1990s is no longer practicing. This exodus has contributed to shortages and, as a direct result, patient frustrations. Coordinating one’s own care can be challenging, especially for older patients with many chronic conditions. They may see a cardiologist for a heart problem, an orthopedist for knee pain, and an endocrinologist for diabetes with no single physician to oversee their care or advocate for them in our complex system. Meanwhile, an increasing number of people are misusing the emergency room for problems such as sore throats and chronic back pain, which crowds out real emergencies while increasing the cost of their care and decreasing the quality of service they receive.
Our country’s reimbursement system must bear some of the blame for the primary care shortage we are experiencing. Throughout much of our health care system, providers are paid more for procedures than for “cognitive services,” such as counseling patients in self-care, helping them make good health care decisions, and coordinating care among specialists. A specialist performing surgery or a diagnostic test earns up to 10 times more than a family doctor who spends the same amount of time caring for a patient with diabetes or asthma. From 1995 to 2003, primary care providers worked increasingly longer hours yet saw a 10 percent drop in their inflation-adjusted income. While family physicians are not in it for the money, we can do the math, and it is clear that such disparities make primary care less attractive to future physicians.

In an effort to sustain their incomes, many primary care providers have become more like entrepreneurs than physicians. Some have set up “boutique practices,” catering to wealthier patients who see value in paying a premium for guaranteed comprehensive care that will result in better health outcomes. Other physicians have dropped out of primary care altogether and now work in any of the growing number of specialized settings, such as surgery clinics. Some have simply picked up the pace, crowding more and more patients and procedures into their already full schedules. As a result, they have less time for quality interactions with patients and are living a high-pressure, workaholic lifestyle that few would recommend. This message is not lost on upcoming physicians: since 1998, more than half of all family practice residency programs have gone unfilled.

Solving the current crisis in health care will require everyone’s leadership. Patients must demand better health care with universal coverage for all citizens. The medical community must bring about restructuring of the payment system to reward better outcomes and facilitate growth in the overall percentage of primary care physicians in United States. Medical schools and health care industry leaders must train and retain adequate numbers of primary care physicians and continually improve technology to enhance communication with each other and ensure that our health care system is sufficient to our population’s growing needs.

All doctors – those in primary care and specialty care alike – should support these actions, rising to the level of professionalism and altruism that will improve the health of the populations we are entrusted to serve.

Dr. Clark is a family physician and member of the Richmond County Medical Society and former CEO of Center For Primary Care (CPC) in Augusta, Georgia. He has been practicing family medicine in the Augusta area since he joined CPC in 1995.

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the Medical Association of Georgia’s Council on Legislation (COL) recently formed the COL Trauma Task Force to evaluate the obstacles associated with funding Georgia’s trauma care system and to develop resource recommendations for trauma care in the state.

According to its chairman, **William R. Hardcastle, M.D.**, the task force will produce a report that will be used in MAG’s advocacy efforts to create an effective and efficient trauma care system in Georgia.

“Some 700 people lose their lives in Georgia each year because of an inadequate trauma system, and trauma injury is the leading cause of death in Georgia,” says Dr. Hardcastle. “The state’s trauma death rate is 20 percent above the national average, which I hope we can all agree is unacceptable.”

Georgia lawmakers have taken some preliminary steps to reinforce the state’s trauma care system. They signed S.B. 60 into law in 2007, thereby creating the Georgia Trauma Commission to oversee the state’s trauma system.

Nevertheless, Dr. Hardcastle says that Georgia lags behind a number of states when it comes to enhancing its trauma system. And, he says, it’s worth noting that the legislature failed to produce a funding package for trauma care in 2007 or 2008.

Gov. Sonny Perdue demonstrated great leadership when he allocated $58.9 million for trauma care in 2008, says Dr. Hardcastle, but he also believes that was the bare minimum to keep the system afloat.

MAG’s Director of Government Relations Larry Lanier is quick to add that, “Most of those dollars are going to be spent by the end of the year, so it’s imperative for our state leaders to use the 2009 session to pass legislation that will provide a longer-term funding solution.” Lanier says...

- Funding for Georgia’s trauma system must be sustainable, it’s got to come from a secure funding source, and it’s got to be renewable on an annual basis.
- The legislature needs to consider increased funding for the trauma network on a yearly basis as the state’s population grows.
- Steps must be taken to ensure that trauma care providers are compensated in a fair and equitable way and to ensure that there are enough incentives in place to entice health care providers to participate in the state’s trauma system.
- The Georgia Trauma Commission must be allowed to operate in a manner that’s fully aligned with its charter’s design, administer and facilitate an effective and efficient trauma network.

Dr. Hardcastle stresses that the trauma system consists of a number of distinct elements, including EMS services (e.g., technicians, transport), communications (e.g., the 911 system), rehabilitation, hospitals, administration, nurses and physicians.

“Each of these links are essential, and each has to be addressed in a unique way if we want to build an exemplary, truly integrated trauma network that works on a macro level,” he says, adding, “Without adequate transport services and EMS personnel, for example, trauma victims would never get to the hospitals and trauma surgeons that they need to have a chance to survive.”

**Physician Shortage in Georgia**

In a study that it conducted for the Medical School of Georgia in 2007 on behalf of the Board of Regents, Tripp Umbach Healthcare Consulting, Inc. estimated that...

- There will be a shortage of 2,500 physicians in Georgia by 2020, including 1,500 in underserved areas.

According to the *Georgia Board for Physician Workforce’s Fact Sheet on Georgia’s Trauma Physicians (September, 2006)*...

- The number of general surgeons in Georgia has decreased by 4.9 percent since 2000.
- The rate of general surgeons in Georgia per 100,000 people is down from 8.6 in 1992 to 8.4 in 2004 – keeping in mind that the national rate for general surgeons was 12.8 per 100,000 people in 2004.
- In 2004, more than 74 percent of Georgia’s general surgeons were 50 years of age or older.
- The rate of neurological surgeons per 100,000 people in Georgia dropped from 1.6 in 1992 to 1.5 in 2004, while the U.S. average for neurological surgeons was 1.8 per 100,000 people in 2004.
- In 2004, more than 50 percent of neurological surgeons in Georgia were 50 years of age or older.
• The number of orthopaedic surgeons in Georgia for every 100,000 people grew from 6.3 in 1992 to 7.0 in 2004, but the national rate for orthopaedic surgeons was placed at 8.1 per 100,000 people in 2004.

“We can’t ignore these numbers,” Dr. Hardcastle warns. “Trauma surgeons provide an incredibly unique skill set, one we can’t afford to lose. These physicians are expected to operate in a fluid, fast-pace and high-stress environment.”

Lanier points out that the financial and personal burden on the providers is a great one, too: “Physicians who provide trauma care face higher malpractice insurance rates and often aren’t even sure if they’re going to get paid. No other profession would require its members to function with that as a backdrop.”

**Uncompensated Care**

According to the Final Report of the Joint Comprehensive State Trauma Services Study Committee (2006)…

• Georgia’s trauma services providers (hospitals, surgeons, EMS) deliver $250 million in uncompensated trauma care each year.

• The estimated cost of trauma care provided by physicians for the uninsured in Georgia in 2005 totaled more than $39 million.

Dr. Harascastle says the MAG task force will recommend that the Georgia Trauma Commission establish the framework for paying physicians who aren’t compensated for on-call or trauma services.

“Physicians don’t have any trust funds for uncompensated care,” Lanier says. “They’re simply forced to write their losses off.”

“Change notwithstanding, it’s unlikely that Georgia’s going to attract or retain physicians to participate in the state’s trauma system,” Lanier continues. “Unless we address uncompensated care in a comprehensive way, we’re going to end up with a trauma system that’s even more dysfunctional and ineffective.”

**Solutions**

Dr. Hardcastle says that those who oversee Georgia’s trauma system will need to employ a long-term, strategic lens. He says that means upgrading the trauma infrastructure, enhancing the state’s readiness capabilities, and accounting for the full spectrum of stakeholders along the trauma network chain.

Most important, he says, is the need to provide the group of health care providers that constitute the trauma system in Georgia with the peace of mind that there’s a permanent and adequate funding stream in place.

Dr. Hardcastle reveals that at least 16 states have established dedicated funding resources to support their trauma care systems. “Without that kind of adequate and sustainable funding mechanism in place,” he concludes, “any trauma system – no matter how effective or well administered – is destined to fail.”

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Georgia Board for Physician Workforce
Fact Sheet on Georgia’s Trauma Physicians
August 2008

This Fact Sheet highlights the current supply and distribution of physicians who play a critical role in Georgia’s trauma network. These specialties include: General Surgery, Emergency Medicine, Orthopedic Surgery, and Neurological Surgery. It is relevant to note that other physicians, in addition to those mentioned in this Fact Sheet, play an important part in stabilizing and treating trauma patients.

Most Frequent Causes of Traumatic Injuries

“Care at a trauma center lowers by 25 percent the risk of death for injured patients compared to treatment received at non-trauma centers.” (Source: A National Evaluation of the Effect of Trauma Care on Mortality; New England Journal of Medicine; Jan. 26, 2006).

Nationwide, Motor Vehicle Accidents account for the greatest number of patients treated in trauma centers. (Source: Division of Advocacy and Health Policy, 2006). In Georgia, hospital discharges, as a result of Motor Vehicle Accidents, have risen from a rate of 89.5 in 2002 to a rate of 92.7 in 2006. (Source: Georgia Dept. of Human Resources; Division of Public Health; Online Analytical Statistical Information System. 2008)

Trauma resulting from falls had the highest discharge rate of all external cases in Georgia in 2006 (182.3 per 100,000 population). (Source: Georgia Dept. of Human Resources; Division of Public Health; Online Analytical Statistical Information System. 2008)

The Core Specialty of General Surgery

The core specialty of General Surgery is particularly important when considering access to trauma services. A General Surgeon manages a broad spectrum of surgical conditions affecting almost any area of the body. The surgeon establishes the diagnosis and provides the preoperative, operative, and postoperative care to surgical patients and is usually responsible for the comprehensive management of the trauma victim and the critically ill surgical patient. (Source: Association of American Medical Colleges)

GENERAL SURGERY
Physician Distribution - 2006
Deficit, Adequate, and Surplus PCSAs*

- Overall, since 1996, the number of practicing General Surgeons in Georgia has increased by 1.2%. However, between 2004 and 2006, it has decreased by 4.6%.

- The growth in General Surgeons has not kept pace with the rapid growth in population. The rate of General Surgeons per 100,000 Population decreased from 9.59 in 1996 to 7.67 in 2006. The national rate in 2006 was 12.5 General Surgeons per 100,000 Population (a decrease from 2004).

- General Surgery shows a deficit in 27 of the 96 Primary Care Service Areas of Georgia (2006). This is 28% of the PCSA’s in Georgia in 2006.

- In 2006, 45.7% of the General Surgeons were aged 50+, and 20.3% were 60 and older.

- According to the American College of Surgeons, each year there are more surgical residency positions offered nationally than there are students waiting to apply.

- In 2006/2007 7.6% of the General Surgery GME slots were left unfilled.
Emergency Medicine

An Emergency Medicine physician focuses on the immediate decision making and action necessary to prevent death or any further disability both in the pre-hospital setting by directing emergency medical technicians, and in the emergency department. (Source: Association of American Medical Colleges)

EMERGENCY MEDICINE
Physician Distribution - 2006*
by Secondary Care Service Areas

- According to the AAMC, the Center for Health Workforce Studies said in 2006: “There are concerns that the supply of board-certified emergency physicians may not be adequate to meet demand.”
- Between 1996 and 2006, the number of physicians practicing Emergency Medicine increased by 55.0%.
- The rate of Emergency Medicine physicians per 100,000 population increased from 7.8 to 9.6 between in 1996 and 2006.
- Georgia’s rate of 9.6 Emergency Medicine physicians per 100,000 population was below the national rate of 10.0 in 2006.
- Seven of the 12 Secondary Care Service Areas were below the state ratio of 9.6 Emergency Medicine physicians per 100,000 in 2006.
An Orthopedic Surgeon is trained in the preservation, investigation and restoration of the form and function of the extremities, spine and associated structures by medical, surgical, and physical means. (Source: Association of American Medical Colleges)

Between 1996 and 2006, the number of practicing Orthopedic Surgeons increased by 24.0%.

The rate of Orthopedic Surgeons per 100,000 Population decreased slightly from 7.6 in 1996 to 7.5 in 2006.

In comparison to Georgia’s rate of 7.0, the national rate was 8.1 Orthopedic Surgeons per 100,000 Population in 2006.

Six of the 12 Secondary Care Service Areas were below the state rate of 7.5 Orthopedic Surgeons per 100,000 in 2006.

Between 1996 and 2006, the number of practicing Neurological Surgeons increased by 23.4%.

The rate of Neurological Surgeons per 100,000 Population remained the same during the period 1996 to 2006 (1.5). In comparison, the national rate was 1.8 Neurological Surgeons per 100,000 Population in 2006 (rate had no change between 2004 and 2006).

Seven of the 12 Secondary Care Service Areas were below the state rate of 1.5 Neurological Surgeons per 100,000 Population in 2006.

In 2006, 41.1% of the Neurological Surgeons were age 50+ and 12.4% were 60 and older.
As shown in the above table, the overall rate of General Surgeons, and Orthopedic Surgeons per 100,000 Population was lower in 2006 than in 1996.

Emergency Medicine is the only listed trauma specialty that has seen an overall rate increase in the last decade.

As shown in the table above, the majority of trauma physicians were practicing in MSA’s in 2006.

In terms of Georgia’s 2006 population, 81.1% of Georgians resided in MSA’s and 18.9% lived in Non-MSA’s.

Most large trauma centers/hospitals are located in MSA’s, which explains the concentration of these physicians in urban areas. However, much of the state of Georgia is considered rural and hospitals in Non-MSA’s are finding it increasingly difficult to ensure trauma physicians are available to serve Georgians in these respective geographic areas.

For more information, please contact the Georgia Board for Physician Workforce at (404) 206-5420 or 1718 Peachtree St, NW, Suite 683, Atlanta, Georgia 30309.
Georgia’s trauma network currently consists of just 15 health care facilities that carry official trauma care centers designations – four at level 1 (the highest), nine at level two, and two at level four. What’s more, 10 of these trauma centers are concentrated within 70 miles of Atlanta, including six in metro Atlanta.

In my opinion, this is no way to care for trauma victims in the largest state east of the Mississippi River. We need an additional 14 to 16 trauma centers in strategic areas in the state. The struggle to fix this problem has been going on for nearly 30 years, and I’m hoping that 2009 represents the light at the end of the tunnel.

Gov. Sonny Perdue added nearly $59 million to the state’s 2008 supplemental budget to jump-start a statewide trauma system with funds to pay physicians, EMS and hospitals for “readiness” and “uncompensated care.” Each trauma center was given a lump sum of money based on its level 1, 2 or 4 designation – a budget that was established by the Georgia Trauma Commission. Finally, the trauma centers were directed to allocate the funds to the trauma surgeons, specialist consultants, and hospitals in a manner consistent with the commission’s budget. Time will tell how well the system works from a stakeholders’ reimbursement standpoint.

Trauma surgeons, whom I classify as general surgeons with a specific commitment and passion to care for trauma victims, are responsible for trauma patient care. And trauma surgeons must often call on specialist physicians in areas like orthopedics, neurosurgery, and critical care to help care for the injured. Unfortunately, it is becoming increasingly difficult to call on these consultants in the trauma care world for myriad reasons. First and foremost is the lack of fair remuneration – or any remuneration at all. Trauma surgeons and trauma consultant sub-specialists simply will not be available to care for trauma victims unless they are compensated. It’s a problem that must be addressed, and it must be addressed in the immediate future. Along with physicians and hospitals, funds must also be available to those who provide EMS and rehabilitation services – and those funds have to be distributed in a fair and equitable manner.

In order to establish a truly viable statewide trauma system, funding needs to be both guaranteed and sustainable. It must come from a fixed resource – not one subject to change on a year-to-year basis vis-à-vis the state budget process. The system could be funded with a “trauma system” license plate registration fee for every motorized vehicle in Georgia. This could be collected each year for the sole purpose of funding the state’s trauma system. I believe this is a reasonable solution since 75 to 80 percent of the trauma injuries in Georgia are the result of either blunt force trauma related to motor vehicle crashes or falls. And I believe this is a fair and equitable solution because every person riding in or on a motorized vehicle is a potential trauma system patient.

The State of Georgia needs some $80 million to $100 each year to maintain its trauma system. I’m hoping that Gov. Perdue’s $58 million funding “gift” in 2008 will serve as the catalyst for a permanent, adequate and sustainable trauma system in Georgia.

“The time to act is now” is no doubt a worn-out phrase, but in my view it has never been more apropos.

Go to www.georgiaitsabouttime.com for additional information about Georgia’s trauma system.

Medical Association of Georgia
Council on Legislation
Trauma Task Force

William Hardcastle, M.D.
Chairman
(General Surgery)

John S. Harvey, M.D.
Vice Chairman
(General Surgery)

William L. Weaver, M.D.
(General Surgery)

E. Daniel DeLoach, M.D.
(Plastic Surgery)

Cesar A. Gumucio, M.D.
(Plastic Surgery)

Douglas W. Lundy, M.D.
(Orthopaedic Surgery)

James W. Barber, M.D.
(Orthopaedic Surgery)

Paul K. King, M.D.
(Neurosurgery)

Florence Barnett, M.D.
(Neurosurgery)

Earl Grubbs, M.D.
(Emergency Medicine)

Larry R. Lanier
Director, Government Relations
Medical Association of Georgia
In The Red Zone

The Friday night gun and knife club, the Monday morning rush hour wreck, the Tuesday afternoon construction site fall: Grady’s trauma team sees the most serious injuries in north Georgia

It is the late afternoon in early fall when paramedics wheel a young woman into the trauma room at Grady Memorial Hospital. Barely conscious, she has just survived a car crash, her vehicle rolling over before coming to a stop. The paramedics have called ahead, and the trauma team is ready. They don’t know much yet, but as the stretcher passes through the double doors, a scene unfolds. The paramedics call out vital signs, and a nurse simultaneously transcribes the information. The woman is rolled to Bay 2, and the trauma group springs into action – surgeons, emergency physicians, nurses, x-ray technicians, and medical students moving together in a well-rehearsed dance. They assess the patient’s level of consciousness, check her airways, look for bleeding. Someone takes x-rays while others pitch in to stabilize the patient. The images are processed, the blood work examined, the tests quickly completed, and a plan takes shape based on the woman’s condition.

Such a scene occurs daily inside Grady’s Red Zone. This is the threshold to the hospital’s trauma bay, where those with the most severe, life-threatening injuries find help. Grady is where patients want to be if they’ve been shot, stabbed, severely burned, or seriously injured in a car wreck. The Red Zone is where they have the best chance of staying alive.

Beyond a place

Most trauma patients are routed from the trauma area to the operating room or directly to intensive care. They eventually wind up in rehabilitation. Although there are various stops and stages of their care, the process is a continuum, says Jeffrey Salomone, M.D., the Emory cardiothoracic surgeon who is chief of general surgery at Grady. Both doctors and nurses keep a close eye on patients’ progress, sometimes following up even after patients have returned home.

Located in downtown Atlanta, Grady has the only level-1 trauma center between Macon and Chattanooga. A level-1 trauma center gives patients immediate access to critical care and vital resources, such as on-site surgeons, trauma and intensive care nurses, emergency physicians, pharmacists, the latest diagnostic equipment, and operating rooms. That translates into a better chance of survival for those with the most severe injuries. Without Grady, Atlanta would be the only top 10 metropolitan area in the United States without a level-1 trauma center.

What’s hurting you, sir?

Later that Friday night, a middle-aged man is wheeled into the trauma room, Bay 3. Georgia clay splatters his face, arms, and clothes, the result of a motorcycle accident. The trauma team peppers him with questions: “What’s hurting you, sir? Does this hurt? Does that hurt? Are you allergic to anything, sir?” The man’s clay-caked helmet and clothes lay in an orange heap on the floor alongside the gurney.

In Bay 2, doctors are trying to determine if the woman from the car accident has internal bleeding. Her x-rays reveal facial fractures, a broken pelvis and arm, and swelling to her face.

The sickest of the sick

Last year, Grady admitted 4,000 trauma patients. Of those, approximately 3,000 stayed more than 24 hours, according to Dr. Salomone. That includes 425 patients who were admitted to Grady’s burn unit, one of only two regional burn centers in Georgia.

“It’s the badly injured or the most ill who get admitted,” Dr. Salomone says. “We’re here to take care of the sickest of the sick.”

The patients who came to Grady for emergency treatment fall into three categories: those who meet trauma criteria and are sent to a trauma bay, those with unusual symptoms who...
are examined by both emergency and trauma physicians and then admitted to the hospital, and those with relatively minor symptoms such as broken bones and cuts who need emergency care but not that of the trauma team.

While many people think of trauma doctors as handling gunshot and stab wounds, these make up only a small percentage of cases at Grady. “Car wrecks, motorcycle crashes, and falls make up at least 70 percent of trauma care seen in the hospital,” says David Feliciano, an Emory surgeon who is Grady’s chief surgeon.

What’s more, he adds, trauma is an injury that is a surgical disease. It can be blunt — as in a car accident, or it can be penetrating — gunshot wounds, stab wounds, and impalements.

**Surge capacity**

In 1999, Grady’s trauma team got word of an office shooting in the Buckhead neighborhood of Atlanta. Of 21 people who had been wounded, nine were dead at the scene. Seven of the gunshot victims came to Grady, and six of those needed emergency surgery. Although the tragedy occurred during a shift change at the hospital, the nurses and anesthesiologist on call stayed so that all six patients were able to be taken to the operating room on arrival. “We were running the equivalent of six emergency ORs at three in the afternoon,” Dr. Salomone remembers. “There’s no other hospital in this town that can do that.”

While needing this capacity is not an everyday event, it does occur repeatedly. For example, in March 2007, a chartered bus carrying the Bluffton, Ohio college baseball team to a tournament in Florida overturned on an exit ramp off I-75 and crashed to the interstate below. The accident claimed the lives of five students, the bus driver and his wife. Dozens of other players needed immediate treatment. The day of the Bluffton bus crash, the media kept asking, “How many people did you call in to help?” Dr. Salomone says. “None. We took care of things with the people who work here. What we have is surge capacity — the ability to accommodate people who show up at your door all at once.”

That ability is enabled by trauma surgeons who staff the hospital 24/7, required for level 1 status and reinforced by Dr. Feliciano as chief surgeon. Dr. Salomone himself lives less than a mile from Grady, a factor that he considered when purchasing a place to live. That proximity also helps him in his volunteer duties to care for any police officer who becomes seriously injured on the job.

**Don’t move**

It’s after 10 p.m., and the motor vehicle accidents keep rolling in. The latest casualty, a young man with his hair damp with blood from facial lacerations, is told to lie still in Bay 4. “Just answer yes or no,” they tell him. “Don’t move.” Then come the questions: “Any pain here? Any allergies? Any drug use? What about anything to drink?”

Now on pain medication, the motorcyclist in Bay 3 is asleep. Soon he will be admitted for observation and further care, but chances are he will not need surgery.

However, the woman in Bay 2 will. Her surgery will take place in one of Grady’s 16 ORs, 14 of which are usually in use during daytime hours. Available just outside the OR are 48 units of O negative blood, more than most hospitals keep in their blood banks. Two surgical nurses are on duty, awaiting a minute’s notice to ready the OR when a patient needs emergency surgery.

After surgery, trauma patients are transferred to a 20-bed surgical ICU, where the woman in Bay 2 is eventually bound. “This unit has nurses with the strongest intellect and capability in the city,” says Dr. Salomone. “They work 12-hour shifts with some very sick patients, and they are the primary reason many of these patients get better.”

**The job doesn’t stop here**

“Those of us who go into trauma medicine like to take people who are critically ill and contribute each day to them getting better, going back to work, and returning to their lives,” says Dr. Salomone.

The woman in Bay 2 did recover and return home to her everyday life. Likewise, all but five of the Bluffton kids returned to Ohio and the ballpark. Dr. Salomone and his colleagues even made a trip recently to see the team play. As they sat in the stands months after the bus crash, they felt the continuum of care had come full circle from the Red Zone to real life.
Survivor Grady

It took an entire community pulling together to keep the doors of Atlanta’s public hospital open. Now what?

Reprinted with permission, Emory Health, Summer 2008

A little more than a year ago, it looked as if Atlanta’s Grady Memorial Hospital was poised to follow in the footsteps of Philadelphia General, D.C.’s General Hospital, and Martin Luther King Hospital in Los Angeles. These public hospitals all closed their doors, forced out of business by spiraling health care costs, falling funding, and rising numbers of uninsured patients.

However, Grady apparently had something the other hospitals lacked—a committed, visionary, and influential group of supporters, who were determined that the hospital must survive. They were able to bring on board a disparate group of political, business, and civic leaders, creating the momentum needed to turn around a vast ship like Grady. Today the hospital has new leadership, an infusion of funding, and a plan for moving forward.

“The community stepped forward and rallied behind its mission and goals. That is what saved Grady,” says Michael Johns, M.D., who was CEO of Emory’s Woodruff Health Sciences Center when the fiscal and governance crisis began more than a year ago and is now Emory University chancellor.

Grady’s mission, established with the hospital’s creation in 1892, is to care for the city’s indigent. “It serves our local citizens in its safety net role as it wraps its arms around the disenfranchised,” Katherine Heilpern, M.D., chair of emergency medicine at Emory, wrote in an editorial in The Atlanta Journal-Constitution. “They turn to Grady for help because it’s ‘their’ hospital, or because they have been turned away by everyone else: the underinsured who can’t make a cash co-pay, the homeless, victims of interpersonal violence too frightened to speak, the resource poor with chronic mental illness, diabetes, hypertension, congestive heart failure, addiction, and asthma.”

But Grady’s importance reaches far beyond its charity mission. Staffed by Emory and Morehouse physicians, it has one of the nation’s leading trauma centers. In fact, it offers the only level 1 trauma center serving Metro Atlanta and North Georgia—the next closest being in Macon or Chattanooga. It operates the state’s only poison control center, Atlanta’s only burn center, and one of the country’s largest and most comprehensive HIV/AIDS programs. And Grady is the training ground for future doctors, nurses, and other health care professionals. Indeed, one out of four doctors in Georgia trained at Grady through Emory or Morehouse.

To fully appreciate the hospital’s importance, consider life without it. “If Grady disappears, our city’s health care system will be thrown into crisis,” says Louis Sullivan, M.D., former U.S. Health and Human Services secretary and a member of Grady’s new governing board. “Our low-income citizens will have a much more difficult time obtaining the care they need and deserve. The special services Grady has available for all of us, such as trauma care, the poison center, the cancer center, and others, will no longer be available. The other hospitals and clinics in Atlanta will not be able to fill the void in health services that would be created if Grady closes. Without Grady, should Atlanta have the misfortune to experience a terrorist attack or a major passenger airline crash, we would be woefully unprepared to care for the many injured persons.”

The loss of Grady would deal Atlanta an economic blow as well. Without Grady, Atlanta would be at a competitive disadvantage in attracting organizations and businesses to locate here, says Dr. Sullivan. “Atlanta’s convention business, a major part of our economy, would also suffer significantly.” All the services Grady provides, while critical, are costly. The deans of both Emory and Morehouse can attest that medical education is expensive. Trauma, burns, HIV/AIDS, tuberculosis, neonatal intensive care, and teaching are not profitable ventures.

And while Grady’s costs have mounted, its funding has failed to keep pace. In fact, annual contributions from Fulton and
DeKalb counties have been flat for the past 15 years, while funding from the state actually has shrunk. In addition, Medicare, Medicaid, and private insurers have cut reimbursement rates in an effort to control costs, and the number of uninsured has ballooned. Today, 40 percent of the patients Grady treats lack any type of insurance.

Rising costs plus shrinking income equals a lot of red. Grady has operated at a loss for 10 of the past 11 years. It finished last year with a $55 million deficit, and one foot poised above the grave.

Rallied by a new sense of urgency, the Metro Atlanta Chamber of Commerce stepped up and—with the Fulton-DeKalb Hospital Authority’s consent—created a task force to develop a plan to resuscitate the hospital. Prominent leaders from diverse businesses and institutions—including Emory’s Dr. Johns and Morehouse School of Medicine President John Maupin, M.D.—lent their time, experience, and talents to the effort.

“This was all about trying to preserve Grady’s historic mission and raising the money to get that done,” says Pete Correll, chairman emeritus of Georgia-Pacific and co-chair of the task force. “Nobody wanted to be involved in running a bankrupt hospital. But here was a unique opportunity to fix Grady if we all came together and were committed.”

In July 2007, the task force issued a concise, 23-page report outlining its recommendations for Grady, which centered on changes in governance and funding. “The task force report was the sea change in the whole process,” says Thomas Lawley, M.D., dean of Emory’s medical school. “The fact that it was prepared by an independent group of people who had no direct stake in Grady lent tremendous credibility.”

High on the list of recommendations was revamping the hospital’s structure from the hospital authority model, characterized by the report as “outdated competitively and a barrier to necessary change,” to a 501(3)(c) nonprofit organization, governed by a non-political, private board. The new 17-member board reads like a “Who’s Who of Atlanta” business and community leaders. Chaired by Correll, it includes Dr. Sullivan, prominent attorneys, CEOs of several large corporations, the Atlanta school superintendent, and others.

“The idea of replacing the politically appointed board with a board whose primary fiduciary responsibility was to the hospital and its mission was a critical piece for success,” says Dr. Johns. “These are people who understand the community, the mission, and the politics, and they can get out there and really work for the success of this organization. They have leadership ability, but they also have clout. People will listen to them.”

The change in management cleared the way for Grady to receive promised funding of hundreds of millions of dollars in private donations and government funding, including a life-saving pledge of $200 million over four years from the Robert W. Woodruff Foundation. The promise of this money, which will be used to buy equipment and support other non-operating costs, was a key incentive in winning support to convert Grady’s management structure.

How did this windfall come about? Correll simply asked for it. “The foundation had been monitoring the Grady situation for 10 to 20 years,” he says. “They had been approached hundreds of times about support, but they had not been comfortable with the previous governance structure. But, as they have many times in our community, they took the lead. The magnitude of the gift has caught everyone’s attention, and it will make it easier for us to raise the balance of what we need.

“We’ve committed to raise another $100 million over the next four years, and I have every expectation we can do more than that,” continues Correll. “So we are well on the way with capital funding. We still have a long way to go toward improving the operations and getting additional operating funding.”

Indeed, some hoped-for operating funding already has fallen through. Although the outlook for legislation to fund a statewide trauma care network was optimistic, the General Assembly ended its 2008 session without approving the bill. The legislation could have provided up to $30 million annually for Grady. Instead, the legislature made a one-time appropriation for trauma care of $58 million, of which $24 million is expected to go to Grady.

“Hopefully, the trauma bill will be back on the table in the next session,” says Dr. Johns. “It’s good for Grady and the entire state. It saves lives, and it’s just the right thing to do.”

The hospital needs to shave its operating costs by $50 to $60 million a year, says Correll. “That means the people working at the hospital need to accept that they are going to have to dramatically change what they do and how they do it.”

Despite the challenges ahead, Grady has managed to get off the critical list and is taking the first steps toward recovery.

“This city, unlike so many others that faced a similar challenge, has come together,” says Morehouse’s Dr. Maupin. “Disparate opinions from disparate groups all filtered down to one message: Grady is vital and needs to thrive. I think we now have the will, the wherewithal, and the expertise to turn the crisis into a model public hospital.”

As Dr. Johns adds, “Now the hard work begins.”
Refinery Explosion: A Trauma Network at Its Best

by Pamela Gallup, M.D., Savannah OB/GYN and president of the Georgia Medical Society and second vice president of the Medical Association of Georgia with Melissa Connor, Managing Editor

It’s been just over seven months since the Imperial Sugar Refinery in Savannah, Georgia, exploded killing 14 people and injuring scores more. Most will remember where they were when the explosion took place at 7:20 p.m. on Thursday, February 7. Some felt the ground shake, others saw the bright illumination in the sky and others experienced the tragedy first hand.

Nakishya Hill, a machine operator who escaped from the third floor of the refinery on the Savannah River, said there was fire all over the five-story building.

“All I know is, I heard a loud boom, and everything came down,” said Hill, who was uninjured except for blisters on her elbow. “When I got up, I went down and found a couple of people, and we all climbed out of there from the third floor to the first floor. Half of the floor was gone. The second floor was debris, the first floor was debris.”

Area hospitals were at full staff as ambulances delivered the injured to their emergency rooms. Helicopters were observed picking up victims of the explosion from the staging area set up by responders behind Port Wentworth Elementary School. Triage sites were set up near the refinery as well as in the parking lot at nearby Our Lady of Lourdes. Many of the injured were sent to Memorial University Medical Center.

“When I first arrived, there were probably 100 gurneys lined up our emergency room outside,” says Jay Goldstein, M.D., the head of the emergency department at Memorial.

In addition to Memorial, patients were delivered to Candler Hospital and the Joseph M. Still Burn Center in Augusta. Citizens of Savannah saw first hand an example of a trauma network in full swing. From what I understand, this coordinated network was a thing of beauty, especially since they could only prepare for this kinds of events with “mock traumas.”

The explosion that night involved the mobilization of physicians, surgeons, medical personnel, volunteers, supplies, ambulances and helicopters which flew non-stop for hours. A trauma team must always be ready to respond, and trauma services always ready.

The Need for Trauma Dollars

On February 7, 11 EMS agencies and three helicopter services responded to the emergency. The state has no system to mandate them to come together. Instead, Memorial acts as a regional coordinator for the response to such incidents.

Care doesn’t always get paid for in a catastrophic event such as the sugar refinery blast. If 32 critically injured patients come in, you’re not worried about the applicable charges for
The Critically Injured

At approximately 8 p.m. on February 7, Fred Mullins, M.D., a burn surgeon and Medical Director of the Joseph M. Still Burn Center at Doctors Hospital and MAG member, received a call from the EMS Director in the Savannah area alerting him of the plant explosion. A team of six, including Dr. Mullins, Alan Smith, M.D., an anesthesiologist, a nurse anesthetist, and three physician assistants made the decision to fly to Savannah and assist the ER staff at Memorial Hospital with evaluating and triaging burn victims.

The first burn patient arrived by helicopter to the Joseph M. Still Burn Center at approximately 9 p.m. By 8 a.m. Friday, 18 burn patients had been admitted to the burn center and two more admitted to MCG Health Inc. Of the 18 patients admitted, 15 were listed in critical condition and three were in serious condition. The majority of the patients were male. The youngest was 18 and the oldest was in his late 50s. The majority of the burns covered greater than 30 percent of the victims, and several were greater than 50 percent. Most of the burn wounds were third degree.

Doctors Hospital implemented its disaster plan by alerting all available hospital staff to assist in caring for the patients.

“I am so proud of our burn center team. They did an awesome, awesome job,” stated Tanya Simpson, Asst. VP, Burn Services.

On August 16, a patient who was severely burned in the Imperial Sugar Refinery explosion headed home after being treated for more than six months at the burn center in Augusta. He suffered burns over 80 percent of his body. One of two critically ill patients remaining at the burn center, died of his injuries on August 22. The staff at the center had grown very close to the family over the past six months and mourned the death of a beloved son and brother. A total of 14 people died in the explosion. It is estimated that more than 50 people were injured. Memorial University Medical Center reported treating more than 30 victims of the explosion. Candler Hospital treated three. Twenty victims were sent to the Joseph M. Still Burn Center in Augusta. Of the 20, six have died as a result of their injuries, 13 have been discharged, and one patient is in rehab and is expected to recover.

The federal Occupational Health and Safety Administration last month proposed $8.7 million in fines against Texas-based Imperial Sugar. I question if this even begins to cover the medical cost of that fateful evening.

IVs and medical syringes. All you’re concerned about is saving lives. Memorial is the regional coordinator, but the hospital is unfunded.

The financial difficulties of Memorial University Medical Center and Grady Hospital in Atlanta are well known. If these two trauma centers cannot sustain the economic pressures, MCG (Medical College of Georgia) in Augusta and MCCG (Medical Center of Central Georgia) in Macon will be the only centers that can handle the added trauma load.

Georgia is in desperate need of adequate funding for the statewide trauma network. Citizens of Georgia need our legislators to find the money to sustain these centers and to develop other centers so every person in Georgia has access to the kind of response that Savannah exhibited. A patient’s chances of survival increases significantly if he or she receives care within one hour following injury. Can you imagine how different the outcome may have been if the workers at the Imperial Sugar Company had been two or more hours away from a trauma center?

Currently, there are only 15 designated trauma centers in the state – and only four Level One centers (Memorial, Grady, MCG, and MCCG). This inadequacy places our citizens at risk. It is estimated that Georgia should have approximately 25 to 30 designated trauma centers in strategic locations to cover all of its trauma and emergency preparedness needs.

Pamela Gallup, M.D., is a Savannah OB/GYN and president of the Georgia Medical Society and second vice president of the Medical Association of Georgia.

Melissa Connor has been managing editor of the Medical Association of Georgia’s Journal for more than eight years. She is also owner of the marketing communications company, Plus One Media, Inc. and executive director of the Atlanta Hospital Hospitality House.

Melvin M. Goldstein, P.C.
ATTORNEY AT LAW
248 Roswell Street
Marietta, Georgia 30060
Telephone  770/427-7004
Fax  770/426-9584
www.melvinmgoldstein.com

- Private practitioner with an emphasis on representing healthcare professionals in administrative cases as well as other legal matters
- Former Assistant Attorney General for the State of Georgia and Counsel for professional licensing boards including the Composite State Board of Medical Examiners
- Former Administrative Law Judge for the Office of State Administrative Hearings
Our shared goal of protecting and improving the health and well-being of the public creates an excellent opportunity to build a stronger partnership between Public Health and the medical community. Our natural partnership is based on continuous collaboration and common goals, and results in better health outcomes for your patients and a more successful practice for you. I believe that the more we work together, the more opportunities we have to provide superior service to your patients.

As the gatekeepers of health and medical information, your patients rely on you for accurate information and advice which is especially important with the proliferation of online medical resources. By encouraging your patients to choose to lead healthier lives by emphasizing the importance of getting regular check-ups, being physically active and avoiding the pitfalls of health fads, you are helping build stronger communities and a healthier Georgia.

You are also the eyes and ears of the Global Public Health Surveillance System. Something that you see on the front lines of patient care can become critical medical intelligence for Public Health. Regular reporting of the 75 notifiable diseases to your state or local health department, allows Public Health experts to conduct the surveillance needed to detect and contain outbreaks including the next influenza pandemic and food borne illnesses, such as salmonella.

Our continuous collaboration to detect and contain outbreaks builds the foundation of relationships necessary to respond to a larger, more overwhelming Public Health emergency. Since 2001, Emergency Preparedness has become more integrated into the Public Health system, and Public Health has been further integrated into the emergency response infrastructure. Throughout FEMA’s National Response Framework and state and local emergency response plans, the Division of Public Health is designated as the agency responsible for health and medical care. We are also responsible for supporting the American Red Cross and Public Health’s sister divisions within the Department of Human Resources with mass care, sheltering and human services. Public Health is also working closely with you, the medical community, to better coordinate the state’s health care resources to ensure an effective response during an emergency or natural disaster. These efforts allow us to better support your patients by providing you with the tools and resources to prepare for a disaster.

Experience has taught us that any disaster can quickly become a Public Health emergency. Tornadoes are not typically considered Public Health emergencies. Yet, when a rash of tornadoes ripped through Georgia in 2007, destroying the only hospital in Sumter County, state and local Public Health officials rushed to the aid of the local medical community to sustain and restore health care services.

When you SERVGA, you save lives
Earlier this year, we launched SERVGA (pronounced serve Georgia), the State Emergency Registry of Volunteers for Georgia, and it is quickly becoming a key tool for Public Health’s emergency responders. The Web portal is a tool for responders and medical volunteers to better coordinate the resources available during an emergency. SERVGA, (www.servga.gov), is a Web-based system that can be accessed by responders across the country to confirm the credentials of medical volunteers. Data from the Composite Board of Medical Examiners and the Secretary of State’s Office are integrated into SERVGA allowing responders to verify professional licensure for all registrants on a routine or
Volunteers who register with SERVGA gain access to a comprehensive volunteer portal. It is a tool for tracking professional training and education, vaccinations, contact information, and allows individuals to volunteer for local, state, regional, or national emergencies.

The seeds of SERVGA were planted following the terrorist attacks of 2001, when Congress mandated that every state develop an Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP). It is designed to help prevent a situation where medical professionals who spontaneously volunteer in response to a major disaster are told that they are unable to provide care because their credentials cannot be confirmed. To do so, the program creates a pool of volunteers prior to a disaster who can be asked to serve. Registered volunteers are then able to choose which incident to respond to based on pre-existing family and work commitments.

SERVGA is a robust system that not only meets the federal mandates set forth in the ESAR-VHP program, but also supports other state and local efforts as they work to recruit and coordinate medical volunteers. Georgia is home to 14 Medical Reserve Corps (MRC) Units based throughout the state. Sponsored by the Office of the U.S. Surgeon General, MRC units are community-based volunteer teams who donate their time and expertise to prepare for and respond to emergencies as well as promote healthy living throughout the year. In Georgia, every MRC coordinator can automatically become a SERVGA administrator. They can use the system to maintain their volunteer database, confirm volunteer credentials, and activate registered volunteers to respond to a local, state, regional, or national emergency.

Resources like SERVGA allow responders to better handle the inevitable influx of medical professionals spontaneously responding to a specific event. However, I feel that the real opportunity SERVGA and the MRCs provide is to enhance the state’s preparedness by engaging the medical community before a disaster. By registering through www.SERVGA.gov or joining a local MRC prior to a disaster, you gain access to resources that will make you a better volunteer. You will be notified of opportunities to volunteer, participate in trainings and exercises, access resources to prepare you and your family for an emergency, and you will be sure that when the next disaster does strike, you will be able to contribute your full range of medical expertise to save lives.

The medical evacuation of the Gulf Coast following Hurricane Katrina is perhaps the clearest recent example of how the partnership between Public Health and the medical community during an emergency can save lives. It also demonstrates how every health care provider in the state could benefit from registering through SERVGA before an emergency. Following Katrina, there was a tremendous outpouring of support from the medical community, especially to volunteer. Physicians, nurses, PAs, mental health professionals, and others showed up to donate their time and medical expertise. Unfortunately, the volunteer coordinators could not allow many of them to provide essential medical care because there was no way to confirm licensure.

The same was true for health care providers evacuated from the Gulf. Physicians with 20 years experience in New Orleans were not able to help support the needs of thousands of new patients suddenly straining Georgia’s health care system. Public Health could not confirm medical licenses because the state licensing boards were closed. The employees had been evacuated, and the files were not accessible because of flooding and power outages.

You have skills and knowledge that is critical to emergency response. Registering with SERVGA will allow a more effective response if the state is ever affected by a large-scale disaster. I encourage you to take the first step in the creation of a more prepared Georgia, by going online to www.servga.gov or www.health.state.ga.us or by accessing your local Public Health Liaison. Every Public Health District has a Public Health Liaison who is there to help you access the state and local Public Health resources that will support your practice and improve your community’s preparedness. You make a difference in people’s lives on a daily basis, and accessing the resources public health offers will help ensure that you have the opportunity to make a difference during extraordinary events. Thank you for your collaboration with public health. I look forward to every opportunity to build a stronger partnership between public health and the medical community.

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Sandra Elizabeth Ford was named Acting Director of the Division of Public Health on April 4, effective May 1, 2008. Dr. Ford served as the District Health Director of the DeKalb County Board of Health since February 2005. Dr. Ford is a board-certified pediatrician.
Increasingly, hospitals and physicians are seeking to align their interests through a variety of models. These range from joint venture arrangements, service line management agreements, to the formation of foundation models for physician practices, and direct employment of physicians by hospitals. The following discusses the potential advantages and the challenges that physicians and hospitals may encounter as part of any employment arrangement.

Generally, the employment model is directly between a hospital and a physician or the hospital may establish a subsidiary or affiliate to employ the physician. The first challenge for the employment relationship is to ensure the arrangement satisfies the applicable regulations. Any such employment must meet important regulatory considerations. Under the federal Anti-kickback Statute and accompanying regulations, there is a safe harbor exception for physician employment, provided that the compensation that a hospital pays to the physician is within the range of “fair market value.”

Although it is a complex subject, in general, fair market value is the price that a willing buyer (in this case a hospital) will pay to a seller (the physician) for his services, when neither the physician nor the hospital is under any compulsion to reach an agreement. When determining the fair market value compensation in an employment relationship, the parties should evaluate the market in the region and in the physician’s specialty to consider the appropriate fair market value range for like and similar services.

Similar to the Anti-kickback Statute, the Stark Law permits employment relationships, provided the arrangement satisfies the employment exception requirements. Stark laws also require that the compensation be fair market value. The compensation cannot take into account the volume or value of any designated health service referrals or business generated for the hospital. Among other things, in determining fair market value important factors include the physician’s personal productivity, the revenues that are collected from a physician’s personal productivity, and the range of compensation that physicians of similar expertise, training and experience command in the market.

In addition, the Stark law requires that such compensation be “commercially reasonable,” without regard to the volume or value of designated health services that a physician may generate through referring patients for services at the hospital. Generally, “commercial reasonableness” implies that a hospital may not employ a physician if the principal reason for the employment is to generate referrals of designated health services to the hospital or its affiliate. In determining commercial reasonableness, it is reasonable to consider similar transactions in the marketplace, the additional clinical services that a hospital may offer to the community as a result of the employment of physicians, the improvement of quality for the services that a hospital offers, and certainly the revenue that would be generated through the performance of services that do not meet the strict definition of designated health services.

Accordingly, establishing fair market compensation acceptable to both parties is the first challenge. A simultaneous challenge is to ensure that a mutually acceptable employment arrangement is agreed upon by both parties and such arrangement complies with the regulatory requirements. Establishing mutually acceptable terms and conditions, including schedules, call coverage requirements and resources, is imperative to enabling an effective alignment between the hospital and physician.

There are certain real advantages for physicians to evaluate when considering whether hospital employment is in their best interests. One definite advantage is that a hospital/physician employment model relieves a physician or group of physicians from dealing with many administrative burdens of operating a medical practice. In an era of uncertain reimbursement, increasing overhead costs, and the day-to-day clinical pressures of any medical practice, being able to work with experienced administrative personnel that a hospital or its affiliates can provide to run the practice efficiently could be very attractive to physicians. In turn, this may provide a physician or group additional time to devote to their clinical practice, or to their family, friends and community.

Another advantage is access to resources to build a high
quality clinical service. Simply by virtue of hospitals’ size and resources, a hospital may be able to invest in cutting edge equipment, information systems, and the employment of top clinical personnel to assist a physician or group of physicians in building a clinical practice that will offer the highest quality services to the community. Aligning with a hospital through an employment model may relieve a physician or physician group from the high costs of investment in equipment and information technology that the physician or group otherwise would be required to fund through incurring debt.

Hospitals resources include multi-faceted benefit plans and insurance programs to benefit its employees. Depending upon the hospital’s health and welfare benefit plan, physician’s may be able to take advantage of a better retirement program than what the physician has access to through his or her practice. Secondly, the hospital, as an employer, normally provides insurance coverage which reduces the physician’s direct expenses associated with an independent physician practice.

Another advantage may be the hospital’s ability to negotiate better rates of payment for its employed physicians with third party payers than the rates a physician or group of physicians could garner in the marketplace. Improved reimbursement can be important to employed physicians, as certain compensation models rely specifically on revenues that a physician or group of physicians generates.

There are disadvantages to a physician considering employment with a hospital. It is important for a physician considering employment to recognize that he or she does not own the practice and will not be guaranteed a share of the profits. Further, if a not-for-profit hospital employs a physician generally the physician may not participate in straight profit-sharing. However, a physician may be paid for his or her personal productivity and participate in bonus payments, provided the compensation satisfies the requirements of fair market value and commercial reasonableness. Any such profit sharing arrangement is also very complicated at a for-profit health system, because while such a system is not constrained to meet the requirements of a not-for-profit hospital’s community mission, the for-profit system still must be mindful of fair market value requirements under the regulations and specifically, Stark law’s limitations on receiving compensation by virtue of generating referrals for designated health services.

Among the challenges that a physician or group of physicians may face in the employment context includes the fact that a hospital may desire for the physician to include a restrictive covenant in his or her employment agreement. A noncompetition provision is an issue that is subject to negotiation between a hospital and physician. However, to the extent that as part of an employment arrangement a hospital may purchase a physician’s practice (such purchase again is closely regulated by requirements of fair market value consideration and other valuation constructs), a hospital will routinely request a restrictive covenant, just like most purchasers of a business will required a seller of a business who then became an employee or consultant to have a restrictive covenant. Even then, it is reasonable for a physician to seek to negotiate the geographic scope, scope of practice restrictions and duration of any restrictive covenant (which can include non competition and non solicitation covenants).

Generally, a physician or group of physicians also will cede governance control over his practice, particularly if employed at a not-for-profit health system. Because the physician employee is not an owner of a not-for-profit health system, generally the hospital or its affiliate will have to retain ultimate governance control over the practice of employed physicians. Notwithstanding the loss of sole control, physicians can have real, meaningful input into the strategic direction and day-to-day operations of their practice as employees. The degree and type of input is generally another matter to be closely negotiated between a hospital and physician or group of physicians.

In summary, hospitals’ employment of physicians enhances hospitals’ services, ensures community access to physician services and may improve the quality of the service lines offered within the hospital. A physician may secure compensation for his or her services without the worry and responsibility to handle the administrative tasks of operating a business. Physicians may obtain better health and welfare benefits. On the other hand, in exchange for set compensation and benefits, physicians may be subject to restrictive covenants and may lose the autonomy of operating an independent practice. Each employment relationship is unique and each individual must evaluate the opportunities, challenges and benefits to determine if it satisfies his or her long-term goals.

References
1 See 42 U.S.C. §1320a-7b, 42 C.F.R. §1001.952.
2 See 42 C.F.R. 411.357.
3 Id.
4 Designated health services generally include: clinical laboratory, physical therapy, occupational therapy, speech-language pathology, radiology, imaging, radiation therapy, durable medical equipment, parenteral nutrition, enteral nutrition, prosthetic, orthotic, home health, outpatient prescription drug, hospital inpatient and hospital outpatient services, and the provision of related billable equipment and supplies. 42 U.S.C. 1395nn.

Robert C. Threlkeld is an attorney with the Morris, Manning & Martin Litigation and Healthcare Practice Groups. He concentrates in complex litigation, including regulatory matters and commercial disputes, with substantial experience in Medicare and governmental investigations. In addition, he represents both physicians and hospitals in a variety of medical staff matters.
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Recovery Audit Contractors (RACs) Are Coming to Georgia:
Why Physicians Should Care and Prepare Now

by Tracy Field, Esq., Arnall Golden Gregory LLP

Introduction

Anytime after January 1, 2009, physicians and other health care providers in Georgia could find themselves being audit-ed by a new Medicare claims reviewer, the Recovery Audit Contractor – the RACs. What makes this type of audit program “new” is that the RAC itself has a financial stake in identifying and recouping improper payments, both underpayments and overpayments. Indeed, because the RAC’s compensation is calculated as a percentage of the improper payments identified, they have become known as the “bounty hunters” for the Medicare program.

Although much of the attention associated with these new audits has been related to large recoupments of funds to the Medicare program from hospitals in particular, physicians are not immune to RAC audits. The RACs are authorized to review physician claims. Moreover, in the event a RAC were to determine that a hospital had been paid improperly, the RAC could then review and adjust associated physician claims for those related services. Therefore, understanding the process and preparing for these audits is critical for all providers involved in a patient’s care. Indeed, physicians will play important roles in responding to RAC audits, not only for care provided in their offices, but for services provided in any setting.

Background: The RAC Program

Concerned with reports of high rates of improper payments by the Medicare program, in 2003 Congress authorized the Centers for Medicare & Medicaid Services (CMS) to launch a demonstration project using new “Recovery Audit Contractors.” As mentioned, one of the unique features of this new audit program was that the RACs were compensated as a percentage of overpayments recovered. In addition, the RAC demonstration was initially designed to provide information to CMS and Medicare claims processing contractors to help prevent future improper payments. The demonstration project began on March 28, 2005 and was to run for three years. Importantly, because this was a new program, Congress authorized RACs to review those claims from providers in the three states with the highest Medicare utilization: New York, California, and Florida. Providers in Massachusetts and South Carolina were later added to the demonstration.1

In the first years of the RAC demonstration, CMS reported that as a result of their work, the RACs had recovered millions of dollars in overpayments. As a result, even before the initial pilot program ended, Congress enacted the Tax Relief and Health Care Act of 2006 which made the RAC program permanent. Moreover, under the new law, the RAC audits would expand to a nationwide program by January 2010. Thus, what began as a demonstration in a few states is now set to rollout across the country, with Georgia providers scheduled to come into the program as of January 2009.2

CMS Reports RAC Program Successes

Physicians may have heard some “horror” stories about the RAC program, particularly in regard to some California rehabilitation hospitals that reportedly had to close after RAC review denied massive amounts of their claims. In South Carolina, there are anecdotal reports that a large provider had “problems meeting payroll” after a RAC audit resulted in a substantial demand for repayment.

Reports of the success of the RAC program substantiate these reports. According to CMS’s June 2008 report, the RACs identified a total $1.03 billion in improper payments during the three-year period for providers. Although that number could be reduced once providers have prevailed in appeals, the figure clearly bears attention. Of the total $1.03 billion identified, it is remarkable that only approximately 4 percent occurred in FY 2006, 34 percent in FY 2007, and 62 percent in the first half of FY 2008.
The RAC and Physicians

Despite the reports that the largest dollar claims recovered through the RAC program may have been for institutional providers, physicians were not immune to the process. For instance, in Florida, physicians reported receiving multiple requests from the RACs for records to support the medical necessity of their services. In some instances, the RAC would review records and calculate a particular error rate based on the sample of charts reviewed. That error rate would then be applied to a larger group of claims and the physician was informed that substantial repayments were due to Medicare. Indeed, CMS reports that approximately $19.9 million in overpayments were collected directly from physicians.

There is an important consideration in reviewing RAC data from the demonstration, particularly for physicians. Specifically, during the demonstration, RACs had restrictions regarding the types of claims that could be reviewed. Coding for evaluation and management (E&M) levels of service were not per se “targets” of RAC review. Rather, RACs were to evaluate E&M coding when it appeared to be duplicative and where physicians coded for services that were properly reimbursed as part of billing for global services (e.g., surgery services, etc.). In the project going forward, however, CMS has indicated that in addition to these sorts of audits for E&M services, the RACs will expand their work. CMS states that after consultation with the physician community and the AMA regarding reviews for any level of E&M visits, the RACs will begin reviewing the propriety of the coding.

Therefore, with the permanent program, physicians may feel a greater impact.

The RAC Audit Process

As you prepare for a RAC audit, it is important to understand how physician claims can be reviewed. The RACs may utilize one of two types of review: “automated” or “complex.” In performing an automated review, the RACs use proprietary computerized programs analyzing claims payment data to identify “obvious” errors. With an automated review, after discovering these clear errors, the RACs would send providers letters indicating that they had conducted this automatic review and demand that any overpayment be returned. It should be emphasized, that for automated reviews, CMS must have identified a clear policy that serves as the basis for the RACs identifying an error. One example would be those instances in which a provider billed for multiple units of a drug when the dosing schedule was clearly improper.

The second type of RAC audit process is called a “complex” review where the RAC requests a certain number of medical records from a provider. The RAC reviewers then examine the charts and make a determination regarding the medical necessity of the services provided. Importantly, if a provider ignores the RAC’s request and no records are produced, a denial will be issued.

 Providers should take note that it is possible that a RAC review of even a small number of physician claims can result in a substantial demand for overpayment. For instance, the auditor could review a sample of claims involving a particular CPT code and determine that a certain percentage of those claims were paid in error. The auditor could then apply that error rate to all claims filed using that CPT code for a particular period to calculate a substantial overpayment. Therefore, what may seem to be a “small” audit could end with a significant demand for funds.

Appealing a RAC Decision

If dissatisfied with the determinations made during a RAC audit, all is not lost! Just as is true for other Medicare audits, providers have the right to appeal denials and succeed. In June 2008, CMS reported that “only” 14 percent of RAC denials were appealed. However, when CMS issued that report, the government noted that the time to file appeals had not expired for approximately $255 million in overpayments that the RACs identified. Importantly, providers have reported successfully overturning RAC denials through the appeals process, and that number has been estimated to be as high as in 30–40 percent of cases. Providers can overturn denials if they appropriately manage the appeals process.

There are five potential stages to an appeal: (1) a redetermination submitted to a fiscal intermediary (or Medicare Administrative Contractor); (2) a reconsideration before a Qualified Independent Contractor (QIC); (3) a hearing before an Administrative Law Judge; (4) an appeal to the Medicare Appeals Council; and (5) an appeal to Federal district court. Each level of appeal has certain guidelines that must be adhered to and there are important considerations in making certain that any evidence that can support a claim be submitted early in the appeals process.

Importantly, a provider facing a large denial who appeals that determination may consider having any recoupment of funds cease during the time an appeal is pending. Under Section 935(a) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), Congress provided that if a Medicare provider received notice of a potential overpayment and appealed that determination, the Secretary of HHS and his contractors were prohibited from recouping an alleged overpayment until a reconsideration QIC decision had been issued. If the provider overturned denials, obviously there would be no recoupment of funds. If the denials were upheld, the provider would have to repay any overpayment plus interest.

On July 3, 2008, a lawsuit involving RACs was filed by 32 hospitals or hospital systems located throughout South Carolina to enjoin the Medicare program from recouping alleged Medicare Part A overpayments while an appeal is pending. The plaintiff-hospitals asserted that the RAC there, working in conjunction with CMS’s contractors, had recouped alleged overpayments totaling approximately $30 million from the hospitals immediately after issuing adverse determinations. Because the providers were given no opportunity to file appeals before the funds were recovered, they contend that...
the recoupments violate the MMA provisions. The outcome of this case will be important for all providers faced with denials and seeking a stay in recoupment while appeals are pending.

Changes Made For the “Permanent” RAC Program

Although CMS touts the demonstration as a tremendous success, there were strong critics of the program. In response, CMS has instituted changes that will impact providers under the “permanent” RAC program. For instance, providers complained that the “bounty” payment system created the wrong incentive for RACs in their audits. Indeed, initially, the RACs were only incentivized to find overpayments, not underpayments, and they were allowed to keep the “bounty” even in cases where providers appealed and successfully reversed denials. Faced with criticism, CMS did modify its policy and offered the payment incentive for both over and underpayments. Nevertheless, the reported underpayments identified in the June 2008 CMS report were “only” four percent of the $1.03 billion total. In addition, for the permanent program, the RAC will not receive the bounty if an appeal at any level results in a finding that the provider was paid appropriately.

Importantly, the permanent RAC is only permitted to review claims paid on or after October 1, 2007. Therefore, providers preparing for RAC audits will not be required to produce records as old as four years, as was reported during the demonstration.

During the demonstration, providers were also concerned that there were unreasonable burdens placed on them in having to respond to a potentially unlimited number of records requests from RACs. CMS has indicated that they are going to address this concern in the permanent program so that requests will be limited.

Troubling too for providers was the fact that early in the demonstration, not all RACs had a medical director or even certified coders. In response to criticisms, CMS modified the program to require that each RAC have a certified coder and a medical director, and this is a continued requirement as the program is rolled out nationally. Although this should be helpful, there is concern that given the territory that each RAC will be charged with auditing, having only one medical director is insufficient.

Preparing Your Practice For Reviews

If audited by any Medicare contractor including a RAC, there are several practical considerations for physicians to bear in mind.

First, it is important that physicians identify individuals in their offices to monitor RAC activities and coordinate preparations. There are strict timelines that must be adhered to when there is a RAC audit as well as for the appeals process, so that it is critical that a responsible individual ensure you adhere to deadlines.

In addition, to avoid denials, some providers have begun self-audits of records for claims paid after October 1, 2007 to identify any concerns and improve documentation and coding efforts going forward.

With regard to documentation issues, Medicare auditors continue to report that inability to read copied records remains a significant problem. To address issues of poor handwriting, auditors suggest that notes could be transcribed to accompany the handwritten chart. There are also recommendations that if records are copied, providers should be sure that the copies are legible and copied on one-sided paper only.

Cryptic chart entries with abbreviations or complex terminology that may not be universally understood can also result in denials. If a RAC requests review of that record, a physician should consider including a narrative explaining the need for the services with the chart. Even simple shorthand that is used in a setting and understood by colleagues such as “admit to 4th floor” can be misunderstood: was the patient so critical that he needed to be admitted to a hospital as an inpatient (the 4th floor) or is that a designated site for observation without an inpatient admission?

Conclusion

Congressional estimates project that the RAC program could save Medicare as much as $10 billion over five years when expanded to a national program. Therefore, although concerns remain regarding the use of the RACs to audit providers, it is important for Georgia providers, including physicians, to prepare now for the reviews. Indeed, now is the time to review your documentation practices to ensure compliance with Medicare coding and billing standards to avoid a RAC “nightmare.”

Notations

1. Although this article focuses on the RACs whose primary work focused on Medicare claims review, the demonstration included another sort of RAC that focused on whether Medicare secondary payor requirements were followed.

2. At the time this article was prepared, CMS had not yet announced what company would be the Georgia RAC, which was to have been named in the summer of 2008. Therefore, although RAC audits could begin here as early as January 2009, it seems more likely that the start date will be later.

Tracy Field is a health care partner at Arnall Golden Gregory LLP. Her undergraduate degree in human biology is from Stanford University. After obtaining her Masters Degree from the University of California-Berkeley, she worked in clinical genetics and reproductive biology for several years before going to law school. Ms. Field uses her clinical background to assist physicians and other providers in reimbursement and regulatory matters.
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RISK MANAGEMENT

Cyber Liability Risks: Questions and Answers

by Steve Haase, MAG Mutual Insurance Company

As this article is being written, the Department of Health and Human Services (HHS) has levied the first penalty for a violation of the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. The Providence Healthcare System was charged with leaving patient information exposed by losing laptops and back up media in an un-encrypted state. Now that we know HIPAA will be enforced, it is imperative that physicians review their risk management processes. This includes considering the purchase of insurance products to minimize any cyber liability they may be subject to.

In this article we will outline some of the areas a medical practice needs to address to guard against cyber liability breaches, review the various types of cyber breaches that can occur and give an up-to-date overview of where legislation stands today. Lastly, we will give you steps to protect your practice against this increasing threat.

Today over 1.4 billion individuals have access to the Internet on a regular basis. The U.S. alone has more than 200 million users, representing more than 71 percent of the population. While this technology has created a host of positives for the world, not the least of which is increased access to and freedom of information, it is also a relatively “open” network making it highly vulnerable to breaches of security. Experts believe that almost everyone’s information has the potential to be compromised by thieves. The best defense is to arm yourself with the tools to make it extremely difficult to breach your network; and if a breach does occur, to have the appropriate coverage in place for your practice.

The typical health care provider faces numerous competing priorities within their practice. Three top priorities include: 1) Providing patients with high quality care; 2) Protecting an individual’s privacy by complying with HIPAA requirements; and 3) Operating a profitable and sustainable business that continues to serve the community efficiently.

To meet these competing priorities, physicians are increasingly turning to more efficient technology based solutions. However, many of us have no clue about this new phenomenon – cyber security liability, which brings with it issues ranging from breaches of patients’ private records to computer viruses. And even fewer physicians have ever given thought to just how devastating cyber liability could be for a medical practice.

Patients want more access
Research shows that health care providers are just responding to what their patients want by using new technologies. The majority of U.S. residents would like to use patient services such as online appointment scheduling and electronic reminders, but most say the services are not available to them, according to a survey by the Wall Street Journal Online/Harris Interactive. The survey finds:

- 64 percent of respondents would like access to an electronic health record;
- 74 percent would like to communicate with their physician via e-mail;
- 75 percent would like to schedule a physician visit online;
- 67 percent would like to receive test results via e-mail; and
- 77 percent would like e-mail reminders when they should schedule a physician visit or some other type of care.

The survey concluded that only an average of about 24 percent of the respondents had the ability to access their Electronic Health Records (EHR) or could schedule appointments online or could receive appointment reminders via email.

What can go wrong with the new technologies?
You may think your system is secure – you see the little shield on your screen indicating virus protection, so what’s all the hoopla about? Seemingly harmless systems we use everyday such as: digitizing patient information stored on networks and connected to the Internet; communicating with clients and health care vendors via e-mail; online prescriptions and appointments; online patient care management resources; Web site content providing health care advice or even transferring health care information to and from third party networks such as insurance companies, other health care providers, laboratories, x-ray technicians etc. could put your data and your practice at risk.

“The 2008 Verizon Business Risk Team Report: 2008 Data Breach Investigations Report” concluded that data can be compromised by internal and external sources, business partners and multiple third parties – all taking advantage of a minor network security failure and gaining unfettered access to your computer networks. At least 34 states require that every affected person be notified that their information may have been compromised when a breach of any kind occurs – a costly and time-consuming process. Cyber breaches can be extremely costly:

In Weston, Florida, a front-desk office coordinator pled guilty to selling information involving more than 1,000 patients. Although the hospital had browser controls to limit the number of records that employees could view, no one noticed that the employee was exceeding the limit on a regular basis. The
case resulted in $7 million in Medicare fraud. A primary care physician practice in Portland, Oregon, recently discovered the theft of $13,000 in cash and patient data. Included were credit card transaction slips, checks and Social Security numbers. In another case, a disgruntled employee sent, via the Internet, lists of patients attending a drug rehabilitation center. As a result, the patients suffered humiliation and potential loss of jobs. Just this summer at a major trauma hospital in the Southeast, an unknown number of hospital records were stolen containing recorded physician comments sent to a vendor to transcribe into medical notes. The records were stolen, from a subcontractor employed by the vendor. These are harsh examples, but they are real-life situations of what can and did happen due to electronic data breaches.

Is your data at risk?
HIPAA regulations make it clear that patient data must be protected. What about other data? Most medical practices maintain patient data, employee information and vendor records on their networks. Driven by the need to share data and be efficient, increasing amounts of sensitive information are being maintained on networks. This information is vulnerable to abuse of access by both employees, such as snooping on a celebrity clients’ health history, and external hackers seeking information to obtain fake identities.

Isn’t your practice already covered?
The short answer is no. Most practices believe they’re covered under their general liability insurance or standard crime policies. For example, your practice probably has coverage for Medical Professional Liability, Property and General Liability, Employee Disability and Workers Compensation. These traditional insurance products primarily respond to claims alleging bodily injury and property damage, and provide almost no protection for breaches of network security and privacy. All of these products were created prior to the commercialization of the Internet and are not designed to cover cyber losses. In fact, the types of losses from lack of cyber security – maintaining sensitive data on your network and creating content for your own Web site – typically lead to allegations of economic harm.

Government assistance
After the terrorist attacks of September 11, the White House warned of the destructive and costly potential that hackers and computer viruses posed to businesses. It also strongly recommended appropriate coverage for commercial data and other computer-based assets. Let’s also not forget that HIPAA is still in its infancy, just five years old, with additional legislative activity expected in the near future. The next piece of legislation at issue – the Wired for Health Care Quality Act, S. 1693, sponsored by Sen. Edward Kennedy (D-MA) – seeks to “enhance the adoption of a nationwide interoperable health information technology system and to improve the quality and reduce the costs of health care in the United States.” The bill was cleared by the Senate Health, Education, Labor and Pensions Committee almost a year ago, but has been held up by Sen. Patrick Leahy (D-VT), Chair of the Judiciary Committee, due to his concerns about the appropriateness of the privacy protections in the bill. Now, recent reports indicate that new language, drafted by Sen. Leahy, has been agreed to by the key Senators involved in this debate, allowing this legislation to move forward in the Senate. Moreover, additional public reports now suggest that these proposals will be subject to hearings in the near future followed by consideration on the Senate floor. (Obviously, Sen. Kennedy’s recently diagnosed illness clouds predictions about this legislation.)

Update coverage and protect your practice
Health care providers need to consider updating their business insurance portfolio to include cyber liability coverage. This coverage has been around for more than 10 years and continues to expand with a wide variety of policy forms and endorsements. The good news is that the insurance industry is under increasing pressure to grow their premium base and this type of coverage is becoming increasingly competitive among a dozen or so insurance companies. In some cases, premiums start at less than $2,000 a year and usually offer a minimum of $1 million of protection.

It is important to seek coverage from a qualified agent as these products are considered complex and they often require modifications, via endorsement, to meet your practices’ specific needs. We recommend you first review your exposures to loss and then map the policy coverages quoted to your actual exposures. It is important to seek coverage from a qualified agent as these products are considered complex and they often require modifications via endorsement to meet the specific needs of an insured. Below is a sample checklist of questions to assist you with identifying your specific risks. We’ve also listed possible coverage enhancements to protect your practice.

Cyber-Risk Coverage Category = Network Security
• Is your network connected to the Internet?
• Do employees have access to sensitive information on your network?
• Is your organization regulated by HIPAA?
• Is any part of your network hosted by a third party?

If you answered yes to most of the questions above, you need broad network security liability protection. The policy should also include a HIPAA provision. If your network is hosted elsewhere, confirm that coverage includes the hosting locations.

Cyber-Risk Coverage Category = Privacy
• Do you maintain paper files onsite with sensitive information?
• Do you maintain paper files offsite with sensitive information?
• Do you or your staff utilize computers away from the office for business purposes?
• Do you have a privacy statement on your Web site?

If you answered yes to most of these questions you need

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**Georgia Academy of Family Physicians**

**GAFP to offer double credit for annual meeting.** Join the Georgia Academy of Family Physicians (GAFP) at its commemorative 60th Annual Scientific Assembly, which will take place November 5-8 at the Cobb Galleria in Atlanta. The GAFP Education Committee says that the format for this year's meeting has been adjusted to provide EB-CME lectures in a main stage ballroom during every hour of the conference, pending AAFP credit approval. Clinical lecture topics will include asthma, excessive daytime sleepiness, the treatment of fibromyalgia, and more. The President's Gala Dinner will be held at the new Cobb Energy Performing Arts Center, which is near the Cobb Galleria. The event will feature Dale Chihuly-designed glass lighting fixtures and the popular swing music of the Grapevine band. Online registration is available at [www.gafp.org](http://www.gafp.org).

**GAFP promoting 2009 Caribbean cruise.** Last year's GAFP/CME cruise was a huge success with 25 physicians from Georgia and faraway places like Wisconsin, Oklahoma and Canada. The GAFP continues to be a leader in CME education – offering 16 CME credits during the seven-day cruise. The GAFP/CME cruise for 2009 will feature several exotic Caribbean destinations, including the Turks & Caicos, St. Thomas and the Bahamas. The cruise will take place February 7-13, and cabins are going quickly. For more information, go to [www.gafp.org](http://www.gafp.org) or call 800.392.3841.

**GAFP in the news.** GAFP was recognized in last month's AAFP News Now for funding state family medicine residency programs. Andrew Reisman, M.D., of Oakwood was quoted in *The Gainesville Times* on proposed Medicare cuts. Brian Nadolne, M.D., of Marietta was quoted on the front page of *The Atlanta Journal Constitution* for cutting his office week in four days to address employee concerns about rising gasoline prices. Frank Don Diego, M.D., of Atlanta was quoted in *The Atlanta Journal Constitution* concerning the shortage of family physicians in Georgia, a story that appeared in newspapers across the state after it was picked up by the Associated Press; it also spurred news stories that appeared on local TV news channels. Harry Heiman, M.D., of Marietta had an op-ed that addressed how family physicians are both vital and poorly paid that appeared in *The Atlanta Journal Constitution*. And Forbes Magazine article on the GAFP Lowering Infant Mortality Rate/Preconception Health Care Quality Circle. And Harry Strothers, M.D., of Atlanta was just appointed to the HHS/HRSA Advisory Committee on Training in Primary Care Medicine and Dentistry.

**GAFP Foundation supports “Pathway to Med School Program.”** With a $4,000 grant in 2008, the GAFP Foundation continues to support the “Pathway to Med School Program” – which is designed to prepare pre-med college students in Georgia for a primary care career in underserved areas. This year’s class includes nine outstanding students who began the four-week program on July 7 in Albany. Of the Pathway graduates who have applied to medical school, 86 percent have been accepted by Georgia medical schools. Contact Pathways Program Director Julie Roth at 229.439.7185 or jroth@sowega-ahec.org for additional information.

**Georgia Society of Ophthalmology**

The Georgia Society of Ophthalmology’s (GSO) Annual Meeting was held at Lake Oconee in May. On hand for the event were 14 distinguished faculty members who offered perspectives on clinical ophthalmology and legislative advocacy. Special guests included U.S. Congressman Phil Gingrey, M.D., and Georgia Sen. John Wiles.

GSO installed its officers for 2008-2009, having thanked G. Baker Hubbard III, M.D., of Atlanta for his service as president in 2007-2008. GSO’s new officers include President Malcolm S. Moore Jr., M.D., of Macon; President-Elect Anastasios P. Costarides, M.D., PhD, of Atlanta; Vice President Anna Kao, M.D., of LaGrange; and Secretary/Treasurer Wallace M. McLeod Jr., M.D., of Augusta.

GSO also introduced the Thomas M. Aaberg Sr., M.D., lecture at the meeting. Dr. Aaberg recently retired as chair of the Department of Ophthalmology at Emory University School of Medicine after 20 years of service. Rich McDonald, M.D., one of Dr. Aaberg’s former retina fellows, traveled from San Francisco to deliver the lecture, which will become an annual fixture at the meeting.

GSO is working with the Georgia Lions Lighthouse Foundation on a number of community service programs, including the presentation of the annual Beacon of Hope Award. The award recognizes an ophthalmologist who serves the uninsured or underinsured in his or her community. This year’s recipient was Walter J. Paschall, M.D., of Jasper, who provides eye exams and eye surgeries to indigent populations in his community, as well as the underserved in countries around the world.

GSO recently unveiled a new Web site that allows its members to perform a number of administrative functions online. An online referral network allows the public to search for ophthalmologists in their area and view individual physician profiles. Online resources also help keep patients abreast of important eye health care issues and concerns. New features are added regularly, and the Web site has proven to be a valuable resource for members, community partners and patients. The Web site can be found at [www.ga-eye-mds.org](http://www.ga-eye-mds.org).

MAG members are invited to attend GSO’s Winter CME Symposium, which will be held on January 24 at the Georgia
Aquarium. Contact GSO Director of Membership and Marketing Laura Faye at 404.299.6588 or laura@ga-eyemds.org for additional information. Or visit www.ga-eyemds.org for more information.

MAG past-president honored by American College of Rheumatology

Joseph P. Bailey Jr, M.D., past president of both the Medical Association of Georgia and the Georgia Society of Rheumatology, has been recognized as a Masters of the American College of Rheumatology (ACR). In a July 15 news release, ACR said that Dr. Bailey has been an effective advocate for physicians and patients alike throughout his career.

Master of the American College of Rheumatology is one of the highest honors the college bestows, ACR added. The designation is conferred on ACR members 65 or older who have “made outstanding contributions to the field of rheumatology through scholarly achievement and/or service to their patients, students, and profession.” And, ACR said, the honor is generally limited to 15 members per year.

The Georgia Society of Rheumatology also elected its slate of officers for 2008-2009. This includes President Kelly Weselman, M.D., Vice President Bruce Goerckeritz, M.D., Program Chair Sam Lim, M.D., Executive Liaison & CME Chairman, John Goldman, M.D., Membership Chair Keith Rott, M.D., and Immediate Past President Marta Bognar, M.D. For more information, contact Executive Director Suzanne Cross at gsooffice@bellsouth.net.

Georgia Chapter of the American College of Emergency Physicians

GCEP hosting reception for emergency physicians with Georgia ties. The Georgia Chapter of the American College of Emergency Physicians will hold a reception for all emergency physicians (not just for GCEP members) who have ties to Georgia during the upcoming ACEP Scientific Assembly in Chicago. Physicians who lived in Georgia, went to school in Georgia, did their residency in Georgia, or are thinking of relocating to Georgia are encouraged to attend. The reception will be held in the Lake Erie Room at the Chicago Hilton on Tuesday, October 28, from 6 p.m. to 7:30 p.m.

GCEP Annual Meeting. GCEP held its annual meeting in conjunction with the Emergency Department Benchmarking Alliance (EDBA) at Hilton Head Island, SC, in June. David Sklar, M.D., from the University of New Mexico and a member of the ACEP board of directors, spoke about a number of current issues, including boarding, tort reforms and legal cases. He also complimented GCEP for its leadership role in addressing rural issues. GCEP has created a strategic plan for addressing issues unique to rural emergency medicine, and it formed a new rural medicine committee that’s chaired by Ralph Griffin, M.D. The committee will consult with physicians who practice in rural areas to identify their concerns and priorities. GCEP says that there are legislative components to provide incentives to residents to choose a rural practice and to encourage residency programs to provide rotations in rural emergency medicine.

Boarding patients in the emergency department is an important issue for ACEP, as well as for Peter Viccellio, M.D., from New York. He’s a national leader on the topic, which he addressed with an entertaining lecture. Shari Welch, M.D., from Utah, a leader in quality improvement, gave an eye-opening lecture on thinking outside the box to solve problems on ED design and process improvement. Other lectures included Early Goal Directed Therapy for Sepsis, Ted Stettner, M.D.; Procedural Sedation, Eric Richardson, M.D.; Interesting Toxicology Cases, Brent Morgan, M.D.; and Emergency Ultrasound and Workshop, Carl Menckhoff, M.D.

A silent auction raised more than $4,000 for GCEP’s PAC, nearly doubling the 2007 total. Through GEMPAC, GCEP supports Georgia legislators who are fighting for tougher seatbelt laws and a better trauma network in the state.

The conference concluded with a Hawaiian luau beach party, complete with music by Prince Pele and his Polynesian extravaganza, fire throwing, and dancing by several grass-skirt-clad attendees. Next year’s annual meeting will be held at Sea Pines in Hilton Head on June 12-14.

Submitted by John J. Rogers, M.D., who can be reached at johnrogersmd@bellsouth.net. Visit www.gcep.org or contact GCEP Executive Director Tara Morrison at tara@theassociationcompany.com for additional information.

DO YOUR PATIENTS SUFFER FROM ANY OF THESE SYMPTOMS?

• Headaches
• Pain behind eyes
• Dizziness
• Difficulty swallowing
• Limited mouth opening
• Clicking or grating in TM joints
• Locking jaw (opened or closed)
• Pain or soreness in TM joints
• Unexplained teeth or facial pain
• Earache, stuffiness or ringing

If your patients have any of these symptoms and are not responding to treatments, they may be suffering from a TMJ disorder. Problems within the jaw can produce a myriad of symptoms which, at first glance, might appear to be totally unrelated to the Temporomandibular complex. Our dedicated team of professionals have years of training and are happy to assist you in the diagnosis and treatment of possible Craniofacial / Temporomandibular disorders.

Center for TMJ Therapy

Dr. Mayoor Patel, DDS, FAGD, DAAPM, FICCMO, FAACP
Dr. Manoj Maggan, DDS, DAAPM, FICCMO, FAACP

3590 Old Milton Parkway
Alpharetta, GA 30005
P: 770.521.1978
F: 770.521.9936
www.tmdatlanta.com
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Visit us online at www.tmdatlanta.com to download a referral form and learn more about our services.
Bibb County Medical Society

By Dale Mathews, Executive Director

Bibb County Medical Society Art Show

BCMS members and spouses presented the May 2008 Art Show at the Macon Arts Gallery. There were paintings and mixed media, furniture, jewelry, digital art, and pottery. Members who participated were: Charles Burton, M.D.; Arthur Gray, M.D.; and G. Michael Shoffner, M.D. Other artists were: Nancy Barnes; Cherry Brewer; Linda Browne; Ginger Concepcion; Joseph Egloff; Chi Ezekwueche; Yvonne Gabriel; Hugh H. Gibson, M.D.; Marian Gibson; Carol R. Griffin; Warren Griffin, M.D.; Chapin Henley, M.D.; Gene M. Kelly, M.D.; Brenda Cooper McCain, M.D.; Gloria Smith; Starling Thornsberry; Betty Perryman Treadwell and Noreen White.

BCMS President A. M. Anderson III, M.D., welcomed members, spouses, and guests to a Sneak Preview Party prior to the public opening of the show. Edward Clark, M.D., and A. K. Harper, M.D., along with the rest of the EKC Quartet entertained guests with jazz, blues, and other favorites. Mrs. Beverly Noller was also recognized for her upcoming installation as MAG Alliance President.

Mercer Students Donate to Macon Volunteer Clinic (MVC)

Mercer University School of Medicine students made a valuable financial donation to MVC. In April, first and second year students held a breakfast to raise funds for the Clinic. With help from Starbucks, Kroger, and Chick-fil-A, they were able to offer coffee, juice, and breakfast sandwiches for sale to students, faculty, and staff, raising $500. Then the Mercer MSS Chapter of the AMA matched the funds for a total of $1,000. The clinic has experienced a 1000 percent increase in patient admissions since January. 2007-08 MSS Chapter President Paul Wang hopes that the fundraiser will become an annual event.

Cobb County Medical Society

By Joanne Thurston, Executive Director

The Cobb County Medical Society (CCMS) and CCMS Alliance recently presented the WellStar Foundation with $50,000 to create a display addressing the history of physicians and hospitals in Cobb County that will be placed in the reception area of the new Lipson Center in the WellStar Kennestone Hospital. On hand for the check presentation in July were CCMS President Edward Lloyd, M.D., CCMS Executive Director Joanne Thurston, and CCMS Past President Elizabeth Street, M.D.

The Cobb County Emergency Management Agency, in collaboration with CCMS and other partners, has introduced a Special Needs/Populations at Risk Program that offers people with special needs the opportunity to provide information to emergency response agencies so they can better serve them in crisis. The program will provide emergency crews with information about participants during emergencies. In particular, the emergency crews will know which patients are electricity-dependent during power outages so they can establish priorities accordingly. CCMS says that this is important since physicians – under HIPAA – can’t notify emergency personnel of a potential problem until an emergency actually occurs, which can be too late. The registration process includes the patient’s physician contact information so they can be notified during an emergency. Call 770.499.4567 or visit www.ema.cobbcountyga.gov for additional information.

DeKalb County Medical Society

By Hank Holderfield, Executive Director

DMS Fall Membership Meeting will be Thursday, October 30 at Druid Hills Golf and Country Club for “Grand Rounds – Closed Claim Review” presented by Roy Vandiver, M.D., Chairman and CEO of MAG Mutual, and Reid A. Pearlman, JD, a senior risk management consultant with MAG Mutual. The course will cover: Medical professional liability case review of closed claim by physician presenter; medical professional liability risk issues, contributing factors to malpractice lawsuits and recommendations to decrease exposure and liability; and the role of the physician in defending against a medical professional liability lawsuit. The meeting will begin at 6:30 p.m. with a brief reception and heavy hors d’oeuvres to be followed by the program at 7 p.m. Thanks to MAG Mutual Insurance Company for supporting this meeting.

The DMS Annual Meeting will be held, Saturday, January 31, 2009 at the Druid Hills Golf Club. For more information, contact Leslie Boulter at 770.271.2798.

Georgia Medical Society

by Carita C. Connor, Executive Director

The Society sponsored a High School Preceptorship Program for seniors from the local high schools on May 13-15, 2008. Seven high school seniors were selected by their principals at each of the high schools that participated in the program. The program began with a luncheon and orientation at the Memorial Health University Medical Center and ended with a meeting
at the St. Joseph’s/Candler Hospital where each student gave a report on their day in medicine. Thirty-three members of the society participated.

The society sponsored the 21st Annual Super Meeting of the staffs of St. Joseph’s/Candler Hospital and Memorial Health University Medical Center and the membership of the Georgia Medical Society on Tuesday, September 9, 2008. The speaker for the evening was Mr. Paul Morgan, Aeronautical Engineer. Mr. Morgan is a world-class marathoner, mountain climber and adventurer. His presentation was on “Reaching Your Peak and Giving Back.”

**Hall County Medical Society**

The Hall County Medical Society (HCMS) hosted Georgia Commissioner of Insurance John Oxendine on May 8, the day he announced his candidacy for governor. On July 8, HCMS heard Lt. Gov. Casey Cagle, whom HCMS President Andrew Reisman, M.D., said delivered a “dynamic and insightful” talk on the medical crisis in Georgia; Sen. Lee Hawkins (R-Gainesville) and Rep. Carl Rogers (R-Gainesville) also attended the event as HCMS guests. And HCMS Executive Director Hank Holderfield said that U.S. Rep. Nathan Deal was the keynote speaker at HCMS’ dinner meeting on September 4.

**Medical Association of Atlanta**

Steven Walsh, M.D., president of the Medical Association of Atlanta (MAA), announced at the July Board of Directors meeting that MAA has a new executive director, David Waldrep. “Mr. Waldrep comes to MAA from private industry and will bring an excellence in management and organizational development that we are pleased to acquire,” Dr. Walsh said. “MAA represents over 4,000 physicians in the Atlanta area and the board is eager to engage those physicians in meaningful ways. The role of the county medical society has evolved considerably over the years. Our county medical society is the only voice for the physicians in the area. Business and community leaders want a means to communicate with and to local physicians. Health care issues affect every American. They love their doctors but hate the system. We have to be at the table to shape the future of health care and it starts at the county society level.”

Due to the changing nature of MAA’s role in the community, MAA looked for an executive director comfortable with business and government leaders as well as physicians. Mr. Waldrep spent 28 years with Caraustar, rising to the role of general manager of mill converting operations. During his “first” career, he was able to coordinate a program focused on “Vision and Values” which he administered at sites across the country. He was tapped for training in Leadership Excellence for the company. He is a UGA graduate and married with two children.

**Walker, Catoosa, Dade Medical Society**

*by David Bosshardt, M.D., Secretary*

A membership meeting was held July 29, 2008 and was called together by Paul Shaw, M.D., President. The scientific portion of the meeting was presented by Jim Williams and Joe Lavoni of Sanofi-Aventis Pharmaceuticals.

The Hutcheson Hospital facelift cost of $34 million was discussed. Problems with Hutcheson’s infrastructure and support of physicians were highlighted. Charlie Hawkins, M.D., long time member and supporter of Hutcheson, related the early days of his urology practice at Hutcheson, comparing and contrasting how things have changed. Other members related similar stories of days gone by and many particular friends and colleagues that were fondly remembered for their contributions to the care of our patients in north Georgia.

At the MAG House of Delegates, Dr. Shaw will be serving on reference committee AB or C and Mike Wilson, M.D., will serve as an Alternate Delegate.
Memorial Resolution for James Rhea Lyle, Executive Director, Richmond County Medical Society

WHEREAS, James Rhea Lyle, beloved husband of Avis Ann Rollins Lyle and friend of the Richmond County Medical Society and the Medical Association of Georgia died on Sunday, December 23, 2007; and WHEREAS, James R. Lyle served the Richmond County Medical Society as its Executive Director for nearly 30 years; and WHEREAS, James R. Lyle was invaluable to organized medicine through his success in business owning his own consulting firm, Healthcare Consultants of America and helping physicians across the nation with such topics as medical billing, coding, and practice management, and becoming Executive Director for such specialty societies as the Georgia Association of Pathologists, Georgia Gastroenterological and Endoscopic Society, Georgia-South Carolina Society of Nephrology, Alabama Association of Pathologists, Louisiana Pathology Society and Mississippi Association of Pathologists; and WHEREAS, James R. Lyle was devoted to organized medicine and was an outstanding role model to others for his dedication, professionalism, hard work and community involvement. James R. Lyle was one of the first recipients of the Donna Glass Distinguished Service Award bestowed on him by the Medical Association of Georgia for outstanding service to the Association by a non-physician; and, WHEREAS, James R. Lyle gave to his community his expertise in such programs as the RCMS Project Access assisting the uninsured and working to make health care available to the citizens in and around Augusta, serving as a little league coach, serving on the Community Development Council for St. Joseph’s Hospital and on the Thomson-McDuffie Board of Tourism and serving the Martinez-Evans Rotary Club as president from 1979-1980, THEREFORE BE IT,

RESOLVED, that the Medical Association of Georgia record its profound sense of loss of a thoughtful and caring friend of medicine, and be it further,

RESOLVED, that the Medical Association of Georgia Board of Directors join with the Richmond County Medical Society to recognize the accomplishments of a great man, James R. Lyle, and be it further,

RESOLVED, that the Medical Association of Georgia pay tribute to James R. Lyle for contributions made during his lifetime to the medical profession, the community, and to the physicians members of the Medical Association of Georgia by his service and advocacy on behalf of, and for, all patients and physicians, and be it further,

RESOLVED, that the Medical Association of Georgia Board of Directors extend to Avis Ann Rollins Lyle its deepest sympathy to her and the family of James R. Lyle and its heartfelt thanks for her devotion and support of his never-ending friendship to the physicians of the Medical Association of Georgia, and be it further,

RESOLVED, that the Secretary of the Medical Association of Georgia transmit a copy of this Resolution to Avis Ann Rollins Lyle on this 19th day of April 2008.

Memorial Resolution Expressing Regret at the Passing of Wilma Robertson Tillman

WHEREAS, on Sunday, February 2, 2008, the Family of Medicine in the State of Georgia lost a great friend and lady with the passing of Wilma Robertson Tillman; and

WHEREAS, Wilma was a loving wife to her husband Dr. Ralph Tillman and a devoted mother to their children, Ralph Jr., John Mark, Paul Benjamin, and Pamela Harris and dear friend to all who knew her; and

WHEREAS, Wilma shared much of her time volunteering and participating in activities to benefit local schools, church activities, local, state, and national politics, the DeKalb County Alliance and the Medical Association of Georgia Alliance and numerous other community organizations; and

WHEREAS, Wilma used her talents tirelessly to the benefit of others, her sense of devotion to champion causes dear to her heart, and her sense of humor to make us all smile; and

WHEREAS, Wilma’s actions throughout her life gave inspiration to others and serve as an example to us all; and

WHEREAS, Wilma’s dedication to the work of the DeKalb County and MAG Alliances and for the Family of Medicine in the state of Georgia earned her a Distinguished Service Award from DeKalb Medical Society and an award named in her honor – The Wilma R. Tillman AMA Foundation Award; THEREFORE BE IT

RESOLVED, that the Medical Association of Georgia record its profound sense of loss of a thoughtful and caring friend of medicine, and be it further,

RESOLVED, that the Medical Association of Georgia Board of Directors join with the DeKalb County Medical Society and the DeKalb Medical Society Alliance to recognize the accomplishments of a great woman, Wilma Robertson Tillman, and be it further,

RESOLVED, that the Medical Association of Georgia pay tribute to Wilma Robertson Tillman for contributions made during her lifetime to the medical profession, the community, and to the physicians members of the Medical Association of Georgia by her service and advocacy on behalf of, and for, all patients and physicians, and be it further,

RESOLVED, that the Medical Association of Georgia Board of Directors extend to Dr. Ralph Tillman its deepest sympathy to him and the family of Wilma Robertson Tillman and its heartfelt thanks for her devotion and support of her never-ending friendship to the physicians and spouses of the Medical Association of Georgia, and be it further,

RESOLVED, that the Secretary of the Medical Association of Georgia transmit a copy of this Resolution to Dr. Ralph Tillman on this 26th day of July 2008.
Samady Conducting Cardiac Research Study

Habib Samady, M.D., is an interventional cardiologist at Emory University Hospital and new member of MAG. He and his co-investigators are involved with clinical research studies performed at the Emory University Hospital Cardiac Catheterization Laboratory evaluating patients at risk for coronary disease with persistent chest pain and negative stress tests, or patients with abnormal CT angiograms with unrevealing invasive angiography. Some of these patients may have endothelial dysfunction, microvascular coronary disease, or angiographically unappreciated epicardial coronary disease that require advanced invasive imaging techniques available at the Emory Cardiac Catheterization Laboratories for diagnosis. These novel diagnostic technologies including endothelial function testing, assessment of coronary and fractional flow reserve, intravascular ultrasound, and assessment of coronary wall shear stress are deployed as part of research studies evaluating patients with persistent chest pain syndromes and unappreciated angiographic disease. For more information or referral of patients for such research studies, please contact hsamady@emory.edu or call 404.712.7424.

Chronos Conducting Peripheral Artery Disease Research Study

Peripheral Artery Disease (PAD), often described as “poor circulation,” is diagnosed when the large arteries of the leg narrow thereby restricting blood flow. The tissues then become starved of blood, nutrients and oxygen they need, and in its most advanced form, skin ulcers begin to develop. At this stage PAD, called Critical Limb Ischemia (CLI), the health threat is serious, with the likelihood of amputation or death. There are no prescription drugs available and limited treatments that will delay or prevent amputation.

Nicolas Chronos, M.D., is currently conducting an investigational research study for PAD at the critical stage of CLI with foot and/or leg ulcers. It is anticipated that the investigational study medication may promote new blood vessel growth and may delay the time to amputation and/or death.

The research study is currently seeking qualified participants. Individuals must be 50 years of age or older with stable skin ulcers or non-infected gangrene on a foot or leg; diagnosed with PAD at the stage of Critical Limb Ischemia; and be suitable for bypass or revascularization. Please call to determine eligibility at 1.888.853.4656 or visit www.tamarisstudy.com.

Georgia Chapter of the American College of Cardiology
2008 Annual Scientific Session
November 21-23, 2008
Ritz Carlton Lodge at Lake Oconee

Featuring:
• Heart Failure Symposium: Focus on Non-Pharmacological Interventions
• Interventional, integrated Non-Invasive and Electrophysiology Workshops
• ACC Update from Jack Lewin, CEO, ACC National
• Q & A with Congressman John Lewis
• Poster Presentations
• Lifetime Achievement Award presented to: Willis Williams, M.D.

www.accga.org

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privacy coverage added to your cyber-risk policy. This coverage may need to be amended to cover laptops, computers offsite, paper files and inadvertent breaches of your privacy statement.

Cyber-Risk Coverage Category = Content Liability
• Do you publish your own content on your Web site?
• Do you publish your own non-digital content?
• Do you maintain any third party intellectual property on your network?
• Do you own numerous domain names?

If you answered yes to most of the questions above, you will need content liability coverage added to your cyber-risk policy. This may also need to include non-digital content, coverage for intellectual property and domain name liability.

Cyber-Risk Coverage Category = Other Exposures
• Cyber-risk coverage can be amended to include coverage for notification cost coverage in the event of a breach of network security triggering the various state requirements to notify third parties.
• Crisis management and public relations expense reimbursement coverage may be added.
• Coverage can be added to cover the failure of new technologies such as online prescriptions, appointment handling etc.

Steve Haase possesses more than 30 years experience in risk management and insurance and serves as CEO at insuretrust, one of MAG Mutual Insurance Company’s national carriers for its insured physicians. Mr. Haase’s expertise with regard to Cyber Liability and Technology Errors & Omissions issues, make him an invaluable asset to MAG Mutual and their insured physicians.
Ordinary...or Not?

There is no way to glorify or whitewash the ordinary, and the ordinary isn't something we easily embrace. The term ordinary means common, nothing special, and of no special importance. Most people don't really want to be thought of as ordinary. Yet most people are indeed ordinary. Why even Rex Harrison in his role as Professor Henry Higgins in the film My Fair Lady proclaimed in song that, “I’m an ordinary man.”

Compared to those who haven’t played tennis or golf for 30 years, I’m pretty good. Compared to those who have, however, I’m pretty ordinary.

Most patients want a doctor who’s “the best” and, in fact, most patients would never go to a doctor whose shingle proclaimed “Ordinary Surgeon” or “Ordinary Radiologist” or “Ordinary Pediatrician.”

Indeed, my non-medical friends are all generally convinced that their respective doctors are the best.

It reminds me of the inhabitants of Garrison Keillor’s Lake Wobegon, the fictitious Midwestern town where all women are good-looking, all men are strong, and all children are smart. I’m sure that Lake Wobegon’s physicians were the best, too.

It’s unlikely that this same group of friends would go to a doctor they considered ordinary.

But let’s face it: most people are ordinary, dull as that might sound.

I’ve known hundreds of board-certified radiologists, and I’m familiar with scores of others. At the end of the day, I don’t believe there’s a hair’s difference between the majority of radiologists. We all had the same training, we all took the same courses, and we all took the same tests. We are all competent, ordinary radiologists.

Compare a first-year medical student with someone walking down the street and they might be unique, but compare that same student with another first-year medical student and you’ll see that they’re rather ordinary.

There’s no way a board-certified radiologist’s imaging skills are ordinary in the context of doctors in general; compared to one another, though, and that skill set is ordinary.

I recently asked a pulmonologist if he considered himself special or ordinary. He said he was ordinary in the world of pulmonologists, but he was also confident that he was special versus doctors in general. No surprise.

To me, there’s a world of difference between an ordinary doctor (or person) of any kind and a special or extraordinary doctor (or person). The extraordinary physician might not have better training, be any smarter, or work any harder. No, what makes the ordinary physician extraordinary is the way they treat others, including his or her patients.

It’s a genuine greeting of, “Hello, how are you?” It’s being fun, and it’s being pleasant. It’s returning that phone call. And it’s helping that person who’s lost in the hospital find their way. It’s a simple smile. It’s doing a favor with no strings attached. It’s being sensitive. It’s writing that note during a time of illness. It’s giving that compliment. It’s making decisions that aren’t always based on finances. It’s standing up for someone when they’re not there to stand up for themselves.

When we leave this earth, our legacy and our reputation are intertwined. You will have achieved something special if your spouse and your children and grandchildren remember you as extraordinary. By my definition, I’m an ordinary radiologist. But when I get up each and every morning, my goal is to conduct myself in an extraordinary way. I hope that’s the way others ultimately see me.

Only time will tell if we’ve been successful.

E-mail comments to m3wejr@bellsouth.net. Dr. Coffsky and his wife, Sandy, have been married 49 years and have three children and eight grandchildren. He started his 42nd year at DeKalb Medical Center in June.

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