THE BULLETIN

OKLAHOMA COUNTY MEDICAL SOCIETY MAY/JUNE 2015

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A: "5-Star" Banking

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May/June Volume 88 Number 3
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ABOUT THE COVER

Thousands of people will be in downtown Oklahoma City June 10-14, 2015, to celebrate the 15th anniversary of the deadCENTER film festival. Each year the festival brings the best and brightest filmmakers from around the world to mingle with Oklahoma filmmakers and fans. Since 2001, more than 1,400 independent films have been screened here, and the festival has grown from a one-night screening to a five-day world-renowned festival.

In addition to the festival, deadCENTER also provides an education program that reaches more than 3,000 high school and career tech students each fall, which was honored in 2014 by the Oklahoma State Arts Council with the Governor's Arts Award for Education. In 2013, deadCENTER also launched deadCENTER University for high school students held during the summer festival.

Festival headquarters this year is the OKC Museum of Arts. Films will be screened there and at Harkins Bricktown Cinemas, Devon Energy Auditorium, the Paramount on Film Row, the Myriad Gardens Terrace Room and outdoors at the Myriad Gardens Grand Lawn. The Opening Night Party will be Thursday, June 11, on the rooftop of the OKC Museum of Art.

Fans can experience the film festival with either an All-Access Pass or with individual tickets. For more information, please visit www.deadcenterfilm.org.

OCMS
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PRESIDENT'S PAGE

By C. Douglas Folger, MD

It was one week from the deadline for this President's Page and my thoughts were well organized to share my experience from the AMA Advocacy Conference in Washington D.C. that I attended in late February. I thumbed through the March edition of the OSMA Journal to find that OSMA President Todd Brockman had already beautifully described the highlights of the conference in his column. My calendar was busy in the week to come, and I felt the stress of time pressure as I contemplated what to say in this President's Page. I was already feeling like there was too much that needed to be done in the time available. I realized that we physicians often feel this way during our busy careers. My thoughts then drifted to the present day common problem of physician burnout.

Over the past few years, much has been written about the increasing and disturbing incidence of physician burnout, which is often described as emotional and physical exhaustion, loss of enthusiasm for work, and a tendency to become cynical. In 2012, the Archives of Internal Medicine published a national survey that revealed that physicians in America experience more burnout than other workers in this country. The 2015 "Medscape Physician Lifestyle Report" revealed that 46% of responding physicians reported experiencing burnout, compared with slightly less than 40% of the respondents from the 2013 report.

The 2015 Medscape survey noted the highest burnout rates in critical care (53%), emergency medicine (52%), and general internal medicine, family medicine, and general surgery (50%). There was a 16% increase in burnout for family physicians and general internists from the 2013 survey to the 2015 survey. Burnout rates among the various specialties ranged from 53% to a low of 37%. Roughly 10% of the physicians in the top three burnout rates reported that they were thinking of leaving the practice of medicine altogether.

Interestingly, the major perceived causes of physician burnout have not changed between the 2013 and 2015 Medscape surveys. In both surveys, too many bureaucratic tasks, too many work hours, increasing computerization of practice, and the impact of the Affordable Care Act have been among the top five items of dissatisfaction. Too many bureaucratic tasks have led the lists in both surveys. Physicians are feeling that too much of their time is devoted to serving as data input technicians, rather than as connected, empathic, patient-centered care givers. The regulatory requirements of meaningful use, PQRS, and ICD-10 have placed a major stress on physicians as we strive to provide high quality, compassionate care to our patients.

Physicians feel that too many requirements have been mandated too quickly to be comfortably incorporated into their day-to-day practice, and they are unhappy about the punitive reimbursement cuts that will occur if the mandates are not made correctly

Continues on page 6 …

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and on time. Also, the implementation of Electronic Medical Records has added extra daily work hours for many physicians. Lastly, the increasingly rigorous requirements for Maintenance of Certification have placed increased financial and time demands on physicians' already heavy loads. All of these distractions tend to take us away from what we love to do---spend our time effectively relating to our patients as we care for them. The end result for many seems to be burnout, and for some, depression and a negative impact on patient care.

A good deal of work has been done looking at various activities beyond maintaining a healthy lifestyle that might decrease or prevent burnout. A 2014 Cochrane review reported a number of activities that can reduce stress in physicians, including cognitive-behavioral training, massage, meditation, changing work schedules, and the practice of "mindfulness." As you may recall, Dr. Murali Krishna wrote a great article in the January/February issue of the Bulletin which described, in detail, the practice of mindfulness for reducing stress.

I am pleased to see organized medicine, at all levels, working to create a better working environment for physicians. Locally, due to the tireless efforts of Dr. Don Murray and colleagues, meaningful tort reform in Oklahoma was passed. Due to much input from OCMS and OSMA physicians and our hard-working lobbyists, we were able to negotiate and get passed a reasonable Prescription Monitoring bill by the state Legislature. Because of strong national physicians' advocacy at the AMA level, it appears that there may be a permanent fix to the SGR, and the ABIM has agreed to readdress the Maintenance of Certification process. It is my hope that through increasing physician advocacy at all levels, nationwide, we will be able to create an environment, over time, that alleviates some of the stresses that are presently leading to physician burnout.

DEAN'S PAGE

By M. Dewayne Andrews, MD, MACP

Graduate Medical Education – residency training – is essential in the American medical education and practice system. We've all gone through residency training; we can't get a license to practice medicine without successfully completing residency training. Graduate medical education positions – not medical school enrollment – are actually the final regulator of the physician workforce for the United States. Despite this well-known fact, the U.S. Congress continually delays effectively addressing the dilemma of the right number of GME positions in the right places as a significant component of facing the looming physician shortage in the U.S.

The U.S. Census Bureau projects a 9.7% increase in the U.S. population by 2025, with a tremendous increase in the component of those over age 65. By 2025, according to the best estimates and projections, the demand for physician services will exceed supply by a range of 46,000 to 90,000 physicians. While physicians are now retiring an average of two years later than for most of the tracked history of the physician workforce, the projected physician shortages persist under every likely scenario studied by experts on physician workforce.

American medical schools have for the past decade responded to the call to increase student enrollment, and new medical schools have developed in states where population growth has been rapid. Overall, by 2017, U.S. medical schools will have increased the medical student enrollment by 30% since 2005. But what about GME positions, which medical schools alone cannot create?

During the 2015 residency "Match," approximately 1,100 U.S. medical school seniors were unmatched. After the SOAP (Supplemental Offer and Acceptance Program–what we used to call the "scramble"), there are still approximately 450 U.S. medical seniors graduating who have not yet obtained a PGY-1 residency position. In addition, 2,354 U.S. citizen International Medical Graduates (US IMG) applying in the Match were unmatched. While some students are unmatched because of unrealistic assessment of their likelihood of success in obtaining a place in highly competitive residency programs, the fact remains that we don't have enough GME positions in the country to match the need for physicians.

Medical education and Graduate Medical Education were declared a "public good" in the 1960s, and teaching hospitals were directly affected through Medicare payments recognizing that declaration. The fact that GME has been tied to Medicare funding since 1964 no doubt accounts for the repeated failure of Congress to address this problem. Some states, including Oklahoma (Physician Manpower Training Commission), have taken on the funding of some GME positions but the number is small overall and usually targeted toward primary care only. The aging population is going to need specialists as well as primary care physicians.

Continues on page 9 …

DEAN'S PAGE *Continued from page 7 …*

As health care market forces continue to change the health care landscape, and as the Affordable Care Act continues implementation over the next 2-3 years, greater pressures will emerge on the physician workforce. The U.S., through both federal and state initiatives and solutions, must address the critically important issue of GME and its importance to the physician workforce and the health care needs of its citizens. Up to the present, recommended solutions have been rebuffed. However, I remain optimistic that progress can be made during 2016, but of course it's an election year …

THE BULLETIN

OCMS
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NEW! FOR MEMBERS ONLY!

OCMS members now can access the new 'for members only' portion of the OCMS website at www.o-c-m-s.org/members. You also can access it from the OCMS website front page by clicking on the 'For OCMS Members' blue ball.
The site includes access to member benefits including:

- free legal advice
- educational webinars (our next ones will focus on the topic of wealth management)
- job postings

The site is easy to access! After clicking on the 'members only' page, type in your email address and then type in ocmsmember as your password. You are strongly encouraged to change your password after logging in for the first time. If you have any questions about logging in, please contact us at 702-0500.

IN MEMORIAM

CHARLES DELHOTAL, MD
1919-2015

CLARENCE ROBISON, MD
1924-2015

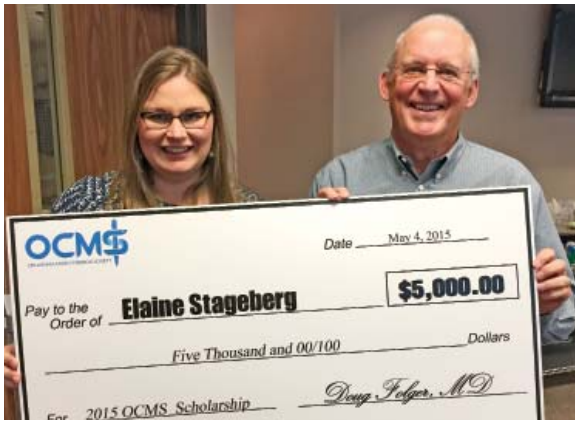
JOSEPH DUDLEY POWERS, MD
1927-2015

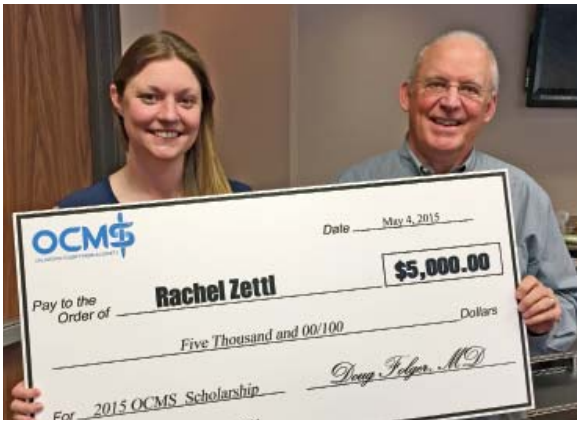
THOMAS R. RUSSELL, MD
1939-2015

K.A. MEHTA, MD
1943-2015

KATHRYN ANN TRISSELL, MD
1957-2015

ELAINE STAGEBERG AND RACHEL ZETTL
2015 MEDICAL STUDENT SCHOLARSHIP WINNERS





The Oklahoma County Medical Society Community Foundation is pleased to announce its 2015 recipients of the OCMS Medical Student Scholarship.

The winners are Elaine Stageberg and Rachel Zettl, both third-year medical students at the OU College of Medicine. Each will receive a $5,000 scholarship toward their fourth-year tuition.

Elaine Stageberg began life in poverty and family instability. After becoming emancipated at age 16, she supported herself through high school and college, eventually earning a master's degree of health administration at the OU College of Public Health before starting medical school at OU College of Medicine.

Elaine is heavily involved in the community. Among other activities, she serves as the vice president of the OU Community Health Alliance, a group that coordinates free clinics in Oklahoma City and that partners with the Health Alliance for the Uninsured (HAU). As part of her scholarship, she will serve as an ex-officio member of the HAU Board of Directors for one year. She plans to pursue a residency in either family medicine or emergency medicine, and to work caring and advocating for the underserved and uninsured. She is married to Nick Stageberg and is expecting their first child.

Rachel Zettl grew up in rural Oklahoma as the eldest child of a single mother and subsequently 'learned a lot about the low income side of health care." She attended Oklahoma City University, earning a bachelor's degree and a master's degree in education before starting medical school.

Among other activities, she is a 2015 EPIC Scholar (Empowering Patients through Interprofessional Collaboration), a volunteer at the Good Shepherd Medical and Dental Clinics, and a volunteer/teacher with the Community Health Care Alliance.

Because she grew up in a rural area, she saw first-hand the struggles that low-income rural residents face. As a result, her passion is to improve health for low-income and rural residents. Eventually she hopes to "employ nutritionists, social workers, counselors, physical and occupational therapists, family medicine physicians, psychiatrists, physician assistants, nurse practitioners, and other health care professionals" to staff medical homes where multiple needs can be met at one location.

As part of her scholarship, she will serve as an ex-officio member of the OCMS Board of Directors for one year. She is married to Jared P. Zettl, who is an OU student.

The Oklahoma County Medical Society takes applications for this scholarship in January from third-year medical students at the OU College of Medicine. Applicants must have been a resident of Oklahoma County for at least five years.

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THE POET'S SPOT

He died suddenly from a heart attack at 46,
leaving his wife and four children,
praying to God for help and understanding.

WHEN A YOUNG FATHER DIES

(A Sonnet)

BY HANNAH SADDAH, MD

Dear Lord, why did you take his age away
And left us all to age in slow decay
Perhaps you wished, that he should never gray
That in our memories his youth should stay.

You're as unintelligible as life
This mad mélange of sorrows, joys, and strife
Which our faith accepts, but not our mind
We yearn, we plead, we search, but do not find.

How make we less this gnawing pain of loss
This loss of love, of nurture, and of friend
How do we bear this sudden, hefty cross?
That once you bore to bless our final end.

You sentenced him to stay forever young
Pray, sentence us to stay forever strong.

The Physicians Payments Sunshine Act[1] (the Sunshine Act), despite its name, currently places no direct reporting requirements on physicians. Rather, the Sunshine Act requires that certain manufacturers of prescription drugs, biologic agents, medical devices and medical supplies (Manufacturers) and group purchasing organizations (GPOs) report to Centers for Medicare and Medicaid Services (CMS) payments in specified amounts[2] and other transfers of value to physicians[3] and to teaching hospitals.[4] In addition, ownership and investment interests in applicable Manufacturers and GPOs held by physicians and immediate family members must be reported annually by applicable Manufacturers and GPOs. Covered payments include cash (or cash equivalent, in-kind items or services), stock (including stock options or ownership interest dividend profit or other return on investment), and other forms of payment to be determined in the future by CMS.

PHYSICIAN PAYMENTS SUNSHINE ACT FOCUSES ON FINANCIAL TIES BETWEEN PHYSICIANS AND INDUSTRY

By Mary Holloway Richard, J.D., M.P.H.

While it is not the physician's duty to report, the reporting requirement directly impacts physicians who receive such payments, as their names appear on a list on the CMS website accessible by patients and other consumers.[5]

The purpose of the Sunshine Act is to identify potential biases in physician prescribing and treatment practices, to reveal conflicts of interest for clinical researchers and educators, and to identify transactions in which payments involving potential referrals by physicians exceed fair market value. The Sunshine Act creates the Open Payments Program for the actual reporting of the financial payments and transfers of value to physicians. Currently the burden is on the Manufacturers to report payments for consulting fees, contracted services, honoraria, gifts, entertainment, food, travel, education, research, charitable contributions, royalty or license, current or prospective ownership or investment interest, grants, direct compensation for serving as faculty or speaking at a medical education program, and any other nature of payment or transfer of value as defined by the Secretary of the Department of Health and Human Services (HHS). The form of the payment and the nature of the payment must be reported (see Table 1). Data has been collected since August 2013, and is due to CMS by March 31 of each year. The first report was available to the public on Sept. 30, 2014, and the 2014 report is predicted to be available on June 30, 2015.[6]

The regulations provide for a formal dispute resolution process whereby physicians can seek to correct inaccurate information. In September 2014, representatives of pharmaceutical and biotechnology companies and organized medicine expressed concerns about the database and its presentation of data to the public in a potentially misleading manner. CMS shut down the Open

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Payments system for a period of time to address these issues. On Oct. 30, 2014, CMS announced a procedure for Manufacturers and GPOs to report information not previously accepted by the system because of data errors, and CMS extended the reporting time accordingly. CMS has provided guides for Manufacturers to use to correct records and for covered recipients to correct information submitted in compliance with the regulations.[7]

Registration with CMS to receive notifications and information submitted by Manufacturers and GPOs is voluntary. This information is now available on the CMS website, to public and regulators alike, but the website itself continues to present issues of accuracy and ease of on-line accessibility. Physicians and teaching hospital representatives have the opportunity to review and, if appropriate, dispute information reported about them in the Open Payments system.[8]

It has been necessary to resolve a number of procedural and substantive issues with the reporting requirements, including initial confusion about the information that had to be reported and by whom. Example of substantive issues to be resolved may be helpful is understanding the regulatory climate. Some confusion has surrounded the CMS treatment of payments related to continuing medical education. "Direct payments" have always been included in the Sunshine Act's reporting requirements. "Indirect payments" refers to payments by a Manufacturer to a continuing education organization where the Manufacturer directs that the third party provide the payment or transfer to a covered recipient. In the October 2014 final regulations, CMS responded to widespread criticism of its treatment of the CME by requiring reporting in 2017 payments (direct and indirect) made to continuing education organizations in 2016 as long as the speaker can be identified.[9]

Further, payments to physicians for speaking at CME programs need not be reported if the following conditions are met:

- The CME program meets accreditation/certification standards of one of the following: (1) the Accreditation Council for Continuing Medical Education, (2) the American Academy of Family Physicians, (3) the American Dental Association's Continuing Education Recognition Program, (4) the American Medical Association, and (5) the American Osteopathic Association, and
- the Manufacturer or GPO does not pay the speaker directly; and
- the Manufacturer or GPO does not select the speaker or provide the third party, such as the CME vendor, with a distinct, identifiable set of individuals to be considered as speakers for the CME program.[10]

Other frequent questions concern Manufacturers providing meals and other event support and sponsorships to physicians. In this context, the Open Payments program is very specific, e.g., where a Manufacturer's sales representative brings a meal to a staff meeting or a community education event for a number of persons, the cost of the meal is divided by the number of persons who actually eat the meal and this benefit is reported only if it exceeds $10 per person. This does not include meals eaten by support staff. Financial support of buffet meals at large-scale medical conferences is not reportable. The "User Guide" for Open Payments published by CMS is over 350 pages long and provides additional guidance to those reporting and those reviewing reports. It is accessible online here: www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Downloads/Open-Payments-User-Guide-[June-2014].pdf.[11]

The Open Payments system is expected to significantly impact historic financial support of provider, patient and community education by industry. Importantly, these regulations and reporting requirements echo federal policy designed to avoid improper payments and incentives and market influence. These are the same concerns that spawned the expansion of federal antitrust, Stark and Anti-kickback law within health care.

Mary Richard is a health care lawyer at Phillips Murrah, P.C. in Oklahoma City and was formerly in house counsel with INTEGRIS Health, Inc.

THE NATURES OF PAYMENT THAT ARE OF INTEREST TO CMS

Nature of payment	Definition	Examples
Consulting fee	Payments made to physicians for advice and expertise on a particular medical product or treatment, typically provided under a written agreement and in response to a particular business need. These payments often vary depending on the experience of the physician being consulted.	Example 1: Company A has developed a drug to treat patients with a particular disease and wants advice from physicians on how to design a large study to test the drug on patients. Dr. J has a large number of patients with this disease and has experience doing research on how well medicines work for this condition. Company A asks Dr. J if he would spend about 10 hours per month to work with other physicians to create a new research study. Dr. J agrees and is paid for his time. Example 2: Company C has designed a new tool for surgeons to use when they are doing heart surgery. The company pays some physicians to give the new tool a “test drive” on a computer-simulated patient at the company headquarters. The physicians are paid an hourly fee for their time testing the tool and giving advice on how to make it work better. They are also paid for flights, hotel rooms and meals.
Compensation for services other than consulting, including serving as faculty or as a speaker at an event other than a continuing education program.	Payments made to physicians for speaking, training, and education engagements that are not for continuing education.	A physician who frequently prescribes a particular drug is invited by the company that makes that drug to talk about the medicine to other physicians at a local restaurant. The physician is paid for preparation time as well as the time spent giving the talk.
Honoraria	Similar to consulting fees, but generally reserved for a one-time, short duration activity. Also distinguishable in that they are generally provided for services which custom prohibits a price from being set.	A medical device manufacturer representative goes to a medical meeting and asks some physicians there for an hour of their time to talk about features they would like to see to improve a particular device. This representative pays each physician a one-time honorarium.

Table 1.

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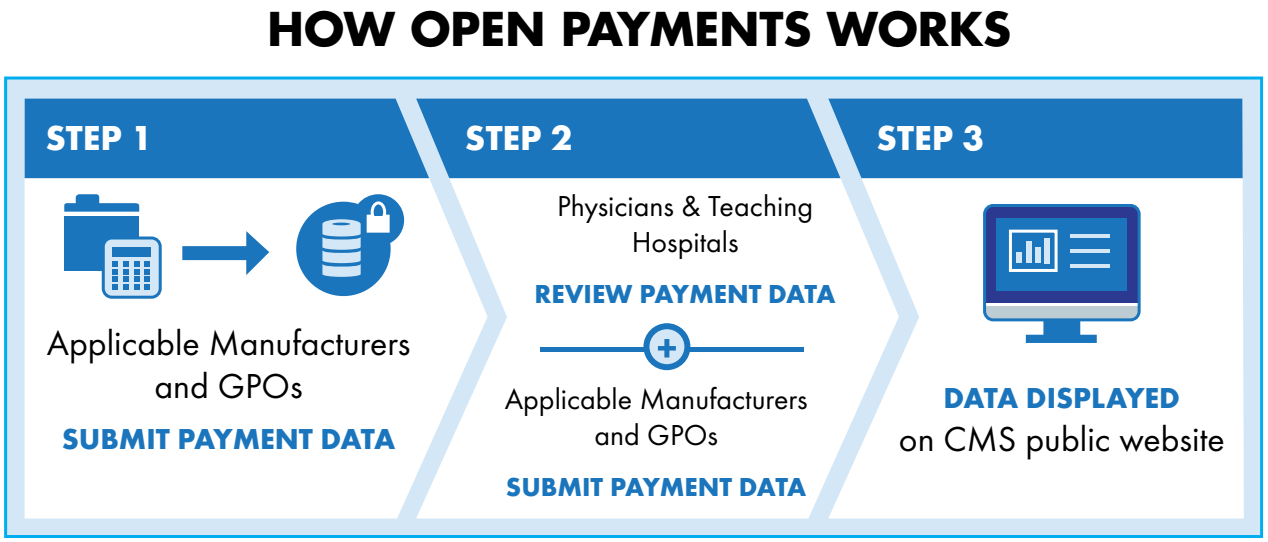

Flow Chart 1. Source: https://www.cms.gov/OpenPayments/About/How-Open_Payments_Works.html

[1] The Physician Payment Sunshine Act is Section 6002 of the Patient Protection and Affordable Care Act, 42 U.S.C.§18001. The regulations can be found at: http://www.cms.gov/OpenPayments/Downloads/Affordable-Care-Act-Section-6002-Final-Rule.pdf.

[2] There are specific reporting thresholds for applicable manufacturers and GPOs. The Open Payments reporting thresholds are adjusted based on the consumer price index. This means that for 2015 (January 1 – December 31), if a payment or other transfer of value is less than $10.21 ($10.00 for 2013, $10.18 for 2014), unless the aggregate amount transferred to, requested by, or designated on behalf of a physician or teaching hospital exceeds $102.07 in a calendar year ($100.00 for 2013, $101.75 for 2014), it is excluded from the reporting requirements under Open Payments. http://www.cms.gov/OpenPayments/Program-Participants/Applicable-Manufacturers-and-GPOs/Data-Collection.html.

[3] This law applies to physicians and other providers, but, for the purposes of this article, we will only reference physicians. The other providers as defined in Section 1861(r) of the Social Security Act to whom this law applies include medical and osteopathic physicians, dentists, podiatrists, optometrists and chiropractors. Providers exempted include medical and osteopathic residents, physician assistants, nurse practitioners and allied health practitioners. However, in some circumstances, payments to these types of providers may be imputed to physicians, thereby triggering the Manufacturers' obligations to report payments.

[4] Manufacturers and GPOs may also be referred to in this paper as "covered recipients."

[5] https://openpaymentsdata.cms.gov/.

[6] http://www.cms.gov/OpenPayments/About/Resources.html

[7] The American Medical Association offers a toolkit for physicians to use in reviewing and dispute reports at: http://www.ama-assn.org/ama/pub/advocacy/topics/sunshine-act-and-physician-financial-transparency-reports/sunshine-act-toolkit.page?

[8] See Flow Chart 1.

[9] 42 C.F.R. §403.902.

[10] 42 C.F.R. §403.904(g).

[11] www.cms.gov/Regulations-and-Guidance/Legislation/National-Physician-Payment-Transparency-Program/Download/Open-Payments-User-Guide-[June-2014].pdf.

WELCOME NEW MEMBERS!

Shaurin N. Patel, MD, is a board-certified OB/GYN in Oklahoma City. He completed medical school at the OU College of Medicine, an internship at Nassau University Medical Center in New York in OB/GYN, and a residency at UMDNJ-Camden in OB/GYN.

Alyson Willis, DO, is a board-certified OB/GYN in Oklahoma City. She completed medical school at Oklahoma State University and a residency at St. Anthony Hospital in Oklahoma City.

Toby Broussard, MD, is a board-certified general surgeon in Oklahoma City. He completed medical school at Louisiana State University Medical School in Shreveport, LA, and an internship and residency at Carraway Methodist Medical Center in Birmingham, AL.

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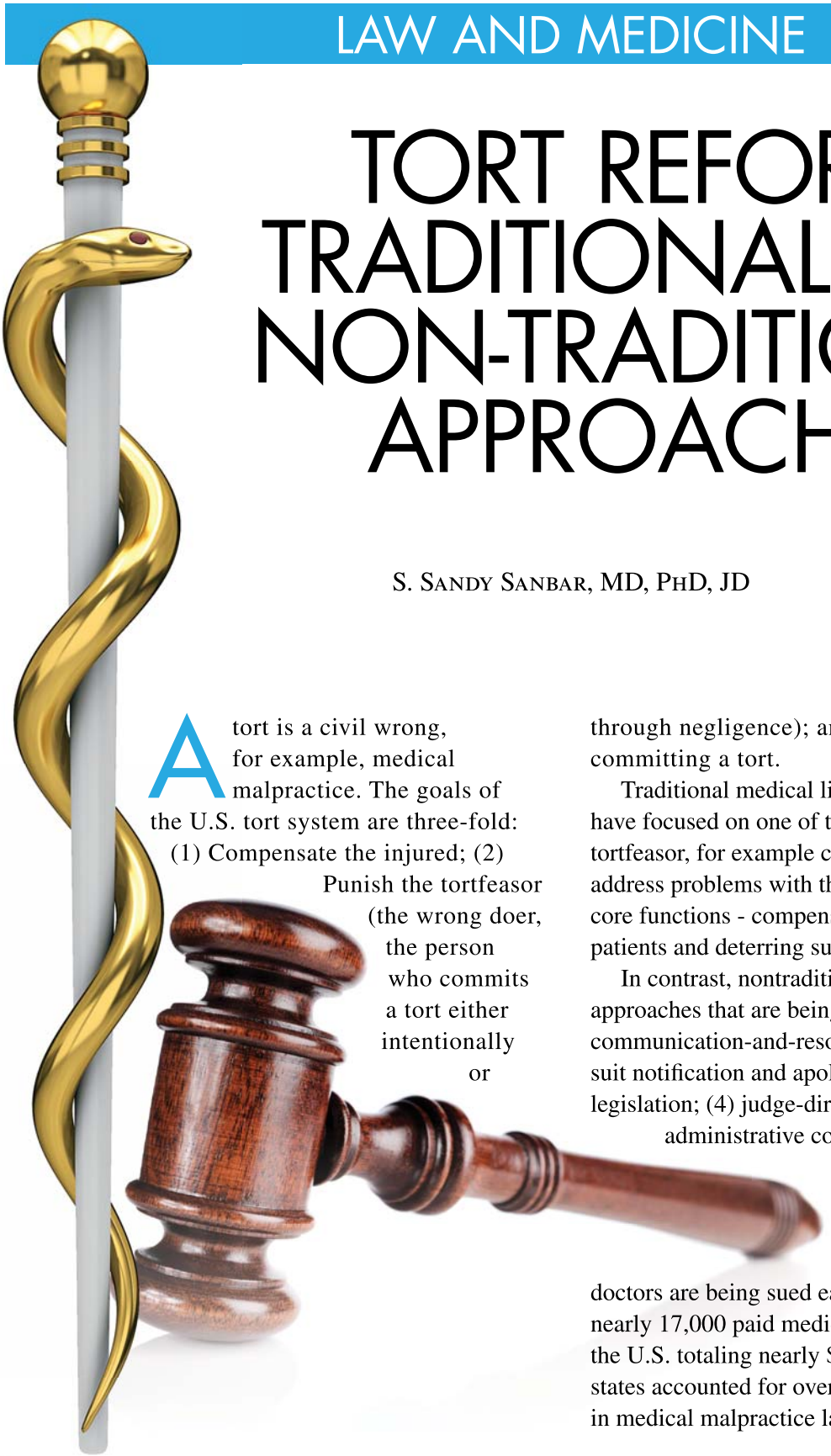
OCMS 2015 BOARD OF DIRECTORS

2015 Members of the OCMS Board of Directors are (front row, left to right): David L. Holden, MD, Vice President; Sam S. Dahr, MD, Secretary/Treasurer; Julie Strebel Hager, MD, Past President; Renee Grau, MD; C. Douglas Folger, MD, 2015 President; and (back row, left to right): Lisa Wasemiller-Smith, MD; Thomas H. Flesher, III, MD; R. Kevin Moore, MD; Don L. Wilber, MD, President-Elect; Don P. Murray, MD; and J. Samuel Little, MD. (Not pictured are Joseph C. Broome, MD; Louis M. Chambers, MD; Jason S. Lees, MD; James A. Totoro, MD; Baolien Tu, MD; and Duc M. Tu, MD.)

TORT REFORM: TRADITIONAL AND NON-TRADITIONAL APPROACHES

S. Sandy Sanbar, MD, PhD, JD



A tort is a civil wrong, for example, medical malpractice. The goals of the U.S. tort system are three-fold: (1) Compensate the injured; (2) Punish the tortfeasor (the wrong doer, the person who commits a tort either intentionally or through negligence); and (3) Deter others from committing a tort.

Traditional medical liability reform approaches have focused on one of the goals, punishment of the tortfeasor, for example caps on damages. They do not address problems with the malpractice system's two core functions - compensating negligently injured patients and deterring substandard care.

In contrast, nontraditional medical liability reform approaches that are being evaluated include: (1) communication-and-resolution programs; (2) pre-suit notification and apology laws; (3) safe harbor legislation; (4) judge-directed negotiation; and (5) administrative compensation systems.

During the past 10 years, the cost of medical malpractice has been dropping nationally. Fewer doctors are being sued each year.[1] In 2003, there were nearly 17,000 paid medical malpractice claims in the U.S. totaling nearly $4.5 billion. In 2010, six states accounted for over half of all the money spent in medical malpractice law suits, and one fifth of all

the money spent on medical malpractice was spent on suits in New York.

By 2011, the number of paid claims dropped below 10,000 and the total amount paid was less than $3.2 billion. That's a 40% drop in the number of paid claims and a 29% drop in the total amount paid. In a study of the financial records for 387 California hospitals, the average that hospitals paid for malpractice in 2003 was just over 1% of their total income. By 2011 that had dropped to just over six-tenths of a percent of their income, a nearly 40% drop.

In 2014, Mello, Studdert and Kachalia[2] reviewed traditional and nontraditional approaches to medical liability reform. They pointed out that state legislatures have enacted tort reforms, such as caps on damages, in an effort to reduce the volume and costs of malpractice litigation. However, attempts to introduce similar traditional reform measures at the federal level have so far been unsuccessful. Furthermore, caps on damages have been ruled unconstitutional, most recently in Florida in 2014.[3] The Florida Supreme Court held that the cap on wrongful death noneconomic damages provided in section 766.118, Florida Statutes, violates the Equal Protection Clause of the Florida Constitution.

Mello and coworkers obtained data from the National Practitioner Data Bank and the American Medical Association's Physician Masterfile to determine trends in the rate of paid claims against doctors of medicine (MDs) and doctors of osteopathy (DOs) between 1994 and 2013. They also examined trends in liability insurance premiums by using data from the Medical Liability Monitor's Annual Rate Survey and the average annual premiums charged over the same period in certain counties of five states: California, New York, Illinois, Tennessee and Colorado. The trends in liability insurance premiums in the five locations examined presented a mixed picture.

The authors found that the rates of paid claims against physicians have decreased since the early 2000s. For MDs, the rate decreased from 18.6 to 9.9 paid claims per 1,000 physicians between 2002 and 2013, with an estimated annual average decrease of 6.3% for MDs and 5.3% for DOs over this period.

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The median indemnity amount among paid claims increased by 63% in 2013 adjusted dollars between 1994 ($133,799) and 2007 ($218,400), an average annual increase of 5% per year. Since 2007, median indemnity has declined slightly, reaching $195,000 in 2013, an average annual decrease of 1.1%.

Nontraditional liability reform approaches are politically and ethically appealing. They benefit the physicians, insurers and patients. They address the underlying problems in the liability system: (a) barriers to filing claims, (b) expensive battles of the experts, (c) the protracted litigation process, and (d) the chilling effects that a highly adversarial and stigmatizing process has on medical error transparency.

Sage[4] noted in an accompanying editorial that approaches that accelerate the recognition of medical errors and the resolution of disputes are likely to further both monetary and nonmonetary goals of malpractice reform. He stated that, "Conventional litigation thrives on delay, producing a host of ill effects. Patients and families are denied critical information and assistance. Timely feedback for safety improvement is impossible. Administrative costs mount. Compensation is withheld but emotional pain and adversarial stress are not. Over the longer term, delay exacerbates actuarial uncertainty for liability insurers and increases the vulnerability of insurance markets. A major advantage of communication-and-resolution programs and most of the other liability reforms evaluated by Mello and colleagues, therefore, is that they save time."

THE BULLETIN

[1] http://www.huffingtonpost.com/david-belk/medical-malpractice-costs_b_4171189.html

[2] The Medical Liability Climate and Prospects for Reform, Michelle M. Mello, JD, PhD, MPhil; David M. Studdert, LLB, ScD, MPH; Allen Kachalia, MD, JD, JAMA, doi:10.1001/jama.2014.10705, published 30 October 2014.

[3] http://www.floridasupremecourt.org/decisions/2014/sc11-1148.pdf

[4] Medical Malpractice Reform When Is It About Money? Why Is It About Time?, William M. Sage, MD, JD, JAMA, doi:10.1001/jama.2014.15416, published 30 October 2014.

DIRECTOR'S DIALOGUE

By Jana Timberlake, Executive Director

"Life is a journey, not a destination."

~Ralph Waldo Emerson

During the month of April, goodbyes were said to two wonderful physicians – K. A. Mehta, MD, and Clarence Robison, Jr., MD. While Dr. Mehta's passing was unexpected, Dr. Robison had experienced failing health for several years. After attending both of their funerals, I reflected on their characters, their love of practicing medicine, the care their patients received and how much they each gave of themselves for the good of the medical profession. Both were surgeons who each had a positive impact on organized medicine at the county, state and national levels. And being a doctor was not what they did, it was who they were.

Dr. Mehta's two sons opened and closed the eulogy portion of his funeral, with friends and colleagues also sharing their memories. Each son's description of their father differed in some ways, but both stated that no matter how busy he was or how little sleep he had, Dr. Mehta always managed to attend their functions. And they both shared his example of how to be good husbands and fathers – by demonstrating his deep love and respect for Dr. Su Mehta.

He was a kind man, who did not have to raise his voice to make a point, and was well respected in this medical community. Early in my tenure as Executive Director, I grew to understand that Dr. Mehta's only "agenda" was to do what was right. Never did I doubt that he would give sound, thoughtful advice, and I asked for it on many occasions. Many of you know that he had a great sense of humor. His facial expression would always give him away before the funny thought bubbled to the surface – you know, when he had that twinkle in his eye, accompanied with a glimmer of a smile.

Dr. Robison's funeral was the next day, and I walked into the church with a heavy heart. But attending this funeral brought me much more comfort than my presence gave his family. I've never heard such a funny obituary/eulogy! Barbara Jett was seated next to me, and we both laughed out loud at the many stories shared by his son, John. It was perfect because it was Dr. Robison – and delivered by a son who resembles his father very much. It was almost as if I was looking at a young Dr. Robison talking about a life well lived! Included were remembrances of the volumes of stories his father could tell, the trips, the "requirement" for everyone to "read up" on their destinations, and the many "historical markers" along the way that the family was required to read not once, but twice.

Continues on page 25 …

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(Seated, l-r) Stefanie E. Rollins, APRN-CNP, Karen L. Gregory, DNP, Patricia I. Overhulser, M.D., Florina Neagu, M.D. and Laura K. Chong, M.D.

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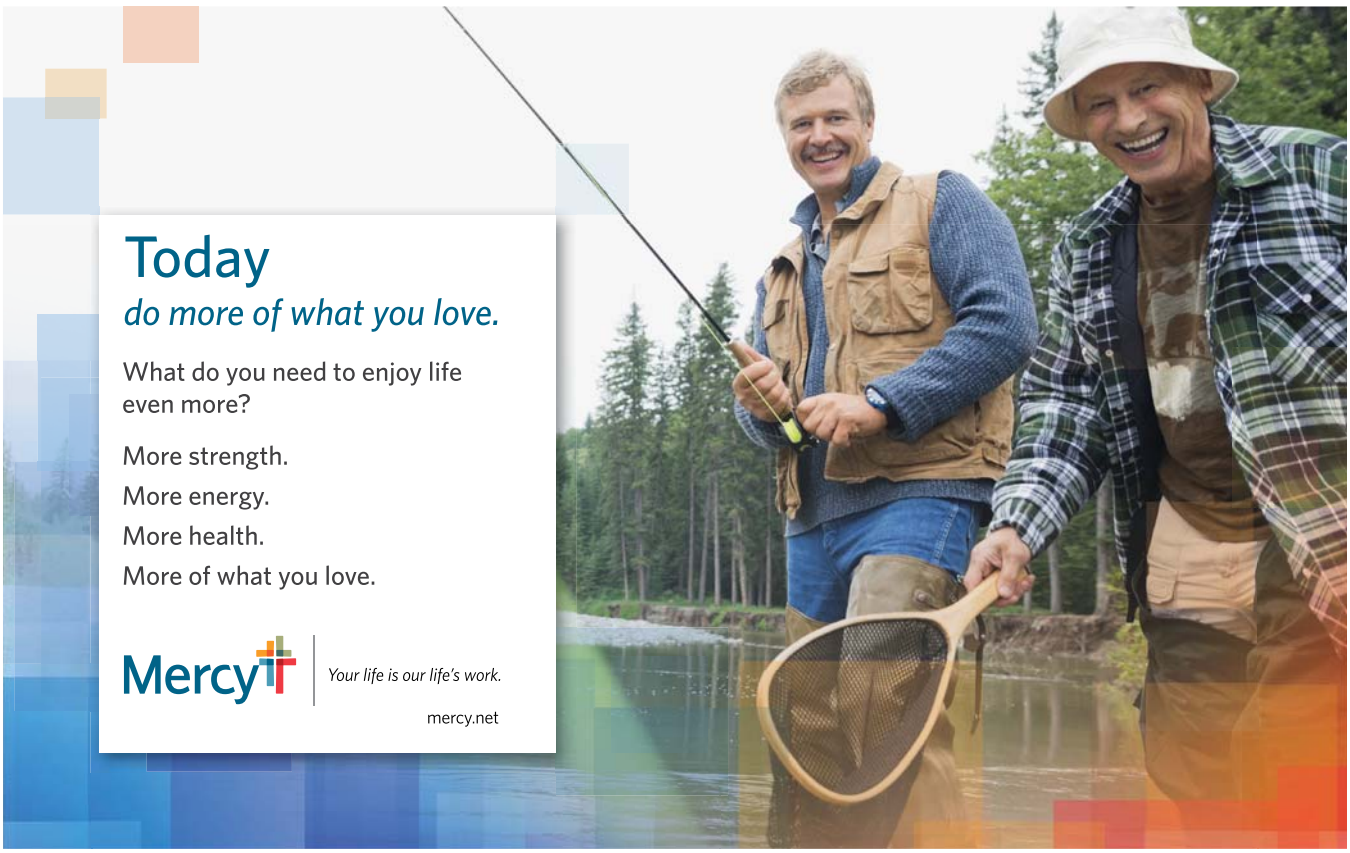
 Continued from page 23 …

Dr. Robison loved practicing medicine, and he loved his patients. When the minister asked for a show of hands of his patients who were in attendance, many hands shot into the air, wanting to honor the man who saved their lives.

He could tell a joke, fly a plane and write a story. He also loved to travel. It was in this context that the minister shared Dr. Robison's traveling motto to his children – it's not about the destination but the journey.

I believe it was "about the destination" for both of these gifted physicians – both so different but alike in many ways. My life was better because of them. And for those who knew them, they would probably say, "ditto." May they both rest in peace …



DANCING DOCTORS

Several of our OCMS members compete in ballroom dancing competitions in Oklahoma City. Shown are (left to right): Mark Mellow, MD; Renee Roy, MD; Laura Rankin, MD; and Bill McGuire, MD. This photo was taken in February at the 2015 Oklahoma Challenge at the Renaissance in Oklahoma City, sponsored by Dance Makers Studio in Edmond.

50-YEAR PHYSICIANS HONORED AT OCMS MEMBERSHIP MEETING MARCH 2

Front Row, left to right: Gary Rahe, MD; Sarah "Betty" Ayres, MD; G. M. Pujari, MD; and Martha Tarpay, MD

Back Row, left to right: Kent Potts, MD; Charles Coker, MD; Stanley Chard, MD; John Bozalis, MD; and Richard Dawson, MD

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