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Summary Notes of the Health Care Community Meeting
22 December, 2008, 1800 – 2000 hours
Alachua County Health Department Auditorium
224 South East 24th Street
Gainesville, Florida

Co-Conveners:

David Black, MD, Dipl. AAFP
Community Family Practice
Gainesville, Florida

A. Joseph Layon, MD, FACP

Professor of Anesthesiology, Surgery, and Medicine
Chief, Division of Critical Care Medicine
University of Florida College of Medicine

Medical Director, Gainesville Fire Rescue Service
Gainesville, Florida

Executive Summary

- Twenty-seven participants took part in the meeting;
- All felt that Quality, Prevention, and Access were central issues that must be dealt with;
- In this context, evidence-based, patient centered, highest-quality primary care was considered central to a reformed health care system;
- Health promotion and disease management, through education nutrition, exercise and so forth are considered of major importance if we are to avoid overwhelming our system of health care provision;
- Recognizing that highest-quality primary care and disease prevention takes on a central role in this new health system, access to specialty care and services must be protected;
- Care provision must be universal and records must be electronic and portable;
- Academic medical centers, drivers of discovery and quality, must be nurtured;
- A National Center for Clinical Excellence, such as the one in the British National Health Service, needs be organized for our reformed health system. This Center would assist in the evaluation and designation of best practices, technology assessments, and so forth;
- Home health care must be a part of the reformed health system;
- Mental health services must be part of the reformed health system;
- The Secretary of Health and Human Services should empanel a small group to visit other countries with excellence in health to learn from them and bring their advances to our system.

Introduction:

Responding to the request of Secretary Daschle, a meeting of concerned citizens was called for 22 December to discuss needed alterations in the health care system. Because the Secretary's call left little time for planning, the meeting was pulled together on short notice¹. A request was made to the Alachua County Medical Society, the local newspaper (*The Gainesville Sun*), and the University of Florida College of Medicine administration to send out notices for this meeting; only the ACMS was able to comply².

The participants met at the above-cite location and, after a brief introduction by the Co-Conveners, were divided into five work groups of five to six people per group. Each group was given the Obama-Biden Transition Project Participant Guide for Health Care Community Discussions and a discussion matrix developed by the Co-Conveners (Attachment 1). Participants were asked only to focus their discussions on the main headings of Quality – Prevention – Access; other issues on the matrix were meant to be used only as idea take-off points.

Participants:

Nicole Yucht
William Allen
Timothy Coons
Tavener Black
Caroline Rains
Kevin L. Ferguson
Patsy Zasciurinkas
Patricia Abbitt
Cathy Cook
Marcia Kent
Richard Stair
Daniel Layon
Kenneth Rand
Mark Alhomsy
Betsy Beers
Diane Valentin
Nancy Hardt
Sally Lawrence
Brian Hoh
Kenneth Marx
William Conwill
Michael T. Johnson
Amin Elamin
Stefania Mondello
Susan M. Currie
Lorraine Austin
Richard Bucciarelli

Introductory Statement:

All Americans should have access to high quality, cost effective, timely, outcome based health care. The decision making process to develop the standards of care should be based on a transparent evaluative process that originates in criteria approved by professional groups such as specialty board accreditation organizations, the Institute of Medicine, the Institute for Healthcare Improvement, and so forth. An honest discussion of futile care and the limitation of care are necessary to set reasonable expectations. Physicians should be educated in the cost of their decisions and partner in revenue savings efforts within

¹ Initial steps to call the meeting were taken on the 16th and 17th of December, with the understanding that Secretary Daschle wished to have final reports in his hands by 31 December.

² A request was made to Ms. Dianne Chun, the Health Reporter for *The Gainesville Sun*, approximately 72 hours before the meeting who the day of the meeting stated that she could not attend. The College of Medicine stated in an e-mail that they felt the meeting was "too partisan" to allow the use of the College's faculty and staff listserv; it was never clarified as to how this discussion could be contrived as partisan. As a result, one of the Co-Conveners sent out approximately 250 individual e-mail invitations over a 24 hour period.

the aggregate system, *i.e.* a dollar saved by eliminating an extraneous diagnostic procedure is used to provide preventive care. Tort reform to reduce needless expenditures in defensive medical practices and futile care is an additional important aspect of health care reform. All components of the health care system should be expected to be accountable to rationally developed standards.

The foundation of the health care system should be well trained primary care physicians – and where appropriate mid-level providers working through these physicians – providing longitudinal, as well as episodic, care for complex multi-system cases. These practices should provide age and gender appropriate preventive medical care services, as well as acute care for more basic events. These physician's practices – serving as medical homes – should be easily accessible to members of the community and should be linked either formally or informally to specialty practices that are available on a timely basis to provide consultative and management care for the more difficult patients. Facilities appropriate to the acuity of the patient should be available so the most high quality, cost effective, and efficient care can be provided on a timely basis. This would include outpatient imaging, laboratory, wound care, rehabilitation services, and mental health services. High quality hospital care, appropriate to the needs of the patient, should be readily available and its' use will encourage facilities to function at their greatest level of competence and efficiency. Patients should seek care in emergency facilities based on need rather than lack of access to a primary care physician. Information technology that allows sharing of data and records between providers and facilities, and that simplifies documentation of the patient encounter, needs to be utilized. This system would transcend proprietary limitations in a universally accessible and translatable format that can be migrated forward with technology advances to make these records available long into the future.

Payment for services should be allocated through a system of risk shared by all citizens, not stratified by adverse selection and exclusion. Billing and payment formats need to be standardized within the system. This system should encourage global reform initiatives and various incentives that attract health care teams to the specialties and localities of greatest need. Training of physicians should encourage specialization in primary care though medical school culture, debt forgiveness, and payment incentives. A priority will be to stabilize the practice environment so these entities will thrive and can provide continuity of care.

Medical schools and medical research should be promoted to maintain excellence in education, progress in medical practice and basic medical science, as well as innovation in treatment modalities. A nationally funded institute, similar to the British National Institute for Clinical Excellence (NICE), dealing with clinical guidelines, technology assessments, public health program guidance, and interventional procedures will be created. Adequate funding should be through state, federal, and private sources as well as revenue sharing with pharmaceutical and technical companies that profit from advances initiated through the basic medical research initiated in these institutions. Compensation for medical care provided within teaching institutions should provide a differential reimbursement to account for the lack of efficiency within the teaching environment. Students should have the opportunity to be exposed to practices outside of the institution such as under served and rural settings.

Above all, the tone of the health system will be high quality, patient centered, and with significant emphasis on health maintenance and prevention.

Summary of Work Group Comments:

Note: When the Work Groups made similar comments, they are not always repeated in the summaries. Each Work Group included physicians, community members, nurses, hospital workers, and administrators; specialty and subspecialty physicians comprised members of each group.

Group I – Hoh Group

- Access to high quality primary and specialty care must be addressed;
- The evident inadequacy of highest-quality primary care results in inadequate health promotion and disease prevention, with the ill presenting with diseases at end stage;
- The health system reform must ensure portability throughout the country with immediate access to health records, *i.e.* a chip / flash drive with records and history;
- Lack of exposure of medical students to Primary Care as well as the deteriorating reimbursement for primary care providers must be addressed;
- Primary care visits / health promotion must be incentivized;

- Secretary Daschle should form a small group that will visit other countries to learn from their systems and bring the best of them back to our country;
- Academic medical centers (AMCs) must be supported.

Group II – Abbitt Group

- Access to appropriate care is very difficult – a “crazy quilt”. A patient needs their own personal social worker to make the system work;
- There should be a seamless, baseline level of care to all people;
- Secretary Daschle should form a small group that will visit other countries to learn from their systems and bring the best of them back to our country;
- The health system should emphasize education in diet, life-style, safety, realistic expectations from the health system, and so forth.
- Real and serious medico-legal (Tort) reform must be carried out;
- Medical students should receive improved training in high quality Primary Care;
- Consideration should be given that financing health care should be reconsidered. Employer-based insurance may not be the best option.

Group III – Coons Group

- Prevention must be a priority: decrease barriers erected by the insurance companies and enhance health promotion (as opposed to only disease management);
- Quality of the preventive services must be enhanced;
- Access must be a priority: especially for working people, i.e. Pediatrics after Hours Clinic, Clinics open at odd hours so that working people have access;
- The provision of services must be transparent, unlike the present situation in which one is never sure what will or will not be covered;
- Care must be universal and portable;
- Highest quality primary care must be strongly emphasized. In one of our local hospitals 85% of patients cared for have no primary physician; this results in delayed and more expensive care.

Group IV – Layon Group

- Prevention and access must be watchwords: Primary care clinics at schools with full time school nurses and physician visits. Obesity rates in children must be altered through the reinstitution of daily Physical Education in schools;
- A two-tiered health system is **not** viewed as a threat. There must be a clearly defined basic level of services, decided upon through discussion and consensus; other non-basic services may be paid for out of pocket or *via* a secondary insurance policy;
- Services must be extended to rural and outlying areas through the use of primary physicians as well as exposing medical students, physician assistant students, and nurse practitioner students to these areas;
- Incentive Programs should be initiated: Federal / State scholarships for nursing, medical, and other health related students would result in their repayment by working for a defined time in an underserved area;
- Tort reform must occur, must be fair and transparent, and should use an arbitration system. Cases and outcomes should be reviewed on at least a twice yearly basis to ensure optimal functioning of the health system;
- Emergency medical services (EMS) must be incorporated into the health reform. Different levels of response and transport should be considered, including using paramedics under specialized protocols to provide elements of highest-quality primary care to at-risk individuals;
- Consider opening the VA Health System to non-veterans;
- Physician-supervised mid-level practitioners / extenders should be appropriately used as needed;
- Home health care, with appropriate elements of such care provided by family members as possible, should be supported;
- A national drug and device formulary should be instituted, with aggressive negotiation to drive down the costs of drugs and appliances / devices;
- It is recognized that triage / rationing of care will of necessity occur; this **must be transparent**. The greatest good for the greatest number of people should be a major consideration;

- If free / charity care is to continue, it must be tax deductible for the provider at the reimbursement rate ;
- All students training for work in our health system should be required to spend some part of their training in rural / urban underserved areas;
- Quality of the system must be ensured. A system such as the NICE must be implemented. The inadequacies and abuses of the present market-driven system of health care must be eliminated without removing the parts that are functional and desirable;
- Mental health services **must be** a part of the new national health system.

Group V – Marx Group

- The reformed health system **must be** patient centered, integrated, and prevention / health promotion oriented;
- The reformed health system **must** support the academic medical center (AMC) in terms of education and research;
- Access **must be** universal and records must be electronic and immediately available anywhere in the country;
- Financing **must be** through progressive taxation, but this is not enough. Waste, fraud **must be** eliminated as much as humanly possible and tort reform **must be** aggressively and carefully performed;
- A system such as the British NICE **must be** implemented to minimize waste and duplicative processes;
- Quality and safety **must be** watchwords. Medical errors need be prevented;
- Secretary Daschle should form a small group that will visit other countries to learn from their systems and bring the best of them back to our country;
- Discussion must be initiated to determine how to define and decrease futile care. It should be widely recognized that death is not always the enemy;
- The health system must be fixed now. We are in a crisis – financial, medical, moral, and ethical as regards this system.

Health Care Community Discussion: Ill Questions

1. *Briefly, from your own experience, what do you perceive is the biggest problem in the health system ?*

- Continuity of care [and] lack of communication between physicians and other health care workers;
- Access: [we] need seamless continuity of care over [entire] lifetime;
- Lack of basic, competent care-seems you have to go to [a] specialist for every health problem;
- The perception that there are “single biggest problems”. No problem can be addressed in isolation;
- Access for the underprivileged;
- Lack of access to affordable healthcare;
- Access;
- Access to care, any time, place;
- Access for the un & under funded;
- Access to primary care;
- Access-inadequate primary care to control chronic illness [and thereby prevent] end stage illness;
- Access, sponsorship;
- Access to primary care / preventative care & Malpractice system;
- Access for all;
- Access;
- Number of uninsured Americans;
- Lack of access to healthcare;
- Access & inadequate primary care.

2. *How do you choose a doctor or hospital ? What are your sources of information ? How should public policy promote quality health care providers ?*
- Recommendations from health care workers. _._³;
 - Word of mouth. _ . Pay for performance;
 - _._. Outcomes;
 - Reputation, friends, family. _._;
 - Insurance, colleagues. _._;
 - _._. Government investment into producing more primary care physicians & incentive programs to encourage MD's to enter primary care;
 - Quality of services and physicians who are available through employer [insurance]. _._;
 - Insurance, reputation, location. _._;
 - Word of mouth. _ . [By] incentives for students to go into the health sciences;
 - Location and insurance coverage. _ . Use evidence based evaluation;
 - _._. Train providers in evidence based medicine;
 - Reputation. Word of mouth. Evidence based evaluation system;
 - Reputation. Word of mouth. Evidence based evaluation;
 - Through employer network. Word of mouth. A baseline level of care;
 - Word of mouth. _._;
 - "I work in a hospital & know the good doctors". _._;
 - Referral by primary care physician. Other physicians. Evidence based oversight of all medical care.
3. *Have you or your family members ever experienced difficulty paying medical bills ? What do you think policy makers can do to address this problem ?*
- Yes. Listen to the people who take care of patients;
 - Yes. Baseline benefits should be provided [to everyone];
 - _ . Reduce cost of medical care;
 - Yes. A baseline level of coverage [should] be developed, not "everything for everyone";
 - No. Sliding scale [coverage ?];
 - No. Expand health coverage to all;
 - Yes. Provide basic coverage for all;
 - No. _;
 - No. Universal health coverage;
 - No. _;
 - _ . Eliminate fee for services ?? Provide same services to everyone & catastrophic services ??;
 - _ . Better access to preventative medicine, less end care diseases being treated in-hospital;
 - _ . National health care;
 - Yes. Catastrophic clause to prevent ruination;
 - No. Standard benefits-have everyone insured and caps on expenditures;
 - Yes. Eliminate the costs of risk rating by insurance companies;
 - No. _ (non sequitur response).
4. *In addition to employer based coverage, would you like the option to purchase a private plan through an insurance exchange or a public plan like Medicare ?*
- Yes (x12);
 - No (once).
5. *Do you know how much you or your employer pays for health insurance ? What should an employer's role be in the reformed health care system ?*

³ .-. = no comment made for the initial or final part of the question; placement of the symbol determines which part of the question was not answered.

- Share cost of insurance (large % [of cost]);
- Yes. Employers should facilitate “wellness” programs;
- Yes. Employers can offer insurance if they want to but shouldn’t be the only source of insurance;
- No. None;
- Yes, but only in relation to my employment contract. Employers should NOT be responsible for providing health care. It has resulted in the difficulties we are experiencing;
- Yes. Provide a payroll deduction plan to assist with paying for their [insurance] premiums;
- No. ;
- No. Either all employers should contribute or none;
- [should be] eliminated, [as] businesses expenses go down, competitiveness goes up;
- Yes. Employers should be involved but not at the expense of their own success;
- Yes. Partial [involvement];
- Provide basic system with enhancement options;
- We need to shift away or have alternatives to employer based health care;
- None;
- Partial role;
- Yes. Partial funding.

6. *Below are examples of the types of preventative services Americans should receive. Have you gotten the prevention you should have? If not, how can public policy help ?*

- Yes. ;
- Public encouragement and education;
- Yes. ;
- Yes. Incentives for people to see a primary care physician;
- EMT/Nutrition/P.H. primary care physician expansion;
- Yes. ;
- Yes. ;
- Yes. ;
- No. Education in schools and media;
- Yes. Incentives to get screened;
- Yes. Provide the public with education needed to understand the need for prevention;
- Yes. Evidence based oversight of health care;
- Yes. ;
- Yes. .

7. *How can public policy promote healthier lifestyles ?*

- More robust public health education;
- [Public Policy] can’t, at least not very effectively;
- Public policy already promotes healthy lifestyles. It is up to people to live healthy life styles. People should also be educated that medicine can’t cure everything-expectations should be realistic;
- Part of healthcare must be education- schools / TV etc on diet, lifestyle, exercise, cigarettes, personal responsibility;
- Make healthcare (esp. primary care) available to everyone;
- “Sticks and carrots”, for example, job restrictions / tax incentives to be healthy;
- Availability of primary care;
- Focus on nutrition and exercise, starting in grammar school;
- Change the cultural acceptance of junk food and lack of exercise, look at “BEST” practices in U.S. and other countries;
- Change Food Policy to promote local produce, increase tobacco and alcohol taxes, oversight of pharmaceutical advertisements to ensure drug safety, ad restrictions to prevent junk food advertisements targeting kids;

- Taxes on junk food, tax incentives for healthy food;
- Incentives for healthy lifestyles – *i.e.* tax breaks;
- Access to primary care;
- Increase access to preventative care.

Summary:

The twenty-seven participants taking part in this discussion spoke of many of the same concerns and issues. First of all, there was concern that a meeting as brief as ours with such little time to consider the issues might not be optimal. None-the-less, all were appreciative of the ability to take part in this process.

Secondly, the major issues brought up were ones that were not too surprising: Quality, Prevention, and Access were the watchwords. Appropriate financing, heavy emphasis on health promotion and highest-quality primary care, home health care, tort reform, universal coverage and a portable electronic record were on everyone's mind. Support for academic medical centers was also high on the priority list.

We did not attempt to define specific coverage, leaving this for another, national, discussion. We did recognize that difficult choices regarding covered services would have to be made. No-one seemed concerned that there would exist in our country a two-tiered system, as long as the basic level of care was acceptable. All felt that the system must be patient centered and high quality. All are interested in further participation.

Attachment 1: Discussion Matrix for Participants

<p>Quality</p> <p><u>Patient centered: Mayo Clinic model</u></p> <p><u>Appropriate level of care:</u> -Community vs. Tertiary vs. Quaternary</p> <p><u>Support for academic medical centers, Research, and training</u></p> <p><u>Robust IT System</u> - Portable Record - Education - Best Practices</p> <p><u>NICE – National Institute for Clinical Excellence:</u> http://www.nice.org.uk/aboutnice/about_nice.jsp - Clinical Guidelines - Technology Assessments - Public Health Program Guidance - Interventional Procedures</p> <p><u>Prevention of Complications</u></p> <p><u>Rationalization of Administrative Demands and Expenses</u></p> <p><u>Support for Patient Families</u> - Travel Vouchers - Hotel Vouchers</p>	<p>Prevention</p> <p><u>Preventive services</u> - Nutrition - Exercise - Tobacco / Drugs / Violence</p> <p><u>Physician training with exposure to community settings</u></p> <p><u>Support for academic medical centers, Research, and training</u></p> <p><u>Home Visits</u> - Primary Providers - EMS</p>	<p>Access</p> <p><u>Highest Quality Primary care availability</u></p> <p><u>Pooling Risk:</u> - One Large Risk Pool - Adverse selection by insurance companies - Pre-existent conditions and policy exclusion</p> <p><u>Debt forgiveness for MDs / RNs serving in certain settings</u></p> <p><u>Malpractice Issues</u> - Tort Reform - Access to Affordable Insurance - Defensive Medicine - Unnecessary Testing</p> <p><u>Home-based health care</u></p> <p><u>Insurance Portability</u></p> <p><u>Financing</u> - Single Payor: Medicare for all - Multi-Payor: Role of the Insurance Companies - Universality</p> <p><u>Support for academic medical centers, Research, and training</u></p>
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Appendix: Detailed Comments Made by Those Unable to Attend the Meeting

Michael E. Mahla, MD

...My only concern is the recurrent theme of emphasis on primary care. While I agree with this it was not managed well before. In the past this created a large number of primary care doctors who were unhappy with their lot. In addition primary care is not well defined. There is family medicine, internal medicine, gyn, etc.

I believe that the group should seriously consider whether primary care should even be provided by physicians and whether training programs for PA and ARNP students could be expanded to cover the role of primary care. Medical school frankly now attempts to cover too much and important topics such as social work, nutrition and prevention are relegated to the afterthought department. In addition geriatric care is only poorly dealt with if at all and residency is little better. If we simply reform health care by shifts in emphasis, I am not convinced it won't fail again.

We must look at all the assumptions and I am not sure that our whole education isn't screwed up. We should really base the education system on the desired outcome, not the other way around. Right now it is assumed that health care professionals know best how to design / reform the system. I am not at all sure that assumption is true. Sorry I could not be there, but the timing was bad.

Michael E. Mahla, MD

Professor of Anesthesiology and Neurosurgery

Associate Chairman for Education, Department of Anesthesiology

University of Florida College of Medicine

Gainesville, Florida 32610-0254

R. Patrick Jacob, MD

1. Access to health care is essential;
2. Primary care base, such as a F[amily] P[ractice] or Primary Care ARNP [Advanced Registered Nurse Practitioner] for straightforward issues is appropriate. Shifting current and expected US medical graduates into primary care will have a significant negative impact on a number of specialties that are already underserved (e.g. General Surgery, OB/GYN, Neurosurgery, etc.). Use of mid-level practitioners as extenders is a far cheaper way of increasing provider resources quickly;
3. Health Promotion: Weight reduction and nutrition, smoking cessation, control alcohol abuse, prenatal and childhood health care (including vaccinations, disease screening, abuse prevention, access to acute care, and appropriate parental education);
4. Support of Centers of excellence and regionalization of tertiary services;
5. Regionalization of Trauma Care;
6. Standardization of medical records

Some of the comments from the small groups are interesting. I am sure providers could learn a great deal about healthcare in other countries by a visit and a look/see. But what we would really need is to take our patients there as well, since they are the ultimate consumer of our services.

Statements like "...death is not always the enemy"; "The greatest good for the greatest number of people" and "Financing **must be** through progressive taxation" would sound very frightening to most Americans and if taken out of context, as these reports often are in the media, will make us look uncaring for the individual patient and his/her needs. I hope would not be included in any formal report.

R. Patrick Jacob, MD
Associate Professor
Dunspaugh-Dalton Professor
Department of Neurological Surgery
University of Florida College of Medicine
Gainesville, Florida 32610-0265

...First let me say that I am sorry I couldn't make your meeting but then let me add that I admire greatly what you have done and what I just read.

Not to incite a riot but to put in a comment or two based on my current context, I would first encourage consideration of insertion of the wording "**highest quality**" in front of every time the phrase "primary care physician or provider" is used. I suggest this not to be disrespectful but rather to make sure that "**primary care**" is somehow held to a very high standard just as we so-called **tertiary** and **quaternary** physicians are. Based on experience in my present practice system there is considerable evidence that such standards are not being adhered to.

Secondly, and maybe too bizarre for consideration is the definition of primary care should be expanded as, in my opinion, it is not always synonymous with family practice or internal medicine or the like. To wit, my specialty often serves as the **primary care giver** for patients with certain diseases, e.g. brain tumors (benign and / or malignant), spinal cord injury, subarachnoid hemorrhage, etc. By my definition, I mean there is never a family practitioner or internist pushing us out of the way to take control of patients with the aforementioned disorders. Perhaps there should be consideration given to educating **primary chronic disease care givers** and **primary acute disease care givers**. To ask a primary chronic care giver to perform up to the level of the primary acute care giver in an urgent/emergent situation is unrealistic.

So just a couple of random thoughts as I read through the excellent summary of your meeting.

Best wishes for a great new year.

J. Richard Lister, MD, MBA
Professor and Associate Chairman
Department of Neurological Surgery
University of Florida College of Medicine
Gainesville, Florida 32610-0265

Roger L. Blackburn, Esquire

I actually read through [the report]. For the most part, it is beyond my competence. Not surprisingly, there was mention of "tort reform" and, on that, I once had some understanding. I think some of what I learned may still have some validity.

The medical profession is accustomed to thinking the BOOGY MAN is your area malpractice attorney. The liability carrier reinforces this perception to make sure everyone feels the need to pay those premiums, no matter what that premium might be. Without question, those premiums can be out of touch with the risk and with the income of doctors, particularly in high risk specialties.

The "first" recognized malpractice crisis came in the 1980's. There were headlines about neurologists and OBGYNs paying over \$200,000 for coverage. This is outrageous. The lawyers, juries, the system were all suspect and easy targets. There have been several other crisis since then with the docs cast as the victims and the legal system as the bad guy. I suggest another villain.

The liability carriers!

Although the insurance industry should be regulated by government (there used to be an insurance commissioner), they enjoy anti-trust protection and can set out what risk they wish to cover and at what cost. Generally, the idea of insurance is to spread the risk over as broad a base as you can. Medical carriers thought it more profitable to pigeonhole the risky specialties. As a result, if a neurosurgeon had a bad day leaving a young man or woman in a lifelong coma, the damages (lifelong medical care, lost income, pain & suffering, loss of support, etc.) will be in 7 or 8 figures. This loss is spread over only a couple of hundred neurosurgeons. Unfortunately, there may be more than one BIG claim in a year. It is not hard to see how this system will fail.

Back in the '80s, when claims were the highest ever, it was determined that, if the risk was spread over all in the medical profession (and therefore all the patients who might need neuro care), the premiums would be very reasonable. As an example, if spread through GPs, their insurance would not exceed \$10,000 a year and the premiums of brain surgeons would be a fraction of what they were paying. The premiums would be a fraction of their incomes, as it should be.

The greatest truism from those days when I paid closer attention to these things is that the COST of CLAIMS, ALL CLAIMS, remains about 1% of the health care dollar. I don't think that any patient would flinch IF given the choice of paying one dollar for every \$100 paid for their care (that is still less than the cost of an aspirin in the hospital isn't it?). Even in these times of financial uncertainty, I don't think the medical professionals would think 1% is too much a burden on the health care system to take care of medical mistakes.

There has been "tort reform" several times since the first "crisis" ALL at the expense of "victims" of below standard care. I submit there exists a need for insurance reform so that risk is spread fairly throughout the system. The cost is \$1 out of \$100 - that will cover ALL claims and costs and seems to be a reasonable cost of doing business which, at the same time, will right some medical wrongs.

I know this is a sensitive topic in your profession and one that has an emotional component. I do understand the history. Reform is needed but it is not the tort system. Let's focus on the REAL boogey man.

Roger L. Blackburn, Esquire
Attorney, Florida Mediation Group

Rose Rivers, PhD, RN, NEA – BC

1. Institute school nurses for health promotion;
2. Offer health and wellness promotion course elective option for all colleges (not just medicine and nursing students);
3. Boards of nursing come together to standardize scope of nursing practice across states to maximize the skills and training of nurses;
4. In addition to a focus on homecare, need to really overhaul long term care (need a new model of care)

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