REPORT OF THE MEDICAL CARE COMMISSION MEETING
HELD ON MARCH 28, 2006

I. CALL TO ORDER AND ROLL CALL

The meeting of the Medical Care Commission was called to order on Tuesday, March 28, 2006, at 9:30 a.m., in the Town Council Chambers. On roll call, the following members of the Commission were found to be present: Chairman Michael Dennis, Vice Chairman Robert Friedman, Commission Members Norman Goldblum, Michael Stein, and Norman Traverse; Commission Member Richard Furlaud was absent.

II. PLEDGE OF ALLEGIANCE

The Pledge of Allegiance was led by Chair Dennis.

III. APPROVAL OF AGENDA

The Agenda was approved with one change: Ms. Etonella Christlieb requested that Item IX., Comments from the Public be heard first.

IV. APPROVAL OF MINUTES OF THE MARCH 7, 2006, MEETING

V. APPROVAL OF MINUTES OF THE MARCH 14, 2006, MEETING

Commission Member Goldblum moved approval of the March 7 and 14, 2006, Minutes. Vice Chair Friedman seconded the motion. On call of the Chair, the motion carried 5-0, as Commission Member Furlaud was absent.

Dr. Dennis read a letter into the record regarding the survey, thanking the Mayor, the staff

of the Palm Beach Daily News, the Palm Beach Citizens Association, and the Palm Beach Civic Association. He discussed the purpose of the Commission, and several of the obstacles the Town residents encountered in healthcare support.

VI. CHAUNCEY CRANDALL, M.D.
INVASIVE CARDIOLOGY

Dr. Crandall apprised the Commission that several of the following cardiology issues at Good Samaritan Hospital were:

- In 1994 the Health Maintenance Organization (HMO) changed the dynamics of healthcare;
- Hospitals were faced with downgrading all patient care to HMO status;
- In 1995, stents changed the heart program, reducing bypass surgeries;
- A heart program would not be economical, because a staff of two or three surgeons would not have enough cases to support each surgeon;
- One surgeon needed 250 cases a year to maintain a profitable income and maintain his talents; and
- Very few surgeons at Palm Beach Gardens Hospital and JFK Medical Center can attain 250 cases, and most do not meet even half the amount.

Dr. Crandall stated that Good Samaritan Hospital would never acquire a heart bypass program, because of the low population density, the low volume of cases, and that there were two excellent programs in the south and north, which were JFK and Palm Beach Gardens.

Dr. Crandall's following responses to several of the Commission Members questions were:

- Emergency angioplasty cases at Good Samaritan Hospital was a liability for the physicians because most did not have malpractice insurance, and the patient was at risk, because the staff was not trained for angioplasty;

- Physicians were struggling to make a good income, and most of the practices at Good Samaritan Hospital were boutique, private practices, with a limited patient volume. Good Samaritan Hospital was a cancer hospital now;

- The ambulance service needed to transport the patient quickly to either the north or south hospital, rather than wasting valuable time at Good Samaritan waiting to identify the problem;

- The Island's perception was that Good Samaritan Hospital should be the "go to" hospital for emergency angioplasty because of the proximity. The medical experts did not know how to reassure the Island's population that their health was not jeopardized by not having an angioplasty program at Good Samaritan Hospital;

- The ideal transport site was Palm Beach Gardens Hospital because it was the shortest distance from the Island. Physicians were now moving to geographic areas that were less seasonal, in the west and north part of county that had working families;

- Helicopters can transport a patient in a very short period of time, however ambulance crews sometimes spend too much time in the field analyzing the patient;

- Bypass surgery was rarely done now, because heart patients were treated with stents;

- Medicare was lowering reimbursement to physicians by 4.5% or 4% per year for the next five years, which was a 20% pay cut for most doctors. A physician could not keep up with volume, and there was great difficulty meeting the needs and keeping employees in practices or hospitals;

- Federal law prohibited physicians from charging anything extra, other than what Medicare allowed, regardless of the wealth of a patient;

- Main problem for recruitment of doctors was the high cost of housing, required salary, and the high cost of malpractice insurance;

- There would be minimal impact of patients from the massive housing program near Good Samaritan Hospital, because the population was seasonal;

- The best thing for the Town would be to acquire an emergency clinic on the Island, supported independently from the hospital system;

- The biggest non-payers in most local practices were the people in the Town of Palm Beach, and many physicians run from those who live in the 33480 zip code, because they were very educated, wealthy, and demanding, and had other physicians in other parts of the country.

- Historically, the teaching hospitals cared for the indigent, and the physician residents receive the best training through hands-on experience. High volume of cases was necessary to justify a teaching and residency program, and universities needed financial support from the community;

- Two cardiologists in his group left town over the last four years, because they could not afford to live in Palm Beach County;

- The state retained the third world physicians because they work hard, treat a huge volume of patients, were honorable and were able to establish an income, and were successful locally;

- Physicians could not take time off anymore, worked 16 hours a day, 5 days a week, and had no time for legislative endeavors;

- There were no neurosurgeons at Palm Beach Gardens Hospital, all of them left to do spine surgery, and refused to treat stroke patients because the liability and malpractice was too high; and

- The interventional cardiologist would take over the stroke programs, but it was a political battle now with the neuroradiologists, who would not be on call 24 hours a day, as opposed to the cardiologists who were accustomed to it;

VII. ELIOT SNIDER, TRUSTEE
BETH ISRAEL DEACONESS HOSPITAL, BOSTON, MA

Mr. Snider noted his credentials and indicated that doctors were concerned as to whether there would be a Good Samaritan Hospital five years from now. Mr. Snider discussed the following:

- In Good Samaritan Hospital neurosurgery, oncology, and hematology categories were vacant; the outpatient clinic had been closed, which placed the outpatient people into a pool where the priority of people were scheduled for major surgery;
- The employees of the Hospital did not stay after their shift, and there was no second shift or justification for it;
- In Nantucket, the season was 10 to 12 weeks, with a population of ten times or more, and they solved their problems with helicopters. A major solution was to provide housing accommodation for eminent physicians to come with their families and stay at no charge in exchange for services for 30 days;
- Good Samaritan Hospital's helicopter pad was no longer used, and the helicopters go to St. Mary's because it was more logical.
- A physician friend of his claimed he had to perform three operations a week in order to pay his malpractice premium;
- Mr. Carl Thieme, the chief partner of Cambridge Research Associates, a hospital consulting business, recently retired three months ago in Florida, and was available to be interviewed.
- Medical people were open to discuss the problems, were worried about the future, and very unhappy. There was a net outflow of doctors not being replaced;
- The qualities of the highly skilled doctors that required special equipment, and an institution to invest and train them, were not available in Florida; and
- The unsound, national policy of Medicare paying 70% of the calculated cost, created the crisis in Florida;

Dr. Dennis commented that the Commission had a need to understand the emigration of physicians, and hoped to mesh together Mr. Snider's and Mr. Thieme's interests with the

Commission's interests.

Mr. Snider indicated that he had read that Mass General and Brigham in Boston were considering a clinical type facility in Palm Beach County. Mr. Snider stated that he was not optimistic about having an eminent institution come in and solve the problems.

Commission Member Traverse commented that the cost of defensive medicine was staggering, and should be solved with the malpractice situation. He indicated that as a united front, all the communities could work together with the legislature to resolve the problems.

Mr. Snider suggested that Florida form an insurance company off shore similar to Harvard's medical facilities called CREICO - Controlled Risk Insurance Company that would bring the malpractice insurance rates under control.

Vice Chair Friedman stated that in New Jersey, one of the major hospitals had an off shore arm, in which the physicians were salaried, and were provided insurance.

Responding to Vice Chair Friedman, Mr. Snider explained that:

- The hospital that was deep in the red and then turned into the black related to charges and accounts receivable handling. He noted that if the charges were incorrect, the insurance company rejected it, and some of the adjustments would not appear for eight years; and

- His experience with salaried doctors as part of the employee base was at Harvard Medical School had a ceiling of $300,000 or $400,000 on what the doctors could earn a year, whereas in Texas, a doctor could earn $2 million a year.

Commission Member Goldblum called attention to a demographic study that was requested at the last meeting depicting the population and loss of physicians, to be presented to the state legislators. He commented that he had an opportunity to speak with Senator Atwater, who indicated that he was willing to work with the Commission.

VIII. RICHARD CAMERON, CONSULTANT
PALM BEACH COUNTY MEDICAL SOCIETY

Mr. Cameron provided an update with the following recommendations:

- The three highest priority recommendations for immediate attention were:

    1. Complete a financial feasibility study, evaluating three different levels of on-call pay systems;

    2. Establish a committee of Emergency Department Management Group (EDMG) to develop and implement a regional based on-call system for critical specialties; and

    3. Conduct a county-wide physician census, by specialty to reflect the impact of supply of physicians by EDMG over short and long term.

- The remaining recommendations were:

    - Implement a community and media relations program;

    - Develop a database to track patient access to emergency care services;

    - Implement a county-wide electronic call schedule;

    - Support the development and funding of community-based clinics to take the burden away from hospital emergency rooms;

    - Evaluate the appropriateness of establishing a funding mechanism by which certain niche providers would help emergency department charity; and

    - Evaluate medical malpractice alternatives.

Mr. Cameron commented that he had meetings with the following agencies:

- The U.S. Department of Justice Anti-Trust Attorneys to obtain their feedback on access issues;

- The state's Agency for Health Care Administration (AHCA) in Florida; he would be

meeting with the State Attorney General's office to coordinate proposal development before going to the U.S. Department of Justice.

- The federal and state, Emergency Medical Treatment Act (EMTALA)required hospitals to have emergency departments follow certain criteria.

Mr. Cameron commented that a committee was working on addressing hand surgery, which was identified as the most critical specialty. He said that the committee would be meeting for the fourth time this week to refine the process and the unique challenges that the proposal represented.

Mr. Cameron noted that EDMG's activities created funding challenges, and additional monies were required to proceed, and that he was hopeful that in the near future, he could announce that approval was received by the proper authorities to move ahead with the first program implementation.

Mr. Cameron's responses to the Commission Members' questions were:

- The basic purpose of the census was to get an idea on where the physicians were in their specialty relative to their practice activities. The data would reflect many of the physicians issues;

- The healthcare district was quite involved in the project;

- The healthcare district, and the local hospital helped to fund the EDMG a year ago, but not since;

- A significant community based clinic on the Island with superior equipment and staff, would not be able to cover its expenses because the cost was relevant to the volume going through the clinic. It may be complimentary to, or a duplicate of, the EMS system that was available on the mainland.

Commission Member Stein moved approval for Mr. Cameron and Mr. Thieme to explore the census issue and bring information back to the Commission. Vice Chair Friedman seconded the motion. On call of the Chair, the motion carried 5-0, as Commission Member Furlaud was absent.

Responding to Mr. Brian Fuller of the Fire-Rescue Department's concern regarding the regionalization proposal, Mr. Cameron explained that if a specialist surgeon was available in the

north area at a certain time, for example, a hand specialist in Jupiter on Monday and Tuesday, the Emergency Medical Service (EMS) would transport the patient to the closest facility and then transfer to Jupiter. Mr. Cameron noted that all the specifics of the proposal had not been worked out yet, but that he would seek dialogue with EMS in order to bring their perspective into the proposal.

IX. COMMENTS FROM THE PUBLIC

Ms. Etonella Christlieb commented that the Town needed a boutique hospital, to serve as an instant, small clinic. She suggested that it could be a private clinic, and everyone could pay $100 to join.

Mr. Royall Victor III, 208 Via Tortuga, commented that, to date, the Commission had focused on the medical aspects of healthcare, and that the political aspects should also be addressed. He noted that a synthesis of the findings of the Commission should be presented to the elected representatives in Tallahassee or the County, and urged the Commission to pursue the inquiry into a political strategy in order to achieve their goals.

Chair Dennis indicated that the Commission was moving toward a point where they were comfortable in making well documented cases for political action.

X. NEXT MEETING: **APRIL 14, 2006, AT 9:00 A.M.**

XI. ANY OTHER MATTERS

There were none.

XII. ADJOURNMENT

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The meeting of the Medical Care Commission of March 28, 2006, was adjourned at 11:30 a.m.

Michael Dennis, M. D.
Chairman

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