



# RHODE ISLAND MEDICAL NEWS

NEWSLETTER OF THE RHODE ISLAND MEDICAL SOCIETY

JUNE 2002

FROM THE PRESIDENT

2 *A Tale of Two Activities*

MEDICAL PRACTICE

1 *Prompt processing*

7 *New AMA compliance forms*

MEDICAL SOCIETY NEWS

7 *Briefly Noted*

9 *Working for You*

10 *Bulletin Board opens*

PHARMACEUTICAL NEWS

6 *Senior Discount Cards*

6 *Drug advertising*

RIMS MEMBERSHIP

12 *Directory reminder*

LIABILITY NEWS

1 *Insurance update*

FINANCIAL PLANNING

5 *Beware of variable universal life insurance*

VOLUME 15 • NUMBER 3

## What's Up with 'Prompt Processing'?

In an ongoing series of meetings that began last October, RIMS is working with state authorities and the health plans toward full implementation Rhode Island's "prompt processing of claims" law.

The law, drafted by RIMS in 2000 and passed by the General Assembly in 2001, has been in effect since October 1.

However, the law has enough novel and unique features that the Department of Business Regulation (DBR), Blue Cross and United have required some time to come to terms with what needs to happen in order to bring about full compliance. RIMS staff and legal counsel, in cooperation with leaders of the Rhode Island Medical Group Managers Association and the law's legislative sponsors, have invested a good deal of effort in facilitating this understanding over the past eight months. The process continues; September 1 is now the target for resolution of outstanding issues.

RIMS members and their office managers can provide valuable assistance in this process by communicating with RIMS about their front-line experience with claims processing. It would be helpful for RIMS to hear from medical practices on the following:

- To what extent has each plan fulfilled its new statutory obligation to communicate clearly to medical practices exactly what a "complete claim" is?
- To what extent do the plans pay "complete" electronic claims in 30 days and "complete" paper claims in 40 days?
- To what extent do the plans provide complete information on all deficiencies in claims that are not found to be "complete" and do so promptly (within 30 days for electronic claims and within 40 day for paper)?

*(continued on page 4)*

## Medical Professional Liability in Rhode Island A Report and Update

**Rhode Island mirrors the rest of the nation right now, in that:**

- 1) Fewer medical professional liability carriers are offering coverage in Rhode Island today than were doing so one year ago.
- 2) Premium rates have increased sharply and will continue to do so for the next 2 or 3 years.
- 3) A spike in the severity of claims (rather than in the frequency of claims) is driving medical professional liability costs higher in Rhode Island.
- 4) Claims against institutions (nursing homes, hospitals) are generating a disproportionately larger share of the increase in losses than claims against physicians and surgeons.
- 5) Claims against non-surgeons now generate losses with greater frequency (but not greater severity) than claims against surgical specialists. The inverse used to be the rule. In particular, costly claims are being brought against non-surgeons for failure to diagnose, delayed diagnosis, and misdiagnosis. (Claims against non-surgeons for medication errors are also driving liability costs

*(continued on page 4)*



**RI MEDICAL SOCIETY  
EXECUTIVE COMMITTEE**

**PRESIDENT**

Yul D. Ejnes, MD

**PRESIDENT-ELECT**

David B. Ettensohn, MD

**VICE PRESIDENT**

Tilak K. Verma, MD, MBA

**SECRETARY**

Frederic V. Christian, MD

**TREASURER**

Peter A. Hollmann, MD

**IMMEDIATE PAST PRESIDENT**

Michael B. Macko, MD

**AMA DELEGATES**

Peter A. Hollmann, MD

Michael E. Migliori, MD

**COUNCILLORS AT LARGE**

Leslie Cashell, MD

K. Nicholas Tsiongas, MD, MPH

**RHODE ISLAND MEDICAL NEWS**

is the newsletter of the  
Rhode Island Medical Society  
106 Francis Street  
Providence RI 02903  
Tel: 401-331-3207  
Fax: 401-751-8050  
Email: RIMS@rimed.org

**SUBSCRIPTION INFORMATION**

A one year subscription to  
*Rhode Island Medical News*  
costs \$50. The publication is  
free to members.

**EDITOR**

Newell E. Warde, PhD

The Rhode Island Medical Society, the eighth oldest state medical association in the country, was founded in 1812 to promote the art and science of medicine. In cooperation with the Brown University School of Medicine and the Rhode Island Department of Health, the Society also publishes a monthly magazine, *Medicine and Health Rhode Island*.

**FROM THE PRESIDENT**

## A Tale of Two Activities

YUL D. EJNES, MD

In this President's Column I will discuss two topics that on the surface appear unrelated but really aren't. The first is RIMS' and the subspecialty societies' partnership with Blue Cross & Blue Shield of Rhode Island (BCBSRI) that I will refer to as the "Radiology Initiative." The other is RIMS' plan to assess where Rhode Island's residency programs stand in the area of resident work hours.

### The Radiology Initiative

Last fall, RIMS learned that BCBSRI planned to institute a preauthorization program for CT, MRI, and nuclear scans for its BlueCHiP for Medicare product. The reason for this was the increase in costs for these studies compared to previous years and to plans in other parts of the country. After some delays, BCBSRI was to begin the program in the middle of 2002. That is, until RIMS asked them to not force this on physicians and to consider alternatives. Our reasons for opposing the preauthorization program will not surprise you. We believe that requiring preauthorization for CT scans, MRI's, and nuclear studies would delay the delivery of care, introduce opportunities for errors, and increase the "hassle factor."

We expressed our concerns directly to the senior management of BCBSRI at one of our regular meetings in March. For the past year RIMS' leadership has met with BCBSRI staff to discuss areas of common concern, exchange information, and avoid the kind of stalemate that characterized our relationship a couple of years ago. When we shared our thoughts on preauthoriza-

tion with BCBSRI, they agreed to look at alternatives and, with RIMS, convened a joint working group consisting of representatives of the major specialties and members of the BCBSRI staff.

Our first suggestion was to identify the physicians whose use of imaging studies was significantly different from that of their peers, and to find out why that was the case. We learned that that kind of analysis was not possible because of the way that BlueCHiP for Medicare claims are processed. The working group then agreed to an educational program for all physicians. BCBSRI will delay its preauthorization program for six months. In return, RIMS and the specialty societies will compile accepted protocols on the appropriate use of imaging studies, and BCBSRI will distribute them to the physician community. Following the six-month period, BCBSRI will review its radiology costs and determine whether its target was met. If so, the education program will continue; if not, BCBSRI will implement the preauthorization program as originally planned. RIMS agreed with working group's proposal, but we did not specifically endorse the concept of a cost-savings target. It is our position that improving patient care by educating physicians on the appropriate use of imaging procedures should be the primary goal of the initiative. While it stands to reason that reducing unnecessary procedures should reduce costs, RIMS believes that the initiative can be successful even without the achievement of specific cost savings.

In early May, I chaired a meeting of representatives of the specialty societies to discuss the Radiology Initiative and reaffirm their support.

We discussed the first task for RIMS and the specialty societies, to identify existing protocols on the use of imaging tests, a task that may be more challenging than first thought. Fortunately, at press time, the societies may be getting help in this from an unexpected source – BCBSRI, which agreed to purchase the guideline set that its vendor was going to use. While the physicians will still need to review, modify, and approve the guidelines, this development will greatly reduce the work of proceeding with the initiative. Even with this assistance, it will be a challenge to be ready by the start date for the initiative, July 1.

This partnership with BCBSRI is groundbreaking and may serve as a model for future interactions with all insurers. Only if we succeed, however. Cynics among our colleagues point out that distribution of protocols to physicians has not worked for insurers before. Others predict that regardless of what we do over the next several months, there will be preauthorization in January 2003. I'm sure that within BCBSRI there is similar skepticism.

In order for us to succeed, RIMS and the specialty societies must convince physicians that self-assessment of their test-ordering behavior, using physician-accepted protocols or other evidence, is integral to good patient care and judicious use of resources. We don't plan to mail a book of protocols to every physician in the state and leave it at that; expect to see this topic addressed in newsletters, society meetings, and special CME programs presented by the physician community. If we fail, don't count on seeing a similar offer anytime soon.

## Resident work hours

Ever since the mid-1980's, resident work hours have been under scrutiny by residency review committees, regulators, legislators, patients, and the residents themselves. The current focus on patient safety and greater appreciation of the effects of sleep deprivation have again put the spotlight on this issue. Last year, there was an attempt to include residents in legislation originally written to restrict mandatory overtime for nurses. This year, a bill was submitted to the U.S. House of Representatives on resident work hours.

The position of the profession on this issue has been that residents must be provided with an environment conducive to learning, that education, not service, should be the primary role of the resident, and that the profession is responsible for making that happen. We have been criticized for not doing enough, hence the call for those outside the profession to take action. The perceived lack of action on our part has many causes. Concerns about the effect of work hour restrictions on continuity of care and quality of the educational experience, the need for resident staffing in hospitals that lack the resources to provide alternatives, and the age-old belief that long hours and large patient loads make the trainee a better physician are just a few of them.

In Rhode Island, there is anecdotal evidence of a wide disparity in resident work hours, ranging from adherence with the 80 hour per week/one day off every seven days/twelve hour ER shift/no more than every third night on call rules, to schedules that have not changed much over the decades. Anecdotes

are not the basis for sound public policy, however.

To help advance the discussion by providing credible data on the extent of the problem in Rhode Island, this autumn RIMS will survey all of the residents in the state's academic programs. We will use a survey written by the ACP-ASIM's Research Center for a recently completed national survey of internal medicine resident work hours. The clustering of residency programs in the Providence-Pawtucket area, the small number of hospitals with academic programs, and the accessibility of residents via electronic mail should facilitate the collection of data. We will also survey the program directors to assess their views of the situation.

Once the extent of the problem in Rhode Island is better known, RIMS can serve as a resource for addressing the issue. We are uniquely positioned as a membership organization that includes residents, clinical faculty, and program directors, as well as a few hospital CEO's, to serve as an "honest broker."

RIMS' collaboration with BCBSRI in the Radiology Initiative and our growing role in the area of resident work hours are related in that they are the types of activities in which a true profession should be engaged. It is our responsibility to ensure that we improve the quality of care whenever possible and that we use resources wisely. It is also our obligation to set standards for how future physicians are educated, to treat our trainees with respect, and to maximize patient safety. These activities, like others that I have discussed in earlier columns, are examples of how we can reassert what we have had all along – control over our professional destinies. v

**Prompt Processing (continued)**

- To what extent are the plans paying interest at the rate of 1% per month when they fail to process and pay claims within these statutory timeframes? (Both United and Blue Cross have told RIMS and the legislators who sponsored the original bill for RIMS that they are paying such interest to medical practices, as is required under the new law.)

The plans have indicated to RIMS that they are already seeing more “complete” claims submitted. The plans also appear eager to meet the new law’s standard of “substantial compliance,” which is being defined in regulation as processing and/or paying within the required timeframes a weighted average of at least 95% of all claims received. Plans that can demonstrate to the DBR that they are in “substantial compliance” must continue to meet all of the processing timeframes, but they are exempt from the 1% per month (12% per annum) interest requirement for the small proportion of claims that may be paid outside of the target timeframes. ▽

**Liability Report (continued)**

elsewhere in the country, but this trend is not mirrored in Rhode Island so far.)

6) Liability premiums are rising and availability of insurance is diminishing because of two basic factors: a) the insurance underwriting cycle, stimulated into a negative phase by the end of the bull market of the ‘90’s; b) judicial and social trends.

**The following carriers have been lost to Rhode Island in the past 12 months:**

(Because the carriers below had so little market share in Rhode Island, the state and the medical community have been spared the greater disruption that other jurisdictions have experienced.)

**AIG** (wrote institutional business only)

**CNA** (wrote mainly institutional business)

**HUM** (wrote very few physicians in Rhode Island, but has many policyholders in Massachusetts, where HUM has filed for a 40% rate increase and is not accepting new business)

**Legion** (wrote many Rhode Island psychiatrists and many other mental health professionals; under regulatory supervision since April 1, 2002, and headed for liquidation)

**PHICO** (wrote institutional business only)

**St. Paul** (will have no physician insureds in Rhode Island after December 31, 2002)

**Zurich** (wrote mainly institutional business)

**Further notes on the insurers currently available to Rhode Island physicians:**

**NORCAL** took a 9% base premium rate increase in Rhode Island for 2002. NORCAL is underwriting new and renewal business far more strictly than it did in the past.

**MedPro (Medical Protective)** is no longer accepting new business in Rhode Island and is non-renewing existing business in Rhode Island at an accelerated rate. MedPro took an extra, off-cycle rate increase in Rhode Island and in many other markets earlier in 2002. MedPro is owned by GE Capital.

**Rhode Island’s JUA** is filing for a 20% rate increase that will become effective (retroactively, if necessary) July 1, 2002.

**A note on NORCAL’s experience in Rhode Island:**

In the almost 7 years between 2/1/94 and 12/31/00, NORCAL closed 1,552 reserved claims in Rhode Island. Of these 1,552 claims, 1,431 were closed without any indemnity payment. The remaining 121 were closed with indemnity payments that totaled \$20.9 million. In addition, NORCAL pays an average of \$1 on defense for every \$3 of indemnity payment. Thus, NORCAL spent about \$7 million on defense in Rhode Island in the period 2/1/94 to 12/31/00.

NORCAL currently has 925 open claims in Rhode Island. (Note that the term “claims” includes incident reports, actual lawsuits, and other events that trigger the creation of a claims file.)

A concern to NORCAL about the Rhode

**Carriers still providing liability coverage to RI physicians as of June 2002**

(Listed approximately in order of greatest to smallest market share)

CARRIER	TYPE OF ORGANIZATION	A.M. BEST RATING	NUMBER OF RI PHYSICIANS <sup>1</sup>	HOME OFFICE
NORCAL	Physician-owned mutual	A (“excellent”)	1700	San Francisco
RISE	Hospital-owned self-insurance	Not rated <sup>2</sup>	700	Bermuda
ProSelect	For-profit stock company	A- (“excellent”)	300	Boston
MedPro	For-profit stock company	A++ (“superior”)	200	Fort Wayne
JUA	Quasi-state agency	Not rated <sup>3</sup>	200	Warwick
Women & Infants’ Indemnity	Hospital-owned self-insurance	Not rated <sup>2</sup>	200	Cayman Islands

Island market is the fact that even after 7 years, claims are still developing on the very first policies NORCAL wrote in Rhode Island in 1994, and some claims go back even farther as part of the book of business that NORCAL took over from the failing Premier Alliance Insurance Company in 1994. In contrast, in its home base of California, NORCAL can generally close the book on a given policy year after about 3 years.

NORCAL finds the judicial and tort environment in Rhode Island to be fairly hostile and unpredictable. On the other hand, NORCAL has found the quality of the defense bar in Rhode Island to be excellent. NORCAL's substantial share of the Rhode Island market, in combination with the company's uniquely aggressive defense of all defensible claims, has had a salutary impact on the liability environment in Rhode Island. It has discouraged frivolous suits and culled the ranks of the plaintiff's bar. ▽

## Buyer Beware!

### A Word of Caution about "variable universal life"

BY ROBERT F. CALISE, VICE PRESIDENT  
CORNERSTONE FINANCIAL GROUP, INC.

You may have heard financial and insurance representatives pitching the up and coming product, variable universal life insurance. The concept sounds great: you purchase a policy that actually buys term insurance and invests the difference in various "mutual fund" type accounts with gains growing tax-deferred. When you're at the point of sale, the representative will usually show an illustration of projected future policy values with an interest rate of 10% to 12%. The policy values are generally shown to grow at a steady pace, and they should, since the policy illustration typically does not assume any "market volatility." However, we all are well aware that the markets are in fact very volatile. To assume a steady rate of growth at 10% to 12% is therefore not realistic.

As a matter of fact, the variable universal life type policies can actually be less stable than a traditional universal life policy, if not funded properly. Part of the problem is the inaccurate projection when the policy is being sold, as we noted above. The other problem is that the internal charges, that is, the cost of insurance, cost to administer the policy and the cost of the underlying mutual funds within these policies are typically much higher than buying term coverage and investing the difference directly with a mutual fund company.

If you have purchased one of these types of policies, you should be reviewing it on annual basis with your representative. If you would like Cornerstone to prepare a complimentary audit of your policy, or, if you have questions in regard to information contained in this article, please contact Cornerstone at 401-821-6200. ▽

<sup>1</sup>These numbers are rough estimates. Also, because many physicians practice in multiple settings and therefore have multiple insurance policies, the totals in this column exceed the number of physicians who are actually present and practicing in Rhode Island.

<sup>2</sup>Hospital-owned off-shore "captives" are not domestically regulated. Information on their capitalization, reserves and loss experience is not publicly available.

<sup>3</sup>The structure of the Rhode Island JUA (Medical Malpractice Joint Underwriting Association of Rhode Island) is such that the JUA could virtually never become insolvent. (This positive assessment of the JUA's strength is supported by the Torres decision of February 1991.)

## Four Major Drug Companies Now Offer Senior Discount Cards

Eli Lilly has joined GlaxoSmithKline, Pfizer, and Novartis in offering prescription drug discount cards to low-income seniors.

Lilly's card, unveiled on March 5, allows low-income seniors to obtain 30-day supplies of medication for \$12. To qualify for the Lilly program, patients must be on Medicare, be over 65, have annual incomes below \$18,000 for an individual or \$24,000 for a household, and must not be eligible for any private or public prescription drug coverage plan. Lilly says that Prozac users, for instance, would save \$856 off the \$1000 yearly cost of the anti-depressant.

Lilly was the fourth drug maker to offer its own discount card in recent months. Its \$12 price is a little lower than Pfizer's \$15, while the two cards have the same income limits. GlaxoSmithKline's and Novartis cards offer smaller savings on drug costs—discounts of 25% or more—but their income eligibility thresholds are higher — \$26,000 for individuals and \$34,000 for couples.

The discount programs come as Congress debates adding a prescription drug benefit to Medicare. Drug makers say the cards will offer low-income seniors meaningful relief until such a benefit is passed, but some consumer advocates dismiss the programs as an industry effort to gain favorable publicity while helping very few seniors.

Patients who might benefit from the discount cards can call the following numbers for applications:

**Eli Lilly** 1-877-RX-LILLY

**Pfizer** 1-800-717-6005

**GlaxoSmithKline** 1-888-672-6436

**Novartis** 1-866-974-CARE

Seniors can also apply by calling participating pharmacies. Applicants will have to provide their Medicare beneficiary number and their most recent federal income tax return.

In addition to the manufacturers' cards, Citizens Health (a division of Citizens Energy of Boston, the non-profit company run by Joseph P. Kennedy, II) offers a prescription card that has no eligibility restrictions on age or income. The card is available to anyone who pays full price for any prescription, those including those without insurance coverage or coverage that does not cover their prescription needs. The Citizens Health card costs \$12 a year per individual (\$28 for families). Citizens Health says its card offers discounts on all prescription drugs.

More information on the Citizens Health card is available at [www.citizensenergy.com](http://www.citizensenergy.com) or at 800-563-5479. ▽

## Consumer drug ads account for only 15% of drug advertising dollars

While spending on drug advertising aimed at consumers tripled from 1996 to 2000 and has grown proportionally faster than drug promotion to health professionals, doctors are still the target of 85% of the advertising dollars being spent to market drugs.

A study in the February 14 *New England Journal of Medicine* found that while spending on direct-to-consumer advertising rose from \$791 million in 1996 to nearly \$2.5 billion in 2000, that still left \$13.2 billion of drug advertising money focused on health care professionals that year.

Researchers also found that drug companies tend to market a small group of drugs to the public. Spending on the 20 most-advertised drugs, including well-known agents like Viagra and Claritin, accounts for 60% of all direct-to-consumer advertising.

The study noted that there are no solid data indicating whether prescriptions generated by consumer requests are appropriate.

Researchers also examined direct-to-consumer advertising touting products other than drugs. They noted that advertising for diagnostic tests like electron-beam computed tomography to screen for coronary artery disease and low-dose spiral CT to screen for lung cancer are on the rise. ▽

*(Taken in part from the ACP-ASIM Observer Express e-newsletter)*

## AMA releases new Health Plan Complaint Form

Are you experiencing administrative and payment hassles with health insurers? Are health insurers rejecting, denying, or ignoring Current Procedural Terminology® codes and modifiers? The greatest bar to getting such problems addressed by health plans, regulators and legislators has always been the absence of cogent and comprehensive data.

Now you can now register your grievances with the new on-line Health Plan Complaint Form developed by AMA's Private Sector Advocacy (PSA) group. The form gathers data on the types and the severity of the administrative and payment hassles that physicians and staff experience with health insurers or third party payers. That information can document trends and facilitate discussions with national health insurers to resolve hassles and complaints, as well as to promote legislative and regulatory change. AMA assures that the data received will be processed and aggregated in a secure and confidential manner. RIMS understands that state medical societies will be able to tap their own state data to support discussions with Rhode Island plans, regulators and legislators.

"The AMA's national clearinghouse of health plan complaints will arm physicians with the ammunition they need to combat the abusive business practices of health insurers," said AMA EVP/CEO Michael Maves, MD, who is encouraging members to send their data to bolster the AMA's arguments with national health insurers. Physicians can complete the form and learn more about the work of the PSA at <http://www.ama-assn.org/go/psa> v

## n Surgical residency positions go unfilled.

The number of U.S. medical students who apply for general surgery residency programs has dropped 30% in 9 years, according to a study published in the March issue of *Archives of Surgery*. A trend of decreasing interest in general surgery began in the 1980's, but 2001 was the first year in which there were fewer applicants than positions offered. The study predicted that by 2005, U.S. medical students will fill just 76.6% of the positions offered in general surgery. According to the report, many medical students "actually want a life outside medicine" and increasingly favor "less demanding" fields that require less training. A delegation of the **American Society of General Surgeons** and the local chapter of the **American College of Surgeons** (including **Dr. Peter Gill**, **Dr. Arnold Herman**, and **Dr. Richard Wong**) along with RIMS staff (**Steve DeToy** and **Newell Warde**) paid a visit to **Representative Patrick Kennedy** on April 5 to alert him to these trends and to their significance.

## n 15 Steps to protect your practice from abusive payment tactics

The AMA's office of Private Sector Advocacy has announced a new product, "15 Steps to Protect Your Practice from Abusive Payment Tactics." These steps are easy-to-implement tools that will organize physicians' practices in ways that make it easier to confront abusive payment practices. For more info, go to: <http://www.ama-assn.org/ama/upload/mm/368/psa15steps.pdf>

[THIS PAGE--FULLPAGE NORCAL AD--PLEASE USE SAME ART AS IN PREVIOUS ISSUE]

## A Month in the Life of RIMS: May 2002

**May 1** RIMS Committee on Continuing Medical Education (Patrick Sweeney, MD, PhD, MPH, Chair).

**May 2** Blue Cross at RIMS on radiology initiative, oncology management.

**May 2** Legal counsel and staff for Blue Cross, United Healthcare and RIMS, at RIMS, on implementation of the Prompt Processing Law.

**May 3** Workers' Compensation Advisory Council

**May 3-4** RIMS host for New England Council of State Medical Societies and New England Delegation to the AMA, in Newport.

**May 5-7** AMA's State Action Team (including New England's representative Steve DeToy of RIMS) met in Charlottesville, VA.

**May 6** RIMS Executive Committee.

**May 7** RIMS' Physicians' Health Committee (Herbert Rakatansky, MD, Chair) met at RIMS with administrators and legal counsel for the Board of Medical Licensure and Discipline.

**May 7** Brown Medical Student Health Council, with RIMS advisors, at RIMS.

**May 8** *Direct-to-Consumer-Advertising and Samples in the Office*, two panel discussions and debates with a representative of Pfizer and community physicians, moderated by Dr. Herbert Rakatansky, at the Radisson Hotel, Warwick.

**May 9** Legal counsel and staff for Blue Cross, United Health-care and RIMS, at RIMS, on implementation of the Prompt Processing Law.

**May 9** Organizational meeting of specialties at RIMS, on radiological initiative (See story, page 2).

**May 9-10** Crittenden's Medical Liability Insurance Conference, RIMS Insurance Brokerage Corporation's director and staff, in Dallas.

**May 11** RIMS Foundation Sixth Annual bicycle helmet give-away at Rhode Island Kids Safety Day.

**May 11** *Tar Wars*: Ninth Annual state-wide antismoking poster contest. (See story in next month's *Rhode Island Medical News*.)

**May 14** American College of Surgeons, at RIMS.

**May 16** Legal counsel and staff for Blue Cross, United Healthcare and RIMS, at RIMS, on implementation of the Prompt Processing Law.

**May 16-18** Physician Insurers Association of America, annual meeting, RIMS Insurance Brokerage Corporation's director, Robert A. Anderson, in Denver.

**May 16** RIMPAC and gubernatorial candidate Myrth York at RIMS.

**May 16** RIMS Medical Review Advisory Committee (Peter A. Hollmann, MD, Chair)

**May 17** Rhode Island Medical Women's Association board meeting at RIMS.

**May 20** State Action Team conference call on professional liability insurance.

**May 23** RIMS and provider relations staff from BCBSRI.

**May 23** *Healthcare Safety 2002: The Challenge of Medical Error*, Richard Frankenstein, 2002 Chapin Oration, Ray Conference Center

**May 30-June 1** NORCAL Mutual Insurance Company Annual Meeting and board meeting, attended by RIMS Insurance Brokerage Corporation president Peter A. Hollmann, MD, and board member David P. Carter, MD, John D. Nisbet, II, MD, and RIMS/IBC staff, in Monterey.

## Thanks to RIMPAC's new major donors

RIMPAC's new major donor program has attracted significant interest. The Rhode Island physicians listed below have already opted to increase their annual donations to RIMPAC under the new program. RIMS salutes and thanks these leaders for their generous support of RIMS' mission through RIMPAC. Their commitment benefits all Rhode Island physicians and patients.

### Participants in RIMPAC's New "Major Donor" Program (As of May 29, 2002)

GREGORY J. AUSTIN, MD  
 JACQUES BONNET-EYMARD, MD  
 COLLEAN A. CLEARY, MD  
 ROBERT E. CURRAN, MD  
 JAMES DOBBIN, MD  
 YUL D. EJNES, MD  
 DAVID B. ETENSOHN, MD  
 DONALD B. FLETCHER, MD  
 ROBERT JANIGIAN, MD  
 LORY C. SNADY-MCCOY, MD  
 MICHAEL E. MIGLIORI, MD  
 CHARLES M. ROSENTHAL, MD

## Bulletin Board Open for Business

Please take advantage of this opportunity to communicate with your colleagues.

RIMS recently opened a new members-only bulletin board. The bulletin board is a place where you can post opinions, ask questions, and participate in online discussions with your fellow RIMS members and RIMS leadership, at a time that is convenient to you. If you prefer to just read what others post (a practice known as “lurking” in cyberspeak), that’s also fine.

To access the bulletin board, go to [www.rimed.org](http://www.rimed.org) and click on the “Bulletin Board” button. Enter your user ID, which is your RI medical license number in the format “MDxxxxx”, with a zero placed in front of your license number if it is a four-digit number. Your assigned password is the same as your user ID, but you can and should change it to something else when you access the bulletin board.

## Important Reminder about the next RIMS Member Directory

RIMS is now in the process of preparing its 2002 member directory for publication. Members are reminded that pages 45 and 47 of the current directory provide copies of forms that should be used to update directory information. These forms can be torn out and mailed or photocopied and faxed to RIMS. Please take a moment to make sure that your information is current and accurate with RIMS and reflects the way you should be listed in RIMS’ next member directory.