

# ST. LOUIS METROPOLITAN MEDICINE

VOLUME 31, NUMBER 5

SEPTEMBER / OCTOBER 2009



## END-OF-LIFE CARE

Difficult Concerns, Caring Choices.....page 18

2010 SLMMS  
Council candidates *page 10*

Year-end tax tips *page 16*

---

# Harry's Homilies<sup>©</sup>

Harry L.S. Knopf, MD

## THERE IS NO SUBSTITUTE FOR GETTING OLDER

How many times have you heard this: "It is hell to get old!?" And what is your answer? "What's the alternative?" Exactly! You get older or you die. Or, you get older **and** you die. There is a difference. The time between now and getting old is "life." Enjoy it!



---

*Dr. Knopf is editor of Harry's Homilies.©  
He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.*

---

# SCAM-Q\*

\* How insurance companies, hospitals, government, etc. Slice Costs And Maintain Quality

## To Be or Not to Be

By Richard J. Gimpelson, MD

Everyone knows the beginning to Hamlet's Soliloquy in which he contemplates death. Since this journal issue covers end-of-life counseling, I felt that I should cover what comes after end-of-life counseling, and that is end of life.

I want to make it clear that HB 3200, the current Democratic proposal on medical care reform, has a mandate for the physician to give end-of-life counseling to individuals over 65 years old at least every five years. One can call it whatever they want, but the bottom line is this is pre-death counseling. It may be good. It may be bad. In either case, it is not appropriate for the government to mandate this to physicians.

To make it easier for you, my colleagues, I have listed a number of quotes on death that you may use in your end-of-life counseling:

"I want to die in my sleep like my grandfather – not screaming and yelling like the passengers in his car." – Wil Shriner

"The difference between sex and death is that with death you can do it alone and no one is going to make fun of you." – Woody Allen

"On the plus side, death is one of the few things that can be done just as easily lying down." – Woody Allen

"According to most studies, people's number one fear is public speaking. Number two is death. Death is number two! Does that sound right? This means to the average person, if you go to a funeral, you're better off in the casket than doing the eulogy." – Jerry Seinfeld

"At my age, I'm often asked if I'm frightened of death and my reply is always, I can't remember being frightened of birth." – Peter Ustinov

"At my age flowers scare me." – George Burns

"My uncle Sammy was an angry man. He had printed on his tombstone: What are you looking at?" – Margaret Smith

"I was with this girl the other night and from the way she was responding to my skillful caresses, you would have sworn that she was conscious from the top of her head to the tag on her toe." – Emo Philips

"There are worse things than death. If you've ever spent an evening with an insurance salesman, you know exactly what I mean." (*Love and Death, 1975*). – Woody Allen

"It is impossible to experience one's death objectively and still carry a tune." – Woody Allen

"Was Uncle Oscar's death very untimely, you ask? Well, it was near lunch." – Archie Bunker

"For three days after death, hair and fingernails continue to grow but phone calls taper off." – Johnny Carson

"I've come to look upon death the same way I look upon root-canal work. Everyone else seems to get through it all right, so it couldn't be too difficult for me." – Joseph Heller

THE END!



---

*Dr. Gimpelson, a past president of SLMMS, is a gynecologist in private practice.*

---



Richard J. Gimpelson, MD

**St. Louis Metropolitan  
Medicine**

**www.slmms.org**

Thomas A. Watters, CAE  
*Managing Editor*  
twatters@slmms.org

James Braibish  
Braibish Communications  
*Associate Editor*  
editor@slmms.org

**Publication Committee**

Erol Amon, MD  
Gregory R. Galakatos, MD  
Arthur H. Gale, MD  
Richard J. Gimpelson, MD  
Harry L.S. Knopf, MD  
Lawrence W. O'Neal, MD  
Michael J. Stadnyk, MD

**St. Louis Metropolitan  
Medical Society**

**Officers**

Elie C. Azrak, MD, *President*  
Sam Hawatmeh, MD, *President-Elect*  
Thomas A. Applewhite, *Vice President*  
Robert A. Brennan, Jr., MD, *Secretary*  
David L. Pohl, MD, *Treasurer*  
George J. Hruza, MD,  
*Immediate Past President*

**Councilors**

David K. Bean, DO  
David E. Bryan, MD  
Katherine A. Burns, MD  
J. Collins Corder, MD  
Joseph A. Craft, III, MD  
Norman S. Druck, MD  
Thomas R. Forgét, MD  
J. Michael Hatlelid, MD  
Beverly B. Kraemer, MD  
Gerald T. Lionelli, MD  
Robert McMahon, MD  
Jay Meyer, MD  
Janet M. Ruzycki, MD  
Michael J. Stadnyk, MD  
Stacey S. Tull, MD  
Marty Vollmar, MD  
Mark D. Wittry, MD

Thomas A. Watters, CAE  
*Executive Vice President*

*St. Louis Metropolitan Medicine*, official bulletin of the St. Louis Metropolitan Medical Society (SLMMS), (ISSN 0892-1334, USPS 006-522) is published bi-monthly by the St. Louis Metropolitan Medical Society; 680 Craig Rd., Ste. 308; Saint Louis, MO 63141-7120; (314) 989-1014, FAX (314) 989-0560. Printed by Messenger Printing Co., Saint Louis, MO 63122. Periodicals postage paid at St. Louis, MO.

**Established 1880.** Owned and edited by the St. Louis Metropolitan Medical Society and published under the direction of the SLMMS Council.

**Advertising Information:** *SLMM*, 680 Craig Rd., Ste. 308; Saint Louis, MO 63141-7120; (314) 989-1014.

**Postmaster:** Send address correspondence to: *St. Louis Metropolitan Medicine*; 680 Craig Rd., Ste. 308; Saint Louis, MO 63141-7120.

**Annual subscription rates:** Members, \$10 (included in dues); nonmembers, \$45. Single copies: \$10.

ST. LOUIS METROPOLITAN

**MEDICINE**

Volume 31

Number 5

**SEPTEMBER / OCTOBER 2009**

**COVER FEATURE: End-of-Life Care**

- 18 Care at the End of Life: Difficult Concerns, Caring Choices**  
*How well do physicians handle end-of-life issues? What can be done? Local experts weigh in*
- 22 Palliative Care: Providing Comfort, Easing Symptoms**  
*An important and growing field of medicine*
- 24 Legal Measures Enable Patients to Express Their End-of-Life Wishes**  
*A look at advance directives for health care*

**Features**

- 10 Meet Your 2009 SLMMS Officer and Councilor Candidates**  
*Voting takes place online between November 2 and 25*
- 16 Now Is Time to Act on 2009 Year-End Tax Savings**  
*Stimulus bill provides tax advantages in depreciation, EHR purchases*  
*By Kris Pearce, CPA, AMD Health Care Services*
- 27 Financial Planning for Your Retirement Years**  
*Paying for long-term care is major concern*  
*By Bill Bender, CPA, PFS, MS, Mason Road Wealth Advisors*

**Columns**

- 4 President's Page: Elie C. Azrak, MD, FACC, FSCAI**  
*Health Reform and Policies on End-of-Life Care: Bipartisanship is on Life Support!*
- 6 Executive Vice President: Thomas A. Watters, CAE**  
*A Report Card on the Health of SLMMS Using the M-S-R-P Formula*
- 1 SCAM-Q: Richard J. Gimpelson, MD**  
*To Be or Not to Be*

**News**

- 5 Director of AMA Litigation Center to Present Hippocrates Lecture**
- 9 Nov. 7 Symposium: Medical Ethics and End-of-Life Care**
- 14 Writings of Arthur Gale, MD, Compiled**
- 29 Q&A with AAIM**

**Departments**

- 1 Harry's Homilies**
- 28 Newsmakers**
- 30 Alliance**
- 31 Calendar**
- 32 Minutes of the SLMMS Council**
- 34 Obituaries**
- 36 Birthdays**
- 37 Welcome New Members**

The advertisements, articles, and "Letters" appearing in *St. Louis Metropolitan Medicine*, and the statements and opinions contained therein, are for the interest of its readers and do not represent the official position or endorsement of the St. Louis Metropolitan Medical Society. *SLMM* reserves the right to make the final decision on all content and advertisements.



## Health Reform and Policies on End-of-Life Care: Bipartisanship Is on Life Support!



Medical Society President  
Elie C. Azrak, MD

*Karen Ann Quinlan, 1976*  
*Nancy Cruzan, 1990*  
*Teresa Schiavo, 2004*

**T**hese, among others, have been landmark court cases that have shaped the end-of-life debate over the past 30 years in the United States. The first of these, the New Jersey Supreme Court decision in the case of Karen Ann Quinlan, established the right to refuse medical care. Since then,

the U.S. Supreme Court has affirmed this right to reject life-sustaining treatment, and the much-publicized Terri Schiavo case further raised public awareness of this issue, leading to a national discussion.

As a result, polls have shown that 80 percent of Americans would not want to be kept alive in a persistent vegetative state. A similar number endorse living wills, also known as advance medical directives. Unfortunately, only 20 percent of American adults have living wills. This number has remained relatively unmoved since the Cruzan decision in 1990.

Now came House Resolution 3200, a monster vehicle for health care overhaul(!) and in it came Section 1233 – *Advance Care Planning Consultation* – a provision allowing Medicare coverage and reimbursement for consultations focusing on end-of-life decisions, including “*explanation by the practitioner ... of living wills and durable powers of attorney ... the role and responsibilities of a health care proxy ...*” and the “*continuum of end-of-life services and supports available, including palliative care and hospice, and benefits for such services and supports*

*that are available under this title.”*

No sooner was this bill marked up in the House of Representatives Tri-Committee on Health Reform, than an immense wave of disdain and repulsion came crashing from a vocal opposition, comparing the above provisions to a government system dictating when to “pull the plug on grandma,” and equating this legislative effort to putting in place “death panels,” implying a Nazi or Stalinist totalitarian concept!

The contentious nature of this high-stakes debate certainly is no surprise to anybody. Nonetheless, one might find it unfortunate that an issue carrying widespread support from 80 percent of Americans, would easily be distorted and misrepresented in the public arena, and that a vocal minority could cause the reason of the majority to be drowned in a sea of distortion.

The central question in my opinion remains the following: once the natural end of an individual’s living time is inevitably close (such as in terminal cancer or persistent vegetative state), once available medical treatments and medical technology can only offer temporizing measures, futile in the sense that they can no longer affect the natural course of an illness or condition, does the individual (or a surrogate) have a fundamental right to determine the circumstances with which he or she wants to be surrounded? If the answer is “yes” (in the opinion of the majority, upheld by the courts), then the institutions of society (government, the health care system, communities, and families) need to set in place the mechanisms and processes to facilitate the expression of this right. However, this should not mean that the institutions can take over that right and act as the *de-facto* surrogate!

The absence of such defined societal mechanisms enables confusion, and can engender undue discretion among third parties (government, insurance companies, ideologically or financially

“ **Once available medical treatments and medical technology can only offer temporizing measures, does the individual (or a surrogate) have a fundamental right to determine the circumstances with which he or she wants to be surrounded?** ”

motivated health systems or providers, or even family members) to overreach and “play God!”

In this context one would view the advanced care planning provisions of House Resolution 3200 as a step in the right direction. Achieving consensus among 80 percent of Americans on any issue, needless to say, is extremely difficult; but on this issue there is consensus. Is the bipartisan effort in the legislature “dead on arrival?” Should we “pull the plug” on any hope to develop reasonable end-of-life policies, or should we keep this hope on life-support?(!)

In this issue of *St. Louis Metropolitan Medicine* we have invited leaders in the field of health care ethics to address important questions regarding end-of-life decisions. I invite all of our members to participate in this discussion, use *St. Louis Metropolitan Medicine* as a forum to share your experience, and to add valuable opinions to the debate. Send us your comments via e-mail at [president@slmms.org](mailto:president@slmms.org).



## Director of AMA Litigation Center to Present Hippocrates Lecture on Dec. 3

Leonard Nelson, director of the Litigation Center of the American Medical Association, will be the featured speaker at the annual SLMMS Hippocrates Lecture on Thursday, Dec. 3 at 6:30 p.m. at Ces & Judy’s Catering, 10405 Clayton Rd. The title of his presentation is, “How the AMA Fights for Physicians in the Courtroom.”

The lecture is free to SLMMS members; admission for non-members is \$75. For information or to register, contact Liz Webb at (314) 989-1014, ext. 108, or [lizw@slmms.org](mailto:lizw@slmms.org).

The Litigation Center of the AMA and the state medical societies is the voice of America’s medical profession in legal proceedings around the country. Established in 1995, the Litigation Center provides physicians with legal assistance and expertise. Since its inception, the Litigation Center has participated in nearly 200 cases. Some of these cases have set important legal precedents; some have had broad, practical implications for patients or the medical profession, and some have simply been the right thing to do.

The Litigation Center’s docket of cases casts a wide net over the medical-legal landscape, including physician payment issues, medical staff privileges, medical liability issues, peer review, and scope-of-practice matters, among many other topics. Forums range from administrative proceedings to cases before the United States Supreme Court. At any given time, the Litigation Center has approximately 25 active cases.

# Matthew P. Reardon

*is your representative  
of the  
SLMMS Association  
Group Health Plan*

- **SLMMS Association  
Group Health Plans**
- **Office Package**
- **Workers Compensation**
- **Surety Bonds**
- **Automobile, Home  
& Umbrella**

## 314.983.2357

**425 North New Ballas Rd.  
Saint Louis, MO 63141**

**[mreardon@missourigeneral.com](mailto:mreardon@missourigeneral.com)**

# MSRP – Manufacturer’s Suggested Retail Price?

*A report card on the health of SLMMS using the M-S-R-P formula*

*By Tom Watters, CAE  
SLMMS Executive Vice President*



**Medical Society  
Executive Vice President  
Thomas A. Watters, CAE**

**S**ome time ago I attended an association management seminar on the topic of evaluating the “health” of an association or membership society. A few key indicators of success were presented, which leaders of organizations might use to determine how well their organization is doing.

I’ve applied these criteria many times over the years, and I believe they are still valuable indicators of the success (or failure) of a membership organization. They are actually

very simple and can be remembered by use of a short acronym, MSRP. No, as you probably expect, it doesn’t stand for manufacturer’s suggested retail price. It stands for Membership, Service, Revenue and Participation – in no particular order.

Membership is probably the criterion most often applied to the evaluation of how well an organization is doing. If your membership

is up, you’re assumed to be doing well; if down, not so well. Sometimes other factors creep in – in a down economy, or with a shrinking potential membership base to draw from – you may be down, but doing well considering a negative environment.

SLMMS has been holding its own, but barely. Two years ago, we gained 15 members. Last year we lost 46 members. This year, we’re slightly negative, and stand at about 1,480 total members – 47 year to date. But, we have several months to add new members, hopefully to get back to even and perhaps even grow a little. (If you’ve been thinking about inviting one of your associates to join and have been putting it off, now’s the time!)

One of the reasons we struggle in finding new members today is because even though there are nearly 6,000 physicians in the St. Louis area, a large portion – perhaps nearly half – are hospital employees. We get very few of these docs to join us in our efforts in organized medicine. For some reason, a larger proportion of the “employed” physicians fail to see the need. I suppose they believe

that we’ll do all the advocacy work with or without them (a little like driving Missouri highways and not paying their taxes) and that the hospitals are already looking after their interests. You think?

So, our membership numbers struggle in a tough environment, but we’re holding our own. I give us a C+.

What about service? Service, in this context, is defined as the programs and services we provide to our members and the community. I believe we do well in this regard. It would take several pages to review all that we do on an ongoing basis, but we publish a quality and informative journal, communicate important issues by e-mail, advocate on behalf of our members with insurance companies and third-party payers, actively support legislation that is good for us and oppose that which is not. We provide continuing medical education and CMEs, convey our local message to the organized bodies at the state and local levels, and constantly monitor local issues of impor-

tance to our members and their patients. As an added benefit, we provide opportunities for local networking and camaraderie that are not available elsewhere.

So, I give us an A- in the service category. How about revenue? Association management gurus say that this is a key indicator of success. It goes almost hand in hand with membership, but it’s nice if you have some additional sources

of income outside of dues.

I’ll cut right to the chase on this one. I give us a B. While dues remain our primary source of revenue, each year we sell nearly \$50,000 in advertising in our journal, we perform administrative services (and bill accordingly) for several regional specialty societies, obtain occasional but important sponsorships for key events, and have reasonable reserves which usually provide investment income each year on which we can draw, if needed.

Finally, participation. This is a sore spot for our group. Unfortunately, I have to give us a D. Our core group of leaders – council members, past presidents, etc. – is stalwart and steady. But each year we struggle to find new leaders willing to serve at either the council level or on committees. This situation is not unique to organized medicine, as indicated by the old association proverb called “The Ten Percent Rule.” It states that 90 percent of most volunteer organization work is done by 10 percent of the members. Unfortunately, this is a truism in the association world, and a reality with which we all must deal.

“ All in all, I believe SLMMS is holding its own in a tough and competitive environment. Recent years have not been the best of times for physicians and their practices. ”

# MSRP – Manufacturer’s Suggested Retail Price?

(continued from page 6)

Our CME events, well planned and normally receiving high praise, are normally attended by only 5-10 percent of our members. Even our most special event, the Hippocrates Lecture, is attended by a minimum number of members, even though it’s a free event for members and spouses and always has an outstanding speaker, usually of national renown. Our annual installation banquet – an important event for the society and a great social occasion – is usually attended by less than five percent of our members.

This lack of participation is the issue that worries me the most. First, in my experience I believe it is THE key indicator of success, and I believe it **leads** the other indicators as a forerunner of prediction. If participation starts to slide, the others will eventually follow. The nice thing is, this one isn’t a mystery to fix. The members are out there, and each one of you has the power to easily do your part. Increasing our participation factor is as easy as you attending an event, or volunteering to serve on a committee or council.

All in all, I believe SLMMS is holding its own in a tough and competitive environment. Recent years have not been the best of times for

physicians and their practices, and I think the negative feelings frequently carry over and hurt organized medicine as well. To continue to succeed in the future as we have in the past, we need to focus on two things. First, we need to focus on the needs of our members, which are not necessarily the same as the needs of the association, and second, we need to clarify and reach consensus on what constitutes “value” to our members. If we can do this, our long-term success will continue.

Let us know where you think we should concentrate our efforts.

## SLMMS Report Card

|               |    |
|---------------|----|
| Membership    | C+ |
| Service       | A- |
| Revenue       | B  |
| Participation | D  |



## Statement of Ownership, Management and Circulation (USPS Form 3526)

1. Publication Title: St. Louis Metropolitan Medicine
2. Publication No.: 0892-1334
3. Date of filing: October 1, 2009
4. Issue Frequency: Bi-Monthly
5. No. of issues published annually: 6
6. Annual subscription price: \$10-Members; \$45-Nonmembers
7. Complete mailing address of known office of publication: St. Louis Metropolitan Medical Society, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120. Contact person: Thomas Watters, (314) 989-1014
8. Complete mailing address of the headquarters or general business office of the publisher: St. Louis Metropolitan Medical Society, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120
9. Full names and complete mailing addresses of publisher, editor, and managing editor:

- Publisher: St. Louis Metropolitan Medical Society, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120. Editor and Managing Editor: Thomas Watters, St. Louis Metropolitan Medical Society, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120.
10. Owner: St. Louis Metropolitan Medical Society, 680 Craig Rd., Suite 308, St. Louis, MO 63141-7120.
  11. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of the total amount of bonds, mortgages, or other securities: None.
  12. Tax Status: Has not changed during the preceding 12 months.
  13. Publication title: St. Louis Metropolitan Medicine
  14. Issue date for circulation data: July/August 2009
  15. Extent and nature of circulation

|  | Average No. Copies Each Issue During Preceding 12 Months |       | No. Copies of Single Issue Published Nearest Filing Date |       |
|--|--|-------|--|-------|
|  |  |       |  |       |
| a. Total no. copies (net press run)  | 2,046  | 2,069 |  |       |
| b. Paid circulation  |  |       |  |       |
| (1) Mailed outside-county paid subscriptions   | 167  | 167   | (1) Outside-county                                       | 76    |
| (2) Mailed in-county paid subscriptions  | 1,535  | 1,480 | (2) In-county  | 47    |
| (3) Paid distribution outside the mails including sales through dealers and carriers, street vendors, counter sales, other | 0  | 0     | (3) Mailed at other classes through USPS                 | 3     |
| (4) Paid distribution by other classes of mail through USPS  | 0  | 0     | (4) Distribution outside the mail                        | 21    |
| c. Total paid distribution (sum of 15b(1), (2), (3) and (4))   | 1,702  | 1,647 | e. Total free or nominal rate distribution               | 147   |
| d. Free or nominal rate distribution   |  |       | f. Total distribution (sum of 15c and 15e)               | 1,849 |
|  |  |       | g. Copies not distributed                                | 197   |
|  |  |       | h. Total (sum of 15f and 15g)                            | 2,046 |
|  |  |       | i. Percent Paid (15c divided by 15f times 100)           | 92%   |
|  |  |       |  | 89%   |

I certify that all information furnished on this form is true and complete. Thomas A. Watters, Managing Editor.

# Now Is Time to Act on 2009 Year-End Tax Savings

Stimulus bill provides tax advantages in depreciation, EHR purchases

*Kris L. Pearce, CPA  
AMD Health Care Services Team*

**W**ith all of the changes that have occurred to date during 2009, physician practices are searching for strategies to maximize the advantages of the new laws. Following are tips to make the most of these changes and to prepare for any additional changes that could come yet this year.

The law that provides the most new items relevant to physician practices is the American Recovery and Reinvestment Act. Signed into law on February 17, 2009, this act contains several income tax incentives that could be applicable to your practice. The most significant relate to bonus depreciation and extending the higher limits for Section 179 expensing. There are also several benefits beyond income tax savings for those who implement and meet certain requirements relating to an EHR, as well as submitting information and data under the PQRI guidelines. Here are some specifics:

## Section 179 Expensing

Set to expire at the end of 2008, Section 179 rules have been extended for one year and now apply to years beginning in 2009. Utilizing Section 179 allows a physician practice to deduct the cost of purchasing fixed assets entirely in the current year, rather than over multiple years. The deduction available remains at \$250,000 and the phase-out threshold stays at \$800,000, both the same limits as 2008. Items to remember regarding Section 179 are:

- It can be utilized on new or used assets.
- It can only be used to the extent that there is income. If there is a net operating loss no deduction is allowed.
- Once a practice purchases \$1,050,000 of eligible property in the current year then the entity is phased out and is no longer eligible for this tax-saving opportunity.
- In 2010 these numbers are set to revert back to pre-2008 numbers adjusted for inflation, unless Congress acts. So, stay tuned.

## Bonus Depreciation

Also set to expire at the end of 2008, bonus depreciation rules have been extended for 2009. Bonus depreciation allows an additional 50 percent of the asset's cost to be depreciated in the year the asset is pur-



chased. Items to remember related to bonus depreciation:

- Property must be new.
  - The property must be purchased and placed in service in 2009.
  - The property must be qualified property which includes MACRS property with a recovery period of 20 years or less.
  - If the property is sold in the same year as purchased then no bonus depreciation is allowed.
  - Bonus depreciation may be allowed in addition to the utilization of Section 179.
- There is no phase-out with regard to the amount of property that is purchased.

## Section 179 and Bonus Depreciation Planning Points

Top three items to remember:

- Section 179 should be used before bonus when the property purchased is less than \$800,000.
- Consider using Section 179 on used property first in order to claim bonus depreciation on new property.
- Not all states conform to bonus depreciation or higher Section 179 rules. It should be verified with a tax preparer if your state follows the bonus depreciation and 179 rules.

## Time May be Right to Purchase EHR

If large purchases are in your near future, it could be advantageous to purchase the property in 2009 rather than 2010. One large purchase of particular benefit to physician practices is the software and other items required to implement EHR. By purchasing an EHR system in 2009, a practice will be eligible to take the bonus depreciation as well as the higher Section 179 limitations. However, if the practice expects income to be significantly higher in 2010, it might be advantageous to wait until 2010.

There are also financial benefits to implementing an EHR system by 2011. Starting in 2011 there will be payments from Medicare to those practices that qualify. The sooner the EHR is implemented, the larger the payments the medical practice is eli-

---

gible to receive. The most a practice can benefit from this program is \$44,000. Even though the financial benefits will not begin until 2011, it is important to start this process as soon as possible as it can take 12-18 months to move from the system selection process to implementing and using it in a “meaningful way.” To qualify for the program the following conditions must be met:

- The EHR system must be certified (most likely CCHIT certified).
- The EHR system must use E-prescribing.
- There must be exchange of health information (for example, sending orders electronically to a lab and receiving results back electronically).

The primary issue with selecting an EHR now is the system must have “meaningful use” to receive the payments from Medicare, and meaningful use has not been defined. A way to avoid a system not meeting the meaningful-use test is to include conditions in the vendor purchase contract that once the definition has been determined the vendor is responsible for upgrading the system to meet the standards in a defined period of time. Since the incentives are paid over five years, it is likely that the meaningful-use definition could continue to be updated over the time frame as well. Before implementing an EHR, it is beneficial to perform an operations assessment to determine what is working well and what is not so that inefficient processes can be improved prior to automation. This assessment will also help evaluate how the automation will affect your current operations.

### Incentives Regarding PQRI

There are also incentives for those practices that submit physician quality reporting initiative (PQRI) data. While this program is a permanent program, payments have only been authorized through 2010. This program results in an additional two percent of Medicare charges for payers who submit specific data elements. CMS has established two reporting periods which are January 1 through December 31, or July 1 through December 31. For 2009 there are nine options for satisfactorily reporting quality measures. The options differ based on:

- the reporting period chosen

- if the physician chooses to report through claims or an approved clinical registry
- whether it is reported on individual or group measures

### Be Prepared – There Could Be More to Come

Another item to consider, when debating whether to make large purchases in 2009 or 2010, is the uncertainty with the current tax rates. There is some speculation that the highest tax rates will increase for 2010, which might be a reason to delay deductions.

For physicians, there have already been a lot of changes in the first part of the year as to the way business is done. With additional changes likely to come before the year is through, it is important to note the savings that are available now and how to maximize them for your current situation.



---

*Kris Pearce is a senior tax associate with Anders Minkler & Diehl LLP's health care services team. For more information on the latest tax updates, contact Kris at (314) 655-5160 or [kpearce@amdcpa.com](mailto:kpearce@amdcpa.com).*

---

# Care at the End of Life: Difficult Concerns, Caring Choices

How well do physicians handle end-of-life issues? What can be done?  
Local experts weigh in

**A**pproaching the end of a patient's life is a difficult time for both the physician and the family. When should the focus be on curing disease and prolonging life? At what point should care shift to emphasizing comfort and dignity?

The answers are not always easy or clear, say local physicians and other experts. Good end-of-life care seeks an optimum balance between prolonging life and providing for the patient's comfort, dignity and well-being.

Treatments designed to prolong life but not necessarily retain quality of life are a focal point of debate. A *New England Journal of Medicine* study in 1993 found that 30 percent of Medicare dollars are spent during the last year of life, and half of that is spent during the last 60 days.

"Today's high-tech medical care can sustain technical life – the beating heart – but utterly fails to restore real quality of life for many," writes Columbus, Ohio, physician Jeff Gordon, MD, in his book, *A Death Prolonged*, recently reported in the *New York Times*. "Patients and loved ones need to know that they can choose treatment goals which allow a dignified natural death with minimal suffering, rather than a prolonged agonizing existence."

Discussing end-of-life issues can benefit patients and save money, says a study lead by researchers at the Dana-Farber Cancer Institute published recently in the *Archives of Internal Medicine*. Of 600 patients with advanced cancer who were interviewed, the majority – 69 percent – said end-of-life conversations had not taken place. Those patients who had talked with their doctors had medical bills that were 36 percent lower on average.

To help provide insight into end-of-life issues, *St. Louis Metro-*

*politan Medicine* posed a series of questions to local physicians and medical ethicists who are expert in the field. Responding to our questions are:

- **Edward Burns, MD, MA** (SLMMS), director of palliative medicine and the ethics department at St. Anthony's Medical Center
- **James DuBois, PhD, DSc**, chair of the Department of Health-Care Ethics at Saint Louis University School of Medicine
- **John Morley, MD**, director of the Division of Geriatric Medicine at Saint Louis University School of Medicine and GRECC, St. Louis VA Medical Center
- **Griffin Trotter, MD, PhD**, professor of health care ethics at Saint Louis University

Drs. Burns, DuBois and Trotter will be speakers at the Nov. 7 SLMMS symposium, "Medical Ethics and End-of-Life Care."

*What message do you most want to convey to physicians on handling end-of-life issues?*

**Dr. Trotter:** Keep patients and their families in the loop. For the most part, they are better able to handle a frank and serious discussion of medical realities than we give them credit for.

**Dr. Burns:** Physicians have been educated to diagnose and treat illness, hopefully for cure and when this is not possible to prolong life. We pride ourselves in our ability to do this well, but as good as we do our jobs it is inevitable that our efforts are limited and eventually will fail. Unfortunately we have had limited education in dealing with this aspect of patient and family care.

My primary message to physicians is that this is as important an opportunity for care as anything else we do. It is often one of the most

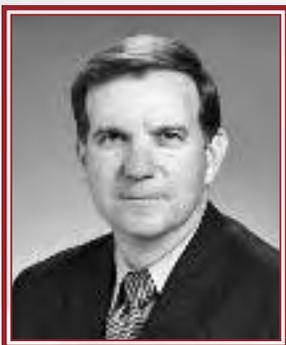
## SLMMS Symposium to Explore End-of-Life Issues

Issues surrounding end-of-life care will be the focus of the fall SLMMS continuing education symposium, "Medical Ethics and End-of-Life Care," on Saturday, Nov. 7, from 8 a.m. to 12:30 p.m.

Speakers will include James DuBois, PhD, DSc, and Griffin Trotter, MD, PhD, both of the Department of Health Care Ethics at Saint Louis University School of Medicine, along with Edward Burns,

MD, MA, director of palliative medicine and the ethics department at St. Anthony's Medical Center and Erin Bakanas, MD, MA, and Miguel Paniagua, MD.

There is no cost to SLMMS members to attend. For more information or to register, contact Liz Webb at (314) 989-1014 or [lizw@slmms.org](mailto:lizw@slmms.org)



Edward Burns, MD, MA



James DuBois, PhD, DSc



John Morley, MD



Griffin Trotter, MD, PhD

stressful times for families, and possessing the skills to effectively provide quality of life and comfort to our patients is just as much a part of being a physician as providing curative treatment.

**Dr. Morley:** The science of handling end-of-life issues has expanded dramatically in the last five years. Thus, an expert on palliative care should be consulted. However, most patients want their physician to continue to be involved in their care. End-of-life care needs to be extended beyond cancer to other areas such as heart failure, dementia and COPD.

***Do physicians avoid having conversations about end-of-life issues with patients? If so, why?***

**Dr. Trotter:** They frequently do, and the reasons seem to be fairly straightforward. Not only patients, but also doctors, have difficulty in accepting the inevitability of death – even as death looms ever closer. Furthermore, talking about end-of-life issues is apt to be interpreted as being defeatist. The thinking is often, implicitly, “Let’s focus on what we’re trying to achieve, rather than what we’ll do if things go very wrong.”

**Dr. Morley:** This is variable. Most physicians are trained to save life and are uncomfortable discussing death.

**Dr. Burns:** Physicians like most human beings struggle with end-of-life issues for their patients. When we cannot make someone whole again there is a sense of failure. But the real failure would be in not providing the expertise and care needed for these people at this time. No one wants to give bad news, and unfortunately this is often true for physicians.

Because we can never be entirely certain about time, in end-of-life care it is easy to delay the conversation, but it is this delay that often causes further distress for patients and families as they attempt to live their lives to the fullest. Recent studies have questioned patients and families and found their biggest concern is that they made changes too late because they were not informed early enough. All felt that compassionate honesty from the health care team would have better prepared them for the time available. This is opposite of a physicians’ survey in which they explained their delaying this conversation to not wanting to contribute to destroying the patient’s hope.

This delay often robs patients and families of precious time to re-focus their hopes and utilize the resources to live their lives to the fullest quality available. I think it is always important for physi-

cians to place themselves in their patient’s position and ask what they would want to know from their doctor at this time.

***Do physicians currently do a good job of handling end-of-life issues with patients? How so or not so?***

**Dr. Trotter:** For the most part, yes. Most experienced physicians have learned well from their experiences, and are adept at handling the nuances of communicating on this difficult subject.

**Dr. Burns:** Once it is recognized that patients are terminally ill with a limited life expectancy, physicians for the most part are doing a very good job. They recognize that this process involves more than just the patient and appropriately utilize the services that hospice can offer. Unfortunately this often occurs late in the process.

I think that the most important aspect for physicians during this time is not necessarily an expertise in management of all of the medical issue in end-of-life care but just in continuing to be a part of that care with the hospice team as this presence for families is very important. Patients are aware of the time constraints placed on their doctors today, but families and patients appreciate that call and concern from their personal doctor, even when they can no longer cure them.

**Dr. Morley:** Most physicians tend to involve end-of-life care too late. This is particularly true of hospice care.

***Some in the health-care reform debate say too much money is spent on futile and expensive treatments (feeding tubes, ventilators, etc.) that prolong life but do not provide quality of life or comfort. Is this true?***

**Dr. Trotter:** I think it is indeed true, if what counts as “futile” is judged retrospectively. Unfortunately, medicine is practiced prospectively. Hence, the magnitude of the “too-many-treatments-near-the-end-of-life” problem is often exaggerated by Monday morning quarterbacks who presume that doctors should usually be able to predict which patients will benefit from intensive treatment and which patients will not. It’s not very helpful to be told to be less aggressive with patients in their last three months of life if you are unable to identify which patients are in their last three months of life.

The best examples are cases where treatment is continued because medical staff or families want to reassure themselves that

---

# Care at the End of Life: Difficult Concerns, Caring Choices

(continued from page 19)

they did “everything possible” for the soon-to-be deceased.

**Dr. Burns:** While it is true that 20-30 percent of the health care dollar for an individual is often spent in the last six months of life I would avoid focusing on simply the futility of these interventions and refocus on ascertaining the risk/benefit of any treatment on an individual level. Ventilators, expensive antibiotics, artificial nutrition, etc. all have a very important place in our medical treatment and can often be employed to save lives and restore patients back to an acceptable quality of life. But these should be used in conjunction with a plan of care that has included a discussion of the risk/benefit and expected quality of life outcome with the patient and/or their surrogate decision maker. Often physicians have taken it upon themselves to make these decisions without true informed consent from patients. While this may hold in an emergency outside of that it is important to respect patient’s autonomy.

**Dr. Morley:** There is little evidence that in the majority of patients feeding tubes extend life. A Michigan study showed that when oncology patients went home rather than continuing chemotherapy, they lived longer.

## *What considerations should the physician and patient take into account when making decisions about life-prolonging treatments?*

**Dr. DuBois:** In many ways, modern medicine fights nature, it intervenes with human technologies to prevent injuries and illnesses from causing death. Often the results are very rewarding. For example, patients who visit the emergency room or who obtain an organ transplantation may gain years of life. However, some times we delay death only at great expense and with little reward. When evaluating whether to initiate or continue life-prolonging treatments, it is important to consider the burdens a treatment will pose and whether the treatment will achieve its intended purpose. It is not morally obligatory to provide treatments that are overly burdensome or futile. However, for physicians decision-making can be very complex when patients or their families demand treatments that physicians believe are futile. In such cases, clear communication of the prognoses is important. But when that does not suffice, calling an ethics consult can also be very helpful insofar as it introduces a somewhat neutral party that can mediate.

**Dr. Burns:** The decision about providing, withdrawing or withholding life-prolonging therapy revolves around the goals of the patient not the health care team. Physicians should respect a patient’s autonomy and seek to provide beneficence (do good) and non-maleficence (avoiding harm). To this end the benefits/risk and expected quality of life outcome should be provided in an honest and unbiased fashion to the patient and/or surrogate so that the decision about care

can be made in an informed way. There often is no right decision in these situations. The *right* decision is whatever the patient feels is best for them. This may not always coincide with what the health care team or their family may think but it is important to respect patient’s choice. The decision between quality of life and preservation of life can only be weighed by the patient. However it is important to realize that even if patients choose to forgo life-prolonging treatment, palliative care should be continued and intensified to minimize any suffering for the patient or family. Patients and families can never be abandoned by the health care team.

**Dr. Morley:** The major question is whether or not the life-prolonging treatment will actually prolong life. Also the physician needs to take into account the effect of these treatments on quality of life.

## *What is the role of palliative care? When should it be implemented?*

**Dr. Burns:** Palliative care is that aspect of patient care that focuses on symptom management generally in those individuals with life-limiting illnesses. These include expertise in physical symptoms such as pain, dyspnea, anorexia, nausea but also addresses the psychosocial, spiritual and existential aspects of suffering often encountered with these patients. Palliative Medicine has recently been recognized by the American Board of Medical Specialties (ABMS) and is now considered a subspecialty with over 48 fellowship programs. Physicians sat for the first ABMS Board exams this past October. We would like to see Palliative Medicine enter into the patient’s care earlier in those with life limiting illnesses to assist with symptom management but also to assist with the often complicated psychosocial and ethical decision issues that arise during this time.

**Dr. Morley:** Palliative care should be implemented together with curative care and then continued to a greater extent as the possibility of a cure becomes more remote. Hospice care should be instituted when it is believed that the patient has less than six months to live.

**Dr. Trotter:** I basically support most of the prevalent arguments for the use of palliative care. Time of implementation is tricky for several reasons. First, doctors are not all that good in predicting how long terminally ill patients are going to survive, and sometimes they struggle even to sort out the terminally ill patients from those who are not terminally ill. Second, there is sometimes a tendency to associate the move to palliative care as a signal that hope has been abandoned.

## *How do physicians strike the right balance between preserving life and providing comfort and quality of life? What is the optimum we should be trying to achieve?*

**Dr. DuBois:** The doctrine of informed consent generally prohibits physicians from providing non-emergency treatments to an adult patient without the patient’s voluntary and informed permission. Thus,

*continued on page 24*

# Palliative Care: Providing Comfort, Easing Symptoms

**A**n important and growing field of medicine for people with terminal or chronic illnesses is palliative care. Most St. Louis-area hospitals have palliative care programs in place, and the field was recognized recently as a specialty by the American Board of Medical Specialties.

The goal of palliative medicine today is to “achieve the best possible quality of life for patients during any stage of an acute, chronic or terminal illness,” said Shari Mareschal, director of the Palliative Medicine Service for St. Anthony’s Medical Center.

Palliative medicine specialists provide a range of support services including expertise in pain and symptom management, psychosocial issues and ethical decision-making, she added. Palliative care can be provided by a palliative medicine specialist alongside

curative treatment; these services are appropriate at any stage of the illness. Local hospital programs offer a team approach to palliative care.

Ms. Mareschal said, “Palliative care can help patients recover from illnesses as well by relieving symptoms such as pain, anxiety, nausea and loss of appetite as the patient undergoes difficult medical treatments such as chemotherapy or surgery.”

Hospice is a specific type of palliative care; it is for people for whom a cure is no longer possible and who likely have six months or less to live. Hospice care can be provided in the patient’s home, at a hospice facility, a hospital or a nursing home, she added. Hospice care also provides support and grief therapy for families.



## Defining Palliative Care

|                          | Palliative Care  | Geriatrics   | Hospice Care  | Case Management   |
|--------------------------|--|--|---|---|
| <b>Patients Served</b>   | Patients of any age, at any stage of advanced and life-threatening illnesses   | Elderly and frail patients   | Dying patients of any age   | All patients with complex care needs  |
| <b>Services Provided</b> | Throughout illness and simultaneous with other treatment, comprehensive, coordinated pain and symptom control, care of psychological and spiritual needs, family support and assistance in making transitions between care settings  | Prevention, rehabilitation, disease management, functional assessment and recovery specific to older adults  | At the end of life and when curative treatment not desired or not effective, comprehensive, coordinated pain and symptom control, care of psychological and spiritual needs, family support and assistance in making transitions between care settings. Bereavement care for survivors. | Assists to develop treatment plans guided by benchmarks, pathways and standards   |
| <b>Key Differences</b>   | <ul style="list-style-type: none"> <li>• Program open to all seriously ill patients, not just those with six-month prognosis</li> <li>• Patients do not have to forgo curative care</li> <li>• Palliative care team coordinates from variety of health care providers, including specialists and primary care physicians to prevent service fragmentation</li> </ul> | <ul style="list-style-type: none"> <li>• Focus on prevention, chronic disease management, functional assessment, recovery and rehabilitation among older adults</li> </ul> | <ul style="list-style-type: none"> <li>• Six-month prognosis required by Medicare and other funders. Coverage includes outpatient medications and supplies. Efforts to cure or prolong life not covered.</li> </ul>   | <ul style="list-style-type: none"> <li>• Assists to coordinate care and facilitate transitions between settings. Independent medical judgment not provided</li> </ul> |

Source: Center for Advanced Palliative Care

---

---

# Legal Measures Enable Patients to Express Their End-of-Life Wishes

**P**utting in place the proper legal measures can help patients set forth their wishes about the extent of care they would receive if terminally ill. Having these measures in place can prevent situations where costly and prolonged life support is implemented even though there is little chance of survival or recovery.

**Advance directive** is the general term describing a legal document expressing an individual's wishes. The advance directive takes effect if the patient has a terminal illness with no reasonable hope of recovery, or if one is persistently unconscious.

A **health-care choices directive** specifies which treatments are to be withheld or withdrawn if incapacitated. The list may include surgery, cardiopulmonary resuscitation, antibiotics, dialysis, ventilator, artificially supplied nutrition and others.

In Missouri, the term **'living will'** refers to a statement in the form of, "... If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain."

Through the **durable power of attorney for health care** or health-care proxy, the individual appoints someone, typically a family member, to make health-care decisions in the event they are incapacitated. The durable power of attorney becomes effective any time the patient is unconscious or unable to make medical decisions. The guidance provided in the advance directive can help

the appointed representative make decisions.

Patients can work with an attorney or use do-it-yourself forms available over the Internet to complete their advance directives, however they should make sure the forms are designed for their state. To ensure a directive that is fully effective legally, patients should consult an attorney. It is estimated that only 30 percent of the population currently has an advance directive.

## Patient Resources

### Missouri Attorney General

<http://ago.mo.gov/publications/lifechoices/lifechoices.pdf>

*"Life Choices" publication includes workbook on advance-care planning along with sample advance directive forms*

### Missouri Bar Association

[www.mobar.org](http://www.mobar.org)

*Publications on estate planning available in print or online; also sample advance directive forms*

### National Association of Elder Law Attorneys

[www.naela.com](http://www.naela.com)

*Information on health-care decision planning along with searchable database of local attorneys who are association members*



---

---

## Care at the End of Life: Difficult Concerns, Caring Choices (continued from page 20)

patients or their surrogate decision-makers are often the ones who need to weigh the burdens of treatment against the anticipated benefits. However, physicians are not merely neutral observers. It is their responsibility to inform patients of their options, along with the anticipated benefits and burdens of those options. Particularly at the end of life, patients are often tired and unable to think very clearly. While they usually want to be informed, many patients also want physicians to play a major role in making their health care decisions. An illuminating book on this subject, with a fair amount of data on patient perspectives, is *The Practice of Autonomy: Patients, Doctors, and Medical Decisions* by Carl Schneider.

**Dr. Morley:** We should ask the patient their needs and be sensitive to which is most important to the patient.

**Dr. Trotter:** By querying patients about their values and goals. Questions of proper balance should hinge more on patient values than on physician values.

*Is there anything else you would like to add?*

**Dr. Morley:** Patients who have good palliative care feel that it

greatly enhances their quality of life.

**Dr. DuBois:** For some patients, it is appropriate to offer organ donation as an option. Physicians sometimes perceive organ donation as a threat to good end-of-life care. They fear that conversations about organ donation could offend families, or that consent to donate could negatively affect the setting of death. However, if it is done well, organ donation can not only prolong the lives of several organ recipients, but it can be very consoling and meaningful for families and is often a way of honoring a patient's end-of-life wishes. Organ donation raises many ethical issues, but these should be addressed well rather than used as an excuse for avoiding discussions of donation with patients or their families.



**Your turn: Please send your comments on health-care ethics and end-of-life care to [president@slmms.org](mailto:president@slmms.org).**