Legal Issues in Medicine

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Official SCAM-Q Obamacare Survey

By Richard J. Gimpelson, MD

With the recent Supreme Court decision, Obamacare has been given an extended lease on life. Since it is still a very controversial law, I felt a scientific survey was needed to get a true picture of the value of Obamacare; so I did my own survey.

I took two hypotheses and went to the most reliable source for opinions, the Internet.

**Hypothesis #1: Obamacare stinks.**
- Obamacare is a bad deal, even with subsidies.
- Subsidies just bolster higher premiums.
- Obamacare was falsely conceived. If the federal government wanted to help the uninsured, it could have hired doctors and built clinics.
- It is just another bloated self-justifying bureaucracy that makes insurance companies richer and doctors and patients poorer.
- I couldn't keep my doctor or my insurance plan, period.
- Deductibles are going way up.
- The UK lost many physicians after establishing the National Health Service and now the U.S. will lose many physicians after establishing Obamacare.

**Hypothesis #2: Obamacare is great.**
- Obamacare reflects American values.
- Young people can stay on their parent's insurance until age 26.
- Health-care screening is fully covered.
- Birth control is fully covered.
- One cannot be excluded for any pre-existing condition.
- Premiums have gone up less than two percent.
- Tens of millions of uninsured will get access to affordable high-quality health insurance through Medicaid.
- Over half of uninsured Americans can get free or low-cost health insurance.
- All plans must provide minimum essential coverage.
- One cannot be charged more for being a woman.

There, you have it; 10 excellent responses to the two hypotheses covered by my scientific survey. Of course I did not check the authenticity of the responses since all of you know: If it is on the Internet, it must be true.

Please, there is no need for any letters congratulating me for explaining the value of Obamacare. Just keep paying your taxes so that when I retire, the federal government can help pay my medical bills.

Dr. Gimpelson, a past SLMMS president, is co-director of Mercy Clinic Minimally Invasive Gynecology. He shares his opinions here to stimulate thought and discussion, but his comments do not necessarily represent the opinions of the Medical Society or of Mercy Hospital. Any member wishing to offer an alternative view is welcome to respond. SLMM is open to all opinions and positions. Emails may be sent to editor@slmms.org.

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**HARRY’S HOMILIES ©**

Harry L.S. Knopf, MD

**ON SELF WORTH**

I dote on myself, there is a lot of me and all so luscious.

- Walt Whitman

Maybe Whitman goes too far; but then again, maybe not. There is a lot about you that is “luscious.” You are kind and honest; you care about your family and your patients; you help the needy; you are good-looking (had to throw that in). In other words, you are a good person and an upstanding citizen. That is most luscious and delicious. If you were any sweeter, you would melt in the rain! OK, I exaggerate. But don’t sell yourself short. There are plenty of “sour” people in this world, and if you count yourself in the opposite camp, good for you! Be proud of it! Pat yourself on the back, or better yet, get someone else to do it, ‘cause you deserve it! HIGH FIVE!!!

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.
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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. SLMMS reserves the right to make the final decision on all content and advertisements.
Let us worry about the health of your portfolio.

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The media and some in government have made it appear that any money that passes hands between a physician and the industry must be inappropriate or even sinister. This belief is simply not true.
me was true. However, the address listed for me is over seven years out of date. If I want to change that, I have to register to be able to interact with the system. That should be simple, right? Well, there is a 45-day window to review and correct any inaccurate data. Have any of you been notified when that 45-day window begins? Inadequate notification to the physician population is a major downfall of the program. If we are not notified of the registration window, how can we register? Problem number two is that there is a time-consuming, non-user friendly and complicated registration process. But don’t worry, there is a 413-page guidance document to which to refer for help in completing the registration.

Granted, there are some unethical relationships between some physicians and those in the industry, but the majority of the relationships are those that are innovative and contribute to the benefit of other physicians and patients. By law, CMS is required to provide context to the data released through the Open Payments program. The agency has done only the minimum to comply with the law.

The greatest risk of this program in my opinion is the misinterpretation of data by the general public. Most consumers have no idea how to draw conclusions from the data. Hardly any of the data was able to be verified by the physicians listed due to lack of knowledge about the program and the inability to register even if desired.

The take-home message is to remain ethical in your interaction with the industry, and certainly search your own name to verify the truth in your data. Good luck if you have any discrepancies. Until next time, I bid you all peace and health.


NEW WUSM DEAN APPOINTED

David H. Perlmutter, MD, has been named executive vice chancellor for medical affairs and dean of Washington University School of Medicine effective Dec. 1. Dr. Perlmutter is a distinguished professor and the Vira I. Heinz Endowed Chair of the Department of Pediatrics at the University of Pittsburgh School of Medicine. He also is physician-in-chief and scientific director of Children’s Hospital of Pittsburgh. He succeeds Larry J. Shapiro, MD, who is stepping down after leading the school for 12 years. Prior to 2001, Dr. Perlmutter spent 15 years as a faculty member in the Department of Pediatrics at Washington University. Originally from Brooklyn, N.Y., Dr. Perlmutter earned his medical degree from Saint Louis University School of Medicine.
The AMA House of Delegates tackled major issues of interest to physicians at the AMA annual meeting June 12-16 in Chicago. SLMMS was represented by delegates Edmond Cabbabe, MD, and William Huffaker, MD, along with alternate delegates Elie Azrak, MD, and Nathaniel Murdock, MD. Dr. Cabbabe was chair of the Missouri delegation and the Heart of America Caucus which includes Missouri, Kansas, Oklahoma and Arkansas.

Following are highlights of delegate actions:

**Maintenance of Certification and Maintenance of Licensure:**

- Asking American Board of Medical Specialties to develop fiduciary standards for its member boards, including full transparency related to the costs of preparing, administering, scoring and reporting MOC exams.
- Making recommendations about assessments, including providing timely content-based feedback to physicians and making available multiple options to accommodate different learning styles.
- Requesting streamlining of Part III of the MOC exam.

Dr. Cabbabe said, “Great debates and numerous resolutions were presented regarding the burdens of MOC and MOL. Delegates felt that the corresponding boards have created giant monopolies with stringent and costly requirements without providing evidence that these tests improve patient care.”

**Graduate Medical Education:** Delegates passed a policy calling on the AMA to advocate for continued and expanded residency funding from federal, state, local and private sources. They also directed the AMA to collaborate with major stakeholders to study common reasons students fail to match with residency positions, and to study potential pathways to re-engage in medicine those who do not match.

**Combating prescription drug abuse:** Policies approved urge states to implement modernized prescription drug monitoring programs that seamlessly integrate into physicians’ workflows and to allow the sharing of data across state lines. Dr. Huffaker said, “As it is now, information is not always shared across state lines. Patients can cross state lines to obtain controlled prescriptions without all physicians involved being aware of the duplication.”

**Other actions by the delegates:**

- Called for elimination of Medicare’s three-day hospital admission requirement before patients can be transferred to skilled nursing.
- Requested a two-year grace period for requiring transition to ICD-10.

Dr. Huffaker noted a resolution passed in response to a Florida state law prohibiting a physician from asking questions regarding gun ownership or storage in the privacy of the physician’s office during a patient-physician encounter. The resolution asked the AMA to strongly oppose any such government attempts to interfere with a physician’s right to free speech. Dr. Huffaker said, “No matter where you stand on the gun issue, I think the Florida law really represents a threat to medicine and should frighten doctors. The AMA has filed an Amicus brief in the Florida case opposing the law and supporting the sanctity of the doctor-patient interview and the First Amendment rights of a physician. Apparently some other states are poised to pass similar legislation if the Florida law is allowed to stand.”

**AMA Strategic Focus:** As to the overall state of the AMA, Dr. Cabbabe said this is the third year in a row that the AMA has shown a modest increase in its membership. He added, “The organization’s current three-part strategic focus includes working for better patient health by early detection and treatment of hypertension and diabetes, improving medical education and training for the new generation of physicians, and supporting medical practices by working with physicians to advance initiatives that enhance practice efficiency, professional satisfaction and improve the delivery of care.”

David Barbe, MD, of Mountain Grove, Mo., has announced his candidacy for AMA president-elect in 2016. He currently is immediate past chair of the AMA Board of Trustees.

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**Former HHS Secretary to Speak**

Former U.S. Health & Human Services Secretary Michael Leavitt will be the featured speaker at the Signature Healthcare Foundation 2015 Annual Health Policy Forum on Friday, Oct. 9, from 8:00 to 11:30 a.m. at the St. Louis Marriott West. Information: www.signaturefoundation.org.
Physician concerns regarding Maintenance of Certification and Maintenance of Licensure will be the topic of the annual Hippocrates Society Lecture scheduled for Wednesday, Sept. 30, at Ces & Judy's Catering, 10405 Clayton Rd.

Paul Kempen, MD, PhD, will present, “Certification, Regulation and Organized Physician Resolve: Past, Present and Future.” Dr. Kempen has been a leader in investigating and illuminating the American Board of Medical Specialties (ABMS) Maintenance of Certification (MOC) and Federation of State Medical Boards (FSMB) Maintenance of Licensure (MOL) programs since 2010. He actively educates and informs physician groups to help understand the available choices and opportunities necessary to preserve physician autonomy.

An anesthesiologist, Dr. Kempen is now in private community practice after decades in academic practice in the United States. American born, with medical school education and training in Germany and with additional residency training at the University of Michigan, he repeatedly identifies the absence of the ABMS and FSMB programs in other countries without any detriment to quality care. He has introduced the economic term “regulatory capture” to refer to the use of laws to create compliance with corporate self-serving programs.

Invitations to the Hippocrates Society Lecture will be mailed to the SLMMS membership in late August. The event begins with a social hour at 6 p.m., then a buffet dinner at 7 p.m. immediately followed by the lecture. CME credit will be available for the lecture. The event is free to SLMMS members, but this year there will be a $40 charge for spouses, guests and any non-members. An RSVP is required. Contact the SLMMS office for more information.

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The Medical Society each year supports the scientific work of middle and high school students by sponsoring awards in the Health and Medicine category of the Greater St. Louis Science Fair.

A team of SLMMS members judged the Health and Medicine entries April 29 and chose seven winning projects. Creators of the winning entries received awards in the form of college savings account contributions and gift cards. The awards are funded by the Medical Society’s charitable foundation, the St. Louis Society for Medical and Scientific Education (SLSMSE).

“The students are so inspired to receive an award from the St. Louis Metropolitan Medical Society,” said Peggy James Nacke, special projects director for the Academy of Science – St. Louis.

Science Fair entrants create experiments using the scientific method to prove or disprove a hypothesis.

**2015 WINNERS**

**Honors Division**

Omkar Venkatesh  
Clayton High School

“Mutant LGC-53 Receptors as Potential Tools to Study Dopamine Networks”

**11th Grade**

Bridget Dillon  
St. Joseph’s Academy

“The Effect of Cooking on the Amount of Fat Lost in Hamburgers”

**10th Grade**

Lauren Reding and Mallory Stock  
St. Joseph’s Academy

“Friends vs. Family Fingerprints”

**9th Grade**

Anna Chen  
Parkway West High School

“The Effect of the Type of Antacid on the pH Level of HCl Solution After the Antacid Has Completely Dissolved”

**8th Grade**

Maya Martin  
St. Ann Catholic School

“How Does Apple Juice Affect Your Glycemic Level?”

**7th Grade**

Jackson Sniff  
Parkway Central Middle School

“The Effect of the Temperature of the Room on the Quality of Sleep”

**6th Grade**

Delaney Sullivan  
Villa Duchesne and Oak Hill School

“Sandpaper Lips: Science that Softens”
SLMMS Extends Agreement with Keystone Mutual

The Medical Society recently renewed its agreement with Keystone Mutual as an approved provider for medical professional liability insurance. This new agreement extends the exclusive approved provider status through 2017, during which time all SLMMS member physicians will receive a 10 percent discount from Keystone.

The partnership has benefited many existing SLMMS members, as well as helped recruit new members into the Society. Keystone remains dedicated to its policyholders; with $36 billion in reinsurance backing from Lloyd’s and special retirement benefits like Keystone Capital®, they have been responsive to SLMMS members’ needs.

“The trust that SLMMS has placed in us allows our team to work even more diligently to strategically guide St. Louis physicians,” said Jim Bowlin, Keystone’s chief executive officer. “We are honored to continue to receive this distinction, and our commitment to SLMMS member physicians is solid.”

Keystone’s policies are sold through its captive agency, Cogeris Insurance Group.

For more information or to obtain a quote, visit www.keystone-mutual.com or call 1-866-212-2424. For information on Cogeris, visit www.cogerisinsurance.com.

NOTICE

St. Louis Metropolitan Medical Society General Society Meeting

Tuesday, September 15, 2015 at 7:00 p.m.
St. Louis Metropolitan Medical Society Office
680 Craig Road, First Floor Conference Room
Creve Coeur, MO

Nomination of 2016 Officers, Councilors, MSMA Delegates and Alternate Delegates
All members are invited to attend.

Agenda

Call to Order  Presidential Michael J. Stadnyk, MD
Nominating Committee Report  Ravi S. Johar, MD

The committee will be recommending members for nomination to the following offices:
President Elect  Vice President
Secretary-Treasurer  Councilors (4)

Additional nominations will be accepted from the floor, but must be approved by majority vote of the members present. It must be known that any member proposed for any office must be willing and able to serve.

A reputation is like trust.
It takes years to grow, but can be ruined in seconds. Make sure your reputation is protected with malpractice insurance coverage from PSIC.
Despite recent innovations in medical education, medical professionals are often unable to address unmet clinical needs with entrepreneurial solutions. Many barriers exist, ranging from a lack of technical expertise to a difficulty forming strategic partnerships in order to transform ideas into realities. IDEA Labs, a student-run medical technology incubator, strives to overcome these barriers.

IDEA Labs, founded in St. Louis in 2013 by Washington University medical students, is an effort to improve health care by teaming medical students with engineering students, business students and practicing clinicians in order to design, prototype, patent and test novel devices and software applications. IDEA Labs empowers future and practicing physicians to work together to identify opportunities and take tangible steps to improve patient care through innovation.

The nine-month IDEA Labs program commences at the annual “Problem Day” in September. Students are exposed to clinical problems that have been submitted by medical professionals, and team leaders recruit students based on their interests and experience. With guidance from mentors, teams determine which problem to pursue based on clinical need, patent review, technical feasibility and market analysis.

Teams then begin the “Invention” phase, where they conduct a needs assessment, develop a product design and carry out iterative prototyping, often with the mentorship of the physician who submitted the problem. During bimonthly design reviews, teams present their progress to a panel of advisors ranging from physicians to entrepreneurs. These reviews provide teams with crucial critiques, advice and progress checkpoints. They also serve as an opportunity for teams to request the funding, lab space and equipment necessary to develop their products.

Simultaneously, the “Development” phase involves mentorship in navigating the entrepreneurial side of product development, along with guidance in filing patents and incorporating. IDEA Labs is uniquely positioned such that team members retain full

Kavon Javaherian and Rachel Goldberg are students at Washington University School of Medicine. Steven Monda is a student at Saint Louis University School of Medicine. All are SLMMS student members and student leaders of IDEA Labs.

At the May 1 Demo Day, the team DataDog shows how their device can help a person cope with the different stressors provided by a virtual reality machine.

The Program

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ownership of all intellectual property and equity from their technologies and company.

Each May, IDEA Labs formally concludes with “Demo Day.” Here, teams have posters, display working prototypes and give presentations to an audience of clinicians, students, innovators and potential investors, which totaled over 350 audience members this year. Teams then continue onto their own “Entrepreneurship” phase where they are connected with various accelerator programs and angel investors, with the ultimate goal of implementing their idea in a clinical setting.

Successes

Over 35 teams have advanced through the program, and many products and ideas are proving to be successful ventures. Here are some examples:

- **Epharmix** addresses the issue of poor patient-provider communication in the time between clinic visits by designing condition-specific SMS/phone-based messaging systems. These “digital interventions” automatically collect and analyze information important to physicians, and simultaneously provide education and support to the patient. Through Epharmix interventions, providers can more closely and efficiently manage patient conditions, including hypertension, depression and COPD. Currently, Epharmix is developing more than 20 interventions and launching over 10 clinical trials.

- **IdealTap**, a group that is reimagining the spinal tap procedure, has designed a mobile chair that accommodates patients of all sizes and provides a stable physician-directed mechanical transition between the seated upright position and lateral decubitus. IdealTap aims to increase physician control and improve patient experience in this common, anxiety-inducing procedure. The team recently won the 2015 Discovery Competition at Washington University School of Engineering and Applied Science.

- **DataDog** tackles the problem of mental health therapy access by providing anxiety interventions at moments of high stress. Their system monitors autonomic signals through wearable technology and prompts the patient to pursue coping techniques while experiencing stress. DataDog has received $250,000 in seed funding and is starting clinical validation work in preparation for launch later this year.

Other examples include CystoView, which transforms the traditional cystoscope into a digital and wireless device, and VoltOptics, which reinvents varifocal glasses with the ability to change prescriptions instantly. In the past year, 133 students, including 31 medical students, worked on 23 teams and have collectively raised over $1.5 million in outside investments. We hope to continue to improve our program, offering participants the resources and connections they need to improve medical care.

Involvement

As student leaders of IDEA Labs, we want to thank SLMMS for attending and sponsoring Demo Day 2015, and we hope to increase SLMMS involvement in IDEA Labs this coming cycle. In order to maintain the caliber of our teams, we must maintain a high-quality bank of clinical problems, submitted by medical professionals. We welcome brief descriptions of clinical problems or unmet clinical needs, which would continue to enable teams to work toward solutions that are both impactful and align with their interests. We also welcome new advisors to the IDEA Labs community to help shape the direction of projects and keep the solutions clinically relevant and practical. IDEA Labs advisorship offers a path both to mentor students and to act on opportunities for clinical innovation, in order to ultimately make tangible changes to medical practice.

We invite the SLMMS membership to attend our annual Problem Day on Sept. 25, 2015, held at CIC@4240 in the Cortex district of the Central West End (more details to come). By attending Problem Day, the SLMMS membership can see what problems the students are considering tackling, provide clinical wisdom, and learn more about the organization.

IDEA Labs is preparing the next generation of physicians with the skills and resources necessary for medical technology innovation. We welcome you to join this effort.

For more information, email us at info@idealabsincubator.org or visit us at www.idealabsincubator.org, where the problem submission portal can be found. We hope to see you at Problem Day on Sept. 25.
Although undernourishment impacts more than 790 million individuals in developing nations,1 food insecurity and malnutrition are not unique to the developing world. Food insecurity, defined as limited or uncertain access to adequate food, affected more than 17 million American households in 2013.2 Furthermore, 5.6 million U.S. households in 2013 had very low food security, with inconsistent eating patterns and reduced food intake due to limited resources—a situation classically known as “hunger.”2 Food insecurity has significant effects on physical, psychological, social, and economic well-being and should be considered a serious public health concern. Missouri is not immune from this issue. In fact, amongst the 50 states Missouri had the single largest jump in the number of households with food insecurity and hunger between 2000 and 2010.3 In 2013, 16.9 percent of Missourians lived in households with food insecurity and 8.1 percent lived in homes with hunger.4 This need is amplified in the city of St. Louis, where approximately one in five households experienced food uncertainty and households spent an average of 18.7 percent of total income on food in 2010.5

**Impact on Children**

The health ramifications of this level of need can be severe. Households with very young and very old inhabitants are particularly likely to experience health and behavioral setbacks. For example, American children in food-insecure families experience more frequent stomachaches, headaches, and viral infections than children in food-secure homes.5 These children are also twice as likely as their food-secure counterparts to experience iron-deficiency anemia, thereby causing weakness and fatigue and limiting activities necessary for child development. Additionally, studies demonstrate that food-insecure children perform worse in school. In one multi-state study, children from food-insecure homes were more likely to experience irritability and have difficulty concentrating; these findings mirror other studies that have linked food insufficiency to poor academic performance.6,7 These behavioral and developmental setbacks can persist into adolescence, during which food insufficiency has been shown to correlate with a higher incidence of depressive disorders and suicidal tendencies.9

Older adults are also susceptible to hunger-associated health and behavioral consequences. A joint study conducted by Feeding America and the National Foundation to End Senior Hunger found that food-insecure seniors are 40 percent more likely to experience congestive heart failure, 53 percent more likely to have a heart attack, and twice as likely to develop asthma than individuals with stable and sufficient access to healthy foods. Additionally, food-insecure seniors are 60 percent more likely to be diagnosed with depression.10

In one multi-state study, children from food-insecure homes were more likely to experience irritability and have difficulty concentrating; these findings mirror other studies that have linked food insufficiency to poor academic performance. These behavioral and developmental setbacks can persist into adolescence.

Amanda Hilmer, MD, an internist at Family Care Health Center in St. Louis, believes that access to quality food is a “top three issue” for her patients, many of whom are homeless, uninsured or on Medicaid, and usually suffering from mental illness. Her patients consume inexpensive, non-perishable options rather than fresh fruits and vegetables. They must allocate a large portion of their income to purchasing food, leaving little for clothes and medicine. Indeed, in Missouri an estimated 60 percent of households utilizing food banks have unpaid medical bills; 80 percent have purchased inexpensive, unhealthy food in the last 12 months to try and secure food for themselves and their families; and 65 percent have had to choose between paying for food and paying for medicine or medical care.11 According to Dr. Hilmer, this phenomenon yields the “paradoxical effect of poorly nourished, overweight patients at high risk for diabetes and cardiovascular disease.”

To address this reality, Dr. Hilmer assigns her patients to teams of social workers and psychologists who help the patients take...
advantage of food resources; she also organizes a bi-monthly group to enable her patients to cook healthy, tasty, and affordable food. She says she has learned as much as her patients “about good choices on a very restricted budget,” and encourages physician colleagues to spearhead their own medical teams knowledgeable about navigating food insecurity.

Public and Private Programs Address Food Insecurity

Many public and private programs in the United States are also attempting to address food insecurity. The United States Department of Agriculture Food and Nutrition Service operates 13 nutrition assistance programs, including the Supplemental Nutrition Assistance program (SNAP), formerly known as the federal Food Stamp Program. Missourians rely heavily on SNAP, with approximately 89 percent of eligible Missouri residents and nearly one-third of all St. Louis residents taking advantage of the program in 2012. The National School Lunch Program (NSLP) funds nutritious lunches at free or reduced cost for eligible children in schools across the nation. More than 224 billion lunches have been served by NSLP since 1946. Additionally, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutritious food, education, counseling, and health referrals for pregnant women and children under the age of 5.

When these federal programs lack funds and time, community organizations often step up to fill in the gaps. For instance, food banks collect donations from individuals, food manufacturers, farmers, and grocery stores, and then distribute these items to local hunger relief agencies, such as dedicated food pantries, homeless shelters, places of worship, and community centers. Missourians can use websites like www.feedingamerica.org and www.foodpantries.org to find their closest food bank or distribution location. The immediate support offered by hunger relief agencies can be a critical resource for individuals who do not qualify for federal assistance, are unable to complete the documentation required for financial support, or are experiencing a temporary loss of food security.

Project Bread’s FoodSource Hotline, a phone-in service, refers individuals to emergency food banks, screens callers for SNAP eligibility, and provides information on other government programs. Locally, the City of St. Louis opened three new and affordable grocery stores in areas designated as food deserts

Volunteer for World Food Day on October 16

For the third consecutive year, SLMMS is a proud sponsor of St. Louis World Food Day. You can help as the St. Louis community comes together to package more than 250,000 meals in a single day for local and international hunger relief.

This year’s event will be held Friday, Oct. 16, in the Field House at John Burroughs School on Price Road in Ladue. The SLMMS team of volunteers will staff a table for one hour from 6:00 to 7:00 p.m. We invite you to join the fun and participate in this important community service event.

To volunteer, contact Liz Webb at the SLMMS office at 314-989-1014, ext. 108 or lizw@slmms.org no later than Monday, Oct. 12. SLMMS has volunteer spots available for member physicians to participate as part of our sponsorship at no charge, however you must sign up through the SLMMS office. Your family and friends are also invited to participate and they may register at www.stlwfd.org and make the required contribution to World Food Day.

in early 2014 to improve access to healthy food. The St. Louis Healthy Corner Store Project provides grocery store owners with strategies to increase their healthy food inventory, and as a result, healthy food content has increased by 25 percent in participating stores since the program’s inception in 2011.

World Food Day Aims at Reducing Hunger

World Food Day is an annual, global event featuring grassroots activities and public awareness campaigns aimed at reducing hunger around the world. Locally, St. Louis World Food Day (STLWFD) was founded in 2012 by high school student Donald Soffer and his parents Allen Soffer, MD, (SLMMS), and his wife, Mary Beth, to provide Missourians with the opportunity to take action against hunger both at home and abroad. On World Food Day, volunteers come together in St. Louis to package nutritious, vitamin-fortified meals. These meals are then shared with hungry families in St. Louis and Tanzania, through partnerships with the St. Louis Area Foodbank and the Outreach Program, respectively. More than 1,800 people participated in 2014. Their registration fees, along with sponsorships and donations, helped defray the
Medical Malpractice Caps – Version 3.0

A look at Missouri’s newly enacted medical malpractice cap law

By J. Thaddeus Eckenrode, Eckenrode-Maupin, Attorneys at Law

Just as software products are updated from time-to-time to fix bugs or flaws, this year the Missouri Legislature enacted the state’s third version of a medical malpractice “cap,” optimistically hoping to have corrected the issues that caused prior versions to be invalidated or eviscerated.

Caps Began in 1986

As most physicians know, Missouri first legislatively enacted a “cap” on medical malpractice case damages in 1986. That original cap set a limit on non-economic damages of $350,000, to be adjusted annually for inflation. Although it was upheld as constitutional in the face of a 1992 challenge in Adams v. Children's Mercy Hospital, over the next several years there remained numerous attacks on that statute.

Subsequent rulings chipped away at the foundation of the law, the guts of which was worn down over time by judicial interpretations of the original statutory language, which proved to have inherent weaknesses in the wording as drafted. In Cook v. Newman, the court held that the statute’s applicability to “any one defendant” could result in multiple caps being applied in cases with multiple defendants; in Scott v. SSM, that court held the cap’s applicability “per occurrence” meant that multiple caps could be imposed where more than one act (occurrence) of negligence was committed by defendants, etc.

Ultimately, these various judicial rulings on the 1986 statute caused its application to be reshaped from the original intent like an ice sculpture sitting in the sun.

As a result of this loss of purpose, and following a wave of vocal activism by the medical community, insurance industry, various chambers of commerce and other interested groups, including famous “white coat days” at the Capitol, the legislature enacted a number of sweeping business-favorable “tort reform” laws in 2005, including a new medical malpractice cap (which we will euphemistically call “Malpractice Caps – Version 2.0”).

The 2005 law set a hard $350,000 cap without any economic escalator, and the new language was drafted to correct the “occurrence” and multiple defendant extensions of the first cap. As proponents of caps predicted, Missouri saw an almost immediate drop in the number of medical malpractice lawsuits filed...but, not surprisingly, also saw the development of a reinvigorated attack strategy from the plaintiffs’ bar and other opposition groups.

The first true assault on the second version of medical malpractice caps fell short of the plaintiff’s goal of completely overturning the law, with the Missouri Supreme Court in 2010 holding, in Klotz v. St. Anthony’s, only that the new 2005 statute could not be applied retroactively to incidents arising before that cap law went into effect but filed thereafter. The court finally addressed the esoteric concept and issue of the caps themselves in 2012, in Sanders v. Ahmed, holding, by a 5-2 vote, that the cap in a wrongful death case was constitutional, giving tort reform supporters a sigh of relief and optimism for long-term applicability of the 2005 caps.

Caps Overturned in 2012

Just four months later, however, the same Missouri Supreme Court, in Watts v. Lester E. Cox, then declared caps in medical malpractice injury (non-death claims) cases to be unconstitutional in a 4-3 vote. While the dissenters held that the Adams case was controlling on the question of the constitutionality of caps generally, the majority used the new statute as an opportunity to re-visit the issue.

The court opinion invalidating the law rationalized that the difference between the Sanders and Watts cases lay in how those

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Medical Malpractice Caps  
continued from page 14

The type of claims first arose historically. In the simplest terms, the court found that “wrongful death” cases were a creation of the legislature (i.e., one could not bring suit for death of a loved one at common law), and as such, the legislature could enact changes or limits to the manner in which those claims could be pursued, including limits on damages awarded.

As to medical malpractice claims for injuries, however, the Supreme Court found that suits or claims for such injuries to persons were available at “common law,” i.e., well before Missouri enacted its constitution in 1820, and they reasoned, therefore, that the legislature could not today limit something that had been a given right of the people (or at least a claim that could be raised in a legal proceeding) long before this state even existed.

Since Watts was handed down three years ago, Missouri had been without any cap on medical malpractice “injury” claims, although the cap still exists as to “death” claims per the Sanders ruling. Opposition to that cap has not abated, and direct appellate attacks on it are still anticipated. As the make-up of the Supreme Court changes, a philosophical shift on that issue would not necessarily be surprising.

New Caps Designed to Withstand Challenges

Despite the strong wording and unique rationale of the court in the Watts case related to the “at common law” issue, cap supporters did not give up the fight. Instead, they started considering ways in which to enact another medical malpractice cap that could withstand constitutional scrutiny.

The most creative idea in this year’s new statute, in an attempt to overcome the Supreme Court’s conclusion in Watts that injury claims are a “common law” action, was by enacting legislation that specifically articulates that medical malpractice suits henceforth are a creation of the legislature:

1.010. 1. The common law of England and all statutes and acts of parliament made prior to the fourth year of the reign of James the First, of a general nature, which are not local to that kingdom and not repugnant to or inconsistent with the Constitution of the United States, the constitution of this state, or the statute laws in force for the time being, are the rule of action and decision in this state; and any custom or usage to the contrary notwithstanding, but no act of the general assembly or law of this state shall be held to be invalid, or limited in its scope or effect by the courts of this state, for the reason that it is in derogation of, or in conflict with, the common law, or with such statutes or acts of parliament; but all acts of the general assembly, or laws, shall be liberally construed, so as to effectuate the true intent and meaning thereof.

2. The general assembly expressly excludes from this section the common law of England as it relates to claims arising out of the rendering of or failure to render health care services by a health care provider, it being the intent of the general assembly to replace those claims with statutory causes of action.

Likewise, in an effort to stem the tide of attacks on other aspects of cap laws that routinely face the most common appellate challenges (e.g., lack of economic escalator, too low of a damage figure, etc.) from cap opponents, both in Missouri and other states with caps, the legislature took a number of steps that make this third medical malpractice cap different from the 2005 law:

1) There is now an economic escalator of 1.7% annually, so the cap will increase yearly to keep up with inflation, overcoming one objection to the 2005 cap, which stayed at a flat $350,000; hence defeating the argument that the value of the cap would actually decrease over time.

2) The new initial cap of $400,000 would apply to cases of less seriously injured plaintiffs, but for patients with “catastrophic” injuries, such as quadriplegia, paraplegia, loss of vision, loss of two or more limbs, brain injury or “irreversible failure of one or more major organ systems,” the initial cap will be $700,000, subject to the annual economic escalator.

3) The cap on wrongful death cases was raised from the $350,000 cap that already passed muster in Sanders to $700,000.

Looking Ahead

Will it work this time? In hearings to evaluate the proposed new law this year, the legislature heard testimony from several plaintiff attorneys on the issue of the value of injuries, the potential impact of a cap on seriously injured plaintiffs and families, etc., and then actually did implement some of the suggestions made to address those perceived injustices, as noted above. Despite the involvement of the plaintiff’s bar in advocating for higher cap figures, of course, we can still expect them to mount further appellate attacks on this cap, and on the concept of caps in general. Undoubtedly, at some point an argument will be raised over the statutory language about what constitutes “irreversible failure,” a “major organ system,” etc.

Another traditional argument, which never goes away and remains a stalwart position of cap opponents, is that a legislative cap impacts a litigant’s inherent right to trial by jury (the argument, as everyone knows, is that a litigant is
entitled to have the jury—not the legislature—assess his or her damages). While this argument has been rejected in past cases decided in Missouri, a shift in philosophy among the court on that issue is not beyond the realm of possibility.

Moreover, given the Supreme Court’s declaration in Watts that the last cap was unconstitutional because such injury cases were not legislatively created like wrongful death claims, it was certainly a creative stroke to try to address that rationale by specifically enacting a law that states that medical malpractice claims are henceforth “excluded” from the common law of England. We can expect the opposition, however, to argue that in spite of the legislature attempting to carve out medical malpractice claims as a statutorily created cause of action going forward, that doesn’t change the fact that such tort claims against health-care providers did exist at common law, and are not now and never will be, therefore, a creation of the legislature. This is the “you can’t put the genie back in the bottle” argument. Hence, the same argument will be made in the fight against the new cap (“Version 3.0”) as has been raised in the past, and as the court ruled in Watts, i.e., that the legislature cannot limit damages on common law claims.

Ultimately, we saw the first (1986) version of Missouri’s cap law (and the concept of non-economic caps themselves) upheld as constitutional by the Missouri Supreme Court in the Adams case in 1992. Because of later rulings that eroded its effectiveness and original intent, the legislature enacted the 2005 version, but that gave cap opponents a new opportunity to challenge the concept, and by the time the Missouri Supreme Court heard the Watts case in 2012, the seven judges sitting on the court had changed completely from those who heard Adams 20 years earlier. Cap laws have been enacted in more than half of the states; some have been invalidated and some upheld. It is a concept that is strongly divisive and clearly not uniformly supported.

It therefore goes without saying that even a slight shift in the make-up of any court which might hear a challenge to a new cap law can certainly impact the potential for it to be upheld. To that end, statutory language that is carefully crafted is critical, since we have seen courts latch onto a single word to deny the application of a law as intended by the legislature. We can only hope that the new “Malpractice Caps – Version 3.0” withstands the challenges that it undoubtedly faces down the road.
Missouri Board of Healing Arts Investigations: The Purpose, Process and Potential Outcomes

Physicians should be informed about the Board and give prompt and serious attention to any request for information

By Mary L. Reitz, Greensfelder, Hemker and Gale, P.C.

There was a time when a physician could practice his or her entire career without interacting with the Board of Registration for the Healing Arts (“the Board”) other than when applying for licensure and renewal. Those days are gone due to the proliferation of lawsuits, the availability of the Internet and the Board’s obligation to, at a minimum, review each complaint, medical negligence lawsuit, or disciplinary action against a licensee made or reported to it. As a result, today’s physician is wise to become aware of the powers and procedures of the Board. This article will briefly address what the Board is, how complaints and reports come before it, the procedure for investigations, and the actions that may be taken against licensees. It is not meant to be exhaustive. The goal is to arm the physician with some understanding of the Board’s roles and powers.

The Missouri Board of Registration for the Healing Arts is not just the entity which issues licenses to physicians. It is actually a multifunctional unit responsible for administering and executing the statutes, rules and regulations relating to physicians and certain other health-care providers. The stated mission of the Board “is to protect the citizens of the state through the licensing of physicians” and other designated health professionals, “assessing their competence to practice and their moral character.”¹ As part of this mission, it is the duty of the Board “to investigate all complaints against licensees in a fair and equitable manner.”¹

The Board receives complaints about licensees from the public and other professionals. It receives information on the filing of medical negligence claims from licensees and the Missouri Division of Insurance. It also obtains reports of physician disciplinary action by hospitals and ambulatory care centers as well as any voluntary resignations made while such actions are pending (henceforth “reports of discipline”).³ The Board must review the information it receives and may order an investigation of the events resulting in the complaint or report.³

The Board consists of nine members, eight of whom must be licensed physicians. At least five of the physicians must “be graduates of professional schools accredited by the Liaison Committee on Medical Education or recognized by the Educational Commission for Foreign Medical Graduates. …”⁴ At least two physician members are required to be graduates of “professional schools approved and accredited as reputable by the American Osteopathic Association.” The ninth member is a non-physician designated as the “voting public member.” Each member is normally appointed for a term of four years. Appointments are made by the governor with the advice and counsel of the state senate.

How Complaints Are Presented

Complaints and reports of matters relating to licensees are presented to the Board in a number of ways. Some complaints are made voluntarily by patients. Other complaints or reports are required by statute or regulation. For example, the Division of Insurance is required to provide the Board with a report containing all medical negligence suits of which it receives notice. Additionally, the law requires hospitals to report physician discipline to the Board. Complaints may be made directly by a patient, hospital, state agency or other health care professional (physicians, nurses, pharmacists). Complaints may address one or more violations of Chapter 334 of the Missouri Revised Statutes. These statutes govern many aspects of practice by physicians and surgeons, including, but not limited to, competency, quality of care, prescribing violations, sexual activity with a patient, failure to comply with medical records laws, substance abuse or other addictions, billing or Medicaid fraud, criminal convictions and actions taken against a licensee in another state.

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The Board also reviews and investigates reports of medical negligence claims. The Board reviews these claims for violations of Chapter 334 of the Missouri Revised Statutes by the physician. On the other hand, the court is determining whether the physician was negligent and if so, whether the negligence damaged the patient. Consequently, the results of the trial of a medical negligence case in court and the Board investigation may not mirror each other. An investigation of a medical negligence claim may occur before, during or after the civil suit is resolved. However, under current Board practice, medical negligence claims are most commonly investigated while the lawsuit is pending in court. As a result, the physician named in a lawsuit often receives a subpoena or other correspondence from the Board within a few months of being served in the civil action.

The procedures for handling complaints, medical negligence claims and reports of discipline are contained in 20 CSR 2150-1.011 of the Missouri Code of State Regulations. Every complaint, medical negligence claim, or report of discipline the Board receives is recorded in a log and then assessed by either the complaint review committee or the medical staff officer. After this review, the complaint or report is sent to the investigative manager (hereinafter “manager”) to obtain records and information, forwarded to the licensee for a response, or submitted to the Board for its review and decision.

What occurs during any particular investigation varies widely. In all matters referred to the manager for further inquiry, a file is opened and an investigator assigned. This investigator conducts the inquiries deemed necessary or directed by the manager. The investigation of medical negligence suits and complaints of improper medical care will generally include the collection of relevant medical records. For this purpose, the Board has subpoena power. If necessary, it may obtain assistance from the courts in enforcing its subpoenas. Whenever a physician receives a subpoena for records of a patient, he or she should always immediately note the deadline for response so that the request can be addressed in a timely manner. The Board has the authority to take disciplinary action against a physician who does not cooperate in an investigation. Failure to respond in a timely manner to a subpoena from the Board may be deemed a failure to cooperate, but simply ignoring it is definitely a failure to cooperate that can result in discipline.

In addition to requesting and reviewing records, the Board investigator may interview the licensee or others involved in the patient’s care or send written questions to the physician for reply. As part of the investigation, a licensee may be subpoenaed continued on page 20
to appear before Board medical staff officers for a recorded oral interview. These interviews are usually conducted by the chief medical officer and one to two other physicians. These physicians may or may not practice in the same specialty as the licensee. These interviews often take less than an hour, but may last much longer, depending on the nature of the complaint or the circumstance being investigated.

If a physician or other licensee receives a subpoena or other request for information from the Board, he or she is entitled to consult an attorney and to have the attorney present for interviews and appearances before the medical staff officers or the Board. Even if the licensee decides not to seek counsel for interactions with the Board, at an absolute minimum, he or she should review the rules and statutes available on the Board of Registration for the Healing Arts website, http://pr.mo.gov/healingarts.asp. If the lawsuit is still pending, as is often the case, the physician should contact his or her defense attorney and/or insurer about the subpoena. Most defense counsel advise their clients not to discuss a pending case with anyone other than their legal counsel. Obviously a physician must participate in a Board investigation, but many defense attorneys prefer to know before a client makes any statement about a pending case, even if it is during Board proceedings.

**Report and Conclusion of Investigation**

Once the investigation is complete, a report is prepared and submitted to the manager. The manager will either return it to the investigator with directions for further inquiry, or send it to the medical staff officer for review. The medical staff officer reviews it and will either return it to the manager with a request for more information or submit it to the Board with recommendations. Upon receipt of the report, the Board may simply close the matter (the best result for the physician) or it may request more review and investigation. If the Board believes there are grounds for discipline, it can submit the report to its legal counsel to file a complaint with the Administrative Hearing Commission. Alternatively, the Board is authorized to take or direct other actions such as issuing a letter of concern or offering a settlement agreement.

A Board investigation may result in a physician being privately or publicly reprimanded, put on probation, or having his or her license restricted, suspended or revoked. The Board also has the power to require a licensee to submit to counseling or treatment by physicians designated by the Board (at the practitioner’s own expense). Further, it may require the licensee to attend specific continuing educational courses and pass certain examinations identified by the Board.

Generally, all Board investigations are confidential until concluded. However, the results of investigations concluding in settlement, a complaint before the Administrative Hearing Commission, or a sanction are public. Settlement agreements are published on the Board’s website. Information on Administrative Hearing Commission activities is open to the public as well.

**The Physician’s Response**

Since the results of any investigation by the Board may profoundly impact a physician’s ability to practice, any request for information from the Board should be given prompt and serious attention. Probation can be imposed for 10 years or less, a suspension for up to three years, and a revocation for as long as seven years. The Board may restrict or limit a license for an indefinite period of time. If the physician is offered a settlement agreement, he or she may accept it as proposed, seek to have it revised, or reject it. If the proposed settlement is not accepted and no agreement regarding terms is reached, the matter will be sent to the Board’s legal counsel for the filing of a complaint with the Administrative Hearing Commission. The hearing process on such a complaint may take a year or more to conclude. The result can be appealed to the circuit court system. Proceedings before the Administrative Hearing Commission are not protected from public disclosure.

Physicians should not be under the impression that the Board may only sanction a license based on the above procedures. In fact, the Board has the power to immediately revoke a license if the physician loses his or her license to practice in another state, and the conduct at issue would result in revocation in Missouri. Additionally, the Board has the authority to automatically revoke a physician’s license if he or she is convicted of certain types of felonies. Further, the Board may initiate a contested hearing procedure to determine the competency of a physician to practice by providing notice as required by R.S.Mo. 334.099. This statute requires only a 15-day notice of the hearing. These statutory sections allow the Board to take action much more quickly than when the complaint against a physician results from an unsubstantiated patient complaint or the filing of a medical negligence case.

The mission of the Board is simple and noble. It is to protect the citizens of this state by licensing qualified and competent physicians and other designated health-care professionals. The Board possesses substantial powers to carry out its responsibilities. As a result, the wise physician will take the time to become familiar with the rules and statutes that govern licensure and discipline before interacting with the Board.

**References**

1. 20 CSR 2150-1.010(1).
2. R.S.Mo. §383.133.
3. 20 CSR 2150-1.011.
4. R.S.Mo. §334.120.1.
5. R.S.Mo. §334.100(4).
6. R.S.Mo. §334.103.
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Sword or Shield? Accountable Care Organizations and the Potential Use of Practice Guidelines in Litigation

Will guidelines be regarded as the “standard of care?”

By Joseph C. Vitale and Thomas J. Hayek, Behr McCarter & Potter, PC, Attorneys and Counselors at Law

Accountable. A word that communicates responsibility by an organization or individual, as well as a warning—a warning of consequences for unacceptable behavior or performance. That word, “accountable,” occupies a prominent location in federal regulations describing new and evolving health-care entities known as Accountable Care Organizations (ACOs). These entities are a key provision of the Affordable Care Act (ACA).1 In this article, we explore how ACOs, and particularly the practice guidelines they adopt, may find their way into civil lawsuits over alleged substandard health care, commonly referred to as medical malpractice. How might “accountable” health-care providers use practice guidelines as a shield in lawsuits? And how can they minimize the risk of these guidelines being used as a sword against them?

What Is an Accountable Care Organization?

To understand the potential connection of an ACO and a lawsuit alleging medical malpractice, we need to review what an ACO is and how an ACO may adopt a document known as Clinical Practice Guidelines. The concept of “accountable care,” a key component of the ACA, aims to reduce costs and improve care by prioritizing coordination and collaboration amongst health-care providers.2 One method by which the ACA intends to achieve such coordination and collaboration is through the use of an ACO.

An ACO is an organization of health-care providers responsible for the quality, cost and overall care of the whole patient. It is an independent legal entity that aims to “mesh quality with efficiency and efficacy.”3 To achieve that stated goal, the ACA created a reward system that pays ACOs for performing under a benchmark cost curve.4 This reward system, called the Medicare Shared Savings Program, incorporates financial incentives to health-care providers who can minimize duplicative or unnecessary treatments in the hopes of reducing the length or number of emergency room visits, hospital stays, surgeries and the volume of patient care in general.5

While the ACA has greatly popularized ACOs in recent years, the convention has existed since at least 2006.6 By April 2014, 522 new ACOs had been formed since the ACA was enacted in 2010.7 There are currently five ACOs operating in the greater St. Louis area.8

What Are Clinical Practice Guidelines?

In order to be certified by the Department of Health and Human Services, an ACO must meet a number of requirements.9 Important for the purposes of our discussion is that an ACO must “define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring and other such enabling technologies.”10

Moreover, in order to comply with the ACA and promote “evidence-based medicine” and “patient engagement,” ACOs often adopt Clinical Practice Guidelines (CPGs).11 CPGs are statements issued by medical associations and societies with recommendations to optimize patient care as well as assessments on alternative care options.12 A clearinghouse is available at http://www.guideline.gov for anyone wanting to research and compare such CPGs.

How Might Accountable Care Organizations Affect Medical Malpractice Lawsuits?

It is not difficult to see how ACOs may affect lawsuits involving alleged medical negligence. One potential avenue is the use of CPGs—generated or adopted by an ACO and ostensibly adopted to hold the organization “accountable”—as a sword or a shield in lawsuits. Let’s consider what a jury hears in such cases, both from the court and from the witnesses.

In a medical malpractice lawsuit, once the evidence is completed, a jury is typically given instructions approved

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by the state’s Supreme Court. These instructions are intended to guide the jury in reaching a decision in favor of the plaintiff(s) or defendant(s). The court instructs the jury to decide whether the health-care provider was “negligent,” and it typically provides a definition of “negligence.” For example, in Missouri, negligence by a health-care provider is defined as “the failure to use that degree of skill and learning ordinarily used under the same or similar circumstances by the members of defendants’ profession.” This “degree of skill and learning ordinarily used” is often referred to as the “standard of care.” Illinois has a similar provision.

What information is a jury permitted to use in deciding such a question? In addition to testimony by witnesses such as the patient and health-care provider, documents such as policies and procedures may be shown to the jury. Experts are also brought into court to opine on whether the provider used that acceptable degree of skill and learning. Each side, of course, wants to convince the jury that their expert’s opinions are objective, unbiased, and not simply bought by the attorney. One way to convey this objectivity is to buttress the expert’s opinions with policies and procedures developed by a person or entity for a reason unrelated to the lawsuit.

This raises the question of whether CPGs are admissible as evidence to buttress the expert’s opinions.

How Might Guidelines Be a Sword or Shield?

Recently, legal and medical analysts explored whether CPGs or other adopted guidelines could be used to establish the standard of care in medical malpractice cases. If so, these guidelines could act as a shield for health-care providers or as a powerful sword for the plaintiff. If, for instance, the physician complies with the guidelines, then the guidelines could be used as evidence in support of the physician having fulfilled his or her duty to meet the standard of care during treatment.

If the physician fails to comply with the guidelines, however, the guidelines may expose him or her to liability. Moreover, even if the physician complies with guidelines, a plaintiff might argue that guidelines developed by the ACO itself emphasize financial motivation for substandard care. The resulting argument would be that the care provided was substandard because guidelines were designed to minimize care for financial reasons.

What Action Has Been Taken to Limit the Admissibility of Guidelines?

Not surprisingly, certain entities are concerned that CPGs may be used to establish the standard of care. In 2012, the American Medical Association proposed legislation entitled the “Standard of Care Prevention Act,” which would prevent federally-mandated guidelines from being used to determine the standard of care. In 2014, the state of Georgia enacted the Provider Shield Act, which is based on the AMA’s proposed legislation but allows CPGs to be admissible if relied upon by experts to support their opinions. On April 16, 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under MACRA, federally-required guidelines cannot be construed to establish the standard of care owed by a health-care provider in a medical malpractice claim. Arguably, however, that language does not prohibit experts from using guidelines to support their opinions on what the standard of care was for a given patient encounter.

Conclusion

ACOs, and any CPGs adopted by them, are a relatively recent development in health care. There is great uncertainty as to how these guidelines used by “accountable” organizations will find their way into cases of alleged medical malpractice. As demonstrated, guidelines could act as a shield for health-care providers or as a powerful sword against them. Given the CPG’s apparent objectivity, level of detail and development by those held “accountable,” health-care leadership and risk management, along with their counsel, should closely monitor the wording of implemented or adopted CPGs.

References

1. The authors recognize and apologize for the potential confusion between the ACA and an ACO. The use of such acronyms is, however, a regretfully unavoidable aspect of discussing government regulations.
4. Id.
6. Zahawa, supra note 2, at 1475.
8. Those ACOs are as follows: BJC Healthcare ACO, LLC; Mercy ACO, LLC; Mercy Health ACO, LLC; St. Louis Physician Alliance ACO, LLC; and SSM ACO, LLC. Centers for Medicare & Medicaid Services, ACOs in Your State, https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/53qt-6tk3? (last visited Jun. 22, 2015).
9. 42 U.S.C.A. § 1395jjj(b)(2). For example, an ACO must have a particular governing administrative structure; it must agree to participate in the program for at least three years; and it must serve at least 5,000 patients with a sufficient number of providers to service patient needs. Id.
13. MAI 11.06.
14. IPI NO. 105.03.01.
15. For example, in Illinois, the jury is told that “[i]n deciding whether the defendant [hospital] was negligent, you may consider . . . (evidence of professional standards) (evidence of by-laws / rules / regulations/ policies/procedures) (evidence of community practice).” IPI NO. 105.03.01.
Protecting Assets in the Midst of a Malpractice Claim

Affordable Care Act could influence rise in malpractice claims and how standard of care is viewed

By Paul Larson, CFP, CLU

Besides being healers and caretakers, doctors are also business owners, putting themselves at risk for additional lawsuits and claims. There are many assets at stake when a physician faces a medical malpractice lawsuit, and it’s not just the assets related to the medical practice that can be vulnerable. Even if there is a settlement out of court, a doctor’s reputation, medical record and credentials could all be tarnished in the process.

The implementation of the Affordable Care Act has led to speculation about the broader impact on medical malpractice claims. A 2014 study by the RAND Corporation theorizes a rise of up to 5 percent in malpractice claims.1 The theory is based on an assumed increase in procedures and patient interactions from a higher percentage of the population being insured. Consequently, higher liability premiums may be expected. Certain factors could have a broader impact on the risk profiles of physicians.

Standards Are Changing

A primary concern for physicians is that the quality and standard measures of the ACA could cause a shift in how “standard of care” is evaluated in the courtroom. The fear is that plaintiff attorneys could use these approved guidelines from specialty boards as “rules” for the standard of practice and patient safety. This would essentially allow operational guidelines to take precedence over proven clinical research.

Just as health care has undergone reform, some entities such as the Center for American Progress have suggested that a reform of medical malpractice law is necessary as well.2 One potential solution would be a safe harbor for physicians with legally-defined criteria for standard of care. Patients who bring malpractice claims must show evidence that their physician did not follow guidelines and meet the standard of care when diagnosing or treating their specific conditions. The ability to show documented proof that the physician did indeed adhere to established guidelines and upheld the standard of care is an effective means for defending such claims in the early stages of litigation.

Physicians can document their adherence to clinical guidelines by using a qualified health information technology system. Research published by the Archives of Internal Medicine suggests that adoption of electronic health records could lead to a reduction in malpractice claims.3 EHRs allow for more effective communication between health-care providers and cut down delays in receiving patient information. Also, the documentation provided by EHRs could improve the chances of a successful defense in the earliest stages of a malpractice lawsuit.

Preparing a Defense

Statistics indicate that the majority of physicians will be sued for medical malpractice at some point in their careers. In fact, a study published by the New England Journal of Medicine found that 99 percent of physicians in high-risk specialties will be sued by the age of 65.4 However, there are some proactive steps that can be taken when facing this ordeal.

Insurance carriers generally require to be notified at the first hint of trouble if there’s reason to suspect that a patient is considering a lawsuit. The insurer usually assigns a claims representative to investigate the claim, gather information and act as a guide through the litigation process. To maximize the defensibility of a malpractice claim, thorough records should be maintained and organized. Missing records and poor documentation in general could harm the chances of a successful defense.

Further, physicians should be cognizant of their rights when determining whether a settlement can be reached. In most cases, carriers won’t settle a claim without the doctor’s consent.
However, some policies have a “hammer clause” that allows the carrier to assert pressure on their insured as to whether a case should be settled. Even if the medical facts are on the doctor’s side, a settled claim could show up in a physician’s professional history, affecting one’s professional reputation and potentially increasing their future risk of similar claims. Having a consent-to-settle clause in a medical malpractice policy may allow a physician to retain a higher degree of authority in this critical decision. Maintaining confidentiality in the terms of any settlement can eliminate or limit the impact of a claim on potential future claims.

References

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cost of the food packaging ingredients. Working together in one-hour assembly line shifts, participants packaged 384,000 meals in a single day.

Dr. Soffer reports that “participants are overwhelmingly enthusiastic both during and after the event. We have a diverse population of participants, ranging in age from 7 to 90-plus. In any given hour, you will find third graders, church groups, local celebrities and executives—all in hairnets and aprons—working together assembling meal packets. After the event, we get letters from participants, describing how much the sense of community in that gym—people working together towards a common goal to help the hungry—moved them, and how they realized that when individuals work cooperatively, they can make a real difference.”

St. Louis World Food Day 2015 will be held on Friday, Oct. 16, at John Burroughs School. A proud sponsor of this event for the last three years, SLMMS invites physicians across Missouri to volunteer with their family and friends. As Dr. Soffer explains, doctors “have lots of talents beyond the bedside or bench, and with their leadership and organizational skills and resources they are in a unique position to help others, whatever their passion or interest.”

To volunteer, contact Liz Webb at the SLMMS office at 314-989-1014, ext. 108 or lzw@slmms.org no later than Monday, Oct. 12. For more information on World Food Day, visit www.stlwfd.org.

References
Highlights from the 2015 AMA Alliance Annual Meeting

By Sue Ann Greco, SLMMS Alliance member and MSMA Alliance president

Alliance members representing every organized state alliance in the country attended the AMA Alliance meeting and educational program June 6-9 in Chicago. The presentations included topics on leadership, social media and medical marriages.

Outgoing AMA Alliance President Sarah Sanders introduced keynote speaker Laurie Guest whose inspiring talk was titled, “Reinventing Yourself in the Espresso Lane.” Laurie encouraged members to take a “Cup of GUTSY to Go.” Her Cup of GUTSY contains “G,” genuine interest in others; “U,” using a person’s name; “T,” talking less and listening more; “S,” smiling; and “Y,” saying “yes” and getting others to say “yes.”

Consultant Jeff Corless, of Venture Strategic in Irvine, Calif., suggested members use social media to develop a trademark and brand, but to be mindful that everything shared on social media is permanent. Jeff suggested that members Google-search their name to see what is out there about them.

Kim Blackham, a licensed marriage and family therapist, spoke on, “Medical Marriages in the 21st Century: Applying the New Science of Adult Love and Attachment.” She is the wife of a surgeon and mother of four children, a regular contributor to the AMA Alliance’s Physician Family magazine, and leads marriage retreats for physician families.

Julie Newman, originally from North Carolina, was installed as the 2015-2016 AMA Alliance president. Julie challenged members to each recruit three new members this year, four next year, and five the year after, as a way to boost membership in the AMA Alliance. Julie hopes to increase membership by 1,500 over the next three years.

Missouri leaders attend the AMA Alliance annual meeting in Chicago. From left: Mary Shuman, Barbara Hover, Stacy Peters, MSMA Alliance President Sue Ann Greco, Jana Wolfe, Marcia Conant, Sandra Murdock and Allene Wright.

For further information on local events, visit www.slmms.org/about-us/slmms-alliance or contact Millie Bever (gabmd01@aol.com) or Gill Waltman (grh@slu.edu). Details on state events are available at www.msma.org/alliance.
Hubert A. Ritter, MD

Hubert A. Ritter, MD, a board-certified obstetrician-gynecologist and SLMMS past president, died Oct. 18, 2014, at the age of 90. Dr. Ritter was active in organized medicine and many community organizations.

A St. Louis native, Dr. Ritter graduated from Westminster College in Fulton, Mo., in 1945, then obtained his medical degree from Saint Louis University in 1948. He completed his internship and residency at Saint Louis University, and served two tours of duty as a medical officer in the U.S. Navy.

Dr. Ritter was director of the Department of Gynecology and medical staff president at SSM St. Mary's Health Center, and also was on staff at Saint Louis University Hospital and the former Deaconess Hospital.

He was president of the St. Louis Medical Society in 1969 and served in leadership roles for many years. He was on the board of trustees of the American Medical Association and served as secretary-treasurer. He held several offices in the Missouri State Medical Association, and was president of the St. Louis Gynecological Society.

In the community, Dr. Ritter was St. Louis County Department of Health commissioner in 1975–76 and served on several Missouri governor's task forces.

Dr. Ritter joined the St. Louis Metropolitan Medical Society in 1952 and was made an Honor Member in 1977. He received the Society's Robert E. Schlueter Leadership Award in 1985.

SLMMS extends its condolences to Dr. Ritter's wife Margaret, daughter Lisa and granddaughter Jennifer.

Jonathan Reed, MD

Jonathan Reed, MD, a board-certified obstetrician-gynecologist, died Nov. 3, 2014, at the age of 80.

After earning his undergraduate biology degree at Fisk University in Nashville, Tenn., Dr. Reed was drafted into the U.S. Army and served in Korea from 1956 until 1958. He graduated from Meharry Medical College in Nashville in 1965 and then completed his internship and residency at the former Homer G. Phillips Hospital in St. Louis.

Dr. Reed served the community for nearly 50 years in private practice, and after retirement as head of the ob-gyn department at Myrtle Hilliard Davis Comprehensive Health Centers.

His hospital associations included Barnes-Jewish Hospital, SSM DePaul Health Center and the former Deaconess Hospital.

Dr. Reed also was a member of the National Medical Association, Mound City Medical Association and the American College of Obstetricians and Gynecologists.

Dr. Reed joined the St. Louis Metropolitan Medical Society in 1969 and became a Life Member at his retirement.

SLMMS extends its condolences to Dr. Reed's wife Bettye, daughters Stacy Reed Mevs, MD; Michelle Reed Arnold, MD; Dana Reed; and four grandsons.

Olga M. Blair, MD

Olga M. Blair, MD, a board-certified pathologist, died Nov. 18, 2014, at the age of 84.

Born in Havana, Cuba, Dr. Blair received her medical degree from Havana University School of Medicine in 1959. She was an associate professor in the Department of Pathology at Saint Louis University School of Medicine.

Dr. Blair was an intern at Michael Reese Hospital in Chicago (1956-57), and a resident at Children's Hospital Medical Center in Boston (1957-60), Boston City Hospital (1960-61) and Cleveland Metro Hospital (1961-63).

Dr. Blair joined St. Louis Metropolitan Medical Society in 1975, and moved to Life status in 2000.

She was preceded in death by her husband, John D. Blair, MD. SLMMS extends its condolences to her family and friends.

Joseph G. Ernst, MD

Joseph G. Ernst, MD, an internist, died July 4, 2015, at the age of 87.

Born in St. Charles, Dr. Ernst received his undergraduate and medical degrees from Saint Louis University. He opened his private practice in Kirkwood in 1957.

Dr. Ernst served as a Captain in the U.S. Air Force from 1952 to 1954, serving as a flight surgeon during the Korean War. He was on staff at the former St. Louis County Hospital as well as the former SSM St. Joseph Hospital of Kirkwood where he served as president of the medical staff in 1967-1968.

Dr. Ernst joined St. Louis Metropolitan Medical Society in 1957, and moved to Life status in 1991.

SLMMS extends its condolences to his wife Ricka Ernst; children Greg Ernst, Karen Mertz, Barb Potts, and Larry Ernst; and his eight grandchildren.
Finding Good Employees

Tips on recruiting and selecting the people who are the face of your practice

By Christine M. Keefe, CPA, CMPE, MGMA of Greater St. Louis

Editor’s Note:

SLMMS has established a partnership with the Medical Group Management Association of Greater St. Louis (MGMA), which will include sharing information in publications, across websites, through organizational committees, and via joint educational programs. MGMA is committed to providing helpful management information to SLMMS members and their office staffs. The MGMA of Greater St. Louis has over 250 practice manager members representing over 140 local physician practices, as well as over 75 business partner members.

Payroll and benefits are often one of the most significant expense line items in a medical practice and one of the most difficult to manage. Employee turnover can be very costly, so it is important we do our best to hire and retain the best employees we can find. How do you find the perfect candidate? It can be an exhausting and time-consuming process. What are the steps involved?

Know What You Need

- Just because an employee quits, doesn’t mean you should replace that exact position. It may be a good time to evaluate your workflow and consider changes. Is the position really necessary? Could the functions be distributed to other employees or minimized through automation? Is there a current employee who would want the position, possibly freeing up a position that is easier to replace?
- The more flexible you can be, the more options you will have.
- Can you use two part-time employees vs. one full-time? It’s more training, but also gives the employer more flexibility. Many hourly workers prefer part-time employment.
- You may think you should hire someone young, but there are older adults available with considerable experience who are ready for a job with less responsibility. Be open to both younger and older workers. Sometimes older workers offer increased flexibility and can adjust their hours or schedules easily.
- You may think you need someone “right away,” but don’t focus only on candidates who are unemployed and available immediately. Sometimes you have to wait for the best person.
- Make a list of the job duties, or write a job description. This will help you stay organized as you evaluate candidates.

Decide Where to Look

- One option that will save you considerable time and trouble is to work with a staffing agency. They can perform the bulk of recruiting, screening, background and reference checks. You receive a supply of qualified candidates.
- If you are handling everything in-house, there are many options. Traditionally, the St. Louis Post Dispatch was the place to look for jobs. However, there are many less expensive options available now. We use Craig’s List, because the cost is minimal. One downside is, you will receive a lot of resumes to sort through, many of whom are not remotely qualified, but there are also some gems. We have also had good luck with Simply Hired, another online service. Of course there is Monster. You can also post an ad on the local Medical Group Management Association (MGMA) website or other professional websites related to your need.
- St. Louis is still a “small town” in the health-care community. Put the word out that you have an opening. Ask your current employees if they know of anyone. Ask your vendors. Ask your former employees. If they have moved onto another medical practice they know another pool of candidates. Or perhaps they would like to return to your practice? Sometimes an employee doesn’t value what they have until they have moved on.
- Consider offering your employees a small “referral fee” for qualified candidates if they are hired. If the new employee is still on board in six months, you can reward the referring employee with part two of the referral fee. This encourages your existing employees to help you recruit qualified candidates. The best candidates usually come from people you know.

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Christine M. Keefe, CPA, CMPE is the CFO & Director of Strategic Initiatives for Metro Imaging, LLC, an independent group of outpatient imaging centers serving the greater St. Louis area. Chris can be reached at cfo@metroimaging.org or at 314-333-6725.
David Sindelar has been appointed chief executive officer and fourth member of the Office of the President at St. Anthony’s Medical Center effective Sept. 1. Formerly CEO and president of Hanley Partners and CEO of several portfolio companies including Viasystems, Sindelar has served on St. Anthony’s board of directors since 2002 and was elected chairman in 2010. The other members of the Office of the President are Christopher Bowe, MD, (SLMMS); David Morton, MD, (SLMMS); and Beverly Bokovitz, MSN, RN.

Kate Becker will become president of Saint Louis University Hospital when it becomes part of SSM Health later this summer. Becker currently serves as president of SSM St. Mary’s Health Center and interim president of SSM Cardinal Glennon Children’s Medical Center. SSM will be searching for leaders for each of those facilities.

Finding Good Employees  
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- Don’t forget our local schools and colleges. If you recruit regularly, build relationships with the teachers or placement departments.
- Make your organization attractive. If you have good benefits, include that in the ad. For instance, when we surveyed our current employees, the most important benefit to them was health insurance. A strong benefit plan can help the recruiting process.

Optimize the Interview Process

The interview process can be very time-consuming but is critical to your success in choosing the right candidate. Here are just a few tips:

- Always do a phone interview first. This will allow you to screen out a number of candidates and takes less time than in-person meetings.
- Be prepared. Your first priority is whether the candidate is even qualified for the position. Start there and have your questions prepared in advance. Have your job description handy.
- Your next priority is to determine if they are a good fit for your practice and culture. This is where leading questions are invaluable.
- Interview questions: MGMA of Greater St. Louis recently asked nine different local medical practice managers “What is your favorite interview question?” They shared their favorites in a video which can be seen on the MGMA of Greater St. Louis website at www.mgmastl.org in the video section.
- Have more than one individual interview the final candidates. Your staff can provide valuable input, especially from the co-worker standpoint.
- Don’t be afraid to interview a candidate more than once. You can definitely learn different aspects about a prospective employee.

When you can find the best employees, you make everyone’s life (including yours) a little easier. Your employees are the face of your practice to your patients. The investment in recruiting the best pays off in the end. 

The National Cancer Institute has awarded Siteman Cancer Center at Barnes-Jewish Hospital and Washington University School of Medicine an “exceptional” rating, based on a rigorous review of Siteman’s research programs. The rating is the highest possible by the NCI, the principal federal institute that funds cancer research. Peer reviews are conducted every five years.

St. Louis Children’s Hospital and Washington University Physicians have opened a specialty care center at I-64/Hwy. 40 and Mason Road in west St. Louis County. The building houses specialists in nearly 20 areas, including allergy/immunology/pulmonology, cardiology, orthopedics, otolaryngology and plastic surgery.

WELCOME NEW MEMBERS

Saima Ahmad, MD
1025 Dunn Rd., 63031-8205
MD, Baqai Medical College, Pakistan, 1997
Born 1973, Licensed 2007  
Active
Family Practice

Edward L. Burns, MD
10010 Kennerly Rd., 3rd Fl., 63128-2106
MD, Univ. of Missouri-Columbia, 1978
Born 1953, Licensed 1979  
Active
Cert: Internal Medicine

Jack Galbraith, MD
5425 Southfield Center, 63123-5984
MD, Univ. of Missouri-Columbia, 2006
Born 1979, Licensed 2008  
Active
Family Practice

Antonella Quattromani, MD
9325 Ladue Rd., 63124-1750
MD, Univ. DiPerugia, Fac Di Med E Chirurgia, Italy, 1982
Born 1958, Licensed 1986  
Active
Cert: Cardiovascular Disease, Internal Medicine

Thomas R. Sanford, MD
3635 Vista Ave. FTD 6, 63110-2539
MD, Univ. of Kansas, 1991
Born 1960, Licensed 1996  
Active
Otolaryngology

WELCOME STUDENT MEMBERS

Saint Louis University School of Medicine
Shivani L. Singh

Washington University School of Medicine
George O. Denny
Rachel L. Goldberg
Rohan Jalalzadeh
Stephen W. Linderman
Annelise Mah
Steven Monda
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