

ST. LOUIS METROPOLITAN  
**MEDICINE**

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*Celebrating 175 Years of Organized Medicine*

2012

**HEALTH-CARE ISSUES AT FOREFRONT IN 2012 ELECTIONS**

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# SCAM-Q\*

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

## The Taxman Cometh, So Be a Patriot

By Richard J. Gimpelson, MD

As if physicians do not have enough to worry about regarding the possible 27.4% decrease in Medicare payments that may take place in 2013 from the Medicare SGR, there are changes in personal taxes and deductions that will also have a real effect on your pocketbook (SCAM-Q August/September 2012). I have covered some of these in prior columns as information; but now, thanks to my personal accountants,\* I have some more details.

These new taxes will be applied if your net or self-employment income is:

- Above \$200,000 if unmarried
- Above \$125,000 if married/filing separately
- Above \$250,000 if married/filing jointly

1) Itemized medical expense deduction increases from 7.5% to 10% of adjusted gross income (new information).

Exceptions: if you or your spouse are 65 or older as of December 31, 2013, the new rate will not apply until 2017. If you or your spouse turn 65 in any year 2014-2016, the rate stays at 7.5% through 2016. In 2017, the 10% applies to everyone.

2) 0.9% Medicare tax on compensation or self-employment income.

Current Medicare tax is 2.9% for self employed and split to 1.75% each between employee and employer (new information).

In 2013, an extra 0.9% Medicare tax will be charged. For those self-employed, the 0.9% additional tax will not qualify for the deduction of 50% of self-employment tax that you are allowed to claim on page one of your Form 1040.

3) 3.8% Medicare tax on investment income (long-term gains and qualified dividends).

Current tax is 15% for capital gains and qualified dividends. In 2013, the tax on long-term gains will rise to 20%

and qualified dividends will be taxed at the rate of 39.6%.

The rest of the story is that these long-term capital gains and qualified dividends will have the additional 3.8% tax applied. Thus, long-term capital gains will be taxed at 23.8% and dividends taxed at 43.4%.

At this time tax-exempt income (e.g. tax-exempt municipal bonds) is not subject to the 3.8% tax.

Oh, by the way, tax on ordinary income increases from 35% for 2012 to 39.6% for 2013.

What can you do about these tax changes? Talk to your accountant and financial advisor.

I hope you appreciate the information and good advice I have passed on. Now, as all of you can see, 2013 will allow you to be "patriots and share the wealth."

Please, do not panic, as there is a possibility that none of these Health Care Act tax changes will actually take place. Be reassured that nothing will happen until after the election on November 6.

SO DO NOT FORGET TO VOTE!!!

\*I want to thank my tax advisors from the firm of Kerber, Eck & Braeckel, LLP.



Richard J. Gimpelson, MD



*Dr. Gimpelson, a past SLMMS president, is now 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](mailto:editor@slmms.org).*



**Harry's Homilies**©  
Harry L.S. Knopf, MD  
**ON ANGER**  
*It always takes two to have an argument.*

Just as it takes two to Tango, it takes two to conduct a proper argument. Now the disagreement does not have to be rancorous, but it may soon turn so if there is any heat in it. So pick your arguments and your opponents wisely. Next time a friend, spouse, sibling or stranger wants to argue: stop, count to three, decide. If it will not bring about anything fruitful, excuse yourself and walk away. It is far more difficult to argue with oneself than with another. And the results of the argument may not be "victory" for one side, but angry disappointment for both.

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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# Upcoming Elections Important for Our Future



Medical Society President  
Robert McMahon, JD, MD

“The hottest election topic related to medicine — and perhaps overall — is health-care reform and the Patient Protection and Affordable Care Act. Candidates have taken markedly opposing viewpoints.”

November marks the time for elections, both the general election for our state and federal officials and ballot propositions, and the election of next year's Medical Society leadership. Each will have significant impact on our future. In this issue of *St. Louis Metropolitan Medicine*, we are pleased to offer information on the candidates that we hope will be of help to you in making your decisions.

Health-care issues are being hotly debated for the November 6 general election. Starting on page 16, you can learn about our local candidates' positions on these issues. Candidates for Missouri U.S. Senator, U.S. Congress and Missouri Governor have provided responses to several questions posed to them on matters of concern to physicians, including the PPACA, health-care costs, the Medicare SGR and tort reform. Their responses illustrate their visions of the future on these critical issues. We thank the candidates and their campaigns for taking time from their busy schedules to respond to our questions.

The hottest election topic related to medicine—and perhaps overall—is health-care reform and the Patient Protection and Affordable Care Act. June's U.S. Supreme Court decision upholding the law puts this issue at center stage. Candidates have taken markedly opposing viewpoints, ranging from support and possible expansion, to calling for repeal. Physicians also have differing views on the direction our nation and our state should take on how the health system should be structured and financed.

In Missouri, another critical issue that has

boiled to the top is lawsuit reform. This follows the July 31 Missouri Supreme Court decision lifting Missouri's lawsuit liability limits. Seeking a remedy that controls liability costs and preserves the viability of practice has become a major priority. MSMA has promised intensive legislative advocacy in 2013 to restore non-economic damage limits. Two articles in this issue of *St. Louis Metropolitan Medicine*, by attorneys John Maupin and Thaddeus Eckenrode, and attorney James Cantalin, look into the impact of the Missouri Supreme Court decision and how physicians might respond to this altered lawsuit reform landscape.

While I do not pretend to be a legal scholar, I do understand and appreciate the reasoning behind both the U.S. PPACA decision and the Missouri decision on lawsuit liability limits. I am encouraged that there was dissent in each court. I also am encouraged by MSMA's active response. How this issue will play out is uncertain.

Related to the judiciary, there is a ballot proposition that should be studied and watched closely. Constitutional Amendment 3 proposes to change the process for selecting nominees to the Missouri Supreme Court and state courts of appeals. Under the amendment, the governor would appoint a majority of the commission that selects these nominees, and allow the governor to appoint lawyers (instead of being limited to non-lawyers) to the commission. While SLMMS is nonpartisan and cannot take a position on this proposed amendment, it would be wise for you to study this amendment and its potential impact on judicial selection.

As we prepare to advocate for the future of health care, it is critical that we have an

active and involved Medical Society membership and strong leadership. Also in November, from the 1st through the 25th, we will be electing officers and councilors for the Medical Society. While our election does not have the acrimonious debate of the general election, it nevertheless still is very important. I strongly encourage you to cast your vote in the election.

In this issue of *St. Louis Metropolitan Medicine*, starting on page 8, we publish profiles on the candidates for 2013 SLMMS officer and Council positions. Please take time to read each of their bios and statements on how SLMMS can best impact the future of medicine in the St. Louis region. These are insightful as to the direction our Society can take as we move forward. I hope they also inspire more of you to serve your Medical Society!

Important issues face medicine today, including transparency in costs and reim-

bursement, stability and fairness in Medicare reimbursement, and meaningful lawsuit reform. These all are key concerns to physicians, and would benefit all of us in society. We should also share these concerns with our patients. Our concerns are their concerns. I remain convinced of this and encourage each of you to speak openly and honestly with your patients. Tell them what you think, what worries you, what you hope for the future, and engage them as our partners for change.

Take the time to become informed about the issues and candidates in the upcoming elections. Be sure to vote your conscience on November 6. Also please take part in the November 1-25 SLMMS election.

“As we prepare to advocate for the future of health care, it is critical that we have an active and involved Medical Society membership and strong leadership.”



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# Nominees Announced for SLMMS 2013 Officers and Councilors

## *Election takes place online November 1-25*

SLMMS members will soon elect officers and councilors to lead the Society in 2013. The election will take place online at [www.slmms.org](http://www.slmms.org) from Nov. 1 to 25.

**David L. Pohl, MD**, will succeed automatically to the position of 2013 SLMMS president from his current status as president-elect. Dr. Pohl is a diagnostic radiologist and director of radiology at SSM St. Joseph Hospital West. He is a graduate of Washington University School of Medicine and holds a master's degree from the University of North Carolina plus a bachelor's degree from Miami University (Ohio). He is a Fellow of the American College of Radiology. He has been an SLMMS councilor since 2008 and served as treasurer from 2009 to 2011.



Up for election will be candidates for president-elect, vice president and secretary along with six councilors. Councilors are elected to three-year terms; an additional 12 councilors will continue their unexpired terms.

Learn more about our 2013 candidates by reviewing their biographies that follow. To help give insight in their thoughts about the Medical Society, we have asked them to respond to the question, "How can SLMMS make the most impact to support physicians in the region?"

**Joseph A. Craft III, MD**  
**President-Elect**

**Practice:** Cardiologist, Mercy Heart and Vascular. Board certified in internal medicine, cardiovascular disease, echo cardiography, nuclear cardiology. Hospital: Mercy Hospital St. Louis.

**Education:** B.S., University of North Carolina, Chapel Hill. M.D., Wake Forest University School of Medicine.



Internship, residency and chief residency in internal medicine at Vanderbilt University Medical Center; Fellowship in cardiovascular disease at Barnes-Jewish Hospital and Washington University School of Medicine, 2003-2006.

**Birthplace:** St. Louis.

**SLMMS/MSMA/AMA Service:** SLMMS vice president 2012, councilor 2008-2011; SLMMS Council Executive Committee, 2010-2011; Councilor MSMA 2005-2007, 2012; Past national chair, vice chair and councilor, AMA Resident and Fellow Section, 2003-2006. Served on SLMMS Grievance Committee and Nominations Committee. Joined SLMMS 2003.

**Other Professional/Community Activities:** American College of Cardiology; American Society of Echocardiography.

**Awards and Honors:** Alpha Omega Alpha Medical Honor Society, 2002; Chairman, Division of Cardiology, SSM St. Clare Health Center 2010-2011; Member, Medical Executive Committee & Peer Review Committee, SSM St. Clare Health Center, 2009-2011; founder and inaugural chair, AMA Resident & Fellow Section Research Poster Symposium, 2005; Resident Teaching Award at Vanderbilt University Medical Center, 2003.

**Personal:** Wife, Liz; two children. Hobbies: Spending time with family, running, exercising, reading, playing golf.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** As we all navigate the dramatically and rapidly shifting health-care landscape, the fundamentals of the practice of medicine should not and will not change significantly. Irrespective of the evolving details of how we work day to day, the patient-doctor relationship will remain essential to high-quality care. Continuing education, medical research, patient advocacy efforts and close interaction with physician colleagues will prove as critical as ever. The St. Louis Metropolitan Medical Society is the oldest and largest physicians' organization in our community. With its rich history, the Medical Society will help unite and lead physicians and the medical community in dynamically changing times. But to deliver on this promise and to increase its impact in our community, SLMMS must modernize and become more attentive to doctors' evolving needs. I would be honored to assist in that effort.

**Michael J. Stadnyk, MD**  
**Vice President**

**Practice:** Diagnostic Radiology. Certified by the American Board of Radiology.



Hospital: St. Luke's Hospital.

**Education:** M.D., UMKC School of Medicine. Internship and residency, general surgery, Truman Medical Center Kansas City; diagnostic radiology, Saint Louis University.

**Birthplace:** Belleville, Ill.

**SLMMS/MSMA/AMA Service:** SLMMS councilor, 2009-2011; secretary, 2012; MSMA delegate 2009-present. Member, SLMMS Publications Committee; Rapid Response Team; By-Laws Committee. Joined SLMMS 2003.

**Other Professional/Community Activities:** Past president Greater St. Louis Society of Radiologists. Member, Radiological Society of North America, American College of Radiology, Friends of St. Luke's Society.

**Personal:** Wife, Cheri; five children. Hobbies: Sports, music, reading.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** SLMMS has a primary duty to inform and educate members in a timely fashion regarding political issues that impact the field of medicine. Current issues that beg attention are the upcoming effects of the Affordable Care Act and patient steering by insurance companies. It is the responsibility of SLMMS to offer avenues for physicians to become better aware of the political landscape both at the local and national levels.

**Gordon M. Goldman, MD**  
**Secretary**

**Practice:** Obstetrics and gynecology. Certification, American Board of Obstetrics & Gynecology. Hospitals: St. Luke's Hospital, Mercy Hospital St. Louis.

**Education:** B.S., University of Toledo. M.D., Saint Louis University. Internship and residency, Good Samaritan Hospital, Cincinnati, Ohio; general surgery and obstetrics and gynecology, Jewish Hospital.

**Birthplace:** Toledo, Ohio.

**SLMMS/MSMA/AMA Service:** SLMMS councilor 1998-2006; Executive Committee 1989-91; Vice President 1991; Chair, Physicians Grievance Committee, 1993-2000; Member, Nominations Committee, 2006-present. MSMA president 2000, president-elect 1999; council chair 1998 and vice chair 1997; 3rd District councilor 1991-96; 3rd District delegate, 1988-present. AMA delegate 2000-01. Joined SLMMS 1973.

**Other Professional/Community Activities:** Missouri Section of the American College of Obstetricians & Gynecologists, secretary/treasurer 2000-01, vice chair 2001-04, chair 2004-07,



webmaster 2001-present.

**Personal:** Wife, Roberta; two children. Hobbies: amateur radio, electronics, computers. U.S. Marine Corps captain 1968-70, served in Vietnam.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** I have been active in organized medicine for most of my professional life; I opted to 'stand down' several years ago to make room for younger physicians to participate in the decisions of policy that will affect their careers far more than my own. There is much to be gained from 'institutional memory.' I offer to serve in that capacity.

**Gregory E. Baker, MD**  
**Councilor**

**Practice:** Family medicine; partner, Baker Medical Group. Hospitals: St. Anthony's Medical Center, SSM St. Clare Health Center, Missouri Baptist Medical Center, Barnes-Jewish Hospital, Mercy Hospital St. Louis.

**Education:** B.A., Saint Louis University. M.D., Meharry Medical College. Internship and residency, Mayo Clinic.

**Birthplace:** St. Louis.

**SLMMS/MSMA/AMA Service:** Appointed to SLMMS Council 2012 to fill unexpired term. Joined SLMMS 2011.

**Personal:** Wife, Paula Knapp-Baker, DO, family practice; two children. Hobbies: golf, movies, reading.

**Other:** Physician to talent at Verizon Wireless Amphitheater, Peabody Opera House and Scottrade Center.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** Support of area physicians starts by unification. With an increase in number and participation of the area physicians, the collective voice will become stronger. Actions however, are sometimes more powerful than words alone.



**David F. Butler, MD**  
**Councilor**

**Practice:** Chief, Radiation Oncology Center, St. Luke's Hospital. Diplomate, American Board of Radiology and National Board of Medical Examiners.



*continued on page 10*

**Education:** Undergraduate, College of William and Mary; M.D., University of Virginia School of Medicine. Internship and residency, Riverside Regional Medical Center, Newport News, Va., and Brown Cancer Center. Fellowship in radiation oncology and chief resident, University of Louisville.

**Birthplace:** Phoenix, Ariz.

**SLMMS/MSMA/AMA Service:** Joined SLMMS 1994. Delegate, American Medical Association/Organized Medical Staff Section, 2003-present.

**Other Professional/Community Activities:** Past president and secretary/treasurer, Greater St. Louis Society of Radiologists. Board of directors, Missouri Radiologic Society. Member, American College of Radiology, St. Louis Society of Medical Oncology, American College of Radiation Oncology, American Society for Therapeutic Radiology and Oncology, European Society of Therapeutic Radiology and Oncology, International Society of Stereotactic Radiosurgery, St. Louis Physicians for Human Rights.

**Honors and Awards:** Fellow of the American College of Radiation Oncology

**Personal:** Hobbies: biking, in-line skating, travel. Grew up overseas during much of youth, including Far East, South America, Europe.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** SLMMS is the most effective means by which organized medicine can advocate on behalf of our patients and the medical community in the St. Louis region through a local grassroots effort. As we enter a new era of health-care legislation in the U.S., we need to convey a coherent, consistent message in our interactions with insurance companies, the government and hospital corporations. SLMMS is the ideal tool to achieve that goal.

### Karen F. Goodhope, MD Councilor

**Practice:** Diagnostic radiology. Radiologist, CDI St. Luke's Midwest Breast Care Center. Certification: American Board of Radiology, American Board of Nuclear Medicine. Hospitals: St. Luke's Hospital, Mercy Hospital St. Louis, SSM St. Mary's Health Center, Des Peres Hospital, Lincoln County Medical Center.

**Education:** B.S., Beloit College. M.D., Southern Illinois University School of Medicine. Internship and residency, Baystate Medical Center, Springfield, Mass.; fellowship in nuclear medicine, Mallinckrodt Institute of Radiology.



**Birthplace:** Chicago.

**SLMMS/MSMA/AMA Service:** Joined SLMMS 1986. Served on Membership Development, Member Benefits committees.

**Other Professional/Community Activities:** Missouri State Medical Association, American College of Radiology, Missouri Radiological Society, Radiological Society of North America, American Roentgen Ray Society, Society of Nuclear Medicine and Molecular Imaging, Missouri Radiological Society.

**Personal:** Husband, Steve Bailey; two children. Hobbies: reading.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** There are many external pressures on physicians today. Some of these pressures threaten the quality of care available to patients as well as how physicians are perceived by the community. We need a unified voice locally and nationally to protect the quality of care, access to care and elevated professionalism for all of us.

### Jason K. Skyles, MD Councilor

**Practice:** Diagnostic radiology. Hospitals: Mercy Hospital St. Louis and Mercy Hospital Washington.

**Education:** B.S. and B.A., Saint Louis University. M.D., Saint Louis University School of Medicine. Internship, Forest Park Hospital; residency and fellowship, Wake Forest University.

**Birthplace:** St. Peters, Mo.

**SLMMS/MSMA/AMA Service:** Appointed to SLMMS Council 2012 to fill unexpired term. Joined SLMMS 2011.

**Other Professional/Community Activities:** American Roentgen Ray Society, Radiological Society of North America, Society of Breast Imaging, American Medical Association.

**Honors and Awards:** Phi Beta Kappa and Alpha Omega Alpha.

**Personal:** Wife, Kristin.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** I believe SLMMS can make the biggest impact by assuring accurate and timely distribution of information regarding health-care policy to all physicians in the St. Louis region. We provide a forum for physicians of all specialties to discuss the important issues regarding us and our patients. During these discussions position statements and talking points can be developed and disseminated to give the providers in our region a unified voice.



**Alan P.K. Wild, MD**  
**Councilor**



**Practice:** Otolaryngology–head and neck surgery. Assistant professor, Dept. of Otolaryngology, Saint Louis University. Hospitals: Saint Louis University Hospital, SSM Cardinal Glennon Children’s Hospital.

**E d u c a t i o n :** Undergraduate and M.D., Tulane University. Internship and residency, Jewish Hospital and Barnes Hospital.

**Birthplace:** New Orleans, La.

**SLMMS/MSMA/AMA Service:** Joined SLMMS 1990. Previous delegate to MSMA.

**Other professional/community activities:** President-elect, Missouri Society of Otolaryngology. Fellow, American College of Surgery, American Academy of Otolaryngology–Head and Neck Surgery. International Medical Assistance Foundation ENT Medical Missions to Honduras.

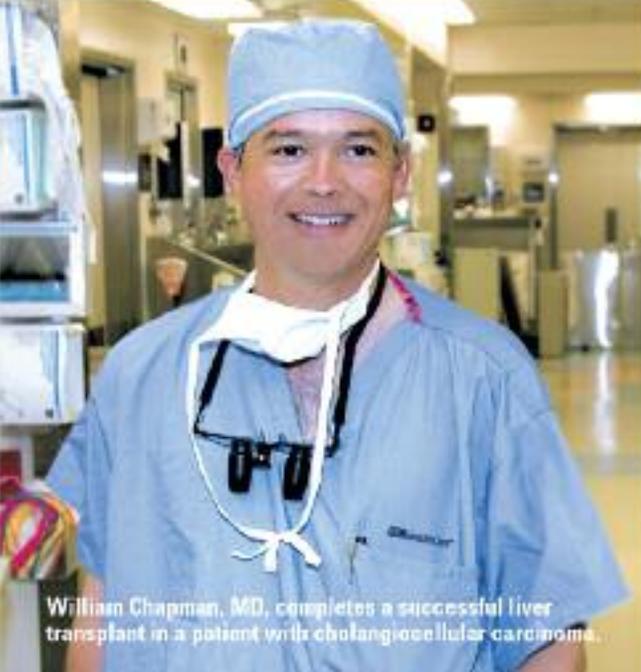
**Personal:** Wife, Sue Ann; two children. Hobbies: sailing, golf, computer maintenance.

**How can SLMMS make the most impact to support physicians in the St. Louis region:** The physicians working and residing in the St. Louis metropolitan area are heterogeneous. Individually, we do not all share the same professional concerns and threats. What we do have in common is the supreme need for a professional organization that has the time and resources to assess the totality of our ever-changing medical milieu. SLMMS is uniquely positioned to keep its physician members and non-members apprised of the educational, regulatory, legislative and legal atmospheres in which we practice our science and art. This support remains the paramount mission for SLMMS.



*A nominee for the sixth Councilor position was pending as of press time. The nominee is expected to appear on the online ballot available November 1-25.*

# Transplant. A Lifesaving Option.



William Chapman, MD, completes a successful liver transplant in a patient with cholangiocellular carcinoma.

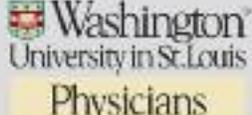
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# Tort Reform Setback

*Analyzing the impact of the July 31 Missouri Supreme Court decision*



John W. Maupin, JD



J. Thaddeus Eckenrode, JD

By John W. Maupin, JD, and  
J. Thaddeus Eckenrode, JD

Eckenrode-Maupin,  
Attorneys at Law

The July 31 Missouri Supreme Court decision nullifying the cap on non-economic damages in medical malpractice cases was a major setback for physicians.

Tort reform has been an issue in Missouri for many years. In 2002 the largest medical malpractice carrier left the state because the tort “reforms” that had been in place in Missouri since 1986 had been significantly eroded by court decisions. Malpractice coverage became difficult to obtain and, when available, extremely expensive, particularly for those in high-risk specialties like OB/GYN, trauma, and neurosurgery. The practice of medicine in Missouri was truly in a crisis.

Significant reforms were enacted in 2005 with the passage of House Bill 393. These included generally restricting where doctors could be sued to the county in which they practice, requiring a meaningful “affidavit of merit” before a lawsuit could proceed, insulating benevolent gestures from liability, and, most significantly, reinstating and limiting non-economic caps. Under the 2005 law, non-economic damages were restored to the \$350,000 cap, not subject to adjustment for inflation, and were restricted to one such award in total per case, no matter how many defendants, plaintiffs or purported acts of negligence existed.

When then-Gov. Matt Blunt signed the bill while surrounded by physicians proudly clad in their white coats, it was a glorious day, not only because of the reforms, but also because it showed that physicians were willing and able to become involved in the political process for the benefit of their patients and their profession.

As a result of the 2005 reforms, several new medical malpractice carriers, including mutual companies, have entered the Missouri market. Premiums have stabilized and declined, saving physicians over \$27 million. Insurance carriers have actually competed for business. More than 1,000 doctors have come to Missouri to practice medicine. The number of negligence cases filed against physicians has dropped by 57%. The “crisis” that was ongoing in 2002 was stemmed and, to some degree, reversed.

## The July 31 Decision

However, on July 31, 2012, the Missouri Supreme Court struck down the \$350,000 cap on non-economic damages as an unconstitutional infringement on the right to a trial by jury. The court found that since medical negligence cases existed as part of the common law when Missourians adopted our constitution in 1820, the attendant right to have a jury determine resultant damages could not be abridged by simple legislation. The decision was by a 4-3 vote, and the strongly-worded dissent pointed out that the Supreme Court had previously rejected an identical challenge to the non-economic caps contained in the 1986 tort reform.

The case decided in July by the Supreme Court was *Watts v. Cox Medical Center, et al.* The suit was brought against the hospital and its associated physicians alleging negligent prenatal care to Deborah Watts had caused catastrophic brain injuries to her son. The jury found in favor of Ms. Watts and awarded her \$3.35 million for future medical expenses and \$1.45 million for non-economic damages. The trial court applied the 2005 tort reform law and reduced the non-economic award to \$350,000. The Supreme Court then reversed the trial court’s reduction and reinstated the entire \$1.45 million non-economic damages award.

A common aphorism is that “bad facts make bad law.” The *Watts* tragedy provided an appropriately egregious setting for the Supreme Court’s decision, but it was not unforeseeable. For one thing, lawyers who typically represent plaintiffs in medical malpractice cases (“plaintiffs’ lawyers”) have been attacking the non-economic caps since they were first adopted in 1986, trying to find the best legal argument and best case for their fight. Second, plaintiffs’ lawyers have been extremely politically active and have backed candidates who share their views on this topic. And, to be completely honest, there are many honorable people, including some doctors, who oppose any limits on recoveries for injured patients. It was only a matter of time until judges appointed by governors generously supported by plaintiffs’ lawyers comprised a majority on the

Supreme Court. Third, the result was foreshadowed in another Supreme Court decision in April of this year, *Sanders v. Ahmed*, in which two judges argued that the cap on non-economic damages was unconstitutional in a case and in which a patient died as a consequence of medical negligence.

The full explanation of why the non-economic cap would be **unconstitutional** in a case for straight damages but **constitutional** in a case in which the patient died is beyond the scope of this article. The shorthand explanation is that when a patient dies, the physician must be sued under a legal theory known as wrongful death, and the cause of action for wrongful death was created by the Legislature in 1855. Thus, the Legislature has the power to limit recovery of damages under that legal theory but not under a theory that existed before Missouri came into being. We know that is confusing to most, lawyers as well as doctors, and we would be happy to explain it if you contact us.

### Some Reforms Not Impacted

Yet, in spite of the *Watts* ruling, physicians still benefit from some of the 2005 tort reforms. The good news is they still can be sued generally only where they practice (the statute limits venue to the county in which the "first injury occurred"). This is a tremendous advantage to the SLMMS members who practice in St. Louis County. While every case presents many challenges and risks, our experience is that jurors in the county are more inclined to favor doctors and much less disposed to be punitive. Many of our friends who are circuit judges share this belief from what they routinely witness from the bench. The absolute requirement that plaintiffs file an "affidavit of merit" from a qualified practitioner definitely helps to obtain early dismissals of questionable lawsuits. A physician can still say "I'm truly sorry" without it being used as an admission of liability. And, as held in *Sanders*, the cap on non-economic damages is still in place for wrongful death actions.

### Upsurge in Cases Expected

Now the bad news. We should expect an upsurge in the number of cases being filed. The limitation that had been in effect on non-economic damage had resulted in some cases being less desirable to many plaintiffs' attorneys, so fewer cases were filed. We estimate that it costs a plaintiff's attorney more than \$100,000 to properly prepare a relatively uncompli-

cated medical malpractice case for trial. If a case looked like the primary damages would be non-economic, and the cap was \$350,000, a lawyer was forced to weigh the risk of spending six figures when the maximum possible net recovery, to both the attorney and his client, after incurring those expenses was \$250,000 or less. Consequently, those cases were far less likely to be filed.

For example, assume that a young child is disfigured as a result of medical negligence. The child will incur very little in the way of economic damages because she will not have lost any wages and her medical expenses will often have been paid by some collateral source. Under the 2005 reforms, she could recover a maximum award of \$350,000 for her pain and suffering and the lifetime of emotional distress resulting from her disfigurement – and this would be reduced by the cost to bring the case to trial and pay her attorney's fees. Now, she will receive whatever a jury believes is fair, and that could be millions of dollars depending on the nature of her injury, her likeability, the personality of the defendant physician, the skill of her lawyer, and the sympathy level of the jurors. A similar scenario can easily be woven for an injury suffered by a retired person or someone not in the work force who cannot be compensated for lost wages.

Some have speculated that a push will be made to re-open cases where the juries' awards of non-economic damages were reduced to \$350,000 by implementation of this now discredited tort reform. While courts have traditionally favored the finality of judgments, some believe that it would be inequitable for a court to refuse to provide relief from the impact of an unconstitutional law. We would hope that the courts will decline to revisit closed cases; but this issue will likely be litigated, and the results are unpredictable.

As a consequence of this lawsuit's impact, we should expect that medical malpractice premiums will increase to reflect the new reality of more medical negligence lawsuits and higher judgments. More problematically, we should anticipate that some carriers will withdraw from the Missouri market completely. We know of two carriers that were preparing to come into Missouri that are now taking a very hard look at their plans because of this ruling. Reduced competition is rarely a good thing.

*continued on page 31*

“As a consequence of this lawsuit's impact, we should expect that medical malpractice premiums will increase to reflect the new reality of more medical negligence lawsuits and higher judgments.”



By James R. Cantalin, JD

Missouri Professionals Mutual

“Understanding your policy and provider is more important than ever to protect yourself and your practice in the event of a lawsuit.”

## Awards Caps are Gone. Is Your Malpractice Insurance Ready? *Key considerations in evaluating insurance carriers*

For the past seven years, Missouri doctors have benefitted from reduced and stabilized medical malpractice insurance rates, thanks in part to the tort reform that capped non-economic damages at \$350,000. However, the Missouri Supreme Court’s July 31 decision to eliminate these caps on the amount of damages sustained by an injured party will create a drastic change in the environment, and your practice needs to be ready.

Taking a walk down the memory lane of pre-2005 tort reform is not pleasant. Those were the days of skyrocketing malpractice insurance premiums, severely limited insurance carrier choices and alarming physician flight. Hundreds of Missouri physicians retired, left the state or quit their practices altogether. Premiums were simply unsustainable. Younger doctors who have entered their practices over the last several years may not even realize how challenging practicing in Missouri was at that time. The court decision ensures they will learn quickly.

In the new era, it’s important to remember that all malpractice insurance is not created equal. Understanding your policy and provider is more important than ever to protect yourself and your practice in the event of a lawsuit.

Prior to tort reform, Missouri physicians faced dwindling choices of insurance carriers, as one after the other closed up shop in our state. However, once tort reform was enacted, there was an influx of options when insurers entered or re-entered Missouri eager for market share. Physicians were relieved to find that rates dropped as many carriers sought to undercut the competition.

But a new problem emerged: many of these providers, whose industry experience was limited to purchasing a policy, started charging actuarially unsound premiums insufficient to cover long-tail liabilities. This is a concern because based on the history of actual claims paid, the rates these carriers have charged are too low to cover the potential risk. Given that this gap was an issue even while the caps were in place, how will these carriers protect their insured physicians now that the limitation is removed and a single claim could easily run in the millions of dollars? All Missouri physicians should be aware of this issue when comparing carriers.

Checking a carrier’s financial viability is not difficult. All carriers are required to file an annual Statement of Actuarial Opinion with the Missouri Department of Insurance and the National Association of Insurance Commissioners. You can find the statements on the Missouri Department of Insurance website ([www.insurance.missouri.gov](http://www.insurance.missouri.gov)) in the “Financial Exams” section on the “Companies” page.

Admittedly, these lengthy statements are challenging to review. However, there is one key question that is telling—question six in exhibit B. It measures whether there is a significant risk that future paid amounts will be materially greater than those provided for in the reserves. In other words, is there a risk that the company will not be able to cover potential claims?

Unfortunately, in 2011 eight of Missouri’s carriers answered “yes”—indicating that these companies were at risk of being unable to cover claims. And that was *before* the non-economic damages caps were removed.

When you decide to compare providers, financial viability is, of course, paramount and should be a top consideration. However, there are several additional key considerations that contribute to the overall security and value that a carrier offers, including:

### Market Share

Ask the carrier what its Missouri market share is and what percentage of its business is conducted in Missouri. Larger market share means more insureds—this helps reduce the risk of loss by spreading out exposure.

### Medical Professional Liability Insurance Experience

It might seem logical that a medical liability insurance company would be managed by doctors, but in reality it’s a business that requires the expertise of seasoned insurance industry professionals who thoroughly understand the business’ long-tail liability as well as how to effectively manage premiums collected and reserves for claims known and unknown.

### Client Service

Outstanding client service comes from companies that are committed to serving the best interests of their insureds, not those of stockholders and/or hospitals. Also, having a main contact who is based locally in Missouri is important to the quality of client service.

### Reinsurance

Ask the carrier if it has reinsured every policy since the company started as well as who provides the company's reinsurance. Companies that fail to secure suitable reinsurance put the solvency of the company, as well as insureds, at risk.

### Advisory Boards

Determine if the carrier has Missouri advisory boards. These communication channels are important to helping a carrier stay current with health-care industry developments as well as understanding its insureds' needs.

### Risk Management Credits

Good carriers reward physicians with premium credits for participating in risk management programs that offer many ways for physicians to enhance the safety and quality of care and reduce errors.

### Claims Management

Swift claims management is vital to effective practice management. Ask the carrier what percentage of all claims filed in the last 5 to 10 years have been closed and how long, on average, it takes the company to close a claim in Missouri.

### Rates

Rate swings are not inevitable. Well-run carriers develop strategies to stabilize rates. Ask the carrier how many times it has raised rates in the last 10 years.

Evaluating your medical malpractice insurance is likely something you do periodically as part of responsible practice

management, but tort reform overturn provides a significant impetus to conduct this evaluation immediately. While the cycle of tort reform damage caps is typically cyclical, historically it has taken years to resolve—meaning we should not look for caps to return anytime in the near future. In the meantime, you need to know if your insurer is prepared to deal with the new risk environment, and if getting prepared equates to a rate increase for you.

If you would like to write to your legislator to voice your opposition of tort reform overturn and your support for caps on non-economic damages, you can visit [www.mpmains.com/tortreform](http://www.mpmains.com/tortreform) to find contact information for your legislator, as well as a sample letter.



James R. Cantalin, JD is general counsel for Missouri Professionals Mutual, the largest professional liability provider in Missouri in both market share and membership since 2004. Cantalin is a member of the Missouri Bar, Lawyers Association of St. Louis, Missouri Organization of Defense Lawyers and Missouri Society of Health Care Attorneys. He also serves as an adjunct professor of law at Saint Louis University School of Law and a frequent speaker on risk management issues throughout Missouri. He was selected for inclusion in the Best Lawyers in America guide for his work in the practice area of professional malpractice law. He can be reached at [jrc@mpmins.com](mailto:jrc@mpmins.com); the company website is [mpmins.com](http://mpmins.com).

# Matthew Reardon

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# Health-Care Issues at Forefront in 2012 Election

## *Candidates for U.S. Senate, Congress and Missouri governor offer responses to issues of concern to St. Louis-area physicians*

Issues affecting the future of health care are prominent in the 2012 election. Candidates offer strong contrasts in their approaches. Besides U.S. President, Missouri voters will be electing a U.S. senator and two Congressional representatives. The governor's race highlights the statewide ballot. Also of great importance, St. Louis-area voters will be electing representatives and senators to the Missouri Legislature. Consult local media websites including [www.stltoday.com](http://www.stltoday.com) and [www.stlbeacon.org](http://www.stlbeacon.org) for more information on candidates and their views. To see a personalized copy of your local ballot, go to the League of Women Voters service, [www.smartvoter.org](http://www.smartvoter.org).

Following are responses of Democratic and Republican candidates for U.S. Senate and Congress along with Missouri governor, to several questions posed to them by *St. Louis Metropolitan Medicine* on issues of importance to physicians. These responses also are posted on the SLMMS website along with responses of the Libertarian candidates. Thanks to all the candidates for taking time in their busy schedules to respond to our questions.

## U.S. Senate

**Todd Akin, Republican**

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

**Claire McCaskill, Democrat (Incumbent)**

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

***What is your position on the Patient Protection & Affordable Care Act? Which elements of the law, if any, would you repeal and which elements, if any, would you strengthen?***

**Akin:** I voted against PPACA and I have since voted repeatedly to repeal it. We have the best health-care system in the world, and adding more government involvement in health care will only make it more difficult for doctors and patients to make the best possible decisions for their health outcomes. Bureaucrats in Washington should not be making health-care decisions for Missouri citizens. There are common-sense ways to improve our health-care system and give more control back to patients and doctors, but PPACA moves us in the opposite direction.

**McCaskill:** I supported the Affordable Care Act because the law

will help to keep long-term health-care costs down, promote preventative care that is so important to keeping folks healthy, and finally bring insurance companies to heel by banning practices like discriminating because of a pre-existing condition. There is a lot of misinformation about what is actually in this law—what it does and does not do. I believe it's important for families and businesses to continue to separate fact from fiction, and when they do I think they'll be pleasantly surprised. Landmark reforms like this will always require a few adjustments as they take effect, and I'm certainly open to improving the Affordable Care Act going forward. In fact, I've already voted to fix a provision related to tax reporting for businesses that was too burdensome. I know we will continue to make improvements to the law, and I'm eager to work with colleagues on both sides of the aisle to make sure the Affordable Care Act is achieving the reforms the American health-care system truly needed.

***What measures do you support to control the growth in health-care costs?***

**Akin:** I have consistently supported health-care reform proposals that are patient-centric and common sense. These proposals include things like meaningful medical liability reform, voluntary purchasing pools for individuals and small businesses, creating true



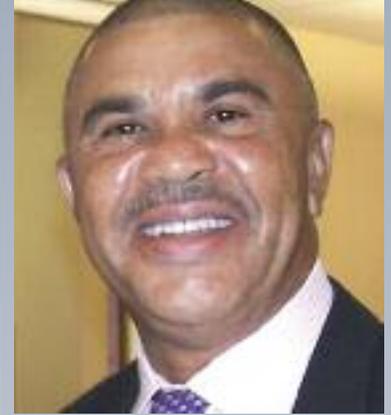
**Todd Akin**



**Claire McCaskill**



**Robyn Hamlin**



**William "Lacy" Clay**



**Ann Wagner**



**Glenn Koenen**



**Dave Spence**



**Jay Nixon**

portability, promoting health savings accounts and tax-free health care, covering pre-existing conditions and rewarding healthy choices. All of these ideas would move our health-care system toward a more affordable and patient-centered system.

**McCaskill:** Rising health-care costs are simply unsustainable for American families and for our country. It's widely agreed that, absent reform, the cost of quality care will continue to increase at an untenable pace. That requires us to be proactive, which is why I've supported an array of commonsense solutions, including cost control measures in the Affordable Care Act, that will work to rein in spiraling health-care costs. Among them are the ability for folks to buy insurance across state lines and the creation of health insurance exchanges that bring more people into insurance pools, promote private-sector competition, and, ultimately, make care more efficient and less expensive. It's also widely known that a major factor in health-care spending is waste, fraud and abuse. I strongly support the many efforts underway to mitigate waste and investigate and prosecute fraud and abuse. I'm also excited about another important emerging tool in curbing spending in health care—the Accountable Care Organization (ACO) model. ACOs are now working to create health-care systems where reimbursement rates are tied to real results, and reductions in the cost of care provided to patients.

**For the past 10 years, legislation has prescribed a Sustainable Growth Rate (SGR) formula for Medicare that prescribes an annual reduction in physician reimbursement. Each year, Congress approves a 'fix' to prevent what now would amount to a 30 percent cut in physician reimbursement. Without a 'fix,' many physicians would leave Medicare. What solution do you propose to permanently set physician reimbursement at a fair rate?**

**Akin:** I support a permanent SGR fix and have voted that way. In addition to the SGR problem, PPACA cut \$716 billion from Medicare, much of it specifically from reimbursement rates for doctors. The government just can't set prices effectively and the attempt to do so in Medicare has only caused problems and pain for doctors and patients.

**McCaskill:** I firmly believe that the SGR must be permanently fixed. While I have voted many times to prevent a reduction in rates for Medicare providers, which would be catastrophic for physicians and patients, I have repeatedly expressed my desire for Congress to compromise to achieve a permanent, fiscally responsible solution. Unfortunately, in significant part because Congress has failed to reach that compromise, a permanent fix has remained elusive. I also continue to advocate for taking an

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approach to addressing the national debt commonly referred to as a “grand bargain,” which entails finding at least \$4 trillion in long-term savings. I believe a balanced, responsible deficit reduction package that achieves those goals can and should include a permanent solution to the SGR.

## U.S. Congress – First District

### **Robyn Hamlin, Republican**

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

### **William “Lacy” Clay, Democrat (Incumbent)**

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

***What is your position on the Patient Protection & Affordable Care Act? Which elements of the law, if any, would you repeal and which elements, if any, would you strengthen?***

**Hamlin:** The Patient Protection and Affordable Care Act overstepped the bounds of protecting personal freedom and liberty. Health insurance is not health care anymore than car insurance is car maintenance. Now that the federal government can fine you for not purchasing a product what will be next? Will it be house insurance because if someone’s house burns down and they didn’t have insurance the community would have to provide them a place to live? There are many people who don’t want anything from the government and this infringes upon them greatly. Penalizing someone for not taking something from the government is just plain wrong. For this reason I would repeal the individual mandate. I would repeal keeping children on their parents plan after the age of 21 unless they were a full time student up to age 26. The ACA is a push to a single payer system by penalizing employers if even one employee opts for the government plan over their plan.

**Clay:** I was proud to co-sponsor, fight for and then defend the Affordable Care Act. It is a landmark statute that the Supreme Court has upheld, and it should be fully implemented without further delay or obstruction. Dependent children are now guaranteed access to health insurance coverage through their parents plans until age 26. Health insurance plans are no longer able to deny coverage for pre-existing conditions. I would never support repeal of the law because thousands of

my constituents are already benefiting from it. We need to make sure that as this law is fully implemented, physicians drive clinical decisions regarding best practices and clinical decision making.

***What measures do you support to control the growth in health-care costs?***

**Hamlin:** Health-care costs will continue to rise for many illnesses as we strive to eliminate many of these diseases. The growth in insurance premium costs could be curbed by not instituting costly mandates routinely. While it is not a popular option the age for Medicare will need to be raised eventually and taxes raised if we don’t get our manufacturing base growing again. Another avenue to control the growth in the government’s health-care costs is to place limits on people who use the emergency room for doctor visits and ambulances as taxis. We could also use some tort reform to stop frivolous lawsuits against physicians.

**Clay:** The Affordable Care Act is already slowing the growth in health-care costs, and we see that in the latest figures from HHS. In the broader economy, the best way to control the growth of health-care costs is to gradually shift the focus of our system to prevention. So many of the costs associated with the current system come from chronic illnesses like diabetes, heart disease, hypertension, cancer and stroke. The risk of all these can be reduced through better patient education, healthier lifestyle choices and improving early access to quality primary care. Physicians have the opportunity assume leadership roles in hospitals and accountable care organizations and earn incentives through clinical decisions regarding management of best practices guidelines, quality and cost.

***For the past 10 years, legislation has prescribed a Sustainable Growth Rate (SGR) formula for Medicare that prescribes an annual reduction in physician reimbursement. Each year, Congress approves a “fix” to prevent what now would amount to a 30 percent cut in physician reimbursement. Without a “fix,” many physicians would leave Medicare. What solution do you propose to permanently set physician reimbursement at a fair rate?***

**Hamlin:** With the Affordable Care Act the SGR will eventually go away as the country moves to a single payer system. Physicians should be paid a fair reimbursement and continually expecting them to accept lower and lower payments is a losing proposition for them while their expenses for staff, insurance, and overhead are increasing. Physicians have free will to accept

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patients on Medicare but they also have an obligation to take care of the injured and sick. With the Congress passing a “fix” every year it is obvious to everyone except the current Congress that there is not enough income from the current Medicare tax without a large growth in the employment sector to sustain the program without external financing. Unfortunately without input from physicians regarding their compensation we will see more doctors leaving Medicare. If it was a patient and the diagnosis was wrong for 10 years friends and family would plead with the patient for a second opinion. The government prescription is faulty.

**Clay:** Physicians should not be subject to the annual crisis over Medicare reimbursement. I have always supported a permanent fix to the SGR with a new formula that guarantees physicians are compensated for care provided to Medicare patients in a manner that incorporates reasonable consideration of increasing practice costs. Physicians should also share through incentive reimbursement in the cost savings of health-care reform. Physicians are best suited to make decisions regarding the best practices in the delivery of high quality health care, and they should be rewarded for making value and management decisions.

## U.S. Congress – Second District

### **Ann Wagner, Republican**

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

### **Glenn Koenen**

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

***What is your position on the Patient Protection & Affordable Care Act? Which elements of the law, if any, would you repeal and which elements, if any, would you strengthen?***

**Wagner:** Simply put, I believe the ACA must be repealed and replaced with free market solutions. The tax increases and regulations it imposes are stifling small businesses. At a time when our country is already going broke, we cannot afford to take an industry like health care that makes up one-sixth of the economy and shift the burden to the government. I support free market principles that encourage individuals to take health care into their own hands and to make the decisions most suited to

their lifestyle. Forced competition among carriers will not only drive costs down but will also improve the quality of care.

**Koenen:** I support most provisions of the Affordable Care Act. After working in community charities for three decades, I see an urgent need for predictable access for working poor and working class families. Expanding Medicaid and the exchanges can help fill this gap. The controls on the insurance industry—including letting children stay on parents’ coverage till age 26—are necessary. I have concerns about the scope of the mechanisms envisioned to manage the act’s provisions and the impact on rural hospitals and health-care providers.

***What measures do you support to control the growth in health-care costs?***

**Wagner:** I support the passage of medical malpractice reform in an effort to curb the number of frivolous lawsuits that burden our economy each year. Damages paid in medical liability lawsuits drive up health-care premiums for all patients. Capping non-economic damages in these lawsuits will lower health-care costs and will result in a higher quality of care for patients. I would also promote greater transparency in health-care markets. If patients know the true costs for services provided to them, they will make economical decisions in what treatments they get and which doctors they use. To that end, I encourage the portability of health insurance across state lines and the option to participate in high-deductible plans and health savings accounts.

**Koenen:** All federally funded health-care programs—Medicare, Medicaid, the VA, federal employee coverage and such—should be rolled into one management plan so the government pays the same for a Lipitor pill or a chest x-ray no matter which way a patient enters the system. Controlling costs on a grand scale is only possible if there is major change in the system. I would be willing to look at a national single-payer system based on Medicare which would be phased in over a decade or two.

***For the past 10 years, legislation has prescribed a Sustainable Growth Rate (SGR) formula for Medicare that prescribes an annual reduction in physician reimbursement. Each year, Congress approves a ‘fix’ to prevent what now would amount to a 30 percent cut in physician reimbursement. Without a ‘fix,’ many physicians would leave Medicare. What solution do you propose to permanently set physician reimbursement at a fair rate?***

**Wagner:** The SGR formula is flawed and must be permanently fixed. The goal of the Medicare system should continue to be ensuring access to quality and affordable care for beneficiaries. Using the SGR formula to achieve this goal is no longer sustainable. Competition is the key to ensuring a fair rate of physician reimbursement. The best course to lead Medicare recipients to a health-care plan that best suits their needs is to allow them to choose from a list of guaranteed coverage options. This would incentivize health-care providers to improve their level of care and give recipients control of their health care. The SGR represents an outdated and arbitrary means of setting health-care prices. Constant cuts in payments to physicians have caught up to us and the system must be updated with a competitive array of choices that benefit both recipients and providers.

**Koenen:** We can't expect doctors to endure a 30% cut in payment rates. The mechanism demanding those cuts needs to be eliminated and longer-term reform of the system pursued. Rates paid by Medicare and all government health programs should be reasonable.

## Governor

### **Dave Spence, Republican**

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

### **Jay Nixon, Democrat (Incumbent)**

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

**Editor's Note:** Gov. Nixon did not provide responses to the questions submitted by St. Louis Metropolitan Medicine as of press time, despite repeated contacts with his campaign staff from Aug. 22 through Sept. 21. If his responses are received after press time, they will be posted on [www.slmms.org](http://www.slmms.org).

**The Missouri Supreme Court recently struck down 2005 legislation that had set a \$350,000 cap on non-economic damages in medical liability lawsuits. It is expected that this will cause medical malpractice insurance costs to increase sharply and could cause physicians to leave the state, retire early, or stop performing higher-risk procedures. How do you propose to restore a liability system that controls unpredictable non-economic damage awards?**

**Spence:** Health-care professionals are under assault in Missouri and America and this decision is going to make it that

much harder on Missouri doctors and nurses. This decision will result in doctors leaving our state as they had been before the 2005 law was passed. It will also cause dramatic increases in malpractice insurance rates and make doctor recruitment a nightmare. In my administration I will work with the General Assembly to re-institute caps on non-economic damages in medical malpractice cases and make any necessary statutory or constitutional changes to ensure that the reforms remain in place. I will also push for other litigation reforms that will protect health-care providers including loser pays lawsuits to curb frivolous lawsuits and other strong tort reforms. Personal injury attorneys have given over \$4 million to our current governor and it's time to end the trial bars' stranglehold on the governor's office. Health-care professionals are engaged in an honorable trade and its time we stopped stacking the deck against them.

**The Legislature has taken positions against the federal health-care reform act, including opting out of forming an insurance exchange, opting out of Medicaid expansion, and going on record as opposing the requirement for individuals to purchase health insurance. Now that the U.S. Supreme Court has upheld the health reform law, how do you believe Missouri should respond to its implementation?**

**Spence:** I believe that implementing Obamacare in Missouri would burden small business, bankrupt the state and federal governments, disrupt the patient/doctor relationship and constitute unprecedented federal intrusion into the lives of Missourians. I am hopeful that Obamacare will be repealed in its entirety and I am committed to pushing back on its implementation in every conceivable way. We need market based solutions to ensure access to affordable care for all Missourians, not more government programs and involvement. If the federal government would allow states the flexibility to manage their safety net programs we could realize tremendous savings and doctors could focus on meeting the health-care needs of our most vulnerable citizens in innovative and cost-saving ways.



# Welcome New Members

## Sherif H. Al-Hawarey, MD

1035 Bellevue Ave., #500, 63117-1843  
MD, Univ. of Cairo, Fac of Med,  
Cairo, Egypt, 1996  
Born 1972, Licensed 2010 ACTIVE  
Cert: Clinical Neurophysiology and  
Neurology

## Rajendra S. Apte, MD

4921 Parkview Pl., #12-C, 63110-1032  
MD, L Tilak Mun Med Coll, Mumbai Univ.,  
India, 1993  
Born 1969, Licensed 2003 ACTIVE  
Cert: Ophthalmology

## Robert K. Atteberry, MD

10777 Sunset Office Dr., #100, 63127-1019  
MD, Saint Louis University, 1998  
Born 1973, Licensed 1999 ACTIVE  
Cert: Pediatrics

## Sarah E. Aubuchon, MD

4920 Walsh St., 63109-3215  
MD, University of Missouri-KC, 2008  
Born 1983, Licensed 2008 JUNIOR  
Pediatrics

## Jeffrey D. Carter, MD

3015 N. Ballas Rd., 63131-2329  
MD, Yale University, New Haven, CT, 1991  
Born 1965, Licensed 1991 ACTIVE  
Cert: Anesthesiology

## Bingzhong Chen, MD

1035 Bellevue Ave., #500, 63117-1843  
MD, Fujian Med Coll, Fuzhou City,  
China, 1985  
Born 1964, Licensed 2010 ACTIVE  
Clinical Neurophysiology

## Ketan M. Desai, MD

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MD, Hahnemann University School  
of Medicine, PA, 1998  
Born 1972, Licensed 1998 ACTIVE  
Cert: Cardiovascular Surgery

## Thomas D. Doerr, MD

9915 Kennerly Rd., #J, 63128-2703  
MD, University of Chicago-Pritzker School  
of Medicine, 1983  
Born 1957, Licensed 1986 ACTIVE  
Cert: Internal Medicine

## John C. Galanis, MD

7331 Watson Rd., 63119-4405  
MD, Saint Louis University, 1984  
Born 1958, Licensed 1984 ACTIVE  
Cert: Ophthalmology

## Robert W. Garrett, MD

3635 Vista Ave., 63110-2539  
MD, University of Missouri-Columbia, 2003  
Born 1976, Licensed 2010 ACTIVE  
Cert: Diagnostic Radiology

## Bari L. Golub, MD

1035 Bellevue Ave., #400, 63117-1844  
MD, University of Missouri-Columbia, 1986  
Born 1960, Licensed 1987 ACTIVE  
Cert: Internal Medicine

## Mary E. Hartman, MD

One Children's Pl., #8116 NWT-8, 63110-1002  
MD, University of Rochester, NY, 1999  
Born 1972, Licensed 2010 ACTIVE  
Cert: Pediatric Critical Care Medicine

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## Possible Remedies

What can be done? Most importantly, physicians need to regain the enthusiasm and activism that led to the 2005 reforms. We have heard from well-placed sources that legal scholars are investigating innovative ways that might allow the General Assembly to reinstate non-economic caps. Others believe the Legislature cannot reinstate the caps because they were found to be unconstitutional. If the latter proves to be the case, an amendment to the Missouri Constitution is the only remedy. Any amendment would need to be approved by Missourians.

There are several ways to place an amendment on a ballot for consideration by Missouri voters, but we believe the most direct and quickest way is to ask the General Assembly to pass a referendum reinstating

caps for non-economic damages. This type of referendum does not require the approval of the governor, and we know legislators who are enthusiastic to bring this issue to the fore. We believe that the cap should be proposed at a level that will appeal to the voters as fair and reasonable. The biggest drawback to this solution is that this amendment could not be considered by Missouri's voters until 2014.

Physicians should take two steps immediately on a personal level. They need to meet with their insurance brokers to review whether their current malpractice limits are sufficient in light of this change in the law. Since there is now no limit on non-economic damages, what formerly were adequate limits may no longer be so. As an illustration, the jury in *Sanders v. Ahmed* awarded \$9.2 million in non-economic dam-

ages. Also, physicians need to meet with their lawyers and financial advisers to make sure their personal assets are protected to the greatest extent possible. There are several perfectly legitimate methods to ensure that one's life's work is not lost because of a single maloccurrence or bad outcome.

We sincerely hope that we will be able to submit another article for publication in this magazine trumpeting the return of non-economic caps. It cannot come soon enough.

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## Tort Reform

