A Special Issue: Hospice / Physician Assisted Living (PAL)

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Connecticut Medicine

Vol. 61, No. 12 *The Journal of the Connecticut State Medical Society* **December 1997**

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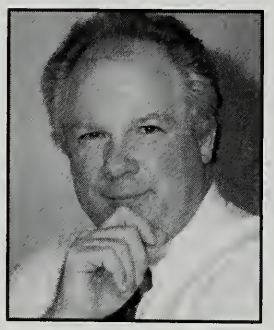

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The Connecticut Initiative

RICHARD BLUMENTHAL, ESQ.

AT every stage of life, even in the face of terminal or irreversible illnesses, we confront choices that define ourselves and determine how happy our days will be. Education is key to making free and informed choices, which is the reason we are launching the Physician Assisted Living (PAL) initiative here in Connecticut.

While most recent attention has focused on assisted suicide, our purpose in physician assisted living is to offer other choices, without criticizing or condemning any particular individual's decision. Very simply, the PAL program offers a means for people to become more aware of their options—discussing them with their physicians, family, clergy, and others—and to indicate their desires and preferences about the kind of care they choose to receive.

Through a document distributed to them in advance of the most severe state of their illnesses, patients would have am opportunity to choose hospice care before experiencing the depression and anxiety that may accompany terminal illness and cloud or confuse their judgment.

Such planning for death—perhaps repugnant in concept, but sometimes vitally necessary in practice—already is done through many documents that are legally binding, including the living will. The PAL document would be different: it would have no binding legal weight, but would be a statement of preference and a means of patient education, so that people will be able to make more informed *choices.*

The initiative is a joint effort between my office, the John Thompson Hospice Institute, Connecticut Bar Association members, and is supported by clergy, professional leaders, and others, demonstrating the kind of broad power elicited by this idea and concept.

Planning for end-of-life decisions is increasingly critical for all of us, regardless of our age, income, or state of health. Attorneys advise us to make wills so as to avoid conflicts and confusion in the disposition of our assets after death, and accountants tell us to take steps that will reduce taxes paid by ourselves and our beneficiaries.

Yet, planning for our own health care in our last days before death is often done—if at all—haphazardly and usually without wise, caring advice from physicians and others with expertise. Too often, elderly friends and relatives struggle at the end of their days, linked to complex life support systems and without hope of recovery.

PAL offers the opportunity to avoid situations that would be abhorrent to people if they could foresee them, but avoidable if they simply could plan or think ahead to those last days.

Connecticut has been a leader in developing planning documents for end-of-life decisions—the living will and power of attorney for health care decisions. These important initiatives have helped countless individuals to continue in control of their lives, even as they face death.

The living will enables an individual to determine what forms of life support and other extraordinary life-sustaining measures, if any, will be instituted when he or she can no longer communicate those instructions explicitly or directly.

The living will and power of attorney for health care decisions, however, address only end-of-life withdrawal of life support decisions.

Through the PAL initiative, individuals may express a preference for hospice care, before the onslaught of pain and depression, through a document similar to the living will and power of attorney for health care instruments Hospice care is designed to address the medical and

RICHARD BLUMENTHAL, ESQ., Attorney General, State of Connecticut. Previously, he was a member of the Connecticut State Senate from 1987 to 1990 and the Connecticut House of Representatives between 1984 and 1987. He served as United States Attorney for Connecticut from 1977 to 1981.

emotional needs of patients with terminal illnesses—the needs of both patients and their families—as they endure the horrendous physical, emotional, and psychological toll often imposed.

PAL includes a document entitled, "Notice of Desire for Hospice Care." This form is clearly drafted and explains the basic tenets of hospice. It states that the patient should talk with the physician, friends, and relatives about hospice; it does not carry the legal weight of the living will or attorney for health care decisions, and clearly states that the decision for hospice care may be overridden by the physician and the patient's relatives if circumstances change and hospice care seems no longer to be the appropriate choice.

PAL also includes a consumer brochure that explains the need for end-of-life planning and offers various planning alternatives for the patient. The PAL initiative will be publicized through articles, symposiums, discussion groups, and, of course, a WEB site.

Plainly, the PAL document is in the best traditions of consumer education—encouraging and facilitating frank, open conversation and awareness about the advantages, downsides, costs, and benefits of hospice care. As attorney general, I have fought for better consumer education about many goods and services offered in the marketplace, because an informed consumer is less likely to become a victim of fraud or misinformation, and more likely to be satisfied with goods and services bought for the lowest possible price.

Consumer education about the choices for end-of-life care is no less important. The PAL initiative is based on this principle. PAL recognizes that hospice is not for everyone, just as the living will and durable power of attorney for health care decisions is not universally sought. Nonetheless, consumers should be aware of their choices and have the opportunity to make them.

At some point, Connecticut should decide whether the Notice of Desire for Hospice Care or a similar notice should enjoy the legal weight given to the living will and power of attorney for health-care decisions. Why should only certain end-of-life decisions be incorporated into a legally-binding document? As the PAL initiative spreads, perhaps it will provide the critical impetus to General Assembly action.

The PAL initiative should not be limited to Connecticut. I hope that other state public officials will be encouraged by our success to implement a similar initiative in their states. I am contacting all 50 state attorneys general to urge their consideration of a PAL initiative, which will give millions of people, regardless of geographic, ethnic, or other background, an enhanced ability to plan for their last days.

With the PAL initiative, patients, and their physicians will be encouraged to make a concerted effort to plan ahead for their end-of-life decisions.

Physician Assisted Living: The PAL Partner Initiative

GERALD E. THOMSON, M.D., ROSEMARY JOHNSON HURZELER, R.N., M.P.H., H.A., GILBERT FRAUNHAR, M.A., AND KAYE HOWE, M.P.H.

PROLOGUE—With all the advances in the care of patients, our many failures in the provision of end of life care have been striking. Although in some circumstances we simply may not know what the right actions would be on behalf of patients, all agree with the need for companionate attention to the comfort of those who are dying. Connecticut's Physician Assisted Living Initiative is an exemplary program, providing a means and framework for coordinated planning by all concerned in the best interest of the dying patient. For physicians, it is the opportunity to create the best possible setting to provide responsive, support and compassionate care.

Gerald E. Thomson, M.D.,
Lambert and Sonneborn Professor of Medicine
and Senior Associate Dean
Columbia University

GERALD E. THOMSON, M.D., Samuel Lambert Professor of Medicine, assistant vice president in the Faculty of Medicine, and an associate dean in the College of Physicians and Surgeons, he was elected president of the American College of Physicians (ACP) at the college's 76th annual session March 16–19 in Atlanta. He is past president of the New York Society of Nephrology, the Society of Urban Physicians, and the Association of Academic Physicians; ROSEMARY JOHNSON HURZELER, R.N., M.P.H., H.A., president and CEO of The Connecticut Hospice, Inc., and the John D. Thompson Hospice Institute for Education, Training, and Research, Inc. Currently chairman of the Hospice Association of America and treasurer for the National Association of Home Care. Chairman of the Yale Alumni in Public Health from 1962–96. GILBERT FRAUNHAR, M.A., Connecticut Hospice volunteer since October 1980. He received a bachelors degree from Harvard College and a Masters from the University of Bridgeport. KAYE HOWE, M.P.H., formerly Dean of Student Affairs, Yale University School of Medicine, Department of Epidemiology and Public Health (deceased 3 December 1997).

Why PAL? and Why Now?

IN recent times, awareness of the sanctity of patient choice has reached new levels of sophistication. The new initiative in Connecticut, Physician Assisted Living (PAL) will spread across the nation. In the language of Wall Street, Americans will participate in a " technical rally" through which each of us will be given the chance to reinvest in ourselves and our future well-being. PAL is a gift to all persons, whether they are well or unwell, which introduces them to the hospice concept—a care modality that will add life to their days if not days to their lives, if and when they confront irreversible illness.

Ten Principles of Hospice Care:

1. Patient and family are regarded as the unit of care.
2. Services are physician-directed and nurse-coordinated.
3. Emphasis is on control of symptoms (physical, sociological, spiritual, psychological).
4. Care is provided by an interdisciplinary team.
5. Trained volunteers are an integral part of the team.
6. Services are available on a 24-hours a day, seven-days a week on call basis with emphasis on availability of medical and nursing skills.
7. Family members receive bereavement follow-up.
8. Home care and inpatient care are coordinated.
9. Patients accepted on the basis of health needs, not on ability to pay.
10. There are structured systems for staff support and communication.

Critical Care Nurse
Volume 16, no. 1, 1993
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The Introduction of Physician Assisted Living (PAL)

The principles of hospice care *(see box on previous page)* were introduced to this nation through a grassroots initiative early in the 1970s when the first American hospice program, The Connecticut Hospice, Inc., began caring for its first hospice home-care patient from its New Haven headquarters on Prospect Street.

The first discussions of hospice as a concept of care began in 1967 when Dame Cicely Saunders, O.M., F.R.C.P., founder of the modern hospice movement, met with a small group of visionaries at Yale University School of Medicine. In 1974, The Connecticut Hospice initiated care for patients with cancer diagnoses, under a three-year grant from the National Cancer Institute. In 1979 Connecticut led the nation in creating the first licensure regulations for hospice care.

In the decade that followed, the hospice model of care was recognized and replicated across the country. In 1977, then Secretary of Health, Education and Welfare, Joseph A. Califano, Jr., promulgated a request for proposals for a hospice demonstration project. As a result of the information generated in that study, the federal government created the Medicare Hospice Benefit in 1983 to be part of the prospective payment system for hospitals.[1] From that time to the present, the number of Medicare-certified hospices has grown from 31 in 1984 to over 2,000 in 1996.[2]

Nearly 75% of all hospice patients are age 65 or older.[3] A description of the hospice population by disease category reveals that a majority of patients have diagnosed neoplasms.[4]

Soon after its inception, The Connecticut Hospice, Inc., created the research and teaching component for hospice care in the United States, The John D. Thompson Hospice Institute for Education, Training and Research. This Institute was incorporated in 1978 to study care of the terminally ill, and in 1995, the Institute, through its research, identified a comprehensive absence of awareness by the general public as to the existence of the hospice choice, its possible application to patients' future needs, and care barriers to effective hospice care. A similar absence of awareness was identified as well as serious gaps in knowledge and experience among health-care professionals regarding hospice care as an alternative to mainstream terminal care. As a result, the Physician Assisted Living (PAL) Partners initiative was conceived to give patients and health-care providers a means for establishing their choice of the hospice option for compassionate care *in advance,* so that individuals might exercise that option in a timely and productive manner.

One of the paradoxes of the many advances in medical care today is that more people are now enduring prolonged deaths from chronic, progressive, and irreversible diseases. If they are not aware of, or do not receive the full and appropriate care and support, they face the prospect of overwhelming physical pain, excessive financial burdens, and emotional isolation. Too often once patients learn that they have a chronic, progressive, or irreversible disease, their reaction is skewed by the demands of the disease itself, which may have degenerative cognitive components, as well as psychiatric aspects, including depression or delusional elements.

The hospice principles have proven to be effective in addressing the special needs of these patients, yet most persons are not aware of their existence and therefore, hospice is not even considered by most patients at the end of life in the United States. PAL Partners strives to achieve the broadest dissemination of information relating to the hospice care option and the hospice principles of care, to assure the greatest possible access to, and possible choice of, hospice.

PAL Partners Goals and Objectives

The John D. Thompson Hospice Institute in collaboration with professionals representing medicine, law, nursing, social sciences, theology, and arts designed the PAL Partners Initiative to achieve these objectives:

- ◇ Assure that potential patients and their families are aware of their full range of health-care options when a disease is diagnosed as irreversible.
- ◇ Create greater access to hospice care by advising all potential patients of the availability of the hospice option, preferably well before they need hospice care or are experiencing serious illness.
- ◇ Afford the mechanism and opportunity for all patients to designate their preference for hospice care in writing as an advance directive.
- ◇ Educate patients and health-care providers regarding the benefits of hospice care as an early intervention for patients with advanced irreversible illness, and the appropriate clinical decision-making processes to facilitate transition to PAL Partners care giving through a hospice program.
- ◇ Encourage dialogue both at the patient and provider level around the principles of hospice care and how care might be optimized during an advanced progressive, irreversible illness.
- ◇ Inspire all physicians to continue to collaborate with patients regardless of length of life.

Advancing Patient Care Toward the Year 2000

The emphasis of the PAL initiative is on the dialogue and conversation that should occur between physician and patient. In the current health-care environment, physicians are distanced from their patients as a consequence

of the increasing emphasis on subspecialities, the intricacies of managed care, and the specter of malpractice litigation. PAL solidifies the physician's role as part of *the process* of preparing for the eventuality of irreversible illness.

The role of the physician in PAL is not only crucial, it is indispensable. The goal of PAL is to raise the level of discussion and introduce crucial questions with which the physician and patient and family must contend—preferably well in advance of the complications of serious, chronic, or irreversible illness. In the same sense that the Hippocratic tradition brings all physicians to the pledge, "first do no harm," PAL brings them to thoughtful discussion with their patients of the options available in the face of serious, life-defining illness. Physician involvement takes place not only within the hospice care modality but as part of the process of moving a patient into the hospice continuum of care. In both instances this role is one only the physician can play and a responsibility that only a physician can fulfill.

It is well established and fully acknowledged that health care revolves around the medical management of patient care. The physician's orders determine the course of the patient's treatment, and, with the advent of managed care, physician authorization now dictates the reimbursement for patient care. The physician must not only direct care at the bedside, but must steer the care process through a maze of medical review and payment mechanisms. PAL Partners must be envisioned as an all-encompassing dimension of patient care, not bounded by revenue and reimbursement parameters, but broadly translated into a wide variety of settings, all of which have the shared goal of improving palliative treatment in the crucial weeks and months of a patient's final illness.

It is anticipated that PAL will be integrated into medical schools, nursing and other professional colleges, and teaching hospitals, as well as the continuing education of health-care professionals.[5] Internet access to the Physician Assisted Living website will continue the dialogue and exchange of information that PAL initiates. The educational component of the PAL initiative will enable the PAL Partners concept to realize its full potential in facilitating the physician's role in translating its 10 principles into reality for their patients who have executed a PAL directive.

The Premise of PAL

PAL proposes 10 principles which, though immutable, are eminently flexible. They are adaptable to every community and every care system, and to the special circumstance of the providers and recipients of health care. The 10 principles upon which PAL is founded are pliant, guiding philosophies that describe what care givers should know to address the needs of patients and families. While PAL promotes *advance* consideration of issues related to care of the patient with an irreversible illness, the configuration of end-of-life care can be adapted to each changing situation regardless of the time at which PAL is introduced.

The Ten Principles:

1. *The patient and family are the unit of care.*—The PAL initiative supports the family's participation in the care of a seriously ill patient by making provision *in advance* for the array of services the patient chooses to receive. The patient's election of the hospice philosophy guides the care she will receive and defines the levels of care and types of services to be provided. Inclusion of the family not only acknowledges their role as care givers but includes their care needs and mandates that those needs be addressed as part of treatment *both before and after* the patient's death.

2. *Services are physician-directed and nurse coordinated.*—The PAL Partners initiative and the physician's role in caring for the patient recognizes that the physician-patient relationship is central to patient choice and decision-making.[1] The role of the professional nurse is to utilize the nursing skills, integrating all dimensions of hospice care and the treatment of all symptoms. The physician and nurse team constitute the infrastructure on which all patient care planning is founded regardless of setting. The principles of hospice care need not be limited in their application to the confines of formalized, certified hospice programs.

3. *PAL emphasizes control of symptoms—physical, sociological, spiritual, psychological.*—In fulfilling the mandate of the PAL initiative, hospice care provides comprehensive management of symptoms related to advanced irreversible illness. The goal of hospice care is control of pain in all its manifestations—somatic, sociological, spiritual, and psychological. The physician's control of the pharmacological and nonpharmacological interventions is the means by which pain and symptom management is accomplished.

4. *Care is provided by an interdisciplinary team of care givers.*—The PAL Partners initiative facilitates the patient's election of services ranging from medical and nursing care to social work, financial counseling, chaplaincy, pharmacy, dietary consultation and services, volunteer support, and bereavement follow-up. The interdisciplinary approach to hospice care calls upon all specialties to contribute to patient well-being, supporting and guiding care at the end of life.

5. *Trained volunteers are an integral part of the team.*—The utilization of volunteers and the mandate that all hospice care shall include volunteer support[6] brings the

talents, experiences, and resources of the many to patient and families in need of hospice care,[7] supplementing the services of the professional staff.

6. *Services are available 24-hours a day, seven-days a* week.—PAL Partners validates the need of patients and families to have not only continuity of care but continuous, uninterrupted access to care givers with the skills as well as the knowledge of their needs.

7. *Family members receive bereavement follow-up.*—A PAL election assures that the preventive aspect of hospice care—bereavement care for family members after the patient's death for a minimum of one year—will be available to support them in their grief after the loss of a beloved friend or family member, enabling them to go on fully to live their lives

8. *Home care and inpatient coordinated.*—In electing the hospice option through PAL the patient or patient-to-be elects a full scope of services delivered in any number of inpatient or home settings. The specific way in which the precepts of hospice care are carried out is secondary to the goal of creating universal access to hospice for all who choose it.

9. *Patients are accepted on the basis of their health needs, not on ability to pay.*—PAL assures the patient and family that access to care will never be denied at the time when care becomes most resource-demanding and when resources are most likely to be most depleted.

10. *There are structured systems for staff support and communication.*—PAL acknowledges that the care of a seriously ill or terminally ill patient requires the full attention of a robust staff who can function in a well orchestrated way. Maintenance of the infrastructure for staff to develop, refine, and continually nurture their strengths as care givers as well as teachers of patients and their families is essential to the continued success of the hospice plan of care.

The Future for PAL Partners

The hospice movement has been, in a sense, the victim of its own success. As more individuals have learned about the hospice concept and hospice care is more readily available, so too has the perception of hospice as the talisman of life's end become more commonplace. Contrary to popular perception, the specialized care of hospice is equally applicable to patients with advanced disease as it is to patients with a severely limited life expectancy. PAL, in embracing the principles of hospice care, offers hope to patients and their families.

Conclusion

PAL must be seen as a beginning that initiates discussion not only between health-care professionals and their patients, but among care-giving professionals of all disciplines. PAL prompts the care giving community to define what care givers should know. PAL is the educational program to prepare caregivers for difficult issues that arise in the face of irreversible illness. PAL will serve as the means that defines the characteristics of the knowledgeable provider who is prepared to serve the patient and family confronting terminal illness. It is the means by which providers and patients alike can:

Communicate on issues related to their care in the event of serious illness;

Articulate their concerns, wishes, and reservations about these issues;

Recognize the issues they need to resolve; and

Evidence their decisions in a written document that articulates care preferences.

As we approach the millennium, the hospice movement enters a new era in its evolution embodied in the PAL Partners initiative. The import of PAL is that it establishes a set of values which all providers—in all specialties and disciplines, in comprehensive cancer centers, and community hospitals, in licensed certified hospices, and home health agencies, in intensive care and subacute care—can apply to the care of their patients by engaging their patients in considering and committing to the PAL principles. PAL opens up a frontier for care-giving in the next century that returns to the grassroots origins of hospice care. As this century approaches its close, PAL fulfills the prophecy hospice has put forth for all patients—to comfort and care always in all ways.

REFERENCES

1. PL 93-641 was enacted and codified as U.S.C. 1965.
2. Source: Health Care Financing Administration (HCFA), Health Standards and Quality Bureau (HSQB). Data as of December 1996.
3. National hospice usage by client age, gender, race, and marital status, 1994. *Hospice Facts and Statistics 1996:* A publication of the Hospice Association of America. 1996; p. 7.
4. Table 14: Percent of current clients receiving hospice care, by first-listed diagnosis at admission, 1994. *Hospice Facts and Statistics* 1997: p. 7.
5. The John D. Thompson Hospice Institute has created an educational initiative, entitled Train the Trainer © for which it has received funding to 1) educate physicians and health care professionals of all disciplines regarding the appropriate criteria for referral of a patient and family to hospice care and 2) provide hands-on training in hospice care. The curriculum for Train the Trainer is designed to equip those who receive the training to return to their home institution or agency and train others.
6. The federal standard on which all hospice care is modeled, (42 U.S.C. Section 1965 et seq.) requires that a hospice must document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals five percent of total patient care hours of all paid hospice employees and contract staff.
7. Hospice Facts and Statistics: 1996; published by the Hospice Association of America, indicate that approximately a quarter of a million patients in the United States die each year in need of a palliative care intervention.

Connecticut Leads the Way in the Physician Assisted Living Initiative

CONGRESSWOMAN ROSA L. DeLAURO

As the "baby boom" generation draws closer to retirement age, our nation faces an explosion in health-care costs. We will need to explore innovative strategies to hold costs down, while at the same time maintaining the highest quality of care to people with incurable illnesses, and while at the same time holding down the costs that come with the extensive medical care of a terminal illness. Connecticut's hospice program is an excellent model for the country as a whole to follow.

Connecticut led the way for the nation when America's first hospice care unit opened in the early 1970s. In 1978, the Connecticut Hospice created the research and teaching component for hospice care with the opening of the John D. Thompson Hospice Institute for Education, Training, and Research. The Institute fostered ground-breaking research in issues surrounding care for the terminally ill.

The Thompson Institute and the Connecticut Hospice program have thrived and expanded since that time. Based on the success of these models, hospice units have moved from Connecticut to hospitals and nursing homes throughout the nation. Countless numbers of terminally ill patients across the nation depend on the care they receive through hospice. In this, along with so many other health-care issues, Connecticut has provided an example to the nation in promoting a health-care climate in which the needs of the patients and their families come first.

Hospice is a blessing for the patients and families who depend on these services. As a cancer survivor and a strong hospice supporter, I understand how hospice can truly become a second family for patients grappling with a serious and terminal illness—with a talented and caring staff who are always ready to help when they are needed, and patients who spend time together, reaching out to offer loving support. A hospice inpatient unit is more than just a hospital ward—it is a true community.

Connecticut, a pioneer in the hospice movement, and is again blazing a trail in the area of heath care with the Physician Assisted Living (PAL) Partners initiative, announced in September by Attorney General Richard Blumenthal. This program is geared to inform people about hospice care and to give them the opportunity to consider their options at a time when they are healthy and not immediately facing a terminal illness.

Once a diagnosis has been made, it often becomes difficult to make an educated and informed decision as to medical treatment. Conflicting emotions rage out of control—anger, fear, denial, deep depression are all too common, not just for the patients, but for their families as well. When patients are trying to come to grips with their own mortality, it is difficult to focus and make educated decisions on issues as to what medical treatment they want and what measures should be taken (or avoided) to prolong life.

Hospice care can help ease the pain and suffering that comes with a terminal illness. Hospice allows patients to spend their final days in a caring atmosphere where pain is controlled and where suffering—both physical and emotional—can be minimized.

Working with doctors, religious organizations, hospice, and other medical groups, PAL will help to educate Connecticut citizens regarding the range of their options before they come face-to-face with that most devastating of news.

Congresswoman ROSA L. DeLAURO, Connecticut's Third District, was first elected to Congress in 1990 and was reelected in 1992, 1994, and 1996. At the beginning of the 105th Congress, was renamed to the Appropriations Committee, where she had served during the 103rd Congress. She sits on the Labor/ HHS and the Agriculture Subcommittees. During the 104th Congress she served on the National Security Committee.

The initiative is aimed at increasing doctor-patient collaboration. Doctors are educated as to available hospice programs and encouraged to sit down with patients to discuss the possibility.

The program includes a directive to be signed by the patient indicating her desire to receive hospice care should she ever be faced with a terminal illness. Although this document is not legally binding, it affords an excellent opportunity for patients to play a role in their medical care.

Patient choice in health care is an issue at the top of our nation's agenda. Choice of doctor, specialist, treatment, and even length of hospital stay is increasingly being made by insurance companies rather than by the doctors and patients who should be making these important medical decisions.

And that is exactly what PAL is designed to foster—conversations and decisions made between doctors, patients, and family. The 10 principles incorporated in the program are common sense and flexible, and acknowledge the fact that every case is different. But the key standards remain the same, among them: addressing the needs of the patient and his family; allowing the physician to coordinate medical services; controlling symptoms through physical, sociological, spiritual, and psychological care; and coordinating home care and inpatient care.

When faced with a serious illness, understanding the implications and making decisions regarding the course of medical treatment is often one of the few things patients can do to maintain a measure of control in their lives. Critical illnesses too often take decisions from you; the idea that you are no longer in control of your body is difficult to fathom; it can be unimaginably more frustrating when an insurance company takes away that control from you.

Hospice care, and the PAL program, helps to put that power of control and decision making back in the hands of patients and their doctors. Patients can stand up and say what type of care they want and what care they do not want. Hospice home care allows patients to retain their independence and spend time with their families while receiving care to control pain and monitor their illness .

Hospice home care also helps to control costs; home care is far more cost-effective than treating a patient in a hospital for along period of time. As we move into the next century and attempt to find strategies to prolong the life of the Medicare Trust Fund, home care is an option we must explore in greater detail.

I am proud that Connecticut has again put itself out in front in the evolution of our heath-care system. From the start of the hospice movement, to ensuring that all patients have knowledge of and access to the options available, Connecticut has led the way. As we see the PAL initiative move into action, I hope that Connecticut will once again prove itself to be a model for the nation.

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State Leadership Perspective

SENATOR GEORGE L. "DOC" GUNTHER AND SENATOR TONI HARP

ONE of the mainstays of our inalienable rights in this country is the "right to choose." The application of this right to health-care choice was clearly evidenced in 1990 when the U.S. Congress adopted the Patient Self-Determination Act requiring all providers of health care in all settings to query patients as to whether or not they had executed advance directives pertaining to their health care, particularly the withholding or withdrawing of life-sustaining treatment. This right has been reinforced in Connecticut by our Living Will statute.[2]

The PAL Partners takes the next step in protecting and preserving choice and access to care for those who may face am irreversible illness. Attorney General Blumenthal, through the administrative process, has created a new opportunity for our citizens to choose how they wish to be cared for if faced with irreversible illness.

Those who receive a diagnosis of am irreversible illness will, be devastated by the news. Not only is the afflicted person torn apart, but his or her family becomes an integral part not only of the devastation, but of the decision making that must begin from the point of diagnosis. It is important that when we are in good health, and calmer minds prevail, we have the opportunity to think about the possibility of such events, and to decide, before we have to, what course of action we would want followed. Many of us do this when we complete our wills and living wills. The PAL initiative makes us aware of the opportunity to receive palliative and hospice care so that in the process of putting our advance directives in order we can also express our choices with regard to the penultimate chapter of our lives, not just the last chapter.

As members of Connecticut's legislature, we are proud to support this endeavor. The State of Connecticut is the home of the first hospice in the United States. The Connecticut legislature was integral to the funding that supported an important "new" model of health care, hospice, that then swept the nation and has been replicated in all 50 states in a similar fashion, through the PAL Partners initiative those who champion the interests of the patients and their families facing irreversible illness will be encouraged to replicate the PAL initiative across the country.

Connecticut's leadership role in PAL must now take the form of funding initiatives to educate and train health-care providers with regard to the implications and implementation of physician assisted living programs. As with other advance directives, providers will be the pivot point from which consumers will receive the information critical to their decision-making it is essential that providers be fully versed in the tenets of hospice care, the identification of individual need for hospice, and the means for insuring that each and every patient and family who needs and desires hospice services will receive them.

SENATOR GEORGE L. "DOC" GUNTHER, N.D., 21st Senatorial District, Deputy Minority Leader, currently serving his 16th term. A retired Naturopathic physician, "Doc" has served on the Public Health Committee since he arrived in the Senate in 1967, serving twice as Senate Chairman. He currently is Ranking Member. Other committees he currently serves on are Regulation Review (Ranking Member) and Legislative Management. He also is Co-Chair of the Bi-State Long Island Sound Committee and is a Commissioner on the Atlantic States Marine Fisheries Commission. SENATOR TONI HARP, 10th Senatorial District, currently serving her third term as the Connecticut State Senator from the 10th Senatorial District towns of New Haven and West Haven. She is currently serving as an Assistant Senate Majority Leader and the Chair of the Legislature's Public Health Committee Also appointed the Vice-Chair of the Appropriations Committee, Chair of the Appropriations Committee's Health and Hospitals subcommittee, and a member of both the Executive and Legislative Nominations and Commerce Committees. She also chairs the Medicaid Managed Care Council.

REFERENCES

1. The Patient Self-Determination Act was signed into law as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA, 1990).
2. Conn. Gen. Statutes Section 19a-575 et seq.

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PAL—The Counterweight to Physician Assisted Suicide

JOSEPH A. CALIFANO, JR., ESQ.

> Whether it is in someone's best interest that his life end in one way rather than another depends on so much else that is special about him—about the shape and character of his life and his own sense of his integrity and critical interests—that no uniform collective decision can possibly hope to serve everyone even decently.[1]

CONNECTICUT gave the nation its first hospice. With Physician Assisted Living, Connecticut becomes the first state to adopt the best way to assure the family of a terminally ill patient of a death with dignity and compassion.

In June of this year, the U.S. Supreme Court addressed the issue of physician assisted suicide in *Vacco vs Quill,*–U.S.–117 S. Ct. 2293 (1997) and *Washington vs Glucksberg,* –U.S.–117 S. Ct. 2258 (1997). In these cases the Court determined that a state ban on physician assisted suicide does not violate the Equal Protection Clause of the 14th Amendment.[2] In so doing the Court recognized the distinction between letting a patient die and making that patient die, between assisting suicide and withdrawing life-sustaining treatment as "a distinction widely recognized and endorsed in the medical profession and in our legal tradition, [as] both important and logical; it is certainly rational."[3]

For two decades courts, legislatures, and the vast majority of medical professionals have respected the "real distinction between the self-infliction of deadly harm and a self-determination against artificial life support."[4] In the case of *Cruzan vs Director, Mo. Dept. of Health,* 497 U.S. 261, 278 (1990) which presented issues similar to the Karen Ann Quinlan case, the Court recognized that the State of Missouri's interest did not outweigh Nancy Cruzan's liberty interest in refusing medical treatment. Justice Stevens dissent acknowledged that:

> Nancy Curzan's interest in life, no less than that of any other person, includes an interest in how she will be thought of after her death by those whose opinions mattered to her. There can be no doubt that her life made her dear to her family and to others. How she dies will affect how that life is remembered.[5]

This passage is especially poignant and applicable to Physician Assisted Living (PAL) The PAL initiative is about each patient and her family's interest in life—how it is lived to its fullest to its end and how it is remembered "by those whose opinions matter." PAL is about making decisions about how to confront serious, advanced, irreversible illness.

Justice Stevens, concurring in *Vacco,* notes that *Cruzan* "did give recognition, not just to vague, unbridled notions of autonomy, but to the more specific interest in making decisions about how to confront an imminent death."[6] Justice Stevens goes on to explore this notion in saying:

> Although there is no absolute right to physician-assisted suicide, Cruzan makes it clear that some individuals who no longer have the option of deciding whether to live or die because they are already on the threshold of death have a constitutionally protected interest that may outweigh the State's interest in preserving life at all costs. The liberty interest at stake in a case like this differs from, and is stronger than, both the common-law right to refuse medical treatment and the unbridled interest in deciding whether to live or die. It is an interest in *deciding how rather than whether,* a critical threshold shall be crossed.[6] *(Emphasis added)*

PAL Partners offers the means to create directives for "how, rather than whether, a critical threshold shall be crossed." Advances in medical technology that created the

JOSEPH A. CALIFANO, JR., ESQ., Chairman and President, The National Center on Addiction and Substance Abuse, Columbia University; Secretary of Health, Education, and Welfare from 1977–1979. During his tenure in that post, at the request of Governor Ella Grasso, he awarded Connecticut the first funds H.E.W. ever gave to establish Connecticut Hospice in New Haven.

ability to sustain life also gave rise to the issues presented in the numerous cases that reached the courts where the withdrawal of life-sustaining treatment was addressed. Federal and state legislatures responded to the issues presented in many cases from *Quinlan* to *Cruzan*, with laws that enables patient self-determination and the creation of advance directives in anticipation of an individual becoming unable to decide or articulate a decision previously made.

As a parallel, Connecticut's PAL initiative responds to the issues presented in *Vacco vs Quill* and *Washington vs Glucksberg*. In the same way the Court grapples with the differences between assisting suicide and withdrawing life-sustaining treatment, the PAL Partners initiative assists patients in preparing for the eventuality of those very issues being presented in their lives. PAL offers a dignified solution to the unnecessary dilemma of physician-assisted suicide or a life extended by tubes and machines. It offers a viable alternative to the desperate choice that confronts patients whose life is limited. It offers the patient an opportunity to die in the arms of family and friends rather than tied to tubes and machines.

As the hospice movement came of age in the United States, the PAL Partners initiative will mature into a fully adopted precept of advance directive initiative. In future years, Americans will remember that these two companion pieces, hospice and Physician Assisted Living, so integral to care of the terminally ill, both originated in Connecticut, as they are integrated into the care of all patients and their families facing irreversible illness, by all providers, in all settings.

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1. Dworkin R: *Life's Dominion.* New York, NY: Kopt; 1993:213.
2. The Fourteenth Amendment of the United States Constitution states in Section 1: No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.
3. *Vacco vs Washington,–U.S.–, 117* S. Ct. 2293, 2298 (1997).
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The Physician Assisted Living (PAL) Program

THOMAS HOYER, B.S., M.S.

THE Physician Assisted Living (PAL) program represents a bold and I hope successful effort to help people grasp the basic concepts they need in order effectively to make choices about the time they have remaining in their lives. The basic concept, is captured in the title—Physician Assisted Living—living being the key word. Death occurs in a moment and all the time that stretches from birth until that moment is, in fact, life in which choices need to be made. The PAL program promises to create a context that will foster the learning necessary to understanding and choice.

Begin with knowledge and choice: Alexis de Tocqueville and countless other observers have commented on the individualism that underlies our American social institutions and behavior. In today's society we take the "right" to know all there is to know about ourselves very seriously, even extending it to the right to know what information others might have on file about us. Similarly, wherever there is the option to make a choice, we take the strong view that we have a "right" to choose and included in this, is the "right" to be informed of the options, to be offered choices.

The Medicare program was enacted with strong provisions asserting that citizens covered by the program would have the right to receive services from any provider willing to meet the program's standards and provide the care. The beneficiary makes the choices; Medicare pays the bills.

But, of course, choice is rarely a simple issue especially if the facts are complex or obscure. For choice to be a real possibility for people, there must be information about the possibilities available, as well as a way for the individuals to receive this information and to consider it in making their choices. The Medicare program has *The Medicare Handbook* and countless other publications to assist beneficiaries in learning the options and making choices. The Department of Health and Human Services (HHS) also provides grants for insurance and other kinds of counseling for the elderly. Still, the appropriate reach of HHS's efforts extends only to making sure that information is available and to assure that choices are honored. To go further than that is to invade the individual's right to choose.

The result of these limitations is that we have a program that offers the right to refuse treatment; that mandates "rights" for residents of nursing homes and other providers; that requires providers to inform patients of all their rights and potential liabilities; and that instructs providers to ask whether an individual has an "advance directive" and, if so, to provide care in compliance with it. Medicare's hospice benefit, where a patient makes an "election" for hospice services, requires an exchange of information and full understanding between the patient and the hospice provider. We *require* that the patient acknowledge at least that "he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness."

At the time this language was written, it was viewed as an easier way to provide a hard truth about prognosis and its result, but it was done that way because information from the hospice community persuaded HCFA that the task of helping individuals work through the issues in-

THOMAS HOYER, B.S., M.S., director, Chronic Care Purchasing Policy Group in the Health Care Financing Administration' s Center for Health Plans and Providers.* Mr Hoyer has been with HCFA in various positions since 1972. He holds B.S. and M.S. degrees from Indiana University and M.B.A. from Loyola University.

*This Group is responsible for Medicare policy on durable medical equipment and devices, skilled nursing facilities, home health agencies, hospices, partial hospitalization, end-stage renal disease facilities, program of all-inclusive care for the elderly, and cost report issues.

volved required that hospice personnel spend some time in assisting patients to understand—in Connecticut's terms, the meaning of palliative care and "assisted living." It is a mark of how deeply imbued the connection between hospice and death is in our society that it has taken me many years to understand the extent to which the hospice benefit is really about living and not about dying.

Planning health care around one's life is not a new idea. Families plan the birth of their children around jobs and vacations and other children. Elective surgery is planned around other life events to assure that their effects fit as well as possible with other activities. Similarly, the media are full of material about planning for one's retirement—perhaps the last period of life. Many of my friends are working diligently to assure that their retirement incomes and savings will be adequate to their needs. But yet, these people, who so carefully plan for an active retirement and for how their estates will pass to their children or other relatives, do not plan for that period when their functioning may be restricted by ill health, but during which they may still be active, in possession of their faculties, and capable of choosing among the alternatives that will affect the quality of their lives.

It is in this area that I believe that the PAL initiative in Connecticut can be most useful. Not just at the time when it becomes mandatory for patients and families to begin planning, but earlier, when they recognize that they will have choices to make and begin to discuss them; earlier, when they begin to do what they need to do to make calm and rational choices.

Choice requires knowledge of possibilities. The law and most systems of morality are based upon both knowledge and choice, and ignorance is not much of a defense if one fails to make a choice when one is offered. Then the choice will be made by others in the "default." People familiar with computers know about "defaults," since this is the term used to define the choice to which a computer program will "default" if the user does not make a choice of his or her own. People with illnesses that limit the time remaining to them and who have failed to learn their treatment options and make their choices use the "default"; they are subject to the choices of others. They have, in fact, thrown their autonomy away.

Over the years, as citizens have learned more about the nature of the forces that affect their lives, they have developed an increased appetite for information and choices—in the labeling of the food they eat and the liquids they drink, in the financing of their homes, and in countless other areas. The mysteries of the end of life remain for many a frontier of ignorance and acquiescence in the choices of others. But there are signs everywhere that this frontier is being breached by better information and the determination of people to take control.

More than any other strength that it has, PAL shows promise of preparing people for the choices they will need to make and enabling them to make these choices naturally and normally in the course of their everyday lives.

I see the PAL program as a program that encourages people to choose life—right up until the end.

What Others are Saying About PAL and Hospice

Medical science is rapidly expanding. Day by day puzzles of human biology are solved and new diagnostic possibilities are realized. Therapeutic options not imagined 25 years ago have become ordinary. However, applying advances in medical science can divert a physician's attention from the person with a disease to the disease as an entity of itself. Molecular biology is beginning to reveal how genes act as switches and motors that maintain normal bodily functions and how we respond to environmental elements that upset our well being. Genes control the mechanisms of cell survival and cell death. Susceptibility to disease is a function of gene structure. Each person has a unique genetic makeup and everyone of us responds to illness in a characteristic and unique manner. Infections and tumors are generate chemicals that activate cells of the immune system to attack and destroy or produce neutralizing substances. Other indigenous chemicals transmit signals that activate immune cells and brain cells. Areas of the brain that determine physical and emotional responses to our environment are linked biologically to the immune system in this way. Although it is recognized that emotional depression lowers resistance to disease, the potential therapeutic value of the relationship between the brain and the ability to combat illness is not yet realized.

The tradition of medical care embodies compassion, empathy, kindness, and respect. These qualities have access to that biologic link that affects response to illness. At a stage of illness when medical science cannot cure with medicines or surgery, care of the person can maximize the quality of life. Hospice care understands the uniqueness of the person/disease interaction. It is an expression of the art of medicine.

Lewis L Levy, M.D.
Clinical Professor of Neurology, Yale University School of Medicine

Sacred Ground at the Bedside: The Hospice Caregiver as Partner of God's Compassion

SR. ELIZABETH A. JOHNSON, PH.D.

IN exploring the meaning of the role of the hospice caregiver, a story in the book of Exodus comes to mind. There a crucial encounter takes place between a man minding his flocks and God who wants to free the Israelites from their awful slavery in the land of Egypt Moses, the shepherd, sees a burning bush which is not consumed despite the fact that it is blazing. The voice of God calls to him from the bush: "Remove the sandals from your feet, for the place on which you are standing is holy ground." Moses does so, and then the sacred voice resounds with a magnificent disclosure: "I have seen the misery of my people who are in Egypt; I have heard their cry because of their taskmasters; I know well what they are suffering. Therefore I have come down to deliver them out of that land and bring them into a good land flowing with milk and honey.... So come, I will send you to Pharaoh to bring my people, the Israelites, out of Egypt." Quite taken aback and fearful, Moses objects. But God ends the encounter by saying simply, "I will be with you." The rest, as they say, is history. (Exodus 3:1-12).

In this encounter, a certain patch of ground becomes holy because God is present there, pouring out divine love in the form of compassion for people who are suffering. The verbs used in the divine address from the flaming bush are highly instructive. Rather than being distant and far removed from the turmoil of earth, the Holy One suffers with those who are sore distressed: I have *seen,* I have *heard,* I *know* what they are suffering. *Know,* in this instance, means a knowing in the heart, a felt experience, as when the Bible says that "Adam knew his wife," indicating sexual intercourse. God's own heart feels experientially what the people are going through. And moved by this compassion, God takes action to deliver them, I have *come down,* and does so in a typical way by calling a human being to act as a partner of divine compassion in the world: *Come, I will send you.*

The bedside of the hospice patient is sacred ground for the same reason that the ground around the burning bush is sacred: because someone is suffering, because God is present there and shares this pain, and because the caregiver is called to be a co-partner of God's compassion in accompanying the dying person throughout the time of transition, out of the place of pain. In effect, the voice of God says to the caregiver: Come, I will send you to bring my presence, warmth, and help to these suffering persons in and through your own human heart and expert care.

The term compassion comes from joining the Latin words *cum* meaning *with,* and *pati* meaning *to suffer.* It means to "suffer with" someone; to have a certain fellow feeling that allows you to gain an interior connection to someone else's pain; to enter into a relationship with a suffering person in such a way that he or she feels respected and empowered; simply to stand with someone, recognizing that despite the pain or disfigurement he or she is a person of mystery, beauty, and strength. Through their own compassionate hearts, those who do hospice care have the profound calling of embodying divine compassion, of being the ones through whom God's care is in reality poured out over dying persons.

It is instructive to trace how often in the Bible the compassion of God is imaged in female metaphors. Of course, God is neither male nor female but Creator of both in the divine image and likeness. Since both male and female image God, the experience of both can provide metaphors for speaking about God. But in the course of history, a prejudice against the goodness and blessedness

SR. ELIZABETH A JOHNSON, PH.D., CSJ, University Distinguished Professor of Theology at Fordham University. She is the author of several books and dozens of essays in scholarly journals, chapters in edited books, encyclopedia entries, and articles in popular journals. Her work has been translated into German, Portuguese, Spanish, Italian, French, and Korean. She is past president of the Catholic Theological Society of America, she has received three honorary doctorates, and been honored with the annual award from *U.S. Catholic Journal* for promoting the cause of women in the church.

and even the full humanity of women titled our language in favor of male images of God. It was thought that a woman's life, her body and emotions, were not worthy to image God. In our day, however, the upsurge in women's awareness around the world is reclaiming the dignity of being female, even before God, and thus female images of God are once again being put into play.

Using female metaphors to speak of God does not mean that God is literally female, just as using male images does not indicate a literal maleness in God. No images are adequate, for the holy mystery of God goes for beyond human ability to comprehend. We use metaphors and analogies simply to point, to say the way God acts and feels and relates is something like this. With regard to suffering, women's experiences of caring and loving provide beautiful language for divine compassion.

One major discovery of recent years has been that the Hebrew word for compassion comes from the same root (rhm) as the word for a woman's womb. When the scripture says that God has compassion on suffering people, the underlying metaphor signals that God is loving them as a mother loves the child of her womb. The prophet Isaiah writes, "The Lord has comforted his people, and will have compassion (womb love) on the suffering ones;" and again, God says, "Can a woman forget her sucking baby, that she should have no compassion (womb love) on the child of her womb? Yet even should she forget, yet I will not forget you." In compassion God is more of a mother than any mother. From an organ of the female body to a physical state: the metaphor suggests the meaning of compassion as self-giving participation in life for the sake of the other whom one helps and protects but does not control. In the New Testament even Jesus, who himself showed such compassion, used the maternal metaphor, telling Nicodemus that a person must be *born* again of water *and the Spirit* in order to enter the kingdom of God. In other words, the Spirit of God is like a mother birthing us into new life.

Another powerful female image of God's compassion is the *shechinah,* or the great Spirit of God who dwells in the world. Mobil and free, she doesn't just dwell there, but accompanies people wherever they go. No place is too hostile. She walks with them through the desert once they have escaped from slavery and, centuries later, she goes with them into exile again, never abandoning them through all the byways of rough times. As the rabbis wrote: "Come and see how beloved are the Israelites before God, for withsoever they journeyed in their captivity the *shechinah* journeyed with them." In other words, God's indwelling Spirit was with them and her accompaniment gave rise to hope and encouragement in the darkness, a sense God was with them to see them through. When the people are brought low then the *shechinah* lies in the dust with them, anguished by human suffering. Even when a criminal is hanged, God feels compassion. As the rabbis write, "When a human being suffers what does the *shechinah* say? My head is too heavy for Me; My arm is too heavy for Me. And if God is so grieved over the blood of the wicked that is shed, how much more so over the blood of the righteous." The biblical understanding that the Spirit of God moves throughout the world to bring life and blessing here receives a special twist in situations of conflict and trouble, God's presence, imaged in female form, embracing those who suffer in this divine compassion is a source of peace, vitality, and consolation in the struggle.

God's compassion, spoken of in female form, becomes embodied in the many women and men who are hospice caregivers. The relationship they set up with patients at the edge of life can be of mutual benefit. The patients are in need; they face the darkness of death and need to feel that they are not abandoned but are enfolded in care. Those who are people of faith also need to feel deeply the nearness of God's compassion. Being carried by God's love, they can believe that their dying opens upon a future where it seems empirically there is no future in this suffering, each patient has the dignity of a human person and can respond in deeply human ways with gratitude, humor, and relief; even merely by being there they have given others the privilege of serving them.

The caregivers are replete with riches to give; their medical expertise relieves pain and soothes jangled bodies, but even more, their own human compassion is the medium that reaches patients at the deepest level of personal need. At the same time, caregivers also have a full range of human emotions that must be respected, including the need to get away or to protect themselves from drowning in too much sorrow. The temptation here, as for other health-care professionals, is to reduce patients to objects, referring to them as a bed number or a room number and forgetting that they are fellow human beings. Hospice principles set up a different idea, asking caregivers to relate to patients on a more person-to-person level in this relationship, both can grow to be more fully and maturely themselves in different ways, provided they honor their own and each other's humanity.

The bedside is sacred ground in the spirit of Hospice, caregivers' work brings them to see and hear and know well what dying persons are suffering. They come to deliver patients from pain, but even more profoundly to share their suffering in a compassionate relationship that sustains human dignity and sees them through the end. In this, they are midwifing persons throughout the "birth" process into the hands of God. They are coworkers with God at a most critical moment of life. Accompanying and giving hospice care to the dying, they image and embody in a beautiful and real sense the infinite mystery of divine compassion.

Enhancing Awareness of Hospice Through Physician Assisted Living: Public Health Perspectives

MICHAEL MERSON, M.D. AND ELIZABETH H. BRADLEY, PH.D.

ABSTRACT—The provision, management, and financing of care for patients with irreversible diseases has become increasingly complex in this era of advanced medical technology. With enhanced capabilities of medicine to prolong life, clinical practice has taken on legal and ethical dimensions that reach beyond the traditional scope of medicine. This paper demonstrates that hospice represents a major area of public health practice and research. It argues for enhanced involvement of public health practitioners and academics in the design and evaluation of efforts to encourage appropriate use of hospice for patients with irreversible diseases. The physician assisted living intervention in Connecticut represents one such effort. However, ongoing educational efforts targeted at both the public and health care providers are needed to ensure that all those with irreversible diseases fully understand and have access to hospice care at the end of life.

THE provision, management, and financing of care for patients with irreversible diseases has become increasingly complex in this era of advanced medical technology. With enhanced capabilities of medicine to prolong life, clinical practice has taken on legal and ethical dimensions that reach beyond the traditional scope of medicine. The nature and pace of such changes challenge conventional wisdom about appropriate care, the role of physicians, and the roles of other heath-care professionals in promoting quality of life for terminally ill patients and their families. Within this context, public heath perspectives can make important contributions to understanding, evaluating, and improving the care of terminally ill patients and their families, as well as the community in which they live. The intention of this paper is to demonstrate that hospice represents a major area of public health practice and research, and that the physician-assisted living intervention is an important step in enhancing awareness of the hospice alternative.

There have been many attempts to define public health. These definitions demonstrate the evolution of a field, continually being reinvented to meet the health needs of the public as knowledge of disease, methods of prevention, and systems of care have evolved in the early 19th century, public health measures focused on enhanced sanitation and reduced communicability of disease. The bacteriologic and immunologic discoveries of the late 19th and early 20th centuries offered disease prevention as a powerful approach to enhancing the health of the public, and prevention became a cornerstone of public health practice populations.[1] In 1920 a more comprehensive view of public health was articulated by Charles E-A Winslow, defining public health as "the science and art of 1) preventing disease, 2) prolonging life, and 3) promoting health and efficiency through organized community efforts."[2] Winslow's view of the field recognized the central role of social sciences in public health and thus foreshadowed the continually evolving nature of the field, changing with the social definitions, expectations, and systems of health. Today, health is defined by the World Health 0rganization as the "state of complete physical , mental, and social well-being." Given this comprehensive view of health, the principles of hospice and the notion of physician-assisted living are wholly consistent with the goals and activities of public health.

MICHAEL MERSON, M.D., Dean of Public Health, professor and chairman of the Department of Epidemiology and Public Health, director of the Center for Interdisciplinary Research on Aids at Yale University School of Medicine. ELIZABETH H. BRADLEY, PH.D., is assistant professor of Public Health, Yale University School of Medicine.

Several aspects of hospice and physician-assisted living are particularly germane to the skills and objectives of the public health professionals. The most fundamental of these aspects is the tenet that the patient and family constitute the unit of care in its founding principles, hospice defines its goal as caring for both patients and their families. This explicit recognition that health is a social phenomenon, and that patients' well-being (or lack thereof) can have profound effects on family and community, broadens the approach of hospice beyond the traditional medical models of health and thus incorporates a public health perspective into the planning and provision of care.

To date, several studies have investigated empirically the effects of hospice care on the quality of life of both patients[3,4] and their families.[5,6] These studies generally demonstrate enhanced satisfaction with care and life among those receiving hospice rather than conventional care.[3,4] With some exception,[7] data confirm that family members and care givers of patients receiving hospice rather than conventional care experience greater satisfaction and reduced bereavement burden after the patient's death.[5,6] Such benefits might be felt throughout a community as survivors are more able to continue their social and productive roles in the larger society. Together, the principles and empirical evidence regarding hospice care demonstrate its commitment to the health and well-being of not only the patient but also individuals supporting and supported by the patient. Such a view of health and of health promotion among families and communities emphasizes the public health nature of hospice.

A second aspect of hospice that demonstrates the relevance of hospice to public health professionals is its focus on the multiple facets of health, including emotional, psychological, and spiritual well-being. Hospice care, with its attention to improving life during advanced stages of irreversible diseases, includes activities beyond the provision of medications and other traditional medical interventions. These activities include active and passive listening encouraging creativity with arts and music, therapeutic touch, and emotional and spiritual healing. Such interventions are central to caring for the whole person, not only the physical manifestations of disease. This integration of physical, psychological, emotional, and spiritual care exemplifies a perspective widely shared in public health practice.

A third characteristic of hospice that is consistent with the public health perspective is the involvement of interdisciplinary teams in the planning and provision of care. Such teams include physicians, nurses, social workers, clergy, and community volunteers who plan, provide, and assess various approaches to care for patients and their families. Similarly, interdisciplinary coordination is a hallmark of effective public health practice. Like hospice care givers, the training and backgrounds of public health professionals are widely diversified including medicine, nursing, law, statistics, economics, and political science, to name but a few. Thus, again, the principles and practices of hospice are consistent with and, in many ways, exemplify the public health approach to caring for terminally ill patients and their families.

While hospice represents the public health approach to care of patients with irreversible diseases, awareness of its potential effect on the health of patients, their families, and the larger communities remains limited. Such limited awareness has been demonstrated directly through national surveys[8] and implicitly through multiple studies demonstrating infrequent discussions among physicians, patients, and families concerning alternative approaches to end-of-life care.[9,10] Nevertheless, public health professionals to date have been fairly silent about their potential embracing of and contribution to hospice and palliative care.

Now is the time to reconsider this silence and recognize the important role of public health in end-of-life care generally and hospice care specifically. The field of public health offers substantial expertise in two areas central to promoting the hospice alternative: the design and evaluation of effective educational campaigns to enhance awareness and appropriate use of such services. Health education has always been important functions of public health professionals. Further, within public health, it has long been recognized that it is not enough to present information.[1] Educational efforts that effect change require an understanding of how individuals and groups view various conditions and how they might be motivated to adapt or alter those views to enhance their welfare. In this way, current public health educators may act as agents of social change.

A public health approach to health education is essential to effecting appropriate patterns of care at the end of life and alleviating what empirical data suggest is common place: deaths that are prolonged, mechanically supported, and painful.[11] A number of educational campaigns to increase public awareness of alternatives at the end of life have been initiated. These include federal efforts to enhance awareness of advance directives through the Patient Self-Determination Act of 1990 (PSDA), as well as the recent implementation of Physician Assisted Living (PAL) in Connecticut PAL is an effort by the Office of the Attorney General to enhance public awareness of hospice principles and to facilitate discussion of hospice care as an option for patients with irreversible diseases. Currently, under the federal PSDA, all patients admitted to health care organizations receive written information concerning their right to refuse unwanted treatment and to complete advance directives. Advance directives are legal documents that describe medical treatment

wishes in case the individual becomes unable to make decisions for herself in the future. PAL is an effort to expand the scope of written information received to include the 10 principles of hospice as well as an optional election of hospice, should one become terminally ill in the future.

Will PAL be effective? Evaluation of the PSDA has demonstrated mixed results, with impact on public awareness of advance directives and advance directive completion being measurable though somewhat limited.[12-14] Like the PSDA, PAL will likely have measurable impact on public awareness of treatment alternatives for those with irreversible disease. The effort should be understood as an important step but one that must be augmented with ongoing educational efforts of both the public and health care providers. Given the emotional and ethical dimensions of care at the end of life, successful educational efforts in this area must involve broad and varied perspectives. The efforts must be credible within existing medical systems yet continue to challenge physicians, patients, and families to recognize the many dimensions of health, explicitly recognizing hospice as an option when curative efforts are no longer effective. Public health practitioners and academics alike can make important contributions to these efforts of change.

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The Physician's Role as Care Giver

The American medical community finds itself in the middle of a debate on what the appropriate role should be for physicians at the end of life. Should the physician, like Jack Kevorkian, help patients terminate their lives when life becomes a "living hell," endless torture, a series of painful hopeless days, each one more dreary than the next? Or rather should the physician help the patient within the family to find comfort and maintain dignity by actively managing pain and other distracting and devastating symptoms? When the question is framed this way the choice is obvious: the physician must strive to help the patient maintain a reasonable quality of life in the face of terminal and irreversible illness. After all, we are care givers, not morticians! This is the essence of hospice care: maintaining quality of life!

Myth #1: Hospice care means abandoning the patient.

Reality: Hospice care does not mean that the physician has given up on the patient it does not mean that the patient is foregoing treatment. Rather it sees the patient within her family unit and strives to maximize the quality and comfort of her final days. The earlier hospice care is initiated the more effective the patient's treatment can be. Aggressive pain management is the farthest thing from withdrawing care.

Myth #2: Hospice puts patients in a drug-induced coma.

Reality: Hospice care is not equivalent to a narcotics stupor. Palliative care becomes like drug therapy when it is initiated so late in the disease process that there is little time remaining to affect the outcome. The beauty of hospice care is that it uses so many modalities to enhance patient comfort: art therapy, pastoral care, social work, and trained volunteers.

The PAL initiative, by educating both the physicians and the public about the choices available to them early on in the disease process, will assist physicians in providing high quality end-of-life care to their patients it will make it easier for physicians to initiate a discussion about choices in care modalities and patient preferences for the future. By putting these preferences in writing, confusion among care givers and unwanted medical procedures are less likely to occur.

Myra L Skluth, M D.
Chief of General Internal Medicine at Norwalk Hospital, and associate medical director of Connecticut Hospice (Norwalk office)

A registration statement relating to the securities of Physicians Care for Connecticut, Inc., has been filed with the Securities and Exchange Commission, but has not yet become effective. These securities may not be sold nor may offers to buy be accepted prior to the time the registration statement becomes effective. This notice shall not constitute an offer to sell or the solicitation of an offer to buy, nor shall there be any sale of these securities in any state in which such offer, solicitation or sale would be unlawful prior to registration or qualification under securities laws of such state.

PHYSICIANS CARE
FOR CONNECTICUT, INC.

Physicians Care for Connecticut, Inc. has recently filed a registration statement with the Securities and Exchange Commission relating to the proposed sale of shares of its Common Stock, representing new financing.

Physicians Care for Connecticut, Inc. was incorporated for the purpose of developing and operating a statewide IPA model HMO.

The Company's registration statement proposes the sale by the Company of:

3,000 Shares of Class A Common Stock at $4,000 per Share
and
3,000 Shares of Class B Common Stock at $4,000 per Share

(prices for Shares are subject to a prompt subscription price of $3,000 if subscription documents are received within the first 90 days of the date of the Final Prospectus relating to the offer of such securities)

It is anticipated that these Shares will be available for purchase in July, 1997, subject to the registration statement becoming effective with the Securities and Exchange Commission.

For a copy of a Preliminary or Final Prospectus, please contact the Managing Underwriter, as follows:

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Medical Students and Palliative Care

FRANK J. BRESCIA, M.D., FREDERICK A. FLATOW, M.D
WILLIAM SCOTT LONG, M.D., AND SANDRA KLIMAS, M.P.H.

THE United States began the decade of the 1970s without a single hospice. In 1974 America's first hospice opened in New Haven beginning with a home care program. A 44-bed, free-standing hospital[1] was opened in 1980 with eight beds added in 1986. Hospice in North American had finally materialized as a philosophical, social, and medical phenomenon. The mission of this experiment was clear: to develop a program that would fulfill unmet needs for the dying and allow people to die with those basic elements of a good death—care, communication, continuity, control, calmness, and closure.

For hospice care, the goals of therapy are directed toward management of difficult and painful symptoms, not only physical but psychosocial as well. To achieve these goals requires a diverse team with unity of purpose, including nursing, pharmacy, social work, volunteers, pastoral care, nutrition, arts, physical therapy, and physicians. More than two million Americans die each year—90% with a clinical illness and 80% within institutions. The magnitude of the problems for dying patients and their families and friends is obviously enormous. Cancer alone kills one person every minute in our country. Over the years, the Connecticut Hospice has become a resource of care for patients with terminal illness, a body of knowledge, the richness of caregivers' observation, and the lessons learned from listening to more than 35,000 patients and their families. From the beginning, there has been a moral obligation to evaluate how care is delivered, to learn from mistakes, and to address the formal needs of sharing crucial information with a wide range of disciplines—physicians, medical students, nurses, pharmacists, etc. through training, education and research. Motivation and expressions of compassion do not necessarily equate with competency at the bedside. Therefore, to invest in physician participation, documentation, history taking, and patient assessment becomes important. How do we measure and monitor what we do? How do we deliver care in an environment where we know patients will die and where clinical options for cure are limited or nonexistent?

Connecticut Hospice made the decision in 1986 to address the needs of medical students and others (residents, fellows, nurses, nurse practitioners, physician assistants) to have exposure outside conventional hospital settings to help develop communicative skills in dealing with dying patients and their families. Elective programs for senior medical students are listed at the Yale University School of Medicine and the University of Connecticut School of Medicine. Two to four week sessions allow hands-on care of patients and their families and friends dealing directly with the patient's complaints, symptoms, fears, and expectations. The curriculum encompasses pharmacological and other protocols for symptom management that are commonplace with the hospice patient and family. The faculty includes members of the interdisciplinary team.

People who are dying become different and difficult because clinicians treat them differently—many times, with apathy and indifference. At the other extreme there is an inability to address the frustration of perceived failures, and the caregivers fall victims to their own inventiveness in ordering tests, then seeking for a cure that can never

FRANK J. BRESCIA, M.D., medical director, Calvary Hospital, Bronx, New York; fellow of the John D. Thompson Hospice Institute for Education, Training, and Research, Inc.; associate professor of medicine, Emory University School of Medicine, chief of the oncology section, Grady Memorial Hospital, Atlanta, GA. FREDRICK FLATOW, MD., director of medicine, Connecticut Hospice, Inc., fellow of the American College of Physicians. WILLIAM SCOTT LONG, PH.D, M.D., attending physician, The Connecticut Hospice, Branford. SANDRA KLIMAS, R.N., B.S.N., M.P.H., vice president, Clinical Operations, The Connecticut Hospice, Branford.

happen. Principals of good hospice care are no different from those used in other medical care situations: clinical competence, experienced technical skills, and a bedside manner are used to define treatment in the patient's best interest.

A difficulty for physicians is to recognize that point in the natural course of a disease that initiates the dying process, ie, to determine when the patient can no longer be effectively treated with a goal to cure or prolong life. The inexperienced physician learns to ask a series of specific questions as clinical options are reviewed:

- What does this patient and family understand?
- What does this patient and family want?
- What degree of futility is there?
- What and how severe are the patient's symptoms?
- What has been the tempo of progression over the last few weeks or months?
- Can I anticipate how the patient will die?
- What are our reasonable goals?
- Will I make this patient worse by whatever I do?
- What do I do if the patient and family disagree with my recommendations?
- What are the specific ways to involve the patient and family in decisions?

Thinking clearly about our goals for a specific patient is critical when we must optimize the quality of life during the time remaining. Good doctors need to learn the difference between what they *wish to happen* for their patients and what the clinical reality dictates likely *will happen*.

During the students' clinical rotation (see Table 1) at Connecticut Hospice, each one participates as a member of the hospice team in defining the comprehensive plan for each patient and family. This allows the student to witness what a coordinated effort among various disciplines can accomplish in most situations. Beyond the severity of their physical symptoms, patients often have distress that encompasses their spiritual, emotional, and cultural lives. This bridge that unites the humanity of the caregivers and those needing care requires an appreciation of human existence itself.

One of the issues explored with students is the care of patients at home. This is an important part of clinical experience, because, despite the difficulties in keeping patients at home, most patients prefer to die there. Only 3% of relatives of patients who died at home would have preferred the hospital setting.[3] The consistent factor that demonstrates satisfaction by hospice families was the place of death. At Hospice patients can be admitted from home care for control of symptoms and to develop a plan of care, which involves teaching the family, then return home again. Some communities do not have the resources and trained individuals to meet the complex needs of patients with a terminal illness at home. Even those families who want their loved ones at home may not fully appreciate the burden of 24-hour care and may feel abandoned by their caregivers.

How well do we attract younger physicians in this important work and allow them to experience the satisfaction perceived in other areas of medicine? Education and experience in care at the end of life must begin early in the education process. As death is a part of life, and we all hope for quality of life for as long as life lasts, then hospice and palliative care must be a part of every physician's practice. All of us agree that failure to provide proper care at the end of life is no longer acceptable since it abandons ideals that guide the profession. We must provide training now for physicians, patients, and families of the future.

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Table 1.—Two to Four Week Elective Rotation

A. One day general orientation—The entire program is supervised by a full-time, credentialed and privileged physician of the Connecticut Hospice.
   1. Introduction to hospice philosophy
   2. Introduction to interdisciplinary approach

B. Interdisciplinary team planning
   1. Ten Principles of hospice care

C. Individual student learning with preceptor

D. Discussion of selected readings (See Appendix 1 in Bibliography on page 798)

E. Pharmacological interventions in the hospice setting

F. Preceptor/student activities—Hospice inpatient
   1. Daily interdisciplinary rounds
   2. Weekly interdisciplinary team meetings
      a. Student presentation of medical and physical history of assigned cases
   3. The admission process
      a. Student participates in admissions
   4. Assignment to patients for bedside teaching, communication, identification of problems and symptoms and detailed investigation and research.
      a. Active participation in patient care, including documentation of orders and progress notes.

G. Preceptor/student activities—Hospice home care
   1. Home visits with preceptor to inform student re: our hospice home care environment and care provided.
   2. Participation in home care interdisciplinary team conferences.
   3. Role of the community physician in hospice home care.

Physician Assisted Living: Medical Educators' Perspectives

GERALD N. BURROW, M.D.

MARGARET JOHNSON BIA, M.D.

I feel that it is essential that physicians in training and medical students learn that there is much more to medical care than technology. Hospice lives and breathes unique concerns for human aspects of life and death, and in the months ahead, we will work to find new ways to introduce our trainees to them.

Robert H. Gifford, M.D.
Associate Dean for Education and Student Affairs
Yale School of Medicine

Medical students in general lack education in the process of dying. Technology is available to delay death, but not to prolong meaningful life. Physicians are not sufficiently aware of the opportunities to make the last stages of life more comfortable. Medical students need to have the educational opportunity to learn about these terminal stages.

The Yale School of Public Health is directing a research project on a palliative care and hospice educational program to be developed and delivered by the John D. Thompson Hospice Institute for Education, Training and Research, Inc. in Branford. This has the potential for generating significant interest in the milieu of "end-of-life care." If the results of this educational intervention are positive, it should be replicated throughout the state.

Physician Assisted Living is in its infancy. Interestingly, though, we all knew about it intuitively but never assigned a name to it. We now have the ability, even the calling, to build upon PAL and the educational program to expand it for the medical profession and our medical schools throughout this country.

Gerald N. Burrow, M.D.
Dean Emeritus and
Special Advisor to the President for Health Affairs
Yale University School of Medicine

A noted thinker once said that "What we have done for ourselves alone dies with us, but what we have done for others and the world remains and is immortal."

Physician Assisted Living provides a message of hope that is durable and doesn't respect time.

I have the perspective of a medical educator introducing medical students and residents in training to the subtleties of care when cure of the disease seems no longer possible.

What has been missing is an overarching theory or tool that allows us safe passage into the world of our patients using universal language.

Physician Assisted Living is an instrument designed to help the medical professional communicate with patients about their needs. The Physician Assisted Living concept creates a means for each patient, through collaboration with the physician, to view the broadest possible array of care options. Physician Assisted Living becomes the master story, the construct, the framework or set of principles that helps relate to a particular patient's unique set of circumstances: a map of the patient's world at any stage of care.

I have observed the caring of The Connecticut Hospice's Interdisciplinary Team approach since its inception. Not surprising then, that this concept, Physician Assisted Living (PAL), was birthed through the energy of will and commitment of soul demonstrated therein.

For medical students, residents in training, and practitioners, the challenge is to care for the whole patient—not just treat their diseases. Total care involves a seamless path between life and death—both processes of equal importance. PAL is a way that allows physicians to care for patients with this perspective—preserving dignity, hope, and caring for the needs of the whole patient.

Margaret Johnson Bia, M.D.
Professor of Medicine
Yale University School of Medicine

Commentaries

The National Legislative Perspective

In recent years, public discourse surrounding the issue of medical care for the terminally ill has been dominated by the issue of physician-assisted suicide. Unfortunately, missing from this national dialogue has been a discussion of the alternative of hospice care. I am grateful to have this opportunity to express my strong support for Connecticut's recently-launched Physician Assisted Living (PAL) Partners Initiative, which is designed to educate Connecticut's citizens about the choices available to them when faced with a terminal illness.

Recent advances in medicine that have saved or extended countless lives have also increased the numbers of patients faced with prolonged illnesses. Hospice care offers individuals for whom a cure is no longer possible the opportunity to live the remainder of their lives in a supportive environment under the care of specially trained medical professionals. Unlike traditional hospital care, which is directed primarily toward curing or ameliorating illness, hospice services focus on managing pain and providing psychological, sociological, and spiritual support for patients and their families. However, despite the tremendous benefits that hospice services can provide to those who chose them, many patients, families, and even providers remain unaware of the existence of these services.

The principles of hospice care are grounded in the belief that individuals should have the right to make their own decisions about the type of care they would wish to receive when confronted by a terminal illness. The PAL program will help support this decision-making by educating Connecticut residents about their options for end-of-life care. Through this program, state residents will be informed about the availability of hospice care and can receive a document, to be signed and delivered to their doctors, explaining their desire to receive hospice care in the event of terminal illness. This allows patients the opportunity to think about alternatives and commit to them in writing prior to such time as they become incapacitated.

I am proud that the first hospice established in the nation was in Connecticut. PAL continues our proud tradition of compassionate care.

Christopher J. Dodd,
Senator

The Helping Hand from Hospice

There clearly is a profound and important value that underlies the work that Hospice does. It is that this great gift of life that God has given us goes from the very beginning to the very end, and from the very beginning to the very end is sacred and deserves the kind of love and respect and compassionate care that is provided here at Hospice.

In its way and in a marvelous affirmation, I think Hospice, as it helps people approach the end of life, really pays tribute to life in as meaningful a way as I know. All of us have been or will be touched by it. Each of us has our own special memories, and if I may take the liberty of being personal, when my father of blessed memory was in his last days, I can remember so clearly his effort to maintain his dignity, to continue to remain involved with the rest of us in the family. In conversation I remember also the wonderful home care we received at that time through Hospice, which helped my dad to do all of those things. It was care given in a most respectful way, it was care given in a way that preserved his dignity and, although he was weakened, preserved his strength. I shall never forget it, We in the family, thanks to Hospice, and also thanks to my dad, really felt that he was with us to the very last second of his life.

As we improve our health-care system, it is critical to remember, hold dear, and enact the values that are reflected in this hospice program: the underlying belief in the sanctity of life from the beginning to the end, the importance of caring, and the quality of care; it is important to remember that we are people trying to help people.

Joseph I. Lieberman,
Senator

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Appendix 1.—Helpful Reading in Palliative Care

Books

Doyle D, Hanks GWC, MacDonald N: *The Oxford textbook of palliative medicine.* Oxford Medical Publications, Oxford, 1993. The gold standard in palliative care in the English-speaking world (and probably elsewhere).

Saunders C, Sykes N: *The management of terminal malignant disease,* 3rd ed: Edward Arnold, London, 1993. A shorter view with some excellent insights.

Twycross R: *Symptom management.* Radcliffe Medical Press, Oxford, 1995. (A rather cut and dried approach from one of the founders of the English hospice movement but will give you a quick access to at least one medical approach with an emphasis on pharmacology).

Articles and book chapters

Breitbart W: Psycho-oncology: Depression, anxiety, delirium. *Semin Oncol* 1994; 21:754–69. (Excellent guide for practitioners).

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Address of the President to the House of Delegates

The mid-point in my term as president seems an appropriate a time provide you with my view of the state of the State, our accomplishments, and our concerns and expectations.

There is no question that this past year has seen the culmination of literally years of interaction with the state legislature, its leadership, the governor's office and various state departments, particularly Public Health and Insurance.

This morning many of you were able to attend the seminar on Legislative Relief and Practice Options in Managed Care. Among the speakers was insurance commissioner George Reider. I am sure you found his comments to be enlightening and reassuring.

Interaction with Commissioner Stephen Harriman and the Department of Public Health continues to be cordial and productive. He has suggested joint participation with us in educational programs on issues affecting the public health, and we of course have indicated our enthusiasm for such joint efforts.

There is no question that the passage of the managed-care bill has been of vital importance to the patients of this state and to us, their physician advocates.

The growth in the various types of managed-health programs has literally changed the face of medical economics in the United States. In just four years, from 1993 through 1996, indemnity plan coverage decreased from 48% of all covered lives to 23% by the end of 1996, a greater than 50% change in that type of coverage. Conversely, the growth in health maintenance plan coverage has increased from 19% to 27% and point of service plans from 7% to 19% over that same time period. The "So what" you all most probably know but I cannot help but mention. Most directly affected by these seminal changes in the reimbursement of health-care delivery and the actual delivery of the care itself are the chronically ill and the elderly. For our nation's seniors, the intense focus on efficiency and short hospital stays may be necessary for institutions to compete and survive, but these changes may prove especially daunting to our elderly who many times feel betrayed by the high-tech, no-longer-so-compassionate hospital environment. While numbers are elusive and the scope of the problem difficult to quantify, anecdotal evidence abounds, gleaned from tales of social workers, medical advocacy groups, and hot-lines whose phones ring off the hook with the halting, sometimes tangled complaints of the gray generation. It is our moral and ethical responsibility as healers and patient advocates not to contribute to the mental and physical anguish that some of our patient population has been forced to endure.

For our chronically ill patients and low income population the tale is even grimmer. Any type of insurance at all remains an elusive, sometimes unattainable goal for too large a portion of the population. There are estimates that upwards of 45 million people will be without health insurance by the year 2002. The recent federal action to fund health coverage for uninsured children acknowledges the problem without really solving it.

Admittedly the costs of providing medical care to our population has risen if not exponentially, at least at a rate substantially higher than several of our widely employed economic indices. I will continue to hold the belief that in great portion these increases in cost may be substantially attributed to the tremendous technological advances made by our profession over the past several decades and, not in the least less important, improvement in our ability to deliver that technology and knowledge to an ever greater number of our patients. At this juncture to see the vast amounts of monies diverted from medical-care delivery into the seemingly insatiable maw of entrepreneurial profit cuts to the quick.

But managed care and its organizations are here to stay and they are playing a hugely significant role in shaping our future health-care delivery system. All the more encouraging then is the passage of the managed-care reform bill, in overwhelming fashion by the state House of Representatives, the state Senate, and signed quickly into law by the governor. Managed-care organizations are defined as insurers, health-care centers, hospital or medical service corporations, or other organizations delivering, issuing for delivery, renewing, or amending any individual or group health managed care plan in this state.

The insurance department and insurance commissioner have been given oversight responsibility in regard to the managed-care law. Managed-care organizations, (MCOs), must annually submit to the Department of Insurance a report on a quality assurance plan addressing enrollee complaints; prior authorization denials; utilization review

determinations; a model contract in force with its providers; a declaration of the types of financial arrangements existing with hospitals, providers, and utilization review companies; and a summary of credentialing procedures.

The law assures that practicing physicians will have input into the development, modification, and implementation of medical protocols. Gag clauses are prohibited, allowing physicians to discuss any and all treatment options and even methods of reimbursement There is protection preventing retaliation against providers who help contract members appeal utilization review decisions and a grievance procedure allowing enrollees to seek review and timely resolution of complaints arising from a managed-care company's action. There will be an expedited review process to deal with life-threatening situations precipitated by ill founded decisions of utilization review companies that jeopardize the medical management of these conditions.

Also created is an external appeal process provided to the patient who has exhausted all other appeal modalities.

Finally, the insurance commissioner will submit annually to the governor and the General Assembly a report summarizing the department's review of MCO activities included in the bill.

How these regulations are implemented is always a concern, but certainly at this point there is room for optimism.

With the advent of managed care and the entrepreneurial environment it has fostered, there has entered our sphere another manifestation of medical economics, the practice management organization. The lure is to lessen our administrative burdens and provide access to capital sources and practice management expertise allowing us to "practice more efficiently and more cost effectively." Thus our attractiveness to the various entities seeking to utilize our medical expertise is enhanced. Attractive, they sound good, after the mind-numbing exhortations of our managerial economics partners—apparently too good to a growing number of physicians in our state, as well as individuals, groups, and IPAs nationwide. So with your forbearance I would like to inject a note of caution. I believe it is part of our mandate as leaders of organized medicine in the state to speak out and provide appropriate cautionary notes to our colleagues subjected to the siren call of these various entities. Most obviously in this case, the so called PPM (physician practice management company) is capitalized through our equity markets and so is responsible to those equity markets' stockholders. If expectations of return on investment, some say as high as 25%, are to be met and the savings and efficiency in reducing practice overhead are in the range of 5% to 10%, then it follows that maintaining the desired revenue stream will fall to acquisition of new risk contracts and to physician performance enhancement. Please do not interpret my comments to suggest that anyone in a PPM contract is in league with the devil. I merely wish to inject a strong note of caution. Those contracts you are asked to sign are generally long-term. In just the past several weeks we have been regaled by the merger antics of two of the most active PPMs in Connecticut. Our managed-care environment has not yet matured. As it does, and as earnings ratios drop, the ability to show gain will become more problematic. The "suits" move on. You remain—with your patients.

A managed service organization (MSO) does provide an option that we at the State Medical Society endorse as a viable alternative. In providing the benefits of more effective billing and collections, economies in purchasing supplies and equipment, sophisticated information systems, and leverage in negotiating favorable contracts, many of the advantages of the PPM are matched. Of greatest importance is governance, and in these situations local physician control is absolute in the MSO model. You can expect community focus and an orientation toward long-term community commitment. **You all know we are sponsoring such an organization.** I ask you to spread the word to associates and friends, and for your own benefit give Michael Deren and James Darnell and MD Advantage a look—before you leap.

The Connecticut State Medical Society is not and should not be all about economics. As the new legislative session begins there are bound to arise new and renewed assaults on our sphere of practice. Encouraged by an attitude of leniency for political expediency the so called alternative care providers as well as the more traditional allied health groups seek ever to expand their scope of activity, disclaiming any negative impact on the quality of life and health of our constituent population. Indeed some broadly proclaim expertise and procedural success with no discernible credentialing in evidence. Recently CSMS has had to oppose an initiative for laser use completely outside a medical setting.

Regrettably, we can expect renewed efforts by the Connecticut nurse practitioner group to expand their nursing activities beyond the limits currently imposed by state statute. In this regard it is important to understand that advanced practice registered nurses are at this time permitted to practice an advanced level of nursing and prescribe medical therapeutics as long as they have entered into a mutually agreed upon protocol with a directing physician. It is not just a political but an ethical and legal concern to remind ourselves that as physicians having entered into such protocol agreements we are obligated to appropriate supervision of these activities.

The Council has endorsed a document jointly developed by the Medical Legal Committee of the Medical Society and the Connecticut Bar Association entitled Principles of Cooperation in Medical-Legal Matters. This

is the culmination of years of effort by New Haven County, Hartford County, and Fairfield County to develop guidelines to assist both physicians and attorneys in dealing with each other and the courts when such interaction is required. While of course the material contained therein does not have the force of law, it nevertheless represents a good faith effort by members of the Bar and the Society at collaboration in a document of potential benefit to both organizations and the public we serve.

It is my pleasure to announce an initiative by the Society and its Committees on Public Affairs and Legislation to proceed with an informational, educational campaign entitled "The MD Makes a Difference" Dr. David Parke developed this theme during his work with the American Academy of Eye Physicians. Special interest groups continue to infringe upon the scope of our practice and the public health. As professional distinctions are increasingly blurred in the public perception, we can no longer afford to presume that anyone is aware of the commitments and sacrifices made by each one of us in achieving the degree of doctor of medicine. This campaign will focus attention and seek to inform and educate everyone it touches as to the dedication and effort required in the degree's attainment. The target of the campaign is the public, the media, our lawmakers. We intend nothing less than to educate our constituency to the issues involved and the decisions to be made in choosing those who will provide that most vital of service—their health care.

Stanley J. Keating, Jr , M.D.
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When the Time for Heroics Has Passed

ROBERT U. MASSEY, M.D.

> Many have studied to exasperate the ways of Death, but fewer hours have been spent to soften that necessity.
>
> *Sir Thomas Browne*

PHYSICIANS have never quite known how to behave at the bedside of their dying patients. It may even have been harder 30 years ago before our amazing life-extending (or dying-extending) technologies were available to keep us busy. I knew a distinguished endocrinologist who, when his patient took her last breath as he stood by, seemed embarrassed, crossed himself, bowed slightly, and backed out of the room. Sometimes in those far off days we would call for an epinephrin-filled syringe with a long needle and aim it at the precordium, empty it, and wait. In my experience nothing ever happened, but we could leave feeling that we had done our best.

Now hospital deaths are often wild, a confusion of unfeeling, but well-meaning, noisy busyness in the ICU, nurses and housestaff standing by or manipulating tubes, defibrillators, respirators, or just watching the monitor as someone forcibly and rhythmically compresses the chest. Hardly the *euthanasia*, the peaceful departure, the good death that the ancients wished for themselves and their families. Daniel Callahan wrote of the "wild death," earlier described by Philippe Ariès, and now so common in our hospitals:

> It is wild not simply because it is out of control and terrorizing in its modern incarnation, but also because, in the name of combating mortality, it has managed simultaneously to subvert the institution of medicine, which cannot overcome mortality, and the morality of human decisions about life and death, which should not have to bear the burden of omni-responsibility.[1]

Callahan hardly intended to deny anyone the right to choose the wild death, "... technological brinkmanship without restraint, aiming to go as far as medical aggressiveness will allow," but that he should know and be prepared to accept "risking a terrible death—a risk for himself but also for those who must care for him."[2]

In discussions with older men and women, those mostly well beyond the Psalmist's three score and ten, I have found an almost universal fear—even terror—that instead of that peaceful death that nature so often provides, they will be pummeled by EMTs, delivered to the ER, and then rolled away to the ICU with absolutely no choice in the matter, and spouses or children powerless, or not aggressive enough, to intercede. Over and over I hear of living wills ignored, especially when they could not be produced on the spot. One elderly man thought he might have DNR tattooed on his forehead! More than this, many are concerned that in the helplessness of their final illness they will be subtly urged by well-meaning families and physicians to have just one more round of chemotherapy or radiation, or will be cheated out of a quiet death from pneumonia. I recall a wife and her two sons, both ministers, blocking the hospital room doorway of her husband and their father, near death from leukemia, for whose pneumonia a resident had, not inappropriately, ordered antibiotics to be given. They won the standoff, but only because they were able to reach the patient's physician and friend by phone. The patient died a peaceful death 24 hours later, and the resident sulked.

Leon Kass writes that our urge to medicalize death is *hubris* and reminds us of the tragic fate awaiting those who succumb to this all-too-human fault. "We do not understand that the project for the conquest of death leads only to dehumanization, that any attempt to gain the tree of life by means of the tree of knowledge leads inevitably to the hemlock...." and that "the victors live long enough to finish life demented and without choice." He concludes:

> The present crisis that leads some to press for active euthanasia is really an opportunity to learn the limits of the medicalization of life and death and to recover an appreciation of living with and against mortality. It is an opportunity to remember and affirm that there remains a residual human wholeness—however precarious—that

ROBERT U. MASSEY, M.D., Professor Emeritus, Division of Humanistic Studies, Department of Community Medicine and Health Care, University of Connecticut School of Medicine, Farmington.

> can be cared for in the face of incurable and terminal illness. Should we cave in, should we choose to become technical dispensers of death, we will not only be abandoning our loved ones and our duty to care; we will exacerbate the worst tendencies of modern life, embracing technicism and so-called humaneness where encouragement and humanity are both required and sorely lacking.[3]

Over 170 years ago, a medical student at Göttingen by the name of Carl Friedrich Heinrich Marx wrote his doctoral thesis, *De euthanasia medica*, "Medical Euthanasia,"[4] by which he meant, not the active euthanasia, the killing that many are demanding as an alternative to a wild medicalized death, but rather the passive good death, the peaceful death of skillful palliation that today defines hospice care. Almost two centuries ago this newly minted *Med. et Chir. Dr.* from his ancient university in Brunswick reminded his fellow academics of that "great Englishman," Francis Bacon, who had written 200 years earlier urging physicians "to stay with the patient after he is given up,..." and "to acquire the skill and to bestow the attention whereby the dying may pass more easily and quietly out of life."

Marx's recommendations were strikingly similar to the principles of hospice care today; he would have understood, as perhaps would Bacon, the notion of physician assisted living (PAL) during life's final exit. "Most physicians," he wrote, "once they see the expected result of their treatment to be wanting,... start to lose interest themselves." He even mentions a program at Heidelberg headed by a Prof. Mai, and funded by Amalia, Duchess of Baden, that provided training to women attendants in caring for the sick and the terminally ill. Marx recommended that these caregivers be "considerate, watchful, quiet, clean, free of prejudice toward people,... and adhere to the doctor's orders with greatest obedience." He described the care of bedsores, and that the "doctor will with his own eyes repeatedly search for" them.

Marx asked, "What good will it do the incurable patient to apply dangerous and dubious therapeutic measures? The entire plan of treatment will here confine itself within 'symptomatic and palliative medication.'" He even reminded his physician colleagues to see that the patient's dry tongue and pharynx be moistened. He urged "soothing, soporific, sedative, analgesic" medicines, and noted that "... narcotics are of enormous help." But later he added the essential caveat, "... and least of all should he be *permitted* (italics mine), prompted either by other people's requests or by his own sense of mercy, to end the patient's pitiful condition by purposely and deliberately hastening death. How can it be permitted that he who is by law required to preserve life be the originator of, or partner in, its destruction?"

In Marx's brief thesis, written in 1826 upon his being admitted to the faculty at Göttingen, we can find all the principles of hospice care and of physician care at the end of life embodied in the PAL program. Nothing new here. But even he was not their originator; we find them not only in Bacon, but in the ancients—Pliny, Cicero, Seneca, the Bible. They are imbedded somehow in our nature, and even, as Lewis Thomas once suggested in nature itself: why else the endorphins? Concerning them he wrote, "If I had to design an ecosystem in which creatures had to live off each other and in which dying was an indispensable part of living, I could not think of a better way to manage."

But when endorphins are not enough for the kinds of nonviolent, prolonged deaths that we often produce and must endure, we have the means and the inherent mercy to ease the passage. We should pay more attention to the business of dying. My Harrison's *Principles of Internal Medicine* devotes one and one half pages out of 2,044 to this matter, but it does address the physician's role: "First of all, the patient must be given an opportunity to speak to his physician and to ask questions."

This is what the PAL program as a part of the advanced directive is all about. It frees patients who are prepared to plan for the inevitable event to consider the options, discuss them with their physicians and families, choose, and then say with Seneca: "I am ready for death, hence I may enjoy life."

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This Month's Reading in Review

TIMOTHY B. NORBECK

The claim of HMO CEO David Lawrence that "the most appropriate care is the least expensive care" is an excellent illustration of why the public doesn't—and shouldn't—trust HMOs [*Are HMOs the Right Prescription?* 13 October]. Of course, the most appropriate care is often not the least expensive care. The most appropriate care for cardiomyopathy is often a heart transplant. The most appropriate care for advanced breast cancer is often a bone-marrow transplant. This isn't the least expensive care. It's cheaper to give only palliative care and to 'allow' the patient to die."

From a letter from a professor of philosophy at Brown University in *U.S. News & World Report* (10 November 1997)

A recent editorial in the *Los Angeles Times* notes that public "negativity" about the managed-care industry "could slow the expansion of managed care."... The editorial recommends that "HMOs would be wise to work on their image," specifically by endorsing "an industry-wide patient bill of rights."... It further criticized the HMO industry for launching a media campaign to turn public sentiment against such rights, noting that the message is not getting through.

Los Angeles Times (7 November 1997)

"We've got to do something to restore consumer confidence. Every time I go to dinner parties and say I'm an HMO executive, I get an earful ...We're getting nickeled and dimed to death by the Disease of the Month Club."

HIP executive David Abernethy, in referring to HIP, Kaiser Permanente, and the Group Health Cooperative of Puget Sound support of patient protections in the *Wall Street Journal* (17 November 1997)

"Employees need a choice of plans to encourage competition in the health-care industry.... But under current Federal law, states cannot force most large employers to provide such choices. Only Congress can impose these rules."

From a lead editorial in the *New York Times* (5 November 1997)

Say What?

A mock news release declares that in response to Justice Department antitrust charges, "Microsoft Corporation announced today that it will be acquiring the federal government."

Wall Street Journal (31 October 1997)

"This battle (over controlling fraud in Medicare) is really over differing answers to the question "How many CPAs can dance on the head of a syringe?" What's lost in all the bureaucratic and legal mumbo-jumbo is a fact that's far more damaging to our nation's health care system: It's too difficult for doctors to do their jobs well while at the same time coping with a proliferating web of fraud-fighting regulations."

Philip R. Alper, M.D. in the *Wall Street Journal* (5 November 1997)

"Are the AARP and other lobbies for seniors misrepresenting their members when these organizations oppose higher premiums for the affluent as a way to save Medicare? It certainly looks like it, judging from a recent poll by the *Los Angeles Times* that found the higher premiums were supported by 59% of respondents 65 or older and opposed by only 32%.

Charles Peters in the *Washington Monthly* (November 1997)

"The number of Americans living with diabetes has increased sixfold since 1958 to the highest level on record, and one reason is that people are too heavy."... The Centers for Disease Control and Prevention reported in late October that more Americans than ever before are suffering from diabetes, with the number of new cases averaging 798,000 annually.... Currently, 15.7 million people in the United States have diabetes, nearly 6% of the population.

Washington Post (31 October 1997)

Only in America: A convicted murderer, serving a life sentence in Massachusetts, told the *Boston Globe* that he would soon legally register an inmates' political action committee to dispense money to candidates and give the incarcerated a stronger voice in state elections. (Prisoners can vote in Massachusetts.)

Boston Globe (20 October 1997)

TIMOTHY B. NORBECK, Executive Director, Connecticut State Medical Society.

Letters to the Editor

Letters to the Editor are considered for publication (subject to editing and abridgement), provided that they are submitted in duplicate, signed by all authors, typewritten in double spacing, and do not exceed 1-1/2 pages of text (excluding references). They should not duplicate similar material being submitted or published elsewhere. Letters referring to a recent Journal article should be received within six weeks of the article's publication.

Board Certification Revisited

Letter to the Editor: The issue of board certification and its use by managed-care organizations to restrict the number of physicians admitted to their panels is a serious one. Though some aspects of it and possible solutions have been discussed recently in the literature,[1,2] there are several important components of this problem that warrant further consideration and action.

1. The American Board of Medical Specialties (ABMS) which oversees the 24 member boards that comprise our profession has made it very clear in the introduction to its directory that the boards were never meant to be used by any individual or organization to restrict physicians' abilities to practice.[3] It seems right that as the responsible parent board it should issue an official position statement corroborating this. Not doing so allows managed care organizations to continue to discriminate against the 90,000 American physicians that are not board-certified (about 1,500 in Connecticut). It is the responsibility of the ABMS to make managed care understand that the boards are voluntary examinations which some physicians take to demonstrate that they have passed a test whose standards are higher than those of the state. Much like a professional merit badge or a badge of honor, but that they were never meant to guarantee physicians' competence.

2. Our CSMS has not been vocal or forceful enough in speaking out against this issue. Some physicians who are not board-certified wonder why this issue has not been pursued more enthusiastically. I suspect that most physicians on our political committees are board-certified and not directly affected. Therefore they are not attacking it as vigorously as they should. Perhaps some physicians do not speak out because they believe that eliminating non-board-certified physicians' participation on managed-care panels protects their own financial interests. And there may be others who feel that having passed their boards, they have "paid their dues" and believe that their colleagues should fend for themselves. There may even be some board-certified doctors who believe that having the boards makes them superior to those who don't, and for that reason alone refuse to defend their colleagues. A fine state of affairs indeed if physicians have allowed their jealousies and turf battles and competitiveness to get to this stage! If so, then the profession has a more serious morale problem than most of us imagined and it just might be impossible to rally and break managed care's grip. Those who are not board-certified need to see a show of concern from those who are. And besides, what example are we setting for medical students and residents? What must their impression be of a generation of physicians who cannot muster enough courage to defend their colleagues when they need them the most?

3. It is not entirely unreasonable that managed-care organizations may require some new type of certification. Whatever form is finally decided upon for these certifications is still unknown. But if new ones are developed they should eliminate the inefficiencies of the current ones. For example, some recertifying examinations are quite expensive. Some doctors recently received their applications for recertification in Family Practice. The examination fee is a hefty 700 dollars.[4] That, and losing a day or two from the office, traveling to another city, and paying for hotel accommodations, will eventually end up costing some of them a few thousand dollars. The time and money and inconvenience involved is considerable. But some of these problems could be solved easily. For example, boards or other new certifications that are introduced could be given in the communities where physicians practice, preferably in their local hospitals. This alone would be a tremendous time and energy-saving convenience.

In summary, using the boards to discriminate against physicians is mean-spirited. It is wrong in principle and no amount of rationalization will ever make it right. Unfortunately the American Board of Medical Specialties has been silent on this issue. Therefore it is the responsibility of the Connecticut State Medical Society to bring it to our legislators.

Edward J. Volpintesta, M.D.
Bethel

[See related resolution, p. 808.—ed.]

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1. Kassirer JP: The new surrogates for board certification: What should the standards be? *N Engl J Med* 1997; 337:43–4.
2. Smoak, Jr RD, Heyman JM, Nelson AR, McCartney RD, Madlon-Kay DM, Volpintesta EJ, Kassirer JP: (Correspondence) Accreditation and certification. *N Engl J Med* 1997; 337:857–9.
3. The Official ABMS Directory of Board Certified Medical Specialists: 1997 Published by Marquis *Who's Who*. A division of Reed Elsevier, Inc. 121 Chanlon Road, New Providence, New Jersey in cooperation with the American Board of Medical Specialties, 1007 Church Street, Evanston, Illinois; pp xiv-xxi.
4. American Board of Family Practice: Recertification preapplication information booklet: 1998 recertification examination: Friday, 10 July 1998. Table of contents.

From the Executive Director's Office

SUMMARY OF PROCEEDINGS
CSMS HOUSE OF DELEGATES — SEMI-ANNUAL MEETING
RAMADA INN, MERIDEN—12 NOVEMBER 1997

Reports and Addresses

The House received reports, addresses and/or remarks from the president, the Council, the AMA Delegation, the executive director, Connecticut Medical Political Action Committee (COMPAC), Connecticut Medical Insurance Company (CMIC), and CSMS-IPA. Most of the reports were published in the Handbook previously distributed to the delegates. The report of President Dr. Stanley J. Keating, Jr. and of Executive Director Tim Norbeck appear elsewhere in this Journal.

PRINCIPAL ACTIONS TAKEN

(a) *Report of the President,* Stanley J. Keating, Jr., M.D., Hartford. Dr. Keating gave a comprehensive report based on the Revolution in Medicine and how CSMS can help physicians respond to it and how CSMS itself should respond to today's challenges and changes. The report appears in its entirety in this issue of *Connecticut Medicine* as the President's Page. The report was accepted as information.

(b) *Report of the Council,* Joseph S. Sadowski, M.D., Hartford. The House voted to accept, as information, the report of the chairman of the Council, which reviewed the activities of the Council since the last meeting of the House of Delegates. Minutes of the interim Council meetings have already been published in *Connecticut Medicine*. Special emphasis was given to the reports from related organizations such as MD Advantage, CMIC and CSMS-IPA; the various reports given at each meeting by the president, the executive director, and the chairman of the Committee on Legislation. The Council reported its approval of the "Principles of Cooperation in Medical-Legal Matters" which were developed by the Liaison Committee with the Connecticut Bar Association. The Council also submitted a budget for 1998 and the action taken on the Council's recommendation also appears elsewhere in this summary.

Because of the resignation of Jerome K. Freedman, M.D., the Council elected Frank J. Scarpa, M.D., Greenwich, AMA Delegate to fill the unexpired term of Dr. Freedman. In accordance with CSMS bylaws, the House voted to approve this appointment.

(c) *Report of AMA Delegation,* Edward A. Kamens, M.D., Fairfield. The House voted to accept the report of the AMA Delegation as information. The report contained the principal actions taken at the 1997 Annual Meeting of the AMA House of Delegates. It was reported that the restructuring of the AMA had begun and that the term of office of members of the Board of Trustees has been expanded to four years and limited to two terms. Legislative high points were discussed and Connecticut was singled out for what it has been able to achieve on issues of interest to physicians in the Connecticut Legislature.

Over 400 resolutions were reviewed dealing with such topics as managed care, delays in payment, not notifying the physicians under the capitation system when patients have been added to their list, funding for insurance and individual ownership of insurance assisted living, medical care for legal immigrants, laboratory studies, rural health care, modification of antitrust regulations, campaign finance reform, medical records, development of universal CPT coding, if possible, etc.

(d) *Executive Director,* Mr. Timothy B. Norbeck, New Haven. The House voted to accept the report of the executive director as information and it appears in its entirety at the conclusion of this summary.

(e) *Connecticut Medical Political Action Committee (COMPAC).* Roger S. Beck, M.D., Wethersfield, chairman of the Connecticut Medical Political Action Committee, gave an update on the current status of COMPAC. He reported that membership has decreased from 712 to 608. This is less than 10% of the membership. COMPAC provides various levels of support to candidates who are supportive of organized medicine's issues. COMPAC-sponsored Legislative Guides were sent to every member of CSMS to utilize during the state and federal legislative sessions.

(f) *Report on Connecticut Medical Insurance Company, (CMIC).* Sultan Ahamed, M.D., president and chairman of the Board of Connecticut Medical Insurance Company (CMIC) reported the following:

1. CMIC's Board of Directors declared CMIC's seventh consecutive and largest policyholder dividend ever of $2.5 million. The 1998 dividend distribution will result in at least an 8% premium credit for most CMIC members. The dividend is applied as a premium credit to members at renewal in January. Combined policyholder repayments now total 20.0 million.

2. In 1998, members in some risk classes will see a modest rate increase, others will have their risk class reduced and some members will see no change at all.
3. It was noted that some members look at the premium and go on to other companies, however, what they lose sight of is the claims staff's presence and strong support throughout the claims resolution process, but especially at the time of trial. Physicians have expressed their appreciation of this support.
4. CMIC has established a relationship with 16 law firms in Connecticut and several in contiguous states. All firms are reviewed for suitability and each has confirmed that they do not sue physicians for medical malpractice.

(g) *Report on CSMS-IPA:* Dr. David D. Thompson, Jr., M.D., president, reported on current activities of the IPA and his complete report appears at the end of this summary.

(h) *1997 Budgets:* The House voted to approve the operational budget, a capital budget and a Physician Health and Education Fund Budget. The dues will remain at $390.

(i) *New Business:* The following individuals were granted the privilege of the floor.

1. Craig C. Czarsty, M.D., Oakville, made a presentation on Physicians Care for Connecticut, Inc., a statewide physician-owned and directed insurance company licensed as an HMO. Presently the company is a wholly-owned subsidiary of MedServe of Connecticut, Inc. Copies of the prospectus were distributed to the delegates.
2. Michael M. Deren, M.D., New London, gave a brief report on the CSMS MSO, M.D. Advantage, and introduced Mr. James Darnell, the CEO of M.D. Advantage.
3. Mr. James Darnell, CEO of M.D. Advantage reviewed for the delegates two key findings of the CSMS feasibility study. First, physicians did not have extra money to invest or financially support HMOs, IPAs, MSOs, or other ventures. The CSMS MSO has taken this into consideration and has identified a strategic partner that has totally funded the project. The second issue that arose from the feasibility study was that physicians wanted to remain independent, therefore, purchasing services from the CSMS MSO as opposed to being acquired—at best they wanted a strategic partner that could provide contracting expertise, management information system capability, and management. He stated that the CSMS M.D. Advantage mission is to develop and operate sustainable health-care delivery systems.
4. Joseph Zeppieri, M.D., Groton, associate councilor from New London County, brought to the attention of the House a recent accident that took the life of Dr. Mark E. Quigley of Suffield, vice-president of ambulatory services and chief of the emergency department at Johnson Memorial Hospital in Stafford. Dr. Quigley was hit by a car on his way to aid a car accident victim. It was voted to commend Dr. Quigley for his exemplary act and to inform his family of this commendation.

(j) *Twelve resolutions were adopted, some with amendments and are published herewith:*

Minimizing the Time It Takes Managed-Care Companies to Credential/Recredential a Physician
(Introduced by Fairfield County Medical Association)

RESOLVED, that the Connecticut State Medical Society shall seek passage of a bill that would require all managed-care companies to complete the credentialing/recredentialing process, and inform the doctor of its decision concerning acceptance/re-acceptance, within 90 days after certified receipt of applicable documentation from the physician.

Dangers Caused by HMO Drug Formularies
(Introduced by Fairfield County Medical Association)

RESOLVED, that the Connecticut State Medical Society advise the Legislature of the confusion and dangers caused by HMOs compelling doctors to use only drugs listed in the HMO's formularies because potentially it endangers patients' health; and be it further

RESOLVED, that the Connecticut State Medical Society convince the Legislature of the urgent necessity of preventing HMOs from coercing physicians into utilizing only the approved drugs on the HMO formularies; and be it further

RESOLVED, that CSMS restate the principle that physicians are responsible for optimal patient care; that mandatory HMO formularies undermine such care; that CSMS supports legislation to prohibit mandatory formularies.

Prohibit HMOs from Using Board Certification as a Singular Criterion for Nonacceptance on its Provider Panel
(Introduced by the Fairfield County Medical Association)

RESOLVED, that the Connecticut State Medical Society shall, through its Legislative Committee, seek legislation to prohibit HMOs from using board certification (or board eligibility) as a criterion for rejecting or terminating physicians from its physician panels.

Payment for Physician Case Management Services
(Introduced by Fairfield County Medical Association)

RESOLVED, that the Connecticut State Medical Society refer to the Liaison Committee with Medicare the appropriateness of automatic refusal by the Medicare intermediary to pay for case management services and

other CPT-coded services for which there is now no recompense unless the physician provides detailed documentation describing the nature of the service.

Lengthen the Duration of the House of Delegates Meeting

(Introduced by Fairfield County Medical Association)

This resolution proposed to extend the House of Delegate' meeting to a full day. The House was informed that a survey was currently being made seeking comments from the delegates concerning various aspects of the House of Delegates' meeting. It was voted to refer this resolution to the Council until the study was completed and report back to the House of Delegates at the annual meeting in 1998.

PAP Smear as a Clinical Laboratory Test

(Introduced by Stephanie Wain, M.D., President, Connecticut Society of Pathologists)

RESOLVED, that the American Medical Association seek from the Health Care Financing Administration and managed-care groups reclassification of Pap smear screening as a medical consultation; and be it further

RESOLVED, that the AMA seek to remove Pap smear screening from categorization as a clinical laboratory test and seek exclusion of Pap smear screening from clinical laboratory bids proposed by managed-care groups, and be it further

RESOLVED, that the Connecticut State Medical Society House of Delegates supports the concepts in the above resolutions and refers them to the AMA delegation for support at the December 1997 meeting.

Guidelines for Review of PAP Smears in the Context of Litigation

(Introduced by Stephanie Wain, M.D., President Connecticut Society of Pathologists)

The Connecticut State Medical Society supports the concerns expressed in the following resolution and referred it to the AMA delegation.

RESOLVED, that if the Pap smear is to continue as an effective cancer screening procedure, it must remain widely accessible and reasonably priced for all women, including, those with low incomes and those at high risk.

RESOLVED, that the finding of a false negative smear is not necessarily evidence of practice below the standard of care. Whether a false negative smear is the result of negligence must be judged not only on the basis of the individual result, but also in the context of overall laboratory performance on Pap smears.

RESOLVED, that disputed cases of atypical cells of undetermined significance (ASCUS/AGUS) are not likely to represent reasonable grounds for allegations of practice below the standard of care.

RESOLVED, that Pap smear slides being assessed for possible litigation should be reviewed without knowledge of clinical outcome. This review should stimulate the normal screening situation as closely as possible. This may be accomplished as a screening process including the contested case as one of a number of Pap smears representing a variety of disease states. Review with knowledge of subsequent development of carcinoma biases the objectivity of the review and does not reflect standard practice.

RESOLVED, that a court reviewing the qualifications of proffered physician-witnesses should consider or utilize these prerequisite criteria:

1. The physician maintains a current and unrestricted license to practice medicine in his/her state of practice; and
2. The physician is certified by the appropriate ABMS specialty or subspecialty board, and is fully trained in the practice of cytopathology; and
3. The physician is knowledgeable in the practice of cytopathology as indicated by years of practice experience, current up-to-date continuing medical education, and active engagement in the practice of cytopathology.

Professional expert witnesses who do not have significant experience in cytopathology are not qualified to express an expert opinion on the standard of care.

RESOLVED, that the standard of care should be that of the reasonable and prudent practitioner. Courts should recognize that a false negative result is not sufficient proof of negligence. Rather, they should look to whether the overall Pap smear practices of the laboratory meet the standard of care.

RESOLVED, that compensation of the physician-witness should reasonably reflect the time and effort expended by witness in preparation, depositions, and trial.

Compensation of a physician-witness contingent on the outcome introduces the possibility of bias and should not be permitted.

Education of Medicare Patients Concerning Previously Covered Medicare Services

(Introduced by Fairfield County Association)

RESOLVED, that the Connecticut State Medical Society, through its AMA delegation, recommend that AMA strongly suggest to HCFA that when it eliminates Medicare coverage for services, that an effective mechanism be utilized by government to inform the public, (ie, letter to beneficiaries, notices in newspapers, etc.) about changes in the Medicare program; particularly those making patients responsible for paying for such services.

Reaffirmation of the "Fairness for Patients" Policy

RESOLVED, that the Connecticut State Medical Society shall reaffirm medicine's strong conviction that HMOs

should not be allowed to persist in the practice of limiting their provider panels and thereby limiting patient choice, by not accepting all physicians who otherwise meet the credentialing criteria of the HMO, and, agree to abide by the plan's policies and procedures.

Physician Supervision of Nurse Practitioners
(Introduced by Fairfield County Medical Association)

RESOLVED, that the Connecticut State Medical Society strongly supports any initiative to ensure that Advanced Practice Nurse Practitioners continue to provide care under physician supervision and in collaboration with physicians. The Connecticut State Medical Society opposes unsupervised practice of patient care by Advanced Practice Nurse Practitioners and supports adequate physician supervision of Advanced Practice Nurse Practitioners.

Prohibiting HMOs from Using Financial Incentives to Induce Physicians to Adhere to Their Policies for Treating Patients
(Introduced by Edward Volpintesta, M.D., Delegate from Fairfield County Medical Association)

It was voted to refer the following resolution to the CSMS AMA Delegation with the recommendation that they review and investigate this policy and report back to the next House of Delegates meeting with any recommendations.

RESOLVED, that the Connecticut State Medical Society shall rescind its adoption of House of Delegates policy 285.982 (3) of the American Medical Association; and be it further

RESOLVED, that the Connecticut State Medical Society shall publish a position statement making it clear that it opposes the use of any and all financial incentives (ie, withholds, capitation, bonuses, etc.) by HMOs and other insurers which can adversely influence how doctors render patient care and be it further

RESOLVED, that the Connecticut State Medical Society shall transmit for similar action by the House of Delegates of the American Medical Association a copy of this resolution opposing the use of any and all financial incentives by HMOs and other insurers which can adversely influence how doctors render patient care.

Creation of CSMS Managed Care Patient Advocacy Committee
(Introduced by the Middlesex County Medical Association)

RESOLVED, that the Connecticut State Medical Society establish a managed-care patient advocacy committee with the following functions:

—To act as an advisor to physicians in the appeals process created by a substitute House Bill #6883, as amended.
—To expedite quality, access, and fairness.
—To engage the Department of Insurance and the Department of Public Health of Connecticut to work in concert with the CSMS to assure physician input into implementation of House Bill #6883.
—To receive, collect and research information concerning problems within the managed-care industry.
—To report to the House of Delegates/Council when appropriate.

AWARDS
CSMS PAST SERVICE AWARDS TO OFFICERS AND COUNTY COUNCILORS

Officers

John P. Bigos, M.D., New London, Secretary, 1995–1997
Sultan Ahamed, M.D., Norwich, Vice-Speaker of the House of Delegates 1995–1997
Jerome K. Freedman, M.D., Princeton, NJ, Delegate to AMA, 1983–1997
Dickerman Hollister, Jr., M.D., Greenwich, Councilor-at-Large, 1996–1997

Councilor

Fairfield County
Stuart B. Mushlin, M.D., Stamford, Councilor, 1994–1997

Address of the Executive Director

CSMS House of Delegates—Annual Meeting
12 November 1997

TIMOTHY B. NORBECK

FEW people in the world will forget that depressing and tragic week that began some 73 days ago on August 31, with Princess Diana's death, and which ended with her funeral on September 6. Two other world notables also died that same week. Almost lost in Diana's tragedy were the deaths of Victor Frankl, Nazi concentration camp inmate No. 119104 on September 2 and Mother Teresa on September 5.

Known as the "Saint of the Gutters," Mother Teresa was known to all for her almost 50 years of devotion to the poor, destitute and dying, and her funeral did receive some attention.

But Viktor Frankl's death almost went unnoticed. The Austrian physician's contributions were different but very meaningful. His *Man's Search for Meaning* was named one of the most influential books in America by the Library of Congress. Though as a Viennese Jew he was certain to be sent to Auschwitz, Dr. Frankl let his American visa lapse in order to remain with his parents. He was sent to Auschwitz and Dachau from 1942 to 1945 and saw his mother, father, and pregnant wife killed in the death camps.

Viktor Frankl gained his fame from his writings of those experiences and of his courage in helping people find a reason to live and survive the atrocities. A trained medical scientist and observer of human health, he found that it was not the prisoners who were physically the strongest who remained the healthiest. Instead, it was those who tried to help others, those in whom kindliness and generosity prevailed. Whatever their size and physical constitution, it was they who turned out to be the durable ones.

Service above self must be why all of you were able to complete your arduous training and fulfill that special covenant with your patients.

I choose to remember Dr. Frankl for his inspirational words that "Everything can be taken from man except the last of the human freedoms, his ability to choose his own attitude in any given set of circumstances—to choose his own way." He also made us think of the plight of those who have enough to live on, but not enough to live for—those who seem to have the means, but no meaning.

In the recent Balanced Budget Act of 1997, federal lawmakers didn't bat an eyelash in reducing the growth of Medicare outlays by $115 billion between 1998 and 2002, with a great majority of it, of course, coming from those who give the care. And home health expenditures will be shifted gradually from Part A to Part B, artificially saving Medicare from bankruptcy for a few more years while still another commission studies the problem. And when Part B expenses rise dramatically because of that home health transfer, guess who once again will be blamed for it—that's right, the nation's physicians.

And the most ridiculous gaffe of all—in an attempt to supposedly offer Medicare patients more options, physicians will be allowed to contract privately with them, but only if they do not bill Medicare for any patients for two years. Of all the perverted attempts to give patients more choices, that one takes the cake. It's an embarrassment to the Congress and Administration and also reveals a blatant distrust of physicians. AMA is working to make the option a real one, but the legislative road will be difficult.

Physicians can relate to the story of the successful businessman who was on his deathbed. He called in his best friend and arranged with him to have his mortal remains cremated. The friend agreed, than asked, "What do you want me to do with the ashes?" The dying man said weakly, "Put them in an envelope and send them to the IRS. Tell them, 'Now you have everything!'"

Let us use our adversaries to make us bolder. To be a major player in this age of health-care giants, physicians must become giants, too. Our new CSMS MSO, MD Advantage, is one way of accomplishing that.

We should be grateful for the challenges and the many bumps in the road, for they strengthen our resolve to fight those who seek to subjugate you.

When Gladstone was prime minister of England, there was one road where more horses died than any other road. Gladstone ordered a study of it and discovered that the road was the only one in England that was perfectly straight and level. The horses traveling this road used only one set of muscles and the rest atrophied. When an attempt was make to use any of the unused muscles, the strain was

too much and the horses died. It was the lack of challenges, the absence of physical and mental stimulation that killed them. We're lucky—our "horses" don't have a life of ease, sameness, and boredom.

We must believe that we can win the physician autonomy battle. We must remember that it is difficult to attain anything if you think you can't. An elephant can easily pick up a one-ton load with its trunk. How is it then that, at the circus, those huge creatures stand quietly tied to a small wooden stake? The reason, of course, is that while the elephant is still young and not so strong, it is tied by a heavy chain to an immovable iron stake. He tries to break the chain but soon discovers he can't—as he grows and becomes stronger, he never again tries to break loose because he *thinks* he can't. Many people behave like elephants—they remain restrained in thought and action all their lives—they never move further than their boundaries of self-imposed limitations.

One bond should unite us all—and that is to win back physician autonomy. Some may scoff at such a lofty goal, but then again, who thought that it was possible to attain an external binding appeals process in the Insurance Capitol of the World? As Theodore Roosevelt said: "The best prize that life offers is the chance to work hard at work worth doing."

Speaking of work, I read recently that the teenage employee's work ethic is worse than a decade ago, according to 58% of U.S. employers polled by Reid Psychological Systems. It reminds me of a story about a congregation that had had the same pastor for many years. When he finally decided to retire, they interviewed for a replacement. They soon found that the younger candidates had very different ideas on the pastor's duties from those of the older generation. Finally they found a bright young man to lead them spiritually into the next century.

The new pastor made many changes which resulted in budget increases. One of the changes was to hire a man to take care of the extensive church lawn and grounds. Concerned about this new and unexpected expense, the budget committee decided it was time for a talk and called the new pastor in for a meeting.

"We see that you have hired a man to take care of the church grounds," they began. "Indeed I did," replied the young pastor, "and he does a fine job of it, too."

"Yes, he does," replied the budget committee spokesman, "but we wondered if you knew that our previous pastor took care of the grounds himself?"

"Yes, I did know that," said the young man. "And?" prompted the spokesman. "And I called him," replied the young pastor, "but he doesn't want to do it any more."

Some 57 years ago, back in 1940, Walter Lippman described the challenges facing Americans by saying, "You took the good things for granted, now you must earn them again. For every right that you cherish, you have a duty which you must fulfill. For every hope that you entertain, you have a task that you must perform. For every good that you wish to preserve, you will have to sacrifice your comfort and your ease. There is nothing for nothing any longer!"

I would add one more line to those words which still apply today. If you want to take back the system—to be in charge again—you must put aside your differences and support those who support you. If you haven't joined COMPAC/AMPAC this year, please contribute your $100.

I was reading an Illinois State Medical Society newsletter the other day where the president, Dr. Jane Jackman, was admonishing her colleagues because *only* 40% of Illinois physicians were members of the PAC. Our membership has never been higher than 10% and now is an abysmal 7%. If you haven't joined, please use the contribution envelope at your seat. Believe me, it will make a difference.

Three weeks ago at a New Haven University managed-care symposium, AMA President-Elect Nancy Dickey did a superb job in keynoting it, and Dr. Shep Nuland, a member of *Connecticut Medicine's* editorial board and Literary Editor, gave a riveting speech. I was on a panel with Toni Harp—an energetic and articulate state senator from New Haven. All panelists were asked to submit to the moderator a short bio for use in an introduction. Senator Harp's introduction, and we should make note of it, was that she was the recipient of the Connecticut State Medical Society's distinguished legislative service award. Our award to her for outstanding work on managed-care reform obviously meant a great deal to her. We are making significant progress.

Physicians are going to take back the system. Why am I so confident, you might ask? Because you deliver the care. You direct 85% of all health-care spending. You are trusted by your patients far more than insurance representatives are. You enjoy the confidence of your patients, and your influence will only increase as more health plans become more patient-driven. All the polls confirm this.

Why am I so confident that doctors will take back control?

I'm confident because AMA Board Chair Tom Reardon recently addressed 100 CIGNA Medical Directors in Washington, D.C., took the hard AMA line on managed-care reform, answered questions for an hour and was warmly received. He was followed at the podium by California Congressman Pete Stark—not exactly considered a friend of medicine, as you know—who told that audience that "physicians need to gain back control of the health care system."

I'm confident because a new Louis Harris poll reported that in August, 44% of the American public said the move

toward managed care is a good trend, compared to 59% in 1995. Another 44% said the trend was bad, up from 28% in 1995. Additionally, 33% said they thought managed-care growth would improve the quality of care, while 54% said it would harm quality. The public is listening, the tide is turning, and while managed care will undoubtedly survive, it won't in its present form.

I'm confident because even *USA Today* came out two weeks ago and acknowledged that the health-care pendulum is swinging toward consumer rights. "There will indeed be some new expenses," it said. "But those costs are alternately essential, inevitable, or defrayable. None are intolerable."

I am confident because recently three HMOs, along with the AARP and Families USA, announced their agreement on principles for patient protection. They seek 18 broad reforms. More HMOs and organizations are bound to join that effort.

I am confident because of physicians like Dr. Mark Quigley, who died so tragically while coming to the aid of an injured motorist, so willingly help their fellow men and women even outside of their practices.

I am confident because the Kaiser Family Foundation/ Harvard University National Poll, released one week ago today, revealed that a majority of the public believes that managed care has decreased the quality of care for people who are sick. Kaiser Foundation President Drew Altman said that "managed care is winning in the health-care marketplace, but it is in danger of losing the battle for public opinion."

I am confident because states have passed 182 managed-care reform bills, up from 100 in 1996—including our wonderful victory in Connecticut. And this is just the beginning.

A beginning better than the one experienced by the lawyer who died suddenly, and found himself waiting in line before the pearly gates to begin his afterlife. Finally his turn came and he faced St. Peter, who said to him, "Well you seemed to have passed the preliminaries; now to get into Heaven, you just have to spell a word correctly."

"What's the word?" he asked. "The word is LOVE." "L-O-V-E" spelled the lawyer. "O.K., you're in," said St. Peter as he opened the gate. At that moment a loud alarm sounded, and St. Peter said, "That means there's an emergency somewhere in Heaven and I have to go check it out. Would you mind staying here at my post for a few minutes until I get back?" "Not at all," replied the lawyer. "If a soul comes up from earth, just do what I did."

No sooner had St. Peter left when the lawyer saw a woman approaching the gates, and recognized his wife standing before him. "Mabel, what are you doing here?"

"Oh, George, I was so shocked when you passed away, I guess I died of a broken heart. But at least, my darling, we'll be together for all eternity. How do you get the gates open?" she asked. "All you have to do is spell one word," said George, "and you're in." "Well, what's the word?"

He paused. "Czechoslovakia."

I have had the opportunity recently to read the latest book by our own Dr. Shep Nuland, and I commend it to your reading. In the book, *The Wisdom of the Body*, Dr. Nuland explains in the most wonderful way why it must be so satisfying to be a physician. On page 23, he describes the euphoria he felt after saving the life of a 42-year-old who had suffered an from a ruptured aneurysm of the splenic artery. In that passage, Dr. Nuland writes that "Something within me wanted to sing and shout, to acclaim my triumph to the heavens and the ages—a woman's life had been saved, and I would always remember the wonder of this night."

What a marvelous expression and feeling: "the wonder of this night." Whether *you* have saved someone surgically or through a timely diagnosis, every physician in this room has had his or her own "wonder of this night"—perhaps every day where you impact the lives of your patients in so many different meaningful ways.

There is too much to fight for—too many reasons to stand up for those future wonders of the night—for you and those who follow in your footsteps—to ever give in to those who would compromise good patient care.

Our managed-care reform package is a wonderful beginning—but that's what it is—a beginning. We need to take back the system, to put physicians back in charge again. There is a steep price to be exacted for that, however. It requires physician unity and strength, hard work, political action and even patient involvement.

Fifty years from now, there may not be HMOs or managed-care organizations. Fifty years from now, there may not be insurance companies. Fifty years from now, there may not be hospitals as we know them. But I would remind our adversaries, those who would sacrifice care for cost, that 50 years from now, there will be patients, and there *will* be physicians to care for them.

In closing, as the French writer Victor Hugo said: "The true leaders move forward through the storm. The air becomes difficult to breathe. The abyss yawns beneath them. Some fall. Others stop and retrace their steps; theirs is a sad weariness. The bold ones continue. They are eyed by eagles; the lightning plays about them; the hurricane is furious. No matter, they persevere."

Or put in different words by George Bernard Shaw, who made this observation about circumstances:

"I am tired of people who blame everything on the circumstances. I don't believe in circumstances. If the circumstances don't suit you, then make up your mind to get up and change those circumstances so that they will."

This is what your CSMS is all about.

CSMS-IPA, INC.
CONNECTICUT STATE MEDICAL SOCIETY
6 Divine Street • North Haven, Connecticut 06473-2174
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REPORT TO THE HOUSE OF DELEGATES OF THE CSMS
DAVID D. THOMPSON, JR. M.D.
PRESIDENT, CSMS-IPA
NOVEMBER 12, 1997

MERGER WITH PHS

Foundation Health System, the parent company of M.D. Health Plan, has purchased PHS. There have been procedural problems with the completion of the sale and the preparation of the prospectus that needs to be mailed prior to the consummation of the deal. However, when completed, medical management will be entirely under the control of Vincent Catrini, M.D., our Chief Medical Officer. Vince will retain this role and title in the new company. CSMS-IPA will be the IPA for all members of the new company. The combined membership of PHS, MD Health Plan and some Foundation Health System PPO members will exceed 600,000 on January 1, 1998. All members will be seen through the CSMS-IPA, a wholly owned subsidiary of the CSMS.

All present CSMS-IPA physician providers will be able to see all members of the new company. No additional applications or paper work is necessary. All present providers of PHS who are not providers with the CSMS-IPA will be allowed to join, and the membership fee will be waived during the transition period. To see any of the members after a brief transition period will require the physician to be a member of the CSMS-IPA.

All policies and procedures will be the present policies and procedures of the CSMS-IPA. The Board of Directors of the CSMS-IPA, composed entirely of practicing physicians representing the County and State Medical Societies, makes all the decisions with regard to fees, utilization, etc. We have total control, but we have to live within a budget.

UTILIZATION

The CSMS-1PA commissioned Milliman and Robertson to evaluate our overall utilization. They found that our imaging expenses were almost double what they should be on a per member per month basis. After extensive interviews and presentations, National Imaging Associates was selected to help with our overutilization problems. Initially, they will be credentialing all imaging providers. Some small scale providers may not be providing the quality necessary to meet the standards we have set. We are also reassessing our laboratory costs. Physician performed tests will soon be paid at a level equal to hospital labs. We expect to continue our present lab provider network but at a reduced cost to the IPA.

CONSULTING ARRANGEMENTS

The Executive Committee of the IPA has been charged with interviewing consulting firms with the intention to have expert help in evaluating and correcting our present operations. We have already heard from several excellent candidates and will be making our recommendation to the Board of Directors at a special meeting on November 3.

In addition to making recommendations for our future undertakings, one main goal will be to integrate a new infrastructure into our organization. The rapid increase in size requires more full time oversight. We will be selecting an Executive Director, and additional support staff to make our operations more effective.

CONNECTICUT'S ONLY STATEWIDE IPA

Book Review

The Wisdom of the Body
by Sherwin B. Nuland, xvi 379 pp, index
New York, Alfred A. Knopf, Inc. 1997
$26.95 ISBN 0–679–44407–6

It is impossible to encapsulate in a few words what Dr. Sherwin Nuland has achieved in 370 pages of carefully crafted prose in *The Wisdom of the Body* a title in the tradition of Starling, Cannon, and Sherrington. Clearly, he has duplicated the success he attained several years ago with *How We Die,* and has again provided the general (nonscientific) public an understandable, colorful, and insightful analysis of human biologic events. It is an added benefit to us that he is a member of our Society and an editor of this journal.

At one level this is a human biology and physiology text for laymen which describes the molecular and cellular basis of life; the intricate workings of most of the major organ systems; the continuum of genetics, reproduction, fetal development, and parturition; and the manner in which the brain and nervous system relate to bodily as well as intellectual function. Fortunately, Dr. Nuland has the rare gift of explaining such profound things in straightforward, comprehensible terms.

At another level this is a poetic celebration of the wonders of the human body in all the intricacy, feedback loops, homeostatic mechanisms, and fine balance that is the "Wisdom" that keeps the whole organism functioning normally in the face of assaults of many kinds. It is the body's instability and adaptability that creates stability. He makes this modern reductionist biology fascinating and entertaining reading by illuminating it with dramatic examples from his own long surgical career, which are often described from the patient's perspective in the patient's own words.

At a third level Nuland makes the strong argument (that reflects his own philosophic position) that it is the elegance of the complex integrated systems of the body that is the basis for the abilities and achievements of man that go far beyond those of any other species. He refers to these achievements collectively as the products of the "Human Spirit" and they include the higher order activities like abstract thought, reason, judgement, emotion, and artistic expression which have enabled the creation of cultures and civilizations. He sees the biologic systems and the "human spirit" as a continuum, without the need for invoking any duality between body and mind or spirit.

Nuland's storytelling ability, his feel for words, and his autobiographical use of clinical examples are important strengths, as is his ability to describe a physiologic phenomenon in lay terms and to dissect a term and trace its etymology. His colorful language, such as describing a GI problem as an "execrable rectal epic," adds to the joy of reading his prose. So does his vivid use of images, as when he describes the limbic system by relating how the fleeting recollection of a fragrance evoked memories of his mother's goodnight kiss, her perfume, and the security she represented when he was a very small boy. I was occasionally distracted from my attention to a theme under discussion by his extended descriptions of surgical procedures, and periodically I squirmed when he described intimate personal events from his own life. But, it is this intensely autobiographical approach that enables him to convey as well as any author what it is like to reap the joys, experience the sorrows, and bear the burdens of being a physician.

Why should physicians read this book? First, for the sheer pleasure of being exposed to the fine writing of a colleague; second, for an excellent current, biomolecularly based review of human biology; third, as a guide for discussing bodily phenomena with patients in understandable terms; and fourth, as a reminder of the remarkable nature of our human biology, and the heights to which the "Human Spirit" is capable of rising.

Finally, one doesn't often experience visceral feelings while studying human biology, but reading this book evoked in me the same romantic thrill of discovery of biologic mysteries that I remember as a youngster while reading authors like Paul deKruif. This volume ought to create excitement, wonder, and inspiration, even in jaded physicians.

C.F. Hinz, Jr., M.D.
Avon

Consumer Concern Or Complaint Form Regarding Group Or Individual Health Insurance Including Managed Care Plans

To Be Submitted To
THE CONNECTICUT DEPARTMENT OF INSURANCE
CONSUMER AFFAIRS DIVISION
P.O. BOX 816
HARTFORD, CT 06142-0816

Phone: (860) 297-3900 or 1-800-203-3447 Fax: (860) 297-3872

The Consumer Affairs Division of the Department of Insurance receives, reviews and responds to complaints and inquiries from state residents concerning insurance related problems. The staff examines each complaint to determine whether statutory requirements and contractual obligations within the commissioner's jurisdiction have been fulfilled. The Consumer Affairs Division coordinates the resources available within the Department to address consumer complaints.

In order for the Division to pursue a formal review of a concern or complaint, the consumer must submit a written explanation to the address listed above with as much pertinent detail as possible. Each written submission to the Consumer Affairs Division will be acknowledged.

Name of person filing the concern or complaint:

_____

Address: _____

Phone where the Department can contact you: (____) _____

This concern or complaint concerns the following Insurance Company or Managed Care Plan: _____
Policy Number: _____
Name of Policyholder: _____
Name of Enrollee: _____
Name of Patient: _____
Patient is ___ self ___ dependent ___other (explain)_____

The following is a detailed description of the concern or complaint:

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CSMS PHYSICIAN PLACEMENT SERVICE

The Society maintains the Physician Placement Service as a *free* service to the medical profession, hospitals, and communities in Connecticut.

***Opportunities* should be typed, double-spaced copy on letterhead and submitted to CSMS, Physician Placement Service, 160 St. Ronan Street, New Haven, CT 06511 (203) 865-0587 or fax to (203) 865-4997. These will be published as space permits and will be distributed to physicians making inquiries of such *opportunities*.**

***Physicians wishing to locate* in Connecticut may call the office requesting opportunities in their specialty. Also, candidates are invited to submit a resume to be kept on file with the Society. An announcement of a physician's availability will be published in two issues of *Connecticut Medicine* as space permits.**

Listing of physicians in the Placement Service does not in any way represent certification by the Society. Investigation of credentials and experience is the responsibility of those seeking applicants for positions.

Announcements on the Physician Placement Service page under Classified Advertising are charged at the regular Classified Advertising rate.

OPPORTUNITIES FOR PRACTICE

DERMATOLOGY

Busy modern office in Eastern Connecticut shoreline seeks third dermatologist full- or part-time. Excellent clinical and surgical skills a prerequisite. Send CV to: Eastern Connecticut Dermatology, 491 Gold Star Hwy., Ste. 310, Groton, CT 06340 or fax to (860) 445-1665.

FAMILY PRACTICE

Tired of the rat race? Licensed physicians (M.D./D.O.) needed for full- and part-time. No nights, no call, no hospital responsibility, no weekends. Full-time: paid vacation and CME time, malpractice insurance. Must be credentialable by most health insurance carriers. Send CV to: FP/RH c/o CSMS.

GENERAL PRACTICE

Northeast's largest and growing occupational screening practice seeks GP. This is a non-traditional (mobile) environment involving well-care examinations for industrial workers for OSHA compliance purposes. Excellent opportunity for physician seeking a change from straight medicine. Position shall mature into Medical Directorship as practice grows. Extensive travel throughout the Northeast is required. Excellent income and benefits package. For more information, send CV to the attention of Christopher A. Crowne, Mobile Medical Testing Service, 71 W. Dudleytown Rd., Bloomfield, CT 0600.

INTERNAL MEDICINE

Physician-primary care-residency manager, Griffin Hospital, Derby. HPSA. A major affiliate of Yale University School of Medicine. Excellent opportunity for academically-oriented individual, minimum requirement three years internal medicine residency. ABIM certification preferred. Title of Clinical Instructor in Medicine at Yale given. Send CV to: Dr. Vincent A. DeLuca, Jr., Chairman, Department of Medical Education and Student Affairs, The Griffin Hospital, Derby, CT 06418.

MEDICAL DIRECTOR OCCUPATIONAL MEDICINE

Excellent opportunity for a BE/BC IM, GP, ER, OM, or GS to join this rapidly growing occupational medicine practice that is completing its Connecticut expansion. Clinical or administrative responsibilities and experience in Connecticut worker's compensation, ADA, and soft tissue injury management required. Extremely competitive salary, bonus, and benefits package offered. For more information, send CV to the attention of Susan Henry, Industrial Health Care Company, 1095 Day Hill Rd., Windsor, CT 06095.

PART-TIME

The Office of Hearings and Appeals, Social Security Administration, is seeking individuals who would be willing to serve as medical experts. We have five United States Administrative Law Judges who preside at hearings and issue decisions on claims involving disability and Medicare benefits. In some cases, a medical expert is needed to review the medical evidence prior to the hearing and then testify at the hearing. The medical expert may be asked to clarify ambiguities, to resolve contradictory medical evidence, etc. This is not a full-time position, and the medical expert serves under contract, not as an employee of the Office of Hearings and Appeals. Pursuant to that contract, the typical rate of reimbursement is $160.00 for studying the record and testifying at each hearing. Our current medical experts especially enjoy the opportunity to provide an important public service. Please contact Bruce H. Zwecker, Hearing Office Chief Administrative Law Judge, Social Security Administration, Office of Hearings and Appeals, 157 Church St., 22nd Floor, New Haven, CT 06510, telephone (203) 787-7771.

Physician wanted for part-time employment in a small college. Student Health Service Persons interested in young adults are encouraged to apply. Please send letter of interest and CV to:

Director, Student Health Services, Quinnipiac College, 275 Mount Carmel Ave., Hamden, CT 06518.

Physicians sought to participate in clinical research studies with a major contract research organization (CRO) in Connecticut. Currently seeking practicing physicians in the following areas: anesthesiology/surgery (post-op pain studies), endocrinology, neurology. Physicians compensated for assisting and recruiting and evaluating study volunteers. Nursing study coordinator provided. No research experience necessary. Call Dr. Cheryl Miller, SCIREX Corporation, (800) 724 0091.

PEDIATRICIAN

Collins Medical Associates, P.C., a primary care group practice affiliated with St. Francis Hospital and Medical Center, is looking to fill three pediatric positions. The first requires a BC pediatrician with an entrepreneurial flair to transition a retiring pediatric practice in Manchester. The second position is with a well-established female pediatrician in West Hartford who is seeking an associate. The third position is with a two-man, well-established, active practice in Bloomfield. All positions have a competitive compensation and benefits package and attractive call schedule. If you are interested in any of these opportunities please call Christine Fucci at (800) 892-3846 or fax your CV to (860) 585-3525.

PRIMARY CARE

HealthFirst, a growing regional community health center with three sites in eastern Connecticut seeks BC/BE FP/IM to provide full range of preventive and primary care. All sites are fully staffed, computerized, and integrated into an organizational network. Competitive salary and benefits. For more information call or send CV to: Recruitment Manager, 112 Lafayette St., Norwich, CT 06360, telephone (860) 885-1308, fax (860) 889-1982.

PHYSICIANS WISHING TO PRACTICE IN THE STATE OF CONNECTICUT

INTERNAL MEDICINE

Available immediately. Licensed in Connecticut. Passed National Boards. American Board certified M.D. at Tufts University School of Medicine. Internship and residency at the Hospital of St. Raphael. Office-based general internist with extensive managed-care experience, seeking to join a group or associates practice. Please respond to: Michael F. Collins, M.D., 53 Cotswold Close, Glastonbury, CT 06033, telephone (860) 633-5698.

RADIOLOGY

Does your walk-in clinic need a radiologist part-time? Will travel within the greater Hartford area. Please respond to: CSMS c/o RA/BK.

PAID CLASSIFIED ADVERTISING

All PAID classified advertising orders, correspondence, and payments should be directed to: CONNECTICUT MEDICINE, Classified Department, 160 St. Ronan Street, New Haven, CT 06511, Tel. (203) 865-0587. The Classified rates are as follows: $60.00 for 25 words or less; plus $1.00 each additional word. For confidential answers, the cost is $3.00 per insertion, sent in care of CONNECTICUT MEDICINE. Ad copy must be typewritten, double spaced, with payment, and delivered no later than the first day of the month preceding the month of issue.

FOR SALE NORTH HAVEN

Classic two-story colonial office building—3,000 sq.ft. Fitted for modern medical practice. Offices, examining rooms, waiting room, storage, medical equipment, including x-ray available. Dow Realty Company, James S. Johnson: (203) 776-0000.

FOR SALE

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PRACTICE FOR SALE

Internal medicine practice and office. Prime location, close to hospitals and highways. Also suitable for other specialties. Great potential for growth and expansion. Inquiries: Tel/fax: (203) 239-4147.

Connecticut Medicine

Journal of the Connecticut State Medical Society

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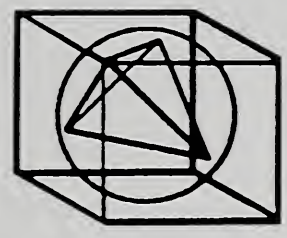

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CORRECTION

In the September Special Issue of *Connecticut Medicine* The Institute of Living, the article entitled *The Hartford Retreat for the Insane: An Early Example of the Use of "Moral Treatment" in America,* the references numbered 13-26 were inadvertently left out of the publication.

The references are as follows:

13. Hartford Retreat for the Insane, *Rules and Directions for Those Employed in the Care of the Patients of the Retreat for the Insane* (Hartford, 1853), p. 6.
14. Hartford Retreat for the Insane, *Annual Report,* 184, p. 24; *Annual Report,* 1844, p.16.
15. Hartford Retreat for the Insane, *Annual Report,* 184, p. 22.
16. Hartford Retreat for the Insane, *Annual Report,* 184, p.16.
17. Hartford Retreat for the Insane, *Annual Report,* 184, p. 4.
18. Hartford Retreat for the Insane, *Annual Report,* 184, p. 32-33.
19. John Danforth to G. Cleveland, Letter dated July 28, 1843, Commitment Papers, Governors' Papers, Incoming Letters, 1828-44, RG5, Box 99, State Archives, Connecticut State Library.
20. See Elizabeth Parckard's *Martial Power Exemplified in Mrs. Packard's Trial* (Hartford, Conn: E.P.W. Packard; 1866); *The Great Drama: Or, The Millenial Harbinger* (Hartford, Conn: E.P.W. Packard; 2 vols., 1878-1879); and Lawrence B. Goodheart, "The Concept of Insanity: Women Patients at the Hartford Retreat for the Insane, 1824-1865," *Conn Hist* 1995; 36:41-5.
21. Andrew Scull, "Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of Bristish Psychiatry," in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era,* ed. Andrew Scull. Philadelphia, Penn: University of Pennsylvania Press; 1981:101-18.
22. For two historical approaches which take into account gender differences, see Goodheart, "The Concept of Insanity: Women Patients at the Hartford Retreat for the Insane," 31-47; and John Starrett Hughes, "The Madness of Separate Spheres: Insanity and Masculinity in Victorian Alabama," in *Meanings for Manhood: Constructions of Masculinity in Victorian America,* eds. Mark C. Carnes and Clyde Griffen. Chicago, Ill: University of Chicago Press: 1990: 53–56.
23. *Twelfth Census of the United States, 1900,* Vol. II: *Population* Washington, DC: 1920; Part 2, xx-xxxi. Race and nationality statistics for Retreat patients were tabulated from the manuscript census schedules of that year, available on microfilm from the National Archives. (See pp 641-9). Hartford's immigrant population was slightly higher than that of the state as a whole, 63% of the city's 80,000 residents. The African- American population for the state in 1900 was 15,226 (or 2%). The population of this community in Hartford at this time also hovered arm 2%.
24. Quoted in Cynthia Zaitzevsky, *Frederic Law Olmsted and the Boston Park System.* Cambridge, Mass: Belknap Press: 1982 p. 75.
25. Hartford Retreat for the Insane, Annual Report, 1875, p. 9.
26. *The Story of the Institute of Living,* Hartford, Conn: Institute of Living 1946: 2-4.

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