

Maryland Medicine

The Maryland Medical Journal Volume 18, Issue 2

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I N S I D E



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Through a Strange Looking Glass



PRESIDENT'S MESSAGE

Stephen J. Rockower, MD
@medchipresident

“But I don’t want to go among mad people,” Alice remarked.

“Oh, you can’t help that,” said the Cat. “We’re all mad here. I’m mad. You’re mad.”

“How do you know I’m mad?” said Alice.

“You must be,” said the Cat, “or you wouldn’t have come here.”

Black is white. Up is down. Left is right. Nothing seems to be what it was before. The past months have been very strange times for our state and our country. The accusations come from both sides on a daily or even hourly basis. Tweets contradict spokespeople, and leaked documents contradict everybody. As one elder statesman put it, “We need to get back to Regular Order.”

The job of the physician does not change through all of this, as we are committed to preserving the health and welfare of our patients. Whether we will be paid for our services is another matter. In late July, the multiple attempts to repeal the Affordable Care Act (ACA), or “Obamacare,” failed when three Republican senators voted “No.”

So, for the time being, we still have the ACA and the expanded Medicaid funds to help us take care of our patients. During the last legislative session, the Maryland legislature established the Maryland Health Insurance Coverage Protection Commission with members from the legislature, MedChi, the hospitals, the Administration, and other stakeholders. I am proud to serve on this commission. The charge of this commission is to preserve health care financing for as many Marylanders as possible within the framework of our All Payer System, which certainly will be a challenge in the current environment. It was fascinating to learn that the uninsured rate in Maryland dropped from 11.3 percent in 2013 to 4 percent in 2016 because of the effects of the ACA. The highest enrollment was in the western counties and those of the Eastern Shore. Limiting insurance coverage in those areas would cause significant harm to hundreds of thousands of people.

Much work still needs to be done to preserve the gains we have already made. We need to be vigilant and active and vocal to maintain funding for vital programs for primary care, children’s care, and more.

The elections of 2018 loom in the near future. As the elections approach, hard and fast positions and statements will be more difficult to be obtained. Already, numerous state wide, congressional, and legislative contests are shaping up. I would certainly encourage all of you to pay close attention even before the primaries are held. Get involved with a candidate. Attend some fundraisers. Know the issues, whether they are medically related or local issues. Good government stems from all of us participating and making our feelings known to our elected representatives.

On a more personal note, I am certainly proud to announce that our Executive Director, Gene Ransom has assumed the presidency of the American Association of Medical Society Executives (AAMSE). Both Gene and Susan D’Antoni, a previous AAMSE president, have been named fellows of that organization. Their service at AAMSE demonstrates that we here in Maryland have the best and the brightest executives working for us in organized medicine. As I travel to other states in my role as president, I am always proud to see how well we do things here in Maryland. There are challenges, to be sure. To make things 100 percent better, we must make one hundred things 1 percent better. We certainly have extremely talented people working for physicians each and every day.

As we prepare this issue of *Maryland Medicine* to go to press, fall is upon us. Schools are in session, and the days are growing shorter. My term is coming to a close, and I want to thank the physicians of Maryland for the opportunity to serve. It has been an exhilarating experience, one I will always treasure. As I watch my children develop their careers in the medical field, one as a nurse and one as a medical student, I am warmed watching their development and dedication to their patients and to medicine, and their joy and wonder in helping people. It is the sense of commitment to others that I learned from my family and that I hope I have passed on to my children.

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Fall is the Time to Remind Your Patients to Get Vaccinated



CEO'S MESSAGE

Gene Ransom, III, Esq.
@GeneRansom

At the end of summer, parents around Maryland prepare their children to begin the school year with everything they need to succeed, including their required school vaccinations. However, immunizations aren't just for our children—they are a lifelong, year-round medical necessity and a critical public health tool for protecting against a broad range of dangerous and potentially deadly illnesses for teenagers, adults, and the elderly.

In the United States, August is National Immunization Awareness Month. The Centers for Disease Control and Prevention (CDC) and the National Public Health Information Coalition (NPHIC) established Immunization Awareness Month to encourage people of all ages to make sure they are up to date with their recommended vaccines.

In Maryland alone, thousands of children go unvaccinated every year, putting themselves and their classmates at risk. We know firsthand the effects of children not having proper vaccinations. In 2015, the Anne Arundel health department had to notify¹ residents of an increase in whooping cough in school-age children.

The practice of getting vaccinated should and does start at an early age. The classroom environment makes Maryland students and their classmates susceptible to contracting and spreading a range of dangerous illnesses. In school communities, vaccines play an important role in creating a “herd immunity”—when an entire community can be protected from disease because a high enough percentage of people are vaccinated, including those who aren't medically able to be immunized.

It is not only young children who should be vaccinated at the beginning of the school year. As Maryland teenagers and young adults begin and return to college—and as students from all over the country return to Maryland colleges and universities—parents should make

sure their children have a conversation with their health care provider about how to be protected from diseases such as meningitis. Unfortunately, incidents of meningitis have become all too common on America's college campuses, including locally. Maryland saw twenty cases of viral meningitis reported at the University of Maryland in the fall of 2014.²

Meningitis, whether viral or bacterial, can spread quickly in close quarters, like college dormitories. The bacterial form of the disease is particularly dangerous, and although fast treatment has proven to save the lives of many individuals, the Centers for Disease Control and Prevention (CDC) estimates³ the fatality rate is between 10 and 15 percent. In addition, 19 percent of survivors suffer permanent complications, such as loss of limbs, injury to the nervous system, deafness, or brain damage.

Thankfully, there are now vaccines available to protect against all types of meningococcal disease that are most common in the United States. The best way to stop the spread of meningitis is by preventing it in the first place, which is why it is so important to make sure our college students are up-to-date with their vaccines.

Although often overlooked, vaccines are a critical part of prenatal care: before a baby even takes a breath he or she should be protected from disease. It is essential for pregnant women to get vaccinated to protect their babies from diseases such as whooping cough or the flu, which are particularly common among newborns and can be deadly.

Finally, there is a broad range of vaccine-preventable diseases that threaten adults. Pneumococcal disease, which can lead to serious illnesses (e.g., pneumonia, blood infection, or bacterial meningitis), causes approximately 22,000 deaths every year. Adults living with chronic conditions (e.g., heart disease, liver disease, asthma, and other lung disease), as well as adults

making certain lifestyle choices (e.g., smoking), should be vaccinated against pneumococcal disease.

Fall is not only an opportunity to ensure our children get the shots they need to return to school, it is also an ideal time to help protect the entire community through vaccinations. I encourage you to have a conversation with your patients about the most appropriate vaccine schedule.

MedChi plays an official role in the review and release of the Maryland Department of Health's Child Immunization Schedule. The schedule can be found on both the Department of Health and MedChi websites (<http://www.medchi.org/Resources/Patient-Public-Resources>).

References

1. Cohn, Meredith. “Measles outbreak exposes holes in vaccine coverage.” *The Baltimore Sun*, January 30, 2015.
2. Burris, Joe. “Viral meningitis cases at UM College Park.” *The Baltimore Sun*, October 23, 2014.
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Of Ice Cream, French Fries, and Physicals



EDITOR'S CORNER

Bruce M. Smoller, MD

We are one of the most regulated professions on the planet. We are asked to do the unimaginable...to safely shepherd our patients from birth to grave without our patients succumbing along the way to nasty disease and disfigurement. We are asked to do it all under the venal eye of the lawyer, the jaundiced gaze of the regulator (so quick to dispense a punishment here, a little rough justice there), and the scurrilous insurer, the hideous green-eyed monster of triple threat, sapping our time, whittling away at our hard-earned bucks and, most egregiously, eating away at our equanimity. I shudder to think.

After the fevered exercise of my dudgeon, I had some thoughts about the way we might do business, spurred on by an article I read about the delivery of food to offices in large metropolitan areas. Food delivery is no small feat, according to the article. French fries tend to get soggy, ice cream melts in ninety-degree heat, pizza gets cold and stale, and customers get angry. At some cost, the deliverers innovate and develop algorithms to match fast deliverers with area traffic patterns on hot days and to find the correct upright container to prevent fries "soggifying." Food delivery has become a \$43 billion industry, with projections showing it will double in the time it takes to deliver a soufflé before it implodes. My point is

that the food delivery industry is flourishing by asking the customers what they want and then delivering.

Health care is a hybrid industry. It is certainly a service industry. Like most service industries, what we as physicians deliver to the customer, our patients, and how we deliver, is guided, or should be guided, by the needs of the customers and the method of delivery to meet those needs.

Health care is also, however, a scientific industry. Scientific endeavors, with rare exception, rest on an exclusive and highly prized body of knowledge that often remains removed from customers because of its complexity and the steep learning curve it takes to master, and a guildlike lock on the precepts of that knowledge that is passed to members of the guild. It is not usually passed on to the customers, only in part because the customers need guidance in the practical use of the core knowledge.

Interposed between the physician and the customer is a layer of cost diffuser—the insurer. The insurer also wants to make its mark and its profit margin, and has effectively accreted enough power to drive the game. To complicate things even further, the insurer has to some degree fudged the game by querying that very same customer to determine which way to play the game. To cap it all off,

the law forbids physicians from even discussing how to eliminate that middle level of control, or at least to combat its more nefarious and controlling portions. We seem stuck. Increasingly, I hear that maybe the single party payer is the way to go. While the single payer system may or may not be the solution, physicians propose as much out of desperation. We are being outplayed by the insurers' more refined and less fettered sense of how to succeed in business.

Perhaps we need to appeal more directly to the consumer. We all, myself included, have bemoaned the "quality industry," which seems to value clean floors and a quick smile over substance and pays little attention to the strong will of biology, which often has its own script to write.

What if we directed ourselves more to the wants of our customers, even if they are not so scientific, and wrest control of that middle layer from the insurers? Yes, we do that with surveys and such now. However, perhaps we need to say to ourselves, in the end, that it is the customer, whom we call patient, who will ultimately decide whether we thrive. Perhaps we need to learn how to deliver ice cream in twelve minutes in ninety-degree heat because that's what the market wants. Perhaps the very legal and mercantile view of our market, quite apart from any

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new payment form, will allow us a longer corporate life and more satisfaction. At first, we may feel that we are giving up control. In the end, however, we gain much more by allying ourselves directly with the consumer, or patient, as not simply the recipient, but the very driver, of how we do business. If we learn to like it, that's great. If our patients are happy because they feel they are a real part of the process, so much the better.

Now pass those French fries, crisply cooked and equally crisply delivered, will you please?

This issue of *Maryland Medicine* is devoted to the interaction between physician and patient. It is a compendium of thoughts and feelings that we, as physicians, would like to communicate to our patients. To have our patients appreciate, and thus help advocate for, the positions we take, the daily burdens under which we labor, and the various slings and arrows of outrageous fortune that descend upon our collective medical flesh.

In "Advocating in Annapolis..." Stephen Rockower, MD, reviews the 2017 session of the General Assembly. Steven Wise

explains the new medical malpractice legislation in "New Medical Malpractice Coverage Legislation Protects You and Your Patients." MedChi members speak to patients about the challenges of caring for patients' health today in "Dear Patient..." In "The Doctor-Patient Relationship," Brooke Buckley, MD, looks at patient satisfaction and the complicated doctor-patient relationship. In "The Maryland Patient Safety Center," Robert Imhoff, MPP, discusses significant initiatives of the Maryland Patient Safety Center and its work in delivering health care and enhancing patient safety in Maryland. Vinu Ganti, MD, looks at improved patient outcomes brought about by accountable care organization arrangements.

MedChi's Gene Ransom, III, Esq., discusses the AMA's new ad campaign designed to increase awareness about prediabetes and Type 2 diabetes and provide physicians and their patients with the tools to prevent diabetes.

As always, we invite your comments, in the form of letters to the editor.

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Letters to the Editor

Dear Editor:

We read with concern the article “Physician Aid in Dying: Its Time Has Come for Maryland,” by Michael J. Strauss, MD, and Terri L. Hill, MD (*Maryland Medicine* 17:4, 2016). In addition to disagreeing with the premise and conclusion of the article, we are troubled by a number of errors and misleading points made within it.

The alleged protections of the Maryland End of Life Options Act are an illusion (House Bill 370: Richard E. Israel and Roger “Pip” Moyer End-of-Life Option Act). There is no requirement for formal psychiatric evaluation, no requirement for a witness to the consumption of the lethal pills or the death of the patient, no independent safety monitoring board for the program, no system for reporting abuse or error, and mandatory falsification of death certificate information. While initiation of a request for assisted suicide is supposed to be made by the patient, there are no penalties should a physician, family member, or insurance company suggest this course to a patient.

The grant of physician immunity in the bill is one of the most dangerous provisions because it shields physicians from any responsibility for error in judgment or action in prescribing assisted suicide. Moreover, the bill protects records and documents related to the prescription of assisted suicide from discovery or subpoena, ensuring that no meaningful investigation of a death under the bill can ever take place.

Some patients prescribed assisted suicide in Oregon have been documented to live more than six months, showing that this provision of the law is unenforceable.¹ We know that almost no one prescribed assisted suicide in Oregon is referred for formal psychiatric evaluation (<5 percent), despite the well-documented high incidence of depression in terminally ill patients (Oregon Death With Dignity Act: 2015 Data Summary, Oregon Public Health Division. February

4, 2016).¹ Finally, the authors ignore the abuses taking place in the Netherlands and Belgium, under a permissive euthanasia regime that began with assisted suicide.^{2,3}

Many in the lay public are unfamiliar with the many options that patients with advanced illnesses already have and so may be choosing support for assisted suicide in that vacuum of information. The MedChi physician survey was flawed and unscientific, with a 2 percent response rate. It would not be publishable in any peer-reviewed medical journal, and it cannot be considered representative of Maryland’s physicians. It should also be noted that in states that do have assisted suicide laws, very few physicians are actually willing to participate.

Assisted suicide is opposed by the American Medical Association, the American College of Physicians, the American Nurses Association, and the National Hospice and Palliative Care Organization.⁴⁻⁶ The Hippocratic Oath specifically forbids physician participation in assisted suicide in stating, “Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.”⁹

Physician assisted suicide is either ethical or it is unethical. The medical profession must decide. If physicians cannot agree on such a basic ethical principle, then we question whether medicine can continue to be a “profession” in any meaningful sense.

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Dear Editor:

Joseph Marine, MD, and colleagues raise issues concerning our article on aid in dying (AID), "Physician Aid in Dying: Its Time Has Come for Maryland," but we do not find them compelling.

Current AID laws have "strong protections" forcing decisions that are serious but not prohibitive and include safeguards against coercion. Not everyone qualifies, and few who qualify choose to participate. To us, such laws strike the right balance between acknowledging patient autonomy and protecting vulnerable patients.

Marine et al. are correct that the legislation was not designed to gag providers or family regarding end-of-life discussions. The requirement of at least one private discussion between patient and physician provides some protection against influence of others. Having someone present at death is encouraged, but it's unclear why it should be required or how it could be enforced. The law addresses breaches in professional conduct and reporting abuse or error. Monitoring is through the Maryland Department of Health.

There are protections regarding practitioner participation and non-participation, and against charges of murder. But there is no immunity, and there can be actions taken against physicians for non-compliance with laws, forging an AID request, unduly influencing participation, administering a lethal injection, coercion, ignoring a patient's request to rescind participation, or unethical behavior.

Marine et al. argue against our statement that there is "No Slippery Slope" because some patients live longer than six months. To the contrary, this illustrates that individuals who do not experience intolerable suffering simply do not take the medication. The issue is quality of one's dying, not length of the dying process.

It is not surprising that fewer than 5 percent of patients are referred for psychiatric evaluation. Attending physicians exclude, and never enter into state databases, the many patients failing to meet mental capacity requirements, for example, individuals with dementia or severe depression. Some with experience suggest at least 20 percent to 30 percent of patients requesting AID are excluded for mental health reasons prior to being entered into databases. Also, after nineteen years of state AID laws there has been no need to expand patient criteria and no reason to expect that our country will follow the lead of Belgium or the Netherlands.

There is much evidence of "Physician and Public Physician Support" for AID. While one MedChi survey does not prove broad support, there have been similar findings in physician surveys by the Montgomery County Medical Society, the Suburban Maryland Psychiatric Society, the Colorado Medical Society, and Medscape. National surveys in 2016 by Gallup and Lifeway Christian Resources, each polling more than 1,000 individuals, show 69 percent support.


We stand by our statements regarding the "Hippocratic Oath." As a medical issue with strong arguments on multiple sides regarding ethical obligations to oath, patient, and profession, abortion illustrates the role of engaged neutrality that allows for honoring practitioner autonomy, privacy, and the sanctity of the

patient-physician relationship; professional responsibility; and standard of care. The idea is not consensus, but rather responsible non-consensus, defining boundaries of professional behavior for the participating physicians.

Michael J. Strauss, MD, MPH
Health Policy Consultant

Terri L. Hill, MD
Member, Maryland House of Delegates

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Contributions in honor of Dr. Gary Pushkin benefit the Center for a Healthy Maryland, the foundation of MedChi, and support medical education, physician health and the history of Maryland medicine.

The Center for a Healthy Maryland invites you to recognize and celebrate Dr. Pushkin's inauguration as he begins his term as the 170th President of MedChi, The Maryland State Medical Society.

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www.healthymaryland/donate.

Thank you.

A copy of the current financial statement for the Center for a Healthy Maryland is available by writing to the Center at 1211 Cathedral Street, Baltimore, Maryland 21201, or by calling 410-539-0872. Documents and information submitted under the Maryland Solicitations Act are also available, for the cost of postage and copies, from the Maryland Secretary of State, State House, Annapolis, Maryland 21401, or by calling 410-974-5534.

Advocating in Annapolis for Maryland Physicians and Our Patients

Stephen J. Rockower, MD



The Maryland General Assembly was in session from January to April 2017. There were more than 2,800 bills considered by the General Assembly, and almost 250 bills considered by the MedChi Legislative Council. Physician members of the MedChi Legislative Council met each weekend by conference call to discuss the newly introduced bills of the week, and the entire Council met one Monday night in Baltimore to discuss further and to focus for support or amendments. The Legislative Council was ably led by Drs. Sarah Merritt and Gary Pushkin, subcommittee chairs; Drs. Clement Banda, Elizabeth Wiley, and Anuradha Reddy; and aided by our legislative team of Pam Metz, Steve Wise, and Danna Kaufman. As always, our concerns were grouped in three major categories: insurance and payment issues, public health, and liability.

Insurance and Payment Issues

The budget, as proposed by the Governor and passed by the General Assembly, maintained the payment structure for Medicaid E&M codes at 94 percent of Medicare, providing sufficient funding for physicians to care for patients within the Medicaid program. As we all know, the continued funding for the Medicaid expansion from the Affordable Care Act (ACA) is under great pressure from the President and certain elements in the U.S. Congress. To examine the effects of federal changes in the ACA on Maryland's unique All Payer Model, the General Assembly created the Maryland Health Insurance Coverage Protection Commission, with representatives from the legislature, physicians, hospitals,

and other affected groups. The other important bill that passed related to payment issues loosened the current self-referral law to allow physicians who are employed by a health care entity to receive additional compensation from them.

Public Health

The costs of pharmaceuticals to the public has been in the news of late as manufacturers and pharmacy benefit managers have continued to raise their prices, especially on generic medications. A hotly contested bill, HB631, authorizes the Attorney General to sue manufacturers that engage in price gouging, loosely defined as raising prices more than 50 percent in one year. Because HB631 has become law without the Governor's signature, the pharmaceutical associations have instituted a lawsuit contesting the bill. The care and treatment of patients with opioid use disorders was also a major topic of discussion in the General Assembly. There were a number of extremely restrictive and punitive bills that MedChi successfully negotiated to much more reasonable positions. Most importantly, physicians were not restricted in the prescribing of opioids to a seven-day course only, but were allowed to follow evidence-based guidelines in the care of individual patients. Certain conditions such as cancer, hospice care, or chronic pain were exempted from these restrictions. In addition, the Heroin and Opioid Prevention Effort (HOPE) and treatment act established a number of treatment facilities and programs to deal

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with patients with opioid addiction. Other bills loosen the requirements requiring prior authorization for treatment of opioid use disorders and expand coverage for alcohol and drug disorders. The proposed expansion of the scope of practice for optometrists was discussed intensely and was hotly contested by the Maryland Society of Eye Physicians and Surgeons and MedChi. The issue was sent for summer study, and certainly will be a topic of discussion in 2018. For those of us worried that the Maintenance of Certification (MOC) process would apply to licensure in the state of Maryland, a bill preventing The State Board of Physicians from using MOC as a requirement for licensure was easily passed. The major public health initiative to prevent hydraulic fracturing (fracking) in the state of Maryland was passed with the Governor's support. In addition, the prophylactic use of antibiotics in animals has been restricted.

Liability

All of the major medical liability proposals failed, save one. Physicians will now need to certify whether or not they have medical liability coverage at the time of their license renewal. Physicians who do not carry coverage must provide patients with a written notice and must post the information in their office. The bills that would have significantly increased awards for non-economic damages (pain and suffering), as well as removing limitations on expert qualifications, also failed. A bill limiting venue shopping was not passed. Other bills of interest included the Moyer End-of-Life Option Act, which would have allowed physicians to lawfully prescribe aid in dying. The bill was withdrawn. The aid in dying issue has attracted a significant following across the country. Because of strongly held beliefs on both sides of the issue, MedChi takes no position.


As always, the participation by physicians across the state is strongly needed to make this process work and work well. If necessary, committee meetings can be done by conference call or with Zoom video conferencing capability, allowing all physicians from Garrett to Cecil to St. Mary's to Worcester Counties to participate and be active members of our team. A day spent as Physician of the Day in Annapolis is time well spent. In addition, as the elections of 2018 are rapidly approaching, contributions to the Maryland Medical Political Action Committee (MMPAC) are greatly needed to assist us in advancing the causes of MedChi. (For a more complete discussion of significant issues that were raised and discussed during the legislative session, visit the MedChi website.)

Take a PAGE out of our HISTORY!

The Maryland Medical Journals, from 1870 to 1960, are now digital and fully searchable. This is just one project of the Center for a Healthy Maryland, and was funded by a gift from a very generous donor.

We hope that you will support all of our important projects. For information on making a gift, email events@medchi.org





New Medical Malpractice Coverage Legislation Protects You and Your Patients

J. Steven Wise, Esq.

For years, legislation has been introduced in the Maryland General Assembly that would mandate that every physician have medical malpractice coverage. However, legislation passed (Chapter 770) this year that requires your attention, as it becomes effective on October 1, 2017.

As background, MedChi has opposed legislation that includes a mandate because, like most issues in Annapolis, it is not as simple as one might expect. For instance, why should retired or academic physicians be required to hold medical malpractice coverage? How much coverage is required? Why not other licensed health professionals, too? Shouldn't there be an insurer of last resort if there is a mandate? MedChi's lobbying efforts resulted in a more simplified solution to the issue, but one that still will affect every physician in one way or another. Here's what you need to know to comply.

For the vast majority of physicians who do maintain coverage, either individually, through your practice, an employer or hospital, only one small change will occur. When you provide information for the Board of Physicians to use on the public profile it maintains for each physician, there will now be a question as to whether or not you maintain medical malpractice coverage. It will be a simple yes or no response, which will be available to the public when a profile is accessed. For physicians with coverage, this is all that will be required. The Board does have the authority

to randomly audit these responses, as sometimes occurs with CME, to ensure that the physician actually does maintain the coverage. If you are audited on this response, the Board can request that verification of the insurance be provided within twenty-five days.

For those physicians who do not maintain medical malpractice coverage or whose coverage has lapsed, as of October 1, 2017, a written notice to patients will be required, along with the patient's signature. The notice must be given directly to each patient on two occasions: (1.) On the patient's first visit (unless the visit is for incidental care that is rendered free of charge), and (2.) As part of each informed consent, obtained before a procedure or operation is performed. The physician must retain a copy of the signed notice as part of the patient's records. Further, a general notice must be posted in the practice for all patients to see. The Board will develop language that satisfies the law, so a physician who does not maintain coverage and needs to give notice should monitor the Board of Physicians' website for that information (www.mbp.state.md.us).

If you do not have medical malpractice coverage, make sure you provide the proper notices, get the patient's signature, and retain the signed copy of the notice. If you do have coverage, just be alert to the question on the profile. In all, compliance with this new law has been made relatively simple for most, thanks to the legislative efforts of MedChi during the 2017 General Assembly Session.

“Dear Patient...”

If you were given the opportunity to speak frankly to your patients, what would you say? Are there myths and realities you would like to share? What do you want your patients to know about medicine today?

We asked MedChi members to share their perspectives about practicing medicine. We present here the responses to our survey.

“I still find medicine fulfilling. My calling has been realized. I do get frustrated with computers and patients trying to treat themselves by consulting the internet. I also get frustrated by prior authorizations for medications. I would not trade this career for any other.”

Anonymous

Doctors are people too. We want as badly as you do to heal your ailment, but we do not have superpowers. We will use all of our wisdom and caring to get you as close as possible to your goals.

Brooke Buckley, MD
General Surgery

Being a physician is a calling.

Lynne Diggs, MD
Internal Medicine

“I realized later in my practice that there are more challenges in health care than ever before. There is more bureaucracy, insurance demands, and increasing amounts of paper work that takes me away from patient care. The wealth of information on the Internet can at times create more confusion for our patients, leading to breaks in the patient–physician relationship. I think, overall, medicine has changed in both directions. It has changed for the better in that there are better treatment options, and more emphasis on evidence-based practices. It has also changed for the worse because of the challenges mentioned above. The stresses of patients having adequate health care coverage during the political process of changing policy is also difficult, in that I feel helpless and at their mercy.”

Anonymous

Doctors are her to take care of you—they are being prevented from doing this by the current system.

Audrey Corson, MD
Internal Medicine

“It is a great honor and privilege to care for patients. Patients need to realize that I try to individualize care for each and every one. If I take too much time with the previous patient, I will be late for you, but I will try to make you my number-one priority while you are with me.”

Anonymous

Know your insurance and plan accordingly.

Given that we are in an era of private health insurance plans that come with high deductibles, we need to be fully aware of what is covered as “preventative services.”

Many a time, physician visits and tests may need to be paid out of your pocket to meet the deductible.

Irrespective of your age, whenever possible you should take advantage of HSAs (health savings plans), or similar, if they are available, or set aside some money for health purposes.

This will help avoid surprises and help in taking appropriate measures to address all your required health care needs on an ongoing basis.

An ounce of planning is worth a pound of cure, maybe even tons of cure in today’s health care environment.

Aruna Nathan, MD
Internal Medicine

“I love being a doctor most of the time. I enjoy interacting with patients and the intellectual challenges of the practice of medicine, but I do get frustrated by the increasing paperwork and bureaucracy in medicine. I feel that there is a larger debate in society about health care and health care delivery (as there should be), and everyone’s position is being respected and accounted for except that of physicians. I find the uncertainty in all aspects of health care right now discomforting.”

Anonymous

“Focus on your relationship with your physician and staff. Do not allow all the distractions (computers, insurance, third-party protocols) to destroy the relationship.”

Jos Zebley, MD
Family Medicine

The Doctor–Patient Relationship: It’s Complicated

Brooke Buckley, MD, FACS

Recently, patient satisfaction has taken its place among the most valued outcomes in medicine. Our industry has gone so far as to grade and pay physicians and systems based on survey data that may only remotely relate to the services rendered provided that the data reflect the satisfied patient. The increasingly common occurrence of data-driven outcomes that feel marginally affiliated with our work and daily experience as physicians is driving the joy out of medicine. As demands rise, and the time to attend them shortens, it is not uncommon to hear hallway conversations turned antagonistic about efforts to lead with satisfaction rather than science. Practicing physicians are rapidly burning out.

While older physicians are struggling with technology, younger physicians were raised in a reality in which face-to-face communication was less valuable than efficiency. We rarely are offered time to reflect. For patients, satisfaction is increasingly the simple combination of outcome and cost. As providers, we understand it isn’t simple math. We are all frustrated. It feels as though no one is winning, especially not the patient and certainly not the physician.

“The increasingly common occurrence of data-driven outcomes that feel marginally affiliated with our work and daily experience as physicians is driving the joy out of medicine.”

While there are elements of truth in all arguments, for a moment, I would like to take an empathetic look at the importance of patient satisfaction. The messaging is often system driven. However, from the provider perspective, an engaged patient is typically the result of an engaged provider. An engaged provider is also typically happy. It’s hard not to like happy.

As technology consumes our time at an untenable rate, physicians are burning out. We no longer have the energy to engage in the patient story. We simply do not have time to do the caring that brought us to medicine in the first place. We are disengaged not only from a patient’s life, illness, and story, but we also have lost sight of our own narrative, and our combined story. In boiling the human experience of illness and treatment into a binary language, we forgo the sacred skill of “living through, not simply knowledge about,”¹ the human condition. Our youngest doctors, the millennials, have suggested that the doctor–patient relationship is evolving to a point at which transaction and efficiency will win the day.



The origin story of the derailed patient–provider experience is partially uncovered in the discussions on narrative medicine: the art of story in patient care. Greenhalgh and Hurwitz, in their 1999 paper, discuss the narrative as access to personal truths greater than facts.

“The same sequence of events told by another person to another audience might be presented differently without being any less ‘true.’ This is an important point. In contrast with a list of measurements or a description of the outcome of an experiment, there is no self-evident definition of what is relevant or what is irrelevant in a particular narrative. The choice of what to tell and what to omit lies entirely with the narrator and can be modified, at his or her discretion, by the questions of the listener.”²

Sound familiar?

Certainly, medicine does not occur in a vacuum, and this topic is particularly relevant as our national narrative becomes increasingly complex and represents a nearly infinite number of discrete personal narratives. In this phase of the twenty-first century, data rules. The electronic medical record has insatiable hunger for time and data. A 2013 article demonstrated that medical interns spend only 12 percent of their time interacting with patients and 40 percent interacting with the computer.³ For many of us, a lack of technical savvy (or typing prowess), which would allow us to translate in shorthand the richness of an engaged patient–physician interaction, degrades provider–team communication. Practicing providers talk to one another through clicks and flowsheets. We record only “codable” observations. The richness of the human experience is wiped from the record. We simply don’t have time.

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The Maryland Patient Safety Center

Making Health Care in Maryland the Safest in the Nation

Robert Imhoff, MPP

For more than a decade, the Maryland Patient Safety Center (MPSC) has been a center for innovation. MPSC brings together providers to collaborate, educate, and implement evidence-based solutions for avoiding preventable harm in the delivery of health care services and enhancing patient safety throughout Maryland and beyond.

Since its inception in 2003, the MPSC has been a leader in developing cutting-edge and practical programming to address constantly evolving patient safety issues. The Center was established by the Maryland Legislature. In 2004, the Maryland Health Care Commission designated MPSC as the state's official patient safety organization.

As one of the first twenty-five federally listed patient safety organizations, the MPSC continues to transform health care

delivery in Maryland by engaging more than 9,000 individual providers in educational programs and 85 percent of Maryland hospitals in collaborative programs.

MPSC's biannual conferences highlight year-round education. Each spring, the Center hosts one of the largest patient safety conferences in the country, drawing close to 1,500 health care professionals. In addition to bringing in nationally known keynote speakers, the conference features a wide array of presentations that examine the latest patient safety challenges and solutions from varying perspectives. While professional education programs take place throughout the year, the fall Medication Safety Conference focuses on delivering the latest information aimed at improving patient safety related to medications.

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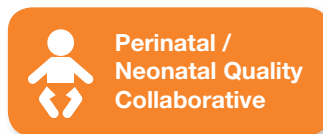
Maryland Patient Safety Center

Making healthcare in Maryland the safest in the nation.

Since our inception in 2003, the Maryland Patient Safety Center (MPSC) has been a leader in developing innovative and relevant programming in order to address today's most important patient safety issues.

As one of the original 25 federally listed Patient Safety Organizations, our programs have led to significant safety and quality improvements to include: lower utilization rates, decreased Healthcare Associated Infection rates, lower falls rates, a reduced incidence of harm to mothers and babies, significant cost savings and lives saved in addition to an improved overall culture of patient safety.

This has been accomplished by developing and disseminating evidence-based best practices through collaboratives, conferences, training classes, seminars, patient safety forums and "safe table" discussions among facilities throughout the provider continuum.



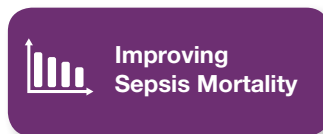
203 fewer first time C-sections,
\$406,000 cost savings (Jan 2016–present)
8,100 fewer early Elective deliveries
(Jan 09–Dec 2013)



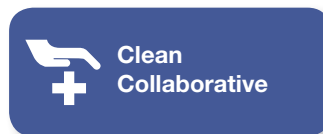
54% decrease in acute care falls w/ injury;
1058 falls avoided, cost savings: **\$9 million**
18% decrease in LTC falls w/ injury;
823 falls avoided, cost savings: **\$7 million**



90% compliance rate of caregivers following proper hand hygiene protocols upon entry and exit from patient room



19.1% decrease in deaths due to sepsis
(July 2014–Dec 2015)
537 lives saved (July 2014–Feb 2017)



56% improved high touch/public area decontamination rate (March 2016–March 2017)
113 fewer C-difficile cases;
\$1,967,556 cost savings



19,568 healthcare provider "touches" since 2004
1,283 annual conference attendees in 2017



29% or \$688,298 reduction in operating expenses (FY 2012–FY 2016)
37% or \$483,373 reduction in HSCRC funding (FY 2012–proposed FY 2018)

FIND OUT MORE ABOUT THE CENTER'S WORK AND INITIATIVES AT

www.MarylandPatientSafety.org



6820 Deerpath Road
Elkridge, MD 21075
410.540.9210

MPSC Initiatives

MPSC has improved patient safety in a number of vital areas through programs, partnerships, and collaboratives.

Maryland Hospital Hand Hygiene Collaborative

The hand hygiene initiative was coordinated in collaboration with the Maryland Department of Health and Mental Hygiene, the Maryland Health Care Commission, the Delmarva Foundation, the Maryland Hospital Association, and the Johns Hopkins Center for Innovation in Quality Patient Care. This program was the first and only statewide hand hygiene initiative of its kind, with forty-four acute care Maryland hospitals and one specialty hospital participating. Over the program's five-year duration, hand hygiene compliance rose from 72 percent to more than 90 percent and was sustained for the final eighteen months of the collaborative.

Safe From Falls

As one of the most successful initiatives to date, the Safe From Falls Collaborative focused on reducing the number of falls with injury. The program was active at thirty-one acute care hospitals, twenty-seven long-term care facilities, and eight home health care providers. The rate of falls with injury in acute care facilities went from 27.72 percent to 12.92 percent (representing a 54 percent decrease in the rate and an avoidance of 1,058 falls with injury), which represents a cost saving of \$9,056,480. Long-term care facilities saw an avoidance of 823 falls with injury, representing \$7,044,880 in cost savings.

Neonatal Abstinence Syndrome

Throughout Maryland, non-profits, for profits, and activist groups are working to fight the opioid epidemic. Neonatal abstinence syndrome (NAS) occurs in newborns who were exposed to opiates, alcohol, narcotic, or other drugs while in the mother's womb. Newborns with NAS have an increased chance of admission to an intensive care unit and prolonged hospital stays. In October of 2016, the MPSC began a two-year initiative to standardize care and treatment of these infants. Through a partnership with the Vermont Oxford Network, MPSC uses their Neonatal Abstinence Syndrome Statewide Implementation Package with the goals of decreasing the length of stay, thirty-day readmissions, and the number of infant transfers from birthing centers to higher levels of care. The collaborative has had a tangible impact already, and the program continues to expand.

Clean Collaborative

In an effort to reduce health care acquired infections (HAIs), MPSC embarked on a one-year initiative aimed at reducing surface contamination in high touch areas of health care facilities. Hospitals, long-term care facilities, and ambulatory surgical centers participated, with a 56 percent improvement in the decontamination rate. In addition, the participating hospitals showed a combined 113 fewer *Clostridium difficile* (*C. difficile*) infections for a cost saving in excess of \$1.9 million.

Reducing Non-Medically Indicated Early Elective Deliveries

One of the first MPSC collaboratives was formed in 2007 and had a perinatal focus that aimed to reduce infant and maternal harm through system improvements and team behaviors. In 2009, the initiative established a substantial infrastructure of obstetrical and neonatal professionals with a focus on reducing elective cesarean sections and inductions at less than thirty-nine weeks in the thirty-one participating birthing hospitals. From January 2009 to December 2013, the collaborative (1) reduced the rate of scheduled early elective inductions by 95 percent, (2) reduced the rate of early elective scheduled cesarean sections by 94.2 percent, and (3) reduced the rate of all early elective deliveries by 95.5 percent, which translates to more than 8,100 early elective deliveries over five years.

The Golden Hour Initiative

The Golden Hour Initiative was developed to decrease neonatal morbidity, mortality, and length of stay through implementation of activities during the first hour of life for infants born weighing less than 1,500 grams. Twenty-six hospitals participated in this initiative, and the collaborative saw a 53 percent reduction from baseline of incidence of chronic lung disease.

Improving Sepsis Mortality

The sepsis mortality initiative, one of the most innovative collaboratives to date, is a recently completed effort that focused on a very misunderstood cause of death. The two participating cohorts saw immense success. Cohort 1 realized a 19.1 percent decrease in sepsis mortality. Although final data are still being analyzed, the indication for Cohort 2 is a reduction of more than 10 percent.

Reducing Primary C-Sections

The rate of c-sections in Maryland is approximately 34 percent, slightly higher than the national average. To address the high rate of c-sections, which are linked to a number of risks for both child and mother, MPSC partnered with the Alliance for Innovation in Maternal Health (AIM) to develop a collaborative based on the AIM bundle on Safe Reduction of Primary Cesarean Births. With thirty-one Maryland birthing hospitals on board, trends are promising. The rate of first time c-sections decreased by 203 over the first nine months, representing a cost savings of \$406,000.

MPSC leadership recognizes that improving patient safety is a never-ending endeavor. Simply put, health care delivery can always be improved and made safer. Leadership continues to listen to the challenges that patients and practitioners face every day, which helps drive new programming endeavors.

MPSC publishes a regular newsletter (*Keeping Patients Safe*), is active on social media, and has recently launched a podcast, "Get Centered." Visit www.marylandpatientsafetycenter.org to learn more about how MPSC programs and initiatives are making health care in Maryland the safest in the nation.

Robert Imhoff, MPP, is President and CEO of the Maryland Patient Safety Center. He can be reached at rimhoff@marylandpatientsafety.org.

Improving Patient Experience and Outcomes Through Value-Based Care and ACOs

Vinu Ganti, MD



A Medicare beneficiary in my Medicare Accountable Care Organization (ACO) lived alone and with chronic pain. She was unable to perform simple activities of daily living (ADLs) and had no relatives or friends to care for her. Her primary care physician (PCP) wanted her to move into an assisted living facility, but she refused to sell her home and move. As a result, her PCP contacted his care coordinator in the ACO to help secure a home health aide. Today, the Medicare beneficiary's pain, depression, and anxiety are controlled, she is able to live independently, and the health care costs to the system and to her are reduced.

The Medicare beneficiary patient's story is unique, but the approach to helping her is quite common among the practices in my ACO, the Accountable Care Coalition of Chesapeake, a Next Generation ACO model. Working with the Chesapeake Independent Physician Association (IPA), and representing more than 150 PCP providers, we will adopt a similar approach to serve members of commercial health plans through commercial ACO arrangements. To remain independent, more and more primary care providers are formally coming together to coordinate patient care, improve outcomes, reduce overall health care costs, and embrace the changes resulting from health care payment reform.

How My Patients Benefit

The ACO gives me tools and support to help keep my patients healthy and out of the hospital. It also encourages me to cultivate better patient relationships and give patients a strong voice in decision-making.

Care coordination, chronic disease management programs, and preventive care are hallmarks of how an ACO operates. We are encouraged to perform Medicare Annual Wellness Visits (AWVs), during which we focus on building a prevention plan and open the door to better relationships with our patients. Chronic disease management services arranged through the ACO for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) help patients manage their health. In the case of more urgent medical issues, I give my patients my phone number so that they can consult directly with me when deciding to go to the emergency department (ED) or an urgent care facility.

Such initiatives lay the groundwork for shared decision-making, a critical component for the patient-centered health care model we strive to follow in the ACO. According to Andy Lazris, MD, a fellow primary care physician in the ACO and author of *Curing Medicare*, Americans take more medicines than anyone else in the world, without better outcomes and typically without life-preserving or life-improving results.¹ We need to talk with our patients to come to a decision together and to avoid unnecessary tests or treatment, while working as a team for improved outcomes.

Through the ACO structure, I have formed close and collaborative relationships with my patients. Mark Wulff and his wife have been my patients for several years, and we have a relationship that results in shared decision-making.

"My wife and I are on a first-name basis with the office. They know who we are when we call. Dr. Ganti is very good at listening and adjusting his approach to our personal needs and concerns. If we bring in articles we've read or information about new medicines, Dr. Ganti will listen to us, talk to us about them, and make changes as needed. It's nice to know we're not just a page in a file on a shelf."

—Mark Wulff

Benefits to the Practice

Over the past ten years, the number of independent providers has decreased, despite being the backbone of the health care system. Participating in an ACO offers physician practices the opportunity for significant upside, with little to no risk, resulting in additional funding for the practice, or "shared savings." The shared savings allow me to remain independent and continue to provide exceptional care for my patients in a financially healthy practice.

I feel confident knowing that my practice is thriving as new quality programs, such as MACRA (Medicare Access and CHIP Reauthorization Act) and the new value-based payment system take hold. I've learned how to seamlessly integrate care coordination into my office routine. Care coordinators and social workers come to my office regularly to review patient cases and determine

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Improving Patient Experience ...

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if any patients need support other than health care. For example, if a patient needs transportation to an appointment, the ACO can arrange for a taxi at no cost to the patient.

Maryland and Virginia ACO Performance: 2012–15 Performance Results for Four ACOs Sponsored by Collaborative Health Systems

- Group Practice Reporting Option (GPRO) quality scores, which measures patient health and patient satisfaction, increased from 83 percent to 94 percent.
- Hospital admissions and thirty-day unplanned readmissions decreased an average of 18 percent.
- Savings for the Centers for Medicare & Medicaid Services (CMS) and a share in millions of dollars of savings were generated.

Technology and data analytics play important roles in my practice. The electronic medical record (EMR) allows us to reduce paperwork and repeat fewer tests. Population health reports provided by the ACO identify patients we want to bring into the office for a visit, whether they are patients who have not received primary care service in a long time or patients with chronic diseases.

Since joining the ACO, the hospitalization rate has declined for my patients, as it has for Maryland and Virginia ACOs sponsored by Collaborative Health Systems. I am not surprised by these results, because we have more frequent communication with our patients and work to meet quality goals. Our patients visit the doctor an average of four times a year, whereas the standard fee-for-service Medicare patient visits three times per year. We have more frequent and personalized contact with our chronic patients with co-morbidities, either with direct patient visits or outreach from care coordinators.

Extending Benefits to Members of Commercial Payers

The experience for my Medicare patients has been so beneficial. I've now entered into a relationship with the Chesapeake IPA to provide the same value-based care to patients through commercial ACO arrangements covered by commercial payers, which represent more than 70 percent of the patient population.

Since I have made the shift to value-based care, patient satisfaction and retention is the highest I've seen at my practice. This model keeps my patients closely connected with me, which results in healthier patients and lower costs for everyone.

Vinu Ganti, MD, is a primary care practice located in Germantown, Maryland. Dr. Ganti is a participant in the Accountable Care Coalition of Chesapeake, a Next Generation Accountable Care Organization model, and co-chair of the Board of Chesapeake Independent Physician Association (IPA). Both organizations are sponsored by Collaborative Health Systems, a WellCare company. Dr. Ganti can be reached at drgantistaff@gmail.com.

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Doctor–Patient Relationship ...

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The art of communication is withering before our eyes... or at least transforming. Language is changing at lightning speed (An excellent read on this concept is *Righting the Mother Tongue: From Olde English to Email, the Tangled Story of English Spelling*, by David Wolman). The way we communicate and the words we choose are loaded with context, and our patience to allow the personal narrative to unfold is thin. It is a perfect constellation in which to disengage at a time when connection is what we need most. I believe the greatest opportunity for our times is mentorship—intentional partnering to find the truth between efficiency and connection, between fact and story.

Our population is increasingly ill. The complexities of diseases and treatments exponentially rise. As a surgeon I am struck often by the need for the physician to serve as something more than human...a superhero of sorts. I cannot be more aware of my own imperfect humanness, but having been a patient, I truly understand the absolute need to believe in the miraculous. Patients search imploringly for physicians to have abilities to repair failed organs and tissues that are statistically beyond repair. We actively engage difficult palliative narratives in our hospitals and try and find a balance between hero and human. Physicians, and patients, are exhausted. But the data pushes on.

How did we get to a place where caring and listening become a nuisance to the required actions of a physician's work? There is a place for conversation in mentoring and caring. As our role evolves and our interface modernizes, we have an opportunity to gather our collective wisdom and strength. As we share our story and add our salient features, the narrative evolves. Together we might just have the strength to re-engage. It's hard to argue with happy.

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Brooke Buckley, MD, FACS, is Chief of the Division of Surgery, Anne Arundel Medical Center, and Medical Director of Acute Care Surgery. She can be reached at bbuckley@aahs.org.

Prediabetes PSA Campaign Provides Tools for Physicians and Patients

Gene Ransom, III, Esq.

How long does it take for your patients to learn if they have prediabetes? A one-minute PSA featuring adorable puppies, hedgehogs, and baby goats offers viewers (and your patients) the opportunity to learn their risk while taking a prediabetes risk test.

The PSAs are part of a new ad campaign from the American Medical Association (AMA), in partnership with the Centers for Disease Control and Prevention (CDC), the American Diabetes Association, and the Ad Council, designed to increase awareness about prediabetes and Type 2 diabetes prevention. MedChi president Stephen Rockower, MD, says that MedChi will join with the AMA and other groups to increase the awareness of the role of excessive sugars in the development of diabetes.

Lifestyle Changes After Diagnosis Help Lead the Way

Eighty-four million Americans have prediabetes, and nearly 90 percent do not know they have it or the long-term risks to their health. It's critical for your patients to know their risk. According to the Maryland Department of Public Health, 1.6 million adults in Maryland are estimated to have prediabetes. Only about 408,000, or 10.5 percent, are aware that they have prediabetes (<https://phpa.health.maryland.gov/ccdpc/diabetes/Pages/prevention.aspx>).

The ad campaign makes viewers aware that by making everyday lifestyle changes, prediabetes can often be reversed. But a diagnosis has to come first. Research reveals that when people are aware of their condition, they are more likely to make the necessary long-term lifestyle changes that can help delay or prevent the onset of Type 2 diabetes.

Lifestyle changes include such things as weight loss and adopting new habits of healthy eating and physical activity. "We need to limit the intake of sugars in children and adults. Discuss with your physician the proper diet and testing," said Dr. Rockower.

In addition to the PSAs, the campaign website also features lifestyle tips and links to the CDC's National Diabetes Prevention Program (<https://www.cdc.gov/diabetes/prevention/index.html>). The site connects visitors to a registry of CDC-recognized programs across the country.

"A lifestyle change program offered through the CDC-led National Diabetes Prevention Program, based on research led by the National Institutes of Health, can help people with prediabetes make those changes—and sets them up for long-lasting success," said Ann Albright, Ph.D., R.D.N., Director of CDC's Division of Diabetes Translation.

People with prediabetes can lower their risk of developing Type 2 diabetes by as much as 58 percent, and by 71 percent for people over age sixty.



Campaign Toolkit Helps Physicians Expand Awareness

In an effort to help physicians grow awareness and extend its reach to patients, the AMA has also developed a Prediabetes Awareness Campaign Toolkit (<http://prediabetes.adcouncilkit.org>).

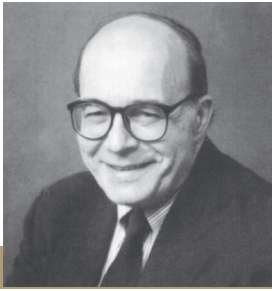
Some of the tools featured in the toolkit include the following:

- Downloadable PSAs across all media and a guide on how to use them.
- Customizable templates and materials to spread awareness.
- Social media messaging to share on social channels.
- Campaign fact sheet and FAQs.
- The toolkit is dynamic, which means that physicians can return to it throughout the year to find new, updated content.

Additional Physician Tools for Diabetes Prevention

There are other resources that can help physicians build awareness around prediabetes and increase diabetes prevention efforts:

- The comprehensive Prevent Diabetes STAT toolkit, which guides physicians to screen and test patients for prediabetes and then refer them to a DPP. The kit includes handouts, sample forms, and step-by-step guidelines on screening and prevention.
- The AMA DPP Cost Saving Calculator, an online tool to determine the net savings and ROI for starting a DPP that serves a patient population in your region.



Orchids, Myxedema, and Terror

CLASSIC WORD ROUNDS

Barton J. Gershen, MD
Editor Emeritus

The English Civil War was fought between 1642 and 1646. It left in its wake innumerable casualties, including King Charles I, whom the parliament ordered beheaded. After an interregnum period of eleven years, his son Charles II was allowed to assume the crown, which he held for twenty-five years. Like his father, he too had faults. However, he was loyal to those soldiers who had been wounded during the conflict. Many of them were provided with jobs, which could be performed by disabled veterans. Some of these lame veterans became night watchman and soon came to be called “Charlies’ men,” or simply “Charlies.”

Subsequently, lame horses also became known as **Charlie’s horses**, since they too walked with a limp. From then on some clever linguists began to call the stiffness, pain, and minor disabilities due to exercise, a “**Charlie horse**.” Cromwell would have enjoyed that.

A century before, during the reign of King Henry VIII, there were but five hospitals available in London for indigent care. The elderly but healthy were sent to Bridewell, the elderly sick to St. Thomas, or St. Bartholomew’s, and children under sixteen went to Christ’s Hospital. However, the remaining facility was reserved for the insane—**St. Mary’s of Bethlehem**. That hospital became the repository for all the psychotic, sociopathic, violent, and drug addicted wretches in the city. It was indeed the first “snake pit.” The clamor, screaming, and bizarre vocalizations emanating from that place was said to have attracted the morbid curiosity of the townspeople, many of whom found macabre entertainment in watching and listening from a safe distance. Thus the origin of “**bedlam**”—a colloquial contraction of **Bethlehem**. (The name Bethlehem is from the Hebrew: “*bet*,” house, and “*lekhem*,” of bread. Thus Bethlehem is the “house of bread,” which in the Hebrew bible referred to the fertile agricultural plain surrounding the city.)

An occasional patient, unfortunately hospitalized in that hospital, was a child afflicted with congenital myxedema. These children were born athyreotic, with errors of metabolism, or with iodine deficiency. They developed bony abnormalities, large thickened tongues and lips, and mental retardation. Moronic or imbecilic in IQ, these strange, sad, defective creatures often spent an entire lifetime within the confines of Bethlehem’s asylum. Phillipus Aureolus Theophrastus Bombastus von Hohenheim (1493–1541), a famous Swiss physician, perhaps better known by his pseudonym **Paracelsus**, first recognized the association between goitrous parents and their myxedematous children. It was he who pleaded for their recognition—not as brutes or animals—but as Christians, which in French is *Chretien*. Thus they became known as **cretins**.

From the 11th through the 13th century a devout and political Islamic sect existed, which called themselves *Nizari Ismailis*. This group considered the murder of their enemies a religious duty, and they vowed to exterminate all Christian Crusaders. Prior to embarking on their murderous expeditions, they ritually consumed the drug cannabis. They were therefore called “Hashishim,” Arabic for “hashish eater.” The Crusaders brought this name back to Europe, where through linguistic evolution “hashishim” became **assassin**. *Plus ça change plus c’est la même chose*.

The Latin word for “witness” is **testis**. At trials one who bore witness against a defendant was made to grab his testicles as he swore an oath of truth. Thus evolved the terms **testify** and **testimony**, as well as the anatomic term with which we are familiar. Clearly, in those early masculine dominated societies, women were not allowed to bear witness against anyone in court.

Incidentally, the Greek word for this organ was orchid and can be found in such medical terms as **orchitis** and **orchieectomy**. The beautiful flower we so admire actually means “like a testicle.” The famous classical naturalist Pliny the Elder (23–79 C.E.) had demonstrated that the bulbous double root of the orchid flower resembled male genitals. And so he named it.

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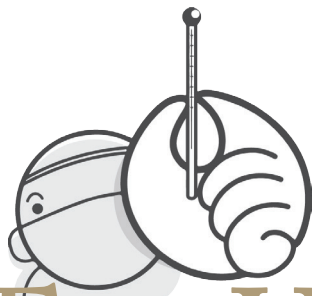
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The Maryland Prescription Drug Monitoring Program gives you access to prescription information for all Schedule II-V drugs filled in Maryland and Virginia.

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