

Maryland **Medicine**

The Maryland Medical Journal Volume 18, Issue 4



Humanities in Medicine

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2018 Legislative Agenda**

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I N S I D E



This issue of *Maryland Medicine* examines the humanities in medicine.

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Wear the Cost: Maryland Health Care Commission Pricing Website



Gary Pushkin, MD
@medchipresident

PRESIDENT'S MESSAGE

The Maryland Health Care Commission (MHCC) recently launched (<http://healthcarecost.mhcc.maryland.gov>), a website that provides “information to educate patients and providers about the difference in cost and quality among the hospitals.” Transparency is a good thing. MedChi has fought for drug pricing transparency and fully supports transparency in all levels of health care.

Transparency efforts must be appropriate and accurate. Our concern is that the website creates very generalized and inappropriate statements, which imply that higher costs are caused by avoidable complications. However, in reality, unavoidable medical issues or patient conditions could contribute to higher costs. General statements are rarely appropriate in the delivery of health care services. Frankly, it is unclear whether the MHCC pricing website is necessary, and whether the costs associated with it are accurate, given that the MHCC’s website currently has its own section dedicated to hospital costs. *Wear the Cost* (http://healthcarecost.mhcc.maryland.gov/vaginal_delivery.html) and the Maryland Healthcare Quality Reports (<https://healthcarequality.mhcc.maryland.gov/public/>

TopDrgPricingForHospitals) contain overlapping categories of costs, such as vaginal delivery. However, the dollar amounts are different for each site, which can only cause greater confusion among patients.

MedChi is troubled by the development of the website. The contractor for the project held a one-day meeting with hospitals to discuss the data, but did not invite physicians to provide insight or include physicians in any part of the process. MedChi suggests the website be taken down, given the mismanagement of the process and the inconsistencies in listed costs. There should be a public process with all the stakeholders providing input to produce a better and accurate product.

In a meeting between the MHCC and MedChi counsel, we discussed the future of these efforts. As a result of the meeting, some changes were implemented and some concessions were made. However, this issue is not resolved. The website only dealt with a small number of orthopedic and obgyn codes, with plans to expand to other specialties. MedChi will continue to work to protect the art and practice of medicine and accuracy of the information presented.

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Maryland Physicians Generate \$39.5 Billion in Economic Activity

AMA Economic Impact Study



CEO'S MESSAGE

Gene Ransom, III, Esq.
@GeneRansom

Physicians add opportunity, growth and prosperity to the Maryland economy by creating 213,060 jobs and generating \$39.5B in economic activity, according to a new report, *The Economic Impact of Physicians in Maryland*, released by MedChi, the Maryland State Medical Society and the American Medical Association (AMA).

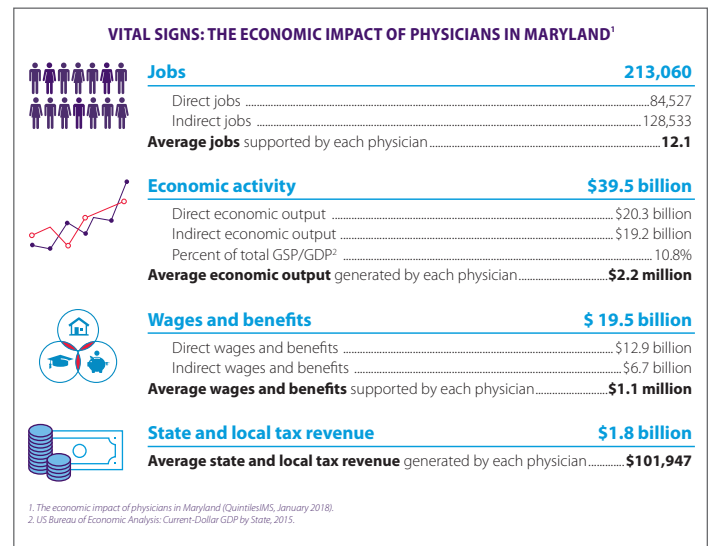
MedChi President Gary Pushkin, MD, explained “The AMA study shows physicians are woven into the community, bringing immeasurable services to Maryland neighborhoods and families. Physicians hire locally, pay local taxes, and produce a local economy.”

Maryland physicians generate more economic output, produce more jobs, and pay more in wages and benefits than higher education, nursing and community care facilities, legal services, and home health.

The study quantifies the economic boost that 17,633 active patient care physicians provide to the state’s economy, producing a ripple effect that is felt statewide. The study measures physicians’ impact using four key economic indicators:

1. **Jobs:** Physicians support 213,060 jobs in Maryland—12.08 for each physician on average.
2. **Economic activity:** Physicians generate \$39.5B in economic output, comprising 17.8 percent of the Maryland economy. Each physician generates \$2,239,882 for the state economy on average.
3. **Wages and benefits:** Physicians contribute \$19,542.0M in total wages and benefits paid to workers across Maryland, empowering a high-quality, sustainable workforce. Each physician contributes \$1,108,263 to workers’ wages and benefits on average.
4. **State and local tax revenue:** Physicians’ contribution to the Maryland economy generates \$1,797.6M in state and local tax revenue for their communities—translating to \$101,947 for each physician on average—enabling community investments to be made.

“The positive impact of physicians extends beyond safeguarding the health and welfare of their patients,” said AMA President David O. Barbe, MD, MHA. “The Economic Impact Study illustrates that physicians are woven into their local communities and have a vital role in fueling state economies by creating jobs, purchasing goods and services, and supporting public services through the tax revenue they generate.”



The report found that every dollar applied to physician services in Maryland supports an additional \$.95 in other business activity. An additional 6.33 jobs, above and beyond the clinical and administrative personnel that work inside the physician practices, are supported for each \$1 million of revenue generated by a physician’s practice. In addition, Maryland physicians generate more economic output, produce more jobs, and pay more in wages and benefits than higher education, nursing and community care facilities, legal services, and home health.

Across the country, physicians add \$2.3 trillion to the U.S. economy, support more than 12.6 million jobs nationwide, contribute \$1 trillion in total wages and benefits paid to U.S. workers, and generate \$92.9 billion in state and local tax revenue.

To view the full report and an interactive map, please visit www.PhysiciansEconomicImpact.org.

Physicians bring economic health to our communities.

The **2018 AMA Economic Impact Study** demonstrates how physicians contribute mightily to the health of Maryland's economy.

213,060
JOBS



\$39.5 billion
IN ECONOMIC ACTIVITY



\$1.8 billion
IN STATE & LOCAL TAX REVENUES



\$19.5 billion
IN WAGES & BENEFITS



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Learn more at **PhysiciansEconomicImpact.org**



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Plus ça change...



EDITOR'S CORNER

Bruce M. Smoller, MD

This issue of *Maryland Medicine* will be the last of the present format, and this editorial will be my last regular column.

The readers of *Maryland Medicine* have told us through many surveys that they enjoy reading *Maryland Medicine*. We are grateful for that support, but change comes to everything, *Maryland Medicine* included.

We have found it increasingly difficult, for a variety of reasons, to meet production goals on a timely basis. We are a membership benefit, a voice (always hopefully) for medicine, a provocative (again, always hopefully), vehicle for MedChi's members, a creative outlet for the editorial board and our contributing authors, and a stick in the eye to the fatuous, the greedy, the hangers-on, and the truly evil arrayed against physicians and our patients. We didn't always succeed, but we tried.

We are also a business, with the goal always in mind (if not on the balance sheet) of being self-sufficient. That means signing up and keeping, and, yes, pleasing, advertisers, and sometimes the authors we solicit. We have been threatened with suit, with being shut down, pressured by big business, cajoled and, sometimes, lauded. Make no mistake about it...we enjoyed it all, and were grateful for the opportunity. Where else could the members of our board have a rather unfettered, but always professional, chance to proclaim and declaim at, almost, our heart's content. Thank you all for that opportunity.

Maryland Medicine, however, is certainly not going away. It will be published more frequently, but will be a little bit smaller. It will change from a journal format to a magazine layout of about half the pages, but be published six times a year. Surveys indicate that our members want more direct mail from MedChi, not less, in this age of sometimes overabundant digital print.

The new format will have much more news and be update focused, with more news about federal issues, health system reform, regulatory updates. It will have more news about legislative issues, many more practice tips, and more about MedChi components, activities, and efforts.

We will continue to have thematic articles...thought provoking, hopefully insightful articles based around a current topic of interest to our readers. These will not, however, be the main thrust of each issue. Our goal is to be more responsive more quickly and more informative than in the past while still retaining the ability to present provocative, thematic ideas. You, our readers, will be the arbiters of this change. Give it some time, and then please let us know whether you applaud this change or decry it. You, our readers, are the only ones who really count here. So let us know and we'll see you on the other side of our changes. I and our great board will still be here, in slightly altered form, to serve you.

In closing, I would like to reprint my editorial from December 2007, ten years ago. I think its sentiment is even more relevant today.

As we reflect on the hard work, the achievements and the disappointments, the gains and losses, the triumphs and tragedies of this waning year, I hope you find special joy in the warmth of family and friends (human and otherwise) and a singular pleasure in that relationship allowed us by virtue of our profession, the amity and friendship, trust and respect of our patients. I believe this is best summed up by the words uttered by Doctor Archibald "Moonlight" Graham in the movie "Field of Dreams."

After being magically transformed into a young man, he is allowed to play ball again. He never was at bat during his short baseball career, and now he is at the plate ready to receive the pitch. But he spies the young daughter of Ray Kinsella choking to death and without hesitation "Moonlight" crosses that enchanted boundary between fantasy and reality, and instantly becomes an old man again...a physician, not a ball player. He saves the young girl but never gets to hit, even in fantasy.

When Ray Kinsella notes that the baseball career and lifelong dream of Moonlight Graham had lasted only five minutes and would therefore be considered a tragedy by many people, Doc Graham replied, "Son, if I'd only got to be a doctor for five minutes, now that would have been a tragedy."

It is the spirit of that thought, especially when all the legislative and regulatory chips are down, that will give perspective to our work and meaning to our days in the year ahead.

What keeps you up at night? Share your thoughts, views, and perspectives in future issues of *Maryland Medicine*.

Going forward, *Maryland Medicine* will feature MedChi members' thoughts, views, and perspectives. Tell us about practicing medicine, professional and personal life balance, and anonymous patient stories or difficult cases, or what you do in your free time. It's a great opportunity to share what keeps you up at night, what you've enjoyed about practicing medicine or your medical training, or what your concerns are for the next generation of physicians. We'd like to hear the good, the bad, and the ugly about running a medical practice or technology, including your favorite apps.

We welcome articles from physicians of all specialties and modes of practice, and residents and medical students too. Please keep your article to less than 300 words. Submit to Cathy Johannesen at cjohannesen@medchi.org.

Keep your pen and pad or iPad by your bedside, and when you can't sleep... capture your thoughts and share it with your colleagues.





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Introduction: Humanities in Medicine

Tyler Cymet, DO

The humanities humanize health care. In appreciating the stories of our patients and ourselves, it is the sociology and philosophy that we have built within us that frames the stories. Including humanities in medical education creates a more empathetic physician. So where do the humanities fit for physicians?¹

In creating a physician, medical education will take people apart to teach medical students about the structure and function of an individual from a scientific understanding. Basic sciences are the primary building blocks for physicians that provide the rules necessary to accept information as valid. Clinical sciences provide a context for normal and abnormal functioning. Health system sciences define the role of a physician at different points of care.

But how do we move from people parts, and ways of explaining and understanding health and illness to the patient as a person? It has long been accepted that the humanities are needed to integrate personalities, health, and the patient's life.²

The humanities provide a different perspective, and a different method to think about health and illness. Having alternate ways of viewing an experience is critical if a physician is to tolerate ambiguity, possess critical thinking skills, prioritize professionalism, and maintain empathy.³

Discovering one's mortality and limitations has a way of changing one's thinking. When our patients are confronted with illness, issues related to defining one's life and purpose as well as relationship to family, community, society, and other defining groups come up and cannot be addressed by the scientific foundations of medicine. These are issues that transcend the defining thinking taught in medicine and health.⁴

Physicians return to the humanities in times of uncertainty—both personal and professional—and often rely on the education and experiences they had before entering the medical profession. The power of the humanities is greatest when provided in a useful and familiar context. It is becoming increasingly important for medical education and physicians to incorporate the humanities into our lives and our education.

This issue of *Maryland Medicine* examines humanities in medicine. The articles here address the question of how we overcome the concrete nature of medical science and apply those sciences to people. In 2017, Frank Cusimano, a DO/PhD student, collaborated with artist Anicka Yi on a Guggenheim exhibit that looked at bacteria and disease as potentially having beauty and capable of expressing more than illness, a viewpoint rarely contemplated in medicine. Frank Cusimano writes about how humanities and the arts encourage professionals to work together and to value other viewpoints. Dr. Sajid Surve looks at performing artists as patients, and how practitioners of the humanities affect how we practice medicine. The person receiving care affects the care received, and the humanities perspective about what we do in medicine. The alternative perspectives introduced by the humanities have value different from the sciences, and are a necessary part of complete care.

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2. A. Meyer. "Objective Psychology or Psychobiology with Subordination of the Medically Useless Contrast of Medical and Physical," *Journal of the American Medical Association* 65(1): 860 (Sept 4, 1915).
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Performing Arts Medicine: An Underserved Population with Unique Demands

Sajid Surve, DO

For more than a decade, my practice as an osteopathic physiatrist has been focused to varying degrees on the performing arts population. For the past three years, I have had the privilege of serving as a co-director for the Texas Center for Performing Arts Health,¹ housed within the University of North Texas. Providers who specialize in this population are unfortunately few and far between, but recent inroads have been made by some national organizations to attempt to fill in the knowledge gaps for medical professionals. The Performing Arts Medicine Association (PAMA)² has been the main interface between the medical and performing arts communities for several decades. Through their peer-reviewed journal, *Medical Problems of Performing Artists*,³ practitioners may expand their knowledge base.

The American College of Sports Medicine (ACSM) is also making its foray into the world of performing artists. ACSM's initiative, *Athletes and the Arts*,⁴ seeks to draw on the parallels between performing arts medicine and sports medicine, with the goal of expanding resources for performers and training opportunities for physicians.

Are performing artists really like athletes? There are arguments both for and against this assumption.

Performing Artists Are Like Athletes

Both populations require years of dedication and practice to achieve mastery of a particular skill. Engaging in the skill places significant physical demand on their bodies, which is often beyond their direct control. Additionally,

the opportunity for adequate recovery time after a rigorous period of activity is not always available. When injuries arise, they create not just a physical stressor, but also significant mental and financial stressors if the ability to perform is in any way compromised. Both artists and athletes struggle with anxiety related to their performance, and have considerable difficulties with self-worth and self-esteem.

Artists and athletes often meet resistance from their providers because of a differing set of priorities. The medical community is generally conservative by nature, especially in the musculoskeletal arena. Rest is the mainstay of our advice when injuries arise, but the performer and athlete are interested in return to work as quickly as possible. Even when no injury is present, the performer and athlete may seek medical advice to optimize performance, through diet, exercise, referral, or possibly even elective surgical intervention. At such times, the medical provider may be hesitant to give advice or sanction such actions on the part of the performer, if there is no medical benefit or indication. Open communication is the key to successfully navigating these conflicts, as well as a consideration of the performer's and athlete's occupational demands. Oftentimes, this consideration leads to more aggressive management than would be prudent in the general population. Again, communication of the risks, benefits, and alternatives will help both parties come to consensus on how best to proceed in most cases.

Performing Artists Are Not Like Athletes

Although artists and athletes share many traits, they also have some key differences. First and foremost is the availability of resources to meet the demands of the occupation. An NCAA Division I sports team that does not provide its players adequate access to physicians, therapists, athletic trainers, coaches, or other appropriately trained allied-health professionals would not only be running afoul of best practices, but could potentially face fines or other administrative penalty from the NCAA itself. Likewise, a professional sporting team without a fully staffed and equipped training room would be unconscionable. However, professional and collegiate dance and music programs often practice and perform with little to no oversight from the medical community. Furthermore, when performance-induced injuries do occur, the same dance and music organizations frequently struggle to provide their performers with adequate medical care, often lacking established relationships or action plans for how to get their performers seen.

Much of the disparity in care stems from the second major difference between artists and athletes: investment in research. Sports science is an enormous industry, investigating everything from helmet safety to training methods to best types of Astroturf. Out of this wellspring of evidence comes better practices, recommendations, and public awareness. All of the health care professionals who support sports teams are able to receive specialized training because of the endeavors of researchers to answer the fundamental questions regarding the underpinnings of sport. How do injuries happen? Who gets injured, and why? What can be done to prevent these injuries? Researchers are only at the preliminary phases of answering these very basic questions for the performing artist. The field of performing arts science has decades to go to catch up with the sports science infrastructure.

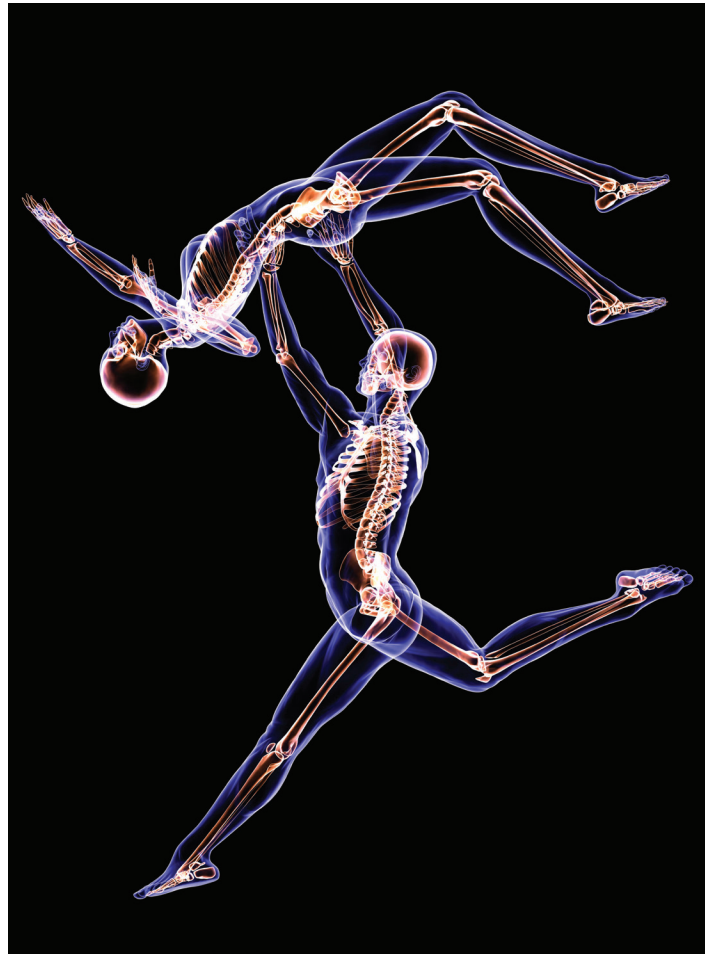
Lastly, athletes are inherently aware of the physicality that their skills require. They are generally in good cardiovascular health, exercise regularly, and maintain good eating habits. Through their training, they are usually taught to pay attention to their bodies and seek medical care if they experience any untoward symptoms. Performers, on the other hand, tend to be more varied in their overall conditioning and habits. Many actively choose to ignore body symptoms and continue to work through injuries either out of a lack of awareness or because they fear reprisal or job security. These differences in attitude can have a profound effect on overall outcomes.

Performing artists face unique challenges that are both similar and dissimilar to their athlete counterparts. With more concerted effort and financial resources, the disparities in resources and research can be overcome in the future. The medical professional who wishes to engage with this community needs to understand the challenges and partner with their patients to help treat and advocate for this vibrant portion of our labor force.

Sajid Surve, DO, is co-director and associate professor of osteopathic medicine at Texas Center for Performing Arts Health. He can be reached at sajid.surve@unthsc.edu.

Further Reading and Resources

1. Athletes and the Arts (<http://athletesandthearts.com>)
2. Medical Problems of Performing Artists (<https://www.sciandmed.com/mppa/>)
3. Performing Arts Medicine Association (<http://www.artsmed.org>)
4. Texas Center for Performing Arts Health (<http://tcpah.unt.edu>)





The Future of Interdisciplinary Health Care

Frank A. Cusimano, MA, MS, MPhil; Brittany N. Cusimano, RN; Elizabeth M. Cusimano, RN

In an attempt to increase specialization within the health care system, health care programs and hospitals have continually divided and subdivided health care workers into their specific jobs and roles. From training technicians to training orthopedic surgeons, each program focuses on teaching the skills required to perform one's given task while on the job. In recent years, interdisciplinary communication and collaboration between different professionals has led to the discussion of interdisciplinary health care, a term that all involved parties—patients, physicians, nurses, and hospital management alike—agree to be a worthy goal.¹

Interdisciplinary health care is defined as the “dynamic process involving two or more health care professionals with complementary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning, or evaluating patient care.”² Teamwork and collaboration within a health care setting can be traced back to the first practitioners of Ancient Greece.^{3,4} Studies have shown that the use of in-hospital multidisciplinary teams reduces morbidity and mortality, improves patient satisfaction, decreases length of stay, increases the quality of procedural outcomes, and improves health care worker's personal satisfaction.⁵ The value of teamwork and collaboration goes beyond what the studies show; interdisciplinary teamwork brings health care workers together and leaves a lasting impression on patients and family members. As we learn more about the value of interdisciplinary health care, hospitals

and educational programs continue to educate health care professionals on the importance of communication and collaboration in medicine.

The implementation of interdisciplinary health care is dependent on two fundamental facts: (1) health care workers must receive education and training on teamwork and collaboration during their education, and (2) hospitals must foster the use of patient-centered health care, or other health care models in which health care teams provide care in unison focusing on the needs, preferences, and values of the patient. To help expand the use of interdisciplinary health care, health professionals must be trained and educated on how to work as a team and how to serve as a valuable member in a health care setting. Incorporating the necessary training to educate health care professionals in their education programs is not easy. The educational component affects the curriculum of medical schools, nursing schools, physician assistant programs, hospital technicians, and more. While some health care professions, like nursing, have largely incorporated interdisciplinary training into their programs at an in-depth level, other professions are only starting to teach and instruct their students on teamwork and collaboration.

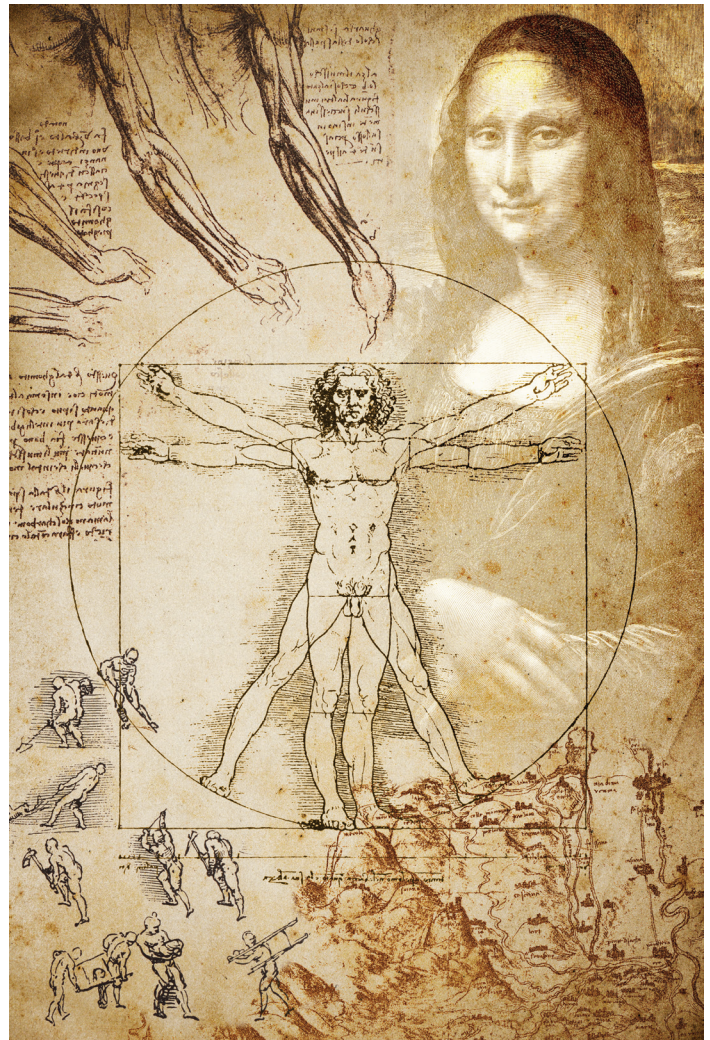
The incorporation of interdisciplinary training in nursing programs has served as the backbone for patient-centered care. Nurses play a unique role in health care, providing constant support for patients and assessing each patient's health status throughout hospitalization. In a pediatric inpatient setting, the use of interdisciplinary teamwork and

collaboration not only improves efficiency, but it also allows a nurse to meet the physical, cognitive, and spiritual needs of the patient ensuring there is a continuity of care between all members of the health care team. It is not uncommon for nurses to be present during a physician's visit with a patient and involved in the treatment decisions. Such a practice helps interdisciplinary communication, prevents medication and treatment errors, and allows for a clear line of communication between the caregivers and the families, which prevents confusion about the plan of care and goals for the patient. In an emergency department setting, the use of interdisciplinary teamwork and collaboration helps to create a cohesive unit ready to respond to any change in patient status or emergency that may walk through the door. In an emergency setting, emergency department nurses have been taught to anticipate and predict the actions of a physician to help facilitate the flow of patients within the department. They work with the other disciplines and allow for open communication between physicians, CT technicians, respiratory therapists, and other professionals who are a part of the health care team.

Throughout medical school and residency, each interdisciplinary team that medical students work with provides the foundation for training in interdisciplinary health care. During their didactic years, medical students have minimal formal teaching in interdisciplinary health care, teamwork, collaboration, conflict resolution, and management. The majority of their education comes from impromptu lessons in the hospital. They learn their role and what a health care team is from preceptors, residents, fellows, and attendings, and they learn the value of interdisciplinary health care and how to work as a team in a collaborative setting from nurses and other members of the health care team. Those medical students who worked in the health care system before medical school or who volunteered at a hospital as a premed student learn that the nurses, administrators, and technicians are the most valuable members of any health care team. They are their first instructors on how to manage and work in a team-oriented environment.

As some medical schools transition to problem-based learning, the incorporation of interdisciplinary education into the curriculum is imperative. First, students must learn their role and the role of other professionals on the health care team. Second, students must learn teamwork, communication, and the behaviors required to create a highly functional health care team.⁶ Learning these core "team-oriented" competencies in school will standardize expectations and improve the transition to working in the hospital. Some of these competencies include instruction on positive leadership and management techniques; communication strategies and structure; personal training and development; supportive teamwork and engagement; individual characteristics that support teamwork; conflict resolution; and group dynamics and skills.⁷

Interdisciplinary health care has come a long way in recent years. Professional programs, institutions, and hospitals alike are beginning to educate health care workers with the skills needed for interdisciplinary collaboration and teamwork. As model systems arise, the use of interdisciplinary health care will continue to reduce morbidity and mortality, improve patient satisfaction, and improve hospital efficiency.



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Maryland Primary Care Program: Opportunities for Medical Practices

PUBLIC HEALTH PERSPECTIVE

Howard Haft, MD, MMM, CPE, FACPE

The state of Maryland anticipates entering into a Total Cost of Care All-Payer Model contract with the federal government beginning in 2019. The model is designed to coordinate care for patients across both hospital and non-hospital settings, improve health outcomes, and constrain the growth of health care costs in Maryland. A key element of the model is the development of a voluntary Maryland Primary Care Program (MDPCP) intended to support the delivery of advanced primary care throughout the state.

In a bold response to the need to curtail hospital costs, Maryland moved to an all-payer rate setting system for hospital payments in 1977. In 2014, in an effort to further modernize and shift from volume-based payment to value-based payment, Maryland received a five-year performance period approval from the Centers for Medicare and Medicaid Services (CMS) for the new hospital payment model waiver, based on global hospital budgets and quality targets, known as the All-Payer Model (APM). The implementation of the APM modernized Maryland's hospital payment system, transitioning hospitals from volume incentives to a value-based payment system through the mechanism of hospital-specific global budgets. Global budgets allow hospitals to contain costs under the APM's commitment, which ties growth in per capita hospital spending to growth in Maryland's overall economy. The All-Payer Model in Maryland has been successful in achieving reduced hospital costs, reduced hospital-acquired conditions, and reduced readmissions among the Medicare population. All of these successes are strong evidence that Maryland is succeeding in shifting hospital payments away from volume and toward value.

Opportunity for Federal Investment

Since the summer of 2016, the Maryland Department of Health, the Maryland Health Care Commission, and the Health Services Cost Review Commission have been working closely with the federal government to develop a program to strengthen and redesign our health care delivery system around primary care and prevention. Under this model, the state has flexibility to devise an advanced primary care program in partnership with CMS. It is important to note that while primary care payments represent a small portion of total health care spending, primary care providers direct the bulk of the overall costs of care. If patients' primary care needs are well managed and supported, community providers can play an increasingly important role in strengthening key components, including prevention, care coordination, and comprehensive population health management, and thereby improve health outcomes, and control the growth in total health care spending. Our partners at CMS recognize the importance of a strong foundation of advanced ambulatory care that attends to the medical and non-medical needs of our population. Accordingly, the proposed program outlines a Medicare focused, Comprehensive Primary Care

Plus (CPC+)–like design, mirroring the national CMS model. The national CPC+ model is currently operating in eighteen regions around the nation. CPC+ Rounds 1 and 2 support nearly 3,000 primary care practices.

Program Design and Organization

Practices participating in the MDPCP would receive additional payments from CMS to make changes to the way they deliver care. As with CPC+, there would be two tracks with incremental transformation. Practices would be assigned to a track based on the information provided in their application. Participation in MDPCP would be voluntary and by application for all practices and Care Transformation Organizations. CMS would provide funding directly to practices to strengthen and transform the delivery of primary care.

Although there has been considerable consolidation and acquisition of primary care practices, Maryland still has a preponderance of small and medium size, independent primary care practices. The MDPCP has proposed the formation of Care Transformation Organizations (CTOs), which would enable these practices to participate and would provide assistance to all practices with transformation efforts. CTOs would provide care management resources, infrastructure, and technical assistance to practices. The CTOs generate economies of scale in the provision of services that are challenging for many practices to engage in financially or operationally, such as pharmacist services, behavioral health counseling services, social services, community health outreach, and health education. CTOs provide additional support and technical assistance to practices that are tailored to the needs of the community. Providers would not be required to contract with and receive services from CTOs, but the state expects many providers would do so.

Opportunities to Participate: Timeline

Maryland is currently negotiating approval of the MDPCP with CMS. Pending approval, there is a preliminary timetable for key dates (see Table 1):

Activity	Timeframe
Submit Model to CMS for Approval	Summer 2017
Release Applications	Spring/Summer 2018
Select CTOs and Practices	Summer/Fall 2018
Initiate Program	Fall 2019

Continued on page 21

Letter to the Editor

Dear Editor:

Kudos to Dr. Smoller for once again exposing the flawed logic and nefarious forces which have conspired to enhance the emergence of the EHR. There is now little debate about the misuse of valuable time, unnecessary expense and the physician frustration and burnout that accompany the adoption of the EHR. He correctly points out that ivory tower types, non-practicing physicians and businesses have found a way to tap into the business of medicine at the expense of the physicians who are directly responsible for generating the revenue and the care attendant to their work. They have done this under such guises as ostensibly collating data to beneficially effect clinical outcomes, enhancing practice efficiency and reducing overall medical costs.

To expand on Dr. Smoller's treatment of this subject, I'd like to add one reason why most physicians find themselves in this predicament. At meetings, doctors lounge conversations and through clinical discussions over my thirty-seven years of practice I came to realize quite some time ago that most physicians are followers and rarely question what is asked—or rather, demanded—of them by insurance companies, hospitals, etc. They do not realize that they provide the product, not the insurance company or the hospital. Insurance companies have nothing to sell without doctors and hospitals have no service to provide without us. Yet, we sign one sided insurance contracts without making any changes and then complain about it and blindly support hospitals that see no problem creating walk in clinics that directly compete with us.

The same applies to the EHR. All physicians have to do is say, "No, this is how it's going to work." If enough physicians had the backbone to respond this way and realize the power they have, things would be different. I, for one, have marked up several extremely one-sided insurance contracts prompting disbelief by the insurance rep. When I asked the rep if he'd sign the original version if he were me, he meekly said, "No." A brief conversation I had with a fellow physician in the doctor's lounge sums up these points. When she asked me what EHR I was using, I responded that I don't use one. Incredulously, she asked, "Why not?" My response was, "Why would I?" She thought for a moment and quietly said, "I don't know."

Jay A. Bernstein, MD
Rockville, Md.

The logo for MedChi, with "Med" in black and "Chi" in a gold color. The background of the entire page features a collage of the Maryland state flag, a white caduceus, and a circular seal of the Maryland State Medical Society.

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for Maryland Physicians and Their Patients

The mission of MedChi, the Maryland State Medical Society, is to serve as Maryland's foremost advocate and resource for physicians, their patients and the public health. To that end, during the 2018 General Assembly Session, MedChi shall work on the following objectives:

AS AN ADVOCATE FOR PATIENTS

OPIOID CRISIS: MedChi will promote physician, resident and medical student education regarding the opioid crisis in Maryland and the services available for patients through the HOPE Act and other legislative initiatives.

PROTECT MEDICAID AND THE UNINSURED:

MedChi will work to incentivize physician participation and to protect the integrity of the Medicaid program, including continuing to advocate for full restoration of E&M payment to Medicare rates for all physicians who serve Medicaid enrollees.

DEFEND THE SCOPE OF MEDICAL PRACTICE SO PATIENTS ARE SEEN BY A PHYSICIAN:

MedChi will fight to ensure that all patients have access to physicians and that physician extenders have appropriate training and physician oversight. It is critical that patients have access to physicians and that non-physicians do not use increased demand for services to inappropriately increase their scope of practice.

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AS AN ADVOCATE FOR PHYSICIANS

DEFEND PHYSICIAN RIGHTS:

- *Monitoring the regulatory and disciplinary actions of the Board of Physicians;*
- *Protecting and enhancing the integrity of the Prescription Drug Monitoring Program and its use by physicians;*
- *Preventing workers compensation insurers from limiting a physician's right to dispense medications to an injured worker;*
- *Supporting continued efforts to address network adequacy and formulary practices; and*
- *Working to further standardize credentialing requirements.*

STRENGTHEN MEDICAL LIABILITY REFORM: MedChi will continue to strongly oppose trial lawyer attempts to increase the "cap" on damages in medical malpractice cases and to abolish the defense of contributory negligence; support efforts to extend the "cap" on damages to physician assistants; establish a pilot project for specialized health courts; limit repeated continuances in medical malpractice cases; establish a birth injury fund; and otherwise work to protect and strengthen the legal liability environment for physicians in Maryland.

ENHANCE PHYSICIAN PAYMENT AND INSURANCE REFORM: MedChi will continue its efforts to improve Maryland's payment climate by working to ensure that gain-sharing and other payment mechanisms for system reform are developed through a stakeholder process that includes broad physician participation and that will have a positive impact on physicians.

AS AN ADVOCATE FOR PUBLIC HEALTH

PROTECTING MARYLAND'S CHILDREN: MedChi will support initiatives to protect children including initiatives to:

- *Address childhood obesity including efforts to reduce the consumption of sugary beverages and other unhealthy food choices;*
- *Increase HPV immunization rates for children at the CDC recommended ages;*
- *Strengthen child safety seat and young driver laws;*
- *Address homelessness, affordable housing and its impact on public health;*
- *Require schools to provide parents with information about the risks of skin cancer and strategies and behaviors to reduce the risk; and*
- *Ban minors access to tanning beds*

ENDING HEALTH DISPARITIES: MedChi will continue to support legislative and regulatory initiatives to reduce health disparities.

MAKING MARYLAND A TOBACCO FREE STATE: MedChi will advocate for continued increases in the Tobacco Tax to discourage smoking and to help fund Medicaid and maintain and restore enhanced E&M payment for all physicians serving Medicaid enrollees. MedChi will also support legislation prohibiting the sale of tobacco products by businesses which provide health care or dispense medications.

DRUG TRANSPARENCY: MedChi will support initiatives that address drug price transparency for name brand and generic pharmaceutical manufacturers, pharmacy benefit managers and insurers.

HIV PREVENTION: MedChi will support policies and initiatives that encourage needle exchange sites throughout Maryland to provide education and referral for consideration for HIV PrEP

CRISIS TREATMENT CENTER EXPANSION: MedChi will advocate for expansion of Maryland's crisis treatment centers throughout the state.



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JOIN YOUR COMPONENT SOCIETY in Annapolis by attending "Physician House Call on Annapolis" lobbying days for an opportunity to discuss important issues with your legislators. RSVP by emailing Kevin Hayes at khayes@medchi.org.

TAKE ADVANTAGE OF OPPORTUNITIES to discuss important issues with legislators.

STAY INFORMED on legislative issues affecting your practice and profession by reading MedChi's weekly e-newsletter, *MedChi News*, and visiting www.medchi.org. All members are welcome to attend the legislative council meetings.

EMAIL OR PHONE your delegates when MedChi or your component sends you a legislative alert about a bill. Visit the Legislative Action Center at www.medchi.org. Remember

to donate to the MMPAC and help keep physician-friendly legislation in Annapolis.

TESTIFY AT A COMMITTEE HEARING. Contact your component medical society for details.

VOLUNTEER TO SERVE. As Physician of the Day in the Maryland State House during the legislative session. Email Kevin Hayes at khayes@medchi.org.



Eponymic Germs

CLASSIC WORD ROUNDS

Barton J. Gershen, MD
Editor Emeritus

A year ago I turned eighty-two, realized my time was diminishing, and decided to stop writing this column. I was content with my decision until recently, when the Zika virus turned up. Newspapers, radio, television, and the Internet have maintained a steady torrent of information on this contagion, rivaled only by their coverage of the 2016 presidential election. My curiosity was roused by its name—what was its origin? That led to a larger question: where did the names of other infectious agents and their illnesses originate? I was hooked, and thus this column. My self-enforced retirement will be breached, at least for this one occasion.

Zika virus is related to Yellow Fever, Dengue Fever, and other Flaviviruses, transmitted by members of the *Aedes* mosquito family. It was initially discovered in 1947 within the **Zika Forest** of Uganda. (**Flavivirus** derives from Latin *flavus*: “yellow,” named for Yellow Fever, the first disease associated with this viral family.) The **Zika Forest** is a sixty-acre tropical reserve next to Waiya Bay, an area devoted to mosquito research, and owned by the Uganda Virus Research Institute of Entebbe. In the Ugandan language, *Zika* means “lush or dense,” referring to its luxuriant growth.

Africa seems to be a repository for many exotic infections, among which the **Ebola virus** may take first place. This virus is endemic in bats, monkeys, and gorillas, and is initially transmitted to humans by contact with the blood or other body fluids of these animals. Once infected, human to human transmission becomes the route of severe epidemics, such as the one experienced in 2014. Mortality rates as high as 90 percent have been reported, making this disease among the deadliest infections in the world. In 1976, the first case of Ebola was found in the Democratic Republic of Congo, within a village located on the **Ebola River**, from which the virus derives its name.

The Ebola virus is a member of the **Filovirus** family, which also includes the **Marburg Virus**. (Filovirus from Latin *filum*: “filament,” named for the fibrils attached to the virion as seen with the electron microscope.) The Marburg Virus causes a severe form of hemorrhagic fever, which carries a mortality rate of 25 to 100 percent. The first cases of Marburg Virus Disease were identified in the city of **Marburg, Germany**, in 1967.

Hanta Virus is confined to rodents, infecting humans by accidental contact with their urine, feces, or saliva. The result may be a severe hemorrhagic illness with renal and/or pulmonary involvement. The virus is named for the **Hantan River** in South Korea, where the first cases were recognized. Hanta Virus is a member of the **Bunyavirus** family, which takes its name from **Bunyawera**, Uganda, a village where the initial type species was identified. In addition to Hanta Disease, this family also includes **Rift Valley Fever**, and **Crimean-Congo Fever**. In 1993, a severe pulmonary disorder emerged within the four corners region of

southwest United States. It was caused by an infectious agent named Sin Nombre Virus, the virus causing the **hantavirus pulmonary syndrome**. Its name in Spanish means “the nameless virus.”

Lassa Fever is another zoonotic infection similar to the Hanta Virus, and spread by human contact with mouse urine, feces, or saliva. It results in acute hemorrhagic fever, and bears a mortality rate up to 50 percent during epidemics. The name originated from the town of **Lassa, Nigeria**, where the first cases were described in 1969. Lassa virus is a member of the **Arenavirus** family, so-named for the granules within the virion, which resemble sand. (Latin *arena*: “sand.” An **arena** where contests are held was originally a sandy area within a stadium.)

Not all viral illnesses are as lethal as those described above. The **Coxsackie virus** is an enterovirus, living in the gastrointestinal tract, and spread by the fecal-oral route. The virus was initially recovered in 1948 from a group of febrile children, who were suspected of having poliomyelitis. The children lived in the village of **Coxsackie, New York**, located twenty-five miles south of Albany, and the virus was accordingly named. *Coxsackie* is from the Iroquoian language and means “place of many owls.” The Coxsackie virus belongs to the Picornavirus family. (**Picornavirus** from Spanish *pico*, “small,” plus *RNA*. It is a small RNA virus.)

There are two divisions of the Coxsackie virus. Group A is associated with herpangina, hand-foot-mouth disease, and conjunctivitis; Group B with pleurisy, pericarditis, myocarditis, and hepatitis. Both groups may cause mild to moderate febrile disease, upper respiratory infection, and aseptic meningitis. A severe form of pleurisy (“epidemic pleurodynia,” or “the Devil’s grip”) caused by Coxsackie B, was initially described in residents living on the Danish island of Bornholm in 1933, thus named “**Bornholm Disease**.”

Bacterial infections also sport eponymic origins. **Tularemia**, caused by the bacterium *Francisella tularensis*, was initially detected in Tulare County, California, from which it received its name. The pathogen is named for **Edward Francis**, a physician and bacteriologist, who contracted the disease and kept meticulous records of his illness. He was awarded the AMA Gold Medal in 1928 for his contributions. Tularemia is classified as a biological warfare agent by the CDC [Centers for Disease Control and Prevention], taking its fearsome place alongside Ebola, Anthrax, and Plague.

In 1975, a group of children and adults living in a small village twenty miles northwest of New London, Connecticut, developed a mysterious arthritic illness. A meticulous investigation discovered that the cause was an infection with *Borrelia burgdorferi*, caused by the bite of the black-legged deer tick *Ixodes scapularis*.

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Public Health Perspective ...

Continued from page 16

Application Process

The state is awaiting approval of the MDPCP by the federal government. Pending approval, the state and the Center for Medicare & Medicaid Innovation (CMMI) anticipate releasing applications for both practices and CTOs to participate in the MDPCP. A general process is as follows:

- CTOs will submit applications first;
- CTO applications will be reviewed;
- CTOs will be selected before the return date of the practice applications to allow practices an opportunity to select a CTO at their discretion.

For updates and more details, visit our web site: <https://health.maryland.gov/MDPCP>.

Howard Haft, MD, MMM, CPE, FACPE, is Deputy Secretary for Public Health, Maryland Department of Health. For more information about the Primary Care Program, contact Chad Perman at chad.perman@maryland.gov.

Classic Round Words ...

Continued from page 20

The village was **Lyme, Connecticut**, and so the disease became known as **Lyme arthritis**. (The name Lyme originated from the English town of **Lyme Regis**, famous for its **Lime trees**, also known as Linden or Basswood trees.) The genus and species name for the Lyme organism derives from Amédée Borrel (1867–1936), a French biologist, and Swiss zoologist Willy Burgdorfer (1925–2014), who discovered the spirochete in 1982.

Numerous microorganisms and their diseases are named for the investigators who discovered them. We haven't the space to chronicle all of them, but a quick inventory would list **Salmonella** for **Daniel Salmon**, a veterinary pathologist who was first to describe the organism now known as *Salmonella choleraesuis*; **Shigellosis** for Japanese bacteriologist **Kiyoshi Shiga**; and **Brucellosis** for **Sir David Bruce**, Scottish physician and bacteriologist who initially recognized the organism, now called *Brucella abortus*, which causes Malta Fever and Bang's Disease. (**Malta Fever** because Bruce isolated the organism on the island of Malta; Bang's Disease is brucellosis in cattle and was named for the Danish veterinarian **Bernhard Bang**.)

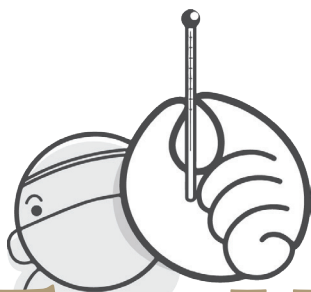
The most interesting eponymic infection is one named for a fictional character in a poem. In 1530, a physician named **Girolamo Fracastoro**, composed a poem about a hapless shepherd boy who had insulted the God Apollo, and was punished by acquiring a sexually transmitted disease. The poem was titled *Syphilis sive morbus gallicus*, which translates to "Syphilis, or the French Disease." The boy's name was **Syphilis**, and the disease was named for him.

The English language is filled with words whose origins often delight and astonish its speakers. The world of medicine is no different in that respect, and finding the roots and ancestry of terms can be as joyful as practicing medicine used to be.

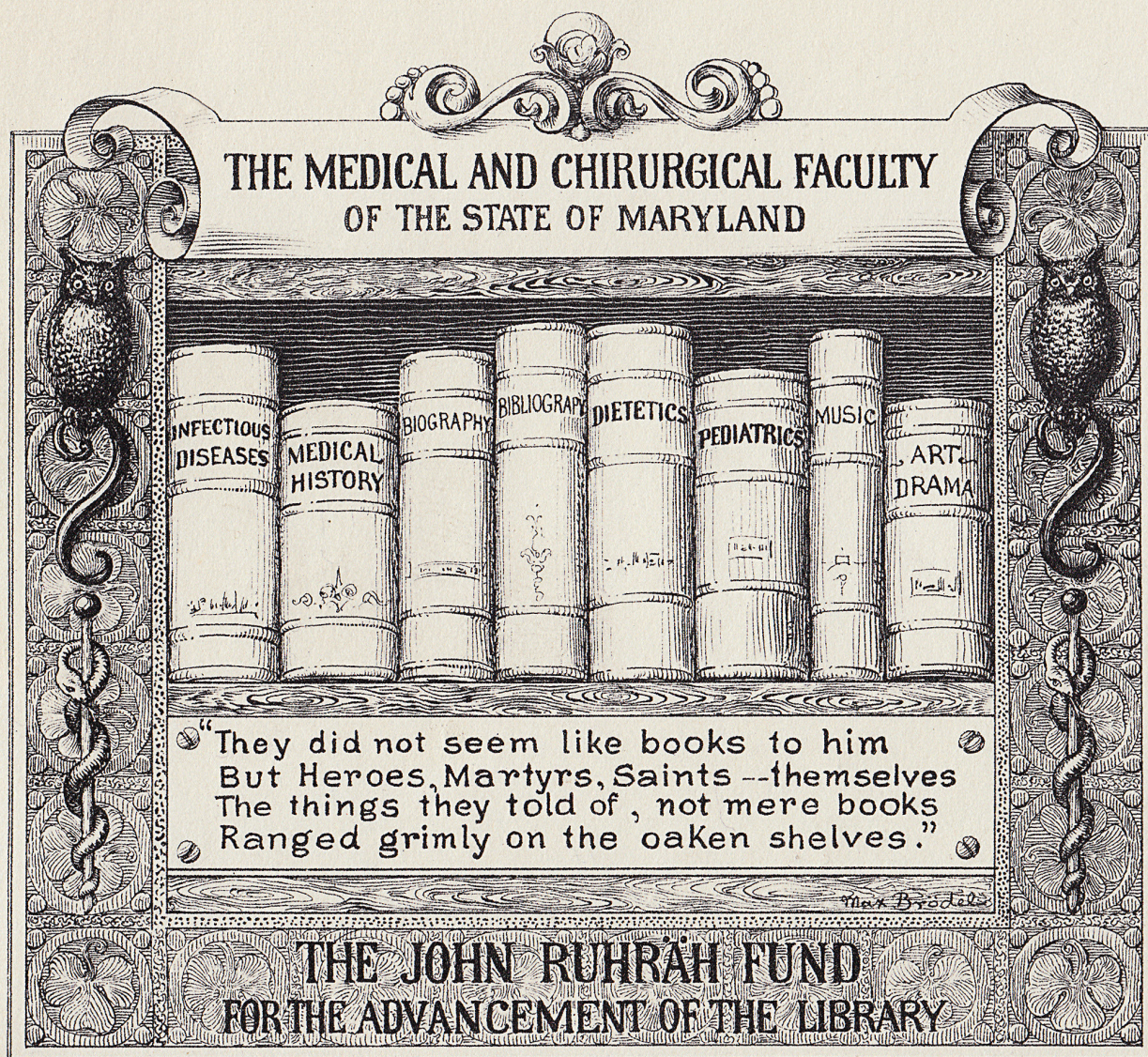
Medicine has mutated, galvanized by illogical and often misguided government legislation. Maryland Medicine has helped its physicians negotiate this alien—and often hostile—new landscape. I hope our revised publication will assist you in a comparable manner.

It has been an honor to have been permitted to write Word Rounds for more than fifteen years. Thank you to those who have written me over the years. I shall not forget your kind words.

THE LAST WORD



Bookplate, John Ruhräh, MD. Designed by Max Brödel.



Max Brödel, a prolific medical illustrator, came to the Johns Hopkins School of Medicine in Baltimore from Leipzig, Germany. In addition to illustrating for such notable clinicians as Harvey Cushing, William Halsted, and Howard Kelly, Brödel presided over the creation of the first Department of Art as Applied to Medicine at Johns Hopkins School of Medicine. Brödel was a great friend of MedChi and designed the bookplate pictured here for John Ruhräh, MD. Dr. Ruhräh was the head of the Library Committee for decades, and left a bequest to MedChi that is still producing income. Dr. Ruhräh is also the author of the 1934 book on Sir William Osler, MD, which was published in 2014 by MedChi's History of Maryland Medicine Committee.



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