QUALITY
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Features

Who Measures the Quality of Medical Care? 6
Barton J. Gershen, M.D.

U.S. Health Care: In Need of an Industrial Revolution? 8
Donald McDaniel, M.B.A., and Dan D’Orazio, M.B.A.

How is Quality Different from Practicing Good Medicine? 12
Thomas R. Jackson

The Role of MedChi’s Quality Assurance Committee 14
Ronald Orleans, M.D.

Quality at Kaiser Permanente: Using the Population Care Model 15
Janice M. Beaverson, M.D., and Jaewon Ryu, M.D.

CMS Data Shows Gains in Key Quality Indicators through Physician Quality Reporting System and ePrescribing Incentive Program 16

The Quality of Medicine: A Senator Reflects on a Year of Living Medically 18
Maryland State Senator Jamin B. Raskin, Esq.

The Quality of Medicine: One Patient’s Opinion 19
Edward C. Ettin

Review of the 2011 Session of the Maryland General Assembly 20
Joseph (Jay) A. Schwartz, Esq., and Stephen H. Johnson, Esq.

Departments

President’s Message 2
David Hexter, M.D.

Editor’s Corner 4
Bruce M. Smoller, M.D.

Word Rounds 24
Barton Gershen, M.D.

The Last Word 28
Send Him to J.C.: Reseting Patient Expectations

David Hexter, M.D.

It’s a warm spring Friday evening. Bill is a middle-aged, overweight male who has just returned home after a being away for a few days driving a long-haul truck. I’ve just woken up for my second of three emergency department night shifts in a row. As I arrive, I see that the rack of charts is full with 20 more in the waiting room, and two nurses have called out sick. Our lives are about to intersect.

Bill noticed a local carnival on his way home and decided to take his wife and two kids out for some fun. It was bit crowded, but they enjoyed the rides and games. At some point after some funnel cake and a corn dog, Bill collapsed in full cardiac arrest. Paramedics stationed at the carnival arrived quickly and instituted advanced cardiac life support. They did a robust job of trying to resuscitate Bill and subsequently brought him to the hospital at around 11:30 p.m. After another 30 minutes of futile effort, our team ended the resuscitation efforts and he was declared dead.

Shortly thereafter, the nurse and I met with Bill’s family to deliver the bad news, a job that is never easy. After I delivered the bad news, Susan, Bill’s wife, became very angry, told us what she thought of our hospital, and demanded that Bill be transferred. She wanted Bill transferred to a certain hospital nearby—one with a statue of Jesus Christ in its lobby, where they could surely save him. Even after we explained that no hospital will accept transfer of a dead patient, she would not take no for an answer.

So I thought about her request for a moment. Despite training at that same hospital, I had never seen an instance where a dead person could be brought to life. I did hear of one case of “Lazarus Syndrome” while I was there (Lazarus Syndrome is auto-resuscitation after failed cardiopulmonary resuscitation). But there was no doubt that only divine, rather than medical, intervention could bring Bill back.

A few weeks later, I attended to a 106-year-old demented, mostly bedridden lady brought in by ambulance because her granddaughter (a senior citizen herself) said she was not acting the same. A thorough evaluation did not reveal any acute etiology for this. I discussed the care plan with her primary care physician, and we decided that she should go home and he would check on her the next day. There was no indication for admission to the hospital. The granddaughter objected to this plan and demanded that grandmother be admitted. No amount of explanation would change her mind. I shared the feedback with her physician, and we arranged for admission. The next day, the woman got out of bed and fell, sustaining a spiral femur fracture.

Where do people develop their expectations of what modern medicine can do? Well, immortality is not on the list, yet. Most likely, it is from entertainment media. You may remember watching a popular medical drama in the 1990s, where every patient who underwent emergency thoracotomy survived, and psychotic patients were admitted instantly to a psychiatric facility with the snap of a finger. People should develop their expectations based on discussions with their physicians and other healthcare providers, (not on what they see on television dramas or in the movies).

Many people today expect to receive all the healthcare they want, at any time of the day, and, in many cases, at little to no personal cost. Such expectations beget an infinite demand for healthcare services. This is not sustainable. I submit that it is we physicians who have the responsibility to reset the expectations of our patients to be rational consumers of healthcare. It is something that needs to be done at the most basic level—the physician-patient interaction. If we fail to lead in this regard by providing sound advice and information in every decision our patients and their caregivers make, others will take the lead for us. We, together with our patients, are not likely to be satisfied with the results when others make the decisions.

How do we begin? When faced with patients or caregivers making demands based on unrealistic or medically invalid expectations, we need to address the underlying beliefs and worries that motivated the request in the first place. We need to explain why their child does not need the fancy antibiotic or a test for a virus that has no bearing on treatment. Such explanations need to be carried out in a culturally sensitive manner—there may be a local custom or belief that is leading to the demand. Finally, if no amount of explanation will suffice, we need to say “no.”

MedChi will continue to advocate for adequate resources to deliver the healthcare that our patients need. But we cannot advocate for care that our patients want, but don’t need.

Reference:

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Quality="Value?"

Bruce M. Smoller, M.D.

Quality: The general standard or grade of something; a characteristic of somebody or something; an essential identifying nature; the highest or finest standard; a consultant’s dream, a doctor’s nightmare.

You cannot read a medical journal, read through a list of continuing medical education (CME) courses, read a newspaper or listen to a “health care consultant’s” alphabet soup laden description of his or her activity without encountering the word “quality” at least once, and more likely, repeated scores of times. It is often used in conjunction with terms such as “best outcome” or the dreaded “pay for performance.” It encompasses the best and the worst in our hopes for our patients, and it, and all that it suggests, is here to stay.

Of course the concept of “quality” has been inherent in medicine and medical training forever. We all strive, as our forebears in earlier generations did, to provide the best of the healing arts, skills and science, to our patients and in the service of better health, better quality of life, longer life and pain free as possible. But the word now, and ever since the 1970s, has meant something really different. It means…cost effectiveness. It has little to do with the nobler qualities of being a good physician. If that occurs, so much the better, but it is not the principal aim of quality as we know it today. The principle aim of the those who work in the field of quality, and which you as practicing physicians are expected to espouse, is saving money for the system. It is to be matched, or so it is proposed with the best possible outcome or the least number of errors, but, for a number of reasons, the term now quite explicitly means that the physician will practice in such a manner as to reduce costs. Unless the consultant, or bureaucrat or administrator is totally without scruple, the reduction of cost is to come with the added benefit of patient improvement. What is more, one of the guiding principles of the “quality expert” is that the patient improvement is to be un-leavened…adherence to some abstracted rule about outcomes will hopefully be consonant with individual patient improvement, but takes a back seat to the concept of cost reduction if it must.

In the 1970s and 1980s the agencies responsible for paying the majority of the healthcare dollar began to look for ways to cut back on the rising cost of medical care. This increase in the bulk cost of care arose from many sources…better, newer and more expensive technology, increases in wages generally across the board, expectations on the part of the population of access to all of these technologies, an aging population and many more sources. The trends, however, and the projections indicated a sharp up tick in the slope of the spending line.

Health maintenance organizations (HMOs) and managed care systems, beginning in the 1970s, were the progenitors of today’s cost cutting alphabet soup…Accountable Care Organizations (ACOs), HMOs, Electronic Medical Records (EMR), Pay for Performance (P for P) and on and on. As Bennet and Slavin write: “enter managed care.” By attempting to reduce overutilization of health care through utilization review, “quality assurance” and “case management,” health maintenance organizations “managed” care of their beneficiaries. They go on to say that the patients themselves began to complain, and sue the HMOs for denial of care and eventually these atrophied, leaving the shell to fertilize current efforts as cost cutting disguised as “quality.” In the sense that quality means excellence, this is misleading. The true holy grail now is “value”…paying as little as possible for the best possible care and getting “good value.”

The efforts at quality control in medicine were preceded by those in industry. Quality engineers such as John Deming would help to make American manufacturing and services more competitive by successfully defining “improvement” and
identifying concepts such as Profound Knowledge and Systems Analysis. He and his fellow quality engineers were successful in differing degrees to the field of true quality improvement. It should be noted also, that the IOM report on medical errors, for all its flaws, singled out systems failures as the chief culprit of hospital morbidity. Great good to patients can be achieved by improving the quality of defective systems. Little good to patients can be achieved by following blind calls for “quality” in the service of saving money and dressing that up with a lot of algorithms leading to nowhere, but fat consulting fees and government regulations set in place to satisfy the existence of a bureaucracy.

The efforts at quality control, both good and bad, are probably here to stay in some form or other. Physicians must be not only a part of the process, but the leading voices of sane quality control. The problem is, this administration and others before it, both at the federal and state level, do not trust physicians to come up with “value.” Remember, we are not speaking here about QUALITY, even though that is the buzzword. Instead of QUALITY, as in “I practice good and effective medicine” you must read “VALUE.” Politicians trust consultants who have not the slightest understanding of disease to define that and propose the boundaries of our freedom of action to practice medicine. This train has left the station. It is not going to stop. We need to embrace the true meaning of quality medicine, not its consultant- and government-driven definition, and help convey this to the people who matter the most...our patients. Once they understand the difference, the train will be on the right track. We present this issue of Maryland Medicine in that spirit.
U.S. Health Care: In Need of an Industrial Revolution?

Donald McDaniel, M.B.A., and Dan D’Orazio, M.B.A.

Health care is an industry in dire need of an industrial revolution. Many of us are familiar with the proof points: national expenditures of $2.5 trillion growing well in multiples of the Consumer Price Index and consuming almost 17 percent of our economy; marginal public health indicators; a well-demonstrated incidence of iatrogenic errors that are maiming and even killing tens of thousands of people each year. Why, in the richest and most productive country in the world, can’t we change our trajectory—from a cost, quality, and safety perspective?

Among other elements, surely a key assessment is that we lack a systems approach in health care—we need to industrialize medicine—at least the substantial parts of the medical complex that treat common illnesses and injuries and produce repetitive services.

What would industrializing medicine mean? It would require leaders in health care to take the lead from other industrialized sectors that have developed a core understanding of variance in their businesses. Some variation is acceptable—we can live with it, but we need to understand it. Most variance is not productive, and studying the root causes of variation and how we might address it is paramount to system improvement. At a macro level, we also need structural change in health care. Today, providers do not focus on managing the health status of patient populations. Instead, providers deliver care on discrete, episodic patient needs. While admirable, this approach is inefficient and unsustainable. We need to move to building sustainable health organizations, organizations built to meet the triple aim of continuous improvement in cost, quality and safety. Sustainable organizations will redefine the value proposition and maximize the utility we gain from a product or service per unit cost. We believe that health care providers who commit to an industrial revolution can build sustainable health organizations.

As mentioned, one glaringly problematic issue facing U.S. health care today is marginal quality and safety. The data are remarkably daunting and disheartening: at least 100,000 preventable deaths, 7,000 deaths tied to adverse events involving prescription drugs, and millions of hospital-acquired infections and adverse drug reactions. Today, we casually recite these statistics, as if to shrug our shoulders and say “healthcare is a part art, part science with many variables—it’s very difficult to perfect.” These shocking, or not shocking any more, data, are not cited here to demean or diminish the millions of caretakers dedicated to serving the myriad needs of their patients every day. They are, however, meant to serve as smelling salts of sorts, to wake us up from the ether that has lulled the health care industry into accepting the status quo. All constituents should be railing against these staggering shortcomings. To put this in perspective, imagine if 200 fully loaded jumbo jets fell out of the sky every year and all of the passengers were killed. Who would ever get on a plane? In healthcare, when we kill 100,000 people a year unnecessarily, somehow an incremental approach is acceptable. What’s more, the scope of the problem may be much worse than we have ever imagined. An April 2011 Health Affairs article found that adverse events “occurred in one-third of all hospital admissions” in the authors sample, 10 times more than previously cited.

Lessons We Can Learn

While at a recent conference with a number of executive health care leaders, we facilitated a panel discussion about opportunities for health care improvement. The panel included the CEO of a large multi-national with varied business interests throughout the world. As the discussion honed in on quality in health care, the group articulated a number of factors driving the
marginal results—industry fragmentation, the concern that technology deployment is overwhelmingly driving costs (even in situations where that technology offers dubious efficacy), a lack of quality standards or evidence-based practices, and an almost complete lack of transparency regarding quality, safety, and specifically, the level of adverse events (near-misses and “never events”—those things that should have never happened). Two critical business process activities were discussed: errors of omission and errors of commission during the various transitions of care (exacerbated by the significant system fragmentation and lack of information interoperability) and the arena of medication management. After listening as to the panel rail against the many challenges facing health care, the CEO said, “I consider myself an industrialist, and have been involved in many businesses in my career—from logistics to technology to appliances to engines—and I can identify times in all of those businesses’ lifecycles when they faced exactly the same kinds of issues. We solved the problems by committing to understanding the variances and their root causes. We took a systems approach to solve the problem—in other words, health care may not be as unique as we claim it to be.” (paraphrase). He went on to suggest that sustainability in health care will require a standards-based infrastructure, and those who assume a systems approach to understanding variation in process and outcomes will be able to resolve long-standing, seemingly intractable issues. In short, providers need to adopt a population management approach and develop the competencies to manage—competencies that will leverage various information technologies, decision support and (remote) telemetry functionality, and advanced analytics. These will be the bedrock of the new era of accountability in health care.

As suggested by the CEO on our panel, there are a number of lessons that we can learn from industries that have prioritized quality and safety. First and foremost, quality improvement means product/service improvement and margin improvement. As Dr. David Nash, the Founding Dean of the Jefferson School of Population Health on the campus of Thomas Jefferson University in Philadelphia, Pennsylvania, states as his immutable rule (and students of competitive industries know already), “high-quality health care costs less.” We feel these opportunities for dramatic improvement are best demonstrated when looking at the tremendous safety improvement in two industries: airlines and automobiles.

**Airlines**

We almost take it for granted, flight safety that is. Save few adverse incidences of fatal crashes, we have become accustomed to departing and arriving safely. Those who are frequent fliers, and even relative novices, barely pay attention to the safety explanation of where the flotation devices reside, or how the oxygen masks will deploy. This is due in large part to the airlines track records and singular focus on safety. In the aviation industry, there is no room for error. Miraculous landings like the one handled by Sully Sullenberger in the Hudson River become lore. However, all generally have the sense that plane crashes generally spell devastation.

There is no corollary, or better yet, there would be no acceptance of healthcare’s iatrogenic errors in the aviation business. Airlines have invested tremendous sums into their technology, training, and process innovations to deliver a safe passenger experience. The data bear this point out emphatically. The National Transportation Safety Board reports that from 1991 to 2009, departures increased 28 percent and flight hours have escalated by 50 percent. While flight times and volumes are up significantly airlines have become safer during this timeframe. Accidents per 100,000 flight hours have declined by 28 percent, and accidents per 100,000 departures have fallen by 11 percent. In the recent past, commercial jet fatalities occurred once every 140 million miles flown. By 2000, safety had improved 10-fold and commercial jet fatalities occurred once in every 1.4 billion miles. This improvement comes from the direct cooperation and participation of key stakeholders including manufacturers, pilots’ groups, civil aviation associations, government regulatory authorities (such as the U.S. Federal Aviation Administration or European Joint Aviation Authorities), and operators (Boeing).

When accidents do occur, intense investigations ensue, with the only goal of understanding the cause. Efforts to recover the black box flight recorder information, find debris, and reconstruct the plane are conducted with painstaking...
The Role of MedChi’s Quality Committee

Ronald Orleans, M.D.

Past

The Quality Committee of MedChi, The Maryland State Medical Society, was initially established in 2004 at the same time that the Medical Policy Council was formed. This occurred not long after the General Assembly had removed MedChi from its longstanding role in peer review of standard of care complaints made to the Board of Physician Quality Assurance (now the Board of Physicians). Its creation reflected a belief by MedChi leadership that quality issues had to continue to be addressed by MedChi and organized medicine. The first meeting of the Committee was held on March 29, 2005. At that meeting, the mission of the Committee was defined as follows: “The Quality Committee shall learn the needs of community practitioners to help them improve delivery of care in their office.” Quality was defined as “…getting the right care at the right time in the right setting from the right practitioner consistent with current medical knowledge.”

Topics of interest for that year included tort reform, information technology alternative dispute resolution, acceptance of the new Pay for Performance model and the Maryland Patient Safety Center refocusing its efforts on the outpatient level of care. At the meeting of October 25, 2005, it was suggested that the Quality Committee function as a bridge between MedChi leadership and its members, providing guidance to help leadership make policy directions. However, based on the meeting minutes of 2005, no specific Committee actions or accomplishments were documented.

In 2006, topics of interest included tort reform, information technology alternative dispute resolution or mediation, and physician education regarding Pay for Performance. Again, based on the meeting minutes of 2006, no specific Committee actions or accomplishments were documented.

Present

The Quality Committee did not meet in 2007 but was revived in 2008. For the past three years, the Committee has dealt primarily with limited ad hoc items including the risk/benefit profile of the medical marijuana legislation and the exception of specific in-office laboratory tests from undergoing the full process of laboratory inspection and certification mandated by the federal CLIA regulations.

Future

Given the changes occurring in medicine over the past few years and the passage of the Patient Protection and Affordable Care Act, will the reinstalled Quality Committee assume a new more extensive role within the medical society? It is clear that the medical society, if it wants to retain a leadership role in health care policy debate, will need to come up with a systematic method of weighing in on quality issues with authoritative advice derived from longstanding principles of scientific medicine. In 2011, the definition of medical quality has significantly changed. The definition that was used in 2005 is, in today’s world, naively simplistic. In view of soaring healthcare expenditures, any definition of quality must now include terms such as evidence-based, value, and health outcomes. The definition must not, in any circumstances, be included in the same sentence with the word quantity.

No one knows what the future of medical practice will be. What is clear is that the costs related to fee-based medicine, as practiced today, are not sustainable. Many of the changes will not necessarily be physician friendly but all agree that the mandate and momentum for change are here to stay. They will not go away. In order to ease the transition, some state medical societies have formed quality improvement organizations or foundations in order to help physicians understand, accept and most importantly, take leadership roles in advocating and supporting quality improvement and cost efficiency efforts within their respective states.

From my perspective, Maryland physicians need to participate in the discussion in a more constructive, proactive manner. The Quality Committee, with guidance from the MedChi Board, would certainly be willing to assume this new role of promoting medical quality in Maryland.

Ronald J. Orleans, M.D., is Chair of the Quality Committee of MedChi, The Maryland State Medical Society.
Abstract

The provision of high quality healthcare is facilitated by an integrated team of multi-specialty physicians who are supported by an advanced electronic medical record. This paper shows how Kaiser Permanente of the Mid-Atlantic States is able to provide proactive care to members through physicians and their teams, integrated with functional health information technology systems.

Kaiser Permanente is an integrated delivery system. Nationally, Kaiser Permanente includes 35 owned hospitals, 454 medical offices, and more than 15,000 physicians serving a membership of almost 9 million members in nine U.S. states and the District of Columbia. Kaiser Permanente's Mid-Atlantic region is comprised of the Kaiser Foundation Health Plan of the Mid-Atlantic States (KFHP) and the Mid-Atlantic Permanente Medical Group (MAPMG). MAPMG is a multi-specialty physician group of nearly 900 physicians that provides medical services to KFHP members in Maryland, Virginia, and the District of Columbia.

Kaiser Permanente's origins date back to the Depression era. During World War II, the industrialist Henry J. Kaiser had an interest in keeping his large shipyard workforce healthy. Kaiser teamed up with Dr. Sidney Garfield, who had founded the concept of prepaid healthcare years before as he provided care for the men who built the Los Angeles Aqueduct. The concept of prepaid medical care was popular among workers and following the war, that popularity continued and led to the formation of what we know today as Kaiser Permanente.

The original ideals of managing the health of a population with a focus on prevention have served as guiding principles for Kaiser Permanente throughout its history and continues as such today. The population care model supports a “whole person” approach to care that focuses on proactively addressing care needs for chronic conditions, lifestyle and behavior changes, and prevention. More importantly, the population care model includes addressing needs for those patients who do not actively seek medical care as well as those who do see us in our offices.

Critical to the success of population management is the ability to identify and satisfy evidence-based care gaps. Panel support tools, embedded within Kaiser Permanente’s electronic medical record—the world’s largest civilian deployment of an electronic health record—help to identify care gaps and preventive services needed. In our setting, not only primary care physicians are accountable for ordering mammograms and lipid screenings, Permanente physicians in all specialties, each of whom has access to the same tools, are alerted about and expected to order missing cancer screenings and evidence-based lab testing needed for the successful management of patients with conditions such as cardiovascular disease or diabetes. This concept of “proactive care” allows us to leverage our integration and shared electronic medical record to understand when a patient might be in the office for an optometry visit, or a visit to a specialty, and let him or her know that we can arrange a screening test such as mammography or pap smear or laboratory work on the same day. In addition, an online clinical library provides access to medical journals, physician education tools, and patient education materials for instant access.

Each year, Kaiser Permanente establishes target goals and performance metrics for a wide variety of quality measures. Many of the organization’s quality measures align with HEDIS (Healthcare Effectiveness and Data Information Set)—and are related to many significant public health issues such as cancer screening, heart disease, smoking, asthma, and diabetes. However, HEDIS does not define the entire scope of Kaiser Permanente’s quality measures which extend to a variety of clinical issues such as offering the option of palliative care to our members, working with our hospital partners to understand and eliminate hospital-acquired conditions, and using our electronic medical record to...
CMS Data Show Gains in Key Quality Indicators Through Physician Quality Reporting System and ePrescribing Incentive Program

2009 data show increases in how many eligible professionals successfully participate as well as how many instances professionals report delivering evidence-based care that can lead to better patient outcomes.

The Centers for Medicare & Medicaid Services (CMS) issued a report on April 20, 2011 that highlights significant trends in the growth of two important “pay-for-reporting” programs. The report also articulates key areas in which physician-level quality measures appear to show positive results in quality of care delivered to Medicare beneficiaries.

CMS’s 2009 Physician Quality Reporting System and ePrescribing Experience Report states that 119,804 physicians and other eligible professionals in 12,647 practices who satisfactorily reported data on quality measures to Medicare received incentive payments under the Physician Quality Reporting System totaling more than $234 million—well above the $36 million paid in 2007, the first year of the program. Under the ePrescribing Incentive Program, CMS paid $148 million to 48,354 physicians and other eligible professionals in 2009, the first payment year for the program. Results show that participation in the Physician Quality Reporting System has grown at about 50 percent every year, on average, since the program began.

Although the two pay-for-reporting programs are open to a wide range of health care professionals, much of the reported data relate to care provided in ambulatory settings, such as physician offices. CMS Administrator Donald Berwick, M.D., explained, “Most beneficiaries get their care in the physician office; however, this is the care setting for which we have the least amount of data about quality of that care. The Physician Quality Reporting System and the ePrescribing Incentive Program help bridge the knowledge gap so we can better understand the care millions of patients receive from physicians and other care providers every day. The significant growth in the Physician Quality Reporting System shows us that the health care community shares CMS’s commitment to improving the quality and safety of care our beneficiaries receive.”

On average, 2009 bonus payments for satisfactory reporters in the Physician Quality Reporting System were $1,956 per eligible professional and $18,525 per practice. Eligible professionals who were successful electronic prescribers received even more from the ePrescribing Incentive Program in 2009: the average bonus payment was just over $3,000 per eligible professional and $14,501 per practice. Physicians and other eligible professionals who satisfactorily reported Physician Quality Reporting System quality measures data and thus qualified for an incentive payment for the 2009 Physician Quality Reporting System received their payments in the fall of 2010.

Along with increases in participation rates and incentive payment amounts, CMS is encouraged by data from the Physician Quality Reporting System that shows growing rates in how often health care professionals report that they are complying more often with evidence-based care practices. These increased reporting rates could signal a positive trend in the quality of healthcare Medicare beneficiaries receive from professionals who report data through the Physician Quality Reporting System. One of the Physician Quality Reporting System’s main goals is to collect information about care practices that can ultimately help improve the quality and efficiency of care for all Americans, especially Medicare beneficiaries. Accordingly, the System’s measures capture evidence-based practices that are shown to improve patient outcomes, such as providing preventive services, taking steps to reduce health care disparities, planning care for patients with chronic conditions to keep them healthy for as long as possible, and integrating health information technology solutions into how providers deliver care. These measures are created by nationally recognized experts from groups such as the American Medical Association, and are endorsed by national quality consensus organizations.

Based on reported data on the 55 measures that have been a part of the System since it began in 2007, providers have improved the frequency for which they deliver recommended care by about 3.1 percent on average. Similarly, of the 99 measures that were part of the System in 2008 and 2009, performance improved at about 10.6 percent on average. In some cases, gains have been even more dramatic.

The measures chosen for the Physician Quality Reporting System also provide increased opportunities for eligible caregiving professionals from all segments of the health delivery system to participate.
Quality at Kaiser...

continue from page 15

avoid medication interactions or allergies. Performance against set targets is monitored and reported on throughout the year. Reports can be generated down to the level of individual practitioners so physicians are able to receive timely feedback on how well they are managing their panels to the established targets.

A common electronic medical record not only helps facilitate population management, but is critical to the transfer of information across specialties and disciplines and supports a culture of patient safety. For example, patients with multiple conditions may be prescribed different medications by different specialists and it is often up to the patient to keep track of all of the medications prescribed. A common medical record lifts the burden from the patient by providing a single documentation source that includes all of the necessary information related to services and medications received in both outpatient and many inpatient settings. A single record also strengthens the primary care physician's ability to manage the "whole patient" by providing a complete record.

At Kaiser Permanente, technology greatly facilitates our quality efforts, but the principles we employ—population management, goal setting, performance monitoring, and information sharing—are applicable to any provider setting and can be employed with various levels of technology integration.

Janice Beaverson, M.D., and Jaewon Ryu, M.D., are Associate Directors of Mid-Atlantic Permanente Medical Group.
The Quality of Medicine: A Senator Reflects on a Year of Living Medically

Senator Jamin (Jamie) B. Raskin, Esq.

"Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place."

—Susan Sontag

As I look back upon my Year of Living Medically, certain truths stand out in my mind.

We are not doing anyone a favor by pretending that they do not need health insurance and can wing it over the course of their lifetimes. At the moment you receive a diagnosis like mine—of colon cancer after 47 years of perfect health—you are so overwhelmed by fear, confusion, guilt, medical appointments, diagnostic tests, and paperwork that the last thing you need to add to your burdens is the inability to pay for the medical care you need. Without insurance, even middle class people stand one serious illness away from financial catastrophe and seeking out uncompensated care. Universal coverage is in the best interest not only of each individual but of the community.

If the "individual insurance mandate" in "Obamacare" survives its legal and political challenges and we come to more fairly distribute health care, this achievement will only resolve the quantity question of how much health care society needs.

But when you are a patient, you are focused on one case—your own—and your main interest is not in the social quantity of health care administered but in the individual quality of the care you receive.

It is both tempting and reassuring to think that "medicine" and "quality medicine" are the same thing, but this may not always be the case. While it is estimated that nearly 45,000 Americans die each year because of a lack of access to healthcare, it has also been reported that 200,000 Americans die because they had access to health care that might have been substandard.

In Maryland there is strong institutional investment in practicing quality medicine. My experience at Johns Hopkins Hospital showed me a hospital passionately committed to achieving positive health outcomes for patients, concerned about patients' emotional well-being, and well aware of the need to maintain appropriate quality practices. I am glad that the finest institutions are taking iatrogenic illness seriously.

The debate over health care quality will clearly provoke a new generation of policy questions about which kinds of quality industry standards should be legislated and which are left to physicians, health care providers and courts to sort through the dynamics of self-regulation, litigation, and professional monitoring and oversight. Although the Maryland General Assembly and public regulatory bodies should obviously review major issues, we are dependent in the first instance on health care professionals to articulate best practices and procedures.

As hospitals and physicians struggle to define the best practices for advancing individual health, legislators are struggling to define the best policies for promoting public health more broadly. One of the strong public health measures passed in the 2011 session was the Drunk Driving Reduction Act, a bill I introduced to dramatically lower drunk driving-related accidents, injuries and casualties on our roads. This legislation will require an estimated 4,500 new convicted drunk drivers to have an ignition interlock breathalyzer installed in their cars, a device that will not permit the car to start if any alcohol is detected on the breath of the driver.

Ultimately, of course, the imperatives of universal coverage and health quality are intertwined. In their book The Spirit Level, British public health scholars Richard Wilkinson and Kate Pickett examined reams of cross-national data about life expectancy and infant mortality, child well-being, mental illness, obesity, educational success and drop-out rates, homicide and suicide, crime, imprisonment, social mobility and levels of social trust.

They arrived at a striking conclusion. While all public and social health indicators improve dramatically for poor countries as they increase their gross national product and average family incomes, once countries reach a certain level of prosperity, national wealth and average income have very little to do with the physical and mental well-being of the population and the happiness of the people. What matters once basic needs are met in a society is not how rich the society is but how equal it is. One thing that makes societies sick is inequality. In the healthiest and happiest societies, the income and wealth gap between the rich and the poor is much smaller than what is found in societies that have high infant mortality, high crime and violence, high rate of mental illness and suicide, high drop-out rates and so on. High inequality produces lives of social chaos.

When the authors turn their attention to the 50 U.S. states, they document the same pattern. The key indicator of public health and wellbeing is not how rich or poor a state is, but how equal or unequal it is. The states that have the worst public health outcomes and the lowest levels of happiness are the most unequal states—such as Mississippi, Texas, Louisiana, and Alabama; the healthiest states tend to be not the richest ones, like Connecticut, New Jersey or Maryland, alas, but the ones with the least inequality, like Vermont, New Hampshire, Minnesota, Utah and Wisconsin.

Wilkinson and Pickett show that everyone benefits from living in a society with "equality of conditions," which is what struck Tocqueville about America when he came here in the 1830s.
The Quality of Medical Care: One Patient's Opinion

Edward C. Ettin

In a truly rational world, the only standard by which our medical care would be judged is by the answer to this question: Was the patient cured and, if not, was he or she made comfortable in order to enjoy life as much as possible? I should add the not unimportant subsidiary question: Was the patient treated with dignity as she died?

If the answers are yes, the medical care is the best that can be and I have the sense that U.S. medical care does extremely well on the first question—for those of us with insurance—and too often poorly on the last question.

Those are rational questions and answers. I pride myself on being a rational person, but when I was asked to write this article, the first question that popped into my mind was: Does the doctor listen to me when I describe my problem? Moreover, when I asked friends how they would judge the quality of medical care and rate their physician(s), the first or second answer was always some variant of this latter question. No one said anything about getting well. Is the key to getting a positive review of quality medical care, therefore, some variant of Lyndon Johnson's principle: the most important thing is sincerity; once you can fake that you got it made?

On reflection, I think what my friends and I are reacting to—this concern about our docs' listening to what we say—is the effect of managed care.

I am a professional economist (please don't stop reading) and the dismal science has trained me to try and look at all sides of an issue and the empirical data if possible. I have tried to do so for health care, but have always walked away failing to come to grips with how best to address the economics of medicine in the United States. Everyone it seems is right. The system is the best, it's inefficient, it leaves the poor out, insurance companies are destroying the system, and government doesn't know what it's talking about. Nonetheless, when I look at what I believe are irreversible fundamentals, here is what I see:

1. Our society cannot continue to allocate an increasing share of its resources to medicine;
2. We are getting older, no small thanks to medicine, and will need increasing medical resources even if nothing else happens;
3. Something else has happened: our society has, I think, decided that everyone, or at least most of us, deserve access to doctors/hospitals even if they can't afford it;
4. Medical technology is opening up new channels of diagnosis and care; and
5. The advance of medical science is very expensive.

These fundamentals suggest that the economics of medicine requires trade-offs. We are going to have to give up a little to get a little and we have to do that in a world of budget constraints. No big insight here, but it implies, I think, that one of those trade-offs means, for sure, managed care, which itself means that those who can afford it will buy themselves into limited practices and the rest of us will have longer waits and less face time. It also means that physicians will earn less and work harder.

Bingo! Why doesn't my physician listen to me? He's too damn busy trying to see more patients, in part because the demand is rising, and in part to maintain his income in a world where managed care reduces the price he receives per patient. This will not get better. Indeed, it will be the conflict situation in medicine in the years to come. It is, so to speak, baked into the cake. Patients and doctors are seemingly caught in gigantic forces beyond their control. But the result is that increasingly patients will judge the quality of medical care, I believe, on what doctors will increasingly have less time to do: listen.

There is, I believe, another channel, aside from dignity, at work here. I am convinced that a significant part of the healing process is the conviction of the patient that the doctor is a special, magical person whose ability to heal requires a sort of laying on of hands. The relationship is special—one on one: we tell the doctor secrets we share with no one else, we expose our naked bodies to the doctor's view, we hang on his/her words as he/she tells us what we must do to regain our health, to live longer. Part of the healing process is disrupted if the doc—the magician—is perceived as not laying on the hands, not listening to us. This may be irrational but I think that's the way it is. (Our younger son is an emergency room doc in a medium sized southern city. Late in the winter he called my attention to a New York Times column entitled "Treat the Patient, Not the CT Scan." We exchanged some emails about it because the title captured its essence. In his response to one of my emails, he replied: "This is why I sit down when I interview a patient and always listen to the heart and lungs, even if they come in for a hangnail. People are comforted by the ritual." He gets it and we have never been prouder of him!)

I don't mean to imply that the patient-doctor relationship is purely magical and that the magician should not be questioned. Explanations of the disease, prognosis, and options—in words I can understand—are important to me, and I hope to most patients. But I do, at the same time, believe that patients and doctors are in an unequal position and to lose sight of that and the role that implies for each endangers the relationship. Listening, kindness, respect, touching, and looking are understood by most doctors to be important in the healing process.

continued on page 23
MedChi was surprisingly successful in implementing its agenda.

The 2011 regular session of the Maryland General Assembly ended at midnight on Monday, April 11, after considering 2,370 bills and resolutions. MedChi reviewed 205 of those through its Legislative Committee.

In 2011, which was the first session of the four year legislative term, approximately one third of the representatives were new to the General Assembly. Typically, the initial year of a term is less productive than the second and third years. However, several significant proposals were enacted, including an increase in the sales tax on alcohol and a proposal to provide tuition at in-state rates to undocumented immigrants meeting certain conditions.

MedChi was surprisingly successful in implementing its agenda. Three important MedChi initiatives were enacted into law, including two proposals pertaining to electronic health records (EHR). HB 736/SB 722 (Electronic Health Records – Incentives for Health Care Providers) was enacted and requires carriers to pay the EHR incentives provided by 2009 legislation in cash and directs the Maryland Health Care Commission to determine if the program should be extended beyond primary care practitioners. HB 784/SB 723 (Medical Records – Health Information Exchange) is aimed at preventing the misuse of information garnered through the Health Information Exchange (HIE) and requires the development of regulations by the Maryland Health Care Commission (MHCC) before any release of information can occur for non-patient care purposes. MedChi caused this legislation to be introduced after it became known that the Ingenix division of the United Health Group had bought the company providing the software for the Maryland HIE.

The third initiative of MedChi’s enacted by the General Assembly was the repeal of the statutory provision providing for criminal penalties to be imposed upon licensed physicians who do not obey an order of the governor during a state of emergency. Henceforth, physicians and other health care practitioners will be subject to disciplinary action by their licensing board rather than to criminal penalties for failing to comply with a governor’s order during a declared state of emergency. This is consistent with the nationally promulgated model legislation.

Several medical specialty groups also initiated legislative proposals. The Maryland Society of Eye Physicians and Surgeons (MSEPS) was successful in persuading the General Assembly to enact SB 701/ HB 888 (Health Insurance – Prescription Eye Drops – Refills) which will require Maryland insurers to use the Medicare rule with respect to early refill of prescription eye drops with their members as well. The guidelines in question provide that insurers must refill prescription eye drops if the patient runs out of eye drops by the 21st day or later of a 30 day prescription. In enacting SB 701/HB 888, MSEPS achieved the same victory for Maryland private carrier insured patients that the American Academy of Ophthalmology achieved not long ago with respect to Medicare patients.

Dermatology was not as successful with respect to SB 604/ HB 1111 (Tanning Devices – Use by Minors – Prohibition). This proposal would have changed Maryland law by forbidding commercial tanning salons from offering ultraviolet tanning to minors. Currently, minors may receive ultraviolet tanning with the written permission of their parents. The House Economic Matters Committee amended the bill to forbid children under 14 to tan but to continue to allow it with parental consent for minors between 14 and 18. The proponents of the bill, which included the American Academy of Dermatology as well as MedChi and the American Cancer Society, asked the committee to kill the bill rather than report out the weakened version.

Since 1993, the Maryland anti-self-referral laws have prevented practices that are not exclusively composed of radiologists from billing for certain radiology services. A decision by the Court of Appeals in January removed all doubt as to the scope of this ban. Consequently, SB 808/HB 782 (Health Occupations – Imaging and Radiation Therapy Services – Accreditation) was introduced with support from several specialties adversely affected by the current law but opposed by radiologists.

Although neither bill emerged from committee, the regulation of the use of radiology equipment will be studied by a MedChi task force this summer.
MedChi successfully opposed SB 887/HB 340 (Health Care Malpractice – Certificate and Report of Qualified Expert – Objection), an initiative of the “Maryland Association for Justice” (formerly and better known as the “Maryland Trial Lawyers Association”) that would have allowed plaintiffs the option of obtaining another certificate of merit if their expert certificate (attesting that their case is meritorious) is rejected as not meeting the requirements of the law.

Two bills proposed by the O’Malley Administration with the purpose of bringing Maryland law into accord with federal health system reform were enacted. SB 182/HB 166 (Maryland Health Benefit Exchange Act of 2011) creates an insurance exchange where individuals can secure health insurance. The federal Patient Protection and Affordable Care Act (PPACA) requires states to set up such entities. The bill was extensively amended to accommodate the concerns of a wide variety of stakeholders, including the health insurance agent and broker community.

SB 183/HB 170 (Health Insurance – Conformity with Federal Law) was also mandated by PPACA and brings Maryland rules on such health insurance related matters as pre-existing conditions and medical loss ratio into conformance with the new federal requirements.

HB 818 (Manufacturers of Prescribed Products – Payments to Health Care Professionals – Prohibition) was an attempt to copy legislation in Vermont and Massachusetts that severely restricts pharmaceutical and medical device manufacturers from supporting doctors and various medical meetings. Although the bill when introduced seemed to have significant support, at the hearing significant flaws became apparent and the bill was withdrawn shortly thereafter. As drafted, it would have effectively outlawed financial support of hundreds of conferences, health fairs and medical screenings. However, the issue is likely to be revisited in 2012 because Maryland health officials have indicated continued concern with manufacturer payments.

An extensive amount of time and effort was expended in connection with SB 883/HB 1229 (Prescription Drug Monitoring Program). This bill will establish a “Prescription Drug Monitoring Program” in the Department of Health and Mental Hygiene. The program is essentially a database recording data from pharmacists and other dispensers regarding dispensing of scheduled drugs. Although many physicians are concerned that the program will discourage pain treatment, MedChi was successful in introducing amendments that should work to decrease the “chilling effect” of the database. Among the amendments proposed by MedChi that were adopted are the following:

1. A prohibition against either prescribers or dispensers of prescription drugs being charged a fee to support the program.
2. A change in the membership of the Advisory Board from being weighted towards law enforcement personnel to a membership primarily consisting of health professionals.
3. A requirement that a Technical Advisory Committee (TAC) composed of four physicians and one pharmacist reviewing all requests for information and provide clinical guidance and interpretation of the information to advise program management in its response to law enforcement subpoenas. The TAC will also provide clinical guidance and interpretation of the information requested to the party requesting a subpoena.

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The initial provision of the bill exempting Health Department employees from penalties for improper disclosure of the information has been stricken and it now provides that any person who knowingly discloses the information in violation of the law shall be guilty of a criminal misdemeanor.

Moreover, the legislation contains a statutory admonition that the data may not be used "...as the basis for imposing clinical practice standards."

Several scope of practice issues arose in this session. HB 100/SB 560 (Health Occupations—State Board of Naturopathic Medicine) would have licensed the practice of naturopathy in the state. At this time, only 14 states license naturopaths. MedChi opposed this legislation and it was defeated in both the House and Senate committees.

Pharmacy interests introduced a number of bills. HB 1268/SB 884 (Prescription Drugs—Dispensing Permits) would have made it significantly more difficult for health professionals with prescription authority to dispense their own prescriptions to patients. This was defeated in committee. Other bills would have increased the power of pharmacists to administer vaccines. Of those, only HB 986 (Administration of Vaccinations—Children) passed, allowing pharmacists to administer influenza vaccine to children nine years and older passed (pharmacists are already allowed to administer the vaccine to adults).

SB 5 (Physicians—Medical Professional Liability Insurance Coverage—Notification and Posting Requirements) would have required physicians to provide notice to patients if they did not maintain malpractice insurance. The bill passed the Senate but died in the House Health and Government Operations Committee.

HB 286 (Hospitals and Freestanding Ambulatory Care Facilities—Practitioner Performance Evaluation) requires that hospitals and freestanding ambulatory care facilities maintain a system to review practitioner performance as a condition of licensure. Much of what the bill requires is existing law in terms of peer review at hospitals. This legislation came about as a result of the St. Joseph Medical Center cardiac surgery controversy, and is intended to ensure that hospitals are properly reviewing utilization matters.

HB 600 (Health Care Providers—Investigations—Information Sharing Among State Agencies) allows the Health Services Cost Review Commission (HSCRC) to disclose certain identifying physician information to the Office of Health Care Quality (OHCQ) (the Department of Health and Mental Hygiene (DHMH) licensing body for hospitals and nursing facilities) and any entity deemed an "investigatory body" under the state or federal government. In addition, the bill requires the State Board of Physicians to disclose confidential investigatory information under certain circumstances to the DHMH Secretary, OHCQ, or HSCRC. The information continues to be protected from discovery in legal proceedings such as law suits.

Certain public health issues received attention from the General Assembly. In addition to the alcohol tax increase mentioned previously, the following initiatives are of particular note. SB 771/HB 858 (Education—Public Schools and Youth Sports Programs—Concussions) will institute a number of measures to improve the safety of youthful athletes, including mandatory removal from play of young athletes suspected of having sustained head injury. The Department of Education will be required to develop a program on concussion awareness as well.

The Maryland ban on text messaging was strengthened by SB 424/HB 196 (Motor Vehicles—Use of Text Messaging While Driving—Prohibited Acts) which includes e-mail within the definition of prohibited activity and clarifies that the prohibition applies to writing, sending and reading messages and that the ban applies whenever one is in the travel portion of the roadway.

SB 743/HB 778 (Family Planning Works) was enacted, extending benefits for family planning services to all women with family incomes at or below 200 percent of poverty regardless of whether they have had a child.

SB 786/HB 714 (Health Newborn Screening Program—Critical Congenital Heart Disease) requires the DHMH to adopt any federal recommendations that may be issued by the Secretary of Health and Human Services on the critical congenital heart disease screening of newborns. In addition, the bill requires the State Advisory Council on Hereditary and Congenital Disorders to develop recommendations on the implementation of critical congenital heart disease screening of newborns in the state.

HB 1276/SB 803 (Drunk Driving Reduction Act) requires the Motor Vehicle Administration (MVA) to establish an interlock program and mandates the participation of a driver as a condition of modification of a license suspension or revocation of a license or the issuance of a restrictive license if the driver is required to participate by a court order; is convicted of driving while under the influence of alcohol or under the influence of alcohol per se and had a blood alcohol at the time of testing of 0.15 or greater; is convicted of driving while under the influence of alcohol, under the influence of alcohol per se, while impaired by alcohol and within the preceding five years was convicted of any specified alcohol and/or drug-related driving offense; or was younger than age 21 and violated the alcohol restriction imposed on the driver’s license or committed the specified alcohol-related driving offense.
The Quality of Medical Care: One Patient's Opinion...

continued from page 19

I have suggested that managed care is probably the major reason for doctors not listening to their patients as much as patients want them to. Tests in lieu of conversation, observation, and questions are also significant. In effect, technology is being substituted for listening. But, apart from its "CYA" role in a world of malpractice suits, it must also be that, in the best interest of their patients, physicians call for tests to be sure of their diagnosis. This tendency, as irreversible as email and tech messaging substituting for the post office and the phone, will, I submit, increasingly be turning patient perception into reality: the trade off of managed care and technology for face time. And if I'm right about how magical the interaction needs to be in the treatment process, patients will only believe that the quality of medical care is declining at the same time that they are living longer in better health. The touching old cartoon of the doctor sitting at the side of the sick little boy, deep in thought and sympathy, captured what we, as patients, want. It forgets the reality that, up until post-World War II, doctors were, as Lewis Thomas observed, trained to make good diagnoses but had little capacity to cure.

One last point: one of the impacts of managed care and changing technology, as well as a dramatic change in the culture of medical practice (perhaps induced itself by managed care and technology), is a significant change in the medical delivery system. Larger size practices and the new specialty of hospitalist have both permitted doctors to “get a life,” to share time off and to limit, if not eliminate, hospital rounds. This seems efficient to me, and must be a blessing to doctors, but it does reduce for each of us that magical connection to my doctor.

Well, as I said, fundamental trends call for trade-offs and that’s what we’re getting. We, as a society, have to allocate scarce resources. Patients may just have to change their expectations about the quality of medical care, complain about it, and try to buy themselves out of it if they can. But the fact is that we, the patients, will probably continue to receive better care while still thinking it’s getting worse. My grandchildren may think of my doctor-patient relationships as old-fashioned and quaint, even if desirable, much as I think of the house call of my own childhood. But as rich as our society of the future may be, we can’t live long, healthy lives and continue to afford the medical delivery systems of the past. I, for one, am sorry about that. But, I understand it.

The other side of changing patients’ perceptions and realities is changing doctors’ perceptions and realities of their work/income ratios. It used to be that a career in medicine ensured a high income. I think that will continue, but not the same relative income because society just can’t pay that bill and increase coverage. Physicians will work harder, even with the new delivery systems, and not earn as much. So many of my doctor friends tell me that they would not advise their children to become doctors: too much time with insurance companies and not the income and respect they expected. I hope that’s not true. The reality is that in our changing world not many professions or jobs are maintaining the same relative positions as globalization and innovation do their thing. Doctors are, like their patients, not exempt from the laws of the dismal science—what the great economist, Schumpeter, called “creative destruction.”

A person should do what he would do if money weren’t involved; that’s the secret of happiness my father told me and I told our sons. Doc, would you really want to be an investment banker?

Edward C. Ettin “has been a patient for three-quarters of a century, thanks to a doc or two.”

Review of the 2011 Session of the Maryland General Assembly...

continued from page 22

As stated at the beginning, this year’s session accomplished an unusual amount for the first year of a legislative term and creates expectations for even greater activity in the next several years.

Joseph (Jay) A. Schwartz, III, is one of MedChi’s lobbyists. Stephen H. Johnson, Esq., is General Counsel, and Director of Law & Advocacy for MedChi, The Maryland State Medical Society.

The Quality of Medicine...A Senator Reflects

continued from page 18

The portrait of society painted by these researchers hit very close to home for me. As an elected official pledged to promote the common good, I am committed to advancing universal access to quality health care, which produces better health and well-being for everyone. Increasingly, taking care of the body politic means taking care of the bodies and minds of the people, but that objective requires us to constantly strengthen and renew the bonds of community.

Maryland Senator Jamie Raskin represents Silver Spring and Takoma Park and serves on the Senate Judicial Proceedings Committee and the Joint Committee on State-Federal Relations. He is also a professor of constitutional law at American University where he directs the Program on Law and Government. In May 2010 he was diagnosed with colon cancer and has been treated at Johns Hopkins Hospital. A year later, he says he is “feeling great—and grateful.”
Curious Eponyms

Barton J. Gershen M.D., Editor Emeritus

Girolamo Fabrizi of Aquapendente, Italy (1533-1619) received his doctorate in medicine from the University of Padua. His mentor was Gabriele Fallopio, of Fallopian tube fame, whom he later succeeded as Professor of Anatomy and Surgery. In turn, Fabrizi's brightest student was William Harvey, who described the circulation of blood.

In the manner of that period, Fabrizi altered his name to a Greek and Latin form, becoming Hieronymus Fabricius. Hieronymous is from Greek hieros: "sacred" and omya: "name." (His original given name, Girolamo is Italian for "Jerome" and Jereme, in turn, means "sacred one"). Fabricius is the Latinized form of Fabrizi.

The man we now know as Hieronymous Fabricius made a number of anatomical discoveries, designed a procedure for performing tracheostomies, and established several original observations in the nascent field of embryology. He became the foremost surgeon of his era and, in contrast to most modern physicians, Fabricius retired as a wealthy man. In addition to humans, he also performed dissections on lower animals. During his dissection of immature birds, Fabricius discovered an interesting outpouching of the cloaca, which disappears as a bird ages to maturity. This sac became known as the Bursa of Fabricius.

A second category of human lymphocyte, also manufactured within the bone marrow, subsequently migrates to the Thymus gland where it matures. These lymphocytes are responsible for cellular immunity, and are known as T lymphocytes - the T representing thymus. T lymphocytes are differentiated by various groups of receptor glycoproteins present on their cell surface. These protein molecules are known as CD receptors, the CD representing "clusters of differentiation," and among other lymphocytic disorders are prominent in the diagnosis and treatment of HIV & AIDS.

The city of Aquapendente, birthplace of Fabricius, derives its name from the waterfalls found there. Aqua: Latin for "water" and pendente from the Latin root pendere: "to hang," that is, "hanging water" a picturesque simile for a waterfall. Pendere has given birth to numerous English words such as pendant [a "hanging" ornament], appendage [something "hanging onto," as an appendix] and pending [something that is metaphorically "hanging around"].

Aquadendente, located in northwestern Italy, remains an active village with a population of 5500 people.

Some 1500 years before Fabricius, a Germanic tribe known as the Ubii established a settlement in an area that is now part of Germany. In 50 C.E. the Roman emperor Claudius captured that town and called it Oppidum Ubiorum ("town of the Ubii"). Claudius had just married his 4th wife, a sister of the previous emperor Caligula. Her name was Julia Augusta Agrippina and she was an ambitious, controlling woman. She demanded that Claudius rename his new city after her, so Oppidum Ubiorum became Colonia Claudia Ara Agrippinensis - "Agrippina's Colony." The name was almost as large as the settlement, and difficult to use in casual conversation, so gradually it was shortened to simply the "Colonia." Over the centuries, as Teutonic people regained control of the city, the word for "colony" became the German Köln. Today we know that city as Cologne.

In 1709, Giovanni Maria Farina moved from Santa Maria Maggiore in Italy, to Cologne. Once there, he altered his name to the German Johann Maria Farina and established a perfume factory, which he named Farina Gegenmüther. Within a year Herr Farina had invented a new toiletery. By adding the scent of lemon, lime, rosemary, lavender, etc. to a 60 percent alcohol base he created the finest perfume of his day. In deference to his new home, he called the product Eau de Cologne, which in French means "water of Cologne." Farina wrote to his brother: "I have found a fragrance that reminds me of an Italian spring morning, of mountain daffodils and orange blossoms after the rain." Unfortunately, patents were not available in Germany at that time, and many perfume factories developed their own version of "Eau de Cologne." In today's market, it is most often sold as a man's after shave lotion, but the original creation was utilized as a perfume for women by all the royal houses of Europe. Of interest, Farina's original factory remains operational to this day.

Words derived from proper nouns, lower-cased and utilized as names for common objects, are known as eponyms.

During his dissection of immature birds, Fabricius discovered an interesting outpouching of the cloaca, which disappears as a bird ages to maturity. This sac became known as the Bursa of Fabricius.
magnetic field. This has made it uniquely useful as a contrast agent during Magnetic Resonance Imaging (MRI).

In 1875, French chemist Paul Emile LeCoq de Boisbaudran discovered an unusual element that emitted two violet lines on spectroscopy. Since he was a loyal Frenchman, he named the new element Gallium for his native country. (The Latin name for France was Gallia.) You may recall the famous line written by Julius Caesar: “Gallia est omnis divisa in partes tres”—all Gaul is divided into three parts.) Gallium—chemical symbol Ga and atomic number 31—has been found to possess a unique biological feature. One of its radioisotopes, Gallium$^{67}$ Citrate (or nitrate), behaves like iron and is bound to leucocytes within areas of inflammation or rapid cell growth. This property makes it useful as an agent in nuclear medicine scans. Another Gallium isotope, Gallium$^{68}$, emits positrons, making it effective in PET imaging.

In 1866, a British-born amateur naturalist discovered a small fish, which has become one of the most popular fresh water aquarium species. The females of this group are 1.5–2.5 inches in length (somewhat larger than the males), and are one of those rare fish that give birth to live, free-swimming offspring. Somewhat later in 1866, the British zoologist Albert Gunther named the new genus for the man who had discovered it—Robert John Lechemere Guppy.

There is a river that arises in west-central Turkey and flows west to the Aegean Sea, emptying near the ancient Ionian city of Miletus. Its riparian course is marked by a convoluted, serpentine channel as it weaves its twisting way to the sea. The modern Turks call it the Büyük Menderes River, but in ancient Greece it was named the Meander—a word that now means “wandering aimlessly.” The writer of this column has occasionally been accused of that same trait.

Finally, in this brief review of curious eponyms, there is the story of a boy who was born in Harer, Ethiopia in 1892. His name was Tafari Makonnen. He grew to manhood and was named Regent of the country in 1916, which in the Amharic language is Ras “prince.” He subsequently became the Emperor of Ethiopia, reigning from 1930 to his death in 1974. As is often the case, upon being crowned Emperor he adopted a new and more regal name. Since he was a devout Ethiopian Orthodox

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PRIMARY CARE PRACTICE: Potomac Physicians, P.A., a primary care medical practice with 7 offices in Maryland is currently looking for primary care physicians interested in moving their existing practices under our business umbrella and into our Catonsville, Annapolis, White Marsh and Laurel offices. If interested, please contact Carol Reynolds, M.D., Medical Director at 410.248.2651 or carol.reynolds@potomacphysicians.com.

LEASE/SUBLEASE/SALE

BETHESDA: Attractive office space for rent in physician's practice w/private office, exam rooms and shared waiting room ready for use. Walking distance to Metro, parking garage, or on street and county garage across street. Please call Aveleen at 301.656.0220.


BOWIE: New medical building, in the heart of Bowie. Conveniently located near the intersection of Rte. 450 and Rte. 193. 2,300 square feet available. Flexible terms and monthly rates. To discuss or see, call Amanda at 301.860.1200.


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GLEN BURNIE: Office space in Empire Medical Building, 200 Hospital Drive, Glen Burnie, MD 21061 (Across from BWMC) 862 sq.ft. call 410.766.5552.

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