

Maryland **Medicine**

The Maryland Medical Journal **Volume 15, Issue 2**

Why Do Physicians Run for Political Office?



Mark Edney, MD
Republican Central
Committee
Wicomico County



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U.S. House of Representatives
First Congressional District



Jay Jalisi, MD
Maryland General Assembly
House of Delegates; District 10



John LaFerla, MD
U.S. House of Representatives
First Congressional District



Terri Hill, MD
Maryland General Assembly
House of Delegates; District 12



Tim Robinson, MD
Maryland General Assembly
Senate; District 42



Dan Morhaim, MD
Maryland General Assembly
House of Delegates, District 11



Thomas M. Walsh, MD
Orphans Court
Queen Anne's County



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I N S I D E



This issue of Maryland Medicine looks at the legislative and elective process.

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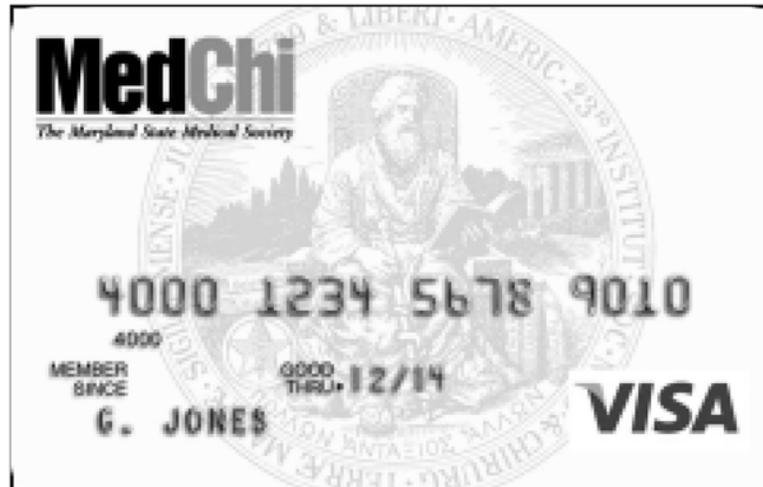
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Managing Change in Medicine



PRESIDENT'S MESSAGE

H. Russell Wright, Jr., MD

The Fourth of July has come and gone, our country has had a birthday and begins a new chapter in its history. Birthdays and new chapters led me to think about “change,” particularly the change we are seeing now in medicine.

The science of medicine changes every day and often at a rate that makes keeping up impossible. When I look just at the practice of allergy, and the science at its core, I can almost become overwhelmed by the increase in the basic science knowledge and the changes in therapy that have evolved. Change in medicine is as inevitable as change in life. The real challenge is to manage the change. The challenges and changes ongoing in medicine may at first glance appear daunting, but they are manageable. It is imperative that each of us examine the changes facing us, accept the changes we cannot control, control those we can, and make sure we influence the remainder. It is vital that all physicians in Maryland stay engaged and vocal, and being involved in MedChi is one way you can contribute to positive change.

Physicians are actually in the best position to manage the changes coming. We are the best-trained caregivers, we are the ones who are held to the higher standards of providing competent, ethical care to our patients, and we are the ones assessed throughout our careers. The changes in payment schemes and the changes in

practice dynamics are and will continue to test the professionalism of which we are so rightly proud. As a songwriter once said, “The times they are a-changin’.” The goal for physicians, and MedChi, is to manage these changes for the betterment of the profession and our patients. If we keep our eyes on that goal, we will have a win-win situation.

To achieve this goal, MedChi launched a Blue Ribbon Commission on July 23, 2014, examining the role of the physician in the future healthcare systems. To address all of the changes going on in medicine, MedChi has put together a group of thinkers to develop a vision and help MedChi plan for the future. We want to make sure that physicians are positioned to practice medicine that is patient focused, professional, and in a system that rewards people for doing the right thing the right way. Tyler Cymet, DO, President-Elect of MedChi, is chairing the Blue Ribbon Commission, which met for the first time on July 23rd. You can follow their thinking and research at www.medchi.org/blueribboncommission.

Wayne Gretzky, former professional hockey player knew that the fastest thing on the ice was the puck. To be a great player, he needed to skate to where the puck was going to be, not where it was at the moment. The future of medicine is similar to the hockey puck. While the

physician-patient relationship will, and must, remain paramount, consumers and insurers are demanding more evidence of outcome quality and cost-effectiveness. Doing things in the same old way is no longer an option. We need to get ahead of the puck.

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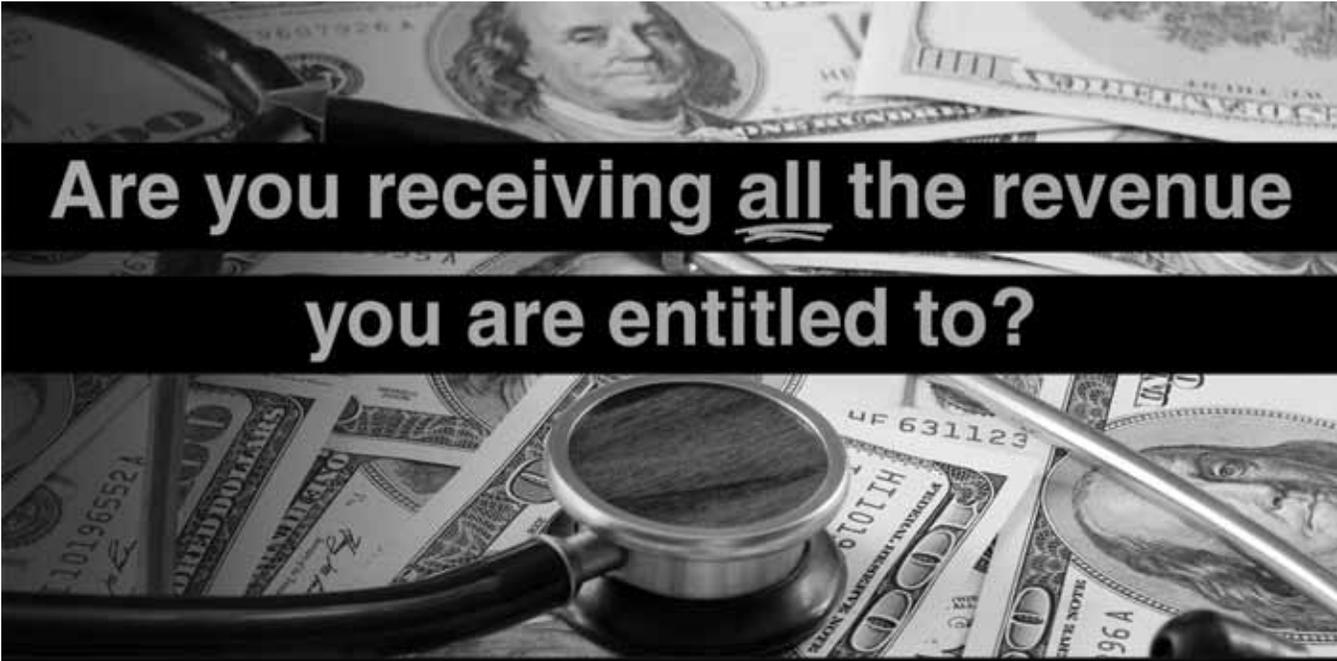
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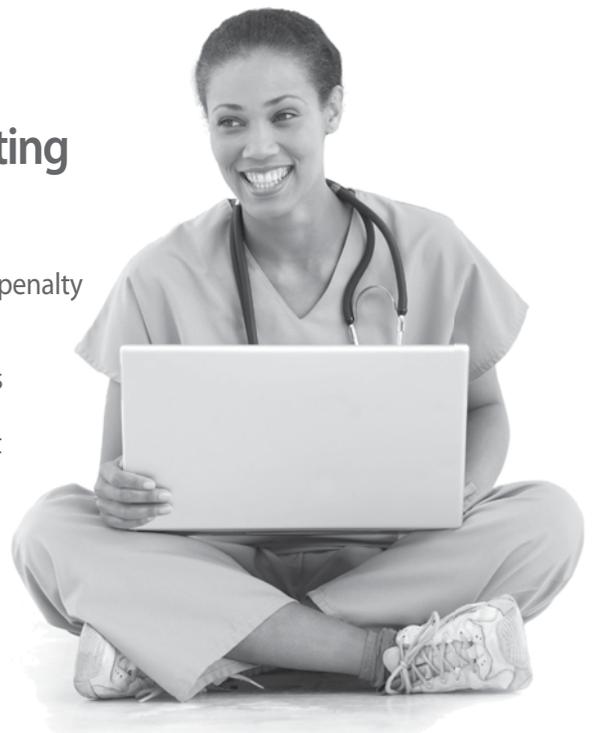
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MedChi Offers Tools for a Changing Healthcare Environment



CEO'S MESSAGE

Gene Ransom, III, Esq.

The direction of Maryland health care is changing at an amazing pace, and the tools that Maryland physicians need also have changed. MedChi is responding to the changes by offering tools for the Maryland physician no matter what setting they practice in. These tools are available in two distinct centers within MedChi: Center for the Employed Physician and the Center for the Private Practice of Medicine.

Center for the Employed Physician

The Center for a Healthy Maryland, a MedChi affiliate, created the Center for the Employed Physician as a home for resources and educational programming to meet the needs of physicians in Maryland who are employed or are considering employment by hospitals or large group practices. Resources were developed through a 2012–2014 grant from The Physicians' Foundation. Additional services and resources were launched in July 2014.

Maryland physicians who are contemplating employment now have assistance available to them in the form of a "Model Physician Employment Contract." Based on a document developed by the California Medical Association, the contract is fully adapted to the healthcare and legal environment in Maryland. The model contract is available on the new "Members Only" section of MedChi's website at www.medchi.org. Members also can access a document explaining basic terminology and concepts for physician employment models, a compendium of resources to help determine physician compensation, and a primer on self-referral laws. We anticipate that the Center for the Employed Physician will serve as a model for other state medical societies and physician professional organiza-

tions in meeting the unique needs of the employed physician, as well as those considering employment.

George Bone, MD, President of the Center for a Healthy Maryland, noted, "The Center was gratified to have the opportunity to coordinate the development of the Model Physician Employment Contract for Maryland physicians, by a highly qualified team of professional advisors."

Informative presentations by professionals in the legal, financial, and practice management fields can be found on the Center for a Healthy Maryland's website: www.healthymaryland.org.

Center for the Private Practice of Medicine

In 2013, MedChi launched the Center for the Private Practice of Medicine. The practice services range from accountable care organization development to basic day-to-day practice needs.

Keeping up with ever-changing technology, policy, and procedures is no easy task for the physician's office. MedChi's consulting division can provide assessment, education, and implementation to help physicians run compliant, successful, and profitable practices. Physicians are urged to take advantage of the following:

Training: Physician and staff training are important to the productivity, profitability, and efficiency of a practice. MedChi will schedule training in the following areas:

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- Medical Records
- Management
- HIPAA
- Employee Management
- MOSH/OSHA
- Insurance Appeals

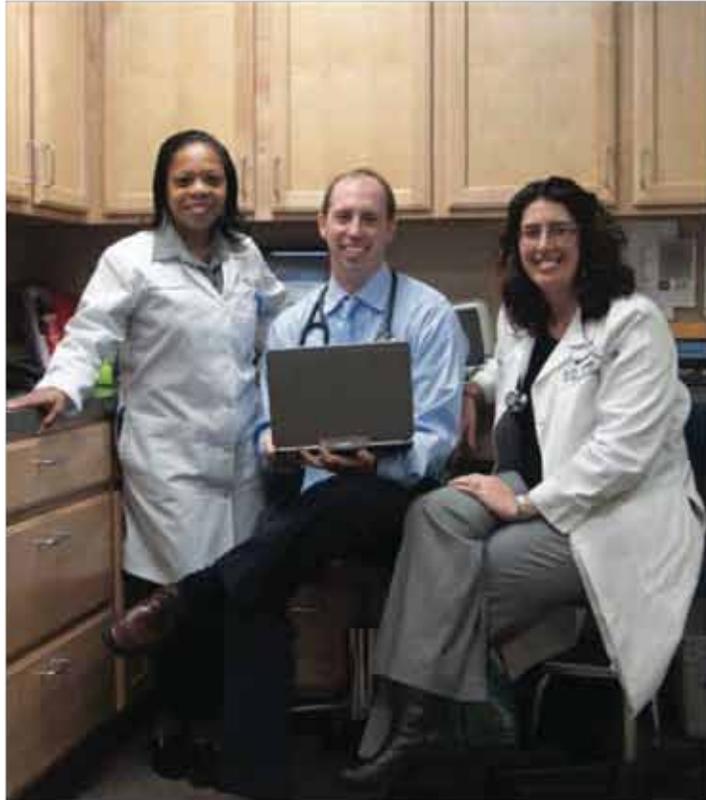
Policies & Procedures: To achieve compliance with federal and state regulations, current policies are an essential part of today's medical practice. Up-to-date policies can minimize staff issues and save time and money.

- Compliance Plan
- Employee Manual
- Job Descriptions
- HIPAA Privacy and Security
- Emergency Protocol
- MOSH/OSHA

Assessment: On-site evaluations and recommendations will help to improve productivity, enhance collections, and minimize risk in the day-to-day operations of a practice.

- Starting/Moving/Closing A Practice
- Front Office: Telephones, Appointments, Patient Flow
- Billing Office: Coding, Appeals, Accounts Receivable
- Back Office: Documentation, Patient Flow
- Medical Chart Audit
- HIPAA Privacy/Security: Gap Analysis
- Documentation/Coding
- Management
- Medical Records

MedChi understands the challenges of delivering health care to Maryland residents. We are working to offer services and tools to ensure that physicians are successful no matter where they work in this changing environment.



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Looking In All The Wrong Places



EDITOR'S CORNER

Bruce M. Smoller, MD

This time, I muttered to myself, I would write an editorial devoted to some really pleasant subject that caused no inner turmoil, undue angst, or the desire to rip into the nearest insurance company with the gusto usually reserved for the Hulk on a bad day. I would write about dogs, or decent people, or "the old fishing hole," but I would avoid that sinking feeling so peculiar to the practice of medicine today; that feeling that we have put our fate and the health of our patients in others' hands. That feeling was reflected in articles for both *Politico* and *The Daily Beast*, the gist of which was that medicine has slid down the razor blade of life to become "the most miserable profession," from...oh well, you know what it once was.

Then I read the *The New York Times* of May 18. "The Gray Lady" is not now, and never was, any great friend of medicine. This day, however, there appeared, on page 4 of what used to be called "The News of the Week in Review," one of a series of articles about the cost of health care: "Paying Till It Hurts" by Elisabeth Rosenthal. Another article which eats physicians for lunch, I mused, ready to move on to an article about artichokes in the south of France. Another opportunity to write a letter to the editor in high dudgeon which would be rejected in no time flat. But no!...This was an article about doctors which, ultimately, said: In the burgeoning economy of health care in this county, it is not the doctors who do the dirty...ready for this...it is the executives, consultants, and business men who make tons more than the doctors and SHOULD SHOULD MUCH MORE OF THE BLAME!!! Hospital administrators, CEOs,

and vice presidents of insurance companies and medical centers, middle men, side men, bottom feeders, and crusty consultants, all make so much money that their average salary is way more than that of "highly trained surgeons" and boosts the cost of medical procedures to obscene levels.

I won't enumerate the booty pulled in by the administrative types because you are probably eating lunch while reading this editorial and I don't want to be responsible for your cleaning bills. The really well paid ones, however, make on average enough to buy a wing of the hospitals they administer or to place a down payment on a small nuclear aircraft carrier.

Strangely, it's we, the physicians, who most often get the brunt of criticism, and, more to the point, become the target of those same bandits when it comes time to cut costs. And we have let this happen! We, each of us, and our organizations, often are left to lead the charge for change around the margins. We nibble, they feast! The same "we" and our organizations seem to operate on the theory that the administrators, both the bandits and government bureaucracy types, are absolutely correct in their calculations that medical care costs too much and so the doctors have to eat it again and again and again. We have a dissonance in first principles...we start with the premise that we need to cut our fees and turn ourselves inside out because "they" must be right... *we must be hurting our patients by our charges!* Except that it isn't we who are hurting our patients; it's *they*. See *The New York Times* and our own common sense for proof!

If this seems like grouching, it is. But it is more than that. There is a true dissonance

in assigning blame to physicians when that is false logic, and then asking us to shoulder the brunt of discounting our services. Dissonance causes stress, and these days we are awfully stressed. Do we need a union? Maybe the time has come. But what we need to do first is realize that we are not the cause of whatever crisis is occurring in medicine, or the delivery of health care. It is time we asked our organizations on a national level to go back to first principles and convey to the people and the government that medical care is expensive and there is no alternative, and that after all these years, it is mainly those other groups who need to shoulder responsibility for cost-cutting. In the matter of communicating our belief that what we do has real value, value way above many other matters in life, and certainly value way above that assigned to us by other actors in the medical universe, we have slipped badly.

Recently, Mayor Rahm Emmanuel of Chicago, looking at the city's terrible crime statistics said that a stand had to be made here and now and he and all the folks in Chicago had to make that stand. I think the time has come in medicine to do the same. We don't care about a seat at the table...the table is tilted and the seats are stacked and we have bargained our birthright for a mess of gruel. Let's not continue to do that. Let's change the parallax on first principles and adopt, as much for ourselves as others, the notion that we should not let these others, especially these particular robber barons, dictate the shape of the curve of our practices and our lives.

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Introduction

Stephen J. Rockower, MD, Guest Editor

As we near the end of summer, we need to look back at some of the events of the past six months. The legislative session of the Maryland General Assembly occupies a large portion of our time and thinking, as what they do in Annapolis has such a profound effect on all our lives, both as physicians and as citizens. This past June, the primary election was held in Maryland, with the general election coming in November. There are numerous physicians on the ballot around the state, and it behooves us to support them to have our voices heard in Annapolis.

This issue of *Maryland Medicine* looks at the legislative and elective process. We present a synopsis of the legislative session, with notes on the bills we supported and those we didn't. Overall, we did not do too badly this year, but the upcoming election can change all that. We present a series of questions that have been placed to physician candidates with their answers. Get to know these people, and all those who are running around the state. It can't be emphasized enough how much *your* lives can be changed in an instant by the things they do. Talk to the candidates. Contribute to their campaigns. Let them know where we stand on the issues. Even a ten-minute conversation in September can be remembered in February when you call the delegate or senator again to press your point.

The other emphasis of this issue is end of life care. We have two excellent articles, one from Hank Willner, MD, and another by Debra Wertheimer, MD. Dr. Willner, a palliative care consultant to Holy Cross Hospital in Silver Spring, sets out the parameters by which palliative care is indicated. The role of a physician is not necessarily to cure, but to make comfortable. Willner's article explores this sensitive topic and promotes discussion. Dr. Wertheimer, of the Veterans Affairs Maryland Health Care System-Baltimore Division, discusses the opportunities for palliative and hospice care for veterans, especially in the community setting. Many of us never realized there were such benefits available to our patients, even those who never received care through the VA system.

Rounding out our issue are messages from our Executive Director, Gene Ransom, our President, Dr. Russell Wright, our Editor, Dr. Bruce Smoller, and of course Word Rounds by our esteemed Dr. Bart Gershen. We also present a thoughtful piece about the medical thought process by our President-Elect, Dr. Tyler Cymet.

Our "Last Word" concerns another event near and dear to every Marylander's heart: The Defense of Fort McHenry. Frances Scott Key witnessed the event as he was on hand trying to negotiate the release of his friend, Dr. William Beanes of Upper Marlboro, who had been captured by the British after the Battle of Bladensburg in 1814. The British agreed to release him, but not until Key and Beanes witnessed the bombardment (and British takeover) of Baltimore Harbor. The next morning, "by dawn's early light," the Brits had failed and retreated, and Key jotted a few lines of a poem on the envelope that held the letter requesting Dr. Beanes' release. The rest, as we say, is history.

I'll end where I started. I exhort each and every one of you to become involved in the legislative and elective process. This election will determine the progress of the state for the next four years. If you don't get involved, you don't have a right to complain when it doesn't go your way. We need to all be in this together.

Stephen J. Rockower, MD, is an orthopaedist practicing in Rockville, MD. He is president of Montgomery County Medical Society, and co-chair of MCMS' Legislative Committee. He also is a member of the Maryland Medicine Editorial board and a subcommittee chair of the Council on Legislation for MedChi. He can be reached at drrockower@cordocs.com.

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MedChi Accomplishments During the 2014 Maryland Legislative Session



Stephen J. Rockower, MD

The Maryland General Assembly met for ninety days again this year, with the 434th session ending on April 7. The General Assembly considered more than 2,600 bills, and the Legislative Council of MedChi examined more than 250 of them. The overall feeling of the session was muted, as this is an election year, and everyone wanted to stake out positions, but nobody wanted to “rock the boat.”

The roll out of healthcare.gov and its compatriot in Maryland, MarylandHealthConnection.gov, was generally agreed to be abysmal. Much of the blame was directed at Lt. Governor Anthony Brown, but it was mostly from his democratic rivals, Attorney General Doug Gansler and Delegate Heather Mizeur. It has recently been replaced by importing the Connecticut system, after \$68 million (or more) had been spent developing our “home grown” one.

MedChi Issues

Naturopaths

One of MedChi’s major issues over the past few years has been licensing of naturopaths. The bill presented in previous years would have allowed them broad capabilities in diagnosis and treatment, without, in our opinion, proper training in the science of medicine. The bill that finally passed this year (House Bill 402/Senate Bill 314) was amended sufficiently that we were able to take no position. Their regulation will be within the Board of Physicians, but they may not refer to themselves as “physicians.” Naturopaths can provide counselling, some skeletal manipulation, some natural substances (but no prescriptive ones), and the like. They will need a collaboration agreement with a physician, which is the most restrictive scopes of practice of any state in the nation. The naturopath issue is behind us for now, but we are sure that, in future years, they will be back asking for more.

Step Therapy

Step Therapy has been a thorn in our sides for many years. To be disallowed to prescribe medications that we feel is best for our patients by the insurance companies’ regulations to use cheaper medications first has been anathema to all of us. SB622/HB 1233 now provides a process to override an insurance company’s protocols, especially in an on-line process. This bill, which becomes effective in July 2015, also forbids the requirement for using a non-FDA approved medication as part of their protocols. It also allows a patient who has changed insurance companies to remain on their previous regimen without having to qualify through a Fail-First provision.

Workers’ Compensation Dispensing

There has been a push for some time by the Pharmacy and Workers’ Comp insurance lobby to restrict the dispensing of medications by physicians. A number of bills were introduced to (a) ban it entirely, (b) restrict dispensing to the first thirty days of treatment, or (c) make the payments to physicians so unfavorable that they would have to abandon the practice. There was significant lobbying by all sides in this matter, but the issue eventually never made it out of committee this year.

Trial Lawyers

The Maryland Trial Lawyers Association, now re-branded as the “Maryland Association for Justice” (*sic*), tried to triple the cap on non-economic damages. Effective testimony by MedChi leadership, Drs. Wright and Cymet, effectively killed this bill.

All-Payer Contracting

Maryland is the only state in the nation in which each hospital is paid the same rate by all insurers. This process is overseen by the Health Services Cost Review Commission, or HSCRC. Medicare has

required this as part of the “waiver” system. The Budget Bill provided an additional \$15 million to hospitals to support implementation of the waiver, and established committees including physicians to oversee the disbursement of these funds. The hospitals are generally more squeezed by this than the private physicians, as they are required to find more savings in their budgets. In addition, the HSCRC must report more regularly to the Governor and General Assembly as to the current fiscal health of Maryland’s hospitals.

Other Issues

Sterile Compounding

After the disaster of non-sterile medications being injected from non-regulated sources, legislation in 2013 put significant and strenuous regulations in place. These regulations put the ophthalmologists and oncologists (and rheumatologists) in a bind, as they often need compounded drugs in their offices for administration. SB1108 opened this up for a slightly looser interpretation for the benefit of immediate patient care.

Birth Injury Fund

SB798/HB1337 would have created a system for a Birth Injury Fund to take birth injuries out of the usual malpractice court system and into the hands of administrators. Although this bill did not pass, it opened the conversation for future years to provide true compensation and care for those with birth injuries without the usual histrionics and outlandish awards that have occurred in the courts.

Prescription Drug Monitoring

Safeguards were put into place under HB1296 to protect physicians whose prescription drug profile may seem suspect from immediate attacks on their

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LETTERS

Margin of Error

Opinion polls usually state results as a percentage, and almost always include the likely error in that percentage (e.g., plus or minus ten percent).

As a physician of many years, I wonder why quantitative medical laboratories never report the margin of error of an individual test result. The margin of error is known, or should be known, for each procedure. Some tests are more precise than others. However, if a result is above or below the normal limits, the patient may be subjected to additional tests or procedures, which may not actually be indicated.

For PSA testing a result above 4 ng/ml may lead to a patient being biopsied. If the margin of error were considered, that same patient might not need a biopsy. Does this ever occur? The same is true for blood sugar tests. Is a patient with a reading of 127 mg/dl diabetic? It might well depend on the error rate of that test result?

For some reason the margin of error is never reported in lab test results. Because the lab report never informs the physician of the margin of error for the value of the test reported, some, or perhaps many, physicians do not consider the possibility of a margin of error when interpreting test results. This is not considered malpractice, since not reporting the margin of error is the common practice, and most probably the universal practice. Malpractice is doing something that is outside of ordinary practice. However, when it comes to lab tests, perhaps ordinary practice needs to be redefined.

John Petrucci, MD

Letters to the Editor are each the opinion of the author and may not reflect the opinion of the Maryland Medicine Editorial Board or MedChi, The Maryland State Medical Society.



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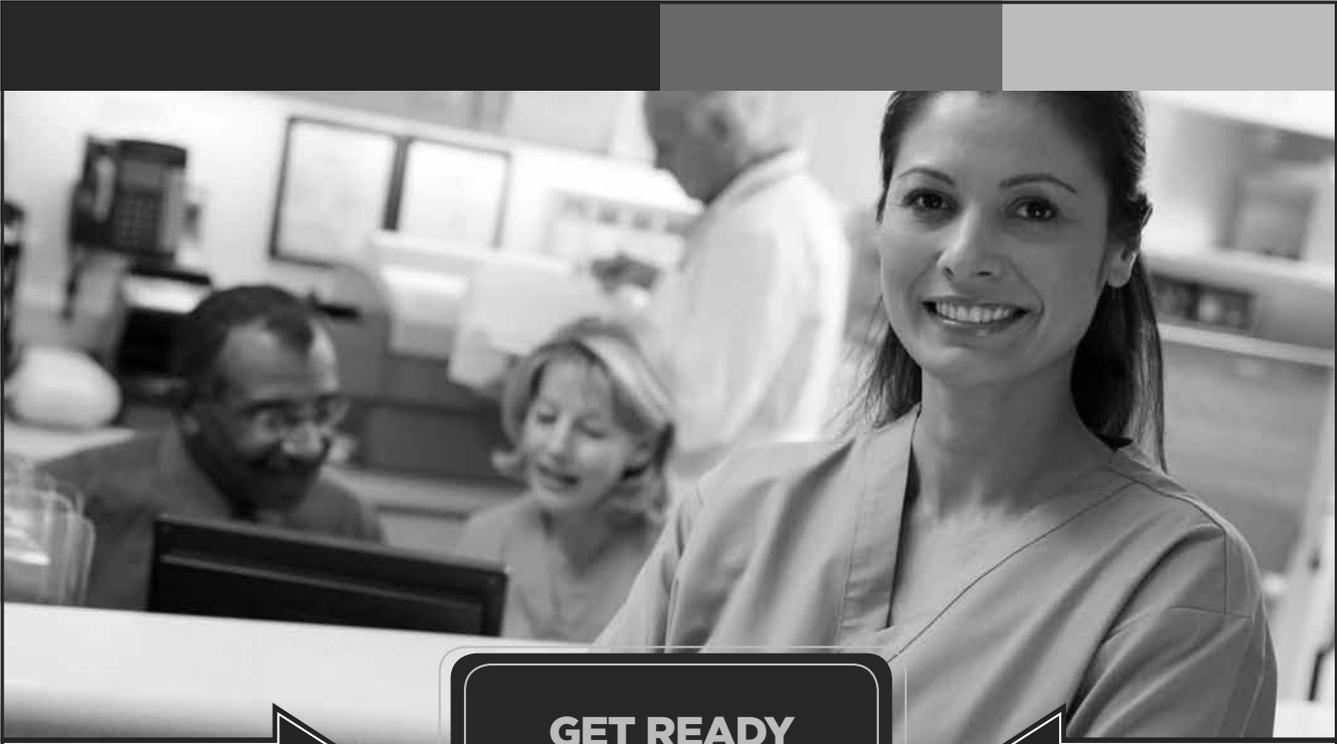
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Why Do Physicians Run for Political Office?

Maryland's 2014 Physician Candidates Speak Out

Maryland Medicine invited all Maryland physician candidates for political office to share their thoughts with our readers about why they have chosen to enter the political arena, and why they think it is important for physicians to be involved in the development of public policy. We are pleased to share their remarks with you.



Mark Edney, MD
Republican Central
Committee
Wicomico County

On June 24, Mark Edney, MD, a specialist in urology from Salisbury, was elected to the Republican Central Committee from Wicomico County.

Why did you run for office? Would you encourage other physicians to run for political office?

I want to help revitalize our party's grassroots activity in my county.... As a physician on the committee I would have a platform to educate both existing office holders, candidates, and the voting public with respect to the many challenges and regulatory obstacles (state and federal) standing in the way of efficient, cost-effective, quality care.

I would strongly encourage any physician who has the inclination to run for office. Healthcare is going to be an ongoing policy concern and a large part of both state and federal budgets for the foreseeable future. The practicing physician has been largely absent from the policy-making and regulatory machine and you can see where that has gotten us.... There is no substitute, however, for having a doctor with years of clinical experience in the trenches sitting in a legislative seat as medical practice-changing laws are proposed, amended, passed, and handed over to the bureaucracy to implement.

What are some of the ways that medical professionals can become involved in political leadership?

Influencing legislative activity is about long-term relationships with lawmakers. ...meaningful relationships with both sides of the aisle.... The ones with most influence over healthcare policy are those who sit on the House Health and Government Operations "HGO" Committee and the Senate Education, Health, and Environmental Affairs "EHEA" Committee. If your delegate or senator is not on the committee, they may have friends and allies who are. Start hanging around, you'll meet them too.

Another good way to insert yourself into the equation is to help candidates who are running.

For too long, many physicians have considered the political process either irrelevant to their daily lives or even "below" them. That mindset needs to change. We all need to engage in some form and take back the practice of medicine for our patients. It's being slowly pulled from our grip.

What impact do you believe that physicians can have by participating in government?

As subject matter experts in a discipline that consumes 25 percent of the state budget, physicians have potential for enormous influence. The front-line practice of medicine is a black box to most who are debating, voting on, and implementing the laws that affect our practices and the way we are able to care for our patients. It would be like a group of doctors deciding legal regulatory policy. How long would attorneys put up with that? But we do! Physician-legislators have enormous potential to influence the form and substance of medical care in our state but we've got to become active YESTERDAY.

How does your expertise affect the debate on health system reform or health issues?

Educating lawmakers and the community with respect to healthcare issues.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

In most cases it's possible to hold county and state-level office and continue to practice. Central Committee seats demand the least amount of time.

Even holding a seat in the House or Senate is not incompatible with practice as long as you can swing a three-month leave of absence every year. I've been in the Army reserve for twelve years and have had three-month deployments. I have an extremely supportive wife. I also have supportive partners who took on the extra call while I was away and saw my urgent follow-ups (I'm a urologist).

It would be difficult in a solo or two-person group but with larger independent groups or hospital employed/academic groups, it is very doable.



Andy Harris, MD
U.S. House of
Representatives
First Congressional
District

Andy Harris, MD, an anesthesiologist from Cockeysville, began serving as the U.S. Congressman from the first congressional district of Maryland in 2011. On June 24, he won his primary reelection bid. He previously served (1998–2010) in the Maryland Senate for District 9, and later District 7.

Why are you running for office? Would you encourage other physicians to run for political office?

I believe we need more physicians in public office, as there are many medical and health issues coming to the forefront of the political agenda.

In Maryland, I helped recruit a physician to run for State Senate, a seat I used to hold....We need to make sure medical professionals are in the General Assembly, bringing their familiarity and expertise.

What are some of the ways that medical professionals can become involved in political leadership?

Medical professionals can run for office representing the public, they can run for a Central Committee to help set a political

party's position on health care and other matters, get involved with a campaign by sitting on an advisory committee, as well as organizing fundraising for a candidate.

What impact do you believe that physicians can have by participating in government?

Physicians could be helping to sponsor and draft legislation, getting good health care legislation passed (as well as blocking bad legislation), and bringing their expertise to the body that may be crafting health care legislation without knowing enough about the field.

How does your expertise affect the debate on health system reform or health issues?

Having been a physician at a major hospital associated with a medical school, I am familiar both with health issues and with systems. As a Congressman dealing with these issues at the national level, I am able to speak about health care from personal, professional experience, giving the advantage of greater understanding to my colleagues.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

For a physician to maintain a level of expertise, it is ideal to have some ongoing involvement in the medical field, enabling him or her to be familiar with new issues, developments, practices, and so forth.

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Terri Hill, MD
Maryland General
Assembly
House of Delegates;
District 12

On June 24, Terri Hill, MD, a cosmetic and reconstructive plastic surgeon practicing in Columbia, won her primary bid for the Maryland House of Delegates, District 12.

Why are you running for office? Would you encourage other physicians to run for political office?

I have always been active in my community, politically minded, and involved in local and state politics. The decision to run for office was based on a realization that my excuses for not becoming more engaged were no longer acceptable.

As a political activist, engineer, medical doctor and small business woman running a successful solo surgical practice for 23 years, I believe I possess key attributes—sharpened through professional training and life experience—that uniquely qualify me to be an effective and responsive.

Similarly, many of my colleagues could apply the attributes that brought them to and through medical school and training, combined with their life and work experiences witnessing and administering to people impacted by the failures, successes and deficiencies in public policy, to affect positive change. We may be uniquely positioned to help redirect the discussion, offer a more pragmatic, less political perspective, approach issues holistically and apply diagnostic and problem solving skills in order to achieve better long-term outcomes.

What are some of the ways that medical professionals can become involved in political leadership?

All forms of involvement are useful and important, whether through professional societies, practice management teams, hospital professional staff leadership or committee work, non-partisan community groups such as PTAs, HOAs, and the boards of community service organizations, and partisan or issue-based groups, clubs and organizations.

Participation starts with paying attention to the issues and engaging in conversations. Medical professionals can become involved in the same ways other citizens do: we can serve in leadership or support roles, give testimony before legislative bodies, contribute financially, write letters-to-the-editor and to elected officials, volunteer for campaigns, hosting candidates in our homes and introduce them to colleagues. We can be on campaign committees and we can run for and serve in political office.

What impact do you believe that physicians can have by participating in government?

As physicians we hold a unique and privileged role in our communities and remain among the most respected professionals. In part this is due to a perceived, and often true, altruistic motivation underlying our choice of life's work and, in part due to the intense screening and academic training processes required to become a physician. We are often able to also speak for the powerless and the disenfranchised

because we are part of the safety net that catches them when social policy fails. Our decision to participate in government can have an enormous impact on how well government does its job and on how quickly it reaches effective and just solutions.

How does your expertise affect the debate on health system reform or health issues?

As a physician in private practice I can speak to the limitations, difficulties, practical considerations, efficiencies, demands, financial costs, and needs of the patients and of the providers. Whatever the future of health care will be, it will change how I am expected to practice medicine. I want a seat at the table when the discussion takes place and decisions are made.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

The particular political office, specialty, type of practice, career stage, strength of personal and professional support systems, and personal and professional obligations may make doing both more or less difficult.... at this stage in my career I found I have the flexibility and autonomy to do both.

Maryland's "citizens' legislature" is made up of lawmakers from a wide range of demanding careers and professions. Delegate work requires full-time attention during the three-month legislative session and yearlong attention to constituent service. As a result, I do not have to choose between my passion for medicine and my passion for service.

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Jay Jalisi, MD
Maryland General
Assembly
House of Delegates;
District 10

On June 24, Jay Jalisi, MD, an otolaryngology and head and neck specialist from Owings Mills, won his primary bid for the Maryland House of Delegates, District 10.

Why are you running for office? Would you encourage other physicians to run for political office?

I believe that only through elected office can one make a significant and long lasting impact on public policy, and thereby improve the lives of his or her fellow citizens....I think everyone who can dedicate his/her self to public service should do so.

What are some of the ways that medical professionals can become involved in political leadership?

I think grass roots political activism is very important for everyone, and medical professionals should start from there, whether you choose to be a Democrat or a Republican. I help run homeless shelters for women, free medical clinics, and soup kitchens... public service projects are very much needed in our community, and doctors can help by donating their time and/or money.

What impact do you believe that physicians can have by participating in government?

Physicians, or medical professionals as a whole, are honest and sincere people who choose their profession to serve humanity, and we need such individuals in the government.

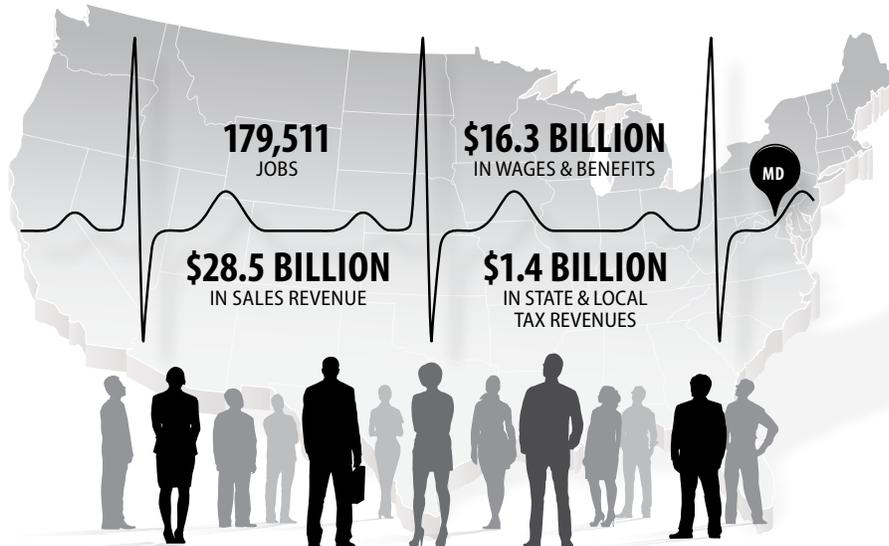
How does your expertise affect the debate on health system reform or health issues?

Only a medical professional can understand the trials and tribulations faced by other doctors, or medical organizations, so it would clearly be helpful to the medical community in particular, and Maryland residents in general, if I win the election and am in a position to influence better policies and enact better laws that affect medical professionals.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

I don't think the current calendar allows a physician to work full time while in office....The annual legislative session for both the House of Delegates and the Senate run from January through April on a daily basis, thereby making it impossible for one to do anything else professionally in that period.

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Clarence Lam, MD
Maryland General
Assembly
House of Delegates;
District 12

Clarence Lam, MD, a specialist in preventive medicine from Columbia, won his primary bid for the Maryland House of Delegates, District 12.

Why are you running for office? Would you encourage other physicians to run for political office?

I have a longstanding record of service on both the federal, state, and local levels.... I believe there is much more that I can do to help a community beyond the walls of the clinic and hospital. I would absolutely encourage other physicians to run for political office. Physicians are significantly underrepresented... we bring a unique perspective given our background in science and medicine.

What are some of the ways that medical professionals can become involved in political leadership?

Healthcare professionals can exhibit leadership by contacting their legislator about a concern, organizing meetings or activities that help raise awareness...taking the time to visit the offices of their elected officials and advocating for their priorities...seeking an appointment to a board or commission.... Healthcare professionals can also look for service and leadership opportunities within their trade or specialty organizations (e.g., MedChi) to influence the political and policy process.

What impact do you believe that physicians can have by participating in government?

...In government, and in particular in the legislature, there are far too few scientists and medical professionals. I believe that physicians not only have some of the strongest credibility of any occupation, but they can be trusted to give science a voice in the legislative process and in keeping politics out of medicine in what has increasingly become a partisan political environment.

How does your expertise affect the debate on health system reform or health issues?

With so much change occurring within the healthcare system, I believe it is our responsibility as healthcare leaders involved in the political process to clarify these misunderstandings by providing coherent explanations and lending our experiences.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

Yes. The advantages are that it keeps key issues and concerns to the medical community in perspective, it allows for continued interaction and outreach with the community and with patients. The disadvantages are that time management can be particularly challenging...and continuity of care can be interrupted for your patients particularly during the 90-day legislative session.

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John LaFerla, MD
U.S. House of
Representatives
First Congressional
District

On June 24, John LaFerla, MD, an obstetrician-gynecologist from Chestertown, lost his primary bid to represent the First Congressional District of Maryland.

Why are you running for office? Would you encourage other physicians to run for political office?

As a group, physicians tend to have good powers of observation, analysis, and ability to communicate. All of these factors can be put to good use in public service.

Ideally, many professions should be represented in all sectors of government, and medicine is one which has been chronically under-represented, so I would encourage more involvement by physicians.

Last, but not least, healthcare reform is in the forefront of our national agenda. Not only are major changes underway, but many adjustments will continue to be needed over many years to improve our system. Physicians should be at the core of this effort.

What are some of the ways that medical professionals can become involved in political leadership?

One of the first places to start may be in one's own organization by working on or leading various committees. Next, local boards are often looking for engaged leadership from the community—volunteer to help! Lastly, many medical associations

conduct seminars or conferences focused on developing the skills needed for political success. These are extremely helpful for those considering embarking on a run for political office.

What impact do you believe that physicians can have by participating in government?

Healthcare reform is in the forefront of our national agenda. Not only are major changes underway, but many adjustments will continue to be needed over many years to improve our system. Physicians should be at the core of this effort.

How does your expertise affect the debate on health system reform or health issues?

My practical experience as an Ob/Gyn for over forty years, and my twenty-five year background in Public Health each provide unique perspectives. Everyone's professional journey is different, and mine included 17 years in academic medicine, followed by 10 years in a large staff-model HMO, then 14 years in private practice. This diversity may allow me to relate to problems and to find creative solutions that others may overlook. ...I am already starting a list of issues that can improve health care outcomes of our citizens while holding the line or even reducing per capita spending.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

Depending on the kind of medicine you have been trained to do and depending on the kind of public service, it may in some cases be possible to continue practicing medicine. For example, specialties that do not require investment in an office or staff with ongoing overhead costs, or practices with many partners to take up the slack when the civil servant is not available, may be more amenable to dual activities.

In general, both activities require so much energy and attention to detail that most physicians would find it difficult to maintain their skills when spending much of their time in political office. So my opinion regarding this question may be summed up as saying: yes, it may sometimes be possible, but not generally desirable to attempt to sustain a practice while in office.

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Dan Morhaim, MD
Maryland General
Assembly
House of Delegates,
District 11

On June 24, Dan Morhaim, MD, a specialist in internal medicine and emergency medicine from Owings Mill, won his reelection bid to represent the Eleventh District in the Maryland House of Delegates.

Why are you running for office?
 Would you encourage other physicians to run for political office?

The key is to participate.... Vote, support [the] candidates who support your views, communicate frequently in a positive way, and consider serving in some manner.... Another key step is to join and participate in MedChi, your local medical society, and specialty group organization.

I am running for reelection to continue public service, which I see as another aspect of the healing profession.

As the only physician in the 188-member Maryland General Assembly, I would certainly encourage other physicians to run for office, not only to contribute on health care issues but also to bring perspective to myriad of other issues confronting the Maryland General Assembly.

What are some of the ways that medical professionals can become involved in political leadership?



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The key is to participate. Even a minimal effort goes a long way. The basics are to vote, support candidates who support your views, communicate frequently in a positive way, and consider serving in some manner to the political policy process. That could include serving on boards, commissions, and task forces. Of course, another key step is to join and participate in MedChi, your local medical society, and specialty group organization.

What impact do you believe that physicians can have by participating in government?

Physicians are a highly recognized group, and their impact can be not only on health care but on the broader range of issues (education, public safety, environment, economy, jobs) as well.

How does your expertise affect the debate on health system reform or health issues?

In my experience, the clinical voice is all too often absent or overlooked in the health care debate, whether from physicians, nurses, PAs, technical staff, and others. I've been to many, many health policy meetings where I am the only person present who has actually practiced medicine and had to make clinical decisions (I have thirty-plus years ER experience). The "administrative physicians" at these meetings often have limited, remote, or almost no clinical experience. Because the clinical voice is not heard, "policy experts", insurers, attorneys, and others dominate decisions.

We need to hear from those on the front lines of health care delivery, just as we need to hear from teachers about the classroom or police about public safety. The people who are doing the work need to be considered.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

Yes, but it can be difficult. First, there is considerable stress on one's family. If your family is not supportive, you probably should not consider running for office. Second, some practices (e.g. emergency medicine, anesthesiology) are more amenable to holding office because these are shift-work jobs, and so giving up time to office does not leave patients and overhead is minimal. Based on my experience, it would be hard for a family physician, internist, or oncologist with a full office practice to hold office. Last, there are financial aspects. For many physicians, holding office will have financial costs, but public service is about contributing to society, and that's more important.

I'm glad that being a legislator in Maryland is a part-time job and that I can return to medical practice when the legislature is not in session. This keeps me in immediate touch with what's happening in the real world, and I like treating patients and doing other medical work at the Hopkins School of Public Health and elsewhere.



Tim Robinson, MD **Maryland General Assembly** **Senate District 42**

On June 24, Tim Robinson, MD, an anesthesiologist in Timonium, won his primary bid (unopposed) to represent District 42 in the Maryland State Senate.

Why are you running for office? Would you encourage other physicians to run for political office?

In the next several years, medicine in Maryland faces critical challenges. We need the knowledge and experience in the state senate that only a physician can bring. If we do not advocate for our patients and our profession, we have only ourselves to blame when changes are made without our input. If you are not part of the solution, you're part of the problem. We all need to be part of the solution.

The legislative committee of MedChi is an incredible crucible in which to learn about medical legislation and the legislative process in Maryland.

What are some of the ways that medical professionals can become involved in political leadership?

Become a member of MedChi and be active. Membership in your local medical society is equally important. The same is true for your component society. All of our medical societies have need for committed physicians who want to lead and make a difference. The legislative committee of MedChi is an incredible crucible in which to learn about medical legislation and the legislative process in Maryland. Go to Annapolis and meet with your legislators, interact with them and help them understand medical issues. Lead your component society.

What impact do you believe that physicians can have by participating in government?

Physicians can inform and teach legislators about patient care, about medical issues and about the realities of our businesses. We are advocates for our patients and our profession. Most General Assembly members bring an open mind to medical issues, and need to hear the perspective of the medical community

How does your expertise affect the debate on health system reform or health issues?

No one else in the legislative arena is going to be able to understand medical issues as well. Having spent many years on the MedChi legislative committee, I have experience dealing with, and understanding, the legislative process in Maryland. As past president of the Maryland Society of Anesthesiologists, I am connected to the issues of my component society, and can better appreciate the issues all our specialties face. Having served as the president of York Road Anesthesia Associates, I have dealt with many of the issues facing our profession as businesses.

I am concerned about the future of health care in Maryland. We have world-class physicians, trained at world class institu-

tions, practicing in fantastic hospitals. But if we harm our system through well meaning but poorly conceived changes, we risk long-term damage. It is much easier to avoid poor decisions than to repair damage after it's done.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

Most of the current group of physicians campaigning for office are employees of groups or hospitals who support their efforts in running. I am, at 61, recently retired and able to devote my time and energy to our campaign for state senate. For a practicing, independent physician it would be very difficult to devote the incredible time and energy needed.

The advantage to maintaining a practice while in office is the staying connected to the issues of medicine and the trials of running a practice.

The other side of that coin is you have less time and energy to devote to the needs of your constituency. Practicing medicine is nearly all consuming for most physicians. Then you add active participation in medical organizations, running a business and most importantly family. It's difficult to add the rigors of public office without taking away from other arenas, basically something has to give.



Thomas M. Walsh, MD **Orphans Court** **Queen Anne's County**

On June 24, Thomas Walsh, MD, a primary care physician from Queenstown, won his re-election bid for the Orphans Court of Queen Anne's County.

Why are you running for office? Would you encourage other physicians to run for political office?

I wanted to find a way to give back to our community. As a physician I have great opportunities.. I would encourage other physicians to do the same, to find a way to use their skills in community leadership positions.

What are some of the ways that medical professionals can become involved in political leadership?

There are numerous local level political leadership positions in every community. ... It doesn't necessarily have to be elected office. There are lots of opportunities out there, whether it be community service organizations, work with youth sports programs, local teaching (health and non-health related subjects), local health department efforts.

What impact do you believe that physicians can have by participating in government?

We as physicians have also had a chance to be involved in people's lives, we know what goes on in families and communities. Local communities, as well as larger jurisdictions, need that kind of approach.

How does your expertise affect the debate on health system reform or health issues?

As physicians we are there 'in the trenches' every day. We know what struggles people go through to get through the health care system and to pay for it as well. Insurance issues, government regulation, costs, are things that patients face every day and I am not sure non-physician leaders can ever get a real sense of what the problems are.

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

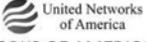
Running for, and holding a political office while maintaining and active practice can cause problems. Both are very time consuming. Being realistic about your time can help avoid problems with your political aspirations, your patients, and your family. Keeping the politics out of your patient encounters requires some skill as well. The political office does however give you a chance to expand your opportunities to help people. It can be very rewarding.

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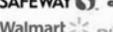
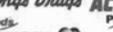
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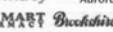
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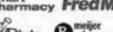


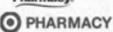








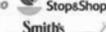
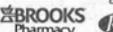










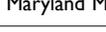
















Eric Wargotz, MD
Orphans Court
Queen Anne's County

On June 24, Eric Wargotz, MD, a pathologist in Lanham, won his primary bid for the Orphans Court of Queen Anne's County.

Why are you running for office? Would you encourage other physicians to run for political office?

Losing a loved one is never easy and if there are estate concerns, either no will or a contested will, the Orphans' Court will handle the matter and that can be very stressful. I know that as a Judge of the Court I will be able to help families through this complex and challenging process drawing from my experiences in medicine, law, government and in matters of my own personal life.

There is no doubt that a physicians' point of view, particularly in medical and health related matters adds considerable value to a discussion or debate. I think such contribution is indispensable, and I encourage all physicians who have an interest in seeking elected office to do so.

What are some of the ways that medical professionals can become involved in political leadership?

The MedChi legislative committee is an excellent way to participate at the State level. At the local level, there are often county and municipal committees, commissions and task forces looking for members to contribute to the discussion/decision making.

What impact do you believe that physicians can have by participating in government?

In most cases, physicians are able to inject a different perspective in a discussion.

How does your expertise affect the debate on health system reform or health issues?

As a physician, we are viewed as having first-hand knowledge and experience as providers, patients, and administrators within the health care system. This translates into being "credible."

Do you think it's possible to maintain a practice while holding a political office? If so, what are the advantages and disadvantages?

It is possible, as many have shown but it is not without additional sacrifice. The rewards of serving your community as a physician and elected official cannot be quantified.

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VA Health Care System: Increasing All Veterans' Access to End-of-Life Care

Debra Wertheimer, MD

There are almost 22 million veterans in the United States. The U.S. government spends \$43 million on their care. Seven million are aged 70 or older. For the seven million senior veterans, hospice care is an essential service

This article was written before the recent events concerning the Veterans Health Administration (VHA) were covered in the news. While there certainly are problems within this system, as with all large administrations, it does not change the wonderful end-of-life (EOL) care that is provided and available to veterans.

Community providers do not have much opportunity to learn about the VA (Veterans Affairs) system and veterans in general. Some facts to know:

1. Twenty-five percent of all deaths in the United States are veterans.
2. Only four percent of veterans are cared for in the VA system.
3. Veterans who served in different eras have different issues, which may have significant impact on their reactions to life threatening illnesses.
4. Post traumatic stress disorder (PTSD), which is very common in the veteran population, increases the risk of terminal agitation and delirium.
5. There has been a marked increase in the number of women veterans, and we need to be sure to ask if someone is a veteran and not presume a woman is not a veteran.

Acknowledging the remarkable death rate for veterans, the VHA decided it was essential to provide quality EOL care for those who have served this country. To achieve this goal, VHA is providing a minimum of 1.5 full-time equivalent (FTE) employees to provide hospice and palliative care in all facilities across the nation, and has funded and established many in-patient hospice and palliative care units. The services offered to veterans in these inpatient units incorporate the more familiar hospice and palliative care principles, as well as concepts that are unique to the veteran population. In Maryland's inpatient units, as an example, we offer a "Final Salute" at the time of the veteran's death. This ritual honors the veteran who has served us, the family of the veteran, as well as the other veterans in the facility and staff.

The VHA is providing ongoing training about hospice and palliative care to providers and employees throughout the system. To ensure improvement in the future with EOL issues and pain and symptom management, there is now a national hospice and palliative care consultation template, through which data are being collected about the care veterans are receiving.

It is imperative that the non-VA provider community is made aware of the services available to those who honorably served our nation. Without this information, the community providers who care for veterans who are not receiving their care within the VA cannot ensure all the veterans who need hospice and palliative care will benefit from these services.

Hospice and palliative care within VAMHCS (Veterans Affairs Maryland Health Care System) is growing dramati-



VA Hospice and Palliative Care Units

Baltimore VA Medical Center
10 North Greene Street
Baltimore, MD 21201
410.605.7000

Martinsburg VA Medical Center
510 Butler Avenue
Martinsburg, WV 25405
304.263.0811

Perry Point VA Medical Center
Perry Point, MD 21902
410.642.2411

Washington DC VA Medical Center
50 Irving Street NW
Washington, DC 20422
202.745.8000

Loch Raven VA Community Living and Rehabilitation Center
3900 Loch Raven Boulevard
Baltimore, MD 21218
410.605.7000

For further information:
<http://veterans.maryland.gov>

cally. However, there are still many veterans who are severely ill and/or approaching the end of their lives who are cared for in the community with little or no contact with the VA. These veterans and their providers are often not aware they are eligible for hospice and palliative care services under the VA.

Many physicians in Maryland are not aware of the EOL resources that are available through the VA. Providers may not know which patients are veterans, and they may be concerned they would lose the relationship they have with their veteran patients if they do begin to use these resources.

As a community provider, it is important to know the following:

It is imperative that the non-VA provider community is made aware of the services available to those who honorably served our nation.

- The VA provides hospice and palliative care to *any* veteran who is registered in the VA, without regard to his or her service connection.
- The VA will expedite registration if the veteran is hospice eligible.
- The hospice benefit follows the same guidelines as the Medicare Benefit for Hospice, whether under Medicare or paid for by the VA.
- Younger patients can receive hospice care even if they are not Medicare or Medicaid eligible, or do not have a hospice benefit under their private insurance.
- The veteran can decide whether he or she wishes Medicare or the VA to pay for the home hospice services.
- The VA will often allow the veteran to receive some palliative care under hospice, care that home hospice agencies could not afford to provide (such as palliative chemotherapy) under the traditional Medicare payment system.
- If the veteran has the VA pay for his or her hospice care, the veteran might be allowed to receive hospice services

while Medicare is paying for the sub acute/skill services in a long-term care facility.

- There are two inpatient hospice units in Maryland (See box: VA Hospice and Palliative Care Units), an inpatient unit in the Washington, DC, VA hospital, and, finally, one in Martinsburg, West Virginia, all of which serve veterans from Maryland. These inpatient units will allow veterans to have long stays in the units (up to six months) if needed,

at no cost to the veteran or the families.

- If the veteran requires respite services, and the VA has a hospice bed available, the veteran is

allowed more than the five-day stay under Medicare.

- The VAMHCS has established partnerships with the home hospice agencies across Maryland, through the Maryland Hospice Network, to provide hospice services at the end of life. These partnerships allow the veterans to obtain the same equality EOL care even if the veterans do not have Medicare or Medicaid or private insurances that provide hospice benefits.
- Veterans who use these benefits are not required or even encouraged to change providers.

It is crucial that health care professionals in Maryland and elsewhere are knowledgeable about the services available to veterans so that they can refer veteran patients for the services to which they are entitled.

The VHA is committed to providing veterans with quality end-of-life care in a setting of the veteran's choice.

Debra Wertheimer, MD, is Director of Palliative Care, Hospice for the VA in Baltimore. She can be reached at Debra.Wertheimer@va.gov.

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When Cure Is Not Possible: The Role of Palliative Care

Hank Willner, MD

It is a profound moment in the doctor-patient relationship when the physician realizes that his or her patient has a life-limiting illness that cannot be cured. An advanced malignancy that has been refractory to multiple treatments is known to shorten a patient's life. A patient's life span is also foreshortened when he or she has a severe chronic nonmalignant illness, such as congestive heart failure, chronic obstructive pulmonary disease, cerebrovascular disease, end stage renal disease, Alzheimer's dementia and several of the relentlessly progressive neurological disorders such as amyotrophic lateral sclerosis (ALS).

What is the most useful approach for a physician in the face of such overwhelmingly poor odds for prolonged survival? How can end-of-life issues be most creatively addressed to preserve a sense of fulfillment and hope in the patient?

I realize that the reader may think it somewhat paradoxical that a person with a terminal illness—defined as a life expect-

tancy of six to twelve months if the disease runs its normal course—may still actually achieve a sense of purpose and hope in his remaining time. Surprisingly, this often is the case, particularly when the physician introduces—and the patient embraces—the notion of palliative care in which most, if not all, efforts are directed at the patient's physical, emotional, social, and spiritual comfort rather than a cure. In truth, good palliative care should accompany curative efforts from the time of diagnosis and become the main focus of care whenever the patient so chooses, or when it becomes apparent that the disease is incurable.

After twenty years in family practice, and thirteen as Hospice Medical Director, I have observed that physicians often are reluctant to “let go” of efforts to cure lest they dash the hopes of patients who persist in demanding aggressive interventions far beyond a point in their disease when there is a realistic chance of substantive gain. My colleagues may provide this kind of treatment in an effort to be kind, to encourage patients'

hopes, and because in many instances they aren't certain how to help patients make the transition from seeking a cure to seeking comfort. Aggressive treatment invites disappointment, because the hopes it raises are false ones. This situation often leads to prolonged hospital stays—often in the Intensive Care Unit—involving medical care that is not beneficial, or futile, in efforts to reverse disease or prolong meaningful life. I have come to believe that physicians have a moral responsibility to help patients make the transition from a hope for the unattainable goal of cure toward the achievable goal of maximizing the quality of life while there is still the time and energy to enjoy it.

The transition from curative-based care to a focus on palliation and comfort can be accomplished in a number of ways. The physician can, in effect, say to the patient, “While it has become sadly clear that your disease cannot be cured, we can still do much to maximize your comfort and assure that you have the greatest quality of life in whatever time is remaining

Case 1: JR

A seventy-one-year-old woman was admitted to Holy Cross Hospital for increasing confusion and dyspnea. She had known small cell lung cancer metastatic to her lungs and left adrenal gland. She was found to have bilateral pneumonia with an empyema versus a malignant effusion; a thoracentesis was planned, and antibiotics were started.

Past medical history was notable for chronic pain from degenerative disc disease as well as a different pain attributable to her adrenal mass, hypertension, treated hypothyroidism, and cataracts.

REVIEW OF SYSTEMS was significant for recurrent swelling of her left neck thought to be due to recurrent superior vena cava (SVC) syndrome, previously treated with radiation therapy. Also of note was significant decline in weight and strength, such that she no longer could walk on her own.

SOCIAL HISTORY was significant in that she is married, mother of two, grandmother of one. She is still working as a realtor. A living will had been completed, and she had already declared that she wanted no heroic measures, and a DNAR order had been placed in her chart.

She had inquired about hospice and was told by her oncologist that she was “not ready for that.” Nevertheless she wondered what her options for treatment were, and the hospitalist requested a palliative care consultation two days after she had been admitted.

The palliative care consultant inquired about what was most important to her at this time. Her answer was, “I want to be comfortable and don't have the strength for more chemotherapy.” It was suggested that she let her oncologist know about her preference, and that she was too weak for more anticancer treatment anyway. Treatment for her pain and dyspnea was immediately started with around-the-clock opioids with provision of hourly prn dosing for breakthrough pain and SOB. Dexamethasone was also added both for her pain and for the recurrent SVC syndrome. She decided that she would rather live with her cancer than continue to fight against it. With the agreement of all family members and the patient, a referral to hospice was made, to begin on arrival after discharge, planned soon.

for you...” It does not serve a useful psychological purpose to say to the patient, “There is no hope, and there is nothing more that I can do for you...” Rather, in this difficult and often painful situation one can state positively to patients, “There is much that we can hope for and work toward.” This may sound paradoxical, but should become clear when one explores some of the multiple dimensions of hope.

Hope for cure is not the only thing that we can offer our patients, but clearly many physicians feel that way, accounting for some of the depression that both patients and their physicians feel when a disease reaches its terminal stage. The different shapes of hope may constitute various goals that will guide future treatments for our seriously ill patients. Certainly, patients hope for total physical comfort and control of some of the most prevalent symptoms of terminal diseases such as pain, fatigue, anorexia, constipation, troublesome edema, skin ulcers, insomnia, nausea, and dyspnea. These symptoms are controllable almost all of the time using some of the basic end-of-life skills taught in the AMA-sponsored program, “Education of Physicians on End of Life Care” (EPEC). Most training programs teach these skills to students, and courses are offered as Continuing Medical Education opportunities for physicians in practice.

Patients generally hope that their physicians will be advocates for their quality of life, and will promote their autonomy and participation in the decisions that affect their care. It is important that patients’ overall function be maintained at the highest possible level so that they can have the opportunity to set realistic attainable goals. They also hope that their family and loved ones will be supported through their illness. Spiritual concerns should be identified and addressed with such questions as “What influence does your faith have in your life, and how would you like me to address these issues in the context of your treatment?”

There are several key questions that my palliative care colleagues and I ask our patients to help them cope with end-of-life issues:

- What is most important to you now?
- What has been the most difficult thing for you about this illness?
- What are your hopes or expectations for the future?
- What do you consider your quality of life to be like now, and how would you balance quality of life with length of life in terms of your treatment?
- What do you still want to accomplish in the time you have left?
- What legacy do you want to leave your family?
- How is your family handling your illness?
- If you were to die sooner rather than later, what would be left undone?

The answers to these questions will help you—and your patient—assess the patient’s current quality of life and recommend a treatment plan that will best honor these hopes and goals.

In seeking excellent and comprehensive palliative care for your patients, you will be doing them a tremendous service by providing them with maximal comfort as they approach the end of their lives. This is in keeping with the notion of a “Good Death” in which patients

- achieve total physical comfort,
- are treated with respect and dignity,
- are never abandoned by their physicians,

Case 2: MK

An eighty-one-year-old man, retired MD pathologist with gastric cancer that recurred after surgery, chemotherapy, and biliary stent placement, was referred to hospice ten months ago when he started to decline and lose weight. He and his large family enjoyed the support of the hospice team, all of whom visited him regularly at home. Though he denied pain, he was prone to recurrent fevers, thought to be due to cholangitis from a blocked biliary drain, that was treated with oral Levaquin, and replacement of his biliary drain. His goal was to take a cruise with his family to Alaska before he died. As his weight continued to decrease, with associated hypotension, periodic infusions of normal saline were tried to help him rally. Nevertheless his hypotension persisted with significant orthostatic change. He became too weak to walk on his own, and the initial impression was that his disease was accelerating to his death. However, it was noted that his cancer had metastasized to his adrenal gland and an empiric trial of dexamethasone and Florinef was begun. He improved dramatically in both strength and well-being. His hypotension and orthostasis vanished. He was able to take his cruise. The case illustrates how an able hospice team will try to enhance the life that is left by attempting to treat potentially reversible illness with low burden interventions to allow patients and their family to achieve some of their remaining goals in their life.

- achieve closure in both personal and community affairs,
- maintain a sense of continuity of self as a unique person until death, and even
- achieve some reconciliation and renewed intimacy with those they love.

All of the above can be achieved if we physicians have the courage to positively recommend thorough, palliative care closer to the time of diagnosis of any serious life-limiting illness, rather than near death when patients are too sick and families are too overwhelmed to actually benefit.

Physicians also must come to believe that when cure is not possible, there is actually much to hope for and even to accomplish. We physicians can help patients redefine and pursue a different and very rewarding type of hope as patients try to cope with their severe, life-limiting diseases. Good palliative care, whether given through consultation in the home or through a comprehensive hospice program, will increase the chance that a patient can stay at home and not be hospitalized, either at all or repeatedly. Palliative care is consistent with current health care goals: to shift the focus of treatment to the home setting and to avoid hospitalization whenever possible.

Hank Willner, MD, is chief medical director, Holy Cross Home Care and Hospice and a palliative care consultant at Holy Cross Hospital. He also serves as the medical consultant to the Hospice Foundation of America and on the Maryland State End of Life Council.



PERSONAL PERSPECTIVE

Thinking About What We Do And How We Care for People: The Physician Difference

Tyler Cymet, DO

Ninety-five percent of what passes for thought isn't thought at all. Looking at a problem and allowing the brain to passively process what it is given—which results in an answer—is a shadow of thinking or “thought lite.”¹

Thinking requires an active process or an imitation of thought. Taking and using the automatic answer that the brain provides in response to input, without an active processing of the information, is a remembering of patterns, a reflexive type of thinking, and not a thoughtful processing of information.

As doctors, we owe it to our patients to engage in the deepest, most appropriate thought processes available to us to serve patients' healthcare needs to the fullest extent possible, and to maximize successful clinical outcomes.

Not to imply that there is anything wrong with remembering patterns. It is fast and efficient. There are times when a physician does not have the luxury of going through the act of full thinking. Often, reflexive thinking leads a healthcare practitioner to the right place—it just isn't the level of care expected from a physician.

Active thinking in medicine starts with what your brain gives you from past experience, then adds in what you know from studying the range of what is possible. Thinking requires that you go past the intuitive answer and allow for the possibility that what is going on with a patient isn't always going to be the most common answer. Sometimes people are different and patterns are individual; thus, a physician should consider more than past experience in the search for an answer. Sometimes there is more than one correct answer, and sometimes the obvious answer isn't correct.

Thinking became popular in the education of physicians in the 1960s beginning with SOAP notes. SOAP notes establish rules for what is recorded on paper and how the thinking process starts. SOAP notes also assign value to the information

we have. Subjective complaints are lower than objective findings. Assessments are meant to be broad and go past the obvious. Assessments do not provide “the answer,” but one of a number of possible answers, including the most obvious as well as the most dangerous and at times even rare possibilities. Assessments introduce the realm of possibilities and not just probabilities. As assessment shouldn't be the first thing that a physician does when seeing a patient. Exploring a problem and understanding the patient is part of the information gathering that is vital to coming up with the best answer; assessment is part of an active thinking process about what could be going on with a patient. The emphasis is on not missing a diagnosis, and not moving ahead with the most likely diagnosis without safely considering other alternatives.

Thinking requires discipline; it requires you to know what you know and to have an understanding of what you don't know. Thinking also means learning how to fill in the gaps of what isn't known by the provider, the patient, the science, and the practice of medicine. Thinking requires discipline to avoid jumping to the easy and obvious conclusion.

“Where are your data?” “How do you know what you know?” The words of Al Kelso, PhD, my research advisor at Midwestern University, still stick in my mind exhorting me to question everything and justify any conclusions with data. Always questioning even the simplest issues requires discipline and training. Practice doesn't make perfect here, because practice without feedback will only solidify bad habits. Deliberate practice with assessment of performance and feedback make for perfect practice. Working with others who have different experiences to share and the ability to criticize are key characteristics of a living learning community.

Thinking in medicine and medical education has evolved since the 1960s. Acknowledging the limitations of our

knowledge and abilities was part of the maturation process of medicine. Harold Sox, MD, stressed the difficulty of making decisions with incomplete information, including information gathered from patients who are usually ill and not able to provide the best information, and patients who are not impartial when it is their own medical situation that is being evaluated.²

In the 1970s, medicine started to go beyond probabilities and started to factor in possibilities. As it became clear that more thinking needed to be factored into decision making.² Jerome Kassirer, MD, focused on examining and applying clinical information in clinical decision making—generating and continually refining the diagnostic hypothesis.³ Kassirer and Pauker developed guidelines for a therapeutic threshold. When is a rare answer worth pursuing? If the probability of disease in a given patient exceeds the threshold, the preferable course of action is to treat. If the probability is below the threshold, the preferable course of action is to withhold treatment.⁴

In the late 1970s, medical decision-making became part of an analytic framework. David Ransohoff divided thinking into intuitive (a decision based on perceptions), aphorismic (decision based on a rule or algorithm), or analytic (a decision requiring a systematic approach to discriminate between likely or possible alternative diagnosis and treatments) thinking.

David Sackett used clinical epidemiological methods to introduce evidence based medicine and decision making into medicine, stressing clinical expertise and the need for the best external evidence to be available as a standard for decision making.⁵ Again, medical decision-making and thinking was becoming more refined. The patient remained at the center, and the well-being of the patient was identified as the most valued part of the interaction.

Today, thinking has become a real skill. Detaching yourself from the urgency of the most obvious information to value the most

accurate information requires some detachment from the patient. Working with the patient to see situations from a vantage point other than the patient's own feelings isn't easy, but is a necessary part of the medical paradigm that provides what is best for each individual.

Enter electronic health records (EHRs), which are changing the thinking model once again. For the first time since the 1960s, medicine is moving away from valuing thought and away from individualizing care. Medical thinking is moving from what David Ransohoff called analytic, to the model he called aphoristic, an algorithm-based model of making decisions that focuses more on the most likely causes and moves away from treating each patient as an individual.

Clicking on or off, cutting and pasting, and established computer protocols are all automatic computer driven pseudo thought that provides a new hurdle to thinking. EHRs can also hide thought so that evaluating the work of a healthcare provider is more difficult. EHRs treat every person alike. There is always the same differential and the same tests are ordered. EHRs turn healthcare into an automatic process instead of an individual one.

The future of thought in medicine is murky, as is the role of physicians in the future healthcare system. Every story doesn't fit into a simple formula. When do we allow care to go outside of a pathway (and who decides if it is OK to do so), it is still an unsettled question. Who is in charge of the software, and who does the EHR report to? These are important questions that could determine who is in charge of healthcare. It isn't a given that physicians are keeping that role. Managers and administrators using big data are actively advocating for a leadership role in healthcare.

In today's environment, thinking about and for each individual patient is seen as inefficient and as a disruption of a system of checklists of established formulas and protocols. The current climate makes it even more important for physicians to protect the role of thinking in healthcare. Patients deserve no less.

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Barton J. Gershen, MD
Editor Emeritus

Since 1841, county fairs have been a tradition in agrarian communities across America. Their original purpose was to introduce farmers to modern agricultural practices, but they have expanded to include contests of truck and tractor pulls, pig racing, hot dog eating matches, frog-jumping challenges, floral competitions, etc., as well as the time-honored livestock judging, horse shows, and 4-H programs.

Common hallmarks of contemporary fairs are cotton candy, amusement rides, weight lifting events, and shooting contests. Prizewinners typically win kewpie dolls or stuffed animals. However, in former times, the winner's prize was often a live suckling pig, valued by many farmers because it would add to their livestock, or provide a future source of food for their families.

Of course, a live pig would have been difficult to manage—often escaping from control—unless it was somehow restrained. Therefore, this small, squirming animal was sometimes placed in a sack with the opening securely tied. Such bags were called “pokes” (from French *poque*: “purse”), a term closely related to “pocket.” [Small **Pox** derives from the same source, the blisters resembling tiny pouches to some early imaginative physician.]

Unscrupulous vendors might place a kitten—of considerably less worth to the farmer—within the closed bag. Therefore, to win—or purchase—a **pig in a poke** was to receive a hidden trophy, often quite different from that which was advertised. Subsequently, the deceived victim would open the sack and literally **let the cat out of the bag**. Ultimately, this idiom has come to mean revealing something secret or hidden.

During our Revolutionary War, combatants fought with rifles, which were smooth bore weapons that utilized a flintlock mechanism to fire each shot. This mechanism consisted of a hammer that held a piece of flint. The rifle was cocked by pull-

ing back the hammer to a locked position. Pressing the trigger released the hammer, causing the flint to strike a metal plate, thus creating sparks. The sparks ignited a small quantity of black gunpowder held in an external pan. The flames from this eruption entered a little touchhole that communicated with a larger amount of gunpowder situated within the rifle barrel. The result was a major explosion, causing a round lead ball to be shot out of the rifle.

The flintlock hammer had two positions. A soldier would bring the hammer back to its first position—which was considered a safety—to ensure no accidental explosions would occur while pouring powder into the barrel. Subsequently, he would pull the hammer to its full cocked position ready for firing. Unfortunately, more than occasionally the safety mechanism would fail, and the hammer would spontaneously release, accidentally firing the weapon and possibly resulting in harm to its owner or to one of his comrades. This was known as going off **half-cocked**, an expression that is now used to describe someone who acts impetuously.

It was imperative for soldiers to ensure that their gunpowder did not become wet during a rainstorm, which led to the injunction to **keep your powder dry**. Today, that expression means “to safeguard your resources.” Of course, wet gunpowder might not ignite properly, resulting in an ineffective detonation—a mere **flash in the pan**. Today that allusion refers to someone who quickly rises to prominence, only to fade away abruptly.

Incidentally, smooth bore rifles were often called **muskets**. This word derives from Latin *mosca*: “a fly” (mosquito originates from the same root.). As *mosca* evolved into French, it became *mousquette*: (“sparrow hawk”), since this bird had speckled wings, which looked as if they were covered with flies. Soldiers often named their personal weapons after something that was powerful and ferocious.

(**Dragoon**, for example, was the French term for a firearm named for dragons. Ultimately, the troops that carried those weapons were also called dragoons.) In keeping with this custom of fierce nicknames for their guns, the smooth bore rifle was nicknamed the “Sparrow Hawk,” or **mousquette**. Eventually, the word became musket, and those who carried the weapon became known as **musketeers**. Alexander Dumas would have been triply proud of that fact.

An examination that provides indisputable results is often referred to as an **acid test**. This term stems from the 17th century, and refers to the way in which a metal was demonstrated to be gold. Nitric acid dissolves many metals. However, gold is highly resistant to its effects. Therefore, to substantiate that a metal was indeed gold, a small sample was subjected to nitric acid. Failure to dissolve proved that the substance was gold. The result was incontestable.

Someone who is inattentive and distracted is often referred to as one who is **woolgathering**. This expression arose during the 16th century and refers to the fact that sheep would lose tufts of their wool as they brushed against thorns or fence rails. At certain times, the lord of the manor would permit his serfs to gather and keep those bits of wool clinging to branches, bushes, and fences. As a result, one might witness these indigent people wandering around the fields, apparently without purpose. Eventually, their aimless movements became a metaphor for one who is lost in reverie—“day dreamers.”

In medieval England, the king would occasionally permit his peasants to collect and keep all the dead branches and limbs that they could find within his royal forests. To retrieve as much wood as possible, the people would use a reaper's billhook

or a shepherd's crook to reach those branches that were dangling higher up in the tree. In time, by **hook or by crook** came to mean achieving one's goal by any clever method.

In 325 C.E., the First Council of Nicaea ordered important religious holidays to be inscribed in red on all church calendars. These came to be known as **red-letter** days. Today that expression has come to signify any day of special importance. The red letters were known as **rubrics**, from Latin *rubric*, "red coloring matter," which in turn stems from *ruber*, "red." (The **ruby** derives its name from the same source.) Initially, a rubric denoted the rules for liturgical services, which were also inscribed in red. Currently, a rubric denotes any authoritative regulation or decree. ("Under the rubric of such and such...")

Early ships were built from wooden planks. To prevent water from leaking through the seams between planks, hot tar or pitch was applied to seal them tightly. That process was known as "paying," from French *paix*, "pitch." The most difficult seam to reach was at the bottom of the hull, between the gar-board strake and the keel, and was referred to as the "devil's seam." When at sea, this seam might spring a leak and require the immediate re-application of hot pitch. The captain would navigate his ship into as shallow water as possible. Then the crew would labor to tilt the ship—a process known as careening—to expose the bottom seam. Once that was accomplished, some of the crew would climb down ropes, carrying hot pitch in their buckets, and attempt to caulk the seam. This has led to the expression the **devil to pay**. (Some etymologists dispute this description. Their explanation suggests that the "devil to pay" simply derives from a Faustian pact with the Devil, ultimately compelling the participant to compensate Lucifer by surrendering his soul.) In any event, the "devil to pay" currently implies serious trouble as a result of one's actions.

(Incidentally, as those sailors dangled precariously from their ropes, attempting to caulk that seam, they were definitely **between the devil and the deep-blue sea**.)

Boilers are closed containers usually made of a steel alloy, and utilized to create steam for purposes of heating or power generation. The companies which manufactured them would place their business name and logo on metal plates attached to the boilers. Each plate was identical to the next, and has become a symbol for anything that is a routine copy—a **boilerplate**.

Modified boilers are used in locomotive engines to produce steam, thus driving the pistons that move the train. Boilers obviously need water to produce that steam, so locomotive engineers had to stop periodically to obtain the requisite supply. The water was kept in large water towers, often located in small, remote towns. The engineer or fireman would pull a heavy cable attached to a chute leading from the tower, and water would flow into the engine boiler. Since the process involved jerking on a rope or cable, and the water tower was located in an out-of-the-way village, those places became known as **jerkwater towns**.

Expressions, like words, have origins that are often colorful and fascinating. They have enriched our language, providing us with a boundless lexicon of metaphors. The next time you use such expressions as "red herring," "loose cannon," "high and dry," "hit the fan," "feet of clay," "cramps my style," or "until the cows come home," stop for a moment and ask yourself where that idiom came from.

A little research might provide you with a surprising answer.

Barton J. Gershen, MD, Editor Emeritus of Maryland Medicine, retired from medical practice in December 2003. He specialized in cardiology and internal medicine in Rockville, Maryland.

MedChi Accomplishments During the 2014 Maryland Legislative Session continued ...

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licenses. Information must be submitted to a "Technical Advisory Committee," which will act as a clinical buffer between law enforcement and regulatory officials.

The Assignment of Benefits law we worked so hard for in 2010 as well as the HMO requirement to pay non-participating providers at least 125% of their network amount were both up for "sunsetting" this year. MedChi fought successfully to make these permanent.

Medical Marijuana

Maryland has not joined Colorado and Washington to permit free possession of marijuana, but the new law would allow physicians to "recommend" its use.

Midwives

House Bill 1211 was not passed, but long conversations were had in which the midwives began to compromise and allow more regulation and supervision via the Board of Physicians and Board of Nursing. More meetings will take place over the summer and fall to work out compromise positions for next session.

Sugar Free Kids

The Sugar Free Kids effort has been on the MedChi agenda for a number of years, and is beginning to yield results. SB716/HB1276 regulates the amount of sweetened drinks in licensed childcare centers and provides for nutritional training. The bill that failed would have prevented children's meals (i.e., "Happy Meals") from including anything other than water or low-fat milk.

Tanning Beds

A MedChi initiative that did not get much traction was the requirement that tanning salons include a strongly worded parental consent form for each session. This initiative is similar to a local Howard County law that we are trying to broaden across the state.

Other bills that MedChi worked on:

- Passed legislation to require insurance companies to meet with physicians and other providers.
- Passed legislation allowing psychiatrists leeway to waive psychiatric privilege when they were threatened by a patient.
- Updated the scope of practice for podiatrists to allow only those with proper training to treat acute ankle fractures.

MedChi Accomplishments During the 2014 Maryland Legislative Session continued...

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- Defeated a bill to require prior authorization for dispensing medications to Worker's Comp patients.
- Retained and increased the payments for Medicaid E & M codes, at least for the next fiscal year. This is paid for out of state funds, and will need to be addressed again next year.
- Tobacco Tax increase of \$1 per pack was introduced but did not pass. This is an ongoing effort by MedChi and others to make Maryland a tobacco-free state.

All in all, the year wasn't bad. With the elections coming up, no one wanted to make any grand stands. With the upcoming elections and the overhaul of the legislature (about one-third of the seats are turning over), it behooves *all* of us to become involved in the election process. Find out who the candidates are. Ask their positions on issues that matter to us. Now is the time to make the contacts. We are their constituents; let them know who we are. Make some contributions. Put a lawn sign in your yard! It is only by persistent involvement that we can make a difference.

Stephen J. Rockower, MD, is an orthopaedist practicing in Rockville, MD. He is president of Montgomery County Medical Society, and co-chair of MCMS' Legislative Committee. He also is a member of the Maryland Medicine editorial board and subcommittee chair of the Council on Legislation for MedChi. He can be reached at drrockower@cordocs.com.

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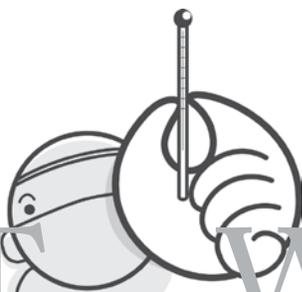
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The Medical & Chirurgical Faculty of Maryland and the War of 1812

The Medical & Chirurgical Faculty of Maryland was founded in 1799, not long after our country was born.

Many of MedChi's early members had fought in the American Revolution, and were prepared to fight again in the War of 1812, and in the Battles of North Point and Baltimore, which took place in September of 1814.

Fort McHenry, which was defended during the Battle of Baltimore, was named after another of MedChi's earliest members, James McHenry.

However, it is one of our founding members, William Beanes, MD, of Prince George's County, Maryland, who played a pivotal, yet largely unknown, role in the history of our National Anthem, The Star Spangled Banner.

If not for Dr. Beanes, Francis Scott Key would not have been on a ship in Baltimore's Harbor, and he would never have written the poem that became our National Anthem.

William Beanes was born at Brooke Ridge, a thousand-acre farm near Croome in Prince George's County, on January 24th, 1749.

There were no medical schools when Dr. Beanes studied medicine, so he most likely apprenticed with a local physician. Professionally, his reputation spread beyond the county, and when in 1799, the Medical and Chirurgical Faculty of Maryland was established, he was one of its founders and a member of its first examining board.

As the War of 1812 raged, in August of 1814, the British Army sailed up the Potomac River, planning to burn the young nation's capital, Washington, to the ground. Some of the army marched up the banks of the Patuxent and Potomac Rivers, and through Upper Marlborough, where Dr. Beanes lived.

British General Ross selected Dr. Beanes' home as his headquarters, and Dr. Beanes agreed not to object to his presence or cause the troops harm. However, when the British Army returned to Upper Marlborough after burning Washington, they were jubilant, drunk, and marauding.

Dr. Beanes and some of his neighbors were forced to arrest some of the most badly behaved of the group. One prisoner escaped and reported to General Ross that Dr. Beanes had taken some prisoners. General Ross returned to Upper Marlborough and arrested Dr. Beanes in the middle of the night.

Dr. Beanes travelled with the British Army down the Potomac River and up the Chesapeake Bay, as the army prepared to burn Baltimore, "a nest of pirates," as they had done to Washington.

At the same time, a young lawyer named Francis Scott Key, a nephew of MedChi's first President, Upton Scott, was engaged to free Dr. Beanes from the British Army.

Key travelled to Baltimore with letters of support from President James Madison, as well as letters from British prisoners whose injuries Dr. Beanes had treated only weeks earlier in Upper Marlborough.

Dr. Beanes was being held on the *Minden*, a truce ship in the waters just south of Baltimore, and Key sailed out to the *Minden* to negotiate for his release. While Key was negotiating with the British, the Battle of Baltimore was beginning.

For more than twenty-five hours the battle raged, and bombs rained down on Fort McHenry.

Dr. Beanes and Francis Scott Key watched and waited all through the night. As long as bombs were being shot back from the Fort, the men knew that all was not lost and the Fort still stood.

Towards the morning, the cannon fire slowed and then stopped, followed by an ominous silence from across the water.

Both men were gripped by hope and fear. Was the Fort lost to the British and would Baltimore suffer as Washington had, just weeks earlier?

As the dawn broke, Francis Scott Key and Dr. Beanes were able to see that the flag was still there, flying above Fort McHenry. They knew that the British had not been able to capture Baltimore.

As the men sailed back to Baltimore, Francis Scott Key penned the now famous poem on the back of an envelope. It was printed in a local paper and then set to the tune of an old drinking song.

Dr. Beanes returned to his home, Academy Hill in Upper Marlborough, and continued to practice medicine. He died at age 80 in October of 1828.

Dr. Beanes is buried in a small graveyard in Upper Marlborough, and is remembered throughout Prince George's county where several roads, schools and parks bear his name, and continue to tell his story.

In 1914, MedChi placed a commemorative plaque on Dr. Beanes' gravesite, where it remains to this day, the 200th anniversary of the writing of the National Anthem.

The Last Word was originally delivered as the Fifth Annual Hunt Lectureship on Wednesday, June 25, 2014, in Baltimore. Fort McHenry Ranger Paul Plamann portrayed Dr. William Beanes, a founder of MedChi and the forgotten man behind the National Anthem.



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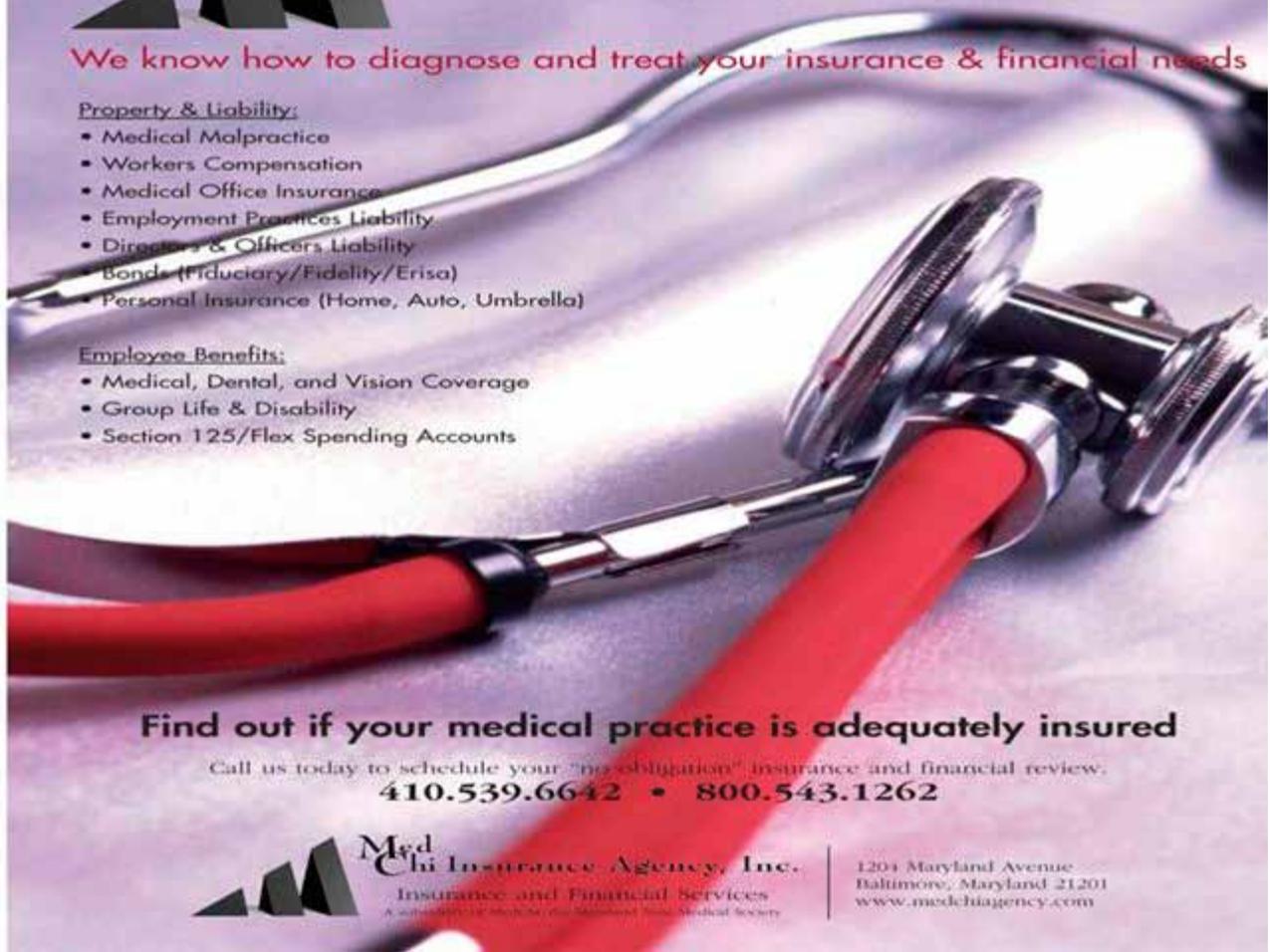
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