



Maryland Medicine


The Maryland Medical Journal **Volume 16, Issue 2**

The Corporatization of Medicine in Maryland

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I N S I D E



This issue of Maryland Medicine looks at the good, bad and the ugly of the corporatization of medicine in Maryland.

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Are you still preparing for ICD-10? For a review of the history of ICD-10, a practice checklist and implementation resources, visit <http://www.medchi.org/news-and-publications> to download or view Maryland Medicine, Volume 15, Issue 1.



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A Generation of Lost Health



PRESIDENT'S MESSAGE

Tyler Cymet, DO

We can argue the details of how technology is making our lives better and how it is making it worse, but what is clear is that technology is changing everything.

Society's best and brightest individuals can be found working to maximize individual health within the healthcare profession. Our patients are taking a more active approach to all aspects of their healthcare, even questioning if healthcare is enough. Increasingly the "ask" of our patients is broader and different from what we have been providing. Professionals have not started to focus on individual well-being that people say they want. Instead, our goals in medicine have been disease related.

A physician's time and focus are dictated by the patient's googled assumption of care and personal well-being goals. The driving forces behind some of the changes in healthcare are spelled out in Gallup's well-being index, which identifies and quantifies well-being (Figure 1). With knowledge readily and easily accessible, everyone can feel that they are the expert, which seems to make applying the knowledge more complicated and challenging.

Despite a growing focus on health, post-Millennial generations will not be as healthy as the generations before them. Tighter healthcare systems and scrutiny by government and insurers are not making people healthier. The goal is not more administration and less healthcare, but that is what is happening.

Healthcare information technology and care systems have become so complicated that it takes technology to tease out the allowed options for care coverage. Everyone, from administrators to healthcare teams to patients, has their own opinions of which problems should be addressed and the potential solutions.

The problem is more complicated than applying knowledge, educating, sharing, and implementing. Every stakeholder wants to define the health focus and to have control over the health algorithms.

The current situation results in confusion and sub-optimal healthcare. This is a

generation of lost health. This is a decade without clear answers. Even the goals of the system are confusing. While people are asking to have their well-being enhanced, physicians are addressing their health.

Technology should increase transparency, but it has not. The free availability of information provides patients with the ability to question everything, and they do. If cigarettes kill, does vaporized tobacco kill? Although a physician would answer yes, the new spin on the question gives a patient room to doubt the answer.

Medical schools speak MeSH (Medical Subject Headings), a language that focuses on research and funding that will not be used once physicians are in practice. Practitioners need to be fluent in ICD (International Classification of Diseases) and CPT (Current Procedural Terminology), the billing languages that establish a price tag on patient care and procedures. However, ICD and CPT do not focus on care or well-being—they break everything down to a billable service. While SNOMED (Systematized Nomenclature of Medicine)—physician terminology in digi-

Figure 1. Gallup-Healthways Well-Being Index

Purpose: liking what you do each day and being motivated to achieve your goals

Social: having supportive relationships and love in your life

Financial: managing your economic life to reduce stress and increase security

Community: liking where you live, feeling safe, and having pride in your community

Physical: having good health and enough energy to get things done daily

Source: <http://www.well-beingindex.com/alaska-leads-u.s.-states-in-well-being-for-first-time>

Happier but not healthier is also an issue. Recent data show that happier patients will use the ER less, but end up in the hospital more and have a higher mortality. Patients want more than what we can deliver. Patients are asking for interventions to let them live better, not healthier or longer, with requests for medications that promise increased vigilance, enhanced sexual enjoyment, and control over normal human physiology.

Physicians are even losing control of the language of medicine. Since the inception of SGR (Sustainable Growth Rate) seventeen years ago, the language of medicine has been science-based care, spoken fluently physician to physician. We have been forced to speak this illogical, administrative based language for the past seventeen years, but finally its use has ceased. Today, the language of medicine has to be computer compatible. Patients want to be able to understand the language without understanding the basic sciences that provide the logic to the language, and administrators who don't speak the language are increasingly in charge.

tal format required for electronic medical records—is becoming more important, it is still a language without "grammar." The rules for speaking SNOMED are understandable only in Base-2.

In all of this confusion it is clear that physicians need to speak with patients in a language that is comfortable and understandable to them. The changes brought on by technology have the potential to make medicine more understandable and to incorporate healthcare into a patient's life.

Transition is often more painful than the change. When the change is unclear, the road ahead is bound to be rough. Taking care of a generation of lost health and a decade of unclear decisions is also frustrating. It is only tolerable because it is clear that where we end up will be a healthier place than where we are now. The big question now is "how long will it take for physicians to gain control of the language of healthcare and well-being?"

Reference:

1. <http://archinte.ama-assn.org/cgi/content/short/archinternmed.2011.1662>

CONSIDERING EMPLOYMENT?



Here are **10** Key Considerations

- 1 Do I need an *attorney*? How do I find the right one?
- 2 How will my *compensation* be determined? Salary plus bonus model? Output? Quality?
- 3 Will I *earn more or less* than in private practice?
- 4 Who is responsible for selling, buying, or leasing my *office and equipment*? What are the tax implications?
- 5 If I'm leaving a private practice, what are the *departure issues*? Can I take my current office staff with me? How much control will I have?
- 6 Who will pay for my *insurance*? Malpractice? Insurance Tail? Life? Disability?
- 7 How will my *quality of life* be affected? Coverage? Call schedule? Vacations?
- 8 What are my *hospital obligations*? Will I be expected to serve on hospital committees?
- 9 How will any *disputes* be handled?
- 10 How will a *non-compete clause* factor if I wish to later choose private practice? Whose patients are they?

MedChi is here to inform and guide you in making the best possible decision for you and your patients. Consider all aspects of the decision to enter into an employment agreement or to remain in an employed situation.

Visit MedChi for details at www.medchi.org or contact the Membership Department at 410-539-0872.

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The Change in and Corporatization of Medicine



CEO'S MESSAGE

Gene Ransom, III, Esq.

As a lifelong resident of Maryland's Eastern Shore, I have had two primary care physicians. My first physician was both a medical doctor and a gentleman farmer who retired when I was twelve years old. A young physician came to Queen Anne's County to take his place, and he has been my primary care doctor for more than thirty years. Both of these physicians practiced in small, solo settings, and harken back to the way it was, and the way some people say it should be. Famous MedChi past president and physician leader, Sir William Osler (1849–1919) believed that “the practice of medicine is an art, not a trade; a calling, not a business.” However, medicine is rapidly changing. The complexity of government and insurance company mandates, combined with a changing economic model for the private practice physician, are resulting in new business models and new care models.

Maryland and America have seen the corporatization of medicine over the last fifty years. Medicine is big business. In Maryland alone, according to the AMA, every physician supports approximately 10.4 jobs. Key economic benefits provided by physicians both nationally and in Maryland in 2012 included the following (see Table 1):

rent an office and hire a nurse. Today, physicians must use complex billing and electronic health systems and have knowledge of a myriad of regulations and laws and newer payment models, which exerts additional pressures and demands on their practices. No one can argue that the cost and complexity of practicing has grown exponentially, which explains in part the rise of corporate medicine.

The complexities of the new world of medicine are leading many physicians to turn to corporate settings for answers. Physicians who wish to remain in private practice are moving to large groups or national organizations, such as PRIVIA, that allow physicians to remain in private practice while managing contracts and billing. Some physicians are forming signal specialty professional organizations, while others are forming concierge practices that often partner with a national corporation to help manage the practice. Even more physicians are becoming employees of hospitals or large groups. A recent study by Athenahealth, Inc., cited business cost and expense and the prevalence of managed care as the top two reasons for physicians considering employment. Working as an

employee in new business settings may solve many of the complexities of private practice, but also comes with new challenges. MedChi is able to help physicians meet these challenges with such tools as model employment contracts, leadership training, and other services.

MedChi is also working on services to help physicians who want to remain in private practice. MedChi established the Center for the Private Practice of Medicine to support independent physicians by providing resources that help them thrive as both clinicians and small businesses. The Center is managed by MedChi Network Services, a subsidiary of MedChi and the largest state-designated management services organization (MSO). As an MSO, MedChi Network Services also provides direct assistance to help eligible professionals transition from paper to electronic health records and reach meaningful use. The majority of the MSO participants are independent primary care physicians. The Center actively identifies opportunities and connects them with eligible practices so physicians can dedicate their time to helping patients.

MedChi Network Services also offers practice services, such as revenue cycle management, through collaboration with Health Prime International, a firm located in National Harbor, Maryland. The goal is to give physicians and their staff the tools they need to run a successful business, without the additional costs experienced by large groups and health systems. The healthcare industry thrives when physicians are given clear and actionable data about their business and their patients. As your state medical society, MedChi has been exploring creative ways to give independent physicians the same advantages as large healthcare institutions.

The healthcare industry is changing and becoming more complex. At the same time, physicians, regardless of where they practice their craft, need to continue their positive patient interactions that will prevent certain diseases and keep people out of the hospital. MedChi will help physicians optimize their practice, and allow them to spend time with those who need them the most: their patients.

TABLE 1: PHYSICIAN-PROVIDED ECONOMIC BENEFIT	Maryland	National
Total Direct Jobs Supported by Physician Industry	79,764	3,336,077
Total Indirect Jobs Supported by Physician Industry	99,747	6,632,265
Total Jobs Supported by Physician Industry	179,511	9,968,342
Average Jobs Supported by Each Physician Including His/Her Own	10.4	13.8

Source: AMA state level economic impact study, March 2014.

When my primary care physician first came to Queen Anne's County thirty years ago, he simply needed to

employee in new business settings may solve many of the complexities of private practice, but also comes with new chal-



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The Work of the AMA



EDITOR'S CORNER

Bruce M. Smoller, MD

Having just returned from the AMA (American Medical Association) annual meeting in Chicago, I dove into the work that had, as it does for all of us, piled up during my absence. I usually keep up a fairly brisk pace, but what was striking as I looked back over the meeting, was the pace of activity amongst the participants in Chicago. Simply put, it did not stop. The delegates and alternates and staff and others were at it literally all day, from 6:30 a.m. to 7 p.m., and then some social activities that involved as much work as conviviality. The reference committee members, on the night of the reference committee meetings, basically stayed up all night with staff to complete the reports by start of business the next day.

There were dozens of caucuses, work groups, section groups, specialty groups, and council meetings taking place at once, repeated every hour. Lunch was often on the fly, breakfast a quick cup of coffee and a bun or a banana, and off to work. There wasn't, though, much grumbling. In fact, there was a great deal of bright-eyed interest and involvement ... certainly not the picture of a moribund profession or organized medicine on the ropes. These folks enjoyed and were invested in working out problems—the problems that vex us in our everyday professional life, and the problems that vex our patients in their search for good medical care.

The topics tackled at the meeting ran the gamut from those that affected our daily and long-term practice, life, and health, to those issues of importance to our patients' daily lives and health. MOC (maintenance of certification) was a topic on everyone's lips. The issues with the ABMS (American Board of Medical Specialties) and especially the ABIM (American Board of Internal Medicine) are a serious matter, and the AMA is very concerned about the relevance and cost of the testing, and the governance behind them.

The advent of ICD-10 has alarm bells ringing in all quarters, and especially the AMA, which supported a two-year grace period before implementing this monumental and potentially disruptive administrative burden. Our physician force is not ready for this burden precisely because we are focused on, of all things, curing disease and promoting health rather than learning 60,000 new codes to satisfy what administrative end we are not sure.

The range of topics germane to public health was notable. Resolves and resolutions concerning vaccinations, the epidemic proportions of opiate overdose, the regulation of e-cigarettes and powdered alcohol, the science of concussion and its role in various sports, and many, many other topics of concern to our patients, were proposed, debated, resolved, discussed, amended and either adopted or

defeated in what was truly a ballet of parliamentary procedure and passionate testimony from the delegates and alternates. It struck me that the one thing that the members of our profession can be assured of is that the current topics of concern to our profession, and our patients, received thoughtful, serious, informed and often trenchant attention from your elected delegates. It's serious work done by serious people, and I wish all of you could attend and see it first hand. I think it would give each of us a little better feeling about the future of our storm-tossed profession. Yes, we are still put upon by all sorts of folks who think they could and should do what we do. Yes, the administrative burdens make us not a little angry and sullen. Yes, the lawyers still circle in the same updrafts the vultures use. Day to day, and engrossed in our individual practices, we get the sense that we are alone in our present travails. We are definitely not ... the AMA and MedChi really do have our backs.

The AMA delegation consists of five delegates and five alternates. Two of our delegates, Tom Allen and Mark Seigel, are termed out and leaving the delegation. We will miss their leadership skills, their vast knowledge of the workings of the AMA, and their mentoring. We thank them and wish them well.

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Introduction

Mark Jameson, MD (*) and Stephen J. Rockower, MD

In millennia past, the Appalachian mountains crossing Maryland were the tallest in the world. In 1608, Captain John Smith sailed up the Chesapeake Bay exploring numerous islands that no longer exist. The Assateague shoreline, at the time Misty of Chincoteague's predecessors swam ashore from a sinking Spanish galleon, vanished with the tides long ago. Even seemingly immutable mountains and unfathomable oceans undergo inexorable change.

The theme for this issue is the changing landscape of medical practice in Maryland, with a focus on the emergence of corporate based entities, both for-profit and non-profit, as a significant source of healthcare delivery.

Medical practice is subject to sculpting forces no less dramatic than the subterranean shifts deep beneath our feet. Like geologic forces, some practice changes are imperceptible on a daily basis, others generate tremors, and a few activate the Richter scale.

Daily imperceptible changes over the past generation include (1) the rise in the number of women physicians, who now constitute more than half of medical school graduates, (2) the emergence of majority employed physicians, and (3) the soon to be surpassing of medical school enrollments by nurse practitioner and physician assistant enrollments.

Tremors are noticed when they occur but are quickly adjusted into daily medical practice, such as a practice expansion, the opening of an urgent care center or walk-in clinic, a new CME (continuing medical education) requirement, or the introduction of telemedicine.

In contrast, seismic Richter scale events change the very basis of medical practice. In recent years, these changes have included mandated electronic medical records, insurance preauthorization requirements even for the standard of care, and the concentrated power of regulatory agencies.

In this issue, Dr. Rockower will discuss the recent legislative session and give an overview of "corporate" medicine. In "The Corporate Practice of Medicine: An Old Conflict Continues in New Forms," Steve Johnson discusses the ethical problems relating to corporate employers. Dr. Beams, Dr. Levine, Dr. Runz, and Dr. Stitely provide personal perspectives on practice choices they've made. In "The Lion and the Mouse," Dr. Brooke Buckley writes about her experience in selecting a career path. Dave Rothenberg, president of Privia Health, discusses employment options in "The Options for Independent Physicians." Dr. Cymet, Dr. Smoller, and Mr. Ransom discuss their views. Although Dr. Gershen has finally retired (despite our pleadings), we are pleased to announce that, beginning with this issue, we will be including "Classic Word Rounds," Word Rounds columns that were previously published in *Maryland Medicine*.

Only the dedicated commitment to serve patients will endure. Company policies, government regulations, insurance preauthorizations, and electronic templates will never substitute for the unique historic healing relationship between a physician and the patient. The question confronting physicians is whether the value and importance of medical care will be reduced like the once pinnaled Appalachian mountains or recontoured like the shorelines of the still majestic Chesapeake Bay.

** The views expressed are strictly those of the author and do not represent the views of the Washington County Health Department or the Maryland Department of Health and Mental Hygiene.*

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MedChi Accomplishments During the 2015 Maryland Legislative Session

Stephen J. Rockower, MD



The ninety-day session of the 2015 Maryland General Assembly ended on April 13. The major focus of all the legislators and the newly elected governor was the budget. The wrangling between the Democratic legislature and Republican governor was to be expected, but it had significant impact on the medical community. At the end of the O'Malley administration, the payments of E&M codes for Medicaid were cut by 13 percent to 87 percent of Medicare (in previous years, they had been on par with Medicare because of vigorous lobbying by MedChi). The budget, as passed, restored the cuts to 92 percent of Medicare, but it remains to be seen how much of this money will actually be approved to be released by the governor.

The Legislative Committee met weekly in Baltimore to review and discuss more than 250 bills relating to medical matters: Insurance, Public Health, and Boards and Commissions (including regulatory affairs). We also spent time in Annapolis, in conjunction with the component

medical societies, discussing these bills with legislators and testifying on behalf of our membership. The 2014 election QUADRUPLED the number of physicians in the General Assembly, with Drs. Terri Hill, Clarence Lam, and Jay Jalisi joining Dr. Dan Morhaim in the House of Delegates. The physician members provide valuable input and are able to answer questions and guide their fellow legislators in medical matters, and give real-world insights into the effects of legislation.

Prior to the 2015 session, MedChi identified four priorities: (1) reversing the above mentioned Medicaid cuts, (2) repealing the 2013 "sterile compounding" law, (3) continuing the 2010 Assignments of Benefits (AOB) law on a permanent basis, and (4) preventing limitations on physician dispensing of medications. Overall, we did well.

Medicaid: As noted, the Medicaid budget got back some of what was cut. In addition, the guidelines for funding for pregnancy care restored funding to 250

percent of Federal Poverty Level (FPL). We are still waiting to see whether the Governor will actually release the funds so that physicians can be paid appropriately for their work.

Sterile Compounding: MedChi had done a lot of work over the summer and fall to reverse the 2013 Sterile Compounding Law. The original law, in response to the injection of fungi prepared by compounding pharmacies, became unworkable in the breadth and sweep as it was written. Federal law passed later actually superseded our law, but we had to reverse it to eliminate the requirement that office based physicians have special permits and equipment to, say, mix Lidocaine with DepoMedrol. Senate Bill 69/House Bill 181 overturned these requirements.

Assignment of Benefits (AOB): In 2010, MedChi assisted in passing a bill, over the strong objections of the insurance lobby, providing that non-contracted physicians be paid fairly by insurance companies. It was originally a five-year bill that

was to sunset this year. SB92/HB230 removed the sunset provision and made it permanent. In addition, SB803/HB1157 was an attempt by the insurance industry to gut the original purpose of the AOB law and to declare as “insurance fraud” any forgiving of co-pays or deductibles. The bills never got out of committee.

Physician Dispensing:

Since Hippocrates’ time, physicians have been dispensing medications to patients. Since 2011, the Workers’ Compensation Commission has been trying to prevent this, and was defeated each and every year since then. The Commission finally realized the information was flawed, and agreed to put a hold on changes in the law for two years while more information can be gathered.

Additional Bills of Significance to Physicians

Nurse Practitioners (NP): The attestation requirements of NPs were changed to require an actual mentoring relationship of a NP with a physician, and to put teeth into the discipline possibilities if this requirement is not met.

Lay Midwives: After many years of negotiations, the lay midwives (Direct Entry Midwives) were permitted to practice under very stringent rules and guidelines, perhaps the most stringent in the nation. The most important rule prohibits vaginal birth after caesarean (VBAC) at home. Other guidelines include transfer and consultation requirements, data and record keeping, and newborn care.

Drug Abuse: To curb the growing number of heroin and opioid overdose deaths, the governor made drug abuse a cornerstone of his program. As many know, the Board of Physicians has already instituted a mandatory one-hour course in narcotic usage as a requirement for license renewal. Further regulations for more extensive education, training, and licensing of all physicians in the use of controlled substances was withdrawn by the Department of Health and Mental Hygiene after MedChi vigorously objected to draconian regulations for physicians whether or not they even prescribe such medications. In addition, a prescription drug and monitoring program (PDMP) has been established with legislative overview. New legislation also expanded the ability of NPs and physicians to prescribe naloxone to trained indi-

viduals who might come in contact with patients with overdoses. In addition, health insurance companies must now cover abuse deterrent analgesics.

“While politics in Washington is important (and the upcoming Senate and House races in Maryland are exciting), the affairs in Annapolis have a much more significant bearing on our daily lives and those of our patients.”

Medical Malpractice: A number of trial lawyer initiated bills did not get very far in this year’s General Assembly. Bills tripling the current cap on non-economic damages or limiting the ability to object to experts were quashed in committees and never reached the floor. On the other hand, some potentially useful bills also were not passed. A bill to reduce the cap did not get out of committee. House Bill 553 would have established a No Fault Injured Baby Fund to remove so-called “bad baby” cases from courtrooms and into an administrative process that provides a more rational framework for awards. A workgroup was established, however, to further evaluate the access to obstetrical care, and these types of tort reform issues will certainly be part of their discussions.

Public Health: MedChi continued to advocate banning the use of tanning devices by minors (similar to the Howard County ban). The bill did not pass. In addition, our initiative to markedly increase the taxes on tobacco was not favorably looked upon by the new administration. Our Hydraulic Fracturing (“fracking”) bill requiring companies to disclose the chemicals used did not pass, but a two-year moratorium on ALL fracking did pass. It is to be noted that there have been no significant earthquakes in Maryland for more than forty years. Our Sugar Free Kids initiative to remove soda from kids’ meals at fast food restaurants did not pass.

All in all, it was not a bad year. With the new assembly, about one-third of the legislature was new, and they were mostly learning on the job. Upcoming years will be much more interesting as the lawmakers settle in. It continues to be a major initiative of MedChi to be involved in the process. The lobbying team of Jay Schwartz, Pam Metz, Steve Wise, and Dana Kauffman do a wonderful job advo-

cating for our interests. Our Executive Director, Gene Ransom, together with our component executives are also extremely strong advocates. These individuals cannot do it all alone. They need the help of physicians across the state to get involved: take part in the Legislative Committee, befriend legislators to inform them of our views, spend a day as “Doc of the Day” in Annapolis, and contribute to the Maryland

Medical PAC. We are all in this together, and we need to continue to work together for the betterment of Maryland. It has been said, “If you are in Medicine, You are in Politics.” While politics in Washington is important (and the upcoming Senate and House races in Maryland are exciting), the affairs in Annapolis have a much more significant bearing on our daily lives and those of our patients. Each and every one of us needs to take some time to be involved.

Stephen J. Rockower, MD, is an orthopaedist practicing in Rockville, MD. He is past-president of Montgomery County Medical Society. He also is treasurer of MedChi and co-chair of MedChi’s Legislative Council. He can be reached at drrockower@cordocs.com and on Twitter (@DrBonesMD).

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The Corporate Practice of Medicine: An Old Conflict Continues in New Forms

Stephen Johnson, Esq.



The prohibition against the “corporate practice of medicine” is a familiar health law doctrine that initially arose at the beginning of the 20th century. Although found in many states and principally embodied in judicial decisions rather than statute, it is uncertain whether it ever existed in Maryland. The doctrine reflects a conflict in the public policy regarding healthcare as to whether the “professional” model or the “market” model will better serve public healthcare goals. Although the doctrine itself is on the wane nationally, the conflict between the two models will almost certainly continue.

Healthcare lawyers, and their legally sophisticated clients, are familiar with the statement that the “corporate practice of medicine is prohibited.” However, in a healthcare environment in which practice under a business name rather than a personal name is prevalent, directives seemingly prescribing standards of care are issued on a daily basis by corporate offices, and large practice groups are being organized under what appear to be corporate forms of governance, the question is frequently raised as to whether the principle still exists as a binding obligation, ethically or legally. A review of case law and recent legal literature suggests that the doctrine itself is largely moribund; however, the ethical and legal conflicts that gave rise to the doctrine remain.

The corporate practice of medicine doctrine has been traced to the early part of the twentieth century, “when medical corporations recruited physicians and then contracted with mining, lumber, and

railroad companies to provide care for their employees in remote areas.”¹ Even earlier, in 1890, the American Medical Association (AMA) officially stated that “corporate involvement in the practice of medicine had brought an ‘excessive spirit of trade’ into the profession and urged physicians to resist further entrance of corporations into the medical profession.”² The AMA added the following statement to the Principles of Medical Ethics: “it was ‘unprofessional for a physician to dispose of his services under conditions that make it impossible for him to render adequate service to his patient.’”³ According to Paul Starr, “[b]etween 1905 and 1917, courts in several states ruled that corporations could not engage in the corporate practice of medicine ... on the grounds that commercialism in medicine violated ‘sound public policy.’”⁵

The rationale for the doctrine has been explained as two fold. First, as a question of common logic: “only [natural] persons can undergo the training, examination, and character-screening that are prerequisites to professional licensure.”⁵ Second, as a matter of public policy: “(1) corporate involvement in medical practice creates a potential for divided loyalty between the corporation and the patient; (2) a lay person should not have control over medical decision-making; (3) a corporation lacks the ability to establish and maintain the trust requisite to the physician/patient relationship; ... (4) a corporation may concern itself more with profit levels than with the patients’ quality of care or personal well-being.”⁶

An unsigned, undated memorandum on the letterhead of the Board of Physicians that has circulated through the healthcare community for several years discusses a number of topics related to the corporate practice of medicine, including the existence of the doctrine itself. The memorandum states that there is an “implied prohibition against the corporate practice of medicine by entities other than hospitals, related institutions, and HMOs” based on the fact that laws relating to those entities specifically give them the power to operate “notwithstanding any prohibition against the corporate practice of medicine” and “to employ staff.”⁷

The Board also relies on *Dvorine v. Castelberg*,⁸ which mentions the doctrine as pertaining to learned professions such as law and medicine, but specifically not applicable to optometry, as the court believes that occupation is fundamentally “mechanical” and, therefore, “the principal concern of the state ... is not so much to protect the calling itself, as is the case in law and medicine, where the public interest may properly demand greater mental and cultural qualifications ... as it is to see that none may practice that art who are not qualified to do so without detriment to the public.”⁹ The Court goes on to state that a “course of conduct may be tolerated in the case of a mechanical art, trade, or calling which would be regarded as wholly objectionable in the case of a profession such as the law.”¹⁰ Therefore, the Court will not presume that the “legislature intended to interfere more than the neces-

sities of the situation actually required” by prohibiting the employment of an optometrist by a for-profit corporation.

In 2000, the Attorney General of Maryland issued an opinion finding that an unlicensed individual or a business entity that is owned by unlicensed individuals may operate a physical therapy business by contracting with a licensed physical therapist to provide services to its customers.¹¹ The Attorney General noted that, generally, courts look first to the language of the licensing statute to determine if there is a restriction on the form of an entity that may provide a licensed service.¹² The Attorney General read the *Dvorine* opinion as turning on the fact that the General Assembly had not prohibited in statute the provision of optometry services through the corporate form. The Attorney General acknowledged that in a later case the Court of Appeals stated, “according to the great weight of authority, state laws generally forbid the practice of medicine or dentistry by a corporation ... through licensed employees.”¹³ “However, the Court of Appeals has never

explicitly embraced this judicially created doctrine.”¹⁴ In the *Backus* case, the Court of Appeals barred the operation of a dental clinic owned by a corporation, but ultimately relied on the express language in the Dental Practice Act prohibiting various actions that might be construed as the

that the doctrine has only been invoked when there is a specific statutory mandate. Unlike the Dental Practice Act, the Maryland Medical Practice Act contains no specific prohibition against the corporate practice of medicine. (Compare the Maryland Medical Practice Act, Annotated Code of Maryland, Health Occupations Article, § 14-101, *et seq.*, with the Maryland Dental Practice Act, Health Occ. § 4-101, *et seq.*, and specifically § 4-101(1)(1).)

“Correctly or incorrectly, a considerable body of thought has developed to the effect that, far from being a hindrance to the provision of quality care, the profit motive can be an incentive to the provision of care.”

corporate practice of medicine, including the issuance of a license to a corporation and the practice by individuals under a business name.¹⁵

Not mentioned by the Attorney General, but pertinent to the discussion, is the court’s opinion in *Brooks v. State Board of Funeral Directors and Embalmers*,¹⁶ in which the court upheld a prohibition against the practice of “funeral direction” by a corporation. That prohibition also was explicitly set forth in statute.

The fair conclusion that can be drawn from a review of Maryland case law is

During the last thirty years, the view of the corporate practice of medicine doctrine has changed considerably. Correctly or incorrectly, a considerable body of thought has developed to the effect that, far from being a hindrance to the provision of quality care, the profit motive can be an incentive to the provision of care.¹⁷ In the minds of those who hold this opinion, the corporate practice doctrine is not truly motivated by professional concern for patients, but by “physician-centric guild[ism].”¹⁸

A critical point in the decline of the doctrine was the Federal Trade Commission’s



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(FTC) antitrust action against the AMA in 1975. Among many strictures imposed on the AMA was a prohibition against “characterizing as unethical the participation by non-physicians in the ownership or management of health care organizations that provide physical services.”¹⁹ “By keeping physicians from adopting what may be more economically efficient business formats in particular situations ... the restraints inevitably have an adverse effect on competition.”²⁰

The 1957 version of the *Principles of Medical Ethics* stated, “a physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.” The 1980 version, promulgated the year after the FTC order, stated that a “physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.” The 1980 language remains in the *Principles* today. However, several opinions of the Council on Ethics and Judicial Affairs have targeted specific concerns regarding conflicts between physician duties to patients and the public versus physician duties toward an employer, particularly one driven by profit concerns. Opinion 8.021, Ethical Obligations of Medical Directors, states that physicians acting as medical directors “have an overriding ethical obligation to promote professional medical standards [including] placing the interests of patients above other considerations, such as personal interests (e.g., financial incentives) or employer business interests.”²¹ Opinion 8.02, Ethical Guidelines for Physicians in Administrative or Other Non-Clinical Roles, states that “[t]he ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care. Rather, these obligations are binding on physicians in non-clinical roles to the extent that they rely on their medical training, experience, or perspective.”²²

Many state medical societies, including MedChi in Maryland, advocated in the late 1990s and early 2000s for legislation drafted to ensure that those employed by corporations and exercising de facto control over the provision of care, were held to the same level of care as the practitioner

providing care. This legislation met with mixed success, generally being resisted by the corporate entities in question.

The struggle that began more than a century ago, which has been characterized as the “professional” model versus the “market” model,²³ and which then took the form of an asserted ban against the “corporate practice of medicine,” continues today. The conflict today is less focused on a literal ban on the practice of medicine by corporations and more focused on issues of how much economic factors should be allowed to influence treatment decisions. A key change in the milieu in which the struggle occurs is the willingness of proponents of medical delivery systems governed by economic factors to openly argue for the merit and desirability of such systems. New practice models continue to be developed that purport to use financial incentives to improve the quality of care and lower costs, not necessarily in that order of priority.

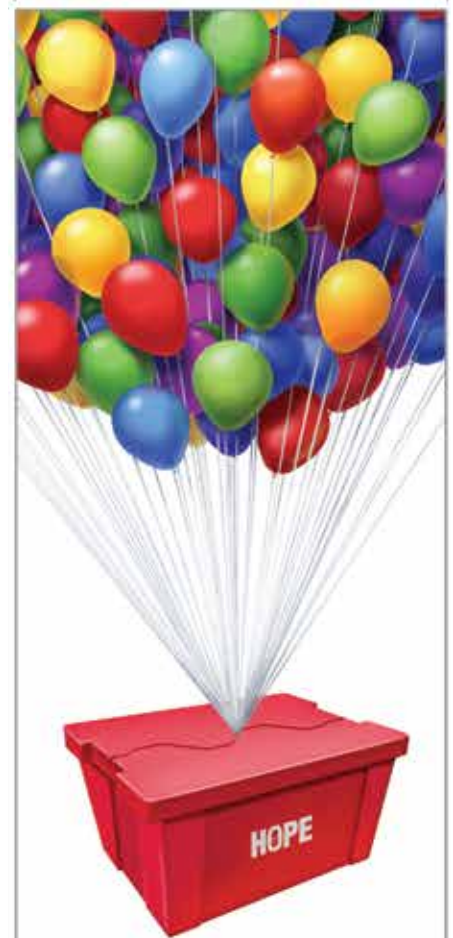
The logic of an economic incentive driven system is such that the only way to control such a system is to ensure that all costs are internalized by such a system, meaning, among other things, an increased role for the tort system in imposing those costs. Ironically, proponents of the market model will be most likely in practice to oppose the full internalization of costs, and proponents of the professional model will be most likely to support it.

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A complete list of references will be provided on request. Contact scarey@montgomerymedicine.org.



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The Transition to Corporate Medicine: Changing from Volume to Value The Good, The Bad, and The Ugly

Stephen J. Rockower, MD

Much has been written about the changes in medicine: how it is delivered, who is delivering it, and how it gets paid for. In the pages of *Maryland Medicine* we have written many times that “the times, they are a-changin’,” and this is no different. The traditional Marcus Welby doc on the corner with his black bag has become a “young buck” with an iPhone and an EMR. Some of these changes are worthwhile; some, perhaps not. Physicians are wondering how the changes will affect them, their practice, and their patients. The *Journal of the American Medical Association* (JAMA) devoted an entire issue recently to exploring professionalism and governance in education, lifelong learning, and employment.

Health Maintenance Organizations, or HMOs, rose to prominence in the 1970s after Richard Nixon signed the HMO act in 1973. The intent of the act was to promote the formation of prepaid health plans, or closed health care cooperatives, akin to the Kaiser system or Group Health in Washington, DC, in which a patient’s care was kept completely within the group of salaried physicians. The American Medical Association (AMA) and local medical societies vigorously fought such measures. Later in the 1970s, insurance companies began to form their own looser cooperatives, but patients were still cordoned within a specific group of physicians. With the infusion of large

amounts of capital from the “nonprofit” sector, non-physicians made significant amounts of money, often to the detriment of patients by withholding or rationing care. Much of the difficulty in actually managing the care of patients (other than the cost of care) revolved around the inadequacy of computer systems to evaluate patient care, individually or in the aggregate.

As the 1990s became the 2000s, it was revealed that much of the cost saving derived from HMOs was actually cost shifting, as healthier patients switched to save money in premiums. In addition, other than the physicians who were early adopters of the HMO movement, more groups were resistant to increasing their HMO panels. A Rand study showed that in a geographical area with a high physician density, many physicians were driven “to affiliate with distasteful HMOs.” It became necessary to develop different models to control medical expenditures that continued to rise, despite the passage of the “Sustainable Growth Rate” law. Many more citizens lacked insurance coverage, and the employer-based insurance system was showing signs of weakening.

Many investigators came to realize that much of the healthcare expenditures were concentrated on a limited number of people. A 2009 Kaiser Family Foundation report showed that almost 50 percent of all healthcare dollars were being spent on 5

percent of the population, which averaged more than \$17,000 per person per year. Thirty percent of these dollars were for hospital care, 20 percent for physician services, 10 percent for prescription drugs, and 15 percent for administration and profit of insurance companies. It became more and more obvious that identifying the large users of healthcare expenditures and instituting wellness programs to prevent illness would greatly decrease the rate of increases in healthcare expenditures. Indeed, since 2002, the rate of increases of expenditures has dropped from 9.5 percent per year to a little less than 4 percent. Much work has gone into data modeling and predicting which patients are likely to develop chronic diseases that account for the bulk of the healthcare dollar. The Agency for Healthcare Research and Quality has noted 25 percent of the U.S. population has one or more of five major chronic conditions: mood disorders, diabetes, heart disease, asthma, and hypertension. Computer systems to identify and coordinate care of these patients can greatly decrease the cost of their care.

Various groups have developed differing approaches to control health care costs. Hospital corporations have developed their own physician networks by purchasing and employing primary care and specialty groups. Previously self-employed physicians often lose patience with the restrictions and hierarchy of a

large organization, despite the newfound freedom from the “burdens” of private practice. In Maryland, groups from Baltimore to Rockville have formed and then severed ties with large hospital-based conglomerates. Many reports, including a report by the Medical Group Management Association, have shown that productivity decreases by as much as 25 percent when a practice is hospital owned. Physicians report long extra hours dealing with clunky EMRs and administrative systems.

The largest and longest surviving prepaid health plan is Kaiser Permanente, located mostly in California, but with a growing presence in Maryland, Washington, DC, and Northern Virginia. The penetration in the region is about 10 percent of the population, similar to that of California. The model of physician employment has worked well, but it has its detractors. Most physicians enjoy the ease of the EMR and the IT structure, but many chafe at the inability to control their patient hours and workload.

The large hospital systems (e.g., Johns Hopkins, MedStar, LifeBridge) also are working to integrate care and physicians. The 2014 Physicians Foundation Survey of Medical Care showed that hospitals and large medical groups employ 65 percent of younger physicians (age forty-five or younger). These physicians do not see themselves as owners or leaders in private practice in the future. When physicians leave employment, they often make a lateral move to another employed situation, rather than strike out on their own.

In Maryland, diverse specialties from Ob-Gyn, ophthalmology, cardiology, orthopaedics, and anesthesia have joined together in recent years to form large single specialty practices. With larger numbers of physicians, better negotiating stances can be held to command higher payments from the private insurers. Care must

be taken to avoid anti-trust concerns. Computer systems can be put into place to streamline the billing process. Larger groups can also reduce costs by centralizing billing and office management. Ambulatory Care Centers, run by the organization, can shift care from hospitals and provide a stream of revenue. Often the individual offices are cost centers and function semi-independently. Single specialty groups, however, often provide little to no coordination of care with primary care physicians or other specialties.

The Patient Protection and Affordable Care Act, sometimes known as “ObamaCare,” strengthened the formation of multispecialty organizations, led by primary care, to better coordinate and regulate care of patients and to promote “wellness” and decrease the need for more expensive medical care. These organizations, theoretically more “accountable” for the care they provide, have become known as Accountable Care Organizations (ACOs). As with previous attempts to rein in the costs of care, significant concerns were raised that rewarding physicians for decreasing costs would lead to inadequate care. In addition, as more and more physicians are employed by organizations not necessarily run by physicians, questions arise as to the pressures imposed to control care with allegiance to shareholders rather than to patients. Organizations such as the Mayo Clinic and Geisinger have created a climate of professionalism, but it remains to be seen whether the newer ACOs, or those growing out of hospital-based systems, can make the transition.

Newer organizations attempt to control expenses by coordinating care across a single EMR and billing system. Privia Medical Group, a newer entry to the market, has been making inroads in all the areas discussed above. As a multispecialty group, Privia has the ability to follow patients throughout the system. Some physicians have shared concerns that their funding by Wall Street introduces a significant conflict in allegiances by the participating physicians.

The new programs are changing the way we work. Some may decry the changes, hoping to go back to the way it was. Many forces are at work, not all of which always have the patients’ (or doctors’) best interests in mind. We must be ever vigilant to preserve the best of traditional medicine while we march into the brave new world.

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Physicians Share Their Stories About the Practice Decisions They've Made



Zaneb K. Beams, MD Private Practice Pediatrics

I just finished reading a list of career “Do’s and Don’t’s” by Samantha Power, the U.S. ambassador to the United Nations. Believe it or not, she has a job I once wanted. Ms.

Power gets to make the world a better place. She travels the world. She meets interesting people and is always learning. Her work has impact, autonomy, and value. She commands respect. Ms. Power has a successful career. So what did I take away from her list? One of her don’t’s—“Don’t plan your career long term.”

I did not plan to own my small private practice in central Maryland when I started medical school. Early in my studies, I enjoyed everything from surgical specialties to geriatrics. I decided to specialize in pediatrics because I valued preventing long-term problems and caring for families. During residency, I appreciated every rotation, most notably intensive care and emergency medicine. Since I enjoyed a little of everything and wanted to take care of sick children, I eschewed sub-specialty training and became part of the first wave of pediatric hospitalists. I chose my first job based on intellectual and professional characteristics.

The job offered widely recognized characteristics of attractive work: value, opportunity for innovation, and recognition. It didn’t offer flexibility or autonomy. And it didn’t meet my purpose. I went into pediatrics to prevent problems. Instead, I felt like I was always extinguishing fires. I started to see how system problems were often causing or perpetuating the ills I was treating. I missed being able to see the results of my work, and having longitudinal relationships with families. I also missed being with my own family. I liked the fast paced, T.V. worthy content of my work, but my personal goals were languishing.

I needed more autonomy, so I could be with my family. After realizing that the root causes of health problems lie in the flaws in the system, I was determined to create a healthier society by advocating for a better healthcare system. I wanted to work for myself, thus maintain control over my schedule and practice management. So I decided to do what all my advisors told me was impossible, and started a private pediatric practice. Four years later, I have a thriving practice with a regular, predictable schedule. This allows me to practice medicine, maintain a regular parenting presence, and continue my advocacy work.

Despite the transformations the medical profession continues to experience, it still offers work with value and recognition, autonomy and flexibility, purpose, and opportunity for innovation. Like Samantha Power at the United Nations, I didn’t plan out a thirty-year career path. Fortunately, medicine can be practiced in a hospital, a small private practice, or even in a non-clinical environment. Currently, self-employed private practice embodies the traits I require of my work. As Samantha Power recommended, I will remain open to opportunities for innovation, growth, and impactful work as my career evolves.

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Robert J. Levine, DO MedStar Medical Group Family Medicine

As doctors we are lucky to be in a profession that offers us so many options for how and where to practice medicine.

When looking at my options to set up my family medicine practice, I chose to become an employed physician and work for MedStar Medical Group, which is an ambulatory multispecialty group. I chose to work for MedStar Medical Group because it offers a combination of things that have proven beneficial to practice medicine the way I feel is high quality and to the benefit of the greatest number of patients.

Going into practice, I was well aware of the rapidly changing medical landscape, and the many obstacles I would likely face if I were to open a traditional private practice. I also felt well informed as to what my options were outside of opening or joining traditional medical practices. In deciding on the right path for me, it was important to define both my short-term and my long-term goals. I knew I wanted to practice full spectrum family medicine, with the exception of obstetrics, and I knew I wanted to do primarily outpatient primary care. One of the challenges that family medicine physicians often face is finding a practice where they can treat both children and adults. This is because of the expense and expertise of managing resources for both children and adults, in particular vaccines. MedStar offers me the ability to treat newborns and geriatric adults, and the resources and flexibility of a practice to provide high-quality care for my patients. In

my situation, MedStar also offers a new site, which started with no patients, allowing my colleague and me to be a part of growing and shaping the practice.

Having the resources of MedStar's specialists, hospitals, rehab, social workers, and teaching facilities allows for continued learning, ease of communication, and assurance of keeping up with health care's rapidly changing regulations that are being introduced routinely. When I was looking to set up my practice, it did not seem possible to offer all the services I wanted for my patients in a smaller private practice, and being a younger doctor I felt employment was my best option to allow me to focus my efforts on care.

Being employed also exempts you from the challenges of negotiating insurance contracts, and managing staff and the multitude of other factors necessary to run your own practice.

While other career paths may have been equally rewarding, I made the right choice for me given my goals and the current climate of healthcare.

Robert Levine, DO, is a family medicine physician with Medstar Medical Group in Gaithersburg. He can be reached at rjlevine@gmail.com.



Christopher Runz, DO Shore Health System Center for Robotic Surgery Urology

Seven years into a hospital employed urology contract finds me reflecting on my decision to join a health system, my initial concerns, and whether I would make all of the same decisions again given the state of healthcare today.

In 2008, my urology partner and I were looking to leave the Eastern Shore when it became clear that a partnership buy-in with the existing practice was not financially realistic. After the local hospital learned about our decision, we entered into a series of conversations to consider an employed position.

In retrospect, my decision to be an employed physician partner was a good one given the significant changes that have occurred in healthcare in the last ten years. Cost shifting by insurers has placed both the financial and the quality responsibilities onto providers and hospitals. Physicians and hospitals are now more aligned than ever before in their goals and incentives, thus fostering a more collegial and team-based relationship.

It is becoming clearer to me each day that coordinated care keeps patients healthier and uses less healthcare services. Just as businesses consolidate and create economies of scale to develop synergy, hospitals today are integrating inpatient and outpatient services and developing large physician networks to optimize information sharing along the care cycle. As payment models evolve to encourage this type of transformation, so too has the hospital-physician relationship evolved. The previous silo-system and fee-for-service model is rapidly becoming obsolete in the environment of population health, capitation and shared savings. Hospital employment, to some degree, insulates the physician from many of these financial, regulatory and IT challenges facing smaller private practice physicians, allowing them to concentrate on what they do best.

But with hospital employment, some potential risks exist, like loss of autonomy, job security, administration turnover, regular contract negotiations, and the possibility of changes to how you practice medicine. I have found that by becoming a proactive physician leader and a part of the management and governance structure of the healthcare organization, these risks are mediated.

Five years ago I organized a group of like-minded physician leaders to work with our hospital administration to create a board of directors, and together we implemented a more organized, physician led, multi-specialty group. That group currently employs forty-five physicians on the Shore and is now a part of a larger, newly created, University of Maryland Community Medical Group of 700+ providers employed within the UMMS system. I am privileged to also represent my fellow employed physicians on the Shore as a board member of this newly formed entity.

Healthcare begins and ends with the provider. As healthcare payments move away from a fee for service model, physicians will be the ones to lead hospitals into this new business and care paradigm. But to do so, we must be in the boardroom and on the committees and actively participate in running the organization. Leaving private practice was a bit of a gamble seven years ago, but the relationship we had developed with our hospital administration was built on mutual need, understanding, and trust. This cross-cultural leadership and collaboration built a highly successful five-urologist group on Maryland's Eastern Shore with each of us involved as directors, section chiefs, board members, and committee members. It is this continuing cross-cultural leadership that will allow us to reach our strategic goals and make us successful stewards of our patients' healthcare.

Christopher Runz, DO, is a board certified urologist who practices all aspects of adult urology with special interest in robotic surgery for prostate. Dr. Runz serves as Director, Shore Health System Center for Robotic and Laparoscopic Surgery, University of Maryland Shore Regional Health. He can be reached at crunz1@yahoo.com, on Twitter (@DrRunz_Urology), and on Facebook at Shore Comprehensive Urology.



Kevin L. Stitely, MD Anne Arundel Medical Group General Surgeon

There are many reasons to transition from private practice to employed—financial, lifestyle, compliance with ever-changing regulations, among others. Probably most times it is several of these. This can make the decision difficult or in some cases easy. In my case, it was a fairly straightforward one. With a senior partner retiring because of burnout, and the prospect of having to go into significant debt to recruit two new partners (because the two of us were running a four-person practice), the financial implications were huge. In spite of what some think, running a practice in a “rural” area is no less expensive than in a city. It would have been a financial disaster to not get help. There are several ways to get assistance from a hospital, but my decision was to get on board with the institution completely. I have never regretted this move. There have been several points of frustration along the way, but they pale in comparison with the issues I was dealing with when I ran

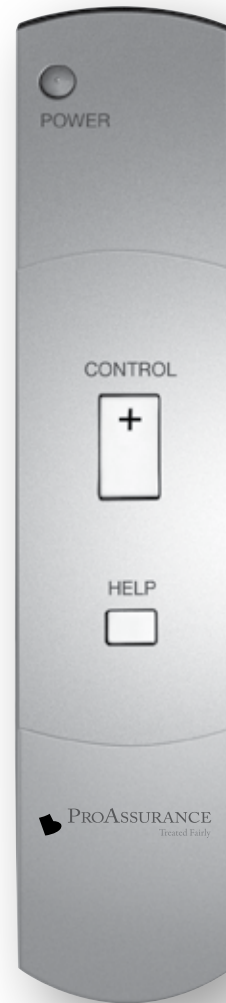
the business with my partner. Not having total control over the day-to-day business was something hard for me to let go, as some have said I am a control freak. In reality, this wasn't hard to do as long as I kept in perspective what I was gaining. I had an excellent working relationship with the CEO, and the transition was smooth. The reality was no different in the day-to-day workings of the practice. The problem came when the CEO and the administrative structure changed. While things were "OK," they were not what I wanted to live with long term. After unsuccessfully trying to elicit change, I realized I would have to work in their system or find something more to my liking, which is what I did. I am very satisfied with my new system and with the structure of the contract and workings of the office from an administrative standpoint, but the need to move was because of my "employer." I'm not sure how different this is from joining a practice and finding you can't work with some of your partners. Many times, a contract with a hospital or a healthcare system is "cookbook" and fairly structured, but there is usually room for negotiation. The biggest issues to negotiate are how compensation is structured (e.g., RVU [relative value units] based, straight salary), how much say you have in the hiring and firing of staff, and the partners you bring in. Most of us are willing to work hard for a decent salary, but those definitions differ depending on which side of the contract you are on. Getting a professional to review a contract in detail before signing is a must. I believe I am a better physician by being employed and will practice longer than planned, as I am much less stressed. Perfect? No. Better? Definitely.

Kevin L. Stitely, MD, is a board-certified general surgeon with offices in Easton. A former Lieutenant Commander in the U.S. Navy, he held previous teaching positions at the Naval Medical Center in San Diego, CA. He can be reached at skstitely@gmail.com.

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The Lion and the Mouse

Brooke Buckley, MD

Employment—a concept that has divided the physician community. The choice of an employed or private practice model has recently served as a platform for negativity, competition, lawsuits, and has even threatened patient care. At the same time it has offered opportunity, freedom of lifestyle, pursuit of research, volunteerism, and administrative endeavors. The recent major uptick in employment is a significant change in the way healthcare is delivered in this country.

I have lived this threat. I was raised in a private practice dental family. The entire family participated, benefited, and suffered. Dad did the dentistry, mom kept the books, I did the landscaping, and we all lived the life—interrupted holidays, slow Januarys, equipment failure, regulatory burden, fluctuating accounts receivable, bartered services, and the cost of electronic adoption among others. Thus, I had little interest in teeth and even less in owning my own business. For me, I wanted the career of medicine, not the hassle. I also did not want to be a businessman. I only sought employed positions.

However, in my eighth year as an employed physician, certain complexities and realities of the physician ecosystem have become evident:

1. Physicians cannot escape being businessmen. Businessmen are never physicians. Business happens. Whether we are negotiating a contract, incorporating electronic records, updating equipment, or submitting for better block time, we need business skills. However, the act of doctoring only occurs when we are face-to-face with a patient. Negotiations and dollars do not have morals. Physicians often find frustration when relating a financial deal with the ethical problem it serves to fund. Any clouding of this distinction weakens the house of medicine and diverts us from our purpose of saving lives and stopping disease.
2. We have to be physicians first. We cannot allow the method by which we are paid to destroy us. Our strength is in our medical community—our training, our oath, our shared humanity. If we divide ourselves related to practice models, we relinquish our power. We offer opportunity for doubt and stalled progress.
3. Employed physicians need private practice. In the absence of private practice, employed physicians lose one of their greatest assets in negotiating with hospital administration. If all care is “owned” by the hospital, then physicians can be no more than full-time equivalents. Human resources, work hours, and regulatory technicalities will have more power than sci-

ence and professionalism. I would argue that this is not only uncomfortable for highly skilled workers such as physicians, but also dangerous for patient care.

4. Private practice needs employed physicians. The regulations and financial pressures are changing so quickly that most physicians cannot both keep up with the business games and provide excellent patient care. So, as is aligned with our oath, most of us put our heads down, work harder at patient care, and try to “weather” the regulatory storms. In this process, some storms pass, but, increasingly, many businesses fail. Hospitals have the economies of scale to purchase employed provider time to manage these regulations. The private practitioners on these medical staffs can then mutually benefit at a fraction of the cost.
5. We have no choice but to evolve. Traditional private practice will likely soon be impossible in most communities and for most specialties. Strict employment will likely be too cumbersome for most hospitals, and while residency training and private practice have worked for one hundred years, we currently need to rethink every aspect of healthcare delivery.

In short, as comfortable as it feels to blame hospitals, or individual doctors, for destroying “the way it was,” employment has taught me that physicians need one another. If we want to provide truly excellent patient care, we have to stand shoulder to shoulder to work through the only constant in this world...change.

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The Options for Independent Physicians

Dave Rothenberg



The current healthcare climate is undoubtedly changing. With the Affordable Care Act, the shift to value-based reimbursements, and increasing healthcare costs, physicians are finding themselves in a very different environment than even a decade ago. In this changing landscape, independent practices have four options:

1. Stay completely independent
2. Join a single-specialty or fee-for-service oriented medical group
3. Join a population health focused medical group
4. Be employed by a health system

Physicians need to decide which option is best for their practice.

Stay Completely Independent

The benefits of staying completely independent are obvious: doctors remain in control of many decisions in their practice—whether and which EMR to use, billing approaches, hiring, productivity, to name only a few options. Over the last one hundred years, most physician practices in the United States have been completely independent. But times are changing. Accenture found that the percentage of independent physicians in the United States decreased from 57 percent in 2000 to 39 percent in 2012.¹ The economic model for small and medium size practices is becoming increasingly difficult. Costs are increasing while reimbursements are not. Moreover, the shift to value-based pay requires investments in technology, care teams, analytics, and workflow that are taxing on practices (not to mention administrative burdens).

Join a Single-Specialty or Fee-for-Service Oriented Medical Group

Another option for physicians is to join a group that can help improve their fee-for-service reimbursement rates. These groups are often single specialty groups, in which doctors come together to use their size to negotiate higher rates and lower costs. Most super groups in Maryland are of this variety. The challenge for these groups is the massive shift in the industry to value-based pay. Many of these groups are new to population health and do not have the technology, teams, resources, and expertise necessary to thrive. Many groups also lack a big primary care base that is important to managing care across the continuum. These groups can provide benefit in the short term; what's not known is how they will adapt to changing reimbursement models.

Join a Population Health Focused Medical Group

Population health focused medical groups are designed specifically to help independent practices get into and succeed in performance and risk-based arrangements. Across the country, physicians in population health focused groups have the biggest opportunity to increase their income, if the group is successful in removing unnecessary costs from the system. The groups tend to be mostly primary care physicians, with medical specialists that manage chronic patients, and fewer proceduralists. The key to success of the groups is a sophisticated strategic partnership with payers and infrastructure, expertise, and support to help bend the cost curve. Many of the most successful of the groups are on the West coast, but they exist throughout the country. (Privia Medical Group falls within this category.) The challenge for these groups is attracting the right type of physicians who share the big goals, and execution around driving costs out of the system (facility steerage, quality benchmarking, engaging high utilizers, PCP access, medication management, acute event management and avoidance, among others).



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Be Employed by a Health System

Selling a practice to a hospital or health system is often an option for physicians. The option to sell is attractive for many reasons: improving reimbursement rates, reducing the burden of running your own practice, and aligning with an entity that has the resources to invest in population health. Health systems in Maryland have been particularly acquisitive. The challenges are well known too: independent-minded doctors sometimes chafe at productivity targets, cuts in salary can happen after the initial term ends, and pressure to steer to certain facilities or specialists can conflict with population health goals.

Whichever option physicians choose, the key is to do homework. Understand short-term economics and long-term vision. Spend time understanding the big trends within payment models that will affect physicians for the next decade. Speak to doctors in the groups to learn what they like and dislike. Some of these options are easily reversible; others are more difficult. For better or worse, healthcare is moving into a new paradigm for reimbursement, and there will be a lot of opportunity for physicians to capture more of the value they create. It is up to physicians to choose their own adventure.

Dave Rothenberg is president of Privia Health, LLC. Before joining Privia in 2010, Mr. Rothenberg started MDLinx, Inc., a physician-focused healthcare media company. Mr. Rothenberg can be reached at dave@priviahealth.com.

Reference:

1. "More U.S. Doctors Leaving Private Practice Due to Rising Costs and Technology Mandates, Accenture Report Finds," Accenture Newsroom, October 31, 2012 (available at <http://newsroom.accenture.com/news/more-us-doctors-leaving-private-practice-due-to-rising-costs-and-technology-mandates-accenture-report-finds.htm#>).

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AMA Principles for Physician Employment

The American Medical Association (AMA) adopted new guiding principles for physicians entering into employment and contractual arrangements. The principles address the unique challenges to professionalism and the practice of medicine arising from the physician employment trend and were adopted at the AMA's semi-annual policy-making meeting in 2012.

"The Principles for Physician Employment provide a broad framework to help guide physicians and their employers as they collaborate to provide safe, high-quality, and cost-effective patient care," said AMA Board Member Joseph P. Annis, M.D. "The guidelines reinforce that patients' welfare must take priority in any situation where the interests of physicians and employers conflict."

The principles address six potentially problematic aspects of the employer-employee relationship, including: conflicts of interest, advocacy, contracting, hospital-medical staff relations, peer review and performance evaluations, and payment agreement.

I. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or undertreat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must

assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships – such as medical director, vice president for medical affairs, etc. – does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities

as permitted by law and in accordance with the ethical principles of the medical profession.

b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.

d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any

other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.

(f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.

(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.

(h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians – not lay administrators – should be ultimately responsible for all peer review of medical services provided by employed physicians.

d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met: i. The agreement is for the provision of services on an exclusive basis; and ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.



Can Politicians Make Us Healthier?

PERSONAL PERSPECTIVE

Tyler Cymet, DO

Politicians' main concern is not your health. Government makes laws, implements laws, and deals with areas of contention between people or groups. There aren't too many groups coming out and saying that they want to do something to hurt people, make people unhealthy, or see that people don't live as long as they do.

Health isn't a government function. Assuring safety is the government's role. Avoiding unsafe situations is the government's role. Protecting people from harmful situations and protecting people from others who would allow harm to occur is a protection that we need.

Preventing pollution that leads to cancer isn't something people can do on their own. Separating out sales from science requires that cigarettes and alcohol have true statements available and clear so individuals can make their own decisions. Government needs to step in when individuals can't. When science learns a way to control behavior without people knowing they are being controlled, the government needs to step in and protect the individual's safety. And health interactions need to be fair, and they are not always fair.

Chemicals in food may not affect the taste, but can affect the behavior. Often food companies will salt our ice cream, fat is put in our cereal, and high fructose corn syrup is everywhere a taste bud can be found. Drug effects can be created with ingredients, and government has to protect people from being given drugs when they don't expect to be given drugs.

We do put people into cages and allow them to hit each other until one bleeds too much or falls unconscious (called mixed martial arts). That isn't a healthy activity. It is a very lucrative business, and one that the government has to regulate. The regulation is there for the sake of safety,

not health. When the Ultimate Fighting Championship is in town they stage fights in which one out of five people needs medical intervention after an event. Most do fine. Some need to be sewn up or treated for concussions. It is likely that at least one

“Politicians need to find a way to protect themselves as well as the people they serve. Ensuring our world is safer is a good step toward making our world better.”

person leaves the stage on a stretcher—or at least should.

Mixed martial arts is a new experience and one area that the government hasn't gotten around to putting safety nets under. Mixed martial arts fights occur in rings with openings not large enough to accommodate most stretchers, so the injured will have to be taken out in a less efficient fashion. We know that the majority of injuries occur with two moves. In an ideal world those two moves—knee to an immobilized head or downward elbow blows to the head of an opponent—wouldn't be used. If we know that one out of five people will be hurt doing something, how does government regulate the event?

Tanning salons can provide tans that look healthy, but also increase the cancer risk. Who is to encourage tanning salons to move to non-cancer causing agents and techniques? Because it is an unhealthy behavior that we allow people to engage in, cancer causing tanning will continue, although hopefully not until a person is old enough to make life effecting decisions on looks versus life (currently defined as eighteen years of age). Making people aware of the risks and protecting those unable to protect themselves is the government's role.

Politics is a full contact sport that in many ways resembles mixed martial arts. Politicians need to find a way to protect themselves as well as the people they serve. Ensuring our world is safer is a good step toward making our world better. I am happy to have a job where my goal is to make life easier and more comfortable for all the people I care for. If you can't be a physician, then politics is another area in which one can have a huge effect on people's lives. I wish our leaders all the best in seeking out ways to improve our lives and offer help from Maryland's physicians whenever needed.

Tyler Cymet, DO, FACP is the president of MedChi and a member of the Maryland Medicine Editorial Board. Dr. Cymet trained in Primary Care Internal Medicine at the Yale University School of Medicine and was an Assistant Clinical Professor of Internal Medicine at Johns Hopkins School of Medicine. Currently he works for the University of Maryland Emergency Medicine Physician group seeing patients at Prince George's Hospital Emergency Department, and is the Chief of Clinical Medical Education for the American Association of Colleges of Osteopathic Medicine. He can be reached at tcymet@gmail.com.

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CLASSIC WORD ROUNDS

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Editor Emeritus

On April 12, 1861, the stillness of Charleston, South Carolina was shattered by mortar fire. Confederate troops under Gen. Pierre Gustav Toutant Beauregard fired the initial round in a long bloody war. Thirty-four hours later Robert Anderson, the commander of the garrison at Fort Sumter, surrendered. Among his eighty-five men was an artillery officer who had ordered the initial retaliatory shots fired by Northern troops. His name was Captain Abner Doubleday.

Today, we remember Abner Doubleday not for this abbreviated niche in our nation's archives, nor for his subsequent advancement to the title of major general of volunteers, nor for a distinguished military career during which he fought at Antietam, Bull Run, Fredericksburg and Gettysburg.

In fact, his most celebrated accomplishment had occurred well before the outbreak of civil (or uncivil) hostilities. It happened in the summer of 1839, while serving as an instructor in a military prep school at Cooperstown New York when Abner Doubleday introduced his students to a new game. The game was based on the English past time known as “rounders.” Doubleday called his version **baseball**. Historical records clearly show that he had neither invented the game, nor the rules by which it was played. Nevertheless, it served the interests of the major-league owners who ultimately took control of the sport, to promote that fiction. In 1939 at the alleged centennial of baseball's origin, the baseball Hall of Fame was dedicated in Cooperstown, New York. Leo Tolstoy once remarked: “History would be a wonderful thing if it were only true.”

Alexander Joy Cartwright, a surveyor who sometimes played for a baseball club called the New York Knickerbockers, was the man who actually designed the rules for baseball. The date was June 19, 1846. The place was the Elysian field at Hoboken, New Jersey. Mr. Cartwright's

Knickerbockers were soundly trounced by the New York Nine, 23 to 1. That contest was the first baseball game played under modern regulations.

In 1869, the first professional team was established. They were called the **Cincinnati Red Stockings**, and their manager was Harry Wright a local jeweler and center fielder. Harry was paid the bountiful sum of \$1,200 that year. Seven years later, on February 2, 1876, at the Grand Central Hotel in New York City, the National League was formally created. Charter members included Boston, New York, Chicago, Philadelphia, Hartford, St. Louis, Cincinnati, and Louisville. The opening game of the very first National League season saw Boston edge Philadelphia 6 to 5. It was on April 22, 1876. Two months later, on the morning of June 25, 1876, a company of 264 men from the U.S. Seventh Cavalry under the command of General George Armstrong Custer entered the valley of the Little Bighorn River.

The story of baseball was temporarily eclipsed.

Baseball patois has entered the language of America from the first cry of: “**play ball**.” To have “**two strikes against you**,” to be slightly “**off base**,” to “**go to bat**” (for some cause), to “**keep pitching**,” and to “**keep your eye on the ball**,” all have their origin from baseball's happy jargon.

Which of us is unfamiliar with the technicality of a **stolen base**, a **double**, a **triple**, a **round tripper**, a **force out**, **double play**, **doubleheader**, **spitball**, **bean ball**, **squeeze play**, **shoestrung catch**, **pop up**, **fly ball**, **pitch-out**, **pick-off**, or **foul ball**? However, a few terms do require some explanation, and I should like to offer a few baseball terms that have piqued my curiosity over the years.

In 1872, a shortstop named Dickey Pearce playing for the Brooklyn Atlantics, reached out with his bat and gently butted a pitch. The ball rolled slowly toward third base and stopped. Before the astonished

third baseman could recover sufficiently to field the ground ball, Pierce had safely crossed the first base bag. A “butted ball” instantly became an offensive weapon. However, as with many words, the nasal Brooklyn patois altered the word to **bunt**.

In 1901, the American League was created. A Johnny-come-lately, they have been known as the **Junior circuit** ever since. The National League is, of course, the **Senior circuit**, since it was created earlier. The American League was initially comprised of eight teams: Chicago, Boston, Detroit, Philadelphia, Baltimore, Washington, Cleveland, and Milwaukee.

The (old) Baltimore Orioles were organized in the 1890s under third baseman-manager John McGraw (later of New York Giants fame), and they became the most surpassing team in early baseball history. Unfortunately, the franchise folded. Most of their best players were seduced into joining the New York Highlanders, leaving the Oriole roster virtually barren. (The Orioles continued in Baltimore as a minor-league franchise for many years.) Baltimore, bereft of big-league baseball, patiently waited fifty years to rejoin the major leagues. Finally, an American League team—the **St. Louis Browns**—moved their team east to start the 1954 American League season as the regenerated Baltimore Orioles. The Browns, a perennial last place finisher, had been fondly known by their fans as “first in shoes, first in booze, and last in the American League.” As the new Baltimore Orioles, however, that wisecrack was heard no longer.

Incidentally, the New York Highlanders—the team which had enticed Baltimore's best players to join them—later changed their name. They became the New York Yankees. Do their tactics sound familiar?

The name “oriole” derives from the Latin *aureolus*: “golden,” referring to the orange color in the team uniform. The Baltimore Oriole bird is distinctly col-

ored orange and black. This species was named for **Cecil Calvert**, founder of the Maryland Colony, whose title was **Lord Baltimore**, and whose aristocratic family colors were orange and black. The Baltimore Orioles baseball team adopted those colors—and the bird—for their uniforms and club logo.

John McGraw and his teammate “Wee Willy” Keeler invented the **Baltimore chop**—a ball deliberately struck so as to be driven into Baltimore’s hardened infield. The impact caused the ball to carom high in the air, hanging up long enough for the speedy batter to reach first base before an infielder could throw him out.

The term **rookie** comes from the word “recruit,” and did not become part of baseball vernacular until after World War I. A **fan** was a shortening of someone who is “**fanatic**” about the game.

The “**Grapefruit league**” stems from spring training, which used to be held exclusively in the **citrus** state of Florida. The “**Cactus league**” is obviously a reference to the fact that many major-league baseball clubs now train in Arizona where those prickly plants are found.

Bull Durham is the name of a company, which makes chewing tobacco as well as cigarettes and pipe tobacco. It was common for the old baseball parks to display a huge billboard with the bright red, green, and brown bull, emblematic of the product. In this same section of the ballpark, enclosed by a fence, and at some distance from the playing field, one usually found the **relief pitchers**. Is it any wonder that some baseball wag, seeing the relievers warming up in front of the Bull Durham sign, enclosed within their own little corral, should coin the word **bullpen**?

A **rhubarb** is a heated, fulminating, window-rattling argument, usually conducted between an umpire and one of the teams, but occasionally involving both squads and often resulting in the expulsion of one or more players. The word rhubarb is actually a theatrical term. It was popularized by **Red Barber**, who was arguably one of baseball’s finest radio sportscasters (for the unhappily extinct Brooklyn Dodgers). The actors in Hollywood’s angry crowd scenes were instructed to mumble “rhubarb, rhubarb, rhubarb...,” which collectively simulated the sound of an irate mob.

Bleacher seats are found at the upper reaches of a ballpark, the area usually occupied by true baseball aficionados. Not covered by roof or dome, the wooden seats are exposed to the weathering rays of sunlight, and so they **bleach**.

No game would be complete without a cadre of umpires to arbitrate, explain, clarify, and disambiguate closely contested calls. Their word is final—they are the law. **Umpire** derives from French *noumper*: “not even”—a reference to a neutral person who referees and adjudicates a dispute between two parties. *Noumper* in turn evolved from old French *nonper* which, in turn, derives from Latin *non*: “not” and *par*: “equal.” After its incorporation into English, and through a linguistic process known as juncture loss or false splitting, “**a noumper**” became “**an oumper**.” Eventually, the phrase emerged as “an umpire.” Juncture loss may also be noted in the word **apron**, which began its life as the Latin *mappa*: “napkin,” evolved through old French *nape*: “tablecloth,” and ultimately becoming *naperon*. Finally, “**a naperon**” became “**an apron**.” The venomous snake the **Adder**, a member of the Viper family, was originally called **Nadder** in Middle English. Gradually, again through loss of juncture, “a nadder” became “an adder.”

In 1887, Peter Finley Dunne, a youthful reporter for the *Chicago Evening Post*, sat in the press box at Sox stadium, and composed his baseball column for the next day. A left-handed pitcher was on the mound, and Mr. Dunne searched his mind for a color-

ful phrase to describe the scene. Sox Stadium, like many open baseball parks, was designed so that the batter faced east. This was done so that the afternoon sun would never shine directly into the batter’s eyes. (Of course the outfielders—especially the center fielder—always look toward the west or southwest. In the late afternoon, he is always looking into the sun, which requires those fancy flip-down sunglasses.) The pitcher also faces west toward the batter. Therefore, a left-handed pitcher’s arm must arc through the south, as his pitch is made. Thus, Dunne coined the term **southpaw** (I’ve never heard of a “north paw.”).

The list of baseball terms is almost endless. Our language has been infinitely enriched by them. Find out for yourself. Take in nine innings—bring a friend. Buy some hot dogs. Maybe you’ll get lucky. Perhaps it will go into **extra innings**. As Jack Norworth and Albert Von Tilzer wrote in 1908:

“Take me out to the ball game, take me out to the park. Buy me some peanuts and Cracker Jacks, I don’t care if I never get back...”

Me, too.

“Baseball” was previously published in Maryland Medicine and appears here as a Classic Word Rounds.

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.

LETTERS

Dear Dr. Gershen,

I’m sorry to hear the news about the end of “Final Words” and “Word Rounds.” It was the most enjoyable, fun, and educating article in the Maryland Medicine Medical Journal. Thanks for teaching me something new each issue.

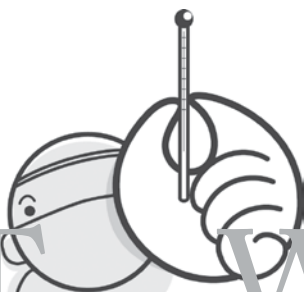
Best wishes,

David Santamore, MD (a grateful reader)



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