

Maryland **Medicine**



The Maryland Medical Journal

Volume 12, Issue 4

PRACTICING

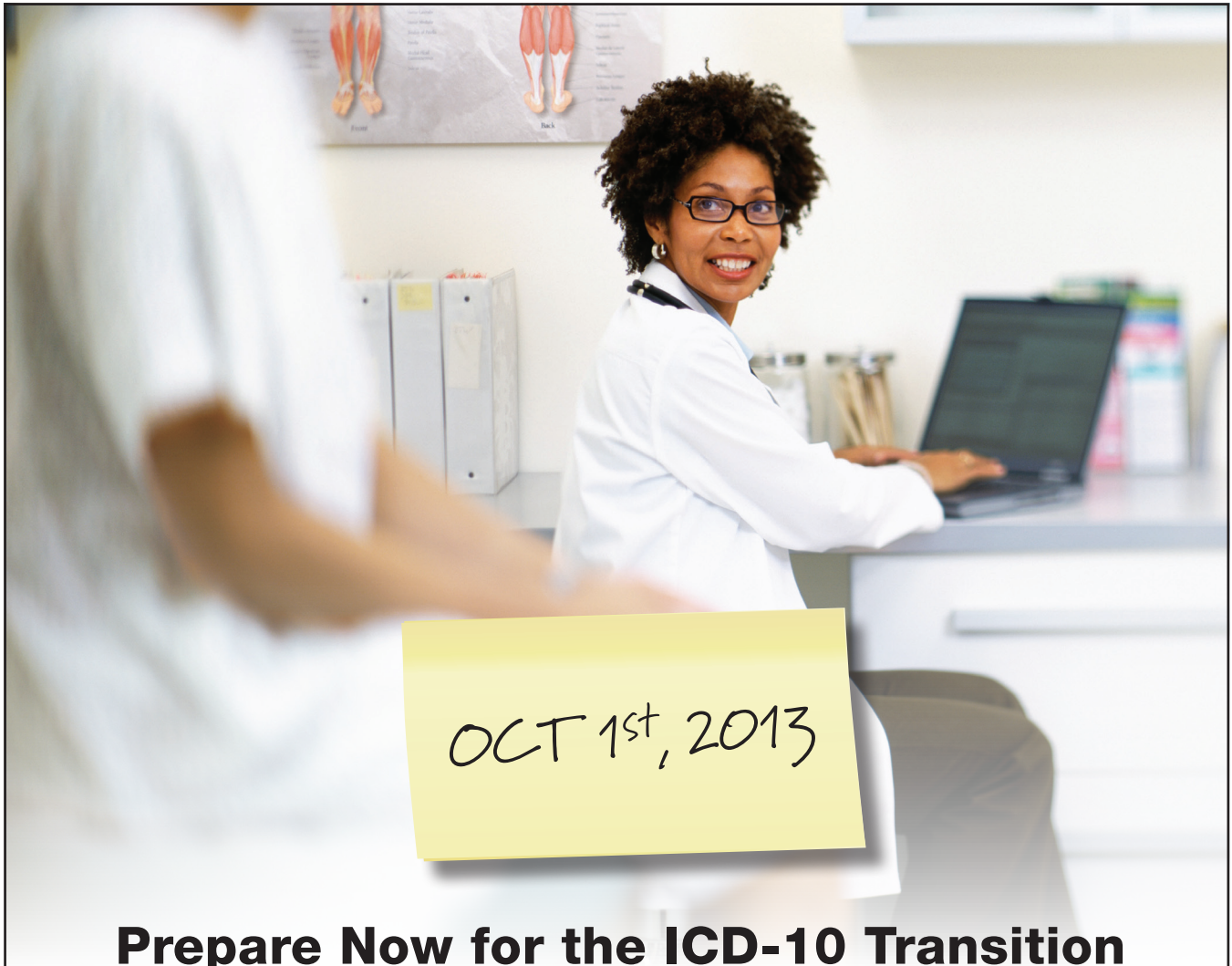
The Reader's Issue

HEALTH INSURANCE

ALSO INSIDE:

***MedChi's 2012 Legislative
Agenda Revealed***

***University of Maryland
School of Medicine Increases
Medical Student Education
in Primary Care***



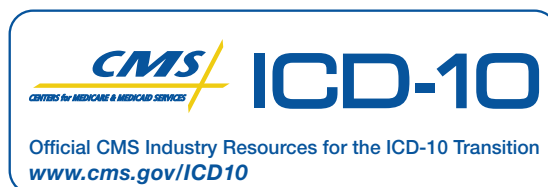
Prepare Now for the ICD-10 Transition

**The change to ICD-10 codes takes effect on October 1, 2013.
What do you need to get ready?**

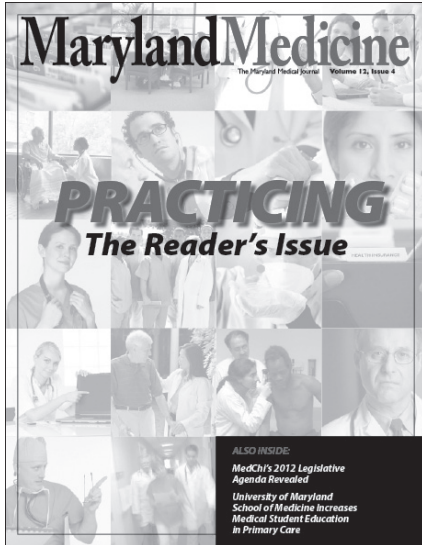
Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013. And in preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards.

Make sure your claims continue to get paid. Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you'll have what you need to be ready. A successful transition to ICD-10 will be vital to transforming our nation's health care system.

Visit www.cms.gov/ICD10 to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.



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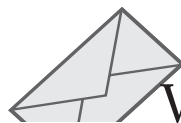


I N S I D E

Please note the perspectives of the authors contained in this issue of Maryland Medicine are theirs alone and are not necessarily endorsed by the Editorial Board of Maryland Medicine.

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Let's Take Our Profession Back!



PRESIDENT'S MESSAGE

Harbhajan S. (Harry) Ajrawat, M.D.

Until the 1990s, the dominant health insurer in the state of Maryland was BlueCross BlueShield (now known as CareFirst).

BlueCross was founded in 1937 with the express purpose to "establish, operate, and maintain a non-profit hospital service plan whereby hospital care is provided by a hospital to persons who become subscribers to such plan, so that such hospital care and service may be obtained at a minimum cost and expense." BlueShield was founded in 1950 by physicians with the similar purpose of "provid[ing] medical care at a minimum cost and expense." When the two organizations were merged in 1985, this public service purpose remained paramount. The bylaws for the combined entity, known as BlueCross BlueShield of Maryland, stated that directors shall be chosen "on the basis of their recognized interest in the welfare of the community, their desire to further the aims and purposes of the Corporation, and their ability to contribute to the intelligent guidance of the Corporation's affairs." The original objective was driven by a selfless interest in the welfare of the community. Are the health insurers of today driven by the same selfless interest in the community? We can certainly hope, however, it does not seem to be the case.

My vision for MedChi in the next year is that we continue to be supportive of new ideas for health care delivery and finance while holding fast to the goals of ensuring that care is provided to all who need it and the health care system remains viable. Our overall supportive, but critical comments on the federal governments' Shared Savings Program for Medicare, such as accountable care organizations (ACOs), is a current example of how we can continue to achieve that objective.

To that end, I commend to your attention the 2012 Legislative Agenda recently formulated by our House of Delegates and Board of Trustees, which can be downloaded from the MedChi website at www.medchi.org.

The fundamental unifying theme of this agenda is MedChi's desire to return the practice of medicine to the physicians, while enabling us to better embrace the technological and management innovations that will enable us to provide better and cost effective care to our patients.

Let us take a look at just a few of our initiatives:

This year, we will advocate for the enactment of legislation that would simplify and accelerate pre-authorization approval. Each insurer or pharmacy benefit manager would be required to have electronic approval systems compatible with the state health information exchange (HIE), allowing for real time approval of medical care and prescriptions, and they would also be required to disclose the clinical criteria being used. This is an excellent example of how technology can be used to restore our autonomy as physicians to the health care system.

With each passing year, that technology will play a greater role in the delivery of health care. As physicians, we need to embrace that technology, but also make sure that it is implemented in a manner that strengthens the health care system. This year, for example, MedChi will campaign to make sure that physician services delivered electronically (i.e., telemedicine) are not disincentivized due to unfair treatment by insurers. We will also work to make sure that ALL physicians are fairly compensated for the costs of implementing the new technologies such as electronic medical record systems.

As part of national health system reform, the focus is being put on innovative methods of delivering health care, such as accountable care organizations and other "bundled payment" systems. Many pilot projects have shown that when a health care delivery system is designed and controlled by physicians, both quality and cost measures improve. We will take steps to ensure that physicians have significant input into the design of these

systems so that we can be sure that the net effect of these models is to enhance patient and physician autonomy, and ensure an improved standard of care with an efficient use of resources.

We will also call for the enactment of "Truth in Advertising" legislation, requiring that all healthcare professionals accurately and clearly disclose their training and qualifications to patients in the treatment setting. Patients need to know the actual credentials of those who are providing treatment to them. Unfortunately, recent studies have shown that patients often believe the allied health professional (optometrist, psychologist, podiatrist, etc) from whom they are receiving treatment is a medical doctor, which he or she is not. Programs like "Doctor of Nursing" or "Doctor of Physical Therapy" will only exacerbate this problem.

MedChi will also ask the General Assembly to pass a resolution calling upon Congress to pass legislation allowing physicians to collectively bargain without running afoul of the antitrust laws. Physicians need to organize collectively so as to have a bargaining power near equal to that of the insurers.

Finally, we will support traditional public health measures, such as adoption of the new child safety seat guidelines, and an increase in the tobacco tax, with the new revenues financing public health initiatives.

What I wish to convey here is that we, in the medical community, are rising to the challenges of new technology, medical innovation, and an uncertain economy. We will embrace the new while still continuing in our time-honored path of rendering service to our patients and our community to the best of our ability.

References:

1. Larsen, Steven B., Comm'r, *Report of the Maryland Insurance Administration on the Proposed Conversion of CareFirst, Inc. to For-Profit Status* p.23 (2003).



EDITOR'S CORNER

Field of Dreams

Bruce M. Smoller, M.D.

This edition of *Maryland Medicine*, the Reader's Issue, is a paean to medical practice. We editors thought that, at least for one issue, we would elicit what our colleagues really like about practicing medicine through many of its varied practice incarnations. We started out with the idea that, in these times of conflicting forces, mind-numbing bureaucratic antagonism and obstinacy, the venal thrusts of insurers and lawyers, the self-congratulatory dances of consultants and other talking heads (did I get them all), some of us have achieved happiness in our work in differing medical venues.

As we've noted in these pages before, Medicine, until quite recently, has inhabited the higher reaches of the work satisfaction scale for many, many years. Despite its recent tumble down the fulfillment ladder in recent years, and despite its being consigned to being the local football by those who think they know how to dictate good care, a number of us have found an answer in diverse practice settings. Medicine still knows how to grab our attention, challenge us, provide the satisfaction of working with smart colleagues, do important things and provide for the common good despite all those forces waiting to take a bite at the apple.

It is implied, if not overtly stated, by some who would dictate guidelines and limits to us, that doctors are venal and uninterested in the welfare of our patients. We in the field know very well the libel contained in such disguised enmity. As attested to by our representative field of articles, doctors join up and stay in for three great reasons.....the chance to make a difference, the connection with our patients, and the fascination of the field. We bask in these things. And our patients benefit from our connection with them and our field. THAT is the reason we must be on guard against intrusion...not the money that our erstwhile benefactors would have the public believe is our main motivation. The vignettes in this issue attest to differing and creative ways to achieve that satisfaction, connection and fascination.

I happened upon a holiday message I sent to our members when I was MedChi president a number of years ago. I would like to reprint it here, as I believe it holds even truer now. You will probably receive

this after the holiday, so please just accept it post hoc and for the light it might shine on why medical school applications are at their highest level ever.

Dear Colleagues, Staff, and Friends of MedChi:

I want to take this opportunity to wish each of you a very joyous holiday season and a peaceful, healthy and happy New Year.

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

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

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

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

Have a wonderful holiday.

*All the best,
Bruce*

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Introduction

Mark G. Jameson M.D., M.P.H.

The Walters Art Museum in Baltimore recently displayed a newly discovered text by Archimedes, who lived a century after Hippocrates. Archimedes is perhaps best remembered for excitedly shouting “Eureka” when he stepped into a bath and suddenly realized that the volume of an irregularly shaped object could accurately be measured by the displacement of water. Among his many achievements, Archimedes elucidated numerous fundamental principles of geometry, pulleys, calculus, and hydrostatics. Modern day pharmacokinetics employs calculus to determine drug distribution in the human body, and current medical textbooks detail the hydrostatic forces described by Archimedes as applied to human physiology. In a peculiar twist of history, the text of Archimedes’ compositions was scraped from its parchment by a monk in the 13th century and overwritten with prayers. Archimedes’ writings were thus lost until their contemporary serendipitous discovery.

Today, many longstanding medical traditions such as home visits, long term relationships with patients, independent practice and professional autonomy are likewise being scraped away or lost. The rules governing medical practice are increasingly overwritten by those completely outside the profession. Even when those intentions are as pure as a monk’s prayer, effacement and erosion of the pristine physician-patient relationship is inevitable.

Since the time of Hippocrates the fundamental primacy of medicine is to serve patients. To rejuvenate those essentials, we invited our readers to annotate their own personal perspective on being a physician. Welcome to the *Maryland Medicine* Reader’s Issue. What could be more natural? Physicians author important events in the lives of their patients every day. Each of us has a story to share.

What inspired us to become physicians and what aspirations, hopes and dreams do we have? What are our greatest sources of professional satisfaction? What challenges and perils lie before us? What advice do we have for our patients and colleagues? If we could wave a magic wand what changes would we make? The personal perspectives in this issue range from a medical student to a physician nearing retirement, from private practice to public health, from primary care to specialty practice.

The Hippocratic Oath repeatedly refers to medical practice as an art, no doubt because the dawn of scientific study had not yet occurred. In the midst of today’s scientific achievements and high technology the art of medicine remains as vital as ever. Few practicing physicians can simultaneously advance the science of medicine, but all physicians can augment the art of medicine.

Artists everywhere share their experiences and creativity through literature, music, painting, drama, etc. Artistic sharing leads to advancement and innovation. In this issue of the journal, it is our hope that by writing personal perspectives our readers may similarly share their experiences and ideas to advance the interests of their patients and the future direction of medicine. Eureka!

Mark G. Jameson, M.D., M.P.H., specializes in internal medicine and public health in Hagerstown, MD. 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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Complex Environment – Difficult Practice Choices

Physician Environment

Why are physicians having to make difficult choices? What in the environment is creating these enormous pressures requiring physicians to do something other than simply practice medicine? Unfortunately, the answer is very clear, but daunting: the uncontrolled rising cost of health care. Although there are other issues that have some impact on the changes that are occurring, this unrelieved increase in the cost of health care is, by far, the largest factor forcing change. Just a few facts illustrate the significance of this intractable problem.

- In 2008, health care expenditures in the U.S. exceeded \$2.3 trillion with costs per resident at \$7,631 per year.¹
- In 2009, the percentage of GDP spent on health care was 17.3 percent. In 2008, it was 16.2 percent, making the increase to 17.3 percent in 2009 the largest one-year increase since 1960.² The country closest to the United States in health care expenditures is Germany, where 11.1 percent of its GDP is spent on health care.³
- The cost of Medicaid grew an estimated 9.9 percent in 2009. The cost of Medicare grew an estimated 8.1 percent in 2009.⁴
- The average annual health insurance premium in 2009 for a family was \$13,027, an increase of more than 54 percent since 2000.⁵

These rising costs are insupportable by either the state or federal governments, the employers who pay the premiums, or the patients who pay the co-insurance particularly when the U.S. fares so poorly on international public health scorecards.⁶

Although the implications of this increasing cost pressure on the health care industry are complex and far-reaching, it is safe to say that all of the following environmental factors are driven largely by this inexorable cost pressure on the health care sector.

Declining Reimbursement

Physician reimbursement has been declining in the United States for years. From 1995 to 2003, a physician's net income adjusted for inflation declined seven percent.⁷ From 1995 to 2008, physician reimbursement declined an even greater 25 percent⁸. There are a number of factors driving this decline:

(a) **Pressure to slow cost increases.** Both insurers and Medicare are constantly trying to slow health care inflation. An easy target is physician reimbursement. Consequently, all payers are continuously using reductions in physician fees to hold costs down.

(b) **Lack of negotiation leverage.** The enforcement agencies' present interpretation of the antitrust laws hinders independent practices' ability to jointly negotiate with health insurers. Since most physicians practice in independent, smaller groups, they cannot unite to negotiate for higher fees, unless the physicians (i) share substantial financial risk for health care services, e.g., via capitation, or (ii) are clinically integrated. Unfortunately, delivery models involving physicians' assumption of such financial risk have fallen out of favor with many purchasers of physician services. At the same time, as currently interpreted by the U.S. Department of Justice and the Federal Trade Commission, the standard of clinical integration sufficient to justify joint price negotiations is extremely expensive and demanding. Consequently, most physicians have very little ability to negotiate for higher rates with health insurers. Instead, the large health insurers have been able to reduce the rates paid in order to keep their health care costs lower.

(c) **The increasing cost of medical groups.** The costs of operating a medical group have continually increased. Everything from rent, to labor, to malpractice costs have continued to go up.⁹ Thus, physicians are caught between decreasing reimbursement and increasing costs.

(d) **Restrictions on revenue diversification.** In order to make up for these decreased fees and the rising cost of practice, physicians have increasingly relied on ancillary service income to supplement their traditional fee-for-service income. However, due to the focus of the federal government (and increasingly, state governments) on self-referral among physicians, the government regulatory apparatus has concentrated on restricting this ancillary income. An objective review of the regulatory efforts of both state and federal governments demonstrates a consistent pattern to reduce or eliminate the ability of physicians to obtain revenue from services other than those that they personally perform.

(e) **Increasing competition.** The new growth of hospital-owned practices has created competition for traditional physician practices. Larger delivery systems have substantial access to capital and resources, which allows those systems to build new facilities with new equipment in close proximity to existing physician practices. Essentially, these hospital-owned groups are competing aggressively for the dwindling numbers of commercial patients.

Change in Culture

In addition to the oppressive financial pressures faced by physicians, there are lifestyle pressures as well. The growing regulatory demands of governmental and insurance programs require that physicians spend ever increasing amounts of time dealing with administrative issues. Consequently, in addition to practicing medicine, doctors operate a very complex business overrun with regulatory requirements. The present-day physician spends a substantial part of his

or her time overseeing these administrative requirements or spend a substantial amount of his or her income in paying others to do this oversight. The idyllic medical practice of Marcus Welby, is a mythological vestige of the past.

Meanwhile, younger physicians now graduating from medical schools are much less interested in long hours and greater responsibilities. Instead, many younger physicians value increased time off, reduced administrative responsibilities, and less leadership responsibility. This change in the goals of physicians creates new economic pressures on medical practices as they must adjust to this more relaxed attitude toward work in the practice.

This combination of factors inevitably restricts the options for the present physician leadership of many smaller practices to seriously evaluate their choices. These cultural changes are a significant factor in forcing physicians to make difficult choices.

The Development of Integrated Systems

Historically, physicians have operated a cottage industry populated by thousands of solo practices or small groups. In 1991-1997, 40.7 percent of physician practices were solo or two-physician practices. At that time, 61.6 percent of physicians owned an interest in their practice.¹⁰ Only 16 percent of physicians practiced in groups with more than six physicians and 10.7 percent practiced with hospitals.¹¹ By 2008, the number of physicians in solo or two-person practices had declined to 32.5 percent while 21.8 percent of physicians practiced in private practices with more than six physicians.¹²

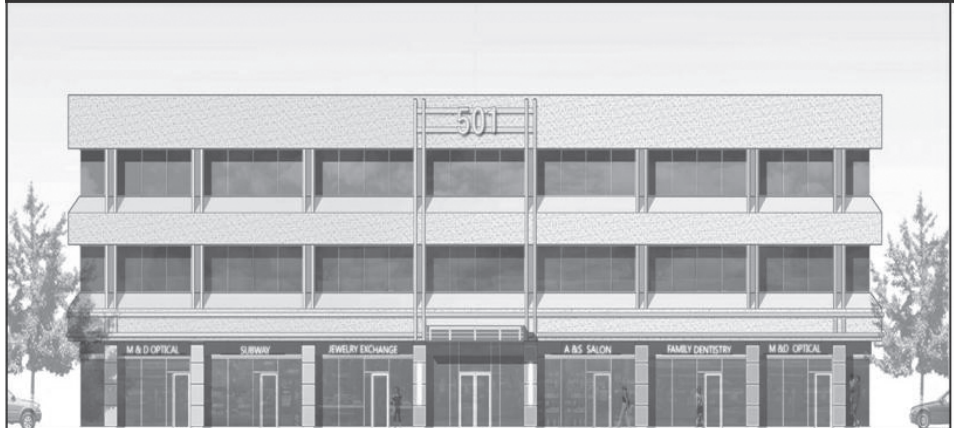
Over 60,000 doctors were employed by hospitals in 2008, approximately twice that number that were employed in 2001. A survey of residents in 2008 indicated that 22 percent of residents expected to be employed by hospitals, as opposed to 2003, when 5 percent did.¹³

This trend has been predicted for years. It is no secret that many of the most respected health care economists in the United States believe that integrated systems are the best structure to reduce health care costs. Influential policymakers such as Alain Enthoven and Uwe Reinhardt strongly advocate integrated delivery systems as a solution to the health care cost issue.

Another factor driving integration is current antitrust enforcement policy, which allows clinically or financially integrated

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provider systems of networks to negotiate with plans, whereas physician groups operating without the requisite level of integration cannot.

Health Care Reform

The culmination of this inexorable governmental and policy push toward integrated delivery systems is reflected in the Affordable Care Act (the "ACA"). The ACA calls for the development of multiple pilot projects, virtually all designed for integrated systems. These

pilot projects encourage episodic payment systems such as bundling, capitation, and quality payments, as well as medical homes and other collaborative programs. In addition to these pilot projects, there is a specific statutory provision authorizing the creation of accountable care organizations ("ACOs"). These are, by definition, integrated delivery systems requiring one entity utilizing participation from providers of all types necessary to deliver complete health care services to Medicare patients.

In the buildup and aftermath of health care reform, it is apparent that the development of integrated delivery systems are a goal of the federal government, and that, as a consequence, such systems will continue to develop and become a large part of the health care delivery system.

Lack of Capital

Given this impetus for the development of large, integrated delivery systems, many physicians would like to participate as equal partners in the development of these systems. However, the infrastructure essential to the development of these systems requires substantial financial resources. Unfortunately, physician practices have not been structured to develop capital resources or to serve as vehicles for raising capital and, as a consequence, it can be very difficult for them to self-finance this move into larger systems.

Shortage of Physicians

The number of physicians per capita will decrease in the U.S. because physician production has not kept pace with population growth. Further, the number of elderly will double because of baby boomers and longer life spans. In addition to more elderly, medical successes extending the life span have resulted in more people living with serious and chronic illnesses (e.g., cancer survivors, AIDS patients). This shortage is already becoming apparent, particularly in primary care. Presently, the U.S. has 352,908 primary care physicians and the Association of American Medical Colleges estimates that 45,000 more will be needed by 2020.¹⁴ Cardiologists, radiologists and anesthesiologists are all also in short supply.¹⁵

This physician shortage should be a countervailing factor in the continual decline of physician income. Logically, if physicians are in short supply, there should be an increase in the compensation payable to them in order to attract physicians. So far, because

of the highly regulated Medicare fee structure, this rebound in physician income has not occurred. However, it is hard to believe that incomes can continue to decline in the face of severe shortages. Paraprofessionals may be able to be utilized to plug some of the gaps, but they cannot substitute for physicians in most situations due to the vast differences in education and training, and in any event, the shortages are so great it seems impossible for it not to have a positive impact on physician incomes.

When one steps back and surveys the environment in which physicians are operating, it is fair to state that physicians are facing one of the most complex situations ever seen by any professional group. In the face of these pressures, it is hard for physicians to conclude that they should stand pat. On the other hand, the correct choice does not seem all that clear either. Nevertheless, common wisdom would indicate that the trends described above are going to continue. Smaller practices will likely be at a disadvantage in almost everything, from reimbursement, to cost, to capital, to hiring. The entities capable of creating the administrative and logistical infrastructure to develop integrated delivery systems will likely become increasingly dominant in the market. Those organizations able to deliver large numbers of physicians to these integrated delivery systems will be at an advantage. On the other hand, the existing and growing shortage of physicians should put many physicians in an advantageous position. For example, ACOs must have primary care capacity under the reform bill. Primary care physicians are at a premium. Their numbers are small and are diminishing. This should mean that they will be able to demand greater income and more benefits from ACOs and other integrated delivery systems. Similarly, other specialties may find themselves in the same position in a short period of time. Cardiologists are becoming rare. Neurosurgeons are always in demand.

Understanding that all of these factors complicate physician decision making, it is useful to at least examine some of the options available to physicians at this point.

Options

There are so many possible scenarios. The situation will be much different for a physician in a small rural area than for specialists in a large single specialty group. A large multi-specialty group will also have a different situation. Much will depend on the number of hospitals in the physician's locale. The possible circumstances are virtually endless. However, as a prelude to the rest of this Physician Guidance*, the following is a list of some of the options available to physicians.


1. **Don't do anything.** This is a possibility for some doctors in unique situations. For example, physicians specializing in *in vitro* fertilization may be able to continue to practice as they have been because of their unique market, which is driven by patient choice. Rural physicians may be able to continue in small practices because of their scarcity. A larger specialty group that has not seen substantial reductions in compensation may be able to watch and wait. A large multi-specialty group may have enough leverage in a particular market to stay independent while demanding support from integrated delivery systems.
2. **Stand pat but attempt to grow the practice.** One fact that seems to be clear even in this muddled situation is that larger will usually be better. Consequently, a smaller

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group of physicians that is not under immediate financial pressure can continue its present course, but attempt to grow by adding physicians or merging groups. Whatever the payer—insurance company, ACO, medical home, Medicare, Medicaid—there will be a need for physicians to provide the services. If the medical group is of substantial size and can deliver a substantial number of physicians to the payer, the group will generally be in a better position to negotiate rates and document its quality. This larger size will also allow the group to be more flexible as it adapts to whatever may come in the future.

3. **Employment by hospitals.** This may be a way for many physicians to eliminate substantial administrative responsibilities while aligning with the hospital system that can provide the infrastructure to be able to compete in a world increasingly dominated by integrated delivery systems. Physicians may choose to be directly hired by hospitals. Alternatively, physician groups may contract with such hospital groups in professional services agreements to provide services on behalf of a hospital group in exchange for compensation from the hospital group.
4. **Form large clinically integrated practice associations which can negotiate as one.** As such, these large clinically integrated systems may be able to provide substantial numbers of physicians to the various integrated delivery systems, such as ACOs or hospital integrated systems. By doing so, the individual physician groups could remain largely independent and negotiate as one to seek better positions in these integrated delivery systems, both in terms of control and reimbursement.
5. **Changing to a concierge or direct practice.** This method of practice will, in all likelihood, still be viable after the insurance reform provisions of the ACA take effect. People may be willing to pay for personalized care beyond their insurance premium. As long as this type of practice methodology is not outlawed, it certainly may remain a viable option.
6. **Partnering with hospitals.** Physician groups may be able to develop service-line management companies by which they can retain some independence but receive compensation from the hospitals for providing management services of a specific service line within the hospital. Another example is to utilize the medical staff relationship with the hospital to try to develop a partnering structure for ACOs or integrated delivery systems. This will be dependent upon the attitude of the local hospital.
7. **Partnering with health insurers.** Physicians may also want to consider arrangements with health insurers to obtain the capital and data necessary to operate an ACO. This scenario may allow physicians to reduce hospitalizations without the potential pushback of a hospital partner. However, the success of such a venture will depend on the willingness of the health insurer to cede significant control to the physician group.

8. **Insurance co-ops may be a possibility.** The ACA authorizes the creation of insurance co-ops that might compete in providing insurance through the health insurance exchanges that the ACA mandates must be operational by January 14, 2014. Physicians may be able to create such an insurance company at a minimum cost because of the subsidies available through the ACA. This would allow them to have greater control over the insurance company with which they would affiliate.
9. **Employer clinics.** Many employers are now beginning to provide medical care clinics for their employees on the job. This is essentially how Kaiser developed in California. This proliferation could provide other employment opportunities for physicians.

In analyzing and evaluating these various options, physicians will have to be very objective and aware of their situation in the market.

- If you are a solo practice in a large city, you will have to recognize that your ability to continue in that practice will likely depend on your willingness to take reduced income or switch to a concierge-type practice. However, on the other hand, your ability to secure a beneficial employment agreement with the hospital may be limited as well, depending on your specialty.
- On the other hand, if you are a small practitioner in a rural area, your importance to the local hospital may give you the clout to secure a strong relationship with the hospital, potentially without becoming a hospital employee. If that hospital is going to be able to deal with integrated delivery systems or insurance companies, it is going to need your allegiance and support. The hospital may threaten to bring in a competing doctor, but that may not be a real threat given the shortage of physicians.
- You may be a substantial multi-specialty group. In that case, you may want to consider potential hospital partners that recognize your value to them. You may be able to develop a relationship with a hospital partner that allows you to maintain a substantial amount of your autonomy while giving the hospital what it needs with your participation in its integrated delivery system. Alternatively, there may be a health insurer that is interested in affiliating with you and providing significant capital and technological resources.

In making an assessment of options, it is important to be realistic about your group's strengths and weaknesses. These are some of the questions that need to be asked:

1. Is your group on sound financial footing and can you continue to sustain reasonable incomes over the next five to six years?
2. Is your group willing to invest in some of the infrastructure—both technological and human—that will be needed to compete with more sophisticated integrated delivery systems?

3. Does your group have strong and deep leadership with cohesion among the members? If you don't have both of those characteristics, staying the course may be difficult.
4. Who are the realistic partners you might work with, and how trustworthy are they? There are differences between hospitals and medical groups in their reliability and credibility. When you can, it is better to partner with a reliable party rather than one who offers more money at the outset but cannot be counted on to stay the course.
5. What is your bargaining position in the community? Are you well-thought-of and do you bring sufficient capacity to give you substantial leverage? If not, it is important to evaluate what kind of leverage you might have and how you might strengthen it.
6. Is your group prepared to spend the time and resources it will take to carve out a strong position in any joint venture such that the group or the physicians in it will have a substantial say in that new, combined organization? It will take time and money to put your group in a position where it will have a substantial say in any organization, be it an ACO or integrated delivery system. If the group doesn't want to spend that time and money, it is probably best not to reach too high for a leadership position.
7. What is your plan for the future? Are you close to retirement or in the prime of practice? If the former, you may want to try to obtain the best money deal possible. If the

latter, you may want to choose a partner for the long-term. This difference in perspective can create difficulties between members of the same practice when making group decisions.

As indicated earlier, the scenarios can go on ad infinitum. The choices are difficult and the clear answers few. However, it is now time to plan. Otherwise, your choices will begin to evaporate, and changes will come without any choice on your part.

David Hilgers, J.D., a health care attorney, is a partner with Brown McCarrroll, LLP in Austin, TX. For a complete list of references contact Susan Raskin at sraskin@montgomerymedicine.org.

*Note: This article is a condensed version of a publication that can be found on the American Medical Association (AMA) website (www.ama-assn.org) and is being reprinted with permission from the AMA. The article is titled, "ACOs, CO-Ops and Other Options. A "How-to" Manual for Physicians Navigating a Post-Health Reform World."

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PERSONAL PERSPECTIVES

The following 14 personal perspectives are written by MedChi members. They have been placed in order from the beginning of training as a medical student, through residency, into one's medical career and through the later years of practice.



"Idiopathic"

Neil M. Neuman

I was shadowing a pulmonologist several years ago when I was a junior pre-med student at Johns Hopkins University when I first heard the word "idiopathic." I asked the physician what it meant and he said, "It basically means that we have absolutely no idea."

A few years later in the fall of 2011, during my second year of medical school at Johns Hopkins University School of Medicine, I was asked the same question by a patient, who had idiopathic peripheral neuropathy in his feet. The physician had momentarily left the room, and the patient wanted to know, from me, what all this meant. I had trouble grasping the best way to explain. I wanted to repeat the same phrase that I had heard before, but realized this would be neither the right time nor the right answer for the patient. I kept asking myself, "What do I tell this patient, right here, right now?" I felt that I was gasping for air, yet trying to find a foothold to let the right words leap out of my mouth. Unfortunately, I could not find them. I ended up falling back on some esoteric patho-physiology to explain it. I broke it down as much as I could for him about the "...nerve endings in your feet ... neurotransmitters ... long term effects of glucose on the vasculature ... trauma ..." I could tell that my choice of words didn't help the patient and left him feeling less enlightened and more confused.

I think this example did not represent the patient's inability to comprehend what I was trying to say as much as it did my inability to explain what was truly happening medically for the patient. I struggled to explain this to the patient because, as a pre-clinical medical student we were learning about patho-physiology, pathology, and pharmacology. Under the new Johns Hopkins University School of Medicine curriculum, called "Genes-to-Society," we are learning about the importance of understanding the individuality of each patient. We learn how each patient's genes are different and affect their health in very different ways. This may affect the way their body and they respond to a certain disease in a certain circumstance at a certain place and time. We also take a whole semester course dedicated to the "Clinical Foundations of Medicine" in which we learn how to interview a patient, perform a physical examination, write reports, learn how to be more empathetic, and learn the beginnings of clinical thinking. I believe this new curriculum is meant to better educate medical students as future physicians on how to incorporate the injection of science into medicine as well as learn how to better interact with patients by being exposed to these interactions earlier. We are not discussing, however, how to educate our patients about what we don't know.

I have had many conversations with my professors in medical school and in the Department of Basic Sciences while working towards my doctorate degree (Ph.D.). These interactions have made me realize that medicine is (finally) becoming more focused on the

individuality of each patient. The ability to sequence entire genomes at a very low cost will vastly alter the way in which the day-to-day practice of medicine and communication between practitioner and patient takes place. Perhaps when I begin practicing on my own there will be a way to explain some "idiopathic" diseases to patients. Part of my interest in science is my drive to explain "idiopathic" mechanisms of disease and follow paths where the information is unknown. There will always be material that we cannot explain to our patients, but the question is how do we best communicate with them even when we don't know the answers? Right now, I feel uncomfortable explaining to a patient that medical science has not yet advanced that far to help us understand his or her illness or disease. Right now I feel as if I am not being very helpful – like all of this hard work and training is not being put to good use. I want to get to a point once I start practicing where my patients will trust in my abilities and my decisions. While I realize that at this point in my education and training I may have to keep saying "I don't know" to patients, I believe that we as professionals always need to push the limits of our knowledge forward as well as acknowledge to our patients when we don't know the answers.

Neil M. Neumann is a 2nd year M.D./Ph.D. student at Johns Hopkins University School of Medicine.

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Life Can Unexpectedly Change in a Moment!

Matthew Loftus, M.D.

“Dr. Loftus, we can’t let you see patients now.”

Those words crushed me. I was only ten weeks into my internship year and felt like I was just starting to at least be able to make it through a simple well child check without freezing halfway through or forgetting a basic question to ask. I still felt very overwhelmed quite frequently, but I was really enjoying the rather steep learning curve of the internship year and all of the people I had the chance to meet, help, and occasionally argue with along the way.

That all stopped when I was found to be immuno-suppressed and forbidden contact with patients. Who knows what diseases they could be carrying? I agreed with the reasoning of my faculty and my own doctor—the risk to my own health was too great—but I only did so grudgingly. I had spent years working to this point where I could meet patients, hear their stories, lay my hands on them, determine what their problems were, and offer solutions. I have even bigger dreams beyond residency—practicing full-time in an underserved country, starting a residency in family practice in a country that doesn’t have any family practitioners, and empowering a generation of leaders from residents down to community health workers. I had known for a long time that I wanted to work with people cross-culturally in the role of a servant and had specifically chosen medicine because I felt like it

married my aptitude for science and my passion for people. Now that was shut off to me and all of my professional ambitions seem to have disappeared in a moment.

I pondered all of this as I laid facedown with a needle inside my bone. I didn’t ask the hematology/oncology fellow how many biopsies he had done before, but from the extensive verbal coaching that his attending gave him, I suspected that it wasn’t very many. When he had bandaged me and we were sitting face-to-face again, I found myself unconsciously learning from him as I asked him what he thought was happening. He was careful with his words, explaining the likely diagnoses and the important “rule outs” as carefully as he could with language that he knew I’d understand. Afterwards, I felt like I was getting the best care I could. He had been in practice for many years before going back to do a fellowship, overwhelmed by the burden of cancer in the population where he was working. His comfortable yet serious manner really impressed me and meant a lot, especially on a day where I had gone from being provider to patient in only the span of a few hours.

The whole experience reminded me of what a great privilege we as physicians have to hear the most intimate stories of our patients and work with them in ways that no other others outside the field of medicine cannot. I was cut off from that privilege for a few weeks and shifted my work to telephone follow-up of some of clinic’s “high-risk” patients—the noncompliant, the super-utilizers, the no-shows, and the frequent flyers. Since I had no other clinical responsibilities, I had all the time in the world to hear their stories. So I decided to simply ask questions with the goal in mind of only finding one self-identified behavior that they might choose to change in order to be healthier.

If there is one thing I find most frustrating about medicine, it is the tension generated between patients and physicians and other health care providers and their passive-aggressiveness that those in health care sometimes display. The locus of responsibility consequently hangs between the two, untouched until the next medical crisis. When I spent hours on the phone asking patients about their most important health priorities and what they wanted to change, I was overwhelmed by how often patients felt like they were trying as hard as they could to manage their health and simply felt like the changes they wanted to make were beyond their (the patient’s) ability. They also spoke very warmly of their physician and other providers—even the “noncompliant” patients! They all, however, expressed great appreciation that someone who was willing to listen to them and ask them what was important to them.

My condition disappeared as mysteriously as it had appeared, and now I’m back into the busy schedule of interning and seeing patients. But my time away from direct clinical work and patient contact was still very formative for me. If I could change anything instantly about medicine, it would be for all my patients to better understand that those in health care are on their side, not their enemies. My recent experience gave me the chance to experience that for myself as a patient, to help patients get to that point as a provider representing our health center, and to appreciate more acutely what a privilege the ability to see patients is. As much as I hope it never happens again, I am glad for what I learned about seeing patients when I wasn’t allowed to.

Matthew Loftus, M.D., is a resident in family medicine at Franklin Square Hospital Center in Baltimore, MD.

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The Cost of Treating Cancer Patients: Treatments versus Reimbursements

Mark G. Goldstein, M.D.

Oncology is a unique specialty which demands of its practitioners the most modern treatments medicine has to offer, while balancing all the complexities of psychological stresses, financial stresses, biological stresses, circadian disruptions, and a myriad of short-term and long-term toxicities, both potential and realized. The fascinating diversity of people and pathology and the interaction between them has intrigued me since my first interaction with a patient diagnosed with cancer during medical school only 10 short years ago.

The science of medicine, especially the practice of oncology, has undergone an unimaginable transformation since then. The advent of targeted therapies has increased efficacy, but exponentially increased cost. As I entered fellowship in 2005, the new reimbursement models began to take hold. Little by little, articles surfaced describing the potential impact these models would have, primarily on private practice. The business of medicine and specifically the business of oncology, including employment contracts, J-codes, infusion times and rebates, were a foreign language to me. Training programs generally do not consider those issues to be a necessary part of the curriculum, and my program was no exception. Inquiries about these topics were met with near silence—reminiscent of the days when the word ‘cancer’ was not uttered. The focus was on oncology without exception. But avoiding questions about the impending problems oncology was facing did not mean those problems did

not exist. Immediately, upon the completion of fellowship training, I was abruptly introduced into the real world of oncology and medicine in which prescribing an effective, tolerable, inexpensive chemotherapy for an elderly man with lung cancer was frowned upon simply because it did not generate revenue. For a variety of reasons I switched from private practice to a hospital-based practice. This practice model is rapidly becoming the norm among graduates from a variety of specialties. Nevertheless the financial constraints continue to pre-dominate every clinical decision. And just as some of the most effective, standard oncology treatments are going generic, numerous critical chemotherapy shortages have arisen partly because the generics are not cost-effective for the manufacturers.

In such an environment, how can oncologists prepare for the future? Cancer is generally an age-related disease process, particularly with the most common diagnoses, including breast, prostate and colon cancer. As the number of retirees increases rapidly, the demand for oncologists and for appropriate, affordable chemotherapy will also increase. If Congress does not prevent the upcoming 27.4 percent decrease in Medicare reimbursement, Maryland and many other states are going to be greatly affected by this perfect storm.

As a young oncologist, newly inducted into a field rich in history, scientific discovery, and more recently dramatic improvements in treatments for cancer, I envy the oncologists who are nearing retirement who have witnessed these astonishing achievements during the last 30 years. But I also worry that during the next 30 years, Medicine’s future achievements will be overshadowed by the financial turmoil of the health care system along with the exodus of overburdened physicians and other health care providers.

Mark G. Goldstein, M.D., specializes in hematology-oncology in Frederick, MD.



Psychiatric Diagnoses in a Managed Care Environment: Taking Time for the Patient

Jemima Kankam, M.D.

I have been in private practice now for over 20 years (although I stopped the nursing home consultations and hospital visits years ago), and throughout that time I have had to deal with frustrating amounts of paperwork by way of treatment plans, and authorizations, as well as employee issues and staff turnover. The business aspect of private practice was something I was unprepared for, and I did not anticipate how much the impact of my naivety about business would cost the practice...several thousand dollars from a biller’s embezzlement to be exact. With all the overwhelming administrative issues, I did not pay close attention to the money trail until thousands of dollars later. It is only when I took legal action that I learned that it was not unusual for physicians in private practice to fall victim to this type of fraud.

In spite of the administrative headaches (and the painful lessons I learned about financial oversight), private practice has brought me great clinical satisfaction, because I have been able to practice medicine in a way that supports my treatment philosophy: that despite the time crunch that the managed care climate has produced, the best way to make accurate diagnosis in psychiatry is through skillfully taking a longitudinal history.

I am continually concerned about the continued inadequacy in training for non-psychiatry residencies, even though a majority of patients will probably be treated first by their primary care physicians. Although they are doing the best they can, this inadequacy in training often results in misdiagnosis, which delays improvement, or results in worsening the patient’s quality of life.

I am very concerned about some of the consequences of managed care. In attempting to compensate for the shortcomings of managed care, sometimes the patient is shortchanged and placed at risk for unnecessary suffering. Over and over, I continue to be humbled by new patients who tearfully express their gratitude for “taking the time to ask all those questions;” when in fact, according to the standard of practice, a clinician *must* ask “those questions” in order to arrive at an accurate diagnosis. Since diagnosis drives treat-

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Health Care Reform = Quality?

Ram Peruvemba, M.D.

It is now two or three years since my revelation that health care was headed in new directions. It seemed clear that the cost of medical care could not continue rising at its present rate and changes adding value to our system needed to be implemented. Suddenly I was confronted by new catch-phrases such as health information exchanges (HIE), accountable care organizations (ACO), patient-centered medical homes and most recently the Triple Aim (care, health and cost). In the end, all these new health reform efforts were aimed at reducing overall health care costs and improving outcomes. I certainly could not argue with such a noble cause, but I had to wonder how struggling primary care physicians would have the time and money to implement such drastic changes. I knew that hospitals represented a major cost center and I was concerned about the effect of health reform on my practice of anesthesiology. As a hospital-based physician, I would not be directly affected by the cost of health information technology but I knew in the age of cost-sharing and outcomes-based payments that I would surely carry some of the financial burden. I knew that I had to become more involved at multiple levels. I had to understand health information technology and its impact on my practice, become more involved in policy and legislative decisions, and at the same time practice excellent clinical medicine. I had to do these things to determine the future direction of my career and the impact of these changes on my family and colleagues.

My quest to understand the impact of health information technology (HIT) on hospital-based medicine took many shapes. I became a consultant for an HIT company that worked exclusively with the Centers for Medicare & Medicaid Services (CMS). It was evident from this work that HIT would eventually transform health care through improved communication. As an anesthesiologist, I could potentially see the entire medical history of my patients by using electronic medical records. As a consequence, I could better care for my patients and potentially avoid duplicating expensive diagnostic or laboratory studies that had recently been done. I learned that the HIE would serve as a warehouse of patient data that I or others could access with the permission of our patients. In addition, CMS would also have access to this data which could be used for billing and public health purposes. However, as I continued my work with HIT I realized that it could potentially provide us with a tremendous amount of information regarding current population health and an impact on preventive medicine. Although we can provide patient reminders and access to personal health records, it remains to be seen whether such intervention will genuinely result in behavioral changes required to impact the health of our population.

The number of policy and legislative issues relating to health care is growing at an astronomical rate. My initial interest in legislative issues began with those regarding assignment of benefits in Maryland. While working on this legislation and speaking to politicians in Annapolis and on Capitol Hill, I realized that changes in our health care delivery system were a top priority for our elected officials, but many remain unclear as to how those changes will result in the most dramatic improvements in health care quality and outcomes. As a hospital-based physician I remain concerned about the effect of ACOs on the future practice

of anesthesiology. How will bundled payments work? Will gain-sharing really work to promote better quality and efficiency in our system? My decision to be involved in health care policy through the Health Care Delivery Reform Subcommittee was fueled, in part, by the realization that these questions needed to be answered in the near future. As I have told many policymakers, the involvement of physicians as stakeholders in the health care reform process is both mandatory and instrumental. In the health reform process we must avoid unintended consequences of policy changes by involving physician stakeholders at the earliest stages of decision making. Scope of care issues serve as an excellent example of policy changes that must involve physician input. As the country looks for more high quality physician extenders to reduce costs, physicians must be present to comment on both the advantages and limitations of allowing an expansion of services provided by non-physicians. We must continue to monitor policy and regulatory changes occurring locally and at the federal level and look for ways to make a direct impact on the final decisions.

Through these changes physicians must continue to practice clinical medicine. In the end we must gauge how the health reform process is transforming the quality and cost of health care. The ultimate goal is improved value of health care such that our future generations can continue to have the best health care in the world but in a more financially viable fashion.

Ramani Peruvemba, M.D., is an anesthesiologist and he practices in Rockville, MD.

Psychiatric Diagnoses in a Managed Care Environment...

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ment, it is not difficult to perceive what can and does happen when diagnostic decisions are based on snapshot cross-sectional history. Managed care has a lot of control over physicians but does not control our clinical acumen. Using time crunch as an excuse to depend on a cross-sectional history increases the risk of misdiagnosis, and thus treatment.

What keeps me up at night? It is that three out of four new patients that I see do not understand their mental illness despite previous treatment. We must not only make an accurate diagnosis, but we must also explain the illnesses to our patients in ways they can understand. In spite of all our training, psychiatrists have collectively not mastered that art. I am often frustrated by the slow progress we have made in getting the right medical information to the average person, since understanding is so critical to helping people become *active participants* in their treatment, not merely subjects.

Have I thought of changing to a self-pay practice? Yes, many times. I know I will be more successful financially, but as my daughter reminds me, I would not be able to stop thinking about numerous people who cannot afford it, those same people who have, and continue to, touch and change me even while I was treating them.

Jemima Kankam, M.D., is a psychiatrist who specializes in geriatric medicine in Laurel, MD.



Finding My Dream Job!

Barbara Brookmyer, M.D., M.P.H.

From a young age I was interested in the practice of veterinary medicine and began research in middle school to learn more about school entry requirements and locations of veterinary schools. Science, particularly biology and environmental ecology, was my favorite subject, so when I opened the big book of careers and with closed eyes pointed to a place on the page that described pharmacology and a note to “See also Toxicology” my undergraduate educational path was set.

There were only three schools at the time that offered a toxicology major at the bachelor’s degree level so I applied to programs in Boston and Philadelphia and ultimately opted for the one with the new pharmacology-toxicology research facility—the Philadelphia College of Pharmacy and Science, now named the University of Sciences Philadelphia.

It was a set curriculum that was heavy in science and light in the humanities. The classes and six-month internship component of the curriculum prepared us well for a career in research. In addition to the six-month, full-time internship opportunity that I had with Ortho Pharmaceutical I also volunteered in a laboratory in a cancer center working with both animals and tissue samples. My preceptors and their colleagues were great at taking the time to talk with me about their experiences and recommendations for someone with my interests. I recall one of the preceptors at Ortho stating that those with medical degrees (M.D.) are more competitive in acquiring grant awards from the National Institutes of Health (NIH). The combination of my laboratory experiences with animals and chemicals, and conversations with people in the field led me to take the Medical College Admissions Test (MCAT). That led to my matriculating at Hahnemann University School of Medicine in Philadelphia, now Drexel University’s School of Medicine.

If it weren’t for an upper classman who came into the large freshman 1st year lecture halls announcing the opportunity for two 1st year students to lead a funded pilot project to prevent adolescent substance

abuse, I may not have continued with medical school after the 1st year. Recognizing the level of my increasing debt load kept me going since I knew what my best earning potential would be as a toxicologist and it was less than what I was spending on the cost of tuition and living expense for a year of medical school. I continued to be active in efforts focused on community health, particularly for low-income communities. While attending a meeting of the American Medical Student Association, I joined a discussion among three people, one who had just finished at the school of public health, one who was in the school of public health, and one who had just been accepted into a school of public health. When I heard them talk about their coursework, I said to myself, “That is what I want to do and what I want to know.” I took a year off between my third and fourth years of medical school to pursue a Masters of Public Health degree (MPH) at Johns Hopkins University School of Medicine. In the Health Policy and Management Department I focused on health policy and environmental health. One of the courses was Introduction to Public Health taught by Professor Tom Burke, Associate Dean for Public Health Practice and Training. When a local health officer came to talk to the class, I knew that one day I wanted to serve as a local health officer.

I then took another year off from medical school to enter the health care reform policy discussion fray that was occurring in 1992 and served as the legislative affairs director for the American Medical Student Association (AMSA). Much of the AMSA’s attention was focused on payment reform of the graduate medical education (GME) system to better align Medicare GME funding with community needs. I studied the publications and deliberations of the Council on Graduate Medical Education (COGME) and decided that some day I wanted to work for COGME.

Upon completion of my one-year term with AMSA, I returned to medical school to complete my fourth year. There was no question in my mind that I would pursue

specialty training in family medicine as the field aligned well with my interest in providing comprehensive health care to a community. By my third year of residency training at the Ventura County Medical Center in California I began to miss public health. I attended the annual meeting of the American Public Health Association (APHA) and looked for job announcements in the career mart. I found only one job posted in the Maryland, Pennsylvania and Delaware area. I interviewed with the Somerset County (Maryland) health officer and was later offered a job that allowed me to work in both the health department and a community health center in both Somerset and Dorchester counties. Working in both settings was a great experience.

I hadn’t been looking to change jobs and never previously received a job announcement from the person whom I worked with at AMSA but who remembered that I wanted to work for COGME. That job announcement led to my working for the federal Division of Medicine and Dentistry that administered COGME, dream job #2.

About five years later I happened to be looking for the first time at the Sunday *Washington Post* Health Careers want ads and saw an announcement for dream job #3 – a local health officer position in a neighboring county. I’ve been the health officer for Frederick County ever since. It’s a great job. I work with a terrific group of professionals who inspire me on a daily basis with their commitment, passion, and good ideas. The community is so supportive of efforts of the Frederick County Health Department to promote, protect, and prevent. I am living my dream.

Barbara Brookmyer, M.D., M.P.H., is Health Officer for the Frederick County, MD Health Department.



Finding Inspiration in the VA Health Care System

Catherine A. Staropoli, M.D.

On entering a fellowship in general internal medicine-women's health in the mid-1990s, the last place I ever thought I would practice medicine was at a Veterans Affairs (VA) Medical Center. I am one of a handful of physicians who had never set foot in a VA hospital at any point during my education or training, and with a background in women's health it didn't seem like an environment in which I would best utilize my skills. More than half of the physicians and nurses trained in this country have received some or all of their training through the VA system. In what turned out to be a stroke of luck for me, while looking for a position, the Baltimore VA Medical Center needed an internist-director for their Women Veterans clinic. And so, I embarked on a career of providing primary care in the VA system.

Having veterans as patients has been an honor for me. These men and women have gone through life-altering experiences during their military career, both good and bad, all in service of our country. Some have been permanently altered in physical and emotional ways that affect their health and well being. Many are my contemporaries or younger than I am. Many participated in historical events we have all learned about. Hearing their stories and the personal impact of their military experiences is a privilege.

Being part of a large organization that exists to serve those who served our country can be very inspiring. I try to pass that feeling on to the trainees in our clinics. I explain why, in addition to the age appropriate preventative screenings we do for all veterans, we also screen for depression, sexual trauma, post-traumatic-stress disorder, brain injury and IED exposure, and why we do this. I explain why we expanded our services to offer comprehensive women's health clinics where one provider can address both gender-specific and general health care and how this benefits our younger veterans. I emphasize how the Veterans Health Administration continues to adapt to the needs of veterans while addressing the new challenges it faces for a generation of veterans with needs different than those before them. As one of the leading research and training organizations in health care, the VA has led the nation in integrated electronic medical records, safety initiatives, and preventative medical interventions.

My administrative role in developing the women's health program has been particularly rewarding. About 15 percent of veterans enrolling in VA health care are women and this is expected to increase. The program I direct is expanding services continuously with national support. Most of these women are under age 35, and so the VA has been adapting to offer these women the services they need, many related to reproductive health. The people I work with at all levels from the national level administrators to the nurses in the clinic are passionate about improving care and care models for women veterans, and to be part of that on a daily basis is motivating.

My practice is varied and has men and women of all ages. Many have been home for decades, but are just as affected by their military time as those who just returned home. Like most general internists,

part of what attracted me to the field was the promise of continuity with patients and the meaningful connections and this has held true for me. Internists on the whole are spending more non-reimbursed time for their patients care and are economically pressured to keep their practices viable. While I also face phone calls and paperwork outside of appointment time, I do not need to worry about reimbursement issues or the myriad of insurance plans and varied formularies that many of my colleagues do and can focus on patients.

My job is varied and satisfying. I have been able to work full-time and part-time in a teaching environment. I've been involved with a growing and special VA population as a clinician and at a programmatic level. Working with veterans is very gratifying as is being part of a large evolving health care system. My colleagues are dedicated and bright. I've been able to keep a career-life balance that works for me and my family. So while it seems like an unlikely place for someone interested and trained in internal medicine-women's health, the VA Maryland Health Care System has been a great match for me.

Catherine A. Staropoli, M.D., is the Medical Director of the Women Veterans Health Clinic for the VA Maryland Health Care System and the Clinical Associate Professor of Medicine, University of Maryland School of Medicine.



Training the Trainers to Help Students Become Good Physicians

Tyler Cymet, D.O.

I am a primary care physician who doesn't see patients every day. After 16 years of making medical practice my life, I moved into a position that is part clinical and very administrative. One day a week I see patients who come to the emergency department. The rest of my time is spent working for an association with physician and non-physician educators.

The career choices I made have allowed me to be a physician, see patients, and be involved in medical education, policy and development of community medical education through the American Association of Colleges of Osteopathic Medicine. It is a unique kind of work, and not one that people generally think about as a career option.

I think I make a difference in people's lives both as a physician and working with osteopathic medical schools, residency programs, hospitals, and others involved in health care and education. I am involved in physician training, how physicians think about the organization of health care, and how we are seen as a community that will help the next generation of physicians.

The next generation of physicians will be different, and tools that are currently available will help the next generation of physicians look at medicine and medical practice differently. Expectations of those seeking health care are different from the past. Information available is much more accessible, and the business of medicine has made it inevitable that practicing physicians in the future will have a different set of challenges. Systems within health care are much more complicated and complex than ever before. Knowing how to help others navigate an increasingly complex system is part of the job of the new physician and demand different skills. Unfortunately, physicians are not being trained to use these types of skills.

Practicing physicians have a sense of what is happening in health care and should be able to make useful decisions. Administrators and other professionals, with all of their knowledge about the business and administration of medicine, are not experienced as practicing physicians. As a chief resident, simple tasks, like setting up schedules, creating contingency plans, working out interpersonal issues that came up gave me a sense of satisfaction, accomplishment, and a connection to the residents under me.

Working administratively has made me feel a more direct part of what is going on in health care. Physicians often feel that changes in the health care system are being made without their input. Often they are right! Too many physicians retreat into a mindset of an employee who wants to do their job well and take satisfaction in having completed their part of patient care. I want to be part of creating new plans that help physicians, administrators and patients alike. I don't want see health care decisions made that are mainly based on business principles and not humanitarian principles.

For the same reasons that I became involved in MedChi, The Maryland State Medical Society, I now spend my days training the trainers in health care, helping medical students navigate the maze of training in order to become physicians, and expanding the concepts of what becoming a physician means.

There are many ways to practice medicine. The majority of newly trained physicians are employees in systems bigger than any one individual. For physicians to make a difference, they too need to be part of something bigger. The physician's role is incredibly important and requires skills broader than just understanding the physiology of a patient.

Working with osteopathic medical schools lets me live the philosophy that I believe in, and helps to instill the values that I want to see in the next generation of physicians.

Tyler Cymet, D.O., is Associate Vice President for Medical Education for the American Association of Colleges of Osteopathic Medicine.



I Love the Team-Based Practice

Judith DeJarnette, M.D.

Twenty-two years ago, I became a physician with Kaiser Permanente's Mid-Atlantic Permanente Medical Group (MAPMG). I chose this type of practice for several reasons. I enjoyed the collegiality of a multi-specialty group all working under the same roof. I look forward to learning from my colleagues. The orthopedist is available to help me with the fracture; the internist can review the EKG with me, and the otolaryngologist can assist me with removal of the foreign body in the ear. Our goals as a group were aligned with my values of providing comprehensive, evidence-based, and medically necessary care. Prevention of disease is one of the core values of a pediatrician. Within the medical group, there are also opportunities to develop managerial and leadership skills. I have taken on various roles as well as maintained an office-based pediatric practice. I currently serve as the Assistant Physician-in-Chief for Quality for the Baltimore area.

I am proud to be a part of Kaiser Permanente Mid-Atlantic. We have achieved our #1 position in quality due to our focus on prevention and the management of chronic conditions. In my role as a quality leader, I am encouraged to help all of our physicians to continuously innovate and apply best practices. This culture at Kaiser Permanente, along with the support we get from our highly sophisticated electronic medical record, allows us to make continuous progress in the quality of care that we provide. I am thrilled to be part of a system of exceptional physicians that can deliver the best possible care.

Judith DeJarnette, M.D., practices pediatrics with Kaiser Permanente's Mid-Atlantic Permanente Medical Group.



My Life of Practicing Medicine

Phillip F. Mac, M.D.

As fate would have it, I have experienced almost every type of practice situation during my medical career. I began with my training in the military. As part of my tour I decided to go into teaching medicine and eventually ran the family practice residency program for the military. After fulfilling my military obligation, I went on to co-direct the residency program at a West Coast university. The practice experience for the residents was at a community-based hospital. At that time, I decided to develop a "traditional physician's office," so residents could learn the nitty-gritty of office-based care, including office management. Unfortunately, the residents did not find it to be valuable. So I decided to manage the practice myself. I knew I would succeed. The practice was doing well but being a solo primary care practitioner was getting tough. So, I joined a primary care group. Finally, I could share the on-call schedule. I also realized that small groups had political issues and practice issues

just like universities and the military. I am not sure how it happened, but a larger primary care group practice swallowed up our little group and the complexities of the practice swelled. Administrators as well as physicians were directing my practice. I resented that type of control. My impression was that dollars pre-empted good patient care.

Eventually I decided to go back to practicing on my own. The main reason was to get back some semblance of control over my practice. For another five years I practiced alone which included assisting in surgery, giving hospital care as well as care in my office, and delivering babies. The long hours, business reality and a failed marriage led me to move cross country to a very rural primary care group where I could practice the type of medicine that I wanted. The job was certainly what I wanted in terms of scope of practice but something was still lacking. I was working hard but did not feel confident about the overall care I was giving to my patients. The physicians were skilled and caring but functioned independently of one and other. After one year, I decided to continue my search for a better job. In addition, I made my final move. That was 10 years ago. I am happier than ever. The care I deliver is better. I feel more confident not only in my care but that colleagues and specialists support me.

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A Full Life as an Academician

Steven Gambert, M.D.

"by my teaching, I will impart a knowledge of this art to my own sons, and to my teacher's sons, and to disciples bound by an indenture and oath according to the medical laws..." Hippocrates

Teacher, preceptor, and mentor. These words have been used to characterize the life of an academic physician, a role I am honored to play at the University of Maryland School of Medicine. I have always had broad interests in medicine and over my 35 years as a physician have enjoyed serving in the role of researcher, clinician, and educator. I guess it is my personality, but I am never as professionally fulfilled as when I am teaching medical students and residents, the future of medicine. A long time ago I realized that, while I could make an impact on humanity by helping one patient at a time in the clinical setting, through my role as a teacher, I could have a positive impact on countless numbers of patients for many years to come. I enjoy the interaction with bright, inquisitive students who, much like a sponge, are eager to absorb new-found information and find ways to incorporate this newly acquired information into their own practice style.

Don't get me wrong, I love my clinical duties in helping to care for older patients at the University of Maryland Medical Center and the R. Adams Cowley Shock Trauma Center. I believe it is important for all academic physicians to remain clinically active, not only as a way of teaching in an active clinical context, but also to maintain the respect of those being taught. It is hard to give information in a vacuum and it is always best to speak from experience and lead by example. Medicine is an experiential field and while we can teach principles in the classroom, it is the clinical setting at a patient's bedside or in the consultation room that a true academic physician can excel. It is also one's clinical experience from past patient encounters that often makes the difference in making the correct diagnosis which guides the medical team through the maze of medical decision making processes, and not just relying on practice guidelines or text-book knowledge.

I came to serve a formal role in medical education perhaps by chance. While trying to introduce geriatric teaching into the curriculum as a young faculty member, I was asked to make a presentation to the curriculum committee. Thereafter, I was soon asked to serve as a member of the Clinical Years Curriculum Sub-Committee and eventually was made a member of the medical school's Curriculum and Education Committee. After a few years, I assumed the role of its chairman and was then asked to be Associate Dean for Academic Programs, a position I held for a decade. Ever since leaving that position, I eagerly accepted responsibilities whenever asked to direct various medical school courses including Pathophysiology, Physical Diagnosis, among others. I spent a decade as a residency program director as well, an extension of my experiences with medical student education and being a fellowship director. At the University of Maryland, I currently serve as the Director of the Medical Student Programs for the Department of Medicine where I am also the Director of the Medicine Clerkship. This past year I was asked to additionally play a leadership role in the medical school's Introduction to Clinical Medicine courses. I could not be happier. Not only am I in a position as a teacher, a reward in itself, but I also can play a key role in shaping curriculum for medical students and many generations of physicians to come. I frequently get phone calls from my former students and residents, many now in senior academic positions themselves. Some call to let me know what they are doing while others still, believe it or not, call for advice. It is nice to know I have not been forgotten and have made a difference.

Academic medicine has been a path that helped me to fulfill all of my career goals and aspirations. It allows me to continue to practice medicine while serving as "teacher, preceptor, and mentor." What else could anyone ask for? I consider myself to be extremely fortunate and am honored to call myself an academic physician.

Steven R. Gambert, M.D., AGSF, MACP is Professor of Medicine and Co-Director, Division of Gerontology and Geriatric Medicine, University of Maryland School of Medicine and Director of Geriatric Medicine, University of Maryland Medical Center and R. Adams Cowley Shock Trauma Center.

My Life of Practicing Medicine...

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I might even be working a little harder. I have financial security. I truly believe in the type of medicine I am now practicing. I joined Kaiser Permanente of the Mid Atlantic. I feel my practice is now on the cutting edge of care. We are technologically very advanced. I am available to my patients by secure (HIPAA compliant) e-mail which my patient's love. I trust in the system and the vision that this is the best way to practice. This is a personal choice. It might not work for many physicians but it does for me.

Our hospitalists care for my inpatients. We have our own physicians caring for my patients in nursing facilities. I remain a crucial part of the continuum of care. In looking back I've practiced medicine in the military, in a medical school setting, in a rural environment, in a larger

metropolitan area, as a solo practitioner, with a small group and a larger group practice, and finally with Kaiser Permanente. I don't view my role at Kaiser like the old HMOs. I'm part of a futuristic, technologically advanced medical system – a system focused on providing high quality personalized care. Even as I enter the last stages of a quite varied career I continue learning something new every day. I learn not only about areas of medicine, but in delivering care in a highly efficient, patient-centered, and technologically advanced way. The quality of the care I give is not just my perception or interpretation. Standards and goals are set. I review the goals and change my behavior. Is this difficult? You bet! Is it better? Definitely! Do my patient's like the care? Indeed!

Phillip F. Mac, M.D., is a Mid-Atlantic Permanente Medical Group primary care physician who practices at Kaiser Permanente's Towson Medical Center.



Keeping Kaiser Medicine in the Family

Bruce Wollman, M.D.

Without hyperbole, I have been associated with Kaiser Permanente since I was three years old. My father was a proud Permanente Medical Group urologist in San Diego, California, for his entire career, and I joined The Permanente Medical Group in Northern California as a staff radiologist, literally the day after I completed my radiology residency training at Stanford University Medical Center. When I started my career at Kaiser Permanente, I enjoyed that I could just come to work and provide great patient care without having to worry about the non-clinical aspects of the practice of the modern medicine. Instead of being concerned about the obstacles and paperwork created by insurance companies, I was simply a physician devoting all my time at the office caring for patients. As I became increasingly involved in leadership positions, I was not surprised to learn that the worries that keep me up at night would be the same worries that our patients might have in terms of their own health. Society has become increasingly fast paced, and if a person can expect their dry cleaning to be done the same day, then it is certainly not unreasonable for them to want perhaps more important matters, such as a needed ultrasound or CT scan, to also be available with such rapidity. In our model of integrated multi-specialty practice, without the burdens of insurance pre-authorization it is my responsibility to put systems in place that will allow patients to have their needed testing done on the same day as their initial examinations to make it as convenient for them as possible.

Although offering these services may not always be most convenient for me as the radiologist, Kaiser is now providing real time radiology coverage 24 hours a day every day of the year. I know that if my family needed this kind of coverage, I would certainly want one of my Kaiser Permanente radiologist colleagues to provide this service, and therefore I feel it is my duty to provide this as well to our patients. I am fortunate to be able to work with a fantastic group of physicians, and it is an honor and a pleasure to know that my radiology department allows our clinical colleagues to best provide outstanding care for their patients. Like my father, I am proud to be a Permanente Medical Group physician.

Bruce Wollman, M.D., is the Regional Medical Director for Imaging Services, Mid-Atlantic Permanente Medical Group.



The Joy of Personal Patient Interactions

Carl Segal, M.D.

I have been in a solo, private medical practice in Columbia, Maryland for 40 years. Before that I served in the U. S. Army for 10½ years (senior medical student program through post-residency training), Chief of Mental Health Services at Fort Benning, Georgia, and finally as Chief of the Department of Psychiatry in the Division of Neuropsychiatry at Walter Reed Army Institute of Research. I also was Director of the Bureau of Mental Health and Addictions in the Howard County Department of Health for 5½ years. Now, at age 77, almost 50 years after graduating from the Jefferson Medical College of Thomas Jefferson University, I have no plans to retire from active, full-time practice. It has brought me personal fulfillment and happiness both for its intellectual stimulation and because I am able to provide help to so many people. I enjoy what I am doing more than I would enjoy retirement.

I decided to become a physician after recovering from meningococcal meningitis during my freshman year in pharmacy school. I decided to enter psychiatry because I was fascinated by the psychotropic drug revolution that began when I was a pharmacy student (Thorazine, reserpine, MAOIs, Equanil, etc.) I also was attracted to psychiatry because my father suffered from severe bipolar disorder. I had a personal perspective being a member of a family struggling with mental illness, as an early advocate of psychopharmacology (when Freudian psychology was the “gold standard”), as a military and civilian community psychiatrist, and as a community-based, solo practitioner. Each of these activities has broadened my understanding both of psychiatry specifically and medicine in general. I still love what I do and, even in retrospect, wouldn’t want to have entered any other profession.

The major challenges that I face today are: (1) maintaining a practice that recognizes the wholeness of patients and allows me to provide both psychotherapeutic and psychopharmacologic treatments as appropriate to a patient’s needs – rather than having treatment directed by what an insurance company dictates; and (2) continuing to provide care to patients covered by Medicare – in light of the low reimbursement policies. I have mixed feelings about the future of medicine. On the one hand I have no doubt that there will be enormous, positive changes in our understanding of disease processes. The expansion of our understanding and clinical use of genes and their interactions, imaging techniques, biomedical instrumentation and the development of innovative pharmaceuticals will change the outcomes of our interventions dramatically. On the other hand, much of medical practice deals with the travails of the human psyche. A great many of the problems presented by patients to psychiatrists, primary care physicians and other health care providers deal with psychological aspects of the human condition. I do have concerns about how these problems will be addressed.

Under the pressures of becoming more “scientific” and facing the economic realities of providing quality care to an increasing

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There is Still So Much Work to Do

Richard C. Shoemaker, M.D.

My 35th medical school reunion is coming up. Most of my classmates at Duke University School of Medicine are retired. I am still in solo practice in Pocomoke, Maryland—far down Route 13 on the Eastern Shore. I have been here since 1980. I see no retirement in sight; there is too much to do.

My practice might be unique in “The Old Line State.” I gave up my practice in family medicine in 2002 to work on a group of illnesses that were poorly defined and poorly understood. Was making such a decision part of a mid-life crisis? Was it professional suicide? No it was not! My new career has been the most rewarding experience, both intellectually and emotionally, in medicine that I have experienced. I traded a high-volume, primary care practice to research the underlying mechanisms in illnesses that are the medical orphans of the 21st century. Instead of seeing 50 patients a day, now I might see five. Instead of being delayed for later appointments if one patient told me about an unscheduled, hidden agenda, now I spend two hours on new patient visits. Instead of having a nice afternoon off I often end up doing literature searches or talking for hours in depositions.

The illnesses I study and help my patients maneuver are contentious enough: mold, Post-Lyme Disease, Ciguatera, Fibromyalgia and Chronic Fatigue Syndrome are all on the short list of those I (and my patients) are dealing with. No wonder so many attorneys (personal injury and disability alike) are contacting my office and me. Just 10 years ago though, who could show the mechanisms of inflammation these illnesses all have? Now we can. And now that the mechanisms by which abnormalities in innate immunity develop in these patients are defined, and they are all chronic inflammatory response syndromes (CIRS), successful therapies can follow. Seeing someone affected by exposure to a moldy building, for example, return to productive life after 10 years of a functional disability brings a sense of joy different from the professional pleasures from my earlier medical life. I used to treasure the feeling that came from helping a three-year-old survive ear infections, mononucleosis, growing up, marriage and parenthood. I still do. The two phases of my medical career have reinforced my belief that physicians can truly make a difference in society.

But I cannot give up what I am doing now to go back to the insulting demands faced every day by current primary care physicians. Look at the family physician now: “Fill out this form; make this referral; do the history and physical for the Baltimore surgeon caring for the new HMO patient; fill out these prescriptions and fax to Medco Pharmacy since the specialist is too busy to do so. Oh, and you need to put new codes on a billing form and keep a fat chart full of duplicated verbiage from the EHR.” These demands are bundled into the office visit fee.

No thanks. I am not a utility company. I am a person (and so are my patients).

Instead, I seek to know why T regulatory cells that are induced by high levels of TGF beta-1 can change in tissue affected by high IL-6 and IL-17 to become pathogenic T cells, ones that add to the burden of humoral inflammatory mediators. I get to see the very worst chronic fatigue patients regain health. And I get to write the

IRB applications that let me do such work. Some days, I feel invigorated by such excitement, but face it, there are the days when people aren't getting better and the defense counsel in the big case in Georgia just produced an affidavit from a guy who has never treated anyone with illness from a water-damaged building that attacks me viciously. Those days are fewer now that the research group I work with has published a lot of good studies, yet they will occur predictably in the future. If one wants to avoid being bitten by snakes, a good idea is to not step into snake pits.

Still, when we see compounds made by biofilm-forming staphylococci producing substances that affect differential gene activation, and we do, the personal impact of attacks from the insurance companies is lessened. If commensals of previously benign staphs now affect our genomics, what other organisms we don't know about are doing things we haven't even dreamed of? The time for meaningful dialogue with colleagues is never enough; the time to see beyond what we thought was true about inflammation and illness just five years ago is always too short. A physician's learning is never done.

I can't retire, not just yet.

Richard C. Shoemaker, M.D., is a family practitioner in Pocomoke, MD, and he specializes in biotoxin illnesses.

The Joy of Personal Patient Interactions...

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number of patients, I fear that the personal relationships between physicians and patients will be severely damaged. Insurance programs that relegate primary care physicians to “interchangeable cogs in the medical wheel” and deny the value of long-term physician-patient relationships will negatively impact medical care. Some patients must change their primary care physicians almost yearly as employers seek lower cost insurance for their employees, and in the process change the physician panels available. Insurance reimbursements that dictate eight minute allocations of a primary care physician's time per visit and limit face-to-face “talk time” will harm medical care. Insurance companies that increasingly tell physicians how to practice medicine will continue to harm medical care. My concern is that the caring, mutually trusting aspects of medicine will diminish substantially, to the detriment of the care we provide to the vast majority of our patients. I fear for the time when a few nationwide insurance companies will own most hospitals and most medical practices, and physicians will become employees of insurance companies. I fear the time when insurance companies, driven by Wall Street's demand for profits, force physicians to relegate compassionate caring for patients to the dustbin of history.

Even as I foresee the ongoing deterioration of the physician-patient relationship, I will continue to strive to treat those who entrust their care to me in a manner as professional, caring and thorough as possible – and continue to sleep well.

Carl Segal, M.D., practices psychiatry in Columbia, MD.

MedChi to Focus on Public Health and Public Safety in 2012 Session

Gene Ransom III, J.D., CEO, MedChi, The Maryland State Medical Society



The mission of MedChi, The Maryland State Medical Society, is to serve as Maryland's foremost advocate and resource for physicians, their patients and the public health. To that end during the 2012 General Assembly Session MedChi has unveiled an aggressive legislative agenda. MedChi will continue its longstanding commitment to improve the Maryland malpractice climate and defend current tort reform protections, such as the cap on non-economic damages and contributory negligence provisions. MedChi will continue to work to improve the dismal payment climate for physicians in the Mid-Atlantic region. Maryland is documented as one of the worst states in the nation for physician payment. However, this year more than ever the focus will be on the patient and public health. Issues we intend to address this session include protecting children, preventing prior authorization, improving Medicaid, improving the Board of Physicians, and promoting Truth in Advertising.

Protecting Children

In 2012 the MedChi public health agenda will focus on important legislative changes to protect children. We will work to improve Maryland's child safety seat law, and protect minors from the dangers of tanning beds. Safety legislation often raises objections from those who believe people should be free to make their own choices even if it imperils themselves, their family members or the public. Parental autonomy is a common objection to laws that compel parents to take prescribed actions with regard to their children. However, in both of these cases the potential damage to children far outweighs those concerns.

With regard to bringing Maryland law into compliance with the federal standard for child safety seats, some will argue that seats that provide room for rear-facing until age two are too expensive or not

readily available for all families. However, the new recommendations are based on significant and compelling scientific evidence that will save children's lives. The seat position and elimination of current weight parameters do not require families to expend funds and dramatically increase the safety of our children.

The case is just as clear for our objective to ban tanning bed access for people under the age of 18. Millions of adolescents use indoor tanning facilities and nearly 25 percent of indoor tanning users are 13 to 19 years of age. The use of such tanning devices early in life is linked to an increased risk of melanoma later in life as tanning devices have UV radiation levels that far exceed that found in natural sunlight. A person who uses a tanning device for more than 50 hours is 2.5 to 3 times more likely to develop melanoma than a person who has never tanned indoors. Indoor tanners are 2.5 times more likely to develop squamous cell carcinoma and 1.5 times more likely to develop basal cell carcinoma than non-tanners. Because of the significant health risk to young people from indoor tanning, coupled with its popularity, particularly girls and young women, it is critical that the law protect those under 18 years of age from the health problems associated with indoor tanning. California has recently enacted legislation to do just that and Howard County, Maryland led the nation by prohibiting the use of tanning devices by minors under the age of 18 a number of years ago.

Proponents of indoor tanning argue that it is a good source of Vitamin D, however, this is false and misleading since Vitamin D is produced by UVB rays as opposed to the UVA rays emitted predominantly by modern tanning devices. A safe way to secure adequate Vitamin D is by use of an oral supplement. The supposed "health benefits" urged by the indoor tanning industry are in direct violation of a January 2010 Consent Order that the Indoor Tanning Association and its affiliates entered into with the Federal Trade Commission which

forbids them from making health benefit claims in their advertisements without giving warnings about skin cancer. These are the same sorts of warnings that are required on cigarette packages.

Preventing Prior Authorization

Insurance carriers and pharmacy benefit managers (PBMs) impose various "preauthorization" requirements before a physician is able to obtain needed pharmaceuticals or medical services for his or her patient. Countless hours of administrative time in a physician's office are spent in securing preauthorization approvals. In almost all cases, the preauthorization is approved but only after considerable delay and administrative expense. MedChi will work to eliminate or at a minimum improve the prior authorization process.

MedChi is working to enact legislation to require insurers and PBMs to have systems in place which would simplify and accelerate preauthorization approvals. Each insurer or PBM should have electronic approval systems that are compatible with the statewide health information exchange network, Chesapeake Regional Information System for Our Patients (CRISP), and that provide real time approvals of pharmaceutical products and medical services. Insurers and PBMs would be required to keep data documenting their approval/rejection ratio. Moreover, insurers would have to post the clinical criteria for their approvals of medical services. The carriers and PBMs object to any time constraints or any requirement imposed on them by law. They say such requirements are "premature" and they are "working on it" and will have electronic systems in the near future.

Improving Medicaid

Maryland is facing significant fiscal challenges which place the Medicaid pro-

gram at great risk for funding cuts, including additional payment rate reductions. Physician shortages, low payment rates and inadequate physician participation in the program threaten the state's ability to provide adequate access to high quality health care for Maryland's low income citizens. Physician participation becomes especially critical with the increased enrollment that will result from the implementation of federal health care reform but without funding and new program initiatives, physician participation is unlikely to increase.

To ensure adequate physician participation in Medicaid, it is essential that Maryland actively pursue programs to increase the recruitment and retention of physicians in Maryland. An essential component of that effort must be fully funding Maryland's Loan Assistance Repayment Program that was enacted into law in 2009. Maryland must also identify means to increase payments for physicians serving Medicaid recipients concurrent with efforts to enhance the quality of care rendered through the program. These objectives can be met through the implementation of alternative payment mechanisms and delivery systems such as "shared savings" and the medical home network model.

Physician payment has frequently been an easy target for quick savings. Managed care organizations (MCOs) which face potential rate cuts may also look to physician payments to recoup the funds lost through rate reduction. Further, alternative payment mechanisms and delivery system models like the medical home network create competitive environments for the MCOs. This increased marketplace accountability may cause the MCOs to oppose changes or alternatives to the current delivery system model. Fiscal constraints also make funding the Loan Assistance Repayment Program difficult. The state continues to look for avenues to include the program in the federal hospital waiver. Creative mechanisms to accomplish that end should continue to be encouraged.

Improving the Board of Physicians

In 2012 MedChi will also work to enhance legal protections for physicians to ensure that the Board's disciplinary process is fair, transparent, and results in the consistent and efficient resolution of complaints with adequate due process protections.

In November the Maryland State Legislative Auditor released a report expressing concern about 47 operational items at the Maryland Board of Physicians. The report prompted Department of Health and Mental Hygiene Secretary Josh Scharfstien, M.D., to request an independent review of the Board of Physicians. MedChi supports the review.

In a letter to Maryland Board of Physician's Chairman Paul T. Elder, M.D., MedChi President Harry Arjawat, M.D. expressed support for an independent review of the Maryland Board of Physicians. Dr. Arjawat wrote, *"we support Secretary Sharfstein's efforts to bring in Jay Perlman, M.D., President of the University of Maryland Baltimore Campus (UMBC), to further review the Board's operations and make recommendations for improvement. MedChi stands ready to assist in this effort however it may. A proper balance must be struck between affording the public the safety it deserves from physicians who do not act appropriately, and at the same time ensuring that physicians are treated properly and that their regulatory board is functioning fairly and efficiently."*

MedChi is currently reviewing the findings contained in the Sunset Evaluation of the Board of Physicians ("Board") conducted by the Department of Legislative Services. While, MedChi's review of the report is not yet complete and the Board will have an opportunity to respond to the findings, we are troubled by a number of issues raised in the evaluation. Primarily, certain issues raised are recurring, including the number of days it takes to bring cases to resolution. The evaluation notes certain improvements in this area, but it also states that with respect to standard of care cases, the number of days it takes to investigate those allegations has increased by 14 percent between 2007 and 2010. From the perspective of the physician that is being investigated, as well as the patient whose concern prompted the complaint, 452 days is an inordinate amount of time of uncertainty.

Related to the disciplinary concerns we will raise is the General Assembly's 2010 requirement that the Board adopt sanctioning guidelines; it has not done so. The purpose of these guidelines, as noted in the evaluation, is to ensure that once a physician has been charged and adjudicated, the sentence imposed is consistent with similar infractions. Both the public and the physician community have a right to

know what to expect when certain conduct is sanctioned, but that information will not be known until guidelines are developed.

Though we do not believe it is raised in the evaluation, MedChi also believes that a physician should have the right to have a disciplinary record expunged under reasonable circumstances and after a suitable period of time. Simply put, if a criminal is entitled to such a right, so should a physician.

MedChi recognizes that the Board's funds have been utilized by the General Assembly for other purposes on numerous occasions, and that this has reduced the Board's resources, but nevertheless efforts must be undertaken to curtail this problem.

Promoting Truth in Advertising

MedChi's newest legislative proposal is patient protection legislation to inform health care consumers. Patients are often confused about the differences in various types of health care professionals. Often, patients mistakenly believe they are seeing medical doctors when they are not. For example, in a recent survey many non-physicians were identified as "medical doctors" by a significant percentage of the respondents including podiatrists (67 percent), psychologists (49 percent), chiropractors (38 percent), and audiologists (33 percent). Respondents believed that these providers were medical doctors.

Additionally, patients are not confident about the truth of health advertisements and confusing and misleading ads undermine the reliability of our healthcare system. A majority of surveyed respondents did not think it was "...easy to identify who is a licensed medical doctor and who is not by reading the services they offer..." and 48 percent were not "confident" that health care professionals advertise and provide services for which they are properly trained. Ninety-six percent of the survey respondents felt that "medical doctors and non-medical doctors should be required to clearly state their level of training and licensing in all advertising and marketing materials."

All health care professionals – physicians and non-physicians – should be required to accurately and clearly disclose their training and qualifications to patients. This can be easily accomplished by enacting legislation with two main provisions. First, the health care practi-

tioner should wear a name tag during all patient encounters that clearly identifies the type of license held by that practitioner. Second, the health care practitioner must display in his or her office a writing that clearly identifies the type of license held by the healthcare practitioner.

The above represents the most important physician issues that will be on the radar screen in Annapolis during the 2012 legislative session. MedChi will continue its mission to serve as Maryland's foremost advocate and resource for physicians, their patients and the public health of Maryland, and this agenda shows we clearly deliver. To review the complete MedChi legislative agenda for 2012 or for more information, please visit www.medchi.org.

Gene Ransom III, J.D., is the CEO of MedChi, The Maryland State Medical Society. He can be reached at gransom@medchi.org.

Dispose of Your Medicine Safely and Say “No” to Bullying

Mano Nava, MedChi Alliance President

The Alliance to MedChi wants to thank everyone at MedChi, The Maryland State Medical Society, for all their support and collaborative efforts with the Safe Disposal of Medicine Project. The latest result of these efforts was the gubernatorial proclamation for the “Clean Out Your Medicine Cabinet” weekend in October.

Please remember:

- Keep an inventory of all medicine.
- Store all medicine in a secure place.
- Dispose of unneeded or expired medicine at a “take back” site or by following FDA guidelines.*
- Take all medicine exactly as prescribed.
- Never give your prescribed medicine to someone else.
- Talk to children about the dangers of prescription and over-the-counter drug abuse.
- Place pills in a sealable container, such as a plastic bag.
- Mix with coffee grounds, sawdust, kitty litter, etc.
- Seal the bag and place in the trash.
- Remove personal information from the empty medicine container before recycling.
- The FDA maintains a list of controllable substances that should be thrown in the trash.

*If no “take back” site is available and medication must be disposed of in the trash.

Please contact the Alliance to MedChi at 800.492.1056, ext. 3350 or 3304, alliance@medchi.org, or visit our website at www.medchi.org/about-medchi/alliance for educational materials. Michele Kalish is chair of the Safe Disposal of Medicine Project.

For those who may think that bullying is a minor problem not affecting many children, consider the fact that more than 160,000 students miss school every day out of fear of attack or intimidation by other students. That number comes from the PACER Center, a parent training and information facility for families of children and youth with disabilities from birth through 21 years of age. Children who are bullied are more likely to develop depression and anxiety disorders that can last a lifetime. In some cases, bullying has led to suicide. A mother, whose son committed suicide after being bullied, advises parents: “Accept your children for who they are and get involved in their lives. If you notice signs they are acting differently, ask them how things are going at school. They will probably not want to open at first, but if you have a feeling in your gut that something is wrong, show them you care by asking questions.”

The school boards and administrators are implementing strict anti-bullying policy. Please tell children who are being bullied to tell their parents and encourage them to meet with the school counselor or principal.



University of Maryland School of Medicine Increases Medical Student Education in Primary Care

Richard Colgan, M.D., Linda Lewin, M.D., Nikkita Southall, M.D., Mozella Williams, M.D., and Claudia Baquet, M.D.

Abstract

In August 2012 the University of Maryland School of Medicine will start a new Primary Care Track for incoming first year medical students as a collaborative program of the departments of Family and Community Medicine, Internal Medicine, and Pediatrics. Its focus will be to introduce all students to primary care role models early in medical school, and to offer a longitudinal experience in primary care in rural and urban underserved communities to interested students, with the intention of increasing the number of UMD medical students who choose primary care careers in these communities.

Introduction

Nationwide, fewer medical students are choosing careers in primary care, and this trend is also present in Maryland. When career choices by medical students are studied, it is noted that many medical students express an interest in primary care in their preclinical years, but this interest wanes for some as they proceed into their clinical years. In response, the University of Maryland's Department of Family and Community Medicine created a Family Care Track (FCT) in 2007 with partial funding from the Maryland Academy of Family Physicians. [1] This longitudinal experience in years one and two has allowed students an opportunity to work alongside family physicians that practice in underserved areas of the state. The FCT has been successful by many measures. In 2010 twenty five percent of the incoming medical school class applied to be in the FCT. In 2011 thirty three percent applied. In 2011 we saw the graduation of the first class of students who matriculated in the FCT. Of the 17 students who completed the FCT 36 % chose family medicine and 73% choose any primary care specialty.

At the same time that fewer students are choosing primary care, Maryland is facing both physician and other health workforce shortages. A comprehensive 2008 study conducted by the Maryland Hospital Association (MHA) and MedChi (The Maryland State Medical Society), revealed that Maryland "is 16% below the national average for the number of physicians in clinical practice." The most severe problems occur in rural parts of the state and will worsen by 2015, based on the study's findings. The situation in Southern Maryland, Western Maryland, and the Eastern Shore—rural areas of the state—is the most alarming. All of these underserved areas are likely to benefit from enhanced primary care education among UMD medical students, many of whom go on to practice in the state.

Building on the success of the FCT, the Departments of Family Medicine, Internal Medicine and Pediatrics are collaborating to create a new Primary Care Track, thanks to a grant from the Health Resources and Services Administration (HRSA). With the recently awarded five year grant, lead investigator Dr. Richard Colgan (Family Medicine), and co-investigators Drs. Linda Lewin (Pediatrics) and Nikkita Southall (Internal Medicine) put together an ambitious academic program which will allow students interested in primary care to gain hands on experience throughout their four years of medical school with the hope of providing increased exposure to primary care early in the education of its students. Support for this project has come from University of Maryland School of Medicine's Dean E. Albert Reece, and the respective chairs of the Departments of Family and Community Medicine, David L. Stewart, M.D., MPH, Internal Medicine, Stephen Davis, M.D. and Pediatrics, Stephen Czinn, M.D. This grant received important support as well from Associate Dean for Health Policy and Planning and Director of Maryland AHEC, Claudia Baquet, M.D., State Delegate John P. Donoghue, as well as the Regional AHEC Executive Directors Susan Stewart, Jacob Frego and Susan Sweitzer.

Focus on Primary Care

The focus of the Primary Care Track will be to introduce all students to primary care role models early in medical school and to offer a longitudinal experience in primary care in rural and urban underserved communities to interested students. The goal is to increase the number of UMSOM students who choose careers in primary care by: 1) connecting first year students with primary care physicians in urban as well as rural underserved communities and create the opportunity for longitudinal mentorship and clinical experiences with them; 2) educating them early about important topics in primary care and community health; and 3) culminating with a capstone project that will be presented to all first and second year students during a new Primary Care Day to allow the senior students to act as role models for their colleagues.

Maryland Area Health Education Centers

The Maryland Area Health Education Center Program (MAHEC) will be a close partner with the co-principal investigators, and Dr. Mozella Williams will act as the liaison between the AHEC physicians and the program leaders as the Community Health Relations Coordinator. The role of the AHECs and more specifically, the community preceptors who offer their time to teach students through the coordination of the AHECs, will be critical to the success of this program. Some information on the MAHEC's follows:

The Eastern Shore Area Health Education Center (Eastern Shore AHEC), a private, non-profit organization, was established in 1997. A key accomplishment of the Eastern Shore AHEC is the continued success of its clinical education program. One of its most successful partnerships is with the Geriatrics and Gerontology Education and Research Program at the University of Maryland Baltimore, providing two interdisciplinary symposiums yearly focused on key geriatric issues.

The Western Maryland Area Health Education Center (WMAHEC), established in 1976, is the longest running of the state's three area health education centers. WMAHEC works closely with its Maryland AHEC Program Office, local health departments, hospitals, federally qualified health centers, and many other community partners, as well as the National and Maryland Rural Health Associations, to address its Appalachian region's healthcare disparities.

Baltimore City Area Health Education Center, established in 2003, is the newest of the three AHECs in Maryland and serves Baltimore City and Baltimore County. BAHEC builds and strengthens inner-city capacity to serve low income and under-served populations via its clinical education program. The later program places 4th year medical students into primary care practices in underserved areas for a four to eight week rotation.

The Primary Care Track Curriculum

The Primary Care Track will have a longitudinal curriculum that will allow for relationships between interested students and primary care physicians over the course of their entire medical school experience. Students will be assigned mentors from one of the AHEC sites early in the first year. They can choose the primary care discipline that they would like to pursue, or remain undecided. This physician will be the student's primary mentor. If the primary mentor practices in a far-off location, the student

will also have an "in town" preceptor. Each student will spend one afternoon each month in the office or clinic of one of those preceptors throughout the first and second years of medical school, and twice each year they will have sessions in the practices of physicians from the other two primary care disciplines in order for all PCT students to gain familiarity with family medicine, internal medicine, and pediatrics.

First and second year students will also participate in a once monthly lecture series in which topics of importance to primary care physicians will be presented using university-based experts as well as outside speakers. Topics will focus on health policy issues such as health disparities, health care funding, workforce issues, medical home initiatives, and care for vulnerable populations. Once each quarter, all PCT students will attend a Primary Care Grand Rounds session during which a primary care case will be presented and appropriate discussion with experts will occur. AHEC preceptors will also participate in Grand Rounds via video conference and student-preceptor pairs will work together after the session to respond to a question that is posted on the program website.

During the summer between first and second years all PCT students will spend at least two weeks with a primary care physician in an underserved community. For those students whose primary mentors are in rural AHEC sites, those two weeks can be spent in those rural practices. The PCT program is working toward offering its third year students the ability to do one of the following three ambulatory clerkship experiences in an AHEC site: the four week family medicine clerkship, the four week ambulatory internal medicine rotation, or the three week ambulatory pediatrics rotation. Students will be placed in these sites based on the availability of the preceptors.

In the fourth year, students will do one month of their two-month required AHEC rotation in the same AHEC site that they have been attached to since the first year. The second month will be spent pursuing a substantive capstone project that will result in a presentation to the first and second year students during Primary Care Day, in May of the fourth year.

In Conclusion

With HRSA funding we will be able to connect beginning medical students with primary care physicians in underserved areas across Maryland, and create longitudinal relationships that can help sustain the students' drive to practice primary care, even in the face of the specialty care that they see during their medical school training. We anticipate being able to show our state legislators that this is a viable model for addressing our physician shortage, and have already begun speaking with them so that this project will be sustained beyond the grant.

* Primary care physicians practicing in underserved areas of the state of Maryland who are interested in serving as preceptors for the Primary Care Track are encouraged to contact the authors.

Affiliated with the University of Maryland School of Medicine in Baltimore, MD, Richard Colgan, M.D., is Associate Professor and Director of Medical Student Education, Dept of Family and Community Medicine; Linda Lewin, M.D., is Associate Professor and Educational Division Chief, Department of Pediatrics; Nikkita

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Nicholas P. Foris, M.D.

HARFORD COUNTY

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Santiago L. Garza, M.D.
Roger L. Raiford, M.D.

WASHINGTON COUNTY

Edmund V. Niklewski, M.D.
Frank B. Thomas III, M.D.

L E T T E R S

With Apologies to Elvis!

After reading your last issue, I found myself haunted by an old Elvis song...and this is the tasteless result:

Well bless my soul, what's wrong with me. I'm hung up on this thing called Quality.

The Feds say it's time for me to shape up, but I'm stuck. I'm all shook up.

There's quality this and quality that so I feel much like a tin roof cat. So please don't ask me what's on my mind. I'm a little mixed up and I don't feel fine.

When I see those rules in the news pipeline, I start to feel ill, I need some wine.

When off to school to get my M.D., the dean said zip about quality. Just know your stuff and score 93 and if you get your degree, you should emulate me.

When passing the boards and setting up shop, this Quality stuff was never brought up.

Just make the right call and treat the whole person...then keep the primary up to snuff...make sure the referrers were well informed... and don't screw up.

Now that was quality pure and simple. And it didn't take an hour to document a pimple.

So excuse my rust but when I read your mag, I feel creaky and ancient work is a drag.

Just when I'm peaking in clinical acumen, along come idea men to better us all with a tightrope agenda but compliance requires the skill of Wallenda.

I've conformed and conformed, but now that I'm shook, I'll look to you leaders to rewrite the book. Hold off those bureaucrats! Make their pens cease! So me and my patients can go live in peace. (with apologies to the King and to the lyrically challenged)

A. Kerr Mudgeon, M.D.
Baltimore, MD

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

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Words and Symbols

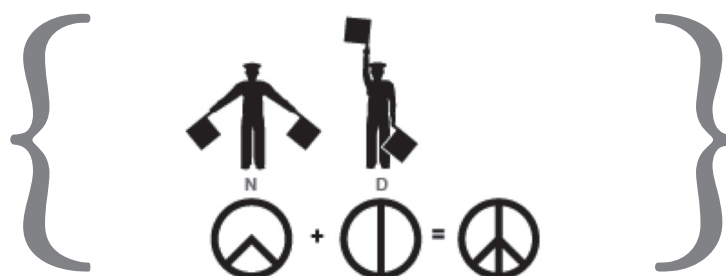
WORD ROUNDS

In the 11th century B.C.E. a tribe of Ephraimites crossed the Jordan River and invaded the land of the Gileadites. Unfortunately for the Ephraimites, the Gileadites won an overwhelming victory. Surviving Ephraimites, seeking the safety of home, tried to recross the Jordan. Gileadites, anticipating this retreat, stationed men at every ford to intercept the fleeing Ephraimite soldiers. Since it was impossible to identify an Ephraimite by his physical appearance, the Gileadites utilized a simple language test. In the Ephraimite lexicon there was no pronunciation for the sound “sh” (as in the word shoot). Ephraimites pronounced such words with a sibilant “s” (as in soft). Therefore, the Gileadites would ask each traveler to pronounce the Hebrew word **shibboleth** (meaning “a stream or torrent of water”). Ephraimites would respond by saying “sibboleth,” thus exposing their identity. The Hebrew bible tells us that “42,000 Ephraimites fell on this occasion” (Judges 12:5-6). The term **shibboleth** thus came to mean a word or phrase that distinguishes one’s regional, social, or group identity. As the years have passed, shibboleth has developed a somewhat pejorative sense. Currently, it is usually thought of as an obsolete motto, or catch phrase.

During World War II, American soldiers utilized a similar test to discriminate between Japanese infiltrators, and our Philippine or Chinese allies. They asked each person to say “lollapalooza.” Japanese soldiers were not able to pronounce the letter “L,” responding with something like “rorroparooza, thus identifying themselves. (The origin of the term lollapalooza is unknown, but was probably a fabricated nonsense word. In 1991, singer Perry Farrell inaugurated a three-day music festival for heavy metal, punk rock

and hip hop bands, which, for reasons best known to him, he called Lollapalooza. The festival still exists.)

A millennium after the Ephraimite



disaster and not far from the site of that battle, an incident occurred that has played a major role in the development of western culture. On a hill just outside the city of Jerusalem, Jesus of Nazareth was crucified. The hill resembled the outline of a human skull and was called **Golgotha**, which in the Aramaic language meant “skull hill.” When the New Testament was translated into Latin, that name became **Calvary**, since the Latin for the “upper dome of the skull” is *calvaria*.

The word **Calvary** has occasionally been confused with **cavalry** – an army mounted on horseback. **Cavalry** stems from Latin *caballus*, which means “work horse.” As Romance languages evolved, the Italian word became *cavalier* and was defined as “one on horseback.” As a noun, **cavalier** designated a knight, one who was gallant and courtly. Regrettably, some of these knights were rather disdainful of the commoners around them, so the adjectival form of **cavalier** has come to mean one who is contemptuous and supercilious – a “cavalier attitude.” (The term **supercilious** derives from Latin *supra*: “above” and *cilium*: “the eyelid,” meaning the **eyebrow**. A supercilious expression is often one in which one eyebrow is raised.) As *caballus* evolved into French, it became *chevalier* and the image

of that fearless but courteous knight, has given rise to our word **chivalry**. In Spanish, the Latin *caballus* morphed into the word **caballero** – a Spanish horseman/gentleman. (In 1940, a young actor named Cesar Romero played the role of the Cisco Kid in a movie titled *The Gay Caballero*. In that context, the term “gay” actually meant “happy”).

The word **cross** is derived from Latin *crux*, descriptive of an upright post with a bar crossing the post at a 90 angle. In addition to the historic Latin or Roman cross there are several additional types, including the Greek, St. Andrews, Maltese, and Tau crosses. The **Crusades** were a series of religious wars between 1095 and 1291, conducted by the Catholic Church under the emblem of the cross – the basis for the term Crusades. To **crucify** is to nail someone to a cross, and **excruciating** pain is the agony experienced while being crucified. A **crucial** decision is one occurring at the crossroads of two conflicting possibilities. A **cruciate** ligament has crossed fibrous bands that help to stabilize a joint, and a **crui**se implies a voyage in which one travels seaward on one route and returns on another, thus creating a metaphorical “crossing” of these paths. Certain place names make use of the concept of a cross: **Las Cruces**, New Mexico and **Vera Cruz**, Mexico are two examples that come to mind. Las Cruces means “the crosses.” At that site in the early 1600s, a Mescalero Apache raid killed many Spaniards. Afterward, several crosses were erected at gravesites, giving rise to the name Las Cruces. Vera Cruz was founded by Hernan Cortes in 1518. Its original name was *villa rica de la Vera Cruz* – “rich town of the True Cross.” I suspect by now you have grasped the etymological **crux** of these words.

continued on page 33

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GLEN BURNIE: Office space for lease. Empire Medical Bldg. 200 Hospital Drive. Glen Burnie, MD. 21061 (across from BWMC). 862. sq.ft. Call 410.766.5552.

GREENBELT: Brand new office, 1250 sq.ft. to share, to lease or to lease with option to buy. Conveniently located 2 miles from Doctor's Community Hospital. Near intersection of Beltway (I-495) and BW Parkway (I-295), on Greenbelt Road (Rt. 193) across from NASA. Please call Paul at 301.299.9571 or email PWang@MRIS.com.

MONTGOMERY VILLAGE: For rent. GYN office located in Montgomery Village Professional Center. Available for sublet. Other specialties welcome. Each 4 hour usage is \$200. (Monthly \$800). Call Nina Vann Jeanes, M.D., at 301.670.1873.

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SILVER SPRING/WHEATON: Lower your overhead expenses by subleasing or sharing medical office space. Luxurious penthouse suite with 3200 square feet, 7 treatment rooms, surgery center, equipment and staff available. All medical specialties welcome. Call: 301.949.3668.

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TOWSON: Office space: 1800 sq ft with 3 exam rooms available for part time sublease in the Odea Bldg at 7505 Osler Dr., Towson. Call 410.321.0882.

TOWSON: 2,087 square feet of second floor medical space available for lease at 660 Kenilworth Drive (directly across from Towson BMW). Suite is fitted for medical professional and landlord will build out to suit tenant's needs. Lease rate includes full utility and janitorial service. Attractive two story professional building with convenient and ample free parking. Caring on-site ownership and management. Excellent access to I-695, I-83, Timonium and downtown Baltimore. To discuss or see, call David Miller at 410.321.9558.

Words and Symbols...

continued from page 31

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As Christianity blossomed, monophonic liturgical music was developed to accompany the religious services. Until the Middle Ages no system of musical notation existed by which a vocalist could easily learn a melody. Choir members were thus taught by listening to someone who already knew the music. In the absence of such a melodic *cynosure*, singers were not able to determine the correct melody. (**Cynosure:** "focal point of attention and admiration" or "something that serves to guide," derives from the Greek *kyon*: "dog" and *oura*: "a tail," that is "a dog's tail." This was the original name for the constellation **Ursa Minor** – the Little Dipper. To the ancient Greeks this constellation resembled a dog's tail rather than a drinking gourd. As an aid to navigation the constellation was closely scrutinized by sailors and others, since the North Star sits at the tip of that tail. Thus a *cynosure* is someone or something that is the center of attention or acts as a guide.)

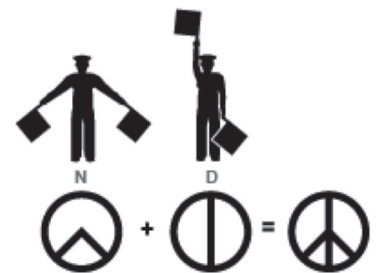
Since church choirs had no system of musical notation, a Benedictine monk named Guido of Arezzo (991-1050 C.E.) developed a new method for recording pitch using lines, spaces, and symbols. His method, slightly altered, is still utilized today. Arezzo's principal duty, however, was not to write music but to organize and train choir members. To simplify their learning process, he developed a mnemonic by which chorus members could quickly learn the music. There was a well-known liturgical hymn extolling John the Baptist, titled *Ut Queant Laxis* ("A Hymn to John"). Each line of that melody was one note higher than the prior one. The verses went like this:

*Ut queant laxis
resonare fibris,
Mira gestorum
famuli tuorum,
Solve polluti
labii reatum,
Sancte Iohannes.+*

Taking the first word of each stanza, Arezzo developed a musical hexachord comprised of six notes: **ut, re, mi, fa, sol, la**. These symbolized the notes C, D, E, F, G, and A. Somewhat later, the note B was added, represented by **ti**, and the initial **ut** was changed to **do**, giving us

our familiar octave **do, re, mi, fa, sol, la, ti, do**. This, of course, was fortunate for Julie Andrews, Rodgers, Hammerstein, and the von Trapp children, else they would not have been able to sing "Doe a deer a female deer, ray a drop of golden sun, me a name I call myself...." etc.

Symbols are often used in place of words. During the 1960s – the era of "flower children" and "hippies" – large crowds of young people gathered to protest the Vietnam War and plead for nuclear disarmament. Two such notorious convocations were the "Be-In" which occurred in Golden Gate Park, San Francisco, and "Woodstock," which was held on a 500 acre farm near Woodstock, New York. A prominent symbol of these gatherings was the Peace Sign worn by many of the participants. This symbol had been fashioned in 1958 by Gerald Holtom, a British artist. To represent "**nuclear disarmament**," he borrowed from naval semaphore in which the sign for "N" is two flags held in an inverted V and the sign for "D" is represented by a single flag held aloft: Putting these two signs together he created the peace sign¹:

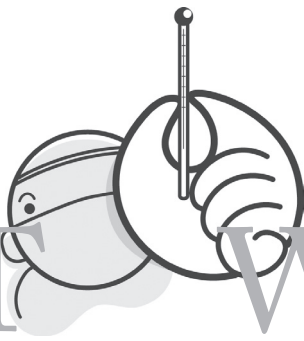


Words, whether actual or symbolic, allow us to communicate complex thoughts and sophisticated concepts. That is the major reason we no longer live in trees.

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

Reference:

1. Wikipedia
<http://www.teachpeace.com/peacesymbolhistory.htm>



HIPPOCRATIC OATH

(ANCIENT VERSION)

I SWEAR by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

TO HOLD HIM who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art - if they desire to learn it - without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I WILL APPLY dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I WILL NEITHER give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I WILL NOT USE the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

WHATEVER HOUSES I MAY VISIT, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

WHAT I MAY SEE OR HEAR in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

IF I FULFILL THIS OATH and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

—Translation from the Greek by Ludwig Edelstein. From *The Hippocratic Oath: Text, Translation, and Interpretation*, by Ludwig Edelstein. Baltimore: Johns Hopkins Press, 1943.

(MODERN VERSION)

I SWEAR to fulfill, to the best of my ability and judgment, this covenant:

I WILL RESPECT the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I WILL APPLY, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I WILL REMEMBER that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I WILL NOT BE ASHAMED to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I WILL RESPECT the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I WILL REMEMBER that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I WILL PREVENT disease whenever I can, for prevention is preferable to cure.

I WILL REMEMBER that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

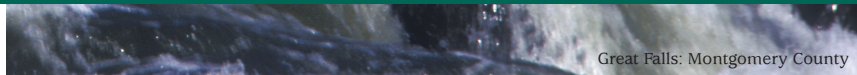
IF I DO NOT VIOLATE THIS OATH, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

—Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.





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