FINDING OUR WAY THROUGH THE HAZE:
Reflections on the Professional and Personal Impact of the Pandemic

Results of Our 2021 Physician Salary Survey

In Their Own Words: Physicians Share How COVID Impacted Them

It’s Tax Season: New Limits for 2022
From the President...

Loralie Ma, MD

It’s 2022 and we are still in the midst of the COVID pandemic. I well remember the beginning of the pandemic: the uncertainty, the shut down, the fear, and the drastic changes we had to make. Physicians and front line health care workers put their lives at risk; some lost their lives. To these physicians we will always be grateful for the ultimate sacrifice they made on behalf of their patients.

At first, physicians were unable to practice unless in emergent settings; gradually we returned to work, learning new facts and gaining new tools for fighting this disease. MedChi was there for physicians, providing updates on the pandemic from the Department of Health, helping us obtain PPE, and keeping us informed.

As we adjusted to a “new normal,” telehealth took on a new and larger role in patient care. Remote patient monitoring (RPM), another new tool, helped us treat chronic disease while reducing patient risk to COVID.

With the new variants, we find ourselves still in the throes of this persistent and changing virus. COVID is an ever-changing virus. However, we have changed as well.

Many physicians have experienced burnout, depression, exhaustion, and a feeling of helplessness on top of pandemic fatigue. In the face of so much disruption in their work lives, some physicians chose to leave their practice; others opted for early retirement. Many physicians saw this as an opportunity for change: new jobs, new cities, new careers even. If you are considering a job jump or a transition, check out the findings from the Merritt Hawkins annual Physician Salary Survey (pg. 3), conducted on behalf of MedChi. Were you affected by COVID professionally or personally? If so you’ll find the article by Annette Pham, MD (pg. 7), perfectly relatable. I cannot imagine what it would be like to be in med school at a time like this, which is why I was fascinated to hear the perspectives from two of our Resident members (pg. 13)

This issue of Maryland Medicine is dedicated to practice viability. How has this pandemic affected your ability to practice medicine? The rapid spread of new variants forces us to continually adapt and change, to learn new therapies and to reject false information. The work is hard and sometimes disheartening, but it is tempered by a determination to help patients keep fighting the ravages of the disease. As always, MedChi is there to help as we fare forward into new territory.

What You Need to Know Now

1. Maryland’s Legislature is in session through mid-April. There are many legislative initiatives which are of interest and concern to MedChi. Pay attention to your inbox for legislative alerts asking for your immediate action to contact your legislator. As Tip O’Neill said, “All politics is local.”

2. Still have questions about the Provider Relief Fund Reporting? HRSA has developed a comprehensive FAQ which could be of help: https://www.hrsa.gov/provider-relief/faq/general.

3. Did you know that MedChi offers free CME credit for the Maryland Department of Health’s Wednesday evening COVID-19 webinars? We send an email with the webinar registration link on Wednesdays. If you are not receiving these emails, please contact members@medchi.org.

4. Regulations for electronic prescribing of Controlled Substances have been postponed until January 1, 2023 for both CMS and the state of Maryland. You MUST complete an on-line waiver form for the state of Maryland in order to avoid any potential penalties. The waiver for eRx in Maryland is https://www.cognitoforms.com/MDH3/ElectronicPrescribingWaiverRequest. If you would like to begin electronic prescribing now, there is an excellent app from DrFirst, a Maryland-based company, called iPrescribe: https://drfirst.com/solutions/mobile-apps/.

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A new survey indicates that wide pay gaps persist between male and female physicians in Maryland, and that Maryland physicians earn less on average than physicians nationwide. Conducted by Merritt Hawkins, a national physician search and consulting firm and a company of AMN Healthcare, on behalf of MedChi, the survey tracks compensation, benefits and practice metrics of Maryland physicians and compares them to physicians nationally. It benchmarks compensation among Maryland physicians by gender, age, ethnicity, and practice status, and examines how Maryland physicians were affected by COVID-19.

The survey shows that average annual 2020 pre-tax income for male Maryland physicians was $320,000 compared to $213,000 for female physicians, a difference of 49.6 percent. This is virtually the same disparity found in a similar survey Merritt Hawkins conducted for MedChi in 2018 examining the 2016 incomes Maryland physicians.

“The fact that significant gender-based income disparities persist among Maryland physicians is both disappointing and perplexing,” said Gene Ransom, MedChi’s CEO. “We expected to see at least some closure of this gap, but it remains as wide as ever.”

Even when compared by specialty groupings, male Maryland physicians earn considerably more than female physicians in the state, the survey indicates. The average 2020 pre-tax income for male primary care physicians in Maryland was $262,542, compared to $172,542 for females, a difference of 41.2 percent. The average 2020 pre-tax income for male surgical, diagnostic, and other specialists was $350,625, compared to $250,115 for females, a difference of 33.5 percent. Male physicians in Maryland who are in private practice make 30.9 percent more than female physicians in private practice, while employed Maryland male physicians make 39.3 percent more than female employed physicians.

The survey found that male and female physicians in Maryland work virtually the same number of hours per week, 48 for male physicians compared to 48.3 for female physicians, suggesting that gender-based physician income disparities in the state are not a result of longer hours worked by male physicians.

What accounts for these differences is difficult to pinpoint. “We see little difference in the employment contracts of male and female physicians,” said Tom Florence, executive vice president with Merritt Hawkins. “Nevertheless, the data show that female Maryland physicians earn less than males, even when specialty, hours worked, practice status and age are factored into the equation.”

MedChi has established a Gender Pay Equity Committee to examine and address gender-based income disparities, according to Ransom.

Income disparities among Maryland physicians also are seen among different ethnic groups. The average annual 2020 income for Maryland Asian/Asian American physicians tracked in the survey was $325,000, compared to $268,000 for white physicians and $225,000 for Black/African American physicians in the state.

The survey suggests that the pandemic had an inhibiting effect on the incomes of Maryland physicians. The average pre-tax 2020 income of Maryland physicians responding to the survey was $276,000, compared to $299,000 in 2016, well before the pandemic hit, a 7.7 percent decline.

Maryland Physicians Earn Less

Compared to physicians nationally, Maryland physicians are at the bottom of the income scale. For example, Maryland pediatricians reported average annual compensation of $165,000, compared to a national starting salary in the specialty of $236,000. Orthopedic surgeons in the state reported an

Incentives for Recruitment and Retention of Physicians During COVID-19

Clearly recruitment and retention of physicians during COVID-19 has been challenging. Physician employers are offering incentives to physicians:

- Increased salaries – especially for particular specialties, like primary care and psychiatry
- Signing bonuses increased across many specialties
- Greater schedule flexibility, including parent-friendly schedules
- Agreement to allow physicians to do more telemedicine and less in-person medicine
- Improved contractual terms favorable to employed physicians
- Enhanced paid time off

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COVID-Related Stress and Work Intentions in a Sample of U.S. Health Care Workers
Christine A. Sinsky, MD; Roger L. Brown, PhD; Martin J. Stillman, MD, JD; and Mark Linzer, MD

Original article published in December 2021 by Elsevier, Inc., on behalf of Mayo Foundation for Medical Education and Research. Approval was granted to *Maryland Medicine* to reprint this article for educational purposes; however, due to space limitations, only the abstract and discussion are reprinted here.

Abstract

Patients and Methods: Between July 1 and December 31, 2020, health care works were surveyed for fear of viral exposure or transmission, COVID-19 related anxiety or depression, work overload, burnout, and intentions to reduce hours or leave their jobs.

Results: Among 20,665 respondents at 124 institutions, intention to reduce hours was highest among nurses, physicians and advanced practice providers while lowest among clerical staff and administrators. Burnout, fear of exposure, COVID-19-related anxiety/depression, and workload were independently related to intent to reduce work hours within 12 months. Intention to leave one’s practice within 2 years was highest among nurses, other clinical staff, and physicians while lowest among while lowest among administrators. Burnout, fear of exposure, COVID-19-related anxiety/depression, and workload were predictors of intent to leave. Feeling valued by one’s organization was protective of reducing hours and intending to leave.

Conclusion: Approximately 1 in 3 physicians, APPs, and nurses surveyed intend to reduce work hours. One in 5 physicians and 2 in 5 nurses intend to leave their practice altogether. Reducing burnout and improve a sense of feeling valued may allow health care organizations to better maintain their workforces postpandemic.

Discussion
In this national study of 20,655 health care workers across multiple role types, we found that approximately one-third of physicians, APPs, and nurses intend to reduce work hours in the next 12 months. Furthermore, 1 of 5 physicians and 2 of 5 nurses are moderately likely or higher to leave their current practice within 2 years. Because multiple studies have demonstrated that intent to leave among physicians correlates with actual departures, these findings are of concern. Costs of replacing health care workers are also substantial. Replacing a nurse may cost up to 1.2 to 1.3 times their annual salary. Replacing physicians may cost $250,000 to more than $2.0 million per physician. The aggregate cost of physicians reducing or cutting back attributable to burnout alone is estimated at $4.6 billion annually in the United States. Additional excessive health care costs are borne by payers in the first year by payors after patients lose their primary care physicians for any reason. Higher levels of burnout, stress, workload, fear of infection, anxiety/depression due to COVID-19, and years in practice area each associated with greater intention to reduce work hours and leave one’s current practice. In contrast, feeling highly valued by one’s organization is associated with lower such intentions. To our surprise, COVID-19 load by county was not associated with intent to reduce work hours or leave current practice, although individual exposure to COVID-19 was not determine in the current study.

Our findings have implications for the adequacy of the US health care workforce. Nurses, physicians, and APPs are at highest risk for intention to reduce clinical work hours or leave their current practice. Prior literature has shown that approximately 25% to 35% of physician who express intention to leave carry out that intention within 2 to 3 years. It would be challenging during ordinary times and even more so were there to be further COVID-19 surges, if a substantial portion of the 40% of nurses and 23.8% of physicians who expressed an intention to leave left their positions.

A recent post in the management sphere predicts a “tsunami” of workers leaving their roles when the pandemic ends. In their survey of non-healthcare workers, one half are seeking other jobs and 25% say they will quite their jobs. They refer to this as “pent-up turnover.” The US health care system may face a similar workforce shortage post COVID-19 due to such pent-up intentions.

Our study provides health care leaders guidance as they consider interventions to improve workforce retention. To

“One in five physicians and two in five nurses intend to leave their practice altogether.”

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The Impact of COVID-19 on My Personal and Professional Life: It Made Me Stronger

Annette Pham, MD, FACS

They say that "storytelling is the currency of life". It's what connects us to each other. We exchange this “currency” to hopefully learn from shared experiences. They also say that "experience is the best teacher." So this is my story and what I have learned. While my experience is by no means unique, I hope that by telling it, I can shed some positive light on the otherwise dark and heavy cloud hovering over all of us for these past two years.

The pandemic has been referred to as an active accelerant on healthcare. The hastened move towards telemedicine and remote patient monitoring; the transition to online conferencing and sharing of scientific data with a prolific number of papers being written in a short timeframe; and of course, the fast pace with which vaccines were developed and approved. Paradoxically, in other aspects of daily living, things slowed down.

In my personal life, my family and I suddenly had more time to spend together. Schools abruptly stopped and then struggled to make a meaningful curriculum out of a few hours of online classes a day. Extracurricular activities were nonexistent and since my meetings moved to an online format, there was less commute time. Lockdowns also meant no more leisure travel which my family and I sorely missed; it also meant that it would be almost fourteen months before my parents visited from California (which I had grown accustomed to, especially the extra help.) My kids rediscovered their loving sibling rivalry; interacting with each other in a more meaningful way rather than spending hours in their rooms. I reveled in rediscovering the Nintendo and Pokemon card games we played when the kids were younger. My husband found the joy of the sourdough starter. Actually, we all found the joy in the sourdough starter, collaboratively baking such delights as sourdough-based pizzas and waffles!

For our family, the pandemic became like a magnifying glass, forcing us to look closely at what was important. We were kinder; we were more patient; and we really did enjoy each other's company. While we realized the value of spending time together, we also recognized the importance of having alone time: time to ourselves to process what was going on outside of our existence as a family.

In my professional life, the impact of COVID seemed harsher. The practice all but shut down except for keeping patients out of the ER for issues that could be treated in an outpatient setting. My divisional partner announced he was leaving the practice; and our lease was due to expire with a newly negotiated lease in the works, all at a time when revenue streams were starting to dwindle and thin out. But with that same magnifying glass applied, this seemingly challenging circumstance became an impactful moment in my career. The staff rallied and while I still felt the burden to thwart the possibility of layoffs, it somehow all worked out.

To be fair, this “somehow” wasn’t just happenstance. It was through the hard work of my colleagues and our collective hive: the larger partnership group which had formed a few years prior. Before we became unified, we were siloed as divisions located in different regions of Maryland, DC, and Virginia, operating like separate states rather than a single country. The pandemic pushed us to become unified and to work as one, trusting in each other. We tapped into each other's experiences and unified plans to address the pandemic from both the clinical and the business side. We rallied for each other and formed stronger bonds.

At the same time, I was becoming more involved in organized medicine as the president of the Montgomery County Medical Society, and Covid kept us nimble and alert. As soon as one piece of information became available, another piece would replace it. We had to be flexible to stay relevant.

All these experiences taught me about the importance of perspective. My pandemic magnifying glass showed me that the little things do matter, as the sum of all the parts is greater than the whole. Every shared story is an opportunity to become a more valuable member of society. In retrospect, the pandemic made me, my practice, and my family stronger.

Annette Pham, MD, is a double board-certified otolaryngologist and facial plastic surgeon currently practicing as a partner physician at Metro ENT and Facial Plastic Surgery, a division of the Centers for Advanced ENT Care, located in Rockville, MD. She is Immediate Past President of Montgomery County Medical Society. She can be reached at drannette09@gmail.com.
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MedChi, The Maryland State Medical Society, established the Maryland Physician Health Program (MPHP) in 1978 by physicians, for physicians.

REMEMBER, YOU ARE NOT ALONE
The Impact of COVID-19 on the Viability of Medical Practice

Julia Konovalov and Kate Gilman

The impacts of COVID-19 have been felt by virtually every health care practice in the United States. From decreased hours and schedules, cancellation of elective and non-life-threatening procedures, a significant increase in virtual medicine, short supply of PPE, and hysteria from patients, physicians and other clinicians have had the burden of trying to save lives while maneuvering in a complex and ever-changing environment. Let’s look at some monumental changes that were implemented when the coronavirus started to spread, and some predictions for the near future:

Regulatory & Legislative Requirements

In response to the coronavirus epidemic, the government issued many new laws and regulations that made it easier for patients to seek medical care and for physicians and other clinicians to deliver it. Here are some highlights:

Telehealth: mandates were passed to decrease requirements for telehealth, allowing physicians and patients to seek virtual care from the comfort of their homes. They also permitted non-HIPAA approved devices to be used for telehealth, and all payers to pay for audio-only and traditional virtual visits.

Cross-state border license: another mandate that was approved during the coronavirus emergency was lessening up on cross-state border requirements. Essentially, physicians were allowed to treat patients virtually, even if they resided in a different state. Off campus hospital/temporary expansion locations - the government tried to increase hospital beds by utilizing other facilities and enabling physicians to treat patients at additional “satellite” venues.

Alternative health care physicians: the mandates gave broader rights and privileges to nurse practitioners, physician assistants, and clinical nurses.

These mandates, along with many others, have been constantly evolving to address the immediate needs and turn of events. Though adjustments had to be made, these regulations made access to care more available.

Patient Care

Patient care delivery drastically altered during the coronavirus emergency. Offices had to quickly adjust to seeing and treating patients virtually. Both physicians and patients had to learn how to use various electronic devices and platforms, such as Zoom, patient portals, and many other programs, to communicate effectively during their e-visits.

If in-office visits were necessary, staff had to wear Personal Protective Equipment (PPE) (which was often in short supply) and allocate adequate time to sanitize between patients. Many patients were instructed to wait in their cars until they were ready to be seen, to avoid gatherings in the waiting room. Even the number of people who could ride in elevators in medical office buildings was limited, and sanitizing wipes, masks, and antiseptic had to be readily available.

Health care practices were instructed to provide educational material to patients about preventing the virus, ways to keep safe, and what to do if they got sick. Posters can be seen everywhere about the importance of properly washing hands, wearing masks, getting vaccinated, and not gathering in large groups. Many physicians sent this information electronically to all their patients and mailed out pamphlets of the latest guidelines. To stay abreast of the most current information, staff time had to be allocated to learn the latest CDC guidelines, update office policies, and get this material to their patients.

Human Resources

Personnel challenges have been and continue to be significant during the pandemic. As vaccines were rolled out, so were the mandates about health care workers and requirements for employment. Many health care practices proactively initiated vaccine requirements for their staff, prior to government directives. This created many challenges, such as shortages of workers, exemption reasons that needed to be considered, and

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How COVID-19 Has Impacted My Practice and Our Ability to Practice Medicine

Joe Weidner, Jr., MD

Our practice had a head start. We were blessed to have developed a pandemic box years prior, considering the potential impact of Ebola and SARS-1. And yes, it was literally ONE box, but this one box saved us in those early weeks, enabling us to continue seeing patients.

We had a learning curve. My staff and I became religious in attending MDH COVID updates and listening to This Week In Virology (TWIV) podcast. We quickly educated ourselves about COVID.

Roles expanded for many office staff. Many nonclinical personnel took on additional temporary roles as scribes, entrance monitors, temperature checkers, parking lot managers, and vaccine testers.

Practice income diversified. During the first several months of the pandemic, we saw patient volume drop by as much as 30 percent. Thankfully, MDPCP and HRSA provider fund payments kept us financially sound. Additional revenue came from in-office COVID testing and monoclonal antibody administration.

Patient care settings and focus changed. We quickly innovated and began to evaluate and treat patients outdoors, under a roofed drive-through. Performing procedures such as EKGs, PFTs, cerumen lavage, and joint injections outdoors was a huge departure for me. Attention to quality measures waned. Implementation of practice improvements focused rarely on areas that did not address COVID. All these made me question the quality of care our patients received.

COVID measures pervaded our every thought. Throw out unused St. Patrick’s Day surgical masks from last year? Looks like we’ll use them. We upgraded one exam room to a negative pressure room, and added HEPA filtration units and UV air purifiers throughout the office. Still, I vacillate between “Are these measures enough?” and “Is this too much?”

Personal Protective Equipment (PPE) affected patient communication. It quickly became evident how patients with some degree of hearing loss were previously reading our lips. PPE made it more challenging to effectively engage with patients, given the compromise of not seeing our full range of facial expressions.

Patient–provider interactions became strained. When we followed the COVID guidelines for isolation, quarantining and testing, our patients became frustrated and distrustful of us. At times my patience was stretched thin, especially when patients second-guessed my judgement.

Internal relationships became strained. At times anxiety ran high among staff. Occasionally there were disagreements in mitigation strategies and the value of vaccination. We felt that we were “holding an umbrella up,” to protect those who were saying it wasn’t raining. In spite of this, our team was able to pull closer together and look beyond our differences.

In the end, COVID produced resilience. In June of 2020 I commissioned a pin for everyone at Stone Run to wear and gave many away to those who helped in the COVID fight. I figured this was going to be a long war, and as military campaigns had pins to honor those who were part of a campaign, so should we. Our staff wear the pins as a show of solidarity now.

Joe Weidner, Jr. MD FAAFP practices at Stone Run Family Medicine and can be reached at drweidner@fkwmd.com.
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How COVID-19 Affected One Trainee
Karen Dionesotes, MD, MPHP

As a psychiatry resident working in the Internal Medicine program at Johns Hopkins Bayview Medical Center, what has stuck with me the most during COVID-19 pandemic has been its effect on our population’s mental health. The impact of quarantine and resulting isolation, along with general fear of the virus and its potential morbidity and mortality has led to a significant increase in psychiatric care, especially for older adults. The influx of older adults into our mental health system allowed me to learn more about the intricacies of caring for our aging population and cultivate an interest in geriatric psychiatry.

COVID-19 has also resulted in an increased awareness of mental health as a part of overall health, resulting in legislation at both the state and national level. My involvement in organized medicine leads me to advocate for aspects of mental health policy that I find important — including increased funding for mental health services with a focus on the older population, and supporting patients’ access to telemedicine.

Access to telemedicine was a concern of mine during my undergraduate medical training in Nebraska. I remember interviewing for residency programs and inquiring about telemedicine as part of the residents’ program. As a result of COVID, I now see many of my patients via audio or video connection with the occasional office visit in-between, which has made access to care easier, especially for those with limited mobility or who live outside of Baltimore City. As much as I value my face-to-face patient time, the ability to utilize telemedicine has substantially lessened the burden on patients who require frequent visits.

Despite the devastating aspects of COVID, these last two years have afforded me more time and training to manage the psychiatric needs of my elderly patients, and to incorporate telemedicine as a part of my practice, which I intend to maintain moving forward in my career.

Karen Dionesotes, MD, MPH, is a third-year psychiatry resident at Johns Hopkins General Psychiatry Residency Program and can be reached at karendionesotes@gmail.com.

Creating a Safe Space for Sharing in Medical School
Emily Daniels, BA

When I started medical school in 2020, I embarked on a journey I never envisioned: everything was virtual: from lectures, to group learning sessions, to patient encounters. It was challenging trying to piece together what I had learned on the screen and then apply it to a patient in front of me. Being virtual made it difficult to make friends, and since I didn’t have roommates, I spent the vast majority of my time studying alone. Oftentimes my neighbor was the only person I spoke to. Like everyone, the pandemic posed great challenges to my mental health and well-being. Adjusting to medical school was difficult enough but transitioning in isolation made it that much harder.

I’ve always wanted to specialize in psychiatry, so I was excited when our school added two wellness representative positions to our Student Government Association. I ran for, and landed, one of the positions and quickly got to work bridging the social gaps caused by the pandemic. We planned numerous events, some with the school’s counseling center, to further the conversation of wellness and help students feel less alone. One event, of which I am most proud of, was Managing Expectations in Medical School. That evening, students, residents, and others shared their struggles maintaining wellness during med school. In an effort to ease anxiety surrounding pre-clinical course grades, we asked administration to share statistics on the student-residency match program data. The numbers were reassuring, showing that most fourth-year students matched with one of their preferred programs.

With more than eighty in attendance, we were the first to host an event of this kind. Many residents on the panel reached out to say, “I wish we had had something like this in school!” Faculty members shared their personal mental health challenges and vulnerabilities, many suggesting the event become an annual one.

The increase in open conversations around mental health has been a silver lining on the dark cloud of this pandemic. While there is a more work to do, we have made great strides. I am more excited than ever to go into psychiatry and be a part of this progress. Encouraging vulnerability and creating a safe space for these conversations is just the beginning of changing the culture in medical school.

Emily Daniels, BA, is a second-year medical student at University of Maryland School of Medicine and can be reached at emilydaniels@som.umaryland.edu.
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average annual salary of $394,000, compared to a national starting salary of $546,000.

“The fact that the total compensation of many Maryland physicians lags what is typically offered as a starting salary nationally underscores the relatively low incomes of physicians in our state,” said Loralie D. Ma, MD, president of MedChi.

Despite this, the majority of Maryland physicians (52.3 percent) described their income as somewhat or extremely reasonable given their effort and expertise, compared to 33.8 percent who described their income as somewhat to extremely unreasonable.

COVID-19 and Workforce Volatility
One half of Maryland physicians surveyed (50.3 percent) said they were not professionally affected by COVID-19, a surprisingly high number given the widespread disruption caused by the pandemic, according to Ransom. Approximately 5 percent closed their practices due to the virus, 4.3 percent joined another practice, 3.7 percent were furloughed, 3 percent found work in another field, 1.2 percent were laid off, and 1.2 percent retired.

“COVID-19 caused a surge in physician workforce volatility in Maryland,” said Dr. Ma. “Practice closures, physician layoffs, and physician departures from medicine are likely to compound staffing challenges at health care facilities throughout the state.”

Survey data are based on responses from 506 Maryland physicians with a margin of error of +/- 4.0 percent. A copy of a report on the survey's findings is available to members only at medchi.org.

meet the societal need for medical care in the future, it will be necessary not only to train new health care workers but also to address attrition in the current health care workforce. A comprehensive approach by national policy makers and health care delivery institutions will be necessary to address this challenge. Here, we briefly mention potential approaches for some of the key factors associated with intent to reduce hours or leave.

Stress and burnout: Leaders can focus on providing adequate personal protective equipment, creating supportive environments, ensuring access to confidential services for mental health and reducing work overload through better teamwork. Applying a systems approach to interventions, aimed at improving organizational culture and practice efficiency will be most successful at reducing burnout.

Feeling valued by one's organization: this was associated with less intent to reduce hours or leave one's job. Mechanisms to enhance health care workers’ sense of value are needed. Transparent communication, support for childcare, and rapid training to support deployment to unfamiliar units may demonstrate organizational appreciation to workers.

morality questions. Many nurses and physicians refused to get vaccinated and had to be let go. In addition, health care workers have seen a lot of mental and physical burnout, from staff and physicians. Many were asked to work overtime, as demands for care kept growing and staff shortages increased. Recruiters and Human Resources Departments across the country were actively looking for healthcare personnel to fill in the gaps, from small practices to large ones. Incentives, such as higher salaries, increased signing bonuses, fewer hours, and increased schedule flexibility, have been offered to attract new staff.

**Impact on Practice Revenue & Expenses**
Financially, COVID-19 has taken a big toll on healthcare practices, employers, and workers. Though the government provided Paycheck Protection Programs, many grants, and payer pay-ahead models, most healthcare practices have significantly suffered during the pandemic. The decrease in patient volume, postponement of surgeries and procedures, staff shortages, and increased costs to sanitize and utilize PPE, have impacted the bottom line. Most practices are still not back to their normal volume compared to pre-pandemic. Many continue to provide most of their visits virtually. Though Governor Hogan in Maryland has created a mandate to promote telehealth and require payers to reimburse for it at the same rates as in-person visits, revenues have been much lower for most practices, since the pandemic began. This is mostly due to decreased volume of patient visits, billing departments trying to catch up from closings or working remotely, and high staff turnover. In addition, many payer pay-ahead models that were extremely helpful during the start of the pandemic, are being retracted from physician's bank accounts, at much faster rates than they anticipated.

There's been a slow increase in remote patient monitoring utilization, as practices seize the benefits of following their patients virtually. Some of it has been difficult, due to lack of staff resources, but overall, it is seen as a beneficial tool, by most physicians.

**Crystal Ball Projections**
It will be a while before everything settles down and the "new normal" takes place. However, as people keep getting vaccinated, possibly experience a mild case of Omicron variant, the fear of the virus will start to decline. People are learning to live with this virus and work amongst it. The health care field has seen the benefits of telehealth and some hybrid version of it will permanently stay. CMS will continue to strive towards value-based care and away from fee-for-service payment models. This will ensure physicians focus on long-term outcomes for their patients, promote continuity of care, and decreased hospitalizations.

People are resilient and will continue to strive forward, even during setbacks. Staff shortages will remain as a top concern for the upcoming year, but hopefully as everything starts to stabilize, so will the employment gaps. Most people are tired of sitting in their house and want to come out, work, and socialize with others.

Government and payer flexibility will be important, as health care physicians try to recoup their losses and adjust to the new "normal." Grants and payer incentives will be very helpful in expediting the revenue streams for practices.

Though no one truly knows what the future will bring, the quickness with which health care workers have been able to pivot during the pandemic has been incredible, regardless of the hardships they had to overcome. Challenges will always be present, but the health care workers will continue to navigate through them to provide optimal care for their patients!

*Julia Konovalov and Kate Gilman, CPC, CPCO, are founders of Medical Business Partners, LLC, a health care consulting company. They can be reached directly at julia@medicalbusinesspartners.com or kate@medicalbusinesspartners.com.*

**The Center for a Healthy Maryland**

**is pleased to present a Silent Auction at the Presidential Gala for Loradie Md, MD on Saturday, April 2, 2022. If you would like to donate art, experiences, event tickets, vacation homes, gift certificates, or other items, please contact Meg Fielding at MFielding@MedChi.org. Funds raised will support the Center's projects and programs. Thank you!**
Making Genetic Risk Assessment and Testing Part of Routine Practice

Flynn O’Neill, FNP, and Reza Sanai, MD

In my thirteen years of practice as a family nurse practitioner focused on women’s health, I have seen some progress in the standard of care for hereditary cancer risk assessment amongst primary care providers, though I believe we still have a way to go. COVID-19 has disrupted cancer screening resulting in a new health crisis of delayed diagnoses.

The 2017 ACOG Practice Bulletin reaffirms the statement that ‘hereditary cancer risk assessment should be part of routine Ob/Gyn practice.’1 Cancer risk assessment improves patient care and outcomes, and hereditary cancer risk assessment is now standard in many practices.

[...]

1. Be disciplined in gathering family history. Simplify the process of gathering family history information for new patients and returning patients by employing an electronic or paper screening tool. Electronic screening tools can be shared with patients in advance so that they have time to collect information from family. By opening this conversation in a systematic manner, your office will consistently gather the necessary patient information.

2. Integrate risk assessment, genetic testing, and interpretation of results into daily practice. Patients whose family history screening meets high-risk criteria should receive pretest education and genetic testing. Testing can be obtained through a blood or saliva sample and taken at the healthcare office or at home. For most patients, testing is covered by insurance. Once test results are available, have a standardized process for patient follow-up, typically no more than four weeks after sample collection. When the workflow is operationalized, patients are less likely to miss a screening.

3. Partner with a high-quality lab. Choose a lab that has deep knowledge and expertise in genetic testing and provides a seamless process for the office. (Practices where I have worked have used Myriad Genetics with excellent results.) A high-quality lab partner will educate newer providers and help them remain up-to-date with the newest cancer screening technology.

Making these processes a routine part of a practice’s workflow requires the understanding and support of physicians and stakeholders alike. Much like recommending a colonoscopy for age-appropriate or at-risk patients for colorectal cancer, hereditary cancer risk assessment should be a routine part of preventive medicine.

Hereditary cancer risk assessment is now nationally recognized by the inclusion of genetic testing in recommendation statements by the United States Preventive Services Taskforce (USPSTF), American College of Obstetricians and Gynecologists (ACOG), Nurse Practitioners in Women’s Health (NPWH), and others. The American Academy of Family Physicians (AAFP) Clinical Preventive Service Recommendation states its support of the U.S. Preventive Services Task Force recommendation on Risk Assessment, Genetic Counseling, and Genetic Testing relative to BRCA-Related Cancer. This recommends that primary care clinicians assess women with personal or family cancer histories consistent with breast cancer susceptibility, and when indicated, offer counseling and genetic testing.

I have seen the power and impact of genetic testing firsthand. I’ve seen hundreds of patients who are provided with critical information that changes their lives. A former patient of mine once sent me an email that said: “I wanted to reach out to share my eternal gratitude for your fervent recommendation I get tested for the BRCA gene a few years back. I was just diagnosed with triple negative breast cancer at thirty-seven — which we found early because of the routine imaging I followed at your guidance. In short, you saved my life.” Reading the words of this young woman reminds me that screening can save lives. For women who qualify for testing, finding those whose history may provide a key to preventing this deadly disease makes dedicating time to these efforts forever worthwhile.


Flynn O’Neill, FNP, is a Family Nurse Practitioner and Senior Provider Liaison at PicassoMD. Reza Sanai, MD is a cardiologist and co-CEO of PicassoMD.
How NOT to Avoid a Plague: A Review of COVID Misinformation in the Marketplace

Stephen J. Rockower, MD

- The Truth About COVID-19, by Dr. Joseph Mercola and Ronnie Cummins, with a forward by Robert Kennedy, Jr.
- Pandemia, by Alex Berenson
- A Plague Upon Our House, by Scott Atlas, MD

With our medical focus on how to prevent, manage, and cure COVID-19, there is a significant force in the marketplace to spread misinformation about the causes, the development of vaccines, and the profits being made in treating the disease. These three books, as examples, demonstrate the fear, distrust, and paranoia that drive a large marketplace, and serve to reduce and destroy confidence in our leaders, the CDC, and other organizations whose mission is to preserve health in the population.

While Wakefield's 1998 paper in The Lancet did not begin the anti-vaccine mindset, it certainly greatly strengthened it. Perhaps the 1982 exposé against the Pertussis component of DPT shots began it. There were those who protested Edward Jenner's introduction of a Smallpox vaccine.

In The Truth About COVID-19, the authors make the case that the virus was lab-engineered in the virology lab of Wuhan, China, as directed by Dr. Anthony Fauci of the NIH under "gain-of-function" research, and promulgated throughout the world, aided by the World Health Organization (WHO), "Big Pharma," Bill Gates, Jeff Bezos, Mark Zuckerberg, and many others. Everybody in the Mass Media is censoring the information from reaching the public. The cure, "obviously," is a combination of "organic and regenerative food, complemented by appropriate nutritional supplements, herbs, and natural health remedies", which Dr. Mercola is all too happy to sell on his web site. There's also a little anti-Semitism thrown in, using a well-known dog-whistle: "We believe that the biotechnocrats, the military, and the transnational economic elite (emphasis added) hell-bent on global domination have overreached themselves."

In Pandemia, Berenson recounts factually much of the early history of the COVID outbreak. He is quite skeptical, however, of the government's explanations of anything, and of the treatments proposed by government physicians. He is partial to the disproven hydroxychloroquine controversy, and believes it wasn't given a chance. Vitamin D and zinc were all that was missing from the "cure," which would have made the hydroxychloroquine work. He praises the president who predicted a death rate of under 1 percent and criticizes "the pundits" who thought it would be higher. "COVID wasn't truly a threat to society — as opposed to a danger to some elderly and vulnerable people." It seems there are 850,000 reasons he was wrong.

In A Plague Upon our House, Atlas purports to restore trust in government, public health leadership, science, educational leadership and fellow citizens. He does this by decrying the "overt bias of the media, the lack of diverse viewpoints on campuses, the absence of neutrality in controlling social media … and the intrusion of politics into science." He doesn't comment that the largest cable news network has its own bias, is not neutral, and has succeeded in imposing politics into everything. It is curious, however, that in both Mercola's book, and Atlas' book (widely distributed by Amazon), that both authors complain about how they are muzzled and cannot get their ideas distributed to their followers. Atlas himself was featured daily on national news outlets in the presidential news briefings on Covid.

Caroline Orr Bueno, PhD, a post-doctoral fellow at the University of Maryland's Applied Research Lab for Intelligence and Security who studies misinformation and disinformation in media, speaks about purposeful communication on social media that is often intended to sway people on the opposite side. She stresses the need to be mindful of what we see and hear on social media and the news and consider whether there is an ulterior motive. Are they trying to sell you something? Are they trying to direct you to or away from a political viewpoint? Dr. Bueno believes that physicians in direct communication with their patients are better positioned to counter the disinformation presented online. Quiet, non-confrontational conversations of factual data are the most effective ways to help change viewpoints.

We recently witnessed a rally in Washington, DC, spearheaded by Robert F. Kennedy, Jr., trumpeting the dangers of vaccination and masking. As shown by his forward in the Mercola book, he likens current scientific consensus to the Spanish Inquisition. "It is a fabricated dogma constructed by this corrupt cast of physician technocrats and their media collaborators to legitimize their claims to dangerous new powers." Dr. Orr Bueno says information only exists in their world as a weapon, not a tool for knowledge or enlightenment. It is difficult to counteract the fear promulgated by these people, but we must. Our lives and those of our patients depend on it.

Stephen Rockower, MD, is a past President of MedChi. His Twitter handle is @DrBonesMD.
Despite No New Tax Legislation, New Limits for 2022

Brian J. Horan, CPWA®, West Financial Services

This article is the second in a two-part series on financial information for physicians.

Since the 2020 election, a lot of time and attention has been spent reporting on potential tax changes that might be passed into law by Congress. However, by the end of 2021, none of the proposed bills were able to garner enough votes in both the House and Senate. While the opportunity for passing new laws is still something to monitor, there are a few things to take note of this year, due to the existing rules set forth in the Tax Cuts and Jobs Act of 2017:

1. The standard deduction for married couples filing jointly for tax year 2022 rises to $25,900, up $800 from 2021. For single taxpayers and married individuals filing separately, the standard deduction rises to $12,950 for 2022, up $400, and for heads of households, the standard deduction will be $19,400 for tax year 2022, up $600.2

2. The annual gift tax exclusion amount rises to $16,000 in 2022, an increase of $1,000 over what was allowed in 2021. The lifetime estate and gift tax exemption amount also increases this year. Individuals can now gift up to $12.06 million (married couples up to $24.12 million).2

3. Although contribution limits on Individual Retirement Accounts (IRAs) did not change for 2022, the limits on contributions to workplace retirement plans increased by $1,000. Individuals can now contribute up to $20,500 ($27,000 if you are fifty years or older in 2022). The maximum total contribution, including employer matching, increased by $3,000, to $61,000 ($67,500 for employees over fifty years old).2

4. 2022 is the last year in which you can utilize the 100 percent bonus depreciation rules for assets acquired and placed in service. Beginning in 2023, the bonus percentage will decline annually until 2026, when it decreases to 20 percent (unless Congress passes new legislation). As this is the last year for the maximum percentage, it’s a good time to consult with your tax advisor if you are thinking about purchasing a high-cost piece of equipment for your business.2

As you can see, while none of the considered proposals made it into law in 2021, there are still opportunities to increase your savings as you plan for the future. The start of the year is an opportune time to check in with your financial advisor to see how these new limits could affect your situation.

H. Margret Zassenhaus Award

The MedChi Ethics Committee is currently soliciting candidate names for the H. Margret Zassenhaus Award.

Named in honor of the German physician who secretly saved the lives of political prisoners in Germany during World War II, this award recognizes a Maryland physician who has taken extraordinary risk to his / her own professional or personal status for the good of patient care and in keeping with AMA principles of Ethics. The award recipient is selected by a committee composed of MedChi’s Sitting President, Immediate Past President and President Elect. Nominations must come from MedChi members.

To learn more contact Chip O’Neil at Coneil@Medchi.org.
Montgomery County Medical Society Begins 2022 with New Initiatives

Susan G. D’Antoni

Montgomery County Medical Society (MCMS) began the new year with several new initiatives to engage physicians and the community. Two of these are highlighted below.

In February, MCMS held its 2022 Red Dress Event: Renewal & Revival for Women Physicians. The virtual event was fun and engaging and including a game of trivia related to notable women physicians in history, and four breakout sessions. The breakout sessions included Optimizing the Every Day which focused on lifestyle changes made during COVID-19 to improve personal and professional satisfaction; Professional Headaches, Heart Aches & Growth which focused on workplace snafus, ongoing frustrations, and stories of overcoming workplace challenges; Work-Life Balance: What’s That? Tips & Ideas for Getting There; and Pandemic Parenting which focused on the challenges of child rearing during the pandemic.

Other fun aspects of this event included sharing of a variety of women physician “superhero” visual Zoom backgrounds for attendees.

In January, MCMS and their related National Capital Physicians Foundation, launched the Webster Sewell, M.D. Access to Care Award. Dr. Sewell was devoted to improving access to care and saw patients without regard to their ability to pay throughout his career. He was one of the first African American physicians in Montgomery County. MCMS and NCPF wish to recognize individuals and organizations which are devoted to increasing access to medical care in meaningful ways. Nominations and applications can be submitted through early March.

MCMS, like all medical associations, is looking forward to reconnecting with physician members in-person later this year.

Susan G. D’Antoni, FAAMSE, is CEO of Montgomery County Medical Society. She can be reached at sdantoni@montgomerymedicine.org.

BCMSF and ABC Partner to Promote Healthy Hearts

Lisa B. Williams

The Baltimore City Medical Society Foundation (BCMSF) recently co-hosted the Association of Black Cardiologists’ annual “Spirit of the Heart Community Forum and Wellness Symposium,” the first held in Baltimore. Speakers representing faith, education, and health organizations shared their current efforts to improve heart health.

BCMS President and BCMSF board member, Camellus Ezeugwu, MD, a cardiologist, facilitated a panel discussion on additional strategies to improve heart health for immediate and long-term implementation.

In addition to the symposium, BCMSF will work with ABC to implement other components of the “Spirit” initiative this year.

Lisa B. Williams is CEO/Executive Director of Baltimore City Medical Society/Baltimore City Medical Society Foundation. She may be reached at info@bcmsdocs.org

Renee Bovelle, MD, Immediate Past President of The Maryland Society of Eye Physicians and Surgeons (MSEPS), accepted the 2021 AAO Star Award presented to MSEPS for innovative delivery of education and value to its members for the 2021 Webinar Series.
MedChi’s Newest Physician Members

MedChi welcomes the following new members, who joined between November 23, 2021, and January 31, 2022.

Sozdar Abed, MD — Women Ob/Gyn
Abdulhosein N. Adham, MD — Capital Digestive Care
Harvinder S. Arora, MD — Adfinitas Health
Pamela M. Aung, MD — Erickson Health Medical Group of Maryland, PC
Romana Baig, MD — MidAtlantic Permanente Medical Group
Mark S. Baran, MD — Adfinitas Health
Desha D. Bedford Kelly, MD — Adfinitas Health
Wondaferew Berhie, MD — Adfinitas Health
Charles Bier, MD
Kevin L. Carr, MD — Adfinitas Health
Pamela Castillo-Martinez, MD — Capital Women’s Care, Div 33
Jeremy James Chaillet, MD — Adfinitas Health
Jiayan Chen, MD — Adfinitas Health
Olivier De Roet, MD — Adfinitas Health
Sydney DeAngelis, MD — US Acute Care Solutions
Robert Lee Dewitty, Jr., MD
Esther Estwick, MD
Anthony C. Falvello, DO — Peninsula Orthopaedic Assoc., PA
Chong Fang, MD — Patient First
Henry B. Fox, MD — Henry B. Fox, MD
Jessica Friedman, MD
Ajay Gangalam, MD — Mid-Atlantic Nephrology Associates
Aman Gebremedhin, MD — Adfinitas Health
Mustafa Gedik, MD — Adfinitas Health
Scott Gelman, MD — Peninsula Orthopaedic Associates, PA
Amy Marie Gillis, MD — Mid-Atlantic Permanente Medical Group
Daniel B Herring, MD — Western Maryland Dermatology
Jonathan Tze-Wei Ha, Mid-Atlantic Permanente Medical Group
Rotimi Iluyomade, MD — Patient First
Ruth M. Jacobs, MD
Jenna Jarriel, MD — Emergency Service Associates, PA
Emmanuel Jean - Louis, MD — Patient First
Kamani Karandana, MD — Patient First
Zeleke Kassahun, MD — Adfinitas Health
Jason Kehrer, MD — Associates in Radiation Medicine
Pankaj Kheterpal, MD — Charm City Healthcare LLC
Jeffrey Young Kim, MD — Capital Digestive Care
Nana Kutateladze, MD — Adfinitas Health
Jennifer Zone-En Lee, MD — Capital Digestive Care
Mark J. Lester, MD — Annapolis Pediatrics
Alisha Tuteja Liu, MD — Mid-Atlantic Permanente Medical Group
Himabindu Manneri, MD — Adfinitas Health
Jose Martinez, MD — Adfinitas Health
Denny Mathew, MD — Adfinitas Health
Marcela McDonald, MD — Women Ob/Gyn
Marsha Carol McNeely, MD
Matthew Micco, MD — Adfinitas Health
Miriam B. Michael, MD — Adfinitas Health
Sana Misalati, MD — Adfinitas Health
Maryam Y. Mizrahi, MD
Anitha Nallu, MD — Mid-Atlantic Nephrology Associates
Kelvin Ng, MD — Patient First
Olubunmi Omolewa Ogunwole, MD — Adfinitas Health
Ijemma Okereke, MD — Mid-Atlantic Nephrology Associates
Daniel Portee, MD — Patient First
Jason Rahme, MD — Adfinitas Health
Jared W. Reaves, MD
David George Rorison, MD — Patient First
Maham Saeed, MD — Adfinitas Health
Kaung San, MD — Adfinitas Health
Frances D. Seymour, MD — Miles River Physicians
Aliya Shaikh, MD — Patient First
Novia Singh, DO — Mid-Atlantic Nephrology Associates
Kunal Sood, MD — National Spine & Pain Center
Clarie Staley, MD — Adfinitas Health
John Edgar Tis, MD — Mid-Atlantic Permanente Medical Group
Pratiksha Vaghela, MD
Ariel Warden-Jarrett, MD — Maryland Primary Care Physicians, LLC
Mozella Williams, MD
Megan Willwerth, MD — Cumberland Valley ENT Consultants
Daren Yang, DO — Mid-Atlantic Permanente Medical Group
Bess Yi-Shan Yeh, MD — Mid-Atlantic Permanente Medical Group
H. Jay Zwally, MD — Patient First
MedChi Events

A complete list of MedChi and component events can be found at: http://www.medchi.org/Calendar-of-Events.

MARCH
16: Baltimore County Medical Association Board of Governor’s Meeting
17: MedChi Board of Trustees Meeting
24: Rural/Small Components Advocacy Lobby Day

APRIL
2: MedChi Presidential Gala for Dr. Loralie Ma
13: Baltimore City Medical Society Board of Directors’ Meeting
13: Baltimore County Medical Association Board of Governor’s Meeting

MAY
1: MedChi Spring House of Delegates Meeting
11: Baltimore City Medical Society Board of Directors’ Meeting
19: MedChi Board of Trustees Meeting

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Our Most Recent Acquisition:
Tristram Thomas, MD

Tristram Thomas, MD, was one of the 101
Founders of MedChi. He
was generally described
as being very tall, with
narrow, sloped shoulders
and carrying a cane
made from wood from
the Mount of Olives.
Dr. Thomas began his
practice in Trappy in
Talbot County, and
then moved to Easton, where he practiced for fifty years.
He was often referred to as “the very model of a polished
gentleman” by his contemporaries.

MedChi was recently given a portrait of Dr. Thomas by
one of his descendants, who is also a MedChi member.
We are so pleased to receive this painting. It is a welcome
addition to our collection of historic portraits, which
date back to the late 1700s and continue up to the 1960s.
Research on this painting will take place this spring.

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MedChi History/Events

Our Most Recent Acquisition:
Tristram Thomas, MD
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